MutualGain

Spending the Mental Health Pound in Newcastle and Gateshead

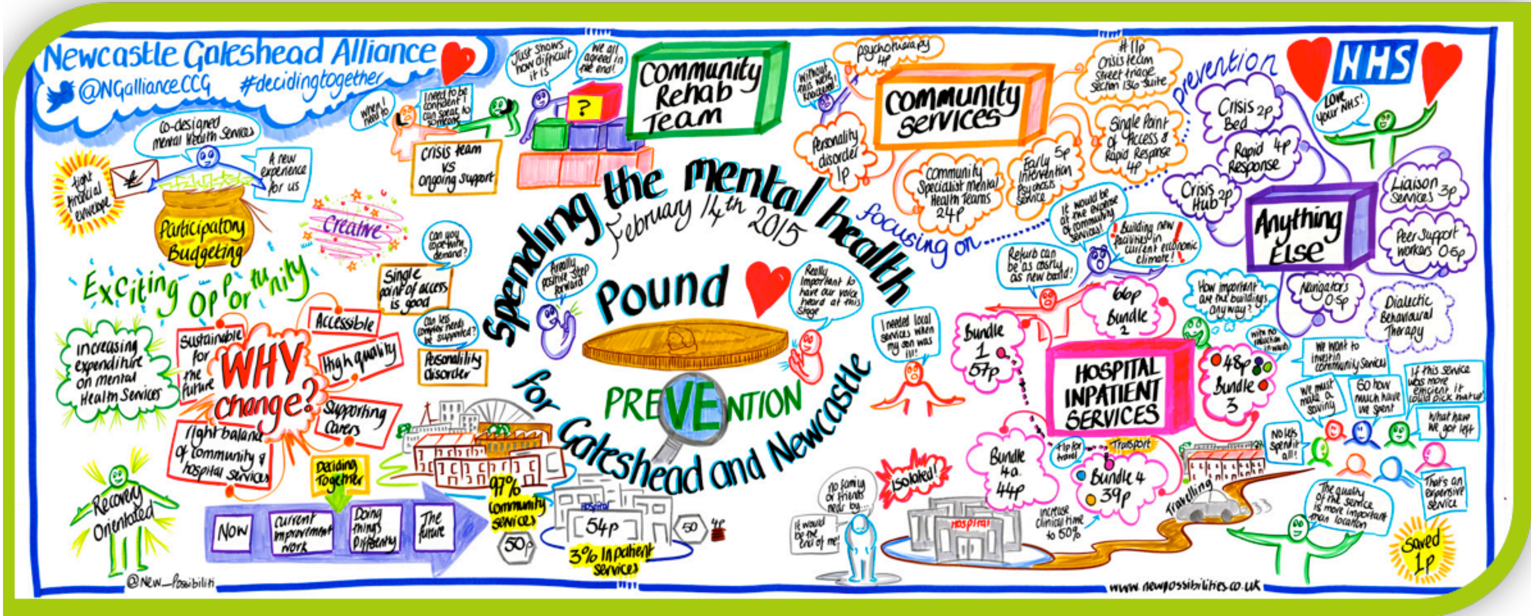


Table of Contents

Context	3
Participatory Budgeting	4
Event Design	5
Key Findings	6
• Listening Document	6
• Engagement Process	7
• General Responses to Presentation	8
Key Findings: Inpatient Bundles	10
Bundle Dialogue	11
• Bundle 1	11
• Bundle 2	12
• Bundle 3	13
• Bundle 4	13
Key Findings: Community Services	15
Possible Models of Care: Providers Event	16
Possible Models of Care: Public Event	17
Decision Making	19
Priorities from Provider Narrative	21
Priorities from Public Narrative	22
Public Feedback	23
Staff feedback	24
Conclusions	25
Next Steps	25
Appendices	26

Context

This report provides the findings and feedback from two Participatory Budgeting exercises on the Gateshead and Newcastle Adult Mental Health Commissioning cycle. The event was designed and delivered in partnership with the UK Participatory Budgeting Network and the Consultation Institute.

Mental health services have changed dramatically over the last 30 years and those changes need to continue. This is so that we can keep improving the quality of services, support people to have a better quality of life, recover sooner and challenge the stigma of mental health, which still exists in society.

In Gateshead and Newcastle we want to provide the best local services, as early and as close to home as possible.

Given the growing demand for services, NHS England predicts a national funding shortfall into the NHS of nearly £30 billion a year if no further efficiencies in the services are made, and funding is not secure at current levels.

(Deciding Together Listening Document)

The Deciding Together listening process includes a variety of engagement processes designed to hear the views of local people and providers. As part of that process, **the voluntary and community sector suggested that those responsible for the engagement process should consider the possibility of embarking on a participatory budgeting process**, to open up the debate and dialogue around the important financial decisions and dilemmas facing mental health services in the future.

Keen to test and learn new methods of engagement, the team approached the Chair of the UK Participatory Budgeting Network (also an Associate of the Consultation Institute) to help them consider how they could meaningfully engage the public on the way in which the mental health pound is spent:

We really want to work with you, our services users, carers and stakeholders to share and understand the challenges we face for mental health care.

(Deciding Together Listening Document)

Participatory Budgeting

Participatory Budgeting (PB) is a structured process that enables citizens to collaborate in decision-making around the allocation of financial resources. They do this with officers responsible for defined budgets in order to 'de-mystify' complex financial arrangements, so that future service models might be developed.

"Done well, Participatory Budgeting (PB) empowers communities, gets more people involved in democracy and improves local public services"

(Unpacking the Values, Principles and Standards: PB Unit, 2009)

Core values of participatory budgeting are:

- Support Representative Democracy
- Shared Responsibility
- Mainstream Involvement
- Local Ownership
- Empowerment
- Deliberation
- Accessibility
- Transparency

The Deciding Together listening process is intended to capture the views of the public prior to forming any decisions about future configurations of service provision. Building on the feedback to date from focus groups, road shows and public meetings, the team worked to incorporate emerging thoughts and ideas into a process of deliberation over the tough financial decisions facing commissioners. They were keen to engage in a budget-focused process that enabled intelligent dialogue and debate: using real budgets the Financial Director worked with the team to transform large budget figures into their broad equivalent of pence in a pound.

Deliberation is an essential component of participatory budgeting: this exercise enabled participants to deliberate at an early stage in the decision making process, which will inform future deliberation on commissioning arrangements.

Event Design

1. 0 Opening presentations by senior officers

2. 0 Participant feedback activity outlining any questions or comments they had on three aspects of the listening process:

- Listening Document
- Engagement Process
- General Responses to Presentations

3.0 Budgeting Detail and Instructions for the afternoon

4.0 Spending the Mental Health Pound

- Inpatients Bundle Deliberation and Selection
- Community Services Deliberation and Selection

5.0 Plenary and next steps

The event was delivered on two separate days for two different audiences: providers and service users. This decision was taken on our recommendation: we wanted to ensure that service users had an opportunity to use their experience to inform debate with other service users, and to enable providers to share their experiences on any relationship/contractual issues that may emerge when spending the mental health pound differently.

