

Delivering Quality, Innovation, Productivity and Prevention (QIPP) and the Sheffield Health and Social Care NHS Foundation Trust Contract

Governing Body meeting

6 April 2017

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Is your report for Approval / Consideration / Noting	
<p>The purpose of this report is to provide Governing Body with a further briefing on the approach that the CCG has taken (and is continuing to take) with regards the delivery of QIPP and the Sheffield Health and Social Care NHS Foundation Trust contract (herein referred to as the Mental Health Transformation Programme).</p>	
Are there any Resource Implications (including Financial, Staffing etc)?	
<p>As Governing Body members will recall from previous briefings, the resource implications of this work are two-fold:</p> <ol style="list-style-type: none"> 1. In line with the CCG's financial plan, the Mental Health Transformation Programme will need to generate £4m of efficiency savings in 2017/18 and a further £2m in 2018/19; and 2. Resources will need to be dedicated to delivering this programme, and therefore work is underway to ensure staff time is 'freed up' so that this can be resourced correctly; which will be of particular importance during the delivery stage(s). 	
Audit Requirement	
<p><u>CCG Objectives</u></p> <p><i>Which of the CCG's objectives does this paper support?</i></p> <ol style="list-style-type: none"> 1. To improve patient experience and access to care; 2. To improve the quality and equality of healthcare in Sheffield; 3. To work with Sheffield City Council to continue to reduce health inequalities in Sheffield; 4. To ensure there is a sustainable, affordable healthcare system in Sheffield; and 5. Organisational development to ensure CCG meets organisational health and capability requirements. 	

Equality impact assessment

Have you carried out an Equality Impact Assessment and is it attached?

An Equality Impact Assessment (EIA) has not yet been carried out; although an assessment will be undertaken for each individual project. The outcomes of each assessment will form a key component of individual delivery plans.

PPE Activity

How does your paper support involving patients, carers and the public?

Each individual project that forms part of the Mental Health Transformation Programme will include engagement with patients, carers and where appropriate the public. This will include, where practical, involvement in the design and implementation stages.

Recommendations

The Governing Body is asked to consider and accept the contents of this report and agree to accept a further update midway through the year (once the delivery stage is well underway).

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1. Introduction

Governing Body will recall from previous briefings that the 2017/19 contract negotiation process between Sheffield CCG and Sheffield Health and Social Care NHS Foundation Trust (SHSC) was challenging; although it should be noted that an agreement was reached by the end of January 2017 (in line with national requirements). A key component of this agreement (which is reflected via a specific contract clause) is the approach we are taking (and will continue to take) regarding the delivery of £4m QIPP in 2017/18 and a further £2m in 2018/19 (alongside SHSCs Cost Improvement Programme).

This has involved the CCG establishing a small transformation team who have been working jointly with colleagues at SHSC and Sheffield City Council (SCC) to define and initiate a series of transformational programmes and projects. A series of workshops have been held over the last 10 weeks involving senior clinical and operational staff from all three organisations (and others as required). These workshops, although arranged on a thematic basis have focused broadly on the following three areas:

- a) 'Quick wins' and costs pressures (i.e. areas where immediate changes can be agreed and actioned);
- b) Changes to existing care pathways, focusing specifically on how SHSC can deliver services differently; and
- c) Changes to existing care pathways, focusing on areas where alternative provision should be considered where this will improve quality and patient outcomes.

Although there is still one final workshop to be held, a total of 21 projects have been identified so far (with 13 having been scoped financially); these range from short-term tactical projects through to major reconfigurations of existing care pathways. It is envisaged therefore that the programme will not only deliver major strategic and financial benefits but also a genuine transformational change to the way in which services are commissioned and delivered in future.

The workshop approach has demonstrated a cross organisational commitment to ensuring this work is undertaken jointly, collaboratively and safely. This latter point is particularly important, as all parties are clear that whilst the driver for this work is the delivery of efficiency savings, 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 prevention and early intervention.

