Minutes of Trust Board meeting held on 19 July 2016

Present:	Ian Black	Chair
	Laurence Campbell	Non-Executive Director
	Charlotte Dyson	Non-Executive Director
	Rachel Court	Non-Executive Director
	Julie Fox	Deputy Chair
	Chris Jones	Non-Executive Director
	Jonathan Jones	Non-Executive Director
	Rob Webster	Chief Executive
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Mark Brooks	Director of Finance
	Alan Davis	Director of Human Resources and Workforce Development *
Apologies:	Adrian Berry	Medical Director
In attendance:	James Drury	Interim Director, Strategic Planning and Contracting
	Kate Henry	Director, Marketing, Engagement and Commercial Development
	Dawn Stephenson	Director of Corporate Development (Company Secretary) (author)
Guests:	Amanda Miller	Team Leader, APTs, Wakefield
	Bob Mortimer	Publicly elected governor (Kirklees), Members' Council
	Jeremy Smith	Publicly elected governor (Kirklees), Members' Council

** Also interim Deputy Chief Executive*

TB/16/44 Welcome, introduction and apologies (agenda item 1)

The Chair (IB) welcomed everyone to the meeting. The apology from Adrian Berry (ABe) was noted. IB outlined his intention to focus a large part of the agenda on risk appetite, the Care Quality Commission (CQC) report and on performance.

TB/16/45 Declaration of interests (agenda item 2)

There were no declarations over and above those made in March 2016 or subsequently.

TB/16/46 Minutes and matters arising from previous Trust Board meeting held on 28 June 2016 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 28 June 2016 as a true and accurate record of the meeting. There were no matters arising.

TB/16/47 Chair and Chief Executive's remarks (agenda item 4)

IB began his remarks by commenting that, following the announcement of the new Cabinet, Jeremy Hunt will continue as Secretary of State for Health. There are uncertain times ahead for the NHS and for this Trust and its services. When Trust Board reviews the assurance framework and risk register later on the agenda, it should consider the risks and what the implications are for the Trust in the current climate.

Rob Webster (RW) introduced his report and commented that Jeremy Hunt remaining as Secretary of State brings a degree of continuity with a continued focus on safety, openness and transparency. Other Ministers, with the exception of Lord Prior, will be changing although there is no information on portfolios as yet. The political uncertainty will continue. In the meantime, it is expected that there will be a re-setting of 2016/17 finances across the

NHS and more central intervention is expected. A pooled risk budget at West Yorkshire-level, with the budget of each clinical commissioning group (CCG) top-sliced at 1%, will be established. NHS England requires CCGs to use this collectively to manage deterioration from control totals locally rather than nationally.

RW went on to comment about the recent submission of Sustainability and Transformation Plans (STPs) and the presentations, for both South and West Yorkshire, to national NHS bodies. In West Yorkshire, which RW chairs, there is a good sense of shared ownership, with emerging governance arrangements in place to support a coherent plan with clarity around priority areas. Between now and October 2016, the focus will be on developing a draft plan with an emphasis on delivery. Links have also been made with other STPs in the North, with Manchester's plan having very similar themes to those of West Yorkshire.

IB invited comments and questions from Trust Board.

- In response to an observation from Jonathan Jones (JJ), RW commented that the STP process is trying to move to a more constructive, collaborative approach and, potentially, shared resources, such as analytics.
- JJ asked whether the West Yorkshire STP budget will come under the Leeds Local Economic Partnership in a similar way to Manchester. RW responded that Leaders of Councils have written to the Government to seek clarification on the position regarding devolution following the change of Cabinet. In South Yorkshire, there is support for devolvement of budgets; however, in West Yorkshire, the position is more complicated as the geography includes Harrogate so there are issues regarding patient flow and footfall.
- Julie Fox (JF) commented that the paper provided a good overview and asked whether it should be shared with staff. RW responded that information is shared with staff through the Huddle on a Monday morning and through the weekly 'The View'. It could also be made available through the intranet.
- Charlotte Dyson (CD) commented that she would like to understand what Trust Board will do to increase and demonstrate visible leadership. RW responded that this is through the View, the Brief and other channels. He would be happy to have a more detailed discussion with Trust Board to review what else can be done to increase visibility. He also confirmed that Trust Board would very much be involved in the staff awards in November 2016. IB added that this would also include governors, members and other stakeholders.
- JF asked if other Board members would have a role in STPs in future. RW responded that it had been discussed; however, the issue in West Yorkshire is the large number of people currently involved in decision-making. As confidence in governance develops, Non-Executive Director input and challenge would be valuable.
- Chris Jones (CJ) commented that he attended the NHS Providers conference where there was a debate on STP governance. Three models of engagement with Boards were identified to 'inform' Boards on STP discussions, for Boards to 'receive' STP updates, and for Chairs and Chief Executives to be involved; however, Boards are legal entities and have statutory duties; STPs do not. RW responded that STPs do not make decisions but make recommendations to statutory organisations. This, of course, takes time when health and social care economies should be moving at pace, presenting a strategic risk. IB commented that this Board's role is the governance of this Trust with an obvious interest in wider work.
- RW also updated Trust Board on the discussions with Leeds and York Partnership NHS Foundation Trust and Bradford District Care NHS Foundation Trust about working more closely together.

