Future needs and services for 18 – 64 year-olds in Herefordshire with mental health problems

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Contents

Summary

Working together and with their partners, Herefordshire Council and the Herefordshire Primary Care Trust are committed to maximising the independence, well-being and choice of people with mental health problems. In doing this, they face a major double challenge: despite additional investment and service improvements in recent years, in important respects they still lag behind what is achieved by high-performing authorities serving comparable areas; and the cost of services has continued to escalate.

Mental health disorders are one of the major causes of ill-health, suffering and social problems in the county. The 874 people between 18 and 64 with psychosis and the other most serious mental health disorders reported by services in Herefordshire is much higher than the 600 that would be expected on the basis of national prevalence rates. There is no present reason to believe that more people will require treatment in either 2012 or 2021.

An estimated 18,000 18 to 64 year-olds suffer from depression and other more common mental disorders. This number is not expected to change by 2012 but seems likely to increase slightly by 2021.

In addition, an estimated 4,650 18-64s have a personality disorder, a number that is expected to increase by 50 by 2012 and by 150 by 2021. However, only 60 of these people currently receive secondary mental health care and it is at present impossible to predict the long-term need for services.

About 50 people aged 30-64 suffer from dementia. This number is not expected to increase by either 2012 or 2021.

Over the past five years, an average of seven 14-17 year-olds a year were identified as having experienced a first psychotic episode. This number seems unlikely to change significantly. This is the only current measure of the numbers of young people with mental health problems who may be in transition to adult services.

Major gaps in current data need to be filled, which means that these estimates will need to be kept under review, in the light of actual demand for fully modernised services and through the new process of Joint Strategic Needs Assessment. Even so, it is possible to be reasonably confident about the needs estimated for 2012.

Users and carers say that services as a whole have improved but that many aspects leave a lot to be desired. They point to a need for much better communications between staff and users, and between services; 24/7 direct access to secondary services and information; refuge at times of crisis; more education, training, work and other day opportunities; and better services for young people, including those from Eastern Europe. The Government and the inspectorates have similar expectations.

Final report: future care needs and services for 18-64 year-olds with mental health problems

Compared with high-performing Dorset, Somerset and West Berkshire, Herefordshire spends a lot more on secure and high-dependency residential and nursing home care, especially on out-of-county placements, but much less on supporting people at home and on supporting carers. Unlike the comparators, it has limited specific mental health primary care services and doesn't provide direct access for users and carers to advice and support 24/7. It does much less to involve users and carers. It does have a good level of psychology services.

Herefordshire lags behind the best practice in helping people with mental health problems to gain or retain employment and in preventative services, including the promotion of mental health.

Overall, Herefordshire spends more per head of population than the comparators but less than the all-England average. It raises significantly more income from users than the comparators but needs to increase external funding, including from the national *Supporting People* programme

To achieve high-performing, cost-effective services by 2012 Herefordshire needs to do much more to support people before they need specialist secondary services; to provide the great bulk of services in, or close to, people's own homes and communities; and to do more to help people recover and stay well after they have received secondary services. This will require the cost-effective, local replacement of much of the current out-of-county provision and, more generally, a significant reduction in the use of residential and nursing home care.

Considering together the demands for new forms of services, the additional costs of provision arising from Herefordshire's uniquely high number of people living in sparsely populated areas, inefficiencies in the current pattern of services and the small increases so far identified in expected demand, **overall it would seem reasonable to conclude that the aggregate level of spending by the Council and the PCT in 2006-07 (i.e including the over-spending against budget of £1.3 million) is the minimum necessary recurrent funding to meet the needs of those with the most serious and the most common mental health problems up to 2012.**

This conclusion should be reviewed by 2012 in the light of better data, including the actual demand for fully modernised services.

Since it is not possible to stop current provision before more efficient and effective services have been put in place, non-recurrent bridging funding of £269K in 2008-09, £298K in 2009-10 and £158K in 2010-11 will be needed.

To avoid a vicious circle of decline, the transformation plans to bring about the new pattern of services must be fully integrated with the steps taken to manage current in-year over-spending against budget.

Existing resources will not do the job without the full and quickest possible integration of all aspects of planning, commissioning, delivery and performance management of health and social care across the Council and PCT.

It will also require a substantial extension of direct payments and personal budgets; better support for carers; maximising the contribution and effectiveness of GP-based commissioning; adjusting the balance of PCT and Council funding to achieve a single, shared set of commissioning targets; attracting significant additional funding from external sources; and working closely with the third sector to mobilise voluntary and community resources behind the development of preventative services, access to generic local services and facilities, advocacy for individuals and help-lines.

