Minutes of Trust Board meeting held on 20 September 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
	Adrian Berry	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Mark Brooks	Director of Finance
	Alan Davis	Director of Human Resources and Workforce Development *
Apologies:	None	
In attendance:	Kate Henry	Director, Marketing, Engagement and Commercial Development
	Dawn Stephenson	Director of Corporate Development (Company Secretary)
	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Emma Jones	Integrated Governance Manager
Guests:	Nasim Hasnie	Publicly elected governor (Kirklees), Members' Council
	Bob Mortimer	Publicly elected governor (Kirklees), Members' Council

** Also interim Deputy Chief Executive*

TB/16/58 Welcome, introduction and apologies (agenda item 1)

The Chair (IB) welcomed everyone to the meeting, in particular Nasim Hasnie and Bob Mortimer, Kirklees elected governors from the Members' Council. He also welcomed Emma Jones who has joined the Trust as Integrated Governance Manager. He also took the opportunity to thank Bernie Cherriman-Sykes for her invaluable support to him and for Trust Board over the last eleven years.

TB/16/59 Declaration of interests (agenda item 2)

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

TB/16/60 Minutes and matters arising from previous Trust Board meeting held on 19 July 2016 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 19 July 2016 as a true and accurate record of the meeting.

There was one matter arising raised by Jonathan Jones (JJ) in relation to the letter sent by Council Leaders in West Yorkshire to seek clarification on the position regarding devolution. Rob Webster (RW) responded that local authorities are part of local plans for collaboration to close the financial, care and health gaps set out in the Five Year Forward View. A meeting was held the previous week with local authority Leaders and Health and Wellbeing Board Chairs to ensure a good process is in place to secure local involvement in plans for local areas. There is no indication that the devolution debate will be re-opened; however, the position is that it now could be given changes to the national position on the requirement to have an elected mayor.

TB/16/61 Chair and Chief Executive's remarks (agenda item 4)

IB began his remarks by confirming that JJ will leave the Trust as a Non-Executive Director at the end of this calendar year. It was his view not to replace JJ until the summer of 2017, subject to Nominations Committee approval. Trust Board will, therefore, run with the same number of Non-Executive Directors as Executive Directors plus IB as Chair.

IB also provided feedback from the South Yorkshire Sustainability and Transformation Plan (STP) Chair and Non-Executive Director Forum.

Trust Board confirmed it was very content with the approach adopted by the Chief Executive in providing a written update report and with the information provided for this meeting. In addition, RW provided an update on the development of an Accountable Care Organisation (ACO) in Barnsley. A Shadow Board has been established and mental health, community and social care services are very much part of the model of care proposed. Further discussion is needed on the governance model and organisational form. Advice was sought from Hempsons, which provided eight options. Trust Board will need to discuss possible options at some point in the future and the role the Trust will play. His suggested criteria for assessment of the options are that to ensure it meets the objectives for service delivery and that it is simple, legal and acceptable to all parties. This was accepted by the shadow ACO Board. There is much work still to do and it is welcome that the Trust is engaged and involved, and able to influence developments.

IB invited comments and questions from Trust Board.

- JJ asked about the fit with the South Yorkshire STP. RW responded that there was a good fit given the emerging group of hospitals in South Yorkshire. Links with commissioners will be further developed and this may be through local accountable care organisations.
- Charlotte Dyson (CD) asked if mental health is a priority for the South Yorkshire STP. RW responded that it was. There are specifics for each area although along the same themes and this is the case for STPs across the country.
- CD also asked if the West Yorkshire STP is led by the acute sector or whether mental health has a bigger voice. RW responded that there is no real history of acute trusts in West Yorkshire working together in a formal group and their West Yorkshire Association of Acute Trusts is relatively new. Mental health is a priority workstream in West Yorkshire and it is well-led with a willingness to work collaboratively and with resource to support joint working. It is important that the Trust is seen as part of this and that mental health has parity with acute care in future models and for future investment.
- In response to a question from Chris Jones (CJ), RW commented that the Executive Management Team (EMT) has considered the Trust's role in each of the regional STPs and the localities we serve. This ranges from stewardship of services which are in future delivered by other organisations to being a thought leader/delivery agent. The EMT view is that the Trust has the potential to be at the thought leader/delivery agent end of the spectrum. James Drury is mapping where the Trust fits in each locality and the engagement and communication needed as support, which will form part of the Trust Board discussion during strategy meetings.

