Overview & Scrutiny

Governance and Resources Scrutiny Commission

All Members of the Governance & Resources Scrutiny Commission are requested to attend the meeting of the Commission to be held as follows:

Wednesday, 10th June, 2015

7.00 pm

Room 103, Hackney Town Hall, Mare Street, London E8 1EA

Gifty Edila
Corporate Director of Legal, Human Resources and Regulatory Services

Contact:
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Members: **Cllr Rick Muir (Chair), Cllr Deniz Oguzkanli, Cllr Will Brett, Cllr Laura Bunt, Cllr Rebecca Rennison and Cllr Nick Sharman**

Agenda

ALL MEETINGS ARE OPEN TO THE PUBLIC

Hackney

10 Governance and Resources Scrutiny Commission - 2015/16 Work Programme (Pages 131 - 138)

11 Any Other Business

Access and Information

Getting to the Town Hall

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Induction loop facilities are available in the Assembly Halls and the Council Chamber. Access for people with mobility difficulties can be obtained through the ramp on the side to the main Town Hall entrance.

Further Information about the Commission

If you would like any more information about the Scrutiny Commission, including the membership details, meeting dates and previous reviews, please visit the website or use this QR Code (accessible via phone or tablet 'app')
http://www.hackney.gov.uk/individual-scrutiny-commissions-governance-and-resources.htm

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The Council will endeavour to provide reasonable space and seating to view, hear and record the meeting. If those intending to record a meeting require any other reasonable facilities, notice should be given to the Monitoring Officer in advance of the meeting and will only be provided if practicable to do so.

The Chair shall have discretion to regulate the behaviour of all those present recording a meeting in the interests of the efficient conduct of the meeting. Anyone acting in a disruptive manner may be required by the Chair to cease recording or may be excluded from the meeting. Disruptive behaviour may include: moving from any designated recording area; causing excessive noise; intrusive lighting; interrupting the meeting; or filming members of the public who have asked not to be filmed.

All those visually recording a meeting are requested to only focus on recording councillors, officers and the public who are directly involved in the conduct of the meeting. The Chair of the meeting will ask any members of the public present if they have objections to being visually recorded. Those visually recording a meeting are asked to respect the wishes of those who do not wish to be filmed or photographed. Failure by someone recording a meeting to respect the wishes of those who do not wish to be filmed and photographed may result in the Chair instructing them to cease recording or in their exclusion from the meeting.

If a meeting passes a motion to exclude the press and public then in order to consider confidential or exempt information, all recording must cease and all recording equipment must be removed from the meeting room. The press and public are not permitted to use any means which might enable them to see or hear the proceedings whilst they are excluded from a meeting and confidential or exempt information is under consideration.

Providing oral commentary during a meeting is not permitted.

Hackney

Governance & Resources Scrutiny Commission 10th June 2015 **Minutes of the previous meeting**	Item No **5**

OUTLINE

Attached are the draft minutes for the meeting on 16 March 2015.

ACTION

The Commission is requested to agree the minutes.

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Hackney

London Borough of Hackney
Governance and Resources Scrutiny Commission
Municipal Year 2014/15
Date of Meeting Monday, 16th March, 2015

Minutes of the proceedings of the Governance & Resources Scrutiny Commission held at Hackney Town Hall, Mare Street, London E8 1EA

Chair	**Councillor Rick Muir**
Councillors in Attendance	**Cllr Deniz Oguzkanli, Cllr Will Brett, Cllr Laura Bunt, Cllr Rebecca Rennison and Cllr Nick Sharman**
Apologies:	
Co-optees	
Officers In Attendance	**Kay Brown (Assistant Director for Revenues and Benefits), Michael Honeysett (Assistant Director Financial Management) and Joanna Sumner (Assistant Chief Executive)**
Other People in Attendance	**Councillor Geoff Taylor (Cabinet Member for Finance), Alice Evans (Director System Change) and Anna Randle (Head of Strategy LB Lambeth)**
Members of the Public	
Officer Contact:	**Tracey Anderson** ☎ 020 8356 3312 ✉ tracey.anderson@hackney.gov.uk

Councillor Rick Muir in the Chair

1 Apologies for Absence

1.1 None.

2 Urgent Items / Order of Business

2.1 None.

3 Declarations of Interest

3.1 None.

4 Minutes of the Previous Meeting

4.1 Minutes of the previous meeting were agreed.

RESOLVED	Minutes were approved.

5 Whole Place, Whole System Review: Long Term Unemployment and Mental Health

5.1 The Chair welcomed Anna Randle, Head of Strategy and co-author of Managing Demand Building Future Public Services from London Borough of Lambeth and Alice Evans, Director System Change from the LankellyChase Foundation.

5.2 The Chair outlined the context of the review; highlighting the Commission was looking at new ways in which service users could be supported shifting the focus of services to prevention and developing partnership working across the system to reduce the demand on services.

5.3 The Head of Strategy from London Borough of Lambeth presented information about the findings from her research work with RSA looking at demand management. The research explored the different tools and techniques use to manage demand e.g. nudge technique. The Head of Strategy also informed Members about the changes Lambeth Council have been making in relation to this; outlining the lessons learnt on their journey towards establishing a more equal relationship with their citizens and the process of changing the organisation into a Cooperative Council and implementing a new commissioning structure.

5.4 The following substantive points were made in the presentation:

5.4.1 The managing demand research identified a small number of Council's building collaborative approaches but these were within borough boundaries. She explained taking the whole place , whole system approach would mean building collaborative strategies based on local circumstances to influence behaviour; addressing need outside of the service lens; and reconfiguring service delivery mechanisms through understanding how demand manifests across a 'whole system' and a 'whole place'. The research revealed this approach required a different relationship between the citizen and state.

5.4.2 The research found many examples of demand management being effective for small scale changes e.g. a specific service area but none across a whole place or whole system.

5.4.3 Taking a whole place, whole system approach to change would mean going beyond the service lens - they found that services did not reflect demand the way that service users experienced or needed it. It was explained that the divers for demand are not fully understood, meaning services are being made available at the wrong point and therefore not solving the problem. In some

cases the structure of services can be re-enforcing the problem. Upon reflection services will need to get closer to the community to understand their needs; then look at how services can work better together. This may mean cultural and structural change. In essence effecting organisational change to meet service user needs.

5.4.4 Changing the system goes beyond partnership working instead starting with the people and working backwards. In some cases this may mean new relationships and collaborating across agencies and sectors because the drivers for demand are often the same across the system.

5.4.5 Changing the system requires a shift in mind-set for the professionals and the organisation. Changing behaviour is often critical and residents need to be viewed as assets and supported to get involved in the service redesign. She highlighted organisations need to get better at Involving people in the process of co-designing, co-commissioning and co-delivering to get improved outcomes.

5.4.6 The final conclusion with this work was that there needed to be a shift in thinking about the citizen and state relationship. Lambeth Council has been changing how it operates to develop a more equal relationship with its citizens and become a Co-operative Council. Imperative is strong local political support. Lambeth started with their relationships and have worked backwards.

5.4.7 To begin the process of change Lambeth established 40 early adopter projects in 2011. Some projects were successful at embedding the new thinking and some were not. In 2012 the Council embarked on a system change focused on changing their internal operations and thinking to develop co-operative commissioning.

5.4.8 The Council the organisation into two commissioning and delivery and abandoned service departments for ‘clusters’ concentrating on outcomes creating a flexible organisation. Cabinet Members have become commissioners and drive the organisations culture change. They have outcome panels to support Cabinet Members. Commissioning has become the focal point of everything they do. Citizens / residents are viewed as assets engaging them to answer questions and get their views. Since making the culture shift for their organisation the Council is in a stronger position to influence their partners to change.

5.4.9 To help identify how the new way of working would operate in practice they initiated projects to understand how community networks would work.

5.4.10 Lessons learnt to date show that citizens are willing and ready to work with the council however the council has to create the right opportunities to get people engaged.

5.4.11 Co-production can bring new solutions and the council has a role to facilitate and enable the change. Sometimes the structure of the organisation re-enforces traditional operation and thinking and this can encourage the organisation to operate in its old ways. Changing the behaviour of the system is hard.

5.5 The Director System Change from LankellyChase Foundation in addition to the reports in the agenda presented information about system change and their findings from research projects.

5.5.1 LankellyChase Foundation is an independent organisation that funds projects that will help to inform system change, to transform the quality of lives for people who face severe and multiple disadvantage.

5.5.2 LankellyChase Foundation view their role - as an independent funders – as being the organisation that takes the findings from the research projects to policy and decision makers to influence system change.

5.5.3 The research project findings were about learning not achieving specific outcomes. Through the research projects they have tried to identify if different sectors look at people in different ways. They found depending on where a person sits in the system, a service users could experience an overlay of different factors. It was reminded that services must not lose sight of the people they provide services to.

5.5.4 LankellyChase Foundation recommend taking an approach of learning and this required a very different mind-set.

5.5.5 To evoke system change, change must first come from within e.g. the organisation structure and culture.

5.5.6 Service providers and commissioners need to build an evidence base which informs them about the problems, the barriers and the needs of the people.

5.5.7 If organisations want a different dialogue with people they have to find a better way of working and have the right commissioners, public values, and principles.

5.5.8 This process of system change is not about an end point but changing how things are done. Considerations should be given to creating different conversations and there should be thinking about the different skills and knowledge needed for the journey of change.

5.5.9 It is important for an organisation to achieve some quick wins. As learning is critical and the target at the outset may change as the journey of change progresses.

5.5.10 The system change being recommended in the research indicates a need for shared leadership resulting in a different use of power.

5.5.11 LankellyChase Foundation have examples from children service projects that demonstrate the importance of working across silos.

5.5.12 There needs to be thought given to the work and role of middle management in the system or service area being changed.

5.5.13 Discussion with the statutory sector revealed huge judgements about what a person can do.

5.5.14 The process of system change is about learning and culture change and using a range of different approaches and not applying one size fits all.

5.6 **Comments Discussion and Queries**

a) Member enquired how they could persuade senior managers to invest in a new way of working that would potentially increase costs at a time of significant budget pressures.

The Head of Strategy from Lambeth Council acknowledged their new model did increase costs up front. They started the process by talking to the community about how they could manage assets and commenced building an evidence base of how the assets could be managed with less resource. The officer informed the Commission one of their projects was managing a park. The asset was not only viewed as a leisure facility but also as a resource to help improve local residents' health and wellbeing. For example ex-offenders were involved in the maintenance of the park which enabled them to give back to the community. The officer emphasised resources for service could not be cut with the expectation that the resources will come from someone else. This approach was about managing the assets in a different and not paying for the service in the same way. This was investing in co-production.

The Head of Strategy from Lambeth Council acknowledged the council's budget process did keep pulling the organisation back into its traditional mind set and efforts had to be made to retain the new way of thinking.

b) Members made the following observations and enquires:

(i) Changing a big organisation was a big task and as the organisation transitioned some tension would exist.
(ii) The emphasis on place and being led by the community was becoming more important.
(iii) If a key worker was required until the organisation changed?
(iv) If there were limits to the achievements under this model and were there examples of unsuccessful projects?

The Director of System Change from LankellyChase Foundation advised having a key workers was not the answer because it can prohibit the organisation from changing. Key workers may be necessary but are not the answer to changing the culture of the organisation. The officer pointed out there maybe unintended consequences to changes applied but this was part of the learning process which has helped to identify what works and what does not.

The Head of Strategy from Lambeth Council explained rather than adding a new layer to the system the key was to change the behaviour of the frontline staff. In Lambeth to challenge the traditional ways of thinking for staff they changed their job descriptions in a radical way. In response to the question about limits to success for the work they are doing at Lambeth they have not identified any limits. It was noted the change does carry high risk in some areas but there is also the potential for big wins. The officer agreed it does become more about the community and acknowledged they are thinking about the place in a different way than previously.

c) In reference to middle management and accountability Members enquired who was responsible for service delivery and who was accountability is something went wrong with the service provision.

d) Members referred to the barriers highlighted in the presentation and enquired who was the driver for change and who decided on the principles for the organisation's change?

The Head of Strategy from Lambeth Council advised the change had strong political support and this was important to drive forward the change. The key to their success was a strong narrative from the local politicians. A commissioning report set out the principles for the change implemented. The officer advised the need for accountability presented some challenge and acknowledged there was some uncertainty and resistance from senior managers in regards to the change. The process of co-production has helped to allay fears which can lead to resistance. In this model accountability is held by the Cabinet Member. It was pointed out for some areas – due to public interest – that can be contention e.g. public realm. In instances where it may not be possible to reach a consensus a decision has to be made.

The Director of System Change from LankellyChase Foundation explained for them fitting accountability into the new way of working was an area they were still developing. For this reason they have not focused on accountability but instead deployed a learning narrative. Risk is acknowledged and they learn from where things go wrong. Instead of viewing projects as unsuccessful they look at how they can do it differently.

LankellyChase Foundation distribute the grant to organisations who meet their criteria which is based on a set of values and principles. They do not do performance monitoring but provide coaching support to the organisation. The officer explained it is not uncommon to be cautious about taking risk but in a time of change the organisation has to be committed to the change and press ahead. It was also important for the organisation to recognise when something was not working and think about doing it differently.

LankellyChase Foundation is managing accountability differently in their view this is providing greater transparency.

e) Members enquired further about accountability and asked about the process in place to manage any problems with the service delivery.

f) Members asked for clarity on responsibility in relation to resolution if a project or service did not deliver. Enquiring if the cost for correction would be the responsibility of the Council.

g) Members referred to ethical values and the Council's obligations through the procurement process. They enquired how Lambeth ensured the organisation being procured had policies and values that fit with the Council's.

h) Members asked the officer to describe what Lambeth Council would look like in 5 years time?

The Head of Strategy from Lambeth Council assured Members there was no abdication of responsibility with the new way of working. The Council was still responsible and accountable for the service. The officer explained their commissioning process enabled them to work with residents in a different way. This way of working was based on a relationship that allowed them to identify problems or issues early and seek a joint resolution on how it would be managed. The officer informed the Commission, one of their first projects (involving an adventure playground) entailed difficult conversations about risk. During the discussions it was recognised they could not completely control risk or allow risk to stop them doing the project. They agreed to manage the risk and if the risk identified occurred they were prepared to have those difficult conversations.

In response to the question about ethical values and principles the Head of Strategy from Lambeth advised the Council still retained it policies, values and principles. It was pointed out the community group managing the park were not procured to manage the service. This community group had developed a working relationship that helped to support ex-offenders in society.

In response to the question about where Lambeth will be in 5 years, the officer informed the Commission she did not view this journey of change as having an end point; rather getting to a stage where behaviours and the ways of working were embedded and that they have increased engagement with local residents and move towards working this way with local partners too.

i) To get an understanding of how outcomes were defined in relation to society's needs; in the discussion about whole place and whole system change Members made the following enquires:

(i) Asked for an example of an outcome achieved and how the outcome was defined
(ii) How they could change a system fit for all members of society
(iii) If a key worker was essential to help residents navigate fragmented services to build confidence.

The Director of System Change from LankellyChase Foundation explained they did not oppose the role of a key worker and believed in some instances they were necessary. The point they were making is a key worker should not be a replacement for a fragmented system. In their projects that have keyworkers. However a key worker is not a long term solution to a system problem. The officer advised at this stage she could not provide an example of a specific outcome because they have not placed an emphasis on achieving specific outcomes.

The Head of Strategy from Lambeth Council advised the Council's structure was constructed around outcomes and they were still improving in this area. A key impact they have identified is housing so they have made housing core to every outcome. It was pointed out the outcomes were not imposed but created in partnership with the local citizens. For example their discussion with older people about their meals on wheels service revealed their primary need from the service was the company it provided; the meal this was a by-product of what they really wanted and valued from the service.

j) The Chair thanked the speakers for their attendance.

k) The Chair summarised the following points from the discussion:

1. When thinking about service design, it was important to start with people, families, communities and relationships, rather than services and professional silos.
2. Culture is more important than structure - it takes hard work to achieve. There needs to be proactive work with staff and constant engagement. At the harder end it may require changes to job descriptions and appraisal processes. We need to change what matters in a person's job.
3. A mobilising narrative is important so that staff and citizens understand what is trying to be achieved.
4. Place based thinking is very important - it may well be the place that demarcates 'the system' when thinking about system change.
5. There is no end point and there is no master plan - it is a learning process and a way of thinking and working. It is iterative and experimental. Scale does not have to be scary – it is not about changing the world overnight.
6. Quick wins are important to build confidence - in Lambeth they used prototype projects to get things moving in communities, whilst changing the Council's culture and structure.
7. There is unresolved tension around accountability and outcomes - in Lambeth outcome based commissioning was seen as a way to unlock innovation, but LankellyChase Foundation were worried that almost any process of outcome based accountability will distort innovation and creativity. It is clear we need accountability at some level - but we need a more mature relationship with risk, and more trust in the system. This whole question needs a lot more thought - perhaps through further work on performance management.

6 Welfare Reform Update

6.1 The Chair welcomed Michael Honeysett, Assistant Director Financial Management; Kay Brown, Assistant Director Revenues and Benefit and Cllr Geoff Taylor, Cabinet Member Finance from London Borough of Hackney.

6.2 At the previous meeting Members of the Commission requested for information on the interdependency of the different housing benefit changes and the cumulative impact of these on residents. A detailed presentation was provided on pages 143-194 in the agenda. The presentation outlined the welfare reform changes and the impact of these on Hackney residents. The substantive points highlighted are detailed below.

6.2.1 The Governments objective for implementing the welfare reform was to promote work and personal responsibility; simplify the system to make work pay; reduce welfare dependency and reduce the cost of the welfare budget.

6.2.2 The Assistant Director Revenues and Benefits referred to the list of welfare benefits that had been impacted. Particular emphasis was placed on the changes to:

- Incapacity benefit reassessments – this benefit is a passport to access other support. The Council still need to improve in this area to support this cohort.
- Disability Living Allowance – implementation of changes to this benefit started in Scotland and are due to be implemented in Hackney in 2015. The aim is to reduce expenditure of this welfare bill by £2.4 billion. This is expected to have a significant impact on Hackney residents once implemented.

6.2.3 In relation to the implementation of the under occupancy / social size criteria, in April 2013 the social rented sector had 4,255 households affected; of which 1,956 were Hackney Homes tenants and 2,299 were with registered providers - Registered Social Landlords (RSLs).

6.2.4 As of the end of January 2015 3,190 households are affected; of which 1,515 are with Hackney Homes and 1,675 are with registered providers.

6.2.5 As of the 31st December 2014 the financial implications for these tenants meant an average weekly loss - for under occupancy - of £25.08 per week. For Hackney Homes the average loss was £22.59 per week and for RSL tenants the average loss was £27.33 per week.

6.2.6 50.2% of Hackney Homes tenants affected by the under occupancy are in rent arrears. This number rose over 50% from January 2015. Although it was pointed out many tenants were in rent arrears prior to the social size criteria being applied. The Council continues to express upon residents in this position to work with the Council. The average rent owed by tenants in this situation has fallen from £751 to £683. A contributing factor to this is the Discretionary Housing Payment (DHP).

6.2.7 Hackney implemented its Council Tax Reduction scheme. This scheme requires all working age claimants to pay at least 15% of their council tax bill. It was highlighted Hackney's Council Tax Reduction Scheme was less stringent than other councils e.g. Waltham Forest were asking residents to pay 16% in 2015/16 and it was expected to increase to 24% in 2016/17.

6.2.8 Since the benefit cap was implemented 1,031 households in Hackney have been affected. All households were offered support. It was pointed out some households may never be ready for employment and some may take a longer period of time to transition. Of the households originally capped there are still 420 capped. The Council has moved 207 households into employment with enough hours to received working tax credit.

6.2.9 The demand for Temporary Accommodation in Hackney is not decreasing. As at January 2015 Hackney had 55 households in TA who are impacted by the benefit cap. The Council is currently supporting 35 of these households with discretionary housing payments to the value of £3642.16 per week.

6.2.10 The Commission was informed 1 or 2 bed properties are just affordable and 3 or 4 bed properties are becoming unaffordable due to market value.

6.3 The key headlines were:

6.3.1 The Council's aim is to keep people in their homes.

6.3.2 Residents in temporary accommodation awaiting housing allocation are in the urgent category. For those requiring a 1 bedroom property the wait is approximately 10 months; for a 2 bed this increases to 2-3 years and if a household is in the general band the waiting time increases to 3-4 years.

6.3.3 Despite the Council acquiring properties, this is still insufficient to meet the demand on the service.

6.3.4 Universal Credit will merge 6 benefits into 1 (this includes housing benefit). This new benefit system will be completely digital from application to award. Pilots of the new digital system have commenced. The Department of Works and Pension (DWP) released a report about the new system, however, this report did not provide any new information or share any learning from the digital pilots.

6.3.5 The Government has decided to accelerate the implementation of Universal Credit and it will be doing the roll out in 4 phases. Hackney will be in the last phase of the roll out and Hackney aim to pick up the learning from the previous phases of implementations. The new system is expected to be fully operational by 2016.

6.3.6 The Officer explained Hackney has experience of contracting out services like this (revenues and benefits) and has learnt many lesson from this process. The Council is very knowledgeable about the potential impact and problems that can be associated with a change like this. If the Job Centre Plus (JCP) do not process claims quickly the Council will not have access to the system to view the progress of a person's claim. All London's local authorities are working together to negotiate a partnership agreement with DWP that is mutually beneficial. It is anticipated the current proposal would result in Councils having an additional cost burden if implemented.

6.3.7 Following a decrease in allocation to the crisis support fund, the Council has contributed £300,000 to return the crisis support fund to its original level, when the responsibility was transferred from DWP to local authorities. The Council has used the crisis support fund and DHP to support residents who have come out of hospital, need resettlement support or for households in receipt of a high fuel bill.

6.4 **Comments Discussion and Queries**

a) Members enquired if the Council had a strategy to mitigate against cost shunting.

The Cabinet Member for Finance explained the Council was concerned about the increasing demand for temporary accommodation and planned to investigate why the demand was increasing. At the first assessment the Council would be collecting as much information as possible to get a full picture of an individual's needs.

b) Members enquired if the Council discharges residents to the private sector.

The Assistant Director Revenues and Benefits confirmed they do discharge to the private sector.

c) Members referred to the 1,000 people affected by the benefit cap and commented only 4 households had managed to secure a reduction in rent – the intended consequence the Government hoped would result from the benefit cap for private tenants.

The Assistant Director Financial Management informed the Council's debt has not increased because the Council was managing the increased pressure on resources. However the Council is expecting this impact to materialise in the not too distant future.

d) In reference to temporary accommodation Members enquired if solutions to this have been identified locally or nationally?

The Cabinet Member for Finance advised the solutions needed were: rent controls, funding for housing benefit and building more homes. He pointed out the Government's focus has been on the financial economy instead of a balanced concern for the whole economy.

e) Members enquired if the Council was lobbying for support services for vulnerable people.

The Assistant Director Revenues and Benefits explained the support agreement that DWP wanted local authorities to sign was based on Payment by Results and only for referrals made by DWP to the Council. The implications of this is if a resident approaches the Council directly for support, the Council would be funding this support from their resources resulting in increased costs for councils. It is estimated that if local authorities in London funded this support costs are anticipated to be in the region of £6 million a year. In London, Hackney has the largest benefit caseload. The Council is in the process of assessing the impact and cost implications.

The key point to note is DWP have set up the system to work with JCP and not the local authorities.

7 Governance and Resources Scrutiny Commission - Work Programme Planning for 2015/16

7.1 The Chair advised the work programme for G&R was on pages 197 - 201 of the agenda.

Members noted the work programme.

7.2 The Chair informed the Commission residents would be consulted about their views and ask them to identify their local concerns during purdah.

7.3 Members agreed to make suggestions to the Chair and Overview and Scrutiny Officer about future work programme discussion items and topic areas for a scrutiny review.

8 Any Other Business

8.1 None.

Duration of the meeting: 7.00 - 9.20 pm

Hackney

Governance & Resources Scrutiny Commission 10th June 2015 **Whole Place, Whole System Approach – Long Term Unemployed with Mental Health Evidence Session**	Item No **6**

Outline

The Governance and Resources Scrutiny Commission have been exploring the principles, thinking and method of approach that should be taken into consideration, when embarking on a process of system change to shift from late to early intervention.

The Commission invited Early Intervention Foundation to talk about their work which aims to shift spending, action and support for children and families from late to early intervention.

The report attached **Spending on Late Intervention – how we can do better for less** provides information about the cost of late intervention and aims to identify the potential fiscal benefits of early intervention.

Action

The Commission is asked to note the report, presentation and ask questions.

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SPENDING ON LATE INTERVENTION

HOW WE CAN DO BETTER FOR LESS

HAROON CHOWDRY AND CAREY OPPENHEIM

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

This report and the technical analysis underpinning it have both benefited from a range of helpful comments and contributions. In particular, we are grateful to Ray Shostak, Jake Hayman, Alison Stathers-Tracey, Clare Burrell, Caroline Slocock, Cody Xuereb, Daniel Breslin, Laura Caton, Toby Evans, Julian Cox, Leon Feinstein, Donna Molloy, Kirsten Asmussen and Ann Griffiths. Nevertheless, the analysis and findings presented in this report are the views of the authors only.

The aim of this report is to support policy-makers, practitioners and commissioners to make informed choices. We have reviewed evidence from authoritative sources and provide examples of promising and innovative approaches. These suggestions must be seen as supplement to rather than a substitute for professional judgement. None of these examples of promising approaches provide guaranteed solutions or quick fixes.

The report includes reference to research and publications of third parties: the What Works centre is not responsible for, and cannot guarantee the accuracy of, those third party materials or any related material.

Foreword

Early Intervention is about addressing the root causes of social disadvantage, ensuring that everyone is able to realise their full potential by developing the range of skills we all need to thrive. It is about getting extra, effective and timely interventions to all babies, children and young people who need them, enabling them to flourish and preventing harmful and costly long-term outcomes.

The Early Intervention Foundation's (EIF) aim is to shift spending, action and support for children and families from Late to Early Intervention, from picking up the pieces to giving everyone the best start in life. We are a charity championing Early Intervention programmes and practice from conception to young adulthood. As a 'What Works Centre' our focus is on catalysing the use of evidence to inform policy and practice, with the goal of driving improvements to children's outcomes and breaking intergenerational patterns of disadvantage and dysfunction.

The focus of this report is on the immediate and short-run fiscal costs of Late Intervention: the acute, statutory and essential benefits and services that are required when children and young people experience significant difficulties in life, many of which might have been prevented.

We estimate that in England and Wales we are spending nearly £17 billion[1] per year on addressing the damaging problems that affect children and young people such as mental health problems, unemployment and youth crime. This is only the immediate fiscal cost in a single year and although it is substantial, it does not capture the longer term impact of these poor outcomes (which can last into adult life and sometimes into the next generation), nor the wider social and economic costs. Late Intervention is not just expensive, it is also difficult to argue it is money spent well. It rarely turns lives around, as seen in recidivism rates for young offenders and poor transitions to adulthood for children in care. What these figures represent is merely the immediate impact on the taxpayer of thousands of lives blighted by thwarted potential and missed opportunities. The human and social costs are far greater.

We do not argue that *all* of this cost could be prevented. Going into care or receiving treatment for acute mental health problems is unquestionably the best solution available for some children and young people. But many of these children and young people might have had a different journey if they or their family had received the right help at an earlier time. Effective and timely Early Intervention should at least put a dent in the need for Late Intervention, and in so doing will free up space in services that are under unprecedented pressure. It can change the life-chances of those children and young people in a way which is better for public services and the economy, generating long term savings as well as improved lives.

This report not only looks at the total cost of short-run Late Intervention but also where that cost currently falls. The £17 billion is spread across different public

[1] See box on next page for further detail.

agencies at national and local level – from local authorities, the NHS, schools, welfare, police to the criminal justice system. Local authorities bear the largest share at £6.5 billion, followed by welfare costs of £3.7 billion and NHS costs of £3 billion. The national estimates we provide are drawn from a similar analysis for each local authority in the country. At local levels we hope that the analysis will catalyse a more preventive approach to commissioning services, by giving local decision-makers and commissioners robust local numbers to help them make the case for increased local pooling of budgets and improved joint action on Early Intervention.

The Report highlights the promising ways in which Early Intervention can and is working in some of our Pioneering Places. These areas are leading the way in understanding local needs, using evidence to shape decisions on commissioning, and engaging in bold system change from the grassroots to the political leaders, to address problems earlier and use resources much more effectively.

While we have estimated how much is spent on Late Intervention, there is no comprehensive estimate of Early Intervention spending for children and young people at either national or local level. And, while all the major political parties are signed up to Early Intervention in principle, there is no government department or Cabinet Minister charged with putting prevention and Early Intervention into action. Yet, the scale of costs illustrated in this report, and the wasted potential and anguish that these costs represent, should make Early Intervention a key priority of any incoming government.

If we are committed to reducing the fiscal deficit that the adults of the future are left with, we should also apply such foresight to reducing the social problems they will experience. This report shows that these two aims are not mutually exclusive, but can be achieved jointly. That is the prize to be won if the next government can put Early Intervention at its heart.

Carey Oppenheim
Chief Executive, Early Intervention Foundation

Late Intervention spending on children and young people

Definition: the short-run direct fiscal cost of acute, statutory and essential benefits and services that are required when children and young people experience severe difficulties in life.

This is an annual fiscal cost in England and Wales and therefore does not capture the longer term impact or the wider social and economic costs.

Approach: this is a first estimate of these immediate fiscal costs. It is original work conducted by the EIF. The technical paper is available now for consultation. We welcome comment and methodological challenge. We intend to have improved estimates that HM Treasury and others can use to inform the next Spending Review.

Summary

Aims

- This report estimates how much our public services – locally and nationally – spend on Late Intervention for children and young people, responding to the more severe problems that they experience. We use 'Late Intervention' as an umbrella term for a range of acute or statutory services that are required when children and young people experience significant difficulties in life, as well other support they may draw upon such as welfare benefits. This report provides initial estimates of the annual cost to the taxpayer of such Late Intervention. As an annual estimate it only captures the immediate fiscal costs, not longer-term impacts.

  In focussing on this spending, our work aims to identify current potential fiscal benefits of Early Intervention, and to show a trajectory for what might be aspired to over the life of a five-year parliament. These costs can not all be reduced quickly, but neither are they all necessary and inevitable.

- We estimate how much is spent each year in England and Wales on dealing with the following issues:

  - Crime and anti-social behaviour
  - School absence and exclusion
  - Child protection and safeguarding
  - Child injuries and mental health problems
  - Youth substance misuse
  - Youth economic inactivity

- The costs are broken down by fiscal cost for each outcome, spend by area of government and spend by area of government in a local authority.

Findings

- Nearly £17 billion per year is spent in England and Wales by the state on short-run Late Intervention, with the largest single items being the costs of children who are taken into care (Looked After Children), the consequences of domestic violence, and welfare benefits for 18-24 year olds who are not in education, employment or training (NEET). Late Intervention services in the area of child protection and safeguarding account for over a third of the total, followed closely by spending in response to crime and anti-social behaviour.

- The £17 billion is spread across many different public agencies at national and local level – from local authorities, the NHS, schools, welfare, police to the criminal justice system. Local authorities bear the largest share at £6.5 billion, followed by welfare costs of £3.7 billion and the NHS at £3 billion.

- Providing effective Early Intervention in a local area requires commitment across the relevant partners in a place. The local analysis of Late

Intervention spending will provide evidence to make the case to Health and Wellbeing Boards, Community Safety Partnerships and others about the need to reduce demands on their acute or specialist services through a combined focus on effective Early Intervention.

- While a detailed 'bottom-up' estimate of spending on Early Intervention has never been collated, existing estimates suggest this spending represents a much smaller fraction of relevant budgets than Late intervention does. For example, while we find that Late Intervention spending in response to anti-social behaviour and youth offending amounts to £1.4 billion a year, it has been estimated previously that the Home Office and Ministry of Justice spend only £200 million on Early Intervention to prevent youth crime.[2]

- The EIF has now reviewed the evidence for hundreds of Early Intervention programmes in order understand what works; many have shown the potential to address the problems outlined in this report, with careful commissioning and high quality implementation.

- As examples from our Pioneering Places show, impactful Early Intervention requires effective systems for identifying individuals or families with problems, working out what help is needed and bringing different services together to work collectively to reduce demand in the system. Close collaboration and alignment of the work of different agencies is necessary and can reduce duplication.

- Success also depends on the skill of frontline practitioners in building relationships with families, identifying need and providing the appropriate support or opportunity. This is not however just the responsibility of the team or service with Early Intervention in their job title; all of the workforce and wider community should feel able to spot and help a struggling family, parent or young person.

