Leicester
City Council

MEETING OF THE HEALTH SCRUTINY COMMITTEE

DATE: WEDNESDAY, 9 FEBRUARY 2011
TIME: 6:00 pm
PLACE: FOUNTAIN ROOM, TOWN HALL, TOWN HALL SQUARE, LEICESTER

Members of the Committee

Councillor Bayford (Chair)
Councillor Manjula Sood (Vice-Chair)

Councillors Clayton, Cleaver, Gill and Newcombe
(One Labour Vacancy)

Members of the Committee are invited to attend the above meeting to consider the items of business listed overleaf.

Elaine Baker

for Director of Corporate Governance

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PUBLIC SESSION

AGENDA

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business on the agenda, and/or indicate that Section 106 of the Local Government Finance Act 1992 applies to them.

3. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 1 December 2010 have been circulated and the Committee is asked to confirm them as a correct record.

4. PETITIONS

The Director of Corporate Governance to report on the receipt of any petitions submitted in accordance with the Council's procedures.

5. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Director of Corporate Governance to report on the receipt of any questions, representations and statements of case submitted in accordance with the Council's procedures.

6. 2011/12 BUDGET PROPOSALS - ADULT SOCIAL CARE **Appendix A**

The Strategic Director Adults and Communities and the Chief Finance Officer submits a report seeking the views of the Health Scrutiny Committee on the draft budget plans for the Adult Social Care Divisions.

7. JOINT COMMISSIONING STRATEGY FOR MENTAL HEALTH 2011-2013 **Appendix B**

A verbal update will be given on the Joint Commissioning Strategy for Mental Health 2011 – 2013. The Committee is recommended to receive the update and comment as appropriate.

8. PROGRESS IN COMMISSIONING GENERAL DENTISTRY

Aileen Holyland, NHS Leicester City, will provide an update on progress with the commissioning of dental services in the City. The Committee is

recommended to receive the update and comment as appropriate.

9. LEVELS OF FLU IN THE CITY - UPDATE

Ivan Browne, Public Health Consultant with Leicester City NHS, will give a verbal update at the meeting on levels of flu in the City and how they are being dealt with.

10. HEALTH-RELATED BEHAVIOUR, KNOWLEDGE AND ATTITUDES IN LEICESTER **Appendix C**

The Deputy Director of Public Health and Health Improvement submits a report on the findings of the Leicester Health and Lifestyle Survey 2010. The Committee is recommended to note the recommendations arising from this Survey and to comment as appropriate.

11. ANNUAL HEALTH CHECK (VITAL SIGNS) NHS & LEICESTER CITY - 2009/10 PERFORMANCE INDICATORS **Appendix D**

Sarah Cooke, NHS Leicester City, submits a report that provides an overview of the NHS Performance Framework and local processes that are in place to ensure that NHS Leicester City provides an effective and efficient health service to its local population. The Committee is recommended to receive this report and comment as appropriate.

12. PUBLIC HEALTH WHITE PAPER AND CONSULTATIONS ON PUBLIC HEALTH OUTCOME FRAMEWORK AND FUNDING AND COMMISSIONING ROUTES FOR PUBLIC HEALTH **Appendix E**

The Director of Public Health and Health Improvement submits a report to inform the Committee of the publication of a Public Health White Paper and two consultation documents and to seek views on the proposals. The Committee is recommended to note the publication of the documents and the consultation arrangements developed so far, and to advise on further steps to support the consideration of the White Paper and consultation documents within the City Council.

13. HEALTH SCRUTINY COMMITTEE WORK PROGRAMME 2010/11 **Appendix F**

The Members' Support Officer submits a document that outlines the Health Scrutiny Committee Work Programme for the municipal year 2010/11. The Committee is asked to consider the programme and make comments and/or amendments as it considers necessary.

14. ANY OTHER URGENT BUSINESS

Appendix A

Leicester City Council

WARDS AFFECTED: ALL

HEALTH SCRUTINY COMMITTEE **9TH FEBRUARY 2011**

2011/12 BUDGET PROPOSALS – ADULT SOCIAL CARE

Report of the Strategic Director Adults and Communities and the Chief Finance Officer

1. Introduction

1.1 The purpose of this report is to seek the views of the Health Scrutiny Committee on the draft budget plans for the Adult Social Care Divisions.

2. Summary

2.1 Given the huge reductions in Government funding, the 2011/12 budget round has presented the Council with immense challenges and although the Council has sought to protect key priorities, significant cuts are unavoidable. Divisional budget proposals reflect the significant financial pressures faced by the Council. Budgets are expected to remain under pressure for the next four years as reflected in the Government's Comprehensive Spending Review published in October.

2.3 Attached as appendix one to this report is the draft budget proposal for Adult Social Care which has been prepared by the strategic director in consultation with the Cabinet Lead Member. Its status is purely a draft for consultation. No formal decisions will be made until the proposals, together with scrutiny comments, are considered by the Cabinet in February.

2.4 The Cabinet has asked for the views of your Committee on the attached budget proposals, and in particular has asked:

(a) whether your Committee has any alternative proposals it would wish the Cabinet to consider;

(b) what your Committee's views are on the budget proposals.

2.5 In giving its views, your Committee is asked to be mindful of the obligation to balance the budget.

3. Recommendations

3.1 The Committee is asked to consider the draft budget proposals at Appendix 1 and make its comments to the Cabinet.

4. Financial and Legal Implications

4.1 This report is exclusively concerned with financial issues.

4.2 As this report deals with next year's budget, Section 106 of the Local Government Finance Act, 1992 applies to members in arrears of council tax.

5. Other Implications

Other Implications	**Yes/No**	Paragraph References within Supporting Papers
Equal Opportunities	Yes	See the equality impact assessment
Policy	Yes	Throughout
Sustainable and Environmental	No	
Crime & Disorder	No	
Human Rights Act	No	
Elderly / People on Low Incomes	Yes	Throughout
Corporate Parenting	No	
Health Inequalities Impact	No	

Kim Curry
Strategic Director
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Appendix 1

ADULT SOCIAL CARE

DRAFT BUDGET STRATEGY

2011/12 – 2013/14

CONTENTS

1. Adult Social Care Service Redesign and Budget Reduction

1.1 In addressing the consequences of the Comprehensive Spending Review and the Local Government Grant Settlement for 2011-12, Adult Social Care have developed a three year service transformation programme to drive out the requisite level of expenditure reduction. This report focuses on the first year of the programme itemising the shifts in service provision and the consequential budget reductions. Although savings have been modelled for years 2 and 3 (see Appendix 1) these must be viewed as indicative and will be kept under constant review.

1.2 The Council is a relatively low spending authority on ASC compared with other authorities in its audit family. Nevertheless Adult Social Care (ASC) in Leicester has not developed and modernised as fast as the services in many other councils. What this means in practice is that what funding there is available is providing out moded services of only adequate quality as it has not been able to disinvest and reinvest in modern, choice based quality services. There has been, and remains, an over reliance on residential care and in-house care, where costs are expensive. Our in house services, particularly residential care, do not provide acceptable, modern environments for group living and require significant levels of capital funding which simply is not available. For example, none of our residential homes have en suite facilities and male and female residents have to share toilet and bathroom facilities. Many councils have taken opportunities over the years to outsource services and make significant savings. As a result, people in Leicester requiring social care support lack the ability to exercise choice and control and to live a life that meets their aspirations. Enhanced partnership working for ASC, Housing and NHS is critical to the delivery of this programme. The service redesign is dependent upon the realignment of assets to achieve the results we are seeking. Each part of the programme represents an interdependent, considered and timed move towards a modernised and empowering system of social care. Overall the programme is designed to improve quality, value for money and performance. Carrying it out successfully will raise the aspirations of our service users and contribute to improving their health and well being and life chances.

1.3 The ASC budget strategy needs to recognise and address the issues identified in the Annual Performance Assessment for 2009/10. In particular, it needs to ensure improvements are made to the health and wellbeing of adults and older people. The strategy builds in a significant increase in enablement / reablement services (intermediate care), as a core part of the customer journey. This will increase the numbers of people benefiting from these services and a strategy is being developed with health services. The budget strategy reflects this shift in resources to intermediate care and away from residential services.
End of life care is also being jointly developed; for adult social care this will be taken forward via commissioning specifications, joint rapid response teams and integrated assessment and care management at locality level. This is also the

case with the commissioning of any future residential services, which will focus on those with complex and specialist needs, and on transitional care. The health of users in such services will be integral to the specification of such services and monitored through increasingly joint health and social care contractual arrangements.

The Health and Wellbeing Board will oversee improvements to health inequalities and ensure strategic alignment of health and social care priorities.

1.3 This report represents the first stage of a three stage programme and sets out the position that will be reached, in the redesign of ASC services, by the end of the financial year 2011-12. The second stage is to develop an implementation plan incorporating an equality impact assessment and HR implications. The final stage of the planning work is to develop clear managerial assignments for the delivery of the modernisation of services and processes, within a clear performance framework.

1.4 ASC services have to be capable of responding to growing need over the next fifteen years and allowance needs to be made for this before savings targets are set. By 2025 the demographic pressure on the ASC budget will require an additional £14m over the 2010-11 budget provision.

1.5 The approach, which has been used for the redesign of ASC provision builds on the 'Putting People First' transformation programme and accelerates the modernisation of services in Leicester and assumes the progressive roll out of personal budgets. For each customer group a detailed analysis and redevelopment plan has been formulated based on: reducing reliance upon support packages, the cost of support packages, and the price paid for services and driving out efficiencies in assessment, commissioning and other transversal services.

1.6 This will be achieved and delivered through:

- maximising the use of universal services and promoting social inclusion and community cohesion;
- developing local community based alternative services to support and sustain people in their own homes;
- ensuring that enablement and reablement services are generically available to promote well being and capacity;
- utilising assistive technology at all stages of the care pathway;
- reducing the use of residential care in favour of assisted housing;
- developing a transparent and equitable charging policy which is easily understood and removes the current discrimination;
- realigning assessment and care management with general practice and community health services;
- ensuring clearer coordination between corporate strategic commissioning and ASC specialist commissioning (jointly with NHS);
- redefining the role of local voluntary organisations and focus the council investment on priority outcomes; and
- reducing use of transport in favour of people becoming more self reliant.

1.7 For each customer group there will therefore be a specified series of disinvestments and reinvestments in services to achieve a more up to date and leaner service. This will begin in 2011-12 but the full effect will not be realised in year. The cumulative effect of the transformational changes grows year on year and the full effect is delivered in 2014-15. The summary of the changes for each service grouping is set out in the table below. A more detailed breakdown is attached as Appendix 1

	2010/11			2011/12		
	Year End Client Numbers	Average net cost £ per week	Annual Net Cost £'000s	Year End Client Numbers	Average net cost £ per week	Annual Net Cost £'000s
Long Term Residential Care	1425	358	26,549.0	1083	418	23,571.3
Short Term Residential Care	136	257	1,820.7	136	250	1,765.2
Supported Living	230	625	7,478.8	280	477	6,945.1
Extra Care	42	143	312.2	90	191	893.9
Adult Placements	3	225	35.1	3	225	35.1
Assisted Accommodation				213	74	821.4
Intermediate care						263.4
Home Care	2476	103	13,241.0	1387	100	7,238.5
Day Care	1951	79	8,044.8	1276	115	7,646.3
Direct Payments, Care Packages	493	191	4,884.9	1379	92	6,620.6
Meals etc	853	18	813.9	105	18	642.4
Carers/Voluntary/Community Services				363	15	289.1
Enabling/Reablement			104.5			3,597.3
Assistive Technology						112.6
TOTALS	**7609**		**63,284.8**	**6315**		**60,442.3**

1.8 The service is over reliant on residential care for all customer groups. During 2011-12 the numbers of people placed in residential care will be reduced by 342 people. In order to achieve the required further savings a decision will be needed about the future of in-house provision. Within the rest of the residential care sector for younger adults there are planned reductions in favour of lower cost community based alternatives.

1.9 These reductions are compensated for by developments in service areas utilising ordinary housing, although the lead time for some of these places to come on stream is longer than one year. However, there are around 100 additional places for customers in Extra Care Housing and Supported Living. To this figure should be added over 200 places in other assisted accommodation. Driving down costs in these services, in line with the budget reduction, are key to the approach and this is being done through the use of the Care Funding Calculator tool and price renegotiation with providers.

1.10 Across these service areas there is a shift from residential care to various forms of more cost efficient assisted housing. Within the assisted housing areas cost changes are being pursued to maximise efficiencies.

1.11 In addition to its customers in accommodation ASC supports much larger numbers of people in the community. Many of these people do not meet the FACS criteria and are not eligible for services. Their needs could be better met in community settings and in mainstream services. During the programme and starting in 2011-12 it is planned to reduce home care services and reduce the numbers of users by around 1200. Traditional day care services will also be reduced by almost 700, offering more inclusive and sociable opportunities for people rather than warehousing them in unsuitable buildings which are separated from the community and community living opportunities.

1.12 Instead of contracted or in-house service provision service users will be allocated a personal budget following the assessment process. With this budget individuals can directly, through an agency/broker or through the council buy the services to meet their needs and help to achieve their desired outcomes and aspirations. There are already a large number of people receiving direct payments and this number will grow year on year with an additional 600 people accessing personal budgets in 2011-12.

1.13 There are currently around 850 people receiving mobile meals at a cost of £814k. The cost per meal is approximately £5.20 and the current charge is £2.95. This represents a significant subsidy for each service user and does not represent good value for money given the rigidity of the service and the lack of customer choice. It is planned to reduce and then close the service during next year yielding savings of £172k by 31st March 2012 and then £714k in the following year. It is planned to consult on decommissioning the service to give improved choice for people as well as yielding savings. There are many different options in this regard all of which should be explored.

1.14 As the availability of ASC direct provision is reduced there will be a continuing need to review the investment in community based voluntary organisations. During 2011-12 there is planned to be additional investment of £289k in the expectation that the sector will serve an additional 363 people. This will largely be in the way of preventative services to support people to remain independent for longer, hence not requiring larger packages of care.

1.15 Reablement and enablement services are at a very early stage of development but the research from other parts of the country shows that these services have a critical role to play in helping people to regain and retain their coping capacities. A rapid expansion of these services next year for both older adults and younger adults will reduce demand for more expensive care packages and delay admission to high cost care placements. It is planned to expand the service from just over 100 people to 440 by the end of next year and continue to grow the service further in future years.

1.16 Intermediate care has not been formally developed although some in-house residential homes have provided some placements. Again this service model interrupts the flow of people into high cost residential care placements. It is anticipated that an investment of £263k next year serving 110 people will be built over the programme to a total investment of £1,473k.

1.17 The potential for assistive technology to replace expensive services throughout the care pathway needs to be exploited. As well as purchasing equipment through personal budgets some individuals and services will be given access to assistive technology devices and provision has been made for additional 295 people in 2011-12.

1.18 The other reduction areas in the strategy and the allocation to 2011-12 are set out below.

	£000's
Voluntary Sector Contracts	(200)
Transport	(200)
Increased Income	(500)
Continuing Health Care	(100)
Total	**(1,000)**

1.19 The focus of change and reduction during 2011-12 will be as follows:

- Voluntary Sector provision is going to be critical in the delivery of a modern service. Although a reduction of £1.9m is planned over 3 years; nearly £1.5m is to be reinvested in the sector in new targeted services. Overall during 2011-12 there is additional investment of £289k. Savings will be identified of £200k on contracts which are not business critical
- The budget provision for transport will be reduced by a third with a target of £1.0m reduction over three years, as many customers on individual budgets will receive direct payments rather than council arranged services, which will include a provision for transport. It is also the case that some service users are in receipt of a mobility allowance. Public transport use will be expanded through travel training.
- Given the proposed changes to the charging arrangements that are to be put in place as part of this programme, it is anticipated that the council will receive around £1,115k in additional contributions from customers by the end of the three years. During year 1 additional income of £500k has been assumed. All service users go through a financial assessment and make a contribution based on their ability to pay. Many service users will not have to meet the additional charges as they are already at their maximum contribution. Over time all services will be charged according to their cost. This will mean a charge for services such as day care where no charge is currently made and an increase in the charge for subsidised services such as home care. The move towards personal budgets (based on an assessment of need combined with a resource allocation system) will only be equitable if charges are levied on the basis of their costs. If services are 'free' or subsidised then the purchasers of those services are advantaged over those who purchase unsubsidised services. This becomes particularly perverse where a subsidy is provided to services purchased by those who are assessed as being able to pay as it works to the detriment of those who are assessed as not being able to pay.
- Over the three years it is expected that through coordinated work with the NHS that the Continuing health care budget will take on additional demand from customers and relieve the ASC budget of around £500k.

During 2011-12 it is anticipated that at least £100k will be financed through CHC rather than the council budget.

1.20 Taken together these changes represent the most comprehensive agenda for change in Adult Social Care, which has been proposed in Leicester.

2. Risk Assessment

2.1 Adult Social Care is undertaking a major transformation programme (Putting People First) while at the same time needing to find substantial savings. The general direction of travel is clear but the extent and nature of the change required over the next three years greatly increases the inherent risk. Clearly the risk increases over time and there will be a need to continually review and re-assess the financial position.

2.2 Some of the changes are highly sensitive. This significantly increases risk levels; particularly around the speed of delivery. Examples include:

- Reductions in the numbers receiving care packages and reductions in the size of care packages for most people receiving them.
- Significant outsourcing
- Closure of residential care homes and day centres

2.3 If the implementation of proposals is delayed then not only will there be a delay in achieving savings but there will be a significant deterioration in the financial position because of double running costs where residential homes and day centres are kept open but are under occupied.

2.4 Inevitably, there are many significant risks. These include:

- Reductions in grant funding have not yet been fully worked through so the impact is not yet known
- Significant savings are predicated on reducing the numbers of people receiving care packages through diversion to universal and lower cost community services
- Savings are predicated on being able to reduce current provider costs in the voluntary and private sectors
- Savings have been calculated on moving some people from residential care to lower cost forms of supported living.

2.5 In addition to the above the social care divisions are likely to carry forward a substantial inherent overspend of around £2m from the current year.

2.6 Overall Adult Social Care is probably the council's greatest risk area from a financial perspective. It has implemented a series of workstreams to help ensure progress is made towards making the required savings and thereby reduce the level of risk.

2.7 However, the significant risk of not making such changes are not only that people requiring care in the city are disadvantaged by an un modernised system but also that the Council will encounter the most severe financial difficulties as a result of not making changes to ASC. As one of the biggest spending parts of the system, the inherent risk in not changing is equal to and probably greater than the risk of change.

3. Initial Equality Impact Assessment (EIA) Stage 1

3.1 The transformation of Adult Social Care has been a government priority since 2007 and is set out in the Putting People First Concordat. The key elements of this aimed to promote a reformed adult social care system in England. A system able to respond to the demographic challenges presented by an ageing society and the rising expectations of those who depend on social care for their quality of life and capacity to have full and purposeful lives.

3.2 Leicester City Adult Social Care (ASC) will always strive to

- Ensure the safety and well being of vulnerable people in the city
- Involve people in making decisions that affect social care
- Promote choice and control for people and carers, who use services
- Distribute resources fairly according to peoples needs
- Re –shape the care market to meet needs of customers and carers

3.3 The budget reduction strategy has been developed as part of a wider adult social care vision and strategy which will deliver a modernised and empowered system of social care that meets the aspirations of the Putting People First concordat.

3.4 The EIA overview and first stage EIA template identifies the key budget reduction elements together with the first stage analysis in relation to race, gender and disability. A comprehensive and detailed EIA is been undertaken on the potential impact for each specific client group.

3.5 The purpose of this Stage 1 assessment is to highlight which protected groups are affected by the proposals, identify any emerging themes, and set the context for further evidence gathering and consultation. This evidence will be used to compile a detailed equality impact assessment on each element of the budget reduction and how this would affect specific groups

3.6 Budget Reduction Elements

The budget reduction items are focused on a number of key areas aligned to the overall ASC strategy which is compliant with

- the Comprehensive Spending Review/Local Government Grant Settlement for 2011/12
- facilitates the redesign of ASC and takes and an overview summary is provided below.
- takes into account the increases in the demand for social care support due to demographic changes.

3.7 The budget reduction strategy focuses on a number of themes:

3.7.1 Increased Choice, Control and Support

A number of proposals are focused on a shift from traditional models of care such as residential care, day care and home care to the provision of personal budgets and the use of self directed support and community based alternatives. The council recognises that a proportion of people with high needs will be at risk of needing admission to residential care but if alternatives were available would choose more flexible support services or to remain in their own home. Self directed support is person centred and the option of using a personal budget will increase choice, control and social inclusion. ASC seeks to enable people to remain in their own homes for longer, with improved quality of life and better outcomes and increase flexibility as current models of residential care and day care offer limited culturally appropriate services. This shift will impact on directly provided and external providers, requiring re design and closure of some specific services.

3.7.2 Expansion in Prevention and Early Intervention

Increasing access to universal community based services in neighbourhoods will promote social inclusion for those not eligible for adult social care services. The planned expansions in reablement, intermediate care, use of assistative technology are all part of a wider prevention and early intervention strategy reducing the number of people who require high cost care packages and enabling people to stay in their own homes for as long as possible. A range of alternatives to traditional services will increase choice and control and enable specific groups and individuals to have their needs met more flexibly eg local culturally specific care personal care.

3.7.3 Fairer Charging

Leicester City Council provides and arranges adult social care services for many people. Unlike health services, adult social care services are not free. They are services that are often charged for, except where people can not afford to pay. With income from charges being a key source of funding, decisions have to take into account the projected levels of demand for social care. A combination of factors means that it is appropriate to undertake a review of the current policy. These factors include a continuing review to ensure that the policy remains consistent with new and emerging guidance and also develop an opportunity to increase income to the council and avoid potential reductions in services.

The council is committed to Putting People First 2007. This means that the council will have to demonstrate that its charging policy is demonstrably fair between different customer groups and also that the overall objectives of social care ie to promote the independence , well being and social inclusion of users are not undermined by poorly designed charging policies. There could be a potential negative impact on some groups, according to their wealth however all charges will be in line with national guidance. Income is an essential component

of funding for social care and secondly they have an impact on the choice people make about their care. Revenue enables additional services to be offered and protects existing services as a result of budget reductions

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3.7.4 Commissioning

The commissioning focus will be centred on delivering reducing the unit costs of current commissioned and contracted services, focusing investment on preventative services for people eligible for ASC support and implement joint commissioning strategies with the NHS. Increasing the take up of self directed support will have in the short term an impact on current grant funding arrangements with small voluntary sector organisations, as users themselves will decide how they spend the money to support their needs. To mitigate against this ASC will continue to work with all providers to plan for full implementation of transformation and develop alternative business and service models that are financially sustainable.

3.8 Stage 1 EIA

The template attached details the stage 1 equality impact assessment, on these specific budget proposals. The implementation of the Putting People First agenda has been subject to continuous EIA overseen by the ASC Transformation Board and these proposals are aligned with this work.

