SHEFFIELD CITY COUNCIL

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 19 August 2020

(NOTE: This meeting was held as a remote meeting in accordance with the provisions of The Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority and Police and Crime Panel Meetings) (England and Wales) Regulations 2020.)

PRESENT: Councillors Cate McDonald (Chair), Steve Ayris (Deputy Chair), Sue Alston, Angela Argenzio, Vic Bowden, Mike Drabble, Jayne Dunn, Adam Hurst, Talib Hussain, Abdul Khayum, Martin Phipps, Gail Smith and Garry Weatherall

Non-Council Members (Healthwatch Sheffield):-Patricia Edney

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillor Lewis Dagnall (with Councillor Sioned Mair Richards attending as his nominated substitute), Councillor Jackie Satur and Lucy Davies, Healthwatch (with Patricia Edney attending as her nominated substitute).

2. EXCLUSION OF PUBLIC AND PRESS

2.1 No items were identified where resolutions may be moved to exclude the public and press.

3. DECLARATIONS OF INTEREST

3.1 Councillor Mike Drabble declared a personal interest in Item 7 on the agenda (item 6 of these minutes) – Covid 19 Pandemic and Mental Health – as a Counsellor for Mental Health; and Councillors Steve Ayris and Adam Hurst also declared an interest in that same item as members of the Sheffield Health and Social Care Foundation Trust - Council of Governors.

4. MINUTES OF PREVIOUS MEETING

4.1 The minutes of the meeting of the Committee held on 22nd July, 2020, were approved as a correct record.

4.2 *Matters Arising*

4.2.1 In item 6.6(e) it was stated that a copy of the resolution would be shared with all Sheffield MPs and the Policy and Improvement Officer confirmed that this had been done.

5. PUBLIC QUESTIONS AND PETITIONS

5.1 Jeremy Short, on behalf of Sheffield Save Our NHS, asked the following questions:-

1. COVID-19

It is widely accepted that the COVID 19 pandemic will significantly increase the demand on mental health services in the short and medium term. The Royal College of Psychiatrists has warned of a 'tsunami of referrals' to be expected. The most direct impact will be on frontline NHS and careworkers suffering from Post-Traumatic Stress Disorder (PTSD) as a result of weeks dealing with seriously ill and dying patients and clients. However, there are many other areas which will increase pressure on services, including:

- Worsening mental health amongst those with a pre-existing condition
- Impact of increased unemployment and financial insecurity
- Anxiety amongst children returning to school while infections are still being passed on
- Effects of loneliness due to prolonged lockdown especially amongst vulnerable people
- Impact on BAME communities from above-average vulnerability to the virus
- Women caught in abusive relationships
- Frontline workers in retail, transport etc. suffering abuse from customers – and pressures maintaining safe working.

We note that the Health and Social Care NHS Foundation Trust has produced a strategy to cope with the impact of the pandemic. However, given that the Trust's performance was found to be 'inadequate' by the Care Quality Commission in April this year, how confident is the Scrutiny Committee that the Trust is capable of delivering? In particular,

(a) What additional financial and other resources is the Trust putting in place to meet the expected crisis?

(b) Are there adequate supplies of PPE available for all mental health workers?

(c) Is rapid and regular testing available for workers and clients?

(d) Is there a commitment to resume face-to-face consultations when it is safe to do so?

2. CQC Report on Sheffield Health and Social Care Trust

(a) The Care Quality Commission (CQC) report on the Trust in April found the Trust to be inadequate overall and requiring special measures. To date we have seen no apology from the Trust leadership to either users or staff who have suffered because of mismanagement. Does the Scrutiny Committee think it appropriate to ask for such an apology?

(b) The CQC found 47 breaches of legal requirements across 8 regulations. How many of these have been rectified to date?

(c) In Involve, the Trust's magazine for members, it was stated that 'you can check on our progress at www.shsc.nhs.uk'. However, there has been no update since an initial post on 29th April outlining 5 general areas for action. Although

information is available buried in dense Board papers, why has the Trust posted no accessible update on its web-site for over 3 months during this critical period?

