28 February 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:	February 2019

October 2018

Question from Jules Jones, Lead Governor to NEDs

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 from Jayne Brown

Thank you very much for your questions to the Board sent in October.

The first 3 questions have been answered by Phillip Easthope, Executive Director of Finance with information taken from the Trust's published annual accounts detailing expenditure over the last 3 years. It has not been possible to provide a regional comparison of the Trust's expenditure because there is insufficient data that would enable like-for-like comparisons to take place.

As I'm sure you appreciate, there is a lot of detail behind the figures. There is also a robust governance process in place to support decisions taken on expenditure, and the Trust participates in a number of benchmarking exercises that provide data for us to look into in order to understand why costs differ nationally and in the NHS as a whole; initiatives like the model hospital which was recently launched for mental health and community Trusts and national procurement work streams aiming to get value for money across the country. Phil would be very happy to meet with you to discuss this if that would be of help to you.

Ann Stanley and Richard Mills have provided a response to your final question and I have assured all the responses including those provided by Phil.

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).*

	2017/18 £000	2016/17 £000	2015/16 £000
Premises	5,068	4,613	5,236
Net impairments	3,403	-	1,527

	2017/18 £000	2016/17 £000	2015/16 £000
Depreciation on property, plant and equipment	2,434	2,313	2,250
Purchase of healthcare from non-NHS and non-DHSC bodies	2,167	2,736	4,244
Purchase of healthcare from NHS and DHSC bodies	1,448	1,552	1,865
Other	1,327	891	652
Rentals under operating leases	1,313	1,449	1,511
Transport (including patient travel)	1,146	1,104	1,250
Research and development	850	1,224	554
Supplies and services - general	829	1,045	1,118
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	722	725	811
Clinical negligence	698	495	354
Establishment	628	954	879

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?

	2017/18 £000	2016/17 £000	2015/16 £000
Consultancy costs	498	317	877

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

   See above

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

   As indicated there is a lot of detail behind this and generally NEDs would not require data on specific non-pay expenditure lines. However, there are two committees seeking assurance on the Trust's financial health and adherence to appropriate internal controls regarding the allocation of our financial resources:

   Finance, Investment and Performance Committee seeks assurance that the Trust's financial risk (Capital and Revenue) is being managed. Typically this might include (though is not restricted to) receipt of reports which focus on achievement of the Trust's current financial plan and scrutiny of progress against CIP targets and individual Directorate on-going financial performance.

   Audit Committee recommends approval by the Board of the Trust`s published financial results for the year. This is done in conjunction with the External Auditor opinion. Whilst we periodically request details of exceptional spending patterns, this would normally be for expenditure considered high risk. So, for example, for 2017/18 we had a strong focus on estate spend and valuation of our buildings. Consultancy and other non-pay items have not hitherto represented high financial risk, but if further detail is ever required, this has always been made available on request. Regarding pricing/benchmarking etc., the Audit Committee also requires assurance that all the Trust's procurement is done in accordance with procurement policy and our delegated limits of budgetary authority. This would also include

engagement of consultants. Any breaches are reported on an on-going basis to the Audit Committee, which is also attended by Internal as well as External Auditors who will advise on best practice across the Sector.

November 2018

No questions received

December 2018

Question from Maggie Young, Staff Governor

Please can you summarise the progress of the Child & Adolescent Mental Health Services/Adult Mental Health Services (CAMHS/AMHS) interface group who are working to improve transition between CAMHS and AMHS. What progress has been made to ensure smooth and timely transitions and to address the difficulties which led to this group being set up in the first place?

Response from Richard Bulmer, Associate Director of Scheduled & Planned Care

There has been a joint interface meeting been established involving Sheffield Children's NHS Foundation Trust (SCH) and Sheffield Health & Social Care NHS Foundation Trust (SHSC). This meeting is jointly chaired by Richard Bulmer, Associate Director (SHSC) and Liz Murch, Associate Director, Community, Wellbeing and Mental Health Division (SCH). Representation includes frontline managers from both Trusts where interface issues are relevant. NHS Sheffield Clinical Commissioning Group (NHSSCCG) are represented. The meeting focuses on joint working, problem solving and highlighting areas for discussion.

The meeting is overseeing the implementation of an action plan from a recent serious untoward incident involving a young person. The action plan is being effectively overseen with timescales being achieved.

A major focus of work has been agreeing a joint transitions protocol that is now in place. This provides clear guidance about how young people transfer between services. The transitions protocol is being audited after the first 6 months of implementation. This will feed into a further review to ensure that it is fit for purpose.

The processes in place are to ensure seamless care for young people who need to transition and to avoid unnecessary hand-offs between services.