<u>Junior Doctors' industrial action</u>

Adrian Berry (ABe) advised Trust Board that approach to contingency plans for the Junior Doctors industrial action are the same as for previous industrial action, albeit potentially for a week rather than a day. The action has relatively less impact than for other trusts as the Trust has less reliance on Junior Doctors in 24-hour care and is able to adjust rotas accordingly to minimise the number of cancelled appointments. ABe explained that NHS England requires Boards to sign-off data collections in relation to the industrial action to

ensure Directors are fully assured of the plans being taken to ensure patient safety during the action. Given the assurance that the Trust's plans would remain as previously supported by Trust Board, **it was AGREED to delegate authority to the Chair and Chief Executive to sign-off the Trust's plans in order to provide flexibility for services.**

TB/16/62 Care Quality Commission inspection report (agenda item 5)

TB/16/62a Care Quality Commission (CQC) action plan (agenda item 5.1)

Tim Breedon (TB) took Trust Board through the process for delivery of actions and assurance through services up to Clinical Governance and Clinical Safety Committee and Trust Board. The Clinical Governance Group will be utilised to ensure a Trust-wide approach. Progress will be included in the monthly performance report. Julie Fox (JF) confirmed that the Clinical Governance and Clinical Safety Committee were satisfied that the process is robust and is comfortable with the arrangements.

IB invited comments from Trust Board.

- He began by commenting that he would like to see a similar process schematic for all Board Committees when the terms of reference are next reviewed. TB responded that this also fits with the wider review of governance arrangements he and Dawn Stephenson (DS) have begun to ensure simple but effective and robust systems and processes are in place to provide assurance and foster improvement.
- JJ asked whether staff were involved and engaged with the process, particularly to engender change. TB responded that there are areas where there is clear engagement; however, there are areas where assurance will not necessarily emerge from improvement activity.
- Laurence Campbell (LC) commented that the Clinical Governance Groups seems to be an additional layer and was unsure of its purpose. TB responded that it provides consistency, co-ordination and a Trust-wide approach. It will also collate and disseminate learning across the Trust. RW added that there are also clear links to Director portfolio discussions, and DS's piece of work to review and streamline operational management and assurance processes. A paper will come to the EMT to simplify current arrangements and ensure fit with governance and assurance processes.
- JJ asked if the meeting with the CQC on 22 September 2016 was to 'mark the Trust's homework'.
- CD commented that the interaction between teams and 'trios' did not feel like how organisations actually work. She would like to see the Trust take the action needed to address areas of improvement and then 'tick' the CQC boxes as a result. TB responded that 'trio' arrangements and relationships are important and will be part of the Clinical Governance Group to ensure a Trust-wide approach and consistency. The balance between improvement and assurance will require leadership throughout the organisation to ensure action is seen as improvement of Trust services not just assurance to the CQC to meet its agenda.
- Rachel Court (RC) commented that the diagram contains many steps and whether the Trust is sure it can be responsive and 'fleet of foot'. TB responded that the main work will be done at 'trio' and BDU Governance Group level with the additional step of the Clinical Governance Group to ensure consistency and cross-Trust working, which should not delay or hinder action.

IB asked that the next report to Trust Board in December 2016 shows progress made and what has been completed, identifies any risks and hotspots, and mitigating action as the next time Trust Board will look at progress will be March 2017 when actions should be complete. TB confirmed there would be a progress report in the monthly performance report.

Regarding the upcoming meeting with the CQC on 22 September 2016, the main question for the Trust is when and how the CQC will review what action the Trust has taken to address the recommendations and 'sign-off' actions. IB appreciated this position but stressed that this is a Trust plan to improve not solely an action plan to address what the CQC has raised. CD added that Trust Board's role is to communication how strongly it is taking the matter. RW commented that he is aware that staff are asking when the CQC will be returning to the Trust. He supported the Chair's comments that this is the Trust's plan and Trust Board holds the EMT to account for its delivery because it is the right thing to do not because the Trust has to do it.

