GLASGOW MENTAL HEALTH SERVICES:
JOINT FUTURE REVIEW

1   ABOUT THE SCMH

1.1   The SCMH is an independently funded registered charity whose sole objective is the promotion of better mental health services. SCMH is based in London but works throughout the UK. We access to a network of national and international specialists covering all aspects of mental health services. SCMH has been instrumental in shaping UK mental health policy over the past decade, for carrying out highly valued operational research and delivering practice and service development support in the field. The centre also publishes valued series of briefing papers on aspects of mental health. The full range of the SCMH activities can be viewed www.scmh.org.uk.

2   SCMH IN GLASGOW

2.1   SCMH is excited by the mental health model being developed in Glasgow. Although we do not have a "Scottish office" we are confident that the general principles of good mental health services are the same throughout the UK and internationally. Although the organisation is London based the majority of our work is in the English regions, Wales and Ireland. Those elements of service that are distinctly Scottish will be examined and contrasted with the best of what is available elsewhere in the UK.

3   CONTEXT FOR THE REVIEW

3.1   There has been a transformation of how mental health services are delivered in Glasgow over the past decade .The Joint Futures agenda for change is radical, and potentially ground breaking in terms of the scale of what is proposed. However, the proposed next steps are necessary and can be seen as the natural next steps in the evolution of Glasgow mental health services. It is the natural progression of a series of changes in the last decade, particularly the last five years, that has seen the focus of mental health move from the old hospitals to more appropriate community based settings; which have enabled a much wider model of health and social supports needed for mental well being.

3.2   The evolution of mental health services over the past ten years has been progressive and, like much of the UK, the pace of change has been variable. The point has now been reached where the mould and pattern of services has been changed. In parts of the city the services are as "modern " and progressive as anywhere in the UK. In others the pace of evolution has been slower. Overall, the general picture is one of establishing new models of provision, central to which are new ways of working between different agencies, statutory and voluntary.

3.3   Although there are gaps in service and at times insufficient resources to meet all of the challenges that Glasgow Mental Health Services face, there are demonstrable improvements that have taken place in the range and disposition of services across Greater Glasgow. The model of service has developed from one based on hospital settings to a well-developed network of specialist community mental health teams and some other specialist supporting infrastructures based in the community.

3.4   In 1999, as part of the Modernising Mental Health process, Greater Glasgow Health Board, Greater Glasgow Primary Care NHS Trust and Glasgow City Social Work Department agreed to start the integration of health services and social care within all Community Mental Health Teams. This has progressed well during the past four years and the integration is at different stages in the teams across the city.

3.5   The current stage of development is in part the product of the availability of resources to facilitate the establishment of new services, but also a reflection of the degree to which there is a concerted and determined professional leadership to adopt different, non-hospital based styles of working. The demonstrable success of some localities in transforming the style of provision now needs to be made universal and consolidated as the base platform for the whole of Glasgow. From that platform minimum requirements for all teams can be established, and higher levels of integration between primary and secondary health services, and between health and social can be developed. New partnerships focused on locality and community with maximum delegation of authority to partnerships between users and carers as citizens of their local communities and the statutory and voluntary providers of services.

3.6   It has been stressed in Glasgow that no other area of Joint Futures integration to date has included the management of all acute services within the management of a single integrated service .The legislative framework for mental health, particularly in terms of compulsory treatments, is largely unique within NHS and social care service delivery. There are regulatory frameworks which

are prescriptive, such as those of The Clinical Standards Board requirements for Psychiatrist in the management of all cases of schizophrenia.

3.7   It requires vertical integration between primary, secondary and tertiary services and horizontal integration across health and social care.

3.8   A managed mental health network involves ongoing management of chronic care by both primary and secondary teams, requiring high levels of shared care and continuity between services. Managed care pathways Service delivery and management arrangements that support such care pathways and integrated service delivery. It has to include short-term interventions as well as ongoing social support right through to tertiary level interventions.

3.9   The changes proposed later in this Report should be seen as a major step, but they are an incremental development of services, building on the strength of what is has already been developed.

3.10   There are good reasons to see the Joint Future mental health agenda in its own right, but there are now also requirements from the White Paper that encourage the same steps to be taken. The idea of a Managed Local Mental Health Network is entirely consistent with the wider White Paper principles of Community Health Partnerships.

4   PARTNERSHIP FOR CARE – SCOTLAND'S HEALTH WHITE PAPER (FEBRUARY 2003)

4.1   The recently issued White Paper sets a wider strategy through which many of the issues of the Joint Future project can be seen in context. That said, the Joint Future Glasgow project has been underway since at least 1999 and the agenda for change in mental health services was already well developed before the White Paper. Many of the themes in the White Paper are those which are progressing in Glasgow under the Modernisation and Joint Future agendas.

4.2   It is not always helpful for front line staff and other stakeholders if they are constantly presented with new agenda priorities so, as far as possible, the requirements of the White Paper should be presented in the context of existing local plans for Modernising mental Health Services and Joint Futures. A simplified statement of the mental health strategy as a core document that uses footnotes to reference different policy directives.

4.3   The mental health strategy should be clear with its own timetables but, as far as it is possible to do so, with assurances as to possible implications of much broader social care and health policy directives such as Community Heath Partnerships. Most of what needs to be done for Joint Futures is a continuation

of what has been done over the last few years and it is entirely consistent with the themes of the White Paper.

4.4   The White Paper emphasises the importance of developing whole system approaches [page 45] and the centrality of Managed Clinical Networks [page 39] to that approach.

4.5   In Glasgow work has been undertaken to develop the concept of a "Managed Local Mental Health Network" and the principles which should inform and underpin its development. Crucially, the development of thinking now embraces the full range of values and supports that put mental health into the much broader context of peoples normal lives and makes the necessary steps to make mental well being and mental ill health a normal part of community development.

4.6   The managed local mental health network concept is at the forefront of current thinking and Glasgow is taking bold steps to progress the implementation of such an integrated network.

4.7   The next natural steps are major ones, but they are attainable. There is every sign of clear commitment from all stakeholders, at all levels, that this is the right direction. What matters now is developing the detail and successfully building on the confidence that exists to make it a reality.

5   THE SCMH PROJECT SO FAR

5.1   Building on the development of conceptual thinking at a strategic level in Glasgow City Council The Health Board and the Primary care Trust, the idea of the Managed Local mental Health Network has been explored at a series of consultation events over a period of four months. Meetings have taken place with several hundred people, service users, carers, voluntary sector and staff in multi disciplinary teams and in some single discipline groups throughout the city. Whilst not all teams and stakeholders have been met with, the consultation has given the opportunity for an extensive and generally representative range of views to be consulted.

5.2   SCMH is confident that the consultation is a genuine one and there is a clear commitment from each of the statutory agencies to this being an inclusive and meaningful consultation, a prelude to making implementation of the vision a reality. There is, on balance, a clearly expressed support from the vast majority of staff to embrace the agenda but they do also expect necessary decisions to be made quickly and will need substantial reassurances.

5.3   **The focus of this report** is on the degree to which existing services are integrated and what may be done to integrate them further. It reflects our

observation of services across the city of Glasgow and does not attribute either observed good practice, or poor practice, to individuals, or to particular teams. To do so would be unfair and detract from the broad principles that are necessary to underpin a strategy for the city as a whole.

6   THE PARAMETERS SET BY INTEGRATION STEERING GROUP

6.1   From the various papers of the brief for SCMH has been distilled to the following:

♦   The overall proposition is that care is best supported from an integrated community mental health service acting for primary, secondary and social care."
♦   The Senior Officers of GGPCT, GCC and GGNHSB have taken the view that the status quo position in which there are separate and different catchment and management arrangements in social and secondary care mental health services, is not in the best interests of patient care and, therefore, unsustainable and unacceptable. The integration process which will require compromise by all sectors.
♦   They have also taken the view that the introduction of a further set of management arrangements and catchment arrangements for the Primary Care Mental Health Services is equally unsustainable if the ambitions of a coherent locality community network are to be achieved.

6.2   **The Integration Steering Group** agreed a set of core proposals that form the minimum requirements of the Managed Mental Health Network. But a more developed concept of a Managed Mental Health Network should be explored.

6.3   Agreed set of core proposals concerning the minimum level of arrangements for integration

Secondary care services and social care services will:

♦   Be integrated at locality and sector level under joint management and service arrangements to be developed through the Sainsbury facilitated integration process.
♦   Share a single service catchment for the joint service.
♦   That no joint CMHT would include a catchment beyond the GCC local authority boundary.
♦   Be managed through governance and partnership arrangements which ensure the joint service is indeed *joint* rather than a NHS led secondary care service which includes social care.
♦   Social Care support, including social work, for people with ongoing mild to moderate mental health needs is seen as part of the locality community

mental health network. These services are therefore to be included in both the integrated network and considered as part of the arrangements for development of primary care mental health services.

♦ The funding for primary care mental health services is intended solely for that purpose and there is unequivocal commitment that it cannot subsequently be used to offset pressures in secondary care services. The service model for primary care mental health services has been agreed.

6.4 **These are the minimum expectations** of all agencies for the Joint Futures initiative. The Integration Steering Group are of the view that there would be significant advantage in pursuing the following proposals:

♦ That service catchments for all mental health services in primary, secondary and social care services should be aligned to the same catchments.

♦ That all specialist mental health services within the locality community mental health network should be managed by a single management arrangement acting on behalf of primary, secondary and social care mental health services.

