Report to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee
17th January 2018

Report of: Dawn Walton, Director – Commissioning, Inclusion & Learning

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Subject: The Sheffield Mental Health Transformation Programme

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Summary:

The Sheffield Mental Health Transformation Programme ('the Programme') is a collaborative programme of work that has been jointly developed and is being jointly delivered by Sheffield City Council (SCC), NHS Sheffield CCG (SCCG) and Sheffield Health and Social Care NHS Foundation Trust (SHSC).

The programme was born ostensibly from a collective need to secure better outcomes for people with mental health problems by working far more collaboratively and by delivering better value for money through economies of scale, reducing overlaps, eliminating wastage and through innovation and creativity. It is anticipated that the programme will improve people's lives plus deliver major strategic and financial benefits. Importantly however the programme has been designed to tackle what are predominantly long-standing issues in Sheffield. Our overarching aim is to ensure services are far more localised, individualised and focused (where possible) on prevention and early intervention. We are confident that despite the level of ambition, the Programme will improve clinical outcomes, clinical quality and the experience of those who use services.

Traditionally such a programme would normally have been developed at an 'organisational specific' level, an approach which has historically been underpinned by a perception that financial risks will undoubtedly be 'shunted' (for example, between commissioners), which inevitably leads to confrontational behaviour. We have however been able to avoid this eventuality by genuinely working in partnership to develop and deliver the programme. It is jointly owned and jointly governed.

The Programme currently consists of 14 project areas which includes 5 large scale transformational schemes. These are focused on Promoting Independence (project 2), Dementia Care (project 3), Liaison Mental Health

(project 6), Primary Care Mental Health (project 21) and Integrated Improving Access to Psychological Therapy (IAPT) Services (project 26).

Type of item:

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	✓
Other	

The Scrutiny Committee is being asked to:

Consider the Sheffield Mental Health Transformation Programme and provide views, comments and/or recommendations for future delivery.

Background Papers:

1. Sheffield Strategy for Mental Health: https://shsc.nhs.uk/wp-content/uploads/2015/04/Item-6ii-Sheffield-Strategy-for-Mental-Health.pdf

2. 'Adding Life to Years and Years to Life' Director of Public Health Report 2017: https://www.sheffield.gov.uk/content/dam/sheffield/docs/public-health/health-wellbeing/Director%20of%20Public%20Health%20Report%202017.pdf

3. Sheffield Joint Health and Wellbeing Strategy 2013-18: https://www.sheffield.gov.uk/content/dam/sheffield/docs/public-health/lifestyle/Sheffield%20Joint%20Health%20and%20Wellbeing%20Strategy.pdf

4. The Five Year Forward View for Mental Health: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

5. Implementing the Five Year Forward View for Mental Health: https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

6. 'No Health Without Mental Health' A cross-government mental health outcomes strategy for people of all ages: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138253/dh_124058.pdf

Category of Report:

OPEN

The Sheffield Mental Health Transformation Programme

1. Introduction

1.1 The Sheffield Mental Health Transformation Programme is an ambitious programme that has been jointly developed and is being jointly delivered by Sheffield City Council (SCC), NHS Sheffield CCG (SCCG) and Sheffield Health and Social Care NHS Foundation Trust (SHSC).

1.2 The overarching aim of the Programme is to address what are predominantly long-standing issues in Sheffield, whilst remaining focused on quality and prevention. Taking a more holistic approach to the delivery of mental health care will genuinely promote parity of esteem by strengthening support across the wider health system for people with mental health problems who tend to (a) have more negative experiences and outcomes when they receive health care, and (b) place a disproportionate level of demand on general health services. It will also help to focus on the wider determinants of mental ill health and develop more preventative services (i.e. Primary Care Mental Health Service). This is very much in keeping with national policy and guidance, including the Mental Health Five Year Forward View[1] and 'No Health Without Mental Health'[2] which have respectively aimed to promote person centred care underpinned by principles relating to health and social wellbeing, prevention, promotion and early intervention.