The new services will only work if all those caring for and supporting people with mental health problems are developed to have the right skills and behaviours. This will need to be done as part and parcel of the introduction of the streamlined processes and ICT-based systems being put in place under the *Herefordshire Connects* programme, buttressed by strong, disciplined performance management at all levels.

The needs of those with personality or eating disorders and the services required to meet them will need to be determined during 2008; in the case of personality disorders, in the light of emerging government expectations; and, in the case of eating disorders, having regard to the results of a local pilot service. This report therefore makes no allowance for the costs of developing additional services for these groups, although it is not out of the question that they could be funded from within the current real terms level of spending in the light of the review in future years recommended above.

Section 1: Introduction

Working together and with their partners, the Council and the Herefordshire Primary Care Trust (PCT) are committed to maximising the independence, well-being and choice of people with mental health problems.

Despite additional investment over previous years, and changes aimed to enable people to lead safe and fulfilled lives in their own homes and communities rather than in unnecessary residential or in-patient care, the Council's and PCT's current pattern and levels of services are not, in important respects, achieving as much and providing the same value for money as are the highest performing comparable areas.

This was confirmed in the results of the Health Care Commission's and Commission for Social Care Inspection (CSCI)'s joint review of community mental health services across England in 2006, *No voice, no choice*. Although it identified some areas of strength, it also found weaknesses, with the net effect that Herefordshire's services were amongst the 43% of areas rated "fair". This compares with 9% of areas being rated "excellent", 45% "good" and 3% "weak".

In addition, the costs of services in Herefordshire have risen substantially in recent years and continue to do so, to the extent that expenditure has significantly exceeded budgets.

This is taking place against the background of the ambitious developments in Government policy for health and social care set out in the White Paper of January 2006, *Our health, our care, our say: a new direction for community services*. This calls for a fundamental shift in services to local communities, to be developed by local partners in ways that better meet the needs of individual people. It sets four main goals:

a. **better prevention and earlier intervention** – reducing the chances of people becoming ill or dependent in the first place;

b. **more choice and a louder voice** – ensuring that people are in control of the services they receive, through involvement in the planning and development of services, and by means of self-directed care, including direct payments and budgets for individuals;

c. tackling inequalities and improving access to a wider range of community services – ensuring that the areas, groups of people and individuals with greatest need get the services they deserve;

d. **more support for people with long-term needs** – better integration of services and joint planning across health and social care for those who make the most intensive use of services.

These goals are developed in more detail for mental health services in other authoritative publications, including *No voice, no choice*, the Sainsbury Centre's *Vision for 2015* and the National Director for Mental Health's *Ten years on* review. They are expressed most concretely in the seven outcomes for people used by the CSCI in their assessments of care: *Improved health and emotional well-being; Improved quality of life; Making a positive contribution; Exercise of choice and control; Freedom from discrimination and harassment; Economic well-being;* and *Personal dignity and respect*.

The goals are underpinned by national consultation showing strong support for more community services. That is reflected in the consistent findings of public consultation in Herefordshire, including that carried out with users and carers specifically to inform this assessment (details are given in Section 3 below). The Council, the PCT and their partners in the Herefordshire Partnership have made *Healthier Communities and Older People* one of the *Herefordshire Community Strategy's* four priorities for better outcomes.

In the light of these considerations, the Council and the PCT are committed to working with their partners, service users themselves and their carers and representatives, to develop and deliver better, sustainable services for the future. They want, in particular, to strike the right balance between preventative services and the provision of more intensive support and care.

In doing this, the Council and PCT are particularly conscious not only of the inter-dependence of health and social care one upon the other in achieving the best outcomes for people, but also of the vital contribution that needs to be made by housing, employment services, education, welfare benefits, generic community-based opportunities (such as cultural and leisure services), the voluntary and community sector, and, not least, by users and carers themselves and by their advocates.

1.10 Crucial too are effective links to ensure smooth transition between the services provided for children and young people and those for adults; and between services for 18-64 year-olds and those for older people.

The purpose of this report

1.11 Having last year assessed future needs for older people and adults with learning disabilities, and agreed how services would be developed to meet them, the Council and the PCT decided to carry out, with the *Herefordshire Alliance*, a thorough assessment of future needs of 18-64 year-olds with mental health problems; of the services needed to meet those needs; and of the costs involved in doing so, taking into account the scope for greater efficiency in moving from the present services to a new, more effective pattern.

