Sheffield City Council

NHS 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:	July 2018

Question from Billie Critchlow, Carer Governor

1. What is the number of ex-SORT service users who have been told their care plans cannot be sustained?

As a consequence Community Mental Health Team (CMHT) reconfiguration, no service users have been advised that their "care plans cannot be sustained", but as part of the routine process of recovery, care plans are reviewed on a regular basis and, in line with changing needs, may be revised. This is part of the recovery programme that fosters and promotes independence and personal decision making within a managed framework.

The teams have been working hard to transfer clients to new care-coordinators. We can confirm that safe transition of SORT clients has taken place and all clients have Care Co-ordinators in the new Recovery Teams. The Senior Practitioners in the teams will provide supervision, support and review of caseloads in order to establish the client needs. Where additional support is needed that cannot be provided by the care co-ordinator, this will be provided by the enhanced support function of the Recovery Teams.

2. **Size of the caseloads of the new Care Co-Coordinators which the ex-sort clients have been assigned?**

The caseloads vary for care co-ordinators. This will depend on the needs of the individuals on the caseload. While there is no figure for what a caseload should be, we are working to caseloads of approximately 40 people. Some of these people will have enhanced needs that will require more assertive involvement and some will be managed in a supportive manner that does not require the same level of care co-ordinator involvement.

We do not anticipate that there will be any reduction in care that will impact on service users. As detailed above, where additional support is required, clients will move in and out of the enhanced support function. The enhanced support function will be able to provide a more frequent and intensive level of support for short periods when clients are in crisis or have additional needs that care coordinators cannot meet though scheduled planned work.

3. How the Trust compares with national benchmarking for assertive outreach clients with regard to the level of input?

Benchmarking data is available for the 2016-17 year. This is pre the recent CMHT reconfiguration.

How many people are on the caseload – similar to the national averages

On the 31st March 2017 we reported that 153 people were on the caseload of the Assertive Outreach service

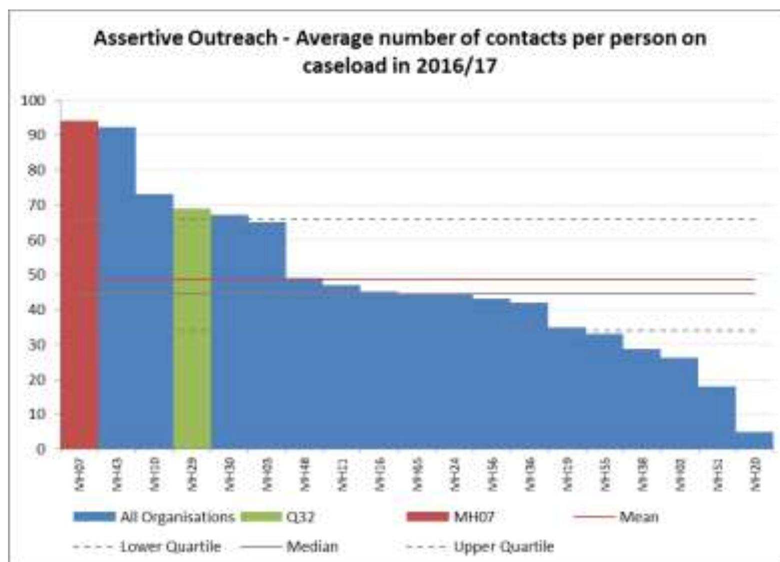
- Total number of people on the caseload on the 31st March 2017 per 100,000 weighted population
- Sheffield – 34 people
- National average – 33 people

99% of the people on the caseload in Sheffield were on CPA, compared to a national average of 90%

How often did people have contact with the service – people had the most contact in Sheffield

The average number of contacts per person during 2016-17 was 94 contacts per person on the caseload. The national average was 49. This includes face to face and non face-to-face activity.