Two service users questioned the rationale for holding two events and asked to attend both, which was agreed. They contributed fully on both dates. On the provider day there was feedback asking why service users were able to contribute to a 'provider' event: we explained the concerns of both service users and in the spirit of transparency they were welcomed to the event.

Mistrust of historic engagement activities is an issue that emerges throughout the dialogue and a problem that the Deciding Together team is aware of and fully committed to improving. This event is a good example of opening up the detail of decision making and inviting new ideas and challenges to potential future service configuration scenarios: the team should be commended for their dedication to move toward a more co-designed approach to scenario development. Our recommendations provide some suggestions on how this might be taken forward in the future.

Key Findings: Round 1 table discussions

After hearing from key speakers participants were invited to comment on the Listening Document, the engagement process or offer general thoughts to information provided.

Listening Document

'The document was really good, helpful and easy to follow'

The Listening Document was felt to provide stakeholders with clear and useful information, with some suggesting that it helped them 'think differently' about the challenging decisions that needed to be made about informing quality and efficiencies.

Many felt that the document pulled out the key issues, particularly around in-patient services, and there was positive support for the inclusion of 'parity of esteem'.

More information was required on:

- The associated costs of St Nicholas
- How the SPA works?
- Travel times not distance, and that these times should be based on real routes (specific example given about information on page 41)

Suggestions for improvement based on the document included:

- Use of 'Metro cards'; taxi passes and bus passes to mitigate any travel issues
- Enable crisis teams to refer into 'listening' services
- Remove the 'bouncing' around the system – people can't get back into services
- Over reliance on GPs involvement should be cautiously embarked upon – some people don't have access to GPs, and where some do, they won't refer into clinics like Hadrian's
- Free mental health education to level 2 in the future
- To ensure that when discussing 'parity of esteem', you do so in terms of understanding what the balance of hospital/community care costs are in physical health provision, so that a reasonable comparison can be made
- More detailed and increased range of case studies for future scenario development
- Like the idea of Single Point of Access but would need to be a freephone number and those receiving the calls should be able to make referrals
- Ensure travel times are based on real routes

•

Engagement Process

“Extremely important and valuable that we are engaged in this”

“I am really happy NTW now involve service users to make decisions together and don't just assume what services people want or need”

‘best consultation ever’

Overall, participants were pleased to be engaged and viewed engagement as an entitlement which the Deciding Together team should continue. However, the process was not without criticism, with many of the criticisms informed by historic tokenistic engagement processes:

‘we’ve done this before and nothing happens’

‘sick of saying the same things and you do what you want anyway’

Concerned that the decisions have already been made and there is no real opportunity to make a decision by coming here.

Comments which seem to reflect this particular listening process were focused around NTW bias and the services forming just one part of the mental health service provision jigsaw:

“We are looking at one piece of the jigsaw - would be useful to link the jigsaw pieces across the whole picture from the point of view of the person”

“CCG not bold - feels like providers (NTW) are in charge”

“Very disappointed with the CCG head. Not have involvement - too many NTW staff”

Not covering primary care here

There were comments made about the potential bias in the survey design, suggesting that the questions were biased against Hopewood Hospital, that the questions from the Royal College of Psychiatry were biased, and that there was no opportunity to respond to questions about where services might be based.

General Responses to Presentations

Many stakeholders liked what they heard in the presentation and felt it was authentic, with some asking why the context and challenge hadn't been shared earlier. The presentations acknowledged the complex issues that the services faced, with participants welcoming the shared presentation of data. The presentation of financial distribution of 3% of patients receiving 54% of the budget was also welcome contextual information.

A few participants felt that the 4% clarity on savings should be split across in-patient and community services to prevent the assumption that the savings would all be made from in-patient care.

Presenting evidence of 54p and 50p - suggests overspend in inpatient - is this correct?

Misleading to represent the 4% saving - it looks like this is on inpatient service. Maybe the 4% should be split.

A question was asked in the group about the cumulative impact of failing to achieve the 4% savings. Responses were provided to the group explaining the reinvestment rules, for instance, no savings this year would give a knock on effect for 2016/2017, which could mean savings of the equivalent of 7p would need to be made to catch up, and that would impact on future decisions.

Participants acknowledged that Local Authority cuts would also have an impact on patients, which should be considered as a whole picture to avoid a negative, fatalistic dialogue, which appeared to have closed by likening the climate in Mental Health to that of Greece within Europe!

The strong concerns about 'waiting times' was reinforced with further concerns shared about patients bouncing between services, and a lack of a patient care plan:

Passed from pillar to post at NTW

Information about who you've seen, what's happened, what's happening next, what else is on offer if you've been refused a service. Some patients not given that information or given it but not understood it

The 'Transition for Children and Young People' into Adult services was a welcome part of the presentation and many stakeholders felt there is a need to do more to support the transition between services. Whilst children and young people's services weren't within scope of this event, there was a call from participants that a similar process should be undertaken with other strands of the Mental Health Programme Board

"Need to look at transition, as more focus is needed"

"Synergies between young people and adult services"

"Handover from children to adult services is not great"

Again demonstrating high commitment to patient centred services, one participant challenged the listening document's suggestion that more time would be spent with patients, arguing that they were:

Not actually managing to increase time spent with patients.

Concern for patient welfare is high, particularly around patients who are not currently accessing services:

People fall between services, depending on how they meet 'critical'

Not enough services to go around to meet demand

Participants took the opportunity to record issues that they felt were missing and needed greater inclusion in future configurations of services:

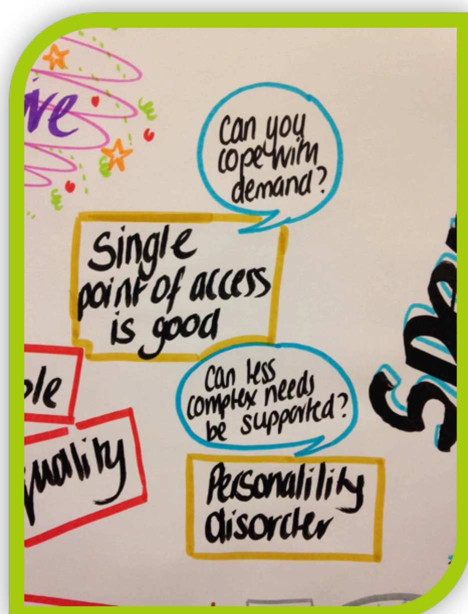
- Medication management
- Well-being – diet and general health need support
- Closer relationship with GPs to ensure they make the right referrals and offer the right support
- Greater focus on patient choice
- Locally accessed, project based services

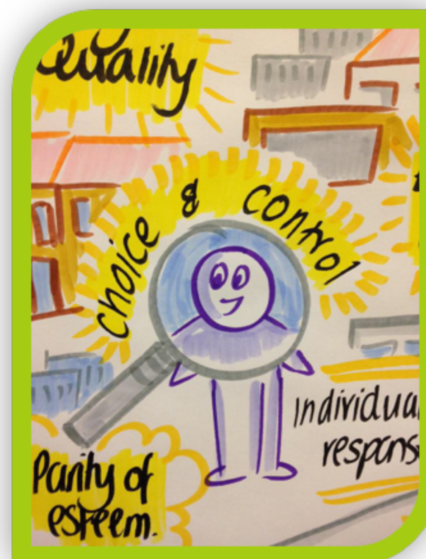
Overall, there was support for more community services within the mental health care pathway, albeit some of that support comes from frustration and obstacles faced in the current service delivery model, and the aspirations that are shared with the desired outcome of the Mental Health Programme Board:

Opportunity to pursue services in a community setting

Easier/quicker access to initial involvement of services.

