Essex Mental Health Review

Final Report

28th September 2015

Contents

1. The Essex Mental Health Review: purpose and scope

Commissioners and providers across Essex have engaged in discussion over the last year around how best to provide mental health care to service users in the context of challenging financial, demographic and operational pressures.

In May 2015 they jointly commissioned a formal review in order to assess the current state and make recommendations around the best way forward[1].

The scope of the review is focused on mental health services commissioned locally and provided by the two main local NHS providers: North Essex Partnership NHS FT (NEP) and South Essex Partnership NHS FT (SEPT). The impact and implications of any recommendations on adjacent services (for example, mental health services commissioned by NHS England) are also considered.

This document is the final output of the review, and provides an overview of the context, findings and recommendations. There are additional detailed facts and data in the accompanying document: **Appendix 1.**

The work has been shaped by over 200 individual points of engagement – including with service users, clinicians and other healthcare professionals, and commissioners. For full details of the stakeholders and overall process see **Appendix 2** below**.**

[1] Review commissioned jointly by Basildon and Brentwood CCG; Castlepoint and Rochford CCG; Essex County Council; Mid Essex CCG; North Essex Partnership NHS FT; North East Essex CCG; South Essex Partnership NHS FT; Southend CCG; Southend Unitary Authority; Thurrock CCG; Thurrock Unitary Authority; West Essex CCG.

2. Key messages

Findings

The ***commissioning*** landscape for mental health is complex driven by three main factors:

Multiple commissioners: feedback suggests that the current configuration of 30-50 roles are not commissioning mental health services effectively. This is driven by (i) fragmented resources in a specialist and increasingly complex environment; (ii) insufficient seniority and capabilities; and (iii) the lack of a robust fact base on needs, service activities and outcomes.

The integration agenda: each CCG is considering different local models of integrated care with different views on which mental health services should be included and are all moving different speeds This 'ragged edge' makes planning from a provider perspective challenging – particularly as some of their mental health teams work across more than one commissioning area. Moreover, we expect these emerging models to be further refined as they receive greater clinical and professional input.

Funding misalignment: the current block contracts originate from PCT days with costs allocated using different approaches in the north and the south. This has resulted in a number of misalignments between CCGs: as finances become tighter and CCGs look to fund some services in local models, these subsidies need to be unwound.

The ***providers*** NEP and SEPT are facing three significant and inter-related challenges:

Shrinking market: The overall market for specialist mental health trusts is shrinking as commissioners pursue their integration agenda. In addition, NEP and SEPT have recently lost market share to competitors, for example Essex CAMHS services to North East London NHS FT (NELFT).

Challenging finances: mental health funding has been historically challenging, and providers face a 4% year-on-year efficiency requirement as well as significant CIP targets. NEP in particular is facing significant short term difficulties.

Potential brand issues: feedback indicates that both providers face challenges around the strength of their brand – perception amongst commissioners is mixed around responsiveness to changes in policy, communication regarding service changes, and data transparency.

Implications

The status quo is not an option: the commissioning landscape will become more complicated as the integration agenda plays out; there are not sufficient facts and data to prioritise services in order to make more efficient (and transparent) use of limited available resources; and providers are likely to fail (financially) posing risk to the continuity of services and the safety of service users.

Summary of recommendations

1. Simplify the commissioning landscape

1a Clarify the integration agenda: commissioners should refine the scope of mental health services planned to be within their local integration models with greater clinical and professional leadership. In addition, rather than each moving at their own pace, we recommend commissioners agree a more uniform integration timeline. This will involve a change of pace for some but result in faster and less complicated implementation.

1b Align around a clear commissioning path: building off *1a* above, commissioners should agree a shared commissioning path to clarify what mental health and personal care services will be commissioned, by whom, and when. A draft view has been described as part of this work for commissioners to consider.

For providers, clarity of the path and timing will enable them to refine their strategy - including which services to focus on, and whether collaboration or merger would result in a stronger financial (and clinical) position from which to deliver care.

1c Work through how best to deploy social workers as the integration agenda plays out: as services are integrated and existing pathways change, local authorities and CCGs will need to jointly assess how best to deploy social workers – for example whether these should follow services or whether they should be organised in a more centralised way.

1d Agree a plan to re-align funding between CCGs: commissioners should agree the approach and timeline to reapportion expenditure and Resource Limit to ensure an affordability neutral solution ahead of implementing the local integration agenda.

1e Define where dementia services should sit: local authorities should agree with their local CCGs whether to move dementia under Public Health and Wellbeing as an all-age pathway, whether it should remain split within Adult Social Care

2. Create a common language and use to clarify needs and expectations

2a Agree a common language: commissioners and providers should agree to use a single terminology / language going forward. Clinical input suggests clusters may be the most reasonable lexicon given the national direction – although there is no single perfect solution.

2b Clarify the desired provider capabilities: commissioners should, working with providers, undertake to create a common and shared set of required provider capabilities, for example around IT; culture; flexibility; data transparency.

2c Optimise section 75 partnership arrangements: in the south, the three local authorities should commit to working together to create a common template, shared performance targets, and single joint oversight meeting in order to reduce effort and avoid duplication.

2c Work with providers around The Care Act compliance: local authorities should develop clear and consistent expectations for providers' compliance with the Care Act, including what should be

incorporated into their contracts in terms of access to pathways for people in distress. This will involve discussions around appropriate funding to ensure these are realistic expectations.

3. Generate and share more data across the system

3a Conduct robust needs assessments: commissioners should work with clinicians and professionals to assess service user health and personal care needs, including how these differ by geography, locality (e.g. urban vs. rural), and cluster segment.

3b Develop and track better outcomes: building off *3a* above, commissioners should work with clinicians and professionals develop desired outcomes – these will inform which services should be commissioned, and how they will be monitored. They will also support funding prioritisation decisions.

3c Share the output of ongoing needs assessment work in dementia: local authorities should ensure learnings and outputs are widely disseminated to avoid duplication.

4. Work more jointly

4a Create a pan-Essex MH commissioning team: commissioners should consider a smaller, more senior mental health team – for example around 10 FTEs – that includes senior analytics, business intelligence, and financial expertise. This would provide real leverage and help make necessary trade-offs between services and cost – the need for which was highlighted at the Clinical Conference held in August.

The exact organisational form and governance processes should be jointly agreed by commissioners in the coming weeks. Importantly, a single team does not mean a 'one size fits all' solution. Needs, services, activities and outcomes need to be tailored to local geographies.

The principles behind having a smaller, shared team are to attract and fund the appropriate seniority of resource; support simplification; enable the use of a common language; create a single fact base of needs, activities, and outcomes; and build off the CAMHS experience of joint working across health and social care.

Between now and April 2016 the team would work through recommendations *3a* and *3b* above: conduct robust needs assessments; determine gaps; agree outcomes; describe what services should be commissioned to deliver these; prioritise funding; draft commissioning intentions; and refine the draft commissioning path described in *1a* above. From April onwards, there are choices around what role it should continue to play – for example whether it should take on a more supportive role or commission pan-Essex services.

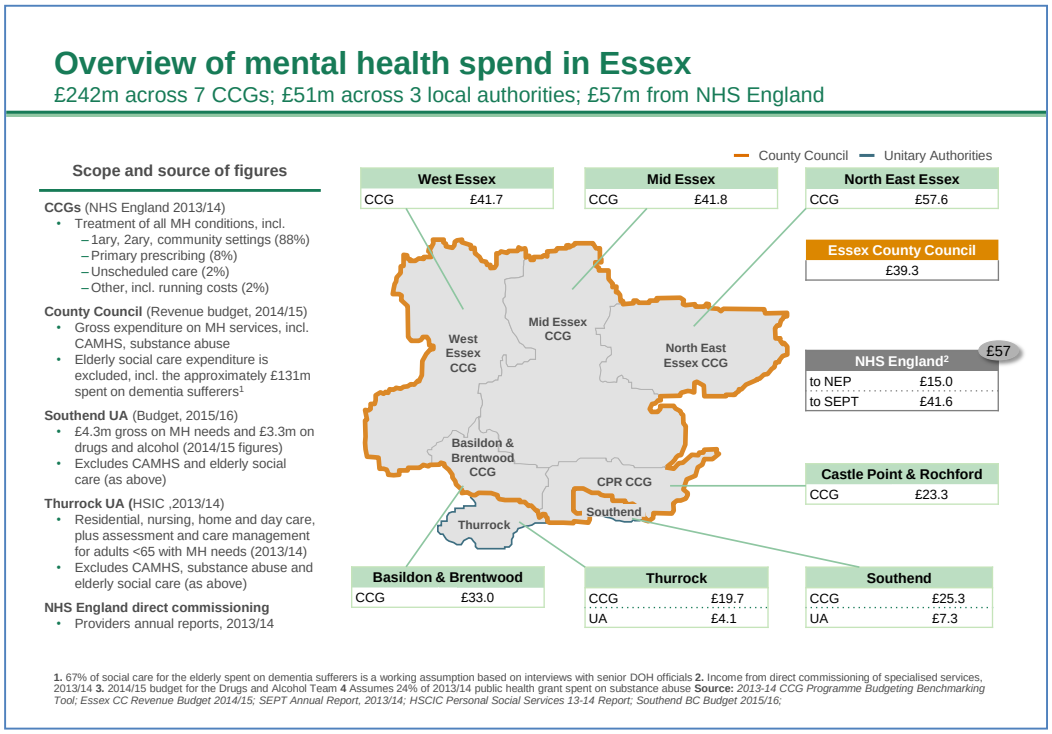
4b Optimise AMPHs arrangements: local authorities should work jointly to increase the overall number of AMPHs, and consider sharing a single rota to maximise efficiency.

