Public Document Pack

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 14 July 2021 at 4.00 pm

To be held at the Town Hall, Pinstone Street, Sheffield, S1 2HH

The Press and Public are Welcome to Attend

Membership

Councillor Steve Ayris, Sue Auckland, Lewis Chinchen, Talib Hussain, Francyne Johnson, Bernard Little, Ruth Mersereau, Ruth Milsom, Abtisam Mohamed, Garry Weatherall and Alan Woodcock

Healthwatch Sheffield
Lucy Davies and Dr Trish Edney (Observers)

Substitute Members
In accordance with the Constitution, Substitute Members may be provided for the above Committee Members as and when required.

Sheffield City Council

PUBLIC ACCESS TO THE MEETING

The Healthier Communities and Adult Social Care Scrutiny Committee exercises an overview and scrutiny function in respect of the planning, policy development and monitoring of service performance and related issues together with other general issues relating to adult and community care services, within the Neighbourhoods area of Council activity and Adult Education services. It also scrutinises as appropriate the various local Health Services functions, with particular reference to those relating to the care of adults.

A copy of the agenda and reports is available on the Council's website at www.sheffield.gov.uk. You can also see the reports to be discussed at the meeting if you call at the First Point Reception, Town Hall, Pinstone Street entrance. The Reception is open between 9.00 am and 5.00 pm, Monday to Thursday and between 9.00 am and 4.45 pm. on Friday. You may not be allowed to see some reports because they contain confidential information. These items are usually marked * on the agenda.

Members of the public have the right to ask questions or submit petitions to Scrutiny Committee meetings and recording is allowed under the direction of the Chair. Please see the website or contact Democratic Services for further information regarding public questions and petitions and details of the Council's protocol on audio/visual recording and photography at council meetings.

Scrutiny Committee meetings are normally open to the public but sometimes the Committee may have to discuss an item in private. If this happens, you will be asked to leave. Any private items are normally left until last. If you would like to attend the meeting please report to the First Point Reception desk where you will be directed to the meeting room.

Please note:

As we are still operating under Social Distancing Rules, if you wish to ask a question or present a petition at the meeting, you must submit the question/petition in writing at least 2 clear days in advance of the date of the meeting, by email to the following address: scrutiny@sheffield.gov.uk or by telephone 0114 2056272). This is necessary to facilitate the management of attendance at the meeting and to maintain social distancing. For meetings held on a Wednesday, questions/petitions will need to be received by 9.00 a.m. on the Monday of that week. You will also be asked to provide a contact email and/or telephone number.

Due to health and safety restrictions in place to ensure current social distancing rules in our meeting rooms, we are unable to guarantee entrance to observers, as priority will be given to registered speakers. To observe the meeting as a member of the public, please click on the 'view the webcast' link provided on the meeting page of the website.

The Chair of the meeting has discretion as to how questions and petitions are presented at the meeting and as to whether you are invited to ask your question or

present a petition at the meeting or they are read out at the meeting. A response to the question or petition will be given by the appropriate Member or Council officer. If you are not able to attend the meeting, your question/petition may be referred to the appropriate Member, Council officer or organisation and an answer/response will be provided to you.

Where a submitted question or petition cannot be answered because time does not allow, or where a Member undertakes to provide a written answer/response, the written answer/response will be provided to you and will be published on the Council website.

If you require any further information about this Scrutiny Committee, please contact Emily Standbrook-Shaw, Policy and Improvement Officer on 0114 2056272 or email emily.standbrook-shaw@sheffield.gov.uk

FACILITIES

There are public toilets available, with wheelchair access, on the ground floor of the Town Hall. Induction loop facilities are available in meeting rooms.

Access for people with mobility difficulties can be obtained through the ramp on the side to the main Town Hall entrance.

HEALTHIER COMMUNITIES AND ADULT SOCIAL CARE SCRUTINY AND POLICY DEVELOPMENT COMMITTEE AGENDA
14 JULY 2021

Order of Business

1. Welcome and Housekeeping Arrangements

2. Apologies for Absence

3. Exclusion of Public and Press
To identify items where resolutions may be moved to exclude the press and public

4. Declarations of Interest (Pages 7 - 10)
Members to declare any interests they have in the business to be considered at the meeting

5. Minutes of Previous Meeting (Pages 11 - 24)
To approve the minutes of the meetings of the Committee held on 10th March and 19th May, 2021.

6. Public Questions and Petitions
To receive any questions or petitions from members of the public

7. Adult Dysfluency and Cleft Lip and Palate Service (Pages 25 - 30)
Report of NHS Sheffield Clinical Commissioning Group.

8. Proposed Merger of Norfolk Park and Dovercourt GP Practices (Pages 31 - 36)
Report of NHS Sheffield Clinical Commissioning Group.

9. Work Programme Discussion
Committee to raise issues for inclusion in the Scrutiny Work Programme 2021/22.

10. Written responses to public questions (Pages 37 - 42)
To note the report of the Policy and Improvement Officer.

11. Date of Next Meeting
The next meeting of the Committee will be held on a date to be arranged.

ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

If you are present at a meeting of the Council, of its executive or any committee of the executive, or of any committee, sub-committee, joint committee, or joint sub-committee of the authority, and you have a **Disclosable Pecuniary Interest** (DPI) relating to any business that will be considered at the meeting, you must not:

- participate in any discussion of the business at the meeting, or if you become aware of your Disclosable Pecuniary Interest during the meeting, participate further in any discussion of the business, or
- participate in any vote or further vote taken on the matter at the meeting.

These prohibitions apply to any form of participation, including speaking as a member of the public.

