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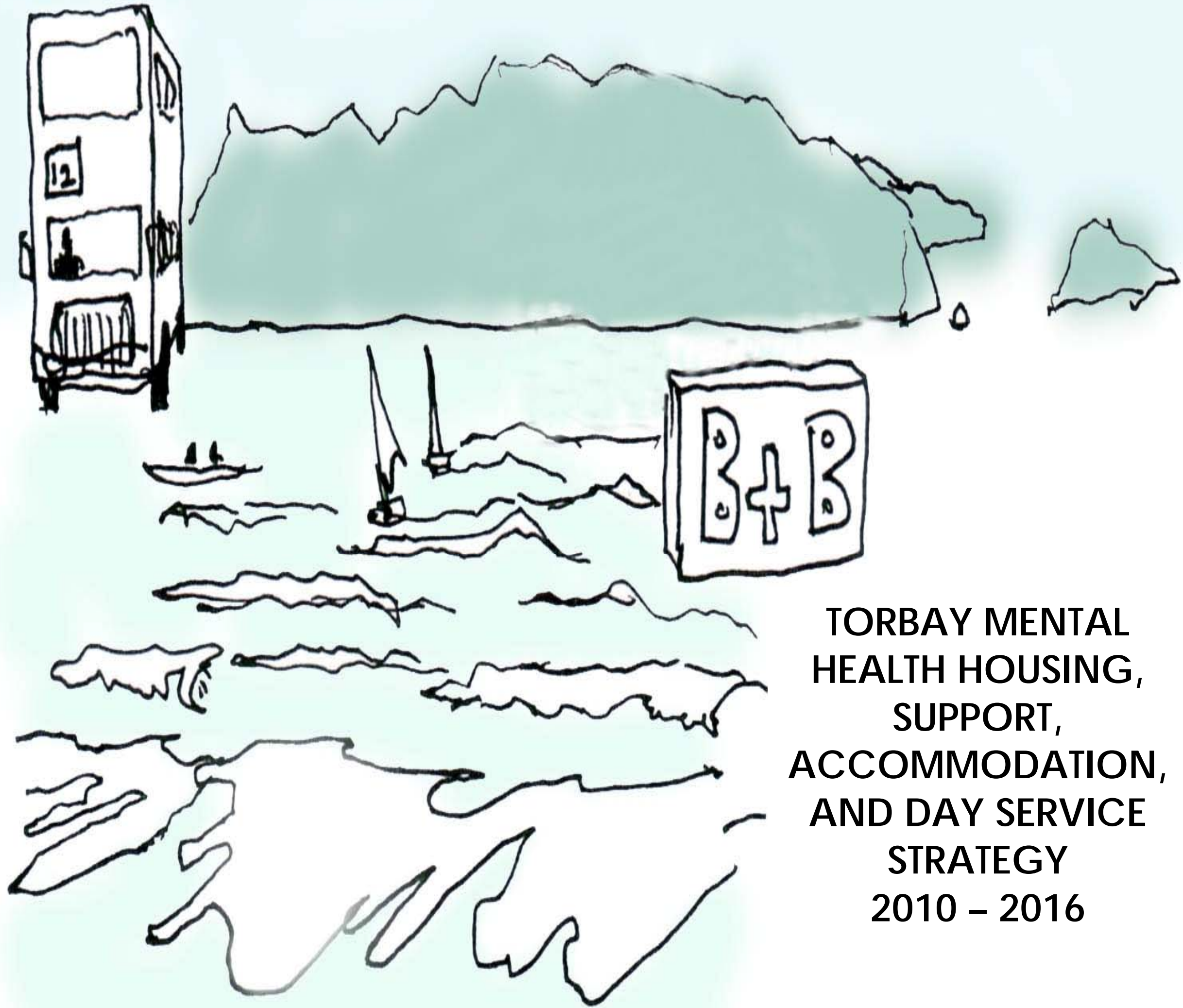
Communities and Local Government

TORBAY COUNCIL



TORBAY MENTAL HEALTH HOUSING, SUPPORT, ACCOMMODATION, AND DAY SERVICE STRATEGY 2010 – 2016

'BUILDING BLOCKS TO RECOVERY'

Devon and Cornwall Probation Trust

Torbay NHS Care Trust

Acknowledgment

Cool Recovery 2011

Cool Recovery is an independent charity for anyone recovering from mental health issues; carers, family and friends, and provides space where people can make changes in their lives.

It evolved from Carers' One-to-One Link (COOL) which began life in South Devon in 1999 as an informal support network and now includes anyone recovering from mental health problems. It is valued and supported by many within the South Devon community, including health and social services.

Cool Recovery has been successfully funded through the Big Lottery, trading, grants and private benefactors. Currently it is in urgent need of new funding in order to continue into 2012. Contributions are welcome.

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Torquay TQ2 5RP
Telephone number 01803 299511
info@coolrecovery.org.uk
www.coolrecovery.org.uk

'Working together in the belief that recovery is possible for everyone'
Company Reg. No. 5490608 Charity Reg. No. 1110955

With grateful thanks to members of the
'Cool Recovery Art Group'
for providing the artwork included in this Strategy
and below some thoughts from Steve Rae.
Steve recently passed away and will be
sadly missed by everyone who knew him.

'I felt happy for about
1 hour this morning
I felt like I did before
I got depression… it was
a great feeling, I turned
the radio up! I usually
turn it down and can
hardly hear it. I did
a little dance and
enjoyed the feeling…'

Foreword

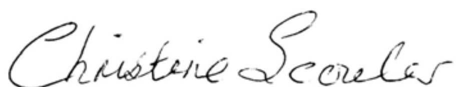
As the Council's Executive member for adult social care I pleased to present this strategy which provides a single plan for the commissioning of housing support, accommodation, respite and day services for people with poor mental health. The focus of the strategy is on wellbeing and recovery and how different agencies will work together with people who use services, their carers and service providers to put in place the building blocks to wellbeing and recovery.

The strategy is written at a time of change with the advent of personal budgets; development of GP commissioning arrangements and; publication of the Government's strategy 'No Health without Mental Health,' which places the emphasis firmly on recovery and removing the stigma of mental health.

We will continue to work in partnership with others to design and deliver the best outcomes at a time of reducing public sector resources. A range of local organisations and individuals including, Torbay Council, Torbay Care Trust, Probation, Devon Partnership Trust and community voluntary sector agencies contributed to the development of the strategy and will deliver the action plan together.

Services will be flexible, meeting individual need and providing the right support at the right time, promoting independence. More services will be provided in the community, supporting people in a preventative way, avoiding homelessness, escalation of poor mental health and supporting people to manage their conditions themselves where possible. In this way we will achieve improved outcomes for people and better value for money.

People will be offered greater choice and be encouraged to contribute their views and expertise to the design, selection and delivery. The intention to put people who use services at the heart of everything we do, adopting the principle of 'No decision about me without me!'



Councillor Christine Scouler
Torbay Council Executive Lead for Adult Social Care and Older People

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1. Consultation (discussion) on the Draft Strategy

The Torbay Mental Health Housing, Support, Accommodation, and Day Service Strategy (2011-2016) is a joint strategy (plan) for Torbay Council, Torbay Care Trust and Devon Partnership Trust.

Torbay Together and other public services in Torbay, are dedicated to delivering top quality and value for money services, to every section of the community, but we need your help to ensure what we provide meets your needs and aspirations. Torbay Together consists of staff from Torbay Council, Health, Police, Fire and Rescue Services.

The Strategy document is available from the Torbay Council, Supporting People web pages:
www.torbay.gov.uk/sppoliciesstrategiesplans
Also on Torbay Council's Consultation web pages:
www.torbay.gov.uk/closedconsultation

The results of what you say can be found

- http://www.torbay.gov.uk/index/community/consultation/closedconsultations/buildingblocks.thm (These results are being used to develop the mental health strategy)
- Or you can ring on 01803 208128 to receive a paper copy
- Also hard copies can be obtained on request by writing to:
  Supporting People Team
  Torbay Council
  Pearl Assurance House,
  101-107 Union Street,
  Torquay TQ1 3DW

  A FREEPOST envelope is available, please telephone 01803 208729

- By sending an e-mail to: supporting.people@torbay.go.uk
- Or by sending us a Fax: 01803 208734

Thank you for all your comments

2. Summary

This Strategy was developed through consultation and research and consists of 2 parts.

Part 1 includes the introduction, aims of the Strategy, the Supporting People Vision, values and outcomes, current strengths, areas needing improvement and, in conclusion, 7 strategic themes.

Part 2 is more detailed, covering current services, outcomes and the consultation process providing the information. Part 2 also includes the Commissioning Strategy, the Glossary (explaining words and terms used in Part 2) and lists of the people and organisations involved in the consultation process.

Good practice needs to be established through better communications with people by:

- Involving people who have experienced poor mental health
- Being flexible about when, where and how communication take place
- Presenting information in understandable formats

'New Horizons', a consultation on a new vision for mental health and wellbeing (feeling healthy and happy) was launched by the Department of Health in July 2009. New Horizons focuses on the promotion of mental health and wellbeing across the population, and improving the quality and accessibility of services. Its key themes are tackling discrimination (prejudice), social inclusion (including people) and personalisation. 'Personalisation' is a term used to describe the services someone receives, which are personal to the individual and help them achieve their desired outcomes. Following New Horizons the Department of Health published 'No Health Without Mental Health' in February 2011, this is a cross-Government Mental Health Outcomes Strategy.

For the purpose of this Strategy 'mental health condition' incorporates both mental health problems and mental illness, as defined below:

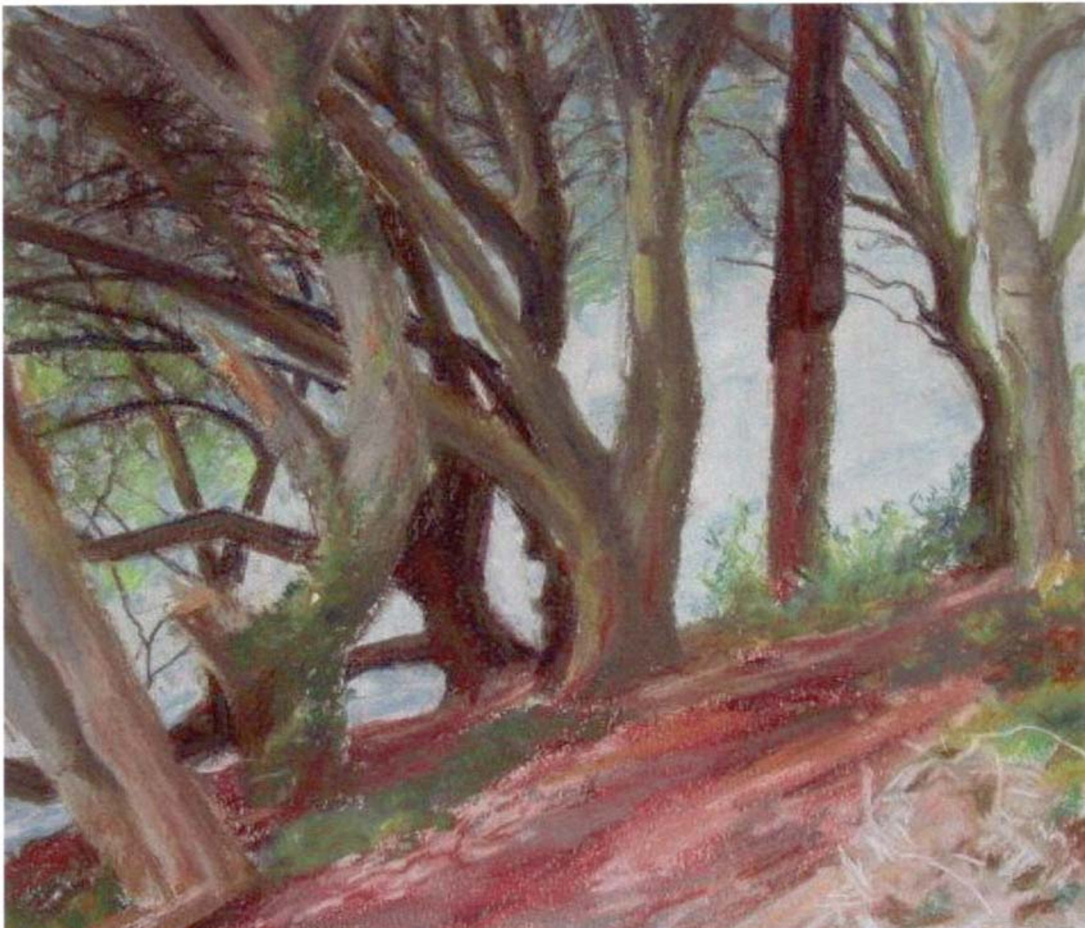
- **Mental ill health/poor mental health** generally refers to difficulties we may experience with our mental health that affect us in our everyday lives. Poor mental health can affect the way we feel, the way we think and the way we function. Poor mental health includes conditions described as personality disorders and also dementia. They can be mild or serious, fleeting or long-lasting.
- **Mental illness** refers to more serious mental health conditions often requiring treatment in specialist services. Someone with a serious mental illness may have long periods when they are well and are able to manage their illness. Many people with mild and serious mental health problems live productive and fulfilling lives.

The strategy covers people falling within these definitions, regardless of whether they have been formally diagnosed, or are accessing professional support or treatment for their condition. Good mental health and wellbeing is about feeling great, and about flourishing as opposed to deteriorating health. How we feel can be majorly influenced by the wider social factors of health, such as where we live, our financial means, and whether we feel like we belong to a community and have a strong network of friends. Tackling health inequalities does play an important part in keeping people and communities mentally well and feeling great.

The main points highlighted by the research carried out for the Strategy are identified as **recommendations** in 7 key themes, found in the last section of Part 1, of this document.

The 7 Key Themes are:

1. Information needs to be more accessible to people
2. Preventative services targeted to reduce the number of situations needing an emergency or more costly response
3. Services should be commissioned (bought) within a "Right Service, Right Time, Right People" philosophy (way of life and values)
4. More formalised partnership working between health, housing, criminal justice and social care services
5. All services maximise the potential for self-management, self-directed care and support promoting recovery
6. Independence and recovery should not only be associated with people living alone
7. There must be greater engagement between all stakeholders (person(s) with a direct interest) in developing a mutually agreed strategic vision



Part 1

'Don't Decide for Us Without Us!'

3. Introduction

Why do we need a Strategy?

- So there is a long-term plan on how services for people with poor mental health will be designed, delivered and evaluated
- To provide information on the needs and ambitions of people with poor mental health and how organisations will work together with people to meet demand
- To support more person-centred care and support.

This strategy promotes improved mental health and wellbeing for adults in Torbay and supports the recovery of people with mental health conditions.

Mental health influences and is influenced by a broad and complex (multiple) range of issues cutting across different areas of people lives, including health (both physical and mental), employment, housing, leisure and social networks (groups). To promote wellness and recovery a strong multi-agency approach is required which addresses people's needs holistically and increases life long success. This means taking into account all of somebody's physical, mental, and social circumstances in the treatment of their condition or illness. People with poor mental health, particularly those with more severe conditions, are more likely to experience social exclusion (unable to be fully involved in society). One of the best ways to help people who are excluded and prevent exclusion in the first place is to support them with everyday life skills. Services must deal with all of a person's needs enabling them to manage their home and employment, realise their potential, and get the most from their life.

Agencies and statutory partners must work together to ensure the inclusion of disadvantaged groups and populations. The prevalence (occurrence) of mental ill health is not evenly distributed across the country so an analysis (study) of need must be carried out to be sure the correct number and type of services are provided.

- **At any one time around one adult in six experiences symptoms of mental illness and one in four will experience mental illness during their lifetime**
- **Mental illness is the largest single cause of disability in our society**

A fine line exists between being mentally well and mentally unwell. Mental health and wellbeing is relevant to us all and is a state of emotional and social wellbeing in which the individual can cope with the normal stresses of life and achieve their potential. It includes being able to work productively and contribute to community life.

National figures indicate more people experience mental health conditions than write with their left hand, but left-handed people are not discriminated against! It is important to remove the stigma and discrimination (being seen as unusual and facing difficulty in being accepted by society) associated with mental ill health and by promoting better mental health and general wellbeing, discrimination and social exclusion will be reduced.

For people to benefit from the information contained in this Strategy, it is essential multiple agencies work together to commission and deliver a person-centred approach by listening, learning and focusing on what is important to each individual. By understanding

the needs and ambitions of people with poor mental health and the impact society can have on their lives, it is essential policies and processes do not disadvantage them.