4c Work together to ensure all-age, cross-system care: all commissioners should build on the CAMHS experience and commit to working together to improve outcomes for the most vulnerable individuals, and ultimately develop a shared vision for mental health in Essex.

3. Context

(i) Spend on Mental Health (MH) services in Essex

The Essex health economy spends a total of £c.350mm on MH services. Of this, £242m is commissioned by the 7 local NHS CCGs; £51m by Essex County Council (ECC) and the two Unitary Authorities (UAs) in the south; and £57m by NHS England. In addition, ECC spends an additional £195m social care of older adults, of which approximately £130m is spent on dementia[2].



Per capita, the CCGs spend between approximately £98 and £151 per capita when adjusted for differences in population - this is broadly in line with the national average. ECC spend £45 per capita which is slightly above the national average, and the two UAs spend £56 (Southend) and £50 (Thurrock) which is slightly below.

Historically, mental health funding has been constrained. National investment in mental health services fell in real terms between 2011 and 2014[3]. In Essex, CCG spend on mental health has decreased by around 6% p.a. between 2010/11 and 2014/15. The funding challenge has been driven by a number of factors, including a tariff deflator of -1.8% (vs. -1.2% in the acute sector). In addition, services have been impacted by budget cuts on the Local Authority (LA) side: ECC spend on adult mental has declined by 2% and older adult mental health by 3% over the same period.

Going forward, the working assumption is that the mental budget has been ring-fenced and so unlike other areas of the system, will not decline further – but is not expected to increase. See **Appendix 1, Section 1** for additional detail regarding mental health spend.

[2] £131m of the £195m spent on social care for older people in 2014/15 is estimated to have been spent on dementia sufferers based on national estimates from DoH; includes residential and nursing care (£80m), homecare and respite (£26m), reablement (£5m) and cash payments (£6m)
[3] Mental Health Network: The Future of Mental Health, March 2014

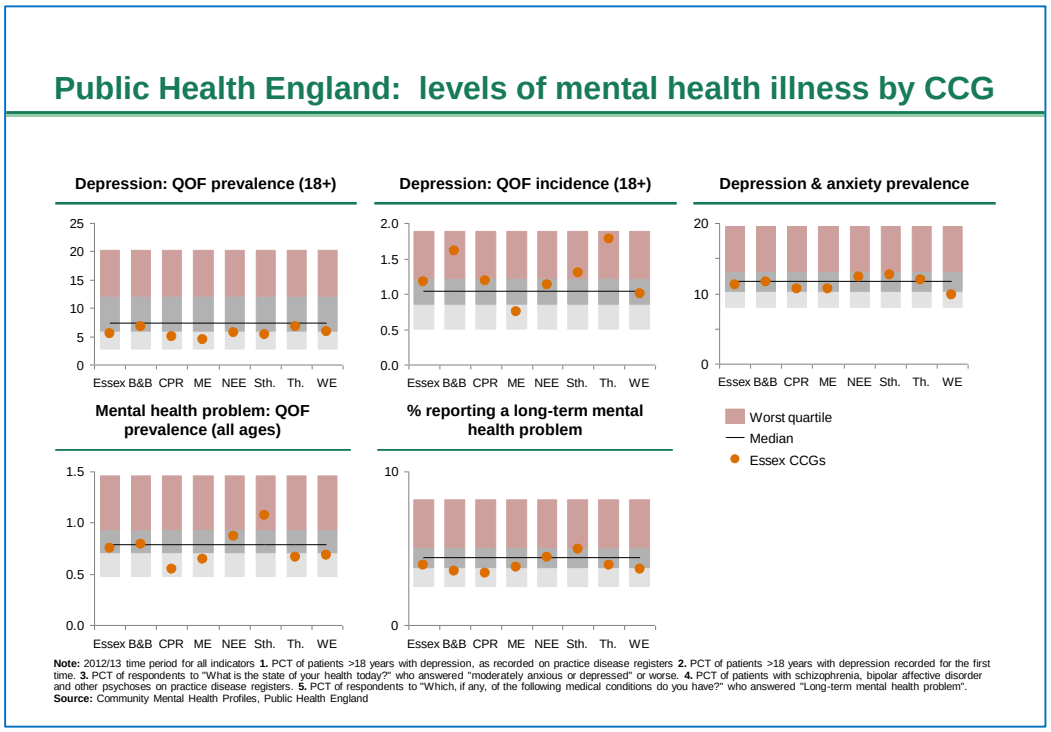
(ii) Demand

The working assumption of this review is that total spend on mental health services in Essex is fixed. However there are no recent, robust needs assessments to properly guide what services should be commissioned, and for which service users[4].

Nationally, demand for mental health services is growing. By 2030, there are likely to be approximately 2 million more adults in the UK with mental health problems due to population growth alone[5]. In addition, prevalence is thought to be increasing, particularly for common mental health disorders such as depression and anxiety[6]. Unmet need is already high. The London School of Economics and Political Science estimates that only around a quarter of people with mental health problems receive treatment[7].

For older adults, demand for dementia services will rise in line with an increasingly elderly population. For example in North Essex, 51% of the population growth by 2016 will be in over-65s[8]. Some estimates suggest that the prevalence of dementia will increase by 40% over the next 12 years[9].

Data from Public Health England for Essex are shown below.

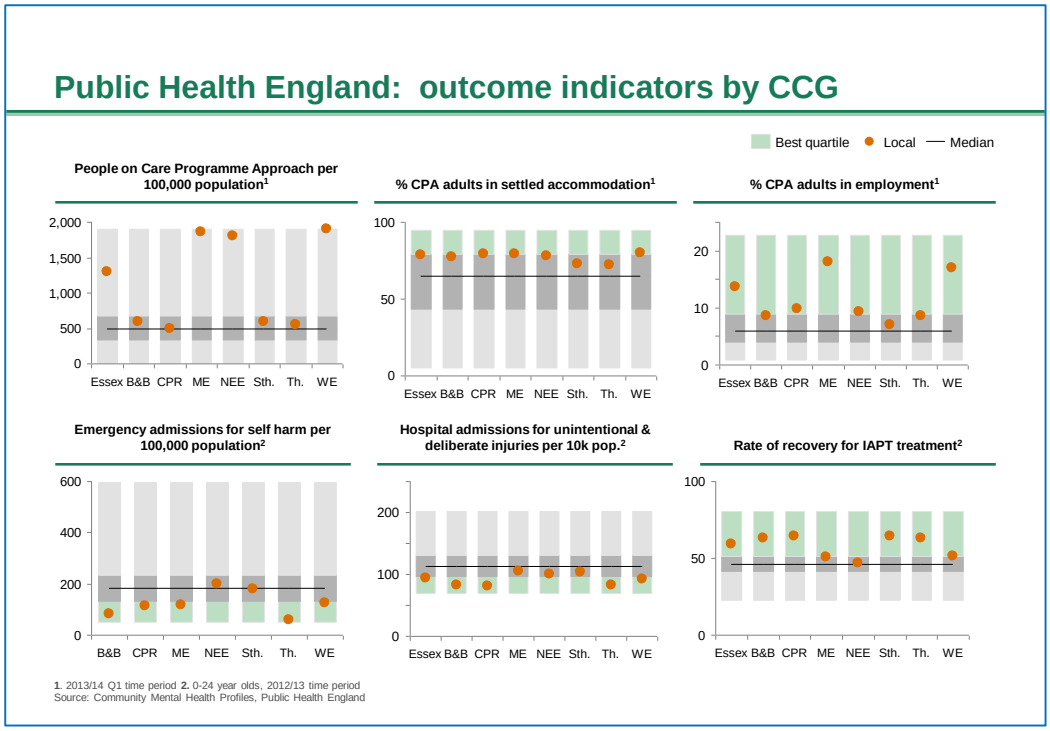


[4] See also Section 7: Recommendations for Commissioners
[5] Mental Health Network factsheet, 2014
[6] Mental Health Foundation: Starting Today: Future of Mental Health Services, 2013
[7] Centre for Economic Performance: How mental illness loses out in the NHS. London School of Economics and Political Science, June 2012
[8] NEP operational plan 2014-16
[9] Alzheimer's Society: http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=412

(iii) Outcomes

There is an overall paucity of robust, consistent outcome data in mental health. This is highlighted in the recent interim report from the Royal College of Psychiatrists[10] which suggests a significant data and information shortfall is making it difficult to understand what is happening throughout the system, to measure variation, and to bring about improvements. The Royal Society of Psychiatry has recently highlighted a significant shortfall in mental health data and wide variations in service models and definitions, which compares poorly to the acute sector.[11] Poor data and inconsistent definitions, compounded by a lack of consensus around outcome measures, is recognised to be undermining management and commissioning of mental health services. Improvements have been made – IAPT is more consistent and data rich for instance – but overall feedback from clinical and professional engagement in Essex reinforces the national viewpoint.

