South West Yorkshire Partnership NHS Foundation Trust

Members' Council
Friday 2 August 2019
12.30pm (with lunch provided / networking at 12.00pm) **to 4.30pm**
The Shay Stadium, Shaw Hill, Halifax, HX1 2YT

Item	Time	Subject Matter	Presented by		Action
	11.30am	*NEW GOVERNORS - Informal introduction meeting with Trust Board members*			
	12.00pm	*Lunch provided and networking*			
1.	12.30pm	Welcome, introductions and apologies	Angela Monaghan, Chair	**Verbal item**	To receive
2.	12.35pm	Members' Council business items			
	12.35pm	2.1 Appointment of Lead Governor	Angela Monaghan, Chair	**Paper**	To agree
3.	12.45pm	Declaration of Interests	Angela Monaghan, Chair	**Paper**	To receive
4.	12.50pm	Minutes and actions of the previous meeting held on 3 May 2019	Angela Monaghan, Chair	**Paper**	To agree
		4.1 Governor representation on the Trust Board Equality and Inclusion Committee	Angela Monaghan, Chair	**Paper**	To agree
		4.2 Governor visits to services	Angela, Monaghan, Chair	**Paper**	To receive
5.	1.05pm	Chair's report and feedback from Trust Board Executive Director comments (on behalf of Chief Executive)	Angela Monaghan, Chair Alan Davis, Director of HR, OD & Estates	**Paper** **Verbal item**	To receive
6.	1.20pm	Trust Board appointments			
	1.20pm	6.1 Review of Chair and Non-Executive Directors' remuneration - process and timescales	Alan Davis, Director of HR, OD & Estates	**Paper**	To agree
	1.25pm	6.2 Non-Executive Director appointment	Jackie Craven, Lead Governor (to 31 July 2019*) / Angela Monaghan, Chair	**Paper**	To agree
7.	1.40pm	Members' Council business items (continued)			
	1.40pm	7.1 Governor appointment to Members' Council groups	Jackie Craven, Lead Governor (to 31 July 2019*) / Angela Monaghan, Chair	**Paper**	To agree

Item	Time	Subject Matter	Presented by		Action
	1.45pm	7.2 Annual Report accounts 2018/19 and Quality Account 2018/19	Mark Brooks, Director of Finance / Mike Doyle, Deputy Director of Nursing & Quality / Caroline Jamieson, Deloitte	**Paper** **Presentation**	To receive To receive
	2.00pm	7.3 Governor engagement feedback	Angela Monaghan, Chair	**Paper**	To receive
8.	2.10pm	- Focus on - suicide prevention	Lin Harrison, Staff Governor / Mike Doyle, Deputy Director of Nursing & Quality	**Presentation**	To receive
	2.25pm	*Break*			
	2.35pm	Integrated Performance Report Quarter 1 2019/20. There will be a presentation of the key issues. Full performance reports are available on the Trusts website under: About us > Our performance > Performance reports	Laurence Campbell, Non-Executive Direct	**Presentation**	To receive
9.	3.00pm	Customer Services and Serious Incidents Annual Reports 2018/19	Mike Doyle, Deputy Director of Nursing & Quality	**Presentation**	To receive
10.	3.15pm	Holding Non-Executive Directors to account - annual session	Governors and Non-Executive Directors	**Paper / Interactive session**	To discuss
11.	4.15pm	<u>Closing remarks, work programme, and dates for 2019/20</u> - Work programme 2019-20 (attached) - Monday 16 September 2019, Annual Members' Meeting (Wakefield) - afternoon meeting, Large Conference Room, Fieldhead Hospital, Ouchthorpe Lane, Wakefield, WF1 3SP. - Friday 1 November 2019 (Wakefield) - 9.30am-2.30pm, Large Conference Room, Fieldhead Hospital, Ouchthorpe Lane, Wakefield, WF1 3SP. - Friday 31 January 2020 (Barnsley) - 9.30am-2.00pm, Legends Suite, Barnsley Football Club, Grove St, Barnsley S71 1ET.	Angela Monaghan, Chair	**Paper** **Verbal item**	To receive
	4.30pm	*Close*			

*NOTE: Jackie Craven was Lead Governor at the time the recommendations were made by the Co-ordination Group and Nominations Committee

South West Yorkshire Partnership NHS Foundation Trust

Members' Council
2 August 2019

Agenda item:	**2.1**
Report Title:	**Lead Governor appointment**
Report By:	Chair of the Trust and Members' Council on behalf of the Nominations Committee
Action:	To agree

EXECUTIVE SUMMARY

Purpose

The purpose of this paper is to seek the Members' Council approval for the appointment of a Lead Governor.

Recommendation

The Members' Council is asked to CONSIDER and AGREE the recommendation from the Nominations Committee.

Background

Since October 2009, the Trust has been required by its Regulator, NHS Improvement (Monitor), to appoint a Lead Governor. The main duties of the Lead Governor are included in the attachment as reviewed and approved by the Members' Council on 3 May 2019. Also attached is the appendix from Monitor's NHS Foundation Trust Code of Governance on the role of a nominated lead governor.

Jackie Craven, publicly elected Governor for Wakefield, was appointed to the role of Lead Governor at the Members' Council meeting on 26 July 2017 for two years ending in July 2019.

Process

The Members' Council has previously agreed that the Lead Governor should be appointed from publicly elected governors and that this process should be overseen by the Nominations' Committee. The process agreed is as follows.

Step 1	Publicly elected Council Members are invited to self-nominate supported by a brief written explanation of why they are putting themselves forward and evidencing how they would be able to fulfil the role.
Step 2	The Nominations' Committee will review and shortlist the self-nominations and invite shortlisted candidates to make a brief presentation answering questions based on their 'application'.
Step 3	The Nominations Committee' will then consider the self-nominations and make a recommendation to the full Members' Council.

Following the Members' Council meeting on 3 May 2019, the Company Secretary wrote to all governors on 20 May 2019 formally inviting self-nominations. A further reminder was sent on 24 June 2019. One self-nomination was received from Jackie Craven.

The Nominations Committee discussed the self-nomination at its meeting on 15 July 2019. Note, Jackie Craven declared an interest in this agenda item and left the room for the discussion.

Outcome

The members of the Nominations Committee individually assessed the self-nomination and following a discussion by the Committee, it was unanimously resolved by those present to recommend the appointment of Jackie Craven as Lead Governor until the end of her current governor term on 30 April 2020.

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

South West Yorkshire Partnership NHS Foundation Trust

Lead Governor arrangements

Approved by Members' Council 3 May 2019

Since October 2009, the Trust has been required by its regulator, NHS Improvement (previously Monitor), to appoint a Lead Governor. The role of a nominated lead governor is outlined in Monitor's The NHS Foundation Trust Code of Governance (Appendix B). The main duties of the Lead Governor are to:

1. act as the communication channel for direct contact between NHS Improvement and the Members' Council;
2. chair any parts of Members' Council meetings that cannot be chaired by the person presiding (that is, the Chair or Deputy Chair of the Trust) due to a conflict of interest in relation to the business being discussed;
3. be a member of Nominations' Committee (except when the appointment of the Lead Governor is being considered);
4. be involved in the assessment of the Chair and Non-Executive Directors' performance;
5. be a member of the Quality Group to support the Trust in the development of its Quality Accounts;
6. Chair the Co-ordination Group to assist in the planning and setting of the Members' Council agenda and governor development
7. support new governors;
8. support the Trust/Members' Council Chair in dealing with governor conduct issues; and
9. liaise with the Chair of the Trust/Members' Council.

The individual appointed should be confident they can undertake the duties outlined above and be able to deal with senior personnel at NHS Improvement should the need arise. The individual should also:

- have the confidence of governors and of Trust Board;
- be able to commit the time necessary should the need arise, which may be at very short notice;
- have effective communication skills, including the ability to influence and negotiate;
- be able to present a well-reasoned argument;
- be committed to the success of the Trust and to its mission, vision, values and goals;
- have the ability to chair both large and small meetings effectively;
- be able to act as an ambassador for the Members' Council and the Trust;
- have the ability to work with others as a team and to encourage participation from less experienced governors; and
- demonstrate an understanding of the Trust's Constitution and how the Trust works with other organisations.

<u>Time commitment - meetings</u>

In addition to attendance at Members' Council meetings (held quarterly), the Lead Governor will be **required** to:

- undertake induction on appointment;
- attend one-to-one meetings with the Chair of the Trust (held quarterly);
- act as chair for items at Members' Council meetings where the Chair of the Trust has a conflict of interest;
- be the chair of and attend Members' Council Co-ordination Group meetings (held quarterly, in Fieldhead);

- be a member of and attend Members' Council Quality Group meetings (held quarterly in Fieldhead);
- be a member of and attend Nominations' Committee (held as required in Fieldhead);
- act as chair for items at Nominations' Committee meetings where the Chair of the Trust has a conflict of interest;
- attend and represent the governors at the Annual Members' Meeting (held annually in different locations within the Trust's geography);
- take part in any Chair or Non-Executive Director (NED) recruitment processes (NED recruitment is next due in early 2020); and
- attend an annual one-to-one review meeting with the Chair of the Trust.

The Lead Governor **may** also:
- attend training and development sessions, both internal and external to the Trust, including the NHS Providers Annual Governor conference (held annually in London); and
- attend Trust events appropriate to the role.

Process for appointment

The Members' Council has previously agreed that the Lead Governor should be appointed from publicly elected governors and that this process should be overseen by the Nominations' Committee. The process agreed is as follows.

Step 1	Publicly elected Council Members are invited to self-nominate supported by a brief written explanation of why they are putting themselves forward and evidencing how they would be able to fulfil the role.
Step 2	The Nominations' Committee will review and shortlist the self-nominations and invite shortlisted candidates to make a brief presentation answering questions based on their 'application'.
Step 3	The Nominations Committee' will then consider the self-nominations and make a recommendation to the full Members' Council.

Appendix B: The role of the nominated lead governor

The lead governor has a role to play in facilitating direct communication between Monitor and the NHS foundation trust's council of governors. This will be in a limited number of circumstances and, in particular, where it may not be appropriate to communicate through the normal channels, which in most cases will be via the chairperson or the trust secretary, if one is appointed.

It is not anticipated that there will be regular direct contact between Monitor and the council of governors in the ordinary course of business. Where this is necessary, it is important that it happens quickly and in an effective manner. To this end, a lead governor should be nominated and contact details provided to Monitor, and then updated as required. The lead governor may be any of the governors.

The main circumstances where Monitor will contact a lead governor are where Monitor has concerns as to board leadership provided to an NHS foundation trust, and those concerns may in time lead to the use by Monitor's board of its formal powers to remove the chairperson or non-executive directors. The council of governors appoints the chairperson and non-executive directors, and it will usually be the case that Monitor will wish to understand the views of the governors as to the capacity and capability of these individuals to lead the trust, and to rectify successfully any issues, and also for the governors to understand Monitor's concerns.

Monitor does not, however, envisage direct communication with the governors until such time as there is a real risk that an NHS foundation trust may be in significant breach of its licence. Once there is a risk that this may be the case, and the likely issue is one of board leadership, Monitor will often wish to have direct contact with the NHS foundation trust's governors, but at speed and through one established point of contact, the trust's nominated lead governor. The lead governor should take steps to understand Monitor's role, the available guidance and the basis on which Monitor may take regulatory action. The lead governor will then be able to communicate more widely with other governors.

Similarly, where individual governors wish to contact Monitor, this would be expected to be through the lead governor.

The other circumstance where Monitor may wish to contact a lead governor is where, as the regulator, we have been made aware that the process for the appointment of the chairperson or other members of the board, or elections for governors, or other material decisions, may not have complied with the NHS foundation trust's constitution, or alternatively, whilst complying with the trust's constitution, may be inappropriate.

In such circumstances, where the chairperson, other members of the board of directors or the trust secretary may have been involved in the process by which

these appointments or other decisions were made, a lead governor may provide a point of contact for Monitor.

Accordingly, the NHS foundation trust should nominate a lead governor, and to continue to update Monitor with their contact details as and when these change.

South West Yorkshire Partnership NHS Foundation Trust

Members' Council
2 August 2019

Agenda item:	**3**
Report Title:	**Members' Council Declaration of Interests**
Report By:	Company Secretary on behalf of the Chair of the Trust and Members' Council
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 Trust's 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 1 February 2019 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.

Further declarations of interest have been received from the following governors in addition to those declared at the Members' Council meeting on 1 February 2019: Andrew Crossley, Lisa Hogarth, John Laville, Debika Minocha, Debbie Newton, Phil Shire, Barry Tolchard.

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 Trust's Annual Report and the Register of Interests is published on the Trust's website.

South West Yorkshire Partnership NHS Foundation Trust

Register of interests of the governors of the Members' Council (members of the board of governors) from 1 April 2019 to 31 March 2020 (updated)

All governors of Members' Council have signed a Code of Conduct for Governors on commencement.

The following declarations of interest have been made by the Members' Council:

Current governors (2019/20)

Name	Declaration
ADAMOU, Marios Staff elected - Medicine and Pharmacy	Director, Marios Adamou Ltd. Board member, UKAAN. Secondary Care Doctor member, NHS East Riding of Yorkshire Clinical Commissioning Group (CCG). Secondary Care Doctor member, NHS Northumbria Clinical Commissioning Group (CCG).
ALEXANDER, Neil Publicly elected - Calderdale	No interests declared.
AMARAL, Kate Publicly elected - Wakefield	No interests declared.
BARKWORTH, Bill Publicly elected - Barnsley	Director, Barkworth Associates Limited.
BATTY, Paul Staff elected - Social care staff working in integrated teams	No interests declared.
CLAYDEN, Bob Publicly elected - Wakefield	Chair, Portobello Community Craft and Camera Group. Occasionally contracted for sessions as freelance artist by Next Generation Artzone. As a freelance artist, may be employed by groups funded or partially funded by the Trust.
CRAVEN, Jackie Publicly elected - Wakefield	Board member, Young Lives Consortium, Wakefield. Member, Alzheimer's' Society. Member, Versus Arthritis. Member, Dementia UK. Volunteer, HealthWatch, Wakefield. Volunteer Ambassador, Dementia UK. Parish Councillor, Crigglestone Parish Council. Trustee, Crigglestone Village Institute. Trustee, Hall Green Community Centre. Trustee, 45 Durkar Scouts.