You **must**:

- leave the room (in accordance with the Members' Code of Conduct)
- make a verbal declaration of the existence and nature of any DPI at any meeting at which you are present at which an item of business which affects or relates to the subject matter of that interest is under consideration, at or before the consideration of the item of business or as soon as the interest becomes apparent.
- declare it to the meeting and notify the Council's Monitoring Officer within 28 days, if the DPI is not already registered.

If you have any of the following pecuniary interests, they are your **disclosable pecuniary interests** under the new national rules. You have a pecuniary interest if you, or your spouse or civil partner, have a pecuniary interest.

- Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner undertakes.

- Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period* in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

  *The relevant period is the 12 months ending on the day when you tell the Monitoring Officer about your disclosable pecuniary interests.

- Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority –

  - under which goods or services are to be provided or works are to be executed; and
  - which has not been fully discharged.

- Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.

- Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.

- Any tenancy where (to your knowledge) –
  - the landlord is your council or authority; and
  - the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.

- Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -

  (a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and

  (b) either -
    - the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or
    - if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

If you attend a meeting at which any item of business is to be considered and you are aware that you have a **personal interest** in the matter which does not amount to a DPI, you must make verbal declaration of the existence and nature of that interest at or before the consideration of the item of business or as soon as the interest becomes apparent. You should leave the room if your continued presence is incompatible with the 7 Principles of Public Life (selflessness; integrity; objectivity; accountability; openness; honesty; and leadership).

You have a personal interest where –

- a decision in relation to that business might reasonably be regarded as affecting the well-being or financial standing (including interests in land and easements over land) of you or a member of your family or a person or an organisation with whom you have a close association to a greater extent than it would affect the majority of the Council Tax payers, ratepayers or inhabitants of the ward or electoral area for which you have been elected or otherwise of the Authority's administrative area, or

- it relates to or is likely to affect any of the interests that are defined as DPIs but are in respect of a member of your family (other than a partner) or a person with whom you have a close association.

Guidance on declarations of interest, incorporating regulations published by the Government in relation to Disclosable Pecuniary Interests, has been circulated to you previously.

You should identify any potential interest you may have relating to business to be considered at the meeting. This will help you and anyone that you ask for advice to fully consider all the circumstances before deciding what action you should take.

In certain circumstances the Council may grant a **dispensation** to permit a Member to take part in the business of the Authority even if the member has a Disclosable Pecuniary Interest relating to that business.

To obtain a dispensation, you must write to the Monitoring Officer at least 48 hours before the meeting in question, explaining why a dispensation is sought and desirable, and specifying the period of time for which it is sought. The Monitoring Officer may consult with the Independent Person or the Council's Audit and Standards Committee in relation to a request for dispensation.

Further advice can be obtained from Gillian Duckworth, Director of Legal and Governance on 0114 2734018 or email gillian.duckworth@sheffield.gov.uk.

This page is intentionally left blank

SHEFFIELD CITY COUNCIL

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 10 March 2021

(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, Lewis Dagnall, Mike Drabble, Jayne Dunn, Adam Hurst, Talib Hussain, Abdul Khayum, Martin Phipps, Gail Smith and Garry Weatherall

Non-Council Members (Healthwatch Sheffield):-

Lucy Davies

.....

1. APOLOGIES FOR ABSENCE

1.1 An apology for absence was received from Councillor Jackie Satur.

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 In relation to Agenda Item 7 (Covid 19 Pandemic and Mental Health), the following declarations were made:-

- Councillor Lewis Dagnall declared a disclosable pecuniary interest as his partner was a Non-Executive Director of the Sheffield Health and Social Care Trust, but felt that his interest was not prejudicial in view of the nature of the report and chose to remain in the meeting during consideration of the item

- Councillor Mike Drabble declared a personal interest by virtue of him providing mental health counselling services in non-urgent Primary Care and chose to remain in the meeting during consideration of the item.

4. MINUTES OF PREVIOUS MEETING

4.1 The minutes of the meeting of the Committee held on 10th February, 2021 were approved as a correct record.

4.2 *Matters Arising*

4.2.1 The Chair confirmed that the meeting, referred to in Item 4.1 with Healthwatch Disability Sheffield, had taken place and would be taken as an item of business at this meeting;

4.2.2 The Policy and Improvement Officer confirmed that the Chair had written to the appropriate organisations regarding greater local flexibility in the contracting arrangements for dental services, that an acknowledgment had been received and the response to this would be circulated to Members when it had been received; and

4.2.3 With regard to the Committee supporting fluoridation, as stated at item 6.9(e), the Chair stated that the National Health Service had now taken away the power of Local Authorities to look into this issue, so it was no longer within the remit of the Committee.

5. PUBLIC QUESTIONS AND PETITIONS

5.1 Jeremy Short, on behalf of Sheffield Save our NHS (SSONHS), submitted the questions set out in full below, and gave a brief outline of those questions.

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?
(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?
(c) Are there sufficient beds to cope with expected increase in demand as a result of the Covid-19 pandemic?
(d) Has the closure of dormitories solved the problems of sexual safety?

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?
(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?
(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?

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?

(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?

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?

4. Future

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

(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)?

(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)?

5.2 The Chair, Councillor Cate McDonald, stated that some of the issues raised by Mr. Short could be answered during the meeting and should some of those questions remain unanswered, the Chair would submit them to the Health and Social Care Trust and the answers received would be published on the Council's website.

