The Mental Health Pooled Commissioning Budget

Review of Commissioning from the Voluntary Sector 2009

REPORT

A. Preface: status of this report

1. Oxfordshire commissions services for adults with Mental Health problems through a Pooled Budget set up between Oxfordshire Primary Care Trust and Oxfordshire County Council. Prior to April 2009 this Pooled Budget funded services commissioned from voluntary sector providers. In April 2009, the Pooled Budget was expanded to include all services for adults with the exception of forensic care. The Commissioning Strategy which sets out the objectives for the expanded Pooled Budget and how these are going to be met has been published as Better Mental Health for Oxfordshire-The Joint Commissioning Strategy 2009-12.

2. Better Mental Health for Oxfordshire sets out at Appendix B the implementation plan to ensure the delivery of the strategy. This draft report sets out the provisional conclusions of a review carried out in line with objective QUAL2 from the Plan:

   we will review all third sector contracts to ensure they are in line with our strategic priorities, to migrate them to the national contract where appropriate, and to inform our commissioning plans for 10/11

3. The report is designed to explain the context of the review and to highlight the provisional conclusions and recommendations that are set out at paragraph O, pages 25-26 below. We are now seeking to obtain the views of users of services, carers, professionals, providers and the general public on these provisional conclusions. Comments are welcomed and can be made via Amanda Millward, Portfolio Administrator at:

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   Oxfordshire Primary Care Trust
   Jubilee House
   5510 John Smith Drive
   Oxford
   OX4 2LH

4. The final report will be considered by the Joint Management Group of the Mental Health Commissioning Pooled Budget on 23rd June 2009. Comments on this report should be submitted by Friday 19th June.

5. The conclusion to this report is that to meet the strategic objectives for the whole population of Oxfordshire we need to rethink the design of services to be commissioned.
by the Pooled Budget from April 2010. Subject to the agreement of the JMG, the process of service redesign will commence from July 2009 and we will carry out an extensive engagement exercise to involve service users, carers, providers and professionals during that process.

B. Provisional conclusions and recommendations

1. Oxfordshire has a strong history of services provided from the voluntary sector for people with mental health services and there are many examples of good practice, innovation and close working partnerships between voluntary sector and statutory providers, and between voluntary sector providers and commissioners. This has been reflected in the information considered in the review, and (as an example) in the current application that Oxfordshire should be recognized as a Sainsbury Centre of Excellence for Employment Support.

2. There are two major shifts set out in *Better Mental Health for Oxfordshire*.
   a) A move away from commissioning services to commissioning outcomes.
   b) The Transformation Agenda and particularly the move to personalised services where people can plan and purchase their own care rather than have it provided for them.

3. This report is less about whether organization X is better than organization Y, but rather about whether the Pooled Mental Health Commissioning Budget is purchasing a pathway that delivers the intended outcomes.

4. The conclusion to this report is that although there is much excellent work being undertaken in the County, we will not deliver the strategic outcomes set out in *Better Mental Health for Oxfordshire* unless we redesign services to
   a) Commission outcomes that are connected to recovery
   b) Commission clear pathways that set out the roles for voluntary and statutory services and meet the needs of all the groups living in every part of the County

5. The conclusion and recommendations are set out in more detail at pp 25-26 below.

C. Introduction: the context for this review

1) Oxfordshire Mental Health Strategy 2007-12

This laid out a vision that by 2012 the full range of organizations’ and agencies involved in mental health in Oxfordshire would be working together to deliver high quality, good value, sustainable services which meet the needs of service users and carers. The strategy suggested that this should be accomplished by focusing on six priority areas, namely:
- Improving access to services
- Improving choice and flexibility of treatment and care
- Improving partnership working between agencies responsible for the provision of care to service users with mental health problems
- Improving social inclusion of service users
- Supporting carers
2. Director of Public Health Annual Reports II and III (08/09, 09/10)

In these reports, the Director of Public Health recognizes the importance of mental well-being as part of Oxfordshire's work to improve the mental health of the county's residents, the need for it to have greater priority and a strategy and outcomes in place to measure these.


In May 2008, a detailed assessment of health needs was carried out to identify areas of need and pressure in Oxfordshire. This found that currently almost 31,000 people are listed on GP records with a diagnosis of mental illness, of which just over 4,000 have a severe mental illness such as schizophrenia or bipolar mood disorder. Up to 20% of the population of Oxfordshire is affected by common mental health symptoms such as sleep problems, fatigue and anxiety that do not lead to a diagnosis of mental illness.

The number of people in Oxfordshire with some of the most common mental health problems, such as depression, as well as the rarer and more severe illnesses is expected to increase over the next twenty years, especially amongst those over the age of 50 years, resulting in the need for more capacity to cope with the demand for mental health services.


Oxfordshire County Council has produced a programme brief for Transforming Adult Social Care and is developing six specific work streams:

- Information
- Access Strategy
- Community Building
- Early Intervention and Prevention
- Self-Directed Support
- Reshaping the Supply Market


The mental Well-being needs assessment (2008) aims to understand what affects the mental Well-being of people living in Oxfordshire. It recommends actions to inform a strategy to improve mental Well-being and prevent common mental health problems in Oxfordshire.

It identified that influences on mental Well-being are complex and broad ranging. Factors protecting mental Well-being include such as having a stable home environment, friends and family who you enjoy spending time with having employment, support, good health and financial stability. Risk factors include long-term illness, fear or worries about money, old age and work issues.

Four priority areas for action were identified:
Individuals and communities
Age groups: children and young people and older people
Settings: work places, schools, prisons,
Stigma and discrimination: changing public attitudes to people with mental health problems

6. The Mental Well-being Improvement Strategy

The Mental Well-being Improvement Strategy provides a clear direction and focus for the improvement of mental Well-being in Oxfordshire from April 2009 to March 2012.

It aims to promote mental Well-being and prevent mild to moderate mental ill health among adults, children and young people. It focuses on the population at large and groups vulnerable to poor mental Well-being. It promotes Well-being by reducing the impact of risk factors whilst actively promoting positive protective factors.

7. Joint Mental Health Commissioning Arrangements

A mental health commissioning pooled budget has existed for three years and has been used to commission services from voluntary and community sector organizations. These arrangements have been of considerable benefit to users of voluntary and community sector services and their carers. In addition, these arrangements have allowed OCC and OPCT to streamline processes and plan strategically to target services across the spectrum of health, social care and Well-being for adults of working age affected by mental illness in the County.

8. Change in public sector organisations in mental health in Oxfordshire

The County Council has adopted a new corporate plan underpinned by three key drivers, which are provision of: low taxes, real choice and value for money

Practice based commissioning will alter the way some mental health services are commissioned and provided by primary care.