Section 4 Budget Equality Impact Assessment Adult Social Care

	Race equality			Gender equality		Disability equality	
	Will the proposal result in negative impacts likely to be experienced by one/some racial groups and not by other racial groups? Racial groups to consider include White as well as Black Minority Ethnic groups. If yes, which group(s) will be affected and how will they be affected?	**If there is a negative impact, what can be done to reduce or remove the negative impact?**	**If the proposal impacts on a particular area of the city, are there any race equality implications because of the racial composition of the particular area?**	**Will the proposal result in negative impacts likely to be experienced more by one gender and not the other gender? If yes, who will be affected and how will they be affected?**	**If there is a negative impact, what can be done to reduce or remove the negative impact?**	**Will the proposal result in negative impacts likely to be experienced by disabled people (for any impairment across the range of impairments experienced by disabled people)? If yes, who will be affected and how will they be affected?**	**If there is a negative impact, what can be done to reduce or remove the negative impact?**
Reduce usage of residential care for all client groups and increase the use of alternative forms of supported accommodation e.g Extra Care, Intermediate Care, Supported Living *N.B this refers to new clients and those in existing residential care who request choice of alternative accommodation and support*	No – positive impact offering greater choice and control	N/A	N/A	No – positive impact offering greater choice and control	N/A	No – positive impact offering greater choice and control	N/A
Reduction in unit costs of external home care, residential care and	No – contractual obligation to provide same level of service	N/A	N/A	N/A	N/A	No	N/A

supported living provider contracts							
Increased use of universal services for those not FACS eligible	No – greater social inclusion	N/A	N/A	No	N/A	No – greater social inclusion	N/A
Reduce use of home care and day care services through the use of personal budgets	No – positive impact of self directed support	N/A	N/A	No – positive impact of self directed support	N/A	No – positive impact of self directed support	N/A
Phased reduction of in house provider services including residential care and day services	Yes – some impact where home offers specialist service for older people from BME populations who have dementia	Retraining of existing staff group to work in expanded reablement Commissioning from voluntary and independent sector specialist providers	Further detailed analysis to be undertaken and consultation process will provide feedback for consideration	Yes - Predominantly female workforce and significant local employer in some areas of the city so may have a disproportionate impact in surrounding community	Retraining of staff to support expansion in reablement and Intermediate care services	Disabled people in existing day services may feel that a change process itself has a negative impact.	Ensure current service users are involved in the change process through coproduction processes
Phased reduction in mobile meals service and shift to personal budget provision • In house • Contracted	It is planned to consult on decommissioning the service to give improved choice for people as well as yielding savings. There are many different options in this regard all of which should be explored.	N/A	N/A	It is planned to consult on decommissioning the service to give improved choice for people as well as yielding savings. There are many different options in this regard all of which should be explored.	N/A	It is planned to consult on decommissioning the service to give improved choice for people as well as yielding savings. There are many different options in this regard all of which should be explored.	N/A
Additional investment in community based voluntary organisations	No – Positive impact as resources redirected/targeted into voluntary sector to meet specific needs	N/A	N/A	No	N/A	No	N/A
Expansion of	No – Positive impact	N/A	N/A	No	N/A	No	N/A

reablement and enablement services	supporting people to live as independently and as close to home as possible						
Increase in Intermediate Care services	No Positive impact supporting people to live as independently and as close to home as possible -	N/A	N/A	No	N/A	No	N/A
Increased use of Assistive Technology	No -Positive impact supporting people to live as independently and as close to home as possible	N/A	N/A	No	N/A	No	N/A
Voluntary Sector disinvestment and reinvestment programme	Yes – Smaller specialist voluntary sector groups are dependent on current grant/block contract commissioning model and move to personal budget income and self directed support may make current operating model unsustainable	Development of provider market place and support to re shape business model	Further detailed analysis to be undertaken	Yes - Smaller specialist voluntary sector groups are dependent on current grant/block contract commissioning model and move to personal budget income and self directed support may make current operating model unsustainable	Development of provider market place and support to re shape business model	Yes - Smaller specialist voluntary sector groups are dependent on current grant/block contract commissioning model and move to personal budget income and self directed support may make current operating model unsustainable	Development of provider market place and support to re shape business model
Reduction in use of specialist transport/directly provided transport inc use of taxis and increased use of public transport through expansion of travel training programme	No – positive impact as supports self directed support, more choice and control	N/A	N/A	No – positive impact as supports self directed support, more choice and control	N/A	No – positive impact as supports self directed support, more choice and control	N/A
Revise Adult Social Care Fairer Charging Policy and increase charges	No	N/A	N/A	No	N/A	No	N/A
Ensure Continuing Health Care (CHC)	No	N/A	N/A	No	N/A	No	N/A

assessments and process is correctly applied							
Joint Commissioning Strategy for Dementia with Primary Care	No – Positive Impact as supports self directed support, more choice and control	N/A	N/A	No- Positive Impact as supports self directed support, more choice and control	N/A	No -Positive Impact as supports self directed support, more choice and control	N/A
Joint Commissioning Strategy for Mental Health with Primary Care	No- Positive Impact as supports self directed support, more choice and control	N/A	N/A	No -Positive Impact as supports self directed support, more choice and control	N/A	No -Positive Impact as supports self directed support, more choice and control	N/A
Joint Commissioning Strategy for Learning Disabilities with Primary Care	No – Positive Impact as supports self directed support, more choice and control	N/A	N/A	No -Positive Impact as supports self directed support, more choice and control	N/A	No -Positive Impact as supports self directed support, more choice and control	N/A
Increase take up of Personal Budgets	No - – Positive Impact as supports self directed support, more choice and control	N/A	N/A	No -Positive Impact as supports self directed support, more choice and control	N/A	No -Positive Impact as supports self directed support, more choice and control	N/A
Reduction in management/Operating costs	No	Further detailed analysis to be undertaken	Further detailed analysis to be undertaken	Yes – social care workforce predominantly female	Further detailed analysis to be undertaken	No	N/A

ADULT SOCIAL CARE REDESIGN AND REDUCTION STRATEGY

	As Is 31/03/2010		2011/12 YEAR 1	2012/13 YEAR 2	2013/14 YEAR 3
	Nos	£000's	£000's	£000's	£000's
RESIDENTIAL CARE					
Long term	1,425	26,549	(2,978)	(6,751)	(9,751)
Short Term	136	1,821	(55)	(63)	(81)
Extra Care	42	312	582	577	786
Supported Living	230	7,479	(534)	(666)	(1,297)
Other Assisted Accommodation	0	0	821	2,122	3,141
Residential Savings Total	1,833	36,161	(2,164)	(4,781)	(7,202)
COMMUNITY CARE					
Home Care	2,476	13,241	(6,003)	(9,585)	(12,571)
Day Care	1,951	8,045	(398)	(3,494)	(6,026)
Direct Payments and Care Packages	493	4,885	1,736	4,860	7,353
Adult Placements	3	35	0	0	0
Meals Service	853	814	(172)	(714)	(714)
Carers/Voluntary Sector	0	0	289	912	1358
Reablement/Enabling		105	3,493	3634	3708
Intermediate Care		0	263	856	1473
Assistive Technology		0	113	249	447
Non Residential Savings Total	5,776	27,124	(679)	(3,282)	(4,971)
Total service Changes	**7,609**	**63,285**	**(2,843)**	**(8,063)**	**(12,174)**
Other Savings					
Voluntary Sector Contracts			(200)	(890)	(1,925)
Transport			(200)	(520)	(1,000)
Care Management Staffing			0	(1,077)	(2,693)
Care Management Management Costs			0	(62)	(155)
Increased Income			(500)	(746)	(1,115)
Continuing Health Care			(100)	(100)	(100)
Savings to be Found			0	0	(400)
Total			**(1,000)**	**(3,395)**	**(7,388)**
TOTAL SAVINGS	**7,609**	**63,285**	**(3,843)**	**(11,458)**	**(19,562)**
Demographic Growth Pressure			0	0	1,357
TOTAL NET SAVINGS (after Demographic Growth)			**(3,843)**	**(11,458)**	**(18,205)**

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Appendix B

NHS
Leicester City

Joint Commissioning Strategy
Mental Health
2011-2013

INDEX

Charter for Mental Health
In Leicester, Leicestershire and Rutland

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

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

1. Foreword / Introduction

Health and social care services have a key responsibility in supporting people who experience mental ill health. They also have lead role in improving health and wellbeing.

Mental health services have changed a great deal over the last twenty years. Whilst these changes have led to many positive outcomes, especially for people with the most severe illnesses, people who experience mental health problems still encounter significant difficulties in their daily lives, experience gaps in services and variation in the support available to them. For too long many people have had to wait too long for treatment, many find that they are not treated as individuals or with dignity and respect and services are not as well aligned as they might be to meet the diverse needs of local communities. While secondary care services have improved, the development of primary and out of hospital services has not proceeded at the same pace; we need to shift the focus and the balance of investment towards primary and out of hospital services.

While this new strategy builds on what has already been achieved it provides a refreshed strategic direction, particularly in light of the Governments programme of action for mental health: *New Horizons: a shared vision for mental health,* which sets out a unique dual approach. This approach, coupled with *Leadership for personalisation and social inclusion in mental health (* SCIE 2009) combines service improvement with a new partnership of central and local government, third sector and the professions, with the aim of strengthening the mental health and wellbeing of the population, through prevention and helping individuals and communities to bring the best out of themselves, with all the health, social and economic benefits that follow.

The traditional service-led approach has often meant that people have not received the right help at the right time and have been unable to shape the kind of support they need. Personalisation is about giving people much more choice and control over their lives in all social care settings including those integrated with health. It is far wider than simply giving personal budgets to people eligible for council funding.

Personalisation means addressing the needs and aspirations of whole communities to ensure everyone has access to the right information, advice and advocacy to make informed choices about the support they need. It means ensuring that people have services such as transport, leisure and education, housing, health and opportunities for employment regardless of age or disability. Personalisation offers the opportunity to further break down mental health stigma and institutionalisation through increasing self-determination, independence, choice and control for and with people with mental health problems themselves. But there are specific challenges of implementation within mental health. These include the need to manage particular types of risk, fluctuations in mental capacity and the mechanics of effective social care delivery within integrated NHS provider organisations.

Essential to NHS Leicester City and Leicester City Council achieving its vision for high quality mental health services is the need for strengthening the prevention agenda and early identification to promote emotional resilience. The way health and social care services are commissioned is changing and we expect to see the market for services expand with new providers entering the market.

The strategic ambitions for mental health services must be delivered against a backdrop of change and a significantly challenging financial landscape. In order to realise these ambitions productive commissioning is essential, through the Quality, Innovation, Productivity and Prevention (QIPP) Programme, and commissioning preventative and people centred services.

Finally, this strategy is intended to provide the framework for effective commissioning to improve the outcomes of care for individuals. It is also intended to build strong leadership and innovative approaches to improving mental health and emotional well-being and redress inequalities, social exclusion and discrimination.

2. Purpose of this document

2.1 The Joint Commissioning Strategy for Mental Health sets out the commissioning intentions of NHS Leicester City and Leicester City Council in respect of services for people with mental health. As the key partners to this plan NHS Leicester is responsible for commissioning health services locally and Leicester City Council is responsible for commissioning social care services.

The White Paper Equity and Excellence: Liberating the NHS, published in July 2010, means that responsibility for commissioning health services will transfer to new bodies of GP led consortia, with the current primary care trust, NHS Leicester City being phased out in 2012. Though the commissioning partners will change, by jointly commissioning services, we can make the best use of shared resources and make sure that no-one falls through the gap between health and social care services.

NHS Leicester City has the lead and is responsible for:

- The commissioning of mental health services for Leicester – children,
- Public health
- Commissioning of primary and secondary care which includes commissioning heath services from acute hospitals, General Practice, community health services

Leicester City Council is responsible for:

- the provision of Community Care Services and Childcare services when required

- the provision of suitably trained and qualified workers by the local authority under the Mental Health Act and the Mental Capacity Act

- the provision social housing either directly or via a social landlord

- the transfer from primarily commissioned services to personalised budgets

This strategy has been developed through the NHS Leicester City Mental Health Programme Board – which brings together a range of stakeholders who are interested in mental health and wellbeing. The role of the Programme Board is to develop the strategic direction for commissioning and delivery of mental health services in Leicester and monitor its implementation.

This strategy is based on an approach to whole population mental health. The focus on prevention and maintaining good mental health is particularly relevant today with people leading more hectic lifestyles and going through the economic uncertainty.

2.2 The Commissioning Strategy explains how NHS Leicester City and Leicester City Council plan to work together with all stakeholders to improve mental health outcomes for the population of Leicester. The focus of the strategy will be on those areas that come within the compass of the two agencies.

The Strategy builds upon the previous local Joint Mental Health Strategy 2005 – 2010 and the National Service Framework for mental health - widely acknowledged as the catalyst for a transformation in mental health care over the last ten years, which comes to an end in 2009.

The main policy drivers for Adult Mental Health over the next 10 years are:

- 'New Horizons' (but noting that a new government policy is due for publication)
- The Transformation of Social Care

This strategy is over arching and covers the following people, linking into other more specific strategies

- People aged between 16-64
- People in transition from child to adult services
- Adult mental health services
- Services for those aged 65 and over.
- People with autistic spectrum conditions (Aspergers)
- People with a dual diagnosis – drugs and alcohol
- People with a dual diagnosis including a learning disability
- People with early on-set dementia

3. Mental Health & Mental Illness

Good mental health is precious, it is fundamental to our well being, yet mental health problems are commonplace and living with the burden of a mental illness can exact a heavy price on individuals and those who care for them. It is well recognised that good mental health is linked to good physical health (New Horizons 2009) and is fundamental to achieving improved educational achievement, increased employment opportunities, reduced criminality, social exclusion, and reduced health inequalities.

The term “mental health problems” covers a range of conditions ranging from anxiety, depression through to severe and enduring mental illness. While some people will recover quickly from their particular problem for some the journey to recovery is long and difficult and is important that services are flexible and personalised so as to maximise the benefits for individuals. Furthermore whilst the impact of mental health problems can be detrimental for individuals, families and communities, there is a lack of understanding that about such problems which often results in people with mental illness being stigmatised by attitudes that in turn exacerbate the problems of people living with mental ill health.

This joint strategy forms part of a suite of plans encompassed by the NHS Leicester City’s- One Healthy Leicester, intended to complement strategies for children and young people, and older people with mental health problems. This dovetails with Leicester City Council‘s vision being developed through the Leicester Partnership and it’s seven priority areas.

In drawing up this strategy we have taken account of the needs of service users, expert and clinical knowledge, evidence of what works and most importantly how the people who use services would like to see them developed. Inevitably not everything can be tackled so the strategy sets out the key priorities for investment and action.

4. Our Vision & Strategic Aims

Local Vision

Our local vision for Leicester is:

> 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.

Priorities

The Mental Health & Well Being Programme Board identified, based on local needs and gaps in services, and consultation with service users, the following top priorities for the next eighteen months:

1. **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

2. **Transforming Social Care**

    - Personalisation – providing individuals with greater choice and control over the support/services they need
    - Personalised Budgets

3. **Supporting the Mental Health of Older People**

    - Dementia - Our priority is to develop an integrated dementia care pathway, covering the spectrum of need for people with dementia from early diagnosis and intervention to end of life care. The development of this pathway will take into consideration local needs, data on existing service provision, evidence from best practice models in dementia care and the outcomes of a series of workshops involving service providers, patients and carers to look at improvements in the dementia pathway.

      We are working with our strategic partners across Leicester, Leicestershire and Rutland to progress this work and deliver an integrated dementia care pathway which includes GPs, primary and secondary health staff, social care staff and voluntary sector staff. We will continue to engage with patients and carers throughout this development to ensure that the services developed will meet their needs.

The following principles/values will underpin the strategy and the delivery of services

- Delivering Race Equality in Mainstream Services

- Implementing the Mental Health Charter
- Value User/Carer experience and use this to inform service design/redesign
- Strengthen partnership working with all key stakeholders including voluntary sector and partners

Strategic aims

In order to achieve our vision the aims of the strategy are to:

- 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.

Improving Mental Health Outcomes

Improving how we commission mental health services is central to improving mental health outcomes and quality of care.

The mental health outcomes to be achieved through the One Healthy Leicester strategy include:

- **Strengthening individuals**: increasing emotional resilience through acting to promote self esteem and develop communication, negotiation, relationships and parenting skills.

- **Strengthening communities**: increasing social support, inclusion and participation to protect mental wellbeing. Tackling the stigma and discrimination associated with mental health will be critical to promoting increased participation.

- **Reducing social barriers to good mental health**: increasing access to opportunities like employment that protect mental well being.

- **Support Service users** to purchase some or all of their social care services through Direct Payments or an Individual Budget.

This strategy sets out the joint commissioning plan for the future development of health and social care services for adults with mental health needs over the next 18 months.

The key partners to this plan are NHS Leicester and Leicester City Council. NHS Leicester is responsible for commissioning health services locally and Leicester City Council is responsible for commissioning social care services. **The White Paper Equity and Excellence: Liberating the NHS**, published in July 2010, means that responsibility for commissioning health services will transfer to new bodies of GP led consortia, with the current primary care trust, NHS Leicester City being phased out in 2012. By jointly commissioning services, we can make the best use of shared resources and make sure that no-one falls through gap between health and social care services.

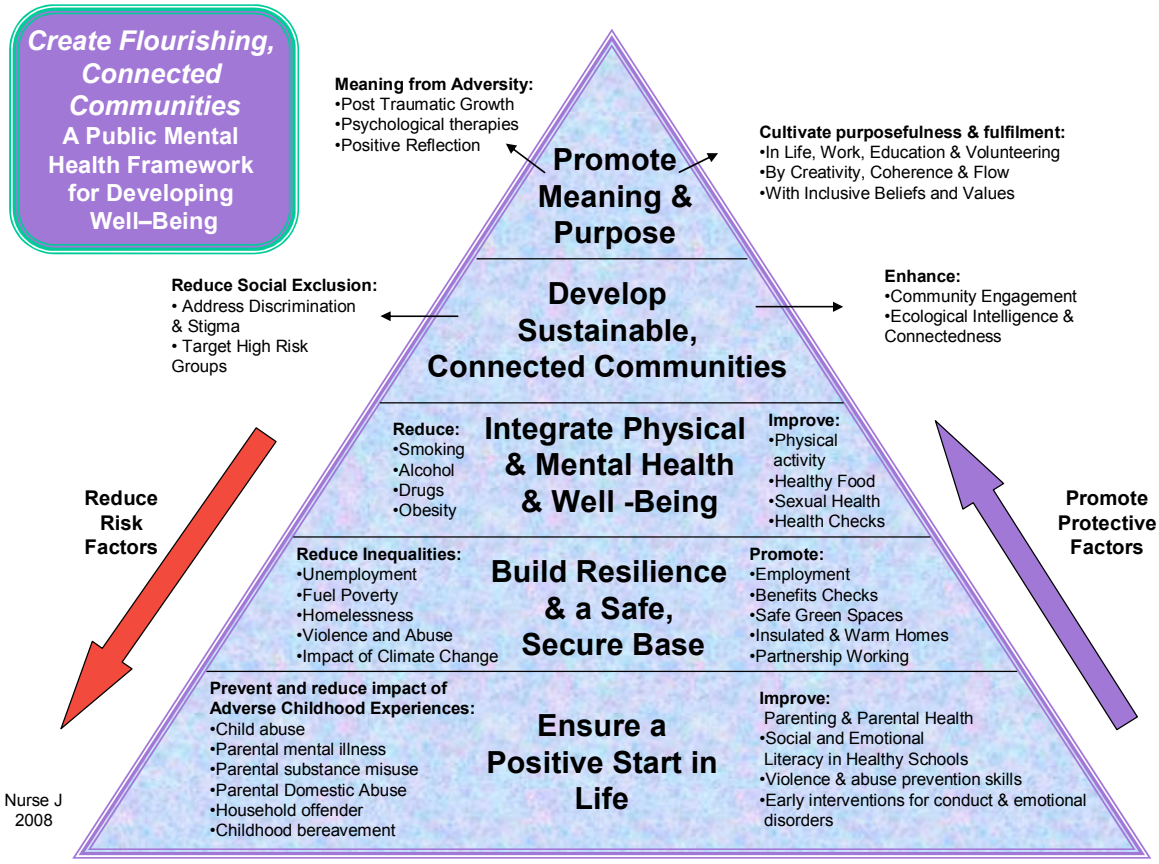
This plan will set out:

- the shared vision and strategic aims of the partners
- the policy framework underpinning the strategy
- an analysis of the current and future needs of people with mental health needs in Leicester
- what sort of services people with mental health needs and their carers want in the future
- what services are currently provided, what they cost and how they perform
- how services need to change to meet future needs and deliver what people want
- the commissioning intentions and priorities of both agencies
- a detailed delivery plan with costs and timescales

As this strategy sets out the joint commissioning plan for the future development of health and social care services for adults with mental health needs, it considers that mental health outcomes will only be improved with more partnership working, a shared understanding of the issues to be addressed and the outcomes to be achieved, maximum co-operation between the stakeholders involved, a consistent approach to dealing with mental well-

being and mental ill health and arrangements to ensure that commissioning of services and other interventions is effective.

A model of care for promoting protective factors and reducing risk factors is shown below. The benefit of integrating this approach is to shift the focus from illness to well-being, towards earlier intervention for high risk groups and to promote well-being in the whole population. It also helps to focus on preventing mental ill health, improved physical health, increased emotional resilience, increased social inclusion and participation and improved productivity.



5. Policy Framework

In developing this strategy, we recognised both the wider national imperatives driving the development of commissioning and services, as well as local strategic priorities including the following:

5.2 New Horizons - Towards a shared vision for mental health (2009). Currently archived – it should be noted that the government is intending to issue a new policy on the future development of mental health services and this Strategy will be reviewed to ensure compliance with new guidance.

New Horizons is the Government Strategy which sets out the next stage for improving mental health in England. It takes a cross Government approach and aims to:

- Take forward what was learnt in the lifetime of the National Service Framework for Mental Health 1999-2009 (NSF) about what works, and broaden our scope to include all groups in society, including children and young people and older people.
- Build on the principles and values set out in the NHS Constitution
- Support the delivery of the NHS Next Stage Review (the Darzi report) and its vision of local commissioners working with providers, the public and service users and carers to devise local approaches to mental health and mental health care.
- Use the growing understanding of the wider determinants and social consequences of mental health problems and mental well-being to influence priorities in other parts of central and local government.
- Reinforce commitment to key mental health policy aims, including delivering race equality and improving access to psychological therapies.

5.4 Transforming Social Care and Personalisation

Across Government, the shared ambition is to put people first through a radical reform of public services. It will mean that people are able to live their own lives as they wish; confident that services are of high quality, are safe and promote their own individual needs for independence, well-being, and dignity.

Personalisation, including a strategic shift towards early intervention and prevention, will be the cornerstone of public services. This means that every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings.

In Leicester, as well as nationally, more and more adults with social care needs are saying they want a greater say and more choice in the way they live their lives. Published in 2007, Putting People First is an agreement between central and local government about the future direction of adult social care. It provides the policy framework for guiding the transformation of adult care services and improving people's experience of local support services.

Over the next two-years we will be transforming adult social care in Leicester so that services are truly centred on what the people who use them want. We will work with people who need help and support to provide a much more personal approach to care.

With the new commissioning framework, the focus to date has been on looking at different commissioner models to see what might work well for us

and to establish what skills we need to deliver an effective commissioning service. Understanding what services people want will be key to developing a strategy for future commissioning activity.

Engagement with stakeholders continues to be essential, if we are to deliver the transformation agenda.

5.5 A Commissioning Framework for Health and Wellbeing (DH 2007)

This established 8 steps to effective commissioning which would link into Sustainable Community Strategy, Local Area Agreement and strategies which would improve Health & Well-Being and reduce health inequalities. These are:

- Putting people at the centre of commissioning
- Understanding the needs of populations and individuals
- Sharing and using information more effectively
- Assuring high quality providers for all services
- Recognising the independence of work, health and wellbeing
- Developing incentives for commissioning for health and wellbeing
- Making it happen: local accountability
- Making it happen: capability and leadership

The idea is for statutory and voluntary organisations to work together to not only meet existing health & welfare needs but also to plan for the future, to look at future housing aspirations and the needs of vulnerable members of the community. Partnership working enables a pro-active approach to meeting and sustaining people's support needs and prevents the duplication of resources and a crisis management approach which can be costly in terms of finances, human respect and dignity.

5.6 Service delivery by Health and Social Care in Partnership.

The national policy on public service and the NHS Constitution encourages joined up working and the delivery of care and support that is coordinated, and delivered through cooperation at an organisational and practitioner level. Partnership working in Leicester has been strengthened by the use of a Section 75 Partnership Agreement between the City and County Councils and the Leicestershire Partnership Trust, the NHS provider, for the integrated provision of mental health services. The development of this Joint Commissioning Plan is essential to ensuring sound partnership working at a commissioning level.

5.7 Social Inclusion

The Government has introduced a requirement for Local Partnerships to ensure that the most socially excluded adults are offered the chance to get back on a path to a more successful life by increasing the number of adults who are in contact with secondary mental health services who are in settled

accommodation and in employment, education or training (Public Service Agreement PSA16). This key public service agreement applies to Health and Social Care and aims to increase the proportion of:

- Socially excluded adults in settled accommodation, employment, education or training.
- Vulnerable people achieving independent living
- Vulnerable people who are supported to maintain independent living

This is because people with mental health problems experience a greater degree of social exclusion than the general population. For example, only 24% of adults with long-term mental health problems are in work. This is measured by Social Care through performance indicators (PI) NI149 and 150. The Future Jobs Fund is a new initiative which will enable people to gain experience of coming into or returning to work, through a fixed term contract. This will enable people to update their skills and experience if they have been out of work for a while, and to receive a current reference. Leicestershire Partnership Trust will be offering 30 such job opportunities.

5.8 Mental Health Payment by Results (PbR)

The implementation of the Mental Health PbR is to create a new approach to fund mental heath care in the NHS based on grouping service users into 21 clusters. It focuses on the characteristics of individual service users, allowing a tailored approach to care. This means that it is in tune with the need for personalised care. Service users will benefit from an informed discussion of their care options and a clear understanding of the support they will receive.

The first stage with mental health is to make national currencies available for use, with prices continuing to be set locally. The aim is to fully implement Mental Health PbR by 2012/13.

6. What sort of services people want

Consultation about the priorities, their current experiences and the type of services they would like in the future took place over August and September 2010.

An online survey was developed including the provision of paper based surveys to gather people's views. Furthermore a series of focus groups took place across the City. The focus groups were held with groups that the organisations often do not engage with. Focus groups were held with the South Asian community, Bengali women's group and the Somalian Community.

Demographic data

Overall there were 240 responses to the survey. 79% of the respondents were mental health service users and 21% were carers.
65% of the respondents were female and 35% were male. The ethnic breakdown of the respondents is as follows:

- Asian/Asian British – 56%
- Black/Black British – 8%
- Chinese – 0%
- Mixed/dual heritage – 1%
- White – 23%
- Other Ethnic Group - 4%
- Non-respondents – 8%

When analysing the ethnicity data it is pleasing that we had such a high percentage response from the Black Minority Ethnic Groups. This is vital in a diverse city like Leicester.

Just fewer than 54% of the respondents considered themselves to have a disability.

