

Personalisation in Mental Health

by Simon Duffy

Published by the Centre for Welfare Reform in association with Yorkshire and Humberside Improvement Partnership, Care Pathways and Packages Project & Association of Directors of Adult Social Services



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A model for the integration of health and
social care mental health services



by **Simon Duffy**



About the author

Simon Duffy



Simon is Director of the Centre for Welfare Reform. He developed the concepts of an Individual Budget and Self-Directed Support and has been active in promoting shifts in power and control towards citizens and families since beginning work in public services in 1990. As a Harkness Fellow he studied welfare reform and inclusive education. He founded and led Inclusion Glasgow and In Control and is the author of Keys to Citizenship. In 2008 he was awarded the RSA's Prince Albert Medal for his work on personalisation. He has a PhD in moral philosophy and continues to work on applying principles of social justice to the organisation of the welfare state. He lives in Sheffield with his wife Nicola and their son Jacob. He loves skiing, windsurfing and trying to learn Latin.



About the illustrations

The artwork has been created by members of the Artists in Mind project in Kirklees. Artists in Mind harnesses the positive benefits of creativity to support people experiencing acute and enduring mental health problems. www.artists-in-mind.org.uk

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Preface

The advent of personalisation offers local authorities and the NHS a golden opportunity to rethink our whole approach to supporting people who face mental health problems. In the future we expect to see people and their families taking much more control over their own support and treatment options. We also expect to see new levels of partnership and collaboration between citizens and professionals.

Mental health is complex and we do not always understand the causes of mental illness or the factors that support recovery or good mental health. However we are clear that the on-going effort to better understand and improve mental health will be supported by a shift towards personalisation:

- To tailor our support and services to fit the specific needs of the individual
- To respect the real and vital relationships the person has with families and friends
- To support people to take more control over their lives and their supports
- To enable people to define the outcomes that are important to them
- To improve the responsiveness and flexibility of our services and supports
- To better involve communities and all stakeholders

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We have been really excited and heartened by the emerging desire for a new integrated approach to mental health in Yorkshire & Humber - what we call the Personalisation Model. We are already pioneering exciting work. The Care Pathways & Package Project, in developing currencies for mental health services, is helping us to better understand how to ensure people

get the right support for their needs. There has also been good progress in transforming adult social care, using individual budgets and self-directed support to enable more people to take control - in whichever way works for them. By combining these two approaches, as we now intend to do, we will be able to become even more effective.

We do not under-estimate the challenges ahead. This paper offers templates for the design of the new model, but the real work begins when we have to implement, test and refine this model - to make sure that it really works for all the citizens we are here to serve. But we are committed to supporting these changes, to learning together and to ensuring that we keep the real experience of people with mental health problems at the heart of all our work.

We endorse the approaches outlined within this paper and the sharing of the learning that will come from their implementation, testing and improvement in the months and years ahead.

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Jonathan Phillips, Director, Adults, Health and Social Care,
Calderdale Council and ADASS Regional Lead for Mental Health

Steven Michael, Chief Executive of the
South West Yorkshire Partnership Foundation Trust

May 2010

Executive summary

This paper sets out a model for a new way of working to support people with mental health problems. We call this new model the Personalisation Model because it is designed to ensure that people get the most appropriate and effective support to meet their needs, but also that they increasingly get the opportunity to shape and control that support.

Designing the Personalisation Model

The Personalisation Model is based upon our analysis of current best practice by services and practitioners and the policy imperatives from people who use mental health services and from national policy-makers. We believe that there is a better way forward, and one that can bridge the different perspectives that sometimes frustrate the possibility of progress and reform.

The Personalisation Model integrates four strands of thinking and practice that are at different stages of development and which have not, until now, been connected:

- Mental health recovery - People who are living with mental health problems are conscious that their own sense of control, resilience and effectiveness is at the heart of good practice. There is an increasing demand for approaches which respect the individual's autonomy and the positive lives that people can lead, whilst living with mental illness.
- Evidence-based practice - There have been on-going efforts to ensure that decisions about support and treatment are based upon the latest empirical evidence, and that more evidence is gathered to test and implement new and improved approaches. These have led to the development of new assessment tools which also enable new models for funding support.
- Personalisation in health and social care - There has been a long-standing demand to see supports and treatments better fit the real needs of the individual. On-going reforms in social care and health have now demonstrated that these demands are reasonable and that services can become more flexible and responsive.
- Total Place - Often the approaches which have received financial support from the state or society in the past are not always those that have delivered the best or most appropriate services. But commissioners are now beginning to move away from merely continuing to fund existing service models; instead they are beginning to shift resources towards individuals, communities and new models of services in order to increase the level of improvement in socially valued outcomes.

In order to shape the Personalisation Model we identified 16 design principles that we used to test and constrain the model. In this way we were able to do two important things. First, we made sure that the model would work for people with mental health problems and their families - to offer support that really works and enhances people's lives. Second, we attended to the practical issues that confront professionals, statutory and non-statutory services - to develop a pragmatic model that can be implemented for real.

There are seven main elements to our Personalisation Model for mental health services which are described in summary here (see Figure 1):

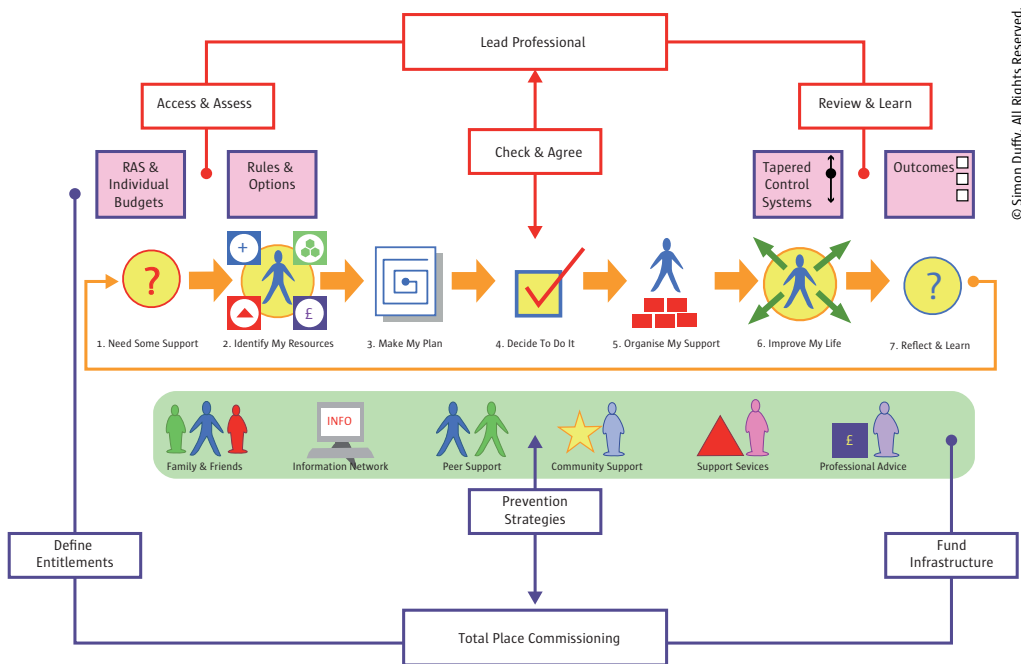


Figure 1. Personalisation Model for Mental Health Services

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1. Total Place Commissioning

Statutory partners need to work to develop a shared account of the outcomes that they are trying to achieve within their local communities. In addition resources then need to be invested so that those outcomes can be co-produced by local people, community organisations and services. This new approach takes us away from a focus on services for service sake - instead we should focus on achieving valued outcomes, by the most efficient means.

2. Prevention

Our efforts need to be re-focused on reducing the causes of mental ill health, on acting more quickly to limit the escalation of mental ill health and helping people onto the path of recovery. Resources can become locked into funding inappropriate services or services that are the result of a crisis. It has proved much harder to invest in responses that help reduce the overall level of need or strengthen community capacity and resilience.

3. Individual Funding

Both the NHS and local government are increasingly conscious of the need to ensure that resources are better targeted and linked to individuals in order to provide more flexible and more appropriate support. We will build on existing work to create a locally defined framework for the allocation of resources. This will support the better synchronisation of allocations and it could also lead to simplification, or even integration, of the current dual assessment process.

4. Self-Directed Support

Many people with mental health problems are already demonstrating that they can improve their path to recovery or better manage their mental illness if they can play a bigger role in designing or controlling their own support. One of the keys to the success of self-directed support in social care has been the way in which, by setting out clear rules or menus, clarifying entitlements and enabling people to do more planning for themselves, there has been a great leap forward in the degree to which people have been able to develop more creative support solutions that make better use of their skills and all the community resources they can access. In mental health there are new complexities to consider, but it should still be possible to clarify the expected outcomes, the menus of available options and to define the flexibilities and constraints within which people and professionals can make their decisions.

5. Co-production

Self-directed support does not mean leaving people to do everything on their own; people need different degrees of support and control. In addition many people with mental health problems find their problems increased by the complex array of different services that they are expected to use: health, social care, housing, benefits, employment, drug and alcohol teams etc. The more complex are the person's needs, the more complex the response. Systems like the Care Programme Approach (CPA) have already tried to tackle some of these difficulties, but the Personalisation Model offers an opportunity to take these practices further with new levels of partnership and integration for individuals.

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6. Community-Based Support

Underpinning self-directed support and prevention strategies must be a commitment to the necessary infrastructure. This must not be conceived narrowly in terms of statutory services. Instead it needs to include community, peer support and information resources - all of the approaches which enable people to take more control and manage and improve their own mental health. Community-Based Support is likely to be the most efficient and effective approach to supporting personalisation.

7. Outcomes-Focus

The Personalisation Model must be framed, both at the macro and micro levels, as being focused on outcomes. Commissioners must identify the valued social outcomes they are trying to achieve on behalf of society and must critically examine their

investments to ensure they are producing those outcomes as efficiently as possible. At the level of the individual, practitioners must help people achieve the outcomes they value by the means that prove most effective for them.

Implementing and Testing the Model

To bring this model to life will take time, hard work and genuine partnership - not just between statutory organisations - but also with the citizens who use mental health services and the third sector who provide many of these services.

Together, we will begin the process of change and development by working with urgency and commitment. In particular we will set up:

- Governance that links people and organisations
- Practical projects that will create the new technologies necessary to make personalisation real
- A process for piloting and sharing innovations

The name of this new development programme and its underlying partnerships will be Personalisation in Mental Health. This paper marks only a beginning. And we will revisit many of our assumptions, terms and ideas as we begin the process of change. But we are confident that personalisation is the right direction for mental health services.



Designing the

Personalisation

Model

Designing the Personalisation Model

This paper has been developed in order to set out a new way forward for mental health services. It has not been created in a vacuum. Instead it is rooted in our shared picture of both the need for radical change and the great will for change that already exists in people and professionals. At its heart is a commitment to demonstrate more faith in the capacities of people and professionals - to give them more trust, flexibility and autonomy - to see people and professionals, rather than systems or bureaucracy, as the key to bringing about increased well-being and better mental health for all.

Emerging Policy & Technologies

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There have been on-going efforts to improve mental health services, from within the NHS, local government and the third sector, but also through the drive and leadership of people with mental health problems themselves. Sometimes there are conflicts or disagreements, but there are also many common themes.

The Government's recent policy statement *New Horizons* helpfully draws out some of the main principles that should underpin future reform (HM Government, 2010):

- Equality and justice
- Reaching our full potential
- Being in control of our lives
- Valuing relationships

The materials used to develop the Personalisation Model are the approaches and technologies that are currently under development in health and social care systems. There are differences between some of these approaches, but these differences can be exaggerated.

At a higher level of magnification many similarities between these different approaches become apparent and with further work one integrated model can be developed.

