



NHS
Modernisation Agency

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National Primary and Care Trust
Development Programme



*National Institute for
Mental Health in England*

The Commissioning Friend for Mental Health Services

A Resource Guide for Health and Social Care Commissioners



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JANUARY 2005

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01 | Introduction

1.1 Purpose

This **Guide to Commissioning Mental Health Services** is the second in a series of guides developed by the National Primary and Care Trust Development Programme (NatPaCT) to assist Primary Care Trusts (PCTs) and Local Authorities in the vital role leading 'Whole System Commissioning' of health and social care. The structure and content has also been informed by a wealth of inputs from the National Institute for Mental Health in England (NIMHE) whose aim is to improve the quality of life for people of all ages who experience mental distress. Working beyond the National Health Service (NHS), NIMHE helps all those involved in mental health to implement positive change, providing a gateway to learning and development as well as offering new opportunities to share experiences and providing an access point to find information on all aspects of mental health. NIMHE's local development centres and national programmes of work help put policy into practice and to resolve local challenges in developing mental health www.nimhe.org.uk

This Guide has been designed to support PCTs and Local Authorities in understanding how to use their commissioning activities as a key part of improving the mental health of the communities they serve by:

1. Highlighting key priorities in commissioning services to promote positive mental health as well as treating those with diagnosed problems.
2. Providing a step by step guide to the commissioning process based on good practice research on commissioning services published by NatPaCT www.natpact.nhs.uk/cms/99.php#prep, and the Audit Commission's **Making Ends Meet** models and protocols www.joint-reviews.gov.uk/money as well as examples from practice.
3. Adding a series of appendices providing links and information to easily access internet resources and key publications that provide detailed information on relevant evidence based research, specialist centres and pressure groups (Appendix C).

1.2 Scope

The guide adds to rather than replicates the guidance from the original Commissioner's Friend www.natpact.nhs.uk/cms/99.php which although primarily addressing the pressing issues of effective commissioning of Acute and Specialist Services, was designed as a base template for Whole System Commissioning of all services.

There are 2 versions of this document available on CD-rom and on NIMHE's web site:

- On-screen version Adobe Acrobat PDF file with hyperlinks and quick click links between sections.
- Printable version Adobe Acrobat PDF file for printing to a desktop printer.

It is designed to cover the range of mental health priorities set out in the National Service Frameworks (NSF), NHS Plans and National Institute for Clinical Excellence (NICE) guidelines. In doing so it takes account of:

- Relevant guidance documents published by the Department of Health.
- Advice and research from a wide range of agencies, universities, charities, pressure groups and voluntary bodies.
- Good practice case studies.

The guide provides a route map to good practice and links to specialist resources rather than being a comprehensive encyclopaedia summarising all the research and practice relevant to mental health services. Specifically it provides for commissioners a framework for thinking about the commissioning issues and how their actions can make a contribution to the positive mental health of the communities they serve as well as to the effective support of those with diagnosed problems.

1.3 Structure

Section 1 sets the policy context

Section 2 explores the levers and alliances to secure improvements in mental health. In many cases there are a greater range of opportunities than for commissioning other services but these may demand a detailed review of current practice linked to different perspectives on mental health and certainly new ways of working. In particular commissioners may need to decommission services from traditional providers in order to commission a range of new services.

Section 3 sets out how PCTs and Local Authorities can work together, and with other stakeholders, to develop a strategic vision for their communities.

Section 4 suggests mechanisms for evaluating the effectiveness of current practice.

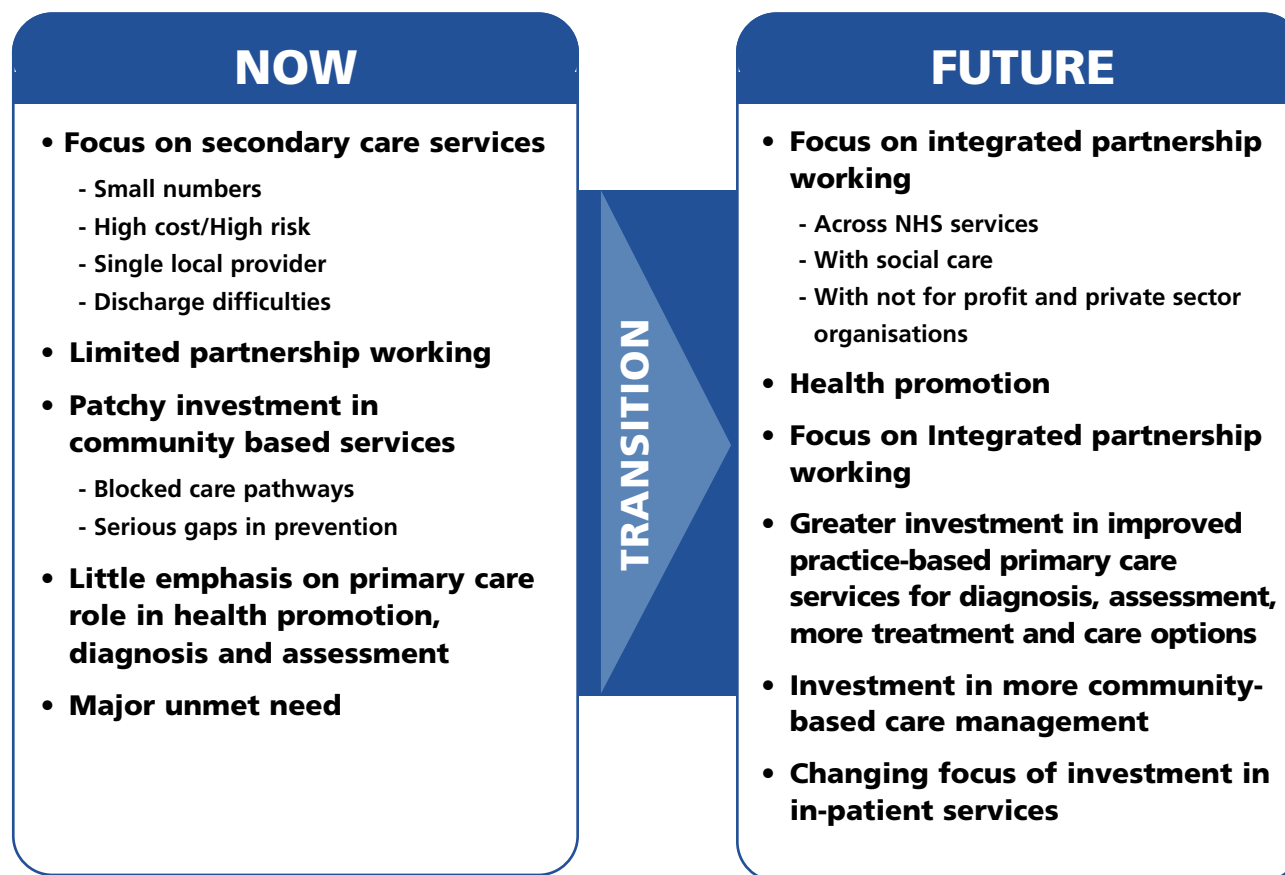
Section 5 presents a framework for ensuring effective commissioning predominately as a collective activity but also sets out mechanisms for ensuring that PCT provided services align with the overall strategic direction.

There are web links to relevant sites and publications throughout the document and the Appendices provide a more detailed route map to specific resources.

Because of the complexity of the approaches needed to promote mental health and provide support to those with diagnosed problems there can be a temptation to deal with other priorities and maintain the status quo because acute mental health services are perceived as a 'small problem'. As Section 2 will explore in more detail promoting positive mental health has major benefits to communities. Research also indicates that **one in four people will experience mental health problems** and much of this is already treated in primary care. Effective commissioning should therefore be recognised as a priority for PCTs and Local Authorities.

1.4 The key challenges facing the mental health commissioner

What does this mean for mental health?



Because of the complexity of the approaches needed to promote mental health and provide support to those with diagnosed problems there can be a temptation to deal with other priorities and maintain the status quo because acute mental health services are perceived as a 'small problem'. As Section 2 will explore in more detail promoting positive mental health has major benefits to communities. Research also indicates that one in four people will experience mental health problems and much of this is already treated in primary care. Effective commissioning should therefore be recognised as a priority for PCTs and Local Authorities.

Because mental health services lie outside the first phase of the Payment by Results (PBR) initiative many PCTs have yet to give it as much attention. We are therefore proposing that PCTs and their partners take the opportunity for a stock-take of what's going on now (Section 4) as well as planning explicitly for change in the future (Section 5). To represent the range of support provided to people with mental health issues some PCTs and their partners have found it useful to adopt the 'tiered model' originally introduced in 1995 for Child and Adolescent Mental Health Services (CAMHS).

It is clear however that this model needs adaptation to meet local circumstances. In Section 4 therefore, we have proposed an audit approach which enables commissioners to form an accurate picture of current services which can then be mapped against the tiers (or other models such as the Steps model proposed by the National Institute for Clinical Excellence - NICE) depending on what best meets their local needs. In using the tiering model it is important to remember that its main use has been in the analysis and reconfiguration of how services are provided to people with diagnosed problems. As Section 2 demonstrates there is an increasing emphasis on promoting the positive mental health of the overall population of whom those with on-going conditions are only a part. Commissioners will therefore need to incorporate strategies for positive health promotion as well as for early diagnosis and treatment.

Categorising the different levels of service provision is a technique which allows the mapping of services as they are now and as it is desired that they will be in the future to clearly identify the specific changes in configuration which are envisaged. One example is described below:

Level 0 – self care and support from family and friends

Level 1 – primary mental health care (9 out of 10 people with mental health problems receive all of their care at this level)

Level 2 – community residential, day and home-based services providing a range of short term interventions for common mental health problems and recovery-orientated services for people with longer term needs

Level 3 – emergency and acute care, including acute inpatient care and crisis resolution and home treatment

Level 4 – highly specialised ‘low volume high cost’ services such as for people who offend, those who need medium to long term secure settings and people with complex and severe eating disorders

Since this year’s commissioning cycle is already well under way the tools described in sections 4 and 5 can be used in parallel so that the strategic direction is set at the same time as assembling a robust set of data on current practice to allow commissioners to determine where current practice and expenditure aligns with the future aspirations and where there needs to be a rebalancing of resources.

There is no doubt that the issues are complex but a systematic approach should enable commissioners to identify the most effective pattern of resource distribution and secure some ‘quick wins’ which have the potential to be a positive benefit to many in the communities they serve.

1.5 Balancing local provision and access with “plurality”, “diversity” and “choice”

A key challenge for commissioners is to establish open book relationships with local providers whilst developing a range of additional options for providing services, which can appear contradictory. However, a thorough analysis of needs matched against current capacity will make it possible to develop a mutual benefit approach to developing capacity by modelling demands for services against current and future performance requirements.

We recommend that this “mutual benefit” approach is based on the following criteria:

1. Promoting early diagnosis of mental health problems.
2. Improving the skills of all health professionals who may come into contact with people with mental health problems so that they follow good practice guidelines to be able to diagnose the problem at the earliest possible stage and appropriately treat or refer.
3. Service users should be treated at the earliest point in the system appropriate to their condition i.e. only being treated in secondary or tertiary environments when it is appropriate to the needs of their condition.
4. Access to care should be appropriate to the diagnostic and treatment needs of the individual.
5. An integrated approach is taken to the provision of care to allow appropriate planning and treatment of patients with multiple health needs.
6. Care should be as local as possible.
7. Packages of care should meet all the needs of service users and their family/carers.
8. All care should represent the best value for money available.

There is much interdependence and common ground between existing providers and commissioners. High public expectations and increases in secondary care referrals mean that acute providers need to work in partnership to ensure that there are appropriate referrals and early discharge schemes in place if they are to meet challenging performance requirements. There is an increasing policy emphasis on the active management of chronic conditions so as to reduce the number and length of all forms of inpatient referrals. **PCTs and Local Authorities will need therefore to continually develop good practice models of integrated health and social care management for the majority of mental health conditions in the community.**

1.6 The legislative framework

1.6.1 The Mental Health Act 1983

This is the principal Act governing the treatment of people with mental health problems in England and Wales. The Mental Health Act covers all aspects of compulsory admission and subsequent treatment. Besides these emergency procedures, there are other sections of the Act under which a person can be detained in hospital without their consent.

Only a small number of professionals are involved in applying the Act. These are primarily Approved Social Workers (ASWs), GPs and doctors approved under Section 12 of the Act - either psychiatrists or others with experience in mental health who have been certified by the Department of Health. Each professional completing a recommendation for detention performs a detailed assessment of the client's mental state and circumstances. If any one of them feels there is insufficient evidence to recommend detention, the person cannot be kept in hospital.

1.6.2 Patients' rights under the Mental Health Act

The Mental Health Act sets out a number of safeguards to protect patients:

- Patients are entitled to an explanation as to why they are being detained. Professionals must ensure that the person detained understands their detention order, and knows how to appeal or complain; they must help the person do this if requested.

- People who have been detained for more than a few days have the right to appeal against their detention to a Mental Health Act Review Tribunal, an independent committee comprising medical, legal and lay people, who have the power to discharge them in certain circumstances. Patients are entitled to free legal representation in these appeals.
- The Mental Health Act Commission is a government body established to monitor the care of people who are detained, and to ensure that their rights are being upheld. The Commissioners make regular visits to all hospitals, and will also respond to individual requests for visits. Most hospitals also have an independent hospital managers' committee to protect the rights of detained people.

Details of the legislation, guidance for GPs and relevant case law can be found at:

www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/MentalHealth/MentalHealthList/fs/en?CONTENT_ID=4001816&chk=Tg1/Et

1.6.3 Proposed new legislation

In September 2004 a new draft Mental Health Bill was presented to Parliament by the Secretary of State for Health. The purpose of this Bill is to introduce a new legal framework for the treatment of people with a mental disorder who meet all the relevant conditions. The powers that the Bill provides are subject to a number of safeguards, which define when a person can be treated without her or his consent; and what that person's rights are in such a case. The Bill will be subject to pre-legislative scrutiny by a parliamentary committee, which has been asked to present its report by the end of March 2005. The full text can be found at:

www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsLegislation/PublicationsLegislationArticle/fs/en?CONTENT_ID=4088910&chk=6GB8PU

Explanatory notes on the Bill can be found at:

www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsLegislation/PublicationsLegislationArticle/fs/en?CONTENT_ID=4088911&chk=/9UE0Q

1.7 Financing mental health services

1.7.1 Programme budgeting

Programme budgeting is starting across the NHS in 2004 and will start to provide similar information to the current Care Group analysis. Further analysis should be undertaken within the care group or programme budget of “mental health”. This is clearly a large area of ‘spend’ and involves a number of significant specialty areas. This can be analysed as:

- Child and adolescent mental health services (if not in a children’s care group).
- Adult services.
- Services for older people age over 65 (if not in an older people’s care group).
- Alcohol and drug services.
- Forensic/secure services.

Under programme budgeting all of the above is classed as ‘mental health’. As the scheme is undergoing its first sweep this year it will probably take another two years before the data is sufficiently assured for true comparative purposes.

1.7.2 Earmarked funding for mental health services

Currently there are some specific funds designated for mental health, which have been earmarked for the next two years. The drive to devolve greater commissioning responsibility to PCTs and Local Authority partners has been linked to an overall a reduction in the level of earmarked funds in order to give them the flexibility to meet locally identified needs. It will be important for PCTs and Local Authority partners to actively manage the balance of priorities as mental health competes for resources against high profile performance requirements e.g. waiting time reductions. Whereas acute performance requirements form part of the PCT's key performance requirements under the star ratings, mental health performance requirements are only reviewed in the 'balanced score card' assessment.

Historic under-investment in mental health services is now manifesting itself in the high levels of special needs placements or, non-NHS out of area placements, for people with a wide range of mental health conditions. These may include:

- Service users who require low security and/or long term rehabilitation.
- Individuals who have personality disorders and with eating disorders.
- People who require intensive psychiatric care.
- Children with severe mental health problems.

Many of these areas are deemed to come under the remit of the regional specialist commissioning groups and thus require service development to occur at a much broader level than within individual or small clusters of PCTs.

It is important for PCT and Local Authority commissioners and service providers to realise that, although a number of elements in funding are for specific purposes, there is currently no formal ring fencing of funds by the Department of Health in PCT allocations. There are, however, a number of Centrally Funded Initiatives and Services and Special Allocations (CFISSA) budgets held at central level. Two such budgets are described below and they are being allocated to PCTs in 2004/05 and beyond.

(i) Child and Adolescent Mental Health Services (CAMHS)

A central allocation has been made to all PCTs in 2004/05 for improving CAMHS services. This funding is designed primarily to improve access to services, particularly those in Tier 3 and to reduce waiting times. The allocation will increase in 2005/06. The funding is linked to some extent to the special grant funding being given to Local Authority Social Services Departments, which was first issued in 2002/03 and that will see additional levels of grant up to 2005/06. The key performance requirement measures are

- An expectation that CAMHS services will grow by 10% per annum (this could be measured in a number of ways, including new staff (capacity)).
- Lower waiting lists (activity).
- Expenditure (increase).

PCTs and Social Services Departments are required to work together and jointly commission new/improved services with this funding to meet these objectives and those set out in Health Service Circular (HSC) 2004/002 CAMHS grant guidance.

