BARNET
LONDON BOROUGH

Full Business Case: Implementation of the Barnet Enablement Pathway

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Table of Contents

List of Tables, Charts and Diagrams

1. Executive Summary

1.1 Adults and Safeguarding Committee approved its Commissioning Intentions for Mental Health for Adults of Working Age in October 2014. Following a programme of resident engagement the Commissioning Plan for the period 2015/16 to 2019/20 was finalised and then approved by the Adults and Safeguarding Committee at its meeting on 19 March 2015 which set out the intention to develop a new Community Model for Mental Health.

1.2 Adults and Safeguarding Committee further approved in June 2015 the development and implementation of the Barnet Enablement Pathway (BEP) as the foundation for delivering the Mental Health Community Model and approved the outline Service Specification for the work. This paper expands on the BEP to clarify the expected new ways of working, staffing, activity levels and summary of approaches to deliver Enablement.

1.3 Enablement can be described as:

"An approach or philosophy within home and community support services – one which aims to help people 'do things for themselves' rather than 'having things done for them'."

1.4 In mental health, 'recovery' means the process through which people find ways of living meaningful lives with or without ongoing symptoms of their conditions. It is not about being cured - it is a personal journey of discovery that involves making sense of and finding meaning in what has happened, becoming an expert in your own self-care, building a new sense of self and purpose and discovering your own resourcefulness.

1.5 Users of mental health services have identified three key recovery principles:

- the continuing presence of *hope* that it is possible to pursue one's personal goals and ambitions
- the need to maintain a sense of *control* over one's life and one's symptoms
- and the importance of having the *opportunity* to build a life beyond illness

1.6 The aim of this business case is to set out an approach and supporting service model which will bring together the philosophies of enablement and recovery to achieve this objective:

More people in Barnet who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and

working, improved chances in education, better employment rates, and a suitable and stable place to live.

1.7 Within Barnet the experience of people to achieve such a quality of life is mixed. The Network have achieved success in supporting people with recovery through the community access support and recovery programme. The Public Health commissioned employment support delivered in partnership with Twinning Enterprise, Barnet Enfield and Haringey Mental Health Trust and Job Centre Plus as offered Individual Placement Support. There is sound individual work across the service on which to take forward an enablement approach. People value the services, but frequently report that support is not consistently available when it is most needed. Professionals report that often they feel they are responding to crisis and feel their capacity to support the person and the family to better manage going forward is constrained.

1.8 The following challenges are present:

- Increasing number of detentions under the Mental Health Act to respond to crisis driving pressures within the Approved Mental Health Service and residential placements
- Increasing spend on Residential Care both in terms of unit cost and increasing service user numbers at a rate which is financially unsustainable
- Limited housing options to enable people to move on from both Residential Care and Supported living
- Service provision prioritising monitoring and risk management with limited capacity to truly focus on well-being.

1.9 Adult Social Care spend for working age adults is just one source of investment in Barnet to improve quality of life for people experiencing mental health problem. Social Care is part of a wider-system of services and community assets that are available to people in Barnet. This Business Case specifically addresses how the London Borough of Barnet will invest in those adults and their carers, whose needs primarily arise as they are experiencing a mental health problem and who have eligible needs within the framework provided by the Care Act 2014. This paper will signal the vision which the London Borough of Barnet (LBB) has for locating the Barnet Enablement Pathway (BEP) within the wider system of provision and support whilst directly addressing the case for change within Adult Mental Health Social Care.

1.10 Services within scope of this paper cover delivery of social care to working age adult service users and carers defined through acceptance of the national eligibility criteria for adults in need as a result of The Care Act 2014. This includes:

- social work and social care (including occupational therapy where relevant) assessment and interventions
- safeguarding vulnerable adults and transition from CAMHS to adult services
- Statutory duties including those relating to the Care Act 2014, Safeguarding Adults, Mental Health Act 2007and Mental Capacity Act 2005.

1.11 The scope also includes work with partners on employment and accommodation to enable recovery and mental health improvement including the interface with public health, early intervention and prevention services. The scope excludes dementia and frail elderly services and services for Children (Child and Adolescent Mental Health Services).

1.12 The Barnet Enablement Pathway has been arrived at through a co-production process to redefine adult social care for people with mental health conditions and to deliver the 10 new ways of working. Stakeholders identified that at the heart of the redefined model should be the optimal enablement of the service user and carer to achieve their full potential as a member of the Barnet community. The new Barnet social care model for people with mental health conditions will provide a focus on social needs as well as integrating with partners to deliver holistic care, building on existing good practice within Barnet, Barnet CCG and primary care, and within Barnet, Enfield and Haringey Mental Health Trust.

1.13 A critical success factor of this new service model is strategic alignment with the enablement programmes across the CCG and BEH. A robust community social care pathway delivering holistic and personalised support is vital to support the transition into a community centred, multi-agency led model of enablement. This can be achieved through the proposed Barnet Enablement Pathway (BEP) for mental health social care which is underpinned by a number of strategic and operational elements.

1.14 The Barnet Enablement Pathway will in summary deliver five key changes:

- An increase of people accessing enablement services through the Network Plus reaching 500 more people
- A focus on integration and joint approaches with family services, primary care and community services
- Through the Local Enablement Hub a redesigned front door that in partnership with BEHMT, primary and voluntary service extends the reach of services whilst reducing dependency on secondary care
- Cultural change building on local best practice and service user feedback to embed enablement approaches throughout the pathway

- Build a skilled multi-disciplinary team with peer support to focus on enablement in residential care and supported living.

2. Ten New Ways of Working

2.1 During the last twelve months, ten new ways of working have been co-produced which stakeholders see as required changes to deliver enablement in social care as part of a wider community system of mental health. This work has been led by LBB and has involved people with lived experience including people who use services, carers, local mental health community organisations, Social Work staff and Managers including those within LBB and BEHMT (Barnet, Enfield and Haringey Mental Health Trust).

Table 1: Proposed 10 new ways of working:

1	**Voice of the service user drives intervention and support throughout the pathway**
	• Build self-reliance and resilience • Choice and control central at every decision point • Self-management is goal and drive and servicer users own the processes • Reduction in the length of service • Increase in enablement access • Decrease in residential care
2	**Greater support to families including parents and carers**
	• Prevention of family breakdown • Earlier intervention with family difficulties • Systemic approaches to build resilience • Building family and carer confidence and expertise • Crisis planning and sources of emergency support • Reducing incidence and impact of crisis • Reduction in admissions to hospital
3	**Constant focus on equipping people and their families for self-management, with a move away from monitoring, coordination, routine visits, professionals as experts**
	• Every contact and intervention seeks to enable the person to better manage their own health and well-being • Maximising professional intervention • Reducing dependence on care
4	**Enablement as first offer and access to social care**
	• Constant focus on person finding sources of support and activities in community • Focus on ability, potential and skills • Building opportunity to retain, regain and train for employment

5	**Intensive support is delivered to enable - reviews are more regular in residential care, identifying outcomes for independence and enablement, clear plans for move from care**
	• Support is focussed and intensive when needed to facilitate the resolution of crisis, independence from institutional care (residential and hospital) • Supported living relentless focus on move to own accommodation
6	**Planned discharge from day of admission**
	• Stay in hospital minimised and every admission is working to independent living once crisis is resolved. • Reducing length of stay in hospital and residential care • Community access and enablement robust part of plans for person in residential and hospital care
7	**Integration of access and joint working to maximise enablement opportunities**
	• Choice appointment focus on community support as part of initial assessment and support planning • Choice meetings as a new way of working for addressing more complex needs and undertaking assessment • Working with GP, IAPT, employment support and community sector • Reducing need for full assessment and secondary care • Reducing crisis and preparation for crisis when it occurs • Close working with Family Services to support with preventative approaches and addressing the toxic trio
8	**Systemic practice and greater focus on employment**
	• Building family, community and support networks. • Employment and housing considered at every intervention
9	**Building pathway with Health Champions and Peer Support at every opportunity**
	• Paradigm shift away from professional care • De-stigmatised support • Sustainable support when professional support ends • Flexible support at times of change, transition and crisis • Community links and capacity
10	**Solution and outcome focussed practice**
	• Focus on what difference support is making • Focus of providers and professionals on improvement, delivery and enablement • Better use of resources • Explicit user-led enablement plans created through choice meetings which are expressed in simple outcomes that provide long-term recovery

3. Strategic Case

3.1 The Business Planning report that was agreed by the Committee on 31 July 2014 set out a vision that all adults will be given the opportunity to live well, age well and stay well. This means that all adults will feel safe and be safe in their environment. Financial constraints should not hinder the delivery of good outcomes for all. There will be a strong sense of community that supports personal growth and independence and an overall focus on early intervention and prevention with a reshaped specialist care offer for those that need it.

3.2 Our overall vision, therefore, could be summarised to:

- Achieve more, with less.
- Move away from 'professionalised' models of care towards more community, home-based, peer-led models of support.
- Reinforce relationships and community connections.
- Rebalance the model and orientate professionals towards prevention and early intervention for both carers and users; integrate community and peer groups into specialist care.
- Help providers, users and carers to be better at long-term planning, managing and supporting demand rather than rationing supply.
- Focus on the quality of relationships (between users and those who support them) and depth of our knowledge about users' needs and assets.

3.3 In October 2014, the Adults and Safeguarding Committee approved its Commissioning Intentions for mental health adults of working age. Following a programme of resident engagement the Commissioning Plan for the period 2015/16 to 2019/20 was finalised and then approved by the Adults and Safeguarding Committee on 19 March 2015.

3.4 The plan identified the following objectives:

- Improved social care response when mental health issues arise that supports recovery, social inclusion and enablement.
- Better support for individuals with mental health issues to retain or regain employment and suitable housing that supports their wellbeing.
- Greater involvement in the planning of social care services and use of direct payments to fund care and support.

