25 April 2019
Item No 5b

Council of Governors: Summary Sheet

Title of Paper:	Governor Questions to Board
Presented By:	Jayne Brown OBE, Chair

Action Required:					
For Information	x	**For Ratification**		**For a decision**	
For Feedback		**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 significant transactions including acquisitions, mergers, separations and dissolutions	
Jointly approving changes to the Trust's constitution with the Board	
Expressing a view on the Trust's operational (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:	Governors
Designation:	
Date:	April 2019

March 2019

Question from Jules Jones, Public Governor

Does SHSC have enough acute Beds (for example on the PICU)? How is the calculation made to determine that SHSC has the correct number of beds?

Response from Dr Mike Hunter, Executive Medical Director

Four years ago the Trust embarked on an ambitious plan to ensure the provision of acute care in the least restrictive way possible. This was achieved by the development of home treatment teams which were funded in part through the disinvestment of ward provision. The exception to this was the PICU where bed numbers were increased from 8 to10 beds when Endcliffe opened early 2016

Our acute bed complement is:

- 54 Acute beds (plus 6 surge beds)
- 10 PICU
- 18 older adult
- 16 dementia beds

Home Treatment is available daily and an out of hours service provides support overnight and at weekends.

In the middle of 2017 the Trust started to experience sustained bed pressures and additional beds were consistently required to be used to manage demand.

It is worthy of note that during 2017/18 there were significant developments in the provision of 24/7 crisis response services and an unintended consequence of this may have been an increase in demand for inpatient/acute admissions to support people detained under the Mental Health Act.

A case for a psychiatric decisions unit (PDU) was developed to enable more flex in the system to allow surges in demand to be managed. Funding for this unit was agreed in 2018. The unit facilities were handed over in February 2019 and the service is currently being implemented. When fully live it will provide a 24/7 provision accommodating up to 12 service users in any one day. The unit will allow for the extended assessment of service users and time to enable a package of care to be set up and available so enabling the service users to return to their usual residence with the necessary support rather than requiring admission.

In addition coordinators have been recruited to manage flow through the system. The coordinators oversee the management and placement of those individuals identified as being at risk of admission, and support and facilitate ward discharges. Flow is also supported through the regular bed management meetings and in addition through a forum that has now been established with the Local Authority and the CCG aimed at addressing

any delays and gaps relating to accommodation and on-going care requirements that may hinder timely discharge.

Step up/down units are available including wainwright crescent, crisis house provision and in addition higher support step down beds have been procured over the winter period and will continue to be spot purchased.
Even though the Trust has experienced significant and sustained bed pressures since mid 2017 no out of area beds have been utilised for services users requiring acute care apart from when this has been agreed in line with the patients best interest (e.g. closer to family).

Out of area beds have however been required for service users requiring a PICU.

When Endcliffe was planned and developed it was anticipated that it would primarily operate at 80% occupancy however the unit has consistently operated at 100%. A number of factors have contributed to this situation:

- Changes to police custody arrangements
- Likely increase in substance abuse and use of new drugs
- Delays in patients accessing low, medium and high secure units; in some cases patients being managed on PICU for months whilst NHSE identify a bed
- Staffing pressures, increase in case mix acuity and out dated acute ward environments making management of patients within seclusion undesirable and referral for PICU gatekeeping, at times, a more desirable/manageable option

Out of area beds for PICU patients have been required to manage

- Demand
- Conflict between patients on the unit
- Staff intimidation and threats

In summary bed management is pressured. The PDU will provide the flex required in the system to support surges in demand, the flow coordinators ensure we are using our capacity to its optimum, challenging and complex discharges are worked through with our partners, step down facilities are available, and we continue to explore options, and it is planned that home treatment provision will be further developed within the next year.

Clinical Operations continue to monitor capacity and demand and the effectiveness of the strategies employed to be able provide the least restrictive and most effective and safe quality care.

How many beds do we have compared to elsewhere?