(d) From the August Board meeting papers, it appears progress is being made in some areas, although even in these there are problems with inadequate reporting systems. Specifically, what action has been taken to:

i. End mixed-sex accommodation to ensure safety

ii. Provide an adequate number of inpatient beds (particularly with regard to expected increase in demand)

iii. Ensure all staff are aware of whistle-blowing procedures and the Speak Up Guardian

iv. Ensure mandatory training will be carried out in the future

v. Ensure adequate experienced staff are in post rather than relying on agency staff

(e) Will the Council establish an independent inquiry, including trade unions and users, to investigate the running of the Trust?

3**. Finance and Management**

(a) Was the deterioration in the Trust's services directly linked to the aim of achieving £7.1 million in 'efficiency' savings targeted as part of the Mental Health Transformation Programme in 2018-19?

(b) Why was this found necessary when the Trust's own accounts show a total of £15 million surpluses over the last two financial years and that cash reserves rose by £10 million to £51m in the year to March 2020?

(c) Should the Trust not have been spending this money to ensure that adequate staff and resources were in place instead of allowing services to continue to deteriorate so dramatically over the last two years?

5.2 The Chair thanked Jeremy Short for his questions and said that, with his agreement, they would be shared with the Health and Social Care Trust. She said that some of the questions would be answered during the meeting, but anything not answered would be put in writing and published in the public domain. With regard to scrutiny, that was the reason for holding this and subsequent meetings. With regard to the question asking that an apology be made, the Chair said that it was for the Trust to offer an apology, not within the remit of the Scrutiny Committee to ask for one. Relating to the question regarding an independent inquiry, there were regulatory arrangements regarding this, however if the Scrutiny Committee felt that appropriate improvement was not being made, then action could be taken in the first instance, but ultimately it was up to the CQC to take responsibility for that and appropriate further action would be taken.

6. COVID 19 PANDEMIC AND MENTAL HEALTH

6.1 The Committee received a report which provided an overview of the Covid 19 Pandemic and the impact it was having on the emotional and mental wellbeing of Sheffield citizens.

6.2 Present for this item were Jan Ditheridge (Chief Executive, Sheffield Health and Social Care NHS Foundation Trust), Mike Hunter (Medical Director, Sheffield Health and Social Care NHS Foundation Trust), Dr.

Steve Thomas, GP (Clinical Director, NHS Clinical Commissioning Group (CCG), Sam Martin (Head of Commissioning (Vulnerable People), Sheffield City Council); Heather Burns (NHS Sheffield Clinical Commissioning Group), John Doyle (Director of Strategy & Commissioning, People Services Portfolio, SCC); and Councillor George Lindars-Hammond (Cabinet Member for Health and Social Care).

6.3 Steve Thomas introduced the report and highlighted the key issues arising from it. He said that a substantial amount of work in the mental health sector had been done pre-covid, during and post-covid, as Covid-19 may be seen and portrayed as predominantly a respiratory virus, it can actually affect many organs and is a multisystem disease that can also be neuro-toxic. This can affect the brain directly and the consequences of Covid-19 clearly impact mental health and wellbeing. Mental health and mental non-wellbeing was also being severely affected by Covid. There was an increase in first episode mental illness, for example anxiety, mood swings, depression, the consequences of loneliness and isolation, brought about by intergenerational adversity, education, employment and housing. He said the risk of addictive behaviours has increased, including the use of alcohol and that there may be an impact on gambling with the use of online access having become more apparent and, as anticipated, there had been an increase in domestic violence. He said there had also been a significant impact on those who had faced bereavement. The Health and Wellbeing Board had requested a Rapid Impact Assessment (RIA) and this had been commissioned to help determine, and therefore plan for the anticipated increase in demand for mental health services. One of the things that had become apparent throughout the Covid pandemic, were social inequalities. There had been positive aspects of the lockdown in terms of mental health and wellbeing, by people spending more time reconnecting with families, nature, hobbies and activities and children feeling less stressed through not attending school. The Voluntary, Community and Faith (VCF) Sector had continued to provide emotional and practical support to those with mental health issues and offer independent mental health advocacy services and specialist mental health advisory services throughout the pandemic. The Sheffield Psychology Board was looking to address the immediate emotional and psychological needs of frontline workers and those working in care homes and care workers, keyworkers, as well as the general public. Over the past six weeks, over 200 people had been seen by the newly established Primary Care Mental Health offer that is currently being tested in four Clinical Network areas covering 200,000 of the Sheffield population and interventions made, with 40% of those interventions having been from the Black, Asian and Minority Ethnic (BAME) community. The anticipated increase in mental health problem presentation as a result of Covid-19 was likely to see up to a 40% increase in demand for support.

