BOARD OF DIRECTORS MEETING (Open)

Date: 12 September 2018 **Item Ref:** 05

TITLE OF PAPER	**Sheffield Learning Disabilities Services: a strategic case for building comprehensive community focussed support**
TO BE PRESENTED BY	Clive Clarke, Deputy Chief Executive, Director of Operations
ACTION REQUIRED	For the Board of Directors support the strategic case for building comprehensive community focussed support for people with learning disabilities, and approve a programme of communications, engagement and further development work to produce a business case for approval by the Board.

OUTCOME	For further work to be undertaken to produce a business case for the proposed change.
TIMETABLE FOR DECISION	September Board meeting
LINKS TO OTHER KEY REPORTS / DECISIONS	None current
STRATEGIC AIM STRATEGIC OBJECTIVE BAF RISK NUMBER & DESCRIPTION	Strategic Aim: The strategic case supports delivery of each of the Trust's four strategic aims and makes a direct contribution to the following strategic objectives A1 02, A1 03, A1 04, A3 01, A3 03, A3 04, A4 02 Corporate Risk No: 4013, suggests that there is risk that the quality and safety of care provided at ATS falls below standard resulting in service users not receiving the care required.
LINKS TO NHS CONSTITUTION & OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	The learning disability improvement standards for NHS Trusts
IMPLICATIONS FOR SERVICE DELIVERY AND FINANCIAL IMPACT	This strategic case recommends expansion in community services provision, decommissioning of specialist inpatient care and a re-investment of existing resources to support the proposed new model.
CONSIDERATION OF LEGAL ISSUES	The Trust will need to agree a new service model with commissioners and undertake an appropriate programme of engagement and consultation.

Author of Report	Jason Rowlands,
Designation	Director of Strategy and Planning
Date of Report	5th September 2018

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS**

Subject: **Sheffield Learning Disabilities Services: a strategic case for building comprehensive community focussed support**

Author: **Michelle Fearon, Director of Operations and Transformation**
Jason Rowlands, Director of Strategy and Planning

1 Purpose

For Approval	*For a collective decision*	*To report progress*	*To seek input from*	*For information*	*Other (please state below)*
X			X		

For the Board of Directors support the strategic case for building comprehensive community focussed support for people with learning disabilities, and approve a programme of communications, engagement and further development work to produce a business case for approval by the Board.

2 Summary

2.1 Background and context

In July the Board of Directors considered a range of current issues relating to the delivery of services for people with learning disabilities in Sheffield and the agendas and considerations that may shape and influence how we move forward. The Board requested that a proposal for the way forward was developed to ensure that the Board was

- fully appraised of the current issues
- aware of the context within which services are being delivered and developed
- able to review and consider a recommended way forward

As part of the development of this strategic case for change a Board Development session was held in August. This provided members of the Board an opportunity to review current issues in more detail. Board members received a presentation from an expert by experience who has used a range of trust services and the Clinical Director for the Trust's Learning Disability Service. Key messages from the session and the subsequent discussion underpin the strategic case that has been produced.

2.2 The strategic case

This strategic case focuses on the needs of adults in Sheffield with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. It outlines why and how local services in Sheffield need to change to achieve at a local level the national vision that

"Children, young people and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition have the right to the same opportunities as anyone else to live satisfying and valued lives and, to be treated with the same dignity and respect. They should have a home within their community, be able to develop and maintain relationships and get the support they need to live a healthy, safe and fulfilling life."

To ensure this vision is fully realised within Sheffield this strategic case recommends the following key changes and developments

a) Improved capacity and expertise to be available within the broader mental health and crisis care pathway across Sheffield – so it can respond better to people's needs and ensure that peoples mental health needs are met within the mental health pathway (GreenLight for Mental Health)
b) Expansion of the Community Intensive Support Service to ensure Sheffield is able to provide accessible and effective support for people with young people and adults with a learning disability and/or autism who display behaviours that challenge, including those with a mental health condition – so we can deliver a socially inclusive offer to the people of Sheffield, providing effective health based support to existing social care packages
c) Ensuring the right pathways are in place for crisis respite support for the client group
d) Discontinuing with dedicated Sheffield based specialist inpatient beds for people with learning disabilities – because peoples needs in the future will be provided at their home, through periods of respite, or through admission to a mental health ward for mental health treatment

We need to do further work to engage, understand and assess if the above changes are the right ones, are achievable and will have the intended benefits and impacts. We need to involve staff from across key services and people with learning disabilities and their carers. Further development is required to

- build on existing general engagement with people with learning disabilities and their carers in Sheffield in relation to general service issues and developments by undertaking specific engagement on this proposed way forward ensuring subsequent proposals are informed by the views of local people
- to consider in detail the requirements and implications of the strategic case and the viability of the proposed model (summarised in Section 9 of the strategic case) – engaging and involving staff from key services, commissioners and other providers of social care services
- develop a subsequent business case by the end of November informed by the outcomes and learning from the above – that will review and confirm if the proposed direction is the right one and is achievable.

Subject to the outcomes from the more detailed development work the current assessment is that the recommended developments in respect of services can be managed through re-deployment of existing resources.

Formal discussions with Commissioners on the proposed way forward have not been initiated yet. However discussions have been on-going regarding service development plans and priorities within Sheffield and there is a shared awareness with Commissioners regarding the issues defined in this strategic case and an alignment of views regarding the proposed direction of travel.

3 Next Steps

Initiate a programme of communications, engagement with staff, service users and key stakeholders regarding the proposed direction for services.

Progress a range of required development work to further consider and test the viability of the strategic case, as defined in Section 9 of the strategic case.

4 Required Actions

1. For the Board of Directors to support the strategic case for building comprehensive community focussed support for people with learning disabilities, and approve

   i. further development work to consider in detail the requirements and implications of the strategic case and the viability of the proposed model

   ii. the production of a business case by the end of November 2018 that will review and confirm if the proposed direction is the right one and is achievable.

2. For the Board of Directors to approve a programme of communications, engagement with staff, service users, carers and key stakeholders regarding the proposed direction for services covering

   i. Staff communications and engagement with the proposed changes, seeking their input and defining the potential transformation and OD requirements going forward.

   ii. Service user, carer and public engagement as a joint programme with Sheffield commissioners and utilising the expertise and support of Speak Up For Action (Note: Speak Up For action are an advocacy group that the Trust has worked successfully with on engagement and development work for the Positive Behaviour Support agenda)

5 Monitoring Arrangements

On-going progress reviews into BPG, EDG and FIC relating to any subsequent Business Case.

6 Contact Details

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NHS
Sheffield Health and Social Care
NHS Foundation Trust

Sheffield Learning Disabilities Services: a strategic case for building comprehensive community focussed support

Version 4

5th September 2018

Document Control

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Version History

Version	Date Issued	Brief Summary of Change	Owner's Name
V3.1	17 August	First Draft for review at BPG	JR
V3.2	17 August	First Draft for review at EDG, with high level finance overview on pages 5 and 24.	JR
V3.3	5th September	Updated draft including feedback from EDG review, discussion with NHS Sheffield CCG and drafting of previous placeholder content.	JR
V4	5th September	Version distributed	JR

Contents

The strategic case

1. The Case for Change - summary

The Transforming Care programme aims to improve the lives of children, young people and adults with a learning disability and/or autism who display behaviours that challenge, including those with a mental health condition. Locally in Sheffield we have made some good progress in delivering the national aims. However we do have some significant gaps in the support and services we can offer the people of Sheffield. As a consequence we are letting people down. We are not delivering services that are socially inclusive and therefore are not maximising the potential and desire for people to live a fulfilled life. Intensive community support options are limited and because of this we are admitting people to hospital when a different solution, not currently available, would have supported them to continue in their local community.

This strategic case, focuses on the needs of adults in Sheffield and outlines why and how local services in Sheffield need to change to achieve at a local level the national model vision statement, 2015[i]:

> *"Children, young people and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition have the right to the same opportunities as anyone else to live satisfying and valued lives and, to be treated with the same dignity and respect. They should have a home within their community, be able to develop and maintain relationships and get the support they need to live a healthy, safe and fulfilling life."*

The change: To ensure this vision is fully realised within Sheffield this strategic case recommends the following key changes and developments

a) Improved capacity and expertise to be available within the broader mental health and crisis care pathway across Sheffield – so it can respond better to people's needs and ensure that peoples mental health needs are met within the mental health pathway (GreenLight for Mental Health[ii])
b) Expansion of the CISS service to ensure Sheffield is able to provide accessible and effective support for people with young people and adults with a learning disability and/or autism who display behaviours that challenge, including those with a mental health condition – so we can deliver a socially inclusive offer to the people of Sheffield, providing effective health based support to existing social care packages
c) Ensuring the right pathways are in place for crisis respite support for the client group
d) Discontinuing with dedicated Sheffield based specialist inpatient beds for people with learning disabilities – because peoples needs in the future will be provided at their home, through periods of respite, or through admission to a mental health ward for mental health treatment

The effectiveness of this proposed transformation is co-dependent on key related developments – the development of bespoke housing solutions on a core and cluster model, and the establishment of a new Learning Disabilities Forensic Outreach and Liaison Service for people across the broader South Yorkshire area.

Risks: As this programme is developed further with key stakeholders to final business case stage, risks and assumptions will need to be defined and analysed in respect of:

- Viability of emergency respite care models for the client group
- Capacity to support people who will need inpatient care in the future locally or as part of the broader Transforming Care Partnership
- Legacy capital and estate costs relating to Firshill Rise from moving away from a dedicated inpatient service model – should re-use of the estate not be viable

- Appreciation and ownership of the risks across the whole system as part of the existing risk share arrangement and future changes across health and social care

Costs: The proposed way forward will require both investments and disinvestments in services. Overall we believe we have the necessary resources in the current system to deliver the proposed change. The table below gives a high level overview of the assumed cost profile to support the proposed change. This is not a final view, but provides an overview of the intended plan to resource the proposed changes, which will be developed further with the subsequent business case. The provision for accessible emergency respite support will need review and testing with current providers and any programme contingencies will require further assessment.

Programme costs	Dis-investment	Investment
Initial dis-investment from Firshill Rise	-£1,236,730	
Investment in mental health pathway		£199,000
Investment in CISS		£860,781
Efficiencies		£176,949
Further estate related costs that may be released – to be analysed through the subsequent business case	-£333,000	

Development challenges: The proposed changes will require significant developments in the following areas

- New and expanded workforce needs and requirements
- Training and culture change across the mental health / crisis care pathways
- Partnership and pathway developments with crisis/ respite providers
- Alternative use of Firshill Rise to mitigate decommissioning plan

Engagement and consultation: As part of the development of the Transforming Care Programme in Sheffield there has been extensive engagement with key stakeholders and people who use services. Their views have shaped the proposals outlined in this strategic case. As we consider this proposed way forward engagement and consultation with service users and key stakeholders will continue to ensure the proposals are in line with the needs of the people of Sheffield.

Benefits: The areas of intended benefits are defined in Section 5.1. At a high level the proposed developments and changes are designed to ensure we provide a genuine socially inclusive service model. It is morally the right thing to do and is aligned with our values and that of our commissioners while delivering on the Transforming Care programmes three key aims for people with a learning disability and/ or autism:

- To improve quality of care
- To improve quality of life
- To enhance community capacity, thereby reducing inappropriate hospital admissions and length of stay

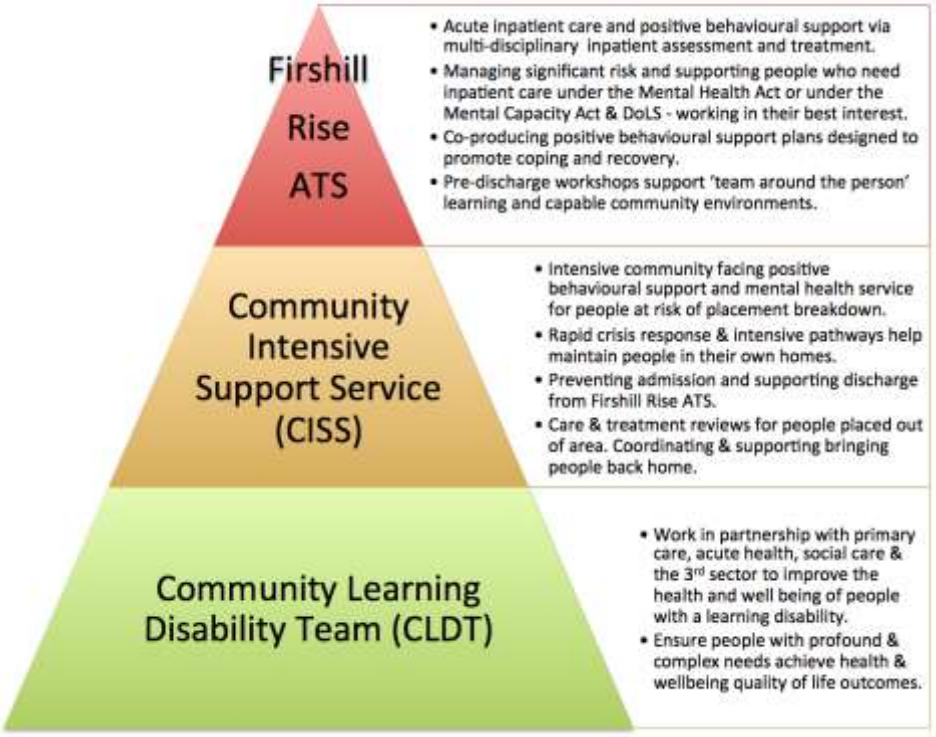
Testing the feasibility: We need to do further work to engage, understand and assess if the recommended changes are the right ones, are achievable and will have the intended benefits and impacts. We need to involve staff from across key services and people with learning disabilities and their carers. During this time engagement and consultation with key stakeholders will be undertaken along with detailed review and further analysis of assumptions in respect of capacity, service models, costs, system risks and intended key delivery stages.