When people with mental health conditions become unwell, it can impact on their families, their carers and the people around them; therefore their input is not only valuable but essential. They often know the person well and share experiences of their illness. Confidentiality must be a priority to each person being supported and cared for and where allowed, services will work closely with family members and other supporters and services should encourage each person to maintain contact with family and friends.

Under the Children and Young Persons Sector, there are proposals to have housing related family support embedded in the Locality Teams working arrangements, so these parents could access support this way. This is a potential area for targeted delivery of community outreach, giving more choice to parents with poor mental health, over their services.

People rarely experience mental health problems in isolation; they normally have additional needs, which must be met to ensure recovery. To enable people to achieve and maintain good health and wellbeing they will need appropriate accommodation and services. This strategy covers the following people with mental health conditions:-

- **Adults from the age of 16 with poor mental health who need support to manage their condition and recovery.**
- **People who have a mental health support need and who may also have secondary needs, such as domestic abuse, learning disability or drug and alcohol issues.**

An important part of this strategy is to promote effective 'step-down' (progression or move-on) to aid recovery, from hospital in-patient services and residential provision into private rented sector, supported and other housing options in the community.

Recovery is mentioned throughout this strategy, but what is recovery?
In mental health, 'recovery' has a range of meanings and does not always refer to the process of complete recovery from a mental health problem in the way that we may recover from a physical health problem. For many people, the concept of recovery is about staying in control of their life despite experiencing a mental ill health. Professionals in the mental health sector often refer to the 'recovery model' to describe this way of thinking.

Putting recovery into action means focusing the support and care given on the recovery process, building the strength and resilience (resistance) of people with mental ill health, not just managing their symptoms. There is no single definition of the concept of recovery, but the key idea is one of hope that it is possible for meaningful life to be restored, despite serious mental illness. Recovery is often referred to as a process, outlook, vision, a framework or guiding principle.

The recovery process:

- **provides a holistic view of mental illness focusing on the person not just their symptoms**

- **believes recovery from severe mental illness is possible**
- **is a journey rather than a destination**
- **does not necessarily mean getting back to where you were before**
- **happens in 'fits and starts' and, like life, has many ups and downs**
- **calls for optimism and commitment from all concerned**
- **is greatly influenced by people's expectations and attitudes**
- **requires a well organised system of support from family, friends or professionals**
- **requires services to embrace new and innovative ways of working**

The recovery model aims to help people with mental ill health to move beyond just survival and existence, encouraging them to have ambition, and develop skills and relationships giving their lives meaning. Recovery emphasises while people may not have full control over their symptoms, they can have full control over their lives. Recovery is not about 'getting rid' of problems but about seeing people beyond their problems. Mental illness and social attitudes to mental illness often impose limits on people experiencing ill health. Recovery looks beyond these limits to help people achieve their own goals and aspirations (ambitions).

Torbay Council and Torbay Care Trust have a duty to make sure the use of public funding contributes to identified outcomes, for example, the number of adults in contact with secondary mental health services in settled accommodation, employment, training and education.

To create 'building blocks' or direction for the strategy a review of current services was undertaken, using both quantitative (measurable) and qualitative (quality as opposed to quantity) data, to identify how the sector performed as a whole. Particular attention has been paid to the messages given by people currently using services and their carers and relatives, about what works, what is frustrating and what they think will meet future needs. It is important to recognise the vital role of carers and must ensure they are supported to maintain their own health and wellbeing.

The strategy is very much in line with the philosophy of personalisation (choice and independence) at the centre of Government's 'Putting People First' agenda for the transformation (modernisation) of Adult Social Care.

The broader strategic framework (outline) was presented at a major stakeholder (somebody with direct interest) event, this outlined the strategic themes and provided critical feedback for the need to sharpen their definitions. The seven strategic themes clearly indicate the direction for policy and practice development, and the type of services to be commissioned over the next 5 years.

Commissioning (buying) of future services must emphasise the importance of self-directed (led by the individual) care and support provision and people self-managing their conditon or illness. Contract performance must be monitored and evaluated with success being measured against the percentage of identified outcomes being achieved. The new models of commissioning are described more fully in Part 2.

4. Plans and Strategies

The development of this strategy was linked to relevant cross cutting (overlapping) strategies including:

- Strategic Move-on
- Supporting People Strategies: Homelessness, Criminal Justice, Drugs and Alcohol; Learning Disability; Older Persons; Children and Young Persons
- Vulnerable Adults Safeguarding
- Affordable Housing Strategy
- Dementia Strategy
- Child Adolescent Mental Health Service (CAMHS)
- Multi-Agency Public Protection Arrangements (MAPPA)
- Children and Young People's Plan (Children's Safeguarding)
- Domestic Abuse Strategy
- The emerging Prevention of Suicide Strategy
- Department of Health's New Horizons Programme
- Department of Health's 'No Health Without Mental Health' outcomes strategy
- Housing Partnerships Emergency Temporary Accommodation (Draft)
- Maintaining Mental Health and Wellbeing Strategy (Draft)

Aims of the Strategy

- **People in Torbay to live as independently as possible in their chosen home, with dignity and the necessary support and care to achieve this, putting them at the centre of all decisions made about them.**

- **To work in partnership with people, their carers and services to support them to meet their needs in the most appropriate way, so they remain as well as possible and improve their quality of life.**

- **To work in partnership with Torbay Care Trust, Devon Partnership Trust, Probation, Stakeholders and the Voluntary Sector; (with particular focus on user led organisations) so that services are focused on mental wellbeing as well as mental ill health, promoting recovery, aligning funding and services to improve outcomes for people providing an active pathway to independent living.**

- **People will have a personalised support plan (individual plan) based on their needs and outcomes they aim to achieve to support their recovery, including the choice of provider and how their support is delivered.**

- **Develop quality services enabling independent living, taking into account peoples' background, values, beliefs and lifestyles.**

Torbay's Supporting People Vision is to …

> "Support people in their communities by involving and empowering (giving power to) people to improve lives through innovative partnership and commissioning"

…. which leads to ….

Values & Outcomes

People with poor mental health should be able to:

- Achieve financial wellbeing
- Enjoy and achieve the life they want
- Stay safe and remain as independent as possible
- Make a positive contribution
- Be healthy
- Develop confidence enabling control and involvement
- Have an active role in the community without fear of discrimination
- Have easy access to up to date and accurate information
- Have personalised support plans, increasing choice
- Be supported by services promoting and enabling recovery and wellbeing
- Self manage their condition
- Prevent further episodes of poor mental health
- Reduce the number of suicides

…. the success of services to date …

Current Strengths

- Listening to people who use services, working to put people at the centre of their own care and support plans, giving them more control over their own lives and what they need to help them achieve this

- Reviewing everything currently provided, keeping what is working well and developing new ideas and services that are missing

- Identifying waste in services, avoiding duplication of services and make savings by better partnership working and by buying services together

- Improving services and putting people first, designing services to fit people *not* fitting people into inflexible services, this enables people to live as independent a life as possible

- Working with Torbay Voice (a group of people who are or have used services), we have achieved more client involvement; people are helping with recruitment, meetings, minutes and sub-groups and bring a wealth of personal experience
- Torbay Voice members are involved with 'Mindful Employer', which is a project aimed at increasing awareness of mental health at work and providing ongoing support for employers in the recruitment and retention of staff
- Employing 'Quest' (a group of people who are using or have used services) to provide an expert view and maximise client's input to help review services and develop new service specifications
- Torbay Voice Link Co-ordinator (who is a current or previous user of services) working as part of the Supporting People Team
- Improving services, crisis intervention (crisis prevention), community services, specialist services, preventative services, day services, meaningful activities, improving education and voluntary or paid employment.

…. and how to achieve the vision …

Areas Needing Improvement

- Increasing the number of people included in developing their support plan
- Allowing people more choice on how to live their lives
- Designing clear pathways for referrals to cross agency services
- Access to emergency accommodation for homeless people with complex needs, enabling support and treatment to begin immediately
- Working towards better outcomes for people; particularly managing poor mental health, gaining employment and accessing training and managing substance misuse
- Enabling people to remain in their own homes by providing innovative and flexible care and support in the community
- Flexible, integrated support and care services tailored to the individual circumstances of people with more complex needs
- Continuously improving services and achieving better value for money
- Partnership working with people, their carers, peer support groups, e.g. Quest, statutory and voluntary agencies
- Responsive preventative services to avoid hospital admissions

- Reduction in the length of stay on acute wards by providing individually planned services in the community on discharge
- Reducing the number of people who are placed in services outside Torbay
- Pooling and aligning resources including funding staff, buildings and skills with partners to commission strategically relevant, best value services
- All carers of people with a severe and enduring mental illness will be eligible for an assessment of their needs.

…. Summing up …

The need for informed delivery, person centred (putting the person at the centre) care and support, at the right time, in the right place, by the right person; being able to respond to the needs of people and their carers through an individual holistic approach ensuring access to appropriate treatments and interventions, including physical care and wellbeing.

…. What supports recovery …

Research has found that important factors that support people on the road to recovery include:

- good relationships
- financial security
- satisfying work
- personal growth
- the right living environment
- developing one's own cultural or spiritual perspectives
- developing resilience to possible adversity or stress in the future

Further factors highlighted by people as supporting them on their recovery journey include:

- being believed in
- being listened to and understood
- getting explanations for problems or experiences
- having the opportunity to temporarily resign responsibility during periods of crisis

Included in the Strategy are success stories highlighting positive outcomes achieved by agencies working together providing people with correct services at the right time, developing skills, achieving goals, turning people's lives around and giving them the opportunity for a brighter future.

Success story: Mr Bay is currently receiving treatment from the Mental Health Team after suffering a serious episode of mental ill health while living in the family home. Since a recent incident, the Bay Family find themselves being treated differently by the neighbours. The children became traumatised after witnessing the incident and are now too afraid to sleep in their own rooms at night, resulting in the whole Family sharing one bedroom. In addition, Mr Bay suffers from paranoia and believes they are all being watched, this fear is heightened because the property backs onto woods. Local services supporting the Bay Family worked together to help them move property. Devon Home Choice awarded the Bay Family an emergency card, giving them priority when bidding for a property. The Bay Family successfully placed a bid for a more suitable property, which has had a positive effect and the whole Family have become healthier and happier. Mr Bay is currently in recovery and their lives are back on track.

5. Key Themes

Key Theme 1

Information needs to be more accessible to people

Objectives

- To ensure greater accessibility of information enabling people to make meaningful comparisons between services.
- To implement an effective way of allowing referrers to talk to each other and share information.
- To identify and explain what needs to change to support personalisation.

Recommendations

- Providers must produce clear information explaining the choice and delivery of service offered, also who and how they can access it.
- Information should be widely publicised in formats accessible to everyone.
- Ensure information is available in places in the community where people access information, advice and advocacy.
- Commissioners must support providers, people and carers to achieve more self-directed support and personalisation of services.
- Partners agree appropriate information sharing protocols and practice.

Success has been achieved when:

- ✓ People talk to commissioners, through reviews or Quest and let them know if their service is working well or not.
- ✓ There is evidence of clients and carers directly influencing the planning and delivery of mental health services.
- ✓ Service specifications are more outcome based enabling choice and personalised services.
- ✓ New services are awarded through a competitive tendering process.
- ✓ Services are contract managed through QAF (Quality Assessment Framework) or CQC (Care Quality Commission) inspection reviews ensuring good quality services and best value.
- ✓ Individual recovery outcomes are achieved.
- ✓ All information is in accessible formats and locations.
- ✓ People and carers can clearly see and understand the pathways for services to care and support people.
- ✓ Partners implement appropriate information sharing protocols and practice.

Key theme 2

Preventative services targeted to reduce the number of situations needing an emergency or more costly response

Objectives

- To promote mental health and wellbeing in order to reduce the demand on emergency and crisis service.
- To identify a lead professional where there is no mental health service involvement.
- To maintain independence allowing individuals to be supported at home.
- To support people with complex and enduring mental health needs to develop self-management strategies.
- Services will be based on the principles of recovery, self-help, early intervention and social inclusion.

Recommendations

- Each person referred to the Supporting People Referral Hub, not subject to a Care Programme Approach (CPA), should have an allocated lead professional or a point of liaison.
- A multi-agency approach is taken to assessment.
- Consultation with people through Torbay Voice, Quest and Links/ Healthwatch (involving people in health and care) encouraging active lifestyle, giving better access to non-statutory and voluntary services.
- To ensure a wide range of meaningful recovery orientated, community activities are available to meet individuals' needs.
- Torbay Council and Torbay Care Trust to review in more detail providers' strategies to engage effectively with minority groups.
- People, their carers and families are able to engage through easy access to relevant service.

Success has been achieved when:

- ✓ Admissions to acute psychiatric wards and residential care are reduced.
- ✓ People have an identified lead professional, a CPA or a point of liaison identified ensuring joint working between MH services & housing.
- ✓ A multi-agency approach is standard practice.
- ✓ Individuals participate in recovery focused community services.
- ✓ Performance indicators show increased engagement from minority groups.
- ✓ Services are available to families and carers.

Key Theme 3

Services should be commissioned within a "Right Service, Right Time, Right People" philosophy

Objectives

- To better enable service providers, (including the Referral Hub, clinical and community networks) to work together to promote recovery to address complex needs and behaviour.
- To enable people to move more easily between or re-access services allowing them to better manage their health and maintain wellbeing.
- Services will be delivered increasingly within community settings.

Recommendations

- Data systems are fit for purpose, analysis of data is accurate and valid, adequate information is provided to make future investment decisions.
- Commissioners should procure future services, taking into account the need for the following:-
  - A specialist service (or set of services) to cater for people with complex and/or enduring needs.
  - More emergency temporary accommodation services with access to specialist mental health support and care.
- All service specifications must be linked to more effective partnerships with education, training and employment providers and services for people who misuse substances, underpinned by the recovery philosophy.
- Community services should link housing, health and employment services into the wellbeing and recovery pathway.
- All service providers must demonstrate how they support these partnerships while achieving individual recovery outcomes.
- To avoid duplication and double funding by providing a consistent service.

Success has been achieved when:

- ✓ People with complex needs, have timely access to relevant services.
- ✓ People are given choices and encouraged to self-manage their condition.
- ✓ When people identify they are becoming unwell, they engage the relevant services specified in their WRAP (Wellness Recovery Action Plan).
- ✓ People have choice over the treatment and services they receive and can plan this in advance through support plans.
- ✓ There are increased numbers of people successfully engaging in education, training and employment.
- ✓ People are supported to work with specialist services i.e. substance misuse.

Key theme 4

More formalised partnership working between health, housing, criminal justice and social care services

Objectives

- A single recovery pathway.
- Best use of the available resources.
- Diagnoses, which may have previously resulted in exclusion from mental health services, will not be a barrier for acceptance to services.

Recommendations

- TCT, TC, DPT and other Torbay Together partners should align and pool funding to maximise resources against commissioning priorities.
- All service specifications and contract management must support the recovery philosophy and encourage effective partnerships with education, training, employment providers and services for substance misusers.
- Procurement of emergency, temporary accommodation and support, suitable for people with complex needs.
- Providers should have a clear planned move-on strategy, which includes continuity of professional and community support networks and removal of barriers to accessing mainstream housing.
- The operational definition of "short-term" should be clarified as no more than 6 months.
- People should be able to access appropriate support and/or care provision to meet their identified need and achieve relevant outcomes.

Success has been achieved when:

- ✓ People are able to access services to meet their recovery pathway.
- ✓ People feel agencies are working together towards the same outcomes.
- ✓ Move-on policies are transparent, easy to understand, well planned and support independence and recovery.
- ✓ People with mental ill health don't feel discriminated against.
- ✓ There is no duplication of services avoiding waste and making the best use of the money available.
- ✓ People are able to choose an individual or provider to supply their services.
- ✓ GP practice based commissioning and personalisation, including self-management is supported and developed.

Key Theme 5

All services maximise the potential for self-management, self-directed care and support promoting recovery

Objectives

- Personal recovery plans are at the heart of delivery.
- Services are flexible and meet individual need, 'right time', 'right place', 'right person' philosophy.
- Emphasis will be on promoting self-directed support services and encouraging people to self-manage their condition towards wellbeing and recovery.