1.3 Prevention (in particular) is an important element of the overall programme; tackling ill health at the earliest opportunity. If we get this right, this will not only improve the outcomes for individual service users but will ultimately deliver financial efficiencies as we will rely far less on secondary health care services. This aspiration therefore underpins the entire transformation programme (as well as the city's Public Health and Mental Health strategies).

2. Context

2.1 Mental health problems are common; one in four people will experience a mental health problem in their lifetime and around one in one hundred people will suffer from severe mental ill health.

2.2 People with good mental health and wellbeing tend to experience lower rates of physical and mental illness, recover more quickly when they do become ill (and remain healthy for longer) and generally experience better physical and mental health outcomes. Good mental health and wellbeing also represents a significant asset in terms of underpinning broader outcomes such as educational attainment and employment opportunities.

2.3 Conversely people with a severe mental illness have a threefold increased risk of premature death than those without such an illness and a reduced life expectancy of approximately 16 years for women and 20 years for men. Although suicide accounts for around 25% of these

[1] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

deaths, physical illnesses account for the other 75% with cardiovascular disease being the most common cause of premature death in people with mental ill health and diabetes the most significant cause of increased ill health. In addition smoking rates in people with mental health problems are, on average, twice as high as those in the general population; as a consequence smoking related illness and early death are also greater.

2.4 It is estimated that in Sheffield around 17.1% of the adult population (over 95,000 people), have either depression or anxiety. In addition around 0.9% of the Sheffield population (over 5,000 people) have a severe mental illness (such as psychosis or severe depression)[3].

2.5 As a city, Sheffield spends around £148 million on mental health services each year, of which around £80 million (55%) is spent on services provided by Sheffield Health and Social Care NHS Foundation Trust. The other 45% is spent on a variety of services provided by other NHS providers, residential and nursing home providers and the third sector.

2.6 The commissioning of, and in many respects the delivery of mental health services in Sheffield has however been historically fragmented. Commissioning plans in particular have been largely developed in isolation meaning opportunities to consider broader clinical and societal benefits, looking at much wider care pathways, have never been fully exploited.

2.7 There is however significant evidence to suggest that integrated care is the right direction of travel for meeting the changing needs of our population, particularly in the context of increasing numbers of older people and people with long-term and complex conditions. What is clear is that fragmented and disjointed care can have a negative impact on patient experience, result in missed opportunities to intervene early, and can consequently lead to poorer outcomes. Poor alignment of different types of care also risks duplication and increasing inefficiency within the system (for example referrals between agencies to address different aspects of an individual's needs).

2.8 Contextually therefore the anticipated benefits of delivering the Programme in a collegiate way are relatively simple to define. A truly integrated approach will offer more effective joined up commissioning and provision, will lead to better patient outcomes which will, by default, deliver better value for money. We will have the opportunity to pool our resources (in the widest sense) to commission whole pathways of care, factoring in other services which were previously out-of-scope of traditional commissioning models (e.g. employment, housing and education).

2.9 This is not to say that we are 'starting from scratch'. Despite the historical context as noted above (underpinned by fragmentation); commissioners and providers have worked hard over the last 18-24 months to build productive working relationships. SCC and SCCG now

[3] https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna/

have a pooled budget arrangement as part of the Better Care Fund (predominantly covering working age mental health spend), and have recently created an integrated commissioning team. In addition we have also worked hard to build constructive and open relationships with our providers, enabling us to deliver a number of significant achievements, for example:

a. Avoiding any out-of-city acute mental health care placements for over three years (through positive bed management and reinvestment into community mental health home treatment services);

b. The delivery of a multi-agency suicide prevention strategy targeted at men;

c. The provision of mental health nurses in A&E 24 hours a day; and

d. The continued commitment of three 'Springboard Cafés', located across the city; designed to help people who are feeling low, isolated, anxious or struggling to manage their mental wellbeing.

All of these have been possible through partnership working, collaboration and (perhaps most importantly) trust.

