The Sheffield Mental Health Transformation Programme

Governing Body meeting

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11 January 2018

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Purpose of Paper

The purpose of this report is to:

a. Provide Governing Body with an update on the Sheffield Mental Health Transformation Programme; and

b. Seek Governing Body approval on the proposed mechanism by which the programme will be delivered in 2018/19 (and beyond).

Key Issues

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

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

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

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

Dementia Care (project 3), Liaison Mental Health (project 6), Primary Care Mental Health (project 21) and Integrated Improving Access to Psychological Therapies (project 26).

Is your report for Approval / Consideration / Noting

Sections 1-4 of the main report are for **noting**, *section 5* is for **approval**.

Recommendations / Action Required by Governing Body

The Governing Body is asked to:

1. Note the update as detailed in *sections 1-4* of the main report; and

2. Consider and approve the recommendations as detailed in *section 5* of the main report, focused on further enhancing the collegiate approach that NHS Sheffield CCG, Sheffield City Council and Sheffield Health and Social Care NHS Foundation Trust have/are proposing to take in terms of delivering the programme in 2018/19 and beyond.

Governing Body Assurance Framework

Which of the CCG's objectives does this paper support?

- To improve patient experience and access to care (Objective 1);

- To improve the quality and equality of healthcare in Sheffield (Objective 2);

- To work with Sheffield City Council to continue to reduce health inequalities in Sheffield (Objective 3);

- To ensure there is a sustainable, affordable healthcare system in Sheffield (Objective 4); and

- Organisational development to ensure CCG meets organisational health and capability requirements (Objective 5).

Are there any Resource Implications (including Financial, Staffing etc)?

As Governing Body members will recall from previous briefings, the resource implications of this work are two-fold:

a. In line with the CCGs finance plan, the Mental Health Transformation Programme will need to generate c£4m of efficiency savings in 2017/18 (plus a further contribution in 2018/19); and

b. It is essential that the programme is resourced correctly, particularly in terms of individual project delivery. Work continues therefore to ensure we secure the appropriate level of capacity and capability. A longer term solution is proposed in *section 5* of the main report.

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

Please attach if completed. Please explain if not, why not

There will not be a single Equality Impact Assessment (EIA) undertaken for the wider programme, given the diverse nature of the individual projects. An EIA has however been undertaken for each individual project, where it has been possible to do so (i.e. the overall project mandate has been adequately defined to allow for a meaningful EIA to be completed).

Have you involved patients, carers and the public in the preparation of the report?

A rolling communications/engagement plan has been developed and is being implemented. This includes engagement with a multitude of different organisations and individuals, including (but not limited to) a variety of groups that represent patients, carers and the wider general public.

In addition we are working closely with Healthwatch Sheffield to ensure we a) get real-time feedback on concerns and issues that are being raised directly with them and b) are able to contribute to and get feedback from a series of focus groups that they are currently planning to deliver to determine what individuals want to see from the provision of mental health services in Sheffield. In particular we are aiming to 'test' the assumptions that underpin the programme; specifically (although not exclusively) in relation to primary care and dementia care.

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

NHS
Sheffield
Clinical Commissioning Group

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1. Introduction

1.1 The Sheffield Mental Health Transformation Programme ('the Programme') is a collaborative programme of work that has been jointly developed and is being jointly delivered by Sheffield City Council (SCC), NHS Sheffield CCG (SCCG) and Sheffield Health and Social Care NHS Foundation Trust (SHSC). It was born ostensibly from a collective need to secure better joined up services and better value for money through economies of scale, reducing overlaps, eliminating wastage and through innovation and creativity.

1.2 The programme consists of 14 project areas (previously reported as being 17, however 3 projects have been discontinued due to viability), including 5 large scale transformational schemes ('big ticket items'). These are focused on Promoting Independence (project 2), Dementia Care (project 3), Liaison Mental Health (project 6), Primary Care Mental Health (project 21) and Integrated IAPT (project 26) (see *Appendix A* for full list of projects).