The way forward

We believe we can start to turn things around through the following steps:

Prioritising Early Intervention

- A challenge for national and local government to reduce the £17 billion Late Intervention spending by 10% – £1.7 billion – over the life of the next Parliament, through better and smarter investment in Early Intervention.

- An incoming government should redirect resources and inefficient spending into a dedicated and ring-fenced Early Intervention Investment Fund tied to the life of the next Parliament. Supplemented by private sector capital such as social investment, this would be awarded to councils, healthcare providers, schools, the voluntary and community sector and other organisations with ambitious plans to redesign local public services around effective Early Intervention.

[2] National Audit Office (2013), *Early action: landscape review*.

Incentivising local services to work together better through public service reform and system transformation

- Ensure public agencies are better able to pool budgets and share information about the communities they serve.

- Health and Wellbeing Boards should have a key focus on Early Intervention for children and young people.

- Putting those most in need at the centre of public service reform efforts by ensuring that all public service transformation plans have a clear focus on how they will improve the reach of services locally and prioritise the most vulnerable.

Putting the Early Intervention agenda at the heart of government

- Early Intervention is the smart and realistic choice for using ever scarcer public money. However, the current broad acceptance of this principle must be matched by the political will to back it for the country's long-term interest.

Introduction

Our vision at the Early Intervention Foundation is to ensure that every baby, child and young person is able to realise their potential. By intervening early before problems become difficult to solve, we can reduce the likelihood of poor long-term outcomes for children, their families and society at large. This not only benefits children themselves but also the wider economy.

If we are to catalyse and achieve a shift in how we support children and young people by intervening earlier, we need to know how much money we spend on both Late and Early Intervention and who spends it. In this first briefing the main focus is on the overall scale and costs of Late Intervention for children and young people – that is, acute services and other spending required because of significant difficulties and problems on the journey to adulthood. We also look at which agencies at national and local level carry those costs. Our analysis only examines short-run annual costs, not potential longer-term costs which are substantially higher.

More specifically, we estimate how much is spent each year on the following sets of issues:

- Crime and anti-social behaviour
- School absence and exclusion
- Child protection and safeguarding
- Child injuries and mental health problems
- Youth substance misuse
- Youth economic inactivity

Knowing what is spent on Late Intervention is useful because it illustrates a *potential* 'fiscal prize' from Early Intervention: if children at risk can be helped early on and their needs prevented from becoming entrenched, then they are less likely to require statutory intervention or acute services – freeing up resources and reducing pressure on the system. While the services themselves are valuable and important, and it is neither desirable nor possible to completely eliminate the need for them, the fiscal challenges we face do require action to minimise the demand on them as far as possible.

Importantly, the figures presented here are merely the immediate, short-term annual cost, not a projected cost cumulated over years or decades. Expressing Late Intervention spend in this form makes it more comparable to the current costs of Early Intervention. It is well accepted that Early Intervention can provide substantial potential benefits over the very long-term, estimated elsewhere to be as much as £486 billion over 20 years.[3] However, not only are there considerable uncertainties inherent over such a long time frame, but these potential benefits do not sit easily within budgetary or political cycles. By focussing on *current annual* government spending on Late Intervention for children and young people while they are still

[3] Action for Children (2013), *The Red Book 2013: Children under pressure.*

children and young people, this work aims to identify current potential fiscal benefits of Early Intervention, and show a clearer trajectory for what might be aspired to over the life of a five-year parliament. These costs cannot all be reduced quickly but neither are they all necessary and inevitable.

Other studies have estimated annual costs of specific problems: youth crime and unemployment both cost over £1 billion a year,[4] and the cost of dealing with child behavioural disorders is estimated at £1.6 billion a year.[5] In healthcare, it was estimated that the NHS spent nearly £10 billion in 2011–12 on the costs of obesity, alcohol misuse and smoking-related illness.[6] In this work, we provide a more 'global' estimate of costs which aggregates across all the key issues above rather than focussing on one. The costs presented here are also 'bottom-up' estimates, rooted in actual data on children and young people and the services they use, within each local area and for the country as a whole. This means we are also able to estimate acute service spend for each local area, in addition to the overall national amount.[7] Technically these are ***first estimates*** that will be improved through consultation over the next six months; nevertheless, they are the best available estimates and can be used to inform decision-making and debate.

Methods and data sources

Our general approach for arriving at the immediate fiscal cost of each of the issues above is to take the quantity of acute services or other Late Intervention – obtained from published statistics – and combine that with an estimated 'unit cost' of providing it. This has the advantage of being directly linked to what we know about outcomes for children and young people, and the services they require. However, estimates of unit costs for public services tend to be for the country as a whole, even though the true cost of providing a service may vary significantly from one local area to another. Therefore, where it would lead to more robust results, we have also used published data on actual local authority spend on particular acute services. Table 1 sets out in more detail the costing approach for each issue.[8]

[4] The Prince's Trust (2010), *The Cost of Exclusion: Counting the cost of youth disadvantage in the UK*.
[5] Department of Health (2013), *Annual Report of the Chief Medical Officer 2012, Our Children Deserve Better: Prevention Pays*.
[6] National Audit Office (2013), *Early action: landscape review*.
[7] We have local estimates for every local authority in England, but not in Wales. This is because many of the figures used in this report are only available for Wales as a whole.
[8] More detail on the costing methodology is available in a separate technical appendix.

TABLE 1. INFORMATION USED TO ESTIMATE IMMEDIATE LATE INTERVENTION COSTS

Issue	Information upon which fiscal cost is based
Crime and anti-social behaviour	• Reported cases of domestic violence[9] • Reported anti-social behaviour incidents • Young people in the Youth Justice System (YJS)
School absence and exclusion	• Number of persistent absentees • Number of permanent school exclusions • Annual spending on Pupil Referral Units
Child protection and safeguarding	• Annual spending on Looked After Children • Number of Child Protection Plans • Number of Children in Need[10]
Child injuries and mental health problems	• Children admitted to hospital due to injuries • Children admitted to hospital due to mental health • Children admitted to hospital due to self-harm
Youth substance misuse	• Young people admitted to hospital due to substance misuse • Children using specialist substance misuse treatment services • Children admitted to hospital due to alcohol
Youth economic inactivity	• 16-17 year olds who are NEET[11] • 18-24 year olds who are NEET

It important to note certain limitations of this analysis. As stated above, this is a *first estimate* that we intend to improve through consultation. Judgements have been made about which items to include in the analysis; there are additional items that could be included, and different conclusions which might be reached about some of the items that have been included. Second, the items in Table 1 in no way represent the totality of acute services or Late Intervention spending. Rather, these are the principal social issues faced by children young people for which national and local data are available, along with information on total or unit costs. Third, these measures provide information about *services* not *children*: they reflect local and national decisions about the availability, resourcing and use of services, rather than the underlying well-being of the population. Finally, all the items in Table 1 are important and valuable services for children who need them. While the total cost of these services should not be regarded as wasteful spending, we should take action to reduce the burden placed on these services where we can.

[9] This analysis focuses on the proportion of cases where children are present, which has been estimated at 90%. See http://www.refuge.org.uk/get-help-now/what-is-domestic-violence/domestic-violence-the-facts/.

[10] Excluding cases where the need is classified as child or parental disability.

[11] Not in education, employment or training.

Current spending on Early and Late Intervention

How much do we spend on Late Intervention for children and young people?

The national perspective

Table 2 shows the scale of each issue, across England and Wales as a whole, along with our first estimate of the resulting fiscal cost. These figures are based on the latest available year (rather than one specific year), which varies for each cost item.

TABLE 2. FISCAL COSTS OF LATE INTERVENTION BY OUTCOME

Cost item	Total number	Annual spend (£m, 2014–15 prices)
Domestic violence cases	750,000	4,060
Anti-social behaviour incidents	2,700,000	960
Young people in the YJS	53,000	474
Persistent absentees	320,000	420
Permanent school exclusions	4,700	450
Looked After Children	73,000	5,150
Child Protection Plans	51,000	280
Children in Need	360,000	570
Child injury hospital admissions	106,000	140
Child mental health hospital admissions	10,500	440
Child self-harm hospital admissions	17,500	40
Youth substance misuse hospital admissions	5,200	3
Children in specialist substance misuse services	23,000	440
Child alcohol hospital admissions	5,200	9
16-17 year olds who are NEET	49,000	30
18-24 year olds who are NEET	800,000	3,690
Total (excluding double-counted costs)		**16,640**

Overall, nearly £17 billion per year is spent by the state, with the largest single items being the costs of children who are taken into care (Looked After Children), the consequences of domestic violence and welfare benefits for 18-24 year olds who are

not in education, employment or training (NEET). Figure 1 presents the breakdown visually.

FIGURE 1. LATE INTERVENTION SPEND ON EACH COST ITEM

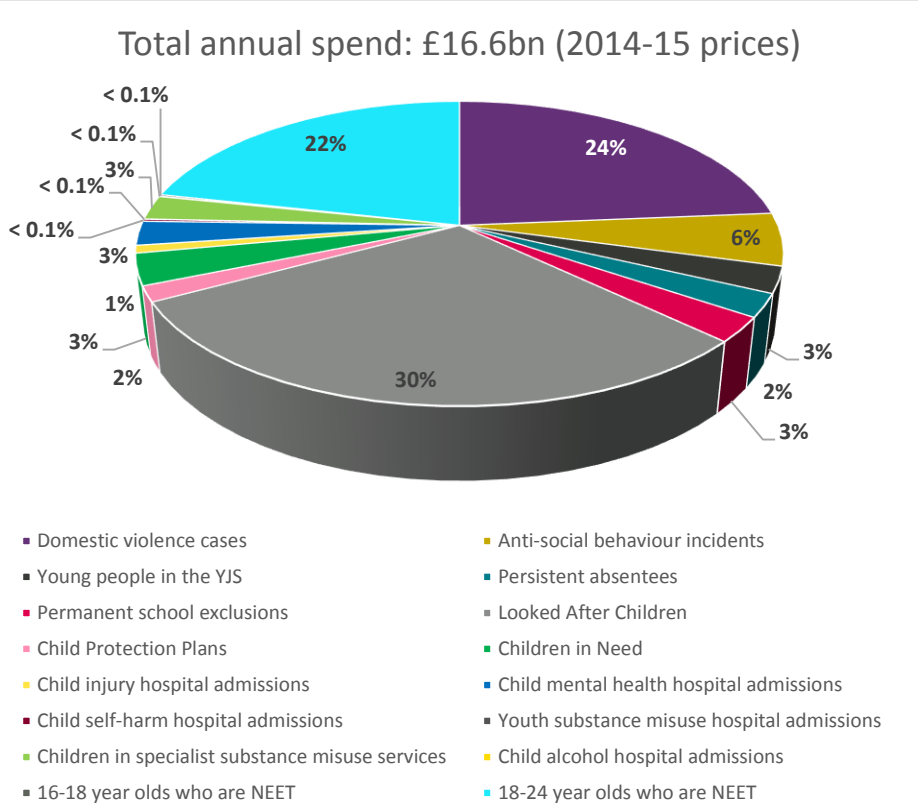
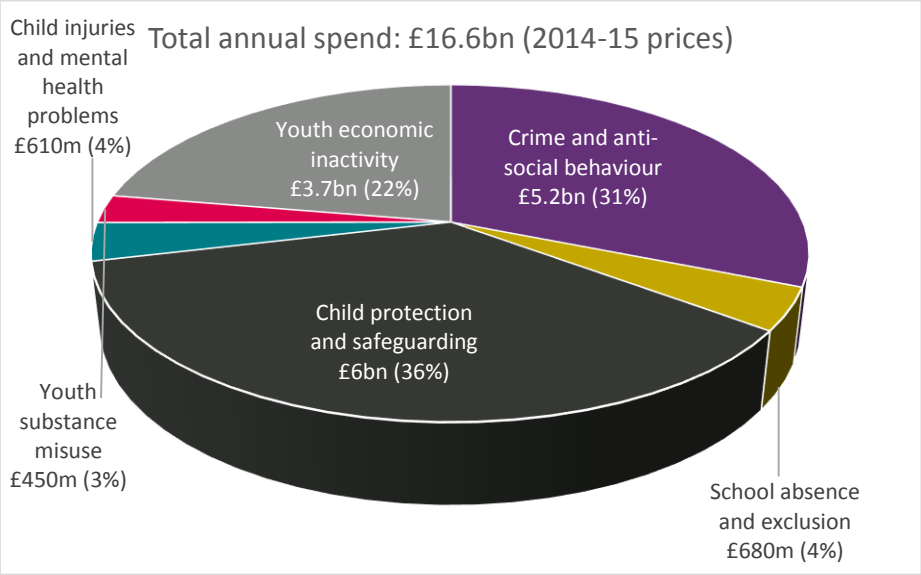


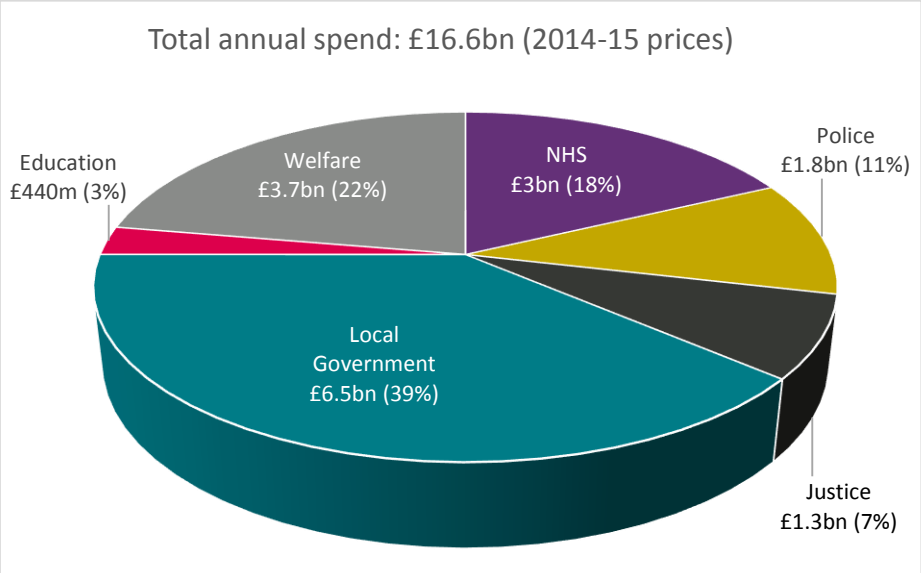
Figure 2 provides a higher level summary by aggregating the cost items under broader headings reflecting a particular issue. This reveals that Late Intervention in the area of child protection and safeguarding accounts for a third of the total amount, followed closely by spending due to crime and anti-social behaviour.

FIGURE 2. LATE INTERVENTION SPEND ON EACH ISSUE



The costs of dealing with these issues fall across different parts of the public sector. Figure 3 sheds light on this by splitting up the £16.6 billion according to the spending department or government agency that ultimately bears the cost. This answers the question of who currently pays for Late Intervention, which is relevant to the debate on public spending but also to the debate on how Early Intervention and prevention should be funded; that is, where the financial contributions towards preventive activity should come from.

FIGURE 3. LATE INTERVENTION SPEND BY AREA OF GOVERNMENT



The local government share is the largest because it reflects the costs of child protection and safeguarding, including over £5 billion per year on Looked After Children. However, it also includes significant costs associated with persistent absence from school and the consequences of domestic violence. This is shown in more detail in Table 3, which breaks down the £16.6 billion both by issue and area of government. Interestingly, the healthcare costs of domestic violence constitute the

largest item within the £3 billion acute service spend by the NHS.[12] Many of the issues considered here are multi-faceted, necessitating late spending by multiple organisations or areas of government. Understanding how these costs are distributed may assist with co-ordinating preventive action at national and local levels.

Locally, these figures can provide useful evidence in making the case to key partners for their contribution to Early Intervention activity. The EIF will provide this analysis individually for our 20 Pioneering Places and support them to use it in highlighting to partner agencies – such as Police, Health, Clinical Commissioning Groups or schools – the extent to which they 'pick up the tab' for failure to tackle problems early enough.

[12] While these services are used by the victim (the abused partner) rather than the child, they nevertheless represent an important part of the total short-run fiscal cost of domestic violence incidents where a child is present.

TABLE 3. LATE INTERVENTION FISCAL COSTS BY OUTCOME AND AREA OF GOVERNMENT (£M, 2014-15 PRICES)

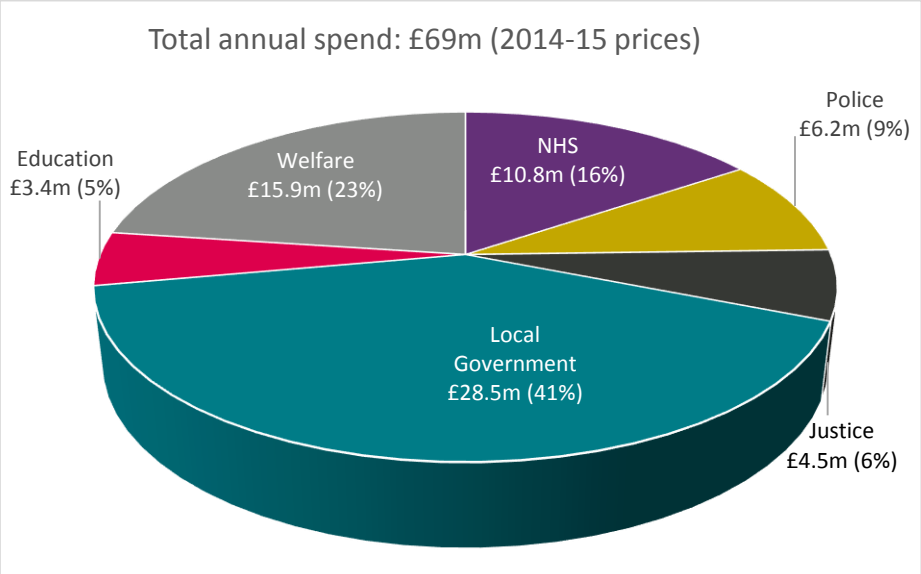
	NHS	Police	Justice	Local Government	Education	Welfare	Total
Domestic violence cases	1,920	760	880	500	-	-	4,060
Anti-social behaviour incidents	-	960	-	-	-	-	960
Young people in the YJS	2	60	390	20	-	-	474
Persistent absentees	20	80	80	230	-	-	420
Pupil Referral Units	0.4	2.8	2.8	6	440	-	450
Looked After Children	-	-	-	5,150	-	-	5,150
Child Protection Plans	-	-	-	280	-	-	280
Children in Need	-	-	-	570	-	-	570
Child injury hospital admissions	140	-	-	-	-	-	140
Child mental health hospital admissions	440	-	-	-	-	-	440
Child self-harm hospital admissions	40	-	-	-	-	-	40
Youth substance misuse hospital admissions	3	-	-	-	-	-	3
Children in specialist substance misuse services	440	-	-	-	-	-	440
Child alcohol hospital admissions	9	-	-	-	-	-	9
16-18 year olds who are NEET	-	-	-	-	-	30	30
18-24 year olds who are NEET	-	-	-	-	-	3,690	3,690
Less double-counting of costs	*-20*	*-90*	*-90*	*-320*	*0*	*0*	*-520*
Net total	**2,990**	**1,770**	**1,270**	**6,450**	**440**	**3,720**	**16,640**

Note: Numbers do not add up exactly due to rounding.

The local perspective

As the information presented in Figure 3 has been gathered through the use of local statistics as far as possible, we can also repeat the exercise for a specific local area, showing how much of the immediate fiscal cost in that area falls upon different agencies and areas of government. In Figures 4 and 5 we show examples of this for two local authority populations in England; the exercise can be done for any local authority area.[13]

FIGURE 4. LATE SPEND BY AREA OF GOVERNMENT IN LOCAL AUTHORITY 'A'



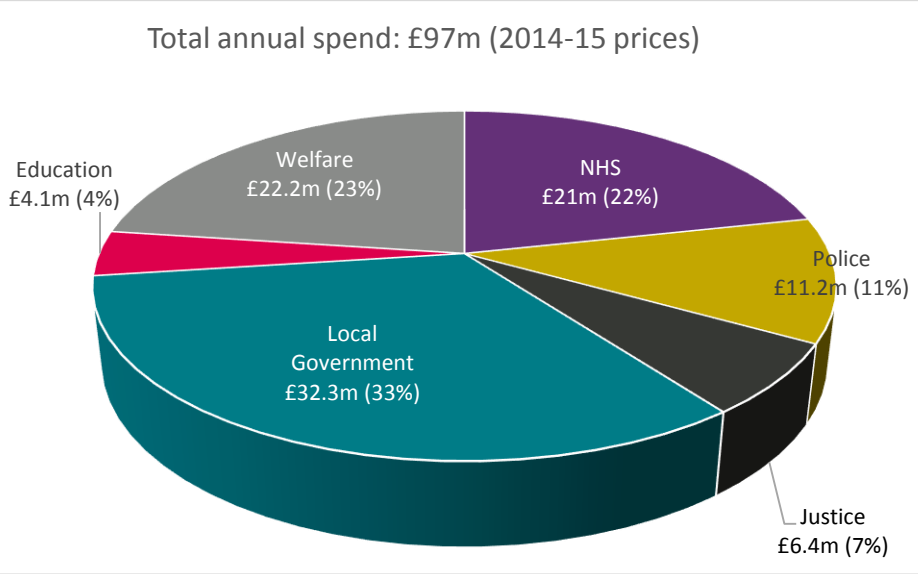
What these figures show is the variation across different local areas in the amount of Late Intervention spend but also in terms of who pays for it. In local authority 'A' a larger share is borne by local government; this reflects the higher rate of children's social care caseloads in that area. In local authority 'B' the local government slice is a smaller share of the overall total; acute health service and police spending are instead larger shares of overall spend. These variations reflect inevitable differences in levels of deprivation and the specific issues and challenges that each local area may face.

Providing effective Early Intervention in a local area requires commitment across the relevant partners in a place. For those areas where the budgets, priorities and commissioning of some key agencies are not sufficiently aligned in support of Early Intervention, this analysis will provide evidence to make the case to these partners about how they might reduce demands on their services. We hope those thinking about Early Intervention in local areas will use this data in making presentations to their Health and Wellbeing Boards, their Community Safety Partnerships, their Children's Partnerships and others, to provoke fresh discussion about the need for a

[13] Repeating the analysis for Welsh local authorities is more difficult since many of the items of source data are only available for Wales as a whole.

collective effort to take demand out of the system through a combined focus on effective Early Intervention.

FIGURE 5. LATE INTERVENTION SPEND BY AREA OF GOVERNMENT IN LOCAL AUTHORITY 'B'



How much do we spend on Early Intervention and prevention services for children and young people?

Measuring how much is spent on Early Intervention and prevention is a more challenging exercise for a number of reasons. By their very nature, these activities intend to promote better outcomes for children and young people and prevent negative outcomes and acute service demand, they cannot be quantified using the methodology above: that would require information on outcomes that did not happen or acute services which were not used. Instead, to measure preventive spend would require classifying each service or activity under consideration as prevention or Early Intervention (see box below).

WHAT COUNTS AS EARLY INTERVENTION?

'Early intervention' is *targeted, preventive activity* which supports people who are at risk of experiencing adverse and costly life outcomes, in order to prevent those outcomes from arising. The activity is not early in terms of a particular stage of life, but early in the onset of problems – *before* the occurrence of such outcomes in order to prevent the costs associated with them. These costs involve some combination of the following:

- Personal harm, with long-lasting effects for the individual or their family
- A wider cost imposed on other people
- A public cost through increased demand upon local or central government resources.

The EIF's focus is on services and provision from conception to young adulthood, but early intervention applies as a principle across the entire life course; it is in such cases referred to as 'early action'. In the language of prevention and public health, Early Intervention corresponds to 'secondary prevention'. It is conceptually distinct from universal services which are early and preventive, but not targeted.

While a detailed 'bottom-up' estimate of spending on Early Intervention has never been collated, the estimates that do exist suggest that such spending represents a fraction of the amount spent on Late Intervention. Work by the National Audit Office estimated that only 6 percent of social policy spending (across health, education, crime and justice) could be designated as "early action" – approximately £12 billion in 2011–12. [14] However, almost all of this was in the health and education budgets, where a broader definition of early action had been applied that included universal early years provision, and health services which are not specific to young people. In the Home Office and Ministry of Justice budgets, where the scope of activity was restricted to more closely match the above definition of Early Intervention, only £200 million of relevant spend was identified.

The Troubled Families programme has provided another estimate of the comparative levels of Early and Late Intervention spending – albeit only for the specific group of 120,000 families served by the programme. As part of the business case, a number of government departments identified the fiscal expenditure attributable to these families, both in terms of "targeted" (Early Intervention) and "reactive" (Late Intervention) spend. The analysis revealed that while £8 billion was spent on the Late Intervention for the 120,000 families each year, only £1 billion was spent on services that might be categorised as Early Intervention and prevention.[15]

If a future government is serious about moving towards a more preventive approach which addresses problems early on, it will be important to understand current

[14] National Audit Office (2013), *Early action: landscape review*.
[15] Department for Communities and Local Government (2013), *The Fiscal Case for Working with Troubled Families.*

spending on prevention and Early Intervention, linked to actual outcomes for children and young people. Only then can progress be made on both fronts.

In the next section we identify some ways in which Early Intervention is happening in practice in our Pioneering Places. These promising examples illustrate the potential efficiencies and improvements in outcomes for children and young people from acting earlier.

What might a better way of doing things look like?

It does not have to be this way. Whilst the fiscal costs shown in the previous section arise from complex and often entrenched issues which cannot always be predicted or prevented, the evidence is starting to show how these challenges can be tackled to turn lives around and save money. Commissioners and policy makers want to understand what this evidence tells us about how practitioners can support children, young people and families to develop skills and change behaviours. We also need to look at new and innovative approaches to delivering public services, redesigned around the needs of children and families with different agencies working together more effectively to provide the support that is needed.

Effective and timely Early Intervention – providing the 'right' help to a child, young person or family at the 'right' time – can stop problems getting worse removing the need for much of the expenditure outlined in this report. The EIF has now reviewed hundreds of programmes designed to address the problems that lead to the Late Intervention costs outline above; many have been shown to work if they can be implemented well. Our online Early Intervention Guidebook provides information and evidence for an initial 50 programmes, which aim to improve child outcomes such supporting children's mental health, reducing child abuse and neglect, and reducing youth crime.

FIGURE 6. THE EIF GUIDEBOOK FRONT PAGE

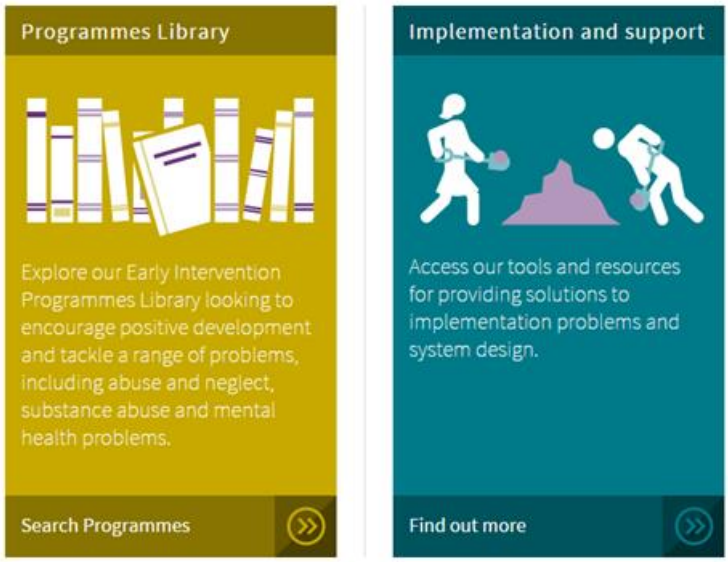


FIGURE 7. THE EIF GUIDEBOOK'S PROGRAMME SEARCH TOOL

Two examples of programmes which have been shown to have strong impacts on improving children's outcomes are *Incredible Years* and *Multi-systemic Therapy*. They are described below. There are many other programmes and approaches which have also been found effective, if implemented well. We have chosen these two to illustrate the potential of Early Intervention.[16]

[16] These are programmes that have found ways to package effective skills and activities, and support their wider implementation. Beyond programmes, other ways to better support children and families through improved commissioning and design of services, training of existing workforces, and better understanding of local needs and provision. Moreover, no programmes or practice has a guarantee of success. However, the evidence on these two programmes provides a well-established proof of concept.

THE INCREDIBLE YEARS PROGRAMME

Incredible Years (IY) is for any parent with a child between the ages of 0 and 12 who has concerns about their child's behaviour. Parents attend between 12 and 16 weekly group sessions where they learn strategies for interacting positively with their child and discouraging unwanted behaviour.

The IY series includes four separate programmes targeting infancy, toddlerhood, the pre-school years and later childhood (e.g. eight to twelve years). Each programme can be implemented universally to all families through schools or children's centres, or can be offered as a specialist Child and Adolescent Mental Health (CAMH) intervention to parents with a child with diagnosed behavioural difficulties.

The IY pre-school programme has consistently demonstrated positive outcomes through multiple randomised controlled trials conducted in the UK and abroad. These outcomes include significant improvements in children's reading skills and pro-social behaviour, as well as decreases in parental reports of physical abuse, stress and depression. In addition, there is good evidence that these benefits are sustained over time. For example, a recent UK study found that IY parents with a child (aged three to seven) diagnosed with severe behavioural problems were significantly less likely to report behavioural and reading difficulties ten years later in comparison to parents who did not attend an IY programme.

The IY programme has undergone several cost-benefit analyses, all demonstrating considerable financial savings when the programme is implemented effectively. One such study conducted in Ireland found that the IY preschool programme had the potential to deliver a taxpayer return on investment of 11% due to reduced education, crime and unemployment costs.*

*O'Neill, D., McGilloway, S., Donnelly, M., Bywater, T., Kelly, P. (2013), "A cost-effectiveness analysis of the Incredible Years parenting programme in reducing childhood health inequalities", *The European Journal of Health Economics*, Vol. 14, No. 1, pp. 85–94.

MULTI-SYSTEMIC THERAPY

Multi-systemic Therapy (MST) is an intensive, family-based intervention that aims to reverse established patterns of anti-social behaviour in teenagers between the ages of 12 and 17. MST does this through a 'whatever it takes' approach that addresses problems existing at the level of the child, family, school and community. Young people identified through the juvenile court system are assigned an MST therapist who is available to the family on a 24/7 basis, but typically provides individual and family therapy through weekly visits that lasting over a period of four and six months.

The MST programme has evidence from several rigorously conducted RCTs of reducing youth offending and improving family harmony. The MST model has also successfully demonstrated benefits in reducing child maltreatment and problematic youth sexual behaviour. A long-term study in the US found that every $1 invested in the programme returned a saving of $6.60 to taxpayers via reduced crime costs.* The MST programme is currently being piloted in Essex as part of a Social Impact Bond to reduce young people's entry into the care system as a result of antisocial behaviour (see Essex example below).

*Klietz, S., Borduin, C., Schaeffer, C. (2010), "Cost–benefit analysis of multisystemic therapy with serious and violent juvenile offenders", *Journal of Family Psychology*, Vol. 24, No. 5, pp. 657–666.

Of course, ensuring the 'right' service or intervention is delivered to a child, young person or family, when it is needed, is not an easy task. It requires effective systems for identifying individuals or families with problems and working out what help is needed; it also requires close collaboration between agencies, using combined intelligence to target limited resources for services like home visiting. Rather than health visitors or children's centres alone trying to identify which families may struggle to give their children a good start in life, it is more powerful if this is combined with police data about families where there is drug use, domestic violence, offending or anti-social behaviour. These approaches can also mean Early Intervention reaches those who may be most in need, but who are not in touch with the services that can assist them.

Effective Early Intervention is dependent on the quality and skill of frontline professionals and their ability to build relationships with other professionals and most importantly with the children and families they are there to help. It requires frontline workers who can build trust, really listen to what families tell them they need and who can respond to this creatively even if it means pushing the boundaries of public service roles and silos.

Ensuring Early Intervention reaches those who need it is not just about public services, but also building the capacity of the local community to take an Early Intervention approach. Through the development of various models of community based support, increasingly many parents, young people and others are being supported to mentor, befriend and help other parents or young people on either a voluntary or paid basis.

Examples among the EIF's 'Pioneering Places'

EIF is working closely with 20 Early Intervention "Pioneering Places" across the country. In these areas, different local partners – including councils, police, clinical commissioning groups and voluntary and community organisations – are joining forces in various ways to deliver a more joined-up and effective approach to Early Intervention.

