Review of the Provider Market for Mental Health Services

Report commissioned by the Department of Health

September 2012
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Executive Summary

Mental health services represent a significant area of expenditure in the NHS. In 2011/12, total investment in adult mental health services in England totaled £6.629 billion. Mental health services are tremendously diverse, from the provision of brief interventions in the form of talking therapies for people with anxiety and depression, longer inpatient stays in secure units, the treatment of children with behavioural problems, through to the care of older people with dementia.

Whilst the vast majority of these services are delivered by statutory providers, there are numerous independent organisations providing NHS-funded mental health care, both from the for-profit and not-for-profit sector, across almost the full spectrum of provision. These range from large national chains, to small local charities and social enterprises.

The Department of Health commissioned the NHS Confederation’s Mental Health Network and Mental Health Strategies to produce this report, which provides an analysis of the mental health market in England. This research that forms the basis for this report was carried out by Mental Health Strategies over the period September 2011 to March 2012.

The government has committed to extending patient choice of Any Qualified Provider for appropriate services, where qualified providers meet NHS service quality requirements, prices and normal contractual obligations. However, in many local health economies, the choice available to mental health service users as to who provides that service remains limited.

Understanding how the market in mental health works is critical - both for the development of future government policy, as well as for the implementation of existing policy relating to competition and choice. Ensuring Clinical Commissioning Groups (CCGs) have a clear understanding of the way in which the market currently operates in the mental health sector will be central to developing effective commissioning arrangements and examining how a more level playing field for providers might be achieved.

Objectives and scope

The review had three core objectives:

1. To provide policymakers with a clear, comprehensive analysis of the current landscape of NHS-funded mental health provision in England.
2. To assess, at a general and segment-specific level, the barriers to effective competition, including provider entry and exit.
3. To indicate possible future trends in market development and their implications for policy development.

The scope of the review includes NHS-funded mental health services for people of all ages (excluding learning disability services, high secure services, and services which are not funded as specialist mental health services by NHS commissioners).

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1 Mental Health Strategies (2012), 2011/12 national survey of investment in adult mental services
Methodology

The project team chose to employ a mixed methodology, including the following elements:

- **Quantitative analysis**: An analysis of current patterns of investment and activity flows across thirteen market segments, using a variety of secondary sources of quantitative data.
- **E-Survey**: An e-survey of commissioners and providers of mental health services to ascertain common currently used contracting arrangements across the thirteen market segments.
- **Delphi exercise**: A Delphi exercise was undertaken with key stakeholders on current challenges, barriers and trends within the market.

In January 2012, a workshop was held to review the project’s emerging findings and recommendations. The views of stakeholders attending that workshop contributed to both the findings and the final recommendations of the review.

Policy context

The report considers the broader policy context for the market and mental health services, including the relevance of recently passed legislation (the Health and Social Care Act 2012). We also examine the importance of the quality and efficiency agenda (including the ‘Nicholson Challenge’ and QIPP), the planned roll-out of personal health budgets and the implementation of the mental health strategy, *No Health Without Mental Health*.

The report also examines government policy relating to the extension of greater patient choice, the introduction of Any Qualified Provider, the implementation of Payment by Results, as set out in the 2010 White Paper, *Equity and Excellence: Liberating the NHS*.

Project findings

Patterns of investment

In the financial year 2010/11, total investment of PCTs in adult and older people’s mental health services was reported to be £7.19 billion. Of this investment 77% (£5.57 billion) was reported to be with NHS providers, with 22% (£1.56 billion) with non-statutory providers, and 1% with local authorities. There is some variation by Strategic Health Authority (SHA) region with statutory providers’ overall market share ranging from a high of 86.1% in London, to a low of 71.6% in the North West.

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3 For the purposes of the review the mental health market was divided into thirteen segments. Further detail on this is contained in section two of the report, which outlines the methodology employed.
8 Mental Health Strategies (unpublished), *Dataset: Adult and Older People’s National Mental Health Finance Mapping Exercise 2010/11*. 
Secondly, what is clear from the analysis of patterns in investment set out in this report, is that (in general) non-statutory providers primarily compete for business at the two extremes of the care continuum.

It is clear there are a set of segmented markets for mental health services. Market structure, participation and concentration varies by segment and region. For example, in Improving Access to Psychological Therapy (IAPT) services, 26% (£44 million) of investment in 2010/11 was reported to be placed with non-statutory providers and 73% (£123 million) with statutory providers. However, this pattern varied significantly by region. For example, in the North East SHA region over half of the NHS investment (53%) in IAPT services was placed with non-statutory providers.

Similarly, at the other extreme of the continuum, the markets for medium secure services and eating disorder also have comparably high levels of non-statutory provision.

Investment in ‘core’ community services for serious and enduring mental illness (community mental health teams, assertive outreach teams, crisis resolution home treatment and early intervention in psychosis) shows that nationally 97.6% of the just over £1 billion NHS (PCT) investment is with statutory providers. NHS South Central does not report any investment in these services with non-statutory providers. North West and West Midlands SHA are the highest investors with non-statutory providers, albeit both spend over 90% with statutory providers. There has been a marked change over the past decade in the distribution of adult services investment, with growth in secure services and psychological therapies matched by a decline in investment in more traditional inpatient services, Community Mental Health Teams and day services.

Survey of commissioners and providers

Our survey of contracting arrangements found a substantial emphasis on local block contracts, but with a marked difference between market segments. Data was provided by 14 PCTs – totaling £923 million of investment. Of this total investment 75% was reported to be through block contracts. Secure services are mostly organised via regional specialist commissioning, and there is a large presence of cost and volume and named patient contracts in eating disorders and in Child and Adolescent Mental Health Services (CAMHS).

Survey results also indicated that statutory providers currently keep a very large majority of provision in-house. Only in eating disorders were a substantial volume of subcontracts reported. 94% of the total spend identified by statutory providers (identified within the e-survey) were reported to be on services provided in-house.

Responses from the Delphi exercise

A Delphi exercise was undertaken with key stakeholders on current challenges, barriers and trends within the market. Appendix A sets out the job titles of those people who took part in this exercise in each of the three stages. This section outlines the main findings from that exercise. In overall rank order, the main barriers to entry and movement were considered by respondents to be:

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9 Ibid.
10 Ibid.
11 Ibid.
12 Detailed responses to the survey of commissioners and providers conducted as part of the review can be found in section four.
1. Block contracts
2. The monopoly of statutory providers
3. Poor integration and partnership working
4. ‘Unsophisticated’ mental health commissioning
5. Absence of a tariff in NHS mental health services
6. NHS terms and conditions
7. Infrastructure and tendering
8. NHS financial stringencies
9. NHS regulatory framework
10. Attitudes and strategies of providers
11. Access to buildings and capital

Respondents suggested that current mental health services remain largely determined by historical patterns of provision and previous investment decisions – tied closely to long-standing block contracts. Respondents considered that the main driving forces within the market are historical arrangements, previous national policy initiatives and a desire to keep services in the “NHS family”.

When asked about future trends, participants thought the following developments, in rank order, would impact on the market for mental health services:

1. Reduction of block contracts
2. Move from inpatient to community care
3. Consolidation/merger of NHS Trusts
4. Increased competition
5. Increased choice
6. Integration of health and social care
7. Increased role for the non-statutory sector
8. Sub-contracting of services by NHS Trusts
9. Improved service quality
10. Improved partnership working between statutory and non-statutory providers
11. Development of integrated mental health and physical health trusts
12. Decreased role for the non-statutory sector

There were a range of differences between responses from the various sectors of respondents. For example, sub-contracting of services was considered a more likely trend by providers than by commissioners. Providers were also more immediately conscious of the prospect of consolidation or mergers of NHS providers. Commissioners were likelier to be conscious of increased choice, and of the potential role of the non-statutory sector.

Discussion

We would suggest that it is important to understand the following seven fundamental issues about the current market for mental health services:

1. The current market for mental health services is not single national market – it is a set of overlapping geographical and service sectors.
2. There is a substantial historical lag in the way services are delivered: sector- and region-specific ways of doing things tend to continue, whether these remain the best ways of doing things or not.
3. The influence of commissioning on service development has been stronger where there have been clear national policies, and weaker in sectors where providers have developed services not in response to clear commissioning plans – but, it should be stressed, the relative power of commissioners and providers is very variable by sector and location.
4. People who use services have less influence over their planning and delivery than many would prefer, both at an individual and community level.
5. The complex, long-term and integrated nature of many ‘core’ mental health services makes it difficult for local competitive markets to emerge.

6. Some areas of the market for mental health services are concentrated, which has important implications for commissioners.

7. There has been a long standing trend in patterns of provision moving from more intensive and more aggregated forms of care, to less intensive and more personalised forms of care.

Building on those observations, we then must consider our recommendations. In doing so, we acknowledge that there are a diverse range of views amongst policy makers and providers around issues of competition. For those who seek a more competitive market for mental health services, the above data may suggest excessive dominance by statutory providers in most regions and sectors – and a need for more formal emphasis on mechanisms which could open up the market. Those mechanisms could include compulsory competitive tendering, significant widening of the Any Qualified Provider programme, and enabling equal access to, what are often viewed as, favourable terms and conditions available to statutory sector employees and providers, such as the NHS pension scheme or the Clinical Negligence Scheme for Trusts.

For those who seek to protect a substantial core service within geographically-based integrated statutory providers, the above data may suggest a level of fragmentation already to be found in some sectors of service. From this perspective, observers may conclude that the measures in the above paragraph will simply heighten that risk – and emphasis should be given instead to work to improve quality, value and integration within existing provider structures.

For those who hold views in between those two poles, competition may be viewed as having a role to play in improving services, but as a means to improving outcomes for service users, as opposed to an end in itself. Creating a fairer ‘playing field’ to allow providers of different types to compete on more equal terms will be necessary, alongside reforming financial incentives to support quality improvement, personalisation and integrated care.

**Conclusion and recommendations**

The final section of the report highlights eight important and overarching issues for the Department of Health, NHS Commissioning Board and wider health service to address. This review did not set out to find evidence either for or against the idea of increasing competition in the provision of mental health services. The recommendations arising from the review are limited to those actions, which would, in our view, strengthen the functioning of the mental health market.

- **Recommendation one: training for commissioners.**
  - For the NHS Commissioning Board to ensure that CCGs have access to high quality support and training in mental health commissioning.

- **Recommendation two: involvement of service users and carers.**
  - At a local level, Health and Wellbeing Boards and CCGs will want to work closely with service users and carers, together with the wider public, in conducting local Joint Strategic Needs Assessments and developing mental health commissioning plans.
  - Providers will want to ensure that their involvement of service users and carers in the design and delivery of mental health services is as robust as possible.
  - Commissioners and providers of NHS services will want to consider how they engage with new structures, such as local Healthwatch, and how
these groups can feed into the development of commissioning and service development plans for mental health services.

- The NHS Commissioning Board will want to ensure that they also involve service users and carers in the commissioning of specialist mental health services at a national level, and consider how they hold CCGs to account for involving service users and carers in their area.

- **Recommendation three: simplify tendering and procurement processes for smaller contracts.**
  - The NHS Commissioning Board, in tandem with CCGs, will want to consider where opportunities lie to streamline and simplify NHS procurement and tendering processes, where this can be justified by the size and nature of the service under consideration.

- **Recommendation four: develop a phased timetable for the supported roll-out of Any Qualified Provider in mental health services.**
  - The NHS Commissioning Board and Department of Health, working with stakeholders within the health service, should develop a phased timetable for the application and roll out of Any Qualified Provider in mental health services.

- **Recommendation five: partnerships and integration.**
  - The NHS Commissioning Board, and CCGs, should encourage further partnership working and joint ventures between statutory NHS and non-statutory providers – through initiatives such as supply chain management. Monitor will want to consider how issues of competition and integration in mental health are addressed in their forward work programme.

- **Recommendation six: continuity of service.**
  - CCGs will want to consider where areas of mental health provision are highly concentrated, and how continuity of provision can be best ensured in the event of a provider exiting the market. The Department and Monitor will want to consider the implications of market concentration for their future work.

- **Recommendation seven: consistent data-gathering**
  - Ensure that the gathering of all activity and performance data is consistent across all types of provider, whilst ensuring overall burden of data collection is addressed.

- **Recommendation eight: outcome data**
  - The Department of Health and NHS Commissioning Board should work to develop consistently used measures of outcomes, including for recovery, for use in mental health services with the support of the sector.
  - Ensure that national datasets include as much outcome-related data as possible, whilst remaining mindful not to increase overall burden of data collection on providers.

This review set out to deliver a clear, comprehensive analysis of the current landscape of NHS-funded mental health provision in England, to assess barriers to effective competition and to indicate possible future trends.

Understanding how the market in mental health works will be critical both for the development of future government policy, and the implementation of existing policy in the area of competition and ensuring choice for service users. Ensuring CCGs have a clear understanding of the way in which the market currently operates in the mental health sector will be central to developing effective commissioning arrangements.
Our conclusions and recommendations, based on both quantitative and qualitative analysis, including in depth work with commissioners and providers, help form a basis for moving forward within the current policy context.
Section One: Introduction

Mental health services represent a significant area of expenditure in the NHS. In 2011/12, total investment in adult mental health services in England totaled £6.629 billion\(^{13}\). Mental health services are tremendously diverse, from the provision of brief interventions in the form of talking therapies for people with anxiety and depression, to long inpatient stays in secure units, treatment of children with behavioural problems, to care of older people with dementia.

Whilst the vast majority of these services are delivered by statutory providers, there are numerous independent organisations providing NHS-funded mental health care, both from the for-profit and not-for-profit sector, across almost the full spectrum of provision. These range from large national chains, to small local charities and social enterprises.

The Department of Health commissioned the NHS Confederation’s Mental Health Network and Mental Health Strategies to produce this report, which provides an analysis of the mental health market in England.

The government has committed to extending patient choice of Any Qualified Provider\(^{14}\) for appropriate services, where qualified providers meet NHS service quality requirements, prices and normal contractual obligations. However, in many local health economies, choice remains limited. The bulk of services in local areas are often provided by a single statutory organisation. Choice is often interpreted as meaning choice between services offered by a single provider, rather than choice between providers. Moving to an Any Qualified Provider model will therefore present practical challenges in terms of implementation in the mental health sector.

Understanding how the market in mental health works will be critical both for the development of future government policy, and the implementation of existing policy in the area of competition and ensuring choice for service users. Ensuring Clinical Commissioning Groups (CCGs) have a clear understanding of the way in which the market currently operates in the mental health sector will be central to developing effective commissioning arrangements.

This review was carried out by Mental Health Strategies over the period September 2011 to March 2012. This report sets out the methodology used, an assessment of the broader policy context. The review’s findings are followed by a discussion of their implications, and a short set of recommendations arising.

Objectives of the review

This review has three core objectives:

1. To provide policymakers with a clear, comprehensive analysis of the current landscape of NHS-funded mental health provision in England.
2. To assess, at a general and segment-specific level, the barriers to effective competition, including provider entry and exit.
3. To indicate possible future trends in market development and their implications for policy development.

\(^{13}\) Mental Health Strategies (2012), 2011/12 national survey of investment in adult mental services

Scope of the review

The scope of the review includes NHS-funded mental health services for people of all ages, including:

- Services to improve access to psychological therapies (IAPT), secondary, and tertiary care.
- Mental health needs of all types (clusters 1-21 in the Payment by Results framework).
- Forensic / secure services.
- Inpatient and community services.

The scope of the review specifically excluded learning disability services, high secure services, and services which are not funded as specialist mental health services by NHS commissioners. The scope of the project also did not include social care services and services commissioned by local authorities.
Section Two: Methodology

This section explains the methodology used in the review, and provides a brief assessment of its strengths and limitations.

Overview

The project brief centred on producing an analysis of the current landscape of NHS-funded mental health provision in England, along with an assessment of barriers to effective competition and possible future trends. The timescale for the work was relatively short, with the review carried out over the period of Autumn and Winter 2011/12.

The project team chose to employ a mixed methodology, including the following elements:

- **Quantitative analysis**: An analysis of current patterns of investment and activity flows across thirteen market segments\(^{15}\), using a variety of secondary sources of quantitative data.
- **E-survey**: An e-survey of commissioners and providers of mental health services to ascertain common currently used contracting arrangements across the thirteen market segments.
- **Delphi exercise**: A Delphi exercise was undertaken with key stakeholders on current challenges, barriers and trends within the market area.

In January 2012, a workshop was held to review the project’s emerging findings and recommendations. The views of stakeholders attending that workshop from contributed to both the findings and the final recommendations of the review.

Further details on each of those stages of the project are set out later in this section, along with an assessment of the strengths and limitations of the methodology employed.

Market segmentation

For the purposes of the review the mental health market was divided into thirteen segments, set out in figure one below. This segmentation was chosen as it reflects the current way services are most commonly organised, marketed and delivered – an approach endorsed by early consultation with stakeholders. For each of the segments, we have reviewed the market at a national, regional (Strategic Health Authority) and local (Primary Care Trust cluster) level.