- IB asked whether, if acute trusts were working more closely on a West Yorkshire footing, mental health trusts will be left behind. RW responded that there is a long-established group of mental health chief executives that meets quarterly.
- IB also asked if there was an issue for the Trust in that it crosses two STPs. RW responded that this Trust is not unique in this regard. Alan Davis (AGD) covers the South Yorkshire STP and RW has weekly calls with other STPs to make connections and foster collaborative working.
- RW also commented that the Trust is using communications and engagement to reinforce its position through, for example, work on the Trust's strategic approach and strategic objectives, the annual members' meeting, staff awards and 'The Brief'.
- JJ asked what impact the STPs would have on the Trust's budget for 2017/18 and beyond. RW responded that Trust Board will need to assess its position for next year by the autumn. STP visions will support the planning process.
- IB asked whether there was anticipation of more involvement nationally. Mark Brooks (MB) responded that a new combined framework from NHS Improvement (Monitor and NHS Trust Development Authority) has been published for consultation with additional parameters for participation in STPs and for control totals. RW added that there is an opportunity to ask for a West Yorkshire control total (an aggregation of all Trust control totals) to be managed between organisations, which would be part of a bigger picture for risk gain/risk share.
- Laurence Campbell (LC) asked if CCGs tender activity was diminishing. RW responded that it did not appear so and the Trust was seeing active examples of tendering currently. Councils' legal frameworks provide a duty to seek best value and CCGs are concerned about their legal position if they do not seek to tender services. LC commented that this was likely to hinder collaboration.
- JF asked where the top-sliced 1% of CCG budgets would go if not used for acute trusts. RW responded that most CCGs have arrangements in place locally with providers for utilisation of the monies if not used.

TB/16/48 Supporting a culture of safety and respect (agenda item 5)

AGD took Trust Board through his paper and highlighted the new role of 'Freedom to Speak Up' guardian and the use of a new self-assessment tool on raising concerns at work. A proposal will come to Trust Board for formal decision in due course. JF commented on an event she attended on Freedom to Speak Up. A national guardian, Henrietta Hughes, has been appointed. For individual organisations, it is not just a matter of appointing a guardian but also about changing culture so staff feel able to speak up. A clear link to Trust Board will be needed, in particular, to the Senior Independent Director. It was suggested at the event that the guardian should attend Trust Board meetings. There is also a clear difference between whistleblowing (extraordinary events) and Freedom to Speak Up (everyday events). The Trust is required to appoint a guardian by 1 October 2016. IB asked for a paper to Trust Board in October 2016 and that AGD involves JF in its development. IB also asked if there was a Non-Executive Director role in this appointment. RW responded that Trust Board will set the 'tone' for the fostering of an open culture. He thought the guardian should be a clinician with Non-Executive Director involvement in the self-assessment tool. AGD was asked to liaise with JF in this regard.

It was RESOLVED to SUPPORT both the use of the self-assessment tool on raising concerns at work and the development of proposals to progress a Freedom to Speak Up Guardian role with a paper to come back to Trust Board in October 2016.

TB/16/49 Risk appetite statement (agenda item 6)

Dawn Stephenson (DS) took Trust Board through the paper and commented that it is recognised that there is risk in all that the Trust does; however, this is mitigated through the risk management strategy. The paper defines the level of risk the Trust is willing to take that can then be communicated throughout the organisation. The approach is built on the Good Governance Institute's work. She also confirmed that the Executive Management Team (EMT) had discussed the approach. IB invited comments from Trust Board.

