

Mental Health Services in Manchester

7th July 2008

Preface:

There is little doubt that Manchester is one of our most vibrant cities. Its energy and opportunity bring many to join those who were born and bred here creating a rich and diverse mix of citizens eager to drive forward their own and the city's aspirations. However it also holds within itself significant areas of need, not least for those whose mental health is challenged or who have developed mental illness.

This review was commissioned to try to identify the blockages that seem to prevent mental health services in Manchester taking their place amongst the best in England, a place which the population has a right to expect. Indeed for a number of years services have been independently evaluated as fluctuating in their quality and despite repeated efforts overall progress has been painfully slow.

Throughout the short period of our work we have been highly encouraged by the openness of the people we have met, the quality of some of the services we have seen and the level of commitment and passion we have found. Although our focus was on identifying obstacles, we have nevertheless seen clear evidence of real achievements and positive success; we have made some reference to this in the body of our report. We have also encountered much frustration but this too has encouraged us as it shows the underlying passion for improvement held by service users, carers and staff alike.

Over the last 8 years mental health services seem to have been beset by a series of challenging events which, when coupled with service reorganisations have in our view served to deprive the city's services of a clear, agreed and focused way forward. This has meant that it has been difficult to rally stakeholders to a common cause and arguments have raged about who truly holds the best interests of patients and carers at heart.

Manchester has so much going in its favour. The health economy is strong and investment in mental health services is amongst the highest in the region even though the needs too are very high. The structure of the mental health community is relatively straightforward and should allow for less complex organisational relationships and the work of the University of Manchester in the field of mental health is held in high regard nationally and internationally.

Yet we have been drawn to the view that over a prolonged period of time it seems to have proved difficult to engage staff, partners, service users and carers and the public alike in an agreed vision for services and a combined determination to achieve it over a long enough timeframe for it to become embedded.

We have witnessed periods of progress, especially in the main provider unit, now Manchester Mental Health and Social Care Trust but at critical points in the history of that organisation there have been senior leadership changes which have created a further gap in progress. Recent times are no exception with the current leadership of the Trust having worked through an extremely difficult set of circumstances over the past 12 months trying to maintain services for service users and carers and deliver much needed changes to community services and now facing a period when it is clear progress is starting to be made. The key challenge however is to be able to maintain the momentum of that change for long enough for it to develop the momentum that has consistently eluded this mental health economy.

Our report looks to the past only to try to identify a way forward and we acknowledge that in order to try to retain our focus on the blockages there are times when the report focuses on the negative. This is not our intention and I want to stress again that we have seen much to encourage us in terms of the potential to move forward.

There will be those who will question our analysis and our recommendations and who will have their doubts as to whether we really have identified the critical obstacles. However if those doubts are allowed to develop into yet more resistance to change or into yet another stalled set of initiatives then it is difficult to see how services will ever achieve what the people of Manchester deserve.

This is not the first report on services in Manchester but we sincerely hope it will be the last and we would ask all who read this report to reflect on the potential in Manchester and to focus their energies on implementing our recommendations to enable it to be achieved.

John Boyington CBE
Review Chair

Background:

This assessment was jointly commissioned by Manchester Primary Care Trust (PCT) and Manchester City Council in April 2008.

Terms of Reference

Aim

To assess the obstacles to mental health service development in Manchester and advise on courses of action to address these, in order to take forward and improve services.

Scope

The scope of the project is the provision of mental health services primarily for adults (16+), including older adults, with severe and enduring mental health needs, and the commissioning arrangements for those services between Manchester Primary Care Trust and Manchester City Council.

In the course of the project, the project team will consider, amongst other relevant issues pertinent to the aims of the project, the following:

- The size and structure of Manchester Mental Health and Social Care Trust
- The distribution of resources across the city and its relation to service levels and need
- The investment of resources compared to the level of mental health need
- The interfaces between mental health services and the organisations directly supporting social inclusion e.g. Job Centre Plus, Manchester City Council housing services
- Identified project stakeholder views and perceptions of CAMHS across the city e.g. issues for young people entering adult mental health services.

The assessment took place over the period May and June 2008.

The Assessment Team would like to thank all staff, service users and carers, organisations and individuals who participated in the assessment. In particular we would like to thank Sandra Nugent for her help in the complex task of organising the assessment in such short timescales.

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1. Introduction

- 1.1 The Assessment was undertaken in a relatively short timescale, with fieldwork interviews being conducted during the four weeks from mid May through to mid June 2008, the final report being produced by the beginning of July 2008. In view of these tight timescales, it was not possible to examine the detail of all aspects of mental health services in Manchester, and the Assessment Team used interviews and document reviews to identify key consistent themes which were getting in the way of services moving forward and improving. The assessment was commissioned specifically to identify obstacles to mental health service development in Manchester, and to subsequently advise on courses of action to address such obstacles in order to take forward and improve services for the population of Manchester.
- 1.2 The Assessment Team comprised:
- John Boyington CBE, Chair – NHS North West Commission for Mental Health Services
 - Kate Caston - Director of Specialised Commissioning, East Midlands
 - Colin McKinless – formerly Executive Director (Social Care and Health), Tameside Metropolitan Borough Council
 - David Snowdon – Chief Executive, Humber Mental Health Teaching NHS Trust
 - Charles Flynn MBE – formerly Deputy Chief Executive/Chief Operating Officer, Merseycare NHS Trust

Attempts were made to secure service user representation to serve on the Assessment Team, but due to the compressed timeframe and other constraints this proved not to be possible.

- 1.3 Whilst it was not possible to include a service user representative as a member of the Assessment Team the assessment methodology paid particular attention to engaging and listening to the views of users and carers. In addition to arranging to meet with existing user and carer groups and networks across the city, an open advertisement was placed in the Manchester Evening News, inviting any individual, group or organisation to meet with the Assessment Team to give their views on mental health services in Manchester.
- 1.4 The list of those interviewed as part of the assessment process some of who responded to the aforementioned Manchester Evening News 'open advert' is set out in Annex A to this report.

Our thanks go to all the people who met with the team for their positive engagement. The vast majority of interviewees displayed a genuine desire to see services improve and a frustration that this had not proved possible to achieve as quickly as they had hoped. That positivity needs to be harnessed as a key ingredient in taking forward the recommendations in this report.

