



Report to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee 11th September 2019

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Subject: The Sheffield Mental Health Transformation Programme

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Summary:

The Sheffield Mental Health Transformation 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 aims are:

- to secure better outcomes for people with mental health problems by working far more collaboratively;
- deliver more effective services through innovation and creativity;
- ensure services are far more localised, individualised and focused on prevention and early intervention; and
- to marshal resources more efficiently across health and social care to focus on shared outcomes and avoid 'cost shunting'.

The Mental Health Transformation Programme currently consists of 26 project areas which includes 4 large scale transformational schemes. These large scale schemes are focused on Promoting Independence, Dementia Care, Primary Care Mental Health and Physical Health.

The Scrutiny Committee received a report in January 2018 which outlined the programme and the individual component projects. This report now focuses in more detail on some of the impacts and outcomes delivered by the programme to date, and considers how the programme might develop further in the future.

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 impacts of the Sheffield Mental Health Transformation Programme as outlined in this report and
- Provide views, comments and recommendations for future developments.

Background Papers:

1. *The Sheffield Mental Health Transformation Programme Report to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee 17th January 2018* ([Click Here](#))
2. *Sheffield Strategy for Mental Health* ([Click Here](#))
3. *The Five Year Forward View for Mental Health* ([Click Here](#))

4. *Implementing the Five Year Forward View for Mental Health* ([Click Here](#))
5. *The NHS Long Term Plan* ([Click Here](#))
6. *NHS Mental Health Implementation Plan 2019/20 – 2023/24* ([Click Here](#))

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 improve the lives of people with mental health problems and mean resources are used more effectively. It will also help to focus on the wider determinants of mental ill health and develop more preventative services. This is very much in keeping with national policy and guidance, including the NHS Long Term Plan¹ which aims to promote person centred care underpinned by principles relating to health and social wellbeing, prevention, promotion and early intervention.
- 1.3 Prevention is an important element of the overall programme. 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).
- 1.4 The Programme began in 2017 and was originally intended to run for 4 years until 2021. We are therefore just over half way through, which means we have the ideal opportunity to reflect on the impact and success of the programme so far; and importantly decide how we can continue to work together in partnership to make further improvements for the people of Sheffield.

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

¹ <https://www.longtermplan.nhs.uk/>

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 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 illnesses are also much more common.
- 2.4** It is estimated that in Sheffield around 17.1% of the adult population (over 80,000 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)².
- 2.5** As a city, Sheffield spends around £150 million on mental health services each year, of which around £86 million (57%) is spent on services provided by Sheffield Health and Social Care NHS Foundation Trust. The other 43% is spent on a variety of services provided by other NHS providers, residential and nursing home providers and the Voluntary, Charitable and Faith sector.
- 2.6** The commissioning of, and in many respects the delivery of mental health services in Sheffield has however had been historically fragmented. Commissioning plans in particular had been largely developed in isolation, meaning opportunities to consider broader clinical and societal benefits, looking at much wider care pathways, were not fully exploited.
- 2.7** An integrated approach to care and support is therefore 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. 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). People tell us that they want their health and social care more joined up and not see lots of people, they want a more centralised offer of help when they need it.

² <https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna/>

2.8 Commissioners and providers have therefore worked hard over the last 4 years to build productive working relationships. In 2017 SCC and SCCG established a pooled budget arrangement as part of the Better Care Fund (predominantly covering working age mental health spend), and have recently created an informal 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 which are outlined later in this report.

3. The Programme

3.1 The Mental Health Transformation Programme currently consists of 26 project areas which includes 4 large scale transformational schemes. These large scale schemes are focused on Promoting Independence, Dementia Care, Primary Care Mental Health and Physical Health. A summary of each project is detailed below:

Project Name	Project Objective
Section 117 Aftercare (Reviewing Function)	To ensure that all individuals who are in receipt of Section 117 Aftercare Services are receiving clinically appropriate and effective care.
Reducing Anti-Depressant Use	To reduce the amount of antidepressant medication that is prescribed in Sheffield (where it is clinically appropriate to do so).
Section 12 Fees	To reduce the amount spent on section 12 fees and also increase the availability of section 12 approved doctors.
Crisis Care Pathway	To ensure that all aspects of crisis care in Sheffield are operating effectively and are having the optimum impact.
Transforming Care	To reduce the number of hospital beds that are commissioned to provide care for people with learning disability and/or autism. This will be achieved through an improvement in community services including better and more accessible crisis support,
Promoting Independence	To support adults with enduring mental health needs to live more independently in the community.

Dementia Care Pathway	To develop work plans focussing on ' <i>Living Well with Dementia</i> '; assessment/respice provision and intensive community support; and reviewing high dependency and on-going care services.
Neighbourhood Health and Wellbeing Service	To consider options for how to progress the development of a Primary Care Mental Health Service which will deliver better outcomes for individuals through more personalised holistic care and through earlier intervention.
Developing a Psychiatric Decision Unit (PDU)	To 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.
Bespoke Packages of Care (Including CHC and IFR Reviews)	To review those service users who currently have complex care needs and are in receipt of high cost packages of care and varying levels of additional observations; across the CHC, s117 and IFR portfolios.
Mental Health Five Year Forward View	To ensure that all requirements of the MH5YFV are delivered.
Eating Disorders	To redesign our eating disorder services to improve the experience of service users and ensure that people get the 'right help at the right time in the right place'.
SHSC Service Specification Reviews	To undertake a robust review of all current specifications as included in the SHSC Contract. This is to ensure they are evidence based, fit for purpose and strategically aligned.
Legacy CHC Grant Arrangements	To jointly review all (legacy) CHC grant arrangements that are currently in place.
Perinatal Mental Health	To enhance the current Perinatal Mental Health service through national transformation funding.

Better Care (Physical Health)	To ensure that people living with severe mental illness (SMI) have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and interventions.
Transitions	To improve both the effectiveness and the service user experience relating to the transition pathway from CYP to Adult Mental Health Services.
Autism	To design and develop a solution in terms of addressing the current demand for the SAAND Service. Currently this is far outstripping capacity. The average waiting time is over 52 weeks.
VCF Sector	To identify key pathways where better integration across statutory and voluntary sector services can be explored. This will improve the service user experience and clinical outcomes.
Personality Disorders	Consider options for the development of a community based specialist personality disorder service.
Trauma PTSD	To scope the potential impact of developing an early intervention trauma service.
Prevention and Early Intervention	To address the determinants of mental ill-health, including (but not limited to) housing, debt and physical health. Ensure that sources of help and support are well publicised and are available to everyone at the earliest opportunity.
Access and Waiting Times	Ensure that plans are in place to deliver the waiting time standards, as detailed in the NHS Long Term Plan.
Digital and Data	To develop a strategy for ensuring that we fully utilise data and digital technology to help improve services and the outcomes of those who use them.

Vulnerable Groups	To develop specific plans to address the needs of individuals who could be described as vulnerable. These are groups whose outcomes, generally speaking, tend to be worse than the general population.
Housing, Benefits and Employment	To ensure that the wider transformation programme does not focus entirely on health and social care. Housing, benefits (income) and employment are significant factors that impact on the recovery and wellbeing of all individuals who experience mental ill health.

4. **What Has The Programme Achieved?**

The following sections of the report set out in more detail the work of a number of key projects which form part of the overall Transformation Programme, and the impact these projects have had.

4.1 **Section 117 Aftercare (Reviewing Function) and Promoting Independence Projects**

There are two key components to these projects:

- Increased oversight of the high cost funding panel and raising the profile of social care in mental health; and
- Creating a recovery and rehabilitation model in residential care using a social investment bond and life chances fund

4.1.1 **What Have The Projects Done?**

4.1.2 For many years the city has had a 'high cost funding panel' where health and social care packages costing over £15,000 per year have been agreed. In 2016 a new policy and approach to the panel process was implemented.

4.1.3 Previously the panel was used mainly as a 'gateway' to funding. The panel was not involved in planning but acted mainly as a sign-off after the person had in many cases already started in a placement. Now the panel requires a planned request with agreed conditions if a decision is required urgently. The panel also acts plays an *advisory* role - indicating alternatives to 24 hour care through provisions under the Care Act such as personal assistants, mixed packages and direct payments. Requests to the panel require more consideration by frontline practitioners of what the needs of the person, rather than just availability of a placement. This more considered and person centred process has enabled many people

to move from hospital to their own tenancy (instead of residential care) which gives them a more secure future and a more independent life.