(ii) Accelerated Discharge Programme (ADP)

The Department of Health has allocated specific revenue funding to support the early discharge of patients from Ashworth, Broadmoor and Rampton Hospitals since a number of the service users currently there do not need the very secure environment that these institutions provide and would be more appropriately treated elsewhere using medium secure forensic services.

This discharge programme has necessitated the development of facilities in those trusts that provide forensic services that PCTs have been required to fund, with specific financial support from the Department of Health. The recurrent funding starts in 2005/06 and support may be less than the full running costs of the new units so PCTs and Local Authority partners therefore need to ensure that this is adequately planned for and funded. Some non-recurrent resources are also available during 2004/05 to help pump-prime elements of the developments and to fund recruitment as well as enabling a number of interim arrangements to be established.

(iii) Other earmarked funds

A further central allocation is expected to be made for service users with a dangerous and severe personality disorder (DSPD). This resource is indicated in PCT baselines for 2004-2005 but has not yet been allocated from the centre. Strategic Health Authorities (SHAs) and PCTs will be required to ensure that this funding goes to high secure hospitals and is not disbursed generally into the local health systems.

There may be other CFISSA funds for mental health, but these are not yet known or are specific for particular issues or areas of the country.

02 | Commissioning to improve mental health

2.1 The performance requirements

The most recent summary of what Government wants to achieve in relation to mental health is set out in **Improvement, Expansion and Reform: The Next 3 Years - Priorities and Planning Framework 2003 - 2006:**

"MENTAL HEALTH

Objective

The Mental Health National Service Framework (NSF) and Suicide Prevention Strategy set out a modernisation programme to:

- Reduce the suicide rate and deaths by undetermined causes by 20% by 2010.*
- Improve access to general community mental health services.*

Services should be delivered in line with the standards in the Mental Health NSF, the Mental Health Implementation Guide, national mental health strategies and compliance with NICE appraisals/guidance. Comparative clinical audit and information from the Mental Health Minimum Data Set (which should be implemented in all trusts by 03/2003) should be used to develop services, and the National Institute for Mental Health England will support development work. Modernisation will be supported by a new mental health legislative framework. NHS and Social Services joint responsibility will be delivered through Local Implementation Team partnership.

The Children's NSF and its emerging findings will set out the standards and milestones for improvement in child and adolescent mental health services (CAMHS), including year on year improvements in access.

Performance requirements

- *Reduce the duration of untreated psychosis to a service median of less than 3 months, (individual maximum less than 6 months) and provide support for the first three years for all young people who develop a first episode of psychosis by 2004.*
- *Offer 24-hour crisis resolution to all eligible patients by 2005.*
- *By Dec 2003, deliver assertive outreach to the 20,000 adult patients with severe mental illness and complex problems who regularly disengage from services.*
- *Increase breaks available for carers and strengthen carer support and networks to the benefit nationally of approximately 165,000 carers of people on Care Programme Approach (CPA) by 2004.*
- *Improve mental health care in prisons so that all prisoners with severe mental illness have a care plan by April 2004 (approximately 5000 prisoners nationally) and ensure appropriate use of secure and forensic facilities by 2004, contributing to the national performance requirement of moving 400 patients from high secure hospitals by 2004.*
- *Ensure that by April 2004 protocols are in place across all health and social care systems for the care and management of older people with mental health problems.*

National capacity assumptions

- *Expanded service capacity in key services, to contribute to national requirements by 2004 of 335 crisis resolution teams; 50 additional assertive outreach teams; 50 early intervention teams; 140 new secure personality disorder places.*
- *Reduced pressure on acute inpatient units by reduction in bed occupancy rate.*
- *All child and adolescent mental health services to provide comprehensive service including mental health promotion and early intervention by 2006.*

- *Increase child and adolescent mental health services by at least 10 per cent each year across the service according to agreed local priorities (demonstrated by increased staffing, patient contacts and/or investment)."*
www.doh.gov.uk/nhsplan/index.htm

2.2 The resource challenges

The Social Exclusion Unit's (SEU) report - **Mental Health and Social Exclusion published in June 2004** includes a useful summary of the costs of various forms of mental health services:

www.socialexclusion.gov.uk/downloaddoc.asp?id=134

- *"Cost per inpatient per day:*
 - *NHS psychiatric intensive care unit - £420;*
 - *Acute psychiatric ward - £165;*
 - *Long stay hospital £141.*
- *Cost per average stay in intensive care unit - around £5,169 and annual cost of care around £31,000.*
- *Community mental health team - around £59 per hour of patient contact.*
- *Specialist community psychiatric nurse - around £70 per hour patient contact.*
- *Cost of privately obtained talking therapy or counselling – around £732 per year.*
- *Basic cost of medication treatment for depression - around £170 per year."*

From these figures it is clear that, with limited resources available to meet the needs, **it is in the interests of commissioners to invest in the less costly early interventions to support people experiencing mental health problems** in order to minimise the use made of the most expensive forms of treatment which people may require if their conditions are left to escalate.

It is therefore important for commissioners to take a broad view of addressing mental health issues which goes beyond the high profile specialist and acute services that are traditionally labelled 'mental health' commissioned primarily from the local mental health trust or ear-marked 'section 31' funding of specialised care:
www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/IntegratedCare/HealthAct1999PartnershipArrangements/HealthAct1999PartnershipArticle/fs/en?CONTENT_ID=4000373&chk=vt%2BrPa

In reality nine of ten adults with mental health problems and 25 per cent of those with severe mental health problems receive all their care in primary care and 30% of GP consultations concern mental health problems:
www.scmh.org.uk

2.3 Promoting positive mental health

This same emphasis on the importance of early interventions through promotion and prevention is also captured in the first standard for mental health (NSF): www.publications.doh.gov.uk/nsf/mentalhealth.htm

“Health and social services should:

- a) Promote mental health for all, working with individuals and communities.*
- b) Combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.”*

The clear message for commissioners is therefore that all the research indicates www.socialexclusion.gov.uk/downloaddoc.asp?id=134 that investment (with partners) in improving the life chances and circumstances for all the communities they serve (including vulnerable individuals) will enable them to successfully manage a range of challenges, including mental health problems.

2.3.1 Defining positive mental health

Mental health is a concept which is defined in a number of different ways. Whilst traditionally there was a deficit model of mental health i.e. the absence of objectively diagnosable disease increasingly there is the acceptance of a positive holistic model of mental health as a state of physical, social and mental well-being.

The World Health Organisation has adopted the following definition:

“Mental health is a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community”.

The Mental Health Foundation has defined a mentally healthy individual as one who can:-

- *“Develop emotionally, creatively, intellectually and spiritually.*
- *Initiate, develop and sustain mutually satisfying personal relationships.*
- *Face problems, resolve them and learn from them.*
- *Be confident and assertive.*
- *Be aware of others and empathise with them.*
- *Use and enjoy solitude.*
- *Play and have fun.*
- *Laugh, both at themselves and at the world”.*

A further exploration of these concepts and how health promotion strategies can enable the widest number of individuals to attain them can be found at the National Electronic Library for Health:

www.nelh.nhs.uk/nsf/mentalhealth/whatworks/default.htm

Increasingly it is being recognised that individuals’ overall social and economic circumstances can dramatically affect their overall mental health www.socialexclusion.gov.uk/downloaddoc.asp?id=134 and therefore that it is essential that commissioners align their inputs with the overall strategies for community well-being that are devised and delivered through local partnership activity. Investment in supporting community outreach and voluntary sector groups with a prevention and promotion focus will enable the overall needs of vulnerable people to be addressed and thereby reduce the likelihood of their needing support from specialised mental health services. Certainly there is evidence of the effectiveness of this approach in working with young people who are the most likely groups to self-harm or commit suicide. www.nimhe.org.uk/smartsearch/itemdisplay_story.asp?id=654 Such approaches will therefore

assist in meeting the performance requirement to reduce the death rate from suicide and undetermined injury by at least 20% by 2010 required by the National Suicide Prevention Strategy for England:

www.nimhe.org.uk/whatshapp/item_display_publications.asp?id=397

2.3.2 Combating stigma and discrimination

Work is being undertaken to operationalise the second part of the first standard described above especially through proactive approaches to combat the stigma and discrimination associated with mental health problems across a range of community settings and with at risk and vulnerable groups. These negative attitudes and behaviours can make it harder for people to acknowledge they have a problem and get the support they need, and can also cause people with mental health problems to be treated with unwarranted distrust and fear as well as preventing people with mental health problems from getting equal opportunities in many areas of daily life. NIMHE is taking the lead in promoting good practice in anti-stigma and discrimination programmes. <http://nimhe.org.uk/antistigma> This research summary indicates that:

- A survey by Mind in 1996 found that almost half of respondents had been harassed or abused in public because of their mental health problems.
- In 2000 a survey by The Mental Health Foundation showed that 56% of people with mental health problems said that they had experienced discrimination within the family.
- In a March 2000 survey, 24% of the public thought that people with a history of mental health problems shouldn't be allowed to hold public office, and 19% were frightened at the prospect of people with mental health problems living in residential neighbourhoods.
- The Mental Health Foundation 2000 survey found that 42% of people with mental health problems didn't tell some members of their family about their experience, 22% didn't tell partners, 74% didn't mention it on application forms and 19% didn't even tell their GP.

People who use mental health services consistently identify the stigma and discrimination linked with their condition to be one of the most, if not the most, debilitating part of being diagnosed with a mental health problem. Conventionally stigma has been understood as a relationship between characteristics of a person and socially constructed negative stereotypes. The active discrimination that often accompanies mental health stigma has been identified as one part of the stigma problem. Programmes to tackle mental health stigma now place more of an emphasis on discrimination than stigma. This approach redirects the focus of programmes on to perpetrators of stigmatising behaviour and away from its victims. The NIMHE review identifies good practice examples already operating and identifies the critical success factors for any programme to address stigma and discrimination: <http://nimhe.org.uk/antistigma>

If members of local communities, health and social care professionals and employers can be encouraged to adopt more positive attitudes to people experiencing mental health problems the risks of these individuals becoming increasingly socially excluded will be diminished. The Sainsbury Centre for Mental Health estimates that the current annual cost of mental health problems in England is £77.4 billion. More than half that figure is accounted for by the impact on the individual's quality of life, including premature mortality. Output losses associated with missed employment opportunities were estimated at over £23 billion and state benefits to adults with mental health problems were estimated at £9.5 billion: www.scmh.org.uk/8025694D00337EF1/vWeb/fsCPIR4PDJ8T

As section 3 will indicate health and social care commissioners have (with their partners) significant opportunities to adopt a holistic approach to community development and well-being that will create both the strategic vision and operational mechanisms to enhance the lives of all the people they serve including those who are suffering from long and short-term mental health problems.

2.4 Resource challenges for commissioners

The Adult Mental Health NSF requires substantial transformational changes in the way that mental services are provided so that the focus is much more on community based care. This expands the service well beyond the traditional mental health team roles. The new teams are expected to provide a wide range of interventional and support services to help patients stay at home and avoid hospital stays.

The issues for commissioners and trusts are in balancing the number of beds available with the need for investment in the new services. The new services may require investment from PCTs and Local Authority partners alongside transformational savings as wards are closed and services re-engineered. Historically mental health services have been under-funded and the transformation of existing services cannot happen without additional investment from PCTs and Local Authority partners.

The key resource pressures that mental health trusts face include:

- Shortage of consultant psychiatrists and doctors generally.
- Costs of locum and agency doctors.
- Shortage of qualified nursing staff.
- High levels of expenditure on bank and agency staff.
- Drugs costs.
- Implications of NICE guidelines.
- Highly specialised care.

The NSF require a seamless service framework that incorporates community based treatment for the majority of service users but can also link effectively with inpatient facilities. If all of these services are in place and effective then there should be less reason for individuals to be placed in high cost private sector care.

Enabling more people to receive care in community settings means that mainly people with more complex needs will be admitted to inpatient facilities with the result that case mix on acute wards will focus on those service users who need considerable support. All mental health inpatient facilities therefore need a Psychiatric Intensive Care Unit (PICU) to provide a secure environment where individuals can be cared for a short period while their condition is being stabilised.

Patients with needs beyond those catered for by the above services, would probably fall under the regional specialist commissioning responsibility and would require PCTs and Local Authority partners to work together in larger geographic areas to commission appropriate capacity.

2.5 Payment by Results (PbR) and Choice

Mental health services are currently not included in PbR because:

- Delays in the implementation of a core minimum data set for mental health (MHMDS) and issues of data quality.
- Many trusts have not met the requirements for data collection as evidenced by the 2004 star ratings exercise.
- Lack of meaningful Health Resource Group (HRG) data for mental health services.

It is not envisaged that PbR will be rolled out to mental health until at least 2007/8 and not until the information systems are in place to support it. It is therefore likely that the 'Choice' agenda will have a greater impact for commissioners in the short term. Currently most specialist mental health service providers cover a large geographic area and most of their service users will require continuing follow-up and support while in the community. At present health commission performance measures assess trust's performance in keeping patients in-area and minimising the numbers of out-of-area referrals. This does not appear to be compatible with the choice agenda!

It seems likely that choice in mental health will therefore focus on choosing where there are options for treatment. It is unlikely to mean a choice of which provider an individual will be referred to as, given the sustained nature of relationship, there will be difficulties in working with providers at a greater geographical distance. Furthermore some patients are detained or sectioned under the Mental Health Act and would have less choice about their placement. Before any such system could be implemented the base data on relative costs needs however to be established and, as was outlined above, many trusts have some way to go in establishing even the minimum data set.

2.6 Primary care interventions to help people with mental health problems

Mental Health NSF Standard 2 states that

“Any service user who contacts their primary care health care team with a common mental health problem should:

- *Have their mental health needs identified and assessed.*
- *Be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.”*

Mental Health NSF Standard 3 states that

“Any individual with a common mental health problem should:

- *Be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care.*
- *Be able to use NHS Direct, as it develops, for first-level advice and referral on to specialist help lines or to local services.”*

Mental Health NSF Standard 4 states that

“All mental health service users on the Care Programme Approach (CPA) should:

- *Receive care which optimises engagement, prevents or anticipates crisis, and reduces risk.*
- *Have a copy of a written care plan which:*
 - *Includes the action to be taken in a crisis by service users, their carers, and their care co-ordinators.*
 - *Advises the GP how they should respond if the service user needs additional help.*
 - *Is regularly reviewed by the care co-ordinator.*
 - *Be able to access services 24 hours a day, 365 days a year”.*

www.publications.doh.gov.uk/nsf/mentalhealth.htm

The most recent national survey of the number of adults (16-74) with mental health problems and living in households (Singleton et al. 2001) sets out that at any one time:

- **One in Six adults** has **common mental health problems** i.e. anxiety, depression, phobias, obsessive compulsive, stress and panic disorders.
- **One in 200 adults** has **severe and enduring mental health problems** including psychotic disorders including schizophrenia and bipolar affective disorder and one in **25 adults** have a personality disorder.
- **One in ten new mothers** experience postnatal depression.

The overall figures are likely to be higher since the research did not include:

- People over 74 who have a greater risk of suffering from dementia.
- Prisoners of whom 72% of male and 73% of female sentenced offenders have two or more mental health disorders.
- Rough sleepers of whom up to 50% have mental health problems.

In addition research indicates that

“People with severe mental health problems are likely to eat less well, smoke more heavily and take less exercise than the general population, resulting in a higher risk of cardiovascular disease. They are up to three times more likely to be dependent on alcohol, and deaths from smoking-related diseases are twice as high among people with schizophrenia. Adults with common mental health problems have been found to be twice as likely to smoke as those with no mental health problems. Deaths from infectious diseases, endocrine, circulatory, respiratory, digestive and genito-urinary system disorders have all been reported as significantly more likely for adults with severe mental health problems. Similarly sustained stress or trauma may increase susceptibility to viral infection and physical illness by damaging the immune system:” www.socialinclusion.gov.uk/downloaddoc.asp?id=134

Since the standards were published PCTs have assumed the responsibility for commissioning mental health services. Historically these are most easily identified as those provided by specialist mental health trusts. However since 9 out of 10 people who receive treatment for mental health problems in primary care www.socialinclusion.gov.uk/downloaddoc.asp?id=134 it is important for commissioners to understand fully how that support is being delivered and how effective it is. Section 4 will provide the audit tools to assist this evaluation so this section will concentrate on a brief overview of key issues for primary care services.

2.6.1 Treatment options

As was outlined above, 30% of GP consultations concern mental health problems; numerically most of these are the 'common' mental health problems which have the potential of being dealt with effectively in primary care if the right form of intervention is made. The research indicates that **the most common form of intervention is the prescribing of drugs. The Department of Health Prescription Cost Analysis System indicates that in 2002 £400,000 million spent on prescribing antidepressant drugs (as opposed to £50 million in 1991)!** A recent survey found that 80% of GPs believed that they were over prescribing these drugs to people suffering from depression, anxiety or stress.