The primary technologies we have used to develop our model are:

- 1. Self-Directed Support** - Self-directed support is a system for providing support to individuals and families who need extra support while enabling them as much control over that support as possible (Poll et al., 2006). It involves a radical change in the role of the lead professional or care manager who now focuses on ensuring that people take as much control as makes sense to them - through planning, implementation and review - but without forcing people to take on responsibilities which would be inappropriate.
- 2. Individual Budget** - An individual budget is an up-front financial allocation that can be directed by the citizen who is entitled to that budget (Duffy, 2005). There has also been some limited success in integrating different funding streams into one individual budget. The further development of individual budgets is now underway in several areas of adult social care (where they are sometimes called personal budgets) health care (where they are called personal health budgets) and in welfare reform and children's services (where they are called individual budgets).
- 3. Resource Allocation System (RAS)** - In order to give people a budget before they plan their support it is necessary to develop a resource allocation system (Duffy, 2005). That is, there needs to be some set of rules that links need to an appropriate level of funding. Different systems have been developed by different local authorities however most systems are broadly similar and define needs by reference to a framework of outcomes.
- 4. Mental Health Clustering Tool** - A framework for assessing mental health needs called the Mental Health Clustering Tool (MHCT) is now being used by pilot sites in the North East and Yorkshire & Humber and is recommended by the Department of Health (DH) for national use and is currently being mandated for inclusion in the Mental Health Minimum Data Set from April 2011. The tool works by distinguishing 17 distinct risks or needs (e.g. depressed mood). This analysis of needs then leads, with the aid of the MHCT, but subject to expert professional judgement, to an individual being allocated to one of 20 possible Care Clusters (e.g. non-psychotic (severe)). Personalised support or support can then be designed with the individual, one that reflects best practice and a fair and appropriate level of funding (CPPP, 2009).
- 5. Payment by Results (PBR)** - The care clusters have also been identified as the key components in a PBR approach to mental health. This would mean payments (initially locally determined) being made for each individual based on the use of the MHCT, supporting increased personalisation by disaggregating block contracts (ADASS & DH, 2009).
- 6. Care Programme Approach** - Mental health services have embraced a disciplined approach to care management which is called the Care Programme Approach. Of particular importance to the CPA is the need to ensure that there is always an appropriate lead professional who is sufficiently empowered to ensure that no one's support becomes incoherent, disorganised or fragmented. This approach is also broadly consistent with personalisation, especially where there is flexibility in determining who should play the role of lead professional (DH,1999).
- 7. Fair Access to Care Services** - An important constraint on local authority freedom is created by the government policy called Fair Access to Care Services which attempts to create local equity in service eligibility based upon severity of risk to independence. There are also likely to be further changes

in the legislation governing social care entitlements and local authority responsibilities as the full implications of personalisation emerge (DH, 2010). However this policy constraint has not, with the right leadership, held back progress towards personalisation in local authorities.

- 8. Well-Being Outcomes** - There has been a growing focus on promoting well-being and identifying measures of well-being, both for use at the level of commissioning and at the individual level and several frameworks for outcomes now exist (for example, see Mental Health Providers Forum and Triangle Consulting, 2007).
- 9. Commissioning** - Since the 1992 reforms and the development of the commissioner role for local authorities and the NHS there has been an increasing emphasis on exploring how investment decisions can be driven by a better understanding of real local needs, priorities and desired outcomes (HM Treasury & Department of Communities & Local Government, 2010). This has led to important initiatives such as Joint Strategic Needs Assessments and the national system of Comprehensive Area Assessments to which local partners are subject. The latest initiative from the NHS, World Class Commissioning, also shows an understanding that personalisation will have a critical role to play in realising the potential for positive change. There is also increasing recognition that the third sector can have a much bigger role to play in providing support into communities.

There is still much to learn about these technologies, many are very new, while others are still being refined or redeveloped. There is often a danger that distinct approaches can obtain their own momentum and that little attention is paid to how developments in one area link to developments in another area. It is for this reason that we have been ambitious in defining one wide-ranging and holistic model for mental health services. It is important that we begin to stand back and really consider how the whole system will work and how these different approaches can be fully integrated with each other.

Design Principles

Our aim has been to produce one model for the commissioning, care management and co-production of mental health services and support and we call this the Personalisation Model for mental health. In order to develop this model we have not only looked at current best practice and emerging technologies, we have also asked ourselves what it was we would need to make a system that was attractive and useful to local people and professionals. In addition we had to think about the practical realities that would determine whether our model could be achieved in reality. We identified the following 16 design principles and we used these to constrain the design of the Personalisation Model.

This new model must work for citizens and their families, in particular:

- Outcomes - Citizens can define and achieve the kinds of positive outcomes that are important to them
- Positive - Citizens are treated as active participants in the co-production of improved mental health and recovery
- Entitlement - Citizens have confidence that they have rights or entitlements that they can use
- Control - Citizens and their families can control or shape their own support
- Choice - Citizens and their families have choice between services and supports
- Safe - Citizens and professionals manage risks effectively
- Integration - Citizens can integrate different services and supports to better fit around their lives
- Responsibility - Citizens have personal and social responsibilities which enable them to contribute to their own life and the wider community

But this model must also work for statutory partners and for the community as a whole:

- Affordable - the system must work within immediate resource levels
- Sustainable - the system must be sustainable in the long-run, not increasing demand or inflationary pressure and ideally reducing costs
- Balanced - the system must not lead to unfair or sudden changes in the balance of financial responsibilities between partner organisations
- Feasible - the system must be implemented within current legal and policy constraints, and recognise the different constraints faced by NHS and local authority partners
- Developmental - the system should encourage changes in investment and commissioning that promote improved outcomes and reflect the real evidence base
- Value - the system should promote improvements in quality, efficiency and effectiveness
- Empirical - the system must generate meaningful evidence of its effectiveness
- Innovation - the system should promote innovation, experimentation and new learning

We were able to construct the Personalisation Model by applying these principles and building on the emerging technologies within mental health services.

Developing a Shared Language

There is however another aspect to the challenge of developing an integrated Personalisation Model. Often we find that language divides us, both because we use different words to mean the same thing or we use the same words to mean different things.

These divisions of meaning reflect important differences in culture and perspective between key groups:

- People with mental health problems and self-advocates sometimes have different ways of describing both mental illness and their own preferred approaches for managing it, and these can be radically distinct from those used by professionals.
- Health professionals have a language that has been developed around clinical expertise, the organisation of the NHS and its professional groups.
- Social workers are trained in a different way to health professionals and their theoretical frame of reference is sometimes different to that used within health care.
- Society often experiences mental illness through the filter of the media and it is often reduced to simplistic or negative images.
- Families can experience mental illness as a powerful and negative disruption that can rip apart family life.
- There are also other perspectives within the third sector or within other specialist services, therapists or independent experts.

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There are natural differences of perspective which are valuable - but when these different perspectives are objectified into the 'one right approach' barriers are created for the development of better mutual understanding and strong and effective practical strategies. Ultimately a stronger community will take more care in building a common language that builds bridges between the different experiences of mental health.

To begin with we have made the following decisions:

- We talk about people who have mental health problems and often we will just refer to people.
- We talk about professionals and we mean all of those who are paid to provide assistance, therapy or treatment to people with mental health problems.

We will describe this whole new approach as the Personalisation Model and we will describe the elements of the model in the body of the paper below. Figure 1 above provides a diagram to describe the whole Personalisation Model for Mental Health. Over time we may choose to revise our terminology as our practice develops and as our community widens and we deepen our understanding.

The Meaning of Personalisation

But before we go further into exploring the details of the Personalisation Model we need to say some more about why we have chosen the word personalisation and what relevance we think it has to mental health. The term personalisation was first adopted by those eager to show that the radical reform of public services was compatible with an on-going commitment to public services (Leadbeater, 2004). And the term has now become associated with a rich vein of reforms and technological innovations.

At the heart of these new approaches is a radically different approach to thinking about people and their relationship to public services. The new approach focuses on the person's capabilities, their real wealth; all that the person can use to ensure that their life goes well (Duffy, 2010). There are 5 dimensions to real wealth (see Figure 2):

- Capacities - our skills, gifts and strengths
- Connections - our family, friends and community connections
- Access - our opportunity to use community resources and public services
- Control - the resources and assets that enable us to control our life
- Resilience - the inner strength or spirit that enables us to galvanise these resources

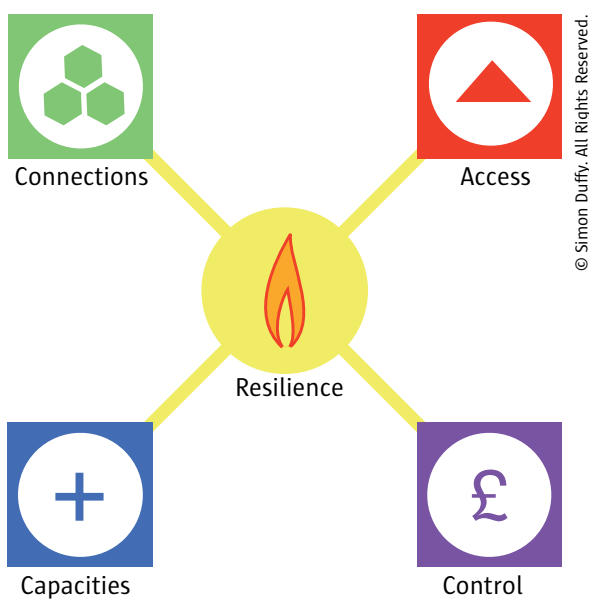


Figure 2. Human Capabilities & Real Wealth.

It is not an accident that the fifth dimension, the inner resilience that enables us to use our other resources, is at the heart of good mental health and recovery. Nor is it an accident that the practical approaches which support personalisation, which will be described in more detail below, are all focused on ensuring that the inner flame of good mental health is respected and strengthened. Personalisation is not contingently related to mental health; personalisation puts mental health at the heart of the human experience and the relationship of the citizen to public services.

No one story can capture all of the different dimensions of personalisation in all their different degrees. But we can get a strong sense of all these aspects of personalisation from Amanda's story (which is in the box below).

Amanda's Story

Before receiving direct payments I was attending Pathways Day Services. I participated in a variety of classes including digital photography, crafts and woodwork. The process of applying for direct payments was rather long and complex. I had to delve quite deeply into my personal history. However on reflection, although difficult at the time, I am grateful for the process of piecing together my life story. This overview has been an insight and learning experience.

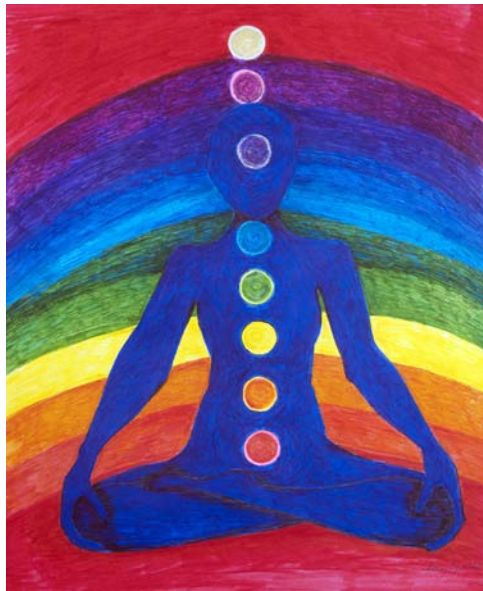
Through the activities I am able to undertake as a result of my direct payments my emotional well-being has improved tremendously. The first few months allowed me to explore creatively and open internal doors that previously had been closed. Mid-term, my creative pursuits have helped to balance me and allowed space for recovery. Presently I am getting better from a severe depression; it has given me time and space to emotionally heal.

My health has been up and down, but having a studio space as well as participating in AIM (Artists in Mind) and HOOT activities has been the foundation, not previously there, to a springboard for the next steps in my life.

Socially, I believe I have been able to develop and unfold. The studio space and activities have allowed me to gain confidence and self-awareness. I am learning to be more open with others in a safe environment. The activities at HOOT and AIM have encouraged social interaction without which I would have been closed off from society while I have been depressed.

I am discovering my true self: accepting the downfalls as well as the peaks and learning to balance the scales. Direct payments has helped me reach for my goal of a stable and lasting recovery and well-being. I would definitely encourage someone to apply for direct payments to help fund activities that can benefit their health. It has certainly been a catalyst on my journey of self-discovery and improved well-being. I am thankful for the opportunities that have been funded by my direct payments.

Amanda





The Model

The Model

This model marks a critical step forward in the development of an integrated health and social care service. It provides one model for the whole system, respecting the roles of everyone who is committed to improving mental health. It is not a description of how things are today; but it does provide a framework for local leaders who want to provide better supports and services for people with mental health problems.

1. Total Place Commissioning

Statutory partners need to work to develop a shared account of the outcomes that they are trying to achieve within their local communities. In addition resources then need to be invested so that those outcomes can be co-produced by local people, community organisations and services. This new approach takes us away from a focus on services for service sake - instead we should focus on achieving valued outcomes, by the most efficient means.

