Equality Impact Assessment – Mental Health Day Services

1. Introduction

This paper outlines the actions undertaken to identify and assess the potential impact of the proposals around modernising day services. The lead person for this equality impact assessment was John Lennon. Members of the assessment team were : Richard Graham, Kim Adams, Iola Shaw and Julie Bootle. The process included engagement with a range of stakeholders - service users, potential service users, staff, council members, voluntary sector organisations, health partners. This information has then informed this assessment.

2. Overview

Public sector bodies are required to consider the impact of changes to policy and spending on equality characteristics. These equality considerations do not preclude cuts or changes in services being made, but do require that these be fully understood, both at an individual decision level, as well as corporately.

Leeds City Council like many other public sector organisations is facing a significant financial challenge as a result of the government's spending review and a reduction in grants, which is without precedent in recent times. In addition to the substantial reduction in government funding, the council also faces significant cost pressures which will also need to be taken into account in setting budgets for the next four years. It is therefore imperative that we ensure that any services we provide are both effective in the terms of the resources required to provide the services, and efficient in terms of producing high quality outcomes for as wide a range of the population of Leeds as possible.

3. Scope

This assessment seeks to analyse the impact of the proposed reconfiguration of in house provided mental health day services on equality characteristics. If the proposals are approved by Executive Board a further impact assessment will be conducted regarding the citywide model of service as part of the recommissioning process. The assessment considers relevant equality characteristics, looking at factual data collected by, Leeds City Council Adult Social Care, NHS Leeds, Leeds Partnerships NHS Foundation Trust (specialist mental health trust) and voluntary sector organisations.

The assessment also takes into account comments, opinions and views from a range of stakeholders including service users, staff, management, other service providers, health providers and commissioners and the public. This information has been analysed by the assessment team to provide an evidence based assessment of potential impacts and identifies actions that may be taken to mitigate these impact should the decision be made to reconfigure this service.

4. Fact Finding – What do we already know?

4.1 Demographics

4.1.1 Leeds. Leeds is the second largest metropolitan district in England with an estimated population in excess of 750,000 people. Whilst the Leeds economy as a whole, has been a success story, Leeds has a significant amount of deprivation. Five wards in the city have more than half their super output areas (subdivisions of wards)

in the 10 per cent most deprived in England. These five wards tend to have the highest levels of deprivation, proportion of people on unemployment benefits and proportion of households in receipt of council benefits.

Like many other cities in the UK, Leeds is now facing unprecedented change and uncertainty. The University of Leeds predicts that by 2026 the total number of people living in the Leeds local authority area will be 830,000. This will include larger numbers of people from ethnic minorities and higher numbers of younger people as well as an increase in people aged 75 and over. In general people are living longer and there are as many people over 60 as under 16. Although the rate of increase in the proportion of older citizens in Leeds is not likely to be as great as in some neighbouring authorities, it is predicted that the number of people in Leeds aged 65 and over will rise by almost 40 per cent to 153,600 in 2031, around 20 per cent of the population.

In particular:

- Leeds has a significantly higher proportion of 15 to 29 year olds (26 per cent compared to the national average approaching 20 per cent);

- there is a significant student population of over 60,000 studying in the two universities in the city;

- Stonewall estimates that a large city such as Leeds with an established gay scene may be made up of at least 10% lesbian, gay and bisexual people;

- Leeds population broken down by religion or belief is 69.9% Christians, 3% Muslims, 1.1% Sikh. 1.2% Jewish, 0.6% Hindu, 0.2% Buddhist and 24.9% no religion or not stated;

- Leeds is now home to over 130 different nationalities;

- in 2006 the Office for National Statistics (ONS) estimated that 15.1% of the total resident population comprised people from black and minority ethnic communities (including Irish and other white populations), a rise of 5 per cent from the 2001 census; and

- by 2030 the black and minority ethnic population in Leeds is estimated to increase by 55 per cent.

4.1.2. Mental Health Needs. Mental health problems are common. Around one in six adults suffer from a common mental health problem such as anxiety or depression. Nationally 29% of women and 17% of men will suffer some form of mental health problem during their lives; 1 in 4 women and 1 in 10 men will experience an episode of a depressive illness; self harm prevalence stands at 400 per 100,000 population. One in ten mothers suffer from post natal depression. Lesbian, gay and bisexual people are more likely to experience mental health problems than heterosexual people, with bisexual people also more likely to experience mental health problems than lesbian and gay people. Mental ill health

occupies approximately one third of GP time. Ninety per cent of people with common mental health problems are managed entirely within primary care.

Leeds Partnerships NHS Foundation Trust saw 21,264 people last year. 5784 of these were on CPA (Care Programme Approach[1]).

Leeds City Council mental health day services support 939 service users. 43% of these service users access the Community Alternatives Team, a service which provides community based support. 57% of service users access services provided by the buildings based day centres but these centres also offer community support so the actual percentage of people accessing day centre based services is lower than this.

4.1.3. Service Provision – Mental Health Day Services

There are a number of voluntary sector organisations offering day support in addition to the council run provision. This is also a mix of buildings based and community support. There are a small but growing number of individuals with FACS eligible needs who are opting for a personal budget rather than a referral to day services.

4.1.4. Leeds City Council Day Services.

From an equality perspective a survey of day service usage conducted in October 2010 completed by 281 LCC day service users and 362 voluntary sector service users revealed the following information:

Demographics of Day Service Users

Gender

	LCC Day Centre (%)	**LCC CAT (%)**	**Voluntary Sector (%)**
Male	53	57	
Female	47	42	
Not stated		1	100

Age Profile

Age	**LCC Day Centre (%)**	**LCC CAT (%)**	**Voluntary Sector (%)**
19-24	0	<1	6
25-34	0	7	14
35-44	19	24	20
45-54	39	37	28
55-64	22	11	16
65-74	12	7	10
75+	<1	0.0	6

[1] CPA – a care management approach used with people with complex mental health problems who are in receipt of a number of supports to help co-ordinate that support.

Ethnicity

	LCC Day Centre (%)	LCC CAT (%)	Voluntary Sector (%)
Didn't want to say	4.9	3.2	
White British	81.7	88.7	52
White Other	1.2	4.8	
W/B Carribean	1.2	0.0	
W/B African	0.0	0.0	
W/Asian	1.6	0.0	
Other mixed	0.0	0.0	
Indian	3.7	0.0	
Pakistani	3.7	0.0	
Other asian	0.4	0.0	
Carribean	0.8	1.6	
Other Black	0.4	1.6	
Chinese	0.4	0.0	

Users who described themselves as registered disabled

	LCC Day Centre (%)	LCC CAT (%)	Voluntary Sector (%)
Registered disabled	58	37	29

Ethnicity

	LCC Day Centre (%)	LCC CAT (%)	Voluntary Sector (%)
Heterosexual	75	80	95
Lesbian	1	0	1
Gay	2	3	1
Bisexual	1	3	2
Other	<1	0	1
Didn't want to say	20	13	

4.2 Consultation

4.2.1. In considering the options around the future direction of the mental health day services the council conducted a four year project known locally as i3. 'i3' was an extensive service user, carer, council, NHS, independent and voluntary sector consultative project, which was conducted between 2005 and 2009. The outcome of this project was strongly influenced by recent national policy drivers, including Department of Health guidance, encapsulated in New Horizons and Putting People First. The external commentary on this project, conducted by National Development Unit for social inclusion is attached at appendix one.

Subsequent consultation involving service users and providers has been undertaken by Adult Social Care and Health Commissioners around developing an outcomes framework for day services.

These proposals were based around this consultation.

In considering the impact of the proposal to reconfigure in house services concentrating resource on a single buildings base and an enhanced community team the department has received representation from a range of stakeholders including staff, current service users, carers, referrers, other providers and interested parties. The consultation activities around this included:

Meeting with full staff team
Meeting with approx. 150 day centre users in City Centre Location
Meeting between Chief Officer and service users at the Vale
Written representations both directly to Officers and via Councillors from service users

4.2.4 Staff. Senior management met with the managers and deputies of services in December to outline the proposal being put forward. The Lead Member for Adult Social Care has since met with the wider staff group to discuss the proposals and offer staff the opportunity to ask questions and voice concerns. There has also been a further meeting with service managers and deputies to consider the impact of implementing the proposed changes. This is summarised and appended to this report at appendix two.