5.3 Neil Calderwood introduced himself as a Junior Doctor based at the Northern General Hospital and was at the meeting on behalf of the Med at Sheffield Healthcare Workers and was supporting the Campaign for Vaccines for All, to ensure that vaccines were accessible to everyone, with particular regard to people who might not have documentation or have other barriers around data sharing. He asked two questions as follows:-

1. Would Sheffield City Council be willing to sign up to the Vaccines for All Campaign as other Councils had done e.g. Oxford and Bristol?
2. The Government had said that the vaccine was available to everyone but there were a number of reasons why some people were hesitant, and that although Sheffield had done great work to address those concerns around health and safety but this was more about practicalities. How could the City Council assist further in addressing these fears?

5.4 Councillor Cate McDonald asked Mr. Calderwood what the campaign wanted to achieve and invited him to address the meeting.

5.5 Neil Calderwood stated that the campaign had been organised by several groups, alongside wider access groups. He said that Government had made promises that the vaccine would be available but there were issues around registration for the vaccine, and although the Government had stated that there was no mandate to say that people should produce ID to have the vaccine, people were afraid that data collected would be shared between the NHS and the Government which could lead to detention or deportation. He said the issue

around data sharing was still unclear and lots of people are working together on this campaign but at local level there was room to protect data sharing.

5.6 The Chair stated that the Committee was proactive in supporting health inequalities, but the vaccination programme was governed by the NHS, not the City Council. She said that she would raise the question of whether the Council would sign up to the campaign to broaden the approach to ensure everyone was vaccinated. The implementation fell within the arena of the NHS but she would draw Dr. Calderwood's questions and comments to the attention of Greg Fell, Director of Public Health for Sheffield, and with his agreement share the questions with the Health Service. The Chair said that the Policy and Improvement Officer would share the website link to Members and that colleagues in attendance at the meeting from the Clinical Commissioning Group (CCG) would also share this information with the Chief Nurse who was the lead for the Vaccination Programme.

6. SHEFFIELD HEALTH AND SOCIAL CARE TRUST - CQC IMPROVEMENT PLAN PROGRESS REPORT

6.1 The Committee received a progress report and presentation on the Care Quality Commission (CQC) Improvement Plan. An update had been requested by the Committee to enable Sheffield Health and Social Care NHS Foundation Trust (SHSC) to demonstrate the progress being made in relation to the delivery of its Improvement Plan following the 2020 CQC inspection and subsequent report in August, 2020.

6.2 Present for this item were Dr. Mike Hunter, Executive Medical Director and Beverley Murphy, Executive Director of Nursing, Professions and Operations (Sheffield Health and Social Care NHS Foundation Trust).

6.3 Mike Hunter introduced the report and presentation and stated that following improvements, the inpatient care team had been able to ensure that patients were now receiving better mental health care than there were previously receiving. Staff were being trained to deal with a range of conditions, such as diabetes and the management of symptoms from the withdrawal from drinks and drugs. He stated that overall mental health care was better now than it was 12 months ago. He said that one of the main factors that contributed to mental health issues was smoking and smoking cessation was very important to stop people dying 20 years earlier than they would have done had they not smoked, and the introduction of the smoke free wards had proved successful. Dr. Hunter said that some patients admitted onto smoke free wards that were smokers, left the ward as "vapers", and although there were some concerns around vaping, it was thought that vaping would ultimately make a difference to life expectancy. Safeguarding issues have improved across the board, and a report published in October stated that safeguarding issues had been addressed and improvement seen across the board and patients were receiving better care with dignity and privacy. Two wards within the Unit were now single sex wards. Psychologists were working alongside psychiatric nurses to offer a highly integrated approach to specialist mental health care. Although in-patient wards were where the serious patients were seen, the vast majority of mental health care was carried

out within the community so there was a need to work together to fix problems by getting specialist mental health care out into communities and plan for the future.

6.4 Beverley Murphy stated that progress had been made to ensure safe staffing levels on inpatient wards and that the Trust was rated highest nationally for Adult Acute Registered Nurses and the Ward Manager and Assistant Ward Manager roles had improved, ensuring that junior nursing staff received a high standard of leadership, ensuring patients received better care. She said that a recovery plan had been developed to include a daily oversight of patient flow to reduce the average length of stay on acute wards and although there had been significant challenges due to Covid 19, which had created an increase in the number of "out of area" placements of older adults due to a lack of beds within the city, the older adults' wards had now reopened, and work was ongoing to return patients back to Sheffield as soon as possible. Work had also been carried out to eradicate dormitory wards and improve inpatient services. Beverley Murphy said that "step down" beds had been introduced which offered patients the choice of where they received care in accordance with their individual needs. However, there were plans to improve inpatient services so that all acute inpatient units would see significant improvement. She said that there had been a number of Covid related absences, which had caused significant challenges, but due to the vaccine programme rollout, the recovery plan was now back on track. It was acknowledged that there were still risks and the need to mitigate and manage those risks. There were still issues around access to care and the length of waiting lists but these were being addressed. Ms. Murphy stated that investment was required into providing additional posts and improving the IT infrastructure. She stated that the Trust was working with NHS England to model what the future demands look like to flex the service.

6.5 Members of the Committee made various comments and asked a number of questions, to which responses were given as follows:-

- The overall rating of the Sheffield Health and Social Care NHS Foundation Trust (SHSC) remained inadequate. As stated in the report, the Trust had been reinspected in August, 2020 and a report published in October had listed very clear, significant improvements, in part because of Covid and in part because there were parts of the service that had not been inspected and re-rated. The Care Quality Commission (CQC) were content and comfortable to let the Section 29A Warning Notice temporarily lapse based on finding improvement.

- Covid had raised many challenges with over 100 members of staff, at some point, being absent, either due to testing positive for the virus or shielding due to health issues so it was difficult to fulfil their commitments. However some staff members who were shielding were able to use technology to facilitate continuity of care and assess service users, look into their specific needs and looked for changes to identify people who needed to be seen regularly and routinely. The Trust tailored clinical interventions to facilitate individual patient needs and have taken a patient-centred approach to match individual needs.