Mental Wellbeing

Over 96% of the respondents considered their mental wellbeing to be very important. The respondents considered that the following were **very important** to their wellbeing:

- Physical Health – 86%
- Housing – 86%
- Financial Position – 76%
- Local Environment – 73%
- Employment – 59%

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%
- Friends – 40%
- Psychiatrists – 41%
- Counselling Services – 28%

39% of the respondents indicated that they/friend/family member were an inpatient in a mental health hospital. Only 4% did not access any support for their mental health issue/s.

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 were asked what types of services would have met/would meet their or their family member/friend's needs. The following types of support were highlighted by the respondents:

- Group Support – 64%
- Drop-in services –56 %
- 1:1 Support –49%
- Community based services – 49%
- Peer Groups – 39%
- Support into Education –24 %

42% wanted hospital based services.

Just over 68% felt it was important to be able to choose the services or packages of support would help maintain their mental wellbeing if they were given the money to do so.

7. Local needs

7.0 What We Know – Health & Social Care Needs in Leicester

Mental ill health is the largest single source of burden of disease in the UK. The Layard[1] report suggested that the output lost from sickness resulting from depression, anxiety and stress in Britain is around £4 billion per year. People with mental health problems have the lowest employment rate of any disabled group and mental illness is more prevalent in the most deprived areas. Perinatal Maternal Mental Illness may be harmful for mothers, children and their families; the mental wellbeing of children is likely to have an impact on their present and future health. For older people, a range of mental health issues from depression to dementia are projected to increase. There is a need to develop appropriate mental health care for people from Black and Minority Ethnic (BME) communities. In particular it is necessary to address the over-representation of people from Black/Black British ethnic backgrounds in

[1] Layard, R., 2005. *Mental Health: Britain's Biggest Social Problem?* London, Sainsbury Centre for Mental Health

the take up of services, the under-representation of people from South Asian backgrounds and a need to meet the challenges presented by new population, some of whom have experienced trauma and abuse prior to their arrival. In addition, prisoners and offenders have higher levels of mental illness than the general population.

7.1 Demography

The total population of Leicester city is 350,000 as registered with Leicester City general practices. The number of people aged 16 to 64 registered with Leicester City GPs circa 200,000. Leicester has a demographic profile that is younger than the national picture. It also has an ethnically diverse population which is outlined below in table 1.

Table 1: Population of different ethnic groups in Leicester compared with England (Source: Mid-year population estimate 2007)

Ethnic Group	Leicester	England
White/White British	61.3%	88.2%
Mixed	2.6%	1.7%
Asian/Asian British	29.6%	5.7%
Black/Black British	4.9%	2.8%
Chinese/Other Ethnic Group	1.6%	1.5%

People who experience mental health difficulties also experience significant problems: social isolation; economic disadvantage; stigma and discrimination; social exclusion; significant differences in access to services according to ethnicity, gender and age. Major gaps mentioned by people who use mental health services include access to talking therapies, peer support initiatives, and more holistic models of care.

7.2 Ethnicity

The estimated proportions of people from different ethnic backgrounds shown in the 2007 mid-year estimate above shows how diverse a city is Leicester is.

People from an Asian/Asian British ethnic background comprise the largest BME group. Since the 2001 census, there have been a number of new arrivals in the city, most significantly the Somali community and people from Eastern Europe. Current assessments suggest that the Somali community in the city numbers between 8-10,000 and that there are now between 3–5,000 Polish people and other economic migrants, including people from Slovakia and Portugal living in the city.

There is evidence to suggest that compared to the general population some ethnic minority groups carry a higher burden of poor health, premature death and reduced access to services. Ethnicity is an important issue in mental health because there are variations in underlying morbidity, diagnosis, and management. Equality in the provision of appropriate mental health services is therefore a vital requirement. In addition, nationwide evidence suggests

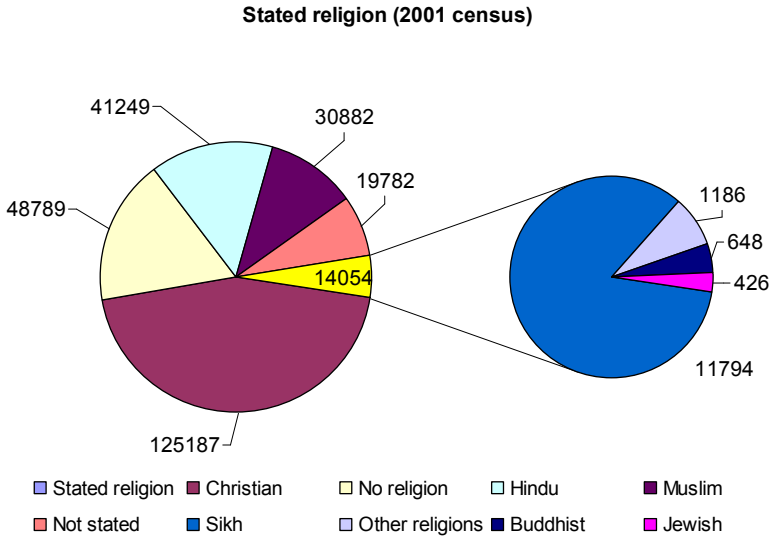
that people from BME communities are particularly dissatisfied with the mental health services they receive, they are over-represented in compulsory detention under the *1983 Mental Health Act*, are overrepresented in incidents of violence, restraint and seclusion in psychiatric inpatient settings, and are under-represented in counselling and psychotherapy, and in involvement in planning and delivering mental health services.

7.3 Culture and religion

This diversity extends to religion. Religion is an important factor in mental health service planning as traditionally religious institutions have played an important role in mental health and the different religions have different perspective on mental health.

Past analyses of the *Count Me In* census of inpatients in mental health institutions show that more people on mental health wards in Leicester state their religion than the national average. This is perhaps indicative of the importance of religion to the people of Leicester. The chart below identifies the main religions practised in local communities.

Figure 2: Stated religion according to the 2001 census



7.4 Mental Health in Leicester

Demand for services

Calculating the prevalence of mental health problems is not an exact science. There is no evidence to suggest any change in the prevalence of serious and enduring metal illness though the numbers of people with mental health problems is expected to rise in line with population growth.

7.5 Risk factors for mental health problems

Measures of deprivation and disadvantage, such as unemployment, overcrowding, few educational qualifications and those who are lone parents with dependent children have been shown to have a detrimental impact on mental health. On such measures Leicester has a rate which is higher than the national average[2]. Leicester scores highly on factors such as employment, poor educational levels and overcrowding. Compared to the national picture, more people in Leicester report that their health is poor or they have limiting long-term illnesses, and a higher proportion of working-age adults live alone.

The relationship between unemployment and mental ill health is a complex one because an individual suffering the onset of mental illness is more likely to leave employment compared with other health conditions. Indeed, as a group those who suffer mental ill health have the lowest proportion of employment of any group with a disability. The number of adults receiving Incapacity Benefit/Severe Disablement Allowance (IB/SDA) because of mental or behavioural disorders may be an indicator of the extent of severe or disabling mental health problems amongst working-age adults. In February 2008, there were 15,820 people aged 18-64 years claiming IB/SDA in Leicester, of these it is estimated that around 6,000 people claiming IB/SDA on the basis of mental ill health or a behavioural disorder.

There is a possibility that mental health problems are increasing in local communities. The percentage of Incapacity Benefit claims in the East Midlands on the basis of 'mental or behavioural disorders' rose from 27% in February 2000 to 38% in February 2008. If replicated in Leicester, this would suggest that the numbers of people claiming Incapacity Benefit on the grounds of 'mental or behavioural disorder' would have risen from 3423 in the year 2000 to 5459 in 2008; a rise of almost 60%. Economic recession would compound this problem raising the likelihood of an even greater increase in the burden of mental ill health in the next few years.

Poor quality of life resulting from physical illness is also closely related to mental health problems. People with mental health problems are twice as likely to report a long term illness or disability, and over two thirds of people with a persistent mental health problem also have a long term physical illness. Physical illness of those with severe and enduring mental health problems often go undetected, contributing to increased morbidity and lower life expectancy.

7.6 Common mental health problems

Mental health problems are common and disabling. The spectrum of mental ill health ranges from problems of depression and anxiety with a prevalence of

[2] Sainsbury Centre for Mental Health, 2003. Leicester had an average score on the York Psychiatric Index of 138. This score was higher than average (100) and indicated a high level of mental health need.

about 14% to less common psychotic disorders such as schizophrenia with a prevalence of less than 0.5%. The table below shows the estimated prevalence of common mental health problems in Leicester City

Table 2: Prevalence of common mental health disorders

	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

- *Source Mental Health Observatory, Durham University 2006 all adults16 - 64 population 199932

7.7 Maternal Mental Health

Evidence suggests that between 3% and 5% of women who have recently delivered will suffer with moderate to severe depressive illness. As there are around 5,000 births in Leicester annually this would suggest that between 150 and 250 women are likely to have a major depressive illness in the area.

Further studies have revealed an incidence of admission to hospital for puerperal (affective) psychosis of 2 per 1000 women delivered. About 2 per 1000 women delivered are admitted to hospital suffering from non-psychotic conditions and clinical experience suggests that about 2 per 1000 women delivered will be suffering from severe, chronic or enduring mental illness, predominately schizophrenia. Women who have experienced an episode of perinatal mental illness will have an increased risk of reoccurrence with subsequent pregnancies.

A study of the experience of motherhood of female service users of Leicester rehabilitation services concluded that many women in long-term psychiatric care experienced multiple loss of contact with their children with 68 % permanently separated from at least one child before the age of 18 years. (Dipple, Smith, Andrews, Evans Social psychiatry and psychiatric epidemiology 2002)

The impetus of change in the care of women with perinatal maternal illness is the NICE Guidelines on the management and service guidance for antenatal and postnatal mental health (NICE 2007) and the Confidential Enquiry into maternal and child deaths. A regional steering group is looking at the way in which perinatal mental health services will be commissioned in the future.

7.8 The mental health of prisoners and offenders

Psychiatric morbidity among prisoners indicates that approximately 90% of prisoners have a psychotic, neurotic or personality disorder or suffer with a substance misuse problem which has an effect on their mental health. As a category B local prison for male prisoners, HMP Leicester has a large throughput of prisoners, including those on remand, making mental health services for offenders a major challenge.

A recent review of prisoners in HMP Leicester showed that 343 out of 368 prisoners had been prescribed medication for mental illness. This equates to 93.2% of the prison population. In another study 60.6% of the prison population had a mental health problem which required referral to mental health services.

A survey of prolific and priority offenders in Leicestershire showed that about 50% were currently or previously known by the local mental health services. The greater the risk the offenders posed, the more likely they were to require mental health services.

There is a need for a joint approach to resolve the management of offenders with mental ill health needs. Achieving better outcomes for offenders will require joint initiatives between NHS Leicester City, Leicester City Council, HMP Leicester and the Leicestershire and Rutland Probation services and other stakeholders.

7.9 Mental health of older people

Provision of mental health care for the elderly is an urgent problem. Between 10% and 16% of people over the age of 65 will develop clinical depression, whilst 25% of people over 85 suffer with dementia. Such problems exert a large socio-economic cost, with treatments for Alzheimer's disease likely to exceed the costs of treating illnesses such as heart disease and cancer.

There are approximately 37000 people over the age of 65 living Leicester. By 2025 this population is projected to exceed 45,000 people, with 22,000 over 75 years of age. Average life expectancy is longer for women, and women comprise the majority of the current and projected elderly population, although the number of male elderly will increase as life expectancy for men improves. As the population of older people increases so it will be important to maintain a sense of wellbeing and quality of life, with social interaction, motivation and self-confidence being important in sustaining a person's mental health.

The National Dementia Strategy (2009) identified a number of key objectives across a whole –system designed to improve the quality of care people with dementia and their carers receive, increase independence and delay the need for institutional forms of care and enable people to '*live well with dementia'* at all stages of their pathway. The strategy emphasised the importance of early diagnosis, information and support, improved community

and housing-related support as well as better care for people in institutional settings.

The prevalence of dementia is expected to increase both nationally and locally due to an ageing population and better diagnosis. The Leicester City dementia profile 2009 states that there were estimated to be 2579 people with dementia, projected to rise to 3272 in 2025. In order to meet the challenges of the increased prevalence of dementia, taking into consideration the current economic climate, we are clear that we must look to deliver services differently to ensure we deliver high quality care for people with dementia. The report ***Dementia UK*** projected that by 2016 there will be 3023 people suffering from dementia. This will increase to 3462 by 2025. The local Dementia Strategy outlines in detail how the priorities outlined above will be addressed and implemented in Leicester.

The diversity of Leicester is also reflected in the elderly population of the city. At the time of the 2001 Census 8,282 people (21.9%) over the age of 65 were from a minority ethnic background. Of these 5245 were between the ages of 65 and 74, 2,456 were between 75 and 84 and those who were aged over 85 numbered 581. It remains a challenge to ensure that mental health services for older people from minority ethnic groups are accessible and appropriate.

The mental health of older people may be affected by issues such as income and housing. Older people require access to an adequate income and appropriate independent housing that meets their needs for as long as possible. In order to ensure that this is done effectively the agenda for Local Authority includes the transformation of adult social care to a personalised system.

The report Dementia UK projected that by 2016 there will be 3023 people suffering from dementia. This will increase to 3462 by 2025. The local Dementia Strategy outlines in detail how the priorities outlined above will be addressed and implemented in Leicester.

7.10 Eating Disorders

Eating disorders including anorexia nervosa and bulimia nervosa and related conditions generally have an onset in childhood and adolescence. However they can have an onset in working age adults. They include a variety of types of disordered eating and range in severity.

Overall 6.4% of adults screened positive for and eating disorder. 9.2% of women were more likely to than men (3.5%) to screen positive for an eating disorder. The prevalence decreases with age and the pattern was particularly pronounced for women.

Eating Disorders has been flagged as a priority at an East Midlands regional level and a steering group is existence to deliver service redesign and improvements at a regional level. This will feed into local delivery of services.

7.11 Autism including Aspergers

Towards fulfilling and rewarding lives: a strategy for adults with autism in England sets a direction for long-term change to realise our vision but also identifies specific areas for action over the next three years. These are:

- increasing awareness and understanding of autism among frontline professionals
- developing a clear, consistent pathway for diagnosis in every area, which is followed by the offer of a personalised needs assessment
- improving access for adults with autism to the services and support they need to live independently within the community
- helping adults with autism into work, and
- enabling local partners to plan and develop appropriate services for adults with autism to meet identified needs and priorities.

The approach taken in the strategy is to make existing policies work better for adults with autism. This approach reflects the fact that there is already a wealth of government policy and initiatives that should support adults with autism. Therefore the emphasis of the strategy is to avoid placing additional statutory requirements or financial burdens on frontline staff delivering public services, on businesses or on local planners.

Leicester has a joint strategy for adults with Asperger syndrome, in partnership with Leicestershire and Rutland and the respective Primary Care Trusts, NHS Leicester and NHS Leicestershire County and Rutland.

The Strategy focuses on adults; however the transition from children's services into adult services is considered a critical and integral element of the Strategy. It is a three year Strategy with a delivery action plan, however it is recognised that change will be a long-term process. The Strategy incorporates some of the requirements of the National Autism Strategy "Fulfilling and rewarding lives" (2010) and covers areas which will be the subject of statutory guidance in line with the Autism Act (2009). Further work is required locally, however, to address all requirements resulting from the National Strategy and the Autism Act; this Strategy lays the foundation for this work.

Each Local Authority in partnership with the NHS will be responsible for delivering the Strategy. The delivery plan identifies key partnerships and programmes of work that are common to all and includes suggested time frames.

7.12 Delivering Race Equality

At the time of the 2001 Census 34% of the population of Leicester came from a black minority ethnic (BME) background. There is evidence to suggest that compared to the general population some ethnic minority groups carry a higher burden of poorer health. Ethnicity is an important issue in mental health because of underlying morbidity, diagnosis and management. Equality in the provision of appropriate mental health services is therefore a vital requirement.

Delivering race equality in mental health care is a national and local priority which is aimed at achieving equality and tackling discrimination in mental health services in England. Nationwide evidence suggests that people from BME communities are over-represented in compulsory detention under the Mental Health Act. People from BME backgrounds are under-represented in counselling and psychotherapy including involvement in planning and delivery of mental health services.

Since 2001 Leicester City has also seen the arrival of new communities such as Somali (current numbers 8-10,000) and people from Eastern Europe (current numbers 3-5000). In the review of Count me In Census on inpatients at Leicestershire Partnership Trust) 2006 identified that there were a high proportions of Polish and Somali speakers having inpatient mental health care. These particular groups may suffer with a deficit in relation to those factors which are protective against mental illness such as accommodation, social isolation, poverty etc. For those people seeking refuge in the UK issues of mental health and wellbeing maybe additionally affected by post traumatic stress and abuse.

Given these issues we intend to through this strategy ensure that there is timely access to mental health services for people from BME communities and that these services are appropriate and responsive. There will be continued engagement with people from BME communities and we will look at different ways in which organisations including the voluntary sector can have a real impact on improving mental health for people from BME communities.

8. Performance and Quality of Current Services

The Audit Commission were commissioned by NHS Leicester City (NHSLC) to undertake a benchmarking audit of the local mental health service delivered by LPT. This Audit was undertaken for NHS LC and NHS Leicestershire County & Rutland (NHSLCR).

The Data sources used to undertake the benchmarking were:

- Programme Budgets
- Hospital Episode Statistics (HES)
- Mental Health Minimum Data Set (MH MDS)
- World Class Commissioning Indicators

A workshop was held in April 2010 where there was further discussion regarding the initial findings and graphs.

The main conclusions the audit commission came up with were as follows:

- There are some data quality issues in some of the datasets which raise a number of questions that need to be discussed further
- The report contains some more detailed follow up analysis which needs to be shared more widely within the PCT
- As the lead commissioner NHS LC needs to investigate the questions raised about the mental health services delivered to the population of both Leicester City and Leicestershire County and Rutland.

Spend

NHS Leicester has a slightly above spend on secondary mental health when Primary Care Trust spend was benchmarked against the National Programme Budgeting data. Conversely the total primary care spend for mental health is below the national average.

The World class commissioning data set includes an indicator showing the proportion of adult mental health spend committed on out of area placements. According to this data NHS LC appears to have a higher than national average proportion of spending. However there does appear to be some data quality issues with this data as some Primary Care Trusts appear to have all their spending on out of area placements. Furthermore the East Midlands Strategic Health Authority data suggests that across the East Midlands region the out of area placements spend for Leicester City is below average.

Prevalence Data

The prevalence data shows that between the City and the County there are significantly differing levels of severe mental illness with Leicester City being in the highest quarter nationally.

The prevalence rates for dementia are less extreme. However both Primary Care Trusts in Leicestershire have recorded a slight increase in dementia between 2007/08 and 2008/09.

Inpatient Activity

According to the benchmarking data NHS LC has higher than average working age adult mental health admissions compared to Primary Care Trusts nationally. NHS LC appears to have just above the median number of occupied bed days. This is particularly low when compared to the need.

For Older Adults admissions does not follow the pattern for dementia prevalence. However this may not be the only condition that requires admission for older adults in mental health. The City has a particularly higher rate of admission compared to the County.

NHS Leicester City is at a lower comparative level for bed days than for admissions. This maybe because there are a high number of short stay admissions.

This could be interpreted in 2 ways either that the service is stabilising and discharging patients straight into the community or that there are a high number of admissions because of a lack of service alternatives for people in crisis in the community.

The average length of stay was analysed using the Mental Health Minimum Dataset (MHMDS 2008/09). The data showed that NHS LC has just under 20% of working age adults admitted for 91 days or more. The Proportion for NHS LCR is 10%.

When this is compared nationally it shows that the above numbers relate to median and lower quartile position relative to the population size.

Access to Services

The MHMDS also records patient contacts for a number of groups of staff. Analysis of this data showed that for both of the PCTs there is a high level of contacts with consultant psychiatrists for adults and older people. Although the data shows high access rates to consultants, it appears that patients are not subject to excessive numbers of follow up appointments.

However CPN contacts per thousand population for adults and older people are below the national average. In addition to this the East Midlands Mapping data identified that Leicester Community Mental Health Teams (CMHT) are the most costly in the East Midlands.

Performance

The following Care Quality Commission target is a key performance measure within mental health:

- Number of separate episodes of home treatment completed by crisis resolution team

In addition the following vital sign is still currently monitored:

- Suicide and injury of undetermined intent and mortality rate

Also included in the regular review of the performance of mental health services is the following key performance areas that form the performance dashboard against

which the main provider of mental health services for Leicester is performance managed against:

- Percentage of people on New Care Programme Approach (CPA) receiving follow up within 7 days of discharge
- Rate of delayed transfers of care per 100,000 population
- Number of people with newly diagnosed cases of 1st episode psychosis receiving early intervention in psychosis
- Number of patients on assertive outreach caseload
- Percentage of patients coded with ethnicity category

Full details of these indicators can be found in the appendix.

As part of an ongoing process there is also a data quality improvement plan in place to support with the future commissioning of services and also to support the implementation of Mental Health Payment by Results.

Adult Social Care Performance

The National Indicators and PAF indicators that are most relevant to Mental Health services are (benchmarked Leicester performance in brackets based on provisional NIS 09/10):

- NI 149 Adults in contact with secondary mental health services in settled accommodation (average, ranked 10/18 – slightly above average for comparator group and just below England average)
- NI 150 Adults in contact with secondary mental health services in employment (poor – ranked 13/18 and well below both comparator group and England averages)
- PAF C31 Adults with MH problems helped to live at home

A sample of the universal indicators for all adults that are set out below – however, without the data being disaggregated to client group there needs to be caution in applying the benchmarked findings against MH services:

- NI 135 Carers receiving a needs assessment or review and a specific carers service, or information & advice (above average)
- NI 136 People supported to live independently through social services (just below average comparator group and well below England average)
- NI 132 & NI 136 (timeliness of social care assessments and provision of social care packages (both poor ranking 17/18 and 16/18, below comparator and England averages)

Leicester places more people with mental health problems in residential and nursing care than comparators, part of which includes the legacy of people on “preserved rights” from prior to the Community Care Act 1993. The Mental Health Opportunity Assessment shows that residential and nursing placements have remained fairly

constant at just over 200 people over the last 4 years whilst there has been a 37% decrease in community based services during the same period.

This makes Leicester at 4.9 per '000 (aged 18-64) the highest user of residential care in its comparator group. Leicester however also is one of the highest providers of home care to adults of working age with mental health difficulties.

Leicester spends significantly more than other local authorities (highest nationally and second highest in comparator group) on residential/nursing care, and less on community support.

Quality

In addition to performance the quality of the services are also measured and monitored regularly. The following key indicators of quality form part of the Quality Schedule that is used to monitor the quality of services:

- Infection Prevention and Control
- Patient Safety
- Privacy and dignity in Care
- Safeguarding children and adults
- Compliance with CQC full registration requirements
- Demonstration of implementation of best practice
- Compliance with NICE Guidelines
- Full compliance with delivering the Race Equality Agenda

Commissioning for Quality and Innovation (CQUIN)

Commissioning for Quality and Innovation (CQUIN) is a payment framework which makes a proportion of the provider's income conditional on quality and innovation. These are used to drive and further improve quality within certain areas that are identified as key areas of need for improvement locally and regionally. This is done through providing a financial incentive to the provider which they receive once they have achieved the identified key improvements.

With our main provider the following CQUIN have been identified. Some of these are regionally identified and some have been locally identified.

- Percentage of patients (18>) with a delayed transfer of care - Non Acute
- Percentage of people on CPA who have had a HONOS assessment within 12 months
- Mean length of Stay for MH inpatients
- Percentage of adults receiving secondary mental health services in paid employment at the time of their most recent formal review or other multidisciplinary meeting care planned meeting
- Percentage of adults receiving secondary mental health services in settled accommodation at the time of their most recent formal review or other multidisciplinary meeting care planned meeting

9. Current Resources

a) Financial Analysis

The total budget spent on adult mental health services during 2009/10 was spilt as follows:

- NHS Leicester City spent a total of **£45 million** on adult mental health services. The breakdown is outlined in the table below:

- Leicester City Council spent a total of **£9.7m**.

Health Spend
Mental Health Spend 09/10

Spend on NHS Provider	Spend on Voluntary Sector	Spend on Other e.g. LA	Total Spend
£44,115,476	£632,000	£451,800	£45,199,276

Mental Health Budget for 2010/11

Budget for NHS Provider	Budget for Voluntary Sector	Budget for Other e.g. LA	Total Budget
£42,377,322	£642,000	£453,000	£43,472,322

Due to the major changes as per the White Paper (DH 2010) to the way health services will be commissioned in the future, subsequent financial plans from 2011 onwards are yet to be determined.

Adult Social Care Spend

The Adult Mental Health Opportunities Assessment identifies that Leicester City spends more than comparators on adult social care services overall, a high proportion of which is spent on residential care.

As shown in table 1 below, of the £9.7m adult social care budget, 24% was spent on assessment & care management and 49% on residential & nursing care.

Of the £3.8m spent on in-house services, 60% was spent on assessment & care management, 22% on day services and 1% respectively on residential care and supported accommodation. Of the £6m spent on independent sector provision, 80% of this is spent on purchasing residential care compared to 3% on purchasing supported accommodation packages.