From April 2009 the commissioning of all mental health services for working aged adults will be lead by the OPCT and supported by the pooled commissioning budget.

All these factors have impacted in some way on mental health and social care service providers, commissioners, those who use and those who avoid using services and carers. It is crucial that organisations commit to work in partnership to find new ways of working so as to ensure positive experiences for mental health service users.

9. Delivering the Strategy: Better Mental Health for Oxfordshire 2009-12

This strategy identifies the key priorities for commissioning services for 2009-12. It brings together a number of strategies, identifies what current services are commissioned, the costs and how we compare within the strategic health authority area. Using the needs assessments both for mental ill health and for preventative initiatives,
we had an engagement process to identify what the people of Oxfordshire identify as their priorities. From this, we devised our key priorities. These are as follows:

- **To promote health and mental well-being for all**
- **To improve access to psychological services** for people using primary care services, to physical health checks for people with mental health problems, to independent advocacy for people detained in services under the Mental Health Act and to a tiered service for people with a personality disorder.
- **To improve access to culturally capable services for people from Black Minority Ethnic (BME) Communities**
- **To enhance the pathway to recovery for people using services**, specifically those using forensic services, crisis services supported housing and community services
- **To promote social inclusion** through commissioning employment services, developing a housing and support strategy and drawing together a social inclusion plan
- **To improve support** for carers
- **To improve quality and choice** for those who use and may use services
- **To scope the utilization of current services** and unmet needs of those with Aspergers’ syndrome and plan the appropriate provision
- **To understand the increased demand for services** to people with eating disorders and ensure the required services are in place

We have identified an action plan and an investment and savings plan of how we will take this forward over three years.

This review of voluntary sector services appears in the Mental Health Strategy Implementation Plan as QUAL 2:

- we will review all third sector contracts to ensure they are in line with our strategic priorities, to migrate them to the national contract where appropriate, and to inform our commissioning plans for 10/11

### D. Services currently commissioned from the voluntary sector

1. The Mental Health Commissioning Pooled Budget currently purchases a range of support services for adults of working age living with mental health problems from voluntary sector providers:

   - Therapeutic work and gardening projects provided by Restore, Root and Branch and Bridewell Organic Gardens
   - Day and other services provided by Mind and Rethink Gemini offering drop in support and more structured support for recovery
   - Supported housing and floating support services from Response, A2 Dominion (Simon House), The Elmore Team and Connection
   - Information, advice and advocacy services from Mental Health Matters and Mind
   - Services for specific groups or to support preventative work around loneliness and isolation (Archway, the Oxfordshire Chinese Community and Advice Centre)
   - A support service for vulnerable parents (Springboard Family Support)
2. In April 2009 the Pooled Budget was expanded to cover all services for adults with mental health problems except for forensic services. This has brought further housing, support and social care services purchased within the voluntary sector into the Pooled Budget, but those services are not subject to this review. See Scope of this Review below.

3. In 2008-09 the value of services commissioned from the voluntary sector by the Pooled Budget was £3.2m.

E. Purpose of this review

1. The aim of this review was to

   a) Measure the performance of a number of voluntary sector contracts as a whole against the strategic objectives
   b) Identify gaps and areas of strength in terms of delivering the strategic objectives
   c) Identify efficiencies to address gaps in current services or new developments such as self-directed support that might be achieved through reshaping existing services
   d) Make recommendations regarding commissioning of services from April 2010

2. There were also a number of cross-cutting issues relating to the care pathway for the range of people affected by mental health problems:

   a) Does access to services vary from place to place in Oxfordshire?
   b) How do people access services?
   c) What is the relationship between services commissioned from the voluntary sector and those services commissioned from the statutory sector?
   d) What other services exist that support the work of the Mental Health Pooled Commissioning Budget, and how do these relate to commissioned services?
   e) What support is there for carers?

F. Scope of this review

1. The scope of the review was restricted to those services commissioned from the voluntary sector from the Mental Health Pooled Commissioning Budget prior to April 2009. However, some of the currently commissioned services have also been ruled out of scope:

   a) Specific contracts recently issued in respect of Employment, Improved Access to Psychological Therapies, Advocacy. These have been developed and issued in line with the Implementation Plan at Appendix B of Better Mental Health for Oxfordshire and so do not need to be reviewed at this point.
   b) Contracts related to housing and support (Response, A2 Dominion, Elmore, and Connection). These will not be reviewed as part of this exercise but will instead be subject to review as part of the development of the Oxfordshire Mental Health Housing and Support Strategy which will be produced in draft at the end of July 2009. Contracts that came into the Pooled Budget in April 2009 relating to Housing and Support also fall under this separate review.
G. How this review has been carried out

1. **Project Board.** A Board was set up to oversee this process. It consists of representatives from Commissioning, Contracting, and Public Health, one of the Community Development Workers and one of the Service Development Workers from Oxfordshire County Council. The Board judged that the available information held by the PCT as part of routine monitoring would not provide sufficient evidence to measure performance against the strategic priorities. Therefore we decided to task the voluntary sector to individually self-assess how their services might meet the objectives.

2. **Self-assessment questionnaire.** The intention was that the form would enable us to assess the voluntary organizations against the following criteria:

<table>
<thead>
<tr>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Delivering Race Equality</strong></td>
</tr>
<tr>
<td>To increase access to culturally competent services delivered in primary care settings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enhancing the recovery process</strong></td>
</tr>
<tr>
<td>All agencies will work together, with service users to improve their experience through ensuring the availability of quality services with good interfaces, which enable recovery and support citizenship.</td>
</tr>
<tr>
<td>Pathway focus:</td>
</tr>
<tr>
<td>- Forensic</td>
</tr>
<tr>
<td>- Crisis</td>
</tr>
<tr>
<td>- Primary/sec. interface</td>
</tr>
<tr>
<td>Recovery to be judged by</td>
</tr>
<tr>
<td>- Reviews of service users</td>
</tr>
<tr>
<td>- Established co-working</td>
</tr>
<tr>
<td>- Moving on</td>
</tr>
<tr>
<td>- Outcomes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employment, Stigma and Housing</strong></td>
</tr>
<tr>
<td>We will tackle social inclusion by supporting people in employment, addressing stigma and improving service user’s accommodation and Housing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Support For Carers</strong></td>
</tr>
<tr>
<td>Working within the new Carer’s Strategy we will improve the experience of carers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>To establish what promotes mental well being and invest in it.</strong></td>
</tr>
<tr>
<td>To have a series of measures to take that will make a difference to the population’s mental well being.</td>
</tr>
</tbody>
</table>

The form was also sent to organizations that are not subject to the current review to offer them a chance to help the Board understand what other services might be contributing to the strategic objectives. In the event we received forms or equivalent feedback from all currently contracted organizations and one other “external” organization.
3. **Project Board scoring.** The forms received from the providers were scored according to the following scale:

- 0=not achieved
- 1=partly achieved
- 2=mostly achieved
- 3=achieved

Our aim was to achieve an average score of at least 2 for each category between members of the Board and also across the voluntary organizations. We assessed that any scores below 2 would indicate the possibility that our commissioning would fail to deliver the strategic objectives.