Accessing and engaging less acute services before situations progresses/deteriorates





Key Findings: Inpatient Bundles

Participants were required to make a decision about their preferred 'bundle' of inpatient services prior to discussing any future community services. The bundles were developed in response to issues, concerns and comments raised throughout the listening process to date. Difficult decisions about the quality, location and composition of inpatient services will inevitably impact of financial decisions, so it was important that a range of approximately costed configurations were offered. Participants were advised that figures were approximate and that they were spending a pound for ease of the exercise, when a full (equivalent) pound might not be available in the future.

Explaining the cost of an individual ward is very difficult. Wards will cost different amounts depending on where they are, what services they provide and what other infrastructure is wrapped around those wards. During the listening exercises so far, and through discussion with the deciding together planning group, people had asked about a number of different potential configurations of wards. From these comments, the planning team pulled together 4 potential bundles of wards and work has been done to cost these.

These costings were developed by NTW and the CCG based on the actual cost of current services, and estimates of the likely costs of works. As with all elements of the mental health pound they are guide costs rather than detailed accountancy. However both the commissioners and providers were confident that the figures used were a fair reflection of likely costs.

The key purpose of the exercise was to improve the way in which providers and service users engage in the difficult financial decision-making, and help decision makers to understand the dialogue accompanying their preferred pathway composition. It also enabled participants to engage in a dialogue about specific locations of services and 'real' services within their community.

Overall, the information from part two of the day will help to inform future scenario and option development.

Bundle 1 – 57p

- Current services at the Hadrian Clinic and Tranwell unit, refurbished to meet minimum standards (5 acute admission wards)
- 2 rehab wards – one in Gateshead and one in Newcastle
- Existing access to Trust wide specialist services (psychiatric intensive care and high dependency units)

Bundle 2 – 66p

- New build in Newcastle and/or Gateshead area with existing numbers of wards (5 acute admission wards)
- 2 rehab wards – one in Gateshead and one in Newcastle
- Existing access to Trust wide specialist services (psychiatric intensive care and high dependency units)

Bundle 3 – 48p

- Single site in Newcastle or Gateshead area with less wards (using an existing site e.g. St Nicholas Hospital), (3 acute admission wards)
- 2 rehab wards – one in Gateshead and one in Newcastle
- Existing access to Trust wide specialist services (psychiatric intensive care and high dependency units)

Bundle 4 – 39p or 44p with the extra rehab unit

- No Gateshead/Newcastle based adult wards – inpatient services provided at St George's Park and Hopewood Park
- Option to add one dedicated local rehab unit
- Existing access to Trust wide specialist services (psychiatric intensive care and high dependency units)

Bundle dialogue

The final selection of bundle was unanimous on day one with all provider tables (and one additional service user table) deciding that bundle 3 was there preferred choice. On day two the majority of service users also selected bundle 3 with two exceptions that resulted in XXX

Participants were guided to stick within the costed figures and advised that by increasing the cost or shaving the cost of a bundle is not always simple: for instance, costing a ward will be different depending on location, surrounding services etc. However, there were some caveats offered by participants which have been captured here for developers of scenarios to take into account.

Bundle 1 – Rejection rationale

Where bundle 1 was rejected, the following rationale was offered:

- Poor building conditions
- Poor transport links
- Described Hadrian and Tranwell as 'grim'
- Would we rather spend more money and have a new build?
- If you create a Tyneside facility onto an existing building we could achieve more
- Hopewood is good but is cited in the wrong place.
- Short term solution to fix poor buildings
- Recruitment and 7 day working would take too long to implement and would therefore ultimately be more expensive
- Location is wrong

Bundle 1 – Considerations for including

- Close to home
- 'Local service on a personal level'
- 'Keep this – we have no concerns'
- Like it

Bundle 1 – further questions

- What is the length of tenure in Hadrian as notice had not been given to leave?
- The group wanted more explanation of what refurbishment meant and had worries over the cost and longevity of refurbishment
- Can we have numbers of how many are ill and what they are suffering?

Bundle 2 – Rejection rationale

Where bundle 2 was rejected, the following rationale was offered:

- Building condition
- Building location:
    - '*Geography is critical to patients and families. This is an important aspect to have as sometimes you can feel trapped'*
    - *'Locality and access supports the recovery journey; Gateshead people will come to Newcastle but Newcastle people won't go to Gateshead'*
- Felt to be appropriate but 'in an ideal world – it is not affordable'
- Standards are more important than 'new buildings'
- Too expensive; 'crazy' to build new in current climate
- *Ideally we would want this one but it has to be at the expense of community services*
- *Make better use of what is already there*

Bundle 2 – Considerations for including

- Support further collaborative working
- People are worth 66p!
- Preferable

Bundle 2 – further questions

- *Why is this so expensive if the capital costs are not included?*

Bundle 3

It is fair to say that although most groups agreed on bundle 3, it was often a compromised position and not always unanimously agreed upon. There were caveats on selections that included:

- Transport solutions to be offered which meet the needs of people in a range of locations
- The unit operates a 7 day discharge process
- A crisis house is offered in an alternative locality to address inequality of access when only having one site]
- Strong support for community teams to assist carers
- 7 day working, not just discharge
- Request costings for a 3 ward option
- Get the community services right
- No reduction in beds:
    - *Mental health is increasing across society;*
    - *More people are presented with mental health issues*
    - *There is more demand and less opportunity to access services.*
    - *Beds are not available when needed*

Bundle 3 – Rejection rationale

- Don't want to see a reduction in beds
- Like it but does not attract a generous enough investment
- Concern about the need to spread staff across 3 hospital sites rather than 2

Bundle 3 – Considerations for including

- Only realistic option
- Site is huge with massive grounds and great access
- Change the name
- Best thing we already have
- Still leaves some money to spend on community services
- 'Good indoor and outdoor balance'
- like Newcastle and Gateshead being merged into one hospital

Bundle 4 – Rejection rationale

Where bundle 4 was rejected, the following rationale was offered:

- 'Get rid of this, it is unacceptable'
- Inaccessible to family and friends
- Local services and support is a must
- 'Disgrace not being able to integrate into community'
- 'Thumbs down on all fronts'
- Impact on travel is too big