Recommendations

- Future commissioning of services should be based on the principles of personalisation, consistent with Putting People First, the vision for development of a personalised approach to delivery of adult social care.
- Services should be based on a "core and flexi" model where there is a balance of commissioned and self-directed support models.
- Providers must take a flexible and person centred approach based on recovery values, enabling people to develop independent living skills.
- Services are accessible to people with complex needs and behaviours who may previously have been excluded.
- Commissioners should procure services, taking account of the need for:-
  - Specialist services catering for people with complex and/or enduring needs and challenging behaviours, avoiding exclusion
  - More emergency accommodation services with access to specialist mental health care and support
- The Link Co-ordinator role was reviewed and recommendations made to strengthen the commitment to increasing take up of personal budgets, supporting planned move-on to greater independence.

Success has been achieved when:

- ✓ People are offered choice over the provider and service they use.
- ✓ The right service is provided at the right time by the right person/agency.
- ✓ People are supported to develop and use recovery self-management plans such as Wellness Recovery Action Plan (WRAP).
- ✓ All services are person centred and flexible.
- ✓ People decide how much of their service they want control over.
- ✓ People are active participants in their community, taking part in education and leisure activities of their choice.

Key Theme 6

Independence and recovery should not only be associated with people living alone

Objectives

- There is an acknowledgment for the need for choice, to live independently either alone or in shared housing.

Recommendations

- Shared housing accommodation is recognised as a positive option for some people, supporting individual choice.
- Providers should consider all options in their move-on policy to meet the needs of each individual.
- Improve partnership working to increase access to existing housing, options including home share, shared ownership, and supported lodgings.
- Torbay Council continues to prioritise people moving-on from supported accommodation through Devon Home Choice.

Success has been achieved when:

- ✓ Shared housing is one of a range of options available.
- ✓ The quality and location of accommodation supports recovery.
- ✓ Providers encourage move-on, as positive progression towards recovery in a timely manner.
- ✓ Services are commissioned that promote independence and empowerment.
- ✓ There is a wider range of housing support options available to help people remain in their own homes.
- ✓ Services are available to people in crisis.

Key Theme 7

There must be greater engagement of all stakeholders in developing a mutually agreed strategic vision

Objectives

- Strategy development is a joint process fully involving **all** people, including people currently using or who have used services in the past, carers, front-line staff, providers and the wider community.
- A common language in which words such as care, support, risk, chaotic, high, medium and low are defined.
- To monitor and positively manage risk regarding the mental wellbeing of people using the service.

Recommendations

- Future commissioning of services should be based on the principles of Recovery and Wellbeing and Personalisation, consistent with Putting People First.
- Consideration is given to the best way to involve Torbay Together Partners and people (clients, carers, communities of interest, providers etc) in all decision making.
- Review current structures and partnerships to determine the most efficient and effective way of aligning resources and devolving (handing over) decision-making.
- Multi-agency approach to managing risk and appropriate information sharing protocols.
- Terminology used to define conditions and length of services is agreed.

Success has been achieved when:

- ✓ Everyone is comfortable with and understands the language used.
- ✓ Partner agencies have mutual understanding of terms used and definitions are consistent across all services e.g. recovery, high, medium and low.
- ✓ People have clear understanding of what they can expect from services.
- ✓ Self-directed care and support is at the centre of all services commissioned.
- ✓ People who chose a Personal Budget can have a combination of services provided and agencies will be willing to work alongside each other to complement the different services provided.
- ✓ Individual outcomes are achieved through effective risk management.
- ✓ Partners are able to share information.

PART 2

'Improving Mental Health and Wellbeing in Our Community!'

6. Where We are Now

2009/2010 (April to March)

Type of Service – Under 65	No of Units or Rooms	Approximate No. of People per annum	Funding Agency	Funds/Cost
Residential Care Long stay	-	51	Adult Social Care	£1,577,000
Residential Care Short stay	18	18 *	Adult Social Care/DPT	£182,124
Independent Hospital	12	27 *	Health	£511,728
SP Long-term Accommodation	46	57	SP	£354,283
SP Short-term Accommodation	23	36	SP	£176,288
Acute Psychiatric Ward	-	240	Health	£2,922,050
Community Networks – Day services	-	24 per week **	Health	£68,596
SP Floating Support	22	42	SP	£80,231
SP Long-term Floating Support	70	94	SP	£270,000
Support Time Recovery	-	291	MH Grant	£164,093
Domiciliary & Enabling	-	72	Adult Social Care	£158,000
SP Learning Disability Funded Accommodation Services	35	39	SP	£350,066
SP Funded Floating Support (other Sectors' Budgets)	45	101	SP	£121,109
Direct Payments	-	7	Adult Social Care	£36,000

* Torbay Residents
** Some people will attend for several sessions

7. What We Know

The National Service Framework for Mental Health Services has been replaced by the Department of Health's *New Horizons* programme *"A Shared Vision for Mental Health"* published in February 2010; this sets out the next stage of mental health policy in England. New Horizons is a cross-government programme of action with the twin aims to:

- Improve the mental health and well-being of the population
- Improve the quality and accessibility of services for people with poor mental health

New Horizons proposes a change of focus to prevention and early *intervention* through effective treatment and recovery, and maintaining good mental health in the whole population throughout a person's lifetime. It outlines the benefits of reducing the burden of mental illness in order to improve physical health, increase educational attainment and reduce unemployment and crime. The need to prevent mental ill health through early intervention, as well as treatment, has been shown to improve long-term outcomes.

New Horizons has been launched alongside two key cross-government delivery plans to support people with mental health problems back into employment:

- "Work, Recovery and Inclusion": a plan designed to support people in contact with secondary mental health services back into work.
- "Working Our Way to Better Mental Health": a framework designed to improve wellbeing at work for everyone and deliver significantly better employment results for people with mental health conditions.

The Impact of Mental Illness as described in the New Horizons Programme is listed below…

Impact of Mental Illness

- **At any one time, just over 20% of working-age women and 17% of working-age men are affected by depression or anxiety; approximately 5% of men and 3% of women can be assessed as having a personality disorder and over 0.4% have a *psychotic* disorder such as *schizophrenia* or *bipolar affective disorders*.**
- **Half of those with common mental health problems are limited by their condition and around a fifth are disabled by it.**
- **Mental illness accounted for more disability adjusted life years lost per year than any other health condition in the UK and the figures for 2004 show that 20% of the total burden of disease was attributable to mental illness (including suicide), compared to 16.2% for *cardiovascular diseases* and 15.6% for cancer. No other condition exceeded 10%.**
- **No other health condition matches mental ill health in the combined extent of *prevalence*, persistence and breadth of impact.**
- **Mental illness begins early; 10% of children have a *diagnosable* mental health condition and 50% of lifetime mental illness is present by the age of 14.**

New Horizons is the National Strategy for adult mental health services, which is currently being refreshed in-line with the new coalition Government's policies; this is due to be published in December. The local version of New Horizons' implementation plan will be delayed until after the national publication is launched.

In July 2010 the coalition Government released a new white paper setting out the proposed direction for the NHS.

"The key points of the new direction include:

- Giving patients greater choice and control, and equipping them to make decision through the provision of a greater range of data.
- Focussing on clinical outcomes rather than targets, building on Lord Darzzi's review and particularly its focus on quality. The aim is to provide continuous improvement through reduced bureaucracy and greater focus on clinical outcomes.
- Empowering clinicians and other healthcare professionals to use their judgement and innovate. This bottom-up approach is designed to draw upon the strengths and knowledge of front-line staff, ridding the system of the top-down approach much criticised in the past, with decisions taken centrally by less-informed politicians."

The Government's policy around mental health is developing, giving emphasis on identifying what actually happens to the health of the person, the outcome, as a result of the treatment and care they receive, as well as giving major importance to the voice of people, and handing GPs a central commissioning role. The Government's intention is to devolve budgets to GP practices in 2013.

There is a recognition mental health policies cannot be devised and implemented by any single government department of the NHS alone, it requires collaboration (joint working) across central government, local government and the independent sector.

Success Story: Stuart, had previously not coped in supported accommodation, had exhausted all accommodation options and due to an incident had received a custodial sentence. On release from prison, Stuart being homeless was provided with accommodation and support in the hostel for a short period of time. During this time Stuart built a good relationship with his support worker. After assessment it was decided Stuart needed a higher level of care and support and accepted a residential placement. Supporting People agreed to "double fund" extra support to cover his move, allowing Stuart to continue working with his current support worker who he engaged well with. Recently, Stuart was approved for a direct payment to fund a training course at college, which could lead to employment. The services will continue to work together supporting Stuart's continued recovery, while helping him plan his "move on" and "step down" to more independent accommodation and less support. This is an excellent example of joint partnership working and good practice, ensuring a positive outcome for Stuart avoiding his situation or health deteriorating while encouraging him to take part in further education and training.

1. Mindful Employment

Stress, depression and anxiety are estimated to be the cause of more working days lost than any other work-related illness. Sick pay reduces profits. Covering absent workers adds more pressure. Loss of valued and talented people costs more than money.

For some, the link between stress and mental ill health may a new one. We all need and, to a degree, thrive on pressure. It gives us energy, helps with performance and inspires confidence. But when pressure becomes too much, perhaps due to workload, lack of time for social, family and personal activities, inadequate training to carryout the job, or external factors, it can lead to high stress levels, which in turn can lead to other mental health issues including anxiety and depression.

The Mindful Employer Charter – the scheme, was launched back in 2004 and is for employers who are positive about Mental Health and is open to any employer whether they are small, medium or large, in the Public, private or voluntary sector, based anywhere in the UK. The Mindful Employer scheme is aimed at increasing awareness of mental health at work and providing ongoing support for employers in the recruitment and retention of staff.

There is also a Government initiative to encourage and help people maintain their employment when first returning to work after a long period of unemployment due to disability; this means someone can accept employment for between 1 and 6 weeks, while remaining on their current benefit, enabling a person to experience work. 'Access to Work' criteria has been negotiated, for people over 16, to purchase employment support and sickness cover; this can be interpreted widely and each case would have to be negotiated to achieve personalised support.

The current Government's Welfare Reform proposals will detail further measures to assist people back into employment.

2. Self-management of Mental Health

Currently co-creating health initiatives are being delivered in partnership with Torbay Care Trust and Devon Partnership Trust. The Self-Help Programme and the Expert Patients' Programme deliver a free self-help course for people living with depression and provide an opportunity for people to learn and understand more about their condition. The course helps individuals, their carers and families to develop the knowledge, confidence and skills to cope with the feelings of helplessness, hopelessness and despair giving the individual confidence to take control of their life and to be able to make positive changes in the way they live.

3. Personal Health Budgets

There is a National study taking place on *Personal Health Budgets* (PHB) and Torbay is one of 20 pilots. Torbay Care Trust will recruit people:

- 75 people on a Personal Health Budget
- 75 people for a control group (existing services)

The group of 75 people will consist of;

- 45 people who have a *neurological illness,* (this is a medical term having to do with the nerves or a disorder of the nervous system e.g. Parkinson's disease, acquired brain injury and multiple sclerosis)
- 15 continuing health care (CHC) patients, (people with a long-term chronic health condition, which entitles them to receive continuing care from the NHS)
- 15 people mental health services (people who have been diagnosed with a severe or enduring long-term condition).

The pilot study will run for 12 months. People taking part in the pilot will be given the opportunity to spend some of their health monies differently and develop an alternative care plan, which will give the person more choice. This pilot is still being developed and therefore the remit is not conclusive but reporting on the pilot should be in March 2012.

4. Needs Assessment

Torbay's Joint Strategic Needs Assessment *(JSNA)* highlights some key demographic issues that should be factored into service planning for this client group. These are set out in the table below.

Key Demographic Indicators from Torbay's *Joint Strategic Needs Assessment (JSNA*)

Indicator	Result
Age of Residents	The average age of residents in Torbay at 43.7 years is higher than the national average of 39.1 years; with two wards having an average age greater than 50 years.
Long-term Illness	The population with a limiting long-term illness is higher in Torbay (at 23.0%) compared with the South West (18.1%) and England (17.9%)
Community Care services	5,000 adults in Torbay received community care services during 2007/08 for physical disability, frailty, sensory impairment, learning disability, mental health, substance misuse and vulnerable people services, a rate of 4,860 per 100,000 locally compared with 3,990 nationally. The proportion of adults with poor mental health helped to live at home is lower (at 2.0%) compared with the South West (5.6%) and with England (4.5%).
Mental Health services	The proportion of people receiving mental health services is lower (at 14.5%) compared with the South West (21.8%) and England (17.1%); although when compared with the indicator for people accessing Supporting People Services for Mental Health and Learning Disabilities Torbay has a greater proportion at (20.9%) compared with the South West (13.7%) and England (12.0%).
Ethnicity and Mental Health Services	The number and percentage of people with non-white British ethnicity and having a mental health need has reduced over the last 3 years from 5.5% to 2.9% of all people entering Supporting People services.
Substance misuse services	The proportion of people receiving substance misuse services is higher in Torbay (1.7%) compared with the South West (0.5%) and England (0.7%).
Hospital Admissions	Alcohol related admissions to hospital in 2008/09 were 1,989 per 100,000 of population in Torbay, 27% higher than the national figure of 1,562 per 100,000.
Suicide	Torbay has the 4th highest rate per 100,000 of population in England. The actual rate is more than would be expected, approximately 11 deaths per year, 10 per 100,000 population

Population at risk of mental ill health in Torbay:
The number of people, at any one time, who could potentially have mental health problems in Torbay, is estimated by PANSI- a system developed by the Institute of Public Care for the Care Services Efficiency Delivery Programme. It is for use by local authority planners and commissioners of social care provision in England, together with providers and supporting organisations. It is a programme designed to help explore the possible impact that demography and certain conditions may have on populations aged 18 to 64

Estimates of mental health problems in Torbay for 2010:

Common mental health disorder	12510
Borderline personality disorder	350
Antisocial personality disorder	269
Psychotic disorder	311
Total	13440

Source: PANSI (Projecting Adult Needs and Service Information System), Institute of Public Care

These figures are based on the report Adult Psychiatric Morbidity in England, 2007, results of a household survey, published by the Health and Social Care Information Centre in 2009. The prevalence of mental health problems found by this survey is shown in the table below:

	% males	% females	% all adults
Common mental disorder	12.5	19.7	17.6
Antisocial personality disorder	0.6	0.1	0.3
Borderline personality disorder	0.3	0.6	0.4
Psychotic disorder	0.3	0.5	0.4

The prevalence rates have been applied to Office of National Statistics population projections for the 18-64 population to give estimated numbers predicted to have a mental health problem, projected to 2030.

In this survey common mental disorders are mental conditions that cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. They comprise of different types of depression and anxiety, and include obsessive compulsive disorder.

Personality disorders are classed as longstanding, ingrained distortions of personality that interfere with the ability to make and sustain relationships.

Borderline Personality Disorder is identified as high levels of personal and emotional instability associated with significant impairment. There are severe difficulties with sustaining relationships, self-harm and suicidal behaviour is common.

Anti-social Personality Disorder is identified as disregard for and violation of the rights of others. There is a pattern of aggressive and irresponsible behaviour which emerges in childhood or early adolescence.

Psychosis disorders in the survey are identified as producing disturbances in thinking and perception severe enough to distort perception of reality. The main types are schizophrenia and affective psychosis, such as bi-polar disorder.