We also assessed gaps and strengths, looking particularly at any duplication of services in some areas of the County and gaps in provision in others.

4. **Review with providers.** We offered all the organizations under review the opportunity to discuss our scoring. This offered the opportunity to clarify any misunderstandings and review our scores. In many cases we revised our scores upwards on further discussion with organizations.

5. **Informal views of service users and carers.** During the process we took informal views of users of services and carers on an ad hoc basis. The view of the Project Board was that service users and carers had given a clear steer in the *Mental Health in Oxfordshire* Engagement Exercise in 2008, and so we decided to postpone a formal consultation until we had specific proposals on service redesign arising out of the review.

6. **Views of Community Mental Health Teams.** We attended two meetings of CMHT managers and asked their views on the effectiveness of our commissioning in the voluntary sector and on the role of the voluntary sector in the clinical pathway. Six CMHT managers completed a questionnaire in a similar format to the voluntary sector self-assessment.

7. **Comparative data from OBMH.** OBMH supplied information on the ages and location of current service users, specifically to help us understand how far services commissioned from the voluntary sector are meeting needs across the county.
H. Provisional findings from the review

1. The averages from the scoring of the self-assessment exercise were as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>Average score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivering Race Equality</td>
<td>1.6</td>
</tr>
<tr>
<td>Recovery</td>
<td>2.4</td>
</tr>
<tr>
<td>Reviews</td>
<td>2.6</td>
</tr>
<tr>
<td>Co-working</td>
<td>2.4</td>
</tr>
<tr>
<td>Moving on</td>
<td>2.2</td>
</tr>
<tr>
<td>Outcomes</td>
<td>2.3</td>
</tr>
<tr>
<td>Employment, stigma, housing</td>
<td>2.2</td>
</tr>
<tr>
<td>Carers</td>
<td>1.6</td>
</tr>
<tr>
<td>Well-being</td>
<td>2.3</td>
</tr>
</tbody>
</table>

These were the scores adjusted where necessary after we had held the review meetings with respective organizations. This needs some commentary:

a) **Services for Carers** are not covered by the current provider contracts and so we were not expecting details of specific services, but wanted to assess how far providers assist carers as part of their currently commissioned activity.

b) **Well-being** here relates to the mental well-being of the general population rather than the well-being of users of the specific services. Again well-being in this context is not part of the service specification as such.

The scoring suggests that overall the services being commissioned at present measure well against the strategic priorities except in the areas of Delivering Race Equality and Support for Carers. However, there are a number of qualifications to this:

c) There were variations between individual providers, so the average score may not be the whole picture.

d) There were factors that are masked by the scores such as geographical and other forms of access (i.e. the services are good for some but not for all); duplication of services; lack of data relating to care pathways and outcomes; and problems in understanding how this work commissioned from the voluntary sector fits in with work commissioned from the statutory sector.

Below we set out our specific findings by each category.

J. Delivering Race Equality

**Overall we marked the success of our current commissioning strategy in this area as 1.6-partly achieved.**

1. This tells us that we are only partly achieving this objective and suggests strongly that without some specific changes to the services we commission we will not meet this
objective in the future. This was not a surprising result. Oxfordshire is already a Focussed Implementation Site and we have a work stream around Delivering Race Equality within the Strategy.

The Mental Health Needs Assessment set out the ethnic breakdown of Oxfordshire as follows:

<table>
<thead>
<tr>
<th>Comparing with Oxfordshire data</th>
<th>Population</th>
<th>Number in non-white ethnic groups</th>
<th>As %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxford City</td>
<td>141,265</td>
<td>12,426</td>
<td>8.80</td>
</tr>
<tr>
<td>Cherwell Vale DC</td>
<td>132,277</td>
<td>3,262</td>
<td>2.47</td>
</tr>
<tr>
<td>Vale of White Horse DC</td>
<td>118,447</td>
<td>1,816</td>
<td>1.53</td>
</tr>
<tr>
<td>South Oxfordshire DC</td>
<td>127,757</td>
<td>1,756</td>
<td>1.37</td>
</tr>
<tr>
<td>West Oxfordshire DC</td>
<td>100,660</td>
<td>989</td>
<td>0.98</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>620,406</strong></td>
<td><strong>20,249</strong></td>
<td><strong>3.26</strong></td>
</tr>
</tbody>
</table>

2. We do not hold a comprehensive breakdown of ethnicity data for people under the care of OBMH, but we do now have a quarterly snapshot for people under the care of the Assertive Outreach, Early Intervention and Crisis Resolution teams:

<table>
<thead>
<tr>
<th>Ethnicity Description to March 09</th>
<th>No of Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>African</td>
<td>12</td>
</tr>
<tr>
<td>Any other Asian background</td>
<td>6</td>
</tr>
<tr>
<td>Any other Black background</td>
<td>14</td>
</tr>
<tr>
<td>Any Other Group</td>
<td>5</td>
</tr>
<tr>
<td>Any other mixed background</td>
<td>5</td>
</tr>
<tr>
<td>Any other White background</td>
<td>53</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>2</td>
</tr>
<tr>
<td>British</td>
<td>505</td>
</tr>
<tr>
<td>Caribbean</td>
<td>2</td>
</tr>
<tr>
<td>Chinese</td>
<td>8</td>
</tr>
<tr>
<td>Indian</td>
<td>10</td>
</tr>
<tr>
<td>Irish</td>
<td>4</td>
</tr>
<tr>
<td>Not Known</td>
<td>1</td>
</tr>
<tr>
<td>Not Stated</td>
<td>69</td>
</tr>
<tr>
<td>Pakistani</td>
<td>4</td>
</tr>
<tr>
<td>White and Asian</td>
<td>6</td>
</tr>
<tr>
<td>White and Black African</td>
<td>3</td>
</tr>
<tr>
<td>White and Black Caribbean</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>716</strong></td>
</tr>
</tbody>
</table>

This indicates that **11%** of service users are from black minority ethnic groups (12% of those for whom there is any record) and **7.5%** from white minority ethnic groups (8% where there is a record).
3. A snapshot of figures from our voluntary sector providers suggests that 93.3% come from white ethnic groups and 6.7% from non-white ethnic groups. We estimate that the majority of the non-white users identified in this snapshot live in Oxford City, so the overall relatively high level of representation may in fact reflect a low level compared with figures from Oxford City (8.8%) and certainly the figures do not reflect the ethnic origin of people using the specified OBMH services. This is important particularly because non-white people are over-represented in in-patient and other secondary mental health settings. If people from ethnic minorities are not using commissioned services we are not, on the face of it, preventing their ill-health nor helping their recovery.

