READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE AND HEALTH SERVICES

TO:	**ADULT SOCIAL CARE, CHILDREN'S SERVICES AND EDUCATION COMMITTEE**		
DATE:	**29 JUNE 2015**	**AGENDA ITEM:**	**14**
TITLE:	**REVIEW OF THE INTEGRATION OF ADULT MENTAL HEALTH SERVICES WITHIN READING**		
LEAD COUNCILLOR:	**COUNCILLOR EDEN / COUNCILLOR HOSKIN**	**PORTFOLIO:**	**ADULT SOCIAL CARE / HEALTH**
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1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report sets out the results of a review of the secondment of local authority Adults Mental Health staff into the Berkshire Healthcare NHS Foundation Trust, based on the findings of a review into resulting outcomes for service users/carers and budget impacts. The review remit did not cover Child and Adolescent Mental Health Services.

1.2 On 18 February 2013 Cabinet approved a proposal to promote Mental Health and Social Care integration which was based on 'structural integration'. This report also recommended that work commenced on a joint Adults Mental Health commissioning strategy. During the last two years the circumstances within which the service operates have changed, with new responsibilities being introduced under the Care Act, redefined responsibilities for 'Deprivation of Liberty' legislation, significant ongoing financial challenges and new expectations of integrated service delivery being articulated through the Better Care Fund agenda. It is now opportune to develop the joint Adults Mental Health Strategy which will align with other parts of the local authority and NHS services. The need to work together on living well, healthy communities and preventative services has emerged more clearly recently.

1.3 Local partners are committed to delivering integrated Mental Health services, but within a changed environment, now wish to progress a functional integration with an emphasis on agreeing shared outcomes and commencing joint commissioning arrangements. It is therefore recommended joint commissioning approaches are developed to determine what the community needs and subsequently determine a structure to meet this. Current secondment arrangements should cease whilst this work takes place in order to provide clarity during the process.

2. RECOMMENDED ACTION

2.1 That ACE Committee note:

(a) The governance arrangements proposed for a multi-stakeholder Adults Mental Health Strategy Group to include people who use services and their carers;
(b) The (co-production) development of an Adults Mental Health joint commissioning strategy to establish the priorities for improving Mental Health services across Health, Social Care and wider support provision in Reading;
(c) Clearly set out the Social Care vision, standards for which people who use services can hold the service providers accountable; and
(d) The development of a Section 75 (NHS Act 2006) agreement between RBC and BHFT to consider pooled resources for the future delivery of Adults Mental Health Services.

2.2 That ACE Committee agree to end the current secondment arrangements of the RBC Mental Health staff to Berkshire Healthcare Foundation Trust pending the outcome of the joint strategic commissioning work;

3. POLICY AND NATIONAL CONTEXT

3.1 The integration of Health and Social Care for users of Mental Health services is high on the national policy agenda and has been encouraged through vehicles such as pooled budgets, jointly appointed workers and co-located teams. A new national taskforce is in place to develop a "whole life" strategy for Mental Health due for publication towards the end of 2015.

3.2 In 'Integrated Care and Support: Our Shared Commitment' (May 2013), the National Collaborative for Integrated Care and Support give a definition of "good" integrated care and support, co-developed by National Voices, and aligned with Making it Real. The definition prioritises putting the individual at the centre of the arrangement of services.

National Voices definition of what "good" looks like –
"I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me."

3.3 Positive examples of integration exist, most notably in Torbay, where improved outcomes are evidenced from integrated mainstream NHS and Social Care services and in Oxfordshire, where an innovative cross-economy partnership shares responsibility for Mental Health services, delivery is more seamless, and user outcomes are the focus.

3.4 The projects within Better Care Fund plans demonstrate the importance of cross organisational 'sign-up' to clearly defined responsibilities and outcomes in order to make integration programmes successful. Without this, partnerships can unravel quite quickly. Strong partnerships are essential to the achievement of a way of working in Mental Health that stresses the centrality of the service user, making it simpler for the user to navigate the complexities of the system/s that they are in. Emphasis is moving towards "co-production" approaches where all community stakeholders are involved in service and community development.

3.5 Properly integrated services join up the pathways for support and should bring together much more than just the Health and Social Care secondary services. Successful projects demonstrate that integration should consider the role that service users and carers can play in determining outcomes for all areas (acute, primary and secondary care as well as wider community and voluntary sector support), and how joint commissioning arrangements across the local authority and CCGs can bring a focus on mutually beneficial rather than conflicting outcomes.

4. THE READING CONTEXT

Background

4.1 In Reading, BHFT and RBC have had arrangements in place to promote integrated Mental Health support for some time, particularly joint appointments and co-located teams within Mental Health and Community Services. In other areas, local authorities have opted to transfer Social Care staff into the employment of the NHS, and many Mental Health NHS Trusts and Foundation Trusts now have significant Social Care delivery responsibilities.

4.2 A report was presented to Cabinet in February 2013 proposing that RBC, in partnership with the two Reading CCGs:

- undertake a joint commissioning exercise to address quality concerns with Mental Health services;
- establish a contractual arrangement against which to monitor local delivery through the Health and Wellbeing Board; and
- merge its own Mental Health service into that operated by Berkshire Healthcare NHS Foundation Trust (BHFT) delivering a 'seamless service' with revenue savings to both organisations.

4.3 This demonstrates the local appetite to ensure good outcomes for the users of mental health services users. Following the Cabinet approval, 40 Council staff working within RBC Adult Mental Health Services were seconded to BHFT with the aim of improving outcomes for service users and carers and delivering savings/efficiencies. Three staff who supported older people with mental ill health (mainly Dementia type conditions) were also seconded to BHFT. No Section 75 agreement or Memorandum of Understanding was thought to be necessary at the beginning of the secondment arrangement within Reading.

4.4 By the end of September 2015, the secondment will have been in place for two years. At the outset, legal advice was that this secondment should not continue beyond two years given the implications of a lengthier secondment acquiring the status of 'custom and practice' (see Legal Implications below).

Local review

4.5 A review of the current Mental Health social care staff and service arrangement in Reading has been underway since September 2014, reporting into the Reading Integration Board. This review has been conducted in the context of developments in Mental Health provision since the initial decision to second RBC staff to the Trust, including the new Mental Health Code of Practice crisis concordat/suicide prevention obligations and the increased emphasis on prevention and the development of community resilience articulated in the Care Act.

4.6 The review was established to consider:

- Have there been benefits to service users and their carers?
- Has the arrangement delivered cost or efficiency benefits?
- Could integration be improved?
- Should the arrangement be continued, and if so through what mechanism (e.g. extension of secondment, TUPE, full integration)?

4.7 The local review has captured the views of service users and carers, stakeholders from across the Council, CCGs, and BHFT – including Social Care staff and other stakeholders - Healthwatch, Reading Voluntary Action and other Mental Health service providers within the Borough. A "Have Your Say" Mental Health service user and carer conference was held in Reading in December 2014. Further meetings with service user and carer groups have been held including at a conference arranged by BHFT to develop the support and understanding of faith and BME groups. (The recommendations from the Have Your Say conference can be seen in Appendix One). The recommendations include an initial list of priorities for service users and a **Mental Health Charter** for working in partnership. This has been a positive step forward in focusing our efforts on what "good looks like" from the service users / patients perspective.

4.8 One to one interviews were held with all Council seconded staff who wished to express a view and with other staff at larger meetings. Discussions were also held with the Union representatives from Unison and Unite. An online staff survey of Trust and social care staff was conducted. The results are in Appendix Two.

5. REVIEW FINDINGS

Performance

5.1 Personalised support options (the availability of support tailored to meet needs through the use of Personal Budgets, including Direct Payments) and a focus on the recovery model have been at the fore of recent developments in Social Care. However, the review has identified that the numbers of ongoing Direct Payments for Mental Health service users have decreased over the period of the secondment arrangement in Reading. Over the last four years the trend for more expensive residential and nursing places for all 18+ adult Mental Health service users has been increasing. This scrutiny of Mental Health services as a result of the secondment and its subsequent review has enabled Health and Social Care to start to understand the key areas of development going forward. Appendix Three details the decline in Direct Payments and other areas of Mental Health Social Care performance over the last four years.