Limited data are available around outcomes for mental health in Essex. Nationally gathered Public Health England indicators are shown below. Over time, there is a need to agree outcome metrics locally to help define the goals for services and against which to monitor provision.[12].



(iv) National policy / trends in mental health

Early intervention

In line with the national policy embodied in *No health without mental health*[13], there has been a push towards increasing investment in early intervention schemes in order to manage demand and avoid costly inpatient admissions. Most notably, the Improving Access to Psychological

[10] Royal College of Psychiatrists: Interim report, Improving acute inpatient psychiatric care for adults, July 2015
[11] Improving acute inpatient psychiatric care for adults in England: Interim report, RCPsych Commission on Acute Adult Psychiatric Care, July 2015
[12] See also Section 7: Recommendations for Commissioners
[13] HMG/DG, No health without mental health, February 2011

Therapies (IAPT) programme aims to improve access to talking therapies for depression and anxiety. The Department of Health estimated that talking therapies can save the public sector £1.75 for every £1 invested.[14] The service model is based on a ratio of ~40 therapists for every quarter of a million of population, and allows both GP and self-referral to maximise access. As at April 2015, there are over one million referrals each year (over 40% are self-referrals) of which around three-quarters enter treatment after an average waiting time of just under 30 days. Of the 40% that complete treatment, over 60% improve and 40-45% recover – although this remains short of the national target of 50%.[15]

The integration agenda

People with severe and prolonged mental illness are now known to die on average 15 to 20 years earlier than the general population, and there are clear benefits to a holistic approach to their care which is unrestricted by provider boundaries. The *Five Year Forward View* set out the ambition and dimensions for integration: physical and mental care, health and social care, primary and specialist care.[16] Commissioners have a critical role in this agenda, particularly in shifting payments and incentive systems to accommodate integrated physical and mental health outcomes.[17] The Kings Fund recently highlighted three main ambitions for commissioners: holding providers to account for outcomes; holding providers to account for streamlining the delivery of patient care across the gaps between service providers; and shifting the flow of money between providers.[18] There are good parallels between the 'diabetes journey' to integrated care and what mental health needs – commissioner and provider engagement; strengthened capability and capacity in primary care; brought about with time and effort from multiple stakeholders; over many years.

Move to commissioning by results / PbR

The mental health sector lags behind the acute sector by more than a decade in moving away from block contracts and towards commissioning and payment by results (PbR). This is related to its relatively poor progress in generating good quality data from a consistent set of outcomes and services. But progress has been made, most notably with the development of the mental health care clusters as a common currency for the sector. Clustering works by assessing patients based on their needs and the severity of their conditions. Each cluster is linked to a set of interventions which have a total cost and for which a tariff could be paid. Widespread adoption of cluster-based PbR could reverse the real terms drop in funding for mental health, as well as facilitate integration.[19] Data quality (and clinical) concerns have delayed creation of a national tariff, but commissioners and providers have been moving ahead on the basis of local data.[20]

However whilst clustering is acknowledged as a potentially helpful commissioning tool, its use clinically is subject to considerable debate: service users within clusters are heterogeneous in terms of diagnoses, needs, risk and severity - which creates challenges around treatment and care packages. Service users themselves are not familiar with the segments and terminology, and clustering has potentially added to the complexity around language and lexicon in mental health[21].

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[14] DH, Impact Assessment of the expansion of talking therapies services as set out in the Mental Health Strategy, 2011
[15] DH, Talking therapies: A four-year plan of action, February 2011
[16] NHS England et al., Five Year Forward View, October 2014
[17] Dr Geraldine Strathdee (National Clinical Director for Mental Health), Treating mind and body together, June 2015
[18] Kings Fund, Commissioning and contracting for integrated care, November 2014
[19] HSJ Intelligence, The future for mental health payment systems, 20 August 2014
[20] RCPsych, Position Statement PS01/2014, January 2014
[21] See also Section 7: Recommendations for Commissioners

The Care Act

The Care Act was introduced in 2014, with many of its provisions coming into effect on 1 April 2015. The Sutton Trust calls it the most comprehensive overhaul of the social care system since 1948.[22] The Act requires a shift from a narrow and clinically-lead focus on the treatment of disease towards a broader conception of promoting individuals' wellbeing – including both physical and mental health – as well as preventing or delaying the need for that support. It also places local authorities under a duty to collaborate and coordinate with other authorities on the integration of social services and health care[23].

The Better Care Fund

The Better Care Fund (BCF) was announced in the June 2013 spending round to promote integration of health and social care. It creates local single pooled budgets to incentivise the NHS and local authorities to work more closely together.

See **Appendix 1, Section 2** for additional detail around key trends and recent publications.

(vi) NHS specialist mental health trusts in Essex

The provision of the majority of specialist mental health services in Essex has been by North Essex Partnership University NHS FT (NEP) South Essex Partnership University NHS FT (SEPT).

NEP

NEP is a £110m turnover organisation headquartered in Chelmsford employing around 2000 staff. It provides a range of mental health services to a population of over 1 million predominantly in Essex. These include adult and older adult mental health services, CAMHS, forensic and substance abuse services. The majority of the adult and older adult work is commissioned by the three CCGs in the north of the county through a block contract worth £69m (lead CCG North East Essex).

NEP – historical data

Financials	2011/12	2012/13	2013/14
Income (£ m)	105.5	108.8	112.7
Special services			*9.4*
Op surplus (£m)	2.9	1.3	-12.2
Ret surplus (£m)	0.8	-1	-14.7

Performance			
2014/15	Q1	Q2	Q3
# Beds	357	356	336
% Bed occupancy	93.1%	95.6%	97.1%
% Patients assigned clusters	55.8%	59.9%	41.6%
% CPA in settled accom	54%	35%	37%
% CPA review within year	68%	51%	63%
Early intv'n psychosis cases	500	450	415

Workforce				
2014/15	Q1	Q2	Q3	Q4
Total workforce	1,798	1,766	1,724	1,699
Medical	*119*	*117*	*109*	*107*
Nursing	*620*	*607*	*597*	*588*
Other	*1,058*	*1,042*	*1,018*	*1,004*

	2012/13	2013/14	2014/15
% Staff recommending care here	60%	59%	55%

Source: HSJ.

[22] Sutton Trust, The Care Act 2014: A briefing, March 2014
[23] See also Section 9: Findings and Recommendations Specific to the Local Authorities

SEPT

SEPT is currently a £324m turnover organisation headquartered in Wickford employing around 5000 staff. It provides a range of services to a population of around 2.5 million in Essex, Luton, Bedfordshire and Suffolk. These include mental health (adults, older adults, IAPT, CAMHS, forensic and substance abuse); general community, and learning disability services. In Essex, mental health services are commissioned via a block contract worth £81m (lead CCG Castlepoint and Rochford).

SEPT – historical data

Financials

	2011/12	2012/13	2013/14
Income (£ m)	314.1	323.9	324.5
Special services			*23.1*
Op surplus (£m)	8,7	10.9	5.3
Ret surplus (£m)	2.4	4.3	-0.5

Performance

2014/15	Q1	Q2	Q3
# Beds	706	707	706
% Bed occupancy	91.2%	90.6%	92.4%
% Patients assigned clusters	83.8%	84.0%	79.3%
% CPA in settled accom	73%	54%	75%
% CPA review within year	88%	41%	42%
Early intv'n psychosis cases	465	425	985

Workforce

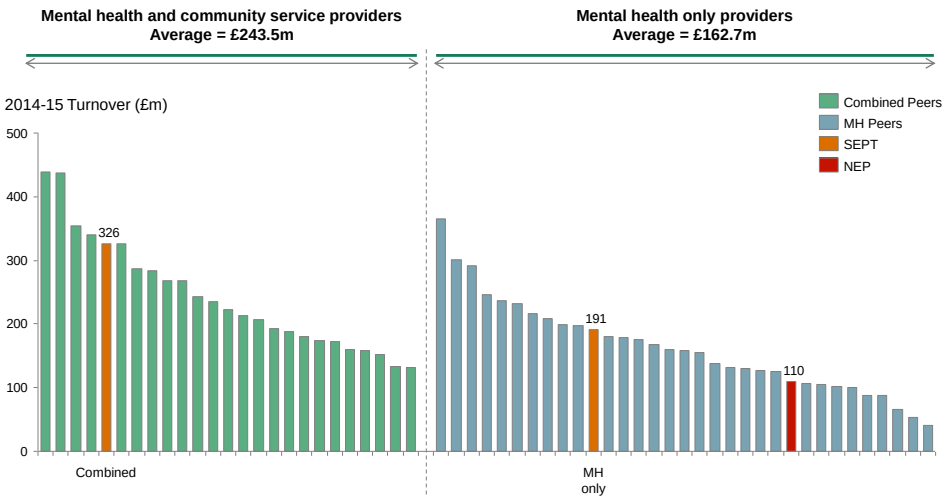
2014/15	Q1	Q2	Q3	Q4
Total workforce	5,114	5,081	5,007	5,007
Medical	*204*	*204*	*193*	*192*
Nursing	*1,590*	*1,568*	*1,529*	*1,524*
Other	*3,319*	*3,309*	*3,285*	*3,291*

	2012/13	2013/14	2014/15
% Staff recommending care here	63%	64%	65%

Source: HSJ.