Cheshire West and Chester

Cheshire West and Chester is delivering many of its Early Intervention services through an Integrated Early Support service which was introduced in October 2013.[17] The service brings together the work of over 20 different agencies and data systems into a single and coherent model. This includes a single 'front door' into services, a single assessment model, shared IT and co-located workers in 7 multi-agency locality teams. A menu of evidence based interventions is available for children and families; for more complex cases a range of different professionals act as the lead worker, developing a clear family plan that meets the needs of the particular family.

An independent evaluation is being commissioned to test the impact of this changed way of delivering Early Intervention. But early monitoring data is showing a range of positive trends since the new system was put in place:

- 13% reduction in Children in Need
- 23% reduction in inappropriate referrals to Children's Social Care
- Increase in the proportion of family support cases managed below the statutory level
- 54% reduction in violent offences among domestic violence perpetrators
- Estimated 20% reduction in demand on Cheshire Constabulary for a sample of people whose cases were managed through Integrated Early Support.

Croydon

Demand for public services in Croydon is increasing: the population is growing, particularly the under-16s; and the area has high rates of A&E attendance, high levels of domestic violence and low rates of immunisation and school readiness. Croydon Council believes that outcomes in the early years could be radically improved by greater integration, aligned work processes and workforce reform. Under their new 'Best Start' programme they are integrating their early years services.

Service delivery will also be brought together through multi-disciplinary local teams of health visitors, nursery nurses, family support and specialist workers who will deliver the Healthy Child Programme and targeted family support delivering services across the community to ensure that support is always 'in pram pushing distance'. New 'community builder' roles are also being pioneered by Croydon's

[17] For more information, see http://www.altogetherbetterwestcheshire.org.uk/?page_id=2186.

voluntary and community sector to ensure families are supported families within strong social networks.

Croydon has carried out financial modelling work which predicts that the total investment of £2.9 million will yield a return of £2.34 for every £1 invested. The upfront investment includes £1.5 million from the Department of Communities and Local Government's Transformation Challenge fund combined with resources from local partners. Over the life of the ten year transformation programme there will be estimated efficiencies from the new ways of working of over £4 million.

Essex

Essex County Council has used a Social Impact Bond (SIB) to provide upfront investment to fund Multi-Systemic Therapy (MST), an evidence-based intervention as part of their strategy to reduce the numbers of children who are taken into care. Their goal was to improve the outcomes for this group and to reduce demand and deliver savings. The catalyst for action was the steady rise in the number of Looked After Children, with 1,600 children on the books when the initial Social Impact Bond feasibility work began.

Investors committed £3.1 million up-front to fund MST interventions for 380 young people aged 11-17 at risk of entering care or custody, over a period of five and a half years, with future outcome-based payments to be reinvested into the scheme over its duration to increase investment to around £5.9 million. This social investment enabled the funding of a new intervention that would not otherwise have been available, to specifically target a cohort whose needs would otherwise be at risk of escalating further into very costly acute services.

The aim was to divert around 100 of these young people away from care, resulting in savings of an estimated £17.3 million gross (at medium performance level), with Essex's repayments capped to ensure they retain net savings of £10.3 million in this scenario. The savings assumptions behind the business case are being tested now that the work is bedding in. Outcomes are tracked for 30 months and repayment to investors is based on reduction in the number of care days (designed to incentivise work with all cases, not just those likely to stay out of care). Additional outcomes around school attendance, wellbeing, and reduced offending are also monitored, but are not associated with repayments.

In its first year, results are broadly as expected.[18] There have been 75 referrals, with 50 cases opened and 24 MST cases completed so far. Of the young people worked with, only five children have gone into care – four of whom were cases opened in the first 4 months of the service, when referrals and other operational processes were still bedding in.

[18] An independent evaluation on the impact of the SIB has been commissioned which will aid further understanding.

Though it is early days and information on success is limited at this stage, the use of social investment to help test and scale evidence-based interventions as part of wider cost reduction and outcomes improvement strategies, looks promising. As Nick O'Donohoe of Big Society Capital (one of the investors) sums up:

"*Essex is leading the way in using outcomes-based finance models to enable innovation and improvement in children's services. As a result not only are we seeing fewer vulnerable young people ending up in care or in prison, but we are also learning valuable lessons about what does and doesn't work in the design and structure of social impact bonds."* [p31, Essex: A Year in Review].[19]

The current financial challenges facing public services require us to think again in order to radically reassess what support is delivered and how. The examples above are just three ways in which our Pioneering Places are innovating, through social investment, bringing services and separate agency processes together, stripping out duplication and building workforce capacity to intervene earlier and more effectively.

To really shift the spending and figures in this report, however, requires us to do more to equip those working on the frontline to respond when they see the need for Early Intervention. Early Intervention must be seen as relevant to *all* the professionals who interact with children and families, not just specific practitioners or services. Noticing and helping a struggling family, parent or young person must become part of the day job of anyone who comes into contact with them. The first worker in the door or that makes contact needs to have the 'Early Intervention toolkit' they need in order to offer support. Many of these frontline workers – police officers, teachers, GPs, housing officers, nurses and others – will have entered these professions to help others. We need to build on this motivation by empowering those on the frontline to do what they came into public service to do, giving them the tools they need and listening to what they tell us about the obstacles they face.

[19] Sources:
Social Finance, *The Essex SIB: A Year in Review*
Essex County Council *People & Families Scrutiny Committee Report, 4 Sept 2014*
Bridges Ventures and Bank of America, Merrill Lynch, *Choosing SIBs: A Practitioner's Guide*

The way forward

We have shown that the immediate fiscal cost of Late Intervention for children and young people in a single year amounts to nearly £17 billon. This cost is spread across different local and national agencies, and the picture in each local area varies depending on the needs of the population.

In response to these findings, policymakers need to take three steps:

1. *Prioritise Early Intervention funding*
2. *Incentivise local services to work together better through public service reform and system transformation*
3. *Put the Early Intervention agenda at the heart of government*

There will always be children and young people who fall through the net and need acute services or other forms of Late Intervention. However, the evidence shows that the right Early Intervention at the right time can help to improve the life-chances of children and young people, addressing problems that emerge and enabling us to reduce the costs of Late Intervention.[20]

1. *Prioritise Early Intervention Funding*

We propose a challenge for national and local government to reduce the £17 billion Late Intervention spending by 10% – £1.7 billion – over the life of the next Parliament, through better and smarter investment in Early Intervention.

One step towards this is for an incoming government to finally measure accurately what we spend on universal services, Early Intervention and Late Intervention for children and young people. The next government should then set a goal of a concerted shift in spending from Late to Early Intervention by 2020. Alongside this the government should track child and family wellbeing using a basket of indicators relevant to Early Intervention. This will ensure that progress is made on the quality and effectiveness of Early Intervention spending, not just the quantity.

The costs of Late Intervention are in danger of stifling investment in Early Intervention. Social finance models offer some important opportunities for investing up front while still dealing with acute need, but there is more that can be done. An incoming government should redirect resources and inefficient spending into a dedicated and ring-fenced Early Intervention Investment Fund tied to the life of the next Parliament. Supplemented by private sector capital such as social investment, this would be awarded to councils, healthcare providers, schools and other organisations with ambitious plans to redesign local public services around effective

[20] See the forthcoming publication from the Early Action Task Force '100 days'.

Early Intervention. Inviting bids from local areas it could develop the evidence base for effective Early Intervention programmes, practice and systems.

2. *Incentivise local services to work together better through public service reform and system transformation*

Ensuring that public agencies pool budgets and share information about the communities they serve is crucial, both to protect Early Intervention but also to make it more effective. Reforms which enable commissioners to secure contributions from other agencies and levels of government (and indeed from the private sector) will help catalyse Early Intervention on the ground.

Health and Wellbeing Boards in each area provide an important focus for working across local government and health functions. Early Intervention for children and young people should feature more centrally in their role.

Finally, even the best Early Intervention can fail to reach those who most need them. Public service reform needs to put this centre stage ensuring that data, whole family approaches and the Early Intervention workforce (such as Family Support and mental health workers, and Health Visitors) reach and prioritise the most vulnerable.

3. *Put the Early Intervention agenda at the heart of government*

Early Intervention is the smart and realistic choice for using ever scarcer public money. However, the current broad acceptance of this principle must be matched by the political will to back it for the country's long-term interest. If we are committed to reducing the fiscal deficit that the adults of the future are left with, we should also apply such foresight to reducing the social problems they will experience. This report shows that these two aims are not mutually exclusive, but can be achieved jointly. That is the prize to be won if the next government can put Early Intervention at its heart.

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Hackney

Governance & Resources Scrutiny Commission 10th June 2015 **Information Reports for Whole Place, Whole System Approach – Long Term Unemployed with Mental Health**	Item No **7**

Outline

The **Depression and Anxiety** report by the Health in Hackney Scrutiny Commission provides information about support services for people with low level mental health and how stakeholders are working to reduce depression and anxiety among working age adults.

The **21st Century Public Service Workforce** report by Dr Catherine Needham and Catherine Mangan asked a series of questions (listed below) and identifies a series of characteristics which are associated with the 21st Century Public Servant.

- What does it mean to be a 21st Century public servant?
- What are the skills, attributes and values which effective public servants will display in the future?
- How can people working in public services be supported to get those skills?

Action

The Commission is asked to note the reports.

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Hackney

REPORT OF THE HEALTH IN HACKNEY SCRUTINY COMMISSION		
Preventing depression and anxiety in working age adults Health in Hackney Scrutiny Commission 16th March 2015	**Classification** **Public**	**Enclosures**

1. FOREWORD

I'd just sat down to write this introduction when I was interrupted by an unsolicited phone call from Ipsos Mori asking me to answer a health questionnaire for Hackney Council. From the questions it was clear that answers were being sought not just about my physical health but my mental health too. "How often had I felt useful in the last week? " "Could I make decisions?", "Did I feel I was thinking clearly?" Promoting mental health is one of Hackney's four priorities in the joint Health and Wellbeing strategy and this was independent confirmation that Hackney is putting in the work to ask residents' about their mental health in order to better shape its services.

Why do scrutiny commissions do reviews when Hackney Council and partners are already prioritising this work? Scrutiny commissions can choose to review areas precisely because it is already a priority. The work of a scrutiny commission can be both collaborative and combative. It is used to suggest new ideas, but also as a check that what is being done is enough and in the right way. The commission had previously looked at Community Mental Health Services in 2011, Hackney Council is also about to go-live with its new integrated mental health network (IMNH) and given the harsh economic climate and its potential negative affect on well-being it seemed timely to return to this subject area.

We wanted to find out how the healthcare commissioners and providers are responding to the high prevalence of depression and anxiety. In prevention services are we targeting the right groups? What can be achieved by partners in looking at the wider mental health determinants of housing and employment? Are we identifying people at risk early enough?

Our recommendations encompass support for front line housing officers, improving 'move-on' accommodation, hospital discharge processes and BME access to services, the operation of the new IMHN, the need for job retention programmes and how Hackney Council and the NHS, as employers themselves, can provide leadership on best practice in supporting employees to avoid anxiety and depression and with a managed return to work.

I would like to thank all of those who generously gave their time to give evidence to the commission or to host a site visit.

Cllr. Ann Munn
Chair – Health in Hackney Scrutiny Commission

CONTENTS

1. INTRODUCTION

1.1 Mental health means more than just the absence of clinically defined mental illness and the need to promote positive mental health and wellbeing is increasingly recognised. Promoting good mental health and wellbeing contributes not only to lower rates of mental illness but also to improved physical health, better educational performance, greater workforce productivity, and improved relationships within families and safer communities.

1.2 Depression and anxiety disorders which include panic disorder, generalised anxiety disorder, obsessive compulsive disorder, social phobia and post-traumatic stress disorder, vary considerably in their severity but all conditions may be associated with significant long-term disability either as a cause, a consequence or else accompanying it. They may certainly have a substantial impact on a person's social and personal functioning.

1.3 Our review focused on mild to moderate mental illness[1], specifically depression and anxiety and we decided to place a particular emphasis on four of the wider determinants of the causes of depression and anxiety: housing, employment, debt and low income and people living with long-term medical conditions.

1.4 Evidence for this review was gathered during three commission meetings, five site visits and through carrying out desk research. The Commission received detailed and extensive reports from the commissioners and service providers who are involved in supporting those with depression and anxiety and for brevity **we will not repeat that information here,** but it can be found with the agendas for 8 Sept, 13 Nov and 9 Dec meetings. Instead, in this report we draw out the main themes from our findings and the basis for our recommendations.

1.5 *City and Hackney's Health and Wellbeing Profile*[2] tells us that 10.25% of patients visiting Hackney's GPs' surgeries suffered from depression in 2011/12, the fourth highest prevalence in London (albeit significantly lower than the average in England of 11.68%). This is likely to be a serious underestimate as it only includes people who have been coded by GPs as having clinical depression whilst milder cases of depression are not always formally coded. Latest figures from Hackney's Local Economic Assessments[3] show that 48% of those claiming Incapacity Benefit/Employment Support Allowance in Hackney do so for reasons of mental ill health and the rate of emergency mental health admissions in Hackney is the highest in London (2010/11)[4]. In addition, common mental health disorders such as depression, anxiety and obsessive compulsive disorder are known to be more prevalent in

[1] Mental health conditions are typically rated on a scale of mild-moderate-severe-very severe

[2] See bibliography.

[3] The Local Economic Assessment is a current picture of Hackney's economy. Details on employment, Hackney's businesses and unemployment can be found in it as well as research on particular aspects of Hackney's economy.

[4] http://www.hackney.gov.uk/Assets/Documents/2014_LEA_Headlines.pdf, page 5.

poorer households and poverty, unemployment, bad housing and physical ill-health are all associated with mental illness.

1.6 Nationally it has been estimated that one in four adults will experience a mental health problem at some time in their lives and one in six adults of working age will experience symptoms of mental illness that impair their ability to function. It has also been estimated that a sixth of the population have symptoms (such as anxiety or depression) that are severe enough to require healthcare treatment.

1.7 '*Promoting mental health, focusing on relieving depression and anxiety for working ages adults'* is one of the 4 priorities in *Hackney's Joint Health and Wellbeing Strategy 2013-14*[5] and has been the driver for the re-commissioning of a new Integrated Mental Health Network which we describe in our report.

1.8 The recently published *Mental Health Needs Assessment* outlines some of the key factors influencing mental health in the borough[6] and which partly prompted our review. Here are some headline points:

- Hackney has a relatively young population compared to the national average and a large percentage of new diagnoses of serious mental illness are identified in early adulthood.
- People of black-Caribbean or Pakistani origin are more likely to suffer severe mental illness and Hackney has a relatively high black, Asian and minority ethic population.
- Research has shown that migrant groups and their children are at greater risk of mental illness including psychosis and we have significant numbers of both new migrants and refugee/asylum seekers.
- There is a strong association between poor housing and mental health problems and Hackney has a higher rate of households in temporary accommodation than the average in England. We also have a higher proportion of over-crowded households than in comparable London boroughs and in, 2012/13, we saw a 20% increase in rough sleepers compared to the previous year.
- Hackney has one of the highest proportions in the UK of people whose day to day life is limited by long-term health conditions (7%) and this cohort is two to three times more likely to experience mental health problems than the general population. Demographic change here means that this proportion is expected to rise creating an additional burden, though it is unclear how the effect of regeneration will impact on the incidence of mental illness.

1.9 There is significant evidence (from the Marmot Review[7] and elsewhere) on the impact of the financial crisis on mental wellbeing. The London Health Forum

[5] Hackney's Joint Health and Wellbeing Strategy explains the joint approach to be taken by senior leaders from the NHS, Hackney Council, Healthwatch and the voluntary and community sector to improve the health and wellbeing of people in Hackney and reduce health inequalities. The strategy focuses on a small number of key issues that can be improved through joined-up working, shared vision and effective collaboration across a range of partners.

[6] Data from a) '*A mental health needs assessment for the residents of Hackney and the City of London'*, Public Health, Hackney Council, Jan 2015 b) *'Integrated Mental Health Network Service Specification',* Adult Social Care, Hackney Council 2014 and c) City and Hackney Health and Wellbeing Profile, Hackney Council and City of London, updated 2014..

reported that three in five people seeking debt advice have reported receiving treatment, medication or counselling as a result of debt related health problems.

1.10 Services to help prevent anxiety and depression in Hackney residents are commissioned by the City and Hackney Clinical Commissioning Group (the "CCG") and Hackney Council (both its Public Health team and its Adult Social Care team). Primarily, these services are provided by the following bodies, all of which are based at St Leonard's hospital: the Homerton University Hospital NHS Foundation Trust's (HUHFT) *Improved Access to Psychological Therapies* **(**IAPT) team and the Tavistock and Portman NHS Foundation Trust's Primary Care Psychotherapy Consultation Service (PCPCS).

1.11 Services provided by the East London NHS Foundation Trust (ELFT")[8] were generally outside the scope of this review because they treat patients with severe and enduring mental illness, whereas the focus of this report is on patients with the mild to moderate illness. Nevertheless, we heard from their BME Access Service because it has been working on the key area of improving outcomes for BME residents in mental health which is just as relevant to those at the mild and moderate end of the spectrum. In addition, when mental health issues are not addressed, they soon move from being mild to moderate.

1.12 To make this review more manageable in the limited time available to us, we had to rule a number of areas out of scope. We did not consider children and young people's mental health (which is the remit of another of Hackney Council's scrutiny commissions, the Children and Young People scrutiny Commission "CYPSC"), parental mental health, the transition from CAMHS[9], perinatal mental health, dual diagnosis, drug and alcohol issues. At the end of our report, however, we make a suggestion to CYPSC on these issues.

1.13 Our work here also builds on this Commission's 2011/12 review on '*Community mental health services*' and our 2009/10 review '*Health and worklessness'* as well as Hackney Council's Community Safety and Social Inclusion (CSSI") scrutiny commission's 2008/9 review entitled '*Tackling worklessness routes to employment for those in receipt of long term inactive benefits'* which ended up having a significant health and mental health focus.

1.14 As we publish our report, Hackney Council's Governance and Resources scrutiny commission has embarked on a "*whole place, whole person*" review of long term unemployment in Hackney relating to mental illness. It will attempt to identify the barriers for this group in re-entering the labour market (*i.e.*, finding jobs) or engaging in education and wider social participation and it will develop proposals for more effective approaches in engaging with Hackney residents affected in this way. We will request that the CSSI scrutiny

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[7] http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

[8] Which covers the City of London and the London boroughs of Hackney, Newham and Tower Hamlets.

[9] Child and asolescent mental health services, specialist NHS children and young people's mental health services. They offer assessment and treatment when children and young people have emotional, behavioural or mental health difficulties.

commission take forward the employment issues that we raise in our review, particularly in relation to job retention.

1.15 We sought to address the following core issues with this review:

- *How are healthcare commissioners and providers in Hackney responding to the continued high prevalence of depression and anxiety in working age adults?*

- *Who is accessing services for the prevention of depression and anxiety in working age adults in Hackney? Who is being targeted by prevention programmes? Are we targeting the right groups who may be at risk – BME, unemployed, those with poor physical health?*

- *What can be achieved by partners in dealing with the wider determinants of mental ill-health in Hackney (debt, housing, employment, long term conditions)?*

- *Are people at risk being identified early enough in Hackney and what is being done to reduce the factors that lead to poor mental health in the first place, e.g. housing, employment issues?*

2. EXECUTIVE SUMMARY AND RECOMMENDATIONS

2.1 Our review set out to examine whether the health and social care commissioners and providers in Hackney are responding appropriately to the high prevalence of depression and anxiety in our working age adult population. We also wanted to ensure the right people were being targeted by prevention programmes and to find out what Hackney Council and its partners are doing about the wider causes of mental ill health in Hackney. In the limited time available to us, we were unable to examine in detail the determinants debt and, long term conditions and we took a closer look at just two of these 'wider determinants', namely housing and employment.

2.2 We spoke to commissioners and providers, including officers from Hackney Council's Adult Social Care Commissioning department and the Council's Public Health department as well as Hackney Homes, City and Hackney CCG, HUHFT and ELFT. We heard from the key providers of psychological therapies locally - the IAPT service at St Leonard's hospital which is provided by HUHFT and a more specialist service provided by the Tavistock and Portman NHS Foundation Trust.

2.3 We went on site visits to City and Hackney Mind, the Vietnamese Mental Health Service, I.R.I.E. Mind Recovery Centre, Bikur Cholim, Derman, the IAPT service at St Leonard's hospital and Family Mosaic's Supported Housing service, where we spoke to frontline officers and many service users. We also heard from Family Action, the national organisation the Centre for Mental Health and from local GPs.

2.4 We examined how the new "Integrated Mental Health Network" (IMHN) was developed and we listened to concerns from providers about the change. City and Hackney Mind is the lead provider and services will be delivered by them and a network of 10 other local voluntary organisations. This new initiative is key in terms of early intervention for those with depression and anxiety and we look forward to seeing how it will develop. It has replaced a more fragmented system which had broadly the same providers but lacked effective co-ordination. We debated with a range of local stakeholders the challenges of treatment vs prevention in service provision. In that discussion, the role of 1:1 vs group therapies featured prominently, particularly within BME communities, where linguistic and cultural barriers are significant and there is a pressing need to reduce the factors which lead to poor mental health in the first place.

2.5 Our recommendations encompass support for front line housing officers, improving 'move-on' accommodation, hospital discharge processes and BME access to services, the operation of the new IMHN, the need for job retention programmes and how Hackney Council and NHS, as employers themselves, can provide leadership on best practice in supporting employees to avoid anxiety and depression and with a managed return to work.

2.6 Our recommendations are:

Recommendation One
The Commission requests the Health and Wellbeing Board to ensure that with the roll out of the Integrated Mental Health Network (the IMHN) from 1 February 2015 that:

a) Talking therapies, particularly culturally specific, one-to-one, therapies provided by BME community organisations, do not lose out to solely generic provision.
b) Any funding gaps arising from the creation of the IMHN which impact on the prevention and early intervention stages are addressed so that those who are unable to make progress via group therapy are also catered for.
c) Consideration is given to whether the provision of IAPT might include a BME voluntary sector element.
d) The role of BME organisations in delivering preventative services which are wider than direct mental health support is better acknowledged as they are providing services to service users who provide difficult to reach for mainstream providers and are thus contributing to wider social capital.
e) Local health and social care partners examine how they might actively recruit staff or volunteers from local BME communities, such as Turkish/Kurdish, with a view to training them or encouraging them to qualify in the health and social care professions.
f) Preventative programmes are better co-ordinated with local health partners and commissioners do not act in isolation when making changes aimed at delivering on their own cost saving programmes.
g) Although the focus of these services is on helping people to become well and able to function in society, there needs to be a range of services to allow people to access continuing support after an initial period of therapy.

We will be expecting evidence of this implementation in the 6 month update.

Recommendation Two
The Commission recommends that the Council's "Housing Needs Service" jointly with Hackney Homes and ELFT:

a) Expand on the existing initiative on mental health awareness training for staff. This needs to build on existing best practice and focus on clear pathways that staff know will work.
b) Ensure that frontline workers are kept up to date on the available care pathways**,** the resources open to them in giving support to vulnerable residents, and that clear escalation procedures are in place. This needs to include dealing with complaints from neighbours about erratic or anti-social behaviour.
c) Consider how they could work with Registered Housing Providers to develop a joint crisis line to which clients with mental health problems could be referred.

Recommendation Three
The Commission recommends that the Cabinet Members for Housing and for Health Social Care and Culture ensure that the opportunities created by the management of Hackney Council's housing stock coming back in-house after 31 March 2016 are harnessed to foster closer working relationships between the management of Hackney's housing stock and the health and social care staff in Hackney. A good model here is the success of the joint working on anti-social behaviour between Hackney Homes and the Council departments. It is suggested that having a mental health worker as part of the Hackney Homes team would represent a useful first step here.

Recommendation Four
The Commission recommends that the Cabinet Members for Housing and Health Social Care and Culture review the provision of move-on accommodation for those in the mental health supported housing pathways. This would involve looking at whether the current Nominations Agreements between the Council and Registered Housing Providers are working in the best interests of tenants with mental health needs and in particular provide the stability which can help prevent crises. These tenants often move in and out of short-term supported housing, typically have fluctuating conditions and their needs often get addressed only when they reach crisis point.

Recommendation Five
The Commission recommends that ELFT reviews planning for discharge for mental health patients in the Homerton Hospital's Mental Health Unit. In particular, housing issues need to be identified at the admissions stage and acted upon through the provision of housing advice in the hospital wards/at GPs' surgeries, as appropriate. Furthermore, the Commission requests that this issue be picked up in the 'Hackney Vulnerable People's Protocol' being developed in Hackney in response to the Care Act 2014

Recommendation Six
The Commission requests the CCG and the Council to consider a proposal from City and Hackney Mind to establish a steering group of the Floating Support Providers in the borough so as to assist in better co-ordination of services and to improve communication.

Recommendation Seven
The Commission requests the Council and the CCG to explore with Job Centre Plus and the Council's own Ways Into Work team the commissioning of services to help people with mild to moderate mental health support needs to either retain their jobs and or find new employment. This acknowledges the significant proportion of people in the borough who are workless because of mental illness.

Recommendation Eight
The Commission suggests that the public sector employers should aim to lead the way in developing practices to ease the path back into work for those who are suffering from depression and anxiety, if the overall cost to society is to be reduced. The Commission requests that the Council's HR and Organisational Development department and the Council's Public Health department as well as the HR departments of the local NHS Trusts and the CCG publish information explaining what initiatives they have in place to improve mental health in their own work environments (*e.g.* anti-bullying, stress management) and how they currently support individuals with lower level mental health problems to remain in work and to plan for a managed return to work after periods of sick leave.

Recommendation Nine
The Commission requests that the CCG's Mental Health Programme Board report back on how it will work with local providers to tackle the ongoing challenge of under-representation of BME people, particularly black men, with mental health issues in primary care settings and their over representation as in-patients. The Commission acknowledges that this is a long term issue but seeks assurances that it does not fall down the agenda in a climate of fiscal constraint.

Recommendation Ten
The Commission requests that the Council and the CCG demonstrate how they are including the 'user voice' in commissioning services for lower level mental health issues.

3. FINANCIAL COMMENTS

3.1 This report explores opportunities for reducing and preventing depression and anxiety in working age adults across Hackney. The recommendations are cross cutting and involve partner organisations such as the East London NHS Foundation Trust and our Clinical Commissioning Group.

3.2 The taking forward of the ten outlined recommendations will need to be managed within existing cash limits, with awareness of savings to come in future years.

3.3 Any specific operational changes that come about as a result of this report will need to be scrutinised separately, in order to assess financial implications.

4. LEGAL COMMENTS

4.1 On 14th May 2014, the Care Bill received the Royal Assent and as such the Care Bill became the Care Act 2014. The Care Act 2014 introduces a single, national threshold to accessing care and support right across England. The Care Act has made changes to Section 117 of the Mental Health Act 1983 by section 75 of the Care Act 2014. The Care Act amends section 117 MHA 1983 and will for the first time provide a definition of what comprises "after care services". It now defines "after care services" as services which (i) meet a need arising from or related to the person's mental disorder; and (ii) reduce the risk of a deterioration of the person's mental condition (and, accordingly, reducing the risk of the person requiring admission to a hospital again for treatment for the disorder).

4.2 The report of the Scrutiny Commission and its recommendations falls in line with the Government's initiatives on Mental Health and as set out by NHS England. NHS England has published updated guidance to help commissioners, GPs and providers support mental health patients exercising their legal rights to choose who provides their care and treatment.

4.3 This follows extensive consultation on the interim guidance published earlier this year. In April 2014, the Government established for people with mental health conditions the same legal right to choice of provider as has existed for several years in physical health, representing a major step towards realising parity between physical and mental health.

4.4 NHS England published interim guidance in May 2014 and consulted widely on this. In response to the feedback received, the guidance has been updated to ensure that it provides the clarity that commissioners, GPs and providers need. In addition, a set of clinical scenarios to illustrate how mental health patients' legal rights should work in practice have been published.

4.5 There are no immediate legal implications arising out of this report and its recommendations.

5. FINDINGS

5.1. CONTEXT AND PREVALENCE

5.1.1 At our first meeting on 8 September 2014, we received detailed reports on the context and prevalence of depression and anxiety in Hackney and these can be referred to here. For brevity we will not repeat that detail here.

5.1.2 National estimates of the incidence of depression within the general population range from 3% to 6% of adults, and it is estimated that the number of people identified with and requiring treatment for depression will increase by 17% by 2026[10]. Mild depression accounts for 70%, moderate depression 20% and severe depression 10% of all cases. It is estimated that depression is two to three times more common in people with a chronic physical health problem (such as cancer, heart disease, or diabetes), occurring in about 20% of this population. The annual service costs of treating people with depression in 2007 were estimated to be £1.7 billion, far less than the cost to the economy attributed to depression (£7.5 billion).[11]

5.1.3 The Council's Public Health team pointed out to the Commission that combining the current estimates for the City of London and Hackney of 4,919 adults with severe depression; 16,396 with mixed anxiety and depression and 4,190 with depressive episode suggests that there could be up to 25,505 people with depression in the City of London and Hackney. Alternatively, they say that applying a 6% incidence rate to the City of London's and Hackney's combined population suggests that there could be 15,583 people in the City of London and Hackney with depression. These two figures provide a very broad ranging estimate for the total number of people in City and Hackney with depression of between 15,583 and 25,505 people.

5.1.4 The CCG gave the Commission the following data for what they define as Mental Health (MH) need in the City of London and Hackney, although not all of this need will be depression/anxiety:

- 33,600 people estimated to have common MH disorder;
- 27,700 people who self-report a common MH disorder; and
- 11,500 people with common MH disorder known to GP.

5.1.5 In addition, the CCG gave us their most recent annual data on the local IAPT service, which they commission and which is provided by HUHFT. This data is based on the Hackney population being 257,379[12]:

- 8,700 IAPT service referrals (per year);
- 5,300 people entering IAPT service (per year);

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[10] NICE (March 2011), "Depression in Adults Quality Standard", www.nice.org.uk/guidance/qs8
http://www.nice.org.uk/guidance/qs8/resources/qs8-depression-in-adults-cost-impact-and-commissioning-assessment2

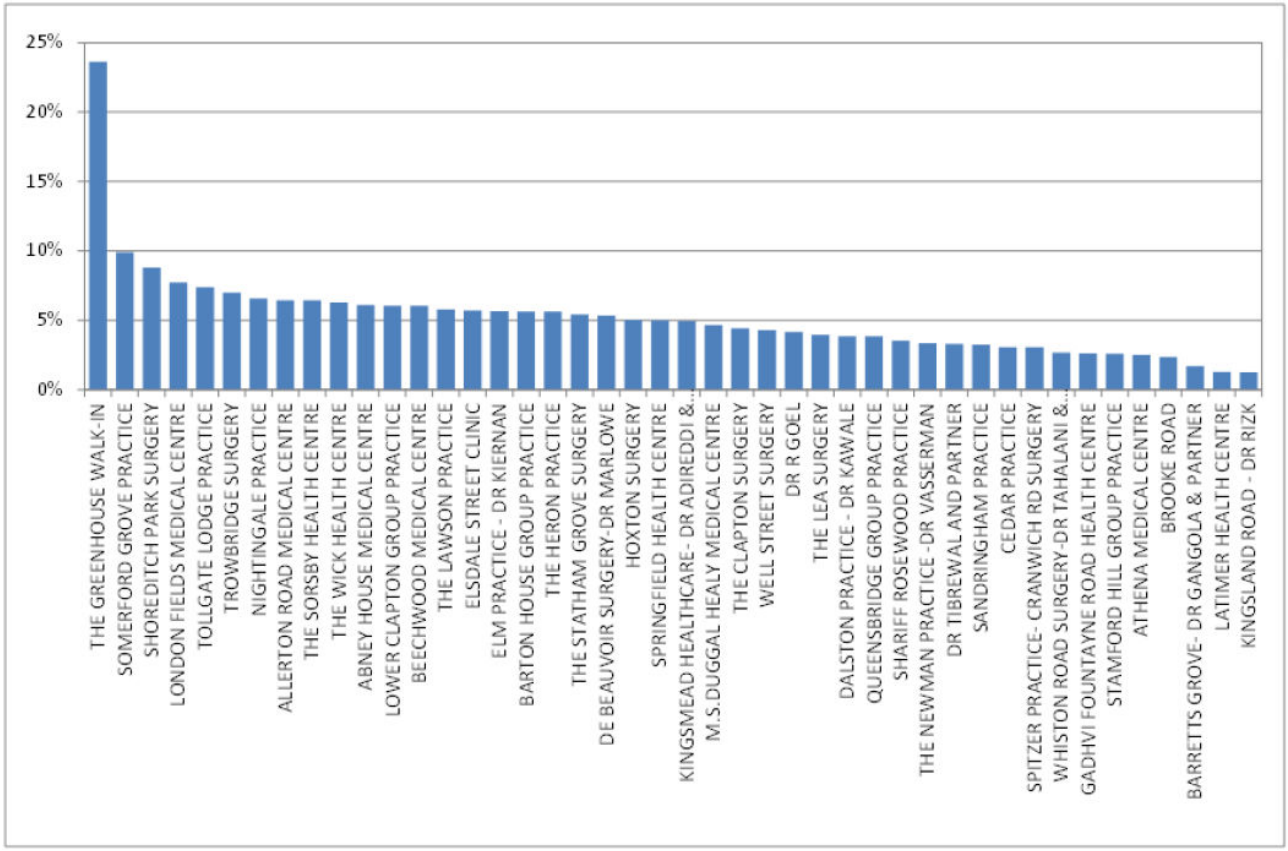
[11] *Ibid.*

[12] http://www.hackney.gov.uk/Assets/Documents/Facts-and-Figures.pdf at Oct 2014

- 2,020 people completing IAPT treatment (per year);
- 904 people achieved reliable recovery following IAPT (per year); and
- 606 people moved to recovery following IAPT.