Table 1: City Council spend on Adults with Mental Health Needs

The data is gross spend and direct cost of the service. Therefore, it excludes overheads and capital charges.

Service Type	In-House £'000	Independent £'000	Total £'000
Assessment and Care Management	2,290.5	0	2,290.5
Direct Payments	-	200.1	200.1
Supported & Other Accommodation	46.5	157.2	203.7
Home Care	129.8	300.6	430.4
Day Care & Services	829.2	96.1	925.3
Residential and Nursing	34.8	4,722.6	4,757.4
Meals	30.8	8.6	39.4
Other Services	448.5	434.0	882.5
Total - Direct Gross Spend	**3,810.1**	**5,919.2**	**9,729.3**

Leicester spends an above average £58.07 per head on support for adults aged 18-64 with mental health difficulties, this representing 10% of its ASC budget compared to 7% England average. Spending has increased by 22% over the past 5 years, the second highest rate of increase after learning disability spend. However, the spend per head on residential/nursing care is a very high £32 per head. This is £15 per head higher than comparator authorities and £24 per head higher than average. Reducing placements to meet these averages would reduce spend on residential/nursing care by between £1.4m and £2m.

The Opportunities Assessment shows that Leicester now spends 55% of its total budget on residential care, compared to the median average of 30%. Spending on residential care increased by 31% over the past 5 years with a 34% increase in community spend.

The majority of ASC unit costs in Leicester are higher than other unitary councils. With high day care costs and lower than average residential care and home care unit costs.

This needs to be considered within the local context with the money available to spend on mental health services reducing significantly in future years – in addition to the economic position and potential additional efficiencies of 30%-40% needing to be identified, the impact of personal budgets and the new Resource Allocation System (RAS) may also result in a reduction in funding that is available for both existing and new individual packages of support.

b) Market Analysis;

The majority of Adult Social Care Services are commissioned from the independent and voluntary sector, with over 60% of the budget in 2009/10 being spent on services provided externally to the council. The over-reliance on residential care is reflected in the market share, with independent sector residential providers dominating the local market. There are a small number of providers of community services, providing packages to people in supported living tenancies, which are mostly in the form of supported housing schemes that are buildings based on licenses rather than secure tenancies.

There is a lack of market capacity generally for all levels of community support. Based on a continuum, supported living needs to include a full range of options from low level floating support to more intensive specialist outreach support. Currently there are few low level support options, and specialist outreach services are undeveloped. An undeveloped market limits the supply of housing options and choice for service users as well as increasing spending through the over provision in residential care. The under use of support related housing is limiting the range of efficient and cost effective service solutions available.

There is a significant under use of telecare which is further limiting the range of service solutions that are available i.e. efficiency opportunities are being missed.

Most day services are provided by the voluntary sector. Day service provision provided by the local authority has been modernised and operates as a Social Inclusion Team. Though there are supported employment services, these are limited.

Internal working procedures and processes are also impacting on the market, reinforcing the current market share and depressing market development by the lack of demand for new types of services.

The Opportunities Assessment case file analysis identified a risk averse culture that is leading to over provision, which then fails to stimulate the market to offer low level support options. A lack of planning with service users, carers and providers may lead to the inappropriate continuation of placements often with long term financial commitment. Interim placements in residential care due to crises drift and become long term causing institutionalisation and incurring longer-term costs. Premature placements of people with minimum support needs into residential care may lead to long-term institutionalisation and incur longer-term costs. A lack of goal setting and evaluation leads to low through put with some people getting stuck in 'the system' and resources remaining static. This is leading to over supply and over provision. This quickly becomes a vicious circle – risk averse practice results in higher cost and traditional provision, and the lack of market capacity and availability of alternative options results in further over-dependence on traditional models and high cost provision. Inadequate support to carers sometimes leads to family breakdown and crises that are resulting in more expensive care needs.

c) Workforce Analysis

There is no overarching workforce plan for mental health services and no co-ordinated approach to mapping the existing workforce across all services. Work needs to be undertaken to identify recruitment, retention and workforce issues and pull together intelligence from providers. There is currently no data on the total number of people working in mental health services within Leicester City, the skill mix, or demographic profile of the workforce. Each agency currently arranges its own training and staff development programme.

Apart from a limited inter agency training programme co- delivered with people with experience of mental health problems that includes Good Practice In Mental Health, Person Centred Planning, Values Based Practice, Aspergers Awareness and Strategies, and Mental Health awareness.

10. The future model for MH services

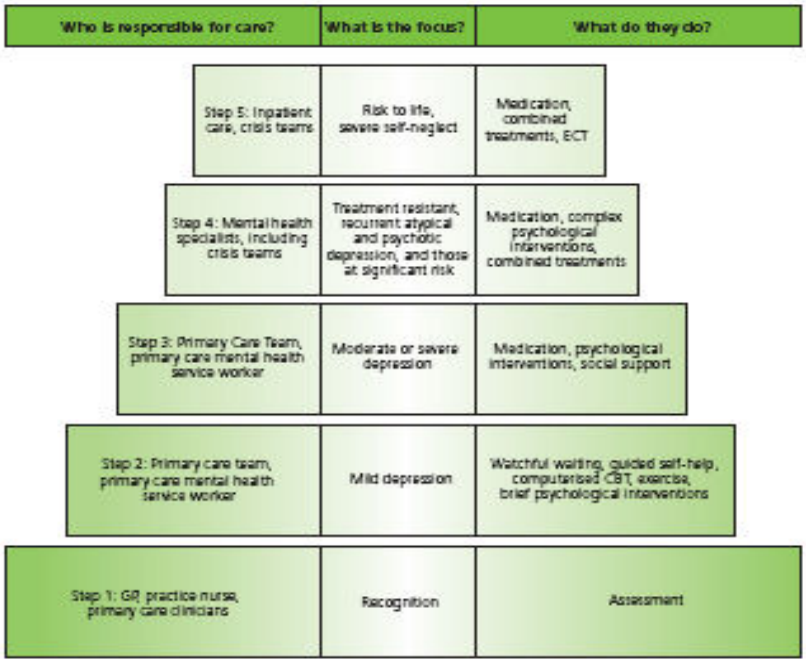
The broad approach to the delivery of mental health services is based on the Recovery Model, underpinned by the development of personalised services based on self directed care, including self assessment and supported self assessments, personal budgets and personalised services. This needs to be aligned to CPA, and incorporate the stepped care approach and use of care pathways. This document does not describe the CPA model, as this is well established practice within mental health services, or the assessment and care management process in detail as this is set out in other documents outlining the new customer journey for all service users receiving adult social care services.

Furthermore, the model needs to align with Prevention and Early Intervention Strategy and be based on the DH framework with 5 key elements of intervention:

- Promoting health & wellbeing
- Maximising independence and functionality
- Delaying or reversing deterioration
- Reducing risk of crisis or harm
- Providing care & support closer to home

This aligns well with the Mental Health Stepped Care Approach and the care pathway approach, which is recognised best practice as a means of determining locally agreed multi-disciplinary practices based on guidelines and evidence for a specific service user group or need. An agreed sequence of procedures ensures better management of clinical processes and outcomes for service users & patients. Good care pathways ensure a high quality patient/service user experience, improves team working across providers, avoids duplications and ensures improved continuity of care**.**

This is set out in the example below on the NICE guidance on the Stepped Care Approach to the Management of Depression:



In mental health, ‘recovery‘ has a range of meanings and does not always refer to the process of complete recovery from a mental health problem in the way that we may recover from a physical health problem.

For many people, the concept of recovery is about staying in control of their life despite experiencing a mental health problem. Professionals in the mental health sector often refer to the ‘recovery model’ to describe this way of thinking.

Putting recovery into action means focusing care on supporting recovery and building the resilience of people with mental health problems, not just on managing their symptoms.

There is no single definition of the concept of recovery for people with mental health problems, but the key idea is one of hope that it is possible for meaningful life to be restored, despite serious mental illness. Recovery is often referred to as a process, outlook, vision, conceptual framework or guiding principle.

The recovery process:

- provides a holistic view of mental illness that focuses on the person, not just their symptoms

- believes recovery from severe mental illness is possible
- is a journey rather than a destination
- does not necessarily mean getting back to where you were before
- happens in 'fits and starts' and, like life, has many ups and downs
- calls for optimism and commitment from all concerned
- is profoundly influenced by people's expectations and attitudes
- requires a well organised system of support from family, friends or professionals
- requires services to embrace new and innovative ways of working

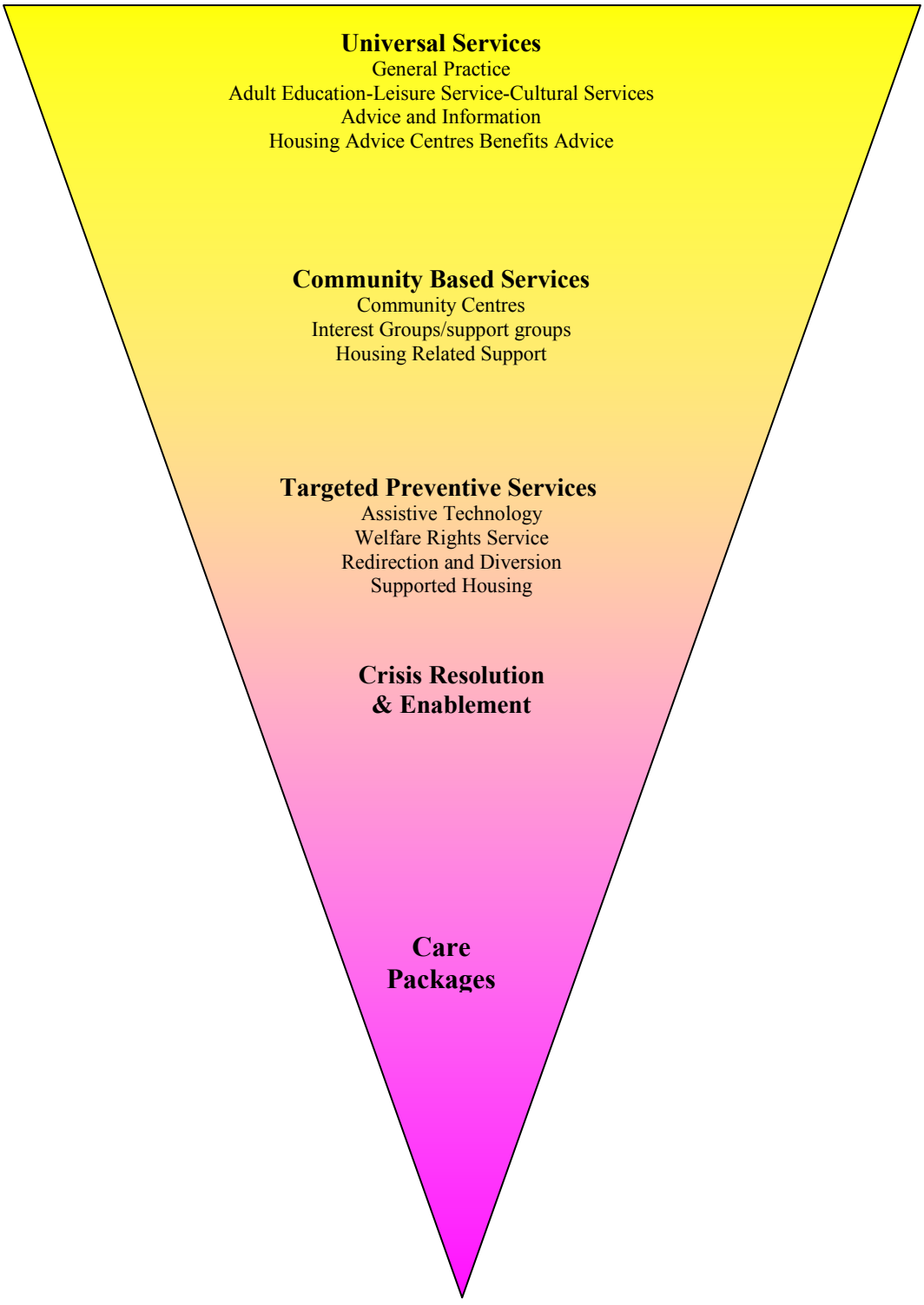
The recovery model aims to help people with mental health problems to move beyond mere survival and existence, encouraging them to move forward and carry out activities and develop relationships that give their lives meaning.

Recovery emphasises that while people may not have full control over their symptoms, they can have full control over their lives. Recovery is not about 'getting rid' of problems. It is about seeing people beyond their problems, recognising and fostering the opportunities that harness their abilities, interests and dreams. Mental illness and social attitudes to mental illness often impose limits on people experiencing ill health. Recovery looks beyond these limits to help people achieve their own goals and aspirations.

In line with government policy, adult social care services provided to people who meet the Fair Access to Services criteria will be limited more effectively to those people who cannot be supported through universal services and targeted community services. The support and assistance available to people must first and foremost keep them safe from abuse irrespective of where they live, will involve people in decision making, and will promote choice based on clear and timely information. Services will focus on retaining and regaining people's place in the community, avoiding wherever possible institutional forms of care and based on the least intrusive options available. This will require adult social care services, other council services and health services to be integrated and co-ordinated.

This approach is illustrated in the inverted triangle below which highlights the types of interventions needed to achieve key outcomes against each level.

The aim is to ensure that all people with mental health difficulties can access the full range of public services that are available to all. Some people will also need to access targeted community and preventative services that are available without an assessment, and could also be purchased using personal budgets. For those people requiring a needs based assessment, the first tier is to access crisis resolution, enablement and assertive outreach services with a focus on trigger points within the customer journey for those with higher levels and complexity of needs accessing care managed specialist services – which can also be purchased using personal budgets.



Services need to move from:	**To**:
High cost residential care	Specialist supported housing Intensive supported living packages Limited specialist residential/nursing

	care Improved health outreach and step down services Intermediate care
Medium cost residential care	Sheltered housing Supported living opportunities Health outreach services Intermediate care
Low cost residential care	Sheltered housing Supported living opportunities Increased support for carers and families Reablement & intermediate care
Buildings based respite care beds provided by NHS and independent sector	Jointly commissioned short breaks services including some independent sector bed provision, holiday breaks, and home based support
Home care services	Reablement, enablement & intermediate care Community support packages
Day Care	Enablement Community support services Low level preventative services Supported employment

The new model of providing adult social care services will be aligned to the new operating model and customer journey – that is, direct access to preventative and low level services, use of personalised budgets determined by the Resource Allocation System (RAS) and the purchase of social care services from a range of independent and voluntary sector providers rather than the local authority or NHS. When care packages are developed the opportunity to utilize universal provision will be maximised and the approach is predicated on the assumption that barriers to

inclusion will come down. Health services will need to be remodelled to reduce the need for hospital admission.

11. Commissioning Priorities 2010-2013

Based on the analysis of needs and consultation with service users on priorities, these have been identified as:

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 - The National Dementia Strategy (2009) identified a number of key objectives across a whole –system designed to improve the quality of care people with dementia and their carers receive, increase independence and delay the need for institutional forms of care and enable people to '*live well with dementia'* at all stages of their pathway. The strategy emphasised the importance of early diagnosis, information and support, improved community and housing-related support as well as better care for people in institutional settings.

The prevalence of dementia is expected to increase both nationally and locally due to an ageing population and better diagnosis. The Leicester City dementia profile 2009 states that there were estimated to be 2579 people with dementia, projected to rise to 3272 in 2025. In order to meet the challenges of the increased prevalence of dementia, taking into consideration the current economic climate, we are clear that we must look to deliver services differently to ensure we deliver high quality care for people with dementia.

Our priority is to develop an integrated dementia care pathway, covering the spectrum of need for people with dementia from early diagnosis and intervention to end of life care. The development of this pathway will take into consideration local needs, data on existing service provision, evidence from best practice models in dementia care and the outcomes of a series of workshops involving service providers, patients and carers to look at improvements in the dementia pathway.

We are working with our strategic partners across Leicester, Leicestershire and Rutland to progress this work and deliver an integrated dementia care pathway which includes GPs, primary and secondary health staff, social care staff and voluntary sector staff. We will continue to engage with patients and carers throughout this development to ensure that the services developed will meet their needs.

The commissioning plan for dementia is being developed separately and the Commissioning Implementation Plan addresses the priority areas of prevention & early intervention and transforming social care.

The **Commissioning Implementation Plan** focuses on 6 key work streams within the commissioning strategy:

- The development of **psychological therapies** to improve access and provide earlier intervention and support
- The redesign of **crisis intervention services** to support people at home during crisis, maintain independence and reduce unnecessary hospital admissions
- The development of an **enablement service** for all existing residents moving out of residential care and all new service users referred to mental health services
- Development of the **supported living model** for both new service users and to move on those already living in residential care
- The redesign of the **residential care model** for adults of working age, based on a premise that no-one is placed permanently within a residential establishment
- The remodelling of **community support** services to move away from existing in-house provision (Social Inclusion team) and low level "home care" to RAS funded packages and increased targeted community services provided by the voluntary sector.

Psychological Therapies

Partnership working will be strengthened and IAPT rolled out across the city and so better manage demand. Actions will include

- moving from a block contract to activity based contracts based on completed treatments
- a full service evaluation by February 2011 – if the service is not delvering the desired outcomes, it will be re-tendered
- Psychological therapies level 4 and 5 will be incorporated into the IAPT stepped care model.

Crisis Resolution

The future model for crisis intervention will be redesigned to include a better interface with social care and better cross working between all LPT services (crisis resolution, assertive outreach, PIER, acute recovery). Actions will include:

- Identifying and addressing barriers
- Developing a broader interface with community services
- Identifying model of best practice
- Developing a new care pathway that integrates health and social care
- A revised service specification

Enablement Services:

A MH enablement service will work with all service users prior to and/or as part of any assessment. This has already been trialled within MH services until end August, when the funding for the MH OT post delivering the services was withdrawn. People moving out of residential care will also receive enablement pre and post move. Enablement will be delivered within their own home or new supported living arrangement post discharge from residential care or hospital supported by step down facilities where appropriate. Enablement will consist therefore of 2 elements:

- In reach enablement service from MH OT/other support staff (not part of costed care package)
- Intensive care package from community provider for first 6 weeks (average) focussing on developing daily living skills and coping mechanisms

In addition some people moving out of residential care may receive an outreach service with residential staff working alongside community staff during the transition period.

Residential Care:

The model for residential care for people with mental health difficulties will be redesigned and based on an enablement model. The commissioning plan includes a Moving On Programme which aims to move a minimum of 50% of existing residents out of residential care over the next 3 years, and through the development of Supported Living options, reduces the number of future residential placements. However, it needs to be assumed that most, if not all, of existing residents of working age will eventually move on, to live in their own homes. Though residential placement will reduce significantly in future years, an approach will be adopted that assumes that any new residents will not be placed “for life” but would actively work towards moving on. The action plan will therefore include:

- Development of a new pathway for residential/nursing care
- A new service spec and contract
- Working with residential providers to change working practices and retrain residential care staff
- Encouraging providers to diversify and offer outreach services
- The provision of in-reach therapeutic support from a MH enablement team

People Moving On would therefore receive an enablement service pre-move whilst still in residential care, followed by a period of enablement following discharge to their own home. This would be critical to success as a significant number of

residents have been living in residential care for long periods (c16 years) and need to develop daily living skills and confidence.

Supported Living:

The future model for supported living will be further developed to include a wider range of types of accommodation and levels of support as current provision of supported living services tend to be based on the more expensive models. This will include:

- Pathways for both accessing housing and accessing community support packages
- Development of new service specifications
- A broader range and type of accommodation based predominantly on individual tenancies/home ownership with possibly some limited buildings based "supported housing" schemes of a "sheltered" nature.
- A wider range of levels of support including floating support/low level support to more intensive outreach services (health & social care), both of which are gaps in current provision.

The model would be based on a low level/low cost core support service (floating support) and a RAS based package based on individual need to cover additional community support if required.

Community Support Services:

The future model for community support will be based on a mixture of 2 elements:

- Low level flexible support from the voluntary sector providing links to access universal services, self help support and supported employment.
- Personal budgets being used for a range of community support services linked to moving on to employment, provided externally to the council

12. Resource Implications

a) Financial Implications

The commissioning plan will result in a shift from investment in residential care and high cost placements to targeting resources on the provision of enablement and an increased range of community support/supported living services filling the current gap of a lack of low level support services. Planned redesign of adult social care services between 2011 and 2014 will include the following key changes which will be planned into a three year programme.
Restructuring of services to reduce the number of residential care placements and increase the range of supported living options will impact on budgets and activity by reducing residential placements by 50% over the next 3 years.

This will require short term investment for a "Moving On" team to work with people currently in residential placements who wish to move into supported living options.

Investment into the commissioning of new floating support services will provide lower level support options within the community, reduce current over-provision and target resources more effectively to maintain independence.

The impact of personalisation will include:

- Increased community opportunities from voluntary sector
- Increased access to and use of assistive technology to promote independence and security
- Development of enablement and reablement approaches, which maximise independence and self reliance

To summarise, resources will need to be invested in enablement and support services such as floating support, to enable people to retain their independence and avoid unnecessary admissions to residential care. This will also require some short term investment in a "Moving On" project to provide opportunities for people to move out of residential care over the next 3 years. However, the cost of the investment will be offset by significant savings through the reduction in the reliance on residential care and high cost supported living. Care Packages will be funded though personal budgets in line with the Resource Allocation System (RAS) which will provide a much fairer resource allocation process for all adults receiving social care services. The overall funding allocation for mental health services will be determined through the council's budget strategy, which in itself will be determined by the October spending review and public sector efficiencies.

Table 1: current pattern of spend on adult social care services:

MENTAL HEALTH	AS IS	14 SEPTEMBER		
		No Client Nos	Average net unit cost £ per week	Net Cost £'000s
ACCOMMODATION BASED SERVICES				
Long Term Residential Care		180	339.9	3,181.2
Short Term Residential care		6	136.4	42.6
Supported Living		18	177.0	165.7
Extra Care		3	298.3	41.8
COMMUNITY BASED SERVICES				
Home Care		75	59.8	233.0

	Day Care				161		57.7		483.2
	Direct Payments and Care Packages				41		85.2		181.6
	Meals etc				53		30.1		82.8
	TOTALS				537				4,411.9

Table 2: forecast pattern of spend on adult social care services following implementation of commissioning strategy

MENTAL HEALTH			TO BE		14 SEPTEMBER				
					No Client		Average net		
					Nos		unit cost		Net Cost
							£ per week		£'000s
ACCOMMODATION BASED SERVICES									
	Long Term Residential Care				96		333.8		1673.1
	Short Term Residential care				6		136.4		42.6
	Supported Living				18		159.3		149.1
	Extra Care				0		0.0		0.0
	Assisted Accommodation				87		183.1		824.7
	Intermediate care				0		0		0
	Adult Placements				0		0		0
COMMUNITY BASED SERVICES									
	Home Care				0		0		0
	Day Care				25		40.7		52.9
	Direct Payments and Care Packages				55		65.7		189.4
	Enabling/Reablement								51.2
	Assistive Technology								13.5
	Voluntary/Community Services				189		26.9		264.2
	TOTALS				476				3,260.7

b) Market Development Implications

The commissioning plan has significant implications for market development. There will be a reduced need for residential provision and a need for increased capacity in the voluntary and independent sector for the provision of care packages and community support services that support people's independence. The use of personal budgets will see a culture change with a reduction in large block contracts and "in-house" provision and replaced by a greater market mix and more flexible services that people will choose to spend their money on.

Current residential providers will need to change the way they work and diversify to provide out reach and community support services that either replace or supplement a smaller residential market. All independent sector and voluntary sector providers will need to develop new ways of working to respond to the new demands of people using personal budgets. Delivery of the plan will be dependent on the ability of the third sector to respond and develop capacity.