4.2.5 Service Users. Since the proposal to reconfigure services entered the public domain in December 2010, there have been a number of representations from current centre users. A meeting was held which was attended by approx. 150 service users, predominantly from the centre based services. Service user views have been captured and responded to this is summarised and appended to this report at appendix 3.

4.2.6 Carers. Carers were involved in i3. A number of carers attended the service user meeting and others have made representations to Officers involved in this impact assessment.

4.3 Workforce Profile

Gender	Number	% of Cohort	Directorate Profile
Female	28	62%	84%
Male	17	38%	16%
Total	45	100%	100%

Disability	Number	% of Cohort	Directorate Profile
Disabled	5	11%	8%
Non Disabled	40	89%	92%
Total	45	100%	100%

Age	Number	% of Cohort	Directorate

			Profile
16-21	0	0%	0%
22-30	3	7%	9%
31-40	6	13%	18%
41-50	17	37%	35%
51-60	14	32%	33%
61-65	5	11%	5%
Over 65	0	0%	0%
Total	45	100%	100%

Ethnic Origin	Number	% of Cohort	Directorate Profile
BME	5	11%	9%
Non BME	38	85%	89%
Not Specified	2	4%	2%
Total	45	100%	100%

Religion	Number	% of Cohort	Directorate Profile
No Religion	8	18%	10%
Christian	5	11%	24.7%
Buddhist	1	2%	0.1%
Hindu	0	0%	0.1%
Muslim	0	0%	0.6%
Jewish	0	0%	0.1%
Other Religion	0	0%	0.1%
Sikh	0	0%	0.3%
None Specified	31	69%	64%
Total	45	100%	100%

Sexual Orientation	Number	%of Cohort	Directorate Profile
Bisexual	0	0%	0.1%
Gay Man	0	0%	0.5%
Heterosexual	5	11%	21%
Lesbian	1	2%	0.4%
Not Specified	39	87%	78%
Total	45	100%	100%

5. Overview of Fact Finding

From the evidence considered:

1) There are a number of voluntary sector organisations which also provide a mix of centre based and community support across Leeds.

2) Demographically younger people are under-represented in all day services but particularly so in the in house centre based services.

3) The number of people being supported from BME communities is significantly higher in the voluntary sector. However, two of the services in the sector are commissioned to support people from BME communities. Removing this data shows that 20% of service users were for people from BME communities.

4) There is a high percentage of service users who are registered disabled accessing all day services but this is particularly pronounced in the in house centre based services.

5) The consultation around i3 recognised that those who used day centres valued the support that they received but the general consensus was that whilst people wished to retain some buildings based support they wanted to see a shift with less dependence on centres and a broader range of community options.

6) Carers concerns have largely centred around a misconception that centre based support would be replaced by one to one support in the service user's home which would not allow them to have a break.

6. Equality Considerations

Equality characteristics

X	Age	X	Carers	X	Disability
X	Gender reassignment	X	Race	X	Religion or Belief
X	Sex (male or female)	X	Sexual orientation		
X	Other				

Stakeholders

X	Services users	X	Employees	X	Trade Unions
X	Partners	X	Members	X	Suppliers
x	Other please specify - referrers				

Potential barriers

x	Built environment	x	Location of premises and services
X	Information and communication	X	Customer care
X	Timing	X	Stereotypes and assumptions
X	Cost	X	Consultation and involvement

7. Potential Issues Identified

Because the proposal is to develop a breadth of flexible services to meet a range of needs, including retaining some buildings based support in both in house and voluntary sector services there were no issues identified that could not be accommodated within the proposal.

In house day centres had a particularly high percentage of service users that were registered disabled but the community based services also offer support to high percentages of service users who are registered disabled.

Carers had a particular concern that centre based support would be replaced by one to one support in the service user's home which would not allow them to have a break. This is not the proposal. There are a range of support options being proposed to meet service users' individual needs. Carers made several suggestions of alternative provision that could meet the needs of the individuals they care for. All of these suggestions were possibilities within the new model.

8. Potential Impacts from Reconfiguring the Service

There are no negative impacts identified that will disproportionately impact on any specific service user groups.

There is a potential positive impact for people under the age of 35 as the broadening of community support allows for the development of appropriate services.

9. Action Plan to Ensure Mitigation is in place

The proposal to reconfigure services includes broadening the range of community support available to people and increasing access to employment support and access into education. It is believed the new model will be of greater benefit to a wider age range of service users.

Appendix One

An External Commentary on the Leeds i3 Initiative

1. Introduction

1.1 This report on the Leeds i3 Project has been commissioned from the National Development Team for Inclusion (NDTi)[2] by the i3 Project Board (which is a multi-agency board chaired by Leeds PCT). Its purpose is to provide an external commentary of the progress achieved through the i3 Project and the issues that this raises for the future development of day services for people with mental health problems in Leeds.

1.2 It is important to stress from the outset that this report is **not** a formal evaluation of the Project in any sense nor of the performance of individual services. It has been produced through a review of available written materials and a series of short meetings and other discussions with a number of key stakeholders. Despite these limitations, there are a number of very clear conclusions that can be drawn and thus the authors have confidence in the report's key findings.

1.3 Within the sections of this report, readers will find additional comments *in italics.* These are direct quotes from people we spoke with that help to illustrate the points being made.

2. Background

2.1 The i3 Project is an innovative approach designed to promote better lives for people by addressing the limitations in day services for people with mental health problems that were identified in the Government's Social Exclusion (SEU) Task Unit report[3]. This report formed part of a developing set of national policies that explicitly expected a move away from traditional day

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[2] The NDTi is a not-for-profit develop agency concerned with promoting socially inclusive lives for people at risk of exclusion. We have specific work programmes in mental health and in community inclusion. Our work has involved development support to national governments and local organisations in the development and delivery of the policy underpinning the i3 Project. This report has been prepared by Rob Greig (NDTi Chief Executive) with support from Peter Bates (NDTi Director of Mental Health Programme and Community Inclusion) and Jo Seddon (NDTi Consultant Trainer in Inclusion).

[3] ODPM: Mental Health and Social Exclusion SEU. 2004

services. A summary of this policy framework is attached as Appendix I to this report.

2.2 A number of key stakeholders in the City, believing there was no reason to assume that services in Leeds achieved different outcomes to those described in the SEU report, instigated what became known as the i3 Project (Inspire, Improve, Include)

2.3 i3's key aim was to remodel mental health day service provision by developing a more integrated approach to service delivery based upon four key components:

- A community team performing a 'gatekeeper' function, which by using person centred approaches seeks to promote community capacity building and support people to access a range of mainstream and other options
- Drop-in's that offer direct access and provide social support at times that suit people across the City – some of which could be user run and/or focused on particular needs or groups of people (e.g. minority communities)
- A limited number of building bases to provide safe space and a location for therapeutic interventions – but with a clear linkage to other parts of the service and the intention to use person centred approaches to support people to move on
- An employment team to work city-wide and in particular use the Individual Placement and Support model.

2.4 In practice, the fourth element has never been developed and this is commented upon later in the report in paragraph 6.

2.5 Two years ago, an 'early implementer' initiative in the East/North East area of the City was set up to test out the model developed by i3 stakeholders and to take the work forward at a more rapid pace

2.6 A decision has been taken to close down i3 as a formal stand-alone project with effect from April 1st 2009 – not because it is perceived to have failed in any sense, but because its life as a transformation pilot project has naturally come to an end and its future should be seen in terms of 'mainstreaming' its actions and learning across all services in the City. In order to help facilitate this, a decision was taken to commission this report so that key lessons and learning can be taken into that process.

3 Summary/Conclusion

3.1 The i3 Project is an initiative that the Council, PCT and providers in Leeds can be proud to have instigated and been a part of. It represents one of the more interesting approaches across England in response to the Social Exclusion Task Force's report. Early indications suggest evidence of changes in both services and people's lives, but less than might have been hoped. The partnership working that has been developed, progress on cultural change and staff attitudes and the developing user involvement work all indicate progress. Limitations on success have, in our opinion, been primarily because

of a lack of some wider systemic supports. Nonetheless, there are now a range of important building blocks in existence that provide a solid basis on which to build. The proposed roll-out of i3 to mental health day services across the City would, in our view, be the right move – provided action is taken to address the issues identified in Section 6 of this review.