1.12 This report has been prepared under the leadership of the Council's Corporate Policy and Research Team, working with staff in the PCT, in the Council's Adult Social Care Department and Resources Directorate, and with *The Herefordshire Alliance* and *Herefordshire MIND*. The membership of the Steering Group is at Appendix 1.

1.13 The Steering Group has been advised by distinguished experts in the field, Professor Gerald Wistow and Eileen Waddington. Further information about the expert advisers is at Appendix 2.

1.14 The first stage of the project was to estimate the need for care of 18-64 year-olds with mental health problems through to 2021. This was to provide the long-term context for the second stage: the assessment of what patterns and levels of cost-effective services would be needed to meet expected needs in 2012.

1.15 Rather than conduct a theoretical assessment of the services that will be needed, the best possible comparator areas were identified; that is those with high-performing services in areas with broadly similar settlement patterns and demographic characteristics to those found in Herefordshire. The selected areas were Dorset, Somerset and West Berkshire.

1.16 Through analysis of comparative data about services and costs, of inspection reports, and by visiting the authorities, we established what patterns and levels of services they provide; how they intend further to change and improve them to meet future challenges; and, crucially, how they manage and deliver them successfully. These findings were then applied, having regard to the distinctive needs and circumstances of Herefordshire and to wider relevant comparisons.

1.17 The final stage was to translate these findings into costed proposals for the development of high-performing services through to 2012.

The structure of the report

1.18 Section 2 of the report examines future needs to 2012 and 2021. Section 3 describes what pattern and levels of services will be needed to meet those needs in 2012. Section 4 looks at the capacity needed to develop and deliver these services successfully. Section 5 sets out the estimated costs of doing so.

Section 2: Assessment of future needs

2.1 The full assessment of future needs for 18-64 year-olds with mental health problems is at Appendix 3. It begins with a summary.

2.2 The crucial points are:

- mental health disorders are one of the major causes of ill-health, suffering and social problems in the county

- **the most serious and disabling mental health disorders** (psychosis, schizophrenia and bi-polar affective disorder) affected 874 people aged 18-64 known to GPs in Herefordshire in January 2007; this is significantly higher than the 600 people that national prevalence rates would suggest

- there is no present reason to assume that more people with these most serious conditions will require treatment in either 2012 or 2021

- **suicide rates** in Herefordshire have appeared in the past to be relatively high, but the 20% reduction target between 1995-97 and 2010 is expected to be met

- **more common mental health disorders** (anxiety, depression, neuroses, phobias, compulsions and stress) are estimated to affect over 18,000 adults aged 18-64 in a year, which is more than 17% of the total age group

- no notable change is expected in this number by 2012; however, an increase of 1% is expected by 2021, which might, on the basis of the proportions currently accessing secondary mental health services, equate to an extra 5 or 6 people needing to do so

- on the basis of national estimates, 4,650 18-64 year-olds in Herefordshire (over 4% of the total age group) may have a **personality disorder**, but only 60 receive secondary mental health care

- this total might be expected to increase by 50 people by 2012 and 150 by 2021; although, on the basis of the current level of access, this would lead to only marginal changes in the demand for care, this could increase more were the county to develop specialist provision for this group in response to changing national and statutory requirements; it is not at present possible to quantify this potential demand but it could be substantial

- **early onset dementia** affects about 50 people aged 30-64 in Herefordshire; currently only 22 of these receive a secondary service, an estimated one-third of whom are suffering from preventable dementia as a result of substance mis-use

- the total number of sufferers is expected to remain at about this level in 2012 and 2021

- although nationally it is estimated that around one-third of patients with serious mental illness have a substance mis-use problem, and that about half of drug and alcohol service users have a mental health problem, it is not at present possible to estimate the extent of **dual diagnosis** in Herefordshire or what it might be in the future

- neither is it possible at present to estimate the numbers of people in **different ethnic groups** in the county experiencing mental health problems; nor to produce estimates of the numbers of people likely to suffer from such problems in **different parts of Herefordshire**

- over the past five years, an average of seven **14-17 year-olds** a year were identified as having experienced a first psychotic episode; on the basis of demographic trends, this number seems unlikely to change significantly; this is the only current measure of the numbers of young people with mental health problems who may be **in transition to adult services**

- an estimated 3,300 people in the county aged 18-64 (3%) are **carers** of someone with a mental disability, with about three-quarters of those cared for also having a physical disability; the number might be expected to increase slightly as a result of the modest increases described above in the expected numbers of people suffering from mental disorders

- a recent survey has identified at least 133 mental health service users living in unsuitable **accommodation**, two-thirds of whom require general needs rather than supported housing

2.3 In considering these estimates, it is important to bear in mind the paucity of reliable data currently available internationally, nationally, regionally and locally as regards both present and future levels of need.