4. There are several examples of good practice. One provider has held a multicultural day attended by 150 people from a wide range of ethnic groups. There is a Black and Asian Men’s Forum and staff are currently being recruited to support it. Another organization has been working to build links with BME communities and has identified the need to work on culturally appropriate language around mental health in referral literature to one of its therapeutic work projects. The Pooled Budget already funds a dedicated service for people from the Chinese Community.

5. Against this we had some concerns. A number of services report that low take up amongst minority ethnic groups reflects the local population. However, in at least one instance the provider has not carried out diversity training for staff, volunteers and Trustees. Such training would not just assist in working directly with minority ethnic clients but also may offer insights in how to break down barriers to access. Further, we are seeking to commission services for the whole county, and there is (on the face of it) no reason why people should not be able to travel around the county if there was a service that might be of benefit to them—the immediate local population should not be the target group.

6. A consistent theme in contractual monitoring has been low take up of services by the more recent white minority groups from Eastern Europe. There is a great deal of evidence that suggests that migrant communities are particularly susceptible to mental health problems when isolated in a host population, and it is a matter of concern that these groups may not have access to services that might help them. This issue has been flagged up by OBMH, and the proportion of white minority ethnic people using services mentioned in (2) above. Only about 1% of users of voluntary sector services come from non-British white groups.

7. Another group that is particularly vulnerable to mental illness is asylum-seekers. The PCT provides some support for a dedicated service, but this has until recently stood outside of the Mental Health Commissioning Pooled Budget. We do not hold comparative data on take up of services either in the statutory or voluntary sector to judge whether this investment is proportionate or sufficient.

8. However, several providers have worked hard to develop access with limited success. This suggests that there may be something about the nature of the services available, or the environment in which they are offered which does not work for people from minority ethnic groups. Perhaps outdoor therapies such as gardening do not meet the needs of certain groups: does gardening fulfil the same role in non-white cultures? In some of the
services (see below) the majority of service users are older (over 30 or even 40). An older established white user group might be more of a barrier than the type of service.

9. It seems very clear that the services commissioned from the voluntary sector are not reaching people from minority ethnic communities and this may be because they are not culturally suitable for them. How should we address this issue? Is it a question of better engagement, perhaps via carers or community groups? Do we need to develop services that are different from those we currently commission? And if so should these be located within general services or in dedicated services for minority ethnic people?

K. Supporting Recovery

Overall we marked the success of our current commissioning strategy in this area as 2.4-mostly achieved.

1. We accept that recovery is a slippery concept: it does not mean that everyone will move on to a job within 6 months. Recovery is personal, has to be tailored to the individual and must acknowledge the need for ongoing support and the risk of relapse. We were interested to try and identify how far organizations promoted the possibility of recovery and brought it about. Recovery from a commissioning perspective offers the possibility that people can move through and on from services and with the result that we can invest resources that promote health rather than treat illness.

2. We judged recovery by considering the way in which providers

   a) Carry out reviews of service user’s needs and development
   b) Co-work with other agencies to support their service users’ development and recovery
   c) How far providers enable their service users to move on through a process of recovery
   d) What outcomes people can achieve through using the service

Our expectation would be that there should be some pathway between services. Day services help people prepare for their own recovery; therapeutic services should offer day time activity that opens the possibility for moving towards “becoming ordinary” and using mainstream services. And some people should be able to move from these to (e.g.) employment projects or other forms of recovery.

3. Overall the scores were good, with a noticeably higher score under reviews and co-working than under move on and outcome. There are a number of qualifications to this scoring however which are explored below.

4. In assessing success in this area we considered the length of time that service users on average stay with the service.
### Average 2008-2009 (quarterly snapshot)

<table>
<thead>
<tr>
<th>Attendance Duration</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1 month</td>
<td>57</td>
<td>9.14</td>
</tr>
<tr>
<td>1-3 months</td>
<td>52</td>
<td>8.34</td>
</tr>
<tr>
<td>3-6 months</td>
<td>32</td>
<td>5.13</td>
</tr>
<tr>
<td>6-12 months</td>
<td>102</td>
<td>16.28</td>
</tr>
<tr>
<td>12-24 months</td>
<td>130</td>
<td>20.85</td>
</tr>
<tr>
<td>&gt; 24 months</td>
<td>251</td>
<td>40.26</td>
</tr>
</tbody>
</table>

We were struck by the large percentage of people who are long-term users of services: what if anything does this tell us about the effectiveness of recovery? There are a number of issues which relate to this:

- **a)** Firstly mental ill health can be cyclical and so service users will re-engage and/or maintain a connection with services as part of their own recovery. This can be helpful to service users particularly at times of relapse or crisis.

- **b)** Secondly, information gathered as part of data monitoring would appear to support this: providers report overwhelming positive feedback and data suggests high levels of structured move-on.

#### Reported Service User Outcomes (Quarterly average 2008-09)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number accessing employment</td>
<td>71</td>
</tr>
<tr>
<td>Number accessing education</td>
<td>69</td>
</tr>
<tr>
<td>Number accessing voluntary work</td>
<td>106</td>
</tr>
</tbody>
</table>

5. However, similar figures are also gathered each quarter on people leaving the respective services. Very few of the people classed as leaving the service seem to have done so for reasons of employment or “not needing” the service. This suggests that few people are leaving services as part of a move to mainstream services. They might be making steps on their recovery, but this does not necessarily involve moving on from the support of the provider. This needs to be considered as part of care pathways: if someone stays in-service although they are otherwise moving on, they may be blocking someone else’s access to that service. Also, in at least one organization under review, there was a sense that service users are encouraged to develop within the service, but then don’t move outside of it.

6. It was clear from our meetings with providers that there is not a common language or understanding in relation to recovery. What might be possible for a service user in one project would not be thought possible in another, and the way providers approach the question of how long and on what basis service users engage with them varies.

**Examples:**

- **a)** One provider has introduced a time limit for attendance of 2 years. Within that there will be a process of review, but the clear expectation is that after 2 years the service user must move on.