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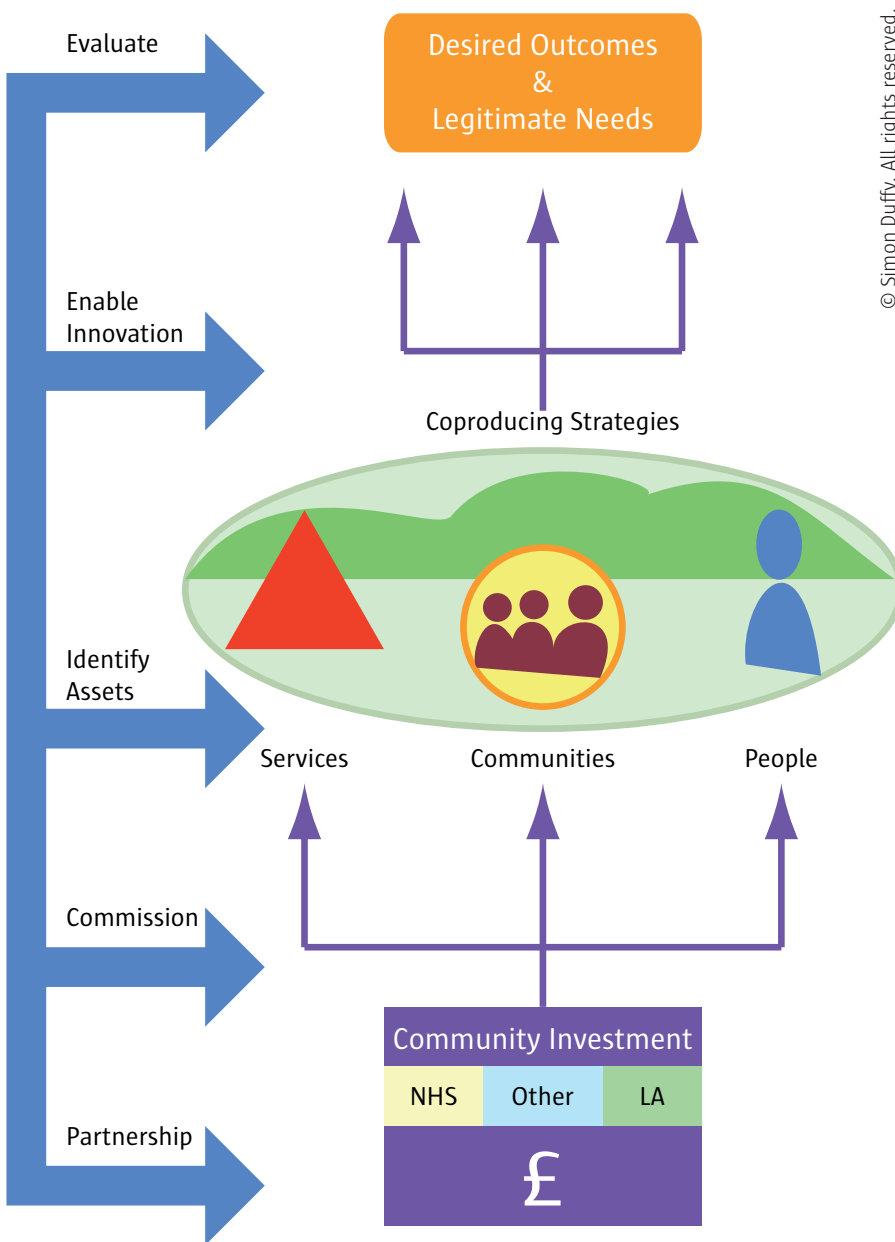
The Personalisation Model must begin with and be framed by Total Place Commissioning. Total Place Commissioning is only at an early stage in its development. But it does provide a framework for interrogating the value of all services provided by the welfare state and for seeking a better understanding of both the purpose and effectiveness of those local investments. Our model of Total Place Commissioning is described in Figure 3 and its main elements include:

- 1. Locally Agreed Outcomes** - There must be an overarching local vision, one which identifies desired outcomes and the needs that must be met to achieve those outcomes.
- 2. Co-production** - The strategy must recognise that these positive outcomes cannot be achieved without the leadership or involvement of citizens and communities. Professionals and services can only co-produce improved outcomes.
- 3. Community Assets** - Strategies to achieve these outcomes must be based on the identification and support of all community assets, this includes public services and the third sector but it goes much further to include citizens, families and the full range of community resources.
- 4. Smart Investments** - Local commissioning and investment decisions must be based upon real evidence of effectiveness and the use of all forms of

investment, this includes prevention and enablement, the use of Individual Budgets, and support for the community infrastructure (Duffy, 2008).

- 5. **Real Partnership** - Local partners must collaborate in order to make investment decisions together in the light of the different obligations and constraints placed upon them by central government and local citizens.
- 6. **Innovation & Evaluation** - The whole process of Total Place Commissioning must be underpinned by competence in encouraging innovation and gathering evidence to determine which practices are genuinely working.

Leaders in mental health have a special responsibility to encourage Total Place Commissioning; for they know that good mental is tied to a whole range of social factors far beyond the delivery of high quality mental health services: family



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Figure 3. Total Place Commissioning

breakdown, unemployment, domestic violence, abuse, welfare dependency etc. Mental health services cannot, and should not, try to solve the underlying causes of mental ill health on their own. And, mental health services themselves are partially commissioned as a response to those wider social problems. Mental health commissioning is a response to poor mental health and the many causes of poor mental health; it cannot be effective by simply focusing on funding mental health services alone.

In practice the move towards Total Place Commissioning may be quite gradual but we can imagine some possible approaches which might emerge from its more holistic perspective:

- Many community organisations that currently focus on holistic needs, including mental health, may begin to be seen as assets for improved mental health by local commissioners. For example, services like the WomenCentre in Halifax offer broad and holistic support to women and families that are experiencing poor mental health (see www.womencentre.org.uk).
- Commissioners may be able to collaborate to tackle complex systemic blocks, like the poverty traps within the current benefit system, which damage mental health but are not just mental health problems. For example, initiatives like those in Barnsley to craft locally tailored approaches to joblessness may result in improved mental health.
- People using services or treatments may be seen as sources of genuine expertise, providing data on improved outcomes and offering peer support and stronger feedback to practitioners and commissioners. For example, the use of peer support to enable people to self-manage their own budgets has proved very successful in improving mental health outcomes in the USA (Aleksan, 2008).
- New approaches are emerging which enable whole communities to address their own, interlocking needs. For example the Connecting Communities approach, pioneered by Hazel Stuteley in the South West of England, has helped deprived estates diagnose and begin to solve their own local problems (see www.healthcomplexity.net). The indirect benefit of such work on improving mental health is obvious, for not only do people improve their social conditions, they also experience the benefits of leading those improvements themselves.

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In other words Total Place Commissioning breaks us out of a simplistic purchaser-provider model and demands that we attend to the whole environment within which improved outcomes are co-produced.

Of particular importance to the development of the Personalisation Model will be to understand how resources are currently invested and to develop a strategy for shifting resources into at least three distinct areas:

- Identifying where resources can be individualised and entitlements clarified.
- Exploring which community assets can provide the infrastructure for personalisation.
- Developing new strategies for prevention and early intervention.

These possibilities will be explored in more detail in the sections below.

2. Prevention

Our commissioning efforts need to be re-focused on reducing the causes of mental ill health, on acting more quickly to limit the escalation of mental ill health and helping people onto the path of recovery. Resources can become locked into funding inappropriate services or services that are the result of a crisis. It has proved much harder to invest in responses that help reduce the overall level of need and strengthen community capacity and resilience.

Thinking and practice about prevention in mental health is not well developed. However we can identify the following distinct and important preventative strategies:

- **Tackle Social Injustice** - We must address the social and economic conditions that damage mental health.
- **Promote Well-Being** - We must help the whole population to understand and promote their own mental health and support the mental health of friends and family.
- **Early Intervention** - Where possible we should provide targeted support and services to those at particular risk of poor mental health.
- **Avoid Escalation** - We must ensure that people with poor mental health are offered timely and appropriate support to avoid the escalation of their needs and to help speed the path to recovery.

We need to see investment and better on-going research and evaluation of all four strategies and thereby ensure that prevention is central to all future commissioning.

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2.1 Tackle Social Injustice

Social injustice - discrimination, extremes of inequality, poverty and social isolation - is correlated with poor mental health, although the relationship is not a simple cause and effect relationship (see Murali & Oyebode, 2004). Just as there is no easy 'cure' for most mental health problems so there is no simple account of their 'cause'. However when commissioning for mental health it is vital to think about the whole community response to mental health.

The Personalisation Model proposes that Total Place Commissioning is used to ensure that the achievement of well-being and the prevention of poor mental health is seen as critical in:

- the analysis of local need
- local target setting
- the use of national targets for local partners
- the development of local plans and agreements

Commissioners of mental health services have an important role in encouraging the necessary partnership work to encourage local social and economic developments which tackle social injustice. In addition it will be vital that commissioners reflect on the equality impact of their decisions. For example, we know that personalisation can be the basis of more flexible and culturally sensitive support; but these new

opportunities will only arise if people from Black & Minority Ethnic (BME) communities are given access to the benefits of systems like individual budgets and self-directed support.

2.2 Promote Well-Being

The relationship between well-being and social conditions is also complex and is not subject to simplistic analysis. However we do know that it is closely associated with sources of meaning, value, enjoyment and productivity such as:

- good family life, love and partnerships
- active contribution, work and productivity
- social networks and friendship
- faith, spirituality and a sense of purpose

It is therefore important that mental health commissioners ensure that they support strategies which seem likely to support the development of those institutions and structures that seem productive of well-being, such as civil society and the family. It will also be necessary to explore how people can take more responsibility for their own mental health, understand the signs of poor mental health and be capable of finding suitable personal strategies. There may be a particularly important role for education and the communication of accessible and useful information about mental health.

2.3 Intervene Early

Some people are at particular risk of poor mental health and it should be a priority for mental health commissioners to understand current patterns of mental health and identify strategies to intervene early to help people avoid mental illness or to react quickly to mental illness.

Some of the immediate areas for focus might be from the following groups:

- young black men
- mothers of young children
- teenagers
- victims of domestic violence and abuse

Strategies for avoiding poor mental health need to be more imaginative than targeted mental health services - these may or may not be effective - but they will certainly involve understanding any further risk factors; helping people understand both the risks to themselves and the strategies available to manage those risks. It will be important to work through existing systems, groups or communities that are already actively engaged with these groups.

2.4 Avoid Escalation

One of the important goals of the CPPP is to enable someone with a recognised mental health condition to better manage their mental health and reduce any risk of escalating their mental health problems.

There is a special responsibility placed upon professionals who are already in touch with these citizens to ensure that they are actively supporting people to manage their mental health and know both the relevant risks and the forms of good practice. It is one of the possible advantages of the emerging assessment process in mental health (that we will go on to explore below) that it increases the opportunity to ensure people get the right support for their needs.

It will be particularly important that the Personalisation Model is developed in partnership with leaders in primary health care services, particularly with General Practitioners. For it is often in these early conversations that mental health issues and risks can be identified. Without the involvement of General Practitioners it is unlikely that prevention in mental health can develop effectively.

3. Individual Funding

Both the NHS and local government are increasingly conscious of the need to ensure that resources are better targeted and linked to individuals in order to provide more flexible and appropriate support. We will build on existing work to create a locally defined framework for the allocation of resources. This will support the better synchronisation of allocations and it could also lead to simplification, or even integration, of the current dual assessment process.

Total Place Commissioning means putting the right level of funding in the right place and this involves balancing three broad approaches:

- Investing in services
- Investing in communities
- Investing in people

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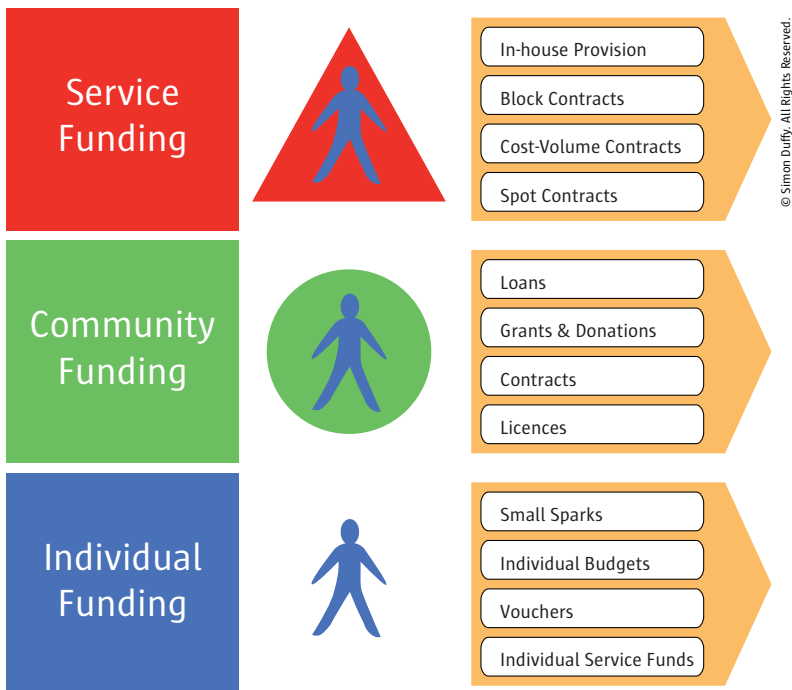


Figure 4. Different Funding Systems in Health Care

Within these broad approaches there are also different ways of investing resources which change the nature of the relationship between commissioners and recipients. It would not be wise to rule out any system of funding in principle, each can be justified in different circumstances (see Figure 4).