5.1.6 Figure 1 below shows the percentage of the adult population (aged 18 and over) at each GP practice in the City of London and Hackney for which depression was recorded on the practice depression register in 2012/13. In total, there were 11,500 patients with recorded depression across the 44 practices within the area. The Greenhouse Walk-in Centre had by far the highest proportion of patients on the depression register and it should be noted that this service was established to provide free health care services and housing and welfare advice for homeless people in Hackney.

Figure 1: proportion of practice population aged 18+ who were on the practice depression register, 2012/13.



Source: Quality Outcomes Framework

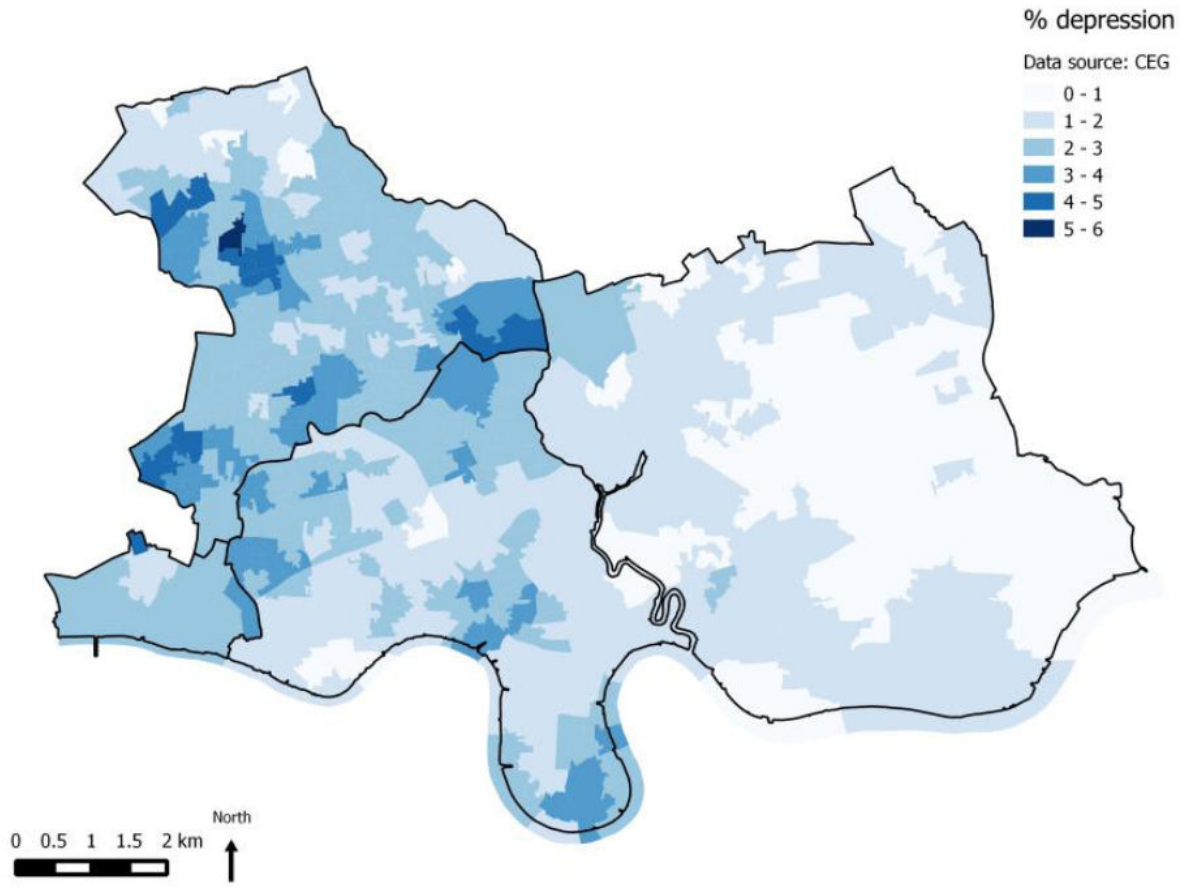
5.1.7 We learned that the figure of 11,500 people on GP registers with depression is fewer than the bottom of our estimated range of people suffering from depression in the City of London and Hackney (15,583 people[13]) suggesting that there is under-recording of depression by GPs. Officers from the Council's Public Health team pointed out that it is possible, however, that this could be due to coding-errors rather than under-diagnosis alone. They estimate too that the available data from the national Quality Outcomes Framework may underestimate those with depression/anxiety by nearly 50%.

[13] [*Cross-reference to para. 5.1.3 above.*]

They add that these figures only include those who are receiving antidepressants, and a large proportion of those with a clinical diagnosis of depression do not receive antidepressants.

5.1.8 Figure 2, below, shows the estimated prevalence of depression by place of residence for the registered population of the City of London and Hackney CCG, the Newham CCG and the Tower Hamlets CCG. This figure shows higher recorded levels of depression (as recorded on GPs' registers) within the Hackney wards of Wick, Stoke Newington, Clissold, London Fields and Hoxton West.

Figure 2: map showing percentage prevalence of depression in City and Hackney, Newham and Tower Hamlets by residence 2012/13.



Source: Clinical Effectiveness Group, extracted April 2013.

5.1.9 The data provided by the Council's Public Health team showed that there is a higher proportion of females than males with recorded depression in Hackney and that the rate of recorded depression was also highest in the 25-39 year old age groups. When viewed as a percentage of the population by age group, however, it was noticeable that prevalence is significant throughout adulthood, particularly within the 40-49 year old and 50-64 year old groups. In terms of ethnicity, the level of recorded depression was highest in white people although a relatively high proportion in the Clinical Effectiveness Group data (referred to in Public Health's evidence) did not state their ethnicity.

5.1.10 Estimating prevalence of depression and anxiety is difficult. One can count those in treatment but often depression and anxiety will take a year or more to develop and a patient may have physical symptoms masking depression. Counting is difficult for GPs and they may not all use the same approach to coding patients. Affluent residents might be more likely to raise the issue with a GP than unemployed residents. Economic deprivation affects BME communities disproportionately and self-referral is likely to be to be higher amongst the affluent, so among BME residents' self-referral is lower. The CCG adds that, in terms of modelled prevalence, there is higher need in the City of London and Hackney than nationally. The Council's Public Health team tells us that estimates of the local prevalence of depression and anxiety from the Public Health Observatory and estimates extrapolated from respondents to a local GP survey who self-report depression and anxiety are well matched but there is a large disparity between this prevalence data and the numbers known to GPs. We also see very high numbers of referrals to IAPT locally and of people entering IAPT treatment compared to the numbers of depression and anxiety patients known as such to GPs.

Seeking care – the first steps

5.1.11 GPs are usually the first service to identify depression and anxiety and they may refer patients to other providers. In Hackney, interventions to help prevent depression and anxiety are delivered by a wide range of statutory and voluntary sector providers. These are commissioned by both the CCG and Hackney Council (both the Council's Public Health department and its Adult Social Care department). Two key providers of IAPT are the Homerton University Hospital NHS Foundation Trust (HUHFT) and Tavistock and Portman NHS Foundation Trust. The services provided by the East London NHS Foundation Trust (ELFT) generally treat those with more severe and enduring mental illnesses. For many from BME groups, however, their first approach will be to their community's own organisation *e.g.* Derman (Turkish/Kurdish), Bikur Cholim (Charedi Jewish) and the Vietnamese Mental Health Service (Vietnamese). Community-specific organisations such as these may either provide support themselves or refer people onwards. Likewise, GPs commonly refer individuals from these communities to their respective community organisations. Many people from these communities will, instead, use the generic provision provided through IAPT either by approaching the IAPT providers themselves or by being referred to IAPT by GPs.

5.1.12 The Council also commissions *Targeted Preventative Support* aimed at individuals who may be starting to develop a mental health support need or who are experiencing severe social isolation. The aim of that support is to reduce or delay the need for specialised or more intensive services. The Council also commissions in-house employment support services and 'Floating Support' (services designed to support people to live independently in their homes) for people with mental health needs (including people suffering from depression and anxiety), the latter being provided by Family Mosaic. A

pilot project to increase the take-up of direct payments[14] for mental health service users is also underway.

5.1.13 At the lower levels of need, Hackney residents struggling with depression and anxiety can also now access free online support via the *Big White Wall* web portal. Residents can visit Big White Wall and enter a Hackney postcode to access the service. It provides 24/7 peer and professional support, plus a range of wellbeing tools to help people self-mange in a way that is both safe and anonymous.

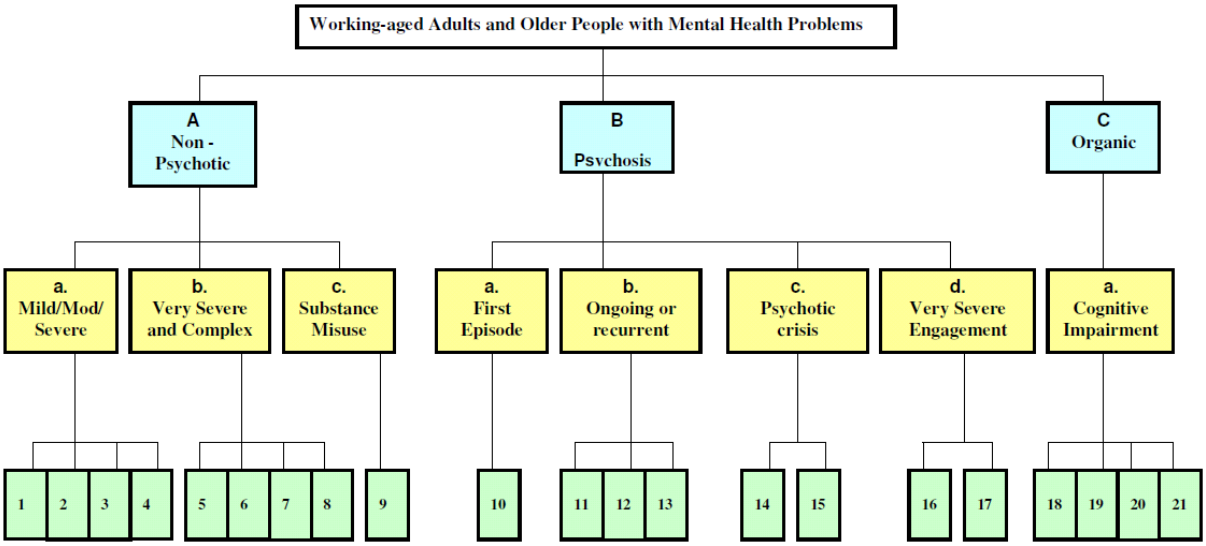
What is IAPT?

5.1.14 The original blueprint for the national programme of *Improved Access to Psychological Therapies* (IAPT) was based on treating depression and anxiety in working age adults through a stepped care approach based on the most current NICE guidance. IAPT services typically offer access to therapies, including guided self-help Cognitive Behavioural Therapy (CBT)-based interventions all of which are NICE approved. CBT is a talking therapy that seeks to help patients to manage their problems by changing the way they think and behave. Talking therapies involve a trained therapist listening to a patient and helping them to find their own answers to problems. CBT is most commonly used to treat depression and anxiety, but can be useful for other mental and physical health problems.

5.1.15 The IAPT model was originally dominated by CBT but it now provides a much wider range of therapies (counselling for depression, couples counselling, Dynamic Interpersonal Therapy *etc.*). All IAPT services use standardised measures to collect and monitor patient outcomes – measuring recovery and patient feedback – at every session. Need is assessed through the use of 'Care Clusters' based primarily on the needs and characteristics of a service user. Clinicians allocate a patient to one of 21 care clusters which are mutually exclusive, in that a service user can only be allocated to one cluster at a time. The focus of this review, as with IAPT, was on clusters 1-8 but predominantly concerned clusters 1-4. The care clusters are as follows:

DECISION TREE – CARE CLUSTERS USED ASSESSING MENTAL HEALTH

[14] Direct payments and personal budgets are offered by local authorities to give patients more flexibility over how their care and support is arranged and provided. They are given to both people with care and support needs, and also to carers.



5.1.16 Treatment approaches used in IAPT for those with low intensity conditions are a mixture of 1:1 telephone and face-to-face therapy, plus education and skills groups and condition-specific interventions for long term conditions. For those with more high intensity conditions, the mix of treatment includes CBT for common mental health problems, 'mindfulness'-based[15] CBT for depression, interpersonal therapy for depression, couples therapy *etc.*

5.1.17 In addition to the IAPT service, which is commissioned from HUHFT, the CCG has also commissioned a Primary Care Psychotherapy Consultation Service which is run from St Leonard's Hospital and provided by the Tavistock and Portman NHS Foundation Trust. The focus of the service is primarily on people with medically unexplained symptoms which are not being managed in secondary care. The service only takes referrals from GPs and puts support and capacity in place within GP surgeries to assist GPs with people who are suffering from depression and anxiety. The service aims to move away from purely psychological therapy to treatment where they look at a community response to help their patients relate to other people and to a wider group. The service often, for example, encourages patients to increase their physical activity. It complements IAPT by working with more challenging patients (clusters 4-8) who do not warm to statutory services. The service typically provides up to 16 sessions. It is not designed to provide long term support however, onward pathways are used should patients require them.

5.2. THE NEW INTEGRATED MENTAL HEALTH NETWORK

5.2.1 Our review took place just as the provision of support services for those with depression and anxiety was undergoing a major transformation. Lower level community-based mental health services were, up until now, provided via a number of small contracts with a range of local voluntary sector organisations.

[15] Mindfulness is a therapy that involves a patient paying more attention to the present moment – to the patient's own thoughts and feelings, and to the world around them – as a means of improving mental wellbeing.

The purpose of the re-commissioning was to create an overarching *Integrated Mental Health Network* (the "IMHN") to make more effective use of resources and to support both the Council's own 'Promoting Independence' and its 'Personalisation' agendas.

5.2.2 City and Hackney Mind has been appointed as the lead provider for the new IMHN. The IMHN will be accessed via a 'single entry process' but with multiple access points from the various network members. The members of the Network are:

City and Hackney Mind – Network Leader with a range of specialisms
Shoredich Trust – Health, wellbeing and alternative therapies
Bikur Cholim – Jewish orthodox specialist
Derman – Turkish specialist
St Mungos Broadway – Turkish and Kurdish specialist and complex needs
Core Arts – Creative arts for complex needs
Vietnamese Mental Health – Vietnamese/SE Asian specialist
Hackney Chinese Community Service – Chinese specialist
PACE – LGBT specialist
Off Centre – Young people including young black men specialism
Chizuk – Jewish orthodox specialist

The network will also engage with **North London Muslim Community Centre** to spot-purchase support for Asian and Muslim communities.

5.2.3 The IMHN will comprise two time-limited service components as follows:

- *Mental Wellbeing and Prevention* (provision for up to 1 yr)
- *Recovery and Social Inclusion* (provision for up to 2 yrs)

The IMHN began on 1 February 2015 and will focus on early access for people in the community who do not meet the thresholds for statutory services[16]. The IMHN will offer a wide range of support through outreach and partnership with other agencies in the areas of employment, housing, leisure services *etc.* The IMHN also aims to increase access for specific groups who have historically been under represented in community mental health services.

5.2.4 From the outset of the review we had heard concerns from some of the voluntary and community sector providers who were part of the previous network (specifically Derman, Bikur Cholim, Family Action) that the new service represented a cut, particularly in relation to one-to-one talking therapies. There were also criticisms that communications with the providers and the CCG during the development of the IMHN had been poor. There was a concern too that there was a lack of clarity on the wider funding picture and on the funding going into this sector both before and after the IMHN's inception.

[16] The 'critical and substantial' threshold to access social care services under the Fair Access to Care Services (FACS) criteria.

5.2.5 It is clear that these changes represented a significant shift in funding for some already fragile organisations which lack solid income streams but which, nevertheless, contribute greatly to the prevention and treatment of depression and anxiety in Hackney. The challenge for commissioners is to continue to support these organisations appropriately while making sure that health outcomes for those with depression and anxiety are improved.

5.2.6 In evidence to the Commission, the Director of Public Health at Hackney Council pointed out that specific funding for mental health support of around £2.4m had been included as part of the transfer of public health funding from the (now-abolished) primary care trust to the Council. The use of this funding was reviewed in terms of its effectiveness and value for money and, in particular, whether the funding was being used for its stated purpose, which was to build mental health resilience. In the Public Health team's analysis, they found that only roughly 50% of the previously contracted activity was used to help people to build resilience and there was not a sufficiently co-ordinated approach to how this money was spent. In developing the IMHN, the Council's Public Health team stated that they worked very closely with the CCG and the individual providers. They focused on developing a single point of access and in ensuring that resources could be used more flexibly across the IMHN.

5.2.7 We learned that the procurement of the IMHN had been delayed to ensure there was sufficient time to work through any problems, particularly around the user-involvement element, and that the CCG had been invited to all the planning meetings. The commissioners of the IMHN reminded us that they had gone to the market with the same budget as previously (£2.4m) so it was not correct to portray this as a cut. During the procurement process, the scope of the services being procured was slightly altered with the procurement of a separate "user involvement" element being paused. This might have accounted for some contractors believing that there had been a reduction in funding.

5.2.8 The contract for City and Hackney Mind to operate the IMHN had come in at £100K less than the previous total. Although the new funding arrangement involved payments being calculated according to the number of patients seen, there was a guarantee that 50% of the projected funding would be paid regardless of the actual caseload. In turn, the IMHN's sub-contractors also received a 60% upfront funding guarantee. Hackney Council's Assistant Director of Commissioning and the Council's Director of Public Health argued that while they understood the concerns of organisations at the passing of the previous model, the key principle underpinning the IMHN was to ensure that the Council paid providers for services received rather than by a block contract fee.

5.2.9 On the issue of communications, the commissioners assured us that conversations were ongoing with the CCG. We learned that, after February 2015, one-to-one therapy would continue to be provided for current service

users if no other arrangements could be made. The focus would be on finding alternative funding and support to enable people to recover and move on.

5.2.10 We noted that culturally-specific organisations such as Derman were struggling to provide vital services to very vulnerable service users. At Derman, we met a group which included people who had fled to the UK as refugees often after having experienced very severe psychological trauma in their country of origin, had then experienced long delays in securing residency during which time they were prevented from looking for work and so became dependent on welfare and had remained in social housing. This group exhibited the long term effects of post-traumatic stress disorder and had become very dependent on Derman. Some had been attending for 10 years or more. None had functional English and so would not be suitable for generic group therapy.

5.2.11 Bikur Cholim, whom we also visited, stressed that group therapy would be totally alien to their community also as it contravened cultural and religious norms relating to privacy. We noted on our visit to them that they had had to set up separate entrances and exits from their consulting rooms so that clients felt that their visit to the centre would remain confidential. They argued that nobody from the Charedi community would attend a generic IAPT service.

5.2.12 When we visited the HUHFT's IAPT service at St Leonard's hospital, we were told that they had both Charedi Jewish and Turkish clients. There is, therefore, a need to take into account (a) patients who cling to their community provision and find it difficult to access generic services outside of it, and (b) other patients from those communities, who will use IAPT provision precisely because it is separate from the community and therefore appears to provide greater anonymity. From the evidence we have seen, it is not realistic to suggest that all those from BME communities could easily be enticed into generic provision.

5.2.13 Following our site visits, we reflected that no commissioner in Hackney seemed to be taking responsibility for the totality of services which an organisation like Derman provides. The fragmentation of funding was part of the problem in that each commissioner only looked to its own deliverables rather than taking a more holistic approach to what these service users actually require. The commissioners of IMHN argued that the new network combines both generic and culturally-specific provision and that, in the former, they have workers who are culturally competent to serve particular local communities. The clinicians in the BME Access Service at ELFT, to whom we spoke, took issue with the whole concept of 'cultural competence', arguing that it involves much more than simply translating interventions and materials into another language but rather forging an understanding of the cultural, social and historical issues relevant to the communities concerned. We will address this further in 5.8.

5.2.14 .We noted that the Council's Assistant Director of Commissioning was meeting weekly with City and Hackney Mind and there were monthly discussions with providers. The Council will also fund clinical governance training which some of the providers require. Providers were encouraged to move towards more group therapy provision but the focus was always on how to ensure the support being provided was productive. The CCG also pointed out that they were making some non-recurrent funding available to fill any gaps in provision.

5.2.15 We noted that Family Action which had previously been commissioned by the (now-abolished) primary care trust had opted out of the IMHN. Local GPs and others had expressed concern about the loss of their valuable family therapy services which they delivered in local GPs' surgeries. The Council's Assistant Director of Commissioning clarified that Family Action had chosen not to be part of the IMHN and they had not been "de-commissioned". We were assured that City and Hackney Mind, as the IMHN's lead operator, was reinvesting this money and no monies were being banked as savings.

5.2.16 In terms of moving forward with the IMHN, the commissioners in the Council and in the CCG all argued that there was also responsibility on the voluntary sector too to know its market well and to develop business models such that commissioners could put in place the best range of funding to support them.

Recommendation One

The Commission requests the Health and Wellbeing Board to ensure that with the roll out of the Integrated Mental Health Network from 1 Feb 2015 :

a) Talking therapies, particularly culturally specific, one-to-one, therapies provided by BME community organisations, do not lose out to solely generic provision.
b) Any funding gaps arising from the creation of the Network which impact on the prevention and early intervention stages are addressed so that those who are unable to make progress via group therapy are also catered for.
c) Consideration is given to whether the provision of IAPT might include a BME voluntary sector element.
d) The role of BME organisations in delivering preventative services which are wider than direct mental health support is better acknowledged as they are providing services and are thus contributing to wider social capital.
e) Local health and social care partners examine how they might actively recruit staff or volunteers from local BME communities, such as Turkish/Kurdish, with a view to training them or encouraging them to qualify in the health and social care professions.
f) Preventative programmes are better co-ordinated with local health partners and that commissioners do not act in isolation when making changes aimed at delivering on their own cost saving programmes.
g) Although the focus of these services is on helping people to become well and able to function in society, there also needs to be a range of services to allow people to access continuing support after an initial period of therapy.

We will be expecting evidence of this implementation in the 6 month update.

5.3 WIDER DETERMINANTS OF MENTAL ILL-HEALTH

5.3.1 Mental health, including depression and anxiety, is affected by a range of factors including employment, education, living and working conditions, diet and nutrition, physical health, social networks and lifestyle choices, which can all, in turn, be affected by mental health. By better understanding these determinants, the Council and its partners can develop means to address them to promote good mental health and prevent the onset or deterioration of mental illness, through the delivery of local government services, as well as partner-led provision of services. Preventing depression and anxiety in Hackney is also likely to contribute to improving citizens' employment prospects, educational attainment, living and working conditions, dietary habits, physical health, social networks and lifestyle choices. Such a virtuous circle is a powerful reason for Hackney healthcare commissioners to take positive action to prevent depression and anxiety amongst our fellow citizens.

5.3.2 Public Health pointed out the broad set of community factors which are known to affect health and wellbeing for the population in general:

- strong association between **low income** and poor health;
- people in **work** enjoy better physical and mental health than those without work;
- people with low levels of **educational achievement** are more likely to have poor health as adults;
- there are important risks to health from the cold and damp associated with **poor housing**;
- **homelessness** can be a significant cause of ill health;
- there are ways in which the environment can have an adverse affect on health - for example, through **pollution**; and
- people are likely to be healthier when they live in 'healthy **neighbourhoods**'.

5.3.3 In the sections 5.4 onwards we address some of these wider determinants in more detail.

5.4 HOUSING/HOUSING-BASED SUPPORT

5.4.1 There is a strong association between poor housing and mental health problems, including depression and anxiety. Those living in local authority housing have, for various reasons, poorer mental health than those in owner occupied accommodation. Poor-quality housing, for example dwellings which are damp, lack security or are noisy, are particularly associated with depression. The decrease in social housing provision and the lack of affordable housing is leading to overcrowding, which damages family relationships and children's emotional development.

5.4.2 Homelessness can be both a cause and a consequence of major problems for a person's health, both physical and mental. A third to a half of homeless people sleeping rough have mental health problems. In particular, homelessness can be a consequence of living with a mental illness. Homelessness itself is a stressful situation and can lead to depression and anxiety, with mothers and children suffering significantly higher levels of mental health problems.

5.4.3 We looked at the types of housing offered by Hackney Homes and by Family Mosaic, which is the largest Registered Housing Provider in the borough, with the latter providing a mental health floating support service in one third of the borough. We also looked at how the Council's social care department commissions a range of targeted preventative services, some of which have a specific mental health component.

Hackney Homes

5.4.4 Hackney Homes manages 31,000 properties on behalf of Hackney Council. Within it, a "Tenancy and Leasehold Services Directorate" is responsible for providing tenancy management services, including enforcement and support. The directorate is divided into various teams, including "Centralised Housing Services" who provide specialist anti-social behaviour case management for high level and complex cases, and "Neighbourhood Services", who deliver generic, highly-localised tenancy management through estate management teams. These estate management teams are the main point of contact for tenants.

5.4.5 Prior to the start of a tenancy with Hackney Homes, any vulnerability and/or support needs are expected to be flagged in the information provided by the Hackney Council's Housing Needs department in a housing application and homelessness assessment. Support to maintain tenancies is generally provided on a reactive, individual basis as required, where a resident has a particular issue that comes to the attention of the estate manager; this can be anti-social behaviour, rent arrears, or general difficulty in managing their tenancy as manifested by hoarding or allowing the property to deteriorate into an unhygienic state. The tenancy management teams then work with colleagues in other parts of Hackney Homes, such as the specialist income and anti-social behaviour teams, and with colleagues in the Council's Adult Services and Mental Health teams to support the tenant. Officers can also

refer tenants on to external specialist support services, such as that provided by the Council's Targeted Preventative Services team.

Targeted Preventative Services

5.4.6 The Targeted Preventative Services (TPS) team forms part of the Council's "Promoting Independence Strategy". The team work on a prevention basis, available to Hackney residents aged 16 and above who would benefit from targeted support to help them with a particular set of issues, to cope in a crisis.

5.4.7 There are three main services offered by the TPS team:

- **Floating Support** to tenants in their own homes;
- A **Volunteering and Befriending** service; and
- A **Health and Wellbeing** service for the local Jewish orthodox and wider Jewish community in the north of Hackney.

5.4.8 The Floating Support service providers are **Family Mosaic** (for Shoreditch), **One Support** (NE and NW of the borough) and **SHP** (Homerton). The Health and Wellbeing Service is provided by **Norwood**, a Jewish charity supporting vulnerable children, families and people with learning disabilities. Referrals to each of these services are managed by **Outward**, who provide a single point of access for all referrals from Registered Housing Providers working in the borough.

5.4.9 The TPS services take referrals from residents considered to be vulnerable because of any of the following factors:

- severe social isolation;
- frailty caused by age;
- mild mental health needs;
- non-complex learning or physical disability;
- long term health needs;
- mild substance abuse issues; and
- who are on the verge of a crisis.

There were 1,500 referrals to TPS services in the last three quarters alone. Hackney residents with more severe mental health or other needs are referred to Council's Adult Mental Health team or the Community Mental Health team which is provided by the Homerton. Hackney Homes has also worked with an organisation known as "Making Room", which provides services to assist hoarders resolve the issues that lead to their extreme behaviour.

5.4.10 The 'Floating Support' service covers such areas as:

- developing skills and providing training to obtain work;
- assistance in contacting or maintaining contact with other agencies such as social services, probation or voluntary agencies;
- making connections with community, friends and family;
- participating in leisure, cultural, faith or informal learning activities;
- access to services such as care or counselling;

- help with registering with a GP or dentist;
- applying for welfare benefits;
- dealing with rent arrears or debt;
- arranging repairs or aids or adaptations;
- practical living skills; and
- dealing with anti-social behaviour.

5.4.11 The Volunteering and Befriending Service aims to tackle loneliness by matching people to a suitable volunteer who can provide emotional support and friendship. People are also encouraged to consider volunteering in order to feel more connected to their community.

5.4.12 The Health and Wellbeing service offers activities such as healthy eating, sports and leisure and work skills.

5.4.13 The intention with all the services is that they interlink.

'Homecheck Scheme'

5.4.14 Hackney Homes has recently developed a 'Homecheck Scheme' which is designed to provide informal support and a 'friendly face' to those residents that do not currently receive support from any other source despite being identified as potentially requiring some assistance. Requiring assistance can be something simple such as needing information or 'sign-posting' to appropriate organisations or - where a greater need is identified – being referred to formal support schemes such as those that fall under the umbrella of the TPS. Any referral to a third party will, in most instances, be made with the permission of the resident concerned. While referrals to more formal support services may be required, it should be noted that this scheme is hoped to be informal in nature, with a resident-centred approach, providing a 'friendly face'. Estate management staff are expected to use the scheme as a way of continuing to build relationships and trust with their residents rather than simply using it as a 'box-ticking' exercise for referring residents on to other provision.

5.4.15 By identifying and visiting residents in this way the estate management teams are, on behalf of Hackney Homes, bridging a gap in service provision. It is intended that estate management staff will help individuals to continue living independently thus preventing a number of low to medium level issues from developing into problems that would ultimately require more high-cost support in the future.

Family Mosaic's mental health services

5.4.16 We heard from and visited one of the 'Floating Support' providers, Family Mosaic, who are also one of the main housing providers in London and the South East with 3000 properties in Hackney alone. They also deliver a wide range of care and support services across the borough, supporting over 800

people aged 18 and over. The following table illustrates the range of provision in Hackney and the activity levels in November 2014:

Mental Health Floating Support	129 customers 18+
Mental Health Supported Housing	170 aged 18+
Health and Wellbeing Project	224 participants aged 50+
Shoreditch Floating Support (contract for 1/3 of the borough)	375 customers 18+
Older People's Services	109 aged 55+
Single Homeless Service	10 customers 18+
Learning Disability Services	36 customers aged 18+

5.4.17 Family Mosaic's floating support service is intended for residents living in their own homes and who are referred to the service by a body known as the "*Mental Health Supported Housing Panel*" (made up of officers from the Council, ELFT and Family Mosaic) when cases come to the attention of officers. Separately, they manage 170 units of mental health supporting housing accommodation on behalf of the Council. This accommodation is for clients with low/medium to high support needs who have to have met the criteria for receiving statutory support. In addition, Family Mosaic provides mental health support to Family Mosaic's own tenants in its 'General Needs' housing. This in-house support can cover tenancy sustainment, debt advice, welfare rights advice, employment support and social inclusion activities and events.

Issues from Housing Providers

5.4.18 We noted concerns from housing managers that they often felt left to manage all areas of concern affecting a resident suffering from mental illness. They reported that this was a strain on their resources as they were usually seen as the link between all agencies. There was also an issue with encouraging people to engage with services so that they could be diagnosed and receive appropriate treatment. They felt that if the tenants didn't engage, they would be discharged from services. Their focus was on trying to drive up mental health literacy and to reduce the stigma attached to and ignorance of mental illness, so people seek help for themselves and their relatives.

5.4.19 Another concern was that partners often only engaged with mental health issues when they reached crisis level. There was an understanding that most agencies, including local authorities, are constrained as to what they are able to accomplish depending on how serious a crisis has become. The Family Mosaic neighbourhood managers, for example, reported that they did not always have risk assessments from the Council prior to residents moving in to a Family Mosaic property and they were sometimes not aware of their new tenants' mental health issues until they moved in and began to show signs of their deteriorating mental health. Family Mosaic neighbourhood managers also reported that they were often unsure of the difference between generic vs community-based mental health support and found it difficult to identify the more specialist services – such as those which are culturally-specific – available locally.

