Leicester
City Council

Minutes of the Meeting of the
HEALTH SCRUTINY COMMITTEE

Held: WEDNESDAY, 9 FEBRUARY 2011 at 6.00 pm

P R E S E N T :

Councillor Bayford- Chair
Councillor Manjula Sood – Vice-Chair

Councillor Clayton
Councillor Cleaver
Councillor Gill
Councillor Newcombe

ALSO PRESENT:

Councillor Naylor – Lead Member for Health and Community Safety

IN ATTENDANCE

Elaine Baker – Democratic Services Officer
Ivan Browne – Public Health Consultant with NHS Leicester City
Sarah Cooke – NHS Leicester City
Aileen Holyland – NHS Leicester City
Rod Moore – Deputy Director of Public Health and Health Improvement
Anita Patel – Members Support Officer
Rod Pearson – Head of Finance (Health and Wellbeing)
Tracie Rees – Director of Commissioning
Heather Roythorne-Finch – Local Involvement Network
Yasmin Surti – Planning & Service Development Officer (Learning Disabilities)
Ben Smith – Local Involvement Network

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53. DECLARATIONS OF INTEREST

Councillor Bayford declared a personal interest in the general business of the meeting, in that his wife was a salaried GP, although she was not a partner in

the practice.

Councillor Manjula Sood declared personal interests, in relation to the general business of the meeting, in that she was a patron of CLASP, the Chair of the Leicester Council of Faiths and an ambassador for the East Midlands for Sporting England.

Councillor Newcombe declared a personal interest in agenda item 6, "2011/12 Budget Proposals – Adult Social Care", as his partner worked for Adults and Communities, and other family members also worked for the City Council.

Although attending the meeting as an observer, Councillor Naylor declared a personal interest in agenda item 7, "Joint Commissioning Strategy for Mental Health 2011-2013", in that he was a Governor on the Leicester Partnership Trust, which delivered mental health services.

54. MINUTES OF PREVIOUS MEETING

RESOLVED:

that the minutes of the meeting held on 1 December 2010 be approved as a correct record.

55. PETITIONS

The Director of Corporate Governance reported that no petitions had been received.

56. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Director of Corporate Governance reported that no questions, representations, or statements of case had been received.

57. 2011/12 BUDGET PROPOSALS - ADULT SOCIAL CARE

The Strategic Director Adults and Communities presented a report seeking the views of the Committee on the draft budget plans for the Adult Social Care divisions.

In presenting the report, the Head of Finance (Health and Wellbeing) drew particular attention to the following points:-

- The budget plan was a one-year strategy, in view of the on-going financial situation;

- The budget plan submitted showed reductions totalling approximately £3.8 million, which had been proposed in line with the "Putting People First" agenda;

- An important aim was to enable as many people as possible to keep living

independently in their own homes. To assist in this, the Council was proposing significant investment in enablement and re-ablement services and assistive technology;

- In line with the personalisation approach, services would be charged at cost. The income would be re-cycled to service users through the Resource Allocation System;

- Commissioning was to be improved. This could include providing some services jointly with health authorities;

- The role of the voluntary sector was to change. However, there would be a net investment in that sector, as people with personal budgets often chose to use voluntary sector services;

- The cost to the Council of using taxis to transport service users was high. The use of personal budgets would help reduce this, as some people would be able to make their own transport arrangements more economically;

- The Council no longer had capital funds available to invest in their own care homes;

- It was anticipated that, over the next three years, fewer people would be entering long-term residential care, but would be using alternative forms of accommodation;

- The budget allocated for Home Care was shown as lower than the current year. This was primarily because this money was going into personal budgets. Service users would then decide how the money was spent and it was very likely that much of it would continue to be spent on Home Care; and

- Service quality issues had been experienced with the Meals on Wheels service. Dis-investment in the service was being recommended. This also reflected the increased use of personal budgets and the choice this gave to people.