(c) Workforce implications

The workforce implications include:

- A greater role for mainstream staff in primary and secondary health care and public services
- Development of new skill mixes within integrated services
- Community support staff needing to be multi-skilled and able to support people with varying levels of need. Development of a learning plan for workers across sectors, including Carers and those directly employed by individuals, around responding appropriately to people who require support.
- All staff being developed as a "public health" workforce at all levels – from mainstream to specialist roles
- Person centred approaches fully rolled out to all staff across all organisations with access to good and creative support planning and brokerage.
- Assessment & care management staff will be required to deliver against the new customer journey and personal budgets including improved delivery and quality of Carers Assessments.
- Requirement to address current risk averse practice, ensuring that people are supported by accessing mainstream and preventative services and the lowest level of intervention required to maintain and support independence
- The significant shift from residential care to supported housing options will require local housing and support providers having appropriately skilled and trained staff
- The shift from council managed social inclusion activities to a range of community services funded from personal budgets will require existing staff to work in different ways and independent and voluntary sector organisations to have appropriately skilled and trained staff
- Training and development of personal assistants and the needs of people with who become employers
- The ongoing pivotal role of people with mental health difficulties and carer trainers in paid employment in the areas of learning and development, advocacy, recruitment, planning and quality.
- Universal services that can respond positively and inclusively to people with mental health difficulties. Considerable investment in market development

and community capacity building and associated workforce requirements in relation to new roles in this area.
- Workforce development support and learning and development for both mainstream and specialist employment/supported employment services
- Development of a Carers Learning Plan to analyse Carer's learning needs and respond in a variety of ways including signposting to existing provision, multi-agency response, commissioning opportunities
- Response to Autism Act 2010 including work with Leicestershire County Council and Leicestershire Partnership Trust to develop a learning plan across sectors in relation to people with Aspergers Syndrome who do not have a learning disability.
- Staff are appropriately qualified to meet statutory, regulatory and legislative requirements including programmes that deliver national induction standards, adult mental health practitioners and other professional training needed to deliver specific mental health services

13. Risk Analysis

The Risk Assessment is attached as a separate document and outlines key risks, likelihood and impact, and mitigating actions. These are summarised as follows:

- There is currently a gap in the local authority commissioning infrastructure which is under review. Any delay in filling the lead commissioning post combined with limited capacity of existing commissioning & planning staff due to other work commitments will impact on delivery.
- Impact of the White Paper and loss of continuity in health commissioning arrangements both in the short term and long term
- Concerns about the accuracy of available data and information may impact on some of the assumptions regarding future service delivery options
- There is evidence of risk averse practice and a need to engage assessment staff in new ways of working that needs to be addressed through operational services
- There will be a risk to implementation if the components of transformation across adult social care are not fully joined up – i.e. personalisation, joint commissioning strategies, efficiency plans and financial strategy plus the cultural change that is required to change practice.
- Resistance to change from existing providers, service users, carers, staff, clinicians and politicians could all impact on delivery
- Public sector efficiencies impact on the availability of universal services as well as reducing funding available for personal budgets
- Some new services commissioned may cost more than existing residential services
- Lack of capacity within voluntary and independent sector to meet demands for increased community services
- Potential gaps in the current workforce regarding the skills and skill mix to deliver new ways of working
- Current contracting and procurement arrangements aren't aligned to new ways of working

APPENDIX A

1. Commissioning Implementation Plan

Action	Lead	Co-dependencies	Resources	Success criteria	Timescale
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	**Lead Commissioner (PCT)**	LPT Vol sector partners Clinical engagement	Within existing investment for IAPT Business case target £255k savings	Improved access to therapies Improved recovery and prevention of crises	IAPT roll out by Sept 2010-09-08 service evaluation Feb 2011 Business case implemented 2011/12 Stepped care model 2011/12
Redesign **crisis intervention** ➢ Identify barriers	**Lead commissioner**	LPT Vol Sector	Within existing resources	prevent people from requiring admission to hospital and maintain	2011/12

➢ 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				support them safely within the community and	
The development of an **enablement service** for all new service users referred to MH services ➢ Develop model ➢ Develop service spec	**Planning officer & Service Manager MH**	Redesign of community health services to re-focus therapy services; Engagement of LPT Advocacy;	Develop within existing resources within integrated community team and home care – investment in 1 wte OT shared with Moving On (SL) Project	More people accessing universal services; fewer people receiving RAS funded package; Care packages cost less;	Model developed by end Jan 11. Staff training Mar – June 11 Implementation 2011/12

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 and agree policy relating to out of area residents accessing community services (with LD) ➢ Develop strategy for managing residential market to mitigate impact of inwards migration to fill released capacity (with LD) ➢ Engage providers and retrain res care staff	**ASC lead/Planning officer**	Engagement of existing res care providers in new way of working. Development of Enablement Service above to provide in reach support. Contracts capacity and input; Regional and County links	Within existing resources other than funding to retrain residential care staff (will need to support providers); Reduction in spend on residential care	Achieve targets to move people on from existing residential placements over the next 3 years, with commensurate 50% reduction in beds – thus resulting in fewer new admissions to res care; and shorter lengths of stay;	Moving On Project to deliver by 2014 Pathways developed by end Jan 11. New service spec and contracts developed during 2011/12 and issued from 1st April 2012.
Develop more **supported living** options and move on existing residents	**ASC Lead** **& Housing lead**	Housing; Access to Advocacy,	Moving on team requires investment (spend	Improved quality of life outcomes; increased independence;	SL model developed and approved by end

➢ Moving On Project (SL Pilot) ➢ Develop pathway for accessing housing options ➢ Develop SL model and specifications ➢ Develop new contractual processes to replace block contract approach ➢ Commission floating support services ➢ Review current high cost SL packages, using Care Funding Calculator and renegotiating existing contracts/retendering	**(via SL Project Board)**	Welfare Rights & enablement Access to primary care and community health services including outreach Contracts input; Care Pathways Personal budgets (& RAS) Supporting People	to save) to deliver cashable savings in future years	maximised life opportunities of both service users and carers; Achieve targets to move people on from existing residential placements as outlined above; fewer new admissions to res care; shorter lengths of stay in res care; more people supported to live at home. Services delivering better value for money and greater efficiency.	of November 10; Pathways developed by end Jan 11; New floating support services commissioned by end 2011/12 (linked to moving on project); Moving On project completed by 2014; Existing services reviewed and, where necessary, re-tendered during 2010/11; new contracts issued April 2012.
Refresh and develop plan for next phase of remodelling in-house **Social Inclusion**	**Planning Officer**	Market development and ability of vol	Reinvestment of existing budget into personal	More people supported appropriately through	Refresh and new action plan in place by Mar

Team to continue development of flexible 24/7 services, supported employment and better market mix ➢ Refresh service spec ➢ Decide procurement route		sector to develop capacity; Advocacy; Workforce development; Link to supported employment developments Link to Carers Strategy;	budgets and in line with overall PCT and LA budget strategy	accessing universal services and low level targeted community services; more people in or moving towards employment; implementation of workforce changes and resolution of issues; Improved quality of life outcomes; increased independence; maximised life opportunities of both service users and carers;	2011; Complete delivery by Mar 2012.
To improve **data accuracy, and performance monitoring**	**commissioning leads**	Data systems; IT; performance management;	Within budget strategy	improved commissioning intelligence, more effective decision making	2011/12
Development of **quality monitoring** and QA processes, especially for	**Commissioning leads**	better co-ordination of quality related information;	Within budget strategy	improved commissioning intelligence, more effective decision	2011/12

social care		contractual requirements relating to customer feedback and quality audits		making	
Put in place a **Market Development Plan,**	**Transformation Group on Market Development**	Contracting, contract monitoring, procurement	Within budget strategy	Improved market capacity; better partnership working with providers; mitigation of risks.	2011/12
Put in place a **workforce development plan**	**Head of workforce development**	Working with independent sector, LPT and in-house services	Within budget strategy	Workforce skilled up to meet future demands, improved recruitment and retention,	2011/12

APPENDIX B

Risk Log

Risk No.	Date Raised	Risk Owner	Description of Risk	Impact on Project / Programme	Impact (I)	Probability (P)	Rating (I x P)	Risk Rating	Mitigating Actions	Target Resolution Date	Action Owner	Date Last Updated	Status
R - 1	15.9.10	Director of commissioning	gap in the LA commissioning infrastructure and potential delay in filling lead commissioner post	no leadership to drive forward the programme and slippage in delivery, with financial implictions	3	2	6	High	Interim lead commissioner appointed for 2 days week until Dec 20101; New structure approved by SLT but risk wont reduce until post advertised	31st Dec 20101	Dir of Commissioning	21.9.10	No Change
R - 2	15.9.10	PCT Dir of ommissioning	NHS White Paper and related interim changes to local commissioing arrangements	loss of continuity in leadership from PCT resulting in slippage	3	2	6	High	planned handover inthe event of change of lead	31st October 2010	PCT Dir of Commissioning	21.9.10	No Change
R - 3	15.9.10	Lead Commissioner	concerns about accuracy of data and information	impacts on assumptions contained in delvery plans	2	2	4	Medium	Project Groups will double check information; to addressin commissioing cycle	31st March 2011	lead commissioners	21.9.10	No Change
R - 4	15.9.10	service manager	risk averse practice and staff anxieties about changes	failure to reduce reliance on residential care	3	1	3	Medium	Staff Communication Plan and cultural change	31st March 2011	service manager	21.9.10	Decreasing
R - 5	15.9.10	Director of commissioning	components of personalisation, ASC transformation, JCS and efficiancy plans not joined up	failure to implement changes	2	1	2	Low	lead commissioner working closely with ASC redesign prgramme	31st March 2011	Dir of Commissioning	21.9.10	No Change
R - 6	15.9.10	Lead Commissioner	resitance to change from exisitgn providers, service users, staff, carers, clinicians	failure to implement changes	2	2	4	Medium	Communication Plan	31st Dec 20101	lead commissioners	21.9.10	Decreasing

R - 7	15.9.10	Director of commissioning	proposed changes not approved by Cabinet; resistance from politicians to change traditional service delivery or support outsourcing	failure to implemet	3	3	9	High	Link to budget setting process	31st March 2011	Dir of Commissioning	21.9.10	No Change
R - 8	15.9.10	PCT commissioner	NHS White Ppaer and lack if engagement from GPs	difficulty in implementing changes to health services	2	1	2	Low	Commication Plan and leadership from clinical champion; priorities taken to clinical cabinet 23rd Sept	31st Dec 20101	PCT Commissioner	21.9.10	No Change
R - 9	15.9.10	Director of commissioning	impact of public sector cuts	reduced availability of universal services to support people in the community	3	3	9	High	Link to budget setting process	31st March 2011	Dir of Commissioning	21.9.20	Increasing
R - 10	15.9.10	Lead Commissioner	some new services cost more than residential services	supported living options are not affordable	2	2	4	Medium	more robust SL model implemented; use of RAS and tighter contrals for approving new developments, using business case process	31st March 2011	lead commissioners	21.9.10	No Change
R - 11	15.9.10	Lead Commissioner	lack of capacity within vol sector to meet demands	slippage on development of supported living opportunities	2	2	4	Medium	Market Development Plan; reinvestment of resources as traditional services are decommissioned	31st March 2011	lead commissioners	21.9.10	No Change
R - 12	15.9.10	Head of workforce development	potential gaps in current workfroce regarding skills and skill mix	unable to deliver new ways of working	2	2	4	Medium	development of Workforce Development Plan	31st March 2011	head of workforce development	21.9.10	No Change

R - 13	15.9.10	head of contracts	current contract arrangements aren't aligned to new ways of working	slippage in delivery	2	2	4	Medium	implementation of new contracts and contractual arrangements	31st March 2012	head of contracts	21.9.10	No Change

Appendix C

NHS Leicester City and Leicester City Council

Health-related behaviour, knowledge and attitudes in Leicester

NB This is a working draft and is subject to some corrections .

The Leicester Health and Lifestyle Survey 2010 was undertaken to provide accurate information about health-related behaviour, knowledge and attitudes in the adult Leicester population. The survey results are based on a representative sample of 2,377 twenty minute, face to face, in home interviews conducted with adults aged 16 and over living in Leicester, between 6th January and 11th April 2010[1].

Health in general

Overall, nearly three-quarters (72%) of adults in Leicester said that they thought their health was "very good" or "good"; a slightly lower proportion than the 76% reporting a similar health status in England via the Health Survey for England in 2008. Only 7% of all respondents said their health was "bad" or "very bad", with more people reporting "bad" or "very bad" health in Spinney Hills (10%), Eyres Monsell and Western Park (11%) and in New Parks (12%) wards.

Long-term conditions

Overall 20% of respondents said that they had a long-term limiting condition (LTLC) – an illness or disability that respondents felt limited their activity in anyway. People living in Freemen (31%) and Thurncourt (30%) wards were most likely and in Westcotes (14%) and in Castle (13%) least likely to report a LTLC.

Attitudes towards leading a healthy lifestyle

Without any prompting, four-fifths or so (86%) of respondents recognised a healthy diet and taking regular exercise (79%) as key elements of leading a healthy lifestyle. However, only a quarter recognised the importance of not smoking (25%) or not drinking too much alcohol (24%) for good health.

Willingness to change

The survey found that the majority of people (71%) said they were willing to change and to make at least one of six changes. The most commonly mentioned being to lose weight (32%), increase physical activity (32%) and to eat more healthily (26%).

This willingness to change was greater in

- younger respondents (85% of those under 55 years, compared to 54% in those aged 55 or over),
- smokers (77%, compared with 69% non-smokers),
- those who had taken drugs in the last year (83%, compared with 71% of non-users)
- and those who were overweight (74%) or obese or morbidly obese (82%) (compared with 66% of people with an ideal Body Mass Index [BMI])

[1] The full report, Leicester Health and Lifestyle Survey 2010, is available. The survey was commissioned by NHS Leicester City and undertaken by GfK NOP.

Smoking

The prevalence of cigarette smoking in Leicester is, at 25%, slightly higher than the national rate of 22% found by the Health Survey for England 2008.

When other tobacco products, for example, cigars, a pipe, sheesha/hookah or bidi, are included the prevalence of smoking any tobacco substance increases to 27%.

Prevalence of smoking – any substance - varies by populations and the survey found:

- men (31%) were more likely to smoke than women (23%)

- age differences were less marked with the proportion smoking only decreasing after the age of 55 (29% of 16-54 year olds but only 21% of people aged over 55)

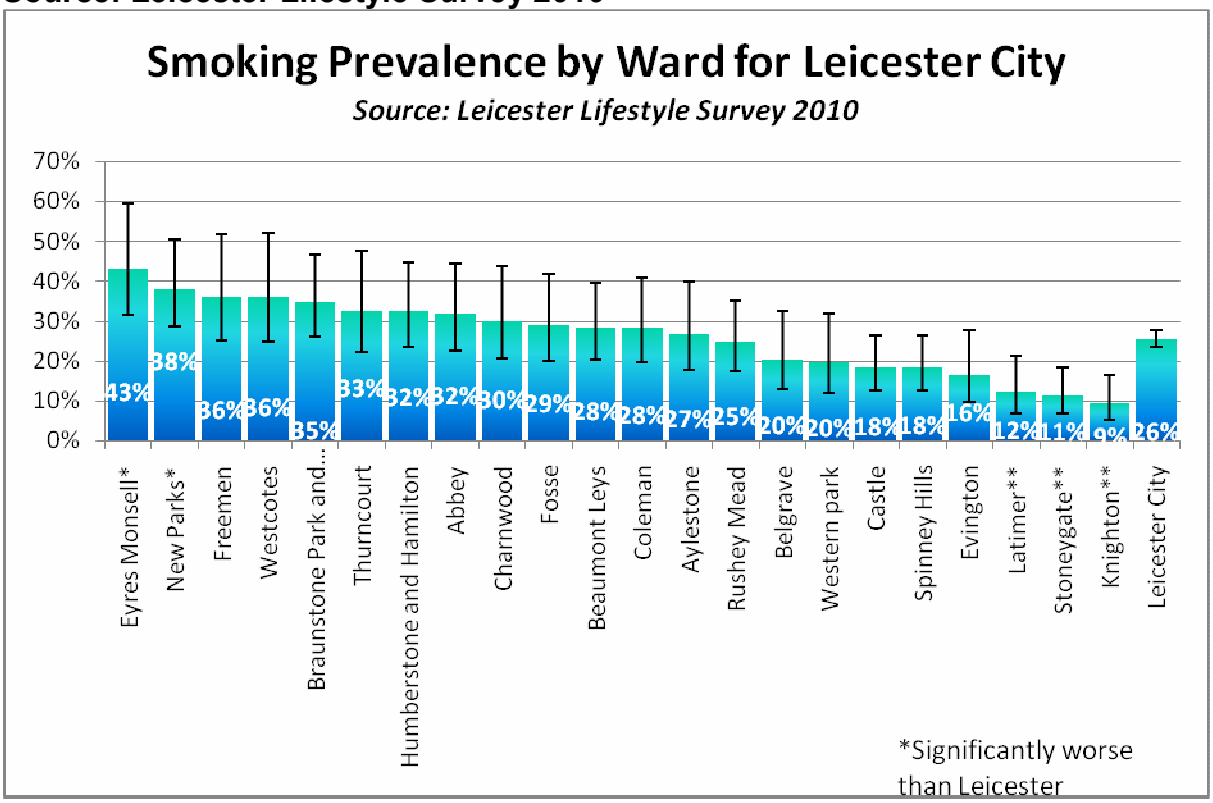
- white respondents (34%) were much more likely to smoke than those from Black and Minority Ethnic [BME] groups (14%), but no significant differences between minority ethnic groups. It is notable that, among South Asians, men were much more likely to smoke (16%) than women (only 2%). Leicester's deprivation profile suggests that its prevalence figure should be considerably higher than the national average, but this is counterbalanced by the high South Asian population in the city, which has much lower smoking rates

- smoking was highest in the most deprived quarter of the city (37%), compared with 26% in the next most deprived quarter and 20% elsewhere

- the highest rates of current smoking was reported in Eyres Monsell (43%), and New Parks (38%), the lowest in Knighton (9%), Stoneygate (11%) and Latimer (12%) wards, reflecting the pattern of deprivation in the city (see figure 1)

- some 7% of the South Asian sample said that they used other tobacco products such as bidi, paan, sheesha/hookah. There was very little use of such substances in the white sample and none at all among black respondents

Figure 1: Smoking prevalence – all substances - by ward: Leicester
Source: Leicester Lifestyle Survey 2010



Quitting smoking

Two-thirds (65%) of those who currently smoke said that they wanted to quit smoking. Those most likely to say that they wanted to give up smoking were:

- younger people (74% of 16-24 year old smokers, compared with 48% of those aged 55 and over)
- ethnic minority smokers (76%, compared with 62% of white smokers)
- those living with children (73%, compared with 61% of those not living with children)

The most common reason given for wanting to quit was “better health”(84% of smokers). Included in this was the desire to reduce the risk of getting smoking-related illnesses (21%) and in some cases there was an existing health problem (17%).

The other main reasons were the cost (23%), influence or expectations of family and friends (23%), and the effect smoking would have on their children (17%).

Quit attempts and awareness of help to do so

A quarter (25%) of all respondents said that they had smoked cigarettes at some point but did not smoke nowadays.

Exactly three-quarters of current smokers had tried to quit smoking at some point. 80% had heard of the STOP! Smoking Service and a quarter (24%) of those aware had used STOP! in the past. Of those who had used the service, 81% were aware that they could use it again, if they resumed smoking.

Smoking in the home

74% of current smokers and non-smokers did not allow smoking anywhere in the home. 26% allowed smoking somewhere in the household, with 17% restricting it to certain parts of the home and one in ten (9%) allowing smoking anywhere.

Respondents were more likely to allow smoking anywhere in the home if they were smokers (27%, compared with just 2% of non-smokers), and those with poor mental well-being (17%, compared with 6% amongst those with good well-being).

The vast majority (93%) of respondents said they would be confident asking visitors not to smoke in their home, with 82% feeling very confident. Just 6% did not feel confident asking people not to smoke in their home.

Alcohol Consumption

Just over half (53%) of those interviewed in the survey said that they currently drink alcohol. 68% of the city's white, 30% of the black and minority ethnic (BME), and within that, 26% of the South Asian population, reported drinking alcohol. 47% of respondents reported that they do not drink alcohol, a higher proportion of non-drinkers than in England overall.[2] [1]

There were also marked differences by religion: around two-thirds of Christians drank alcohol, compared with 39% of Hindus and only 7% of Muslims.

Alcohol consumption also differed by levels of deprivation as well as by other health behaviours:

- Those living in the more affluent half of the city were more likely (57%) than those in more deprived areas (47%) currently drink alcohol (the term used in the survey was 'nowadays')
- Smokers (62%) were more likely to drink nowadays than non-smokers (49%)
- Those who had taken drugs in the last 12 months (78%) were more likely to drink alcohol than those who had not done so (51%)

Daily unit and weekly consumption

Just over a quarter of all respondents (27%) drank above the *daily* recommended maximum units on a typical day when they were drinking alcohol (see figure 2); 25% drank within recommended guidelines, and the remainder were non-drinkers. Men were more likely to drink above the threshold on a typical day when they have alcohol (32%) compared to women (23%).

Five percent of all respondents reported exceeding the *weekly* recommended maximum (see also figure **2**) and men (7%) were more likely than women (2%) to consume above the weekly recommended limits.

[2] 10% of males and 18% of females are non-drinkers in England.

The difference between the proportion of the sample drinking in excess of the maximum recommended units on a daily and weekly basis suggests that some respondents engage in a pattern of 'binge' drinking. A commonly used definition of 'binge' drinking is double the recommended daily limits, so for men this is consuming more than eight units of alcohol in one day and for women, more than six units of alcohol in one day[2]. National data suggests that around 22% of men and 22% of women[1] in England exceed the weekly maximum units.

When looking at ward level data, as per Figures **2** and **3**, those wards with large BME populations, for example Spinney Hills and Latimer, have some of the lowest proportions of their populations exceeding the recommended limits.

Figure 2: Drinking more than the daily recommended units by ward (%)
Source: Leicester Lifestyle Survey 2010

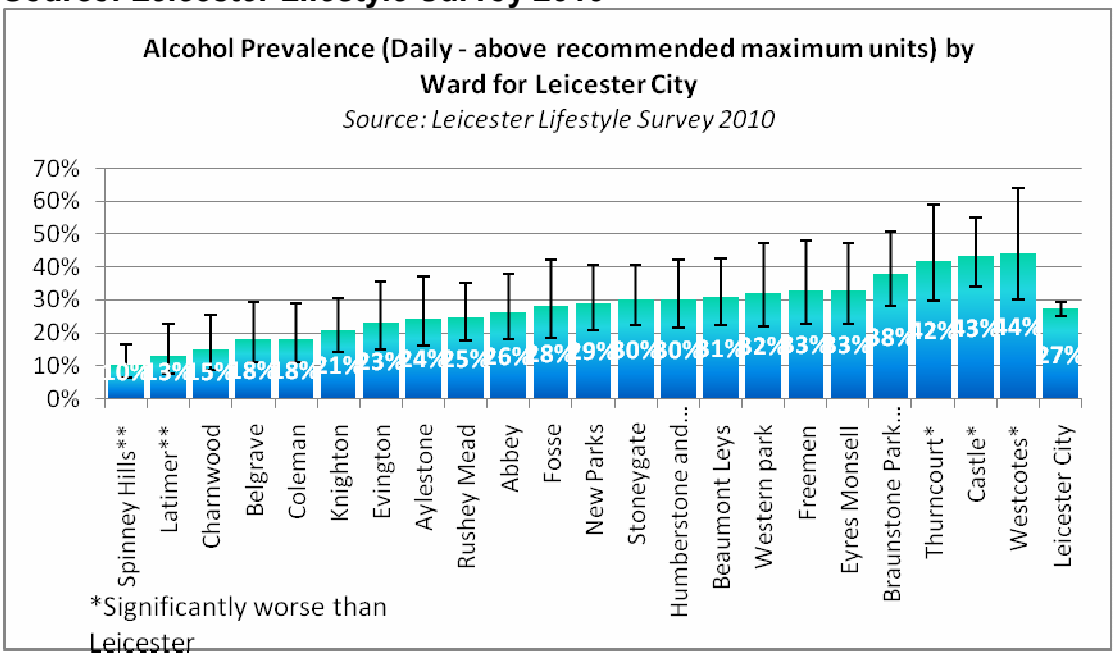
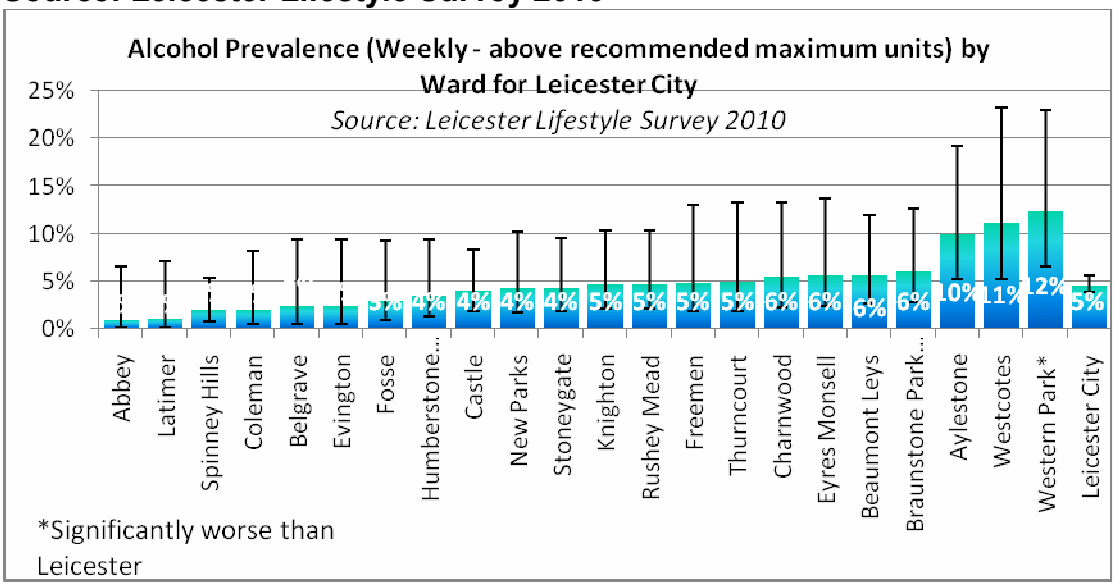


Figure 3: Drinking more than the weekly recommended units by ward (%) Source: Leicester Lifestyle Survey 2010



Proportions exceeding the daily recommended limits are significantly higher in Westcotes (44%), Castle (43%) and Thurncourt (42%). Proportions exceeding the weekly recommended limits are statistically significantly higher than the city average in Western Park (12%).