Part of the reason that there is the reliance on prescribing drugs is the lack of access to talking therapies. Although no statistics on waiting times are collected centrally anecdotal evidence gives a consistent picture of insufficient provision and therefore long waiting lists so that those who have the means regularly pay for this sort of support from non-NHS sources. The statistics for those who do benefit from talking therapies show that there are some anomalies which may need further investigation:

- Only 25% of those accessing counselling services are male despite the fact that young males are a particularly high risk group for suicide.
- Adults from minority ethnic communities are less likely to be referred for these sorts of treatments.
- 11% of respondents to the SEU survey referred to below identified the need for more access to these services.

www.socialexclusion.gov.uk/downloadaddoc.asp?id=134

2.6.2 Workforce issues

In addition to the overall shortage of people with specific expertise in working with people with mental health problems NIMHE assessment of current workforce issues indicates many health professionals acknowledge that they receive less training about mental health issues than for other conditions that they are likely to encounter in primary care (as well as in other settings). www.nimhe.org.uk/downloads/DOH%20MH1.pdf This has been addressed partly by the creation of new roles in primary care with a particular focus on mental health which can both provide direct help to those with common mental health problems and help them access the full range of help available to them both within health and social care and other forms of support including:

- 1,000 new graduate mental health workers to treat and manage common mental health disorders in primary care.
- 500 new gateway workers to link between primary care and specialist services.
- ‘Support, Time and Recovery’ or STR Workers, located in health, social care, housing or employment schemes.

The overall workforce issues are now being addressed through the **National Mental Health Workforce Strategy** www.nimhe.org.uk/downloads/DOH%20MH1.pdf (key aspects of this strategy are summarized in Appendix A).

This Workforce Vision translates into the following principles:

- “1. Services should be commissioned, provided and evaluated with the key purpose of making a positive difference to people with mental health problems, their family and friends.*
- 2. Staff are the means of delivering effective services and need to be valued and supported in doing this.*
- 3. Staff within the mental health workforce include professionally qualified and unqualified but trained practitioners.*
- 4. Staff may work in statutory services, NHS, social services at primary, secondary and tertiary levels, housing, police, probation and prisons or in non-statutory services, voluntary and independent sectors.*
- 5. Staff should reflect the culture of the local communities they serve, including the experience of those using mental health services.*
- 6. Staff should have the appropriate education, training and supervision to enable them to deliver person centred, socially inclusive services.*
- 7. Staff should work collaboratively and flexibly across disciplines and teams, overcoming professional and organisational boundaries, to meet the needs of the people using services.*
- 8. Service users’ and carers’ contributions are crucial to delivering effective services and need to be valued and supported.*
- 9. As a key contribution to meeting the above objectives, staff training should include opportunities to develop the Ten Essential Shared Capabilities (ESC) to support effective decision-making in the context of conflicting as well as of shared values and needs”.*

2.6.3 Holistic support

As the SEU report on mental health and social exclusion emphasises there is increasing evidence of how providing overall support to vulnerable individuals can reduce the likelihood of their mental health problems escalating as well as of them becoming socially excluded. The report presents examples of good practice that have had positive impacts on the communities where they have been piloted. These include:

- Bradford 'Health Plus' is a PCT-funded project with advisers in 30 GP surgeries focusing on benefits, debt, housing, employment and immigration rights. Staff are provided by local advice agencies. Evaluation demonstrated that 'Health Plus' saved time for GPs and nursing staff, as well as reducing stress/anxiety levels and improving the clients' quality of life.
- The National Institute for Adult Continuing Education supports over 20 'Prescriptions for Learning' projects in England. In the Nottingham pilot, 65% of clients referred had no qualifications, and almost all said that they would not have taken up learning without the help of the project. One quarter reported improvements in their mental health.
- 'Arts on Prescription' projects arrange referrals to local arts organisations. Early evaluation showed a reduction in the number of recognisable mental health problems amongst participants.

www.socialexclusion.gov.uk/downloaddoc.asp?id=134

2.7 Secondary care

Mental Health NSF Standard 5 states that

“Each service user who is assessed as requiring a period of care away from their home should have:

- *Timely access to an appropriate hospital bed or alternative bed or place, which is:*
- *In the least restrictive environment consistent with the need to protect them and the public.*
- *As close to home as possible.*
- *A copy of a written after care plan agreed on discharge, which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis”.*

Mental Health NSF Standard 6 states that

“All individuals who provide regular and substantial care for a person on CPA should:

- *Have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis.*
- *Have their own written care plan, which is given to them and implemented in discussion with them”.*

2.7.1 Community based services

It appears that the decision to refer individuals to specialist mental health services remains problematical and research has indicated that up to 28% of referrals from primary care to specialist services are inappropriate. www.mentalhealthstrategies.co.uk/pdf_files/Modern%20Guide.pdf The audit process outlined in Section 4 should assist in helping commissioners evaluate better the effectiveness of their current practice locally as well as their overall relationship with the specialist mental health trusts from which they commission services.

The majority of specialist support to adults with mental health problems is provided by multi-disciplinary Community Mental Health Teams (CMHTs). They support people with complex mental health problems (as well as their families) in the community when their needs cannot be met by GPs or generic social services. Patients are referred back to

their GP when their condition has improved. CMHTs also provide long-term care of people with enduring mental health problems.

In addition the NHS Plan introduced specialist teams in secondary care, with significant potential to build in a stronger focus on vocational and social issues.

- **Early intervention teams** provide community based treatment and support to young people aged 14-35 years with first episode psychosis. This should include ensuring that involvement in education and work is maintained, and future prospects are not unnecessarily jeopardised.
- **Assertive outreach teams** focus on adults aged 18-65 years with severe and enduring mental health problems, and additional complex needs such as homelessness, self-harm or neglect, or high levels of disability. Assertive outreach can achieve better outcomes than standard community care on accommodation status, employment and patient satisfaction.
- **Crisis resolution teams** aim to prevent the need for hospitalisation for adults having an acute psychiatric crisis. They provide 24-hour community-based treatment until the crisis is resolved.

In addition in 2002-03, health and social care spent £140 million on day and employment services for adults with severe mental health problems in England. Traditionally, day services have often focused on specialist support services that are solely for people with mental health problems. They often provide a 'one-stop shop', providing a practical place of support during the day, as well as access to other services and advice.

2.7.2 Inpatient services

Investment in more community based mental health services has been paralleled by some disinvestment and decommissioning of inpatient services. Whilst much of this is appropriate to the modernising of mental health services, it has, in some health communities, reduced significantly the number and range of inpatient facilities. **It is essential that commissioners maintain a positive, informed and considered approach to the continuing need for capital and revenue investment in inpatient facilities.** There will continue to be some individuals for whom these are

the most appropriate settings for the delivery of care on a long and short term basis. The benchmarks for these services were set by Government in 2002 in the **Adult Acute Inpatient Care Provision: Mental Health Policy Implementation Guide** www.nimhe.org.uk/whatshapp/item_display_publications.asp?id=310 and NIMHE has been tasked to assist the implementation of its key requirements which need to inform commissioning decisions and service level agreements with local mental health trusts:

- *“Define the purpose and place of adult inpatient care in their local mental health care system.*
- *Establish effective means of service co-ordination of acute services in a whole system of service delivery.*
- *Restructure ward arrangements to better provide a safe and therapeutic inpatient experience.*
- *Develop effective service user centred decision-making processes and ward arrangements.*
- *Address the need to enhance the role, status, training, support and career development of inpatient staff.*
- *Direct clinical leadership and management attention and expertise on the organisation and management of inpatient services.*
- *Ensure adequate clinical and support inputs to inpatient wards in order to maximise the time spent by staff therapeutically engaged with service users.*
- *Promote ways in which future acute care provision can project a more positive and socially inclusive and less disruptive perception of mental health.”*

Reports by the then Commission for Health Improvement and the Sainsbury Centre for Mental Health emphasised that there continue to be key challenges for operating these services that will have an impact on the effectiveness of the care that can be delivered.

“Mental health trusts are typically large organisations, with a range of Local Authority and PCT partners, operating from a multiplicity of sites. This makes the challenge for trust boards of communicating effectively with users, carers and staff and assuring the quality of services more difficult.

While mental health trusts are moving in the right direction, their ability to develop further the quality of their services is inhibited by serious capacity problems in management, staffing and the infrastructure and the scale of change needed. The ability of providers to meet the challenges set out in the national service framework is dependent on these capacity issues being resolved.

Shortages of skilled staff, problems in recruiting experienced managers and years of under investment in information systems inhibit progress. Similarly, staff and service users work too often in environments which are unacceptable. Within the sector itself, the focus on adult mental health services has been at the expense of, for example, services for older people and child and adolescent mental health services”.

www.chi.nhs.uk/eng/cgr/mental_health/mental_health_report03.pdf

“Inpatient care still consumes some £800m per year, representing some 25% of the total health and social care budget for mental health. Yet the limited evidence base does not support the use of inpatient care as a therapeutic intervention – it does however show that excessive lengths of stay are damaging.

There is overwhelming evidence of overcrowding, poor environments, a lack of coherent therapeutic programmes for service users, too many adverse incidents and staffing problems. Surveys of user views show that they are often frightened, bored or bewildered by their experiences in inpatient care and that they find it unhelpful and even damaging. Yet there are many dedicated staff working in the sector”.

www.scmh.org.uk/8025695100388752/GenerateFrameset1?OpenAgent&doc=wpPCHN4ULFWD

2.8 Tailoring care to meet the needs of all service users

Research has consistently demonstrated that many people do not receive the care tailored to their particular needs. www.nimhe.org.uk/whatshapp/item_display_publications.asp?id=689 Adopting the partnership approach described in Section 3 should ensure that future provision is commissioned with the needs of user groups in mind. As an aide memoir Appendix B provides links to the major research reports and websites that will help commissioners to ensure that they learn from established good practice.

03 | Working in Partnership

3.1 Why partnership working is important

As the SEU report on mental health and social exclusion emphasises people can rapidly become socially excluded and, in economic terms alone, cost more to re-engage and treat as well as no longer making an economic contribution to society as a whole. www.socialexclusion.gov.uk/downloaddoc.asp?id=134 The personal and emotional cost is also very high.

Section 2.1 stressed promoting positive mental health as a holistic activity that not only involves effective treatment but needs also to take account of individuals' socio-economic and emotional needs including provision of appropriate housing and employment opportunities. The recent Turning Point and Institute of Public Policy Research report explores the negative consequences of the current fragmented approach:

“Too often services fail to recognise the inter-connected nature of people’s needs, namely that people have physical, social and emotional requirements, and that their individual needs are closely related to factors in the wider community such as poverty and social exclusion. Many services tend to focus on people’s problems in isolation from the rest of their life. Rather than experiencing a single targeted intervention to meet their whole needs, they receive multiple interventions that lead them on an unpredictable and repetitive journey around different agencies”.

www.turning-point.co.uk/Information+Resources/Publications

The report then goes on to propose an alternative approach that provides a good basis for partnership working which should drive what people can expect from health and social care services.

“Whole Needs: An approach of understanding ‘the whole person’ rather than a single problem should become embedded in every stage of service delivery, from assessment and treatment to aftercare;

Creative Whole Systems Services: Rather than relying on average ‘off the peg’ methods, service providers need to be encouraged to be flexible and creative in their response to people;

Single Point of Entry: Users of all public services should be able to access an entire system of integrated support through a single point of entry;

User Empowerment: Users of social care services need to be recognised as equals and co-producers in their own care. The agenda of user empowerment cannot stop at the care of the most vulnerable.”

www.turning-point.co.uk/Information+Resources/Publications/

Both the NHS and social service departments have formal statutory responsibilities for people with mental health problems. In some cases, such as in relation to Section 31 funding, they are required to work together to meet the needs of service users. To make these arrangements work it is very important for there to be formal agreements so that a pooled fund can be established that allows full use of the health act flexibilities to be made. Section 31 will enable the control of all mental health placements and services to be managed by one organisation – the mental health trust social workers remain employed by the Local Authority pending a new Mental Health Act; all other staff can be employed by NHS.

Establishing pooled budgets is a performance requirement for PCTs, but there is a need for greater clarity about how this forms part of the performance management and star ratings measurement. Mental Health Trusts were required to have a measure of integration at multi-disciplinary Community Mental Health Teams (CMHT) level by 31 March 2004.

Despite the fact that the NHS and Local Authorities have been required to work together for some time all the evidence (including the Audit Commission's report on Transforming Primary Care) is that there is a considerable differences in the effectiveness of these working relationships including the extent to which each has recognised how to work effectively with the other's cultures and established ways of working. www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=ENGLISH^574^SUBJECT^605^REPORTS-AND-DATA^AC-REPORTS&ProdID=8AE80592-69BC-48bc-AA1A-C707CFAD8DE0&prodType=NATIONAL-REPORT

Unfortunately here are no magic solutions, only the need to work even harder to understand better the communities that health and social care serve and jointly work through how their needs can best be addressed. Crucial to this process is the effective involvement of service users and carers who are often in the best position to clarify what would best help them as well as how current approaches may need changing. Increasingly there is also recognition that voluntary sector organisations have a major part to play both as advocates and increasingly, as providers of services.

3.2 Working with stakeholders

3.2.1 Identifying and engaging stakeholders

One way of learning to work more effectively in partnership is to carry out an exercise together and one useful shared activity for PCTs and Local Authority partners is a stakeholder analysis so that they can be sure in mapping need that all voices are heard.

3.2.2 What is a stakeholder?

The term is used in a number of different ways. In simple terms stakeholders are internal or external organisations, groups or individual who can “throw a spanner in the works”. Effective identification of stakeholders needs to be systematic, thorough and analytical. The key steps in identifying and engaging stakeholders are:

1. Identify all the stakeholders
 - a. Establish key individual contacts within organisations.
2. Establish their
 - a. Power.
 - b. Influence.
 - c. Interests.
3. Manage conflicting interests
4. Develop a commitment matrix mapping
 - a. Where they are now?
 - b. Where they need to be?
 - c. Gap analysis to develop individual stakeholder strategies.
5. Develop a plan to manage the transition
 - a. Communication plan to address their interests.

Below is an example of categories of stakeholder relevant to how a PCT discharges its commissioning responsibilities for mental health; each of the cells will need to be carefully populated so that the PCT Board and senior management team can understand fully how partnership working can best be achieved. A similar exercise can then be carried out as a shared exercise with all commissioners:

Categories of Stakeholder

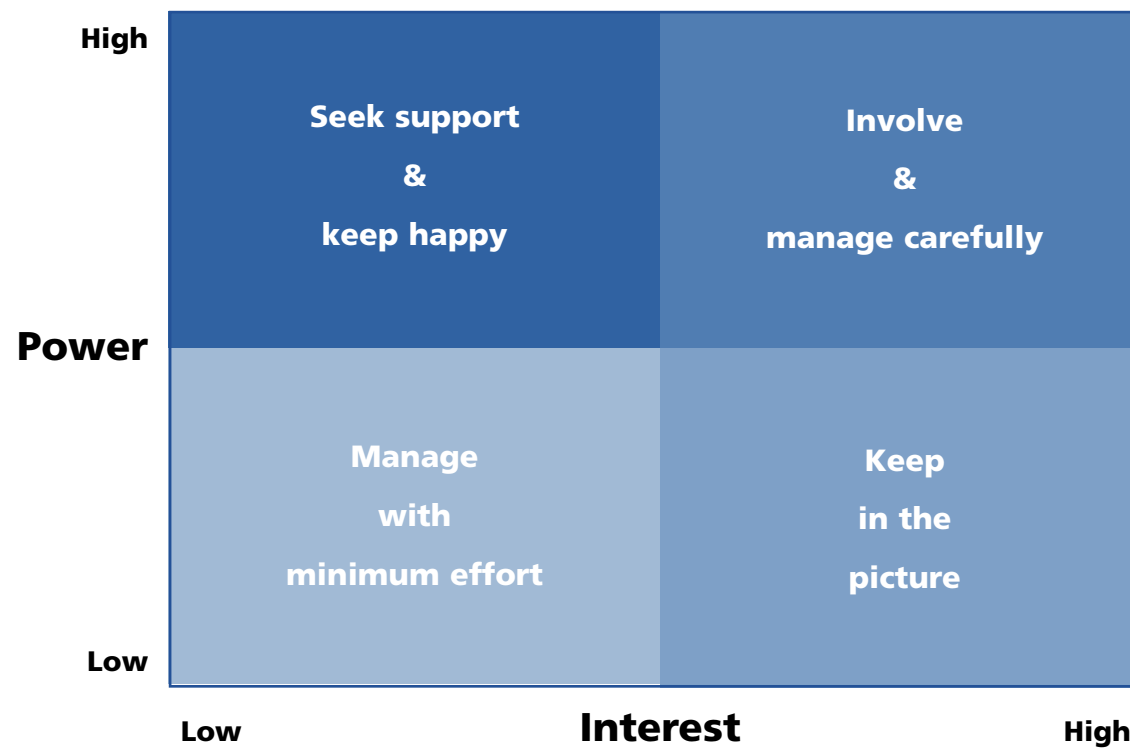
PCT	NHS	External
Board	DoH	Local Authority/ Housing/ Education
Professionals	SHA (WDC's)	Interest/pressure groups
Managers	Provider Trusts Levels 1/2/3	ISTC's/Private providers
Co-workers	Staff organisations	Media
Clients & Carers	Professional bodies	MPs/MEP's

To think of stakeholders in a slightly more sophisticated way it is helpful against each strategic objective to develop a commitment matrix mapping all of the stakeholders in terms of:

- Who needs to actively be involved in the delivery of the objective?
- Who needs to give support?
- Who needs to let it happen without blocking?
- Who is not relevant or important to the delivery of the objective but must not be ignored?