However we do believe that individual funding will become much more important in future. One of the main priorities for change in mental health services should be to increase the level of individualisation and to increase the control or influence of citizens and families over that funding.

In particular:

- **Individual Budgets** - Individual budgets are up-front transparent allocations of funding. They will be an important part of this new system and are likely to be the default option for people whose needs are significant and likely to be long-standing. This may lead to the use of direct payments but there are also other ways in which people can get increased control: but with more support and lower levels of personal responsibility.
- **Grants** - Modest grants will be useful for small or short-term interventions, particularly those that require innovation and individual control.
- **Vouchers** - Where the type of interventions should be fixed, but choice of provider is possible, vouchers will often make sense.
- **Individual Service Funds** - These are individual budgets that are managed by service providers. This model of individualisation could be particularly valuable for enabling statutory and third sector services to embrace personalisation.

In addition many existing mental health services may benefit from shifting to forms of individualised funding, even if the individual does not yet control that funding. Individualised funding will not be the only system for funding mental health services, but we advise that funding is increasingly individualised.

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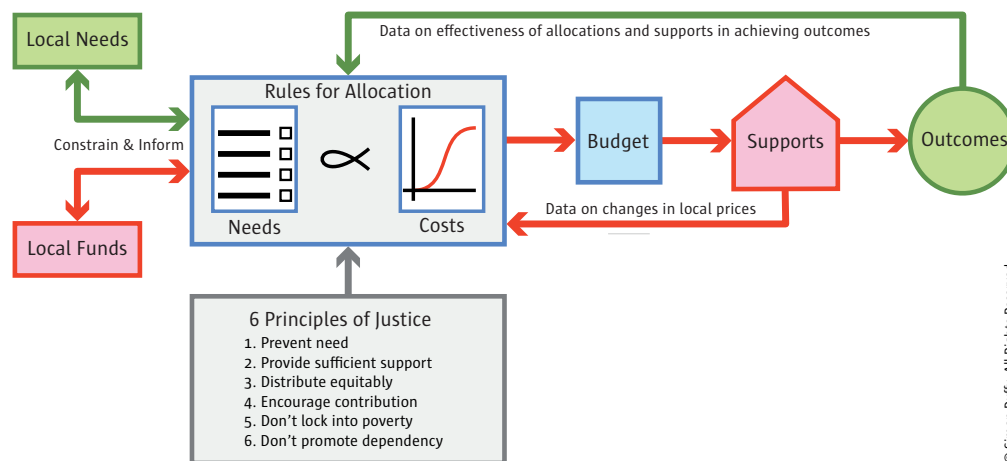
3.1 Setting Individual Funding Levels

At the heart of any approach to individualising funding must be a system for setting individual funding levels, and there are two prevalent systems currently in place for mental health services. First there is the system developed by CPPP which is being explored as the basis for Payment by Results in the NHS (PBR). Second there is the system that has been developed by local authorities called the Resource Allocation System (RAS).

These two systems may appear to be very different in style and approach but they are in fact very similar and there is, at their core, a shared methodology for they each work by identifying the correlation between:

- **Needs** - Those needs that are to be treated as legitimately demanding some kind of response.
- **Costs** - The level of resources that is appropriate to the particular levels of need.

They can also be seen as being part of a more sophisticated and iterative methodology which can be developed over time as the system measures the on-going effectiveness of its interventions (as in Figure 5).



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Figure 5. Resource Allocation System

The Personalisation Model recognises the value of both the RAS and PBR methodologies, in particular we recognise that they both have their own distinct strengths:

- **PBR** - By building on professionally secured accounts of need and by identifying care pathways and packages that are appropriate for those levels of need, the PBR system not only allows the validation of funding levels but also helps identify that the best possible options for service and support are identified.
- **RAS** - By building on well established patterns of individual expenditure and establishing new approaches to analysing need the RAS has enabled much more flexibility and creativity in the use of resources. It is also underpinned by a framework of outcomes that both helps identify need and validate plans and expenditure.

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Neither system is fully developed and each will be subject to further innovation and testing - but there seems no reason why, with intelligent joint working, both systems could not develop together to offer a complimentary or, even with time, an integrated approach to allocating resources.

3.2 Integration of Allocation Systems

In the light of this shared commitment to create a clearer and better validated allocation system it seems possible to consider a number of ways in which local authority and NHS funding for mental health services could be better integrated. There appear to be four logical options:

1. **Two utterly independent systems of resource allocation** - Different amounts are allocated to individuals with no shared framework. However, this would seem to be potentially wasteful and confusing and there would be a real risk that some people would get inadequate allocations, while others may get more than is really necessary.
2. **One fully integrated resource allocation system** - The most radical approach would be for partners to pool funding in one overall budget and then draw

down individual allocations without any assumption that funding was either ‘health’ or ‘social care’. Some areas, where there is already significant joint working, may be able to deliver to this model; furthermore it raises interesting questions about the long-term coherence of the ‘health - social care divide.’

- 3. One integrated allocation system, but with tracked funding** - Somewhat less radical would be a model where there was one allocation system, but with rules that specified the distinct levels of contribution from partners for individual situations. For the individual this would risk being more cumbersome than a fully integrated model, but it would still mark a significant step forward and would enable a radically simplified assessment process for mental health.
- 4. One framework for resource allocation** - It would also be possible to define an integrated framework for resource allocation in mental health. This would not automatically define one budget at the level of the individual, but it would clarify the rules for each distinct allocation system and could lead to a series of further incremental improvements (see below).

Currently, for most locations, the most attractive and feasible option will be the fourth option - an integrated framework for resource allocation. This will enable the developing allocation technologies to develop independently on both sides, but will enable learning and the development of a shared framework that will make sense of the distinct legal and policy constraints.

An integrated framework remains an ambitious goal and with sufficient trust and understanding it would enable some or all of the following:

- Individual budgets that the citizen can integrate
- Triggers to identify eligibility to partner (or other) funding
- One assessment (even if there are distinct LA & NHS elements)
- Using one support plan, one contract, subject to only one review
- Movement of funds for different purposes between partners
- One set of criteria and one point for signing-off a support plan
- Simplification of the assessment process
- One set of regulations and one system of monitoring
- Improved risk management and coordination
- Administrative efficiencies

Using this integrated framework for making allocations for individuals we will then work to promote individual funding across health and social care services. In particular we will develop all of the following approaches.

3.3 Individual Budgets

Individual budgets will not work for everyone in all circumstances. However they are an important innovation which will be an important option within the Personalisation Model. Individual budgets are particularly valuable when:

- services and supports need to be integrated into the wider life of the individual
- needs are likely to change and responses need to be flexible
- people get value from feeling some degree of control over their situation
- there is uncertainty about the right treatment or support

Individual budgets are not cash grants nor direct payments (although they sometimes can be managed in those forms). Instead individual budgets are budgets that are allocated to an individual in order to enable the design of appropriate personalised support. As set out in Figure 6 the Resource Allocation System enables people to be assigned a budget before they begin planning - this transparency is what has enabled greater creativity, flexibility and personalisation. Even though the budget may or may not be directly controlled by the individual it is still their entitlement, used to meet their needs in ways that fit better with their whole life. Individual budgets are conditional resource entitlements which people use, subject to appropriate controls, to meet legitimate needs (Duffy et al, 2010b). Individual budgets are assessed, agreed and monitored by professionals - but they enable empowerment and the co-production of support solutions that are integrated into the full community life of the individual.

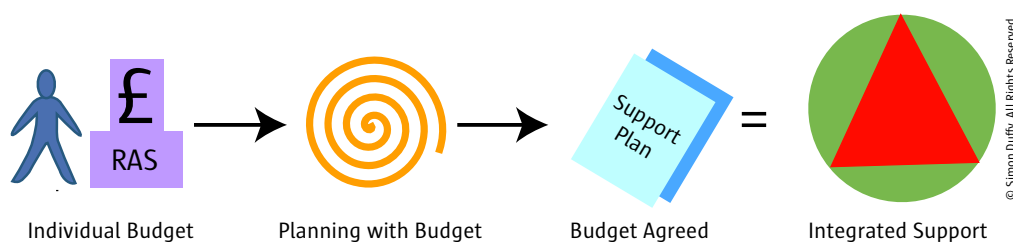


Figure 6. Individual Budget

3.4 Small Sparks and the use of grants

It is also worth noting that the use of small cash grants may be a very sensible, low-cost, additional system which could be used for people who may not be entitled to an individual budget but where the ability to use modest resources flexibly may be very valuable and may enable people to either solve problems that are causing great anxiety or which may encourage greater social interaction. One particular system, Small Sparks, is particularly focused on giving people modest grants which must be used for community development purposes - these can have significant investment benefits - improving mental health, building social capital and solving community problems (Carlson, 2009).

3.5 Vouchers

Sometimes vouchers are also a useful form of individual funding. They are particularly useful where it is agreed that a particular type of support services is advisable, but there is a reasonable choice between different service providers, for example many therapy services have been funded using voucher systems in other countries. This approach, in the right context seems to drive up efficiency and speed market development (Block et al, 2002).

3.6 Personalised Support

A model of individualisation which can be developed by service providers is Personalised Support. This model was developed in the mid 1990's to provide support to people with particularly complex needs, including people with mental health problems and challenging behaviour (Fitzpatrick, 2006). Personalised Support is described in Figure 7 and involves a number of critical elements.

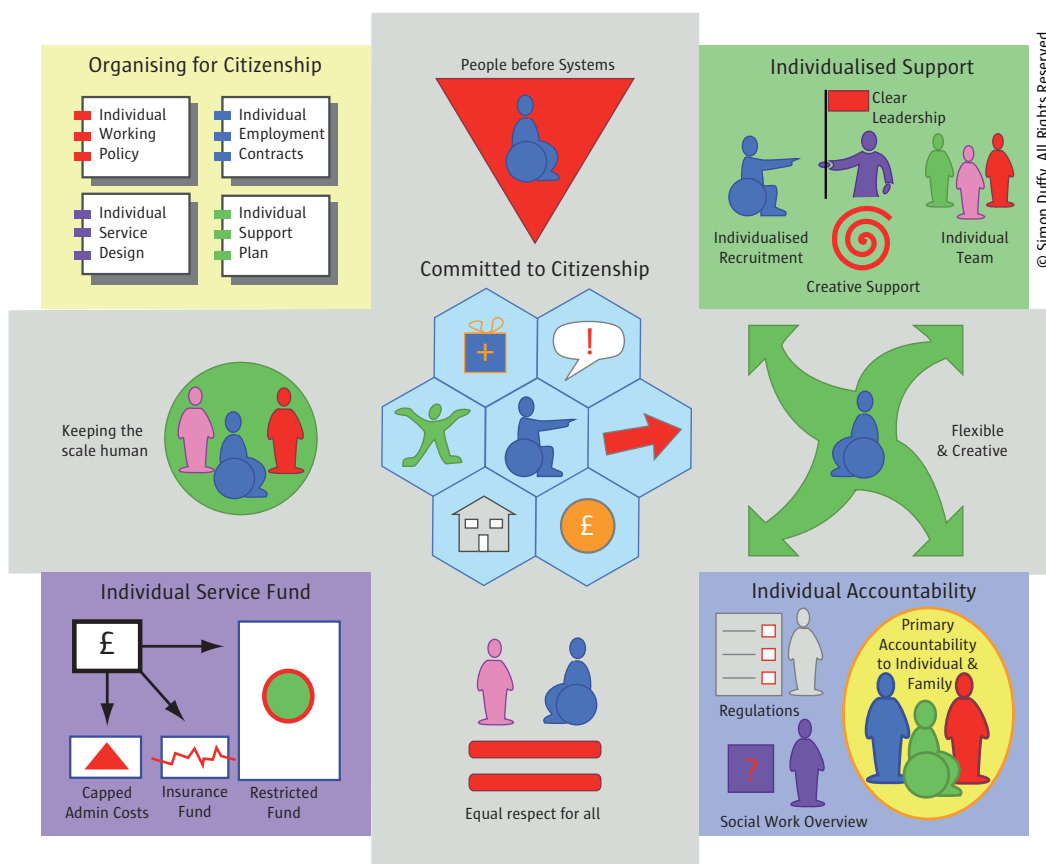


Figure 7. Personalised Support and the Use of Individual Service Funds

It is our view that many current service providers could become much more familiar with the advantages of personalisation if they developed the necessary systems to implement personalised support as a matter of priority. These systems are particularly useful for offering Personalised Support for people who do not want to manage their own direct payments.