It was RESOLVED to SUPPORT the CQC action plan implementation, monitoring and evaluation arrangements and the SUPPORT the final version of the action plan.

TB/16/62b Safer staffing (agenda item 5.2)

TB outlined the background as a reminder for Trust Board. A key question is how the Trust rationalises its position with that of the CQC. The Trust approach to safer staffing is based on 'optimum', that is, what is needed, and is set using an evidence-based tool. Wards do not operate at unsafe levels and there are clear escalation processes. Information on the Trust's approach, its processes and data were provided to the CQC; however, the inspection report did not acknowledge any of the information the CQC had been given. This will be a subject for discussion on 22 September 2016, particularly in relation to minimum vs. optimum levels. His view is that the Trust should not compromise its position and change to levels that are based on minimum requirements. He would explore the CQC concerns, stressing there is a need to understand how we approach monitoring to ensure that there is no indication that services are unsafe. IB asked if Trust Board was comfortable with the Trust's approach on "optimal" staffing levels.

LC asked how the Trust compared with other organisations. TB responded that optimal is an evidence-based approach. There are some other Trusts that publish reports at a basic/minimum level; however, these are just that. There are some Trusts that take a similar approach to ours; however, it is difficult to compare across the board as the detail of ratios is not always available. JF commented that unpacking the information behind the figures to understand the staffing position is important and its impact on associated areas, such as recruitment and retention. RW commented that the components of quality are outcomes, experience and safety. "Optimum" levels take account of all three rather than safety alone. TB added that the evidence-based tool provides for a level of staffing to provide a quality service not just a safe service. RW added that we must always be conscious of where slippage may reduce the experience for service users but should never reduce safety. TB confirmed there is professional guidance in place to assess safety levels in relation to ratios, assessment of need, etc. RW summarised that experience and outcomes are affected by staff levels; however, processes are in place to ensure services are safe and the Trust should, therefore, explore the CQC position to determine what else it requires the Trust to do to address safety.

CJ commented that it is difficult to take assurance purely on numbers so the minimum/optimal argument may be a false one. Therefore, he would take assurance more from the processes in place than the figures in terms of how staff care for patients. He challenged TB on his statement that the "Trust never does anything unsafe" as the Trust would need to be clear on what safe and unsafe look like in every situation. He would prefer to receive assurance in relation to what action the Trust takes where safer staffing levels are not met rather than purely reporting figures. JF commented that she was pleased to see the needs of patients included as a consideration in determining staffing levels as the acuity of patients can have a serious impact on a service.

RC asked if the Trust could publish “optimal” and “minimum/safe” data and track against both even if only internally. TB was not sure that this would fit with the Trust’s values, its service delivery ethos or variations in services and service user need. RC added a concern that averaging out the fill rate that is reported to the Board could mask individual days and ward information and individual areas of concern could be hidden. TB responded that individual ward information is presented to the Clinical Governance and Clinical Safety Committee; however, this could perhaps be scrutinised in more detail. RC suggested reporting by exception to Trust Board on areas where levels are not met.
CD commented that what is missing from the CQC analysis is the added value of an optimum level of staffing; however, it is difficult to evidence and quantify. TB responded that the Trust could use the evidence-based tool to describe the added value of the Trust’s approach.

JJ asked if the Trust would ever get to the “optimal” level. TB responded that there is much work in train in relation to recruitment and retention and there is no suggestion that “optimum” levels are not achievable. He did not think that ‘Brexit’ would be an influence. JJ asked Mark Brooks (MB) if this was the type of discussion undertaken at his previous Trust. MB responded that it was the same debate; however, the vacancy rate was much higher in his previous Trust.

ABe commented that Trust Board should not focus on the debate between “optimal” and “minimum”. Safer staffing is just that, **safer** not safe and relates to improvement. He added that the Trust is absolutely right to take this approach. Generally, the level of registered nursing at night is ‘safe’ and fill rates are always over. He felt the Trust, therefore, achieves or over-achieves at night and may underachieve “optimal” levels during the day reflecting a ‘safer’ approach and that .some assurance can, therefore, be taken from the figures. ABe confirmed that there is a level of 90% of the agreed fill rate that triggers exception reporting and the detail can easily be brought to Trust Board (it is already reported to the Clinical Governance and Clinical Safety Committee).