5.2 Personalisation via Direct Payments can be a cost effective way to meet and improve outcomes for people with very complex and specific needs. A commitment to deliver more personalised care and to encourage Social Enterprises and more creative support opportunities should be part of a way forward which would include targets and performance expectations surrounding these areas. Service users and carers have not reported that they have noted any difference in the service since the secondment of staff as this in itself did not change any practices.

5.3 A new management structure is in place in BHFT services, with the joint appointment of a joint service manager and a locality manager who are changing the way that services are provided with a focus on service user and carer outcomes and the recovery model. This is making a positive impact on service provision especially with regard to joining up pathways and working with the voluntary sector. Strategically

BHFT has been developing partnerships and posts that promote prevention and recovery which is what service users say that they would like to see – communities where stigma is decreased and support can be found outside of a purely medical model. The managers are to be commended in that their efforts have been more instrumental in bringing about change than a structural model has to date.

Commissioning budgets

Although pooling budgets across Health and Social Care may offer some opportunities for efficiency gains, including economies of scale, targets and outcomes have not yet been mapped. Currently the price of RBC commissioned placements is comparatively high, and the level of Direct Payment take up is very low indeed. The risk of transferring the function to BHFT is that the benefits of the current frameworks and negotiated or tendered contracts might not be realised. It is likely that new contracts would have to be negotiated and these may be on less favourable terms. With the drive for more efficiencies within the Social Care budgets it would make sense to ensure that these are economically viable before considering any transfer. Further work is being undertaken to understand and address this.

Care Act Implications

5.4 From April 2015, eligibility for Social Care services is based on national criteria set out in the Care Act. However local authorities have a duty to offer Social Care assessments on the appearance of need and an extended duty to offer carer assessments, including to carers supporting someone who may not be eligible for Social Care services themselves. Whether or not someone who has a Social Care assessment is found to be eligible for Social Care services, they are entitled to receive information and advice to prevent any care or support needs from increasing. In practice, this means an obligation to signpost/direct a wide range of people to other sources of support. Work is required to identify the way forward to ensure that the requirements within the Care Act and the eligibility for mental health services within NHS eligibility works together. The Local Authority emphasis on prevention and early intervention can only support and strengthen the way we deliver positive outcomes for individuals. With the new Care Act duties coming into effect so recently, the impact in terms of increased workload can still only be estimated. A risk to the Council or to the Trust is that either may incur a significant amount of additional work and responsibility for carer assessment and provision or for promoting wellbeing under the remit of the Care Act. This pressure was not envisaged at the time of the original secondment and therefore not planned for and must be addressed in determining future arrangements.

Another area of development required is to ensure that the Approved Mental Health Practitioner (AMHPs) service for Reading is reviewed, to ensure that we can continue to meet our statutory obligations and have a sustainable service. It is recommended that a review of the current AMHPs' rota is undertaken.

A Mental Health Strategy

5.5 In order to develop a shared understanding of priorities, responsibilities and accountabilities, a strategic stakeholder group was formed. This was in response to recommendations made by the Berkshire West Partnership Board and arising from the "Have your Say" Mental Health user and carer conference. The proposal is that this group should oversee the development of a vision and joint commissioning strategy for Mental Health in Reading, dovetailing with other relevant commissioning strategies developed locally or Berkshire wide. It is currently proposed that the Mental Health Strategy Board will report into the Reading Integration Board and the Berkshire Health Foundation Trust Executive Board. However there may be

opportunities to use the momentum of this group to contribute to a West Berkshire strategy which is currently being discussed. It could also establish task and finish groups to work on priorities identified by stakeholders. The proposed terms of reference of the group are at Appendix Four.

5.6 The review has put a focus on mental health within Reading and has highlighted that there is a need to work more closely with service users, carers and the voluntary sector to determine a strategy and clear pathways for the future. The way to do this will be working in a collaborative, partnership approach valuing the opinions of all contributors to determine a vision and organisation of funding for Mental Health services for the future. This will be based on the principles of the Charter and the Mental Health strategy priorities.

Social Care Staff

5.7 Reading Mental Health Social Workers have expressed concerns that their role could be compromised under the current arrangements. Social work training follows a social model of disability, which considers the social and environmental barriers that prevent a person achieving their full potential, maximising their independence, coping skills and recovery. This approach is often cited in opposition to the medical model of Mental Health. More specifically, Social Care staff are concerned that the value they add could be overlooked if there is a necessity to deliver NHS targets under the 'payment by results' (PBR) mechanism**.** Health staff may also express similar worries in being diverted from their focus**.** Social work staff within a Trust may be 'diverted' to meet NHS targets. (Conversely within a council employed arrangement the social workers could potentially be diverted from Mental Health work to meet additional assessment demand from the Care Act – as described above).

5.8 It must be noted that BHFT has and continues to offer great opportunities for Social Care staff in terms of continual professional development and specialised mental health training.

6. OPTIONS PROPOSED

6.1 Offering integrated Health and Social Care – and wider - support for Mental Health service users remains a national and a local priority. There has been a focus recently within the Reading context on achieving closer structural integration. Going forward, however, there needs to be greater emphasis on improving outcomes and a clear focus on benefits realisation. With the right partnerships, rather than structural changes in place, Mental Health integration in Reading still has the potential to deliver:

- Service improvement
- IT efficiencies (clinical and non-clinical)
- Back office efficiencies
- Improved value for money on commissioned activity

6.2 Neither legal advice nor staff feedback favour protracted secondment arrangements for RBC staff. These arrangements in themselves do not appear to have delivered service improvement or efficiency gains to date, and may indeed have served to blur lines of responsibility. There is no evidence as yet that progressing to a formal TUPE transfer of staff from the local authority into BHFT alone would confer benefits at this stage. Furthermore research such as that by the Audit Commission and the Kings Fund on Service Transformation: Lessons from Mental Health, has shown that this can be a costly distraction in terms of time and money spent establishing the pensions and

HR systems attached. The recommendation is therefore that the secondment arrangement be suspended pending the development of a joint commissioning strategy which articulates an outcomes focused way forward informed by the views of all stakeholders.

6.3 A robust partnership arrangement such as the agreement within Oxfordshire might provide a much more integrated solution in joining up pathways and access to holistic support. BHFT CMHT has made much headway in its partnerships with community groups and resources such as education and employment providers in order to address aspirations of employment, physical activity and education for service users.

6.4 Pooling resources for mental health services in Reading under a Section 75 agreement could be a mechanism to establish a whole system which reflects shared accountabilities, standards, duties governance and priorities; and which is responsive to and developed in the light of patient and carer experiences. Key financial and performance measures must be included in a Section 75 agreement. A joint information system is not available at present but agreement on streamlining performance indicators and how these are collected is being developed and could be included in the Section 75 agreement. The Council, CCGs and BHFT have further work to do in determining how these will be measured and ensuring that the NHS targets do not mean that Social Care targets are compromised – for example a Social Care worker focusing on delivering smoking cessation sessions would have less time to spend on developing a Social Care support plan with someone to include Direct Payment options.

6.5 A Section 75 agreement would also provide an opportunity to clarify expectations and responsibilities so as to recognise the distinct values that all disciplines bring.