Name	Declaration
	Trustee, Worrills Almshouses.
CROSSLEY, Andrew Publicly elected - Barnsley	Shareholder (non-controlling), Liaison Financial Services. Volunteer, Victim Support, Wakefield. Placement Counsellor, Mind, Barnsley & Rotherham
DEAKIN, Adrian *Staff elected - Nursing*	*No interests declared.*
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.*
HARRISON, Lin Staff elected - Psychological therapies	Part time secondment as Suicide Prevention Project Manager for West Yorkshire and Harrogate Health and Care Partnership (WYHHCP). Member of the Labour party.
HASNIE, Nasim Publicly elected - Kirklees	Trustee of Voluntary Action Kirklees.
HOGARTH, Lisa Staff elected - Allied Healthcare Professionals	Member governor, Salendine Nook High School Huddersfield. Member of the Labour Party.
IRVING, Carol *Publicly elected - Kirklees*	*Volunteer Ambassador, Dementia UK.*
JACKSON, Hannah *Publicly elected - Kirklees*	*No interests declared.*
JHUGROO, Adam Publicly elected - Calderdale	Primary Care Diabetes Team, NAPP Pharmaceuticals. Daughter, Student Nurse / Staff Bank, South West Yorkshire Partnership NHS Foundation Trust
LAKE, Trevor Appointed - Barnsley Hospital NHS Foundation Trust	Chair, Barnsley Hospital NHS Foundation Trust. Chair, Joint Independent Audit and Ethic Committee, West Yorkshire Police and Crime Commissioners and West Yorkshire Police Force. Director, Six Degrees Consultancy (non NHS work). Chair, Trustees of Barnsley Hospital Charity.
LAVILLE, John Publicly elected - Kirklees	Director and Shareholder, EMS (Hartshead) Ltd (dormant company). Member/Carer Representative, Kirklees Mental Health Partnership Board. Chair, Popplewell Charity.
LUND, Ros *Appointed - Wakefield MC*	*No interests declared.*

Name	Declaration
MASON, Ruth Appointed - Calderdale and Huddersfield NHS Foundation Trust	Member, Board of Directors, 'Mind the Gap' theatre company, Bradford, which employs actors with a learning disability.
MINOCHA, Debika Publicly elected - Wakefield	No interests declared.
NEWTON, Debbie Appointed Governor for Mid Yorkshire Hospitals NHS Trust	Director of Community Services, Mid Yorkshire Hospitals NHS Trust.
PILLAI, Chris *Appointed - Calderdale MBC*	*Independent Hospital Manager.*
SAUNDERS, Caroline *Appointed - Barnsley MBC*	*Councillor, Barnsley MBC*
SHIRE, Phil Publicly elected - Calderdale	Director, Greenroyd Bowling Club Limited.
SMITH, Jeremy *Publicly elected - Kirklees*	*Director, Predictlaw Ltd.*
STUART-CLARKE, Keith Publicly elected - Barnsley	No interests declared.
TEALE, Debs Staff elected - Nursing support	No interests declared.
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.* *Expert by experience, Care Quality Commission (not involved in inspections of South West Yorkshire NHS Foundation Trust)*
WILLIAMS, Paul *Publicly elected - Rest of South and West Yorkshire*	*No interests declared.*

Where no return has been received by the Trust, the current entry on the Register has been included in italics.

Past governors (who left in 2019/20)

Name	Declaration
SMITH, Richard *Appointed - Kirklees MC*	*Employee, NHS Digital.*

Name	Declaration
HEPTINSTALL, Councillor Faith *Appointed - Wakefield MC*	*Business Manager, Havercroft and Ryhill Community Learning Project, Wakefield (who are a member of Nova and have been granted Health & Wellbeing funding in partnership).* *Deputy Cabinet Member, Adults and Health, Wakefield Council.*

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Members' Council meeting held on 3 May 2019
Textile Centre of Excellence, Huddersfield

Present:	Angela Monaghan (AM)	Chair
	Neil Alexander (NA)	Public – Calderdale
	Kate Amaral (KA)	Public – Wakefield
	Bill Barkworth (BB)	Public – Barnsley
	Bob Clayden (BC)	Public – Wakefield
	Jackie Craven (JC)	Public – Wakefield
	Andrew Crossley (AC)	Public – Barnsley
	Adrian Deakin (AD)	Staff - Nursing
	Stefanie Hampson (SH)	Appointed – Staff side organisations
	Lin Harrison (LH)	Staff – Psychological Therapies
	Dr Nasim Hasnie OBE (NH)	Public – Kirklees
	Lisa Hogarth (LHo)	Staff – Allied Healthcare Professionals
	Carol Irving (CI)	Public – Kirklees
	Adam Jhugroo (AJ)	Public – Calderdale
	Trevor Lake (TL)	Appointed – Barnsley Hospital NHS Foundation Trust
	Ruth Mason (RM)	Appointed – Calderdale and Huddersfield NHS Foundation Trust
	Debbie Newton (DN)	Appointed – Mid Yorkshire Hospitals NHS Trust
	Phil Shire (PS)	Public - Calderdale
	Jeremy Smith (JS)	Public – Kirklees
	Keith Stuart-Clarke (KSC)	Public – Barnsley
	Debs Teale (DT)	Staff – Nursing support
	Paul Williams (PW)	Public – Rest of South and West Yorkshire
In attendance:	Rob Adamson (RA)	Deputy Director of Finance (attending for MB)
	Laurence Campbell (LC)	Non-Executive Director
	Ashley Hambling (AH)	HR Business Manager (attending for AGD)
	Emma Jones (EJ)	Company Secretary (author)
	Erfana Mahmood (EM)	Non-Executive Director
	Kate Quail (KQ)	Non-Executive Director
	Sean Rayner (SR)	Director of Provider Development
	Dr Subha Thiyagesh (SThi)	Medical Director
	Rob Webster (RW)	Chief Executive
	Salma Yasmeen (SY)	Director of Strategy
Apologies:	<u>Members' Council</u>	
	Marios Adamou (MA)	Staff – Medicine and Pharmacy
	Paul Batty (PB)	Staff - Social care staff working in integrated teams
	Daz Dooler (DD)	Public – Wakefield
	Faith Heptinstall (FH)	Appointed - Wakefield Council
	Hannah Jackson (HJ)	Public – Kirklees
	John Laville (JL)	Public – Kirklees
	Debika Minocha (DM)	Public – Wakefield
	Chris Pillai (CP)	Appointed – Calderdale Council
	Caroline Saunders (CS)	Appointed – Barnsley Council
	Richard Smith (RS)	Appointed – Kirklees Council
	Barry Tolchard (BT)	Appointed – University of Huddersfield
	Debby Walker (DW)	Staff - Non-Clinical Support Staff
	Mike Walker (MW)	Public – Kirklees
	<u>Attendees</u>	
	Tim Breedon (TB)	Director of Nursing & Quality / Deputy Chief Executive
	Mark Brooks (MB)	Director of Finance & Resources (from agenda item 6 onwards)
	Alan Davis (AGD)	Director of Human Resources, Organisational Development & Estates
	Charlotte Dyson (CD)	Deputy Chair / Senior Independent Director
	Carol Harris (CH)	Director of Operations
	Sam Young (SYo)	Non-Executive Director

MC/19/08 Welcome, introduction and apologies (agenda item 1)

Angela Monaghan (AM), Chair, welcomed everyone to the meeting including newly elected governors Debs Teale, Adam Jhugroo, Keith Stuart-Clarke, re-elected governors Phil Shire, Carol Irving, Jeremy Smith, Bob Clayden, and a newly appointed governor Trevor Lake. The apologies as above were noted. There were no members of the public in attendance.

MC/19/09 Members' Council business items (agenda item 2)

Members' Council elections 2019 - results (agenda item 2.1)

AM reported that the paper provided an update on the outcome of the election process for 2019. An updated paper with additional governors who had been elected since the paper was distributed was tabled at the meeting. All 34 seats on the Members' Council are now filled which is a testament to the engagement and diversity. We look forward to working with you.

It was RESOLVED to RECEIVE the update.

MC/19/10 Declarations of interest - annual declarations (agenda item 3)

AM reported that the paper provided information regarding the declarations made by governors on their interests. An updated paper with additional declarations received since the paper was distributed was tabled at the meeting.

Neil Alexander (NA) asked what UKAAN stood for. Rob Webster (RW) commented that it was a network that provided support to practitioners. AM will confirm.

Action: Angela Monaghan

NA asked what S.M.A.S.H. Society stood for. Lin Harrison (LH) commented that it was a lived experience peer support network.

It was RESOLVED to NOTE the individual declarations from governors and to CONFIRM the changes to the Register of Interests.

MC/19/11 Minutes of and matters arising 1 February 2019 (agenda item 4)

It was RESOLVED to APPROVE the minutes of the Members' Council meeting held on 1 February 2019 as a true and accurate record. The following matter arising was discussed:

- MC/18/34 regarding governor service visits - NA commented that the actions from 1 April 2018 seemed to be taking a long time to organise. Bob Clayden (BC) commented that other trusts hold walk-arounds with NEDs as a good way to engage with them as well as services. Carol Irving (CI) commented that it was important for governors to be more visible in the Trust, to be there if service users, carers or staff members wanted to talk to them, as the wellbeing of staff can determine the quality of the care. NA commented that he did not feel he had any practical experience of the services the Trust provides and suggested that an access point either through arranging a meeting or going to an existing meeting could provide governors with a broader context of what the Trust does practically and how it impacts on people. AM commented that the Trust agreed and recognised it was an area important to governors. The issues had been the time taken to coordinate visits and some of the pressures in staff teams which is why it has not been advanced to date. RW commented that there were potentially three opportunities where governor could be involved. The first was quality monitoring visits against the five Care Quality Commission (CQC) domains with the NEDs taking part. The second were Patient Led Assessments of the Care Environment (PLACE) inspections which had been postponed for a period due awaiting updated national guidance. The third could be bespoke meetings.

  ACTION: Emma Jones / Tim Breedon / Alan Davis

Stefanie Hampson entered the meeting.

MC/19/12 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 commented that a written report had been included in the meeting papers and provided an update on the Trust Board meeting held on 30 April 2019 with governors LH, NH and JS in attendance. The meeting was a business and risk meeting with a lot of governance matters on the agenda including statutory items to close for 2018/19, performance, which will be updated under agenda item 8, and updates on strategies. AM asked the governors who attended if they would like to provide any comments.

LH commented that she welcomed discussion on quality in relation to community services as sometimes it can be focussed on inpatient areas.

NH commented that it was a forward thinking and looking meeting.

NA commented that he was increasingly concerned about the lack of feedback on the Integrated Care Systems (ICSs) and the role of governors to hold Non-Executive Directors (NEDs) to account and people that attend meetings of the ICSs. NA felt that, although the ICSs are voluntary partnerships, reading the Memorandum of Understanding (MoU) for the West Yorkshire Mental Health Services Collaborative (WYMHSC) there does not seem to be any way of the Trust leaving the ICS and he would have liked to have held the NEDs to account for this decision. He was also not aware of any feedback given to governors in the build up to this decision. AM commented that there is a presentation in relation to the ICSs under agenda item 8 for today's meeting and that ICSs are not organisations, they are collaborative working arrangements. RW commented that the Trust is not a "subsidiary of the ICS". As an organisation the Trust has said that it wants to work together with people on things that are of common interest. Sometimes when we want to make decisions collectively, we have a board committee of our organisation that meets with the other trusts as Committees in Common (C-in-C), and just like any committee of the Trust Board they report into the Board. Examples of the benefits of working together include how we are working in partnership to reduce suicide, and how we are collaborating on reducing out of area beds so people aren't sent out of area. These are in the MoU and decisions may need to come back to the Trust Board or another meeting held in public. NA commented that if the ICS creates bureaucracy, the Trust might want to come out of it and there is nothing in there for a process to leave. RW commented that the MoU is not a legally binding agreement which means we can leave the arrangement should we wish to do so. NA commented that people were being paid money and making budgetary decisions in the ICSs. RW commented that if they were budget decisions they would be made in public. NA commented that he had attended a meeting where governors were told they would be given feedback and involved with four paid lay member roles and he had written a letter to them in respect of that. Salma Yasmeen (SY) commented that the presentation under agenda item 8 may assist with explaining the ICSs further and also a presentation under agenda item 10 demonstrates some of the work we have done collaboratively. RW commented that feedback was provided through the reports and discussion at every Trust Board meeting, which governors are encouraged to attend. They are also included in The Brief monthly communication to staff, which is sent to governors, and an update provided as part of the annual joint Trust Board and Members' Council meeting. There is a Partnership Board which will start to meet in June 2019 which will be chaired by a local authority Councillor and vice chaired by a chair of an NHS organisation. The Trust's members on the Partnership Board are the Chair and Chief Executive and it includes the chairs and leaders of Councils, Health and Wellbeing Boards, and the four co-opted members who are remunerated as lay members. NA commented that the engagement of governors is important in holding NEDs to account. RW commented that in relation to NED involvement it would be AM as a member of the Partnership Board and also as Chair of the WYMHSC C-in-C.

AM commented that the points about the need for engagement raised previously had been noted and the presentation under agenda item 8 was in response to this. The ICSs were discussed at every public board meeting under standing agenda items and the MoU was put through detailed scrutiny by the NEDs before it was approved.

Chief Executive's comments

RW commented that his report was included in the public papers for the Trust Board meeting held on 30 April 2019 and described the external context and the time of year as "the apex of busyness". There are additional pressures to make services safe in a potential 'no deal' Brexit, accounting processes are being finalised for reporting 2018/19 to the regulators, and there were 19 papers on the Trust Board agenda that were in relation to governance and accountability. Work is taking place to meet the Mental Health Investment Standard and in the medium term every Clinical Commissioning Group (CCG) has to work with GPs to create primary care networks (PCNs) that operate in their geography to be in place by 1 July 2019.

BC asked, in relation to the Mental Health Investment Standard, how much would be received by the Trust and local authorities. RW commented that he felt there was a reasonable split for 2019/20 which may not have been the case previously. Sean Rayner (SR), Director of Provider Development is the lead for the Mental Health Network in Wakefield and the commissioners have asked the providers how they think it should be allocated, which was felt to lead to a better and fairer allocation.

Keith Stuart-Clarke (KSC) asked if there is anything specific for veterans who may not wish to talk to someone outside of services. RW commented that the Trust had worked with voluntary groups to provide peer support. In 2019/20 there would be a West Yorkshire based service for psychiatric support for veterans and it was an area that could be looked at further, including that it was know that veterans were more likely to end up homeless. SR commented that the Trust was signed up to the Armed Forces Covenant in each district and that the majority of staff in Barnsley had been through a course to provide specific skills to work with veterans. LH commented that she works in Psychological Services and if someone wanted to access the service for Post-Traumatic Stress Disorder (PTSD) they would be prioritised, which is the Armed Forces Covenant in action. In relation to peer support there was a great group in Calderdale which was started through Creative Minds and they had just received a small investment for 2019/20.

CI commented that she would like reassurance that service users won't be told via a letter that they are being discharged from Trust services. An inquest identified that a service user who did not attend an appointment with a counsellor received a letter that they had been discharged. RW commented that he had not seen the details of the inquest but it was important that the Trust communicates with services users effectively. Any areas of concern from inquests would be fed back through the Clinical Governance & Clinical Safety Committee and assurance on this specific case would be sought from Tim Breedon, Director of Nursing & Quality.