The following points were made during discussion on the proposals:-

- There was concern at the speed of the transformation of the service. Although there was an anticipated reduction in client numbers, it appeared to be causing an increase in costs;

- As service users would have a choice of where they spent their personal budgets, the Council needed to be careful how it set its charges. If they were too high, they would not be used, so alternative ways of financing those services would have to be found, or ultimately they could have to close;

- Personal budgets were allocated to people not receiving residential care according to assessed need. Therefore, the higher someone's needs, the higher the budget allocated;

- The actual number of people using personal budgets (following a full assessment and application of the Resource Allocation System) was believed to be less than 25% of the total number of service users;

- Some cases had been identified where Fair Access to Care criteria had wrongly categorised people as having critical or substantial needs. These cases were now being rectified;

- The use of personal budgets would enhance community cohesion, through the increased use of community services;

- There was some concern that personal budgets were not being properly explained, particularly to vulnerable older people, which could result in them feeling that the Council was not interested in them. Care therefore needed to be taken to ensure that communication with the budget holders and those caring for them was appropriate;

- The Council was doing a lot of work to direct people to services they needed. For example, a web site was being developed and brokerage services would be provided;

- In response to a question, it was noted that the pilot personal budget system was not the same as the current system. Under the pilot scheme, individuals had received direct payments of the amount needed to fund the level of the services they were receiving at that time, but they had not been assessed through the use of the Resource Allocation System;

- Concerns that personal budgets could be misused by the families or carers of budget holders were acknowledged;

- Unfortunately, "double running costs" could not be avoided during the transition period when residential care homes and day centres were closed and current users transferred elsewhere. However, these would be one-off costs;

- The budget proposals were based on the transformation agenda and cuts in public expenditure, which in turn would affect the voluntary sector. Work was ongoing to determine what these effects would be; and

- In response to concern that any reduction in the voluntary sector could leave a gap in services that would affect many of the City's residents, Members were reminded that the proposals presented were for a net investment in that sector.

RESOLVED:

1) that the Director of Corporate Governance be requested to circulate the additional papers relating to Adult and Social Care budget proposals being presented to the Overview and Scrutiny Management Board adjourned meeting on 15 February 2011 to members of this Committee and the Lead Member for Health and Community Safety as soon as they are available; and

2) that, in considering the draft budget plans for the Adult Social Care divisions, the Overview and Scrutiny Management Board be requested to take account of the comments recorded above.

58. JOINT COMMISSIONING STRATEGY FOR MENTAL HEALTH 2011-2013

Tracie Rees, Director of Commissioning and Business Support, and Yasmin Surti, (Planning & Service Development Officer (Learning Disabilities)), introduced themselves to the meeting.

Yasmin Surti then gave a presentation on the Joint Commissioning Strategy for Mental Health, during which particular attention was drawn to the following points. (A copy of the presentation is attached at the end of these minutes for information.) :-

- The audit of mental health services on which the Strategy was based had been done during 2009/10;

- A lot of consultation had been undertaken, enabling key priorities to be based on what people had said they wanted;

- Although 42% of those consulted had expressed a preference for hospital based services, local services also were very important to them, with 49% preferring community-based services. However, there were not enough providers to give people the kind of support in their own homes that they wanted; and

- Proposals for how the service could move forward were included in the Strategy, along with commissioning priorities and actions.

At the invitation of the Committee, Councillor Naylor, Lead Member for Health and Community Safety, addressed the meeting, reminding Members of the interest he declared in this item, in that he was a Governor on the Leicester Partnership Trust, which delivered mental health services.

The following points were raised during discussion on the draft Strategy:-

- In response to a question about what joint initiatives were being undertaken for prisoners and offenders, it was noted that the Bradley Report in 2010 had set out specific outcomes that should be sought when

people returned to the community from prison. The court process could be used to help offenders as well. Work also was underway to identify how offenders could be removed from previous associates, the results from which were expected in September 2011;

- Autism in children needed to be identified as early as possible, so that they could be helped to overcome the barriers they faced and possibly also reduce their levels of need in later life;

- Although autism was dealt with through the Mental Health Strategy and overseen by the Mental Health Implementation Board, there was a separate Autism Strategy for Leicester, Leicestershire and Rutland;

- Training needed to be provided for families and carers of people diagnosed with dementia, particularly those caring for sufferers at home;

- A provider / commissioner service split had been established for mental health services. The lead commissioner was the health authority, although some City Council officers worked on this, (for example, looking specifically at supported housing);

- The City Council worked with other providers to ensure that the data used to monitor and evaluate the Strategy was sound. There previously had been some problems with the quality of data, but the gaps were being identified and closed;

In response to questions from the Committee, Yasmin Surti undertook to consider how to make it clearer in the Strategy how it was linked with the local Carers Strategy.

