Manchester Community and Mental Health

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Response to 'Mental Health Services – Our Plans to Stop some of our Services'

The numbers relate to the Response Form, but we have not confined our response to these questions.

1. No, these services should not close. It doesn't make sense in terms of recovery, or ethically or financially. We do not agree with the Trust's distinction between 'essential' or 'core' services and others. All the services are essential for the people who use them. Furthermore, on the Trust's own definition, we believe that some of the services should actually have been defined as 'core' – for example, the Psychosexual Service and the Specialist Service for Affective Disorders, as they appear to fit the criteria for 'core'.

2 We do not accept that the savings are 'necessary'. The Trust should put its responsibility to service users, and to staff, above its financial responsibilities, and should not cut any services. The cuts minus the 'investment' of £200,000 would meet only a fraction of the Trust's deficit, so what is the point of so much destruction? Why won't the Trust refuse to implement these cuts?

We understand that there is a threat (we are not sure whether this is from the Department of Health, NHS England or Monitor) to send in 'administrators' if the Trust were to default on its financial responsibilities. We do not believe it would be any worse for service users or staff if the government carried out this threat.

3 & 6 We believe the £200,000 is an attempt to deflect attention from the cuts, and set the services in competition with each other for this meagre funding. Management have admitted that whatever the £200,000 is spent on will not be a 'core' service - so there is no guarantee that this funding will not be cut after the initial 'investment'. It is unclear what this £200,000 could be spent on: it would only be enough for 4 or 5 staff (if normal Trust oncosts are included), OR materials and facilities, such as building costs. There is clearly no way it could substitute for all the services to be cut.

4 We think it is wrong to ask people to which service they think is most important and would like to keep, and which is the least important. This is not X Factor or a beauty contest. All the services are important.

5 The Recovery/Wellbeing services already include peer-led groups and sessions. These are clearly of great value. But they cannot safely be run without specialist, trained, paid staff to provide support, and supporting volunteers takes a lot of time and resources. It is not, and should not be, a cheap option. Service users are experts in their own health, but not necessarily in supporting other people; and trying to do this could put undue pressure on them

if there is not a supportive team to provide back-up. Other teams are already over-stretched and cannot take on more work. It is insulting that having just suffered a massive reduction in staff when Recovery & Connect and the Community Support teams were closed, to now suggest that the Community Inclusion Service could take on more work. It is also insulting to the IPS Employment Specialists, who have developed an expertise in helping service users to get and retain jobs, that their work in helping people to get jobs could easily be replaced by other, untrained, staff.

There is no evidence that any group in the voluntary sector or the community is in a position to substitute for the existing experienced services. While the experience of people who have had mental health problems can be very helpful for others, there is a great danger in setting up service users and former service users as volunteers to run groups or sessions unless there is very good support from experienced paid staff, and clear limits and boundaries to what is expected of volunteers. Volunteers may themselves become unwell, particularly if they were to face the sort of pressures that existing community staff are facing, from the numbers and complex needs of service users.

7 The Trust has no future. All these services should be maintained to give a chance for whichever organisation takes over to decide how to incorporate them into their existing services.

The proposed cut of all these services only amounts to under £800,000, once the £200,000 is deducted from the total. This nowhere near meets the Trust's continuing deficit. So, other than providing some sacrifice to appease the government, we cannot see any logical reason for destroying so much for so little return.

We have already queried several of the figures (of service users and costs of and income into the services) and other information in the consultation document, using information supplied by staff in the services, but management has refused to make any of the changes we requested (apart from acknowledging the title of the Specialist Service for Affective Disorders). We believe the Trust has underestimated the number of service users directly affected (we calculate 700-800 people* who are current users or were on waiting lists – though waiting lists have now been closed), and there is no mention of all the potential users of these services in the future.

We questioned how the costs have been calculated for some services, and why income which some services generate had not been included in the consultation paper, and we do not feel we received an adequate response to this.

