Brent	**Cabinet** **27 July 2015** **Report from the Strategic Director of Adults**
	Wards Affected: ALL

Brent Mental Health Operating Model and Section 75 Agreement

1. Summary

1.1 This report sets out the outcomes of the Mental Health Operating Model work, which has been undertaken in partnership with Central and North West London NHS Foundation Trust (CNWL) and NHS Brent CCG to develop a new assessment and care management model for community mental health services in Brent. It explains the thinking behind the new operating model and how it fits into the broader mental health system and the wider work on mental health improvement that is taking place in North West London.

1.2 The local work on mental health improvement has been taken forward in a joint project involving CNWL, Brent CCG and Brent Council. The focus of this work has been on commissioning mental health services in the borough, restructuring community mental health services and improving access to accommodation for mental health service users so that they can reintegrate back into society and be supported to live independently. It is important to acknowledge that inpatient services were out of scope for this work, and that the focus of the work has been on services for adults aged 18-65.

1.3 Finally, the report seeks members' approval to extend the Section 75 agreement between the council and Central and North West London NHS Foundation Trust for a further 12 months, for the delivery of mental health social care services.

1.4 It should also be noted that while the work outlined above was being undertaken, CNWL underwent an organisation wide Care Quality Commission (CQC) inspection. The overall rating for the Trust was 'requires improvement'. The nature of the inspection makes it difficult to extrapolate issues specific to Brent Community Mental Teams, the focus of this report. The only specific reference is to insufficient care co-ordination resource within these teams, which is one of the areas this model seeks to address. (A more detailed overview of the inspection findings are included at Appendix1)

2. Recommendations

It is recommended that the Cabinet -

2.1 Notes the work of the Brent Mental Health Improvement Project to date

2.2 Endorses the emerging Brent community mental health service operating model and approves the move towards implementation

2.3 Endorses a move towards joint commissioning with Brent CCG of community mental health service teams and mental health services commissioned from the voluntary sector

2.4 Approves the extension of partnership arrangements with Central and North West London NHS Foundation Trust by entering into a 12 month partnership agreement under section 75 National Health Service Act 2006 for the delivery of mental health social care services.

2.5 Approves an exemption from the usual requirements of Contract Standing Orders to carry out a tendering process in relation to High Value Contracts to permit the council to enter into the partnership agreement referred to in Recommendation 2.4 for the good operational reasons set out in paragraphs 3.54 and 3.56 of the report.

3. Report

3.1 Introduction and Context

3.2 Brent Council and Brent CCG spend approximately £48m 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 statutory duties under the Mental Health Act 1983, the NHS and Community Care Act 1990 and the Care Act 2015, and CNWL are a key provider for the CCG. 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.

3.3 Brent Council staff are seconded and integrated into CNWL teams, working alongside health staff to provide mental health and social care services. However, this does not fully reflect the reality on the ground as CNWL, and therefore the integrated teams, are commissioned separately by Brent Council and Brent CCG. In other words, there are integrated teams working to deliver 'un-integrated' commissioning intentions. Brent Council has a Section 75 partnership agreement with CNWL to deliver services. The CCG commissions CNWL to deliver mental health services via a contract agreed with four other CCGs. The different commissioning arrangements add an extra layer of complexity to the working arrangements.

3.4 The council, Brent CCG and CNWL are committed to continuous improvement in mental health services. A service transformation project has been developed by all three organisations to drive improvement in services locally. The council, CCG and CNWL have built a strong partnership over the last two years which is being further developed by the transformation project. The underpinning objective of the project is to strengthen the partnership between the three organisations as a necessary precursor to delivering the changes that will make a difference to the lives of the people of Brent. This means building a relationship which is focused on a shared

understanding of what makes a difference to people's lives and a commitment to work with service users and carers to deliver evidence based change and improved outcomes for individuals with a focus on recovery.

Care Quality Commission Inspection

3.5 CNWL has recently been subject to an organisation wide inspection by the Care Quality Commission. The inspection was primarily focused on health services as social work is not an inspected service. However, Brent Council social workers are part of the Community Mental Health Teams, so it is relevant to the council, and to this report.

3.6 Although there were areas of good and outstanding practice identified, overall the trust was given a "requires improvement" rating. The strengths of the service relating to Brent identified in the inspection relate to the use of peer support workers and engagement with service users and their family. The main issues highlighted in the Brent Community Mental Health Teams were access to physical health checks and defibrillators and the number and responsiveness of care co-ordinators. This latter point is being addressed directly by the MH operating model work set out in this report, which has looked closely at service capacity and care coordinator numbers. The new model will help to ensure that the Community Mental Health Teams has the capacity to manage effectively the service users in their care.