- ‘Dreadful!’
- Patient recovery negated
- Visiting is important

Bundle 4 – Considerations for including

- Some inpatients would like to be out of their locality
- Good offer if transport was considered
- Good offer if savings can be reinvested in community services

Key Findings: Community Services

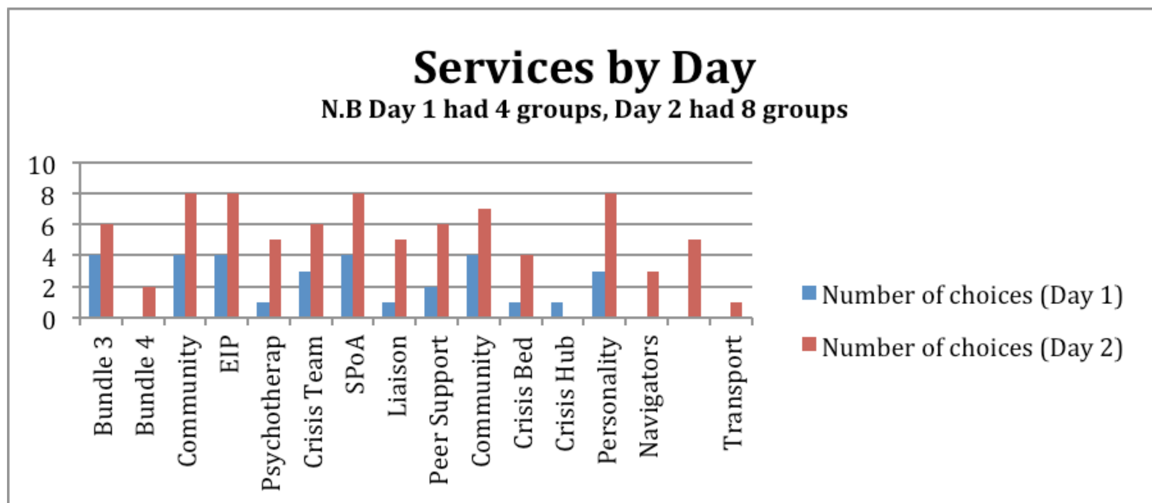
Community Services

After selecting their preferred inpatient bundle, participants were *required* to add on the Adult Community Mental Health services, costed at 24p. The rationale for making this service a compulsory element of any pathway was that the team could not imagine a pathway without the service being part of a core offer.

By adding the price of their required 'bundle' together with the Adult Mental Health Services, the remaining balance was used to select their configuration of community services – they spent their mental health pound.

A description of all the community services on offer are provided in appendix A. Orange coloured services were part of current provision, and purple coloured services consisted of new ideas to the Alliance, but which are currently offered elsewhere in the country enabling a rough costing.

The table below amalgamates all of the models developed across both days by providers and the public (four on day one and seven on day two). It shows real synergy of the decision and choice made to support the Inpatient Service offered through Bundle 3, and shows the variation in decisions made about preferred community services



Personality Disorder, Community Rehab and Community Specialist all gained high support for the allocation of resources. Conversely, 'Transport' which featured in the majority of discussions did not secure strong allocation of money, despite the dominance of transport needs during conversations. This could be because it was discussed as a central caveat on all the dialogue around selecting the preferred bundle

Possible Models of Care: Providers Event

MODEL OF CARE 1	
Price (p)	Service
48	Bundle 3
24	Community Specialist
14	Bundle 1 - Home treatment + Hub + Bed - want this for 14p
5	EIP
4	Psychotherapy
1	Community Rehab
4	SPoA
100	TOTAL

MODEL OF CARE 2	
Price (p)	Service
48	Bundle 3
24	Community Specialist
5	EIP
4	AO
11	Crisis/S.Triage
1	Community Rehab
4	Psycotherapy
1	PD
98	TOTAL
-4	AO
+4	SPoA
-4	Psycotherapy
1	Peer support workers
2	Crisis Hub
2	Crisis Beds
99	REVISED TOTAL

MODEL OF CARE THREE	
Price (p)	Service
24	Community Specialist
1	Pers. Disor
48	Bundle 3
5	Early introductions to psychotherapy
4	Assertive outreach
4	SPoA
1	Community Rehab
11	Crisis Team/Street Triage
1	Peer Support
3	Liaison
102	TOTAL

MODEL OF CARE FOUR	
Price (p)	Service
48	Bundle 3 plus 7 day working
24	Community Specialist
11	Crisis Bundle
4	SPoA
1	Community Rehab
5	EIP
1	pd
94	TOTAL

Possible 'Models of Care': Public Event

Price (p)	**Public Participants Model of Care 1**
48	Bundle 3
24	Community Specialist
4	Psychotherapy
4	SPoA
1	Community Rehab
3	Liaison Services
1	Peer Support Workers
5	EIP
1	PD
1	Navigators
2	Crisis Beds
94	TOTAL

Price (p)	**Public Participants Model of Care 2**
48	Bundle 3
24	Community Specialist
4	Psychotherapy
4	SPoA
1	Community Rehab
3	Liaison Services
1	Peer Support Workers
5	EIP
1	PD
1	Navigators
2	Crisis Beds
4	Assertive outreach
1	Specialist Services
99	TOTAL

Price (p)	**Public Participants Model of Care 3**
48	Bundle 3
24	Community Specialist
11	Crisis Team
4	SPoA
1	PD
5	EIP
1	Community Rehab
4	Psychotherapy
3	Liaison Services
2	Crisis Bed
103	TOTAL

Price (p)	**Public Participants Model of Care 4**
48	Bundle 3
24	Community Specialist
1	Community Rehab
4	SPoA
11	Crisis Team
4	Psychotherapy
5	EIP
5	PD
1	Peer Support Workers
103	TOTAL

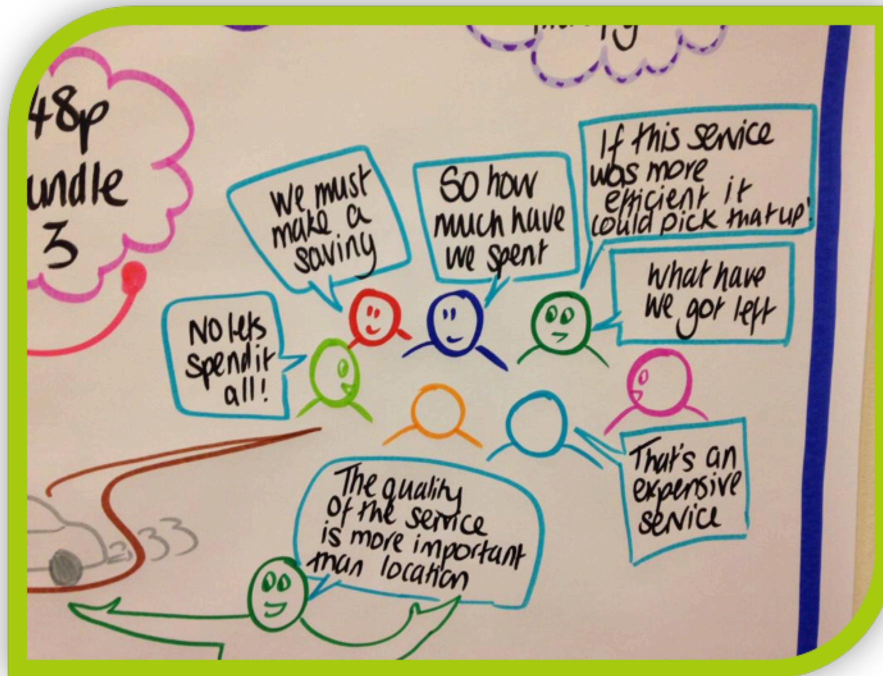
Price (p)	**Public Participants Model of Care 5**
39	Bundle 4
1	Transport
24	Community Specialist
4	Assertive Outreach
4	Specialist Services
5	EIP
11	Crisis Teams
4	SPOA
1	PD
1	Peer Support Workers
3	Liaison Services
2	Crisis Bed
1	Community Rehab
100	TOTAL