♦ That such a joint and integrated service would require governance and accountability arrangements which ensured the joint service is accountable and responsive to each agency for the contribution of the service to that agency.

♦ The partnership retains the confidence and ownership of its constituent partners and is accountable to them for its contribution to their respective areas of responsibility more than this.

♦ Joint management arrangements of full and equal partners.

♦ Ensuring that form follows function.

6.5 **The Brief for the SCMH.** The essence of the brief and subsequent discussions at the Integration Steering Group is reflected in the points below:

♦ "To consult on a sector basis with all stakeholders on the proposals in the paper "Integrating Primary, Secondary and Social Care Mental Health Services" with the aim of ascertaining views on how to ensure the proposed model achieves seamless, co-ordinated and person centred care across the agencies."

♦ Options for broader structural organisation and governance arrangements within which the unified structure at locality and sector level is located;

♦ Development of detailed arrangements for practical operational integration. Development of detailed arrangements for practical operational integration.

♦ To work with community networks to resolve integration gaps, look at how links to LHCC's should work and agree a process to take forward the integration of primary, secondary and social care mental health services. Option(s) for detailed structure of the locality managed networks and their aggregation to sector level.

- The development of a locality focus.
- SCMH will also ascertain views on the different options for configuring and managing the proposals for Shared Catchment Populations & Service Management Arrangements.
- Review how the community mental health teams are currently working.

6.6   A brief was agreed on 10/4/03 for the detailed analytical study which will profile the disposition of services throughout the city, area by area, showing the range of provision against morbidity, and contrasting resources available to mental health in each locality. This will take three months to complete.

6.7   The analytical work will be combined with the observations made in the first phase meetings to provide profiles, by locality and for the city .The Profiles will contrast Glasgow with best information available on comparative systems elsewhere.

6.8   Arrangements are based on the pragmatic consideration of minimal disruption to existing services.

7   COMMITMENT TO JOINT FUTURE AGENDA- CONCESSIONS FROM ALL STAKEHOLDERS.

7.1   There is recognition, reflected by the engagement of SCMH as independent advisers, and the scale of the consultation already undertaken, that Joint Future can become a reality but that it must be built on mutual trust and confidence between all stakeholders.

7.2   Awareness of Joint Future agenda.

It should be no surprise that many stakeholders did not have a detailed understanding of this as a particular initiative, or how it relates to other initiatives such as Modernising Mental Health Services. There is no reason that they should as long as in practice they understand the model of service, their part in it and how what they do relates to other parts of the whole system. There were substantial demonstrations of knowledge and commitment to the values and principles underpinning the Joint Future agenda.

 7.3   **Service Users and carers** are realistic about the pace of change and how long it takes for changes in organisational arrangements to materialise as the services they are entitled to expect, but they do see what is suggested for Joint Futures as the best way of improving services in the longer term. However, based on the slow pace at which user and carer experiences have changed, as opposed to arrangements for service delivery, they want to believe Joint Futures will succeed but remain sceptical about what impact there will be on future experiences.

7.4 **For the many staff, in all agencies**, including the voluntary sector, there is the reality of coping with the now, trying to do the best they can on a daily basis to meet the needs of users and carers, but without much time to reflect on practice and try alternative approaches.

7.5 They have to be reassured as individuals, and as professionals, that what they do is recognised, valued and not marginalized in any restructuring of services. It should not be underestimated how potentially de-stabalising such change processes, however desirable, can be. That said, this is not an argument for inertia. A well-supported organisational development programme is essential.

7.6 Services have been delivered by staff finding ways around organisational and professional impediments to service delivery, but there are limits as to how far that can be productive. At some point, and that point can realistically be now, it is right to remove some more of the structural impediments.

7.7 The test for Joint Future, when progressed, must be that the resultant stimulus to service delivery changes the experiences of service users and carers in receiving services, and of staff in being able to use their skills and motivations to best effect.

7.8 For service users, carers and staff there is the difficulty of relating the positive beliefs about the Joint Futures vision with the realities of day-to-day service provision. That said, virtually all respondents acknowledged that there had been major changes for the better in Glasgow's mental health services. Positive examples need to be regularly highlighted and praised. There has to be demonstrable positive outcomes from the process.

7.9 During the consultation, a number of concerns were not surprisingly expressed about what was being proposed. At one level there are personal anxieties about change, professional concerns and loyalties to existing teams, organisations and ways of working. At another level there are genuine concerns about other change programmes only partially completed, e.g. modernisation, and the limits to how much change can be delivered at once. We would suggest that the proposed Joint Futures programme and, indeed, the White Paper Partnership for Care proposals build on, develop and incorporate the work that is already being done and the change programmes underway. The scale of change is significant and it should not be under-estimated in terms of the difficulty in sustaining momentum and delivering actual change. The nature of the change required is such that it has to be approached in a multi-facetted way and that is the only way that will bring about substantial change to the service user and carer experience. An illustration of this is that whilst the focus for many people appears to have been on integrating a relatively small number of social workers with a much larger group of health professionals, we would argue that

the reality is that the issues of integration for social workers are no different to those of existing health professionals in the CMHT's. To make the change for social workers requires similar changes and similar scale effort in relation to all of the other professions.

7.10   Some of the particular concerns to be addressed for staff are:

♦   Security of Employment and earnings.
♦   What changes there might be to roles.
♦   Fear of an agenda to establish a generic workforce.
♦   General management rather than professional or uni organisational.
♦   Availability of professional support.
♦   Mental illness is too narrow a focus
♦   Concerns about notions of medical models prevailing.
♦   Concerns about diminishing the Mental Health Division's single focus on mental health.
♦   Application of East Dunbartonshire model for the whole of Glasgow.
♦   What difference will it make to the availability of resources?
♦   Is there commitment at the top to ensure that all professions are fully on board?

8   PRIMARY CARE

8.1   **Primary care** do not see that mental health services are best organised separately from the rest of a persons well being. Mental health is only one aspect, although at times the overriding one, of a persons life and general well being. Throughout the consultation it was strongly emphasised that mental health services should, in principle, be managed from primary care based organisations.

8.2   In Scotland as in England and Wales, there is a clear and concerted effort to put primary care at the heart of mental health services. The White Paper demonstrates this intent unambiguously:

"Primary care is pivotal to the NHS. It is the right place to promote good health and to manage illness, particularly chronic illness……. Primary Care is particularly well placed to meet these challenges, as one of its strengths is the ability to provide a generic and holistic approach to care, which is pivotal when a patient presents with more than one condition. When people need more specialist care, Managed Clinical Networks will support primary care practitioners to work with others to provide the best possible integrated care to their patients." (Page 36, paragraph 22).

" We want to see a more consistent and strengthened role for LHCCs at the heart of a decentralised but integrated healthcare system. We therefore

expect to see LHCCs evolve into Community Health Partnerships to reflect their new and enhanced role in service planning and delivery." (Page 35, paragraph 19).

8.3   For them to "have greater responsibility and influence in the deployment of resources by NHS Boards;" (Page 36, paragraph 19)

8.4   Based on the experience of primary care mental health services not being prioritised in the past, there is a belief that if the Managed Local Mental Health Network is driven by the Secondary mental health organisation primary care mental health needs will still be afforded low priority.

8.5   The prevailing and pragmatic stance taken was to recognise the progress made by the MH division. Primary care respondents are, with caveats, prepared to have management of the network driven by the secondary organisation .The best description of their position was in the analogy given at one Sector event, of the man paying for a car when not a driver himself, but expecting to influence his partner in the use of the car and where the car goes on some occasions he needs transport; to have involvement and influence over the important decisions relating to the car.

8.6   There is an unequivocal commitment to primary care mental health recognised in the brief for this Joint Futures Initiative. The commitment of Primary care to mental health as a priority is demonstrated by the primary care mental health investment plan, which is directing some £3.3m to mental health services.

9   SOCIAL CARE

9.1   Like primary care, Social Services do not see mental health as a completely separate domain. Although the benefits of more integrated mental health team working are recognised by practitioners and managers in social services, there is the dilemma that to achieve more integrated mental health teams is a major step away from the current integrated locality approach where mental health is just one component of the Area teams work. The *generic model* currently working sees mental health in a much broader context, not least of which is the spectrum of clients with needs that do not meet the classification of severe and enduring but who nevertheless need social services interventions. The exclusion of such clients from the remit of integrated mental health teams would be unacceptable. This is recognised in the brief but not always in the statements by secondary health colleagues during the review.

9.2   There are also significant issues to be addressed for social services staff and managers in terms of MHO roles and regulatory accountability arrangements.

9.3   The importance of professional supervision and professional development roles will be crucial although it should be stressed that in this respect the same professional issues arise for other health professionals. Although they are health workers, they too do not recognise a medical model as being appropriate, nor indeed as being the prevalent model for most of Glasgow. The common needs of social workers and other health care professional were widely acknowledged by the social workers in their contributions to the consultation.

9.4   The majority of practitioners when asked were, with significant caveats, prepared to openly consider working exclusively in mental health teams rather than continuing with generic teams. Some with experience of already working that model were positively supportive.

