Brent	**Executive** **17 February 2014** **Report from the Strategic Director of Adult Social Services**
	Wards Affected: ALL

Adults' Mental Health Service Improvement – Phase 2 Options

1. Summary

1.1 This report sets out a summary of the phase 1 Mental Health Improvement Project and options for taking forward phase 2.

2. Recommendations

2.1 Executive is recommended –

2.2 To note the results of phase 1 of the Mental Health Improvement Project

2.3 To agree that the Council continues to deliver its adult mental health social care responsibilities in partnership with Central and North-West London NHS Foundation Trust (CNWL) in 2014/15.

2.4 To agree that officers will not implement the decision taken in April 2013, to progress with the procurement of mental health services by way of a competitive dialogue process.

2.5 To note that any proposed future procurement or partnership arrangement for the provision of mental health services for adults will return to the Executive for approval.

2.6 To approve a continuation of the transformation work in 2014-15, building on integrated commissioning by working in collaboration with the Brent Clinical Commission Group (CCG), with the aim of moving to a whole person approach to mental health services in 2015/16 in partnership with Brent CCG and CNWL.

2.7 To enter into a short term section 75 agreement with CNWL, to cover the 12 month period from 1st April 2014 to end of March 2015, while work takes place on developing integrated commissioning arrangements with the CCG.

2.8 To approve an exemption from the usual requirements of Contract Standing Orders to carry out a tendering process in relation to High Value contracts, to allow the award of the section 75 agreement referred to in paragraph 2.6, for the good operational reasons set out in paragraph 3.17 and 3.26 of the report.

3. Report

3.1 Phase 1 – Mental Health Improvement Project

3.2 Brent Council spends approximately £7m per year on adult mental health services provided by Central and North West London NHS Foundation Trust (CNWL). The service forms a critical element of the Council's approach to fulfilling its duties under the NHS and Community Care Act 1990 and the Mental Health Act 1983. The service comprises a number of different functions including assessment, brief treatment, care co-ordination, early intervention, assertive outreach, acute, community, and residential care for people with mental health conditions. Brent council staff are integrated into CNWL teams, working alongside other mental health professionals providing integrated mental health and social care services.

3.3 In April 2013 Executive approved plans to progress with a procurement of mental health services by way of a competitive dialogue process for the re-provision of local adult social care mental health services subject to the outcome of community consultation and appropriate market research and testing. There were a number of reasons why this decision was taken –

- There were concerns about the degree to which the service has become medicalised, process-oriented, and insufficiently focused on individual outcomes.
- The need to improve the service's approach to covering the Approved Mental Health Professional (AMHP) function.
- The desire to implement a Recovery Model i.e. place recovery at the heart of local mental health services, increase the degree to which services are preventative and oriented towards the achievement of social outcomes.
- To ensure that the Council's investment in these services is delivering value for money and good outcomes for service users within its resource envelope.

3.4 Before the Executive's decision was implemented, and following representations by CNWL it was agreed that Adult Social Care (ASC) and CNWL would jointly put in place an improvement project for the service provided by CNWL, focussed on five work streams, to determine whether changes could be made to the service to meet the council's ambitions for mental health service provision. The project ran from August 2013 until the end of January 2014. The work streams were:

Work stream 1: Residential Care and Panel Processes

- Implement a recovery pathway which supported people to live independently, thereby reducing by 15 the number of services users in residential care
- Redesign the panel approval process to improve decision making and improve standards of assessment and care planning.
- Increasing alternative options via commissioning (re-aligning the commissioning function which have in the past been split across CNWL and the Council)

Work stream 2: Review of S117/aftercare procedures:

- Carry out a thorough review of service users currently subject to S117 and receiving a funded package of care, and to implement S117 discharge procedures for those service users who no longer need aftercare as defined by the Mental Health Act.

Work stream 3: Review of all Mental Health Act activity:

- Set up robust system of reporting on all Mental Health Act activity, and specifically looking at the use of Community Treatment Orders and guardianship to ensure practice is delivering the least restrictive option.
- To provide assurance that Approved Mental Health Professionals (AMHPs) are effectively using the least restrictive alternative and applying the law correctly.
- To review the level of AMHP provision in the borough and conduct a detailed options appraisal on the deployment of AMHPs within the borough.

Work stream 4: Review of the Employment, Welfare and Support Team

- Conduct a detailed options appraisal on the future of the Employment, Welfare and Support Team to understand the degree to which the team is supporting people to be independent.