The outcome of this work will inform the subsequent business case that will review and confirm if the proposed direction is the right one and is achievable. The key areas for further and detailed exploration are outlined in Section 9.

2. Current situation and challenges

2.1 Current service summary

SHSC provides a specialist learning disability service operating a stepped care model. This is designed to provide a stratified approach to meeting a broad range of needs and respond to increasing levels of complexity, intensity and risk. This model is designed to serve an extremely diverse group with non-homogenous needs that traverse age, disability, gender identity, pregnancy, race, religion and sex.



	Budget provision (full cost)	Number supported each year
Firshill Rise ATS	£1.9m	11
Community Intensive Support Service (CISS)	£0.45m	55-60
Community Learning Disability Team (CLDT)	£1.6m	860

As the above highlights most of the NHS resource to support people with learning disabilities is tied up with inpatient care. We have allocated most of the resource to a service area that few people access and which has limited potential to deliver positive experiences (see Section 2.3). In terms of value for money across the current pathway it is evident, and to an extent obvious, that investment in community care supports more people as the simple table below highlights

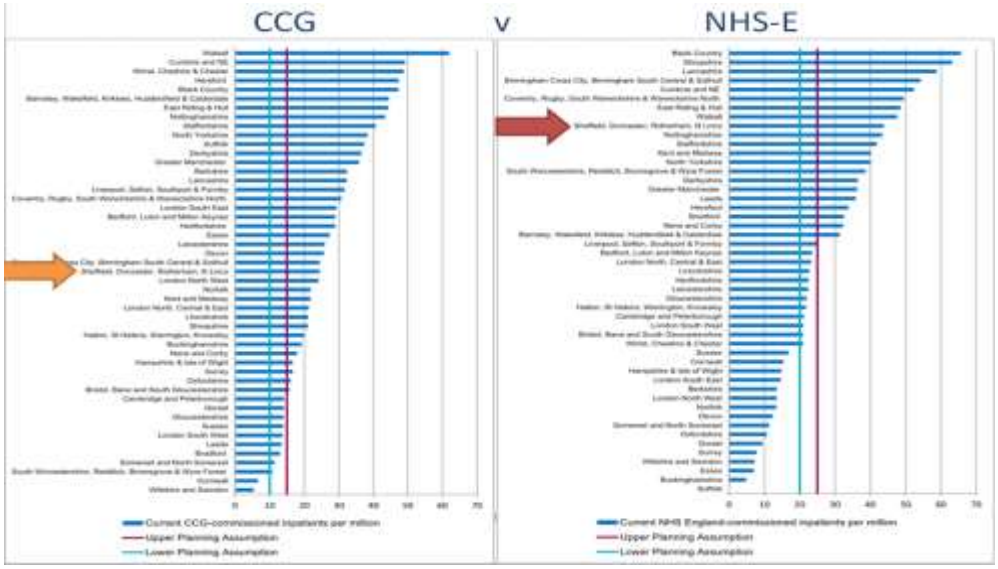
	Resource allocation	Numbers supported per year	Resource per person supported
Firshill Rise ATS*	£1.9m	11	£172,000
CISS	£455,000	55-60	£7,500
CLDT's	£1.6m	860	£1,860

* This is the resource allocated. Operationally the service has not been able to deliver care within this resource envelope and additional non-recurrent costs have been incurred over the last 2 years. The cost of care, per person admitted is in the region of £235,000

2.2 Over reliance in inpatient care

Sheffield as a system has been over reliant on inpatient care for people with learning disabilities. In this context we mean any type of inpatient care – specialist inpatient care such as Firshill Rise, locked rehabilitation services, acute mental health wards. Over the last two years good progress has been made to change this and support more people to live independent lives. However, compared to national trends more Sheffield and Doncaster residents are cared for in out of town locked rehabilitation services. Sheffield is the only area in the footprint that continues to provide specialist Assessment Treatment unit (ATU) inpatient beds (Firshill Rise).

The graphs below show the local position relating to the use of inpatient care for CCG and NHS England funded care. South Yorkshire and North Lincs Transforming Care Partnership was above average.



The table below summarises inpatient activity over the last three years. Key messages are

- We are reducing the frequency at which inpatient care is used in Sheffield and have significantly reduced the use of out of city locked rehabilitation placements
- We are improving admission avoidance approaches - how we take decisions around people experiencing a crisis and are supporting more people in the community (emergency CTR's - care and treatment reviews)
- As we have made progress more people have been discharged from medium and low secure care into locked rehabilitation services, and we need to continue to develop future plans for them (NHS Stepdowns column in table below)

Sheffield inpatient activity summary					
Year	Number of Discharges	Number of Admissions	Emergency CTRs (aiming to avoid admissions)	Actual Avoided Admissions via Emergency CTRs	NHSE Stepdowns
16-17	20	12	10	7	4
17-18	13	8	24	18	4

18-19	9	5	7	4	2

The most frequent type of inpatient care used is Firshill Rise ATU. Whilst we deploy a stepped model of care, with community services available, we do not have enough enhanced community based services to support people effectively as crises develop within their lives or their support package. As highlighted on page 6, the significant resource is invested within inpatient care, and therefore in the absence of an effective enhanced community service to support people we have to resort to inpatient admission for a number of people (see Section 2.3 below).

Type of inpatient care used – since 2016	Number of people
Firshill Rise ATS	19
Sheffield mental health rehabilitation wards	3
Sheffield acute mental health ward	4
Sheffield PICU	3
Secure Care (RDaSH)	6
Private Locked Rehabilitation Note: Some people in both ATU and locked rehabilitation had been in hospital care for longer than five years due to the nature of their complex needs and limited alternative models of care	12

When the Transforming Care Programme began there were 24 Sheffield residents in inpatient care. 22 of them have since been discharged and are now living within the community in Sheffield. While people have been admitted since the programme began the numbers of new admissions have reduced and lengths of stay have reduced so the overall use of inpatient care has come down. At the start of the programme there were 24 people receiving inpatient care funded by Sheffield CCG and the Trust, now there are 9 people. These numbers include 11 people who have stepped down from secure hospitals, compared to an original prediction of 2 people.

While improvements have been made we remain in comparative terms a high user of inpatient care for people with learning disabilities. Sheffield is an outlier nationally and concern regarding the local position has been raised and reviewed nationally by NHS England.

2.3 Changes required in the pathway to support the persons journey

Appendix 2 provides a high-level summary of nine examples and scenarios of how and why people may have been admitted to Firshill Rise for inpatient care during 2017-2018. It presents a typical reason for the decision to admit, what work would have been undertaken at the ATS and a description of what could have been provided as an alternative if we operated an enhanced community model more suited to their personal needs.

The nine case scenarios, informed by the experiences of senior clinicians, illustrate a number of key points in relation to the opportunities provided by alternative enhanced community provision and how the persons needs could be met in the future:

- Inpatient admission would be unlikely in 4 of the 9 cases
- It may be possible to avoid admission in 3 of the 9 cases, but if required admission within a mental health / respite care supported by CISS in-reach
- Inpatient care within a mental health ward would be likely in 2 of the 9 cases

- Inpatient length of stay could be reduced in all cases due to active joint working between mental health services and CISS working collaboratively around the needs of the person

This information strongly suggests that an enhanced community offer including intensive work delivering mental health and/or positive behaviour support care pathways in partnership with closer Greenlight working, out of hours support and responsive access to emergency respite/crisis beds could provide a more person-centred and appropriate care offer for adults with learning disability.

2.4 Challenges in delivering a safe and positive inpatient experience

The Trust provides a 6 bedded specialist inpatient service at Firshill Rise for people with complex learning disabilities. Firshill Rise ATS supports people whose needs cannot at that time be safely managed within a community setting. People may be admitted in terms of detention under the Mental Health Act (MHA) (1983), a Deprivation of Liberty order (DOL) or (on rare occasions) admitted on an informal basis for a spell of voluntary treatment.

Previously services have been poor, with a CQC rating of inadequate in 2014 and Requires Improvement in 2016. The service is now rated as Good by the CQC, across each of the five domains, reflective of the focussed efforts of the service to deliver safe care and positive experiences for the inpatient population. It remains the case however that the Trust has experienced challenges in sustaining the required levels of safety for service users and staff alongside delivering expected standards and quality of care, and over the last year concerns in this area have been raised by commissioners for review. This is partly due to the increased need for intensity of staffing support and interventions which significantly increases costs above previous funded levels alongside a basic fundamental limitation on the ability to support people with complex learning disabilities in a hospital inpatient environment.

Various reports have been reviewed by the Board of Directors and the Quality Assurance Committee over the last two years regarding the acuity of needs and the challenges of delivering good quality care in the inpatient environment and these content of those reports is not repeated here. Key relevant messages however are

- The acuity and complexity of need for the inpatient client group is high and has consistently remained high for a number of years
- Delivering the required levels of care in respect of safe staffing levels in line with the Health Education England L&D Staffing model is challenging and significant increased investment in staffing is required. To date this has been managed on a non-recurrent basis.
- People with a learning disability who access ATS are not a homogenous group, they present with extremely diverse needs and vulnerabilities. By caring for this group in one setting we are often working at odds to their diverse primary needs. ATS often brings together challenges in relation to service user compatibility and risk, for example:
  - A female service user who needs to feel safe and access gender sensitive care away from the opposite sex
  - A young male service user who needs to learn about appropriate boundaries including interpersonal or sexual boundaries
  - A service user in crisis who needs to be noisy and learn to express anger appropriately
  - A service user recovering from depression who needs access to a quiet and structured environment due to sensory issues

2.5 High cost inpatient care with clear risks to sustainability

During 2017-18 options to improve services were reviewed jointly with Commissioners. This work focussed on a revised business model that would see

- Increased investment in the inpatient care element, through funding higher staffing levels and skill mixes, to sustain safety and quality
- Reduced bed provision for Sheffield residents, with Sheffield CCG commissioning 4 of the 6 beds in response to agenda to reduce inpatient provision
- The Trust securing replacement contract income from other NHS CCG's for the 2 beds no longer commissioned by Sheffield
- Funds released from the current Sheffield spend by reducing from 6 to 4 Sheffield beds being invested in more community care and community services

As this work has progressed the following conclusions have been reached

a) The revised option will continue to make the Sheffield pathway dependent on inpatient care at the expense of a more socially inclusive approach – with significant levels of resources still committed to inpatient care at the expense of an effective community offer.
b) Inpatient care is very high cost for an expected very small number of people, and consideration needs to be given to value for money against other options
c) The funds released to support investment in community service and pathways will not be adequate to deliver the level of community services required to support people with complex needs successfully in the community
d) Following engagement with other NHS CCG's in the ICS and TCP footprints there was a formal confirmation in June 2018 that there is no wish or intention from any commissioning body within the South Yorkshire and North Lincs TCP to contract for the 2 beds freed up from the above plan. Other CCG's outside of the TCP would be unwilling to have a block contract as all are subject to the Transforming Care programme for reducing hospital bed capacity.

Simple summary of possible new business model considered during 2017-18		
	Current arrangements	2017-18 Development proposal
Total inpatient cost	£1.9m	£2.3m
Number of beds for Sheffield	6	4
Other beds	-	2
Cost per bed	£328,000	£384,500
Sheffield funded	£1.9m	£1.53m
Funded by other TCP CCG's	-	£766,117
Resources released for community investment		£429,000
Note (1) the resource released to support more community care is low Note (2) the model requires a significant amount of service income to be secured from non-Sheffield CCG's, with no clear interest in this from neighbouring CCG's.		

2.6 Under- developed community model and pathway

The current service model is summarised above in Section 2.1. The capacity to deliver prevention, early detection, rapid response & intensive support is limited due to level of investment in ATS and lack of capacity in CLDT/CISS and the responsiveness of the broader system.

Challenges to the current community service model

The community facing services have faced a number of challenges in recent years in response to the strategic and political climate:

- New ways of working as a result of the Transforming Care agenda (e.g., Community at Risk Register and Care & Treatment Reviews).
- Supporting system wide improvements in care via the rolling out of Positive Behaviour Support training across learning disability health, social services and independent sector.
- Leading on MCA training and workforce development.
- Undertaking LeDeR reviews to support the national programme investigating mortality.
- Continued initiatives to release financial efficiencies and meet CIP targets.

All of this work has been undertaken without any extra recurrent funding coming into the system.

Challenges to the current CISS model

The current Community Intensive Support Model is recognised as offering a quality service due in most part to the experience and dedication of its professionals and their ability to flexibly triage and prioritise risk and need. However, the following issues are apparent when considering gaps in service and opportunities for improvement:

- The resource within the team is not configured in a manner that enables it to provide a truly intensive or responsive offer to its caseload.
- The team only operates a Monday to Friday, 9-5 service.
- Whilst the team membership is made up of different professions giving the impression of an MDT, in reality there is not sufficient resource or time to operate a truly coordinated MDT model in line with NICE pathways.
- The team currently employs a number of part time staff or staff whose role is split between two or three teams.
- The team only has one support worker available to offer in-reach support to people in crisis.
- Pathway and working linkages with the range of mental health Crisis Hub services and SAANs need to be strengthened through agreed protocols to maximise collaborative working to meet the needs of complex clients with multiple morbidity.

The current level of resources within CISS significantly limits our ability to deliver a genuinely socially inclusive support offer to people in Sheffield

2.7 Conclusion

The key conclusions from the summary of current arrangements are

1. Our community services are under-invested in and have limited scope to support people well in the community. As a consequence our pathways and services are not promoting a socially inclusive offer in the least restrictive environment to the people of Sheffield.
2. We rely too much on inpatient care to support people with a learning disability and/ or autism who display behaviours that challenge. Most people admitted needed and would have benefitted from a more enhanced community support offer earlier in their developing crisis.
3. Inpatient care, in small specialist services, will always have limitations on its ability to deliver a positive experience for peoples personal needs
4. The high cost of providing a specialist inpatient care service for very small numbers of people raised key questions about value for money and sustainability.
5. Pathways for specialist learning disability, mental health and autism are not effectively integrated to provide the most appropriate support and responses at times of crisis.

