Sheffield City Council

Sheffield Health and Social Care NHS

NHS Foundation Trust

16th July 2015

Item No 10b

Council of Governors: Summary Sheet

Title of Paper:	Governor Questions to the Board
Presented By:	Chair, Professor Alan Walker

Action Required:					
For Information		**For Ratification**		**For a decision**	
For Feedback	x	**Vote required**		**For Receipt**	

To which duty does this refer:

Holding non-executive directors individually and collectively to account for the performance of the Board	x
Appointment, removal and deciding the terms of office of the Chair and non-executive directors	
Determining the remuneration of the Chair and non-executive directors	
Appointing or removing the trust's auditor	
Approving or not the appointment of the trust's chief executive	
Receiving the annual report and accounts and auditor's report	
Representing the interests of members and the public	x
Approving or not increases to non-NHS income of more than 5% of total income	
Approving or not acquisitions, mergers, separations and dissolutions	
Jointly approving changes to the trust's constitution with the Board	
Expressing a view on the Trust's forward plans	
Consideration on the use of income from the provision of goods and services from sources other than the NHS in England	
Monitoring the activities of the Trust to ensure that they are being conducted in a manner consistent with its terms of authorisation and the constitution.	x
Monitoring the Trust's performance against its targets and strategic aims	x

How does this item support the functioning of the Council of Governors?

Putting questions to the Board allows governors an additional measure to hold the Trust to account for its performance and to ensure that the views of governors and members are heard and responded to at the highest level.

Author of Report:	Sam Stoddart
Designation of Author:	Deputy Board Secretary
Date:	1st July 2015

Questions from Jules Jones (April)

Q1: What is the Board doing about the high levels of sickness absence amongst staff? Specifically, what is the board doing to:

- **bring it down to our target levels (or below) across all of the directorates;**
- **mitigate the high costs associated with sickness absence;**
- **support staff in order to return to work, and what does the trust do to promote staff wellbeing.**

Response from Dean Wilson, Director of HR

The Trust's current sickness absence rate (May 2015) is 5.11% and the current year average is 5.99%. This is against a Trust target of 5.1%. The Trust's current level of sickness absence compares unfavourably not only with its own target but also is higher than the reported average for other Mental Health Trusts and Community Trusts within the EWIN database and the recently circulated data from NHS England relating to Annual Accounts 2014-15.

This is not a new situation. Historically the Trust has exhibited even higher levels of sickness absence. From a longer-term perspective there has been some improvement but the underlying theme is the apparent intractability of the rate and what seems to be a need for a paradigm shift.

In May 2015 the Trust introduced an Action Plan to assist in improving attendance. The key recommendations of the Action Plan are:

1. To ensure there is proper and appropriate ownership and accountability within Directorates for reducing the level of sickness absence. Service directors / Clinical Directors to identify their plans for reducing sickness absence to the Trust target. For these plans to correlate with their plans for CIPs and quality improvement.

2. To have specified service agreements with Directorates on:
(i) The data which they will receive for review.
(ii) The Directorate Lead for taking action in relation to the data
(iii) Who the data will be disseminated to (e.g. provision of team data to teams)
(iv) The support available from HR and other Corporate Services.
(v) The arrangements for monitoring actions taken and the results.

A template SLA to be drawn up and shared with Directorate Management Teams. Iteration between HR and Directorates to complete the template.

3. To review the current policy on Managing Sickness Absence to identify any improvements (e.g. any trigger automatically results in a review meeting).

4. To take forward with I.T the basis for better utilising electronic data on sickness to:
- make the data more accessible to individual managers to manage individual absences.
- enable senior managers (see Recommendation 2) to evaluate progress by line managers.

5. To assess where there are any urgent requirements for additional training / coaching in managing sickness absence and to put in place the most effective training tools.

6. To action the Sickness Absence Case Manager role to evaluate the impact of dedicated time / resource on improving sickness absence levels and closer management of individuals with poor attendance.

7. To re-appraise the proposals and requests for funding set out in the Report on Promotion of Attendance at Work (to include the Occupational Health provision]. To identify what should be taken forward with the available resources in conjunction with Julie Edwards (for the Staff Health and Wellbeing element) and the Joint Sickness Absence Working Party (with Staff Side).

