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CABINET

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ADULT MENTAL HEALTH SOCIAL CARE: OPTIONS FOR THE FUTURE

Portfolio Holder: Councillor David Brake, Adult Services

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Summary

Medway Council must ensure the social care needs of adults, who are vulnerable because of their mental health, are met, that effective safeguarding arrangements are in place, and the Council's legal duties are discharged.

Since 1 February 2012 Medway Council has directly delivered Mental Health Social Work Services for Adults. This report sets out what has been learnt from taking these services into direct Council management.

The report presents the options available to the Council to set the longer-term strategy for mental health social care in Medway, and includes the comments of the Health and Adult Social Care Overview and Scrutiny Committee, which considered this report on 22 May 2012.

1. Budget and Policy Framework

1.1. The decision to be taken is within the Council's Policy and Budget Framework and Council Plan, therefore, this is a matter for Cabinet. Medway Council must ensure that the social care needs of adults, who are vulnerable because of their mental health, are met, that effective safeguarding arrangements are in place, and the Council's legal duties are discharged. Adult social care refers to the responsibilities of local social services authorities towards adults who need extra support. The legal framework for provision is complex. The main obligations are set out in the NHS & Community Care Act (1990), the National Assistance Act (1948), the Mental Capacity Act (2005) and the Mental Health Act (2007).

1.2. This report is consistent with the Council Plan priority in relation to "adults maintaining their independence and living healthy lives" and the commitment to ensuring that older people and disabled adults are safe and well supported.

1.3. Medway Council has a statutory duty to directly deliver, or contract with a provider who can deliver, safe services to achieve good social care outcomes

for vulnerable people with mental health problems living in Medway. In addition, the safety and well-being of others, including children and other family members and members of the wider community, is achieved by carrying out timely mental health assessments and delivering effective social care interventions.

1.4. For mental health, Medway Council's statutory duties are centred on social work interventions, in the form of professional advice and support, care management, statutory assessment under the Mental Health Act 2007, services (including statutory after care) and individual care packages. Social work supports individuals experiencing severe mental health problems achieving and maintaining their tenure and ordinary daily life in the community. It promotes social change, problem-solving in human relationships, and the empowerment of vulnerable people, with the aim of enhancing well-being and safety. Medway Council is a key local leader and influential partner in the organisation and delivery of services designed to improve the health and wellbeing of local people, including individuals and families who are vulnerable because of their experiences of mental ill-health.

2. Background

2.1. The duties to provide mental health social work on behalf of Medway Council had been contracted to Kent & Medway NHS and Social Care Partnership Trust (KMPT) in 2009. The provider did not deliver adequate social care outcomes and so notice to terminate the contract was served on 15 June 2011 and the contract ended on 1 February 2012.

2.2. On 20 December 2011, Cabinet agreed that officers would carry out a review of its mental health social care strategy and that the Council would directly manage the delivery of mental health care management and services from 1 February 2012. Cabinet instructed officers to evaluate and bring proposals to Cabinet by June 2012 to determine the future delivery of mental health care management and services.

2.3. A safe and effective transition to new operational arrangements was achieved. The immediate priority of stabilising the delivery of mental health care arrangement and services has been achieved since 1 February 2012. The Cabinet will now be asked to recommend to Council the basis for setting the longer-term strategy for the effective delivery of mental health social care outcomes.

2.4. Bringing mental health social work into direct Council management has been an important opportunity to understand and evaluate the improvements needed in the short term and also to determine what is necessary to set the longer-term mental health strategy for the Council.

2.5. An assessment of the baseline position of the service is set out below. This is followed by setting out the options available to Council to set the longer-term mental health strategy for the Council in the light of the findings.

3. Baseline Position

3.1. When the service transferred an important priority was to evaluate the strengths, weaknesses and risks of the service.

3.2. A social care workforce, comprising 58 staff, was transferred to Council employment. The service was named the *Medway Mental Health Social Work Service*. This service now occupies a single ground floor administrative office base at Compass Centre South, Pembroke. The workforce consists of senior social work practitioners and team managers; qualified social workers; care manager assistants; outreach workers; day resource workers (operating from the two day resources services); and administrative staff. In addition there are specialist posts in relation to vocational advice, carers' support and safeguarding.