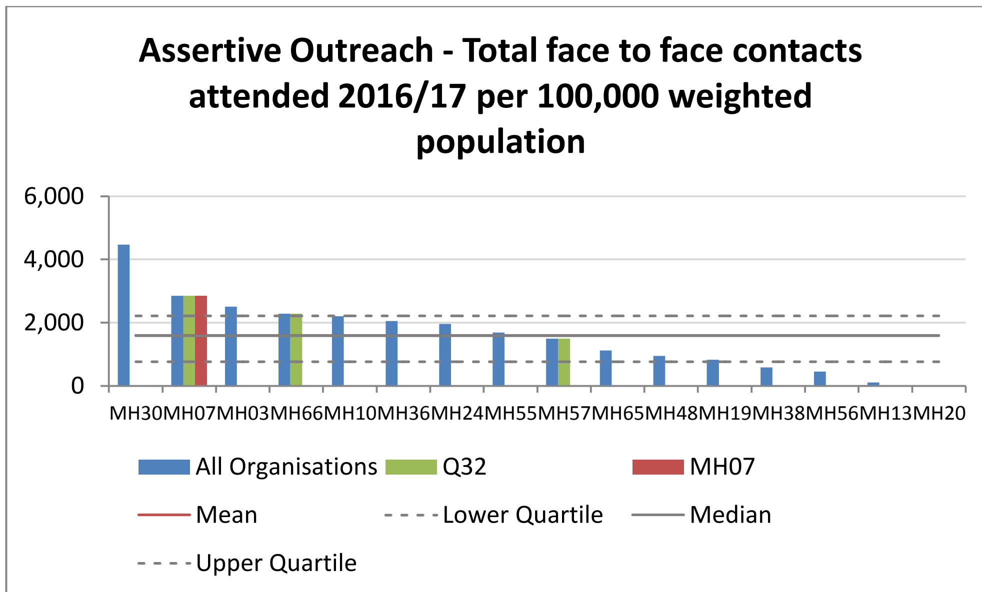
On average the 153 people on the caseload of the Sheffield service each had 94 contacts during the 2016-17 year. This was the highest rate of contacts within the benchmarking set. See graph below (we are the red bar), note the sample size in the graph is 19 organisations, including Sheffield.



The total number of face to face contacts in Sheffield is also very high.

The benchmarking tool does not allow you to compare face-to-face activity or non face-to-face activity separately against the numbers of people on the caseload. So the above graph can't be broken down to show face to face and non face-to-face.

It is possible to compare our face-to-face activity against the local population (weighted). This shows that compared to the size of the Sheffield population (weighted), there is a lot more face-to-face activity happening for people in Sheffield receiving Assertive Outreach services than elsewhere.



So in conclusion

In Sheffield we have the same numbers of people receiving Assertive Outreach care than the national average, but the people in Sheffield have the highest rates of contact with the service, and within this, high rates of face-to-face contact.

4. The number of Did Not Attends (DNAs) from the implementation date of the re-configured CMHT model?

The community model does not readily report DNA's as this is typically an outpatient model whereas the Community teams seek to engage and deliver care in different ways such as home visits or other community based support.

Question received from a number of governors

A question was received which contained personal information and made a number of allegations. The Trust has addressed these issues via Trust processes and has confirmed there remains the option to ask additional questions.

Question from Maggie Young, AHP Staff Governor

I work in Sheffield Eating Disorders Service and we are aware of the changes to the CMHTs. Many of our service users are now on 'Case Management'.

Please can the Board outline what level of support service users can expect to receive when on Case Management.

Clarity about this would be helpful to Specialist Services who are often working with Service Users in conjunction with CMHTs. How does this new system dovetail with Care Co ordination? Service users used to have an identified Care Co-ordinator, if they were on Enhanced CPA. Have patients who are no longer on Enhanced CPA been regarded and how do other services identify a named clinician to liaise with?

Response from Richard Bulmer, Associate Director, Scheduled and Planned Care

The Recovery Service has three core functions; it provides evidence based interventions under the Care Programme Approach framework, it provides an enhanced level of support to service users when they present outside of scheduled care appointments or with needs for a more holistic package of care, and it also provides low level intervention to maintain the health and wellbeing of service users or to support service users to become independent of the Recovery Service. Service users may move between these three core functions as their needs change.

