HSJ LOCAL briefing

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MANCHESTER REWIRING MENTAL HEALTH SERVICES

HSJ Local Briefing is our new in-depth analysis of the key issues facing the NHS's major health economies

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In brief

Issue Commissioners in Manchester are developing commissioning intentions they anticipate will require their current mental health providers to "act radically differently". The high level proposals suggest a series of short to medium term reforms to address "immediate major structural shortcomings", and a longer term move to outcomes based commissioning and a single or lead provider for most of the services they commission.
Context The plans follow an independent report on the city's mental health system, which emphasised the relatively fragmented nature of current services and made a series of recommendations for reform. Probably the report's most controversial recommendation was that Manchester Mental Health and Social Care Trust should be merged with a neighbouring provider.

Outcome: The clinical commissioning groups have distanced themselves from the merger strategy advocated by the independent report, and the health and social care trust's chief executive believes the high level commissioning intentions are consistent with the trust's own business plan. The implications of the commissioning intentions for individual providers will probably not become clear until detailed service specifications are agreed.

An "unusually fragmented service"

The three clinical commissioning groups responsible for buying NHS care in Manchester (alongside Manchester City Council) are in the process of developing detailed commissioning intentions for mental health services, which they say will require their providers to "think and act radically differently".

A draft of the commissioners' high level intentions, published in July, outlined a series of concerns about the city's current mental health service provision. Among these, it said, commissioners were "particularly concerned about services for adults of working age experiencing severe mental health crises", with "too many people" having to wait "too long to access the services they need" or being sent to services "a long way from Manchester".

It added that the "interfaces" between services and providers did "not work as well as they should", the small number of wards to which Manchester patients had routine access did not "promote the development of local specialist wards", and the current balance of services between different age groups was not "well aligned to the pattern of local needs".

The paper acknowledged that historic commissioning decisions in the city had contributed to current problems, "in that piecemeal procurement exercises have created an unusually fragmented service, with a greater level of complexity than we would now consider desirable".

The CCGs' main provider of adult services is Manchester Mental Health and Social Care Trust, while Central Manchester University Hospitals Foundation Trust provides services for children and adolescents. However, the commissioning groups include a number of other NHS and third sector providers, the largest of which are Rotherham, Doncaster and South Humber FT for early intervention in psychosis, Greater Manchester West Mental Health FT for offender healthcare, and the charity Self Help Services for psychological therapies.

The paper added: "We are therefore signalling, via these commissioning intentions, a clear determination to address these deficiencies."

The plan outlined by commissioners has three elements:

- First, a series of short to medium term reforms to address what they call the "immediate major structural shortcomings" of the city's mental health system.
- Second, an intention to move away from paying for services by volume to paying for outcomes.
- Third, the commissioners envisage bringing most of the mental health care services they purchase into a "single system-wide contract".

The latter element would mean buying all those services either from a single provider or, more likely, a lead provider that subcontracted parts of the work to other organisations. The document says that commissioners will consult with affected providers to determine "exactly which services should be reintegrated", but notes that they do not expect children's mental health services to be rolled into this single contract, given the "particular need" to integrate these services with other children's health and social care services.

What needs to change

The commissioning intentions are, in part, a response to the findings of a recent independent report commissioned by NHS Manchester and the city council, which found that the city's mental health services were "more fragmented" than typical "with contracts placed beyond the main provider (Manchester Mental Health and Social Care Trust) for early intervention in psychosis, learning disability services, mentally disordered offender services, substance misuse services and most secure services".

However, many of the issues now being aired are not new. The Mental Health Independent Report notes that much of what its authors found was consistent with the findings of a "remarkably extensive series of previous reviews of mental health services in Manchester", namely: "concerns about inpatient services and acute care", "problems with access and referral systems" and "reported difficulties with communications between organisations" – despite "apparently sufficient investment".

The report – which was completed in April but only made public recently – gives commissioners 10 recommendations on "what needs to change". Recommendation number one is that they act to ensure acute care is "local and resilient".

The document's authors state they are "very concerned at the many signs that the acute care system for adults of working age is not working properly", including the level of overspill placements in often geographically remote private sector services, a history of delays in accessing beds for people assessed as requiring detention under the Mental Health Act and the length of stay in acute wards.

According to the report, of the 328 patients assessed under the act between April and December 2012 who required acute admission, 79 per cent were admitted on the day of assessment, 7 per cent waited one day for a bed, 2 per cent waited two days and 1.5 per cent waited 3-13 days. The remainder were either not admitted "because inpatient admission was no longer appropriate" or were recorded as "allocated to an appropriate

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community treatment pathway within 48 hours of assessment".

