Author/Lead Officer of Report: Melanie Hall, Commissioning Manager Mental Health

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Report of:	Laraine Manley, Executive Director Communities
Report to:	The Leader
Date of Decision:	25th October 2016
Subject:	Future Commissioning of Mental Health Services

Is this a Key Decision? If Yes, reason Key Decision:-	Yes	✓	No	
- Expenditure and/or savings over £500,000		✓		
- Affects 2 or more Wards				

Which Cabinet Member Portfolio does this relate to? Cllr Cate MacDonald, Cabinet Member for Health and Social Care

Which Scrutiny and Policy Development Committee does this relate to? Healthier Communities & Adult Social Care

Has an Equality Impact Assessment (EIA) been undertaken?	Yes	✓	No	

If YES, what EIA reference number has it been given? *(Insert reference number)*

Does the report contain confidential or exempt information?	Yes	✓	No	

If YES, give details as to whether the exemption applies to the full report / part of the report and/or appendices and complete below:-

Appendix E is not for publication because it contains exempt information under Paragraph 3 of Schedule 12A of the Local Government Act 1972 (as amended).

Purpose of Report:

There have been significant changes within the health and social care landscape, nationally and locally. Many of these changes are not reflected in the current arrangements for mental health services with Sheffield Health and Social Care NHS Foundation Trust (SHSC) and a new arrangement that reflects the changed landscape is now required.

The current arrangement for the provision of mental health services with SHSC, which is under section 75 NHS Act 2006, will expire on the 31st October 2016. This Report sets out the recommendation for the provision of the services from 1st November.

Recommendations:

The Leader is recommended to:

- Allow the current Section 75 Agreement between the Council and SHSC to expire at the end of October 2016.
- Agree to enter into 4 new contracts for services with SHSC for delivery of mental health services from 1st November 2016 until 31st March 2017
- Agree that the Council will supply staff to SHSC for delivery of the mental health services commissioned by the Sheffield Clinical Commissioning Group under an agreement for the supply of staff and under robust secondment agreements between Sheffield City Council, SHSC and the relevant employees.
- Delegate authority to the Director of Commissioning, Communities in consultation with the Director of Finance and Commercial Services and the Director of Legal Services to agree the terms of and award the contracts for services including the distribution of the allocated funding across the 4 services.
- Delegate authority to the Director of Commissioning, Communities in consultation with the Director of Finance and Commercial Services, Director of Human Resources and the Director of Legal Services to agree the terms of and enter into the agreement for the supply of staff with SHSC and the secondment agreements.
- Delegate authority to the Chief Property Officer, in consultation with the Director of Commissioning, Communities and the Director of Legal Services to agree arrangements in relation to premises at Wainwright Crescent and Pitsmoor Road.

Background Papers:

Not applicable

<table>
<tr><td colspan="3">Lead Officer to complete:-</td></tr>
<tr><td rowspan="4">1</td><td rowspan="3">I have consulted the relevant departments in respect of any relevant implications indicated on the Statutory and Council Policy Checklist, and comments have been incorporated / additional forms completed / EIA completed, where required.</td><td>Finance: Jane Wilby</td></tr>
<tr><td>Legal: Sarah Bennett</td></tr>
<tr><td>Equalities: Simon Richards</td></tr>
<tr><td colspan="2">Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.</td></tr>
<tr><td>2</td><td>EMT member who approved submission:</td><td>Larraine Manley</td></tr>
<tr><td>3</td><td>Cabinet Member consulted:</td><td>Cate McDonald</td></tr>
<tr><td rowspan="3">4</td><td colspan="2">I confirm that all necessary approval has been obtained in respect of the implications indicated on the Statutory and Council Policy Checklist and that the report has been approved for submission to the Decision Maker by the EMT member indicated at 2. In addition, any additional forms have been completed and signed off as required at 1.</td></tr>
<tr><td>Lead Officer Name:
Joe Fowler</td><td>Job Title:
Director of Adult social care Commissioning</td></tr>
<tr><td colspan="2">Date: 26th September 2016</td></tr>
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1. PROPOSAL

1.1. The current agreement with Sheffield Health and Social Care Foundation Trust (SHSC) was refreshed in 2008. However, there have been many changes in the health and social care landscape since that review including, new strategies; changes to legislation; revised structures for statutory bodies; reduced funding; and developments in practice. Some of the key changes are set out in Appendix A.

