6 December 2018
Item No 5b

Sheffield Health and Social Care NHS Foundation Trust

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:	November 2018

Question from Toby Morgan, Service User (July 2018)

It is not uncommon for some service users, due to their mental health, to forget to take medication which can result in them having an excess of medication in their homes. On top of this, repeat prescriptions often provide 2 months' of medication at a time which can add to the excess. This can ultimately lead to people taking out of date medication, or worse, having a large amount of medication available at a time when they may have suicidal thoughts. Can the Trust detail any procedures that are in place to both identify and reduce the risk to service users who may find themselves in such a situation?

Response from Chief Pharmacist, Abiola Allinson

Leave/Discharge/Out-Patient Prescribing

The routine quantity of medication to be supplied on discharge and outpatient prescriptions will be one months' supply (a patient pack). However, the prescriber must use his or her clinical judgement in deciding the appropriate quantity of medication to be handed to a patient, for example patients who are considered at risk of self-harm or have previous episodes of self-harm should only be prescribed limited quantities of medication (e.g. no more than 7 to 14 days or less). In most cases for periods of short term leave - a full patient pack (28 days) would not normally be considered appropriate.

Guidelines on Prescribing

General Practitioners in Sheffield and the Primary Care Trusts would expect patients to be discharged with one months' supply of medication.

From the Clover Group GP SOP (Standard Operating Procedure); repeat prescriptions should be preferably 28 days or multiples thereof to coincide with calendar packs. There is a caveat that shorter prescriptions entail more work and longer prescriptions risk waste and are less controlled.

Medication supplied from the Trust will usually have a long expiry date. If medication to be provided has a shorter expiry date, then there is clear information on the supply stating a do not use after date.

From a Trust perspective we have quite clear procedures in place to limit supply dependent on identified risks.

As part of medicines optimisation and partnership working, it is key that service users work closely with their Care coordinators, CMHT and the pharmacy team to address any issues with medication adherence and to support with removal of any excess medication they have available.

Question from Jules Jones, Public/Lead Governor (July 2018)

1. What are the Executives doing to tackle the 51 week waiting list for a first appointment at the Gender Identity Clinic (Porterbrook)?

2. How are the NEDS holding the Executives to account on this issue?

Response from Jayne Brown OBE, Trust Chair

Thank you very much for your questions sent on 18th July 2018 which were two-fold.

1. What are the Execs doing to tackle the 51 week waiting list for a first appointment at the Gender Identity Clinic (Porterbrook)?
2. How are the NEDs holding the Execs to account on this issue?

Please find below a comprehensive response to your first question which was produced by Mark Parker, the Deputy Associate Director of the Scheduled and Planned Care Network where the GIC sits, and which has been assured by Clive Clarke.

In terms of your second question, at the last Council meeting I informed governors that I had met with Kevan to discuss this matter and to question the actions which the Trust is taking to address the issue. This includes discussions with NHS England who is the commissioning body for this service and who determines the level of service that can be provided based on the contract value.

Whilst it is acknowledged that the waiting time is far from acceptable not only in Sheffield but in all areas where this specialist service is provided, I am assured from the information provided and discussion undertaken with executive colleagues, that once a person is within the service, they are very satisfied with the service they receive. However, the NEDs will continue to seek assurance on this matter through their scrutiny of the Trust's performance.

Additionally, I intend to ask for a Board presentation on this and other smaller services before Christmas so that the matter can be scrutinised further.

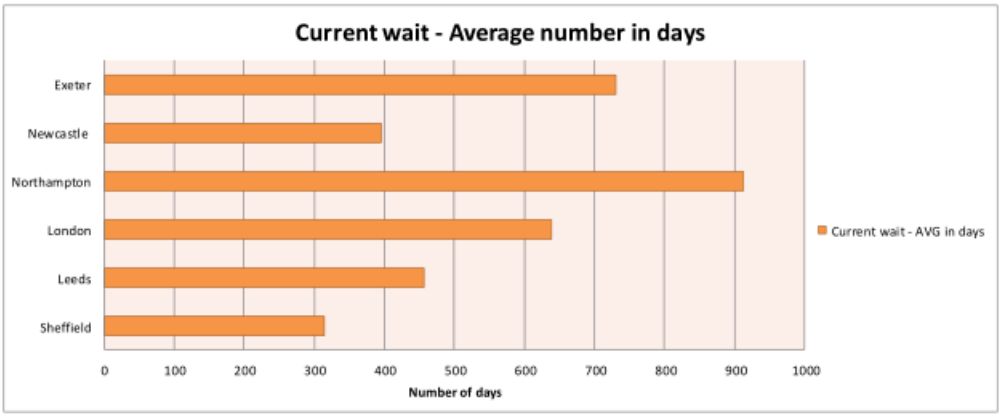
Yours, Jayne Brown

Current Sheffield vs National Waiting Times

The current waiting time for Sheffield is **314 days** (45 weeks) from referral to assessment.