ACTION: Tim Breedon

MC/19/13 Trust Board appointments (agenda item 6)

MC/19/13a Non-Executive Director re-appointment (agenda item 6.1)

NA asked if Trust Board members in attendance could leave the room to discuss the item except for the Chair. The Chair agreed.

All Directors, Non-Executive Directors, and staff in attendance left the meeting except for the Chair and EJ.

Jackie Craven (JC) reported that the recommendation from the Nominations Committee reflected the discussion of the skills required on the Trust Board and succession planning for Non-executive directors. AM added that it was the role of the Members' Council to appoint the

Chair and NEDs and to agree their remuneration and that the Nominations Committee was the Committee that makes the recommendations to the Members' Council on the appointments. The paper detailed background information, considerations at the Nominations Committee, and the case for re-appointment.

NA commented that Chris Jones (CJ) was eminently suitable for the position. However when a NED leaves the Trust Board on a formal basis the process should be to appoint by selection and if not it should be stated by what that means they have been recommended for appointment. He felt that within the report, where it states that for the previous two NEDs there was a specific intention to recruit someone with financial experience and neither of them had it, was news to him and he had been on the governor discussion panel as part of the selection process. Paul Williams (PW) commented that he had been part of the governor discussion panel and felt that there had been robust conversations through the process and verbally the panel knew. LH commented that she had been on another discussion group and it had been included in the information received. AM confirmed that the recruitment pack had made clear we were seeking someone who was both financially qualified and had senior financial experience.

NA commented that he felt there had been nothing in writing and that the Trust had failed to appoint someone with a financial background. All other NED appointments had gone through a process and it felt CJ was being incidentally appointed. NA asked whether or not there was legal consideration given to not going through a selection process.

Phil Shire (PS) asked for clarification that CJ stood down in 2018 for health reasons and outside work pressures. AM commented that CJ resigned from the Trust Board for personal reasons and had no other employment currently. Under normal processes the Trust would go out to a open recruitment process, however, for pragmatic and financial reasons, the recommendation was to re-appoint. as it is very clear the Board needs an additional NED with a financial background.

Stefanie Hampson (SH) commented that, if it was in relation to a staff member, from a staff side point of view, you wouldn't be able to appoint someone into a role if they did not work for the organisation, it would need to be advertised. While CJ was a good NED, other candidates may be the same or better.

BC commented that presumably CJ had already been through the rigorous process and was therefore already selected. The concern would be in relation to health and whether the Trust would be putting him at any risk. AM outlined CJ's previous health condition and that he has stated that he was fit to work again. Emma Jones (EJ) confirmed that he had completed an Occupational Health check as part of the due diligence checks.

NH commented that as a member of the Nominations Committee these issues had been raised and discussed in detail, including equality of opportunity and the recommendation is what was concluded after lots of consideration. However there may be concerns in relation to the precedent it could set.

AM commented, in relation to the NED recruitment process in 2018, the Trust had specifically sought someone with financial expertise. Through the process only one candidate with financial expertise was shortlisted and , following interview, it was decided to appoint two candidates who did not have a financial qualification. In relation to the re-appointment, the Trust has sought advice from NHS Providers who confirmed that there was nothing in the NHS Code of Governance to prevent Trusts from reappointing the NED and the Trust's Constitution was silent on whether it was possible to have a gap between terms. She reiterated that CJ had been through an open recruitment process when appointed in 2015.

BC asked if CJ had not resigned would he have continued as a NED. AM commented that, had he sought reappointment at the end of his first term in 2018, it is likely he would have been recommended for re-appointment.

NA commented that he did not feel the process had been conducted in accordance with the Equality Act and Employment Act.

Ruth Mason (RM) provided assurance that the Nominations Committee had given the recommendation a lot of thought and consideration acting on behalf of the full Members' Council. The recommendation was debated by the Nominations Committee for a length of time and it was felt that, if he had notresigned due to serious illness, he would have been recommended at that time for re-appointment.

Debbie Newton (DN) commented that her concern was also in relation to legal aspects and potential reputational damage. If the process was taking place at her organisation it would go out to advert and we would recruit again through the process.

LH commented that this discussion was a great example of governors holding to account. She thanked the Nominations Committee and understood the reasons for the recommendation. However she felt that the reputation of the Trust would be damaged if not put out to an open recruitment process.

Governors requested that the recommendation be put to a vote.

NA commented that if the recommendation was supported he would raise formally with Charlotte Dyson, as Senior Independent Director, the role of the Nominations Committee and also that it has not been through an open recruitment process.

AM reiterated that CJ had been through an open recruitment process when appointed in 2015, his first term came to the end in 2018 and he would have been recommended for re-appointment at that time.

Trevor Lake (TL) asked for clarification of whether the recommendation was for appointment, not a re-appointment. AM commented that the recommendation was for re-appointment for a second term.

A vote took place of the governors present and the recommendation was not supported.

It was RESOLVED to NOT SUPPORT the recommendation from the Nominations' Committee to re-appoint Chris Jones as a Non-Executive Director.

All Directors, Non-Executive Directors, and staff returned to the meeting in attendance.

AM advised those in attendance that the recommendation had not been supported.

MC/19/14 Members' Council business items (continued) (agenda item 7)

MC/19/14a Process for the appointment of Lead Governor in August 2019 (agenda item 7.1)

AM reported that the current Lead Governor's appointment in this role ends on 31 July 2019. The paper outlined the current process in place for appointment for review.

NA asked what would happen if no-one put a self-nomination forward. AM commented that the process would start again seeking self-nominations.

It was RESOLVED to REVIEW and SUPPORT the process for the appointment of a Lead Governor. It was noted that, following this review, self-nominations would then be requested

from publicly elected governors for consideration by the Nominations Committee at its meeting on 18 July 2019. The Nominations Committee would then make a recommendation for appointment to the next Members' Council meeting on 2 August 2019.

MC/19/14b Governor attendance at Members' Council meetings (agenda item 7.2)
AM reported the paper outlines a proposed process for reviewing governor attendance at Members' Council meetings and removing governors on the grounds of non-attendance if required, in accordance with the Trust's Constitution.

NA commented that any governor should be given an opportunity to talk to the full Members' Council regarding their non-attendance. BC commented that they would still be a governor at that point and could therefore come to any meeting. AM commented that, if it should occur, then the governor concerned would be informed that the item was on the agenda and that they would be able to attend and represent themselves as part of the discussion.

It was RESOLVED to SUPPORT the proposed process for reviewing governor attendance at Members' Council meetings, and removing governors on the grounds of non-attendance if required.

MC/19/14c Members Council Group Annual Reports 2018/19, including update to Terms of Reference: Members' Council Co-ordination Group and Members' Council Quality Group (agenda item 7.3)
AM reported that the annual reports provide assurance to the full Members' Council that the groups are meeting their terms of reference and outlines the work undertaken for the period 1 April 2018 to 31 March 2019. The Terms of Reference had also been reviewed with minor amendments made to reflect the current membership and to ensuring consistency between the terms of reference of each group.

It was RESOLVED to RECEIVE the annual reports for 2018/19 and APPROVE the updated Terms of Reference for the Members' Council Co-ordination Group and Members' Council Quality Group.

MC/19/14d Nominations Committee Annual Report 2018/19, including update to Terms of Reference (agenda item 7.4)
AM reported that the annual report provides assurance to the full Members' Council that the Nominations Committee was meeting their terms of reference and outlines the work undertaken for the period 1 April 2018 to 31 March 2019. The Terms of Reference had also been reviewed with amendments made to reflect the current membership and attendance to ensure consistency with the terms of reference of other committees.

NA asked what the term of membership was for the Nominations Committee. EJ commented that, as agreed by the Members' Council on 2 November 2018 in relation to governor appointment to groups, the term of membership on a group for any new members was three years, unless a governor wished to stand down from a group, or was not re-elected / re-appointed as a governor on the Members' Council. This was to allow for consistency of membership. AM commented that the terms could be added to the terms of reference.

Action: Emma Jones / Angela Monaghan

NA commented that he did not understand why governors could not be in attendance. AM commented that the Nominations Committee discussed confidential matters. Any recommendations from the Nominations Committee for decision come to the full Members' Council and the Minutes were publically available.

It was RESOLVED to RECEIVE the annual report for 2018/19 and APPROVE the updated Terms of Reference for the Nominations Committee.

MC/19/14e Review of Audit Committee Terms of Reference (agenda item 7.5)
AM reported that, from the annual review of the Audit Committee Terms of Reference, some minor updates had been incorporated including member's names and further areas recommended for action by the Internal Auditors as part of their internal audit on governance in 2018/19, which received 'significant assurance' overall. These had been considered by the Audit Committee on 9 April 2019 and formally approval by Trust Board on 30 April 2019. The role of the Members' Council in relation to audit is the appointment of the Trust's external auditors. The current external auditors are Deloitte who present on the audit of the Trust Annual Report and accounts to the Members' Council annually in August.

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

MC/19/14f Update of the Scheme of Delegation (agenda item 7.6)
AM reported that the update to the Scheme of Delegation included any improvements identified, clarification of roles, and general updates since the last review in 2017. The full Scheme of Delegation was included in the papers with the recommended changes highlighted using track changes. This update was approved by the Trust Board on 30 April 2019 with some further minor points of clarification, which included an updated reference to innovation and change, an update to the name of the quality strategy, changing the Equality & Inclusion Forum to a Committee, NHSLA is now called NHS resolution, and that the Charitable Funds Committee is a committee of the Corporate Trustee.

NA asked if the Equality & Inclusion Committee (EIC) would be accessible to governors in the same way that other committees might be. AM commented that the committees of the Trust Board are not held in public, however the Minutes are publically available.

NA asked how the governor attendee at the Equality & Inclusion Committee was appointed. RW commented that originally the Trust wanted to have a Forum to recognise and support our equality and diversity work. As part of that we said we must make use of the governors and have a governor attend to assist us in being accountable. NH commented that at the time the Trust Board started taking a lot of interest in quality, including "e" for equality. There was a national push for equality in the NHS and the Chair at the time took an interest and there was a meeting facilitated by the Trust. The Chair at the time recognised the contributions NH had made through his Doctorate and invited him to be in attendance at the Equality & Inclusion Forum and then, through his input to the Forum, he was invited to be a member.

AM commented that as the Forum had now changed to a Committee, only directors of the Trust Board could be formal members, but that a governor would still be invited to be in attendance. AM advised that she would check the process that took place under the previous Chair and bring a proposal back to the next Members' Council regarding governor representation on the EIC

Action: Angela Monaghan

NA commented that he felt all governors should have access to the committee.

It was RESOLVED to APPROVE the updates to the Scheme of Delegation as set out in the paper.

MC/19/14g Governor engagement feedback (agenda item 7.7)
AM reported that the paper had been compiled from information provided by governors on events they have attended. The item continues to be a standing item on the Members' Council agenda as an opportunity for governors to formally feedback on the events they have attended and for other governors to ask them questions.

PS commented that there were two items from the discussion at the NHS Governor Regional Workshop held in Leeds for further consideration. These were walkabouts to visit services and the possibility for governors to have a separate meeting without Directors present, and suggested that the Members' Council Co-ordination Group consider these and possibly bring a proposal back to the next Members' Council meeting. Bob Clayden (BC) commented that the separate governor meetings may be difficult in terms of timing and believe they had been tried in the past and not been well attended. AM will place it as an agenda item on the MCCG.

Action: Emma Jones / Angela Monaghan

AM thanked the governors for all the engagement they had been involved in.

It was RESOLVED to RECEIVE the details provided from governors on events attended.

MC/19/15 Integrated Performance Report Quarter 4 2018/19 and Focus on Integrated working and Integrated Care Systems (ICSs) (agenda item 8)

Integrated Performance Report Quarter 4 2018/19

The key messages from the Integrated Performance Report were presented by Laurence Campbell (LC), Dr Subha Thiyagesh (SThi) and RW in relation to quality, Ashley Hambling (AH) in relation to workforce, and Rob Adamson (RA) in relation to finance. Governors were reminded that full Integrated Performance Reports (IPRs) are available in Trust Board papers and on the Trust's website.

LH commented, in relation to safer staffing numbers, if it could be clear that it did not include community staff. SH commented that safer staffing also did not include Allied Health Professionals. RW commented that the workforce planning was based on all staffing requirements and this year (2019/20) would include safer staffing for community staff. CI asked if it included Admiral Nurses. SH commented that most of them work in community services so they would not be included.

Adam Jhugroo (AJ) asked, in relation to the Friends and Family Test (FFT) for Mental Health Services, how many people made up the 95% who would recommend mental health services. RW commented that it would be 95% of those who have responded. AM commented that detailed information was included in the full IPR. AJ commented that, in relation to Child and Adolescent Mental Health (CAMHS) in Calderdale, the response is not as high. RW commented that the numbers had improved and indicated that people who use the service like it in comparison to those who were waiting to access services.

PS asked, in relation to the deficit budget, whether the Trust would be able to borrow money. RA commented that the deficit would normally come from cash reserves, however because the Trust had achieved the deficit target for 2018/19, an additional £4.7m was provided from national funds, which meant the Trust was reporting a surplus. The reason it is represented this way is to show the underlying position which helps to show whether the Trust was sustainable.

KSC asked if the Trust owned NHS property and, if it was sold, what happens to the money received. RA commented that for property owned by the Trust it comes back to the Trust, however due to historical arrangements it was not always that clear. Generally the sale of NHS property goes back into the Trust for reinvestment into NHS services. The Trust would reinvest this in the current estate, technology or services in order to make improvements.

LH asked if there was any impact from Interserve on the Trust. RA commented that the redevelopment work at Fieldhead in Wakefield was due to be completed soon, so it had not impacted the Trust and the risk had been well managed. LH asked if it would impact any future projects. RA commented that the market place had changed which would impact everyone going forward. RW commented that the Trust's experience working with Interserve has been generally positive.

LH asked who will be responsible for the CAMHS project. RW commented that it would be Leeds Community Healthcare NHS Trust as the lead for CAMHS.

NH asked how the overspend on the agency cap will be funded. RA commented that it was a cost pressure that the Trust had been able to deliver within the overall budget. The Trust had received some additional contribution from commissioners on areas such as out of area placements and there were also some one-off provisions.

NA commented that the financial position felt positive for a deficit budget. RA commented that what was reported was the year end position up to 31 March 2019 and it did remain a challenging position. Some of the pressures experienced in-year would continue and the Trust would need to find ongoing solutions. LC commented that the Trust still had a deficit budget and that is what has been able to be achieved.

CI asked what the Trust was doing in response to the push by the government for more care in the community. RA commented that the money the Trust was receiving was to support the estate and investing into new, more modern and appropriate buildings which will support some of that. RW commented that it was important to note that the Trust had not reduced the bed numbers for mental health services.