The Personalised Support model involves a number of discrete elements, each of which contributes to creating better conditions for excellence in support provision. It is particularly important to note that this system enables services to manage individual budgets on the person’s behalf - if this is the most appropriate option - and so creates another important system for enabling people to have an individual budget, without undue complexity.

This model could usefully be adopted by services and local authorities to accelerate the drive towards personalisation. The five key elements within the model are:

- 1. Committed to Citizenship** - The organisation has a commitment to support citizenship for everyone; this commitment not only underpins the organisation’s purpose it also shapes a culture which is respectful, creative, human and, above all, is focused on doing the right thing for the person, rather than serving organisational convenience.
- 2. Organising for Citizenship** - Everybody has a support service that has been designed to meet their individual needs and aspirations. No assumptions are made at the outset about the elements of a successful design; instead creativity and person-centred planning are used to build the best support arrangement

for the individual. This may be further reflected in individual working policies, support plans and employment contracts.

- 3. Individualised Support** - People need support from people who are right for them, as individuals, and this demands radically individualised systems of recruitment, employment, management and leadership to those that are provided in more traditional or institutional services. Often different forms of support make sense: live-in supporters, supportive flatmates, neighbourhood or natural supports, equipment or technology.
- 4. Individual Service Fund** - The individual's budget belongs to them; but for some people it is best if that money is managed as a flexible, outcomes focused fund, within an organisation. And when a budget is managed within the organisation it is restricted for the benefit of the individual and subject to clear and public rules.
- 5. Individual Accountability** - As well as being subject to the normal checks and balances of care management and regulation the service provider makes itself primarily accountable to individual and their representatives (often their family); this often leads to clear controls over important decisions being managed through a partnership with the person or their representative.

In practice what this model can offer people with mental health problems and their families is almost all of the choice, flexibility and creativity that they should rightly expect, but without all the administrative responsibilities, complexity and risk that goes with managing a direct payment.

4. Self-Directed Support

Many people with mental health problems are already demonstrating that they can improve their path to recovery or better manage their mental illness if they can play a bigger role in designing or controlling their own support. One of the keys to the success of self-directed support in social care has been the way in which, by setting out clear rules or menus, clarifying entitlements and enabling people to do more planning for themselves, there has been a great leap forward in the degree to which people have been able to develop more creative support solutions that make better use of their skills and all the community resources they can access. In mental health there are new complexities to consider, but it should still be possible to clarify the expected outcomes, the menus of available options and to define the flexibilities and constraints within which people and professionals can make their decisions.

Self-directed support is the name for the process by which individuals can plan, organise and develop their own support. Although this methodology was adopted by some local authorities in order to reform adult social care, it is not defined by or limited to its application in adult social care. The same methodology can be used in private life, education, children's services - it is also useful pattern for supporting personal leadership and autonomy in any sphere.

4.1 The Process of Self-Directed Support

The actual process of planning and implementation is cyclical and can often be fragmented or confused.

But nevertheless the following framework is useful, especially if we remember that people may be at different stages and that the seventh stage brings them back to the first (see Figure 8):

- 1. Identifying need** - Planning begins with an awareness of a need, the existence of a problem to solve or a goal that we wish to achieve. Primarily we offer people help, advice and an assessment of their needs in order to help them come to an understanding of those needs, and in order to help them take control of responding to the needs themselves.
- 2. Mapping & exploring resources** - People have assets, gifts, relationships or networks - services are only part of what people want or need. It is by planning in the context of an holistic understanding of our own assets, networks, rights and resources that we can develop plans which make sense to us. The advantage of systems of individual funding like individual budgets are that they clarify the level of funding as a flexible entitlement which then allows people to plan how best to use that entitlement in the context of their wider life. In general, making entitlements clearer and more flexible will tend to facilitate self-directed support.
- 3. Designing your own support plan** - People need plans which are consistent with needs and preferences and therefore underpinned by their own real motivations. A plan which is not rooted in your own desires and motivations will not be sustainable. Moreover such planning often does not require professional support. Many people have found that they can get support from friends, family or others who have shared their experiences in order to develop helpful plans which better support their mental health. Tools or guidance which makes planning easier for people to plan for themselves can be very useful too.
- 4. Negotiating & agreeing support** - For most of us planning ends when we decide to take action, to implement our plan. Moreover, in all but the most extreme circumstances, the consent of the individual is a requirement for the intervention of any service and professionals. Even where strict consent is not required it is usually much more likely that a strategy will be successful if it has been agreed by the individual concerned.
- 5. Organising your support** - Services and supports should be managed and organised so that control is as close as possible to the person and support can be changed quickly and easily as needs change or as new opportunities or risks emerge. The key to high quality support is not good planning but the ability to respond quickly to problems or failings. Even if people cannot or will not manage a direct payment then shifting control to a point closer to the person is likely to be helpful.

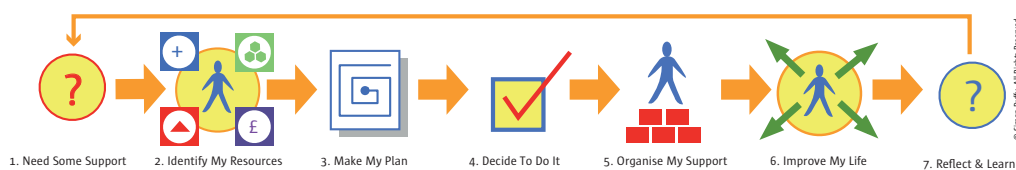


Figure 8. Self-Directed Support

- 6. Using and developing your support** - Services and supports should be organised to respect and strengthen the individual's lifestyle, gifts and community connections. They should help people achieve socially valued goals and outcomes that are defined by the person. Often the best support comes from people who share things in common: interests, communities, language, culture etc. Support which is not sensitive to the individual's own make-up will be less competent.
- 7. Reflecting upon the strengths and weaknesses of your support** - Personal and organisational development and learning is impossible without time to reflect on what is working and what can be improved. Structuring opportunities to reflect, amend and improve is vital to improving quality.

It is also important to note that self-directed support can be applied even when rationality is impaired by a crisis or a long-term condition. When the person can only make decisions with the help of others then self-directed support is still possible. The Personalisation Model requires that substitute decision making and supported decision making are integrated into self-directed support. All of this is consistent with and required by mental capacity legislation.

By understanding the process of self-directed support we can better design the interaction of public services and systems of entitlements in order that they can better respect the ability of the individual to maximise their own control and enhance their own resilience.

4.2 Rules and Menus

We have already argued that individual funding is likely to better promote personalisation. However it is important to note that this does not mean that all resources can always be used with complete flexibility: entitlements are created for definite social purposes - to meet needs and achieve valued outcomes - and that will be constrained by our understanding of what is appropriate.

In particular professionals cannot support people in ways that are:

- Unduly risky for the citizen or others - It is for this reason that the lead professional must work with the individual to ensure that their plan is appropriate and is not unduly risky.
- Illegal or which encourage or support criminal activity - It is for this reason that some uses of individual budgets or public funds will sometimes be deemed inappropriate.
- Unhelpful or contrary to good practice - It is for this reason that sometimes public money may be committed to particular treatments or supports and may not be used flexibly.

This issue is particularly important in the context of health care which has (a) a strong tradition of trying to empirically verify treatments and (b) a reasonably well-defined boundary. In general medicine at least there is a tendency to assume that some kinds of intervention are just not 'health care' - even when they have outcomes that improve health.

Mental health has a slightly different tradition to general medicine. Definitions of need are more contested and the treatments which are recommended to meet those needs are more open or contested. However it remains the case that there will be rules

which may impact on the decision-making process. These rules may have different characters (see Figure 9):

- Absolute Exclusions - Some forms of expenditure will be forbidden in all circumstances.
- Controlled Treatments - Some expenditure will be limited to accredited treatments (and choice - if any - would then be limited to the provider - however vouchers may prove useful in this context).
- Co-Designed Solutions - Some services or supports will come recommended as good practice, but professional judgement will allow for innovations and adaptations as individual circumstances dictate; alternatively there may be no strong pattern of good practice but alternative treatments would need to be given thoughtful consideration.
- Citizen-led Support - For some expenditure the expertise of the citizen will be dominant and resource flexibility will be critical to enabling good decisions.

The Personalisation Model will need to be underpinned by a clear, public and contestable understanding of the rules within which decisions about funding can be made and any necessary menus or controlled options. There may also be different constraints for the NHS and local authorities and this issue will need to be explored in more detail.

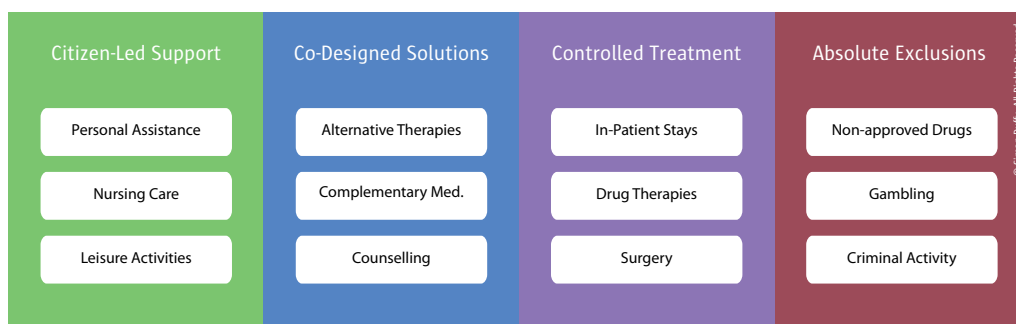


Figure 9. Menus, Options & Flexibilities

An important part of our work in Yorkshire & Humber will be to build upon the work of the CPPP which has already begun to define pathways that can be evidenced as best-practice treatments or supports. It will be important to ensure that this work is respected in the next iteration of this model, but also that there is care taken to ensure that best-practice pathways are used appropriately and do not dictate provision in ways which would not respect individual preferences, opportunities or risks.

4.3 The Framework for Personal Planning

In order to enable people to co-produce personal plans it will also be important that there is a shared understanding of what any plan needs to cover. We envisage that personal plans, which can be developed by people with mental health problems or their allies, will be a functional replacement for care plans.

As such they play a vital role in enabling the individual, their community and any professionals to work together to understand and integrate their different forms of support (Duffy et al, 2010a).

One framework for personal planning involves six criteria for a good plan (see Figure 10):

1. **Outcomes** - The plan is clear about the outcomes that it aims to achieve (we will go on to discuss the valuable role that a focus on outcomes can play in the final section of the model).
2. **Effective Treatment** - The plan is clear about what support or treatment is necessary and how it will be achieved.
3. **Integrated Support** - The plan makes good use of all available support (both professional and community-based).
4. **Managed Risks** - Significant risks are identified and effectively managed.
5. **Resource Efficiency** - The plans makes good use of resources (not just individual budgets or statutory resources but also community resources).
6. **Clear Decisions** - It is clear who is responsible for what kinds of decisions and it is clear when decision-making might need to change if needs change and how this will be reviewed.

As should be very clear, it is unlikely that a competent plan can be done ‘for’ someone. If people are not involved in creating or leading the development of their own plan then it will be difficult for the plan to achieve any of these criteria.

Clarity about the criteria for a good plan is useful in that it helps citizens and professionals to plan successfully and helps citizens and professionals to understand the purpose of planning together. It is important that the application of the criteria is proportionate: the effort needed to plan and the details demanded within any plan should reflect the level and complexity of need. Simple interventions or strategies will normally only require simple plans.

There are also specific planning techniques which can be used to help people develop good plans (e.g. Cognitive Behaviour Therapy, Essential Lifestyle Planning etc.) but it will not be the use of any specific technique that will determine whether a plan

is competent. Learning, however, about such techniques and sharing any tools for planning that are developed will be an important part of training and education for both professionals and non-professionals alike.

It will be particularly important to draw in the experience of people with mental health problems themselves. There has already been extensive development of models and approaches to personal planning within the mental health community and these offer a rich resource to the Personalisation Model.