6.4 Members asked a number of questions, to which responses were provided as follows:-

- Sheffield had seen an increase in domestic violence cases, however hard data regarding domestic violence was not clear and whether there had been an increase in cases during lockdown or whether numbers had been hidden due to people not attending A&E, GP surgeries or contacting the police. It had been anticipated at the start of lockdown that numbers would rise due to people spending more time together but the true picture was not known. Nationally there had been a massive increase in calls, but locally it had not translated into a flood of requests for help.

- There had been an increase in the number of perpetrators who had been abusive towards their partners or ex-partners and had referred themselves to the Perpetrator Behaviour Programme aiming to change their behaviour and develop respectful, non-abusive relationships.

- There was an extended online counselling helpline available to children, aimed at providing stability during lockdown, although very few calls had so far been received but was starting to increase slowly. It was anticipated that towards the end of September, referrals from CAMHS would start to come through and teachers can see social pressures. Reference was made to the Door 43 Wellbeing Service, a service which offered support to 13-25 year olds on a range of emotional wellbeing issues, providing information, advice and guidance to young people experiencing issues such as low mood, stress and anxiety, loneliness, and who may have been particularly affected by the pandemic by the transition from primary to secondary school, transition to 6th Form, transition to university or the workplace and the lack of SATs, GCSE and A-Level examinations and results.

- It was anticipated in the school return, that a whole suite of services would be put in place by the end of September by working with clinicians, CAMHS, MAST and school representatives to prepare for the return to school, to offer support and training for schools to create a healthy environment for children as well as members of staff. Lots of measures were being put in place to help children get around school buildings safely, infection control and “bubbles”.

- The City Council had engaged in the Government’s “Everybody In” initiative and worked with a range of partners to accommodate all rough sleepers in either supported or hotel accommodation at the beginning of lockdown and this had proved very successful in getting the homeless off the streets.

Successes had been seen and a number of rough sleepers were ready to move into assisted accommodation, but not every rough sleeper wished to make that transition and some have drifted back into hanging around city centres. The Government, through Public Health England, were providing resources to maintain the work that had been initiated, as it was not possible to leave rough sleepers in the accommodation that had been provided throughout lockdown. There are resources to sustain that work to offer a number of options to help maintain the support they have received and continue with that support.

- The Homeless Assessment and Support Teams had worked throughout the crisis and there hadn't been a complete stand down of face-to-face care in services. The decision to offer face-to-face service had been based on assessments of the whole situation carried out by doctors wearing full Personal Protective Equipment (PPE) and making sure they got the assessments they needed. The Early Interventions Psychosis Service, consisting of staff from a variety of disciplines, including nursing, social work, occupational therapy, and psychology, had held fewer face-to-face consultations, and contact had been made by telephone, although it would be disingenuous to suggest that not seeing people face to face there wouldn't be a downside to that as seeing people was fundamental to what they do.

- Covid was an amplifier and magnifier of health and social inequalities. The NHS Implementation Plan refers to everything that we are trying to put in place to measure and modify to take into account the effects of Covid on the most disadvantaged groups and also including BAME, in all services and mainstream mental health services. In relation to the point raised about substance misuse, the evidence was not clear on this, although the use of alcohol has shown an increase. Services were keen to carry on conversations to make sure we have the most resilient plans possible.

- The physical health of approximately 30% of those affected by Covid are thought to have long term health conditions but it was not known at present what the medium or long term health consequences were likely to be.

- Some of the frontline workers who had cared for and gave support to those affected by Covid, were now requiring support themselves.

- It was predicted that there would be a big demand for mental health support services across all ages and as yet, we have not seen the full mental health impact caused by the virus.