Below is a framework for mapping stakeholders in terms of where they are now and where you want them to be:

Stakeholder analysis matrix



From this analysis a stakeholder map can be developed which identifies the interest of each stakeholder and their importance to the delivery of the objective. This can be used as a basis for ensuring that all of the stakeholders' interests can be catered for in the commissioning and delivery programmes.

The content of the map should include:

- A matrix showing all the stakeholders or groups of stakeholders and their particular interest.
 - Conflicting requirements should be flagged for resolution.
- Communication routes and frequency for each stakeholder/group of stakeholders.

3.2.3 Communications strategy

The purpose of the communication strategy is:

- To identify by stakeholder their interests.
- To document.
 - How they will be kept informed including the content frequency and method.
 - How information will be received from them.
- To provide common standards of communication.
- To plan resources for communication.

Checklist

1. Has the information disseminated to stakeholders met their requirements?
2. Has the information received from stakeholders met the PCTs and Local Authority partners requirements?
3. Has all the necessary information been disseminated?
4. Have the roles and responsibilities of individuals carrying out the communications strategy been understood by them?
5. Have the roles been carried out satisfactorily?

6. Suggested content

- List of stakeholders and information requirements.
- Communication mechanisms to be used e.g. written reports, emails, workshops, seminars newsletters, personal briefings.
- Key elements of communications to be distributed by the different mechanisms – including frequency and information collection and collation.
- Roles and responsibilities of key individuals to ensure that communication is appropriate and timely.
- Identification of how unexpected information from other parties (including stakeholders) will be handled within the scope of the activity.

With regard to commissioning mental health services there are particular groups who should have significant roles in informing the process and the following sections outline suggestions about how this involvement might be best achieved.

3.3 Using care pathways

Work sponsored by the NHS Modernisation Agency and its partners has demonstrated that process mapping is one of the most powerful ways for multi-disciplinary teams to understand the service users' perspective, and to identify opportunities for improvement. www.modern.nhs.uk/improvementguides/process

Putting together a map of the care pathway as a collaborative process gives the PCT and its partners:

- Perspectives from all the multi-disciplinary teams from primary, secondary, tertiary and social care as well as creating a culture of ownership, responsibility and accountability.
- An overview of the complete process which helps people to understand how complicated the systems can be for service users especially in terms of waits, referrals to different people and multiple requests for the same information.
- An opportunity to see whether all service users are treated equally through ensuring that diversity data is collected and used.
- Data on how the care pathway is changed for people with multiple problems.
- A way to identify where to test ideas for improvements that are likely to have the most impact.
- Innovative ideas – especially from staff who don't normally have the opportunity to contribute to service organisation, but who really know how things work.
- An event that is interactive enabling people to get involved and talking.
- An end product – the map – which is easy to understand and highly visual that can also be shared easily with colleagues.

The detailed steps to devising new pathways once the mapping process has been completed are set out in Appendix C.

04 | Audit and evaluation

4.1 Introduction

As was set out in the introduction the activities described in sections 4 and 5 should be carried out in parallel. The tools and techniques set out in Section 5 will enable commissioners to set the shared strategic direction and operational frameworks for the future shape of commissioning for their local communities whilst those in this section should enable commissioners to form a clear picture of what goes on currently and how effective it is.

4.2 Importance of audit

Mental health services differ from other care services because of their complexity, the variety of settings in which they are delivered and the number of stakeholders who are involved. Whilst the most visible part of the system is the delivery of acute services, often from a local mental health trust, the vast majority of mental health care is provided in primary care itself.

Where audits of primary care provision of mental health services have been undertaken it is clear that even within a single PCT service provision is patchy and there is little sharing of good practice. Furthermore because there are a wide range of treatment options individual GPs within practices may be addressing mental health issues in different ways but without systematic evaluation of their relative effectiveness.

www.chi.nhs.uk/eng/cgr/mental_health/mental_health_report03.pdf

In contrast to other areas of care it is likely therefore that most commissioners may have only a limited picture of how the PCT's resources are being deployed to meet the mental health needs of their communities. Consequently a detailed audit of how both individual practices and the PCT as a whole addresses mental health issues should provide

data both to inform service redesign and improvement as well as ensuring best value. The outcomes of these audits can then be shared with the other agencies in the local health economy whose individual decision-making is likely to be enhanced by a better understanding of what is happening within the PCT and its constituent elements.

Furthermore both promotion and prevention have a particularly important role to play in addressing mental health issues. Even more than most care pathways various forms of information services, self-help groups and help lines may provide early interventions that may prevent mental health problems escalating. From a purely value for money perspective investment in these services may well reduce the call on prescribing, talking therapies or referral to acute services. Although these services may be provided by the voluntary sector their focus and expertise means that, in some cases, they may more appropriately be regarded as 'specialist' providers in the same way as some more traditional 'acute' services. Commissioners therefore need to make the audit process as inclusive as possible so that there can be a clear understanding of what services are available and the future configuration of services that can best meet the emerging needs of the local health and social care economy.

4.3 Mapping services

4.3.1 A framework for mapping mental health services

Key resources are:

- Durham University Adult Mental Health Service Mapping Atlas:
www.dur.ac.uk/service.mapping/amh/index.php
- Durham University Child and Adolescent Mental Health Service Mapping Atlas:
www.dur.ac.uk/camhs.mapping
- The National CAMH Service Mapping exercise aims to improve mental health services for children and young people by:
 - Assisting the bid for resources at a local and a national level by providing accurate information on service provision against population size and deprivation.
 - Supporting commissioners and services to manage and develop by providing detailed information about their individual services.
 - Informing and supporting the development and implementation of the National Service Framework for Children.
 - Providing data for NHS Plan implementation.
- The Visual Commissioner has been developed by the West Midland Strategic Health Authority as a software tool to support the commissioning of services and can be used in conjunction with the Durham data to assist with mental health commissioning. Details of the system and its application are provided in Appendix G.

4.3.2 Auditing current practice

In order to establish the baseline data collection we have prepared a number of checklists to enable uniform data collection at three levels:

- The overall system (4.3.3).
- The PCT as a whole (4.3.4).
- Individual practices (4.3.5).

It is likely that the process of data collection itself will identify where links and systems can be improved as well as where there is good practice to be shared.

Checklist 1 - Local system audit

1. How is the mental health of the local communities promoted and how is the strategic vision for its achievement planned?
 - Who are the commissioners?
 - What are the mechanisms for commissioning?
 - How is the Local Implementation Team working?
 - What are the other mechanisms?
 - How are resources allocated?
 - How is the effectiveness of interventions evaluated?
 - How are service users and carers involved?
 - How is the potential for social exclusion issues identified and addressed?
 - What are the monitoring and evaluation mechanisms?
2. What health promotion/prevention work is undertaken?
 - By which groups?
 - Where?
 - How is it funded?
 - How is it publicised?
 - How is its effectiveness evaluated?
3. What agencies other than the PCT and Social Services are involved in the provision of support to people with mental health problems?
 - Other trusts?
 - Other Local Authority services?
 - Statutory services?
 - Voluntary services?
 - Employment services?
 - How are service users and carers involved?
4. How are relationships managed?
 - Strategically?
 - Operationally?
5. How does referral between primary, acute and specialist services work?
 - Who pays for what and how is cost effectiveness evaluated?
 - What are the mechanisms for joint working and at what levels does it happen?
 - What are the quality assurance mechanisms?
 - What out of hours' services are available?
 - What help-lines are there?
 - How are Early Intervention, Assertive Outreach and Crisis Intervention interventions working?
 - How does the criminal justice system fit in?
 - What happens in relation to substance abuse?
 - What happens in relation to eating disorders?
 - How does care of the elderly fit in?
 - How are the needs of refugees, asylum seekers and people whose first language isn't English taken into account?

- What happens for children and young people?
 - How do services for people with learning disabilities fit in?
 - How are the needs of minority ethnic communities taken into account?
 - How are the particular needs of women accommodated?
 - What happens to support people with physical disabilities especially in relation to communication?
 - How are the needs of rough sleepers and homeless people addressed?
 - How are people with complex needs dealt with?
6. What service redesign projects have been undertaken?
 7. What 'Changing Workforce' new roles have been implemented?
 8. How are the needs of people with mental health needs incorporated in projects to address social exclusion and economic and social regeneration?

Checklist 2 – PCT Audit

1. What mental health services did the PCT commission last year?
 - At the practice level?
 - In primary care settings generally
 - From the voluntary sector?
 - From mental health trust(s)?
 - From social services?
 - From within the PCT?
 - From other sources?
 - What was the cost of drugs?
 - What was the cost of talking therapies?
 - What proportion of service users follow Care Programmes?
2. How was the clinical and cost effectiveness of the various forms of investment measured?
3. What determines the choice of therapeutic options and how is the effectiveness of that choice measured?
4. How much was spent on health promotion and, on what basis and how was their effectiveness evaluated?
 - Information services.
 - Help-lines provided by voluntary groups.
 - Support to voluntary groups.
 - Other activities.

5. What progress has been made to meet the NSF standards and whose job is it to monitor progress?
6. To what extent have new ways of working been implemented?
 - Early Intervention Teams?
 - Assertive Outreach?
 - Crisis resolution?
 - Gateway workers?
 - Graduate Mental Health workers?
 - Practitioners with a special interest new General Medical Services Contract (nGMS)?
7. How are service users and carers involved in decision-making?
8. What mechanisms are there in place to assess unmet demand?
9. What mechanisms are there to ensure that the needs of all users are met?
10. What training and development is provided on mental health issues and for whom?
3. Who in the staff team are involved in the assessment and care of people with mental health problems?
4. Who determines the strategic and operational choices about how mental health conditions are addressed?
5. How is the effectiveness of the various options addressed?
6. What health prevention and promotion initiatives does the practice provide in relation to mental health?
7. What assessment tools and processes are used?
8. Which care pathways are used for which conditions?
9. What are the protocols for prescribing?
10. What are the protocols for referrals?
11. What treatment resources are available within the practice?
 - Talking therapies.
 - Drugs.
 - 'Alternative' therapies.

Practice level

1. What was the volume and type of last years' mental health cases (how does the practice categorise these?)
 - On-going.
 - 'Completed'.
2. What is the level of staff knowledge and expertise in mental health conditions?
12. What relationships are there with other agencies (statutory and voluntary)?
13. What service user involvement is there?
14. What carer involvement is there?
15. What learning and development has been carried out in relation to mental health issues?
16. What proportion of the practice budget is spent addressing mental health issues?
17. Who from the practice is involved in the wider health and social care economy in relation to mental health issues?

4.4 Audit of PCT organisational capacity and capability

4.4.1 Where is our PCT now?

Once the audit of practice and resource allocation has been carried out and as a preliminary to the shared activity of commissioning for the future it is worth the PCT staff responsible for commissioning mental health services checking out whether the PCT's internal processes are generally on track using the two self assessment checklists that follow. The outcomes can then be shared with senior management and the PCT Board to indicate to them the importance of the systematic strategic process that needs to be carried out with the full range of partners.

Are we making sufficient progress?

Question	Score
1. Are we meeting the Mental Health NSF standards?	
2. Are we meeting the Children's NSF performance requirements?	
3. Are we meeting the Older People's NSF performance requirements?	
4. Will we deliver our NHS Plan performance requirements?	
5. Are we meeting national indicator performance requirements?	
6. How well are we implementing NICE guidelines?	
7. How well are we addressing local priorities?	
8. Do we have positive strategies for both investment in new services and disinvestment/ de-commissioning of services which are no longer required or delivered in other ways?	
TOTAL	

Rating your organisations performance:

- 0 – Doing worse than last year.
- 3 – Not achieving progress on many performance requirements.
- 5 – Meeting some performance requirements but significant gaps.
- 7 – Achieving most performance requirements.
- 10 – Achieving all performance requirements.

Evaluating your scores

- 0 - 24 You need to get some real pace into your commissioning or you are heading for failure – never let this guide out of your site!
- 25 - 40 Some progress but a lot to do especially in getting to the action plan – use this guide thoroughly.
- 41 - 67 Reasonable progress - need to focus on gaps and delivery – dip into some parts of the guide.
- 68 - 80 Really good progress; if your views are accurate – you don't need this guide.

Is our delivery plan robust?

Question	Score
1. Do we have an overarching control plan for commissioning?	
2. Is there a milestone map with clear review points?	
3. Is there a prioritised set of activities with a critical path?	
4. Is there a map of dependencies between activities?	
5. Are there clearly identified risks and contingency plans with associated risk funds?	
6. Is there a resourcing plan for each specified set of activities?	
7. Is there a clearly defined benefits realisation process?	
8. Are accountabilities clear and in writing?	
9. Have we identified all stakeholders and is there a communication plan for each of them?	
TOTAL	

Rating your organisations performance:

- 0 – No
- 3 – Very poor
- 5 – Yes but average
- 7 – Yes and used most of the time
- 10 – Yes and followed systematically

Evaluating your scores

- 0 - 27 You are heading for 0 star status get an experienced project manager fast!!
- 28 - 45 You risk missing a lot of your performance requirements – follow our resource guide on project management. Appendix E.
- 46 - 63 Reasonable progress - need to focus on gaps and delivery - perhaps some training in project management for key staff.
- 64 - 90 Using project disciplines well - carry on with what you are doing.

As well as understanding where resources are currently spent it is important for the PCT to understand the strengths and weakness of the people within the organisation who will be involved in planning and implementing what needs to be done.

4.4.2 Organisational capacity

This is the amount of resource available to the PCT to deliver its key accountabilities - essentially people, money and systems. The assessment will need to be informed by current and future pressures and priorities, governance requirements and contingencies. Key to getting this right are:

- Modelling the changes in demand on the PCT over a 1 and a 3 year time frame.
- Building in capacity for managing the unexpected and contingencies for risks that go wrong.
- Constantly updating the analysis as new pressures and changes in demands occur.

PCTs and Local Authority partners, faced with an ever increasing agenda will be sorely tempted to “make do and mend”. However, if proper resource plans are not developed the true pressures and risks will not be capable of assessment. Even if it is not possible to fund all of the needs it is important to specify them to test other ways of making up the shortfall and to identify the capacity risks which need to be managed.

It is our experience that many PCTs are still working through the commissioning process for all their services so we make no apologies for including the organisational context for commissioning. Furthermore given the traditional ‘Cinderella status’ (at best) of mental health services in comparison with the focus on achieving performance requirements in other areas it is even more vital that there is a systematic assessment of what are the available organisational resources to address this part of the whole system commissioning process.

4.4.3 Organisational capacity audit

1. What resources do we have?
2. What additional resources do we have planned?
3. What is required to:
 - a. Develop the strategy?
 - b. Commission services?
 - c. Manage delivery of commissioning?
 - d. Manage primary care services?
 - e. Manage the internal functions of the PCT?
4. Where are the gaps?

4.4.4 Organisational capability audit

An assessment of PCT staff and those who work closely with is needed in terms of their:

- Skills.
- Experience (technical and general).
- Abilities.

NatPaCT competency frameworks and the Learning Skills Matrix can assist but it will be essential to link these to a robust appraisal and performance management process which constantly informs and updates the analysis.

Once the key gaps have been identified a range of possible interventions can be explored as part of an Organisational Development (OD) programme in which each member of staff has a Personal Development Plan. These may include:

- Recruitment.
- Buying in skills.
- Generic training e.g. team development, communications etc.
- Specialist training in technical and professional skills.
- Planned job experience.
- Distance learning.

This is simply the people element of the business plan which identifies the gaps, interventions for addressing them, performance measures and links to the business plan priorities of the PCT. Key to a robust and effective Organisation Development (OD) programme are:

1. Every development objective is measurable and can be evidenced.
2. There is a clear link between OD investment and business plan priorities.

4.4.5 The ten essential shared capabilities for mental health practice

NIMHE has identified a range of skills, attitudes and behaviours which should inform all work carried out in addressing mental health issues. PCT commissioners need to audit how these capabilities are currently represented and work through how NIMHE's suggestions about developing them further in practice can be applied in their local setting: www.nimhe.org.uk/downloads/78582-DoH-10%20Essentials.pdf

1. **Working in partnership.** Developing and maintaining constructive working relationships with service users, carers, families, colleagues, lay people and wider community networks. Working positively with any tensions created by conflicts of interest or aspiration that may arise between the partners in care.
2. **Respecting diversity.** Working in partnership with service users, carers, families and colleagues to provide care and interventions that not only make a positive difference but also do so in ways that respect and value diversity including age, race, culture, disability, gender, spirituality and sexuality.
3. **Practising ethically.** Recognising the rights and aspirations of service users and their families, acknowledging power differentials and minimising them whenever possible. Providing treatment and care that is accountable to service users and carers within the boundaries prescribed by national (professional), legal and local codes of ethical practice.
4. **Challenging inequality.** Addressing the causes and consequences of stigma, discrimination, social inequality and exclusion on service users, carers and mental health services. Creating, developing or maintaining valued social roles for people in the communities they come from.
5. **Promoting recovery.** Working in partnership to provide care and treatment that enables service users and carers to tackle mental health problems with hope and optimism and to work towards a valued lifestyle within and beyond the limits of any mental health problem.