1.2. The Council has also worked with partners across the health and care system, and with the public and service users, to develop new strategies and approaches in relation to mental health and wellbeing. A short summary of the strategic context for this proposal is provided at Appendix B along with some of the headline messages from a recent mental health needs assessment.

1.3. This paper proposes that we recognise the changes in context discussed above and move to some new interim arrangements between Sheffield City Council and SHSC. The current and future arrangements are set out below.

Current arrangements

1.4. The mental health social care services commissioned by the Council are predominantly delivered through a Section 75 Partnership Agreement with SHSC (the "Section 75 Agreement"). The Section 75 Agreement was initially created and agreed in 2003. It was refreshed in 2008.

1.5. Under the agreement, SHSC agree to discharge the Council's statutory duties relating to mental health. The agreement also sets out resources SHSC can utilise to achieve this. This arrangement allows the pooling of resources. Operationally this means:

- Council social care employees are embedded within SHSC where they work alongside health staff. Social workers can be supervised and managed by health staff and vice versa. This is set out in the current staff secondment arrangements
- Health staff carry out social care activity (i.e. social care assessment) and Council employees carry out health work (i.e. assessing mental health needs of people who may not meet social care eligibility criteria)
- Council employees can be responsible for the co-ordination of health related interventions – e.g. making referrals to psychology as well as social care provision. This means that a person has one assessment and one jointly developed care plan across their health and social care provision

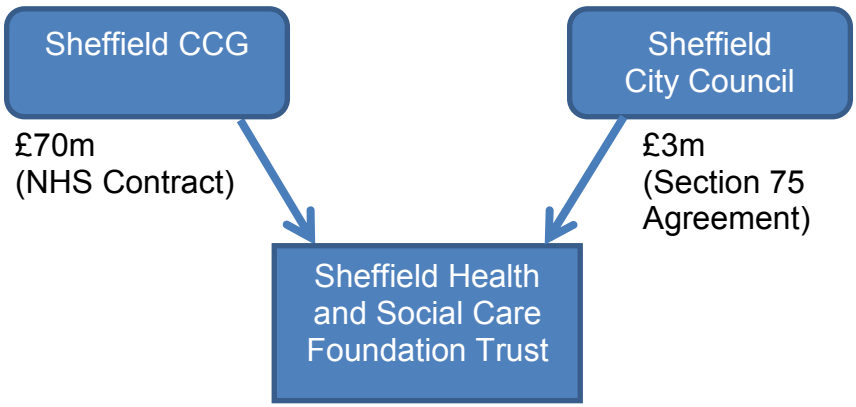
1.6. Since 2008, some elements of service have been removed from the Section 75 Agreement. For example, Hurfield View Dementia Resource Centre was removed from the Section 75 agreement in October 2015 and Supporting People 'Floating Support' was removed from the Section 75 Agreement in early 2016. This reflects the requirement for social care service provision to be subject to commercial procurement. This has also meant that SHSC has needed to compete with other providers to retain existing contracts.

1.7. The Agreement has also been used as a framework for pilots and one off programmes of work (e.g. mental health support for Building Successful Families).

1.8. As a result of the changes the Section 75 Agreement only now covers seconded staff (approx. £2.3m), management costs and some minor service delivery arrangements.

1.9. Figure A below shows a simplified view of the commissioning of mental health services across Sheffield City Council, Sheffield Clinical Commissioning Group, and SHSC.

Figure A Current Arrangements (simplified)



1.10. Officers within the Council and SHSC are of the view that the Section 75 Agreement is no longer the best mechanism for defining arrangements between Sheffield City Council and SHSC in relation to the delivery of mental health services. The Agreement is out-dated, focused on activity not outcomes, and does not reflect the major changes to the health and care landscape of the last few years, nor our ambitions going forward.

1.11. A brief analysis of the strengths and weaknesses of the current arrangements and an illustrative case study is included at Appendix C.

1.12. There is now significant planning being carried out between the Council, Sheffield Clinical Commissioning Group and SHSC on the future of mental health services in the city. This includes the development of a joint medium-term plan for mental health that will be taken through the formal governance arrangements of the Council and CCG.

1.13. However, we cannot continue to extend arrangements that are not fit for purpose whilst we get clarity on medium-term plans and arrangements.

