26 April 2018
Item No 6b

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:	April 2018

Follow on question from Terry Proudfoot submitted 5/2/18

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?"

Response from Giz Sangha, Deputy Chief Nurse

1. During the Comprehensive Safeguarding Mandatory Training day the Domestic Abuse session takes 60 and 75 minutes. The time allocated for Domestic Violence was increased from previous sessions to include Adult Family Violence (which is a new concept to many people).

   The safeguarding team encourage staff to seek out and further attend specific training from the Sheffield Drug and Alcohol/*Domestic Abuse Coordination Team (*DACT) and information as to how to access this course is given to staff.

2. The training does include indicators of Domestic Abuse and relevant questions for professionals to ask.

3. The MARAC briefings are shared with individual teams following meetings and in the Single Point of Access. There are two CPD sessions per year for doctors, of one which focuses on Domestic Abuse and Adult Family Violence.
4. In both the Core Mandatory Training and in the briefings we state that the questions must be asked about Domestic Abuse (DA), (there is already a question regarding abuse in the Initial Assessment which is a requirement so it's more of a reminder that DA should be a specific ask).

   Service users are encouraged to see staff without others present; this can also be discreetly facilitated proactively by staff if they feel a person is at risk.

5. The Policy does incorporate relevant agencies that can be contacted for support / advice and referral pathways.

Question from Liz Donaghy, Public Governor

I have recently had a discussion with a Board member of the Manor and Castle Development Trust. Concern was expressed about the increase of service users with significant mental health issues. There appears to be confusion in this organisation about service reconfiguration, in particular the future of Eastglade and the single point of

access. Therefore, what steps have been taken by the Trust to try to keep the many third sector organisations who provide valuable support to service users, up to date with changes?

Response from Deborah Cundey, Service Development Manager

Manor and Castle Development are on the email distribution list for our stakeholder Comms. In terms of reconfiguration they have received:

20 December 2017 – News for Partners (second edition of our quarterly newsletter to partner organisations and stakeholders) which included a feature on reconfiguration and a link to the pages on our website for further information

01 February 2018 – Stakeholder briefing sent along with poster for service user drop in sessions

07 February 2018 – clarification of how to contact SPA sent (i.e. telephone number, fax, email) along with information on what SPA is/does

The email distribution list for stakeholder Comms includes lots of third sector organisations such as SYHA, Sheffield MIND, Carers in Sheffield, Healthwatch Sheffield etc as well as CCG, SCC, other NHS Trusts in the region, Police, Universities etc.

Questions from Billie Critchlow, Carer Governor

1. How many service users now have Care Co-ordinators with caseloads that are significantly higher that their previous Care Co-ordinators?
2. How many service users have been told that their existing care plans are unsustainable?
3. How do current clients under outreach care plans benchmark against national standards regarding the amount of contact time they receive?

Response from Clive Clarke

1. The Trust confirms the average caseload for care co-ordinators in the newly reconfigured adult recovery service is currently greater than it was in the previous model when there were five community teams. However, the service is in the early stages of implementing a caseload management and enhanced support process that will ensure that service users continue to receive the appropriate level of support at the required intervals in line with care plans.

   The model is based on the experience of the Trust that care and support needs fluctuate in the sense that some individuals require an assertive approach for a number of weeks, while others require this approach for a significantly longer period of time. The previous model had a small, fixed number of service users who had access to assertive outreach; the new model seeks through the enhanced support function to provide greater flexibility in providing an increased level of support to more individuals at the point at which they most require it.

   Similarly, there are a larger group of service users who are well supported by a consistent but less frequent level of contact. This is the case management function that will have a high number of service users who are monitored and who will be in

contact with a small group of staff. It is a model that is widely used in many other Trusts around the country and it evaluates positively with staff and service users alike.

The Trust has planned to gather data to evaluate the impact on those service users previously supported by SORT via the old model – this will take place over a six month period from February 2018 and will make a comparison with the same period in February 2017. This will compare all health and social care activity provided in terms of contact with mental health professionals alongside the number of in-patient admissions and contact with Crisis and Home Treatment services as indicators of any deterioration in mental health.

2. The Trust is not aware of any service users being told that their existing care plans are unsustainable. The Trust and its community teams are working extremely hard to implement the new model to ensure that all care plans are sustainable. All care plans are reviewed regularly and agreed based on need, the new structure being utilised in order to manage the required need. On-going review and collaboration with service users will underpin the success of the new model.

3. Initial benchmarking suggests that the Trust compares favourably with national benchmarking data. However, further analysis is taking place and as additional data is generated over a longer period of time, this will provide an enhanced understanding of the evolving position

Question from Adam Butcher, Service User Governor

How is the Trust ensuring that service users supported in the CMHTs have a clear understanding of the new clinical structures within the service so that they understand who to approach if they have any concerns about the service they are receiving?

Response from Clive Clarke

I can confirm that existing systems for expressing concerns or worries are still available to service users. These include Fast track compliments and complaint forms which are all available at:

- Our bases
- On our website at https://shsc.nhs.uk/about-us/corporate-information/complaints/
- Via care coordinators

As part of the mobilisation process we have also sent out regular communications to service users updating them on progress and provided a dedicated email box AMHCR@shsc.nhs.uk that has been used by many service users and is still monitored.