An Impact Assessment for each of the service was produced in October 2015, but as these were confidential internal Trust documents, we are not able to comment on them. We believe that these Impact Assessments should have been made public. In response to the Branch request that the Impact Assessment be made public, the Trust said that a comprehensive summary of them was included in the paper which went to the Health Scrutiny Committee on 29th October 2015. Apart from the fact that people responding to this consultation may not have been aware of or had access to that paper, without seeing the full Impact Assessments we cannot know whether the summary did indeed include all relevant information. The summary information, we believe, underplays the potential impact on service users and their families and carers if these services close.

Nevertheless, we believe that the impact of closure of these services will obviously be very significant for service users (both current and potential) but also for other services within the Trust. Management have admitted (at consultation meetings) that there are very few, if any,

alternative services – in the NHS or in the voluntary or community sector – to which service users could be referred if these services close. That means there will be more pressure and work for other teams, and service users will suffer. Many of them may deteriorate and have to be admitted to in-patient beds, with all the distress that will cause them and their families. At a cost of at least £350 a day for an in-patient bed, these costs will soon eat into the so-called savings the Trust will make by closing these services, so it is a completely false economy. As an example of potential cost of other services, SSAD research showed that there would be a 23% increase in bed usage if SSAD service was not available; based on 68 service users a year, that would be 15 people at £350 per day each which totals £5,250 per day – and usually such service users have long stays in hospital.

Specific Queries and Points

Benchmark: In response to the branch's queries, the Trust gave figures for income and expenditure associated with making furniture from 2010 onwards. These figures miss out the year when Benchmark had the greatest income, of £76,578 in 2009/10. They also appear to miss out the fact that the Trust can claim back VAT on materials used, which amounted to £32,000 in the five years up to 2010. Clearly, the work attracting income which Benchmark has done in recent years has been much less, but there is obviously the potential for work to be carried out which could make Benchmark 'break even'. This is quite apart from the fact that this is not meant to be a profit-making service – it is a therapeutic service, although Benchmark does not have a budget for its therapeutic activity, other than the salaries of the two staff. A few years ago, the possibility of turning Benchmark into a full social enterprise, separate from the Trust, was explored. There are possibilities of funding for such organisations in the third sector. While as a branch we would not support outsourcing of NHS work, we do think that in this case the potential for more outside work as a 'social firm' could help to keep Benchmark going. We also believe that the Trust could use Benchmark to provide carpentry and furniture in-house, rather than paying private companies to do this.

There are currently 15 service users who receive social wages, 'supported permitted earnings', at the rate of the minimum wage for up to 15.9 hours per week. The Trust has said that as they do not have employment contracts with the Trust, they will not be entitled to any redundancy payments if Benchmark closes. These social wages are obviously an important source of permitted income for these service users, and it will have a major detrimental impact on them if these social wages cease. The cost is currently only about £300 a month, though it has been about £1,000 a month in the past.

Note on figures for Benchmark: The figures the Trust provided for Benchmark differ from Benchmark's actual figures - but this may be to do with beginnings and ends of years and when invoices are actually issued and payments received. The figures which the Trust has provided for 2009/10 do not appear to be correct: income £78,205, expenditure £102,223, which should make a total deficit for that year of £24,018, not £34,556. In total, from 2009/10 to December 2015, Benchmark received income of over £216,000 and the so-called 'deficit' is overall only about £124,000 in total over 7 years - which given that this is a therapeutic service not a profit making company is a small amount per year, less than £18,000.

Individual Placement and Support Service: The Employment Specialists in the IPSS have an excellent record of helping people with mental health problems to get jobs and to stay in work. Taking referrals mainly from Care Coordinators, they provide help with finding and applying for jobs, interview preparation, liaison with employers (if clients want this) and time unlimited 'in work' support (that is, they will continue to support service users for as long as they need support, rather than having a specific time cut-off – though, of course, they do 'discharge' service users who no longer need their support).