SH asked what understanding commissioners had about the requirements of services. RW commented that, in relation to out of area placements, this was part of the reason why the Trust asked an external organisation to look at what was needed and a joint plan has been agreed with commissioners to work together to reduce the numbers. Sometimes when commissioners retender services it can be for a lower financial envelope, which can cause pressures. Going forward the solution was about joined up care and collaboration.

Focus on Integrated working and Integrated Care Systems (ICSs)
The key messages from the work taking place in the Integrated Care Systems (ICSs) were presented by RW. This was an area identified at a previous Members' Council meeting requiring further information.

BC asked how governors should describe the ICSs if people ask. RW commented that it is what people have asked for, joining up care because it had been difficult to navigate services.

PS asked if it would have an impact on social care. RW commented that it should provide a positive impact because services will be working together at a local level and across the places.

NA commented that some Councils were good at dealing with their local area and sometimes harmonising best practice can stifle innovation.

CI commented that it was important to educate people to help themselves and bring people together.

MC/19/16 Care Quality Commission (CQC) – update on our inspection and annual report unannounced/planned visits (agenda item 9)

Due to time constraints this item was not presented. Hardcopies of the presentation were provided to governors.

MC/19/17 Strategy and priority programme update (agenda item 10)

Due to time constraints this item was not presented. Hardcopies of the presentation were provided to governors.

MC/19/18 Closing remarks, work programme, and dates for 2019 (agenda item 11)

AM thanked the governors for their attendance and input.

Meeting feedback

A hardcopy form was available for governors should they wish to provide feedback on the meeting, which would also be circulated electronically.

Work programme

The work programme for 2019 was included with meeting papers for noting.

Dates for 2019/20

The dates for the Members' Council meetings in 2019-20 held in public were noted as follows:

- Friday 2 August 2019 (Calderdale) – 12noon, Venue to be confirmed.
- Monday 16 September 2019 - Annual Members' Meeting (Wakefield) – Times to be confirmed, Large Conference Room, Wellbeing & learning centre, Fieldhead Hospital, Ouchthorpe Lane, Wakefield, WF1 3SP.
- Friday 1 November 2019 (Wakefield) – 9.30am, Large Conference Room, Wellbeing & learning centre, Fieldhead Hospital, Ouchthorpe Lane, Wakefield, WF1 3SP.
- Friday 31 January 2020 (Barnsley) – 9.30am, Legends Suite, Barnsley Football Club, Grove Street, Barnsley S71 1ET.

Signed: **Date:**

South West Yorkshire Partnership NHS Foundation Trust

MEMBERS' COUNCIL 3 MAY 2019 – ACTION POINTS

= completed actions

Actions from 3 May 2019

Minute ref	Action	Lead	Timescale	Progress
MC/19/10 Declarations of interest - annual declarations	Neil Alexander (NA) asked what UKAAN stood for. Rob Webster (RW) commented that it was a network that provided support to practitioners. AM will confirm.	AM		Complete. UKAAN stands for the UK Adult ADHD Network.
MC/19/11 Minutes of and matters arising 1 February 2019 (MC/18/34 regarding governor service visits)	RW commented that there were potentially three opportunities where governor could be involved. The first was quality monitoring visits against the five Care Quality Commission (CQC) domains with the NEDs taking part. The second were Patient Led Assessments of the Care Environment (PLACE) inspections which had been postponed for a period due awaiting updated national guidance. The third could be bespoke meetings.	EJ / TB / AGD		In progress. Email sent from Company Secretary on 18 July 2019 to all governors regarding training session dates for PLACE inspections. Further correspondence due to be sent in relation to quality monitoring visits.
MC/19/12 Chair's report and feedback from Trust Board and Chief Executive's comments	CI commented that she would like reassurance that service users won't be told via a letter that they are being discharged from Trust services. An inquest identified that a service user who did not attend an appointment with a counsellor received a letter that they had been discharged. RW commented that he had not seen the details of the inquest but it was important that the Trust communicates with services users effectively. Any areas of concern from inquests would be fed back through the Clinical Governance & Clinical Safety Committee and assurance on this specific case would be sought from Tim Breedon, Director of Nursing & Quality.	TB		

Minute ref	Action	Lead	Timescale	Progress
MC/19/14d Nominations Committee Annual Report 2018/19, including update to Terms of Reference	NA asked what the term of membership was for the Nominations Committee. EJ commented that, as agreed by the Members' Council on 2 November 2018 in relation to governor appointment to groups, the term of membership on a group for any new members was three years, unless a governor wished to stand down from a group, or was not re-elected / re-appointed as a governor on the Members' Council. This was to allow for consistency of membership. AM commented that the terms could be added to the terms of reference.	EJ / AM		Complete. Current member terms added to the Terms of Reference.
MC/19/14f Update of the Scheme of Delegation	AM commented that as the Forum had now changed to a Committee, only directors of the Trust Board could be formal members, but that a governor would still be invited to be in attendance. AM advised that she would check the process that took place under the previous Chair and bring a proposal back to the next Members' Council regarding governor representation on the EIC.	AM		Complete. Paper included on the Members' Council agenda for 2 August 2019 under item 4.1.
MC/19/14g Governor engagement feedback	PS commented that there were two items from the discussion at the NHS Governor Regional Workshop held in Leeds for further consideration. These were walkabouts to visit services and the possibility for governors to have a separate meeting without Directors present, and suggested that the Members' Council Co-ordination Group consider these and possibly bring a proposal back to the next Members' Council meeting. Bob Clayden (BC) commented that the separate governor meetings may be difficult in terms of timing and believe they had been tried in the past and not been well attended. AM will place it as an agenda item on the MCCG.	EJ / AM		In progress. This was considered by the Members' Council Co-ordination Group and a question is included on the Members' Council Meeting Feedback Form for 2 August 2019 to allow all governors to indicate if they would be interested in the scheduling of governor only pre-meetings prior to Members' Council meetings.

Outstanding actions from 1 February 2019

Minute ref	Action	Lead	Timescale	Progress
MC/19/05e Feedback from Annual Members'	SH commented that there was a free bus that transported people between Dewsbury Hospital and Pinderfields Hospital that could be used. Debbie Newton (DN) commented that she could talk to her Trust to see whether this was an option.	DN / EJ	August 2019	To be discussed as part of the planning for the 2019 event.

Minute ref	Action	Lead	Timescale	Progress
Meeting 2018	RW commented that as we move towards supporting people being digitally enabled a further area to consider was whether the meeting could be streamed live.	SY / EJ	August 2019	To be discussed as part of the planning for the 2019 event.
	NH commented that it was important to be inclusive and include engagement and suggested that as part of the planning to consider schools being invited to attend.	EJ	August 2019	To be discussed as part of the planning for the 2019 event.

Outstanding actions from 2 November 2018

Minute ref	Action	Lead	Timescale	Progress
MC/18/34 Minutes and actions of the previous meeting held on 3 August 2018 (MC/18/27f Governor engagement feedback (service visits))	Lisa Hogarth (LHo) commented that she would provide a list of Allied Healthcare Professionals who would be willing to arrange governor visits to services. Adrian Deakin (AD) commented that there may be potential for governors and Trust Board members to attend patients' council meetings. Lin Harrison (LH) commented that there may be potential for governors and Trust Board members to attend Multi-Disciplinary Meetings (MDT). AM commented that any visits would be coordinated by the Membership office. Governors to provide information on meetings to Emma Jones (EJ).	All		Ongoing (see action from 3 May 2019 Minute Ref MC/19/11)
	Mike Doyle (MD) commented that there were quality visits that governors may be able to attend. AM requested that the details be provided.	MD / TB		Superseded (see action from 3 May 2019 Minute Ref MC/19/11)
MC/18/38 Performance Report Quarter 2 2018/19 (Focus on sickness absence)	AM commented that the Members' Council Co-ordination Group could also consider timing for a further discussion by Members' Council, with the possibility for a staff governor to present.	AM / JC		In progress. On the list of possible items for consideration by the Members' Council Co-ordination Group.

Outstanding actions from 3 August 2018

Minute ref	Action	Lead	Timescale	Progress
MC/18/27f Governor engagement feedback (service visits)	Carol Irving (CI) asked what opportunities were available for governors to be more visible within the Trust to be able to talk to staff, service users, carers, members and the public so that governors can develop their skills and bring back any areas of concern. AM commented that when information is received in relation to public engagement events these are circulated to governors, such as the Commitment to Carers events. EJ commented that other events also included the West Yorkshire & Harrogate Health and Care Partnership engagement event and West Yorkshire Mental Health Services Collaborative joint Governor / Non-Executive Director event. This is an area that the Members' Council Coordination Group can consider as part of the development needs of governors.	EJ		Ongoing. Members' Council Co-ordination Group continue to consider opportunities for governors to be more visible within the Trust to be able to talk to staff, service users, carers, members and the public as part of the development action plan.
	TB commented that the Members' Council Quality Group would also be discussing governor attendance at quality visits to services.	TB		Superseded (see action from 3 May 2019 Minute Ref MC/19/11)

South West Yorkshire Partnership NHS Foundation Trust

Members' Council
2 August 2019

Agenda item:	**4.1**
Report Title:	**Governor representation on the Trust Board Equality and Inclusion Committee**
Report By:	Chair of the Trust and Members' Council
Action:	For decision

Purpose

The purpose of this paper is to enable the Members' Council to discuss and agree if any change is required with regard to the current governor representative on the Trust Board Equality and Inclusion Committee (EIC).

Recommendation

The Members' Council is recommended to CONFIRM that, in order to provide continuity, Dr Nasim Hasnie remains in attendance at the EIC until the end of his term of office on 30 April 2020, and that a process to appoint a representative to the committee be undertaken prior to 30 April 2020, in accordance with the agreed procedure for appointing governors to sub-groups and committees.

Background

1. The Equality and Inclusion Forum was initially set up by Trust Board in May 2015 for a twelve-month period, subject to review, to support the Trust's commitment to equality and diversity. In 2018, the Forum became a standing forum, and in 2019 it was recommended that the Forum became a formal committee of the Board. This was approved on 30 April 2019.

2. The terms of reference set out that the Equality and Inclusion Committee's prime purpose is to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does, through promoting the values of inclusivity and treating people with respect and dignity. The Equality and Inclusion Committee (EIC) will develop and oversee a strategy, including an approach to positive action, 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.

3. In October 2016, the then Trust Chair, Ian Black, felt that it would be valuable to have a governor attend the forum, to draw on their knowledge and input and to assist us in being accountable. He invited Dr Nasim Hasnie OBE to attend meetings, recognising his extensive experience and expertise in the field of

equality, diversity and inclusion, including involvement in national work. At this point in time, there were no formal processes in place for appointing governors to committees or subgroups.

4. When it became a standing forum in 2018, it was proposed and agreed at Board that the governor representative, Dr Nasim Hasnie, should become a full member. When the Forum was changed to a formal Board Committee from 1 May 2019, Dr Hasnie was no longer eligible to be a full member as, under the Trust Constitution, only Trust Directors can be members of Board committees. However, it was confirmed that a governor would still be invited to be in attendance and that they would be able to participate fully in the work of the committee, as had been the case previously. In line with the decision taken by the Members' Council on 2 November 2018, regarding governor appointment to groups and committees, Dr Hasnie remained the governor representative.

5. When this change was reported to the Members' Council on 3 May 2019, as part of the update to the Scheme of Delegation, one governor questioned how the governor representative to the EIC was appointed, and if the change in the terms of reference required that the governor representative to the EIC be reviewed. It was agreed to bring a paper back to the next meeting.

Appointing governors to sub-groups and committees

6. Governors are reminded that, prior to 2 November 2018, there had been no formal process for appointing governors to Members' Council sub-groups and committees. At the Members' Council meeting on 2 November a paper proposing a process was discussed and the recommendations agreed - a copy of the paper is attached at appendix 1 for reference. This included the proposal that *'Current members on all groups would remain until the end of their governor term or until they step down'.*

7. In relation to the Equality and Inclusion Forum, it was noted that:
'This is a forum of the Trust Board and the Board is responsible for appointing members. Membership on Trust Board committees and forums is reviewed annually in April as part of the annual review of their Terms of Reference. There is currently 1 public governor member on the Forum whose term ends in April 2020.

In the event of a vacancy, the same appointment process outlined for the Members' Council groups and committee could be followed, with the difference being that the final decision would be made by the Trust Board rather than the Members' Council. It is desirable for the governor member of the Forum to have knowledge/experience/interest in equality and inclusion matters, but not essential.'

8. Governors are asked to consider if the recent changes to the terms of reference for the Equality and Inclusion Committee require that the current governor representative step down and be reappointed; or if Dr Nasim Hasnie should remain in attendance at the EIC until the end of his term of office on 30 April 2020.

South West Yorkshire Partnership NHS Foundation Trust

Members' Council
2 November 2018

Agenda item:	**7.1**
Report Title:	**Governor appointment to Members' Council groups and committee**
Report By:	Chair of the Trust / Company Secretary on behalf of the Members' Council Co-ordination Group
Action:	For approval

EXECUTIVE SUMMARY

Purpose

The purpose of this paper is to propose a process to the Members' Council for approval regarding how governors become members of its sub-groups. The paper also proposes the establishment of consistent member numbers across the Members' Council Co-ordination Group and Members' Council Quality Group, with all governors still welcome to be in attendance and participate even if they are not a 'formal' member of these two groups. The objectives of the changes are to address the current lack of clarity about appointment to the groups, to make the appointment process more transparent, and to ensure effective operation of the groups, whilst maintaining a commitment to openness and inclusion.

Recommendation

The Members' Council is asked to APPROVE the recommendation from the Members' Council Co-ordination Group on the process for the appointment of governors onto the sub-groups and committee and changes to the membership numbers on the sub-groups.

Background

There are two-sub groups and one committee of the Members' Council as follows:

- **Members' Council Co-ordination Group** - which supports the Chair in setting the agenda for Members' Council meetings, and the induction and development of governors.
- **Members' Council Quality Group** - which looks at the Trust's quality performance report, patient experience, Quality Accounts and other quality issues.
- **Nominations' Committee** - which ensures the right composition and balance of the Board and oversees the process for the appointment the Chair and Non-Executive Directors (NEDs), Deputy Chair / Senior Independent Director, and the Lead Governor.

In addition, there is also an Equality & Inclusion Forum of the Trust Board which has a governor member.

The attached paper outlines a proposed process for appointment of governors to the groups and committee and recommends changes to the current number of governor members on the Co-ordination Group and Quality Group.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Governor appointment to Members' Council groups and committee

Previously there has been no formal process for appointing governors to the Members' Council sub-groups. To assist with establishing an open and transparent process to encourage membership and attendance, a proposal was discussed by the Members' Council Co-ordination Group meeting on 6 June 2018 and 3 September 2018 and is outlined below for approval by the Members' Council.