3.5 The plan identified that these objectives would be met through the following service developments:

- A new specification for mental health social work focused on employment, housing, earlier intervention and enablement.

- A shift in demand and spend from expensive specialist registered provision of community based services.
- Increased demand for community based services including early intervention and prevention.

3.6 The Barnet Enablement Pathway delivers the published Commissioning Intentions in the following ways:

3.6.1 **Re-focusing of social care on recovery, social inclusion and enablement**

The Barnet Enablement Pathway has been designed through a process of co-production involving service users, officers from the council, social care professionals, experts from housing and employment and other stakeholders. A wide range of evidence was also considered from research and case studies of best practice elsewhere in the UK. The pathway aims to prepare the person for self-management at all stages with a constant focus on choice, community access and the enablement programme being accessed and re-accessed as a routine offer.

The holistic care planning model generates a simple one page enablement plan which allocates service users to a tailored enablement programme ranging from an initial six week 'brief enablement' package through to standard social work packages and specialist health packages (provided by CMHTs) and family work . This care planning model will be aligned with the requirements of the Care Act 2014 and include elements of public health such as development of health champions, social prescribing, and interventions at an early stage. The planning model will be built on a recovery outcomes model with broad and meaningful outcome measures to provide baseline and interim evaluation scores for service users and carers.

3.6.2 **Promote a social work role which focuses on protective factors located outside of a medical model with much stronger working with primary care**

The Local Enablement Teams (LETs) will reach into family services, primary care and IAPT (Improving Access to Psychological Therapies), as well as a range of other community services and will continue to work alongside BEHMT to ensure rapid access to secondary care if needed. The goal of the social work intervention will be to support enablement in partnership with the person and those around them to build resilience through skills development, social problem-solving, family work and crisis support.

3.6.3 **Renewing the focus on the quality of services through strengthening the voice of workers and service users through the delivery model**

The Barnet Enablement Pathway has been developed through a strong co-production approach and this work will continue through implementation and into business as usual. The work going forward is a workstream of the Barnet Reimaging Mental Health co-production work plan and the involvement of service users and multiple stakeholders will be embedded.

Peer Support and Health Champions are a feature in the BEP in all aspects of the work to strengthen the service user and community voice; as well as adding value in terms of a model of care that builds community capacity. Whilst the shape and principles of Peer Support in Barnet is yet to be fully scoped, the principle that Peer Support is a key feature of services has been accepted and will be developed through co-production as set out in the implementation plan.

3.6.4 **The Social Work Consultant roles with adult social care delivery will establish robust professional leadership for social care staff and provide a continuous focus on quality and standards**

The Consultant Social Worker role is established in the staffing proposal. A Consultant Social Worker will provide leadership into each team with a focus on supervision, practice development and quality of practice.

The Consultant Social Work roles will have particular priorities:

- Developing graduate Social Workers with Think Ahead
- Creating a family approach with family services to address family mental health, early intervention and prevention
- Driving change and influence within the mental health system to bring about practice change to improve social outcomes

3.6.5 **Integrated pathways across the wider public sector and establish a 'hub' which provides coordinated support to help people with mental health problems (back) into work**

The BEP sets out a clear process for working through a LETs hub where both the initial choice meeting and choice appointment are managed through the hub process and these provide simple user-led assessment and needs planning processes. The shape and function of this is being coproduced through a task and finish group as part of the Barnet Collaborative with the intention of developing access and a process involving key partner providers. The LETs will be responsible for delivering the social care element aspect of the hub. This is set out in Diagram 3 in section 4.0. The Hub will include close working with Job Centre Plus, the public health led employment support initiatives (provided by Twining Enterprise) and specific services such as

BOOST (Burnt Oak Opportunity Support Team). Co-location of the Twinings employment team will continue as part of the implementation of the new hub. The employment pathway development is aligned to this approach and section 5.3 describes how this happens in practice.

3.6.6 **Increased range of accommodation options**

Barnet Homes in partnership with the Delivery Unit is refreshing the joint working protocol which will set out how the teams work together to provide an integrated approach to enable appropriate housing advice and assessment for housing options. This will be in place from October 2015 and will set out delivery options that adds the greatest value in terms of supporting individuals to access housing options.

The Accommodation Commissioning strategy will set out how the future shape of accommodation based support and placements will drive enablement and how the market will be shaped and incentivised to improve the move-on within mental health services.

3.6.7 **Promoting mental wellbeing and reducing stigma through establishing joint commissioning of social care with public mental health provision**

The LETs will provide the key link into community initiatives including the Public Health commissioned Health Champions and digital interventions which are being developed to support self-management. The Health Champion approach is being piloted in Barnet in 2015 with a focus on mental health. A primary Care partner is currently being sourced and the pilot will start in November.

3.7 In summary, the Barnet Enablement Pathway delivers the commissioning intentions in the following ways:

- Supports service users and carers in realising their full potential in terms of relationships, occupation and social achievement
- Aligns with the requirements of the Care Act 2014
- Builds on current best practice in Barnet in assessing and delivering enablement
- Provides intensive time-limited enablement packages which promote self-sufficiency and accommodation in the community where ever possible
- Addresses wider social care needs as the core driver
- Provides a platform for planning for and managing longer terms needs along with personal budgeting, including direct payments or support planning.
- Provides a robust process by which to keep service users support needs under review and to track enablement performance

- Delivers change in the ways in which service users have set out through on-going feedback and coproduction.

3.8 Impact of Legislative Changes

3.8.1 Impact of the Care Act 2014

Phase 1 of the Care Act 2014 came into effect on 1 April 2015 bringing together existing care and support legislation into a new, modern set of laws which focuses on people's outcomes and well-being. The Act sets out new duties on local authorities to provide information and advice; along with preventative services that reduce the need for formal social care support. It brings in a national eligibility threshold for those in need of care and support services; along with new rights for portability of care when a service user moves to a new area. It also provides increased rights for carers, with national eligibility thresholds for carers care and support services and a right to review

Although it is too early to measure the impact of the Care Act within Adult Social Care, it is projected that the Act will have a significant impact on the Adults Social Care budget as the new duties will result in more people making contacting for information, advice and support. The impact on Mental Health is expected to be seen in demand for prevention and enablement services as well as the numbers of new people expected to come forward for a carers assessment.

The national eligibility criteria set a minimum threshold for adult care and support and carers care and support. All local authorities must meet the care and support needs of individuals at this minimum level. Section 9 requires identification of needs and section 13 requires consideration of what is to be done to meet **those** needs. The threshold is based on identifying how an individual's needs affect their ability to achieve relevant desired outcomes, and whether as a consequence this has a significant impact on their wellbeing. This is a marked change from the current access through Secondary Mental Health Service provision into social care requiring a change in the method of referral and assessment.

In summary, the impact on mental health provision is:

- Access to enablement for all eligible service users
- New rights to services for carers
- Changes to assessments for carers and those with mental health needs

3.8.2 Impact of Deprivation of Liberty Safeguards

A key duty that Mental Health Social Workers deliver on behalf of the Local Authority is the undertaking of Approved Mental Health Professional (AMHP) responsibilities and Best Interest assessments under the Mental Health Act 1983 and Mental Capacity Act 2005. These roles ensure that people have

their human rights protected, balanced with care and safety for themselves and others. AMHPs respond to Barnet Residents who are in acute need or in mental health crisis and have the responsibility for organising, co-ordinating and contributing to Mental Health Act assessments. The recent Supreme Court Judgment on Deprivation of Liberty (*P v Cheshire West and P & Q v Surrey County Council)* creates greater complexity of assessment and decision-making for AMHP work. Whilst in Barnet the impact on time has not been fully assessed, anecdotally these changes have impacted on the time, practice and training of the AMHP service.

4. Economic Case

4.1 The Local Context

4.1.1 Many people will have experienced mental health difficulties in their lives and Barnet's residents are no different. Nationally, one in four people will seek professional treatment or support for their mental health problems, but only a small proportion of these will experience difficulties so severe that they need social care support.

4.1.2 Within Barnet, 1059 people of working age received social care support for their mental health problem in 2014 and this represents the second largest care group. This support includes a spectrum of services from professional support as well as more substantial packages of care at home or in a placement.

Table 2: Numbers of service users within Adult Social Care 2011/12 to 2013/14 by client category (SWIFT Social Care data)

Client Category	2011/12	2012/13	2013/14
Physical Disability and Sensory Impairment (18-64)	752	740	710
Learning Disability (18-64)	540	551	573
Mental Health (18-64)	993	1,104	1,059
Other (18-64)	28	47	42
Older Adults	3,979	3,868	3,894
Total Service Users	6,292	6,310	6,278

4.1.3 The number of people with mental health conditions within the borough is expected to rise and it is also expected that those who are eligible for social care services will also increase. The Joint Strategic Needs Assessment

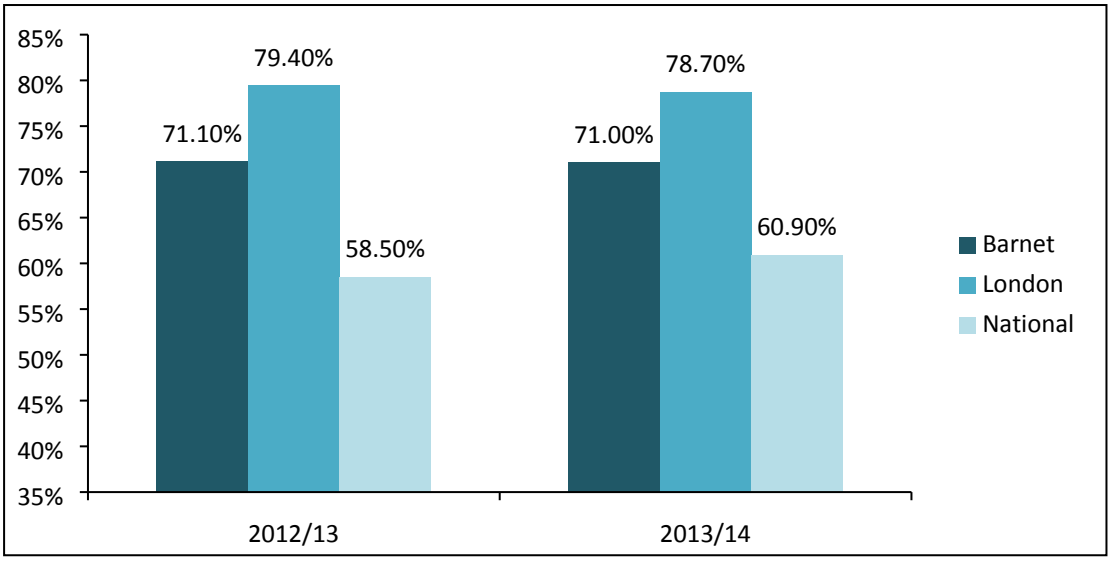
(JSNA) 2015 for Barnet projects a steady rise in potential service user numbers in the next four years.