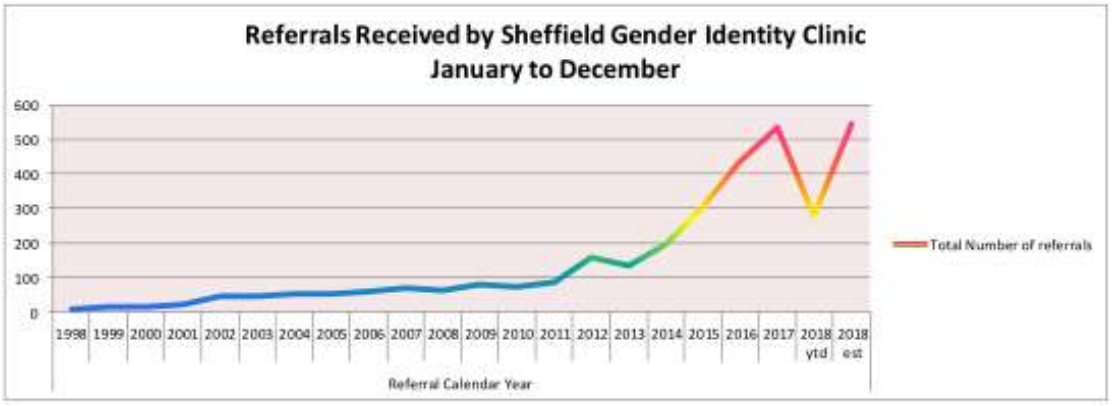
National data for other specialist providers is inconsistently reported. Of the 6 other providers, some post waiting times on their websites, whilst other do not. Sheffield does post this information which is regularly updated on a monthly basis.

National waiting times are given below for services that either posted information directly, or where there was recent data on the internet that had been released via FoI requests.



Referrals to Sheffield GIC

The number of referrals to the Sheffield GIC has grown exponentially in the last 4 years from just over 100 in 2013 to over **500** by the end of 17/18. Current referral rates for the year 18/19 are expected to exceed these. The contract was renegotiated in 2014 when NHS England first recognised the requirement for a national service specification and the need to increase frontline resources to meet growing demand and address the waiting list. At that time, Sheffield calculated the resources and operational model required to meet a referral rate of 172 p.a. Current referral rates are running at 3 times that contracted number. The demographic is also changing with a significant lowering of the average age seeking the help of the clinic, and an increase in the presentation of non-binary issues.



Actions being taken by Sheffield GIC to address demand

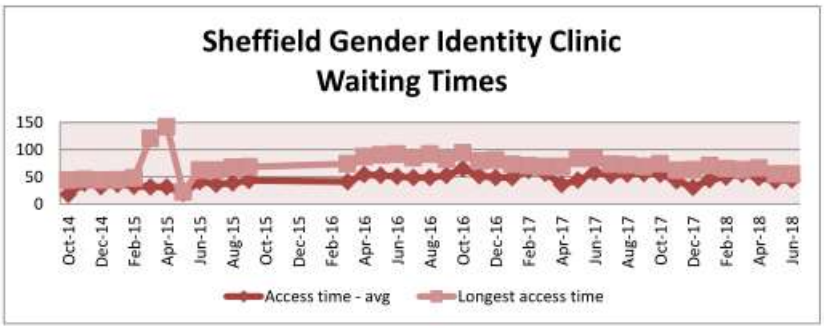
Since 2014, the Sheffield GIC has taken significant actions to try and increase service efficiencies in response to the challenges presented by the requirements for a national specification and the growing demand on limited resources. Actions include:

- Inviting all patients on the waiting list to an all-day, pre-assessment workshop that gives information on support networks and information to support ‘active’ waiting.

- Employing someone with lived experience of gender dysphoria as a peer support worker to support people on the waiting list.