Price (p)	**Public Participants Model of Care 6**
39	Bundle 4
1	Transport
24	Community Specialist
4	Assertive Outreach
4	Specialist Services
5	EIP
11	Crisis Teams
4	SPOA
1	PD
1	Peer Support Workers
3	Liaison Services
4	Specialist Services
1	Community Rehab
102	TOTAL

Price (p)	**Public Participation Model of Care 7**
24	Community Specialist
11	Crisis Team
4	SPoA
3	Liasion Service
1	Peer Support Workers
1	Community Rehab
2	Crisis Bed
4	Psychotherapy
1	PD
5	EIP
48	Bundle 3
104	TOTAL

Price (p)	**Public Participation Model of Care 8**
48	Bundle 3
24	Community Teams
1	Navigators
2	Outreach
6	EIP & PD
11	Crisis Team
4	SPoA
96	TOTAL

Decision-making



Overall the process demonstrated the challenge that commissioner's face as they seek to address increasing demand with unmatched resources:

> *"Balance is hard to reach between increasing investment in community services, which will help the majority, against reducing investment in inpatient services that help people with the greatest need"*

Some groups didn't spend all of their pound. Despite the earlier presentations clarifying that savings could be passed to the CCGs for transformational change within mental health, there was still some confusion about that, which will need to be clarified when developing future scenarios.

At the point where groups started to show slight confusion on the choices they were making, or begin to debate the value of specific services, they reverted to asking each other questions about their selection:

- How does 50p add up now?
- What's not included?
- Who have we missed?

Confusion over required bed numbers, and whether rehab beds could be provided by another organisation also dominated many of the conversations:

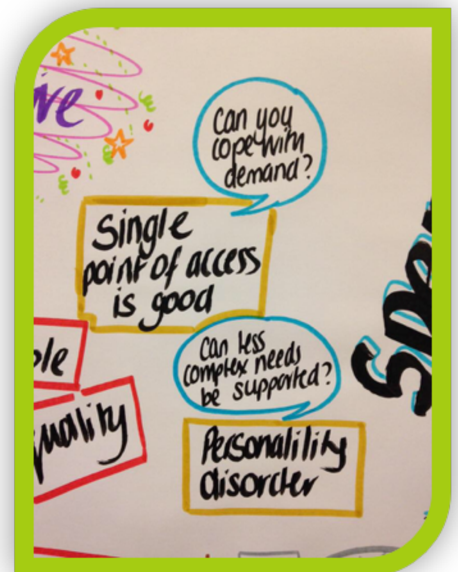
- How many beds do you need for in-patients?
- What's the minimum number of beds we need?
- If we remove beds this doesn't make savings, does it?

There was evidence that there was a lack of confidence in existing community services with groups insisting that these services '*MUST be brought up to scratch'* outside of this listening process.

Better understanding about how the voluntary sector can provide the community services and more talking therapies should be included for future scenario development as many felt this would be a more efficient use of the pound and possibly provide a higher quality of service. There were some misconceptions about the 'cost' of using the voluntary sector, and the use of volunteers (especially within the areas of peer support): some participants thought it might be free!

Other conversations surrounding the decisions about which community services should be commissioned included the following points:

- Need to reduce the admin burden on frontline teams
- Take out psychotherapy and offer a broad range of talking therapies
- Bring triage and outreach together
- Single Point of Access would be very helpful
- Peer support incredibly important
- More housing support needed
- Peer support vital
- What's going to happen to the mother and baby units?
- Is there a point of minimum amount of beds – saturation point?
- What does the outreach team do?
- Is personality disorder expecting to work with people for longer?
- Imbalance – early Intervention and personality disorder costs 5 times more - why should it be 5 times as much?
- 2.5 year waiting list for personality disorder – the current service is not doing a good job



Overall, there is strong support for 'early intervention' services, but also for services to link in together earlier in the pathway.

Some of the comments recorded indicate low faith in the current crisis services and some confusion about what 'crisis' is. Across all provider discussions there were calls to merge the crisis hub and beds, and three suggestions to move assertive outreach to community rehab teams.

Some argued that cost of crisis could be shared with emergency services if it means less people using section 136 and saving police time in this process. There was a view that police should be more connected to street triage: it was broadly felt that crisis bundles should ensure that those with mental health problems do not end up in prison.

There was a conversation about the transfer of addiction, eating disorder and Medi-Secre(?) to CCG commissioning and the aim of saving money by doing so – is this the case?

The group felt that the CCG, GPs and primary services were missing and should have been immersed in the event.

Priorities from the Provider Narrative

Across all discussion groups that took place at the provider's event, there was strong consensus on the core component needed within a new Mental Health Service Pathway – bundle 3 configuration. Underpinning their decisions, the narrative exposed the priorities, opportunities and questions that they feel need to be addressed in the future:

- The 'quality' of services provided must maintain a higher priority over new buildings and refurbishments
- There is a general reluctance to spend scarce resources on new buildings
- Transport and access must be **fully** considered before movement of services to out posted locations so that regular visits by family and friends can be maintained
- Location of in-patient care needs to be situated so that leave and accompanied leave enables a sense of familiarity for inpatients – out posted difficult locations is not desirable
- Support for carers and carers services must be maintained as the shift to community increases their role
- A hesitancy exists over the diversion of savings back into CCGs – this will require better explanations of any agreement to reinvest achieved savings
- The separation of crisis beds from the crisis hub is not understood – stakeholders believe that the service would be more effective if combined
- Currently, the opinion of the crisis service is very low and this perception must be addressed to give confidence to stakeholders that the shift to community will work
- The role of psychotherapy is negatively perceived with a stronger commitment to alternative talking therapies which may have a home in primary care and could potentially be delivered through the Voluntary sector
- There is some confusion on role and capacity of the community rehab services. Many see opportunities for this service to provide assertive outreach services and have made suggestions for other mergers.

