LD COMMUNITY SERVICES INVESTMENT UPDATE

SHEFFIELD HEALTH AND CARE PARTNERSHIP BOARD

11 DECEMBER 2023

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Purpose of Paper

- To update the Partnership Board on the future Learning Disability (LD) service model which will be achieved through realignment of resources from outdated learning disability inpatient care, into an enhanced community service model fit for the future.

Key Issues

- Over recent years, Sheffield ICB has achieved national targets to reduce the over reliance on admissions to hospital care for people with learning disability (LD) although inevitably, this has taken away focus from other areas of service delivery by the Community Learning Disability Team (CLDT) for the LD population on their wider health needs.
- SHSC's Firshill Rise specialist learning disability inpatient Assessment and Treatment Unit was voluntarily closed to admissions by SHSC following feedback from ICB and CQC on quality and safeguarding concerns in Spring 2021. This service offered a hospital-based intervention when a person with a learning disability experienced a deterioration in their emotional wellbeing, mental health or presented with behaviour that is challenging to support/behaviours of distress.
- The potential options for the future of this provision and alternative enhanced community-based models have since been under review and development, all set within the context of a national Learning Disability and Autism programme, *Building the Right Support,* delivered in partnership across SYICB and Local Authority, in which there is an emphasis on early intervention, enhanced community provision and prevention of avoidable hospital admissions.
- It should be noted that there has been limited opportunity to invest in enhancing our community adult LD services over the last 5 -10 years in Sheffield as we have had resources ringfenced to the Firshill Rise inpatient beds, with only small pots of national Service Development Funding being available for transforming community services. The closure to admissions at Firshill Rise therefore presented a good opportunity for a substantial review of community LD services to bring Sheffield up to benchmarked levels of other national and local community learning disability service provision.

Is your report for Approval/Consideration/Noting
Sheffield Health and Care Partnership Board is to note this report.
Recommendations/Action Required by the Sheffield Health and Care Partnership Board
To acknowledge the good work and progress made in this area.
What assurance does this report provide to the Sheffield Health and Care Partnership Board in relations to the ambitions of the Health and Wellbeing Strategy 2019-2024

	Please ✓
Every child achieves a level of development in their early year for the best start in life	
Every child is included in their education and can access their local school	
Every child and young person has a successful transition to independence	✓
Everyone has access to a home that supports their health	
Everyone has a fulfilling occupation and the resources to support their needs	✓
Everyone can safely walk or cycle in their local area regardless of age or ability	
Everyone has equitable access to care and support shaped around them	✓
Everyone has the level of meaningful social contact that they want	✓
Everyone lives the end of their life with dignity in the place of their choice	

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

- The new model will see the funding that had previously been committed into Firshill Rise be reinvested into the community LD service model described. This breaks down to £1.5m staffing resource, £0.12m for spot purchase inpatient care and the remaining for non-pay and overheads to be added to the existing community provision. The total cost of the future service which includes the new model and existing community learning disability service is £5.1m.
- The ICB team is progressing plans to develop a gain/risk share with SHSC for any inpatient admissions, against a continual review of performance against the incremental implementation of the new model.

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

Yes.

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

- SHSC have engaged with other NHS Trusts to learn from their experiences, and they and Sheffield place team have co-produced the proposed solutions and

recommended options with service users, carers, staff and key stakeholders. Our engagement work was noted as good practice by the Health Scrutiny Committee, NHE England Assurance Checkpoint Process and North-West Clinical Senate.

- We have worked extensively with Sheffield Voices and Sheffield Mencap as experts by experience and advocates to understand the needs and views of the LD population and carers when designing the model, and to mitigate concerns arising from the closure of the Firshill inpatient beds. Engagement work and interactions with service users and their families will continue as the new service model is implemented and reviewed over time.

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1. Introduction and background

1.1 People with a learning disability have been evidenced to have overall poorer experience of care, increased morbidity, and earlier preventable deaths than the rest of the population. They have been shown to experience avoidable inappropriate admission into the restrictive care of specialist inpatient assessment and treatment units, with prolonged lengths of stay and poor outcomes for them and their families, as reintegrating people back into community lives can be challenging to achieve and lead to inappropriate stays of many years.