Proposed process for appointment

When vacancies arise, the proposed process for appointment recommended is a shortened version of the process for the appointment of the Lead Governor, which has been in place since 2009.

Step 1	When a vacancy arises, governors are invited to self-nominate, supported by a brief verbal or written statement about why they are putting themselves forward. If only one self-nomination is received, they will automatically fill the vacancy, otherwise the process will move to Step 2.
Step 2	If more than one self-nomination is received for a vacancy, the Members' Council Co-ordination Group will discuss the self-nominations supported by input from the Chair and make a recommendation to the full Members' Council.

The recommended term of membership on a group for any new members will be for three (3) years to allow for consistency of membership. If a governor wishes to stand down from a group, or is not re-elected / re-appointed as a governor on the Members' Council during the three years, the above process would take place to fill the vacancy.

It is expected that governors are a member of only one group to allow opportunities for more governors to be involved, however if sufficient membership is not reached through the self-nomination process this would be extended to two.

Current members on all groups would remain until the end of their governor term or until they step down.

All governors continue to be welcome to attend and participate at the Members' Council Co-ordination Group and Members' Council Quality Group even if they are not 'formal' members. Non-members would not normally attend the Nominations' Committee, for reasons of confidentiality, unless invited by the Chair.

Membership numbers

<u>Members' Council Co-ordination Group</u>

The current membership is 7 x governors. There are no specific skills required to be a member. The current breakdown of governor membership is as follows:

- Lead Governor. *Note,this is a requirement of the Lead Governor role.*
- 4 x Public governors (1 x vacancy)
- 1 x Staff governor (1 x vacancy)
- 1 Appointed governor

It is recommended that the membership be increased by 1 x Public governor for the Rest of South and West Yorkshire so there is a member from each of the five public constituencies (Barnsley, Calderdale, Kirklees, Wakefield, Rest of South and West Yorkshire).

All governors continue to be welcome to attend the Members' Council Co-ordination Group even if they are not 'formal' members.

Members' Council Quality Group

The current membership is 9 x governors. There are no specific skills required to be a member of the Group. The current breakdown of governor membership is as follows:

- Lead Governor. *Note, this is a requirement of the Lead Governor role.*
- 5 x Public governors
- 2 x Staff governors (1 x vacancy)
- 1 x Appointed governor (1 x vacancy)

It is recommended that when vacancies arise for Public governors that they are re-aligned to one member from each of the five public constituencies (Barnsley, Calderdale, Kirklees, Wakefield, Rest of South and West Yorkshire) and 1 x Staff governor to be consistent with the Co-ordination Group.

All governors continue to be welcome to attend the Members' Council Quality Group even if they are not 'formal' members.

Nominations Committee

There are a set number of governor members which is consistent with national guidance, therefore no change to the number of members is proposed. It is a requirement for the governor members of the Committee to undertake recruitment training, which is provided by the Trust. The Committee membership of governors is as follows:

- Lead Governor. *Note, this is a requirement of the Lead Governor role.*
- 1 x Public governor
- 1 x Staff governor
- 1 x Appointed governor

Equality & Inclusion Forum

This is a forum of the Trust Board and the Board is responsible for appointing members. Membership on Trust Board committees and forums is reviewed annually in April as part of the annual review of their Terms of Reference. There is currently 1 x Public governor member on the Forum whose term ends in April 2020.

In the event of a vacancy, the same appointment process outlined above for the Groups and Committee could be followed, with the difference being that the final decision would be made by Trust Board rather than the Members' Council. It is desirable for the governor member of the Forum to have knowledge/experience/interest in equality and inclusion matters, but not essential.

OPPORTUNITIES FOR GOVERNORS TO VISIT SWYPFT SERVICES 2019/20

There are currently three different opportunities for governors to visit Trust services and facilities:

1. Patient Led Assessment of the Care Environment (PLACE) inspections
2. Quality monitoring visits (QMVs)
3. Governor requested service visits

Further details on each of these are provided below. To take part or get further information, please contact the membership team at membership@swyt.nhs.uk or phone 01924 316462.

1. Patient Led Assessment of the Care Environment (PLACE) inspections

We are working with our Estates & Facilities team to coordinate governor participation in Patient Led Assessment of the Care Environment (PLACE) inspections. This will provide you with an opportunity to go into our services as part of teams to assess how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness and general building maintenance and, more recently, the extent to which the environment is able to support the care of those with dementia and disabilities.

The inspection dates are yet to be scheduled, however they are expected to start in September 2019 and the time commitment for governors wishing to take part in the inspections will be 1 day, plus a 1-2 hour training session prior (see below).

The following dates are available for the training sessions which will provide you with an understanding of the inspection process. They will be held in the Estates & Facilities block, Fieldhead, Ouchthorpe Lane, Wakefield. **If you would like to take part, please let us know your preferred training date/s from those below** as space is limited in each session to 8 people.

Date	Time
Tuesday 20th August 2019	9.30am-11.30am
Tuesday 20th August 2019	1.00pm-3.00pm
Wednesday 21st August 2019	1.00pm-3.00pm
Thursday 22nd August 2019	9.30am-11.30am
Thursday 22nd August 2019	1.00pm-3.00pm

Further information regarding PLACE inspections and last year's assessment forms for mental health and learning disability hospitals (due to be updated) can be found here: https://digital.nhs.uk/data-and-information/areas-of-interest/estates-and-facilities/patient-led-assessments-of-the-care-environment-place.

2. **Quality monitoring visits (QMVs)**

The aim of these visits is to look at how teams and services are meeting care standards, to look at their good practices, how they may improve and to provide assurances that quality and safety standards are being met. The focus of the visits is about quality improvement and assurance.

The QMV teams include experienced practitioners from various professions and specialists. These include doctors, Practice Governance Coaches, clinicians, safeguarding nurse advisors and representatives from the Mental Health Act team. Our Non-Executive Directors (NEDs) also take part and governors are now being invited to join the teams.

The visits will include those services that were mostly recently visited by CQC and who were given 'must' do and/or 'should' do actions. We will also be visiting teams and services that have been nominated by their business delivery unit (BDU) because of their good and outstanding

standards. We also undertake themed visits to our inpatient teams to assess how they are compliant with the Mental Capacity Act. Additional visits will also be undertaken when we receive intelligence to indicate concerns and risks within a team or service.

QMVs consist of looking at various sources of information. We look at care records and other documentation. We also speak with service users, carers, staff and the management team. The QMV team also carries out observations including such things as the layout of the environment.

All of our visits our announced so we can give teams advanced notice that we are going to be visiting them, and can collect a variety of different sources of information about the teams being visited. The visits usually last a whole day and teams receive immediate verbal and written feedback at the end of their visit. Where the QMV team has serious concerns, they escalate these issues to the relevant senior management.

Following the visit, teams and services receive their draft report including the findings and any actions that are needed. The team has the opportunity to comment on the content of the report before it is made final. Teams are expected to submit action plans back to the Quality Improvement and Assurance Team (QIAT) describing the actions that are going to be taken to address any identified issues along with timescales. These action plans are then monitored for progress via their relevant governance groups.

Because QMV teams access to care records and talk directly with service users and carers, it is essential that all team members have a current Disclosure and Barring Service (DBS) check before taking part. If you wish to take in QMVs, please contact us to arrange a DBS check.

Details of the dates of QMVs for 2019/20 will be circulated after the Care Quality Commission (CQC) inspection report has been received and an action plan agreed. Visits will probably take place between September 2019 and April 20120.

3. Governor requested service visits

Governors can also request to visit services relevant to their constituency and we will make arrangements to facilitate that where possible. If a visit is arranged and additional governors can be accommodated, we will then invite others to attend. The Members' Council Quality Group may also suggest visits following discussions at meetings.

If you wish to visit a particular service in your constituency, please contact the membership team, who will then pass on your request to the relevant staff team. DBS checks are not required for these visits.

It may be necessary to limit the number of visits arranged due to limited staff resources, but we will do our best to accommodate all requests and ensure opportunities are available in all our places.

July 2019

South West Yorkshire Partnership NHS Foundation Trust

Members' Council
2 August 2019

Agenda item:	**5**
Report Title:	**Chair's Report**
Report By:	Chair of the Trust and Members' Council
Action:	For information

Purpose

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

- issues discussed at Board meetings
- Chair and NED activity
- other issues of relevance and interest to Governors

Recommendation

The Members' Council are recommended to NOTE the contents of this report and RAISE any items for clarification or discussion, either at or outside of the Members' Council meeting.

Report

1. Review of Trust Constitution and Code of Conduct for Governors

The Trust (SWYPFT) Constitution is due for review this year, and governors agreed the process of review at the Members' Council meeting held on 1 February 2019. To support this review, I am planning on holding a facilitated workshop for governors to consider any changes required due to changing Foundation Trust requirements and governor recommendations. The review will also incorporate all supporting documents and guidance including the **Code of Conduct for Governors,** which has not been reviewed for 5 years.

The SWYPFT Constitution is based on the model core constitution produced by NHS Improvement (formerly Monitor) and we are expecting them to issue new guidance imminently; however, this has not yet been published. In the 2019/20 Members' Council work plan, the revised constitution is due to come to the November 2019 Members' Council meeting, which would require it to be discussed at the October 2019 Trust Board meeting. In light of the delay in publication of the new guidance, and also to allow sufficient time for governor engagement, **I am proposing that this is moved to the January 2020 meeting in the work plan.**

I will consult with the Lead Governor and the Company Secretary about the timing and arrangements for the workshop and all governors will be invited to attend.

2. Chair and Non-executive Director activity in the last quarter

To support governors in their role of holding the Chair and Non-executive directors (NEDs) to account, this section of the report highlights the range of activity in which they have been engaged since the previous Members' Council meeting. Please note that NEDs are expected to work around 3 days a month and the Chair 3 days a week.

This quarter, in addition to the activity noted below, the Chair and NEDs were all engaged in the **Care Quality Commission (CQC) well-led review,** which took place over 11-12 June 2019. This included both 1:1 and group interviews with members of the inspection team. Thank you to all those governors who took part in the governor focus group.

They have also prepared for and attended the following Trust committees and governance groups, including the newly established **Finance Oversight Group**, which currently meets fortnightly:

- Audit Committee (quarterly) – Laurence Campbell (LC) (chair), Erfana Mahmood (EM), Sam Young (SYo)
- Clinical Governance and Clinical Safety Committee (bi-monthly) – Charlotte Dyson (CD) (chair), Angela Monaghan (AM), Kate Quail (KQ)
- Workforce and Remuneration Committee (quarterly) – Sam Young (chair), Charlotte Dyson, Angela Monaghan
- Mental Health Act Committee (quarterly) – Kate Quail (chair), Laurence Campbell, Erfana Mahmood
- Equality and Inclusion Committee (quarterly) – Angela Monaghan (chair), Erfana Mahmood, Sam Young
- Charitable Funds Committee (quarterly) – Charlotte Dyson (chair), Angela Monaghan, Kate Quail
- West Yorkshire & Harrogate Mental Health Services Collaborative Committee in Common (quarterly) – Angela Monaghan (chair)
- Finance Oversight Group (fortnightly) – Laurence Campbell (chair), Sam Young + all NEDs invited to attend
- Nominations' committee (as required/at least once a year) – Angela Monaghan (chair)
- Barnsley Integrated Care Partnership Group (monthly) – Angela Monaghan
- West Yorkshire & Harrogate Health & Care Partnership Board (quarterly) – Angela Monaghan
- Members' Council Coordination Group (quarterly) – Angela Monaghan, Charlotte Dyson
- Members' Council Quality Group (quarterly) – Charlotte Dyson

Chair engagement with SWYPFT staff, governors, NEDs, volunteers, service users and carers included:

- monthly meetings with Lead Governor Jackie Craven
- 1:1 annual review and induction meetings with governors
- monthly Trust Welcome Events for new staff and volunteers
- Non-executive director and CEO annual appraisals
- Service visits to: pharmacy team at Fieldhead, Wakefield; learning disability

team at Fox View, Dewsbury; health integration team at Urban House, Wakefield; bank team at Fieldhead; Cross the Sky theatre company/Creative Minds, Barnsley
- Presentation of Institute of Healthcare Improvement (IHI) certificates to SWYPFT staff
- Consultant interview panel
- National Staff Networks Day exhibition at Fieldhead
- meeting with publicly elected governor to discuss service user concerns
- NED recruitment: open evening and interviews
- Extended executive management team meetings (EMT) (monthly)
- 1:1 meetings with chief executive, Rob Webster (monthly)
- NEDs' meetings (quarterly)
- 1:1 meetings with Deputy Chair (monthly)

Chair attendance at external meetings and events included:
- 1:1 meeting with new Chair of Mid Yorkshire NHS Trust;
- Yorkshire & Humber Academic Health Science Network briefing
- Board to board meeting with Locala
- NHS Confederation Mental Health Network Third Sector member dinner
- Calderdale Vision 2024 leadership seminar on health and climate
- West Yorkshire & Harrogate Mental Health Services Collaborative Governor and NED engagement event (Leeds) – thank you to the 5 SWYPFT governors who attended
- South Yorkshire & Bassetlaw ICS guiding coalition engagement conference
- Meetings with individual MPs: Craig Whittaker (Calder Valley), Holly Lynch (Halifax), John Healey (Wentworth and Dearne)
- Meeting of NHS system leaders and MPs for Wakefield and North Kirklees (quarterly)
- Retirement event for Barnsley Council Chief Executive, Diana Terris

Additional NED activity included:
- Independent Hospital Manager reviews (for Mental Health Act Committee) (KQ, LC, EM)
- NED recruitment open evening and interviews (LC, CD)
- Locala Board to Board meeting (LC)
- Annual appraisal (all)
- NEDs' quarterly meeting (all)
- Psychotherapy Consultant recruitment panel (LC)
- Service visits to: Horizon Centre; Barnsley CAMHS (CD)
- NHS Confederation national conference (free place) (CD)
- Freedom to speak up interview (CD)
- Multi agency Section 136 meeting (KQ)
- MH Code of Practice - Reducing Restrictive Practice ('blanket restrictions') Group; and Reducing Restrictive Physical Interventions (RPPI) Trust Action Group (KQ)
- NHS Providers National Quality Conference (KQ)
- Aspire Together: The North Regional Talent Board launch (KQ)
- West Yorkshire Mental Health Services Collaborative (WYMHSC) Joint NED

and Governor engagement event (KQ)

3. Issues discussed at Board meetings

Since the previous Chair's report, the Board has met three times and I have highlighted the key items discussed below. May I please remind Members' Council that all governors are welcome to attend all public Board meetings and there is the opportunity to raise questions and comments at the end of each meeting. Papers are available on our website a week before at www.southwestyorkshire.nhs.uk/about-us/how-we-are-run/trust-board/meeting and for all previous meetings.