6.6 With this in mind it is proposed that the current secondment arrangement ceases to enable work to be undertaken to ensure the "right" service offer is established. At which point, it may be logical for Reading Borough Council and BHFT to enter into a robust integrated relationship through a secondment arrangement, subject to Reading Borough Council committee processes and BHFT Executive Board,

7. CONTRIBUTION TO STRATEGIC AIMS

7.1 The proposals outlined in this report are consistent with the Council's 3-5 Year Plan for Adult Social Care approved by Policy Committee in September 2014. The proposals will also contribute to meeting the following priorities set out in the Council's Corporate Plan 2015-18:

- Ensuring that all vulnerable residents are protected and cared for;
- Enabling people to live independently and also providing support when needed to families;
- Ensuring care and support provision is effective and of good quality;
- Building capable communities for local people to become more involved and help themselves;
- Changing the Council's service offer to ensure core services are delivered within a reduced budget so that the Council is financially sustainable and can continue to deliver services across the town; and
- Co-locating services with partners to have better joined up services and community hubs so that residents have better access to services.

8. COMMUNITY INVOLVEMENT

8.1 The phased approach to Mental Health integration in Reading has meant that so far the focus has been on structural change. The well-established service continued on a business as usual basis in terms of front line delivery, and service users experienced no change to service provision. When interviewed for the recent review, service users and carers did not report any knowledge of the secondment arrangements.

8.2 Whilst it is reassuring that service users and carers report no negative impacts, the perception that 'nothing has changed' may in itself illustrate a failing of the current arrangement. As personalisation has become better embedded in Social Care services for other client groups Mental Health service users are increasingly falling behind and failing to enjoy the benefits of personalisation. This does not fit with the "parity of esteem" aims for Mental Health both locally and nationally.

8.3 Furthermore, discussions with BHFT and RBC managers for Older Peoples Services have indicated that Mental Health pathways and support for older people should be included within plans for a whole system Mental Health model and within mainstream Adult Social Care plans as these are not perceived as equal.

8.4 The development of a strategy with strong user and carer representation will provide a means to keep the service user and carer perspective at the heart of future development of mental health services in Reading. The focus on developing a joint commissioning strategy will drive ongoing and wider user involvement in planning, developing, review and analysing provision The majority of service users have indicated they would prefer to receive support outside of secondary/acute settings, and a priority for the Mental Health Strategy will be promoting resilient communities that are Mental Health friendly and where people with mental illness can access the right support at the right time. Public Health is also involved with the strategy group which will link to the wider Partnership Board.

9. LEGAL IMPLICATIONS

9.1 Staff secondments are designed to be temporary arrangements or to offer developmental opportunities. There is no fixed limit on how long a secondment may last and many local authorities use extended secondment staff agreements. However, protracted secondments are not considered good practice and can give rise to legal challenges when an employee claims that the secondment arrangements have become permanent by reason of 'custom and practice'. The legal advice for RBC has been that continuing secondments beyond the 2 year point is not recommended, especially as many staff have indicated that a protracted arrangement is not what they would favour.

9.2 The Care Act received Royal Assent in 2014. It brings in new statutory duties and these need to be reflected in future plans for Mental Health integration, particularly the new wellbeing duty and extended responsibilities towards carers. The previous legal framework governing Adult Social Care is repealed by the Care Act.

9.3 Section 75 of the NHS Act 2006 provides for NHS bodies and local authorities to enter into arrangements for pooling resources when either the local authority is to exercise an NHS function or the NHS body is to exercise a health-related function of the local authority.

9.4 The Local Authority has a statutory duty to provide a sufficient number of Approved Mental Health Professionals (AMHPs) in order to carry out Mental Health Act assessments and this responsibility cannot be delegated. However there may be an

opportunity to work more efficiently with partner local authorities in supporting parts of the AMHP service.

10. EQUALITY IMPACT

10.1 An equality impact assessment was not relevant to the decision to approve the first phase of the mental health integration project. Similarly, terminating the secondment arrangements would not impact on service delivery or on staff terms and conditions. As the proposed joint commissioning strategy for mental health services is developed this is likely to identify potential service changes, at which point equality impacts will be identified in order to inform decision making in accordance with the Public Sector Equality Duty as set out in the Equality Act 2010.

11. FINANCIAL IMPLICATIONS

11.1 Revenue Implications

The net budget for the Mental Health Service provided by the Council is approximately £5m. This forms 9% of the overall Adult Social Care budget.

The original report envisaged that "Savings of approximately 4% of the budget (£200,000 per year) could be achieved by integration, but this may have to be equally shared between the NHS and the Council to ensure the NHS Trusts financial requirements are also delivered".

The current Transformation Programme led by RBC is set to deliver savings through the introduction of the Supported Living Accreditation Select List and review of current care packages. Additional savings are also possible with a review of the skill mix of teams and of pathways, with an increased focus on prevention and stronger links with CCGs and Public Health to ensure that service users, carers and other stakeholders receive training and support to develop community capacity and resilience. This is not dependent on a structural transfer and forms part of the efficiency savings programme for the service.

11.2 Capital implications and value for money

There are no specific capital implications arising from the Mental Health integration plans, although estates and value for money plus potential joint funding arrangements will be reviewed within the development of the joint commissioning strategy and in delivering the Mental Health efficiency programme.

11.3 Risks

The 2013 Cabinet report set out the case for the integration of the Council's Mental Health Service with local NHS provision. However, this case was made in a different economic and legislative climate. The resource implications of meeting Care Act duties presents a level of risk that means it would take a leap of faith on the part of the Trust and the Council to agree to any transfer of commissioning budgets at this time.

Similarly, without a clear commissioning strategy in place any transfer of staff and functions would also be a risk both to BHFT and to the Council, either of which may subsequently conclude resources have been tied into one structure/service prematurely.

The development of the Adults Mental Health Strategy will provide a more measured approach to developing services, community options and integrated care which will consider risk as part of the strategy. As such the strategy development provides a real opportunity to work in an integrated way across a much wider group than purely BHFT and RBC in order to bring parity of opportunity to people with mental illness.

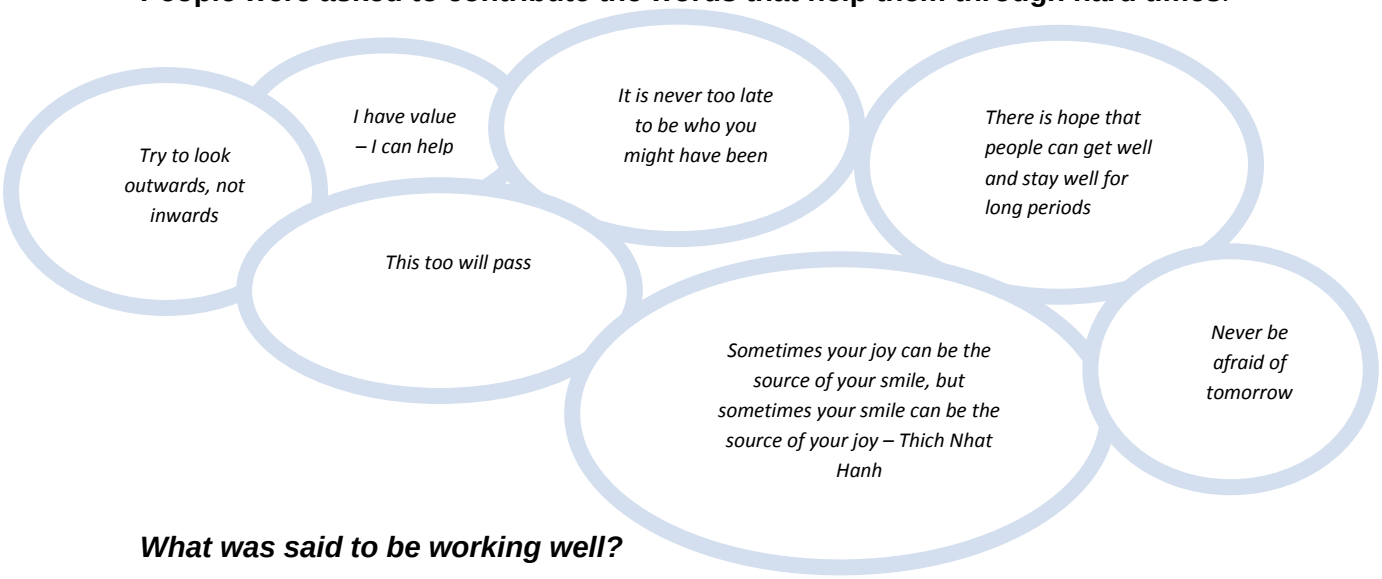
11. BACKGROUND PAPERS

Appendix One:	"Have Your Say" conference
Appendix Two:	Staff survey
Appendix Three:	Performance 2010-2014
Appendix Four:	Terms of Reference – Mental Health Strategy Group

Have Your Say – Adult mental health services within Reading – conference held 2nd December at Reading Town Hall.

