Report to Healthier Communities and Adult Social Care Scrutiny Committee
14th July 2021

Report of: Policy and Improvement Officer

Subject: Written responses to public questions

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Summary:

This report provides the Committee with written answers to public questions asked at the Committee's meeting on the 10th March 2021, relating to Mental Health Services in Sheffield. The Committee asked the Sheffield Health and Social Care NHS Foundation Trust and NHS Sheffield Clinical Commissioning Group to respond – the questions and responses are set out overleaf.

The written responses are included as part of the Committee's meeting papers as a means of placing the responses on the public record.

Type of item: The report author should tick the appropriate box

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	
Other	**X**

The Scrutiny Committee is being asked to:

Note the report

Background Papers: None

Category of Report: OPEN

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Public Questions to Healthier Communities and Adult Social Care Scrutiny Committee 10th March 2021; and responses from Sheffield Health and Social Care Foundation Trust and NHS Sheffield Clinical Commissioning Group.

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1. Acute Beds

The report to Scrutiny states that the number of nurses per 10 beds has increased to well above national average but gives no figures for total numbers:

a) How many acute beds did the Trust have available in 2016, 2019 and currently?

The number of acute inpatient beds has fluctuated due to the need to achieve social distancing during covid and because of the requirement to eradicate dormitories hence improving the privacy, dignity and safety for people that use inpatient services. In addition, there will be a further temporary reduction across 2021 – 22 as we complete essential environmental safety work.
The bed numbers should be understood in the context of adding step-down beds, new community services, a decisions unit, and an extended 24 / 7 crisis service. This improved choice of services is aimed at providing the least restrictive treatment option for the people of Sheffield and increasing care close to home.
Currently the bed numbers are:

Maple Ward	19
Burbage Ward	16
Standage Ward	16
Endcliffe Ward	10

This represents a reduction of 7 beds.

b) How does this compare to the national average and other large cities (e.g., Leeds, Manchester) in terms of numbers of beds per 100,000 population?

The national benchmarking data shows that SHSC has a comparatively low bed base at 10.9 per 100,000 population compared to the national mean of 18.8 beds

c) Are there sufficient beds to cope with expected increase in demand because of the Covid-19 pandemic?

The demand for admission to acute beds is closely monitored and to date the pandemic has not increased the need for admissions. The pandemic does seem to have increased the need for crisis services. The impact of the pandemic is not yet fully understood, and we are currently modelling what future provision may need to be.

d) Has the closure of dormitories solved the problems of sexual safety?

Dormitories were not a major factor in sexual safety incidents. Dormitories were not mixed gender; the closure of dormitories does improve privacy and dignity.

We have moved two acute wards to single gender wards and are planning to move our PICU to single gender. We anticipate that this will have an impact of sexual safety incidents as will the improvement work, we are undertaking as a part of a national safety collaborative.

2. Community Services

a) *Given the significant capital programme, are there plans to restore the number of community mental health services/recovery centres from 2 to 4 as there were before the last reorganisation to improve accessibility?*

Taking our learning from working during the pandemic our aim is to have nimble community services where we align to primary care networks and become less dependent on fixed bases and make more use of technology. We are currently reviewing our estates strategy.

b) *The report appears to recognise the connection between art and improved mental health, but we understand that art therapy services have been severely curtailed over the last few years. What services does the Trust provide and does it still employ art therapists directly?*

The number of art therapists employed directly by SHSC has increased in the last 12 months. We have arts therapists working directly into our acute admission wards and our PICU. We are working with NHSE to complete a review of our inpatient establishments and will use this opportunity to revisit our broader skill mix, there may be opportunities to increase the of art therapy.

c) *At the Scrutiny Meeting in August 2020, the Trust reported on a new service for those in need of more complex help than that available under IAPT: how successful has this and other services (e.g., CERT) been in preventing patients needing hospitalisation?*

Whilst the need for help in a crisis has increased the demand for admission has been consistent over the last two years. We have worked into primary care as part primary and mental health transformation programme ensuring that the people of Sheffield have access to mental health care in primary care.
Key deliverables for Early Implementer sites (and for Framework roll out) include:

Increased accessibility to interventions for people with Serious Mental illness in the gap between IAPT and secondary care

Population based Primary Care Network (PCN) focus of delivery

Improved physical health checks and integrated physical, psychological, and social care

Workforce transformation to consider new roles and partnerships (VCSE)

28-day access to evidence-based interventions for either Personality Disorder, Eating Disorders or community rehabilitation

The programme has been live since June 2020 and to date has supported 1000 patients with Serious Mental Illness (including Personality Disorder) in 4 Primary Care Networks (Sheffield has 15 in total). It is too soon to understand the full impact however the model has been very well received.

