South West Yorkshire Partnership NHS Foundation Trust

Members' Council
Friday 3 August 2018
12:30pm to 3.30pm. This will be followed by a Development Session for governors from 3:30 to 4:30pm
The Shay Stadium, Shaw Hill, Halifax, HX1 2YT

Item	Time	Subject Matter	Presented by		Action
	12.00pm	*Lunch and networking*			
1.	12:30pm	Welcome, introductions and apologies	Angela Monaghan, Chair	**Verbal item**	To receive
2.	12:35pm	Declaration of Interests – Further declarations as part of annual exercise	Angela Monaghan, Chair	**Paper**	To agree
3.	12:40pm	Minutes of the previous meeting held on 27 April 2018	Angela Monaghan, Chair	**Paper**	To agree
4.	12:50pm	Chair's report and feedback from Trust Board	Angela Monaghan, Chair	**Paper**	To receive
		Deputy Chief Executive's comments	Tim Breedon, Director of Nursing & Quality	**Verbal item**	To receive
5.	1:10pm	Trust Board appointments			
		5.1 Appointment of Non-Executive Directors	Angela Monaghan, Chair	**Paper**	To agree
		5.2 Chair and Non-Executive Directors' remuneration - process and timescales	Alan Davis, Director of HR, OD & Estates	**Paper**	To agree
6.	1:30pm	Members' Council business items			
		6.1 Annual Report accounts 2017/18 and Quality Account 2017/18	Mark Brooks, Director of Finance / Tim Breedon, Director of Nursing & Quality /	**Paper**	To receive
			Paul Hewitson, Deloitte	**Presentation**	To receive

With **all of us** in mind.

Item	Time	Subject Matter	Presented by		Action
		6.2 External auditors – continuation of contract	Laurence Campbell, Non-Executive Director / Mark Brooks, Director of Finance	**Paper**	To agree
		6.3 Members' Council Coordination Group Annual Report 2017/18	Jackie Craven, Lead Governor / Angela Monaghan, Chair	**Paper**	To receive
		6.4 Membership on Members' Council groups	Jackie Craven, Lead Governor / Angela Monaghan, Chair	**Verbal item**	To receive
		6.5 Nominations Committee Annual Report 2017/18 and Terms of Reference	Angela Monaghan, Chair	**Paper**	To receive / agree
		6.6 Governor engagement feedback	Angela Monaghan, Chair	**Paper**	To receive
	2.20pm	*Break*			
7.	2:30pm	Integrated Performance Report Quarter 1 2018/19. *There will also be a presentation of the key issues. Full performance reports are available on the Trusts website under: About us > How we're run > Performance.* - Focus on: Out of Area Beds	Laurence Campbell, Non-Executive Director ./ Mark Brooks, Director of Finance / Karen Taylor, Director of Delivery	**Presentation**	To receive
8.	3:00pm	Customer Services and Serious Incidents Annual Reports 2017/18	Tim Breedon, Director of Nursing & Quality	**Presentation**	To receive
9.	3:20pm	<u>Closing remarks and dates for 2018</u> - Monday 17 September 2018, Annual Members' Meeting, afternoon meeting, The Shay Stadium, Shaw Hill, Halifax, HX1 2YT - Friday 2 November 2018, morning meeting, Large conference room, Wellbeing & learning centre, Fieldhead, Wakefield	Angela Monaghan, Chair	**Verbal item**	To receive
	3.30pm	**Members' Council Development Session - Understanding NHS Finance and Counter Fraud**			
	4:30pm	*Close*			

South West Yorkshire Partnership NHS Foundation Trust

Members' Council
3 August 2018

Agenda item:	**2**
Report Title:	Members' Council Declaration of Interests
Report By:	Company Secretary on behalf of the Chair
Action:	To agree

EXECUTIVE SUMMARY

Purpose and format

The purpose of this item is to provide information regarding the declarations made by governors on their interests as set out in the Constitution and Monitor's Code of Governance.

Recommendation

The Members' Council is asked to NOTE the individual declarations in addition to those declared at the meeting on 27 April 2018 and to CONFIRM the changes to the Register of Interests.

Background

The Trust's Constitution and the NHS rules on corporate governance, the Combined Code of Corporate Governance, and Monitor, require a Register of Interests to be developed and maintained in relation to the Members' Council. During the year, if any such declaration should change, governors are required to notify the Trust so that the Register can be amended and such amendments reported to the Members' Council.

Both the Members' Council and Trust Board receive assurance that there is no conflict of interest in the administration of the Trust's business through the annual declaration exercise and the requirement for governors to consider and declare any interests at each meeting.

There are no legal implications arising from the paper; however, the requirement for governors to declare their interests on an annual basis is enshrined in the Health and Social Care Act 2012 in terms of the content of the Trust's Constitution.

These declarations of interest are in addition to those declared at the Members' Council meeting on 27 April 2018.

Process

The Company Secretary is responsible for administering the process on behalf of the Chair of the Trust. The declared interests of governors are reported in the annual report and the Register of Interests is published on the Trust's website.

South West Yorkshire Partnership NHS Foundation Trust

Members' Council – Declaration of Interests
3 August 2018

The following declarations of interest were made by Governors in addition to those made at the Members' Council meeting on 27 April 2018:

Name	Declaration
AMARAL, Kate Publicly elected - Wakefield	Volunteer Patient Research Ambassador, South West Yorkshire Partnership NHS Foundation Trust Volunteer Befriender, South West Yorkshire Partnership NHS Foundation Trust
CROSSLEY, Andrew Publicly elected - Barnsley	Director, Pathway Sales Limited. Shareholder (non-controlling), Liaison Financial Services. Director, Samaritans, Barnsley. Volunteer, Victim Support, Wakefield.
DOOLER, Daz Publicly elected - Wakefield	Chair, S.M.a.S.H Society. Seconded position through Nova, Live Well Wakefield Team, South West Yorkshire Partnership NHS Foundation Trust.
HAMPSON, Stefanie Appointed - Staff side organisations	No interests declared.
HASNIE, Nasim Publicly elected - Kirklees	No interests declared.
HOGARTH, Lisa Staff elected - Allied Healthcare Professionals	School governor, Salendine Nook High School Huddersfield. Member governor, Salendine Nook High School Huddersfield. Members of the Labour Party.
SAUNDERS, Caroline Appointed - Barnsley MBC	Councillor, Barnsley MBC
SMITH, Jeremy Publicly elected - Kirklees	Director, Predictlaw Ltd.
TOLCHARD, Professor Barry Appointed - University of Huddersfield	No interests declared.
WALKER, Debby Staff elected - Non-clinical Support Services	No interests declared.
WALKER, Mike Publicly elected - Kirklees	Trustee, Mission Huddersfield. Member, Creative Minds Collective Kirklees. Expect by experience, Care Quality Commission (not involved in inspections of South West Yorkshire NHS Foundation Trust)

Name	Declaration
WILLIAMS, Paul Publicly elected - Rest of South and West Yorkshire	No interests declared.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Members' Council meeting held on 27 April 2018
Textile Centre of Excellence, Huddersfield

Present:	Angela Monaghan	Chair
	Marios Adamou	Staff – Medicine and Pharmacy
	Neil Alexander	Public – Calderdale
	Bob Clayden	Public – Wakefield
	Jackie Craven	Public – Wakefield
	Andrew Crossley	Public – Barnsley
	Adrian Deakin	Staff – Nursing
	Claire Girvan	Staff – Allied Health Professionals
	Stefanie Hampson	Appointed – Staff side organisations
	Lin Harrison	Staff – Psychological Therapies
	Nasim Hasnie	Public – Kirklees
	John Haworth	Staff – Non-Clinical Support
	Carol Irving	Public – Kirklees
	Ruth Mason	Appointed – Calderdale and Huddersfield NHS FT
	Debika Minocha	Public – Wakefield
	Jules Preston	Appointed – Mid Yorkshire Hospitals NHS Trust
	Phil Shire	Public – Calderdale
	Jeremy Smith	Public – Kirklees
	Gemma Wilson	Staff – Nursing Support
	David Woodhead	Public – Kirklees
In attendance:	Mark Brooks	Director of Finance and Resources
	Laurence Campbell	Non-Executive Director
	Rachel Court	Non-Executive Director
	Alan Davis	Director of HR, OD and Estates
	Charlotte Dyson	Non-Executive Director
	Aimee Gray	Corporate Governance Manager (author)
	Lisa Hogarth	Staff – Allied Health Professionals (from 1 May 2018)
	Karen Taylor	Director of Delivery
	Dr Subha Thiyagesh	Medical Director
	Rob Webster	Chief Executive
	Salma Yasmeen	Director of Strategy
Apologies:	Members' Council	
	Shaun Adam	Public – Barnsley
	Bill Barkworth	Public – Barnsley
	Tina Harrison	Public – Kirklees
	Chris Pillai	Appointed – Calderdale Council
	Caroline Saunders	Appointed – Barnsley Council
	Richard Smith	Appointed – Kirklees Council
	Attendees	
	Tim Breedon	Director of Nursing & Quality
	Carol Harris	BDU Director, Calderdale, Kirklees, Forensic and Specialist Services
	Kate Henry	Director of Marketing, Communication and Engagement
	Chris Jones	Non-Executive Director
	Kate Quail	Non-Executive Director
	Sean Rayner	BDU Director, Barnsley and Wakefield

MC/18/09 Welcome, introductions and apologies (agenda item 1)

Angela Monaghan (AM), Chair, welcomed everyone to the meeting. Apologies as above were noted.

AM welcomed Lisa Hogarth, newly elected governor from 1 May 2018, and Dr Subha Thiyagesh, Medical Director to their first meeting of the Members' Council. AM also noted that the University of Huddersfield had appointed a new representative, Professor Barry Tolchard, but that the Trust was still awaiting an appointed member from Barnsley Hospital NHS Trust. AM informed the meeting that David Jones had stepped down as an appointed governor for Wakefield Council due to a conflict of interest with his role as Councillor. AM thanked David, in his absence, for his contribution to the Members' Council.

MC/18/10 Members' Council business items (agenda item 2)

MC/18/10a Members' Council elections (agenda item 2.1)

AM informed the Members' Council of the outcome of the recent governor election as follows:

- Public - Wakefield: Kate Amaral and Daz Dooler
- Public - Rest of South and West Yorkshire: Paul Williams
- Public - Kirklees: Mike Walker
- Staff - Non-clinical support services: Debby Walker
- Staff - Allied Healthcare Professionals: Lisa Hogarth
- Staff - Registered Medical Practitioners and Registered Pharmacists: Marios Adamou (re-elected)
- Staff - Registered Nurses: Adrian Deakin (re-elected)

Vacant seats remain for Public - Calderdale and Staff - social care staff in integrated teams.

AM advised that Claire Girvan and John Haworth would retire as staff governors by rotation and thanked them for their contributions to the Members' Council during their years as governors. Adrian Deakin (AD) added that he was looking forward to working with the new staff representatives but that he would miss Claire and John's input.

Lin Harrison (LH) queried what had been done to promote awareness and encourage nominations for the social staff in integrated teams seat. Aimee Gray (AG) advised that information had been circulated within the Trust's Business Development Units (BDUs) in a bid to encourage nomination. The meeting discussed that the staff group was small in comparison to other groups which may also be a factor contributing to the lack of nominations. It was suggested that the public and staff groups are reviewed at the next review of the Constitution.

Action: Angela Monaghan

MC/18/11 Declaration of Interest – annual exercise (agenda item 3)

The Members' Council noted the paper.

David Woodhead (DW) queried if declarations should only be of a commercial nature. AM encouraged governors to make any declarations that may cause, or be seen to cause, a conflict of interests. The following additional declarations were made:

- David Woodhead – Labour Party
- Jackie Craven – member of Dementia UK

Jeremy Smith (JS) advised that he had interests to declare that were not included in the paper. JS agreed to submit outside of the meeting.

It was RESOLVED to NOTE the individual declarations from governors and CONFIRM the changes to the register of interests.

MC/18/12 Minutes of the previous meeting held on 3 February 2018 (agenda item 4)

It was RESOLVED to APPROVE the minutes from the meeting held on 3 February 2018.

The meeting discussed the outstanding action points:

- MC/18/04 service user stories for Trust Board – AM updated the meeting to advise that the Members' Council Quality Group would discuss future service user stories to be presented to the Trust Board. Neil Alexander (NA) provided feedback on the story that was presented at the April 2018 Board meeting and felt that it was focussed on process rather than a service user issue and how an issue was solved. Rob Webster (RW) commented that there had stories at previous Board meetings which focused on service user issues and lessons learned. The role of the Members' Council Quality Group will be to discuss the best way to reflect service users' and carers' experiences at Board.

MC/18/13 Chair's report and feedback from Trust Board and Chief Executive's comments (agenda item 5)

Chair's report and feedback from Trust Board

AM highlighted the followings:

- Since the report was circulated to the governors, the West Yorkshire Mental Health Services Collaborative (WYMHSC) Memorandum of Understanding (MoU) had been agreed by all Boards and that governors would receive written confirmation of this.
- Dr Adrian Berry has retired from the role of Medical Director but will continue to work with the Trust as Responsible Officer. Dr Subha Thiyagesh began her role as Medical Director from 12 April 2018.
- Outline of the key areas of discussion at the Trust Board:
  - Focus on the Board Assurance Framework (BAF) and risk register. The Board agreed to update the Risk Appetite and that a risk should be added to the organisational level risk register regarding out of area placements.
  - Safer staffing report.
  - Finance and performance reports.
  - Annual report on safe working hours for doctors in training that was presented by Dr Richard Marriott.
  - The Board also reviewed and approved the committee and forum terms of reference and AM noted that Nasim Hasnie was now formally a member of the Equality and Inclusion Forum. AM added that further work is required to consider how the Forum would determine which governor would be a member of the Forum in the future and advised that governors are welcome to attend the Forum should they wish to.

NA fed back that it was useful to receive a copy of The Brief. The meeting discussed the NHS 70 Superstar Awards and the positive feedback that had been received from staff across the Trust about this.

Marios Adamou (MA) raised the issue of out of area placements and queried what plans were in place to reduce the number of placements. Mark Brooks (MB) noted that there was a lot of work across the WYMHSC and that all mental health providers were being asked to agree a trajectory to reduce the number of out of area placements over three years. The trajectory would be agreed with commissioners and plans will be submitted in April / May 2018.

Chief Executive's Comments
RW reported the following:

- Feedback from the most recent Care Quality Commission (CQC) visit that the Trust had retained the right culture.
- The risks the Trust will face over the next year relating to finance in particular around out of area bed placements, and informed that the spend in February and March 2018 had been the highest so far.
- During the pre-election period, the Trust were not permitted to make any decisions or announcements that could be politically sensitive. RW noted that the Prime Minister had pledged to produce a long term settlement for the NHS and it was expected to be announced for the 70th birthday of the NHS. The Trust would also have 70 new volunteer roles and RW asked governors to promote this across their networks.

Carol Irving (CI) advised that she had seen a negative article relating to Locala and queried if this could tarnish the reputation of the Trust as we have worked with Locala. RW noted that the adult services and inpatient services run by Locala were rated as 'inadequate' by the CQC and the Trust immediately checked if any Trust services were impacted. Support has been offered to Locala to assist them in improving the areas rated as 'inadequate' and Tim Breedon (TB) attends their governance meetings.

Phil Shire (PS) queried the high spend on out of area beds and Karen Taylor (KT) explained that this was a challenging situation with variance in demand and capacity across the footprint, and the Trust was trying to learn from other organisations to get it right. The team has visited Sunderland and was working closely with Bradford.

MC/18/14 Trust Board appointments (agenda item 6)

MC/18/14a Re-appointment of Non-Executive Directors (agenda item 6.1)
Rachel Court (RC) and Charlotte Dyson (CD) left the room for this agenda item.

AM outlined what the Members' Council were being asked to consider and approve. NA commented that more information should be provided as to why the Nominations' Committee are making the recommendations to the Members' Council. It was noted that the Minutes from the Nominations' Committee meetings are publicly available and that members of the Committee present at the Members' Council meeting were open to questions. It was suggested that future papers should include an extract from the Minutes to show the discussion that took place. The recommendations made and the value that RC and CD bring to the Trust was discussed.

It was unanimously RESOLVED to SUPPORT the following recommendations from Nominations Committee to:

- **re-appoint Rachel Court as Non-Executive Director of the Trust for a period of up to 12 months from 1 October 2018 to 30 September 2019;**
- **re-appoint Charlotte Dyson as Non-Executive Director of the Trust for a further three-year period from 1 May 2018 to 30 April 2021; and**
- **re-appoint Charlotte Dyson as the Deputy Chair and as Senior Independent Director for a further two-year period from 1 August 2018.**

MC 18/14b Non-Executive Director recruitment (agenda item 6.2)
AM outlined that recruitment information events were held in each of the localities, the events were well attended and AM thanked governors for attending where possible. The roles had also been advertised in the Guardian, the Yorkshire Post, on social media and within networks.

It was RESOLVED to NOTE the update.

MC/18/15 Members' Council business items (continued) (agenda item 7)

MC/18/15a Update to the Members' Council declaration and register of interests including gifts and hospitality policy (agenda item 7.1)
It was noted that an extra 'and' should be removed from 'section f' and MB confirmed that 'section g' covered any other declarations not covered under the points above in the interest of openness and transparency.

It was RESOLVED to APPROVE the updated Policy.

MC/18/15b Members' Council Groups – Terms of Reference (agenda item 7.2)
It was RESOLVED to APPROVE the changes to the Members' Council Quality Group Terms of Reference.

MC/18/15c Review of Audit Committee Terms of Reference (agenda item 7.3)
Governor attendance at the Audit Committee was discussed. Laurence Campbell (LC) confirmed that governors had attended in the past and an example of this was to appoint the internal auditors. MB confirmed that all Audit Committee items are included in the public session of Board meetings. It was agreed to share the Audit Committee work programme with the governors and for the Committee Chair to discuss with the Lead Governor where governors may be invited to attend for certain items.

Action: Emma Jones / Laurence Campbell

It was RESOLVED to NOTE the Terms of Reference for the Audit Committee.

MC/18/16 Integrated Performance Report including finances Quarter 4 2017/18 (agenda item 8)

The key messages from the Integrated Performance Report were presented by LC.

PS queried the staffing numbers in the report and AGD confirmed that the safer staffing fill rate relates to the shifts rather than the number of staff.

The Trust would receive targeted support due to the level of financial risk, however it was noted that the agency spend has improved by 41% since 2016/17. MB advised that the Trust would have an approximate deficit of £2 – 2.5m for the first time in 2018/19.

MC/18/17 Care Quality Commission (CQC) – update on our inspection and report on unannounced / planned visits (agenda item 9)

The key messages from the CQC inspection and visits were presented by Dr Subha Thiyagesh (SThi).

MC/18/18 Strategy, transformation / priority programme update (agenda item 10)

The key messages from the strategy, transformation and priority programme update were presented by CD.

AM asked for any questions relating to the presentations for items 9 or 10:

- Claire Girvan (CG) queried if there was a correlation between the transformation process and what the future plans were in relation to this. AM suggested that there should be a more focussed session on out of area beds at a future Members' Council meeting.

  Action: Karen Taylor
- NA queried the metrics for safer staffing fill rates and if this should be re-evaluated to correlate more closely to 100%. It was discussed that the fill rate % does not mean that we are overstaffed, but is the right level of staff for the care needed by our service users. NA also queried if the cash is 'ring-fenced' and MB explains that as a Foundation Trust we can retain the cash balance and invest capital.
- LH requested more information of sickness absence at a future meeting to fully understand the drivers and what can be done to address them.

  Action: Alan Davis
- BC asked what the savings would be if internal beds were used rather than out of area beds. MB responded that this would depend on the type of bed, but it would be approximately half of the cost.
- Stefanie Hampson (SH) queried if the levels of staff sickness are influencing the level of agency spend. Alan Davis (AGD) advised that the Trust always puts safety first and will use bank staff where possible to cover any sickness.
- MA queried what is included in the strategy in relation to saving in excess of 6%. MB advised that income is reducing year on year and less service provision has an impact on the level of savings.
- PS noted that a £6m saving has been identified and queried where the additional £3m saving could come from. MB advised that there was work ongoing to make some savings from this financial year recurrent and to look at vacancies and restructuring if required. In addition, there may be some upsides from this year that we are yet to bank. It is recognised that this will be a significant challenge.
- Andrew Crossley (AC) queried if there is a strategy to increase more high profile media coverage such as the recent news article on suicide. It was acknowledged that the Trust needs to do more external communications.
- Nasim Hasnie (NH) queried if children who are inpatients in adult beds are in separate rooms. KT explained that if children are placed in an adult bed, they are between 16-18 and are nursed in a room of their own with ensuite facilities and are not mixed with adult inpatients.
- CG suggested that STP agreements about use of beds across the patch should help with patient flows.