3.7 Whilst the overall rating was disappointing, the council is committed to continuing its partnership arrangements with CNWL and delivering the improvements required. The transformation projects and the work on the operating model are evidence of the desire to seek continuous improvement within the service, something the council will continue to drive with CNWL and Brent Clinical Commissioning Group for the benefit of Brent residents.

3.8 The better outcomes that the project is seeking to achieve will be delivered through two fundamental changes:

- The project will build on the social care 'Recovery Pathway' to deliver a full implementation of a health and social care 'Recovery Pathway'. This will mean further work with partners to embed the key elements of the pathway and to align this with the health agenda 'Shifting Settings of Care' to ensure there is a single approach to recovery, which supports people with a severe and enduring mental health illness to lead independent lives in the community (and evidences a significant reduction in the use of institutional care).

- There will be a comprehensive review of the integrated community teams in order to design and implement a new operating model for community mental health services. The aim will be to ensure these teams are designed to deliver the health and social care 'Recovery Pathway' and that Brent has a true recovery model in its mental health services that also meets our statutory requirements.

3.9 There are a number of reasons why work on the operating model is considered necessary and why now is an appropriate time to be doing this work, not least the financial challenges facing all three organisations. Brent Council has to save £750,000 from its mental health social care budget over the next two years. The operating model work will help the service deliver £350,000 of savings from the Adult

Social Care budget between 2015/16 and 2016/17. CNWL has a savings target across the organisation of £45m, to be achieved by April 2016. Locally, the operating model is expected to help the Brent service save £1.2m in health service savings and help to fund a Single Point of Access for North West London.

3.10 There are also a number of related projects which will have a significant impact on any changes made to the mental health operating model that are in development and moving towards implementation. Understanding the interfaces with local community services is crucial. The key projects and interfaces are summarised below -

(i). North West London Single Point of Access

The NWL single point of access (SPA) will provide 24/7/365 access to CNWL's adult mental health services replacing existing local borough based referral points into the service. Access to services will be coordinated from a centralised entry point. The process of ensuring that the right person gains access to the right service should be faster and leaner, releasing secondary care clinical capacity to where it is needed most along the care pathway. Around 25 staff will work in the SPA, primarily made up of Band 6 nurses, admin support, a manager and a part time consultant psychiatrist. The SPA will provide an enhanced Urgent Advice Line (UAL) service with greater functionality and access to appointments. Service users will have access to the 24/7/365 SPA via one phone number. GP's will be able to contact a team of clinical staff (including a psychiatrist) to discuss potential referrals or shared care. The team will process emergency, urgent and routine referrals and tele-triage calls, signposting to appropriate services either within CNWL or to other statutory and third sector providers.