2. Events and Organisational Changes

2.1 There is a real sense that the recent history of mental health services in Manchester has been characterized by a number of significant events and recurring challenges which have meant that services have never really 'got into their stride'. However this applies more to services for adults of working age than to those for older people or children and adolescents where we received a much higher level of positive feedback.

2.2 The following analysis provides the supporting evidence for that statement and suggests that the history of the Manchester Mental Health and Social Care Trust in particular, has been characterized by a series of "events", which have deflected the organisation away from the core business. Whilst our brief extended to all areas of provision our ability to review the many independent sector services was limited. However as the predominant health and social care provider in Manchester, issues related to the Care Trust inevitably took a considerable amount of our time and focus. The issues that affect the Care Trust inevitably knock-on across the whole of the sector and this is also true of the distractions that have occurred over recent years.

a) Creation of Manchester Mental Health Partnership - 2000

The initial coming together of the various facets of mental health service in October 2000 was driven by a positive vision of providing consistent, integrated health and social care services to users in Manchester but appears to have got off to an inauspicious start. The new single organisation was structured as a directly managed unit under the auspices of the then Manchester Health Authority. There appears to have been an initial funding deficit which we have been told resulted from the inherited transfer of funding from the predecessor service providers, predominantly acute hospitals. It therefore seemed to us that from almost day one the organisation became focused on dealing with a funding problem. We were told that Manchester Health Authority transferred its Director of Finance to be the Chief Executive of the new organisation after he had led the project to bring together the various services. They also provided non-recurrent financial support to help with the management of the inherited difficulties. There is no implied criticism of the HA either in bringing the organisation together in the way that it did or by installing the first Chief Executive but we think that this was the first in a series of compromises on selection for the most senior roles in the provider organisation which may over time have played some part in subsequent difficulties.

b) Creation of the Health and Social Care Trust - 2002

Manchester Mental Health and Social Care Trust was one of the first examples in England of an integrated Health and Social Care Mental Health service and formally came into being in April 2002. We heard that many were keen to be in the vanguard of this new approach to delivering a more integrated approach to services, but we would question whether the timing of the integrated opportunity provided a sufficient period for effective planning and whether the objectives and aspirations of

integrated health and social care were well enough articulated and understood. This coupled with the underpinning financial issues may have meant that the associated business processes and governance and accountability systems were not in place to ensure effective delivery. This was further compounded by the next set of events.

c) **Rowan Ward - 2003**

No sooner had the Care Trust been brought into being than the issues of care in Rowan Ward came to light with the subsequent commissioning by the Trust of the report of the Commission for Health Improvement. The report published in September 2003 was damning and as a result a new Chief Executive was brought in to manage implementation of the report's recommendations and to restore the services reputation. For understandable reasons this appointment was initially not via an open recruitment process, but the appointment was subsequently made substantive via open recruitment. As in the case of the previous Chief Executive there is no implied criticism here but recognition of a developing theme in the history of the provider organisation. The new chief executive established a new management team and good progress was made in a number of areas. The Care Trust went from a position of being rated as a zero star trust (2004) to two stars (2005); it achieved year-end financial balance for the first time in 2004/05

d) **Change In Mind - 2005**

However, assessment with hindsight suggests that some of the above events had meant that Manchester had been slow to adopt and implement significant elements of the National Service Framework (NSF) for Mental Health. Recognising the ground that needed to be retrieved the health community decided to embark on producing and consulting upon the "Change in Mind" strategy to update service design across the city. The consultation ran from December 2005 to March 2006 and although we heard that it was locally praised for the way in which it engaged with service users and other stakeholders it certainly absorbed a great deal of time and energy. We also heard evidence that, notwithstanding the praise that it received in some quarters, in others (particular amongst some staff groups and amongst some user groups) it led to entrenchment and polarisation of views. Perhaps some of this reaction was due in part to the fact that, as Change in Mind was largely associated with implementing national policy, there was limited room for consideration of alternatives or options.

The Chief Executive left the Care Trust to become Manchester PCT Chief Executive shortly after the approval in July 2006 by the Joint Committee of the then 3 PCTs in Manchester and the approval by the Executive Committee of the Council. That approval confirmed the intention to implement the proposals consulted upon in the Change in Mind document. The Chief Executive post was then held temporarily by an acting postholder who carried the responsibilities for approximately 6 months including those for initial implementation of the Change in Mind proposals. During this period, the Care Trust with its partner, HARP, secured the contract to run Manchester's enhanced assertive outreach service and the annual healthcheck on the Care Trust for 2006/07

awarded the organisation a rating of fair for the use of resources and fair for the quality of services.

e) **Industrial Action - 2007**

Nevertheless, the polarisation of views and the strength of feeling amongst some staff about the changes resulting from the Change in Mind programme resulted in a deterioration in the industrial relations climate and two days of industrial action in early 2007. In April that year the current Chief Executive was appointed on a fixed term basis with a brief to determine the strategic direction for the organisation, establish long term financial sustainability, address the industrial relations culture and complete the implementation of Change in Mind. This appointment was made on an interim basis amongst other reasons to enable an assessment to be made of the long term viability of the Care Trust without making a long-term commitment to an appointment. As in the previous circumstances this seems an entirely reasonable course of action to have been taken at the time but was in fact another compromise on the normal process for such senior appointments

In June 2007 the Care Trust found itself subject to serious industrial action following the suspension of a member of staff. This action caused severe disruption and distress to many patients and their families and indeed to many staff with over 300 staff taking action at the height of the dispute. Whilst the energies and efforts of many staff and managers within the Care trust and beyond helped to reduce the impact of this action there is no doubt that it prevented significant progress being made. In the short term it was another serious distraction from the business of getting to grips with the range of fundamental issues within the organisations across Manchester. More positively, the experience of industrial action did prompt the creation by the Strategic Health Authority of an emergency plan for mental health services in Greater Manchester and the Care Trust's experience was very valuable in ensuring that this plan was robust. Additionally, by the year's end there was evidence of real achievement in the Care Trust's performance on hitherto poorly performing services, e.g., crisis resolution and home treatment services, where the nationally determined final quarter target was exceeded for the first time.