1.3 The overarching aim of the Programme is to address what are predominantly long-standing issues in Sheffield, whilst remaining focused on QIPP principles, i.e. quality, innovation, productivity and prevention. The latter 'P' of QIPP is particularly important and is a key component of the programme; tackling ill health at the earliest opportunity. If we get this right, this will not only improve the outcomes for individual service users but will ultimately deliver better value for money as we will rely far less on secondary health care services. This aspiration therefore underpins the entire transformation programme.

1.4 In addition we believe that by taking a more holistic approach to the delivery of mental health care will genuinely promote parity of esteem by strengthening support across the wider health system for people with mental health problems who tend to (a) have more negative experiences and outcomes when they receive health care, and (b) place a disproportionate level of demand on general health services. It will, as noted above, also help us to focus on the wider determinants of mental ill health and develop more preventative services.

2. Delivery

2.1 The Programme is being delivered jointly by SCCG, SCC and SHSC. In addition Primary Care Sheffield (PCS) have taken the lead on project 21 (Primary Care Mental Health). An overview of the programme (including a description of each individual project) is detailed at *Appendix A*.

2.2 All but one of projects (project 25) are now in the implementation stage. Every Project has an identified Senior Responsible Owner (SRO) and appropriate project

management support. The 5 large scale transformational schemes also have an identified clinical/professional lead; whose mandate is to ensure that clinical standards and quality are not unduly compromised.

2.3 As noted above, the overarching aim of the programme is to deliver efficiency by addressing inefficient practice and pathways. This will, it is anticipated, improve clinical quality, improve clinical outcomes and improve the experience of those who use services.

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

2.5 We also anticipate that clinical benefits will exceed earlier expectations, particularly given the system wide 'buy in' that we have been able to secure. The Programme has helped to build what are extremely productive working relationships between organisations and individuals who have historically had limited interaction or have had a less-than-constructive working relationship. So whilst we are only in year one of a four year programme, we have already seen significant benefit in terms of collegiate working and through the adoption of 'accountable-care principles'. From the moment we started this work we have continued to ask the question 'what would we do if we were all working in the same organisation', an approach that has helped to break down traditional organisational boundaries. We still have some way to go, but the foundations are certainly strong.

3. Governance

3.1. A governance structure (see *Appendix B*) has been established to support the delivery of the programme, ensuring that:

a. There is a rapid escalation procedure, so that all problems (however minor or indeed major) can be resolved quickly and (perhaps more importantly) collaboratively; and

b. There is a clear line of accountability right up to our respective Chief Executive Officers.

3.2. Perhaps the most important element of the governance structure however, is that it remains collegiate at every level. The programme is, by its very nature, intended to promote the concept of accountable-care and collective decision making; it is important therefore that every aspect of delivery is undertaken jointly, including the resolution of problems. This will help in terms of ensuring that 'traditional parochial behaviour' does not impact on delivery.

4. Benefits

4.1. Whilst we have already started to see significant benefits in terms of organisations coming together to develop a programme of work that is focused entirely on the needs of our patients (as opposed to the needs of each individual organisation); it is clearly important to ensure that these benefits are defined and therefore measurable.

Financial savings are relatively easy to measure; qualitative impact is much more difficult. A series of metrics have been developed to help measure the qualitative elements of the programme, these are however being continuously reviewed and refreshed.

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

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

5. 2018/19 (and Beyond)

5.1. The aspirational aim for 2018/19 is that there will be one single efficiency target and one single plan for delivery across all three partner organisations. This will, it is anticipated, avoid unnecessary duplication, promote economies of scale, allow the pooling of resources and prevent decisions being taken that could have unintended consequences on other parts of the health and social care economy. Having a single plan will allow transformation to continue to cut across traditional organisational boundaries and therefore present opportunities to improve whole pathways of care and therefore continue to improve clinical quality, clinical outcomes as well as generate a greater level of financial efficiency.

5.2. This approach will also allow for the pooling of clinical expertise; meaning any decisions taken will take account of a multitude of different clinical opinions both from a primary and secondary care perspective, physical and mental health perspective and from differing clinical viewpoints including (but not limited to) medical staff, nurses, social workers, psychologists, occupational therapists and healthcare assistants. This will further support (and promote) the anticipated improvements we hope to make in terms of clinical quality and outcomes.

