Sheffield City Council

Sheffield Health and Social Care NHS
NHS Foundation Trust

Council of Governors: Summary Sheet

24 November 2016
Item No 5c

Title of Paper:	Performance Overview Group Notes
Presented By:	Jayne Brown OBE, Chair

Action Required:

For Information		For Ratification		For a decision	
For Feedback		Vote required		For Receipt	x

To which duty does this refer:

Holding non-executive directors individually and collectively to account for the performance of the Board	
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	
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.	
Monitoring the Trust's performance against its targets and strategic aims	x

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

The Performance Overview Group is a mechanism by which governors can better understand the detail behind the Trust's performance data and question board members on questions that arise as a result of this.

Author of Report:	Sam Stoddart
Designation of Author:	Deputy Board Secretary
Date:	7th November 2016

Council of Governors
Performance Overview Group (POG)

Minutes of the ninth Performance Overview Group held on 13th September 2016 at Fulwood House

Present:

Name:	Title:	Name:	Title:
Jules Jones (Chair)	Lead Governor	Michael Thomas	Governor
Elaine Hall	Governor	Terry Proudfoot	Governor
John Buston	Governor	Phillip Easthope	Executive Director of Finance
Sam Stoddart	Deputy Board Secretary	Dean Wilson	HR Director
Jason Rowlands	Director of Strategy & Planning	Karen Jones	PA to Chair
Dr Jonathan Mitchell	Consultant Psychiatrist	Paul Nicholson	Deputy Service Director
Naomi Hebblewhite	Assistant Service Director		

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POG09/01	**Welcome** The Chair welcomed everyone to the meeting and emphasised that this was an opportunity for governors to ask in depth questions.	
POG09/02	**Notes of the meeting held on 10th May 2016** The notes of the meeting were accepted as an accurate record.	
POG09/03	**Matters arising from notes of the meeting held on 10th May 2016** **POG 08/03 Crisis Care City-wide Plan (Concordat)** – Sam Stoddart confirmed that this will be on a future Council of Governors agenda. **POG08/05** Dan Creber, Governor, had asked if the number of CMHT referrals could be audited. Jason Rowlands said that since this question was asked things have moved on and issues improved. It was agreed that CMHT referrals should be discussed at a future meeting. It was also agreed that Dean Wilson would provide data/information on the staffing group and directorate of those staff moving/transferring. Agreed to put on January's agenda.	S Stoddart D Wilson S Stoddart

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	As part of the annual audit of quality accounts, Jason suggested more discussion between governors takes place to establish which quality objective would be most useful to audit and provide. It was agreed that this needed to be finalised by the January meeting. **POG08/07** – Sam Stoddart agreed to action the suggestion of sharing any pertinent information arising in this meeting with fellow governors. **Staff Survey – Equality and Diversity**. Dean Wilson confirmed this went to Board and governors were sent a copy of the report.	J Rowlands S Stoddart
POG09/04	**Early Intervention Service (EIS)** At the request of governors there was a short presentation by the Early Intervention Service. Paul Nicholson, Deputy Service Director, Naomi Hebblewhite, Assistant Service Director and Dr Jonathan Mitchell, Consultant Psychiatrist provided information on EIS. EIS was set up 15 years ago and underwent reconfiguration in 2012. Due to an increase in demand the model needed to be re-examined. In July 2015 changes took place in an effort to fill any identified gaps and expand the service. The service is now better at tracking demand and is more able to identify peoples' needs. Indicators show that the service receives twice as many referrals as expected with 100 new people per year. The service needed to manage capacity and meet need whilst facing issues with the additional funding required. Current plans are to move to one central city-wide service for those with a first episode of psychosis. A clinician has been appointed to work across the (current) four EI Teams to look at standardising processes and practices in preparation for the transition to city-wide implementation. The aim is to: • Develop a clear city-wide definition/acceptance criteria with regard to EI eligibility. • Develop a consistent standard operating procedure with regards to referral, early identification and treatment. • Develop a standard system for local data collection and tracking. • Help teams to embed the Triumph (treatment and recovery in psychosis) model into practice. • Ensure that we are working in the most creative and efficient way with current resources and to assure that practice and processes are standardised across the city. The floor was opened to question. It was asked if there was one referral point or if GPs could choose where to pass referrals.	

