Mental Health STRATEGIES

Barnet, Enfield and Haringey Mental Health Services

FINANCIAL REVIEW

– Final report

March 2014

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1. INTRODUCTION

This document reports the findings of a project carried out between 20th December 2013 and 14th March 2014 to review whether local NHS mental health commissioners can afford the range of adult and older people's mental health services currently provided to them by the Barnet, Enfield and Haringey Mental Health Trust (BEH-MHT).

Commissioners from Barnet, Enfield and Haringey were seeking to ensure that they secure the best possible value for money from the investment made in mental health care, and to consider all ways in which local service models could be redesigned to secure both efficiencies and cost savings. This project is intended to provide both a body of evidence to inform this process, and independent recommendations as to specific actions which could be taken.

The project's specific objectives were to provide:

a) An assessment of the potential gap between the investment provided by the commissioners to BEH-MHT and the realistic expected cost of providing the range and volume of services currently specified.

b) An assessment of high level options to address that gap, including the potential contributions of:

- capping activity levels and/or changing access thresholds
- decommissioning of services
- estates rationalisation
- service redesign, including improvements in integrated care and/or workforce redesign

The scope of this project included all local mental health services for adults. It therefore did not include:

- Child and adolescent mental health services
- Services provided by BEH-MHT to residents of other boroughs
- Specialist mental health services which are commissioned via regional or national specialist commissioning arrangements

The main body of the report is structured in two main sections:

- section 2 explains our findings on the level of the financial gap, from a range of perspectives
- section 3 explains our findings on opportunities which may be available to meet that financial gap

The report contains finally our conclusions and recommendations.

2. ASSESSMENT OF ''THE GAP''

This section provides an assessment of the potential gap between the investment provided by the commissioners to the Trust and the realistic expected cost of providing the range and volume of services currently specified. The gap can be described or measured in different ways:

- *Benchmarking assessment*: the level of investment per capita compared with other areas, and between the 3 CCGs
- *Contractual assessment*: the level of under/overperformance based on traditional activity unit prices
- *Cash assessment:* the level of investment by the 3 CCGs compared with the costs of the Trust services

We have considered each of these three types of assessment in turn, using appropriate data to measure each type of 'gap'.

Where we have compared investment or activity per capita, we have weighted the population data as follows:

Investment per capita: adult populations are weighted for need, using the standard DH method; all populations are adjusted for the market forces factor.

Activity per capita: adult populations are weighted for need, again using the standard DH method

Populations are derived from the 2011 Census.

2.1. Benchmarking assessment

How does the level of investment per capita compare with other areas?

To compile a comparator group, we have used the 'Nearest Neighbours' model published by the Chartered Institute of Public Finance and Accountancy. For any given local authority, the model will produce a list of other local authorities which are most similar, on a statistical basis, taking into account a number of socio-demographic factors. We have compiled separate lists for the boroughs of Barnet, Enfield and Haringey (Figure 2.1).

Figure 2.1: Borough comparator groups

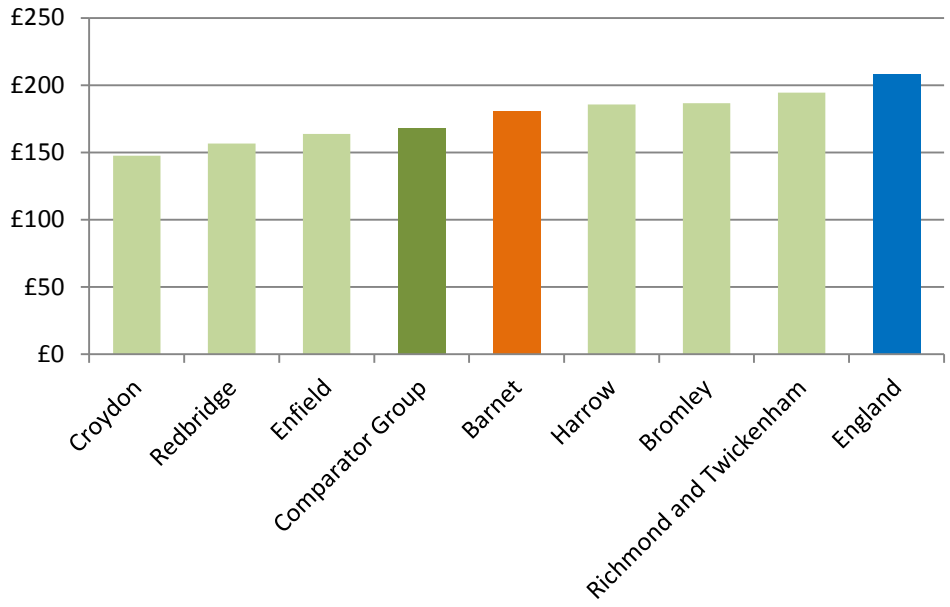
Barnet	Enfield	Haringey
Bromley	Croydon	Brent
Croydon	Ealing	Ealing
Enfield	Harrow	Hounslow
Harrow	Hounslow	Lambeth
Redbridge	Redbridge	Lewisham
Richmond and Twickenham	Waltham Forest	Waltham Forest

As much of the analysis is at a trust level, we have also compiled a list of 9 trust comparators. Where possible, we have used the trusts which serve the areas in the boroughs list above. The trust comparator group is:

- Berkshire Healthcare NHS Foundation Trust
- Central and North West London NHS Foundation Trust
- East London NHS Foundation Trust
- North East London NHS Foundation Trust
- Oxleas NHS Foundation Trust
- South Essex Partnership University NHS Foundation Trust
- South London and Maudsley NHS Foundation Trust
- South West London and St George's Mental Health NHS Trust
- West London Mental Health NHS Trust

Programme budgeting 2011/12[1] shows that the 3 CCGs' overall investment in mental health services (primary and secondary care for all ages) is lower than the England average (Figures 2.2, 2.3 and 2.4). Barnet spends slightly more than its comparator group average, while Enfield and Haringey spend slight less. Enfield spends slightly less than Haringey and Barnet (Figure 2.5). It should be noted that all three comparator groups have an average below the England average i.e. after allowing for deprivation, this tends to be an area which invests less than might be expected in mental health services.

Figure 2.2: Barnet CCG - Overall mental health investment per weighted capita adjusted for market forces factor 2011/12



[1] Programme budgeting is an analysis of total commissioning expenditure by healthcare condition (for example, mental health, cancer) in all NHS settings (for example, primary care and secondary care)

Figure 2.3: Enfield CCG - Overall mental health investment per weighted capita adjusted for market forces factor 2011/12

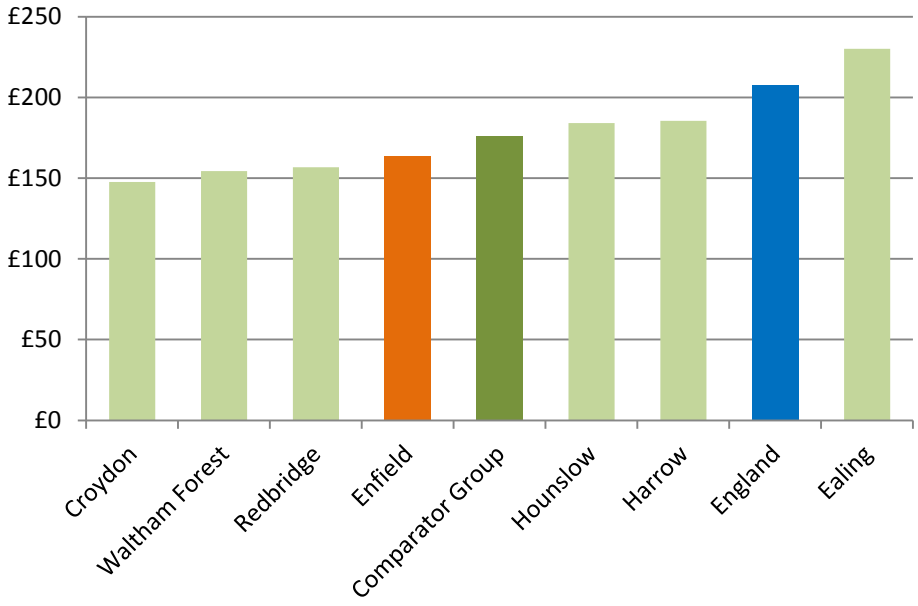


Figure 2.4: Haringey CCG - Overall mental health investment per weighted capita adjusted for market forces factor 2011/12

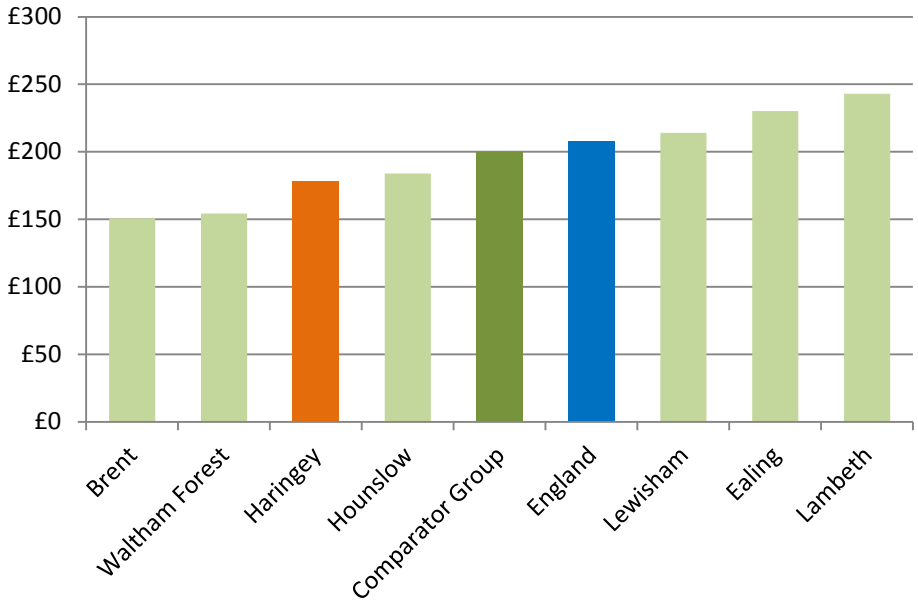
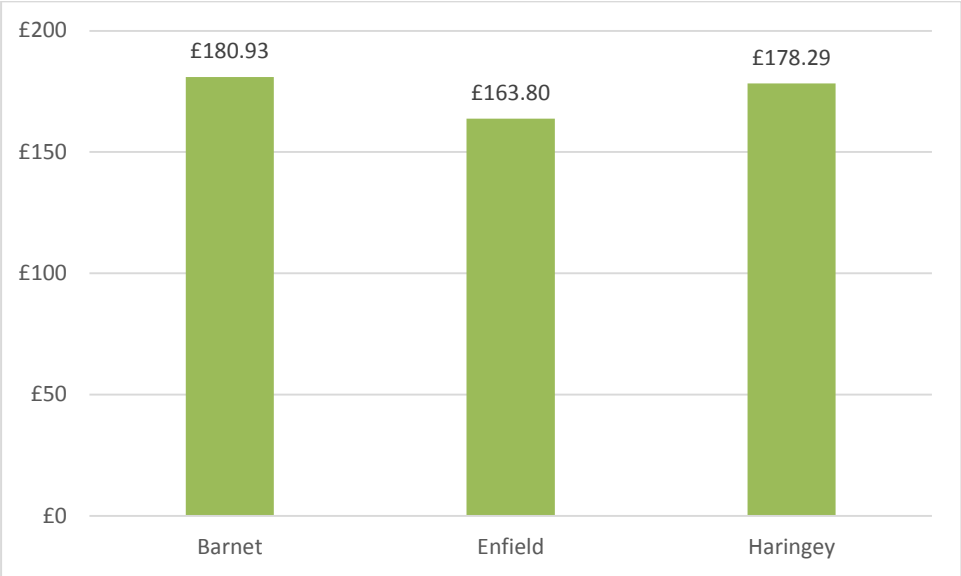
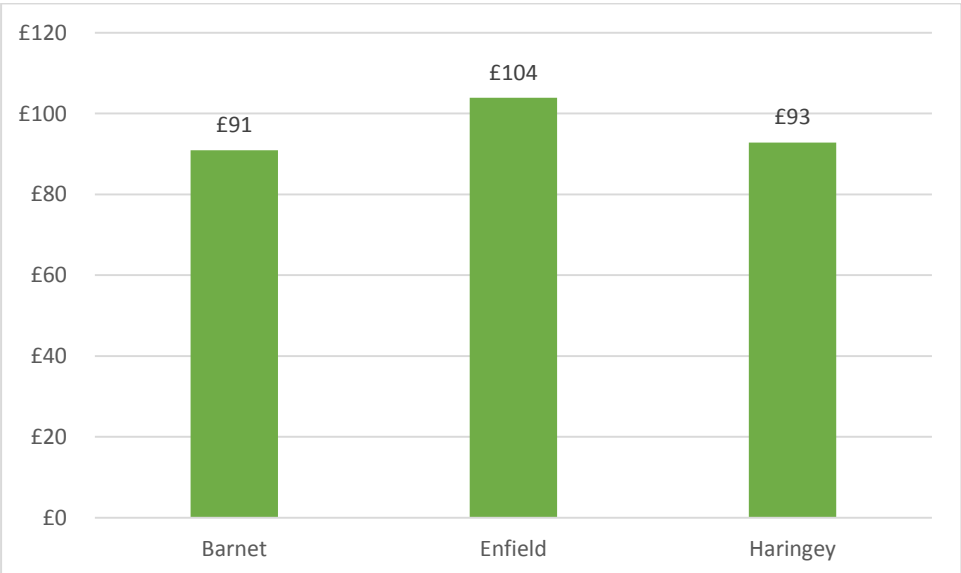


Figure 2.5: Overall mental health investment per weighted capita adjusted for market forces factor 2011/12



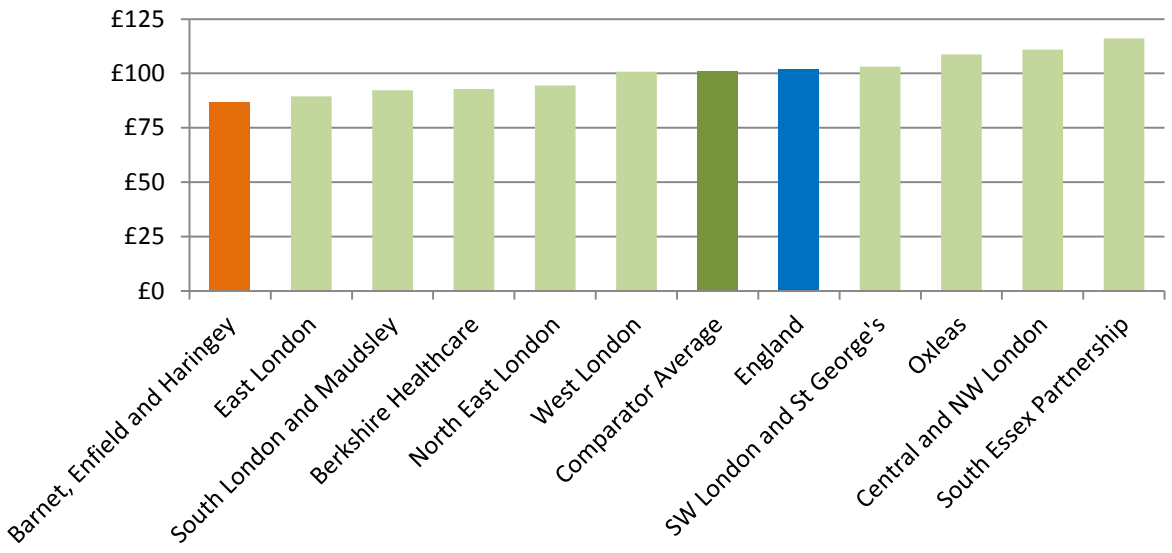
Data provided by the 3 CCGs listing their total investment in mental health services provides a slightly different picture. Programme budgeting includes an estimate of all health costs incurred in treating mental health, including primary care, while this locally provided data only includes secondary care, IAPT and third sector providers. Enfield's investment per capita is slightly more than Barnet and Haringey (Figure 2.6) and all the figures are lower than for programme budgeting data.