In terms of scale, the NEP is in the lower quartile; SEPT, in 2014/15, is currently above average.

Relative size (by income) of SEPT and NEP against relevant peer group in 2014/15



Source: Annual Account and Reports 2013-14; HSJ Intelligence; SEPT annual reports; SEPT 2015/16 operational plan; Data received from SEPT, 28 July; NEP Board Papers, May 2015, updated for current LFTM

See **Appendix 1, Section 3** for additional data on NEP and SEPT finances, operations and quality.

4. Findings: Commissioners

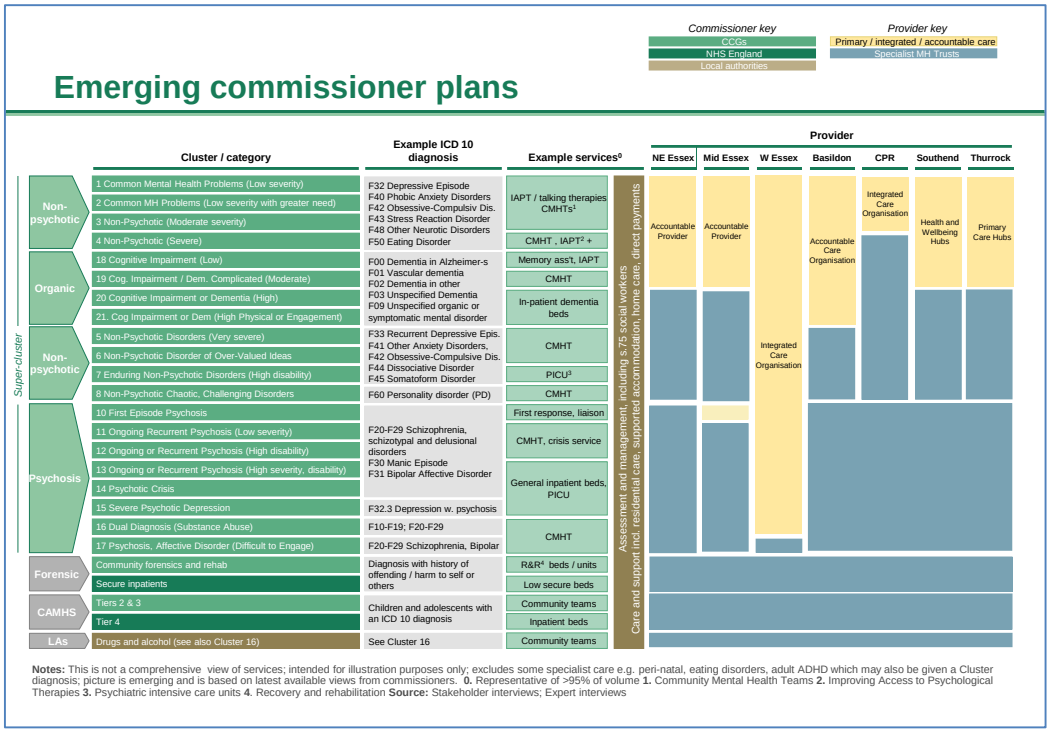
The commissioning landscape for mental health services in Essex is a complex picture which would benefit from simplification. There are three main factors contributing to the complexity:

Multiple commissioners:

Each of the 10 commissioning bodies has resources commissioning mental health services, involving a total of around 40-50 roles, fragmented across the patch. Stakeholder feedback suggest this lacks sufficient contextual oversight and does not have robust data around the services commissioned (outcomes and costs), and service user needs. For example, clinicians have identified potential service gaps – including adult ADHD and community forensic – but there is insufficient data to ascertain whether these should be prioritised. Additionally, there is no shared language – clusters, services, diagnoses, care setting are used interchangeably.

The integration agenda

Each CCG is moving at different speeds and considering different local models of integrated care, and has different views on which mental health services should be included.



Notes: This is not a comprehensive view of services; intended for illustration purposes only; excludes some specialist care e.g. peri-natal, eating disorders, adult ADHD which may also be given a Cluster diagnosis; picture is emerging and is based on latest available views from commissioners. **0.** Representative of >95% of volume **1.** Community Mental Health Teams **2.** Improving Access to Psychological Therapies **3.** Psychiatric intensive care units **4.** Recovery and rehabilitation **Source:** Stakeholder interviews; Expert interviews

This 'ragged edge' makes planning from both commissioner and provider perspective quite challenging – for providers more so given that their teams work across different CCGs. Cfeedback suggests further work is needed to fully understand which service users can appropriately be managed in primary care, new models of care, and shared care teams.

Funding misalignment

The current block contracts originate from PCT days with costs were allocated using different approaches in the north and the south. The impact of this is a number of misalignments between resources and utilisation between CCGs through the block contracts, which creates a complicated picture and hinders pan-Essex commissioning. **See Appendix 1, Section 4** for additional detail around historic CCG allocations.

5. Findings specific to the Local Authorities

In addition to those described above, there are additional findings which are specifically related to Essex County Council, Southend UA and Thurrock UA (the local authorities).

Section 75 partnership agreements

Section 75 of the National Health Service Act (2006) provides – amongst other things – for local authorities to enter into arrangements with NHS trusts for the exercise of authorities' health-related functions, and the provision of staff for those purposes. Essex County Council has section 75 agreements with both NEP and SEPT, and provides social workers to the trusts' multi-disciplinary assessment and care management teams under those agreements. County Council social workers are TUPE'd to NEP and seconded to SEPT.[24] Southend UA and Thurrock UA also have their own section 75 partnership agreements with SEPT. These arrangements ensure mental health and social workers are integrated in operational teams at the front door.

The Essex Local Authorities are not alone in using section 75 to integrate their mental health social workers into healthcare teams – or in facing challenges with this approach. Results of a Freedom of Information request from late 2013 suggest that about half of local authorities use section 75 in this way. But it also highlighted authorities' concerns – including loss of social work focus, slower progress on personalisation, slower progress on recovery models and financial pressures – that had prompted some authorities to withdraw from these arrangements.[25]

In Essex, feedback suggests that integration of social workers into the trusts is variable. There are challenges around communication back into the local authorities so as to ensure the desired ways of working are in place. In the north, recent changes to service models and pathways at NEP (Journeys) have exacerbated concerns around integration within teams. In the south, there are challenges around NHS management and leadership of local authority staff. In addition, there is significant duplication of effort around the section 75 arrangements. SEPT has different partnership agreements with all three local authorities – Essex County Council, Southend UA and Thurrock UA – which involves three sets of monitoring arrangements, performance targets, and oversight meetings. For example, Essex County Council hold monthly performance and budget meetings with both trusts – and a three monthly partnership meeting.

AMHPS

Approved mental health professionals (AMHPS) are responsible for organising and coordinating assessments under the Mental Health Act (1983), including detentions (sectioning) and community treatment orders (CTOs). Traditionally performed by specially trained social workers, the role is increasingly held by occupational therapists, community mental health nurses and psychologists due to shortages of staff and the cost and length of training. The CQC has highlighted falling numbers and rising workload for AMHPs across the county.[26] Most recently, it has highlighted the pressure that AMHPS are under to section users under the Act purely to increase their chances of securing a bed amidst the general shortage.[27] The revised Mental Health

[24] TUPE refers to the Transfer of Undertakings (Protection of Employment) Regulations 2006 regulating terms of employment for staff transferred to new employers.
[25] Andy McNicoll, Councils split on integration of mental health social workers in NHS, Community Care, 24 September 2013
[26] CQC, Monitoring the Mental Health Act 2011/12, January 2013
[27] CQC, Monitoring the Mental Health Act 2013/14, January 2015

Act code of practice – which came into force on 1 April – requires local authorities and providers to support AMHPs in addressing delays to bed access.

Essex is facing a severe shortage of qualified AMHPs (and the trusts bed occupancy are generally above target levels). Essex County Council currently employs 84 AMHPs and estimates that it will need to train and deploy another ~50% by 2017, and then continue to train 20 AMHPs a year to manage the churn. Feedback suggests that the role has become less financially and professionally attractive, partly as a result of these pressures, and failure to maintain numbers has made it more difficult to maintain a reasonable rota, putting more pressure on the remaining personnel. Part of the problem is reported to be a lack of consensus between the trusts and the council around ultimate responsibility for closing the gap and covering the costs. Section 75 of the NHS Act is not clear on this point.

In terms of provision of the service, the providers run the in-hours rota on behalf of the local authorities. In the north, Essex County Council runs the out-of-hours rota. In the south, Southend UA contracts Essex County Council for out-of-hours services, whilst Thurrock UA runs its own out-of-hours rota. In practice, due to the shortage of staff, the same AMHPs work on all of the rotas.