(ii). Shifting Settings of Care and Primary Care Plus

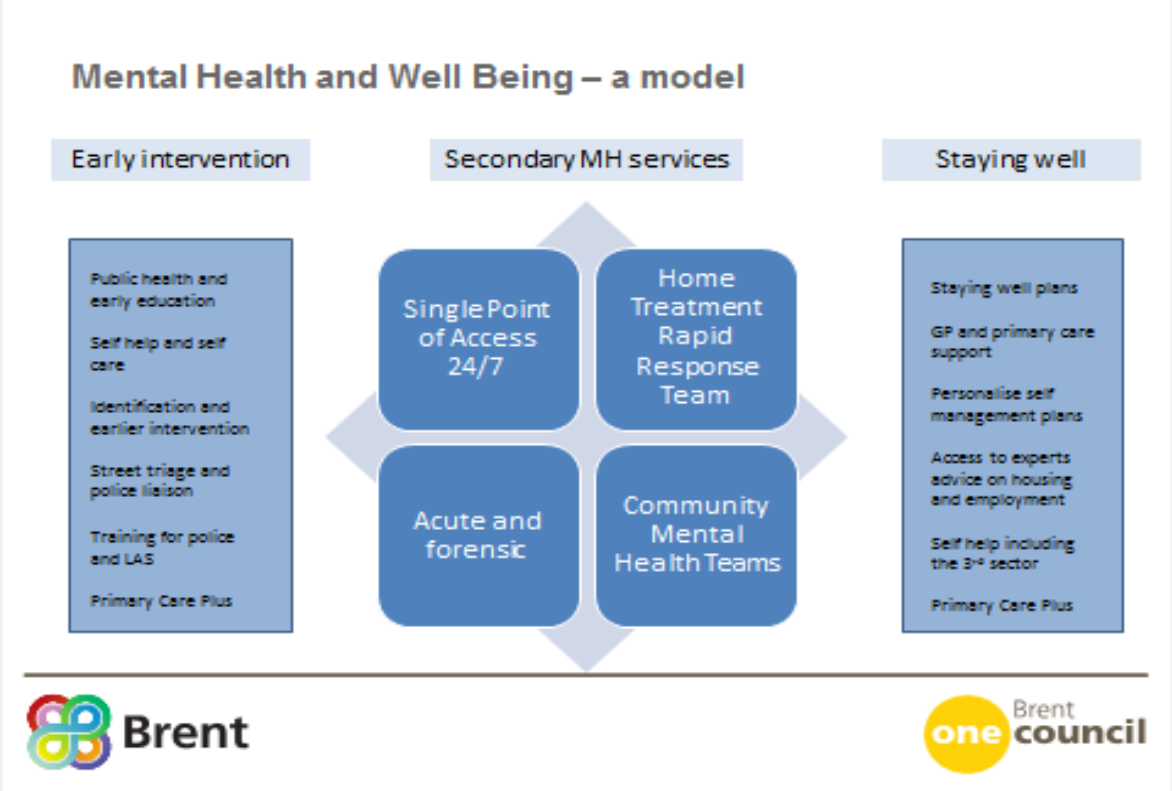
Brent CCG is part of a collaboration of North West London CCGs (NWLCCGs) implementing the 'Shaping Healthier Lives' strategy. This identified significant numbers of people in secondary care who could manage their own condition better in primary care (shifting settings of care), some of whom might require additional low-intensity support (primary care plus). In working to develop a new operating model for community mental health services, CNWL and the CCG have identified around 250 people who are potentially eligible to transfer to primary care in 2015/16, where they will receive support from the Primary Care Plus service.

The CCG's aim is to reduce the caseloads in secondary care by putting in place sufficient support and capacity to prevent people going into secondary services in the first place, and to assist with discharge out of services back to primary care. Primary Care Plus will form an integral element of the care pathway for mental health service users. For GPs, it will be a point of reference prior to any referral via the single point of access, helping to provide care and support to service users for a defined, short period of time to prevent acceleration into secondary services. The population eligible for PC+ will need to be agreed, along with the clinical presentations that will be covered by the service.

At the other end of the pathway, CNWL have identified service users who are ready to be discharged from secondary services. Reducing the numbers of people in secondary, community based services, will be essential if the revised community service operating model is to work within capacity limits. Understanding who is to be discharged and what their clinical presentation is will be crucial. Further work as part of the operating plan development has just begun, with the focus on length of stay in the service. Analysis has shown that fifty three percent of service users under the

care of the existing CNWL Recovery Team have been in services for five years or longer. Understanding which service users could be discharged and their diagnosis will be an important element of implementing the new operating model. Although this work has been initiated as part of the operating model work, it is contributing to the aims of shifting settings of care – it shouldn't be seen as a separate piece of work.

3.8 The development of the new community service operating model along with additional changes happening in the mental health system will have a transformative effect on services. It is important to understand that the changes to services, including the new operating model for community services, are not happening in isolation. The diagram below shows that community services are part of a wider network of services, and changes in one area will have an impact on another. This is why the developments of the Single Point of Access and Shifting Settings of Care work is happening at the same time as the changes to community services, and that these changes should complement each other.



3.9 Community Mental Health Services in Brent

3.10 In developing the new operating model external changes happening to services across North West London have been considered and the model has been designed with these changes in mind. What is proposed is in line with the changes that are emerging from the work on the single point of access for mental health services and the CNWL transformation programme. However, Brent cannot afford to wait until all other work streams are complete before starting to make changes particularly in terms of proposals for community teams. In this regard we are ahead of other boroughs. The changes to the operating model are in line with prevailing ideas for mental health, and are about making the service work in a more efficient way, improving social care support, refocusing on outcomes, recovery and good practice and putting in place a more manageable structure.

3.11 Changing the community operating model isn't an especially radical step. The purpose of the new model is to make the service work in a more efficient way with effective interfaces with the other elements of the mental health system – Primary Care Plus, the single point of access, Home Treatment and Rapid Response (when it's developed) and acute services.