Proposed Arrangements for 1st November and Future Plans

1.14. It is proposed that from 1st November 2016 the Council enters into 4 separate contracts for services with SHSC for the following mental health services:

- **Assessment and Care Management services** including substance and abuse, assessment and care management, and the Approved Mental Health Practitioners service.
- Section 117 **Reviewing Officer** Service
- **Recovery Education Programme** (STEPS)
- Building Successful Families

1.15. It is proposed that all of the contracts are awarded until **31st March 2017**.

1.16. The Section 117 Reviewing Officer Service is likely to continue beyond 31st March 2018. However, there will be an on-going need for the Assessment and Care Management services and potentially for the other two services as well, dependent on funding. Options for delivery of services in the future, including the potential for joint commissioning with the Sheffield Clinical Commissioning Group (CCG), continue to be explored, and a further report will be brought forward in due course as referenced at 1.12.

1.17. The Assessment and Care Management services and the Section 117 Reviewing Officer Service are currently provided by SHSC with employees provided by the Council 'free of charge'. The Council also provides 10 FTE employees with whom SHSC deliver services to the CCG. SHSC are invoiced for the cost of these employees. It is proposed to continue these arrangements.

1.18. The remaining services currently covered by the current Section 75 Agreement is the provision of 3 beds at Wainwright Crescent that provide accommodation that acts as a transition for service users between a hospital stay and a return to their own home. This kind of provision is primarily commissioned by the CCG and the Council funded beds are not required. Discussions about the future use of the building are being held with the CCG and SHSC and the Leader is asked to delegate authority to make the final decision regarding this building to the Chief Property Officer.

2. HOW DOES THIS DECISION CONTRIBUTE ?

2.1. The proposal puts the current arrangements onto a firm contractual and legal footing, without disrupting the delivery of services and support to people struggling with their mental wellbeing

2.2. The short-term nature of the proposal also gives the Council maximum flexibility as to how it commissions and delivers mental health services in the medium-term.

3. HAS THERE BEEN ANY CONSULTATION?

3.1. Not applicable.

4. RISK ANALYSIS AND IMPLICATIONS OF THE DECISION

Equality of Opportunity Implications

4.1. The EIA indicates there are no significant equalities implications (Appendix D).

Financial and Commercial Implications

4.2. The costs of the services is included at Appendix E.

4.3. The direction of travel for services post April 1st 2017 will be set out in the Future Mental Health Commissioning Strategy. The preferred option is to collaborate with the CCG within pooled budget arrangements through the Better Care Fund as an Associate Member to the agreement. A final recommendation on this will be confirmed early in 2017.

4.4. If the Council has to re-procure these services independently of the CCG then this would need to commence immediately and in line with the Public Contracts Regulations 2015. Consideration would in this case need to be given to any associated impacts for these interim arrangements to allow sufficient time for the re-procurement to take place.

Legal Implications

4.5. The Council has a number of powers and duties relating to mental health social care services under the Mental Health Act 1983, Mental Capacity Act 2005 and the Care Act 2014. In addition the Care Act 2014 provides the legal frame work against which care services must be provided.

4.6. Under the 2014 Act a local authority must exercise its functions with a view to ensuring the integration of care and support provision with health provision and health-related provision where it considers that this would—

(a) promote the well-being of adults in its area with needs for care and support and the well-being of carers in its area;

(b) contribute to the prevention or delay of the development by adults in its area of needs for care and support or the development;

(c) by carers in its area of needs for support, or

(d) improve the quality of care and support for adults, and of support for carers, provided in its area (including the outcomes that are achieved from such provision).

4.7. The existing arrangements for the integration of care and support currently take place under a 'Section 75 Agreement' (under s75 National Health Service Act 2006). Under the Agreement SHSC discharge the Council's statutory duties. This report highlights and sets out the way in which new legislation has been introduced and how the landscape has changed which requires changes to the way that the Council ensures that their statutory obligations are met.

4.8. The proposal to end the current arrangement and to enter into new arrangements (4 new contracts) will continue to ensure integration and to ensure that the Council meets its statutory duties.

4.9. The services that are the subject of this Report are social care services covered by the "light touch" regime set out in the Public Contracts Regulations 2015. The value of each of the proposed contracts is below the threshold set out in those Regulations, although the Council does have a duty to act in accordance with its general European Treaty principles.

Human Resources Implications

4.10. The secondment arrangement for each of the Council employees to be seconded to SHSC would need to be set up as a standalone secondment agreement, supported by a supply agreement between the Council and SHSC.

4.11. This arrangement will strengthen the alignment between seconded staff and social care more widely as well as setting out agreed standards of practice.

4.12. The secondment agreement will clearly define expectations of both the Council and SHSC in relation to the management of Council employees and will clarify the terms and conditions of employment during the secondment period.