Just over 60 people attended a conference to contribute their views to a partnership charter for working together and to outline their priorities for the future for the Reading area, nearly half of these were service users or carers.

People were asked to contribute the words that help them through hard times:



What was said to be working well?

Compass * wellbeing group * talking therapies * Common point of Entry (CPE) * older adults service* Post Traumatic Stress Disorder service * Sport in Mind * Learning Disability co-ordination from Berkshire Healthcare Foundation Trust (BHFT) *(some) GP services* peer support * Reading Your Way *Berkshire autism services *some very caring people and good care co-ordinators * some good communications within Prospect Park (but sometimes not outside of this with other agencies) * good medication in some cases

What could be better?

Some GP services having more training and time so they don't overprescribe medication instead of a range of support * less stigma and lack of understanding which should be addressed by information and training* some are seen as a diagnosis not as an individual with unique needs *information about where to go for support * liaison between Reading Borough Council (RBC) and BHFT * crisis team support sometimes minimise problems, are hard to contact (it was suggested that mystery shoppers review the service) * waiting lists for psychology are too long * rape support services for women should not be run by men * support where there is more than one diagnosis alongside of mental illness – e.g. learning disability, drug or alcohol problem, autism or head injury - A need for some specialist training and services around these areas * Joined up patient notes across East and West Berkshire but with a caution about ensuring that confidentiality is maintained *Training for employers, job centre, schools, the police, front door staff, the wider voluntary sector and the community about mental health* information needed about - mobile apps and technology. medication, earlier intervention and prevention * more involvement from service users and carers in deciding what is needed.

A charter for working in partnership towards positive mental health within Reading:

We will:

* Listen to people and value their views
* Make sure that everyone has good information about sources of support in a format that is easy to understand
* Ensure that it is clear to understand how to access and use the sources of support available
* Involve and provide for our diverse communities
* Ensure that there is support for people *before* as well as during a crisis
* Concentrate on the individual and their family/wider supporters needs
* Look at the person and not the diagnosis, focus on recovery and strengths
* Consider the impact of confidentiality when sharing information
* Work together as services, service users and carers, voluntary, independent and faith sectors, employers and the community
* Work together to actively challenge and break down the stigma of mental ill health
* Value the importance of early intervention and promote good mental and physical health and wellbeing within the wider community

Themed discussions:

Recovery star and Wellness, Recovery, Action Plans (WRAP) – working well, received positively, request for more peer support around plans with people with lived experience supporting this. There should be choice about what works for people and also an acknowledgement that not everyone can or wants to recover.

Involving service users, patients, carers – more networking forums/groups, more input is needed into the way services work, including evaluation of services, ensure that there are beds when needed, people should have a named contact when using services. More to be done around employment and reducing stigma with employers.

What do you want from your G.P/primary care? – more options for progressive treatment, better communications about medication between GP and CMHT, Not just medication but looking at the bigger picture, more empathy and understanding needed generally, more training in mental health, learning disability, autism, appropriate referrals to CMHT.

Public Health, prevention and keeping well – Reduce stigma to make it easier for people to seek help, help reduce hate crime by educating the community, develop joined up holistic alternatives to medication and services, education in schools (Young ambassador project), promote GPs as a first contact, build communities including the use of Time banks, help join up the community, reach those who are hard to reach – e.g. BME communities, men (men in sheds project), reduce the reliance on the medical model, arrange more promotional events and training.

BHFT and RBC – Raise the profile of mental health, revamp the partnership board to feed into the Health and Wellbeing Board, Determine which stakeholder groups are working and learn from these, more focus on hard to reach groups and social prescriptions (social activity, sport, leisure), link GP services and mental health services together, bridge the gap between dual diagnosis, substance misuse, autism and other specialist services.

IRIS – Drug and alcohol services – More joined up working with mental health services including older people services, break down barriers within services, more work with health, housing, carers, social care and service users

Priorities for integrated working within Reading adult mental health services:

- ***Develop more ways to involve people who use services and their carers/supporters.***
- *Identification of pathways into and out of services – **from** how to access information about prevention types of support, self- help and voluntary services **to** how to gain help in an emergency and discharge follow up.*
- *A resource directory of support and advice and information*
- *Develop better information sharing and communications but be mindful of confidentiality*
- *Improve joined up working between GPs, voluntary, independent and faith sectors and drug and alcohol, autism, learning disability and mental health support and services*
- *Develop training for the community, front door staff and the statutory and voluntary sector about common mental health conditions and how to support each other*
- *Plans to be put in place to actively challenge stigma and campaign for mental health issues (Time to Change organisation may assist)*
- *Develop a holistic assessment model that focuses on prevention, recovery and the individual strengths and not solely on diagnosis or medication*
- *Review and improve crisis support services involving people who use or have used them*
- *Make sure that people who use services can have a named co-ordinator and face to face contact where possible*
- *Develop social prescribing and access to mainstream/community activities not just specialist mental health ones*
- *Improve waiting times for assessment and treatment*

These priorities will form an action plan that will be developed further with other groups over the next few months. **A big thank you to all who contributed in this start to working together from:**

Anna Grainger - RBC, Andy Kimber - RBC, Dr Gwen Bonner -BHFT, Jo Ambler – Berkshire Carers Support Group, Merlyn Barrett – Healthwatch Reading, Dr Rosemary Croft and Sarita Rakhra – CCG.

Reading Mental Health Staff Survey 2015

The survey link was sent to all mental health staff employed in the Reading CMHT area – with reminders to complete this. However, only 17 staff replied – the survey was anonymous unless people wanted to offer which teams they worked for – 6 did. The respondents were split fairly evenly with 9 being seconded social care staff and 8 being NHS staff.

Most of the staff had worked within health or social care for more than 10 years (11 people). 7 of these had been in the Reading area for this amount of time.

The survey was a drop down yes or no check box to most questions for ease of completion and analysis. The majority of questions asked if people thought specific things could be improved within their own teams or the wider mental health community services.

15 people thought that the service in the wider mental health services could be improved. They were given options for how services might be improved with the following results:

Different staffing configurations – the majority thought these could be improved in both their own and the wider team.

Different allocation of resources – the majority said that these could be improved in the immediate team (13) and wider team (15).

Different team structures – in the immediate team 9 yes, 8 no In the wider team – yes 15, no 2

More training – immediate team – 11 yes no 6 wider team 9 yes no 8

Review of policies and procedures – immediate 9 yes , no 8 wider team 14 yes, 3 no

More involvement of patients/service users – immediate 10 yes, no 7 wider team yes 14 no 4

More carer involvement – immediate 11 yes, no 6 wider yes 14 no 3

A change in skill mix – immediate yes 8, no 9 wider yes 13, no 4

Access and availability of other services – immediate yes 11, no 6 wider yes 14, no 3

Improved supervision - immediate yes 8, no 9 wider yes 11 no 6

Better work allocation - immediate yes 8 no 9 wider team yes 13 no 4

Better use of distinct skills – immediate yes 10 no 7 wider yes 13 no 4

Less bureaucracy – immediate yes 16, no 1 wider yes 17

Better working with the acute wards – immediate yes 11 no 6 wider yes 14 no 3

More links with other agencies and partners – immediate yes 11, no 6 wider yes 15, no 2

Better links with the voluntary sector – immediate yes 12 no 5 wider yes 15 no 2

Comments received were about people needing training for some practical skills including PIP payments, carer assessments and involving other agencies and the public, better allocation of cases and SMART support plans which integrate both health and social care targets. The need to focus on

recovery and personalisation was stressed. Reviewing the skill mix seemed to be viewed favourably including better use of all disciplines including non professionally qualified roles such as community support workers.