- 4.1.4 The Transformation Programme has also raised the profile and importance of *social care* as a priority within the overall mental health system. The programme enabled us to recruit a senior social worker to review health and social care packages with the delegated function from both the CCG and SCC. So far over 150 people have now had a comprehensive person centred review of their needs. In some instances no change has been made to the package (or the costs) but more frequently packages *have* been revised and in 18 instances clients have been moved into supported accommodation and other ordinary housing with care support in a planned way. An audit of these 18 clients in February 2019 showed a 96% sustainment rate; in other words those people had maintained their new tenancy/accommodation and had not required readmission to 24 hr care.
- 4.1.5 All clients within the remit of this project have complex needs, severe and enduring mental health problems and in many cases long histories of hospital and institutional care. The cohort includes clients subject to Home Office restrictions and Community Treatment Orders. Reviewing work requires extensive engagement with clients, their families, advocates, providers, community mental health teams and this can be a slow and delicate process, lasting several months in some circumstances.
- 4.1.6 In one particular case, the individual had been in residential care for over 6 years; the care was good but did not encourage independent living. For example the staff used to shower him, and read him a book at night. Through the work of the reviewer, this person now lives in his own tenancy with help from his sister. He now showers himself with visual prompts and after having his eyes tested he now reads the book himself, which he much prefers.
- 4.1.7 Further case studies are detailed in *Appendix A*.
- 4.1.8 Alongside the clear benefits and impacts this work is having on individual people's lives, it has also led to a reduction in mental health social care costs from a total of £258,000 in 2016-17 to £133,000 being the forecast spend in 2019-20:
- 4.1.9 This collaborative way of working is now 'business as usual' and has paved the way for the more ambitious project focused on reshaping our approach to residential provision.
- 4.1.10 The work on the panel and new approach to reviewing people's care has also helped commissioning staff to have a more 'informed conversation' with service providers who deliver health and social care. Providers have seen that increasingly our ambition is to work actively to promote recovery and independence, and reduce the number of people needing

traditional residential care type offer. A number of providers are therefore already responding very positively to this approach and are shaping their offer to be more rehabilitation focused.

4.1.11 The commissioning team has held provider events over the last 3 years with all current and potential providers. The events are an opportunity to listen to the market and speak with them about up and coming trends and planning related issues. Through this market shaping and development we have prepared the residential care market and home 'one to one' support for change. We have secured a social investment bond and consortium of providers willing to change to residential rehabilitation. This was led by the commissioning team with support from the social policy team and commercial services within Sheffield City the Council.

4.1.12 The outcomes of this work have resulted in:

- The integrated commissioning partners (SCC, CCG, SHSC) investing £3 million in to our existing Mental Health residential rehabilitation services;
- Access to £750,000 funding from the Government's Life Chances Fund;
- Sheffield is working with a South Yorkshire Consortium to actively help people to recovery from the effects of serious mental illness though skilling people up to have full and active lives in their own home;
- A social investment organisation - *Big Issue Invest* - is working with us to change the residential care market to focus on rehabilitation so people can live in their own homes successfully;
- The project is starting in August 2019 and will be funded for the next 5 years; and
- The Project will see more people receiving support and will deliver savings of up to £1.4 million over the next 5 years.

4.1.13 What Impact Have The Projects Had?

- Through this work the section 117 reviewing function has become 'business as usual' and a more recovery focused approach to care planning has become more embedded in service culture;
- 51 people are now living in less restrictive settings, making more independent decisions about their day to day lives;
- Costs have been reduced by approximately £2 million across the health and social care system;
- Residential care staff have reported having more job satisfaction;
- Residential homes which have moved to residential rehabilitation, report lower sickness and 'a new energy' in the way people are supported;
- Reduction in the number of residential beds used;

- Shaping the market to offer residential rehabilitation not just a 'safe and secure' offer. Three residential care homes have moved to residential rehabilitation and two others are indicating they will move soon;
- Sheffield has secured additional £750,000 life chances fund to support the delivery of the move from residential to own tenancy; and
- The new processes have 'trail-blazed' the way SCC, CCG and SHSC make commissioning decisions collegiately.

4.2 Mental Health Liaison

4.2.1 What Has The Project Done?

4.2.2 The Sheffield Mental Health Liaison Service provides specialist mental health assessment and care to anyone over the age of 16 who is admitted to Sheffield Teaching Hospitals NHS Foundation Trust or who attend the Emergency Department at Northern General Hospital.

4.2.3 The new service is available 24 hours a day. It is available to individuals who have been diagnosed or have a suspected mental health problem, people who need additional help during their hospital stay or who have psychological difficulties as a consequence of a physical illness. This includes individuals who have self-harmed or are expressing suicidal ideas or plans.

4.2.4 Since 2018 the liaison mental health offer has also been complemented by the introduction of an integrated IAPT (Improving Access to Psychological Services) service. This development has introduced psychological therapists who work alongside physical healthcare practitioners. This is particularly important because people with physical healthcare needs, including life limiting conditions or disabilities, are also at higher risk of mental health issues including depression or anxiety. It is important that services are able to respond effectively to the needs of these patients.

4.2.5 We are also in the process of extending our perinatal mental health service and have been successful in securing additional funding from NHS England to support this. This will provide a more effective service for mums to be who experience mental health problems, to enable them to have a more positive pregnancy and birth experience and make for a better start in life for their babies.

4.2.6 Liaison mental Health service development is a key component of the new national NHS Long Term Plan. Through the work outlined about Sheffield will *already be fully compliant* with the 'core 24' standards outlined as a future target in the Long Term Plan, having achieved this in 2018.

4.2.7 Our ambition is to ensure that care support and treatment is based on *need not on the availability of services*. A key element of the mental health liaison teams remit therefore is to ensure:

- Awareness training is continually delivered;
- Consultation is always available to all staff in wider health and social care services; and
- That services across the Sheffield Teaching Hospitals sites provide holistic seamless care.

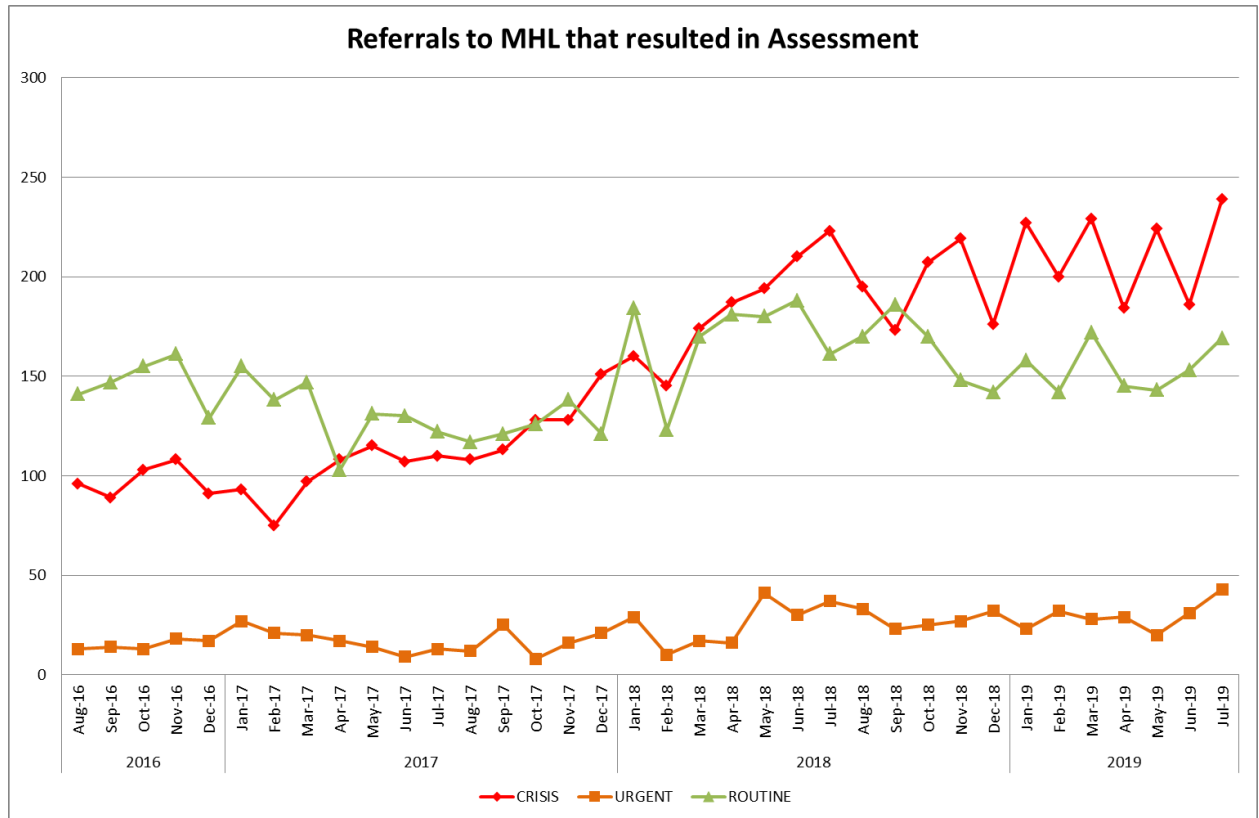
4.2.8 What Impact has the Project Had?