Table 3: Barnet residents experiencing mental health problems and projections for the next four years (JSNA)

Type	2014	2015	2016	2017	2018
People aged 18-64 predicted to have a common mental health problem	38,076	38,542	39,061	39,572	40,046
People aged 18-64 predicted to have a severe and enduring mental health problem	2,827	2,865	2,906	2,946	2,984
People aged 18-64 predicted to have two or more mental health problems	16,975	17,196	17,438	17,680	17,901

4.1.4 Those who are eligible for social care tend to be those with complex social needs arising from severe and enduring mental health problems. These residents face considerable social exclusion evidenced through high rates of unemployment, social isolation, poorer physical health and insecure housing arrangements. Barnet would like all service users to remain at home for as long as they want to retain or regain employment and lead active, fulfilling lives. In 2013/14 a smaller proportion of Barnet's residents, who were in contact with secondary mental health services, lived independently compared to the London average (71% and 79% respectively). Given Barnet's aspiration for residents, clearly there is a need to deliver services that can increase the numbers of people living independently beyond our current performance.

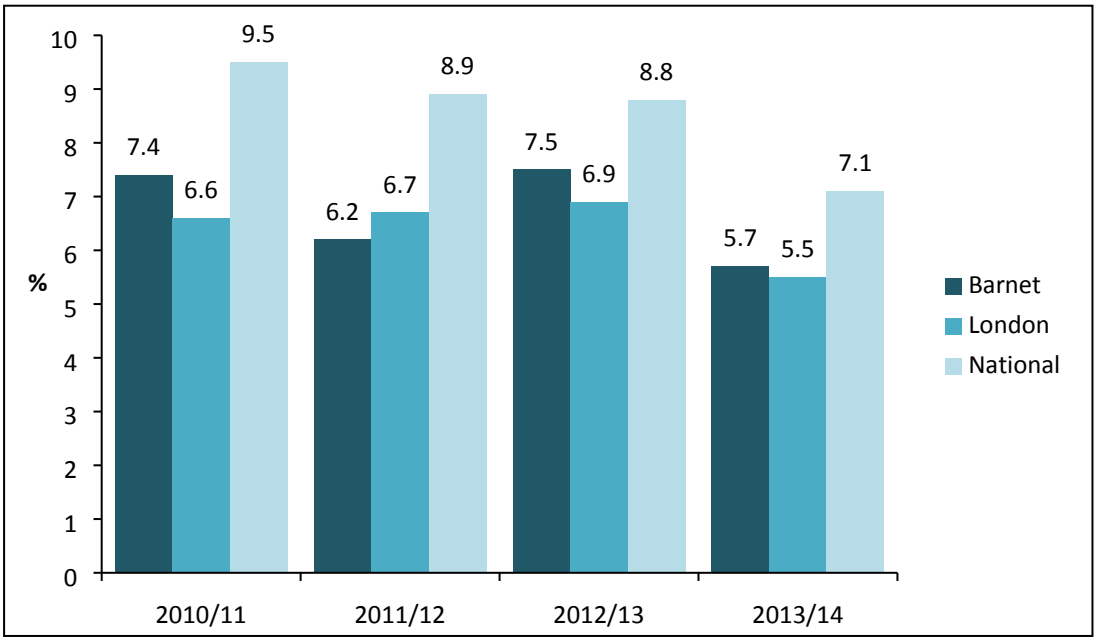
Chart 1: Proportion of adults in contact with secondary mental health services who live independently, with or without support, 2012-2014 (Barnet, London and National) (Joint Strategic Needs Assessment 2015)



4.1.5 The numbers of people with a mental health problem who are in paid employment has fluctuated in recent years, and was at its lowest point in 2014. With mental health problems being the most common issue preventing Barnet residents from being able to work, Public Health and the Health and Wellbeing Board identified 'supporting more people with mental health problems into employment' as one of their priorities. Following the successful piloting of approaches to support people's health and employability, services have been developed in 2015 in partnership with Job Centre Plus and the Barnet and Enfield Mental Health Trust. In order to continue to focus on employment in this way, staff will need to invest time in understanding the unemployed person's entire life, including the barriers and obstacles that they face and the effects that these and other factors have on their mental health, their goals and aspirations. This holistic approach supports clients to bring stability to their home, mental wellbeing and lifestyles; to allow a focus on employment.

4.1.6 There is a clear link between a personal sense of wellbeing, job satisfaction and productivity. Having a mental health problem remains the number one labour market trigger for exclusion from the workforce. Nine out of ten people believe that disclosure of either a past or present mental health problem would damage their career.

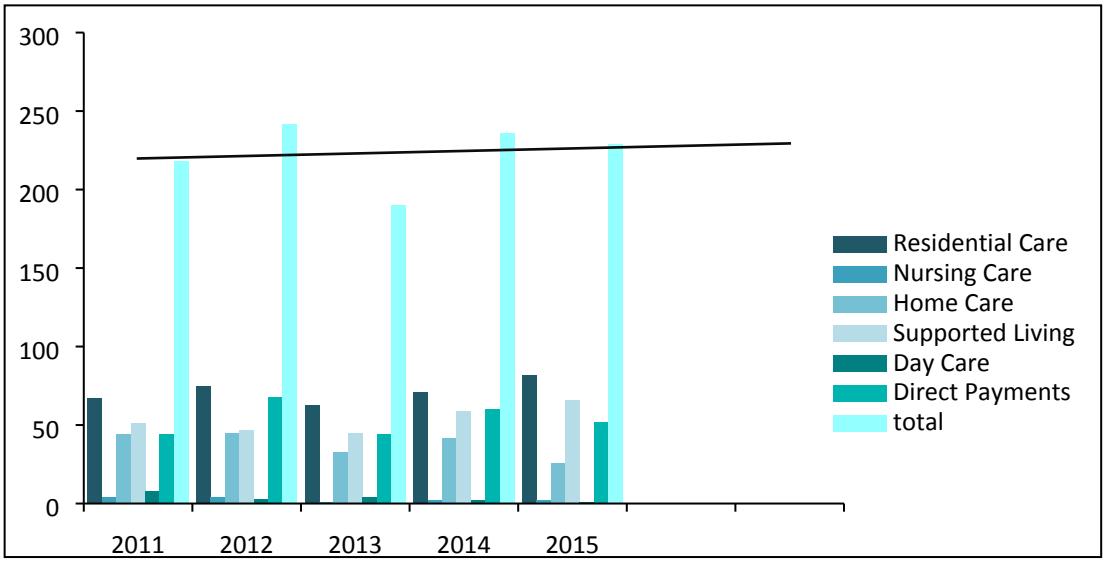
Chart 2: Barnet performance on supporting people into employment (Joint Strategic Needs Assessment)



4.1.7 This trend of increasing numbers of people with mental health needs, decreasing numbers who are supported to live independently and decreasing numbers of people who are in secondary care in paid employment, is driving patterns of social care use and therefore spend. Chart three demonstrates that whilst the numbers of people who receive social care fluctuate, the trend is an overall increase. The numbers of people accommodated by the Local Authority in Residential Care and Supported Living has steadily increased and if this direction of travel is not consistent with the vision of enabling people to live independently for longer.

4.1.8 Nationally the NHS reports (for example, NHS Confederation 2014) that there is a national increase in demand for acute care, crisis care and a shortage of inpatient beds. The number of mental health detentions is double that of 2000. The impact on this on Social Care is increased demand for Mental Health Act Assessment through the AMHP service, increased demand for residential care and supported living as people are discharged from hospital.

Chart 3: Numbers of service users by care type (SWIFT)



4.2 Combining the expected trend of future population needs with past patterns of social care service use, the emerging future for Barnet is:

- Increased demand for service overall
- Increasing numbers of people admitted to Residential Care
- Fewer people able to access paid employment
- Increased dependence on Social Care

4.3 Barnet needs to find a cost effective way to redesign services so that they:

- Meet the needs of population with increasing incidence of mental health problems
- Improve outcomes from care, support and enablement
- Reduce spend given current spend patterns and projections are unsustainable.

4.4 The Barnet Enablement Pathway is designed to deliver three top-level outcomes:

- Improved experience for service users and their families
- Improved outcomes for service users
- Reduced funding requirements

4.5 The overarching aim of the BEP is to provide support at an early opportunity and in a timely way which supports the choices, goals and needs of the service user; thereby increasing resilience and self-management of people and their families with the aim of reducing and preventing the need for more intensive social care services.