3.12 Developing the Operating Model

3.13 In developing options for change, it was felt important to articulate a number of drivers for the new service which have emerged from engagement with service users and staff. These factors have been taken into account when putting together the new model as they set out what would be expected from highly performing integrated community mental health and social care service -

3.14 Service user feedback -

- The service needs to be genuinely holistic, taking into account all health and community support needs.
- The service needs to be person-centred, with the service user setting their own goals.
- Better information should be available at the point of referral about what services are available, and how they are accessed.
- Assessment and Brief Treatment needs to be improved – assessments aren't timely enough and brief treatment is not always provided.
- Community services for those who are not in acute crisis need to be improved so that support doesn't drop away when an individual's mental health starts to improve.
- The service needs to be better linked with the third sector in order to address broader needs.
- There needs to be clear information for service users on what they should do if they go into crisis and they need emergency support.

3.15 Service users also felt quite strongly that they would benefit from having a consistent care coordinator throughout their care if possible. Whilst it is understood that changing care coordinator can be disruptive, particularly if it happens on a regular basis, it will be difficult to deliver a model that ensures service users have the same care coordinator throughout their time with secondary mental health services. What is important though, is that the care coordinators with the right skills to most help a service user recover is allocated the case – better case allocation is something that will be achieved from the new operating model.

3.16 Staff feedback –

- There should be fewer handoffs between teams and service users should move less between teams.
- There should be clarity around third sector services in Brent and how service users can access them.
- The single front door, with senior people carrying out the first assessment, should be more effective than it currently is where services find they are "playing catch up" with the core assessment – eliminate the need for more than one assessment.
- Bureaucracy should be reduced in the new model

- The advantages and disadvantages of generic care coordinators should be considered – new skills have been learned, even if social care assessments aren't as good.
- The continuity of care should be improved.
- Staff may feel unsettled if they don't like the new structure – Brent already has recruitment and retention issues
- The service should have sufficient capacity to manage demand
- Links to other services, such as Housing, need to improve
- Effective discharge planning with service users is essential.
- The implementation plan has to be well thought through. The impact on service users has to be considered as services are reorganised and staff moved around.
- Ensure specialist functions aren't lost in the reorganisation.
- Interfaces shouldn't be replicated elsewhere, such as between Primary Care Plus and the secondary service.

3.17 There is little in the service user and staff feedback to disagree with, but there are other areas where the new model has to make a difference. Easy access to the service is crucial. The single point of access has been developed with GP endorsement, but what happens once a referral is made and passed to community teams is just as important. The timeliness of response is crucial and ensuring that resources are there to provide an emergency face to face service if needed is important. The community service will have to respond to this challenge until options for a Home Treatment and Rapid Response service are brought forward and service standards around speed of response will need to be set. There are also other changes to the local offer which are being proposed to improve service access, which are set out in the details below.

3.18 Changing the culture within the mental health service

3.19 Changing the operating model and the size and structure of teams will help to improve services, but this also needs to be accompanied by changes to culture and working practices if there is to be genuine transformation. As well as making changes to the teams staff work in, work will take place with staff to change the way they work. There is more to do in terms of changing what people do, as opposed to the teams they work in. Ideas which need to be taken forward include –

- Better recognition of social breakdown and the contribution it has to a person's mental health at the initial assessment stage. Multi skilled workers are required, people who can perform a health and social care role and recognise when social factors are the cause of mental ill health. There needs to be a range of services available for staff to refer people to so that social issues are addressed, rather that in the absence of anything else, people have to be accepted into the secondary service. Referrals to supporting people services, day services, the use of direct payments, third sector and peer support services have to become the main tools for the service and available to staff for their work with service users. Commissioning these services to improve the mental health system will be essential.
- The service should focus on a period of intervention, not on keeping cases open indefinitely. Developing and implementing a recovery pathway, where people are not kept in the service indefinitely in case they should relapse, will be central to the new model. There will be a strong focus on outcomes, which services users will be encouraged to work towards during their time in the secondary service. The service will not be judged on time spent with service users, but on the results it delivers.

- Named case workers should be allocated to the most difficult cases so that there is a clear contact and named person to call if there is a problem with a particular service user. Accountability for cases will be clearer.
- Better management of urgent referrals is a key priority and, with staff, plans will be put in place to help prevent a backlog of referrals building up as they have in recent months.
- For people discharged to Primary Care there will be, for an agreed period of time, the ability to get support from secondary services without having to re-refer back to the SPA. Links to primary care need to be improved, to bring about a more cohesive mental health system. The community mental health service will only work effectively if its links with other parts of the system are effective.

3.20 The New Operating Model

3.21 The current community mental health service carries out a range of functions relating to the assessment, treatment and care management of people with complex mental health problems. The service has been structured along a service line basis, based on service lines created within CNWL. In summary, the existing teams in Brent do the following –

Assessment and Brief Treatment Team – This team provides a single point of entry/access, including an initial assessment, to the Brent Mental Health Service. The team provides short-term, multi-disciplinary interventions over the course of six to twelve sessions, at which point the service user is either discharged back to their GP or referred to another team within the service for further treatment.