- The acute inpatient wards based at Forest Close, Middlewood, had been rated as good by the CQC and the rehabilitation team based there have won Positive Practice Awards for Mental Health Services. The challenges facing these longer-term rehabilitation wards were known and was thought to be in good shape.

- Refurbishment works were underway with the development of 10 single bedrooms with en-suite facilities, being made available for those in distress to ensure their privacy and dignity was maintained and the possibility of preventing patients going into a NHS acute hospital bed, and the Trust along with the third sector were working to manage the service to assist with recovery and de-stigmatisation of mental health. A White Paper on the reform of the Mental Health Act was out for consultation and currently going through Parliament, and part of that reform was to offer more single bedroom facilities which offer privacy and dignity to patients.

- The Trust was keen to work with Healthwatch to collect equality data. Two main areas of concern had been identified as patients being unable to access the mental health service and restrictive intervention methods that were used to restrict the movement of an individual or limit their freedom to act independently. The Trust needs to understand the best way of serving communities and currently there was no data to convincingly assure the Board of Directors there weren't any access issues.

- With regard to the delivery model, the evaluation report looked at staff and service users to make sure that the Trust had the right technical abilities so that it doesn't fall back on the organisation's preferences for offering treatment as it had been found that some clinicians were keen to return to offering face-to-face treatment because that was the way they had worked historically, but there was a need to understand during the initial assessment process, what type of treatment the patient preferred and improve the service offer.

- One group who were often digitally poor and excluded, were asylum seekers and it should be borne in mind the terrible trauma these people had experienced on their way to safety in this city and the impact on their mental health such experiences would have taken, and there needed to be a link to these people so that they do not remain digitally excluded.

- Sheffield Psychology Board, whose membership included the voluntary and community sector, the Children's Hospital, the Teaching Hospitals and partners working in the psychological wellbeing service, had agreed to carry out a review across all services from the perception of clinicians having concerns about whether the digital offer was safe in all cases, and to assess risk to children when adults remain in the room, and to look at the impact of the digital service on offer and carry out a risk assessment and process what was suitable.

- Data which was gathered last summer formed part of the report on the next item on the agenda for this meeting. Included within the report were details from several different groups, and different people across the city, who felt excluded from mental health services and support. Gaps are being identified and by speaking to different groups, some of those gaps were being filled.

- One solution to improve the Improving Access to Psychological Therapies (IAPT) services was to get specialist care staff into primary care. IAPT was a specifically designed service. There was enthusiasm amongst clinical directors and primary care networks to work collectively on this to resource the alignment of primary and secondary care services to fill the gaps in mental health services.

6.6 RESOVED: That the Committee:-

(a) thanks Mike Hunter and Beverley Murphy for their contribution to the meeting; and

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

7. COVID 19 PANDEMIC AND MENTAL HEALTH

7.1 The Committee received a report giving an update on how the Covid 19 Pandemic had impacted on the emotional and mental wellbeing of the people of Sheffield.

7.2 Present for this item were Heather Burns (Head of Commissioning (Mental Health, Learning Disability, Autism and Dementia) NHS Sheffield Clinical Commissioning Group (CCG)), Sandie Buchan (Director of Commissioning Development Sheffield CCG), Colette Harvey (Sheffield MIND), Sam Martin (Head of Commissioning for Vulnerable People, Sheffield City Council), Eleanor Rutter (Consultant in Public Health), Joanna Rutter (Health Improvement Principal, Sheffield City Council), Steve Thomas (Clinical Director for Mental Health, Learning Disability and Dementia, Sheffield CCG) and Councillor George Lindars Hammond (Cabinet Member for Health and Social Care).

7.3 Sam Martin introduced the report stating that since August, 2020, a comprehensive Impact Assessment on Mental Health had been completed, the assessment had formed of a suite of rapid impact assessments, commissioned by the Sheffield Health and Wellbeing Board, and conducted to assess the impact of the Covid-19 pandemic on mental health. He stated that the purpose of the report was to provide Members with more detail of the likely ongoing impact of the pandemic on mental health and emotional wellbeing, based on local and national emerging evidence, and he referred to a short update at the beginning of the report on the recommendations contained within the rapid impact assessment report.

7.4 Colette Harvey said that her role within Sheffield MIND was to co-ordinate up to

50 community groups and organisations across the City which focused on mental health. She gave a brief update on service demands and said that overall data showed that as the pandemic continued, mental health problems had worsened and the charity was dealing with more complex cases, as people were experiencing disadvantage and there were growing issues around housing, employment, relationships, financial uncertainty, and the impact of long-covid. She said many people had expressed their nervousness of when the restrictions were lifted. She said that community associations were overstretched and their resources were overstretched to enable them to support communities in their homes. The lockdown had impacted on mental health, social isolation and increased levels of stress and anxiety so there was a need for preventative support. The pandemic had impacted on the mental health of the black and minority ethnic (BAME) communities in particular, but also other groups such as children, young people, carers, those whose lives were complex, digital exclusion, and also people who had been bereaved, so there was a need for more resources to be put into these areas. People with autism were facing difficulties at being unable to access mental health services.

7.5 Members of the Committee made various comments and asked a number of questions, to which responses were given as follows:-

- It was not known whether long covid had more of an impact on women than men. Work with clinicians was being carried out following discharge from intensive care wards and follow up on the psychological wellbeing of those patients. The CCG was to investigate whether there were any trends in gender or traits to see if Covid had more of an impact on these groups. Meetings had taken place with the deaf community to identify their problems throughout the pandemic.

