The Royal Borough of Kensington and Chelsea

CREST WILL BE ADDED HERE, AS AND WHEN REQUIRED, BY GOVERNANCE SERVICES

Key Decision Report dated 27th October 2010

For Decision by Councillor Julie Mills Cabinet Member for Adult Social Care, Public Health and Environmental Health

Report by the Executive Director of Health, Housing and Adult Social Care Services

OPTIONS FOR THE FUTURE OF MENTAL HEALTH DAY AND OUTREACH SERVICES

1. Introduction

1.1. The purpose of this report is to secure a decision in relation to the future of community day and outreach services for people with mental health problems, and the level of future investment in these services

1.2. In order to do this the report seeks:

- To provide information about prevalence (2.1)
- To describe the context for the development of Mental health services (2.2)
- To outline the statutory obligations (3)
- To provide a broad overview of adult social care spend on mental health services in the Royal Borough (4)
- To identify possible areas for savings from within the overall mental health budget (4.5 - 4.10)
- To present the work that has taken place so far in relation to the planned procurement of day and home (floating) support services (5)
- To provide an overview of savings already identified for 2011/12 (6.2)
- To present a range of alternative options for day and home (floating) support services, and the impact of different levels of saving (7).

1.3. There is particular pressure to complete the procurement, given that the externalisation of in-house day service provision was agreed in April 2009, and the continued uncertainty over the future of these services is problematic for staff and users of the services.

1.4. Additional pressure arises because this procurement is a key element in the development of personalisation across mental health services.

1.5. A Cost Challenge was undertaken earlier in the year which identified scope for achieving savings within Mental Health Day services. Proposals in this report offer opportunities to achieve savings from within these services.

1.6. Given the current economic climate, and the fact that we are considering entering contracts that will define the level of spending for the next 2-3 years, four options for possible ways forward are presented, with their respective savings, benefits challenges and risks.

2. Background

2.1. Mental Health Prevalence

2.1.1. The Joint Strategic Needs Assessment provides the following key messages in relation to the prevalence of mental ill-health in the Royal Borough:

- The borough ranks fourth highest in the country for the proportion of people on Primary Care practice registers with severe and enduring mental illness (2200).
- There are likely to be 4,000 - 5,000 people at any one time with depression, 7,000 to 8,000 with anxiety, and a significant number with other disorders. The vast majority of people with common mental illness (probably about 90 per cent) are seen within a primary care setting.
- Severe and common mental illnesses are probably not becoming more prevalent, but more and more people will be diagnosed due to better case finding and more primary care counselling capacity.

2.1.2. People supported through secondary care will tend to be those with the most severe mental illness, and most likely to need and be eligible for social care services. A recent exercise carried out by the Mental Health Trust, (CNWL) showed that they were supporting 1720 patients. 1001 were supported through the community teams, 518 though outpatients, and 201 through psychological services. It also showed that users with both non-psychotic and psychotic problems are supported, but that there are particularly high numbers of patients with ongoing or recurrent psychosis, affective disorders, many of whom are difficult to engage.

2.1.3. It is reasonable to assume that most of the 1519 patients supported through community teams and outpatients services would have eligible needs (see **3.3 The Duty to Provide Services**).

2.1.4. Further, the JSNA shows 2200 people severe mental illness (SMI) supported through primary care, and some of these may also be eligible for social care services. The potential need is therefore likely to be significantly higher than the numbers of users currently in receipt of social care services (1100).

2.2. The Development of Mental Health Services

2.2.1. The proposed reconfiguration of services represented by the procurement comes about in the context of a continuing pattern of changes to mental health services that date back before the NHS and Community Care Act. The background to these changes was covered in an earlier Key Decision Report Key (KD03038), which was discussed at committee in January and March 2009 and agreed on 14th April 2009.

2.2.2. In brief this described the decline of inpatient numbers since 1954 and the parallel increase in social methods of rehabilitation and resettlement in the community, the availability of welfare benefits and the use of antipsychotic medication.

2.2.3. Until fairly recently, services have focused on the containment of a mental health condition and its impact, and as a consequence people with mental health problems often remain stuck in specialist mental health provision, or living isolated lives disconnected from mainstream services and the wider community.

2.2.4. However, there is now an increasing focus on Recovery as key to the delivery of effective mental health services. This assumes that the majority of mental health issues are treatable and should be regarded in the same light as other health conditions, as ones from which the individual can, with appropriate support, to a greater or lesser extent recover. It requires front line services to be delivered in a manner which is customised to the needs of the individual, rather than being delivered in a generic style into which individuals have to fit.

2.2.5. This Recovery approach is echoed and supported by the White Paper, **"Our Health, Our Care, Our Say: a New Direction for Community Services"** (DOH 2006) and the development of "personalisation", which in social care, means every person across

the spectrum of need having choice and control over the shape of his or her support, in the most appropriate setting.

2.2.6. The local Mental Health Trust is currently engaged in a process of modernisation of their community services, with changes and reorganisation of community teams, focused on the principle of Recovery (as described in 2.2.4). In developing the model for procurement, officers have been conscious of the need to ensure that the developments in social care services mirror and support these developments in secondary care, and the Trust is equally dependent on the Royal Borough for the delivery of services to support the changes they are making.

3. Statutory Duties

3.1. In considering the obligations of the Local Authority to provide services to people with mental health problems, there are 2 aspects that need to be addressed. First, there is the assessment of a person's needs, and secondly, bearing in mind the outcome of that assessment, a decision to provide (or not) particular services.

3.2. The Duty to Assess

3.2.1. There are a number of statutes that deal with the matter of assessment. The overarching duty on local authorities is set out in the **NHS and Community Care Act 1990**.

3.2.2. **Section 47(1)** imposes a duty on local authorities to carry out an assessment of need for community care services with people who appear to need such services and then, having regard to that assessment, to decide whether those needs call for the provision by them of services.

3.2.3. An assessment is triggered where :

- The person appears to be someone for whom community care services could be provided **and**
- The person's circumstances may need the provision of some community care services

3.2.4. There are a number of other Acts which deal with the matter of assessment. For mental health services there are particular duties under the **Mental Health Act 1983,** which was amended by the **Mental Health Act 2007.**

3.2.5. **Mental Health Act Assessment**

3.2.5.1. Under the mental health legislation, Approved Mental Health Professionals (AMHP's) who until the 2007 Act were called Approved Social Workers (ASWs), have the legal duty to co-ordinate MHA assessments.