MC/18/19 Members' Council Development (agenda item 11)

Ruth Mason (RM) gave an interactive presentation with governors about holding Non-Executive Directors to account and opportunities to be involved with the Trust.

MC/18/20 Holding Non-Executive Directors to account – annual session (agenda item 12)

The governors held an interactive 'speed-dating' session with the Non-Executive Directors to hold them to account in their role on the Trust Board.

MC/18/21 Closing remarks and dates for 2018 (agenda item 13)

AM thanked the governors for their attendance and input, and reminded of the following dates for 2018 including the date and venue for the Annual Members' Meeting:

- Friday 3 August 2018, afternoon Members' Council meeting (Elsie Whiteley, Halifax)
- Monday 17 September 2018, afternoon Annual Members' Meeting (Shay Stadium, Halifax)
- Friday 2 November 2018, morning Members' Council meeting (Fieldhead, Wakefield)

Signed: **Date:**

South West Yorkshire Partnership NHS Foundation Trust

MEMBERS' COUNCIL 27 APRIL – ACTION POINTS

Actions from 27 April 2018

Minute ref	Action	Lead	Timescale	Progress
MC/18/10a Members' Council elections	Lin Harrison (LH) queried what had been done to promote awareness and encourage nominations for the social staff in integrated teams seat. Aimee Gray (AG) advised that information had been circulated within the Trust's Business Development Units (BDUs) in a bid to encourage nomination. The meeting discussed that the staff group was small in comparison to other groups which may also be a factor contributing to the lack of nominations. It was suggested that the public and staff groups are reviewed at the next review of the Constitution.	Chair	2019	Noted for discussion as part of the next review of the Constitution.
MC/18/15c Review of Audit Committee Terms of Reference	Governor attendance at the Audit Committee was discussed. Laurence Campbell (LC) confirmed that governors had attended in the past and an example of this was to appoint the internal auditors. MB confirmed that all Audit Committee items are included in the public session of Board meetings. It was agreed to share the Audit Committee work programme with the governors and for the Committee Chair to discuss with the Lead Governor where governors may be invited to attend for certain items.	Emma Jones / Laurence Campbell		Audit Committee work programme circulated to governors on 22 June 2018. Committee Chair and Lead Governor to discuss where governors may be invited to attend for certain items.
MC/18/18 Strategy, transformation / priority programme update	Claire Girvan (CG) queried if there was a correlation between the transformation process and what the future plans were in relation to this. AM suggested that there should be a more focussed session on out of area beds at a future Members' Council meeting.	Karen Taylor	3 August 2018	Scheduled for a focus session under the Integrated Performance Report presentation to Members' Council on 3 August 2018.

Minute ref	Action	Lead	Timescale	Progress
MC/18/18 Strategy, transformation / priority programme update	LH requested more information of sickness absence at a future meeting to fully understand the drivers and what can be done to address them.	Alan Davis		Members' Council Coordination Group to consider timing for a focus session under the Integrated Performance Report presentation at a future Members' Council meeting.

Outstanding actions from 2 February 2018

Minute ref	Action	Lead	Timescale	Progress
MC18/04 Chair's report and feedback from Trust Board and Chief Executive's comments	AM asked governors to advise if there were any service user stories that they think the Board should hear. Rob Webster (RW) added that the Members' Council Quality Group could potentially pick the stories in the future. *Update 27 April 2018:* AM updated the meeting to advise that the Members' Council Quality Group would discuss future service user stories to be presented to the Trust Board…The role of the Members' Council Quality Group will be to discuss the best way to reflect service users' and carers' experiences at Board.	Governors / Tim Breedon		Complete. The Members' Council Quality Group was asked about potential service user stories and it was agreed that any examples would be brought to future meetings.
MC18/06 Integrated performance report Quarter 3 2017/18	CI advised that she had met recently with the manager of Improving Access to Psychological Therapies (IAPT) in Kirklees to talk through some issues raised by the public, such as the number of people attending a clinic. CH commented that she was aware that workshops were offered for groups of people but she was not aware of clinics being offered in this way. CI commented that she was unsure if people were aware that they could ask for a one to one appointment rather than in a group. TB commented that there could be benefits of dealing with situations in large groups, however this matter could be looked at further by the Members' Council Quality Group.	Tim Breedon		Complete. This was discussed by the Members' Council Quality Group and those present understood and supported the approach of group work as it is only on a voluntary basis.

Members' Council 3 August 2018

Chair's Report

The papers provided to the Members' Council, plus the monthly Brief now circulated to Governors, provide comprehensive and up-to-date information on Trust performance and activity. This Chair's report aims to supplement these by highlighting:

- feedback from Board meetings
- Governor engagement
- Chair activity
- and other issues which may be of interest to Governors

1. Feedback from the Board

Since the last Members' Council meeting, the Board has met twice:

a. **May** was a *strategy* meeting, which takes place in private to enable the Board to explore and develop their thinking before decisions are taken. Our discussions were focussed on emerging integrated care developments in Barnsley and Wakefield and proposed changes to director portfolios at South West Yorkshire Partnership NHS Foundation Trust (SWYPFT).

   Since these discussions took place, Barnsley Clinical Commissioning Group (CCG) has announced their intention to change the way that health and care services across the Borough are provided and I wrote to all Governors on 16 July 2018 with details of these developments. Their proposal concerns how they intend to join up and integrate services more closely, potentially through developing a single provider called an Integrated Care Organisation (ICO). This single provider would include the community services, mental health and learning disability services we currently provide in Barnsley. These developments are still in their early stages and we will ensure Governors are kept informed and engaged as they progress.

   In relation to director portfolios, Rob Webster, Chief Executive, sent a letter to all Governors on 13 July 2018 explaining the changes taking place in the executive management team. This includes the appointment of Tim Breedon, Director of Nursing and Quality, as Deputy Chief Executive, which will support Rob Webster to continue in his dual role as Chief Executive and Accountable Officer for SWYPFT and Lead Executive for the West Yorkshire and Harrogate Health and Care Partnership (the ICS). These changes align our senior leadership with our 2018/19 priorities. They will also reduce the number of directors and result in savings for the organisation in these tough financial times.

b. **June** was a *performance and monitoring m*eeting (in Huddersfield), so our focus was on the integrated performance report (IPR). In particular, we discussed the Learning Disabilities Mortality Review (LeDeR) programme annual report and considered what further steps we should take to improve our services for people with learning disabilities. We also received our incident management annual report. In relation to developments in our two integrated care systems, West Yorkshire & Harrogate and South Yorkshire & Bassetlaw, we formally received the new Memorandum of Understanding agreed for the West Yorkshire Mental Health Services Collaborative, which Governors have been engaged in developing. Under governance items, we received a final copy of the SWYPFT operating plan for 2018/19, which has been submitted to our regulator, NHS Improvement. We were pleased that a number of Governors were able to attend this meeting.

The **July** Board meeting, which is a *business and risk* meeting, is taking place just prior to the Members' Council (on 31July 2018 in Wakefield) and I will be able provide a verbal update at the Members' Council meeting.

Please note that Governors are welcome to attend all public Board meetings and that papers are available on our website a week before at www.southwestyorkshire.nhs.uk/about-us/how-we-are-run/trust-board/meeting.

2. **Governor engagement**

Governors have been invited to join a number of engagement events since our last meeting, including:

a. Commitment to Carers: 4 events have taken place across the Trust - in Barnsley, Calderdale, Kirklees and Wakefield - to help us understand better the needs of carers and review our Carers' Charter.
b. West Yorkshire Mental Health Services Collaborative (WYMHSC) Joint Non-Executive Director (NED) and Governor Event, 17 July 2018: this follows-up a similar event held in February.
c. NHS Providers Governor Focus Conference – attended by Jackie Craven, Lead governor.

Governors who attended these events may be able to provide a brief verbal update at the meeting.

3. Chair activity

To help governors understand the range of activities undertaken by Non-Executive Directors (NEDs) and to support governors in their role of holding the NEDs to account, I provide some brief information here on the range of activity I have been engaged in as Chair since the last Members' Council meeting. Over the last 3 months, my activities have included:

- induction meetings with newly elected and appointed Governors, plus regular contact with Lead Governor Jackie Craven
- engagement with staff, volunteers and service users, including:
    - monthly Trust Welcome Events for new staff
    - staff listening event

    - BAME staff network
    - volunteer celebration event
    - Creative Minds learning disability football fun day, and EASI world cup
    - Middle Ground leadership development programme
    - Hospital Managers' Forum
    - visit to the Unity Centre, Fieldhead
    - shadowing Barnsley pharmacy team
    - EyUp! NHS70 tea party
- attendance at a range of governance meetings, including:
    - Members' Council Coordination Group
    - West Yorkshire Mental Health Services Collaborative Committees in Common
    - South Yorkshire and Bassetlaw Acute Federation and Mental Health Alliance
    - Barnsley Provider Alliance
    - Equality and Inclusion Forum
    - Workforce and Remuneration Committee (formerly the Remuneration and Terms of Service Committee)
    - Audit Committee
    - Nominations Committee
    - Charitable Funds Committee
    - Clinical Governance and Clinical Safety Committee
    - Medical Education Trust Action Group
    - Improving Clinical Information Group
- attendance at a range of external events, including:
    - launch of the NHS Providers/NHS Confederation Community Services network
    - Windrush Awards
    - NHS Confederation annual conference
    - NHS Workforce Race Equality Standard (WRES) round table discussion
    - South Yorkshire & Bassetlaw ICS NEDs' engagement event
    - NHS70 staff celebration event at York Minster
    - Mid Yorkshire Hospitals Trust AGM
- annual appraisals with all Non Executive Directors
- NED and consultant interview panels
- disciplinary appeal panels
- meetings with MPs from across our patch

I would be happy to answer questions or provide further information on any of the above.

4. Other

As mentioned above, one of the things I have had the pleasure of attending recently was the national Windrush Awards in June and I'm delighted to report that Evelyn Beckley, our patient affairs officer, was chosen as the winner of the Operational Service Excellence category. Evelyn has worked for the NHS for 25 years and was nominated for going beyond the call of duty to make a positive difference to service users. The whole event was an uplifting and positive celebration of talent.

The ever-inspiring Debs Taylor, a Peer Project Development Worker with the Trust's Creative Minds, was also celebrated as she was voted number 5 in England in Health and Care's Top 70 stars as part of the NHS's 70th birthday celebrations. The campaign saw patients, staff and public nominating people who have made an exceptional contribution to patient care, services and local communities over the last 70 years. It was a proud moment for her, her team at Creative Minds, and us as a Trust.

And it's just been announced that Creative Minds has made the shortlist for the West Riding Football Association's Awards in the 'Outstanding Contribution to Disability Football'.

I'm sure you will join me in congratulating them all.

Angela Monaghan
Chair

South West Yorkshire Partnership NHS Foundation Trust

Members' Council
3 August 2018

Agenda item:	**5.1**
Report Title:	Non-Executive Director (NED) appointments
Report By:	Chair and on behalf of the Nominations Committee
Action:	To agree

EXECUTIVE SUMMARY

Purpose and format

The purpose of this report is to update the Members' Council on the appointment of two (2) Non-Executive Directors (NEDs) to replace Chris Jones who is retiring from the Trust Board and his last day will be 31 July 2018 and Rachel Court who will be retiring from the Trust Board shortly. Governors will be asked to approve the appointment of two (2) new Non-Executive Directors at the meeting.

Recommendation

The Members' Council is asked to RECEIVE the update and APPROVE the recommendation from the Nominations Committee on the appointment of two (2) new Non-Executive Directors.

Background

The role of the Nominations Committee is to ensure the right composition and balance of Trust Board and to oversee the process for appointing the Chair and Non-Executive Directors, Deputy Chair/Senior Independent Director, and the Lead Governor.

Process

The Nominations Committee oversaw the process through its meetings held from February 2018 to 16 July 2018 and an update was provided to the Members' Council meeting on 27 April 2018. It was agreed that the recruitment process would be managed in-house on this occasion rather than using external recruitment consultants. However, the recruitment process to a large extent mirrored that undertaken by the external recruitment consultants for the Chair and previous NED vacancies. The outline timetable for recruitment was as follows:

- Post advertised in the Guardian and Yorkshire Post on line - week commencing 26 May 2018
- Information event for potential candidates held in Calderdale (Halifax), Kirklees (Huddersfield), Wakefield and Barnsley during April 2018

- Closing date for applications - 7 May 2018
- Longlisting agreed - 21 May 2018
- Long listed candidates interviewed by Chair, Deputy Chair/Senior Independent Director, Director of Finance & Resources, and Director of Human Resources, Organisational Development and Estates - 29 May 2018
- Shortlist agreed by Nominations Committee - 20 June 2018
- Panel discussions (governors; service users/carers; staff including representatives from the Black and Minority Ethnicity (BAME) and Disability Staff Networks) - 9 and 11 July 2018
- Final panel interviews - 13 July 2018 (Interview Panel members: Angela Monaghan, Chair; Jackie Craven, Lead Governor; Nasim Hasnie, Elected Governor; Charlotte Dyson, Deputy Chair/Senior Independent Director)
- Nominations Committee considered and agreed recommendations for appointment to two NED vacancies - 16 July 2018, for consideration and approval by Members' Council on 3 August 2018
- Members' Council approval - 3 August 2018
- Appointment start date - 6 August 2018

The Nominations Committee considered the skills and experience required of two new NEDs as well as the diversity and overall mix and composition of the Trust Board. The advertisement welcomed applicants with either:

- a financial qualification, and senior-level financial management experience

and/or

- expertise and experience in one or more of the following areas: workforce/human resources; health and social care; IT/digital technology (especially within healthcare) and law.

plus:

- Experience of working in or with large complex organisations
- Strong relationship management and influencing skills
- Committed to quality and delivering excellence
- Ability to engage positively and collaboratively in Board discussions
- Ability to act as an ambassador for the Trust
- Strong commitment to promoting equality, inclusion and diversity

The advertisement also welcomed applications from all aspects of society, including people from BAME communities, people with disabilities, younger people, service users and carers.

<u>Outcome</u>

In all, **39 applications** were received.

13 candidates were invited for a preliminary interview following the review and longlisting by Angela Monaghan, Chair; Charlotte Dyson, Deputy Chair/Senior Independent Director; Mark Brooks, Director of Finance & Resources; and Alan Davis, Director of Human Resources, Organisational Development & Estates.

7 candidates following the above process were recommended for the shortlist for the final interviews and this was agreed by the Nominations Committee on 20 June 2018. However, 2 candidates withdrew prior to the final interviews. The remaining 5 candidates were involved in a stakeholder engagement event involving panel discussions with: Service Users/Carers; Governors; and Staff (including representatives from BAME and Disability staff networks) on 9 and 11 July 2018. The final interviews were held on the 13 July 2018 and the panel members were Angela Monaghan, Chair; Charlotte Dyson, Deputy Chair/Senior Independent Director; Jackie Craven, Lead Governor; and Nasim Hasnie, Public Governor.

The Nominations Committee met on 16 July 2018 and discussed and agreed the recommendations for appointment from the final interview panel. On behalf of the Nominations Committee, the Chair is making a recommendation to the Members' Council on 3 August 2018 for the appointment of two (2) new Non-Executive Directors. **The 2 candidates the Nominations Committee are recommending for appointment are:**

Erfana Mahmood

Erfana is a corporate property lawyer working for a number of large organisations in the financial sector. She has just finished her two terms of office as a NED at Yorkshire Ambulance Service, including a period as the Senior Independent Director.

Erfana has experience in the housing sector and is a Non-Executive on Chorley and District Building Society and Plexus/Omega Housing (part of the Mears Group).

Samantha Young

Samantha runs her own consultancy business with a focus on technology and transformation. Previously she has worked in the housing, local authority and IT sectors in a number of senior roles. Samantha was head of IT at Kirklees Council, worked for BT on NHS contracts and spent 2 years as a Director of Business Transformation at the New Charter Group.

Currently Samantha is also a NED, Great Places Housing Group.

The final interview panel and Nominations Committee feel that the two candidates both demonstrated a strong value base consistent with the Trust's values and with their experience and background believe they will both be able to make a significant contribution to the Board and the organisation.

South West Yorkshire Partnership NHS Foundation Trust

Members' Council 3 August 2018

Non-Executive Director (NED) recruitment 2018

Candidate attraction

As agreed by the Nominations Committee, the Non-Executive Director (NED) recruitment was managed in-house rather than using costly external recruitment consultants. A combination of advertisements (Guardian and Yorkshire Post online and other NHS websites) was used to attract candidates for the NEDs posts for the South West Yorkshire Partnership NHS Foundation Trust. To support the recruitment process, four drop in events were held in Calderdale (Halifax), Kirklees (Huddersfield), Wakefield and Barnsley across April 2018 for potential applicants.

The closing date for applications was 7 May 2018 and a total of 39 applications were received.

Longlisting

Following the closing date, the 39 applications were then categorised in one of the four categories: "1" (Recommended for interview), "2" (Strong Marginal for discussion), "3" (Marginal for discussion), and "4" (Not recommended), based on the assessment of the Curriculum Vitae (CV) and the supporting statements submitted. The Chair, Deputy Chair, Director of Finance & Resources and Director of Human Resources, Organisational Development & Estates reviewed all CVs and supporting statements and agreed the final category for each applicant. 13 candidates were rated as Category 1 and it was agreed they would all be invited to a preliminary interview on the 29 May 2018.

Shortlisting

Following the preliminary interviews, a report was prepared for the Nominations Committee on the 20 June 2018 recommending a shortlist of 7 candidates for the final assessment process. The report provided an overview of the background and relevant experience of all the candidates who applied with the recommendations for either shortlisting or not.

The Nominations Committee agreed 7 candidates to go forward to the final assessment process, however 2 candidates withdrew before the final assessment.

Final assessment

The 5 remaining candidates selected for final assessment attended three (3) focus group discussion panels on 9 and 11 July 2018:

- Governors.
- Service user/carers.
- Staff - questions from a group of staff members.

The final interview panel members were:

- Chair - Angela Monaghan
- Lead Governor (publicly elected Governor for Wakefield) - Jackie Craven
- Elected Governor (publicly elected Governor for Kirklees) - Nasim Hasnie
- Deputy Chair / Senior Independent Director - Charlotte Dyson

Alan Davis, Director of Human Resources, Organisational Development & Estates was in attendance supporting the panel.

Following the interview process and considering the feedback from the focus groups, the panel's recommendation to the Nominations Committee on 16 July 2018 was that Samantha Young and Erfana Mahmood are appointed as NEDs. The Nominations Committee agreed the recommendations for appointment to go to the Members' Council on 3 August 2018.

Summary of the Candidates CVs:

Samantha Young

Overview:

Samantha runs her own consultancy business with a focus on technology and transformation. Previously she has worked in the housing, local authority and IT sectors in a number of senior roles. Samantha was head of IT at Kirklees Council, worked for BT on NHS contracts and spent 2 years as a Director of Business Transformation at the New Charter Group.

Currently Samantha is also a Non-Executive Director Great Places Housing Group.

Qualifications:

- Bachelor of Arts (BA) Honours Degree in Business Studies
- Master of Science (MSc) in Information Technology and Management

Career Summary:

- 2017/Present **Founder and Managing Director,** ISAY Consulting Limited
- 2017/Present **Non-Executive Director,** Great Places Housing Group, October
- 2017/Present **Lead Associate Consultant,** HQN Ltd
- 2015/2017 **Director of Business Transformation**, New Charter Group
- 2010/2014 **Head of IT,** Kirklees Council

Erfana Mahmood

Overview:

Erfana is a corporate property lawyer working for a number of large organisations in the financial sector. She has just finished her two terms of office as a Non-Executive Director at Yorkshire Ambulance Service, including a period as the Senior Independent Director.

Erfana has experience in the housing sector and is a Non-Executive on Chorley and District Building Society and Plexus/Omega Housing (part of the Mears Group).