4.6 The BEP is expected to deliver these outcomes in the following way, set out against the ten new ways of working:

Table 4: Impact, Outcome and metric for the 10 new ways of working

	New Way of Working	Intended Impact	Outcome	Metric
1	Voice of the service user drives intervention and support throughout the pathway	• Build self-reliance and resilience • Choice and control central at every decision point • Self-management is goal and drive • Reduction in the length of service • Increase in enablement access • Decrease in residential care	• Improved self-management • Support provided at home • Increased family, carer and network resilience • Decrease in incidence of crisis and admissions to hospital • Improved whole person planning • Increase in those with access to employment	• Reduced admissions to residential care and reduced spend on residential care • Improved user satisfaction (service level and national survey results) • Increased people reporting outcomes are met (service feedback) • Increased carer satisfaction • Increase in directed packages of care (increase number is direct payment and SDS
2	Greater support to families including parents and carers	• Prevention of family breakdown • Earlier intervention with family difficulties • Systemic approaches to build resilience • Building family and carer confidence and expertise • Crisis planning and sources of emergency support • Reducing incidence and impact of crisis • Reduction in admissions to hospital		
3	Constant focus on equipping people and their families for self-management, with a move away from monitoring, coordination, routine visits, professionals as experts	• Every contact and intervention seeks to enable the person to better manage their own health and well-being • Maximising professional intervention • Reducing dependence on care		
4	Enablement as first offer and access to social care	• Constant focus on person finding sources of support and activities in community • Focus on ability, potential and skills • Building opportunity to retain, regain and train for employment		
5	Intensive support is delivered to enable - reviews are more regular in residential care,	• Support is focussed and intensive when needed to facilitate the resolution of crisis, independence from		

	New Way of Working	Intended Impact	Outcome	Metric
	identifying outcomes for independence and enablement, clear plans for move from care	institutional care (residential and hospital) • Supported living relentless focus on move to own accommodation	and service building paths to employment • Increase in sustainable and permanent housing options • Efficacy in placement and supported accommodation • Increase in use of wellbeing, community and universal services	as % of overall numbers and spend) • Increased numbers receiving enablement • Reduced referrals into secondary care (CMHT) • Reduced admissions from those receiving enablement and with a Joint Crisis Plan • Increase in service users engaged in paid employment • Increase is service users engaged in voluntary and community activities
6	Planned discharge from day of admission	• Stay in hospital minimised and every admission is working to independent living once crisis is resolved. • Reducing length of stay in hospital and residential care • Community access and enablement robust part of plans for person in residential and hospital care		
7	Integration of access and joint working to maximise enablement opportunities	• Choice appointment focus on community support • Choice meetings with give easy access • Working with GP, IAPT, employment support and community sector • Reducing need for full assessment and secondary care • Reducing crisis and preparation for crisis when it occurs		
8	Systemic practice and greater focus on employment	• Building family, community and support networks. • Employment and housing considered at every intervention		
9	Building pathway with Health Champions and Peer Support at every opportunity	• Paradigm shift away from professional care • De-stigmatised support • Sustainable support when professional support ends • Flexible support at times of change, transition and crisis • Community links and capacity		
10	Solution and outcome focussed practice	• Focus on what difference support is making • Focus of providers and professionals on improvement, delivery and enablement • Better use of resources		

5. Management Case

5.1 Current Provision of Adult Mental Health Social Care

Adult Mental Health Social Care is delivered in two ways – firstly, through a direct investment in social care staff who are currently seconded to the local secondary mental health services, which are delivered by the Barnet, Enfield and Haringey Mental Health Trust; and secondly through the supply of care services either through a placement or personal budget. Third sector and independent organisations such as Richmond Fellowship, MIND in Barnet and Barnet Refugee Service provide a range of support services including residential, housing/tenancy support, community inclusion, peer support and employment support. Service users either directly access or are supported to access these community services and support through the current Enablement Programme provided through The Network and managed by BEHMT. This paper focuses on the Social Care Pathway for people eligible for services under the Care Act 2014.

5.1.1 Social Work

Social work resource is deployed through the Trust and aligned to the BEH MH Trust team structures. All referrals into social work and The Network are through the Trust Triage Team which manages all referrals to secondary care. Safeguarding work is carried out within the teams but with a higher rate of referrals for residents who are in residential care or supported living, a higher proportion of safeguarding work is carried out by the Community Rehabilitation Team (CRT) who lead on work with service users in placements.

Social Workers undertake the following roles:

- Care coordination under Care Programme Approach (CPA)
- Professional support
- Carer and family work
- Safeguarding
- Social care assessment, support planning, statutory review, assessment for a personal budget, support for Direct Payment
- Work associated with the Mental Health Act including protection of property, AMHP function and Social Supervision.
- Mental Capacity assessment

Social Workers are part of integrated teams with line managers who are team managers, and may have either (or both) a health or social care background or professional qualification. The Service is managed by the BEHMT Assistant Director for Barnet.

Social Workers are currently deployed in the following teams (expressed as numbers of staff):

Table 5: Number of staff currently deployed across the MH Integrated teams

East and West Support Recovery Teams	
Team Manager	2.00
Social Worker/ Senior Practitioner	7.00
Social Worker	3.00
Principal Practitioner	1.00
Total	**13.00**

Community Rehab Team and Primary Care Team	
Team Manager CRT	1.00
Principal Practitioner	1.00
Social Worker/ Senior Practitioner	1.00
Social Worker	3.00
Principal Lead Practitioner	1.00
Total	**7.00**

Triage Team	
Principal Practitioner	1.00
Principal Lead Practitioner	1.00
Social Worker	2.00
Clinical Nurse Specialist	1.00
Total	**5.00**

Early Intervention Service	
Team Manager	1.00
Social Worker	1.00
Social Worker/ Senior Practitioner	1.00
Total	**3.00**

5.1.2 Caseload of the integrated service

BEHMT activity data is available for the integrated teams with individual contacts and caseloads. Within the current systems, social care work is not captured as an isolated task across the piece and is reflected in overall caseload and contacts.

Within Adults and Communities, the following Social Care specific activity data (BEH & SWIFT) is available:

Table 6: Social Care specific activity data (BEH & SWIFT)

2014/2015	
Professional Support	1059
Safeguarding Cases	120
Residential Reviews	80
Community Reviews	145
Care Package Assessments	160

Within the integrated service, the caseload of a Care Coordinator will range between 20 and 30 cases. The snapshot for the Trust in March is shown below – this is the caseload for the teams as they are currently configured.

Table 7: Snapshot for the MH Trust team case load in March 2015

Barnet Teams	**CPA**	**Non CPS**	**Total Caseload**	**No. of Carers Assessments (LBB)**
Barnet Triage Team	1	328	329	8
Barnet Early Intervention Team	128	5	133	19
Barnet Adults East Day Therapy	47	17	64	
Barnet Community East Support and Recovery Team	196	161	357	46
Barnet Community Rehab Team	205	67	272	21
Barnet Community West Support and Recovery Team	260	177	437	45
Barnet Complex Needs Team	87	1047	1134	7
Barnet CRHT	19	69	88	
Barnet Wellbeing Team	270	239	509	
	1213	**2110**	**3323**	**146**

5.1.3 Approved Mental Health Practitioner Service

The Approved Mental Health Practitioner (AMHP) Service, discharge the Local Authority duties within the Mental Health Act through the operation of a 24 hour rota for Barnet. Within Barnet, AMHPs are Senior Social Workers and each AMHP is expected to work two days and two nights a month. The Service is supported by a full-time AMHP Manager and one full-time AMHP. Additional AMHP capacity is sourced from temporary staff. To deliver the rota based on the current service model, requires a minimum of 15 full time equivalent AMHPs.

Table 8: Current FTE breakdown of staff in the AMPH Team

AMHP Team	
AMHP Manager	1.00
Senior Practitioner AMHP Duty	1.00
Social Worker AMHP	13.00
Social Worker (as and when) AMHP	7.00
Total	**22.00**

The number of Mental Health Assessments and detentions under the Mental Health Act has increased in the last three years. Each detention or conversion of a section requires an AMHP to undertake the assessment.

Table 9: Summary of data from BEHMT (most relevant for AMHP activity, not total detentions)

Mental Health Act Sections	**12/13**	**13/14**	**14/15**
Informal Patients admitted	165	211	272
Section 2	139	138	172
Section 3	19	29	17
Section 37, and 47 (41 +49)	8	13	7

5.1.4 The Network Service

The Network provides an enablement and social inclusion service through support and interventions which enhance and promote recovery, social inclusion and community integration. The Network delivers safe, person-centred support and evidence based practice, which promotes recovery and directs people away from dependant institutional responses to crisis and, wherever possible, supports service users in their everyday surroundings. The Network is also a joint service with BEHMT and has three clinicians from BEHMT working as part of the team. The Network provides this in the following ways:

- Enablement Programme through three Enablement Modules WRAP (Wellness Recovery Action Plan), New Steps and Skills In Action courses run on average twice per a week for between 3-5 weeks, depending on the module.
- Community Access Workers work on a one-to-one basis in enabling clients to make and action informed decisions regarding their social inclusion. Working collectively with the key worker on a short term basis, they form part of the seamless journey towards inclusion and recovery.