4. Organisational Context

4.1 The organisational context within which the i3 Project has been delivered is perhaps the most important issue to consider. As in most parts of the country, mental health services are commissioned in part by the PCT and in part by the Council's Adult Social Care Department. Also similar to elsewhere, provision is through a mix of NHS Trust, Council in-house services and the voluntary/independent sector. There appears to be a greater amount of Council managed in-house provision than would typically be the case elsewhere.

4.2 This multi-agency context underpinned the initiation of i3 in that it was initially conceived through the (former) Leeds Mental Health Modernisation Team – now called the Mental Health Programme Board. This group was the Local Implementation Team (LIT) for the mental health NSF in Leeds and includes senior management representation from all the key mental health, primary care and public health agencies in the city. It oversees strategic developments but individual agencies such as the PCT and the Council still retain their own individual decision making structures.

4.3 The i3 project board was created with the approval of the Mental Health Modernisation Team and was, indeed, chaired by the chair of that team. However, key decisions by the i3 Board still had to be taken separately through the participating agencies' governance structures for approval and implementation – as is usually the case in inter-agency initiatives. Whilst the Council's ASC Department was a major stakeholder (and indeed provided the project management function through their transformation team) and a PCT commissioner representative chaired the i3 board from a PCT commissioner's perspective, i3 does not appear to have been driven by the statutory sector as a high priority policy or commissioning expectation. Much of the drive for change came from the providers themselves.

4.4 This approach has had two fundamental implications for i3's progress and dynamics, namely in terms of:

- The interface with the commissioning process
- The decision-making and control model that applied to i3.

Commissioning

4.5 The i3 project started prior to the Council's ASC Dept defining and developing its commissioning capacity and approaches. Although ASC commissioners have been members of the Project Board for i3, their direct involvement in its

development has been limited and this is regretted by i3 stakeholders. All the services connected to the i3 Project are funded by one or both of the Council or the PCT. However, not all of them were commissioned in the understood sense of the word (i.e. a contract with a service specification detailing the service to be provided and outcomes expected alongside a monitoring process which could then result in an assessment about whether the service was meeting the needs and producing the outcomes as expected). Indeed, many of the existing service specifications have been developed by providers themselves rather than driven by a commissioning process. Some of the consequences of this were:

- There is limited clarity about who services are to be provided for (see Section 6.3)
- Where service specifications do exist, they relate to an old model of working and not the community inclusion focus of i3
- Even where more formal commissioning does take place (e.g. aspects of PCT commissioned services) the data collected does not relate to the outcome of achieving social inclusion.

A process to review day services that are jointly funded by the Council and PCT is currently under way, but the timescale of this process is not aligned to that of the i3 project. This has created a degree of uncertainty around i3, with some providers wishing to makes changes in the short term, but not knowing whether such changes will have full commissioner support.

4.6 Linked to this, although a five year (2006 – 11) City-wide mental health strategy was published, this was viewed by stakeholders as being too 'broad brush' and aspirational in nature. As a result, that strategy was not perceived by people managing and leading mental health day services connected to i3 as providing a framework for the Project's development. There was thus a belief held by almost all stakeholders interviewed that there was insufficient City-wide strategic direction to help steer and contextualise i3 and this was widely seen as problematical.

"We still don't know what the big plan is"

Decision Making and Control Model

4.7 This resultant provider led approach to i3 appears to have had a number of implications – some are positive:

- By common consent it has fostered a new spirit of partnership between providers – with a willingness to share, work together on issues and see themselves in a collective role to improve mental health day services.
- Linked to this, it appears to have created a dynamic whereby at least some providers have recognised and taken responsibility for changing their services in ways that might otherwise not have happened.

"In the absence of a lead from the commissioners, we realised we had to take responsibility for improving our services ourselves as best as we could"

‘The i3 Project gave us a kick up the backsides. Without it, I doubt if we would have changed services that we knew in our hearts were poor quality”

4.8 The long-term benefit of this could be the establishment of inter-agency working that will be of benefit to local people. For example, the providers are intent upon retaining the i3 Provider Forum after April 2009 because they see mutual benefit in its continued existence.

4.9 On the negative side, i3 being provider led created some difficulties including:

- A heavy reliance upon goodwill and commitment from managers (and staff) in the organisations concerned. Whilst we were not able to verify this in the scope of our work, we received several statements about differing organisations having varying degrees of commitment to the i3 goals which, in the absence of a commissioning structure to specify and monitor outcomes, risked some paying lip service to the aims rather than changing practice in reality.
- Authority around the Project appears to be difficult to pin down. The Project Manager’s role was more one of co-ordination and leadership by encouragement and enthusing – rather than having formal devolved authority. A common concern was that a number of issues identified by the Project Task Group which would have helped the Project to deliver (such as work on eligibility criteria and defining the user care pathway) remained uncompleted at least in part because of a difficulty in engaging people with the authority to make those changes. It is important to emphasise the widespread positive comments from stakeholders about the work and contribution to the i3 Project of the Project Manager(s).

“To start with we thought the Project Managers had the authority to get things done. Then we realised they didn’t and they had to take our ideas back to argue for them within the Council structures”

4.10 Taken together, these issues created challenges that, in our opinion, were <u>the</u> major constraints on the innovative i3 Project being able to achieve much greater levels of change, namely:

- The lack of a commissioning strategy and clear leadership that could give a long term commitment to the service model meant that there could be no de-commissioning strategy for services that were understood to be out-dated or providing poor outcomes. Thus, changes could only be made within the broad parameters of the existing services and the degree of innovation became, by definition, limited.
- The uncertainty in at least some people’s minds about how i3 related to an overall strategic direction for mental health services created a degree of uncertainty about whether the more radical changes that could be made would be supported over time i.e. There is anxiety about whether a decision by providers to re-design their services in the light of the i3 framework has the commissioner’s full support and will thus form the basis of commissioning specifications when they are introduced. The Project Manager’s view is that key decisions on the i3 model have been taken through the Council’s decision-making processes and have involved senior

officers responsible for commissioning. Thus, changes do have commissioning support. Our understanding is that commissioners are likely to develop an outcomes based approach, whereby it is the outcomes achieved, rather than the specific model that is delivered, by which they will commission. This has particular implications for providers given the early stages of outcome based data collection across all of the day services. Clarification about future commissioning intent would thus create greater confidence amongst and direction to (particularly voluntary sector) providers. At present some fear they are going through the pain of change only to subsequently be told their service was no longer wanted. There are thus limited incentives to promote change.

"The lack of clarity about future strategy and commissioning intent was a fault line that ran all through the i3 project and got in the way of change"

5. The Success of The i3 Project

5.1 This description of how elements of strategic decision-making have hindered progress should **not** be interpreted as a statement that the i3 Project was unsuccessful. There appears to be significant evidence of progress. There is a strong case to support the decision to expand the work that has been done and 'mainstream' it into all aspects of mental health day service commissioning and provision.

Multi Agency Stakeholder Support

5.2 Firstly, having commented upon leadership, we wish to note that the willingness of the Council and PCT to support the initiative of the Project Board to develop the i3 model was important. Without this, the potential for a policy and evidence-based approach to improve services and outcomes around these services would have been limited. Few authorities across England that decided to respond to the Social Exclusion Unit's report in such a positive way.

Evidence of Change

5.3 It is difficult to identify hard data that quantifies the impact on people's lives as a result of the changes – primarily because although a number of systems and approaches have been used, there was inconsistency in their application and/or their introduction from the outset.

5.4 The Institute of Health Sciences at the University of Leeds have developed and piloted a tool to measure social inclusion[4]. A full analysis of this was awaited at the time this review was carried out, but an early conclusion from a small, self-selected sample suggested that service users viewed the new services negatively. This contradicts the information from the Service User

[4] Marino-Francis F. *Mental Health Day Services and Social Inclusion Questionnaire* University of Leeds

Forum (see Section 5.13). Indeed the User Forum were concerned that a questionnaire in itself should not be the only way of obtaining people's views for a range of reasons (e.g. accessibility for non-English readers, role of staff in supporting questionnaire completion)

5.5 The Realise Team (a cross agency team part of the early implementer initiative) have used the University questionnaire to undertake their own analysis by using it with a small number of service users at a six-month interval. The conclusions from this small sample, contained in a published progress report[5] start to indicate positive progress across most outcome areas assessed.