- LC commented that this is a subjective area and Trust Board needs an understanding of what it means. He added that reporting needs to be considered. Deloitte has offered training in this area. DS responded that this relates to alignment of the risk register, performance reports, etc. rather than focusing on individual targets.
- Rachel Court (RC) commented that this was a good building block and asked what the key risk indicators would be for each top-line risk that will indicate if the risk was outside the risk appetite. Also, the risk register process is 'bottom-up' and the risk appetite, 'top-down'. How would the Trust ensure these meet in the middle? DS responded that this would be demonstrated through a 'heat map' and through communication and Trust Board discussion. RC also asked what objective measures Trust Board will use to assess whether a risk is in or outside of risk appetite. MB responded that any papers for approval/consideration by Trust Board should include reference to risk appetite.
- JF commented that it would be useful to have some examples and Tim Breedon (TB) added that context would be useful.
- LC thought it was positive that Trust Board can communicate the approach to the organisation and TB that it was helpful from a clinical perspective.
- JJ suggested that the Trust Board front sheet should include an additional category for risk level/assessment and this was supported.
- RW agreed it would be useful to apply to some live examples, such as selling a piece of land as a whole as opposed to selling in two parts and the respective risks, to provide a richer picture.
- IB commented that the serious incident report is another example and he would like to see the report mapped against the risk appetite.
- He added that the Trust has two regulators, which can be at odds with each other, which creates difficulty for the Trust.
- RW commented that the risk appetite should be managed down to a level Trust Board is content with and, if this is not possible, it should be raised and discussed through Trust Board Committees and escalated to Trust Board if necessary.

It was RESOLVED to SUPPORT the approach set out in the paper and to INTRODUCE from September 2016.

TB/16/50 Strategic overview of business and associated risks (agenda item 7)

James Drury (JD) took Trust Board through the paper. IB invited comments and questions from Trust Board.

- JF asked if this had been shared with staff. JD responded that much of the content is informed by staff feedback from a variety of mediums, such as listening events; however, he thought there would be benefit from sharing with staff and JF suggested with stakeholders and partners as well.
- CD asked if the strategic direction resonates with external partners. JD responded that feedback from partnership boards and team-to-team discussions are reflected; however, he will ensure that it is tested with partners.

- JJ commented that this was a robust piece of work and any validation/questioning would be helpful. He was interested in the strategic output. JD responded that this would be through service line analysis to build plans, triangulating finance, performance, quality and delivery of cost/efficiency savings. RW commented that one of his objectives is to develop a refreshed strategy by October 2016 for approval by Trust Board in December 2016. Progress will be monitored by the EMT through revised performance reporting.
- RC commented, in relation to the SWOT analysis, that opportunities sometimes become about fixing weaknesses and the Trust (and the paper) should look at wider strategic opportunities.
- CD was still unsure whether the Trust is a mental health or community services organisation. Trust Board should be clear what it wants the Trust to be known for and how community services fit. LC suggested using the four-tier model as a starting point. RW responded that 95% of what the Trust does is in the community and there is a national drive to integrated community, physical and mental health services. The Trust's range of services positions it well in Barnsley.
- CJ commented that the 'weaknesses' provide a good start for focus and action plans. He questioned the weakness in relation to data quality. JD responded that this covered two aspects, firstly, that data requires improvement and, secondly, that some services require improvement.

It was RESOLVED to NOTE the report.

TB/16/51 Care Quality Commission inspection report (agenda item 8)

TB commented that the paper provides a further update since the last meeting in June 2016. The action plan, which includes the Trust's response to both the 'must do' and 'should do' recommendations, will be submitted to the CQC by its deadline of 8 August 2016. More detailed plans sit at BDU level; however, the CQC will look at the organisational high level plan. The plan will be aligned to the Trust's existing quality improvement plan whilst enabling the Trust to demonstrate action against the CQC findings. The CQC may want to discuss the plan with the Trust prior to final approval. The CQC will also give an indication of any plans to re-visit Trust services to check progress and how much of this will be done through regular Mental Health Act visits. IB invited questions and comments from Trust Board.