Figure 2.6: Mental health investment per weighted capita adjusted for market forces factor 2013/14 forecast



Care cluster reference costs show that the Trust has lower costs per capita for adult and older adult mental health services than the England average and its comparator trusts (Figure 2.7). The costs represent the total costs included within the 2012/13 care cluster reference cost return i.e. costs for admitted care, non-admitted care and initial assessments.

Figure 2.7: Care cluster costs – per weighted capita adjusted for market forces factor 2012/13



We have compared the Trust cluster unit costs with the national average. The results should be reviewed with some caution as care cluster reference costs are a relatively new method of costing, and there are concerns at a national and local level about their data quality. Given that this dataset is however beginning to be cited both nationally and locally, we have included it here for completeness.

23% of Trust days were associated with service users who have not been allocated to a cluster. The average for England was 13%. The costs for unclustered users are recorded under Cluster 99 (Figure 2.8). If the Trust 2012/13 activity levels were costed at the national average, the Trust would have incurred additional costs of £26m. The only Trust unit cost which was higher than the national average was cluster 21 (Cognitive impairment or dementia (high physical or engagement). The comparatively high use of continuing care beds, discussed below, may have contributed to this variance.

Figure 2.8: Trust cluster costs compared to the national average adjusted for market forces factor, using actual activity 2012/13

Cluster	BEH Actual	If at mean	Difference
	£'000	£'000	£'000
Cluster 00: Variance (unable to assign mental health care cluster code)	9	33	-23
Cluster 01: Common mental health problems (low severity)	590	703	-113
Cluster 02: Common mental health problems (low severity with greater need)	887	1,188	-301
Cluster 03: Non-psychotic (moderate severity)	2,670	3,677	-1,007
Cluster 04: Non-psychotic (severe)	1,862	2,012	-150
Cluster 05: Non-psychotic (very severe)	2,776	5,252	-2,477
Cluster 06: Non-psychotic disorders of over-valued ideas	777	1,595	-818
Cluster 07: Enduring non-psychotic disorders (high disability)	3,237	4,121	-884
Cluster 08: Non-psychotic chaotic and challenging disorders	2,418	3,023	-605
Cluster 10: First episode psychosis	3,516	3,812	-295
Cluster 11: Ongoing recurrent psychosis (low symptoms)	8,211	8,704	-492
Cluster 12: Ongoing or recurrent psychosis (high disability)	6,619	8,088	-1,469
Cluster 13: Ongoing or recurrent psychosis (high symptom and disability)	9,761	12,112	-2,351
Cluster 14: Psychotic crisis	3,627	5,916	-2,289
Cluster 15: Severe psychotic depression	736	1,676	-940
Cluster 16: Dual diagnosis	598	1,185	-586
Cluster 17: Psychosis and affective disorder (difficult to engage)	1,940	3,234	-1,294
Cluster 18: Cognitive impairment (low need)	870	1,273	-404
Cluster 19: Cognitive impairment or dementia (moderate need)	3,152	4,678	-1,526
Cluster 20: Cognitive impairment or dementia (high need)	2,500	3,664	-1,164
Cluster 21: Cognitive impairment or dementia (high physical or engagement)	1,705	1,376	329
Cluster 99: Patients not assessed or clustered	6,155	13,784	-7,629
ALL CLUSTERS	64,617	91,106	-26,489

The NHS Benchmarking Network report[2] shows that for the Trust at March 2013:

- Adult acute beds per weighted capita were at the median (Figure 2.9). The report does not include information on out of area placements or 'interim' (temporary) beds
- PICU beds per weighted capita were between the median and lower quartile (Figure 2.10)
- Older adult acute beds per unweighted capita were the second lowest in the database
- Longer term complex and continuing care beds for older adults per unweighted capita were the highest in the database, with only 9 providers showing such beds (Figure 2.11). The Trust had 71 beds per 100,000 population, while the median was 14 beds.

Local service models for community services vary between trusts. For the purposes of benchmarking the Network report includes the following services within the definition of community mental health services:

- Generic CMHTs
- CRHTs
- Assertive outreach
- Early intervention

[2] *NHS Benchmarking Network Mental Health Benchmarking 2013. Includes data from 56 NHS Mental Health Providers, including 4 Welsh Boards. The Trust code is T28. We have not been able to identify other trusts as trusts provide data on the understanding that it remains confidential.*

- Early onset psychosis
- Assessment and brief intervention (including primary mental health teams)
- Rehabilitation and recovery
- Older people
- Memory services
- Other adult community mental health teams

The report shows that for the Trust community mental health services at March 2013:

- Caseload numbers per unweighted 100,000 population were between the median and upper quartile (the report does not provide the community indicators using a weighted population)
- Contacts per unweighted 100,000 population were between the median and upper quartile

Figure 2.9: Adult acute beds per 100,000 weighted population

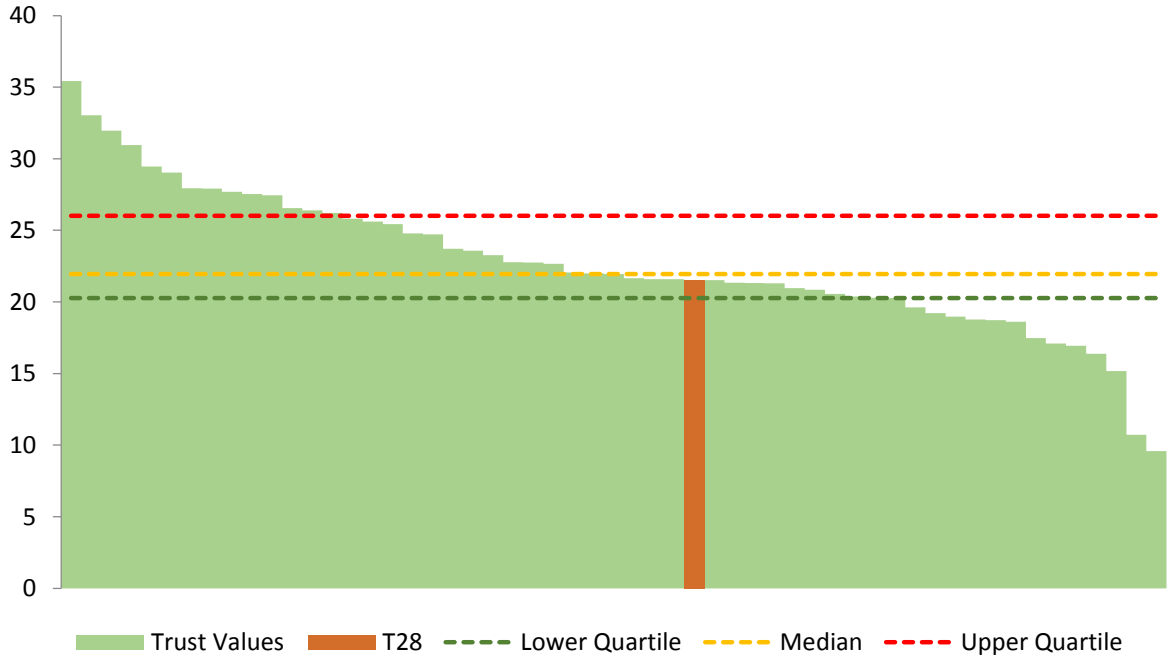


Figure 2.10: PICU beds per 100,000 weighted population

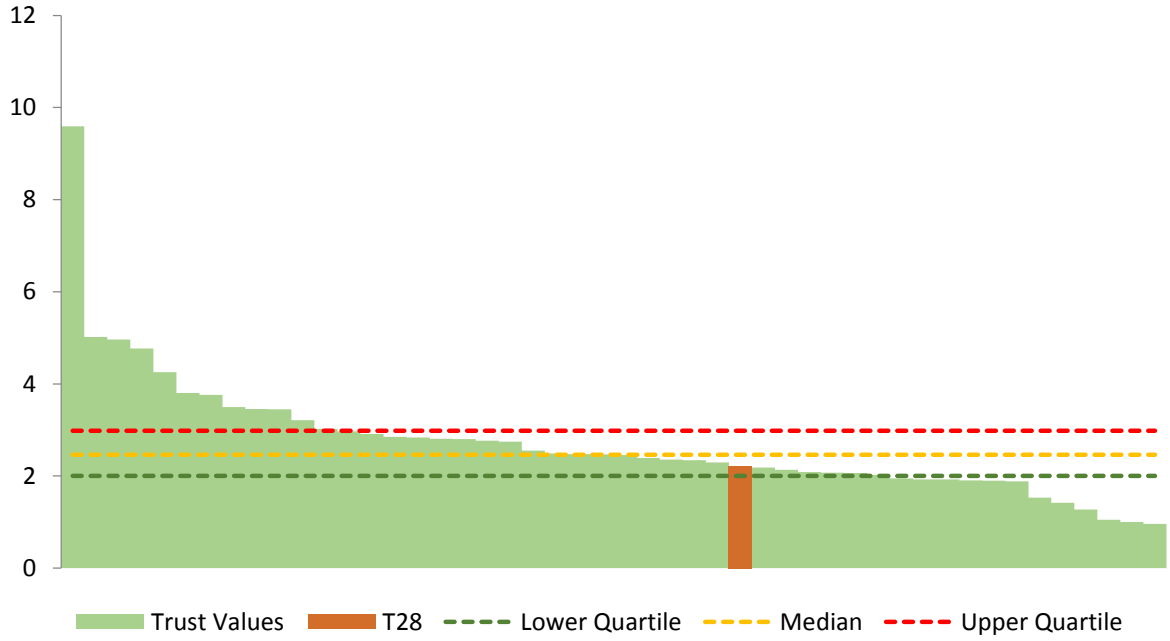
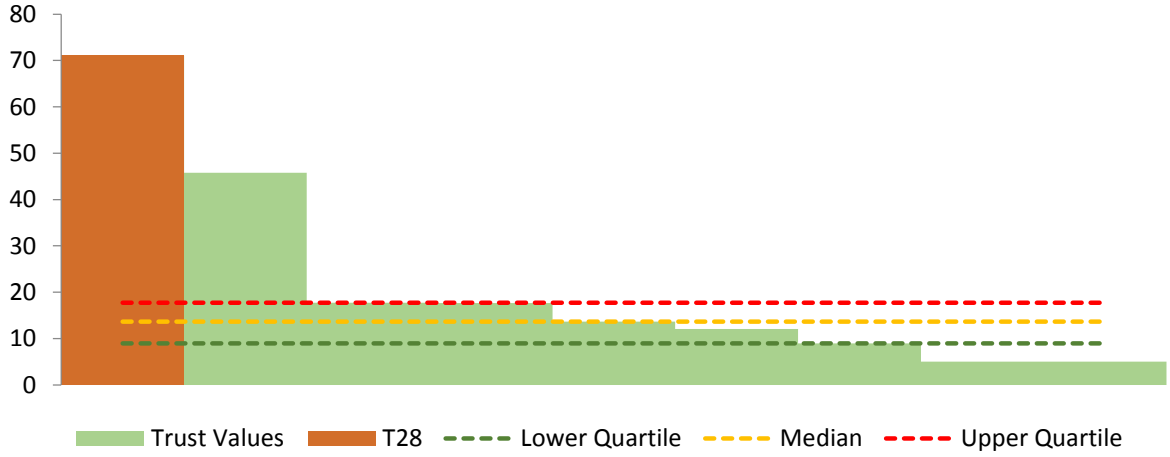


Figure 2.11: Longer term complex/continuing care beds for older adults per 100,000 unweighted population



How does the level of investment in BEH-MHT compare between the three CCGs?

Figure 2.12 shows the value of the CCG mental health contracts with BEH-MHT. The contracts cover adults, older adults, CAMHs and other mental health services. The majority of 'other' is IAPT, which only Barnet and Enfield purchase from the Trust.

Figure 2.12 Mental health contract values with the Trust 2013/14

	Barnet	*% of total contract*	Enfield	*% of total contract*	Haringey	*% of total contract*
	£		£		£	
Adults	17,298,548	*64%*	17,513,309	*57%*	22,723,444	*73%*
Older adults	4,937,282	*18%*	8,710,749	*28%*	5,442,985	*18%*
CAMHs	3,297,454	*12%*	3,219,642	*11%*	2,756,227	*9%*
Other	1,495,325	*6%*	1,132,836	*4%*	130,442	*0%*
Total contract	**27,028,609**		**30,576,536**		**31,053,098**	

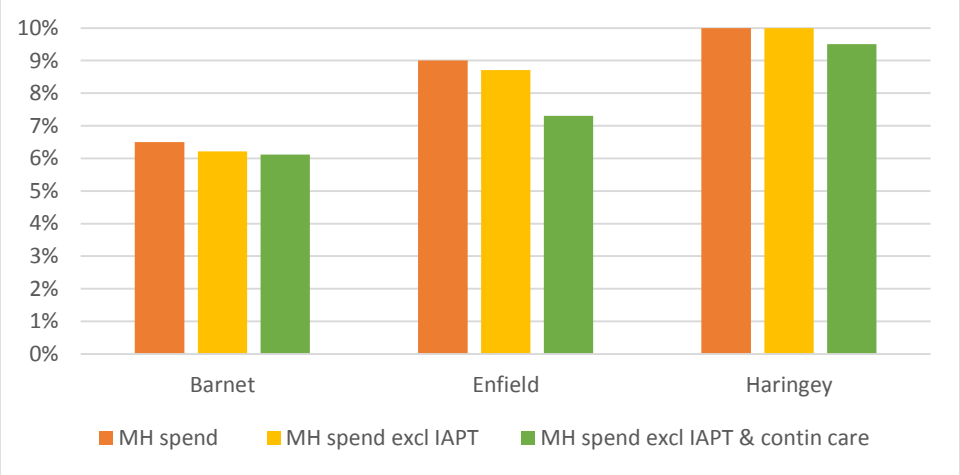
We have compared the level of investment in the Trust by CCG in 3 ways:

- Level of mental health investment in the Trust as a proportion of total CCG NHS spend
- Level of mental health investment per head of population
- Level of activity provided for local residents compared with the contract value

Comparison of mental health investment in the Trust as a proportion of total CCG NHS spend

Barnet invests a lower proportion of its total spend on the Trust than Enfield and Haringey (Figure 2.13). Haringey invests the highest proportion of its total spend on the Trust. The difference between the 3 CCGs is slightly less if spend on IAPT and continuing care are excluded.