Population of working age with serious mental ill health:
Disability Living Allowance/ Incapacity Benefit claimants of working age as in February 2010:

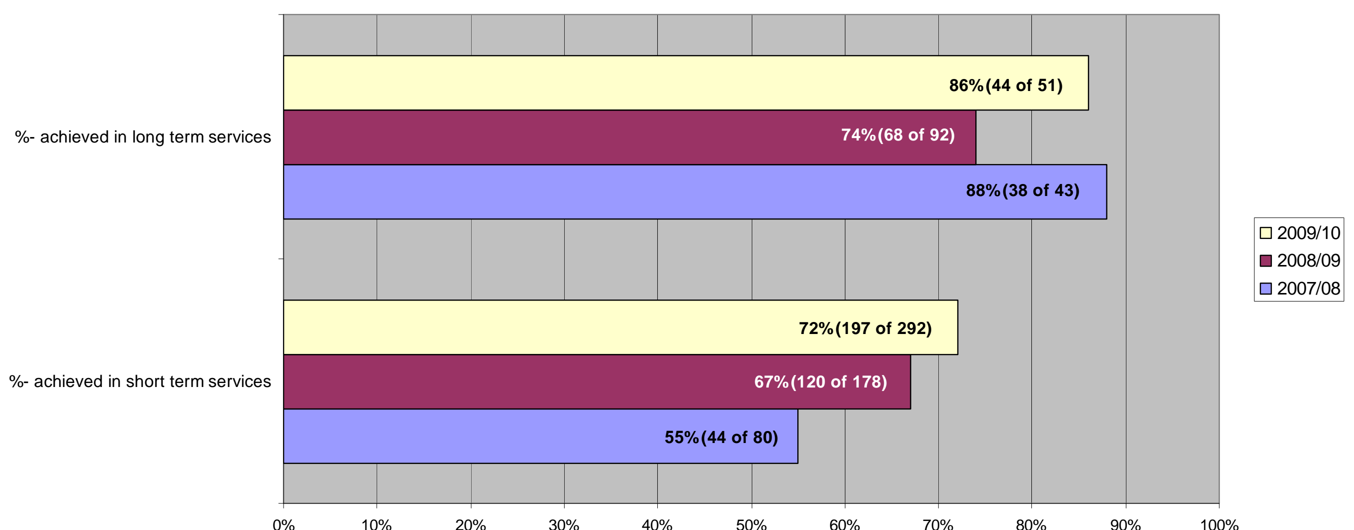
Area	Number claiming for poor Mental Health	% of all claimants
Torbay	2925	44.49%

This compares with 43.34% of all claimants claiming due to mental ill health in England on the same date in February 2010. Torbay therefore has a higher % of claimants for this issue. These people could already be receiving Supporting People services and not all will require services, but it does give an indication of need at any one time.

The figures below are approximate numbers of people who may need Supporting People services. These figures are approximate but give an idea of the type of unmet need there is for Supporting People services.

Number who could move out of residential care with appropriate support if the opportunity arose	= 21 (Current clients in residential care for mental health was 88 at October 2010)
Annual homelessness acceptances with mental health as priority need (1 July 2009 – 30 June 2010) This does not include people who have mental health problems which were not their priority need	= 6 (Some of these may be in a Supporting People service)
Number on waiting list for SP services	= 98

Supply of mental health services:
Number of accommodation based units- 78
Number of floating support units- 92



The above chart shows the percentage of people who better manage their mental health out of:

- A sample of people using long-term services
- People who moved-on from short-term services

There is a need to improve the percentage of people who have a need to 'better manage their mental health'. The main recorded reasons for non-achievement are unable or unwilling to engage in support. Services need to continue to focus on engagement and work more intensely, more flexibly and provide a person centred approach to achieve better outcomes.

In Conclusion, this gives an indication of the number of people who may need services but this will not be a conclusive list; in addition there will be people not known to services, in hospital and those with low level need. Some people may already be receiving treatment from their GP and this may be sufficient.

Torbay Council's Housing Strategy "The Future of Housing in Torbay – A Partnership Strategy 2008-2011" does contain clues to demand for mental health supported housing services and desired outcomes for service commissioners.

The outcomes listed under the "assisting independent living" are:

- **Service development and review is led by people who use services.**
- **All services deliver positive outcomes for people increasing choice and control.**
- **Improve quality & value for money by taking forward plans to design and buy services for people with different needs.**
- **Improve access to and move-on from support services to increase independence of vulnerable people.**

5. Personalisation

By 2011, everyone living in Torbay will be given the opportunity to meet their social care needs in a way that is personal to them, which focuses on what helps them to achieve their goals in life. This is known as personalisation and it means making the support people receive personal to them by offering the option of Self-directed Support and/or a Personal Budget. People will also have the chance to be more involved in decision making to shape local social care services.

One of the key implications of personalisation is the need for a single assessment and the sharing of information between agencies.

The government launched '*Putting People First*' in 2007. This is a national programme for change within Adult Social Care, aimed to give people more choice and control over their support so they can live their life the way they choose.

6. Wellness and Recovery

Wellness Recovery Action Plan – 'WRAP' is mentioned in Part 1, in Themes 3 and 5 and is explained in more detail below.

WRAP is a self-management and recovery system developed by a group of people in the US who had mental health difficulties and who were struggling to incorporate wellness tools and strategies into their lives.

WRAP is designed to:

- decrease and prevent intrusive or troubling feelings and behaviours
- increase personal empowerment
- improve quality of life
- assist people in achieving their own life goals and dreams

WRAP is a structured system to monitor uncomfortable and distressing symptoms. It can help reduce, modify or eliminate symptoms by using planned responses. These include plans for how an individual wants others to respond when symptoms have made it impossible for them to continue to make decisions, take care of themselves or stay safe. The person who experiences the symptoms develops their personal WRAP, although they may choose to ask family, carers, the people who support them or health professionals to help them create it.

7. Advocacy

The role and use of advocacy is essential, especially as personalisation progresses; the advocate will help support people with poor mental health, enabling them to speak out, get their views heard and take greater control over their lives. Advocates play an important role in ensuring that the needs of individuals in this group are met, including facilitating access to a service or *safeguarding* the person's rights. Evidence shows that advocacy is effective in reducing barriers faced by vulnerable people. Advocacy can take many forms, including protecting people who are vulnerable due to mental ill health or lack of capacity to make informed decisions; this can be done formally or informally.

8. What We Did

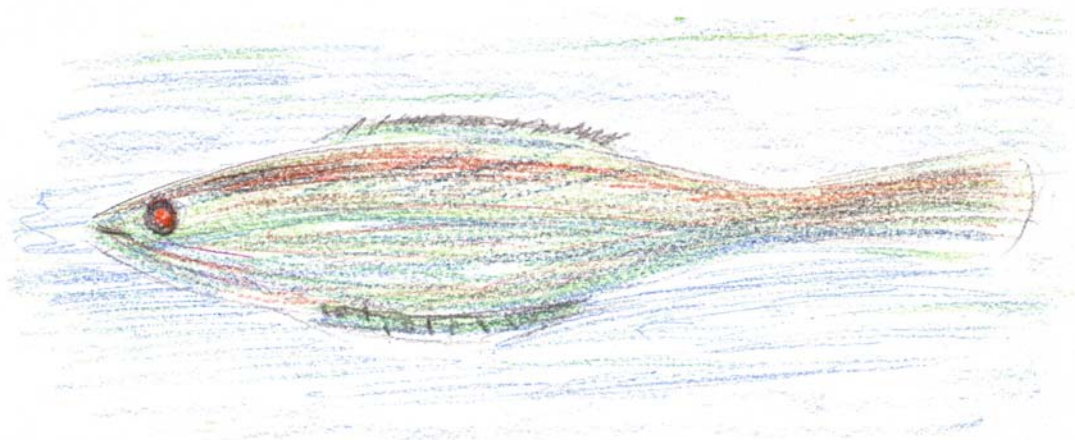
To develop this strategy a range of consultation activities took place, with people who use services, carers, providers, commissioners and community voluntary services. This included one-to-one interviews and group meetings, and covered a general review of existing services and identification of peoples' aspirations for future services.

Torbay Council and Devon Partnership Trust compiled data on performance, need, current service capacity and finance.

This information was used to create the strategic themes detailed in part 1, which were discussed at a major stakeholder event. These themes clearly indicate the direction for policy and practice over the next 5 years, and the future commissioning of housing and related accommodation, care and community services in Torbay to support the recovery of people with mental ill health.

The key strategic themes will shape services detailed in the next section:

- **Gateway - the point of entry into services: engagement, access and planning**
- **Early Intervention – preventing crisis and escalation of illness**
- **Preparing for move on - what will help people sustain recovery**
- **Sustaining Independence and Wellbeing – sustaining recovery, inclusion and enterprise into the future**



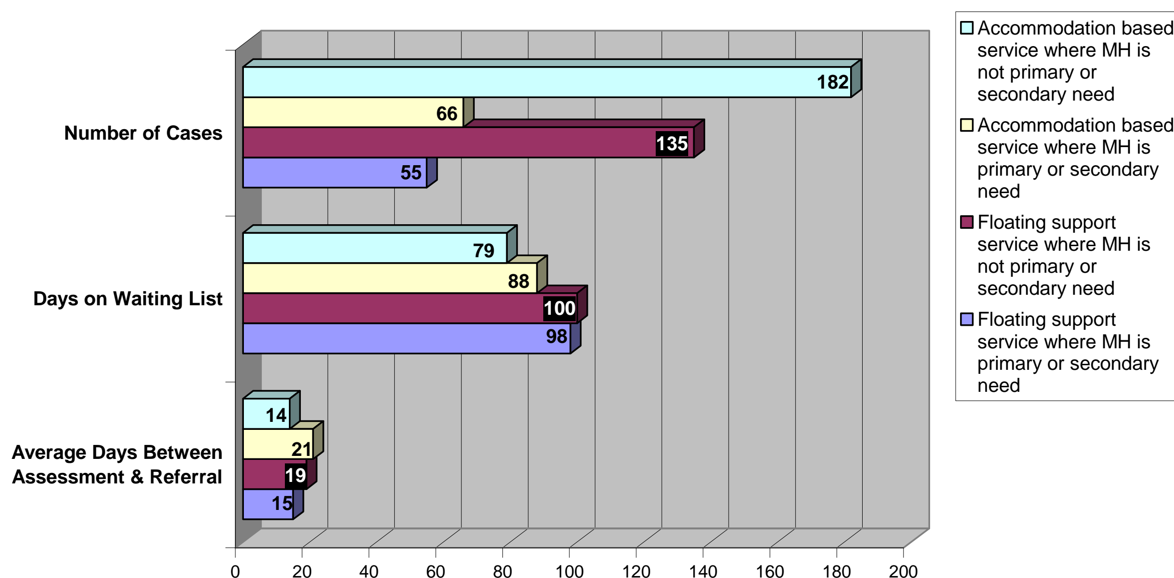
9. Gateway – The Point of Entry to Services

1. Housing Options Team

The Supporting People Referral Hub is part of the Housing Options Team and it is the central contact point and gateway for all referrals to housing related support services in Torbay. People can self refer or are referred by various agencies, e.g. mental health teams, GP, hospital, relatives or carers. This ensures people are able to access the most relevant service.

Data provided by the Hub shows the waiting time for people with poor mental health seeking to access accommodation-based services is longer than for other client groups (see chart 2 below). The waiting times for floating support services are slightly better. The longer someone is without support, the more likely it is their health and wellbeing will deteriorate and this in turn can prolong their recovery time.

Chart 2 - Summary of waiting times for Supporting People services in Torbay



Analysis of other data provided by the SP Referral Hub also showed that waiting time varied significantly between providers, ranging from 68 days to 238 days. The way data is currently collected does not routinely record where people are staying while waiting for a placement, except when someone is in hospital or residential care.

The available data indicates there is almost certainly a capacity issue, with the SP Referral Hub receiving more referrals for this client group than any other. This issue is mainly caused by lack of move-on of clients from services. This will need to be addressed as part of the procurement of Mental Health services.

The need to provide the 'right service' at the 'right time' by the 'right people' tests the services when people present at Housing with severe complex needs and challenging behaviour, or if the person has developed unhealthy coping mechanisms (e.g. substance misuse) or is in an abusive or exploitative relationship. To ensure services respond to individual circumstances, this needs to be looked at on a case by case basis.

There is a need for appropriate emergency accommodation for those people who may have become homeless. The Draft Emergency Temporary Accommodation Strategy addresses these issues.

The Hub is the *gateway* to some housing provision, private landlords and registered social landlords via Devon *Home Choice.* This is a choice-based allocation scheme and people are banded according to priority need and can bid for properties. The Hub also makes referrals on to other health, social care and community voluntary services following assessment.

Success story: Sandy lived with her partner, who owned the property they lived in. Unfortunately, their relationship broke down and Sandy became a victim of domestic abuse. Sandy was under the Mental Health Team and was suffering from depression and severe *agoraphobia*. Sandy's dog had become an important part of her life. She refused to give him up and he had been included in her recovery plan, which meant she was unable to be housed in temporary accommodation, Bed and Breakfast or the Women's Refuge. Working together services planned and supported to access a deposit, rent in advance and moving costs via Housing Options team, successfully moving her into private accommodation. Sandy is now recovering and enjoying living her life with the new independence she has achieved.

As stated in Table 1, the number of people from *Black and Minority Ethnic* Groups (BME) in Torbay is relatively small and the percentage of people with a non-white British ethnicity and having a mental health need has been reducing over the last three years, from 5.6% to 2.9% of all people entering the service. However this reduction is not specific to mental health and has been seen across all sectors. The Support, Time and Recovery Service made active attempts to engage with the small populations of Chinese, Polish and other Eastern European people, many of these were economic migrants, who use services proportionately less than the majority white population.

2. Social Care Panel

The Torbay *Social Care Panel* (a joint health care/social care arrangement) is the gateway to nursing and residential care. Services need to be developed to prevent unnecessary admission to hospital, which can increase the risk of tenancy breakdown and homelessness.

Delays in discharge from hospital are less frequent now. The Housing Link Co-ordinator role has been both advantageous as a member of the Social Care Panel, where housing options are discussed on admission, and successful in reducing the number of people waiting, by working across agencies. It is recognised people should be discharged from hospital to appropriate accommodation and support as soon as they are medically well enough.

The Social Care Panel is held to assess requests for placements in the Torbay area for access to residential care or for placements to the independent mental health hospital in Paignton or high need or specialist placements. The Panel regularly reviews people in current placements.

Secondly, the panel deals with requests for *direct payments* and *personal budgets*. The panel is usually attended by staff from the mental health sector; *DPT* Contracts Officer, TCT Commissioner, DPT Senior Management, providers, 2 clinical team leaders from Recovery and Independence and Assertive Outreach; plus the Modern Matron from the Acute *Psychiatric* Ward in Torbay Hospital.

Out of area placements (needed when local services are not available or unsuitable), i.e. specialist, high level secure services for the cases where people are most at risk are presented to the Individual Placement Panel.

3. Psychiatric Liaison Team
This is a new team that are based in Torbay Hospital. The remit of the team covers any patient, who may present with a psychiatric need throughout all departments of the Hospital.

4. Acute Services
There is a new and effective gateway to the Acute Psychiatric Ward in Torbay Hospital, the APOS Suite, (an alternative place of safety). Police can use this facility to detain a person safely while awaiting a psychiatric assessment, previously people may have been detained in a cell.

5. Safeguarding Adults
Recently the Single Point of Contact (SPOC) system has been introduced, which provides a safe and consistent process for all safeguarding concerns and referrals. The team aims to:
- Act as a single point of referral for all safeguarding alerts
- *Triage* alerts as they enter the system
- Gather initial information from across agencies as part of the triage process
- Determine if a referral should proceed under safeguarding process.

Currently, a Risk and Complexity Group is developing a pathway to enable people with complex needs to access the support and care they need. These people's needs span several services but may not reach Fair Access to Care (FACS) criteria, which means they are sometimes not eligible for statutory services. Also if they have dual diagnosis, such as alcohol and mental ill health, they may present as a challenge to services or they need to access both types of services, which could be avoided if the relevant services were jointly commissioned. In addition, it removes the barrier for people with diagnoses, which may have previously resulted in exclusion from mental health services, being accepted.

6. Day Services
Following a review of day services Torbay Care Trust has adopted a personal budget approach to the purchase of community services. This will form part of people's support and care plans.

There is a '*drop-in*' centre run by a voluntary organisation, mainly dependent on charitable funds, also a self-referral service in Paignton offering structured activities only, funded by Torbay Care Trust. There are the Women's and the Men's *Network* meetings and friendship groups, which are held in community venues to reduce the *stigmatisation* of the settings. Also available is the Employment Support group, provided by PLUS.

7. GPs and Secondary Health Services
Research shows that people generally access mental health services through their GP, who then refers them to the appropriate service and specialist mental health

professionals. In Torbay under current arrangements, if a person is not under a Community Mental Health team, it may result in them not receiving continuing mental health services.

In future more direct links will be made through GP practice based commissioning. The specific shape of services will be subject to the outcome of the Government's White Paper (Equity & Excellence – Liberating the NHS).

Those consulted shared concerns about the support delays accessing support. Due to the lack of capacity in mental health floating support services, people may be signposted to an existing *generic* service but it is not always clear who the service is intended for or what it offers. By developing more generic services alongside some specialist mental health input, people can be referred to services based on the level of need identified, e.g. low, medium or complex needs, leading to greater capacity and choice.

There was evidence from the consultation with providers that the terms 'low', 'medium' and 'high', in relation to either support or risk, are used in different ways by different organisations There is a need for clarity when using these terms, to avoid confusion when developing future service specifications. The expected level of support must be clear from the outset and staff need to be skilled to deliver at the level required.