The report also found there had been a "significant increase" in overspill placements, funded by the health and social care trust, to out of area acute and psychiatric intensive care unit facilities in the first nine months of 2012-13. Between April and December 2012 this translated to 1,543 independent sector bed days in adult acute facilities, compared with 970 in 2011-12.

Michele Moran, who became chief executive of the mental health and social care trust in December 2012, told HSJ that since she took up her post "nobody has waited" for an acute bed, "detained or otherwise". However, she added that as a result there had been an increase in out of area placements. She said the trust was currently picking up the cost of these placements out of its existing allocation, but was trying to negotiate a risk share agreement with its commissioners.

The report recommends, in the short term, that it would "clearly make sense" for acute overspill to be directed to neighbouring services in Greater Manchester; it also says there is a clear case for redesignation of some of Manchester's older people's beds as beds for working age adults.

Its other nine recommendations cover a number of proposals for tackling fragmentation, such as the implementation of "robust protocols" for managing interfaces between different services. They also cover proposals for investment prioritisation and performance management to be based on "completely open book information". The report says: "We have concerns that (in our view) misplaced ideas of commercial confidentiality have been used as a justification in Manchester for not sharing the detail of investment, staffing, turnover or outputs in full detail. This applies equally to data held by commissioners."

Much of the substance of the 10 recommendations is reflected in the commissioners' intentions for short to medium term service change, including an expectation that providers will be "required to work on a wholly open book basis with us", and a wish to ensure that a "suitable local bed is available within at most four hours" for patients assessed as requiring hospital admission.

Securing change

However, the independent report also included a more controversial section, outlining what its authors saw as the commissioners' options for securing change. The authors' preferred option here was, essentially, for the CCGs to withhold support for the health and social care trust's bid to become a foundation trust and to instead seek its merger with another local provider. The independent report says it "may well be the case" that there is "an intrinsic problem with the configuration of Manchester's mental health services that has eluded even the best intentioned and most skilled efforts of many people over the years".

It continues:

"Nowhere in England is a trust as small as the Manchester trust tasked with managing the level of deprivation and need which is seen in Manchester...

"We do not have significant concerns about the issue of financial viability; there are smaller entirely successful organisations. We think there may however be an issue of clinical viability – whether the Manchester system, given the complexity and scale of local demand, has access to a sufficient critical mass of skills, and sufficient interdependent services, to function successfully and safely. There may also be a problem of the absolute size of the Manchester bed pool, and therefore the local flexibility to manage even small spikes in demand."

The report speculates that if Manchester CCGs withdrew their support for the trust's FT bid it would "very probably be placed in the 'mergers and acquisitions' path of the provider development process". It suggests if bidders for the subsequent acquisition were restricted to neighbouring providers it would produce a "range of potentially beneficial outcomes: a larger local bed pool, opportunities for new specialist services to emerge, strengthened staff recruitment [and] removal of some of the more difficult interfaces between services".

It concludes: "On balance, we find it hard to believe that the continuation of the Manchester Mental Health and Social Care Trust in its current form offers the best means of achieving the service improvements sought by the large majority of local stakeholders."

"It's no longer on the table"

The CCGs, however, seem keen to distance themselves from the independent report's proposed strategy. North Manchester CCG chief clinical officer Martin Whiting told HSJ: "That was one of the thoughts of the writers of the report. It doesn't reflect what the commissioners particularly wanted."

Asked if he thought the merging of the mental health and social care trust with a neighbouring provider was a bad idea, he replied: "I think it was an idea we would have to explore in rather more detail before we decided whether it was worth pursuing or not. But it's no longer on the table because we've decided to go down the commissioning intentions route."

The position taken by the commissioners may be partly due to a judgement that the CCGs have limited control over what would actually happen if they withdrew support for an the trust's FT bid. Craig Harris, executive nurse and city-wide director of commissioning, quality and safeguarding for the three Manchester CCGs, told HSJ: "There are only certain gifts within commissioners' abilities... The report outlines what the report writers felt would be appropriate, but actually from a commissioning point of view what we [had] control over was articulating our commissioning intentions."

It's worth noting, in this context, that the independent report's authors acknowledge the commissioners they interviewed were divided about the appeal of a merger or acquisition. They say: "The potential for the services provided by Manchester Mental Health and Social Care Trust to be transferred... to other providers was regarded by some as a welcome and necessary change, by others as reluctantly required and by others as an unwelcome distraction."

Greater Manchester's providers were even less enthusiastic. The report states: "Almost all [provider] interviewees had little appetite for a major restructure or reprovision. Many expressed an open wish to help the system, perceiving many of the problems as systemic, rather than all to be laid at the door of [the trust]." HSJ approached two neighbouring mental health providers for this article – Pennine Care Foundation Trust and Greater Manchester West – but neither organisation wished to comment.