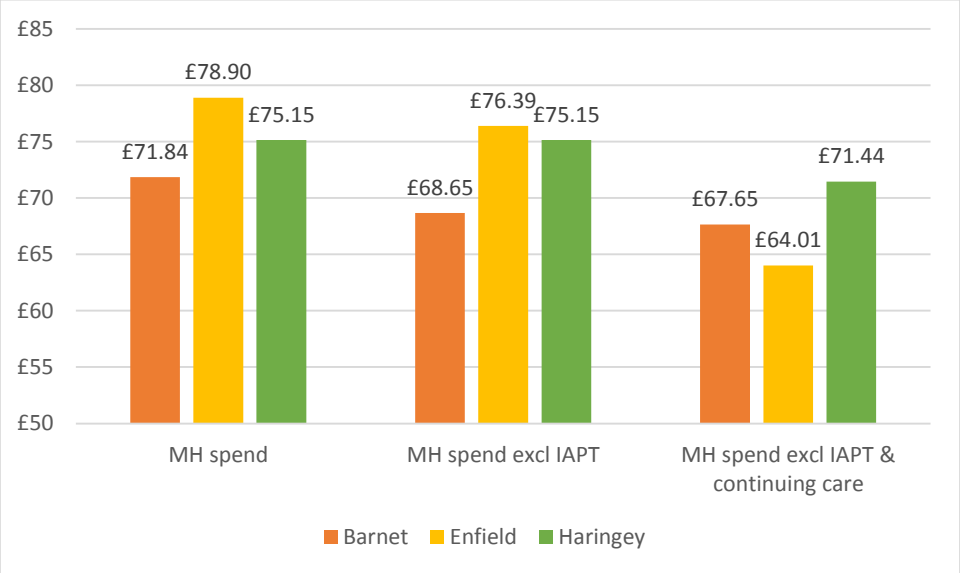
Figure 2.13: Investment in BEH-MHT as % of total CCG spend 2013/14



Comparison of mental health investment in the Trust per head of population

We have compared the CCG contract values per head of population. Overall Barnet invests less per capita in the Trust than Enfield or Haringey (Figure 2.14). However, this comparison is somewhat misleading, as there are some significant differences in the level of investment per capita between the 3 CCGs with regards to IAPT and older adult continuing care beds. Figure 2.14 therefore also compares spend per head with the Trust excluding IAPT and continuing care. Although Enfield's overall spend per head is higher than the other 2 CCGs, their spend per head is lower than the other 2 CCGs if one excludes spend on IAPT and continuing care.

Figure 2.14: Total mental health contract value with BEH-MHT per weighted capita adjusted for market forces factor 2013/14



We have also compared contract values per capita separately for adult and older adult services:

- ***Adult mental health services –*** Barnet spends 10 % more per head than Enfield, and 7% more than Haringey (Figure 2.15). This is due to their £1.9 million investment in continuing care (Enfield invests £7k and Haringey zero). Investment in acute inpatients and community services is very similar between all 3 CCGs (Figure 2.16).

- ***Older adult services*** - Barnet's contract value is half that of Enfield and Haringey (Figure 2.17). Enfield invests significantly more in continuing care, while Haringey investment in older adult acute services is three times higher than for the other two CCGs (Figure 2.18). We have been told by the Trust that there may be some mis-coding with regards to Haringey as the CCG does not invest in continuing care. The matter is being investigated, and the actual resource distribution may therefore be somewhat different for Haringey.

Figure 2.15: Adult spend with BEH Trust per weighted capita adjusted for market forces factor (2013/14 contract values)

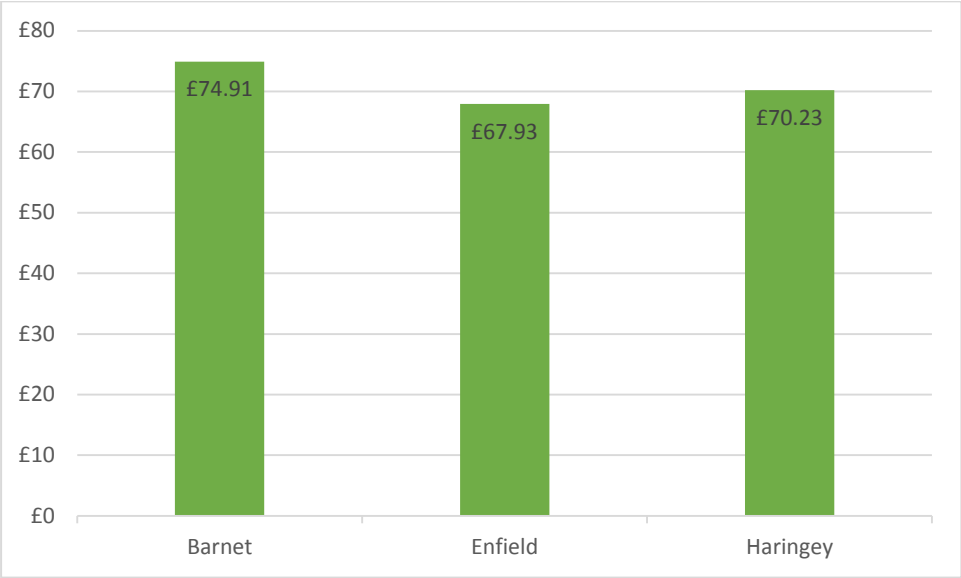


Figure 2.16: Adult spend with BEH Trust per weighted capita adjusted for market forces factor (2013/14 contract values) by service line

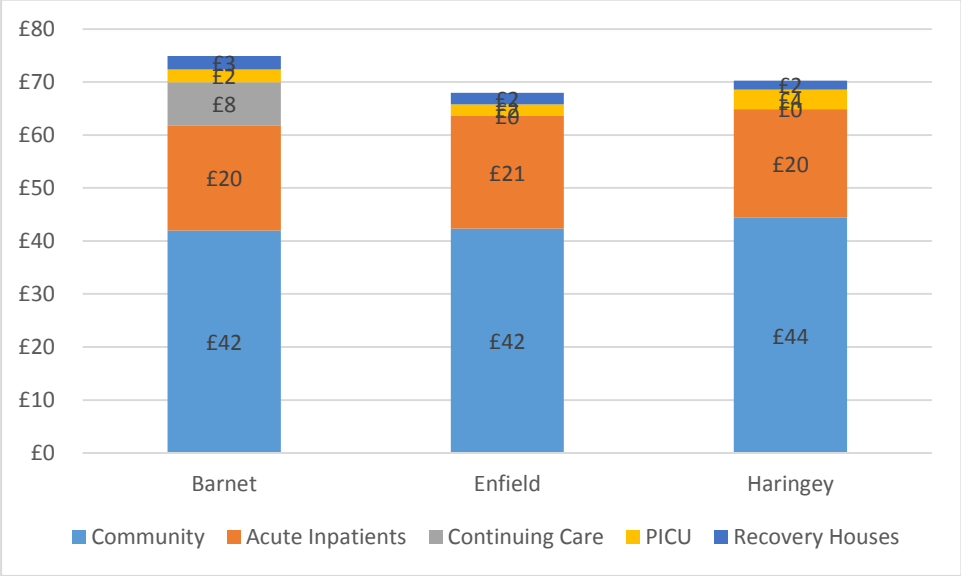


Figure 2.17: Older adult spend per unweighted capita adjusted for market forces factor (2013/14 contract values)

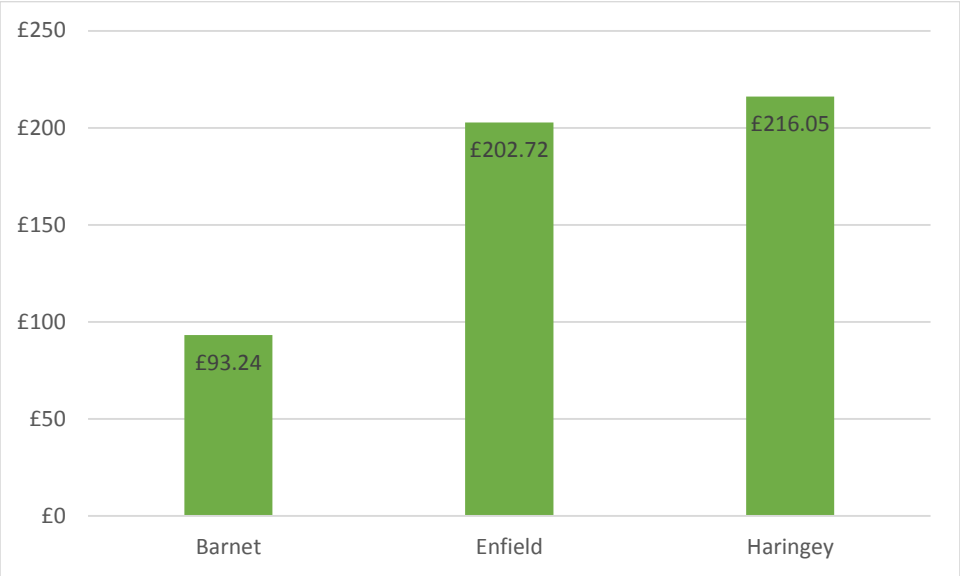
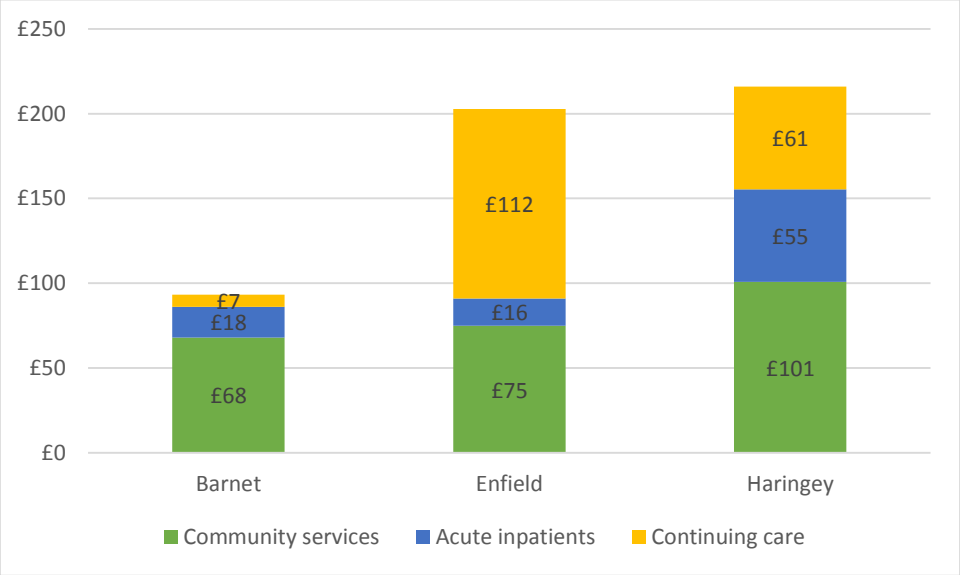


Figure 2.18: Older adult spend per unweighted capita adjusted for market forces factor (2013/14 contract values) by service line



Level of activity provided for local residents compared with the contract value

We have compared the level of activity provided by the Trust with the size of the CCG contracts. Service line unit prices vary between the 3 CCGs, depending on the size of their contract and the level of activity in the plan, for example the unit cost for adult acute inpatients ranges from £323 to £356 (Figure 2.19).

Figure 2.19: Adult acute inpatient unit price per bed day 2013/14

	Cost £	Activity OBDs	Unit Price £
Barnet	4,556,441	14,108	323
Enfield	5,481,018	15,104	363
Haringey	6,612,990	18,582	356

To get a sense of the level activity provided for the level of investment, we have used trust wide unit prices to compare 2013/14 planned and forecast level of activity with the CCG contract values.

Figure 2.20 shows that Barnet receives considerably higher levels of activity for its level of investment than Enfield and Haringey, when one compares planned activity levels with the value of the contract. A comparison of forecast activity levels with contract values shows a similar picture, although the differences between contract value and value of level of activity received are greater (Figure 2.22). There is also a small (£264,000) apparent cross-subsidy of other CCGs beyond the local three CCGs.