Work stream 5: Improving the reporting framework:

- Set up a robust financial and performance reporting framework, which will ensure that monthly reports are consistent and the historical data does not change from one period to the next.

3.5 Although a final evaluation of the project and closure report needs to be written, the consensus amongst officers is that the project has been a success. The working relationship between the council and CNWL has improved significantly and benefited from the investment of resources in the five work streams. It should also be noted that the input of the CCG has been important to ensure the health perspective to this project is clear and that developments between the council and CNWL are shared with health sector commissioners. Improvements have been demonstrated in a number of areas.

3.6 Project Outcomes

3.7 **Residential Care and Panel Processes** – After a comprehensive assessment and support planning process, eleven service users have been supported to move from residential care to supported or independent accommodation during the project. The number of residential placements at the start of August was 59. The number at the end of December was 50. This is a net reduction of nine due to two moves into residential care during the course of the project. It is expected that by the end of January there will be 47 service users in residential care. By the end of March it is likely there will be as few as 40 service users in residential care, depending on the speed with which supported accommodation units become available. Work will continue to ensure a further reduction in residential placements throughout 2014/15, because this is to the benefit of service users who will continue their recovery supported in the community, and it will reduce costs for the council.

3.8 Through closer working between the Council's director of Adult Social Care, ASC Commissioning, Housing and CNWL staff, new accommodation options have been opened up to CNWL care coordinators, including the use of social housing and private sector accommodation. The importance of step down from residential care, and a culture of supporting service users to become less dependent on services has been reaffirmed and CNWL and the council have demonstrated a willingness to work in partnership to embrace this challenge and work with service users and carers at different stages in their recovery to ensure they are in the least restrictive environment and have the support to regain their independence.

3.9 As well as improving step down processes, the number of new residential care placements has reduced. Between April and August 2013, nine service users moved

into residential care. Since August the number of residential care approvals is two. This is partly because the Funding Panel, which approves placements, has taken a different approach with requests for residential placements (challenging allocated workers to support people to live in the community, rather than defaulting to institutional care), but mainly because care co-ordinators are already seeking alternatives before requesting a residential placement. The change in working practice is starting to take hold and this is being seen in places like Funding Panel.

3.10 Panel processes have also been redesigned to better fit the council's aim to implement the Recovery Model, improve accountability and clarity around decision making and make it clearer to care coordinators what is expected of them in terms of assessment and identifying needs. There will be one panel which will consider all social care cases, and review placements on a regular basis – all new placements will be reviewed within three months to ensure that the service user is moving towards recovery. Cases where there are joint funding implications for the CCG will be passed to a joint panel with council and CCG representation. New arrangements will be implemented from April 2014.

3.11 **Section 117 –** There is a duty under section 117 of the Mental Health Act to provide free aftercare services to certain patients who have been detained under the Mental Health Act until the council and CCG agree that the service user no longer needs it. However, a practice of not reviewing and discharging from Section 117 is in place in Brent and across the country, which inhibits supporting people to move back to full independence away from statutory services. Progress on discharge or variation of s117 services hasn't been as advanced as hoped at the beginning of the project. However, this needs to be seen in context. Despite slow progress with this work stream Brent is leading the way in London in attempting to address s117. No borough appears to have a set procedure for s117 discharge and Brent has put in place the changes to working practice that should enable progress on this beyond the life of the project, including agreeing jointly with Brent CCG a discharge policy. The actual process of discharge involves complex liaison between care coordinators, psychiatrists, service users, families and carers. Care coordinators and psychiatrists have to agree that it is in the service user's interests to vary or discharge s117.

3.12 **Mental Health Act -** Approved Mental Health Professionals (AMHPs) are responsible for Mental Health Act assessments, when it is considered that someone needs to receive assessment or treatment in hospital for serious mental disorder. It is the AMHP's duty, when two medical recommendations have been made, to decide whether or not to make an application for the detention of the person who has been assessed. This is a local authority responsibility, carried out by AMHPs who work for the council, but who are based with CNWL. There had been concerns about consistency of service and difficulties implementing the AMHP back up rota. A service improvement plan for the AMHP service has been completed (and jointly agreed) and the recommendations will be implemented up to April 2014, which will resolve the identified issues.

3.13 **Employment and Welfare Support Team** - An options appraisal for the Employment and Welfare Support Services provided by CNWL has been carried out and a decision is to be made as to whether the recommended changes are implemented. The options appraisal has identified ways the council can reduce duplication of activity, deliver savings and increase care coordinators focus on personalisation.