Priorities from the Public Narrative

Public participants allocated resources to reflect the priorities seen in their dialogue. There was strong support for the Inpatient Bundle 3, although there was some level of mistrust in the construction of the Bundles on offer. For many, Bundle 3 is the only viable bundle, with some suggesting that the Mental Health Programme Board constructed it to be the 'preferred outcome'.

The experiences shared have shown there to be real concerns about issues in *current* service delivery that need to be addressed swiftly eg:

- Access to services, referrals and waiting times
- Mass discharge

Those concerns cannot wait until the implementation of any future model – these are real concerns that are barriers to trust, and which will have a negative impact on future engagement of this programme. While a few participants declared little trust in their comments being listened to post event, the majority were very positive about the process and dialogue.

A greater level of dialogue was seen during the community services discussions reflecting the public appetite to receive a more personalised and pragmatic approach to supporting mental Health patients. They are strongly supportive of early interventions services, and see a need to ensure that carers support needs are a focus within community teams.

In developing new models of care, future scenario development should reflect the common themes from the public discussion:

- Transport (access and costs) - there are strong concerns about the future location of services. The public are concerned about personal cost impacts and see a role for the mental health service to invest in transport services and actual reimbursement to families, carers and friends
- The role of the crisis hub and crisis bed – there is uncertainty on the value of providing a crisis hub without crisis beds and a future thought that the crisis service will be a lesser future need, if other early intervention services are working well. Though some see the services potential if merged.
- The offer of navigators/peer support workers was seen as duplication. The public believe that only one role should exist
- Psychotherapy is seen as a service that does not have to remain a 'core' Mental Health Service. It was seen as having a home in primary care and could be provided externally.
- The quality of services is a far higher priority that the investment into new buildings – indeed, by many groups this is seen as wasteful.
- Some participants question the quality and content of the information given (Listening Document) and feel more exact modelling assumptions are needed to make an informed choice
- Key partner involvement was not visible – it was noticed that the CCG, clinicians, GPs and nurses were not visibly involved. The public struggled with the absence of primary care, indicating that they understand the interdependencies of the whole system and do

not think there is adequate focus on the impact and capacity of the wider healthcare economy.

Public Feedback

Immediately after the event participants commented vocally on the quality of interaction and the appeal of the process: they enjoyed learning more about the commissioning process of decision making, and recognised the challenge that commissioners faced. As a result they were very keen to be further involved in developing future scenarios to reflect the comments they made in their table discussions.

All participants were asked to complete an evaluation form at the end of each event. The results are extremely positive with exceptionally high ranking for the ability to contribute to the table discussions.

Written feedback comments were again exceptionally positive with comments including:

Excellent - good discussion, thoughtful, flexibility of response encouraged.

Good that we can go away and think about today's outcomes and come together again when material collated and possible scenarios suggested.

Really enjoyed the opportunity to discuss, explore and debate, with other colleagues. It made me realise the difficulty placed on ensuring the appropriate services are being offered.

A brilliant unusual way to understand the budget and how to prioritise services.

It was a very useful process and quite enjoyable to 'wear a commissioners hat' and have to pick and choose which services are most important.

Well organised.

Great interactive day.

Participants highly valued the presentation content and appreciated the opportunity to learn more about the healthcare system. They were asked what they liked least about the event, and most comments were about:

- The lack of discussion on young people's services
- Not fully understanding the component parts of services; and
- The boundaries outside of NHS mental health services not being discussed (the wider healthcare economy).

Not everyone understands the specific functions (or importance of) specialist teams. e.g. liasion dismissed

Narrowness of services discussed (no older/younger people's services/carers service/VCS provision.

NHS boundary meant that other ways of achieving financial efficiency were not discussed

There were also some comments about a lack of time to read the information in advance and insufficient publicity about the event.

On being asked what they liked most, many participants praised the opportunity to be given a voice and the friendly environment.

Service users and carers given a strong voice

An honest attempt to present challenges of improving services with limited resources

The full evaluation findings are reported in Appendix B.

Staff Feedback

It is important to capture staff feedback on the process given it is the first time this has been done within the team, and had proved challenging at times.

What worked well?

- Building Blocks enabled to focus to remain on conversations
- Working lunch – did not disrupt the flow of conversations
- Participants remained focused on solutions
- High willingness to participate
- Healthy debate
- Small group at each table
- Safe environment
- Honest sharing of experiences
- See potential peer advocates in participants
- Healthy disagreements
- Good to listen at this – the right - time in process
- Presentations – good

What could be improved?

- Should have read the facilitators briefing in advance
- Use the stories and present them in a different way
- Comments/questions could be included
- Minimise Powerpoint – discussion felt rushed
- Post its on round 1 could have been clearer
- Building Blocks - £ on top name on side
- Keep scribe notes to self
- Need more space for flipcharts
- Rules of engagement – listen, private conversation – role of facilitator.

Conclusions

The events of 13th and 14th February were designed to hear how service users and providers would 'spend' their pound if they were commissioners. This is part of the *listening* process – not the decision process: feedback from the events will inform the next stage of PB, opening up the budgets further.

Listening to how people made their decisions and observing the types of decisions they made at the events was part of the team's learning and understanding about what people value, and how they would address the challenge of transformation within the budgets available. **By listening and understanding what participants valued, future scenarios can be developed to reflect the variety of voices on the topic (Service Users, Frontline Practitioners, Professional Standards Bodies, Central and local government Guidance etc).**

The PB process can help to demonstrate shared responsibility, engage the population in discussions they might not ordinarily have in common listening processes, help to identify local priorities, and produce fairer, better informed decisions about those priorities.

In a recent report of participatory budgeting in mental health, a Medical Director wrote:

"Participatory budgeting has been used across the world for over 30 years. Since its emergence in Brazil, it has spread to hundreds of cities. The international results show that participatory budgeting produces ***more equitable public spending, better quality of life for individuals, increased satisfaction, and greater government transparency.*** *It grows vertical bridging social capital and social efficacy and can decrease the impact of the fundamental social causes"*

This PB process was suggested by a community organisation in the area, and the team acted on the suggestion to make it a reality: it was a locally led request, and not a top down imposition. The first time that the team has embarked on a possible participatory budgeting process has revealed their integrity and commitment to transparency, which will no doubt help to shift the tide of mistrust held by those they serve when it comes to engagement.

The core values of participatory budgeting are:

1. Support Representative Democracy
2. Shared Responsibility
3. Mainstream Involvement
4. Local Ownership
5. Empowerment
6. Deliberation
7. Accessibility
8. Transparency

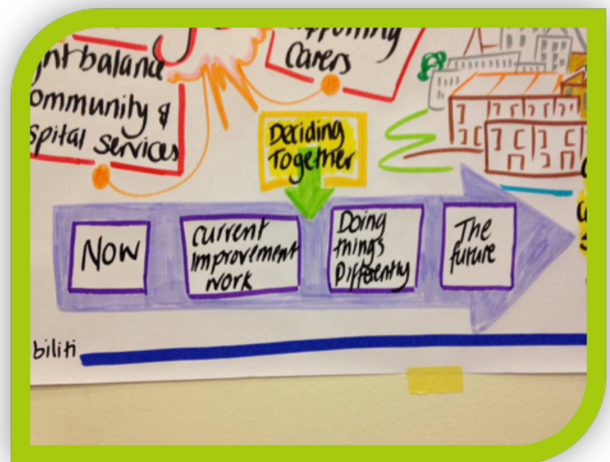
This event focused specifically on transparency and deliberation in an attempt to develop a greater understanding on how to ensure the remaining values are captured in future processes.