- Support into employment for individuals through the collocated employment Twinnings service and through the National Careers Service following referral by keyworker.
- Support into work, voluntary work, community and leisure activities.
- Client Forum to inform service delivery

Table 10: Number of Social Care staff currently deployed in the Network team

The Network Team	
Community Network Manager	1.00
Network Deputy Manager	1.00
Business Support Manager	1.00
Business Support Assistant	4.00
Assessment and Enablement Officer	5.75
Community Access Worker	2.00
Total	**14.75**

Table 11: The Network activity and performance data

Activity Measures	**Year 1 targets**	**Jan 2013-Dec 2013**	**Jan 2014-Dec 2014**
Referrals to the Network	200	562	460
Average caseload per worker		25	26
Proportion of support plan outcomes achieved	80%	82%	83%
The number of service users engaging in unpaid volunteering and paid employment	9	128	82

5.2 Current pathways

5.2.1 Social Care pathways are integrated within secondary care and managed through BEHMT process and systems. Access into Mental Health Adult Social Care is through BEHMT Triage into secondary care and referral to the Network is through the Community Mental Health Teams. Enablement is not routinely offered to all of those who are eligible for this service. Whilst it is thought that most people who would benefit from the Network do get referred, it is not at the earliest point in their journey through mental health services.

5.2.2 Access to Care packages and placement is made via the BEHMT Care Coordinator (could be Health or Social Care) and through the panel process. There is a current pilot evaluating the effectiveness of social work within the Primary Care Locality pilot, otherwise access for primary care (and all other referrers) is through Triage.

5.3 Employment Support

5.3.1 The role of Social Care is to support a person to consider employment and to work holistically to enable a person to build their work readiness (where this is appropriate). The newly commissioned Employment Services, through Public Health providing Individual Placement and Support service, is focused on people with more severe mental health problems. Individual Placement and Support is evidence based model that sees Employment Specialists based alongside clinical and social care teams, offers intensive one to one support and encourages rapid job search. This service is embedded within the CMHT and The Network, and through this integration there are firm links between the Employment Pathway and Social Care Pathway, enabling links with Job Centre Plus.

5.3.2 The Network has also built close working links with another public health commissioned provision that supports people in the community and JobCentres. This provision offers low level psycho-educational support (including motivational interviewing), holistic support with any barriers to work that people may have and job searching support. The key difference between this service and the IPS service is that this service is open to anyone who may need support with their health and employment and that it is based in the community. The Network report that this more mainstream provision can be more suitable for people further along their recovery pathway.

5.3.3 There is a great deal of national interest in the IPS model to supporting people with mental health problems. Barnet expects to benefit from investment from Communities and Local Government and European Social Fund in IPS models for people with common mental illness in 2016-2018. There will be opportunities for this support to working closely with and alongside social work professionals reviewing how Social Work can be incentivised and rewarded in partnership with DWP to reduce dependence on Employment Support Allowance. Work is taking place across the sector through the West London Alliance.

5.3.4 These pilots are informing the discussions between London Government and Central Government around a London Devolution deal. London Government is arguing for better integration between local services and JobCentre Plus as well as opportunities to co-design and commission a support with better outcomes for those with complex needs on an invest to save basis that recognises, for example, the contribution of social care in supporting an individual to prepare for work.

5.4 Patterns of Service use across the system

5.4.1 The Joint Strategic Needs Assessment 2015 and the Clinical Commissioning Group (CCG) Review of Mental Health 2015 examined current patterns of

service use and current investment in services against service outcomes and population need. The common conclusion was that future investment should focus on primary care and community services in a model which is able to support outcomes for recovery, intervenes earlier improves patient experience. The CCG review further identified that admission rates are higher than expected in Barnet and it surmised that this is due to an insufficient supply of community services to enable and intervene early. Experience from delivery in social care both nationally and locally is that admissions to hospital drive admissions to residential care as service users are discharged. Admissions to hospital and crisis service will also drive demand for the AMHP service who undertake Mental Health Act Assessment.

5.4.2 Best Practice sources, for example Social Care in Excellence, recommend that people with mental health problems should be supported by community and primary care teams working collaboratively with other services to access specialist expertise and skills.

5.5 Barnet Enablement Pathway

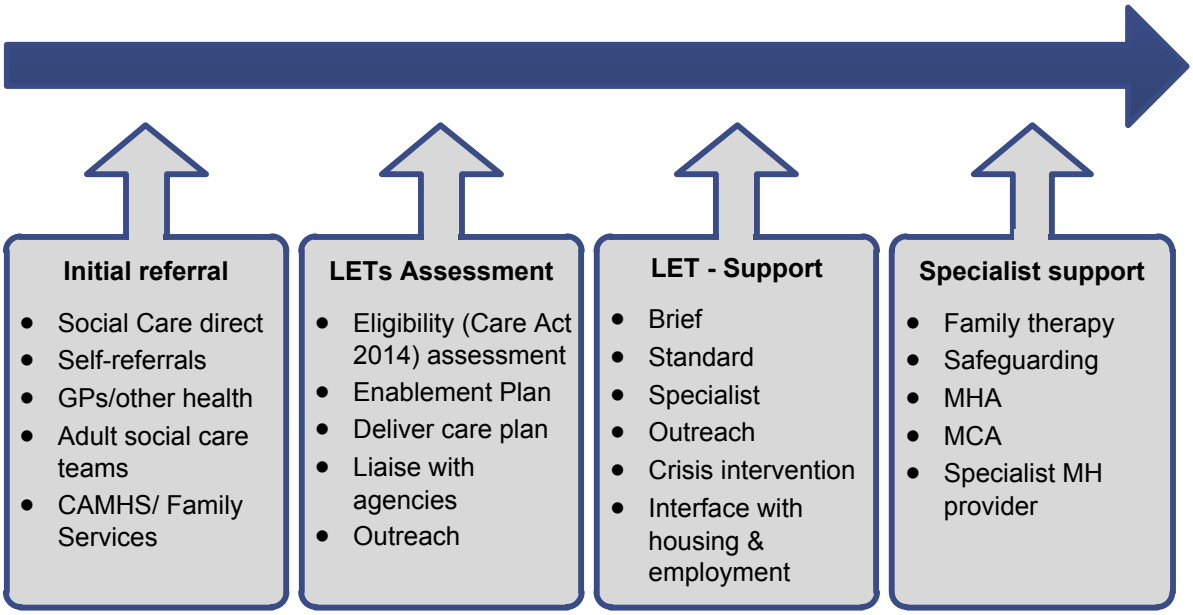
5.5.1 Residents within Barnet may require support with a range of needs throughout their lives. These needs include social support, housing, employment, mental and physical health, protection and leisure pursuits. While some residents may possess the internal capability and external support to manage these needs themselves, others will require a service to support them in addressing their needs

5.5.2 The BEP incorporates a number of elements which have been developed from best practice and co-production. The core principles from this process include:

- Balanced Teams – driving specific re-tasking of social care practitioners to deliver more optimal care aligned with the BEP, including refreshing professional roles and locations.
- Network Plus – expanding the current Network service to broaden both function and capacity to manage and drive the new BEP model.
- BEP performance dashboard – to capture and report against performance along the BEP with a more defined data set and information collection process.
- Prevention and early intervention – to drive the public health agenda through integration of prevention and early intervention in all aspects of the new model.
- Enhanced Enablement Initiatives – to drive specific improvements across Barnet mental health social care with greater integration of technology and voluntary sector initiatives into the enablement pathway.

5.6 Barnet Enablement Pathway Overview

5.6.1 **Diagram 1:** BEP Overview



5.6.2 At every stage of the process the service user and/or carer will be actively engaged to ensure their needs are appropriately identified and assessed, and to develop appropriate enablement, recovery and/or support plans that clearly set out actions with outcomes about how those needs will be supported.

5.6.3 The Social Care Pathway will work within and alongside the Treatment Pathway of BEHMT as well as being part of the wider system of Mental Health Services. The detail of how the pathways will work and in particular, how the access hub will operate, is currently being coproduced through reimaging Mental Health and will be shaped by the work of the task and finish groups set out in the implementation plan. Diagram 2 shows the relationships of the pathways.