3.3. The service consists of a Social Work team for both adults of working age and older adults, the Day Resources Team (operating from Eagle Court, Rochester and Nelson Road, Gillingham) and the Community Support and Outreach Team (C.S.O.T.).

3.4. An interim Head of Mental Health in charge of operations (reporting to the Principal Officer for Mental Health) was appointed to introduce robust management and professional support, to improve staff confidence and morale and establish the new team. A dedicated Safeguarding Lead was appointed to improve the focus on safeguarding, and three interim social workers were deployed to reinforce the team's capacity to carry out Mental Health Act Assessments as Approved Mental Health Professionals (AMHPs). Staff supervision was embedded, where previously this had been absent. A training survey was initiated. Early staff training sessions were conducted on Fair Access to Care Services (FACS) eligibility and Child Protection. Training on the requirements of the Mental Capacity Act 2005/Deprivation of Liberty Safeguards (DOLS) is planned. Development work has started on improving local mental health housing options following award of a Social Care Institute for Excellence (SCIE) grant (as one of the Social Work Practice Pilot sites).

3.5. Urgent action was taken in the weeks leading up to transfer to adapt the Council's *Care Director* client information system to ensure user information was routinely recorded to understand service performance and contribute to user and staff safety. This was required when it became clear that the workforce transferring from the Mental Health Trust would no longer be provided with access to RiO, the Trust's patient information management system. Kent and Medway NHS and Social Care Partnership Trust (KMPT) arrangements to provide transferring staff with paper records, in relation to users, being transferred to Council care also failed. In practice this has meant that the burden of inputting information has rested with the Social Work team, but this is being resolved.

3.6. Social work staff transferred with care responsibilities for users that were open to them previously. Some users had health needs rather than eligible social care needs. A reallocation according to need could have been completed before transfer if there had been more co-operation from the Trust. Failure to do so has delayed some of the necessary work required to most effectively

deploy the members of the team. 57 users were identified as requiring health intervention only. These cases have been returned to the KMPT Community Recovery Service and closed to the Social Work Team. It is anticipated that there are a further 20 users who require health intervention only. These will be transferred to health following social work assessment. The Social Work Senior Practitioners are now meeting with health managers, nursing colleagues and psychiatrists on a weekly basis to discuss and review cases. A Senior Social Work Practitioner also routinely attends the Access team at Medway Hospital on several occasions each week to review new referrals for social care.

3.7. The inability to directly access the RiO information system since the constraints imposed by the previous provider on social workers making direct referrals to secondary health services means that, effectively, social workers in the Medway Mental Health Social Work service can no longer act as Care Co-ordinators within the terms set out in Care Programme Approach. This also imposes a significant burden of risk on the operation of the Medway Social Work service and the Council as well as for service users and their families.

3.8. The Safeguarding Lead, the Principal Officer for Mental Health and the Adult Safeguarding Principal Officer have worked closely with the team to improve our reporting and response to safeguarding concerns. To date, 40 historical safeguarding cases inherited from KMPT have been reviewed and closed.

3.9. A recent review of team activity provides the following information:

550 people receive support and services from the team;
25 referrals are received per month;
105 people currently receive services and support through Day Resources. On average each user attends 2/3 sessions per week;
100 people per week receive services and support through C.S.O.T. On average clients receive 2/3 hours contact time per week (the range is from 30 minutes to 7 hours per week);
60 Carers' Assessments have been completed since 1 February 2012.
220 people had a SDS payment during 2011/12.
124 were new within the year. The majority of this was achieved post-transfer.
61 people are in residential care where the Council meets payment (with or without client contribution).
39 are working age adults (18-64 years).
23 are 65 years+.