5.4.20 Hackney Homes told us that their front line housing officers are not sufficiently trained to recognise the symptoms of clinical depression and the challenge for them is that many of these symptoms will lead to the sufferer refusing to engage with their support service, whilst behaving in a way that results in the housing provider being forced take enforcement action to deal with the problem (*e.g.*, failure to pay rent due to inability to deal with the benefits system, anti-social behaviour, deterioration in the condition of the property). We acknowledge here that the housing providers' priority is always to offer support in the first place but if the tenant refuses to engage with them, or with the specialist agency to which they are referred, the housing provider cannot force them to accept that support. In any case, there would appear to be both a training need and for solutions to be found to better share the burden on individual providers, for example by creating a joint crisis line.

Recommendation Two
The Commission recommends that the Council's "Housing Needs Service" jointly with Hackney Homes and ELFT:

a) Expand on the existing initiative on mental health awareness training for staff. This needs to build on existing best practice and focus on clear pathways that staff know will work.
b) Ensure that front line workers are kept up to date on the available care pathways**,** the resources open to them in giving support to vulnerable residents, and that clear escalation procedures are in place. This needs to include dealing with complaints from neighbours about erratic or anti-social behaviour.
c) Consider how they could work with Registered Housing Providers to develop a joint crisis line to which clients with mental health problems could be referred.

5.4.21 While there is a complex matrix of services here with some support being tied to tenure and some being universal and provided, albeit with qualification thresholds, by the Council, a provider like Family Mosaic is in many ways better placed than others to provide support because it also has expertise in delivering mental health specific support as well as general housing provision. We noted that because of its size Family Mosaic is in a good position to integrate and coordinate provision. Hackney Homes however appeared to suffer, at times, from disconnect with other agencies or with departments of the Council. With Hackney Homes coming in-house, we are asking Cabinet members to consider how Hackney Homes can better interact with the Council's Adult Social Care department and its Public Health department (also in-house) to better support its tenants in preventing depression and anxiety. There is history of good practice here in the unified approach which Hackney Homes and the Council's Community Safety Team and others have taken to handle anti-social behaviour on estates and we would urge that such an approach is replicated in the area of mental health.

5.4.22 Some frontline officers appear apprehensive about offering assistance because of the perceived complexity of the care pathways. They are concerned that, if they engage with a resident, they may not be able to follow up with some concrete support. While it is always easy to suggest better co-ordination then to implement it, there is certainly an opportunity with the management of Hackney Council's housing stock coming back in-house to look again at how mental health support could be provided more holistically to Hackney's social tenants and leaseholders.

Recommendation Three
The Commission recommends that the Cabinet Members for Housing and for Health Social Care and Culture ensure that the opportunities created by Hackney Homes coming in-house are harnessed to foster closer working relationships between Hackney Homes and the health and social care staff. A good model here is the success of the joint working on ASB between Hackney Homes and the Council departments. It is suggested that having a mental health worker as part of the Hackney Homes team would represent a useful first step here.

Move-on accommodation for those in mental health care pathways

5.4.23 Persuading residents with depression and anxiety to seek support can be difficult but there are further challenges down the line when they come to the end of their initial treatment. Those in Mental Health Supported Housing, for example, who like many people with mental health needs will have fluctuating conditions, can often find themselves moving in and out of short term supported housing. We noted there had been a small allocation of housing for such residents but that this accommodation had recently been withdrawn by Housing Needs and Family Mosaic was very concerned at this.

5.4.24 The Council allocates in the region of 80 units of housing quota to supported housing to facilitate move-on from short-term services. Currently, Hackney Council's Access and Inclusion Team makes 12 self-contained accommodation units available each year, to aid move-on from the mental health supported accommodation pathway. These units allow supported housing providers, of which Family Mosaic is one, to move people on, enabling new users with mental health needs to be accommodated, and preventing these services from becoming blocked. A decision has been made not to accept nominations to this quota from residents in these services housed by and/or receiving support from Family Mosaic. Family Mosaic currently support over 80% of the people in this pathway. The Council's rationale appears to be that, as Family Mosaic is the largest social landlord in Hackney, it should be able to house the people it supports itself. In summary, dedicated mental health move-on accommodation is being withdrawn from Family Mosaic and they are being asked to make up the shortfall from their own existing general needs housing stock. Family Mosaic has formally responded by saying that, if this continues, they will have to reduce the general needs housing that it offers to the Council by the same amount. This

would appear to be a zero sum game in terms of Hackney's stock allocation and it highlights the complexity here.

Recommendation Four
The Commission recommends that the Cabinet Members for Housing and Health Social Care and Culture review the provision of move-on accommodation for those in the mental health supported housing pathways. This would involve looking at whether the current Nominations Agreements between the Council and Registered Housing Providers are working in the best interests of tenants with mental health needs and, in particular, provide the stability which can help prevent crises. These tenants often move in and out of short term supported housing, typically have fluctuating conditions and their needs often get addressed only when they reach crisis point.

Housing as part of discharge planning

5.4.25 We also heard concerns that discharge pathways for mental health patients are not clear and there is insufficient support for these patients. Good practice should dictate that discharge planning happens at the admission stage and not soon before discharge. From our discussions, it is clear that these patients should be offered housing advice far earlier.

5.4.26 We also heard that people suffering from mental health illness generally struggled to navigate Hackney Council's "choice-based lettings system". Under this system, people on Hackney Council's waiting list for social housing must apply for available properties which are advertised, rather than being allocated a home. Quite apart from the difficulties that the person may encounter in understanding the bidding process, they may also, for example, be invited to view a property and, if they missed the appointment, they would then lose out. People with mental illness left to their own devices in navigating these systems could often end up in crisis. Helping these clients to attend Hackney Council's "Homelessness Persons Unit" was also suggested as a way forward. Providing specific housing needs advice in hospital wards/GPs' surgeries was suggested as another solution here. Likewise, we heard from City and Hackney Mind that if there were to be a steering group of the various floating support providers in place some progress might be made in this area.

Recommendation Five
The Commission recommends that ELFT reviews planning for discharge for mental health patients in the Homerton Hospital's Mental Health Unit. In particular, housing issues need to be identified at the admissions stage and acted upon through the provision of housing advice in hospital wards/at GPs' surgeries, as appropriate. Furthermore, the Commission requests that this issue be picked up in the 'Hackney Vulnerable People's Protocol' being developed in Hackney in response to the Care Act 2014.

Recommendation Six
The Commission requests the CCG and the Council to consider a proposal from City and Hackney Mind to establish a steering group of the Floating Support Providers in the borough so as to assist in better co-ordination of services and to improve communication.

5.4.27 One aspect of the welfare reforms which is impacting on people with mental illness are the restrictions on shared accommodation. In the past, there was an expectation that clients might be able to move to 1-bedroom housing. However, following the welfare reforms they must now share accommodation if they are single and under 35. Clinicians agree that shared accommodation is not appropriate for those recovering from mental health issues if their first tenancy is not in a supported housing environment.

'Health Begins At Home' report

5.4.28 We discussed the interim findings of Family Mosaic's major research project '*Health Begins at Home*'[17] which is being undertaken with the LSE. Central to these findings was the belief that good housing can help to reduce costs in the NHS. One way in which this can be achieved is by working with GPs and hospitals to provide home-based services that take the strain off expensive health facilities. Another approach is preventative, promoting health and wellbeing initiatives among tenants, so that their health improves and their NHS usage declines. The report's interim findings make a solid case for early intervention and draw on data from Family Mosaic's housing in Hackney, Islington, Hammersmith & Fulham and Haringey. Alarmingly, a headline finding in the report is that 71% of over-50s in Family Mosaic's housing have one or more long term medical conditions. It is clear from the interim report that need amongst their tenants and among social housing clients generally is much higher than in the general population. We look forward to the publication of the full report in April 2015.

5.5 EMPLOYMENT

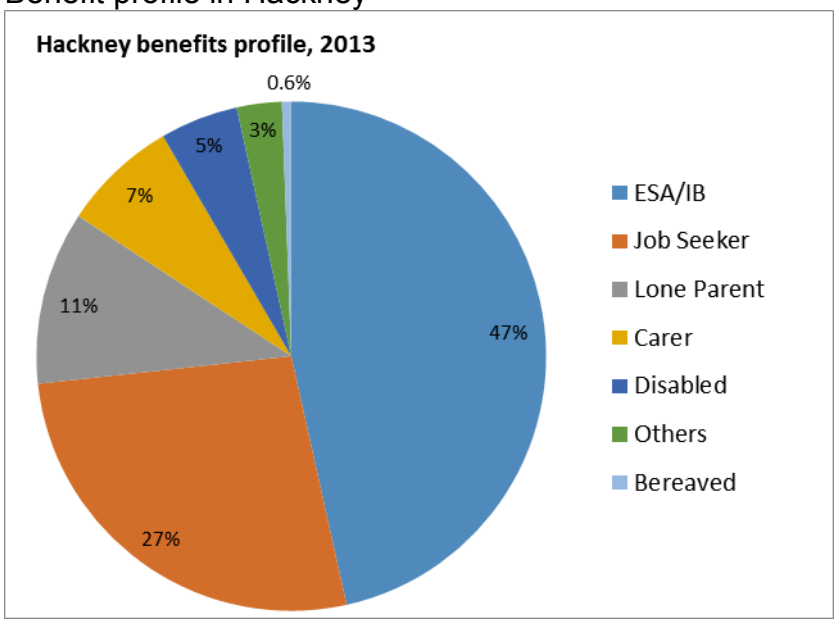
5.5.1 We learned from the Council's Public Health team of the important role that employment plays in maintaining good mental health and the extensive research which backs this up. The obverse of this is that unemployment has been recognised as having major links with poor mental health. National research has found that unemployed people are the group most likely to suffer high levels of all psychiatric disorders. This is a complex issue, because people may also be less likely to be in paid employment due to pre-existing mental illness. Alternatively, unemployment may lead to deterioration in mental health. Both may apply of course, but studies suggest the latter is significant.

[17] http://www.familymosaic.co.uk/userfiles/Documents/Research_Reports/Health_Begins_At_Home_web.pdf

5.5.2 Similarly, the research shows that people at higher risk of common mental health problems include those with no or few qualifications and who are unemployed. There is a well-established link between learning and mental health beyond the school years, with participation in learning opportunities leading to increases in human, social and individual capital, in terms of knowledge, skills, trust, dependency, positive self-image, assertiveness and confidence. Adult learning has an important part to play in promoting health and wellbeing also.

5.5.4 The latest data from the Council's Local Economic Assessment shows that 48% of the c14000 people in Hackney on long term inactive benefits (*i.e.*, 6,420 people) are claiming because of their mental or behavioural health.[18] In addition, 57% of benefit claimants have been claiming for 5 years or more.[19] The benefit profile in Hackney, below, shows that nearly half of all claimants are on ESA or Employment and Support Allowance (what was previously incapacity benefit).

Benefit profile in Hackney[20]



Source: DWP administrative data / nomis

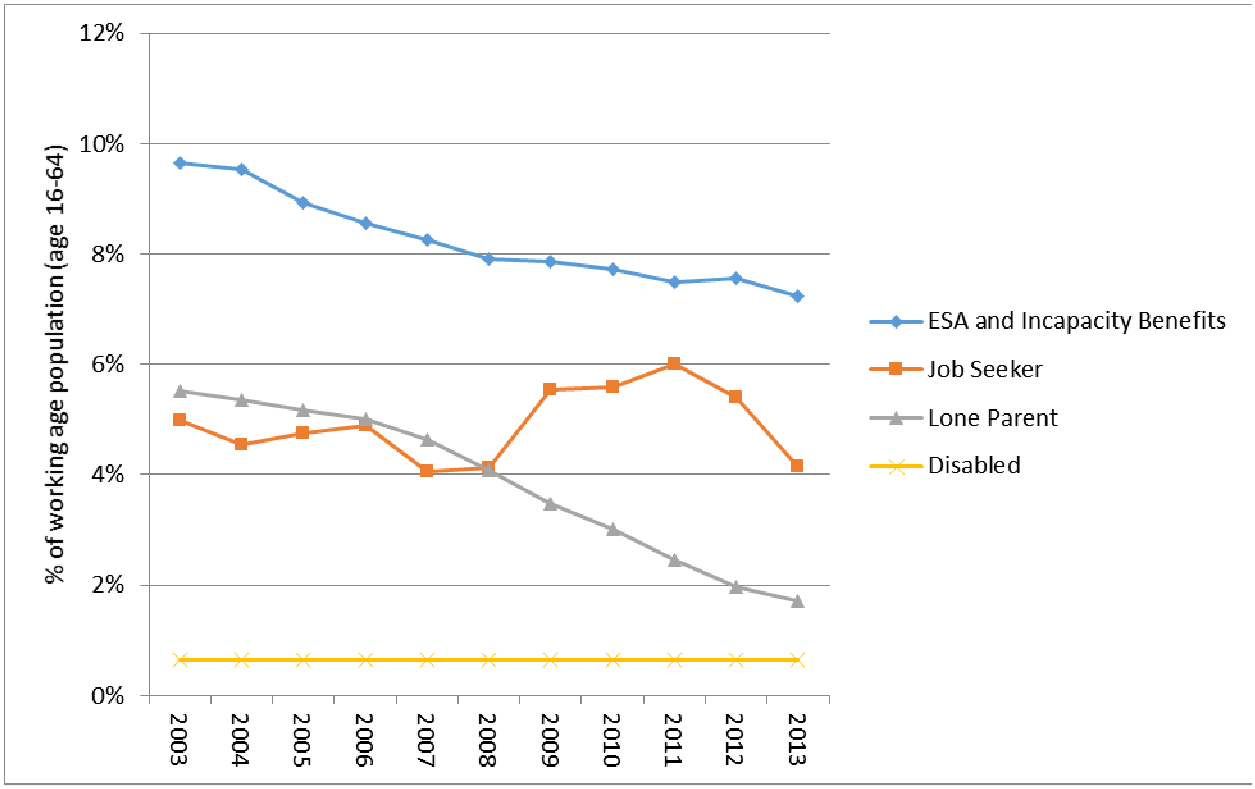
The following chart shows a slight decline in the numbers on ESA in Hackney as a proportion of the working age population:

Key out of work benefits, as proportion of working age population

[18] http://www.hackney.gov.uk/Assets/Documents/2014_LEA_Headlines.pdf, page 5.

[19] *Ibid.*, page 4.

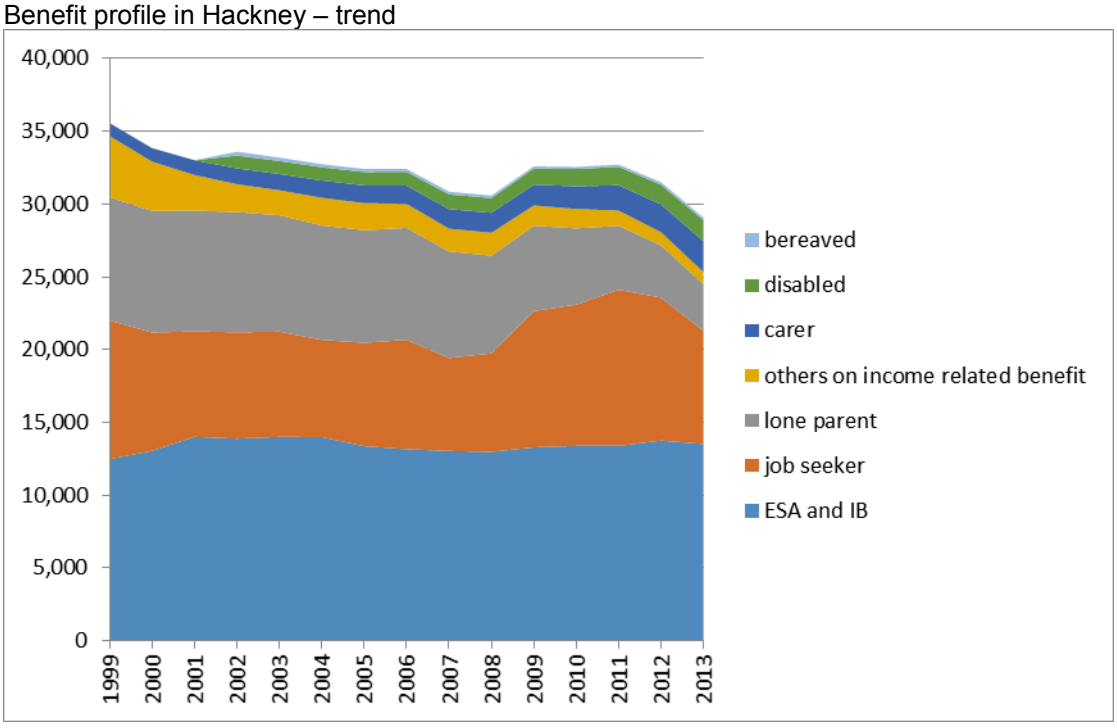
[20] Briefing on duration and characteristics of long term unemployed in Hackney, Policy Team, Oct 2014



Source: Source: DWP administrative data, nomis. Note: working age population figures are from ONS mid-year population estimates. 2013 data is not available yet, and so the 2013 figure has been extrapolated using the average working age population growth from 2007-12.

However little impact seems to have been made on overall numbers on ESA

Benefit profile in Hackney – trend



5.5.4 This persistent high level of long-term ESA claimants underlines the importance of having a greater focus on prevention and early intervention because, once an individual starts claiming ESA, they tend to remain on it in

spite of the greatly increased sanctioning taking place under the Coalition Government's welfare reforms. It is interesting too that most of the fall in long-term benefit claimants in Hackney over the past decade has occurred among women and this relates to a significant drop in the number of lone parent claimants. Increased conditionality under the welfare reforms and the redistribution to JSA are major contributors to this reduction however.

5.5.5 In the area of depression and anxiety, we learned that people often deteriorate to crisis or breakdown before they seek help. Typically, if they are working, they will be 'signed-off' and, if there isn't sufficient support in place to organise a managed return to work, their situation worsens. Some people can stay off work for long periods because they fear not being able to cope on return or because their managers lack confidence that they can handle them or their co-workers or a mixture of both. Obviously, if specific work-related stress was the cause of the breakdown in the first place then a return to the same job may not be the answer but there will be alternatives. Generally, we heard that if a person can negotiate or be assisted to negotiate an effective gradual return to work, then it is the best solution for both parties.

5.5.6 Helping people into employment or to return to work is a key part of the support which many of the organisations we heard from provide for those suffering from depression and anxiety. We were particularly impressed with the work of the job retention service run by City and Hackney Mind. In addition to their employment advisers, they have embedded an adviser within the IAPT service provided by the HUHFT. The service has supported 66 people to retain their jobs in the past year. Clients are referred generally by GPs and have been signed off sick with depression and anxiety. With the client's permission, the advisor might contact the client's HR manager or line manager to mediate a managed return to work or perhaps to draft a compromise agreement or help someone in dealing with an Employment Tribunal.

5.5.7 City and Hackney Mind works with employers to campaign to improve mental health and wellbeing in workplaces and have, for example, run courses on stress management with such large city employers as Société Generale. It was heartening to hear from them that, more often than not, employers are happy to engage although their advisers do not have any rights to accompany a person to an arbitration meeting. The main constraint on these services is the very limited number of hours that have been commissioned. We would encourage commissioners in the Council and the CCG to look more closely at developing this further.

Recommendation Seven
The Commission requests that the Council and the CCG explore with Job Centre Plus and the Council's own Ways Into Work team the commissioning of services to help people with mild to moderate mental health support needs to either retain their jobs and or find new employment. This acknowledges the significant proportion of people in the borough who are workless because of mental illness.

5.5.8 Our discussions on support to employees covered both private sector and public sector employers and we feel that if progress is to be made in this area, public sector employers must be seen to set an example. City and Hackney Mind and the IAPT providers told us they had a number of clients who were staff of local authorities or the NHS. We heard directly from clients at the IAPT service about their varied experiences with managing a return to work and the clinicians at the IAPT service underlined again the importance of returning as an aid to recovery.

5.5.9 Flexible hours, compressed hours, some home working and stress management courses should be used better by managers. Often, modifications such as simply moving a person's desk to a more discrete position or providing a quiet room for someone to regain composure if they have experienced panic or distress can be transformative in this context. Being able to take short breaks or a short walk away from a desk can also be vital and none of these measures should place an undue burden on employers. At the early stages of a return to work, a manager's flexibility in allowing a staff member time to attend clinician appointments is important as is being understanding should an employee experience problems during a changeover of medication. City and Hackney Mind told us that employers were less sympathetic and less likely to make reasonable adjustments for employees with mental health problems than they would if those same employees had physical problems. This stigmatisation needs to be actively challenged in 'mental health in the work place' campaigns. Most support measures cost little or nothing to implement and the investment in existing staff can produce large returns, so greater flexibility should be heavily promoted to all employers.

5.5.10 We heard from the Centre for Mental Health about the NHS's system called "*Individual Placement and Support*" where they would find a job for the individual in the NHS and then support them while in it. The Centre argues that a key focus must be to get people real jobs quickly rather than parking them in 'Work Programme'-type placements. The aim is to move the risk for the individual from high level to low level and get support in early.

5.5.11 We noted too the successes thus far of the Council's "*Ways Into Work*" team in helping mostly younger people into employment and we ask Hackney Council's Cabinet to consider if a similar focus might also be brought to bear on helping back into work, even a small proportion, of the over-6,000 Hackney residents who are on ESA for mental and behavioural health reasons. In terms of the Council's in-house employment support services we request that they be reviewed to take into account the model of intensive employment support which could be offered to people with low level mental health needs.

5.5.12 We learned that the Council is working to gain accreditation to the "*London Healthy Workplace Charter*" (which includes workplace standards relating to mental health and wellbeing) and we look forward to seeing what initiatives the Council's HR&OD and Public Health departments will be implementing as part of this.

Recommendation Eight
The Commission suggests that the public sector employers should aim to lead the way in developing practices to ease the path back into work for those who are suffering from depression and anxiety, if the overall cost to society is to be reduced. The Commission requests that the Council's HR and OD department and its Public Health department as well as the HR departments of the local NHS Trusts and the CCG publish information explaining what initiatives they have in place to improve mental health in their own work environments (*e.g.*, anti-bullying, stress management) and how they currently support individuals with lower level mental health problems to remain in work and to plan for a managed return to work after periods of sick leave.

5.6 DEBT, POVERTY AND DOMESTIC VIOLENCE

5.6.1 The relationship between high levels of deprivation and high rates of mental ill-health is well established. We heard from the Council's Public Health team that studies have found an association between mental health and socio-economic status, showing higher rates of psychiatric admissions and suicides in areas of high deprivation and unemployment. Regardless of age or gender, there is an increased risk of mental illness for the poor when compared to the better-off.

5.6.2 Similarly, those living in poverty are more likely than average to be victims of crime, suffering more home break-ins, vandalism or deliberate harm to their home or car, or theft. Fear of crime is also greatest amongst the poor and the elderly, and this is linked closely to poor mental health. Crime, especially violent crime, is linked to mental health issues in a number of ways: links with drugs, alcohol and deprivation; victims of crime are more likely to suffer mental health problems; and violent crimes which are committed by people with mental disorders are more frequently reported. Consequently, areas with high levels of violent crime are likely to have higher levels of mental illness.

5.6.3 The links between mental health and deprivation also have a bearing on domestic violence. Men and women with all types of mental health disorders have increased odds of involvement in domestic violence compared to people without a mental disorder, with prevalence rates being higher for women. Officers from the Council's Public Health team told us that the median prevalence rate for having experienced partner violence in the last year was 35.3% for women with depressive disorders and 28.4% for women with anxiety disorders. These prevalence rates are between two and seven times higher than for women without mental health problems. All this evidence points to the importance of early intervention in mental health.

5.6.4 We heard about the support which the Council and social housing providers offer. Hackney Homes, for example, provides in-house debt management support to tenants via the welfare reform team within Hackney Homes' "Income Services". These work on financial inclusion, and the provision of debt and welfare rights advice. Their *Money Smart* project takes referrals with

the aim of assisting tenants to avoid eviction for rent arrears. All of these facilities must be sustained, particularly during a period of austerity when the need for these services is going to be higher.

5.7 LONG TERM CONDITIONS/ SOCIAL ISOLATION

5.7.1 Mental health and physical health are intrinsically related. The national mental health strategy "*No Health without Mental Health*" states that having a mental health problem increases the risk of physical ill health. Overall, the evidence suggests that at least 30% of people with a long-term physical illness also have a mental health problem. In relation to common mental health disorders, the Council's Public Health team reminded us that:

- depression is two to three times more common in people with a chronic physical health problem, such as cancer, heart disease, diabetes or a musculoskeletal, respiratory or neurological disorder.
- depression increases the risk of mortality by 50% and has been associated with a four-fold increase in the risk of heart disease, even when other factors are controlled for;
- untreated depression and anxiety disorders are associated with increased health care usage - not only ongoing consultations and treatment in relation to the specific mental health condition, but also increased health care usage more generally; and
- co-morbid mental health problems have a significant impact on the costs related to the management of long-term conditions. For example, the total cost to the health service of each person with diabetes and co-morbid depression is 4.5 times greater than the cost for a person with diabetes alone.

5.7.2 The CCG detailed for us the diverse range of long-term condition (LTC) care pathways which they have in place. These cover: gastroenterology, dermatology, ASD/Aspergers, cardiac disease, chronic obstructive pulmonary disease, diabetes, older adults (*e.g.*, dementia), women's health and tinnitus/hyperacusis. Their research on older people locally revealed that 71% stated that they, or a family member, had a LTC and 49% had multiple LTCs. 25% of those with LTC experienced depression or other mental health issue and 76% of those who were depressed had LTC. 44% of this group were living alone.

5.7.3 Social isolation has been recognised by the government as a major issue when addressing mental illness as highlighted by the National Institute for Mental Health in England: "*Tackling isolation is fundamental and may be the most significant area in which mental health promotion strategies can support the mental health of older people. After income and poverty, lack of social participation was the key issue*."[21] There is therefore a clear relationship

[21] National Institute for Mental Health in England (2005), "Making it possible: Improving mental health and well-being in England", Web: www.apho.org.uk/resource/item.aspx?RID=22605

between social support and the risk of mortality and morbidity. Social networks are quantified as the number, frequency and density of contacts with other people. There is a strong relationship between social networks and mental health: those with few social contacts are at increased risk of mental health problems. Social networks can prevent problems arising from stress. Research suggests that they can help people to recover from depression. The focus of Hackney's new Integrated Mental Health Network (IMHN) in helping reduce isolation is therefore a vital one and we support commissioners here in identifying the need to 'build resilience' as playing a key role for the IMHN.

5.7.4 We noted that the CCG has been running a primary care referral pilot called the "*Social Prescribing Project*". This is being run in 3 of the 6 GP consortia areas in the City of London and Hackney and the aim is to test out the effectiveness of providing a social prescription offering a menu of community-based activities provided by voluntary and statutory services as part of their core business. We understand the pilot is for patients experiencing social isolation, those over 50 and those with Type 2 diabetes. It has the potential to deliver improved outcomes for those with anxiety and depression and we will be keen to see whether it has succeeded and what lessons have been learned.

5.7.4 Physical activity is also known to be associated with less depression and anxiety, better sleep, better concentration and possibly a reduced likelihood of problems with memory and dementia. Structured group physical activity programmes are one of the treatment options recommended by the National Institute for Health and Care Excellence for people with mild to moderate common mental health disorders and again developing this aspect of the IMNH and building on links between mental health support programmes and physical activity programmes needs to be a focus for the CCG and the Council's commissioners.

5.7.5 A neglected area here is the mental health of carers. Again, national research has revealed that 40% of carers experience psychological distress or depression,[22] carers have an increased rate of physical health problems[23] and 51% of carers for someone with dementia report that they don't feel they get support to talk about their needs[24]. Allied to building this support is the benefit which carers and sufferers can get from improved neighbourliness. Neighbourliness relates to the percentage of adults speaking to their neighbours, the number of neighbours known and how many are trusted, as well as whether people have received favours from their neighbours in the previous week. It is considered an important aspect of social capital and provides protection from mental health problems, particularly depression and anxiety.

[22] RCGP, 2007

[23] Carers UK, 2007

[24] Carers Trust Report, 2013

5.8 IMPROVING ACCESS AND LISTENING TO SERVICE USERS

5.8.1 We were not looking at East London NHS Foundation Trust (ELFT)'s services as part of this review but the work of their BME Access Service was brought to our attention. Although their work is in secondary care, some of the principles and practices are relevant to people with mild to moderate anxiety and depression. The service consists of one full time Clinical Psychologist (currently a job share) within ELFT's secondary care Psychology Service. Their approach has been developed in response to a substantial body of evidence highlighting how lack of trust becomes a barrier for people from BME communities in accessing statutory services. For these reasons, clients will often disengage from services, *e.g.*, following a traumatic compulsory admission to hospital or after experiences of racism. In light of this, the focus of the service's work is to culturally-adapt therapies to meet the needs of BME communities in secondary care.

5.8.2 There is much evidence of over-representation of BME communities in mental health in-patient settings with an under-representation of these groups in primary care (mostly, GPs' Surgeries). Among the key barriers to people from BME communities accessing primary care are a lack of knowledge of talking therapies, stigma within the communities, language and culture and a general mistrust of services. This cohort also has concerns about the relevance of talking therapies and specific fears that talking therapies will lead to a loss of religiosity. ELFT's main recommendation to services is to develop much closer links with local BME community groups and a substantial amount of their time therefore is spent on outreach activities and in providing training.

5.8.3 ELFT argues that generic and culturally-specific services must work in partnership. They described how the presentation of 'anxiety and depression' among BME communities may be different to that of the white British population. They explained how depression and anxiety are common western idioms or conceptions of distress. In exploring BME women's beliefs and attributions around illness and pain, for example, they showed that for them pain was the physical expression of anxiety, depression and trauma and that it needed to be understood within the context of their history, migration experience and current social situation. The Tavistock and Portman's PCPCS service similarly reported to us that their clients from BME communities (who represent 60% of their patients) are more likely to have manifest physical symptoms or somatisation.[25] For some of these communities, there has been a high incidence of trauma (related to coming from war torn counties) and there are issues of community integration.

5.8.4 We learned about the Trailblazer Project for African and Caribbean men where culturally-specific interventions have been designed around the needs of this group. This project has made great strides in tacking the mistrust of mental health services. They also pointed to research which showed that black men, in particular, may not view primary care as an appropriate place to

[25] Somatisation disorder is a long-term (chronic) condition in which a person has physical symptoms that involve more than one part of the body, but no physical cause can be found.

seek support for psychological distress and that outreach initiatives may therefore be more appropriate.

5.8.5 The Trailblazer team also talked about the need to challenge stereotypes and assumptions about who benefits from talking therapies. These include African and Caribbean men being labelled as "*hard to reach*" or assumptions that they don't want talking therapies. The Trailblazer research made clear that this was not the case. They also wanted to challenge assumptions they found among service providers that the mental health needs of African and Caribbean communities were synonymous with psychosis, *e.g.*, comments like "*We probably won't be working with African or Caribbean community because we don't work with psychosis*".

5.8.6 In terms of their recommendations to improve services for African and Caribbean communities in particular, they argue that work needs to be done to build trust and to develop partnerships with trusted organisations including engaging in proper consultation from the outset. Outreach activities need to promote good practice and they cite the "*Black men on the couch*" initiative of the UK Council for Psychotherapy. These are events in which famous black men have a public 'therapy session' with a black male psychotherapist and which aims to promote the relevance of psychological therapy to black men both as clients and as a career[26]. They also argued that there is a need to work with service providers and those making referrals to challenge stereotypes and assumptions about who benefits from talking therapies. Finally, they suggest that multiple points of access, including self-referral be prioritised because there is some evidence that self-referral selectively favours black communities. We would ask City and Hackney Mind and the commissioners of IMHN to take on board these suggestions as they develop the network.

Recommendation Nine
The Commission requests the CCG's "Mental Health Programme Board" to report back on how it will work with local providers to tackle the ongoing challenge of under-representation of BME people, particularly Black males**,** with mental health issues in primary care settings and their over representation in in-patient settings. The Commission acknowledges that this is a long term issue but seeks assurances that it does not fall down the agenda in a climate of fiscal constraint.

5.8.7 Issues about barriers to access were echoed to us by Heatlhwatch Hackney who pointed to the research done as part of the 'Fund for Health'[27] community research projects. This research revealed that 100% of Vietnamese community surveyed did not know how to access services of a memory clinic or talking therapy. Also, 83% of the Halkevi/Alevi community surveyed did not know how to access mental or emotional health support if they needed it.