2.3 In addition to the above events the health community in Manchester has, like all other health communities undergone a series of organisational changes. These included the disbanding of original Health Authorities and creation of new larger HAs, the creation and subsequent amalgamation of PCTs, disbanding of revised HAs and creation of new regionwide Strategic HAs, all in the short space of 8 years. Coupled with the other events highlighted above this sequence has clearly had unintended consequences for the health community in general and for the Care Trust in particular including:

- Changes in the nature of oversight
- Lack of business continuity
- Lack of consistent focus on management and performance systems, and associated governance arrangements

- Staff, service users and carers feeling unclear about the future of the organisations and their leadership
- 2.4 This catalogue of events and organisational changes has also and inevitably distracted and disrupted other key partners and from the creation of the Care Trust up to the last 12 months there appears to have been a struggle to achieve robust commissioning as a mechanism of focusing the Trust on the key care issues. This remark should not however detract from joint commissioners' achievement by the second half of 2007/8 in enabling Manchester for the first time to have in place all of the key services and capacity required by the NSF for Mental Health.
- 2.5 During the material period there has been the publication of a number of external reports relating to mental health services:
- 2003 – Commission for Health Improvement
 - 2005 – Commission for Social Care Inspection review of Manchester City Council Mental Health Services
 - 2005 – Internal Trust report by General Electric Healthcare Consulting
 - 2006 – Health and Social Care Advisory Service (HASCAS) review
 - 2006 - Review by KPMG Management Consultants
 - 2007 – Joint Health Care Commission/CSCI Community Mental Health Service Review

A number of recurring themes have been evident in these reports and these are consistent with impressions framed during our assessment.

- 2.6 This report is therefore one of a series of reports. Previous reviews/inspections have spent considerably more time and deployed more resources to analysing the Manchester situation than we have. However, the main conclusions seem remarkably similar.

3. Common Issues - Obstacles and Blockages

Our discussions across the health economy and with users and carers revealed a number of issues common to those raised in the other reports highlighted above. In this section of the report we have attempted to identify their nature and the fact that they present blockages to the future progress of services.

3.1 Resources

There are two main aspects to the resource theme - availability and utilization/value for money. Since the Care Trust's inception there have been debates and discussions about whether the resources available match the significant needs of the population. There have also been consistent challenges to the way in which resources are used and whether these represent best value for money. Most frequently raised of these is the issue of lengths of stay in acute beds within the Care Trust and the high utilisation of secure and other out of area services. Although some work has been undertaken in respect of length of stay this has still not been seen as an issue critical to the future success of the health economy albeit this was a key theme of the HASCAS report referred to above. Additionally, across the

health community little attention appears to have been focused on the fact that almost 27% of the economy's resources are deployed on secure and out of area placements for patients.

3.2 Engagement

There are a number of elements to this theme that are creating obstacles and blockages:

3.2.1 Staff – there appears to be less than effective engagement with staff at all levels on the part of both the Care Trust and the PCT.

There is limited evidence of the engagement of consultants in leadership and performance arrangements within the Care Trust and within the commissioning process. We acknowledge that posts exist in medical management but it is clear that many of these posts are not effectively resourced and therefore able to carry out those medical leadership duties and be effectively accountable for them.

Colleagues who hold clinical roles allied to the University of Manchester seem not to be seen as a key resource to either the Care Trust or the JCT/JCE and despite their international reputation seem not to contribute as fully as they might to the organisation and delivery of mental health services across the city. We note that the Care Trust has become a partner, together with the University and other NHS services, in the recently announced Manchester Academic Health Science Centre and welcome this strategic initiative but still feel that much more needs to be done to cement collaboration specifically around mental health.

The influence of social care appears to be limited despite the existence of a joint Health and Social Care Trust and a Joint Commissioning Team.

There seems to have been a small but significant group of staff who have resisted the Change in Mind programme and consequent implementation of national policy. It is our view that fuller engagement of these staff at an earlier stage might have forestalled some of the problems that have consequently arisen although it is possible that some of the opposition to change was motivated by a deeper opposition to national policy and may not have been amenable to resolution by the Trust. We would hasten to add that these criticisms are not leveled at individuals but at the lack of fully effective organisational structures and processes which have been further compounded by the less than effective governance mechanisms within and across organizations.

We have seen early signs of improvements in some of these areas and commend colleagues for trying to engage with this agenda after such recent serious disruption. The key to full success however will be in sustained and systematised engagement over a concerted time period.

3.2.2 Users and Carers – systematic and sustained engagement of some service users by the Trust and JCT/JCE as part of the core business has been inconsistent. There is evidence of service users/service user groups being by-

passed due to polarisation of views and in some cases this seems to have led some user networks to retreat into campaigning roles. Equally there are very well established user groups who hold very strong views which are not always in-line with current approaches to modernisation. This is not unique to Manchester but the events of the past two years have served to make relationships with these groups even more difficult. We did note good practice in other areas though, for example the joint commissioning team include service users on tender panels and, whilst tendering for Manchester's advocacy service, gave users on the panel the majority vote. The Care Trust is progressing the establishment of a user involvement post at associate director level, to be filled by a service user and provided that this process fully engages existing service users we welcome it.

The users and carers that we met consistently indicated that they wanted to see a more positive relationship with statutory services and felt tired of what they recognized had become their campaigning and often protectionist stance.

- 3.2.3 Independent (including not-for-profit) Sector – whilst independent sector mental health services in Manchester appear to be well developed, for example, in the provision of computerized cognitive behavioural therapy, a number of engagement obstacles were identified to us. Colleagues in the independent sector identified to us that their services are sometimes not trusted or valued by NHS professionals either because they may be perceived to be "profit-making" or in the case of voluntary sector services that they may be amateurish or not subject to rigorous governance processes.

They feel that their services and service benefits are not always effectively communicated, especially to GPs and that commissioners underestimate for some organisations, the difficulties involved in engaging on a level playing field in procurement processes.

Finally we were told of difficulties engaging in discussions with some NHS colleagues about patient pathways as the independent sector are sometimes made to feel that they are not perceived to be a legitimate part of the 'system'.

Most of these issues are not unique to Manchester and need to be tackled in many other health communities. However if Manchester is to capitalize on good development to date the health community needs to continue to recognize and focus on these issues.

- 3.2.4 Communication and Information – underpinning much of the above is the lack of effective communication and information strategies and systems. Staff are often not aware of the existence of other teams, or eligibility criteria in other parts of the system; regular information/data regarding the performance of the whole mental health system is not routinely available to the Care Trust or the PCT/Local Authority or practice based commissioners/ GPs.