There has been work to ensure that there is clarity when young people require admission. Those under 18 years of age should, where possible, be admitted to an age appropriate service but there are some instances where the young person is admitted to an adult ward. A policy is in place to ensure the safe management of those circumstances.
Where young people between 16 – 18 years of age attend A&E at the Northern General Hospital there is a clear protocol to inform key services in CAMHS.

There are specific work streams to effectively manage young people over 16 years of age who access the Early Intervention Service and the Eating Disorders Service. NHSSCCG are developing a pathway for whole age range for all eating disorder services.

Question from Toby Morgan, Service User Governor

My understanding is that Sheffield Commissioners have suggested that the PDU has pastors who are trained volunteers from the Church. If this suggestion is taken forward, what assurances can the Board provide on the following matters:

1. The safety of the volunteer pastors on the unit?
2. Safeguarding PDU clients from potential pressure from pastors to commit to a particular faith.

Also, if taken forward, would the pastors be part of the Trust's chaplaincy service, which in itself would provide additional safeguards.

Response from Clive Clarke, Deputy Chief Executive

Thank you very much for your question. I can confirm that this suggestion from the CCG has not been accepted so will not be taken forward at this point in time.

If this were to change at any point in the future, then appropriate checks and balances would be put in place to ensure appropriate safeguarding of volunteers and service users.

Question from Adam Butcher, Service User Governor

How effective is the Trust's approach to supporting mental wellbeing in the workplace in reducing stress related sickness rates and how assured are the NEDs that the Trust is managing staff wellbeing effectively?

Response from Dean Wilson, Director of Human Resources

Stress related sickness absence is reviewed on a monthly basis as part of the Workforce Report within Human Resources (HR). It is the most common cause for sickness absence, and has been for a long time. This is line with almost every other organisation nationally. We compare favourably with other organisations, in that the level of reported absence due to this reason is lower than the national average. We await the most recent staff survey results, as this is a factor that is specifically asked in the survey.

Staff have access to a variety of support interventions available to them if they need to access. Our Occupational Health providers are able to provide initial or 'low level' support, and Workplace Wellbeing offer a confidential service to staff. We receive regular reports regarding the number / amount of access made to those services, and these are reviewed within HR and escalated if necessary to Workforce and Organisational Development Board sub-Committee (WODC), or Board. We have a policy on this subject, which includes a self-assessment tool. Staff are also supported on occasion by Trade Union representatives or HR colleagues and there are procedures in place for this, depending on the circumstances. And finally, as was raised at our most recent Compassion Conference, supportive teams are vital in our approach to reducing stress for staff.

The Trust has a Health & Wellbeing Group that meets regularly to look at aspects of this area as well as others, and WODC receives reports as required. The Trust also has the Health & Safety Group.

Comment from NED, Ann Stanley

As a member of the Workforce and Organisation Development (WODC) board committee I am assured that sickness absence and in particular work related stress is under constant scrutiny by virtue of the numerous projects and reports that Dean describes. In addition NEDs have stressed that our staff wellbeing strategy should have appropriate focus on building mental resilience as well as physical health. How to measure our progress against this and other workforce strategy targets is currently under review in WODC.

January 2019

Question from Adam Butcher, Service User Governor

What is the Board going to be doing to implement the new long term plan for the NHS and also the new work plan under the cross government Suicide plan?

Response from Clive Clarke and Mike Hunter, assured by the Trust Chair

From a citywide perspective, the Mental Health and Learning Disability Delivery Board is overseeing a refresh of the transformational plans in line with long term plan priorities for funding. The Mental Health and Learning Disability Delivery Board is chaired by Kevan Taylor, and reports directly to the Executive Delivery Board for the city.

The Trust's Annual Plan is currently being drafted. Jason Rowlands, Director of Strategy, Planning and Performance has met with a number the Trust's internal stakeholders including two sessions with governors, to discuss the content of the long term plan. The annual plan will reflect the long term plan's objectives and will continue to be discussed with Board members at Board meetings and Board Development Sessions, to ensure full engagement. Where appropriate the plan will link to other documents, such as the Board Assurance Framework and other strategic documents.

The new cross-government suicide plan is being implemented via the local suicide prevention steering group overseen by the Integrated Care System (ICS) linked regional suicide prevention steering group. Each area is currently submitting a local plan to the regional group and the region has been awarded £2 million over the next 2 years to implement these plans, with a view to reducing suicide by 10% over this period. We are working currently on implementation of 'real time surveillance' and data sharing processes across the region and level 1 and level 2 training (as an organisation we have completed the implementation of the training for both levels and we are assisting in the roll out more widely). Each area has a robust plan for focus on the male demographic and a focus on reduction within this group.