Figure 2.20: Comparison of planned activity levels with value of contract by CCG 2013/14

	Barnet £'000	Enfield £'000	Haringey £'000	Other CCGs £'000	Total £'000
Contract value	27,029	30,577	31,053	1,721	90,380
Trust unit price x planned activity (sum of individual service lines)	29,406	29,824	29,164	1,986	90,380
Difference	-2,377	752	1,889	-264	0

Figure 2.21: Analysis of differences in Figure 2.20 by service line

		Barnet £	Enfield £	Haringey £
Adults	Community Rehabilitation	-56,803	-11,154	72,231
	Complex Needs	-293,039	-84,066	395,168
	Day Therapy	1,594	-1,208	-752
	Dual Diagnosis	-240	-16,126	28,948
	Early Intervention Services	-330,529	166,007	171,571
	Emergency Assessment Centre	143,824	-200,391	66,776
	Home Treatment Teams	-121,981	-305,785	450,088
	Occupational Therapy	-87	32	55
	PCMHT	-556,929	283,649	300,725
	Personality Disorder	145,381	95,658	-200,514
	Psychology	2,098	-9,898	10,252
	Support and Recovery Teams	-217,299	425,476	-144,896
	Wellbeing Teams	-194,736	111,095	76,494
	Adult community sub total	*-1,478,744*	*453,290*	*1,226,145*
	Acute Inpatients	-345,673	232,823	156,293
	Continuing Care	-869	869	0
	PICU	-44,773	21,368	23,405
	Recovery Houses	-61,317	-93,778	155,095
	Adult inpatient sub total	*-452,632*	*161,282*	*334,793*
	Adults total	**-1,931,376**	**614,573**	**1,560,938**
CAMHS	CAMHS Community Services	-239,608	145,934	73,146
Older People	Community Mental Health Teams	185,207	-11,882	-122,879
	Day Services	-50,060	25,830	2,836
	Memory Treatment Clinic	-184,362	-60,586	246,704
	Occupational Therapy	-94	124	-1,226
	OP Home Treatment Teams	-43,806	-28,557	78,102
	Physiotherapy	-65	0	183
	Psychology	-1,134	-20,959	26,205
	Older people community sub total	*-94,314*	*-96,029*	*229,925*
	Acute Inpatients	-69,198	31,899	37,299
	Continuing Care	-41,772	54,335	-12,451
	Older people inpatients sub total	*-110,970*	*86,235*	*24,847*
	Older people total	***-205,284***	***-9,795***	***254,772***
Other	Adults ADHD	-1,007	1,463	578
	Eating Disorders referrals	-17	-14	-14
	Eating Disorders attendances	244	144	160
	Other total	**-780**	**1,593**	**724**
	GRAND TOTAL	**-2,377,049**	**752,305**	**1,889,580**

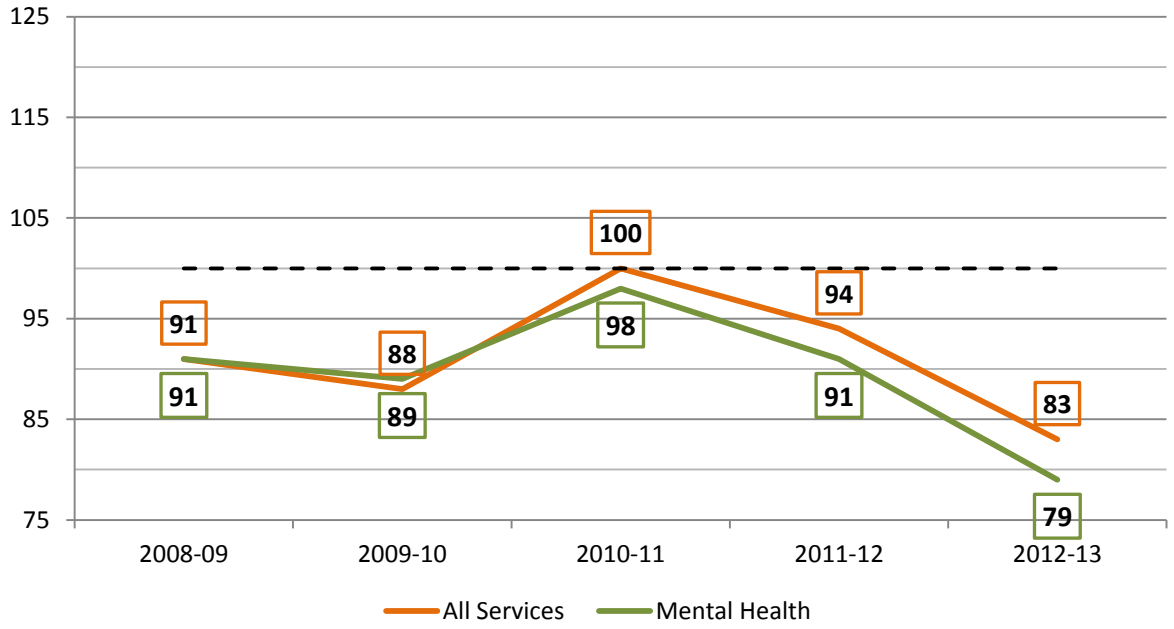
Figure 2.22: Comparison of forecast activity levels with value of contract by CCG 2013/14

	Barnet £'000	Enfield £'000	Haringey £'000
Contract value	27,029	30,577	31,053
Trust unit price x forecast activity (sum of individual service lines)	31,911	32,021	29,050
Forecast external placements	601	555	463
Difference	-5,483	-1,999	1,540

What is the trend in the Trust reference cost index (RCI)?

The Trust RCI has fluctuated over the years (Figure 2.23). From 2011/12 the RCI included mental health care cluster costs rather than the traditional activity costs. Whilst the exact figures should be taken with caution, there is a clear and a continuing trend of the Trust's costs being low for the basket of care it provides.

Figure 2.23: BEH-MHT Reference Cost Index 2008/09 to 2012/13



Benchmarking assessment conclusion

Programme budgeting shows that Enfield and Haringey may invest less overall in mental health services per capita than other CCGs in their comparator group, while Barnet may invest more. However, it is hard to draw any strong conclusions without having a better understanding of the range of mental health providers in each area, and being more confident in the data quality of the national data sets.

There are substantial differences between service arrangements across the three CCGs. Barnet invests a lower proportion of its total budget in BEH-MHT than the other two CCGs, and Haringey invests the highest proportion. Barnet invests less per capita in the Trust overall, but this figure hides significant differences in investment by service line. Enfield has the lowest investment per capita if one excludes IAPT and older adult continuing care.

Barnet's spend per capita on adult mental health services is considerably higher than the other 2 CCGs due to its investment in adult continuing care. However its spend on older adult mental health services is half that of Enfield and Haringey. Enfield invests substantially more in continuing care, while Haringey's investment in older adult beds is three times higher than for the other two CCGs.

CCG service line unit prices vary between the three CCGs, depending on the relationship between the level of planned activity and the value of the contract. Using Trust wide unit prices, Barnet receives substantially higher levels of activity for its level of investment than Haringey. Enfield also receives more activity for its level of investment.

2.2. Contractual assessment

What are the financial implications of current levels of under/overperformance based on traditional activity unit prices?

Month 8 2013/14 activity and finance reports forecast an overspend of £4.9m for 2013/14. This figure reflects activity differences rather than actual over and underspends.

After taking account of external placement costs, all 3 CCGs are forecast to overspend (Figure 2.24). The reason that Haringey shows an overspend in Figure 2.24, but an under spend in Figure 2.22 is because Figure 2.24 uses different unit prices for each CCG, while in Figure 2.22 trust wide unit prices are used.

Figure 2.24: Forecast financial variance 2013/14 – difference between planned activity and forecast activity

	Barnet £'000	Enfield £'000	Haringey £'000	Total £'000
Forecast over/under spend per activity & finance report M8	2,988	2,318	-372	4,934
Forecast external placements	601	555	463	1,620
Total forecast over spend	***3,589***	***2,874***	***91***	***6,554***
Total forecast over spend as % of contract value	13%	9%	0%	7%

Data source: Activity and finance report M8 2013/14. Overspend is shown in black and underspend in red

Figure 2.25 analyses the financial variances by service. The most significant variances are:

- *Adult acute inpatients and external placement*s form the most substantial area of overspend (£5.8m)
- The major area of overspend in o*lder adults community services* are the memory treatment clinics.
- In *CAMHS community services* Barnet is forecasting a significant overspend, while Haringey shows a significant underspend.

Figure 2.25: Forecast financial variance 2013/14 by service

		Barnet £'000	Enfield £'000	Haringey £'000	Total £'000
Adults	Community services	*494*	*911*	*-1,493*	*-89*
	Acute Inpatients	1,448	705	2,017	4,171
	Continuing Care	-16	-8		-24
	PICU	263	317	-417	163
	Recovery Houses	-33	-11	-7	-51
	Total adults	*2,156*	*1,914*	*100*	*4,170*
CAMHS	*CAMHS Community Services*	*460*	*86*	*-412*	*134*
Older People	Community services	*458*	*-250*	*480*	*688*
	Acute Inpatients	-16	389	-275	98
	Continuing Care	-31	216	-262	-77
	Total older adults	*410*	*356*	*-58*	*709*
Other	*Total other*	*-37*	*-38*	*-3*	*-78*
Total per activity and finance report		***2,988***	***2,318***	***-372***	***4,934***
	External placements	601	555	463	1,620
Grand total		**3,589**	**2,874**	**91**	**6,554**

Data source: Activity and finance report M8 2013/14. Overspend is shown in black and underspend in red

There has been some discussion concerning whether local services subsidise specialist mental health services. Trust data indicates that the opposite is true (Figure 2.26). Enfield Community Services are forecasting a small deficit (£282k).

Figure 2.26: Specialist services contract performance (forecast 2013/14 outturn)

	Eating Disorders £	CAMHS Tier 4 £	Forensic £
Surplus	446,251	550,939	1,382,351

We had hoped also to measure the 'contractual gap' by using PbR care cluster data. This is not possible as the PbR reports do not include those service users in external placements, recovery houses or bed and breakfast placements. The absence of these service users has a material impact on the reports: while the activity and finance report forecasts an overspend, the PbR report forecasts an underspend. We therefore do not think that the PbR data can be used reliably for these purposes.

Contractual assessment conclusion

Trust activity and finance reports, using traditional activity unit prices, forecast an overspend of £4.9m for the three CCGs. After taking account of forecast external placements the overspend increases to £6.5m, with an overspend of £3.6m for Barnet, £2.9m for Enfield and £91k for Haringey. Adult acute inpatients form the most substantial area of overperformance for all three CCGs.

2.3 Cash assessment

How does the level of investment by the 3 CCGs with BEH-MHT compare with the costs of Trust services?

During 2013/14 the Trust has experienced severe pressure on its adult acute inpatient beds due to an increase in the number of patients needing to be admitted. In December they estimated that the additional costs incurred equated to an additional £5.3m for 2013/14. The additional costs are for:

- Keeping open 2 Trust wards which were due to be closed
- Using private placements
- Using bed and breakfast accommodation to provide additional capacity for patients whose inpatient care has concluded, but who have no suitable accommodation to be discharged to.

Updated forecast figures for 2013/14 show that the additional costs may be slightly higher (Figure 2.27).

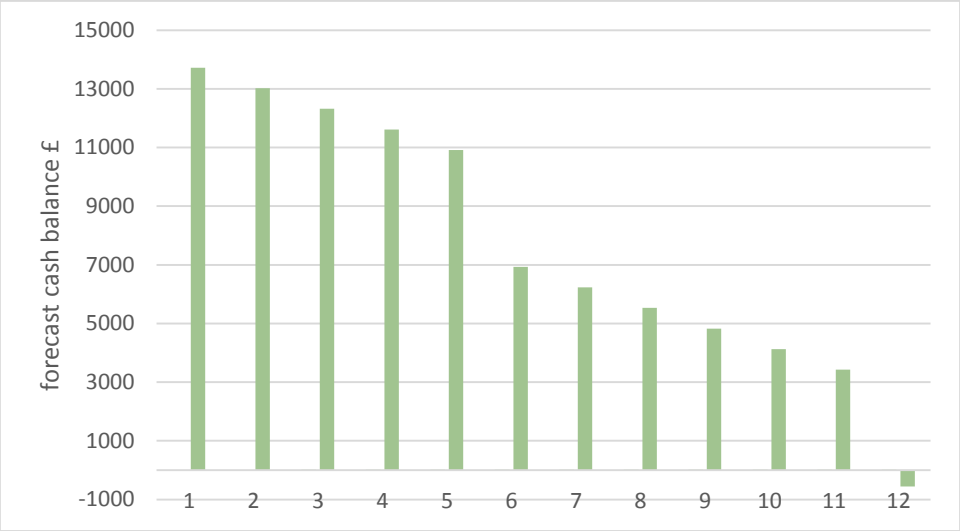
Figure 2.27: Financial impact of over performance in adult acute inpatients

	2013/14 Plan Bed days	2013/14 Forecast Bed days	variance Bed days	Trust unit price £	Additional costs £
ADULT ACUTE					
Barnet	14,108	18,593	4,485	347.47	1,558,403
Enfield	15,104	17,048	1,944	347.47	675,482
Haringey	18,582	24,251	5,669	347.47	1,969,807
Total adult acute	***47,794***	***59,892***	**12,098**	**347.47**	**4,203,692**
EXTERNAL PLACEMENTS					
Barnet	0	1,052	1,052	571.28	600,987
Enfield	0	972	972	571.28	555,284
Haringey	0	811	811	571.28	463,308
Total external placements	***0***	***2,835***	**2,835**	**571.28**	**1,619,579**
GRAND TOTAL	**47,794**	**62,727**	**14,933**		**5,823,271**

Latest Trust forecasts for 2014/15[3] indicate that:

- The 2014/15 budget shows a surplus of £1.9m. The baseline pay budget assumes the wards that could not be closed during 2013/14 remain open, as well as the additional ward opened during the year. The budget includes £3.7m to offset the increased activity in adult acute wards which in 2013/14 resulted in higher expenditure on bank and agency staff and private placements.
- However, the Trust is forecast to have a negative cash balance by the end of 2014/15 due to monthly negative cash flow movements (Figure 2.28). This trend continues the erosion of the cash balance which also occurred during 2013/14. The cash balance at the start of 2013/14 was £18m and is forecast as £ 14m at M12 2013/14.
- There are two reasons for this disparity: unfunded emergency activity and a challenging Cost Improvement Programme (CIP).The 2014/15 CIP is £14.9m, which represents 8% of 2013/14 forecast operating expenses. Less than half the savings have been identified. Most of the identified savings are regarded as risky (Figure 2.29). Non delivery of the CIP programme would impact on the Trust's planned surplus.

Figure 2.28: Cash flow forecast 2014/15 by month



[3] *1. Update on Budget Setting and Business Planning Process for 2014/15 – a report to Finance and Investment Committee 21 January 2014. 2. High level cash flow forecast as at 5.2.14*

Figure 2.29: Draft CIP programme 2014/15

Draft CIP Programme 2014/15 **Appendix 2**

Service Line	CIP Scheme	Estimated Start Date	Solid	Agreed but Risky	Yet to be identified	Total	Target	Notes on Risky Schemes
C&E	Closure of Refuge House	01/09/2014			136	136		This scheme was identified some time ago, it may no longer be feasible given the current activity pressures.
C&E Subtotal			**0**	**0**	**136**	**136**	**0**	
DCI	Day Hospital	01/06/2014		110		110		This scheme is risky as it is dependant on CCG commissioning intentions and their CQUIN.
	Memory Clinic efficiencies			45		45		
	Continuing Care beds	01/04/2014		525		525		This scheme is risky as it is dependant on there being sufficient beds empty to sell and also on demand.
DCI Subtotal			**0**	**680**	**0**	**680**	**0**	
SCNP	CAMHS Tier 3 Reorganisation	01/04/2014		544		544		This scheme has slipped from 2013/14 due to the start of the Service Line Review. A re-worked paper is due to be presented to Exec Board in January 2014, and the consultation paper is ready for circulation.
	CAMHS Consultants on Call	01/04/2014		110		110		A consultation paper is being prepared on this, which again slipped from 2013/14.
	Merge PD and CCT	01/04/2014		67		67		
	Additional CAMHS Tier 4 beds	01/04/2014		275		275		
SCNP Subtotal			**0**	**996**	**0**	**996**	**0**	
Psychosis	Psychosis Re-organisation	01/04/2014		700		700		This scheme is being worked up, but is risky due to consultation reducing the level of savings that can be achieved.
Psychosis Subtotal			**0**	**700**	**0**	**700**	**0**	
Forensic	Camlet 2 - addtiional beds	01/04/2014		150		150		
Forensic Subtotal			**0**	**150**	**0**	**150**	**0**	

Draft CIP Programme 2014/15 **Appendix 2**

Service Line	CIP Scheme	Estimated Start Date	Solid	Agreed but Risky	Yet to be identified	Total	Target	Notes on Risky Schemes
Estates	Estates savings	01/04/2014			1,400	1,400		Detail to be worked up however the Director of Estates is confident of this level of savings.
Estates Subtotal			**0**	**0**	**1,400**	**1,400**	**0**	
Corporate	IT staff restructure	01/04/2014		60		60		
	Finance	01/04/2014	80			80		
Corporate Subtotal			**80**	**60**	**0**	**140**	**0**	
ECS								
Trustwide	Allowances Review	01/04/2014		250		250		This scheme has slipped from 2013/14 as it is dependant on the job planning process. This process is underway with job plans being updated by Clinical Drectors.
	Service Line Review	01/07/2014		3,000		3,000		Work on this scheme has already started with a paper to be presented to the Board in January outlining the options for a new Service Line structure.
	Unidentified				7,401	7,401		
Trustwide Subtotal			**0**	**3,250**	**7,401**	**10,651**	**0**	
Total			**80**	**5,836**	**8,937**	**14,853**	**0**	

Cash assessment conclusion

The Trust's forecast cash position is poor, as the Trust's expenditure continues to be higher than its income. The Trust faces a challenging CIP for 2014/15. If it is unable to quickly identify realistic cash releasing savings, the Trust's cash position could be negative by the end of 2014/15.