5.6 The views of carers were sought through a Carer's questionnaire in autumn 2008. Although an important action in terms of seeking their views on day services and promoting their inclusion in service planning, the data from this source adds little to an understanding of the impact of the i3 Project – in part because less that 20% of carers said they knew anything about the modernisation of day care in the City and only just over 10% of them had heard of the i3 Project. The data therefore provides useful information on carers' views about day services in general, but not on the impact of the i3 Project – and indicates a need for greater communication about the Project with carers.

5.7 The 'Traffic Lights' analysis has also been used. This approach, developed by the NDTi[6], identifies whether day service activity is promoting community integration by categorising activities as to whether they are:

- Segregated activities taking place in segregated settings (Red)
- Segregated activities taking place in integrated settings (Amber)
- Integrated activities taking place in Integrated settings (Green)

When running this system with staff to identify how staff use their time, a fourth category of blue was introduced at the request of i3 participants at the time to identify activity not directly concerned with supporting people directly.

5.8 This analysis was done at the start of the i3 Project and then repeated in the summer of 2008. However, there are limited conclusions that can be drawn from it primarily because it was carried out by different people, in slightly different ways, over the two time periods. (Project Manager overview in the first case, external independent consultant supporting direct staff completion in the second). Also, it was not possible to get returns from all service areas in the 2008 data collection so the dataset is not complete. Nonetheless, some broad conclusions can be drawn.

5.9 The 2008 data showed a significant increase in staff time spent in 'blue' activities. This is almost certainly partly attributable to different interpretations of definitions between the different people undertaking the data collection over the two different time periods. In addition, staff may not have identified the

[5] Medford R. *The First Six Months of the East/North East Social Inclusion Pilot.* Realise: November 2008

[6] Bates, P.; Gee, H.; Klingel, U. & Lippmann, W. (2006) Moving to inclusion *Mental Health Today* April, pp16-18.

outcome impact of elements of community connecting work (see Section 6.12) and interpreted it as administrative rather than outcome orientated. However, it is also possible that there has been an increase in administration-related tasks that staff are being asked to perform – this view was certainly expressed by a number of staff and managers at the time of the 2008 data collection. There would thus be some benefit in a local discussion taking place about this and its impact on the ability of services to deliver client focused outcomes. However, it is not conceivable that this fact in itself explains the very large increase in 'blue' time. It is therefore more appropriate to look at shifts between just the red, orange and green data - which shows the following:

	Original	**2008**	**Difference**
Red	69%	55%	-14%
Amber	15.5%	23%	+7.5%
Green	15.5%	22%	+6.5%

5.10 This suggests that there has been a reduction in the proportion of staff/user interaction time devoted to segregated activities in segregated places and a commensurate increase, roughly equally balanced, between segregated activities in integrated places and fully integrated activities. However, the predominant model of staff activity is still in support of segregated services.

5.11 The variations in how the data was collected does not allow any meaningful comparison between different organisations or elements of service provision.

5.12 Finally, the Project Manager undertook an analysis using the traffic light framework of the type of activity currently being delivered by the ASC provided services. This involved describing the type of activity/support provided and the numbers of people attending/involved in that activity. This confirmed the predominance of 'red' services/support being offered and also demonstrates the significant difference between supports offered by CAT (which are predominantly amber) and those of the ASC day centres (which are predominantly red).

Views from the i3 Service User Forum.

5.13 The NDTi would wish to place particular emphasis on the views and opinions obtained directly from people who use services themselves. Recognising that user consultation meetings and the like do risk obtaining the views of a self-selecting vocal minority, the work of the two Service User Network supporters to get beyond a limited number of people through outreach work gives some confidence that these views are an important source of peoples' real experiences. Additionally, we understand that the workers made links with the other existing service user involvement networks to ensure a wider coverage. In this context, the following are important conclusions:

- There are clearly different views about the changes – (i) keep elements of the day centres but also develop new community focussed opportunities (probably the predominant view), (ii) a real concern about loss of the social support associated with traditional day centres (iii) varying views on

employment, recognising that for some people work was a contributory factor to their poor mental health (iv) a concern that insufficient attention has been paid to the needs of older people who may want less active lives.

- One differentiating factor is that those who have been directly involved and whose services have changed tend to be positive about the changes. Those on the edges, whose services have not changed but can see it happening to others, tend to be worried and concerned because they fear losing what they have and cannot directly see the benefit of the new support options. There are important lessons here in terms of (i) open communication and (ii) the case for faster delivery of change so that people are not left in uncertainty for a long time building up their fears.
- The retention of some buildings as 'safe space' is important
- A belief that the Social Services resources are changing at a slower pace that the voluntary sector ones
- A concern about a growing 'two tier' service, with those accessing new options getting a wider range of opportunities – and thus a need to ensure there is continued investment and attention paid to services not yet part of the new approach until such opportunities are available to them (or alternatively move faster and change services across all the City over a shorter time period).
- People want real and direct involvement in the planning of new developments.
- A need and desire for greater attention and investment in employment support.
- A concern that some of the quieter and more vulnerable people who may be hard to reach need a greater focus on their needs during the changes.

5.14 Perhaps the most telling factor is that a recurrent discussion at Service User Forum meetings was apparently the future of the i3 Project and whether it would continue – the clear implication that the loss of it as a focus, with the direction of travel it has been taking, would be viewed negatively.

The Project Board

5.15 The creation of the Project Board, with multi-stakeholder involvement, was seen positively by stakeholders. Its core role in developing the i3 model and thus instigating these changes was important. In addition, people commented positively on how the Board has performed a number of important functions including:

- Providing a focus for the work and for discussion and debate about its future direction – particularly in the absence of city-wide mental health leadership vested in individuals
- A genuine multi-agency forum where different agencies could come together as equals
- The capacity it created for shared ownership of the work, which was reported as helping to overcome some of the initial fears about the purpose of i3.

User involvement mechanisms

5.16 By common consent the user involvement mechanisms that have been established around i3 are a positive development that have been welcomed both by people who use services and service providers. With hindsight it would have been beneficial to have had them in place from the outset, but despite this the decision to resource co-ordinators to communicate with people who use services, produce 'The Eye' newsletter and bring people together for discussions and events is clearly an important part of the model.

5.17 Beyond this, the existence of service user groups around each service in the early implementer group and the establishment of several service user run groups indicates progress. The next stage will be to turn that into the meaningful and direct involvement of people who use the services in operational decision-making and management of the services in question.

Innovative Practice

5.18 As noted earlier, this review will not comment in any detail on the individual services. Its role is rather to look at the i3 Project overall. However, it is worth briefly noting that a number of innovative and interesting practices and service models have been emerging during the course of i3. For example, the development of Realise as a multi-agency staff team, focusing on supporting people to identify and access other community resources, coming significantly from a minority community perspective whilst also being given authority to progress systemic issues such as recommendations for direct payments, are all things that could and should form part of the next stages of development. (Though the multi-agency employment model may need refining or streamlining). Similarly, there are examples that cold be identified from a range of other services involved in the Project.

Change budget for specific activities

5.19 The concept of i3 as a development project, with an associated budget to assist change management, appears to have been an important aspect. As well as creating an identity and thus a sense of 'belonging' from the organisations involved, the benefit of having a discrete budget that could be used to fund small-scale actions and activities such as training, events or similar cannot be overstated.

5.20 For example, the budget used through the Service User Forum to fund equipment and related resources for a range of initiatives appears to have had the twin benefits of (i) helping groups of people progress ideas that were important to them and (ii) building confidence amongst service users in the i3 Project.

5.21 This concept has been used elsewhere in the country and the evidence is that, for comparatively small levels of investment, giving project managers (along with their stakeholder partners) a small resource to promote the initiative achieves disproportionately positive benefits.