2.4 Some of the international and national estimates suggest a growth in needs at odds with the conclusions in this report. For example, the World Health Organisation predicted in 2001 that there would be world-wide increase in depression that would make it the leading cause of disability by 2021; while, in its March 2007 study for the

Disability Rights Commission, the Institute of Public Policy and Research (IPPR Trading Ltd) projected possible big increases by 2020 in impairments caused by mental health problems, including a doubling – to an enormous 38% - in the proportion of 20-29 year-olds experiencing them.

2.5 It plainly makes no sense to take a world-wide forecast and apply it to Herefordshire, while the IPPR's UK projection was based on self-reporting as part of a labour force survey and doesn't distinguish between the different types and severity of mental health problems. The IPPR report itself says, "*Given the limitations of the data….this report cannot offer a definitive account of the circumstances and experiences of disabled people in 2020*."

2.6 Within Herefordshire difficulties with data arise either because it simply hasn't been collected or because the various separate data-bases maintained by the Council and the PCT about individuals mean that there is likely to be extensive double-counting or more. On the other hand, some things are probably not being counted at all. These deficiencies will need to be addressed to provide a sound basis for the future monitoring and planning of services, as well as to meet fully statutory requirements in respect of equalities and those to come requiring a Joint Strategic Needs Assessment for health and social care.

2.7 It is of great importance that we rectify these deficiencies as quickly as possible. Much of this will be made possible by the introduction of a single user data-base and other improvements under the *Herefordshire Connects* programme, including the development of shared systems between the Council and PCT within the Public Service Trust. The longer-term estimates of need in this report should be reviewed as these improvements bear fruit.

2.8 That said, the present estimates are the best possible current basis for planning and delivering improved services to 2012, in respect of which it is possible to be reasonably confident about the extent and nature of future needs.

Section 3 - The pattern and levels of services to meet needs in 2012

3.1 Drawing on the views expressed by users and carers in Herefordshire, on Government and other authoritative national requirements and guidance regarding mental health services, together with the evidence about high-performing services gathered from the comparator areas – Dorset, Somerset and West Berkshire – this section describes what needs to be done, to what extent, to achieve services that will meet the needs identified in section 2.

The views of users and carers

3.2 The views of users and carers on present and future services were sought at two forums in July 2007. Nearly 40 took part, expressing clearly and forcefully what they want from services.

3.3 Their main points were:

- although services as a whole have improved a lot over the past decade, many aspects of them still leave much to be desired
- the need for much improved two-way communications between staff and those receiving assessments and care, with all staff exhibiting a positive, respectful attitude to users and carers
- and for much better communications between professionals in respect of individuals receiving assessments and care, so as to ensure continuity and consistency
- in particular, the need to tackle a lack of co-ordination between mental health and acute hospital services, including as regards user records
- the need for all GPs, acute hospitals and accident and emergency departments to have an acceptable minimum level of understanding about mental health problems; for example, in respect of self-harm
- being able to access the crisis team whenever they feel the need to do so, rather than having to be referred by primary care, which was reported to be reluctant to do so, particularly at evenings and weekends; they believed that this would have the effect of avoiding at least some admissions to the Stonebow hospital unit
- the particular value of a designated 24/7 telephone helpline that would give users and carers immediate access to information and support

- the need for a safe place in the community to go to in a crisis, particularly out-of-hours and at weekends

- the day centres provided by MIND were regarded as crucial by many, not least as somewhere they feel supported, safe and not judged

- others had mixed feelings about them, but it was noted that MIND is aiming to develop a wider range of provision to cater for diverse needs

- a general call for a wider, more flexible range of services, extending beyond specialist mental health services and those prescribed under the *National Service Framework*

- linked with this, the need for support to enable them to access generic community services and facilities, coupled with educating the public on mental health issues to break down barriers

- and more secure long-term funding for suitable educational opportunities, not least those that help people to gain qualifications in preparation for employment

- a need to improve the quality of services for young people (it was said they will not attend day centres), including Eastern Europeans who have mental health problems but are not known to services

- and to ensure a smooth transition for those moving between young people's services and those for adults

Government and inspectorate requirements

3.4 The things users and carers want to see reflect most of the national requirements and guidance on good practice. Other key elements expected by Government and the inspectorates are:

- the fullest possible participation in society being the touchstone, including meaningful employment