3.2.5.2. AMHP's can be social workers, nurses, occupational therapists or psychologists, but in the Royal Borough are all Social Workers. They have been trained and approved by the local social services authority to carry out certain functions under the Mental Health Act including the power to make an application for admission to hospital under a section of the Act where necessary and proper. Before doing so, the AMHP carry out an assessment and satisfy themselves that detention in hospital is, in all the circumstances, the most appropriate way of providing the care and medical treatment the patient needs.

3.2.5.3. Compulsory detention in hospital will be a last resort. Having gathered the facts the AMHP will look for the least restrictive alternative. The AMHP will also consider the wider social factors and implications for the person in making a decision.

3.2.5.4. **Section 117** of the Mental Health Act also requires a Local Authority jointly with the Health Authority to provide aftercare services for people leaving hospital after being compulsorily detained. It is implicit in such a duty that a process of assessment must be undertaken prior to discharge to identify needs and how they will be met.

3.3. The Duty to Provide Services

3.3.1. Once a community care assessment is carried out, councils need to make decisions about whether to provide support or not to individuals. Fair Access to Care Services (FACS) provides councils with an eligibility framework for adult social care to identify whether or not the duty to provide services is triggered.

3.3.2. The duty on social services to provide or arrange services is triggered only for those people with eligible needs - that is needs above the threshold for services line. The national FACS policy states that councils may take account of the resources available to them in deciding which level of need to meet.

3.3.3. Needs that are identified as eligible needs and which sit within the laws relating to a duty on Social Services to provide services must be met. How those needs are met is a separate issue.

3.3.4. The duty to arrange/provide services for people with Eligible Needs is addressed in several pieces of legislation. In particular:

- The **National Assistance Act 1948 Section 29** specifies that that the local council has a duty to exercise its powers for people 'ordinarily resident' in its area and must provide social work advice and support service, facilities for rehabilitation and adjustment to disability and for occupational, social, cultural and recreational activities

- The **Chronically Sick and Disabled Person's Act 1970 Section 2 (1)** sets out the types and range of services that should be available to meet the needs of 'disabled people', including; the provision of practical assistance in the home; recreational facilities outside the home or assistance to take advantage of educational facilities; assistance with works for adaptation in the home; provision of meals.
- As indicated above, the **Mental Health Act 1983 Section 117** creates a **joint duty** on Health and Local Authorities to provide after care services to various categories of people who have been detained in hospital, for as long as the person needs them. Aftercare services are not defined in the Act but will include social work support in helping the ex-patient with problems of accommodation or family relationships, the provision of domiciliary services and the use of day centre and residential facilities.

3.3.5. Thus, there is a clear duty embedded in legislation for Local Authorities to provide for the assessed needs of people with mental health problems. Though the type or model of day service is not specified, there is a clear expectation that support be provided in the areas of need currently delivered through day and outreach services.

3.4. Equalities Legislation and Duties

3.4.1. Like other public sector bodies, the Council is subject to various legal obligations and duties in relation to the fair and equal treatment of people who receive Council services. These are embedded in the Race Relations Act 1976 and the Race Relations (Amendment) Act 2000, the Disability Discrimination Act 2005 and the Equality Act 2006.

3.4.2. The Council's general disability equality duties which require due regard to be given to:-

- The need to eliminate unlawful discrimination;

- The need to promote equality of opportunity between disabled persons and other persons;
- The need to take account of disabled persons disabilities even where it involves treating disabled persons more favourably;
- The need to promote positive attitudes towards disabled persons;
- The need to encourage participation by disabled persons in public life.

3.5. Housing Duties

3.5.1. Local authorities' "main housing duty", as it is often described, arises from Part 7 of the Housing Act 1996 (as amended by the Homelessness Act 2002). Where an authority is satisfied that a housing applicant is eligible for assistance, unintentionally homeless and falls within a specified priority need group, there is a statutory duty to ensure that suitable accommodation is available for the applicant and his or her household. The groups specified within the definition of priority need include people who are vulnerable in some way, mental illness being one of the examples given. People for whom a local authority accepts a duty in this way are described as statutorily homeless.

3.5.2. The duty to ensure suitable accommodation is available (usually discharged by the Council arranging temporary housing of some kind) continues until such time as a settled housing solution becomes available to the applicant or some other circumstance brings the duty to an end. For the majority of all statutorily homeless cases, the "settled housing solution" is currently delivered through an offer of permanent social housing, via the local authority housing register.

3.5.3. Locally, the agreed aim within HHASC has been to minimise the number of mentally ill people needing to be dealt with under the homeless legislation by commissioning a range of appropriate support services. These fall into two main categories:

- Supported housing schemes, which provide a more suitable option for mentally ill people who would struggle to live independently and to manage the responsibilities of a tenancy.
- Floating support, outreach and other community-based services including daytime activities, which support mentally ill people in independent housing and help to prevent tenancies breaking down.

3.5.4. The Royal Borough has developed good provision in both the above areas over the past 10 years and this has had a major impact in reducing a number of identified problems. These included a large "revolving door" population of people caught in a repeated

cycle of tenancy breakdown, homelessness and hospital admission, with accompanying repercussions for the local community. If current service provision were significantly reduced, these problems would return. With more mentally ill people going through the statutory homeless route, there would also be an increase in:

- The use of inappropriate temporary accommodation for this client group, placing both individuals the local community at risk.
- The number of people inappropriately allocated their own tenancy, with negative consequences for neighbours and housing management services.

4. Current Funding for Mental Health Services

4.1. The total level of funding for mental health services across NHS K&C and the Royal Borough is therefore £52m of which the Royal Borough contributes 18%.