April 2019
As reported verbally at the last Members' Council meeting, the April Board took place in Folly Hall, Huddersfield and was a *business and risk* meeting. There were seven members of the public in attendance, including three governors. As is the norm, the meeting opened with a **service user story,** this time from our learning disability service and full details are in the minutes.

The main items discussed at the public meeting were:

- Strategic overview of business and associated risks – a 6-monthly report linking the SWOT, PESTLE, risk and priority programmes.
- The quarter 4 Board Assurance Framework (BAF) and corporate risk register for 2018/19.
- An update on the many developments in our two integrated care systems (ICSs), West Yorkshire & Harrogate and South Yorkshire & Bassetlaw.
- The month 12 integrated performance report for 2018/19, including the 6-monthly safer staffing report.
- The annual report from the Trust Guardian of safe working hours (in relation to doctors in training).
- A report on progress with the Trust's digital strategy, and an update of the risk management strategy and risk appetite statement.
- A number of end-of-year governance items, including: approval of the audit committee annual report and updated terms of reference for all the board's committees; draft annual governance statement; update to the Scheme of Delegation; and the Trust's 2019/20 operational plan.

In the private session the Board discussed:

- the **investment appraisal framework**, which covers business development opportunities and current contract risks.
- commercially confidential **financial matters,** including an update on the development of our **financial sustainability plan.**
- commercially confidential **risks.**
- commercially confidential business developments in both of our **integrated care systems,** including the ICS financial framework.

May 2019
The May meeting was a *strategic* board, which is not held in public. At that meeting we discussed the metrics and targets for the 2019/20 integrated performance report; our organisational development strategy; and our corporate partnerships and

relationships, using an interactive stakeholder mapping technique. We also had a Board briefing prior to the Care Quality Commission (CQC) well-led review, which took place on 11-12 June.

June 2019
The June Board was a *performance and monitoring* meeting and took place in the Laura Mitchell Centre, Halifax. There were 3 members of the public in attendance, including one governor. The meeting opened with a compelling **service user story** concerning the different experiences of twin boys on neurodevelopmental pathways, one before improvements were made and one after.

At this meeting the Board discussed:

- the month 2 integrated performance report – not all data were available at this meeting due to the move to our new clinical records system, SystmOne.
- Learning disability services in the light of the recent Panorama programme and publication of two significant reports concerning the care of people with learning disabilities.
- Developments in our two integrated care systems, including:
  - Calderdale Cares – one year on; and
  - The Wakefield Integrated Care Partnership
- An update on delivery against our Communications, Engagement and Involvement Strategy.
- Governance - approved the setting up of a new Finance Oversight Group, led by Non Executive Directors; and received the 2018/19 Incident Management Report, and Safety Services Report.

In the private session the Board discussed:

- commercially confidential **financial matters**
- updates on ongoing enquiries into **serious incidents**
- commercially confidential developments in both of our **integrated care systems,** including an update on the development of the forensic new care model, and approval to progress an application to lead a provider collaborative for this work.

July 2019
The July Board meeting, which is a *business and risk* meeting, is taking place just prior to the Members' Council on 30 July in Barnsley and I will be able provide a verbal update at the Members' Council meeting.

4. NED recruitment

The Nominations' Committee met on 3 June 2019 and agreed to go out to open recruitment for a financially qualified Non-executive director with financial experience at a senior level. It was agreed that the recruitment process would be carried out in-house due to the significant cost of appointing recruitment consultants.

The recruitment campaign commenced on 5 June 2019 and ran for 4 weeks. Details were sent to all governors by email on 14 June 2019. The process included an open evening held at Fieldhead on the evening of 24 June 2019 – no candidates attended in spite of being widely advertised.

Five applications were received, but two did not meet the qualification requirement. Shortlisting took place on 5 July 2019 and three candidates were shortlisted for interview. The assessment centre and panel interviews took place on 12 July 2019 – this process included governor, staff and service user stakeholder panels. Thank you to all those governors who took part. The interview panel comprised the Trust Chair, Trust Deputy Chair, Lead Governor and the publicly elected governor member of the Nominations' Committee.

The Nominations' Committee met again on 15 July 2019 to consider the recommendation of the interview panel and decided that a further round of assessments and interviews is required before a recommendation can be put to the full Members' Council. These will take place by 26 July 2019 and a recommendation will be brought to the Members' Council meeting on 2 August 2019.

South West Yorkshire Partnership NHS Foundation Trust

Members' Council
2 August 2019

Agenda item:	**6.1**
Report Title:	**Review of Chair and Non-Executive Director remuneration - process and timescales**
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 paper is to review and reconfirm support for the current process for the annual review of the Chair and Non-Executive Directors (NEDs) remuneration.

Recommendation

The Members' Council is asked to REVIEW and SUPPORT the process for the review of the Chair and NED remuneration.

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 Trust has now received the 2018 survey results. 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. Previously the Nominations Committee has used this survey as the basis of the review, rather than commission external consultants. The Director of Human Resources, Organisational Development and Estates will support the Nominations Committee undertake the review and develop recommendations to the Members' Council in November 2019 on the remuneration levels for the Chair and NEDs.

South West Yorkshire Partnership NHS Foundation Trust

Members' Council
2 August 2019

Agenda item:	**6.2**
Report Title:	**Non-Executive Director (NED) appointment**
Report By:	Chair on behalf of the Nominations' Committee
Action:	For decision

EXECUTIVE SUMMARY

Purpose

The purpose of this report is to update the Members' Council on the recruitment of a Non-Executive Director (NED) with a financial qualification and senior-level financial experience and recommend the appointment of a new NED.

Recommendation

The Members' Council is asked to RECEIVE the update and APPROVE the recommendation from the Nominations' Committee to appoint Chris Jones as a Non-Executive Director for a period of 3 years, with effect from 5 August 2019.

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.

At its meeting on 3 June, the Committee considered the current make-up of the Board and concluded that, given the challenges facing the Trust, an additional NED, who is both financially qualified and has senior-level financial experience, should be appointed to strengthen the skills and experience of the Trust Board.

The Nominations' Committee also recognised that the Members' Council agreed, on 3 May 2019, that the post should be recruited to through an open process and advertised nationally.

Process of Recruitment

The Nominations' Committee oversaw the process through its meetings held on 3 June, 5 July, 15 July and 26 July. The recruitment process mirrored that undertaken to appoint two new NEDs last year.

The outline timetable for recruitment was as follows:

- Post advertised nationally week commencing 5 June 2019.
- Information event for potential candidates held at Fieldhead on 24 June.
- Prospective candidates were offered the opportunity to speak informally to the Chair and/or Deputy Chair and/or Chief Executive.
- Closing date for applications – 3 July 2019
- Shortlist agreed by Nominations' Committee – 5 July 2019
- Panel discussions (governors; service users/carers; staff including representatives from the Black and Minority Ethnicity (BAME) and Disability Staff Networks) - 12 and 25 July 2019
- Final panel interviews - 12 and 26 July 2019 Nominations' Committee considered and agreed a recommendation for appointment to the NED vacancy - 26 July 2018, for consideration by Members' Council on 2 August 2019
- Members' Council approval - 2 August 2019
- Proposed start date for appointment - 5 August 2019

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

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

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.

Outcome and Process of Selection

In all, **5 applications** were received and **3 candidates** were recommended for the shortlist. This was agreed at the Nominations' Committee on 5 July 2019.

The 3 shortlisted 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 12 and 25 July 2019.

There was also a discussion with the Chair of the Audit Committee on technical financial aspects of the role.

The final interviews were held on the 12 and 26 July 2019, due to the availability of the candidates, and the panel members were Angela Monaghan, Chair; Charlotte Dyson, Deputy Chair/Senior Independent Director; Jackie Craven, Lead Governor; and Nasim Hasnie, Publicly Elected Governor. The panel unanimously agreed that Chris Jones be recommended as the preferred candidate.

The Nominations' Committee met on 26 July 2019 and discussed the recommendation of the final interview panel. The Committee unanimously agreed that Chris Jones be recommended for appointment.

<u>The recommended candidate</u>

Chris Jones has extensive experience as a Chief Executive and Director of Finance in the Further Education Sector. He has held a number of Non-Executive/Trustee roles and has NHS experience. Further information regarding Chris Jones experience is contained in the attached paper. A file of supporting documents, including his letter of application and references, will be available at the meeting for governors to view if required.

The final interview panel and Nominations' Committee believe that Chris demonstrated a strong values base, consistent with the Trust's values, and, with his experience and background, believe he will be able to make a significant and valuable contribution to the Board and the organisation.

<u>Term of office and remuneration</u>

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, as agreed by the Members' Council, is £13,584 per annum.

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

South West Yorkshire Partnership NHS Foundation Trust

Members' Council 2 August 2019
Non-Executive Director (NED) Recruitment

1. Introduction

The Nominations' Committee agreed to the appointment of an additional NED to strengthen the financial skills and experience on the Trust Board, given the financial challenges facing the organisation. In reaching this decision, they considered that the Board currently has only one financially qualified NED, Laurence Campbell, whose second term of office will end on 31 May 2020.

The Members' Council agreed, at its meeting on 3 May 2019, that the NED vacancy should be subject to an open recruitment process and advertised nationally.

2. Candidate Attraction

The Nominations' Committee agreed to mirror the previous recruitment process that had been used to successfully appoint 2 NEDs in 2018. It was agreed to advertise the post through:

- Yorkshire Post On line
- LinkedIn: targeted approach to senior finance professionals.
- NHS Improvement website
- Cabinet Office website

The last two websites have links to various public appointment websites.

In addition, a drop in event for interested candidates was organised on 24 June 2019. The advertisement also included the opportunity for prospective applicants to speak informally to the Chair and/or Deputy Chair and/or Chief Executive.

The post was advertised on 5 June 2019 and closed on 3 July 2019. A total of 5 applications were received by the closing date of 3 July 2019.

3. Shortlisting

The 5 applications received were categorised in 1 of 4 categories, shown below, based on their Curriculum Vitae (CV) compared against the person specification:

1 : Recommend for interviews
2 : Strong marginal for discussion
3 : Marginal for discussion
4 : Not recommended

There were 3 candidates in category 1 recommended for interview and 2 candidates in category 4 not recommended for interview.

The 2 candidates not recommended for interview, whilst having a strong CV, did not possess the required financial qualification essential for the role.

The Nominations' Committee agreed to shortlist the 3 candidates in Category 1.
The selection process had 3 stages:

- Stakeholder Groups discussions
- Informal discussion with the Chair of the Audit on technical aspects of the role
- Formal Interview

4. Final assessment

The 3 candidates selected for final assessment attended three (3) stakeholder group discussion panels on 12 and 25 July 2019:

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

The formal interviews took place on 12 and 26 July 2019, due to the availability of the candidates, and the 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 and Estates was in attendance supporting the panel.

Following the interview process, and considering the feedback from the stakeholder groups and the Chair of the Audit Committee, the panel's recommendation to the Nominations' Committee on 26 July 2019 was that Chris Jones is appointed as a NED.

The Nominations' Committee decision is to recommend to the Members' Council on 2 August 2019 that Chris Jones be appointed.

5. Recommendation

The Members' Council is asked to APPROVE the recommendation from the Nominations' Committee that the Trust appoints Chris Jones as Non-Executive Director (NED) for an initial three (3) year term commencing 5 August 2019.

Summary of the Candidate's CV

Chris Jones

Chris Jones has extensive experience of Chief Executive and Director of Finance roles in the further education sector. He has also held a number of Non-Executive/Trustee roles, including in the NHS.

Qualifications

BA (Hons) Economics, Accounting and Financial Management Chartered Institute of Public Finance and Accountancy (CIPFA).

NED/Trustee roles

- NED, South West Yorkshire Partnership NHS FT
- Trustee, Children's Food Trust
- Member, Calderdale Safeguarding Children Board
- Member, Leeds City Region Skills and Employment Panel
- Chair, Leeds City Region Skills Network
- Chair, West Yorkshire Consortium of Colleges
- Trustee, Trinity Academy, Halifax
- Co-Opted Board member, North Halifax Partnership
- Board Member, Halifax Opportunities Trust
- Chair, Calderdale Council Economy and Environment Partnership
- Member, Sheffield First Partnership
- Governor and Chair of Finance Committee, Netherton Infant School

Employment

2018
Interim Chief Executive, Bradford College

2015 – 2018
FE Advisor, Department for Education/Independent Consultant

2000 – 2008
Finance Director/Deputy Principal, The Sheffield College

1995 – 1999
Finance Director, Huddersfield Technical College

South West Yorkshire Partnership NHS Foundation Trust

Members' Council
2 August 2019

Agenda item:	**7.1**
Report Title:	**Governor appointment to Members' Council groups**
Report By:	Lead Governor and Chair of the Trust on behalf of the Members' Council Co-ordination Group
Action:	For decision

EXECUTIVE SUMMARY

Purpose

The purpose of this paper is to seek the Members' Council approval for the appointment of a governor to the Members' Council Quality Group.

Recommendation

The Members' Council is asked to CONSIDER and AGREE the recommendation from the Members' Council Co-ordination Group to appoint Phil Shire to the Members' Council Quality Group.

Background

At the Members' Council meeting on 2 November 2018, a process was approved regarding how governors become members of its sub-groups (attached) and the establishment of consistent member numbers across the Members' Council Co-ordination Group and Members' Council Quality Group. The objectives of these changes were to address the lack of clarity about appointment to the groups, to make the appointment process more transparent, and to ensure effective operation of the groups, whilst maintaining a commitment to openness and inclusion. All governors continue to be welcome to be in attendance and participate in the meetings even if they are not a 'formal' member of these two groups.

Process

In accordance with the process, following the end of some governors previous terms on the Members' Council, the Company Secretary wrote to all governors on 14 May 2019 seeking self-nominations for available vacancies on groups. The Chair also wrote to those governors whose previous term ended on the groups. Some previous members were eligible to self-nominate again to be a 'formal' member. The exception to this was Public - Kirklees on the Quality Group which previously had three 'formal' members and it was agreed in November 2018 that when vacancies arise membership should be re-aligned to one 'formal' member from each public constituency, one staff, and one appointed. These governors were encouraged to still continue to attend and participate. Further reminder emails were sent on 24 May 2019 to the groups of governors of the specific vacancies where no self-nomination had been received (Public – Kirklees for Co-ordination Group; Appointed for Quality Group). The following self-nominations were requested to be put forward:

Group	Vacancy	Self-nominations received
Co-ordination Group	1 x Public governor - Kirklees	Nil.
Quality Group	1 x Public governor - Calderdale	• Phil Shire • Adam Jhugroo
Quality Group	1 x Appointed governor	Nil.

As more than one self-nomination was received for the vacancy on the Quality Group, in accordance with the process the Co-ordination Group discussed the self-nominations at its meeting on 10 June.