3. Strategic Context

3.1 Trust strategy and direction

The Trust's vision is to improve the mental, physical and social wellbeing of the people in our communities. Our strategic aims are:

- *Quality and Safety:* We will provide high quality care and support as early as possible in order to improve physical, mental and social wellbeing.
- *People:* We will promote a culture of collaboration, supporting people to work together to make a difference.
- *Future Services:* We will develop excellent mental, physical and social wellbeing for the communities we serve through innovation, collaboration and sharing.
- *Value for Money:* We will provide sustainable services through ensuring value for money, reducing waste and unproductive time for our staff.

A key feature of our strategic direction is de-institutionalisation – transforming how we deliver care. This has been a significant focus of our work as we have moved from a paternalistic institutional model of mental health, dementia and learning disability care to a model which supports people to stay at home, reduces out of city admissions, minimises lengths of hospital stay and reduces the total number of beds we offer. The current arrangements (Section 2) do not support the delivery of our ambition and strategic direction.

a) We are not able to deliver enough community focussed, socially inclusive care and support – people are being admitted due to the lack of comprehensive and accessible community care
b) We are over-reliant on inpatient care to support people with complex needs when they experience a crisis
c) Despite good progress made we still have a small number of Sheffield residents being care for away from home in institutionalised environments that deliver poor outcomes
d) We are making poor use of the available resources with costs overly concentrated in high cost inpatient care for a very small number of people

This strategic case supports progress and improved outcomes against the following trust strategic objectives.

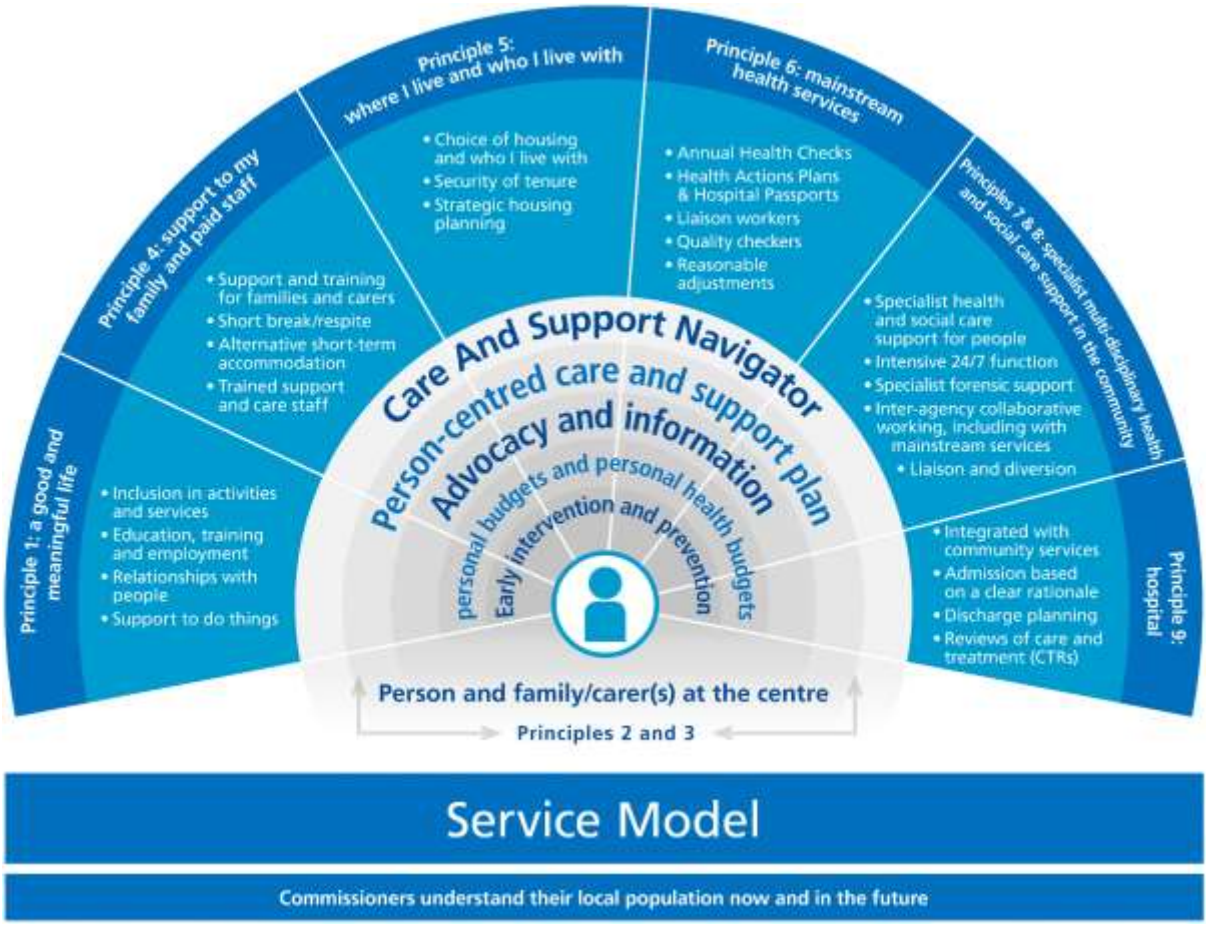
Strategic Aim: Quality and Safety
A1 02: Deliver safe care at all times
A1 03: Provide positive experience and outcomes for service users
A1 04: Timely access to effective care
Strategic Aim: Future Services
A3 01: Deliver interventions and support closer to general practice, neighbourhoods and embedded within other services.
A3 03: Provide effective community care and treatment
A3 04: Provision of high quality inpatient services supported by effective alternatives
Strategic Aim: Value for Money
A4 02: We will adapt some of the services we provide in response to demand and market conditions

3.2 Policy context

Transforming Care

The national steer is clear - for a minority of people with a learning disability and/or autism, we remain too reliant on inpatient care. As good and necessary as some inpatient care can be, people are clear they want homes, not hospitals. On the 30th October 2015 NHS England, the Local Government Association (LGA), and the Association of Directors of Adult Social Services (ADASS) published Building the right support and a new service model.

These outline nine principles designed to support community rights and inclusion with a view to proactively reducing the risk of restrictive care resulting from mental health, challenging behaviour or forensic needs. The principles are summarised below and the focus is on reducing the need for and amount of care provided in a hospital setting.



Transforming Care has brought a long overdue national focus on improving service user rights, reducing restrictive care and increasing access to community choice and provision.

The national model and plan focuses on the following at risk groups.

1. People with mental health problems:

   The future aim is provide better identification and treatment of mental health problems amongst children and adults with learning disabilities and / or autism in the community.

2. People who present significant challenging behaviour:

   The future aim is to offer highly skilled, highly personalised care and support that can be stepped up and down in intensity as required.

3. People who present with forensic risk to others:

   The future aim is to have better coordinated services where specialist health & social work effectively alongside forensic health teams to provide planned, proactive and coordinated support from an early age.

4. People who are long stay NHS campus patients:

   The future is to eradicate these through the provision of highly personalised packages of care within the community; ensuring rights are safeguarded via advocacy support.

Across the South Yorkshire and Bassetlaw Integrated Care System, the South Yorkshire and North Lincs Transforming Care Partnership and the Sheffield Accountable Care Partnership there is clear alignment, endorsement and full support for the national direction and a full commitment to see local plans in place to deliver the required and desired change.

NHS Improvement Standards

The learning disability improvement standards for NHS trusts were published in June 2018. The four standards concern:

1. Respecting and protecting rights
2. Inclusion and engagement
3. Workforce
4. Specialist learning disability services

While not providing a full overview of the improvement standards, the following improvement measures have more relevance and bearing on the scope of this proposal

Respecting and protecting rights

- Trusts must demonstrate they have made reasonable adjustments to care pathways to ensure people with learning disabilities, autism or both can access highly personalised care and achieve equality of outcomes. This means that our mental health pathways must be accessible to people with a learning disability, or that joint work between services enables and supports access to appropriate pathways rather than seeing 'hand offs' between services.
- Trusts must have measures to promote anti-discriminatory practice in relation to people with learning disabilities, autism or both.

Inclusion and engagement

- Trusts must demonstrate that they co-design relevant services with people with learning disabilities, autism or both and their families and carers

Specialist learning disability services

- Trusts must have plans for the development of community-based intensive support, including treatment and support for people accessing mental health services and the criminal justice system

3.3 Population

The City of Sheffield is England's third largest district authority. It is estimated that Sheffield has a population of 575,400 in mid-2016.

There is a clear bulge in the population in the 20 to 24 age group. This is caused by Sheffield's significant student population at its two universities. The increase in recent years is largely the result of 2 factors:

- there are now more births than deaths in Sheffield, resulting in a positive 'natural change' in the population
- there has been an increase in the level of international migration to Sheffield

Population projections

The most recent population projections for Sheffield are based on the 2014 population estimates. Sheffield's population is projected to increase by around 88,600 people over the 25-year period to 652,300 in 2039.

According to the projections, there will be more males than females in Sheffield from 2023 onwards. Longer life expectancy has meant that there were more females than males in the population, but increases in life expectancy for men coupled with higher male in-migration had resulted in this change. Figures also suggest that the number of people aged over 65 will grow by 42% in the next 25 years, whilst the number of those aged 85 and over will more than double.

Ethnicity & diversity

Sheffield is an ethnically diverse city, with around 19% of its population from black or minority ethnic groups. The largest of those groups is the Pakistani community, but Sheffield also has large Caribbean, Indian, Bangladeshi, Somali, Yemeni and Chinese communities.

More recently, Sheffield has seen an increase in the number of overseas students coming to the city and in the number economic migrants from European Union ascension states (countries which joined the European Union in or after 2004).

People with learning disabilities

In recent years the number of people with a learning disability has steadily increased.

Year	Number known to Case Register	Number known to LA (Care First)
2014	3265	1938
2015	3327	1975
2016	3390	2012
2017	3455	2051
2018	3520	2090

From the above Case Register cohort

- 1755 (40%) of people were identified as having a behaviour problem.
- Of these 1274 (29%) were identified as having a severe behaviour problem.
- Data illustrates a spike in prevalence between the ages of 10 and 30 years.
- 453 (10%) have accessed Community Intensive Support for issues relating to mental health and/or challenging behaviour. The largest category of access is seen in the 18-29 age group

- 17 (0.4%) have accessed Firshill Rise ATS. 60% are young adults.
- 48 (1.1%) of these people have required an adult mental health inpatient stay.
- The age range spans the life span with greatest demand identified in the 20-29 age range.
- 369 (8.4%) of people with a learning disability have required input from CMHT.
- Nearly half of these people are in the 18-39 age group. However it is worth noting that mental health care and support is required across the life span.

3.4 Needs and risks to good health

Mental health risks

People with learning disabilities are **more at risk** of significant mental health problems than the general population. For example:

- People with learning disabilities experience proportionately more trauma, abuse and socioeconomic deprivation with resultant impacts on health and well-being.
- Schizophrenia is three x more prevalent (RCN, 2014).
- Diagnosable psychiatric disorder 4.5 x more prevalent.
- For those people who have a learning disability and a mental health problem, accessing good quality care can be difficult.

Physical health risks

People with learning disabilities are **more at risk** of significant physical health problems than the general population. For example:

- Many people present with a complex set of needs such as co-existing neurodevelopmental issues (e.g., epilepsy, ASD, ADHD) and/or genetic conditions resulting in increased physical health risks and vulnerabilities (e.g., dementia, thyroid problems, respiratory health problems).
- Left untreated, these problems can become worse and have a devastating impact on a person's health and wellbeing.
- Premature death (often caused by avoidable harm) resulting in people dying 15-20 years younger than the general population.

Challenging behaviour (behaviour that challenges services)

- Challenging behaviour is a mode of communication that reflects significant unmet need.
- Prevalence rates are around 5–15% in educational, health or social care services for people with a learning disability.
- Rates are higher in teenagers and people in their early 20s, and in particular settings (for example, 30–40% in hospital settings).

The table below provides an example of prevalence data mapped onto the local case register figure.

Issue	People without LD	People with LD (Sheffield = n)	Reference
Premature death[iii]		Men 13 yrs early Women 20 yrs early	http://researchbriefings.files.parliament.uk/documents/LIF-2016-0052/LIF-2016-0052.pdf
To live in poverty, to have few friends and to have additional long term health problems		Much more likely	https://www.mentalhealth.org.uk/learning-disabilities/help-information/learning-disability-statistics-/187699

Diagnosable psychiatric disorder	8%	36% (1563)	People with Learning Disabilities in England 2011
Schizophrenia	1%	3% (130)	Doody GA, Johnstone EC, Sanderson TL, Cunningham-Owens DG & Muir WJ (1998). 'Pfropfschizophrenie' revisited: schizophrenia in people with mild learning disability. British Journal of Psychiatry 173, 45–53.
Anxiety & depression amongst people with Down's syndrome		Higher	RA Collacott . S-A Cooper. C McGrother. Differential rates of psychiatric disorders in adults with Down's syndrome compared to other mentally handicapped adults. Br J Psychiatry 1992: 161: 671–4.
Challenging behaviours (aggression, destruction, self-injury and others)		10-15% (434 - 651)	Emerson et al., 2001: Key Highlights of Research Evidence on the Health of People with Learning [Intellectual] Disabilities
Dementia	5.7%	21.6% (938)	Cooper, S.A. (1997a). High prevalence of dementia among people with learning disabilities not attributable to Down's syndrome. Psychological Medicine, 27, 609-616.
Early onset dementia & Down's syndrome		Age of onset 30-40 years younger than the general population	Holland, A.J., Hon, J., Huppert, F.A., Stevens, S. & Watson, P. (1998). Population-based study of the prevalence and presentation of dementia in adults with Down's syndrome. British Journal of Psychiatry, 172, 493-498.