3.3 Service Integration

- 3.3.1 "The Old and New" – the Care Trust has consistently had difficulty in integrating the services that came together from the 3 former geographical localities (the "Old") with services resulting from NSF implementation and associated funding streams (the "New").

The integration of original core services has been problematic with each of the three localities in many cases operating to different policies, procedures and protocols. New services being introduced as part of the modernization process appear to be "bolted-on" partly because of previous delays in implementing. We saw little evidence of effective whole-service monitoring in the time we spent with the Care trust or PCT/LA. New services are monitored against nationally determined targets but there is no systematic monitoring of their impact on existing services. We did see evidence that data and performance management can be used to good effect within the mental health community as was the case in the elimination in 2006/07 of the waiting list for inpatient beds but there is little evidence that this approach is being rolled-out systematically across the health community.

The "bolting-on" process is also characterised by an absence of pre-planned, communicated and understood patient pathways leading to inter-team tensions between services. Staff, service users and carers, GPs and colleagues in acute trusts are unclear about who is responsible for what. Amongst those we spoke to there was a common position that described situations where they can be on the telephone for hours trying to establish who will take responsibility for their mental health issues.

The commissioners' pursuit to plurality of providers is to be commended as it is clearly and positively extending the range of options available to those with a mental health problem. However plurality always brings the attendant issue of integration difficulties and these need to be given particular attention so that the benefits are not undermined. The promotion of a mixed economy of providers has to be undertaken in the context of a clear and concerted vision for better outcomes for service users and carers.

- 3.3.2 Health and Social Care – the integration of health and social care in both the Care Trust and the Joint Commissioning arrangements does not appear to have been built on solid foundations and many have spoken to us of the sense that the process was rushed and poorly planned. As such it seems clear that integration has not really produced anticipated benefits and there is limited evidence of social care being able to shape and influence the activity of the Care Trust or the Joint Commissioning Team. On a broader PCT/Local Authority relationship level, there is very positive evidence of more integrated activity to promote good health and well being via Local Strategic Partnership and Local Area Agreement processes.

3.4 Relationships/Trust and Confidence

The Manchester mental health economy has been characterised by poor interorganisational relationships between key partners and needs swiftly to develop.

Re-organisations and leadership changes have been evident since the inception of the Care Trust and when combined with the events referred to in section 2.2 there has been a lack of consistency of leadership and partnership over a strategic time period.

The development of this dynamic has also been exacerbated by less than effective system oversight over a number of years. The Health Authority level of the NHS has had various configurations over the material period and appears to have struggled in the past to consistently exercise a significant performance monitoring role over Manchester mental health issues. This has in part compounded the fact that a number of reports and their recommendations appear to have gone unaddressed although the primary responsibility for this rested with local organisations.

With the advent of the Strategic Health Authority in 2006, their role changed significantly to one of broader and more strategic oversight focusing the responsibility for monitoring more clearly on local organisations. This reinforces the need for clear and consistent performance monitoring at PCT/LA level.

3.5 Other Issues

The Terms of Reference for the Assessment requested that the Assessment Team consider five specific issues

- The size and structure of Manchester Mental Health and Social Care Trust
- The distribution of resources across the city and its relation to service levels and need
- The investment of resources compared to the level of mental health need
- The interfaces between mental health services and organisations directly supporting social inclusion e.g. Job Centre Plus, Manchester City Council Housing Service
- Identified stakeholder views and perceptions of Child and Adult Mental Health Services across the city e.g. issues for young people entering the adult mental health service

3.5.1 The size and structure of Manchester Mental Health and Social Care Trust

In terms of income, the Care Trust is currently at the smaller end of comparable organisations and has a resource profile which lacks any significant capital element. The simplicity of organisational arrangements within Manchester is however a significant benefit and the environment should be highly conducive to effective partnership working. In respect of

structure we are concerned at the extent to which previous separate locality approaches are still carried forward in the current Care Trust locality structure. We would also query the extent to which a lack of functional structure affects services such as those for older people.

- 3.5.2 The distribution of resources across the city and its relation to service levels and need - We deal with this issue in more detail in section 4 of this report.
- 3.5.3 The investment of resources compared to the level of mental health need - We deal with this issue in more detail in section 4 of this report.
- 3.5.4 The interfaces between mental health services and organisations directly supporting social inclusion e.g. Job Centre Plus, Manchester City Council Housing Service - The problems highlighted above relating to mental health service commissioning to service integration and to trust and relationships across organisations all impact on the quality and effectiveness of these interfaces. However we also found very positive evidence of cross agency work in relation to promoting wellbeing and positive mental health and this is to be commended. We were told also that the Care Trust has recently entered into a partnership with the City Council and Mental Health Matters to provide employment support services for its users; this is to be welcomed.
- 3.5.5 Identified stakeholder views and perceptions of Child and Adult Mental Health Services across the city e.g. issues for young people entering the adult mental health service - A range of stakeholders interviewed were asked about their views of CAMHS across the city with particular reference to transition of 16/17 year olds into adult mental health services. More specifically the team also interviewed the CAMHS Joint Commissioning Manager, the Team Manager for CAMHS Services and the Head of Joint Commissioning for Substance Misuse.

Among the matters been brought to our attention were some to do with the fact that transition planning being seen as inconsistent across the three localities with an absence of robust and uniform protocols and those that are in place sometimes ignored with no mechanism of redress.

We were also told that tensions exist in the system particularly revolving around private/independent service providers and that commissioning of CAMHS is not fully integrated into the 10 year Strategy for Mental Health and is perceived to be a second order commissioning priority.

Schools have limited direct access to CAMHS but pilot projects in high schools and feeder primary schools are now rolling out. We were told that young people with mental health and drug and alcohol (substance misuse) problems do not seem to be part of the mainstream thinking of the Care Trust and PCT.

Finally we were reminded of the upcoming requirement of the Mental Health Act for specific services for 16-17 year olds to be in place by 2010. We were advised that currently such clients in Manchester are often served inappropriately by adult acute beds when capacity in the specifically commissioned service is not available.