Qualifications:

- LLB (Hons) Law.
- LPC – Postgraduate Certificate is Law (Law Society Finals. Admitted as a Solicitor in November 1999)

Career Summary:

- 2017/Present: **Non-Executive Director,** Plexus/Omega Housing part of Mears Group
- 2012/2018: **Non-Executive Director,** Yorkshire Ambulance NHS Trust

- 2011/Present: **Non-Executive Director**, Senior Independent Director and Chair of Nominations and Remuneration committee for Chorley and District Building Society
- 2011/Present: **Consultancy,** advising bank's in-house functions on policies and procedures
- 2003/2011: **Head of Legal Finance Team,** Walker Morris Solicitors

Term of office and remuneration

In accordance with the Trust's Constitution, the Standing Orders for the practice and procedure of the Trust Board within the Trust's Constitution states under section 3.8 that the Members' Council is responsible for the appointment "*…for an initial period of three years or as determined by the Nominations Committee.*

The current remuneration for a Non-Executive Director in the Trust is: £13,383pa, as agreed at the Members' Council meeting on 28 April 2017.

Recommendation

The Members' Council are asked to SUPPORT the recommendation from the Nominations Committee that the Trust appoints Samantha Young and Erfana Mahmood as Non-Executive Directors (NEDs) for an initial three (3) year term commencing 6 August 2018.

South West Yorkshire Partnership NHS Foundation Trust

Members' Council
3 August 2018

Agenda item:	**5.2**
Report Title:	Review of Chair and Non-Executive Director remuneration
Report By:	Director of Human Resources, Organisational Development and Estates on behalf of the Nominations Committee
Action:	To agree

EXECUTIVE SUMMARY

Purpose

The purpose of this report is to provide the Members Council with recommendations on the process for the review of the Chair's and Non-Executive Directors (NEDs) remuneration. The Members' Council undertake regular reviews of the remuneration rates for the Chair and NEDs to ensure they are fair and justifiable.

Recommendation

The Members' Council is asked to AGREE to establish a sub-group of the Nominations Committee supported by the Director of Human Resources, Organisational Development and Estates, to review the NHS Providers Remuneration Survey and to develop recommendations for the Members' Council on the remuneration of the Chair and NEDs.

Background

The role of the Nominations Committee is to make recommendations to the Members' Council on any uplift to the Chairs and NED remuneration based on benchmarking information as applicable.

The Trust is a participant in the NHS Providers Annual Remuneration Survey. The survey covers both Executive and Non-Executive Directors (NEDs) (including the Chair and Chief Executive) remuneration. The result of the survey was published in January 2018. The NHS Providers Survey is comprehensive and contains responses from 145 NHS organisations across England on the remuneration of their Chair and Non-Executive Directors.

The proposal of the Nominations Committee is that we use the NHS Providers Survey as the basis of the review, rather than commission external consultants. The Director of Human Resources, Organisational Development and Estates would then support a sub-group of the Nominations Committee to review the survey and develop recommendations on the remuneration levels for the Chair and NEDs to go to the Members' Council in November 2018.

South West Yorkshire Partnership NHS Foundation Trust

Members' Council
3 August 2018

Agenda item:	**6.1**
Report Title:	Annual Report, accounts and Quality Account 2017/18
Report By:	Director of Finance and Resources
Action:	To receive

EXECUTIVE SUMMARY

Purpose and format

The purpose of this report is to enable the Members' Council to receive the Trust's Annual Report, accounts and Quality Account for the period 1 April 2017 to 31 March 2018 which were approved by the Trust Board on 24 May 2018.

Recommendation

The Members' Council is asked to RECEIVE the Annual Report, accounts and Quality Account for 2017/18.

Background

As a Foundation Trust, the Trust is required to prepare an Annual Report and accounts to meet guidance issued by the Regulator, Monitor (operating as NHS Improvement). The Annual Report, accounts and Quality Report are audited by the Trust's external auditors, Deloitte LLP. Under its Constitution, the Trust is required to present its Annual Report and accounts to the Members' Council at a general meeting.

The Audit Committee has delegated authority from Trust Board to review and scrutinise the Annual Report, accounts and Quality Account and to recommend them for approval. The Audit Committee reviewed and recommended the documents for 2017/18 for approval at its meeting on 22 May 2018. The report and accounts with supporting documents were submitted to NHS Improvement in line with the national timetable and were laid before Parliament on 5 July 2018.

Outcome

Annual report 2017/18

- The annual report was developed in line with NHS Improvement's requirements and this was confirmed by the Trust's external auditors.
- The Audit Committee reviewed and recommended the annual report for to be approved. Trust Board approved the annual report.

Annual accounts 2017/18

- The Audit Committee considered the report from the Director of Finance & Resources on the final accounts (attached for the Members' Council), the Head of Internal Audit Opinion (see below) and the findings of the external auditors, Deloitte LLP (ISA 260 attached for the Members' Council). The Trust met its financial targets and achieved a use if resource risk rating from NHS Improvement of 2. The Trust received an unqualified audit opinion on the 2017/18 accounts and a positive opinion on the requirement to demonstrate Value for Money.
- The Head of Internal Audit Opinion for 2017/18 provided positive assurance on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.
- The Audit Committee reviewed and recommended the annual accounts for 2017/18 for approval. The Trust Board approved the annual accounts./

Quality Report

- The Quality Account was reviewed by the Members' Council Quality Group prior to presentation for approval.
- As requested by Trust Board, the Quality Report was scrutinised in detail by the Clinical Governance and Clinical Safety Committee prior to its presentation to the Audit Committee and a recommendation made for it to be formally approved.
- The external assurance review conducted by Deloitte was received by the Audit Committee on 22 May 2018 (included in these papers for the Members' Council with the Trust's response to audit recommendations). Deloitte was satisfied with the content and consistency of the report.
- Deloitte also undertook a data quality review of two nationally mandated indicators (early intervention in psychosis and inappropriate out of area placements). An unmodified assurance opinion was issued by Deloitte.
- Deloitte also undertook a review of the local indicator chosen by the Members' Council in relation to waiting times across children & young people's eating disorder pathways. Deloitte made a made an observation in relation to inconsistent recording of the data within the RiO system which did not affect the underlying reporting.
- The Trust Board approved the Quality Report for 2017/18.

To support this item, the following papers have been provided to the Members' Council and the Trust's external auditor, Deloitte, will make a brief presentation at the meeting on the key points arising from its audit:

- the Director of Finance's report on the accounts for 2017/18;
- the Director of Finance's report on the year end process and submissions for 2017/18;
- the report from Deloitte to those charged with governance (ISA 260);
- the Chief Executive's Annual Governance Statement;
- statements of income, financial position and cash flows for the period;

- the external assurance report on the Quality Accounts from Deloitte; and
- the limited assurance report on the Quality Accounts from Deloitte.

The Trust's full Annual Report and accounts including the Quality Account for 2017/18 can be found on the Trust's website under **About us > Our Performance > Annual report** (http://www.southwestyorkshire.nhs.uk/about-us/performance/annual-report/)

South West Yorkshire Partnership NHS Foundation Trust

Members' Council 3 August 2018

Annual Accounts – 2017/18

Introduction

The purpose of this paper is to provide the Members' Council with a brief summary of some key numbers and movements in the 2017/18 annual accounts. It is designed to accompany the annual accounts, which will be presented more fully at the Annual Members' Meeting scheduled for September 17th. At this point it is worth the Members' Council being aware of the fact the Trust achieved its financial targets in 2017/18 against a challenging background of lower income and increase demand for services.

Income

Total income was £222.9m, which compares to £229.9m in the previous year, a reduction of 3%. The most significant reasons being the full year impact of no longer providing 0 – 19 services in Barnsley and health & wellbeing services in Wakefield; along with other service reductions/changes such as intermediate care and respiratory in Barnsley. Given these comments the main income reductions year on year when analysed in the accounts relate to clinical commissioning groups and local authorities. Education and training income was largely unchanged. Income includes £2.9m of Sustainability & Transformation Funding (STF) in 2017/18 and £2.5m in the prior year.

Operating Expenses

Operating expenses decreased from £227.2m in 2016/17 to £215.5m in 2017/18. Costs reduced as a direct consequence of the income reductions identified above, the delivery of cost improvement schemes, a £4.3m year on year movement on asset impairments (impact of valuation changes), and lower depreciation costs (there was a sizeable amount of accelerated depreciation in 2016/17).

Operating Surplus and Total Comprehensive Income

The operating surplus position improved from £2.7m in 2016/17 to £7.4m in 2017/18. Total comprehensive income for year closed at £12.6m compared to a close to break-even position 2016/17. A reconciliation between the surplus in the annual accounts and the management accounts has been provided to the Audit Committee, but is simply explained as follows:

Total Comprehensive Income	£12.6m
Impairments & Revaluations	(£8.0m)
Net Impairments	(£0.6m)
STF	(£2.9m)
Pre STF Surplus in management accounts	£1.1m

The key number to be aware of is the £1.1m pre STF surplus as this is the number our regulators require us to achieve and what the Trust can influence itself. Asset impairments are largely a consequence of changes in valuation of land and buildings as changes in market values are reflected each year.

Employee Costs and Numbers

Total employee costs decreased in the year from £170.9m to £166.3m largely as a result of service reductions and cost improvement savings offsetting pay increases and movements in vacancies. The most notable change was in agency staffing costs which reduced by £4m in the year. Substantive pay costs reduced by £1.1m year on year whilst average staff numbers employed reduced from 4,223 to 4,124. On average 11.8 days were lost per member of staff to sickness last year which compares to 11.2 days in 2016/17.

Within the year there were 28 compulsory redundancies which cost £967k

Asset Valuations

Taking into account asset additions, disposals, impairments, revaluations and depreciation the net book value of fixed assets increased from £110.7m to £123.4m in the year. Additions accounted for £10m of this increase, with revaluations also being a prominent driver.

Current Assets

The end of year cash position was very similar to that of the previous year at £27.1m although total current assets reduced from £37.6m to £35.5m given the disposal of assets held for sale. Trade and other receivables reduced from £8.6m to £8.1m. Bad debt provision amounts to £121k, which is a slight increase on the previous year. This largely relates to ex members of staff with overpaid salary or salary sacrifice payments owing

Cash Flow

As stated above the net cash position was largely unchanged year on year, but there are some notable movements in generating this position. Capital expenditure exceeded deprecation charges by £4.2m. Proceeds from asset disposals were £2.5m which is £1.8m lower than the amount raised in the prior year.

Current Liabilities

Current liabilities reduced from £23.4m to £21.0m year on year with reductions in both trade payables and provisions.

As a consequence of the current asset and liabilities positions net current assets position is very similar to the prior year at £14.5m compared to £14.3m.

South West Yorkshire Partnership NHS Foundation Trust

Members' Council 3 August 2018

2017/18 Annual Report, Annual Accounts and Quality Account

Introduction

In line with statutory requirements the Trust has submitted an annual report, its annual accounts and quality account to NHS Improvement. Each of these has been subject to internal scrutiny and governance, and to external audit. The documents become publicly available documents once laid before parliament, which occurred in mid-July. This document explains the process undertaken and provides the external audit reports.

Annual Governance Statement

The Annual Governance Statement (AGS) was produced in line with guidance and instructions provided by NHS Improvement based on Treasury requirements. The draft AGS was reviewed by the Trust Board on 24 April 2018 and then reviewed by the Audit Committee on 22 May 2018 before being approved by the Trust Board on the 24 May 2018. The AGS contained the Head of Internal Audit overall opinion of significant assurance.

Annual Accounts

The annual accounts were produced in line with accounting standards (FRS) and followed guidance and instruction provided by NHS Improvement. The draft accounts were shared with accountants on the Trust Board for comment and feedback. Responses were provided for all questions and where appropriate amendments were made to the accounts (typically within the notes to the accounts). They were also shared with members of the Extended Management Team (EMT) for comment and feedback.

The accounts were subject to audit by Deloitte LLP and to a review at the Audit Committee on 22 May and were approved at the Trust Board on 24 May 2018. Signature took place on 25 May. A log was kept of all adjustments made from version to version. The accounts were then submitted to NHS Improvement in line with the required timescales.

Annual Report

The production of the annual report was co-ordinated by the Company Secretary and included contributions from appropriate executive directors and other senior managers. The annual report was shared with non-executive directors and the lead governor for comments. As with the annual accounts the report was reviewed at the Audit Committee on 22 May 2018 and approved at the Trust Board on 24 May 2018. Signature again took place on 25 May 2018. The report was then submitted to NHS Improvement.

Quality Account

The Quality Account 2017/18 was produced in line with the requirements of both the Department of Health, ***'Quality Account Toolkit (2010)***' and NHSI, '***Detailed requirements for quality reports'*** (2018).

The production of the quality account report is a year -long process. Quality priorities were agreed by EMT (2017), allocated a lead individual and monitored in relevant working groups throughout the year, for example, the Patient Safety Group. A bi -monthly progress report was submitted to Clinical Governance & Clinical Safety Committee, Members' Council Quality sub- group on a quarterly basis and Clinical Commissioning Groups Quality Boards, as requested.

The Quality Improvement and Assurance Team facilitate the production of the quality account report with input from BDU representatives and quality academy support teams such as finance, performance and information, information governance, human resources and contracting. A requirement of the quality account process is that our External Auditors (Deloitte) are required to undertake an audit of two mandated data items, in line with NHSI requirements set out in '***Detailed guidance for external assurance on quality reports 2017/18'.*** Following the audit the Trust were issued with the Limited Assurance report, that is a requirement of the quality account process, and minor recommendations were made to further improve the quality of our data. A copy of the External Assurance report is attached.

A draft quality account report was produced that was commented upon by EMT, Member's Council Quality sub-group and Clinical Governance & Clinical Safety Committee before sign off by the Trust Board on 24 May as part of the Annual Report. The report was submitted to NHSI in line with the required timescales. **External Audit Report**

Deloitte LLP are the Trust's external auditors. Following completion of their audit they have produced an audit report (ISA 260). A copy of the ISA 260 is attached to this report. Key points to note from the report are:

- No significant audit adjustments or disclosure deficiencies were identified
- An unmodified audit opinion was issued with no reference to any matters in respect of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources, or the Annual Governance Statement.
- There were not any identified inconsistencies between the financial statements and the FTCs.
- With regard to areas of risk identified Trust management judgements were consistent with Deloitte's expectations.

Conclusion and Recommendation

In conclusion the Trust met all its submission deadlines associated with its statutory returns covering the annual accounts, annual report and quality account. Input and feedback was regularly sought from all Board members and a range of other key stakeholders. External Audit provided an unmodified opinion in relation to the accounts.

The Members' Council is asked to note the submission of the statutory returns, process undertaken to generate the accounts and reports and the assurance provided by our external auditors.

Deloitte.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

South West Yorkshire Partnership NHS FT

Final report to the Audit Committee on the 2017/18 audit

Contents

01 Final report

02 Appendices

Director introduction
The key messages in this report

Audit quality is our number one priority. We plan our audit to focus on audit quality and have set the following audit quality objectives for this audit:

- A robust challenge of the key judgements taken in the preparation of the financial statements.
- A strong understanding of your internal control environment.
- A well planned and delivered audit that raises findings early with those charged with governance.

I have pleasure in presenting our final report to the Audit Committee for the 2017/18 audit.
I would like to draw your attention to the key messages within this paper:

Status of the audit	Our audit is complete. Our Independent Examination of EyUp! (formerly South West Yorkshire Partnership NHS Foundation Trust and Other Related Charities) is underway and will finalise this work over the next month.
Conclusions from our testing	• We have not identified any significant audit adjustments or disclosure deficiencies. Unadjusted audit misstatements would not have affected the Trust's achievement of its control total. See page 17. • Based on the current status of our audit work, we envisage issuing an unmodified audit opinion, with no reference to any matters in respect of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources, or the Annual Governance Statement. • We have not identified any inconsistencies between the financial statements and the TACs.
Financial sustainability and Value for Money	• The Trust reported an overall surplus for the year of £4.5m, including STF income of £2.9m. • CIP delivery was £7.5m against a £8.3m target; • The Trust has a Single Oversight Framework segmentation of 2 which is in line with the planned rating. It is not currently subject to any regulatory action from either NHSI or the Care Quality Commission (CQC); and • Subject to appropriate disclosure in the Annual Report and Annual Governance Statement we do not anticipate reporting any matters within our audit report in respect of the Trust's arrangements for securing the economy, efficiency and effectiveness of the use of resources.
Annual Report & Annual Governance Statement	• We have reviewed the Trust's Annual Report & Annual Governance Statement to consider whether it is misleading or inconsistent with other information known to us from our audit work. Based on our review, we consider that the Trust has followed the format prescribed by the Foundation Trust Annual Reporting Manual. We have suggested a number of minor changes to management.
Quality Accounts	• We will issue a clean quality report opinion. The findings from our work are set out in the accompanying paper, which will also be presented to the Council of Governors at their next meeting.

Responsibilities of the Audit Committee

Helping you fulfil your responsibilities as an Audit Committee

The primary purpose of the Auditor's interaction with the Audit Committee

Clearly communicate the planned scope of the financial statements audit

Provide timely observations arising from the audit that are significant and relevant to the Audit Committee's responsibility to oversee the financial reporting process

In addition, we seek to provide the Audit Committee with additional information to help them fulfil their broader responsibilities

We set out here a summary of the core areas of Audit Committee responsibility to provide a reference in respect of your responsibilities and highlight throughout the document where there is key information which helps the Audit Committee in fulfilling its remit.

Integrity of reporting

- Impact assessment of key judgements and level of management challenge.
- Review of external audit findings, key judgements, level of misstatements.
- Assess the quality of the internal team, their incentives and the need for supplementary skillsets.
- Assess the completeness of disclosures, including consistency with disclosures on business model and strategy and, where requested by the Board, provide advice in respect of the fair, balanced and understandable statement.

Oversight of external audit

- At the start of each annual audit cycle, ensure the scope of the external audit and fee are appropriate.
- Make recommendations as to the auditor appointment and implement a policy on the engagement of the external auditor to supply non-audit services.

Internal controls and risk

- Review the internal control and risk management systems (unless expressly addressed by separate board risk committee).
- Explain what actions have been, or are being taken to remedy any significant failings or weaknesses.

Oversight of internal audit

- Monitor and review the effectiveness of the internal audit activities.

Whistle-blowing and fraud

- Ensure that appropriate arrangements are in place for the proportionate and independent investigation of any concerns that are raised by staff in connection with improprieties.

Our audit explained

We tailor our audit to your business and your strategy

Identify changes in your business and environment

The Trust continues to focus on its options for sustainability in the medium term and in particular the shape and scope of services delivered in the Barnsley area. The Trust is operating in an increasingly financially challenging environment. The Trust continues to invest in a large capital programme.

Scoping

Our scope is in line with the Code of Audit Practice issued by the NAO.

Other findings

As well as our conclusions on the significant risks we are required to report to you our observations on the internal control environment as well as any other findings from the audit. These are set out on pages 13 of this report.

Determine materiality

For planning purposes we estimated materiality at £4.4m (2016/17 £4.4m) which is based on 2% of planned incoming resources as per the 2017/18 Operational Plan. At this level of materiality we have reported all misstatements in excess of £222k (2016/17 £220k) to the Audit Committee. For our final audit we updated our assessment which confirmed materiality as £4.4m and reduced the reporting threshold to above £221k.

Significant risk assessment

We identified significant audit risks in relation to income recognition and management override of controls. See page 7 of this report.

Conclude on significant risk areas

We draw to the Audit Committee's attention our conclusions on the significant audit risks. In particular the Audit Committee must satisfy themselves that management's judgements in relation to going concern are appropriate.

Our audit report

Based on the current status of our audit work, we envisage issuing an unmodified audit report.

Significant risks
Dashboard

Risk	Material	Fraud risk	Planned approach to controls testing	Controls testing conclusion	Management paper received	Consistency of judgements with Deloitte's expectations	Expected to be included in the significant issues section of the Audit Committee's report	Expected to be included as a key audit matter in our audit report	Slide no.
NHS Revenue recognition	✓	✓	D+I	Satisfactory	✓	●	✓	✓	8
Management override of controls	✓	✓	D+I	Satisfactory	✓	●	✓	✗	9

Overly prudent, likely to lead to future credit ⊖ ⊖ ● ⊕ ⊕ Overly optimistic, likely to lead to future debit.