2.10 Of course whilst agencies have an important role in promoting mental health and well-being (in particular by making sure treatment and support is available when required); good mental wellbeing is as much about feeling good and functioning well; therefore increasing the focus and emphasis on population and community level resilience[4]. A social and economic environment that supports good mental wellbeing is therefore as important as high quality specialist services. **Mental Health is everybody's business**.

3. The Programme

3.1 The programme consists of 14 project areas, including 5 large scale transformational schemes: (Promoting Independence (project 2), Dementia Care (project 3), Liaison Mental Health (project 6), Primary Care Mental Health (project 21) and Integrated Improving Access to Psychological Therapy (IAPT) Services (project 26)). A summary of each project is detailed below:

Project Number	Project Name/Description
1	Section 117 Aftercare (Reviewing Function) The purpose of this project is to deliver savings against health and social care individual purchased care packages for individuals who are section 117 eligible. Our aim is to reduce the risk of institutional dependency and to enable people to move to less restrictive settings/practice.

[4] https://www.sheffield.gov.uk/content/dam/sheffield/docs/public-health/health-wellbeing/Director%20of%20Public%20Health%20Report%202017.pdf

2	<u>Promoting Independence</u> This project will support adults with enduring mental health needs to live more independently in the community. This will involve supporting nearly 200 people who are currently living in residential or nursing home settings to move out of a 24 hour care environment (where it is beneficial and appropriate to do so) into a more flexible supported tenancy that meets their needs.
3	<u>Dementia Care Pathway</u> The purpose of this project/programme is to develop work plans focussing on the following elements of dementia care in Sheffield: a. Living Well with Dementia (providing better support post diagnosis); b. Assessment/respite provision and intensive community support (providing a better crisis management and home treatment response so that unnecessary hospital admissions can be avoided); and c. Reviewing High Dependency and on-going care services (to ensure that the care provided to those individuals who have complex and/or challenging needs is appropriate and effective).
6	<u>Liaison Mental Health</u> The purpose of this project is to implement a 'Core 24' Liaison Mental Health Service based on the successful bid against national monies. Core 24 is designed to provide services for: • People in acute settings (inpatient or outpatient) who have, or are at risk of mental disorder; • People presenting at A&E with urgent mental health care needs; • People being treated in acute settings with co-morbid physical disorders such as long-term conditions (LTCs) and mental disorder; • People being treated in acute hospital settings for physical disorders caused by alcohol or substance misuse; • People whose physical health care is causing mental health problems; and • People in acute settings with medically unexplained symptoms (MUS). The aim of a Core 24 Service is to: a. Reduce excess morbidity and mortality associated with co-morbid mental and physical disorder; b. Reduce excess lengths of stay in acute settings associated with co-morbid mental and physical disorder; c. Reduce risk of harm to individuals and others in the acute hospital by adequate risk assessment and management; d. Reduce overall costs of care by reducing time spent in A&E departments and general hospital beds, and minimising medical investigations and use of medical and surgical outpatient facilities; and e. Ensure that care is delivered in the least restrictive and disruptive manner possible.

8	Short Term Educational Programme (STEP) The purpose of this project is to undertake an options appraisal on the future of the STEP service. The service is a (potential) component part of a number of care pathways including anxiety, depression, bi-polar disorder and borderline personality disorder. The service offers education and self-management skills.
10	Relationship and Sexual Health Service The purpose of this project is to enact agreed changes to the Relationship and Sexual Health Service pathway in Sheffield. This involves the streamlining of service delivery and introducing a single point of referral. Currently there are multiple referral points and some overlap in terms of provision.
16	Reducing Anti-Depressant Use The purpose of this project is to explore possible options for reducing the prescribing of antidepressant medication. Sheffield is currently an outlier. Investment in psychological therapies may be needed to support any reduction.
18	Reduce Number of People with Dementia in High Cost Long-Term Care Settings The aim of this project is to appraise and (where appropriate) implement new models of care so that patients with Dementia can be cared for in a less restrictive setting, closer to home and at a reduced cost compared to their current CHC package(s).
19	Reduce Number of People with a Learning Disability in High Cost Long-Term Care Settings The aim of this project is to appraise and (where appropriate) implement new models of care so that patients with a Learning Disability can be cared for in a less restrictive setting, closer to home and at a reduced cost compared to their current CHC package(s).
20	Reduce Number of People with SMI in High Cost Long-Term Care Settings The aim of this project is to appraise and (where appropriate) implement new models of care so that patients with SMI can be cared for in a less restrictive setting, closer to home and at a reduced cost compared to their current CHC package(s).
21	Developing a Primary Care Mental Health Service The purpose of this project is to consider options for how to progress the development of a Primary Care Mental Health Service. This is based on national evidence that indicates that people would prefer to be seen in their practice for common mental health issues (thus reducing stigma) and that with support General Practitioners (and the wider practice workforce) can deliver better outcomes for individuals through more personalised holistic care and by intervening much earlier.

