Appendix 1.

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.

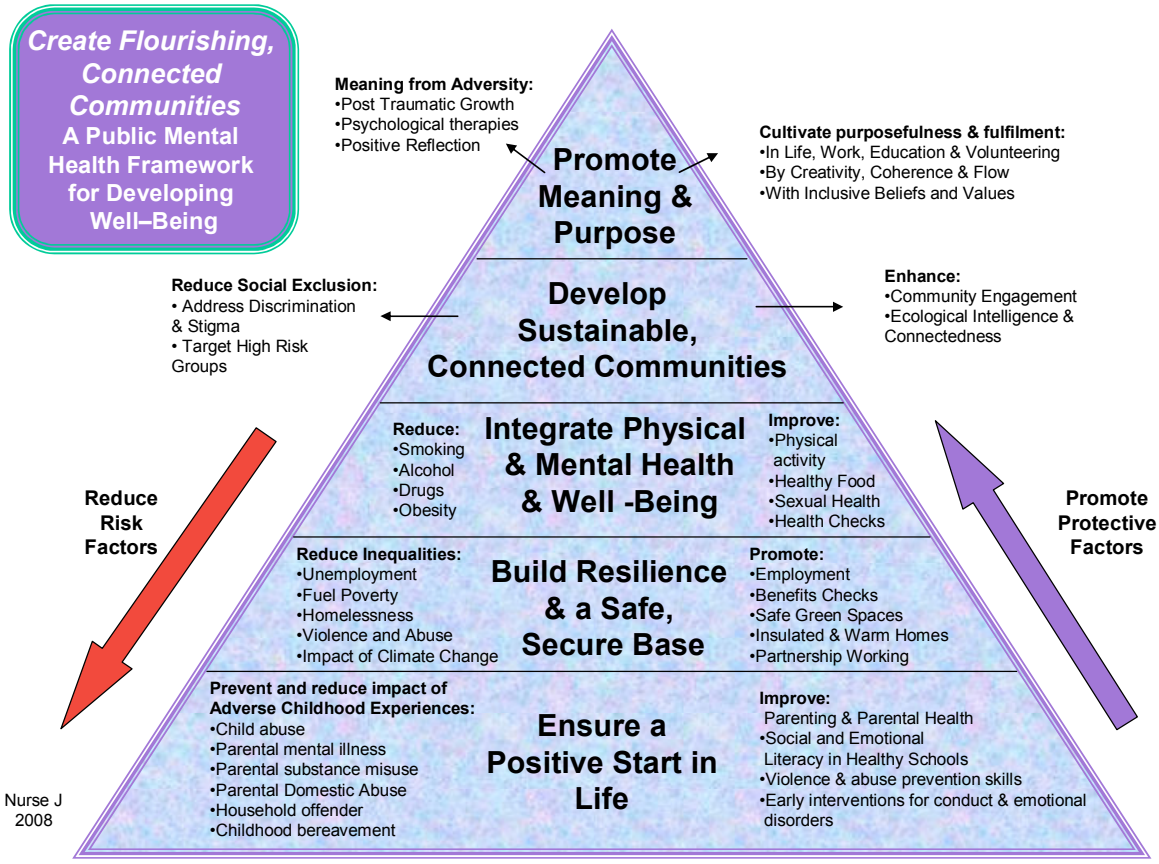
This plan will set out:

- 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

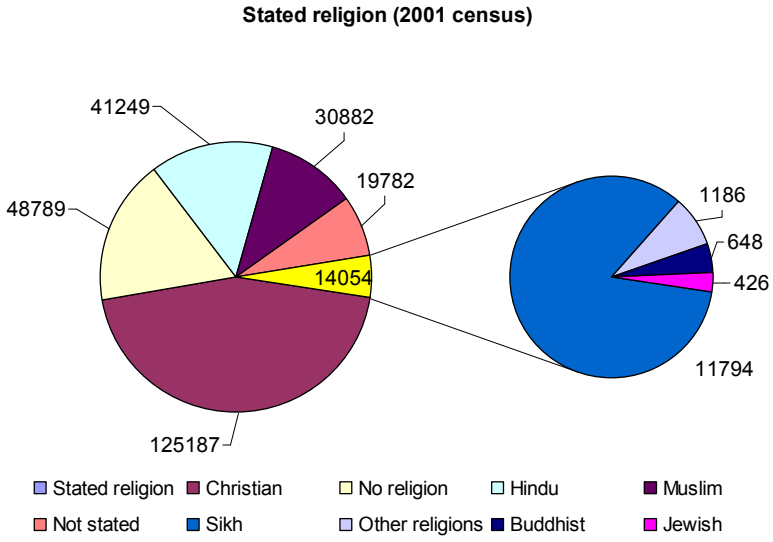
that people from BME communities are particularly dissatisfied with the mental health services they receive, they are over-represented in compulsory detention under the *1983 Mental Health Act*, are overrepresented in incidents of violence, restraint and seclusion in psychiatric inpatient settings, and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