2.4. Discussion

In this section we have assessed the potential gap between the investment provided by the commissioners to the Trust and the realistic expected cost of providing the range and volume of services currently specified. Our analysis shows how the 'gap' can be described and measured in different ways:

- Benchmarking data as to overall levels of investment are of uncertain quality, and should not be relied on for detailed decision-making purposes. The conclusions we can most confidently draw are that overall levels of investment in local mental health services appear not to be high, allowing for levels of need and relative cost – and that the costs of services provided by the Trust appear not to be expensive.

- Local data reveal many important differences in service arrangements between the three CCGs. Barnet invests a lower proportion of its total budget in the Trust than the other two CCGs.

- CCG investment per capita varies significantly by service line. Barnet invests considerably more in adult mental health services, but significantly less in older adult services. Haringey invests substantially more in older adult beds, while Enfield spends more on continuing care.

- The level of activity the CCGs receive for their level of investment varies significantly. Barnet receives considerably higher levels of activity for its level of investment than Haringey. If the three CCGs used the same trust-wide unit price, and considering the current level of forecast activity including external placements, Barnet's contract value would cost £5.5 million more, Enfield's would cost £2 million more, and Haringey's would cost £1.5 million less.

- The Trust is forecasting an overspend of £4.9m for 2013/14, using traditional activity unit prices. After taking account of external placements the overspend increases to £6.5m. This total is made up of an overspend of £3.6m for Barnet, £2.9m for Enfield and £91k for Haringey. Adult acute inpatients form the most substantial area of overspend for all three CCGs.

- Most pressingly, the Trust faces a worsening cash position month on month with its expenditure exceeding its income. Historically, it appears that the Trust has managed to provide typical to high levels of activity at typical to low prices; this has become unsustainable as a result of unplanned levels of acute inpatient activity, and a very high level of CIP expectation. This expectation requires the Trust to deliver similar activity levels with considerably less cash investment. Without rapidly finding realistic cash releasing savings, the Trust's cash position is likely to be negative by the end of 2014/15. This cash gap is probably the most certain of these various ways of assessing the scale of the current problem.

3. ASSESSMENT OF HIGH LEVEL OPTIONS

This section contains the findings of the work we have done to assess options for addressing the cash gap.

3.1. Additional investment

If, as there appears to be, there is a significant cash gap between the current and expected cost of services, there is clearly a theoretical option that additional investment could be made by the CCGs into the Trust's services. We have, however, raised this as an option with the Chief Officers of each of the CCGs, and been given a very clear indication that, given the wider financial pressures, this is wholly unrealistic. It therefore appears that the cash gap will have to be met by a mix of genuine efficiency savings and service reductions. The rest of this report is written on that presumption.

3.2. Bed management / acute overspill

With the exception of the CIP, the problems of acute overspill appear to be the largest cost pressures currently facing the mental health system locally. We have therefore undertaken an analysis of data which could help to provide context and understanding for the local problem. It should be noted that this local problem exists in the context of a much wider problem facing mental health services across the country; Mental Health Strategies are encountering high levels of acute bed pressure in many other locations.

3.2.1. Adult acute inpatients

2012/13 benchmarking

The latest NHS Benchmarking Network report[4] shows that for BEH-MHT for the year 2012/13:

- Adult acute bed days per 100,000 *unweighted* population were at the median (the report does not provide this indicator using a weighted population)
- Adult acute admissions per 100,000 *weighted* population was between the median and lower quartile (Figure 3.1)
- Median length of stay excluding leave was between the median and upper quartile (Figure 3.2)
- Delayed transfers of care were joint highest at 11% (Figure 3.3)

The needs weighting index for the overall BEH Trust area is 1.22. The median level of bed days could therefore be considered to be a relatively low level of acute inpatient activity, given local needs. We noted, however, in figure 2.9. above that the weighted level of beds is close to the median. It therefore appears that a contributory factor to the local problem is the relatively slow throughput, and in particular the high level of DTOCs. In the context of high DTOCs, and slightly high lengths of stay, it is unsurprising that this has fed through to low rates of admission, difficulties in accessing beds, and, from 2013/14, persistent use of overspill beds.

[4] *NHS Benchmarking Network Mental Health Benchmarking 2013. Includes data from 56 NHS Mental Health Providers, including 4 Welsh Boards*

Figure 3.1: Adult acute admissions per 100,000 weighted population

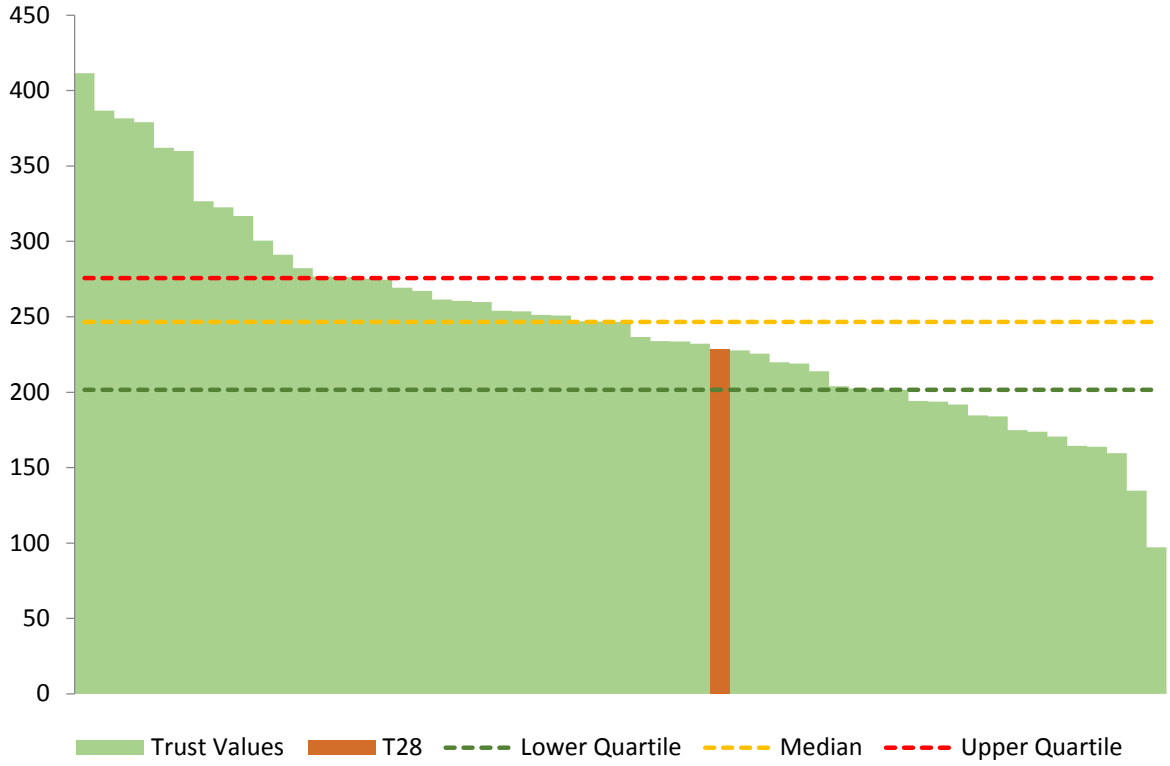


Figure 3.2: Median length of stay excluding leave

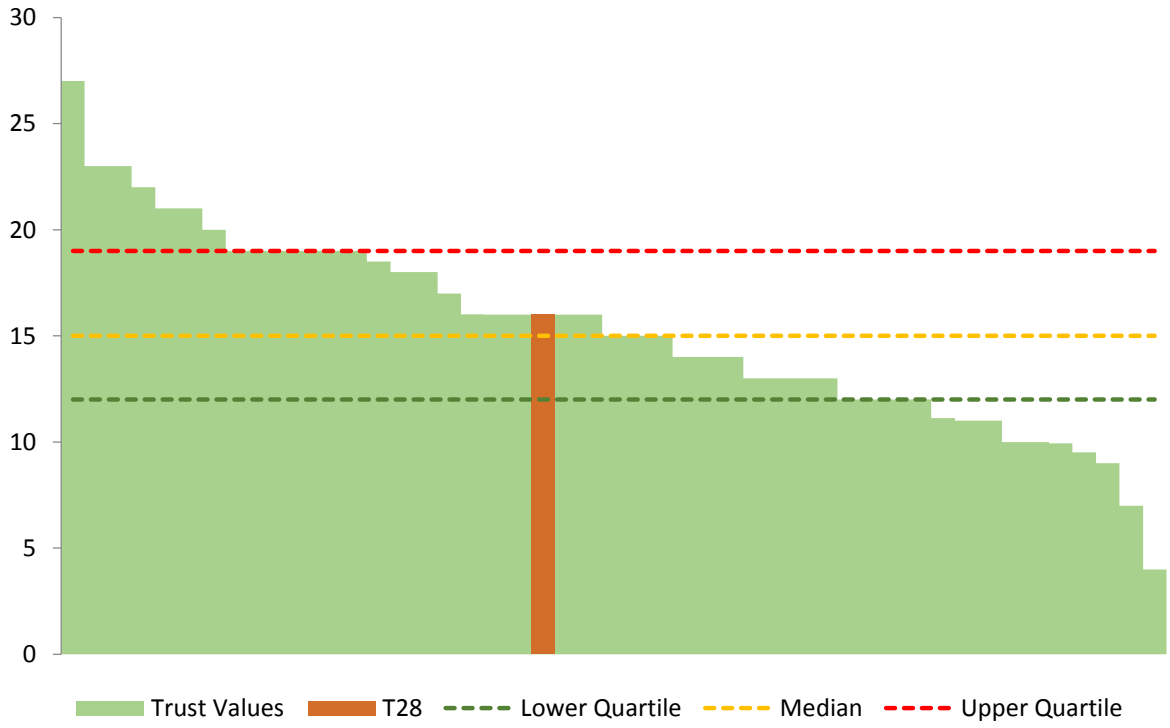
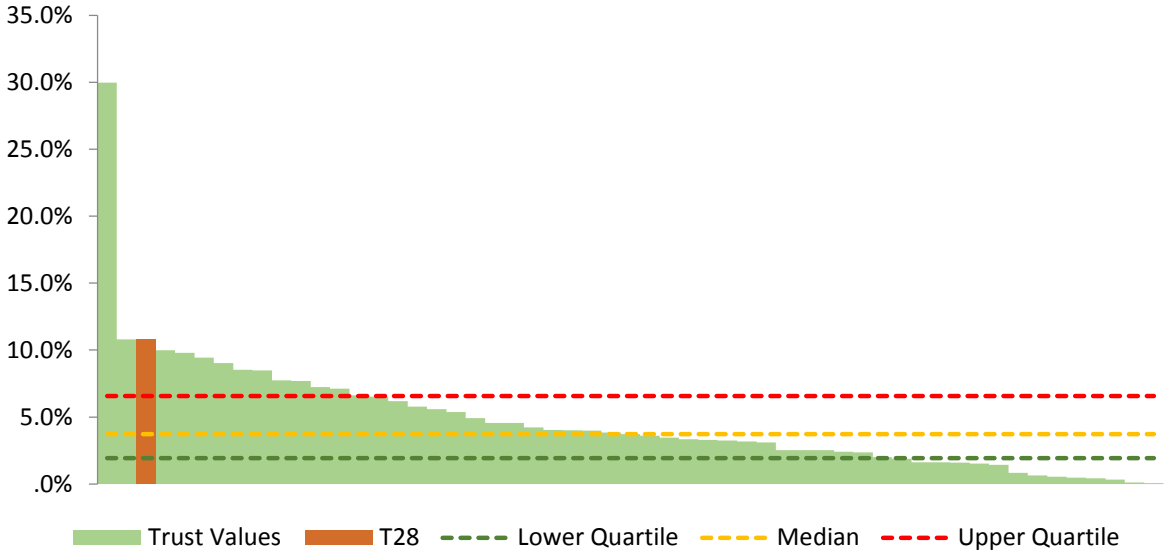


Figure 3.3: Percentage of bed days (excluding leave) lost due to delayed transfers of care



2013/14 forecast for adult acute inpatients including external placements

Trust data shows that:

- Adult acute bed days including external placements are forecast 31% higher than planned (Figure 3.4). There is variation between the CCGs: Barnet's forecast is 39% higher, Haringey 35% and Enfield 19%.
- Planned adult acute bed days per weighted capita are similar between the 3 CCGs. Forecast bed days including placements per weighted capita vary due to the increases described above (Figure 3.5).
- Bed days (including placements) have increased by 12% from 2011/12 to 2012/13 (Figure 3.6). The greatest increase has been in Haringey (19%).