- One of the things resulting from the pandemic was the digital revolution platform. St. Luke's Hospice had championed an educational methodology called ECHO, allowing care homes to participate in a wide variety of training, for example on the use of PPE, dealing with social distancing and how to reintegrate visits from family and friends into care homes.

- Greg Fell, the Director of Public Health in Sheffield has set out clear guidance around visits to care homes. The guidance sets out the only practical way of doing things and there may be times when there were clashes, but there was no easy resolution to this issue.

- Access to mental health services were currently at different levels, and prevention and promotion of wellness was of great importance. The methodology may have changed, with increased use of video and telephone conference. The Primary Care Mental Health Framework operates across 21 GP practices. 200 people who have been seen would traditionally not have accessed mental health services, due to being too complex for IAPT and not complex enough for secondary mental health services.

- There was a need to develop services to be able to see more people, and as we become confident in delivery of care we need to meet the challenge. There was an opportunity to do something different and get on top of prevention through focussing efforts and resources into primary prevention so there wasn't as much need for secondary care.

- The key was to stop looking at pre-covid and focus more on post-covid and carry out a review across all services.

- At present, initial assessments being carried out by GPs was via telephone or video conferencing, GPs then deciding whether someone needed to be seen face-to-face the same day, by proper use of PPE, then deciding what steps should be taken. A number of people have been proactive in their choice, preferring telephone or video conferencing, reducing the need to travel or sit in a busy waiting room.

- The caseloads of workers in every Service have been risk assessed to ensure they aren't taking on too much.

- For those with physical disabilities, there hasn't been a large impact. Phase 3 will request GPs to review at least two thirds of patients with learning disabilities.

- There is a difference in national funding regimes for mental and

physical health - every time someone attends hospital presenting with physical health issues, the hospital gets paid. Mental health services aren't funded in this way, which has resource implications.

- Mental illness and mental health problems account for nearly 25% of all the mortality and illness that the NHS deals with, yet only receives approximately 12% of the budgetary resources. This will only worsen as we continue to live with Covid-19.

6.5 RESOLVED: That the Committee:-

(a) thanks Jan Ditheridge, Mike Hunter, Steve Thomas, Sam Martin, Heather Burns, John Doyle and Councillor George Lindars-Hammond for their contribution to the meeting;

(b) notes the contents of the report and the responses to the questions;

(c) is keen to see that the good practice and learning developed in mental health services through Covid19 is captured and built upon;

(d) recognises that there is commitment in Sheffield to overcoming barriers to accessing mental health services, and will be looking for evidence that access to services is improving;

(e) notes national issues around parity of esteem and insufficient funding for mental health; and expresses concern that it will be difficult for local areas to meet the anticipated increase in demand for mental health services due to Covid19, unless national government puts appropriate financial arrangements in place;

(f) notes that digital solutions have been an important part of accessing services during Covid19, and as such, the City needs to address issues of digital exclusion;

(g) supports efforts to improve how the mental health needs of Sheffield people are met, and recognises the importance of doing so; and

(h) recognises that work is ongoing to analyse the impact of Covid19 on mental health in Sheffield, for example through the Rapid Impact Assessment, and looks forward to seeing an action plan to address the issues identified as a result of this assessment.

7. CARE QUALITY COMMISSION IMPROVEMENT PLAN - PROGRESS REPORT

7.1 The Committee received a report detailing the progress that had been made in relation to the delivery of the Sheffield Health and Social Care NHS Foundation Trust Improvement Plan, following the Care Quality Commission inspection of the Trust in January, 2020 when the Trust received an overall rating of "inadequate".

7.2 Present for this item were Jan Ditheridge (Chief Executive) and Mike Hunter (Medical Director) (Sheffield Health and Social Care NHS Foundation Trust) and Alun Windle (Acting Chief Nurse, Sheffield NHS Clinical Commissioning Group).

7.3 Jan Ditheridge referred to the questions asked by Jeremy Short and stated that the Trust was truly sorry for the inadequate rating it had received and had written to its members and all members of staff with an apology for what had happened. She said that an apology had also been made at a public Board Meeting and at a number of other arenas. Jan Ditheridge thanked Mr. Short for pointing out that the link, included in the Trust's magazine, did not work and said that this would be put right. There were two action plans, one around core services and the other around "well led". The Trust had been given tasks and have a number of actions to complete. Oversight arrangements have been different because of Covid and lockdown, although meetings were held on a regular basis to scrutinise progress against the actions in the action plan.