Training and mentoring opportunities

5.22 There were generally positive comments about the external training and support provided as part of the change agenda. In particular the social inclusion training, mentoring and support to managers, provided through the NDT, was described as beneficial. Similarly the two day induction to social inclusion training offered to staff was positively received, although other training, such as on auditing local communities was not felt to be equally effective by all staff – perhaps in part because the staff were not at the stage where they were ready to make best use of the training when it was being offered (see section 6.10). Similarly, work undertaken by the now defunct Care Services Improvement Partnership to lead collaborative work between staff and users helped people to understand the challenges each faced in the change programme.

Readiness for the Next Step

5.23 An underpinning theme of this commentary report is that whilst good progress has been made – it could have been greater. A major positive factor to emerge from this is that the work undertaken to date, whilst having resulted in less direct impact on people's lives than had been hoped, has resulted in organisations and staff being ready for a major strategic change that could deliver those different outcomes. Organisations and managers are ready for it to happen and are largely enthusiastic. Staff have an understanding of new ways of working and, with the right support, are reported as being ready to take that step.

> *"We've now got a workforce that is more fit for the future"*
> *"i3 helped us in the voluntary sector to think about social inclusion in a way we hadn't done before"*

6. Outstanding Questions and Challenges

6.1 The overall message of this review is that the i3 Project has been an initiative well worth progressing and there appears to be sufficient enthusiasm for it, and learning from it, to merit it being broadened out across the entire City's mental health day services. There are, however, a range of issues that require further consideration and/or action if the benefits of the change are to be maximised. These include the following:

The Commissioning Strategy

6.2 The earlier points about commissioning and strategic direction need not be repeated beyond emphasising (i) the importance of commissioners being fully engaged in the next stage of the roll-out (ii) the rapid introduction of a commissioning framework for day services and (iii) assuming that the commissioning framework is based on the delivery of outcomes around community inclusion and recovery, then providers having evidence based outcome measurement systems to demonstrate success.

Eligibility Criteria

6.3 A number of people raised the question of who is eligible to access the services covered by the i3 Project? The responsive nature of the services, with their significant element of self-referral, are a key strength. The potential for self-referral, thus containing a 'preventative' component, is likely to be cost-effective in the medium term. However, the development of a commissioning strategy, and in particular the introduction of individual budgets, will necessitate clarity about who is eligible to access the services and/or what proportion of each service's capacity is to be taken up by people who fall outside the eligibility criteria threshold.

Links to the Personalisation Agenda

6.4 One of the impressive aspects of the i3 Project is that it effectively anticipates key elements of the personalisation agenda. A movement away from buildings based services to enable people to access ordinary community activities is central to the objectives around individual budgets. There are some strong similarities between the activities of the Realise and CAT teams and the concept of brokerage - which will be an essential component of people using individual budgets effectively. The development of new service options (the market) in the way that has begun through i3 will be an inevitable result of personalisation.

6.5 Having said this, the way in which individual budgets and personalisation are to be delivered in Leeds will have a major impact upon the services connected to the i3 Project for the following reasons, amongst others:

- For people in receipt of social care funding, the money attached to their use of these services will presumably become part of their individual budgets. How this will work, how those individual budgets are to be costed, and most fundamentally whether people will want to buy back into either the old style or new style of supports are all crucial questions to be resolved.
- Following the above point about eligibility criteria, if a proportion of people who use the services are outside the FACS threshold, how will this funding operate after individual budgets are introduced? Will core-funding make available directly to providers for non-FACS eligible service users with the balance going to people's individual budgets for them to buy into the services if wished?
- Those elements of the service that are primarily about supporting people to explore alternatives and community options (e.g. elements of CAT and Realise) could be seen as part of the infrastructure support around personalisation rather than service delivery e.g. as noted above, there are some similarities between Realise/CAT and aspects of service brokerage. There is thus a question about whether they should be resourced as part of the service infrastructure or else seen as part of the menu of services that people can choose to buy into with their individual budgets.

6.6 There are no quick and simple answers to any of these things. However, the important point is that the future development of the i3 Project needs to be

seen as part of the programme of work within the Council to develop Self Directed Support and individual budgets.

Employment

6.7 The original model for i3 included a proposal for a dedicated employment capacity. However, this was never developed. Plans to have specific individuals focusing on employment around the Realise team and elsewhere have also yet to be achieved. Although Dove employment does provide an employment service, it does not appear to have a major focus on supported open paid employment and to the extent that it does, this is an inadequate resource for the City. We understand that some employment supports are delivered from within day services and day centres. The problem with this approach is two-fold. Firstly, it can be difficult for employment to gain the focus of staff time and degree of expertise that can be achieved through stand-alone operations. Secondly, employers will see the employment of people with mental health problems as being a social care/charitable activity (coming from within social care day services) rather than a matter of commercial decision making as they recruit from an employment agency that generates good quality staff for them (as could be the case in a stand-alone entity).

6.8 We know that employment is a major expectation of a large proportion of people with mental health problems and that being in work is a major contributory factor to social inclusion and (for most people) mental well-being. The development of the employment component as originally envisaged, as part of a city-wide employment strategy linked to the delivery of the PSA 16 indicator, is therefore something that we suggest should be a priority over the coming months. Without this, a major plank of the i3 Project will remain missing and the resultant outcomes for people will be poorer than they might otherwise be.

The Involvement of the NHS Trust

6.9 At the outset of i3, there was an NHS Trust provided service involved in the work, but as that changed and closed, there ceased to be direct NHS service delivery involvement in the work. Policy also expects the outcomes from NHS mental health services to be focused on the promotion of social and community inclusion. Therefore their lack of direct service delivery involvement (beyond the PCT's participation in the Project Board) is perhaps regrettable.

Approaches to Change Management

6.10 Service change can be a complex matter and effective change always requires significant attention and capacity in order to maximise the likelihood of success. The availability of the Project Manager as a resource to this was a contributory factor to the progress that has been made. Despite those successes, there are a number of aspects that, with hindsight, could have been more successfully progressed if additional approaches to change

management had been deployed. Some of these have already been commented upon. For example, the two essential starting points to effective change are that (i) people are dissatisfied with the present situation and (ii) there is collective sign-up to a vision of the future. As noted, not everyone (staff or service users) was unhappy with current services and there was a lack of a full strategic vision for the future.

6.11 If this widely owned demand for change is not strong, then it becomes more important to have a clear policy/commissioning/managerial directive to implement change. i.e. An ideal change scenario is driven by the people directly involved wanting change to happen, with a fall back position of it being driven through by those with the authority to require it to happen. Neither of these situations strongly applied in Leeds. As noted above, the demand for change and shared vision for the future from stakeholders was limited. Alongside this, there was no commissioning strategy in place to progress or even require the changes. Thus, proponents of change were left to rely upon persuasion, encouragement and good P.R. to drive the agenda. As noted in paragraph 4.10, this inevitably meant that change had to be gradual with limited potential for radical or swift implementation. Looking to the future, there is a need to progress both of these approaches, i.e. build wider and deeper stakeholder demand for change and require new approaches through the commissioning strategy. Without these things, it will continue to be difficult to achieve and demonstrate significant change within short time-scales.

6.12 In addition, change is always a difficult time for staff and there were a number of added complications surrounding the i3 Project. For example, the staffing review instigated part-way through the project for Council employees resulted in disquiet and a demand for clarity about future roles and expectations. One of the characteristics of effective change is that it involves a degree of exploring the unknown. To define the end position too early places constraints upon change and innovation. So, even though elements of staff practice were not totally new, it would be unhelpful to tie down things like job descriptions too tightly whilst the project was still developing. Equally, whilst job descriptions were being discussed, some staff may have been reluctant to do new things – for example we were informed of one manager declining to require staff to support people at evenings and weekends because it was not in the job descriptions that were being reviewed at that time. We were also informed about how Leeds Mind had sought to bring services together in an initiative linked to but not directly resultant from i3. This resulted in staff having to re-apply for their jobs. The creation of a stable environment for staff to enable them to be positive about service change and thus live with evolving roles and expectations would help in the future. Evidence suggests that changing service culture to empower people who use services is more difficult if the staff working in services feel disempowered themselves.

“Good intentions but in some places and times it went wrong
“Staff anxiety feeds user anxiety’

The Nature of Community Inclusion Work

6.13 Staff roles in promoting community inclusion are fundamentally different to those in many traditional day services. Indications from this review are that there are different levels of understanding about these changes. For example, staff time spent developing and nurturing contacts and relationships with mainstream community resources can and should be seen as valued outcome focused activity – rather than an administrative task. Information from the 'Traffic Lights' data returns implies this may not always be the case. Further development work on defining staff roles and promoting understanding of the different components of new roles may prove beneficial.