4.13. The supply agreement will include the working arrangements for managing the secondees and the monitoring, standards and governance for the secondment. An operational protocol, which will be a schedule of the supply agreement, will further specify the individual and joint responsibilities between the Council and SHSC managers for managing the secondees. It is proposed that the secondment agreements and supply agreement would commence on 1st November 2016 for 24months ending on 31 March 2018 with a break point at 31 March 2017 and an ability to terminate in the event that the contract for services come to an end. This will provide the Council with flexibility going forward.

4.14. The new working arrangements and expectations would help Council staff to feel more in touch with the Council as their employer and help to ensure consistent standards across social care.

4.15. The new secondment arrangement would need to set out transparent costs and budgets – this could lead to some upwards pressure on existing budgets as SHSC are likely to argue that the overheads of staff management are currently not met in full.

4.16. The approver of Approved Mental Health Practitioners (AMHPs) must be the Local Authority. The Mental Health Act requires AMHPs to be employed whilst they carry out their duties, and the Local Authority holds the Vicarious Liability for those staff.

4.17. At present the Council does not employ full time stand-alone AMHPs. Instead the AMHP duties form part of the wider duties undertaken by certain employees including some of those seconded to SHSC. The majority of employees who carry out AMHPs duties are seconded to SHSC.

Other Implications - Property

4.18. SHSC have informally indicated they wish to retain occupation of two properties, Pitsmoor Road (used for delivery of the Recovery Education Programme - STEPS) and Wainwright Crescent.

4.19. Under the current arrangements for the Pitsmoor Road building SHSC must repair the building so that it is returned to the Council in the same condition as it was provided to them. SHSC pay no rent for occupation of the premises. It is proposed that this arrangement continues with the new arrangement being co-terminus with the service contract for the STEPS service.

4.20. It is not proposed to renew the service currently provided to the Council from the Wainwright Crescent building. However, SHSC also deliver services to the CCG from this building and have expressed interest in retaining an interest in the building to facilitate continuity in the provision of this service. Under the current arrangements for the Wainwright Crescent premises SHSC must repair the building so that it is returned to the Council in the same condition as it was provided to them. SHSC pay no rent for occupation of the premises. It is proposed that this arrangement continues with the new arrangement being entered into for 6 months.

4.21. The Leader is asked to delegate authority to make the final decision regarding the specific arrangements for these two buildings to the Chief Property Officer.

5. ALTERNATIVE OPTIONS CONSIDERED

Continue the Section 75 agreement with SHSC

5.1. This option was discounted as SHSC are not willing to agree to the extension of the current Section 75 Agreement and are looking for an arrangement that offers greater certainty.

Complete the termination of Section 75 agreement with SHSC and manage the legal duties and staff within SCC

5.2. It would be possible for the mental health services to be delivered in-house. However, this would require careful transition alongside a review of service delivery to minimise disruption to customers and to prepare staff for changes to management, practice and environment. It is anticipated that this would take more than 12 months to complete.

5.3. If SCC staff were removed from the integrated teams, this would create increased demand on Health staff, requiring extra resources from Sheffield CCG. This may not be in the interest of the wider health and social care economy or foster a continued positive relationship with Sheffield CCG. Given these dis-benefits and the converse benefits of integration with the health sector already identified in this Report, it is not felt that this option would improve the customer journey or offer opportunities for improved outcomes in the short- or medium-term.

5.4. This option was therefore discounted due to national and local commitments to integrated health and social care services and wish to avoid the duplication of assessment and care management activity. However, the proposed arrangement does allow for this option to be considered in the future.

6. REASONS FOR RECOMMENDATIONS

6.1. It is recommended that new contact arrangements with SHSC are put in place to enable the continued delivery of integrated health and social provision as described in the proposals above, including the supply of SCC staff.

6.2. The intended outcomes for service users are

- No disruption / delayed transfer of care out of hospital.
- A named worker who can manage both health and social care arrangements
- Continued single assessment and care planning across health and social care

6.3. The intended outcomes for staff

- Clear roles and responsibly from their employer (SCC) and host (SHSC)

6.4. The intended outcomes for both organisations

- Clear partnership working with contractual arrangements
- Transparent cost breakdowns for each organisations
- Enable each organisation to deliver strategic priorities

Appendix A – Changes to Legislative and Policy Context

Health and Social Care Act 2012

The Health and Social Care Act brought in considerable changes to the structures of health and social care commissioning, purchasing, delivery and where key functions were placed. The two main aims were:

- modernisation - This has led to changes including payment by results in adult mental health based on a clustering tool to pay day rates for episodes of care on an individual basis
- placing clinicians at the centre of commissioning, freeing up providers to innovate, empowering patients and giving a new focus to public health - This has led to changes including Personal Health budgets which can be integrated with social care.