Someone commented that there was a need to embrace 21st century mental health care. Others thought that there some issues about their workload being stressful due to shortages of staff and managers not always being available for decision making. There was a comment that the new management changes were positive.

The "friends and family test" was also used with 9 people likely or extremely likely to recommend the service to family or friends, and 9 people likely to recommend Reading mental health services as a place to work. In both cases three people were unlikely to with varying reasons such as their family did not live in the area or that people were not given enough time at appointments.

Summary:

The survey was by no means conclusive but the responses gave a balance between health and social care views of those people who did reply. Prior to the survey the project manager had met with a number of social care staff on a one to one basis so it may be that they had felt that they had already had their say and did not need to complete a survey – or that it might not make any difference. Whatever the rationale, the survey provides a snapshot in time and a view that there are people who are open to some changes within both their teams and the wider service. This will be followed up in the review of the skill mix within the teams and the wider integration work.

Of the 17 people who responded 6 agreed that it was necessary for social work to be employed by the trust to improve outcomes for service users (4 of these were NHS staff), 6 did not know and 5 **disagreed**. This reflects the general view from interviews with RBC staff in that most were unsure of whether it would be of benefit for them to transfer into the Trust with some actively against this option. The survey and interviews form one part of the staff engagement concerning the evaluation of the employment options for the Reading integration project.

Anna Grainger Project Manager Reading Mental Health Integration, May 2015

Analysis:

The highlighted areas within the spreadsheet show those aged18-64 and 65 plus with a Mental Health Primary Support Reason.

Over the period of 2013/14 there were only 14 ongoing direct payments in place - the remainder were one off payments. Direct payments for carers were also few.
Data captured for the amount of advice and support (signposting) of carers was poor - this is now a Care Act requirement and measurement will need to be addressed

The number of clients with Mental Health Primary Support Reason receiving services has increased in line with other service areas.

The number of carers receiving services increased during 2013/14 largely due to the work of a social worker focussing in the Community Mental Health Team on carers.

All clients with DPs 1 April to 9 October 2014

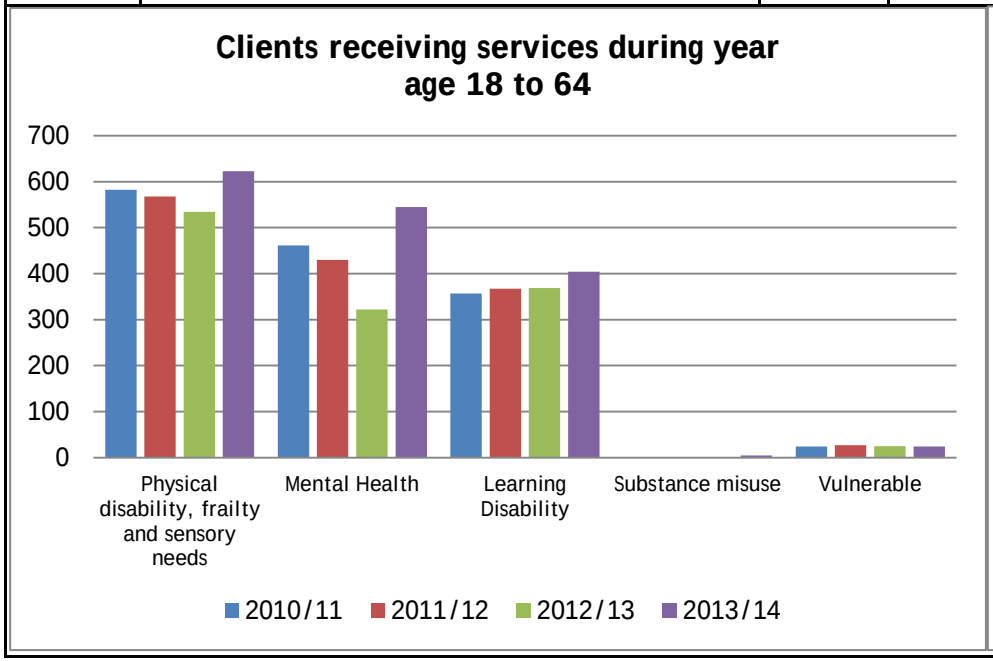
Direct Payment - Employers Liability Insurance	5
Direct Payment - One off	63
Direct Payment - Weekly ongoing	172
Direct Payment to rep - One off	1
Direct Payment to rep - Weekly ongoing	2
Grand Total	243

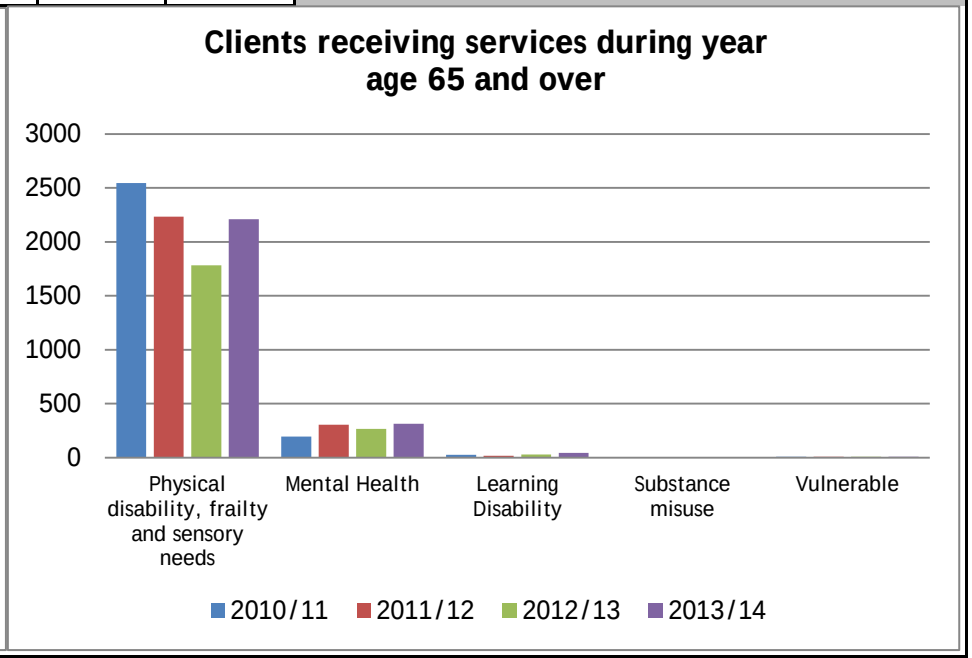
MH clients with DPs 1 April to 9 October 2014

Direct Payment - Employers Liability Insurance	1
Direct Payment - One off	22
Direct Payment - Weekly ongoing	14
Grand Total	37
Percentage of all clients with DPs	15.23%

Mental health 2013/14 NASCIS RETURN	England Average	Reading
Proportion of gross expenditure on Nursing/Residential care Homes 18-65	22%	23%
Proportion of gross expenditure on day and domiciliary care for MH	40%	46%
Proportion of spend on Assessment and care management (social work	28%	30.30%
Proportion of gross expenditure on direct payments	8%	4.40%