Definition by Devon Partnership Trust professionals for categorisation of cases:

- 'High' expects a multidisciplinary response where children or safeguarding issues are involved
- 'Medium High' means recovery co-ordination, settled in therapy
- 'Medium Low' necessitates an active review at least 2 twice a year, still need services going in and/or signposting to services
- 'Low' needs a responsive review, where there is still contact e.g. regular medication required

Common definitions need to be developed for other frequently used terms, for example move-on, recovery etc; Care Co-ordinators are now called 'Recovery Coaches' and Care Plans are called '*Safety Plans*'.

Agencies need to work more closely with people and carers to raise awareness of the Hub and the support services available; this needs to include up-to-date information about services available, which must be in an easily understood format.

There are currently a number of posts in mental health services designed to improve the supply of information to people. The overwhelming view from all *stakeholder*s was that the Housing Link Co-ordinator post, which liaises in the process of referral and placement between partner agencies, has a significant impact on improving outcomes for people. At present this post is not permanently funded, but an evaluation is being undertaken to determine the savings and benefits made by the post to date. The Link Co-ordinator role needs to be adopted as part of the Strategy.

10.A Early Intervention

People interviewed were generally very satisfied with their housing related support provider and felt satisfied with what was done to make them feel safe and secure; to enhance their wellbeing and skills; and to face the future with confidence.

Stakeholders felt more effective communication within partnerships would improve outcomes for people and provide a step towards "right service, right time", within the available capacity.

The continuing financial reductions within Local Authorities will inevitably lead to pressure on all services, including statutory for example Adult Social Care. This will lead to an increasing need for preventative services such as those delivered through the Supporting People programme, which provide savings against statutory provision. This is demonstrated in Torbay's Financial Benefits Model, which is detailed at the end of this section. This tool was developed by CapGemini for the Department for Communities and Local Government.

The *National Indicators* (NI) currently used to measure contract performance are subject to change under the Coalition Government. Future contracts will be monitored against targets which will agreed at a local level and will be specified in future contracts.

Torbay Supporting People annual mental health monitoring and performance report for 2008/09 highlights an improvement from the previous year against the following indicators:

- minimising harm and/or the risk of harm from others
- maximising income and collecting the correct benefits

Performance dipped against the following outcomes:

- helping people obtain paid work
- participate in training and/or education
- better manage substance misuse

These outcomes, particularly those relating to managing substance misuse and accessing paid work are the least well achieved across all client groups using Torbay's Supporting People services, as well as the least well achieved by similar Local Authorities.

The report identifies the main reason for non-achievement as people being unable to engage with support or participate in training and/or education due to health problems. It also shows overall performance is improving, as well as performance against the national performance indicators (below), which are reported by each service provider.

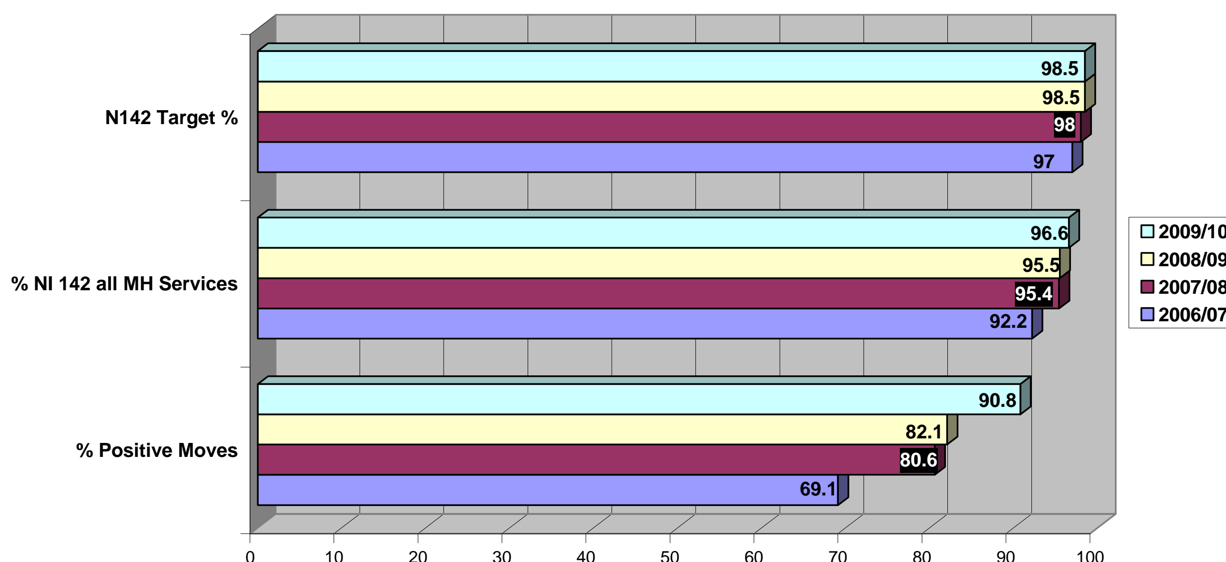
- NI 141 – Percentage of vulnerable people achieving independent living (planned move-on from short-term accommodation).
- NI 142 – Number of vulnerable people who are supported to maintain independent living (People maintaining their support service and/or positive move-on from long-term accommodation and all floating support).

Despite a reduction in the number of units the sector has consistently improved on the number of people who have established or maintained independent living, including

positive *move-on.* The percentage of positive move-on from services has increased considerably in 2009/10 to reach 90.8% .The target for NI 142 in Torbay is 98.5%, in 2006/07 92.2% was achieved, and this has increased to 96.6% in 2009/10.

This is set out in Chart 3 below:

Chart 3 - Performance of mental health Supporting People services in Torbay (Based on NI 142)



From consultation with individuals and group interviews the following issues affecting performance were identified:

- There is a lack of integration of referral, assessment, information sharing and care management systems between agencies
- The level to which support providers and *Community Mental Health Teams, Waverley and Culverhay,* involve people in assessment varies and the lack of personal involvement in the support planning
- The strength and quality of partnerships across all of the agencies providing care and support to an individual person varies. With multi-agency involvement there is often a lack of clarity around who is responsible for taking the lead on individual cases
- People felt that they were labelled and this led to them not receiving a fully personalised service

A pilot scheme for the mental health sector is underway; aimed at providing a personalised service to people being discharged from the acute psychiatric ward at Torbay Hospital. This service will be for a maximum of 6 weeks, meeting the outcomes identified by patients and facilitating to on-going services where needed. The main aim of the service will be to prevent re-admission to hospital. If this is achieved, savings could be reinvested to deliver prevention work to avoid admissions. Day services should also have a much bigger role in engagement and prevention.

Outcome based commissioning will ensure services meet the needs of individuals and the outcomes they want to achieve.

10.B Financial Benefits Model for Mental Health Services

The 'Financial Benefits Model for Mental Health Services' shown below, is an excerpt from the full Report - **Estimating the financial benefits of Supporting People Programme in Torbay July 2010**, which covers all the client groups.

Estimated saving because of Torbay SP of **£3.11M** for 256 units per year - 111 units of supported housing and 99 units of floating support specialising in mental health - and 46 units of generic floating support estimated as used for mental health. (This also includes 48 units where mental health clients are using services for learning disability).

This equals a saving of **£12,148.44 per unit** per year.

The Model makes a working assumption of the most likely alternative scenario for people with poor mental health needing an SP service, if SP was not available. This is:

- 59% of household units/ individuals living as independently as they are able to without an SP service. Financial impact arises through the costs of adverse events (such as loss of tenancy, ambulance call outs, hospital admissions etc) that would be more likely to occur without an SP service
- 8% of household units/ individuals receiving residential care and
- 33% of household units/ individuals receiving inpatient hospital care

For the latter 2 groups, it was felt that this percentage would not be able to maintain any meaningful level of independence without the input provided by SP.

Savings seen in Figs 1 and 2:

- Residential care costs- these are eliminated as SP prevents people from entering residential care and long stay hospitals
- Benefits and related services costs - SP prevents the need for people to enter long stay hospital care which would increase these costs
- Health service costs- SP services help people improve their general health. This results in lower use of Accident and Emergency, GPs and community mental health services, and fewer admissions to acute mental health wards
- Costs of homelessness and tenancy failure- SP helps people maintain their tenancies and mortgage conditions, and move on to more suitable stable accommodation if necessary

SP services reduce homelessness and episodes of mental illness and can prevent further mental health problems. SP helps reduce the likelihood of suicide or hospital admission, and reduces the burden on informal carers. Support helps in the self-management of conditions, encourages healthy lifestyles and helps people access services appropriately. Support helps to develop life skills such as cooking, shopping and dealing with correspondence, also reducing social isolation and generally improving independence and confidence. This is demonstrated in the case study about 'Jane'.

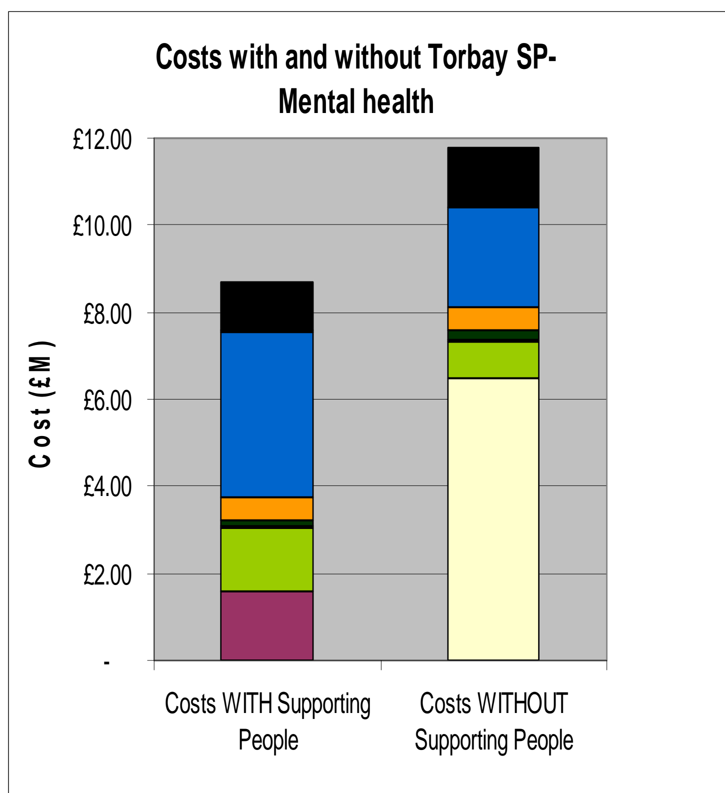


Fig 1

Fig 1 shows the estimated savings made because of Torbay SP per year in the client group of mental health.

The savings equal the right minus the left column

Fig 2 below shows the chart as a table. The net benefit column in Fig 2 shows savings and also additional costs (shown by a minus figure) incurred when an SP service is in place- explained above.

Fig 2: Table version of Fig 1. Estimated costs and benefits of Torbay SP programme per year- mental health.

Category	Cost with SP (£M)	Cost without SP (£M)	Net Benefit of SP (£M)
SP package	£1.61	£0	-£1.61
Residential package	£0	£6.49	£6.49
Housing costs	£1.42	£0.84	-£0.58
Homelessness costs	£0.04	£0.05	£0.01
Tenancy failure costs	£0.16	£0.19	£0.03
Health costs	£0.54	£0.56	£0.02
Social services care	£3.78	£2.26	-£1.52
Crime costs	£0.02	£0.02	£0.00
Benefits and related services	£1.10	£1.36	£0.26
Other services	£0	£0	£0
Total	**£8.68**	**£11.78**	**£3.11**

Figures may not sum due to rounding. Source: SP Financial Benefits Model, CLG, 2009

Additional costs seen in Figs 1 and 2:

Some of the cost types show additional expenditure incurred when an SP service is in place (those showing a minus figure):

- Housing costs- in the Model these consist of estimated rent costs for clients. Rent costs are not incurred when people are in residential care. SP prevents people from entering residential care so increases these particular costs
- Social services care costs- these include *domiciliary* and day care, and nursing care at home. These costs are not incurred when people are in residential care. SP prevents people from entering residential care so increases these particular costs

The case study below based on real events (with names changed) is used to illustrate potential savings made, and how SP services can improve outcomes for a person with poor mental health:

Case Study - Jane presented with depression and is receiving support from an SP mental health floating support service. Due to an episode of mental ill health she failed to open her mail or deal with day to day issues which created problems with her Benefits and a risk of losing her home. Since this episode she has been treated differently by her neighbours adding to her social isolation - she has become increasingly agoraphobic. Rent arrears mounted as her anxiety prevented her from managing her finances. The bed sit she lived in was tiny and in a bad state of repair; this added to her pessimism about herself and her life in general. She was not eating or looking after herself properly and her health was deteriorating.

Six months on, with the help of her support worker, Jane has signed up to Cognitive Behavioural Therapy and moved to a new flat, which she is taking great pride in setting up. She has cleared all her arrears and is in credit with her current utility bills. She is taking more pride in her appearance and personal hygiene. Her general health has improved - she is eating more healthily and has arranged an appointment with the dentist. Jane is also taking advantage of the Pathways back to work scheme and is considering new career paths. She is generally feeling more optimistic about life and although there are still dark days she has remained out of hospital. It is likely Jane will make a full recovery in time.

The previous table, Fig 2, show the estimated potential savings made because of Supporting People services being in place.

If Jane finds employment it will mean reductions to Benefits paid to him such as Job Seekers Allowance, Housing Benefit, Income Support and Disability Living Allowance.

11. Preparing for Move-on

Discussions with Council's Housing Options team highlighted the shortage of all types of housing in Torbay. The Supporting People Team feeds into the Affordable Housing Strategy and this can, and does, deliver specific supported housing projects.

In terms of value for money and maximising available resources, there is a need to make the best use of existing housing stock by re-providing/allocating where it is no longer fit for purpose; for example some sheltered housing schemes, promoting downsizing into more suitable accommodation, enabling and facilitating shared housing.

A number of people said they would prefer shared, rather than self-contained housing as a move-on solution, providers agreed they found this to be the case. This can reduce fear, which in turn can aid stability for some people; it can also help people avoid becoming *socially isolated* while still providing some private space. Shared housing must be recognised in commissioning terms as a positive option to people in this sector and may, for some people, be the maximum level of independence they strive for. Accommodation-based or floating support services can be delivered in shared housing. Feedback from the review suggested the amount of shared housing available to people with poor mental health needs to be increased. Ideally supported housing will provide a mix of self-contained and shared units, with a mix of both housing related support and mental health care to support tenancy sustainment.

Some providers appeared strong on signposting people to community agencies, supporting them to engage in *meaningful occupation*. Current contracts do not require the provision of 24 hour support and this means most services only offer support between '9-to-5', Monday to Friday. The move to more personalised services will mean providers will need to be more flexible to ensure services are provided in line with individual needs and wishes.

Future commissioning of services must include provision for people with more challenging and particularly complex mental health needs, taking into account the extension of Multi Agency Public Protection Arrangements (MAPPA) categories to include 'potentially dangerous or mentally disordered people' and 'mentally disordered offenders'. It was noted some housing related support staff have to deal with a level of health and social care difficulties they are neither trained nor paid to deal with. Failure to provide the right service for these small numbers of people can prove costly. Jointly commissioned contracts alongside partnership working is worth investing in to avoid financial waste and improve outcomes for people.

There is currently an absence of specific services for women with mental ill health and this is being addressed by providing 6 units of support as a new service. The service aims to work with women who may have mental ill health, be at risk of offending, be possible substance misusers, have a possible learning disability or need support around parenting. This service would also provide support to women who are inappropriately using a number of services. An example of this would be when someone excessively calls out the ambulance service unnecessarily. This service is being piloted for 12 months to establish whether it will deliver better outcomes for women than a gender non-specific service. Creating better value for money or creating savings within other services.

Mental health problems can contribute to women's offending and may be made worse rather than addressed in prison. This can be extremely damaging, both to the women themselves and to their families and children.

People with mental ill health who significantly abuse drugs or alcohol should receive appropriate, skilled assessment and treatment services to enable them to better manage or eliminate their dependency; simultaneously with the assessment and treatment of their mental health needs. The Drug, Alcohol and Sexual Health Team (*DAASHT)* pointed out that 30% of referrals to hospital A&E departments are alcohol and/or mental health related.