D+I: Testing of the design and implementation of key controls
OE: Testing of the operating effectiveness of key controls

Significant audit risks

Revenue recognition in respect of CQUIN Income and Barnsley Intermediate Care

Risk identified	The risk of fraud in revenue recognition is a presumed risk under International Standards on Auditing. At the Trust the risk of revenue recognition is deemed to be applicable to the recognition of income from the Commissioning for Quality and Innovation (CQUIN) payment framework. The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. It therefore is subject to variations. Our discussions with key staff whilst planning for the audit in 2017 identified that at that time the Trust was providing services in respect of Barnsley Intermediate Care with no signed contract variation following the notice given under this service by Barnsley in June 2016 for 12 months. We considered that there was a risk in relation to the recoverability of the balance and the judgement in relation to the income accrual.
Key judgements	The key judgement in this area concerns the measurement of the Trust's performance against the agreed indicators.
Deloitte response	We are completing our work in respect of a retrospective review of accuracy of management estimation techniques used in application and allocation of CQUIN income and are challenging this. We have tested the Barnsley income recognised for accuracy following through to physical evidence. • We have assessed the design and implementation of management controls aimed at challenging, validating and agreeing the original CQUIN target measures and for reviewing progress against the target; • We have obtained evidence that CQUIN income for Q1-3 was agreed between the trust and the commissioners; ensuring that the income recognised by the Trust was in line with that which had been agreed; • We have reviewed the Q4 estimate of CQUIN income and have agreed this to supporting information from the Trust on activity performance; • We have reviewed the design and implementation of the controls covering the recognition and valuation of debts owed by Barnsley Commissioners; • For the Barnsley Intermediate Care contract we have agreed the total revenue to all invoices and confirmed receipt of cash.
Conclusion	We have completed our testing of CQUIN income, and have noted no issues in relation to this.
Draft audit report findings	We have made reference to this risk in our auditor's report as it had a significant effect upon our overall audit strategy, allocation of resources, and direction of the efforts of the team.

Significant audit risks

Management override of controls

Risk identified	In accordance with ISA 240 (UK and Ireland) management override is a significant risk. This risk area includes the potential for management to use their judgement to influence the financial statements as well as the potential to override the Trust's controls for specific transactions. The key judgments in the financial statements are those which we have selected to be the significant audit risk of revenue recognition which is where, inherently, management has the potential to use their judgment to influence the financial statements.
Key judgements	Our audit work is designed to test for instances of management override of controls.
Deloitte response	We have considered the overall sensitivity of judgements made in the preparation of the financial statements, and our work has focused on: • the testing of journals, using data analytics to focus our testing on higher risk journals; • significant accounting estimates relating to estimates discussed above in respect of NHS revenue recognition and provisioning; and • any unusual transactions or one-off transactions including those with related parties In considering the risk of management override, we: • assessed the overall position taken in respect of key judgements and estimates; and • considered the rationale for the accounting estimates and assessed these for biases that could lead to material misstatement due to fraud.
Conclusion	We have not identified any significant bias in the key judgements made by management. The control environment is appropriate for the size and complexity of the Trust. We have considered the tone at the top and note that there are no concerns we wish to draw to the attention of management or those charged with governance.
Draft audit report findings	We have not included this risk in our audit report because it did not have a significant effect upon our overall audit strategy, allocation of resources, and direction of the efforts of the team.

Other areas of audit focus

We have also identified two areas of management judgement which we consider a higher risk, which are detailed below.

Area 1 – Property Valuations

Details	The Trust is undertaking a desktop review approach to the revaluation of its estate. The Trust uses a hypothetical alternative site model. The complexities of the audit, and in the required accounting transactions, mean that there is a risk over the valuation of the property assets.
Deloitte Response	• We have reviewed the Trust's Modern Equivalent Use valuation rules and assess how these align to the strategic development and the Trust's Capital Plan. • We have challenged management's assessment that the District Valuer reported values, which we expect to be dated 31 December 2017, remain valid as at the reporting date of 31 March 2018. • We have examined the accuracy of the posting of the valuations to the general ledger and financial statements. • We will assess the impairment and the MEAV – AS assumptions recorded against Mount Vernon following the restructuring of services.
Conclusion	We have not noted any issues through our testing. We have however raised a judgemental adjustment as seen on page 17 in relation to the movement in the BCIS from 31 December 2017 to 31 March 2018.
Draft audit report findings	We have not included this risk in our audit report because it did not have a significant effect upon our overall audit strategy, allocation of resources, and direction of the efforts of the team.

Other areas of audit focus

We have also identified two areas of management judgement which we consider a higher risk, which are detailed below.

Area 2 – Provisions

Details	There are a number of judgements and provisions which will be taken by management in the financial statements for the year ended 31st March 2018, with the main judgement in provisions being in relation to the redundancy provision.
Deloitte Response	In considering the risk of management provisions and judgements, we performed the following audit procedures: • We considered the judgements and supporting evidence used in forming the provision, and corroborate its communication pre year end to the relevant parties. • We assessed the redundancy provision in relation to the managements strategic plan and also any relevant CIP schemes.
Conclusion	We have noted one error through our testing in relation to an overprovision in relation to redundancy, which is detailed on page 17.
Draft audit report findings	We do not expect to include this risk in our audit report because it did not have a significant effect upon our overall audit strategy, allocation of resources, and direction of the efforts of the team.

Value for money (VfM)

We have not identified any VfM significant risks

Value for Money

We are required to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. VfM is assessed against the following criterion, and three sub-criteria (informed decision making, sustainable resource deployment, and working with partners and other third parties):

"In all significant respects, the audited body had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people."

Our work takes account of the Annual Governance Statement and the findings of regulators. We are required to perform a risk assessment through the course of our audit to identify whether there are any significant risks to our VfM conclusion, and perform further testing where risks are identified.

Overall Financial & Quality Performance

As part of our risk assessment, we have considered how the Trust's performance compares to plan and prior year:

	Actual 2017/18	Plan 2017/18	Variance	Plan 2018/19	Actual 2016/17
Surplus before impairments and transfers	£4.0m	£2.4m	£1.6m	(£1.2m)	£0.4m
EBITDA margin	6.2%	11.6%	85.6%	3.8%	4.4%
CIP target and identified to date	£7.5m	£8.3m	90.3% identified	£9.7m	£9.0m
Single Oversight Framework segmentation	2	2	0	2	2

Risk Assessment work performed

As part of our risk assessment, we have considered information from: a combination of:

- "high level" interviews with key staff
- review of the Trust's draft Annual Governance Statement;
- consideration of issues identified through our other audit and assurance work;
- consideration of the Trust's results, including benchmarking of actual performance (including on CIP delivery as summarised below) and the 2017/18 Annual Plan;
- review of the Care Quality Commission's report on the Trust dated April 2017;
- review of NHSI's risk ratings;
- benchmarking of the Trust's performance

Conclusion

We have not identified any VfM significant risks and have provided an update on the area for monitoring identified in relation to the CIP Programme.

Area for monitoring in relation to our Value for Money Opinion

Delivery of CIP programme

Risk identified	From discussions with key members of staff as part of our planning meetings, it was noted that the Trust was performing well against its operational plan, reporting a surplus at the month 5 position. The Trust's CIP programme is not currently presenting challenges but it is noted that next year's will prove more challenging. We will review progress as part of our year end audit in relation to developing robust plans in relation to this.
Risk assessment work performed	We have undertaken a review of the Trust's medium term financial plan as well as the 2018/19 Operational Plan to assess the reliance of the Trust on the delivery of the planned CIP Programme. From this we have performed a sensitivity analysis to review the impact that differing levels of CIP delivery would have on the Trust's financial position and available cash. As well we have obtained the month 1 CIP report to review performance against plan. No residual risks have been identified from the work we have performed over the governance of the overall transformation programme.
Conclusion	Whilst there remains risk to the delivery of the cost reduction plan, the current financial position of the Trust, the governance arrangements that the Trust has in place and the history of good delivery of CIPs means that we do not consider there to be issues that would have an impact on our Value for Money opinion. We have not identified any issues which we would need to report in our audit opinion.

Other significant findings

Internal control and risk management

During the course of our audit we have identified a number of internal control and risk management findings, which we have included below for information.

Area
No significant internal control or risk management issues noted during our audit.

The purpose of the audit was for us to express an opinion on the financial statements. The audit included consideration of internal control relevant to the preparation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of internal control. The matters being reported are limited to those deficiencies that we have identified during the audit and that we have concluded are of sufficient importance to merit being reported to you.

Low Priority

Medium Priority

High Priority

Other significant findings

Financial reporting findings

Below are the findings from our audit surrounding your financial reporting process.

Qualitative aspects of your accounting practices:

There were no significant findings in relation to the accounting policies maintained by the Trust.

Liaison with Internal Audit:

The audit team, has completed an assessment of the independence and competence of the internal audit department and reviewed their work and findings. From this work we do not have any significant findings. In response to the significant risks identified, no reliance was placed on the work of internal audit and we performed all work ourselves.

We have obtained written representations from those charged with governance on matters material to the financial statements when other sufficient appropriate audit evidence cannot reasonably be expected to exist. A copy of the draft representations letter has been circulated separately.

Appendices

Purpose of our report and responsibility statement

Our report is designed to help you meet your governance duties

What we report

Our report is designed to help the Audit Committee and the Board discharge their governance duties. It also represents one way in which we fulfil our obligations under ISA 260 (UK and Ireland) to communicate with you regarding your oversight of the financial reporting process and your governance requirements. Our report includes:

- Results of our work on key audit judgements and our observations on the quality of your Annual Report.
- Our internal control observations.

What we don't report

As you will be aware, our audit was not designed to identify all matters that may be relevant to the board.

Also, there will be further information you need to discharge your governance responsibilities, such as matters reported on by management or by other specialist advisers.

Finally, our views on internal controls and business risk assessment should not be taken as comprehensive or as an opinion on effectiveness since they have been based solely on the audit procedures performed in the audit of the financial statements and the other procedures performed in fulfilling our audit plan.

We welcome the opportunity to discuss our report with you and receive your feedback.

The scope of our work

Our observations are developed in the context of our audit of the financial statements.

This report has been prepared for the Board of Directors, as a body, and we therefore accept responsibility to you alone for its contents. We accept no duty, responsibility or liability to any other parties, since this report has not been prepared, and is not intended, for any other purpose. Except where required by law or regulation, it should not be made available to any other parties without our prior written consent.

Deloitte LLP

Newcastle | 25 May 2018

Audit adjustments

Unadjusted misstatements

The following uncorrected misstatements have been identified up to the date of this report which we request that you ask management to correct as required by International Standards on Auditing (UK and Ireland). The net impact of these is an increase of £407k in the surplus for the period.

		Debit/ (credit) income statement £m	Debit/ (credit) in net assets £m	Debit/ (credit) prior year retained earnings £m	Debit/ (credit) in reserves £m	If applicable, control deficiency identified
Misstatements identified in current year						
Revaluation Movement	[1]	(£0.096m)	£0.621m		(£0.525m)	
Overprovision in relation to redundancy	[2]	(£0.494m)	£0.494m			
Management judgements in relation to the financial statements						
Over recognition of Income from NHS	[3]	£0.373m	(£0.373m)			
Over recognition of Debtors from NHS	[3]	£0.226m	(£0.226m)			
Over recognition of Creditors from NHS	[3]	(£0.255m)	£0.255m			
Aggregation of misstatements individually < £0.222m						
Misstatements less than £0.222m		(0.161m)	0.161m			
Total		**(£0.407m)**	**£0.932m**		**(£0.525m)**	

(1) Judgemental difference noted on revaluation movement indices between the valuation date (31 December) and the year end (31 March), we have also calculated a notional split based on the other in year adjustment between the revaluation reserve and the I&E for illustrative purposes.
(2) Extrapolated judgemental error in relation to redundancy provision in relation to specific CIP scheme.
(3) Variation between SWYPFT and other NHS counterparties per the Agreement of balances exercise.

Audit adjustments
Disclosures

Disclosure misstatements

The following uncorrected disclosure misstatements have been identified up to the date of this report which we request that you ask management to correct as required by International Standards on Auditing (UK and Ireland).

Disclosure	Summary of disclosure requirement	Quantitative or qualitative consideration
We have not identified any significant disclosure deficiencies in the financial statements and the deficiencies identified have been corrected by management.		

Other disclosure recommendations

Although the omission of the following disclosures does not materially impact the financial statements, we are drawing the omitted disclosures to your attention because we believe it would improve the financial statements to include them or because you could be subject to challenge from regulators or other stakeholders as to why they were not included.

Disclosure	Summary of disclosure requirement	Quantitative or qualitative consideration
We have not identified any significant disclosure deficiencies in the financial statements and the deficiencies identified have been corrected by management		

Fraud responsibilities and representations

Responsibilities explained

Responsibilities:

The primary responsibility for the prevention and detection of fraud rests with management and those charged with governance, including establishing and maintaining internal controls over the reliability of financial reporting, effectiveness and efficiency of operations and compliance with applicable laws and regulations. As auditors, we obtain reasonable, but not absolute, assurance that the financial statements as a whole are free from material misstatement, whether caused by fraud or error.

Required representations:

We have asked the Board to confirm in writing that you have disclosed to us the results of your own assessment of the risk that the financial statements may be materially misstated as a result of fraud and that you are not aware of any fraud or suspected that affects the entity or group.

We have also asked the Board to confirm in writing their responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

Audit work performed:

In our planning we identified the risk of fraud in revenue recognition and management override of controls as a key audit risk for your organisation.

During course of our audit, we have had discussions with management and those charged with governance and no instances of fraud have been identified

In addition, we have reviewed management's own documented procedures regarding fraud and error in the financial statements

We have reviewed the paper prepared by management for the audit committee on the process for identifying, evaluating and managing the system of internal financial control.

Independence and fees

As part of our obligations under International Standards on Auditing (UK and Ireland), we are required to report to you on the matters listed below:

Independence confirmation	We confirm the audit engagement team, and others in the firm as appropriate, Deloitte LLP and, where applicable, all Deloitte network firms are independent.
Fees	Details of the fees charged by Deloitte for the period have been presented below.
Non-audit services	In our opinion there are no inconsistencies between FRC's Ethical Standard and the Trust's policy for the supply of non-audit services or of any apparent breach of that policy. We continue to review our independence and ensure that appropriate safeguards are in place including, but not limited to, the rotation of senior partners and professional staff and the involvement of additional partners and professional staff to carry out reviews of the work performed and to otherwise advise as necessary. We have not carried out any non-audit services in the period 2017/18.
Relationships	We have not other relationships with the Trust, its directors, senior managers and affiliates, and have not supplied any services to other known connected parties.

Independence and fees

The professional fees expected to be charged by Deloitte for the period from 1 April 2017 to 31 March 2018 are as follows:

	Current year £	Prior year £
Audit of Trust	45,672	45,672
Total audit	**45,672**	**45,672**
Quality Accounts procedures	5,000	5,000
Independent examination of the charity	828	828
Total assurance services	**828**	**828**
Total fees	**52,500**	**52,500**

Deloitte.

Annual Governance Statement 2017/18

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

This Annual Governance Statement reflects the challenging context within which I deliver my responsibilities and demonstrates the complexity and diversity of the services the Trust provides across a broad geographical area.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of South West Yorkshire Partnership NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in South West Yorkshire Partnership NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Our Board has overall responsibility and accountability for setting the strategic direction of the Trust and ensuring there are sound systems in place for the management of risk. This includes responsibility for standards of public behaviour and accountability for monitoring the organisation's performance against the Trust's strategy and objectives, ensuring corrective action is in place where necessary. The Trust Board's attitude to risk is based on appropriate tolerance to risk. The Board acknowledges that the services provided by the Trust cannot be without risk and ensures that, as far as is possible, risk is minimised and managed within a risk tolerance. This is set out in the Trust's Risk Strategy and Risk Appetite Statement.

The Board is supported and governed by an involved and proactive Members' Council, a key part of the Trust's governance arrangements. Since becoming a Foundation Trust in 2009, the Members' Council has matured, in its role of holding Non-Executive Directors to account for the performance of the Trust Board. The agendas for Members' Council meetings, produced in partnership with the Members' Council Co-ordination Group, focus on its statutory duties, areas of risk for the Trust and on the Trust's future strategy. Training and development ensures governors have the skills and experience required to fulfil their duties.

The Board includes an Executive team with the day to day responsibility for managing risk. Over the last year, we have had a largely stable Executive Director team. There has been a reduction in the number of Business Delivery Unit (BDU) directors of one, with that individual now fulfilling a Director of Delivery role to focus on operational excellence. The

Director of Corporate Development role ceased during the year with the associated responsibilities transferring to other directors. Executive director portfolios are continually reviewed to ensure appropriate balance and capacity is in place to meet the needs of the Trust.

The Members' Council, Board and Executive team are operating in an environment of change and system pressure where risk is constant and at a heightened level.

The Trust operates within a strategic framework that includes a Vision, Mission and Values, supported by three Strategic Objectives and a number of Priority Programmes. This approach is agreed and set by the Board and provides an effective underpinning of the Chief Executive objectives and the objectives of the Executive team determined in line with director accountabilities. I review these objectives on an on-going basis with individual directors with progress, issues and risks reflected in the Board Assurance Framework and corporate/organisational risk register.

This approach reflects the Trust's framework that devolves responsibility and accountability throughout the organisation by having robust delivery arrangements. Capacity for delivery is assured through business planning processes and control is executed through an appropriate Scheme of Delegation and Standing Financial Instructions.

The Trust works in partnership with health economies in Calderdale, Kirklees, Wakefield, Barnsley and the Sustainability and Transformation Partnerships of South Yorkshire and West Yorkshire. We identify and manage risk at those levels as well as at Trust level, as reflected in the roles and responsibilities of the Board, of Executives and staff within the Trust. This is evident from the Board Assurance Framework and Trust risk registers.

The Trust strengthened its risk management arrangements during 2017/18 by creating a formal Risk Officer role and scheduling regular reviews of risk at Executive Management team meetings, and the Trust Board, alongside the forums of the Board and its sub-committees. This recognises the dynamic nature of the environment in which we operate and the need to constantly focus, assess and manage risk.

Risk management training for the Trust Board is undertaken bi-annually. The training needs of staff are assessed through a formal training needs analysis and staff receive training appropriate to their authority and duties. The role of individual staff in managing risk is supported by a framework of policies and procedures that promote learning from experience and sharing of good practice. The Risk Management Strategy was updated and approved by Trust Board on 31 January 2017.

Alongside this capacity, the Trust has effective Internal Audit arrangements, with a work plan that helps to manage strategic and business risk within the Trust.

The risk and control framework

The risk and control framework flows from the principles of good governance. It uses effective Board and committee structures, supported by the Trust's Constitution (including Standing Orders) and Scheme of Delegation. The Risk Management Strategy describes in detail how risk is applied within this framework.

The Audit Committee assures the Board and Members' Council of the effectiveness of the governance structures through a cycle of audit, self-assessment and annual review. The latest annual review was received by the Board on 24 April 2018.

The Audit Committee assessment was supported by an internal audit that was undertaken on Risk Management and the Board Assurance Framework in October 2017 and provided 'significant assurance'. Furthermore, the new Trust internal auditors conducted a survey of Trust Board members in relation to risk management which again supports this assessment.

The cycle of Trust Board meetings continues to ensure that the Trust Board devotes sufficient time to setting and reviewing strategy and monitoring key risks. Within each quarterly cycle, there is one monthly meeting with a forward-looking focus centred on business risk and future performance, one meeting focusing on performance and monitoring, and one strategic development session. The Trust Board meetings relating to business risk and future performance, and performance and monitoring are held in public and the Chair encourages governors to attend each meeting.

The Board has recognised the development of stronger partnerships across the geography in which we operate. Formal partnership Boards and committees have reports and Minutes received by the Board and are reflected in our risks.

The Trust's Risk Management Strategy sets out specific responsibilities and accountabilities for the identification, evaluation, recording, reporting and mitigation of risk. The Trust's Risk Appetite Statement was defined in line with the *'Good Governance Institute risk appetite for NHS Organisations'* matrix aligned to the Trust's own risk assessment matrix. The Statement was approved by Trust Board in July 2016 for implementation from September 2016. The Risk Appetite Statement sets out the Board's strategic approach to risk-taking by defining its specific boundaries and risk tolerance thresholds under four categories (strategic, clinical, financial or commercial, and compliance risks), and supports delivery of the Trust's Risk Management Strategy and procedures. Risks that are significant are monitored by the appropriate committee. Over 2017/18, further work has been undertaken to review risk registers where organisational risks not considered significant (level 15 and above) fall outside the Risk Appetite.

During the year, improvements have been agreed with a risk exception report being developed to go to the relevant committee or forum of the Board setting out the actions being taken and the consequences of managing the risk to a higher risk appetite level. Work is also taking place to further develop risk tolerance following a discussion at a Board strategic meeting.