9.5   The sense of each of the meetings with social services staff was that with the necessary assurances in place they were willing to adopt a different model of working. It is, therefore, essential that this is dealt with supportively and is not described by some health managers as just taking on a few social workers into existing teams and that thereafter all the "problems of social work" will be resolved; they will not. There is no track record in Glasgow of Health organisations delivering social services and, therefore, no justification for such statements.
There are many examples of fully joint services in England working well but if the early phases of such developments are characterised by notions of take-over these negative connotations will prevail long after the formalities have been completed. In this regard there are lessons to be taken from the Glasgow Learning Disabilities service which was frequently described by some in mental health as being an unmitigated disaster. It is not, and when those critics were challenged they did not argue that it was the wrong model, or that it was not improving the delivery of service. The concerns relate to how a small number of health professional have, or have not been supported as minority workers in a social model of care. The managers of Learning Disabilities are the first to acknowledge that in the early days of the model not enough attention was given to this aspect of staff concerns. The valuable lessons for Joint Future in mental health is to ensure that the social services staff, who will be numerically a minority profession, are properly supported, professionally supervised and developed from the start.

9.6   In terms of an open commitment to this process senior Social Services Officers are prepared to reconsider Area Office boundaries.

9.7   For Social Services there are substantial issues of detail that need developing and addressing, but there is evidence of a willingness to do what is necessary to move the services on and to develop a genuine managed network of services.

9.8   There is much that is common between primary care and social services, not least of which is the provision of services to those who do not attract a label of severe and enduring and the closeness of community support networks. Redefining the role of mental health teams in a much more holistic sense is important if it is to be a joint service rather than a take-over by the secondary services. At the same time the reasons historically for focussing on severe and enduring still need to be accounted for.

10   THE MENTAL HEALTH DIVISION

10.1   Having brought the services to current stage of development, a factor commonly acknowledged in the consultation as a major improvement, staff in the Mental Health Division are justifiably proud of how much has been achieved in only a few years.

10.2   Having established a greater priority relative to the Acute Hospitals, the Mental Health Division does want to manage the network. They have concerns based on their experience of history of mental health being a low priority when managed with everything else. In England this concern to afford mental health a higher priority has resulted in the last five years with a model which is of single focus mental health trusts covering several metropolitan boroughs, or a whole county; Mental Health Care Trusts which are new statutory bodies with fully integrated secondary mental health services and social care, and a few Primary Care Trusts which manage primary and secondary health and have the local authority on their Boards. PCT's are possibly the closest to the full Glasgow model, but they are very much smaller, and more akin to a Glasgow sector. There are many PCT's that aspire to manage mental health services but usually limit their ambitions to psychological therapies, counselling, and nursing in primary care settings.

10.3   Some senior mental health managers expressed the view that primary care might be the best driver of the network as this would be the most effective way of trying to control the demand for secondary services. Others expressed concerns about being managed by Area Social Work managers which has never been the proposal.

10.4   There was a more widespread assumption with health managers that existing structures could be the joint structures and the primary care and social services staff could easily be assimilated in to them. It is our view that such a move would give a widespread and justifiable claim of having been taken over and subordinated.

10.5   There are, however, some very pragmatic reasons for supporting the proposal that the Mental Health Division should take responsibility for managing

the joint network on behalf of all the stakeholders, and be accountable to them for discharging that responsibility. The Mental Health Division have the concentration of mental health resources, the largest pool of specialist mental health skills and a corporate infrastructure in place to enable continuity in the early stages of the network. It is also very clear, as it is in the rest of the UK, that there is the need to properly define the role and function of the various specialist teams and services already managed by the secondary organisations. Unpicking and establishing clarity in the web of relationships between specialist teams and the rest of the system is essential to whole system working and delivering co-ordinated services to the individual service user.

10.6   It does, however, have to be recognised that the skills needed to lead a network of mental health services are not exclusively in the Mental Health Division, particularly those that relate to Social and Primary care. A genuinely joint network will have to draw managerial and professional skills from each of the prime organisations and ideally also from the voluntary sector.

10.7   A genuinely joint arrangement needs to build on what is good about existing structures and ways of working in parts of the city but it also requires change in how the combined services are led, managed and delivered.

11   STAGE ONE OF THE REVIEW – WHAT NEEDS TO BE DONE TO ACHIEVE A HIGHER LEVEL OF INTEGRATED WORKING AND PARTNERSHIP

11.1   Joint futures – what do we mean?

From the published literature and discussions in Glasgow with senior managers, we deduce the Joint Futures' agenda to be distilled to three key points:

- ♦ "Joint Services"
- ♦ "Managed Local Mental Health Network"
- ♦ "Mental Health System Manager"

11.2   "Joint Services"

11.2.1 As with the term "partnership" our observation from many parts of the UK would be that these two terms, although almost universally used to describe mental health organisational arrangements, do really amount to "all things to all [men] ". There is no one standard application of the terms and it is sometimes the case that the services professing to be the most joint and operating in partnership are, in fact, much less so than those who keep quiet about it. The real test of joint is that as well as services being effective "[*Patients] see one system and we must create the care without barriers that they want.*" (Malcolm Chisholm, MSP, page 5)

11.2.2 SCMH observations are that there is much in the Glasgow mental health services to be proud of and whist there are, as there are for all other services in the UK, areas in which lessons could be learned from elsewhere, there is no single whole system that is demonstrably better than Glasgow. There are elements of Glasgow's service that would be good examples for other parts of the UK.

11.2.3 Glasgow's current stage of joint working is very similar to many other cities in the UK. Like those places there is the recognition that the next logical stages of development require more formal and structural changes to be made.

11.2.4 Where Glasgow is different and potentially leading the way is in the integration of primary care mental health services in one strategic step. This is a bold move, but is one that offers real prospects of a genuinely integrated and managed mental health network across a major city.

11.2.6 The integration of social and secondary health care services is at the level of the formal partnership organisations in England that have chosen, at this stage, not to be come new statutory organisations, Health and Social Care Trusts.

11.2.7 Joint in these partnership organisations can be seen at two levels, the operational and the strategic. The real test of joint working is, we would suggest, what happens in practice between those staff in Social services and secondary mental health services who work together to deliver their services in a joint way. Good joint working is not always reflected in formal arrangements with health taking the lead organisational responsibility for the whole system, but it is the most common arrangement. Some locations have focused on integration only at the level of the CMHT, with joint managers being appointed for the CMHTs /locality.

11.2.8 Others have focused on developing strategic frameworks which have put in place Joint Strategic groups, officers and members/non executives and see this as the first stages of developing integration. Some organisations have done both.

11.2.9 It is essential to be clear about what joint means and the limits of joint working should be explicit. As is common in most other areas going through these changes, there were many respondents who expressed their fears of what would happen, was a take-over of one organisation by the other. Oddly, there were people in both health and social who believed that Joint Future was about the take over of their organisation by the other. Joint Futures will not succeed if any party involved in the process perceives that their profession, or organisation, has been taken over. A genuinely joint service network is not about

take-over. It requires trust and respect for different perspectives. It challenges professions and organisations into focussing on the needs of service users and carers and indeed, making them jointly part of the development and delivery of services. It is crucially not the professional structure, or the organisational form that matters, but rather that there is a single focus on mental health which is developed in a wider context.

11.2.10 Joint in the Glasgow context means joint between primary and secondary mental health care professions and organisations, Social Care, voluntary sector, and users and carers themselves.

11.2.11 At the heart of establishing joint services, is the anxiety provoking balance between generic and specialist services. We are absolutely clear that whilst the needs of service user and carers are in many respects requiring a more generic approach to the delivery of care and support, that does not correspond with a diminishing of the importance of professional contributions. There is a difficult balance to be struck between how the scarce resources of all professionals involved in mental health care, most of whom are in relatively short supply, are used to best effect and, at the same time, the needs of service users and carers will not be met within the straight confines of the existing professional domains. It is for that reason that the emphasis on joint working which essentially evolves as team working, team development and team management is so important.

11.3   Mental Health Network

11.3.1 *"Joint Working" is particularly important in improving mental health services. Within this broad framework, networks of mental health service professionals can address the problems of patients or service users as they move from one service provider, or partner organisation to the next. Such care networks can improve the patient's pathway of care and promote the better use of the shared resources."* [White Paper p38 para 29].

11.3.2 Glasgow will be required to *"develop a network of modern, sustainable and integrated community services focused on natural localities:*
integrate community-based services and specialist healthcare services through clinical and care networks; (*Page 38, paragraph 30*) and …*"*

11.3.3 *"Such teams will be less confined to particular buildings and will work across communities and care settings so that patients can access services at a range of locations from a range of professional staff. This multi-disciplinary and multi-partner approach is particularly critical for the provision of local, integrated mental health services."* (*White Paper ,Page 33, paragraph 13*)

11.3.4 A network for Glasgow must, by virtue of size, but more positively because of the benefits of local diversity, be a series of related local networks. Overall there needs to be a clear framework for services and that framework will define core minimum requirements for each locality building block. The basic model of service and the key principles that underpin it will be clearly defined.

11.3.5 The relationship to whole city tertiary level services would also be explicit. Beyond that there would be a range of services and service models which are locally determined, draw on locality and community strengths, and deliver locally responsive services. What is essential to this is that the services to be delivered and the vehicles for doing so are integrated. As far as is practical, the objective should be for clearly defined points of access to those services by service users and their carers. It is unlikely that there will be a single point of entry to services but the network must be organised so that the service user, or member of staff, does not get passed round the system. To achieve such a simple objective is quite complex and tests joint working in terms of assessments processes and the effectiveness of team working.