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	Paul Nicholson said this was one of the things the service hopes to improve ensuring that all referrals are received straight away without delay. Sam Stoddart asked if there was a timescale to create one team. Paul said a paper will be presented to the November Board of Directors meeting with a view to implementation next year. Terry Proudfoot about the Triumph model. Jonathan Mitchell explained that the Trust is involved in research to develop the perfect EIS pathway ensuring full comprehensive care, not just the provision of medication. Terry asked if the business plan was a way to increase funding. Jonathan said the commissioners couldn't provide any money but did help with the business case. The Chair agreed that centralising the teams was, on paper, a good idea but how will the Trust ensure equality/access to services. Paul Nicholson said this would be achieved through staff sharing their experience and skills. Jonathan Mitchell added that access to services would be flexible with provision of community bases and staff going out into the community. Michael Thomas asked if people would be expected to travel when the service is centralised. Paul Nicholson said there will still be facilities within the community in which to see people. The Chair raised concerns on meeting the 2 week standard (access quickly – 50% in line with national standard). Jonathan Mitchell agreed that this is tough to achieve but streamlining is the key. The care pathway work will help clarify and identify where resources are required ensuring quality across the city. He emphasised how quality care is achieved through face to face interaction and the ability to provide access to support, not just being put on a caseload and given prescriptions. John Buston asked about the psychosis rates for the North of England. Jonathan Mitchell said predicting demand is difficult and commissioning is based on nationwide 'model testing' results. Northern regions are reluctant to share information/data. Michael expressed concern that based on this national model errors are possible for Sheffield if the model is not a full representation. Terry Proudfoot asked if there are plans to improve the model. Jonathan said the model is based on the national census which is undertaken every 10 year. Therefore changes are not likely until after the next census. The Chair thanked Paul, Jonathan and Naomi for attending.	
POG10/05	**Workforce Report** Dean Wilson shared key points and highlights from the quarterly	

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	workforce report. Mandatory training levels are lower than expected and will need to increase to achieve CQC compliance. Work is underway to address this. Both the Community and Primary Care Directorates are working hard to improve sickness absence with successful results. Sickness absence within Learning Disabilities (LDS) reduced for the fourth month in a row. The Inpatient Directorate reported an increase in sickness absence and therefore the newly appointed Case Manager is working with them to address this. Long term and short term sickness data has been split. Long term sickness is relatively low. In line with national figures stress/anxiety/depression is the top reason for absence. On page 6 of the report is the addition of new data showing the number of employees under sickness review. Dean reported changes made to the sickness/absence policy. This has been simplified and the informal stage removed. Staffside has been informed and are happy with changes. Staff turnover is within target at 11.92%. Figures within the report exclude TUPE transfers, bank staff and Junior Doctors. Sam Stoddart asked on behalf of governors if the information could be broken down further to provide the information about the staff leaving (staff group and directorate). Dean agreed to provide this. June 2016 saw the loss of Beighton Road (LDS) and staff were TUPE'd out of the Trust. Terry asked what FTE was. Dean explained this stood for full time equivalent and is always less than the head count. Sam asked about age profiling and wanted to know if it helps inform succession planning. Dean said yes this is used by the HR Partners to help with planning. Dean Wilson spoke of the Government's plans to implement an apprenticeship levy for large organisations from next year. This aim of the initiative is to increase apprenticeships but the Trust would have to take three times more than at present to break even (approx. 120). Plans are still up in air and more information is coming out all the time, but when implemented the levy will be ongoing year on year. He added there was a possibility of linking up with other Trusts for a city-wide approach. The Trust currently has 49 EU employees and the Trust is keen to help reassure staff with concerns following Brexit. As a whole Trust staff represent 41 different nationalities.	D Wilson