1.2 Sheffield's Firshill Rise specialist learning disability inpatient Assessment and Treatment Unit offered a hospital-based intervention when a person with a learning disability experienced a deterioration in their emotional wellbeing, mental health or presented with behaviour that is challenging to support. The unit was voluntarily closed to admissions by SHSC following feedback from ICB and CQC on quality and safeguarding concerns in spring 2021.

1.3 The national model, Building the Right Support, stresses that least restrictive pathways of community care should be in place to replace inpatient care of the kind that had been provided at Firshill Rise. Over time and with the success that we have had in transforming our approaches, inpatient care is no longer a model of care that we routinely require. However, people with learning disability and their families are now experiencing longer waiting times for the general pathway interventions that a Specialist Community Learning Disability Service should be offering, as resources for prevention and early intervention and work on wider health needs are diverted into the crisis pathway mental health and pathways supporting behaviours of concern.

1.4 SYICB partners had previously closed their equivalent inpatient units following quality issues before the commencement of the national Transforming Care/LDA Programme, and therefore they had been already able to invest in enhancing their community LD services. Sheffield had the only remaining inpatient beds in our area at the start of the programme in 2015, which both we and partners at that time required, and therefore Sheffield had recurrent funding committed into the inpatient beds and so were unable to invest in our community services.

1.5 Whilst our South Yorkshire commissioning partners had spot purchased beds over the programme period at Firshill Rise, they were unwilling to commit to co-commissioning the inpatient unit post pandemic, and confirmed this position in 2022, leaving Sheffield in a difficult position, as the unit was no longer of use for Sheffield alone, and therefore became unviable.

1.6 The closure to admission of Firshill Rise therefore presented an opportunity for a substantial review of LD services to bring Sheffield up to benchmarked levels of other national and local community learning disability service provision.

1.7 A paper on lessons learned from the quality issues identified at Firshill Rise was presented in March 2023 by Sheffield Health and Social Care NHS Trust (SHSC), as the provider of

the LD inpatient service, to Health Scrutiny Sub-Committee alongside a paper presented by Sheffield place ICB on the initial future proposed model for the adult LD service. Extensive reflection, engagement and development work has been taking place between SHSC and Sheffield ICB team to further shape the future model for community learning disability services, with a recognition that we did not want to continue to commission such restrictive inpatient care.

1.8 Working with Sheffield Place ICB team, SHSC have since produced a sustainable business model, financial, demand and capacity plan, staffing plan and specification, considering regional and national best practice and benchmarking, which was signed off by the Sheffield Place Executive Team (SPET) in November 2023.

1.9 The aim of this paper is to update the HCP on the new enhanced community Learning Disability (LD) service model through the redirection of resources from outdated inpatient care.

2. Overview of the new model

2.1 It is proposed that the new model will provide:

2.1.1 **A single pathway** to replace two entry points into one Community Learning Disabilities Team (CLDT), which will re-establish more of the standard early intervention and prevention in general health support pathways, alongside more enhanced mental health, and behavioural interventions.

2.1.2 **A strengthened central point of access** for all referrals into the service, with a greater emphasis on a more coordinated and holistic community multidisciplinary team (MDT) to better assess and manage both physical health and mental health risks as early as possible.

2.1.3 **Extended operating hours during the week** (to 8am-6pm on weekdays and 9am-5pm on call on weekends, in phase one, and to 8am-8pm in phase two), with referral to the general SHSC out of hours crisis team outside of those hours, to offer earlier pre-working day appointments as requested by working families in our engagement work, with additional on call clinical advice and support over the evenings and weekends. This will enable the service to better manage crisis prevention through **more direct and urgent support in response to a crisis** that might otherwise lead to family/service breakdown, admission to an inpatient setting, or an out of area placement.

2.1.4 **Increased clinical and support staff**, to reduce waiting times, to add to and complement the MDT, to support the additional operating hours, and to carry out tasks such as Positive Behavioural Support,[1] physical health monitoring, depot injections and blood desensitisation work.

- General professions such as Speech and Language Therapy, Occupational Therapy and Nursing will see their staffing levels increase in line with national benchmarking carried out by SHSC. Demand and capacity analysis has shown that for many of the professions in the service, including Speech and Language Therapy (SALT), physiotherapy, occupational therapy and psychology, people are waiting in excess of 18 weeks for interventions, and that the range of interventions

[1] "One in five adults with learning disability have behaviour that is challenging. A person-centred approach known as positive behavioural support is recognised as best practice." Better-Health_Care-For-FINALWEB.pdf (nihr.ac.uk) p.4, 26.

is restricted. For example, SALT capacity is mainly focussed on eating and swallowing problems, so that even severe communication issues, which can lead to behavioural issues, are not addressed in a timely way.