- the promotion of emotional health in schools

- all public services playing an active role in mental well-being

- access for all to psychological and other "talking" therapies

- the extension of direct payments and individualised budgets to as many people as want them, with all users and carers involved in the development of care packages

- and plans agreed between users and staff for personal recovery goals

- advance planning with users and carers for crises, including anti-psychotic treatment
- attending to the needs of the whole person, with a particular emphasis on improving the physical health of those with mental health problems
- advocacy and other help for individuals to promote their social inclusion
- user and carer involvement in service planning and development
- choice about appointment times
- an effective partnership between primary and secondary care
- treatment in the community, wherever possible, rather than in hospital
- good, timely information for users and carers about medicines and their side-effects
- under the Department of Health *National Service Framework*, a prescribed minimum level of staffing for specified services, including carers' support, securing access to services for black and other ethnic minorities, and mental health promotion
- the provision of information, advice and, where appropriate, assessment to the whole population, including self-funders

Comparing with high-performers

3.5 In comparison with the relatively high-performing Dorset and Somerset (and, where indicated, West Berkshire, in respect of which there is incomplete comparative data), Herefordshire:

- commissions substantially more continuing residential and nursing home care (57 per 100,000 population aged 18-64, compared with an average of 20, spending proportionately about a third more); Herefordshire's lower costs per placement support the view that it has a lower threshold of needs before it resorts to these forms of care
- commissions a lot more secure and high-dependency provision, spending almost double per head of population more than Dorset; about half of this spending is on 21 out-of-county placements
- has the same trends in terms of falling hospital admissions (424 in 2002-03; 368 in 2006-07); fewer discharges (431 down to 371); and increased average lengths of stay (median up from 12 to 17 days), but these are magnified in the comparator areas

- secures a tiny level of home support services (only ten people were receiving home care on 31 March 2007), spending at one-fortieth the average level of the comparators

- provides a good level of psychology services, at the level of the best of the three comparators

- has more people attending day care centres (over 100 per 100,000 aged 18-64, compared to an average of 54), with fewer accessing more flexible, community-based and generic opportunities

- unlike the comparator areas, doesn't have 24/7 direct access for users and carers to advice and support (although a crisis assessment and treatment service is available 24/7)

- has a low number of people receiving direct payments, similar to the comparators

- has a lower level of advocacy services, particularly for individuals

- has a similar level of social workers in community mental health and other specialist teams (18 per 100,000 of the 15-64 population, compared with an average of 17)

- like the comparators, provides no specialist services for people with personality disorders

- apart from practice counselling, has limited primary care services specifically for people with mental health needs, compared with the well-established arrangements in the comparators

- has a lower level of community eating disorder services

- has very much lower provision for carers, incurring expenditure about a tenth of Dorset's (but with a carers' support worker about to be appointed)

- does much less to involve users and carers in the planning and development of services

- spends a little below the average on housing

- provides less support to prepare people to gain or maintain employment

- overall across health and social care, has gross spending above the average of the comparator areas (£135 per head of the 15-64 population, compared with an average of £114 in Dorset and Somerset) but less than the all-England average (£156)

  (For detailed consideration of this comparison see paragraphs 4.2 to 4.10 in section 4 below.)

- social care expenditure is slightly above average (£26.71 per head of the 18-64 population, compared with an average of £25.55)

- generates significantly more income from client contributions (nearly ten times the level in the lowest, West Berkshire)

- has far less effective and efficient systems for data collection, analysis and performance management

3.6 In addition, Herefordshire lags behind best practice as regards preventative services, including the promotion of mental health. It also needs to do more to maximise external funding, including from the national *Supporting People* programme.

The new pattern of services required

3.7 This analysis leads to our recommending the following principal changes to achieve the more balanced, modern pattern of services that would meet Herefordshire's needs cost-effectively.

3.8 The fundamental strategic shifts needed are to do much more to support people before they need specialist secondary services; to provide the great bulk of secondary services in, or close to, people's own homes and communities; to do more to help people recover and stay well after they have received secondary services; and to place much more influence and control in the hands of users and carers.