However many of the issues identified above are not specific to Manchester and bedevil the system across England. We saw nothing in the CAMHS transition issues that lead us to believe that these are significant to the overall quality of services in Manchester. The service is traffic light rated 'green' in the indicators for 'comprehensive CAMHS' and in the latest available national mapping of CAMHS, Manchester was shown as spending more per head on CAMHS than any other PCT in the north west. However all would agree that there is some considerable distance still to travel in delivering a wholly young person centred service across the city.

4. **Conclusions and Recommendations**

4.1 This section of the report summarises the key conclusions arising from our analysis of the common themes, obstacles and blockages referred to in Section 3 and presents suggestions and recommendations to address the obstacles and enable the Manchester Mental Health economy and services to move forward for the benefit of users and carers. We have limited ourselves to those recommendations which we think will have maximum impact on reducing or removing blockages and securing progress and all but the first of these is referenced specifically to section 3 above.

4.2 **Leadership and Management**

In the light of our analysis that progress in Manchester has started on a number of occasions before being stalled, our primary recommendation is for a concerted period of 3-5 years for senior leadership and management within the Care Trust. This organisation has experienced a series of frequent changes over the years since its inception and must now restore its reputation and the trust and confidence of its key partners and the public of Manchester. The current vacancies within the Care Trust for clinical leaders in medicine and nursing are essential to this and we would recommend even at this late stage in these processes as full engagement as possible from all stakeholders in the final appointment procedure for these two posts.

In respect of the current Chief Executive we recognise that she was initially brought into the organisation on an interim basis and has through a very challenging and difficult period worked with her top team and others across the Care Trust to hold together the delivery of services. Having led the organisation through very difficult times she is now starting to focus on service improvement. However our concern is not for progress in the short term, we are clear that it can and will be delivered. Our prime concern is about that change programme being carried forward for a period which is long enough for it to become inexorably embedded across the city.

The current Chief Executive has recently been given a permanent appointment so the matter of whether or not she continues in post is for the Care Trust. However we recommend strongly that a commitment is made for a three to five year period in post either for her or a successor.

This timeframe is essential to ensuring that change is properly embedded such that services achieve and maintain their potential for the people of Manchester.

4.3 **Resources (section 3.1 refers)**

4.3.1 Resource Availability - The Assessment Team's conclusions in regard to resource availability focus on two specific issues: the overall level of spending relative to need in Manchester and the allocation of resources across the 3 localities

4.3.1.2 The Assessment Team has not had sufficient time as part of this exercise to undertake a detailed analysis of the resource position in Manchester. However we have been able to undertake some analysis of resource information supplied by the Care Trust and PCT and this has been cross referenced with the information and findings included in previous independent reviews of the Manchester mental health economy referred to at para 2.5 .

4.3.1.3 Analysis of information on NHS spend provided by the PCT for 2006/2007 indicates that Manchester spent significantly more than most other PCT's in the North West on mental health overall, absolutely (£86m) and on a per head basis (£190). Spending per head was well above average on CAMHS, adult services, secondary care, specialised commissioning, prevention and health promotion, user engagement, the voluntary sector and the private sector both separately and when combined. More recent information provided by the PCT (anticipated budgets for 2008/09) indicates an overall level of anticipated spend of approximately £110m (including Care Trust contract, social care contribution to the pooled budget and secure commissioning).

4.3.1.4 By contrast, Manchester records one of the lowest spends on primary care, absolutely and on a per head basis despite the provision of three Primary Care Mental Health Teams and a below average proportion spent on older people although these services continue to be well thought of across the health economy.

4.3.1.5 Spending on mental health commissioning arrangements in Manchester in 2006/07 was the highest in the North West, absolutely (£668k) and after adjusting for population size (£1.49 per head). Whilst investment in the commissioning process in Manchester is high in comparison to other PCTs in the North West we felt that the benefit derived from this investment was not clear. The Joint Commissioning Team would benefit from both improved internal coordination and a clearer strategic focus on the whole mental health system. Furthermore it seems that there is significant scope for greater social care influence on the operation of the Joint Team.

We have reviewed all the available data and independent assessments in the HASCAS Report 2006, the Local Implementation Team Annual Assessment 2006/07 and the KPMG report on efficiencies within the

pooled fund in 2007. From this review and our own work we see no compelling reasons to disagree with the findings in the report from the Joint Commissioning Team to Manchester PCT Board Meeting on 4 July 2007 that whilst levels of need are amongst the highest in the country current levels of investment appear to be broadly in line with need. That report also goes on to state -

"However, this does not mean:

- *That there is not room for efficiencies (KPMG)*
- *That the balance of investment between services and client groups is right (2006/07 Annual Assessment)*
- *That there was not under-investment in the past "*

In our view the focus of the Care Trust, Local Authority and Joint Commissioning Executive and Team should now be firmly focused on resource utilisation and not overall availability. In saying this we recognize that there may be some who will want to continue what to date has in our view been a sterile argument serving only to deflect from what we believe is the current core task of making the most of what is available. When the health economy believes that it has maximized the use of available resources then further work can and should be taken forward to review the overall level of availability.

- 4.3.1.6 With regard to the allocation of resources across the 3 localities our analysis of data included in key source documents in para 2.5 and information for 2008/09 provided by the Care Trust does not support a view that there is any major discrepancy between levels of investment across the three localities relative to need. However there are two points of interest to note. The population figures supplied by the Care Trust differ from those in the HASCAS report with the most significant being in North Manchester where the Care Trust figure is 21,000 (14%) lower than the HASCAS estimate. We have not been able to resolve this issue but suggest that it should be the subject of further investigation by the Care Trust and PCT. We also noted that whilst overall resources seemed broadly equitable the spend on direct care services in South Manchester was significantly lower than in the other localities. We suspect that this may be in some measure due to the high costs of the patient accommodation in the South but this requires further analysis.