8. To identify the scope and nature of any incentives for good attendance.

9. To review and simplify the documentation relating to sickness absence (Return T Work Form).

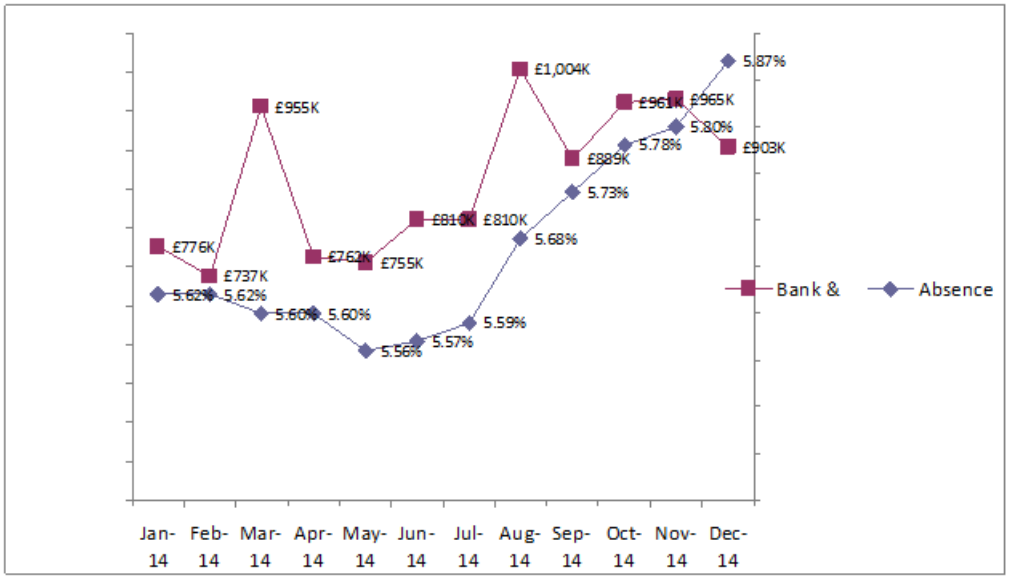
10. To consider the scope for making incremental progression dependant on no formal warnings for sickness absence.

Q2: What is the Board's opinion on how staffing levels (+ subsequent workloads) and staff sickness absence may be interrelated, and what, if anything do they intend to do about this?

Response from Dean Wilson, Director of HR

The figures for Absence against Bank and Non-NHS Spend indicate that there is no correlation between the two.

For example:



It may be reasonable to suggest that any correlation between the level of absence and Bank & Non-NHS spend should be more aligned than the graph suggests. It would be unsafe therefore to infer a link. This is counter-intuitive in some respects, so further analysis will be carried out, in order to definitively determine any such link.

The recommendations contained in the Improving Attendance Action Plan will be taken forward (see previous response to Q1).

One of the primary recommendations, as outlined in the Action Plan, is the appropriate ownership and accountability of Directorates to reduce sickness absence, whilst being mindful of CIPs and agency spend.

Questions from Pat Molloy (May)

Q1: Recent (late April 2015) reports in the media and informed sources have found that some Trusts are 'dipping into' next winter's contingency monies to avoid spring problems. Is this happening at SHSC?

Response from Phillip Easthope, Director of Finance

Put simply, no. Sheffield CCG, like many others, is taking a more proactive managed approach to system resilience funding, setting up The Sheffield system resilience group requesting bids for monies based on a set of principles which they will measure the bids against. Bids are open to the NHS, voluntary and Independent sectors. Dr Rachel Warner is the Trust representative. But there is a shift in thinking to a more proactive/preventative approach to admission and hospital avoidance, care closer to the home and system integration.

That said some previous projects funded through system resilience are been kept going, but funding has been agreed from other sources. These include Street Triage, now recurrent funding from CCG and the A&E liaison project, funded for 9 months non-=recurrently until the final new service configuration is defined and service provision in place.

Q2: One possible new administration has stated that should they form the next government "within 100 days it will commence a repeal of the 2012 Act". Has SHSC any contingency plans should this come to fruition?

Response from Phillip Easthhope, Director of Finance

This is complex area, and the details behind any repeal are limited which therefore limits the trusts ability to contingency plan.

The area of competition and privatisation in the NHS is certainly an area that will be looked at and something other NHS systems limit whilst remaining compliant with EU competition law. As an FT we can have 49% of our income as private income but as a trust it's nil. Therefore any direct impact to the Trust in this area will be limited to the extent of competition from non-NHS providers should privatisation be eliminated. This will take time and it would seem unlikely that any government would be able to redact any contracts currently in place to non-NHS organisations. But in the medium to long-term this could limit competition and provide opportunities for growth. Depending on your political and economic standpoint this could increase prices to the treasury.