Recovery Team - This team works with individuals who have severe and enduring mental health problems. Service users are supported to identify and achieve personal goals e.g. returning to work/college, self-managing their condition etc. Generally people under the care of the Recovery Team are living independently in the community, although a small number live in mental health accommodation services, including SP funded services.

Rehab Team - This team works with service users with complex mental health needs who have been discharged from acute services and are in need of rehabilitation, residential care or supported accommodation and help towards independence.

Assertive Outreach Team (AOT) - AOT is an outreach service for individuals with complex mental health and social care needs, who are particularly difficult to engage with services.

Early Intervention Service – The EIS provides works with people under the age of 35 experiencing a first episode of psychosis.

3.22 In developing a new operating model for the service, it was agreed that it was important to create a model where teams are smaller, more manageable and have a clear remit. The current Brent Recovery Team has over 50 people, which is too large to manage effectively. Creating a model based around the Recovery function, but split into two network groups will enable management and supervision arrangements to be more robust and create better links to other services in the area. None of the functions of the current teams will be lost, but structure arrangements simplified. Importantly, the two local networks will be able to focus on building effective working relationships with GP practices, which will help in managing services in a way that

can be tailored to meet local needs. This will be one of the key priorities for the managers of the local network teams.

3.23 The financial challenges facing the council, CCG and CNWL are set out earlier in the report. It is important to understand that there will be fewer staff in the new model. From the local authority side, it is proposed to reduce the establishment by seven, including five social workers. From the health side, it is proposed to reduce staffing numbers by 16.5 wte although some of the health savings will be reinvested in the Single Point of Access and Primary Care Plus. There are currently more vacancies in both health and social care staff than posts to be deleted.

3.24 The other important factor was reducing the number of handoffs between teams and being clear about what each team would be responsible for. In the new model the number of handoffs is reduced significantly, and the structure is simplified and based around a core Recovery function. Full details on the new operating model are included as an appendix to this report. In summary it is proposed to introduce a structure based on the following principles –

3.25 Single Point of Access

3.26 This is summarised earlier in the report, but the North West London single point of access will provide an access point for all new referrals to the Brent Mental Health service.

3.27 Recovery Service

3.28 A Brent Recovery Service will be established, split into two network groups which will deliver a range of functions including –

- Responding to referrals and providing brief treatment as required – providing an initial response to referrals, particularly a face to face response within four hours for urgent access, pending Trust-wide work on the development of a HRRTT model, which will be crucial for the networks.
- Assessment Function – a full Core Assessment, Risk Assessment and Carer's Assessment will be carried out in network groups following referral from the screening service.
- An outcome based Care and Support Plan will be put in place for each person, with progress reviewed against this plan on a regular basis by the Care Coordinator. Working towards discharge from the secondary service back to primary care will be a key function of the service.
- The service will engage with people to ensure they are involved with Employment Support Services, training and other activities designed to promote independence and recovery and to avoid social isolation.
- The functions of the Rehab Service will be carried out within the network teams. Care for service users in residential care and supported accommodation services will happen from the networks.
- A "Staying Well Plan" for each service user will be put together at the point of discharge. This will be personalised for each service user, so they are aware of the services available to them in primary care and the voluntary sector, and what to do if they feel they are relapsing.

3.29 One of the key service standards that will be introduced is based around length of time in the Recovery Service. The team has to start thinking about how long it is appropriate for someone to stay in recovery. Of the 869 service users allocated to the

current Recovery Team, 457 have been in the service for five years or more. This has been challenged and progress made in reviewing and discharging people who don't need to be in the service. A new model with clear standards and expectations for staff, as well as stronger links with other parts of the system will deliver further progress with this issue. The service is moving towards a model where working with service users on the basis of a maximum of a two year period for recovery is the ambition. It is acknowledged that a step-down to primary care services will be impacted upon by the implementation and monitoring of agreed and not yet agreed shared care protocols and the current lack of specialist services such as Personality Disorder Service, Community Forensic Service, and Dual Diagnosis Services in Brent, as well as the lack of clear commissioning streams/budgets for service users with complicated needs such as ADHD, Autism, Brain Injury etc. This will be reliant on better commissioning between the council and CCG.