4.3.2 Resource Utilisation/Value for Money

- 4.3.2.1 Drawing on external reports at para 2.5 and the key issues arising from our stakeholder interviews and document review the Review Team identified two major issues
- Length of stay for inpatients in acute adult beds (LOS) and
 - Level of spend on secure services and other out-of-area placements

- 4.3.2.2 The LOS issue seems to have been a constant feature of the Manchester landscape for a number of years and has been specifically referenced in the independent reports referred to above and in the report to Manchester PCT Board on 4 July 2007. Average LOS for Manchester has been continually above national averages. Data for 2007/08 also suggests significant differences between the 3 localities in Manchester with the central locality displaying the most significant variations. Despite this issue featuring in a number of action plans it does not appear to have been fully addressed nor does it appear to be part of any systematic performance monitoring either by the Care Trust or PCT/LA. In our view whilst achievement of targets in respect of new services is being monitored the impact they are having on existing services is not. This seems to be a significant flaw in performance monitoring and we believe that the Care Trust and the PCT/LA require a better balanced scorecard for monitoring overall performance more coherently.
- 4.3.2.3 The second key resource utilization issue is the level of spend on secure and other out-of-area services. Figures obtained from the Specialist Commissioning Team for the North West for 2007/08 indicates a level of spend of £24.6m (approximately 27% of the total NHS mental health spend in Manchester). Usage of secure services is very high relative to other PCT's in the North West although we have not had the opportunity of comparing with similar areas of need across England. We suspect that comparison with, for instance, some of the London Boroughs would set this in a clearer context. We note that in the HASCAS report in 2006 the utilisation for Manchester was comparable with some London areas and that position needs reviewing again as there is the potential to release resources for more local investment for the benefit of the users and carers.
- 4.3.2.4 As mentioned above we found no evidence of regular monitoring of these key system indicators by the PCT or Care Trust and a lack of focus on the associated problems and opportunities. In respect of secure services this arises in part from the specialist commissioning arrangements adopted across the North West which serve sometimes to mask these issues at local level.

In respect of adult acute beds we were regularly told about beds being 'silted-up' due to difficulties in arranging discharge for people no longer requiring acute in-patient care. The knock-on effect of this is for patients needing urgent admission to be allocated any available bed often meaning that they are located some distance from their own locality and clinical teams. A key reason which was cited to us for delayed discharges was the lack of appropriate supported accommodation or social care support. However the city council informed us that there was mental health supported accommodation available but referral rates from the Care Trust were low. In the time available we were not able to resolve this obvious and very significant difference of view but were taken by the fact that these problems appear to persist despite the joint nature of the commissioning and provider endeavor between health and social care. Joint focus on this

issue should enable significant improvements to be made which would have whole-system benefits.

- 4.3.2.5 The evidence with which we were presented suggests that there could be a stronger whole systems focus and that in partnership the Care Trust and the PCT/LA should agree a set of key performance indicators covering the whole mental health system in Manchester. Such indicators need to be jointly monitored and assessed and at the core of performance management/governance arrangements for these organisations. We would expect the development and monitoring of these indicators to be picked-up in the implementation of World Class Commissioning and as part the Local Area Agreement and Comprehensive Area Assessment_processes.

4.4 Engagement

4.4.1 Staff (Section 3.2.1 refers)

- 4.4.1.1 The Care Trust should strengthen its clinical leadership mechanisms and their resourcing to enable clinical leadership and accountability to be fully and effectively integrated into the Care Trust's business.
- 4.4.1.2 The PCT/LA also needs to strengthen its mechanisms for clinical engagement in the commissioning process to ensure that it is embedded throughout the whole system.
- 4.4.1.3 Both the Trust and the PCT/LA should strengthen their current levels of engagement with colleagues working with the University of Manchester as a mechanism of influencing improved operational and commissioning practices and processes.
- 4.4.1.4 Communication throughout and across organisations and along patient care pathways should be significantly better and accordingly the Trust and the PCT/LA need to review their Communication and Information strategies and the engagement of their staff. Furthermore the organisations should consider the benefits of joint organisational development approaches to support effective pathway management for users and carers between independent sector, primary and secondary care and social care services settings

4.4.2 Users and Carers (Section 3.2.2 refers)

- 4.4.2.1 Recognising the situation outlined in section 3.2.2 strenuous efforts need to be made to re-engage and sustain user and carer involvement. Relationships, and above all trust need to be re-established with current networks groups and individuals (see also section 4.6). Both the Care Trust and the PCT/LA need to invest in an effective infrastructure for sustained user and carer engagement, and to work in partnership to avoid duplication of effort and make efficient use of user and carer time and capacity. We would commend investigation of the approaches and investment made by Merseycare NHS Trust as an example of good practice in this area.

4.4.2.2 As a key part of restoring confidence and trust users and carers will have a key role to play in relation to the proposed Care Trust "Shadow Council of Governors" which is referred to in greater detail in section 4.6. This will be critical in bridging the perceived stakeholder deficit and in helping current groups and individuals to move from their current position to a more constructive and positive dialogue with all organisations.

4.4.3 Independent Sector (Section 3.2.3 refers)

4.4.3.1 As we have highlighted there are some excellent examples of good practice in the independent sector in Manchester but it is clear that commissioning relationships need to be developed in order for the positive advantages of investment in to be fully realised. This needs to also feature as part of the PCTs/LAs communications strategy especially in respect of making GPs and other staff aware of, and confident in services which are contracted from the independent sector.

4.4.3.2 The independent sector needs to be proactively engaged in commissioning and operational discussions and decisions about patient pathways and access criteria, and pathway training initiatives. It is especially important that the Care Trust and Joint Commissioners see the potential for engaging independent sector providers in partnership working to deliver more effective and user focused services.

4.4.3.3 The health economy, supported by service users and carers needs to address some of the negative preconceptions held by staff about the contribution of the non-statutory sector to alternative options for patient services.

4.5 Service Integration

4.5.1 "The Old and New" (Section 3.3.1 refers)

4.5.1.1 The characteristics of the "old and new" are described in section 3.3.1 of the Report. It is recommended that blockages should be tackled by:

- (a) The introduction of an effective Performance Monitoring system which reviews the build-up and operation of new services against those already in place as part of the whole systems performance management approach referred to in Section 4.3.2.5. This system would be characterised by improved data collection and utilization together with improved practice audit as part of better governance arrangements. Again it is important that the partnership approach to development and operation of this system is emphasised and delivered.