The Board Assurance Framework (BAF) describes the strategic risks that will continue to be managed by the Trust. The BAF is aligned to the three strategic objectives of the Trust. This ensures alignment between the business of the Trust and the risks we manage across the organisation and the system. The BAF is used to help shape the agenda of the Board and its sub-committees.

As Chief Executive and the Accounting Officer, my accountabilities are secured through delegated executive responsibility to the Executive Directors of the Trust for the delivery of the organisational objectives, ensuring there is a high standard of public accountability, probity and performance management. In 2017/18, personal objectives were set for each director and reflected in the Board Assurance Framework through the strategic objectives assigned to each Director.

In support of the BAF, the Trust also has a corporate/organisational risk register in place which outlines the key strategic risks for the organisation and action identified to mitigate these risks. This is reviewed on a monthly basis by the Executive Management Team and quarterly by Trust Board, providing leadership for the risk management process.

Risk registers are also developed at service delivery level within BDUs and within the corporate directorates. These are reviewed regularly at the Operational Management Group. **The Trust's main risks at the end of 2017/18, can be summarised as follows:**

Area of focus	Sample of actions underway
Workforce pressures	Workforce plan being implemented following revised strategy. Focusing on wellbeing and engagement, recruitment and retention (participating in NHS Improvement's support programme).
Acuity and demand pressures	Successfully implemented waiting list initiatives, with more underway. Extra focus on hotspots such as CAMHS and inpatient wards. Continued focus on serious incident reporting, investigations & learning. Greater partnership working with local partners, e.g. Wakefield autism pathway and work across West Yorkshire and Harrogate. Ongoing discussions with commissioners.
Financial sustainability in a changing environment	Enhanced quality impact assessment process introduced. Maintaining focus on quality improvement. Working with NHS Improvement on a financial improvement plan and delivering challenging cost improvement programmes.
Out of area placements	Improved internal controls. Focusing on gatekeeping and flow. Developing a single bed-base across West Yorkshire Mental Health Services Collaborative.
Cyber-crime	Anti-virus software in place, including additional email security and data loss prevention and security patching regime covering all servers, client machines and key network devices. Annual infrastructure, server and client penetration testing. Disaster recovery and business continuity plans which are tested annually. Data retention policy with regular back-ups and off-site storage. NHS Digital Care Cert advisories reviewed on an on-going basis & where applicable applied to Trust infrastructure. Implementation of three year (data centre) infrastructure plan, including security and firewall rules for key network and computer devices, and IT services business continuity and disaster recovery. Increased training for information asset owners and managers.
Tendering activity	Horizon scanning for potential tender activity and work with staff in relevant services. Lessons learned from tenders being systematically actioned. Development of provider alliance in Barnsley. Workforce plan being implemented following revised strategy. Focusing on wellbeing and engagement, recruitment and retention (participating in NHS Improvement's support programme).

Given the strategic context within which we operate, the risks outlined above will continue into 2018/19 with mitigating actions in place. The creation of Sustainability and Transformation Partnerships (STP) across West and South Yorkshire will provide a further mechanism for managing some risks across organisations. As the lead Chief Executive for the STP in West Yorkshire & Harrogate, I will be able to ensure we are closely engaged in the leadership and delivery of these plans. As an engaged member of the leadership team of the South Yorkshire & Bassetlaw, I will ensure that the risks inherent in the move to an Integrated Care System are understood and mitigated.

Our Licence

The Trust was awarded a Licence by Monitor on 1 April 2013 with no conditions. There are currently no risks to compliance with the Licence conditions that apply to the Trust, including NHS Foundation Trust condition 4, which applies to Foundation Trusts only.

The Trust operates under the Single Oversight Framework issues by NHS Improvement which assists the Trust in compliance with the Monitor Licence. Our rating under this framework is 2 – targeted support

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). The Trust continues to assess its compliance with CQC registration requirements through an internal regulatory compliance review process and by learning from a regular programme of unannounced visits. Following the CQC visit in March 2016, the Trust developed a new internal visit programme, which initially targeted those services rated as 'requires improvement'. Feedback reports are received and reviewed by BDU management trios, BDU deputy directors and team managers, who develop an action plan to address areas for improvement that are monitored through BDU governance functions. Feedback, lessons learned and good practice from the process are shared with the Clinical Governance and Clinical Safety Committee and used to inform changes to the next planned visit programme.

The Trust is rated GOOD by the CQC. This includes Safety, Caring, Effectiveness and for being Well-Led. We are still rated as 'requiring improvement' for being Responsive and we will continue to address issues in this area.

Our ratings chart shows that 90% of the ratings within our service lines were found to be 'Good' or 'Outstanding'. The CQC found that, without exception, our staff were caring and compassionate as well as respectful and warm towards patients. This reflects a values based culture within the Trust.

The Trust assesses itself annually against the NHS Constitution. A report was presented to Trust Board in December 2017 which set out how the Trust meets the rights and pledges of the NHS Constitution.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Value Based Culture

The Trust works hard to provide the highest standards of healthcare to all its service users. The promotion of a culture of openness is a prerequisite to improving business resilience, patient safety and the quality of healthcare systems. Good governance and a risk aware culture is emphasised in the Values of the Trust and reinforced through values based recruitment, appraisal and induction.

Learning from incidents and the impact on risk management is critical. The Trust uses an e-based reporting system, DATIX, at directorate and service line level to capture incidents and risks, which can be input at source and data can be interrogated through ward,

team and locality processes. This encourages local ownership and accountability for incident and risk management. Data is interrogated regularly to ensure that any risks are identified and escalated at the appropriate level. Staff are assured they will be treated fairly and with openness and honesty when they report adverse incidents or mistakes, ensuring risks are reduced. In 2017/18, 12,303 incidents were reported, of which 89% resulted in low or no harm to patients and service users, recognising that the Trust has a risk based culture.

The Trust works closely with safety teams in NHS Improvement and uses Root Cause Analysis (RCA) as a tool to undertake structured investigation into serious incidents. Our aim is to identify the true cause of what happened, to identify the actions necessary to prevent recurrence and to ensure that the Trust takes every opportunity to learn and develop from an incident and mitigate future risk.

The provision of mental health, learning disability and community services carries a significant inherent risk. Unfortunately, serious incidents do occur which require robust and well governed organisational controls. During 2017/18, there were 71 serious incidents across the Trust compared to 65 in 2016/17. There were no 'Never Events' (as defined by the Department of Health) relating to serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Where harm has taken place, the Trust ensures that communication with staff, service users and families is open, honest and occurs as soon as possible following any patient safety event. Our Duty of Candour is taken extremely seriously and staff understand their role in relation to Duty of Candour; they have the support required to comply with the duty and to raise concerns; the Duty of Candour is met through meaningful and sensitive engagement with relevant people; and all staff understand the consequences of non-compliance. This is monitored through the Executive Management Team and reported through the governance structures to Board.

The Clinical Governance and Clinical Safety Committee has a leading role to play. It scrutinises and monitors quarterly serious incident reports and bi-annual reports on how and where lessons have been learnt and practice improved and/or changed. The Committee also monitors implementation of recommendations arising from external reviews and reports. In the last year, this has included the Trust's action plan in response to the CQC in relation to waiting lists, a review of arrangements for Child and Adolescent Mental Health Services (CAMHS), and a report on improving the quality of the mortality review process. The Committee oversees all work until actions have been completed and closed and it is satisfied that risks have been moderated.

The Clinical Risk Scan, chaired by the Director of Nursing and Quality, provides an organisational overview of the incident review, action planning and learning processes to improve patient safety and provide assurance on the performance management of the review process, associated learning, and subsequent impact within the organisation.

The key elements of the Trust's quality governance arrangements are as follows:

- The Trust's approach to quality reinforces its commitment to quality care that is safe, person-centred, efficient and effective. The Quality Strategy outlines the responsibilities held by individuals, BDUs, the Executive Management Team and Trust Board. The Trust Board approved an updated Quality Strategy on 27 March 2018.
- The Clinical Governance and Clinical Safety Committee is the lead committee for quality governance.

- This is supported by the Patient Safety Strategy to improve the safety culture throughout the organisation whilst supporting people on their recovery journey, to reduce the frequency and severity of harm resulting from patient safety incidents, to enhance the safety, effectiveness and positive experience of the services we provide, and to reduce the costs, both personal and financial, associated with patient safety incidents. The Trust has also signed up to the national 'Sign up to Safety' initiative and will deliver against a specific safety improvement plan over the next three years.
- Monthly compliance reporting against quality indicators within the Integrated Performance report. Trust Board also receives a quarterly report on complaints.
- CQC regulation leads, monitor performance against CQC regulations and the Trust undertakes regular self-assessments.
- External validation, accreditation, assessment and quality schemes support self-assessment for example, accreditation of electroconvulsive therapy (ECT), Psychiatric Intensive Care Unit (PICU) and Memory Services, CQC Mental Health Act Visits, national surveys (staff and service user).
- Trust Action Groups provide organisational overview and performance monitoring against key areas of governance such as Serious Incidents, Infection Prevention and Control, Information Governance, Management of Aggression and Violence, Drugs and Therapeutics and Practice Effectiveness.
- Quality Impact assessments are carried out on all Trust cost improvement plans with Medical Director and Director of Nursing approval required before a scheme can proceed.
- Measures are implemented and maintained to ensure practice and services are reviewed and improvements identified and delivered, such as the Trust's prioritised clinical audit and practice evaluation programme.
- The annual validation of the Trust's Corporate Governance Statements as required under NHS foundation trust conditions. The Board certified that it was satisfied with the risks and mitigating actions against each area of the required six areas within the statement.

The Trust continues to build on its existing service user insight framework to enhance and increase understanding of the Trust's services, to demonstrate the quality of services and to show the actions taken in response to the feedback. A number of initiatives have been established to strengthen customer insight arrangements, including the following:

- Systematising the collection of service user and carer feedback, with a consistent approach to action planning and communication of the responses, including assessment against the Department of Health's Friends and Family Test.
- Insight events for members and the public.
- Ongoing facilitated engagement events for service users and carers, staff and stakeholders in support of the Trust's transformation programme.
- Quantitative and qualitative local and national surveys undertaken on a regular basis and actions taken.
- The principle of co-production being embedded throughout the Trust, such as co-production of training in Recovery Colleges.
- Accreditation against the Cabinet Office's Customer Service Excellence award.

This approach has resulted in an increase in the number of issues raised and in the number of compliments received, which is a positive development in the context of the encouragement the Trust gives to people to offer feedback in all its forms.

The Trust continues to lay the foundations for its ambitious vision to provide outstanding physical, mental and social care in a modern health and care system, developing service change programmes and associated structures to transform the way it delivers services. The priority programmes are focused on ensuring the Trust continues to deliver services that meet local need, offer the best care and better outcomes, and provide value for money whilst ensuring the Trust remains sustainable and viable. The Trust has six priorities with a number of programmes that provide the framework for driving improvements. These include:

- Joined up care - working with our local system partners in each of the places that we provide services including the two integrated systems that we are part of across South Yorkshire & Bassetlaw and West Yorkshire & Harrogate.
- Quality counts, safety first - is a key priority that focuses on programmes to develop and deliver safe, effective and high quality services, including mental health services, learning disability services, general community services and forensic services.
- Operational excellence - focuses on improving productivity, making the best use of all our resources and ensuring that we reduce waste, duplication, unnecessary waste and variation in our care pathways and patient flows.
- Digital by default - ensures we embed the use of technology to improve clinical care and improve our productivity through agile working and the implementation of a new clinical record system.

This is underpinned by our values based culture and our approach to Leadership and a culture of improvement and inclusive change that is co-produced. Each programme has a Director sponsor and clinical lead, and is supported by robust project and change management arrangements through the integrated change team.

The Trust continues to develop and create additional capacity in the community and different models of delivery and support for service users and carers. This is through initiatives such as Creative Minds and the development of a recovery approach and recovery colleges across our districts, as well as continuing to host Altogether Better, a national initiative which supports development of community champions.

The Trust continues its commitment towards carbon reduction. South West Yorkshire Partnership NHS Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Equality and Diversity

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with and the value of diverse thinking and staffing is secured. This is achieved through Trust policies, training and audit processes. Early in 2015, Trust Board established an Equality and Inclusion Forum to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does.

The Forum develops and oversees the Equality Strategy to improve access, experience and outcomes for people from all backgrounds and communities including people who work and volunteer for the organisation, those who use Trust services and their families, and those who work in partnership with the Trust to improve the health and well-being of local communities. Staff survey results in 2016/17 suggested that the overall experience of British

Black, Asian, Minority Ethnic (BAME) staff working in the Trust is positive, a number of scores being better than the national average and they were generally more positive than white staff. BAME staff who responded to the survey had a higher overall engagement score, a higher number recommending it as a place to work or receive treatment and a higher number feeling valued by the Trust and senior managers that white staff. Areas where BAME staff were less positive than white staff are harassment and bullying and opportunities for career progression. The Trust has been engaging with staff on developing a new approach to tackling harassment and bullying and a positive action development programme for BAME staff was launched in 2017/18. The BAME staff network was established to empower and support BAME staff to achieve their potential and maximise their contribution in delivering the Trust's Mission, Values and Strategic Objectives and had a celebration of their first year, which showcased some of their achievements, in October 2017. The Trust has looked to establish a disability staff equality network which is due to start operating in 2018. In 2017/18, the Forum received reports on the following:

- Barnsley pilot for service users into employment.
- initiatives to encourage engagement with young people.
- Dementia awareness.
- Wellbeing survey results.

During 2016/17, we worked with our Members' Council to develop our Membership Strategy which was approved by the Members' Council in April 2017. The key objectives of the strategy, underpinned by a detailed action plan, are:

1. We will build and maintain membership numbers to meet our annual plan targets, ensuring membership is representative of the population the Trust serves.
2. We will communicate effectively and engage with our public members and our staff members, maintaining a two-way dialogue and encouraging more active involvement.
3. We will develop an effective and inclusive approach to give our public members and our staff members a voice and opportunities to contribute to the organisation, our services, and plans for the future.

The Trust has adopted the National Equality Delivery System 2 (EDS2) Framework and focussed on improving the following areas, working closely with service users, public and commissioners:

1. Better health outcomes for all
2. Improved patient access and experience
3. Empowered, engaged and well supported staff
4. Inclusive leadership at all levels

The Trust Board approved a Workforce Strategy in March 2017 which includes objectives, linked to the EDS2 Framework and the NHS Workforce Race Equality Standards (WRES), to support a representative workforce. The Trust has a joint EDS2 and WRES action plan which included action on increasing BAME representation in senior roles, including at Board level, career development programmes for BAME staff and a clinical network looking to address harassment and bullying by service users and carers which BAME reporting significantly higher levels than the average.

We ensure Equality Impact Assessments (EIA) are undertaken and published for all new and revised policies and services. This ensures that equality; diversity and human rights issues and service user involvement are systematically considered and delivered, through core Trust business.

Review of economy, efficiency and effectiveness of the use of resources

The governance framework of the Trust is determined by the Trust Board. It is described in the Trust's annual report and includes information on the terms of reference, membership and attendance at Trust Board and its committees, including the Nominations Committee, which is a sub-group of the Members' Council. The Trust complies with Monitor's (now NHS Improvement) Code of Governance and further information is included in the Trust's annual report.

The Executive Management Team has a robust governance structure ensuring monitoring and control of the efficient and effective use of the Trust's resources. Financial monitoring, service performance, quality and workforce information is scrutinised at meetings of the Trust Board, through Executive Management Team meetings, The Operational Management Group (OMG), BDU management teams and at various operational team meetings. To strengthen financial oversight and challenge Non-Executive Directors are invited to the financial review ate Executive Management Team meetings. The Trust is a member of the NHS Benchmarking Network and participates in a number of benchmarking exercises annually. This information is used alongside reference cost and other benchmarking metrics to review specific areas of service in an attempt to target future efficiency savings. Work has continued with BDUs to implement and utilise service line reporting.

The Trust has a well-developed annual planning process which considers the resources required to deliver the organisation's service plans in support of the Trust's strategic objectives and quality priorities whilst aligning Trust plans with commissioning intentions and local health and wellbeing plans. Increasingly we are ensuring that Sustainability and Transformation Plans (and their successors) inform our work. These annual plans detail the workforce and financial resources required to deliver service objectives and include the identification of cost savings. The achievement of the Trust's financial plan is dependent upon the delivery of these savings.

A robust process is undertaken to assess the impact on quality and risks associated with cost improvements both prior to inclusion in the annual plan and during the year to ensure circumstances have not changed. The process and its effectiveness are monitored by the Clinical Governance and Clinical Safety Committee. Quality Impact Assessments (QIA) take an objective view of the impact of cost improvements on the quality of services in relation to the CQC five domains of safe, caring, effective, responsive, and well led. The Assessments are led by the Director of Nursing and Quality and the Medical Director with BDU Directors and senior BDU staff, particularly clinicians.

As part of the annual accounts review, the Trust's efficiency and effectiveness of its use of resources in delivering clinical services are assessed by its external auditors and the auditor's opinion is published with the accounts.

The Trust delivered against its financial control total of £1.0m by achieving £1.1m. This entitled us to receive Sustainability and Transformation Funding (STF) of £2.9m. In total, £7.5m cost savings were delivered against a target of £8.3m (90% delivery). Of the £8.3m, £6.7m was delivered recurrently and a further £1.6m non-recurrently.

Information Governance

Information governance compliance is assured through a number of control measures to ensure that risks to data security are identified, managed and controlled. The Trust has put an information risk management process in place led by the Trust Senior Information Risk Owner (SIRO). Information asset owners cover the Trust's main systems and record stores, along with information held at team level. An annual information risk assessment is undertaken. All Trust laptops and memory sticks are encrypted and person identifiable information is required to be only held on secure Trust servers. The Trust achieved the target of 95% of staff completing training on information governance by 31 March 2018.

To strengthen its arrangements, the Trust's approach in 2017/18 has been to review guidance and policies, take a targeted approach to providing advice and support to staff through proactive monitoring of incidents, providing awareness raising sessions at all levels in the organisation, including senior level through Extended Executive Management Team, and offering advice and increasing availability of training for staff.

Incidents and risks are reviewed by the Improving Clinical Information Group which informs policy changes and reminders to staff.

In November 2016, the Information Commissioner's Office (ICO) undertook a consensual data protection audit. The final report, which provided reasonable assurance, was issued to the Trust in February 2017 and the executive summary was published on the ICO's webpage and the Trust's website. At each meeting of the Audit Committee an update on the progress made on the actions identified is provided. An update of progress made was provided to the ICO in December 2017. The vast majority of actions have now been completed.

The Trust is required to report any information governance incidents scoring level 2 or above externally to the Information Commissioner's Office (ICO). There have been 3 such incidents reported in 2017/18. This is a reduction compared to the nine reported incidents in 2016/17 and they are summarised below together with the actions taken:

- A letter including highly sensitive personal data was sent to a patient's home address despite their request that no correspondence be sent: the letter was opened by relatives who were previously unaware of the patient's diagnoses, causing significant distress to both the patient and their family – actions taken include ensuring outgoing post is checked by a clinician before release and the issue of a briefing paper to the team outlining the principles and practice for patient correspondence.
- A letter pertaining to one patient was left in the home of another by a community nurse after it had been collected from a standalone printer with a leaflet and stapled into the leaflet – actions taken include removing standalone printers from the premises and only using multi-functional devices and briefs at service and team meetings outlining responsibility for checking printed information when collecting from devices and prior to handing over to patients.
- Two highly sensitive reports about children were sent to the other's intended recipients – actions taken include immediately implementing a two-person check of post items before sending and recruiting an additional member of administrative staff to reduce pressure on the team.

Good information governance will continue to be a feature of the Trust in 2018/19. The Information Toolkit was submitted at level 2 – satisfactory.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*. We have fully compiled our Annual Report with the guidance issued, with our Quality Account being published alongside our Financial Accounts to ensure there is a balanced picture of the value delivered by the Trust. Our public and staff members are represented by the Members' Council Quality Group who are fully involved in agreeing the indicators within the Quality Account. Public facing and easy read versions of the Quality Report will be made available and the full report will be accessible on the Trust's website.

The following steps have been put in place to assure the Trust Board that the Quality Report presents a balanced view and that there are appropriate arrangements in place to ensure the quality and accuracy of performance information.