11.3.6 In organisational terms it is the network that matters most and which has to be nurtured and where appropriate structurally reinforced. It will always be a lose confederation of changing interests but with a common core set of objectives determined with and for users of services. The relationships between the constituent parts, the role clarity for professionals, teams and services in the network, and beyond the network, must be better understood and more explicitly defined.

11.3.7 A crucial set of relationships to be defined is those relating to locality. The Glasgow network, like those in other major cities, is in reality a series of more local but integrated networks. The issues are about how localities can determine their own service priorities, how much delegated authority resides in the locality and what the mechanisms for accountability to local people are. *"By devolving management authority to the front line, …"* (Page 57, paragraph 1) *"…By empowering staff to initiate change locally in response to these demands."* (Page 44, paragraph 57). There is even to be duty placed on Health Boards to put in place devolved decision making (page 58,para 8).

11.3.8 It is in this context that **the "East Dunbartonshire Question"** should be considered. There does not need to be the apparent widespread concern about a possible variation in management arrangements as long as it is always defined in terms of a service model and how that fits within a Managed Network. Like other parts of Glasgow City, there is a reasonable expectation to ensure the best mental health services for that area. Some services and resources can be identified as local and they may, subject to cost critical mass and the availability of expertise be separately managed and directly accountable to the Local Authority. They will not, however, be fully comprehensive, or able to exist as a completely separate service. It would not have all the necessary elements

of a mental health service that are needed to exist as a separate mental health network. It would be inappropriate to consider separation of community services from in-patient and specialist teams that cover Greater Glasgow.

11.3.9 The brief is explicit that the Local Managed network should not go beyond the city boundary. In principle this is right and necessary particularly in respect of establishing formal partnership agreements between health and local authorities. Again, with the emphasis on the whole network, there is the need to consider how localities beyond the city are dealt with when they are currently provided for by teams also working in the city. This is principally an issue for health, but it should be possible to ensure separately identified resources for East Dunbartonshire, with agreed models of working and accountability, even if it is provided from an organisation that is predominantly in the City.

11.3.10 Decisions about priorities will still be influenced by what professional, or organisational background, a stakeholder is from, but it is more likely that a wider perspective will be taken. The necessity for a more inclusive debate may well reveal that the best way of effecting improvement in one part of the network is, in fact, to make an investment elsewhere in the network. If there is an issue about CMHT support to primary care then it may be that more CMHT time is created for primary care through investing in specialist crisis resolution services. Alternatively, the best way of reducing pressure on the CMHT may be to invest directly in primary care services.

11.3.11 As long as the principles of managing the network as an integrated system is maintained, it is possible for any of the participant organisations to take the lead responsibility for managing the network. A simple review of recent organisational arrangements for mental health in the UK would reveal a range of organisational forms that were successful in delivering good mental health services: Specialist Mental Health Trusts, Care Trusts, Partnership Trusts, and Community Trusts, and the existing form of the Primary Care Trust. It could also be said that the reverse has been true in some of those organisational forms. In their final years many of the old asylums which were essentially single focus mental health services did not deliver the services needed.

11.3.12 The potential of the network is in the ability to take a more holistic approach to meeting the needs of carers and users. Joint Teams with more clearly defined, but still flexible remits are more likely to give a better service, for services to be more tailored for users and less necessity for users to be slotted into existing service boxes.

11.4 "Managed"

11.4.1 Services as complex as mental health do not just happen. To be effective they have to be lead and managed and it is the style and clarity of those

arrangements that will either enable front line practitioners and service users and their carers to deliver appropriate care, or to frustrate them in that objective. Top down, command and control styles will simply not work for a Local Mental Health Network with multiple professions, organisations, and complex health and social needs to be met. However, the objectives of the Network, the standards to be achieved and the ethos of service do need to be managed. The style of management has to be facilitative of all stakeholders' interests without the comfort of hierarchy. That is a complex managerial role, at all levels of the network, particularly at the front line of service delivery. It is, however essential to the success of a Managed Local Network and it is one of the challenges being set by the White Paper.

11.4.2 " - *develop organisations to support the necessary changes in service delivery*" (Page 38 paragraph 30)

11.4.3 "*To drive this network approach, we invite NHS Boards, Local Authorities and other partner organisations to work together to redesign the way in which mental healthcare is delivered. To complement the care network approach we will work with local Joint Future partners to extend joint management and joint resourcing to mental health services from April 2004.*" [White Paper page38,para 29] .

11.4.4 The White Paper is also forthright that command and control is explicitly rejected as the style of leadership for networks. (page9, para9).

11.4.5 It is because no one organisation or profession in the current arrangements has the full range of skills and background needed for managing the network and that what is needed are new management roles that we are recommending that there will need to be a recruitment process to support the next phase of network development.

12   PRESENT DEGREE OF INTEGRATION IN GLASGOW SERVICES

12.1   The resource centres in Glasgow and associated Community Mental Health Teams have been developed at differing paces and with differing levels of resource during the past ten years, mainly within the last five. In a city the size of Glasgow, it is reasonable that there should be differences between the approaches in the Sectors and that the CMHTs should not be expected to comply with a uniform prescription across the whole of the city. There should, however, be a clear understanding within each sector as to what the core minimum requirements of a CMHT should be across the whole of Glasgow and what it is and why it is that arrangements are different within a particular team. The strengths and weaknesses of those different approaches should be clearly understood. The same basic premise also applies to the emergent Primary Care Mental Health Teams.

12.2   This phase of the report is not a detailed account of the services in each of the sectors and the differences between sectors in service delivery. That work, although significantly informed by the interviews already undertaken, will require the data analysis and pathway work which has been commissioned and will be undertaken during the next three months. The focus of this part of the Report is purely on the stage of integration reached and what it is that needs to be done to achieve higher levels of integration and partnership working.

12.3   The views presented here are based on our knowledge of similar process taking place in the rest of the UK and reflect discussions with a wide range of multi-disciplinary teams, uni-disciplinary groups and individuals numbering some several hundred during the past three or four months. What is presented are the themes common across Glasgow which needs to be considered at a corporate level in order to advance the integration process. The ambitions of the Integration Steering Group and the sponsoring organisations are realistic and achievable. The issues of integration between health and social services are not unique to Glasgow and there is good practice from elsewhere which can be usefully drawn upon in order to achieve that part of the Joint Future agenda. This is particularly so for integration at a corporate level in terms of partnership agreements between agencies and the statutory frameworks that are necessary for governance.

12.4   It is in the area of integration with primary mental health care, that the Glasgow proposals are the most radical. There is a clear willingness in Glasgow, in all quarters, for this to succeed and when taken together with the integration with social care, offers the potential of creating the most comprehensive attempt at establishing an integrated managed mental health network.
At the strategic level there appears to be good working relations and a common commitment to delivering the best possible integrated mental health services. The relationships and differences in function between some group meetings [Integration steering group and PIG] are not always clear to an outsider but it is clear that that there is a process which can deliver the Managed Local Health Network. There is evident top officer commitment to the process.

12.5   As part of the formal partnership agreement that will be needed, there should also be a statement that clarifies the different roles in health between the Health Board and the Trust, for commissioning, performance management and management of the network. There are many examples of formal mental health partnership agreements from elsewhere and they could provide a template for Glasgow.

12.6   At the practitioner level, practitioners wherever they sit in the system, including voluntary organisations, get on and deliver whatever the organisational

constraints. Where it works well it is inspirational and demonstrates values and commitment, determination and passion for services to be as good as they can be. There are strong relationships at personal level. Those that know the systems and the key players in any team are able to influence without managerial relationships. There is plenty of evidence of practitioners, in health and social care, stretching the boundaries and the rules to do what is best for the client. They are-not absolute in clinical or social criteria; social workers providing support without reference to area teams, CMHTs undertaking substantial caseloads of patients who are not severe and enduring ;of individual and team efforts to work between primary and secondary health settings; flexing professional roles without formal negotiated agreements of professions. There is strong personal support between professionals in the different professions and organisations.

12.7   The absence of clear minimum requirements for the CMHTS has worked well in many examples where local teams have thrived on the ability to do it differently and tailor their own styles to local needs.

12.8   But that position, whilst the dominant one in the city, is not universal. There are CMHTs that are frustrated by the lack of formal requirements about active participation and priority for community based working by all professions. This seriously limits the ability of some teams to function in a way that makes best use of the whole system and leads to a separation between the inpatient and community based services.

12.9   Co-location of professions is not enough, although for some teams even that would be a major step forward. There are teams functioning well out of less than ideal accommodation because they are committed to that style of service delivery. The reported refusal of a small minority of consultants to move in to, or be present more often in the CMHT is dysfunctional for the rest of the team, even in matters such as secretarial support being developed in the team base. More crucial is the fact that the alternatives to hospital admission are not going to be as effectively engaged if decisions about admission to a bed are made separate from the rest of the multi disciplinary team.

12.10   The perception of psychology services is of a valuable but unaccountable professional resource. The same arguments were articulated about some of the other professions, but not so universally as for psychology. The basic issue is about the extent to which others in the CMHTs and primary care teams can at least have a discussion about how scarce psychology resources is best deployed, in conjunction with those of the rest of the team, to meet the demands made on the whole team. The widely held belief is that the department determines their own workload priorities in isolation to the rest of the service, in a take it or leave it fashion, and the only discussions about workloads are demands from psychology for more resources. That said, there are very positive examples of

individual psychologists fully prepared to participate in the teams and to openly discus the best use of their limited time. The department has also established a very strong presence in primary care and will be pivotal to the new teams. There is a presumption that psychology leads the primary teams, which may be reasonable in many situations, but should not be prescriptive. A psychology led primary mental health model is no more appropriate than notions of a medical model in secondary mental health services. Such strictures would not be helpful to psychology in their development of a better understanding of their valuable role in the Managed Local Mental Health Network.