- Statistics had shown that there was a disproportionate burden on women not only contracting the disease, but also the socio-impact on women who had disproportionately lost their jobs, had shouldered the increased burden of caring both for children and elder relatives or visiting relatives in care homes. It was thought that many of the socio-economic problems caused by Covid, could ultimately lead to suicide, as well as poverty, isolation, unemployment etc. Regarding intersectionality and strains within the system, those that were disadvantaged suffered more, whether they were women or from the BAME community and this needed to be addressed.

- The Sheffield Psychology Board had carried out a lot of work at the start of the pandemic giving advice and psychological wellbeing advice targeted at certain groups, but the information needed to be revisited on how to give advice moving forward. Leaflets had been distributed in 30 supermarkets around the city giving advice on the Improving Access to Psychological Therapies (IAPT) Services. In terms of how we come out of lockdown, there was a need to look at several areas on how to offer targeted support. The mantra of “It’s OK not to feel OK” was applicable to all because everyone had experience of the pandemic and had been impacted upon in some way, and it was perfectly acceptable to have

good days and bad days, but people should be aware of where to access mental health services if required. The Sheffield IAPT website contained very useful information, some regarding self-help.

- The narrative about recovery and coming out of lockdown was a national narrative but we have a local role to play. There was a need to develop resilience specific service delivery that can grow and respond to needs as they emerge.

- Non-medicalisation doesn't negate or decrease the impact on the severity of mental illness, the perspective changes so there was a need for preventative level education to bring people's attention to what was important and point them in the direction of what was important to minimise risk. Employers have a responsibility for the health and wellbeing of their employees and, in the city, the Sheffield Occupational Health Advisory Service looks at risk and challenges around employment and offers advice to employers.

- There had been a dramatic increase in the numbers of referrals and retention in secondary care under the Mental Health Act, as there had been an increase in the police bringing in people in mental distress. It was difficult to forecast what Covid would do to demand for mental health services, but there were toolkits available to try and do some local modelling to see where demand might start to emerge. As a Joint Commissioning Service, it was not intended to "wait and see", but to try and get ahead in anticipating demand. Things have got worse form a Council social care perspective, spending had gone up although if was not possible to identify any spend that could be directly due to Covid. Home care costs were rising due to people staying more in their homes and there were big pressures on the system.

- There has been an indication from the spending review that additional funding of around £5m for Sheffield would be made available to identify pressures and where investment was needed the most to make a difference. The CCG and its partners would be looking at, amongst other services, perinatal mental health services, children's support and crisis intervention services and individual placement support services for those with mental health conditions.

- Particularly around IAPT, going forward in a joint commissioning way we must make sure that its not just about improving services, but a need to communicate to the public what was being done well and by working together to make Sheffield a mentally well healthy city.

- One of the recommendations contained within the impact assessment was for additional resources to be made available to the Voluntary and Community Sector (VCS) and this investment was being made to develop a framework for rapid and progressive commissioning of mental health services to enable a timely response to changing community mental health support needs and service demands.

- Funding bids had been put together and one such funding stream that had been successful was the creation of crisis buddies and it was planned to place some of those crisis buddies where needed with the assistance of the voluntary sector. We are trying to get a closer relationship with the VCS to collaborate more, to develop bids together and look where to invest additional resource into the VCS.

- There was a strategic approach to VCS, and the Accountable Care Partnerships (ACP) hold a strategic position and was working with VCS colleagues who were members of the ACP, looking at the approach to Sheffield as a whole. The Primary Care Mental Health Framework has four Primary Care Networks covering 200,000 of population and VCS colleagues were working into that programme and £300,000 had been invested into that programme for delivery through VCS colleagues.

7.6 RESOLVED: That the Committee:-

(a) thanks Heather Burns, Sandie Buchan, Collette Harvey, Sam Martin, Eleanor Rutter, Joanna Rutter, Steve Thomas and Councillor George Lindars Hammond for their contribution to the meeting; and

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

8. COVID 19 AND DISABILITY

8.1 The Committee received a report of the Scrutiny Sub-Group on Covid and Disability which had met to consider a report from Disability Sheffield and HealthWatch Sheffield, setting out what disabled people have been telling them about their experiences during Covid.

8.2 The Chair asked for comments on the report and thanks were expressed to those involved in the Sub-Group for the work they had undertaken.

8.3 RESOLVED: That the Committee receives and notes the report.

9. WORK PROGRAMME

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

9.2 RESOLVED: That the Committee:-

(a) approves the contents of the Work Programme;

(b) considers that the nine meetings that had been held during the past year had been very useful;

(c) thanks the Chair for the hard work she had undertaken over the past Municipal Year; and

(d) thanks the officers who have supported the work of the Committee this year.

10. DATE OF NEXT MEETING

10.1 It was agreed that the next meeting would be on a date to be arranged.

This page is intentionally left blank

S H E F F I E L D C I T Y C O U N C I L

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 19 May 2021

PRESENT: Councillors Sue Auckland, Steve Ayris, Penny Baker, Neale Gibson, Talib Hussain, Francyne Johnson, Bernard Little, Abtisam Mohamed, Martin Phipps, Jackie Satur, Garry Weatherall, Richard Williams and Alan Woodcock

Non-Council Members (Healthwatch Sheffield):-

.....

1. APOLOGIES FOR ABSENCE

1.1 There were no apologies for absence.

2. APPOINTMENT OF CHAIR

2.1 RESOLVED: That Councillor Steve Ayris be appointed as Chair of the Committee for the Municipal Year 2021/22.

3. DATES AND TIMES OF MEETINGS

3.1 RESOLVED That meetings of the Committee be held on a bi-monthly basis on dates and times to be determined by the Chair, and as and when required for called-in items.