6. **Identifying people's needs and strengths.** Working in partnership to gather information to agree health and social care needs in the context of the preferred lifestyle and aspirations of service users, their families, carers and friends.
7. **Providing service user centred care.** Negotiating achievable and meaningful goals; primarily from the perspective of service users and their families. Influencing and seeking the means to achieve these goals and clarifying the responsibilities of the people who will provide any help that is needed, including systematically evaluating outcomes and achievements.
8. **Making a difference.** Facilitating access to and delivering the best quality, evidence-based, values-based health and social care interventions to meet the needs and aspirations of service users, their families and carers.
9. **Promoting safety and positive risk taking.** Empowering the person to decide the level of risk they are prepared to take with their health and safety. This includes working with the tension between promoting safety and positive risk taking, including assessing and dealing with possible risks for service users, carers, family members, and the wider public.
10. **Personal Development and Learning.** Keeping up-to-date with changes in practice and participating in life-long learning, personal and professional development for one's self and colleagues through supervision, appraisal and reflective practice.

05 | Effective commissioning

10 tips for commissioners

1. Always think and plan from the experience/perspective of service users as well as those of their carers.
2. Ensure that there is a shared understanding of what you are trying to achieve.
3. "The perfect is the enemy of the good" – make sure aspirations are achievable.
4. To avoid constraining thinking start from the vision of where you want to get to before looking at where you are now.
5. Where significant changes are envisaged remember to consider decommissioning services no longer required as well as developing new/improved services.
6. Avoid terms such as "core and "non-core" as they do not have an accepted definition and can cause misunderstandings between partners.
7. As well as a broader vision plan for some "quick wins" to build confidence and motivation amongst stakeholders.
8. Systematically identify all the potential levers and incentives available and match them appropriately to the strategic objectives.
9. Constantly focus on integration of services within the NHS, with social care and with all other interested agencies.
10. Share the effort through partnership and joint commissioning arrangements - be sure to formalise agreements in advance so that there are no misunderstandings.

5.1 Introduction

As Section 3 emphasises to be successful the promotion of the mental health of the community and the provision of services must be a shared activity which is driven by an integrated approach involving all partners. In each health and social care economy commissioners need to ensure that national performance measures are delivered in the context of local need. In many cases the commissioning of services will be a formal joint activity between Social Services and the PCT (as in the case of Section 31 allocations). In other cases Local Authorities and PCTs will plan together but be responsible for different parts of the commissioning process and their performance will be measured through their own individual accountabilities.

Because their responsibilities for mental health commissioning have been longer established there is well established good practice to inform Local Authorities' commissioning activities. In particular the Audit Commission's Making Ends Meet site provides an excellent overview as well as practical tools and techniques to inform commissioning.

www.joint-reviews.gov.uk/money

PCTs can learn much from these models but, because of the different responsibilities for commissioning this guidance does not cover all the areas for which they are responsible. Similarly although Local Authority Health Scrutiny Panels have an interest in PCT funded commissioning, PCTs also have performance accountabilities to the Department of Health, their SHA and the Healthcare Commission. The following sections are therefore specifically aimed at PCTs Boards, Chief Executives and those responsible for mental health commissioning and build on the models described in the Commissioning Friend for Acute Services as well as emerging good practice.

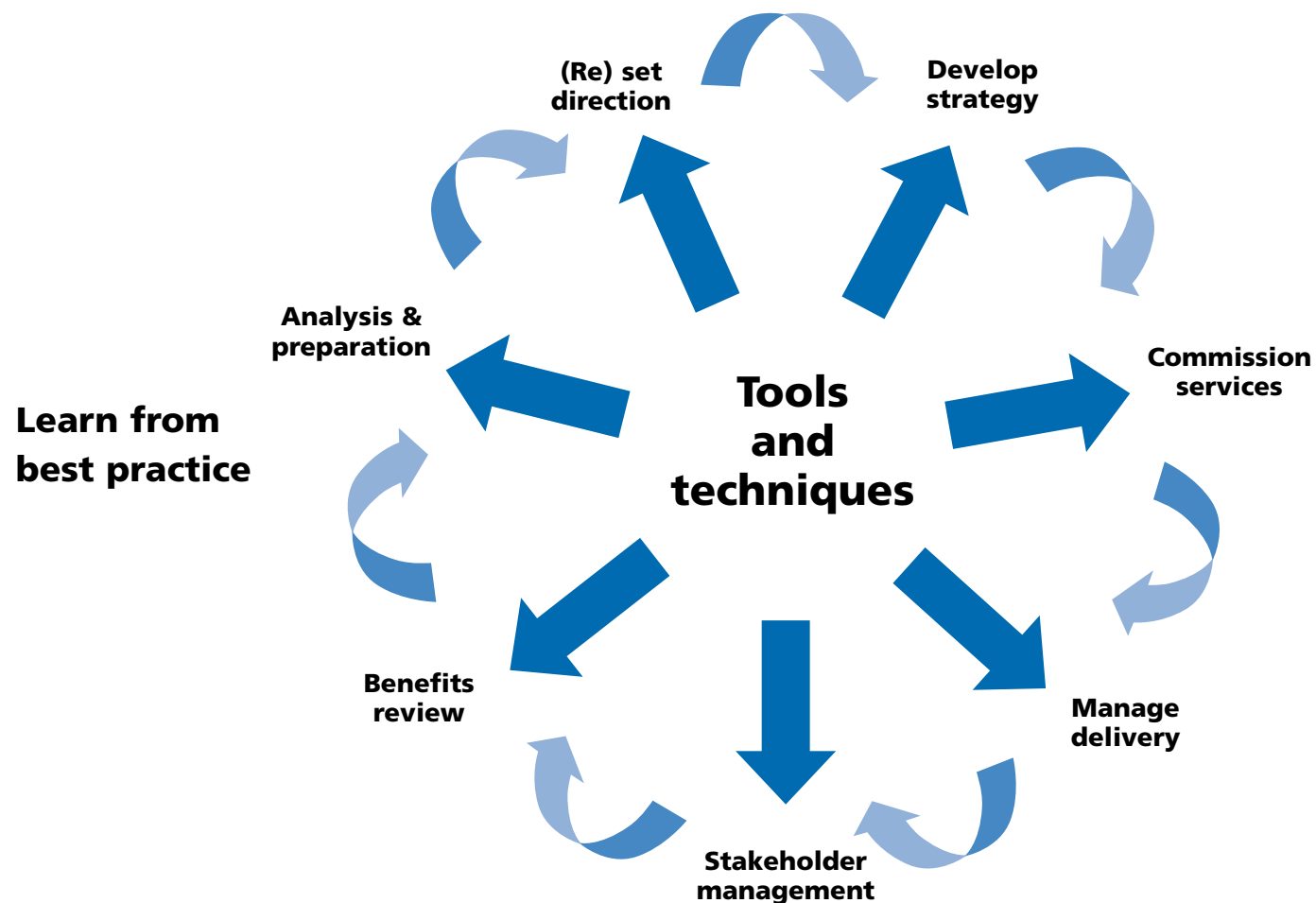
www.natpact.nhs.uk/cms/99.php#prep

Given the pressures on PCT's outlined in the introduction there is a general consensus that in many cases mental health issues are not as prominent on the board and senior management agenda as other aspects of health. Working through this section of the guide should help PCTs clarify their role in the network of those promoting positive mental health and, with the data from the audit mechanisms set out in section 4 identify how resources can be most effectively deployed.

5.2 Commissioning framework

The following sections are drawn from the sections of the original Commissioners' Friend which are of particular relevance to mental health; they have been updated to take account of our experience of working with PCTs and their partners since the publication of the guidance and emerging policy trends. We have found that the model set out below is the best representation of the processes that commissioners need to follow to most effectively undertake all their commissioning activities. Given the complexity of mental health services undertaking a systematic process that takes full account of gathering and using evidence to underpin decision making is all the more important.

The commissioning framework



For commissioners who feel that they have a well developed commissioning strategy a summary of the process is set out in [Appendix D – the 10 Minute Guide to Commissioning](#).

5.3 Developing the vision

The vision sets the direction of travel for services and it should influence all the smaller, shorter term decisions and in year changes to ensure progress is made in the right direction. It will be influenced by a wide range of factors including:

- National policy & performance requirements.
- National service frameworks.
- Guidance from the National Commission for Clinical Excellence.
- Health needs analysis and priorities identified by local Partnership Boards.
- Service users' perspectives.
- Outcomes of Local Authority Health Scrutiny Panels.
- The policies of partner agencies and organisations.
- The existing pattern of services.
- Redesigned care pathways.
- Inputs from clinical networks.
- Views and preferences of local people including carers and families that include people with mental health issues.
- Inputs from elected members.
- Expert knowledge and opinion of clinical and management staff in the local health and social care community.
- Existing good practice established elsewhere.
- Research evidence.

The vision is likely to comprise a short list of principles and value judgements about future direction, for example "More people with mental health problems will be investigated, treated and managed in primary care in the future wherever that can be achieved cost effectively to an appropriate clinical quality standard".

To test the quality of your vision complete our self-assessment checklist

Self-assessment checklist - How robust is our vision?

Question	Score
1. How clear is our vision for mental health services?	
2. How effective was the process of developing it?	
3. Have we systematically identified all of our key stakeholders and their interests?	
4. How effectively have we involved them?	
5. Are we convinced that our commissioning strategy will achieve the vision?	
6. Have we identified and considered all of the available levers/incentives?	
7. Do we know what all the potential barriers are?	
8. Have we identified and made plans to manage all of our risks?	
9. Do we know how we will determine whether we have achieved our goals?	
TOTAL	

Rating your organisations performance:

- 0 – Very poor
- 3 – Poor
- 5 – Average
- 7 – Quite good
- 10 – Excellent

Evaluating your scores

- 0 - 27 You need to get some real pace into developing your strategy or you are heading for failure
- 28 - 45 Some progress but a lot still to do
- 46 - 63 Reasonable progress - need to focus on gaps and delivery
- 64 - 90 Either you are making really good progress or you are deluding yourself! – Check it out with colleagues and other stakeholders

5.4 The strategic story

Each PCT and its Local Authority partner should have a clear short and easily communicated strategic story which is owned both by policy makers and by the executive team because they created it in partnership with their stakeholders. The elements of the strategic story should include:

1. An intelligent (joined up analysis) of NHS and Local Government performance requirements, NSFs, national policy imperatives and guidance and their relevance to local needs.
2. A succinct analysis of the needs of the local population, how they will be met by implementing national objectives and what else needs to be done to meet local needs not sufficiently emphasised/covered by national guidance.
3. How the PCT and the Local Authority intends to make a positive difference to mental health services
 - this year
 - over the next 3 years and
 - over the next 10 years.

5.4.1 Developing an effective strategic story

1. Ask each of the policy makers and the executive team to imagine they are being asked to describe in 10 minutes **“What are we doing to promote the mental health of the communities we serve including providing mental health services?”**
2. Get them to write the main points down and then share them with colleagues.
3. Note down the areas of similarity and difference.

4. Assess the stories against the checklist below.

Checklist:

- Is the focus on outcomes i.e. measurable improvements in the range, quality of and access to client services?
- Is it in plain (jargon free) English?
- Can the story be told in less than 10 minutes?
- Is it relevant and interesting to all stakeholders?
- Is it unique to this local health and social care community e.g. meeting national performance requirements is essential but is a requirement of all Local Authorities and PCTs?
- Would all policy makers and senior managers tell the same strategic story if asked independently?
- Does it give an analysis of the relevance of national policies and performance requirements to local health needs?
- Is it clear what improvements will be achieved in patient services as a result of the commissioning strategy?
- Does it include relevant, practical examples of achievements?

Share the analysis in the team and develop a team story which is then agreed and communicated to key stakeholders.

It is vital for all of the partner organisations (including the directors of the PCT) to have a shared understanding of the key themes of the strategy which are communicated clearly and consistently to stakeholders.

5.5 Service strategy

Service strategies identify programmes of activity in the Local Delivery Plan (LDP) that are mutually coherent and affordable within the commissioners' longer term resource prospects. The strategies should be developed on a broad brush basis rather than in detail. Major areas for change, the broad process and timescale for making the changes and the associated financial strategy should be included in the overarching strategy document.

It is recommended that service strategies be developed on a limited range of care group headings in the interest of keeping them understandable – in this case – the mental health service strategy it will be necessary to drill down to a more detailed level as one moves into the planning stage (i.e. looking at years 1 to 3). **It is vital to keep the vision and strategy at a high level.**

5.6 Financial strategy – the seven key steps

The main building blocks of a financial strategy are:

1. Resource prospects.
2. Current expenditure.
3. Current deficits (and recovery plans to balance them).
4. Future expenditure forecasts from service strategies.
5. Efficiency and inflation.
6. Non-recurrent resources and expenditure, including capital and trust funds.
7. Risks.

Each element is described in more detail in the Commissioner's Friend Resource Guide No.2:

www.natpact.nhs.uk/cms/47.php

Service strategies should be developed in the context of a realistic financial strategy. The purpose of the financial strategy is to ensure that service strategies are affordable against a range of resource prospects and to ensure that all the available resources are disclosed and made available for strategic service planning.

Openness should be a core principal in developing strategies and therefore all finance staff should work collaboratively to develop the financial strategy just as their clinical colleagues will on the service strategies.

It is essential that recurring and non-recurring resources and expenditure be separately identified to minimise the danger of developing unaffordable strategies where recurring deficits are masked by non-recurring resources.

The key end product of the strategy is a high level summary which should show total expenditure (and percentage of total resources) by care group reconciled to available resources. It should compare the present position to the forecast future position highlighting the proposed shifts between care groups. It should also be analysed by provider to illustrate the proposed changes in commissioning patterns.

It is useful to produce an analysis of where future growth is going (by care group and by provider). This will highlight areas of net disinvestment and the care groups attracting the highest priority for new resources.

Strategies should be led by needs and quality standards but must also be contained within realistic resource prospects. Resource guidelines can be produced for each client group to influence the strategy makers' thinking. One way to do that is to make a high level judgement, using the principles in the vision, about the future share of total resources for each care group. For example commissioners may decide that primary care should grow more quickly than the average rate of growth over the next decade. If so its share of future resources may increase from say 23% now to say 25% in the future. Other types of care would therefore need to have lower growth performance requirements. This can be a powerful tool to concentrate minds on achieving the preferred future pattern of care. It must however be treated with caution as the basis for such guesstimated resource prospects is a series of value judgements.

The development of a vision, associated service strategies and an underpinning financial strategy will provide commissioners with a clear direction to inform all the smaller decisions they must take. The documents representing that vision must be designed to serve widely different audiences and it is critical that they be kept at high level and be written in an accessible way. They do rely on lots of detailed professional work but those technical professionals must find simple ways to communicate the import of their technical work. A separate technical exposition booklet should be produced for the aficionados who want to access the underlying work!

The vision and strategies depend on being understood if they are to happen and be sustained in times of great change. A few clear words and some simple graphics in a short overview publication are most likely to succeed and capture people's imaginations

5.7 Preparing the commissioning strategy

It is becoming increasingly evident that in relation to a number of key services **individual PCTs and their Local Authority partners do not have the resources or expertise to 'go it alone' in relation to their commissioning.** It is therefore very important that mental health commissioners think through the best approach to commissioning to the variety of services that they are responsible for ensuring are commissioned. This process also makes clear how commissioning can in itself provide a very powerful lever for change. We would therefore recommend the following seven steps:

1. Choosing the right commissioning model.
2. Leading the process.
3. Building in incentives for modernisation.
4. Ensuring a competitive tendering process.
5. Developing mature commercial relationships.
6. Balancing local provision and access with Plurality, Diversity and Choice.
7. Developing a Transition Strategy.

5.8 Models for delivering whole system commissioning

By whole system we mean:

- Services are designed to be responsive to the needs of service users and carers.
- Stakeholders accept their interdependency and that action by any one of them may affect the whole system.
- There is shared agreement amongst all stakeholders regarding the vision, principles, approach to service delivery, management of performance and review processes.
- Those using the services do not experience gaps or duplication.
- Relationships and partnerships are enhanced.

A range of approaches to commissioning are emerging which can be summarised as follows:

Independent Commissioning, where individual PCTs and their Local Authority partners undertake all their own negotiations. A variant on this would be merger retaining a single organisational entity but increasing its size.

Joint or Collaborative Commissioning, where a group of commissioners create a framework within which they commission services jointly.

Lead Commissioning, where one organisation acts on behalf of a group of PCTs and their Local Authority partners. A subset of this is **Specialist Commissioning**, the evolution of different approaches to managing specialised services previously managed by Regional Specialised Commissioning Groups (RSCGs).

A Formal Consortium, where an organisational entity is created to commission on behalf of a group of organisations and is funded by them.

Shared Services, where new collaborative organisational arrangements create a one organisation approach to commissioning.

5.8.1 Practice led commissioning

In early October 2004 the Department of Health announced that:

“From April 2005, practices will be able to receive an 'indicative budget' from Primary Care Trusts (PCTs) that they can use to improve the delivery of services.

PCTs themselves will continue to be legally responsible for the contracting process. But any savings which result from managing referrals more efficiently will be shared between practices and PCTs with all of those savings being reinvested into patient care. PCTs will also remain responsible for specialist commissioning.

No targets will be set for the numbers of practices to become involved in Practice led commissioning - practices will be encouraged to respond to it at their own pace. Groups other than practices - such as community based nursing teams - could also hold indicative budgets for groups like vulnerable adults.

