CYGNET/CAS MERGER INQUIRY

Summary of hearing with Mental Health Commissioners Network on 20 June 2017

Mental Health Commissioners Network Steering Group

1. The Mental Health Commissioners Network (MHCN) was established about four years ago. It said it was a membership organisation to give mental health Commissioners a national voice.

2. It said that a number of CCG Chairs felt strongly about the mental health agenda so they had established the Mental Health Commissioners Network Steering Group and it reported to the Board of NHS Clinical Commissioners. Its role was to share good practice between CCGs and undertake transformational work. The aim was to provide good quality mental healthcare across the country.

3. It said that mental health and wellbeing had suffered from under-investment and this could have catastrophic impacts, not only on patients, but also on the wider economy. Much of the role of the MHCN was to keep up pressure to invest in good mental health care, including social care, as that was an important part of the jigsaw.

4. A key aspect of the transformation in mental health was the Children and Young People Future in Mind Programme which was now an implementation plan with some new funding, to which all CCGs were signed up. Key pieces of transformational work had been around early intervention. Ensuring that children got evidenced-based treatment was important and this was improving.

Rehabilitation services

5. MHCN said there was a lack of attention to commissioning in mental health care and it continued to be under-funded. The commissioning focus had been on A&E and cancer care and people with other long-term conditions had not had access to the right kind of support. There had, however, been pockets of good work in learning disability and adult mental health.

6. It said that a decision on whether a patient needed rehabilitation services should start at the point of admission and be part of the ongoing care plan. In any event, there should always be a recovery plan at the point of discharge. Practice varied hugely from area to area. The approach taken depended a lot on the mindset of Commissioners and the medial directors on the Mental Health Trust – some were better than others, but in general there had been progress.

Contracts

7. MHCN said that how rehabilitation services were commissioned for patients varied between CCGs and was complicated. In one area where there were seven CCGs over a wide geographical area they would agree a strategy and then go to the market together. In some areas where the CCG was large enough they did not have to collaborate. Key factors were expertise, geography of the CCG and the number of providers available.

8. It also stated that most contracts were the result of spot purchasing and that even in an urban area there tended not to be a huge selection of providers.

Quality

9. The MHCN said that when considering which provider to use quality and safety should always be the key driver. Safety was top of the list and then quality, which would be considered alongside cost. The wishes of the patient and relatives would also be considered, but practice was variable across CCGs.

10. It said that it made sense from a cost perspective to treat patients in-area but also because they may have a support network and it was easier to monitor whether the patient was getting the right, good quality care. However, some areas had not invested in good rehabilitation and community care and the CCGs in these areas tended to use areas which had invested. The MHCN thought that there was huge variability in access to rehabilitation across the county.

11. In some cases, out-of-area services had to be used, for instance if there was a lack of beds in the area, or the patient's needs were very specialised. Sometimes patient choice also led to out-of-area services being used – for example to be nearer relatives, but this was not frequent.

12. Normally there were regular progress reports on patients in a rehabilitation unit, either monthly or bi-monthly.

Length of stay

13. Early intervention was key to tackling mental health issues and that included working with other emergency services. The rehabilitation strategy could vary from ‘slow stream’ which might be one to three years’ rehabilitation to ‘fast stream’ which tended to be a few months. Slow stream rehabilitation strategies were more worrying both in terms of cost and managing the treatment effectively.

14. The MHCN said that it was not easy to quantify the sort of issues that might lead to ‘slow’ or ‘fast’ stream rehabilitation strategies – it depended on the nature and complexity of the challenges that a patient faced, and that was what made commissioning so problematic.

15. Early identification of mental health challenges was key. It was sometimes the case that people with a registered address in one area suddenly appeared as being treated in another area and getting them back to their home area for treatment presented real challenges.

Facilities

16. The MHCN said that new opportunities were identified by independent providers to fill gaps in NHS provision. Although it knew of a case where a CCG had closed a hostel because it was not providing appropriate care and set up several smaller community-based family groups to replace it.

17. There was a move away from treating patients in hospital to providing more intensive treatment in community-based settings.

18. As with physical illness, people suffering from long-term mental health issues did recover but there were some, again like those with long-term physical illness, where the illness would continue and would need to be managed in the community. In MHCN’s view, more hospital beds were not the answer, better and earlier identification and management in the community was the way forward.

19. While CCGs probably saw the provision of rehabilitation services by the independent sector as different from NHS rehabilitation services, there were not in any event a huge number of such NHS services. MHCN did not think that the NHS was necessarily the most efficient and effective provider of rehabilitation services and the third sector may be more geared up to provide such services.

20. The needs of personality disorder (PD) and long-term mental health patients were very different and there was not much overlap. The main difference between the two diagnoses was in the intervention required and how that impacted on recovery. The real challenge in rehabilitation was setting goals and outcomes and sticking to them. Goals and outcomes should be set in discussion between the Commissioners, providers, patient and carer.

21. The broad principles applied by providers of rehabilitation in PD were much the same. In choosing a provider consideration would be given to what regular services they had in place: did they have regular activities; debriefs; physiological input etc and was it a structured environment focused on rehabilitation.

22. Complex cases were the patients who suffered from, for example, mental disorder along with learning difficulties or some other neuro disability along with mental disorder. In these sorts of cases the complexity grew and the treatment specialisation had to match the needs.

Staffing

23. Consultants did not tend to be tied to one facility, but the position would vary from area to area. However, in the last 18 months one acute Mental Health Trust had become a recovery department which had two consultants responsible for progress of their patients.

The merger

24. MHCN said that there were five key questions about a merger: would it benefit patients; would it be safer; would it be more economical; would it produce better outcomes and much store should be given to what those impacted thought (ie patients/carers). MHCN also said that if a merger could increase quality and reduce costs then it will attract investment.

25. MHCN stated that the quality of leadership depended on individuals rather than the size of the organisation.