22	Developing a Psychiatric Decision Unit The purpose of this project is to consider options for how to progress the development of a psychiatric decision unit (PDU). The PDU will provide an effective alternative to A&E, a place of safety for those needing immediate care (and attention) plus provide an informal facility from which to provide ad-hoc and immediate treatment to avoid crisis situations (therefore preventing the use of secondary care services).
25	Outcomes of Open Book Session Yet to be determined; areas of potential efficiency are still being scoped.
26	Integrated Improving Access to Psychological Therapies (IAPT) Programme The purpose of this project is to implement the Integrated IAPT programme based on the successful bid against national monies. The integrated IAPT programme aims to address the fact that two thirds of people with a common mental health problem also have a long term physical health problem, greatly increasing the cost of their care by an average of 45% more than those without a mental health problem. By integrating IAPT services with physical health services we can provide better support to this group of people and achieve better outcomes.

3.2 All but one of the projects (project 25) are now in the implementation stage. Every Project has an identified Senior Responsible Owner (SRO) (an officer from one of the partner organisations) and appropriate project management support. The 5 large scale transformational schemes also have an identified clinical/professional lead; whose mandate is to ensure that clinical standards and quality are not unduly compromised.

4. Programme Objectives

4.1 The overarching aim of the Transformation Programme is to address what are predominantly long-standing issues in Sheffield, whilst remaining focused on prevention and early intervention. These are particularly important components of the programme; tackling ill health at the earliest opportunity. If we get this right, this will not only improve the outcomes for individual service users but will ultimately deliver better value for money as we will rely far less on secondary health care services. This aspiration therefore underpins the entire transformation programme.

4.2 There is a genuine cross-organisational commitment to ensuring this work is undertaken jointly, collaboratively and safely. All parties are clear that whilst one of the (key) drivers for this work is the delivery of better value (see 4.3 below), the desired outcomes are very much quality focused; changing the way that mental health and learning disability services are delivered in Sheffield so that the quality of services are not undermined and that the offer of care and treatment is far more localised, individualised and focused (where possible) on preventing ill health and recovery.

4.3 In terms of financial efficiency the Programme is aiming to deliver £4m in 2017/18 (which is the combined cost pressure on respective SCC and SCCG mental health budgets). We are currently forecasting £1.94m. The preparatory work however that has been undertaken during the first 6 months has been significant. The forecast in years 2, 3 and 4 of the programme has therefore been amended to reflect this; essentially showing that the programme will exceed earlier projections.

4.4 Savings delivered in 2017/18 are subject to a risk and benefit share agreement between SCC and SCCG. SHSC, although a joint contributor in terms of delivery, will not directly benefit financially from the programme.

4.5 The agreement (which forms part of the wider section 75 agreement that underpins the Better Care Fund) has been purposely designed to enable both parties to address their respective financial pressures (as noted above) in a mutually beneficial way; addressing areas of greatest need in the first instance. The first £800,000 of efficiencies will therefore be made available to SCC, up to £1.6 million. Efficiencies generated after this point will be shared on a 50:50 basis.