With overwhelming support from the public who participated in the process, they are encouraged to extend the process of participatory budgeting further into other workstreams of the Mental Health Programme Board as well as developing *this* process further into the scenario development stages of commissioning new models of care.

Next Steps

This learning from this process should be developed into scenarios for further engagement with the public and providers. Possible areas for inclusion in any future rounds of participatory budgeting could include:

- Numbers of beds included in each scenario
- Accurate indication of occupancy of current beds
- Costs of bed clarified
- Understanding of the range of professional standards that inform each bundle
- Draw on real or comparable building costs for new builds
- Use existing data to show current demand in the relevant areas
- Use existing data to show travel routes and socio economic profiling to inform the relevant scenarios



Some of the above was explored in preparation for these events, but the team wasn't able to include all the data on the day due to timing. One way of addressing this in the future would be to provide pre event material that could be explored before the actual event date.

INFORMATION FOR BUILDING BLOCKS USED TO CREATE BUNDLES OF COMMISSIONED SERVICES

Orange

Community Specialist Mental Health Teams

Description

A combination of doctors, nurses, psychologists and occupational therapists who provide care and treatment to people either in community based clinics or in people's own homes.

The teams will increasingly offer things like:

- Evidence based therapeutic interventions
- Increased availability of psychological therapies
- More access to staff
- Evening and weekend clinics and visits
- Community review of medication

Increasing investment

Community specialist mental health teams are at the heart of support for people who live with mental ill health. This is a service which most people use and rely upon.

Decreasing investment

It is likely community specialist mental health teams will see less people and there may be more delays in getting help. This may result in more people becoming unwell and needing to go into hospital.

Cost
24p

Assertive Outreach Service

Description

This is a service for men and women over the age of 18 years who need very specialist support to live in the community.

Assertive outreach aims to improve the quality of life of patients by:

- **preventing social exclusion**
- **helping to manage and cope with difficulties**

- **promoting choice**
- **managing risk**
- **reducing hospital admissions**

This service is already included within community mental health teams in some areas – this still costs the same, but is more flexible.

Increasing investment

Investing in this service helps people with specific needs feel more supported in their community.

Decreasing investment

If we spend less on this service, people with really complex mental health needs could become more excluded and more unwell.

Cost
4p

Early Intervention in Psychosis Service

Description

This service works with young people who are experiencing a first episode of psychosis (up to 34 years old) and helps them recover from a psychotic episode.

Also helps reduce the likelihood of experiencing further psychotic episodes in the future.

The service is made up of a team of professionals (including nurses, psychologists and psychiatrists) who have specific experience in working with people with psychosis.

Increasing investment

In some areas, early interventions in psychosis services are provided as part of the community mental health team.

Supporting this function makes sure that young people with psychosis get the best chance to recover quickly.

Decreasing investment

If we spend less on this service, younger people with psychosis might not get the evidence based treatments which we know help them to recover. This means that they may become more unwell for longer, leading to poorer quality of life and unnecessary time in hospital.

Cost
5p

Psychotherapy

Description

Psychotherapy is a specialist NHS service for outpatients. It is used to help people with a wide range of mental health, emotional and relationship problems.

Psychotherapy is a "talking" treatment and takes place either one to one with a clinician, or in a group with others and a clinician.

The psychotherapy service is for people with complex, very difficult to treat conditions, which require more specialist support than the community mental health team can provide.

Increasing investment

Investing in a specific psychotherapy service means that people with complex mental health issues will be provided with an opportunity to recover and will be less likely to spend long periods of time in hospital. The service provides a number of therapeutic interventions that can be tailored to meet the needs of individual service users.

Decreasing investment

If this service wasn’t provided individuals with complex mental health issues would be unable to access the specialist treatment necessary to promote recovery.

This would result in ongoing distress for the individual, their family, demands in other aspects of healthcare, for example, GPs and potential for extended hospitalisation.

Cost

4p

Personality Disorder Service

Description

Is a specialist service which provides expert advice and support to people with very complex emotionally unstable personality disorders.

Clinicians directly support and treat people with the highest levels of need, and also advise community mental health teams and others about the care and treatment of people with personality disorders.

NHS Choices describes personality disorders as ‘conditions in which an individual differs significantly from an average person, in terms of how they think, perceive, feel or relate to others. Changes in how a person feels and distorted beliefs about other people can lead to odd behaviour, which can be distressing and may upset others’.

Increasing investment

People with personality disorders can be high users of health and social care services and can need very high levels of support; this is often due to the risk they present to themselves and sometimes to others.

Hospital admissions can be very long and can have a negative effect. Specialist support is more effective as the care and treatment can be tailored to meet the individuals' needs and therefore focuses on recover.

Decreasing investment

Likely to increase lengthy, unnecessary stays in hospital.

Individuals with a personality disorder who are not in a hospital bed will place demands on other health care and social care services, for example, GP, A+E, housing, and on other public services such as police.

A lack of specialised assessment and treatment will lead to ongoing distress for the individual and their family. Inability to access specialist care can increase the risk of harm to themselves and/or others significantly reducing the risk of recovery.

Cost

1p

Green

Community Rehabilitation Team

Description

Provides support for people with serious mental illness and complex needs who require additional specialist help to move from hospital into the community; or to stay well in the community and avoid relapse.

Increasing investment

Investment in this service over recent years has helped people to move on from longer stays in hospital – especially from the rehabilitation inpatient services; and enables people with very complex needs to avoid hospital or have shorter stays.

Decreasing investment

Without this support, people with more complex serious mental illness may have unnecessary stays in hospital or longer lengths of stay

Cost

1p

Yellow

Crisis Team, Street Triage and Section 136 Suite

Description

Crisis Team - Is a group of experienced mental health staff offering assessment and home treatment for people experiencing a mental health crisis.
Provides support to people in the community and prevents people going into hospital unless absolutely necessary.

Works 24 hours a day, 7 days a week.

Street Triage: Is a small team of police officers and nurses working together over defined hours, 7 days a week.

This team works to ensure anyone with mental health problems who comes into contact with the police will get the right support and signposting to avoid an arrest under Section 136.

Section 136 suite: Is a safe place in hospital if a police officer feels that a person may have a mental disorder and they are concerned that the person is vulnerable and requires support. The removal to a 136 suite (place of safety), for a maximum of 72 hours, will enable a formal assessment of your mental health needs to be undertaken.

Increasing investment

These elements help people to get timely access to mental health services, manage crisis situations, and avoid unnecessary hospital admissions, assessments or stays in custody. They also provide better support for your carers and family.