4.2. The current level of Department of Health funding for Mental Health services is illustrated in the table below.

Service Area	**Cost (£)**
In Borough Placements/Services	1,200k
West London Mental Health Trust patients	1,200k
Central and North West London NHS Foundation Trust	29,800k
Specialist Consortia (Forensic, eating disorders)	5,300k
Other Placements	3,000k
Forensic Team	920k
Forensic Hostel	690k
Primary Care Liaison Nurses	350k
Dementia Service	450k
Court Diversion Scheme	10k
Perinatal Services	5k
Improving Access to Psychological Therapies	2k
Total	**43,000k**

4.3. The current level of funding for Mental Health services provided by the Royal Borough is illustrated in the table below (this includes only costs within the control of this Business Group, recharges from other Business Groups have been excluded):

Service Area	**Gross (£)**
Management & Support Services	681k
Assessment & Care Management	1,681k
Residential Home Placements	1,026k
Supported/Other Accommodation	1,034k
Supporting People Funding	2,132k

Home Care	19k
Day Care	2,239k
Other	666k
Total	**9,478k**

4.4. The following sections (4.5 - 4.10) provide some detail of these costs, and some indication of the potential for savings from each area.

4.5. Management & Support Services

4.5.1. The budget for this area of service is £681k. The costs relate to recharges of Business Group management and support functions which support mental health services. The majority of the posts charged to the service are not dedicated to mental health services and the costs represent proportions of individual officer's time. Savings in these costs would therefore need to arise from a review of Business Group management and support functions which is outside the scope of this report.

4.6. Assessment & Care Management

4.6.1. The budget for on this area of service is £1,681k, which provides support to 1100 service users (based on 2009/10 data).

4.6.2. This includes funding for mental health social work posts, all of whom are also AMHP's (see 3.2.5.1) and therefore responsible for delivering the Local Authorities duties under the Mental Health Act. This is a statutory service, and includes work with a non-resident population (if they have a mental health crisis in the Royal Borough). This is a high profile service, and is very important in managing risk to users and the wider population.

4.6.3. As well as their AMHP duties, the social workers work jointly with Mental Health Trust staff as part of the community mental health teams (CMHTs) to deliver other assessment and care management functions to people with mental health problems. There are 27.6 full time equivalent posts.

4.6.4. The Trust are currently in the process of review and reorganisation of their services (see 2.2.6), so this is an opportune time to flag up the need for economies. However, experience suggests that the CMHT's are operating at capacity and it is doubtful that savings could be made in this area without a significant impact on frontline services to users. The JSNA also suggests that secondary care services match need well.

4.6.5. Nonetheless, discussions with the Mental Health Trust have commenced on the possibility of convert a Social Work Post to carry out placement reviews. This would help to ensure that users are placed in the most appropriate accommodation which is a key function in driving down these costs. This option is explored further in 4.7.

4.7. Residential Care and Supported Accommodation

4.7.1. The budget for this area of service is £2,060k, which funds specialist residential and supported accommodation for 145 users. 105 of these places are funded by Adult Social care, and further 40 places are jointly funded with Supporting People (see 4.8 below)

4.7.2. These services caters for those people whose level of need is such that they require high levels of support within their living environment in order manage their lives in the community (as described in 3.5.3).

4.7.3. Though this is a large area of spending within the budget, it is a complex area from which to identify and secure savings. Work has taken place, and will continue:

- To ensure that the costs of individual placements is reasonable and good value for money,
- On a scheme to offer direct lets to people in medium support accommodation to free up those places to users needing move out of placements offering higher levels of support
- As indicated in 4.6.5, on ensuring that placements are reviewed in a timely way and users remain in more costly higher support options for no longer than is necessary.

4.7.4. All these options will help to drive down the costs, but savings are likely to be delivered in future years, rather than in 2011/12.

4.8. Supporting People Funding

4.8.1. The budget for this area of service is £2,132k. Though not Adult Social Care Funding, this is a significant area of spend, which funds 19 projects offering different levels of specialist mental health supported accommodation, and delivering 234 places (beds). 4 of these projects, delivering 40 places are jointly funded with Adult Social Care (see 4.7.1 above)

4.8.2. The future of Supporting People funding is subject to a separate review process.

4.9. Home Care

4.9.1. The budget for this area of service is £19k, which funds homecare for around 50 users.

4.9.2. A review of cases may enable some reduction in the packages, but is not likely to generate high levels of savings.

4.10. Day Care

4.10.1. The budget for this area of service is £2,239k which funds a range of day and outreach services, supporting 680 users (based on 2009/10 data). As this has been identified as an area where savings might be made, more detail of budget is provided below.

4.10.2. The budget breakdown is as follows:

Service	Gross (£)
Oremi Centre Westminster	61k
In-House Day Service Provision	1,134k
Hestia Floating Support	366k
Al-Hasinaya Moroccan Women's Project	21k
MIND Core Services and Service User Network	113k
Other	3k
SMART	330k
MIND Skills Development service	211k
Total	**2,239k**

4.10.3. As a consequence of the focus on Day Care prompted by the Cost Challenge, significant potential savings have already been identified and this is addressed in more detail in 6.2 below. This includes Oremi Westminster.

4.10.4. In House Day Services and Hestia are the services that are included in the proposed procurement and are addressed in 6 below.

4.10.5. Annual grant funding totalling £134k is provided to Al Hasinaya for a service targeting Moroccan Women, and to MIND for some core funding and to support the Service User Network (so support users in having a voice and being involved in service review and delivery). Both organisations have applied for similar levels of funding for 2011/12, and this is currently being considered.

4.10.6. Some further savings may need to be considered from the procurement of the current contracts with SMART and MIND.

4.10.7. **SMART (£330k)**

4.10.7.1. SMART offers a service based in Gertrude Street, that promotes mental health through purposeful activities including work, training and social opportunities. Services include advice and information, advocacy, a training and employment service, a community cafe, a gardening and floristry project, ICT training, a packing project and a variety of social clubs.
They supported more than 180 clients in 2009/10, are well used and very popular with users and professionals

4.10.8. **MIND (£211k)**

4.10.8.1. The MIND Skills Development Service is based on 2 sites, in Acklam Road and Meanwhile Gardens. They offer pre-vocational and vocational accredited training, work experience and employment support through a three-step programme (skills training, work experience and preparation for move on) for people who are currently unable to access mainstream training and employment services due to mental ill health.
Courses include information technology and office skills, practical skills and home maintenance and horticulture and wildlife gardening.

4.10.8.2. Though not funded through the contract, Mind have also developed a trading arm, Many Hands Trading, which provides added value and enhances the work of training service. The service supported 60 users in 2009/10 and like SMART, is well used, popular with users and valued by other professionals

4.10.9. These services are in contrast with, and often function to prepare users for, the job finding service that is now provided by Pure Innovations.