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	Michael Thomas questioned if there was any correlation between staff receiving warnings and sickness absence and suggested that it may need investigating further. Dean Wilson reported that Personal Development Reviews (PDR) compliance was high at 97%. However this is no measure of the quality of PDRs taking place. Elaine Hall asked that a survey be conducted first to determine if PDRs are fit for purpose before changing the current process. Terry Proudfoot asked if the number of work days lost through anxiety/stress was at the expected level and if this was being looked at. Dean advised that lots of work was underway to address this and as it is the highest cause for long term sickness tackling it effectively would make a significant change. A national survey reported that the single largest reason for sickness absence through anxiety/stress was the relationship between employee and line manager. Training programmes have been developed for line managers to help them manage this. Staff wanting help can be fastracked to the Workplace Wellbeing service for additional support. The Chair referred to the Performance Report and the reported increase in staff experiencing bullying and harassment. Dean Wilson explained that this arose from the staff survey and following this the Board of Directors instigated an investigation and a full report was presented at the April meeting. Dean said this had been reported in the staff survey twice but remained unreported through official processes. The Chair thanked Dean for his report.	
POG10/06	**Finance Report** Phillip Easthope presented the financial overview data as of 30th June 2016. Within the Strategic Planning round for 2016/17 the Trust has agreed a break-even financial plan. It was then asked by the Regulator, NHS Improvement, to achieve a £1m surplus, but it was ultimately agreed on a surplus of £970k. In return for achieving the surplus, the Trust will receive £720,000 income from NHS Improvement's Sustainability and Transformation Fund in four quarterly payments. If the Trust does not meet its surplus target it will not receive this income. Phillip was asked if this Trust's existing capital surplus can be used to help achieve the surplus, but it was confirmed that capital cannot be used in this way. Phillip then went on to illustrate the current financial position. As	

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	of June/July the position is ok and the Trust is on plan with no concerns. The forecast is slightly ahead of plan. Capital is slightly behind plan due to timing but is of no concern. The Cost Improvement Programmes (CIPs) are of concern and if not achieved will increase year on year. Sam Stoddart asked what happens if CIPs continually don't meet targets. Is there a cut-off point when it is considered not sustainable? Phillip said things change and the Trust should be able to make at least historic CIPs. Nationally CIP targets have slightly reduced to make them more achievable.	
POG10/07	**Performance Report** Due to the timing of the meeting Jason Rowlands advised that he would be reporting on Quarter 1 only as Quarter 2 was yet to be presented to Board. Jason provided brief highlights from the report. On national/core quality standards the Trust achieved all targets except one. This is acceptable but if the Trust continues to fail over three quarters this will trigger action. This target is in relation to Early intervention in psychosis: people assessed and access treatment within 2 weeks of referral. The target is 50% and we are at 47.9%. Jason reported that this target was met in July 2016. G1 Ward experienced an increase in delayed discharges; however, reporting for July/August looks ok. The Intensive Support Service still has four people waiting for discharge but is being addressed. In July/August bed occupancy came down and remains challenging but is going in the right direction. On the safety dashboard Jason reported that missing patients had gone down this year. This if reflective of increased engagement and new practices. John Buston asked about the increase in restraints and asked if this was of concern. Jason Rowlands said the data reflects the number of incidents; however, levels remain consistent and don't change much. Seclusions are also more or less static. Although the Trust is not happy with the data it can be used for improvements. Safe wards are still in the process of being implemented. Terry Proudfoot referred to the medication table and asked what constitutes a major medication risk. Jason agreed to ask Peter Pratt, Chief Pharmacist. Elaine Hall asked why people are experiencing delayed discharge and if the Trust is charged as a result of this. Jason said the Trust is not charged and delays occur for a variety of reasons. For example, in older adults it could be the time it	J Rowlands

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	takes for an assessment or obtaining the funding, or a lack of vacancies in the appropriate environment needed for aftercare. Jason informed the group that the Trust is investing in a new software system which will map performance against the trust's objectives and once it 'goes live' the information will be shared with governors. The Chair thanked everyone and closed the meeting.	