Care Act compliance

As described earlier, the Care Act, key elements of which entered into force on 1 April 2015, shifts the focus in mental health from a narrow conception of disease management to a broader duty to promote wellbeing and early help and prevention for service users and their carers. Local authorities are the responsible bodies under the Act. Feedback included concerns that the two providers were not yet fully compliant with the Care Act, and specifically that the trusts' thresholds for specialist treatment varies across the county. Too high a threshold may not be compatible with the legislative shift to 'wellness'. More generally, feedback has suggested that local authorities would like greater transparency and input earlier in the patient journey to manage the implications of thresholds for admission being set low in some instances.

Dementia

Currently, the vast bulk of local authority spend on older adults suffering from dementia is accounted for under adult social care spend not mental health spend. For example, Essex County Council spent ~£131 million on social care for older adults suffering from dementia in 2014/15. This includes residential and nursing care (£80m), homecare and respite (£26m), re-ablement (£5m) and cash payments (£6m). Note that many of the older adults receiving these services have not been officially diagnosed with dementia, even though their carers will be confident of the fact.

On the one hand, accounting for this spend under social care rather than mental health spend obfuscates the size and shape of the combined spend on mental health in Essex. It can inhibit coordination between the local authority teams responsible for different aspects of care for the same set of service users. On the other hand, shifting the budget and related structures may inhibit coordination between adult social and older adult social care, which also share commonalities.

In addition, this is an area where there is significant unmet demand. The local authorities are currently participating in a needs review around dementia to assess this in further detail.

All age and cross-system working

Evidence suggests that 50% of mental health problems start by the age of 15 and 75% by the age of 18[28]. More work is needed to ensure a joined up, all-age approach to mental health. For Essex County Council for example, mental health services relate to adult mental health for adults up to the age of 65 and sit separately to CAMHS. Within the providers, there have been challenges in securing sufficient Adult Mental Health input into the Children's Social Care Family Solutions teams. There also needs to be good integration into schools and other young peoples' services. More widely, local authorities are a key interface with other parts of the system: police, housing, voluntary and community sectors, district councils and employment as well as public health.

[28] Annual Report of the Chief Medical Officer 2012, Our Children Deserve Better: Prevention Pays, Chapter 10

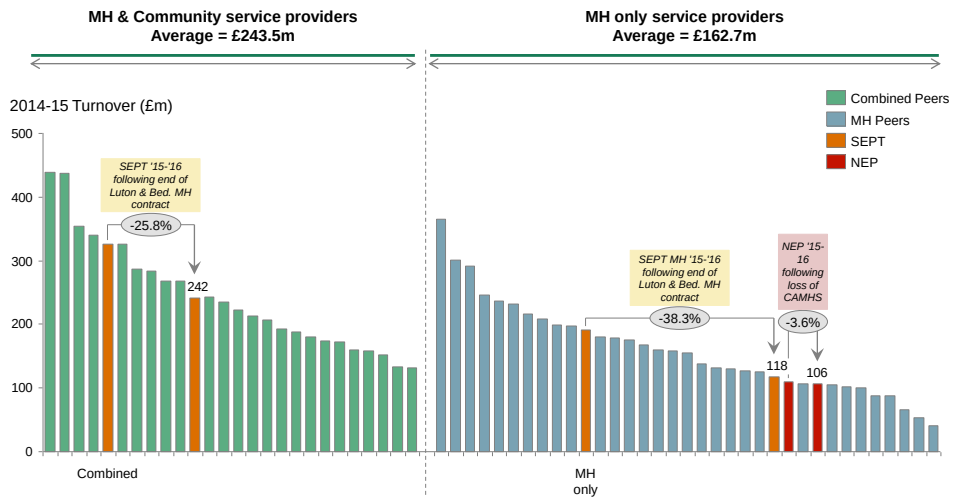
6. Findings: Providers

NEP and SEPT are facing three significant and inter-related challenges:

A shrinking market

The overall market for specialist mental health trusts is shrinking as commissioners integrate the lower acuity services into primary care and new models as described above. In addition, NEP and SEPT are losing market share. They increasingly face competition from out-of-area trusts for local services: the recent pan-Essex CAMHS contract was lost to North East London NHS FT (NELFT); IAPT services in the north are already provided by Hertfordshire Partnership University NHS FT (Herts Parts); SEPT's community mental health contract with Luton and Bedfordshire is not being renewed. These developments will see SEPT lose around 30% of total turnover, and NEP 3.6%.

Relative size (by income) of SEPT and NEP against relevant peer group for 2015/16



Source: Annual Account and Reports 2013-14; HSJ Intelligence; SEPT annual reports; SEPT 2015/16 operational plan; Data received from SEPT, 28 July; NEP Board Papers, May 2015, updated for current LFTM

Challenging finances

As described above, mental health funding has been historically challenging. Funding for the providers is constrained, with a 4% year-on-year efficiency requirement and significant CIP targets. NEP in particular is facing short term difficulties. It posted a deficit in 2013/14 and the plan for 2015/16 as submitted to Monitor is dependent on realising significant CIPs; on CCGs not realising all their planned savings around Clusters 1-4; and on being able to offset activity loss with a reduction in associated costs.

Potential brand issues

Stakeholder feedback indicates that both providers face brand issues. Perception exists amongst some commissioners that there has not been an adequate response to changes in policy, such as The Care Act, and that the threshold for admission into secondary care is too high. Communication around changes to services – for example, Journeys at NEP – has not been deemed sufficient, and there is a perception that providers are not sufficiently data transparent.

7. The momentum case

The status quo is not an option: the commissioning landscape will become more complicated as the integration agenda plays out; there are not sufficient facts and data to prioritise services in order to make more efficient (and transparent) use of limited available resources; and providers are likely to fail posing risk to the continuity of services and the safety of service users.

For providers, as the integration agenda progresses, they may ultimately lose access to between 30-50% of the current available mental health market in Essex[29]. Both trusts risk becoming subscale in mental health care, with difficulties attracting, training and retaining staff, supporting consultant rotas, and having the capacity and capability to effectively bid for new contracts – thus effectively creating a downward spiral.

In the north, NEP has already submitted a challenging financial forecast to its Board which indicates that it is unlikely to be financially viable in the short term.

NEP: Current 5-year financial plan

As discussed at the NEP Board, May 2015

2015/16 plan reflects material changes since April submission
- £2.9m net pressure from changes to the main contract
- £0.5m net pressure from the loss of CAMHS
- Plus a £2.0m reduction in working capital due to unpaid cluster 1-4 activity and reduced property receipts

NEP will need to address 3 non-recurrent items from 2015/16 to break even in 2016/17
- £0.5m of CCG income is for 2015/16 only
- £1m of planned savings are non-recurrent
- £1.2m of full-year impact of CAMHS contract

Plus any additional recurrent cost pressures/income reductions from 2015/16

5-year base case, May 2015

£m	14/15[1]	15/16	16/17	17/18	18/19	19/20
Income	110	106	101.4	100.8	100.2	99.6
Ops surplus	(17.3)	0	0.2	0.2	0.5	1.0
CIP *% income*	*2.5* *2.3%*	4.2 *4.0%*	5.9 *5.8%*	3.2 *3.0%*	3.2 *3.2%*	3.3 *3.3%*
Cash	10.4	8.7	6.6	10.5	15.6	15.2
CoSRR	3	3	3	2	3	4

NEP believes that savings of ~6% in 2016/17 will be difficult to achieve without major service reductions
- Recent savings of 3-4% have been challenging

Downside case models the implications of 3% CIPs in 2016/17
- Cash position deteriorates 53% by 2017/18
- CoSRR deteriorates to 1 by 2017/18

5-year downside case, May 2015

£m	14/15[1]	15/16	16/17	17/18	18/19	19/20
Income	110	106	101.4	100.8	100.2	99.6
Ops surplus	(17.3)	0	(2.6)	(2.7)	(2.5)	(2.1)
CIP *% income*	*2.5* *2.3%*	4.2 *4%*	3.1 *3%*	3.2 *3%*	3.2 *3%*	3.3 *3%*
Cash	10.4	8.7	3.8	4.7	6.8	3.4
CoSRR	3	3	3	1	2	2

1. Actual figures
Source: NEP Board Papers, May 2015, updated for current LFTM

SEPT has other business units in addition to mental health – community healthcare and learning disabilities – which mean that there is more strategic ambiguity over its future. However its 2014-19 strategic plan suggests that without further income growth, "SEPT would need to merge by 2018/19" to ensure sustainability.

[29] Based on approximate costs per cluster grouping and range of ambition around CCG integration plans. See Appendix 3, Section 5 for further details.