- **b)** Several services are moving from “time-based” services to “activity-based” programmes as part of recovery. These services are seeking to encourage
people to use particular services as part of their recovery, rather than attending the service at a specific time to the exclusion of other activity. Attending to do something rather than simply attending.

c) Some providers seem to struggle with the idea of recovery and want to emphasise “giving people time” over setting out on a programme. Some report that their own staff, volunteers, Trustees have misgivings about how far to promote the idea of recovery for fear of in some way harming service users.

d) Other providers effectively require people to engage in a programme as soon as the service user decides to take up a place. There are good examples of how this can be done in a supportive, user-led way. Such programmes carry a sense of obligation on the part of the service user to attend at agreed times and engage in an agreed manner as if the service was equivalent of a job or similar commitment. It is possible to provide such a service in a supportive way that is sensitive to people’s needs but helps them develop the sort of structures to their lives that promote recovery. This kind of approach also seems to work in short-term housing projects: setting a time boundary and other targets can be helpful in helping service users think about their recovery.

e) One organization makes good use of individual successes in moving on to foster a sense of what is possible amongst other service users. This can be a key feature of encouraging people to think about their own recovery.

7. The various approaches to the question of recovery can be accounted for in a number of ways:

   a) Many organizations have been reviewing their approaches to this question recently and independently of this exercise. This is reflected in the different stages of development around this issue and the range of responses to it.

   b) It is not really clear whether those organizations who are more cautious about this issue are reflecting philosophical or resource issues: are they saying that something is not possible because they believe it isn’t or because they don’t have the structures to address it?

   c) Some providers seem to be moving towards a more structured engagement in response to other issues: e.g. waiting lists caused by a lack of turnover. This pragmatic need has led them to review the basis on which they provide services.

   d) Similarly, a number of organizations are developing outcome measures to establish their effectiveness and this is raising the question of long-term use of the service.

   e) It was reported to us that some of the most effective recovery-based providers are unpopular with service-users because “they make you work”. Some providers seem to sense that they might be “holding” people who are ambivalent around recovery.

8. So, although the scoring under this heading is generally good, it might be more accurate to say that in some cases we scored providers highly on what they are hoping to achieve rather than necessarily on current performance. Comments on this would be welcome: how far are the commissioned services helping the people use their services move towards recovery?
9. The final question in respect of recovery is whether it applies to all commissioned services equally. Therapeutic work projects clearly have the potential to offer a structured recovery model in that anyone using the service has to be referred or accepted into a specific vacancy. However, open access services might have to perform a dual role-helping some people who are looking to recover identify ways forward, but also providing a safe haven for those in crisis and/or severely unwell.

10. Mind estimate that the proportions of these different types of users in their case is about 50:50. The comment has been made by clinicians and service users that sometimes, and for some people, there is a need just for “somewhere to go”. It is not clear what level of open access service is needed to meet the “somewhere to go” issue. Could this actually be accommodated within projects that have a more explicit focus on recovery?

L. Enabling social inclusion

Overall we marked the success of our current commissioning strategy in this area as 2.2.-mostly achieved.

1. Our work streams around social inclusion are largely around offering people the chance to obtain employment in mainstream environments and move through into independent housing and to address the broader question of stigma around mental illness. As such most of our commissioned activity under this heading is outside the scope of our review. However, we were interested mainly to see how far providers help people access these services and support them in being able to use them. This is therefore linked to Recovery above.

2. Generally the intention to support inclusion is strong amongst providers. Our concern was how far providers are succeeding in helping people access mainstream services. This is not straightforward: it can be a risky step for people who are vulnerable to prejudice on account of their mental health to move into the mainstream, but we were looking to see how service users might be supported in this.

3. There are some interesting examples of promoting social inclusion e.g. where service users run cafes used by the general public. Some projects deliberately foster an approach where the distinction between service providers and users is played down.

4. A concern that was raised in the Project Group was how far the work done in day services and therapeutic work projects actually encourages or provides people with the opportunity to move into mainstream services. As noted in Recovery above, one concern was the perception that people might progress but remain within the organization, or circulate within the “mental health sector”.

5. Restore has recently won the contract to provide individualised personal support to help people into employment, and is looking to find ways of moving people on from its therapeutic projects into that service. Another provider is looking to employ a Link Worker to help people access work. Many organizations have links with the employment service. It would be good to get comments on how far the services we currently
commission help people move through to employment. Would a different type of service be more effective at helping people prepare for “becoming ordinary”? Comments would be welcome on this.

5. Most organizations hold anti stigma activities in terms of public education and events. Mind has a wide-ranging programme of publicly-accessible events. Stigma remains a big problem for individuals and for the sector. Do we need to commission further specific services to address this?

M. Support for carers

Overall we marked the success of our current commissioning strategy in this area as 1.6-partly achieved.

1. The Pooled Budget has commissioned a dedicated service for carers from Rethink since July 2008. This service has been well-received and we are not intending to re-commission this service as part of this exercise.

2. In the current service specification there is no requirement for providers to offer support to carers. It was interesting to see the range of responses to this issue:

   a) Some providers clearly view carers as potential partners and aim to involve carers as much as is possible with the consent of the service users
   b) Some providers will engage with carers when they are approached by them
   c) Some providers appear to keep carers at arms length. One described a situation where they feel that carers may be “part of the problem” and so are reluctant to engage with them at all.

3. This range of responses may (in some ways) be valid but it does not help carers to be faced with such inconsistencies. We are not intending to commission any further specific carers services but the question does arise whether a clause should be entered into all contracts which requires providers to engage with carers with service user’s permission but also to recognize the needs of carers and actively support and signpost them to appropriate organizations. It would be good to get feedback from carers on their experience of services commissioned from the voluntary sector.

4. The other issue relating to carers is their own experience of anxiety, depression and isolation arising from their caring responsibilities. At least one of the current providers (the service helping with loneliness and befriending) might offer a resource that could be extended to carers. Do we need further specific services for carers?

N. Promoting well-being

Overall we marked the success of our current commissioning strategy in this area as 2.3-mostly achieved.

1. Well-being in this context means the mental health of the whole population rather than that of people using services. The Pooled Budget is seeking to invest in helping people earlier through services such as TalkingSpace, offering psychological support via
general practice. Public Health is also investing in Mental Health First Aid training to offer ways of identifying people who might be at risk of mental distress and helping them deal with that. Within the Pooled Budget we commission one service specifically looking at loneliness and the prevention of mental illness through an early intervention and other organizations provide educational resources and information to schools, workplaces, community groups around recognizing and understanding the symptoms of ill-health, as well as addressing anti-stigma.