Conclusion

7. The i3 Project is an initiative that the Council, PCT and providers in Leeds can be proud to have instigated and been a part of. It represents one of the more interesting approaches across England in response to the Social Exclusion Task Unit's report. There is some early evidence of changes in both services and people's lives, but less than might have been hoped. The partnership working that has been developed, progress on cultural change and staff attitudes and the developing user involvement work all indicate progress. This limitation on success has, in our opinion, been primarily because some of the wider systemic supports to the project were not fully in place. Nonetheless, there are now a range of important building blocks in existence that provide a solid basis on which to build. The proposed roll-out of i3 to mental health day services across the City would, in our view, be the right move – provided action is taken to address the issues identified in Section 6 of this review.

Appendix I

Summary of the Policy Framework Around Mental Health Day Services (up to, but including the Personalisation Agenda)

Day Services policy context

Back in 2002-03, some £140 million was spent on day and employment services for working-age adults with severe mental health problems and this spending was reviewed in the Social Exclusion Unit report in 2004 (ODPM 2004a). The judgement was that the money was not being used well and so those services needed to be redesigned to bring them in line with the clear objectives that were set out in the subsequent guidance. Four clear objectives are explained in the following paragraphs, followed by five principles of service delivery.

#1: Recovery is a dominant goal for all mental health services (DH 2004, MHWC 2004, DH 2005a) and should be a key function of day services (DH 2006a). Recovery encompasses:

a) A return to a state of wellness (e.g., following an episode of depression);
b) Achievement of a personally acceptable quality of life (e.g., following trauma);
c) A process or period of recovering (e.g. following trauma);
d) A process of gaining or restoring something (e.g. one's sobriety);
e) An act of obtaining usable resources from apparently unusable sources (e.g. in prolonged psychosis where the experience itself has intrinsic personal value)
f) To recover optimum quality of life and have satisfaction with life in disconnected circumstances (e.g. severe dementia).

#2: Independence and Self-Directed Support is a strong theme across adult social care (DH 2005b, DWP 2005, HMG 2007a) and is enshrined in the statement of core skills for the whole mental health workforce (MHWC 2004).

- People who need care should have the least invasive form in the least intensive settings in order to promote choice and dignity, self management and self care, enable independence and minimise the burden of disease (NHS 2005, DH 2006a).
- Direct Payments have been available since 1997 and this has been expanded to Individual Budgets but take-up has been low and increasing take-up will assist the modernisation of day services (DH 2006a, DH 2006d). Direct Payments must now be discussed as a first option with everyone (DH 2006e) and personal budgets form the basis of all non-emergency publicly funded adult social care (HMG 2007a). Day service staff should support people to access and use direct payments. (ODPM 2004b).

- The refocused Care Programme Approach explicitly anticipates people moving from reliance on the specialist service towards self-directed assessment and support (HMG 2007a, DH 2008).
- People need to be involved in the design and running of their own services (ODPM 2004a) and this will involve seeking the views of people who have not used traditional services, but may benefit from redesigned provision (DH 2006a).
- This includes addressing the need for advocacy and befriending (ODPM 2004a), social contact and peer support which should be on an open access, drop-in and self-referral basis (DH 2006a).

#3: Social inclusion and participation in community life beyond health and social care services and in the most non-stigmatising settings possible is central to all work with disabled people (DWP 2005), all mental health work (DH 2001, MHWC 2004, NSIP 2007), is the driving force for mental health day services (DH 2006a) and has become the principle around which all investment for disabled people is designed (DWP 2005).

Combating isolation is central to reducing death by suicide (DH 2004), addressing need (DH 2008) and keeping people safe (No Secrets review). People may need support to retain their inclusive roles and relationships through times of crisis, as this is a high risk time for such connections to be lost (DH 2006a).

- Services should have a greater focus on providing access to mainstream services in the community rather than being 'building based' (ODPM 2004a, ODPM 2004b, DH 2006a). Where buildings remain, opportunities should be increased for the wider community to access them, eg use facilities for evening courses or concerts (ODPM 2004b, DH 2006a).
- Project workers should be assigned to accompany people to mainstream community services if needed so that they can participate alongside people from across the community (ODPM 2004b).
- Ensure that there are clear opportunities for progression from day services to mainstream services offering a variety of opportunities (ODPM 2004b).
- Remove barriers to participation and so tackle inequalities (DH 2007)
- Staff will need good knowledge of and relationships with community organisations and to join with people using services and others in combating stigma (HMG 2007a).

#4: Employment opportunities need to be increased (ODPM 2004a, ODPM 2004b, DWP 2005, DH 2006b, DH 2006e) for people with mental health difficulties. Indeed, separate guidance has been issued on vocational services that need to run alongside day services (DH 2006b)

. This will meet national targets (HMG 2007b).

- Individual Placement and Support services should be available, since the evidence shows it to be the most effective means of securing and sustaining employment (HMG 2006).
- Public sector employers need to lead the way (DH 2002)
- Care Coordinators need to address employment and learning needs, partly by linking with Jobcentre Plus (DH 2008) and this will be supported by targeted anti-stigma employer-based campaigns (HMG 2006).

In order to deliver these objectives, services need to be:

Person-Centred. This is underlined in the SEU report (ODPM 2004a).

- Ask individuals what they wish to do with their time (ODPM 2004b).
- Introduce flexible opening hours to enable people to access services who are in employment or who have other commitments during the day (ODPM 2004b).
- Everyone should have a personalised care plan based on their needs, preferences and choices (NHS 2005).
- Personalisation and inclusion are key themes of the refocused Care Programme Approach (DH 2008).

Proactive and Responsive to groups of people with specific needs. This includes

- Preventative work. The Minister of Health's vision for all adult social care clearly indicates that services should intervene in time to prevent problems (SCIE 2004, HMG 2006) and to keep people healthy and independent (DH 2007). Introduction of the stepped care model (DH 2006e), primary care mental health teams, improved access to psychological therapies in primary care and services that offer early intervention in psychosis all help to identify and treat mental ill health at the earliest possible moment. Women's day services and user-run social support should offer open access as well as referral from primary as well as specialist health services (DH 2006c).
- people with the most severe mental health problems who may need support on an ongoing, time-unlimited basis (ODPM 2004a, DH 2006a). Day services should in-reach into inpatient wards and sheltered accommodation (DH 2006a). People who find it difficult to leave their own homes should be offered to opportunity to be visited at home and to receive transport assistance and support to engage in social activities (DH 2006a).
- women with mental health issues (DH 2006c). The National Service Framework (DH 1999) first drew attention to the importance of developing gender sensitive services. In 2000, the NHS Plan (DH 2000) made a commitment to the provision of a women-only day centre in every health authority by 2004. Subsequently (DH 2003), a

more flexible target was set that sought to meet women's needs within the context of mainstream services. Indeed, all forms of daytime support should be seen as a route into social inclusion and mainstream opportunities (DH 2006c).
- People from diverse ethnic and cultural groups. This may require commissioning of specialist support from local voluntary and community groups. (ODPM 2004b)

Diverse. Commissioners need to consider how they can maximise the contribution of the voluntary and independent sector in service provision, supported by statutory services (DH 2004, DH 2006a, DH 2006e).

Well-connected to other health and social care services and community organisations (ODPM 2004a). This is demonstrated within health and social care settings by a single shared assessment and care plan (DH 2008) and through links beyond the mental health system (DH 2006a). Information about social inclusion needs should be drawn together from individual care plans to assist the commissioning process (DH 2008).

Accountable. It was anticipated (ODPM 2004a) that progress in service redesign would be monitored through the annual review of mental health services (the 'autumn assessment') by Local Implementation Teams. An outcomes framework is available (CSIP 2007). Local councils also have a duty to promote gender equality and disability equality (HMG 2005, HMG 2005) as part of the Disability Discrimination Act (1995, amended 2005). The *Public Sector Duty to promote gender equality (Gender Public Sector Duty)*, introduced as part of the Equality Bill (March 2005), placed a legal obligation upon all public sector bodies to ensure gender equality from April 2007.