This page is intentionally left blank

Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee

Report of: Sandie Buchan (Director of Commissioning Development, NHS Sheffield Clinical Commissioning Group

Subject: Adult Dysfluency and Cleft Lip and Palate Service

Author of Report: Kate Gleave, Deputy Director, Commissioning, NHS Sheffield Clinical Commissioning Group

Summary:
The purpose of this report is to inform the Committee of potential changes to the provision of Dysfluency (stammer) and Cleft, Lip and Palate services for adults within Sheffield.

The report provides background context and outlines the current situation. Given the nature of ongoing discussions around the service, it is proposed that a verbal update is provided at the meeting to ensure the committee is informed of developments over the couple of weeks between the paper being drafted and the meeting.

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

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

The Scrutiny Committee is being asked to:
The Committee is asked to note the current position of this service and consider whether the proposed change constitutes a substantial change.

Background Papers:
None

Category of Report: OPEN

Report of the Director of Commissioning Development, NHS Sheffield Clinical Commissioning Group
Adult Dysfluency and Cleft Lip and Palate Service

1. Background

1.1. In 2011, the government policy Transforming Community Services required the movement of services historically provided by Primary Care Trusts to those of provider organisations. Within Sheffield, the Speech and Language staff who provided assessment and treatment of dysfluency (stammer) and cleft, lip and palate were transferred to the Sheffield Children's NHS Foundation Trust (SC(NHS)FT. It is believed that this was on the basis that the majority of patients needing this service were children, with a minority of patients requiring ongoing treatment into their adult lives.

1.2 SC(NHS)FT has seen increasing demand of around 8% year on year since 2015 for Speech and Language assessment and treatment. Despite increases in capacity and service efficiencies, demand has continued to outstrip capacity. This has resulted in the service being unable to provide the treatment interventions specified in Education, Health and Care Plans (EHCP) for children in mainstream schools (a statutory requirement), being unable to meet the needs of children within mainstream schools who do not have an EHCP and a lack of capacity to provide the necessary input into the process to challenge the content of EHCPs through tribunals. It has been difficult to quantify the scale of this deficit, but what is clear, is that the educational attainment and progress and wider outcomes of children with speech, language and communication needs are sub-optimal as a result.

1.3 In recognition of the service's challenging position, the CCG, Sheffield City Council (SCC) and SC(NHS)FT agreed to undertake a review of the Paediatric Speech and Language service in May 2019. This has progressed over the last two years (although with a significant pause due to the COVID pandemic) and the outputs of the review are in the process of being finalised.

2. Service Provision

2.1. The Trust, CCG and SCC have been working together with colleagues from Education and the Voluntary Sector to undertake the review which has included examining different aspects of the service in detail. As part of this process it became apparent that the Trust was assessing and treating adults as well as children on the dysfluency and cleft lip and palate pathways.

2.2. The Trust reviewed the potential clinical risks associated with this provision and decided to temporarily close the service for both

pathways to new referrals from 1st April 2021. The rationale for this decision was based on the following risks:

- Therapy service treating patient cohorts significantly outside of the Trust's normal (and extended) age range
- Limited governance to support this extended age range
- There is limited capacity in the service which cannot meet all the demands placed upon it (e.g. adult v paediatric patients)
- Lack of alignment with other therapy services for adults which hinders integration and provision of holistic care for these patients

2.3. The service has continued to treat and support adults who were in the service prior to 1st April, regardless of their age. This is believed to be approximately 21 dysfluency patients and 92 cleft lip patients over the age of 18 (figure accurate as of November 2020). Some of these patients will be discharged from the cleft lip pathway following a check up at age 20, as per NICE guidance, whilst others may clinically need to remain on the pathway until much later in life.

2.4. The Trust may wish to close the service to all adult patients at a point in the future. This would involve any adults still receiving treatment at that point having their treatment transferred to an alternative provider.

2.5. It is anticipated that the closure of the service to new referrals will impact between 13 and 30 patients per year with dysfluency and approximately 5 patients per year needing treatment or support for their cleft lip. To date the CCG believes that up to 5 new patients may have tried to access the service over the last 3 months.

2.6. Up to this point, there has been no engagement with patients to understand the impact of closing the service to new referrals or of the potential impact of closing the service to existing patients. An equality and quality impact assessment has yet to be undertaken. The CCG and the Trust are however in active conversation and will work together to ensure that the legal duties of both organisations are met with regard to the involvement of patients and the public.

2.7. The CCG has undertaken exploratory work to understand how other CCGs commission this provision for adults (which varies from face to face provision, to virtual provision, to no service being commissioned).

2.8. The CCG is in the process of trying to procure treatment for the individual patients referred since 1 April 2021 from an alternative provider as a temporary measure. This may be outside of Sheffield.

3. Future Provision

3.1 The CCG and the Trust recognises the changes will impact on the current users and potential users and want to involve them in planning of future options and services. We also know that under the Health Service Act 2006, the closure of the service to new adult patients and the potential closure of the service to all adults at some point in the future

constitutes a change that requires the involvement of patients and the public.

3.2 We will develop an inclusive engagement plan, offering all those affected the change to have their voice heard. It is anticipated that this involvement should focus on two points:

- Asking people how potential changes will impact on them
- Asking people what the important aspects of a service are to them to shape a service with current and potential patients

3.3 This feedback would be used to inform and shape the design and commissioning of a service.

3.4 The CCG recognises that whilst small numbers of patients will be affected by the proposed change, it would mean patients having to attend a different location and see a different team for their assessment. This is likely to be outside Sheffield or may be available from within their homes but via a telephone or virtual appointment.