3.9 The specific changes to achieve this should be:

- commissioning cost-effective services within the county to replace many of the current out-of-county placements and, wherever possible, avoid them in the future, including through the existing residential rehabilitation unit

- developing own-home and community-based services so as to reduce to the absolute minimum the use of residential and nursing home care

- improving crisis provision, ensuring direct access 24/7 for users and carers to information and advice; and, where necessary, home treatment

- providing temporary refuge, integrated with day care

- enhancing recovery and rehabilitation services, including home support, housing, education, training and employment opportunities, and support, where necessary, to access general community facilities

- the maximum possible number of people securing their own care with direct payments or personal budgets

- securing effective, independent advocacy for individuals

- developing primary care mental health services, including therapies, closely linked to the work of the community mental health teams (members of which should operate at least partly within GP practices) and the enhanced domiciliary and community-based services*,* with the objective of there being a lead GP for mental health in each practice

- greatly enhancing preventative services, mobilising community resources and volunteers, including from amongst the ranks of service users and carers

- securing services to support carers to continue in their role and improve their own health and well-being, including, where necessary, help to retain or gain employment

- extending mental health promotion services

- all of the above enabling both a reduction in acute hospital bed provision and a greater capacity within the acute hospital to provide effective treatment for those with the most intensive needs

- systematic, continuous user and carer involvement in the planning and development of services, including financial assistance and capacity-building to make this possible

- developing a shared philosophy and approach across children's and adults' services, reflected in fresh protocols, to ensure a smooth and successful transition for young people moving between them

- taking equal care to achieve fair and effective transition for people to older people's services

- determining the nature and extent of services needed for people with personality disorders (the aim is to develop a service specification by March 2008)

- evaluating the pilot community eating disorder service (scheduled to take place after twelve months, in July 2008) and determining the nature and extent of future services

- identifying the needs of ethnic minority groups, including the significant number of young people who have come from Eastern Europe in recent years, and tailoring services to meet them

3.10 A number of the necessary improvements are already beginning to happen or are planned. For example, over the past year there have been significant developments at the Stonebow Unit, including a suite to assess those arrested under Mental Health Act powers rather than the use of police cells; the piloting of a consultant working closely with the crisis team over admissions, which has reduced the occupancy rate by 15% and will be rolled out generally in January 2008; and funding secured to provide single-sex accommodation.

3.11 Other important recent developments include:

- tighter scrutiny of out-of-county and long-term care home placements, with reviews of existing placements that will be repeated regularly; already this has led to the repatriation from out-of-county placements of two service users, saving £200,000 a year

- strengthening staffing in the early intervention service to meet the target of supporting at least 20 people experiencing a first episode of psychosis

- a mental health services housing plan and a development officer to make sure it is implemented

- service users and carers sitting on the reference group for adult mental health services, and a regular programme of meetings between carers and senior managers

- getting an expert to develop urgently the detailed specification for improved rehabilitation and recovery services that will lead to the reduction of out –of –county placements and other long-term care, and generally create a more user-led service

3.12 The overall pattern and levels of high-performing services proposed are set out in Appendix 4, which also explains the underlying assumptions

Section 4 - The capacity needed to deliver the improvements

4.1 Achieving successful change on the scale necessary to meet future needs cost-effectively requires not only careful, detailed planning across health and social care (and beyond) but also a firm, co-ordinated grip on all aspects of managing projects, finance, human resources and performance.

Funding

4.2 Assessing the adequacy of Herefordshire's 2006-07 level of budget and spending (i.e. including the overspend against budget of £1.3 million) to meet future needs is complicated by there being two bases for comparing Herefordshire with our chosen comparator areas, and also with the wider group of statistical neighbours and England as a whole. One is to do this by comparing funding on the basis of the total actual populations; the other is to apply the weighted populations used by central government for the financial mapping of mental health services across England.

4.3 The results of these two methods are as follows (data on the numbers of people between 15-64 is the nearest available to the 18-64 population in question):

Area	**Gross spend per head of *weighted* population 15-64 (£)**	**Gross spend per head of *un-weighted* population 15-64 (£)**
Herefordshire	174	135
Dorset	144	102
Somerset	161	125
West Berkshire	162	Not available
Average of Dorset and Somerset	153	114
ONS statistical neighbours average	141	Not available
England	156	156

4.4 Compared with Somerset and Dorset, both methods show Herefordshire to be a high spending area.

4.5 On the other hand, on the basis of actual, un-weighted population,

Herefordshire is shown as a low spender compared with the all-England average.

4.6 Although it would be wrong wholly to disregard the weightings applied nationally (there is, for instance, a well-established link between relative deprivation and levels of mental disorder), there are good reasons neither to accept them as definitive nor to apply them mechanically.

4.7 The effect of the weightings is to reduce Herefordshire's actual 15-64 population figure of 15-64 year-olds from some 109,000 to about 84,000 – a reduction of nearly 22%. This is achieved by applying various indices about expected levels of mental illnesses derived from data going back, in some cases, to the early 1990s; and also factors from the national resource allocation formula that take no account of the current known level of mental illness in an area. Nor do the weightings take account of the recent work of the Council's Research Team that demonstrates the higher costs associated with delivering services in a county that has the highest proportion of people living in areas with fewer than 0.25 persons per hectare.