IB would seek comfort from any network or evidence that other Trusts are taking this approach. TB was asked to bring information back to Trust Board. IB added that the Trust must make clear to the CQC that this is an approach that works for this Trust and that the Trust recognises its valid concern but this is what suits the Trust. He went on to reiterate that Trust Board supports the Trust’s approach, understands the Trust’s position and would like to see the matter clarified with the CQC. He also asked for reporting to the Clinical Governance and Clinical Safety Committee on the detail of the figures and exceptions. LC commented that he would like to receive a report at Trust Board first to provide assurance. JF responded that feedback from the CQC meeting would be considered by the Committee and then into Trust Board with stronger, more robust reporting of performance, where the 90% level is not met, the reasons and mitigating action taken. RC asked if the outcome of this discussion could be included in the inspection action plan. TB responded that all information was presented to the CQC but not acknowledged and is, therefore, an issue to discuss with the CQC to understand its position. IB supported the suggestion from RC and asked that an additional action be included.

It was RESOLVED to RECEIVE the report on safer staffing and AGREED to secure additional regular reporting on safer staffing through the performance report, with escalation of exceptional circumstances through Clinical Governance and Clinical Safety Committee.

TB/16/63 Transformation update (agenda item 6)

RW provided a brief introduction to the paper. LC commented that he is still struggling to get an overview of progress from this report. RW explained that the narrative from James Drury provides a summary of progress with the detail contained in the appendices that had been submitted to the CGCSC. He asked Non-Executive Directors to confirm how much detail they would find useful. LC responded that he would appreciate more tangible information with clear deliverables. This was supported by RC who would like to see a summary level dashboard of delivery and benefits, whether transformation is on track and exception reporting to provide assurance that the Trust is on track. CD added that the appendices are difficult to follow and she would find a one-page summary for each individual project with timescales useful. DS suggested that this is further discussed by EMT. RW commented that this fits with work to ensure consistency for how the Trust uses RAG ratings/traffic lights to demonstrate progress. Development of a consistent template for each project and programme update would support reporting to Trust Board, which identifies risks and issues affecting reputation, strategy, workforce and finance.

IB summarised the agreement that this was too much detailed information for Trust Board, particularly when transformation is already monitored by one of its Committees, and that work is in train to address this. Consistency in RAG rating/tracking will be adopted across all Trust Board report.

JJ commented that Trust Board had agreed to include a risk tolerance section in the front sheet for papers. DS responded that a new front sheet has been issued to describe risk appetite and modelled in the independent governance review (well-led) paper for comment. If Trust Board thinks this is useful, it will continue for all Board reports.

TB/16/64 Performance reports month 5 2016/17 (agenda item 7)

TB/16/64a Performance report month 5 2016/17 (agenda item 7.1)

MB outlined development of reporting to Trust Board in line with Trust objectives and CQC metrics with a clear Director lead. There will also be a number of additional metrics to reflect improvement and quality, with a clear focus on both.

He also advised that NHS Improvement has just published the Single Oversight Framework, which applies from 1 October 2016. A detailed review of the Framework and its implications will be undertaken; however, from an initial review, MB highlighted the following.

- The Trust currently has a governance rating of 'green' and a financial risk rating of 4, which is the highest achievable level.
- In the revised framework, a risk rating of 1 will provide for full autonomy (highest), level 4 would put a trust in special measures with trusts at levels 2 and 3 needing some form of support.
- A trust can only achieve governance level of 1 if it receives a 'good' or "outstanding" CQC rating; therefore, this Trust could only receive a rating of 2).
- Financially, this Trust would report at level 1 for all metrics except for its agency spend compared to ceiling where it would currently rate at 3, but based on current trajectory could result in 4.
- If a trust receives level 4 for any measures, it can only receive a financial rating of 3 overall. It has been agreed at EMT that MB will write to NHSI explaining the Trust's concerns over how this could be interpreted.
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MB went on to highlight the following from the month 5 report.