As a result of the Act the PCT (Primary Care Trust) was replaced by a Clinical Commissioning Group, which has a different structure and different governance and commissioning arrangements.

Mental Capacity Deprivation of Liberty Safeguards (MCA DOLS)

Amendments to the Mental Capacity Act 2005 and subsequent Court judgments have increased the activities required as part of assessment and care management.

Care Act 2014

This Act describes new approaches to assessment and care management and brings in national eligibility criteria for social care. Information systems, policy and practice have changed significantly to meet duties placed on the Council.

NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (2015 Amendment)

This amendment extended the permitted scope of partnership arrangements between local authorities and health bodies to NHS England's primary medical care functions.

Better Care Fund

Government have set out a shared vision of integrated health and social care and the shared commitment to pooling resources in a Better Care Fund.

Sheffield Health and Social Care Trust awarded Foundation Trust Status

Foundation Trust status gave SHSC greater independence as a 'public benefit' company. The Trust can now, for example, generate a surplus to reinvest in other services.

Cluster payment, Personal Health Budgets, and Personal Care Budgets

In line with a National directive the Clinical Commissioning Group is moving to payment and contracting arrangements for mental health services based on nationally defined **mental health care 'clusters'**. There are 21 'clusters' – groupings of service users with similar needs and problem severities. This 'clustering' is being used to standardise levels of care *and* payments for care. Over the next year, payment for mental health services in Sheffield will increasingly move towards payment by 'cluster' and away from 'block payments'.

Personal health budgets were piloted and evaluated in a number of areas between 2009 and 2012. People in receipt of NHS continuing healthcare and children receiving continuing care now have the right to have one. The NHS Mandate states that from April 2015, people with long-term conditions who could benefit should have the option of a personal health budget. This is reinforced by NHS England's 2015/16 planning guidance, which sets expectations that: clinical commissioning groups (CCGs) lead a major expansion in 2015/16 in the offer and delivery of personal health budgets to people where evidence indicates they could benefit.

Some areas have already linked 'clusters' and personal health budgets –using the agreed cluster rate as the indicative personal health budget (which is then finalised based on an agreed care plan).

Over the last 5 years in Sheffield, there has been significant take-up of **personal budgets** for people with eligible social care needs relating to their mental health. Sheffield now has around 700 mental health clients (under 65) using a direct payment to arrange some or all of their own care and support.

Sheffield is also starting to make greater use of '**individual service funds**' – where a support provider works flexibly with an individual and an individual *social care* budget. This approach is being used to support people to achieve greater independence and wellbeing – with the support provider using the budget flexibly to arrange intensive and tailored recovery support at the right time for each individual. A similar approach is also being used by SHSC in partnership with South Yorkshire Housing Association – with intensive support being provided to help people with a history of serious mental illness to move from health care settings into their own tenancies in the community.

Appendix B – Local Strategic Context, Needs Assessment, Commissioning Intentions

Local Strategic Context

Sheffield now has a shared mental health strategy which aligns with the National Mental Health strategy, the Health and Wellbeing Strategy and the Council's Corporate Plan. All of which aim to:

- Promote good physical and mental health and wellbeing
- Reduce physical and mental health inequalities
- Reduce levels of ill-health

The Mental Health Strategy has the following specific priorities:

- Parity of Esteem – Equal emphasis on physical and mental health
- Promote Prevention
- Promote Mental Wellbeing
- Appropriate Response in a Crisis
- Accessible care when needed
- Seamless integrated Services

Sheffield is actively pursuing a *neighbourhood approach* to early intervention and prevention. The next few years will increasingly see local partnerships of community organisations, primary care, and statutory services working together to deliver more targeted prevention work and support – helping more people to maintain or regain their physical and emotional wellbeing.

This more integrated local approach provides a significant opportunity to consider mental and physical health together (*parity of esteem*), and provide *seamless integrated services* and support for people who are finding it difficult to live independently, safely, and well.

Mental Health services have led the way in the development and delivery of integrated health and care arrangements, which provide a more seamless, consistent service for people that need care and support. Our preference is to make sure that support continues to be person-centred.

Headline messages from needs assessment

The needs of Sheffield people are captured in the mental health needs assessment completed by Sheffield Public Health in 2015. Some key findings from the needs assessment are set out below.