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\(^{15}\) For the purposes of the review the mental health market was divided into thirteen segments, detailed later in this section.
Figure 1: Market Segmentation

<table>
<thead>
<tr>
<th></th>
<th>Services for common mental health problems (anxiety, depression etc)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2a</td>
<td>Services for serious and enduring mental health problems</td>
<td>Inpatient services</td>
</tr>
<tr>
<td>2b</td>
<td>Secure and PICU services</td>
<td>Community services</td>
</tr>
<tr>
<td>3a</td>
<td>Services for organic mental health problems (dementias)</td>
<td>Inpatient services</td>
</tr>
<tr>
<td>3b</td>
<td>Community services</td>
<td></td>
</tr>
<tr>
<td>4a</td>
<td>Addiction services</td>
<td>Inpatient services</td>
</tr>
<tr>
<td>4b</td>
<td>Community services</td>
<td></td>
</tr>
<tr>
<td>5a</td>
<td>Eating disorder services</td>
<td>Inpatient services</td>
</tr>
<tr>
<td>5b</td>
<td>Community services</td>
<td></td>
</tr>
<tr>
<td>6a</td>
<td>Child and adolescent services</td>
<td>Inpatient services</td>
</tr>
<tr>
<td>6b</td>
<td>Community services</td>
<td></td>
</tr>
</tbody>
</table>

Quantitative analysis of finance and activity

The following data sources were considered in undertaking the quantitative analysis.

1. Mental Health Strategies: Adult and Older People’s National Mental Health Finance Mapping Exercise (Financial Years: 2002/03 – 2010/11)\(^{16}\)
2. Department of Health: Programme Budgeting Reference Cost Based Primary Care Trust Benchmarking Workbook (Financial Year: 2009/10)\(^{17}\)
3. NHS Information Centre: Hospital Episode Statistics (Bespoke Tabulation) (Financial Year: 2010/11)\(^{18}\)
4. Laing and Buisson: Mental Health and Specialist Care Services UK Market Report (Financial Year: 2010/11)\(^{19}\)

Significant limitations to national data sources were identified in undertaking this project – particularly in relation to financial and activity data on non-statutory sector providers. We have presented the data as fully as practicable, allowing for this.

The quantitative element of the review aimed to present an analysis of current patterns of investment and activity flows across the 13 market segments. A technical note included at Appendix B explains the use of the Herfindahl index in some of our analyses.

E-survey of commissioners and providers

As part of developing an understanding of how the current market operates, and what barriers exist to entry and exist, an important objective of the project was to understand

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\(^{16}\) Mental Health Strategies, Dataset: Adult and Older People’s National Mental Health Finance Mapping Exercise 2010/11.

\(^{17}\) Department of Health (2009/10) Programme Budgeting Reference Cost Based Primary Care Trust Benchmarking Workbook. Available at: <http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH_075743#_1>

\(^{18}\) NHS Information Centre, Hospital Episode Statistics - Financial Year 2010/11, bespoke tabulation, unpublished

current contracting arrangements between commissioners and providers of mental health services.

There is currently no national database of contracting arrangements available for mental health services. In order to obtain the required information, the project team therefore undertook an e-survey of commissioners and service providers.

The project team contacted each PCT and PCT cluster in England, asking them to complete an online survey detailing their 2010/11 investment in each of the 13 market segments included within the review. Respondents were asked to estimate the proportion (%) of each market segment, in financial terms, that is commissioned by the following contracting arrangements:

1. Block contract.
2. Cost and volume.
3. Named patient contracts.
4. Specialist commissioning.

The project team also contacted each NHS mental health trust in England and a range of non-statutory providers (including for profits, not for profits and social enterprises), asking them to complete an online survey detailing their 2010/11 spend on mental health services. Respondents were also asked to breakdown their financial spend in each of the 13 market segments. Finally, they were asked to estimate the proportion (%) of each market segment provided in the following ways:

1. In-house.
2. Via joint ventures / partnerships.
3. Sub-contracted.

Following a poor initial response, commissioners and providers were both sent a simplified e-survey, which asked commissioners to detail their total investment / spend across all services - with no breakdown by market segment.

In total there were 47 responses to the e-survey, including 33 from providers, and 14 from commissioners.

**Delphi exercise**

A Delphi exercise was also undertaken in order to understand the views of key stakeholders within the mental health market on current challenges, barriers and trends within the mental health services market. Appendix A sets out the job titles of those people who took part in this exercise in each of the three stages.

The Delphi method is typically used as a means of drawing together and testing the views of participants on a particular topic. Information and responses on the topic(s) under discussion are circulated, in a series of rounds, to interested stakeholders, who comment on it and modify the opinion(s) proposed at each stage until some degree of mutual agreement is reached. It differs from a simple survey in that respondents can see the range of others’ responses, and are therefore able to modify or clarify their own views in the light of the emerging discussion.

The Delphi exercise for this project was undertaken in three rounds. The number of responses at each stage are summarised in figure 2 below, broken down by type of organisation. In the third round of the exercise respondents were also asked to rank order the propositions which had emerged in the previous two rounds.
Figure 2: Delphi responses

<table>
<thead>
<tr>
<th>Delphi Stage</th>
<th>PCTs</th>
<th>NHS Trust</th>
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</table>

Project review workshop

On 24th January 2012 a workshop was held to review the project’s emerging findings and recommendations. The evidence from this workshop, which was attended by a wide range of stakeholders from across the sectors concerned, has contributed to both the findings and the final recommendations of the review.

Strengths and weaknesses of the methodology

Given the broad objectives of the review, the project team decided to employ a mixed methodology. Combining quantitative analysis of financial activity, a survey and the Delphi exercise allowed the project team to gather a wide variety of rich data.

Whilst the approach was the strongest available, given the resources available to the project, it does have a number of weaknesses which should be acknowledged.

The first relates to the quality of secondary data available, and the considerable gaps that exist in those datasets relating to activity in the non-statutory sector. The current scope of national datasets on financial investment and activity, provides limited information relating to investment and activity in the non-statutory mental health sector.

Secondly, related to the survey of commissioners and providers, it should be acknowledged that the response rate from commissioners, at 14 total responses, is low. Given the current changes taking place within commissioning, resulting from the Health and Social Care Act 2012, it is perhaps not surprising that engaging this group has presented significant challenges.

We also recognise that alternative approaches could have been taken with the segmentation of the market into thirteen groups. Limitations of the available data and time necessitated a pragmatic approach be taken, by using those segments which commissioners and providers would most readily recognise and for which information could be readily accessed.
Section Three: Policy Context

This section of the report provides a summary of the current NHS policy context, in so far as it is material to the report’s subject.

Health and Social Care Act 2012

A number of important structural changes, including new commissioning arrangements, arise out of the Health and Social Care Act 2012. Whilst the system is in the midst of that transition, CCGs will be under pressure to deliver on the £20 billion of efficiency savings that are needed to be achieved by 2014-15. Key changes include:

- **Establishment of Clinical Commissioning Groups (CCGs):** CCGs will be held to account for the outcomes they achieve – including mental health outcomes – through the Commissioning Outcomes Framework. Improving the commissioning of mental health services will form a vital element of CCGs’ work to secure efficiency and value for money. There are concerns amongst stakeholders relating to both the capacity and capability of new CCG commissioners to commission mental health services effectively.

- **Establishment of commissioning support structures:** Subject to CCG support, there is the potential for wider-scale aggregate commissioning of some mental health services than there is currently, particularly for specialist services of a relatively high-cost low-volume nature.

- **Establishment of Monitor as the sector regulator for health services:** Monitor will regulate health services to promote and protect the interests of patients. It will do this through licensing providers, ensuring the continuity of services, and addressing anti-competitive behavior.

- **Establishment of Public Health England:** Creation of a new focus for expertise and activity in epidemiological analysis, and in the identification and promotion of factors which are protective against mental health problems.

- **Establishment of Healthwatch:** A new route for the involvement of service users and carers in monitoring and influencing the planning and delivery of services, alongside existing national and local voluntary organisations.

- **Establishment of Health and Wellbeing Boards:** Potential for the influence of local authorities to increase over commissioning strategy – mental health services could well be an area of particular interest in many local authority areas.

- **Parity of Esteem:** The Act includes a commitment to ‘parity of esteem’ between mental and physical health.

Quality, Innovation, Productivity and Prevention (QIPP)

The QIPP agenda centres on the ‘Nicholson Challenge’, for the NHS to deliver £20 billion of efficiency savings by 2014-15. Mental health services are expected to contribute an appropriate proportion of this saving, placing a strong emphasis on services’ cost-effectiveness and cost-efficiency. Whilst actions in support of making QIPP savings are not centrally mandated, a number of particular areas have received considerable attention:

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• **Focus on acute care pathway:** Focus is likely to continue of reducing lengths of stay, closing acute beds where appropriate, plus developing alternatives to admission, including crisis resolution/home treatment and more community-based short-stay residential services\(^\text{22}\).

• **Focus on out of area treatments:** There is likely to continue to be pressure on commissioners to reduce the use of both existing and new high-cost low-volume placements, predominantly outside the statutory sector, where clinically appropriate services (which in very specialist care may not be expected to be available) are available nearer to service users’ homes\(^\text{23}\).

• **Focus on acute and mental health integration:** Service growth areas are likely to include acute hospital psychiatric liaison services (including, but not limited to, Accident and Emergency liaison); and integrated provision of mental health and physical care in the management of long-term conditions, such as diabetes, chronic obstructive pulmonary disease, and long-term neurological disorders.

### Any Qualified Provider (AQP)

The government has been clear about its commitment to extend choice in the health service – of treatment, setting and of consultant-led team. As part of this, the government has committed to extending patient choice of Any Qualified Provider (AQP)\(^\text{24}\) for appropriate services, where qualified providers meet NHS service quality requirements, prices and normal contractual obligations. So far, extension of the full application Any Qualified Provider policy into mental health has been limited to talking therapies where locally agreed tariffs are in place. However, with the commitment to roll out Payment by Results in mental health, Any Qualified Provider will become in future applicable to a much greater degree\(^\text{25}\). Implications for the mental health market include:

• **Qualification and registration process:** All providers will be required to meet equal quality standards.

• **Referrers’ offering choice:** For service users to be offered a choice of providers, greater clarity will be needed as to the range of providers and services which are available in a given area.

• **Competition on quality, not price:** This important principle highlights the need to agree common outcome measures across the sector. Improving the consistent capturing and publication of data about services’ outcomes and effectiveness will be critical.

• **Adoption for IAPT services:** There is potential for increasing the diversity in the type and range of providers offering IAPT services – and an increase in the existing tendency for these services to be relatively un-integrated with other mental health services in their area.

### Personal health budgets


\(^{25}\) Further information / documentation on the AQP policy can be found on the Department of Health Website at: <http://healthandcare.dh.gov.uk/any-qualified-provider-2/>
The Government has declared its intention to begin a national roll out of personal health budgets\textsuperscript{26}. The NHS must prepare itself for the impact of this policy. Implications for the mental health market include:

- **Current evaluation of extension of personal budgets\textsuperscript{27} to healthcare:** Greater use of personal budgets has the potential to reinforce the “bite” of the Any Qualified Provider policy, giving more direct control to service users. There is potential for some mental health service users to prefer non-healthcare applications of their funds – for example on support to access physical access, green spaces or training/employment in preference to medication or psychological therapies.

**No Health Without Mental Health**

*No Health Without Mental Health*, a cross-government mental health outcomes strategy for people of all ages, was published in February 2011\textsuperscript{28}. An implementation framework was published in July 2012\textsuperscript{29}. Implications for the mental health sector include:

- **Shift to outcomes-focused commissioning:** There is an expectation that providers will need to be able to demonstrate the benefits to service users of the care and treatment they are providing. This includes social and vocational outcomes, in addition to “health” outcomes such as symptom reduction.
- **Emphasis on community wellbeing:** The potential for a shift towards mental health wellbeing and promotion activities. Those services are unlikely to be provided by many existing mental health service providers.
- **Emphasis on recovery:** There is an expectation that providers will need to demonstrate how they are supporting service users to achieve independence and control over their own process of recovery – notwithstanding, in some cases, continuing symptoms of mental illness.
- **Emphasis on safety:** Providers will need to demonstrate that their governance processes both reduce the risk of, and ensure appropriate response to, serious untoward incidents.
- **Aim to reduce stigma and discrimination:** Mental health providers are encouraged to act as local champions on this issue, in the way they recruit and support staff, and in the way they engage with their local communities.

**Mental Health Payment by Results (PbR)**

The White Paper, *Equity and Excellence: Liberating the NHS*, said the Department will "implement a set of currencies for adult mental health services for use from 2012/13, and develop currencies for child and adolescent services". It also committed to "develop payment systems to support the commissioning of talking therapies"\textsuperscript{30}. The mental health Payment by Results development national project is now moving into the implementation

\textsuperscript{26} Mental Health Network (2011), *Personal health budgets: countdown to roll-out*. Available online at: <http://www.nhscf.org/Publications/briefings/Pages/Personal-health-budgets.aspx>

\textsuperscript{27} Department of Health (October 2011), *Personal Health Budgets* [online – accessed 20\textsuperscript{th} May 2012]. Available at: <http://www.dh.gov.uk/health/category/policy-areas/nhs/personal-budgets/>


phase. In October 2011 Payment by Results draft guidance for 2012/13 for mental health was published\textsuperscript{31}.

The introduction of Payment by Results in mental health is a critical part of ensuring AQP can be applied to the mental health sector. This area of work has important implications for the mental health market, including:

- **Care clustering:** An important first step in improving transparency in the market includes establishing what types of mental health problems are being treated by which teams and services, in which locations.
- **Costing of care clusters:** Enables an understanding of providers' cost structures not only by service block, but also by service user group.
- **Agreement of care pathways by cluster:** Could be a potentially important step in standardising approaches to the delivery of mental health care, and reducing the current substantial variation between localities.
- **Agreement of local tariffs:** In the short-term, likely to be of modest significance, given expectations that commissioners and providers agree arrangements to give some assurance of stability of income for the provider and of stability of expenditure for the commissioner. In the medium term, with data in which local parties have confidence, this could support increased competition between providers.
- **Movement towards a national tariff:** The government is committed to developing a national tariff for mental health services. If that can be done successfully, it could create incentives for providers to improve their cost-efficiency and to attract and undertake a greater volume of work. It could also create incentives for commissioners to reduce referrals, and for providers to distinguish themselves from others by measures of quality.
- **Movement towards prime contractor ‘capitation’ funding for particular groups or pathways, e.g. dementia:** CCGs may be interested in contracting on a population/capitation basis for sub-groups or pathways. This would involve selecting a prime contractor who gives best value and manages risk. This could have the effect of taking significant groups of services locally out of tariff.

Section Four: Project Results

This section sets out the review’s findings, structured in accordance with the three core project objectives:

1. To provide policymakers with a clear, comprehensive analysis of the current landscape of NHS-funded mental health provision in England.
2. To assess, at a general and segment-specific level, the barriers to effective competition, including provider entry and exit.
3. To indicate possible future trends in market development and their implications for policy development.

The current landscape of NHS-funded mental health provision in England

Common mental health problems

Within the market analysis, investment in Improving Access to Psychological Therapy (IAPT) services was used as proxy for the common mental health problems market segment. Non-statutory providers have a significant share of the market for IAPT services. In 2010/11 PCTs invested £168 million investment in IAPT services, of which 26% (£44 million) was reported to be placed with non-statutory providers and 73% (£123 million) was reported to be placed with statutory providers.

That pattern varies across the country, as figures 3, 4 and 5 all illustrate. In the North East SHA region over half (53%) of investment in IAPT services was with non-statutory providers. In the East Midlands and Yorkshire regions over 30% of the investment in IAPT services is with non-statutory providers. The SHA region with the lowest percentage investment with non-statutory IAPT providers is NHS South East Coast.

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32 Mental Health Strategies, Dataset: Adult and Older People’s National Mental Health Finance Mapping Exercise 2010/11.
Figure 3: Total investment in IAPT - 2010/11 (£000s)\(^{33}\)

<table>
<thead>
<tr>
<th>SHA Region</th>
<th>Statutory NHS</th>
<th>Non-Statutory NHS</th>
<th>Local Authority</th>
<th>Total</th>
</tr>
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<td><strong>879</strong></td>
<td><strong>168,041</strong></td>
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</tbody>
</table>

Figure 4: Total investment in IAPT - 2010/11 (%)\(^{34}\)

Key: Blue = Statutory NHS, Orange = Non-statutory NHS, Green = Local Authority

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\(^{33}\) Ibid.  
N.B. the data includes all reported PCT investment from the National Mental Health Finance Mapping exercise for 2010/11, displayed by SHA region. Where Local Authorities are reported to provide services these are services funded by the PCT investment. All local authority investment has been excluded as Local Authority commissioned services were outside the project brief.