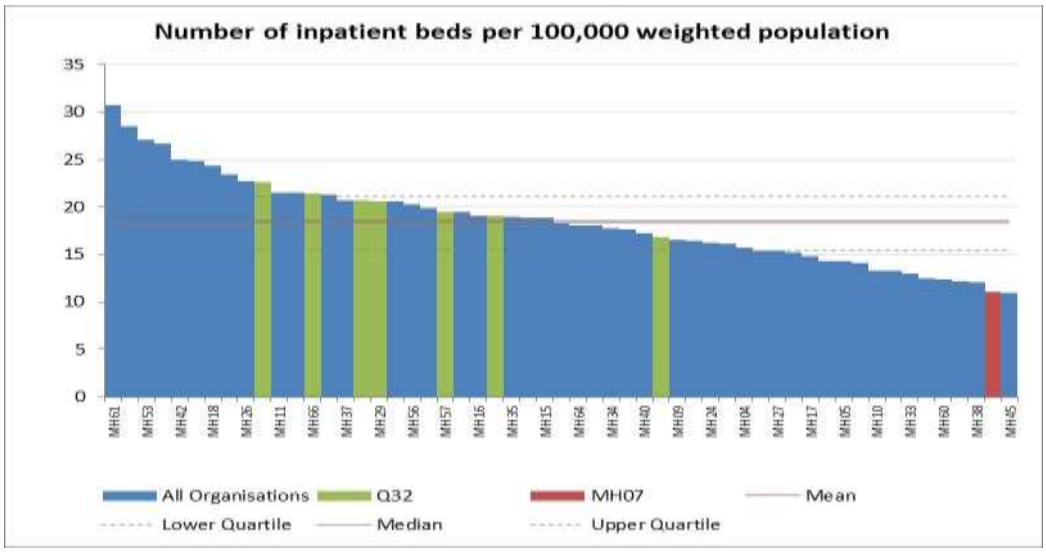
While this doesn't answer the question of 'how many beds do you need?', or 'how many beds should you have?', it does help us understand how capacity across different service in Sheffield compares to the rest of the country.

There is a well established national benchmarking organisation, funded collectively by all the NHS Trusts in the country to organise benchmarking programmes and to collect information from providers. NHS Benchmarking provides reports and data in relation to the national averages, the range or variance compared to the average and where an

organisations fits within that range. It does this on an annual basis. The last report relates to the full financial year 2017-18.

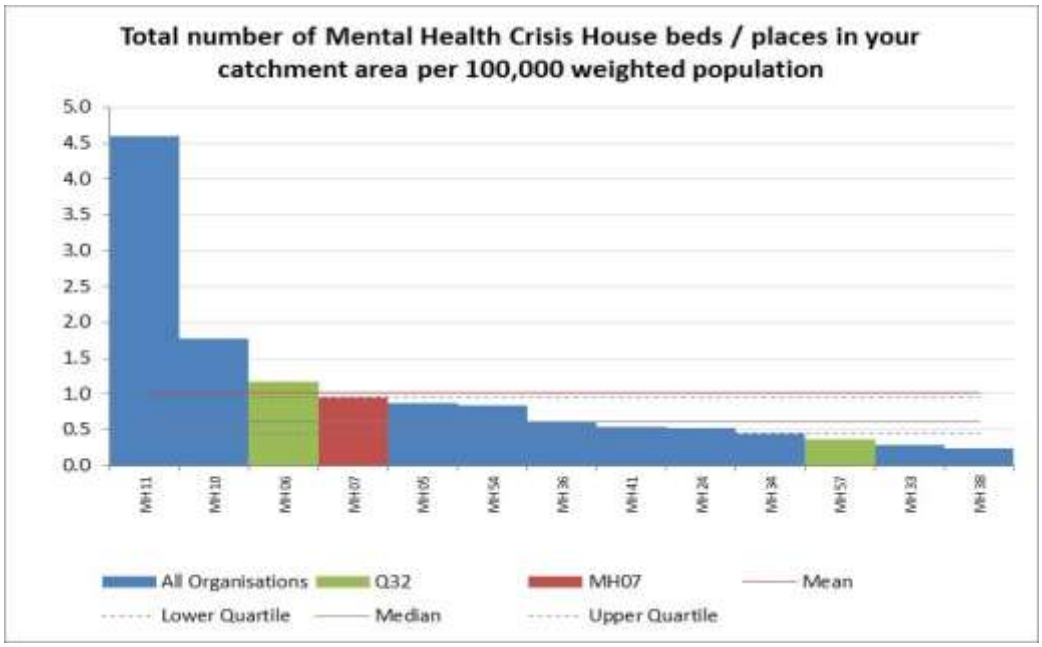
How do we compare for adult acute inpatient beds for the year 2017-18