4.2.9 The project has, from November 2017, increased the availability of mental health professionals in inpatient and outpatient settings.

4.2.10 Comparing the 12 month periods August 2016 - July 2017, and August 2018 - July 2019 the Liaison service has seen:

- A 47% increase in the average number of referrals per month, from 354 to 521;
- A decrease in the amount of referrals received that end up being discharged without assessment, from 218% to 25%. This is seen as an indicator that there are fewer *inappropriate referrals* as clinicians get to know the service and what it can offer; and
- A 54% increase in the average number of assessments per month from 354 to 521, split as follows:

	Crisis	Urgent	Routine
2016-17	99	16	138
2018-19	204	29	158
	106% increase	81% increase	14% increase



4.2.11 In July 2019 the Liaison service was reviewed by the National Psychiatric Liaison and Accreditation Network, which is part of the Royal College of Psychiatrists as part of a National accreditation process in line with nationally agreed quality standards. The report from this visit has not yet been published in final form, but the draft report includes a number of points that can be shared with the Scrutiny Committee.

4.2.12 In terms of the working of the Liaison Team, the review highlighted a range of support available to different staff groups. The team reported that they feel supported in their roles with a range of training opportunities available, including monthly CPD activities. Staff also reported there is a thorough and detailed induction into the team, with a 4-day Trust induction and 6-week local induction. The service is proactive, particularly working to overcome challenges and identifying new ways to respond to these. The team have access to the decision unit within the Care Trust, who support them in the role as well as in relation to patient outcomes. Information given to patients about the liaison team is clear and detailed.

4.2.13 A quote from the review: *“The team here is extremely supportive and professional and the leadership is the best I have ever experienced in my 30 years of working. There is constant communication within the team, whether in email form or verbal and I never feel unable to seek advice no matter who is on duty. I have nothing but praise for everyone and feel very privileged to work within the team”*

4.2.14 In terms of the team working with clinicians and colleagues in acute services, colleagues gave very positive feedback on the liaison team moving to being a 24 hour service. The support discharge team were found to be very useful as a resource to enable patients to be fully supported on discharge. Communications worked well with acute services, and the training provided by the team to acute services was well received, as it is delivered in an accessible format (including through, for example, breakfast club type sessions). One of the clinicians surveyed in the review was quoted as saying *“When the liaison team is involved it can change the dynamics of how we manage complex patients. It is a game changer”*.

4.2.15 Patient feedback as part of the review was positive, for example:

- *“The nurse who saw me was kind and professional”*
- *“The staff listened to me and give me time to try to explain my problems”*
- *“They treated me well and helped me with my depression and support. They discussed medication and asked my choice”*

4.2.16 Case Studies from the Mental Health Liaison Service

4.2.17 **John** was a 30 year old man with a 10 year history of contact with Mental Health Services in Sheffield. He had a diagnosis of borderline personality disorder and had frequent unscheduled contact with different services. He had been discharged from the Mental Health Recovery Service due to non-engagement with scheduled community care support. Up to this year he had had 17 admissions to the Acute Medical Unit at the Northern General Hospital following self-harm. John was considered to be at high risk of accidental death due to misadventure and a high risk of irreversible harm due to repeated paracetamol overdoses. Acute service staff found it very hard to work with John repeatedly when he presented in crisis.

4.2.18 Under the new arrangements a Senior Practitioner from Liaison Psychiatry took over clinical leadership and organised a Professionals Meeting involving senior practitioners from Decisions Unit, Recovery Service, Intensive Home Treatment Service and Single Point of Access.

4.2.19 It was agreed that an Occupational Therapy assessment would be carried out at John’s home to determine his level of functioning and the safety of the home environment. In order to prevent further unplanned care seeking admissions to Emergency Department and Acute Medical Unit, regular *planned* admissions to the Psychiatric Decision Unit at the Northern General was offered for a month. During these admissions, John would be offered crisis and contingency planning and helpful coping strategies and improve his awareness of triggers for self-harm. If this helped then longer term psychosocial interventions would be offered by the Recovery Service.

4.2.20 Since this plan was implemented John has not presented to the Emergency Department or self-harmed. He has had 2 planned admissions to the Decision Unit and has engaged in a crisis and safety plan. The Occupational Therapy assessment found that John's housing is poor and he was being threatened by drug dealers in the area. He has been referred for medical priority for rehousing. Due to consistent engagement will be referred to Recovery service for a social care package including befriending service to improve social activities.

4.2.21 **Yasmin** is a 20 year old woman who sought asylum in the UK and had been living in Sheffield for 18 months. Yasmin had more than 30 attendances at the Emergency Department with chest pains and palpitations. All the usual test results came back normal, and Yasmin was diagnosed with severe anxiety.

4.2.22 Yasmin was seen in the Liaison Psychiatry clinic, and a complex history emerged of post-traumatic stress disorder following being subject to torture in her home country and being socially isolated in the UK. She had anxieties about her health, psychotic depression and heard voices commanding her to die by hanging. Yasmin started a course of antidepressant and antipsychotic medication, and was referred to the Home Treatment team who monitored medication and provided a support worker to improve her social inclusion. Through this she established contact with her local mosque and other community organisations

4.2.23 Yasmin's social network has grown and her low mood, hearing voices and suicidal thoughts have improved. However her post traumatic stress and health anxiety remain, though are less acute. Yasmin has since been discharged from Home Treatment to the Improving Access to Psychological Therapies Service (IAPT) for Cognitive Behavioural Therapy to manage the health anxiety, with a long term plan to then begin to address the post-traumatic stress.

4.3 Reducing Antidepressant Prescribing

4.3.1 What Has The Project Done?

4.3.2 The purpose of this project is to explore potential and possible options for reducing the prescribing of antidepressant medication in Sheffield. This was an area that was highlighted as an opportunity to review as prescribing data shows that Sheffield was higher than the national average in prescribing of antidepressants.

4.3.3 The current National Institute for Clinical Excellence (NICE) guideline for depression in adults (CG90) recommends that:

- For adults with mild to moderate *depression* clinicians should consider offering low-intensity psychosocial interventions (e.g. computer based cognitive behavioural therapy);

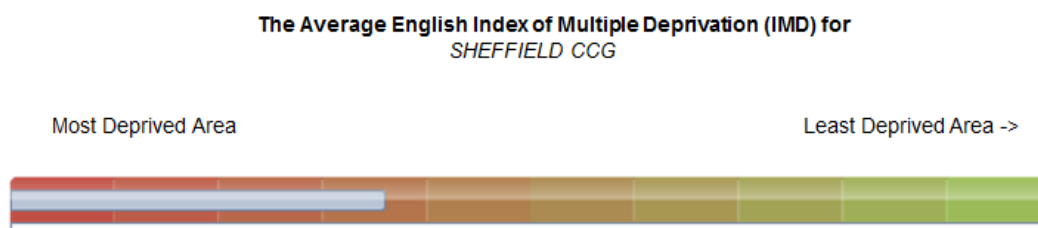
- For adults with persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions, and/or moderate and severe depression in adults clinicians should offer either high intensity psychological therapy or antidepressant medication.
- 4.3.4 A number of factors should be considered when deciding the treatment most suitable for an individual patient (for example patient preference, how likely the patient is to stick to a treatment plan, and previous response to other treatment options). If a response is seen to an antidepressant, this usually happens with 2-4 weeks after commencing treatment. The current national measure for accessing IAPT (Improving Access to Psychological Therapies) for high intensity psychological therapy is 6 weeks, although low intensity interventions can be offered straight away. These factors are taken into consideration when discussing options with patients.
- 4.3.5 There are other conditions and NICE guidelines that recommend antidepressants, the main alternative condition being *anxiety disorders*, e.g generalised anxiety disorder (GAD), post-traumatic stress disorder (PTSD) and obsessive compulsive disorder (OCD). The use of antidepressants for GAD is part of a stepped care pathway, generally *after* psychological support has been offered.
- 4.3.6 The duration of time that a person should be on an antidepressant is always patient and condition specific based on clinical assessment and judgement. However, NICE guidelines recommend:
- Patients with depression should remain on treatment for *at least 6 months after remission*. People with recurrent or severe depression or at high risk of relapse should consider staying on treatment for *at least 2 years*; and
 - Patients with GAD should remain on treatment for *at least 12 months* after remission as the likelihood of relapse is high.
- 4.3.7 NICE is currently updating its guideline for depression in adults (CG90), this was due to be published in September 2018, however has been delayed until December 2019 to allow more time to assess evidence and effectiveness of treatments available.
- 4.3.8 Initial Scope of the Project
- 4.3.9 The following were suggested actions in the original scope of the project:
- Conduct and audit current use of antidepressant against NICE guidance
 - Consider the pros and cons of establishing a neighbourhood special interest Mental Health GP or Health Care Practice to whom patients could be referred to assess appropriate pathway and ongoing review of patients with depression;