Figure 3.4: Adult acute bed days including external placements – planned and forecast 2013/14

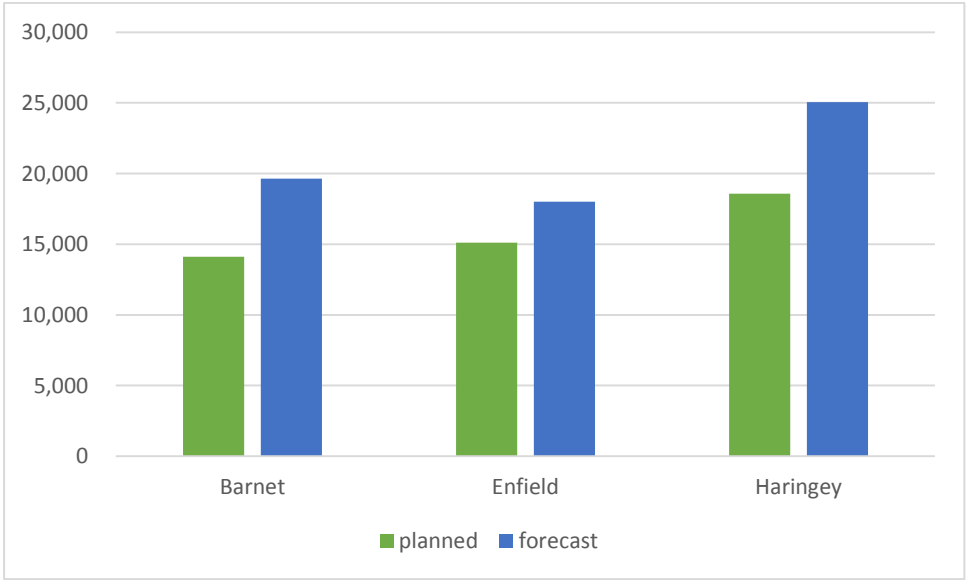


Figure 3.5: Adult acute bed days including external placements per 100,000 weighted population – planned and forecast 2013/14

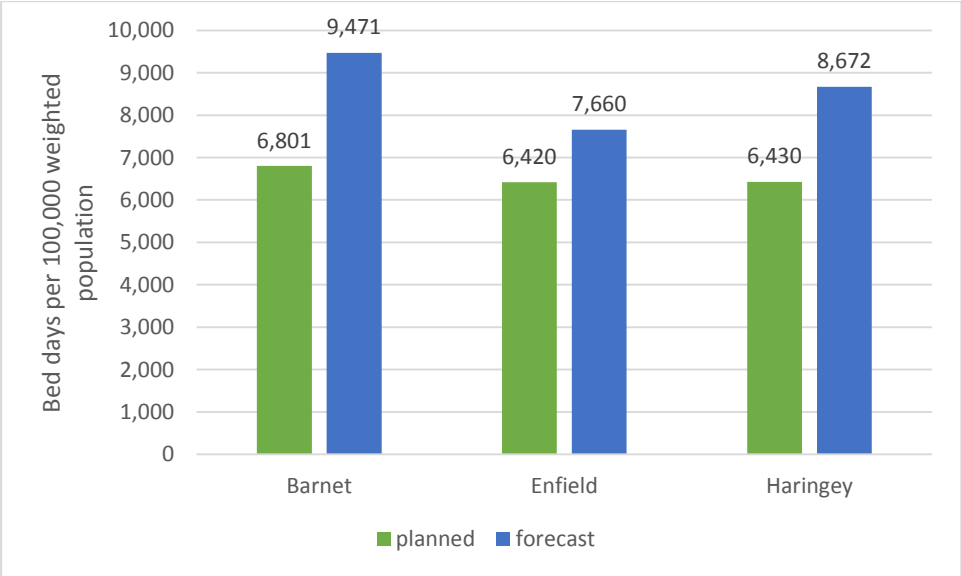
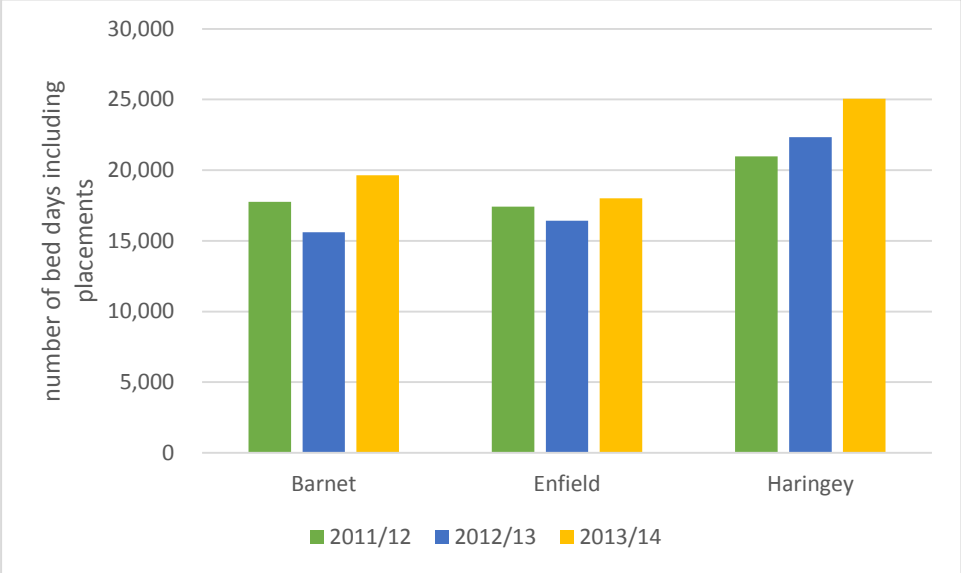


Figure 3.6: Adult acute bed days including external placements 2011/12 to 2013/14



Trust adult acute beds

The following analysis refers to adult acute activity in Trust beds only i.e. it does not include external placements:

- The number of bed days is forecast to increase by 7% from 2011/12 to 2013/14. The trend varies between CCGs: Enfield bed days are forecast to slightly decrease, while Haringey bed days are forecast to increase by 16% (Figure 3.7).
- The number of overall admissions is forecast to decrease from 2011/12 to 2013/14 by 6%. Admissions for Enfield are forecast to decrease by 14%, while admission numbers for Haringey are forecast to remain level (Figure 3.8).
- Patterns in length of stay have changed little over the three years (Figure 3.9). Haringey has the lowest proportion of 0 -28 days length of stay, and there has been some deterioration against this target for both Enfield and Haringey. Figures 3.10 to 3.12 provide further detail on length of stay by CCG.
- Total bed days lost through delayed transfers of care remained static for 2011/12 and 2012/13. Lost bed days are forecast to increase by 29% in 2013/14 to 6,475. These represent approximately half of the forecast excess acute bed days over plan. The cost of these bed days is £2.2 million, using the trust wide unit price.
- Haringey has a higher number of lost bed days and a higher proportion of bed days represented by lost bed days (Figures 3.13 and 3.14). A paper recently produced by Enfield CCG recommends a number of actions for the Trust, CCGs and local authorities to address the problems of delayed transfers of care (Figure 3.15). The Trust also has commenced a QIPP project with the aim of reducing the number of delayed transfers of care over the next year.