3.14 **Reporting Framework** - Performance and finance information is improved, in terms of accuracy and relevance to service performance. Performance information is more

consistent, and isn't being retrospectively updated month to month. The Section 75 meetings provide a monthly forum where service performance issues are picked up and challenged. There are robust finance monitoring meetings in place, where service managers are held to account on spending and budget forecasting.

3.15 More generally, the project has helped to identify that there are significant issues with the quality of core assessments of service users' needs, which has an impact throughout subsequent delivery of mental health services. The importance of good quality assessment can't be overstated, as the core assessment forms the basis of the care plan and ultimately the services received by service users. Getting this wrong at the start can have implications which can take some time to work through and can be significant.

3.16 Additionally, the project has opened up other issues connected to the relationship between CNWL and the council, and in particular which organisation is responsible for which part of the service. Previous Section 75 and monitoring arrangements were focused on assessment and care management services only, which were the responsibility of CNWL. The project has confirmed that there wasn't clarity around commissioning arrangements – this is a common issue which has also been identified as part of the London Mental Health Section 75 project. The council has largely been taking responsibility for commissioning without working closely with CNWL, and CNWL using a panel process to place service users in the services that exist rather than challenging ASC commissioners to provide what is required. However, in working through the residential moves work stream, there needs to be greater clarity about the role of commissioners (currently in ASC) and care coordinators (some of whom are Council care management staff seconded to CNWL) and closer working to ensure the Council has secured the availability of the services and support the service users need, rather than simply what currently exists.

3.17 Given the project will deliver many of the outcomes and changes hoped for when it was established, the question for the local authority is how it takes forward its relationship with CNWL and whether the Executive decision from April 2013 needs to be revisited. On the basis of the evidence from the phase 1 project (that the council and CNWL are able to work together to deliver agreed outcomes) officers recommend to the Executive that the decision to go out to competitive dialogue to re-procure the service isn't implemented and instead a different approach to mental health improvement is put in place. Further detail of the three different options considered before recommending this approach are set out in paragraph 3.26.

3.18 Phase 2 – Mental Health Improvement

3.19 It is important to consider the critical success factors the council wants to achieve going forward into phase 2 of this project. Firstly, the progress that has been made on a recovery pathway, which put service users, their individual outcomes and independence at the heart of practice, has been significant. In Phase 2 we would want to build on this, working even more closely with service users and carers to redesign services to meet these objectives.

3.20 Secondly, it is crucial that however the service is redesigned there needs to be clearer managerial accountability in the borough – local must be sovereign and borough management must take precedence over service line management. CNWL's service line structure doesn't always assist with this goal and it is something the council feels needs to be addressed.

3.21 Thirdly, there needs to be greater clarity around roles and responsibilities within teams and how the council is able to influence the operation of staff in an integrated service. This is best illustrated using a training example – the council can instruct its own staff to attend assessment training or s117 training, but can't require all care coordinators to attend as not all are employed by the council. One concern this creates is that CNWL health staff are fulfilling social care functions on the local authority's (LA) behalf, but they are not trained to the LA standard. Clarity around roles and responsibilities would help to resolve these types of issues. Joint commissioning between health and social care is one way of doing this.

3.22 Finally, ASC staff working within CNWL by secondment work to a different model to ASC staff in the Council's ASC department. ASC seconded staff are both care co-ordinators (assessors and care planning) and service providers (delivering what is called professional support, directing services in a non-quantifiable way to their customers). The council's approach to social care is focused on social work staff providing assessment and care planning, and then commissioning other organisations to deliver services, so that the services and support delivered are quantifiable and there are clear review periods. The Council believes that this approach could be replicated for mental health services, and would reduce costs and improve outcomes by giving services users access to a wider range of services and support.

3.23 From the outset of the phase 1 Mental Health Improvement project it was clear that a phase 2 would be required. The phase 1 project was limited in time and scope, and both the council and CNWL are committed to further service improvement and the implementation of the Recovery Model. Funding is a significant issue that will need to be addressed in phase 2. The mental health service has previously had an overspend of approximately £1m per year. Although steps have been taken to reduce this, an underlying overspend persists. The Council needs reassurance that the social care mental health service is clearly focused on its priorities and is delivering value for money in line with those priorities. Changes to services are inevitable, but there is a belief among partners that those changes can be transformational to meet the demands of service users and the financial pressures the council faces.