[26] These recordings are online at www.psychotherapy.org.uk

[27] *Fund for Health 2014*, report of Healthwatch Hackney and City and Hackney CCG,

Similarly their research on those who have a hoarding condition identified a clear lack of awareness by them of where they could turn to for support.

5.7.8 The evidence from the BME Access team about the need for statutory providers to go into BME community organisations and begin the work of building trust there is an important one. More broadly, there is a greater need for the 'user voice' to be listened to. We learned from the Centre for Mental Health that a lot of mental health care is now being co-produced, with service users involved even in the commissioning stage and their input is threaded through every part of the system. There are examples even of user representatives being represented on recruitment panels within health trusts and provider organisations. It is clear that mental health services as opposed to physical health services have a longer journey to travel here.

Recommendation Ten
The Commission requests thatthe Council and the CCG demonstrate how they are including the 'user voice' in commissioning services for lower level mental health issues.

5.9 A NATIONAL PERSPECTIVE

5.9.1 Our review benefited from input from, Andy Bell, the Chief Executive of the national Centre for Mental Health. The Centre came to our attention since it carried out an evaluation, which we considered of the Tavistock and Portman's Primary Care Psychotherapy Consultation Service at St Leonard's hospital. The Centre acts as a bridge between the research/policy world and service providers but does not provide services itself.

5.9.2 Some of the key points he highlighted have a resonance for Hackney and we would urge commissioners and providers to take them into consideration:

- There is no age when people are not vulnerable to mental health issues and the vast majority of those affected receive no support.
- Despite the vast quantities of NICE guidance published on mental health, unlike the situation with physical health guidance, it is not always implemented with the same rigour.
- There is a critical point of opportunity in mental health prevention and having people other than mental health professionals with the knowledge and capacity to offer help is vital
- Front-line officers in both housing and education must be 'mental health confident' not just 'mental health aware'. They need to be able to convince clients that if they intervene to help them, they won't be deemed 'sub-threshold' by mental health services and denied support.
- A key problem nationally is the significant disparity between the provision of physical and mental health services with the former swallowing up a disproportionate amount of funding. Another was the disconnected nature of the commissioning systems.

- The Tavistock and Portman's PCPCS service was a good example in their opinion of taking a relatively small pot of funding but targeting it so it could have a wide impact
- A better balance needs to be struck between generic and culturally-specific provision. Maintaining a job or securing a job is a key part of recovery for anyone with mental health issues and so spending on mental health awareness at work is vital. The self-enablement agenda such as the Council's 'Promoting Independence' one means that there will be a larger cohort who will require support for longer periods and building the flexibility to deliver this is a major challenge for commissioners. Some people with long term conditions will have associated mental health issues and some may not and this relationship will fluctuate. Time-limited interventions need to be planned therefore with a view to where a client will 'move-on' to.
- The old system, under which there was a tendency for clients to become stuck in a service over an extended period, was not effective either. Clients need to have the ability to drop back in to services and so Floating Support is a vital start.

5.9.3 Mr Bell concluded his evidence to us by arguing that demonstrating or realising 'cashable savings' in mental health is difficult. The Tavistock and Portman's PCPS service might result in clients going to their GPs 25% less frequently but this saving may not mean it is possible to close part of a nearby mental health ward as a consequence. GPs might have a slightly lower caseload but it would be hard to demonstrate how services could be cut because of a successful intervention. However, if we aligned physical and mental health interventions better there would be less need for many pointless GP appointments

5.9.4 We would agree with him that the fundamental justification for health interventions is "better health" and this should be sufficient. We do not judge cancer interventions on the basis of cashable savings elsewhere and there should be no such need in relation to mental health. Building up preventative services in order to reduce bed-based provision is justifiable on the grounds that people do not want to be in hospital, rather than that hospital costs are very high.

6. CONCLUSION

6.1 In our review, we examined whether the commissioners and providers in Hackney are responding appropriately to the high prevalence of depression and anxiety in our working age adult population. We also wanted to ensure the right people were being targeted by prevention programmes and to find out what the Council and its partners are doing about the wider determinants of mental ill health. In the limited time available to us, we looked closely at just two of these in particular - housing and employment. A key focus must be whether those at risk are being identified early enough and what is being done to reduce the factors which lead to poor mental health in the first place.

6.2 Our investigations coincided with the introduction of the Integrated Mental Health Network (IMHN) which will be crucial in helping people to build resilience and it will hopefully reduce the incidence of depression and anxiety in Hackney. We noted some disagreements between providers and commissioners here but ultimately the change to the IMHN involved the same level of funding but a slightly different organisation of it. We noted the Cabinet Member's comments that the (now-abolished) Primary Care Trust had not always been a robust commissioner of services and it was perfectly legitimate for the Council to review how this £2.4m of the public health budget was being spent and to spend it in a different way. Having listened to both sides of the argument, we are confident that misunderstandings can be overcome. The challenge which the Cabinet Member must now set the IMHN is to make sure they demonstrate that it is a significant improvement on the previous uncoordinated and fragmented service. Too often the old model created dependency amongst clients who were not 'moving on' even if this was not the intention of providers who were doing their best to support people. The needs of service users must be central to the IMHN and vital services should not be lost to them because of any lack of clarity between commissioners. We recognise too the wider role which the voluntary sector plays in terms of social capital and how the providers here deliver much more than just mental health support for some clients. We note that in bringing together partners including the CCG and the Council's Public Health team, the Health and Wellbeing Board has a key role in identifying what the local community's needs are and in ensuring that there is sufficient partnership working in place to deliver it.

6.3 On the subject of 'moving on', we saw the challenge faced by Housing Needs and the local Housing Providers to maintain levels of provision for those with mental health problems who need to move-on from supported housing. The current, national financial climate has resulted in greater pressure on services and the Council and social housing providers will need to fight their corner in maintaining the numbers of floating support contact hours and resisting further pressure to increase access thresholds. We can see that, in the new financial climate, the support offered by statutory agencies is now generally confined to those in the greatest or most extreme need and those with low or medium level need will often be classified as ineligible for support. Unless floating support services can engage with and assist these "sub-threshold" clients, there will be a real danger that their housing providers will take action, against them, or even evict them. Such action creates even greater burdens on the

public purse in the longer term. There is a need for longer term thinking in this area as budget holders scramble to protect their own budgets.

6.4 A key issue is to challenge stigma. Too many of those seeking help do so too late and they feel humiliated or alienated by their condition. Too often problems are only recognised when they have reached crisis levels. Progress with employers in both the public and private sectors is vital if we are to reduce the number of wasted lives and the numbers on long term incapacity benefits. As we learned, the adjustments needed to assist employees with a managed return to work are generally not onerous on employers. The social costs of not funding 'job retention' programmes for example means that such programmes deserve much greater attention from commissioners.

6.5 There is a need to strike a balance in service provision between social facilitation vs mental health treatment models such as counselling. Arguments about what is prevention and what is treatment are ultimately futile in that the approach required locally demands providers of both public health services and clinical care to work together. Similarly, generic and culturally-specific provision of therapies must exist in tandem. We acknowledge that arguments about community-based vs generic provision are much wider than just in mental health and that it is an ongoing debate within the Council.

6.6 In relation to improving access, the disparities in treatment in the mental health system remain of great concern. For example, black men are disproportionately being detained by police or in in-patient settings and fewer have their mental health issues picked up by GPs. There is an issue to be explored here in how mainstream services go about identifying local need and how they shape services to meet the specific needs of black men. The key to improving this situation would appear to be the provision of a range of community-based organisations which are credible in their communities and with whom the Council and the CCG can work closely.

6.7 NICE Guidance has highlighted access to IAPT services as vital as well as the encouragement of self-referral and a stepped-care approach. The problem appears to be however that those lower down the level of need generally have their funding cut first. The role of councils here is to ensure a range of support at different levels of need. City and Hackney's IAPT service is mandated to meet a national standard of 15% of need and, while this is low, it is very expensive to meet. Recovery rates are poor but City and Hackney's IAPT service has a target of meeting 18% of need as opposed to the national target of 15%. It is hoped that the IMHN will begin to improve this situation.

6.8 Finally, during the review we heard from a number of sources about the importance of early intervention with children's mental health in order to prevent adult onset problems. Children and young people's issues are outside the scope of our Commission and of this review but we would ask our colleagues in Hackney Council's Children and Young People Scrutiny Commission to give serious consideration in its work programme for 2015/16 to a review on *Children and Adolescent Mental Health Services (CAMHS).* In

particular we ask that such a review address perinatal mental health and the issue of the transition from children's to adult services.

7. CONTRIBUTORS, MEETINGS AND SITE VISITS

The review's dedicated webpage includes links to the terms of reference, findings, final report and once agreed, the corporate response. This can be found here

Meetings of the Commission

The following people gave evidence at Commission meetings or attended to contribute to the discussion panels.

8 September 2014

Dr Nicole Klynman	Consultant in Public Health, LBH
Gareth Wall	Public Health Manager, LBH
Genette Laws	AD Commissioning, LBH
Krishna Maharaj	Chief Executive, City and Hackney Mind
Hana Vilar	Head of Clinical Services, City and Hackney Mind
Dr Rhiannon England	Chair Mental Health Programme Board, CCG

13 November 2014

Ann Thomas	Employment Advisor, City & Hackney Mind
Ian Causer	Employment Advisor, City & Hackney Mind
Dr Brian Rock	Service Lead, Primary Care Psychotherapy Consultation Service, Tavistock & Portman Trust
Dr Angela Byrne	Clinical Psychologist, BME Access Service, ELFT
Dr Naomi Scott	Clinical Psychologist and Service Head, BME Access Service, ELFT
Dean Henderson	Borough Director, City and Hackney, ELFT
Dr Lucy Carter	GP at Well St Practice and LMC Member
Paul Fleming	Board Member, Healthwatch Hackney
Dr Clare Highton	Chair, City and Hackney CCG
Paul Haigh	Chief Officer, City and Hackney CCG

9 December 2014

Dr Penny Bevan CBE	Director of Public Health, City and Hackney, LBH
Genette Laws	AD Commissioning, LBH
Heather Bates	Commissioning Manager – Supporting People and Prevention, LBH
Kate Simpson	Operations Manager – Health and Wellbeing, Family Mosaic
Alex Reeve	Regional Director of London Supported Housing,

	Family Mosaic
Sarah Chapman	Head of Neighbourhoods, Hackney Homes
Andy Bell	Chief Executive, Centre for Mental Health
Emel Hakki*	Hackney Services Manager, Family Action
Heather Loxley*	Director of Services, Family Action

*produced paper but not presented at committee due to illness

Site Visits

The Commission conducted site visits for this review where Members also had an opportunity to meet with service users.

1.) City and Hackney Mind, Tudor Rd headquarters and their site (IRIE Mind) at the Homerton hospital on Fri 26 September 2014 from 10.00 hrs

Present: Cllrs Munn, Etti and Sales.

C&H Mind staff:
Krishna Maharaj, Chief Exec
Psychological Therapies Team – Hana, Nichola, Shane, Abeola
Employment Team – Anne, Ian, Kalpna, Michelle, Resma, Abdul, Anna, Stephanie, Michaela
IMHN Implementation Team – Jess, Vicky, Becky, Becky, Sahil

Vietnamese Mental Health Service who have weekly drop-in sessions at Mind. Met with the Jack Shieh (Director), staff and service users.

Also visited *IRIE Mind Centre for Recovery* at 15a Homerton Row, E9 and met with **14** service users including some peer supporters and staff.

2.) Launch of the Centre for Excellence and Innovation in Mental Health and Wellbeing on Wed 17 September 2014 at City University.

Cllr Sales and Cllr Snell attended this event which launched this Centre.

3.) Site Visits to:

Bikur Cholim, Ground Floor, 2a Northfield Rd, N16
Derman, The Basement, 66a New North Rd, N1
Local IAPT Service operated by HUHFT, Louis Freedman Centre, St Leonard's Hospital, Nuttall St, N1

All on Thursday, 30 October 2014 from 14.00-21.00 hrs

Present were: Cllrs Munn, Hayhurst, Etti, Peters, Sales, Snell

At Bikur Cholim
Yocheved Eiger, Manager
Dr Lisa Shostall, Consultant Clinician
A support worker
A service user

At Derman
Nursel Tas, Chief Executive Officer
2 counsellors
6 service users

At IAPT
Dr James Gray, Consultant Clinical Psychologist
Mervyn Freeze, Service Manager
Dr Victoria Roberts, Consultant Psychologist
Lisa Hoyles Principal Psychologist
Megan Prowse, Senior Psychologist and Wellbeing Practitioner
Fabienne Palmer, Psychological Wellbeing Practitioner
2 service users.

Also received input from the service head - Dr Paul Sigel, Head of Primary Care Psychology

4. Site Visit to Family Mosaic, Supported Housing Scheme, 2-26 Link St, E9 on Wed 3 December 2014 at 17.00hrs

Present were: Cllrs Munn, Hayhurst, Etti, Sales and Snell

Family Mosaic
Kate Simpson, Operations Manager – Health & Wellbeing
Gunter Gosain, Team Leader – Link St

8. MEMBERS OF THE SCRUTINY COMMISSION

Councillor Ann Munn (Chair)

Councillor Ben Hayhurst (Vice Chair)

Councillor Sade Etti

Councillor Sally Mulready

Councillor James Peters

Councillor Rosemary Sales

Councillor Peter Snell

Overview and Scrutiny Officer: Jarlath O'Connell ☎ 020 8356 3309

Legal Comments: Dawn Cater McDonald ☎ 020 8356 4817

Financial Comments: Deirdre Worrell ☎020 8356 7350

Lead Director for the review: Kim Wright, Corporate Director, Health and Community Services ☎ 020 8356 7347

Lead Cabinet Member for the review: Cllr Jonathan McShane, Cabinet Member for Health, Social Care and Culture

9. BIBLIOGRAPHY

The following documents have been relied upon in the preparation of this report or were presented to the Scrutiny Commission as part of the investigation.

- **Minutes and agendas of the meetings of Health in Hackney Scrutiny Commission held on 8 September, 13 November and 9 December 2014.**
- Notes on Site Visits carried out by the Commission Members presented to 21 January 2015 meeting of the Commission

The following are further reading:

Local

- City and Hackney Health and Wellbeing Profile: Our Joint Strategic Needs Assessment, 2011/12, updated 2014. Hackney Council and City of London
- *Hackney's Joint Health and Wellbeing Strategy 2013-14*, Hackney Council and City and Hackney CCG.
- A mental health needs assessment for the residents of Hackney and the City of London', Solutions for Public Health, for Public Health Dept, Hackney Council, Draft. Sept 2014
- *'Integrated Mental Health Network Service Specification'*, Adult Social Care, Hackney Council 2014
- http://www.hackney.gov.uk/Local-Economic-Assessment.htm#.VNd1PuasWxU
- Voice of Men – Mental Health Needs Assessment of Turkish/Kurdish and Cypriot/Turkish Men in Hackney, Derman, Mar 2008
- *Bikur Cholim Annual Review and Accounts 2013*, Bikur Cholim
- *Impact of Welfare Reform on Turkish and Kurdish Communities in Hackney, Survey of Derman Service Users*, Derman, 2013
- *Commissioning third sector counselling: valuing and enabling services*, British Association for Counselling and Psychotherapy, 2014
- *City and Hackney Mind Annual Impact Report 2012-13*, CHM, 2014
- *Vietnamese Mental Health Services Annual Report 2013-14*, VMHS, 2014
- *Job Retention Practitioner's Handbook*, Roger Butterworth/Dave Costello, Lorraine Looker/Heidi Cuming, CHM, 2011
- *Mental Health and Employment: A Mind to Work – a good practice guide*, CHM, 2011
- *A range of reports from East London Foundation Trust's BME Access Service relating to their Trailblazer Project*
- The second Trailblazer report
- Extracts from the first Trailblazer report (Carlin, 2009)
- Article on the Trailblazer project
- *Report of Health in Hackney Scrutiny Commission's review on 'Community mental health services', 2011/12*
- *Report of Health in Hackney Scrutiny Commission's review on 'Health and worklessness', 2009/10*
- *Report of Community Safety and Social Inclusion Scrutiny Commission's review on 'Tackling worklessness – routes to employment for those in receipt of long term inactive benefits', 2008/9*
- *Fund for Health 2014, Report of Healthwatch Hackney and City & Hackney CCG, 2014.*

National:

- Health Begins at Home, Family Mosaic, Nov 2013
- Making Mental Health Services More Effective and Accessible, Department of Health, April 2014
- NICE guidance on mental health and wellbeing, NICE, 2014.
- Fair Society Healthy Lives, The Marmot Review - Strategic Review of Health Inequalities in England post 2010, UCL Institute of Health Equity, Feb 2010
- Social Determinants of Mental Health, UCL Institute of Health Equity for WHO and Gulbenkian Foundation, June 2014

- No Health Without Mental Health, A cross government mental health outcomes strategy for people of all ages, Dept of Health, Feb 2011

- A range of reports from the **Centre of Mental Health** including

  - Barriers to employment, what works for people with mental health problems, Centre for Mental Health, Sept 2013
  - *Managing patients with complex needs: Evaluation of the City and Hackney Primary Care Psychotherapy Consultation Service* by Michael Parsonage, Emily Hard and Brian Rock, March 2014
  - *The Bradley Commission – BME communities mental health and criminal justice*, a briefing, Sept 2013
  - *The Bradley Report five years on* by Graham Durcan, Anna Saunders, Ben Gadsby and Aidan Hazard; Bradley Commission and Centre for Mental Health, June 2014
  - *A place for parity –Health and Wellbeing Boards and mental health*, Jonathan Scrutton, Nov 2013
  - *Welfare advice for people who use mental health services – developing the business case*, Michael Parsonage, Dec 2013
  - *Building a better future – the lifetime costs of childhood behavioural problems and the benefits of early intervention*, Michael Parsonage, Lorraine Khan and Anna Saunders, Jan 2014
  - *Doing what works – individual placement and support in employment* – a briefing, Sainsbury, Feb 2009.
  - *Long term conditions and mental health – the cost of co-morbidities*, Chris Naylor, Michael Parsonage, David McDaid, Martin Knapp, Matt Fossey, Amy Galea; The Kings Fund/ Centre for Mental Health, Feb 2012
  - *Bridging the Gap – the financial case for reinvesting in mental health – briefing paper*, Royal College of Psychiatrists and Centre for Mental Health, Sept 2013

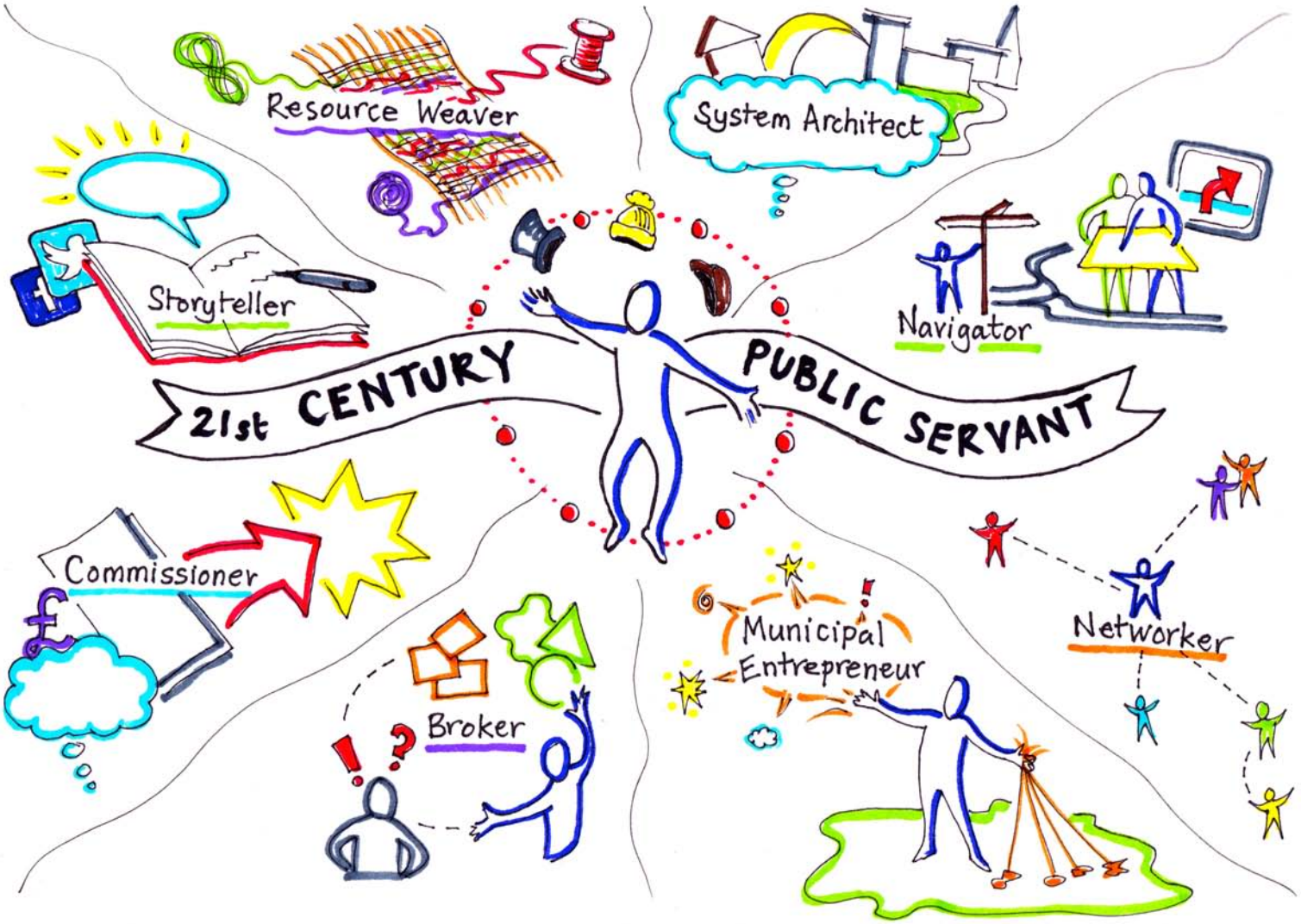
10. GLOSSARY

CCG	City and Hackney Clinical Commissioning Group
HUHFT	Homerton University Hospital NHS Foundation Trust
ELFT	East London NHS Foundation Trust
Family Action	Is a national charity which provides practical, emotional and financial support to families who are experiencing poverty, disadvantage and social isolation across England. They work with over 45,000 families through around 120 community-based services.
Family Mosaic	A housing association that provides affordable homes to rent and buy (in Hackney and across London, Essex and the South-East of England), as well as care and support services to their residents, such as training, employment and access to learning.
Centre for Mental Health	Centre for Mental Health is a national independent charity whose mission is to inform policy and practice in mental health, based on high-quality evidence, presented impartially**,** and often collaboratively. It doesn't provide support services itself but acts as a link between the research world and health/social care providers.
Hackney Homes	A not-for-profit organisation that is responsible for managing Hackney Council's council homes. This involves collecting council housing rent, and repairing and maintaining council homes. It will cease to exist when the management of Hackney Council's housing stock is returned to the Council at the end of the Council's contract with Hackney Homes on the 31 March

	2016
City and Hackney Mind	The leading provider of voluntary sector mental health services in the City of London and in Hackney. It is a registered charity, providing a range of services including advocacy and advice, counselling and psychotherapy, and education and employment services.
IRIE Mind	I.R.I.E. stands for Integration, Respect, Inclusion and Empowerment. It is also a word that expresses positivity in the Afro-Caribbean culture. I.R.I.E. Mind centre for recovery and social inclusion targets marginalised, at-risk and disengaged service users in Hackney. It is run by City and Hackney Mind and based at the Homerton Hospital site. Most of its users have a long history of severe and enduring mental health problems and multiple traumas, and they struggle with substance and alcohol misuse. The centre seeks to help its users to improve their mental and physical wellbeing.
Bikur Cholim	A community organisation serving the Charedi Jewish community in the north of Hackney.
Personalisation	A social care approach defined by DoH as every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings
Supporting People	Supporting People programme was introduced in April 2003 and brought together a number of uncoordinated funding streams to ensure that services were commissioned in line with local need rather than funding opportunity. It provides housing related support to enable people who need that support to remain safe and independent in the community.
Choice Based Lettings	Hackney Choice is a choice based lettings scheme which gives applicants on the housing waiting/transfer list more choice and control over where they live. It allows applicants to apply for available properties which are advertised, rather than wait to be allocated a home.
Employment and Support Allowance	Is the state benefit which replaced Incapacity Benefit. You can claim it if you're ill or disabled and if offers financial support if you're unable to work and personalised help so that you can work of you're able to.
Long Term Conditions	Is a condition that cannot, at present, be cured but can be controlled by medication and other therapies e.g. diabetes, heart disease or chronic obstructive pulmonary disease.

The 21st Century Public Servant

Catherine Needham and Catherine Mangan



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We would like to thank the ESRC for funding this research, and for Birmingham City Council for acting as our knowledge exchange partners. We are grateful to all the interviewees, survey respondents and bloggers who gave up their time to participate in the research. We also want to thank the members of the advisory group for their input, Helen Dickinson for her ideas, Laura Brodrick for her illustrations, Nick Booth for his advice and Liz Haydon and the PSA for their support.

Preface by Mark Rogers, Chief Executive of Birmingham City Council

The 21st Century Public Servant

"Cui servire est regnare." To serve is to rule

Always good to start with some random Latin, I think, when aiming for that all elusive quality of profundity.

But this quote has, believe it or not, been selected very carefully. To my mind, it is no longer relevant or acceptable for public sector leaders to promote, let alone deploy, the concept of benevolent municipalism in which the "great and good" (some of whom aren't always that great or that good) believe that they know what's best for the citizen. Hierarchical power is, rightly, giving way to networked authority, the roots of which are firmly in the community.

We do not exist in our own right. The political leadership is elected and the officers are appointed by the democratically mandated. We are all here to serve others - and that is the only kind of power we are entitled to wield: we rule only in order to serve.

As each year passes, it has become clearer and clearer to me that our raison d'etre is the business of making (either through our own actions and/or the actions of others) a positive difference to people's lives. No more, no less. And, if this is our primary purpose, then to be successful we need to articulate and live up to a set of values that make this likely to happen in reality. Personally, I like empathy, respect and trust, but you'll have your own.

All, however, should have service - implicit or explicit - at the heart of them. If we take this as our starting point, then we can indeed aspire to rule from the Town Hall - because our authority to lead comes from the community itself which we have vowed to serve.

Introduction

What does it mean to be a 21st Century public servant? What are the skills, attributes and values which effective public servants will display in the future? How can people working in public services be supported to get those skills? These are some of the issues that we are addressing in this research.

Public services are going through major changes in response to a range of issues such as cuts to budgets, increased localisation, greater demands for service user voice and control, increased public expectations and a mixed economy of welfare provision. This 21st Century Public Servant project builds on the findings of the 2011 University of Birmingham Policy Commission into the 'Future of Local Public Services' which identified the need to pay attention to the changing roles undertaken by public servants and the associated support and development needs.

Through a review of the literature and interviews with 40 people involved in supporting and delivering public services, the research has considered how the public service workforce is changing, and what further changes are needed to develop the effectiveness of public servants. Here we present the findings and outline next steps for the research.

The research project is funded by a Knowledge Exchange grant from the Economic and Social Research Council. The University of Birmingham and Birmingham City Council are partners in the research.

Who is a 21st Century Public Servant?

Public servants have largely been thought to reside in the public sector but with increasingly mixed economies of welfare, many who have public service roles work for for-profit or not-for-profit organisations outside of the public sector. We have been inclusive in our approach by defining a public servant as someone working in public services (even outside the public sector). However we have been exclusive in focusing little attention on the career development of civil servants in central government: our focus has been on the local public service workers and managers who are part of the delivery infrastructure of public services.

The research concentrates on the workforce: we did not interview any citizens, and this is something we would like to develop in future work. The research was also focused on England, and we plan to develop comparative work in the future, beginning with the Australian public services, in collaboration with the University of Melbourne.

Research design

The research was undertaken in three phases:

Rapid evidence appraisal: A desk-based review of the peer reviewed and grey literatures identified the state of knowledge about public service professionals, the competencies and capacities that they are thought to require and information about how they are currently developed. This literature review is available here. (**http://www.birmingham.ac.uk/Documents/college-social-sciences/public-service-academy/twenty-first-century-public-servant--eight-lessons.pdf**)

Exploratory research: Interviews were conducted with a range of people working in the public sector (e.g. local authority, health, fire, police), private sector (service providers, commissioning support functions) and third sector (service providers, service user and carer advocacy bodies). These 40 interviews were used to gather perspectives of current public servants on how this role is changing, the types of roles, skills and competencies that will be important in the future and a sense of how these might most effectively be developed. We also conducted a focus group of officers and members in one local authority and undertook a survey with recent graduate entrants into local government. The interviews and focus group drew on a purposive sample of people working in public services in the West Midlands region and in national stakeholder organisations. We used semi-structured interviews, based on a standardised topic guide. Interviews were audio recorded. The survey was undertaken online, with a link sent to recent recruits to the National Graduate Development Programme for local government. Ethical approval for the project was granted by the University of Birmingham.

Disseminating the research: Bringing these different streams together we are now sharing the findings of these earlier stages in this report, at events and on our project blog (**http://21stcenturypublicservant.wordpress.com/**). We are encouraging debate about topics such as the range of different public servant roles, the competencies required in these roles, the options available in developing these skills and competencies, plus a range of more general themes around accountability, risk, and knowledge sharing as indicated by the research process. We are not presenting this report as an end to the work, but rather as an ongoing discussion where we invite responses to the work, and in particular encourage people working in public services to reflect on what some of the next steps might be to realise the principles of 21st Century public service.

The following **research questions** have run through the different phases of the work:

- What is the range of different roles of the 21st century public servant?
- What are the competencies and skills that public servants require to achieve these roles?
- What are the support and training requirements of these roles?
- How might central and local government better support and promote public service careers?

In this report we present the findings of the project as a series of descriptors of the characteristics of the 21st Century public servant. The literature review led to the identification of 8 characteristics which were discussed with and evolved in conversation, by interview or questionnaire, with practitioners, into the ten themes presented here.

For updates and discussion about the themes of the research, go to the 21st Century Public Servant blog at **http://21stcenturypublicservant.wordpress.com/ and contribute to the debate on Twitter #21cps**.

Summary of Findings

The research has identified a series of characteristics which are associated with the 21st Century Public Servant. These are described in summary below and later in the full body of the report.

The 21st Century Public Servant ...

1....is a municipal entrepreneur, undertaking a wide range of roles

Future public services require a set of workforce roles which may be different from those of the past. As one interviewee put it, *'In the future you will need to be a municipal entrepreneur, a steward of scarce public resources.'* New roles that may be performed by the public servants of the future include story-teller, resource weaver, systems architect and navigator.

2....engages with citizens in a way that expresses their shared humanity and pooled expertise

The notion of working co-productively, or in partnership, with citizens was the preferred approach of most interviewees: *'Valued outcomes in public services are not things that can be delivered, they are always co-produced*', as one put it. One of the suggested approaches was alluringly simple: *'It's about being human, that's what we need to do'*. One clear finding from the research was that the widespread calls for whole person approaches to care and support necessitate working practices in which staff are also able to be *'whole people'*.

3....is recruited and rewarded for generic skills as well as technical expertise

Generic skills are becoming as important as professional skills, with 'soft skills' around communication, organisation and caring becoming more highly prized. One interviewee said: '*We need people who are really good with people and can form relationships, who are able to learn quickly.'* According to another, *'engaging with citizens and the use, analysis and interpretation of data to understand your local populations, they are quite newish sets of skills for people who work in local authorities'.*

4.....builds a career which is fluid across sectors and services

People are unlikely to stay in one sector or service area for life and require portable skills that are valued in different settings. People need opportunities to learn and reflect on new skills, which may be through action learning, mentoring, job shadowing and sabbaticals rather than formal training: *'People will have portfolio careers, working in different sectors, working for different people at the same time, not just sequentially. It's not a job for life, or even for 5 years'*, said one interviewee.