We have a low number of acute inpatient beds compared to the rest of the country. This has been the case for the previous 3 to 4 years where we are consistently in the lower quartile range.



Alternatives to Acute Inpatient bed provision – Crisis House services

Alongside this however we have 6 Crisis Beds. The graph below suggests most parts of the country do not have alternatives to hospital care, such as Crisis Houses, as only 13 Trusts reported that such services were available in their area.



Alternatives to Acute Inpatient bed provision – Step Down services

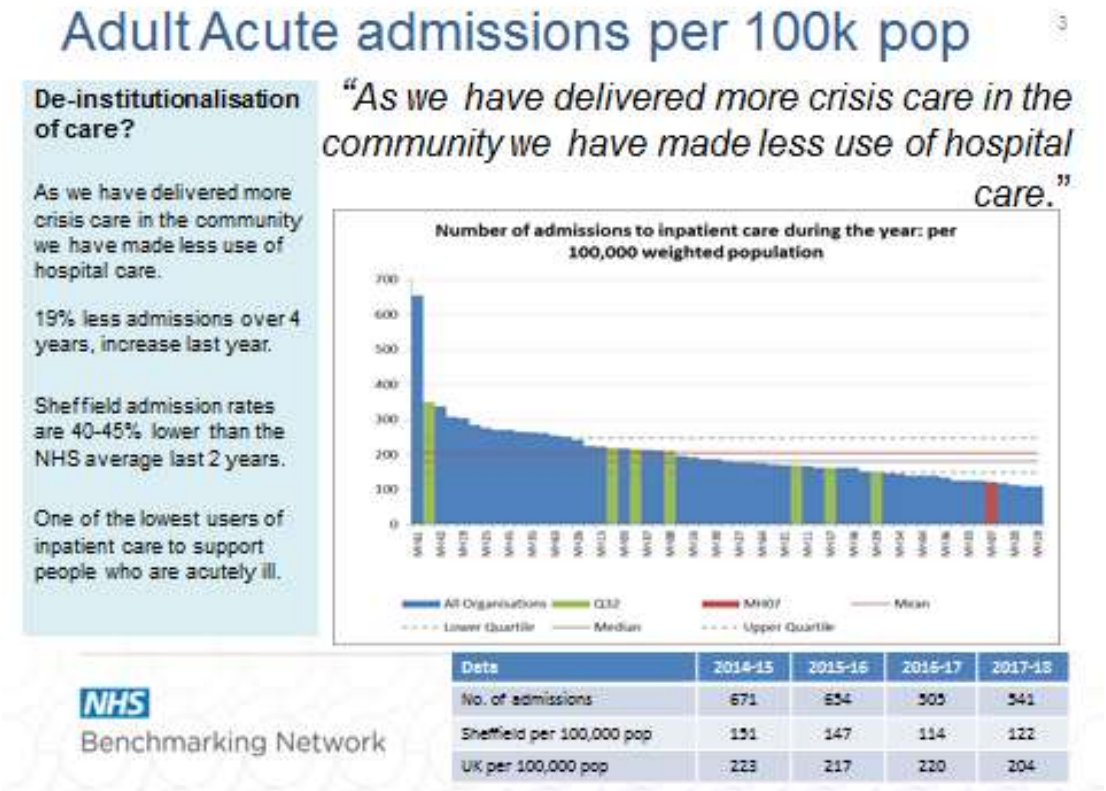
Within Sheffield we also have 10 Step Down beds, provided at Wainwright Crescent. Again nationally hardly any other parts of the country reported that such alternatives to inpatient care were available locally. Step Down services, through the Benchmarking review, were only available in 4 services.