- Review the formulary recommendations which are used locally; and
- Undertake education and training of GPs regarding NICE pathways / IAPT and carry out targeted medication reviews, for some patients including those with increased anticholinergic burden score (increases risks of side effects), those who have been on treatment for longer than 2 years; or on the medications which are more expensive or which have higher risk of side effects, where a more cost effective or option with a better safety profile may be a suitable alternative.

4.3.10 Ongoing and additional investment in IAPT provision was also anticipated to have an impact on prescribing patterns, with greater access and reduced waiting times to psychological therapy it was anticipated that the use of antidepressants may reduce.

4.3.11 In 2016-2017 clinicians in Sheffield issued 643,854 prescription items for antidepressant medication (excluding amitriptyline that is mainly used for other indications). This cost £2,590,748. To help put this into perspective this accounted for 5% of the total prescribing budget for the city and 3% of all items dispensed.

4.3.12 Sheffield is more deprived than the England average and NHS Right Care data (2017) stated Sheffield has a higher prevalence of depression when comparing against similar 10 CCGs. The graphic below is from ePACT2:



4.3.13 Multi-morbidity is more common among more deprived populations – especially those that include a mental health problem. There is research evidence that the *number of conditions* a patient has can be a greater determinant of a patient's use of health service resources than the specific diseases or conditions.

4.3.14 People with long-term conditions and co-morbid mental health problems disproportionately live in deprived areas and have access to fewer resources of all kinds (economic, social etc). The interaction between co-morbidities and deprivation makes a significant contribution to generating and maintaining inequalities. There is evidence that the relationship between having multiple long-term conditions and experiencing psychological distress is exacerbated by socio-economic deprivation in two ways. Firstly, a greater proportion of people in poorer areas have multiple long-term conditions. Secondly, the effect of this

multi-morbidity on mental health is *stronger* when deprivation is also present.

4.3.15 Although addressing the mental health needs with medication and psychological therapies can help individual patients when the condition arises, this alone is not enough. A wider approach is needed to address deprivation as well as providing tools and resources to promote healthy lifestyles to reduce multimorbidity and mental health conditions (e.g. physical exercise, healthy diet, smoking cessation).

4.3.16 Additional investment in IAPT has directly been used to develop the Sheffield Health and Wellbeing service. This service is aimed to support people with long term physical health conditions with their mental health, or to offer early interventions and support to prevent mental illness in groups that are more likely to becoming mentally ill due to their long term conditions.

4.3.17 The increased prevalence in Sheffield, increasing public awareness and growing lack of stigma associated around mental illness is likely to result in an increase in patients presenting to their health care professional seeking advice at times when they are not feeling mentally well.

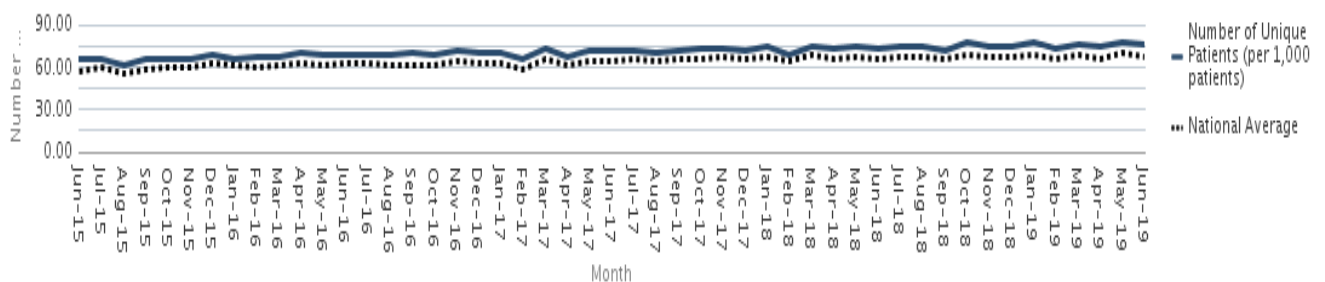
4.3.18 Actions Taken to Date

- Due to the delay in the update of the NICE guideline for depression (CG90) a local audit of antidepressants has not yet happened.
- After exploring a number of routes, NHS Sheffield has now been successful in securing funding to *increase Mental Health expertise in primary care setting and across the interface with the adult and children mental health specialist teams*. A recruitment process for a pharmacist to carry out targeted work in this area is underway.
- The *Sheffield Formulary* offers guidance and advice to primary care clinicians around the most clinically effective and cost efficient choices. The chapter relating to mental health was updated in April 2018. This was then shared via a number of routes; utilising the GP clinical practice systems; GP practice bulletin; GP attached pharmacists, locality and practice meetings.
- Local protocols to support the care and management of patients that present with depression and generalised anxiety disorder (GAD) have been produced, shared and promoted using various methods, including an education session at a primary care Protective Learning Initiative (PLI).
- The addition of dosulepine and trimipramine to the Sheffield STOP list. These were added to the guidance because compared to alternative antidepressants they increased risks (dosulepine has an increased side effect profile) and costs respectively. Medicines included in the Sheffield STOP list should not be initiated in new patients and existing prescribing should be reviewed at the next routine review.

- Investment in core IAPT has continued to increase year on year as part of a separate strand of the Transformation Programme. On top of this growth, additional investment into the IAPT service over the last three years has been made to directly fund the integrated IAPT work (the Sheffield Health and Wellbeing service).

4.3.19 What Impact has the Project Had?

The proportion of unique patients prescribed antidepressants in Sheffield over the last 3 years (per 1,000 patients):



4.3.20 The graph above, taken from the ePACT2 mental health dashboard, is showing the number of unique patients being prescribed an antidepressant over time. From this it can be seen that Sheffield continues to track slightly above the national average, apart from a couple of months where levels seem to dip.

- From local prescribing data the number of prescription items for antidepressant medication has increased from 643,854 in 2016/7 to 717,009 in 2018/19.
- Adding dosulepin and trimipramine to the STOP list has seen a reduction in the number of items and spend on these two medicines. This reduction has resulted in improved patient safety and a reduction in costs of £31K (annualised).
- IAPT activity continues to grow year on year. The number of people within Sheffield CCG (i.e. registered with a Sheffield GP) accessing IAPT has increased from 12,960 (in 16/17) to 13,335 (in 18/19), an increase of 5.21%. The national 6 and 18 week waiting time targets, set at 75% and 95% respectively, continue to be achieved. The proportion of people being seen within 6 weeks has improved from 84.52% in 16/17 to 89.67% in 18/19. The proportion seen within 18 weeks has improved from 98.17% to 99.03%.

4.3.21 The increasing rate of diagnosing depression / GAD is seemingly greater than the rate of people in remission and thus stopping antidepressant medication. This can be seen from the increasing volume of prescriptions being dispensed and investment and use of IAPT services.