12.11   Health workers and managers express their frustration at what is perceived to be the lack of social work presence and capacity in the CMHTs and the drawing away of decision making to the social work Area Offices. Many social workers are themselves unhappy at the dual demands made on them between work in and for the CMHT's and their workloads beyond the CMHTs. The generic model of practice has benefits for a wider population but is, we would suggest, not the best model to support a dedicated mental health service. If there were to be a move towards specialist mental health teams then the interfaces, through social services, to the wider supports of employment, education and housing would have to be more clearly defined.

12.12   The relationship of CMHTs to rest of the specialist health services is as variable in Glasgow as they are in other cities. Where they works well they are as good as any where in the UK. Where relationships not so strong, or for new recruits, it is problematic and results in unacceptable variations in service delivery.

12.13   The integration of the secondary services with primary care is also, unsurprisingly, variable. There are positive examples of good individual and team practice and there are some interesting interface projects with services outreaching from the CMHT. Most CMHTs readily, and in some cases proudly, demonstrated that they do provide services to people who do not attract the severe and enduring label. However, some are still too rigid, if only in their language, about protecting secondary services from primary care. There are some disparaging views in both directions between primary and secondary mental health services.

12.14   Now is the stage of evolution where these dysfunctional characteristics which arise from misconceptions about the roles of others, and feelings by some of not being valued for what they do could be positively challenged as part of the process to develop the Managed Local Mental Health Network

12.15   A starting point has to be working with the different teams and professions to foster confidence in their own professional roles, to enable them to be comfortable to discus role boundaries in multi disciplinary settings. To

establish the confidence and flexibility to allow for working in different ways. For roles to be set against the workload demands of the team within a spectrum that ranges from primary to tertiary and embraces social. This already happens in some parts of the City's mental health services.

13   DEVELOPING NETWORK LEADERSHIP

13.1   It was clear in the feedback from some of the sector events that it is difficult for staff to conceptualise working in a different framework to that of their existing profession and organisation. That is not surprising and is consistent with change processes elsewhere. The leadership of a network requires many of the skills needed in order to manage a professional or organisational team, but it also requires new skills that work beyond professional and organisational boundaries and are more about leadership than of management of specific services. It is inescapably more difficult to lead services over which the manager is not necessarily in a line relationship although it has to be said that for those who succeed in this style of leadership, it is incredibly invigorating and has major benefits in terms of maximum delegation to staff at the frontline.

13.2   It is necessary to consider team leadership in the context of what has already emerged in Glasgow around the management of the CMHT's and the primary mental health teams.

13.3   In the course of the review, all groups interviewed were asked about team leadership within the CMHT. As always, a spectrum of views were presented, ranging from at one end an emphatic belief that it was Trust policy that doctors were in change of CMHT's, through to at the polar extreme, and indeed the more prevalent view, that CMHT's already worked as teams with joint decision making processes in place, such that no one profession asserted authority over the others. The reason that this is important is the symbolic importance of who leads teams and implications that it has for perceptions about models of care. Whilst there is no reason why psychiatrists should not lead the clinical teams, if it is believed to be a categorical Trust policy then it inhibits the engagement and participation of other professions. A medical model, which is so often caricatured in social services, is also unacceptable to the other health professions. It is, however, not the reality for most of Glasgow. There are in most of the CMHTs competing health perspectives which together with the social dimension give a much broader approach to service determination.

13.4   <u>Network Leadership</u>

13.4.1 What we mean by this concept? Network leadership is critical at all levels, but most crucially at the point of delivery. It should, however, extend all

the way from the point of delivery through to the corporate level at which there is partnership agreement between the statutory agencies.

14   NETWORK LEADERSHIP AT THE POINT OF DELIVERY

14.1   Put simply, at this level the integrated network comprises: social services, primary and secondary mental health services, service users and carers, voluntary organisations and a whole range of community infra-structures which can only be networked and accessed at this level. This basic building block is in some ways an amalgam between the existing a CMHT, the associated general practice configurations and the area social work staff out posted to mental health services.

14.2   What we propose is that at this most essential level leadership is through designated Team Leaders. They would be from any profession, and would be practitioners with some form of sessional recognition for the Team Leader role. The role is not about telling the other professions what to do, but is about ensuring the effective delivery of service across their part of the network. Enabling the team to function.

14.3 Depending on local circumstances some Teams would be integrated Primary and secondary health workers alongside social care colleagues. In others, where they are already established, there would be separate Primary Care Teams operating but managed by the same manager who manages the secondary /specialist elements of the network. Glasgow is capable of sustaining and evaluating both service models concurrently.

15   INTERMEDIATE LEVEL

15.1   Integrated network management at the next level is at a level which is somewhere between what is currently designated in health as locality and adult services and the corresponding area social work offices. At this level, existing arrangements also embrace a range of specialist services managed within the existing structure at this level. We are recommending that there should be one level of network management/leadership between the service delivery point and the Sector level. That is, there should be at least one level of hierarchy in health less than there currently is. The functions currently deployed between the locality and the adult services i.e. the integration of community services and ward services needs to happen at this level but in a way which is integrated with the broader concept of a network, which also embraces social and primary.

15.2   The current arrangements with health Localities accountable to Adult Services are widely perceived as having community services managed from the hospital base.

16   SECTOR LEVEL

16.1 The next level of integrated network is at the sector level. The sectors in Glasgow are of sufficient size and complexity to justify being mental health systems in their own right. Whilst they will never be entirely comprehensive, they are of a size that enables them to have the full range of local services supported by a substantial number of specialist services which may be shared across the City or for a wider area. At this level, the integrated network should be driven both in terms of planning and performance management.

17 DEVELOPING MEANINGFUL USER AND CARER ENGAGEMENT

17.1 *"The NHS was set up in an age when people had different expectations, treatment possibilities were more limited and scientific progress was slower. People now expect to be involved in deciding about heir own healthcare as responsible partners in care. They wish to be treated with dignity and respect, to be treated as individuals and not as cases, and to have the right care in the right place at the right time. Meeting people's changing expectations while encouraging greater personal responsibility is a key theme of the White Paper."* (Page 17, paragraph 2)

17.2 It is essential that service users and carers are jointly responsible in the network at all levels. The ability of the user network to respond is an issue that needs consideration. It is reasonable that the mental health trust expects a clearer performance framework in which the user network is being developed but at the same time, it is essential that it is users themselves that set the direction and priorities for the network.

17.3 *"Looking at services from a patient's point of view underpins everything that we are seeking to do in the health services. Patients are concerned about the quality of care; treatment at the right time and in the right place; being treated with dignity and respect; having their say in decision-making; having their feedback taken into account; and getting clear explanations at every stage. All this amounts to a massive culture change in the health service compared to the first fifty years of its history".* (White Paper Page 7, paragraph 4)

17.4 *"… Patients must be seen as partners in their own healthcare. The health service must engage with patients, their carers and families, and listen to them "* (page 8, paragraph 5)

17.5 Glasgow is taking positive steps to develop effective and meaningful user and carer engagement in service planning, management and delivery but as elsewhere in the UK there is a need for much more substantial steps to be taken.

17.6 At a cultural level user and carer determination over what happens in services has to be more automatic and natural rather than an after thought.

17.7   There are a number of structural approaches that could be adopted from elsewhere that would ensure that user and carer engagement becomes more a way of working than is currently the case. This would, however, place significant demands on the User Network and the support it needs.

18   ACCOUNTABILITY FOR THE NETWORK

18.1   The network will only succeed if each constituent feels that their particular interests are properly accounted for. The network managers, at all levels will have to devote substantial efforts to maintain effective participation in the network, and to be accountable for it's performance. The brief states that the joint service is accountable to each agency for the contribution of each agency. Whilst this will be a formal requirement there is also a need to be accountable for the performance of the whole network. There will also have to be accountability mechanisms at a locality level direct to service users, carers, and the local community." *the Service has now always handled such consultations with local communities well, and it must learn to engage the public far more effectively in future."* (Page 43, paragraph 50)…. " *Traditional forms of consultation on options for change or service development are no longer enough"*. (Page 43, paragraph 51).

19   MAXIMISING THE ALIGNMENT OF SERVICE CATCHMENTS OF COMMUNITY MENTAL HEALTH SERVICES IN PRIMARY, SECONDARY AND SOCIAL CARE MENTAL HEALTH SERVICES.

19.1   There will never be a perfect or an easy answer to catchment boundary issues and when there is consideration of changing them then there must be a strong belief that the work involved and disruption caused is more than offset by the service benefits. The clear view to come from the consultation was that there are real benefits to be derived from a closer alignment of boundaries and a decision is needed. We would suggest that a small group comprising one person from Primary care, one from social, one from the Health Board and one from secondary services be tasked to make a firm recommendation from the three much discussed options. That group's recommendation would then go to Chief officers for decision. It is possible to come to a view for mental health that would still allow for the boundaries of the mental health network to be decided without compromising the bigger discussion about Health partnerships. Failing that there would at least be clarity in the mental requirements in the broader restructuring.