In Sheffield we have 10 Step Down beds, the handful of other areas that provided step down services consisted of 6-7 beds.

PICU Inpatient care

Benchmarking data is not available in respect of how many beds are provided based on local population sizes. This is because many services like PICU's and Low Secure inpatient services often provide care from people from different towns or catchment areas. Therefore benchmarking based on population sizes is not readily available through NHS benchmarking.

Other considerations or comparisons that may be of interest



Data	2014-15	2015-16	2016-17	2017-18
No. of admissions	671	654	505	541
Sheffield per 100,000 pop	151	147	114	122
UK per 100,000 pop	223	217	220	204

Adult Acute beds per 100k population

4

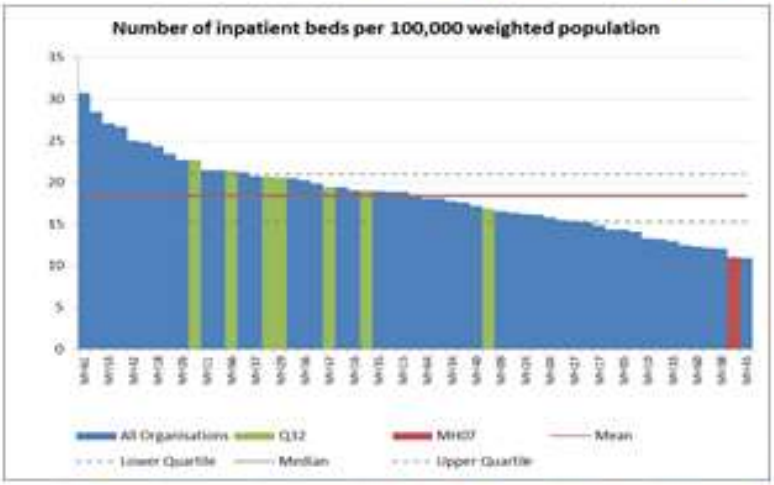
De-institutionalisation of care?

Clear plans have reduced bed numbers hand in hand with reducing admissions

Sheffield bed numbers have reduced by 45% over the previous 4 year period and Sheffield has a low bed base per weighted population when compared to the rest of the country.

Nationally bed numbers have remained stable

"We have a low bed base as we deliver more care in the community"



NHS Benchmarking Network

Data	2014-15	2015-16	2016-17	2017-18
No. of beds	90	66	49	49
Sheffield beds per 100,000 pop	20.3	14.8	11	11
UK beds per 100,000 pop	19.5	19.4	20	19

Mental Health Act Admissions rate #1

5

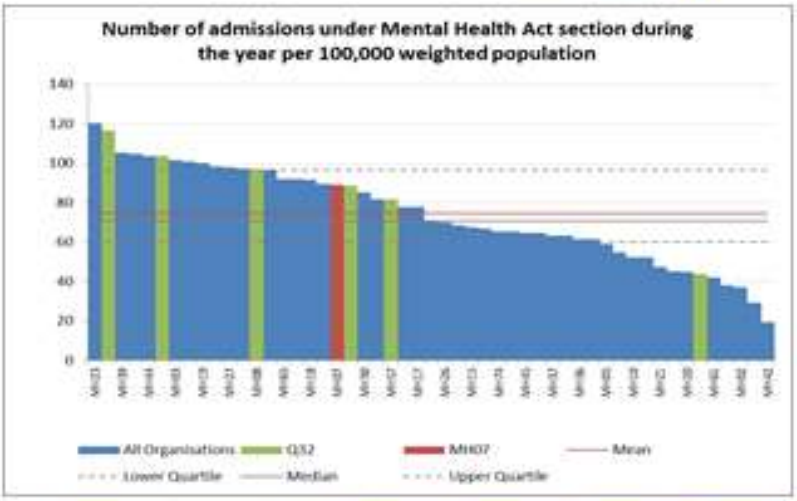
Are services safe and effective?