3.10. Since 1 February 2012, the better arrangements around safeguarding, the increased number of completed Carers' Assessments, and the increased take up of self-directed support provide evidence to suggest mental health social work delivery in Medway has improved. Requests for statutory mental health act assessments remains high, but these and other referrals are responded to in a timely and professional way. The new working arrangements at the Compass Centre have generally been welcomed by the transferred staff. Positive feedback about operations has recently been received from the Mental Health Trust practitioners.

3.11. The impact of completing work on establishing proper operational systems has put back the task of engaging key stakeholders, including staff, in consultation about the future operation of the service. Staff are aware that direct Council management is regarded as an interim arrangement and that in future the service will be delivered by a suitable provider organisation. However there has been little discussion about the options available to take this next step. We have kept users informed of progress but have not formally consulted upon future options.

3.12. The transfer was achieved without incurring any financial liability to the Council arising from either redundancy or additional operations costs. Since 1 February 2012 the service has operated within a reduced cash limit. This has contributed to the overall savings target required from Adult Social Care. In addition two Council properties that were the C.S.O.T. administrative base (7 & 9, Montgomery Avenue, Chatham) and an adjacent plot of land were sold at auction in April for £273,000.

4. Review Findings to inform future options

The following key findings are derived from evaluation of the current service:

4.1. **Routine collection and in-put of client information on Care Director** is critical for client safety, risk assessment and risk management, as well as the safety of staff. There are also significant financial risks to the Council where the client's legal status and residence is not recorded, e.g. clients subject to Section 117 cannot be charged for services that are part of their aftercare. There is evidence that the team is now getting to grips with the requirements of Care Director. The needs of Mental Health need to be reflected in the new IT specification. The team must focus on ensuring that Individual Needs Portrayals (INPs) are complete on the system.

Key Learning Point:
(i) any subsequent transfer of delivery to another organisation must ensure that there is strong interoperability between information management systems and this is tested in advance of transfer.

4.2. **Case allocation and review**: a clear and definitive list of all of the clients open to the Medway Mental Health Social Work team is essential for safeguarding purposes and for leading and managing the complex work of this team. In addition it allows the Council to be clear in relation to performance against key social outcomes. Since 1 February, good progress has been made on understanding the nature and level of individual needs and introducing safeguarding, supervision and review procedures. However the team must work to increase its skills base, to ensure it is ready to respond to an increasing focus on personalisation, the introduction of charging and adopting better referral arrangements from primary care and other key referral agents.

Key Learning Point:
(ii) ongoing support and challenge to staff through supervision and skills training in FACs assessment; risk assessment and management; case review and safeguarding.

4.3. **Integration of health and social care**: It has been difficult to engage the Trust positively in joint and integrated working following transfer. This is illustrated by the continuing difficulties around information sharing, and the lack of access to client information held on their patient information system, including risk assessment. Co-location could have brought a positive impact on supporting a strategy of joint working. Joint working is essential for understanding risk and achieving better outcomes for service users and their families.

<u>Key Learning Point</u>:
(iii) a successor provider with a good understanding of the value and advantages of integration and a track-record in joint working must be sought.

4.4. **Specify strategic commissioning intentions to drive up performance targets for social care outcomes**: the improvement in achieving social care outcomes by the team since 1 February illustrates what can be done in the short-term to make up ground. However more effort will be required to bring about better outcomes in relation to employment and housing outcomes. This requires closer working with housing partner organisations and increasing our focus on skills and opportunities for employment placements and outcomes. There is a low level of voluntary sector mental health activity in Medway and this needs to be fostered to improve these two outcomes.

<u>Key Learning Points</u>:
(iv) a successor organisation should be contracted to deliver the service with specific social care outcomes written into the operation and performance framework;

(v) work needs to be completed in setting out strategic Commissioning Intentions in an overall strategy that stimulates the development of the local mental health voluntary sector around employment and housing.

4.5. **Define outcomes that matter to service users and carers**: the presence and support of users and carers through the transitional groups was vital in supporting the changes that were required. The uptake of self directed support by Medway mental health users has shown a significant increase. Increasingly outcomes in mental health social care must be defined by what matters to service users and carers, and not only by clinical pathway and payment regimes. Research highlights that the outcomes that matter are closely related to the main social care priorities: safety; settled housing (a home); employment (a job); valued relationships (partner, family, friends); health and well-being (recovery and staying well); and income (money).