4.8 Crucially, as paragraph 2.2 in section 2 above shows, the number of 18-64 year-old people in Herefordshire identified by services to have serious mental illnesses (i.e the group which has the greatest need for services and in respect of which the lion's share of expenditure needs to be incurred) is nearly 46% higher than the 600 people that national prevalence rates would suggest. The reasons for this are not known but, even if the data were not wholly reliable (the level does seem improbably high), it would be both perverse and dangerous to base the appropriate level of funding on an assumed level of prevalence rather than the recorded number of people who need and will continue to need services. (It should be borne in mind that, even were the actual prevalence in Herefordshire to be as low as 600, the use of the un-weighted figures would be justified.)

4.9 Based on the comparisons with Dorset and Somerset alone and without regard to Herefordshire's distinctive circumstances, there could be no argument that our mental health services are relatively well-funded: taking the Somerset level of funding alone and applying it proportionately to Herefordshire, we would have spent £1.1 million less in 2006-07 (i.e about £200K above budget, as opposed to the £1.3 million actual over-spend).

4.10 On the other hand, the available figures suggest that we are having to cope with a level of serious mental illness that may be in excess of the national prevalence, which makes the wider comparison with the England average of more than academic interest. On that basis, Herefordshire's spend in 2006-07 might be considered to have been light to the tune of about £2.3 million, and its budget by £3.6 million.

4.11 There is the further, pragmatic consideration that a cost-effective

service cannot be achieved in Herefordshire until the recommended high-performing new pattern has been established. Thus, while it might be possible, over the long-term, to realise cash-releasing savings from the new pattern of services, reducing the level of spending before the new pattern is substantially in place and a more accurate understanding of demand for modernised services has been gained would not only have a damaging impact on current service users but also make it impossible to establish the new services.

4.12 Considering together the demands for new forms of services, the additional costs of provision arising from Herefordshire's uniquely high number of people living in sparsely populated areas, inefficiencies in the current pattern of services and the small increases so far identified in expected demand, **overall it would seem reasonable to conclude that the aggregate level of spending by the Council and the PCT in 2006-07 (i.e including the over- spending against budget of £1.3 milion) is the minimum necessary recurrent funding to meet the needs of those with the most serious and the most common mental health problems up to 2012.**

4.13 For the reasons explained in paragraphs 2.3 to 2.7 in section 2 above and earlier in this section, **this conclusion should be reviewed by 2012 in the light of better data, including the actual demand for fully modernised services**.

4.14 **This assumption about the adequacy of the 2006-07 level of spending until 2012 would hold true only if it were to be maintained in real terms and if the efficiency savings that would be secured under the new pattern of services were retained for investment in those new services, at least until the position is reviewed in the circumstances pertaining by 2012.**

4.15 **Moreover, although the reduction in services no longer required, for example many of the expensive out-of-county residential placements, should be expected to pay the recurrent costs of the new pattern of services, this can only happen if there is targeted, time-limited, non-recurrent funding to develop the new services to the point where the current services can be discontinued.**

4.16 It remains to be seen, in the light of further, detailed work and piloting over the coming year, what will be needed to provide services in the future to meet the needs of those with personality or eating disorders.

4.17 The assumption that the 2006-07 real level of spending by the Council and the PCT combined should be an adequate minimum basis for emulating the achievements of the high-performing comparator areas rests on six crucial additional provisos:

- that the large-scale extension of direct payments and personal budgets will be managed in such a way that efficiency savings are generated for recycling in mental health services

- that support for carers will be strengthened (recent research by the University of Leeds estimates that the average carer saves the nation more than £15,000 a year)

- that the contribution and effectiveness of GP-based commissioning will be maximised

- that the balance between PCT and Council funding will, where necessary, be adjusted within the Public Service Trust to achieve a single, shared set of commissioning targets

- that we will attract significant additional funding from external sources (such as Government grants, including Supporting People, charities, private business and the National Lottery)

- that this and wider benefits will be achieved by working in close partnership with the third sector, so as to provide access to wider sources of external funding and, even more important, to mobilise voluntary and community resources behind the development of preventative services, access to generic local services and facilities, advocacy for individuals and help-lines; this may include the development of user-led organisations as service providers

4.18 Moreover, the plans for radical transformation that will produce sustainable, affordable and cost-effective services must be fully integrated with the steps taken in response to the current over-spending. Unless this is done, on the basis of establishing an agreed programme of change for the coming four years, underpinned by the necessary minimum recurrent and targeted non-recurrent funding, services will deteriorate in a vicious circle of ad hoc cuts and retrenchment that will render them incapable of meeting future needs

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4.19 These considerations underpin the costings in section 5 below.