59. PROGRESS IN COMMISSIONING GENERAL DENTISTRY

Aileen Holyland, NHS Leicester City, gave a verbal update on progress with the commissioning of dental services in the City, explaining that:-

- There currently were 215 dentists working in 58 NHS dental practices in the City. Of these, 46 were general practices and 12 were specialist, (mainly orthodontic). These practices also were able to offer private treatment;

- 31 practices across the City currently were accepting patients. A plan showing their location in the City was tabled and is attached at the end of these minutes for information;

- One large orthodontic practice in the City had a waiting list of approximately 12 – 18 months;

- Contracts for dental services were activity based and were monitored through annual reviews;

- A patient pathway had been commissioned with City practices for minor oral surgery;

- The current budget for dentistry was £14.5 million. Of this, approximately £12 million was ring-fenced for general dentistry;

- Additional investment had been received during 2010/11 to set up new practices. As a result, 2 new sites had been created in the City and five new contracts established with existing practices, enabling an additional 22,000 patients to be treated;

- There was a target to treat 202,000 patients by 2013. As at January 2011, just over 188,300 patients were being treated. Information on the numbers of patients treated was tabled and is attached at the end of these minutes for information;

- Monthly checks were made with each practice, by telephone, to determine if they were treating new patients. This also was monitored through each practice's annual review;

- NHS Leicester City had the highest number of children in the East Midlands with decayed, decaying, or missing teeth. This situation was being addressed, for example through the issue of tooth brushes and specific training for hygienists;

- Some practices called patients every 6 months, even though National Institute for Health and Clinical Excellence guidelines stated that recalls could be every two years. Leaving longer gaps between recalls would help release capacity for other patients to be seen;

- Work was ongoing to try to make contact with hard to reach groups in the City;

- Practices were being encouraged to market themselves;

- There was a national proposal to introduce contracts with providers of dentistry services based on capitation, registration and quality. Some local practices had applied to be included in the 60 pilot studies that would be carried out nationally;

- Procurement was underway for a salaried dental centre and domiciliary provision was being reviewed;

The following points were then made during discussion on this item:-

- The oral health team visited schools to educate children and young people in oral care and hygiene;

- It was recognised that some people were scared of visiting the dentist and

that work needed to be done to encourage them to attend;

- Communication was important, particularly in settings such as care homes. Further training could be useful, for example in how to communicate with people with dementia;

- Dentists were required to give three months' notice of leaving a practice, so that the PCT could make alternative arrangements. However, it was noted that there had been a case where a dentist's practice had closed, but there had been no clear signposting for patients from that practice to alternative provision;

- Quality control was done through work with the Care Quality Commission and targets for practices. If practices did not conform, the PCT could evoke contract levers, such as issuing remedial notices;

- The water supply in this are did not have fluoride added, although evidence nationally and internationally showed there to be benefits of doing this;

- There was a walk-in emergency dental centre off London Road. Part of its role was to sign-post patients to a high street dentist; and

- All cases referred for orthodontic work were assessed. Complex cases were passed to the University Hospitals Leicester and the rest were passed to primary care providers. For the former, there was an average wait for treatment of approximately three months. For the latter, the average wait for treatment was approximately six weeks.

RESOLVED:

1) that the report be noted; and

2) that the Director of Corporate Governance be requested to circulate a list showing the 58 NHS dental practices in the City to all members of the Committee.

60. LEVELS OF FLU IN THE CITY - UPDATE

Ivan Browne, Public Health Consultant with Leicester City NHS, gave a verbal update on levels of flu in the City and how they were being dealt with:-

- During 2010/11, one of the largest increases for a long time in the incidence of flu was experienced. There were a lot of viruses around, which led to a very sharp increase in reported respiratory illness;

- A graph comparing flu levels in Leicester City in 2009/10 and 2010/11 was tabled at the meeting. This is attached at the end of these minutes for information;

- Leicester tended to experience flu before other areas of the country. Its

levels of flu this year were not considerably higher than national levels, but were experienced earlier than in many other parts of the country;

- Very high numbers of people had accessed emergency care departments, resulting in 509 confirmed or suspected influenza admissions in December 2010. Of these, 17 needed critical care, as a result of which a number of elective procedures needed to be rescheduled;

- A lot had been learnt from the Swine Flu outbreak in 2009/10, so the authorities were quick to react this year;

- This year, anti-viral medication had been distributed through community pharmacists, but they had not been advised in advance that this would be done. They therefore had not had an opportunity to acquire stocks of the medication. However, when it appeared that there would be a shortage, some stocks were obtained from the national stockpile. As a result, the area did not run out of anti-viral medication;

- A vaccination programme also was undertaken this year. When the vaccine became in short supply, arrangements were made to share it between surgeries, so supplies did not run out; and

- Flu levels were now returning to expected levels.