5.3. Whilst work is still ongoing to determine the overall level of efficiency that all three organisations will need to deliver in 2018/19; there is a genuine desire to enact the ‘single target approach’, which will in effect negate the need for a separate Cost Improvement Programme (CIP) and separate QIPP. In addition, it also negates the need to have separate teams of staff working on different (often conflicting) transformational programmes. To support the delivery of the proposed single plan therefore, it seems sensible to have a single delivery team. Although the practical aspects of a potential joint team are yet to be fully worked through, it is likely, subject to agreement, that this will consist of a number of staff (from all three organisations)

who will, for the majority of their time, work as an integrated team focussed on delivering the transformation programme and other priorities as agreed.

5.4. It is likely (again, subject to agreement), that the single efficiency target will be delivered, predominantly, through an extension to the existing Transformation Programme. We accept that there will continue to be a need for small scale transactional projects, and in many respects this is right; however there is widespread acknowledgement that large scale transformational change will be the way in which large scale efficiencies will be achieved.

5.5. It is important to reiterate however that the underlying principle should be to ensure quality standards and clinical outcomes are, as a minimum, maintained as a result of transformation; although ideally we would like to see improvements. Generally speaking we have agreed to continue to tackle *inefficiency* (in the first instance) by way of delivering *efficiency*.

6. Action for Governing Body/Recommendations

The Governing Body is asked to:

a. Note the update as detailed in *sections 1-4* above; and

b. Approve the outline principles (as detailed in *section 5*) that will underpin the delivery of the Programme in 2018/19 and beyond, including (but not limited to) the creation of a single efficiency target, supported by a single transformation plan and delivered by a single team.

Paper prepared by: Jim Millns, Deputy Director of Mental Health Transformation and Integration (NHS Sheffield CCG, Sheffield City Council and Sheffield Health and Social Care NHS Foundation Trust)

On behalf of: Brian Hughes, Director of Commissioning and Performance

December 2017

Appendix A
Outline of the Sheffield Mental Health Transformation Programme

Project Number	Project Name/Description	Senior Responsible Owner	Project Manager	Clinical/Professional Lead
1	Section 117 Aftercare (Reviewing Function) The purpose of this project is to deliver savings against health and social care individual purchased care packages for individuals who are section 117 eligible. Our aim is to reduce the risk of institutional dependency and to enable people to move to less restrictive settings/practice.	Jim Millns (SCCG, SCC, SHSC)	Mel Hall (SCC)	N/A
2	Promoting Independence This project will support adults with enduring mental health needs to live more independently in the community. This will involve supporting nearly 200 people who are currently living in residential or nursing home settings to move out of a 24 hour care environment (where it is beneficial and appropriate to do so) into a more flexible supported tenancy that meets their needs.	Sam Martin (SCC)	Mel Hall (SCC)	Julia Walsh (SHSC)
3	Dementia Care Pathway The purpose of this project/programme is to develop work plans focussing on the following elements of dementia care in Sheffield: a. Living Well with Dementia (providing better support post diagnosis); b. Assessment/respite provision and intensive community support (providing a better crisis management and home treatment response so that unnecessary hospital admissions can be avoided); and c. Reviewing High Dependency and on-going care services (to ensure that the care provided to those individuals who have complex and/or challenging needs is appropriate and effective).	Mandy Philbin (SCCG)	Debbie Horne (SHSC)	Dr Peter Bowie (SHSC)
6	Liaison Mental Health The purpose of this project is to implement a 'Core 24' Liaison Mental Health Service based on the successful bid against national monies. Core 24 is designed to provide services for: • People in acute settings (inpatient or outpatient) who have, or are at risk of mental disorder; • People presenting at A&E with urgent mental health care needs; • People being treated in acute settings with co-morbid physical disorders such as long-term conditions (LTCs) and mental disorder; • People being treated in acute hospital settings for physical disorders caused by alcohol or substance misuse;	Michelle Fearon (SHSC)	Debbie Horne (SHSC)	Dr Abi Shetty (SHSC)