3.5 Learning from successful innovation

Mental Health Living Well & Community Enhanced Recovery Team services

SHSC has delivered nationally recognised innovation and transformation in the mental health pathway for people previously cared for in locked rehabilitation services. Previous experiences were characterised by prolonged periods of secure hospital care with limited to no positive outcomes, isolation from contact with family or social networks, disconnected and isolated from basic elements of day to day life in respect of access to employment, education, leisure, primary health care services.

We have learnt and demonstrated that a radically different model works and can be delivered and sustained safely while truly transforming the lives. Key features that made this a success would be

- Leadership drive and focus to ensure people were enabled to live independently in the community
- Mental health wrap around team resourced to delivered planned therapeutic programmes focussed on community living, with the capacity to flex intensity of support in live with individual need
- Partnership with a housing provider committed to supporting people to sustain their tenancy
- Strong focus on staff and team based supervision, support and guidance focussed on understanding complex needs

Success in supporting people with complex learning disabilities to return to Sheffield

Section 2.2 highlights that we remain over dependent on inpatient care. While this is the case it is also true that we are getting better at supporting people in crisis through community based responses and solutions.

The 'Blue Light' Care and Treatment Review process of everyone with a learning disability who experiences a crisis has been effectively implemented and has a positive impact on ensuring a system wide community focussed response – and through this numbers of admissions have been decreasing.

3.6 Capacity building across the care sector to support people with complex needs

The South Yorkshire and North Lincolnshire Transforming Care Plan (TCP) highlights the need to develop considerable numbers of community based options for people coming out of hospital to enable it to deliver on the ambitions of Building the Right Support. The TCP identified a need for more settled housing options to meet the need of the people with learning disabilities and behaviours that challenge. Historically there has been an over reliance on residential care to meet the housing needs of those patients leaving inpatient settings and the TCP's ambition is to deliver more choice and control to individuals.

Currently there is an acute shortage of self-contained accommodation for the Transforming Care population. It can be particularly difficult for people with complex needs to share their housing with others. Individual self-contained accommodation supports people's privacy and dignity whilst affording opportunities for peer support and shared staff support, and is a cost effective model for commissioners.

Sheffield CCG and Sheffield Local Authority Capital Accommodation Plan has already been funded partly by NHS England capital funding and partly by the City Council. A further bid to NHS England, if successful, will directly facilitate the development of 8 new units of self-contained accommodation at Wordsworth Avenue, Sheffield NHS capital investment), and 8 more units of self-contained accommodation at the Adlington Road site City Council capital investment). In total there will be 16 new units of accommodation. The flats will be clustered into groups of eight to provide a level of peer support and shared staff support where appropriate. They are located within established residential communities.

The accommodation is to provide supported living for adults with learning disabilities and/or autism, display behaviour that challenges, including those with a mental health condition. Those accessing the accommodation may also have additional physical disabilities.

It will facilitate community living for people who may have been in hospital settings, people returning to Sheffield from out of city residential and nursing care placements or '52 week' educational placements and people at risk of hospital admission. It may also accommodate young people in transition to adulthood who wish to move on from their family home. Supported living accommodation will offer greater choice and control and provide the least restrictive environment possible.

This purpose built cluster accommodation will enable the city to provide affordable and sustainable accommodation and support services locally.

This is a key and important development that supports the system to move forward with a clearer focus on community based support for young people and adults with a learning disability and/or autism who display behaviours that challenge, including those with a mental health condition.

Alongside this a range of other developments are progressing as part of the Sheffield wide plans

- **Positive Behaviour Support model continued rollout across Sheffield-** 400 staff have been on the training programme in NHS and independent sector providers
- **Bespoke tailored solutions** for difficult-to-place individuals- e.g. residential providers and supported living providers would tender together with a stepped model of care over an 18-month period and supported living providers would work into the residential placement from start date of transfer to aid later transition to least restrictive environment.

- **Regional Forensic Service** implementation and joint working with RDASH as lead providers, working in close collaboration with SHSC.
- **Supported living complex needs framework – joint tender with SCC and SCCG** for 2018 which will enable providers to be more easily procured for the more complex TCP cases- tender in late summer 2018. There is also a regional procurement for complex needs provision, being developed across the Yorkshire region.
- The Trusts development of the Crisis Hub model including the **SPA and Psychiatric Decision Unit** planned to be opened in late 2018, which will improve approaches to supporting people in crisis.

Overall the commissioning direction is in line with the Transforming care programme and locally NHS Sheffield CCG and Sheffield Council have

- Been building capacity and resilience across the care sector
- Been commissioning new service models to support and enhance the existing supported living and accommodation sector
- Wish to see a reduction in the frequency with which people need to be admitted, along with a reduction in the amount of inpatient care provided
- Wish to see more equitable access to a mental health services for people with learning disabilities who have mental health needs
- Been supportive of the development of a more robust and enhanced community support offer for people

3.7 Service user views and opinion

During 2017 engagement work was undertaken across Sheffield seeking views and opinions about the best approaches to building the right support and achieving positive outcomes for people with learning disabilities. There was a specific focus in the engagement work on the role of Positive Behaviour Support (PBS), but in line with Transforming Care programme the engagement work was also concerned with asking fundamental questions about innovation and change such as:

1. How do we work together to improve the quality of life of people with learning disabilities and their carers?
2. How do we ensure are working to prevent distress and promote inclusion and recovery?
3. How do we monitor and continuously improve the quality and capability of our care providers?
4. How do we support people whose behaviour challenges not to become restricted or admitted to hospital?
5. How do we ensure best value?

Key feedback from a stakeholder day with people with learning disabilities highlighted the following themes that stakeholders identified as being key for improving support, experiences and outcomes

1. Training to support families and the independent sector
    - The right training – values, skills, knowledge & application
    - Consistent standards about what ‘good’ looks like
    - High quality Behavioural Support Plans that act as a passport across opportunities for the individual

2. Focussed efforts to support the wider community to understand and accept people with a learning disability whose behaviour challenges?
3. More advocacy and advocacy informed approaches to support the rights of people.
4. Ensuring approaches to support for people are focussed on including GPs and Primary Care from the start
5. Effective crisis support – clear out of hours support that is confident working with people with learning disabilities
    - Proactive prevention needs to replace the current reactive responses that lead to police arrest and section 136.
6. Care and Treatment Reviews were viewed positively and were recognised as having brought about change in the right direction.

Ultimately it was acknowledged that Positive Behavioural Support should become the bedrock of how we develop and deliver quality care and support. The ultimate aim is to work together to build system capacity and resilience, improve the quality of life of service users, families and staff and reduce safeguarding risks, restriction (including inpatient admission) and segregation.

3.8 Conclusion

The key conclusions from the summary of the strategic context are

1. National policy and local population needs require solutions and services that will enable better and more effective interventions to support people in the community
2. Past arrangements and service models, over reliant on hospital care and separate from other health services result in poor outcomes for people with learning disabilities
3. We have experience and considerable success in delivering intensive community focussed services that keep people at home and a range of related developments across services are building capacity and more resilient options.
4. Key stakeholders, particularly people with learning disabilities in Sheffield, want to see a service model that is focussed on promoting positive health and lives, responsive and accessible during times of needs and crisis and able to support people to live independently within their community

4 Vision and aims – moving to an enhanced community offer

"Children, young people and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition have the right to the same opportunities as anyone else to live satisfying and valued lives and, to be treated with the same dignity and respect. They should have a home within their community, be able to develop and maintain relationships and get the support they need to live a healthy, safe and fulfilling life."

Enhanced Community Offer

Our approach to transformation must be based on a whole system approach to delivering high quality support and services for people. For this to be a reality, services need to demonstrate a strong commitment to a shared value base which places the individual and their quality of life at the centre everything they do.

This value base defines the 'golden threads' of the service model and be evident on the basis of capable environments within which care and support is delivered. Capable environments are characterised by:

- Positive social interactions
- Support for meaningful activity
- Opportunities for choice
- Encouragement of greater independence
- Restriction reduction
- Support to establish and maintain relationships and
- Mindful and skilled family/carers and paid support/care staff

Given the diversity of the population a range of enhanced community options are required and are proposed. The key features are:

- **Enhanced GreenLight capability:** offering and ensuring access to all community and inpatient services with reasonable adjustments for people with a learning disability. People with learning disabilities and/or autism who display behaviours that challenge who need to access the mental health crisis services and pathway should be able to do so, receiving responsive and personalised support.
- **Enhanced Community Intensive Support Service:** offering seven day a week 8 a.m. - 8 p.m. services that provide highly skilled, highly personalised care and support that can be stepped up and down in intensity as required and working alongside other services.
- **Effective and accessible Crisis Respite:** offering an effective and accessible alternative to inpatient hospital admission for people whose home/provider package is at risk of break down, or who need a period away from their home to help during times of stress or crisis.

5 High Level Benefits

5.1 Outcomes

Outcome	Measurement Domain	What this would mean for the individual
Preventing people from dying prematurely Improving the wider determinants of health	NHS Outcomes Domain 1 Public Health Outcomes Framework Domains 1 and 4	"My health needs are met by services making the reasonable adjustments I need." "I am supported to access mainstream health care provision, ensuring parity of esteem, in relation to my health needs." "I'm supported in a way that works for me and I get support to communicate what I need and how I am feeling." "I have access to a range of support that helps me to remain well and healthy." "I have a choice about where I live and who I live with." "I have a good and meaningful life."
Enhancing quality of life for people with long-term care and support needs	NHS Outcomes Framework Domain 2 Adult Social Care Outcomes Framework Domain 1	"I am treated with dignity and respect and I feel that I am valued." "I am in control of planning my care and support." "I am supported to maintain my independence and to have family relationships and friendships." "The people who are supporting me have the specialist skills and expertise I need." "I am supported by people who help me to make links in my local community."
Helping people recover from episodes of ill health or injury Delaying or reducing the need for care and support	NHS Outcomes Framework Domain 3 Adult Social Care Outcomes Framework Domain 2 Public Health Outcomes Framework Domain 2	"I understand how the care, support and treatment I am getting is responsive to my needs." "I can get specialist help and support at an early stage to avoid a crisis." "I am supported to understand and manage my own behaviour, and to understand the consequences of my actions."
Ensuring that people have a positive experience of care and support	NHS Outcomes Framework Domain 4 Adult Social Care Outcomes Framework Domain 3	"I have information about my care and support that is accessible and up to date." "My family and paid staff are supported and know how to support me." "I am able to maintain relationships with family and friends." "I have help to make informed choices." "I am treated with dignity and respect and I feel that I am listened to."

Safeguarding vulnerable adults and children, and supporting people in a safe environment	NHS Outcomes Framework Domain 5 Adult Social Care Outcomes Framework Domain 4	"I am supported to manage any risks." "I am supported to be safe and a part of my community." "I feel that my community is a safe place to live and local people look out for me."
Reduced reoffending Reduced first time entrants to youth justice	Public Health Outcomes Domain 1	"I have my needs recognised in mainstream services and get the support I need." "I am offered early support to maximise my life chances."

5.2 Benefits

Assessment and analysis of benefits are to be developed further as part of the business case. Currently the following high level benefits have been identified in addition to the outcomes defined in Section 5.1 above.

Ref	Benefits	Type	Measure
B1	Reduces the risk of placement breakdown	Service Users	Reduced package breakdowns Reduced accommodation evictions Number of people with complex needs supported in community while in crisis
B2	Supports admission avoidance	Service Users	Reduced number of admissions Successful use of short term crisis house support
B3	Minimises the need for restrictive inpatient care for people with complex challenging needs	Service Users	Reduced number of admissions Reduced length of stay Reduced periods of delayed discharge
B4	Value for money	Financial	Number of people supported in crisis

5.3 Dis-Benefits

Assessment and analysis of dis-benefits are to be developed further as part of the business case. Currently the following high level benefits have been identified in addition to the outcomes defined in Section 5.1 above.

Ref	Dis-Benefits	Type	Measure
B1	Vacant inpatient facility	Financial	**Cost of un-utilised space**
B2	Workforce transformation and redeployment	Workforce	100% of ATS staff successfully contributing to new service model
B3	Reactions to bed closures – not everyone will agree with direction	Reputational/ confidence	Feedback and engagement with consultation.

6 Key Risks

The following provides an overview of the current risks within the current services and service arrangements as recorded on risk registers.