3.24 As a result of joint working, the overspend stood at £0.377m at the end of month 9, which is a significant reduction on where it has been, and is part of an ongoing downward trend (see table below). This has been achieved despite the trend for additional placements in the period up to the start of the project. The project has ensured a shift away from using residential placements and had a significant impact in terms of cost avoidance.

Mental Health	**2013-14**
Overspend at beginning of 2013-14	£996,467
Savings achieved to date	-£820,232
Additional cost pressures identified during the year	£363,337
Forecast position month 9	**£376,961**

3.25 There is also work which will continue to be delivered through to the end of the year with the expectation of further reducing this overspend, particularly the ongoing focus on reducing residential placements. Phase 2 will be a fundamental redesign of services, but Phase 1 has already identified some key areas on which to build.

3.26 In taking forward phase 2 there are three ways that the council could take forward phase 2 with CNWL and the CCG. In summary they are:

1. Redesign Mental Health Social Care

The council and CNWL could design a phase 2 project on the same basis as Phase 1: focused on social care, but maintaining CCG involvement. Within this option there are three broad approaches to improvement –

- A straight procurement, using the competitive dialogue approach or a more traditional tender process.
- A joint re-design project which leads to a new Section 75 agreement between the council and CNWL
- Bring social care staff back into the council and manage them directly.

The phase 1 project was established to show that the council and CNWL could work together in partnership to deliver improve the services we commission and provide, and deliver some discrete outcomes – in this regard it can be considered a success. Procuring with a different provider, as originally agreed, would not be in the borough's best interests because of the potential disruption for service users and the loss of transformational work that has already taken place. There would be significant challenges in re-procuring a service of this nature because of the lack of alternative providers in the market. It would lead to fragmentation between services because the CCG has no plans to change provider, and goes against the principles of integration which are central to national health and social care policy and Brent's successful Pioneer Bid. Additionally, health and social care integration is a local priority in the Health and Wellbeing Strategy. Partnership working is a better way to deliver closer integration with the CCG and improving mental health services in the borough. In short, this option is not recommended to the Executive.

2. Redesign Mental Health Social Care and Secondary Mental Health Services

The council, CCG and CNWL could re-design and commission existing mental health services together using an agreed methodology and commissioning framework. Despite the teams and job roles at CNWL being fully integrated, commissioning of mental health services is separate at the moment – the council commissions mental health social care, the CCG commissions the secondary health components of mental health services.

In choosing this option the likelihood is that the council and CCG would focus on the current services rather than commissioning new services. Arguably this would be a service improvement project rather than service transformation. However, the potential to achieve improvements is considerable as well as deliver budget reductions. For example, staff would have one set of demands from health and social care, rather than aligned, but separate demands that they face currently. An integrated work force plan could be put in place to deliver a jointly commissioned service to deliver agreed outcomes. Joint

commissioning is also likely to be supported by CNWL, which would benefit from a single approach to mental health commissioning in Brent.

3. **Whole Person Care (Primary Care, Community Care, Secondary Mental Health Services, Social Care and Public Health)**

   It is known that mental health service users are often non-compliant with treatment that has been put in place for their physical health needs. Diabetes care is a common example in North West London. Non-compliance with treatment, combined with long term needs that are a consequence of medication to treat mental illness, has led to a 25 year gap in life expectancy between those receiving secondary mental health services and those that aren't. This is unacceptable, but it is a problem that persists.

   A whole person care approach would give the council, CCG and providers an opportunity to really tackle this issue. A system could be established, using capitated budgets, that makes one organisation responsible for all health and social care needs for people with a sever and enduring mental illness. The combination of providers that may be working with a service user – GP, mental health trust, social services authority, acute provider, private provider, community health provider etc., is confusing for the service user and the organisations involved. Whilst there are working relationships, no one organisation is responsible for the totality of the care that the individual receives. As a result, problems persist, service users disengage and a vicious circle is created where the health problems of the individual are getting worse, whilst the solutions being put in place to help them are ever more complex.

   An approach, building on the successful North West London Whole System Integrated Care Programme, which the council and CCG are a part of, could be used to transform the care provided for those with mental health needs. This work requires participating organisations to choose areas of focus and priorities for integration. Mental health is on a long list of initial ideas, but could be worked up in more detail and put forward as an Early Adopter in this programme.

   This option gives the council and CCG a significant opportunity to look beyond mental health services, and improve the physical health of mental health service users, capitate health and social care budgets for people who have a severe and enduring mental illness. An integrated care approach could help to develop a new and innovative service that offers greatest scope and potential for service transformation and budget savings and make most difference to peoples' lives.