	• People whose physical health care is causing mental health problems; and • People in acute settings with medically unexplained symptoms (MUS). The aim of a Core 24 Service is to: a. Reduce excess morbidity and mortality associated with co-morbid mental and physical disorder; b. Reduce excess lengths of stay in acute settings associated with co-morbid mental and physical disorder; c. Reduce risk of harm to individuals and others in the acute hospital by adequate risk assessment and management; d. Reduce overall costs of care by reducing time spent in A&E departments and general hospital beds, and minimising medical investigations and use of medical and surgical outpatient facilities; and e. Ensure that care is delivered in the least restrictive and disruptive manner possible.			
8	<u>Short Term Educational Programme (STEP)</u> The purpose of this project is to undertake an options appraisal on the future of the STEP service. The service is a (potential) component part of a number of care pathways including anxiety, depression, bi-polar disorder and borderline personality disorder. The service offers education and self-management skills.	Jim Millns (SCCG, SCC, SHSC)	Mel Hall (SCC)	N/A
10	<u>Relationship and Sexual Health Service</u> The purpose of this project is to enact agreed changes to the Relationship and Sexual Health Service pathway in Sheffield. This involves the streamlining of service delivery and introducing a single point of referral. Currently there are multiple referral points and some overlap in terms of provision.	Jim Millns (SCCG, SCC, SHSC)	Robert Carter (SCCG)	N/A
16	<u>Reducing Anti-Depressant Use</u> The purpose of this project is to explore possible options for reducing the prescribing of antidepressant medication. Sheffield is currently an outlier. Investment in psychological therapies may be needed to support any reduction.	Jim Millns (SCCG, SCC, SHSC)	Heidi Taylor (SCCG)	N/A
18	<u>Reduce Number of People with Dementia in High Cost Long-Term Care Settings</u> The aim of this project is to appraise and (where appropriate) implement new models of care so that patients with Dementia can be cared for in a less restrictive setting, closer to home and at a reduced cost compared to their current CHC package(s).	Mandy Philbin (SCCG)	Various	N/A
19	<u>Reduce Number of People with a Learning Disability in High Cost Long-Term Care Settings</u> The aim of this project is to appraise and (where appropriate) implement new models of care so that patients with a Learning Disability can be cared for in a less restrictive setting, closer to home and at a reduced cost compared to their current CHC package(s).	Mandy Philbin (SCCG)	Various	N/A

20	Reduce Number of People with SMI in High Cost Long-Term Care Settings The aim of this project is to appraise and (where appropriate) implement new models of care so that patients with SMI can be cared for in a less restrictive setting, closer to home and at a reduced cost compared to their current CHC package(s).	Mandy Philbin (SCCG)	Various	N/A
21	Developing a Primary Care Mental Health Service The purpose of this project is to consider options for how to progress the development of a Primary Care Mental Health Service. This is based on national evidence that indicates that people would prefer to be seen in their practice for common mental health issues (thus reducing stigma) and that with support General Practitioners (and the wider practice workforce) can deliver better outcomes for individuals through more personalised holistic care and by intervening much earlier.	Steven Haigh (PCS)	Robert Carter (SCCG)	Dr Jennie Joyce (SCCG)
22	Developing a Psychiatric Decision Unit The purpose of this project is to consider options for how to progress the development of a psychiatric decision unit (PDU). The PDU will provide an effective alternative to A&E, a place of safety for those needing immediate care (and attention) plus provide an informal facility from which to provide ad-hoc and immediate treatment to avoid crisis situations (therefore preventing the use of secondary care services).	Michelle Fearon (SHSC)	Debbie Horne (SHSC)	N/A
25	Outcomes of Open Book Session Yet to be determined; areas of potential efficiency are still being scoped.	Not Yet Identified	Not Yet Identified	N/A
26	Integrated Improving Access to Psychological Therapies (IAPT) Programme The purpose of this project is to implement the Integrated IAPT programme based on the successful bid against national monies. The integrated IAPT programme aims to address the fact that two thirds of people with a common mental health problem also have a long term physical health problem, greatly increasing the cost of their care by an average of 45% more than those without a mental health problem. By integrating IAPT services with physical health services we can provide better support to this group of people and achieve better outcomes.	Michelle Fearon (SHSC)	Toni Mank (SHSC)	Dr Mike Hunter (SHSC)

Appendix B
Governance Structure