The following points were then made in discussion on this item:-

- The flu season had occurred a few weeks earlier this year than last;

- Some people had refused the flu vaccine this year, as that given in 2009 had made some people feel ill and some people did not want it if it contained a swine flu vaccine. This initially had led to low take-up of the vaccine, but as flu levels increased, so had take-up levels;

- It was not known why Leicester had such high levels of flu. Investigations had been made in to likely factors as far back as the early twentieth century, but no conclusive evidence had been found. The suggestion that the physical location of the City, in a dip, could be a factor would be considered;

- Although the severity of flu in children became a major issue, the Department of Health decided that it was not appropriate to vaccinate children under five. Health representatives from across Leicester raised their concerns about this with the government, but the reply had been that vaccinations should continue to be targeted to the previously identified “at risk” groups; and

- From the start of the vaccination programme, expectant mothers were a high priority, as they experienced the worst outcomes from having flu. A lot of work was done to raise the profile of the vaccination programme,

which saw the number of people electing to be vaccinated increase.

61. HEALTH-RELATED BEHAVIOUR, KNOWLEDGE AND ATTITUDES IN LEICESTER

The Deputy Director of Public Health and Health Improvement submitted a report on the findings of the Leicester Health and Lifestyle Survey 2010, explaining that it provided an overview of self-reported health. He further advised the Committee that it would form part of the Director of Health's Annual Report 2009/10 and would be used as the basis for future improvement.

The Deputy Director of Public Health and Health Improvement drew particular attention to the following points:-

- A sample size of just under 2,400 people aged 16+ (male and female) had been used for this survey. This equated to approximately 100 people per Ward;

- 47% of the population of the City did not drink alcohol and a high proportion had never drunk it. This was largely due to the high Black and Minority Ethnic population. However, high drinking levels were concentrated in the remaining population, leading to high levels of resulting harm;

- Levels of drug taking in the City were low;

- With regard to diet, very few people did not eat any fruit and vegetables;

- This survey recognised physical activities often not included in other surveys, so obtained different results to those surveys;

- Responses to questions on sexual health showed quite high rates of condom use, but actual levels varied between different age groups;

- Risk factors could be relevant to several issues, giving clustering of multiple risk factors. For example, the survey showed that people who smoked more were less likely to eat well; and

- It had been hoped that the report would be annual, but in view of current financial restraints, it now was likely to be undertaken every two years.

The Committee was concerned to note that only a quarter of respondents recognised the importance of not smoking. One reason for this could be that, if smoking was taken for granted, people could be not noticing health warnings, or it could be that more publicity was needed for the message about the health implications of smoking. This also applied to alcohol consumption.

At the invitation of the Committee, Councillor Naylor, Lead Member for Health and Community Safety, addressed the meeting. He expressed disappointment that it would only be possible to undertake this valuable survey every two years

and questioned whether it would be feasible to undertake it in conjunction with partners, such as the local universities. In reply, the Deputy Director of Public Health and Health Improvement advised that a number of regular surveys had been curtailed by a number of bodies, due to financial restrictions. The City Council currently was considering if it could do a survey of some kind, in conjunction with its partners, to cover the resulting gaps.

Councillor Naylor also drew attention to how some areas had improved. It was noted that it was not known at present if these improvements had occurred as a result of health programmes, or whether factors such as ward boundary changes had produced these results. Some "super-output areas" had been identified a few years ago, but more detailed analysis was needed to determine the influencing factors.

In reply to a question from the Committee, the Deputy Director of Public Health and Health Improvement advised that, if it was known that an area had a particular problem, targeted work was done in that area. For example, this approach had been used to try to reduce the prevalence of smoking in certain areas.