4.10.10. The total contribution from the Royal Borough for these 2 contracts is £541k. Both services operate at capacity, and any reduction in funding may impact on users.

4.10.11. Both these contracts come to an end in March 2011, and officers are currently in the process of developing new specifications for these services. This will help to determine the extent to which savings can be generated through efficiencies, as opposed to reductions in service.

5. The Current Procurement of Mental Health Day and Floating Support Services

5.1. Over the past six months, officers have been working towards a major procurement exercise to deliver a new personalised day and outreach service for mental health service users. The procurement brings together the reorganisation and externalisation of in-house services (5.2), the re-procurement mental health outreach/floating support services (5.3), and the development of personalisation (5.4). Each of these 3 areas is addressed below.

5.2. The Reorganisation and Externalisation of Day Services

5.2.1. This procurement exercise is a continuation of a change process begun in 2008 which was described in an earlier Key Decision Report Key (KD03038, agreed on 14th April 2009).

5.2.2. This report detailed a change process for day services, which drew on national policy and local consultation, and resulted in a range of changes across day services. This was most apparent in the closure of Pembroke Centre and the creation of an Outreach and Bridge-Building Service (ORBBS), but actually saw culture change across all day services, embedding the principles of Person Centred Planning and Recovery (see 2.2.4), and a far greater focus on supporting users to maximise their life opportunities and personal aspirations, rather than just helping them to manage their mental health problems.

5.2.3. The ORBBS offers users a flexible range of 1-1 interventions, supporting users in the community, rather than depending on them to attend a building based day centre (which it was known from consultation that many users did not want). It works to identify what users want to achieve, and to support them in accessing opportunities for support across the whole range of community services, rather than just within specialist Mental Health provision. This parallels the service being offered by the Oremi service to BME users through their day and outreach services.

5.2.4. At the same time, the day centres provided by Oremi and at the Grove have continued to offer drop-in space for those users for whom having somewhere to go, to meet other users, to engage in purposeful activity and to get support from staff is important.

5.2.5. A key driver for the changes was that by offering this more flexible range of services, users who were not engaging with day services would be able to get support (particularly younger users, women

and users from BME communities). Analysis of current patterns of service use shows that this does seem to be the case.

5.2.6. Since it's inception in September 2009, the ORBBS service has supported 91 users and has a current caseload of 70 users. These are made up of:

- 31% BME users
- 27% users under 40 years old (compared with just 7% of the Pembroke Centre population)
- 41% female users. This is an improvement, but may need more work.

5.2.7. Oremi is supporting 141 users through its day and outreach services, of which:

- 31% are under 35
- 45% are female
- (100% users are from BME communities)

5.2.8. Overall, day services supported 680 users in 2009/10, compared with 600 in 2008/09.

5.3. Floating Support

5.3.1. Having extended the range of day services functions to include the delivery of outreach and Bridge Building, it is a natural next step to also include the support to users in their homes (floating support) that is currently delivered through the separate contracts with Hestia and Notting Hill Housing Trust.

5.3.2. Practice has shown that there are overlaps between the functions of outreach, bridge-building, floating support (and befriending), and that the skills required for these different services are broadly similar. There are evident benefits to users and services in bringing these functions together, not least because a user who needs these different elements of support will no longer need to be referred to 2-3 different services to get them.

5.3.3. The planned procurement therefore seeks to bring services together, reducing what is currently six separate services into a single new contract (see **Appendix 1**).

5.4. Personalisation

5.4.1. The planned procurement is also closely linked to (and intended to facilitate) the introduction of Personal Budgets (PBs) for mental health service users.

5.4.2. Further details of the existing service configuration and the proposed new day and outreach service are given in **Appendix 1**, together with the rationale for change, procurement assumptions and a summary of anticipated benefits.

5.4.3. In order to illustrate how the new service would work with users, **Appendix 2** provides some examples of how the service might help. These are illustrative, rather than actual cases, though elements are drawn from real cases.

5.5. In terms of timescale, it is hoped that the tender will go out in December 2010, with a view to the new service being operational in July/August 2011.

6. Savings

6.1. Day services have been subject to savings associated with change and reorganisation over a number of years. St Lukes, Denbigh and Pembroke centres have been closed, and since 2005 savings of £156k have been made.

6.2. In terms of further financial efficiencies, a number of areas for savings from day care have been identified through the Cost Challenge process. Aside from the procurement itself, potential efficiency savings of £86k have been identified as follows:

- 28k from changes to the provision of meals
- 19k from changes to funding of Oremi Westminster
- 39k from reductions in controllable costs budgets

6.3. For the purposes of the procurement, and in order to understand the impact of changing the resources available for the newly procured services, a model was developed which allowed an estimate of the staff hours and hours of direct work with users that particular levels of savings would allow.

6.4. Though the modelling is imprecise, and the actual levels of service delivery will vary depending on how the new provider deploys the resources, what it indicates is presented as part of the options in section 7 below.

6.5. As indicated in section 10, legal advice is that TUPE is likely to apply to this procurement. Though this might be seen as limiting the opportunities for savings through the process, comparison of average salaries for day centre officers in in-house services (£29,953) and the average salaries for equivalent workers in current voluntary sector providers (£29,464) shows a relatively small difference of £489 per anum. For the staffing arrangements

proposed in option B (see 7.3) this would amount to a difference of £9000 pa, and for option C (see 7.4), £7,700 pa.

7. Options

7.1. The procurement described in 5 above has been the focus of work and represents the officers preferred option. However, in the current economic climate, it was considered prudent to develop a range of alternatives, with their respective savings, benefits and challenges/risks.

7.2. Option A

Service Configuration
To leave arrangements as they are. In practice this would mean: • Continuing to provide the existing in-house services. • Continuing to commission two externally-provided outreach/ floating support services, both of which would need to re-procured within the next 6 months as the contracts are coming to an end. This option does not facilitate the introduction of Personal Budgets.
Level of Savings
£86k This represents is 5.7% of the current total spend on these services (£1,500k), and 3.8% of total day care spend (£2239k)
Detail of Savings
As described in 6.2
Service Levels
As now
Benefits
• Minimises disruption for current users of service, maintaining existing services and relationships • Preserves current levels of service
Challenges/Risks
• Delivers low levels of savings • Does not secure experienced providers for in-house provision • No economies of scale. • Does not offers users a personalised service, or increased

choice and control
- Does not properly mirror and join up services with the Mental Health Trust in line with their modernisation process.
- Perpetuates the problems of fragmentation and duplication that arise when a single package of day and outreach services is delivered by two or more providers.
- Constrains providers from deploying staff flexibly

Equalities Impact

- Preserves the work started through the Day Services reorganisation, delivering better support to users who are younger, female and from BME groups
- Facilitates the continuation of current specialist BME provision (Oremi)
- The variety of building-based and outreach support offers a service that is more able to respond flexibly to issues of access by disabled users.