<u>Key Learning Point</u>:
(vi) users and carers should have opportunities to be involved in the governance of future provider arrangements as well as in Medway Council's strategic commissioning intentions.

5. Options available for development of longer-term mental health social care strategy for Medway

5.1. Option 1: Service remains in Council management

Advantages:

1. Continuity of operations following long period of poor social care outcomes.
2. Direct control to undertake further transformation of service.
3. Less disruption and uncertainty to staff subject to recent major change and previous poor leadership, serial change and uncertainty.
4. Opportunity for direct management of the improvement of social care outcomes through improving the skills and responsiveness of staff team
5. Opportunity to align mental health social work operations to Health and Wellbeing Board objectives and Council policies.

Disadvantages:

1. Against Council's stated ambition to be a Commissioning-led authority.
2. Commissioning and providing functions potentially confused.

5.2. Option 2: Mental Health Social Work Staff form a Mutual organisation (see appendix 1)

Advantages:

1. Social Work professionals have autonomy and direct control of governance and operations and directly contract with Medway Council.
2. Ensures Specialist Mental Health Social Work focus remains central.
3. Governance of organisation could include service users and carer members.
4. All operating surplus held by the organisation for local reinvestment.
5. Consistent with Government Policy of supporting professional groups to run local services.
6. Back office functions could be provided by a local social enterprise (e.g., Medway Community Healthcare, Sunlight).

Disadvantages:

1. Unaffordable model for a relatively small staff group because of overhead costs, including set up costs and full governance structure, including Board.
2. Small group of staff may not contain all the necessary skills and leadership required.
3. Sustainability problematic due to cost pressures across local health and social care system.
4. Does not benefit from the advantages of integration with potentially high transaction costs.
5. Would require staff to formally "declare" an interest in taking on this task.

5.3. Option 3: Open Market Tender (see appendix 1)

Advantages:

1. Potentially wide interest from a range of providers across statutory, voluntary and for-profit sectors.

2. Opportunities identified for potential cost savings in the delivery of services.
3. Introduces innovation and a new model for service delivery.
4. Potentially introduces new expertise and experience into Medway.
5. Clear separation of commissioning and statutory function and provider functions.

Disadvantages:
1. Costs incurred in running tender relative to the value of contract is high.
2. Time-consuming process of tendering may contribute to uncertainty over strategic direction, impact on staff morale and delay in operational decisions.
3. Relatively small financial value of contract, together with pension and insurance liabilities, may make an unattractive prospect to providers.
4. Tender may be perceived by KMPT as hostile encroachment by another NHS specialist provider placing already fragile co-operation at further risk.
5. Length of contract to enhance value of offer to attract suitable providers may tie the Council into longer-term or inflexible arrangements.
6. Lack of broad interest may constrain Council to consider less than optimal solution and have an impact on reputation and morale.

5.4. **Option 4: Mental Health Service transfers to be a Subsidiary of an established Social Enterprise** (see appendix 1)

Advantages:
1. Subsidiary would operate independently within an agreed governance framework with a strategic plan agreed and monitored by the parent Social Enterprise Board.
2. Subsidiary fully supported by the parent Social Enterprise, including leadership and back office functions.
3. Governance model for subsidiary could include membership of service users and carers.
4. Autonomous decision-making for the subsidiary stakeholders within an agreed framework.
5. Value-driven as decisions will be made by mental health staff, users and carers within the agreed framework.
6. Cost-effective as Subsidiary will be supported by the parent Social Enterprise, minimising the costs of establishment and business transfer.
7. Clear separation of commissioning and statutory function and provider functions.
8. Potential to forge important links between physical disability, long-term conditions and mental health.
9. Flexibility around income generation.

Disadvantages:
1. New governance model for Subsidiary and Social Enterprise Board and accountability, will need full involvement and understanding of respective roles and responsibilities.
2. Long time-scale to establish governance framework.
3. Use of any operating surplus ultimately decided by Social Enterprise Board.
4. Limited choice of local Social Enterprises for transfer and lack of experience in Mental Health for potential local Social Enterprises.

