Statements and Questions from Mr Mike Simpkin, Sheffield Save our NHS, to the CCG Governing Body 6 April 2017

Statement / Question 1: Paper K on what is called 'Mental Health Transformation' is one of the most dismaying papers we have seen presented to public sessions of the CCG Governing Body. We recognise that the CCG and Council have unified their commissioning budgets in order to work with providers to try and achieve the level of cuts they have set themselves although we cannot support this exercise. We note that the cuts are being classed as QIPP efficiencies, a programme with a chequered history of achievement. This enables commissioners to dress up proposals whose principal driver is cost savings as bringing benefits to patients

CCG response:

We understand your concerns but it is absolutely not the case that this is being driven by cost savings rather than benefits to patients. The purpose of this approach is to improve care and outcomes for patients in Sheffield.

The rationale for NHS Sheffield CCG and Sheffield City Council pooling our mental health commissioning budgets is to ensure that health and social care services are much better co-ordinated around the individual. It is not about making cuts but ensuring that the right care is offered at the right time and in the right place.

All the evidence we have reviewed suggests that integrated care is the right direction of travel for meeting the changing needs of our population, particularly in the context of increasing numbers of older people and people with long-term and complex conditions. It is also very clear that fragmented and disjointed care can have a negative impact on patient experience, result in missed opportunities to intervene early, and consequently can lead to poorer outcomes. Poor alignment of different types of care also risks duplication and increasing inefficiency within the system.

As stated above, the benefits we will achieve for patients in Sheffield are, quite simply, better care and outcomes. These will arise from more effective joined up commissioning and provision of services. This will also deliver better value for public money meaning we can invest in other areas. Pooling our resources (in the widest sense) will enable us to commission whole pathways of care, factoring in other services which were previously not in the scope of traditional commissioning models, such as employment, housing and education.

Historically commissioning plans have been largely developed in isolation by each separate commissioner. Although we have made significant improvements in Sheffield over recent years, segregated commissioning approaches have led to disjointed services and resulted in unintended consequences to different component parts of much wider care pathways. Similarly, opportunities to consider broader clinical and societal benefits, looking at much wider care pathways have never been fully exploited. Our aim is to secure better joined up services and better value for money, through economies of scale, reducing overlaps, eliminating wastage and through innovation and creativity.

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

These proposals do form a key part of our QIPP programme, which we are genuinely approaching in the way QIPP was intended. This is not simply a series of cuts; it is about addressing what are predominantly long-standing issues, whilst remaining focused on quality, innovation, productivity and prevention. The latter 'P' of QIPP is particularly important and is a key component of the wider mental health transformation 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.

We hope this reassures you that improving the quality of care for patients is very much the motivation for this approach. We do envisage that this will ultimately help in terms of addressing the financial pressures faced by both organisations, not by making cuts but by commissioning improved services that will drive out efficiencies.

Statement / Question 2: Many of the assumptions in the four main projects described are open to challenge – for example the talking down of residential care for adults – a stance that, as with children in care, is subject to pendulum evaluation. Residential care may sometimes be the best option

CCG response:

Our assumptions are predominantly based on clinical evidence and national best practice, consolidated through input from a variety of different clinicians. While this doesn't automatically mean that each of the proposals will work in Sheffield, we feel that transformational change needs to be based on robust and fully evaluated evidence rather than preconceived beliefs and aspirations. This is therefore the approach we have chosen to take but we actively welcome any challenges, which will help us in terms of shaping our proposals and ensure we consider all relevant information.

In terms of your point regarding residential care, we totally agree that for some people this will be the best option. However, for many others it will not. Sadly, residential care is often the only option available for some individuals, regardless of their needs or personal choice, and this is what we are committed to rectifying.

Statement / Question 3: The paper complains about the unsuitability and cost of hospital care for people with dementia yet the CCG stood by while Hurlfield View, whose services were intended to reduce the need for hospital was being readied for closure; furthermore the CCG is transferring purchasing for Birch Avenue and Woodland View away from block contract, thus undermining an already fragile care economy. Where exactly will the savings come from?

CCG response:

We have to dispute your assertion that the CCG 'stood by' whilst Hurlfield View was 'being readied for closure'. As you will be aware, Hurlfield View was commissioned by Sheffield City Council to provide residential respite care. Throughout the tender process and subsequent closure programme, we sought and received regular confirmation and assurance regarding all aspects of the programme, including information on the services that have now been commissioned in place of Hurlfield View and how these can be accessed. Services have been commissioned on a like-for-like basis from a number of different organisations across the city. We are therefore assured that there has been, and will be, minimal impact on the care commissioned for this very specific purpose.

In terms of the Birch Avenue and Woodland View nursing home contracts, these continue to be commissioned on a block contract. Whilst you are correct that our longer-term aspiration is that these services will eventually be commissioned on a cost-per-case basis, we feel this is the most appropriate approach. Currently, when there are empty beds at Birch Avenue or Woodland View, these continue to be paid for in full and this money could be better used elsewhere to provide care for people who need it.

As outlined in the paper to Governing Body, savings will come from reducing inappropriate admissions and delayed transfers of care, and introducing a much more seamless care pathway, which promotes independence and personal choice. Again, this is an example of where improvements to current services can be made which will also result in better value for money.

Statement / Question 4: The paper's implication that people with dementia are being deprived of civil rights by being sectioned because appropriate care is not available is highly disturbing especially as the paper reads as if it is more concerned with the overall financial implications – including the inability to charge for hospital services - than with those for patients

CCG response:

We agree entirely that the inappropriate use of the Mental Health Act is indeed disturbing. The paramount issue is absolutely the impact this is having on patients and we are committed to ensuring this is investigated and, where required, addressed immediately.