\(^{34}\) Mental Health Strategies, Dataset: 2010/11. Op Cit.
Serious and enduring mental illness

Analysis of investment in ‘core’ community services for serious and enduring mental illness (community mental health teams, assertive outreach teams, crisis resolution home treatment and early intervention in psychosis) found that, nationally, 97.6% of the just over £1 billion NHS (PCT) investment is placed with statutory providers. NHS South Central did not report any investment in these types of services with non-statutory providers. North West and West Midlands SHA make the most investment with non-statutory providers, albeit both spend over 90% with statutory providers. Figures 6, 7 and 8 illustrate how the picture varies across the country.

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Figure 5: Total investment in IAPT - 2010/11 (£000s)

Key:  Blue = Statutory NHS  Orange = Non-statutory NHS  Green = Local Authority

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35 Ibid.
Figure 6: Total PCT investment in Community Mental Health Teams, Assertive Outreach Teams, Early Intervention Teams and Crisis Resolution and Home Treatment Teams (£000s)\textsuperscript{36}

<table>
<thead>
<tr>
<th>SHA Region</th>
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<th>Non-Statutory NHS</th>
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Figure 7: Total PCT Investment in Community Mental Health Teams, Assertive Outreach Teams, Early Intervention Teams and Crisis Resolution and Home Treatment Teams (%)\textsuperscript{37}

Key: Blue = Statutory NHS  Orange = Non-statutory NHS  Green = Local Authority

\textsuperscript{36} Ibid.  \textsuperscript{37} Ibid.
The market for these types of services, across SHA regions, was found to be most concentrated in the North East, and least so in the North West, as illustrated in figure 9. A full technical note about the Herfindahl index is included at the end of this report at Appendix B. Briefly, the Herfindahl Index is a commonly accepted measure of market concentration. It is calculated by squaring the market share of each firm competing in the market and summing the resulting numbers. It can range from 0 to 1.0, moving from a large number of very small firms to a single monopolistic producer. Increases in the Herfindahl index generally indicate a decrease in competition and an increase of market power, and decreases indicate the opposite.

Within the report the Herfindahl index is calculated for various segments of the market at a regional (SHA level). The data sources used to calculate these measures have limitations to their usage, which are again outlined in Appendix B.

A key issue for consideration when considering the Herfindahl index, particularly in the context of mental health services, is the geography of a market. Providers within a geographic region (SHA) may not in reality ‘compete’. Because of this bigger SHAs with a number of NHS Trusts (e.g. London and the North West) may look more competitive than smaller SHAs with fewer NHS Trusts (e.g. the North East). This is despite the fact that these organisations may not actually compete on core services that are commissioned under block contracts.

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**Figure 8: Total PCT Investment in Community Mental Health Teams, Assertive Outreach Teams, Early Intervention Teams and Crisis Resolution and Home Treatment Teams**

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38 Ibid.
With regards inpatient services for serious and enduring mental illness, 94.4% of the NHS (Primary Care Trust) investment in adult acute inpatient services was reported to be placed with statutory providers, compared with just 5.6% of the overall total with non-statutory providers. It should be noted that this figure does not include the commissioning of residential rehabilitation services from the independent sector. The South East Coast region did not report any investment with non-statutory providers. The Strategic Health Authority (SHA) are with the highest percentage investment placed with non-statutory providers was the North West (10.6%). Figures 10, 11 and 12 illustrate this.

Ibid.
Figure 1010: Total PCT investment in adult acute inpatient services -2010/11 (£000s)  

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Figure 111: Total PCT investment in adult acute inpatient services -2010/11 (%)  

Key: Blue = Statutory NHS    Orange = Non-statutory NHS    Green = Local Authority

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40 Ibid.  
41 Ibid.
As with community services for serious and enduring mental illness, the market was found to be most concentrated in the North East. In this case the market was least concentrated in London. Figure 13 illustrates the degree of market concentration for these services across the country by SHA area.

[Figure 122: Total PCT investment in adult acute inpatient services -2010/11 (£000s)]

Key: Blue = Statutory NHS  Orange = Non-statutory NHS  Green = Local Authority

Ibid.
Figure 13: Herfindahl index - adult acute inpatient services – 2010/11

Ibid.
Secure and Psychiatric Intensive Care Unit Services

In 2010/11, PCTs in England invested £925 million in secure (both low and medium) and psychiatric intensive care unit (PICU) services. Of this investment, 34% (£315 million) was reported to be with non-statutory providers, and 66% (£610 million) was reported to be with statutory providers. In two SHA regions over half of the investment was reported to be placed with non-statutory providers - East Midlands (58%) and the West Midlands (51%). The region with the lowest proportionate investment with non-statutory providers is London Strategic Health Authority (10%). Figures 14, 15 and 16 illustrate these patterns of investment across the country.

Figure 14: Total PCT investment in Psychiatric Intensive Care Unit (PICU) and low & medium secure services - 2010/11 (£000s)  

<table>
<thead>
<tr>
<th>SHA Region</th>
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<td>609,738</td>
<td>314,862</td>
<td>30</td>
<td>924,630</td>
</tr>
</tbody>
</table>

44 Ibid.
Figure 15: PCT investment in PICU and low & medium secure services - 2010/11\(^{45}\) (%)  

![Bar chart showing investment percentages for different regions and services.](image)

*Key:* Blue = Statutory NHS, Orange = Non-statutory NHS, Green = Local Authority

Figure 16: Total PCT investment in PICU and low & medium secure services - 2010/11 (£000s)\(^{46}\)

![Bar chart showing total investment amounts for different regions and services.](image)

*Key:* Blue = Statutory NHS, Orange = Non-statutory NHS, Green = Local Authority

\(^{45}\) Ibid.

\(^{46}\) Ibid.
It should also be noted that the analysis showed that 77% of independent sector medium secure beds are provided by four providers. According to the figures available, a single provider (Partnerships in Care) has a 33.6% market share. This pattern of investment is illustrated in figures 17 and 18.

**Figure 17: Independent sector – national market for medium secure beds**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Beds</th>
<th>Market Share (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnerships in Care</td>
<td>850</td>
<td>33.60%</td>
</tr>
<tr>
<td>St Andrew’s Healthcare</td>
<td>613</td>
<td>24.20%</td>
</tr>
<tr>
<td>Priory Group</td>
<td>268</td>
<td>10.60%</td>
</tr>
<tr>
<td>Care Principles</td>
<td>228</td>
<td>9.00%</td>
</tr>
<tr>
<td>All other independent providers</td>
<td>187</td>
<td>7.40%</td>
</tr>
<tr>
<td>Alpha Hospitals</td>
<td>119</td>
<td>4.70%</td>
</tr>
<tr>
<td>Cygnet Healthcare</td>
<td>90</td>
<td>3.60%</td>
</tr>
<tr>
<td>Glen Care</td>
<td>72</td>
<td>2.80%</td>
</tr>
<tr>
<td>St George Healthcare</td>
<td>58</td>
<td>2.30%</td>
</tr>
<tr>
<td>Ludlow Street Healthcare</td>
<td>48</td>
<td>1.90%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2533</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>

**Figure 18: Independent sector – national market for medium secure beds (%)**

---


48 Ibid.
Services for organic mental health problems

In determining the current pattern for investment in services for organic mental health problems (dementias), it is important to be aware that key national datasets either do not include data on non-statutory providers (e.g. Hospital Episode Statistics), or do not break data down by type of provider (e.g. programme budgeting data). For these reasons providing an analysis of the picture for these sorts of services is not straightforward.

In light of this, we have analysed the market for organic mental illness using the national finance mapping database – which includes detailed information in investment in older people’s mental health services by service type. It does not, however, break investment down between functional and organic illness. This is because many services (e.g. Community Mental Health Teams, some inpatient beds) serve patients with both disorders. We have therefore used investment in older person’s mental health services as a proxy for organic mental illness. Where data is available for services that are specific to organic mental illness (such as memory assessment clinics) this has been included under the heading of community organic services.

Total PCT investment in older people’s mental health services was just under £1.8 billion in 2010/11, of which just over 75% was spent with statutory providers. This varies fairly substantially by region. The highest proportionate investor with statutory providers is the South East Coast region (93%), the lowest is the South West region (65%). These patterns of investment are illustrated in figures 19, 20 and 21.

Figure 19: Total PCT investment in older people’s mental health services -2010/11 (£000s)49

<table>
<thead>
<tr>
<th>SHA Region</th>
<th>Statutory NHS</th>
<th>Non-Statutory NHS</th>
<th>Local Authority</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS South East Coast</td>
<td>111,558</td>
<td>8,098</td>
<td>0</td>
<td>119,656</td>
</tr>
<tr>
<td>NHS North East</td>
<td>92,531</td>
<td>36,355</td>
<td>1,817</td>
<td>130,703</td>
</tr>
<tr>
<td>NHS South Central</td>
<td>92,275</td>
<td>47,456</td>
<td>0</td>
<td>139,731</td>
</tr>
<tr>
<td>NHS East Midlands</td>
<td>117,749</td>
<td>31,882</td>
<td>0</td>
<td>149,631</td>
</tr>
<tr>
<td>NHS West Midlands</td>
<td>128,600</td>
<td>44,756</td>
<td>282</td>
<td>173,638</td>
</tr>
<tr>
<td>NHS South West</td>
<td>130,881</td>
<td>69,575</td>
<td>0</td>
<td>200,456</td>
</tr>
<tr>
<td>NHS Yorkshire and Humber</td>
<td>143,923</td>
<td>62,463</td>
<td>2,557</td>
<td>208,942</td>
</tr>
<tr>
<td>NHS North West</td>
<td>176,539</td>
<td>60,548</td>
<td>936</td>
<td>238,022</td>
</tr>
<tr>
<td>NHS London</td>
<td>203,367</td>
<td>50,785</td>
<td>252</td>
<td>254,404</td>
</tr>
<tr>
<td><strong>ENGLAND</strong></td>
<td><strong>1,353,697</strong></td>
<td><strong>426,027</strong></td>
<td><strong>9,410</strong></td>
<td><strong>1,789,133</strong></td>
</tr>
</tbody>
</table>

The market was found to be most concentrated in the South East Coast SHA region, and least so in Yorkshire and the Humber, as figure 22 illustrates.
Figure 22: Herfindahl index – older peoples mental health services – 2010/11

Ibid.
Organic Mental Health Problems - Community

This section of the report provides an analysis of community services for organic mental health problems – using investment in memory assessment services as an indicator. Memory assessment services are, in the vast majority of cases, provided by statutory providers across all Strategic Health Authority regions, as illustrated in figures 23, 24 and 25. This market was found to be most concentrated in the South East region, and least so in London.

Figure 23: Total PCT investment in memory assessment services – 2010/11 (£000s)\(^{53}\)

<table>
<thead>
<tr>
<th>SHA REGION</th>
<th>Non Statutory NHS</th>
<th>Statutory NHS</th>
<th>Local Authority</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS South East Coast</td>
<td>135</td>
<td>135</td>
<td></td>
<td>135</td>
</tr>
<tr>
<td>NHS East Midlands</td>
<td>940</td>
<td></td>
<td></td>
<td>940</td>
</tr>
<tr>
<td>NHS North East</td>
<td>1,062</td>
<td></td>
<td></td>
<td>1,062</td>
</tr>
<tr>
<td>NHS West Midlands</td>
<td>219</td>
<td>1,645</td>
<td></td>
<td>1,864</td>
</tr>
<tr>
<td>NHS South Central</td>
<td>2,172</td>
<td></td>
<td></td>
<td>2,172</td>
</tr>
<tr>
<td>NHS South West</td>
<td>149</td>
<td>2,416</td>
<td></td>
<td>2,565</td>
</tr>
<tr>
<td>NHS East of England</td>
<td>40</td>
<td>3,552</td>
<td></td>
<td>3,592</td>
</tr>
<tr>
<td>NHS North West</td>
<td>2</td>
<td>3,600</td>
<td></td>
<td>3,602</td>
</tr>
<tr>
<td>NHS Yorkshire and Humber</td>
<td>4</td>
<td>5,048</td>
<td></td>
<td>5,052</td>
</tr>
<tr>
<td>NHS London</td>
<td>142</td>
<td>6,763</td>
<td>51</td>
<td>6,956</td>
</tr>
<tr>
<td>ENGLAND</td>
<td>555</td>
<td>27,333</td>
<td>51</td>
<td>27,940</td>
</tr>
</tbody>
</table>

Figure 24: Total PCT investment in memory assessment services -2010/11 (£000s)\(^{54}\)

Key: Blue = Statutory NHS, Orange = Non-statutory NHS, Green = Local Authority

\(^{53}\) Ibid.  
\(^{54}\) Ibid.
Figure 25: Herfindahl index – memory assessment services – 2010/11

Herfindahl Index

- NHS London
- NHS Yorkshire and Humber
- NHS West Midlands
- NHS North East
- NHS South of England
- NHS South West
- NHS Midlands West
- NHS North
- NHS South
- NHS East Coast

Ibid.
Organic Mental Health Problems - Inpatient

The market for specialist inpatient services for older people is also almost entirely provided by the statutory sector. The analysis showed that in the North East, South East Coast, West Midlands and East of England SHA regions, in 2010/11, all investment was placed with statutory providers. The highest proportionate (%) investor with non-statutory providers was the North West SHA region (5%). Figures 26 and 27 illustrate this pattern. This market is most concentrated in the North East and least so in London, as illustrated by figure 28.

**Figure 26: Total PCT investment in older adult acute inpatient services – 2010/11**

<table>
<thead>
<tr>
<th>SHA Region</th>
<th>Statutory NHS</th>
<th>Non-Statutory NHS</th>
<th>Local Authority</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS South Central</td>
<td>24,460</td>
<td>51</td>
<td>0</td>
<td>24,512</td>
</tr>
<tr>
<td>NHS North East</td>
<td>25,262</td>
<td>0</td>
<td>0</td>
<td>25,262</td>
</tr>
<tr>
<td>NHS Yorkshire and Humber</td>
<td>27,772</td>
<td>136</td>
<td>0</td>
<td>27,908</td>
</tr>
<tr>
<td>NHS South West</td>
<td>36,789</td>
<td>56</td>
<td>0</td>
<td>36,845</td>
</tr>
<tr>
<td>NHS South East Coast</td>
<td>37,599</td>
<td>0</td>
<td>0</td>
<td>37,599</td>
</tr>
<tr>
<td>NHS West Midlands</td>
<td>38,550</td>
<td>1,239</td>
<td>0</td>
<td>38,789</td>
</tr>
<tr>
<td>NHS East Midlands</td>
<td>45,597</td>
<td>0</td>
<td>0</td>
<td>45,597</td>
</tr>
<tr>
<td>NHS London</td>
<td>53,132</td>
<td>74</td>
<td>0</td>
<td>53,205</td>
</tr>
<tr>
<td>NHS North West</td>
<td>62,881</td>
<td>3,220</td>
<td>0</td>
<td>66,101</td>
</tr>
<tr>
<td><strong>ENGLAND</strong></td>
<td><strong>389,576</strong></td>
<td><strong>4,776</strong></td>
<td>0</td>
<td><strong>394,352</strong></td>
</tr>
</tbody>
</table>

56 Ibid.
Figure 27: Total PCT investment in older adult acute inpatient services - 2010/11 (£000s)

Key: Blue = Statutory NHS
Orange = Non-statutory NHS
Green = Local Authority

Figure 28: Herfindahl index – older adult acute inpatient services – 2010/11

---

57 Ibid.
58 Ibid.
Addiction Services

The available data enables us to understand the size of this market, but not its make-up in terms of the pattern of provision. Anecdotally, this is a market in which the independent and voluntary sectors have established a substantial presence. The SHA region with the highest investment and services in 2009/10 was London (£178 million – 18.5% of the national total) and the lowest was South Central (£52 million – 5.4% of the total). Figures 29 and 30 illustrate patterns of investment in these services.

Figure 29: Spend on Substance Misuse – 2009/10

<table>
<thead>
<tr>
<th>SHA Region</th>
<th>Spend (£000s)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Central</td>
<td>51,964</td>
<td>5.4%</td>
</tr>
<tr>
<td>South East Coast</td>
<td>55,118</td>
<td>5.7%</td>
</tr>
<tr>
<td>East Midlands</td>
<td>67,432</td>
<td>7.0%</td>
</tr>
<tr>
<td>East of England</td>
<td>71,538</td>
<td>7.4%</td>
</tr>
<tr>
<td>North East</td>
<td>74,252</td>
<td>7.7%</td>
</tr>
<tr>
<td>South West</td>
<td>82,684</td>
<td>8.6%</td>
</tr>
<tr>
<td>Yorkshire and Humber</td>
<td>110,680</td>
<td>11.5%</td>
</tr>
<tr>
<td>West Midlands</td>
<td>114,856</td>
<td>11.9%</td>
</tr>
<tr>
<td>North West</td>
<td>156,580</td>
<td>16.3%</td>
</tr>
<tr>
<td>London</td>
<td>177,995</td>
<td>18.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>963,099</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Department of Health (2009/10) *Programme Budgeting Reference Cost Based Primary Care Trust Benchmarking Workbook*. Available at: <http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH_075743#_1>
Figure 30: Spend on substance misuse by SHA region - 2009/10

Ibid.
Adult Eating Disorder Services

We estimate that over 50% of adult inpatient eating disorder beds, nationally, are provided by non-statutory sector providers. The Priory Group has the greatest market share, with a third (33%) of all adult eating disorder beds nationally. No other individual provider has a market share greater than 10%. Beyond the six individual providers listed below, all other providers make up just over 40% of the total market. Figure 31 illustrates this pattern in more detail.