Refs – listed in publication order to show the evolution of policy

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ODPM (2004b) *Action on mental health: A guide to promoting social inclusion. Factsheet 3: Mental Health, Day Services and Community Participation.*
DH (2004) *National Standards: Local Action*.
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HMG 2005 *Disability Discrimination Act* 1995, amended 2005
HMG (2005) *Equality Bill*
DH (2006a) *From segregation to inclusion: Commissioning guidance on day services for people with mental health problems*
DH (2006b) *Vocational services for people with severe mental health problems: Commissioning guidance*
DH/NIMHE (2006c) *Supporting Women into the Mainstream*
DH (2006d) *Direct Payments for People with Mental Health Problems: A Guide to Action*
DH (2006e) Our health, our care, our say: a new direction for community services.
HM Government (2006) *Reaching Out: An Action Plan on Social Exclusion*
DH (2007) *Commissioning framework for health and wellbeing*
HM Government (2007a) *Putting People First: A shared vision and commitment to the transformation of Adult Social Care*
HM Government (2007b) *PSA Delivery Agreement 16: Increase the proportion of socially excluded adults in settled accommodation and employment, education or training.*
National Social Inclusion Programme, CSIP (2007) *Capabilities for Inclusive Practice* Department of Health.
DH (2008) *Refocusing the Care Programme Approach. Policy and positive practice guidance.*
CSIP (2007) *Outcome Indicators Framework for Mental Health Day Services*

Appendix Two
Discussion with Day Service Staff about the MH day service proposals
Officers met with day service staff to discuss the proposals being put to Executive Board regarding changes to day services. The main issues raised by staff are captured below.

	Concern	Response
1	We were told that i3 was not going ahead. Many of the suggestions within i3 have been implemented and others were rejected as unsuccessful. The momentum was lost, why has it now been found again?	The i3 model was far wider than the in house service and was put on hold for a variety of reasons. It is recognised that many of the approaches suggested have been adopted by the in house service but this is a model for the whole day service and it would be wasteful and unnecessary to repeat the investment in time and effort that has already been undertaken if the benefits of that work are still evident. The recommissioning of the whole of Mental Health day services in Leeds is sought in this context.
2	Why are you proposing to close centres when it seems apparent that there is a clear need for these as a focus for activity?	The buildings based services work extremely well for the service users that choose to use them but there are groups of individuals who do not access these who also need of the support of Mental Health day services. To continue to improve the service we must reduce our dependency on buildings and reinvest that resource in support.-the majority of investment is in staff and buildings. The support that is available to people is essential, and it is the staff that provide this. Whilst progress has been made to enlarge the community resource it is very difficult to continue to do this whilst staffing three buildings. It is very encouraging to hear the staff group understand the financial position of the Council and accept there are no additional funds available to do this and we have to use what we have more wisely
3	In i3 several day centres were recommended, why are we going down to one?	The final report recommended 2 day centres across the whole service – this includes both in-house and externally commissioned services.
4	The people who have been in the service for a long time are those who	Within the proposal being put to the Executive Board is a suggestion that

	were promised a service for life when they left the old MH hospitals, what will happen to them - some retain this expectation.	within the re-commissioning process there may be grants available to provide services for people who fall into this category and we want to encourage this as a means of self help and user control
5	The Day services provide a stabilising support. They are not for people in crisis but there has been a lot of discussion focusing on this. It is also not all about services in the centres – a lot of outreach is already undertaken, as well as inviting others in to use the buildings.	Service users told us that when they have a crisis then it is their day service they turn to for support and the day service responds. This may not be a medical definition of Crisis (staff pointed out that if service users do present in Crisis they immediately refer on to appropriate services) but it is a compliment paid to staff about the responsiveness of their support. Ensuring that outreach, services that occur out of hours etc can continue and grow further is one of the aims of this change. The intent is to develop a service which builds on the personalised approach to supporting individuals to meet their needs and supports recovery and inclusion. Ideally each individual will have a clear needs based pathway through the whole of Mental Health services. Clarifying this for day services is the area this work can influence.
6	Will our eligibility criteria change? What will happen to existing users who do not meet the new criteria?	Yes for new users in future there will be a need to assess FACS eligibility for some elements of service and people will be provided with support appropriate to their level of need. Preventative services will continue to be important within a tiered model of service. Existing service users will continue to be able to access our services but the way in which their support needs are met may be delivered differently. Finding the most effective way to meet individual needs, rather than fitting people to existing services is one of the principles of the model.
7	It is not physically practical to run all activities and have all staff based at the Lovell park site.	This is true. But the expectation is that the majority of the staff would not be in the building but in the community. There is also the option

		for the building to open for extended hours to offer a more flexible service. Where the bulk of time is spent elsewhere in the city this would not be practical either. However there are several bases for ASC provision that have capacity for more staff to use office space. Where staff do this and as resources are freed up mobile working facilities can be provided – laptops with remote log ins will be essential for staff including facilities for those who would chose to work from home. These are within the scope of the service to provide currently. We are being challenged to think more creatively about how we deliver support in the future and that will mean more flexible, mobile patterns of working fully utilising all the resources of the council and its assets as well as those of our partners.
8	Concerns were raised about specific aspects of the change. How much 1-1 working, change to working times, what will be the employment and management structure etc. How much is already in place and if it's not mapped out already how can we be sure that the savings required will be made?	The detail of the delivery cannot be developed without the involvement of the staff delivering the change – you are the experts in this. However we are talking about proposals at present. If the proposals are agreed at Executive Board then we will work with you and current and potential service users to look at the detail of the service and the needs of the service user population. We are talking about reconfiguring to provide part of a tiered service not all of it. Where other providers are already covering areas of service we may not wish to provide those elements but to concentrate our resource elsewhere. We need further discussion with service users on their requirements. Once we have a service specification then we can look at the requirements to deliver that model.
9	What happened to the suggestion of a social enterprise centre at the Vale.	As an independent organisation New Leaf cannot be handed over to any

	New Leaf is independent of ASC, owned by staff and service users, there is an implication that this will be handed to the voluntary sector but how can this be when they have not been consulted?	other organisation and no proposal to do so is contained within the Executive Board report When discussing the Social Enterprises in the original Executive Board report the proposal was around supporting them to find suitable alternative accommodation should this support be required.
10	What assurances can be made to staff, including management and temporary staff, regarding their security?	This is conversation is about gaining an understanding of where the future lies. The details of how to achieve this will follow and staff and trades unions will be fully involved in this The authority is not in a position to give cast iron guarantees regarding future jobs and terms and conditions but at this stage it is very difficult to visualise a means of continuing to develop this service to meet the projected needs without the current skills set and staff resource in place however we will be asking staff to work in different ways in the future and there is a formal process to follow to gain agreement with union representatives should changes in working patterns and conditions of service be required.
11	But without this work how can cost effectiveness be shown? What saving is expected to be made? What budget do we have?	Identifying the priorities will be the next step as well as what funding is available. The budget for next year has not yet been set. and whilst there are indications of what it may be, it's not finalised .When it is this can be shared with staff . Adult Social Care will have a cost envelope in which to deliver mental health day services . Officers believe that this resource can be used more efficiently by concentrating on one buildings base and an enhanced community support team rather than in trying to deliver the existing model. Adult Social Care also believe that in line with the vision of i3 and work that has been done nationally the shift in emphasis to a tiered model with services built around recovery,

		community support and social inclusion can support people more effectively without creating dependence.
12	Communications regarding this proposal have been very poor to date. This has created a great deal of uncertainty and worry for staff and service users. Please can we have an assurance that this will be rectified? Will better information be provided in the future? For both staff and service users. Who will be involved? What is the date for implementation?	An apology was extended at the beginning of the meeting regarding communication to date. We will take on board your comments regarding communication and ensure clear information is provided. The model of change will also facilitate this – be this a joint management and trade union approach, a project management approach or otherwise. What ever way we choose to do it will involve you. We want to work together with service users and staff. If Executive Board approves the proposal we will all need to work together. Formal consultation involving staff, HR and trade union representatives will take place regarding any proposals to change job roles and specifications to meet the needs of the new service.
13	What provision for independent monitoring and evaluation of the new service is planned?	In the past this has been a weakness, more recently the in-house service has not had the same requirements placed on it as the commissioned services. The work that has been started around outcomes specification and performance monitoring will be developed to do this.
14	Does this activity at this time suggest a wider population view that MH services are not a priority?	This is about service modernisation and developing a whole system model of support for service users. In the wider context of ASC there is not a service that is not facing major changes – be it older peoples residential and day care, learning disabilities or home care.