Governance and leadership of quality reporting

- Quality metrics are reviewed monthly by Trust Board and the Executive Management Team, alongside the performance reviews undertaken by BDUs as part of their governance structures.
- The integrated performance report covers substantial quality information and is reported to the Board and Executive Management team. This is supplemented by detailed reports on specific elements of quality, such as incidents, complaints and patient experience.
- The Clinical Governance and Clinical Safety Committee oversees the development of the Quality Report and associated detailed reports.
- Corporate leadership of data quality through the Director of Finance, supported by the Director of Nursing and Quality.
- Data quality objectives that are linked to business objectives, supported by the Trust's Data Quality Policy and evidenced through the Trust's Information Assurance Framework.
- The commitment to, and responsibility for, data quality by all staff is clearly communicated through Trust induction, mandatory training for information governance and training for the Trust's clinical information systems.
- The Director of Nursing and Quality and Director of Finance co-chair the Trust-wide Improving Clinical Information and Information Governance Meeting. The group ensures there is a corporate framework for management and accountability of data quality, with a commitment to secure a culture of data quality throughout the organisation.
- The effectiveness of the Trust's arrangements is scrutinised by the Audit and Clinical Governance and Clinical Safety Committees.

Role of policies and plans in ensuring quality of care provided

- Good clinical record keeping is part of good clinical practice and provision of quality care to the people who use our services.
- There is comprehensive guidance for staff on data quality, collection, recording, analysis and reporting which meets the requirements of national standards, translating corporate commitment into consistent practice, through the Data Quality Policy and associated information management and technology policies.

- There are performance and information procedures for all internal and external reporting. Mechanisms are in place to ensure compliance through the Improving Clinical Information and Information Governance Meeting with reports to the Audit and Clinical Governance and Clinical Safety Committees on data quality.

Systems and processes

- There are systems and processes in place for the collection, recording, analysis and reporting of data which are accurate, valid, reliable, timely, relevant and complete through system documentation, guides, policies and training.
- Corporate security and recovery arrangements are in place with regular tests of business critical systems. These systems and processes are replicated Trust-wide.

People and skills

- Behaviours and skills are an essential part of good data quality, recording and reporting and compliance with policy.
- Roles and responsibilities in relation to data quality are clearly defined and documented.
- There is a clear training plan for Information Governance and the Trust's clinical information systems (RiO, SystmOne and a small number of additional systems) with the provision of targeted training and support to ensure responsible staff have the necessary capacity and skills.

Data use and reporting

- Data provision is reviewed regularly to ensure it is aligned to the internal and external needs of the Trust through Executive Management Team meeting and Trust Board, with key performance indicators set at both service and Board level. This includes identification of any issues in relation to data collection and reporting and focussed action to address such issues

The Trust is committed to a continual improvement in the quality of its data in order to support improvement of the service it offers to users of its services and to meet its business needs. Regular reviews of the quality of the Trust's clinical data are undertaken by the Improving Clinical Information Group and, where data quality standards are identified as a risk factor, these are reported to the Trust's Senior Information Risk Owner (SIRO) for further investigation.

The Trust's external auditor, Deloitte, provides external assurance on the Quality Report and the findings are presented to the Audit Committee, Clinical Governance and Clinical Safety Committee, Trust Board and the Members' Council. During 2017/18, an Internal Audit of data quality baseline assessment within the Trust found significant assurance.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, the Audit Committee and the Clinical Governance and Clinical Safety Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board Assurance Framework (BAF) provides evidence that the effectiveness of controls put in place to manage the risks to the organisation achieving its principal objectives have been reviewed. The BAF is approved by Trust Board on an annual basis and reviewed and updated on a quarterly basis throughout the year. There were no significant gaps identified in the BAF.

Directors' appraisals are conducted by the Chief Executive with objectives reviewed and prioritised on a quarterly basis. This has provided a strong discipline and focus for Director performance. Non-Executive Director appraisals are undertaken by the Chair of the Trust.

The Trust has refined its values-based appraisal system for staff with a target for all staff in Bands 6 and above to have an appraisal in the first quarter of the year and the remainder of staff by the end of the second quarter. The Trust also uses values-based recruitment and selection.

All committees of Trust Board are chaired by Non-Executive Directors to reflect the need for independence and objectivity, ensuring that effective governance and controls are in place. The committees have met regularly throughout the year and their minutes and annual reports are received by the Board. Further information on Trust Board committees is contained in the annual report and in the Trust's Risk Management Strategy.

The Audit Committee is charged with monitoring the effectiveness of internal control systems on behalf of the Board and has done so as part of its annual work programme. This was reported through its Annual Report to the Board. The Audit Committee was able to provide assurance that, in terms of the effectiveness and integration of risk committees, risk was effectively managed and mitigated. Assurance was provided that committees met the requirements of their Terms of Reference, that committee work programmes were aligned to the risks and objectives of the organisation, in the scope of their remit, and that Committees could demonstrate added value to the organisation.

The role of internal audit at the Trust is to provide an independent and objective opinion to the Trust, its managers and Trust Board on the system of control. It provides a Head of Internal Audit opinion each year. The opinion considers whether effective risk management, control and governance arrangements are in place in order to achieve the Trust's objectives. The work of internal audit is undertaken in compliance with the NHS Internal Audit Standards. The internal audit function within the Trust for 2017/18 was provided by 360Assurance.

The work undertaken by internal audit is contained in an annual audit plan approved by the Audit Committee. Development of the work programme involves pre-discussion with the Executive Management Team. It is based on an audit of core activity around areas such as financial management, corporate governance and Board assurance processes, and audit of other areas following assessment and evaluation of risks facing the Trust. This includes priority areas identified by the Executive Management Team focusing on risk and improvement areas. Internal audit provides the findings of its work to management, and action plans are agreed to address any identified weaknesses. Internal audit findings are also reported to the Audit Committee for consideration and further action if required. A follow up process is in place to ensure that agreed actions are implemented. Internal audit is required to identify any areas at the Audit Committee where it is felt that insufficient action is being taken to address risks and weaknesses.

From 1 April 2017 to 31 March 2018, 10 internal audit reviews were presented to the Audit Committee. Of these, there were eight ‘significant assurance’ opinions and two ‘limited assurance’ opinions in relation to General Data Protection Regulations and additional pay spend. There were no ‘no assurance opinions’. These opinions and any resulting actions support the Trust in delivering an effective governance system.

The follow up review prior to submission of the Trust’s Information Governance toolkit return resulted in a ‘significant assurance’ opinion.

The fieldwork for three remaining reports from the 2017/18 plan relating to Pharmacy procurement, IT Strategy, and staff engagement are in progress with the assurance rating subject to agreement with management.

Action plans are developed for all internal audit reports in response to the recommendations and the Audit Committee invites the lead Director for each ‘limited’ or ‘no’ assurance’ report to attend to provide assurance on actions taken to implement recommendations. For all ‘limited’ and ‘no’ assurance’ reports, a follow up audit is undertaken within twelve months.

The Head of Internal Audit’s overall opinion for 2017/18 provided ‘**significant assurance**’ that there is a generally sound framework of governance, risk management and control designed to meet the organisation’s objectives, and that controls are generally being applied consistently.

Conclusion

I have reviewed the relevant evidence and assurances in respect of internal control. The Trust, its Board and members of the leadership and management structure are alert to their accountabilities in respect of internal control. Throughout the year, the Trust has had processes in place to identify and manage risk.

The review confirms that the Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives. A small number of internal control issues outlined in this statement are not considered significant. I can confirm that those control issues have been or are being addressed.

Over the past year, the Trust has delivered its business in a context of significant change. During this time, the system of internal control has remained robust and enabled change and risk to be managed effectively.

Rob Webster
Chief Executive

Date: 25 May 2018

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2018

		Group		Trust	
		Year Ended 31 March 2018	Year Ended 31 March 2017	Year Ended 31 March 2018	Year Ended 31 March 2017
	note	£000	£000	£000	£000
Operating income from patient care activities	5	208,032	213,967	208,032	213,967
Other operating income	5	14,848	15,940	14,760	15,851
Operating Expenses	6	(215,451)	(227,203)	(215,246)	(227,172)
Operating surplus / (deficit)		**7,429**	**2,704**	**7,546**	**2,646**
Finance costs:					
Finance income	10	66	66	65	64
PDC Dividends payable		(3,393)	(3,110)	(3,393)	(3,110)
NET FINANCE COSTS		**(3,327)**	**(3,044)**	**(3,328)**	**(3,046)**
Gains/(losses) of disposal of assets	13	425	9	425	9
SURPLUS/(DEFICIT) FOR THE YEAR		**4,527**	**(331)**	**4,643**	**(391)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	27	(1,719)	(186)	(1,719)	(186)
Revaluations	27	9,841	465	9,841	465
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**12,649**	**(52)**	**12,765**	**(112)**

The Group accounts are the consolidation of the Trust (South West Yorkshire Partnership NHS Foundation Trust) and EyUp! charity (see note 1.29 for more details).

The notes numbered 1 to 38 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2018	note	Group 31 March 2018 £000	Group 31 March 2017 £000	Trust 31 March 2018 £000	Trust 31 March 2017 £000
Non-current assets					
Intangible assets	14	231	356	231	356
Property, plant and equipment	15	123,419	110,693	123,419	110,693
Investment Property	16	160	150	160	150
Total non-current assets		**123,810**	**111,199**	**123,810**	**111,199**
Current assets					
Inventories	20	232	166	232	166
Trade and other receivables	21	8,132	8,634	8,134	8,659
Non-current assets for sale and assets in disposal groups	17	0	1,768	0	1,768
Cash and cash equivalents	22	27,108	27,053	26,559	26,373
Total current assets		**35,472**	**37,621**	**34,925**	**36,966**
Current liabilities					
Trade and other payables	23	(16,917)	(18,310)	(16,882)	(18,283)
Provisions	25	(3,377)	(4,307)	(3,377)	(4,307)
Other liabilities	23	(670)	(754)	(670)	(754)
Total current liabilities		**(20,964)**	**(23,371)**	**(20,929)**	**(23,344)**
Total assets less current liabilities		**138,318**	**125,449**	**137,806**	**124,821**
Non-current liabilities					
Provisions	25	(3,113)	(3,243)	(3,113)	(3,243)
Total assets employed		**135,205**	**122,206**	**134,693**	**121,578**
Financed by					
Taxpayers' equity					
Public Dividend Capital		44,015	43,665	44,015	43,665
Revaluation reserve	27	24,938	18,765	24,938	18,765
Other reserves		5,220	5,220	5,220	5,220
Income and expenditure reserve		60,520	53,928	60,520	53,928
Others' equity					
Charitable fund reserves		512	628	0	0
Total taxpayers' and others' equity		**135,205**	**122,206**	**134,693**	**121,578**

The financial statements on pages 2 to 39 were approved by the Board of Directors and authorised for issue on the 22 May 2018 and signed on their behalf by:

Signed.....

Rob Webster Chief Executive

Date 25 May 2018

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2018		Group		Trust	
		Year Ended 31 March 2018	Year Ended 31 March 2017	Year Ended 31 March 2018	Year Ended 31 March 2017
	note	£000	£000	£000	£000
Cash flows from operating activities					
Operating surplus/(deficit) from continuing operations		7,429	2,704	7,546	2,646
Operating surplus/(deficit)		**7,429**	**2,704**	**7,546**	**2,646**
Non-cash income and expense:					
Depreciation and amortisation	6	5,853	7,010	5,853	7,010
Net Impairments	6	(613)	3,678	(613)	3,678
Income recognised in respect of capital donations (cash and non-cash)		0	(6)	0	(6)
(Increase)/Decrease in Trade and Other Receivables	21	516	(1,547)	539	(1,569)
(Increase)/Decrease in Inventories	20	(66)	24	(66)	24
Increase/(Decrease) in Trade and Other Payables	23	(1,355)	(1,372)	(1,355)	(1,372)
Increase/(Decrease) in Other Liabilities	23	(84)	(35)	(84)	(35)
Increase/(Decrease) in Provisions	25	(1,060)	(2,467)	(1,060)	(2,467)
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows		8	12	0	0
NET CASH GENERATED FROM/(USED IN) OPERATIONS		**10,628**	**8,001**	**10,760**	**7,909**
Cash flows from investing activities					
Interest received	10	65	64	65	64
Purchase of intangible assets	14	(19)	(26)	(19)	(26)
Purchase of Property, Plant and Equipment		(10,019)	(10,053)	(10,019)	(10,053)
Sale of property, plant and equipment and Investment Property		2,486	4,299	2,486	4,299
NHS Charitable Funds - net cash flows from investing activities		1	2	0	0
Net cash generated from/(used in) investing activities		**(7,486)**	**(5,714)**	**(7,487)**	**(5,716)**
Cash flows from financing activities					
Public dividend capital received		350	173	350	173
PDC Dividend paid		(3,437)	(3,100)	(3,437)	(3,100)
Net cash generated from/(used in) financing activities		**(3,087)**	**(2,927)**	**(3,087)**	**(2,927)**
Increase/(decrease) in cash and cash equivalents		**55**	**(640)**	**186**	**(734)**
Cash and Cash equivalents at 1 April		27,053	27,693	26,373	27,107
Cash and Cash equivalents at 31 March		**27,108**	**27,053**	**26,559**	**26,373**

Deloitte.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

South West Yorkshire Partnership NHS Foundation Trust

Findings and Recommendations from the 2017/18 NHS Quality Report External Assurance Review

Contents

Executive Summary

We are in the process of completing our Quality Report testing

Status of our work

- The audit is complete.
- The scope of our work is to support a "limited assurance" opinion, which is based upon procedures specified by NHS Improvement in their "Detailed Requirements for External Assurance For Quality Reports for Foundation Trusts 2017/18".
- We have signed an unmodified opinion for inclusion in your 2017/18 Annual Report.

CQC Rating "Good"

The Care Quality Commission re-inspected the Trust during the prior year and gave it an overall rating of 'Good'.

	2017/18 (Draft)	2016/17
Length of Quality Report	78 pages	78 pages
Quality Priorities	32	32

Scope of work

We are required to:

- Review the content of the Quality Report for compliance with the requirements set out in NHS Improvement's Annual Reporting Manual ("ARM").
- Review the content of the Quality Report for consistency with various information sources specified in NHS Improvement's detailed guidance, such as Board papers, the Trust's complaints report, staff and patients surveys and Care Quality Commission reports.
- Perform sample testing of three indicators.
  - The Trust has selected Early Intervention in Psychosis (EIP) and Inappropriate Out Of Area Placements as its publically reported indicators.
  - For 2017/18, all Trusts are required to have testing performed on a local indicator selected by the Council of Governors. The Trust has selected waiting times across children and young peoples' eating disorder.
  - The scope of testing includes an evaluation of the key processes and controls for managing and reporting the indicators; and sample testing of the data used to calculate the indicator back to supporting documentation.
- Provide a signed limited assurance report, covering whether:
  - Anything has come to our attention that leads us to believe that the Quality Report has not been prepared in line with the requirements set out in the ARM; or is not consistent with the specified information sources; or
  - There is evidence to suggest that the Early Intervention in Psychosis (EIP) and Inappropriate Out Of Area Placements indicators have not been reasonably stated in all material respects in accordance with the ARM requirements.
  - Provide this report to the Council of Governors, setting out our findings and recommendations for improvements for the indicators tested.

Executive Summary (continued)

We have not identified any significant issues from our work to date

Content and consistency review

We have completed our content and consistency review. From our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018 the Quality Report is not prepared in all material respects in line with the criteria set out in the ARM).

	Overall conclusion
Content Are the Quality Report contents in line with the requirements of the Annual Reporting Manual?	B
Consistency Are the contents of the Quality Report consistent with the other information sources we have reviewed (such as Internal Audit Reports and reports of regulators)?	B

Performance indicator testing

NHS Improvement requires Auditors to undertake detailed data testing on a sample basis of two mandated indicators. We perform our testing against the six dimensions of data quality that NHS Improvement specifies in its guidance.
From our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018, the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the ARM and the six dimensions of data quality set out in the "Detailed Requirements for External Assurance on Quality Reports for Foundation Trusts 2017/18".

	Early Intervention in Psychosis	Inappropriate Out of Area Placements	Local Indicator
Recommendations identified?	✓	✓	✓
Overall Conclusion	Unmodified Opinion	Unmodified Opinion	No opinion required

The six dimensions of data quality:
Accuracy Is data recorded correctly and is it in line with the methodology.
Validity Has the data been produced in compliance with relevant requirements.
Reliability Has data been collected using a stable process in a consistent manner over a period of time.
Timeliness Is data captured as close to the associated event as possible and available for use within a reasonable time period.
Relevance Does all data used generate the indicator meet eligibility requirements as defined by guidance.
Completeness Is all relevant information, as specific in the methodology, included in the calculation.

G No issues noted A Requires improvement B Satisfactory – minor issues only R Significant improvement required

Content and consistency findings

Content and consistency review findings

No issues have been noted to date in relation to the content and consistency

The Quality Report is intended to be a key part of how the Trust communicates with its stakeholders.

Although our work is based around reviewing content against specified criteria and considering consistency against other documentation, we have also made recommendations to management through our work to assist in preparing a high quality document. We have summarised below our overall assessment of the Quality Report.

Key questions	Assessment	Statistics
• Is the length and balance of the content of the report appropriate?	Yes	Length: 78 pages
• Is there an introduction to the Quality Report that provides context?	Yes	
• Is there a glossary to the Quality Report?	Yes	
• Is the number of priorities appropriate across all three domains of quality (Patient Safety, Clinical Effectiveness and Patient Experience)?	Yes	Patient Safety: 8 Clinical Effectiveness: 7 Patient Experience: 3
• Has the Trust set itself SMART objectives which can be clearly assessed?	Yes	
• Does the Quality Report clearly present whether there has been improvement on selected priorities?	Yes	
• Is there appropriate use of graphics to clarify messages?	Yes	
• Does there appear to have been appropriate engagement with stakeholders (in both choosing priorities as well as getting feedback on the draft Quality Report)?	Yes	
• Does the Annual Governance Statement appropriately discuss risks to data quality?	Yes	
• Is the language used in the Quality Report at an appropriate readability level?	Yes	

Deloitte view

Overall, the Quality Account has been prepared in all material respects with the Foundation Trust Annual Reporting Manual.

Particular areas of good practice include:

- The use of graphics throughout the report; and
- Concise presentation of information.

Possible areas for improvement next year include:

- Clearer reporting of the indicators which are subject to external audit.

Performance and Indicator Testing

Early Intervention in Psychosis ("EIP")

	Trust reported performance	Target	Overall evaluation
2017/18 (average)	88.2%	50%	B
2016/17 (average)		50%	Not subject to testing

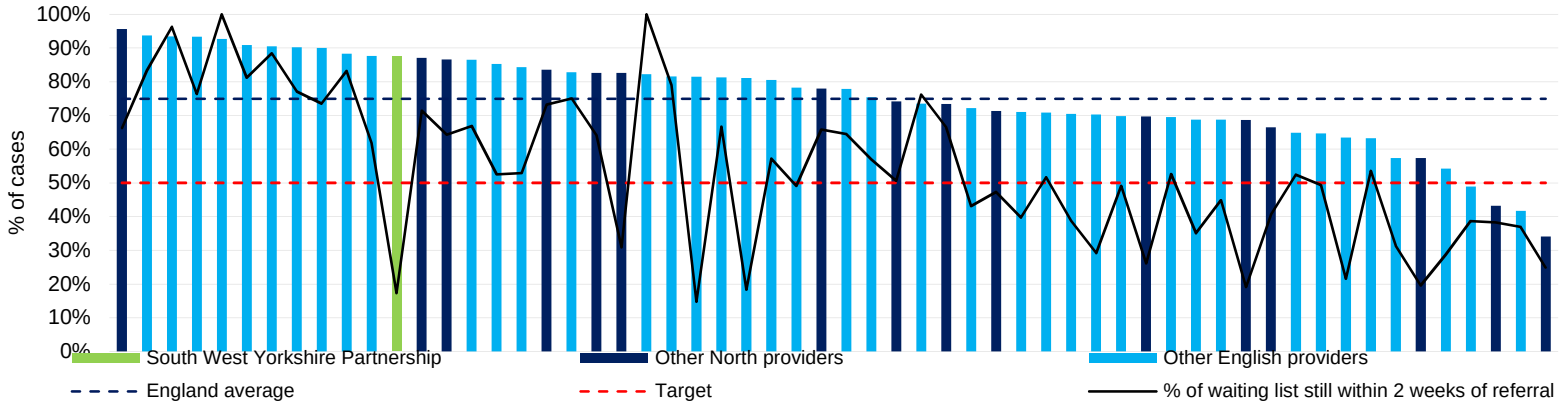
Indicator definition and process

Definition: "The proportion of people experiencing first episode psychosis or 'at risk mental state' who wait two weeks or less to start NICE recommended package of care."