There is substantial evidence that the IPS model is the best at helping people with mental health problems to get and keep jobs (for example, see extensive list of references on Centre for Mental Health website, www.centreformentalhealth.org.uk/ips-evidence)

They have a much higher rate of success than government schemes such as the Work Programme. In 2014-15, out of 132 referrals, the 4 staff helped 42 people to get jobs, supported 35 people to retain jobs, 15 people gained voluntary work opportunities, and 30 people went into education or training. The Work Programme is reported to help about 5% of people receiving ESA for mental health problems to get work (see Mind website, www.mind.org.uk).

Start and Studio One: Both these services already support peer-led sessions. The Trust has said that "MMHSCT employed staff are not expected to support this service in any formal arrangement". This is disingenuous, in that the support of qualified, trained and paid staff is crucial to these peer-led groups. They would not exist without the support of these two services, and it is part of a service user's discharge plan if they become involved in peer-led sessions.

Start 2: Despite the fact that the Trust says there is no plan to retract this service, and so it was not included in the consultation, it is unclear how it can continue if Start is closed. The activities were created by Start staff, and the art work (some of it by service users) cannot be amended without permission. Furthermore, the Trust said in response to the branch that "The plan is for the online service to continue and for it to be supported by the Trust's Health and Wellbeing Team." A new Health and Wellbeing Service has recently been established, with a new service specification from Manchester City Council Public Health Commissioners, based largely on neighbourhood working. The only two people with any art experience and skills were made redundant during the restructure. So it is unclear how this service could in any way take over the running of Start 2. Its future must, therefore, also be in serious doubt if Start is closed. Also, to be in line with current use of online and social media technology, it is recognised that Start 2 should developed to be able to be used on mobile phones.

We believe, therefore, that Start 2 is also at risk of closure, even though it was not included in the consultation paper.

Psychosexual Service: The Mental Health Improvement Programme published in 2014 specifically included a pathway for psychosexual services, which was added after the consultation process. It is listed as one of the 'Specialist Liaison Pathways' within the Mental Health Improvement Programme in the presentation by Craig Harris to the Health Scrutiny Committee on 19th January 2016. So how will it be provided / who will provide this service if the current service is closed?
It is still unclear how the cost of £99,000 has been calculated. The same figure has been quoted, even though the number of staff was corrected – from 1.2 wte to 1.0 wte. The salary costs of 1.0 wte would be about £47,000 so we do not know what the remaining £52,000 covers.

It is unclear how the referrals from outside Manchester, about one-third of the caseload, are accounted for. In response to the branch's queries, the Trust said that these were included in the block contract from Manchester CCG, which includes 'Associates' from other CCGs. Do these other CCGs / GPs who make referrals know that it is proposed to close the service? Has the possibility of them continuing to fund their referrals to this service been explored?

Specialist Service for Affective Disorders: There are only three such services in England. If the Manchester SSAD closes, this will lose actual and potential income for the Trust, since the Manchester service receives referrals from elsewhere in the country. It will also cost more to refer Manchester clients in future to one of the two other services. SSAD also attracts research funds, although these cannot be used for current service users, but this clearly adds to the status of the service nationally.

* We have based our calculations on information from staff in each of the services; they are not all from the same dates (as indicated). Staff say that Amigos is often not accurate in recording numbers of service users.
Benchmark: 31
Green Wellbeing: 14 + average 19 per week from Park House (acute wards and Acacia ward) + 4 Young Onset Dementia = 37
IPSS: 72
Start: 127 (September 2015 recorded on Amigos)
Studio One: 56
Chronic Fatigue Programme: 60 + 51 on waiting list = 111
Psychosexual Service: 79 + 186 on waiting list = 265 (over 200 referrals per year)
SSAD: 61 including waiting list (November 2015)
Total, including waiting list: 760