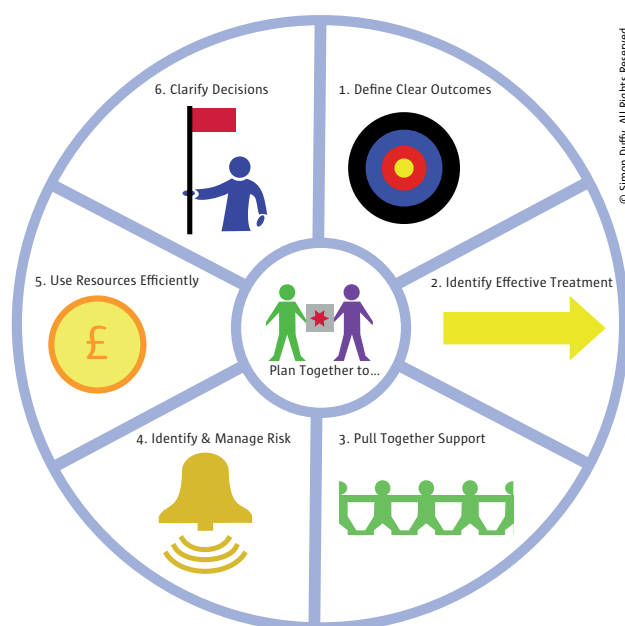


Figure 10. Framework for Personal Planning

5. Co-production

Self-directed support does not mean leaving people to do everything on their own; people need different degrees of support and control. In addition many people with mental health problems find their problems increased by the complex array of different services that they are expected to use: health, social care, housing, benefits, employment, drug and alcohol teams etc. The more complex are the person's needs, the more complex the response. Systems like the Care Programme Approach (CPA) have already tried to tackle some of these difficulties, but the Personalisation Model offers an opportunity to take these practices further with new levels of partnership and integration for individuals.

There is a tendency for us to treat public services as if they exist for their own sake. But this is a false perspective - services exist in order to help achieve outcomes - improvements in health, safety, wealth, contribution etc. Accordingly, services must be judged by the degree to which they help us achieve those valued outcomes. Ultimately it is people themselves, often with considerable help, who achieve these outcomes: it is **our** health, safety, wealth or contribution.

Once we realise that people are at the heart of achieving valued outcomes then we need to reconsider the relationship between the person and the professional. It is clear that this needs to become a mutually supportive relationship - where the professional supports the person to achieve their valued outcomes - and the person supports the professional to fulfil their responsibilities. This relationship of mutual support and creativity is called the co-production relationship (see Figure 11).

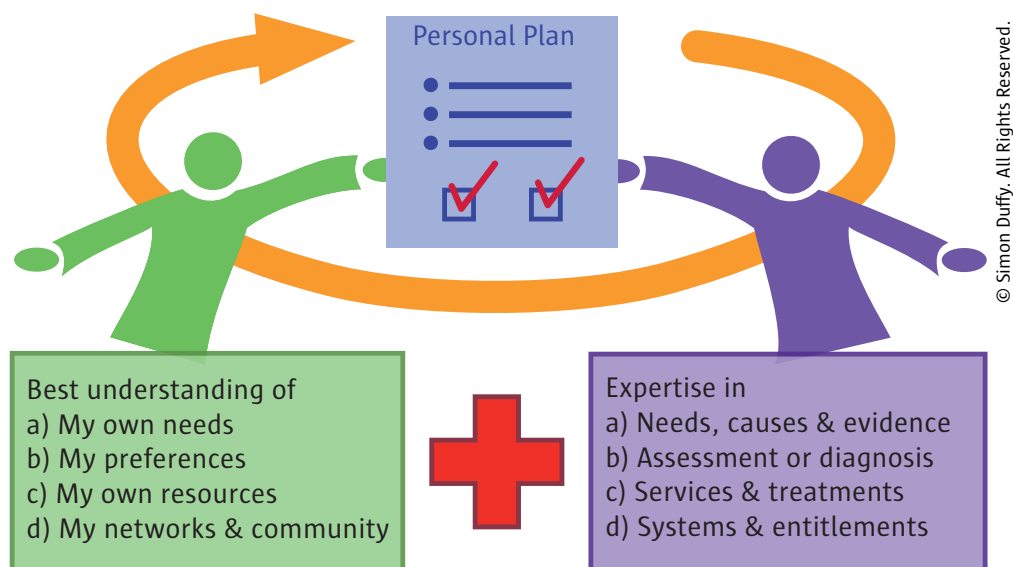


Figure 11. The Co-production Relationship

It is important to note that the dynamic of this relationship will change depending upon the context. In some situations we will rightly expect professionals to exercise considerable authority and leadership (e.g. a surgeon performing an operation.). But often the reverse is true and most of the leadership must come from the person themselves (e.g. finding and keeping a job).

The value of the co-production relationship depends upon the synergy that comes from the combination of these diverse forms of expertise. And again the detail of the balance of expertise will vary with context and the individuals concerned but generally speaking we can expect:

- **Citizen expertise** - The individual knows their own situation and their own problems in a way which nobody else can; they will also tend to know more about themselves, their gifts, their friends, their family and their community - the world from their point of view.
- **Professional expertise** - The professional will have seen many people with similar problems and may have expertise in the needs which have created the citizens' problems (whether that be physical, psychological or social); they will also tend to know more about the resources which they control and possibly the resources available from other parts of the system - the world from their point of view.

Co-production is particularly valuable where problems cannot be easily solved with standard solutions. It is ideally suited to helping people to manage and improve their mental health, a circumstance which demands careful attention to the perspective of the person, but one which must also be balanced by a supportive external perspective.

5.1 Tapered Control

It is also important to note that the co-production relationship can serve to enable the individual to have different degrees of control in different circumstances. One of the most basic misunderstandings of personalisation has been to assume that it also requires the individual citizen to take full control of their individual budget, to employ their own support staff or take other extreme degrees of control over their own lives. Nothing could be further from the truth and any such assumption would actually undermine personalisation. In fact personalisation demands tapered control - different degrees of control to allow for different situations and different individual needs (see Figure 12).

The Personalisation Model will allow all of the following six systems and individual decisions will be subject to professional judgement and the agreement of the citizen:

1. **Direct Payments** - this is a citizen controlling their own funding directly as cash.
2. **Indirect Payments** - this is where a trusted representative controls the budgets as cash.
3. **Individual Trusts** - this is a legal body set up to manage funds for someone on their behalf, particularly useful if someone is going to lack capacity to manage funding for themselves for an extended period of time.
4. **Community Brokerage** - this is where a community organisation manages someone's budget on their behalf, brokering services or providing cash as required.
5. **Individual Service Fund** - this is where a support service manages someone's budget for them. Often this is done by treating that funding as 'restricted' and managing it subject to clear rules - this an approach which can be used by statutory services themselves.
6. **Professionally Managed Fund** - this is where people choose to have their fund managed by a care manager or lead professional, who can commission suitable support for the citizen (as discussed above).

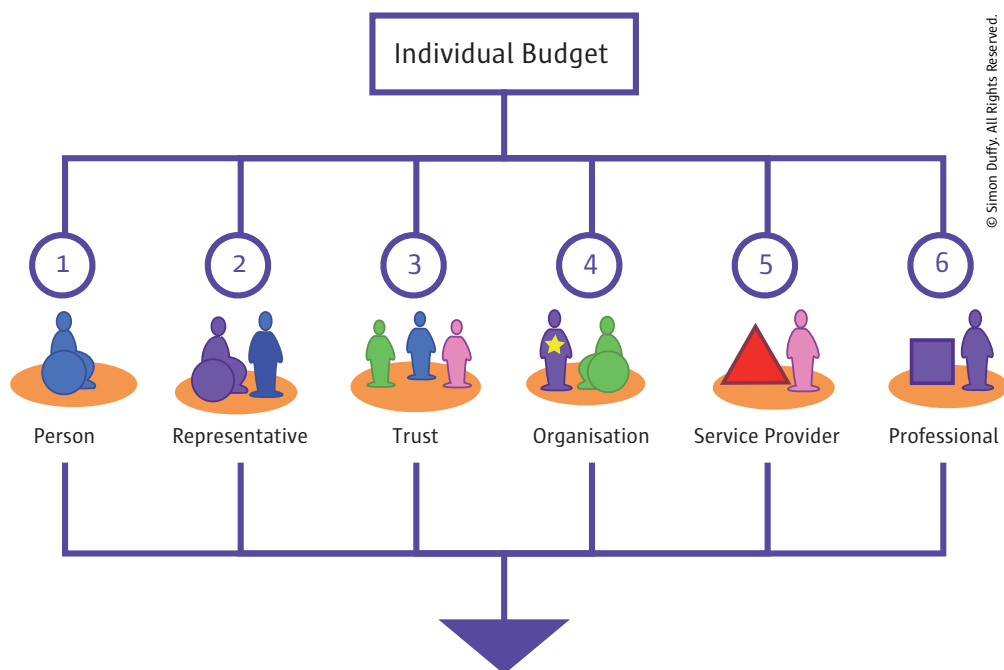


Figure 12. Tapered Control

These systems of control do not need to remain static. For instance it is possible for people with fluctuating conditions to use 'living wills' to shift control dynamically as their condition changes. It is also possible for the lead professional to determine that a particular system is no longer working and to shift control to a different point.

However public services often further complicate the questions of control and co-production because those services are themselves complex and people often find they need a number of different kinds of support, entitlement or service.

This is particularly true for people with mental health needs who very often receive many different forms of support from some or all of the following:

- National Health Service
- Local authorities social care - family or adult services
- Tax-benefit systems
- Employment support systems
- Housing systems

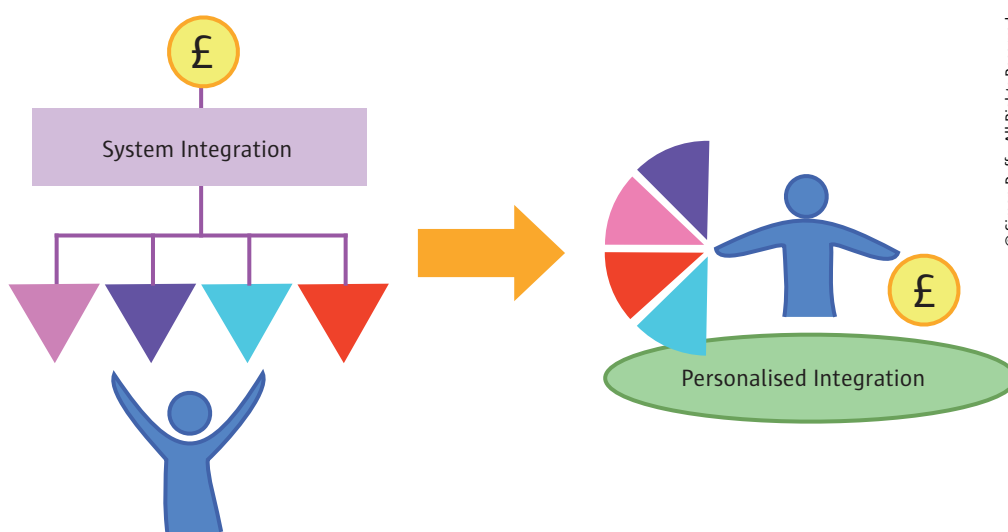
There are even other systems, like the criminal justice system, which can play a significant role in the lives of some people with mental health problems. It is for this reason that we will explore the possible opportunities for increased integration and better co-ordination of support.

5.2 Personalised Integration

From the perspective of the person it is clear that public services often operate according to distinct principles, are delivered in different ways, by different people. For people with particularly complex needs - including many with mental health needs - this means that the help they need comes in very complex and fragmented packages. This is a long observed problem.

In the past the solution to this problem has been to seek some form of system integration - this has often then played out as some form of horizontal or vertical organisational merger. But with each organisational change new distinctions and differences open up. The departmentalised nature of public services is actually an inevitable feature of any public system with broad social responsibilities and a complex array of resources.

But the problem of integration may not be impossible to solve if we pursue the logic of personalisation - for individuals can integrate the different resources, support and services that they receive for themselves - if they have sufficient control over them. Personalisation then allows people to ensure that those public services fit their lifestyle, priorities, preferences and other resources (see Figure 13).



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Figure 13. Personalised Integration

This approach does not remove the imperative to integrate resources, organisations or systems where this will add real value. In fact the shift towards personalised integration may reveal all the more sharply points where two different systems have duplicated or have overlapping functions, or where there are obvious gaps and where responsibilities need to be clearer. It will be particularly important to commissioners to ensure that they do not place unnecessary obstacles in the way of people who aim to integrate their own support.

5.3 Identifying the Lead Professional

Even if personalisation creates a better context for integration it still requires the system to try and clarify its own leadership and ideally to identify a lead professional who can act on behalf of, or at least co-ordinate, the array of public services. The Personalisation Model therefore includes a central role for the lead professional and creates possibilities for further rationalising roles and responsibilities between professionals. In particular, it could be possible - given greater transparency about rules, resources and outcomes - to avoid any unnecessary handing over of responsibility from one professional to another for 'organisational reasons'.

The Personalisation Model aims to develop a public framework which will minimise multiple professional handovers. This would have two components:

- **One care manager** - the lead professional - for both health and social care - drawing from the widest feasible source of professional expertise.
- **Flexible use of community support** - including professional and non-professional resources (peers, family, friends and community members).