Risk Ref	Risk Description	Risk Score	Risk Response	Residual Score
Corporate Risk Register				
3996	Quality A report commissioned by executive directors, and currently in draft format, suggests that there is risk that the quality and safety of care provided at ATS falls below standard resulting in service users not receiving the care required and potential reputational damage.	HIGH	Development of project plan to cover all aspects of improvement identified as required	MODE RATE
Service Level Risk Register				
3982	Business CCG have confirmed that they wish to commission 4 beds only with funding being redirected to support further investment in the community. ATS will need to sell remaining beds to remain viable.	MODE RATE	Development of business case	MODE RATE
3877	Safety Increase in risk to staff and patients at Firshill Rise due to an increase in physical assaults to staff by patients and physical assaults patient to patient over the past 12 months.	HIGH	Analysis of patient incident data to be reviewed at MDT on a monthly basis or more frequently if required.	MODE RATE

Interdependencies

Related activity	Description of the interdependency and its possible management
Social care costs	Social care more community care and affordability costs for supporting people with complex needs – to review with commissioners as part of next stage development
Provider market	Capacity and maturity of provider care market to support people with complex needs – progressed as part of commissioning development plans plus Greenlight + PBS development plans
Mental Health Pathway	Greenlight maturity across mental health and crisis care pathways – progressed as part of this proposal

7 Outline Options

7.1 High level review of options

Do nothing – Continue with current arrangements and services as described

- Remain too dependent on inpatient care – not delivering a socially inclusive offer, not achieving national priority, delivering poor outcomes for some people
- No commissioning support. Sheffield modelling does not require six specialist beds.
- Does not support investment in required development of community services
- Challenge remains of delivering personalised care and positive experiences within a dedicated specialist inpatient facility
- Not affordable – current arrangements need additional investment of at least £357,000 to provide required level of staffing support

Option 1: Continue to provide 4 bedded specialist inpatient service, closing two of the current beds

- Remain too dependent on inpatient care – not delivering a socially inclusive offer and not achieving national priority
- Does not support investment in required development of community services at scale required
- Challenge remains of delivering personalised care and positive experiences within a dedicated specialist inpatient facility
- Poor value for money in respect of opportunity costs. Unit costs would increase and be significantly higher

Option 2: Provide 6 bedded specialist inpatient service with 2 beds funded via ECR's and use funds to invest in an enhanced community service model

- Remain too dependent on inpatient care – not delivering a socially inclusive offer and not achieving national priority
- Partial investment in required development of community services, limited expansion of CISS and limited scope to build system wide capacity in respect of Greenlight
- Challenge remains of delivering personalised care and positive experiences within a dedicated specialist inpatient facility
- Significant income risk of a third of income being dependent on ECR or other CCG commissioning of services
- No interest from neighbouring CCG's in entering into a contractual arrangements to commission the 2 beds

Option 3: Comprehensive community support model with no specialist inpatient service. Full investment in an enhanced community offer, decommission Firshill Rise and improve access to mental health crisis care pathway

- Will significantly reduce use of inpatient care through improved resources available within the community
- Community based capacity and expertise to support people in the community
- Enhanced capacity and expertise across the mental health pathway delivering more effective and responsive support and making use of services appropriately. People requiring crisis support away from home in the future will access short term respite with wrap around CISS support. If mental health admission is indicated then this will be managed through the crisis hub and pathway and a designated mental health ward.

7.2 Financial appraisal of the Options

The following table provides a high level overview of the expect cost implications of the options, showing intended or required investments and disinvestments.

Services		Options			
Service line costs	Baseline resources	No change	Reduce to 4 beds	Move to 4 block + 2 ECR	Full Community investment
Firshill Rise ATS (*)	£1.9m	£357,000	-£31,885	£152,703	-£1,248,744
CISS	£455,000	-	-	£292,663	£830,223
CLDT's	£1.6m	-	-	-	-
Mental health pathway	-		-	-	£199,000
Efficiencies	-	-	-	-	£178,362

Notes:
(1) Firshill Rise full cost is £1.9m.
(2) Due to a recent revaluation of our entire estate and the potential significant change in asset life (on a relatively new and high cost unit) the overheads and capital charge impact will need further review.
(3) For example, the capital charges will only be able to be released for reinvestment or efficiency subject to asset disposal. Also, in the event of any closure, redeployment success would impact on any non-recurrent exit costs
(4) For the purposes of this modelling £1.2m has been released for re-investment during the initial phase of the development.
(5) Overheads make up 37% of the service cost (£731,000) of which 17% is estate cost related (£333,000). Further funds may be released, subject to points 2 and 3 above, following analysis during the outline to full business case stage and further consideration of the future use of Firshill Rise its re-use or disposal (see below)

Financial review of the Options

Option	Description	Conclusion
No change	Current arrangements	Not affordable requiring additional investment of £357,000 without delivering any change
Option 1	Reduce to 4 beds	Addresses inpatient cost challenges but results in very high unit cost, value for money concerns and does not support investment of new community services
Option 2	Move to 4 block + 2 ECR	Releases some resource for development of the current CISS offer but no broader impact under the Greenlight agenda. High risk to income under this option, being dependent on third of service income on ECR basis.
Option 3	Full Community investment	Maximum investment in community services with defined solutions in place for those who need a mental health admission or crisis / respite care.

Costs associated with Firshill Rise

- The book value of Firshill Rise is £3.5 million
- Estate running costs are £142,000
- Capital charges are £191,000, with depreciation at £70,000 and PDC £121,000

If Firshill Rise was decommissioned as a specialist inpatient unit the plan would be to review the appropriate relocation of other Trust services into it and then undertake a further review of costs.

Should the option to dispose of the site be considered the depreciation costs to be written off would be an estimated £560,000 from the capital receipt.

As part of the next stage development of this proposal further analysis and assumptions for the future of Firshill would be finalised.

7.3 Recommended option for further development and business case production

The recommended option from the review is option 3: Adopting a comprehensive community support model with a decommissioned specialist inpatient service. Full investment in an enhanced community offer including optimised access to mainstream mental health pathways including crisis care via greenlight working.

8 An overview of the recommended option

Crisis & Emergency and "Green Light" capacity

The recommended option would see considerable investment in crisis and emergency LD services that would work alongside the Mental Health Crisis Hub embedding trained nurses and support workers from CISS, into the Hub, from 7pm – 12am midnight Monday to Friday and 8am – 12am Saturday and Sunday. The trained nurse(s) will take a handover from CISS of the service users most at risk "out of hours", work proactively with families and carers and deliver appropriate clinical interventions, alongside colleagues working in the Crisis Hub, Psychiatric Decisions Unit, A&E Liaison, Health Based Place of Safety and Maple Ward. The nurse(s) will provide coordination and oversight of the additional support capacity available to services from the Band 3 support worker whose role would be to support crisis intervention overnight and at weekends regardless of where the service user is. This may be to support a person in their own home, supported living, respite care or in a general adult ward.

The closure of dedicated ATS beds will require people with a learning disability, whose mental health assessment and treatment can only be safely facilitated in a 24-hour environment, to utilise inpatient mental health wards. Section 2.3 highlights that current assessments, following a review of admissions during 2017-18, suggests this may be between 2 and 5 admissions a year. It is proposed that Maple Ward at the Longley Centre would be up-skilled with additional training and support and the ward environment itself reviewed to ensure that accessible information / adaptations are in place, in the first instance. Wherever practically possible, any admission of a person with a learning disability, would take place on Maple Ward. The robust use of Care & Treatment Reviews would be used as part of a Standard Operating Procedure to ensure that there is strong clinical leadership and decision making, in collaboration with the service user and their family/advocates for any potential inpatient admission.

The acute admission ward, for those that absolutely require it, has a number of advantages. Service Users will be admitted locally, our workforce further develops its expertise and mainstream services are utilised thereby reducing stigma for the individual.

A strong component of this reinvestment is the up-skilling via enhanced education and training of staff working across the pathway of services provided to people with learning disabilities with mental health needs and behaviors that challenge. PBS training will be provided to staff across the crisis and emergency care pathways in mental health, as well as to key independent providers who CISS works in collaboration with.

This option also proposes paid employment options for experts by experience whose role would be to support the education and training of staff as well as to assist in service and quality checks and reviews and advising on accessibility/adaptations. This role will be key to support achievement of the accessible information standards.

This will result in the following changes to how the system currently works

- An integrated approach to meeting the needs of people presenting with complex presentations arising out of co-morbidity to reduce "suboptimal management" due to skills and system knowledge deficits across teams
- AMPS and Section 12 Doctors will be fully aware of all options and solutions available for crisis support for this population during the out of hours periods, to reduce the likelihood of admission to hospital

- Mental Health Liaison, Home Treatment Team, Street Triage and SPA service have an improved knowledge of meeting the needs of people with learning disability, autism and behavioural challenges
- The PDU and Health based Place of Safety (Section 136 suite) is responsive to the needs of this population
- Appropriate admissions occur to mental health beds within Sheffield when admission avoidance is not possible, with wrap around support from the enhanced team to promote a minimum length of stay

Further development

As this work progresses to the business case stage further work is required to fully consider and define the ways of working, skill mixes and roles required to effectively provide for peoples needs within the crisis hub services and particularly with regard to effective care on the mental health ward for those requiring mental health treatment. This will need to have considered the skill mix/workforce implications in particular for nursing and how CISS/CLDT will in-reach and how our Wards (Acute, Rehabilitation, Forensic, Dementia) are staffed appropriately to support a person with a learning disability in a mental health bed in line with Greenlight principles.

Community Intensive Support Service (CISS)

The CISS clinical function is designed to meet specific objectives set out in the national model with regard to high risk learning disability groups as follows:

1. People with mental health problems: To provide better identification and treatment of mental health problems amongst adults with learning disabilities and/or autism in the community. To support admission avoidance where appropriate and to engage in proactive admission and discharge transitions and aftercare where inpatient care is absolutely necessary.
2. People who present significant challenging behaviour: To offer highly skilled, highly personalised care and support that can be stepped up and down in intensity as required. To support admission avoidance where appropriate and to engage in proactive admission and discharge transitions and aftercare where inpatient care is absolutely necessary.
3. People who are long-stay NHS campus patients: To eradicate these through supporting capable environments and increased resilience in local community provision by supporting highly personalised packages of care ensuring rights are safeguarded via advocacy support.

In order to deliver its specialist functions the Community Intensive Support Service (CISS) is a highly skilled multi-disciplinary team capable of providing assessment, support and treatment to adults who have a learning disability and complex needs including autism, severe challenging behaviour and mental health needs.

CISS offers both direct and indirect support to service users, families and care providers in line with national best practice models and NICE guidelines. BILD (2016) defines good PBS as follows:

BILD: Five signs of good PBS

The overall aim of PBS is to improve the quality of the person's life and the quality of life for those around them. PBS is not a quick fix. PBS means that people receive the right support at the right time. The right conditions need to be created and maintained so people can achieve the quality of life that they want and deserve to have. Successful implementation needs a whole organisational approach and ongoing commitment. We would be able to see good PBS happening in these five ways:

1. The support would be personalized: We would see evidence of consistent actions being taken to enhance the quality of life and wellbeing of the person. These actions would have been created or agreed with the person and written into a plan. The actions would support the person to be engaged in activities that were meaningful to them and would enable them to experience an ordinary life within their own community.

2. A psychological understanding of behavior: The support would be based on the psychological understanding of how that person learns and what the behaviour of concern means for a person. Practitioners would use standardised assessment tools to inform function-based interventions that are practically applied to the benefit of the individual. Any assessment would take into account the person's history and their unique and individual characteristics including their strengths, any cognitive differences, emotional and physical needs and any traumatic life events.

3. Active implementation: The support would be well planned, implemented and monitored. There would be clarity around every person's role and responsibilities together with evidence of good leadership at the service and organisational level. Support would be progressive and developmental for the individual and all other people involved. This would include the teaching and learning of new skills. Any restrictions deemed necessary would be kept under continual review and the least restrictive approach would always be taken.

4. Evidence based: The support would be based on different kinds of data collected and analysed at all levels in the system. Data, both hard and soft, would be used to inform assessment, to evaluate intervention, and to monitor and improve the quality of life and wellbeing of the person and others. Information should be collected from the person themselves and their families and supporters to see if things have got better for them.

5. Multicomponent interventions: Support would be implemented at different levels and in different ways. We would see proactive strategies to prevent or reduce the triggers and events that evoke or maintain the behaviours of concern. Interventions would be designed to support personal development and the learning and maintaining of new skills. Coping strategies would be prioritised and there would be evidence that the environment had been altered to ensure it was the best possible fit for the person. There would be some reactive strategies to help people keep safe when needed. Support would be based on assessed need and may utilise a range of evidence-based therapies.

The values of positive behaviour support and mental well-being and recovery underpin the work of the team. This includes:

- A person-centred, proactive, assessment-based approach following the principles of PBS[iv] & NICE guidelines (see Appendix 2).
- Examining not only the service user but their life context/environment.
- Encouraging collaboration and partnership between service users, families and professionals and building the skills of everybody involved.
- Promoting positive, durable and sustainable lifestyle changes.

CISS works alongside other specialists within the Community Learning Disability Team (CLDT) and with mainstream mental health services to help service users achieve positive outcomes.

Enhancing the community offer

CISS will support people with autism, challenging behaviour and mental health needs living in a range of care settings:

- At home
- Residential and nursing care
- Supported living
- Short-term care provision
- In-patient hospital settings (both in and out of city)

The service will function to provide a specialist multi-component model supporting lasting change across the following four domains:

- **Ecological change:** This is about making changes to the buildings, places and team around the person and ensuring 'goodness of fit'. This is achieved by matching the right people with the right skills working in the right environments to support the person's physical health and emotional well-being. Involving and supporting carers and families through education, training, consultancy and supervision is a key factor in building resilience and building capable environments. A capable environment will include carers who can:
  - develop personalised daily activities adapting a person's environment and routine
  - deliver interventions effectively for people with a learning disability and behaviour that challenges
  - seek help for difficulties arising from working with people with a learning disability and behaviour that challenges
  - recognise and manage their own stress
  - work with regular high-quality supervision that takes into account the impact of individual, social and environmental factors

- **Focussed support:** This is about helping the person to access any support/intervention that is designed to reduce the frequency, severity or duration of challenging behaviour. Examples include, psychotherapies such as CBT, anger management, mindfulness, behavioural approaches, medication, sport and exercise (as a management tool for anxiety or low mood) and interventions for sleep problems. Communication approaches supporting the understanding of relationships (e.g., social stories) or the identification and expression of emotions (e.g., emotion cards) can also have an important part to play.

- **Positive programming:** This is about supporting fun, usual and functional skills that help the person lead a fuller and more independent life. Support workers, occupational therapists, education and employment support services all have a part to play in increasing the person's skill set and confidence. A big focus is 'active support' which involves supporting the person to participate in all activities across the day with the minimum level of support needed for them to complete each task. Each new skill is aimed at helping the person reach their goals and maintain their well-being. The aim is to build support across social, education and work environments as appropriate.

- **Risk management:** This is about safeguarding the person and others by having a completed risk assessment that informs primary and secondary risk management strategies. These should support the identification of early warning signs and primary strategies designed to calm and divert the person if they show early signs of distress. Secondary reactive strategies come into play if the risk keeps escalating. Any strategies that involve restriction should be proportionate to risk and be as minimally intrusive as possible. Where restriction is required this will need to operate in line with an appropriate legal framework such as MHA or MCA and may make the person eligible for DoLS.