**Figure 31: National market for adult eating disorder beds**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Beds</th>
<th>Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priory Hospitals Group</td>
<td>143</td>
<td>32.9%</td>
</tr>
<tr>
<td>Cygnet Healthcare</td>
<td>27</td>
<td>6.2%</td>
</tr>
<tr>
<td>Oxfordshire and Buckinghamshire MH NHS FT</td>
<td>26</td>
<td>6.0%</td>
</tr>
<tr>
<td>Life Works Community Ltd</td>
<td>24</td>
<td>5.5%</td>
</tr>
<tr>
<td>Huntercombe Group</td>
<td>20</td>
<td>4.6%</td>
</tr>
<tr>
<td>Leeds Partnership NHS FT</td>
<td>19</td>
<td>4.4%</td>
</tr>
<tr>
<td>All other providers</td>
<td>175</td>
<td>40.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>434</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

**Figure 32: National market for adult eating disorder beds**

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61 Mental Health Strategies (2011), unpublished research  
62 Mental Health Strategies (2011), unpublished research
Child and Adolescent Mental Health Services

Data currently available enables us to understand the size of this market, but not its make-up in terms of patterns of provision between statutory and non-statutory providers. The SHA region with the highest total investment in Child and Adolescent Mental Health services (CAMHs) was found to be London (£153 million – 21.7% of the national market) and the lowest was South Central (£47 million – 6.6% of the national market). For the avoidance of doubt, this does not represent highest or lowest spend per head. Figures 33 and 34 illustrate this pattern further.

Figure 33: Spend on CAMHS in 2009/10

<table>
<thead>
<tr>
<th>SHA Region</th>
<th>Spend (£000s)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Central</td>
<td>46,694</td>
<td>6.6%</td>
</tr>
<tr>
<td>North East</td>
<td>48,285</td>
<td>6.8%</td>
</tr>
<tr>
<td>East Midlands</td>
<td>48,800</td>
<td>6.9%</td>
</tr>
<tr>
<td>South East Coast</td>
<td>52,566</td>
<td>7.4%</td>
</tr>
<tr>
<td>Yorkshire and Humber</td>
<td>54,303</td>
<td>7.7%</td>
</tr>
<tr>
<td>South West</td>
<td>56,397</td>
<td>8.0%</td>
</tr>
<tr>
<td>East of England</td>
<td>72,713</td>
<td>10.3%</td>
</tr>
<tr>
<td>West Midlands</td>
<td>82,840</td>
<td>11.7%</td>
</tr>
<tr>
<td>North West</td>
<td>91,185</td>
<td>12.9%</td>
</tr>
<tr>
<td>London</td>
<td>153,491</td>
<td>21.7%</td>
</tr>
<tr>
<td>Total</td>
<td>707,277</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Figure 34: Spend on CAMHS by SHA – 2009/10

Investment (£000s)

South Central, North East, Midlands, South East, Yorkshire and Humber, South West, East of England, Midlands, West, North, London

64 Ibid.
Summary and Observations

Based on the information set out above, we can make a number of observations relating to the current landscape of NHS-funded mental health provision in England.

Firstly, at a very high level, the vast majority of mental health care in England is provided by statutory providers of NHS services. In the financial year 2010/11 the total investment of PCTs in adult and older people’s mental health services was reported to be £7.19 billion. Of this investment 77% (£5.57 billion) was reported to be with NHS providers, with 22% (£1.56 billion) with non-statutory providers, and 1% with local authorities. There was some variation by SHA region, with statutory providers overall market share ranging from a high of 86.1% in London, to a low of 71.6% in the North West, as illustrated in figure 35 below.

Secondly, a further generalisation we can make is that non-statutory providers primarily compete for business at the two extremes of the care continuum, as illustrated in the figure below.

<table>
<thead>
<tr>
<th>SHA Region</th>
<th>Statutory NHS</th>
<th>Non-Statutory NHS</th>
<th>Local Authority</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS North East</td>
<td>317,467</td>
<td>87,393</td>
<td>14,308</td>
<td>419,168</td>
</tr>
<tr>
<td>NHS South Central</td>
<td>357,412</td>
<td>117,551</td>
<td>0</td>
<td>474,964</td>
</tr>
<tr>
<td>NHS South East Coast</td>
<td>392,971</td>
<td>99,469</td>
<td>0</td>
<td>492,440</td>
</tr>
<tr>
<td>NHS East Midlands</td>
<td>415,948</td>
<td>131,430</td>
<td>0</td>
<td>547,377</td>
</tr>
<tr>
<td>NHS East Of England</td>
<td>538,203</td>
<td>95,425</td>
<td>4,543</td>
<td>638,171</td>
</tr>
<tr>
<td>NHS South West</td>
<td>464,671</td>
<td>177,315</td>
<td>951</td>
<td>642,937</td>
</tr>
<tr>
<td>NHS Yorkshire and Humber</td>
<td>533,535</td>
<td>180,433</td>
<td>9,540</td>
<td>723,508</td>
</tr>
<tr>
<td>NHS West Midlands</td>
<td>576,004</td>
<td>191,620</td>
<td>16,390</td>
<td>784,015</td>
</tr>
<tr>
<td>NHS North West</td>
<td>744,549</td>
<td>284,320</td>
<td>10,693</td>
<td>1,039,563</td>
</tr>
<tr>
<td>NHS London</td>
<td>1,231,346</td>
<td>195,414</td>
<td>2,464</td>
<td>1,429,225</td>
</tr>
<tr>
<td>ENGLAND</td>
<td>5,572,107</td>
<td>1,560,370</td>
<td>58,890</td>
<td>7,191,366</td>
</tr>
</tbody>
</table>

66 Ibid.
There are a set of segmented markets for mental health services. Market structure, participation and concentration varies by segment and region. For example, in IAPT services, 26% (£44 million) of investment in 2010/11 was reported to be placed with non-statutory providers and 73% (£123 million) with statutory providers. This varied significantly by region. For example, in the North East SHA region over half of the NHS investment (53%) in IAPT services was with non-statutory providers.\(^{67}\)

Similarly, at the other extreme of the continuum, the markets for medium secure services and eating disorder also have comparably higher levels of non-statutory provision.

Analysis of investment in ‘core’ community services for serious and enduring mental illness (community mental health teams, assertive outreach teams, crisis resolution home treatment and early intervention in psychosis) shows that nationally 97.6% of just over £1 billion of NHS investment is placed with statutory providers. The South Central region does not appear to have any investment in these types of services with non-statutory providers. North West and West Midlands SHA regions are the highest investors with non-statutory providers, albeit both spend over 90% with statutory providers on these sorts of services.\(^{68}\)

For those areas of service provision where the market is highly concentrated (be that by statutory and non-statutory providers), this has implications for commissioners in developing market management strategies to secure best value for money and, in the event of a provider exiting the market, in ensuring continuity of service can be provided.

The following figures illustrate the degree of variation in spend between statutory and non-statutory sectors across the country.

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\(^{67}\) Ibid.

\(^{68}\) Ibid.
There has been a marked change over the past decade in the patterns of investment in adult mental health services, with growth in secure services and psychological therapies matched by a decline in investment in more traditional inpatient services, Community Mental Health Teams and day services. This is illustrated in figure 39 below.

Ibid.
Figure 39: Change in direct services investment 02/03 to 10/11\textsuperscript{71}

\textsuperscript{71} Mental Health Strategies, Dataset: Adult and Older People’s National Mental Health Finance Mapping Exercise 2002/03 to 2010/11
Survey of Commissioners: Contracting Arrangements

Our survey of contract structures found a substantial emphasis on local block contracts, but with a marked difference between market segments. Secure services were mostly organised via regional specialist commissioning. There are a large number of cost and volume and named patient contracts used in eating disorders and in Child and Adolescent Mental Health Services.

It would appear that the greater the independent sector role in the market, the smaller the use of block contracts.

Data was provided by 14 PCTs, overall representing under 10% of all commissioners – and totaling £923 million of investment. Of this total investment 75% was reported to be via through block contracts. A detailed breakdown of responses is provided in figures 40 and 41 below.

Figure 40: Commissioner contracting arrangements by market segment

<table>
<thead>
<tr>
<th>Service</th>
<th>Investment (£000)</th>
<th>Block</th>
<th>Cost and Volume</th>
<th>Named Patient Contracts</th>
<th>Specialist Commissioning</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common MH</td>
<td>£75,044</td>
<td>88.3%</td>
<td>3.8%</td>
<td>7.9%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Serious &amp; Enduring</td>
<td>£292,655</td>
<td>84.9%</td>
<td>6.7%</td>
<td>7.7%</td>
<td>0.0%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Secure / Forensic</td>
<td>£98,374</td>
<td>9.8%</td>
<td>10.7%</td>
<td>11.7%</td>
<td>67.7%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Organic</td>
<td>£85,478</td>
<td>86.4%</td>
<td>8.8%</td>
<td>3.8%</td>
<td>0.0%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Addiction</td>
<td>£35,391</td>
<td>94.2%</td>
<td>2.2%</td>
<td>0.3%</td>
<td>0.2%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>£2,775</td>
<td>20.4%</td>
<td>36.5%</td>
<td>42.9%</td>
<td>0.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>CAMHS</td>
<td>£43,717</td>
<td>51.6%</td>
<td>24.7%</td>
<td>12.2%</td>
<td>11.0%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Other</td>
<td>£1,828</td>
<td>76.2%</td>
<td>23.8%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Unspecified</td>
<td>£287,790</td>
<td>81.2%</td>
<td>0.2%</td>
<td>7.7%</td>
<td>7.0%</td>
<td>3.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£923,052</strong></td>
<td>74.7%</td>
<td>5.9%</td>
<td>7.8%</td>
<td>9.9%</td>
<td>1.6%</td>
</tr>
</tbody>
</table>
Figure 41: Commissioner contracting arrangements by market segment (%)
Survey of Providers: Contracting Arrangements

Our survey results indicated that statutory providers generally retain a large majority of provision in-house. Only in eating disorders were a substantial volume of sub-contracts reported. 94% of the total spend identified by statutory providers (identified within the survey) were reported to be on services provided in-house. Further illustration of the main findings of the survey are detailed in figures 42 and 43 below.

Figure 42: Contracting arrangements survey – statutory providers by market segment

<table>
<thead>
<tr>
<th>Segment</th>
<th>Spend (£000s)</th>
<th>In-House</th>
<th>Joint Venture / Partnership</th>
<th>Sub-Contracted</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common MH</td>
<td>57,650</td>
<td>96.3%</td>
<td>1.4%</td>
<td>1.1%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Serious &amp; Enduring</td>
<td>532,552</td>
<td>96.2%</td>
<td>0.0%</td>
<td>3.8%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Forensic / Secure</td>
<td>207,348</td>
<td>93.1%</td>
<td>0.0%</td>
<td>6.9%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Organic</td>
<td>172,946</td>
<td>99.9%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Addiction</td>
<td>39,085</td>
<td>94.7%</td>
<td>1.8%</td>
<td>0.3%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>6,677</td>
<td>67.0%</td>
<td>0.0%</td>
<td>33.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>CAMHS</td>
<td>79,836</td>
<td>99.5%</td>
<td>0.0%</td>
<td>0.5%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other</td>
<td>20,108</td>
<td>97.7%</td>
<td>0.0%</td>
<td>2.3%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Unspecified</td>
<td>1,622,830</td>
<td>93.1%</td>
<td>2.8%</td>
<td>4.0%</td>
<td>0.1%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>2,739,031</strong></td>
<td><strong>94.4%</strong></td>
<td><strong>1.7%</strong></td>
<td><strong>3.8%</strong></td>
<td><strong>0.1%</strong></td>
</tr>
</tbody>
</table>

Figure 43: Contracting arrangements survey – statutory providers by market segment
Barriers to Entry and Movement in the NHS-Funded Mental Health market

A Delphi exercise was undertaken with key stakeholders on what they felt the current challenges, barriers and trends within the market are. This section outlines the main findings from that exercise. It should be emphasised that the views outlined in this section represent the views of respondents, not necessarily those of the report’s authors or commissioners.

In overall rank order, the main barriers to entry and movement were considered by respondents to be:

1. Block contracts
2. The ‘monopoly’ of statutory providers
3. Poor integration and partnership working
4. ‘Unsophisticated’ mental health commissioning
5. Absence of a tariff in NHS mental health services
6. NHS terms and conditions
7. Infrastructure and tendering
8. NHS financial stringencies
9. NHS regulatory framework
10. Attitudes and strategies of providers
11. Access to buildings and capital

There were some important differences between responses from the varying respondent groups. Respondents tended to rate more highly those perceived barriers which were present in other parts of the system, as opposed to be in the gift of their own organization (e.g. participants from provider organisations rated ‘unsophisticated’ commissioning more highly in the rank order as a barrier to entry and movement than participants from commissioning organisations did). Those responses are set out in figures 44 and 45 at the end of this section. Below we draw out some of the comments made, aiming to give a flavour and understanding of the nature of opinion in the market.

Block Contracts

Although not ranked as the most significant barrier by any individual organisation type, overall block contracts was ranked as an important barrier to entry by all types of organisation. Block contracts were ranked as the second biggest barrier to market entry by statutory, for-profit and not-for-profit providers, as well as by commissioners.

As a board member from a for-profit provider that participated in the Delphi exercise stated:

“The vast majority of mental health services are provided by the NHS through block contracts and devolved budgets which makes it difficult if not impossible for new market entrants”

Similarly a respondent from an NHS Foundation Trust stated:

“Block contracts are not a preferred approach by NHS organisations either - it makes it very difficult to develop effective management accounts and improve service efficiency”.

A movement away from the use of block contracts was ranked overall as the most important area to address in terms of current barriers to market entry, and as the most
important barrier to entry by commissioners and for profit providers. It was also ranked second by NHS Trusts. One respondent from an NHS Trust stated:

“The move away from block contracts is a positive move and will drive change and productivity”

Another respondent from an NHS Trust stated:

“The statutory sector with block contracts, whilst being advantageous in giving certainty about income has little control on the volumes of demand placed upon it. This can create huge clinical and financial pressures for the sector”.

This view was not, however, universal. Some argued that the guaranteed income offered by block contracts allows providers to develop services. A respondent from an NHS Foundation Trust stated:

“Without block contracts we would not have many of the developments we do without clinicians being able to develop services in this way. The private sector has not been the developer of e.g. personality disorder services, women's PICUs”.

A Chief Executive from an NHS Foundation Trust argued that a movement away from block contracts could risk the financial stability of statutory providers:

“If you cherry pick the market segments for serious and enduring mental illness (both inpatient and community), as these services are (predominately) commissioned under block contracts ....then the provider will lose its core of provision and is likely to collapse. If this is as a consequence of a planned commissioning strategy then all well and good, but it is more likely to happen by default”.

**Monopoly of statutory providers**

Across all of the respondents this was ranked as the second most significant barrier to market entry, and as the biggest barrier to market entry by commissioners, for-profit providers, not-for-profit providers and social enterprises.

The power of local statutory providers across the mental health care pathway is argued to make it difficult for new entrants into the market to provide core services (e.g. CMHTs) that are commissioned under a block contract. One commissioner stated:

“The reality is that if you are running a monopoly you need to feel the pressure of competition or you will not need to innovate, review and change. Without this services have a tendency to stagnate unless there are particularly enthusiastic leaders within the organisation. This is evidenced by large variations in quality in similar services in different parts of the same organisation. Why are CMHTs better in one part of a Trust than another?”

Some respondents however argued that the dominant position of many statutory providers is appropriate and that local statutory providers should provide the 'core' mental health services in a given geography. Other respondents argued that that they do not see the mental health market as monopolistic and that real competition does exist, including from other statutory providers. A respondent from an NHS Trust stated:

“I do not see provision as a monopoly and indeed most providers face competitive threats from FT's, acute providers, community providers, social care, third sector and commercial sector”
Despite the variation of opinion about the extent to which the market is concentrated, there was a consensus that providers that the statutory and non-statutory sectors should be encouraged to work together to improve the quality of services in the future.

A respondent from the charitable sector stated:

“One approach which could bring new providers in without compromising the stability of the NHS Trusts is to require those Trusts to sub-contract amounts of their services. The trusts could become the commissioners for their whole district, rather than being a near-monopoly provider”.

Another respondent stated:

“A positive of the economic climate is that our local mental health Trust is now looking to sub-contract some of its work to local smaller providers - we can operate with greater efficiency and flexibility (if allowed)”

Absence of a tariff in mental health services

The absence of a tariff for mental health services was ranked as the 5th biggest barrier. Statutory providers ranked it as the single biggest barrier to market entry.