- (b) Ensuring clinical engagement in the development and monitoring processes (Section 4.4.1.1 and 2 refers)
- (c) Introduction of joint organisational development processes to ensure effective pathway management (section 4.4.1.4 refers)

4.5.2 Health and Social Care Integration (section 3.3.2 refers)

- 4.5.2.1 It is clear from our assessment that the benefits of health and social care integration have not been fully realised, and that social care has not been able to most effectively shape or influence the activity of the Care Trust or Joint Commissioning.
- 4.5.2.2 We recommend that social care mechanisms are reviewed to ensure that they are fully integrated within the Care Trust and the Commissioning structure and processes. This should include management and accountability systems for ensuring that social care statutory responsibilities are met and targets delivered. The availability of supporting social care and housing support services should be assessed and communicated to all relevant staff. The operation and accountability arrangements for JCE also need to be reviewed to ensure that social care considerations adequately and appropriately influence the allocation of the pooled commissioning budget.
- 4.5.2.3 The Local Authority should review the resources available to them to ensure that they are able to hold to account the exercise of joint arrangements in both commissioning and provision.

4.6 Relationships Trust and Confidence

- 4.6.1 It is clear from our assessment that inter-organisational and user/carer relationships are less than adequate and a lack of trust and confidence between parties is affecting their respective ability to change and improve services and systems. The key reasons for this are set out in Section 3.4 of this report.
- 4.6.2 The Assessment Team makes the following recommendations aimed at restoring relationships, trust and confidence:
 - (a) The creation within the Care Trust of a Shadow Council of Governors. Modelled on Foundation Trust requirements this would be an approach to bridging the perceived stakeholder deficit in its current operation. Stakeholders in the Shadow Council should be drawn from users and carers, clinicians, commissioners, Local Authority, University of Manchester, nominees from local MP's and representatives of the 3rd sector. The Shadow Council would sit in support of the Trust Board and would provide a level the stakeholder engagement needed to provide effective governance and accountability in the Care Trusts management.

- (b) The proactive engagement of colleagues working in and with the University of Manchester to lend their support to new clinical leadership arrangements and inform the commissioning process.
- (c) The PCT should nominate a senior mental health commissioning lead at Director Level with a clear client manager role focused both on the Care Trust and the Local Authority.

There has also been a suggestion emerging from our stakeholder interviews that Practice Based Commissioning (PBC) could be a significant lever in relation to the change/improvement process and we support that general thrust of policy. The current timescale for introduction of PBC for mental health in Manchester is April 2009 although it appears that a great deal of preparation work has yet to be undertaken.

In the current circumstances we believe that there is a risk that the target date for the introduction of PBC could introduce yet another 'event' which might deflect attention away from the priorities recommended in this Report. In our view these recommendations are the prerequisite to the full introduction of PBC and we would therefore recommend that the full introduction be delayed for a year to enable the system improvements, adequate pre-planning and selected piloting to take place.

- (d) The North West SHA needs to adopt an active role in relation performance monitoring and encouraging the development of positive working relationships in Manchester. As part of this process the SHA should work closely with the Healthcare Commission, the Commission for Social Care Inspection (CSCI) and the Mental Health Act Commission with regard to the performance monitoring process in relation to our recommendations.
- (e) In order to create an environment for rebuilding trust and confidence we recommend the setting of a Strategic Service Alliance Agreement (SSAA) between the Care Trust and the PCT/LA with the incentive of the Care Trust becoming NHS provider of choice conditional upon delivery of staged improvements over a 2 year term of the SSAA. Examples of the areas for key achievements could be:
 - Reductions of LOS and Delayed Discharges
 - Full integration of Social Care Staff into the Care Trust infrastructure
 - Review/reductions of secure service and out of area placement utilisation
 - Delivery of a clear risk sharing framework and
 - Production of whole system performance metrics and associated monitoring systems

This approach would have the advantage of assisting with preparation for Foundation Trust status and the SSAA would also be a key focus for the Shadow Council of Governors.

We would stress that the timeframe for the SSAA sets a maximum limit to its effect but we would expect the generation of a more positive culture to begin quickly under this arrangement. We would also want to make clear that the proposal does not fetter the PCT/LA responsibility/duty for securing the best possible services and they may feel the need to do this by other means if the agreed indicators in the agreement are not being delivered at the points agreed.

5. **Summary of Recommendations**

- 5.1 Our primary recommendation is for a concerted period of 3-5 years for leadership and management, especially within the Care Trust so that the changes now being brought into effect can be sustained for long enough for them to be properly embedded beyond the point of no return.
- 5.2 The current vacancies within the Care Trust for clinical leaders for medicine and nursing are essential to a concerted approach to management and leadership we recommend even at this late stage in these processes as full engagement as possible is achieved across the partner organizations in the final appointment procedure for these two posts.
- 5.3 The focus of the Care Trust, Local Authority and Joint Commissioning Executive and Team should now be firmly on resource utilization and not overall availability.
- 5.4 In partnership the Care Trust and the PCT/LA need to agree a set of key performance indicators covering the whole mental health system in Manchester. Such indicators need to be jointly monitored and assessed and at the core of performance management/governance arrangements for these organisations.
- 5.5 The Care Trust needs to strengthen its clinical leadership mechanisms and their resourcing to enable clinical leadership and accountability to be fully and effectively integrated into the Trust's business.
- 5.6 The PCT/LA needs to strengthen its mechanisms for clinical engagement in the commissioning process to ensure that it is embedded throughout the whole system.
- 5.7 Both the Trust and the PCT/LA need to review their current levels of engagement with colleagues working with the University of Manchester as a mechanism of influencing improved operational and commissioning practices and processes.
- 5.8 The Trust and the PCT/LA need to review their Communication and Information strategies and the engagement of their staff. Furthermore the organisations should consider the benefits of joint organisational development approaches to support effective pathway management for users and carers between independent sector, primary and secondary care and social care services settings.