Outcome

The members of the Co-ordination Group individually assessed the self-nominations and following a discussion by the Group, it was agreed by those present to recommend the appointment of Phil Shire as a 'formal' member to the Quality Group, noting that the Quality Group would benefit from the continuity of Phil's existing experience. However, they recognised that both candidates would make a valuable contribution and also strongly encourage Adam Jhugroo to attend and participate meetings as an attendee where possible.

The remaining vacancies for a 1 x public governor - Kirklees on the Co-ordination Group and 1 x appointed governor on the Quality Group will continue to be promoted.

Co-ordination Group members: Angela Monaghan, Charlotte Dyson, Jackie Craven, Bill Barkworth, Neil Alexander, Bob Clayden, Paul Williams, Lisa Hogarth, Ruth Mason

South West Yorkshire Partnership NHS Foundation Trust

Members' Council
2 November 2018

Agenda item:	**7.1**
Report Title:	**Governor appointment to Members' Council groups and committee**
Report By:	Chair of the Trust / Company Secretary on behalf of the Members' Council Co-ordination Group
Action:	For approval

EXECUTIVE SUMMARY

Purpose

The purpose of this paper is to propose a process to the Members' Council for approval regarding how governors become members of its sub-groups. The paper also proposes the establishment of consistent member numbers across the Members' Council Co-ordination Group and Members' Council Quality Group, with all governors still welcome to be in attendance and participate even if they are not a 'formal' member of these two groups. The objectives of the changes are to address the current lack of clarity about appointment to the groups, to make the appointment process more transparent, and to ensure effective operation of the groups, whilst maintaining a commitment to openness and inclusion.

Recommendation

The Members' Council is asked to APPROVE the recommendation from the Members' Council Co-ordination Group on the process for the appointment of governors onto the sub-groups and committee and changes to the membership numbers on the sub-groups.

Background

There are two-sub groups and one committee of the Members' Council as follows:

- **Members' Council Co-ordination Group** - which supports the Chair in setting the agenda for Members' Council meetings, and the induction and development of governors.
- **Members' Council Quality Group** - which looks at the Trust's quality performance report, patient experience, Quality Accounts and other quality issues.
- **Nominations' Committee** - which ensures the right composition and balance of the Board and oversees the process for the appointment the Chair and Non-Executive Directors (NEDs), Deputy Chair / Senior Independent Director, and the Lead Governor.

In addition, there is also an Equality & Inclusion Forum of the Trust Board which has a governor member.

The attached paper outlines a proposed process for appointment of governors to the groups and committee and recommends changes to the current number of governor members on the Co-ordination Group and Quality Group.

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Governor appointment to Members' Council groups and committee

Previously there has been no formal process for appointing governors to the Members' Council sub-groups. To assist with establishing an open and transparent process to encourage membership and attendance, a proposal was discussed by the Members' Council Co-ordination Group meeting on 6 June 2018 and 3 September 2018 and is outlined below for approval by the Members' Council.

Proposed process for appointment

When vacancies arise, the proposed process for appointment recommended is a shortened version of the process for the appointment of the Lead Governor, which has been in place since 2009.

Step 1	When a vacancy arises, governors are invited to self-nominate, supported by a brief verbal or written statement about why they are putting themselves forward. If only one self-nomination is received, they will automatically fill the vacancy, otherwise the process will move to Step 2.
Step 2	If more than one self-nomination is received for a vacancy, the Members' Council Co-ordination Group will discuss the self-nominations supported by input from the Chair and make a recommendation to the full Members' Council.

The recommended term of membership on a group for any new members will be for three (3) years to allow for consistency of membership. If a governor wishes to stand down from a group, or is not re-elected / re-appointed as a governor on the Members' Council during the three years, the above process would take place to fill the vacancy.

It is expected that governors are a member of only one group to allow opportunities for more governors to be involved, however if sufficient membership is not reached through the self-nomination process this would be extended to two.

Current members on all groups would remain until the end of their governor term or until they step down.

All governors continue to be welcome to attend and participate at the Members' Council Co-ordination Group and Members' Council Quality Group even if they are not 'formal' members. Non-members would not normally attend the Nominations' Committee, for reasons of confidentiality, unless invited by the Chair.

Membership numbers

<u>Members' Council Co-ordination Group</u>

The current membership is 7 x governors. There are no specific skills required to be a member. The current breakdown of governor membership is as follows:

- Lead Governor. *Note,this is a requirement of the Lead Governor role.*
- 4 x Public governors (1 x vacancy)
- 1 x Staff governor (1 x vacancy)
- 1 Appointed governor

It is recommended that the membership be increased by 1 x Public governor for the Rest of South and West Yorkshire so there is a member from each of the five public constituencies (Barnsley, Calderdale, Kirklees, Wakefield, Rest of South and West Yorkshire).

All governors continue to be welcome to attend the Members' Council Co-ordination Group even if they are not 'formal' members.

Members' Council Quality Group

The current membership is 9 x governors. There are no specific skills required to be a member of the Group. The current breakdown of governor membership is as follows:

- Lead Governor. *Note, this is a requirement of the Lead Governor role.*
- 5 x Public governors
- 2 x Staff governors (1 x vacancy)
- 1 x Appointed governor (1 x vacancy)

It is recommended that when vacancies arise for Public governors that they are re-aligned to one member from each of the five public constituencies (Barnsley, Calderdale, Kirklees, Wakefield, Rest of South and West Yorkshire) and 1 x Staff governor to be consistent with the Co-ordination Group.

All governors continue to be welcome to attend the Members' Council Quality Group even if they are not 'formal' members.

Nominations Committee

There are a set number of governor members which is consistent with national guidance, therefore no change to the number of members is proposed. It is a requirement for the governor members of the Committee to undertake recruitment training, which is provided by the Trust. The Committee membership of governors is as follows:

- Lead Governor. *Note, this is a requirement of the Lead Governor role.*
- 1 x Public governor
- 1 x Staff governor
- 1 x Appointed governor

Equality & Inclusion Forum

This is a forum of the Trust Board and the Board is responsible for appointing members. Membership on Trust Board committees and forums is reviewed annually in April as part of the annual review of their Terms of Reference. There is currently 1 x Public governor member on the Forum whose term ends in April 2020.

In the event of a vacancy, the same appointment process outlined above for the Groups and Committee could be followed, with the difference being that the final decision would be made by Trust Board rather than the Members' Council. It is desirable for the governor member of the Forum to have knowledge/experience/interest in equality and inclusion matters, but not essential.

South West Yorkshire Partnership NHS Foundation Trust

Members' Council
2 August 2019

Agenda item:	**7.2**
Report Title:	**Annual Report, accounts and Quality Account 2018/19**
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 2018 to 31 March 2019 which were approved by the Trust Board on 23 May 2019.

Recommendation

The Members' Council is asked to RECEIVE the Annual Report, accounts and Quality Account for 2018/19.

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 2018/19 for approval at its meeting on 21 May 2019. The report and accounts with supporting documents were submitted to NHS Improvement in line with the national timetable and were laid before Parliament on 26 June 2019.

Outcome

Annual report 2018/19

- 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 2018/19

- The Audit Committee considered the report from the Director of Finance & Resources on the final accounts (summary 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 of resource risk rating from NHS Improvement of 2. The Trust received an unqualified audit opinion on the 2018/19 accounts and a positive opinion on the requirement to demonstrate Value for Money.
- The Head of Internal Audit Opinion for 2018/19 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 2018/19 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 21 May 2019 (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 cardio metabolic assessment. No significant issues were identified from the work carried out by Deloitte.
- The Trust Board approved the Quality Report for 2018/19.

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 summary report on the accounts for 2018/19;
- the Director of Finance's report on the year end process and submissions for 2018/19;
- 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 2018/19 will be published on the Trust's website on 31 July 2019 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 2 August 2019

2018/19 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 by Deloitte LLP. The documents became publicly available documents once laid before parliament, which occurred towards the end of June. 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 30 April 2019 and then reviewed by the Audit Committee on 21 May 2019 before being approved by the Trust Board on the 23 May 2019. 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 (IFRS) and followed guidance and instruction provided by NHS Improvement. The draft accounts were shared with the qualified accountant 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) and Audit Committee for comment and feedback.

The accounts were subject to audit by Deloitte LLP and to a review at the Audit Committee on 21 May and were approved at the Trust Board on 23 May 2019. Signature took place on 23 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 21 May 2019 and approved at the Trust Board on 23 May 2019. Signature again took place on 23 May 2019. The report was then submitted to NHS Improvement.

Quality Account

The Quality Account 2018/19 was produced in line with the requirements of both the Department of Health, ***'Quality Account Toolkit (2010)***' and NHSI, '***Detailed requirements for quality reports'*** (2019).

The production of the quality account report is a year -long process. Quality priorities were agreed by EMT (2018), 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 corporate 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 2018/19'.*** 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 23 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.

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Members' Council 2 August 2019

Annual Accounts – 2018/19

Introduction

The purpose of this paper is to provide the Members' Council with a brief summary of some key numbers and movements in the 2018/19 annual accounts. It is designed to accompany the annual accounts, which will be presented more fully at the Annual Members' Meeting scheduled for September 16th. At this point it is worth the Members' Council being aware of the fact the Trust achieved its financial targets in 2018/19 against the continuing challenging background of lower core income, cost pressures and increase demand for services.

Income

Total income was £224.8m, which compares to £222.9m in the previous year, an increase of just under 1%. There were a number of movements in income year on year which are worth noting. Following achievement of our financial targets the Trust was ultimately entitled to £4.7m of Provider Sustainability Funding (PSF) which compares with £2.9m in the previous year. In addition we received £1.25m of unbudgeted income from our commissioners in the year, with more than half of this supporting the out of area beds overspend in Kirklees and Calderdale. Income relating to community health services reduced in the year by £3.9m with the full year impact of prior year reductions along with decommissioning and other service changes in year the reasons for this. Income of £2.5m was also received in year to pay for staff pay increases over and above what was originally assumed in our plan. Education and training income was largely unchanged.

Operating Expenses

Operating expenses increased from £215.5m in 2017/18 to £231.0m in 2018/19. £12.5m or 81% of this movement was related to a reduction in the value of some of the Trust's land and buildings. Pay costs moved from £166.3m to £167.7m with savings associated with income reductions, vacancies and cost efficiencies being offset by the annual pay award and use of agency and bank staff to cover vacancies.

Operating Surplus and Total Comprehensive Income

The operating deficit position is a little confusing to report. The Members' Council will be aware that at each meeting the Director of Finance has provided an update of how well the Trust is performing against its control total target of £2.0m deficit. The Trust actually delivered an improved performance against this target by achieving a £1.6m deficit. The net deficit as shown in the accounts was a deficit of £23.4m which compares to a £12.6m surplus in the previous year. A reconciliation between the deficit in the annual accounts and the management accounts has been provided to the Audit Committee, but is simply explained in the table at the end of this section. The main difference between the two numbers is the impact of revaluations of our land and buildings in the year. In total this amounted to £26.5m and is what is technically referred to as

impairments. As this is not something within the Trust's direct control nor does it impact on the day to day running and financing of the Trust it is most important to focus on the £1.6m deficit to understand how the Trust is performing financially. This is the number our regulators focus on and also what the Trust can influence itself.

Total Comprehensive Income	(£23.4m)
Impairments & Revaluations	£14.6m
Net Impairments	£11.9m
Provider Sustainability Funding (PSF)	(£4.7m)
Pre PSF Deficit in management accounts	(£1.6m)

.

Employee Costs and Numbers

Total employee costs increased in the year from £166.3m to £167.7m with the main movements explained in the above section relating to operating expenses. Substantive pay costs increased by £0.9m year in year whilst average staff numbers employed reduced from 4,124 to 4,039. On average 11.6 days were lost per member of staff to sickness last year which compares to 11.8 days in 2017/18.

Within the year there were 6 compulsory redundancies which cost £308k.

Asset Valuations

Taking into account asset additions, disposals, impairments, revaluations and depreciation the net book value of fixed assets decreased from £123.8m to £100.0m in the year. As previously identified the most significant reason for this move was a downward revaluation of our land and buildings. In addition it is worth noting there were £8.3m of asset additions in 2018/19.

Current Assets and Cash

The end of year cash position showed a small increase compared to the previous year at £27.8m with total current assets showing an increase of £3.9m year on year moving from £34.9m to £38.9m. Trade and other receivables increased by £2.7m from £8.1m to £10.8m. The cash position was boosted by £1.3m of asset disposals.

Current Liabilities

Current liabilities increased from £20.9m to £24.0m year on year with the most notable increase seen in trade payables.

As a consequence of the current asset and liabilities positions net current assets position shows a modest improvement against the prior year at £14.8m compared to £14.0m.

Deloitte.

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Final report to the Audit Committee on the 2018/19 audit

Issued on 17 May 2019 for the meeting 21 May 2019

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01 Final report

02 Appendices

Partner 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 2018/19 audit.
I would like to draw your attention to the key messages within this paper:

Status of the audit	Our audit is substantially complete subject to completion of the following principal matters: • completion of internal quality assurance procedures; • Whole of Provider Accounts reporting; • receipt and checking of final, updated, financial statements and annual report; • our review of events since 31 March 2019; and • receipt of signed management representation letter. 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 based on our work to date. Unadjusted audit misstatements are detailed on page 16. • 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.

Partner introduction
The key messages in this report (continued)

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.

Financial sustainability and Value for Money	The Trust reported an overall deficit for the year of £8.6m, including PSF income of £4.7m. • CIP delivery was £10.6m against a £9.7m target; • The Trust has a Single Oversight Framework segmentation of 1 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.
Quality Accounts	• Based on the current status of our audit work, we plan 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.

Paul Hewitson
Lead audit director

Responsibilities of the Audit Committee

Helping you fulfil your responsibilities as an Audit Committee

Why do we interact with the Audit Committee?

- To communicate audit scope
- To provide timely and relevant observations
- To provide additional information to help you fulfil your broader responsibilities

As a result of regulatory change in recent years, the role of the Audit Committee has significantly expanded. We set out here a summary of the core areas of Audit Committee responsibility to provide a reference in respect of these broader responsibilities and highlight throughout the document where there is key information which helps the Audit Committee in fulfilling its remit.

Oversight of external audit

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

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.
- Assess Quality Accounts disclosures and reporting.
- Consider the content of the Annual Governance Statement.

Internal controls and risks

- 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 Trust and environment

In our planning report we identified the key changes in your business and articulated how these impacted our audit approach.

Scoping

We have performed our risk assessment in line with current NHSI requirements and our audit plan.

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

When planning our audit we set our Group materiality at £4.269m based on approximately 2% of planned incoming resources. Materiality has changed since our planning report to £4.5m (PY: £4.46m) still based on 2% of group incoming resources. We report to you in this paper all misstatements above £225k (PY: £221k).

Significant risk assessment

In our planning report we explained our risk assessment process and detailed the significant risks we have identified on this engagement. We report our findings and conclusions on these risks in this report. No additional risks have been identified since our audit plan.