5. Competition and contestability need to be determined.

5.5. **Option 5: Integrate into an existing local Social Enterprise**

Advantages:

1. Cost-effective model, with little additional management structure of governance structure required.
2. Service operates in an integrated manner alongside other Social Enterprise services.
3. Long-term sustainability
4. Local focus.
5. Clear separation of commissioning and statutory function and provider functions.
6. Potential to forge important links between physical disability, long-term conditions and mental health.

Disadvantages:

1. Lack of control of autonomy as service would be one of several service lines and accountability would need to be clear.
2. Use of any operating surplus decided by Social Enterprise Board.
3. Mental Health social work focus may be lost if local social enterprise has no significant prior experience in social care.
4. Limited choice of local Social Enterprises for transfer and lack of experience in Mental Health for potential local Social Enterprises.

6. Advice and analysis

6.1. Depending on which option is agreed, it will be necessary to organise full consultation upon the change with mental health service users, carers and staff, other stakeholders and interested partner organisations.

6.2 Diversity Impact Assessment - the Council has legal duties to give due regard to race, gender and disability equality in carrying out its functions. This includes the need to assess whether any proposed changes have a disproportionately negative effect on people from different ethnic groups, disabled people and men and women, which as a result may be contrary to these statutory obligations. Depending on which option is agreed, a Diversity Impact Assessment will be undertaken and reported to Members as the consultation process takes place.

6.3 A preliminary review suggests that there is no current evidence that the options set out will make a differential impact on any marginalised group afforded protection by the Equality Act.

6.4 Appendix 1 provides a brief description and examples of a mutual organisation, a social enterprise and the open market process.

7. Risk management

Risk	Description	Action to avoid or mitigate risk
Council Reputation	Council decisions may be publicly challenged if the longer-term strategy and transfer arrangements do not continue to address and improve poor historic performance	Ensure people using services, their families and representatives are consulted over changes. Performance and commissioning arrangements are robust. Potential benefits of users and carers involvement in governance.
Continuity of care and support to users of the service	Integrated health and social care systems, pathways and signposting to services.	Users are consulted and have opportunities to question new arrangements. Cases are reviewed including risk management to ensure continuity of support.
Safeguarding and statutory responsibilities	Responsibilities are significant and cannot be outsourced so arrangements back at the Council need to be appropriately covered.	Specifically reviewed by the project board and Directorate Management Team to ensure safeguarding and statutory responsibilities are discharged.
Financial risk	The proposed service must operate within existing approved budgets with no greater financial liability arising from the transfer.	The contract performance will continue to be monitored monthly to Adult Social Care Management Team and quarterly to Directorate Management Team.
Staff engagement and safe transfer from Council employment to new provider	Further change and potential disruption to staff leads to lower staff morale.	Open, early and continuing opportunities for staff to be engaged with and informed of changes and the likely impact to their specific job roles. Pension transfer will be addressed.

Risk	Description	Action to avoid or mitigate risk
Delay in implementation or key stages of the project.	The timetable is overtaken by other local priority changes (e.g., acute psychiatric in-patient site; adult social care management changes; new health commissioning arrangements etc.)	Tasks for completion are set out in a detailed Project Plan that this R/A/G rated with clear deadlines for completion of specific tasks and early warning alert and escalate action. Robust governance arrangements.
IT System	Interoperability needs to be achieved of IT systems.	The needs of Mental Health are reflected in the new Social Care System specification.

8. Governance

8.1. A Project Board to oversee Adult Social Care transformation projects, of which this is one workstream, has been established and will meet monthly. This specific workstream will be project managed by the Principal Officer for Mental Health, assisted by the Commissioner for Mental Health. The Project sponsor is the Assistant Director for Adult Social Care. The members of the Project Board are made up of the senior officers of the Council. The Principal Officer for Mental Health will be working with colleagues and specialist leads at the Council and will lead the implementation group who will report to the Project Board on progress against a detailed project plan. The Portfolio Holder will be provided with up-date reports and will review progress with the Director and Assistant Director on a monthly basis.