- The new structure also includes new roles of specialist dieticians and art therapy to address both waiting times and gaps in service around the morbidity associated with poor diet and obesity, and to provide specialist psychotherapy for non-verbal individuals who have experienced trauma, which is widespread in this population.

2.1.5 **Enhanced partnership working** between SYICB, SHSC, Local Authority, using a nationally mandated "Dynamic Support Register" and "Care and Treatment Reviews" to avoid admissions to specialist LD inpatient services.

2.1.6 **Further implementation of the national "Greenlight Toolkit" guidance**, to improve the support they give to people with learning disability/autism in receipt of mental health care in acute mental health wards, if admission to this type of care is required, as an alternative to an out of city placement.

2.1.7 **The introduction of more evidence-based outcome measures** coproduced with experts by experience and families. This will include quality of life and health measures, aimed at reducing early preventable deaths, using analysis from our learning from the reviews of deaths through the LeDeR programme and linked to our SMI Physical Health Strategy recently reported to SPET.

2.1.8 **A more consistent application of the national programme to Stop Over Medication of Patients with a learning disability/autism (STOMP)** due to the increased risk of morbidity and early death that overmedication brings.

2.1.9 **Working more collaboratively with SHSC autism specialists** to advise on avoiding out of city admissions for autistic people. It should be noted however, that the focus for this service is on people with a learning disability, who may also have co-morbid autism. People who have autism only without learning disability are supported through a different SHSC service and pathway, although it is recognised that that we need to further enhance collaborative working practice between the two.

2.1.10 In addition, as an adjunct to this work on adult learning disability at Sheffield place, we are collaborating with the SYICB LDA Programme and place leads, and with Local Authority partners to finalise plans to jointly commission for South Yorkshire an autism only specialist community team and a short stay residential model for LD and/or autism as a de-escalation provision and admissions avoidance initiative funded through SYICB Service Development Funding. This is a significant aspect of our plans to continue to impact on admissions avoidance to specialist inpatient beds.

2.1.11 **Enhanced support to those who do need admission to an inpatient unit.**

- It is recognised that the demand for inpatient admissions is not perfectly predictable, but we have evidence of a consistently reducing level of demand, over a five-year period through our work on admissions avoidance.
- We feel that it is prudent as part of our planned model to have a risk share with SHSC for up to one admission per year, with quarterly reviews of the position between ourselves and SHSC.
- Financial resource will therefore be held in reserve over the financial year to mitigate the risk should a specialist inpatient learning disability or autism admission be required, and which would be sourced as close to Sheffield as possible, with all quality assurance measures in place to oversee any such placement, and to achieve appropriate lengths of stay.

- On the rare occasion that a specialist LDA bed does need to be sourced and mainstream MH inpatient admission is not an adequate solution, there will be:
  - An enhanced monitoring regime which will exceed the national Safe and Well Review schedule of 6-8 weeks delivered by SHSC clinical and/or ICB staff for any hospital placements made. This will exceed SYICB wide guidelines for quality and safety assurance. We have committed to this enhanced approach to address a point raised by Health Scrutiny Committee around quality of care and safeguarding.
  - Suitable mitigations such as practical, emotional, or possible financial support for family travel, where appropriate, (subject to suitable controls), or support for virtual visits for families as required for any hospital placement that must be made outside of Sheffield.
  - We have committed to this enhanced approach to address a point raised by Health Scrutiny Committee around support to families who may be disadvantaged from the continued closure of Firshill Rise.

3. Benefits of the new model

3.1 There are a significant number of benefits expected from this proposed investment and transformation to community LD services. These benefits include:

3.1.1 Service users and their families will be better able to access **earlier and more enhanced and prevention interventions**, at the right time, in a person-centred way, leading them to live **as healthy, full, and independent lives as possible** with the right levels of medication.