A number of respondents considered that Payment by Results could be a good vehicle for change in mental health services – particularly in respect of facilitating a move away from block contracts and increasing patient choice. NHS Trusts and NHS Foundation Trusts ranked Payment by Results as the most important of the proposals to address current barriers to entry in the mental health market, with the for-profit sector ranking it as second most important.

The not-for-profit sector respondents did, however, identify concerns about the implementation of Payment by Results. These concerns focused on whether the implementation of Payment by Results will lead to statutory providers managing the full care pathway.

“The impact of PbR will be interesting as more standardised cost/volume pricing mechanisms come into play, though if PbR equals lead provider arrangements this could lead to a shrinkage of opportunities for non NHS providers”.

“I would highlight the potential risks for PbR in restricting not-for-profit participation in an NHS dominated care pathway”

NHS terms and conditions

NHS Foundation Trusts ranked NHS terms and conditions as the single biggest barrier to entry in the mental health market. For-profit providers ranked it as the fourth biggest barrier. Key issues highlighted were NHS pensions and TUPE (transfer of undertakings) arrangements:

“TUPE regulations and the NHS terms and conditions do make it more difficult, particularly for smaller providers, and the NHS terms need to change to reflect today’s and tomorrow’s society”

“One of the main barriers is the necessity to TUPE NHS staff – not-for-profit providers can’t match NHS terms and conditions and redundancy and other costs are prohibitive”
Tendering

The current complexity of tendering processes was identified as particularly challenging for smaller providers who often do not have the internal resources and infrastructure to respond to tenders:

“The tendering process are incredibly time-consuming and cumbersome, massive amount of pre-consultation on service specs, etc and a very burdensome administrative process. Most commissioners do not have capacity to do this.”

“Tendering could be made simpler and more available to not for profit companies with little infra structure and in that way fewer costs. Evaluation could be made simpler so that everything does not have to be proved by extensive paperwork that each organisation is having to repeat.”

Streamlined tendering processes were ranked as a key proposal to address current barriers to market entry – ranking fourth most important across all respondents. Commissioners, not-for-profit providers and social enterprises all ranked it as the second most important proposal.

‘Unsophisticated’ mental health commissioning

‘Unsophisticated’ mental health commissioning was ranked as a key barrier to market entry. It was identified as the 3rd most significant barrier to market entry by for-profit providers, not-for-profit providers and by social enterprises.

Respondents offered a variety of opinions as to how the establishment of CCGs and changes to the commissioning architecture will impact on the mental health market. Some thought that CCGs will be more willing to test the market in mental health services, and more willing to challenge the traditional role of statutory providers in their locality.

A Chief Executive of an NHS Trust speculated:

“Trusts will experience a change in the experience of working with commissioners when the CCGs are fully formed as their views as practitioners and local providers will bring a different perspective to the process. This will prove to be challenging in parts, an important change of emphasis.”

However, others thought that the move to CCGs commissioning services would have a more limited impact on mental health commissioning. This was based on a concern that CCGs may view mental health commissioning as a lower priority than acute services. One respondent from the not-for-profit sector stated:

“I agree that there is a need for improved mental health commissioning but...I personally do not feel that GPs commissioning will improve access to mental health services for the populations they serve and that this will not be a priority.”

In light of the concerns identified about the competence and expertise of CCGs to undertake mental health commissioning, a clear need for training of new commissioners was identified by participants. It was also suggested that this should include a strong service user voice. A respondent from the not-for-profit sector commented:

“Support and training for CCGs must address the meaningful participation of service users within this process so that the valuable ‘lived experience’ of people using services can be tapped into appropriately.”
Integration and partnership working

Across all respondents this ranked as the third significant barrier to market entry, referring to a need for improved partnership working between both statutory and non-statutory sector providers, and between health and social care, to improve value for money and to deliver better quality care. A Managing Director of a for-profit provider said:

“We need to start commissioning for a pathway of care that is integrated across health and social care....this means putting an end to bed blocking and protectionism by all providers and an openness to think outside of the box. There is evidence that this is resulting with some Trusts being open to new ideas and more inclined to partner to deliver services. We need to strive for a real mixed economy where all types of providers are valued if they deliver results for service users, after all this is who we are in business for.”

Figure 44 sets out the ranked responses given in the Delphi exercise by organisation type. Whilst there is a high degree of commonality between responses, it is clear that different organisation types hold differing perspectives on what the main barriers to market entry are. Figure 45 sets out responses around proposals to address current barriers to entry, ranked by organisation type.
Figure 44: Barriers to entry in the mental health market – ranked by type of organisation

<table>
<thead>
<tr>
<th>Rank</th>
<th>Commissioners</th>
<th>NHS Trusts</th>
<th>FTs</th>
<th>For profit</th>
<th>Not for profit</th>
<th>Social Enterprises</th>
<th>Others</th>
<th>Total Composite Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>‘Monopoly’ of NHS mental health trusts</td>
<td>Absence of a tariff in mental health services</td>
<td>NHS terms and conditions</td>
<td>‘Monopoly’ of NHS mental health trusts</td>
<td>‘Monopoly’ of NHS mental health trusts</td>
<td>‘Monopoly’ of NHS mental health trusts</td>
<td>Unsophisticated mental health commissioning</td>
<td>Block contracts</td>
</tr>
<tr>
<td>2</td>
<td>Block contracts</td>
<td>Block contracts</td>
<td>Absence of a tariff in mental health services</td>
<td>Block contracts</td>
<td>Block contracts</td>
<td>Infrastructure and tendering</td>
<td>Block contracts</td>
<td>‘Monopoly’ of NHS mental health trusts</td>
</tr>
<tr>
<td>3</td>
<td>Poor integration and partnership working</td>
<td>NHS financial stringencies</td>
<td>NHS financial stringencies</td>
<td>‘Unsophisticated’ mental health commissioning</td>
<td>‘Unsophisticated’ mental health commissioning</td>
<td>‘Unsophisticated’ mental health commissioning</td>
<td>Poor integration and partnership working</td>
<td>Poor integration and partnership working</td>
</tr>
<tr>
<td>4</td>
<td>Absence of a tariff in mental health services</td>
<td>‘Unsophisticated’ mental health commissioning</td>
<td>Infrastructure and tendering</td>
<td>NHS terms and conditions</td>
<td>Poor integration and partnership working</td>
<td>Poor integration and partnership working</td>
<td>‘Monopoly’ of NHS mental health trusts</td>
<td>‘Unsophisticated’ mental health commissioning</td>
</tr>
<tr>
<td>5</td>
<td>NHS regulatory framework</td>
<td>Infrastructure and tendering</td>
<td>NHS regulatory framework</td>
<td>Absence of a tariff in mental health services</td>
<td>NHS terms and conditions</td>
<td>Attitudes / strategies of providers</td>
<td>Attitudes / strategies of providers</td>
<td>Absence of a tariff in mental health services</td>
</tr>
<tr>
<td>6</td>
<td>NHS terms and conditions</td>
<td>NHS terms and conditions</td>
<td>Block contracts</td>
<td>Poor integration and partnership working</td>
<td>NHS regulatory framework</td>
<td>Block contracts</td>
<td>Infrastructure and tendering</td>
<td>NHS terms and conditions</td>
</tr>
<tr>
<td>7</td>
<td>NHS financial stringencies</td>
<td>Poor integration and partnership working</td>
<td>‘Monopoly’ of NHS mental health trusts</td>
<td>Infrastructure and tendering</td>
<td>Access to buildings / capital</td>
<td>NHS financial stringencies</td>
<td>Infrastructure and tendering</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Infrastructure and tendering</td>
<td>NHS regulatory framework</td>
<td>‘Unsophisticated’ mental health commissioning</td>
<td>NHS financial stringencies</td>
<td>Absence of a tariff in mental health services</td>
<td>NHS regulatory framework</td>
<td>NHS financial stringencies</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>‘Unsophisticated’ mental health commissioning</td>
<td>‘Monopoly’ of NHS mental health trusts</td>
<td>Attitudes / strategies of providers</td>
<td>Attitudes / strategies of providers</td>
<td>Access to buildings / capital</td>
<td>NHS financial stringencies</td>
<td>Access to buildings / capital</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Attitudes / strategies of providers</td>
<td>Access to buildings / capital</td>
<td>Access to buildings / capital</td>
<td>Access to buildings / capital</td>
<td>Absence of a tariff in mental health services</td>
<td>NHS terms and conditions</td>
<td>NHS terms and conditions</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Access to buildings / capital</td>
<td>Attitudes / strategies of providers</td>
<td>Poor integration and partnership working</td>
<td>NHS regulatory framework</td>
<td>Attitudes / strategies of providers</td>
<td>NHS regulatory framework</td>
<td>Absence of a tariff in mental health services</td>
<td>Access to buildings / capital</td>
</tr>
</tbody>
</table>
Figure 45: Top 8 proposals to address current barriers to entry in the mental health market – ranked by type of organisation

<table>
<thead>
<tr>
<th>Rank</th>
<th>Commissioners</th>
<th>NHS Trusts</th>
<th>FTs</th>
<th>For profit</th>
<th>Not for profit</th>
<th>Social Enterprises</th>
<th>Others</th>
<th>Total ‘Composite’ Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Movement away from block contracts</td>
<td>Development of a currency and tariff for mental health (Payment by Results)</td>
<td>Development of a currency and tariff for mental health (Payment by Results)</td>
<td>Movement away from block contracts</td>
<td>Tendering of a wider range of services</td>
<td>Support for the voluntary sector and social enterprises to enter the mental health market and tender for services</td>
<td>Outcome focussed service specifications</td>
<td>Movement away from block contracts</td>
</tr>
<tr>
<td>2</td>
<td>Stream-lined tendering processes</td>
<td>Movement away from block contracts</td>
<td>Address NHS pensions – exploring options for their portability</td>
<td>Development of a currency and tariff for mental health (Payment by Results)</td>
<td>Stream-lined tendering processes</td>
<td>Stream-lined tendering processes</td>
<td>Improved integration and partnership working</td>
<td>Development of a currency and tariff for mental health (Payment by Results)</td>
</tr>
<tr>
<td>3</td>
<td>Development and roll-out of the Any Qualified Provider (AQP) Policy</td>
<td>Training and support for mental health commissioners (including new CCGs)</td>
<td>Stream-lined tendering processes</td>
<td>Development and roll-out of the Any Qualified Provider (AQP) Policy</td>
<td>Outcome focussed service specifications</td>
<td>Tendering of a wider range of services</td>
<td>Development of a currency and tariff for mental health (Payment by Results)</td>
<td>Outcome focussed service specifications</td>
</tr>
<tr>
<td>4</td>
<td>Development of a currency and tariff for mental health (Payment by Results)</td>
<td>Stream-lined tendering processes</td>
<td>Outcome focussed service specifications</td>
<td>Allow NHS FTs to fail and develop a failure regime for them</td>
<td>Improved integration and partnership working</td>
<td>Enhanced role for the voluntary sector and social enterprises</td>
<td>Increased role / voice for service users</td>
<td>Stream-lined tendering processes</td>
</tr>
<tr>
<td>5</td>
<td>Tendering of a wider range of services</td>
<td>Development and roll-out of the Any Qualified Provider (AQP) Policy</td>
<td>Agreed and specified quality metrics for mental health</td>
<td>Improved integration and partnership working</td>
<td>Increased role / voice for service users</td>
<td>Training and support for mental health commissioners (including new CCGs)</td>
<td>Support for the voluntary sector &amp; social enterprises to enter the mental health market and tender for services</td>
<td>Tendering of a wider range of services</td>
</tr>
</tbody>
</table>

A full list of responses is included at Appendix C.
<table>
<thead>
<tr>
<th>Rank</th>
<th>Commissioners</th>
<th>NHS Trusts</th>
<th>FTs</th>
<th>For profit</th>
<th>Not for profit</th>
<th>Social Enterprises</th>
<th>Others</th>
<th>Total ‘Composite’ Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Enhanced role for the voluntary sector and social enterprises</td>
<td>Improved integration and partnership working</td>
<td>Movement away from block contracts</td>
<td>Tendering of a wider range of services</td>
<td>Enhanced role for the voluntary sector and social enterprises</td>
<td>Separation of the contracting monitoring functions in MH</td>
<td>Movement away from block contracts</td>
<td>Development and roll-out of the Any Qualified Provider (AQP) Policy</td>
</tr>
<tr>
<td>7</td>
<td>Support for the voluntary sector and social enterprises to enter the mental health market and tender for services</td>
<td>Increased role / voice for service users</td>
<td>Training and support for mental health commissioners (including new CCGs)</td>
<td>Increased role / voice for service users</td>
<td>Support for the voluntary sector and social enterprises to enter the mental health market and tender for services</td>
<td>Increased role / voice for service users</td>
<td>Development and roll-out of the Any Qualified Provider (AQP) Policy</td>
<td>Improved integration and partnership working</td>
</tr>
<tr>
<td>8</td>
<td>Outcome focussed service specifications</td>
<td>Support for the voluntary sector and social enterprises to enter the mental health market and tender for services</td>
<td>Development and roll-out of the Any Qualified Provider (AQP) Policy</td>
<td>Outcome focussed service specifications</td>
<td>Movement away from block contracts</td>
<td>Movement away from block contracts</td>
<td>Training and support for mental health commissioners (including new CCGs)</td>
<td>Increased role / voice for service users</td>
</tr>
</tbody>
</table>
Future Trends in Market Development and Implications for Policy Development

The findings in this section are based on the results of the Delphi exercise. They begin with an assessment as to why the market has developed in the way it has, and why it currently operates as it does.

Factors driving the current market

Respondents proposed that the three leading factors that should determine the range of services provided within the market are:

1. Local need and demand
2. Service user views and needs
3. Evidence-based services and interventions.

Respondents however considered that the main driving forces within the market are in fact:

1. Historical arrangements
2. Previous national policy initiatives
3. A desire to keep services in the “NHS family”

A fuller set of those responses are illustrated in figures 46 and 47.

Respondents suggested that current mental health services remain largely determined by historical patterns of provision and previous investment decisions – tied closely to long-standing block contracts.

The National Service Framework (NSF) for Mental Health\(^\text{73}\) was said to have led to the development of a range of services (for example crisis resolution and home treatment teams, assertive outreach teams) that remain cornerstones of current service structures. More recently the national IAPT programme was identified as contributing significantly to the development of psychological therapy services and the promotion of early intervention in mental illness. It was suggested that current policy initiatives (e.g. Any Qualified Provider and Payment by Results) could be a stimulus for further development of the mental health provider market – but with variation of opinion on if (and how) this would be achieved. In particular, there was significant debate on the potential benefits of Payment by Results and how and when it will be implemented.