Diagram 2: Health and Social Care pathways

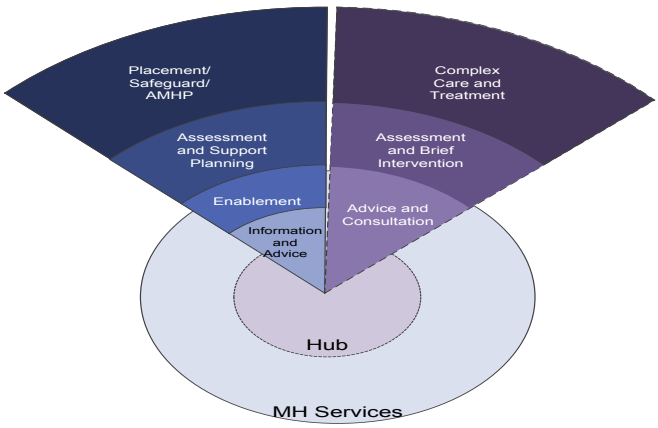
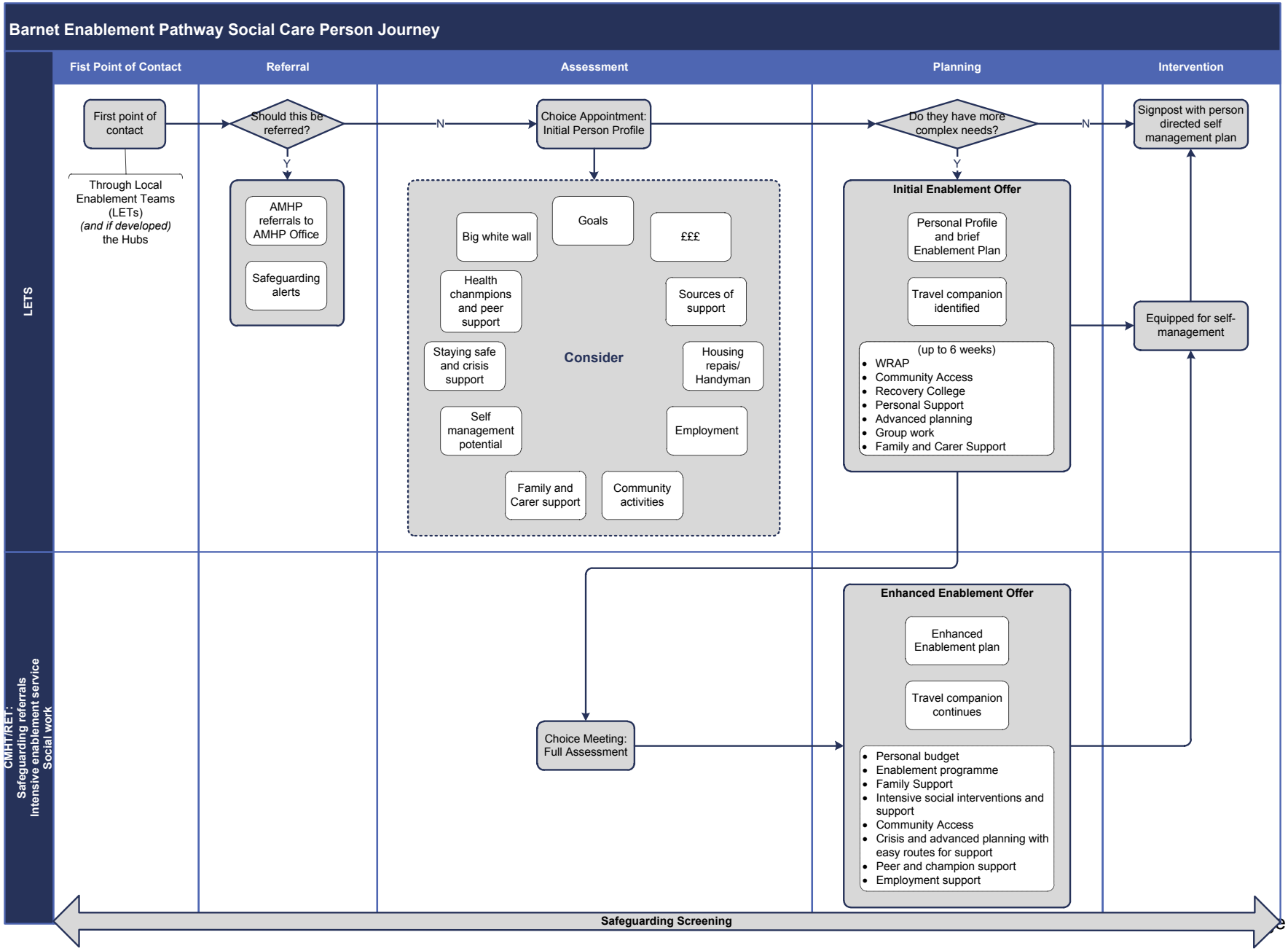


Diagram 2: BEP Social Care Person Journey



6. Financial Case

6.1 Current Budget - Social Care element of Integrated Service

6.1.1 The Adult Mental Health Social Care staffing budget is currently aligned and managed with the health BEHMT budget for the Integrated Mental Health Service. The current budget for the social care element of the staffing is £1.8 million.

Table 12: Adult Social Care Budget (including on-costs and non-pay)

		15/16 Budget
Adults MH Teams	10497	1,253,562
Primary Care Mental Health Team	10499	6,490
MH Divisional Management	10500	233,186
Other Services MH	10521	148,267
Community Network	10523	454,149
Mental Health ASW Service	11067	61,827
	Total	**2,157,481**

6.2 Cost of Care

6.2.1 Spend on care within Adult Mental Health has increased by one million over a five year period. Spend on residential care and supported living has increased both in terms of unit cost and numbers of service users; with spend on direct payments increasing in terms of service user numbers but representing less than 10% of overall spend.

Chart 4: Spend on care broken down by type of provision (SWIFT)

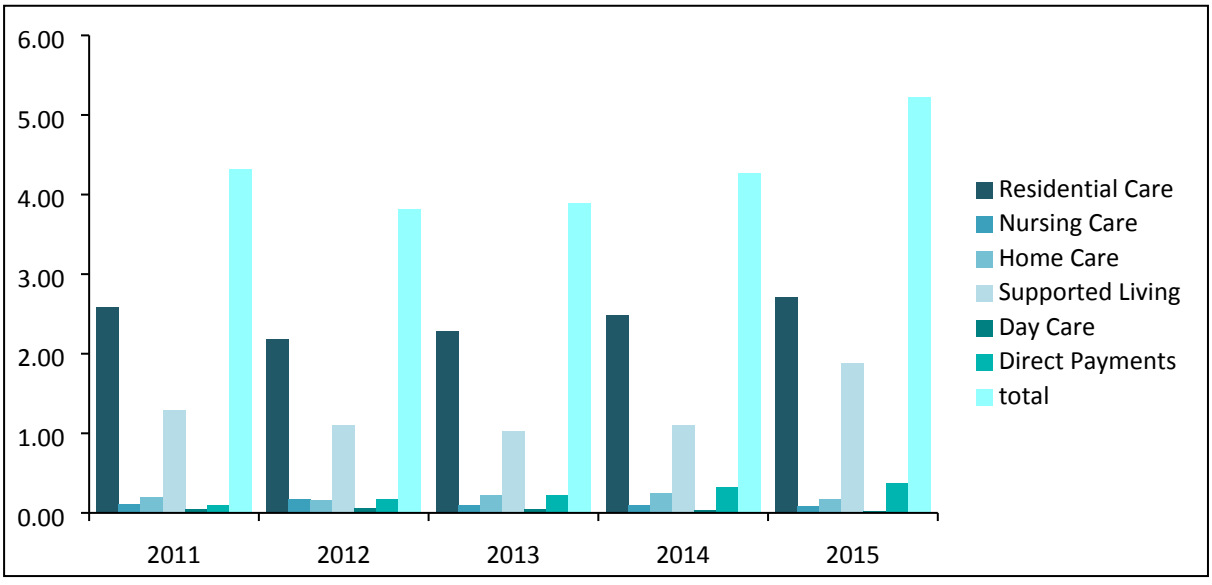


Table 13: Unit costing summary of client numbers and average weekly costs for major client groups

Care Type	Cohort	2012/13			2013/14			2014/15		
		Client numbers	Outturn £m	Average weekly unit cost	Client numbers	Outturn £m	Average weekly unit cost	Client numbers	Outturn £m	Average weekly unit cost
Residential Care	PD	34	£1.486	£936	34	£1.536	£987	35	£1.455	£985
	LD	198	£14.095	£1,421	203	£14.313	£1,241	196	£13.597	£1,444
	LD>65	32	£1.566	£1,000	35	£1.645	£887	34	£1.619	£1,003
	MH	63	£2.285	£798	71	£2.478	£686	82	£2.705	£887
	EMI	93	£1.558	£568	92	£1.791	£568	100	£2.001	£580
	OA	440	£9.892	£552	421	£8.541	£568	389	£8.285	£548
	TOTAL	**860**	**£30.884**	**£691**	**856**	**£30.303**	**£681**		**836**	**£29.661**
Nursing Care	PD	24	£0.728	£899	25	£0.871	£908	22	£0.747	£875
	LD	0	-£0.001	£0	1	£0.033	£1,721	1	£0.025	£1,721
	LD>65	1	£0.028	£519	1	£0.021	£524	1	£0.021	£524
	MH	1	£0.095	£963	2	£0.100	£757	2	£0.077	£752
	EMI	24	£0.436	£552	32	£0.742	£583	38	£0.821	£601
	OA	209	£4.630	£541	193	£4.165	£554	185	£4.209	£561
	TOTAL	**259**	**£5.916**	**£439**	**254**	**£5.933**	**£449**		**249**	**£5.899**
Home Care	LD	64	£0.641	£223	48	£0.594	£253	71	£0.564	£264
	LD>65	4	£0.034	£151	6	£0.034	£108	8	£0.196	£109
	MH	33	£0.221	£142	42	£0.242	£147	26	£0.173	£156
	EMI	49	£0.238	£119	55	£0.269	£160	49	£0.297	£183
	OA	828	£5.507	£127	822	£5.387	£137	730	£5.191	£165
	PD	103	£0.811	£182	118	£0.755	£178	128	£0.858	£170
	TOTAL	**1,081**	**£7.452**	**£133**	**1,091**	**£7.281**	**£128**		**1,091**	**£7.121**
Supported Living	LD	182	£8.004	£856	208	£8.088	£622	210	£8.026	£689
	PD	6	£0.218	£1,254	13	£0.357	£809	14	£0.122	£570
	MH	45	£1.019	£428	59	£1.097	£417	66	£1.880	£457
	EMI	1	£0.016	£357	0	£0.005	£0	1	£0.003	£41
	OA	1	£0.035	£426	1	£0.058	£303	4	£0.086	£381
	LD>65	20	£0.961	£858	32	£1.184	£673	29	£1.148	£671
	TOTAL	**255**	**£10.253**	**£773**	**313**	**£10.789**	**£663**		**324**	**£11.265**

Care Type	Cohort	2012/13			2013/14			2014/15		
		Client numbers	Outturn £m	Average weekly unit cost	Client numbers	Outturn £m	Average weekly unit cost	Client numbers	Outturn £m	Average weekly unit cost
Day Care	PD	26	£0.454	£157	24	£0.311	£238	22	£0.301	£237
	MH	4	£0.041	£232	2	£0.029	£106	1	£0.018	£253
	EMI	46	-£0.003	£138	51	£0.005	£99	34	£0.000	£122
	OA	178	£1.746	£111	157	£1.617	£109	130	£1.132	£118
	LD	186	£4.454	£223	202	£4.164	£377	206	£4.506	£402
	LD>65	4	£0.061	£212	9	£0.046	£156	7	£0.082	£184
	TOTAL	**444**	**£6.754**	**£293**	**445**	**£6.172**	**£267**		**400**	**£6.039**
Direct Payments	PD	267	£3.443	£284	280	£3.414	£285	253	£2.802	£282
	MH	44	£0.222	£60	60	£0.322	£106	52	£0.366	£154
	EMI	32	£0.173	£243	33	£0.478	£246	37	£0.511	£311
	OA	465	£4.616	£212	444	£4.371	£214	413	£4.192	£236
	LD	213	£2.446	£235	243	£2.913	£234	268	£2.829	£258
	LD>65	4	£0.030	£267	4	£0.024	£223	5	£0.020	£174
	TOTAL	**1,025**	**£10.931**	**£205**	**1,064**	**£11.522**	**£208**		**1,028**	**£10.720**

6.2.2 Whilst the numbers of service users fluctuate which is in part due to changes to the way in which people are counted or receive professional support within community teams, the financial analysis clearly shows that the number of people receiving a package of care has increased over the last four years. As set out in the introduction this trend is projected to continue.