- RC commented that, under forensic safer staffing, no mention is made of long-term plans to resolve staffing issues; however, the response indicates that there is a plan in place. TB responded that safer staffing is an important area of discussion with the CQC. Although the CQC did not ask for any long-term plans for safer staffing in forensics, a copy was sent; however, the CQC has not commented that the plan is inadequate and it has accepted long-term plans in other areas. The Trust has clear evidence of what it submitted to the CQC.
- IB commented that some actions have a completion date of 31 March 2017, which is eight months after the action plan is submitted and thirteen months after the visit. He understood there was a six-month timeframe. TB responded that this is the case. The end of March 2017 timeframe refers to the dates for the Trust to audit action taken. IB asked that this distinction is clear on the action plan and shows when the Trust expects action to be completed and when it will be audited. MB asked, from a safety perspective, if timeframes were appropriate for any actions that impact on clinical safety.
- IB asked who would approve the plan for submission. TB responded that Trust Board comments will be incorporated and a revised plan will be presented to the EMT for approval. AGD, as Accounting Officer in RW's absence on leave, will agree the final submission with TB as Lead Director. IB asked that the action plan is re-circulated to

Trust Board and that there is a Chair/Accounting Officer discussion in advance of the final submission.

- It was suggested that a risk appetite analysis is undertaken and that the action plan includes an additional column to monitor progress.
- CJ commented that, for some actions, there are different responses by different BDUs. TB responded that, for example, in the case of high dose medication, it is not quite the same issue in each BDU; however, there are some areas where consistency could be improved.
- MB asked how Trust Board will be assured that outcomes have been met. IB commented that he would expect this to be through Trust Board Committees.
- AGD commented that safer staffing is not a 'static' issue and changes constantly.
- He also commented that, during environmental audits, no ligature risks were identified. The Trust will need to understand the discrepancy with the CQC's expectations and adjust internal processes accordingly.
- RC commented that, in relation to Mental Health Act/Mental Capacity Act training, the report mentions that there are no effective systems for monitoring oversight and asked where Trust Board would have oversight. TB responded that this is included in the Trust's response elsewhere and he will ensure that this is reiterated against the appropriate recommendation from individual reports.
- JF confirmed the action plan will be a key agenda item for the Clinical Governance and Clinical Safety Committee and she will discuss this with TB at the agenda setting meeting on 15 August 2016.
- RW commented that Trust Board should be assured of its oversight of the plan, the role of Committees, in particular, the Clinical Governance and Clinical Safety Committee, and the EMT. In particular, assurance is needed that all actions are on the risk register and managed appropriately within appropriate tolerances, any immediate risks have been addressed, and all actions will be addressed within six months, with any exceptions highlighted.

TB provided an overview of the Quality Summit held on 14 July 2016. IB commented that the support from partners able to attend was reassuring.

It was RESOLVED to NOTE the high-level action plan and to APPROVE the approval process for the submission of the action plan to the CQC.

TB/16/52 Performance reports month 3 2016/17 (agenda item 9)

TB/16/52a Performance report month 3 2016/17 (agenda item 9.1)

MB explained that, due to the timing of the meeting, a detailed report was not available. It will be circulated to Trust Board following consideration by the EMT. MB presented an overview of key areas and provided assurance that the improving access to psychological therapies (IAPT) target was now at 76%, which means the Trust has achieved its target in this quarter and not failed to achieve the target for three consecutive quarters. Work is in train to ensure this level of performance is sustainable. All other NHS Improvement performance areas are currently reported as 'green'.

In terms of quality performance, TB reported on:

- good progress has been made to fill vacancies despite underlying issues;
- new training has been delivered to 78 care homes in Barnsley to support prevention of pressure ulcers; and
- although there was nothing specific to report in relation to serious incidents in Q1, a longer-term view will be taken before any conclusions are drawn from the reduction in incidents from the last quarter.

AGD reported that sickness absence has reduced in forensic services and in Barnsley due to concerted efforts to bring down absence levels; however, there are some service issues across the Trust that are driving an increase in sickness levels. The Trust continues to benchmark well with its peers.

The following were raised.