8.2. Users of services and carers and partner orgaisations have been engaged and briefed on the current Social Work Service on 29 January, 5 March, 29 March and 10 May. There has not been an opportunity to discuss the specific options presented in this report, although users and carers are aware that the current operations are at present considered a short-term interim arrangement. Staff and their managers have been kept informed of the direction of travel and opportunities to discuss options have been provided on 11 May and 21 May 2012.

8.3. Depending which option is agreed, a detailed project plan will include a series of consultation events with staff, user and carers and their representatives and other key stakeholders.

9. Health and Adult Social Care Overview and Scrutiny Committee

9.1 The Committee considered this report on 22 May 2012. The Council's Principal Officer Mental Health introduced the report on options for the future of the adult mental health social care service supported by the Council's Mental Health Social Care Commissioning Manager.

9.2 He explained the background to the decision to take into Council management the adult mental health social work service from KMPT, on the grounds that KMPT did not deliver adequate social care outcomes. He referred to ongoing problems with KMPT since February 2012 and stated that social care staff were still unable to access the KMPT patient information system (RiO). A commitment had been received from the KMPT Chief Executive Officer that access would be available with effect from next Monday. Members requested to be notified in the event that this did not happen.

9.3 Tributes were paid to officers and staff about the way in which the transfer to the Council had been managed and the improvements which were evident as a result. Members felt it was important to ensure some stability for the service before any longer term solution was sought. They felt that any change at this point would be retrograde in that it was too early in the process of improvement for it to be beneficial. The Committee suggested that after a period of twelve months a further report be brought back to them, prior to a Cabinet decision, to look in more depth at options, which should be weighted, in relation to advantages and disadvantages, to allow Members to assess the impact of each option. Officers explained that the interoperability of any IT systems would be vital in the event of any option being considered. A request was made that the report should be explicit as far as risk assessments and necessary control measures for the protection of both employer and employees involved.

9.4 Discussion took place about the recent team activity and Members expressed their thanks to both officers and the staff involved in adult mental health social care for their hard work and dedication. Officers were urged to bring about improvements to the delivery of day care resources.

9.5 It was agreed to recommend Cabinet to agree to option 1 in the report, to retain the service in Council management and to review the matter after a twelve month period, setting out the weightings on the advantages and disadvantages of any options put forward for future delivery of the service.

9.6 The Committee requested that their thanks be passed to relevant officers and staff for their hard work and dedication in making improvements to the service.

10 Director's comments

10.1 The opportunity to debate the options for the future of mental health social care with Councillors at Overview and Scrutiny Committee was most welcome. Officers will work with the team to ensure the service is stabilised and to bring about further improvements to support service users and their families. In addition Officers will jointly work with KMPT to bring about improvements in cooperation for the benefit of service users.

11 Legal and Financial Implications

11.1. **Legal implications**

11.1.1. Equality obligations

When considering making changes to service provision, the decision-maker needs to comply with its obligations as to equalities under the Equality Act 2010. In essence this requires decision-makers to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act;

- Advance equality of opportunity between people who share a protected characteristic and those who do not;

- Foster good relations between people who share a "protected characteristic" and those who do not. (Protected characteristics, as defined in the 2010 Act, are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation).

Having due regard to the above needs involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.

- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.

- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

- In order to comply with its equality duties, the Council is required to engage with service users, representative groups, staff and unions and to use the information and views gathered as a result of such engagement (together with other equality information the Local Authority has) in assessing the equality impact of the proposals.

11.1.2. TUPE

TUPE is the Transfer of Undertakings (Protection of Employment) Regulations 2006 to protect the employment rights of affected staff. This will apply following agreement that the service will transfer to another provider. Early communication, followed by formal consultation with affected staff, will be a key plank of the Council and the new provider Business Transfer Plan. The transfer of pension rights needs to be established.

11.1.3 The Council would have to follow a proper procurement route depending on the option chosen. Detailed procurement and legal advice would be needed at

that stage.