SEPT: 2014-19 Strategic Plan, 2014

From Annual Report and Operational Plans

Extracts

"Assuming no other income is secured, SEPT is sustainable over the 5-year planning period ... as long as it is able to deliver the required year on year efficiency requirements [through] 10 programmes of work" *(p.12)*

"Although Trust has an excellent track record of delivering CIPs ... it has been increasingly difficult to deliver planned efficiencies as the 'low hanging fruit' schemes have been delivered" *(p.16)*

" Opportunities for growth will have to be pursued to minimise longer term risk to sustainability...without growth in income SEPT would need to merge by 2018/19" *(p.13)*

5-year base case

£m	13/14[1]	14/15	15/16	16/17	17/18	18/19
Contracted income	325.6	316.6	234.4	194.9	193	191.1
Ops spend	326.0	315.4	234.9	193.1	192.4	189.3
Ops surplus	(0.5)	1.2	-0.5	1.8	0.6	1.8
CIP *% income*		16.5 *5%*	13.7 *6%*	10.8 *6%*	10.8 *6%*	10.8 *6%*
Cash	38.6	40.4	36.5	33.9	29.6	26.5
CoSRR	3	4	3	4	3	4

5-year upside

£m	13/14[1]	14/15	15/16	16/17	17/18	18/19
Contracted income	325.6	316.6	342.7	361.2	358.2	355.1
Ops spend	326.0	315.4	339.4	349.4	347.6	343.3
Ops surplus	(0.5)	1.2	3.3	11.8	10.6	11.8
CIP *% income*		16.5 *5%*	9.0 *3%*	13.7 *4%*	6.9 *2%*	9.4 *3%*
Cash	38.6	40.4	36.5	40.3	45.9	44.6
CoSRR	3	4	3	4	4	4

5-year downside

£m	13/14[1]	14/15	15/16	16/17	17/18	18/19
Contracted income	325.6	316.6	228.4	159.2	157.6	156.0
Ops spend	326.0	315.4	231.8	160.2	159.6	157
Ops surplus	(0.5)	1.2	(3.4)	(1.0)	(2.0)	(1.0)
CIP *% income*		16.5 *5%*	13.7 *6%*	10.8 *7%*	10.8 *7%*	10.8 *7%*
Cash	38.6	40.4	36.5	41.8	40.8	41.8
CoSRR	3	4	3	3	3	3

Notes: 13/14 actuals based on annual report; 14/15 actuals and 2015-19 forecasts based revised data received from SEPT; Text extracts from 2014-19 Monitor Strategy
Source: Annual Report 2013/14; Revised 5-year forecast received 28 July

Clinical and professional feedback supports the need for change: there is broad agreement that the current state is not sustainable. Clinical and operational performance is already under pressure, with bed occupancy over 100% in some areas for example.

Importantly, service users consulted as part of this review also reflected back the increasing complexity of the current landscape. They describe the need to become experts in order to 'navigate' to the right services, and describe having to 'game' the system so as to access the care they need.

See **Appendix 1, Section 5** for additional data around provider findings and the momentum case, and **Section 6** for selected competitor vignettes.

8. Recommendations: Commissioners

In order to change path and avert the momentum case, this review makes a number of recommendations. These are described below, grouped according to four key themes.

1. Simplify the commissioning landscape

1a Clarify the integration agenda: commissioners should refine the scope of mental health services planned to be within their local integration models. This should be done with greater clinical and professional leadership, and tailored to local primary care capacity and capabilities. Clinical risk currently lies with the clinicians in secondary care: how this works in shared and integrated care teams will need to be clarified a part of this process. In addition, rather than each moving at their own pace, we recommend commissioners agree a more uniform timeline. This will involve a change of pace for some but potentially result in faster and less complicated implementation.

1b Align around a clear commissioning path: this review considered a number of paths for commissioners. Each represents different trade-offs and has a range of impacts on providers. A preferred path – 'Option 2b' – has been described below. See **Appendix 3** for the longer list of options and additional detail around the option appraisal process.

As part of this path, and to allow commissioners to de-average their approach to commissioning, mental health has been considered in segments. These segments are based on clusters and have been tested with clinicians[30]. They are intended as a way of approaching service user health and personal care needs in a more customised, de-averaged way in order to ultimately describe which future services should be commissioned. The timelines for each segment are based on how long is needed before any competitive benchmarking, market testing and potential procurement processes can be considered.

For example, for clusters 1-3, all commissioners are aligned that these form part of the integrated care agenda and will provided locally – either in primary care, new models of care, shared care, or by locally commissioned providers. The services that are needed are relatively clear. There is no requirement for a fixed or shared timeline: contracts can be commissioned locally and timelines are variable.

At the other end of the acuity spectrum, for clusters 10 and 13-17, most commissioners are agreed that the majority of care will continue to be provided by specialist mental health trusts. However there is work to be done by both commissioners and providers, as described in the recommendations above, to conduct robust needs assessments; agree outcomes; determine which services to commission; and allocate funding. Moreover, if a competitive process was to be considered around inpatient services, a strategy would need to be found to address the current estate ownership. For this segment, contracts would therefore be continued for a further 5 years. However importantly, there would be clear stage-gates in place. For example, for providers, these would be around meeting pre-agreed conditions around and ways of working; for commissioners, these would be around providing clarity in terms of service specifications.

[30] These segments are not intended to replace clusters as the unit for PbR

Draft commissioning path

All timelines commence April 2016

Commissioner key: CCGs; NHS England; Local authorities

Provider key: Primary care; Shared care; Specialist MH Trusts

Super-cluster	Cluster / category	Example ICD 10 diagnosis	First cut of SUs that could be in primary / new models / shared care (depending on local capacity / capability)[1]	Draft timeline by segment[1]
Non-psych.	1 Common Mental Health Problems (Low severity)	F32 Depressive Episode F40 Phobic Anxiety Disorders F42 Obsessive-Compuls. Dis. F43 Stress Reaction Disorder F48 Other Neurotic Disorders	Up to 95% of SUs	Variable, local, 2 year max
Non-psych.	2 Common MH Problems (Low severity with greater need)			
Non-psych.	3 Non-Psychotic (Moderate severity)			
Non-psych.	4 Non-Psychotic (Severe)	F50 Eating Disorder	~60-70% of SUs	3 years; % (TBC) shift by Y2
Organic	18 Cognitive Impairment (Low)	F00 Dementia in Alzheimer-s F01 Vascular dementia F02 Dementia in other F03 Unspecified Dementia F09 Unspecified organic or symptomatic mental disorder	~80-90% of SUs	2 years
Organic	19 Cog. Impairment / Dem. Complicated (Moderate)			
Organic	20 Cognitive Impairment or Dementia (High)		~60-70% of SUs	
Organic	21. Cog Impairment or Dem (High Physical or Engagement)			
Non-psych.	5 Non-Psychotic Disorders (Very severe)	F33 Recurrent Depression F41 Other Anxiety Disorders, F42 Obsessive-Compuls. Dis. F44 Dissociative Disorder F45 Somatoform Disorder	~50-60% of SUs	3 years % (TBC) shift by Y2
Non-psych.	6 Non-Psychotic Disorder of Over-Valued Ideas			
Non-psych.	7 Enduring Non-Psychotic Disorders (High disability)			
Non-psych.	8 Non-Psychotic Chaotic, Challenging Disorders	F60 Personality disorder (PD)	~50-60% of SUs	
Psychotic	11 Ongoing Recurrent Psychosis (Low severity)		~60-70% of SUs	3 years
Psychotic	12 Ongoing or Recurrent Psychosis (High disability)	F20-F29 Schizophrenia, schizotypal and delusional disorders F30 Manic Episode F31 Bipolar Affective Disorder	~40-50% of SUs	
Psychotic	10 First Episode Psychosis		Up to 5% of SUs	5 years with stage gates at 2 years and 3.5 years
Psychotic	13 Ongoing / Recurrent Psychosis (High severity, disability)			
Psychotic	14 Psychotic Crisis			
Psychotic	15 Severe Psychotic Depression	F32.3 Depression w. psychosis		
Psychotic	16 Dual Diagnosis (Substance Abuse)	F10-F19; F20-F29		
Psychotic	17 Psychosis, Affective Disorder (Difficult to Engage)	F20-F29 Schizophrenia, Bipol.		
Forensic	Community forensics and rehab	Diagnosis with history of offending / harm to self or others		NHS England / LA / recently commissioned
Forensic	Secure inpatients			
CAMHS	Tiers 2 & 3	Children and adolescents with an ICD 10 diagnosis		
CAMHS	Tier 4			
LAs	Drugs and alcohol (see also Cluster 16)	See Cluster 16		

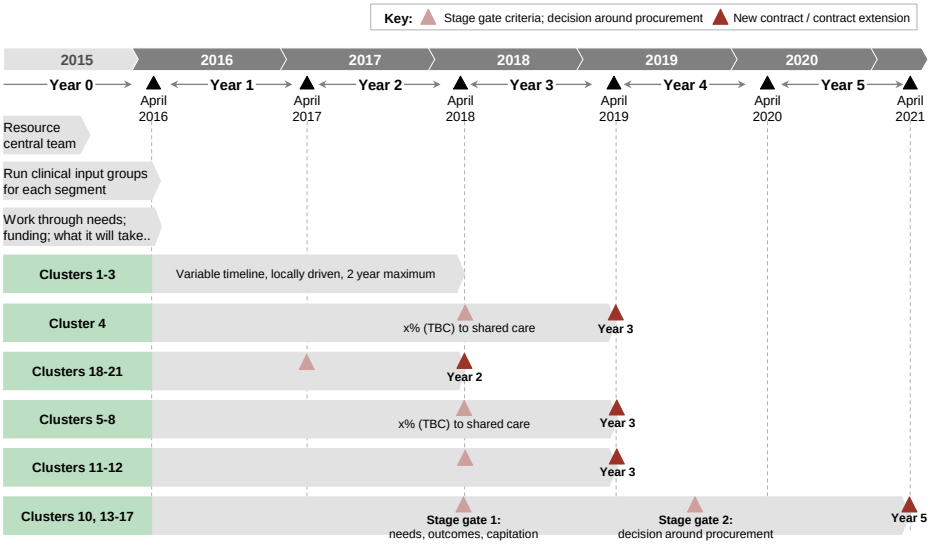
Assessment and management, including s.75 social workers; Care and support incl. residential care, supported accommodation, home care, direct payments

1. Each segment is heterogeneous in terms of diagnoses, severity, and service user (SU) needs: this view will need refining and working through with clinicians. Shared care refers to care shared with a specialist provider.