- JJ asked if Brexit had had any impact on staffing. AGD responded not as yet although the next six months will be worrying for staff affected. The Trust needs to ensure people continue to feel valued. The Trust is looking at overseas recruitment for some areas and Brexit may have an impact in terms of reluctance to take up posts.
- JJ asked if there were any contingencies in place. AGD responded that the Trust is looking at a broader staffing mix. There are also concerns in relation to other providers paying bonuses and the Trust will look at what is in its control to recruit and retain staff, including improved career structures, associate nursing roles and earlier recruitment.
- MB advised that the Trust has reported three information governance incidents to the Information Commissioner's Office in the last twelve months. The incidents are similar in nature and are from similar areas in the Trust. The Trust already has one undertaking and is now awaiting judgement for the most recent referral. One consideration is whether the information governance training is working across all parts of the organisation. Bespoke, face-to-face training is being introduced for some teams. Whilst the Trust complies in terms of the numbers of staff undergoing training, it is not clear whether this is always effective. RW commented that the position poses both a financial risk with the possibility of a fine up to £500,000, and a reputational risk. MB assured Trust Board that targeted and personalised training is in place for areas of risk.
- RW commented that the update on performance shows the Trust is delivering its targets, managing its money and has stable quality. Areas for focus are vacancies in specialist services and increasing sickness absence as well as robust management of the use of agency staff.

It was RESOLVED to RECEIVE the performance report for Q1 2016/17.

TB/16/52b Finance report month 3 2016/17 (agenda item 9.2)

MB introduced the finance report and commented that the Trust is on plan currently. He highlighted the following.

- Agency spend is increasing and a detailed review is in train to look at each individual role filled by agency staff across all BDUs.
- NHS Improvement has set criteria for providers to access the sustainability and transformation funding, which, for this Trust, is £1.35 million. Trusts will need to achieve their control totals (for this Trust £500,000), achieve access targets (acute trusts only) and ensure plans are in place to reduce agency spend and start delivering against these plans.
- The forecast projection suggests the Trust has a number of risks, which may impact on its ability to achieve its year-end target. As well as the agency position, there are risks in relation to out-of-area placements and non-achievement of the cost improvement programme. This requires more detailed analysis and a report to Trust Board in September 2016. IB suggested a discussion with NHS Improvement at the Q1 call to outline the concerns and actions being taken.

The following were raised.

- In response to an observation by LC in relation to depreciation and the impact on the Trust's income and expenditure position, MB responded that this was a timing issue in relation to the Fieldhead site and the year-end forecast remains in line with plan.
- JF asked if the Trust was talking to other Trusts within STPs about their agency spend. AGD responded that all Trusts are struggling with the level of agency spend currently and balancing this with regulatory requirements. Quality and safety are the Trust's first priority. Provider trusts do need to work more collaboratively to identify solutions and reduce competition. IB added that safety always comes first when it comes to staffing.
- JF commented that the Trust needs to think about how it attracts and retains staff. The Trust requires loyalty and people who want to stay not just for financial reasons. AGD responded that insight from the wellbeing survey will be useful.
- RW commented that one of AGD's objectives is to revise the workforce strategy by December 2016 and this will be an important component. STPs are also looking collectively at workforce and use of agency staff.
- MB commented that there is some loss of contribution relating to the loss of 0-19 services in Barnsley.
- In response to a question from CD in relation to the management and administration review, AGD commented that the Trust will need to deliver the savings non-recurrently to allow the right model to be established and to ensure there is no double counting.
- CD also asked if the Trust reviews cost savings that may have been rejected previously, particularly if there has been a change in risk appetite. AGD responded that there will be substitutions and these will be subject to the quality impact assessment process. MB added that it would be beneficial to look at previous schemes to ensure they have been delivered and this will be picked up in planning for 2017/18.
- LC asked if there was anything the Trust could do to address the delays in local authority payments. MB responded that he would discuss with finance colleagues in partner organisations and speed up the Trust's invoicing processes.

It was RESOLVED to RECEIVE the report.

TB/16/52c Customer services report Q1 2016/17 (agenda item 9.3)

DS introduced this item and advised that there will be a review of indicators, for example, the number of complaints closed in 40 days. The Trust is currently not meeting this target. BDUs are provided with a weekly monitoring report to expedite work flows. Further work is needed on equality and inclusion information, which is complicated by the complainant not always being the service user, to enable this to be used to improve services.

RC asked whether the Trust follows up on the effectiveness of actions that "remind" staff and whether this resulted in a reduction in complaints. DS responded that work is undertaken with practice governance coaches and with teams; however, it is sometimes difficult to ensure information has been disseminated due to staff changes. She thought that a more detailed piece of work might be needed and agreed to take a proposal to the Patient Experience Group.