This model is designed to strengthen clinical involvement in commissioning and to increase the emphasis on primary care by creating financial incentives to reinvest “savings” in local services. The approach is outlined in the Department of Health publication Practice Based Commissioning: Engaging Practices in Commissioning: www.dh.gov.uk/assetRoot/04/09/03/59/04090359.pdf

A helpful review of the evolution of this approach to commissioning and the issues which need to be considered is provided by Richard Lewis in a June 2004 Kings Fund publication: Practice- led commissioning harnessing the power of the primary care front line: www.kingsfund.org.uk/pdf/practiceledcommissioning.pdf

As the policy is designed to be tested over the next few months it is anticipated that there will be further clarification at a later date.

5.9 How to choose the right commissioning model

5.9.1 Decision criteria – the 5 Cs

The following criteria are suggested as a way of deciding which model is right for each group of commissioners:

1. **Clout** – the commissioning organisation must have the negotiating muscle to be taken seriously.
2. **Credibility** – what real differences is the commissioning strategy going to make and where are the short term signs of delivery?
3. **Capacity** – which model will create the most capacity?
4. **Capability** – which model will maximise the skills and experience available?
5. **Competition/Collaboration** – which model most suits the commissioners' strategy?

Models of commissioning

<i>Form</i> \ <i>Criteria</i>	Clout	Credibility	Capacity	Capability	Collaborative/ Competitive
Pooled Commissioning					
Consortium					
Lead Commissioner					
Joint / Collaborative (LAs)					
Clinical Networks					
Independent					

Within each of these models there are options for how administrative and managerial arrangements are organised and funded:

- Remain with each local health and social care economy.
- Owned by commissioners but work on joint projects.
- Paid by commissioners but pooled in an independent office.
- Funded by commissioners but appointed to central office.

In relation to mental health commissioning it is likely that some (and an increasing number in the future) of services could be funded by direct payments from service users. It is important therefore to identify how these streams of activity are incorporated into the resource management framework.

5.9.2 Agreeing the rules of engagement

It is essential that whichever form of administrative or managerial arrangement is followed that there is a formal written understanding between the commissioners involved as to how it will operate. To use the example of lead commissioning a formal agreement will need to specify:

1. Rules of entry into the shared arrangements.
 - Criteria of eligibility to join.
2. The rights and responsibilities of the lead commissioner.
3. The rights and responsibilities of each PCT, Local Authority and other commissioners.
4. Resourcing of the commissioning process.
 - Funding.
 - Staffing.
 - Other resources e.g. hosting, physical facilities, managing central resources.
5. Communication processes to keep other commissioners informed.
 - Service Level Agreement.
 - » Frequency, type and quality of communication on key accountabilities.
 - » From who in the host organisation.
 - » To who in the receiving organisation.
 - » Standards for reply e.g. response to routine emails will be within 1 working day.

6. Trigger mechanisms that alert other commissioners when they need to be involved in the decision-making process.
7. Process for managing in year changes.
8. Managing disagreements.
9. Process for managing organisations or individuals defaulting on or unilaterally changing obligations.
10. Review points.
11. Rules of disengagement.
 - Minimum period of involvement.
 - Notice period of disengagement.

5.10 Leading the process

So often the commissioning round starts with providers presenting a list of additional funding requirements for discussion. It is essential that the commissioning process is designed and led by the commissioners and is focused upon the commissioning objectives to be achieved. The agenda is challenging and can only be achieved with radical change.

5.11 Establish clear business processes

Commissioning processes such as the commissioning business cycle, developing financial and service strategies and review and evaluation are discussed in more detail later in this guide. However at an early stage it is important to establish the core business processes within the commissioners' organisations and the linkages between them. Again thinking may have gone on with respect to the subset of commissioning that relates to commissioning acute services however our experience suggests that checking out the applicability of processes and thinking as it relates to mental health services will pay dividends for all managers, not only those concerned with commissioning mental health services.

Business process checklist

1. Set up and manage the internal functions of the commissioners' organisations

- a. As relatively new collaborative organisations this is both a significant and difficult set of tasks
 - Who manages the internal functions of the PCT and Local Authority Departments?
 - » Payments.
 - » Staff management.
 - » Internal and external communications.
 - » Information management.
 - » Performance management.
 - How are these coordinated?
- b. How do the commissioners calculate and manage corporate overheads?
- c. How is the added value of the commissioners' management overhead demonstrated?

2. Developing a vision and strategy

a. How is this done?

- Who does it and what are their roles?

- » Chair.
- » Chief Executive.
- » PEC Chair.
- » Non Executive Directors.
- » Local Authority elected members.
- » Scrutiny panel.
- » Executive Directors.
- » Senior Managers.
- » Board.
- » Partnership Board.
- » Executive Team.
- » PEC.

- What are the business processes?
 - » What do we mean by vision?
 - » How does it inform strategic priorities?
 - » What do we mean by strategy?
 - Over what timescale?
 - Range?
 - Scope?
 - Level of ambition/challenge to status quo?
- How do we know they are fit for purpose?
 - » What are our measures of performance?
 - » How do we calculate them?

3. Delivering the strategy

a. Commissioning

- How do we ensure a whole systems approach?
 - » What is our transition strategy?
 - » Which models of commissioning do we adopt and why?
- What resources do we invest in health promotion and prevention?
- How do we incentivise providers?

- How do we achieve value for money?
- How do we utilise Section 31 benefits?
- How do we ensure service user and carer involvement
- How do we ensure public involvement?
- How do we achieve clinician engagement?
- How do we achieve plurality and diversity of provision and develop constructive relationships with local providers?

b. Delivery

- How do we identify our major work programmes?
- Which of these are best delivered in a Project Management framework?
- How do we map and control the streams of activity?
- How do we manage changes to contracts?
- How do we incentivise continuous improvement in service delivery?

c. Benefits realisation

- How do we identify and specify measurable benefits?
- How do we track benefit management in the delivery phase?
- How do we ensure benefit realisation?

d. Review and learning

- What are effective review processes for:

» Strategy.

» Delivery and

e. How do they inform and improve the next commissioning cycle?

5.12 Achieving radical change in health delivery systems

Commissioners have 3 key levers to effect change in health care:

1. Change the model of contract.
2. Extend the range and types of service provision.
3. Incentivise new models of service delivery.

Commissioners must therefore think outside the box if they are to meet the challenging performance requirements for delivery of health care over the next few years and it cannot be the case that existing models of commissioning, provision methods of service delivery are the right way to deliver radical change. The first step on the path to change is from Block Contracts to Cost and Volume contracts. Other options include Weighted Case Mix and Managed Care. Commissioners will need to improve the sophistication of techniques for assessing needs and ensuring appropriate levels of uptake of services as Payment by Results (PbR) is rolled out as there will be financial consequences if the estimates are incorrect and are exceeded.

5.12.1 Building in incentives for modernisation

The key question when trying to effect change is why would others wish to change? The answer is because there is mutual benefit in the process. The job of the commissioner is to devise a strategy that incentivises change and continuous improvement in services.

Incentives need to be included in contract terms. An example of incentives for continuous improvement is decreasing the price year on year. It is important to bring down costs rather than margins as decreasing margins will act as a disincentive to providers.

5.13 Different outcomes of commissioning

There has been considerable work done on helping public sector organisations improve the quality of their procurement processes and this good practice can help commissioners understand how they can obtain best value from their suppliers as well as nurturing mature commercial relationships. A detailed summary of best practice can be found at the website of the Office of Government Commerce. www.ogc.gov.uk/ In respect of the specifics of local authority and NHS procurement:

Detailed advice on social service commissioning can be found at the Making Ends Meet website:
www.joint-reviews.gov.uk/money/homepage.html

and on NHS Service Level Agreements at:
www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSFinancialReforms/NHSFinancialReformsArticle/fs/en?CONTENT_ID=4000333&chk=q8gyyw

5.14 Developing a transition strategy

Acute mental health services have high fixed elements of cost and will need to plan carefully for when the changes that Payment by Results, Patient Choice and other national policies begin to directly affect mental health services. Whilst it is not the job of commissioners to manage the impact of these changes on acute services it will be important for them to be sensitive to the impact on their acute providers (particularly local providers) and develop transition strategies with them to ensure managed change that minimises unproductive disruption and maximises opportunities to modernise services.

Appendix A | Workforce issues

The NIMHE report sets out the following framework for addressing the workforce issues relating to mental health services:

1 Aims of workforce strategy

There are six key aims:

- “1. To improve workforce design and planning so as to root it in local services planning and make it understandable and meaningful to people in local services and other key organisations.*
- 2. To identify and use creative means to recruit and retain people in the workforce in order to increase the overall numbers in successive years.*
- 3. To facilitate new ways of working across professional boundaries. To make the best use of specialist staff groups to meet the needs of service users and carers.*
- 4. To create new roles to tap into a new recruitment pool and complement existing staff groups.*
- 5. To develop the workforce through revised education, training and development at pre and post qualification levels and for continuing professional and practitioner development, increasingly focusing on the shared and distinct capabilities required to meet both staff and user needs.*
- 6. To develop leadership and change management skills within professional and managerial staff in all stakeholder organisations and multidisciplinary settings.”*

2 Performance requirements

Set out below is the mental health and workforce performance requirements for 2003-2006 to be implemented in the Local Delivery Plans. Chief Executives of Primary Care Trusts, Specialist Mental Health Trusts, Strategic Health Authorities, Workforce Development Confederations (WDCs) and Personal Social Services Departments (PSS) are responsible for meeting these performance requirements.

To achieve the performance requirements, Local Implementation Teams for adult mental health (LITs) and other local health and social care systems for CAMHS and Older People, need to develop:

- A shared vision and common agenda.
- Effective joint working across the statutory and non-statutory sectors.
- Based on explicit priorities and funding.

By 2004

- 335 crisis resolution teams.
- 50 additional assertive outreach teams.
- 50 early intervention teams (to be fully operational by April 2006).
- 140 new secure personality disorder places.

By 2004

- 1,000 new graduate workers in primary care.
- 500 “gateway” workers.
- 700 more staff to support carers.
- 300 additional prison in-reach staff to ensure prisoners with severe mental health problems have an appropriate care plan and care co-ordinator on release.
- 400 staff to support secure step-down.

By 2006

- 300 more prison in-reach staff.
- 500 community development workers for black and minority ethnic communities (BME).
- 200 staff and six outreach teams for personality disorder.
- 3000 Support, Time and Recovery (STR) workers.

Appendix B | Meeting the needs of particular groups

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Appendix C | Using care pathways

The following sections have been adapted from the Modernisation Agency's guidance on best practice and service redesign: www.modern.nhs.uk/improvementguides/process

1 Analysing the care pathway

1.1 Understanding what's going on

Having mapped the service users' care pathway, get the team to analyse it by considering the following questions:

- How many steps are there for the service user?
- How many times is the service user passed from one person to another (hand-off)?
- What is the approximate time taken for each step (task time)?
- What is the approximate time between each step (wait time)?
- What is the approximate time between the first and the last step?
- When does the service user join a queue or is put on a waiting list?
- How many steps add no value for the service user?
- Where are there problems for service users?
- What do service users and their carers complain about?
- Are the issues the same for all service users?

- What effects do multiple problems have on service users' care?
- Where are there problems for staff?

Then ask:

- Is the service user getting the most appropriate care?
- Is the most appropriate person giving the care?
- Is the care being given at the most appropriate time?
- Is the care being given in the ideal place?
- How are service-users' particular needs taken account of in terms of any requirements for interpreters, aids to address physical disability, cultural or gender support?

2 Case studies from process mapping, analysis and redesign (Modernisation Agency Improvement Guide)

2.1 Mental Health Service in London

A mental health trust in London and the community mental health trusts realised there were problems with access to outpatient clinics, which were being described as a 'lottery system'. The team used process mapping to really understand how new patients were referred, where they had to wait and what the patient experienced. The team soon realised that there were high non-attendance rates, lengthy waiting lists, misuse of consultant resources and a high potential for gaps in communication.

2.2 Department of Psychological Medicine in the Midlands

The Department of Psychological Medicine is a key point of access to mental health. A team from the department, primary care, local acute hospitals and mental health services got together to map the patients' pathway and the administrative process. They are using the understanding to develop a referral protocol and an electronic referral form for the department as well as for access to other mental health services.

3 Understanding blockages and delays

At the steps where there are the longest delays **keep asking 'why'** to try to discover the real reason for the delay.

Who does what?

Q Why do clinics always overrun so service users have to wait?

A Because the doctor or consultant doesn't have time to see all the service users.

Q Why?

A Because s/he has to see everyone on the list.

Q Why?

A Because that's what we've always done.....

By analysing the workload it should be possible to distinguish what service users are being seen for and work out who is the best person to see them depending on how complex their needs are. In many cases routine processes can be dealt with by other members of the care team leaving the most experienced and skilled team members to deal with the more complex problems.

4 Organising backup processes

Estimate the number of queues (groups of people waiting) and the amount of time and effort required to manage those queues:

- Look to see if administration work or patients are 'batched'. This is when the work accumulates for hours, or even days, before it is considered to be enough to bother attending to. For example, reporting a whole week's test results in one go, or allocating appointments for a whole week's referral letters at one time, rather than dealing with them as they come in.
- Look to see if the 'expert is doing what they should be doing', or whether they have to do other things that take up their time. 'Experts' include all staff with expertise including medical, nursing, administration and technical staff.
- Map in more detail those parts of the process where there are particular waits and delays for patients. These are often the parallel processes for tests or administration.

5 Redesigning how service are delivered

5.1 Redesign around the service user

- Always focus on the service user and their carer(s) when considering what changes to make.
- Change processes arranged around the needs of staff or organisations at the expense of service user care and experience.

5.2 Co-ordinate the process of care

- Establish and document formal links between care teams to manage effectively individuals' transition from different settings and organisations.

- Create opportunities for all relevant staff to meet, share information and problems as well as develop integrated care solutions.
- Fax or email orders and clinical information between care settings.
- Reduce the number of hand-offs. Each time there is a hand-off there is potential for delay, duplication of work and errors.
- Keep the number of steps in the process to a minimum and eliminate those that do not add value.
- Establish the needs for specialist services (such as translation or signing) for service users and share the across organisations.

5.3 Pre-plan and pre-schedule care at times to suit the service user

- Co-ordinate the scheduling of appointments for service users with multiple providers. For example, if a service user needs multiple tests, book the test with the longest wait for results first. This way all the results are given at the same time.
- Provide the service user with a comprehensive care plan with booked, convenient times for future care.
- Create a trigger system so that booking a diagnostic test triggers a future appointment.

5.4 Reduce the number of times a service-user has to travel to visit the surgery, clinic or hospital

- Reduce the number of follow-up appointments freeing up clinic slots to see new referrals.
- Ask if the service user really needs to return to clinic to see a consultant? If not, can the follow-up be done by someone else in another location – for example, by the GP or community nurse?
- Consider introducing open follow-up appointments where the service user requests a follow-up only if indicated by the progress of their condition.

- Are there procedures that could be, done in the same visit?
- Can clinics be held in parallel?
- Could service users or their carers complete a symptom or information form at home before attending a clinic?
- Could service users or their carers carry their own records? This would mean they wouldn't have to fill in the same information several times.
- Could the care be carried out nearer to the service user's home, or at the place of their patient's choice so as to reduce or eliminate batching?
- Do work when it arrives, rather than waiting to deal with a whole set of similar tasks at the same time. Reduce the number of queues to be managed.

5.5 Extend staff roles

- Work out what skills are needed to provide assessment and care.
- Map the skills of the care workforce.
- Provide learning and development to help everyone work to their full capacity.
- Allocate care tasks to people with the skills required.
- Encourage staff flexibility in the roles they undertake and the hours they work.
- Introduce nurse and mental health worker-led clinics and services to reduce delays and improve the patient experience.
- Overall match capacity and demand.

Appendix D | 10 minute guide to commissioning

1 Learning from experience

- **What happened locally**

- Gather data on what happened in year one of the contracts for which the local commissioners has been responsible.
- Evaluate outcomes against contracts and performance requirements.
- Identify what worked well and where there were problems.
- Discuss with providers and clients.
- Decide what changes are needed.

- **Good practice from a range of sources**

- Pact Consultancy's original research.

The Commissioning Friend was informed by a research project on best practice in procurement and commissioning in Government. NatPaCT commissioned PACT Consultancy to research established good practice from both within and beyond the NHS to support PCTs and Local Authority partners in developing excellent Whole System Commissioning. [Natpact](#) or click on the links below:

- Click on the link www.natpact.nhs.uk/cms/99.php to download a PowerPoint presentation on key points of the Research Findings (899kb) and to download a Presentation and the full text of Research Findings (909kb).
- Office of Government Commerce Successful Delivery Toolkit. www.ogc.gov.uk/sdtoolkit

2 Integrated planning with partners

- Review competing priorities.
- Ensure stakeholder engagement.
- Evaluate options for commissioning (More detail on Models of Commissioning are explored in the Commissioning Friend): www.natpact.nhs.uk/cms/19.php
- Decide what needs to change to promote joint working.

3 Stocktake

- Audit of current services provided internally and externally.
 - Costs.
 - Deficiencies/gaps.
 - Un-met demand.
 - Staff development requirements.
- Using National Benchmarks.
 - NSFs.
 - NICE.
 - Star ratings.
 - CHI reviews.
- Local “Business” health and social care needs analysis.
 - Establishing local priorities.

4 Stakeholder Involvement

- **Identification** – who they are.
- **Prioritisation** – analysing their power, influence and interests.
- **Understanding** – what they want.
- **Planning** – how to manage them.