Nearly 1 in 5 adults in Sheffield suffer from common mental health problems (anxiety and depression). Estimated prevalence of psychosis amongst adults in Sheffield is 40 per 10,000 adults (just over 2,000 people). Around 1 in 10 children and young people are estimated to have diagnosable mental health disorders in Sheffield.

Prevalence estimates vary between socio-demographic groups and therefore between different areas of the city. Prevalance of mental illness in Manor and Castle is estimated to be 60 – 70% higher than in Fulwood.

In Sheffield, nearly 1,200 people are being treated under the 'Care Programme Approach' within secondary mental health services (i.e. with a serious mental illness). This is below comparable areas. A little under 5,000 people are categorised as having a significant mental illness by Sheffield GPs.

On average, 38 people committed suicide each year in Sheffield (2008-13). This is lower than the England average. Over three-quarters of suicides in Sheffield were men (generally in mid-life). This is in line with the national picture. Depression was cited in 40% of suicides.

In Sheffield, people with severe mental illness are over 3.5 times more likely to die early. Liver disease and respiratory illnesses accounts for most of this health inequality. People with mental illness stay in hospital being treated for physical health conditions significantly longer than the general population. It is estimated that investment in specialist mental health support in hospitals produces a 4 to 1 return on investment (due to reduced secondary health care costs).

People with poor mental health 'self-medicate' with alcohol and smoking – often because they believe it helps them cope with stress and anxiety. However, the evidence shows that alcohol and smoking generally have the opposite effect, and have a significant negative impact on physical health. Stopping smoking has been shown to be at least as effective at alleviating mood and anxiety disorders as anti-depressants.

Poor mental health costs Britain £70 billion a year through productivity losses, higher benefit payments and the increased cost to the NHS. Mental health problems are the cause of 40% of new disability benefit claims each year nationally. Nationally only 10-16% of people with mental health conditions, excluding depression, are in employment. However, 86% - 90% want to work. Employment is also recognises as a key protective factor for peoples mental wellbeing.

Estimates of the cost of mental disorder in Sheffield are over £1.2bn. This is broken down below.

Mental Disorder Annual estimated cost in Sheffield	**(£m)**
Depression	82
Anxiety disorders	97
Psychosis	71
Dementia	139
Personality disorder	85
Alcohol misuse	207
Smoking	155
Class A	196
Medically unexplained symptoms	186
Total	**1,218**

Data from Sheffield Mental Health Needs Assessment 2015

Compared to other cities, NHS expenditure rates on mental disorders in Sheffield are:

- High on care provided in other settings
- Mid-range on primary prescribing, community care and health-related social and secondary care
- Low on primary care, non-health-related social care and prevention / health promotion for people with mental disorder

Social care investment in mental health services for adults (18 – 65) is amongst the lowest amongst comparable cities. The proportion of the social care budget spent on mental health for adults is also relatively low.

Analysis of health spend also suggests that levels of investment are not correlated with deprivation as would be expected given the close association between deprivation and mental illness, and the level of health inequalities in Sheffield.

The facts above, and the more in depth needs analysis from which they are drawn, highlights how interconnected mental and physical health services are with each other and with wider 'social care' and public health programmes (e.g. smoking cessation). The data also shows that we have more to do to move investment into preventative services, and more to do to target investment at those who need it most.

Mental Health Commissioning Intention

Analysis of the current arrangements, the mental health needs of the population, and the national and local direction of travel, have led to a draft set of commissioning intentions that are currently being considered by the Council and the Clinical Commissioning Group.

- **Strengthening support in the wider health system for people with mental health problems** who tend to (a) have more negative experiences and outcomes when they receive health care; *and,* (b) place a disproportionate level of demand on general health services (for example mental health liaison).

- **Supporting more people with mental ill-health into less restrictive care settings;** including people currently in NHS England funded specialist care placements

- Improve the city's response to mental health **Crisis Care.**

- **Build the capacity and capability of primary care** and universal services to support more people with Mental Health in their community and improve preventative outcomes (including IAPT).

- Give more people choice and control over the support they get from for the mental – including a NHS-funded roll-out of **Personal Health Budgets** as a mechanism and enabler for individuals to achieve better health outcomes.

- **Continue to develop acute mental health care services** including developing services aimed at addressing the specific needs of those with a personality disorder

- Improve access times and the availability of **eating disorder services** across the City.

- Develop a coherent **accommodation strategy** to ensure there are viable alternatives to residential and nursing care homes.

