Sheffield City Council

Sheffield Health and Social Care NHS
NHS Foundation Trust

Council of Governors: Summary Sheet

15 February 2018
Item No 7b

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

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:	February 2018

One question was submitted in January 2018

Question from Terry Proudfoot, Service User Governor

Having seen the incident regarding the possible domestic homicide of a service user in the performance report, I would like to ask: How does the Trust implement and monitor compliance with recommendation 6 of the NICE Guidelines on Domestic Violence?

Response from Giz Sangha, Deputy Chief Nurse

In addition to comprehensive safeguarding training provided by the Trust, which incorporates a domestic abuse element, the Trust has an Independent Domestic Violence Advocacy Service (IDVAS) providing direct briefings to community mental health teams and inpatient services in order to improve communication links and share lessons learned.

In addition multi-agency risk assessment conference (MARAC) briefings are given to staff (inpatients / community) as often the service user/s are involved with our services. The doctor's receive briefings on domestic abuse and awareness of adult family violence in their continued professional development sessions. The latter having been the subject of a recent domestic homicide review.

Follow on question from Terry Proudfoot submitted 5/2/18 – response outstanding

1. How much time is spent on Domestic Violence training for professionals?
2. Does this training include indicators of Domestic Violence and relevant questions for clinicians to ask of service users?
3. How frequent are the MARAC briefings and the CPD sessions with a Domestic Violence element?
4. Are all service users asked whether they have experienced Domestic Violence or abuse and seen alone if appropriate?
5. Are access (for professionals) to information on relevant local agencies regarding Domestic Violence and formal referral pathways for Domestic Violence enshrined in policy?"

Two governors submitted questions for the February 2018 Board of Directors.

Question from Adam Butcher, Service User Governor

During this period of winter pressures, how assured can the Trust be that there are sufficient inpatient beds with the right numbers and mix of staff to ensure the safety of patients?

Response from Richard Bulmer, Associate Director

The question about the right number of inpatient beds in Sheffield has been reviewed methodically as part of the redesign of acute care in Sheffield. This work has modelled the number of admissions into acute care and the average length of stay patients require to support their on-going treatment in the community. The design of the acute care system

also takes into account the capacity of intensive home treatment to support people in acute crisis at home rather than admitting to hospital where appropriate.

The acute care system also manages proactively a crisis house as an alternative to hospital admission and step down beds at Wainwright Crescent that provides a safe alternative to inpatient care when patients no longer require inpatient care but require a social care alternative.

There is a weekly meeting of senior clinical leaders from the acute care system that supports the flow of patients through the inpatient system. This meeting is able to identify problems with obstacles to discharge and proactively support resolution of these issues.

The staffing establishment on the wards has been agreed by board. The level of staffing was agreed with the involvement of clinicians to be able to manage effective treatment. A staffing update is a specific report that is considered by Trust board. This identifies staffing levels across the inpatient system and identifies any areas of concern.

There have been no patients placed out of city because of lack of beds for over three years. This is in contrast to other areas where patients are placed out of city.

Note: Adam Butcher and Richard Bulmer will meet to discuss this further

Question from Billie Critchlow, Carer Governor

Is the Trust taking all the necessary steps to assure themselves that the care of patients, especially those under the new community teams, is in keeping with the Trust's values?

What evidence is there that caseloads and waiting times are being benchmarked against national standards and that these are maintained during the reconfiguration process and will be sustainable into the future.

What evidence is there that all practice, especially in community teams, is currently safe? How is this evidence collected and collated?

Is the Board assured that they have received, and will continue to receive, a comprehensive account of service user and carer and staff experiences, now and over the coming months and years? Is the board satisfied that that it is receiving the best information?

Response from Richard Bulmer, Associate Director

Thank you for your question for the February Board.

The care of patients in the community teams is in line with the trust values. This is assured in a number of ways.

All staff are recruited using the values based recruitment system. Most recently the senior operational management has undergone a process where the senior managers were interviewed. The interview panels included service user representation. The process included value based interviews, group activity and an exercise that were designed to test the candidates against the trust values. All senior operational managers will have

development plans based on the feedback from this process. This values based recruitment is established for all posts in clinical services.

All staff in community teams have regular clinical supervision. This is a place to explore clinical practice to ensure it is in line with best practice and the trust values. The trust has invested in training for staff to give assurance of the quality of the supervision. A new system of recording has been established for supervision which will support audit of practice.

Collaborative Care Plans are being introduced for all service users. This will support recovery practice and is in line with the trust values. Clinical staff will be attending the training that is jointly led by service users. Collaborative Care planning is the foundation of good quality care for service users.
The trust is supporting staff to have reflective space to consider both the changes and the challenges of providing good quality care. Teams are being supported to have away days to consider practice development and best practice.

The new clinical directorate structure has been developed to support clinical practice. The structure supports two clinical networks with strong multi-disciplinary leadership that feeds through the Trust governance structures to support assurance from clinical team to board. All clinical teams have senior operational managers working alongside senior clinicians to support best practice.

Caseloads in community teams are being managed through senior practitioners that assess the needs of the service users and the capacity of the clinicians delivering the service. The trust is part of an annual benchmarking exercise that is reported into the board. There are a number of performance measures that are reported into board that consider the performance of community teams. These include data about annual reviews of care plans, 7 day follow-up after discharge from hospital and access to services. The development of the new model of delivery of community services included detailed modelling to ensure that the services can deliver care in line with standards that have been developed for community teams.

During the reconfiguration process senior clinicians have been appointed to manage the mobilisation of the changes. These posts have developed in collaboration with clinical teams operating procedures that will ensure sustainability of the services into the future.

The safety of the practice is being monitored at different levels in the trust that feed into the board. All teams have a detailed risk register that feed upwards to highlight risks to board. The Trust Service User Safety Group, chaired by the Medical Director reviews safety standards for services. This includes deep dives into clinical services every month where the group looks into issues within clinical teams. This includes reviewing a range of indicators including complaints and incidents. The number of incidents are tracked on a monthly basis and correlated against individual teams. Thematic reviews of incidents and complaints have considered teams that are outliers and require further exploration to consider issues related to safety of care.

Clinical services are being supported to apply for national accreditation where this is a possibility. The home treatment service has received national accreditation. National accreditation offers an opportunity for services to benchmark against other services and assure the quality of care against best practice.

In addition to the above assurances that the board receives, the Chief Operations Director and Medical Director provide executive leadership on clinical services and safety.