\(^{73}\) Department of Health (1999), National service framework for mental health: Modern standards and service models for mental health. Available at: <http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4004765>
Figure 46: Top 8 factors that determine the range of services offered by providers – ranked by type of organisation\(^7^4\)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Commission-ers</th>
<th>NHS Trust</th>
<th>FTs</th>
<th>For profit</th>
<th>Not for profit</th>
<th>Social Enterprises</th>
<th>Others</th>
<th>Total ‘Composite’ Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Historical arrangements</td>
<td>Historical arrangements</td>
<td>Historical arrangements</td>
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<td>Historical arrangements</td>
<td>Historical arrangements</td>
<td>Historical arrangements</td>
</tr>
<tr>
<td>2</td>
<td>Previous national policy initiatives (e.g. National Service Framework for Mental Health)</td>
<td>Previous national policy initiatives (e.g. National Service Framework for Mental Health)</td>
<td>Drive for efficiency savings (CIP &amp; QIPP)</td>
<td>Desire to keep services in the ‘NHS family’</td>
<td>Drive for efficiency savings (CIP &amp; QIPP)</td>
<td>Mental health driven provider market</td>
<td>Weakness of mental health commissioning</td>
<td>Previous national policy initiatives (e.g. National Service Framework for Mental Health)</td>
</tr>
<tr>
<td>3</td>
<td>Local need and demand</td>
<td>Weakness of mental health commissioning</td>
<td>Access to buildings / capital</td>
<td>Drive for efficiency savings (CIP &amp; QIPP)</td>
<td>Current economic climate</td>
<td>Drive for efficiency savings (CIP &amp; QIPP)</td>
<td>Local politics</td>
<td>Mental health driven provider market</td>
</tr>
<tr>
<td>4</td>
<td>Current national policy initiatives (e.g. Payment by Results, Any Qualified Provider)</td>
<td>Drive for efficiency savings (CIP &amp; QIPP)</td>
<td>Previous national policy initiatives (e.g. National Service Framework for Mental Health)</td>
<td>Previous national policy initiatives (e.g. National Service Framework for Mental Health)</td>
<td>Local politics</td>
<td>Local politics</td>
<td>Mental health driven provider market</td>
<td>Local politics</td>
</tr>
</tbody>
</table>

\(^7^4\) This figure lists the top 8 responses given. A full list is given at Appendix D.
<table>
<thead>
<tr>
<th>Rank</th>
<th>Commissioners</th>
<th>NHS Trust</th>
<th>FTs</th>
<th>For profit</th>
<th>Not for profit</th>
<th>Social Enterprises</th>
<th>Others</th>
<th>Total 'Composite' Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Desire to keep services in the 'NHS family'</td>
<td>Current economic climate</td>
<td>Weakness of mental health commissioning</td>
<td>Current economic climate</td>
<td>Adherence to the 'medical model'</td>
<td>Adherence to the 'medical model'</td>
<td>Previous national policy initiatives (e.g. National Service Framework for Mental Health)</td>
<td>Weakness of mental health commissioning</td>
</tr>
<tr>
<td>6</td>
<td>Local politics</td>
<td>Local politics</td>
<td>Local politics</td>
<td>Mental health driven provider market</td>
<td>Local politics</td>
<td>Current national policy initiatives (e.g. Payment by Results, Any Qualified Provider)</td>
<td>Current economic climate</td>
<td>Current economic climate</td>
</tr>
<tr>
<td>7</td>
<td>Mental health driven provider market</td>
<td>Local need and demand</td>
<td>Current national policy initiatives (e.g. Payment by Results, Any Qualified Provider)</td>
<td>Weakness of mental health commissioning</td>
<td>Drive for efficiency savings (CIP &amp; QIPP)</td>
<td>Desire to keep services in the 'NHS family'</td>
<td>Local need and demand</td>
<td>Drive for efficiency savings (CIP &amp; QIPP)</td>
</tr>
<tr>
<td>8</td>
<td>Evidence-based interventions and services</td>
<td>Mental health driven provider market</td>
<td>Adherence to the 'medical model'</td>
<td>Current national policy initiatives (e.g. Payment by Results, Any Qualified Provider)</td>
<td>Weakness of mental health commissioning</td>
<td>Weakness of mental health commissioning</td>
<td>Evidence-based interventions and services</td>
<td>Local need and demand</td>
</tr>
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</table>
### Figure 47: Top 8 factors that should determine the range of services offered by providers – ranked by type of organisation

<table>
<thead>
<tr>
<th>Rank</th>
<th>Commissioners</th>
<th>NHS Trusts</th>
<th>FTs</th>
<th>For profit</th>
<th>Not for profit</th>
<th>Social Enterprises</th>
<th>Others</th>
<th>Total 'Composite' Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Evidence-based interventions and services</td>
<td>Local need and demand</td>
<td>Evidence-based interventions and services</td>
<td>Service user views / needs</td>
<td>Local need and demand</td>
<td>Evidence-based interventions and services</td>
<td>Evidence-based interventions and services</td>
<td>Local need and demand</td>
</tr>
<tr>
<td>2</td>
<td>Local need and demand</td>
<td>Service user views / needs</td>
<td>Service user views / needs</td>
<td>Local need and demand</td>
<td>Service user views / needs</td>
<td>Local need and demand</td>
<td>Service user views / needs</td>
<td>Service user views / needs</td>
</tr>
<tr>
<td>3</td>
<td>Service user views / needs</td>
<td>Current national policy initiatives (e.g. Payment by Results, Any Qualified Provider)</td>
<td>Local need and demand</td>
<td>Current national policy initiatives (e.g. Payment by Results, Any Qualified Provider)</td>
<td>Service user views / needs</td>
<td>Current national policy initiatives (e.g. Payment by Results, Any Qualified Provider)</td>
<td>Service user views / needs</td>
<td>Local need and demand</td>
</tr>
<tr>
<td>4</td>
<td>Current national policy initiatives (e.g. Payment by Results, Any Qualified Provider)</td>
<td>Evidence-based interventions and services</td>
<td>Current national policy initiatives (e.g. Payment by Results, Any Qualified Provider)</td>
<td>Drive for efficiency savings (Cost Improvement Programmes &amp; QIPP)</td>
<td>Evidence-based interventions and services</td>
<td>Current national policy initiatives (e.g. Payment by Results, Any Qualified Provider)</td>
<td>Current national policy initiatives (e.g. Payment by Results, Any Qualified Provider)</td>
<td>Current national policy initiatives (e.g. Payment by Results, Any Qualified Provider)</td>
</tr>
<tr>
<td>5</td>
<td>Previous national policy initiatives (e.g. National Service Framework for Mental Health)</td>
<td>Previous national policy initiatives (e.g. National Service Framework for Mental Health)</td>
<td>Previous national policy initiatives (e.g. National Service Framework for Mental Health)</td>
<td>Evidence-based interventions and services</td>
<td>Mental health driven provider market</td>
<td>Current economic climate</td>
<td>Previous national policy initiatives (e.g. National Service Framework for Mental Health)</td>
<td>Previous national policy initiatives (e.g. National Service Framework for Mental Health)</td>
</tr>
</tbody>
</table>

75 This figure presents the top 8 responses given by participants. A full list is provided at Appendix E.
<table>
<thead>
<tr>
<th>Rank</th>
<th>Commissioners</th>
<th>NHS Trusts</th>
<th>FTs</th>
<th>For profit</th>
<th>Not for profit</th>
<th>Social Enterprises</th>
<th>Others</th>
<th>Total 'Composite' Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Mental health driven provider market</td>
<td>Current economic climate</td>
<td>Drive for efficiency savings (Cost Improvement Programmes &amp; QIPP)</td>
<td>Current economic climate</td>
<td>Current economic climate</td>
<td>Previous national policy initiatives (e.g. National Service Framework for Mental Health)</td>
<td>Drive for efficiency savings (Cost Improvement Programmes &amp; QIPP)</td>
<td>Drive for efficiency savings (Cost Improvement Programmes &amp; QIPP)</td>
</tr>
<tr>
<td>7</td>
<td>Drive for efficiency savings (Cost Improvement Programmes &amp; QIPP)</td>
<td>Drive for efficiency savings (Cost Improvement Programmes &amp; QIPP)</td>
<td>Desire to keep services in the 'NHS family'</td>
<td>Drive for efficiency savings (Cost Improvement Programmes &amp; QIPP)</td>
<td>Drive for efficiency savings (Cost Improvement Programmes &amp; QIPP)</td>
<td>Current economic climate</td>
<td>Current economic climate</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Current economic climate</td>
<td>Access to buildings / capital</td>
<td>Weakness of mental health commissioning</td>
<td>Mental health driven provider market</td>
<td>Access to buildings / capital</td>
<td>Local politics</td>
<td>Mental health driven provider market</td>
<td>Mental health driven provider market</td>
</tr>
</tbody>
</table>
Future Trends

Participants in the Delphi exercise proposed twelve future trends, in overall rank order:

1. Reduction of block contracts
2. Move from inpatient to community care
3. Consolidation/merger of NHS Trusts
4. Increased competition
5. Increased choice
6. Integration of health and social care
7. Increased role for the non-statutory sector
8. Sub-contracting of services by NHS Trusts
9. Improved service quality
10. Improved partnership working between statutory and non-statutory providers
11. Development of integrated mental health and physical health trusts
12. Decreased role for the non-statutory sector

There were a range of differences between responses from the various sectors of respondents, as set out in figure 48 below. Sub-contracting of services was considered likelier by providers than by commissioners. Providers were also more immediately conscious of the prospect of consolidation or mergers of NHS providers. Commissioners were likelier to be conscious of increased choice, and of the potential role of the non-statutory sector.

In considering policy initiatives, as outlined in figure 49, respondents identified the advent of CCGs as the single most important change. Some respondents thought that the movement to CCGs will strengthen mental health commissioning in the future – with a better clinical interface between CCGs and providers. CCGs may be more willing to test the market in mental health services and more willing to challenge the traditional role of ‘powerful’ mental health NHS trusts. There is also an expectation that there will be an increased focus on primary care and the prevention agenda under CCGs.

“The advent of CCGs will be helpful as they can bring their influence to bear.”

“The emergence of the CCGs is critical and comes at a time where mental health commissioning is improving.”

“CCGs....may start to develop some of the preferred models of the 1960s i.e. day centre in GP location, respite care above the surgery, etc other community bed and day care based options based on primary care.”

However, others thought that the move to CCG commissioning will have little or no impact on improving mental health commissioning, or that they may see mental health commissioning as lower priority than acute services. Many thought that substantial support and training will be required for commissioners in the new commissioning environment. It was also suggested that service users should be given an enhanced role / voice in the new commissioning:

“I agree that there will be a need for support and training for CCGs in mental health commissioning and that GPs will need encouragement (and probably financial incentives) to see the benefit of engaging with local voluntary sector organisations.”
### Figure 48: Top 8 expected changes in the structure of the mental health market in the next 5 Years - ranked by type of organisation

<table>
<thead>
<tr>
<th>Rank</th>
<th>Commissioners</th>
<th>NHS Trusts</th>
<th>FTs</th>
<th>For profit</th>
<th>Not for profit</th>
<th>Social Enterprises</th>
<th>Others</th>
<th>Total 'Composite' Ranking</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Reduction of block contracts</td>
<td>Reduction of block contracts</td>
<td>Consolidation / merger of NHS Trusts</td>
<td>Consolidation / merger of NHS Trusts</td>
<td>Increased competition</td>
<td>Sub-contracting of services by NHS Trusts</td>
<td>Reduction of block contracts</td>
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<tr>
<td>2</td>
<td>Increased choice</td>
<td>Consolidation / merger of NHS Trusts</td>
<td>Reduction of block contracts</td>
<td>Sub-contracting of services by NHS Trusts</td>
<td>Move from inpatient to community care</td>
<td>Reduction of block contracts</td>
<td>Integration of health and social care</td>
<td>Move from inpatient to community care</td>
</tr>
<tr>
<td>3</td>
<td>Move from inpatient to community care</td>
<td>Move from inpatient to community care</td>
<td>Move from inpatient to community care</td>
<td>Development of integrated mental health and physical health Trusts</td>
<td>Increased role for the non-statutory sector</td>
<td>Consolidation / merger of NHS Trusts</td>
<td>Development of integrated mental health and physical health Trusts</td>
<td>Consolidation / merger of NHS Trusts</td>
</tr>
<tr>
<td>4</td>
<td>Increased role for the non-statutory sector</td>
<td>Increased choice</td>
<td>Sub-contracting of services by NHS Trusts</td>
<td>Move from inpatient to community care</td>
<td>Sub-contracting of services by NHS Trusts</td>
<td>Increased competition</td>
<td>Increased role for the non-statutory sector</td>
<td>Increased competition</td>
</tr>
<tr>
<td>5</td>
<td>Improved service quality</td>
<td>Sub-contracting of services by NHS Trusts</td>
<td>Integration of health and social care</td>
<td>Increased role for the non-statutory sector</td>
<td>Improved partnership working between statutory and non-statutory providers</td>
<td>Increased role for the non-statutory sector</td>
<td>Increased competition</td>
<td>Increased choice</td>
</tr>
<tr>
<td>6</td>
<td>Improved partnership</td>
<td>Integration of health and</td>
<td>Increased competition</td>
<td>Integration of health and</td>
<td>Integration of health and</td>
<td>Increased choice</td>
<td>Improved service quality</td>
<td>Integration of health and</td>
</tr>
</tbody>
</table>

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76 This table outlines the top 8 responses given. A full list is given in Appendix F.
<table>
<thead>
<tr>
<th>Rank</th>
<th>Commissioners</th>
<th>NHS Trusts</th>
<th>FTs</th>
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<th>Social Enterprises</th>
<th>Others</th>
<th>Total 'Composite' Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>working between statutory and non-statutory providers</td>
<td>social care</td>
<td>social care</td>
<td>social care</td>
<td>social care</td>
<td>social care</td>
<td>social care</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Increased competition</td>
<td>Increased competition</td>
<td>Development of integrated mental health and physical health Trusts</td>
<td>Increased choice</td>
<td>Reduction of block contracts</td>
<td>Improved service quality</td>
<td>Increased choice</td>
<td>Increased role for the non-statutory sector</td>
</tr>
<tr>
<td>8</td>
<td>Integration of health and social care</td>
<td>Improved service quality</td>
<td>Improved partnership working between statutory and non-statutory providers</td>
<td>Improved service quality</td>
<td>Increased choice</td>
<td>Improved partnership working between statutory and non-statutory providers</td>
<td>Sub-contracting of services by NHS Trusts</td>
<td>Sub-contracting of services by NHS Trusts</td>
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### Figure 49: Policy initiatives expected to impact on the mental health market – ranked by type of organisation

<table>
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<tr>
<th>Rank</th>
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<th>Non FT</th>
<th>FTs</th>
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<th>Not for profit</th>
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<th>Others</th>
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</tr>
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<tr>
<td>1</td>
<td>Clinical Commissioning Groups</td>
<td>Payment by Results</td>
<td>QIPP Savings Targets</td>
<td>Clinical Commissioning Groups</td>
<td>Any Qualified Provider</td>
<td>Clinical Commissioning Groups</td>
<td>Clinical Commissioning Groups</td>
<td>Clinical Commissioning Groups</td>
</tr>
<tr>
<td>2</td>
<td>Payment by Results</td>
<td>Any Qualified Provider</td>
<td>Clinical Commissioning Groups</td>
<td>Clinical Commissioning Groups</td>
<td>Any Qualified Provider</td>
<td>Any Qualified Provider</td>
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<td></td>
</tr>
<tr>
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<td>Any Qualified Provider</td>
<td>Payment by Results</td>
<td>National Mental Health Strategy</td>
<td>QIPP Savings Targets</td>
<td>Any Qualified Provider</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Any Qualified Provider</td>
<td>QIPP Savings Targets</td>
<td>Clinical Commissioning Groups</td>
<td>Any Qualified Provider</td>
<td>Clinical Commissioning Groups</td>
<td>Payment by Results</td>
<td>QIPP Savings Targets</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Personal Health Budgets</td>
<td>National Mental Health Strategy</td>
<td>Personal Health Budgets</td>
<td>National Mental Health Strategy</td>
<td>Personal Health Budgets</td>
<td>Personal Health Budgets</td>
<td>National Mental Health Strategy</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>National Mental Health Strategy</td>
<td>Personal Health Budgets</td>
<td>National Mental Health Strategy</td>
<td>Personal Health Budgets</td>
<td>National Mental Health Strategy</td>
<td>QIPP Savings Targets</td>
<td>Personal Health Budgets</td>
<td></td>
</tr>
</tbody>
</table>
Section Five: Discussion

Within the mass of data presented here, some clear trends can be discerned. There is firstly a “core” service market, consisting of acute inpatient and generic community mental health services. This core market could be said to:

- Is managed almost entirely via block contracts. Commissioning of these types of ‘core’ services is often described as relatively “unsophisticated”.
- Established providers of core services are often perceived by non-statutory providers as presenting a series of local monopolies, within which it is hard to gain a market presence.
- In terms of overall investment, whilst spend on mental health services over the past decade has increased, the trend in terms of the proportion of spend on these types of services has been one of decline.

There is secondly a “specialist” market (in reality a series of sub-markets) for services which are either short-term or episodic in nature, or which are based around specialist in-patient beds. This specialist market:

- Consists of many types of services operating with regional or national catchments.
- Are mainly managed via a mix of cost and volume contracts, named patient placements, and contracts arising from competitive tenders. Many of these services have received considerable attention from commissioners, including from regional specialist commissioning teams.
- Present little or no sense of monopolistic practice.
- Have been in long-term growth, in terms of the proportion of overall mental health investment it has received.

It could finally be suggested that there is a third, “emerging”, market for those services which will be promoted by current policy, such as integrated care, acute liaison and community wellbeing services. These are markets for which existing providers may not be considered an automatic choice, although there is as yet little data as to how these services may be provided in future.

It should be noted here that there were two important limitations to this project. The first was the current scope of national datasets on financial investment and activity. The majority of national datasets provide only very limited coverage of mental health investment and activity in the non-statutory sector. If the market is to be better understood in future, it is clear that national level data collection processes will need to relate equally to all providers of NHS-funded services (and, ideally, extend to social care, given the integrated nature of many services.) This will also support opportunities to compare and assess the relative performance and value for money of statutory and non-statutory providers. Without this data, direct comparison is limited.

The second important limitation is the lack of benchmarkable data as to the outcomes of services across sectors – so that, even where we know the market shares of various providers, or types of provider, we do not understand properly the value for money those services are achieving.
The Office of Health Economics (OHE) completed a substantial review of the operation of competition in healthcare earlier this year. Its report recommends:

- That where current providers' performance suggests health care could be improved, competition should be given serious consideration.
- The likely effectiveness of competition can be assessed before it is tried – using the analytical tool developed by the OHE Commission and described in the report.
- "Any qualified provider" arrangements allowing patients, helped by their GPs, to choose where to get their health care are suitable in some cases.
- In other cases, competitive procurement by local NHS commissioning bodies on behalf of the populations they serve will be more appropriate.
- Routine collection and publication of patient outcome measures should continue to be expanded to enable evaluation of the effects of competition.

The OHE review neither firmly endorses or discourages greater use of competition in healthcare provision, but proposes a set of factors which should be considered locality by locality, and service by service. We would strongly support the OHE's recommendation that better outcome data are essential if a safe and effective market is to be developed.