Human resource, organisational and systems considerations

4.20 Developing and delivering the new pattern of services will require considerable, sustained management effort and a systematic approach to workforce planning and performance management, so as to ensure that all those providing care and other support to people with mental health problems have the right skills and exhibit the right behaviours.

4.21 Elements of a good basic infrastructure have now been created in the Council and the PCT which, together with an increasingly productive relationship with both the third and private sectors, has the potential to bring about the necessary changes. Notably, this includes an Interim Head of Adult Social Care, a dedicated Head of Learning Disability, a Change Manager, the strengthening of the PCT and Council joint Planning and Change Team, including a Mental Health Commissioning Manager, and additional appointments to the Council's contracts and adult safeguarding teams.

4.22 However, this strengthened capacity is already tackling a comprehensive transformation programme that includes the fundamental reshaping of older people's and learning disability services, and the development of wholesale new procedures and management systems; to which will now need to be added, as well as that in respect of mental health, a similar reshaping of physical disability services. These and other **existing resources will not be able to do the job without the full and quickest possible integration of all aspects of planning, commissioning, delivery and performance management of health and social care across the Council and PCT**. In turn, this will require the putting in place of single procedures, processes and ICT systems as part of the *Herefordshire Connects* programme.

4.23 **Additional operational capacity will be needed at the start of the programme** to meet Department of Health National Service Framework targets for key elements of the new services, as follows:

- 1.5 whole-time equivalent (wte) posts to develop support for carers

- 1 wte post to ensure good access to services for members of black and other ethnic minorities

- 1 wte post to further develop mental health promotion

4.24 These will need to be funded either from existing budgets or, if that is not possible, from the first tranche of non-recurrent investment in 2008-09, with the recurrent costs absorbed as the new pattern of services produces off-setting savings.

4.25 Underpinning all of this, there will need to be a cross-agency development programme for all those caring for or supporting people with mental health problems. A partnership workforce strategy for the whole of adult health and social care is already in the early stages of development. This will need to include a dedicated element to deliver the mental health improvements.

4.26 Similar considerations apply to the rolling out of the communications strategy and action plan for the comprehensive

transformation programme.

4.27 The adequacy of the new pattern of services should be subject to regular review and periodic formal evaluation, taking account of a progressively better understanding of the nature and level of need. This should include an external, independent element, if possible linked to national evaluation programmes.

Section 5 - The costs

5.1 Appendix 4 contrasts the proposed high-performing services in 2012 with the services in place in 2006-07.

5.2 Unless services are fundamentally reshaped along the lines proposed in this report, they would fail to meet the needs and wishes of users and carers, and also the expectations of Government and the inspectorates. Worse still, this would take place in a context where the performance of other areas can be expected, on average, to continue to improve year-on-year and in which Government and the inspectors are likely to have ratcheted up the minimum acceptable standard for services and, therefore, the threshold for intervention.

5.3 Additionally, the maximum possible sustainable improvements in efficiency can be achieved only if services are modernised as proposed. This is illustrated by the growth, from 16 in 2005-06 to 21 in 2006-07, in the number of out-of-county placements, which cost nearly £1.7 million a year. There is a substantial danger that, in the absence of adequate local, community-based services, this trend will continue, with the effect of even higher levels of over-spending against budgets.

5.4 **The total expenditure of £16.65 million in 2006-07, maintained in real terms, will be required recurrently through to 2012. This should be reviewed by 2012 in the light of better data, including the actual demand for fully modernised services**.

5.5 **In addition to these recurrent costs, non-recurrent investment of the following order will be required to put in place the new pattern of services so that inefficient, poor value for money current services can be discontinued**:

Year	£
2008-09	269
2009-10	298
2010-11	158
2011-12	(-62)

5.6 The needs of those with personality or eating disorders and the services required to meet them will need to be determined during 2008; in the case of personality disorders, in the light of emerging government expectations; and, in the case of eating disorders, having regard to the results of a local pilot service. **This report therefore makes no allowance for the possible costs of developing additional specialist services for people with personality or eating disorders, but it is not out of the question that that they**

could be funded from within the 2006-07 level of spending, maintained in real terms, in the light of the review recommended in paragraph 5.4 above.