3.5 The Committee is therefore asked to advise whether it views the closure of the service to new adult patients and/or the potential closure of the service to existing adult patients at some point in the future as a substantial change requiring formal public consultation.

3.6 Given that the involvement will need to commence over the school summer holiday period, it is anticipated that the duration would likely to be for 12 rather than 8 weeks, regardless of whether it is formal or informal to ensure that people have had sufficient time to engage and feedback.

4. What does this mean for the people of Sheffield?

4.1. Whilst there will undoubtedly be an impact on the individuals affected by the service closure and for those of working age, the Trust has advised that they would not expect any of the patients to require urgent treatment from a clinical perspective.

4.2. It is anticipated that this proposed change in service will increase the capacity of the Trust to assess and treat children and young people with speech, language and communication needs. This should particularly positively impact on those with the greatest needs.

5. Recommendation

5.1. The committee is asked to:

5.1.1. Note the briefing on changes to the service

5.1.2. Advise whether it views the closure of the service to new adult patients and/or the potential closure of the service to existing adult patients at some point in the future as a substantial change

This page is intentionally left blank

Report to Health Scrutiny & Policy Development Committee
14 July 2021

Report of: Report of the Director of Commissioning and Development, NHS Sheffield Clinical Commissioning Group

Subject: Proposed Merger of Norfolk Park Health Centre with Dover Court and Consultation on the Proposed Closure of Norfolk Park Health Centre.

Author of Report: Abigail Tebbs, Deputy Director of Delivery - Primary Care Contracting, Digital and Estates, NHS Sheffield Clinical Commissioning Group

Summary: This briefing note is presented at the request of the Scrutiny Committee to enable it to scrutinise the proposed merger of Norfolk Park Health Centre with Dovercourt Surgery and the associated closure of the surgery at Norfolk Park Health Centre. The practices are currently consulting on the proposals. Other options are being considered including continuing to provide services from Norfolk Park. The benefits of the proposed merger and site closure are set out together with the principal risks and mitigations.

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	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	✔
Other	

The Scrutiny Committee is being asked to:
The Committee is asked to consider the proposals and provide views, comments and recommendations.

Category of Report: OPEN

Report of the Director of Commissioning and Development, NHS Sheffield Clinical Commissioning Group

Proposed Merger of Norfolk Park Health Centre with Dover Court and Consultation on the Proposed Closure of Norfolk Park Health Centre.

1. Background

Dovercourt Surgery is held on a Persona Medical Services (PMS) contract by two GP partners and employs 9 salaried GPs as well as other clinical and administrative staff. Services are provided from two sites Dovercourt and Manor Top surgeries. The practice currently has 8,791registered patients.

Norfolk Park Health Centre is held on a General Medical Services (GMS) contract by two partners, in addition they employ 1 salaried GP and other clinical and administrative staff. Services are provided from Norfolk Park Health Centre, a LIFT building managed by Community Health Partnerships. The practice currently has 5,057 registered patients.

Both practices are rated by CQC as good and are within the same primary care network, GPA1.

Map 1 in Appendix 1 to this paper shows the distribution of the registered population of Norfolk Park Health Centre by Lower Super Output Area (LSOA).

2. Proposal

The two practices wish to merge under the single Personal Medical Services contract already held by Dovercourt Surgery and as part of this merger to close the surgery located in Norfolk Park Health Centre (the health centre itself would remain open).

If a merger is approved patients registered at Norfolk Park Health Centre would become part of the registered list of the merged practice. The partners both surgeries would join a partnership and the Norfolk Park partners would become signatories to the PMS contract. All employed clinical, management and administrative staff would transfer to the new employer.

The new practice would provide all services from the Dovercourt and Manor Top sites. Map 2 at Appendix 1 to this paper shows areas accessible within 10 minutes by public transport from Norfolk Park Health Centre, this includes the Manor Top surgery. However, as set out in the consultation, the longer term future of the Manor Top surgery is subject to review.

3. Current Position

No decision has been made on the closure or merger. The proposal to close the surgery at Norfolk Park Medical Centre and merge with

another practice has been made by the GPs at Norfolk Park Medical Practice, not the CCG.

As the delegated commissioner for primary medical services, the CCG's role is to approve any proposed changes. To reach a decision the practices will submit a final business case including a quality and equality impact assessment and summary of the consultation to our Primary Care Commissioning Committee.

An equality impact assessment has been developed to identify risks, impact and mitigations. As a result of the proposed relocation of services, the practice is required by law to consult and a 12 week consultation commenced in May 2021. The CCG has offered resources to support the practices to undertake the consultation to ensure that the patient voice is heard and presented as part of the decision making process.

Our role is also to oversee the consultation; a paper came to a board sub-committee that oversees engagement and equality, called SPEEEC. They have assured the consultation plan (they didn't consider the business case) is robust and inclusive although there were issues with a case for change and providing adequate information for people to make an informed decision).

The proposal will be considered by the Committee at a meeting in public. This is currently planned for September. The Committee will also receive additional information from the CCG to support them to decide on the application to merge and proposed site closure.

4. Further Options

During the consultation, the practices are listening to the views of their patients and continue to consider other options for service provision. These include re-assessing the feasibility of continuing to provide services from Norfolk Park. These remain under review and the CCG is supporting the practices to develop these.

5. What does this mean for the people of Sheffield?

5.1. Benefits of the Proposed Merger

The practices consider that this merger and associated premises changes would provide resilience for the staff and patients of Norfolk Park and Dovercourt Surgery.