6.2.3 Spend in Mental Health Social Care has seen dramatic increases in terms of increased numbers of people, increased cost of care package due to complexity of need, and an increase in terms of unit cost. Spend on residential care and supported living has seen the biggest growth against all other care types as shown above.

6.2.4 Additionally, the spend on care is not evenly distributed across age ranges, with a small number of very high cost placements for those aged between 20 and 25; and a growing number of people being placed in residential care who are aged over 55. For younger adults a focussed and intensive method of working to support recover and enable them to move on to more independent living is needed to avoid a life-time in residential care. For older adults (those aged 55-65), enablement is crucial to maximise independence to reduce the likelihood of this support being required into older age and increasing the care burden on the Council.

6.2.5 An Intensive Enablement Team is being created to address this particular care issue. This team will provide dedicated focus on intensive enablement for those in placements and with additional resource including social work, occupational therapy and peer support to deliver enablement plans with residential providers that increase move-on. This work will be directed by an in-depth audit of those in placements and set milestones for each person and their move-on potential. This audit will in turn drive the development of a business case which will set out the plan for reducing use of residential care and consider these factors:

- Resource required in the team: short, medium and longer-term
- A spend projection for the borough based on need and intensive move-on work
- The cost benefits analysis of integration with the BEHMT rehabilitation team who also work with people in placement and who have complex needs.
- Alignment with the Accommodation Commissioning Strategy

6.2.6 The Barnet Enablement Pathway aims to reduce demand and reliance on secondary care services and is an enabler to the savings programme for Adults within the MTFS in year 2016 and 2017. Delivery of placement savings linked to the intensive enablement team will be dependent on the

accommodation commissioning strategy which will develop sustainable alternatives to residential care. The analysis on spend indicates a saving of 350k each year from 2017 on the reduction admissions to residential care and a cost avoidance of 500k which is not cashable by managing the increased demand for mental health care through enablement.

6.3 Operational spend

6.3.1 The ongoing staffing costs will remain as they are with any changes in the workforce being managed through vacancies within the service. This will minimise the financial impact of the cost of implementing the BEP.

6.3.2 There is a cost to Adults and Communities and BEHMT in disaggregating current management structures, systems, and processes. This does not have a cash value and is a management opportunity cost.

6.3.3 There are costs associated with the change including programme management, workforce development and cultural change management costs. These will be funded through the transformation fund and off-set against future savings on the cost of care.

6.3.4 Social care staff will use Mosaic when it is implemented and this cost will need to be reflected in the mosaic programme.

6.3.5 The implementation of the BEP will not create disintegration with the mental health provider and where possible the aim is to maintain a degree of co-location. These costs are already budgeted within Adults and Communities.

6.3.6 The Network building is at capacity and due to be demolished and therefore an element of the implementation is to source appropriate estate for staff to operate from.

6.4 Cost Benefit Analysis

6.4.1 Impact on financial pressures on local authority

<u>Cost negative:</u>

- Set up costs of Local Enablement Teams
- Staff consultation and recruitment costs for new Consultant Social Worker and Peer Support Worker roles
- Reconfiguration of line management for Local Enablement Teams back to social services
- Cost of expansion of The Network premises and capacity from its current status

<u>Cost positive:</u>

- Delivery of commissioning intentions
- Delivery of public health strategy
- Benefits realisation from current pilot and established projects
- Reduction in overall residential home costs
- Shifting of mental health secondary care budgets to social care through nominal savings in secondary care resource use (aspirational – managed through renegotiation of s75 agreement).

6.4.2 Impact on local mental health provider

Based on a review of stakeholder feedback and assessment of the new proposed model, the following factors will apply:

Costs:

- Loss of team members from CMHTs into Local Enablement Teams - resulting in shifting some workload previously taken on by 'generic' social workers to health staff particularly a risk around CPA
- Reduction in access to specialist social work input and skills
- Reduction in line management of social work team moving to LETs

Benefits:

- Reduction in referrals through improved management of early detection & prevention of mental health conditions and therefore demands on secondary care resources
- Opportunity for 'step down' service users into Enablement programmes outside CMHTS
- Opportunity to focus health resources on more severely ill service users

7. Proposed Service Model

The key changes that result from the implementation of the BEP are:

7.1 Staffing

7.1.1 Line management of social care separate from BEHMT

This will deliver a greater focus on social care outcomes without losing the benefit of close working with BEHMT.

7.1.2 Withdrawal from CPA by Social Care staff

This will enable staff to move away from professional intervention being about monitoring and supervision to one focussing on choice, enablement and

intervention aiming for self-management, with the goal being "how can I support you to do this yourself?"

7.1.3 Changing roles of Social Care staff

The LETs will enable social work to intervene at the front door and to maximise each service users potential for community access and enablement at an early opportunity. Social work will reach into primary care and access to The Network will be direct. Service Users can self-refer to the LETs.

Investment in Peer Support and Assessment and Enablement roles at all aspects of the pathway to enable service user led intensive support and a continued focus on recovery and enablement. This will require different management support and approaches.

The Introduction of the Consultant Social Work role to provide professional leadership and to lead the links with family work and to provide particular expertise in key social work areas such as Approved Mental Health Professional practice and Safeguarding.

7.2 Development of the LETs and Hub model

7.2.1 Local Enablement Teams will lead the development and operation of the hub model for social care ensuring that enablement opportunities with partners (including service users) are maximised. This will mean different ways of working, working with new partners, and leading development work.

7.3 Development of Network Plus

7.3.1 Expansion of The Network to offer Network Plus, with the creation of a six week offer, a refresh of the enablement programme to account for new pathways and creation of the "top up" offer for those requiring brief interventions following completion of the enablement programme.

7.3.2 The Network to lead the development of new enablement initiatives which further promote self-management.

7.3.3 The Employment Strategy group has considered the additional investment of Employment Support within The Network and LETs. Options were considered including conversion of a social work role into Employment Specialist, additional investment within current services and developing existing roles further into the pathway. Given the benefits are not realised into social care and the need is for specialist work supporting the IPS (Intensive Placement Service), further investment from social care at this time was not a recommended option. Therefore the LETS will focus on ensuring integration with existing provision.

7.4 New Referral routes and processes

7.4.1 LETs will take referrals direct from the hub including self-referrals.

7.4.2 Introduction of Choice Appointment, Choice Meeting and Personal Profiles changing the way we think about access and planning for support.

7.4.3 Redesign of the pathway and focus on escalating interventions:

- Choice appointment
- Brief enablement offer
- Standard enablement offer
- Specialist support
- Intensive enablement

7.5 Proposed Staffing Model

Table 14: Staffing resources required to deliver proposed model

	FTE	Spinal Point		Budget (incl. on-costs)
		Min.	Max.	
Barnet Enablement Pathway				
Barnet Enablement Manager	1	46	49	£56,411
Total	**1**			**£56,411**
Community Team (aligned to BEHMT CMHT) and reaching out into three LETS				
Consultant Social Worker	3	42	45	£154,112
Senior Social Worker (AMHP)	11	33	42	£447,856
Early Intervention Social Worker	1	35	41	£42,663
Assessment and Enablement Officer	3	29	32	£108,647
Total	**18**			**£753,278**
Local Enablement Team delivering Network plus and reaching out through three hubs				
Community Network Manager	1	46	49	£56,411
Consultant Social Worker	1	42	45	£51,371
Business Support Manager	1	34	37	£41,826
Business Support Assistant	3	18	21	£77,082
Assessment and Enablement Officer	3	29	32	£108,647
Community Access Worker	3	25	28	£95,469
Social Worker	3	33	39	£122,143
Peer Support/AEO	1	29	32	£36,216
Total	**19**			**£709,255**
Intensive Enablement Team				
Consultant Social Worker	1	42	45	£51,371
Social Worker	5	33	39	£203,571
Assessment and Enablement Officer (Peer Support)	1	29	32	£36,216
Occupational Therapist	1	33	39	£40,714

	FTE	Spinal Point		Budget (incl. on-costs)
		Min.	Max.	
Total	**8**			**£331,871**
AMHP Service				
Consultant SW AMHP	1	46	49	£56,411
Social Worker	1	33	39	£40,714
Business Support Officer	1	18	21	£25,694
Total	**3**			**£122,819**
TOTAL	**46**			**£1,853,542**

7.6 The proposed staffing model has been costed at the current year's staffing cost and all changes to the skills mix have been created through changes to vacant posts. Recruitment to the staffing structure is a key enabler to reduce spend in Adult Social Care given the high use of agency staff within mental health services. Barnet has initiated a scheme in partnership with Think Ahead and BEHMT to recruit, train and then employ Trainee Graduate Social Workers. This scheme will commence in 2016 and those posts are funded for year 1 outside of these costs.