4.3.22 Feedback from Clinicians

4.3.23 In writing this report feedback was sought from a small number of GPs, responses are below:

- *'My guess is that the numbers of new starters may have slowed but there is a growing group who value their antidepressants and are hard to get off. The meds themselves are physically difficult to wean off and often the original problems don't go away either.'*
- *'Whilst the increase in IAPT services is very welcome it may not be adequate or sufficient to fully meet the ever changing demand. Although the therapy offer at hand to the clinician has changed in this time, it doesn't mean that patient expectation will have changed to match this over the same time.'*
- *'GP colleagues may not follow guidelines particularly about watchful waiting and we are not so good at discontinuing antidepressants after successful treatment. Just like colleagues have previously stated that there are (in their perception/experience) huge wait times for Memory Clinic when in fact the whole diagnostic pathway is currently 6 weeks from referral to diagnosis, we still think similarly for Core IAPT services, when the data/evidence says that nearly 90% of people are seen within a 6 week pathway and 100% (well, 99.6%!) in an 18 week pathway. Of course many of those people will also be using antidepressants as well as psychological interventions.'*
- *'We should invest in more psychological support and treatments, but we should also be directing resources to prevention of illness and promotion of wellness which goes well and way beyond the remit of the NHS.'*

4.3.24 Conclusion

4.3.25 The high use of antidepressants is a complex and challenging issue, and not completely unique to Sheffield. It is difficult to conclude whether the actions taken by the project so far, which have undoubtedly led to some changes in prescribing practice, have been offset by an increased number of new patients presenting with depression or anxiety.

4.3.26 There is increasing acuity of mental illness presentations across the system, and unmet need is being revealed. GPs and other professionals sometimes don't recognise that there are psychological interventions available in a timely manner before prescribing becomes necessary. In such a complex system as the NHS it often takes time for information about changes to services to become well known across the system. GPs sometimes therefore feel that prescribing is the only option open to them, when often it isn't.

4.3.27 It is important to note that sometimes it is absolutely necessary to both prescribe medication AND have psychological interventions for a patient. Additionally, sometimes 'antidepressants' are used for other purposes e.g. treating anxiety or migraine or premenstrual syndrome

4.3.28 This highlights the importance of the Transformation Programme as an interrelated set of strategic activities, not just a group of 'standalone' projects. It strengthens the case for a more comprehensive approach to mental health wellbeing and prevention

4.3.29 Next steps

- Once the updated NICE guidelines for depression have been published we will review our local guidelines, formulary and protocols and cascade any advised changes in practice accordingly.
- We will work with the newly recruited pharmacist to promote MH pathways and guidelines and audit / review patients on long term antidepressants and assess if IAPT is being offered in line with national / local guidelines.
- Public Health England are currently undertaking a review looking at prescribed drugs that may cause dependence, this is due to be published in September 2019. Antidepressants have been part of this review³. Once this report is published we will review it to see if there are any suggested actions that need to be taken locally.

4.4 Transforming Care

4.4.1 What Has The Project Done?

4.4.2 Transforming Care was a national three year transformation programme, originally due to finish at the end of March 2019. The programme aimed to reduce over reliance on admitting people into specialist hospitals who have learning disability and/or severe autism but who also who have additional highly complex behaviours that are challenging to support within community settings, by developing alternative community service models to provide care in less restrictive environments.

4.4.3 Many people nationally had previously "lived" inappropriately for several years in hospital, as alternative skilled community provision was not available for people with additional very complex needs. These may include behaviours that are challenging to support such as self-injurious behaviours, or those that present a risk of harm to others, through for example serious aggression and offending behaviours.

4.4.4 However, a series of undercover exposures and national scandals around poor care and criminal abuse in some, mainly private, hospital settings across the country drove the government to develop the Transforming Care Programme to commit to transformational change.⁴

³ <https://www.gov.uk/government/collections/prescribed-medicines-an-evidence-review>

⁴ <https://www.england.nhs.uk/learning-disabilities/care>

- 4.4.5 The programme is therefore built on the fundamental principle that '*Hospitals are not homes*'. Admission to hospital should therefore take place for the least possible length of time, and only if other less restrictive alternatives are not possible to address the presenting complex mental and behavioural needs of the individual. Whilst initially aimed at adults, the programme was extended to include children and young people. NHS England commission inpatient hospital treatment for this age range, but we work in partnership with them to reduce admissions where possible, and to discharge children into appropriate community settings.
- 4.4.6 The programme therefore set a national target of a minimum reduction of 45-65% of CCG commissioned specialist hospital inpatient capacity and 25-40% of NHS England commissioned capacity over the 3-year period, to drive a reduction in over-reliance and inappropriate usage of hospital admissions for this specific group of people with learning disability and complex behavioural needs.
- 4.4.7 To respond to this programme, Local Authorities, Clinical Commissioning Groups and NHS England Specialised Commissioners were asked to form a Transforming Care Partnership (TCP) in each region, to work together on implementation. The TCP for this area is South Yorkshire and North Lincolnshire (SY&NL TCP) comprising Doncaster, Rotherham, North Lincolnshire and Sheffield CCGs and the corresponding Local Authorities.
- 4.4.8 The SY&NL TCP had 45 adult CCG inpatients at the start of the programme, and NHS England set an end target reduction of no more than 10-15 inpatient beds commissioned by CCGs for our TCP area by the end of March 2019.
- 4.4.9 This emphasis on '*Hospitals are not Homes*' also included a new national model of enhanced community based support, "Building the Right Support"⁵ which NHS England and ADASS both committed to. The model states that each area is expected to reinvest savings from hospital bed closures into enhancing community services to provide alternative care in less restrictive environments, and to develop local provision to meet needs, so that people could be cared for closer to home.
- 4.4.10 Due to a national failure to deliver on this Transforming Care agenda, the programme has now been extended to run until April 2021. However it should be noted that our South Yorkshire Transforming Care Partnership has been nationally highlighted for the progress made on moving people out of hospital and into less restrictive environments, and has been identified as having been one of the most successful areas in the delivery of this programme in the country, with Sheffield itself highlighted for its performance.

⁵ <https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf>

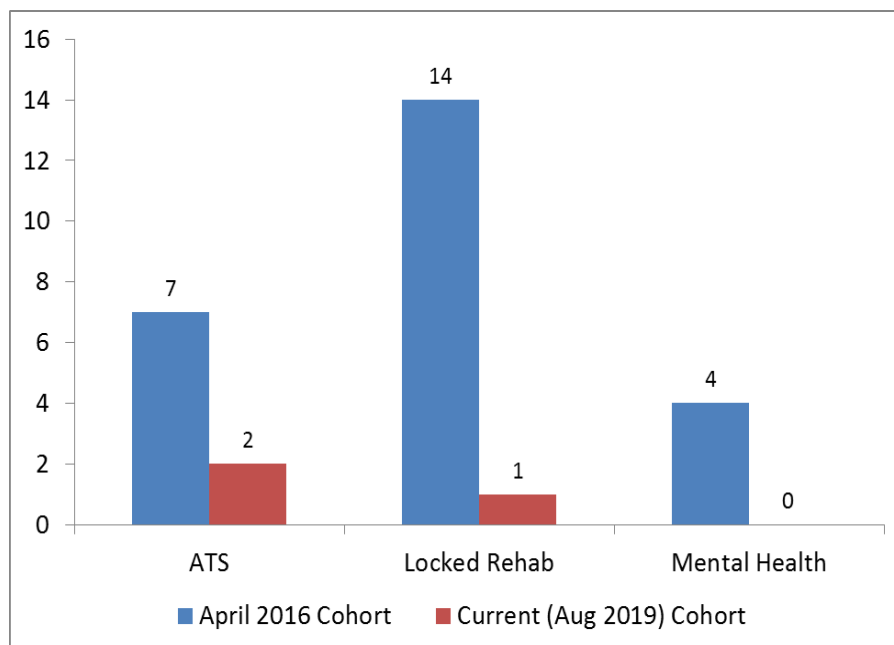
4.4.11 What Has The Project Done?