Numbers fluctuate from one year to the next.

In 2016-17 the numbers of people detained was similar to the national average.

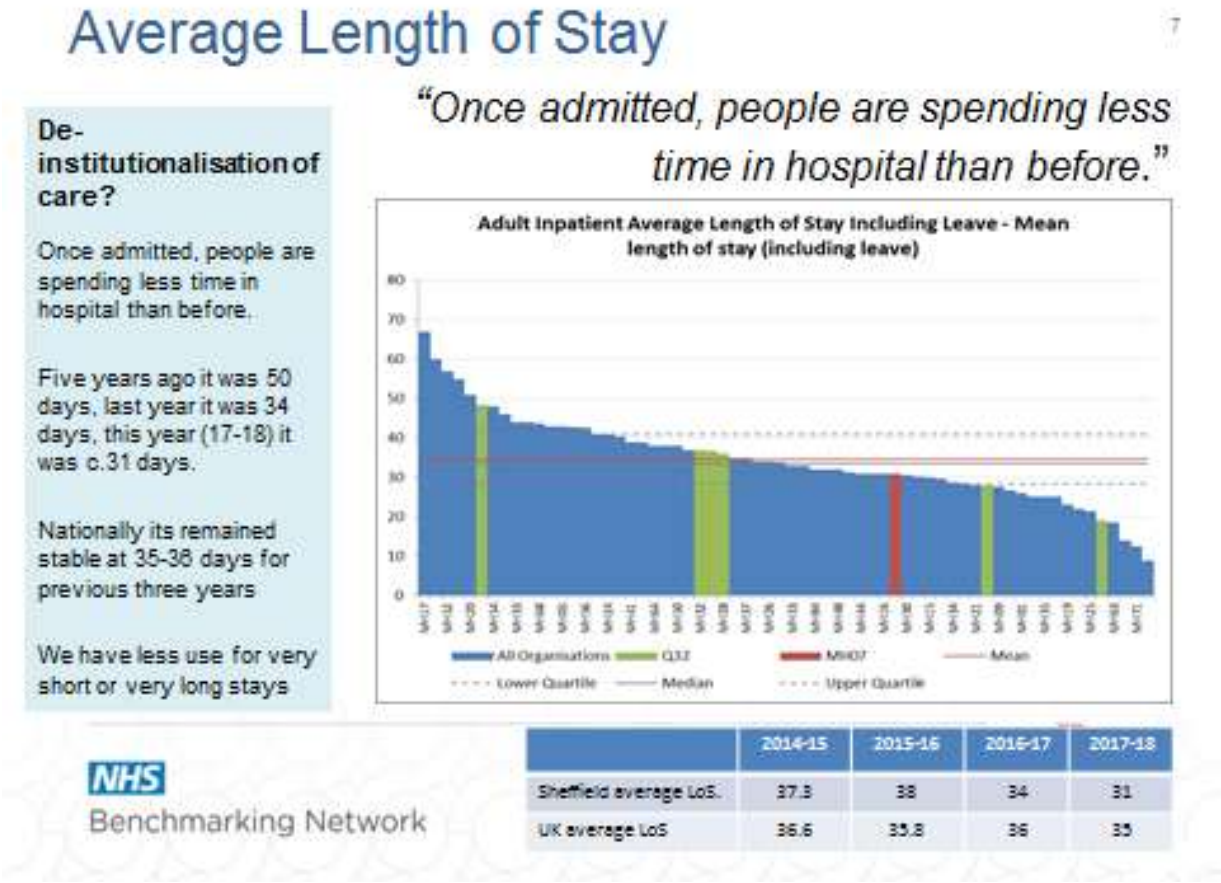
Last year, 2017-18 the rate of people being detained in Sheffield was in the middle range.

"People in Sheffield are detained at comparable rates to the national averages."