- As reported to Trust Board, the performance issue for improving access to psychological therapies (IAPT) improved in quarter 1 and the threshold should again be achieved in quarter 2. That this performance remains sustainable is the focus of action in BDUs.
- The slight reduction in performance on data completeness relates to a dip in postcode inputting and improvement activity is focussed on hotspots; however, a slight concern for quarter 2 performance remains.
- A change in metric and incorrect reporting for memory assessment services in Barnsley has led to some concern from NHS Barnsley Clinical Commissioning Group. An action plan is in place and should be completed by the end of September 2016. An audit by KPMG began on 19 September 2016 to identify if there are any other issues or if this was an isolated incident.
- Work continues to realise full performance against commissioning for quality and innovation (CQUINs) targets.

TB took Trust Board through the quality section, particularly serious incidents, MRSA, child and adolescent mental health service transition to adult services, and bones and falls health. DS commented that Trust Board had asked for benchmarking information for Friends and Family to be included from quarter 2. BDUs can respond to quantitative and qualitative data at both BDU and cross-Trust level.

Alan Davis (AGD) highlighted a number of workforce areas.

- He advised that the vacancy rate for Barnsley includes the 0-19 service. The risk in relation to staffing levels when the service transfer has been flagged with the local authority.
- To enhance recruitment and retention, a pilot is underway to introduce a nursing associate role in forensic and Wakefield acute services.
- An internal audit of the application and operation implementation of the Trust's approach to sickness absence is complete and will be reported to the Audit Committee in October 2016.

CD commented that she was surprised the Trust is an outlier on bank/agency spend. MB responded that the measure is of spend above the "agency cap" set by NHS Improvement. RW has written to NHS Improvement to explain the Trust's position and action it is taking to address spending on agency.

IB commented that, although he had concerns about focusing on one line, the "agency cap" does have significant implications for the Trust's risk rating. In the next planning round, Trust Board should be comfortable with the Trust's agency budget/cap rather than an imposed cap. It was agreed that the letter from RW to NHS Improvement should be circulated to Trust Board and that the NHS Improvement changes through the Single Oversight Framework and the implications should be included in reporting to the Members' Council and Trust Board in October 2016 once further work to review the position is complete.

RC commented that there is little reference in the narrative in relation to the trend around vacancies and she would like to see this information included. AGD responded that vacancies overall across the Trust are not high in comparison with other Trusts; however, there are individual areas where vacancies are having a major impact. MB confirmed that this will be covered in the full performance report.

MB also confirmed that he will present an updated performance report to Trust Board in October 2016 for comment and guidance on any further development.

It was RESOLVED to RECEIVE the performance report for month 5 2016/17 and it was AGREED that the letter to NHSI from RW be circulated; and an analysis of the impact of the SOF on the Trust's position be reported to COG and Trust Board in October.

TB/16/64b Finance report month 5 2016/17 (agenda item 7.2)
MB introduced the finance report and highlighted the following.

- The Trust's current position is favourably influenced by the non-recurrent release of provision from 2015/16 of circa £700k.
- The Trust has achieved its target to attract sustainability and transformation funding in the first quarter.
- There is a shortfall in CQUIN achievement year-to-date of £180k.
- Agency spend was close to £1m in August, which is £260k more than forecast; however, this is balanced by other pay savings.
- Out-of-area placements are higher than forecast and plan.
- There are, potentially, additional redundancy costs in September 2016 as a result of de-commissioning of services, as well as some dilapidation costs which may impact on the Trust's position for September and the second quarter
- The Trust retains a financial risk rating of 4.

MB also advised that NHS Improvement has brought forward planning timescales and that a two-year operational plan will be required in December 2016. Trust Board will be provided with an update on the requirements, challenges and assumptions in October 2016. The November strategy meeting will focus on the Trust's plans and the plan will be approved by Trust Board at December's meeting, prior to submission to NHSI by 23 December 2016

The following were raised.