3.30 Early Intervention Service

3.31 The Early Intervention Service (EIS) works with people under the age of 35 experiencing their first episode of psychosis. It is a time-limited service, focussed on intensive interventions and recovery. By delivering sustained support over a three year period, the possibility of an individual developing a long-term condition is minimised. There is a strong focus on social support networks and support is also offered to the families of service users, to try to ensure relationships are maintained.

3.32 Because there is a national directive, based on strong evidential support for the effectiveness of Early Intervention Services, the EIS will remain a standalone team, but will be hosted within one of the network teams. The importance of recognising the EIS clinical pathway and service standards for those experiencing their first episode of psychosis is such that it will remain a separate team providing borough wide coverage. The key service standard that has been introduced since April 2015 is that all those referred to and accepted into the service shouldn't have to wait longer than 14 days from referral to treatment.

3.33 Mental Health Act Team

3.34 The Mental Health Act Team is a council funded team, made up of Approved Mental Health Act Practitioners (AMHPs). AMHPs are responsible for carrying out Mental Health Act assessments and can deprive people of their liberty if it is felt that this is required for treatment for their illness. It is a specialist role that is governed by legislation. At present all of the AMHPs in Brent are social workers, and those who work in the Mental Health Act Team don't carry a caseload, their focus is on Mental Health Act work.

3.35 For the time being it is proposed that the Mental Health Act Team remains as a stand alone team, providing coverage across Brent. This includes AMHPs based at Brondesbury Road and Park Royal, who are to be brought together as one team. In time it is proposed that AMHPs are integrated into the Recovery and Rehab Services leaving only a core Mental Health Act Team, of one AMHP manager and one permanent AMHP. AMHPs will provide coverage on a rota basis as this evolves. The Mental Health Act Team will continue its interface with the EDT, to ensure that there is Mental Health Act coverage 24 hours a day in the borough.

3.36 Service Standards

3.37 As part of the work in developing a new operating model, an audit of case files has been undertaken to look at strengths and weaknesses in practice and to help clarify

service standards which will guide working practice and the implementation of a recovery model. There are some clear issues that have been identified from the audit as well as analysis of the current case load data and work with service users which has led to the development of the service standards set out below –

- Monthly contact as a minimum with all service users
- Urgent referrals seen and assessed within four hours; routine referrals seen within 28 days
- Targets for length of time people are in the secondary MH service – two years as a maximum, based on the point that it isn't a service for life and that the primary goal is recovery
- Uniform approach to discharge planning including a "staying well plan" - pro-active management to avoid the need for crisis intervention, jointly agreed with GPs
- Better interaction between secondary and primary care based on "staying well plan" to ensure people can access secondary support even when in the community
- Reduced hand offs between teams - smaller teams based on two networks – better links with primary care and the local community

3.38 For staff, the service standards and service capacity will mean that each of the 51 care coordinators in the service will be expected to do -

- 1 service user review per week
- 1 new assessment per week
- 11 "contacts" with service users on their caseload (2.5 hours is set aside for each contact), so that every service user is contacted every 3 weeks

3.39 Each care coordinator will have a caseload of around 35 people. Cases will be segmented into one of 4 zones, depending on the complexity of the persons' illness –

- Reablement: 1-12 weeks – It is expected that 40% of cases will be included in this zone
- Targeted treatment: 2-6 months - 15% of cases will be included in this zone
- Continued Care: 3-9 months - 15% of cases will be included in this zone
- Complex needs: 9 months plus - 30% of cases will be included in this zone

3.40 There will be 51 care co-ordinators in the service, 22 of which will be social care funded social workers. The community service will be able to manage a caseload of 1,500 service users at any one time. This is a reduction from the 1,800 currently in the service, but reflects the changes that are happening in the system – the development of Primary Care Plus and discharge of service users to that service, as well as a better focus on service user recovery.

3.41 Commissioning within the Mental Health System

3.42 Changing the operating model and improving the way teams work in CNWL will only be effective if other services in the mental health system are commissioned to compliment those provided by the secondary care service. The council and CCG have been working on this, to look at ways of aligning existing commissioning arrangements and reviewing contracts and grants with voluntary and third sector organisations that provide mental health services in the borough. The aim of this work is to ensure that there is a range of services in Brent that are commissioned jointly to help provide a recovery focus to mental health, and that also dovetail with

the services provided by CNWL. This is especially important with the development of the SPA, that the total service offer in Brent is understood to enable effective signposting to services if a person does not meet the criteria for secondary services.

3.43 The feedback from staff and services users during the work on the operating model was clear – there needs to be better access to services provided by voluntary organisations; staff want to know what is provided and, that alternative service provision should link up with services provided by CNWL. The commissioning work is taking this into account in developing plans for mental health commissioning.