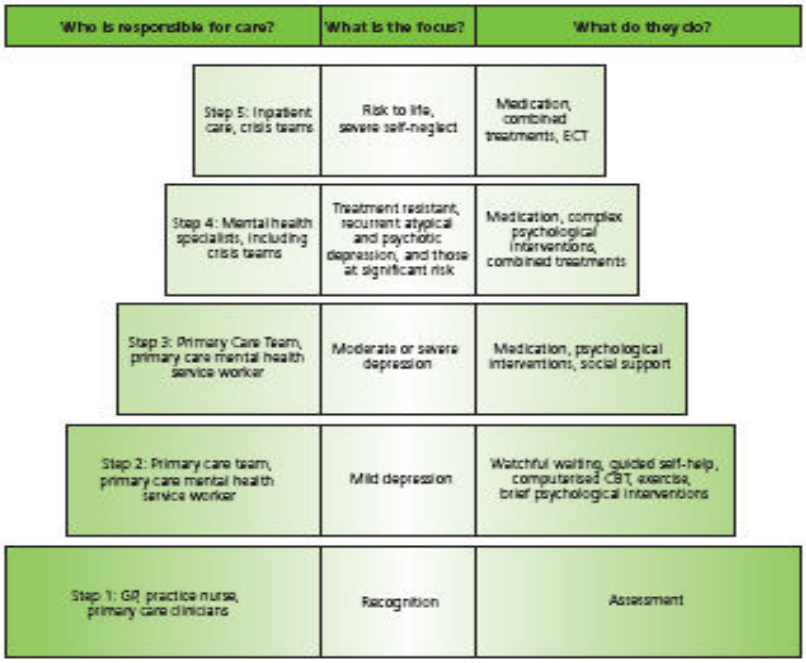
The broad approach to the delivery of mental health services is based on the Recovery Model, underpinned by the development of personalised services based on self directed care, including self assessment and supported self assessments, personal budgets and personalised services. This needs to be aligned 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

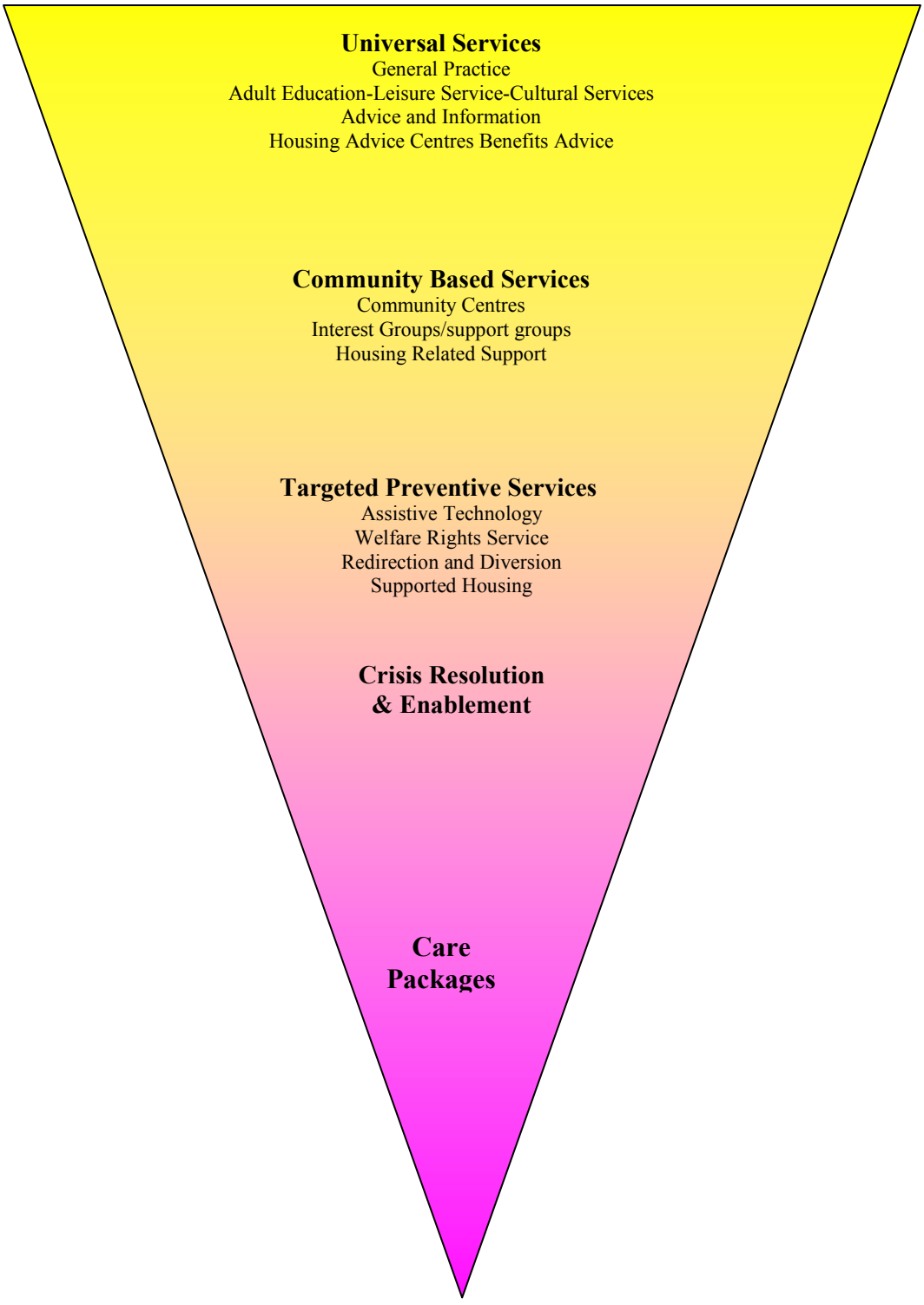
The recovery model aims to help people with mental health problems to move beyond mere survival and existence, encouraging them to move forward and carry out activities and develop relationships that give their lives meaning.

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