A repeal in this area could be simply limited to remove Monitor's powers of competition putting this back to the Office of Fair Trading, which would have little impact.

At the extreme end, an end to competition and privatisation could mean an end to Foundation Trusts, so without any detail it is impossible to understand the implications let alone mitigate against them, especially if one considers the same parties have also stated that there will be no more structural reform to the NHS. The two standpoints do seem somewhat contradictory or will limit the extent of the implications.

Other structural changes - the provider and commissioner split, putting GPS at the heart of commissioning and a move towards integration of health and social care budgets could be repealed and remain in current structures, but the implications are unknown depending on what they actually do.

The Act made a number of bodies independent from the NHS including NICE and the Information Centre – we don't anticipate a repeal would have any implications.

Other issues such as a much needed update to outdated legislation is a matter of legislation / law and no doubt may be built on by any government but unlikely to be repealed.

The best mitigation the Trust can do is to continue to work with our partners (commissioners and providers) to deliver whole system reform across Sheffield. We will plan to deliver the reforms necessary to deliver sustainable services for the people of Sheffield and adapt to the legislative changes as required. Something the NHS is used to doing.

Questions from Dorothy Cook

Q1: I am wondering what plans there are for the future of the Crisis House beyond its three year contract with Rethink.

Response from Richard Bulmer, Service Director, Acute Directorate

The Crisis House has contributed an additional resource as part of the acute care pathway. It has now been operational for 2 years. The contract is reviewed on a quarterly basis. This year the crisis house will undergo a detailed review to consider the impact the crisis house has had on acute care in Sheffield. Negotiations about the on-going future of the crisis house will commence this year. The decision about the future provision of the crisis house will be made at a board meeting.

Q2: I presume most service user's physical health is monitored by the registered GP. Does the trust have access to the results so that any changes/improvements can be monitored and discussed with the service user?

Responses from Debbie Cundey, Clover Group and Tom Davidson, Director of IT

Debbie Cundey: Patient information held by the GP is held on the patient information system that the particular GP practice chooses to use (in the main in Sheffield this tends to be TPP SystmOne or EMIS). In the case of Clover Group this is SystmOne.

The majority of the Trust records (depending on service/team) are held on Insight. At the moment, Insight and external GP solutions do not talk to each other. So the short answer is no the Trust does not have access to a service user's GP patient record. Consent for information sharing aside.

Communication between GP and other healthcare professionals (in this case SHSC workers) relies on the communication methods and information sharing agreements that are in place between the professionals. E.g. someone under the care of SHSC CMHT I would expect to see incoming and outgoing correspondence between the GP and the CMHT scanned into Insight, and into the GP system.

Tom Davidson: This is a fairly complicated answer and varies across the trust, but the answer is that in inpatient services, ISS and Longley Respite they have access to the GP record when they have consent from the service user to access it.

We are currently working on Community Team Access but this is not a priority at the moment. However, we are working in the background to achieve it.
Pharmacy has access to the summary Care Record that has access to all service users nationally. The trust will have full access to all Sheffield Patient Information as part of the Prime Minister's Challenge fund work.

Questions from Dan Creber

Q1: Given the current financial considerations within SHSC, how much is SHSC paying for Meridian's services & what is the Trust hoping to achieve by employing their services?

Response outstanding

Q2: Given that the recent CQC report highlighted staffing issues & low staff morale, how is it intended that Meridan's approach at CMHT West will improve this situation?

Responses from Dr Mike Hunter, Clinical Director and Liz Lightbown, Executive Director

The work that the Trust is undertaking with the West Recovery Team is designed to improve service users' experience and quality of care by increasing the amount of time that staff have available for face-to-face therapeutic contact and activities. The aim is to improve outcomes by promoting the best possible use of clinicians' time. The team is being supported by its own clinical leaders and by the Community Directorate throughout the process of change. We anticipate that this work will have a beneficial effect on staffing issues, including caseload management. Our experience of similar work elsewhere in the Trust suggests that staff respond positively to being able to spend more time with service users and that this has a beneficial effect on morale.

Liz Lightbown: I would add that whilst there was a bit of a sticky start with this work in this Directorate, the Directors are fully on Board and supporting staff to become much clearer about what they do and how well they do it. Ultimately the aim is to enable staff to spend higher amounts of effective time in direct care with service users. To do this we firstly need to understand how productive each staff member and the overall team is and then we can work to improve productivity i.e. both operational efficiency and clinical effectiveness, in turn this will enable greater accountability.