20. **Managed Local Mental Health Network -Implications for Community Health Partnership Agenda.**

20.1 The Managed Local Mental Health Network needs to be seen as what is essential for the delivery of good mental health services. It represents the fundamental components of a mental health service that need to be managed together if a locality is to have the range of services it needs for the population served. Within the managed network are the defined relationships between the different elements of any mental health service that need to function in an integrated and co-ordinated way .The network is the model of service delivery that is, evidenced by contemporary practice in Glasgow and elsewhere, the best way of ensuring effective delivery of mental health services.

20.2 In considering services for different parts of Greater Glasgow, or the City itself, the localities in question have to be clear that the elements of the network that are clearly identifiable as local are either comprehensive enough to be networks in their own right, or, more likely, how they interface with the network that is bigger than the locally provided services. Modern mental health services cannot function without the system operating and being managed as a whole system. It is entirely feasible and in some cases desirable for integrated parts of the whole network to be managed and accountable locally, but they are crucially still part of a singly managed network.

20.3 The proposals for the Managed Local Mental Health Network will fit with whatever the outcomes of the broader White Paper review are. The basic principle of a three tier structure for the delivery of mental health services is adaptable at each tier to fit with geographical configurations for non-mental health services. The network managers will be accountable to both Primary care based organisations and Local Authorities. The network will be managed on behalf of and as part of Community Health Partnerships.

21   RECOMMENDATIONS

<u>**Decisions in principle to be taken on degree of joint/integration in the network**</u>

1.The Managed Local Health Network comprises all services in Social Services, Primary healthcare and secondary/tertiary healthcare that relate to mental health.

2. There will be Single Management of the network, at all levels of the network, but with defined accountability arrangements at each level.

3. Agreement to the principle that the network has three tiers of organisation, Team, Intermediate and Sector.[August]

4. Decision on generic or specialist mental health social work teams. [August]

5. Is the intention to integrate budgets? Recommend, but suggest it should follow at least 12 months after the other changes -probably April 2005 and possibly with a period of shadow budgets.

6.Timetable for implementation. MLMHN operational by 1/4/03 but with final decisions about exact boundaries for Teams, Intermediate and Sector Tiers pending outcome of Community Health Partnership debate.[August]

7. Produce formal corporate partnership agreement including accountability arrangements with Glasgow City Council and consider for other Local Authorities.[.For agreement in December.]

8. Define the accountability arrangements to primary care as part of management roles and responsibility of the Trust/Mental Health Division.

9.Timetable for decision on Geographical/organisational boundaries that best fit mental health services but do not prejudice decisions on Community Health Partnerships. [Recommend 3 months.]

10. That whatever the agreed number of levels, all of the team leaders whether in primary or secondary services and management posts should be recruited to through a restricted process, between staff in Social, Primary and Specialist services. The process should be completed by [November/December.]
- Because these are new joint posts there should be a set rate for each post rather than an attempt to offer different salaries dependent on professional backgrounds. It should be a rate for the job.
- An early joint statement should be made to reassure staff, many of whom would not be directly affected.
- A timetable for the whole process should be published ASAP.[August]

11.Whole system

- Develop Organisational Development Programme Early priority for project manager. Needed to support new joint teams and to facilitate exploration of roles and responsibilities in the specialist teams.

12. CMHT/Specialist Team Working.

- Confirm minimum requirements for participation in CMHTs. Where necessary review departmental or individual workload priorities.

- Reaffirm the role of the cmht/pcmht so that there is clarity about how all clients for social, primary and specialists are directed. Social Care support,

including social work, for people with ongoing mild to moderate mental health needs is seen as part of the locality community mental health network.

♦ Explicit statement, agreed in system, on criteria adopted and of priorities for services.

♦ Confirmation of how system, in each Sector, should function through the 24 hours.

♦ Redefining the role of mental health teams in a much more holistic sense is important if it is to be a joint service rather than a take-over by the secondary services. At the same time the reasons historically for focussing on severe and enduring still need to be accounted for. [March 2004.]

♦ Clarification of roles in teams. To be encouraged and facilitated rather than directed, but should have timetable that is generous to allow teams to do it in comfort and with confidence. [ongoing]

♦ Statement on arrangements for professional supervision and development in the context of integrated team working. For Social Work, but also for other professions. [September]

♦ Statement of function and ways of working.

♦ Explicit statement of decision making processes in Sectors and probably a schedule of delegated authority. [December]

13. Primary Care Mental Health Teams

Reconsider, in the light of MLMHN, whether primary services should be separate teams or combined with CMHTs. There would be advantage in trialing both models, particularly as some PCMHTs are already established. Determine criteria against which models can be evaluated.

14. Organisational Development support for the Team development

♦ O/d support for individual professions e.g. doctors-RMO/Clinical Standards Board/nature of broader team functioning and beneficial impact on consultant workload. Clarity of consultant role. Ref RCP work Kennedy and others.

♦ For hospital based staff/community-based staff to acquire the necessary network skills.

♦ No single management domain meets the requirements of a network – development needs for all professions in taking on the roles.

15. User engagement/developing the network

♦ Each team to develop programme for improving user /carer engagement. A formal part of the performance framework.

♦ Using the requirements of the White paper as a starter/minimum.

♦ Defining how in structural terms service users will be involved in the management of services at all levels of the network, in all localities.

- Establish formal requirements for service user positions to be established at all levels of formal decision making in the network.
- Inclusion of service users in qualitative evaluations of services.

16. Miscellaneous recommendations /action points

- A simplified statement of the mental health strategy as a core document that uses footnotes to reference different policy directives.
- Positive examples of network working and development needs to be regularly highlighted and praised.

APPENDICES:
1. Summary notes of User/Carer Stakeholder meeting on 31 March 2003.
2. Summary Notes of Stakeholder days in December 2002.
3. Presentation to Feedback sessions in April 2003.

An open letter from Ian Reid,
Chair of the Mental Health Integration Steering Group

I am pleased to enclose a copy of a joint report prepared by Doug Adams, Assistant Director of Joint Commissioning, and agreed by the Primary Care Trust, Glasgow City Council and Greater Glasgow NHS Board, based on the key themes agreed through the Mental Health Integration Steering Group.

The report sets out the basis of the agreement between partner agencies to the creation of an integrated mental health service to deliver primary, secondary and social care services within a single mental health service.

The report :

    a)   sets out the recommendations of the Sainsbury Report;
    b)   summarises the responses which have now been agreed between The Trust, NHS Glasgow and Glasgow City Council
    c)   sets out the framework for further implementation.

A key feature of the process to date has been the high level of stakeholder and practitioner involvement.   The partner organisations have particularly valued the extent of this input and are committed to ensuring a high level of involvement is retained throughout the implementation process.

I wish to thank you again for your continued support and would welcome your comments on the joint response and the implementation plan.   Comments should be sent to Heather McVey, Business Manager at the above address (e:mail : heather.mcvey@gartnavel.glacomen.scot.nhs.uk) by 29th August 2003.

**Ian Reid – Chief Executive, Greater Glasgow PCT
Chair of the Integration Steering Group**

JOINT FUTURE AND THE DEVELOPMENT OF AN INTEGRATED COMMUNITY NETWORK FOR MENTAL HEALTH

1.   UPDATE AND FEEDBACK ON PROGRESS

1.1   This progress note sets out:

A summary of the key themes from the Sainsbury report and recommendations on the design of an integrated community network.

A summary of the joint agency decisions in response to the recommendations of the Sainsbury report.

An overview of the timetable and implementation process for further implementation of the development of the integrated community network, and the organisational and partnership governance arrangements within which the networks are located.

Next Steps

1.2   The principles agreed jointly by the three organizations (NHS Board, Greater Glasgow PCT and Glasgow City Social Work) are set out in this briefing note.

1.3   However comments on the further implementation process are welcomed and should be forwarded to Heather McVey, Business Manager (and support officer to the Joint futures Mental Health Integration Steering Group) by 31/8/03. (heather.mcvey@gartnavel.glacomen.scot.nhs.uk)

2.   SUMMARY OF THE MAIN THEMES FROM THE SAINSBURY REPORT : GLASGOW MENTAL HEALTH SERVICES JOINT FUTURES REVIEW

2.1   The first stage of the process was the design of an integrated community network and the consideration of a range of detailed issues and options as part of that design work.