In response to further questions, the Deputy Director of Public Health and Health Improvement advised that the sample used for this survey was statistically acceptable, but users of the data had to be aware of confidence levels in the data supplied.

62. ANNUAL HEALTH CHECK (VITAL SIGNS) NHS & LEICESTER CITY - 2009/10 PERFORMANCE INDICATORS

Sarah Cooke, NHS Leicester City, submitted a report that provided an overview of the NHS Performance Framework and local processes that were in place to ensure that NHS Leicester City provided an effective and efficient health service to its local population.

Sarah Cooke introduced the report, explaining that NHS Leicester City had had a strong performance framework in place since 2007/08. The framework was set nationally, but it was decided at a local level how it would be achieved. As a result, the local performance framework for Leicester City was a joint one with the County. This facilitated consistency of targets, which were set through the strategic operating plan.

Targets were regularly challenged, to ensure they were being delivered, as the NHS was required to achieve a certain threshold. These were the "vital signs" set out in the report.

The following points also were noted:-

- Improvement had been achieved in a number of areas. These were set out in Appendix A to the report;

- As a good practice measure, there had been a change in the definition of

Thrombolysis. Making it more appropriate had enabled a better picture of service delivery to be obtained;

- Chlamydia screening and dental services had improved;

- Recorded childhood obesity had increased;

- NHS Leicester City had some concerns about mortality rates, but these were improving, through work undertaken through the Health Inequalities Plan;

- There were two measures for stroke care. The first of these was that people referred to hospital should go on to the right unit and the second was that people suspected of having had a TIA should receive a scan within 24 hours;

- New data collection methods had been established in 2009. These had not been validated, so some of the results appeared to be low. The statistics were now improving;

- It was not known why some people with suspected heart attacks were being taken to the Leicester Royal Infirmary, rather than Glenfield Hospital and, in some cases, had to wait several hours to be transferred to Glenfield Hospital. It was possible that this was due to how the service had been commissioned by either the University Hospitals Leicester or the East Midlands Ambulance Service. This would be investigated and Members advised; and

- The Committee welcomed the increased rates of immunisation.

RESOLVED:

that the Director of Corporate Governance be requested to circulate a link to the website containing national indicators / comparators for the information contained in this report to all members of the Committee.

63. PUBLIC HEALTH WHITE PAPER AND CONSULTATIONS ON PUBLIC HEALTH OUTCOME FRAMEWORK AND FUNDING AND COMMISSIONING ROUTES FOR PUBLIC HEALTH

The Director of Public Health and Health Improvement submitted a report informing the Committee of the publication of a Public Health White Paper and two consultation documents. The Committee's views on the proposals also were requested. It was noted that it was intended that the proposals would be implemented during the next 12 – 24 months.

At the invitation of the Committee, Councillor Naylor, Lead Member for Health and Community Safety, addressed the meeting, advising Members that a meeting for all Councillors to look at these documents was being arranged. The date for this had not been agreed yet, but would be before the new

consultation end date of 31 March 2011. In the meantime, all Councillors were encouraged to respond individually, or collectively, via the Department of Health website.

Councillor Naylor further reported that he had attended a consultation event on 9 February 2011 in Nottingham. Key comments made at this event included:-

- The proposed framework was sound and should work;
- Fewer performance indicators were requested; and
- Local flexibility to change indicators was requested.

64. HEALTH SCRUTINY COMMITTEE WORK PROGRAMME 2010/11

RESOLVED:

1) that the Health Scrutiny Committee Work Programme for the 2010/11 municipal year be noted; and

2) that any comments on, or suggestions for, the Work Programme be passed to the Members Support Officer.

65. CLOSE OF MEETING

The meeting closed at 8.44 pm

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Joint Commissioning Strategy for Mental Health

Executive Summary

Purpose of the Joint Commissioning Strategy

- To set out the plans for the development of health and social care services over the next 3 years
- The partners are Leicester City Council for social care and NHS Leicester City for health services
- The plans are in line with One Leicester and One Healthy Leicester

The Plan sets out:

- The vision and aims for future services
- The Policy framework we have to work within
- What our local needs are
- What people want
- What services are currently provided and how they need to change
- What services cost and the financial context
- The performance & quality of our services
- The commissioning priorities and implementation plan