Notes: This is not a comprehensive view of services; intended for illustration purposes only; excludes some specialist care e.g. peri-natal, eating disorders, adult ADHD which may also be given a Cluster diagnosis; picture is emerging and is based on latest available views.

Source: Stakeholder interviews; Expert interviews

Draft timeline



The belief is that this path potentially represents the best balance between ensuring commissioners have sufficient time to implement the recommendations, whilst ensuring the needs of service users are met in a timely manner. It also provides NEP and SEPT the opportunity – in terms of space and clarity – to rethink their strategies around service and form.

See **Appendix 1, Section 7** for additional detail around the emerging integration agenda and Option 2B.

1c Work through how best to deploy social workers as the integration agenda plays out: as services are integrated and existing pathways change, local authorities and CCGs will need to jointly assess how best to deploy social workers – for example whether these should follow services or whether they should be organised in a more centralised way.

1d Agree a plan to re-align funding between CCGs: commissioners should agree the approach and timeline to reapportion expenditure and Resource Limit to ensure an affordability neutral solution ahead of implementing the local integration agenda. This has already been agreed in principal in the north of the county.

1e Define where dementia services should sit: local authorities should agree with their local CCGs whether to move dementia under Public Health and Wellbeing as an all-age pathway, whether it should remain split within Adult Social Care.

2. Create a common language and use to clarify needs and expectations

2a Agree a common language: commissioners and providers should agree to use a single terminology / language going forward. Clinical input suggests clusters may be the most reasonable lexicon given the national direction. However it remains imperfect: in clinical practice, services users within clusters are heterogeneous and clustering does not align perfectly with diagnoses, nor are services users familiar with the terminology.

2b Clarify the desired provider capabilities: commissioners should, working with providers, undertake to create a common and shared set of required provider capabilities, for example around IT; culture; flexibility; data transparency.

For example, regarding IT systems, commissioners should agree the key requirement – for example that all IT systems be compatible and able to interface effectively – and then work collaboratively with providers and key experts to understand the different options and the trade-offs around these. For example, moving towards System 1, as has been done in Hertfordshire, will have funding implications which would need to be worked through jointly.

2c Optimise section 75 partnership arrangements: in the south, the three local authorities should commit to working together to create a common template, shared performance targets, and single joint oversight meeting in order to reduce effort and avoid duplication.

2c Work with providers around The Care Act compliance: local authorities should develop clear and consistent expectations for providers' compliance with the Care Act, including what should be incorporated into their contracts in terms of access to pathways for people in distress. This will involve discussions around appropriate funding to ensure realistic expectations.

3. Generate and share more data across the system

3a Conduct robust needs assessments: commissioners should work with clinicians and professionals to assess service user health and personal care needs, including how these differ by geography, locality (e.g. urban vs. rural), and cluster segment.

3b Develop and track better outcomes: building off *3a* above, commissioners should work with clinicians and professionals develop desired outcomes – these will inform which services should be commissioned, and how they will be monitored. They will also support funding prioritisation decisions - which clinical feedback suggests are inevitable given the tight funding environment.

3c Share the output of ongoing needs assessment work in dementia: local authorities should ensure learnings and outputs are widely disseminated to avoid duplication and ensure a shared understanding of what is needed.

4. Work more jointly

4a Create a pan-Essex MH commissioning team: commissioners should consider a smaller, more senior mental health team – for example around 10 FTEs – that includes senior analytics, business intelligence, and financial expertise. This would provide real leverage and help make necessary trade-offs between services and cost – the need for which was highlighted at the Clinical Conference held in August.

The recent CAMHS commissioning points to a more effective model. Despite some initial challenges around the process, the outcome to date is deemed positive. The team was co-led by senior health and local authority resources who had sight of the overall context, the right skills and capabilities, and led joint working across the patch on behalf of all commissioners.

The exact organisational form and governance processes should be jointly agreed by commissioners in the coming weeks. Importantly, a single team does not mean a 'one size fits all' solution. Needs, services, activities and outcomes need to be tailored to local geographies.

The principles behind having a smaller, shared team are to attract and fund the appropriate seniority of resource; support simplification and enable the use of a common language; create a single fact base of needs, activities, and outcomes; and build off the CAMHS experience of joint working across health and social care.

Between now and April 2016 the team would work through recommendations *3a* and *3b* above: conduct robust needs assessments; determine gaps; agree outcomes; describe what services should be commissioned to deliver these; prioritise funding; draft commissioning intentions; and refine the draft commissioning path described in *1a* above. From April onwards, there are choices around what role it should continue to play. It should take on a more supportive role around common templates and sharing best practices; or it could commission pan-Essex services provided by specialist mental health trusts – this would exclude for example clusters 1-3 and the dementia clusters, which will be integrated.

4b Optimise AMPHs arrangements: the three local authorities should confirm the numbers required over the next 3-5 years across Essex and work with the trusts to agree costs and approach. At the same time, local authorities should work with the trusts to ensure AMHPs receive appropriate support in addressing delay, as this may improve retention. Finally they should review the service arrangements to ensure that it is as efficient and cost-effective as possible. For example, they may consider contracting a single provider to run the entire rota.

4c Work together to ensure all-age, cross-system care: all commissioners should build on the CAMHS experience and commit to working together to improve outcomes for the most vulnerable individuals, and ultimately develop a shared vision for mental health in Essex. For example, with the new CAMHS contract in place, there is an opportunity to take a life course approach, setting out the vision and standards of care needed from early life, childhood, teenage years into healthy older age and end of life. In addition, local authorities should ensure that the wider impact of mental illness – on employment, housing, and families for example – are accounted for in future commissioning and service specifications. Finally, local authorities should continue to work with public health and primary care to ensure that the stigma that surrounds mental health is continuously addressed through public awareness campaigns.

9. Recommendations: Providers

Providers need to react strategically to the challenges described above, in the context of greater clarity around the integration agenda and timelines from commissioners.

Focus on the core portfolio of services

Providers should review the current portfolio in order to focus on what is core. This will involve defining what their key competencies are and identifying the key adjacencies, skillsets and capabilities required to support these core services. It may also involve a de-prioritisation of non-core services – providers may choose not to bid for these as they are tendered over time.

Build greater depth of capability

In collaboration with commissioners and service users, they should seek to build greater depth around the capabilities which are seen as 'requirements' by commissioners (see Recommendation 4 above).

Consider the form and scale required to deliver within the confirmed timeframe

For providers, the recommended path creates clarity around timelines – and provides them with space to pursue an appropriate strategy around form and scale for their core services. Doing this economically may involve collaboration or merger.

10. Next steps

The proposed next steps are for stakeholders to:

- Consider the recommendations outlined in this report
- Agree which to take forward
- Work together to agree a robust implementation plan
- Set up appropriate governance processes

Appendix 1 (attached PDF): Contents

Section 1: mental health funding in Essex

Section 2: additional detail around key trends and recent publications

Section 3: NEP and SEPT financial, operational, and quality data

Section 4: historic CCG allocations

Section 5: provider findings and momentum case

Section 6: selected competitor vignettes

Section 7: additional materials around Options 1 and 2

Section 8: commissioning cycle and best practices

Appendix 2: Engagement as part of this review

The project team conducted nearly 50 1:1 interviews with the following stakeholders:

Interviews: providers and CCGs

Providers (10)

NEP (5)	Andrew Geldard, CEO	23 June
	Ian Carr, Area Director (West Essex)	23 June
	Vince McCabe, Director of Operations	23 June
	David Griffiths, Director of Resources	14 July
	Mike Chapman, Director of Strategy	25 June
SEPT (5)	Sally Morris, CEO	22 July
	Dr Llewellyn Lewis, Dep. Medical Director	6 July
	Andy Brogan, Exec. Director of Clinical Gov. & Quality	22June
	Dr Milind Karale – Medical Director	23 June
	Malcolm McCann – Executive Director of Operations	6 Aug

CCGs (22)

North East Essex (4)	Sam Hepplewhite, Chief Officer	16 June
	Lisa Llewelyn, Director Nursing & Quality	16 June
	Christine Dickenson, Head, MH Commissioning	16 June
	Joanne Reay, Commissioning Lead	23 June
West Essex (4)	Clare Morris, Chief Officer	17 June
	Miranda Roberts, Clinical Lead, Mental Health	28 July
	Dean Westcott, CFO	17 June
	Kirsty O'Callaghan , Finance Lead	20 July
Mid-Essex (4)	Caroline Rassell, Chief Officer	22 June
	Dr. Caroline Dollery, Chair	19 Aug
	Daniel Doherty, Clinical Commissioning	30 June
	Dee Davey, CFO	14 July
Basildon & Brentford (1)	Tom Abell, Chief Officer	16 June
Castle Point & Rochford (4)	Ian Stidston, Chief Officer	29 June
	Kevin McKenny, Chief Operating Officer	23 June
	Margaret Hathaway	9 July
Thurrock (2)	Mark Tebbs, Head of integrated commissioning	23 June
	Jane Itangata, Head of MH Commissioning	23 June
Southend (3)	Melanie Craig, Chief Officer	29 June
	Dr José Garcia, Chair & mental health lead	23 July
	Hugh Johnston , MH commissioning mgr	23 June