The Care Programme Approach already provides a clear template for identifying the lead professional and the Personalisation Model proposes that we continue to build on and improve this model. In particular this will mean clarifying which professional is best positioned to:

- **Assess** - Ensure that the citizen is accessing all that they are entitled to - wherever those entitlements might be sourced.
- **Sign-off** - Ensure that the person's plans make sense, are safe and are likely to be effective.
- **Review** - Ensure that the person is making positive progress.

All of this may require the involvement of many more people than the person and the lead professional, but this relationship needs to be central to the relationship between the person and the whole system of mental health services and supports.

6. Community-Based Support

Underpinning self-directed support and our prevention strategies must be a commitment to the necessary infrastructure. This must not be conceived narrowly in terms of statutory services. Instead it needs to include community, peer support and information resources - all of the approaches which enable people to take more control and manage and improve their own mental health. Community-based support is likely to be the most efficient and effective approach to supporting personalisation.

The lead professional is at the apex of the relationship between the individual and the wider support systems available to the person. But these systems of support do not merely extend across the public service system. There are also many other forms of support which the person may be able to identify and use or which the professional may be able to help open up for them (see Figure 14).

The Personalisation Model will promote the appropriate use of professional support, but also support for the development and use of non-service supports. In particular it will be important to identify strategies to support:

- **Families & Friends** - Too often families, who are often providing most of the support someone is receiving, feel that they are excluded from decisions or the development of creative solutions. While some families may be at the root of someone's mental ill health, most families are essential to good mental health.
- **Peer Support** - Peer Support, or what is sometimes called user-led support, will be an essential part of the Personalisation Model. Learning from the

experiences of others who have shared similar conditions and found ways of managing or overcoming those conditions is one of the most powerful tools in helping improve our mental health or achieve recovery.

- **Community Networks** - Many of the most important sources of support for people with mental health problems are found within forms of association or membership that have developed outside public services and are rooted in civil society: churches, mosques, temples and faith groups, leisure groups, interest groups or neighbourhood groups, employment and volunteering etc.

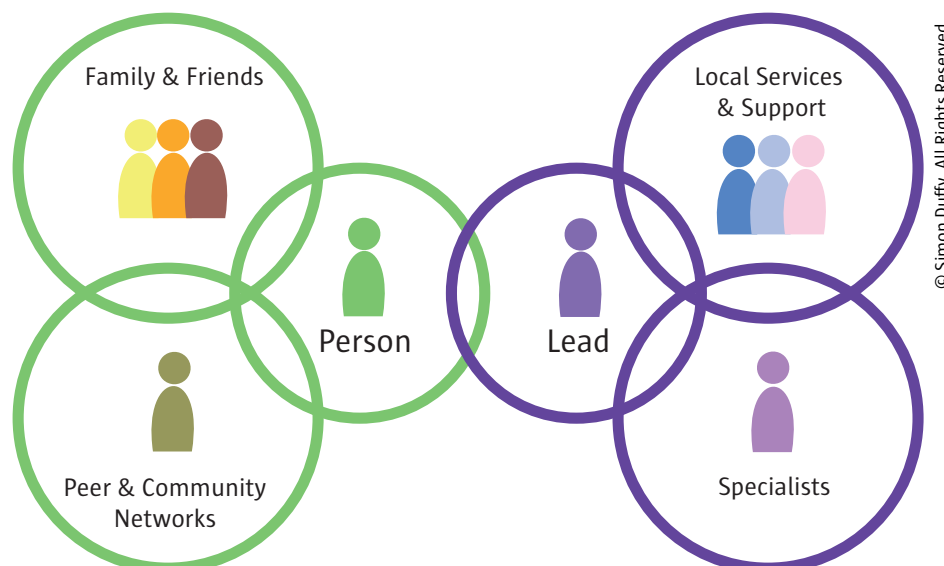


Figure 14. Community & Professional Support

The Personalisation Model needs to harness all the assets of the wider community in generating community solutions to improve mental health. This does not necessarily mean commissioning or grant-funding these other forms of support. But it does mean respecting and supporting these other forms of support; in particular recognising that some forms of involvement by professional services can even risk damaging those community supports if they do not respect their role and integrity.

6.1 Limiting brokerage or care navigation

There is one particular issue that will need careful attention. Several commentators on personalisation have made the assumption that increased individual control will require the development of new professional roles: independent professional brokers or care navigators (Bartlett, 2009). This is a tempting assumption and it reflects a long-standing pattern of responding to problems by developing new professional roles.

However there are a number of reasons why it seems advisable to be highly cautious about developing or extending the scope of any such new professional roles.

1. Despite the growth in these roles, especially in the USA and Canada, there is no empirical evidence to suggest they add any significant value.
2. The inherent costs associated with new professional roles, especially in a system which struggles to disinvest from other systems, seem likely to drive up infrastructure costs and increase inefficiency.

3. Focusing on increased professional input is likely to distract systems from developing more empowering approaches: (a) making systems simple to navigate and (b) enabling people, family or community organisations to provide leadership.
4. A new professional role, developed alongside existing professional roles, is likely to create increased complexity, ambiguity and a further narrowing of role definition. Instead the focus should be on helping existing professionals identify how they can embrace personalisation within their own existing professional role.

We are sceptical that the new professional roles of broker or care navigator will add significant value. We also note the hazards that will arise if too much attention is given to developing such roles. This does not mean that there should be no innovation in professional role definition; but we expect that it will be more powerful to focus on developments that promote community-based support.

7. Outcomes-Focus

The Personalisation Model must be framed, both at the macro and micro levels, as being focused on outcomes. Commissioners must identify the valued social outcomes they are trying to achieve on behalf of society and must critically examine their investments to ensure they are producing those outcomes as efficiently as possible. At the level of the individual, practitioners must help people achieve the outcomes they value by the means that prove most effective for them.

Commissioning has always been concerned with promoting the efficient use of resources. However the development of the purchaser-provider split and similar quasi-market models may have led to a failure to examine where real efficiencies are generated. Frequently the focus has been on trying to create 'market pressures' for efficiency - but these have often led to a very narrow conception of efficiency.

There are in fact three very different paths to efficiency (see Figure 15):

- **Input-focused efficiency** – that is, reducing the costs associated with services and supports. Primarily this will mean reducing the growth in salary levels and prices.
- **Process-focused efficiency** – that is, identifying more creative and appropriate ways of delivering support for any given level of funding. This will almost inevitably require the co-production of solutions with those who need support, in order to draw in their expertise.
- **Outcome-focused efficiency** – that is, reducing the need for services and supports. This means increasing the capacities of citizens and communities or tackling the problems that create need.

If we make the mistake of assuming that services and supports are already pre-defined and there will be no room for innovation, we will be left focusing only on input-focused efficiency - which will largely result in price and salary controls. However there is good reason to think there is much more room for innovation and improvement than is normally recognised.

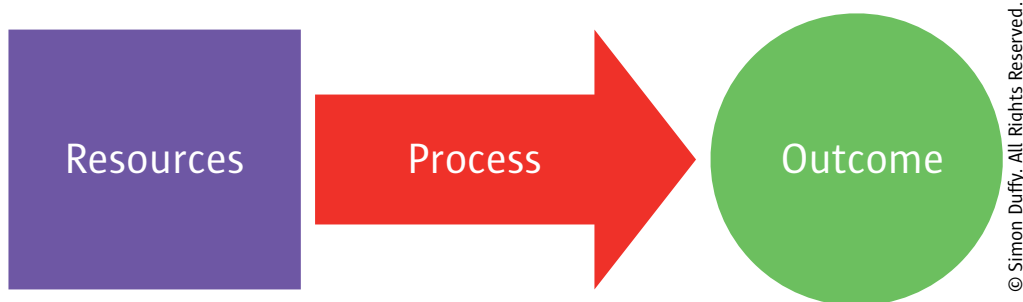


Figure 15. Resource - Process - Outcome

This is partly why an increased focus on outcomes can be so helpful. When we define the outcomes that we want people to be able to achieve for themselves, and the given level of resources, we can then explore new and innovative ways of achieving those outcomes (process-focused efficiency). Or, we may even be able to identify totally different approaches to achieve those outcomes that do not rely on the use of standard resources or processes (outcome-focused efficiency).

To date commissioning has primarily focused on input-focused efficiency - getting the same services for less money. In the future smart commissioning for mental health should shift the use of resources to support the development of co-production and innovation, the strengthening of community capacities and attention to the real causes of poor mental health. New systems which provide greater flexibility, increased opportunities for citizen-control and social justice will still fail if they do not enhance the quality of planning and decision-making at the level of the individual.

It is essential that the Personalisation Model supports the conditions for improved decision-making by all. It will do this by:

1. Helping people focus on the desired outcomes - enabling people to ensure that support and services are really operating in their best interests.
2. Create greater clarity about controls, flexibilities and best-practice - helping people to understand what is known, and what is not known, about good practice and enabling people to find creative solutions to meet their desired outcomes.
3. Empower people to do more planning for themselves, with support - giving people the tools and frameworks that will enable them to take more control over the planning process itself.

This shift in approach cannot be achieved over night. It will require principled leadership and innovation by professionals themselves as well as real collaboration with people with mental health problems. But we have already seen exciting examples of this approach developing in Rotherham and other local authorities in the region.

7.1 Outcomes at the Micro-Level

We plan for the outcomes we hope to achieve and no personal plan can be meaningful unless it represents the interests, preferences, values and perspectives of the person whose plan it is. There has been increasing focus on helping citizens to achieve the best possible outcomes in their own lives by offering them some kind of outcomes framework that can be used for self-assessment and monitoring success.

There are several examples and one attractive model is the Mental Health Recovery Star which has 10 defined outcomes and a ten-point scale assessing our level of self-reliance (MacKeith and Burns, 2010) which is displayed in Figure 16.

See www.outcomesstar.org.uk

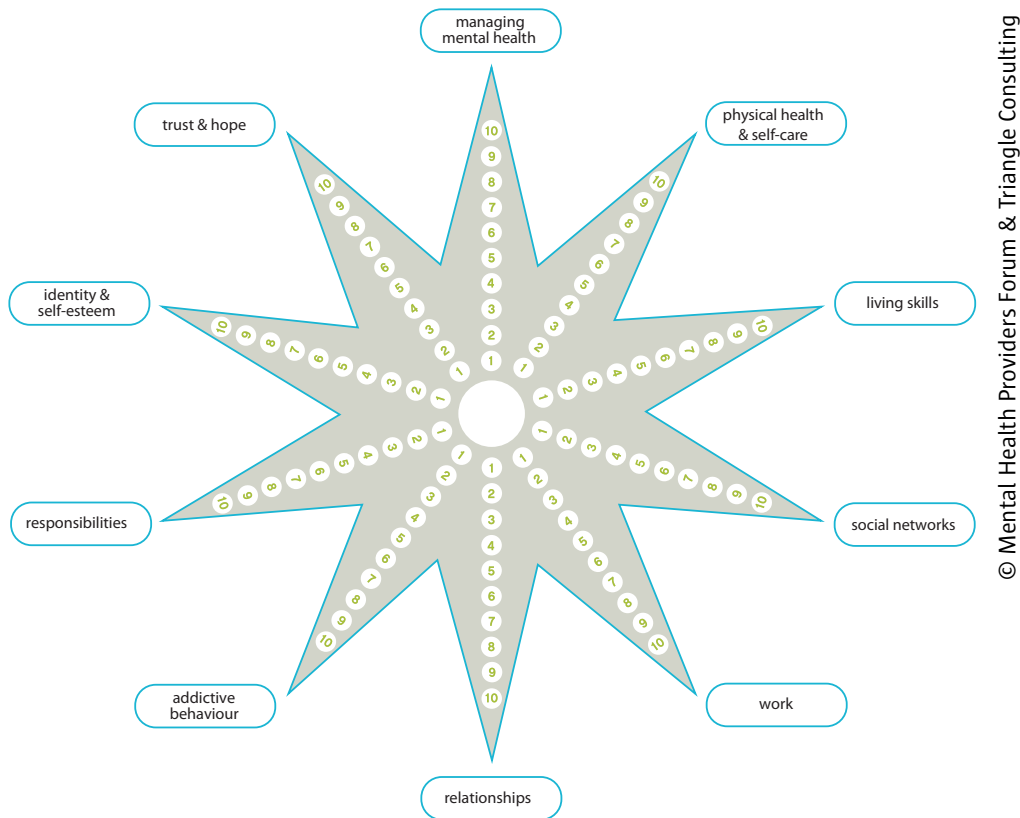


Figure 16. Mental Health Recovery Star

There are a number of reasons why an outcomes framework is valuable:

- **Supporting aspirational planning** - People can use the framework to help them think about the full range of things they might want to achieve. Sometimes, without this people can fixate only on those aspects of their life which are hardest to change.
- **Supporting achievement** - People can use the framework to track their own progress.
- **Monitoring success** - Services can use the framework to help them track how well they are supporting people.
- **Defining need** - Needs are created by the failure to achieve valued outcomes; by defining the outcomes that public services wish to help people achieve we can also define their needs. This in turn provides a framework for identifying the resources and processes that are necessary to meet those needs.