- Changing operational procedures in line with the recommendations of the national specification. This includes halving the amount of time and sessions spent in assessment. This means that the clinical team attempts to offer first assessments to

TWICE the number of people than we are contracted to see on a monthly basis. The impact of this is demonstrated in the graph below that shows the waiting time remaining stable despite the threefold increase in demand. While we recognise that this is an unacceptable waiting period, the operational changes that we are making show how we are can mitigate some of the risks in the face of increasing demand and very limited resource.



- Operating a recruitment policy that seeks to employ professional staff that can flex to help meet demand across assessment and intervention pathways and move people through the system. Recruitment is slow due to the scarcity of professionals with a specialism in gender dysphoria.

- Working with primary care to lead on hormone prescription and monitoring to release specialist medical staff within the GIC to undertake other duties.

- Working with other providers and non-statutory bodies to increase support within communities and reduce the reliance on specialist services.

Assurances to Board

- Strong management team in place with a Clinical Lead, Business and Performance Manager, Senior Operational Manager and Deputy Director all with active roles at local and national levels

- Report and monitoring through Business Planning Group regarding commissioning intent for service.

- Project Charter to be monitored through the Clinical Network Change and Improvement Meeting

- Close working relationship with Trust Contract management team and local specialist commissioner

- Quarterly Performance review of service with Associate Director and Associate Clinical Director

Question from Adam Butcher, Service User Governor (August 2018)

What is the Board doing to make sure that we are ready for the next five year plan for the NHS and Mental Health?

Response from Jason Rowlands, Director of Strategy & Planning

Each year the Board reviews its plans to ensure they continue to support our strategy, and that our strategy remains relevant to the communities we serve. Through this work the Board reviews progress made, the changing needs of local health and social care services and national policy and developing priorities for the future. This provides the Board with the framework to review the next stages of the Mental Health Five Year Forward View, the developing Long Term Plan for the NHS and the opportunities and challenges for the provision of mental health services in the future. The Board would obviously also review related implications for the other key services we provide in addition to mental health.

This work starts in September 2018 and the Board will consider the implications in Board Development sessions, Board meetings and in its work with the Governors and other partners as part of the Sheffield Accountable Care Partnership. Updated plans, informed by this review, will be scheduled for Board consideration through January and February 2019.

While plans are formally updated each year, the Board continues to review developments in national policy throughout the year. This may either be as key strategic items or briefings to the Board of Directors in its formal meetings, or through dedicated Board Development time which supports the Board to consider in more detail key developments. As the Long Term plan for the NHS is developed the Board will use this time to consider identified key issues and how the Trust needs to evolve its strategic plans and direction.

Question from Michael Thomas, Young Service User/Carer Governor (August 2018)

With reference to the Trust's Estates Strategy (2017-2022), is the Board still considering the sale of St George's Community Health Centre and if so, what are the anticipated budgetary benefits and timescales? Should the Board make the decision to sell St George's, what options are available in terms of relocating the services currently based there?

Response from Helen Payne, Director of Facilities

The Trust is still considering sale of St. Georges Community Centre. This is a building which requires considerable expenditure on backlog maintenance to bring it up to an acceptable standard from which to operate our clinical services. This requirement is in the region of £0.5M, much of which relates to a need to completely refurbish the roof, as well as replacing all the windows. The roof is in a very poor state of repair as evidenced by various leaks into parts of the building in periods of inclement weather. Due to the design of the building and the layout of the site, it is particularly expensive to access and repair. Thus the main budgetary benefit is avoidance of expenditure that would be better spent on front line clinical services.

There may be additional budgetary benefit by moving services into a more modern building which has lower operational costs such as reduced expenditure on heating and lighting.

An extensive scoping exercise will commence at the beginning of September to review and refresh the property requirements for all Trust non bed-based services (aside from those being addressed via the ACR Phase 2 and Fulwood House projects); it is anticipated

this will take in the region of 6 months to undertake and for recommendations to be made. This will include consideration of all services currently based at St. Georges. There will be discussion and consultation with the various service managers to ensure service and service user needs are correctly taken into account.

Until the scoping exercise has been completed and recommendations made, it is difficult to say what options may be available in terms of relocating services currently based at St. Georges. However the range of options to be considered is expected to include other current Trust sites; new sites (available to either lease or purchase); co-locating with other Public Sector organisations such as other NHS Trusts or the Local Authority.