Interviews: local authorities and external experts

Local authorities (12)

Essex (5)	Mike Boyle, Director of Local Delivery (South)	16 June
	Barbara Herts, Director, Integrated Commissioning & VPs	16 June
	Ben Hughes, Head of Commissioning PH & Wellbeing	16 June
	Emily Oliver, Commisioner, Vulnerable People	16 June
	Matthew Barnett, Senior Analyst	24 June
Thurrock (3)	Catherine Wilson , Lead Commissioner	23 June
	Fran Leddra, Lead Council Ops	15 July
	Roger Harris	18 Aug
Southend (4)	Sharon Houlden, Head of Adult Services & Housing	6 July
	Jacqui Ainsley, Director Integrated Care Commissioning	4 Aug
	Jo Dickenson	4 Aug
	Simon Leftley, Director for Adult Services	16 July

External (3)

Martin Brown	Professor, University of York	9 June
John Richards	Director, J Richards Solutions	16 June
Dr. Geraldine Strathdee	National Clinical Director for MH	28 July

The project team met with service users to understand their perspectives and gain their input on July 14th.

Robust clinical input into the review was ensured through a Clinical and Professional Leadership Group, set up as part of the review, and attended by individuals nominated by each stakeholder organisation. Two meetings were held on July 6th and July 28th.

A wider Clinical Conference, attended by over 50 clinicians and professionals from primary and secondary care, was held at the Marconi Club in Essex on August 3rd.

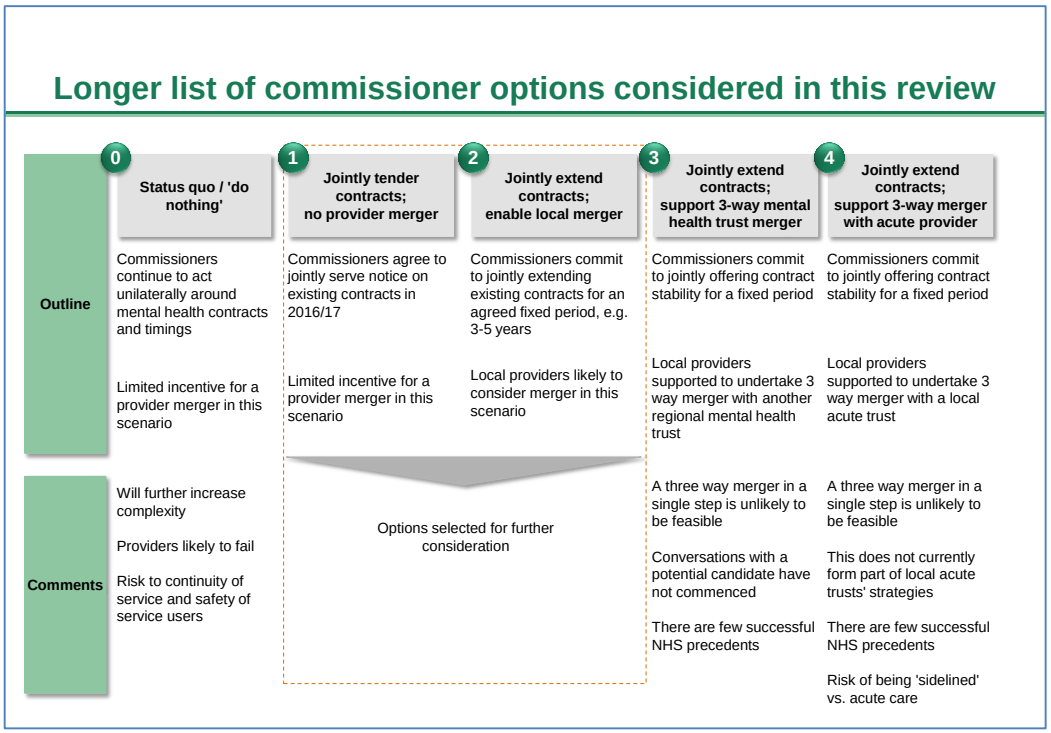
Clinical and professional input: Clinical conference and leadership group attendees

Name	Organisation
Sunil Gupta	CP&R CCG
Michael Bailey	Mid Essex CCG
Elizabeth Towers	Mid Essex CCG
Lisa Llewelyn	N Essex CCG
Miranda Roberts	N Essex CCG
Alexina Weston	N Essex CCG
Liz Carlisle	NEP
Ian Carr	NEP
Benita Christie	NEP
John Cleaver	NEP
Sarah Croot	NEP
Ian Daldry	NEP
Tom Dannhauser	NEP
Lloyd Davies	NEP
Sarah Dowse	NEP
Malte Flechtner	NEP
John Gardner	NEP
Ratna Ghosh	NEP
Harsha Gopisetty	NEP
Natalie Hammond	NEP
Mary Kennedy	NEP
Linda Law	NEP
Ian Lea	NEP
Anna Marley	NEP
Gbolahan Otun	NEP
Hemraj Pal	NEP
Jo Paul	NEP
Lynn Prendegast	NEP
Abdul Raoof	NEP

Name	Organisation
Stephanie Rea	NEP
James Sawtell	NEP
Toni Scales	NEP
Kallur Suresh	NEP
Lizzy Wells	NEP
Russell White	NEP
Gaynor Abbott-Simpson	SEPT
Maria Gutierrez	SEPT
Ron Gutu	SEPT
Annie Heining	SEPT
Milind Karale	SEPT
Gary Kupshik	SEPT
Llewellyn Lewis	SEPT
Julia Renton	SEPT
Karin Thies-Flechtner	SEPT
Andrea Ather	Southend CCG
Sharon Connell	Southend CCG
Linda Dowse	Southend CCG
Hugh Johnston	Southend CCG
Andrea Metcalfe	Southend CCG
Syed Taz	Southend CCG
Anand Deshpa	Thurrock CCG
Jane Itangata	Thurrock CCG
Catherine Wilson	Thurrock UA
Sanjeev Rana	West Essex CCG
Miranda Roberts	West Essex CCG

Appendix 3: Option appraisal

A number of options were considered as part of this review.



These were discussed and assessed against agreed criteria, which included risk to continuity of care and the safety of service users; sustainability; access to services; compatibility with overall national policy; feasibility; and preservation of mental health expertise and parity of esteem.

Based on the discussions, Options 1 and 2 were selected for further more detailed consideration. Both involve trade-offs, and these are different for different commissioners.

Option 1:

In this scenario, commissioners would align around jointly serving notice on the existing NEP and SEPT contracts in 2016 in order to commence new provision in Q1 2017, in line with existing contract timelines. There is little incentive for a provider merger in this scenario; local providers may still choose to bid for services. If the local providers are not successful, a transition plan would need to be agreed to ensure short term continuity of service in the north – in the south, SEPT would still have other business units to consider and may not be immediately financially unsustainable.

The key beliefs around this option are that:

- Service users are best served by moving quickly to a final configuration around provision of mental health services
- Any short term instability and risks to continuity of service can be mitigated
- Commissioner recommendations described as part of this review can be conducted in sufficient time and / or in parallel to the re-procurement process: this includes setting up new models of integrated care and ensuring enablers for the integration agenda are in place, for example new clinics and the necessary support in primary care practices

- A strategy around estates can be worked through in time so as to enable competition around inpatient services (given the incumbent local providers are the legal owners of their infrastructure)
- There is sufficient high quality competition in the system to enable a robust procurement process for all services…
- …and that should the local providers be unsuccessful, having local providers present in Essex longer term is not a key requirement

Option 2:

In this option, commissioners would align around jointly extending the existing NEP and SEPT contracts for a fixed time period, for example 3-5 years. This would be subject to clear conditions, such as agreed outcome metrics and a commitment to joint dialogue around service optimisation – and involve clear stage-gates to review progress. Under these circumstances providers may consider proceeding with a merger, building on discussions that have already commenced.

The key beliefs around this option are that:

- This timeline would ultimately lead to a better final answer for service users with less risk of service disruption in the interim
- Commissioner recommendations described as part of this review will require time to implement, and should be done prior to commencing procurement for new contracts – for example, conducting robust needs assessments, describing what services are required, prioritising funding, and writing robust service specifications
- There is not yet sufficient high quality competition in the system, and competition for inpatient services is not yet possible given the current estates ownership
- Giving local providers the space to consider merger, refocus strategically, and remodel their services will enable them to remain competitive in the longer term – and that having sustainable local providers is in the longer term interest of services users

See **Appendix 1, Section 6** for additional materials around Options 1 and 2.

Following discussion amongst commissioners at the Steering Committees and at three Accountable Officer meetings in July, August and September, a middle ground - Option 2b - was considered the preferred path and is described in detail above.