2.2   This process was initiated with stakeholder events in each of the three geographic sectors within Glasgow City, followed by a series of meetings. The initial findings were fed back to stakeholder events in each sector. Subsequently the Sainsbury centre finalised its findings based on the stakeholder process, and the Mental Health Planning and Implementation Group received this report in May. A full copy of this report can be Downloaded from:
www.show.scot.nhs.uk/ggnhsb/pubsreps/reports/sainsbury/sainsbury_report_05-03.doc
Or alternatively www.nhsgg.org.uk (Click on NHS Board tab, go to "click here to visit site" and then open Publications & Reports)

2.3.   The main themes from the Sainsbury report are:

- The demonstrable success of some localities in transforming service provision now needs to be made universal and consolidated as the base for all of Glasgow
- Through the establishment of minimum requirements for locality services, higher levels of integration between primary, secondary and social care can be achieved which overcome some existing barriers of the need for commitment to the team by all professional groups, or service priorities which create barriers between primary, secondary and social care
- There is overwhelming support from all stakeholders for further integration and the development of the local community mental health managed networks, and a desire for more rapid decision making and implementation
- There is overwhelming support for shared catchments for all mental health services in primary, secondary and social care albeit no particular preference expressed on the detail of such arrangements
- At the same time there is the difficulty of relating positive beliefs about the joint future vision with the realities of day to day service provision and all groups require substantial reassurances that the detail of implementation will build on valued strengths and roles which might otherwise be at risk of being marginalized, and the need for true integration of full and equal partners, rather than takeover by more powerful partners
- Both primary care and social care are concerned that the focus on a mental health network should not undermine a focus on the needs of individuals on a more holistic and generic basis
- All parties recognise that notwithstanding such misgivings there are clear advantages in the establishment of the managed mental health network and are prepared to compromise to support this, subject to the necessary arrangements to ensure real influence in accountability and decision making
- This partnership will require a redefinition of the role and content of community mental health services and the functions of their component teams, to remove unhelpful barriers within a new service responsible for mental health supports across primary, secondary and social care
- The proposals for integration in Glasgow were bolder than elsewhere in the UK in their inclusion of primary care mental health services within the network, and the focus on the full range of values and supports that put mental health in the broader context of peoples normal lives
- Whilst these proposals are bolder than elsewhere, they are a natural evolution from the current stage of Glasgow's development and represent the possibility of enabling more comprehensive arrangements which are achievable in the context of Glasgow
- For service users there was both a frustration at the pace of change in the reality of their experience of services, recognition that the integration arrangements offered significant potential to improve their experience as service users, and scepticism as to whether this would be translated into their future experience.

- There was also a recognition of the need to formalise arrangements for user engagement in performance management, service quality review, and decision making, and that more formalised arrangements required to be developed within the new integrated service
- That the whole system of mental health services in primary, secondary and social care was best managed as a singly managed service with no separation between community, intermediate and inpatient services.
- That such a service required three tiers of organisation and management at team, locality/intermediate level and sector level.
- That without prejudice to the eventual geography of Community Health Partnerships there was scope for the accountability of the integrated mental health service to be through the community health partnerships, and for an alignment of catchments between CHP's and the relevant tier of mental health services

2.4   The Sainsbury report concluded that:
- the proposals for the development of the integrated community network had overwhelming support, were a natural evolution from the current stage of development in Glasgow, and were feasible.
- A genuinely joint arrangement needs to build on what is good about existing structures and ways of working in parts of the city, but it also requires change in how the combined services are led, managed and delivered.

2.5   Successful implementation would be contingent on confirmation by all agencies of their commitment to a number of detailed principles set out in a series of recommendations relating to:

1. The degree and nature of jointness within the integrated service

2. Principles of service redesign and the redefinition of the community service in the context of an inclusive, combined and integrated service consisting of dedicated mental health resources within primary, secondary and social care.

    In essence a redefined service and organisational arrangement rather than an amalgamation of existing services - in which there were agreed minimum core standards and expectations of the role of professionals, teams and service at each of the 3 geographic tiers.

3. Principles of more formalised arrangements for user engagement at each level of the integrated service.

4. Human resources principles to underpin the changes in how services are managed, delivered and led which include restricted list arrangements for appointment to management posts at each level and minimum turbulence in HR assimilation arrangements to other posts

5. Timetable and substantial organisational development support to underpin an implementation process which was informed both by corporate standards, and facilitated team and practioner led involvement in the development of detailed operational arrangements.

3. JOINT AGENCY DECISIONS IN RESPONSE TO THE RECOMMENDATIONS OF THE SAINSBURY REPORT

3.1 Subsequently each agency was asked to respond to the recommendations of the Sainsbury report in terms of its own commitment and contribution, and what was required from partner agencies.

3.2 The responses from agencies indicate a high level of support for the recommendations as set out in the Sainsbury report. In broad terms the recommendations were accepted in full with only a small number of minor caveats. These caveats were more about the detail of implementation than the spirit of the recommendations.

3.3 A summary of the recommendations and the joint agency responses is attached as appendix 1 of this report.

3.4 The main themes to emerge from the agency responses, beyond the detail of individual recommendations, were:

Development of an integrated community service rather than amalgamating existing services

3.5 A theme of the Sainsbury report echoed by all agencies was for the need to see the integrated network as different from an amalgamation of previous separate services.

3.6 The network needed to recognise and build on the strengths of existing services, but needs to be seen as defining new parameters for an integrated service which breaks down barriers between primary, secondary and social care. This redefinition of the service takes place in the context of significant new investment for primary care mental health services, and the imperatives of Partnerships for Care to remove organisational and structural barriers, and enhance devolution of operational decision-making.

3.7 Indeed this view of a combined and integrated primary, secondary and social care service, in which there was a need to ensure an appropriate use of specialism without creating inflexible and unresponsive boundaries between primary, secondary and social care, was seen as a prerequisite by all agencies for meaningful movement to a truly integrated service.

3.8 Furthermore there is shared agreement of the prerequisite requirement for all partner agencies to confirm that the integrated network is a new organisational structure, and

that current organisational and management arrangements will necessarily be reconfigured within this context.

High levels of support from stakeholders and agencies

3.9   The consultation exercise and the participation of staff within all agencies, users and carers were seen as excellent. It was particularly clear that there is general support from all stakeholders that a truly integrated mental health service is the way forward to ensuring the provision of a better service for "service users".

Confirmation and clarity of vision for integration

3.10   The aim of integrating primary, secondary and social care mental health services across Glasgow is to provide a whole system approach to the delivery of mental health services for service users. The core of the new integrated network will be delivered by a citywide partnership providing integrated service delivery from the 2 major statutory sector providers i.e. the Primary Care Trust and Glasgow Local Authority Social Work Services. This would include dedicated adult mental health services within primary, secondary and social care

3.11   Additionally the partnership would need to include users, carers and voluntary organisations, community mental health partnerships, specialist and citywide services beyond the directly managed integrated primary, secondary and social care mental health services. All of these partners who are important parts of the wider community network.

3.12   The partnership will also need to develop interfaces with city wide and tertiary services, and other services where there are co morbidities requiring multiple inputs.

The benefits of such an arrangement

3.13   The benefits of an integrated mental health service including dedicated mental health resources within primary, secondary and social care would include:

- "the design and management of the single mental health and social care network will follow the patient and their care consistently through primary, secondary and tertiary levels."
- "services within the network can be delivered appropriately in practices, patients homes and in hospital or community mental health premises";
- "clinicians and practitioners can work within the managed system without artificial organisational boundaries"
- "resources within the system can be managed to meet clinical and other needs"
- "Those commissioning services i.e. the Board, Social Work, CHP's, LHCC's can agree service provision and have the mental health system account for that service delivery across the whole system to meet local and service wide needs"

Locating the mental health proposals in the context of the development of Community Health Partnerships

3.14   Given the timing of the developments in relation to Community Health Partnerships (CHP's) this aspect appears to have been insufficiently reflected in the feedback from the stakeholder process.

3.15   There is widespread agreement by all agencies that ;

- Whatever the detail of the organisational arrangements for mental health, these needed to be developed in tandem with the development of Community Health Partnerships, and be complementary to such developments
- A minimum prerequisite for this was to ensure that the Community Health Partnerships would be the vehicle for partnership accountability, both for the population of the Community Health partnership and also for the wider sector based services (to the extent these are delivered to a population beyond a single Community Health Partnership).
- Additionally there is recognition of the need to minimise fragmentation between mental health services / catchments and other community services. This is most likely to be supported by ensuring coterminosity between mental health services (at either intermediate or sector level dependant on size of Community Health Partnerships) and the eventual geography of Community Health Partnerships

Reassurances to staff which minimise instability, whilst enabling the necessary changes in the way services are led, managed and delivered

3.16   The integration proposals take place at a time when there continues to be significant expansion in mental health services in Glasgow.

3.17   Additionally the work of the combined integrated service is broader than an amalgamation of existing separate services.

3.18   In this context all organisations are committed to ensure that the Human resources arrangements maximise stability, whilst enabling the more modest necessary changes which are a necessary prerequisite of the development of the combined and integrated service

4.   IMPLEMENTATION PROCESS

4.1   The detail of the implementation process is being developed and refined over the summer period. However in broad terms the main components and timetable of the implementation process are summarised below.

4.2   The proposed overall timetable is:

Decisions on detailed issues   Dec 2003
Final decisions formalised through agency committee processes   Apr 2004
Implementation of agreed organisational arrangements and   Apr to assimilation
into the new teams   Dec 2004

4.3   Decision areas included in the above timetable include:

- Organisational and governance arrangements for the mental health network and its relationship to community health partnerships
- Minimum core standards, essential components and team roles within the context of a combined and integrated community mental health service
- Outstanding structural, financial and Human resource issues concerning:
    i.   The boundaries and coterminosity arrangements
    ii.   The content of management structures at each tier
    iii. The identification of financial resources which transfer into the integrated service
    iv.   The detailed human resource processes to be applied within the previously agreed principles

4.4   Within the above framework it is envisaged the facilitated work on the development of the integrated community network can continue beyond April 2004 as part of the detailed operational implementation arrangements but should start by September 2003.

4.5   The section below provides more detail on the main components of work to be covered within the implementation process.

Organisational and governance arrangements

4.6   Sainsbury Centre have been commissioned to develop options and recommendations for organisational arrangements within which the integrated community network is located; and the necessary governance and accountability arrangements required to underpin a partnership of full and equal partners, whilst also meeting the necessary statutory requirements of the constituent agencies.