Question from Joan Toy, Service User Governor (September 2018)

I have recently witnessed a family member who was an inpatient on an adult ward with a lighter in their room. This obviously has fire safety ramifications for the Trust. I understand that the Trust's Smoke Free and Nicotine Management policy identifies lighters and smoking paraphernalia as prohibited and I would therefore like to ask the Board how it receives assurance that these items are being identified and are held in safekeeping when a service user is admitted and throughout their stay.

Response from Clive Clarke

In your question you said "I have recently witnessed a family member who was an inpatient on an adult ward with a lighter in their room. This obviously has fire safety ramifications for the Trust. I understand that the Trust's Smoke Free and Nicotine Management policy identifies lighters and smoking paraphernalia as prohibited and I would therefore like to ask the Board how it receives assurance that these items are being identified and are held in safekeeping when a service user is admitted and throughout their stay."

A response has been provided by Lisa Johnson, Deputy Director and which has been quality assured by Clive Clarke, Deputy Chief Executive and is as follows.

Acute ward specific
Inpatient acute wards are finding smoke free implementation challenging.

In terms of managing lighters staff ask all service users to hand in any prohibited items on admission and have posters on display and leaflets to support this.

For the acute wards (not PICU) all service users are not searched on admission unless there is a very good reason to do so which means handing in lighters is dependent upon the service users.

Staff continually advise service users on the smoke free policy and the requirement to hand in lighters, but this is currently proving challenging as there is a real reluctance on the part of service users to do this. In addition there are many cases where family and visitors replace lighters which have been taken and stored by staff.

Following some learning events and reviews, the Trust is working with the Smoke Free Team to revisit the Trust's plan of action and how this issue can be tackled without service users feeling that they have no choice.

The Trust would remind visitors and friends and family they can report someone having a lighter or anything else that may cause harm to staff or service users.

Trust wide approach to Smoke free
A programme of work is underway to support acute wards including the following:

- A regional event entitled 'Pausing for Breath: challenges of implementing smoke free mental health inpatient wards and working together the find solutions' was held June 7th, hosted by SHSC
- A 'Pausing for Breath Away Day' was held in July 2018 forward and senior managers, as the regional event clashed with the CQC unannounced inspection on acute wards.
- A training day for the Trust Respect Practitioner team was held in April 2018
- The scope and potential to increase access to electronic cigarettes for people on acute inpatient wards is under active consideration
- The Trust is participating in a Yorkshire and Humber and North East Mental Health Trusts 'Smoke Free and Smoking Cessation Free Task and Finish Group', where we are working with colleagues to share approaches to successfully addressing the challenges for acute wards.

Governance arrangements
Implementation of smoke free and general ward safety is monitored and managed through governance processes locally on wards and in Clinical Operations. The risk management is overseen by the Directorate and Trust Board. The implementation and challenges of smoke free are managed through the Service User Safety Group. There is work ongoing with colleagues within the Facilities Directorate in terms of fire and environmental safety.

Next steps
A member of the Crisis and Emergency Senior Management Team and the Trust Smoke Free and Nicotine Management Lead would be happy to attend a Governors Meeting to update and discuss further with Trust Governors if so desired.

Question from Jules Jones, Public Governor (October 2018)

1) What are NEDS going to do to improve the organisation following the CQC judging the Trust as 'requires Improvement' in the 'well-led' domain?

2) Do NEDS feel that they have the capacity to improve in the 'well-led' domain?

3) Insight and forward planning: Prior to CQC coming in, what level of understanding did NEDS have of the issues which eventually led to a judgement of 'requires improvement' on how 'well led' the organisation is? How insightful would NEDS say that they were of the potential for downgrading 'well-led'?

Question from Dr Nusrat Mir, Staff Governor (October 2018)

Can the Board reassure governors that they have a robust action plan in place to deal with the recent downgrading of the Trust's CQC rating? We would like some specific details of how it plans to ensure that the Trust is safe and well led?

Response to Dr Mir and Jules Jones' questions answered in the Council of Governors meeting of 18 October 2018

Question from Jules Jones, Lead Governor to NEDs (October 2018)

1) What are your top 10 non-pay spends and how do these prices compare to the best quartile in this region? *(Could include comparison to acute Trusts where there is a similar type of spend e.g. PFI finance or building work etc).*

2) What is your expenditure on outside consultants, 'facilitators', paid mentors and the like (if not included in the above top 10), how does this price compare to the best quartile in this region?

3) How has expenditure on outside consultants etc changed over the last 5 years?

4) How have NEDS interrogated this data? What has changed as a result of NEDS interrogating this data?

Response outstanding