NHS Benchmarking Network

Data	2014-15	2015-16	2016-17	2017-18
No. of detained admissions	314	375	348	395
Sheffield per 100,000 pop.	70.9	84	78	89
UK per 100,000 pop.	67.6	74	74	75



Question from Kate Steele, Service User Governor

The primary focus when it comes to therapy in the Trust appears to be that of CBT. However, there are many other forms of therapy such as Transactional Analysis which have shown to be of great value. Can the Trust describe the range of psychological therapies that it provides and to whom, and whether it has plans to invest in more specialist therapies and the skilled workers needed to deliver them?

Response from Linda Wilkinson

Summary of Psychological Therapies
We employ a full range of Psychological practitioners that deliver a number of evidenced based therapies across a range of services within Sheffield Health and Social Care Trust.

Improving Access to Psychological Therapies (IAPT) and Health and Wellbeing Service
This service provides access to psychological therapies for people with mild to moderate difficulties with Anxiety, Depression, Obsessive Compulsive problems and Post Traumatic Stress Disorder.

We have been successful in obtaining national funding for the expansion of IAPT services over the last 18 months to provide psychological interventions for people with long-term health conditions across 10 condition specific pathways, for example, Chronic Pain, Irritable Bowel syndrome and Diabetes. They offer a range of psychological interventions which include:

Low Intensity Interventions offered by Psychological Wellbeing Practitioners (PWP):
1. Guided self-help (1-1 & in groups)
2. Psycho-education
3. Online computerised CBT (cCBT)

High Intensity Interventions are offered by staff with additional training as Cognitive Behavioural Psychotherapists and Counsellors. Sheffield IAPT has a substantial counselling workforce (which is comparable to the CBT workforce) and NICE recommended therapies within this bracket are non-CBT based and include Counselling for Depression, Dynamic Interpersonal Therapy and Interpersonal Therapy (IPT). We are investing in more staff training for IPT to expand what we can offer to service users with Long-Term Conditions as this way of working has a strong evidence base of being an effective intervention with this service user group. The range of therapies offered in this service includes:

- Counselling for Depression (CfD)
- Couples Therapy for Depression (CTfD)
- Interpersonal Therapy (IPT)
- Cognitive Behavioural Psychotherapy (CBT)
- Acceptance and Commitment Therapy (ACT)
- Mindfulness, Mindfulness Based Stress Reduction (MBSR) & Mindfulness Based Cognitive Therapy (MBCT)
- Eye movement desensitization and reprocessing (EMDR) for Post-Traumatic Stress Disorder (PTSD)
- Dynamic Interpersonal Therapy

Health & Wellbeing Clinical Psychologists
In addition to Counselling, CBT & the third wave therapies outlined above the Clinical Psychology staff have a wider remit and can also offer:

- Compassion Focussed Therapy (CFT)
- Cognitive Analytic Therapy (CAT)

The choice of modality and choice of delivery is designed to help people reach the right intervention for them.

Learning Disabilities Services: have Clinical Psychologists and Assistant Psychologists working as integrated members of the multidisciplinary teams with in the broader Inpatient and Community based teams across the Trust. They offer a range of adapted Psychological Therapies to meet the needs of the people who use the services and support family members this includes:

- Adapted CBT
- Mindfulness/ACT adapted approaches
- Psychodynamic
- Systemic work with families
- Cogintive Anyaltic Therapy informed approaches
- Psychoeducation
- Positive Behaviour Support including behavioural approaches

The key developments for Learning Disabilities Services have been around introducing models of positive behavioural support alongside working with all of the services that provide psychological interventions to enable psychological practitioners to adapt their practice to support people with a learning disability to access mainstream psychological services where this is appropriate to meet the persons needs.