Appendix Three

Feedback and questions raised at the Service user meeting held on 13th January 2011 and through representations made directly to Officers or Members of Leeds City Council by letter or Email.

The table below captures the main concerns and issues expressed by day service users since details of the proposals around mental health day services entered the public domain.

This includes feedback at a service user meeting attended by approximately 150 people. A message wall was available at the event, people had the opportunity to raise questions and if they preferred could leave written versions with staff. The aim was to gather as many views as possible in a variety of formats.

	Concern	Response
1	**Service User Consultation** The i3 consultation was sometime ago and has been dormant for some time. Not all service users felt it included them in the consultation. People who have accessed the services in the last 18 months were not involved. If it's the best way to change things why was it not followed up before? • An example of the concern expressed: i3 was intended to be an intelligence gathering exercise. It was always based in large groups in busy places thus excluding many service users who are unable to cope with such public places. Also as far as I can remember only 4 or 5 people from each centre could attend these meetings so not many users had a say at all so how can i3 say they had consultations and feedback from service users?	The i3 project ran for over four years across the whole of day services - both council and voluntary sector. A range of methods were used to gather service user views including work in groups, a service user involvement forum and suggestion boxes in all centres. There was also work done with mental health service users who chose not to use day services to establish the types of support that they wanted. Commissioners have involved service users and staff in the work they have done since i3 on developing an outcomes framework. All of these views have been taken into consideration in arriving at the model that is being proposed.
2	**Concerns at Proposals to Concentrate Buildings Based Support on one site** Each day centre building is a focal point for the vast majority of people here why should this change?	The proposed changes to day services will mean reducing the number of building bases that are used exclusively for provision of mental health day services. However, in all of the consultation with

	Concern	Response
	Don't close our centre Closure will result in isolation	service users people told us that providing places where people feel safe to go is an important part of what day services do, and this will continue to be part of the redesigned service. Adult Social Care is proposing keeping a buildings base for mental health service but the expansion of the community team will allow people to go to meet in other places in their local community. Staff will work with current service users to identify how their needs can best be met.
3	The buildings are seen as safe havens, life lines and a cornerstone for mental health management for many attendees. Removing this will lead to great distress and deterioration in health	When people spoke to individual Officers about what is important to them about the day centre they talked about the type of support they received, the helpfulness and understanding of the staff and having someone that they knew they could turn to for support when they need it. Adult Social Care believe that the staff can continue to provide this support but in different settings and in different ways. People also expressed a lot of worries about the idea of social inclusion when talking to officers. Some people may feel further away from being included in wider society than others, and may need more support to get to the point of taking part in activities that happen in the community, but social inclusion is for everyone. Adult Social Care is talking about a range of support being available in the community. For some people this may be a mental health support group for other is may be accessing local community facilities like the sports centre or college.

	Concern	Response
4	Activities in the centres have been cancelled, why not just re-implement these.	Activities in Centres have been cancelled because the staff team are trying to offer a full range of services to meet service user needs across the three buildings at the same time as providing a range of community based support and there are not enough staff to fully implement this. There is no additional funding to take on more staff.
5	What is the criteria for reassessment? Who will undertake the assessments of everyone currently using the service?	Centre staff will undertake this as part of the regular review of service users needs
6	What will happen to people who are currently using day services but are not eligible for day services in the future?	People currently using day services can continue to access day services under the proposals but the type of support that they receive to meet their needs may change.
7	We don't understand why you are closing the day centre then taking 18 months to consult on services. What will happen in the gap?	The Executive Board report is seeking two separate things, one regarding the in house service changes and the second in relation to the re-commissioning of all ASC funded Day services in Leeds. This does not result in a gap.
8	**About Dosti:** • What will happen to Dosti at Stocks hill? • Dosti also asked would ASC pay for the running cost of these premises? • Would they provide funds for transport? • Would Dosti be closed down?	Currently Dosti is hosted by Adult Social Care at Stocks Hill . If the proposals are approved then Adult Social Care will work with Dosti to support them in finding an alternative host option.
9	The Vale has money raising projects, what will happen to these? What will happen to the vale Garden and who will pay for storage for the equipment?. What will happen to the activities at the centres that close?	If the proposals impact on social enterprises – for example if the proposals mean that the social enterprise would need accommodation - adult social care will work with the social enterprise to help identify this.
10	Why close the Vale and Stocks Hill and not Lovell Park?	Adult Social Care have suggested that Lovell Park be used as the buildings base as it is the most central of the

	Concern	Response
		buildings, is on main bus routes and has recently been refurbished.
11	What will happen to the buildings? Weren't they all purpose built therefore what use are they to anyone else? Would it be possible for a user led group to take charge of one centre?	This proposal is not making any recommendations around buildings that are no longer used as mental health day centres.
12	How can community based groups offer what the buildings bases can in terms of one to one provision, daily support, self help groups and peer support? Where is the back up if things go wrong when getting support in the community?	Community based support can develop a range of different things including one to one support, peer support and self help groups and staff led support groups. The model that is being proposed is a tiered model of support with more intensive support when people need it and preventative services.
13	There is nothing suitable out in some communities to help people with mental health issues to access. In some communities there are no activities at all.	The day services already operate outreach groups in local communities where people have little or no access to other activities. Adult social care would like to develop more of this type of support.
14	Will people on CPA be able to use the CAT groups and will they use other council venues (eg leisure centres)?	People on CPA already use CAT groups. This will stay as an option.
15	Community Support visiting people in their home for ½ hr a fortnight is not the same as going out to a centre for a whole day, how can this be comparable?	The model is proposing a range of services and groups. It is a flexible model to be able to respond to different needs. For some people one to one support may be most appropriate but for others it may be accessing peer support, volunteering, group support, training or something else entirely.
16	Hasn't the decision already been made?	At this stage it is a proposal to make changes to day services. The Council's Executive board will make a decision on the proposals in February. If Executive Board approve the proposals officers will work with all stakeholders – but especially service users and staff – to discuss in more detail what the new service model would look like and the types of support people need.
17	Isn't this just about saving money, not making services better for people?	It is about offering a range of services that promote recovery and social inclusion.
18	How can people who don't have a	We want to offer people a range of

	Concern	Response
	car or can't drive or catch the bus travel round the city to one centre or to community venues?	opportunities local to them rather than expecting people to travel to a particular part of the City because this is where services are based.
19	When will our concerns be answered?	Staff will pull together the concerns as a question and answer sheet and this will be available through centres and by email for those individuals who have opted to be contacted in this way. If the proposal is approved we will put together an involvement strategy which will include various mechanisms for keeping people informed and engaged in changes.
20	What about people who are too old or ill to be able to consider work in the future. Where is the support for them?	The model is about providing a range of options to meet a range of needs. Support into employment is only one aspect of the support we would expect services to offer.
21	The voluntary sector provision is switching to a time limited service and doesn't suit everyone. This is why some people are using the in house services. What will they do if the in house services go?	We want to move to an approach where we can offer support to those most in need whilst having preventative services and peer support for people when they feel their mental health is improving. It is important that we do not create dependency on services but we also want services to be flexible so that people know they can access them when they need them. Some service users tell us that they just need to know the support is there as a safety net when they need it. We think this is a very important point.
22	How will these changes affect my incapacity benefit and disability living allowance	Using a day service does not currently have an impact on these benefits. This situation will not change.
23	How can you prevent people feeling isolated if there are no centres for them to access to meet other people and get out of their homes?	A day centre is just one way in which people can meet one another. A community based service is also able to arrange opportunities for people to meet as a group.
24	The statements and letters issued by the council and Social Services do not take into account the importance of peer support which is received by all members at the different Day centres	Adult Social Care believes peer support is incredibly important but we also believe that this can happen in a number of different ways. Service users can be supported to develop peer led groups and activities in community

	Concern	Response
		settings too. There are many positive examples of this happening.