7.3. **Option B**

Service Configuration

To proceed with the planned procurement, creating a single contract, offering a range of drop-in (building based) support, outreach, bridge-building and home-support, including a specialist outreach service and day centre for BME users. Personalisation would be taken forward.

In order deliver the required savings it is proposed that the currently provided befriending scheme is ended, and staff offered redundancy or redeployment.
The Befriending Scheme (BFS) comprises 2.4 FTE equivalent staff, and recruits and trains volunteers who are then linked with mental health users who are isolated in the community.
The level of service provided will fluctuate over the course of a year, depending on the numbers of trained volunteers available, but is currently delivering 23 befriending sessions per week.
The service has a very high unit cost, estimated at £55 per 2 hour session), and this is based on a significantly higher level of activity than currently provided. An additional post was added to the service in June 2009, on the basis that this would enable a higher level of activity, but this has not been delivered.
Modelling suggests that ending this service, and focusing resources on staff working directly with users will provide 14 additional hours of direct work with users per week, and an increase of 27 in overall caseload.

Level of Savings
£200k With £86k of other savings (see 6.2), this totals £286k, which is 19.1% of the current total spend on these services (£1500k), and 12.7% of total day care spend (£2239k).
Detail of Savings
A staff reduction of 5.34 FTE posts, 3.76 (amounting to £156k) from reductions in in-house staff, and the equivalent of 1.57 staff (£44k) delivered through reducing the budget available for the new service. The in-house staff reductions would comprise: • 2.4 FTE posts from the Befriending Scheme (see above) • 1 FTE post on a fixed term contract. This is the current manager of the ORBBS, the Grove and Befriending Scheme, and is a temporary appointment to oversee the development of these services up to externalisation. • 0.36 FTE vacant posts There may be redundancy costs associated with the posts with in the Befriending Scheme.
Service Levels
Modelling suggests that with more efficient deployment of staff and more user focused staff time, a similar level of support (to that provided currently) could be offered (607 hours of direct work with users per week, compared with 599 currently). The service would be able to manage a caseload of up to 491 clients at any one time (compared with around 500 currently). It is difficult to estimate the numbers of users supported, as this will depend on the number of hours individual users require, but if the average of 1-1 work is 3 hours per week, around 355 people could receive a service each week. Service levels would therefore be comparable with those currently provided, and the impact on service users, apart from those supported through the befriending scheme, would be minimal. The service would have the capacity to offer the small number of current clients of the befriending scheme alternative means of support (through the ORBBS service, or through the development of a more costs effective volunteer scheme).
Benefits
• Can deliver significant savings while maintaining the level of service provided • Creates economies of scale by replacing six small services with a single provider service • Offers users a more personalised service so improving individual outcomes and increasing choice and control.

• Creates a service which is holistic and joined up with the Mental Health Trust, and removes the problems of fragmentation and duplication that arise when a single package of day and outreach services is delivered by two or more providers. • Embeds the recovery approach and reduces the number of people receiving long term support. • Ensures the survival of essential services by the provider some financial security whilst also exerting strong pressure on them to deliver the sort of services users need and want. • Enables the provider to deploy staff flexibly, working wherever they are needed rather than in a particular location, so facilitating the move away from a centre-based service.
Challenges/Risks
• Is a significant change to the organisation of services, which will raise concern from users, some of whom will experience this as a closure/loss of services. • The closure of the befriending service would impact directly on current users of the service.
Equalities Impact
• Preserves the work started through the Day Services reorganisation, delivering better support to users who are younger, female and from BME groups • Facilitates the continuation of current specialist BME provision (Oremi) • The variety of building-based and outreach support offers a service that is more able to respond flexibly to issues of access by disabled users.

7.4. **Option C**

Service Configuration
To proceed with the planned procurement, but with a higher level of savings. This would still allow the creation of a single contract, offering a range of drop-in (building based) support, outreach, bridge-building and home-support, including a specialist outreach service and day centre for BME users. Personalisation would be taken forward. As described in option B above, and for the same reasons, it is proposed that the currently provided befriending scheme is ended, and staff offered redundancy or redeployment. For this option, modelling suggests that ending this service, and focusing resources on staff working directly with users will provide

20 additional hours of direct work with users per week, and an increase of 33 in overall caseload.

Level of Savings

£350k

With £86k of other savings (see 6.2), this totals £436k, which is 29.1% of the current total spend on these services (£1500k), and 19.5% of total day care spend (£2239k)

Detail of Savings

A staff reduction of 10.33 FTE posts, 6.59 (amounting to £246k) from reductions in in-house staff, and the equivalent of 3.74 staff (£104k) delivered through reducing the budget available for the new service.

The in-house staff reductions would comprise:

- 2.4 FTE posts from the Befriending Scheme
- 3.83 posts on fixed term contracts. This would include (as in option B), the current manager of the ORBBS, the Grove and Befriending Scheme, 2 ORBBS workers and 1 day centre officer from the Grove.
- .36 vacant posts

There may be redundancy costs associated with the posts with in the Befriending Scheme.

Service Levels

Modelling suggests that the resulting services could deliver 501 hours of direct work with users per week, (98 fewer hours than currently)

The service would be able to manage a caseload of up to 402 clients at any one time (compared with around 500 currently).

It is difficult to estimate the numbers of users supported, as this will depend on the number of hours individual users require, but if the average of 1-1 work is 3 hours per week, around 319 people could receive a service each week.

Service levels would therefore be 16% less than those currently provided, and there would potentially be some impact on current service users. The model will ensure the continuation of all the currently provided service apart from the Befriending Scheme, including the day centres at Oremi and the Grove, the outreach and bridge building services provided through Oremi and the ORBB service, and the support to people in their homes currently provided by Hestia and Notting Hill Housing Trust, but there will inevitably be a reduction in the overall volume of service available.