2. The challenge for the Pooled Budget is how far to invest in preventative services when that will mean the disinvestment in other services. Will the investment off-set the potential loss of resource elsewhere over time? More immediately our concerns were

   a) Ensuring access to well-being services across the county. Presently the service working around loneliness only covers Oxford and Abingdon.
   b) Identifying outcome measures and particularly identifying ways of helping people move into mainstream services. One provider has a model for helping younger people using their services to buddy up and move on together, but some older people remain in contact with the service for a long time.
   c) Looking at whether services around well-being offer more effective ways of supporting carers, younger people and people from ethnic minorities
   d) Working out the balance between 1:1 support, and open access group environments, and getting this sort of service advertised in the mainstream as well as through other support services. If it is to be truly preventative it should be reaching people ahead of or at the point of crisis.

<table>
<thead>
<tr>
<th>O. Access to services and Care pathways</th>
</tr>
</thead>
<tbody>
<tr>
<td>There were a number of other issues that either formed part of the review or arose out of it which relate to access to services and how they fit into care pathways.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OBMH Oxfordshire service users by age May 2009 (community and in-patient, non-forensic) compared with voluntary organization service users (2008-09 quarterly snapshot)</th>
<th>OBMH no</th>
<th>as %</th>
<th>Vol org no</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE &lt;18</td>
<td>27</td>
<td>0.53</td>
<td>3</td>
<td>0.47</td>
</tr>
<tr>
<td>AGE 18-24</td>
<td>623</td>
<td>12.20</td>
<td>32</td>
<td>5.04</td>
</tr>
<tr>
<td>AGE 25-29</td>
<td>583</td>
<td>11.42</td>
<td>57</td>
<td>8.89</td>
</tr>
<tr>
<td>AGE 30-39</td>
<td>1231</td>
<td>24.10</td>
<td>119</td>
<td>18.73</td>
</tr>
<tr>
<td>AGE 40-49</td>
<td>1248</td>
<td>24.44</td>
<td>171</td>
<td>26.83</td>
</tr>
<tr>
<td>AGE 50-59</td>
<td>806</td>
<td>15.78</td>
<td>159</td>
<td>24.94</td>
</tr>
<tr>
<td>AGE 60-64</td>
<td>252</td>
<td>4.93</td>
<td>86</td>
<td>13.45</td>
</tr>
<tr>
<td>AGE &gt;64</td>
<td>337</td>
<td>6.60</td>
<td>11</td>
<td>1.65</td>
</tr>
</tbody>
</table>

a) Providers have not been commissioned under the current service specification to work with people below the age of 18 or over the age of 64 and so we would expect there to be disparity in the numbers from those of OBMH. However, what is striking
about these figures is the fact that 23.6% of OBMH service users are under the age of 30 compared to 13.9% of users of services commissioned from the voluntary sector, and conversely 38.4% of users of voluntary sector services are over the age of 50, compared to 20.6% of people under the care of OBMH. Only in the 40-49 ages range is there consistency between the sectors.

b) It should be noted that the providers all recognize the issue of take up by younger people and have in many cases taken steps to provide dedicated services for this age group. There is Headspace a service for students and another provider offers a younger people’s service which aims to promote well-being for isolated younger people through peer social networking. Take up amongst younger people is better in the therapeutic work projects than in “day services”, and some in particular have a similar profile to the OBMH figures.

c) This is not necessarily a straightforward picture:

- It may be that the services we commission are more attractive/useful for older people
- However, as noted above the therapeutic work services have a more even take up in relation to age range than the day services.

d) There may be a link with Recovery, above. Several providers have significant levels of long-term users of services and this may in turn explain the higher average ages: both in the sense that they have grown older while using the service over an extended period, and also the older user population may act as a barrier to take up amongst younger groups.

e) There is something of a mystery: are younger people failing to recover because they do not have access to services? Or do they use other, mainstream services? Or do they not need non-clinical services at all? If we commissioned different sorts of day and therapeutic services to try and offer something to younger people, would these in fact be taken up?

e) Community Mental Health Teams report frustration that some projects will not take people over the age of 65, which is consistent with the current contracts. They feel that the therapeutic gardening projects may be particularly useful for this client group. With the development of a strategy for Older People’s Mental Health, we will have to review such restrictions.

2. Gender

a) There are a slightly higher proportion of men rather than women using services commissioned from the voluntary sector (52 against 48%). The figures for the OBMH snapshot mentioned in Section J above are 62% men and 38% female.

b) Most commissioned services reflect this distribution between men and women. There is one provider where 70% of service users are men. This is understood to reflect historical trends and possibly reflects the nature of the therapeutic work which is outdoor and craft-based. However, that is not reflected in similar projects.
c) A number of services offer women-only services and Mind also offer a men's discussion group. Do we need to commission more or different services designed for single sexes?

3. Sexuality

a) Currently we have not had any specific request for mental health services dedicated to the needs of the Lesbian, Gay, Bisexual and Transgender community and that is why this does not currently feature in Better Mental Health for Oxfordshire.

b) There is a service (Queer Mind) provided a commissioned organization which is a user led organization and which promotes social inclusion. Comments are welcome on whether there is a specific need for further mental health services for the LGBT community.

4. Services for Parents

a) We currently commission a service that supports parents with mental health problems with a short-term intervention that also seeks to help the children during the period of the intervention.

b) This service does not feature as a priority in Better Mental Health for Oxfordshire and we do not see services for parents as part of the scope of the Joint Commissioning Strategy for adult mental health services.

c) That said we would be interested in comments on the need for this sort of service, and we are continuing to explore what kind of services are available to address the needs of parents.

5. Geographical distribution of commissioned services

a) The current range of OBMH service users compared with the geographical take up of services commissioned from voluntary sector providers is as follows:

<table>
<thead>
<tr>
<th>Users by district:</th>
<th>OBMH</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nos</td>
<td>Nos</td>
<td>Nos</td>
</tr>
<tr>
<td>Oxford City</td>
<td>2000</td>
<td>39.09%</td>
</tr>
<tr>
<td>Cherwell Vale DC</td>
<td>1093</td>
<td>21.36%</td>
</tr>
<tr>
<td>Vale of White Horse DC</td>
<td>553</td>
<td>10.81%</td>
</tr>
<tr>
<td>South Oxfordshire DC</td>
<td>852</td>
<td>16.65%</td>
</tr>
<tr>
<td>West Oxfordshire DC</td>
<td>619</td>
<td>12.10%</td>
</tr>
</tbody>
</table>
b) This suggests an oversupply of services in Vale and South Oxfordshire to the detriment of Oxford City and Cherwell.

c) Within these figures there are a number of other issues. Via Bridewell, Restore and Root and Branch we commission Therapeutic Work Services that are located in all districts except Cherwell. This gives rise to the following take up:

<table>
<thead>
<tr>
<th>Therapeutic work projects</th>
<th>Average figures 2008-09</th>
<th>Nos</th>
<th>as %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxford City</td>
<td></td>
<td>72</td>
<td>35.47</td>
</tr>
<tr>
<td>Cherwell DC</td>
<td></td>
<td>19</td>
<td>9.36</td>
</tr>
<tr>
<td>Vale of White Horse DC</td>
<td></td>
<td>44</td>
<td>21.43</td>
</tr>
<tr>
<td>South Oxfordshire DC</td>
<td></td>
<td>39</td>
<td>19.21</td>
</tr>
<tr>
<td>West Oxfordshire DC</td>
<td></td>
<td>30</td>
<td>14.53</td>
</tr>
</tbody>
</table>

Clearly, there is no reason to suspect that service users would be any less likely to take up these services in Cherwell and so there is an access issue that needs to be addressed. This may be addressed by transport (Bridewell Organic Gardens is based in West Oxfordshire but has people attending from Cherwell and Oxford City) or by establishing dedicated services.

d) There is a similar issue relating to Well-being services which are noted above.

e) The numbers of people using open access day services parallels the OBMH service user figures except for a slightly lower figure for Oxford City and slightly higher for Vale. This might not be a complete picture of access to services however. There are a number of centres which offer a different number of sessions. If we take a snapshot from one quarter in 2008, this suggests that there is some sort of mismatch between session availability and take up, and that there is a disproportionate level of usage compared with the number of people under the care of OBMH. It is difficult to make sense of this.

e) Overall the picture seems to be quite confused. There are (effectively) more services in certain areas, but these are being used in different ways. It would be good to get a view from people who use and refer to services whether there gaps in the distribution of services that is affecting the opportunities for recovery for people from different parts of the county? And if so, is it realistic to expect people with mental health problems to travel to services around the county?

6. Duplication of commissioned services
a) The review of geographical take up tends to identify gaps, but there are some areas in which we feel that there is an overlap of services. This is very difficult to assess, but there is a sense that particularly in Oxford City service users may be using a range of services at the same time, particularly using x service one day and y service the next. Note that we cannot be certain what the number of service users reported by voluntary sector providers amounts to: one person may be counted 2 or more times in each quarterly monitoring exercise if they are using more than one service.

b) There are 2 concerns around this:

- Service users exercising choice and making use of a range of services from a number of different outlets might be fine—it is what anyone would do. But, there is a risk that service users become institutionally dependent on having a range of services available to fill their time. This might undermine the attempts of individual agencies to work with users around recovery. It also means that people are dependent on the “mental health sector” rather than looking elsewhere for support and occupation when that is appropriate.

- There is a resource issue. If the Pooled Budget is effectively funding overlapping service because people need/want to have a 5 days a week service, it may be more cost-effective to have one provider an extended service that 2 or 3 providers cover part of the week each.

c) Where there are different services meeting different needs there isn’t duplication (e.g. Oasis providing a service for women does not duplicate the Mill, even if women might use both services) but we do need to understand whether we have the right range of services in the City.

d) Outside of Oxford there is no such issue. See also paragraph 11 below.

7. Variation in services

During the course of the review a number of issues around variations came to the attention of the Project Group:

a) One relates to Recovery as discussed above. Different providers offer apparently similar services in a different way. Because many providers work in a specific part of the county that might mean that the range of services available to someone may differ significantly depending on where you live. Unless that can be justified in some way, that must be a matter of concern.

b) We currently commission a county-wide service through a number of community resource projects. It is accepted that these projects are differently resourced and so offer services that will differ, either in terms of availability or perhaps specific services. The provider seeks to back these services with their central services, and intends that services provided in one “outlet” would be available to anyone, even if they are from another part of the county. The question here is whether this is the best model: should we be looking to have a smaller number of outlets with more local services?

8. Care pathways-secondary care
a) An unforeseen aspect of this review was the unsatisfactory relationship between the services commissioned in the voluntary sector, and those commissioned from the statutory sector. We sought and obtained feedback from both sectors on their working relationship and this highlighted a number of issues:

I. With the exception of one agency, voluntary organizations receive referrals from a wide variety of agencies. The number of people directly referred by local community health teams [CMHT] as part of a care plan approach [CPA] varied from 10-70%.

II. Voluntary organizations report relatively poor levels of communication with CMHT. There tend to be local examples of good practice, and there are always 1:1 relationships that work well.

III. Voluntary organizations report a resource issue about keeping CMHT updated about their service. CMHT advise that voluntary organizations don’t attend their team meetings like they might have done before.

IV. A particular issue for some providers is that they either (1) receive a referral as part of a CPA and then find out later or by chance that the service user has been discharged back to primary care or (2) that the service user has been diagnosed with personality disorder and has in effect been referred to the provider as part of their discharge. This leaves the voluntary organization to manage issues that may be beyond their role and/or resources.

V. CMHT report frustration that there are no spaces in projects owing to the perceived failure of the voluntary organizations to move people on. But CMHT also confirm that they do use the voluntary sector providers in some instances as their discharge plan.

VI. There has not been much of a sense in the review of how “day services” fit into the pathway. The few comments we have received from the CMHT suggest that these services are seen as an available option for service users rather than being used as a specific part of a care plan approach.

b) From a commissioning perspective our concern is that it appears that we have commissioned two broad services that have an unsatisfactory and sometimes non-existent relationship with each other. There is a lack of a clear pathway that describes how the services commissioned from the voluntary sector contribute to the recovery of people under the care of the CMHT. It appears commissioners need to:

I. Commission a whole pathway that maps out how services relate to each other and deliver outcomes for service users

II. This needs to be clear about the expectations of the CMHT and the providers in terms of who is managing the care and recovery plan for the person using a voluntary sector service

III. Identify ways and means of tracking the effectiveness of these pathways.

c) If we don’t resolve the pathway issue the effectiveness of our commissioning will be undermined. Currently there may be people who could use services and benefit from them who may not be able to access them for want of a referral from their CMHT. And there may equally be people who are using voluntary sector services but who have no care plan and for whom the voluntary sector provider has an uncertain role. In some cases these people should perhaps be moved on and “discharged”, but that now falls to the voluntary sector provider. This may be picked up by adopting a structured recovery
approach from the outset, but there may be confusion when people are perceived to have continuing health needs.