- 4.4.12 Sheffield CCG and Local Authority started this programme with 25 people in adult inpatient beds, seven of whom were in a local Assessment and Treatment Unit, Firshill Rise, run by Sheffield Health and Social Care NHS Foundation Trust (SHSC). The rest of the placements were purchased in out of city locked rehabilitation placements by SHSC in a devolved commissioning arrangement for detained patient care. This represented an opportunity to improve the lives of this cohort of people by identifying less restrictive environments in which to provide their care.
- 4.4.13 All 25 of the original cohort of 25 people have now been discharged into less restrictive environments, such as residential care and supported living settings, and are now living more independent lives.
- 4.4.14 Many of these individuals were previously under Ministry of Justice restrictions, so this represents significant transformation in the lives of the individuals concerned. This change has been achieved through coordinated, determined and sustained effort by Social Workers, Clinicians, and leaders within the Local Authority, Sheffield CCG and SHSC to achieve this major improvement in the lives of these individuals, and greater personal freedom, from living in less restrictive settings than a hospital affords.
- 4.4.15 Overall, over the 3 year programme duration, 54 people have been discharged into community placements, as 12 additional patients were stepped down by NHS England from secure hospitals to care commissioned by Sheffield, and additional new people were admitted appropriately, treated and discharged through the Assessment and Treatment Unit in Sheffield, for varying lengths of stay during this period. The average length of stay has significantly reduced over the three year period from over 180 days to 90-180 days average.
- 4.4.16 In line with the national aims of the programme Sheffield has successfully discharged 23 people with a length of stay in hospital of over 5 years, including 3 patients who had had been in hospital settings for over 30 years.
- 4.4.17 Sheffield has successfully *avoided* over 50 people being admitted to hospital as part of the programme, through timely multiagency Care and Treatment Reviews, and preventative interventions. There are currently now only 3 Sheffield adults receiving treatment in hospital beds, commissioned by Sheffield CCG. Sheffield has therefore surpassed its target of seven hospital beds for adults in use by the end of the original programme in March 2019, as people are receiving better care closer to home to avoid unnecessary admissions.

4.4.18 Additionally Sheffield has significantly reduced the usage of out of city locked rehabilitation beds and acute mental health wards for inpatient admissions for people with Learning Disabilities, so that the majority of admissions are now to the specialist Assessment and Treatment Unit in Sheffield.

4.4.19 We have also seen successful discharges and avoided admissions for children and young people, (CYP) but will be focussing more resource on admissions avoidance for this group, through the provision of a specialist CYP Care and Treatment Review Coordinator, and through the recently commissioned Home Treatment Team for young people. We are also reviewing the provision of services to young people with autism, as this is an area of prevalence growth.

4.4.20 Transforming Care Cohorts 2016-2019: CCG Inpatient Locations



4.4.21 What Impact Has The Project Had

As described previously, people who had delayed and often blocked discharge pathways out of hospital settings, are now rigorously tracked at admission, and agencies work more effectively together to plan robust discharges. This means that individuals are able to move to less restrictive environments more quickly and sustainably, once their episode of care has successfully stabilised their original presenting conditions. Individuals experience a return to a more “ordinary life” living within community settings, rather than segregated in hospitals. For the original cohort of people, particularly those individuals who had “lived” in hospitals for many years, the transformation has been enormous, as they now have more choice and control, and live more integrated lives within communities, in less restrictive settings.

- 4.4.22 **Case Study 1:** One man in his forties, spent many years in restrictive hospital care out of city, under restrictions imposed by the Ministry of Justice, and is now living in specialist supported living in his own tenancy with support, doing paid work as an Expert by Experience
- 4.4.23 **Case Study 2:** One woman in her fifties who was detained under the Mental Health Act in hospital for several years is now living in a specialist new build residential unit and has stated that she is happy that she is “not a patient anymore” and is participating in more community based activities.
- 4.4.24 **Case study 3:** One man who was considered to be one of the most complex people to support due to a long history of aggression, has moved into a specialist residential setting, after careful discharge planning. This took many months to achieve due to the destabilising effect that change had previously had on him, and included a very lengthy introduction to his new staff team. He has settled into his new home better than had been anticipated and participated in a five mile walk within the first week of moving in.
- 4.4.25 In addition to the impact on individuals as illustrated above, Sheffield has implemented the nationally recommended model of Positive Behaviour Support, and over 500 staff and family members in the city have been trained in this approach to better support people with the additional complex needs described earlier. This has been identified as an area of good practice in our region.
- 4.4.26 Market stimulation has taken place with commissioners across the region to attract community care providers to the area and to the city who have more highly specialist skills to successfully support this cohort of people with complex needs. There was previously a limited market, due to the highly specialist nature of the skills required to support people well, and due to the difficulty of attracting providers to work with small numbers of people who present with this high level of complexity. This lack of appropriate provision previously led to hospital admissions as care packages with less skilled providers broke down.
- 4.4.27 Work has started on 2 new build sites of self-contained apartments built to a high specification, designed to better support people with additional complex needs, partially funded by a recent successful capital bid of £674k from NHS England, to add to a previous bid of circa £500k, which contributed to the Local Authority accommodation strategy for this cohort of individuals, to reduce reliance on out of city residential placements in the future.
- 4.4.28 Greater collaboration and consistency of approaches are now embedded into the management and coordination of support for the adult Transforming Care cohort between social workers in the Future Options Team and SHSC clinicians, working closely with Sheffield CCG, based on the best practice approaches that were evidenced in the Named

Social Work pilot. This has been highlighted as positive practice regionally, and has led to smoother discharges, as the Future Options team have the necessary skill, experience and can give greater continuity to this complex cohort of individuals than social workers with more generic skills.

4.4.29 As stated above, the national service model, “Building the Right Support” required local areas to move towards a community-based approach and to reduce the reliance on inpatient hospital facilities such as Sheffield’s Firshill Rise, by enhancing specialist community services. Some additional capacity has therefore already gone into the community clinical teams aimed at providing better support to individuals with complex needs. However, we have further ambitions to enhance this service offer to individuals and their family and paid carers, to meet the requirements of “Building the Right Support.”

4.4.30 We have therefore been engaging with people with learning disability, their family carers and paid staff, clinicians and other stakeholders around what would sustain people to live within their own communities, as an alternative to hospital care, working with *Speak Up Rotherham*, an organisation of self-advocates with lived experience of learning disability. It is therefore intended to extend access to specialist clinical support into the evenings and weekends, when currently no specialist clinical support is available. This will be funded, as nationally mandated, by releasing the costs associated with the reduction in the use of inappropriate hospital care.

4.4.31 There is an acceptance of the benefit of working together to co-commission the region’s remaining Assessment and Treatment Unit at Firshill Rise, run by SHSC, with commissioning colleagues across Rotherham and Doncaster, as Sheffield had been successful in reducing its reliance on inpatient beds and no longer needs all of the beds that we previously commissioned. This collaborative commissioning approach will enable Sheffield CCG to invest more into the above community services, in order to deliver the national model of evidenced based practice, as outlined in “Building the Right Support”, whilst retaining some local hospital provision.

4.4.32 This will improve the lives of more people with learning disability, complex needs and their families in Sheffield, and enable us to implement what they have identified as the best ways to sustain people within their own homes and communities.

5. Wider System Impacts

5.1 Financial Benefits

5.1.1 The Transformation Programme is underpinned by a Memorandum of Agreement (MOA), which provides a framework for how the Clinical Commissioning Group (CCG), the Council (SCC) and the Sheffield

Health and Social Care Trust (SHSC)e to work together, ensuring that we remain focused on quality and outcomes not on organisational priorities. It also details how the programme will be refreshed and expanded, so as to meet system wide efficiency requirements, including workforce development, capacity management and also financial efficiencies. Whilst the MOA has not been the only reason why partner organisations work differently, it has certainly provided an important and clear point of reference and framework.

5.1.2 The MOA also articulates how the 3 partners will share both the benefits and the potential risks of working together. Whilst improving quality does of course remain the primary focus, the financial sustainability of each constituent partner is equally important (if one fails, we all fail). This has ensured that we have systematically approached financial efficiency in a way that mutually benefits each organisation, and avoids 'cost shunting', even when this occurs inadvertently. The programme has therefore positively changed inter-organisational behaviour.

5.1.3 In year one of the programme we delivered £2.6m efficiency and in year two a further £3.9m (which included SHSCs contribution). In year three we are currently forecasting £2.2m in financial efficiencies. This has been delivered largely by addressing inefficient practice, for example by ensuring individuals have the opportunity to live fulfilling and rewarding lives outside of institutional care, that people in crisis can receive appropriate support and treatment in the right environment and that we provide holistic care based on needs not based on artificial access criteria.

5.1.4 We remain committed to delivering the programme based on the principles of improving quality, improving experience and improving outcomes; and therefore everything we do is subject to clinical and professional scrutiny.

5.2 Service Reconfiguration

5.2.1 As well as the examples highlighted in section 4 of this report; the scope of the programme effectively extends to every aspect of mental health, learning disability, autism and dementia care in Sheffield. In particular we are consistently looking for opportunities to improve and enhance clinical quality and outcomes through collaboration, creativity and innovation.