- 5.9 Both the Trust and the PCT/LA need to invest in an effective infrastructure for sustained user and carer engagement, and to work in partnership to avoid duplication of effort and make efficient use of user and carer time and capacity.
- 5.10 The independent sector needs to be proactively engaged in commissioning and operational discussions and decisions about patient pathways and access criteria and pathway training initiatives.
- 5.11 Social care mechanisms should be reviewed to ensure that they are fully integrated within the Care Trust and the Commissioning structure and process. This should include management and accountability systems for ensuring that social care statutory responsibilities are met and targets delivered.
- 5.12 The Local Authority need to review the resources available to them to ensure that they are able to hold to account the exercise of joint arrangements in both commissioning and provision.
- 5.13 That the Care Trust adopt a Shadow Council of Governors. Modelled on Foundation Trust requirements this would be an approach to bridging the perceived stakeholder deficit in its current operation. Stakeholders in the Shadow Council should be drawn from users and carers, clinicians, commissioners, Local Authority, University of Manchester, nominees from local MP's and representatives of the 3rd sector. The Shadow Council would sit in support of the Trust Board and provide a level of stakeholder engagement needed to provide effective governance and accountability in the Care Trusts management.
- 5.14 The PCT should nominate a senior mental health commissioning lead at Director Level with a clear client manager role focused both on the Care Trust and the Local Authority.
- 5.15 We recommend that the full introduction of PBC be delayed for a year to enable the system improvements, adequate pre-planning and selected piloting to take place.
- 5.16 The North West SHA needs to adopt an active role in relation to performance monitoring and encouraging more positive working relationships in Manchester. As part of this process the SHA should work closely with the Healthcare Commission, the Commission for Social Care Inspection (CSCI) and the Mental Health Act Commission with regard to the performance monitoring process in relation to our recommendations.
- 5.17 In order to create an environment for rebuilding trust and confidence we recommend the setting of a Strategic Service Alliance Agreement (SSAA) between the Care Trust and the PCT/LA with the incentives conditional upon delivery of staged improvements over a 2 year term of the SSAA.

- 5.18 We recommend that the PCT, Local Authority and Care Trust in Manchester now work together to prepare an action plan to deliver the recommendations of this report.

Postscript:

We recognise that these recommendations frame a significant agenda for all involved with mental health services in Manchester but we are aware that many of the actions we recommend are already under consideration or being planned.

In almost all of the visits and interviews we conducted we met with staff and service users and carers alike who were frustrated with the current situation, enthusiastic for change and eager to see services moving forward in a clear and concerted way. We firmly believe that the leaders in the Manchester mental health economy can capitalise on this energy to combine it with an ambition to reposition services amongst the best in the country.

Mental health Services in Manchester Interview List

Manchester Primary Care Trust

Laura Roberts	Chief Executive
Evelyn Mensah	Chair
Rajan Madhok	Medical Director
Gary Raphael	Director of Finance
Iain Bell	Director of Performance
Dr Liam McGrogan	PEC Chair
Chris O’Gorman	Associate Director of Joint Commissioning
Janet Mantle	Public Health Consultant
Craig Harris	Head of Mental Health
Linda Colgan	Joint Commissioning Manager – Adults of Working Age
Mohammed Abas	Policy, Strategy and Engagement Manager
Brian Travis	Assistant Commissioning Manager
Tracey Langley	Commissioning Manager/Principal Manager Older Adults Services
Val Morris	Commissioning Manager – Quality and Placements
Juliet Eadie	Joint Commissioning Manager – CAMHS
Nick Gomm	PPI Lead
Tony Ullman	Assistant Director Commissioning – Central HUB
Nicola Baker	Assistant Director Commissioning – South HUB
Simon Wooton	Assistant Director Commissioning – North HUB

Primary Care GPs LMC

Dr Ceri Dornan	General Practitioner
Dr Carolyn Chew-Graham	General Practitioner
Dr Ian Smith	General Practitioner
Tom Pickup	Clinical Manager (Primary Care Mental Health)

Manchester Mental Health and Social Care Trust

Sheila Foley	Chief Executive
Wyn Dignan	Chair
Tracy Ellery	Director of Finance
Tony Harding	Director of Performance
Carol Harris	Acting Director of Nursing
Dr Judy Harrison	Acting Medical Director
Margaret Worsley	Director of Operations
Lacey Ingham	Director of Social Care Inclusion
Mike Ridley	Turnaround Director
Lynn Campbell	Acting Locality Director
Dr Sean Lennon	Consultant Psychiatrist (S)
Dr Tim Garvey	Consultant Psychiatrist (C)
Dr Bamrah	Consultant Psychiatrist (N)
Frank Margison	Consultant Psychotherapist
Andrew Manners	Communications Manager

Cara Pursall	Reconfiguration
The Assessment Team also met with the Clinical Directors Team and visited in-patient units at Laureate House, Edale House and Park House	

Manchester City Council

Caroline Marsh	Director of Adult Services
ClIr Basil Curley	Cabinet Deputy (Adult Social Care)
ClIr Sue Cooley	Chair, Health Overview and Scrutiny Committee
Fionnuala Stringer	Assistant Director (Older People)
Caroline Ciliento	Head of Joint Commissioning Substance Misuse

Users Groups/Users/Carers/Individuals

David Williams	Carers Forum
Alan Hartman	North Manchester User Network
Les Swain	South Manchester Unser Network
Evelyn Price	Responded to MEN Advert
John Butler	MACC
Mike Riley	Service User
User Group	Harpurhey Day Centre
North Manchester User Network	

Independent Sector/Other Providers

Tony Bamber	Turning Point
Gemma French	Crisis Point
Tom McAlpine	Mood Swings
Helen Dabbs/ Louisa Chappell	RDASH
Nicky Lidbetter	National Phobics Society
Jeanette Stanley / Collete Bradshaw / Denis Mullins / Pauline Clear	Afro Caribbean Mental Health Services
Susan Ashcroft-Simpson	Admiral Nurse Team Leader
Elaine Dixon / Elizabeth Simpson / Megan Ohri	HARP
Mark Greenwood	Wai Yin Chinese Women's Society

Other NHS Organisations

Mike Farrar	Chief Executive NHS North West
Carole Jobbins	NW Secure Commissioning Team
Gill Heaton	Director of Patient Services / Chief Nurse CMMCU Hospitals
Mandy Bailey	Chief Nurse University Hospitals of South Manchester Foundation NHS Trust
Kathryn Thomson	University Hospitals of South Manchester Foundation NHS Trust
Karen James	Director of Operations, Pennine Acute NHS Trust

Gill Saker	Provider Manager CAMHS
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Other Organisations/Individuals

Professor Alistair Burns	Old Age Psychiatrist and University Lead for Mental Health (Manchester University)
Profession Louis Appleby	National Director for Mental Health
Mary Tenouth	Business Relationship Manager CSCI (North West)
Lisa Holt/Sarah Penkethman	Healthcare Commission
Amanda Crook	Manchester Evening News
Paul Goggins MP	Member of Parliament
Barry Windle	Mental Health Act Commission