3.1.2 There will be a **wider range of clinical support professionals working together** with reduced handovers to better meet the health needs of the population with reduced overall waiting times. The population can present with very complex needs which requires a suite of professional skills to support people best. This additional support offer will also support providers and other partners as they seek to help this cohort live as independently as possible.

3.1.3 **Prevention of causes of physical health deterioration, and reduced presentation at primary care and A&E** [2] through better management of health needs, signposting to correct pathways and offering consultation support to other health services where appropriate.

3.1.4 **Reduced inpatient admissions**, and care will be provided in the least restrictive settings possible, and at better value for money when compared to the cost of inpatient care, which can vary between £214k, to significantly more than this if enhanced staffing levels are required.

3.1.5 Where people are admitted onto local acute mental health wards in SHSC, they will be **better supported with more qualified and appropriate staff** through the improved specialist learning disability community teams in reaching and the 'green light working[3]' model of care, and consequently should experience shorter lengths of stay, through partnership working on active discharge. Where people are admitted into learning disability provision out of city, they and their families will have an increased support offer from this clinical model, and again the shortest possible length of stay.

[2] "People with learning disabilities are more likely than other people of the same age to be admitted to hospital as emergencies." Better-Health_Care-For-FINALWEB.pdf (nihr.ac.uk) p.4.
[3] Green Light Toolkit - NDTi

3.2 **Outcome measures** will be developed over the first two years of the new service to enable qualitative and quantitative measures to be co-produced with service users and carers, benchmarking and establishment of data collection, reporting and monitoring. These measures will include:

- CORE-LD.
- WHO-QoL8.
- Honos-LD.
- Health Equalities Framework (HEF).
- Progress towards STOMP.
- Service user outcome measures / goal setting.
- Feedback from service users, carers and staff. This will be co-produced as the new service is implemented.
- Prevented/reduced hospital admissions.
- Prevented out of city placements.
- Reduced episodic care.
- Waiting time for assessments.

4. Scrutiny of the model

4.1 NHSE Assurance Checkpoint and North-West (NW) Clinical Senate

4.1.1 The model and our engagement work was presented to NHS England through their NHSE Assurance Process. They were happy for us to proceed with no requirement for further formal consultation but asked that we present to NW Clinical Senate as an additional sense check, which we did on two occasions (30/6/2023 and 11/09/2023).

4.1.2 Extensive information was supplied to the NW Clinical Senate at a full day panel in September, and they reviewed us against 8 key objectives. The panel were highly complimentary on the depth and scale of information that we provided to them, and the breadth of our engagement work (in common with the HSC and NHSE Assurance checkpoint feedback). The panel's advice is not mandatory.

4.1.3 The panel result was that they gave what they called "caveated assurance" with "no red lights" to Sheffield, against all key lines of enquiry, and commented that this was "a good place to be" at the end of the panel, and that we were consequently able to proceed with our plans.

4.1.4 We will build in learning from these caveats into the final model. They had concerns about whether spot purchasing an out of city placement was in line with least restrictive care closest to home, but our proposed model will further reduce our likelihood of needing to admit people, and that it is not possible to retain a previously 8 bedded hospital unit for the risk of an occasional up to once a year admission, from both a quality assurance and safeguarding perspective, and is also not cost effective.

4.2 Health Scrutiny Sub-Committee

4.2.1 The first report went to the Committee on 07/12/2022 to inform them of the work taking place to develop and implement a future model for the delivery of community and inpatient health services for people with a learning disability.

4.2.2 Subsequent updates on the progress were then taken back on 23/03/2023 and 01/06/2023 and they approved our proposal to decommission Firshill Rise and reinvest

in community services. We will take a further update on the progress in Autumn/Winter of 2023/24 when the model is signed off.

4.3 Sheffield Place/ SYICB Governance

4.3.1 Recommissioning the adult learning disability community and inpatient services is one of the Mental Health, learning Disability, Autism and Dementia (MHLDDA) Delivery Group priorities, and work is reported through this group.

4.3.2 The work is also overseen by the Learning Disability/Autism Programme Board, which is co-chaired by an expert by experience and SHSC LD Clinical Director and has Sheffield Place ICB and Local Authority attendance and the LDA Programme Director from SYICB.

4.3.3 The work in this area has been informed by the SYICB Learning Disability and Autism Programme Board which the Sheffield place MHLDDA team is a contributing member of, and there have been regular updates through this structure.

