Primary Care Trust Network

THE NHS CONFEDERATION

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Department of Health
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Dear Bob

**NHS Standard Contract Mental Health – PCT Network Response**

Following your recent consultation on the draft mental health contract, I am writing to highlight and summarise some of the key themes and messages that we have received from mental health commissioners on this subject.

As you are aware, the NHS Confederation Networks have been working together, and with the Department, to help shape the mental health standard contract throughout the drafting process. We have welcomed the opportunity to contribute in this way although, during this period, all three networks have highlighted some concerns regarding the content of the contract and the approach to its development. I know that Steve Shrubb and Sue Slipman have also written to you today reiterating and expanding on some of the issues with the contract they have previously raised on behalf of their members. Much of the feedback we have received from PCT Network members reinforces these comments from providers. In particular, disappointment that the core contract has not incorporated mental health specific priorities, and concern that the approach does not take sufficient account of integrated health and social care arrangements, appear to be shared by members across all of the Networks. Inevitably, however, commissioners hold slightly different views from providers on certain topics, hence I am writing separately to ensure that these are clearly articulated.

**Standardisation vs. local flexibility**

Feedback from our members suggests there is general support for a standard contract for mental health services. In particular, standard clauses relating to terms and conditions of contract will help to facilitate effective collaborative commissioning arrangements with other Primary Care Trusts and reduce the workload associated with negotiating different contracting regimes. Likewise, the specification of quality requirements will help to reduce variability in service standards.

However, the majority of responding members expressed the view that a degree of local flexibility will be critical to the successful operation of the contract. There are a number of reasons for this, including the extent of variation in local arrangements for commissioning and providing mental health services, the fact that some health communities have already developed sophisticated contracting arrangements which they do not wish to see undermined, and the desire to develop service specifications in partnership with their local PBC clinical leads. While happy to see nationally determined *minimum* standards of quality and performance, PCTs wish to levers which enable them to specify (and where appropriate incentivise) delivery routes and pathways, and standards that go beyond minimum requirements. That is, members strongly urge that the contract is implemented in such a way that the inclusion of national standards does not inadvertently limit the

innovation and aspiration of service providers, or undermine more stretching agreements regarding quality standards that have already been reached.

Another area in which some degree of flexibility has been proposed is that of monitoring and review. A framework for structuring performance monitoring, and particularly clinical quality review, is welcomed by members as a positive development. However, some respondents have queried whether the proposed review process is over-specified, and suggest that where effective local arrangements providing equivalent assurance are in place these should be allowed to continue.

While acknowledging that national work on this is progressing, in the absence of PbR for mental health, some commissioners have expressed a desire to move more quickly towards locally designed tariff-based funding mechanisms.

**Relationship between health and social care commissioning**

One of the most important issues our members have highlighted is that the contract does not take adequate account of the reality that mental health services incorporate the provision of both health and social care. Several respondents have indicated that in everything from the language used to the standards included, the document reads as a health service contract acknowledging social care requirements only at the periphery, rather than as a framework that assumes integration and collaboration. On this basis, we strongly suggest that the document needs to do more to reflect, support and encourage joint commissioning of health and social care services.

**Partnership arrangements and co-ordinating commissioner roles**

One of the reasons why members have highlighted a need for flexibility is the fact that partnership and joint commissioning arrangements vary across the country. While co-ordinating and associate commissioner roles have been established for mental health providers in some areas, this is not universally the case. Similarly, while pooled budget arrangements and S 75 agreements are used effectively in some health and social care communities, others have found ways of achieving the benefits of joint working through other means. Our members therefore support a flexible approach to partnership/consortium arrangements.

However, the contract does needs to be fit for purpose in situations where formal partnership arrangements are in place. Respondents therefore welcome the inclusion of the annexe on Partnership Issues as this begins to explore some areas which are of concern to joint commissioners. More work is required here, however, to ensure that contractual accountability under different partnership arrangements is clear, and that the social service responsibilities of Local Authorities are fully acknowledged.

In addition to clarifying circumstances under which the contract must be used by different types of commissioner, some respondents have indicated that confirmation is required as to whether this contract is to be used with NHS only or all mental health providers.

**Managing activity, referrals and information**

Members have indicated that they welcome the movement away from traditional block contracting, and the increasing emphasis on performance. However, there is a concern that the contract as currently constructed reflects the aspirations for commissioning mental health services more than it reflects the realities. While recognising that schedule 3 (Part 1) sets out a direction of travel, there is a risk that the usefulness of the contract is diminished by not acknowledging the reality of the poor information baseline for a significant number of mental health providers (and, therefore, commissioners).

In this context, while respondents were encouraged to see levers to develop the quality of information in the mental health system under Schedule 5, significant problems are envisaged in accessing accurate data to support the contracting process. There was also some concern that the "national data set" has not been given sufficient consideration, in that it is not reflective of information actually required nationally, and not supportive of prescribed information reporting for Vital Signs and LAAs.

The contract therefore needs to allow for commissioners and providers to agree reasonable trajectories for improving data collection and activity planning over the next 3 years.

**Quality and performance standards**

Commissioners have expressed concern and frustration that the current version of the document represents a missed opportunity to develop a contracting framework that has real meaning and resonance for mental health.

For example, while respondents recognise that performance on national standards such as 18-weeks and C-Diff. is important for all types of provider, they had hoped to see standards relating more directly to the priorities of mental health service users (promoting independence; avoiding admissions; supporting people in employment; care planning etc.).

Clearly, the points highlighted above do not capture the full detail and range of views in the responses we have received from commissioners (and which you will have received directly). However, I hope that this is helpful in emphasising and summarising some of the issues of greatest concern to our PCT Network members.

In summary, we believe that commissioners do in principle welcome the move towards a standard approach to mental health contracting, which begins to provide them with more formal and structured mechanisms for developing relationships with providers, and managing their performance. However, it is clear from the responses we have received that members are concerned that the contract does not take account of some of the most important elements of mental health commissioning, in particular the integrated nature of health and social care in the mental health sector. They are also disappointed that in basing the contract on the version developed for acute services, an opportunity has been lost to include specific quality and performance standards relevant to mental health service users. As a result, significant work will be required locally to develop the contract framework into a meaningful tool for use in 2009/10.

If you would like to discuss any aspect of this letter in more detail, please do not hesitate to contact me.

Otherwise, I look forward to hearing from you with your response to this consultation exercise, and to our continued engagement with your team as work on the contract progresses.

Yours sincerely

David Stout

**David Stout**
**Director**
**PCT Network**