Scrutiny Board (Adult Social Care)

Scrutiny Board Inquiry: Supporting Working Age Adults with Severe and Enduring Mental Health Problems

Working Group Meeting: 25th November 2009

Present **Members**
Cllr Judith Chapman – Chair (JC)
Cllr Sue Bentley (SB)
Sally Morgan (co-opted member) (SM)
Leeds Partnership NHS Foundation Trust
Michele Moran - Director of Service Delivery & Chief Nurse (MM)
Volition
Pip Goff (PG)
Gill Crawshaw (GC)
NHS Leeds
Carole Cochrane – Director of Development and Commissioning for Priority Groups (CC)
Jane Wood - Strategic Development Manager – Mental Health (JW)
Officers
Kimberley Adams – Business Change Manager (KA)
Steve Callaghan – Adult Commissioning Officer (SCa)
Sinead Cregan – Adult Commissioning Manager (SC)
Debbie Forward – Supporting People Manager – Env and Neigh (DF)
John Lennon – Chief Officer, Access and Inclusion (JL)
Paul R Mason – Unit Manager, Provider Services (PM)
Sandra Newbould – Principal Scrutiny Advisor (SN)
Tim O'Shea – Head of Adult Social Care Commissioning (TO)

Apologies Eddie Mack (co-opted member)
Joy Fisher (co-opted member)

No.	Item	Action
1	**Attendance** The attendance and apologies as above were noted. The Chair welcomed everyone to the meeting.	
2	**Minutes of Previous Meeting** Agreed	
3	**Matters Arising** JC asked which the working group would be provided with a copy of the integrated services action plan as referred to on page 18. JL advised that the plan still had to be signed off and would be provided to the group at the next meeting.	JL
4	**Care Provision** KA introduced the care pathways report to the working group explaining the history and purpose of the Care Programme Approach and how it has been applied since 2008 to only those who have a number of needs.	

	Care planning commences when a person is admitted, a care plan is devised which should identify needs and expected outcomes. The process is overseen by a care-coordinator who supports the individual. Care Cooradinators normally come form a range of professional staff within ASC and LPFT but there are examples within the voluntary sector, for example Aspire currently perform this function for young people experiencing early signs of psychosis. MM added that the biggest major change the mental health service has undertaken is the review of discharge planning, focusing on the individual from admission rather than at the end of their hospital stay to ensure that discharge and care planning is as smooth as possible. As part of the suicide prevention strategy and in the wider context of mental health support all service users discharged from hospital should receive a follow up meeting/discussion seven days later. 96% of users receive this. There are usually exceptional reasons for those who don’t, e.g. one individual had returned to their country of origin. There are some integrated elements of the service that are being evaluated for duplication of effort such as the Community Mental Health Teams and Crisis resolution support to identify if there is a more effective way of delivering support. JL advised the group later in the meeting that ASC also provide a 365 day a year out of hours support service. DF advised the working group of the project which, in November 2008, reviewed the system of accommodation referrals and the assessment processes for those receiving secondary mental health in patient services. The aim was to improve the discharge process and remove accommodation barriers which delay discharge. A joint working protocol has been produced which has yet to be implemented. Timescales for implementation are unknown anticipated when departmental/NHS restructures are complete or suitably settled. JC requested that the working group be provided with a copy of the final report with recommendations. Historically individuals were approaching housing offices for emergency accommodation. Housing options officers are conducting specific work with individuals admitted to the Newsam and Becklin Centres to review accommodation and undertake housing needs assessments. This may be to identify accommodation, re-house or resolve issues arising at the current abode. To quality assure this process weekly meetings are convened to review cases. The supporting people commissioning team monitor complex cases and the housing options team review unresolved cases in order to identify a solution.	DF

	Questions arising: SB – • Do individuals know about the 24/7 support service and how to access it? Councillors would appreciate this information in order to support their constituents. • SB also advised the group of casework examples where anti social behaviour and mental heath problems are linked with the outcomes being complaints from neighbours or threat of eviction. • During the accommodation review project did we consult with service users and what lessons have we learnt from cases? In response MM advised that 24 hour crisis support is in place 7 days a week, however it is already acknowledged that this service needs to be more widely publicised and confirmed that work is currently underway to achieve this. It is common for individuals to be treated with or experience eviction when admitted to hospital. The accommodation referrals and assessment pilot is a start to resolving this problem. The telephone number for the 24/7 support service will be provided should the councillors with to use it. DF advised that all cases are reviewed to identify what could be done better, some useful feedback had been received . JC – • How useful is the CPA for those with less conventional circumstances, with no fixed abode of those with drug or alcohol problems? • How well do we perform in ensuring a care package is put together before discharge from hospital, what is the measure of performance? The report states that the councils letting policy is contributing to difficulties in co-ordinating discharge from hospital, why is this and what needs to change? • With regard to the settling down period described by DF, is there a particular problem, who are the best people to contact Housing Options or the ALMO's? • How quickly are housing issues being resolved, what is effective and timely? • Paragraph 3.15 refers to a new referral protocol, will this be ready in time to bring to the January meeting? • Is there sufficient temporary accommodation? • The report states that the majority of service users admitted to hospital are already receiving care through community mental health services. Does this mean our preventative measures are failing. Have we analysed the cause of this? In response MM advised that individuals should not be discharged with no fixed abode. Care co-ordinators try where possible to arrange face to face meetings or will contact by phone. Where it is impossible to track and individual down an incident report is	MM/SN MM/JL/SN