4.3.4 The new service will be scrutinised on a regular basis by locally based commissioners and contract managers through the above Programme Board and through Contract Management Group.

5. Financial implications

5.1 The new model reinvests the funding that had gone into Firshill Rise into the community service model described above, to provide more clinical staff who will be able to offer a wider range of interventions, pathways and extended working hours with therefore an additional £1.5m going into the Community Learning Disability Team, with a remaining amount identified against a risk share and overhead costs.

5.2 It is proposed that there would be a phased approach of applying this increased investment over a three-year period using the resource previously allocated to the inpatient unit with a continuous review with SHSC, Sheffield Place and wider SYICB learning disability leadership and other stakeholders, and with reserved funding to offset if there were any unforeseen unavoidable admissions.

5.3 Work is ongoing with SHSC to determine what budget might be required to offset any future admissions to specialist Learning Disability and/or autism inpatients care. However, it is felt that there will be underspends through slippage which could be used whilst the additional posts are being recruited to in year 1, and we will determine a risk share to manage any risks over the subsequent years, through a proposed 50:50 gain/risk share that means any underspends on inpatient care are split but any costs exceeding the budget are also split 50:50.

6. Consultation and engagement

6.1 NHS South Yorkshire Integrated Care Board, Sheffield Health and Social Care NHS Foundation Trust and Sheffield City Council learning disabilities commissioners have been working in partnership to ensure that local people who may use this service are involved in the development and consideration of proposals about this service, and that their individual legal duties around involvement are met.

6.2 As previously reported, to ensure we engaged service users, families, carers and stakeholders in a person-centred way, we provided grants to two community organisations

(Sheffield Voices and Sheffield Mencap & Gateway) supporting individuals with a learning disability to co-produce involvement activity and to help us to develop the set of open questions to accompany the issues paper to promote meaningful dialogue on the issues faced. Using two organisations meant we were able to increase the diversity of the people consulted.

6.3 Full details on the main engagement work were presented to the Health Scrutiny Sub-Committee in March 2023.

6.4 Sheffield Health and Social Care NHS Foundation Trust have also been engaging with stakeholders throughout the process which is summarised below:

Benchmarking against services visited

- South West Yorkshire Partnership NHS Foundation Trust
- Humber Teaching NHS Foundation Trust
- Mersey Care NHS Trust
- Northern Care Alliance (Salford)
- Kent and Medway NHS and Social Care Partnership Trust
- Nottingham Healthcare NHS Foundation Trust
- Greater Manchester Mental Health NHS Trust

Coproduction and feedback from Service Users, carers and various Stakeholders:

- Carers – young people with complex Learning Disabilities & Autism (LDA)
- Experts with lived experience of LDA
- NHS South Yorkshire Integrated Care Board
- Social Care colleagues
- Social Care Providers
- NHS England
- Learning Disabilities/autism Clinical Staff Team
- Wider Sheffield Health and Social Care clinicians
- Sheffield Voices and Sheffield Mencap

7. Equalities and diversity

7.1 The Equality and Health Inequalities Impact Assessment was completed in May 2023. This process was coproduced with Sheffield Voices (a LD community advocacy group) and carried out jointly with SHSC, to ensure all impacts could be captured and mitigated against.

7.2 Appropriate mitigations were built into the model, for example the offer of greater wrap around support for carers at time of crisis/placement breakdown, develop greater links and better joint working with community/peri natal/post-natal teams, ensuring joint working with CYP navigators to support Looked After Children at transitions age, sharing of learning on multicultural STOMP to embed good practice across service in relation to delivering a more culturally appropriate service.

8. Key risks and issues

8.1 The main risks and issues associated with implementing this business model include:

- Difficulties in recruiting qualified staff (or upskilling existing staff) to deliver the new model that we wish to invest in.
- Potential for unavoidable admission to high cost out of city hospital placements when treatment is required.
- Culture change and transition to new ways of working in the service will take time.

- SHSC do not have a well-functioning EPR system and are in implementation of their new system, RIO, which presents, a risk to data flow until this is in place.
- The specialist residential and supported living market is pressured.

9. Recommendations for HCP

- To note the report and acknowledge the good work and progress made in this area.

Paper prepared by:
MHLDDA commissioning Team

On behalf of:
Heather Burns, Deputy Director – MHLDDA 27 November 2023