Decreasing investment

Increased number of avoidable hospital admissions placing unnecessary demands on hospital beds. Potentially more distress for service users and their families.

Cost
11p

Single Point of Access and Rapid Response

A single point of access for anyone needing to access mental health services 24 hours, 7 days a week for queries, advice, help, support and access to NTW services.

Increasing investment

Providing a single contact phone number reduces confusion for everyone. No bouncing or being passed around services. People get the correct advice and treatment first time. Every contact will be dealt with quickly and appointments can be arranged directly with you at a time that suits you.

Decreasing investment

Continuing confusion about how to access mental health services in NTW and risk of delays in getting the right help.

Cost
4p

Fuschia

Inpatient Services

Bundle 1

- Current services at the Hadrian Clinic and Tranwell unit, refurbished to meet minimum standards (5 acute admission wards)
- 2 rehab wards – one in Gateshead and one in Newcastle
- Existing access to Trust wide specialist services (psychiatric intensive care and high dependency units)

Advantages

- Closer links to community teams
- Inpatient care closer to home for some patients
- Greater opportunity for co-terminus working with local authorities and other organisations

Disadvantages

- No supportive heart of the hospital facilities
- Less opportunity for 7 day medical working
- Despite upgrade, facilities not to the same standard as other areas within the Trust
- Recruitment difficulties within limited service model
- Requires more investment in inpatient services at expense of community services

Cost
57p

Inpatient Services

Bundle 2

- New build in Newcastle and/or Gateshead area with existing numbers of wards (5 acute admission wards)
- 2 rehab wards – one in Gateshead and one in Newcastle
- Existing access to Trust wide specialist services (psychiatric intensive care and high dependency units)

Advantages

- High quality purpose build has positive impact on patient care
- Closer links to community teams

- Inpatient care closer to home for some patients
- Greater opportunity for co-terminus working with local authorities and other organisations

Disadvantages

- Less opportunity for 7 day medical working
- Requires more investment in inpatient services at expense of community services

Cost

66p

Inpatient Services

Bundle 3

- Single site in Newcastle or Gateshead area with less wards (using an existing site e.g. St Nicholas Hospital), (3 acute admission wards)
- 2 rehab wards – one in Gateshead and one in Newcastle
- Existing access to Trust wide specialist services (psychiatric intensive care and high dependency units)

Advantages

- High quality purpose build has positive impact on patient care
- Closer links to community teams
- Inpatient care closer to home for some patients
- Greater opportunity for co-terminus working with local authorities and other organisations

Disadvantages

- Less opportunity for 7 day medical working
- Requires more investment in inpatient services at expense of community services

Cost

48p

Inpatient Services

Bundle 4

- No Gateshead/Newcastle based adult wards – inpatient services provided at St George's Park and Hopewood Park
- Option to add one dedicated local rehab unit
- Existing access to Trust wide specialist services (psychiatric intensive care and high dependency units)

Advantages

- High quality purpose build has positive impact on patient care
- Access to a broader range of clinical services i.e. heart of hospital
- Access to 7 day medical working
- Will aid recruitment of more skilled practitioners
- Reduces financial pressure on community services

Disadvantages

- Outside the boundaries of Gateshead and Newcastle
- Further for carers to travel
- Potentially harder to link with social care
- In-patient services are further from home and community

Cost

39p (or 44p with one local rehab unit)

Potential New Services

Crisis Hub

A non-residential place that offers immediate advice and support/signposting and some level of safe place (sanctuary) to those in mental health crisis

What's important to you?

Cost - 2p

Crisis Bed

This is usually a short term facility, residential services with staff onsite through the night.

Can be staffed with a high level of clinical staff providing onsite care, or alternative models provided by user led organisations with fewer or potentially no clinical staff.

Strong links with mental health teams/primary care.

What's important to you?

Cost - 2p

Navigators

Support workers (sometimes volunteers) who help people identify their different needs. Advise them about the services and wider community resources that could be useful to them and to actually help them access and be involved with these services.

What's important to you?

Cost - 1p

Peer Support Workers

People who are experts by experience who provide social, emotional or practical support but this is on a mutual and reciprocal basis. Might be employed or volunteers. Developed out of self-help movement

What's important to you?

Cost - 1p

Potential New Services

Liaison Services

Usually refers to services provided by mental health professionals who work in non-mental health settings for example A&E, other parts of the hospital, police, primary care etc.

What's important to you?

Cost - 3p

Participant Feedback

The word cloud below summarises what participants liked most about the event

When asked what they liked least, the word cloud below summary captures the words they used most

When asked what they thought of the day, there was an overwhelming majority of positive comments including the following:

Very good start. Blocks/packages possibly a bit dictatorial follow-up sessions needed to be 'creative' with that pound.
Excellent - well worth attending
Very good.
Excellent - good discussion, throughful, flexibity of response encouraged. Good that we can go away and think about today's outcomes and come together again when material collated and possible scenarios suggested.
Really enjoyed the opportunity to discuss, explore and degate, with other colleagues. It made me realise the difficulty placed on ensuring the appropriate services are being offered.
Abrilliant unusual way to understand the budget and how to priotitise services.
It was a very useful process and quite enjoyable to 'wear a commissioners hat' and have to pick and choose which srervices are most important.
Well organised.
Great interactive day.
Good
An interesting experiencewith some surprises. Thank you to all.
Fantastic Great
Useful and hopefully effective
Excellent - very well worth it
Successful
Very interesting. A lot of views, and values captioned through the discussion work.
Very informative. It is a useful response to problems of re-structuring.
Good as a first start
Very good. Interesting and accessible method to work through difficult issues
Very informative, I did think however that the event showed up the inadequacies of mental health provision so far
Interesting. Very good excellent idea.
Very good - informative and throught provoking
Interesting day wiht opportunity to get a better understanding of difficulties involved in the planning etc of provision
Very good - super to give service users and carers a voice - thank you
Very good to feel your opinions are being listened to.
Excellent
Very good Constructive comments and feedback
It was good
Very good Thought provoking A good decision making exercise
Was well presented, and enough information given for workshops to be of value
Very good
Excellent day. VERY useful, challenging and awakening

Good organisation and disseminatin of event information. The format with building blocks is a great way to do this. Facilitators excellet at ensuring all views were heard, clarified and captured.
Brilliant event. Able to contribute with boxes, understand more about services and get an idea of things that must be thought about in terms of finance.
Arrived late, but I thought the participatory budget was excellent
Very good. Kept people focused
Well organised, focused and timing well managed. Very valulable exercise with the boxes, which highlighted the difficulty in managing the budget.
Informative, very open discussion, very well facilitated
Very well done. Worked better than i would have imagined
A very transparent process and good to have our videos heard.
It's refreshing to share opinions of service users to give them a voic before changes are made and help destimatise mental health.
Very interesting.
Good, informative, diverse. A bit vague on some statistics, such as bed availability etc
Misleading information which seems to weigh towards out of area services.
Excellent, thought provoking & well organised.