- CD commented on the underspend on information management and technology and asked where the Trust would use the money if it is not spent. MB responded that this would be reviewed in conjunction with a range of other issues that impact upon the Trust's cash position. He explained that increased focus on RiO has resulted in delays to some other IT projects; There will be a review of capital priorities in the coming year; however, it is his view that strategic investment in IT could benefit the services the Trust provides
- JF asked if the overspend on agency was in particular areas. MB responded that it is being incurred with nursing and medical professions, and in a range of geographies and services. JF asked how the Trust was seeking to improve the position. ABe responded that there are different uses of medical agency staff, which have different solutions, and there are some areas where the use of locums is appropriate, for example, externally funded posts. However, there are some sub-specialisation and speciality doctor posts the Trust cannot recruit to and the Trust, therefore, needs to develop long-term solutions to address the position in other ways, which is related to re-design of the workforce.
- CJ commented that it is difficult to understand the pay cost budget and he asked what forms the underspend. MB responded that it represents a combination of factors, but at a high level it is a result of the number of vacancies, partly offset by increased temporary staffing costs MB will meet CJ outside the meeting to review the pay savings further.
- CJ also asked if there were any organisational implications for the vacancy position. AGD responded that the Trust is carrying 358 vacancies out of 4,500 staff, which is a relatively low proportion and there are a number of factors influencing the position, which is compounded by supply issues nationally. The workforce strategy will support the Trust to address areas affected by internal and external factors. RW advised that there

is a weekly operationally focussed meeting to review staffing pressures and how these are addressed within services. There will also be a re-budgeting and re-forecasting based on experience during 2016/17 to enable better planning for next year, which will also be to an earlier timescale during the planning process.

- IB commented that consideration of the Trust's operational plan in December 2016 will obviously be significant. There will be control totals at local and STP level, an agency cap and a potential capital cap; however, this must be the Trust's plan and budget not one that is influenced solely by external control totals. The plan will be considered by Trust Board in the public meeting in December 2016 and it is likely that Trust Board will need an additional meeting prior to the formal meeting to consider the detail of the plan. He also advised that the Members' Council joint meeting with Trust Board has also been brought forward to November 2016 to allow the Members' Council to influence the Trust's forward plan. IB expressed a concern, however, in relation to the quality of plans given the shorter timescales. The possibility of forming a sub-group of the Board to be kept engaged with and able to challenge the development of the plan was discussed.
- RW commented that there needs to be sufficient Board time to consider the Trust plans well and this will become clearer when guidance is published on 22 September 2016. One benefit of the West Yorkshire STP is that Directors of Finance are working more closely together and, therefore, the discussions on money between commissioners and providers has already started. Guidance will hopefully link STP and provider two-year plans.

It was RESOLVED to RECEIVE the report.

TB/16/64c Exception reports: Sustainability annual report (agenda item 7.3(i))
It was RESOLVED to NOTE the progress made against the Trust's Sustainability Strategy and to NOTE the areas of work for the coming year.

TB/16/64d Exception reports: Medical appraisal/re-validation (agenda item 7.3(ii))
It was RESOLVED to NOTE the report and APPROVE the statement of compliance confirming the organisation is a designated body as in compliance with the regulations.

TB/16/64e Exception reports: Nurse re-validation (agenda item 7.3(iii))
TB introduced this item. JF asked for assurance that the re-validation process is effective and staff are not just re-validated to ensure that the effect of 5% of staff not being re-validated is minimised. TB responded that there is a robust and clear process in place which sets out what staff have to achieve; he, therefore, has no concerns in this respect.

It was RESOLVED to NOTE the update on progress and that the processes in place have achieved expected outcomes.

TB/16/64f Exception reports: Workforce race equality standard (agenda item 7.3(iv))
AGD introduced this item and commented that this must not be a 'tick box' exercise and must engender change and development through action to:

- establish networks throughout the Trust, in particular, the Black Asian Minority Ethnic (BAME) network;
- challenge tolerance levels within the Trust;
- engage with local communities; and
- be seen as a good partner within the NHS and work with other organisations across Yorkshire and the Humber.