Crucially the most effective risk management strategy is to maximise the effectiveness of the three previous areas of the multi-element model as people with higher levels of positive opportunity and well-being invariably challenge less.

Access to Emergency Respite Beds

Access to the out of hours emergency respite beds is crucial if we are to provide a real alternative to inpatient admission. Financial and operational improvements are required to enable an effective system of delivery, including:

- Such beds need to be used as a last resort as the emphasis needs to be to provide support directly into the person's home rather than displacing them.
- System wide bed availability needs to be clearly communicated (e.g., online dashboard) and made available to out of hours teams.
- Funding to access these beds needs to be based on a pre-agreed arrangement which covers the first critical period in someone's respite (e.g., first week).
- Standard Operating Procedure required to support later decisions about the share of social versus health funding (to support decision making about the extent to which challenging behaviour represents a health or social funding responsibility).

Service Delivery

The team of clinicians and support staff will provide support and interventions where and at the level that is most appropriate for the individual. For example:

- Intensive interventions to support the individual could be across a seven day period up to 16 hours per day (8am – 12am) dependent on individual need
- Support could be by way of daily visits over a shorter time period of 2-4 weeks to help manage or overcome a certain issue or problem
- Support may include advice over the telephone or via meetings
- Support will be reviewed to ensure it continues to meet the individual's needs
- Education, training and support

Referrals to the CISS are made via the Community Learning Disability Team (CLDT) for adults with a learning disability 18 to 65 years. However iin order to be truly preventative, the service will also support/joint work with people in the transition from child to adult services (14-18 yrs). This pending contractual agreements between SHSC and the lead commissioner.

Service availability

Services will be available 365 days a year. The service will provide crisis and emergency intervention and specialist, enhanced home treatment for people with a learning disability who are in crisis.

The core CISS team will be available from 8am-8pm Monday to Friday. Nursing and support staff from CISS will work from the Crisis Hub from 7pm – 12am Monday to Friday and 8am-12am Saturday and Sunday.

Further development

As this work progresses to the business case stage further work is required to fully consider and define the required skill mixes within the CISS team and pathway and joint working links to the CLDTeams. This work will focus on ensuring clarity on the potential for the Nursing contribution (skill mix) to the enhanced CISS Model. This review will consider the benefit of the following roles being part of a new enhanced CISS Clinical Staffing /Operating Model: Non-Medical Prescriber(s) (NMP), LD Trainee Nurse Associates, Advanced Nurse Practitioner (ANP) & Nurse Consultant the Approved /Responsible Clinician (AC/RC) role if required.

9. Outline Plan

Discovery and Design Phase to be completed by end of November 2018

To support the production of a business case, key areas of work need to be progressed and, in some cases, progressed in partnership with key stakeholders. This has not been feasible in advance of the strategic case being considered and approved.

	Development stage	Completed by	Leads
1	**Consultation and engagement** with key stakeholders regarding the proposed new model. Programme to be delivered in conjunction with Speak Up For Action advocacy group – Finalise engagement programme – Complete engagement programme and finalise proposals	14 September 16 November	Speak Up For Action David Newman Heather Burns
2	**Review respite care pathway** and capacity requirements with existing range of providers commissioned by the local authority in respect of ability to deliver emergency respite supported by the enhanced CISS offer. Define resource implications.	2 November	Michelle Fearon/ Deborah Horne Richard Parrot
3	**Define future CISS Clinical MDT staffing model requirements** in respect of skill mix and ensuring maximum contribution from nursing within the service	16 November	Julia Shephard David Newman Michelle Fearon/ Deborah Horne
4	**Define CISS relations and interface to CLDT's** in respect of pathways, operational procedures, joint working and ensuring effective stepped care	16 November	Julia Shephard David Newman Michelle Fearon/ Deborah Horne
5	**Define future crisis hub and inpatient care requirements** with consideration of the skill mix/workforce implications in particular for nursing and how CISS/CLDT will in-reach and how our Wards are staffed appropriately to support a person with a learning disability in a mental health bed in line with Greenlight principles.	2 November	Julia Shephard Lisa Johnson Kim Tissington David Newman Michelle Fearon/ Deborah Horne

6	**Define pathway interfaces with SAANs** and consider and define what further changes may be required to support the aims of this programme	2 November	David Newman Mark Parker Heather Burns Michelle Fearon/ Deborah Horne
7	**Analyse and define impact** of the proposed way forward in respect of – Activity modelling, – Benefits analysis – Impact on social care commissioned care – Impact on current risk share agreements in respect of out of town care	2 November	David Newman James Sabin Heather Burns Richard Parrot Michelle Fearon/ Deborah Horne
8	**Financial appraisal** and options for future use of Firshill Rise to be completed in respect of option to accommodate other services within potentially vacated space or disposal of asset. – Options for re-use reviewed – Financial appraisal of options completed – Resource implications confirmed	 2 November 2 November 16 November	Deborah Horne Helen Payne Gabriel Recalde
9	**Workforce planning and development** planning regarding new services and transition for existing teams and staff into enhanced CISS service or key elements of the mental health crisis care services.	2 November	David Newman Julia Sheppard Michelle Fearon/ Deborah Horne
10	**Develop implementation plan for 2019-20** as part of assessment of feasibility of business case including phasing of changes and supporting financial plan.	16 November	Michelle Fearon/ Deborah Horne

10. Obligations and Impact for the Trust

Patient Safety, Care Standards and Regulations

We will be caring for and supporting people differently as a result of this proposal. With more people in crisis supported in the community and more people accessing the mental health crisis care pathway. While the numbers will be small overall this will be an important development. We will need to ensure the appropriate oversight of care standards and regulatory requirements are progressed in support of the proposed development.

Finance, Commissioners and Contracts

There will be a need for new service level agreements / contract schedules for the proposed enhanced service, clarity of expectation across the supported living sector and a review of risks under the current risk share agreement and current out of town agreements. This will require careful review and development with contract leads across the existing partnership in respect of risk share arrangements.

The proposal raises the option of disposal for Firshill Rise as an estate asset.

Policy and Legal

A new operational policy will need developing for the new services and new pathways.

Procurement and Supplier Partnerships

No significant impacts identified.

Data, Information and Reporting

No significant impacts identified outside of the general need for responsive Insight systems

Impact sign-off

As applicable, expert authorities to agree on Obligation and Impact for the Trust Sign-off - completed by the PMO

Signature: David Newman	Role: Alignment with Transforming Care and national policy aims and direction Clinical Director, Learning Disability Service	Date:
Signature: Michelle Fearon	Role: Alignment with operational and transformation plans Director of Operations and Transformation	Date:
Signature: James Sabin	Role: Financial and contractual assurance Deputy Director of Finance	Date:
Signature: Jason Rowlands	Role: Alignment with Trust strategy and strategic objectives Director of Strategy and Planning	Date:
Signature: Liz Lightbown	Role: Alignment with Trust clinical strategy and direction Executive Director of Nursing, Professions & Care Standards	Date:

Signature: Mike Hunter	Role: Alignment with Trust clinical strategy and direction Medical Director	Date:

Strategic Case Approved: authorisation to review

Signature: Clive Clarke	Role: Executive Sponsor Deputy CEO and Executive Director of Operations	Date:
Comments	This strategic case has been reviewed by Transformation Operational Group – 8th August 2018 Business Planning Group – 21st August 2018 Executive Directors Group – 23rd August 2018	

Appendix 1: Case scenarios

Case Scenario 1			
Legal status:	MHA: S2 - S3		
Presenting problem:	Scenario 1, a young person with mild learning disability, ASD and early onset psychosis, self-harm & bereavement. They were transferred to ATS from Endcliffe Ward. They have had a number of recent admissions to adult mental health wards following discharges with limited social support package. They are under the Early Intervention in Psychosis team (EIP)		
Under current model - ATS input:	ATS would work to stabilise their mental state, via medical review and medication optimisation, develop a positive behaviour support plan including accessible psycho-education regarding psychosis, build relational support and trust enhancing direct communication as a coping strategy rather than self-harm. Discharge planning would look to secure a more robust social support package in terms of hours and staff skills and provide community facing support for bereavement and psycho-social interventions.		
Future enhanced alternative:	Joint work between EIP & CISS would support a more robust community support package in partnership with social services. Reasonable adjustments regarding information about psychosis and well-being would be developed. Minimum inpatient stay within adult mental health wards would be supported via in-reach with post-discharge follow up from CISS & EIS. An enhanced CISS function would undoubtedly support a shorter length of stay within inpatient services.		
In future would inpatient care needed?	[ ] unlikely	[ ] moderate	[✓] likely

Case Scenario 2			
Legal status:	Voluntary (informal)		
Presenting problem:	Scenario 2, is a young person with cognitive difficulties and ASD. They struggle with sensory issues relating their voice, who they are and transition into adult life. They displayed high levels of expressed emotion towards their family. They were receiving CLDT input and the family were waiting for their PA support package and accommodation to be funded. The family went into crisis following assaults to parents. Police were called, and the service user was taken to A&E in the night for a mental health assessment by psychiatric liaison.		
Under current model - ATS input:	The young person agreed to come into ATS on a voluntary basis. This provided an emergency place of safety. ATS provided medication reconciliation and improved compliance. Psychological assessment and SaLT work was completed regarding their emotional significance of their voice. A PBS plan was developed. A sensory assessment was started by OT. They were discharged to their own flat with PA support when their package was agreed. There will be ongoing work in the community from CISS/CLDT.		
Future enhanced alternative:	A more intensive community approach from CISS extending into the evening and access to crisis respite (with in-reach from CISS) would have provided an alternative community-based pathway for this young person.		
In future would inpatient	[✓] unlikely	[ ] moderate	[ ] likely

care needed?			

Case Scenario 3			
Legal status:	MHA: S2		
Presenting problem:	Scenario3 is a young person with a mild learning disability, substance misuse and schizophrenia. Admission was due to drug induced psychosis and risk behaviour towards others.		
Under current model - ATS input:	They were transferred to ATS following admission to the adult mental health ward. Work on the ward focussed on medication compliance and education on substance misuse and its relationship with psychosis. Discharge included ongoing CISS input.		
Future enhanced alternative:	Greenlight working between CMHT/Recovery teams and START and CISS learning disability services would provide a community focussed pathway for this person. Admission to an adult inpatient bed with CISS in reach could be considered as a last resort to manage significant risk. An enhanced CISS function would undoubtedly support a shorter length of stay within inpatient services.		
In future would inpatient care needed?	[ ] unlikely	[✓] moderate	[ ] likely

Case Scenario 4			
Legal status:	Voluntary (informal)		
Presenting problem:	Scenario 4 is a young person with moderate learning disabilities, health anxiety, OCD and PTSD. They admitted themself voluntarily as they were struggling with their level of anxiety. Parents reported that they were unable to support them due to exhaustion and emotional burnout.		
Under current model - ATS input:	They agreed to come into ATS on a voluntary basis. This provided respite and space for parents and allowed for a more in-depth assessment to take place regarding their anxiety and past trauma. They became distressed by the clinical acuity of other service users and was unhappy with their own care. At this point they were discharged home with a package of care from CISS.		
Future enhanced alternative:	A more intensive community approach from CISS/CLDT extending into the evening and access to crisis respite (with in-reach from CISS) would have provided an alternative community-based pathway for this young person.		
In future would inpatient care needed?	[✓] unlikely	[ ] moderate	[ ] likely

Case Scenario 5			
Legal status:	MHA: S2 - S3		
Presenting problem:	Scenario 5, is a middle-aged person with a mild learning disability, emotional unstable personality disorder, mood disorder, self-harm, past trauma and physical health needs (Diabetes, COPD, mobility issues). Their mental state went into decline resulting in high risk behaviours towards herself and their partner.		
Under current model - ATS input:	They are transferred to ATS following admission to the adult mental health ward. Work on the ward focussed on medication reconciliation and psychological support to help develop anger management/arousal management strategies (including mindfulness). Discharge included ongoing CISS input and access to psychology for trauma related work.		
Future enhanced alternative:	Greenlight working between adult mental health PD services/psychotherapy and CISS learning disability services would provide a community focussed pathway for this person. Admission to an adult inpatient bed with CISS in reach could be considered as a last resort to manage significant risk. An enhanced CISS function would undoubtedly support a shorter length of stay within inpatient services.		
In future would inpatient care needed?	[ ] unlikely	[✓] moderate	[ ] likely

Case Scenario 6			
Legal status:	MHA: S2 - S3		
Presenting problem:	Scenario 6, is a young person with a mild learning disability, ASD traits who had childhood ADHD. They have been presenting with long-standing anti-social behaviours including deliberate harm and intimidation of other people. These behaviours meant that they could not be cared for at home or the emergency respite he accessed.		
Under current model - ATS input:	Their behaviour on the ward has involved significant risk requiring seclusion. There has been police involvement and a court appearance due to assaults on staff. They have received a forensic gatekeeping assessment and a recommendation has been made that they required specialist locked rehab. Work is ongoing to support them with understanding of boundaries, anger management and arousal control. A specialist placement is being sought.		
Future enhanced alternative:	Early intervention in teenage years and specialist behavioural support, coupled with community forensic input may have diverted SU6 from his current escalated pathway. Access to robust emergency respite with intensive CISS in-reach coupled with community forensic support FOLS may have diverted them away from ATS. However, the severity of their behaviour would have challenged this pathway, with the result being potential CPS involvement.		
In future would inpatient care needed?	[✓] unlikely	[ ] moderate	[ ] likely