   This approach would be the most complicated to deliver and contains the most risk, but it does have the potential to provide the greatest rewards. It needs to be acknowledged that the biggest risk would be for the CCG, as a much greater portion of health budgets (not only the current secondary mental health budgets, but also primary and acute budgets) would be required to make this work. However, the opportunity to make one organisation accountable for the well being of a person with mental health needs is an exciting one and would be ground breaking nationally. It also ties in with the borough's health and wellbeing strategy, particularly the ambitions to improve mental wellbeing throughout life and working together to support the most vulnerable adults in the community. The latter priority is centred on health and social care integration.

3.27 All of these approaches have their benefits, and all could lead to service improvement and budget reductions. The scope to have a significant impact on

individual lives, tackle enduring health inequalities and realise efficiencies is significantly greater for option 3 than options 1 and 2, but the level of risk is higher (especially for the CCG as their budget for Mental Health services is much larger than the Council's) and deliverability more complicated. But, health and social care integration is the accepted way for forward to transform services and the success of the Pioneer bid and the subsequent development of the Wholes Systems for Integrated Care programme, gives Brent an opportunity to bring about transformational change to mental health services, assuming a project can be scoped that it is acceptable to the council, and CCG. This is a prime opportunity to make a transformational change to services and one that the council is keen to embrace.

3.28 Commissioners and providers (the council, Brent CCG and CNWL) are committed to work with service users and carers to deliver service transformation through integration of commissioning and delivery of mental health services. However, it is recommended that this is done in a phased approach based on options 2 and 3 set out above. The Executive is recommended to approve that the council continues to deliver its mental health social care responsibilities in partnership with CNWL, but that in 2014/15 it works in collaboration with Brent CCG to jointly commission mental health and social care services in Brent. In 2015/16, assuming a joint commissioning framework has been agreed and implemented it is recommended that the work is developed around the whole person care approach, set out in option 3, which will bring benefits to the mental and physical health of service users.

3.29 In approaching improvement and transformation this way, the council and partners can build on the achievements from phase 1 of the project, in particular the increased focus on the Recovery Model, and deliver a service which is absolutely focused on the promoting independence and delivers an individually tailored approach to supporting people to achieve the outcomes that enable them to regain their independence. The work that has started to support people to move from institutional care, to supported living to general needs housing will continue. as this is a fundamental part of the recovery pathway, in that service users are living in placements in the community which is better for them than being housed in a residential unit. Implementation of the recovery pathway will be at the heart of phase 2 and will guide the council's approach to integrated commissioning and whole person care.

3.30 Because of the phased nature of this work, and the transformational nature of these projects, it is recommended that a progress report is presented to the Executive in July 2014 to update members. An update report will include details that need to be agreed with the CCG and CNWL on how an integrated commissioning project should look, including the areas of focus for integrated commissioning, the practicalities and timescales for implementation and the agreed outcomes that all sides will be looking for from this project. Whilst all sides have given a commitment to this work, the details do need to be agreed. However, the project outcomes and key success factors outlined above set out some of the areas the council could seek to address.

3.31 There are implications with not progressing with the Executive's original decision to retender for mental health social care services, using a competitive dialogue process. In working in partnership with the CCG and CNWL on a plan to integrate commissioning in line with integrated delivery, the council is not required to retender for this service. Setting up a partnership arrangement is recognised within Contract Standing Orders and members are able to agree not to pursue a competitive dialogue. However, it is important that there are clearly identified benefits from

entering into a partnership arrangement, as proposed. Many of the benefits are already set out in the report, but in summary they are:

- To minimise disruption to service users
- The opportunity to build on the transformational work already undertaken
- It is in pursuance of duties imposed on local authorities to work in partnership with health bodies in their area
- Partnership working is a better way to deliver closer integration with the CCG
- There is a lack of alternative providers in the market, and potentially disproportionate costs for another provider(s) to set up in Brent
- The decision not to tender will be reviewed at regular intervals

3.32 In order to ensure that the existing arrangement with CNWL is on a firm legal footing, it is recommended that a section 75 agreement is agreed with them for a relatively short period, e.g. 12 months and will include further joint working and close monitoring of service improvement whilst the re-commissioning work takes place. By agreeing to a short term section 75 agreement, both parties have the reassurance that they are committed to working together in partnership and that they will progress the integrated commissioning and ultimately whole systems approach as set out in this paper.