The provision of low level intervention has been called case management. Service users receive several different offers of care under the case management part of the Recovery Service, which is agreed as part of a collaborative care plan. The frequency of contact is determined by the offer of care that the service user is receiving. For example within tier 1 of case management, service users typically receive fortnightly contact to receive a depot injection. Service users within tier 2 of case management may receive contact every three months, which may be reduced to promote independence in accordance with an assessment of need and risk. Service users within tier 3 of case management may only receive an annual review of their social care package. Most service users within case management are not subject to the Care Programme Approach framework and therefore do not have a Care Coordinator. However, all have a lead clinician associated with their care.

We are in the process of making significant changes to NHS Insight to reflect the changes in care. This work is expected to be completed within the first week of June and the lead clinician and the offer of care will be made clearly visible to those accessing the care record.

Greg Hackney has offered to present these changes to the Eating Disorder service if you would like to contact him directly.

Question from Jules Jones, Public Governor

Can the Board please inform the governors and Members of how it has assured itself that the slowly worsening position for membership engagement – as shown in successive reports over a period of months - is an acceptable situation, how has the Board arrived at that position? If the Board does not think this is an acceptable situation – what is it going to do about the issue? Why has the Board not taken action sooner? Since the monthly performance report has shown a slow decline for many months – it is fair to conclude that the Board is aware of the issue and would have a position on the subject. Please share.

I would point out that as SHSC is a membership organisation, and that Governors have a statutory duty to represent the interests of members and the public (2012 Act). The position and ability of governors to fulfil this requirement (to represent) is compromised by the complete lack of membership events for nearly a year - since last July. The Board needs to either act or set out why it feels that there is no need to act on this issue. If the Board feels that there is no need for action – when will it review that stance? Could part of the problem be that the membership and governance position has been unfilled since last year?

Please could NEDS answer this question rather than delegating to the Board Secretary.

Response from Jayne Brown, Trust Chair

The Trust can confirm membership has remained static for the past year, however numbers remain positive at 12,440 with a data cleanse currently taking place to ensure membership information is as up-to-date as possible.

As acknowledged the Board receives membership information each month and with an additional resource being secured it is intended to review and refresh the Trust membership Strategy including the approach to membership engagement. An invitation will be issued to Governors to participate in this process later this year.

Recently as part of the recent exercise to recruit Governors the Trust has taken the opportunity to promote membership and of course there are many ad hoc events attended by both executive and non-executives where membership is promoted.

The Trust Board is also pleased to once again support this year's Wellbeing Festival which is taking place on Wednesday 18 July 2018 in Barkers Pool in the city centre. As in previous years, governors will be invited to attend to support the event and talk to the public with the option to recruit new members. Along with the many networks governors have to engage with a broad range of people, this event will be an additional opportunity for governors to undertake their duty to represent the interests of members and the public.

Question from Adam Butcher, Service User Governor

What is the board doing to make sure we have safe wards from all violence in the trust?

Response from Michelle Fearon, Director of Operations and Transformation

Sheffield Health and Social Care NHS Foundation Trust are committed to ensuring all service users receive care and treatment which is delivered in a safe environment. The Trust actively monitors and reviews safety and quality. Below are some of the interventions and measures in place:

Environment

The physical environment is an important aspect of the reduction and management of violence on the wards. The current and future ward environments are continually being reviewed and updated where required to ensure they provide the optimum provision of the following:

- **Provision of sufficient therapeutic rooms / facilities**
- **Alarm systems –** for service users and staff
- **Ability to carry out observations by design**
- **Secure doors on and off the ward** to support service users in their care and to prevent unauthorised persons from entering.
- **Provision of green rooms for de-escalation and seclusion where required**

Staffing Skill Mix and Training

Sufficient staff with the right experience and skills are key to the delivery of safe effective care. The Trust increased the staffing numbers on the wards a few years ago and currently our staffing levels benchmarks well with the national picture. However we are challenged within the national context to recruit nurses and doctors, particularly for some of our wards. We are approaching this in a range of ways including:

- Creative recruitment
- Creation of new posts such as nursing associates, band 5 Occupational therapists working into ward rotas
- Reviewing the staffing mix in our teams
- Implementation of the acuity tool which helps us identify when additional staffing is required.