Given these limitations, what, therefore, can we conclude from the range of data presented here?

We would suggest, based on our analysis of the research findings set out earlier in this report, that it is important to understand the following seven fundamental issues about the current market for mental health services.

1. **The current market for mental health services is not single national market – it is a set of overlapping geographical and service sectors**

Beyond the general distinction offered above between core and specialist markets, each of these can be broken down further in considering the impact of any proposed policy initiatives. Any Qualified Provider arrangements may have a rapid effect on the pattern of provision for short-term episodic services, though its effect is potentially more limited with longer-term integrated care.

Patterns of provision varies around the country. For example, over half of the secure care in the Midlands is provided by the independent sector, but only 10% in London. The regions will therefore start from quite different places in their assessment of appropriate next action to take in developing local markets.

2. **There is a substantial historical lag in the way services are delivered: sector- and region-specific ways of doing things tend to continue, whether these remain the best ways of doing things or not.**

This sense of historical lag came across strongly from the qualitative elements of this review. There have been changes in overall patterns of investment, but these suggest the greatest single change has been the growth in the provision of secure care services. Change has come mostly within the specialist services sector, rather than within much of the core mental health market. It is striking that every group of actors, (providers, commissioners and policy

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makers) in the market considered this historical lag to be the single main driver of current service provision and market structures.

3. The influence of commissioning on service development has been stronger where there have been clear national policies, and weaker in sectors where providers have developed not linked to clear commissioning plans – but, it should be stressed, the relative power of commissioners and providers is variable by sector and location.

Notwithstanding the strength of “historical lag”, national policy, in particular the 1999 National Service Framework for Mental Health, has undoubtedly had considerable traction over the past decade. Crisis resolution services, assertive outreach and early intervention in psychosis teams have been widely developed, and investment in general acute beds has (in general) reduced. Latterly, the IAPT initiative has led to significant growth in investment in psychological therapies. The implementation of these initiatives has, in all cases, been strongly performance managed.

Beyond such national initiatives, the perception remains that the commissioning of mental health services has remained, for a variety of reasons, ‘unsophisticated’.

The national mental health strategy, No Health Without Mental Health, is based more upon on values and principles than on targets or structural change. The strategy has left considerable freedom for local commissioners to interpret and apply its principles to their local situation. Amongst responses from the participants in this review, there have been relatively few references made to the strategy. After the publication of the accompanying implementation framework this summer, it will be interesting to see if this changes.

4. People who use services have less influence over their planning and delivery than many would prefer, both at an individual and at a community level.

It was interesting to see this theme emerge from this review process. It is clear that there remains a strong and widespread belief, not only that service user and carer involvement is the right thing to do (as a value-based approach), but also that this involvement could be the lever to bring about changes in the mental health market. The assumption appears to be that service users and carers, with greater influence, would commission patterns of service from patterns of providers in very different ways from the current situation.

Responses to this desire for greater service user and carer involvement could come in both individual and aggregated commissioning. Personal health budgets, with effective advice and support, offer a means of supporting greater individual choice – but only, of course, between such services as exist locally. Aggregated commissioning will still be required to manage the local market. Service user and carer involvement in those decision-making processes, if it is to be meaningful, implies a much more extensive and wide-ranging approach to researching and assessing the views of local communities and service users.

5. The complex, long-term and integrated nature of many core mental health services makes it difficult for local competitive markets to emerge.

Those services in which there is a substantial non-statutory presence are very largely those which can be provided separately from the existing local ‘core’ services, without unduly

complicating individual service users’ care pathways. Relatively short-term psychotherapeutic treatment, for example, does not necessarily need to be integrated with other aspects of mental health care, indeed there may be a stronger argument for its integration with treatment for other long-term conditions.

Within the ‘core’ service, in particular those services dealing with long-term psychotic illness, there are strong service arguments for integration of acute community and inpatient care, long-term community support, and meaningful daytime activity. Does this mean ‘seamless’ services (provided by the same provider) are always best, or could ‘well-seamed’ services work equally well? What seems clear is that a provider offering only part of this spectrum is currently unlikely to gain a successful presence in local services unless, and until, they can achieve clear partnership agreements with other providers serving that community.

6. Some areas of the market for mental health services are concentrated, which has important implications for commissioners.

Some areas of the market for mental health services are subject to higher levels of concentration. This has implications for commissioners in developing market management strategies to secure best value for money and to protect continuity of service, and for policy for sector regulation. This also has important implications for Monitor in its role.

7. There has been a very long process of patterns of provision moving from more intensive and more aggregated forms of care, towards less intensive and more personalised forms of care.

We think it important to consider not only which providers are likely to be affected by policies, but also the more fundamental issue of which services. Clinical policy has for many years encouraged care to be provided in the least intensive setting, consistent with individual need. Some aspects of current market structures provide incentives consistent with that policy. Providers operating across inpatient and community services, and funded under block contracts, have financial incentives aligned with this clinical policy. However, providers who offer only more intensive services, and who are funded according to the volume of their activity, could be said to have differing financial incentives.

Full implementation of an episodic Payment by Results system in mental health appears to be widely sought in the market – although not universally. Given current financial constraints, it also seems likely that there will continue to be significant pressure to reduce expenditure on inpatient services, both within block contracts, and via named patient placements.

Much attention and comment, during the various elements of this review, have focused on the current structural and process changes - with stakeholders trying to anticipate what effect they might have. We have heard, in particular, much discussion of:

- The establishment of CCGs and NHS Commissioning Board, and the potential for greater influence from General Practitioners on commissioning processes.
- The anticipated change from block contracts to care-cluster based episodic contracts.
- Perceived inequalities in the detail of staff terms and conditions, and contracting arrangements across sectors, with consequences for the openness of competition.

In terms of commissioning, it is certainly conceivable that clinicians, in some areas, will take on an active commissioning role to redesign local mental health services. It is equally conceivable that commissioning support arrangements will continue to work in ways which are recognisably similar to what has gone before.
Implications for Recommendations

The purpose of this review was principally to present the facts of the current market – both quantitative data and qualitative market sentiment. Our three objectives were:

1. To provide policymakers with a clear, comprehensive analysis of the current landscape of NHS-funded mental health provision in England.
2. To assess, at a general and segment-specific level, the barriers to effective competition, including provider entry and exit.
3. To indicate possible future trends in market development and their implications for policy development.

Building on those observations, we then must consider our recommendations. In doing so, we acknowledge that there are a diverse range of views amongst policy makers and providers around issues of competition.

A diverse range of views exist on issues of competition. For those who seek a more competitive market for the provision of mental health services, the above findings may suggest excessive dominance by statutory providers in most regions and sectors – and a need for more formal emphasis on mechanisms which could open up the market. For those holding views at the other end of the spectrum, the above data may suggest a concerning level of fragmentation already to be found in some sectors of service.

For others, competition may be viewed as an important lever in improving services as a means to improving outcomes for service users, as opposed to an end in itself. Creating a fairer playing field to allow providers of different types to compete on more equal terms will be necessary to allow this to work, alongside reforming financial incentives to support quality improvement, personalisation and integrated care. A further observation to make is around the high level of concentration in some areas of the market, with some service areas dominated by relatively few providers – be they statutory or non-statutory. There is a need to address questions of how continuity of service can be guaranteed in those areas, in the scenario that a provider exits the market.

At the project review workshop in January 2012, delegates were asked to rank seven possible project recommendations. The results are set out in figure 50 below, with 1 being the most important recommendation(s) for implementation.

Figure 50: Ranking of emerging project recommendations

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase service user and carer input into mental health commissioning</td>
<td>1 (equal)</td>
</tr>
<tr>
<td>Encourage partnership and joint working between NHS and non-statutory providers - through initiatives such as supply chain management</td>
<td>1 (equal)</td>
</tr>
<tr>
<td>Consider opportunities to stream-line and simplify NHS procurement and tendering processes</td>
<td>3</td>
</tr>
<tr>
<td>Development of a training programme and ongoing support for CCGs and CSOs in mental health commissioning</td>
<td>4</td>
</tr>
<tr>
<td>Ensure that access to specialist training and ongoing support in tendering for NHS-funded mental health services is available for the full range of mental health providers</td>
<td>5</td>
</tr>
<tr>
<td>Consider, as an area of policy development, which mental health services should be a priority for developing AQP commissioner implementation</td>
<td>6</td>
</tr>
</tbody>
</table>
The highest overall ranking went to areas of action which could be seen as relatively “neutral” in terms of the effect that they could have on opening up the mental health market to increased competition. Better trained commissioners, working more closely with service users and carers, and pursuing well-integrated care via processes which are no more complex than they need to be – this could be seen to be a “consensus vision”, and which could support a more competitive market, but which need not have this effect.

Prioritise the portability of NHS pensions for staff working in mental health services as a key objective within the moves to enable greater portability of NHS pensions

<table>
<thead>
<tr>
<th>packs</th>
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</thead>
<tbody>
<tr>
<td>Prioritise the portability of NHS pensions for staff working in mental health services as a key objective within the moves to enable greater portability of NHS pensions</td>
</tr>
<tr>
<td>7</td>
</tr>
</tbody>
</table>
Section Six: Conclusion and Recommendations

In this section of the report, concerned with recommendations for action, we build on the information gathered about current policy, the quantitative and qualitative data gathered as part of this work and set out in previous sections.

We highlight eight important and overarching issues for the Department of Health, NHS Commissioning Board and wider health service to address. This review did not set out to find evidence either for or against the idea of increasing competition in the provision of mental health services. The recommendations arising from the review are therefore limited to those actions which would, in our view, strengthen the functioning of the mental health market, irrespective of the extent to which a more competitive structure is actively sought. The recommendations are not listed in priority order - but are grouped for ease of understanding.

Recommendation one: training for commissioners

For the NHS Commissioning Board to ensure that Clinical Commissioning Groups have access to high quality support and training in mental health commissioning.

If service configurations are to be driven by local need and demand, evidence-based practice and service user aspirations, this will require commissioners (and those supporting, or advising, them) with an excellent understanding of all of these. If block contracts are to be turned into new forms of contracts which incentivise and reward good practice, commissioners will need to effectively manage this process.

Those responsible for mental health commissioning should have (or have through commissioning support) to the necessary competencies to do the task effectively. They will need to be in a position to:

1. Assess and understand the types of need in their local community, from depression to dementia, eating disorders to psychotic illnesses.
2. Engage effectively with the various service user and carer communities, to understand their aspirations and concerns.
3. Understand, and be able to act on, the opportunities to improve value for money in the mental health market, whether they arise from unclear care pathways, weak integration between service tiers, or insufficient use of more effective alternatives to traditional models of care.
4. Develop strong relationships with key partners outside the NHS, especially local authorities and the criminal justice sector.
5. Work effectively with acute sector colleagues to improve the integration of mental health and physical health care, both in the community and in acute hospitals.
6. Understand and discharge commissioners’ responsibilities under the Mental Health Act and the Mental Capacity Act.
7. In some cases, take a relatively ‘hands-on’ role in agreeing protocols between providers for the treatment and referral of groups of service users, and approving individual care packages.
8. Apply to mental health services the usual proper commissioning disciplines of service specification, procurement, and contract management

**Recommendation two: Involvement of service users and carers**

*At a local level, Health and Wellbeing Boards and CCGs will want to work closely with service users and carers, together with the wider public, in conducting local Joint Strategic Needs Assessments and developing mental health commissioning plans.*

*Providers will want to ensure that their involvement of service users and carers in the design and delivery of mental health services is as robust as possible.*

*Commissioners and providers of NHS services will want to consider how they engage with new structures, such as local Healthwatch, and how these groups can feed into the development of commissioning and service development plans for mental health services.*

*The NHS Commissioning Board will want to ensure that they also involve service users and carers in the commissioning of specialist mental health services at a national level, and consider how they hold CCGs to account for involving service users and carers in their area.*

All NHS organisations are under a legal duty to involve patients and the public in decisions about their health services\(^8^0\). The Health and Social Care Act 2012 places a duty on CCGs and NHS Commissioning Board to involve the public throughout the commissioning process.

Public involvement, including the involvement of service users and carers, should be seen as a dialogue, with the opportunity for people to be involved in the evaluation of any changes that are implemented. The duties allow scope to determine the best method of involvement in each instance, though the NHS Commissioning Board and CCGs need to be able to demonstrate that it had acted reasonably when exercising this duty. The 2012 Act requires CCGs to set out in their constitutions what arrangements they will make for exercising this duty and the principles that will underpin their approach. The NHS Commissioning Board will also have powers to produce guidance for CCGs on the exercise of the duty, to which CCGs would have to have regard.

There is clear evidence from this report that stakeholders think public involvement, including the involvement of service users and carers, should carry more weight than currently. This includes involvement across the range of commissioning activities - from the development of the Joint Strategic Needs Assessment, through to service specification and procurement choices, and monitoring of providers. Means for best achieving this will vary by location and service. Commissioners, where they are not already doing so, should think beyond traditional engagement approaches with (sometimes, small and self-selected) groups, and ensure that there are routes for a wide range of experience and opinion to influence the planning and delivery of services.

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\(^8^0\) Section 242 of the NHS Act 2006 places a duty on Primary Care Trusts (PCTs), and other NHS organisations, to make arrangements for users, directly or through representatives, to be involved in: the planning the provision of services; the development and consideration of proposals for changes in the way services are provided, and; decisions to be made affecting the operation of services, (affecting the manner in which services are provided, or the range of services available to users).
This therefore implies use of a wide range of social marketing approaches, tailored for the particular interests and concerns of the range of communities, which will typically include specific groups with experience of and concerns about, for example, serious and enduring psychotic illness, dementia, and eating disorders. It should also extend to those groups which tend to have less well-developed interest groups, such as children with mental health problems, or people with experience of substance misuse.

These approaches could include:

- Use of social media to engage with and seek feedback from service users.
- Regular communications between commissioners and the local membership base of both voluntary organisations and Foundation Trusts, and users of non-statutory mental health services, making use of those organisations’ existing communication networks.
- Use of local newspapers and radio.
- Approaches via partner organisations which are not mental health specific, but which are likely to include many members with experience of mental health problems (for example Age UK, or long-term condition organisations working with people with multiple sclerosis, or diabetes, or heart disease).

In addition, consideration should also be given to more established methods of involvement, including periodic formal consultations and focus groups. Those involved in training for new commissioners may also want to consider how the experience of service users and carers can be incorporated into training, including how service users and carers can participate in training events.

**Recommendation three: simplify tendering and procurement processes for smaller contracts**

The NHS Commissioning Board, in tandem with CCGs, will want to consider where opportunities lie to stream-line and simplify NHS procurement and tendering processes, where this can be justified by the size and nature of the service under consideration.

Ranked third by participants in the project workshop, our third recommendation centres on considering opportunities to stream-line and simplify NHS procurement and tendering processes. Participants in the Delphi exercise (results from which were outlined in section four of this report) when asked about barriers to market entry, reported current complexity of tendering processes was identified as particularly challenging for smaller providers who often do not have the internal resources and infrastructure to respond to tenders.

For example, the current standard contract mechanisms work relatively well for larger contracts – and there was considerable support for the principle of national standard contract mechanisms amongst the participants the researchers spoke to – but they are widely regarded as unwieldy and burdensome for small aggregate contracts. There is currently little flexibility for commissioners to adjust contracting and procurement mechanisms to allow for the scale or nature of the service under consideration.

This could be addressed via the development of an additional suite of simpler standard contracts, designed for small contract values. Alternatively, this issue could be addressed via
delegated freedoms to commissioners to develop local and simpler arrangements under agreed contract values.

**Recommendation four: develop a phased timetable for the supported roll-out of Any Qualified Provider in mental health services**

*The NHS Commissioning Board and Department of Health, working with stakeholders within the health service, should develop a phased timetable for the supported roll-out of Any Qualified Provider in mental health services.*

In view of the different situations pertaining in different sectors and markets, it is essential that this timetable is published alongside clear criteria which should be used to assess the suitability of a service for the Any Qualified Provider approach in a given locality.

The Department of Health has published a list of national priority services to which Any Qualified Provider could be applied during 2012/13 – of which Primary Care Psychological Therapies (adults) is currently the only mental health service. Any Qualified Provider is seen by large sections of the market as a key opportunity to equalise access to the market and promote choice.

Substance misuse services, where they are provided as part of an NHS service, may perhaps be the best national candidate for a next-phase supported roll-out, given their relatively distinct nature and pattern of provision – but other services may be more relevant in specific locations. Local commissioners should have the flexibility to apply this approach to their local situation, drawing on the national criteria, including those proposed by the OHE.

**Recommendation five: partnerships and integration**

*The NHS Commissioning Board, and CCGs, should encourage further partnership working and joint ventures between statutory NHS and non-statutory providers – through initiatives such as supply chain management.*

The joint top ranked recommendation from participants at the project review workshop was to encourage greater partnership and joint working between NHS and non-statutory providers through initiatives such as supply chain management.