3.33 Conclusions

3.34 The Mental Health Improvement Project that the council and CNWL have set up has demonstrated on a small scale what can be achieved if organisations are prepared to work collaboratively on service improvement. What has been clear to the council, Brent CCG and CNWL is that the phase 1 project is just the beginning of a much more comprehensive piece of work to transform and improve services, and inevitably, look for greater budget savings from the service. How the second phase of work is taken forward will be crucial in determining the extent of the improvements and savings that can be made.

3.35 The Whole Systems Integrated Care programme approach, whilst still in development, provides an opportunity for the council, CCG and CNWL to do something innovative around mental health service improvement, focussing not only on mental health but the physical health of service users as well. However, to take this forward the council, CCG and CWNL have to agree that this is the approach they wish to take. The council and CNWL believe that a second phase is needed based on joint commissioning of mental health services, and that in addition the current service provision by CNWL is under-pinned by a one-year section 75 agreement pending more scoping work with the Brent CCG.

4. Legal Implications

4.1 The Council has a statutory obligation to complete assessments and put in place appropriate community care services for those with mental health needs in their area. The Council must also ensure that there are sufficient Approved Mental Health Professionals (AMHPs) to conduct assessments under the Mental Health Act 1983. Under the Care Bill currently going through Parliament it is intended that the Local Authority will have a duty to exercise its functions with a view to promoting integration of health and social care provision where this will improve quality of care and support and promote the well-being of individuals in their area (s3 Care Bill). The aims set out within this report of phase two should enable the Council to better achieve these aspirations, all the more so should they become law.

4.2 Presently CNWL are commissioned to provide services on behalf of the council in line with a memorandum of understanding. This is not a formal agreement under section 75 of the National Health Service Act 2006 and regulations made thereunder, however it would count as an arrangement made in pursuance of that section. Section 75 allows local authorities and health bodies to enter into various arrangements, including pooled budgets and partnership arrangements, if these are likely to lead to an improvement in the way that the respective functions of those bodies are exercised. Under Contract Standing Order 85, partnership arrangements require the use of a written agreement as well as approval from the Chief Finance Officer. In addition, partnership arrangements of this type require Executive approval, because there is a delegation of the Council's functions to CNWL, and here the Executive are being asked to approve a one year section 75 agreement to document the current service. Phase 2 of the improvement project will require consideration of the basis for any new s75 agreement if it is intended that CNWL or an alternative external service provider conduct assessments and commission services on behalf of the Council.

4.3 Where a partnership arrangement is approved under Contract Standing Orders and the arrangement includes the delivery of services by the health body, then an exemption from Contract Standing Orders, relating to the usual requirement to tender such services, is required. As indicated in the recommendation, such an exemption can only be granted where there are good financial / operational reasons for doing so.

4.4 There are no legal implications flowing from the recommendation not to implement last year's decision about carrying out a procurement exercise by way of competitive dialogue, as the procurement did not commence.

5. Finance Implications

5.1 Brent Council spends approximately £7m per year on adult mental health services provided by Central and North West London NHS Foundation Trust (CNWL). The service forms a critical element of the Council's approach to fulfilling its duties under the NHS and Community Care Act 1990 and the Mental Health Act 1983.

5.2 The mental health service has previously had an overspend of approximately £1m per year. Phase 1 of the project put forward an efficiency programme that set out to reduce the overspend. As a result of joint working, the overspend stood at £0.377m at the end of December 2013, which is a significant reduction on where it has been, and is part of an ongoing downward trend (see table below). This has been achieved despite the trend for additional placements in the period up to the start of the project. The project has ensured a shift away from using residential placements and has had a significant impact in terms of cost avoidance.

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5.3 Phase 2 will build on this work through a stronger focus on reducing residential placements as well as a fundamental redesign of the service. The recommended option is for a 'whole person' care approach that makes one organisation responsible for all health and social care needs for people with a sever and enduring mental illness. An integrated care approach could help to develop a new and innovative service that offers greatest scope and potential for service transformation and budget savings and make the most difference to peoples' lives. Because of the phased nature of this work, and the transformational nature of these projects, it is recommended that a progress report is presented to the Executive in July 2014 to update members and clearly set out the financial implications of this option. An update report will also include details that need to be agreed with the CCG and CNWL on how an integrated commissioning project should look, including the areas of focus for integrated commissioning, the practicalities and timescales for implementation and the agreed outcomes that all sides will be looking for from this project.

5.4 Any additional costs incurred in a 12 month extension of the Section 75 agreement with CNWL to 31/03/2015 will be met from existing budgets, specifically from the full year effect of savings made in 2013/14.

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