CJ asked if the Trust has a process for people under the age of eighteen and whether this was different from other complainants. DS responded that Customer Services is working with child and adolescent mental health services (CAMHS) to develop templates for children and young people to use. The Trust is also looking at a library of easy read information. CJ also commented that two out of three complainants are female and asked whether there were any access issues for males to provide their views. DS agreed to review this.

JF asked whether the Trust is learning from positive experiences in Barnsley given the outcome of the Friends and Family Test. DS responded that Sean Rayner, District Director

for Barnsley and Wakefield, is looking at cross-BDU learning. She added that community services in general have a higher response rate.

IB commented that he would like to see a comparison of Friends and Family Test results nationally. RW commented that, as the Trust is revising its balanced scorecard, there should be a goal/aim in relation to Friends and Family Test outcomes and national comparison.

RW also commented that he was surprised by the number of cases referred to the Ombudsman. He approves all responses to complaints and ensures there is a "golden thread" running through all responses that acknowledges what has happened and provides clear information on how the Trust will learn, ensuring empathy with complainants. Regarding the cluster of complaints relating to CAMHS waiting times, it was noted that action is not in the Trust's control to resolve being a multi-disciplinary assessment process. This is frustrating for all involved in areas such as autism assessments. This reinforces the requirement to work with partners more closely. He would hope to see complaints closed more quickly in future, form 40 to 25 days, and a reduction in the numbers referred to the Ombudsman.

It was RESOLVED to NOTE the feedback received through Customer Services in Q1 of financial year 2016/17.

TB/16/53 Equality and diversity annual report (agenda item 10)

DS explained that a public-facing summary document would be produced and that the report reflects the four Equality Delivery System 2 (EDS2) objectives approved by Trust Board and the four local priorities set by the Equality and Inclusion Forum. IB commented that there is still some way to go in developing the role of, and scrutiny provided by, the Forum; however, good progress has been made. CJ commented that, in his view, the report comes across as unambitious and is light on data both from a service user and staff perspective. He did not get a sense of urgency from the report in relation to achievement of priorities. DS responded that she had tried not to replicate other reports but will take on board for future reports to the Forum and Trust Board. RW commented that, as the Trust is revising the balanced scorecard, one or two of the EDS2 indicators should be identified for regular reporting.

It was RESOLVED to NOTE the progress made during 2015/16 and the continued work in 2016/17.

TB/16/54 Assurance framework and risk register (agenda item 11)

RC asked whether both documents should be tied into the definitions in the risk appetite statement. For example, should a risk be seen as 'amber' if it is within the Trust's risk appetite? DS agreed to review in line with the risk appetite statement. RW commented that the Trust will continue to have a discipline on how risks are described in line with the risk appetite statement and those risks that are outside of appetite tolerance. TB commented that both should be aligned and provide commentary on the link to risk appetite.

It was RESOLVED to NOTE the controls and assurances against corporate objectives for Q1 2016/17 and NOTE the key risks for the organisation.

TB/16/55 NHS Improvement return for Q1 2016/17 and Board self-certification (agenda item 12)

It was RESOLVED to NOTE the report and to DELEGATE AUTHORITY to the Chair and Chief Executive to APPROVE the submission and exception report to NHS Improvement.

TB/16/56 Assurance from Trust Board committees (agenda item 13)

TB/16/56a Audit Committee 12 July 2016 (agenda item 13.1)
TB/16/56b Remuneration and Terms of Service Committee 7 July 2016 (agenda item 13.2)
TB/16/56c Equality and Inclusion Forum 21 June 2016 (agenda item 13.3)
TB/16/56d Information Management and Technology Forum 28 June 2016 (agenda item 13.3)

Trust Board noted the feedback from Committees and Forums.

JF commented that it would be useful for all members of Trust Board to see the papers in relation to Forums, particularly the independent review of the implementation of the upgrade to the Trust's clinical information system. IB agreed and asked DS, as commissioner of the review, to circulate to Trust Board. All papers for Committees are now provided on BoardPad and IB will ensure that papers for Forums are also published. IB asked for any comments from non-members to be provided to the Committee/Forum chair before the next Trust Board meeting if at all possible.

TB/16/57 Date and time of next meeting

The next meeting of Trust Board will be held on Tuesday 20 September 2016 in rooms 49/50, Folly Hall, Huddersfield, HD1 3LT.

Signed …… Date ……