5....combines an ethos of publicness with an understanding of commerciality

Ethics and values are changing as the boundaries of public service shift, with notions of the public sector ethos being eclipsed by an increased push towards commercialism, along with a wider focus on social value. One interviewee said, *'Local government will need more private sector skills, more crossover of skills and people. If staff in local government don't have the commercial skills they won't be employable. We have to help them get them.'* Another interviewee said: *'I think there will be a fight between altruism and commercialism. We need managers who still care.'*

6.....is rethinking public services to enable them to survive an era of perma-austerity

Perma-austerity is inhibiting and catalysing change, as organisations struggle to balance short-term cost-cutting and redundancies with a strategic vision for change. Some interviewees expressed this in very negative terms: *'There's a narrative of doom…..it's all about survival'*. For others there was a potentially positive aspect to the financial context: *'The cuts are forcing us to confront change. In public service, change doesn't necessarily happen unless there is a crisis or a disaster, or it happens very slowly.'*

7....needs organisations which are fluid and supportive rather than silo-ed and controlling

Many of the organisations where our interviewees were located had been through recent restructuring and there was little appetite for more structural change. Nevertheless there was a feeling that the organisations were not necessarily fit for purpose: *'We are trying to be 21st Century public servants in 19th Century organisations. There's that constant struggle. Not only how do we change what the people are but also how do we change the organisations to allow the people to be what they need to be?'* This can be about addressing issues of organisational culture, rather than assuming that new structures will be the solution.

8....rejects heroic leadership in favour of distributed and collaborative models of leading

Hero leaders aren't the answer. Rather than emphasising the charisma and control of an individual, new approaches focus on leadership as dispersed throughout the organisation. This could be about thinking about leadership at the front line in a way that traverses traditional service sectors: *'We should offer a career in community leadership. The 21st century public servant should be able to cross organisational boundaries.'*

9....is rooted in a locality which frames a sense of loyalty and identity

The role of place in public service needs to be recognised: public service workers often have a strong loyalty to the neighbourhoods and towns/cities in which they work as well as an organisational loyalty. For some interviewees this was about staff being based in the locality: *'Above a certain grade you should be required to live in [the council area], because you are making huge decisions on how people will live, work and spend their recreational time.'* For others it was about putting professional knowledge into an appropriate context for the locality: *'Professionalism will be the death of local government. It's that lack of ability to soften and shape stuff according to locality.'*

10....reflects on practice and learns from that of others

The public service changes that we have set out here in which structures are fragmenting, citizens require authentic interactions, careers require much greater self-management, commerciality and publicness must be reconciled and expectations of leadership are dispersed across the organisation, require time and space for public servants to reflect: '*You need spaces where you take yourself apart and sort it out with the fact that the organisation is expecting you to glide along like a swan looking serenely happy with no mistakes whatsoever.'*

Getting from here to there

The challenges to current practice encompassed in these ten themes are wide-ranging, and require personal reflection, internal organisational dialogue, external networking and peer learning. Here are some questions to stimulate further thinking:

1. **Roles:** how can people be trained and supported into the broader range of roles that we have identified here?
2. **Engaging with citizens:** how can staff engage with citizens in a way that feels human, and supports people's assets rather than highlighting their deficiencies?
3. **Do recruitment practices** get the right balance between generic and technical skills? How can people be recruited on the basis of values as well as skills?
4. **Career development** What opportunities can be created to encourage sabbaticals and secondments, into and out of the organisation?
5. Is there a strong **ethos of publicness** and do staff know what it means to combine this with more commerciality?
6. **Perma-austerity:** are honest conversations going on about what the organisation can and can't do in an era of austerity, and do people understand their own role in that future?
7. **Organisational redesign:** are systems-based approaches being considered as an alternative to repeated cycles of organisational restructuring?
8. **Leadership:** what is being done to develop leadership at all levels of the organisation, and how is that being facilitated through incentives such as the appraisals system?
9. **Place:** how are feelings of identity and loyalty to place supported so that public servants feel like citizens of the place not just officers in an organisation?
10. Do appraisal, mentoring and peer support give people scope for **reflective practice**, to share and learn from mistakes and to take on new challenges (such as using social media) in effective ways?

The remainder of the report sets out the ten research themes in more detail. The themes have been presented on our **blog**, with guest responders identifying key challenges, controversies and next steps in what we have found. Join the debate at **#21cps**.

1. The 21st Century Public Servant is a municipal entrepreneur, undertaking a wide range of roles

Public services of the future require a different set of workforce roles than in the past. This is a consistent finding from the literature synthesis, interviews and survey findings that were undertaken for this project. The concepts of networking and governance have been dominant in the public management literature for many years, as the limitations of hierarchy and market-based approaches have become evident[1]. Both networking and governance theories understand local public services as a system, characterised by ambiguity, complexity and messiness[2].

The workforce implications of these more fluid approaches are starting to get the attention that they require. As one interviewee put it, in a local government context: *'There's an urgency now about it, what does the future council look like?'* Workforce roles need to be less rigid to flourish in a context of messiness. According to another interviewee, *'In systems leadership everything is both/ and. This takes a different sort of being. Ambivalence is culturally necessary. Social workers and GPs mean different things by a care plan and we need to accept that.'*

Whereas existing organisational structures have labelled people according to their technical competence – planner, accountant, housing officer – there may be more appropriate terms to encompass the workforce roles that public servants are performing. A University of Birmingham Policy Commission into the Future of Local Public Services in 2011 suggested four new roles that will be performed by the public servants of the future: story-teller, resource weaver, systems architect and navigator[3]. In a survey of new entrants to local government undertaken for this project, all of these roles were viewed as relevant and important, with resource weaver being rated highest as the one that was most important to their own job[4].

The new entrants to local government also suggested alternative roles such as:

- Developer: increasing the sustainability, ability and flexibility of public services.
- Defender: negotiating to ensure local government is getting the most for its buck, as are its residents.
- Balancer: balancing conflicting demands, pressures and views.

Other roles suggested by interviewees include *municipal entrepreneurs*, and *stewards of scarce public resources.*

These new roles are likely to co-exist with more established roles. The Policy Commission report highlighted existing roles which were likely to continue to be important: commissioner, broker, networker, adjudicator, regulator, protector[5]. Of these, it was commissioning which was raised most frequently by interviewees. There was a widespread assumption that commissioning was a vital function but one that often is not done well. The Government's Commissioning Academy was felt to be too small to encompass the numbers of people now engaged in public service commissioning. One said of commissioning, *'It's such an important job to spend money well, but commissioning teams are often pulled apart, good people have left. That's not where you should be cutting from.'* However some interviewees cautioned against seeing commissioning as the cure-all for public services: *'We are seeing the development of a commissioning cadre over everything... commissioning is seasonal and no-one should have it in their job title. What is the value of commissioning? Strategic commissioning adds value but does micro commissioning?'*

Similarly not everyone accepted the narrative of changing roles: *'the roads will still need to be swept, the leaves will still fall off the trees so for some parts of the workforce it will be business as usual. The idea of change has been oversold'*, said one interviewee.

Challenge: How can people be trained and supported into the broader range of roles that we have identified here?

2. The 21st Century Public Servant engages with citizens in a way that expresses their shared humanity and pooled expertise

The literature review for the project highlighted the growth of a citizenry which is more assertive, and in which the notion of deference to professional judgment feels increasingly out of date. This partly reflects greater affluence and education levels. It is also about demographic changes such as the increased incidence of long-term health conditions about which citizens have time to develop a level of expertise. New technologies are changing expectations about how and when citizens engage with the state, as well as fostering the emergence of 'scientific citizenship' which challenges existing notions of professional expertise[6].

The workforce challenges of engaging with a more assertive and technologically-savvy citizenry are not necessarily well understood. For some interviewees the notion of customer service was evoked to convey an approach which offered timely and effective contact with citizens. The limits of the customer metaphor were noted however, given that demand management was seen as a crucial element of future public service working, with no obvious private sector analogy[7]. Many of the interviewees saw consumerism as a potential blind alley, which threatened to artificially raise citizen expectations but also to dampen the political aspects of the role of citizen – *'let's not call them customers, I hate that word',* as one said.

The notion of working co-productively, or in partnership, with citizens was the preferred approach of most interviewees: *'Valued outcomes in public services are not things that can be delivered, they are always co-produced*', as one put it. The skills needed for this may not be in place however. A third sector chief executive commented on poor practice in engagement with citizens by the local authority: *'...managers were meant to be working with community groups but didn't know how to just be human, not part of the system. They don't know how to just participate as a person without the weight of the organisation on them.'* For a number of people interviewed there was concern that the public were absent from the conversations about how to do co-production well. As one put it:

> *The public are a partner in the conversation that's just not there, they keep being talked about. If you are interested in co-production, in solutions coming from communities and individuals, then you are going to have to start talking to them about how you see things, how might that work for them. Otherwise it's not going to happen.*

As well as making the citizen visible, there is a need to recognise and harness their expertise, as initiatives such as the Expert Patient Programme and People Powered Health have done[8]. One interviewee working in local government observed the big cultural challenge that this posed: *'We need to be enablers not managers, enabling people to do it for themselves. We won't be in charge. That's a big culture change, it's difficult for people to get their heads around. It requires us to be more honest and trusting.'*

Facilitating this cultural change is of course a key challenge for local authorities. One of the suggested approaches was alluringly simple: *'It's about being human, that's what we need to do,'* as one interviewee put it. This notion of being human in dealings with citizens is a recurrent theme of what interviewees see as essential to a 21st Century Public Servant. As one said:

> *People need to be able to relate humanly to each other in the way they deliver services but in the way they assess people for services too. You can satisfy the requirements of the system but you won't have solved the problem that's dragging someone down in their life. That's why public services work again and again with the same people as their problems get deeper and deeper.*

The tendency to engage with citizens only partially or temporarily dealing with issues was reflected by several interviewees: *'Individuals need the power to resolve a resident's problem – e.g. currently if the police make a visit to a home they can't resolve issues – they can only send people to the homeless shelter.'* One interviewee used the metaphor of citizens being treated as items on a conveyor belt: *'Officers have responsibility not authority – like Yo Sushi, lots of trays going round but no-one wants to pick them up. We need a mechanism to identify those things they want to change and come together to work on them.'* More holistic ways of working were seen as delivering high levels of job satisfaction for workers: *'People want to go the extra mile because there's a satisfaction in good work well done and in solving someone's problems. There's an end point.'* The work intensification and episodic nature of citizen interaction in call centres, in contrast, was felt likely to increase staff burnout: *'Answering phones in a call centre has no end point.'*

There is a symmetry to the way that people spoke about the changing relationship between staff and citizens. If workers can crack this more human way of engaging with people it will enable citizens to be treated more holistically – as a whole person rather than a set of conditions or needs. One clear finding from the research was that the widespread calls for whole person approaches to care and support necessitate working practices in which staff are also able to be 'whole people'[9].

For some respondents this common humanity will emerge if unnecessary regulations are stripped away. One interviewee gave this example: *'Statutory workers with looked after children are not allowed to hug them. What crazy system have we got when those most in need of affection are denied it by the corporate parent on the grounds of somehow protecting them, that's crazy?'* For another, *'Authenticity...is critical. We need to learn its ok to say I made a mistake: this isn't car insurance – you have to start off saying you're sorry.'*

Good interaction with the public is partly about giving people permission to 'be themselves', as these quotes suggest, but it will also require effective planning and support. The skill set identified in the co-production literature suggests that it is a combination of more informal roles ('part good neighbour') with more formally trained roles ('part facilitator, part advocate, part support worker')[10]. The expertise for more effective relationships with citizens may well not exist within the corporate centre of the organisation but on the periphery. One interviewee suggested that the community engagement work that *'used to be tucked out in neighbourhood offices'* now *'has to be part of the corporate function of the local government.'* According to another, *'The council doesn't know how to combine knowledge and information e.g. from ward councillors. They need to develop internal co-production.'*

More attention also needs to be given to the emotional labour of public service workers, particularly in a context in which they are engaging in more naturalistic ways with citizens. As one interviewee put it, *'You need to be prepared to get out there and mingle with the real world and other people. And that's emotionally draining. So when I go home in the evening (I'm actually an introvert) I'm really drained.'* Emotional labour is defined as, 'the expression of one's capacity to manage personal emotions, sense others' emotions, and to respond appropriately, based on one's job'[11]. In its response to the Francis Report into events at Mid-Staffordshire NHS Foundation Trust, the government explicitly evoked the concept of 'The Emotional Labour of Care', writing: 'Working in health and care is inherently emotionally demanding. To support staff to act consistently with openness and compassion, teams need to be given time and space to reflect on the challenging emotional impact of health and care work'[12].

This increased awareness of the need for resilient responses to emotional labour constitutes a new dimension of public service practice. However there are challenges here for traditional notions of professionalism and distance. More humane services in which 'authentic' connections are made between people using and providing services, challenge the assumption that professionals should preserve distance and restraint. Yet professional boundaries may be an important part of self-care, and it is important to consider what support staff themselves need in order to sustain good relationships with citizens[13]. The need for reflective practice in response to this emotion work and boundary spanning[14] is dealt with in chapter ten below.

Challenge: Engaging with citizens: how can staff engage with citizens in a way that feels human, and supports people's assets rather than highlighting their deficiencies?

3. The 21st Century Public Servant is recruited and rewarded for generic skills as well as technical expertise

The rising awareness of the 'emotion work' of public service and of the ways in which effective public service requires boundary spanning, highlights the significance of a generic skill set which is different from the technical skill set which has been valued in public services in the past. So-called 'soft skills' around communication, organisation and caring become more highly prized. Davidson writes about 'twenty-first century literacies'. These include: interpersonal skills (facilitation, empathy, political skills); synthesising skills (sorting evidence, analysis, making judgements, offering critique and being creative); organising skills for group work, collaboration and peer review; communication skills, making better use of new media and multi-media resources[15]. This more relational way of working has been the focus of recent reports from the IPPR, Participle and others[16]. However the workforce elements of relational working have not been explored in depth. As one interviewee put it, *'Dealing with people in a more relational way is a skill that will need to be developed.'*

A survey of public service employers by Hays found that employers valued 'soft skills' such as communication as highly as technical skills when recruiting new staff[17]. However, there remains a need for what might be termed 'hard' skills around contracting and decommissioning. What is distinctive about these skills, perhaps, is not the distinction between 'hard' and 'soft' but between the techno-professional and the generic cross-sectoral. As one interviewee put it, *'We need more skills as the council becomes smaller - not just professional skills but facilitators, good questioners, coaches.'* There may be a need for more generic analytical skills than has been realised in the past: *'Some of the things around engaging with citizens and the use, analysis and interpretation of data to understand your local populations, they are quite newish sets of skills for people who work in local authorities.'* Another saw the future this way: *'In the future we won't have structures that are wholly lawyers, HR professionals. People will have to be able to manage across different professional groups.'*

These findings chime with the national public service reform agenda set out by Cabinet Office minister Francis Maude, in which the key skills of people working in public services were identified as:

- the commercial skills necessary for public servants to feel confident commissioning services from the private and voluntary sectors.
- the digital skills needed to design online services based around user needs.
- the leadership skills necessary to embrace the changes needed to deliver government priorities and projects on time and on budget[18].

These more generic skills in central and local government demand new types of integrated skills training. However higher education and other training and development and support continues to offer highly specialised and professional pathways that lead to particular professional qualifications[19]. Post-qualification training remains focused on particular sectors. Those courses which look cross-sectorally tend to be leadership programmes (e.g. the Local Vision programme[20]. There is a tendency to assume that public service careers are linear and specialised and therefore predictable.

A somewhat different theme that was evident in some of the interviews was the promotion of multidisciplinary working rather than generic approaches. Some felt that it is unrealistic to expect an individual to be able to span the wide range of skills required: *'If you try to make everyone good at everything, they end up being bad at everything'*. They were also wary about the retreat from professionalism that was evident in the embrace of soft skills and generic training. As one put it, *'We discount the importance of experience and professionalism at our peril. It is quite risky to run helter skelter into a view that you can be a generic manager in any service...You need to find a way to reconcile the generic skill base with an understanding of the specific skills of the area you are managing. We have to understand and not undervalue the knowledge base that goes with public sector workers.'*

Here multi-disciplinary problem-solving was felt to offer the most productive way forward, with different people coming around a table to work collaboratively:

> *I prefer the notion of multi-disciplinarity rather than generic. Of course if me and my team are dealing with someone living in appalling conditions then we take a view about the whole person. But if I am then asked to assess whether the person has capacity under the Mental Health Act that's not something you can just do without having skills, experience or training...The more you can build the workforce around localities then we don't need to necessarily be generic workers but the way our team know our local police team and children's services team that's how we collaboratively solve problems.*

There was a consistent view in the interviews that Human Resources (HR) teams needs to be engaged in the debate about future workforce at both a strategic and operational level. Several interviewees suggested that current HR practices are too rigid to enable a flexible and agile

workforce, or to provide organisations with the skills they need when they need them. Interviewees commented that traditionally HR professionals tended to focus on the narrow operational issues rather the wider workforce planning *'it's all about how do we keep ourselves out of the courts, not about planning our future workforce*'. Others suggested that we need to translate the strategic picture into something that HR professionals doing the recruitment can understand.

A number of interviewees talked of the need to recruit staff differently; focusing more on values and behaviours than experience:

> *In recruitment we ask for the easy things, experience of delivering a housing repair service, knowledge-based things. And maybe it is more about asking about innovation – how have they changed a culture, impacted on a policy, introduced a new idea.*

Recruiting to different criteria was seen as important. As one interviewee said, *'It's about recognising and rewarding the wider competencies which aren't about the kind of job you do but the kind of person you are.'* According to another, *'We have always done values-based recruitment, tested out values in recruitment, but that really just meant a question in an interview that people learned the right answer to. We are now working with Skills for Care on recruitment and retention tools around values.'*

In responding to the 'recruitment for values' movement, Cole-King and Gilbert have pointed out that compassion is not only a value, it is also a skill[21]. Thus recruitment needs to focus on the extent to which people have a set of competencies which will enable them to behave with compassion in high-stress environments and to cope with the emotional labour discussed in the previous section[22].

Traditional public sector recruitment methods and processes were seen by some interviewees as limiting the diversity of the type of person who might join the public sector: *'We are working to deliberately try and put articles out into different parts of the media to capture a broader range of people. We won't be advertising in the MJ [Municipal Journal] because we don't just want local government people.'*

The greater use of headhunting was suggested by some third sector interviewees as a way to increase diversity and enhance recruitment to values:

> *It is about seeing the people in other contexts and headhunting them. That's what they do in the private sector. At [this organisation] despite being as fair as possible in our recruitment policies at a senior level we have only 1 non white person out of 50 people. So maybe our current practices are the problem.*

> *Some of the equalities thinking has made it harder to recruit for aptitude and personality. Those are really important for a relational model, but they are more subjective. Here we put personal qualities and aptitudes and ask for demonstrations of how they were used in a current job. We are looking for a kind of person. In most of government they put out an advert, rather than headhunting, because they feel it's fair, but I'm not sure it's a very good way of getting the right person. We don't do it, we advertise and we use our networks to get people to apply.*

To support the skills for good relationships it is also necessary to value the more relational and interpersonal aptitudes of the workforce in performance and appraisal schemes. *'You need public servants who account for themselves less by what is easy to measure and more by the relationships they have with people'*, as one interviewee put it. According to another, '*Wherever you are in the systems it's about relationships. Relationships take a huge amount of resource...Government doesn't get it really.*'

People suggested that we need to move beyond rigid national pay arrangements and job evaluation schemes that reward and promote people based on the size of the budget they manage or the number of people in their team. There was a recognition from most interviewees that management skills were lacking in public service and that these skills are not valued through the incentive systems: '*Most people that get promoted – yes they want more responsibility but not necessarily more responsibility for managing people, it's wanting more financial responsibility or they want more money.'*

There was a suggestion that organisations also needed to be more flexible in terms of how we remove people from the workforce. Current HR practice, in response to austerity, is to ask for voluntary redundancies which may mean losing key skills and experience from the organisation, whilst retaining people who may not have the appropriate skills. One interviewee suggested that most councils have staff working in roles that won't exist in a couple of years' time but they can't be open and transparent about this. A more productive approach might be to *'have a conversation with those people that in the next two years if you decommission services successfully there's a reward for you at end of that process – we'll help you move to new organisation or new career pathway.'*

Moving away from rigid HR practices was seen by many to be the way to facilitate a more agile workforce. However others referred to how the traditional incentives that made the public sector attractive, such as good pensions, stable employment and guaranteed progression were being undermined which could have an impact on the sector's ability to attract high quality people in future. Alongside innovative recruitment practices the sector will want to ensure that they are able to attract the 'brightest and the best' with the skills to act as effective public servants.

Challenge: Do recruitment practices get the right balance between generic and technical skills? How can people be recruited on the basis of values as well as skills?

4. The 21st Century Public Servant builds a career which is fluid across sectors and services

For many people working in public services a new kind of career path is emerging, far removed from the traditional 'job for life' that was seen to characterise some parts of the public sector in the past. As one interviewee put it, *'People will have portfolio careers, working in different sectors, working for different people at the same time, not just sequentially. It's not a job for life, or even for 5 years.* One interviewee described it as a zigzag career path rather than the traditional linear one where people moved up the hierarchy.

For some of the interviewees this portfolio career was felt to be a euphemism for race-to-the-bottom employment practices in public service organisations that were rapidly shrinking in response to austerity (*'The weekly sound of handclapping for another leaving do'*). However for others, there was a positive aspect to having a career which took in a number of different organisations and sectors. There was a recognition that in a complex delivery context public servants need to have a better understanding of the cultures and motivations of other agencies who have roles in achieving outcomes for citizens: *'If you've had couple of roles in commissioning, you need to experience life on the provider side, support service or central service – get different perspective and get broader experience.'* People's willingness to consider working in different sectors, or experience of having done so already confirms Lewis' empirical work with third sector leaders, many of whom lacked 'an explicitly "sectored" perspective on their careers'[23].

Several local authority respondents talked about the benefits of working in other parts of public services and in particular the third and private sectors which gave them an insight into different cultures. People in the third sector spoke of the value of encouraging more local authority workers to experience other sectors: *'The local authority has a particular problem in that because they are historically and culturally established institutions they get a lot of people who are used to one culture. Who could be developed to step outside of that? There is less of that in the third sector, funding comes and goes and people are more mobile. It is useful for the third sector to get into the local authority and see the whites of their eyes.'* Likewise, local authority respondents talked about the importance of bringing in people with private sector experience to help with procurement – one interviewee referred to it as a poacher turned gamekeeper approach.

Participants also spoke about the benefits of working across boundaries, and how people could be better supported to do this:

> *I've learned a huge amount by having crossed over into the private sector from local government. I would do my old job in a much different way with the skills and experience I've learned. I don't see enough of the skills I've acquired in my current role being applied in the public sector. The private sector can learn from the public sector as well as vice versa. I brought some skills to my current role that many of my peers who have never worked in the public sector haven't got, and in particular around working in a political environment.*

Creating a shared understanding of other sectors and organisations would create *'more understanding and more mutual respect',* as one interviewee put it.

A willingness to look across boundaries to other parts of public services was evident within the survey of recent graduate entrants to local government. Although a third saw themselves working solely within local government in five years time, 27% saw themselves working in the wider public sector, and 10% saw themselves in different delivery vehicles, such as social enterprises.[24]

In these conversations with people working in different sectors interviewees talked of the importance of high trust, partnership and collaboration between public, private and third sectors, but retained low levels of trust in each other in practice. Local government was characterised as 'centralised', 'controlling', 'patronising'; the private sector as 'a vehicle to make profit', the third sector as having too narrow a sense of mission. One third sector interviewee characterised local government in this way:

> *At a strategic level, in terms of how to solve these problems, the [local authority managers] see this as entirely their responsibility, they want to control it, they wouldn't want to get together with leaders from the third sector to think it through. The culture is still quite closed and controlling.*

This low-trust environment is not one in which the public, private and third sectors appear to be able to work together under a common umbrella of public service:

> *If we are going down the privatisation of public services route then there's going to be lots more partnerships between the third sector and the private sector. At the moment that's a nightmare, there is a complete culture clash. But they are going to need to understand each other better...and challenge the stereotypes about each other.*

Whilst mobility across sectors may be one way to build trust and credibility, a number of interviewees highlighted the scope for learning from other sectors through job shadowing and secondments rather than formal changes of employer.

Sabbaticals and secondments were seen as useful tools for sharing learning and gaining exposure to other organisational cultures: *'Where I have gained most has been being located in those organisations. There needs to be structured placement opportunities of some significant length with requirement to be reflective, and some tasks as part of that. Experiential stuff is the best.* Interviewees also referred to coaching, mentoring, shadowing and action learning as effective ways of developing new skills, as well as networks and relationships across the organisation and more widely:

We train people into their role too much. We don't do any real training and development. We need more work shadowing, but with a structure. It doesn't need to cost a lot. We need to get people working across the council with partners, not just within directorates and services. Managers need to do a lot more developing as part of PDR process.

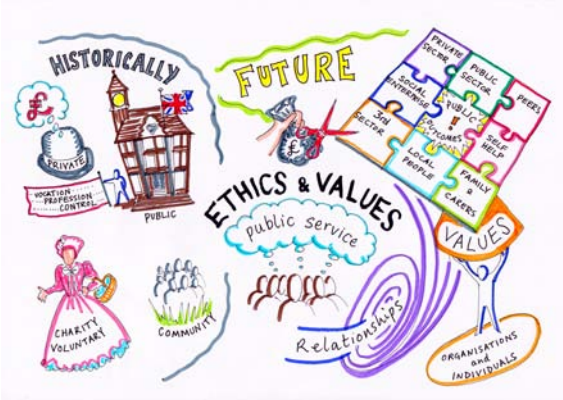
Work Shadowing

One example of such a scheme, praised by our interviewees, is the National Council for Voluntary Organisations' A Day in the Life programme of paired secondments between the civil service and the voluntary sector. This is a four day work shadowing programme which provides participants with the opportunity to see the commissioning landscape from the other perspectives.

www.ncvo.org.uk/practical-support/cross-sector-working/work-shadow-scheme.

Challenge: What opportunities can be created to encourage sabbaticals and secondments, into and out of the organisation?

5. The 21st Century Public Servant combines an ethos of publicness with an understanding of commerciality



The public service ethos has been a common reference point in discussions about public service reform for many years. Ethos captures the sense of an intrinsic motivation to service the public, distinct from extrinsic motivations such as material reward or fear of sanctions.[25] Intrinsic motivations are particularly important in public services since users often cannot impose extrinsic sanctions like exit on poor quality providers.[26]

There was widespread agreement among interviewees that the public service ethos has an enduring importance. A survey of graduate entrants into local government showed that 'wanting to serve the public' was the most powerful motivator of choice of career.[27] Two-thirds (69%) of these trainees believe that there is a distinctive set of public service values. Furthermore, these values are not usually seen as static. Of the 33 trainees who believed in a public service ethos, three-quarters (73%) felt that these values are changing as public service roles change.

The word cloud overleaf illustrates the terms which the respondents used to describe their sense of a public service ethos. The prominence of money and profit in the word cloud highlights the extent to which there is a financial component to ethos, either in terms of delivering value for money for citizens, or – in the negative – as being the absence of a profit motive.

The interview findings supported the literature review which highlighted that a public sector ethos has been eclipsed by a public service ethos, which reflects the variety of different public service providers and the value of a shared commitment to service. Certainly, private sector interviewees affirmed the relevance of the public service ethos to their own work, rejecting the notion that profit-motive is a barrier to such an ethos: '*I strongly believe that my public service ethos is as strong as, if not stronger than, many people who*

work in the public sector. I make more of an impact on the public that I serve now than I did when I was a chief officer in local government.'

Some interviewees were wary of investing too much in the concept of ethos, pointing out that that behaviours are more important than values:

> *As long as when they're at work they make the public member feel valued, the fact that they might not give two hoots for public sector and think everything should be privatised, I don't think that really matters...It's the behaviours that affect quality of service that users will receive that matters more than someone's personal motivations.*

For some the concept of social value offers a way to update the public services ethos. The Social Value Act 2012 places a duty on public bodies to consider social value ahead of the procurement of goods and services. The extent to which the Social Value Act will change procurement and commissioning practices is as yet uncertain, particularly given the context of austerity within which many public service commissioning bodies are operating.

As well as this commitment to public and social value, the need for greater commercial awareness and skills was a recurrent and consistent theme throughout the interviews, as the quotes in the box indicate.

Most of the interviewees did not see a tension between a commitment to publicness and a stronger set of commercial skills within the public sector. Commerciality was linked to better value for money and more effective contract management, both of which were felt to be strongly in the public interest.

Ethos and Commerciality

'Local government will need more private sector skills, more crossover of skills and people. If staff in local government don't have the commercial skills they won't be employable. We have to help them get them.'

'Chief officers will probably need a whole new set of skills. How do you do business relationships – how do you take elected members with you?'

'There's no good having an altruistic approach to managing a contract.'

'Commercial skills – we know what we mean but if I said to you what would a commercial social worker do? Does it mean I can make money for council or I can make relationships with commercial partners, does it mean I can sell things? A piece of work needs to be done that fleshes those out. '

'It would help if people from commercial backgrounds came from private sectors to run those contracts.'

'We need commercial acumen. That's not been favoured in social care in the past. But it's not about profit, it is about what things costs, are we making the best use of public money. And can the third sector or private sector sometimes do things better, better value for money.'

Challenge: Is there a strong ethos of publicness and do staff know what it means to combine this with more commerciality?

6. The 21st Century Public Servant is rethinking public services to enable them to survive an era of perma-austerity

Perma-austerity is inhibiting and catalysing change, as organisations struggle to balance short-term cost-cutting and redundancies with a strategic vision for change. Many interviewees gave a sense of moving into a second phase of austerity: *'There may have been a narrative about the cuts being a burning platform for stuff that should have been done years ago, but it doesn't feel like that anymore, the easy stuff has all been done.'* As another put it, *'It's not about doing more with less now, it's about saying what we can't do, being very clear to the public about the limitations of that and say well yes we can do this but only to that standard, or we can't do it, or accepting that someone else might be better able to do it.'*

For some interviewees the current 'narrative of doom' was inhibiting their organisation from moving forward. Some talked about a sense of loss and grief for the past, with organisations paralysed by the impact of the cuts, and unable to provide a new vision to work towards. As one put it, *'No message of hope – leadership is putting council into survival mode by the language they're using. Nobody is planning for post austerity.'* One interviewee spoke about the effect of losing large numbers of staff: *'You hear the language of loss everywhere. I get affected by it.'*

These sentiments resonate with findings from research into local government responses to austerity, by Lowndes and McCaughie which concluded that 'ideational continuity seems to dominate within local government...witness in salami slicing tactics (less of the same) rather than bold new visions'.[29]

Although interviewees accepted that the financial context offered opportunities for doing things differently, some commented on the challenge of moving forward whilst dealing with the reality of the impact of large scale redundancies: *'The cuts are forcing us to confront change. In public service, change doesn't necessarily happen unless there is a crisis or a disaster, or it happens very slowly. But think tanks and consultancies can find it exciting, for them it's a massive playground. We have to remind them that people are losing their jobs, services are being cut. There has to be a balance.'* Others commented that the enormity of the challenge needs to be recognized and responded to: *'It's not salami slicing because you wouldn't have salami that big, it's hacking things off. It's about rethinking the role of the state in light of the changing economy, technology, the changing ways that people live their lives. The cuts are so big that we have to confront the questions we have been putting off: what is a library service, what is a leisure service? '*

The biggest shift being driven by austerity is developing a different relationship with citizens: *'We won't have the money so we will have to focus on the enabling and facilitating, enabling the rest of community to do it.'* As one interviewee put it: *'You can only get so far by being a supply side mechanic, cutting and slicing. You need a better sense of what your people are like, who they are, what their networks are, how they can do more not for themselves but how they can be more a part of the value that you create about what you do as a council.'* This perspective is supported by research which concludes that the role of institutional bricoleurs will become more important: individuals who bring together or recombine resources in particular ways to bring about opportunities.[30]

However another interviewee described the difficulties she encountered in reconciling the efficiency/austerity agenda with more relational ways of working:

> *There is a complicated tension between the desire on the one hand for efficiency and rational processes versus the expectations and needs of customers which is more relational and focused on the personal and local. Public service workers have to find their way through that knot. We are expected to do both, to move to the more relational in the government's commitment to localisation and neighbourhoods. But elsewhere we are moving to customer relationship management and call centres. You phone or visit a call centre, pick up a ticket, it's not a holistic relationship with the person on the other end of the phone.*

Challenge: Are honest conversations going on about what the organisation can and can't do in an era of austerity, and do people understand their own role in that future?