Charter for Mental Health In Leicester, Leicestershire and Rutland

Every person in Leicester, Leicestershire and Rutland has the right to mental health services that:

- Make a positive difference to each person they serve.
- Stop doing things that are not working.
- Are guided by the individual's views about what they need and what helps them.
- Treat everyone as a capable citizen who can make choices and take control of their own life.
- Work with respect, dignity and compassion.
- Recognise that mental health services are only part of a person's recovery.
- Recognise, respect and support the role of carers, family and friends.
- Communicate with each person in the way that is right for them.
- Understand that each person has a unique culture, life experiences and values.
- Give people the information they need to make their own decisions and choices.
- Support their workers to do their jobs well.
- Challenge "us and them" attitudes both within mental health services and in the wider society.

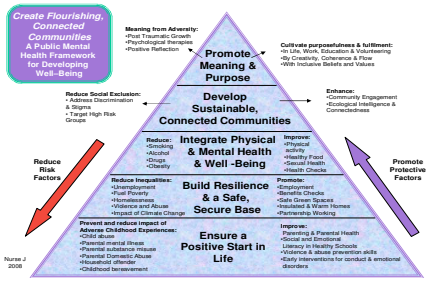
Vision & Aims

Improving the wellbeing of the people of Leicester by strengthening resilience, reducing health and social barriers to good mental health and wellbeing and improving the communities within which we live.

AIMS:

- Promote good mental health and well-being,
- Improve services for people who have mental health problems.
- Help people to look after their mental health and prevent them from becoming ill.
- Tackle the stigma that's associated with mental ill health by focussing on whole population mental health.
- Recognise that mental health and well-being is everybody's business
- Work in partnership with service users and their carers throughout the commissioning process.
- Commission services of a high quality that will meet the needs of the service users.
- Ensure Mental Health services are closely integrated with general health services
- Develop services closer to home, where ever possible.
- Develop well planned care which will aim to support people in achieving recovery.
- Implement personalised care plans for people assessed as needing services.

The Framework



Policy Framework

- New Horizons - Towards a shared vision for mental health (2009). Currently archived –the government is intending to issue a new policy on the future development of mental health services
- NHS White Paper (Equity & Excellence)
- Putting People First
- High Quality Care For All
- Caring for Carers – the national strategy
- Autism Act & Strategy

All focus on increasing choice and control and supporting people to live in the community, supported by modern, flexible, high quality services, with people using personal budgets to decide on how best to meet their needs

Consultation with people who use our services

- The plan is based on what people (who use services and their carers) have told us they want from services
- Consultation with service users and family carers August & September 2010 including:
  - On line survey
  - Focus groups across the city including South Asian community, Bengali women's group and the Somalian community

People told us that the big priorities for them are (1):

Mental Wellbeing

- Over 96% of the respondents considered their mental wellbeing to be very important. The following were **very important** to their wellbeing:
  - Physical Health – 86%
  - Housing – 86%
  - Financial Position – 76%
  - Local Environment – 73%
  - Employment – 59%
- Just over 68% felt it was important to be able to choose the services or packages of support that would help maintain their mental wellbeing if they were given the money to do so.

People told us that the big priorities for them are (2):

Access to mental health services

- Over 86% of the respondents felt that access to mental health support was important. When asked what type/s of services/support people accessed when they or a family member/friend needed support; we received the following responses:
  - GP – 70%
  - Family members – 54%
  - Psychiatrists – 41%
  - Friends – 40%
  - Counselling Services – 28%
- Less than half - 42% - wanted hospital based services.

People told us that the big priorities for them are (3):

- Over 83% of the respondents felt it was very important to have mental health services that are local i.e. within 3-5 miles of where they live.
- Over 89% said that services need to be easily accessible i.e. convenient opening hours, parking, meets their specific cultural and religious requirements, good disability access and public transport links.
- People said the following types of support were important:
  - Group Support – 64%
  - Drop-in services – 56%
  - 1:1 Support – 49%
  - Community based services – 49%
  - Peer Groups – 39%
  - Support into Education and Training – 24%

Local Needs

- Mental ill health both nationally and locally looks likely to increase

•The table below shows the estimated prevalence of common mental health problems in Leicester City