2. Outcome of Workshops

As noted above, the overarching outcome of the workshops has been the identification of 21 project areas. Current (conservative) estimates suggest that the savings potential could be as high as £7-8m recurrently by 2020/21 (based on the financial scoping undertaken so far).

Of the 21 project areas however, there are four large scale transformational schemes ('big ticket items'). These are focused on independent living, dementia care, liaison mental health and the development of a primary care mental health service (see 2.1 below for further details). Our forecasts suggest that these schemes account for well over two thirds of the overall savings projection; and on that basis should be given priority. This approach is further compounded in light of the scoping work that has been undertaken around these areas which describe and articulate a major change in the way services are delivered in future. This is very much in keeping with the 'Quality' component of QIPP.

This is not to say that each of the other 17 project areas should be ignored. Indeed at least four of these have already progressed to the delivery stage. However, the recommendation to focus on the four major schemes is an acknowledgement that whilst there are some resources identified to ensure delivery of this programme, these are relatively limited and should therefore be targeted towards the areas of greatest potential impact. The other schemes should therefore be factored into the programme when resources allow, meaning delivery may not commence until year two (or indeed later).

2.1 'Big Ticket Items'

As noted above there are four major schemes that have been identified which form the foundations of our transformational programme. These are summarised below (including an overview of the savings potential):

Supporting Independent Living (Project 2)

2017/18	2018/19	2019/20	2020/21
£0.05m	£0.38m	£0.97m	£1.7m

The use of basic residential homes for adults with mental health problems is a poor strategic fit and a bad deal for the Sheffield economy due mainly to the fact that residential care is a low aspiration option for adults with mental health problems; with timetabled meals, a generic/limited activity offer, and a financial model that involves residents getting weekly 'spending money'. This model often slips into an institutional approach i.e. one that does not help people build links with the local community nor develop independent living skills. People very rarely move on from residential care to more independent living as they quickly form a co-dependency with the model.

Increased use of residential care is also at odds with the innovative and progressive work that SHSC have done with partners (e.g. SYHA) to support more people with enduring mental illness to live in the community in a supported tenancy. The acuity of need of many of the people supported through this innovative work is actually greater than many of the people currently living in more restrictive registered care accommodation; we need to work hard across all client groups to support people to reach their potential.

There is therefore a strong economic case for reducing the use of residential care. The net cost to the local economy when people are supported in residential/nursing care (as compared to a well-supported tenancy of their own) is around £15,000 per person per year; predominantly a result of people becoming ineligible for key Government benefit payments when they live in residential care for longer than a few weeks.

Dementia Care Pathway (Project 3)

2017/18	2018/19	2019/20	2020/21
(£0.15m)	(£0.15m)	£2.0m	£2.0m

Initial analysis and case review work by SHSC, which correlates with recent reviews of hospital discharge arrangements, and national studies; shows that people with dementia are at high risk of negative outcomes in Sheffield's secondary care system.

The basic issue is that the presenting acuity of people with dementia is dependent on their clarity of thinking at the time, and, clarity of thinking is adversely and progressively affected by being in an unfamiliar, busy, hospital environment. So, when people with dementia are admitted to hospital due to a physical health condition they can become increasingly confused and can present to family members and medical staff as being incapable of resuming the life they had prior to admission. This can be compounded further by other debilitating factors like hospital acquired infections, dehydration, malnutrition, and the use of sedatives.

As a result, people with comorbid physical conditions and dementia stay much longer in hospital than other patients and are more likely to be considered unsuitable for a return home; meaning they are more likely to end up in a residential/nursing home. Furthermore, as people with dementia in hospital become increasingly confused, the health system focuses increasingly on the dementia diagnosis, leading to the optimisation of care for dementia while the individual continues to deteriorate because of poor management of a comorbid physical condition.

National studies have found that inpatients with dementia are over three times more likely to die during their first admission to hospital for an acute medical condition than those without dementia. The human costs of people with dementia staying too long in secondary care are clear. The financial costs to the local health and care economy associated with treating people with dementia in secondary care are also significant; linked to comparatively long lengths of stay and the costs of avoidable permanent admissions to long-term residential or nursing care.