By supply chain management, we mean managed processes for several providers to contribute to an integrated system of care delivery. This could include primary care providers, statutory secondary care providers, plus for-profit and not-for-profit providers. It could also increasingly include partnerships with providers of acute and general physical healthcare, to ensure best practice in the management of co-morbid long-term conditions. For people whose needs are relatively long-term and complex, increased choice and plurality of providers without good partnership working risks fragmentation of care across care pathways.

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Whilst there is much agreement in principle with this idea, the practicalities locally are not straightforward. Issues for consideration include:

- Defining partners’ roles in care pathways in sufficient detail as to ensure gaps and overlaps are minimised – but not so as to stifle sensible day-to-day clinical practice and clinical discretion.
- Clarity as to where clinical responsibility actually sits at each stage of integrated processes.
- Aligning of incentives. For example, if a particular provider has a larger role in the “upstream” elements of a care pathway, their clinical success could reduce demand for “downstream” services (e.g. integrated community management of long-term conditions reducing demand for inpatient care.) How do mental health, acute and community providers, and commissioners share the costs and benefits of this change?
- Governance structures, and the respective decision-making influence of each of the partners.
- The need (or otherwise) to create special purpose organisational vehicles to take forward partnerships and integrated services.

National support, perhaps most appropriately developed by the NHS Commissioning Board, on legal frameworks and good practice would help to support initiatives in this area. This could include the creation of template agreements, not necessarily as nationally mandatory forms, but as a guide to shortening and simplifying local discussions.

**Recommendation six: continuity of service**

**CCGs will want to consider where areas of mental health provision are concentrated, and how continuity of provision can be best ensured in the event of a provider exiting the market. The Department and Monitor will want to consider the implications of market concentration for their future work.**

Some areas of the market for mental health services are highly concentrated, which has important implications for commissioners. This is the case for the provision of ‘core’ services for serious and enduring mental illness, including acute inpatient beds and ‘core’ community teams, mainly provided by statutory providers. The provision of some specialist services, most notably the market for medium secure and eating disorder services, are also concentrated. This has implications for commissioners in developing market management strategies to secure best value for money and to protect continuity of service, and for policy for sector regulation.

**Recommendation seven: consistent data-gathering**

**Ensure that the gathering of all activity and performance data is consistent across all types of provider, whilst ensuring overall burden of data collection is addressed.**

As sections of this report illustrates, there are some sections of the market where our understanding of activity is weak. A functioning market requires data about services to be as consistent and as transparent as possible. Ensuring data collections collate information relating to activity in the non-statutory section would be, without doubt, extremely helpful in developing our understanding about how the market is operating. Those collections include,
but are not limited to, Hospital Episode Statistics, the National Mental Health Minimum Dataset, and the finance mapping and programme budgeting.

Simultaneously, work is needed to address the burden of data collection on statutory providers. Some data collections may need to be reduced in scope to make the burden manageable. We must be mindful not to extend this burden onto providers currently not subject to these data collection requirements. Improving the consistent measurement of outcomes must be a priority. By “all types of provider” we do not limit the requirement of consistency to providers of NHS services. The extent of integration between health and social care in the mental health market is such that there would be considerable value in ensuring aligned data definitions and data collections across the health and social care sectors.

**Recommendation eight: outcome data**

_The Department of Health and NHS Commissioning Board should work to develop consistently used measures of outcomes, including for recovery, for use in mental health services with the support of the sector._

_Ensure that national datasets include as much outcome-related data as possible, whilst remaining mindful not to increase overall burden of data collection on providers._

For many mental health services, we may know who is commissioning them, who is providing them, and how much they cost, but we often have little data as to the outcomes they achieve for service users. Where outcomes data is available, the variety of indicators used do not allow for effective benchmarking and comparison.

The notion of measuring outcome in mental health is of course not wholly straightforward, but nor does it escape proper clinical assessment and understanding. Further work must be done to establish a coherent set of outcomes indicators, to be collected across mental health services, is needed. Work on a mental health ‘dashboard’, currently underway by the Department of Health in support of the mental health strategy’s implementation framework is an important opportunity to do so.

National work to mandate such data capture, regularly reviewed and improved, would be a very significant means of improving the transparency (and, in due course, the functioning) of the mental health market.

**Conclusion**

This review set out to deliver a clear, comprehensive analysis of the current landscape of NHS-funded mental health provision in England, to assess barriers to effective competition and to indicate possible future trends.

Understanding how the market in mental health works will be critical both for the development of future government policy, and the implementation of existing policy in the area of competition and ensuring choice for service users. Ensuring Clinical Commissioning Groups have a clear understanding of the way in which the market currently operates in the mental health sector will be central to developing effective commissioning arrangements.
The conclusions and recommendations set out here, based on both quantitative and qualitative analysis, including in depth work with commissioners and providers, help form a basis for moving forward within the current policy context.
Bibliography

Publications


Mental Health Strategies (2012), *2011/12 National Survey of Investment in Adult Mental Health Services*


**Websites**


**Datasets**

Mental Health Strategies (unpublished), *Dataset: Adult and Older People’s National Mental Health Finance Mapping Exercise 2002/03 - 2010/11.*

Department of Health (2009/10) *Programme Budgeting Reference Cost Based Primary Care Trust Benchmarking Workbook*. Available at: <http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH_075743#_1>
Appendix A: Participants in the Delphi Exercise

Stage One Participants

- CEO
- Chief Medical Officer
- Medical Director
- Chief Operating Officer
- Head of MH/LD/SM Commissioning
- PbR Implementation Lead
- Mental Health and Learning Disability Lead
- Chief Operating Officer
- Head of Mental Health Commissioning (Health and Social Care)
- Associate Director of Operations
- Deputy Director of Operations
- Acting Assistant Director (Mental Health)
- Director for Mental Health
- Commissioning Manager – Mental Health
- CEO
- Interim Associate Director - Strategic Planning and Information
- Senior Advisor - External Affairs
- Managing Director Mental Health Services
- Associate Medical Director
- Director of Planning & Performance
- Mental Health Commissioning Manager
- Head of Business Development
- Programme Manager
- Chief Executive
- GP
- Chief Executive
- Director of Business Development
- Director of Provider Policy - Clinical Services
- Director of Service User Involvement – Together Working for WellBeing / Service User
- Associate Director Strategy and Planning
- Associate Director of Strategy
- Senior Commissioner - Mental Health
- GP & Mental Health Lead for the Clinical Commissioning Group
- Head of Business Development
- PbR Project Lead - Mental Health
- Chairperson
- Director of Mental Health and Disability
- Chief Executive
- Head of Planning and Business Development
- Director
- Consultant Psychiatrist
- Joint Chair
- Company Secretary
- Consultant Psychiatrist
- Deputy Director of Children’s Health Services
- Assistant Director Learning Disability and Mental Health
- Associate Director Joint Commissioning
- Chair
- Head of Mental Health and Learning Disability Commissioning
- CEO
- Associate Director
- Managing Director
- Commissioning Project Lead mental Health
- Director of Business Development
- Managing Director
- Head of Mental Health/ Learning Disability /SM
- Coordinator National Involvement Partnership
- Head of Joint and Integrated Commissioning
- Executive Director of Resources
- GP Principal, Joint Mental Health Lead for CCG
- Director of Service Development and Performance
- Commissioning Lead - Children, CAMHS and Maternity
• Children's Commissioner
• Assistant Director of Commissioning
• Head of CAMHs commissioning
• Contract Manager
• Head of Commercial Development
• Director of Strategy and Business Development
• Director of Service Development
• Strategy and New Business Manager

• Director of Development and Planning
• Executive Director of Operations
• Home Manager
• Director of Clinical Outsourcing
• Programme Manager-Mental Health
• Joint Commissioning Manager Mental Health

Stage Two Participants

• Chief Executive
• Chief Executive
• Medical Director
• Consultant Psychiatrist and Clinical Lead
• Head of Integrated Commissioning
• CEO
• head of mental health commissioning
• Business Manager
• Associate Director of Strategy and Planning
• AMD, MH, NHSL
• Chief Operating Officer
• Foundation Trust Project Director
• Deputy Director, Service User Involvement
• Assistant Director of Procurement
• Chief Executive
• GP and Mental Health lead
• Associate Director
• Assistant Director Mental Health & Learning Disability
• Not known
• Not known
• Managing Director Mental Health Services
• Chief Operating Officer
• Director
• Director of Business Development
• Corporate Strategy Development Manager
• Director of Strategy and Business Development
• Acting Assistant Director
• Joint Commissioner MH
• Senior Commissioner

• Contract Manager
• Programme Manager
• Assistant Director Strategic Planning and Information
• Mental Health / Learning Disability Lead
• CEO
• Director of Business Development
• Head of Mental Health Commissioning
• GP/locality chair
• Commissioning Manager
• Head of Planning and Business Development
• Executive Director of Resources
• Director of Service Development and Performance
• Director
• GP MH Lead
• CEO
• Not known
• Head of Business Intelligence and Commercial Development
• Director of Development and Planning
• Policy lead : children's mental health
• Consultant Clinical Psychologist
• DoH
• Head of Business Development
• CEO & Medical Director
• Regional Project Manager South West
• Director of Operations, Mental Health
• Team Leader
• ETE Worker
• Centre Director
• CEO
• Associate Director of Business Development
• Director
• Centre Manager
• CEO
• Manager
• Freelancer & User

Stage Three Participants

• CEO & Medical Director
• GP/ Commissioner
• Assistant Director of Procurement
• Head of Mental Health Commissioning (Health and Social Care)
• Project Manager PbR
• Associate Director
• Consultant Psychiatrist
• Co-ordinator
• Director of Resources
• Business Manager
• Associate Director of Strategy and Planning
• Freelancer
• Director of Business Development
• Corporate Strategy Development Manager
• Chief Executive
• Director
• MD Mental Health Services
• Director of Operations
• Chief Executive
• Chief Operating Officer
• Joint Commissioner MH

• Project Manager PbR and Outcomes
• Co-ordinator
• Business Manager
• Mental Health Development Worker
• Manager
• National Programme Director

• SEO
• Acting Assistant Director
• Head of Joint and Integrated Commissioning
• Deputy Director, Service User Involvement
• Director of Strategy and Business Development
• COO
• Head of MH Commissioning
• Chairperson
• Head of Business Development
• Policy Lead
• Managing Director
• Head of Service Improvement
• Area Manager - Mental Health
• Associate director
• Director
• Consultant Clinical Psychologist
• Children's Commissioner
• Senior Commissioner (Mental Health)
• Director of Development and Planning
Appendix B: Technical Note – The Herfindahl Index

The Herfindahl Index is a commonly accepted measure of market concentration. It is calculated by squaring the market share of each firm competing in the market and summing the resulting numbers. It can range from 0 to 1.0, moving from a large number of very small firms to a single monopolistic producer. Increases in the Herfindahl index generally indicate a decrease in competition and an increase of market power, and decreases indicate the opposite.

Within the report and supporting appendix the Herfindahl index is calculated for various segments of the market at a regional (SHA level). The primary data source used is the national finance mapping exercise – undertaken by Mental Health Strategies on behalf of the Department of Health. Finance mapping data includes information on non-statutory providers. Other key national data sources such as Hospital Episode Statistics (HES) do not include non-statutory providers.

Finance mapping data does not, however, disaggregate between different non-statutory providers, so it is not possible to calculate the exact Herfindahl Index in some instances. As such, we have presented the minimum (blue bar) and maximum (error bar) index in each case. The true value of the Herfindahl Index lies between these two values.

If there is only a single one non-statutory provider providing services within a given geography/domain the Herfindahl Index will be the upper value. If many non-statutory providers provide services with the geography/domain pairing, the Herfindahl Index will tend towards the lower value.

A key issue for consideration when considering the Herfindahl index, particularly in the context of mental health services, is the geography of a market. Providers within a geographic region (SHA) may not in reality ‘compete’. Because of this bigger SHAs with a number of NHS Trusts (e.g. London and the North West) may look more competitive than smaller SHAs with fewer NHS Trusts (e.g. the North East). This is despite the fact that these organisations may not actually compete on core services that are commissioned under block contracts.
## Appendix C: Proposals to address current barriers to entry in the mental health market – ranked by type of organisation- full responses

<table>
<thead>
<tr>
<th>Rank</th>
<th>Commissioners</th>
<th>NHS Trusts</th>
<th>FTs</th>
<th>For profit</th>
<th>Not for profit</th>
<th>Social Enterprises</th>
<th>Others</th>
<th>Total 'Composite' Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Movement away from block contracts</td>
<td>Development of a currency and tariff for mental health (Payment by Results)</td>
<td>Development of a currency and tariff for mental health (Payment by Results)</td>
<td>Movement away from block contracts</td>
<td>Tendering of a wider range of services</td>
<td>Support for the voluntary sector and social enterprises to enter the mental health market and tender for services</td>
<td>Outcome focussed service specifications</td>
<td>Movement away from block contracts</td>
</tr>
<tr>
<td>2</td>
<td>Stream-lined tendering processes</td>
<td>Movement away from block contracts</td>
<td>Address NHS pensions – exploring options for their portability</td>
<td>Development of a currency and tariff for mental health (Payment by Results)</td>
<td>Stream-lined tendering processes</td>
<td>Stream-lined tendering processes</td>
<td>Improved integration and partnership working</td>
<td>Development of a currency and tariff for mental health (Payment by Results)</td>
</tr>
<tr>
<td>3</td>
<td>Development and roll-out of the Any Qualified Provider (AQP) Policy</td>
<td>Training and support for mental health commissioners (including new CCGs)</td>
<td>Stream-lined tendering processes</td>
<td>Development and roll-out of the Any Qualified Provider (AQP) Policy</td>
<td>Outcome focussed service specifications</td>
<td>Tendering of a wider range of services</td>
<td>Development of a currency and tariff for mental health (Payment by Results)</td>
<td>Outcome focussed service specifications</td>
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<td>4</td>
<td>Development of a currency and tariff for mental health (Payment</td>
<td>Stream-lined tendering processes</td>
<td>Outcome focussed service specifications</td>
<td>Allow NHS FTs to fail and develop a failure regime</td>
<td>Improved integration and partnership working</td>
<td>Enhanced role for the voluntary sector and</td>
<td>Increased role / voice for service users</td>
<td>Stream-lined tendering processes</td>
</tr>
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<td>Rank</td>
<td>Commissioners</td>
<td>NHS Trusts</td>
<td>FTs</td>
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<td>Not for profit</td>
<td>Social Enterprises</td>
<td>Others</td>
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<tr>
<td>5</td>
<td>Tendering of a wider range of services</td>
<td>Development and roll-out of the Any Qualified Provider (AQP) Policy</td>
<td>Agreed and specified quality metrics for mental health</td>
<td>Improved integration and partnership working</td>
<td>Increased role / voice for service users</td>
<td>Training and support for mental health commissioners (including new CCGs)</td>
<td>Support for the voluntary sector &amp; social enterprises to enter the mental health market and tender for services</td>
<td>Tendering of a wider range of services</td>
</tr>
<tr>
<td>6</td>
<td>Enhanced role for the voluntary sector and social enterprises</td>
<td>Improved integration and partnership working</td>
<td>Movement away from block contracts</td>
<td>Tendering of a wider range of services</td>
<td>Enhanced role for the voluntary sector and social enterprises</td>
<td>Separation of the contracting monitoring functions in MH</td>
<td>Movement away from block contracts</td>
<td>Development and roll-out of the Any Qualified Provider (AQP) Policy</td>
</tr>
<tr>
<td>7</td>
<td>Support for the voluntary sector and social enterprises to enter the mental health market and tender for services</td>
<td>Increased role / voice for service users</td>
<td>Training and support for mental health commissioners (including new CCGs)</td>
<td>Increased role / voice for service users</td>
<td>Support for the voluntary sector and social enterprises to enter the mental health market and tender for services</td>
<td>Increased role / voice for service users</td>
<td>Development and roll-out of the Any Qualified Provider (AQP) Policy</td>
<td>Improved integration and partnership working</td>
</tr>
<tr>
<td>8</td>
<td>Outcome focussed service specifications</td>
<td>Support for the voluntary sector and</td>
<td>Development and roll-out of the Any</td>
<td>Outcome focussed service</td>
<td>Movement away from block</td>
<td>Movement away from block</td>
<td>Training and support for mental health</td>
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<td>Address NHS pensions - exploring options for their portability</td>
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<td>Tendering of a wider range of services</td>
<td>Training and support for mental health commissioners (including new CCGs)</td>
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### Appendix D: Factors that determine the range of services offered by providers – ranked by type of organisation

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Appendix E: Factors that should determine the range of services offered by providers – ranked by type of organisation

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Appendix F: Expected changes in the structure of the mental health market in the next 5 Years - ranked by type of organisation

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<td>Consolidation / merger of NHS trusts</td>
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<td>Move from inpatient to community care</td>
<td>Move from inpatient to community care</td>
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<td>Increased role for the non-statutory sector</td>
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<td>Development of integrated mental health and physical health trusts</td>
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<td>Increased choice</td>
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<td>For profit</td>
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<td>Social Enterprises</td>
<td>Others</td>
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<td>Increased choice</td>
<td>Reduction of block contracts</td>
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