	Rates per /1000 *	Estimated cases p.a.
All phobias	1758	3553
Depressive episode	2864	5788
Generalised anxiety disorder	4609	9313
Mixed anxiety depression	9449	19093
Obsessive compulsive disorder	1000	2020
Panic disorder	582	1175
Any neurotic disorder	17820.	36009

How good are our services

- The Audit Commission identified that there are some data quality issues in some of the datasets and raised some questions about service delivery across the city and the county
- Leicester has placed too many people in residential care - more than other areas
- Spend more on secondary care and less on primary care than other similar areas
- Leicester is poor at supporting people to live independently through social services including moving onto employment

What we spend on services

- NHS Leicester City spent a total of £45 million on adult mental health services in 09/10
- Leicester City Council spent a total of £9.7m in 09/10.
- Leicester City Council spends more than other similar councils on adult social care services, and spends a lot more on residential care – 55% of the total budget compared to 30% in other areas
- Spending on social care increased by 22% over the past 5 years

Who provides services

- Most residential services are provided by the independent sector
- Day services are mostly provided by the voluntary sector with a small council Social Inclusion Team
- There aren't enough providers to deliver support to people in their own homes (supported living)
- Specialist health services for mental health are provided by a big NHS provider (LPT)
- We tend not to take risks and sometimes provide people with more support than they need

The future model for services

Based on

- Recovery model
- early intervention and prevention
  - Promoting health & well being
  - Maximising independence
  - Delaying or reversing deterioration
  - Reducing risk of crisis or harm
  - Providing care and support closer to home
- Care Pathways to improve team working, better clinical processes and improve user experience through less duplication and better continuity of care
- Stepped Care Approach

Future Model: Personalisation

- Better access to universal public services and direct access to preventative services
- Enablement or reablement to help people stay as independent as possible
- Personal budgets for people who meet Fair Access to Care criteria
- Based on assumption that barriers to inclusion come down and care packages ensure universal provision is maximised

Future model – services need to move from:

- High cost residential care **to** a mix of intensive support and some specialist placements, improved health outreach
- Low cost residential care **to** supported living, sheltered schemes, floating support
- Home care **to** reablement and enablement
- Day care **to** enablement, universal services, social inclusion and supported employment
- Specialist health services **to** primary care and improved community health services

Commissioning Priorities

- **Prevention & Early Intervention**
- Improving access to psychological therapies (this includes specialist CBT, Personality Disorder and Psychodynamic Therapy) steps 1-5 including early intervention with people who have long-term health conditions (diabetes/COPD).
- Supported Living – supporting people with mental health conditions to move from residential homes into independent housing and maintaining people to continue to live in their own home with support
- Strengthening crisis intervention within health and social care in order to prevent people from requiring admission to hospital and maintain and support them safely within the community
- **Transforming Social Care**
- Personalisation – providing individuals with greater choice and control over the support/services they need
- Personalised Budgets
- **Supporting the Mental Health of Older People**
- Dementia

Commissioning Actions 1

- Improving access to **psychological therapies**
- Strengthen partnership
- Roll out IAPT
- Change contract
- Evaluate service
- Implement business case for psychological therapies
- Bring level 4 & 5 into stepped care model

Commissioning Actions 2

- Redesign **crisis intervention**
  - Identify barriers
  - Identify model of best practice
  - Develop a care pathway that integrates health and social care to meet all needs
  - Develop new service spec
  - Assess market capacity
- The development of an **enablement service** for all new service users referred to MH services
  - Develop model
  - Develop service spec

Commissioning Actions 3

- **Remodel Residential Care** based on an enablement approach
  - Develop new Pathway for entering res care
  - Develop new Pathway for leaving res care
  - Develop new Service Spec and revise & reissue contracts and bandings
  - Develop strategy for managing residential market to mitigate impact of inwards migration to fill released capacity
  - Engage providers and retrain res care staff

Commissioning Actions 4

- Develop more **supported living** options and move on existing residents
  - Moving On
  - Develop pathway for accessing housing options
  - Develop model and specifications
  - Develop new contractual processes to replace block contract approach
  - Commission floating support services
- Refresh and develop plan for next phase of remodelling in-house **Social Inclusion Team** to continue development of flexible 24/7 services, supported employment and better market mix