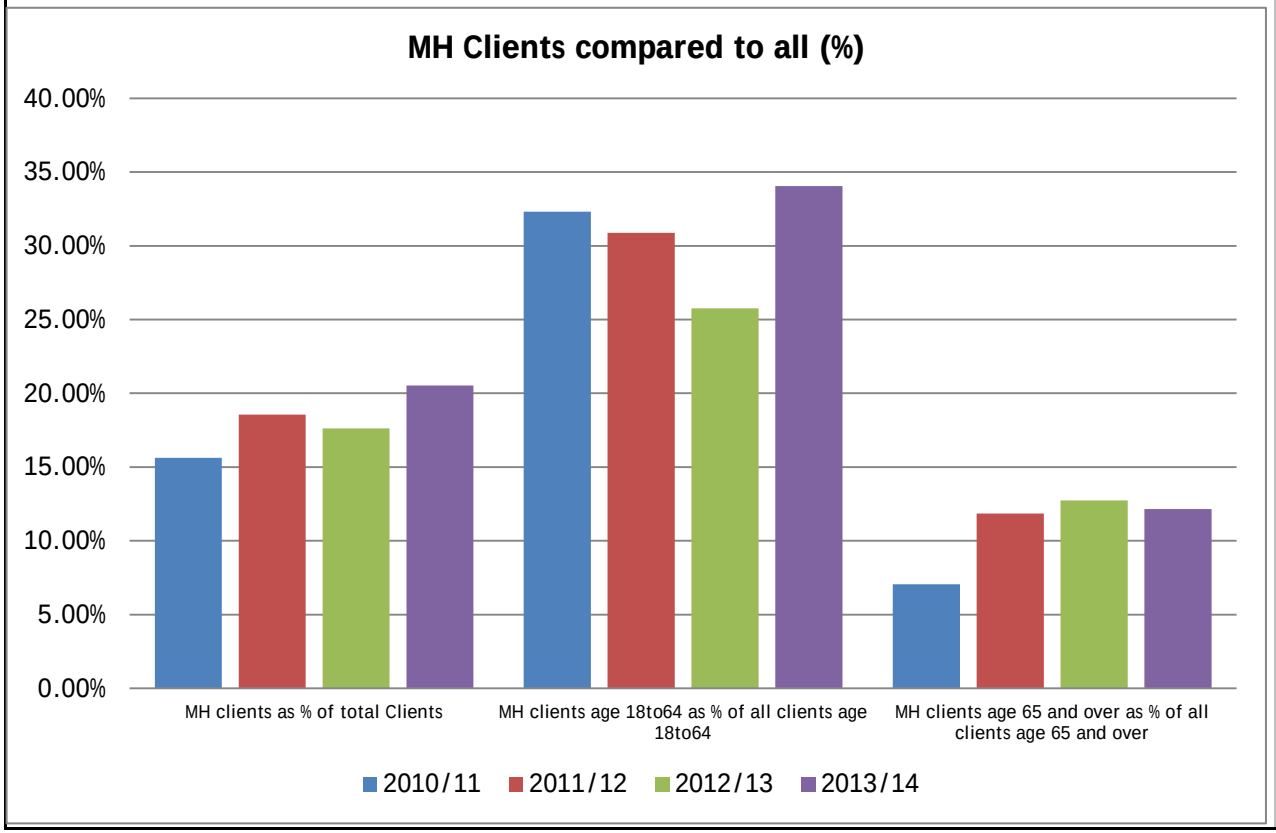
RAP P1 tables - Clients receiving services during the year					
		2010/11	2011/12	2012/13	2013/14
Total number of clients		4202	3956	3338	4178
P1 page 1	18-64	1427	1392	1250	1601
18 to 64	Physical disability, frailty and sensory needs	582	568	534	623
age group	Mental Health	461	430	322	545
by client	Learning Disability	357	367	369	404
category	Substance misuse				5
	Vulnerable	24	27	25	24
P1 page 2	65+	2775	2564	2088	2577
65+ age	Physical disability, frailty and sensory needs	2546	2233	1784	2210
group by	Mental Health	196	304	266	313
client	Learning Disability	26	18	29	45
category	Substance misuse				2
	Vulnerable	7	9	9	7





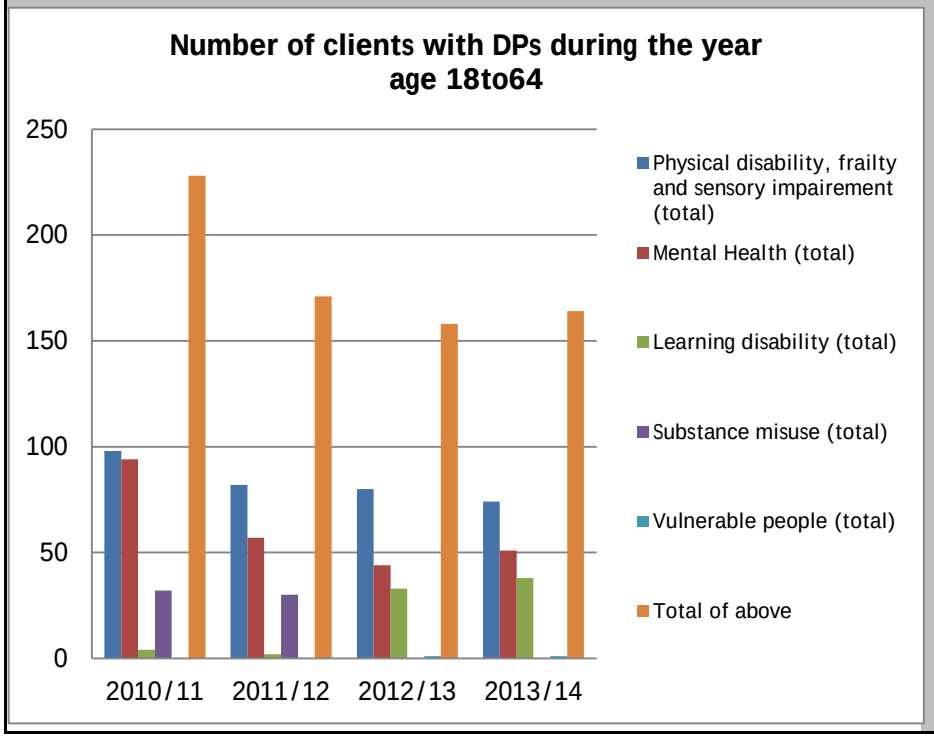
MH clients compared to all

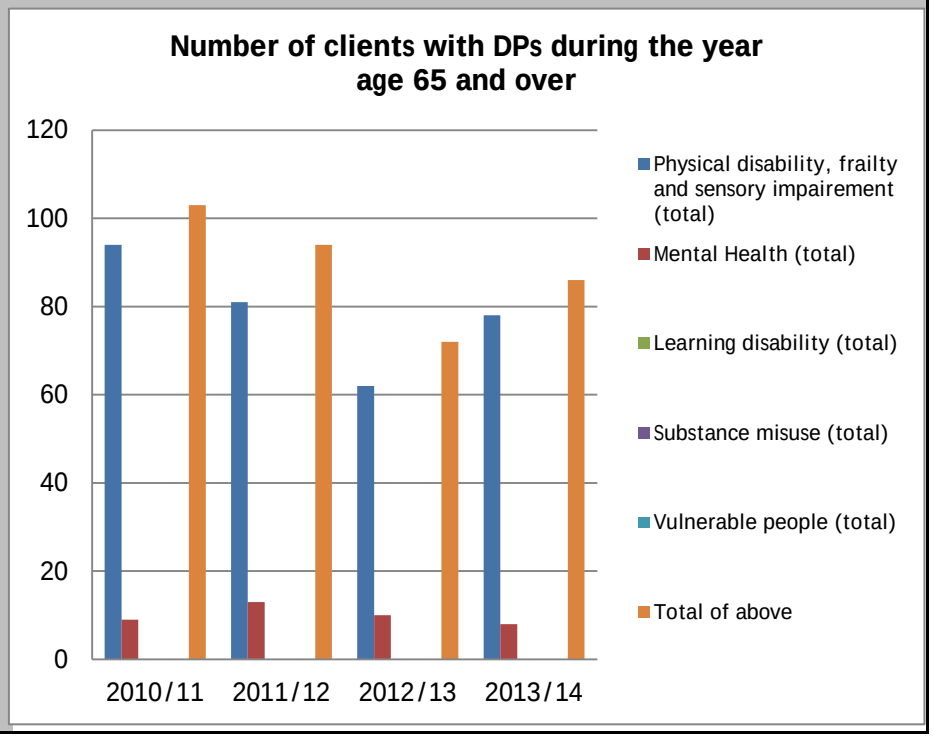
	2010/11	2011/12	2012/13	2013/14
MH clients as % of total Clients	15.64%	18.55%	17.62%	20.54%
MH clients age 18to64 as % of all clients age 18to64	32.31%	30.89%	25.76%	34.04%
MH clients age 65 and over as % of all clients age 65 and over	7.06%	11.86%	12.74%	12.15%