60 – 70% of offenders identify themselves as having difficulty in coping in relation to their own mental health. It is essential there is continuity of mental health services for people in prison with a seamless transition into the community. According to new research the government could save £700m annually from criminal justice costs if it overhauled the process for diverting offenders with poor mental health from jail to the mental health system. Too many people with complex mental health needs end up in prison. This is extremely expensive to the taxpayer, it is inappropriate as a setting for mental health care and it is ineffective in reducing subsequent offending.

Recently, a SP pilot was set up as a joint service with DAASHT and the Probation Service to work with offenders, the service targets people experiencing difficulty with their emotional wellbeing. The service spot purchases counselling and the outcomes have been good for offenders who have poor mental health and need specialist debt advice.

One of the current models commissioned in Torbay sources and supports private sector landlords to deliver supported housing. Depending on the severity of the mental health condition and the type of support required, the provider, while needing to be quickly 'at hand', does not necessarily have to be on site. Housing related support is received from the resident landlord; while mental health support is provided by a member of the *CMHT* as part of an agreed support plan. The need for this type of service should be taken into account and its success in involving Community Mental Health Team staff in support planning when developing future services reducing the reliance on public sector housing.

While stakeholders felt getting the numbers right was less important than getting the services right, it is essential a balance is achieved between the two. It is recognised that there will be a continuing need for highly intensive and skilled recovery focused support services which include an accommodation based services. The available data clearly suggests there is a need to access more support services within the restraints of a reducing budget, which may be achieved by increased utilisation and *throughput* and a more flexible, person centred approach to delivery.

The consultation for the Strategy produced some agreement for the following services, within the level of budget:

- A specialist service (or set of services) to support people with complex and/or long-term conditions and challenging behaviours
- More specialist mental health floating support units
- More emergency temporary accommodation
- Availability of more respite services with access to specialist mental health support and care

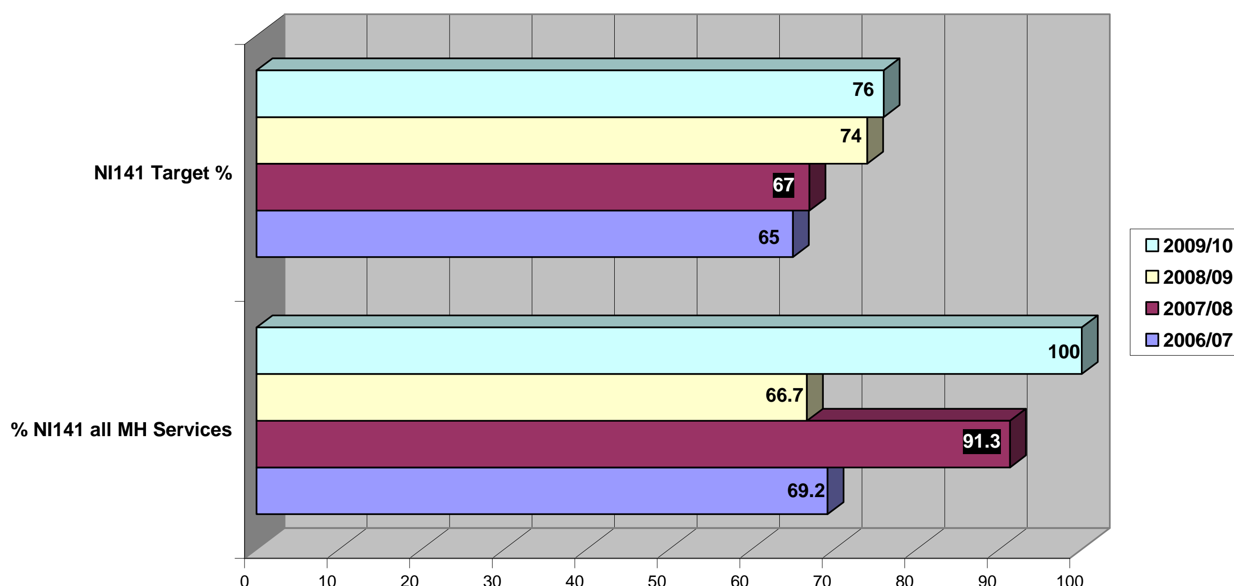
During the consultation opinions were divided between people requesting that floating support services remain linked to the accommodation provider; as well the flexibility for floating support to remain with the person if they wished as they moved-on. The second option will be more readily available with the progression of self-directed care and support and personal budgets. This second principle, that new services should promote flexibility, was a key outcome from the stakeholder event. The number of hours of support should vary according to individual presenting need.

In addition, further personalisation could be achieved through the 'core' and 'flexi' model. The "core" element of the service is commissioned by the Local Authority and the "flexi" element is the additional services chosen and bought by the individual.

Performance data shows that move-on from Supporting People services has improved over the last 3 years, with significant progress in reducing unplanned or negative moves.

Chart 4 below shows the rate of move-on from short-term accommodation services. In 2006/07, 69.2% was achieved against a target of 65% and this has increased to 100% for 2009/10 against a target of 76%, this again shows improvement.

Chart 4 - Performance of mental health Supporting People services in Torbay (Based on NI141)



The level of move-on from, length of stay in services is crucial in determining the services to be *commissioned* and in ensuring value for money is achieved. The aim for people with poor mental health entering the service is to move them on to greater independence and reduce the need for care and support. There are however, a number of circumstances to consider: delivering cost-effective and innovative services in a period of recession

- People may remain within the system (but with varying levels of care and support needs) throughout their life
- People may move in-and-out of mental health and related support services throughout their lives in times of crisis

- People may have their needs met first time and move on into independent living and never use services again

People may require occasional '*maintenance*' support to prevent relapse and during times of crisis; but the approach to maintenance services must be cautious as maintenance can equal co-dependency and limit capacity for independence.

Services must be personalised and flexible enough to cater for varying levels of need. The research showed some people in this sector have a fear of moving-on. This may be a combination of the illness, past or present housing experiences or the level of choice in support planning. These experiences may include:

- Poor quality accommodation
- Problems with neighbours
- Location of accommodation
- Being away from their support networks, causing *social isolation*

These factors can cause a decline in health and increase the need for support. The review showed over the last 3 years the number of people staying in services for a long period of time has increased. This has reduced the availability of services for new people. Reasons may include:

- They still need the service
- Insufficient affordable housing - The Local Housing Allowance does not usually cover the cost of rent from a private landlord, therefore restricting the people who can apply to privately rent a property i.e. people with access to private funding or people on high level Disability Living Allowance
- Lack of Social Housing, which is only 8% of total housing stock in Torbay
- Unsuitable accommodation
- Lack of positive promotion of move-on
- Fear of losing services

People of no fixed abode can create bed blockages in hospital and residential care.

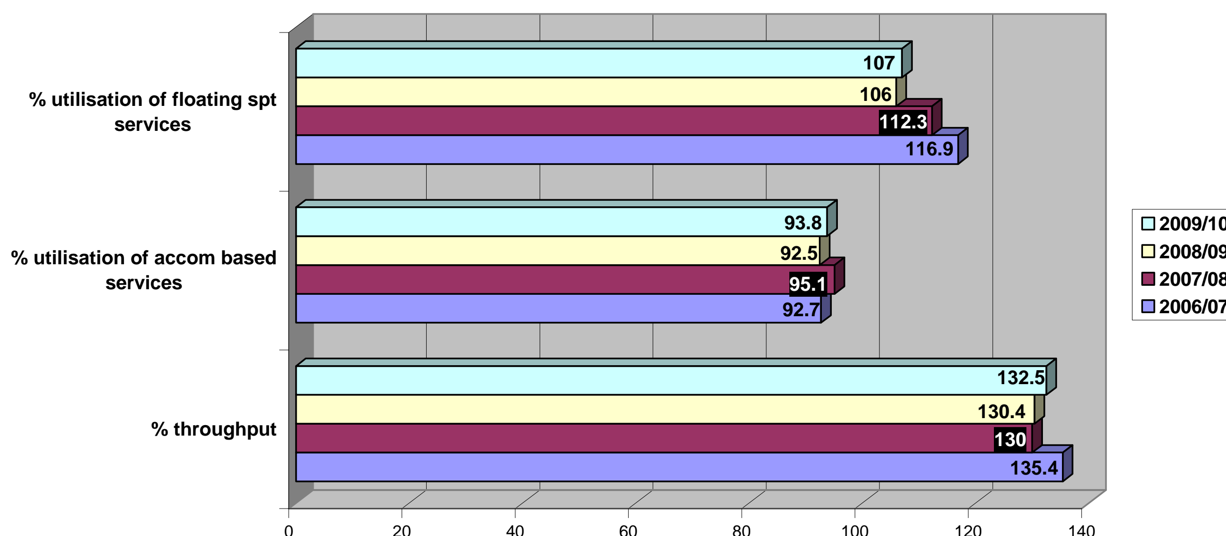
Success story: Carolyn was living in residential care, she became ready to 'move-on' and capable of more independent living. In addition, if she remained in residential care once she no longer needed that level of service, she would be bed blocking. Carolyn was supported to complete an application, apply and bid on-line for a property through Devon Home Choice. Carolyn bid for a property not far from the residential home where she was living. Unfortunately, she was refused the tenancy due to previous rent arrears. Carolyn was encouraged and supported to appeal against the decision, explaining she had got into arrears when she was ill, and therefore, had been unable to deal with her affairs. A fair and affordable payment plan was agreed to address her arrears. Carolyn's application was successful and she has now moved into the property.

The Coalition Government's priority is to reduce the financial deficit and indications are that most government departments will have to make substantial savings over the next 4 years. There will be a need to make efficiencies within the support and care provision delivered. Future services will need to be flexible allowing people to choose their accommodation and support, which may not be in a combined service. Research showed people prefer to remain in their property and not move to different accommodation to acquire the correct level of support. Therefore, the preferred option is to deliver support where people live, enabling them to maintain settled accommodation as their support needs change.

Community services could support people to access more settled accommodation (working with the Housing Options team and the Hub), employment, training and education opportunities. One of the outcomes of this would be an improvement in Torbay's performance against *PSA 16*. This is one of the Government's targets, which relates to the proportion of socially excluded adults in settled accommodation in employment, education or training.

Chart 5, below, shows a slight increase in throughput in support services. It is essential to improve the level of throughput, increasing the number of people who can be supported by moving people on efficiently and positively. The reductions in the level of support people require needs to be managed sensitively to maintain recovery.

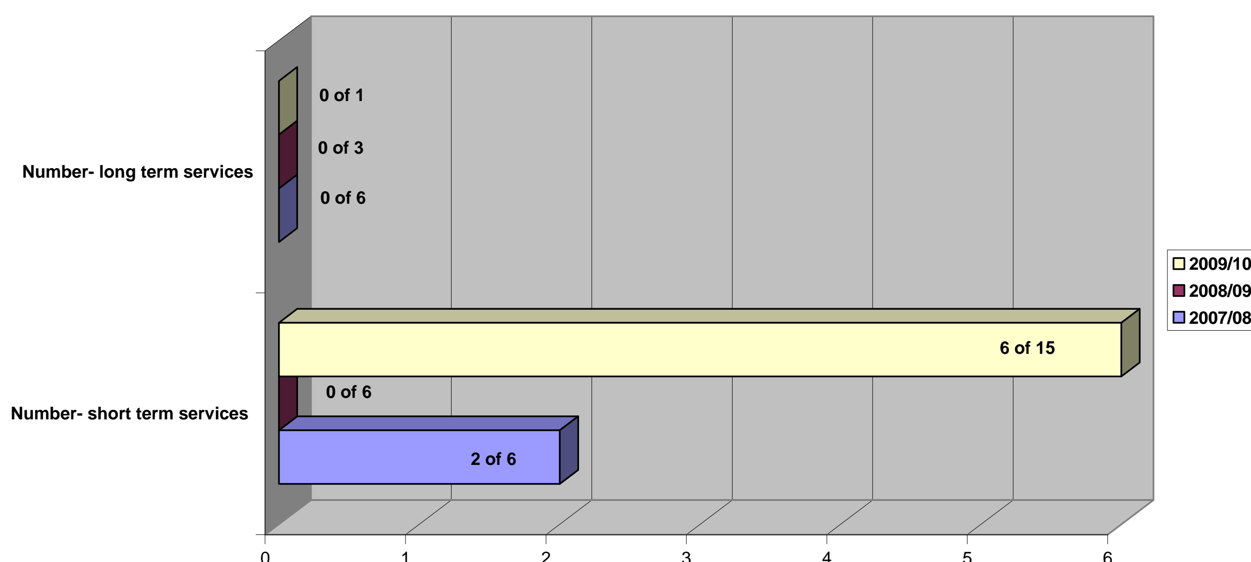
Chart 5 - Throughput and utilisation of mental health Supporting People services in Torbay (Based on SPI 2 and 4)



For people with mental ill health labelling services 'short-term' and 'long-term' is unhelpful. People can also find the phrase 'move-on' frightening, especially if they have become comfortable and well where they are living, made friends and generally feel settled. For some people there will be a need for continuing residential and/or nursing care. Others will need to plan their move-on from these services. The approach to 'move-on' should be dealt with in a sensitive, positive and planned individual way to reduce fear.

Moving-on needs to be supported by success in other outcomes, for example support to manage mental health, access training, employment and daytime activities; suitable good standard, affordable housing; continuing professional and community support networks; and safety of the neighbourhood.

Below, chart 6 refers to all people with a mental health need who left all SP services not just the services under the MH sector. It identifies the number of people who have accessed employment against the number with a need or desire to do so. Although this number has increased it is still small – only 6 people found work in 2009/10 but this was out of only 15 people who identified the need, this was out of the 142 people who left short-term services during that time. As people's health improves, services need to encourage people to identify employment as a desired outcome in the care and support plan as well as support them to access employment.



Move-on can be restricted due to the lack of appropriate, affordable accommodation. Most people interviewed believed Torbay has a large number of poor quality properties within the private rented sector, which restricts their choice.

An acceptable standard of move-on accommodation becomes as important as the quality of support available. Good quality housing and accommodation support services are essential in maintaining people with mental health problems in the community. It is important people are able to choose from a range of housing options. This is particularly important if people are to be supported to remain in their homes and not admitted to hospital or residential care during a period of poor health. The term short-term is only meaningful if this is how a service operates in practice.

After two years in a short-term accommodation support service, people have had time to put down roots, become settled, become familiar with a neighbourhood and build a network in the community. Some people will not have the desire, or see the need, to move-on. Insisting on move-on within strict timescales for people with poor mental health

can undermine recovery for some people. This is understandable and one reason for the need to increase floating support.

Torbay's social housing is accessed through Devon *Home Choice*; this requires a person to register and be allocated a priority banding and they are able to bid for properties which meet their needs. Under Devon Home Choice, applicants with unusual or high support needs can be considered through the Health and Wellbeing Assessment Panel.

Bidding requires the applicant to have access to the internet or to be able to visit an information desk at the Local Authority Connections office. For some people this may become the first barrier as they may not have access to these facilities or have the confidence to use these systems without support or an *advocate*. This system of access will need to be closely monitored and reviewed to ensure vulnerable people are not being disadvantaged in any way.

There is a potential new development in the pipeline, if the necessary funding can be sourced. If this development goes ahead there will be a percentage of affordable housing and a mixture of single and shared units.

Floating support services clearly have a vital role to play in supporting the process of move-on, or transition between services. The ratio of floating support to accommodation services has slightly increased from 2006/07 to 2009/10. There is a greater demand for floating support services, and short-term, emergency accommodation.

There is a need for emergency temporary accommodation for people with poor mental health who become homeless or those who require a short-term housing solution while their homelessness is prevented and a sustainable living arrangement found. It is expected that emergency temporary accommodation will be procured in partnership with the Housing Options Service in line with the Temporary Accommodation Strategy and action plan.