Services for older adults: there are a range of services for older adults within the Trust including Dementia Care Pathways, services for people with complex mental & physical health needs within community and inpatient settings. Clinical Psychologists work into these services and offer a range of therapeutic interventions:

One to one talking treatments using :

- Cognitive Behavioural Psychotherapy (CBT)
- Acceptance and Commitment Therapy (ACT)
- Mindfulness
- Eye movement desensitization and reprocessing (EMDR)
- Compassion Focussed Therapy (CFT)
- Work with teams, care homes and family / carers when systemic interventions are required
- Carer support for families when there are complex needs
- Neuropsychological assessment
- Group work including -Overcoming worry group (12 week CBT based intervention for generalised anxiety disorder)
- Group work for Anxiety & depression management group (6 week CBT based intervention for anxiety &/or depression)
- Formulation sessions with staff for people who have complex needs (use a range of models for this including emotion focussed formulation)

There have been three main areas of development for the older adult psychological therapies staff, firstly employing staff who could deliver eye movement desensitization and reprocessing EMDR. Secondly successfully applying to Health Education England for additional monies to train a psychological with the advanced skills needed in Neuropsychological assessment. Thirdly the development of a clinical dashboard which tells staff about clinical outcomes which has helped to plan and deliver effective and efficient psychological services.

Adult Mental Health Services: the Trust offers a range of services for adults with complex mental health problems that require secondary mental health care and specialist services, for example, Eating Disorders, Specialist Psychotherapy and Early Intervention for Psychosis. There are a range of psychological practitioners integrated with services and teams including Clinical Psychologists**,** Cognitive Behavioural Psychotherapists, Psychodynamic Therapists, Cognitive Analytic Therapists, Perinatal Clinical Psychologists, Parent Infant Psychotherapist, Assistant Psychologists and Medical Psychotherapists employed by the Trust to deliver a range of therapies including:

- Cognitive Behavioural Psychotherapy (CBT)
- Acceptance and Commitment Therapy (ACT)
- Mindfulness
- Eye movement desensitization and reprocessing (EMDR)
- Compassion Focussed Therapy (CFT)

- Psychodynamic psychotherapy & Group Psychodynamic psychotherapy
- Cognitive Analytic Therapy (CAT)
- Systemic/ Family therapy
- Dialectical behavior therapy (DBT)
- Cognitive Behavioural Psychotherapy for Psychosis (CBTp)
- Formulation sessions with staff for people who have complex needs (use a range of models for this including emotion focussed formulation)
- Work with teams, inpatient wards and family / carers when systemic interventions are required
- Carer support for families when there are complex needs

The areas of development and additional training include Dialectical Behavior Therapy for people who are self-harming and struggling to regulate and manage emotions. Additional investments from Health Education England (HEE) to train 4 members of staff in eye movement desensitization and reprocessing (EMDR) to enhance the psychological interventions for people presenting with complex trauma within the recovery teams. HHE funding for 2 places this year for staff to train in Cognitive Analytic Therapy (CAT). We have received national monies to develop Perinatal Clinical Psychologists and Parent Infant Psychotherapist roles to support mothers, babies and the broader family interventions.

Glossary of Terms

Interpersonal Therapy (IPT) is a form of psychotherapy that focuses on the Service User and their relationships with other people. It's based on the idea that personal relationships are at the centre of psychological problems.

Acceptance and **Commitment Therapy** (ACT) is a unique empirically based psychological intervention that uses **acceptance** and mindfulness strategies, together with **commitment** and behavior change strategies, to increase psychological flexibility. ACT differs from CBT in that instead of challenging distressing thoughts by looking for evidence and coming up with a more rational response (CBT), in ACT, the thought is accepted as a thought, for example, "I'm having the thought that this boat is going to sink", and then defused using a variety of techniques, which may include mindfulness, metaphors and language.

ACT uses three broad categories of techniques: mindfulness, including being present in the moment and diffusion techniques; acceptance; and commitment to values-based living

Psychodynamic Psychotherapy draws on theories and practices of analytical psychology and psychoanalysis. It is a therapeutic process which helps service users understand and resolve their problems by increasing awareness of their often unconsciously based emotional and relationship problems both past and present. It differs from most other therapies in aiming for deep seated change in personality and emotional development.

Cognitive Analytic Therapy (CAT) is a form of time-limited psychotherapy. CAT is about forming a trusting, explorative and collaborative relationship with the therapist. It is a collaborative programme for looking at the way a person thinks, feels and acts, and the events and relationships that underlie these experiences (often from childhood or earlier in life).

It brings together ideas and understanding from different therapies including psychodynamic and Cognitive behavioural therapies.