Knowledge of alcohol units

Four-fifths (79%) were aware of units of alcohol as a measure of alcohol content. However only three in 10 men (29%) and a third of women (34%) were able to accurately identify the maximum daily recommended units.

Awareness of units was highest for men who were:

- white respondents (39%, compared with 18% of the ethnic minority sample, relatively few of whom actually drink alcohol), and
- those drinking above the maximum recommended weekly units (49%, compared with 27% of those drinking within the limits)
- Awareness of units was highest for women who were:
- younger (40% of 16-24 year old women, compared with only 8% of women aged 55 and over), and
- white respondents (46%, compared with 17% of ethnic minority respondents).
- Given that awareness of units is high amongst a group that exceeds recommended limits, this may suggest that it is difficult to move from awareness to a point of sufficient understanding and motivation which results in modification of drinking behaviour.

Willingness to change

Those who reported drinking above the maximum recommended weekly guidelines were more likely to be thinking about cutting down the amount of alcohol they consume than those who drink within the guidelines (32%, compared with 10%).

Drug-taking in the last 12 months

The vast majority of all respondents (93%) had not taken any illegal or proscribed drug on the list shown in the box below in the previous year.

List of Illegal or proscribed substances offered in the Lifestyle Survey Questionnaire

Amphetamines (speed, whizz, uppers, billy)
Cannabis (marijuana, grass, hash, ganja, blow, skunk, draw, weed, spliff)
Cocaine/coke
Crack/rock/stones
Ecstasy (E)
Heroin (smack, H, brown)
LSD/Acid
Magic Mushrooms
Methadone/physeptone (not prescribed by a doctor)
Semeron
Tranquillizers (Temazepam, valium, not prescribed by a doctor)
Amyl Nitrite (poppers)
Anabolic steroids (not prescribed by a doctor)
Glues, solvents, gas or aerosols to sniff or inhale
Ketamine (green, K, special K, super K, vitamin K)
Any other pills or powders not prescribed by a doctor, even if you didn't know what they were
Anything else you may have smoked when you didn't know what it was
Anything else you knew or thought was a drug (not prescribed by a doctor)

Six percent said that they had used at least one of the drugs on the list. Five percent reported taking cannabis, 2% cocaine and 1% Ecstasy. Men (9%, compared with 3% of women) and younger respondents (14% of those aged 16-24, compared with 5% of 25-54 year olds and less than 1% of those aged 55 and over) were more likely to have taken an illegal or proscribed drug.

The proportion that had taken any drug (6%) was lower than that reported on the 2008/9 British Crime Survey (BCS) (10%). The difference is at least partly explained by the ethnic profile of Leicester and the fact that the drug-taking section of the BCS was only asked of 16-59 year olds. However of the corresponding sample of the Leicester Lifestyle survey, i.e., those aged 16-59, 7% had taken drugs in the previous year, still lower than the BCS proportion.

Prevalence of drug use was consistently quite low at individual ward level, largely in line with the overall reported drug-taking levels across the city. However, there were a number of wards in which the prevalence of reported drug use was higher: Freemen (16%), Castle (11%), Westcotes (12%) and Stoneygate (12%).

Willingness to change

Respondents who had taken drugs in the last year (83%) were more likely than those who were non-drug-users (71%) to want to make a lifestyle change. The survey did not include questions to assess willingness or barriers to change amongst drug-takers.

Diet

Eating fruit and vegetables

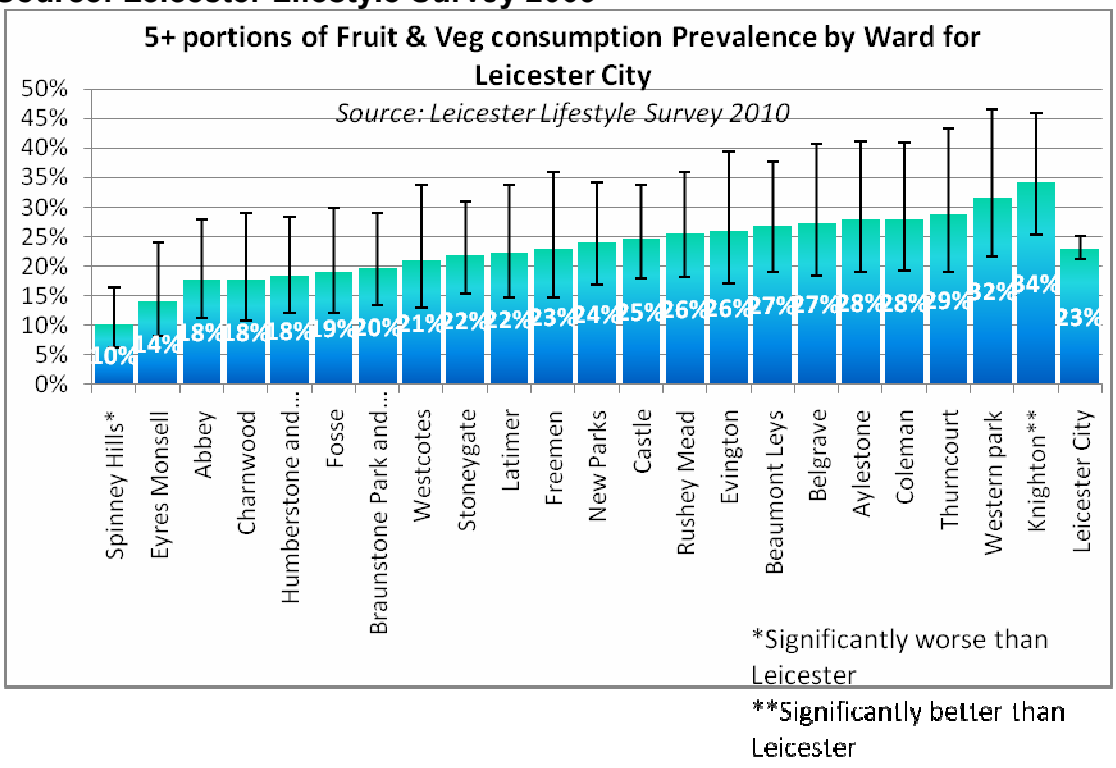
Almost a quarter (23%) of respondents reported eating the recommended five or more portions of fruit and vegetables a day. Over a third (37%) were eating three or four portions, with a further third (35%) eating one or two daily. Just 4% said they did not eat any fruit and vegetables. The average number of portions of fruit and vegetables consumed per person was 3.1 per day.

The proportion eating five or more portions of fruit and vegetables a day in Leicester (23%) is slightly lower than that reported on the 2008 Health Survey for England (HSE) (27%). However, this is not strictly comparable, as the HSE asked a large number of more detailed questions than the current survey to determine overall fruit and vegetable consumption.

72% of respondents correctly identified that the recommended daily intake of fruit and/or vegetables is five portions.

Figure 4 shows that 34% in Knighton said they ate five portions of fruit and vegetables a day, significantly higher than the Leicester average, while only 10% of those in Spinney Hills eat five or more portions of fruit and vegetables a day, which is significantly worse than the Leicester average.

Figure 4: 5-a-day prevalence by Ward for Leicester City
Source: Leicester Lifestyle Survey 2009



Willingness and barriers to change

26% of respondents said they wanted to eat more healthily. Those who ate fewer than five portions of fruit and vegetables a day (28%) were more likely than those who eat five-a-day (19%) to say they would think about eating more healthily in the next six months.

Barriers to healthy eating were financial issues (about 20%), including affordability, and "lack of will-power" (14%). Around 40% of respondent felt that there were no barriers to eating more healthily. There were fewer perceived barriers to healthy eating, than for increasing physical activity.

Physical Activity

46% of respondents reported that they undertook five or more sessions of 30 minutes physical activity per week, the recommended minimum amount of exercise a week. A further 18% said they took 3-4 sessions a week, 11% took one or two sessions and 23% said that they took no such exercise.

The findings, should be treated with caution, as it is much higher than that reported in the Active People's Survey 3 for 2008/09, which found that 18% of adults (16 years plus) participate in sport and active recreation at moderate intensity for at least 30 minutes, on at least 12 days in the previous four weeks. Different questions, additional physical activity categories included and less focus on sport and recreation may account for these differences. The physical activity categories used in this survey are listed below.

List of activities generating faster breathing and heart rate, through physical exertion, included in the Lifestyle Survey 2010

Cycling
Swimming
Jogging/running
Sports (e.g. football, tennis, netball)
Exercise like aerobics, weights
Brisk walking (e.g. walking to work, walking to the shops, walking to school, hiking, rambling)
Dancing
Heavy gardening
Heavy work around the house (e.g. heavy housework, DIY)
Heavy manual work as part of your job
Other (specify)

There was no significant difference by ward of residence from the Leicester average for those reporting undertaking physical activity on at least three days a week.

Willingness and barriers to change

32% of respondents wanted to increase the amount of physical activity they take. Those who report that they already do physical activity for even 30 minutes once or twice a week were more likely than those who do not take any exercise to be thinking about increasing the amount of physical activity they take (40%, compared with 31%).

Barriers to increasing the amount of physical activity respondents take in the next six months were cited as being too busy or not having time (42%), ill-health (16%), and laziness (6%). 25% said "nothing" would stop them from increasing the amount of activity they take.

Sexual Health

All respondents aged 18 to 54 years were asked a number of questions relating to sexual health and findings below relate only to this age group.

Preferred access to sexual health services in Leicester

Three-quarters (77%) of those aged 18-54 indicated that their preferred method of access to sexual health services was via their own family doctor or GP. Seven percent said that they would like to access sexual health services via Contraceptive Services, and 5% said they would like to go to a separate service that provides both contraception and testing for sexually transmitted infections (STIs). Four percent said they would prefer to access these services through Genitourinary (GUM) clinics. Just 1% said they did not need to access sexual health services. Seven percent of the sample, including 9% of South Asians refused to answer this particular question.

Those aged 20-24 (5%) and 25-34 (8%) were more likely than those aged 35-54 (2%) to prefer accessing sexual health services through GUM clinics.

Use of condoms in the last 12 months

Two in five (41%) said that they had not used a condom in the past year but almost as many (38%) had used condoms to prevent pregnancy and 16% had used them to protect against HIV and other STIs.

Patterns of motivation for condom use by age group are shown in Table **2** below. In all ages condoms were more often used for contraception than to protect against STIs and HIV. Younger people and men rather than women were more likely to report using a condom. These results are consistent with national surveys[3]

Table 2: Proportions using condoms and reasons for such by age and/or sex
Source: Leicester Lifestyle Survey 2010

Age Group	Percentage using condoms	Percentage using condoms for contraception	Percentage using condoms for protection from HIV or STIs
All 16 +		38	16
16-24	57	46	34
25-34	50	28	20
35-54	31		6
Men overall	20		
Female Overall	14		

The top three reasons for not using a condom in the past year were being in a long-term relationship and only having one partner (35%), no sex in previous year (23%), or using a different method of contraception (14%).

53% of those who drink above the weekly recommended limits have not used condoms in the past year.

One person in seven (14%) refused to answer this particular question. Age and ethnicity seem to have had an impact here, as well as some positive health behaviours. Those most likely to refuse to answer this question were:

- Older respondents (18% of 35-54s, compared with 12% of those aged 16-24 and 11% of 25-34 year olds)
- Respondents from South Asian communities (22%, compared with 9% of the white sample and 11% of black respondents)

Mental Health

To determine views on positive mental health, respondents were assessed against a shortened version of the validated Warwick-Edinburgh Mental Well-Being Scale[4].

The results showed that 13% of the sample reported good mental well-being, 76% were in the average group and 9% had poor mental well-being.

Poor mental well-being was reported in 11% of those living in most deprived quartile, compared with 6% in those from more affluent areas. Data by ward shows higher rates of poor mental well-being in Beaumont Leys (13%), Spinney Hills (14%) and Freemen (16%). These wards all have at least 31% of their respondents in the most deprived 10% nationally, when measured against the Indices of Multiple Deprivation 2007.

Multiple Risk Factors

Throughout the survey results, the findings pointed to the fact that risk factors for poor health and unhealthy behaviour are often shared by groups or populations.
For example, those not undertaking regular exercise are more likely to: be female, older, living in a deprived area, report bad or very bad health, have a long-term, limiting condition, be a current smoker, eat less than three portions of fruit and vegetable a day and report poor mental wellbeing. Current smokers are more likely to report bad or very bad health, drink more than the recommended weekly units of alcohol, to have taken an illegal or proscribed drug in the last year, eat unhealthily, take no regular exercise and have poorer mental health.

The results indicate the importance of having more integrated interventions aimed at improving health behaviour and engaging communities, rather than parallel interventions for different issues such as alcohol, smoking, diet and physical activity, mental health and well being,

Recommendations

- The information in this report is used to inform efforts to improve the physical and mental health of people in Leicester

- Practical means of implementing integrated interventions aimed at improving health behaviour and engaging communities, are considered, where this suggests greatest benefit

- Steps are taken to increase awareness of the importance of not smoking and of moderate alcohol consumption, as key features of a healthy lifestyle

- Efforts to reduce smoking and its impacts, continue to be focused, targeting areas of highest smoking prevalence

- Understanding of the motivational issues which limit capacity to give up smoking, is deepened

- The dangers of non-cigarette-related tobacco use continue to be highlighted

- The steps to be taken locally to improve the understanding of alcohol content in drinks are considered, along with what these mean for health.

- Those groups in the population drinking in excess of recommended guidelines and most willing to change their behaviour, are targeted

- Further data analysis and research is conducted to determine the particular populations and factors involved in the high drug-taking prevalence in Freemen, Castle and Stoneygate

- The information in this report is considered in conjunction with other dietary and healthy weight and obesity data, and that resource is targeted at groups and wards where obesity is most prevalent

- The provision of open access, integrated sexual health services in primary care is explored

Rod Moore
Deputy Director of Public Health and Health Improvement
30 January 2011

References

[1] Deborah Lader & Matthew Steel. 2009. Opinions Survey Report No. 42 - *Drinking: adults' behaviour and knowledge in 2009 - A report on research using the National Statistics Opinions Survey*. London: NHS Information Centre for Health and Social Care

[2] Parliamentary Office of Science and Technology. Binge Drinking and Public Health. *Postnote*, 244, 1-4, July 2005. London: Parliamentary Office of Science and Technology

[3] Office of National Statistics. 2009. *Opinions Survey Report No. 41 Contraception and Sexual Heath, 2008/09*. London: Office of National Statistics

[4] NHS Health Scotland, University of Warwick and University of Edinburgh. 2006. *Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)*. Edinburgh: NHS Health Scotland, University of Warwick and University of Edinburgh

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Appendix D

NHS Leicester City (LC)

Annual Health Check (Vital Signs) 2009/10 Performance Indicators

Introduction

The following document provides an overview of the NHS Performance Framework and local processes that are in place to ensure that NHS LC provides an effective and efficient health service to its local population. It covers :

- The NHS Performance Framework and Processes
- NHS LC's Internal Performance Framework
- 2009/10 Performance Status for Vital Signs
- 2010/11 Deliver y Plans in place for Vital Signs by Exception

The NHS Performance Framework and Processes

In 2008/09, the NHS set up a new performance framework, which included a Care Quality Commission Annual Health Check for each NHS Trust. This included Existing Commitments, National Priorities, Core Standards and Financial Management. The Existing Commitments consisted of targets that were required to be maintained (eg EMAS response calls) and the National Priority Targets also know as Vital Signs. The Vital Signs were organised into three tiers, with Tier 1 (VSAs) and Tier 2 (VSBs) being priorities for healthcare. Tier 3 (VSCs) are indicators that are joint NHS/LA responsibilities, and performance status is available if required. These were not previously part of the Annual Health Check. There are a number of indicators in all three Tiers that mirror LA National Indicators.

Target setting is undertaken through the annual Local Operating Plan (LOP), with the Strategic Health Authority (SHA)and Department of Health (DoH) signing off all NHS Trust targets that are set. Targets in the majority of cases are set nationally (eg Cancer or Immunisation), where local variation is allowed often the SHA asks for "stretch" to be applied.

NHS LC's Internal Performance Framework

The PCT's Performance Framework has been set up as follows:

- The Framework has been developed and set up in-conjunction with NHS Leicestershire & Rutland (LCR), to maintain consistency in service improvement across Leicester, Leicestershire and Rutland.
- Targets were either refreshed or set as part of 2009/10 LOP ensuring consistency with LA National Indicators. They cover services in primary care, secondary care and public health.
- The SHA holds a Quarterly Review with PCTs, and challenges delivery plans.
- An NHS LC & LCR Performance Management Group runs on a monthly basis and provides assurance to the Trust Board on target delivery. It scrutinises target and actual performance at Executive level. During 2009/10, NHS LC held a similar group on a monthly basis focusing on city performance risks.
- Each Director is held responsible for target delivery in specified service areas (See Appendix A).

- Each Existing Commitment & Vital Sign is monitored on either a weekly, monthly, quarterly or annual basis dependent on when data is available.
- Health Inequalities are being tackled through a joint partnership framework with Leicester City Council, which consists of a Health & Well Being Partnership Board.

2009/10 Performance Status for Vital Signs (See Appendix A)

In 2010/11, and as a result of the new coalition government, requirements have changed. The Annual Health Check rating for 2009/10 was no longer required, however, NHS Trusts are still expected to maintain and improve on the Existing Commitments and Vital Sign performance.

The 2009/10 Performance Status for Vital Signs is documented in Appendix A. It is a self assessment that NHS LC has undertaken, and mirrors the previous Annual Health Check methodology (including thresholds) published by the Care Quality Commission.

- Existing Commitments – 13 of 16 indicators were achieved. Two indicators; East Midlands Ambulance Service(EMAS) response times for category A & B calls and Thrombolysis Call to Needle Time underachieved against national thresholds.
- National Priorities – 21 of 28 indicators were achieved. Five indicators underachieved , and two failed against national thresholds.

2010/11 Delivery Plans for Vital Signs by Exception

The 2010/11 Performance Framework has focused on Performance Risk areas, based on the non-achievement of targets in 2009/10 and also on targets that have been "stretched" by Department of Health for 2010/11.

NHS LC has two main areas of concern with non achievement of targets:

- Contractual Targets – there are a number of targets that form part of the contracts that NHS LC has with the providers of services. These include EMAS, UHL, Community Health Services and LPT. Target performance is managed through these contracts, and the providers are held to account for their service delivery. Particular emphasis is on ambulance response times, waiting times, cancer screening, infection control and stroke care.

- Health Inequalities – Leicester City is a deprived area, and as a result has high health inequalities. This in turn has seen poor performance in certain target areas (eg mortality rates, teenage pregnancy). Delivery in these areas is being targeted through the Health Inequality Improvement Plan. This is a partnership plan which brings together organisations across Leicester City and focuses on various delivery areas. The Plan is reported through both NHS LC & LCRs Performance Management Group and also to the Health & Well Being Partnership.

Detailed delivery plans are in place for all performance risks, and are available if more detailed information is required by the Committee.

Sarah Cooke
12 November 2010

2009/10 Performance Status for Vital Signs

		Commissioning Lead Director	2009/10 Out-turn	2009/10 Target
Existing Commitments				
NT1	Access to GUM clinics within 48 hours	Deb Watson	100%	100%
EX6	All ambulance trusts to respond to 75% of Category A Calls within 8 minutes	Simon Freeman	73.72%	75%
EX7	All ambulance trusts to respond to 95% of Category A calls within 19 minutes	Simon Freeman	96.53%	95%
EX8	All ambulance trust to respond to 95% of Category B Calls within 19 minutes	Simon Freeman	94.51%	95%
EX10	Commissioning of crisis resolution/home treatment services	Simon Freeman	864	815
NT9	Commissioning of early intervention in psychosis services	Simon Freeman	117	73
NT14	Data quality on ethnic group - completeness of coding on health data (Acute & Mental Health)	Nigel Skea	98.992% (UHL) 98.004% (LPT)	85%
VSC10	Delayed Transfers of Care - Delays per 100,000 population	Toby Sanders	7 per 100,000 population	20 per 100,000 population
EX14	100% of people with diabetes to be offered screening for the early detection of (and treatment if needed) of diabetic retinopathy	Simon Freeman	100.02%	100%
EX15	A maximum wait of 26 weeks for in-patient procedure	Simon Freeman	0%	0 (0.00%)
EX16	A maximum wait of 13 weeks for out-patient appointment	Simon Freeman	0.002%	0
EX17	3 month maximum wait for revascularisation	Simon Freeman	0	0
	Thrombolysis: Part 1:Call to Needle of at least 68% within 60 minutes where thrombolysis is preferred local treatment for heart attacks	Simon Freeman	56.757% (Apr - Dec 09)	68%
EX19	Thrombolysis Part 2: Call to Balloon 150 mins SHA have not been able to confirm the target		82.051% (Dec 09)	N/A
EX20	Total time in A&E: four hours or less	Simon Freeman	98.24%	98%
VSB12	Emotional health and well being and child and adolescent health services (CAMHS)	Toby Sanders	Level 4	Level 4
VSB13	Chlamydia Screening	Deb Watson	26.091%	25%

2009/10 Performance Status for Vital Signs

		Commissioning Lead Director	2009/10 Out-turn	2009/10 Target
National Priorities				
VSA04	NHS reported waits for elective care (18 Weeks Referral to Treatment)		95.33%	90%
	Admitted	Simon Freeman		
	Non Admitted		98.12%	95%
	Direct Access Audiology			95%
	6 weeks diagnostics		0	0
VSA06	Practices Offering Extended Hours	Toby Sanders	74.3%	75%
VSB18	Dental Services	Toby Sanders	184132	192308
VSA11 (a)	31-Day Standard for Subsequent Cancer Treatment Chemo	Simon Freeman	99.60%	98%
VSA11 (b)	31-Day Standard for Subsequent Cancer Treatment Surgery		95.46%	94%
VSA12	31-Day Standard for Subsequent Cancer Treatment (Radiotherapy)	Simon Freeman	99.40%	94%
EX3	Maximum Waiting Times of 31 days from diagnosis to treatment for all cancers	Simon Freeman	99.56%	96%
VSA13 (a)	Part 1: Extended 62 Day Cancer Treatment Targets (from screening referral)	Simon Freeman	95.04%	90%
VSA13 (b)	Part 2: Extended 62 Day Cancer Treatment Targets (from consultant upgrade)		100%	100%
EX4	Maximum Waiting Time of 62 days from urgent referral to treatment of all cancers	Simon Freeman	85.3%	85%
VSA08	Breast Symptom Two Week Wait	Simon Freeman	95.37%	93%
EX5	2 Week Maximum Wait from urgent GP referral to first out-patient appoint for all urgent suspected cancer referrals	Simon Freeman	94.4%	93%
VSA15	Cervical Cancer Screening - women 25-49 received screening in the last 3.5 years (08/09 data)	Simon Freeman	69.725% (08/09)	70%
VSB01	All Age All Cause Mortality - based on calendar year.	Deb Watson	846 (2009)	741 (2009)
	Male, per 100,000 population			
	Female per 100,000 population		578 (2009)	519 (2009)
VSA09	Extension of NHS Breast Screening: % of eligible women aged 47-49 and 71-73 invited for breast screening over the year	Simon Freeman	N/A	N/A
	Breast Screening: % of eligible 50-73 year old women screened for breast cancer in the last three years as at March 2010. Data monitored a year in arrears		74.9%	70%

2009/10 Performance Status for Vital Signs

		Commissioning Lead Director	2009/10 Out-turn	2009/10 Target
National Priorities				
VSB09	Childhood Obesity	Deb Watson	9.99%	11.0%
	% of children in Reception with height & weight recorded who are obese			
	% of children in Reception with height & weight recorded		88.67%	87.0%
	% of children in Year 6 with height & weight recorded who are obese		17.78%	21.0%
	% of children in Year 6 with height & weight recorded		86.94%	86.0%
VSB15	Self Reported Experience of Patients/Users Access & waiting Safe high quality co-ordinated care Better information, more choice Building relationships Clean, comfortable, friendly place to be	Toby Sanders	(Mar 10) 76.156 76.276 67.985 83.606 61.044	National Average 79.047 80.345 70.348 86.954 65.191
VSB05	Smoking Cessation	Deb Watson	2484	2418
VSA03	PCO - Incidence of CDIFF	Liz Rowbotham	147	192
VSB17	NHS Staff Survey based Measures of Job Satisfaction Survey on an annual basis	Nigel Skea	3.58	3.6
VSB14	Drug Misusers recorded as being in effective treatment	Deb Watson	13%	6.0%
VSB11	Breastfeeding at 6-8 weeks	Deb Watson	53.03% (136.453% performance vs plan)	37.2%
	Prevalence			
	Status Recorded		93.22%	90.0%

2009/10 Performance Status for Vital Signs

		Commissioning Lead Director	2009/10 Out-turn	2009/10 Target
National Priorities				
VSB10	Individuals who complete immunisation	Deb Watson	Note: 2009-10 targets are on booster doses	
	Aged 1 (DTaP/IPV/Hib)		93.2%	93%
	Aged 2 (PVC)		90.2%	90%
	Aged 2 (Hib/MenC)		92.1%	90%
	Aged 2 (MMR)		90.1%	90%
	Aged 5 (DTaP/IPV)		89.2%	89%
	Aged 5 (MMR)		87.6%	85%
	Girls 12-13 (HPV)		75.7%	70%
	DTAP School leaver booster		82.1%	80%
VSB03	Cancer Mortality Rate - Based on 3 year rolling average	Deb Watson	117.66 (2008)	99.1 (2008)
VSB02	CVD Mortality Rate - Based on 3 year rolling average	Deb Watson	117.77 (2008)	124 (2008)
VSA14	Quality Stroke Care	Simon Freeman	56.82%	70%
	Proportion of people who spend at least 90% of their time on a stroke unit			
	Proportion of people who have a TIA who are scanned and treated within 24 hours		46.2% (UHL)	45.0%
VSB08	Teenage Pregnancy	Deb Watson	48.6 (within 2 standard deviations)	42.8
VSB06	Early Access for Women to Maternity Services	Toby Sanders	82.97%	82.5%

Appendix E

Leicester City Council

WARDS AFFECTED
ALL

FORWARD TIMETABLE OF CONSULTATION AND MEETINGS:

Health Scrutiny Committee **9 February 2011**

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

Report of the Director of Public Health and Health Improvement

1. Purpose Of Report

1.1 The purpose of this report is:

a) to inform the Health Scrutiny Committee of the publication of the Public Health White Paper Healthy Lives, Healthy People and of two further consultation documents published on the 20 and 21 December 2010

- Healthy Lives, Healthy People: Transparency in outcomes
- Healthy Lives, Healthy People: Consultation on the funding and commissioning routes for public health.

b) to seek views on the proposals, and

c) outline the arrangements so far for local consultation.