In practice this is likely to mean that most people will be able to continue to receive the kinds of support that they are currently

getting, but some may not get as much. And it will be necessary to be much clearer about whether people really need the services that they are getting, and to help people to move on from services that they longer need.

The service would need to offer the small number of current clients of the befriending scheme alternative means of support (through the ORBBS service, or through the development of a more cost effective volunteer scheme).

Benefits

- Delivers higher levels of savings than options A or B.
- Creates economies of scale by replacing six small services with a single provider service
- Offers users a more personalised service so improving individual outcomes and increasing choice and control.
- Creates a service which is holistic and joined up with the Mental Health Trust, and removes the problems of fragmentation and duplication that arise when a single package of day and outreach services is delivered by two or more providers.
- Embeds the recovery approach and reduces the number of people receiving long term support.
- Ensures the survival of essential services by offering the provider some financial security whilst also exerting strong pressure on them to deliver the sort of services users need and want.
- Enables the provider to deploy staff flexibly, working wherever they are needed rather than in a particular location, so facilitating the move away from a centre-based service.

Challenges/Risks

- Requires a significant reduction in resources available and consequent reduction in level of service provided. A reduction of 10.33 FTE staff reduces the capacity of the services (in terms of direct support hours to users) by 16%. In particular the befriending service would be closed which would impact directly on current users of the service.
- May increase the risk of legal challenge to the Council on the grounds of failing to meet statutory duties.
- Would generate high levels of concern and protest from users, carers and other partners in MH service provision
- May increase the need for and expenditure on specialist supported accommodation and residential care.
- May contribute to increases in delayed discharge from hospital as specialist accommodation gets silted up, and an increase in users being placed in unsafe temporary accommodation.
- May contribute to increases in admissions to hospital, which

could impact on partnerships with the Mental Health Trust and NHS K&C. • The decrease in the capacity of the service to deliver home support may result in an increased demand for domiciliary care • Remaining services like SMART or Mind could also be subject to increased demand • There may be an increased risk of untoward incidents in the community, and community safety issues
Equalities Impact
Bearing in mind the reduced capacity of services overall: • Preserves the work started through the Day Services reorganisation, delivering better support to users who are younger, female and from BME groups • Facilitates the continuation of current specialist BME provision (Oremi) • The variety of building-based and outreach support offers a service that is more able to respond flexibly to issues of access by disabled users.

7.5. **Option D**

Service Configuration
To close down all existing mental health day and outreach services and cease to provide or commission these services. Users would be able to access remaining contracted services, like SMART and MIND, homecare and meals on wheels. Personal budgets would not be available. Though a small number of users might be able to access non-mental health specialist day services, it is unlikely that these could adequately meet the specialist needs of the majority, and will not offer a real alternative.
Level of Savings
£1.500m £1.134m – in house day care £366k – External Contracts This represents 15.8% of the current total 2010/11 budget for Mental Health Services of £9,478k
Detail of Savings
All staff would be made redundant (24.7 FTE)
Service Levels
There would be no service provided.
Benefits

• Delivers high levels of savings
Challenges/Risks
• Requires a severe reduction in resources and consequent reduction in services. • Will severely increase the risk of legal challenge to the Council on the grounds of failing to meet statutory duties. • Would generate very high levels of concern and protest from users, carers and other partners in MH service provision • Will increase the need for and expenditure on specialist supported accommodation and residential care. • Will increase delayed discharge from hospital as specialist accommodation gets silted up, and an increase in users being placed in unsafe temporary accommodation. • Will contribute to increases in admissions to hospital, which would impact negatively on partnerships with the Mental Health Trust and NHS K&C. • The capacity of the service to deliver home support would disappear, with a consequent high demand for domiciliary care • Remaining services like SMART or Mind would be overwhelmed. • There would be increased risk of untoward incidents in the community, and community safety issues • Would require high levels of redundancy, with associated costs.
Equalities Impact
• Such a major reduction in services for this disadvantaged group would impact in all areas of equality, though all groups are equally disadvantaged. • All specialist BME provision would be lost, impacting specifically on BME users.

8. Consultation

8.1. In terms of the proposed model described in 5 above, consultation has been carried out with staff within current services, service users, and other stakeholders. A specific user reference group has been established, comprising user's representatives from the Service User Network (SUN) and the K&C Link.

8.2. To date the focus has been on the model and specification for services, and further meetings to consult on the recommended levels of savings will take place during November and December 2010, in order to inform the final key decision report.

9. Financial Implications

The financial implications of the options are set out within the main body of the report.

10. Legal Implications

10.1. Subject to detailed consideration of all the facts of the potential transfer it is likely that TUPE will apply to the project. Any changes to terms and conditions will need either to be for a reason unconnected with the transfer or for a genuine Economic, Technical & Organisational (ETO) reason entailing changes in the workforce in order to be effective and/or connected dismissals not unfair.

10.2. The procurement process and assessment methodology used to tender the new day and outreach service would be conducted in compliance with the EU Procurement Regulations and the Council's Procurement Code of Practise and Contract Regulations.

10.3. Where the options described in 7 involve the transfer of existing staff under TUPE regulations (Options B & C), consideration has been given to implications of the statutory Code of Practice on Workforce Matters – often referred to as the "Two Tier Workforce Code". A two-tier workforce is created when workers transfer from the public sector to the private sector and are joined by new recruits with different pay and conditions. The purpose of the Code is to prevent this situation from arising by requiring that new recruits must be offered pay and conditions that are "overall, no less favourable" than those of former public sector staff. Local authorities are required to include the terms of the Code within any contract involving a TUPE transfer and to ensure the terms are upheld.

10.4. The Director of Legal Services is of the view that with regard to the procurement that would take place under Options B & C, the Council may be justified in departing from the above guidance provided that the Council has due regard to it but considers that in all the circumstances that there are sound and legally relevant reasons for departing from it. In this case officers are of the view that such a departure is justified on the grounds that:

10.4.1. The service procured would, from the outset, include former Council employees alongside former voluntary sector staff, who would also be protected under TUPE. On this basis it would incorporate at least two (and potentially three) different sets of pay and conditions, making the provisions of the Two Tier Workforce Code impracticable to implement in an effective and economic manner.