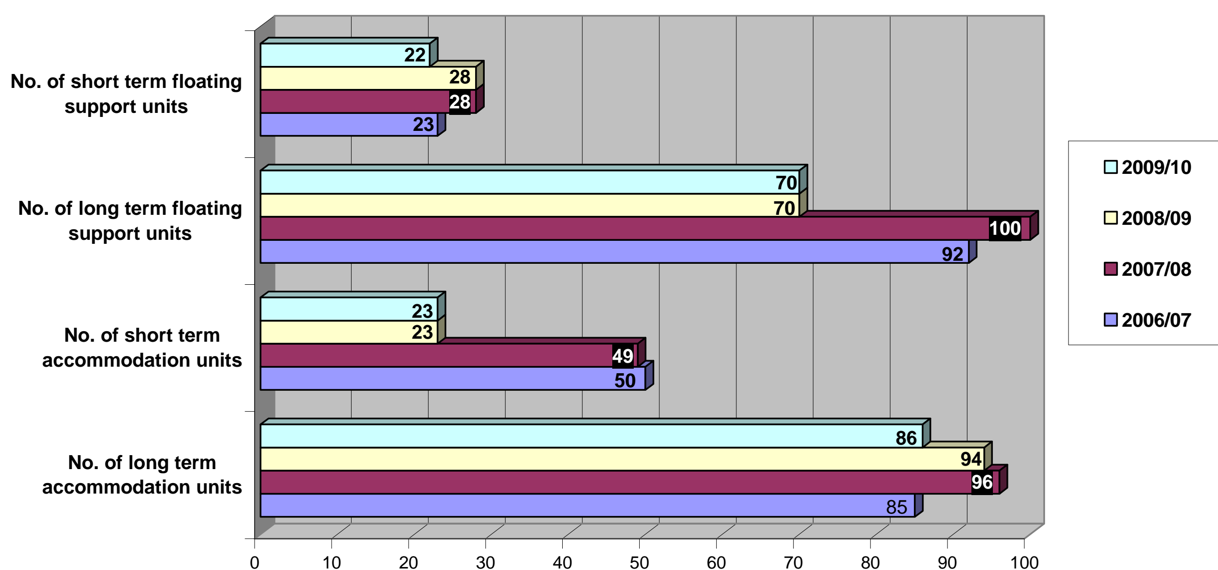
12. Sustaining Independence & Wellbeing

Consultation showed there does not seem to be a clear preventative strategy. Effective preventative strategies with a multi-agency focus must be in place to aid recovery and prevent or respond quickly to crisis. This means the involvement of health care, social care or criminal justice professionals is essential in achieving better outcomes for people. The Recovery and Independence team work with people to support them to take responsibility for their own wellbeing as far as possible. The recovery focus must be on the person first and how they can be supported to meet their own needs rather than thinking in terms of their diagnosis.

It is clear people with particularly complex needs find it more difficult to sustain independence, recovery and wellbeing. This is made worse if they are caught in the 'revolving door' of hospital admission - homelessness – unsuitable accommodation - prison - hospital etc. Services often find it difficult to engage with people with mental ill health, but this is a challenge that needs to be embraced and overcome. A number of examples where people, not part of the *Care Programme Approach*, relied only on supported housing staff to meet their housing, health and social care needs. The lack of involvement of clinical staff means support workers are left to meet all of a client's needs, sometimes without the appropriate knowledge, training and experience. These challenges must be addressed when developing new services.

The number of accommodation based services reduced from 95 to 69; this had a greater effect on short-term services, which have declined by over half, than on long-term services. The number of units of floating support reduced from 128 to 92, with long-term services reduced by a third. See Chart 7 below. One of the main concerns about the reduction of capacity in this sector is the Hub waiting list, which can impact on delayed discharge, increase in acute hospital admissions and increase residential care spend.

Chart 7 - Number of units of dedicated mental health Supporting People services in Torbay



The decision to cut the number of Supporting People units in mental health reflected financial pressures on the budget in 2008. This came about following a comparison with similar local authorities which showed the mental health sector in Torbay had a disproportionate share of the total budget. Spend to save initiatives linked to alternative provision of day services, reduction in residential care placements and early discharge from hospital; as well as an increase in self-management programmes and the roll out of personalisation, all have a role to play.

Further savings could be achieved by investing in support options providing better value for money, alongside greater partnership working and jointly commissioned and funded services. The integration of care and support services will ensure there is no duplication of provision, deliver better outcomes for people, avoiding waste and double funding.

There is some overlap between housing related support (commissioned by Torbay Council) and enabling support and *domiciliary* care (purchased by Torbay Care Trust). One benefit of jointly commissioned services would be the ability to deliver more personal services, for example removing the need to change provider for different service deliveries of support and care, because the service boundaries would be flexible between care and support delivery, or while waiting for a specialist floating support service. Research for this Strategy found enabling support is often used to bridge the gap, in the short-term, between care and support services. For example, one provider identified they received £40,000 per year to deliver an enabling service in addition to Supporting People funding.

Reviews show approximately 45 Supporting People units are occupied by people who could be described as having care, rather than support needs. Additional services are being provided in supported accommodation, for example provision of meals, laundry, domiciliary services and 24-hour cover for people who would alternatively be in residential care, adding greater financial burden to the overall system. This limits the potential of Supporting People budgets to address independence through recycling funds.

In addition, a service funded by Devon Partnership Trust providing Support Time and Recovery workers (STR), who play a critical role in supporting *step-down* from hospital and residential care, and preventing re-admission to hospital. STR workers carry out a range of tasks not previously seen as housing related support, such as shopping, cooking and other household tasks, to aid recovery and prevent tenancy breakdown. Housing related support workers enable people to carry out these tasks themselves *promoting independence*. STR workers use a similar method called '*graded recovery*' in working with people. The idea of promoting independence and recovery in the community is at the heart of each service, but each is funded by separate funding streams and not aligned.

The main gap appears to be services supporting people with anxiety problems in their own homes. Helping someone with shopping can be a good way of encouraging them to go out into their community. The STR and Enabling contracts are an excellent resource for a service that would otherwise be difficult to arrange.

This Strategy addresses these issues by ensuring single more personalised, jointly funded services; consideration is also given to development of more *generic* services, with access to specialist support advice, supervision and treatment, where and when appropriate.

There is a connection between available resources and waiting times for services, however at the present time it is difficult to identify why people with mental health issues wait longer than other client groups for accommodation based services. One factor is the reduction in the number of units available and adding to this, the number of people

remaining in services for a longer period. The level of throughput needs to be increased. The increased length of stay in services is, in part, due to the lack of suitable move-on accommodation and the quality of support planning. The Supporting People Mental Health Housing Strategy Sub-group is actively reviewing the waiting list in order to assess barriers and seek solutions. This also includes identifying where people are living and what services, if any, they are receiving whilst they are waiting.

Torbay Care Trust's Mental Health Involvement Worker provided the review with a number of case studies showing the importance to people and their carers of the previous 'open door' day treatment services in supporting the process of transition and recovery. In a world of increasingly personalised support services it would seem quite likely on the evidence available from this piece of work, people will want to purchase some form of safe refuge, respite service when they are ill with professionals on hand to provide support, advice and *signposting* to the required services. Self-management programmes suit people who have continuing mental health conditions. Self-management also enables people to involve their families and carers if they wish to do so and to the level they want.

Day services are currently under review by Torbay Care Trust and future services will be delivered in the community. The new services will have a critical role in any preventative strategy and there is the potential for joint delivery with support services. This joint approach should lead to improved outcomes for people.

The Recovery Strategy over the last few years has seen a move away from 'drop-in' style day services to '*specified activity'* community services. This has, in part, been based on research showing how meaningful activity contributes to better wellbeing and more positive mental health. While some people could see the value in this change many felt provision of a drop-in service was essential to their recovery and wellbeing. People said when they were unwell a place of sanctuary, without any demands, with professionals and other users on hand to simply talk to was critical to facing up to recovery.

Torbay's *ROOUTE Enterprise Centre,* is an example of a '*community hub'* providing the ideal opportunity to offer facilities within a wider network of services. Consultation with people would be needed to establish if, and under what conditions, a 'community hub' could meet their 'drop-in' needs.

When reviewed, these services may prove to be working well as a combination of client groups therefore no changes are required and they will remain under the Learning Disability sector budget and be managed as a single contract. The additional units and funding have been shown as an option in the future service commissioning strategy for the present time, but detailed analysis would be need to be carried out and alternative *feasibility* options produced, to show best value for money and outcomes, before a decision could be considered.

The strategy recommends maximising the self-directed approach to support, producing the best outcomes for people within a declining budget. During consultation some stakeholders felt moving to a personal or individual budget approach could cause a degree of instability. However, it must be pointed out not everyone will be eligible, or want control of their funding, just their services. It is likely there will always be the need for a small number of block contracts. The restrictions around people holding their own budget may be around the services they need, for example crisis intervention, preventative and very short term services etc where the urgency of the service required would take precedence over the development of a personal budget; where this is the case there is the option for self-directed service if appropriate.

13. The Future Vision

The Government's vision for the Big Society is exciting. The Big Society is about turning less often to central government to provide all the answers, and instead supporting local communities and volunteers to build their own solutions. Voluntary and community sector (VCS) organisations are at the centre of delivering the Government's vision for the Big Society. Commissioning is the process which can ensure the skills of the voluntary and community sector are harnessed as part of a consistent, effective and efficient range of support and services for people and their families.

Torbay Council and Torbay Care Trust are committed to transforming service through personalisation. This changes the power relationships, putting more control in the hands of people using the services; this may challenge current working practices, e.g. decisions to be made after consultation with people, not only within the limits around budgets and safeguarding procedures.

Torbay Strategic Partnership is committed to 'putting people at the centre of decision making' and involving people throughout the commissioning cycle.

All future contracts with Torbay Council will be subject to procurement inline with European Regulations and Torbay Council Standing Orders. To make the process less time consuming and offer greater flexibility Supporting People are currently putting a *Framework Agreement* in place. The Framework will be in place by mid March 2011 and will be used for purchasing the majority of services in the future.

The content of this Strategy informs the following Commissioning Strategy, which relies on pooled and aligned resources to develop a range of person centred and responsive services to promote wellness and recovery of people with poor mental health.

What is a *Commissioning Strategy*? - A commissioning strategy is a formal statement of plans for securing, specifying and monitoring services to meet people's needs at a strategic level and provides a framework to support the provision of flexible, responsive and fair services. This strategy is committed to the meaningful and effective involvement by people, their families and carers, who are 'experts by experience', overcoming the barriers, which have previously prevented meaningful participation. Their views are not only essential to the planning and self-management of their own care and support, but also required in all aspects of mental health service planning, development, delivery and evaluation of services. It will ensure sufficient choice of providers and services and there is a continuous incentive to improve quality and provide value for money.

14. Commissioning Strategy

What is commissioning?
Commissioning is a step-by-step process that helps prioritise how a local authority seeks to secure the best outcomes for their community by making use of all available resources to meet its needs. Commissioners act on behalf of the public to provide services they need, both short and long term services, now and in the future.

Commissioning is a cycle generally considered to have 4 key stages:
- Assessment of need, supply and resources
- Plan and prioritise the use of resources
- Buying services through a procurement process
- Monitor, review, improve and decommission services

The aim and end result of future commissioning is achieving better outcome for better lives. It is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers. Involving key stakeholders at all stages of the commissioning process is vital, including people who use services, their families and carers as well as service providers, with a focus on improving outcomes.

The commissioning cycle assesses the needs of people with mental ill health in the area, the designing and securing of appropriate services. Commissioning should be a needs-led-activity and the steps taken are illustrated in the diagram below:

Commissioning is sometimes mistaken to mean procurement, purchasing or contracting. This is misleading as commissioning is a process that involves all of the four elements outlined above.

The Supporting People programme started in 2003. Throughout the last 7 years it has developed and continued to improve outcomes for people in support services. The strongest emphasis for new services is now choice, personalisation, self-management and self-directed support.

Following the successful integration of health and social care in Torbay, the development of further integration continues with housing, health, care and support for people with poor mental health, across tenures, across the public, private and voluntary sectors, recognising the importance of wider services and activities, one example is leisure as a

preventative tool. The strategy is informed by cost analysis of prevention and early intervention. The central point for services provided by partners, agencies and voluntary services is housing around which community living, working and activities fit.

The knowledge and experience gained by commissioners, partners, providers, carers, people and their families should be pooled when assessing what communities need from services. Effective commissioning must respond to local need. However, it is easy to assume that everyone has the same level of understanding or access to knowledge as commissioners do. Although the commissioning principles of understand, plan, do, review are readily understandable by businesses and organisations, jargon can alienate some of the people who do incredibly valuable work with people who have poor mental health. Relationships between commissioners, organisations and the community can be greatly improved by provision of clear information, engaging and enabling people to be involved in consultation from an early stage in the development of a strategy.

Commissioners and staff working within the local community can respond to people's needs by offering a range of activities, services and support. They have a key role to play throughout the commissioning process to identify local need and gaps in service provision, shape effectively, delivery of services, and evaluate their effectiveness. This can have a double benefit by bringing ownership, employment and volunteering opportunities to the community where they live.

The next 5 years will be very challenging times throughout the public sector as a result of the spending reviews. The need to achieve more for less reinforces the principle of commissioning and commissioners have a vital role in ensuring we continue to support people, their carers and families in a sustainable manner. It will require a critical examination of what, how and who delivers public services with a greater emphasis on the involvement and role of voluntary, community and self-help organisations to ensure success.

A definition of effective commissioning:

The process of deciding how to use the total resource available for people in order to improve outcomes in the most efficient, effective, equitable and sustainable way….

The way forward for mental health commissioning is increased partnerships this will remove some of the barriers currently restricting people accessing relevant services. There is also a need to jointly commission outreach services to obtain better value for money, continuity of service, while achieving greater success through outcomes. There is a need to work together with all partners who provide services for people in their homes for example domiciliary, enabling, care and support services.

The commissioning strategy needs to be fully informed, to prioritise and ensure services have the ability to effectively provide services, matching the unmet need of the population, ensuring future development of services deliver care and support to people in their own homes enabling them to remain independent for longer while increasing the choice of where they live and who supports them. The move towards much more personalised services means that more and more people will be involved in making decisions about the commissioning of their own services. This means commissioning will be affected and should be influenced by these individual decisions taken by people who have or control their own budget.

15. The Focus of Services

On the basis of the seven key themes and recommendations, future services should be commissioned in three basic groups. Each group should include a balance of commissioned services and the option to purchase services through personal budgets. The three groups cover accommodation and resettlement services, community outreach services and services commissioned by people.

The aims and outcomes for service delivery within each group are given below:-

- **Type 1 – Emergency, Temporary, Brief Interventions, Accommodation and Resettlement Services**

This group of services are linked to the provision of accommodation and may include temporary accommodation, housing related support, domiciliary care, residential care with a recovery/resettlement focus, re-enablement provision and certain types of day services. There may also be an element of floating support services included. The overarching aims are to enable the person to obtain and sustain settled accommodation and live more independently, supporting the recovery philosophy. There are a number of accommodation models which may be used in the delivery of individual services and some examples are given below:-

Emergency Accommodation - The aim of this model is to enable the Authority to discharge its duties under the Housing and Homelessness Legislation, through the provision of appropriate emergency temporary accommodation and support to people, who are often in crisis and require support on a wide range of issues. Placements into emergency accommodation are made with the aim of assisting the person or family to resettle into more suitable and sustainable accommodation.

Accommodation Based – The aim of this model is to enable the person to develop independent living skills, enabling them to move on to more settled accommodation, through the provision of accommodation and short term interventions promoting wellness and recovery.

- **Type 2 - Community Outreach Services**

This Group covers the provision of services to people where they live or within the community. This may include floating support type services, befriending, outreach, advocacy, brokerage, some treatment and self-management services, family group conferencing and mediation, domiciliary care and other interventions and programmes delivered in a community setting.
The overarching aim is to enable the person to remain or become independent in their own home, empower them to participate in their local community and develop social networks.

- **Type 3 - Services Commissioned by People**

This Group covers the provision of services commissioned by people who have chosen a personal budget and who may also receive a direct payment. The key outcome for delivery is enabling the person to achieve the outcomes detailed in their support or care plan.

Outcomes for Service Delivery

The overarching outcomes for services *called-off* the Framework are detailed below, together with some examples of what success may look like.

1. **The independence of vulnerable and disadvantaged people is promoted.**
   What will success look like?
   1.1. The number of situations requiring an emergency response for example, hospital admission, secondary care or custodial sentence is reduced.
   1.2. The number of people achieving or maintaining independence is increased.

2. **The health, emotional and economic wellbeing, as well as the abilities and achievements of vulnerable people in Torbay are maximised**.
   What will success look like?
   2.1 Escalation of issues is prevented and crisis is avoided through early intervention and prevention.
   2.2 The number of people in education, training and volunteering is increased.