Figure 3.7: Number of bed days in Trust adult acute beds

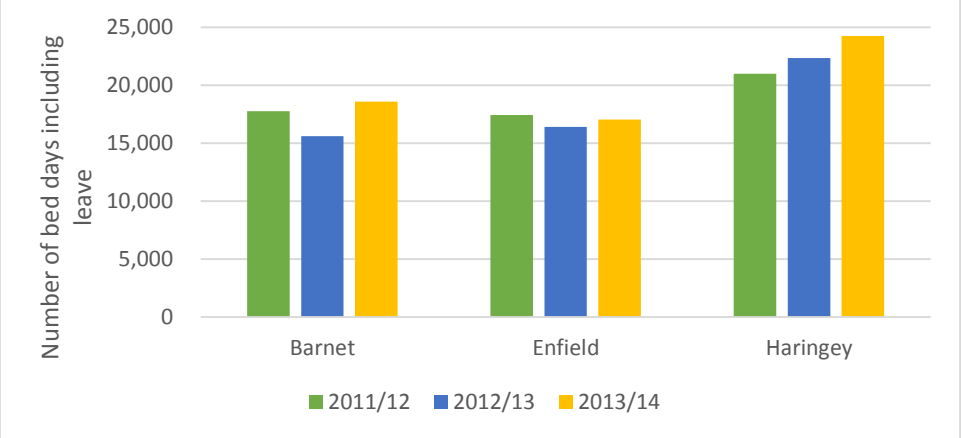


Figure 3.8: Number of admissions to Trust adult acute beds

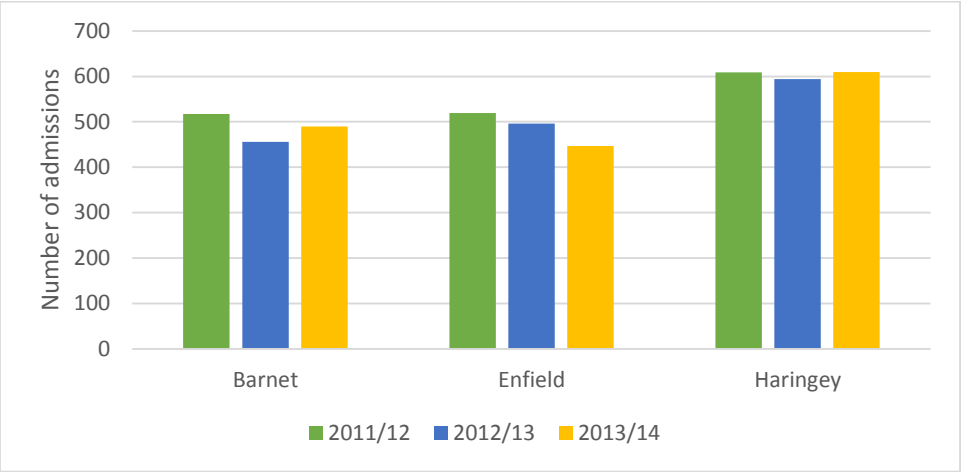


Figure 3.9: Percentage of discharges with length of stay 0 – 28 days

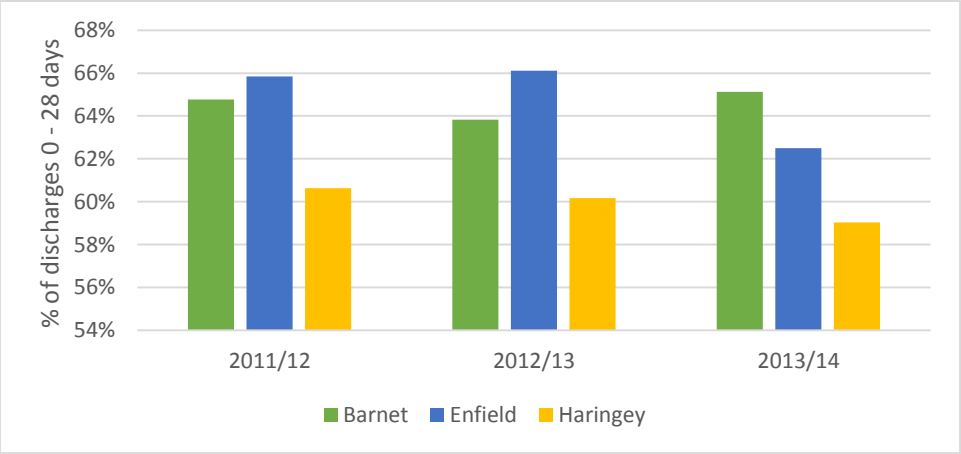


Figure 3.10: Length of stay – Barnet

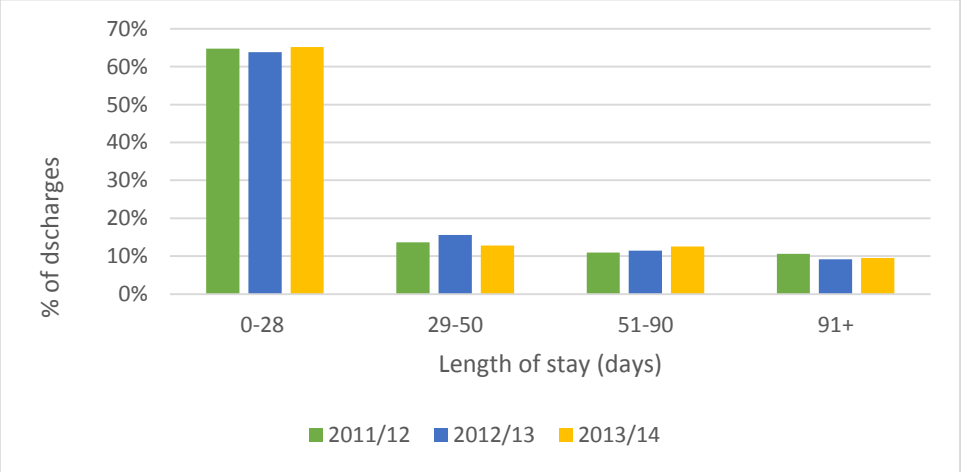


Figure 3.11: Length of stay - Enfield

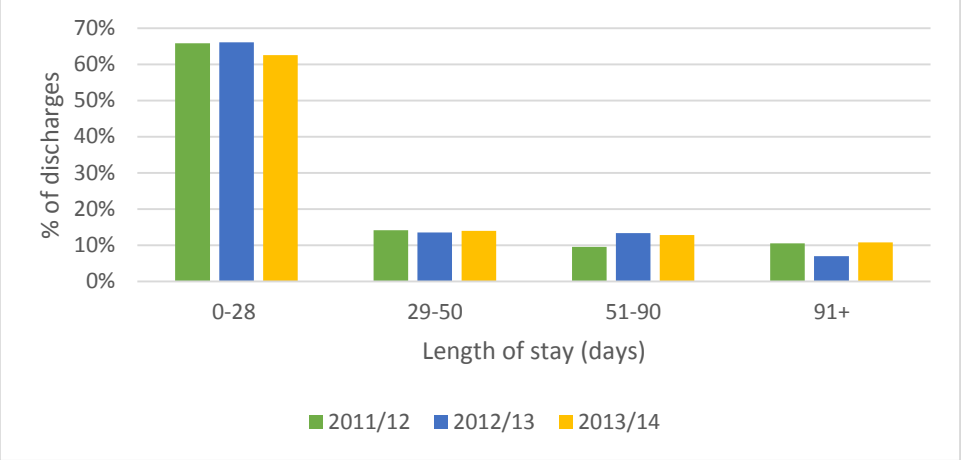


Figure 3.12: Length of stay – Haringey

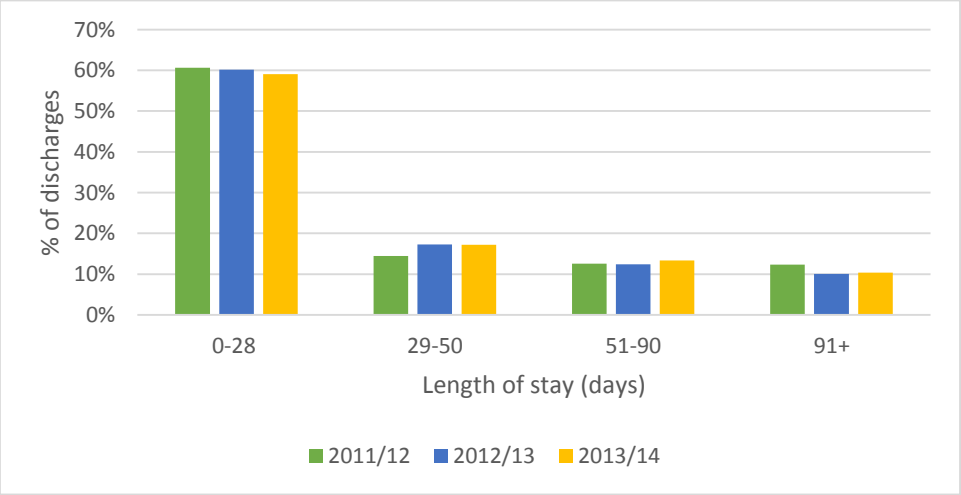


Figure 3.13: Delayed transfers of care – number of bed days lost

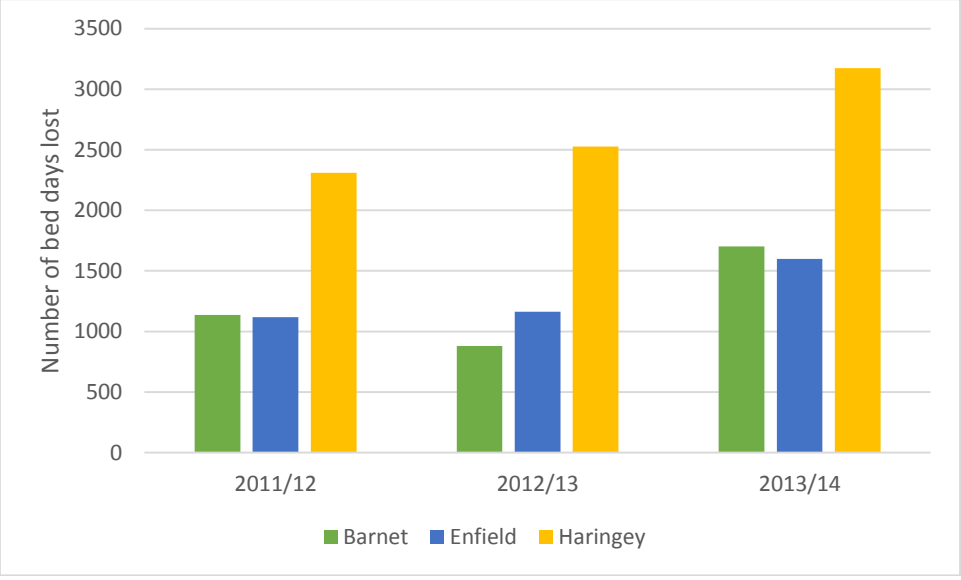


Figure 3.14: Lost bed days as percentage of total Trust acute bed days (including leave)

	2011/12	2012/13	2013/14
Barnet	6%	6%	9%
Enfield	6%	7%	9%
Haringey	11%	11%	13%
Total	8%	8%	11%

Figure 3.15: Recommendations to address the problems of delayed transfers of care

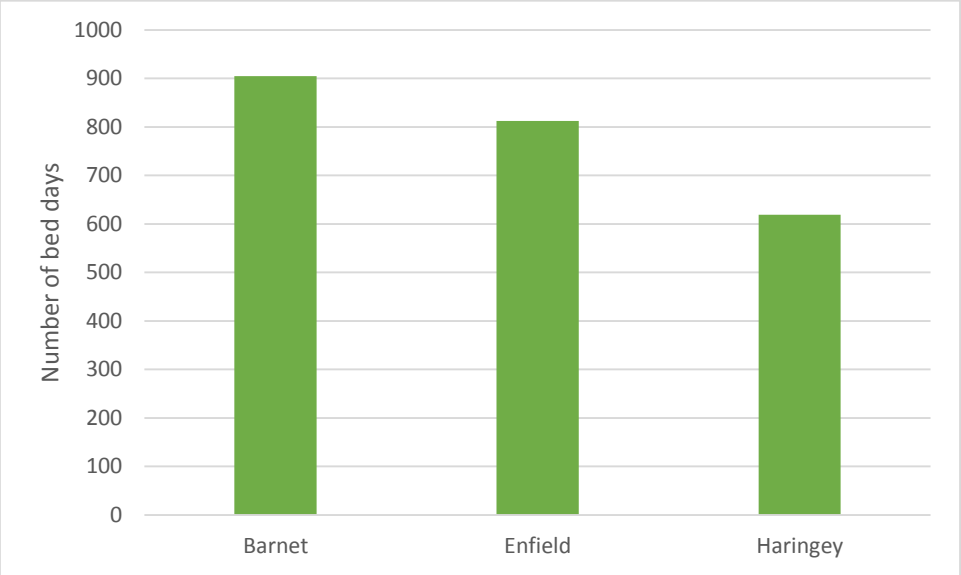
- Lead Mental Health Commissioners facilitates a one off meeting with BEHMHT and Housing Officers/Social Services to Case manage the current cohort of discharged patients out of bed and breakfast and into more appropriate accommodation.
- Each commissioner undertake a stocktake of the current state of the local supported accommodation strategy and if required initiate a review/update leading to the implementation of a Strategy which ultimately brings to an end the use of Bed and Breakfast accommodation for recently discharged vulnerable patients with mental health problems.
- The Trust and commissioners discuss openly adopting the practice of discharging patients back to the Homeless Persons Unit or similar facility rather than Bed and Breakfast accommodation.
- Local authority(s)/Trust and Commissioners agree to adopt the strict definition of delayed transfers of care outlined in section 3 above. This will make the distinction between a delayed discharge and delayed transfer of care.
- A senior officer from both the Local Authority and CCG become standing members of the 'Code Black' meeting when convened. Those attending must have authority in two respects – to be able to authorise funding for placements if required and also accept organisational responsibility for a delayed transfer of care under the definitions outline above.
- The Trust, Local Authority and CCGs adopt the attached draft protocol for avoiding delayed transfer of care or at least minimising them.
- Daily bed states from BEHMHT are shared with CCG mental health commissioners showing bed utilisation, admissions and discharges and number of patients in the private sector. In addition a weekly breakdown of DTOCs and reason for the delays and responsibility are provided to Commissioners by BEHMHT.
- If required the CCG Commissioners will use this information to invoke the Escalation procedure attached to the Protocol to senior officers in the Local Authority and CCG. Once this practice has been adopted it is likely to ensure regular attendance at the 'Code Black' meetings with individuals of appropriate authority to ensure decisions are taken at the appropriate level.

Source: Enfield CCG February 2014 – Pressures on acute adult inpatient services position paper

3.2.2. External placements

External placements for adult acute inpatients were not used in 2011/12 and 2012/13. In 2013/14 2,336 bed days are forecast (Figure 3.16).

Figure 3.16: Number of external placement bed days 2013/14 forecast



3.2.3 Trust PICU beds

Data provided to us by the Trust shows that:

- The overall number of PICU bed days was similar in 2011/12 and 2012/13. In 2013/14 they are forecast to increase by 8%. The three CCGs show different trends in the use of PICU over the three years (Figure 3.17).
- The number of admissions is forecast to increase by 23% from 2012/13 to 2013/14. This is due to a significant increase in Barnet (Figure 3.18).

Figure 3.17: Number of Trust PICU bed days

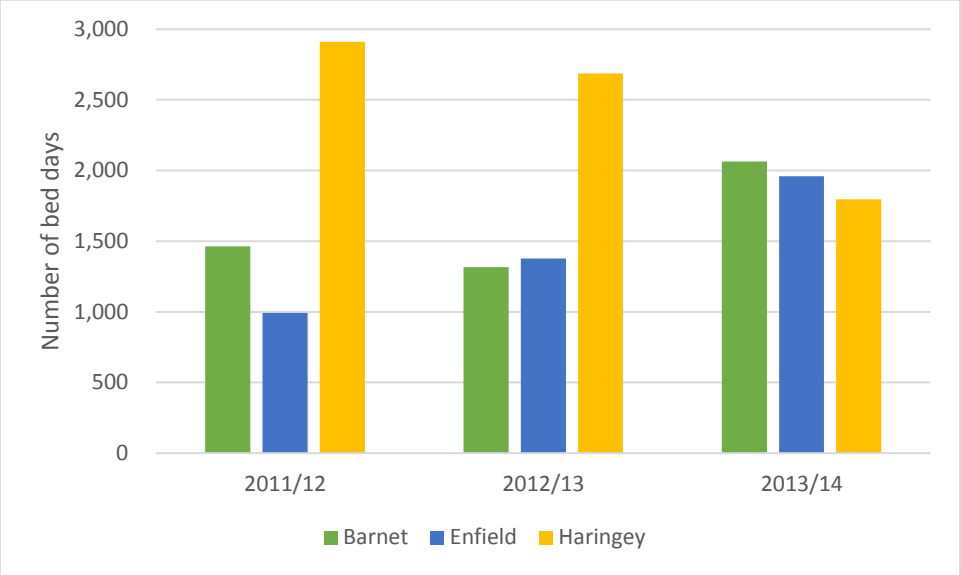
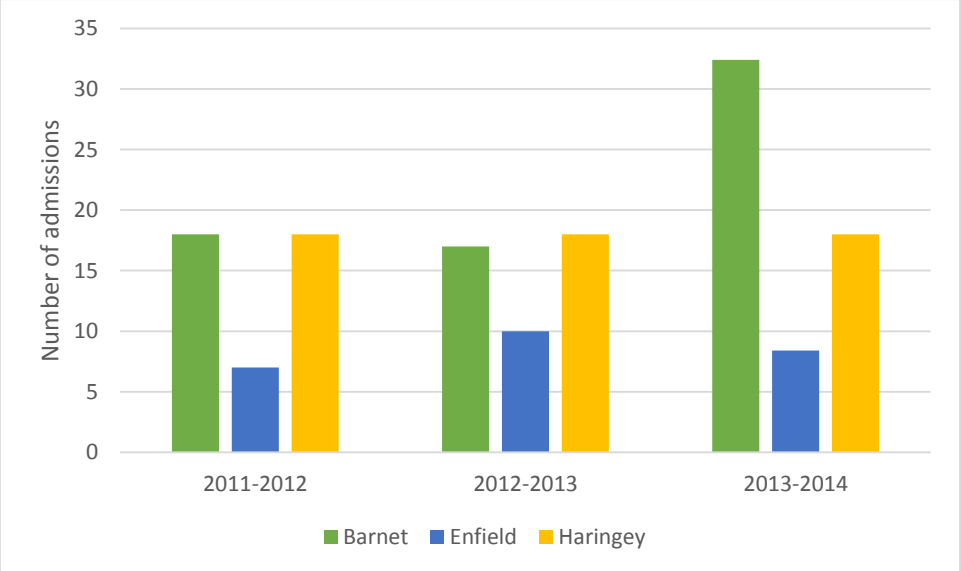


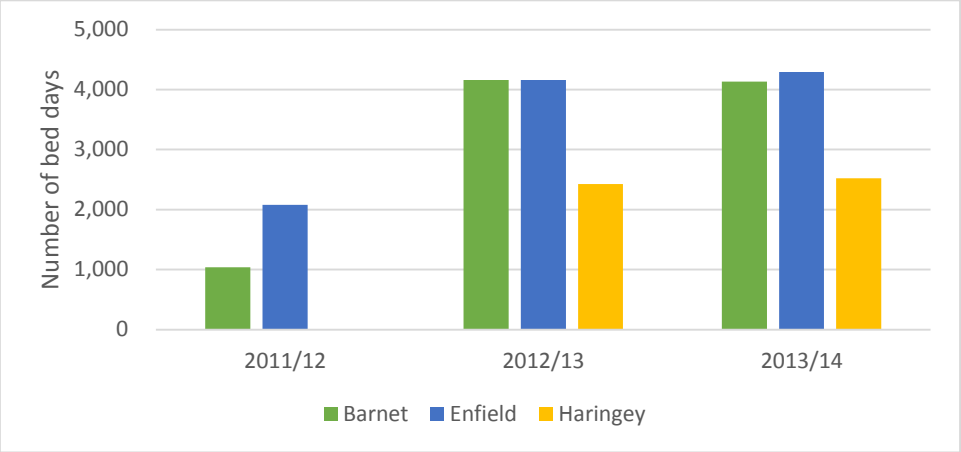
Figure 3.18: Number of admissions to PICU



3.2.4. Recovery Houses

Recovery houses opened in later 2011/12 and therefore 2012/13 saw a significant increase in the use of recovery houses with a threefold increase in bed days. The number of bed days in 2012/13 and 2013/14 is forecast to be fairly similar. (Figure 3.19).

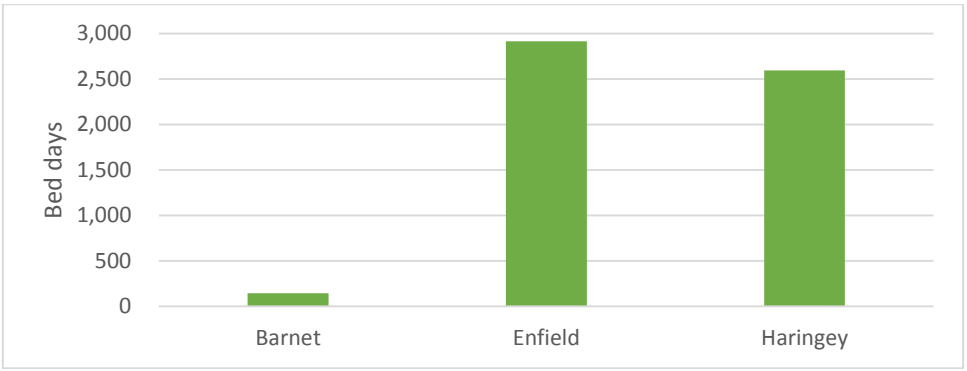
Figure 3.19 Number of bed days in recovery houses



3.2.5. Bed and breakfast

Bed and breakfast facilities were not used in 2011/12 and 2012/13. 5,653 bed days are forecast in 2013/14, the majority of them in Enfield and Haringey (Figure 3.20).

Figure 3.20: Number of Bed and Breakfast bed days 2013/14 forecast



Based on this range of evidence, it currently appears implausible that the financial pressures arising from acute beds are likely to reduce in the immediate future. None of our interviewees had any real optimism that pressure on acute beds was likely to fall. However, there were views that the Trust could do more to manage throughput and reduce delayed transfers of care. As well as actions from the Trust and CCGs, this could require actions from the three local authorities, and it is currently unclear how likely those would be.

3.3. Estates

All of our interviewees have discussed this issue with us. There appears to be an almost universal view that there is a financial opportunity to be realised by reducing the number of sites from which the Trust provides its main inpatient services. To provide some context for this, we have benchmarked the Trust internal site floor area against income, staff numbers and number of beds (Figures 3.21, 3.22 and 3.23).