10.4.2. More fundamentally, the duty on local authorities to have regard to the Code came into being over ten years ago, under the Local Government Act 1999. We are now working in a very different economic climate in which the underlying premise, that best value cannot be delivered through a two tier workforce, is outweighed by the Council's duty to balance its budget in the context of the CSR and its general fiduciary duty to its Council Tax payers.

10.5. On this basis there are grounds for the Council to depart from the Code and to allow contractors to set pay and conditions for new recruits as they see fit, in order to deliver the best possible value for money.

11. Personnel Implications

11.1. With the procurement of a new day and/or outreach service (Options B & C), depending on the option, different groups of staff in the existing in-house and external services detailed in Appendix 1 would transfer to the new contractor under TUPE regulations. The employees and trade unions would be consulted prior to the transfer taking place and the transfer would be conducted in accordance with the Council's Personnel policy and procedures.

11.2. Likewise in respect of the possible redundancy of the 2.4 FTE staff in the Befriending Service. Consultation with the affected employees and trade unions would be conducted in accordance with the Council's policy on Redundancy and Redeployment.

12. Equalities Implications

12.1. An initial assessment has been included as part of the separate options, but a full equalities impact assessment is being carried out in order to assess the impact of the recommended level of savings, and will be included as part of the final key decision report.

13. Recommendation(s)

13.1. I recommend that officers proceed with the proposal described as Option C, as detailed in section 7.4, specifically:

- To proceed with the staff changes
- To commence the procurement
- To deliver the savings

Stella Baillie
Head of Adult Social Care

Jean Daintith
Executive Director of Health, Housing & Adult Social Care Services

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FOR COMPLETION BY AUTHOR OF REPORT:

Date of first appearance in Forward Plan: [17 (view Forward Plan for this date)]

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Contact officer: Toby Dickinson, Mental health Services **Tel:** 02073612517 **E-mail:** toby.dickinson@rbkc.gov.uk

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Report circulated to: [25] on [26]

Appendix 1:

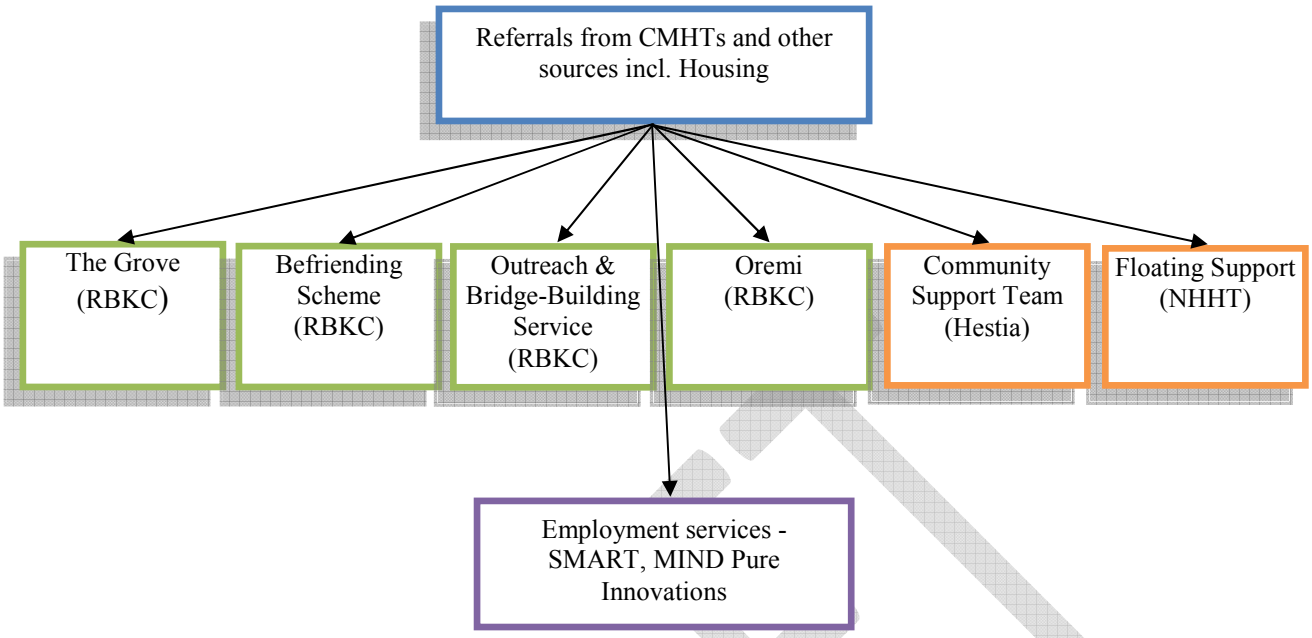
PROPOSED PROCUREMENT OF A NEW MENTAL HEALTH DAY AND OUTREACH SERVICE

This new service is intended to replace a number of standalone services (some Council-run and two externally commissioned) with a new, integrated model of day and outreach support. It will be delivered by a single external provider, offering a range of flexible inputs and activities with the overall aims of promoting recovery, independence and social inclusion.

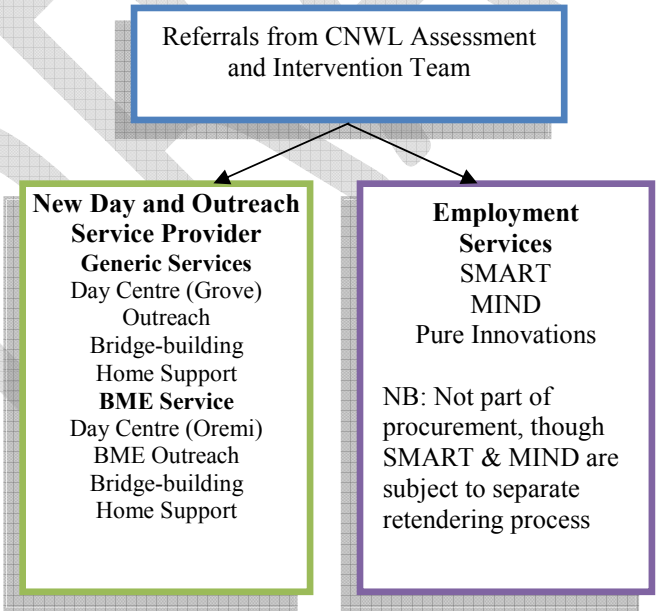
This procurement is driven by a number of different factors, all of which need to be addressed fairly urgently. In particular there is a need to:

- Take account of the worsening financial climate and the need to deliver "more for less" – generating savings while supporting more people to achieve better outcomes.
- Adopt a more personalised and person-centred approach and as part of this, to move away from a building-based model to one where support is provided in a wide range of community venues.
- Embed the principle of recovery throughout the service and adopt ways of working that reflect this, so helping more users to access mainstream employment, training and other activities outside of ASC.
- Strengthen our focus on user outcomes, leaving providers with scope and flexibility about how services are organised.
- Develop a service model which supports the implementation of personal budgets for mental health service users
- Improve integration between social care services and secondary care community mental health services.
- Ensure a consistent approach to assessing eligibility for social care under FACS and to offering appropriate services to meet assessed need.
- Attract and support a wider range (and larger numbers) of people with significant mental health needs and to cater better to under-represented groups

Current Service Configuration



New Service Configuration



Procurement assumptions

The selected contractor will deliver the full range of day, outreach, bridge-building and home support functions. Partnership bids will be encouraged so that the provider is able to offer the specialist experience and

knowledge necessary to deliver the BME specific services required in the specification.

The provider will be contracted to deliver a core volume of service, expressed as an average number of direct contact hours per week at an agreed hourly rate. In addition, they will be required to deliver further hours of service subject to demand. The contract will include the capacity to reduce the number of core hours year on year if required.

Service Model

Key features are as follows:

- A single point of referral via the new CNWL Access and Intervention Team.
- Holistic, multi-disciplinary assessment undertaken by this team, incorporating assessment under Fair Access to Care Services (FACS) criteria. Day and outreach support (where needed) is therefore integral to a user's overall statutory care plan and monitored through CPA.
- The day and outreach service is delivered in two distinct phases:
  a) an initial reablement phase for all new users – intensive work to maximise independence and link people in wherever possible to mainstream activities and services
  b) if user is still FACS eligible following 3 months reablement, a personal budget (PB) is allocated and used to pay for a further period of support (see below for timescales).
- Most PBs do *not* involve a direct payment to the service user. Instead they are managed by the day and outreach service provider as Individual Service Funds (ISFs).
- Users select from a wide menu of costed activities and inputs which are charged against their ISF.
- Direct payments available where an activity that would promote a service user's recovery is not on the menu offered by the day and outreach provider (or available more cheaply from another source).
- Personal budgets are agreed on a fixed term basis (max 12 months but often for shorter periods) and can only continue if agreed necessary at a subsequent CPA.

Expected benefits

The model and procurement approach together are designed to:

- Create economies of scale by replacing six small services with a single provider service
- Offer users a more personalised service – so improving individual outcomes.

- Introduce personal budgets in a way which delivers real choice and control to service users
- Minimise administrative costs associated with direct payments.
- Create a service which is holistic and joined up, removing the problems of fragmentation and duplication that arise when a single package of day and outreach services is delivered by two or more providers, also joining up effectively with CNWL.
- Embed the recovery approach and reduce the number of people receiving long term support.
- Ensure the survival of essential services by offering providers some financial security whilst also exerting strong pressure on them to deliver the sort of services users need and want.
- Enable the provider to deploy staff flexibly, working wherever they are needed rather than in a particular location, so facilitating the move away from wholly centre-based provision.

Appendix 2: How the Service will Help

1. Re-ablement

Client A has severe mental illness but has been living in the community for some time, in their own accommodation and managing part-time employment. As a result of deterioration in his mental health, he has run up debt, there have been concerns from neighbours about noise and the state of his accommodation and he has lost his job.

The service, working in partnership with the lead professional in secondary care, provides 1-1 support with managing finance and access to specialist debt advice services, and with re-establishing a routine for management of his accommodation (help with shopping, cleaning). They liaise with the landlord in relation to the concerns of neighbours, and support him in accessing employment support services.

After 3 months of intense work, he has control over his debt, is managing his accommodation again and engaged with employment support services who are helping him to find alternative employment. He continues to be supported through secondary care, and the case is closed to the Day and Outreach service.

2. Longer Term Support

Client B is a 49 year old woman with a history of chronic depression and alcohol use. She has had employment in the past, but has not worked for many years. She is lives in low support specialist mental health supported accommodation, but is at risk of losing this because of alcohol related anti-social behaviour. She is keen to avoid this and wants to address her alcohol use, but anxious about engaging with specialist detox services.

The service, working in partnership with her dual diagnosis worker support, accompany her to the detox service. They offer person centred planning and through this identify help with retaining her accommodation, improving her financial situation, her physical health and access to further education as areas where she would like support. They help to liaise with the accommodation provider to reduce the risk of losing the accommodation. They signpost to specialist income maximisation and debt advice services, and assist in applications for grants, one of which is to secure a bike to improve her physical fitness. They negotiate with the local college to agree a support package for her, which includes extra time in completing assignments, additional tutorial time, and on occasion a worker present in lectures to assist with note taking because she has intermittent difficulties in concentrating.

After 3 months she is assessed as needing continued support, and completes the process to establish her personal budget. This is managed as an individual service fund on her behalf by the service, and she chooses to purchase continued support hours from the Outreach and Bridge building element of the service.

Client C is a 30 year old black male referred from secondary care after a compulsory admission to hospital having experienced a psychotic episode and a serious suicide attempt. He has a long history of mental health crises, usually preceded by withdrawal from friends and family and disengagement from mental health services, which usually results in compulsory admission. He is very isolated, has low motivation and is highly suspicious of statutory services, which means he has difficulty in keeping appointments.

Working closely with the care coordinator in secondary care, the service offers BME specialist outreach, and spends 3 months working to engage with him and develop some trust in the service. Once this relationship is established, they support and encourage him to maintain links with secondary care, and to engage in his treatment programme. They also support him in accessing the centre based service, which provides opportunities for activities and peer support and reduce his isolation.

After 3 months he is assessed as needing continued support, and completes the process to establish his personal budget, which is managed as an individual service fund on his behalf by the service. He chooses to purchase continued outreach support, and regular use of the day centre. His pattern of breakdown and admission is reduced, and he is supported though person centred approaches to identify what recovery would mean for him. He is interested in employment, and the service supports him in accessing the specialist supported employment service provided by MIND as a first step.