9. Primary care

a) In some areas of the country access to services commissioned from voluntary sector providers is restricted to an assessment and referral process that is managed by the secondary mental health services. We have not had that approach in Oxfordshire, and have set up services to be accessible on the basis of need rather than referral route.

b) This raises a number of issues, some of which were mentioned above:

i. When taking a referral from other than the secondary sector voluntary sector providers need to take on a planning role, as set out in recovery above. Our sense is that most organizations are already moving to this if they have not already adopted it.

ii. The question of who manages care issues may be difficult for people who have been discharged from CMHT and are under the care of their GP. Also many service users are unwell but do not meet the threshold for CMHT involvement. How can voluntary sector providers engage the support of appropriate medical care?

iii. How do we track and monitor this “primary care pathway”?

iv. And if services commissioned in the voluntary sector are accessible outside of the CMHT route, should a proportion of spaces be formally allocated between CMHT and other referrers?

c) There is clearly a role for giving people access to services that have not been referred by the CMHT. One provider is interested in short-term placements for people who may have had anxiety and depression and may be looking for activities that help them back to work. There may be a read across from the TalkingSpace psychological service to some of the therapeutic work that we commission. Given the cyclical nature of mental illness it would be unfortunate if past users of services necessarily had to go back through CMHT when they might be able to self-refer as part of managing their own recovery.

10. Role of advice, information and advocacy

1. In addition to the services that we reviewed in relation to the commissioned outcomes under H-N above, we also commission advice, information and advocacy services. These sit outside the care pathways, but also underpin them. They are vital forms of direct access support for service users and their carers but also offer useful signposting opportunities for all organizations, statutory and voluntary.

2. We have received very positive feedback regarding advocacy services, and it would be good to get comments on information and advice for people affected by mental illness which looks at the same sort of access issues we have discussed above: are these services as currently commissioned meeting the needs equally of minority ethnic, younger and female people?
3. There are a range of facilitative roles that support service users and carers like advocate, adviser, broker (in the context of self-directed support) which might be rolled up into one service. It would be good to get feedback on this.

11. Role of services not covered by this review

a) We had some feedback from organizations not commissioned from the Pooled Budget, and we also had evaluation forms completed by Response and Connection who are commissioned to provide accommodation and floating support respectively.

b) There are a number of issues relating to housing services for people with mental health problems:

i. There has been a great deal of work done around common referral processes that seems to have greatly improved the housing pathway between different levels of service, led to examples of good working relationships between CMHT and providers and achieved good outcomes as people move towards more independent accommodation

ii. Housing and Support providers often have a near 1:1 relationship with service users which might offer the opportunity to deliver services and aid recovery that might otherwise be offered in day service settings.

iii. The development of the Mental Health Housing and Support Strategy needs to reflect the work of this review.

P. Financial issues

1. It had been the intention of this review to highlight a number of financial issues and explore ways in which commissioned services could offer value for money, resources could be identified to address any new services that need to be commissioned, and the impact of self-directed support be considered. This has proved difficult:

a) In the current service specifications there are no outputs identified and so it is difficult to identify a unit cost

b) Further, the data monitoring that we have undertaken against the service specifications does not help us identify value for money. Different providers have different level of turnover and in some cases it may be appropriate to count people, in some “courses”, in some attendances. Clearly this needs to be addressed in any future contracts.

c) The amounts paid to each provider seem to be based on historic costs. This does mean that attempts to compare are difficult.

d) Several of the voluntary organizations currently make great use of unpaid volunteer support and this means that the value of the work we purchase often far exceeds the cost to the Pooled Budget. This would need to be recognized in any future commissioning and procurement.

Q. Self-Directed Support
1. There is currently a learning exercise in the North of Oxfordshire regarding self-directed support which includes adult mental health and the intention is that this will be extended to all service users during the course of 2010.

2. This presents a number of challenges to the Pooled Budget in that resources will need to be identified to cover the costs of brokerage and of SDS itself. Resources dedicated to SDS will have to be disinvested from other services.

3. Personalization offers exciting possibilities for service users particularly around recovery. In housing the introduction of Choice Based Lettings has proved popular with people looking to move on to independent housing, and moreover has contributed to their recovery, apparently by the process of being involved in planning their own future.

4. This might indicate how choice and a sense of control can, when properly supported, offer a significant tool in the recovery of service users.

5. If it is accepted that offering people choice is a good thing, we will have to identify how to disinvest from current commitments to resource personalization. There a number of options:
   a. We could disinvest from the sort of services that people might choose to explore under SDS-therapeutic work projects or other forms of day time activity.
   b. Or we could reduce the provision of direct access day time service and try to address the needs of the users of these services in another way.

6. Comments on these issues would be welcome.

O. Conclusions and Recommendations for future commissioning

1. The review has highlighted a number of issues.

   a) There appear to be barriers to access and/or a problem with services that do not address the needs of minority ethnic groups and young people.
   b) The services we are commissioning are not necessarily reaching all parts of the County, and we may have over-supply in some areas and gaps in others.
   c) There is a significant lack of clarity around care pathways which is partly about referral, and partly about care-planning responsibility, particularly when a service user is being clinically treated in primary care.
   d) There is unevenness around the approach to recovery which means that people will in effect receive a different type of service depending on where they live given that many different organizations are locally based.
   e) We need to strike a balance between crisis and relapse prevention support and recovery services, but it is not quite clear where the balance lies.
   f) We need to think about the relationship between housing and housing support and services commissioned to support day time activity.
   g) We need to rethink services if we are to be able to offer people living with mental health problems the chance to engage with the personalization agenda.

2. And our conclusion is that although there is a great deal of good work being done with and on behalf of service users by voluntary organizations these issues of access to all communities, geography, care pathways, approaches to recovery, and personalization will hinder the delivery of the Strategic objectives without substantial service redesign.
3. Therefore, subject to any responses arising out of the consultation the recommendations of the review are as follows:

In broad terms we should ensure

a) That we commission outcomes and that outcomes should be linked to recovery at all levels through a structured process designed to:
   • prevent someone falling ill owing to unrecognized distress;
   • help someone with anxiety and depression back into mainstream life through quick and easy access to support and therapeutic services;
   • help people with severe mental illness manage crisis, and identify what is important to them in managing their illness,
   • help people plan their recovery and move as far as possible towards “becoming ordinary”

b) That services designed to deliver these outcomes should meet the needs of all sectors of the community, including young people, women and people from BME communities and be available across the county

c) That people should have the opportunity to plan and commission their own care under personalization wherever possible

d) That we commission care pathways where services delivered in the voluntary sector and services providing clinical care in the statutory sector have a clear, designed relationship to each other.

e) That care pathways include preventative services and services delivered in primary care and are not linked solely to referrals from Community Mental Health Teams

f) That we should require all providers commissioned by the Pool to provide a specified level of service to carers

g) That the Mental Health Housing and Support Strategy reflects this approach through dedicated accommodation and floating support

h) That we should explore the possibility of developing systems that allow providers and commissioners to track people’s movement through care pathways and identify outcomes

Ian Bottomley
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