There is also a legal/technical issue that is impacting particularly in Sheffield due to our level of delayed discharges. Because people with dementia are being delayed

(‘detained’) in hospital beyond 30 days, they are being sectioned under the Mental Health Act. This means that any subsequent care costs are covered by Section 117 of the Mental Health Act and must be paid for jointly and in full by the CCG and Council (i.e. no contribution from the individual regardless of their personal wealth). This can add thousands of pounds per year to care costs per person.

This project aims to improve the outcomes for people with dementia that enter the secondary care system by reducing length of stays, reducing the use of sections under the Mental Health Act, and reducing the number of admissions to nursing and residential care, particularly from secondary care settings.

The business case for this project will attempt to scope the project more cleanly and look at a range of options for achieving the outcomes sought.

Liaison Mental Health (Project 6)

2017/18	2018/19	2019/20	2020/21
£0.2m	£0.4m	£0.6m	£0.8m

The competitive tender exercise undertaken in 2016 to secure a ‘Core 24’ Mental Health Liaison Service (MHLS) was paused in November due to Sheffield Teaching Hospitals NHS Foundation Trust (STH), as co-commissioner, withdrawing their financial support. The procurement exercise therefore remains live, but incomplete.

Following the decision to pause the process however, the CCG have taken the opportunity to reassess the overall scope of the proposed service; and have recently commissioned a full review of all hospital based psychology services; including those provided by STH. All such services were previously excluded from the liaison specification.

It is possible therefore that following this review the MHLS the CCG choose to commission/procure is much broader than that previously tendered and this may therefore change the approach the CCG need to take with regards the procurement process. Given the procurement is still technically live, it may be possible to restart the process without having to undertake a new tender exercise; although this, alongside other options, will be presented to Governing Body for final approval.

Developing a Primary Care Mental Health and Wellbeing Service (Project 21)

2017/18	2018/19	2019/20	2020/21
£0	(£0.15m)	£1.0m	£1.0m

Sheffield has 600 people living in the community under the secondary/clinical care of SHSC Community Mental Health Teams. Many of these people could be supported more effectively outside of the expensive and often paternal secondary care system.

Patients have basically come to be dependent on the support of community health teams, and health staff are too concerned about the very real risks associated with withdrawing support from individuals to discharge them from secondary care. There

are now dozens of people, potentially hundreds, who are under secondary care in the community who, with the right support, could be discharged into primary care.

There is a strong view that there is too much of a cliff edge between being under the care of a CMHT and being 'just another' registered primary care patient. It is also important to stress that many of the people under secondary care in the community are genuinely at risk of very negative outcomes, including suicide and violent crime.

This project is at an early stage of exploration, but initial ideas include moving investment from secondary care teams into a strong community/primary care infrastructure that supports people with mental health problems outside of the formal health system; with a particular focus on making sure that people discharged from community-based secondary care services do not feel 'dumped' by the system (e.g. ensuring that they can still access ad hoc and responsive support without having to demonstrate formal eligibility).

Any savings from changes in this project are highly sensitive to the success and cost of the replacement support put in place and the level of latent, unmet demand that undoubtedly exists in communities now.

3. Recommendations

Whilst the principle driver for undertaking this programme of work, at the scale and pace being proposed, is related to the well-documented system wide financial challenge; the approach we have taken to this work has instilled a genuine sense of collaboration and creativity. In many respects it has also helped to build productive working relationships between organisations and individuals where previously joint work was limited or, to be frank, less than constructive. So whilst we are still some way from actually enacting all the schemes that have been proposed so far; the programme has been approached very much in a collegiate way, adopting accountable-care principles. On more than one occasion, throughout the workshop programme, the question has been posed, 'what would we do if we were all working within one organisation'.

We have therefore built firm foundations from which to now deliver each respective project. The Governing Body is therefore asked to consider and accept the contents of this report and agree to accept a further update midway through the year (once the delivery stage is well underway).

Prepared by Jim Millns, Assistant Director of Contracting

On behalf of Peter Moore, Director of Strategy and Integration

March 2017