5.2.2 In addition to the 5 examples given therefore, the programme has also delivered the following key improvements:

- We have developed, for the very first time, a genuine system wide Dementia Strategy for Sheffield;
- We have developed a new (proposed) eating disorders pathway, which has been undertaken with service users, carers, experts by experience and other interested parties;

- We now have psychological therapists working alongside physical healthcare clinicians in 10 clinical pathways at STH;
- We are just about to launch a system wide physical health strategy/programme;
- We have streamlined the relationship and sexual health service; and
- We have recurrently secured all investments into the Children's and Young Peoples Local Transformation Plan (as part of our lifespan mental health aspirations – see section 6.1).

5.3 Societal Benefits

5.3.1 This Transformation Programme aims to collectively change how we approach mental health commissioning to improve the lives of people with mental health problems, through our joint focus on addressing the wider determinants of mental ill health, as part of the city's Public Health and Mental Health strategies.

5.3.2 Positive mental health and wellbeing underpins a range of wider societal benefits, such as happier and healthier individuals, stable and secure families, increased educational attainment and increased levels of employment. These benefits help build and maintain thriving families and communities in our city, and a healthier local economy.

5.3.3 In Sheffield for the 80,000 citizens who have either depression or anxiety and over 5,000 people who experience severe mental illness, they have a poorer quality of life and poorer health than other citizens, which can impact on their families, friends, neighbours and employers. Given this prevalence and the impact on physical health, by working in an integrated way to transform care across health and social care we aim to improve these life experiences and outcomes for individual service users and their family and friends, which will also create a wider benefit to society, through our focus on mental health promotion, prevention and on early intervention.

5.3.4 Additionally, the Transformation Plan will also achieve financial efficiencies in the reduction in our use of the most expensive parts of the secondary health and social care services through an improved community offer through our focus on mental health promotion, prevention and on early intervention.

6 Challenges and Next Steps for the Programme

6.1 Lifespan Mental Health

6.1.1 Levels of Acuity and Demand are rising in both children's and young peoples and adult mental health services. In other words more people are coming forward for help, with more serious and complex problems. We are therefore keen to enact a commissioning approach that will have a long-term sustainable impact on the wider system not just on specific parts of the traditional 'care' pathway. For us this means taking a *lifespan*

approach to the commissioning and provision of care. This means creating a system where:

- The focus is on early intervention and prevention;
- Where we see a reduction in the number of individuals who develop severe and enduring mental ill health;
- We genuinely adopt person centred care principles, where services are provided based on need. Age, for example, would no longer be used as criteria for determining access;
- ‘Non-health’ issues are taken into account when determining packages of care and support; such as housing, debt and employment etc.
- We focus on the whole, rather than individual component elements of our families. As we now know the family dynamic during pregnancy, infancy and childhood has a direct impact on a child’s mental health and wellbeing; and
- Where improved Infant mental health is measured by school readiness and Improved School Mental Health is measured by reduced school exclusions in primary and secondary school.

6.1.2 Our overarching ambition is to create a ‘one stop shop’ approach for mental health; where parents and their children are treated by a single team of professionals, thus presenting us with an opportunity to proactively address intergenerational problems.

6.2 Health Inequalities

6.2.1 In widely publicised national evidence, it is acknowledged that there is up to a 30 year mortality gap between people with severe mental ill health and the rest of the population. People with mental health conditions are therefore dying earlier from preventable and treatable health conditions.

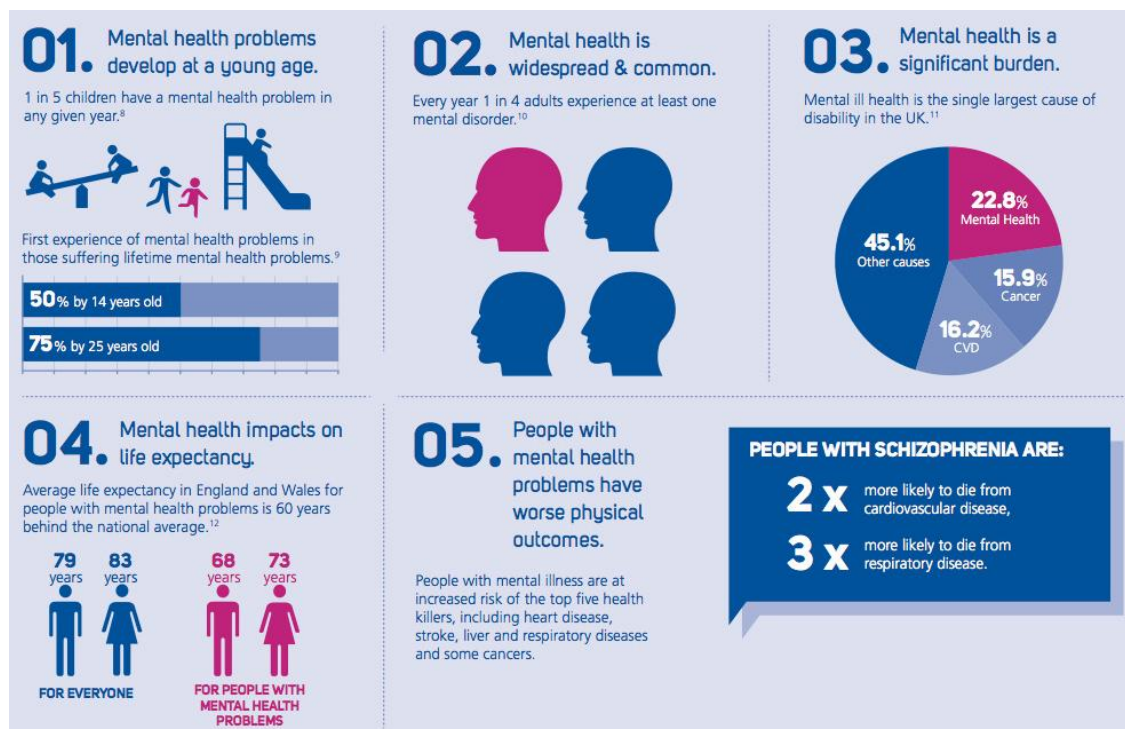
6.2.2 Mental illness has a similar effect on life-expectancy to smoking, and a greater effect than obesity, and is also associated with increased chances of physical illness, such as coronary heart disease, Type 2 diabetes, or respiratory disease.

6.2.3 In addition, poor physical health increases the risk of mental illness. The risk of depression is doubled for people with diabetes, hypertension, coronary artery disease and heart failure, and tripled in those with stroke, end-stage renal failure and chronic obstructive pulmonary disease. Children experiencing a serious or chronic illness are also twice as likely to develop emotional disorders.^{6 7 8}

⁶ <https://www.centreformentalhealth.org.uk/publications/long-term-conditions-and-mental-health-cost-co-morbidities>

⁷ <http://www.bris.ac.uk/cipold/>

6.2.4 The infographics below illustrate the health inequalities faced by people who experience mental ill health.

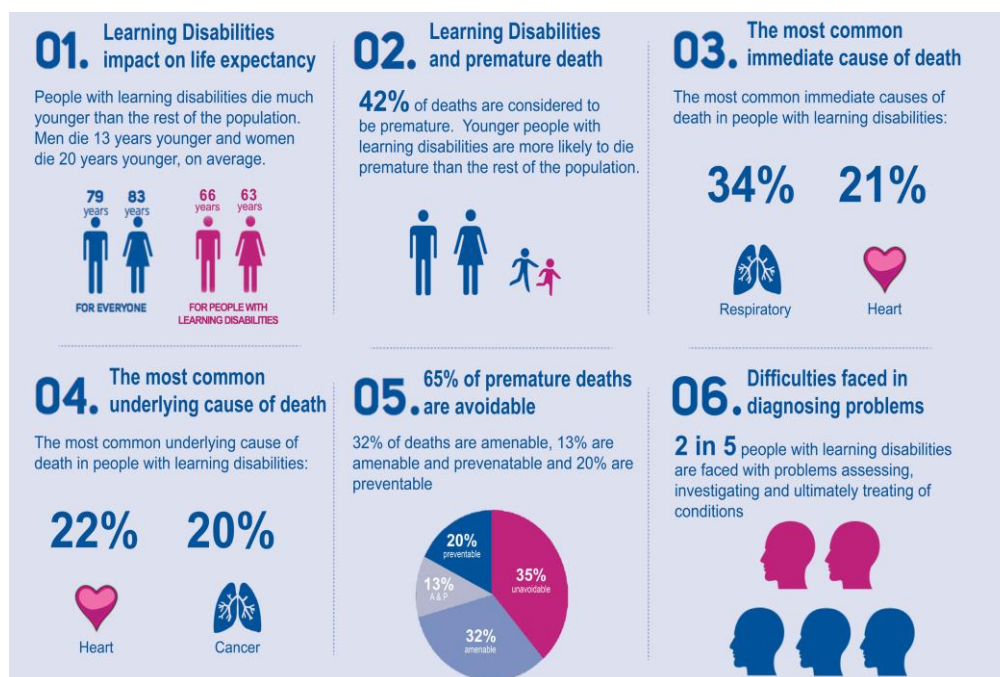


6.2.5 There are similar patterns for people with learning disability, who face the additional health inequalities associated with communication and physical impairments and who may have less opportunity to express their needs, or to seek access to health services themselves See infographics overleaf