4.7   This work will need to take account of the development of Community Health Partnerships as the main vehicle for partnership working for the population of the Community Health Partnership.

4.8   Decisions in principle by each agency by Dec 2003 and in full by April 2004

Detailed development of the integrated community network

4.9   Facilitated process to develop the core specification and standards for the integrated network with support from OD and Sainsbury but primarily based on sector based work involving a broad cross section of practitioners

4.10   Development of the role of individual professional groups and the operation of team processes within the integrated network

Outstanding structural issues for the integrated community network

4.11   The content of management responsibilities at each tier.

The agencies have supported the need for three tiers of management as recommended by the Sainsbury report, but there is a need to further clarify the roles of management posts at each of those levels. Further discussions between agencies to achieve decision in principle by Autumn 2003.

4.12   Arrangements for achieving geographic coterminosity of primary, secondary and social care services within the integrated mental health community network whilst also taking account of the need to achieve coterminosity with the eventual geography of Community Health Partnerships.

4.13   Principles paper to be agreed by Autumn 2003 with application of those principles in the context of the emerging recommendations on geographic catchments of CHP's by Dec 2003.

Community services benchmarking

4.14   This work has been commissioned to identify and benchmark the position of Glasgow's community mental health services in comparison with other similar urban areas with the UK and will inform the further development of the community network.

4.15   The detailed brief is currently being finalised but results should be available by late Autumn 2003.

Project Director for Integration

4.16   There is a recognition that the development of the integrated service will require dedicated capacity to manage and coordinate the process of integration. Accordingly a post has been established and in the process of recruitment to create such capacity.

4.17   Additionally there will continue to be access to consultancy and other organisational development support from agency resources or external support from the Sainsbury Centre for Mental Health

5. NEXT STEPS

5.1   The Joint Future Mental Health Integration Steering Group (JFMHISG - Chaired by Ian Reid, Acting Chief Executive of the Primary Care Trust) will continue to coordinate the implementation of the development process for the integrated service.

5.2   Through the summer the detail of the implementation arrangements will be further refined and once again communicated more widely.

5.3   In the meantime this progress feedback briefing has sought to provide an update on the outcome of the Sainsbury led stakeholder process and the decisions of the JFMHISC in response to the recommendations.

5.4   Further comments on the proposed implementation arrangements are welcomed and should be forwarded to Heather McVey, Business Manager email address heather.mcvey@gartnavel.glacomen.scot.nhs.uk

APPENDIX 1

 RECOMMENDATIONS FROM SAINSBURY REPORT AND JOINT AGENCY RESPONSE

The recommendations from the Sainsbury report are set out below. A summary of the joint agency responses is set out in bold below each recommendation

<u>Decisions in principle to be taken on degree of joint/integration in the network</u>

1. The Managed Local Mental Health Network comprises all services in Social Services, Primary healthcare and secondary/tertiary healthcare that relate to mental health.
- **Agreed, additionally all partners recognise this will require a redefinition of the community mental health service rather than an amalgamation of existing services within existing organisational and management structures**

2. There will be Single Management of the network, at all levels of the network, but with defined accountability arrangements at each level.
- **agreed**

3. Agreement to the principle that the network has three tiers of organisation, Team, Intermediate and Sector.
- **Agreed, with requirement for appropriate health and social care expertise at each level; the detail of the content of management responsibilities at each level requires further consideration**

4. Decision on generic or specialist mental health social work teams.
- **Agreed, generic social workers will be located within the specialist mental health teams**

5. Is the intention to integrate budgets? Recommend, but suggest it should follow at least 12 months after the other changes -probably April 2005 and possibly with a period of shadow budgets.
- **Principle of full integration of budgets agreed based on developmental process, in which budgets are initially aligned within the integrated service and subsequently integrated more fully over time**

6.Timetable for implementation. Managed Local Mental Health Network operational by 1/4/03 but with final decisions about exact boundaries for Teams, Intermediate and Sector Tiers pending outcome of Community Health Partnership debate.
- **Proposed timetable of decisions in principle by December 2003; final decisions by April 2004 and detailed implementation of the new organisational structure and detailed operational arrangements during 2004.**
- **Principles on geographic boundaries by Autumn 2003 and subsequent application of principles based on emerging geography of Community Health Partnerships c Dec 2004.**

7. Produce formal corporate partnership agreement including accountability arrangements with Glasgow City Council and consider for other Local Authorities.
- **Agreed, but in context of a partnership agreement which goes beyond the statutory accountability arrangements to the NHS Board and to GCC and which sets out accountability of the partnership to both to the NHS Board, GCC, CHP's,LHCC's, users and carers, services**

beyond the network such as specialist city wide services or to other client groups with comorbidities

8. Define the accountability arrangements to primary care as part of management roles and responsibility of the Trust/Mental Health Division.
- **As above**

9. Timetable for decision on Geographical/organisational boundaries that best fit mental health services but do not prejudice decisions on Community Health Partnerships.
- **Principles on geographic boundaries by Autumn 2003 and subsequent application of principles based on emerging geography of CHP's c Dec 2004; all agencies committed to flexibility of existing arrangements to achieve coterminosity of boundaries within mental health and beyond mental health to CHP's and thereby other community care groups**

10. That whatever the agreed number of levels, all of the team leaders whether in primary or secondary services and management posts should be recruited to through a restricted process, between staff in Social, Primary and Specialist services.
- Because these are new joint posts there should be a set rate for each post rather than an attempt to offer different salaries dependent on professional backgrounds. It should be a rate for the job.
- An early joint statement should be made to reassure staff, many of whom would not be directly affected.
- A timetable for the whole process should be published ASAP.
- **Agreed in principle but the feasibility of the proposed approach remains to be clarified in terms of the prevailing national and local agreements in relation to professions and pay rates; the detail of the arrangements will need to be applied in the context of the eventual new organisational arrangements**
- **Timetable issues as per 6 above**

11. <u>Whole system</u>

- Develop Organisational Development Programme Early priority for project manager. Needed to support new joint teams and to facilitate exploration of roles and responsibilities in the specialist teams.
- **Agreed, to be covered within implementation plan**

12. <u>CMHT/Specialist Team Working</u>.

- Confirm minimum requirements for participation in CMHTs. Where necessary review departmental or individual workload priorities.

- Reaffirm the role of the cmht/pcmht so that there is clarity about how all clients for social, primary and specialists are directed. Social Care support, including social work, for people with ongoing mild to moderate mental health needs is seen as part of the locality community mental health network.
- Explicit statement, agreed in system, on criteria adopted and of priorities for services.
- Confirmation of how system, in each Sector, should function through the 24 hours.
- Redefining the role of mental health teams in a much more holistic sense is important if it is to be a joint service rather than a take-over by the secondary services. At the same time the reasons historically for focussing on severe and enduring still need to be accounted for.

- Clarification of roles in teams. To be encouraged and facilitated rather than directed, but should have timetable that is generous to allow teams to do it in comfort and with confidence.
- Statement on arrangements for professional supervision and development in the context of integrated team working. For Social Work, but also for other professions.
- Statement of function and ways of working.
- Explicit statement of decision making processes in Sectors and probably a schedule of delegated authority.
- **Redefinition of a new integrated community mental health service which breaks down the barriers between primary, secondary and social care, in the context of both Partnerships for Care and Joint Futures is seen as a fundamental prerequisite by all partners which underpins the commitment of partners in making compromises from unilaterally preferred positions**
- **Development of corporately agreed core minimum standards and essential elements for all community based mental health teams (including psychiatry, psychology and social work) agreed as fundamental prerequisite without which partner agencies could not commit their own organisations**
- **Facilitated process for development of clarification of roles, teams, and arrangements for professional supervision and clinical leadership in context of integrated working agreed**

13. Primary Care Mental Health Teams

Reconsider, in the light of MLMHN, whether primary services should be separate teams or combined with CMHTs. There would be an advantage in trialling both models, particularly as some PCMHTs are already established. Determine criteria against which models can be evaluated.
- **Incorporate function of primary care mental health within the locality integrated management of the community based mental health teams**
- **Location of primary care mental health teams in this context avoids the need for trialling models of teams located beyond the integrated community based teams and this is not supported**

14. Organisational Development support for the Team development

- O/d support for individual professions e.g. doctors-RMO/Clinical Standards Board/nature of broader team functioning and beneficial impact on consultant workload. Clarity of consultant role. Ref RCP work Kennedy and others.
- For hospital based staff/community-based staff to acquire the necessary network skills.
- No single management domain meets the requirements of a network –development needs for all professions in taking on the roles.
- **Agreed**

15. User and carer engagement/developing the network

- Each team to develop programme for improving user /carer engagement. A formal part of the performance framework.
- Using the requirements of the White paper as a starter/minimum.
- Defining how in structural terms service users will be involved in the management of services at all levels of the network, in all localities.
- Establish formal requirements for service user positions to be established at all levels of formal decision making in the network.
- Inclusion of service users in qualitative evaluations of services.

- **Agreed and needs to be considered as part of development work of framework for user engagement and for carer engagement**

16. Miscellaneous recommendations /action points

- ♦ A simplified statement of the mental health strategy as a core document that uses footnotes to reference different policy directives.
- **Agreed and to be produced in late summer**
- ♦ Positive examples of network working and development needs to be regularly highlighted and praised.
- **Agreed**

Doug Adams
Joint Head of Mental Health
On behalf of the Joint Future Mental Health Integration Steering Group