5 Developing a strategy

- Agreeing the Strategic story.
 - Inputs:
 - » National imperatives.
 - » Local needs analysis.
 - » Best practice.
 - a. System redesign.
 - b. Changing practice.
 - c. Changing workforce.
 - Output:
 - » Jargon free and capable of being told in 5 minutes.
 - » Short statement of purpose and direction of travel.
 - » Examples of what this means for clients and carers, services and staff.

- Drawing up key plans.
 - Services.
 - Staffing.
 - Finance.

6 Commissioning models

- Development of options for models of commissioning.

7 Agreeing the rules of engagement

It is essential that whichever form of administrative or managerial arrangement is followed that there is a formal written understanding between local commissioners and any other partners involved as to how it will operate.

8 Commissioning processes

- Deciding what provider(s) best meets need.
 - Internal/external provision.
 - Securing value for money.
- Evaluation of options.
 - New forms of commission from existing providers.
 - Identification of alternative/additional providers.
- Risk assessment.
- Is tendering appropriate?
- Drawing up clear specifications.

9 “Procurement”

- To include.
 - Own services.
 - Jointly provided services.
 - Externally provided services.
- Contracting.
 - Payments.
 - Incentives.
 - Review process
 - » Changes to specification.
 - » Incentive management.

10 Delivery

- Project management disciplines.
- Overarching control plan.
 - For each work programme.
 - » Board sponsor.
 - » Executive level manager.
 - » Benefits management plan.
- Process for in year changes.
- Managing risks and contingencies.
- On-going stakeholder management.

11 Review

- In year and year end performance management.
- Explicit attention to quality standards.
- Key lessons
 - Process.
 - Management.
- Input to next planning cycle.

12 Governance

Importance of both clinical and corporate governance.

- Ensuring appropriate
 - Reporting lines.
 - Monitoring and evaluation.
 - Accountability.
 - Safety.
 - Complaints procedures.
 - Training and development.

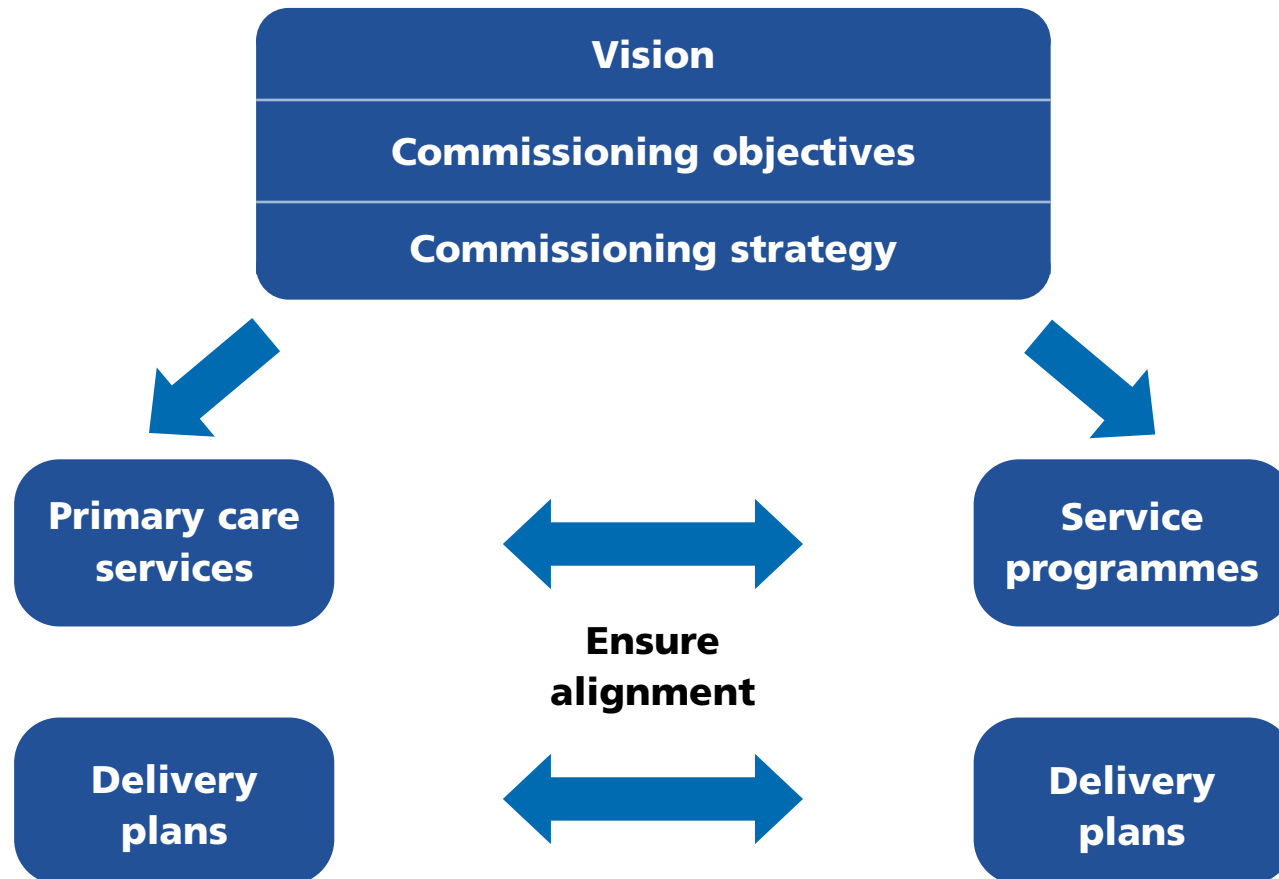
Appendix E | Programme and project management

1 Aligning strategy and services

Once the commissioners have agreed the overall strategy it is important to ensure that this informs the commissioning strategy. The executive team should identify a series of key programmes to deliver the strategic goals. A programme is a related group of activities such as delivering the NSFs for older people in relation to mental health provision. This is then broken down into individual projects. Experience in a number of local health and social economies is that it is often this process can often be very challenging. The following sections draw on established best practice to spell out the essential steps to establishing effective whole system commissioning programmes.

Key to this process is ensuring that the local commissioners are consistent in their strategy and direction with their role as provider of services as illustrated in the diagram below.

Aligning strategy and services



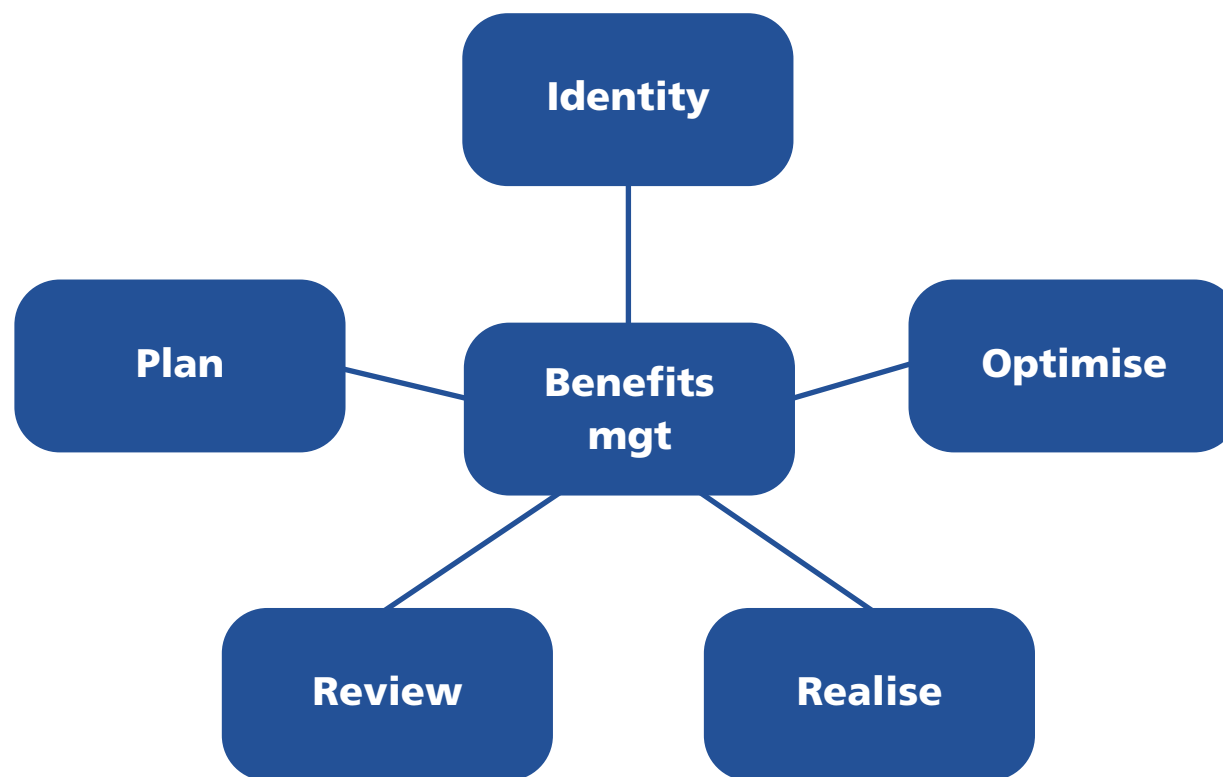
Once the commissioners have established the strategy each partner organisation needs to designate a senior member of staff to ensure its effective implementation. For example, the PCT Board should designate an Executive Director who will take the lead on its behalf. This Director will work with other key senior staff to put together the high level plan that identifies for the Board:

- How the programmes align with the overall strategy.
- The benefits to be achieved (normally in terms of service delivery and improvement).
- Risks and issues to be resolved.
- Estimated costs, timescales and resources to be committed (including a list of associated projects).

Once the Board has agreed the plan in principle the Executive Director then identifies the team to be involved in developing the detailed operational programme and its constituent elements taking account of:

- The skills and knowledge are required.
- Which parts of the organisation need to be involved.
- All of the stakeholders.

2 Benefits realisation



Benefits management is the identification of potential benefits, their planning, modelling and tracking, the assignment of responsibilities and authorities and their actual realisation as a result of investing in change. A benefits management approach has a great advantage over many other planning methods in that it focuses attention on outcomes i.e. what will be achieved rather than only on inputs and processes. It is of particular benefit for mental health commissioning where there are a wide range of alternative routes to achieving improvement in service-users' conditions. Developing this approach makes it much easier to evaluate the effectiveness of different interventions on the care pathway. Its main advantages are therefore that it :

- Identifies expected benefits, contributions to business objectives and stakeholders.
- Establishes a benefits management structure defining functions, relationships, communications, roles and responsibilities.
- Develops models of benefits, including intermediate and final outcomes.
- Defines the benefits, including their attributes and measures, owners and risks.
- Assesses value and organisational impact, dependencies and risks; it will also show how the benefits are interrelated.
- Develops a benefits realisation plan, including a schedule for delivery, assessment or review points, alignment/linkage/inter-dependencies with other modules, projects or programmes, and business change processes for implementation and delivery.
- Establishes accountability for realisation and a means of tracking benefit realisation, including any performance management requirements.

2.1 Key factors for success

Benefits management needs to be part of, and not separate from, programme, project and business management activities. To achieve this, there needs to be:

- Clear definition and acceptance of accountability of those involved, including users, managers and the wider organisation, in terms of governance, roles and responsibilities.
- A benefits management structure and organisation.

In addition, the organisation needs to be able to.

- Identify the totality of potential benefits.
- Recognise the components of the benefits (business, technology, organisation, people and processes).
- Identify measurable benefits from the investment.
- Assess their relevance and priority to the organisation.
- Focus on the people aspects that will achieve the benefits.
- Recognise if the benefits are being achieved, by benchmarking current performance.
- Specify the risks in achieving them.
- Specify the risks in not achieving them.
- Identify and maximise unexpected benefits.
- Establish how to achieve more.

Successful benefits management is not an overhead or separate activity conducted at "arm's length" from programme or project management. For it to be effective, it needs to be part of good management practice throughout the business change lifecycle - from strategic business planning through to eventual disposal of the service or asset.

As part of this cycle, benefits management performs an important function in capturing lessons over a longer time-span from a series of comparisons between what was anticipated (in terms of benefits) and what actually happened after project deliverables were brought into operational use. The lessons learned in the application of benefits management are also fed back as modifications to the benefits management process itself.

2.2 Checklist

1. Establish the strategy and policies for benefits management as part of the commissioners' management and technical policies.
 - These should describe how the commissioners wishes to manage and achieve benefits from any investment in service change.
2. Establish a benefits management framework and ensure all relevant staff know how to use it.
3. Establish benefit management plans for each programme of work.
 - Benefits realisation plans should be developed for each project including:
 - » A definition of the investment and service objectives.
 - » Details of the benefits tracking process including a clear description of the benefits management activities in the programme and their sequence.

- » A list of benefits and those assigned responsibility for delivering them.
 - » Timescale.
 - » Significant benefit dependencies – e.g. any essential requirements for benefits realisation.
 - » Resources required for activities and when they are required.
4. Link benefits management to investment appraisal and construction of business cases.
5. Key questions for policy makers, elected members, directors and senior managers:
- How do we identify the potential benefits from each investment?
 - How do we assess their relevance and priority?
 - How do we know if we are achieving them?
 - What are the risks in achieving them?
 - What are the risks in not achieving them?
 - How do we identify and maximise unexpected benefits?
 - How can we achieve more?

2.3 Benefits Identification and structuring

Step 1- Identify high level benefits.

- Mandatory – National policy, legal requirements.
- Quality of service – benefit to service-users.
- Internal management – improving the quality of decision-making or management productivity.
- Efficiency gains or cost avoidance.
- Workforce motivation – leading to flexibility, increased productivity etc.
- Risk reduction.
- Economy – reducing costs while maintaining quality.
- Strategic fit – enables the achievement of other objectives.

Step 2 - Link to “business” objectives.

Step 3- Identify the benefits and describe them according to benefits criteria.

- Can quantify and value – Financial.
- Can quantify but difficult to value – Direct non-financial benefits.
- Can identify but difficult to quantify and value.
- Wherever possible use S.M.A.R.T. (Specific, Measurable, Achievable, Relevant and Timely).

Step 3a - Techniques for identifying benefits includes:

- Analysis of current activities, objectives and success factors.
- Consultations with:
 - Professions.
 - Public and service users.
 - Providers.
 - The commissioners' own staff.
- Brainstorming.
- Workshops.
- Comparison with best practice case studies.

Step 4 - Identify risks and dis-benefits:

- Poor design and implementation.
- Costs of change.

Step 5 - Understand the structure of benefits.

Step 5a – Some possible groupings are:

- Sequencing.
- Linkages and dependencies.
- Attributable to introducing new technology.
- Realised with the fewest management actions.
- The most easily measurable and quantifiable.
- Not of significant value on their own.

2.4 Benefits review

Typically many of the benefits expected from a programme of service change will not start to materialise until after the completion of the programme. It will therefore be necessary to conduct a review to check that the benefits performance requirements are being achieved. The benefits review may form part of a wider post-implementation review (PIR) of the programme or project.

A benefits review should cover the following topics:

- An internal audit of compliance against benefit performance requirements in the benefits profiles.
- Analysis of the reasons for over or under achievement of benefits.
- Identification of opportunities for further benefits.
- A review of project and programme plans to ensure that all the activities related to benefits realisation were successfully completed.
- A review of benefits realisation related to service change management activities.

The audit of benefits achieved against performance requirements should be initiated immediately after the latest performance requirement time recorded in the benefits profiles for the project. Interim compliance audits may be appropriate for large programmes with multiple, significant benefits streams.

Checklist of questions

- Which planned benefits have been achieved? If they have been achieved, were the performance requirements correct or should they be increased?
- Which planned benefits have not been achieved? Why were the benefits not achieved? Can remedial action be taken to achieve them or must they be foregone?
- Is there any pattern to the success/failure that can be used to inform other realisation plans or further exercises/programmes?
- Were the assumptions on which the realisation of benefits based correct? If not, what effect did this have on the realisation of benefits?
- Were there any unexpected benefits that have resulted? If so, how can they now be planned and maximised further?
- Have identified dis-benefits been managed and minimised? Have the dis-benefits resulted in achievement of benefits of a higher value?
- Were there any unexpected dis-benefits that resulted? If so, can they now be managed and minimised?
- Are there any further benefits on offer which warrant a further benefits identification exercise?
- Do the measures applied to specific benefits appear to be the correct ones?
- Has the information collection regime worked?
- Do new performance requirements/baselines need to be set for the next review?

3 Detailed operational planning

This group will work together to develop the **detailed operational plan** which needs to cover for each programme:

- A scheduled *Project Portfolio*, including costs. The projects should be grouped linked to significant milestones and review points.
- The *Benefit Profiles* and *Benefits Realisation Plan* which sets out clearly what will improvements will be achieved by when, who will be responsible and how progress will be measured.
- A *Programme Risk Log* so that everyone involved can identify and share potential problems and how they will be resolved.
- Programme management resources and costs.
- How stakeholders interests will be identified and how they will be involved.

It is important to include as much information as possible in the programme plan but also to recognise that some details will not be available at this stage as the plan will develop over the life of the programme.

At this stage, the programme team should also consider the skills profiles for each project and where there may be skill shortages, e.g. in project management or technical skills. It will also be necessary to think about commissioning requirements and the possibilities for collaborative commissioning across the projects - even across programmes.