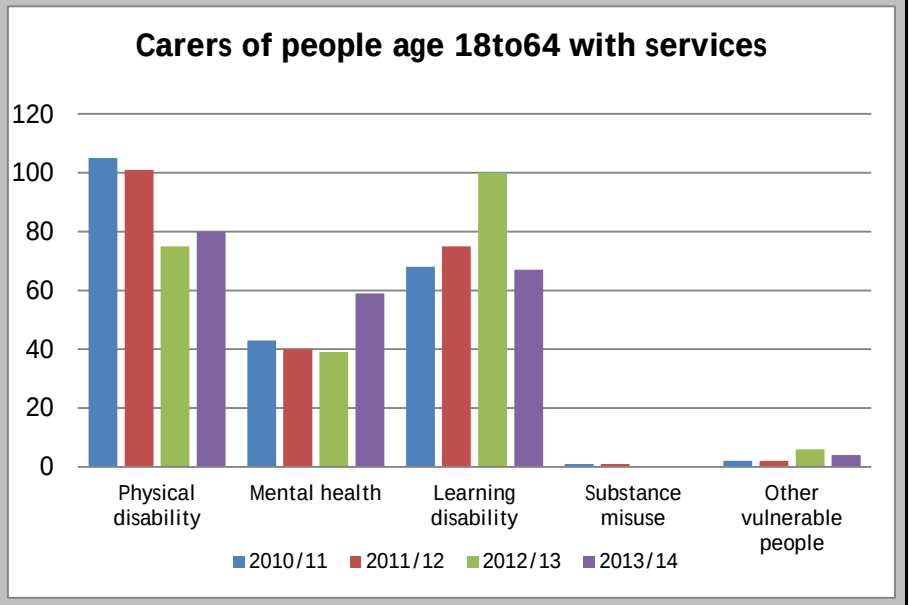
Number of clients with DPs during the year age 18 to 64	2010/11	2011/12	2012/13	2013/14
Physical disability, frailty and sensory impairement (total)	98	82	80	74
Of which: Physical disability, frailty and/or temporary illness	92	80	78	73
Hearing impairment	3	0	0	
Visual impairment	3	1	1	
Dual sensory loss	0	1	1	1
Mental Health (total)	94	57	44	51
Of which: Dementia	0	0	0	
Learning disability (total)	4	2	33	38
Substance misuse (total)	32	30	0	
Vulnerable people (total)	0	0	1	1
Total of above	228	171	158	164

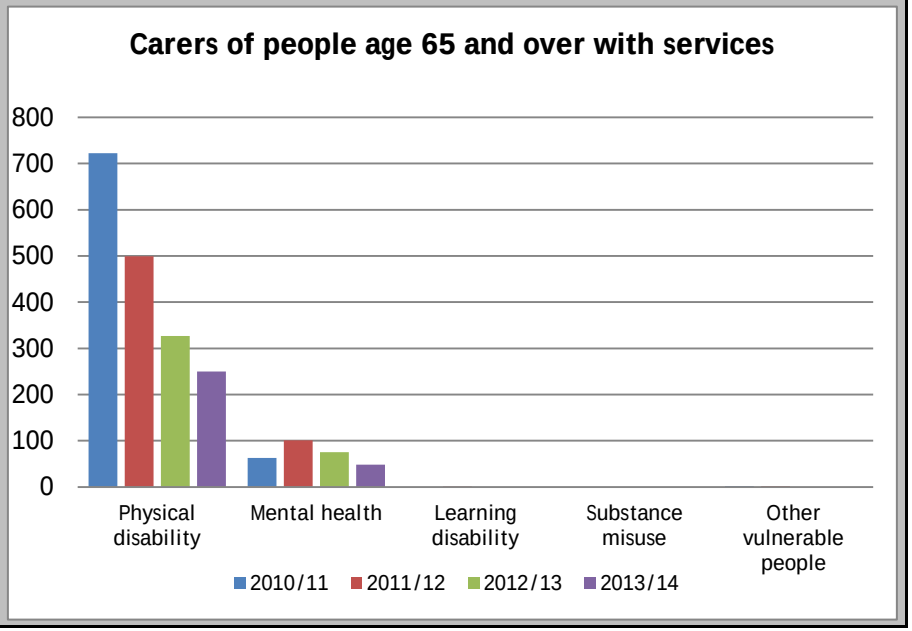
Number of clients with DPs during the year age 65 and over	2010/11	2011/12	2012/13	2013/14
Physical disability, frailty and sensory impairement (total)	94	81	62	78
Of which: Physical disability, frailty and/or temporary illness	93	81	62	78
Hearing impairment	0	0	0	
Visual impairment	1	0	0	
Dual sensory loss	0	0	0	
Mental Health (total)	9	13	10	8
Of which: Dementia	6	11	6	3
Learning disability (total)	0	0	0	
Substance misuse (total)	0	0	0	
Vulnerable people (total)	0	0	0	
Total of above	103	94	72	86