11.2. Financial Implications

11.2.1. The 2012-2013 budget available for an outsourced mental health services is £2,070,000. The proposed service must operate within an approved budget with no financial liability arising from the transfer. It must deliver improved outcomes for service users and carers and ensure the Council's safeguarding responsibilities are discharged.

11.2.2. Council must retain a non-operational budget to ensure it can discharge its statutory duties and commissioning functions. This is currently budgeted, in addition, at £155,000. In addition Council will retain responsibilities for the commissioning of residential care for eligible users.

12. Recommendation

12.1 Cabinet is asked to agree to option 1 in the report, to retain the service in Council management and to review the matter after a twelve month period, setting out the weightings on the advantages and disadvantages of any options put forward for future delivery of the service.

13. Suggested reasons for decision

13.1. This will provide service continuity for a further 12 months prior to a further review of the service.

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Background papers

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BASW (2010) *Policy on Social Work in Multi Disciplinary Mental Health Teams: Executive Summary*

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DH (2008) *Refocusing the Care Programme Approach.*

Henderson G (2012) *Summary Report on Thematic Day: Mental Health in the New Public Health System.*

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Medway Council (2008) Cabinet paper: *Fundamental Review of Mental Health Services*. 6th November 2008.

National Voices (2011) *Integrated care: what do patients, service users and carers want?*

SCIE: Social Care Institute for Excellence (2009) *Think child, think parent, think family: a guide to parental mental health and child welfare.*

SCIE (2012) *Factors that promote and hinder joint and integrated working between health and social care services*. Research Briefing 41.

APPENDIX 1

1. What is a Mutual Organisation? (Kings Fund 2006)

A mutual organisation is an organisational form that can be used to create a social enterprise. There is no single definition of a mutual organisation, but existing Mutuals share a number of common features (see the list below). Mutual organisations have members, rather than shareholders. These members may be the direct beneficiaries of the work of the organisation, such as patient members of a Foundation Trust. Alternatively, members may act on behalf of another group of stakeholders, for example, a mutual may have a small group of members whose job it is to represent the interests of the wider community.

However, not all Mutuals are social enterprises; some may have been created simply to serve the interests of their members with no wider community purpose. In the context of Medway and the options to be considered in relation to the longer-term mental health social care strategy we are interested only in a Mutual that is a Social Enterprise.

Characteristics of mutual organisations are as follows:

- Mutuals are established to serve a specific community or interest group.

- Mutuals are all 'owned' by their members. This ownership is vested in the membership community of each mutual, and is expressed commonly. In other words, no individual can take away their 'share' of the assets. Each generation is a custodian of the organisation for the next. There are no equity shareholders, and Mutuals do not belong to the government.

- Mutuals all operate democratic voting systems, with all members having equal power – one member, one vote.

- Mutuals have governance structures that formally incorporate stakeholder interests, and seek to ensure that these different stakeholders have an appropriate role in running the organisation proportional to their relative stake.

Examples of Mutuals include NHS Foundation Trusts.

2. What is a Social Enterprise?

Social enterprises are businesses that deliver goods and services but in pursuit of primarily social objectives. Surpluses are either reinvested into the business for the benefit of the community, or used to support local community groups, rather than being driven by the need to maximise profit for shareholders. Social Enterprises are co-owned organisations that give staff the opportunity to become shareholders with associated voting rights. Shareholding does not involve any profit share scheme. Shareholders may be voted onto the 'elected member's forum' which acts as the voice for all staff. The government is committed to supporting social enterprise in the economy at large and has suggested that social enterprise models of service delivery can be part of the provider market in primary and community care.

Local examples include Sunlight, a Community Development Trust, consisting of Sunlight Development Trust and Sunlight Social Enterprises, a Community Interest Company; and Medway Community Healthcare (MCH - a healthcare provider).

3. Open Market Tender

This is the process by which contracts to provide services are publicly advertised by organisations seeking to commission products or services through a procurement process. The process is regulated by European Union rules and regulations that Councils and other authorities are required to follow.