It would deliver benefits to both registered populations, provide stability, future viability and minimise any future impacts on surrounding Practices, the Network and the Locality and offer employment security for all staff.

The merger would also provide other efficiencies for example, through economies of scale. No clinical services will be lost to patients as a result of the proposed merger and patients are likely to benefit from extended opening times (early morning/evening).

5.2. Principal Risks and Mitigation

Consultation will identify patient concerns, impacts and suggest appropriate mitigation. The following risks have been identified already:

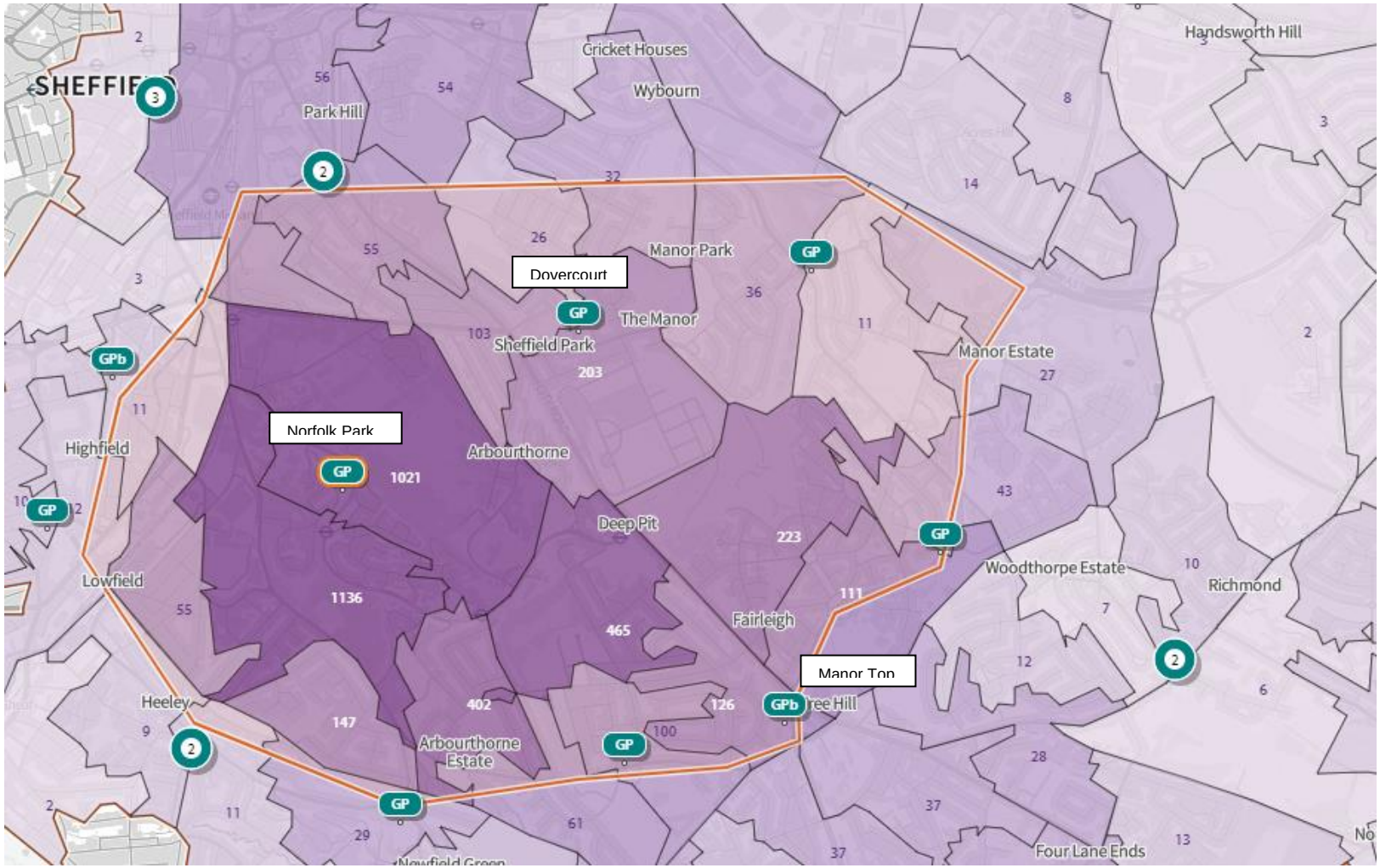
- Distance to travel between Norfolk Park and the new surgery – the Manor Top site of Dovercourt Surgery will continue to operate in order to mitigate distance to travel for affected patients and the practice will continue to review patient experience and future requirements.
- Change of staff – clinical and administrative and management staff from Norfolk Park will transfer to Dovercourt ensuring continuity of experience for patients.
- Capacity – Dovercourt Surgery forms part of the South Yorkshire and Bassetlaw ICS Wave 4 B Capital Bid Programme and development of a project initiation document and SOP are progressing well. Subject to final approval this will provide further clinical and administrative capacity for the merged practice as well as space for PCN services.

6. Recommendation

The Committee is asked to consider the proposals and provide views, comments.

APPENDIX 1

Map 1: Registered Patients of Norfolk Park Health Centre by Lower Super Output Area



The orange line is the inner boundary of the Norfolk Park Health Centre catchment area.

The number of patients registered at Norfolk Park Health Centre is shown in each LSOA. The darker the purple shading the greater the number of registered patients in that LSOA.

Map 2: Travel Times from Norfolk Park Surgery

The green shaded areas are accessible within 10 minutes by public transport from Norfolk Park Health Centre.

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

Author of Report: Emily Standbrook-Shaw
emily.standbrook-shaw@sheffield.gov.uk

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

This page is intentionally blank

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.

---

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.

End