6.2.6 The Learning Disabilities Mortality Review (LeDeR) programme is a national review of the underlying causes of the premature deaths of people with learning disability, in which Sheffield is an active participant.⁹ It is the first national programme of its kind aimed at making improvements to the lives of people with learning disabilities by understanding the inequalities in health and social care that may have contributed to their premature deaths. Reviews are being carried out with a view to improve the standard and quality of care for people with learning disabilities to reduce their health inequality, and reduce preventable deaths. People with learning disabilities, their families and carers have been central to developing and delivering the programme nationally and locally.

⁸ <http://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf>

⁹ <http://www.bristol.ac.uk/sps/leder/>



6.3 Parity of Esteem

- 6.3.1 Society has traditionally not seen health conditions in a holistic and integrated way, and there is a national disparity between the way that we value and invest in the physical health of our population compared to their mental health. There is therefore an impact of this *social inequality* on *health inequality*.
- 6.3.2 *Parity of Esteem* is the principle through which mental health should be given *equal priority* to physical health when planning and delivering services. Although currently, nationally, mental health problems account for 23% of the burden of disease, mental health services account for only 13% of NHS spending. In order therefore to reduce the burden of physical and mental ill health we need to take a more integrated approach to collaboratively addressing the underlying social determinants of ill health, such as poverty, unemployment, poor housing, to address the social and health inequalities that disparity of esteem leads to.
- 6.3.3 The Integrated Transformation Programme of work enables us to better understand the societal factors at play which lead to health inequality, and to collaborate in a more coordinated way when we design and commission services to address these factors.
- 6.3.4 Many of our Transformation Projects as described above contribute to this approach. Others include joint work with partners around improving access to specialist employment support, improving access to GP delivered physical health checks for people with learning disability and for people with severe mental illness, developing the dementia strategy in the city, improving access to diagnosis and support for autism.

6.3.5 We have initiated the multiagency Physical Health Implementation Group, which has a series of workstreams aimed at identifying and addressing health inequalities faced by this group, led by Dr Steve Thomas, Clinical Director and GP, with support from Liz Tooke, from Sheffield City Council.

6.4 Developing an Improved Offer

6.4.1 For the Integrated Transformation Programme to be judged as effective, it has to be tangible to local people as users of local services and their families and friends. We want to improve the way that we engage with people to seek their views, preferences and experiences of mental health services, and the services offered to people with learning disability, autism and dementia.

6.4.2 We have therefore externally commissioned a piece of work to help us to improve the way that we both engage with and co-produce local services so that we are able to understand from a user's perspective what an improved offer would look like.

6.4.3 An improved offer from the perspective of us as partners across health and social care also means improving our joint understanding of our priorities and objectives, so that we can work more effectively together to develop plans that really do lead to improved commissioning outcomes.

6.4.4 Previously, as separate organisations, we would develop and implement plans in isolation, which would often lead to inefficiency, duplication or gaps in services. Now, by working collaboratively, we are able to see where decisions previously taken in isolation can be improved by having a full perspective on impact and outcomes

7. Recommendations

a. The Healthier Communities and Adult Social Care Scrutiny and Policy Committee is recommended to:

- Consider the development and impacts of the Sheffield Mental Health Transformation Programme as outlined in this report and provide views; and
- Provide comments and recommendations for future developments.

Appendix A

Case Studies

CASE STUDY 1 – ‘Lucy’

Lucy is diagnosed with schizophrenia and a learning disability. She has been unwell for many years and was admitted to hospital every year until 2009. She has a significant risk history, involving being sexually inappropriate, setting fires, being threatening towards family members and assaulting other patients and staff.

From 2009 to 2015 Lucy was treated in hospital and spent a number of years in a nursing home outside of Sheffield. Following discussions with Lucy and her mother, it was agreed that she would be better placed living in Sheffield where her support team and mother would be able to visit more easily and regularly, and Lucy wanted to return to Sheffield. There was concern that Lucy was being “over cared for” at the nursing home during the day, and that they were not enabling her to be as independent as she was capable of being.

Various residential places were considered in Sheffield and it was hoped that the placement would continue Lucy’s journey towards independence.

Lucy moved to specialist residential accommodation in Sheffield in April 2016. She re-settled in Sheffield, and continued her recovery from mental ill health. A re-assessment in January 2018 gathered evidence that she did not require this level of care anymore, and indicated that she was ready to move on to greater independence, in accordance with her own wishes.

Assessment of Lucy’s mental health needs led to the conclusion that his needs could be met outside of registered care home provision. Lucy was shown various supported accommodation options. There was a measure of resistance from both the residential home who had formed an attachment to Lucy in her time there, as well as concern from his mother, who was worried that Lucy’s mental health might deteriorate if she moved. In accordance with the 2014 Care Act, an advocate was employed to assist the process.

Suitable independent supported accommodation in an area that Lucy wanted was found. The care hours were tailored to the needs that Lucy has, notably giving assistance around meals, medication and feeling supported in the community. Lucy moved to her new independent accommodation with visiting support in June 2019. This move had the support and backing of both the commissioners for Health and Social Care in Sheffield.

Since moving Lucy has settled well. Enough support hours were commissioned to ensure that the move out of residential care was both safe and helped Lucy to adjust to the change in environment. This was reviewed again in August

2019, and the hours were reduced by 11 hours a week in line with Lucy's continued recovery. It is envisaged that Lucy will continue to progress in her mental health recovery, and that her reliance on support organised by statutory services will reduce further in the future.

CASE STUDY 2 – 'Sean'

Sean has a diagnosis of Paranoid Schizophrenia and has been involved with mental health services since 1993. He also has a number of physical health problems.

Sean was admitted to hospital in August 2008 after living independently in his own flat. He had become quite ill, not taking medication, seriously neglecting himself and his flat and falling into debt, as well as exhibiting worrying behaviour that could be a serious risk to himself or others. Whilst in hospital on a number of occasions he assaulted staff and other patients.

Sean was discharged to an out of city nursing home in August 2009, as it was felt too unsafe for him to continue living independently in the community and Sean lived there until 2018.

In 2016 a comprehensive review of Sean's needs and wishes was undertaken, which indicated that 24 hour residential accommodation, rather than nursing care, would be more suitable for him. Incidents of challenging behaviour had not been evident for several years.

However, Sean did continue to have on, was that he had needs relating to his physical health. These physical needs were initially cited by the nursing home, his advocate and community mental health team as reasons why he should not move on. Work was done with all concerned regarding drugs and medication for these conditions. It was planned that the physical health needs for S could all be met in a residential setting, by staff who had the relevant training, and through the relevant local community health services.

Sean made it known directly and with the aid of an advocate that he did not want to move out of his current accommodation, which he had come to view as his home. Indeed, thinking and talking about moving, seemed to increase his anxiety, and cause a periodic worsening in his voices, becoming more demotivated and becoming less physically well. Work was undertaken at a pace which allowed Sean to make the necessary adjustments and consider the more positive aspects of moving. In turn Sean recovered from these anxieties and the effects they had.

Sean went to see a number of residential homes, who all said that they could accommodate him and manage his mental health aftercare needs, as well as

his physical health difficulties. Due to unpleasant memories, Sean stated that he wanted to stay out of Sheffield. In accordance with his wishes, a residential home was found, geographically close to where he had been living for a number of years. In addition to this, a residence was found that would allow him to have a larger bed, have somewhere to exercise outside, and have satellite television, which were three specific preferences he had for move on accommodation. Sean moved to the new residential home in June 2018 and has lived there successfully and positively since.