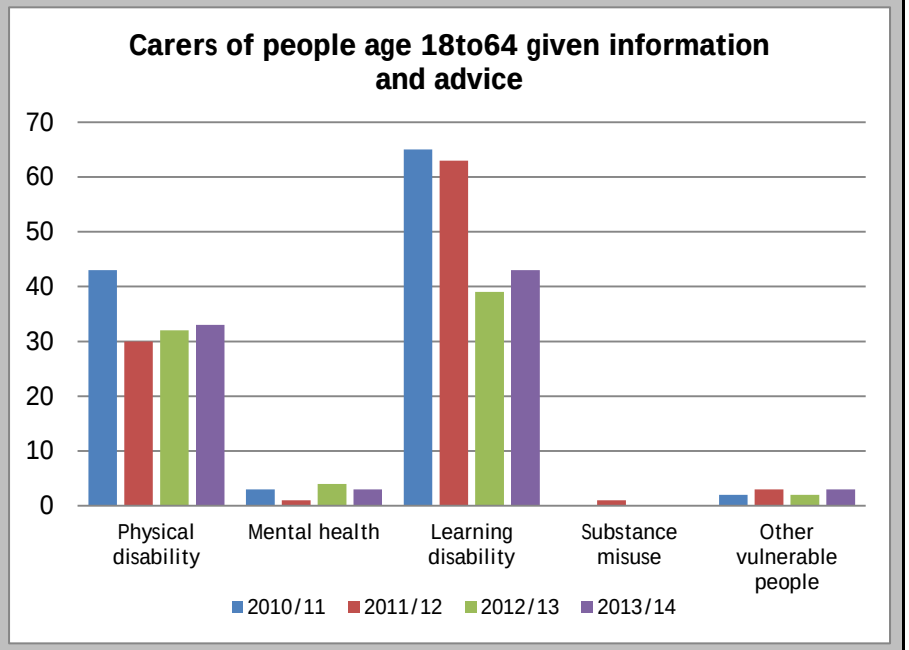


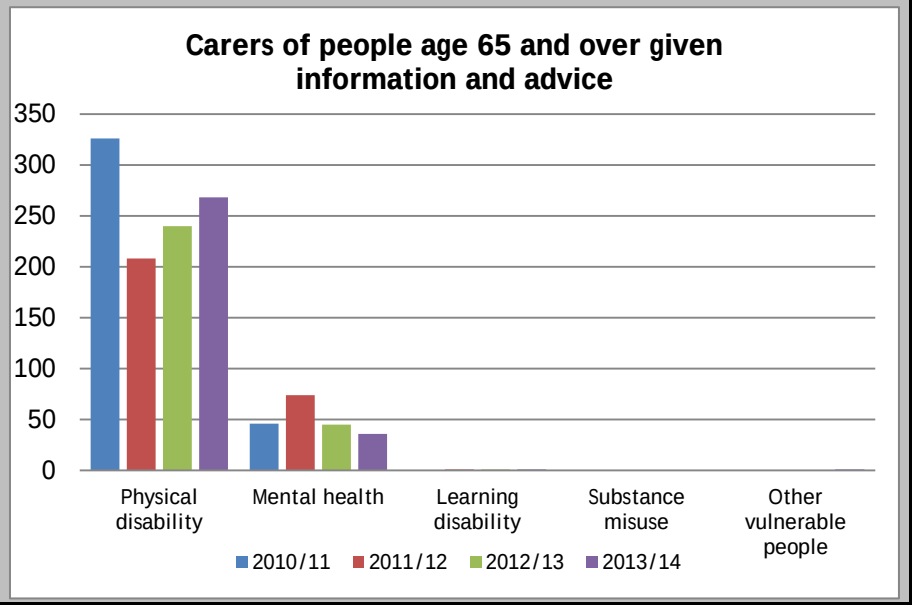
Services including respite for the carer and /or other carers' specific services				
Primary client type and age group of person cared for by the carer:	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Aged 18 - 64				
Physical disability	105	101	75	80
Mental health	43	40	39	59
Learning disability	68	75	100	67
Substance misuse	1	1	0	0
Other vulnerable people	2	2	6	4
Total 18 - 64	**219**	**219**	**220**	**210**
Aged 65 and over				
Physical disability	722	499	327	250
Mental health	63	101	75	48
Learning disability	0	1	0	0
Substance misuse	0	0	0	0
Other vulnerable people	2	2	0	0
Total 65 and over	**787**	**603**	**402**	**298**
Total 18 and over	**1006**	**822**	**622**	**508**





Information and advice only for Carers				
Primary client type and age group of person cared for by the carer:	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Aged 18 - 64				
Physical disability	43	30	32	33
Mental health	3	1	4	3
Learning disability	65	63	39	43
Substance misuse	0	1	0	0
Other vulnerable people	2	3	2	3
Total 18 - 64	**113**	**98**	**77**	**82**
Aged 65 and over				
Physical disability	326	208	240	268
Mental health	46	74	45	36
Learning disability	0	1	1	1
Substance misuse	0	0	0	0
Other vulnerable people	0	0	0	1
Total 65 and over	**372**	**283**	**286**	**306**
Total 18 and over	**485**	**381**	**363**	**388**





Terms of Reference

Reading Mental Health Strategy Group

Document Revision History

Revision date	Author(s)	Change summary	Version
26/02/15	Anna Grainger	Initial document	26/2/2015

Approvals

Revision date	Author(s)	Change summary	Version

Purpose

This document details the Terms of Reference (ToR) for the Reading Mental Health Strategy Group.

1. Role and Reporting

The role of the Reading Mental Health Strategy Group is to:

- Oversee the development of adult mental health support within Reading and ensure that issues, risks and interdependencies are reported appropriately to the Reading Integration Board.
- provide a central point for the voices of service users and carers to be heard and acted upon, particularly informing recommendations for implementation
- promote initiatives to support mental wellbeing and resilience across a broad stakeholder group, including commissioners and providers across the statutory, independent, voluntary and community sectors
- share and co-ordinate information which will help inform the commissioning and delivery of services to meet needs effectively, safely and within budget.
- horizon scan, share best practice and information in order to be prepared for the future.
- Develop and agree a strategy and action plan to achieve the strategic aims of mental health services within Reading, Monitor the delivery of the shared action plan, including establishing short, time limited task and finish groups to achieve this as necessary.
- strive to ensure that the profile of mental health issues is raised and that outcomes for people who use mental health services and their carers are improved.

2. Responsibilities

- Oversee the Reading Mental Health Strategy Group action plan.
- All members to have a responsibility to gather relevant information to feed into the group and to feed relevant information out from the group as determined by the group.

- The group will not be delivering plans specifically for CAMHS (child and adolescent mental health services) nor people with dementia which are covered elsewhere, although consideration will be taken to ensure that any plans should not adversely affect these areas.

3. Membership of the Group

3.1. Core Membership

Service user and carer reps to be requested via expression of interest
Head of Adult Social Care - Reading Borough Council
Commissioning *Berkshire West Clinical Commissioning Groups*
Representative – South Reading CCG
Representative – North and West Reading CCG
Head of Mental Health Reading locality – Berkshire Healthcare Foundation Trust
Adult Mental Health Service Manager– Berkshire Healthcare Foundation Trust
Reading Integration Programme Manager
Lead for Mental Health Commissioning - Reading Borough Council
Public Health – Reading Borough Council
Healthwatch Reading
RBC – Preventative Services Development Manager
Project Manager for Mental Health - Reading Borough Council
Healthwatch Reading
BHFT – PALS representative

3.2. Additional Attendees

The following additional attendees will be invited as required:

- Specialist reps and leads from task and finish groups, guest speakers.

3.3. URGENT MATTERS BETWEEN MEETINGS

In the event of an urgent matter arising between meetings that cannot wait for resolution until the next scheduled meeting, a virtual meeting will be convened, this will determine recommendations for consideration. Such meetings should consist of at least one person from each of the following – service user rep, carer rep, BHFT rep, RBC, voluntary and CCG rep in order to be quorate.

4. Decision-Making

Decisions with a material impact on key organisations will require sign off from a minimum of the Reading Integration Board. The Integration Board will determine what to feed through to the Health and Wellbeing Board and what to feed to the Strategy group.

5. Frequency of Meetings

The strategic group will meet on a quarterly basis.

6. Confidentiality

All members of the group have a duty of confidentiality regarding all information disclosed by Partners. There will be occasions when selected information must not be disclosed outside the Reading Mental Health Strategic Group. The person disclosing such information to the Group is responsible for identifying it as confidential at the time it is given, and for ensuring that its confidential status is identified in all relevant written material. Any challenge to the confidentiality of information given to the Reading Mental Health Strategy Group will be referred to the Chair, whose decision on the matter will be final.

7. Conflicts of Interest

A conflict of interest is where an individual has a direct or indirect pecuniary or non-pecuniary interest in a matter that is being discussed. These can be defined as follows:

- A **direct pecuniary interest** is when an individual may financially benefit from a decision (for example moving services to them from an alternative provider)
- An **indirect pecuniary interest** is when an individually may financially benefit from a decision though normally via a third party (for example where an individual is a Commissioner, member or shareholder in an organisation that will benefit financially from the consequences of a reconfiguration decision)
- A **direct non-pecuniary interest** is where an individual holds a non-remunerative or not-for profit interest in an organisation (for example, where an individual is a trustee of a voluntary provider that is bidding for a contract)
- An **indirect non-pecuniary interest** is when individual may enjoy a qualitative benefit from the consequence of a decision which cannot be given a monetary value (for example, a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual's house)
- In addition, where an individual is closely related to, or in a relationship, including friendship, with an individual in the above categories, this will constitute a conflict of interest.

The Group members must follow the Conflicts of Interest Policy if they are bound by one by their appointing organisation.

7.1. Main Control Documents

1) Quarterly highlight / status reports
2) Project Initiation Documents (PID's), Business Cases for submission to the Integration Board
3) Delivery milestone plans for submission to the Integration Board
4) Where required an Issues / Risk and Dependencies log

These documents will also be used to update the Integration Board.

8. REVIEW OF TERMS OF REFERENCE

Given the evolving nature of integration these Terms of Reference will be reviewed as required.