7.4 Mike Hunter stated that the Trust's core services had been inspected by the Care Quality Commission (CQC) in January, 2020 and immediately following this inspection, a Section 31 Notice, stating that 16 and 17 year olds should not be admitted to shared accommodation in the Psychiatric Decisions Unit, was served and the Trust took immediate action and complied with the Notice within 24 hours. In February, 2020, the Trust received a Section 29A Warning Notice, which identified four areas which required significant improvement. The CQC found issues with staffing, mandatory training, safeguarding, the management of physical health, environmental safety and incident reporting. The two main areas where there were problems were in Acute Wards and Crisis Services, in that they were inadequate in terms of safety and not well led. Since then, management on a day-to-day and weekly basis had seen significant progress being made, and the CQC have engagement calls on a fortnightly basis to monitor progress. It had been challenging to adhere to safe staffing numbers on acute wards, and flexibility of working practices was required. The Trust put in place an Improvement Plan, and a "Getting Back to Good Board" meets monthly to oversee and drive delivery of the actions required, which the Trust thinks will take 12 months to implement. All of the urgent actions in the notice have been completed, and the Trust were about one third of the way towards implementing all the actions required.

7.5 Members asked a number of questions, to which responses were provided as follows:-

- Staff morale had been hit hard, but the issues have been addressed, although staff felt that they were still in the thick of it. There still remained a number of staff vacancies. The Covid 19 pandemic had lifted staff spirits as they worked as a team, were more flexible and volunteered and felt well supported by the team response. They had proved to themselves that where there were infections they managed to contain the virus very well.

- The Trust still rely very heavily on bank staff and agency nurses, who were very much part of the team. Bank nurses work regularly, in the same areas, and go through the same training as regular staff.

- There were 22 newly qualified nurses due to start at the end of August, 2020, which was a welcomed development. They are newly qualified and enthusiastic.

- Improving Access to Psychological Therapies (IAPT) services continued to grow and change. The Trust has now appointed more care co-ordinators in its Community Mental Health Teams in order to reduce caseloads and allow for more therapeutic time with patients.

- Governance arrangements have been refreshed and data was available to understand where the risks are. The Trust has undertaken a lot of work to build a performance framework and this had been complemented by Board visits and visibility out in the field.

- Memory Services perform well in Sheffield and responded well to change. The services that had slipped were the acute wards and indicators show that the Trust is heading in the right direction and improvements were being made.

- There was a distinction between management and practice supervision. The CQC want to see improvements in practice supervision (reflective practice), getting practitioner leaders to engage with staff more readily. The Trust have not changed the leaders and managers through the organisation but what has emerged is that there are many layers of management and this was a root cause that has tripped them up. Leadership programmes were in place but there was room for more. The results being seen are in terms of compliance with supervision and appraisals.

- The usual response to an inadequate rating, was that there was

an NHS Improvement Management Team established to oversee improvement. Feedback received shows that there had been rapid improvement in some areas. The Regional Executive Management Team will continue oversight of the Trust.

7.6 RESOLVED: That the Committee:-

(a) thanks Jan Ditheridge, Mike Hunter and Alun Windle for their contribution to the meeting;

(b) notes the contents of the report;

(c) is satisfied with the information provided by the Sheffield Health and Social Care Trust on the CQC Improvement Plan; and

(d) requests a further report to the Committee in six months on progress, with a focus on how the changes being implemented as a result of the Improvement Plan will improve outcomes and make a difference to Sheffield people.

8. WORK PROGRAMME

8.1 The Committee received a report of the Policy and Improvement Officer on the Work Programme for the Committee.

8.2 RESOLVED: That the Committee:-

(a) approves the contents of the Work Programme; and

(b) requests that the local impact of changes to Public Health England be added to the work programme long list.

9. DATE OF NEXT MEETING

9.1 It was noted that the next meeting of the Committee will be held on Wednesday, 14th October, 2020 at 4.00 p.m.