National context

The chart below shows how the Trust compares to other organisations nationally for the first three quarters of 2017/18, based on the latest national data available.

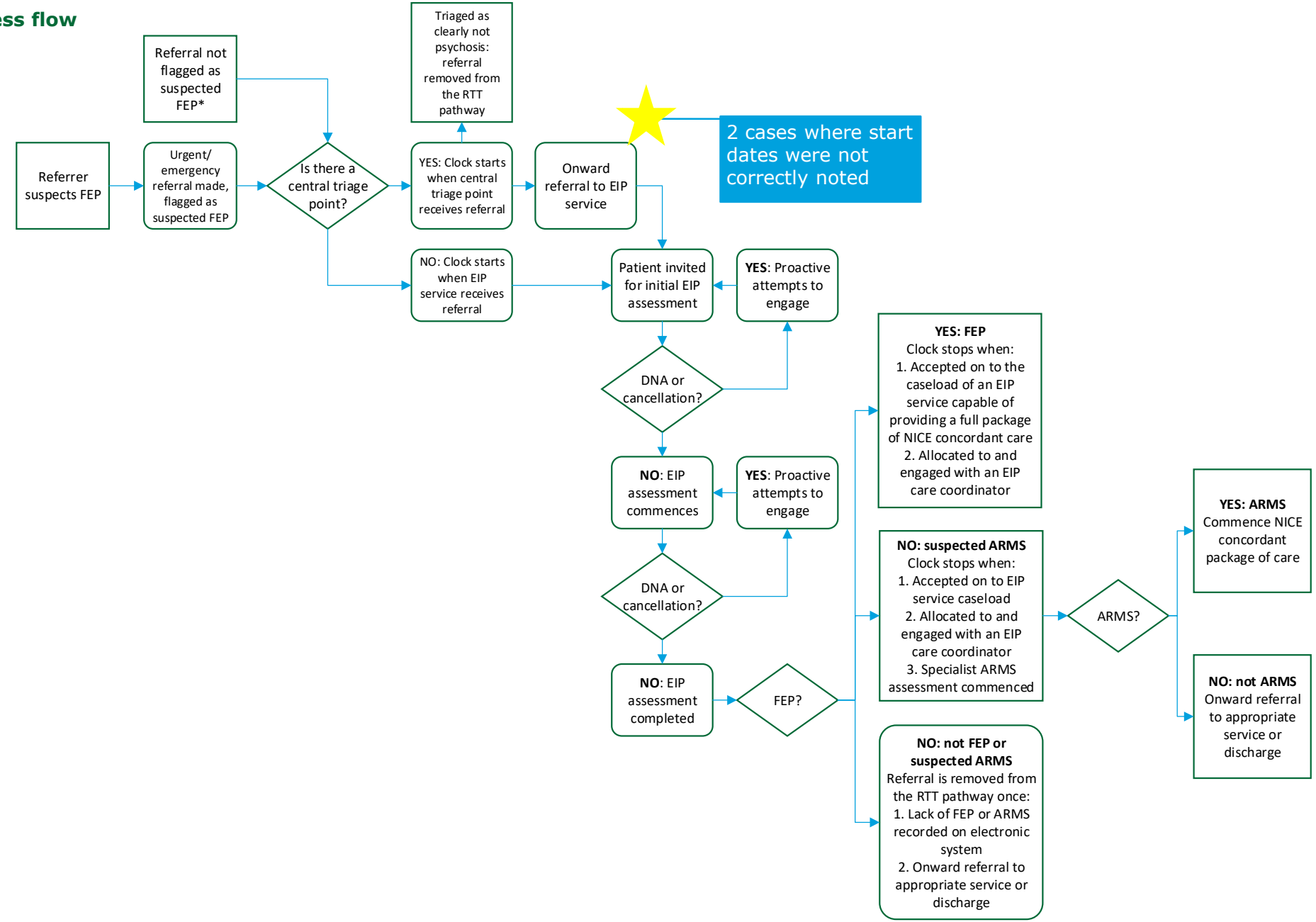
Early intervention in psychosis - starting treatment within 2 weeks - Q1-3 2017-18



Source: Deloitte analysis of NHS England data. Percentage of waiting list still within 2 weeks of referral calculated as average of month end figures.

Early Intervention in Psychosis (continued)

Process flow



Early Intervention in Psychosis (continued)

Approach

- We met with the Trust's leads to understand the process from a referral to the overall performance being included in the Quality Report. This is a newly tested indicator, and so there are no recommendations from the prior year.
- We evaluated the design and implementation of controls through the process.
- We selected a sample of 25 from 1 April 2017 to 31 March 2018 including in our sample a mixture of cases in breach and not in breach of the target.
- We agreed our sample of 25 to the underlying information held within RiO and patient notes.
- We have recalculated the indicator presented in the Quality Accounts using data provided to us.

Findings

- 2 instances where the clock start dates were incorrect based on the patient notes and information held in RiO however the difference had no impact upon the indicator.

Deloitte View:

We have completed our testing on this indicator, and have tied this item through to the reported position in the Quality Account.

Inappropriate Out of Area Placements

	Trust reported performance	Target	Overall evaluation
2017/18 Q4	1,527	Progress against trajectory	B

Indicator definition and process

Definition: "Total number of bed days patients have spent out of area" on placements assessed as inappropriate, calculated as the average of the monthly position."

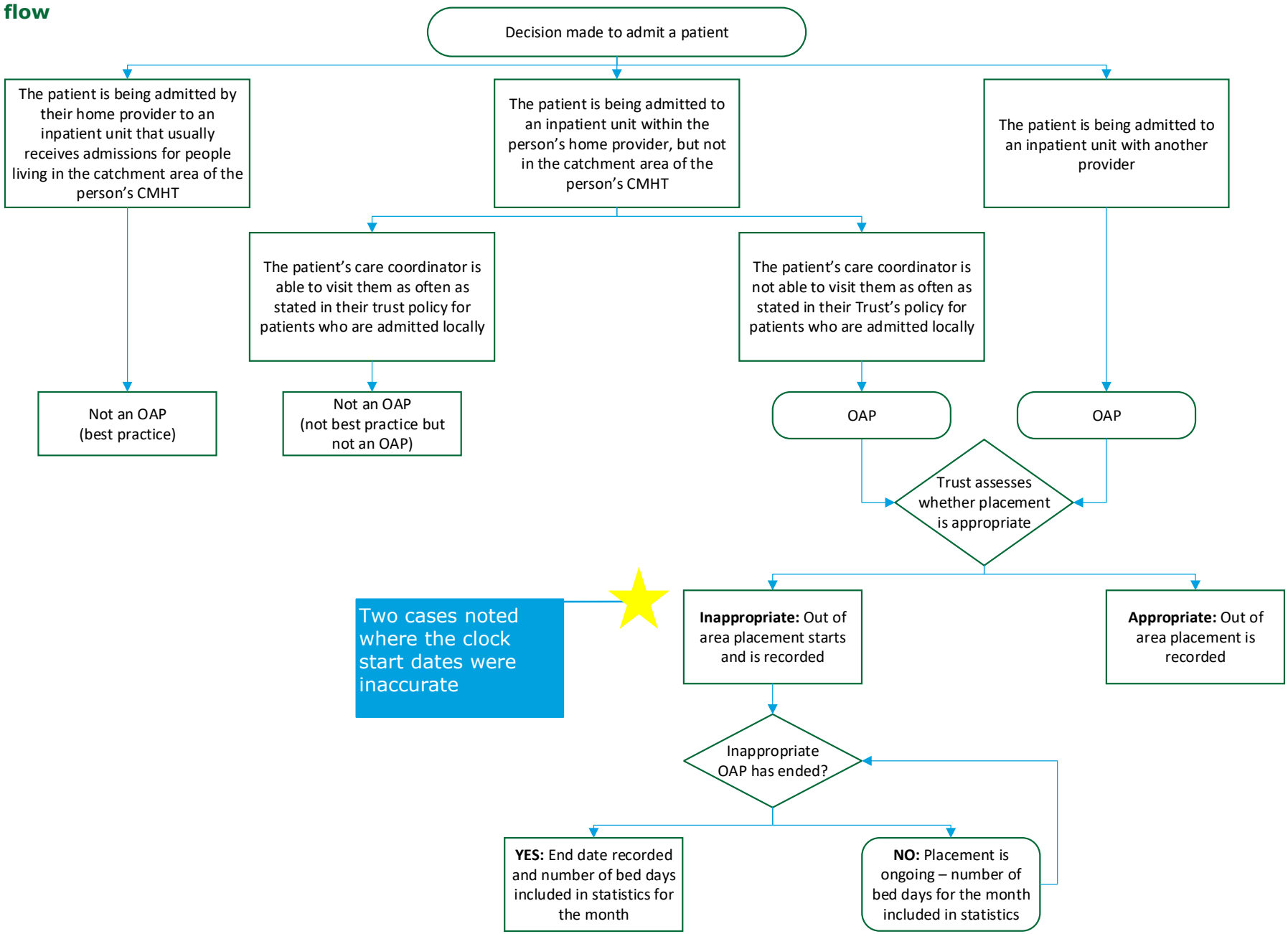
National context

Inappropriate Out of Area Placements has been mandated as an indicator for the first time this year. Due to the relatively recent inclusion in the Single Operating Framework, and so increased focus on this metric, NHS Improvement has given providers the choice for 2017/18 of reporting figures for Quarter 4 only, or for the whole year. The Trust has decided to report figures for the whole year, however, our audit is based on the Q4 position as detailed by the indicator guidance.

The indicator has a number of potentially complex judgements to assess whether an Out of Area Placement is, in fact, appropriate. We understand from NHS Improvement that over 90% of placements are reported as "inappropriate", though it is not clear whether this is due to any overall issues in reporting or identifying "appropriate" placements, or reflects the actual split of cases. However, discussions in testing across our portfolio suggest that some of this may be due to less focus on classification for the metric than just reporting overall numbers of placements.

Inappropriate Out of Area Placements (continued)

Process flow



Inappropriate Out of Area Placements (continued)

Approach

- We met with the Trust's leads to understand the process from placement through to the overall performance being included in the Quality Report. This is a newly tested indicator, and so there are no recommendations from the prior year.
- We evaluated the design and implementation of controls through the process.
- We selected a sample of 25 from 1 April 2017 to 31 March 2018.
- We agreed our sample of 25 to the underlying information held within RiO and patient notes.
- We have recalculated the indicator presented in the Quality Account using the data provided to us.

Findings

- Two cases noted where there was an incorrect start start date based on the information held within RiO and patient notes however, as the error occurred prior to 1 January 2018, it has no bearing upon the indicator.

Deloitte View:

We have completed our detailed testing of the indicator and have recalculated the percentage shown in the Quality Account.

Based on our testing we have issued an unmodified opinion.

Local Indicator

	Q3	Q4
Urgent	76.47%	69.23%
Routine	92.00%	94.44%

Indicator definition and process

Definition: Waiting times across children & young people's eating disorder (CYP-ED) pathways.

Reason for testing: Selected by Governors to validate the process of collection.

Approach

- We met with the Trust's leads to understand the process from identifying eating disorder to the overall performance being included in the Quality Report. There were no recommendations from the previous auditor's review of last year's Quality Report as this indicator was not part of the external assurance work.
- We selected a sample of 25 from 1 April 2017 to 31 March 2018.
- We agreed our sample to the underlying data held within RiO and the patient notes.
- We have recalculated the indicator presented in the Quality Report.

Findings

Inconsistent recording of the data within the RiO system where referral received dates were not consistent within the different screens of RiO. This did not affect the underlying reporting, however meant when tied to supporting evidence there were multiple referral dates on different screens in RiO.

Deloitte View:

Our testing is complete and management are asked to note the findings within the report.

Appendices

Appendix 1: Recommendation for improvement

Indicator	Deloitte Recommendation	Management Response
Early Intervention in Psychosis	**Inappropriate start dates** There should be consistency in terms of the recording of start dates the recording of referral dates where there is a referral from within the Trust.	No management response received.
Inappropriate out of area placements	**Inappropriate start dates** There should be consistency of record keeping between the referral and the acceptance of an out of area placement.	No management response received.
Local Indicator	**Completion of RiO system** There should be consistency in terms of the dates input within the RiO system. Dates should be consistently input on the relevant screens within the RiO system.	No management response received.

Appendix 2: Update on prior year recommendations

Our prior year recommendations have been addressed

Indicator	Prior year finding	Current year status
7 day follow up	Incorrectly excluded cases - We recommend the Trust research and understand the reason for the cases which were missed from the report.	Helen Smith investigated this and it was noted that the cases identified were actually correctly omitted from the report and therefore the recommendation is closed.
DTOC	Capture of MDT decisions - In line with our recommendation in the prior year, we recommend that the Trust improve the consistency of its recording of MDT decisions.	Julie Bowser has cascaded this through the teams, and reminded of the single operating procedure that is in place and is Trust policy to follow.
Wait times	Recording of direct contact – We recommend that the Trust ensure that staff are documenting outcomes consistently.	Linda Moon has taken these actions back and this has been cascaded through team meetings and also through direct supervision of the team.

Responsibility statement

Purpose of our report and responsibility statement

Our report is designed to help you meet your governance duties

What we report

Our report is designed to help the Council of Governors, Audit Committee, and the Board discharge their governance duties. It also represents one way in which we fulfil our obligations to report to the Governors and Board our findings and recommendations for improvement concerning the content of the Quality Report and the mandated indicators. Our report includes:

- Results of our work on the content and consistency of the Quality Report, our testing of performance indicators, and our observations on the quality of your Quality Report.
- Our views on the effectiveness of your system of internal control relevant to risks that may affect the tested indicators.
- Other insights we have identified from our work.

What we don't report

- As you will be aware, our limited assurance procedures are not designed to identify all matters that may be relevant to the Council of Governors or the Board.
- Also, there will be further information you need to discharge your governance responsibilities, such as matters reported on by management or by other specialist advisers.
- Finally, the views on internal controls and business risk assessment in our final report should not be taken as comprehensive or as an opinion on effectiveness since they will be based solely on the procedures performed in performing testing of the selected performance indicators.

Other relevant communications

- Our observations are developed in the context of our limited assurance procedures on the Quality Report and our related audit of the financial statements.

We welcome the opportunity to discuss our report with you and receive your feedback.

Deloitte LLP
Newcastle Upon Tyne
25 May 2018

This report is confidential and prepared solely for the purpose set out in our engagement letter and for the Board of Directors, as a body, and Council of Governors, as a body, and we therefore accept responsibility to you alone for its contents. We accept no duty, responsibility or liability to any other parties, since this report has not been prepared, and is not intended, for any other purpose. Except where required by law or regulation, it should not be made available to any other parties without our prior written consent. You should not, without our prior written consent, refer to or use our name on this report for any other purpose, disclose them or refer to them in any prospectus or other document, or make them available or communicate them to any other party. We agree that a copy of our report may be provided to Monitor for their information in connection with this purpose, but as made clear in our engagement letter only the basis that we accept no duty, liability or responsibility to Monitor in relation to our Deliverables.

Deloitte.

Independent auditor's report to the Council of Governors of South West Yorkshire Partnership NHS Foundation Trust on the quality report

We have been engaged by the Council of Governors of South West Yorkshire Partnership NHS Foundation Trust to perform an independent assurance engagement in respect of South West Yorkshire Partnership NHS Foundation Trust's quality report for the year ended 31 March 2018 (the 'quality report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of South West Yorkshire Partnership NHS Foundation Trust as a body, to assist the Council of Governors in reporting South West Yorkshire Partnership NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors as a body and South West Yorkshire Partnership NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter
The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Early Intervention in Psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE) – approved care package within two weeks of referral; and
- Inappropriate out of area placements for adult mental health services.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors
The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual' issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified below; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with the documents listed below:

- Board minutes for the period April 2017 to March 2018;
- papers relating to quality reported to the Board over the period April 2017 to March 2018;
- feedback from Commissioners, dated 17/05/2018;
- feedback from local Healthwatch organisations, dated 23/05/2018;
- feedback from Overview and Scrutiny Committee, dated 18/05/2018;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated June 2017 (Q1), Oct 2017 (Q2), Dec 2017 (Q3) and March 2018 (Q4);
- the national community health patient survey 2017;
- the national staff survey 2017;
- Care Quality Commission inspection report, dated 13/04/2017; and
- the Head of Internal Audit's annual opinion over the trust's control environment, dated 25/05/2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed
We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS Foundation Trust Annual Reporting Manual' to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual'.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified above; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance.

Deloitte LLP
Newcastle Upon Tyne
25 May 2018

South West Yorkshire Partnership NHS Foundation Trust

Members' Council
3 August 3 2018

Agenda item:	**6.2**
Report Title:	External Audit – Continuation of Contract
Report By:	Chair of the Audit Committee
Action:	To agree

Introduction

In July 2015, following a recommendation by the Audit Committee, Deloitte LLP was appointed as external auditor to the Trust by the Members' Council. This contract commenced on 1 October 2015. The nature of the contract with Deloitte is such that they can be used for a period of five years before the Trust needs to enter into an exercise to re-procure external audit services. The Trust does have an option to review the provision of these audit services after a period of three years as the contract allows for three years initial provision with the option to extend for a further two years. The two years extension could be reviewed annually i.e. in both 2018 and 2019.

Recommendation

It is recommended the Members' Council CONFIRM that the contract with Deloitte for provision of external audit services continues for a further two years, therefore until 30 September 2020.

Background

The purpose of this paper is for the Audit Committee to make a recommendation to the Members' Council that the contract with Deloitte for external audit services continues for a further two years, during which time a procurement exercise will need to take place in mid-2019. It is worth noting that two governors were part of the team involved in the assessment of bids in 2015, along with Audit Committee members and Trust executives. The rationale for this approach is:

- First and foremost, Deloitte has provided strong external audit services to the Trust.
- Deloitte has engaged well with the Members' Council, presenting annual accounts, audit reports, providing training on understanding of financial statements, and facilitating the annual governor evaluation.
- The Audit Committee reviews the performance of external audit annually and is satisfied with the service provided.
- Deloitte understands our Trust, the issues we face and our year-end processes.

- Deloitte has provided expertise on a number of items to enable Audit Committee and Trust Board members to carry out their roles such as cyber-crime and General Data Protection Regulations (GDPR) introduction.
- It would be disruptive and costly to re-procure and potentially use new external auditors.
- Based on performance there is no reason not to continue with Deloitte as external auditor.
- The contract allows for this continuation.

South West Yorkshire Partnership NHS Foundation Trust

Members' Council
3 August 2018

Agenda item:	**6.3**
Report Title:	Members' Council Co-ordination Group Annual Report 2017/18
Report By:	Company Secretary on behalf of the Members' Council Co-ordination Group
Action:	To receive

EXECUTIVE SUMMARY

Purpose

The purpose of this paper is to provide assurance to the Members' Council that the Co-ordination Group is fulfilling its remit and meeting its terms of reference.

Recommendation

The Members' Council RECEIVE the Members' Council Co-ordination Group Annual Report for 2017/18.

Background

The Co-ordination Group was originally established as the Members' Council Development Group in July 2008, with an initial remit to plan the development programme for the Members' Council. When the Trust was authorised as a Foundation Trust on 1 May 2009, it was agreed that the remit of the Group would be extended to include supporting the Chair in the setting of the agenda for Members' Council meetings. A report to the Members' Council in January 2010 recommended that the Group's name should be changed to 'Co-ordination Group'. This was agreed along with the remit to co-ordinate the work and development of the Members' Council.

The attached annual report provides assurance to the full Members' Council that it is meeting its terms of reference and outlines the work undertaken for the period 1 April 2017 to 31 March 2018.

Members' Council Co-ordination Group members: Angela Monaghan, Charlotte Dyson, Jackie Craven, Bill Barkworth, Neil Alexander, Jeremy Smith, Ruth Mason.

With all of us in mind.

South West Yorkshire Partnership NHS Foundation Trust

Members' Council 3 August 2018

Members' Council Co-ordination Group Annual Report 2017/18

Purpose of the Report

This report provides the Members' Council with an update on the work of the Co-ordination Group over the past year.