7.7 Activity

7.6.1 The following table sets out the expect demand and activity levels within the BEP. This has been modelled using demand data from the NMDS and Barnet's weighted mental health need, intelligence from the Care Act modelling for Barnet and the population impact set out in the JSNA.

Table 5: Expect demand and activity levels within the BEP

Area of Activity	Activity levels
Total possible referrals (weighted population secondary care)	5000
Total possible referrals carers	600
Numbers of choice appointment	1310
Choice Meeting number	1180
Up to 6 week Enablement package	1100
Network plus	770
Specialist Services (CMHT)	500
Safeguarding (IET and CMHT)	120
Reviews – community (CMHT)	145
Intensive Enablement Team	140
AMHP (assume 15 available AMHPS)	Capacity for 700–1000 assessment

7.6.2 The change is achievable within existing resources and with a programme of workforce development will deliver the following:

- Ensure joint working at all aspects of the pathway and with key partners
- Maximise existing staff resource to expand enablement offer
- Ensure safe management of safeguarding
- Deliver a more robust AMHP service with a full-time member of staff operating duty and safety of workers.
- Through the implementation plan deliver a safe plan of transition ensuring sound caseload transfer

8. Implementation

8.1 Programme Management

8.1.1 The Implementation of the BEP will be supported with dedicated programme support and managed within a programme approach to enable LBB and partners to develop sustainable integrated care that understands and meets the needs of people with mental health problems in Barnet.

8.2 The main objectives of the Programme

1. Embed the Barnet Enablement Pathway for the design and delivery of all current and future integrated health and social care services.
2. Embed in people a perception and expectation that people will live independently in their community, only using care services designed to protect and extend this if necessary.
3. Move as much activity as possible from acute, residential or nursing care to people self-managing their conditions and accessing services in the community.
4. Deliver integrated services which:
    a. Promote and support self-management, health and wellbeing in the community.
    b. Operate end-to-end across the pathway to respond quickly and to plan, deliver and track enablement focused care wherever possible.
5. Put in place operational infrastructures, workforce development, systems and working arrangements to facilitate integrated working to deliver the Barnet Enablement Pathway

8.3 Programme Governance

8.3.1 The BEP Coproduction Group will deliver the implementation plan set out below. This group has in place a communication and engagement plan to ensure robust participation from stakeholders and that particular groups have their needs addressed in specific ways. This group links with the Reimaging Mental Health but reports in through to the Commissioning Director for Adults and Health.

8.4 Key Milestones

8.4.1 Staff consultation will take place in November and December given the change of teams and line management for staff. There are no redundancies proposed in the structure and changes to the skills mix of the team will be managed through changes to vacant posts.

8.4.2 Co-production will continue through the autumn and spring to finalise the team structure and on-going discussion with BEHMT will take place concerning integrated teams, use of estate and pathways. Through this period the Section

75 will be reviewed and assessed to test its relevance for the new service model. The form of Partnership Agreement required which enables joint working, co-location and information-sharing within the CMHT will be assessed at this point.

8.4.3 Staff will be involved in task and finish groups to design processes and systems to support the model ready for adoption in March and April 2016.

8.4.4 Should this work progress as planned, the new service model will be in place from the 1st October 2016. As far as possible, the implementation will be aligned to the transformation work undertaken by the CCG and BEHMT to minimise impact on services users and staff. The implementation plan may also be adjusted to ensure adequate time for consultation and coproduction, although the plan has been developed these processes at its heart.

Table 16: Milestone plan for new service model delivery

Ref	Tasks/ Activities	Start	End
0	**Presentation & sign off of business case**	**16/09/15**	**16/09/15**
1	**Set up and definition of BEP model**	**30/09/15**	**30/09/15**
1.1	Set up working group	30/09/15	30/09/15
1.2	Activity modelling of new BEP pathway	08/10/15	14/1/16
1.3	Set out clearly integration and pathways: • Safeguarding • AMHP • Crisis • Intensive Enablement	14/10/15	14/2/16
1.4	Final modelling and stakeholder consultation	1/3/16	28/6/16
1.5	Process for safe caseload transfer set out	1/7/16	1/7/16
2	**Balanced Team implementation**	**01/10/15**	**01/02/16**
2.1	Set up balanced team working group	01/10/15	01/10/15
2.2	Define & test initial job descriptions and activity estimates	14/10/15	14/11/15
2.3	Go to Staff Consultation on proposed changes	14/11/15	14/1/16
2.4	Advertise and appoint to Consultant Social Worker role	14/2/16	14/04/16
3	**Reconfiguration of Network to LETs**	**01/10/15**	**01/04/15**
3.1	Set up network working group	01/10/15	01/10/15
3.2	Review capacity and current activities of the Network	14/10/15	14/11/15
3.3	Build specification for new LET capacity including physical estates, facilities (for assessment, training and therapy)	01/10/15	01/12/15
3.4	Consultant on changes to the Network buildings and function (including interface with housing and employment)	01/01/16	01/03/16
3.5	Scope and agree capacity source and provision for employment and housing expertise	01/10/15	01/12/15
3.6	Implement changes	01/04./16	
4	**Implement Staff and Management Changes**	**1/4/16**	**1/10/16**
4.1	Scope impact on posts document	1/11/15	14/11/15

Ref	Tasks/ Activities	Start	End
4.2	Staff consultation process	14/11/15	30/12/15
5	**Ensure Clear Systems, forms and process**	**01/12/15**	**01/07/16**
5.1	Choice appointment, choice meeting, personal profile	01/12/15	01/06/16
5.2	Configuration of Mosaic	01/12/15	01/03/16
5.3	AMHP referrals and activity	01/12/15	01/03/16
5.4	Configuration of CMHT with balanced team	01/12/15	01/07/16
5.5	Hub operation with partners	01/12/15	01/07/16
6	**Intensive Enablement Audit and Business Case**	**01/10/15**	**30/04/16**
6.1	Undertake audit of all placements and scope move-on potential	01/10/15	02/02/16
6.2	Develop case for staff investment	02/02/16	01/03/16
6.3	Implement staffing changes	01/04/16	30/04/16
7	**Design pathway and approach with family services**	01/11/15	01/03/16

9. Summary of Key Risks

9.1 Risk and Issues Categorisation

9.1.1 The risks and issues associated with the Barnet Enablement Pathway fall into four main areas:

1. **Implementation** risk due to resourcing issues creating delay, poor leadership and engagement taking longer than planned.

2. Risk associated with **managing cultural and organisational change** where the desired impact is not achieved to the level required or change is not at the intended pace

3. Risk associated with **partnerships** and in particular BEHMT where there is mutual dependence but managerial independence.

4. **Financial** risk where there are reductions in the staffing resource and inadequate capacity to deliver the service as scoped.

Table 17: Top Risks

The top risks have been identified with the following mitigation plan:

No.	Owner	Risk	Probability (L,M,H)	Impact (L,M,H)	Effect on Project	Risk Reduction Actions
1	Project lead	Delay on initiate project	Low	High	Unable to action objectives	Strong buy in and leadership from senior team
2	Project lead	Delays in consultation and agreement to staffing and team	M	H	Unable to transition remainder establishment to Network	Early agreement on CSW job description and appointments. Early identification of candidates for both CSW and other social worker roles Staff coproduction at all stages
3	Project lead	Delays in expanding footprint of the Network to accommodate Local Enablement Teams	H	M	Unable to relocate Social Workers out of CMHTs into the Local Enablement Teams	To review locations and capacity of the Network early with potential to locate suitable geographic venues to act as temporary accommodation to Local Enablement Teams
4	Project lead	Cost pressures leading to reduction in establishment numbers	M	H	Unable to deliver current Establishment Team model with estimated activity and service users to staff ratios	To identify establishment cost control strategy earlier to allow reworking of Local Establishment Team models
5	Project lead	Performance dashboard not developed for BEP	M	M	Unable to performance manage and therefore target BEP service improvements	Establish early agenda item around BEP performance including development of active performance dashboard

TBA

Appendix A – Proposed task breakdown

Proposed Task and Caseload Breakdown	LETS	Network	CMHT	IET	AMHP
Brief Enablement					
Choice Appointment	✓	✓	✓	✓	
Choice Meeting and Enablement plan	✓	✓	✓	✓	
Travel companion	✓	✓	✓	✓	
Involvement will not exceed six weeks	✓	✓			
Single professional support with evidence of intervention	✓	✓			
Brief enablement programme - courses, groups and one to one	✓	✓			
Housing support	✓	✓	✓	✓	
Employment support	✓	✓	✓	✓	
Welfare rights including benefits and debt	✓	✓	✓	✓	
Carer and family support	✓	✓	✓	✓	
Direct payments	✓	✓	✓	✓	
Small package of short breaks	✓	✓	✓	✓	
Community Access and support	✓	✓	✓	✓	
Signposting and access to self-management, community activities	✓	✓			
MDT working to maximise enablement including GP and IAPT	✓	✓			
WRAP	✓	✓			
Skill building	✓	✓			
Access to Peer Support/Champions	✓	✓			
Network Plus					
Choice meeting for full assessment	✓	✓	✓		
Low risk, long-standing case (may involve multiple agencies)	✓	✓	✓		
Requirement for ongoing adult services		✓	✓	✓	
Safeguarding	✓	✓	✓		
review of community care package and direct payments		✓	✓		
Crisis support		✓	✓		
Medium-term family support					
Specialist Support					
Complex casework			✓	✓	
Outcome focussed case management based on WRAP			✓	✓	
Safeguarding			✓		
117			✓	✓	
MH Act Assessment					✓
MCA					✓
Family and carer support			✓		
Social Supervision			✓		✓
Complex Crisis intervention			✓		
Ordinary Resident casework			✓		
Hospital Social work				✓	
Move-on and Residential review				✓	