3.44 The focus of work to date has been on bringing together information on mental health services in the borough. Over £1m is spent each year on mental health services commissioned from the voluntary sector by the council and CCG. In looking at the smaller contracts that the council and CCG have outside of the CNWL partnership agreement and contract, there are a number of organisations that are being engaged by both organisations. Some organisations also receive funding from different parts of the council, but coordination between service areas in their commission work could be better. This is an area where it is felt that the council and CCG can make progress and at the very least align commissioning arrangements before moving to joint commissioning of services.

3.45 In the future, including for 2015/16, work will take place with services commissioned from the same organisations in order to implement joint arrangements with a single service specification. The importance on being clear on the vision for mental health, and what is wanted from these services, will be highlighted by the joint commissioning work. A mental health vision and strategy will help to guide this work and a draft of this is included as an appendix to the report.

3.46 Going forward, the work on commissioning will be based around a “Ladder of Care” model, looking at services and spend at each level of the service user pathway – Universal Services, Early Intervention, Rehab and Reablement, Community Care and Acute Care. The Improvement Project Group will make recommendations on future commissioning intentions based on achieving the aims set out in the vision for mental health and realigning spend on services accordingly. Work will be done with the teams in secondary services and with GPs so that referral routes and the offer provided by commissioned services is clear to all.

3.47 The commissioning work will ask some fundamental questions about the approach to services and how they connect to the recovery model. For example, service users have found the point of discharge from the secondary service to be a difficult transition for them. There are concerns about coping with their illness, how they will be managed in primary care, whether their benefits will be affected and the impact the discharge could have on recovery. Linking service users up with community providers and/or the Recovery College that offer advice and support and help people continue with recovery will be crucial. The work will look at existing commissioning decisions and determine whether the areas of investment are correct to enhance recovery and prevent people coming back around and into the secondary system.

3.48 It is important to acknowledge this context and see the operating model work and commissioning work as one. Ultimately, the council and CCG should consider moving towards a point where they are jointly commissioning a CMHT pathway across health and social care, focussing on a recovery model. This work is a starting point on a more ambitious and joint approach to commissioning which it is hoped that the CCG Executive and council Cabinet can support. Even at this stage, a model has been developed in the context of the work that is happening across NWL, the

principles of which it is hoped can be endorsed before moving to implementation stage.

3.50 Section 75 Agreement

3.51 Currently the council and CNWL have a partnership arrangement to cover the delivery of mental health social care services, delivered in integrated mental health and social care teams. It is recommended that a partnership agreement pursuant to section 75 of the National Health Service Act 2006 is entered into for a further 12 months so that both parties have the reassurance that they are committed to working together in partnership to deliver improvements in mental health and social care services in Brent.

3.52 There has been considerable investment in the partnership between the council and CNWL over the past two years, particularly the two improvement projects that have been undertaken. The Phase 1 project led to a significant reduction in the use of residential care for service users. The Mental Health Act team was reviewed to improve quality and resilience and the work of the Employment and Welfare Support team was mainstreamed in the Recovery Service to reduce staff overheads. The foundations were set to deliver a wider savings plan, which reduced the overspend in the service. This has been continued in Phase 2, with further reductions in the use of residential care, as well as the work on the operating model and commissioning. The financial position has improved significantly. The budget for the service in 2012/13 was £7.603m. This has reduced to a forecasted budget of £5.412m in 2015/16, without compromising the quality of service.

3.53 There are still improvements that can be made, and the new operating model, assuming it is approved, will need to be implemented. Additionally, there is work taking place with Housing Services to improve the supply of private sector accommodation for mental health service users. If this is successful, it will help to further reduce the use of residential care and supported accommodation, giving more independence to service users and focussing services on their recovery. The commissioning work outlined above also needs to be completed. Improvements to the mental health system as a whole require strong partnerships with providers such as CNWL. Entering into a 12 month 75 agreement will help provider the stability required to deliver further improvements in services.

3.60 Conclusions

3.61 The work on the operating model has led to a proposal that if implemented will help to improve mental health services in Brent. Changing structures and teams in itself will not improve services; looking at processes and working practice are as important, if not more important if service improvement is to be delivered. This work has attempted to do this, and with staff a comprehensive implementation plan will be developed to take this work forward in the coming months.

3.62 There is much happening across mental health services, which the operating model work has had to take into account, such as the development of the single point of access and primary care plus. There are to be further system changes in due course as well. What is worth stressing is that the proposed changes to community teams in Brent are in line with other work that is taking place and do not take Brent Mental Health Services in a different direction of travel to the wider NWL system or CCG intentions. But, Brent cannot afford to stand still and wait for all other work to be

completed before making changes to the way services operate in the borough. We want to proceed to implementation, involving GPs, service users and other key stakeholders in working this through.