IB suggested inclusion of the pilot work with Gatenby Sanderson to increase the breadth of candidates for Non-Executive Director and Governor positions. AGD responded that it is crucial to include both Trust Board and the Members' Council as work at senior level is needed to deliver some objectives and targets. RW added that the tone set by Trust Board and the visual representation of the Trust on this agenda is very important. The BAME network will launch on 29 September 2016 and this may identify additional areas for inclusion on the action plan. Recognise that senior leaders within the organisation are from BME backgrounds, particularly amongst clinicians, and the Trust must ensure engagement in the leadership of the organisation.

In response to a question from CJ, AGD responded that staff subject to disciplinary action are small in number; however, evidence shows that staff from BME backgrounds are more likely to be subject to disciplinary action. This has been reviewed in detail but there is no obvious trend within the Trust. The BAME network will provide positive challenge for the way Trust does things and how it addresses and taps into potential benefits for the organisation. It will also inform work to remove barriers to recruitment, retention and progression and how the Trust can address these and seek to improve.

RW commented that, as a Board, Directors should push and question this issue, working to understand movements around underlying factors. IB commented that he would also like to look at excellence statistics, for example, Clinical Excellence Awards and the Trust's own Excellence Awards.

Subject to adding some narrative around Trust Board and the Members' Council, **it was RESOLVED to APPROVE the WRES action plan and ongoing monitoring through the Equality and Inclusion Forum.**

TB/16/65 Governance matters (agenda item 8)

TB/16/65a Independent governance review (agenda item 8.1)

IB asked whether there was a match between the well-led review and that undertaken by the CQC. DS responded that there is a different assessment approach from different regulators. The CQC's well-led domain is not restricted to Trust Board but looks at leadership at all levels within the organisation whereas the well-led review focused on Trust Board.

CD asked that the timescales for recommendation 8 in relation to communication and engagement mechanisms are clarified and included in the plan.

It was RESOLVED to NOTE the update on progress against the recommendations arising out of the independent review of the Trust's governance arrangements and CONFIRM that the mechanisms outlined in the paper provide sufficient governance and assurance for the action plan to be signed-off by Trust Board.

TB/16/66 Assurance from Trust Board committees (agenda item 9

TB/16/66a Clinical Governance and Clinical Safety Committee 13 September 2016 (agenda item 9.1)

JF reported that the Committee received a thorough report on child and adolescent mental health services (CAMHS); however, concerns remain for the Committee. There is a mixed picture across BDUs against a backdrop of increasing demand, which is a difficult position to manage. The concerns, particularly around waiting times, have been reported to Trust Board previously. The Committee did appreciate and recognise that staff are working hard to address the position.

CD commented on the tenders for CAMHS in Calderdale and Kirklees. RW responded that the Trust provides a combined service currently across both areas. In Calderdale, the clinical commissioning group (CCG) tendered for the service. The process finished in August 2016 and has now been stopped as the CCG was unsuccessful in finding a provider to deliver the services to the specification. In Kirklees, CAMHS is included in a wider bid for 0-19 services, which has only just been issued. The risk to separating the services has been raised with all three CCGs, particularly in relation to the crisis service, which has to be based on population size and, therefore, there is a risk to the sustainability of the service.

TB/16/66b Mental Health Act Committee 2 August 2016 (agenda item 9.2)
CJ highlighted a theme running through the Committee agenda in relation to data recording, and systems sharing and interoperability.

TB/16/66c Information Management and Technology Forum 12 September 2016 (agenda item 9.3)
IB commented that the Forum's agenda is dominated by the RiO V7 upgrade issues. The Forum also discussed the work to develop integrated care records and portal, and options for procurement of a mental health clinical information system.

On a general point, it was agreed to take a 'risk appetite' approach as previously discussed and approved by Trust Board. Where a risk is not managed at an acceptable level, it should be escalated to Committee and/or Trust Board level. Where a Committee is not assured, the risk should be escalated to Trust Board for discussion and agreement of continued monitoring and scrutiny.

TB/16/67 Use of Trust seal (agenda item 10)

It was RESOLVED to NOTE the use of the Trust's seal since the last report in June 2016.

TB/16/68 Date and time of next meeting

The next meeting of Trust Board will be held on Tuesday 25 October 2016 in meeting room 1, Block 7, Fieldhead, Wakefield, WF1 3SP. It was noted that the meeting will be chaired by JF as Deputy Chair.

Signed …… Date ……