4.6 It should be noted that the sovereign rights of each respective organisation are not compromised by the risk and benefit share agreement. Decisions regarding reinvestment, for example, can continue to be made separately. However in the spirit of partnership working it is anticipated that all such decisions will be made jointly (in the best interests of the wider population).

4.7 It is also important to note that none of the anticipated financial efficiencies will be achieved through decommissioning or compromising on clinical quality. Savings will be achieved by the avoidance of unnecessary cost and treatment, primarily through:

a. A reduction in A&E attendances;
b. A reduction in the number of outpatient attendances;
c. A reduction in the average length of stay on physical healthcare wards;
d. A reduction in the number of readmissions into physical healthcare services;
e. Better proactive case management of people with complex needs and multi morbidity;
f. A reduction in secondary mental health care activity (where it is appropriate and safe for an individual to be cared for within primary care); and
g. A reduced reliance on residential and long term nursing care (through the provision of better, more accessible community based services and targeted support).

4.8 We also anticipate that as the programme progresses, clinical benefits will also exceed earlier expectations, particularly given the system wide ‘buy in’ that we have been able to secure. The Programme has helped to build what are extremely productive working relationships between organisations and individuals who have historically had limited interaction or have had a less-than-constructive working relationship. So

whilst we are only in year one of a four year programme, we have already seen significant benefit in terms of collegiate and collaborative working. From the moment we started this work we have continued to ask the question 'what would we do if we were all working in the same organisation', an approach that has helped us to break down traditional organisational boundaries. We still have some way to go, but the foundations are certainly strong.

5. What does this mean for the people of Sheffield?

5.1 Whilst we have already started to see significant benefits in terms of organisations coming together to develop a programme of work that is focused entirely on the needs of our patients (as opposed to the needs of each individual organisation); it is clearly important to ensure that these benefits are defined and therefore measurable. Financial savings are relatively easy to measure; qualitative impact is much more difficult. A series of metrics have been developed to help measure the qualitative elements of the programme, these are however being continuously reviewed and refreshed.

5.2 In general terms we believe that by taking a collaborative approach across wider care pathways will ultimately mean that inefficient practice can be proactively addressed without organisational boundaries having an impact. This will ensure we create seamless pathways, we reduce onward referral, the provision of care is much more holistic (based on need) and individual patient outcomes become the way we jointly measure success (as noted above). Measuring inputs will partially give an indication as to the quality of clinical services; however we also want to improve the experience of those who use services. We are keen to promote good mental well-being not just good mental health.

5.3 To ensure we continue to engage with service users (and the general public more widely), we are working closely with Healthwatch Sheffield to ensure we (a) get real-time feedback on concerns and issues that are being raised directly with them and (b) are able to contribute to and get feedback from a series of focus groups that they are currently planning to deliver to determine what individuals want to see from the provision of mental health services in Sheffield. In particular we are aiming to 'test' some of the assumptions that underpin the programme.

5.4 In addition we are also considering options for how to engage with individuals who do not use statutory services; either because they are not unwell or because they have developed strategies and/or alternative approaches to managing their own mental health. Ascertaining both viewpoints will be really valuable, albeit for slightly differing reasons.

5.5 Our expectation is that families and carers will also benefit from taking a collegiate approach through improved coordination between different services and providers, a greater focus on prevention and early intervention and more community based support. A key component of the wider programme is an acknowledgement of the enormous contribution families and carers make in terms of providing care and support across the city. We remain committed therefore to ensuring that they themselves receive appropriate support as required. Caring for our

carers will be as important to this programme as providing the right clinical care and support.

6. Recommendation

6.1 The Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee are asked to:

a. Note the contents of this report and to provide views, comments and/or recommendations for the future delivery of the Programme;

b. Give a steer as to how Council Members can support the implementation of the programme and engage with the communities they serve;

c. Agree to accept a further report in approximately 12 months' time, which will provide Committee Members with an updated position on delivery; and

d. Acknowledge that whilst the Programme is still termed 'transformation', an alternative name is being considered. This will be incorporated into a proposed rebranding/relaunch exercise.

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