Questions from Debjani Chatterjee

Q1: I was very pleased to observe the valuable poetry readings offered by the Trust's current Reader-in-Residence and wish to commend all responsible for having confidence in Bibliotherapy. But I believe the post is only a part-time and very short-term appointment. When does it end and are there plans to extend it? May we please also give accountable consideration to such posts as Writer-in-Residence, a Dancer-in-Residence, a Storyteller-in-Residence, an Artist-in-Residence and a Musician-in-Residence?

Responses from Dr Rachel Warner, Deputy Medical Director and Julie Edwards, Therapy Services Director

Rachel Warner: The Trust is in discussion with Recovery Enterprises and The Reader Organisation about how to obtain funding for continuing and expanding the contract to support the reader in residence post. This includes ideas around how to promote opportunities for service users and staff to access theatre, music and dance. The current post is funded until November.

Julie Edwards: My understanding is that the reader in residence post is due to finish at the end of the year. I am keen to look at how this is being evaluated with a view to how we might extend this. The idea of other 'in-residence' posts is very welcome and very much in line with the trusts' arts in health strategy. As I mentioned in my annual report to the board last month we are hoping to work with the Sheffield hospitals charity around an arts coordinator who could help us look for external support and opportunities to invite external artists into the Trust. Last week I also spoke to Rachel Warner about how making further links with Recovery Enterprises could help us to bring in other funding streams to support this work.

Q2: As a service user with hospital-induced post-traumatic stress and acute needle phobia during my cancer journey, I was offered CBT, even though CBT is a talking therapy and it was extremely difficult for me to verbalise my traumatic experience. There was no mention of other psychotherapies being available and at the time I did not know that the Trust also have Art and Music Therapies. Some other service users have also said that this was their experience too. Is it normal practice not to inform patients of a range of therapy choices, and is it because other therapies are in very short supply? Could service users please be told of the range of therapies available so that they can make an informed choice?

Responses from Dr Rachel Warner, Deputy Medical Director & Julie Edwards, Therapy Services Director

Rachel Warner: Discussions about available therapies would include those that had an evidence base for efficacy in a particular situation in order for service users to make an informed decision about their options. It would not be useful or helpful to offer therapy or intervention which is not relevant. It is good practice to inform services users of interventions that are recommended but not available - as they may want to approach the CCG for funding to access this elsewhere

Julie Edwards: Currently Art and Music Therapy are only available in a very limited way within the community mental health teams (2.4wte at present) so I do not believe that these are routinely offered in view of raising unrealistic expectations where demand could not be met. There is also some concern of the limited 'gold standard' evidence base for the efficacy of some of these therapies which may affect what information is provided to service users. I am aware however that anecdotally, from practice based evidence and feedback, that 'arts therapies' are very well regarded and highly valued by service users and some staff.

Q3: While attending a recent PTGC meeting in my Governor role, I was disturbed to learn that there is a plan to reduce the 2.4 Art Therapy posts to only 1.3 for work with outpatients in the Community. Were service users and staff consulted? I know that service users generally think highly of Art Therapy and would like to see more provision, not less. It is also one of the expressive therapies that can reach places that talking therapies have difficulty with. What is the Art Therapy provision across the Trust and are any cuts in this provision proportionate; if disproportionate, why is this the case? Please let me know also about the current and intended provision of any other expressive arts therapies.

Response from Julie Edwards, Therapy Services Director

At this moment in time service users and staff have not been consulted on the proposals but we are planning on doing this once we have met with the therapists affected as we want to consider the best way of doing this

As mentioned at my annual report to the board last month there was a proposal from the community directorate to take out 2.4wte all together to enable delivery of their CIPs (cost improvement plans) However I and others have worked together and got agreement to keep 1.30wte (whole time equivalent). This funding for this is coming from the community directorate, the acute directorate and the specialist directorate. I have also had a tentative enquiry from learning disabilities about buying some input.

At present the 2.4wte is only available within the community teams. The new proposal will provide input onto other areas of the trust, within in patient areas, where there is a stronger evidence base and involving groups as well as individual therapy. So whilst the overall provision will be less in terms of wte it is the intention for greater access for a range of people and services. For example there will be sessions at G1 and Woodland View

There are other arts therapies posts not directly affected by this - 0.2 linked to SORT, 0.4 at Forest Close and 0.4 at Spaces

As this new way of working becomes established, and we will be routinely collecting outcomes, we can look at shortfall and if there are any further opportunities to expand the reduced provision we will seek to do this.