CPPP have also have also been developing a suite of quality indicators that relate to the individual care clusters; and it is likely that these would form the basis of a larger outcome framework to support planning at individual and system levels.

7.2 Outcomes at the Macro-Level

Outcomes are not just useful at the level of the individual. As set out at the beginning of this description of the Personalisation Model, outcomes are central to understanding the purpose of commissioning. We should measure the value of our public services by their ability to achieve social outcomes that we really want to achieve.

Unfortunately it is all too easy for services to be measured only in terms of their immediate impact - the systems outputs: hospital beds, appointments in clinics, hours of support etc. However the value of these outputs is not clear. Nor can we be clear that any output, even if the ultimate outcomes that flow from it are good, is efficient. Each pattern of outputs is at the cost of many alternative patterns. Efficient use of resources depends upon moving resources towards those outputs which produce better outcomes.

It also clear that the issue of the value of outcomes is in itself contentious. Different groups value different outcomes to varying degrees. Moreover we also fail to notice that some of the outcomes we value may be significantly undermined by other outcomes that we also desire. Some strategies may not even be sustainable, for example increased reliance on professional services in some areas of civil society may threaten the creation of greater resilience and capacity of community resources. Some good outcomes can compete with other outcomes.

The New Economics Foundation have been working on developing an outcomes framework for local areas that tries to represent some of these complexities and information about this approach is contained in the box below.

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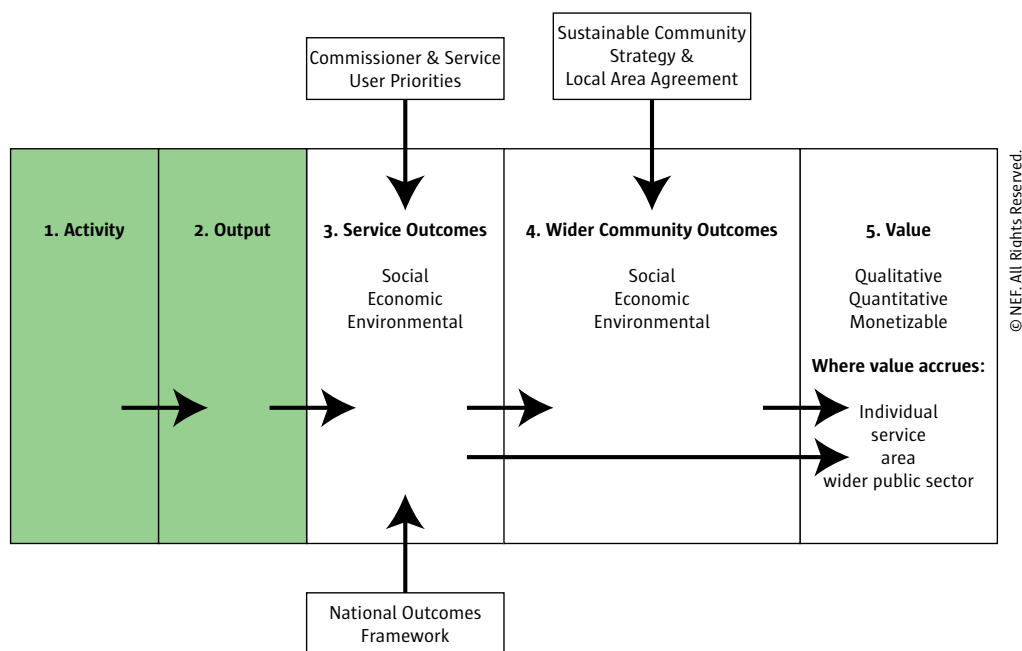


Figure 17. New Economics Foundation Outcomes Framework

Definitions:

- * Activity – The key components that describe how you intend to deliver the service and which effect some sort of change in the service user – e.g. providing a service, a programme or a good.
- * Outputs – The direct results and beneficiaries of the activity. These usually show that people receive something, learn something or take part in something as a result of what you do, or how you do it, e.g. the number of people involved, number of hours of support delivered.
- * Service Outcomes – Describes the effect the outputs have on the service users, other groups of people or the local area. These are broken down into social, economic and environmental outcomes.
- * Community Outcomes – The wider social, economic and environmental objectives for the area. These are drawn from the Sustainable Community Strategy, the Local Area Agreement and national strategies. These are broken down into social, economic and environmental outcomes.

Definitions courtesy of the New Economics Foundation

At this point we have returned to our starting point - Total Place Commissioning.

We have described the Personalisation Model in some detail and there are real examples of all of these approaches being developed within our region of Yorkshire & Humber and beyond. We will now begin work on further advancing, integrating and learning from the implementation of the model.





Implementing
and Testing the
Model

Implementing and Testing the Model

This paper has set out a radical new model for personalisation in mental health, one which could bring the NHS, local authorities and the third sector together around some new practical methodologies. However the ideas within this paper need to be implemented, tested and improved in practice in order to develop a genuinely new way of working.

Previous experience of implementing personalisation suggests that real progress can happen without any undue extra resources and at a significant pace, if the following conditions are achieved:

1. Findings, experience and models are shared freely and quickly.
2. There is a permissive environment where innovation is valued and supported.
3. There is a focus of effort on areas where the conditions for success are strongest.
4. There are real champions for change at the local level.

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To support the creation of the right environment for these innovations the Yorkshire & Humber Improvement Partnership will support the creation of a piloting process. The development programme will be called Personalisation in Mental Health.

The Personalisation in Mental Health development programme will be managed by the Yorkshire & Humber Improvement Partnership (YHIP) on behalf of the Mental Health Pathway Leadership Board.

There will be an initial steering group which will oversee the development of a learning programme to support local innovations that promotes personalisation and the further integration of mental health supports and services. The group will:

1. Oversee the innovations, best-practice and intellectual property of the programme.
2. Provide strategic guidance and support to local leaders.
3. Help identify useful resources to support local change.
4. Link to national initiatives and policy developments.
5. Provide risk management for the whole programme.
6. Enable research, evaluation and economic analysis.
7. Review and develop its own membership in the light of local progress.

Local leaders and innovators will share their learning through a Leadership and Learning Group which will also be supported by YHIP. This group will be task focused and will draw together the real local champions for change to collaborate and learn together.

Possible Work-streams

The model itself provides a framework for the work of Personalisation in Mental Health. The following work-streams will be important in order to build an effective and sustainable environment for future innovation:

- 1. Begin Total Place Commissioning** - We need to map the current resources invested in and around mental health services in order to understand how they are currently invested, both in terms of services and wider systems. This resource map can then be used to identify early opportunities for change within a clear strategic framework.
- 2. Begin the Shift to Prevention** - We need to build on current commitments and plans; we need to identify how current prevention strategies are developing, where they can be improved and which approaches hold most promise. This review will then feedback into the strategic overview above.
- 3. Build an Integrated Allocation Framework** - This is an important technical task which needs to be completed at an early stage. This will mean using some of the existing RAS models that are already well developed in Barnsley and Sheffield and integrating them with the best version of the CPPP approach. It will also be vital to work with people with mental health problems to enable increased opportunities for self-assessment.
- 4. Build Systems to Support Self-Directed Support** - The practical contractual and engineering systems required to enable self-directed support in health and social care still need to be further developed, although some areas have made more progress than others. By building on best practice across the region a model can be developed for local implementation; this will also build-in the maximum feasible level of integration between health and social care.
- 5. Develop the Care Programme Approach to Embrace Personalisation** - Progress in developing the role of the lead professional, promoting more empowering strategies around individuals and reaching out to forms of community support will be most likely if we begin by respecting the on-going work of the Care Programme Approach and ensure that it is made fit for personalisation.
- 6. Encourage Peer Support** - The best place to start a new approach to planning is to work with people with mental health problems themselves, to learn what approaches have been most successful, to respect existing peer support networks and to encourage further development and partnership with professionals.
- 7. Encourage use of Individual Service Funds** - Many existing service providers could quickly be put on a new footing, given new contractual flexibilities and encouraged to work with people within the Personalisation Model. This would enable much more dynamic engagement by the third sector and NHS Trusts at an early stage.
- 8. Collaboration with Practitioners** - It is vital that practitioners are given every chance to understand and explore the possible benefits of personalisation to

their work. Key groups will include psychiatrists, community psychiatric nurses and General Practitioners and many, many more. An early task will be to map these groups and identify how best to engage with them.

These are ambitious plans, but the Yorkshire & Humber Region is well positioned to support this level of innovation. There is good communication across the region and the numbers involved, while significant, are not too large to make the project unmanageable.

Building on Local Initiative

However it will be important, given the early stage of innovation, that the primary focus is on spotting and supporting real or emerging points of innovation rather than trying to bring about change where leadership is lacking.

Some examples of areas where progress is already well underway, and where existing leadership is clear and active include:

- Places like Rotherham, who already have many people with mental health problems managing their own individual budgets
- Places like Kirklees, who already have new commissioning arrangements for providers coming into place.
- Places like Barnsley, who have well established joint working arrangements between health and social care.
- Several places who are currently working with the Department of Health on the Personal Health Budget pilots.
- Several places, like Barnsley & Sheffield, who are working with the Department of Work and Pensions on funding integration ('Right to Control Trailblazers').

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Further mapping needs to take place over the coming months in order to ensure that the regional strategy respects, rather than undermines, local initiative.

Key Risks

One of the roles of the steering group will be to manage any risks which may obstruct or undermine the process of innovation. Some of the keys risks which it will need to watch for include:

- Implementation and innovation being frustrated by burdensome processes.
- Failure to focus on meaningful outcomes.
- Providers becoming disengaged, unduly fearful and their skills and energy not being used.
- Unexpected side-effects and equality issues.
- Failure to really integrate funding from health and social care.
- Practitioners or other stakeholders not being engaged or enabled to lead innovations.
- The experience and the leadership of people with mental health problems not being respected.

At the heart of the piloting of the Personalisation Model will be a commitment to learn together about approaches which work and the sharing of material, ideas and expertise. In this way the process of experimentation and piloting can take place quickly and without undue cost. There must be particular care not to treat inevitable anxieties about competence and expertise as a reason to draw in excessive level of consultancy or external training.

Experience teaches us that an undue reliance on external help can encourage dependency and a failure to commit to new innovations. We must innovate together, learn together and support each other through the difficulties ahead. Only in this way can we build a sustainable path to a better future.



Information

Information

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Useful resources

The following websites provide useful resources and further information on the topics discussed:

www.yhip.org.uk | www.cpppconsortium.nhs.uk | www.centreforwelfarefrom.org
www.neweconomics.org | www.womencentre.org.uk | www.healthcomplexity.net

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Centre for Welfare Reform

The Centre for Welfare Reform is an independent research and development network. Its aim is to transform the current welfare state so that it supports citizenship, family and community. It works by developing and sharing social innovations and influencing government and society to achieve necessary reforms.

YHIP

Yorkshire and Humberside Improvement Partnership

The Yorkshire & Humber Improvement Partnership is the only initiative dedicated to improving health and social care outcomes for Yorkshire and Humber. It works across health and social care boundaries and with a range of partners from both health, social care, criminal justice agencies and independent and third sectors to create the best overall outcomes for people and families who need support and/or use services. Our key partners in the region are Primary Care Trusts, Local Authorities, Mental Health Trusts, and Strategic Health Authority, Third Sector and most importantly people and families who need support.

CPPP

Care Pathways and Packages Project

The Care Pathways & Packages Project (CPPP) is a consortium of organisations in the Yorkshire & Humber and North East SHA areas who are working together to develop National Currencies and Local Tariffs for Mental Health Payment by Results. The work is innovative and groundbreaking as on an international basis there are no comprehensive and effective examples of this type of approach. The consortium feeds into the national Mental Health Payment by Results Project Board and supporting governance arrangements and links with other development sites to undertake joint work and share learning. The project has a small core team of key personnel who work closely with the seven pilot sites within the project to develop the key products and objectives.

ADASS

The Association of Directors of Adult Social Services

The Association of Directors of Adult Social Services (ADASS) represents all the directors of adult social services in England. It works to inform and brief government ministers and civil servants about the impact of their policies; work with them on policy initiatives wherever appropriate, while engaging with opinion formers across the whole spectrum of current media outlets.





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