In addition, there are financial implications which also need addressing, particularly in light of s117 aftercare costs. The issue here is not about trying to avoid paying for an individual's care, it is about eligibility. Isolated clinical practice should not create significant inequity in terms of access to funded aftercare. The Mental Health Act should be administered correctly, which in turn should mean that only those who are genuinely eligible for funded aftercare services receive these. We potentially have a situation where

the Act is being used incorrectly, which is artificially changing eligibility criteria. The CCG has a statutory as well as moral duty to rectify this.

Statement / Question 5: The crucial area of Mental Health Liaison appears to be in chaos and it is not clear how this was or is being tendered for

CCG response:

The Mental Health Liaison development is not in chaos. We are currently reviewing the commissioning arrangements for this with all parties involved and are also using the opportunity to reassess the overall scope of the project so have paused the competitive procurement exercise while this takes place. This has not affected the current service which is continuing as usual.

Statement / Question 6: The issue of appropriate support for people with significant mental health problems who live in the community also reads as if it is based on financial and administrative priorities despite references to 'paternalistic' secondary care. Our own assessment is that the number quoted, 600, is astonishingly low, meaning that transfer to a different system may be more difficult than suggested. The paper recognises issues about patients feeling 'dumped' but seems grossly to underestimate the damage which system transfers can cause or the time and care needed to achieve them – especially when the receiving system (primary care) is under severe challenge. Problems with the budget for social prescribing (paper C) are also relevant

CCG response:

We are starting with an initial 600 patients who Sheffield Health and Social Care NHS Foundation Trust (SHSCFT) have identified as being stable and ready to enter the next stage of their recovery. We are working closely with our primary care colleagues to try and determine what is needed to enhance services to enable this cohort of patients to be transferred back into primary care, safely and with a continued focus on recovery.

This will require some degree of investment but we anticipate that the eventual service will be capable of reducing onward referrals as well as accepting referrals from secondary care. We accept that this is not a straight forward development, and one which will require cultural as well as structural changes. However, the evidence from areas that have already started this process is really encouraging, with reductions in secondary care usage and genuinely integrated primary and secondary care services.

In fact, our aspiration in future is that we stop using terms such as 'secondary' and 'primary' care, and instead focus on the needs of every individual and how these can best be met in line with personal goals and choice. For example, we know that people who have mental health issues are far more likely to have comorbid physical health issues so we want to eradicate the delineation between mental and physical healthcare so that people receive treatment based on their needs rather than organisational parameters. The development of a primary care service will, we feel, genuinely promote this and grow to support far more than the initial 600 patients we are starting with.

Statement / Question 7: It is of course good that commissioners and providers are coming together to try and create a positive approach for how services should change. There are sufficient references in the paper to suggest that they recognise some of the likely effects on patients. What is surely not acceptable is talk about the changes as progressive rather than mitigating the effects of expenditure reduction. There may be genuine positive developments, but it is hard to find credibility in the overall approach. Of course we stand against any expenditure reduction

CCG response:

We do believe that these are progressive changes, which will support our commitment to the parity of esteem principles set out in the Five Year Forward View for Mental Health.

We completely agree that expenditure reduction as an isolated exercise is not justifiable and this is not the driver for our approach. Whilst there are many fantastic examples in Sheffield of high quality, compassionate mental health care, there are some areas that we know can be delivered better and these are the areas that we are focusing on.

We also have a statutory duty to ensure that we get maximum benefit for the money that we spend both in terms of patient experience and clinical outcomes. Focusing on QIPP principles, our aim is to deliver a better offer for people in Sheffield, which we also anticipate will make efficiency savings in both 2017/18 and 2018/19 through more effective working.

Statement / Question 8: How does the scale (what %?) of cuts fit with the CCG's commitment to parity of esteem?

CCG response:

NHS Sheffield CCG is fully committed to parity of esteem, both from a contextual as well as financial perspective. We are still planning to meet the investment standard in both 2017/18 and 2018/19, and have confirmed this to NHS England in a jointly signed letter with Sheffield Health and Social Care NHS Foundation Trust (SHSCFT).

Statement / Question 9: What is the current nature of the procurement for Mental Health Liaison Services?

CCG response:

As explained earlier, the tender is temporarily on hold as we are reviewing the commissioning arrangements and scope of the project.

Statement / Question 10: What levels of disclosure and patient / frontline staff involvement will there be in considering these projects?

CCG response:

Whilst the component elements of the transformation programme are at very different stages, we are committed to ensuring that service users, carers, staff and the general public are actively involved in this work and supported to contribute to individual projects, which we know is essential to achieve improvements for patients. We are currently developing an engagement plan with Sheffield City Council and Sheffield Health and Social Care NHS Foundation Trust, which will include learning from good practice used in other areas of our work.

Statement / Question 11: What will happen if the projected savings are not achieved as quickly as indicated, something which happens a lot under QIPP?

CCG response:

As you are aware, we are undertaking the Mental Health Transformation Programme jointly with Sheffield City Council and Sheffield Health and Social Care NHS Foundation Trust. This has instilled a sense of collegiate and collaborative working, coupled with a degree of joint accountability and there is cross-organisational commitment to ensure that the efficiency programme is delivered in full.

We therefore do not anticipate any underachievement, but to ensure effective programme management, we do have a contingency plan. This is based primarily on the fact that our plan is set to achieve a ‘stretch’ target, which is greater than the actual QIPP requirement, and we have a series of alternative projects to consider if the need should arise.