The commissioning intentions document stresses that plans to move towards a lead or single provider arrangement for most mental health services are not intended "to direct any provider to seek any particular form of consortium, partnership,

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association or merger".

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

Strategic implications

The strategic question for Manchester's mental health providers is how much organisational change will they need to make to meet the commissioners' expectations? At the moment, however, the commissioning intentions are very broadly defined; the commissioners are in the process, over the summer, of developing a detailed specification, working with providers, patients and the public. It may genuinely be too soon to say what this will mean for the future shape of Manchester's mental health system.

Asked what the implications of the CCGs' approach were for the current providers, Dr Whiting replied: "That depends on what the current providers think of the commissioning intentions when they're published, and whatever process we go through in order to recommission mental health services. I guess that's a question for the providers."

When HSJ put the same question to Manchester Mental Health and Social Care Trust chief executive Michele Moran, she said: "At the moment we're working through all that with the commissioners. They've published their high level commissioning intentions, which really need a lot more detail, including exactly what it is they want and in what particular area[s] of service."

She added that the CCGs had not yet decided whether they were going to seek a lead provider model, but if they did her trust would be interested in attaining that lead provider role. "We are the main provider of mental health services in Manchester, and we could do that lead providing role," she told HSJ.

Earlier this summer, the trust withdrew from the FT status application process, while it awaited publication of the commissioning intentions, but it remains an aspirant foundation trust. Ms Moran said the decision to withdraw had been a "timing issue": "One of the things the commissioners were very clear on is until they had formulated their strategic commissioning intentions it was difficult to support any FT application."

She continued: "Now we've got the [high level] commissioning intentions we can see how aligned they are to our integrated business plan. And they are very aligned to our initial [plan]."

The "idea" she said, was for the trust to take another look at its business plan and the commissioning intentions "and then to make the decision to go forward to being an FT". She said this decision would probably be taken around October.

A spokeswoman for the NHS Trust Development Authority said it was "fully supporting the trust following its decision to withdraw from the Monitor process".

She added: "We have held joint discussions with commissioners and the trust to help plan with regard to emerging commissioning intentions. As these intentions are not yet agreed, we can't speculate on any outcomes."

On the specifics of the independent report, Ms Moran rejected the suggestion that the trust might be too small to be clinically viable. "The document doesn't actually give any justification or reason for that," she said. "And when we challenged the commissioners they couldn't either...

"We've got no signs to say that we're not clinically viable in any of our services. Because we don't have a lot of specialist services, to be honest, which is where the clinical debate usually starts to develop."

She added that there was "quite a simple answer" to the issues of access to beds and out of area placements identified in the report: "They need to commission more capacity for acute inpatient adult mental health services.

"It's well known and benchmarked that they don't commission enough services. The national benchmarks [which need to be adjusted for things like acuity] say there should be 24-25 beds [per 100,000 of the population], when we get commissioned for 17 beds. We've done some capacity work and we're under-resourced by about 40 beds. So there is a commissioning responsibility there."

Asked if he was concerned about the absolute number of acute inpatient beds available in Manchester, Dr Whiting said: "I'm concerned that the number should meet the demand, and it probably doesn't at the moment. But that demand depends a little bit on things like average length of stay, and the types of patients, and the community services that back those patients up. So the absolute number is difficult to arrive at."

The commissioners and the trust are currently working together on the scope for redesignating some beds for older people as beds for working age adults, but both emphasise that this is not a simple process.

Ms Moran said: "We're doing that together, because we also need to make sure [of things] around the shift into community services for later life users. There's still a growing demand for later life services, it's just it's closer to home – as it should be – and in the community. We need to make sure we're balancing that system across Manchester, not creating a problem elsewhere later."

Conclusions

The aspirations set out in the CCGs' high level intentions could imply radical changes for Manchester's mental health providers. However, the commissioners are in the process of working through the details of their plans, with the involvement of providers, and it remains to be seen how radical those changes will be and at what pace they might have to take place.

The organisation with most at stake in this is Manchester Mental Health and Social Care Trust. Its chief executive has expressed confidence that the commissioning intentions – as described so far – are consistent with the possibility of her trust making an independent bid for FT status; however, to secure the trust's independence she will also have to convince regulator Monitor of that.

The apparently limited appetite in Greater Manchester for the trust being merged or acquired may also work in its favour. Whatever the implications for individual organisations, it's clear commissioners and providers will have to work through an intricate tangle of problems if the commissioning intentions are to do what is intended and, in Dr Whiting's words, "provide a mental health service that's joined up [so] that patients don't get lost in the cracks,

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that they don't get confused by the systems [and] that GPs, urgent care services can navigate systems promptly and safely".