Financial Implications

- Within a financial climate of severe cuts to public spending, the plan requires:
  - Investment into enablement services
  - Investment to support people to move on from residential care
  - Reducing spend on residential placements with investment into wider range of community support services
  - Achieving a better balance of services that enables people to access universal and lower cost services first
  - Better market mix and more robust & resilient voluntary sector
  - better support during crisis to prevent un-necessary hospital admission

Dental Practices accepting patients

Public Health & Health Improvement. Feb 2011

Minute Item 59

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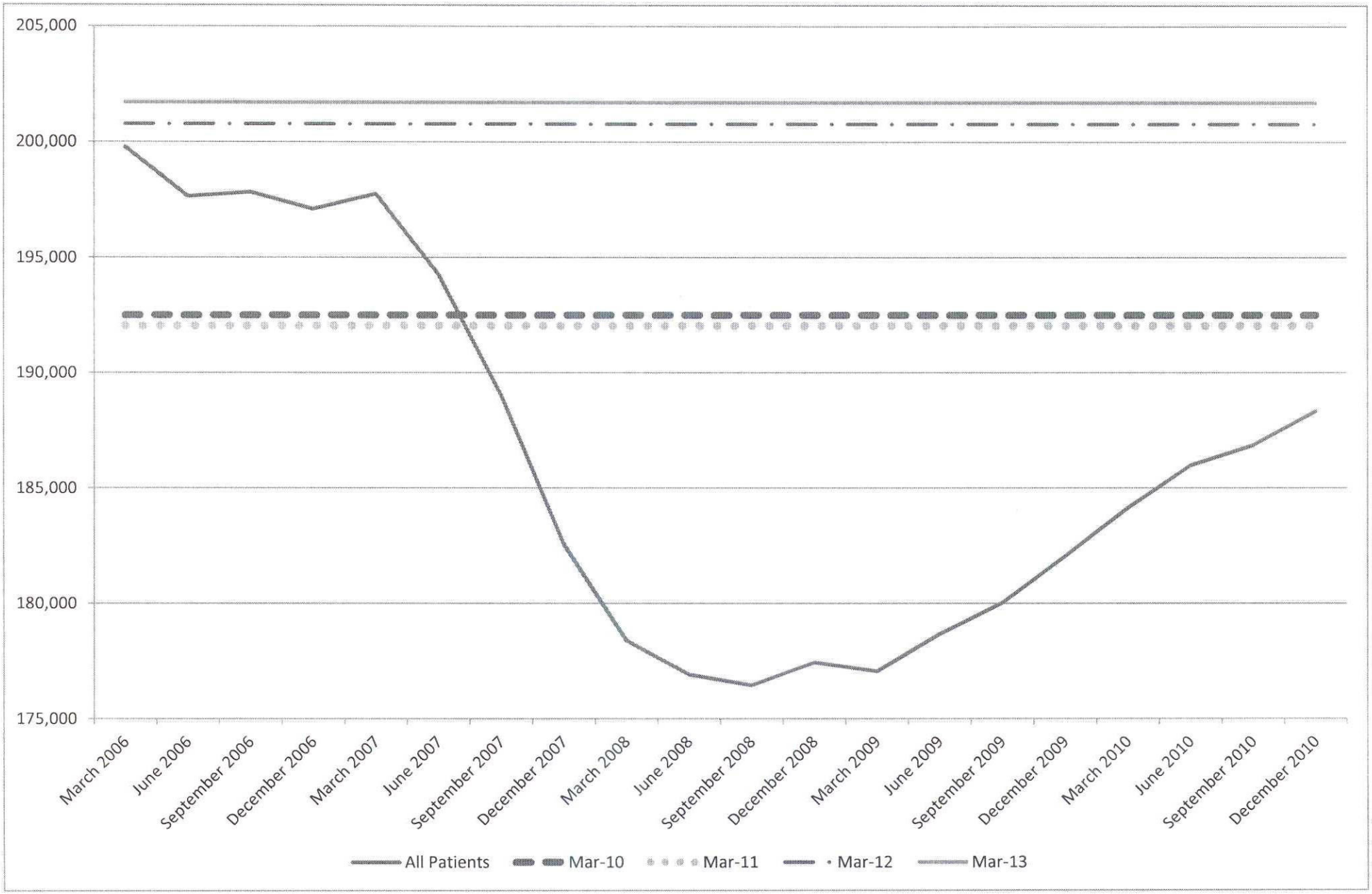
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