3.63 Assuming the model is approved in principle, the main focus of the work in the coming months will be on developing the specific service standards and interfaces and implementing the new model. As set out previously in this paper, we want to make the service work in a more efficient way, refocus on outcomes, recovery and good practice and put in place a more manageable structure rather than radically change the nature and principles of the service.

3.64 It is important that changes to the operating model are not seen as an end in itself. They have to be coupled with a new approach to commissioning, and ensuring that there are services in place to compliment those provided in secondary (and primary) care. Working collaboratively, starting with the development of a vision for mental health services, the council, CCG and partners will be looking to develop a more cohesive mental health system and ultimately move to a position where it is jointly commissioning community mental health and social care services in Brent.

4. Legal Implications

4.1 The council has various statutory duties in relation to mental health matters, including 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 Section 3 of the Care Act 2014 the Local Authority has 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. The Recommendations of this report would appear to be consistent with the council's Section 3 duties.

4.2 Members are recommended to approve the council entering into a 12 month partnership agreement with CNWL under section 75 of the National Health Service Act 2006. 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 Cabinet approval because there is a delegation of the council's functions to CNWL.

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. Such an exemption can only be granted where there are good financial / operational reasons for doing so and Members are referred to paragraph 3.54 to 3.56 for details.

5. Financial Implications

5.1 The council's Adult Social budget for Mental Health service for 2015/16 is £5.4m.

5.2 As part of the 2015/16 budget setting process, the council agreed to set a savings target of £500k in 2015/16 and a further £250k in 2016/17 for the Mental Health

service. The proposed new operating model will deliver £350k of the £500k savings required in 2015/16, with the remainder delivered via other work steams.

5.3 It should be noted that the department's short term budgeted savings plans have assumed a continued partnership arrangement with CNWL. If the Section 75 agreement was not renewed the delivery of these savings would be at risk and alternative savings would need to be found.

6. Equalities Implications

6.1 An equalities analysis of the work has been carried out to assess the impact of the proposals on service users and staff. It should be noted that the work on the mental health transformation is referenced in the council's Equality Strategy 2015-2019, as it is included in the section on the council's priorities, under the "Enabling people to live healthier lives and reducing health inequalities". The work on the operating model is part of a wider programme of change, which will have an impact on service users.

6.2 The model will improve services for people with a recognised protected characteristic, disability. The changes are designed to encourage recovery and independence and for people to take greater control of their lives and not become dependent on services. This is based on previous work that has been done with the mental health service, to encourage step down from residential care and high level supported accommodation - we want to move away from institutionalising service users, even in community services. Research with service users through the project has shown that they support this principle and the changes to the operating model.

6.3 There are no plans to remove services from people, but the way that services are set up and delivered will change for those in the secondary mental health service. The biggest change is the abolition of existing teams and creation of two networks. For most service users, changing teams will mean very little. But, change of care coordinator is more of an issue. Service users don't like changing care coordinator if it can be avoided, and so this will need to be carefully managed. One of the problems with the current structure is that when people change teams, their care coordinator changes. This can happen frequently, but in the new model it will happen less – once someone is given a care coordinator when they enter the service, unless there is good reason to change they will remain with that care coordinator until discharge.

6.4 The other main change is that links with primary care are to be enhanced, through the creation of Primary Care Plus. We need to change the approach to discharge, and increase the flow of service users out of the service - we can't hold people in secondary care in case they should ever relapse. This will need careful management with service users, to see discharge as a positive step, but also provide reassurance that there are ways back into services if they ever relapse. People who have mental illness and their carers and family are often sensitive to change. This is understandable and strong relationships can be forged between service users and staff. Within the new model we want to encourage independence and recovery and to see the achievement of these things as a positive step for people.

6.5 Analysis of staff who work in the service has uncovered one striking feature that stands out - the age of staff. Only 13 of the 61 council staff are aged under 40. Twenty six are aged 51 to 60 and five are aged 61 to 70. Over 50% of the staff are aged 50 or over. This could have had implications for the operating model work, but savings will be taken from vacant posts rather than existing staff. However, this will be an issue for the service and it will need to take steps to ensure experienced members of staff are replaced as they leave in the future. It has already been

recognised in the AMHP function, where a programme of training has been instigated to train social workers to become AMHPs, partly because a number of existing AMHPs were approaching or already at retirement age.

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