2. Recommendations

2.1 The Health Scrutiny Committee is asked to:

- note the publication of the above documents and the summary provided in the appendices to this report;
- note the consultation arrangements developed so far; and
- advise on further steps to support the consideration of the White Paper and consultation documents within the City Council.

3. Report

3.1 The Public Health White Paper, *Healthy Lives, Healthy People: Our strategy for public health in England*, sets out the government's new approach to public health and some of the structures and processes that will support delivery – including the formation of Public Health England and a ring-fenced public health funding for upper tier and unitary local authorities from within the overall NHS budget. The vision is to protect the population from serious health threats, helping people live longer, healthier and more fulfilling lives; and improving the health of the poorest fastest.

3.2 In terms of structures the government intends to:

- enable the creation of Public Health England from 2012;
- transfer local health improvement functions to local government with ring fenced funding allocated to local government from 2013; and
- give local government new functions to increase local accountability and support integration and partnership working across social care, the NHS and public health

3.3 Much of the detail behind the outlines sketched out in the white paper is provided in two separate consultation documents.

a) *Healthy Lives, Healthy People; Transparency in outcomes.* This consultation document sets out the government's goals in relation to health improvement and health inequalities and provides a mechanism for transparency and accountability across the public health system at the national and local level. It is part of a suite of three outcome frameworks covering the NHS, adult social care and public health, and is intended to provide equivalent arrangements for the delivery and monitoring of improvements in public health.

The outcomes framework proposes five domains: –

1. Health protection and resilience
2. Tackling the wider determinants of health
3. Health improvement
4. Prevention of ill health
5. Healthy life expectancy and preventable mortality

Each domain includes a proposed set of indicators to be supported by nationally collated and analysed data which will be published in a common format by Public Health England. This should include indicators that target different age groups, and target communities that experience differential outcomes in health.

The new framework for Public Health Outcomes will be in operation from April 2012.

b) *Healthy lives, healthy people; consultation on the funding and commissioning routes for public health* provides significant details to the proposals in the White Paper and is particularly concerned with funding and commissioning flows and

the responsibilities of different parts of the new public health system – Public Health England, local authorities and NHS commissioning board.

Key points are:

- that the public health services will be funded by a new public health budget separate from that managed through the NHS commissioning board for healthcare, to ensure that investment in public health is ring-fenced.

This new public health budget will be managed within the department of health by Public Health England which will fund public health activity through three principal routes;

- allocation to local authorities
- commissioning services via the NHSCB
- commissioning or providing services itself

The consultation document proposes detailed guidance on the commissioning route and responsibilities of Local Authorities, Public Health England and the NHS (see summary 3 page 3 onwards).

It should be noted that the DH is treating existing functions of local authorities as separate from the Public health ring-fence as they are already funded through the existing funding settlement.

Local authorities will be free to integrate management of these functions with their new public health responsibilities, should they wish. They will also be able to commission activity at a supra-local level, though there will be no government structure for this.

Health and Wellbeing Boards will provide a mechanism for bringing together discussions about investment and cross-cutting services including existing social care primary prevention.

Local Authorities will have a new statutory duty to take steps to improve the health of their population in addition to other related statutory functions and will receive a ring-fence grant in order to fund the activities carried out in the exercise of these functions.

The expectation is that the majority of services will be commissioned with an opportunity to support engagement of communities and to deliver best value and best results. It is also intended that local people have access to information about commissioning decisions and the outcomes that have been achieved.

From April 2013 Public Health England will allocate ring-fence budgets, weighted for inequalities, to upper-tier and unitary authorities and local government for improving the health and well being of local population.

There will be shadow allocations to LAs for this budget in 2012/13 and allocations will go live in 2013/14. During the transitional years 2011/12 and

2012/13 a need for the NHS to retain its emphasis on public health will be stressed.

The independent Advisory Committee on Resource Allocation (ACRA) will support the detailed development of the resource allocation to LAs and the creation of a formula that can be used to calculate each local authority's target allocation.

LAs will receive an incentive payment, or premium, depending on the progress made in improving the health of the local population and reducing health inequalities. The detailed model will be set out once the baseline and potential scale of the premium have been established, and there is an agreement about how the public health outcomes framework will be used. Partners will be consulted on the premium.

4. Consultation process

4.1 Consultation on the white paper itself closes on the 8th March 2011. Consultation on the Outcomes Framework and funding and commissioning routes closes on the 31st March 2011. As the two consultation documents fill in a substantial amount of the detail outlined in the white paper it is proposed that the consultation for all three documents be being taken together. The three attached summary documents (Appendix A) will form part of the consultation package.

4.2 A full programme of consultation will be circulated once arrangements are finalised.

5. Report Author

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On behalf of:

Deb Watson
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NHS Leicester City and Leicester City Council

Appendix A

NHS Leicester City and Leicester City Council
Healthy Lives, Healthy People Consultation Summary 1

Healthy Lives, Healthy People: Our Strategy for Public Health In England published on 30 November 2010. Consultation closes on 8 March 2011. The full document, which includes details of how to respond to the consultation, is available from
http://www.dh.gov.uk/en/Publichealth/Healthyliveshealthypeople/index.htm

Introduction

Healthy Lives, Healthy People: Our Strategy for Public Health In England sets out the Coalition Government's new approach to public health and some of the structures and processes that will support delivery. The vision is to protect the population "from serious health threats, helping people live longer, healthier and more fulfilling lives; and improving the health of the poorest fastest".

What the new approach will do

- Protect the population from health threats
- Empower local leadership and encourage wide responsibility across society to improve everyone's health and well being and tackle the wider factors that influence it
- Focus on key outcomes and doing what works to deliver them
- Provide transparency and accountability through a new public health outcomes framework
- Reflect the government's core values – freedom, fairness, responsibility by
    - strengthening self esteem, confidence and personal responsibility
    - positively promoting healthy lifestyles
    - adapting the environment to make healthier choices easier
- Balance the freedoms of individuals and organisations with a need to avoid harms to others, using the Nuffield Council on Bioethics 'ladder' or interventions;
- Be responsive, resourced, rigorous and resilient

Health and wellbeing throughout life

The key issues are set out as:

- Empowering local government and communities with new resources, rights and powers to shape their environments and tackle local problems.
- Taking a coherent approach to different life stages and key transition points instead of tackling individual risk factors in isolation.
- Emphasis on mental health
- Giving every child in every community the best start in life
    - Reducing child poverty
    - Increasing health visitor numbers
    - Doubling reach of Family Nurse Partnership programme
    - Refocusing Sure Start Children's Centres on those that need them most
    - Olympic style sports programme for schools from 2012
- Making it pay to work through comprehensive welfare reforms.
- Working with employers as champions of public health
- Designing communities for active age and sustainability
- Working collaborative with business and the voluntary sector through the public health Responsibility Deal. Five networks on:

- Food – less salt, better information for consumers
- Alcohol – more responsible retailing and consumption
- Physical activity
- Health at work
- Behaviour change – develop Change4Life, vouchers for healthy lifestyle choices

Approach

- Localism - with responsibilities, freedoms and funding devolved wherever possible;
- Directors of Public Health (DsPH) will be the strategic leaders for public health and health inequalities in local communities, working in partnership with the local NHS and across the public, private and voluntary sectors.
- A new, dedicated professional public health service – Public Health England – will be set up as part of the Department of Health to strengthen emergency preparedness and health protection
- There will be a ring-fenced public health funding for upper-tier and unitary local authorities (LA's) from within the overall NHS budget – currently estimated at £4 billion - and a new health premium to reward LA's for progress made against elements of proposed public health outcomes framework, taking into account local health inequalities.
- The best evidence and evaluation to be used, supporting innovative approaches to behavioural change. New NIHR School for Public Health Research to be established
- The Chief Medical Officer (CMO) will have a central role in providing independent advice to the secretary of state for health and the government
- Public health will be part of the NHS commissioning board's (NHSCB) mandate
- There will be stronger incentives for GPs so that they play an active role in public health

Structures

The Government plans to:

- Enable the creation of Public Health England (PHE) from 2012
- Transfer local health improvement functions to local government with ring-fenced funding allocated to local government from April 2013 and
- Give local government new functions to increase local accountability and support integration and partnership working across social care, the NHS and public health.
- Further consultation documents on outcomes framework, funding and commissioning arrangements for public health and specific areas of health improvement

Role of the Director of Public Health

- Principle adviser on all health matters to the local authority
- Key role in new function of LAs. Contribute to Joint Strategic Needs Assessment (JSNA), Joint Health and Wellbeing Strategy and produce authoritative independent Annual Report

- Ensure LA and partners have access to high quality analysis and evidence to inform JSNA, Annual Report, emergency preparedness and response, and all public health services for which responsible.
- Work closely with GP consortia to help identify, prevent and manage a range of conditions (e.g. mental ill health, CVD, diabetes and cancer)
- Input into the commissioning of services for people with established diseases and long term conditions
- Work with NHS colleagues locally in:
    - advising on commissioning and effective operation of population health services;
    - ensuring the provision of services for diverse and potentially excluded groups (for example, people with mental health problems and with learning disabilities; the homeless; people in prisons and ex-offenders; children with special educational needs or disability and looked after children; and travellers);
    - advising on how to ensure equal access and equity of outcome across the population; and
    - working with and supporting health and social care colleagues to increase opportunities for using contacts with the public and service users to influence behaviours positively and thereby improve health.
- Important role in emergency planning and response, supported by local Health Protection Units
- Contribute to Local Resilience Forum (LRF) and ensure sufficient trained Public Health staff to maintain on-call rota
- Responsible for health improvement and addressing health inequalities in health outcomes, and working in partnership locally and with Public Health England to achieve better public health outcomes for the whole of their local population.
- Jointly appointed by LA and PHE. Accountable to Secretary of State for Health and professionally to CMO.

Rod Moore
Deputy Director of Public Health
29 December 2010

NHS Leicester City and Leicester City Council
Healthy Lives, Healthy People Consultation Summary 2.

Healthy Lives, Healthy People: Transparency in outcomes published on 20th December 2010. Consultation closes on 31 March 2011. The full document, which includes details of how to respond to the consultation, is available from http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_122962

Introduction
This is part of a suit of three outcomes frameworks – NHS, Adult Social Care, and Public Health - and is intended to provide equivalent arrangements for the delivery and monitoring of improvements in public health.

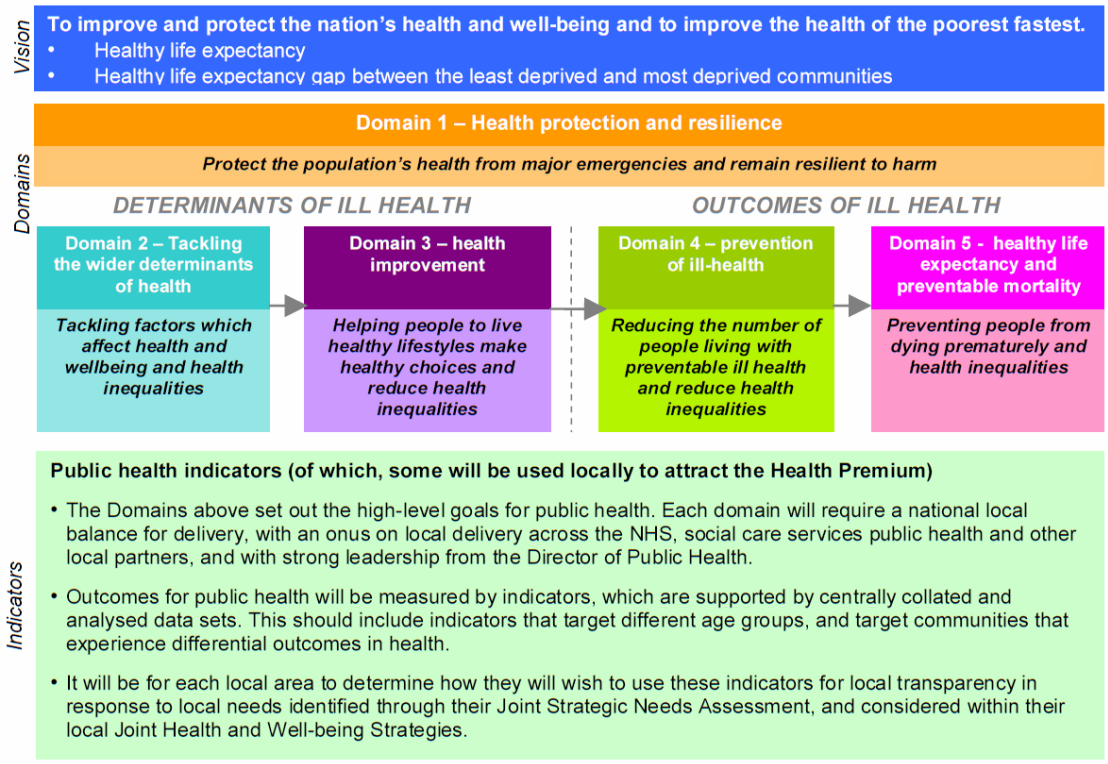
It sets out the government's *goals* in relation to health improvement and health inequalities and provides a *mechanism* for transparency and accountability across the public health system at the national and local level, and a means to incentivise local health improvement and inequality reduction through the "health premium".

The new framework for Public Health Outcomes will be in operation from April 2012.

Goals/domains
The outcomes framework (see figure 1 below) proposes five domains:
1. Health Protection and resilience
2. Tackling the wider determinants of health
3. Health Improvement
4. Prevention of ill health
5. Healthy life expectancy & preventable mortality

The framework also specifies responsibility for these domains (see Figure 2).

Figure 1 A framework for public health outcomes



The consultation document indicates:
- the strong case for domain 5, reducing rates of premature mortality, to be shared with the NHS;

- that local authorities and their partners must also seek to advance equalities, eliminate the impact of discrimination and narrow inequalities in health behaviours between communities;
- that further consideration will be given to whether outcomes relating to safeguarding and child protection should be included in the framework in the light of the national review of Child Protection to be completed in April 2011.

Indicators
Each domain includes a set of indicators (see figure 2) to be supported by nationally collated and analysed data which will be published in a common format by Public Health England. This should include indicators that target different age groups, and target communities that experience differential outcomes in health.

A small number of indicators will focus on health improvement relating to the causes of the greatest burdens of disease and death (e.g. obesity, smoking, alcohol and the level of physical activity). The remaining indicators will cover other domains of public health including health protection and preventative services, and reflect the wider determinants of health, to link in the different local services that play a part in delivering health and wellbeing and to hold national Government to account.

For a sub set of those indicators, to be agreed with public health and local government partners, a "health premium" will incentivise councils to make progress on health improvement priorities and reduce health inequalities.

Purposes
The framework is not intended as a performance management tool, rather the information:
- at the national level will allow partners and government to understand the key priorities for health and aid efforts to prioritise actions.
- at the local level will be interrogated as required and used to compare areas with others across the country, and where possible how performance is changing within areas, and lever improvements.
- it will be for each local area to determine how they will wish to use the final indicators for local transparency in response to local needs identified through the JSNA and in the Joint Health and Well Being Strategy developed by Health and Wellbeing Boards.
- the government will work to ensure that public health data can be disaggregated by key equality characteristics and neighbourhoods where possible
- will support local partners to work together where they share common outcome goals

Consultation
The consultation document includes questions and invites suggestions as to which indicators will finally be included in the outcomes framework and on the structure of the framework itself.

Figure 2 'Long list' of proposed indicators for each domain of the Public Health Outcomes Framework.
NB. Detailed definitions of the indicators are provided in the consultation document. Indicators marked in *italics* are to be developed.

VISION – To improve and protect the nation's health and wellbeing and to improve the health of the poorest, fastest.
- Healthy life expectancy

- Differences in life expectancy and healthy life expectancy between communities.
1. Health Protection and resilience
National coordination by Public Health England with contribution from LAs
- Comprehensive, agreed, inter-agency plans for a proportionate response to public health incidents are in place and assured to an agreed standard. These are audited and assured and are tested regularly to ensure effectiveness on a regular cycle. Systems failures identified through testing or through response to real incidents are identified and improvements implemented. - Systems in place to ensure effective and adequate surveillance of health protection risks and hazards. - Life years lost from air pollution as measured by fine particulate matter - Population vaccination coverage (for each of the national vaccination programmes across the life course) - Treatment completion rates for TB - Public sector organisations with a board approved sustainable development management plan.
2. Tackling the wider determinants of health
Health and Wellbeing Boards and “all public services”
- Children in poverty - School readiness: foundation stage profile attainment for children starting Key Stage 1 - Housing overcrowding rates - Rates of adolescents not in education, employment or training at 16 and 18 years of age - Truancy rate - First time entrants to the youth justice system - Proportion of people with mental illness *and or disability* in settled accommodation** - Proportion of people with mental illness *and or disability* in employment *, ** - Proportion of people in long-term unemployment - Employment of people with long-term conditions - Incidents of domestic abuse** - Statutory homeless households - Fuel poverty - Access and utilisation of green space - Killed and seriously injured casualties on England's roads - The percentage of the population affected by environmental, neighbour, and neighbourhood noise - Older people's perception of community safety** - Rates of violent crime, including sexual violence - Reduction in proven reoffending - *Social connectedness* - *Cycling participation* **Shared responsibility with the NHS* *** Shared responsibility with Adult Social Care*
3. Health Improvement
Local Government led by DsPH in partnership with Health and Wellbeing Boards
- Prevalence of healthy weight in 4-5 and 10-11 year olds - *Prevalence of healthy weight in adults* - Smoking prevalence in adults (over 18) - Rate of hospital admissions per 100,000 for alcohol related harm - Percentage of adults meeting the recommended guidelines on physical activity (5 x 30 minutes per week) - Hospital admissions caused by unintentional and deliberate injuries to 5-18 year

olds - Number leaving drug treatment free of drug(s) of dependence - Under 18 conception rate - Rate of dental caries in children aged 5 years (decayed, missing or filled teeth) - *Self reported wellbeing*
4. Prevention of ill health
Health and Wellbeing Boards – public health, NHS, adult social care, children's services
- Hospital admissions caused by unintentional and deliberate injuries to under 5 year olds. - Rate of hospital admissions as a result of self-harm - Incidence of low-birth weight of term babies - Breastfeeding initiation and prevalence at 6-8 weeks after birth - Prevalence of recorded diabetes - Work sickness absence rate - Screening uptake (of national screening programmes) - Chlamydia diagnosis rates per 100,000 young adults aged 15-24 - Proportion of persons presenting with HIV at a late stage of infection - *Child development at 2 - 2.5 years* - Maternal smoking prevalence (including during pregnancy) - Smoking rate of people with serious mental illness - Emergency readmissions to hospitals within 28 days of discharge*, ** - Health-related quality of life for older people** - Acute admissions as a result of falls or fall injuries for over 65s** - *Take up of the NHS Health Check programme by those eligible* - *Patients with cancer diagnosed at stage 1 and 2 as a proportion of cancers diagnosed* **Shared responsibility with the NHS* *** Shared responsibility with Adult Social Care*
5. Healthy life expectancy & preventable mortality
Health and Wellbeing Boards –shared by NHS, public health, care services and Public Health England locally
- Infant mortality rate* - Suicide rate - Mortality rate from communicable diseases - Mortality rate from all cardiovascular disease (including heart disease and stroke) in persons less than 75 years of age* - Mortality rate from cancer in persons less than 75 years of age* - Mortality rate from Chronic Liver Disease in persons less than 75 years of age* - Mortality rate from chronic respiratory diseases in persons less than 75 years of age* - Mortality rate of people with mental illness* - Excess seasonal mortality **Shared responsibility with the NHS*

Rod Moore
Deputy Director of Public Health and Health Improvement
29 December 2010

NHS Leicester City and Leicester City Council
Healthy Lives, Healthy People Consultation Summary 3.

Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health. Published on 20[1st] December 2010. Consultation closes on 31 March 2011. The full document, which includes details of how to respond to the consultation, is available from
http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_122916

NB: additional headings have been introduced in this summary to help organise the material. Page references to the consultation document are provided.

Introduction

This consultation document provides significant detail to the proposals outlined in Healthy Lives, Healthy People: Our Strategy for Public Health In England which set out the Government's new approach to public health and some of the structures and processes that will support delivery.

Funding and commissioning flows (page 7)

Public Health services will be funded by a new public health budget separate from that managed through the NHS Commissioning Board (NHSCB) for healthcare, to ensure that investment in public health is ring fenced.

Public Health England (PHE) will fund public health activity through three principal routes:

- allocations to local authorities (LAs);
- commissioning services via the NHSCB;
- commissioning or providing services itself.

Decisions as to how services would be best commissioned will determine how much funding flows through different parts of the system. The majority of the public health budget will be spent on local services either commissioned by the NHSCB acting on behalf of PHE, or led by LAs through a ring fenced grant.

For funding purposes, the DH is treating existing functions of LAs as separate from the public health ring-fence, as they are already funded through the existing funding settlement e.g. local authority health protection activity. LAs will be free to integrate management of these functions with their new public health responsibilities, should they wish. Health and Well Being Boards will provide a mechanism for bringing together discussions about investment and cross-cutting services including existing social care primary prevention.

Local authorities (p8)

LAs will:

- have a new statutory duty to take steps to improve the health of their population in addition to other related statutory functions;
- receive a ring fenced grant in order to fund the activities carried out in the exercise of these functions;

The DH expects that:

- the majority of services will be commissioned, as an opportunity to engage local communities and deliver best value and best results;
- local people will have access to information about commissioning decisions and the outcomes that have been achieved.

LAs and GP consortia will each have an equal and explicit obligation to prepare the Joint Strategic Needs Assessment (JSNA), and to do so through the Health & Wellbeing Board.

Health & Wellbeing Boards should develop a high level Joint Health and Well Being Strategy that spans the NHS, social care, public health (and could potential consider wider health determinants such as housing, or education) to provide the overarching framework within which commissioning plans for the NHS, social care, public health and other services are developed.

The government will place a duty on commissioners to have regard to the JSNA and the joint health and well being strategy when exercising their functions.

These freedoms and the new ring-fenced budgets open up opportunities for local government to take innovative approaches to public health involving new partners including:

- Contracting for services with a wide range of providers;
- Incentivising and rewarding those organisations for improving health and well being outcomes and tackling inequalities;
- Voluntary, community and social enterprise sector organisations;
- Sharing expertise, and wider initiatives such as the Big Society Bank;
- Local communities to support preventative community focussed activities - such as volunteering, peer support , befriending and social networks;
- Generally LAs should be commissioning on an any willing provider/competitive tender basis.

National level (p10)
Where necessary PHE will commission and/or provide services, such as national campaigns and directly provide some activity which will be exercised locally e.g. health protection units.

Sub National or Supra-local commissioning arrangements (p10)
There will be no formal structures for sub national commissioning. Where necessary these could be established as part of PHE, or by LAs choosing to adopt supra–local arrangements for commissioning activities for which they are responsible, through, e.g., one LA leading on behalf of others.

Public health funded services commissioned via the NHS (p11)
PHE may ask the NHS to take responsibility for commissioning public health interventions and services funded from the public health budget e.g. screening programmes. This will be mediated via relationship between PHE and the NHSCB.

Where the NHS takes responsibility for commissioning public health interventions, the NHS commissioning architecture will determine how it does so appropriately – usually via GP consortia. However, it will be possible for PHE to influence how services are commissioned in certain instances e.g. childhood immunisation and cervical screening tests.