7. The 21st Century Public Servant needs organisations which are fluid and supportive rather than silo-ed and controlling

Several interviewees talked about how the hierarchical structure of local government and the wider public sector reduces the flexibility to respond to change. Many commented that the service-based structures were developed to suit the needs of the organisation rather than citizens and those trying to work with the institution and had not changed to accommodate new ways of working. As one put it, *'We are trying to be 21st Century public servants in 19th Century organisations. There's that constant struggle. Not only how do we change what the people are but also how do we change the organisations to allow the people to be what they need to be?'*

There was a recognition that the bureaucratic structure of government does not lend itself to engaging with partners and communities and that the culture needs to change – a real challenge for a large, traditional type of organisation with hierarchical structures:

> *That's the real thing to bottom out, we've got to find a way of delivering relevant and engaging public service without the trappings of a big bureaucracy. We need to remove some of the barriers that stop people – some of the things that are about micro-businesses, individual people thinking we have spotted a niche for something here. The council could play a role in facilitating that, getting people together to share ideas. I know there are attempts to do that but I don't think it's as easy as it should be. It might be about creating the conditions in which that can thrive.*

Most interviewees felt that the current service-based structures restricted the workforce from being agile and entrepreneurial: *'The processes that organisations need to have in place to meet their legal liabilities are the very things that hamper that flexible and responsive working'.*

Interviewees argued for the need for new ways of working, such as task and finish groups rather than rigid organisational structures, with people taking part on the basis of skills not job title: *'We don't invite people to take part in project based on "you're a head of" – much more about core skills or core behaviour that will be required – you have those things, come and work on it.'*

Some organisations are already moving towards different structures: *'We need a customer/place based approach. Here we're organised in a way that satisfies the needs of our citizens not in a way that satisfies our own professional boundaries'*. However this is by no means the norm. There was also a recognition that adopting more flexible, organic structures could challenge the traditional professions and services. One interviewee suggested that *'Maybe we need a new structure for local government where you have seniors that have a technical expertise, alongside people capable of making relationships, and then members.'* Health and social care integration was seen by one interviewee as an opportunity to explore how structures could encompass different ways of working whilst ensuring that citizens experienced an integrated service. But here too challenges remain: *'How do you manage to marry different traditions and disciplines (in a way that) respects them but doesn't lead to citizens being pushed from pillar to post.'*

There was also a sense that public services need to harness technology better in order to enable more flexible working. Several interviewees made the point that as the younger generation enter the workforce they are less likely to want to be in an office from 9-5: *'It will be less hierarchy in the future, more organised chaos, more project management. Will need to make more use of cloud technology, let people work from cafes, from home.'* The flexibility that such working provides is likely to be welcomed by many staff, although the potential isolation that mobile working can create, particularly for those workers engaged in more emotionally intense encounters with citizens, is an important counterweight.

Challenge: are systems-based approaches being considered as an alternative to repeated cycles of organisational restructuring?

8. The 21st Century Public Servant rejects heroic leadership in favour of distributed and collaborative models of leading

The traditional individual leader approach is not one that will be effective in the context of complex, adaptive problems facing society.[31] The skill sets of leaders in the future need to be different, and the type of leadership approach also needs to change. Several interviewees mentioned the concept of systems leadership, as proposed by the recent report by the Virtual Staff College.[32] They argue that the concept of systems leadership (or collaborative leadership in the health service) replaces the traditional notion of the leader as the sole source of power and authority with a version of leadership which reflects the complexity of modern society and the decline of deference. The argument is that 'in these troubled, uncertain times, we don't need more command and control, we need better means to engage everyone's intelligence in solving challenges and crises as they arise'.

Interviewees reflected this – with one saying that *'collaborative leadership is about creating conditions in which others can thrive'*. The leaders themselves recognise this shift, with a recent survey of council chief executives finding that: 'public services can only be more responsive to the needs of service users if employees on the front line are trusted to innovate and empowered to act with more autonomy. This requires a fundamental culture change away from traditional command and control models of leadership to one in which leadership is distributed across organisations'.[33] As one interviewee put it 'The kind of system leadership which is required now is seen to favour a different skills set to the 'fix it' leadership of the past'. Leaders also need to be self aware and emotionally intelligent: *'Someone who understands what they are bringing to the table so understands who else needs to be there.'*

Interviewees suggested that leaders needed to do different things, but also needed a different style of leadership: *'The concept of leadership is changing from being one where leaders are expected to perform to one that enables others to be effective.'* This is an approach which, '… *requires being with people and allowing them to be themselves, listening, noticing, observing and deploying yourself accurately in situations…. it's about making teams and networks effective... about having a repertoire'.*

Interviewees emphasised the importance of leaders having passion, strong values and motivation if they are to support others to improve outcomes; one interviewee commented that *'Leadership for outcomes only works if people care'.* There was a call for leadership to promote shared endeavour across the whole system rather than merely enabling others to do things: *'It's about making it happen. It is so difficult to make it happen that it will only happen through passion and belief in what's to be done.'* One interviewee suggested that *'What links all the different models of leadership is uncertainty, doing things where you can and when you can.'*

Although an organisation needs someone to act as the face of the institution it *'doesn't require a charismatic leader',* as one interviewee put it. This suggestion reflects the Virtual College findings that there is a distinction between the 'old fashioned notion of the domineering leader, whose power comes from their willingness to coerce others, and the requirement on a modern leader to be a member of a team, making their presence felt by their ability to achieve a collective sense of purpose'.[34] One contributor to the Virtual College report felt that social media could be a real opportunity for leaders to make their presence felt as it 'gives the leader a name and gets the messages across as a leader.'[35] The engagement of public servants with social media is discussed in more detail in section 10 below.

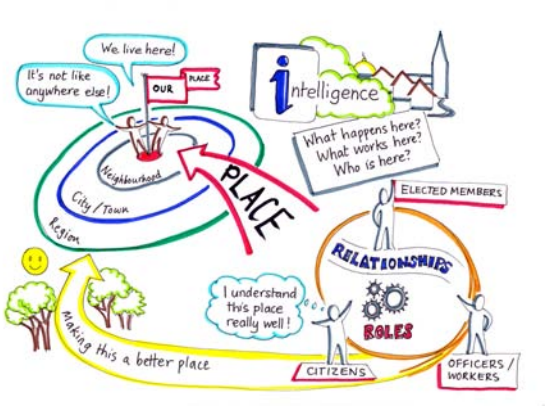
Whilst recognising the need for this new type of leadership, interviewees questioned whether there were the right levers in place to make a change. Although some organisations are being explicit about the different types of leadership behaviours they want and recruiting to those competencies, the traditional models of leadership and the associated 'macho' type behaviours still exist and tend to be rewarded within the public sector.

Several interviewees expressed concern that the traditional, command and control type of leadership was having a detrimental effect on the decision making within the organisation; particularly in the current financial context where decisions about cutting services are being made. One interviewee stressed that *'People need to have managers and leaders who are honest, honourable and listening and who will help people make best of it – will create teams where people can survive. If leadership is saying don't bring me problems then people will leave'.*

Another interviewee said that it is a challenge to ask people to make difficult decisions when they are operating in a command and control culture: *'If people are worried, they will avoid making a decision or will refer it up all the time, which creates paralysis in the system.'*

Challenge: what is being done to develop leadership at all levels of the organisation, and how is that being facilitated through incentives such as the appraisals system?

9. The 21st Century Public Servant is rooted in a locality which frames a sense of loyalty and identity



The role of place in public service needs to be recognised: public service workers often have a strong loyalty to the neighbourhoods and towns/cities in which they work as well as an organisational loyalty. Several respondents talked about the importance of place in public service; one interviewee suggested that the building of a grand Town Hall had once been a physical statement of commitment to public place and questioned whether we now have such a sense of why public service exists. With the move towards more commissioning rather than delivery, this sense of serving a place will become even more important. An interviewee suggested that this service to place should be the fundamental role of councils: *'God knows what services [the council] will deliver in future but there will be someone thinking I have a responsibility to this place – I'm the leader of this place. That's the long term mission – all else is ephemeral'.*

Interviewees suggested that it was essential for public servants to '*know and walk their patch'*. One interviewee argued: *'Above a certain grade you should be required to live in [the council area], because you are making huge decisions on how people will live, work and spend their recreational time'.* Living outside of the community, removed from the daily life of the area means that public servants may struggle to understand their residents, according to this view. Interviewees also suggested that although public servants need to have a vision of place this is challenging if they are trained to view the world through the perspective of services rather than the place: *'We need to get people to look after the place rather than just meet their professional responsibilities. People need to get out of their professional silos and work with voluntary groups, people in the area, do their best for the neighbourhood regardless of their professional role.'*

Some interviewees felt that this commitment to place was special to the public sector: *'You don't have that working for a private sector company. You are like a GP or priest, who wants to do the best for the people in their area.'* Another respondent agreed that GPs are *'community workers who are based in their communities and have pride and commitment to the City and their area'.* However, he noted that the loss of the requirement to provide out-of-hours service has weakened this link to place, as many GPs no longer live in the community where their practice is based. There is potential for similar impact on the sense of commitment to place with more services being outsourced; *'The frontline...there a bunch of things happening over which they have no control whatsoever and the chances are that you are going to be part of an organisation that won't be the council. Whether that's an arms length or mutual body or straight off to Capita.'* Becoming part of a national organisation could have an impact on that sense of commitment to place currently felt by many of our interviewees.

Several interviewees suggested that those working on the front line and in neighbourhood roles have the deepest sense of place, and need to relay this to others higher up the organisation. One suggested that a local government officer *'should get out of bed thinking about the city not services'.* Public sector organisations also need to recognise that many of their residents are also staff, and create opportunities for staff to respond and contribute to consultations and strategies as residents: *'Staff are beginning to challenge decisions being made – reflecting service user views but also their own views as residents.'*

The concept and importance of pride in the place in which they work was raised by several interviewees. One interview said: *'There's a sense that we are there to make a difference and we're proud to be part of that. Pride in place is part of that, people feel proud of their city or neighbourhood. Just because you live in the city doesn't mean that you are of the city. It's not the living in it, it's about having a genuine commitment to and being proud of the work we are doing in the city'.* There was also a view that leaders have a clear political task to bind people round a place and create a shared identity; in order to create civic pride. One interviewee suggested that the role of champions of a place is a key task because civic pride comes out of identity and this assertion of pride creates things which then pull other people into it.

Challenge: How are feelings of identity and loyalty to place supported so that public servants feel like citizens of the place not just officers in an organisation?

10. The 21st Century Public Servant reflects on practice and learns from that of others

The public service changes that we have set out here in which structures are fragmenting, citizens demand authentic interactions, careers require much greater self-management, commerciality and publicness must be reconciled and expectations of leadership are dispersed across the organisation, requires time and space for public servants to reflect. Many interviewees said that more value is placed on activity rather than reflection and this leads to risk aversion and lack of innovation: *'We put huge amount of store in activity and need to get better at valuing reflection, anticipating. The risk is if we focus on here and now we may not be able to transform and innovate. How do you slow it all down?'*

Another said:

> *You need spaces where you take yourself apart and sort it out with the fact that the organisation is expecting you to glide along like a swan looking serenely happy with no mistakes whatsoever. Self assurance can be reason for making an appointment but then that person can be very short fused. How can you recruit for self criticism?*

This reflective practice can help people to cope with the emotional aspects of their work, highlighted above. It can also be a way to manage the anxiety that people are dealing with because of the cuts. Managers in the interviews suggested that they don't have resources to do the job and something will go wrong and no one is listening to them (one person suggested that this can be seen in what happened with the recent flooding). Social workers are worried that they can't keep people safe. Chief officers are trying to balance the need to motivate people with determining where to cut the budget: *'Directors of adult care are taking decisions about where best to create the harm'*, as one put it. The end result is a 'fake resilience' which is unsustainable.

New technologies are also creating new challenges for workers about how to manage boundaries and to work appropriately. Social media in particular was seen as a great opportunity to engage with citizens in a different way, and one that public service organisations had not always embraced with sufficient creativity. *'We are too controlling around social media at the moment. That's how people in the real world talk to each other.'* It was recognised to also bring challenges around time pressures: *'It's all leading to information overload, people become very stressed trying to deal with it all.'*

Staff also reported concerns about how to manage the boundaries between professional and personal selves when using social media:

> *A lot of public sector organisations fall into the trap of putting out this bland stuff... We're talking about personality now. Comms are saying you need to be blogging as you. But when I do get the time, fitting it into the day job, what guarantees do I have that no one is going to say you've overstepped the mark here?*

For officers in local government, social media was felt to bring problems with exposure:

> *You have to be careful with Twitter. It's difficult to draw the line between personal and professional life. I tend to retweet things but without a value statement attached. We are in politically restricted posts so we have to be careful.*

For elected members, who are already well exposed, the challenge was rather different:

> *Twitter and Facebook are about publishing what you do in your life. But huge parts of my life are in the public arena and I want to keep part of it private. I wouldn't want it to be that being a publicly elected person meant that I don't hang on to part of my life being private. And I wouldn't want to continue as an elected member if that was the expectation.*

The reflective practice that will help staff to cope with these multiple challenges was seen as best supported through experience, coaching and mentoring than traditional training courses. One interviewee said: *'There is a real need to work on people's ability to learn, not just sitting in a classroom, go out, think for yourself, what it is that we don't know. We need managers who are able to do that and do that with their staff and think about how do we help people learn.'* Several participants suggested that people should view their relationships at work with colleagues and line manager as best source of education and skills: *'It's less about training, more about experience.'*

Organisations also need to be receptive to the learning that comes from exposure to other ways of practicing. One interviewee expressed her frustration: *'People have been out and brought ideas back but it's like throwing seeds onto stony ground.'* Personal development processes were felt to be too process oriented, with little emphasis on personal development and no sanction for managers who failed to develop their staff: *'There is limited effective challenge for managers who don't develop their staff, no one notices, whereas if people didn't manage their budget effectively we'd be down on them straight away.'*

Staff were seen to need more help to carve out time for reflection and training:

> *We don't create the right environment for internal managers to develop the skills and knowledge that they now need. The biggest barrier to that is people's time. There is a lot of organisational support, please feel free to take this course, but translating that aspiration into staff doing the training takes a different lever. You have to make the space for it to happen, you have to make them learn, otherwise they won't find the time because there is never enough time to do everything already.*

Challenge: Do appraisal, mentoring and peer support give people scope for reflective practice, to share and learn from mistakes and to take on new challenges (such as using social media) in effective ways?

Conclusion and Next Steps

The findings we have set out here are a combination of descriptions of how people perceive their current practice and aspirations of where they want to be. The report has aimed to give voice to what a cross-section of people working in different public service organisations feel are their current workforce issues and the best ways to address them. They contain clear challenges for 21st century public servants as well as opportunities, and we have included a specific challenge at the end of each section. What we haven't offered is a 'how to' guide or a toolkit. The aspirations set out in the report are much more likely to be achieved through personal reflection, internal organisational dialogue, external networking and peer learning than they are by working through a new human resources tool.

The fleet-of-foot worker, who manages a portfolio career and an emotionally rich engagement with citizens at the same time as exercising personal development and self care, risks being as mythic as the heroic leader who will single-handedly lead an organisation to success. It is of course more likely that attributes will be pooled within teams rather than displayed within one person. The 21st Century Public Servant is a composite role and exists to illuminate a series of working practices rather than to provide a blueprint for a single worker.

There are several perspectives which are underexplored in this report. The first is that of the citizen. This was a short project, and there was not sufficient scope to engage the public in this conversation in a way that did not feel tokenistic. There is scope for follow-up work here, particularly around what the public want at the frontline interface. It seems likely that that notion of 'being human' that resonated with staff will also be relevant for the public, but that will be offset with convenience and efficiency. The balance is likely to depend on the service, and also perhaps on the age and social profile of the citizen. These are all fertile areas to explore in future work, building on the research of others.[36]

The second missing perspective is that of politicians. Only three elected members were interviewed for this work, and the report does not have much to say about what it means to be a 21st Century politician. There were some interesting tensions surfaced by the research – for example around how far officers' use of social media trespasses on the role of councillors as the public face of the council – and these again warrant further exploration in the context of the changing role of elected members.[37]

The third is the political and financial context. For the interviewees, and the recent graduates who completed the survey as the upcoming generation of public service managers, the context of austerity was taken as a given, as was the mixed economy of public service providers. The widespread emphasis on commerciality as part of public service working reflects how far the assumptions of new public management have penetrated all tiers of government. With few exceptions, there was little critical reflection on this new terrain or on the political choices that have facilitated it, although this is a topic that has been covered elsewhere by the authors.[38] The role of trade unions and professional organisations was also underdeveloped, primarily because they were mentioned rarely by interviewees, but they clearly have an important role to play in thinking through how to modify working practices in ways that advance publicness and individual wellbeing.

The fourth is the international perspective. Other public service contexts have leant themselves to similar types of enquiry and related conclusions, although with a civil service rather than local service focus. In Canada for example a project on the Public Services in the 21st Century included a recommendation to 're-commit to "on the job" learning', including through mentoring and sabbatical programmes.[39] Singapore's Public Service 21 (PS21) programme has identified the workforce principles which it sees as essential for the future including: 'a mindset that welcomes experimentation and a desire to continually find new and better ways of doing things. PS21 gives every public officer the mandate and platform to contribute their ideas for a successful Public Service.[40] Helen Dickinson and Helen Sullivan at the University of Melbourne are exploring public service workforce challenges in Australia in parallel to our research, and we plan to undertake comparative research with them in the future.[41]

Next steps

In this report we have brought forward what it means to be a 21st Century public servant. We have also identified some of the steps which are needed to get there. These include a greater role for lead professionals and multi-disciplinary teams; increased scope for work shadowing and sabbaticals; and stronger recognition of the generic and relational skills which make public services work for citizens. Some of what we have found is about refocusing current practices: incentivising managers to take personal development processes seriously and holding to account managers who fail to invest time in staff development; recognising the importance of place to workers' identity and loyalty. Much of what is here will need a more structured response: different kinds of professional training and development; opportunities to engage in cross-sectoral training; facilitation of more reflective ways of working. There are cultural challenges too, linked to notions of control and risk aversion which fail to respect staff or citizens, or to reflect new technological norms in communication. Some of the cultural prejudices towards other sectors (public, private, third) seem as entrenched as ever, despite decades of partnership working. These are the many issues on which we are encouraging comment and debate. Join the discussion on the blog http://21stcenturypublicservant.wordpress.com/ and help to share ideas on how to ensure that the 21st Century Public Service workforce is fit for purpose.

Notes

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Hackney

Governance & Resources Scrutiny Commission 10th June 2015 **Whole Place, Whole System Approach – Long Term Unemployed with Mental Health**	Item No **8**

Outline

The Governance and Resources Scrutiny Commission embarked on a programme of work to look at conducting a whole place, whole system review and the approach to be taken. The Commission decided to focus on areas of high spend and high need.

This review has involved conducting qualitative research with local residents to show case the 'customer journey' to help understand the triggers, barriers and their interaction with current local services. BRDC Continental were commission to carry out this research on behalf of the Commission and conducted 24 qualitative in-depth interviews with residents who are long term unemployed in Hackney.

This item is to discuss the findings from the qualitative research. The aim of this research is to reduce duplication of support and services to the same individual and to support the redesign of services around early intervention or at the point of need.

Action

The Commission is asked to identify recommendation for the deep dive service area and the barriers to whole place, whole system approach to service redesign.

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Hackney

Governance & Resources Scrutiny Commission 10th June 2015 **London Living Wage Executive Response**	Item No **9**

Outline

The Governance and Resources Scrutiny Commission held two meetings in Spring 2014 to consider the Council's journey to paying all of its staff, including contractors, a London Living Wage. At the time of our inquiries, Hackney was understood to be one contract away from being a total London Living Wage employer. The authority expected to re-let that final contract in September 2014 and complete the journey. This is an achievement the Commission commends highly. We also note that constant vigilance will be required in both future commissioning exercises and through ongoing contract monitoring to ensure compliance with the London Living Wage commitment.

The Commission sent a letter of reference to the Cabinet Member for Finance asking questions about the Council's work to further promote and strengthen the London living wage both within the Council and more widely.

The letter attached is the Executive response.

Action

The Commission is asked to note the Executive response.

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Hackney

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Cllr Rick Muir
Chair of Governance & Resouces Scrutiny Commission
Hackney Town Hall
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E8 1EA

22 April 2015

Dear Cllr Muir

London Living Wage

Further to my attendance at the Governance & Resources Scrutiny Commission meeting last year, thank you for your letter of 11 February 2015 regarding the Commission's short inquiry into Hackney's work on implementing the London Living Wage. I apologise for the delay in responding.

In your letter you set out five questions, which I have responded to in turn below.

1. *Is the council aware of any employees of the council or of the council's contractors who have seen their hours reduced following the introduction of living wage and is this something that we can monitor in the future?*

No, the Council is not aware of this happening, although a few staff employed by the Council's office cleaning contractor raised a concern about this in 2013, which was fully investigated at the time.

Quite separately to the living wage policy, before tendering the new office cleaning contract the Council had undertaken a thorough review of the cleaning specification to ensure that it met the needs of the organisation and provided value for money. It was found that the previous schedule of a full daily clean for all administrative areas was not required and that environmental quality would be maintained by cleaning these areas on alternate days only. Kitchens, toilets and public spaces are still cleaned daily.

The new contract, under the revised specification, was secured by the incumbent supplier, Servest, and commenced on 1 July 2013. In a few cases the review resulted in increased hours for a particular site, but overall Servest determined that the specification changes resulted in an overall reduction in the required working hours. Their bid was priced accordingly and accepted on this basis.

Servest chose to implement the changes to its contract by a broad application of reduced hours for cleaning staff, rather than the alternative approach of reducing the total number of staff. However, the Council

did not expect the old specification to be delivered by Servest with less cleaning hours. Experience has demonstrated that the revised cleaning specification adopted in 2013 has been successful, with no noticeable impact on standards of cleanliness in Council buildings.

This misunderstanding was the subject of considerable work at the time. Servest undertook a thorough review of the ways in which shifts are allocated and staff recruited to the contract. The Council took particular care with the Building Security Contract which was let a few months afterwards to ensure that the changed specification was not conflated with achievement of the London Living Wage, and indeed these problems were avoided.

Staff levels are monitored for contracts where these are directly relevant to the quality of the service being provided (cleaning and security for example). However, they are not monitored where the relationship is not direct, because the Council must also make the best use of its own staff resources when managing contracts.

2. *Is it the Council's intention to encourage other employers in Hackney to pay the London Living Wage?*

   If so what specific measures is the council considering to achieve this?

The Council has developed the Hackney Business Charter that was launched by the Mayor in March 2015, to encourage and support businesses in Hackney to adopt or aspire to a set of best practice principles that will help them invest and integrate into the local community, invest in their employees and deliver their services ethically and sustainably.

Employment is one of the three pillars of the Business Charter. Specifically, businesses signing up to the Charter are asked to adhere to the principle of Fair Pay and providing staff with career development opportunities, including initiatives such as Hackney 100 project which provides paid work experience for 16 and 17 year olds at the London Living Wage.

By the end of the 2015, the Council hopes to have signed up over 100 businesses who will demonstrate a solid commitment to the charter and it's principles around community, environment and employment. The Council will target local businesses through the Hackney Business Network, through our existing Ways into Work and Hackney 100 business clients and connections via our Town Centre Managers.

Working with the early businesses signatories as champions, a press and social media campaign will also be developed to proactively encourage further uptake and demonstrate the benefits Hackney has received through these partnerships.

3. *What is the Council doing more widely to promote progressive employment practices in the borough?*

In addition to the LEW, Council contracts encourage and require where appropriate local recruitment, especially utilising the Council's Ways into Work service, and the provision of training and apprenticeships. We are a signatory to the London Council's Apprenticeship Pledge.

In relation to the Council's cleaning contract with Servest, 75 of the 132 employees (57%) are employed locally. Other contracts also employ a significant number of local residents, although not as high as Servest (e.g. the Council's security contracts with CIS and G4S employ 21% and 27% local staff respectively). The proportion will depend largely on the nature and flexibility of the work; as the work on the Servest contract is overwhelmingly part-time it makes local working much more attractive since travel costs and commuting time is more significantly reduced as a proportion of earnings per shift.

Our contracts for services do not generally prescribe how out contractors should organise their staff, to do this would lose the benefit of the expertise that external contractors can bring with them. However we do discourage the use the use zero hours contracts and require that where they are genuinely required they are not exploitative e.g. they are not exclusive (so staff can take other work too) and they are not used where there is an obvious pattern of regular employment.

The Hackney Business Charter has a focus via the 'Community' pillar on encouraging businesses to make a commitment to employing local people and actively supporting the local community. One example of how this commitment could be demonstrated is through developing a procurement policy that creates job and apprenticeship opportunities for local people, and gives weight to the use of local suppliers to source products and services.

4. *Does the Council or its subcontractors use zero hours contracts? What are we doing to phase these out and discourage their use more widely?*

The Council does not directly employ anyone on exploitative zero hour contracts, and has a clear policy and guidance in place against their use. The Council's policy makes clear that the Council will only use zero hours contracts in exceptional circumstances and where their use is wholly justified by the specific demands and nature of the required work. Furthermore, zero hours contracts may only be used where a regular and consistent level of work cannot be guaranteed and where there is a need for a specific individual to undertake - and commit to undertaking - the available work. Where work requirements become regular and consistent over a sustained period, managers must reconsider the contractual terms and where possible offer permanent or part-time contracts or annualised hours.

Council zero hours contracts may not specify that the employee cannot work for another employer when not undertaking work for the Council (although individuals may be required to disclose interests or other work), and managers intending to use a zero hours contract must have the express permission of the relevant Assistant Director before offering the contract.

The Council currently has twelve directly employed zero hour contracts. Seven of these are within the Registrar Service, to provide additional staffing mainly at weekends for marriages and civil partnerships. The demand for this service depends on how many marriages and civil partnerships are booked.

In relation to the Council's contractors, as stated in response to question three above, the Council requires that any zero hours contracts that are in place are not exploitative. As with the Council, zero hour contracts are rarely used by our contractors and, for example, they are not used in our cleaning and security contracts, which are often areas of work where such contracts are common.

5. *Are we able to consider whether more of the council's pension fund could be invested locally?*

The Council's ability to invest more of the Council's pension fund locally is restricted by its legal and fiduciary responsibilities. Both the Law Commission and Leading Counsel have recently considered the position of pension funds and their fiduciary responsibilities, with the latter a direct question in respect of Local Government Pension Schemes, namely that funds have a duty to use investment power for the purpose of producing returns to pay benefit, although they are not simply to maximise returns at the expense of other considerations. Instead the aim of investment strategy should be to secure the best realistic return over the long-term, given the need to control risks. The Council as the Administering Authority of the Pension Fund has fiduciary duties to both scheme employers (the Fund has a range of employers not just the Council that participate in the Fund) and to scheme members. The power of that investment must be exercised for investment purposes and not for any wider purposes. Investment decisions must therefore be directed towards achieving a wide variety of suitable investments and to what is best for the financial position of the fund (balancing risk and return in the normal way). Indeed, to quote QC opinion:

"it would be impermissible, for example, for the administering authority to invest fund monies in the local football club, because it was thought important to the area to keep the club afloat, in circumstances in which that was not likely to be a good or prudent investment (as compared to other investments that might be made). Similarly, it would not be permissible to invest in social housing just because there was a need for more such housing, if that was not a good or prudent investment."

The QC does go on to say that "the administering authority can in principle have regard to wider considerations where that does not run the risk of material financial detriment to the fund", which means that in theory the fund can invest in local social housing projects but not if the only reason for the investment is because it is local. In brief, this means that the Pension Fund is there to invest monies in order to pay the pensions of those that have been promised benefits whether those be people who have worked for the Council or for other employers in the Fund. The fund is not there to invest in local projects, although it is able to consider local projects but only where the appropriate returns within specific risk parameters could be achieved, and provided that the reason for that investment isn't simply because it is local and the Council wants to fund local projects. The Pensions Committee which has delegated powers to manage the Fund is also required under legislation to take appropriate

financial advice when making investments and to consider those investments as part of a broader investment strategy and to take into consideration the diversification of its investments.

I trust that this response is helpful and provides reassurance on how the Council is addressing these matters. However, should you require any further information please do not hesitate to contact me.

Yours sincerely

Cllr Geoff Taylor
Cabinet Member for Finance

Hackney

Governance & Resources Scrutiny Commission 10th June 2015 **Governance & Resources Scrutiny Commission Work Programme for 2015/16**	Item No **10**

OUTLINE

Attached is the first draft of the Governance and Resources Scrutiny Commission work programme for 2015/16. Please note this is a working document and regularly revised and updated.

Provision has to be made in the timetable for one-off items or items of concern which might come up during the year.

Members have been asked by the Chair to give consideration to the next phase of their 'Delivery Public Services Whole Place, Whole System' review.

The Chair will liaise with the Director of Finance & Resources to confirm the dates when the regular finance updates will be provided.

The Chair will liaise with Cllr Taylor (Cabinet Member for Finance) to confirm the date for Cabinet Question Time.

ACTION

The Commission is requested to agree a topic for the main review for 2015/16 and to agree the one-off items to be scheduled in work programme for the year.

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Overview & Scrutiny

Governance and Resources Scrutiny Commission

Rolling Work Programme June 2015 – April 2016

All meetings take pace at 7.00 pm in Hackney Town Hall unless stated otherwise on the agenda. This rolling work programme report is updated and published on the agenda for each meeting of the Commission.

Dates	Proposed Item	Directorate and officer contact	Comment and Action
Wed 10th June 2015 Papers deadline: Mon 1st June	Election of Chair and Vice Chair	Chief Executive's	First meeting of newly elected Commission.
	London Living Wage Executive Response	Chief Executive's	Cabinet Member for Finance response to letter of reference following the outcome of G&R's short inquiry
	Delivering Public Services – Whole Place, Whole System Approach Evidence session	Early Intervention Foundation Donna Molloy – Head of Implementation	Presentation by Donna Molloy from Early Intervention Foundation about prevention and spending on late intervention.
	Delivering Public Services – Whole Place, Whole System Approach • Health in Hackney Scrutiny Commission – Depression and Anxiety Report • The 21st Century Public Servant	Chief Executive's	Review the findings from the Health in Hackney Scrutiny Commission Depression and Anxiety Review. Review of the finding from a review conducted by Dr Catherine Needham and Catherine Mangan on

Dates	Proposed Item	Directorate and officer contact	Comment and Action
			the changing public service workforce.
	Delivering Public Services – Whole Place, Whole System Approach • Long Term Unemployed People in Hackney – The Customer Journey	Chief Executive's	Discussion based on the findings from the qualitative research report by BDRC highlighting the customers journey for the long term unemployed in Hackney.
	Work Programme Discussion	Chief Executive's	To agree a review topic and topics for one-off items for the year.
Mon 8 July 2015 Papers deadline: Fri 26 June	London Borough of Hackney 2015 Elections	Chief Executive's (Tim Shields)	Report on the 2015 Elections - voters registration and postal votes
	Devolution	Chief Executive's (Tim Shields)	Discussion about the opportunities devolution could provide for Hackney
	Corporate Cross Cutting Programmes	Chief Executive's (Tim Shields)	Update on the progress of the Corporate Plan 2015-18 cross cutting programmes

Dates	Proposed Item	Directorate and officer contact	Comment and Action
Tues 8 Sept 2015 Papers deadline: Thu 27 August	Finance update	Finance and Resources (Ian Williams)	Briefing on the budget scrutiny process and update on General Fund savings 2011/12-2013/14.
	ICT Review Recommendation Update	Finance and Resources (Ian Williams and Christine Peacock	
	Complaints Service Annual report	Chief Executive's (Bruce Devile)	Annual report of the Council's complaints service
Tues 13 Oct 2015 Papers deadline: Thu 1 Oct			
Tues 10 Nov 2015 Papers deadline: Thu 29 Oct			

Dates	Proposed Item	Directorate and officer contact	Comment and Action
Tues 8 Dec 2015 Papers deadline: Thu 26 Nov	Cabinet Question Time with Cllr Taylor (Cabinet Member for Finance) TBC	Cllr Taylor – Cabinet Member Finance	Cabinet Question Time is now carried out by individual Commissions. Cllr Taylor has lead responsibility for revenues and benefits, audit, procurement, pensions, and customer services.
	HR Workforce Strategy	Legal, HR and Regulatory Services (Gifty Edila)	
	Finance update	Finance & Resources (Ian Williams)	
Tues 12 Jan 2016 Papers deadline: Mon 21 Dec			
Mon 22 Feb 2016 Papers deadline: Wed 10 Feb	Budget and Finance update	Finance & Resources (Ian Williams)	Budget and Finance update on local government settlement and Council Budget for 2015/16.

Dates	Proposed Item	Directorate and officer contact	Comment and Action
Tues 8 Mar 2016 Papers deadline: Thu 25 Mar			
Tues 12 Apr 2016 Papers deadline: Thu 31 March	Work programme for 2016/17 discussion		Discussion on topics for work programme for 2016/17.

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