Appendix C – Strengths and Weaknesses of Current Arrangements

Strengths	Weaknesses
• Pooling of resources (staff and buildings) allows flexibility for service delivery and monitoring • Joined up health and social care assessment and care planning – improved customer experience • Few delays in discharge from acute mental health and Drug and Alcohol rehab services due to joined up arrangements • 13 years of partnership and learning from experience	• Relatively low investment in preventative services • Investment not focused on those that need it most • Current arrangements are not outcomes-focused • Commissioning tensions and bureaucracy working against delivery of outcomes • Limited ability for SCC to control purchasing budget spend • Commissioning of mental health not integrated with Council commissioning of other services for vulnerable adults • SCC staff feel isolated from SCC as their employer • The partnership does not manage potential conflicts of interest (support planning and direct service provision)
Opportunities	**Threats**
• Flexible contracting for pilots • Further integration of health and social care assessment and care management for other client groups – including vulnerable adults outside mental health services • Integrated primary care, community mental health teams, and social care in localities	• Austerity drives further tensions between commissioners and providers as resources tighten – particularly for SCC forcing reductions in preventative services • SHSC are 100% shareholder in care provider organisation – potential for conflict of interest • Lack of transparency of costs leads to relationship breakdown • Failure to prioritise across health and care (reduced ability to deliver aims strategic aims) • Potential breach of TUPE transfer regulations due to length of secondment

It is worth illustrating the SWOT analysis with a case study.

Over the last 5 years we have seen a steady movement of people out of health funded services into social care funded provision. This is a major positive as it means that more people are being supported in less restrictive settings.

These achievements have not only transformed lives, they have enabled health services to achieve government set efficiency targets (CQUIN). However, the transfer of costs has put a pressure on social care budgets that are already under pressure as a result of Government funding cuts. This has led to reductions in social care support, and has meant savings have had to be made from other Council services.

Two years' ago, SHSC were directly incentivised by Sheffield CCG to increase activity in this area and, over the last year, this has led to the transfer of further budgetary pressure onto Council budgets.

Whilst collaborative working between the Council, Sheffield CCG, and SHSC should mean that the impact of this shunting of costs between organisations will be mitigated

in the medium-term, it demonstrates the importance of having joined-up operational and financial arrangements for mental health services and social care – particularly when people living more fulfilling and independent lives is such a key priority.

Appendix D

Sheffield City Council Equality Impact Assessment

Name of policy/project/decision: Future Commissioning of Statutory Mental health services
Status of policy/project/decision: Requires Cabinet approval

Name of person(s) writing EIA: Dave Luck/ Melanie Hall

Date: 14/12/15 **Service:** Commissioning Services (Adult mental health)

Portfolio: Communities

What are the brief aims of the policy/project/decision?

Proposal

The Council's Section 75 partnership agreement with the Sheffield Health and Social Care Trust (SHSC) is coming to an end. The Section 75 agreement has been the arrangement by which SHSC has delivered mental health social care on behalf of the Council.

The report looks at the options for the future delivery of these services within the context of Sheffield's needs and local and national policy. It recommends a new Section 75 agreement with the Sheffield Clinical Commissioning Group (CCG) to jointly commission services.

Background

The Section 75 Partnership agreement between Sheffield City Council and Sheffield health and Social Care Trust was initially created and agreed in 2003. It was refreshed in 2008. Since that time there have been many national and local changes within the health and social care landscape which have not been reflected in the partnership agreement. The current agreement and arrangements terminate in April 2016. The end of the agreement provides an opportunity to review the mechanism by which services are delivered.

There are a number of changes in local and national policy, which promote the greater integration of health and social care services. These include:

- The 2012 Health and Social Care Trust, which replaced Primary Care Trusts with Clinical Commissioning Groups and placed health practitioners at the centre of commissioning
- The introduction of the Better Care Fund arising from the government's ambition for greater integration of health and social care
- The development of a shared mental health for Sheffield

What will the changes mean?

The changes will not have an immediate effect on the services offered to service users. Rather, the changes will affect the arrangements through which services are commissioned.

The changes will increase the scope for future efficiency and the development of best practice by working alongside the CCG. As a partner with the CCG the Council will have increased access to information to shape future services.
Within the new section 75 arrangement with the CCG and contract agreement with SHSC the Council will ensure it takes the opportunity to address key requirements including information sharing, meeting the accessible information standard and all other equalities legislation.

Further EIA's will be submitted if required as a result of implementing any new agreement.