Once the operational plan has been developed, evaluated and agreed by the Executive Management Team a Programme Manager needs to be designated. It is important that this person has been involved in developing the programme plan but it could be that another senior colleague has more relevant managerial skills to lead the detailed implementation process than the Executive Director who has led the process to date.

The Programme Manager is responsible for commissioning projects within the programme portfolio and should ensure that appropriate individuals are appointed to the key project roles. Each project is accountable to the programme for the successful completion within specified time, cost and quality parameters.

As each project is about to begin, the Programme Manager should agree the project brief in detail with the project manager and project team. The brief for each project should provide a clear scope and a measurable definition of its required deliverables or outputs and should include the following information:

- Description of required services.
- Dependencies on other projects.
- Performance requirement delivery date and key milestone reviews.
- Cost profile.
- Resource profile.
- Benefit profile(s) relevant to the project.
- Any risks identified at programme level relevant to the project.

As projects get underway the Programme Manager is responsible for the oversight of the overall process to resolve problems and manage the risks. To ensure that this is achieved project reports should align with the information held at programme level and should be provided regularly to the programme. Any departures from previously published project plans should be assessed for impact on the rest of the programme. Impact assessment needs to be carried out as early as possible in order to manage any consequent changes. The Programme Manager is also responsible for ensuring that learning from individual projects is made available to all the others through an effective communications strategy.

The point at which a programme may be closed is determined by the completion and implementation of the last project or when the new services are stable and operating effectively. There needs to be a rigorous review process the objective of which is to formally assess and measure the delivery of benefits into the operational environment. It is very important that the review processes is framed in terms of learning rather than blame so that individuals and groups will report honesty on what has happened. The Programme Manager is responsible for the reviews and will need to involve relevant internal and external stakeholders. The Programme Manager is also responsible for ensuring that any resource or skills gaps are addressed so that staff are appropriately supported for future activities.

The review outcomes will be presented to the Board to inform the next phase of strategic planning as well as being disseminated as part of the communications strategy.

Linked to the review process will be:

- A review of all programme documentation to ensure that all elements have been covered.
- Any contracts used by the programme should be finalised and closed, or responsibility for continued contract management handed over to business management/operations.
- Programme closure is confirmed by the responsible Executive Director, the Programme Manager and the sponsoring group, and all stakeholders informed of the overall outcome.

4 Mapping and managing risk in mental health commissioning

Risk is defined as uncertainty of outcome, whether positive opportunity or negative impact. Risk allocation is the process of apportioning individual risks relating to projects and service delivery to the party best placed to manage each risk. Risks are allocated across the supply chain – that is, between the organisation, its customers, its suppliers and their subcontractors.

www.scmh.org.uk/8025694D00337EF1/vWeb/fsCPIR4PDJ8T

Appendix F | Key information and data sources

1 Websites

Durham University Adult Mental Health Service Mapping Atlas: www.dur.ac.uk/service.mapping/amh/index.php

Durham University Child and Adolescent Mental Health Service Mapping Atlas: www.dur.ac.uk/camhs.mapping

Eating Disorders Association: www.edauk.com

The Foundation for People with Learning Disabilities: www.learningdisabilities.org.uk

Healthcare Commission: www.healthcarecommission.org.uk

Improvement and Development Agency: www.idea.gov.uk

King's Fund: www.kingsfund.org.uk

Making ends meet: www.joint-reviews.gov.uk/money

Mental Health Foundation: www.mentalhealth.org.uk/

Mentality: www.mentality.org.uk/

MIND: www.mind.org.uk

The National Collaborating Centre (NCC) for Mental Health is led jointly at the British Psychological Society and the Royal College of Psychiatrists, and thirteen organisations form a reference group for the Centre:
www.nice.org.uk/cat.asp?c=73141

National Electronic Library for Mental Health: www.nelh.nhs.uk/nsf/mentalhealth

National Institute for Mental Health (NIMHE): www.nimhe.org.uk

National Primary Care Research and Development Centre: www.npcrdc.man.ac.uk

National Primary and Care Trust Development Team: www.natpact.nhs.uk/

Royal College of Psychiatrists: www.rcpsych.ac.uk

Sainsbury Centre for Mental Health: www.scmh.org.uk

2 2004-2005: Health Commission performance requirements

Performance requirements for 2004/5 for Acute Trusts, Mental Health Trusts and PCTs have been released at the start of the financial year. These provide important focal inputs on commissioning priorities. They can be downloaded by clicking on the link below:

2005 key target indicators for acute and specialist trusts

2005 key target indicators for trusts providing mental health services

2005 key target indicators for primary care trusts (PCTs)

2005 key target indicators for ambulance trusts

http://ratings.healthcarecommission.org.uk/Indicators_2005

3 Policy documents

Improvement, expansion and reform: The Next 3 Years - Priorities and planning framework 2003 - 2006:

www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4008430&chk=IXp8vH

Draft Mental Health Act 2004:

www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsLegislation/PublicationsLegislationArticle/fs/en?CONTENT_ID=4088910&chk=6GB8PU

Fast forwarding primary care mental health:

www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/MentalHealth/MentalHealthArticle/fs/en?CONTENT_ID=4001917&chk=vn2rpo

Mental health policy implementation guide, Department of Health (2001):

www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4009350&chk=THUXgd

National Service Framework for children, young people and maternity services child and adolescent mental health (CAMHS): www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/fs/en

National Service Framework for older people. Department of Health (2001):

www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4003066&chk=wg3bg0

National Service Frameworks for mental health: Modern standards and service models, Department of Health (1999):

www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4009598&chk=jmAMLk

Commission for Health Improvement: What CHI has found in mental health trusts:

www.chi.nhs.uk/eng/cgr/mental_health/mental_health_report03.pdf

4 Key topics

4.1 Assertive Outreach

Assertive outreach and crisis resolution, Sainsbury Centre for Mental Health (2001):

www.scmh.org.uk/8025695100388752/GenerateFrameset1?OpenAgent&doc=wpASTN5J3EDV

Independent and able to cope, Evaluation of working together in London: An integrated mental health initiative

J Lee, P McCrone, R Ford Sainsbury Centre for Mental Health (2002):

www.scmh.org.uk/8025695100388752/GenerateFrameset1?OpenAgent&doc=wpASTN5J3EDV

Transforming mental health care: Assertive outreach and crisis resolution in practice, Anne Chisholm and Richard Ford, Sainsbury Centre for Mental Health/National Institute for Mental Health in England (2004) downloadable from: www.scmh.org.uk

4.2 Care Programme Approach

An audit pack for monitoring the care programme approach, Department of Health (1996):

www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4008226&chk=v7hmYJ

Effective care co-ordination in mental health services care programme approach, Department of Health (1999):

www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4009221&chk=k0eztB

4.3 Carer Involvement

A commitment to carers, Produced by Rethink for the Department of Health:

www.rethink.org/publications/pdfs/commitment%20to%20carers.pdf

Children caring for parents with mental illness: perspectives of young carers, parents and professionals, Aldridge J and Becker S, (2003), (Bristol, The Policy Press).

User and carer participation route map, Allies in Change (2001), (Edinburgh, Scottish Development Centre for Mental Health).

Developing services for carers and families:

www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4009233&chk=qDc1ps

Involving users and carers in policy implementation, Foster S and McHarron A (2001), (Birmingham, West Midlands partnership for mental health).

Developing services for carers and families of people with mental illness, Department of Health (2002):

www.rethink.org/publications/pdfs/commitment%20to%20carers.pdf

Good practice guidelines for involving service users and carers in Local Implementation Teams, North West Mental Health Development Centre (2001), Manchester, North West Mental Health Development Centre.

A survey of policy and practice on expenses and other payments to mental health service users and carers participating in service development, Journal of Mental Health, Ryan T and Bamber C (2002), 11 (6):635-644.

Carers and community mental health service, Schneider, J, Carpenter, J, Wooff, D, Brandon, T. and McNiven, F. (2001). Social.

Psychiatry and Psychiatric Epidemiology, 36, 604-607.

Mental health of carers, Singleton N, Maung, NA Cowie A, Sparks J, Bumpstead R and Meltzer, H (2002), (London, Office for National Statistics, The Stationery Office).

4.4 Child abuse

Child abuse and neglect: the role of mental health services, Council Report CR120 Royal College of Psychiatrists London (2004): www.rcpsych.ac.uk/publications/cr/council/cr120.pdf

4.5 Combating Stigma and Discrimination

Attitudes to mental illness, Taylor Nelson Sofres and National Institute for Mental Health (2003): www.nimhe.org.uk/downloads/mentalillnessreport.pdf

Changing minds, Royal College of Psychiatrists: www.rcpsych.ac.uk/campaigns/cminds/printed_materials.htm

Stigma, discrimination and social exclusion: What's in a word, Sayce, L. (1998). *Journal of Mental Health*, 7 (4), pp. 331-343.

From psychiatric patient to citizen: Overcoming discrimination and social exclusion, Sayce, L. (2000), (London MacMillan).

4.6 Commissioning

Commissioning mental health services: Experiences from the USA, A Cohen, D Light Sainsbury Centre for Mental Health (2003): www.scmh.org.uk/8025695100388752/GenerateFrameset1?OpenAgent&doc=wpASTN5J3EDV

Commissioning friend NatPaCT: www.natpact.nhs.uk/cms/99.php#prep

Practice-led commissioning: Harnessing the power of the primary care frontline, Lewis, R (2004), King's Fund: www.kingsfund.org.uk/pdf/practiceledcommissioning.pdf

Making ends meet: www.joint-reviews.gov.uk/money

PACT research on procurement commissioned by NatPaCT:

Click on the link www.natpact.nhs.uk/cms/99.php to download a PowerPoint presentation on key points of the Research Findings (899kb) and to download a Presentation and the full text of Research Findings.

Setting the standard: The new agenda for primary care organisations commissioning mental health services, Sainsbury Centre for Mental Health (2001):

www.scmh.org.uk/8025695100388752/GenerateFrameset1?OpenAgent&doc=wpASTN5J3EDV

4.7 Complementary therapies for mental health problems,

Mental Health Foundation Fact Sheet (2000): www.mentalhealth.org.uk/page.cfm?pagecode=PMSTCO

4.8 Crisis Resolution

Assertive outreach and crisis resolution, Sainsbury Centre for Mental Health (2001):

www.scmh.org.uk/8025695100388752/GenerateFrameset1?OpenAgent&doc=wpASTN5J3EDV

CGST Eureka: crisis card: www.cgsupport.nhs.uk/Resources/Eurekas/Mental_Health/Crisis_Card.asp

Transforming mental health care: Assertive outreach and crisis resolution in practice, Anne Chisholm and Richard Ford published by The Sainsbury Centre for Mental Health/National Institute for Mental Health in England (2004).

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4.9 Direct payments

Direct what?' A study of direct payments to mental health service users, Ridley J and Jones L (2002), (Edinburgh, Scottish Executive Central Research Unit.

Direct payments, independent living and mental health, Spandler H and Vick N, (2004), (London, Health and Social Care Advisory Service).

Payments and the benefits system: A guide for survivors and service users involved in improving mental health services, Scott J and Seebohm P (2001a), Institute for Applied Health & Social Policy, King's College London.

Payments and the benefits system: A guide for managers paying survivors and service users involved in improving mental health services, Scott J and Seebohm P (2001b), Institute for Applied Health & Social Policy, King's College London.

Direct payments: The Impact on choice and control for disabled people, Witcher S, Stalker K, Roadburg M and Jones C (2000), Scottish Human Services Trust and Lothian Centre for Integrated Living, The Scottish Executive Central Research Unit.

4.10 Dual diagnosis

Dual diagnosis mental health policy implementation good practice guide, Department of Health (2004):
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4009058&chk=sCQrQr

4.11 Early Intervention

Early intervention for people with psychosis, National Institute for Mental Health in England (2003):
www.nimhe.org.uk/downloads/early.pdf

A Window of opportunity: A practical guide for developing Early Intervention Services, The Sainsbury Centre for Mental Health (2003):
[www.scmh.org.uk/website/SCMH_MHT.nsf/59ae2dc0a615100a802567e4004f2d1e/c4658ab5f3f96b1b80256e5c00490b59/\\$FILE/briefing%2023%20-%20A%20Window%20of%20Opportunity.pdf](http://www.scmh.org.uk/website/SCMH_MHT.nsf/59ae2dc0a615100a802567e4004f2d1e/c4658ab5f3f96b1b80256e5c00490b59/$FILE/briefing%2023%20-%20A%20Window%20of%20Opportunity.pdf)

4.12 Employment issues

Vocational rehabilitation: The way forward, British Society for Rehabilitation Medicine (2001), British Society for Rehabilitation Medicine, (London, British Society of Rehabilitation Medicine).

Managing mental health: Research into the management of mental health in the workplace, Diffley C (2002), (London The Work Foundation/Mindout).

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Employment for people with mental health problems, National Institute for Mental Health in England:
www.nimhe.org.uk/downloads/employment.pdf

Working minds: making mental health your business, Mindout for mental health (2000). (London Mind).

The Pathfinder user employment programme: Increasing access to employment within mental health services for people who have experienced mental health problems, Perkins R, Evenson E and Davidson B(2000), (London, South West London & St George's Mental Health NHS Trust).

4.13 Funding

Money for mental health: A review of public spending on mental health care. Sainsbury Centre for Mental Health (2003): www.scmh.org.uk/8025695100388752/GenerateFrameset1?OpenAgent&doc=wpASTN5J3EDV

4.14 Gays, Lesbians, Bisexuals and Mental Health

Mental Health Foundation Fact Sheet (2004): www.mentalhealth.org.uk/page.cfm?pagecode=PEAMGL

4.15 Health and Social Care integration

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Appendix G | The Visual Commissioner: A software tool to assist both commissioners and service providers

This appendix describes a tool developed by West Midlands Strategic Health Authority and its partners to support the commissioning process.

Commissioning and service modernisation

- The health care commissioning process requires careful attention in that it spans the clinical and management issues ranging from identifying the need for care and treatment, to the monitoring of standards in the services made available.
- This process is just as relevant for commissioning of mental health services as it is for acute (surgical, medical etc) specialities.
- Mental health services are being modernised in a concentrated and intensive way. Delivering benefits to service-users, their families and carers through the implementation of new service models continues to be the focus of both PCTs and Provider Trusts.

This work and its planned achievements is typically expressed in the Local Delivery Plan (LDP).

Software to assist, and its principal functions

- So the need for a robust commissioning process becomes ever more important. This software can be used in that part of the local process that requires a 'contract / service level agreement' to set out what services are to be provided over the period under review; and how these will change at agreed times as part of the service improvement / service modernisation actions.

- The software has four principal functions and uses;
 - its design is consistent with that of the National Mental Health Service Mapping and Finance Mapping exercises which cover all parts of the English N.H.S.
 - it works as a project planning and monitoring tool so that changes, either proposed or agreed, for current services can be shown. Current services are set out in activity and finance terms, and staffing data can also be added if required.
 - the potential impact that one change in service provision may have on another can be modelled and incorporated in to the 'project plan'.
 - the risks relating to the 'contract/service level agreement' and all of the associated service improvement changes can be built into the commissioning project plan. Any risk described in this function is also expresses in financial terms ('how much will it cost to 'buy-out' this risk?').

The software and its uses

The tool will neither solve problems nor generate a strategic direction for service delivery, but it provides a project framework for setting out proposals, to take into discussion, or for confirming joint agreements. In this way the LDP can be directly built into the patterns of current services and can cover either one year, or all three.

By using the service and financial mapping data in combination, and adding the associated staffing data if required, then the effect of agreed and timed changes on the (annual) cost, activity, and manpower, can be quickly and easily seen through the standard reports generated by the tool.

Each change is readily entered into the project framework at its planned implementation date, and so the individual and collective effect on cost, activity, outcome, staffing are produced.

Each time a 'main change' is made to a current service the tool encourages careful and deliberate consideration on the effect this will, or could, have on other services. This function is built-in to avoid the framework having a simple 'incremental' approach to service change.

Each service line in the project framework (the same structure of ---lines as in the maps) has a prompt / text box which offers the facility of encouraging a range of other service-lines to be considered for change. For example, a service change relating to the introduction of part of an early intervention service might prompt a consideration of the impact on: CMHT (activity); drug prescribing (costs); in-patient facilities. Each impact can be expressed in text form plus cost / activity / outcome as required.

Often these impacts will carry a level of risk and in considering the extent of risk it may have lead us not to change that affected service and so avoid any risk - for example, not actively planning to close in-patient facilities as a result of a crisis resolution service becoming established locally.

The software allows a value to be put on the risk associated with any change, and this is particularly useful for risks linked to 'impacted services'. The standard report on 'risks', linked to individual changes or a whole year, provides a schedule of the type of risk, and the estimated cost of reducing or avoiding them; perhaps a useful tool when negotiating proposals for change.

Moving forward and using the software

PCTs and NHS Trusts involved in commissioning and delivering mental health services are currently monitoring the LDP year 1 position and reviewing the Years 2, 3 outlines as these come closer to being the 'new Years 1, 2'; and preparing the updates for the service mapping and financial mapping exercises as part of the National Mental Health Autumn assessment for 2003.

The software provides a valuable tool for all parties to use in the preparations for such joint reviews and discussions, and for project planning the agreements that will certainly result.

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