NHS funded and commissioned services (p11)
Public health work should remain an integral part of the services provided in primary care, and will continue to be funded from within the overall resources used by the NHSCB to commission these services. This includes public health activity carried out by GP practices, dentists, and community pharmacists.

Public health expertise will inform the commissioning of NHS funded services, facilitating integrated pathways of care for patients.

DsPH are able to advise GP consortia on public health issues and nationally via the relationship between the secretary of state/PHE and the NHSCB.

Ensuring flexibility on commissioning services (p12)
Where commissioning arrangements are providing an inadequate service, PHE will be able to change the funding and commissioning route, subject to contractual or other constraints.

GP practices are currently the preferred provider for a range of public health services under the GP contract e.g. childhood immunisations, contraceptive services, cervical cancer screening and child health surveillance. There may be a case for PHE and LAs in the future to have greater flexibility to choose how such services are commissioned, as circumstances change or if services can be better delivered another way.

Defining commissioning responsibilities (pp13-15)

The consultation document details the activities that will be funded by the public health budget, the proposed primary commissioning route and the associated NHS-funded activities.

LAs should be the lead commissioner for:
- Weighing and measuring children
- Dental public health
- Fluoridation
- Medical inspection of school children

The Secretary of State for Health should be the primary commissioner for:
- Former functions of the health protection agency
- Standardisation and control of biological medicines
- Radiation, chemical and environmental hazards
- National immunisation and screening programmes: and
- Emergency preparedness (in so far as it is done nationally)

Functions of the Current Health Protection Agency (p20)
PHE will take responsibility for functions of the current Health Protection Agency, including:
- Surveillance
- Public Health and Reference microbiology
- Leadership to co-ordinate outbreak investigation and contact tracing
- Public Health advice on infection prevention to the whole health and social care system

The NHS will remain responsible for funding and commissioning infectious disease treatment and related public health activity.

Table A (attached) details the activities that will be funded by the public health budget, the primary commissioning route, and NHS associated activities. The section below expands on this table.

Further detail on the commissioning of specific public health activity

In general, health improvement work will be led by LAs using funds from the ring-fenced public health budget.

Services the Consultation proposes LAs should lead on, will not be commissioned by PHE at a national level, or commissioned by the NHS using public health funds.

Immunisation (p20)
PHE will be responsible for the National Immunisation Schedule and setting standards as advised by the Joint Committee on Vaccination and Immunisation and will fund the delivery of immunisation programmes through LAs and the NHSCB.

LAs should be responsible for commissioning immunisation programmes primarily delivered through schools, such as HPV and the Teenage Booster from a range of providers.

PHE will transfer funds from the Public Health budget to the NHSCB to allow them to commission the remaining immunisation programmes – including the childhood, seasonal flu and pneumococcal vaccination programmes.

The NHSCB will be responsible for commissioning a service for the whole population. Where GPs are not preferred providers, or where individual GPs opt out or are decommissioned from providing a service, the NHSCB will commission alternative providers as appropriate e.g. community pharmacists.

The NHS will continue to commission targeted neonatal hepatitis B and BCG vaccination provision, funded by PHE.

Screening (p21)
PHE will be responsible for funding all national screening programmes. The NHSCB will commission established programmes on behalf of PHE with funding transferred for that purpose.

Sexual Health (p21)
LAs will be responsible for commissioning comprehensive open-access sexual health services using funds from the ring-fenced public health budget, including:

- testing and treatment of STIs, (including opportunistic Chlamydia testing)
- high quality partner notification activity
- working with GP practices to encourage opportunistic testing and treatment of STIs in primary care
- fully integrated termination of pregnancy services (services that also offer the full range of contraception, STI testing and, where appropriate, treatment

PHE will fund the commissioning by the NHSCB of contraceptive provision through primary care commissioning arrangements. LAs will fund and commission contraceptive services (including through community pharmacies) for patients who do not wish to go to their GP or who have more complex needs.

PHE will work with the NHSCB to provide more specialised commissioning for human immunodeficiency virus (HIV) treatment and care, where efficiencies can be made.

Tobacco contact, obesity, physical activity and nutrition (p22)

LAs will be responsible for smoking cessation services and other local tobacco control activities, including commissioning or providing STOP smoking services, prevention activities, enforcement and local communication.

Obesity and physical activity programmes, including encouraging active travel, will also become the responsibility of the LAs as will the National Child Measurement Programme at the local level, with PHE co-ordinating the programme at the national level.

Any local initiative relating to nutrition will be commissioned or undertaken by LAs. However, PHE will be responsible for running national nutrition programmes, such as Healthy Start.

The LAs should have responsibility for workplace health at a local level.

Alcohol and drug misuse (p22)
LAs will be responsible for commissioning treatment, harm reduction and prevention services for the local population, providing an opportunity to more comprehensively join up the commissioning of drug and alcohol interventions and recovery services locally. This will be supported by PHE which will provide evidence and effectiveness, guidance and comparative analysis to support local areas in the task.

The NHS Health Check Programme (p22)
LAs will commission the NHS Health Check Programme with PHE responsible for design, piloting and role out of any extension of the programme.

Early presentation and diagnosis (p23)
PHE will be responsible for designing and funding initiatives to promote early presentation and diagnosis e.g. national bowel symptom campaign. LAs may also choose to commission such initiatives from the local ring-fenced budget

Reducing birth defects (p23)
PHE will be responsible for the surveillance of birth defects and anomaly registers.

PHE will lead on the co-ordination of oral health surveys.

Dental Public Health (p23)
LAs will lead on providing local dental public health advice to the NHS, as well as commissioning community oral health programmes.

Contracts for existing (and any new) fluoridation schemes will become the responsibility of PHE.

Consultations on proposals for new schemes will be conducted by LAs using a majority rule where a scheme covers more than one local authority area.

Public mental health (p23)
LAs will take on responsibility for funding and commissioning mental wellbeing promotion, anti-stigma and discrimination and suicide and self-harm prevention public health activities.

Treatment of mental ill health, including improving access to psychological therapies e.g. (IAPT) will be funded and commissioned by the NHS. Health and Wellbeing Boards will need to ensure appropriate integration.

Emergency preparedness and response (p24)
PHE will be responsible for emergency preparedness and response relating to public health emergencies and for working together with the NHS to offer support and technical expertise to manage incidents which impact upon both public health and NHS areas of responsibility.

The NHSCB will be responsible for mobilising the system in times of emergency in ensuring the resilience for preparedness of the NHS to respond to emergency situations.

Most incidents will be managed locally with the public health response being led by the Director of Public Health and PHE Health Protection Units, as part of multi-agency local response arrangements.

Public Health information and intelligence (p24)
PHE will be responsible for information and intelligence for public health (including surveillance), taking on the existing functions of Public Health Observatories, specialist observatories and cancer registries, alongside relevant current function of the HPA. This will include:

- collecting and managing data
- analysing, evaluate and interpret data to assess needs, set priorities and forecast future requirements, focusing effort on public health and wellbeing outcomes and inequality reductions supporting the specific requirements of LAs
- Identify interventions which are most cost effective and linked to improved health outcomes.
- modelling the potential impact of particular interventions for different groups and communities where possible and providing economic assessments of costs and benefits in specific settings.
- The public health budget will support information and functions at a national level that will provide the basis for effective DsPH Annual Reports and Joint Strategic Needs Assessment, for example the Public Health Compendium.
- Establishing an accessible and authoritative web based evidence system for public health professionals;
- Sharing good practice using the Chief Medical Officer's Public Health Awards.
- LAs will require a core of information and evidence capacity to support DsPH, although large scale analysis will be done once at a national level.
- Communicating with the public will be a priority for LAs, providing people and communities within their areas with the knowledge and understanding they need to challenge their local health system.
- Equivalent standards will be set for social care and public health services to those in the NHS for management and use of data relating to care. Where data is collected from the NHS (consortia and providers) for public health purposes, whether by PHE or by LAs or their agents, this will need to conform to those information standards set by the NHSCB.

Children's Public Health (p25)
Public health services for children under 5 years will be a responsibility of PHE, which will fund the delivery of health visiting services, including healthy child programme for under 5's, health promotion and prevention interventions by the multi-professional team and the Family Nurse Partnership. The need for local areas to consider how they join up with Sure Start Children's Centres is recognised.

In the first instance, these services will be commissioned on behalf of PHE via the NHSCB. In the longer term, it is expected that health visiting will be commissioned

locally. The Department will be publishing shortly an implementation plan for a larger, reenergised health visiting service.

NHS partners will need to help to focus on child protection and the early intervention end of supporting families through local Safe Guarding Children's Board.

LAs will commission from the ring-fenced public health budget services for children aged 5 – 19, including public mental health for children. The healthy child programme 5 – 19, health promotion and prevention interventions by the multi-professional team and the school nursing services.

LAs may wish to encourage active travel for children and the needs of vulnerable groups.

Community safety, violence prevention and social exclusion (p26)
Using their ring-fenced public health budget when they decide it is appropriate, LAs will be responsible for working in partnership to tackle issues such as social exclusion, including intensive family interventions, social isolation amongst older people, community safety, including road safety awareness and violence prevention and response. This could include super-local commissioning of services such as sexual assault referral centres, or female genital mutilation (FGM clinics) where appropriate.

Public health for those in prison or custody (p26)
Where public health services are delivered in prison or for those in custody, these will be funded by PHE but commissioned by the NHSCB as part of an integrated service.

Armed forces public health_(p26)
Public health activity for the armed forces will not be funded from the national public health budget.

Quality and outcomes framework (p26)
In order to increase the incentives for GP practices to improve the health of their patients, the department proposes that a sum at least equivalent to 15% of the current value of the QOF should be devoted to evidence-based public health and primary prevention indicators. Information on achievement by practices will be available publicly, supporting people to choose their GP practice based on performance and enabling communities to hold the local NHS to account.

The funding for this will be held within the public health budget. On a cash neutral basis by replacing indicators that are less effective with indicators that will have a greater impact on improving patients health and preventing disease.

From 2013 PHE will decide on the level of investment in QOF public health primary prevention indicators, based on priorities for improving people's health and reducing inequalities.

A requirement to provide certain services? (p27)

The consultation acknowledge that some Public Health services for which LAs will take responsibility will need to be provided in a universal fashion in all areas e.g. immunisation programmes, open-access sexual health services.

Secondary legislation could set out that local authorities should be mandated to provide or commission a particular service.

The Department of Health will ensure that the supply of medicines is fully considered and arrangements made for funding and commissioning of services in the new system.

Health and Well Being Boards will have responsibility for producing pharmaceutical needs assessments which will inform the commissioning of community pharmacy services by the NHSCB and local public health commissioning decisions.

Funding and accountability

Baseline spend (p28)

Based on the commissioning responsibilities in table A early estimates suggests that the current spend in the region of £4 billion in England. This includes the spend by DH, SHAs arm's length bodies and PCTs. There will be further validation and triangulation process to better inform the national estimate of spend.

Ring-fenced grant to LAs will be of an appropriate size and where provision of a service is mandatory, and would become a statutory function of LAs, this will be supported by a transfer of the necessary resources.

Estimate of cost is subject to further significant revision, including responses to this consultation.

Accountability (p28)

The Secretary of State for Health remains accountable for resources allocated to the health and social care system as a whole, for strategy and the legislative and policy framework and for progress against national outcomes.

As part of the Department of Health, PHE will be accountable to the Secretary of State for Health. For services commissioned by PHE from the NHS there will need to clear accountability lines for example through a service level agreement.

The primary accountability for local government will be to their local populations –

- Through transparency – PHE will publish data on national and local performance against the public health outcomes framework
- Through the Health and Well Being Board which will provide a forum in which elective representatives, DsPH, children and adult services, GP consortia, the NHSCB where necessary , Health Watch and potentially local community and voluntary organisations can come together to coordinate commissioning of NHS, social care and public health services.
- Through new statutory functions. The secretary of state for health will place some health protection duties on LAs or through secondary legislation specify services which all LAs should provide. This would mean that LAs would take on a broader public health role than merely health improvement, backed by the appropriate resources.
- to PHE through transparency of progress against the outcomes framework and for the proper use of the ring-fenced grant.

To ensure transparency, specific data and information about health and care services and outcomes will need to be made available in order to support PHE and local government to assess the impact of public health interventions and actions.

Public health grants to LAs will be made under section 30 under the local government act 2003 and as a ring-fence grant will carry some conditions about how it is to be used.

LAs and DsPH will have the freedom to pool and align budgets locally as part of a local application of community (place-based) budgets. Where this is the best route to improving health and well being outcomes for the local people, and to support preventative public health work to benefit the local area. LAs may also want to consider pooling funding across local authority areas.

The health premium will provide an incentive to better performance providing a formula and results based payment to incentivise action to reduce health inequalities. It will be for LAs to determine their priorities in this regard.

Directors of public health will be jointly appointed by the local authority and PHE. LAs will have the power to dismiss DSPH for serious failings across the full spectrum of the responsibilities, the secretary of state for health will have the power to dismiss them for serious failings in discharge of their health protection functions. Alongside this, there will be a line of professional accountability from DsPH to the Chief Medical Officer.

Allocations (p32)

From April 2013 PHE will allocate ring-fence budgets, weighted for inequalities, to upper-tier and unitary authorities and local government for improving the health and well being of local population.

There will be shadow allocations to LAs for this budget in 2012/13 and allocations will go live in 2013/14. During the transitional years 2011/12 and 2012/13 a need for the NHS to retain its emphasis on public health will be stressed.

The independent Advisory Committee on Resource Allocation (ACRA) will support the detailed development resource allocation to LAs and the creation of a formula that can be used to calculate each local authority's target allocation.

The consultation identifies three general approaches to establishing a formula –

- "Utilization" based on model and statistical relation between current patterns of public health activity and need across the country;
- "Cost effectiveness" based on potential gains in health and outcomes using available information about the cost effectiveness of public health interventions;
- "Population health measures" based on measures of health outcomes, such as standardised mortality ratios, or disability-free life expectancy. Allocations will be higher to areas with poorer health taking into account health inequalities. These measures will link to the outcomes framework.

Depending on the final public health scope of the LAs, the allocation could include a number of components, taking different approaches. But these would be combined to form a single grant within which LAs would be free to prioritise spending in a way that is appropriate to their local circumstances.

A pace-of-change policy would apply as the government may not be able to set LAs actual allocations immediately at the target allocation, and would move toward this over a period of time.

Health premium (p34)

LAs will receive an incentive payment, or premium, depending on the progress made in improving the health of the local population and reducing health inequalities. The Health Premium will:

- be simple and driven by a formula developed with key partners, representative of local government , public health experts and academics;
- based on elements of the public health outcomes framework;
- be greater for disadvantaged areas if they make progress;
- aim to balance responsiveness to local action with incentivising interventions offering greater long term benefits;
- be comprehensive enough not to distort local decisions and needs to incentivise health improvements that will spread across a local authority's population such that inequalities are reduced as overall health improves;
- be a sliding scale depending on the size and extent of the local authority's progress and relative to the authority's position in terms of relative health outcomes;
- will not be a target regime dictated by central Government. The view is that the combination of a national framework, financial incentives, local freedom of how outcomes will be achieved and greater transparency will be far more effective and energising empowering local services delivered of their best, rather than having to work to prescriptive targets for which they have little or no ownership.

The DH aims to pay LAs for the progress they make and to ensure that they do not automatically receive additional funding if the health of the local population deteriorates. Nor should they be punished by seeing their funding reduced if they are successful in improving the health of the nation. Potentially, an area that makes no progress might receive no growth in funding for these services, but, other than losing the opportunity of the incentive payment, which would be a legitimate local decision, there would be no automatic financial detriment to not making progress on the indica tors.

It is intended that LAs share of funding for non-discretionary services, where the health premium will not apply, will grow in line with the estimated relative need of the population.

The detailed model will be set out once the baseline and potential scale of the premium have been established, and there is an agreement about how the public health outcomes framework will be used (separate consultation). Partners will be consulted on the premium.

Rod Moore
Deputy Director of Public Health and Health Improvement
30 December 2010

Table A – Public health funded activity

	Proposed activity to be funded from the new public health budget (provided across all sectors including NHS)	**Proposed commissioning route/s for this activity (including direct provision in some cases)**	**Examples of proposed associated activity to be funded by the NHS budget (including from all providers)**
Infectious disease	Current functions of the Health Protection Activity in this area, and public health oversight of prevention and control, including co-ordination of outbreak management	Public Health England with supporting role for local authorities	Treatment of infectious disease (see sexual health below) Co-operation with Public Health England on outbreak control and related activity
Sexual Health	Contraception, testing and treatment of sexually transmitted infections, fully integrated termination of pregnancy services, all outreach and prevention	Local authority to commission all sexual health services apart from contraceptive services commissioned by the NHS Commissioning Board (via GP contract)	HIV treatment and promotion of opportunistic testing and treatment
Immunisation against infectious disease	Universal immunisation programmes and targeted neonatal immunisations	Vaccine programmes for children, and flu and pneumococcal vaccines for older people, via NHS Commissioning Board (including via GP contract) Targeted neonatal immunisations via NHS Local authority to commission school programmes such as HPV and teenage booster	Vaccines given for clinical need following referral or opportunistically by GPs
Standardisation and control of biological medicines	Current functions of the HPA in this area	Public Health England	-
Radiation, chemical and environmental hazards, including the public health impact of climate change	Current functions of the HPA in this area, and public health oversight of prevention and control, including co-ordination of outbreak management	Public Health England supported by local authorities	-
Seasonal mortality	Local initiatives to reduce excess deaths	Local authority	-

All screening	Public Health England will design, and provide the quality assurance and monitoring for all screening programmes	NHS Commissioning Board (cervical screening is included in GP contract)		-
Accidental injury prevention	Local initiatives such as falls prevention services	Local authority		-
Public mental health	Mental health promotion, mental illness prevention and suicide prevention	Local authority		Treatment for mental ill health
Nutrition	Running national nutrition programmes including Healthy Start Any locally-led initiatives	Public Health England some local authority activity		Nutrition as part of treatment services, dietary advice in a healthcare setting, and brief interventions in primary care
Physical activity	Local programmes to address inactivity and other interventions to promote physical activity, such as improving the built environment and maximising the physical activity opportunities offered by the natural environment	Local authority		Provision of brief advice during a primary care consultation e.g. Lets Get Moving
Obesity programmes	Local programmes to prevent and address obesity, e.g. delivering the National Child Measurement Programme and commissioning of weight management services	Local authority		NHS treatment of overweight and obese patients, e.g. provision of brief advice during a primary care consultation, dietary advice in a healthcare setting, or bariatric surgery
Drug misuse	Drug misuse services, prevention and treatment	Local authority		Brief interventions
Alcohol misuse	Alcohol misuse services, prevention and treatment	Local authority		Alcohol health workers in a variety of healthcare settings
Tobacco control	Tobacco control local activity, including stop smoking services, prevention activity, enforcement and communications	Local authority		Brief interventions in primary care, secondary, dental and maternity care
NHS Health Check Programme	Assessment and lifestyle interventions	Local authority		NHS treatment following NHS Health Check assessments and ongoing risk management
Health at work	Any local initiatives on workplace health	Local authority		NHS occupational health
Reducing and preventing	Population level interventions to reduce	Local authority and Public Health		Interventions in primary care such as

birth defects	and prevent birth defects	England	pre-pregnancy counselling or smoking cessation programmes and secondary care services such as specialist genetic services
Prevention and early presentation	Behavioural/ lifestyle campaigns/ services to prevent cancer, long term conditions, campaigns to prompt early diagnosis via awareness of symptoms	Local authority	Integral part of cancer services, outpatient services and primary care. Majority of work to promote early diagnosis in primary care
Dental public health	Epidemiology, and oral health promotion (including fluoridation)	Local authority supported by Public Health England in terms of the co-ordination of surveys	All dental contracts
Emergency preparedness and response and pandemic influenza preparedness	Emergency preparedness including pandemic influenza preparedness and the current functions of the HPA in this area	Public Health England, supported by local authorities	Emergency planning and resilience remains part of core business for the NHS NHS Commissioning Board will have the responsibility for mobilising the NHS in the event of an emergency
Health intelligence and information	Health improvement and protection intelligence and information, including: data collection and management; analysing, evaluating and interpreting data; modelling; and using and communicating data. This includes many existing functions of the Public Health Observatories, Cancer Registries and the Health Protection Agency	Public Health England and local authority	NHS data collection and information reporting systems (for example, Secondary Uses Service)
Children's public health for under 5s	Health Visiting Services including leadership and delivery of the Healthy Child Programme for under 5s, prevention interventions by the multiprofessional team, and the Family Nurse Partnership	NHS Commissioning Board	All treatment services for children (other than those listed above as public health-funded)
Children's public health 5-19	The Healthy Child Programme for school-age children, including school nurses and including health promotion and prevention interventions by the multiprofessional team	Local authority	All treatment services for children (other than those listed above as public health funded, e.g. sexual health services or alcohol misuse)

Community safety and violence prevention and response	Specialist domestic violence services in hospital settings, and voluntary and community sector organisations that provide counselling and support services for victims of violence including sexual violence, and non-confidential information sharing activity	Local authority	Non-confidential information sharing
Social exclusion	Support for families with multiple problems, such as intensive family interventions	Local authority	Responsibility for ensuring that socially excluded groups have good access to healthcare
Public health care for those in prison or custody	e.g. All of the above	NHS Commissioning Board	Prison healthcare

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Appendix F

Health Scrutiny Work Programme 2010-11

February – March 2011

SUBJECT	PRESENTED BY:	DATE FOR	THEME / COMMENTS
Annual Health Check (Vital Signs) NHS & Leicester City - 2009/10 Performance Indicators	Sarah Cooke NHS Leicester City	February 2011	This was postponed from December meeting to review progress against key Performance Indicators (PI's) set the previous year
Results of the Life Style Survey	Rod Moore Deputy Director of Public Health & Health Improvement	February 2011	Deb Watson asked to bring this before HSC to disseminate the results of the survey to Members
NHS Dentistry Update	Aylene Holliland NHS Leicester City	February 2011	This item was deferred from December 2010
The Future of Public Health	Rod Moore Deputy Director of Public Health & Health Improvement	February 2011	Under the new Health White paper, PCTs are to be abolished, GPs responsible for commissioning and LAs responsible for narrowing health inequalities / public health issues – how does LCC intend to respond to this?
Focus on Health Inequalities (2) Annual Report of the Director of Public Health *(Health Inequalities Audit 2009 – R8)*	Deb Watson Director of Public Health & Health Improvement	March 2011	Focus on revised analysis of health inequalities in Leicester including use of the following shared data - Typology analysis - Leicester lifestyle survey 2010 results This should form the basis of consideration of the <u>impact</u> of inequalities for this committee and relates to the presentation received in October 2010
Joint Commissioning / Personalisation Agenda	Kim Curry Strategic Director - Adults & Communities	March 2011	Deferred from August 2010 due to the release of the new Health White Paper in July 2010

Health Scrutiny Task Group Topic(s)

SUBJECT	ISSUES RAISED	START & COMPLETION DATE	COMMENTS
Adult Mental Health Services	A review of how adult mental health services mare delivered across the City taking into account the experiences of the following groups	Feb - Dec 2010	Child and Adolescent Mental Health Services to be excluded from this review
Women's Health Issues	MSO to carry out desk top research into health issues affecting women in the city to gain an understanding of how services are currently being delivered	On-going	This was requested by Councillor Sood (Deputy Chair)

Health Scrutiny Work Programme 2010-11

Areas of Future Interest / Requiring a Watching Brief

SUBJECT	ISSUES RAISED	START & COMPLETION DATE	COMMENTS
Andrew Lansley's Health White Paper	Re-configuring of NHS services – potential abolition of SHAs / PCTs	July 2010 onwards	Watching brief at the moment
Public Health White paper	Focuses on the role & responsibilities of Local Authorities and the tackling of health inequalities	December onwards	

Topics Completed in 2010/11

- Presentation by the Cabinet Member for Health & Community (LCC) — Feb 2010
- Update on Swine Flu (LPT) — Feb 2010
- Smear Testing + Detection for Cervical Cancer (LPT) — Feb 2010

- Introduction to GP Balanced Scorecards (PCT) — Apr 2010
- Leicester LinK (LCC) — Apr 2010
- New Management Arrangements for Leicester City PCT — Apr 2010
- LIFT Project Update (PCT) — Apr 2010

- Presentation by the Cabinet Member for Health & Community (LCC) — Jun 2010
- Public & Patient Involvement (LINk) — Jun 2010
- Healthy Lifestyles (LCC) — Jun 2010

- Alcohol-Related Harm Strategy (LCC) — Aug 2010
- Consolidation of Community Nursing Clinic Provision (PCT) — Aug 2010
- Presentation from the Cabinet Member for Environment (LCC) — Aug 2010

- Medical Practice Closures (PCT) — Oct 2010
- Intermediate Care (UHL) — Oct 2010
- Focus on Health Inequalities – Part 1 (LCC) — Oct 2010

- GP Balanced Scorecards (PCT) — Dec 2010

Special HSC Meetings / Workshops

- Tim Rideout – an overview of the Health White Paper — Aug 2010
- Professor Mandy Ashton - GP Commission / Govt Health Agenda for LA's — Jan / Feb 2011