Systemic/Family therapy looks to help members of a family understand each other better, change negative behaviours and resolve conflicts. Systemic/Family therapy gives families the chance to express and explore their feelings in a safe, non-judgemental environment.

Counselling is a process through which service users works with a trained Counsellor — in a safe, caring and confidential environment—to explore their feelings, beliefs, or behaviours, work through challenging or influential memories, identify aspects of their lives that they would like to.

Dynamic Interpersonal Therapy, or DIT, is a semi-structured, treatment protocol that has been primarily developed to work with depressed and anxious service users. This protocol for brief dynamic work is being rolled out nationally within the IAPT programme for work with depressed service users.

Compassion focused therapy (CFT) is a system of psychotherapy that integrates techniques from cognitive behavioral **therapy** with concepts from evolutionary psychology, social psychology, developmental psychology, Buddhist psychology, and neuroscience. Compassion focused therapy was developed to work with issues of shame and self-criticism. The CFT model complements and expands the traditional cognitive behavioral approach to human thought, emotion, and behaviour.

Eye movement desensitization and reprocessing (EMDR) is a distinct therapeutic approach which uses bilateral stimulation (of which eye movements can be an example) to aid the integration (processing) of distressing information. EMDR is commonly used to treat post-traumatic stress disorder (PTSD) and this is where the majority of the evidence base lies although there is emerging evidence of use with people experiencing psychosis.

Guided self-help is recommended by the National Institute for Health and Clinical Excellence (NICE) and is a Cognitive Behavioural Therapy (CBT) based approach for supporting people with mild to moderate anxiety, depression or stress. CBT is an evidence-based, problem focused method of changing the way people think, feel and behave.

Computerised CBT. cCBT is the name used for delivering Cognitive Behavioural Therapy (CBT) via computers, tablets and smart phones. Some people prefer using a computer rather than talking to a therapist about their private feelings. This intervention is monitored by Psychological Well being Practitioner via telephone contact to guide you and monitor progress.

Psycho-education is an evidence-based therapeutic intervention for Service Users and their families that provides information and support to better understand and cope with illness. Psycho-education is most often associated with serious mental illness, including dementia, schizophrenia, clinical depression, anxiety disorders, psychotic illnesses, eating disorders, personality disorders and autism, although the term has also been used for programs that address physical illnesses, such as cancer. Psycho-education offered to service users and family members teaches problem-solving and communication skills and provides education and resources in an empathetic and supportive environment.

Cognitive behavioural therapy is a psycho-social intervention that aims to improve mental health. CBT focuses on challenging and changing unhelpful cognitive distortions and behaviors, improving emotional regulation, and the development of personal coping strategies that target solving current problems. Originally, it was designed to treat depression, but its use has been expanded to include treatment of a number of mental health conditions, including anxiety.

Cognitive behavioural therapy for psychosis (CBTp) a person-centered, time limited, evidence-based therapy for psychosis carefully tailored to the individual through formulation (not a package intervention) and specific to psychosis.

Dialectical behavior therapy (DBT) is an evidence-based psychotherapy that began with efforts to treat people presenting with multi-problematic issues particularly suicidal women. DBT has been proven useful in treating mood disorders, suicidal ideation, and for change in behavioral patterns such as self-harm, and substance abuse. DBT evolved into process in which the therapist and client work with acceptance and change-oriented strategies. This approach is designed to help people increase their emotional and cognitive regulation by learning about the triggers that lead to reactive states and helping to assess which coping skills to apply in the sequence of events, thoughts, feelings, and behaviors to help avoid undesired reactions.

Psychodynamic Group Psychotherapy. A psychodynamic group is a long term group made up of people with similar types of problems, such as depression, general anxiety disorder etc. The purpose for joining this type of group is to learn how to cope with relationships while becoming self-aware through interactions with the group.

Question from Sue Roe, Carer Governor

In view of articles in the press can the Board reassure governors that they are doing all they can to stamp out the bullying culture that appears to be happening in the health sector as retaining and supporting staff is essential to enable them to give the care they are trained to do.

Response to be provided