Additionally, drop-in sessions have been held in each of the bases and in central locations so that service users could raise general and individual concerns and a mail out to around 300 service users was sent describing the new case management system and how to contact the service regarding this.

As part of the way forward, the Trust will be developing information leaflets for the new services which will describe the services on offer and which will also provide contact details for raising concerns.

Question from Terry Proudfoot, Service User Governor

1. The general data protection regulation will apply in the UK from May 2018. How is the Board assured that the Trust is fully prepared for this?

2. Is the Board confident that the Trust has a high standard of cyber security and is protected against future cyber attacks on the NHS?

3. Has the Trust got a policy to address the gender pay gap, and is it yielding results?

Response to question 1 from Phillip Easthope, Executive Director of Finance

Following a recent Audit Review, the Trust has an action plan in place to meet the relevant deadlines. This action plan is being managed through the Executive Directors' Group.

Response to question 2 from Phillip Easthope, Executive Director of Finance
As governors will appreciate this is very much a live threat in a fast changing environment where hackers are continuously trying to penetrate security measures that are utilised by the trust (this is not to say that the Trust is continuously under attack). As such this environment continues to be risk assessed and the Trust will respond according to those assessments with any actions deemed necessary. With reference to the recent attacks the trust was well placed to respond to the threats due to the investments made in this area and we continue to deploy the latest security and software to protect information. As new security measures become available these will be assessed and adopted as appropriate.

Response to question 3 from Dean Wilson, Director of HR

The Trust has not yet reported on the Gender Pay Gap (though this is planned for 8 March 2018) along with all other Yorkshire and Humber Trusts. We will review the outcomes of the Gender Pay Gap reporting going forward with a view to what response may be required. Realistically it is too soon to say whether anything the Trust has done is 'yielding results'.

I believe this may be an item at the March Board.

Question from Maggie Young, AHP Staff Governor

We heard at the Council of Governors Meeting on 15/2/18 about the problems in recruiting qualified Nursing staff.

I am aware that Occupational Therapists have been recruited to work alongside Nurses in a new role Mental Health Practitioner. Please can the Board explain why Nursing Vacancies in the Community Mental Health Teams including Recovery Teams, Home Treatment Teams and Emotional Wellbeing Teams can't be filled by Occupational Therapists who have a lot of relevant skills to offer to the CMHTs?

There is no reason why OT's should not be Care Co-ordinators and although I appreciate that a large percentage of positions do need to be filled by Nursing staff, please could the Board consider whether at least a percentage of the positions should be opened to qualified OTs?"

Response from nursing colleagues and Julie Edwards, Director of Therapy Services

In relation to Community Recovery Teams; staff feel this could be an option if the issue of administering medication as sometimes this is urgent and in particular regular depot injection management which falls to nurses has proper consideration. Often if depot / medication is needed and the service user is on a nurse caseload there are no issues. If they are on a non-nurse caseload this often falls to nurses on **duty** or **added duties** to nurses which is not necessary reflected in their caseload management and can be risky to give medication to service users you are unfamiliar with.

Regarding inpatients: this is in pilot and Noelle Riggott, Occupational Therapist, will be doing a formal evaluation. Which is due to be completed in the next few weeks and this would give us some valuable learning information. Anecdotally the two posts are going well & MDT feels they are beneficial and improve care offers.

Either way both parties feel it would be a good way forward and improve service user treatment offers. The suggestion is to consider if service users could be moved to other professionals once stable so they themselves see they are improving and getting on with their lives

Response from Julie Edwards:

My thoughts are as follows

1. Having worked in a community mental health team myself many years ago and having talked to our current OT staff I think it is worth looking at opening up adverts to other professionals than nurses given the current shortfalls. There are a lot of shared and common skills as well as the unique ones that could be really useful given the pressures in teams.

2. We are currently trialling OTs as mental health practitioners on our acute inpatient wards and this is so far positive so it would be good to apply similar principles in our community teams.

3. Given that there are no OT staff currently in the home treatment team, which is a key gap and we now find referrals being made into the other services for OT which is adding to pressures in those other teams then this would be a good place to trial.

Question from Toby Morgan, Service User Governor

In relation to the CMHT reconfiguration, has the Board considered moving from the title of Care Coordinator to that of Case Manager? I ask because I am involved with the Sheffield Integrated Personal Commissioning Group and have gained insight into that certain role's title/terminology and the fact that within service delivery it can sometimes unintentionally become limiting. Also, many Care Coordinators primarily function in the capacity of a social worker or CPN. A Case Manager opens the door to introducing other experienced workers such as OT's and even experienced Support Workers. I would encourage the Board give serious consideration to this.

Response from Paul Nicholson, Deputy Director on behalf of Clive Clarke

I agree the Trust can be more explicit about case management and care coordination.

There a more fundamental answer though ... The Care Programme Approach is the nationally agreed framework for effective mental health care for people with severe mental health problems. One of its key requirements is - *The appointment of a 'care co-ordinator' to keep in close touch with the service user, and to monitor and co-ordinate care.*

The term ‘Case Manager’ particularity in the local authority is something completely different and refers to someone that has a limited responsibility and intervention for a large number of service users

It would be confusing to all around if we were to move away national terminology. On a local level, I do think given the scale of change teams and workers have just been exposed to, now is probably not the time to be changing the name of workers.