Case Scenario 7			
Legal status:	MHA: S2 - S3		
Presenting problem:	Scenario 7, is a young person with severe learning disability, ADHD, ASD and epilepsy. They struggle with appropriate boundaries and emotional dysregulation and challenging behaviour. Prior to admission their placement broke down due to risk associated with challenging behaviour.		
Under current model - ATS input:	They have been supported to optimise their mental health following a medication review. They are supported via positive behaviour support to manage their levels of arousal and work to appropriate adult interpersonal boundaries. Their stay at ATS was somewhat extended to support a slow transition to their new placement.		
Future enhanced alternative:	CISS would offer intensive support including the development of a PBS plan based on functional analysis and skills training and staff training/support. Any placement breakdown would be managed via access to emergency/crisis respite rather than an admission to mental health services.		
In future would inpatient care needed?	[✓] unlikely	[ ] moderate	[ ] likely

Case Scenario 8			
Legal status:	MHA: S2 - S3		
Presenting problem:	Scenario 8, is an older person with a mild learning disability and treatment resistant schizophrenia. They have chronic fluctuating poor mental health with both positive and negative symptoms. They have a past history of forensic issues. Prior to admission they were being cared for in an acute hospital due to clozapine related neuro-malignant syndrome.		
Under current model - ATS input:	They have been supported to optimise their mental health following a medication review. They are supported via a psycho-social approach designed to encourage them to access community opportunities and develop their confidence and sense of pleasure and mastery in life. They are currently experiencing a delayed transfer of care due to difficulties in sourcing an appropriate community provider.		
Future enhanced alternative:	Greenlight working between adult CMHT/MH Recovery and CISS would support a robust package of support in the community including early detection and relapse prevention. Community FOLS would also be accessed to provide consultancy regarding forensic risk management. Short episodes of inpatient care within adult mental health wards with CISS in-reach could be accessed if mental health deteriorated significantly. An enhanced CISS function would undoubtedly support a shorter length of stay within inpatient services.		
In future would inpatient care needed?	[ ] unlikely	[ ] moderate	[✓] likely

Case Scenario 9			
Legal status:	MHA: S2 - S3		
Presenting problem:	Scenario 9, is a young person with a mild learning disability, severe ASD, OCD and pathological demand avoidance. They are at risk of self-neglect due to their rituals impeding their ability to take medication or complete key tasks such as eating or self-care. They also displayed aggressive behaviour towards others. At the point of admission their community home had gone into crisis due to safeguarding concerns which had impacted on their mental state.		
Under current model - ATS input:	They have been supported via a PBS approach to re-establish more healthy routines and boundaries relating to eating, sleeping and medication. Their medication has been rationalised. They have been supported to reduce rituals and delaying behaviours so that they can access community opportunities. They are currently a delayed transfer of care due to difficulties in sourcing an appropriate community provider.		
Future enhanced alternative:	Intensive PBS work with the individual and their provider team to formulate and manage care, boundaries, consistencies and interpersonal relationships would reduce the dependence and/or length of stay within an inpatient setting. Relational support for the staff team including workshops and supervision would support the sustainability of placements.		
In future would inpatient care needed?	[ ] unlikely	[✓] moderate	[ ] likely

Appendix 2: CISS Model – staffing overview

Post	Band	Current Funding from Transforming Care/Out of City (a)	Current Community Intensive Support Service (b)	Proposed New Establishment for Community Intensive Support Service incorporating wte within (a) and (b)	Crisis Care Capacity "Green Light"
Consultant Psychiatrist	YM52		0.35 wte	0.65 wte	
Specialty Doctor	MC46	.30 wte		0.5 wte	
Consultant Clinical Psychologist	Band 8d			0.4 wte	
Psychologist	Band 8b	0.20 wte	0.80 wte	1.0 wte	
Nurse Consultant	Band 8a		1.00 wte	1.0 wte	
Occupational Therapist Lead	Band 8a	0.69 wte		0.69 wte	
Pharmacy	Band 7			0.2 wte	
Occupational Therapist	Band 7			0.6 wte	
Speech & Language Therapist	Band 7		0.30 wte	0.8 wte	
Specialist Nurse Practitioner	Band 7		1.09 wte	1.09 wte	
Speech & Language Therapist	Band 6			1.0 wte	
Nurse	Band 6			4.0 wte	2.0 wte
Psychology Assistant	Band 5		0.50 wte	1.0 wte	
Nurse	Band 5			2.0 wte	
Speech & Language Therapist / Communication Assistant	Band 4			1.4 wte	
Psychologist Assistant	Band 4			1.0 wte	
Clinical Assistant	Band 4	1.50 wte		2.0 wte	
Development Worker	Band 4		1.00 wte	Remove post	
Support Worker	Band 3			6.0 wte	2.0 wte
Business Support Manager	Band 5		0.50 wte	1.0 wte	
Senior MDT Secretary	Band 4			1.0 wte	
Business Support	Band 3		1.15 wte	1.5 wte	
Service User Expert - Paid Employment	Band 3			1.0 wte	

Descriptor of Nursing and Support Worker Team

The team will include a nurse operating as an Advanced Clinical Practitioner[5] (ACP) with the scope of enhancing capacity and capability within the multi-professional team by supporting existing and more established roles. Advanced clinical practice is delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence.

Advanced clinical practice embodies the ability to manage clinical care in partnership with individuals, families and carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions[6] to enhance people's experience and improve outcomes.

Under ACP Nurse direction a team of support workers will through utilising the principles of Positive Behaviour Support assess risk both human and environmental, and support therapeutic risk taking based on the least restrictive approach.

They will deliver direct interventions based on the principles of Positive Behaviour Support (PBS), building on this by promoting active support - which encourages individuals to help themselves maintain their independence and abilities. A key part of their role will be working alongside other clinicians in the development of capable environments.

The support workers will provide support to family carers (some of the support provided is emotional support, talking to them, role modelling, making sure what they are doing is not illegal e.g. respect techniques and signposting to other appropriate services).

Provide service users with time limited interventions: This can range from daily to 24-hour support around an individual, working alongside the staff team to role model or daily visits dependent on what the individual needs of the person and staff team.

As Positive Behaviour Support is an evidenced based model the support workers will support clinicians in data collection e.g. functional assessments, incident monitoring, medication side effects monitoring, adherence to care plans and support plans, to facilitate the development of evidenced based interventions.

The LD/MH Nurse will:

- Ensure that the support workers have good quality clinical and managerial supervision, ensuring that all the principles of Positive Behaviour Support are embedded and evidenced in practice.
- Co-ordinate the inputs and the work plans of the support workers, including rota management.
- Through assessment and joint working, they will formulate the Positive Behaviour Support (PBS) Plans and monitor and review these; reviewing outcomes and undertaking outcome measures as a part of this process.
- Develop and deliver bespoke training packages to staff; being able to question and support peoples understanding of relevant legal frameworks around the support of an individual e.g. Care & Treatment Reviews, Community Treatment Orders; chairing roles

as CPA co-ordinators; role modelling of evidenced ways of working and demonstrating adherence to relevant bodies of guidance.
- The RMN will pay particular attention to co-morbidity and monitoring the relationship between mental health, physical health, medication and challenging behaviour.

Descriptor of Speech & Language Roles

Communication is fundamental to good health. The ability to be 'heard', to tell our stories and have someone listen is central to how individuals engage with each other and make sense of the world. Communication is the starting point of any therapeutic action or health intervention.

Nurturing communication is key to engagement with people and the immediate environment, this being essential to good physical and mental health. However, the act of communicating can be problematic, barriers often exist that affect a person's ability to express themselves and/or understand the world around them. This creates a 'silence' in which issues affecting individual need aren't always fully heard or possible solutions understood.

Speech and Language Therapy within the CISS would focus on reducing any barriers' that impact on the client's everyday life and longer-term needs. Supporting them to be engaged more effectively, expressing their needs and desires in a positive way, while

ensuring those working to support them have the ability to adapt to the communication needs of the client. This is especially important when supporting service users to access mainstream provision.

The Speech and Language Therapy team will:

- Assess a client's level of comprehension and advise on how those working with them need to adapt their communication to improve the client's ability to understand. They will also adapt and advise regarding the communication environment. Working with staff teams to create an environment that is accessible to the individual, allowing them to make more sense of their surroundings, creating a holistic and consistent approach to communication needs.
- Assess and plan intervention to optimise the client's ability to express themselves using low and High-Tec communication aids, signing systems and individual interventions such as Intensive Interaction and Phonology work plans.
- Lead on any communication training needed for staff teams regarding individual client need.

Under supervision from the Band 7 & 6, the Band 5 Speech and Language Therapist will work to support staff teams in the development, implementation and monitoring of optimum communication environments for individual clients and/or the communication approaches of individual staff teams.

This would be completed in-line with the RCSLT 5 good communication standards. The band 5 would also implement initial therapy programmes such as phonology work or social skill interventions while supporting staff teams through on-going monitoring to continue these intervention programmes once established. Baseline comprehension and expressive communication to be incorporated into detailed Communication Passports enabling their support network to have a detailed awareness of the individual's communication needs.

Descriptor of Clinical Assistant Roles

Under supervision of the Nurse Consultant the Clinical Assistant will provide a programme of baseline training in Positive Behaviour Support (PBS) and reactive strategies as part of unifying approaches across the city and across the Transforming Care Partnership. This will be achieved through delivery of the PBS Knowledge, Skills and Understanding Workbook. The Clinical Assistant will maintain an up-to-date database of PBS training delivered and required; signpost providers to other training opportunities and/or resources which may help in the delivery of care and support and service enhancement.

The Clinical Assistant will highlight to the Nurse Consultant where more detailed person specific PBS workshops may be required, support organisation of these, obtain and feedback/evaluations from the workshops and analysing the results.

Descriptor of Clinical Psychology Roles

The Clinical Psychologist will work closely with the Assistant psychologist to oversee and produce completed functional assessments outlining the typology of behaviour, including onset, function and formulation of maintaining factors and protective factors. This will be used to develop a PPSP (PBS Care Plan) incorporating MDT input and including the following elements:

- Functional analysis
- Formulation of problem and maintaining factors
- Environmental supports (staff training and support requirements)
- Focussed supports (coping mechanisms, behavioural interventions that reduce the frequency, duration and severity of challenging behaviour)
- Positive programming (learning of new and useful skills in partnership with OT & Support Workers)
- Risk management (primary and secondary risk management strategies and reactive crisis management)

The Clinical Psychologist will lead on all psychological interventions (e.g., adapted trauma focussed therapy, EMDR, anger management, CBT, behavioural interventions) and support in the delivery of staff training, supervision and organisational support.

The Assistant Psychologist will complete standardised assessments of mental health and challenging behaviour under the supervision of the clinical psychologist. They will also complete observations and analyse ‘ABC’ information supporting the process of functional assessments, formulation and outcome/progress. The Assistant Psychologist will support in the delivery of structured clinical interventions conducted under the supervision of the clinical psychologist including mindfulness, relaxation, graded exposure.

Speciality Doctor/Consultant Psychiatrist

Challenging behaviour as a term carries no diagnostic significance, and makes no inferences about the aetiology of the behaviour. It covers a heterogeneous group of behavioural phenomena across different groups of people; for example, oppositional behaviour in children, faecal smearing in those with a severe learning disability and deliberate self-harm in adult mental illness. Challenging behaviour may be unrelated to psychiatric disorder, but can also be a primary or secondary manifestation of it. Due to their specialist medical training Speciality Doctor/Consultant Psychiatrist can help to identify the

cause for behaviour, particularly if the cause is related to mental illness or complex physical health, genetic and/or neurological issues. Medical input can support treatment by prescribing medication that impacts on comorbid factors (e.g., mental illness, epilepsy) and support the person to reduce levels of anxiety/agitation if behavioural methods are proving not to be effective.

Specific medical therapeutic interventions:

Pharmacotherapy: The treatment of an underlying mental disorder, epilepsy or other physical condition should be the target of any specific medication in the first instance.

Self-injury: The opioid antagonists naloxone and naltrexone have been used for the reduction of SIB in learning disability patients. It is thought that this reduction is mediated by a selective blockade of endorphin receptors leading to removal of the biologically based reinforcing properties of self-injury. There have also been reports on the effective use of serotonergic antidepressants for the treatment of SIB.

Aggression: Although some drugs have been marketed as having a specific anti-aggressive effect (lithium and chlorpromazine), it is more likely that any reduction of aggression is either secondary to a reduction of a primary psychopathology, or results from a non-specific sedative effect. Neuroleptics, benzodiazepines (caution is required because of possibility of paradoxical excitement), mood stabilisers and antidepressants have all been used for the treatment of aggressive behaviour.

Medication Rationalisation & STOMP

Whilst medical input can support the initiation of medication it can also be employed to review and rationalise unnecessary drug treatments. NHS-England have recently launched the Stopping the Over Medication of People with Learning Disabilities (STOMP[7]) campaign stating we all need to make it a priority to reduce and stop the use of inappropriate drugs, to reduce adverse side effects and potential drug interactions. This is vital to our patients' safety and their quality of care. The goal is to improve the quality of life of people with a learning disability by reducing the potential harm of inappropriate psychotropic drugs that may be used wholly inappropriately, as a "chemical restraint" to control challenging behaviour, in place of other more appropriate treatment options. It is time for action, it is time for you to lead a medication review of all people with a learning disability, with a view to implementing a planned supervised dose reduction and stopping of inappropriate psychotropic drugs

Pharmacist Input

Pharmacy input provides a crucial oversight into safe medication, ensuring side effects, interactions and complexities are considered when prescribing a new medication or reducing an existing medication (e.g., changes to epilepsy seizure thresholds following the introduction of a new medication). Pharmacists are concerned with the service users smoking status, alcohol consumption, physical activity, weight, and BMI and how these interact with medication and health. Ultimately senior pharmacy[8] input further supports medication rationalisation and ensures medication safety factors are paramount in care planning and delivery[9].

Benefits

Key benefits to be delivered are:

- Earlier direct clinical specialist assessments and prevention programmes to reduce the severity and progression of a condition, limit complications and provide rehabilitation to restore functionality.