The estates information is from the most recent (2011) return to the Estates Return Information Collection (ERIC); Income/staff/beds data are taken from the Binleys database.
The Trust position is lower than the comparator average for all 3 benchmarks. Whilst this is of course not conclusive, it is indicative that the Trust is starting from a position which is not significantly expensive, in terms of the scale of its estate. This would be consistent with its typical reference cost index.

Figure 3.21: Gross internal site floor area (m²) per £1m income

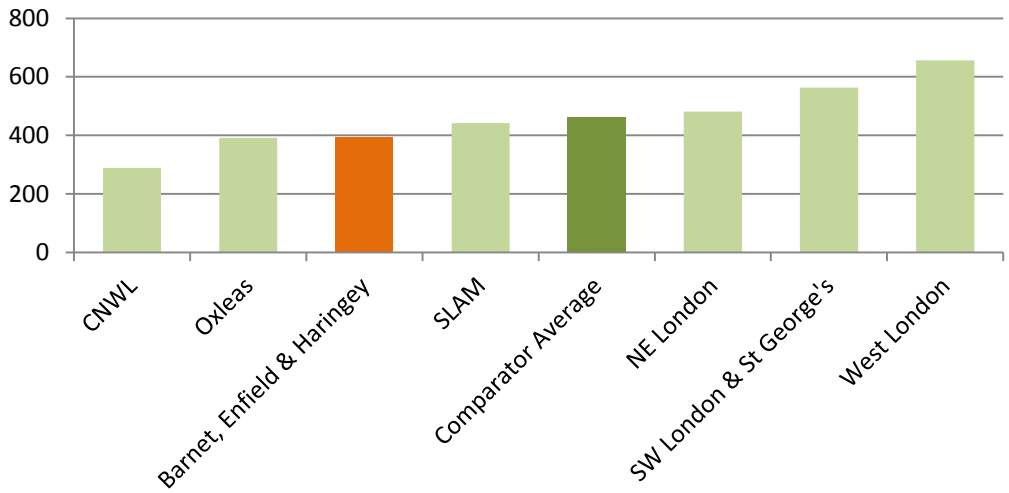


Figure 3.22: Gross internal site floor area (m²) per 100 staff

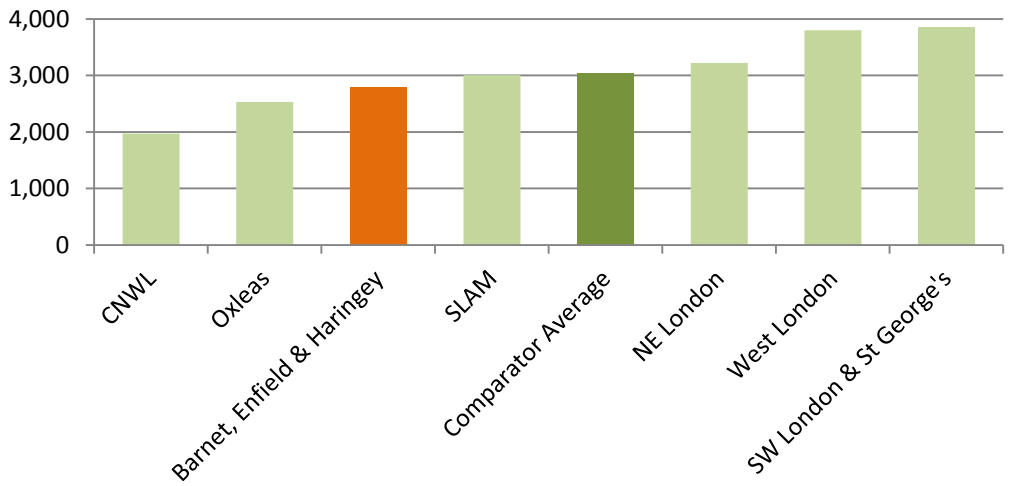
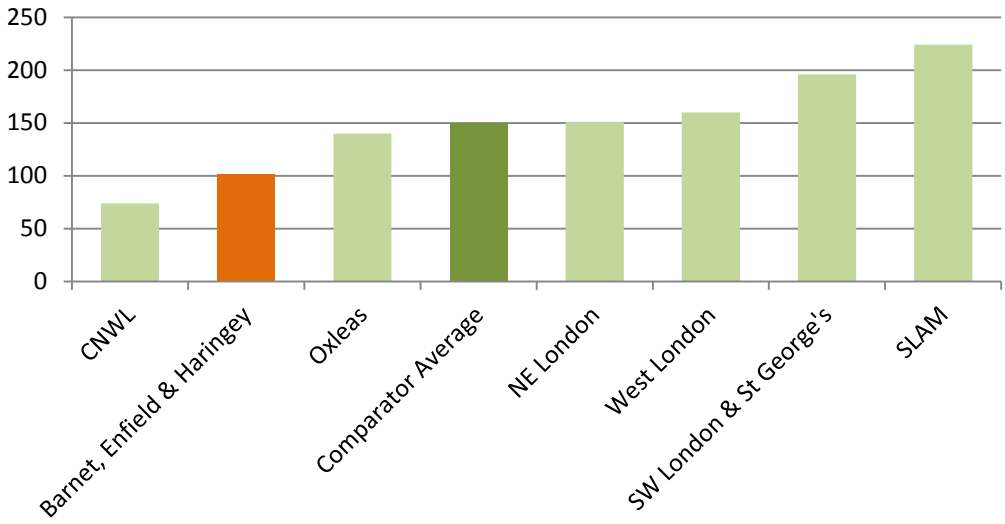


Figure 3.23: Gross internal site floor area (m²) per bed



The Trust is reviewing the use of estates through the Finance and Estate Sub-Group. Initial work suggests that there are not substantial estate savings to be made, because the scale of capital investment required for a major estate rationalisation would increase capital charges and depreciation to such an extent that it would more than offset the other revenue savings possible.

We have discussed this issue with senior staff from the Trust, who have advised us that they are currently conducting an option appraisal of alternative site configurations. This, we understand, currently suggests that the cheapest option would be for the Trust to relocate its services from the Springwell Unit at Barnet Hospital, so that it would then have only one inpatient site in Barnet, and to proceed with redevelopment of St Ann's Hospital in Haringey. The Trust currently estimate that these changes could lead to estates related recurrent savings of approximately £3 million in total in the medium term, although this estimate is not yet internally or externally validated.

The Trust, we understand, has also examined the option of centralising all its inpatient services onto one main site. However, this would require major capital investment as there is not sufficient existing vacant space available on any of the Trust's sites. The Trust estimate that the significant additional capital charges that would be incurred would more than outweigh the revenue savings, and this solution would therefore be more expensive overall that the current estate configuration.

Estates-related savings would of course require several years to realise; we understand that it is possible that some level of transitional funding could be available to support such a reconfiguration, if it were agreed.

We understand that some smaller savings have been identified as potentially available from reconfiguration/better utilisation of smaller premises, but that these are at only modest levels.

3.4. Other service redesign

3.4.1. Current commitments

Key commitments made in the local mental health commissioning strategy, and mirrored in the Trust's Clinical Strategy include, with our view of their likely financial effects:

Further extending capacity in primary care, including co-location of some Trust services	We are aware that this is hoped to reduce costs within secondary care services. It is however unclear what mechanism is expected to achieve that. There are risks that: these will be additional, rather than replacement services; freed Trust capacity will not be withdrawn, but used for other services.
Further development of IAPT	This may reduce demand on other public services, but is not likely to reduce demand on specialist mental health services; there is a risk that it could be increased
Delivering services as close to people as possible	Dispersing services and/or travelling to see patients is typically more costly than more centralised arrangements
Specific service developments in ADHD, autism and personality disorder	These developments address perceived gaps in services, rather than cost pressures
Increasing assessment and treatment services for dementia	Increasing the detection rate and intervention rate for people with dementia is not likely to produce any financial saving, and could produce additional costs

We are not aware of any specific financial provisions underpinning these commitments. None of these appear likely to be cash-releasing. It is currently difficult to see how additional investment could be found to support these initiatives, however desirable they may be from a clinical perspective.

However, there are also commitments which could be cash-releasing:

Reduce the numbers entering secondary care mental health services	This is a key issue. The overall pressure on the specialist mental health system needs to fall, and this can only be achieved by reducing the number of referrals into it
Develop local rehabilitation services for people requiring 12-18 month lengths of stay (instead of out-of-area placements)	There is a potential savings opportunity here. Aggregate commissioning at a local level, with rigorous throughput management could be cheaper (and clinically preferable) to spot purchased alternatives
Deliver alternatives to hospital admission, including home treatment teams and recovery houses	This will be essential to reducing the £5.8 million unfunded activity. Some invest-to-save could well be justified, particularly in home treatment services. Avoiding admissions completely has a greater impact on bed use than shortening lengths of stay
Implement RAID services	This will create costs rather than save money within the mental health service – but there is good evidence that savings can be made within acute services, if beds are closed as lengths of stay reduce, particularly for older people
Remodel day services	Such services can be remodelled and save money if the alternatives are based on (a) use of mainstream services (b) non-estate-based options (c) shorter lengths of use (d) peer support / recovery-focussed models

Given the current serious financial position, it appears that it may be necessary to focus both commissioner and provider time and effort on the commitments which are most likely to produce financial benefits.

Within the Trust's CIP programme, £110,000 has been earmarked as arising from day hospital savings. It is not clear that any other savings have been identified which specifically relate to the cash-releasing commitments identified here.

3.4.2. Other savings opportunities

In local discussions, only the following further ideas have come forward:

- capping caseload and activity levels at affordable levels, even if this results in waiting lists for some services
- subcontracting some provision to third sector providers, with assumed lower wage costs
- pursuing greater integration of mental health and acute services, in the hope of making acute sector savings

In terms of the potential for rapid impact, within the timescales required, only the first of these has any real potential for early cash-releasing savings. Each reduction of 1% in the overall caseload of the Trust's community mental health services (with consequent reductions in staffing levels) would save approximately £620,000, assuming that the reductions were distributed evenly across teams. It is far from clear that subcontracting services would result in significant savings, and there is no convincing evidence that general integration of physical and mental health care produces any savings in the cost of mental health services.

4. CONCLUSIONS

The recurrent cash gap between commissioner investment and Trust costs is of the order of £15 million. There is no evidence that the Trust is significantly expensive as a provider, and its specialist services are financially supporting rather than draining local services. There is also very clearly no additional investment available. With some exceptions (referred to below) the models of care on offer do not differ significantly from those typically available. On those assumptions, what follows are our recommendations; these are clearly not the only course of action available, but they represent what we would do if we faced the responsibilities which you now face.

We make no recommendations regarding rebasing between commissioners. There is clearly a case for this, but, firstly, any rebasing makes no overall change to the overall financial position facing the NHS in Barnet, Enfield and Haringey; and, secondly, these are win-lose choices where it is impossible for us to advise four clients simultaneously. We are recommending only options which have the potential for closing the overall gap between NHS available finances and mental health costs across the three boroughs.

We should also stress that what follows represents what we would regard as the necessary elements of a financial recovery plan; it does not represent everything which commissioners and providers need to or could do, as many such actions are beyond the scope of this project.

Recommendation One
Halt or withdraw from all commitments which involve new expenditure on additional mental health services. Specifically withdraw from or halt: additional developments in primary care; IAPT expansions; new services for people with dementia; service developments for personality disorder, autism and ADHD. This will save nothing, but will prevent the cash gap worsening.

Recommendation Two
Redirect a proportion of the cost of acute overspill into significant expansion of home treatment services, with continuing funding explicitly linked to reductions in admissions and lengths of stay. Ensure that the resource is ringfenced to respond to cases at genuine risk of admission, and does not get diverted into less urgent work; we understand from local threshold audit work that local CRHT teams fulfil functions which would elsewhere fall to CMHTs. Assessing the exact financial potential here requires detailed modelling beyond the scope of this report, but the total cost of the acute overspend is currently £5.8 million. All of this sum should be considered as a savings target, net of any reinvestment in CRHT.

Recommendation Three
Commence robust negotiations with the respective local authorities as to the management and placement of people no longer requiring mental health inpatient care. We support the plan of action proposed to reduce DTOCs; for full effect this will obviously need full involvement of the local authorities. Each agency needs fully to respond to its respective statutory responsibilities – there is no good reason whatever, for example, for the NHS to be buying bed-and-breakfast accommodation. Eradicating DTOCs could save £2.2 million. It should be noted that this effectively forms part of the £5.8 million referenced in recommendation two. It should not therefore be double-counted.

Recommendation Four
Pursue the site consolidation opportunities as a matter of urgency. It is essential that the NHS speaks with one voice on this issue, such as to ensure the necessary political and community support. The estimated opportunity is at least £3-4 million, with the possible option for transitional financial support – which should also be pursued urgently. In conjunction with other recommendations, which could reduce the required size of the Trust's estate, it is possible that greater savings could be found here.

Recommendation Five
Pursue strongly the opportunities for local aggregate commissioning rather than spot purchasing of rehabilitation services. This is a genuine win-win for local services. Financial benefits can only be appraised following a patient-by-patient review of individual cases, which should be undertaken urgently.

Recommendation Six
Take forward the plans to remodel day services, emphasising short-term and mainstream options, linked to peer support and third sector models. It is possible that this could yield savings ahead of the £110,000 already proposed.

Recommendation Seven
Undertake a rapid and rigorous review of caseloads of and referral patterns to community teams (including support and recovery, wellbeing, and community rehabilitation services), with the intention of reducing their net caseloads by at least 10%, and reducing the teams' size accordingly. This is clearly something of an arbitrary figure, but supported by similar caseload review work elsewhere – it would obviously need local validation following caseload assessment. The intention should be to discharge people with long-term stable needs, and to reduce referrals of relatively less severe needs. This should be linked to the development of peer support – and to the refocussing of the work of primary care mental health services to ensure continuing support for people with stable longer-term needs, if needs be by reducing their work with common mental health problems. To be effective, this action would need to be linked to long-term agreement and management of sustainable caseload and activity volumes, to ensure that the reduced caseloads remain reduced. This has the potential to enable up to £1.3 million in recurrent savings.

Recommendation Eight
Recommission all continuing care services, seeking the most economically advantageous offer. These are a highly unusual part of the local service model, and there is a reasonable prospect that better value for money could be secured. Even if the direct service cost were unchanged, this programme would support estate consolidation. If 10% savings could be found, this would realise approximately £860,000.

It should be stressed that the financial estimates in these recommendations are very broad and high-level only. All would require detailed assessment, and service and financial modelling. The purpose in including them here is to enable a very broad assessment of whether the cash gap appears to be capable of being bridged. This very broad assessment appears to suggest that there <u>are</u> identifiable courses of action which could yield recurrent savings at levels broadly similar to the cash gap, when taken together with other CIPs proposed within the Trust – although, taken together, they of course represent a course of action which we are conscious will prove difficult and controversial.