Staff are required to undertake a range of mandatory training which includes:

- Respect (which includes de-escalation of potentially violent incidents and how to respond safely and effectively if such incidents do occur)
- Safeguarding
- Clinical Risk

Plus staff are supported to attend additional training to allow them to continuously develop their skills and knowledge and hence to provide the best care possible.

Reducing Restrictive Practice and Promoting Meaningful Activities

Safewards

Safewards is a model that works to reduce incidents on ward environments by introducing a range of interventions aimed to encourage staff and patients on ward to work together to create a therapeutic environment and reduce conflict. Safewards are implemented across all SHSC wards. We are also implementing a process to check that this is fully embedded and monitored on an ongoing basis.

Post Incident Reviews and Debriefs

Post incident reviews and debriefs are very important for staff and service users. We are continuing to ensure these are delivered on a timely basis. These are important to support service users and staff after incidents as well as having the potential to avoid future incidents.

Access to Psychology

All of our ward teams have access to psychologically informed interventions to provide support and formulation for the delivery of the safest clinical care.

Therapeutic Activities and Access to Education

All wards have programmes of activity to engage service users and to support their recovery journeys. These include on ward activity, communal activities and activities within the wider community. We are continuing to increase the range of activities through initiative such as the Forest Close Recovery College site. Access to physical activity and exercise is also important. All our sites and teams continue to increase access through a range of means – on and off site. This includes for example provision of cardio walls.

Risk Reduction and Shared Management

Effective clinical care
On admission to the ward a comprehensive assessment is undertaken with the service user which includes

- Detailed Risk Assessment and Management plan – with link from community to inpatients
- Development of a Collaborative Care Plan

Care provision and intervention is continually reviewed and amended as clinically indicated throughout the stay as agreed with the service user and the plan updated accordingly. When appropriate action is taken to safeguard service users and staff this may include

- Increased levels of observation
- Ward moves
- Use of formal safeguarding procedures
- Accessing the appropriate clinical environments and level of care including transfer to psychiatric intensive care (Endcliffe) or secure services

Systems and processes
Risks are identified and management plans created with service users and the following are some of the ways structure is provided to this and that risks are shared.

- **Safety Huddles** where all staff focus on safety and work to reduce incidents from day to day
- **Blanket Restrictions** (rule that applies to all in all circumstances) are managed in a clear and transparent way to minimise restrictions and provide consistency
- **Management of prohibited items** in a consistent way that reduces risk and makes it clear to service users and visitors what cannot be brought on to wards e.g. lighters and weapons
- **Patient Safety Champions** to ensure a focus on safety at team level
- **Use of electronic flags** to prompt information required and action to be taken

Management of incidents
When an incident does occur this is immediately managed in line with Incident Policy. The incident is reported, graded and immediate action taken to address the risk and prevent reoccurrence. When indicated a full investigation will be undertaken. In addition:

- **Deep Dive will be undertaken to review incidents** to understand themes
- **Learning is shared** within and cross teams through a variety of forums
- **Incidents of assaults to service users and staff are monitored** at team, Directorate and Trust Board level including scrutiny at the service user safety group.
- **Effective joint working with the Police** and appropriate use of the criminal justice system to follow up e.g. incidents of assault

Service User Feedback
Service user concerns and feedback are gathered, logged and acted upon in a range of ways. These include through direct 1:1 clinical care as well as in community meetings and with the Quality and Dignity Survey. The Quality and Dignity Survey is carried out by service user experts. The issues raised and themes generated are review and acted upon.

Strategies and Policies

All service provision is delivered in line with a range of policies and procedures which support our governance framework. Key documents include:

- Risk Management Strategy
- Incident Policy
- Medicines Management Policy
- Physical Health Policy
- Safeguarding Policies
- Service specific documents such as the Acute Care Pathway

Question from Toby Morgan, Service User

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 to be provided