	written. Where individuals are re-admitted within 28 days investigations are made to ascertain why this has happened and a report is written, however most hospital admissions are planned in advance. With regard to performance MM will provide CQC data, JL added that other satisfaction info can also be provided such as a customer survey and accommodation KPI data. DF added there is no particular problem but restructures are delaying implementation and considered Housing Options staff to be the best initial place to contact where problems arise. The longest outstanding case to be resolved was 130 days, the target is 17 days. The new protocol will be in ready to bring to the January meeting of the working group. There is sufficient temporary accommodation but this is not the best option for individuals with mental health problems SM – • How are the more transient population tracked? • How do we manage housing stock, do we have a surplus earmarked for individuals? In response MM that there is some cross area co-ordination, however notification is not always received and sometimes some research work is required.	DF/SN
5	**Commissioning - Types and Scopes of Services** **Volition** Pip Goff and Gill Crawshaw provided an overview of the 3rd sector service provision provided in the City, reassuring the working group that Leeds was fortunate as the sector is thriving. The 3rd sector has the flexibility to work on large and small scale projects in a responsive way which may be a challenge to large organisations. The voluntary do provide some statutory functions and work in partnership with Leeds City Council and mental health services within the NHS. The presentation clearly outlined that the 3rd sector would like to collaborate and work more closely with its partners on commissioning, and would like to be recognised for their work which has an impact and stop the downward spiral of ill health. A number of concerns were also listed which includes geographical inequalities across the city. I3 needs to be progressed and genuine partnership working on a level playing field. SN to circulate copies of hard copy presentation information referred to at the meeting. Questions Arising: SM – is there a problem with short term commissioning of 3rd sector services? In response PG advised that funded mental health voluntary seems to be stable however with a lack of long term commitment it	SN

	is difficult to be innovative and become involved strategically. Smaller organisations do not always prosper due to short term financial commitment. A further report was presented to the working group by SC and colleague Carole Cochrane from NHS Leeds which outlined the complexity of services commissioned for those with severe and enduring mental health problems explaining that a joint mental health commissioning plan is in the process of being written which outlines the intentions for commissioning for the next three years. Service reviews have been undertaken which have identified some issues such as lengthy waiting lists, small case loads and low levels of throughput, however work is being done to address this. Questions Arising: JC – • Which services have long waiting lists? • Why are there inconsistencies in Home Support provision in the city? • The voluntary sector has not been mentioned much, why is that? Is Volition seeing a change in commissioning? • Cllr JC also requested that the MHNA be brought to the April Scrutiny Board in April. SN to add this to the work programme. SB – • Do we ever quantify the value to the economy of getting individuals back into work, and do we use this as an argument for additional funding? • Why are we 4% higher in cost compared to other areas? • What gaps have been identified in service provision and where is the duplication and what are we doing to resolve this? In response the working group were advised that Leeds MIND recovery service did have a long waiting list however work has been done in partnership with them to reduce this. PG also pointed out that some organisations are a victim of their own success and therefore may have long waiting lists because they are popular. Inconsistencies in Home support has developed as support as generated and then subsequently developed in a particular part of the city. There are difficulties with large scale national NHS contracts but more positively the NHS is moving more to using the voluntary sector. PG concurred that this seems to be the case. The value of the work undertaken tends to be quantified in identified reductions in the payment of sickness benefits. There are targets to be met. JW to provide SN with further target information. With regard to cost, recent PFI initiatives have pushed up cost, however MM did specify that the methodology for calculating reference cost is a convoluted and subjective process and the quality of the service provided in Leeds demands the	

	investment, therefore a 4% higher cost does not equate to a bad service, it mean additional resources are being invested. SC advised that there is very little duplication in commissioned services however there are gaps in the crisis service provision which needs to be resolved and is currently being worked on to provide additional opening hours at evening and weekends.	
6	**Further Action** Session 3 - During the third session of the inquiry the working group will examine: 15th December 2009 • Recovery Model - How do we reduce the negative outcomes such as relapse, demoralisation, disengagement, homelessness, worklessness, violent behaviour, re – hospitalisation? How do we stop people from being vulnerable to social exclusion and stigma? How do we reduce risk for carers (who may be LCC employees) and families? Report Deadline for Officers – 9th December 2009.	
7	Future Meeting Dates • 15th December – 2pm – 4pm – Committee Room 2 • 14th January 2010 – 10am - 12am	SN