- Deliver PBS training and advice to families and paid carers particularly identifying those most at risk or breakdown and of the care arrangements.
- Closer multi-disciplinary assessment, scrutiny and monitoring of accommodation and support providers to reduce requests for additional staffing levels as a result of poor performance in managing autism, challenging behaviour and mental health.
- A stepped model of care for interventions around autism, challenging behaviour and mental health.
- Planned crisis management and intervention through active monitoring of local risk registers, to avoid off the shelf expensive high cost placements.
- Development of local accommodation and support provider capacity through expert guidance from the CISS clinicians to support people with complex needs more effectively locally, to better contain costs and improve individual outcomes.
- Specialist clinical advice and support to primary and secondary care to improve the management of people with autism, challenging behaviour and mental health through improved pathways and co-ordination in mainstream services to reduce avoidable hospital admissions.
- Development of interdependent relationships between clinical service providers and local support providers to more cost effectively support individuals for better outcomes
- Support families and other carers more effectively so that living arrangements within the home, as the most cost effective and family friendly solution is sustained for longer.

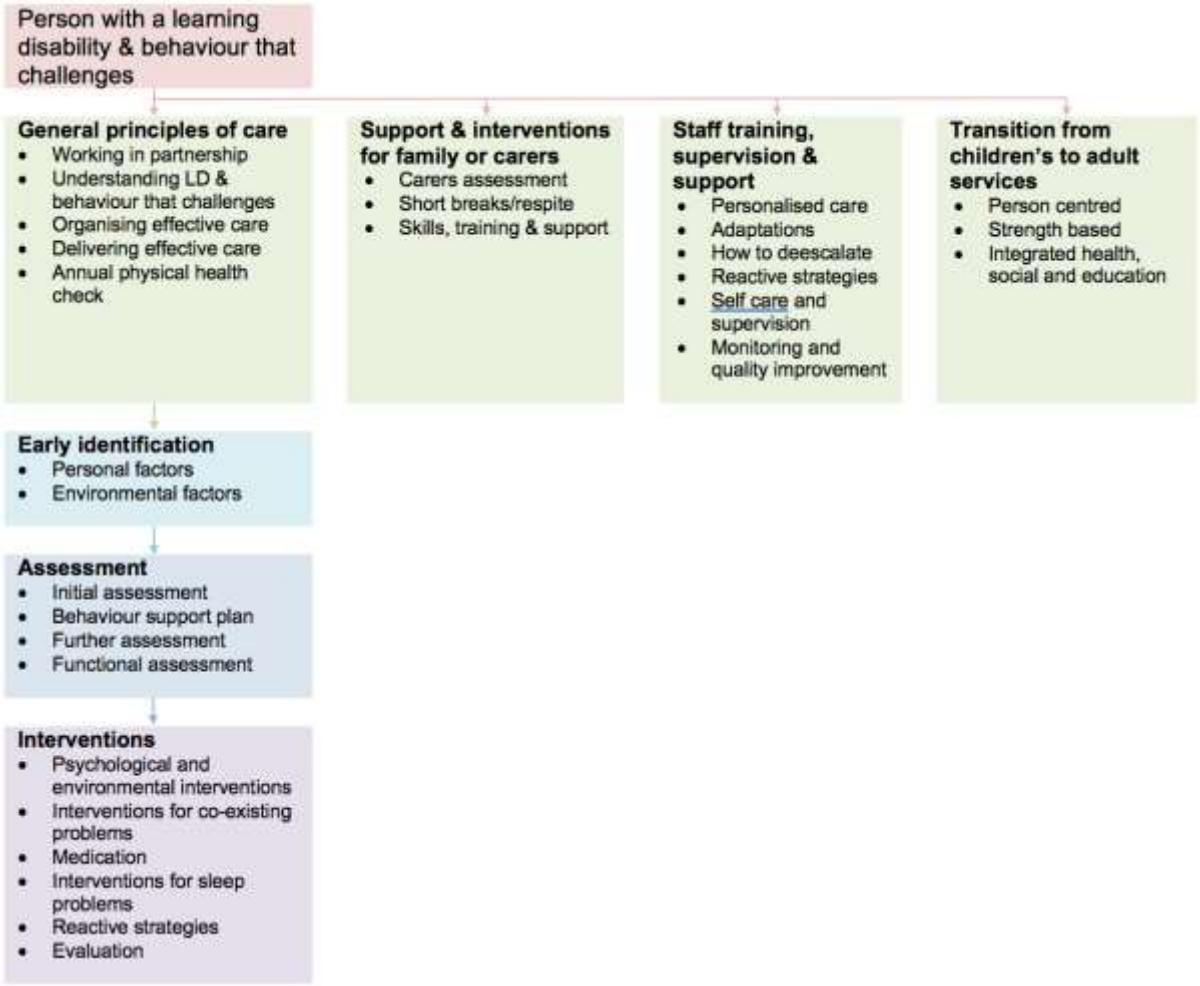
Key outcomes to be delivered:

- In line with TCP priorities this model will support local discharge and/or return of people back to live in Sheffield or closer to home with more opportunity for cost containment around packages of care by improved multi-disciplinary clinical assessments, interventions and monitoring. **The CISS will work with local authority partners to support the development of local alternatives to bring people back to Sheffield and prevent new people being placed out of town.**
- Improve the local market by developing the competency of local accommodation and support providers to work more effectively with people with autism, challenging behaviour and mental health needs through improved clinical support and monitoring to local providers. **Thereby ensuring there is local supported accommodation as part of the local package of care, reducing the likelihood of adults going out of town to expensive services by working with local authority partners in developing local alternatives.**
- Reduce avoidable hospital admissions, and/or reduce the length of stay by improved case management and co-ordination by primary and secondary care supported better by specialist learning disability clinicians. **Thereby reducing the number and therefore cost of avoidable admissions and reducing lengths of stay.**
- Will allow for more in-depth working around Blue Light requirements in respect of CTRs, through providing additional support into the person's current residence to minimise the risk of admission.

Appendix 3

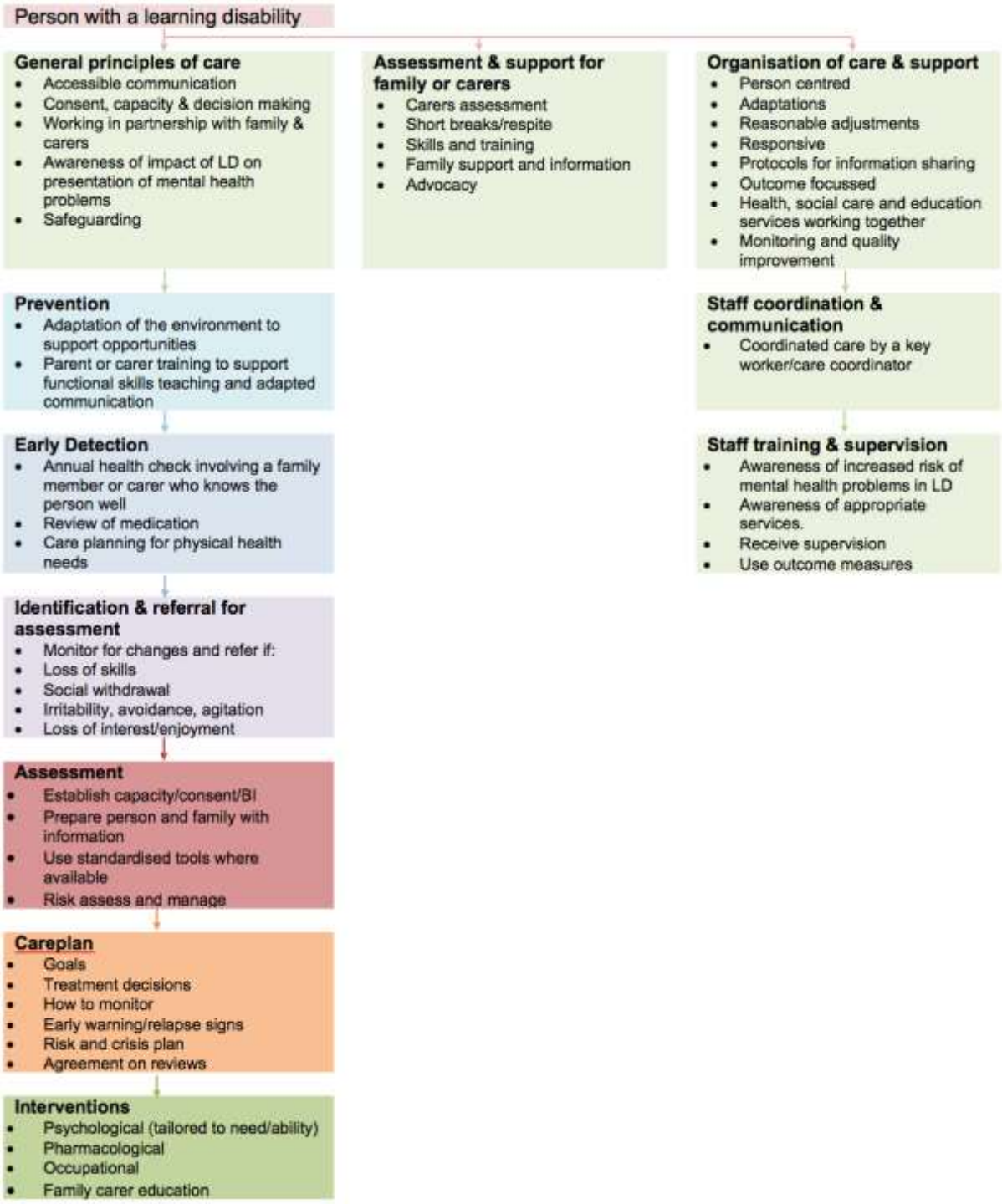
NG11: **Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges.**

This guideline covers interventions and support for children, young people and adults with a learning disability and behaviour that challenges, and ways of preventing challenging behaviour. It aims to improve quality of life for the person and their family members or carers.



NG54: **Mental health problems in people with learning disabilities: prevention, assessment and management**

This guideline covers preventing, assessing and managing mental health problems in people with learning disabilities in all settings (including health, social care, education, and forensic and criminal justice). It aims to improve assessment and support for mental health conditions and help people with learning disabilities and their families and carers to be involved in their care.



End Notes & References

[i] Building the Right Support: https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf

[ii] Greenlight for Mental Health: https://www.ndti.org.uk/uploads/files/Green_Light_Toolkit_22_Nov_2013_final.pdf

[iii] Learning Disabilities Mortality Review - LeDeR: https://www.hqip.org.uk/resource/the-learning-disabilities-mortality-review-annual-report-2017/

[iv] Positive behavioural Support: http://pbsacademy.org.uk/people-with-learning-disabilities/

[5] Multi-professional framework for advanced clinical practice in England: https://hee.nhs.uk/sites/default/files/documents/Multi-professional%20framework%20for%20advanced%20clinical%20practice%20in%20England.pdf

[6] Health Education England (2017). Framework to promote person-centred approaches in health and care: https://hee.nhs.uk/news-blogs-events/hee-news/new-framework-promote-person-centred-approaches-healthcare

[7] Stopping the over medication of people with LD (STOMP): https://www.england.nhs.uk/learning-disabilities/improving-health/stomp/

[8] Royal Pharmaceutical Society Faculty (2013) The Royal Pharmaceutical Society Advanced Pharmacy Framework. RPS Faculty: London. https://www.rpharms.com/resources/frameworks/advanced-pharmacy-framework-apf

[9] Sheehan R, Hassiotis A, Walters K, et al (2015) Mental illness, challenging behaviour, and psychotropic drug prescribing in people with intellectual disability: UK population-based cohort study. BMJ, 351: h4326.

BILD (2016). *Centre for the Advancement of PBS: Five signs of good PBS.* Cooper, J., Heron, T. & Herward, W. (2014). *Applied Behavior Analysis (2nd Edition) 2nd Edition.*

Beadle-Brown, J. and Mills, R. (2010). Understanding and Supporting children and adults on the autism spectrum. Brighton: Pavilion Publishing.

Beadle-Brown, J. and Murphy, B. (2016). What does good look like? A guide for observing in services for people with learning disabilities and/or autism. http://www.unitedresponse.org.uk/what-does-good-look-like

Department of Health (2014). Positive and Proactive Care: Reducing the Need for Restrictive Interventions. London: Department of Health. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf

Durand, M. (1990) Severe behavior problems: A functional communication training approach. New York, NY: The Guilford Press

Gore, N.J., McGill, P., Toogood, S., Allen, D., Hughes, C., Baker, P., Hastings, R.P., Noone S., & Denne, L. (2013). Definition and Scope for Positive Behavioural Support. International Journal of Positive Behavioural Support 3 (2) 14-23.

LaVigna, G.W. & Willis, T.J. (2005) A Positive Behavioural Support Model for Breaking the Barriers to Social and Community Inclusion Learning Disability Review, 10, 16-23.

LGA & NHS England (2014). Ensuring Quality Services for Children and Adults with Behaviour that Challenges. http://www.local.gov.uk/place-i-call-home/-journal_content/56/10180/5971490?_56_INSTANCE_0000_templateId=ARTICLE

Mansell, J., & Beadle-Brown, J. (2012). Active Support: Enabling and Empowering People with Intellectual Disabilities. London, UK: Jessica Kingsley Publishers.

NICE (2015). Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges. NICE guideline 11. https://www.nice.org.uk/guidance/ng11

PBS Academy & The Challenging Behaviour Foundation resources for family carers, people with learning disabilities, support workers, service providers, & commissioners available at http://pbsacademy.org.uk/

Positive Behavioural Support (PBS) Coalition UK. (2015) Positive Behavioural Support (PBS): A Competence Framework. http://pbsacademy.org.uk/pbs-competence-framework/

Skills for Care & Skills for Health (2014) A Positive and Proactive Workforce. A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health, London: SfH/SfC

Skills for Care and NTDi (2013) Supporting staff working with people who challenge services: Guidance for employers, London: SfC/NTDi

United Response (2014). Positive Behaviour Support and Active Support. http://www.unitedresponse.org.uk/transforming-care