Are there any potential Council staffing implications, include workforce diversity? NO

There are no perceived equalities implications related to the proposals related to employees

Under the Public Sector Equality Duty, we have to pay due regard to: "Eliminate discrimination, harassment and victimisation, advance equality of opportunity and foster good relations." More information is available on the council website

Areas of possible impact	**Impact**	**Impact level**	**Explanation and evidence (Details of data, reports, feedback or consultations. This should be proportionate to the impact.)**
Age	-Select-	-Select-	The proposed change in how services are provided continues the multi-disciplinary approach where service users only have to deal with a single assessment process. The recommendation will safeguard this approach.
Disability	Positive	Low	**The Section 75 agreement has been the arrangement by which SHSC has delivered mental health social care on behalf of the Council**. The proposed change in how services are provided continues the multi-disciplinary approach where service users only have to deal with a single assessment process. The recommendation will safeguard this approach.
Pregnancy/maternity	-Select-	-Select-	The proposed change in how services are provided continues the multi-disciplinary approach where service users only have to deal with a single assessment process. The recommendation will safeguard this approach.
Race	-Select-	Low	The proposed change in how services are provided continues the multi-disciplinary approach where service

Areas of possible impact	Impact	Impact level	Explanation and evidence (Details of data, reports, feedback or consultations. This should be proportionate to the impact.)
			users only have to deal with a single assessment process. The recommendation will safeguard this approach.
Religion/belief	-Select-	Low	The proposed change in how services are provided continues the multi-disciplinary approach where service users only have to deal with a single assessment process. The recommendation will safeguard this approach.
Sex	-Select-	Low	The proposed change in how services are provided continues the multi-disciplinary approach where service users only have to deal with a single assessment process. The recommendation will safeguard this approach.
Sexual orientation	-Select-	Low	The proposed change in how services are provided continues the multi-disciplinary approach where service users only have to deal with a single assessment process. The recommendation will safeguard this approach.
Transgender	-Select-	-Select-	The proposed change in how services are provided continues the multi-disciplinary approach where service users only have to deal with a single assessment process. The recommendation will safeguard this approach.
Carers	-Select-	Low	The proposed change in how services are provided continues the multi-disciplinary approach where service users only have to deal with a single assessment process. The recommendation will safeguard this approach.
Voluntary, community & faith sector	-Select-	Low	VCF organisations are not expected to be affected by this change
Financial inclusion, poverty, social justice:	-Select-	Low	N/A
Cohesion:	-Select-	-Select-	N/A
Other/additional:	-Select-	Low	

Overall summary of possible impact (to be used on EMT, cabinet reports etc):

Future Commissioning of Mental Health Services

The recommended proposal to enter into a new Section 75 agreement to jointly commission services with SCCG will ensure customers continue to receive integrated mental health services.

If you have identified significant change, med or high negative outcomes or for example the impact is on specialist provision relating to the groups above, or there is cumulative impact you **must** complete the action plan.

Review date: **Q Tier Ref** **Reference number:**

Entered on Qtier: -Select- **Action plan needed**: yes

Approved (Lead Manager **Date: Approved (EIA Lead person for Portfolio):**

Date:

Does the proposal/ decision impact on or relate to specialist provision: yes

Risk rating: low

Approved (Lead Manager): Date:

Approved (EIA Lead Officer for Portfolio): Date:

Action plan

Area of impact	**Action and mitigation**	**Lead, timescale and how it will be monitored/reviewed**
All groups, in particular disability (mental health)	Within the new section 75 arrangement with the CCG and contract agreement with SHSC the Council will ensure it takes the opportunity to address key requirements including information sharing, meeting the accessible information standard and all other equalities legislation.	Melanie Hall, Commissioning To be reviewed alongside completion of new agreement
All groups, in particular disability (mental health)	Further EIA's will be submitted if required as a result of implementing any new agreement.	Melanie Hall, Commissioning To be reviewed alongside completion of new agreement

1.2

Appendix E

Commissioned Services:	**SCC 5 Month Commitment***
	£
1. Assessment & Care Management Service	-
2. STEPS	-
3. S117 Reviewer Service	-
4. Building Successful Families	-
TOTAL COMMISSIONED SERVICES	**379,349**
SCC liability Seconded Staff costs **	989,010
TOTAL SERVICE COSTS	**1,368,358**
BUDGET ENVELOPE	**1,368,358**

* Demonstrates the commitment to SCC for the remainder of the financial year

** Seconded staff to deliver provision of service remain liability of SCC and do not form part of contract value