Background

The Group was originally established as the Members' Council Development Group in July 2008. In January 2010, this became the 'Co-ordination Group' with the following remit.

Overall aim

The Co-ordination Group's prime purpose is to co-ordinate the work and development of the Members' Council.

Duties

The Group will:

a) with the Chair of the Trust, develop and agree the agendas for Members' Council meetings;
b) work with the Trust to develop an appropriate development programme for Governors both as ongoing development and as induction for new Governors; and
c) act as a forum for more detailed discussion of issues and opportunities where the Trust seeks the involvement of the Members' Council.

Membership

Membership consists of governors (with representation from public, staff and appointed governors) plus the Chair and Deputy Chair of the Trust. The Director of Corporate Development / Company Secretary, as lead Director, also attends meetings of the Group.

A governor's term of office on the Group is determined by their term of office as a governor. If an individual resigns or is not re-elected onto the Members' Council, the individual taking their seat does not automatically take the place on the Group.

The membership of the Group from 1 April 2017 to 31 March 2018 was as follows:

- Chair of the Trust - Ian Black (to 30 November 2017)
- Chair of the Trust - Angela Monaghan (from 1 December 2018)
- Deputy Chair of the Trust - Julie Fox (to 31 July 2018)
- Deputy Chair of the Trust - Charlotte Dyson (from 1 August 2018)
- Lead Governor (publically elected Barnsley) - Andrew Hill (to 30 April 2017)
- Lead Governor (publically elected Wakefield) - Jackie Craven (from 28 July 2017)
- Director Corporate Development / Company Secretary (lead director) - Dawn Stephenson (to 31 July 2018)
- Governor (publicly elected Barnsley) - Bill Barkworth
- Governor (publically elected Calderdale) - Neil Alexander
- Governor (publically elected Kirklees) - Bob Mortimer

- Governor (publically elected Kirklees) - Jeremy Smith
- Governor (publically elected Wakefield) - Peter Walker
- Governor (staff elected, Allied Health Professionals) - Claire Girvan
- Governor (appointed Calderdale and Huddersfield NHS Foundation Trust) - Ruth Mason

What the Co-ordination Group has done

Agenda setting

The Co-ordination Group has met on a regular basis throughout the year, approximately 6 (six) weeks prior to each Members' Council meeting. This has allowed sufficient time for agenda planning and given the opportunity for members to suggest items for inclusion. The Group reviewed and input into the Members' Council work programme and also considered what discussion topics to focus on.

Forum for discussion

The Group regularly considers other issues relevant to the Members' Council. The following examples give an indication of the range of discussion. The Group has:

- worked with the Chair of the Trust to develop and **agree the agendas** for Members' Council meetings;
- identified issues to focus on in **table discussions**;
- emphasised the importance of Members' Council involvement in discussions about **larger scale change** within the Trust, for example, in relation to the review of the Trust's strategic objectives, operational plan, and annual report and quality account;
- considered issues relating to the **additional responsibilities of governors** particularly in relation to holding Non-Executive Directors to account for the performance of the Trust;
- contributed to planning the ongoing **development programme** for governors following the annual evaluation session;
- contributed to the development of the **induction programme** for new governors; and
- contributed to the planning of the **Annual Members' Meeting**.

How have we done

We consider that the Co-ordination Group has carried out its remit over the past year as demonstrated by the activity outlined above. However, the Co-ordination Group is aware that other governors may wish to comment on the work undertaken or to suggest further issues the Co-ordination Group could focus on.

The Co-ordination Group's sincere thanks are extended to previous members for both for their support and contribution. Although the Co-ordination Group remains relatively large for a working/business group, it includes good representation from the Members' Council. If any Governor would like to join the Co-ordination Group, their self-nomination would be welcomed, particularly a publically elected governor for Wakefield and a staff elected governor for which there are currently vacancies.

Recommendation

The Members' Council is requested to receive the report.

South West Yorkshire Partnership NHS Foundation Trust

Members' Council
3 August 2018

Agenda item:	**6.5**
Report Title:	Nominations Committee Annual Report 2017/18
Report By:	Company Secretary on behalf of the Nominations Committee
Action:	To receive / agree

EXECUTIVE SUMMARY

Purpose

The purpose of this paper is to provide assurance to the Members' Council that the Nominations Committee is fulfilling its remit and meeting its Terms of reference.

Recommendation

The Members' Council are asked to RECEIVE the Nominations Committee Annual Report for 2017/18 and APPROVE the updated Terms of Reference.

Background

The Nominations Committee was established in May 2009 to assist Council Members to exercise their statutory duty to appoint the Chair and Non-Executive Directors of the Board, to appoint the Deputy Chair and Senior Independent Director of the Board and to appoint the Lead Governor of the Members' Council.

The Nominations Committee's prime purpose is two-fold. Firstly, to ensure the right composition and balance of the Board and, secondly, to oversee the process for the identification, nomination and appointment the Chair and Non-Executive Directors of the Trust, to oversee the process for the identification, nomination and appointment of the Deputy Chair and Senior Independent Director of the Board and to oversee the process to identify, nominate and appoint the Lead Governor of the Members' Council.

The attached annual report provides assurance to the Members' Council that it is meeting its terms of reference and outlines the work undertaken for the period 1 April 2017 to 31 March 2018. At its meeting on 20 June 2018, the Committee reviewed and made some minor changes to its Terms of Reference in relation to the names of members and job tiles of those in attendance which were approved by the Committee on 20 June 2018. These are also attached for formal approval.

Nominations Committee members: Angela Monaghan, Marios Adamou, Jackie Craven, Nasim Hasnie, Ruth Mason.

With **all of us** in mind.

South West Yorkshire Partnership NHS Foundation Trust

Members' Council 3 August 2018

Nominations Committee Annual Report 2017/18

1. Purpose of report

The purpose of the report is to provide a summary of the Committee's activities during the financial year 2017/18 to provide assurance and evidence to the Members' Council of its effectiveness and impact through compliance with its Terms of Reference.

2. Background

The Nominations Committee was established in May 2009 to assist Council Members to exercise their statutory duty to appoint the Chair and Non-Executive Directors of the Board, to appoint the Deputy Chair and Senior Independent Director of the Board and to appoint the Lead Governor of the Members' Council. It has no executive powers. The authority of the Nominations Committee is limited to those powers specifically delegated to it in these terms of reference and, as appropriate, by the Members' Council.

The Nominations Committee's prime purpose is two-fold. Firstly, to ensure the right composition and balance of the Board and, secondly, to oversee the process for the identification, nomination and appointment the Chair and Non-Executive Directors of the Trust, to oversee the process for the identification, nomination and appointment of the Deputy Chair and Senior Independent Director of the Board and to oversee the process to identify, nominate and appoint the Lead Governor of the Members' Council.

The duties of the Committee are:

- Regularly review the structure, size and composition (including the skills and experience) of Trust Board and make recommendations to the Board and Members' Council regarding any changes and appropriate processes.
- Ensure there is a formal, rigorous and transparent procedure for the appointment of the Chair and Non-Executive Directors of the Board, which fits the criteria set out by the Committee as a result of its regular review and meets the requirements of a confidential recruitment process.
- Give full consideration to succession planning in respect of the Chair and Non-Executive Directors of the Board, taking account of the challenges and opportunities facing the Trust and the skills and expertise required by the Board.
- Make recommendations to the Members' Council on the appointment of the Chair and Non-Executive Directors ensuring all information, such as job descriptions, person specifications and process, are available to Council Members to make an informed decision.
- Make recommendations to the Members' Council any uplift to the Chairs remuneration based on benchmarking information as applicable and the pay spine point, dependant on the outcome of Chair appraisal process through the Members' Council.
- Make recommendations to the Members' Council any uplift to Non-Executive Directors remuneration based on benchmarking information as applicable.

- Ensure there is a formal, rigorous and transparent procedure for the appointment of the Deputy Chair and Senior Independent Director of the Board, which fits the criteria set out by the Committee as a result of its regular review (as above).
- Ensure there is a formal, rigorous and transparent procedure for the appointment of the Lead Governor for the Members' Council, which fits any criteria set out by the Committee and meets the requirements of a confidential recruitment process.

Changes to Committee terms of reference
In 2018, the Committee reviewed and made some minor changes to its Terms of Reference in relation to membership and attendance which were approved by the Committee on 20 June 2018. These will be presented to the Members' Council for formal approval.

Reporting to Members' Council
Under its Terms of Reference, the Committee is required to produce a brief annual report on its activities, which is presented formally to the Members' Council. The Committee's minutes are presented to the Members' Council and Trust Board once ratified.

Membership
The Committee met six times in 2017/18 and its membership was as follows:

Name/role	**Attendance 2017/18**
Ian Black, Chair of the Trust (to 30 November 2017) *Committee Chair to 30 November 2017	4/5*
Charlotte Dyson, Deputy Chair of the Trust **Committee Chair in absence of Ian Black*	*1/1**
Angela Monaghan, Chair of the Trust (from 1 December 2017) *Committee Chair from 1 December 2017	1/1*
Rob Webster, Chief Executive	5/6
Andrew Hill, Lead Governor (to 30 April 2017) - publically elected *Committee member to 30 April 2017	1/1*
Jackie Craven, Lead Governor (from 31 July 2017) – publically elected *Committee member from 1 July 2017	3/3*
Nasim Hasnie, Governor – publically elected	5/6
Marios Adamou, Governor – staff elected	3/6
Ruth Mason, Governor – appointed	4/6

The Director of Human Resources, Organisational Development and Estates (or a member of his team) attends meetings to offer specialist or expert advice to the Committee. The Company Secretary is also in attendance.

3. Review of Committee activities

The activities during 2017/18 have been cross-referenced to the purpose of the Committee as outlined in the Terms of Reference below:

	Progress
Regularly review the structure, size and composition (including the skills and experience) of Trust Board and make recommendations to the Board and Members' Council regarding any changes and appropriate processes.	Discussed by the Committee in: - April 2017 and February 2018 as part of the Non-Executive Director recruitment processes. - April 2017 as part of the update on Director's Portfolios. - February 2018 as part of the Non-Executive Director recruitment processes.

	Progress
Ensure there is a formal, rigorous and transparent procedure for the appointment of the Chair and Non-Executive Directors of the Board, which fits the criteria set out by the Committee as a result of its regular review and meets the requirements of a confidential recruitment process.	Discussed by the Committee in: - April 2017 regarding the Non-Executive Director recruitment process, updates provided in June 2017, July 2017, October 2017. - July 2017 regarding the Chair recruitment process, update provided in October 2017. Procedure and criteria for the appointment of Non-Executive Directors was reviewed by the Committee in February 2018 regarding the Non-Executive Director recruitment process.
Give full consideration to succession planning in respect of the Chair and Non-Executive Directors of the Board, taking account of the challenges and opportunities facing the Trust and the skills and expertise required by the Board.	Discussed by the Committee in: - April 2017 and February 2018 as part of the Non-Executive Director recruitment processes. - July 2017 regarding the Chair recruitment process, update provided in October 2017. - February 2018 as part of the Non-Executive Director recruitment processes.
Make recommendations to the Members' Council on the appointment of the Chair and Non-Executive Directors ensuring all information, such as job descriptions, person specifications and process, are available to Council Members to make an informed decision.	Recommendations made by the Committee for the appointment and re-appointment of Non-Executive Directors in: - April 2017, supported by the Members' Council on April 2017. - July 2017, supported by the Members' Council in July 2017. Recommendation made by the Committee for the appointment of the Chair in October 2017, supported by the Members' Council in November 2017.
Make recommendations to the Members' Council any uplift to the Chairs remuneration based on benchmarking information as applicable and the pay spine point, dependant on the outcome of Chair appraisal process through the Members' Council.	Reviewed in April 2017 and recommendation made to the Members' Council in April 2017.
Make recommendations to the Members' Council any uplift to Non-Executive Directors remuneration based on benchmarking information as applicable	Reviewed in April 2017 and recommendation made to the Members' Council in April 2017.
Ensure there is a formal, rigorous and transparent procedure for the appointment of the Deputy Chair and Senior Independent Director of the Board, which fits the criteria set out by the Committee as a result of its regular review (as above).	Discussed by the Committee in July 2017 as part of the Deputy Chair and Senior Independent Director appointment. Recommendations made by the Committee in July 2017, supported by the Members' Council in July 2017.
Ensure there is a formal, rigorous and transparent procedure for the appointment of the Lead Governor for the Members' Council, which fits any criteria set out by the Committee and meets the requirements of a confidential recruitment process.	Procedure and criteria for the appointment of the Lead Governor was agreed by the Members' Council in October 2009. The last recommendation for appointment was made by the Committee in June 2017 and supported by the Members' Council on July 2017.

4. Review of Committee administrative arrangements

The Committee met six times in 2017/18 and has been quorate at each meeting. The requirement to send papers out five working days has been met throughout the year. There have been some instances where individual papers have, with agreement, been sent out after the five-day requirement.

South West Yorkshire Partnership NHS Foundation Trust

NOMINATIONS COMMITTEE
Terms of Reference
To be approved by Members' Council 3 August 2018

Under the terms of the Trust's Constitution as a Foundation Trust, the Members' Council may not delegate any of its powers to a committee or sub-committee; however, it may appoint committees consisting of its members, Directors, and other persons to assist it in carrying out its functions. The Nominations Committee is, therefore, a standing Committee of the Members' Council set up to assist Council Members to exercise their statutory duty to appoint the Chair and Non-Executive Directors of the Board, to appoint the Deputy Chair and Senior Independent Director of the Board and to appoint the Lead Governor of the Members' Council.

The Nominations Committee was established in May 2009. It has no executive powers. The authority of the Nominations Committee is limited to those powers specifically delegated to it in these terms of reference and, as appropriate, by the Members' Council.

Purpose
The Nominations Committee's prime purpose is two-fold. Firstly, to ensure the right composition and balance of the Board and, secondly, to oversee the process for the identification, nomination and appointment the Chair and Non-Executive Directors of the Trust, to oversee the process for the identification, nomination and appointment of the Deputy Chair and Senior Independent Director of the Board and to oversee the process to identify, nominate and appoint the Lead Governor of the Members' Council.

Membership
The Nominations Committee is usually chaired by the Chair of the Trust (see below). As a minimum, the Chair of the Trust, the Chief Executive of the Trust and four members of the Members' Council (including the Lead Governor, one publically elected Governor, one staff elected Governor, and one appointed Governor) will form the membership.

Membership as at 1 June 2018
Chair – Angela Monaghan (Chair of the Trust)
Rob Webster (Chief Executive)
Jackie Craven (Lead Governor)
Nasim Hasnie (Publicly Elected Governor)
Marios Adamou (Staff Elected Governor)
Ruth Mason (Appointed Governor)

In the absence of the Chair of the Trust or when the Committee is considering matters relating to the appointment of the Chair, the Committee will be chaired by the Lead Governor. If the Lead Governor is unavailable, the Committee can either ask the Deputy Chair/Senior Independent Director to chair the meeting if there is no conflict of interest or agree one of its members to act as Chair for that meeting, again if there is no conflict of interest.

Attendance

The Company Secretary is in attendance at meetings. The Director of Human Resources, Organisational Development and Estates (or a member of his team) may also be asked to attend meetings to offer specialist or expert advice to the Committee. Administrative support is provided by the Corporate Governance team.

Quorum

The quorum will be three members of the Committee.

Frequency of meetings

The Committee will meet as necessary to ensure a timely and efficient process is in place to appoint a Chair or Non-Executive Director, Deputy Chair and Senior Independent Director, and Lead Governor for the Members' Council and will always meet following the resignation of an individual from one of these posts from the Board or Members' Council. In the absence of any other meetings, the Committee should meet a minimum of once per year to ensure a regular review of the structure, size and composition of the Board is undertaken, at a time which fits with the business cycle of the Trust Board

Authority

The Committee is able to seek any information it requires from any employee in relation to the duties of the Committee and all employees should co-operate with any request made by the Committee. The Committee is also able to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary to fulfil its duties.

Duties

- Regularly review the structure, size and composition (including the skills and experience) of Trust Board and make recommendations to the Board and Members' Council regarding any changes and appropriate processes.
- Ensure there is a formal, rigorous and transparent procedure for the appointment of the Chair and Non-Executive Directors of the Board, which fits the criteria set out by the Committee as a result of its regular review and meets the requirements of a confidential recruitment process.
- Give full consideration to succession planning in respect of the Chair and Non-Executive Directors of the Board, taking account of the challenges and opportunities facing the Trust and the skills and expertise required by the Board.
- Make recommendations to the Members' Council on the appointment of the Chair and Non-Executive Directors ensuring all information, such as job descriptions, person specifications and process, are available to Council Members to make an informed decision.
- Make recommendations to the Members' Council any uplift to the Chairs remuneration based on benchmarking information as applicable and the pay spine point, dependant on the outcome of Chair appraisal process through the Members' Council.
- Make recommendations to the Members' Council any uplift to Non-Executive Directors remuneration based on benchmarking information as applicable.

- Ensure there is a formal, rigorous and transparent procedure for the appointment of the Deputy Chair and Senior Independent Director of the Board, which fits the criteria set out by the Committee as a result of its regular review (as above).
- Ensure there is a formal, rigorous and transparent procedure for the appointment of the Lead Governor for the Members' Council, which fits any criteria set out by the Committee and meets the requirements of a confidential recruitment process.

Reporting to the Members' Council

The Members' Council will receive the minutes of Committee at its meeting following the Committee meeting. The Committee will also report to the Members' Council annually on its work.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Members' Council
3 August 2018

Agenda item:	**6.6**
Report Title:	Governor engagement feedback
Report By:	Company Secretary on behalf of governors
Action:	To receive

The following feedback was received from governors on events attended since the last Members' Council meeting on 27 April 2018 up to 16 July 2018.

Name	Role	Events attended / feedback provided
Marios Adamou	Staff Governor - Medicine & Pharmacy	➢ Nominations Committee meeting 20 June 2018.
Neil Alexander	Public Governor - Calderdale	➢ Non-Executive Director recruitment governor discussion panel 9 July 2018 and 11 July 2018. ➢ West Yorkshire & Harrogate Health & Care Partnership (WY&HHCP) Public Panel Task & Finish Group 10 July 2018.
Bill Barkworth	Public Governor - Barnsley	➢ Non-Executive Director recruitment governor discussion panel 9 July 2018
Jackie Craven	Lead Governor (Public Governor - Wakefield)	➢ NHS Providers Annual Governor Focus Conference, 24 May 2018: • Presentations and notes available at the NHS Providers website (https://nhsproviders.org/) under: NHS Providers > Programmes > GovernWell > Events for governors > Governor focus conference > Governor focus 2018 ➢ Members' Council Co-ordination Group meeting 6 June 2018: • Annual Members' Meeting planning update. • Members' Council Co-ordination Group Annual Report 2017/18. • Members' Council development plan. • Members' Council agenda items for 8 August 2018 and future meetings. ➢ Nominations Committee meeting 20 June 2018. ➢ Non-Executive Director recruitment final interview panel 13 July 2018. ➢ Nominations Committee meeting 16 July 2018.
Adrian Deakin	Staff Governor - Nursing	➢ Members' Council Quality Group 17 May 2018.

With all of us in mind.

Name	Role	Events attended / feedback provided
Lin Harrison	Staff Governor - Psychological therapies	➢ Freedom to Speak Up Guardian foundation training. ➢ Trust Freedom to Speak Up Guardian meeting. ➢ Non-Executive Director recruitment staff discussion panel (Staff governor representative) 9 July 2018 and 11 July 2018. ➢ LGBT staff network steering group meeting.
Nasim Hasnie	Public Governor - Kirklees	➢ Members' Council Quality Group 17 May 2018. ➢ Non-Executive Director recruitment final interview panel 13 July 2018. ➢ Nominations Committee 16 July 2018.
Ruth Mason	Appointed Governor - Calderdale and Huddersfield NHS Foundation Trust	➢ Nominations Committee meeting 20 June 2018. ➢ Non-Executive Director recruitment governor discussion panel 9 July 2018 and 11 July 2018.
Phil Shire	Public Governor - Calderdale	➢ Non-Executive Director recruitment governor discussion panel 9 July 2018 and 11 July 2018.
Jeremy Smith	Public Governor - Kirklees	➢ Members' Council Co-ordination Group 6 June 2018.
Paul Williams	Public Governor - Rest of South and West Yorkshire	➢ Non-Executive Director recruitment governor discussion panel 9 July 2018 and 11 July 2018.