3. **People have maximum choice and control over their services.**
   What will success look like?
   3.1 Vulnerable people with complex needs and behaviours are included.
   3.2 Services are person centred.
   3.3 Self management of conditions is supported.
   3.4 A wide range of flexible and individually tailored services, meeting the 'right time' 'right place', 'right person' philosophy, are available.
   3.5 Support is self-directed.
   3.6 Learning from people who use services, complaints and incidents are incorporated into service delivery.

4. **Service providers deliver value for money.**
   What will success look like?
   4.1 Duplication of service delivery is reduced.
   4.2 Economies of scale are achieved.
   4.3 Benchmark cost of outcomes is delivered.
   4.4 More is delivered for less over the life of the contract.
   4.5 Additional funding is attracted and opportunities for raising revenue maximised.

5. **The way in which services are commissioned supports and encourages multi-agency and collaborative partnership working**
   What will success look like?
   5.1 The level of delivery through consortia and collaborative partnership working is increased.
   5.2 Alignment and pooling of funding against shared outcomes for Torbay is increased.
   5.3 Co-location of back office functions and/or service provision is increased.
   5.4 The level of shared services/costs is increased.

6. **Services match individual and community needs and aspirations and play a role in building and sustaining successful communities in Torbay.**
   What will success look like?
   6.1 Services are community focused, taking into account the views, needs and aspirations of specific neighbourhood areas and the wider community.
   6.2 The number of people in education, training and volunteering is increased.
   6.3 Torbay Gross Value added (GVA) is increased
   6.4 Outcomes for people with focus on principle of 'first and most' are improved.
   6.5 Serious incidents, because of improved management of risk to individuals and the public, are reduced.
   6.6 Community participation is increased.
   6.7 Services contribute directly to Torbay Community Plan priorities.

The future of the Budget and total funding is currently undecided, which makes it difficult to decide the quantity of units to be commissioned. Through research carried out and available data, it became clear there is a need for more capacity in the mental health sector. In line with strategic priorities and relevance, the need for more floating support services and less support provision attached to accommodation is the future direction. People expressed concern over the need to move-on as they became more independent and commented they would prefer to remain in settled accommodation and use floating support when necessary.

Services also need to operate outside of traditional 9 – 5 hours to support people, who may require a brief intervention (i.e. support by telephone) to help them through an immediate crisis, preventing further decline in their health.

The Commissioning Plan identifies the actions to be taken, to ensure delivery of the Key Themes of the Strategy. Progress against achieving these recommendations will be monitored by the Supporting People Commissioning Body and the Mental Health and Housing Strategy Sub-Group.

Commissioners have a duty to contract manage, review and evaluate the services commissioned. To ensure the quality and achievement of new services, stability of the provider market and continued development of personalisation, monitoring arrangements must be clearly explained and appropriate for each contract and carried out regularly.

Torbay Voice and Quest members will be able to assist commissioners to evaluate the effectives of services through their involvement in reviewing services. They have a wealth of experience and knowledge, as well as direct access to people receiving services, which will be essential in assessing the effectiveness of contracted services. Contract performance will be monitored by Outcomes Based Accountability, measuring the achievements of each individual, ensuring the outcomes identifies are achieved. This completes the commissioning cycle described above; the assessment of need; planning the services within the resources available; procurement of services; and review of services. In conclusion, commissioners will monitor current services and future need.

The following 7 pages contain a table headed by the Key Themes, containing Objectives, Actions and Measures of Success. This forms the Action Plan for implementation by the Mental Health and Housing Strategy Sub-Group.

- Having read the Strategy you now have an opportunity to give your views on the commissioning priorities for each of the objectives listed; and secondly…
- The last column headed Partnership Involvement welcomes your commitment to engage in areas of preference. For example, this may be team involvement, financial or resource commitment, sharing of good practice and knowledge.

Please complete and return the following Commissioning Plan Section to:
Supporting People Team,
Torbay Council,
Pearl Assurance House,
101-107 Union Street,
Torquay TQ1 3DW

or e-mail your comments and offers of commitment to: Rose.knapman@torbay.go.uk

Thank you, your support is greatly appreciated.

16. Commissioning Plan

Theme 1 - Information needs to be more accessible to people				
Objectives	**Actions**	**Measures of Success**	**Commissioning Priority**	**Partnership Involvement**
o Greater accessibility of information o Implementation of effective data sharing o Identify necessary changes to support personalisation	o Providers must produce clear information o Information, advice and advocacy must be easily accessible o People should be enabled to achieve self-directed support and personalised services o Appropriate information sharing protocols and practice are agreed	o People let us know how well services are working o People directly influence planning and delivery of their services o People are involved commissioning of services and ensuring services meet Quality Assessment Framework (QAF) or Care Quality Commission (CQC) standards o Recovery plans focus on individual achievements o Information has proved useful o Appropriate information sharing is achieved while maintaining data protection policy		

Theme 2 – Preventative services targeted to reduce the number of situations needing an emergency or more costly response				
Objectives	**Actions**	**Measures of Success**	**Commissioning Priority**	**Partnership Involvement**
o Reduction in demand for emergency and crisis services o People have an identified point of contact o People are supported in the community where possible o Services focus on recovery, self-help, self-management, early intervention and social inclusion	o People not subject to a Care Programme Approach (CPA), have an allocated person o All assessments follow a multi-agency approach o Consultation across communities to include specialist user led organisations o Services are responsive to community needs o Providers ensure they engage effectively with minority groups	o Reduced numbers of admissions to acute psychiatric wards and residential care o Improved partnership working between MH & Housing services o A multi-agency approach is evidenced o People participate in recovery focused community services o Increased involvement from minority groups o Services are available to families and carers		

Theme 3 - Services should be commissioned within a "Right Service, Right Time, Right People" philosophy				
Objectives	**Actions**	**Measures of Success**	**Commissioning Priority**	**Partnership Involvement**
o A partnership approach to promote recovery for people with complex needs o To enable people to better manage their condition, being able to re-access services when required o Improved service delivery within community settings	o Accurate information is provided for future commissioning and investment decisions o Services commissioned provide: ▪ specialist support for people with complex needs ▪ emergency temporary accommodation ▪ effective partnerships with education, training and employment ▪ best value for money	o People have timely access to relevant services o People self-manage their condition and engage relevant services when required o Increased numbers of people successfully engage in education, training and employment		

Theme 4 - More formalised partnership working between health, housing, criminal justice and social care services				
Objectives	**Actions**	**Measures of Success**	**Commissioning Priority**	**Partnership Involvement**
o Partners work to a single recovery pathway o A diagnosis or a lack of one should not exclude people from services	o Partners should align funding to maximise resources o Services must support the recovery philosophy and encourage education, training and employment o Procurement of emergency, temporary accommodation for people with complex needs o Providers' move-on policies ensure continuity of a range of support networks and access to housing o Agree the definition of "short-term" as no more than 6 months	o People are able to access appropriate services o Feedback demonstrates partners are working together o Move-on policies are transparent o People feel socially included and participate in the community o Services aren't duplicated o People are at the heart of services o There is increased take-up of self- management and self-directed support		

Theme 5 - All services maximise the potential for self-management, self-directed care and support promoting recovery				
Objectives	**Actions**	**Measures of Success**	**Commissioning Priority**	**Partnership Involvement**
o Personal recovery plans are at the heart of delivery o Services are flexible o Focus on services enabling self-management and self-directed support	o Services will be person centred o Self- management and self-directed support services are developed o Temporary accommodation services have access to specialist care and support o Housing Co-ordinator post is reviewed to support Personalisation	o The right service should be available at the right time by the right person/agency o People are supported in self-management o People decide how much of their service they want control over o Increased level of people accessing education and leisure activities		

Theme 6 - Independence and recovery should not only be associated with people living alone				
Objectives	**Actions**	**Measures of Success**	**Commissioning Priority**	**Partnership Involvement**
o Acknowledgment for the need for choice, to live independently either alone or in shared housing	o Move-on policies should recognise peoples' aspirations and capabilities o Engage with private landlords to increase housing options o Prioritise people moving-on from supported accommodation through Devon Home Choice	o The quality and location of accommodation supports recovery o Providers encourage move-on, as positive progression towards recovery in a timely manner o Services promote independence o Services are available to people in crisis		

Theme 7 – There must be greater engagement of all stakeholders in developing a mutually agreed strategic vision				
Objectives	**Actions**	**Measures of Success**	**Commissioning Priority**	**Partnership Involvement**
o Strategy development is an inclusive process o A common language is adopted o Positively manage risk regarding the mental wellbeing of people	o Personalisation is at the heart of services commissioned o People are involved in decision making o Alignment of resources for better value o Information sharing protocol to be developed o Everyone is comfortable with and understands language used o Partners' definition of terms used is consistent across services e.g. recovery, high, medium and low o Risk enablement is supported	o People have clear understanding of what they can expect from services o People receive timely and appropriate information to enable self-management o People who chose Personal Budgets can have a combination of services o Individual outcomes are achieved through effective risk management o Partners are able to share information		

17. Glossary

Advocate	Person who takes action to help someone to say what they want, secure their rights, represent their interests and obtain the services they need
Agoraphobia	A condition characterised by an irrational fear of public or open spaces
Analysis	Study of information
Bipolar affective disorders	Bipolar affective disorder is characterised by extreme mood swings from depression to mania; people may be totally unaware of being in the manic phase of the condition
Black and minority ethnic	Generic term for people or communities who are not White British
Called-off	Bought from
Cardiovascular disease	Heart disease
Care Programme Approach (CPA)	A way of co-ordinating community health services for people with mental health problems in which one person co-ordinates all aspects of care, including health and social care
Commissioned	Specially designed made to order
Commissioner	Officer responsible for buying services
Community hub	A group of people with shared interests within society
Community Mental Health Teams - *CMHT*	The teams within the Devon Partnership Trust providing multidisciplinary mental health assessment
Community psychiatric nurse	A specialist nurse who cares for people who have primarily mental health needs
Complex needs	Multiple needs i.e. mental health and drug or alcolhol needs
DAASHT - Drug, Alcohol and Sexual Health Team	Torbay team commissioning drug, alcohol & sexual health services
Devon Home Choice	System for letting Housing Association homes in Devon; priority is given to people with the most urgent need, where possible allocation to the person who has been waiting the longest
Devon Partnership Trust	Is a trust working in partnership with other health and social care providers across Devon to deliver high quality services to support the recovery of people with mental health needs
Diagnosable	Able to be diagnosed or identified
Direct payment	Allows a person to have their care funding paid direct to themselves so they choose and pay for their service provision
Domiciliary care	A provision for or attending to people in their own homes
Drop–in	An informal service people can visit without an appointment
Enabling	To make possible or support to help make something happen
Fair Access to Care	Fair access to adult socila care - guidance on eligibility criteria
Feasibility	Achievability
Framework Agreement	List of pre-approved providers who may be offered the opportunity to bid for work
Generic	General or nonspecific
Graded recovery	Evaluation and staged improvements
Intervention	An action that is intended to prevent an escalation or increase, altering the course of an illness

Joint Strategic Needs Assessment	A process whereby the Local Authority and partners identify the current and future health and wellbeing needs of the local population, informing commissioning priorities
National Indicators	The only set of indicators central Government uses to measure and manage local government's performance
Maintenance	Looking after or upkeep
MAPPA - Multi-Agency Public Protection Arrangements	A central, initial point of contact for referrers and people wishing to access Supporting People services
Meaningful occupation	Activities, education, training and employment
Mindful Employer	Scheme to raise awareness of mental health in the workplace, supporting employers in recruitment and retention of staff
Network	Group of people and contacts
New Horizons	A Shared Vision for Mental Health published in February 2010
Outcome	The result of an *intervention*
Outcome based	Evidence based on results achieved
Outcome base accountability	OBA is an approach to planning services and assessing their performance that focuses attention on the results – or outcomes – that the services are intended to achieve
Pathway or care pathway	A multi-disciplinary outline of planned care and support designed to help a person achieve a positive outcome
Peer Reviewers - QUEST	People who have used SP services in Torbay who are now employed on a sessional basis to go into services to talk to current clients about the service they receive
Person centred	Focuses on individuals and their needs by putting them in charge of defining the services they need
Personal budgets	A way of bringing together fuding from various sources for an individual to use on their care or support package
Personalised	Services that are delivered to people in line with their wishes and their convenience
Philosophy	beliefs and values in a way of life
Prevalence	Frequency
Promoting Independence	A principle that underpins the delivery of services stressing the aim to maintain and develop independence and respect people's dignity
Procurement	The buying of service delivery and implementing the commissioning requirements
Provider	An agency that provides services to people, which can be a public sector, voluntary or private sector organisation or person
Psychotic	Psychotic disorders are severe mental disorders that cause abnormal thinking (such as hearing voices) and are surprisingly common, but can lead to diagnoses such as schizophrenia or bipolar disorder
Public Service Agreement	The aims and objectives of the Government and their key priorities.

Public Service Agreement 16	Government target to increase the proportion of socially excluded adults in settled accommodation in employment, education or training
Putting People First	Government paper highlighting the ambition to put people at the centre of services
Qualitative	Quality as opposed to quality
Quantitative	Measurable
Referral Hub	A central, initial point of contact for referrers and people wishing to access Supporting People services in Torbay
Recovery	Refers to people staying in control of their life despite experiencing a mental health problem
Revolving door	Going round, unable to get out
ROOUTE Enterprise Centre	New project offering training and education facilities avoiding isolation
Safeguarding	Protecting vulnerable people from abuse
Safety Plan/Care Plan	An agreed plan of the treatment for a person who is receiving health or social care normally following an assessment
Schizophrenia	*Schizophrenia is a chronic mental health condition*
Self-management	When a person manages their own health condition
Service Provider	Organisations delivering Supporting People funded services
Social Care Panel	Panel to agree joint health and social care packages
Social exclusion	When people have multiple and complex problems that leave them unable to be a part of or prevent them from making the most of the opportunities society has to offer
Social inclusion	Making a positive contribution towards the economic, social and environmental well-being of the local population
Socially isolated	To be socially remote or cut off from other people
Specified activity	Arranged activities, less casual service than the 'drop-in'
Stakeholder(s)	Person(s) or organisation (s) with direct or indirect interest, interested party
Step-down	A progressive move-on from hospital or residential care
Stigma	Prejudice against an individual who has a condition that society generally finds difficult to accept
Support plan	A Support Plan is designed to identify the outcomes that are important to a person. It should identify the help and support needed and how they would like to receive that assistance and confirm the outcomes are being achieved
Throughput	To move through or on from services
Torbay Care Trust	An integrated NHS organisation responsible for providing and commissioning (buying) health and adult social care services for local people
Triage	Triage is a process of determining the priority of patients treatments based on the severity of their condition
Utilisation	Amount of use or take up
Wellbeing	The state of feeling healthy and happy

Appendix 1 – List of People Interviewed

Commissioners - 8

Strategic Housing Manager, Affordable Housing Manager, Service Development Officer, Torbay Council
Partnership and Joint Commissioning Manager, Devon & Cornwall Probation Area
Treatment Effectiveness Manager, Torbay Public Health Commissioning Team
Mental Health Development and Commissioning Manager, Torbay Care Trust
Personal Budgets Service Manager, Torbay Care Trust/Torbay Council
Mental Health Service Development Officer, Supporting People, Torbay Council

Providers - 17

Housing Team Leader, Housing Team Leader and Hub Assessment Officer, Supporting People Hub
Mental Health Housing Link Co-ordinator, DPT/Torbay Council
Torbay Mental Health Involvement Worker, Devon Partnership Trust
Providers Meetings 15 January (10 organisations present)
Parkview Manager
Supported Housing Director, Westcountry Housing Association
Parkview office staff/support co-ordinators
Westward service staff, Paignton
SP accommodation based service 4 staff, Torquay
Access & Wellbeing Team Leader, Waverley
Assertive Outreach Team Leader, Waverley
Recovery & Independence Team Leaders, Waverley
CPN @ Waverley House
Contracts Co-ordinator, Waverley
Recovery and Independence Team Leader and team, Culverhay
Modern Matron, Torbay Hospital
Support Time Recovery Co-ordinator, Haytor Unit
Support Time Recovery Team @ Daybreak

People - 35

2 @ Parkview, Paignton
2 @ Conway House, WCHA (1 had additional enabling support from Parkview)
3 @ Leonard Stocks Centre
3 @ Jatis Project
1 @ CCT, Shirburn Road
3 @ Alpine Lodge
6 @ Riviera Court
8 @ Braddons
4 @ Cool House
3 @ Daybreak

Carers – 6

This document can be made available in other languages and formats. Please call the Supporting People Team on 01803 208729, who will arrange this for you.