3. Staffing

a) *The CQC found that staff were generally unaware of the whistle-blowing procedures and the Speak Up Guardian. Has this been rectified?*

Staff do use the Speak Up Guardian to raise issues of concern. We believe that the CQC will see an improved position when they next inspect.

b) *We understand that there have been long waiting times to access some services (e.g., clinical psychologists): in addition to nursing recruitment, is the Trust recruiting sufficient professional staff to resolve this?*

We have a good understanding of the waits for assessment and treatment across the range of services. In our recovery services waits for allocation were caused due to staff turnover which has been addressed and is improving. In our Single Point of Access there is a combination of factors that have led to delays, a recovery plan is in place, we are seeing progress and the Quality Assurance Committee has oversight. In specialist services there are issues meeting increasing demands for services. We are looking carefully at our treatment models to ensure they are evidence based and efficient and are also looking at this with our local and national commissioning partners.

c) *Does the Trust anticipate that the Government's suggestion of only a 1% pay increase for NHS workers will cause further problems for morale and staff shortages, with workers leaving the NHS?*

This is not something that the Trust can comment on, it is a matter for national consideration.

d) *Has the imbalance between experienced and newly qualified staff identified in the CQC report been improved – what are the ratios now compared with 2019?*

SHSC acute mental health wards rate the highest in the country for the ratio of registered nurses per 10 beds at 12.5 against a median of 7.2 and the lower quartile at 6.1. The CQC found in Feb 2020 that we had an over reliance on nurses in the early part of their registered practice, called preceptorship, leading shifts. We have been able to recruit to all ward manager and deputy ward manager posts across our acute wards hence improving the available leadership capacity. It is now exceptional that a nurse in preceptorship will lead a shift. We currently have a high number of vacancies for staff nurses and have an active recruitment programme.

4. Future

a) *How much additional funding has been secured to cope with the expected increase in demand due to the Covid-19 pandemic?*

The Chancellor announced in November 2020, a £500m package to support mental health services in England after increased demand for support during the pandemic. Sheffield CCG currently has £3.2m confirmed funding for 2021/22 against national set priorities. Commissioner and providers are

working together to ensure this funding is used on the greatest need including reducing long waiting times in priority areas.

b) *In the joint report on the impact of Covid-19, it is stated that 'A formal review has not begun' of the shift to digital services. Should this be prioritised due to the struggles many people face with digital services (and that over-use of Zoom etc can create its own health problems)?*

An evaluation has been conducted across services, the Board of Directors received a report March 2020 that summarised the experience of staff and service users in the move to digital services. The findings to date are in keeping with those reported by other mental health trusts in that for some staff and service users the use of technology has been very positive however it is not suitable in every situation or for all people. We are keen to take the learning from the evaluation and build on the increased use of digital technology where appropriate whilst also ensuring that face to face or clinic-based treatments are available according to need.

c) *Overall, how will the Trust measure the impact of the Back to Good programme and what improvements will users experience directly (e.g., reduction in waiting times, ease of access to services)?*

The programme is reviewed monthly by the Back to Good Board, the Quality assurance Committee, and the Board of Directors internally. Regionally the impact of the Back to Good Programme is monitored by the Quality Board chaired by the Regional Chief nurse which has membership across the system including the CQC, the CCG and the Local Authority.
The programme reports the delivery of set actions to meet the must and should do requirements and reports against agreed measures that indicate impact to people who use services and our staff.
We are confident that people in inpatient care are receiving improved physical health care including improved support to reduce tobacco dependence and are being cared for by a more consistent care team that are supervised and supported.

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