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	Consistency of judgements with Deloitte's expectations	Expected to be included as a key audit matter in our audit report	Slide no.
Valuation of Provisions	✓	✓	D+I	Satisfactory	●	✓	8
Accounting for property valuations	✓	✗	D+I	Satisfactory	●	✓	9
Management override of controls	✓	✓	D+I	Satisfactory	●	✗	10

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

Risk 1 – Valuation of Provisions

Risk identified	At the end of the prior year the Trust held a material balance of provisions (£6.490m) with £3.708m of this related to redundancy provision mainly in relation to the ongoing service changes within the Barnsley area. Discussions with management indicate that there is an expectation that provisions will be released in the year as there is an expectation that the Barnsley position will crystallise and this is the significant part of the current provision. There are also further CIP plans that require redundancy of individuals however, timings have yet to be finalised. We therefore conclude that there is significant management judgement involved in the continued recognition and valuation of this provision.

Deloitte response	We have:
	• Identified and tested the processes and controls that management have put in place to;
	  • Consider the recognition criteria for provisions set out in IAS37 and determine whether the criteria continue to be met at the year end,
	  • Identify the staff impacted by the decommissioning of the service,
	  • Estimate the value of the provision required for redundancy payments connected to the staff impacted.
	• Reviewed the status of the Barnsley service negotiations and determine whether redundancy provisions are required;
	• Obtained evidence that provisions have been recognised in accordance with IAS37 and continue to require recognition;
	• Reviewed the provisions recognised in the prior year and derecognised in the year to ensure that the circumstances which gave rise to the provision have changed sufficiently to require derecognition; and
	• Tested the calculation of the provision and challenge any material estimates or judgements inherent in the valuation.

Conclusion	We have completed our testing, and note one judgemental difference totalling £132k which would increase the provisions balance.
Draft audit report findings	We have made reference to this risk in our audit report because it had a significant effect upon our overall audit strategy, allocation of resources, and direction of the efforts of the team.

Significant audit risks

Risk 2 – Accounting for property valuations

Risk identified	The Trust held £114.1m of property assets (land and buildings) at 31 March 2018 which increased from £100.0m as at 31 March 2017 following the updated revaluation. In 2018/19 the Trust commissioned the District Valuer (DV) to perform a full revaluation of estate, to implement amendments to the existing MEAV-AS design and is considering making changes to the basis of estimating the fair value of the estate. The complexities of the model, and in the required accounting transactions, mean that there is a risk concerning the valuation of the property assets and any UEL's subsequently adopted.
Deloitte response	We have: • examined the terms of engagement of the valuer, the instructions issued and the management controls within the Trust concerning the receipt, review and acceptance of the DV's report; • reviewed the MEAV – AS assumptions and sought to corroborate the assumptions made against the Trust's estate's strategy and existing gross internal area information; • used our valuation specialists, Deloitte Real Estate to review and challenge the appropriateness of the assumptions used in the year-end valuation of the Trust's properties; • challenged managements assessment that the DV reported values, which were dated 1 April 2018 and 31 December 2018, remained valid as at 31 March 2019; • commented in our reporting upon the key assumptions used in the valuation; and • examined the accuracy on a sample basis of the posting of the valuations to the general ledger and financial statements.
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 2018 to 31 March 2019. In reviewing the Trust calculations of the impairment to be recognised in operating expenditure we noted a small number of errors, totalling £180k, which understate the balance recognised in expenditure.
Draft audit report findings	We have made reference to this risk in our audit report because it had a significant effect upon our overall audit strategy, allocation of resources, and direction of the efforts of the team.

Significant audit risks

Risk 3 - 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 risks overstatement of provisions and valuation of the Trust's estate. These are inherently areas in which management has the potential to use their judgment to influence the financial statements.
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 finished our work in relation to journals, and note no issues. From our work to date 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 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 2018/19	Plan 2018/19	Variance	Plan 2019/20	Prior year 2017/18
Surplus (before impairments)	£3.2m	£0.6m	£2.5m	£1.5m	£4.0m
EBITDA margin	4.4%	4.6%	+0.2%	4.2%	5.7%
CIP target and identified to date	£10.6m	£9.7m	+£0.9m	£10.6m	£7.5m
Single Oversight Framework (finance rating)	1	1	0	1	1
CQC report conclusions	Requires Improvement				

Risk Assessment work performed

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

- "high level" interviews with key members of 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) and the 2018/19 Annual Plan;
- review of the Care Quality Commission's report on the Trust dated July 2018;
- review of NHSI's risk ratings;
- benchmarking of the Trust's performance

Conclusion

We have not identified any specific risks in respect of Value for Money.

Other significant findings

Internal control and risk management

During the course of our audit we have not identified significant internal control and risk management findings, which we have included below for information.

Area	Observation	Priority
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

Areas for monitoring in relation to our Value for Money Conclusion

Areas of monitoring	As part of our planning work and discussions with the Trust we noted three areas of monitoring which were potentially relevant to our Value for Money conclusion, these were: switch from RiO to SystmOne, CIP delivery and responding to the CQC comments.
Conclusion	We monitored these areas throughout the year and, based on this work, we did not consider that any of these areas of crystallised into specific risks and therefore there are no issues identified that would have an impact on the Value for Money conclusion.

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 (UK) 260 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.
- Other insights we have identified from our audit.

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.

The scope of our work

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

We described the scope of our work in our audit plan.

Use of this report

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.

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

Deloitte LLP

Newcastle Upon Tyne

17 May 2019

Appendices

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). The net impact of these is an increase of £467k in the deficit 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 – update to valuation	[1]		1.584		(1.584)	
Aggregation of misstatements individually < £0.225m						
Misstatements less than £0.225m		0.467	(0.288)		(0.179)	
Total		**0.467**	**1.296**		**(1.763)**	

(1) Judgemental difference noted on revaluation movement indices between the valuation date (31 December) and year end (31 March).

As part of the agreement of balance work, we note that there is a range of uncertainty. Whilst all differences are clearly trivial, on the debtors and creditors, there is a margin of uncertainty of £1.011m and on income and expenditure there is a margin of uncertainty of £1.441m. This is not raised as an error but is noted here as a range of uncertainty as a result of the agreement of balance process.

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).

Disclosure	Summary of disclosure requirement	Quantitative or qualitative consideration
Up to the date of this report 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
Up to the date of this report 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 fraud 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 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.

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), 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 of the Group and our objectivity is not compromised.
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 2018/19.
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.

The professional fees earned by Deloitte in the period from 1 April 2018 to 31 March 2019 are as follows:

	Current year £	Prior year £
Audit of Trust (including WGA)	45,672	45,672
Total audit fees	**45,672**	**45,672**
Quality Accounts	5,000	5,000
Independent examination of the Charity	828	828
Total fees	**52,500**	**52,500**

Sector benchmarking

Sector benchmarking

We have reviewed the Trust's performance to 31 March 2019.

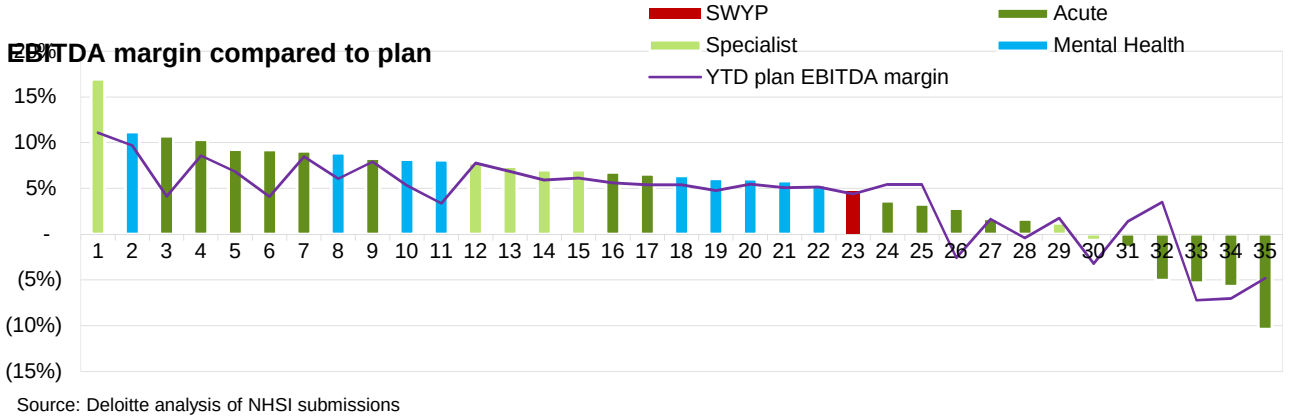
Our audit process includes an on-going assessment of internal and external factors affecting the Trust. This includes considering the Trust's actual and planned performance on financial, quality and other governance metrics compared to its peers, to enable us to identify and understand risks specific to the Trust.

We have summarised for the Audit Committee some of the comparisons we have performed as part of our concluding analytical procedures, comparing the Trust's performance to 31 March 2019 to other trusts we audit and national data from NHS Improvement.

The table below shows how the Trust's results compare to other trusts we audit:

(£m)	Trust Actual	Trust Plan	Trust Variance	MH Actual	Acute+ Specialist Actual	All Trusts average Actual
Operating income	224.6	214.7	9.9	179.5	494.2	395.3
EBITDA	10.4	9.4	1.0	12.0	19.3	17.0
EBITDA (%)	4.6%	4.4%	0.3%	7.0%	4.0%	4.9%
Surplus/deficit	(8.7)	0.6	(9.3)	3.1	4.2	3.8
Performance against control total	2.5	-	2.5	2.8	0.4	1.2

The chart below shows EBITDA margin for trusts we audit, compared to plan. The Trust's EBITDA of £10.4m compared to plan of £9.4m gives an EBITDA margin of 4.6%. This compares to an average margin for mental health trusts of 7% and all types of trust of 4.9%.



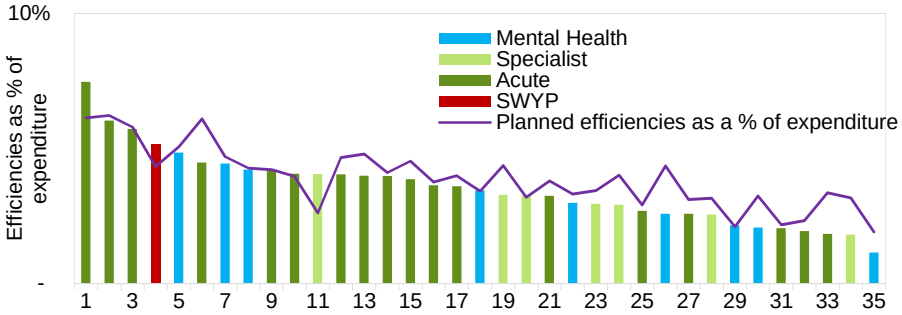
Source: Deloitte analysis of NHSI submissions

Sector benchmarking

The sector is behind plan on delivery of efficiency savings. The trust has exceeded the planned level of savings for the year.

Nationally, providers delivered £2.1 billion of savings through efficiency (cost improvement programmes (CIPs) and revenue generation schemes during the first three quarters of the year, of which £1.5bn (71%) were from recurrent schemes. Overall, the sector forecast to finish the year was £313m behind plan with £3.3bn of savings, an increase of 3.6% of spend, compared to 3.1% for the first three quarters of the year.

Achieved efficiencies - year to 31 March 2019

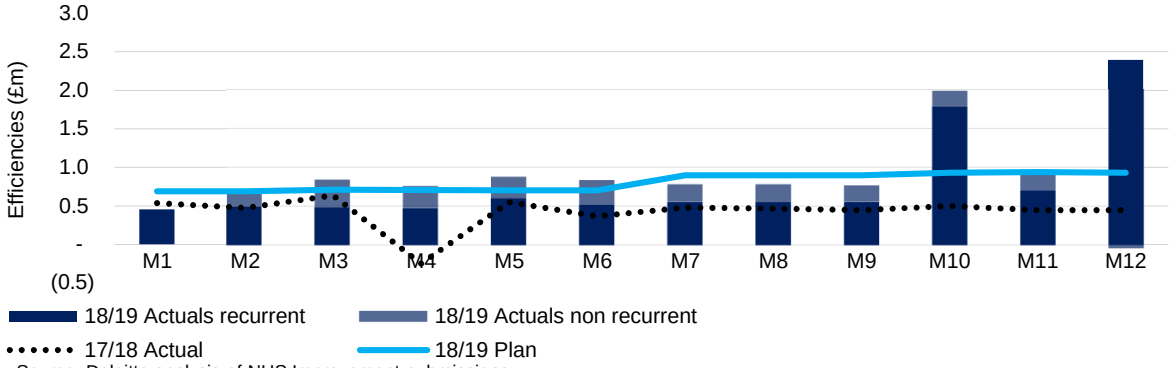


Source: Deloitte analysis of NHSI submissions

Efficiencies (including revenue schemes) %/£m	Trust	Mental Health Trusts	Acute and Specialist trusts	All Trusts
Planned efficiencies - YTD to 31 March 2019	9.7	6.8	18.5	14.8
Actual efficiencies - YTD to 31 March 2019	12.0	6.1	17.1	13.6
Actual as % of plan - YTD to 31 March 2019	123.9%	90.1%	92.3%	92.0%
Recurrent efficiencies as % of total to date	79.6%	69.4%	72.0%	71.6%
Plan CIPs as % of operating expenses	4.6%	4.1%	3.9%	3.9%
Actual CIPs as % of operating expenses	5.2%	3.5%	3.5%	3.5%

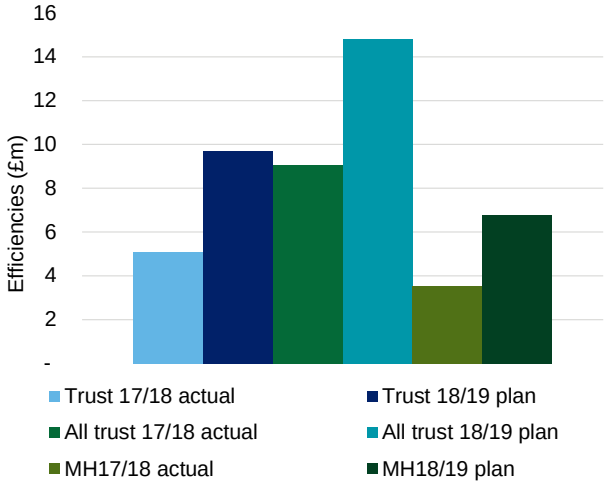
On average, the trusts reviewed had planned to achieve efficiencies of 3.9% of operating expenses in 2018/19 (the Trust planned savings of 4.6%). The Trust has achieved efficiencies of 5.2% of operating expenses, £2.3m above plan.

Efficiencies



Source: Deloitte analysis of NHS Improvement submissions

Efficiencies



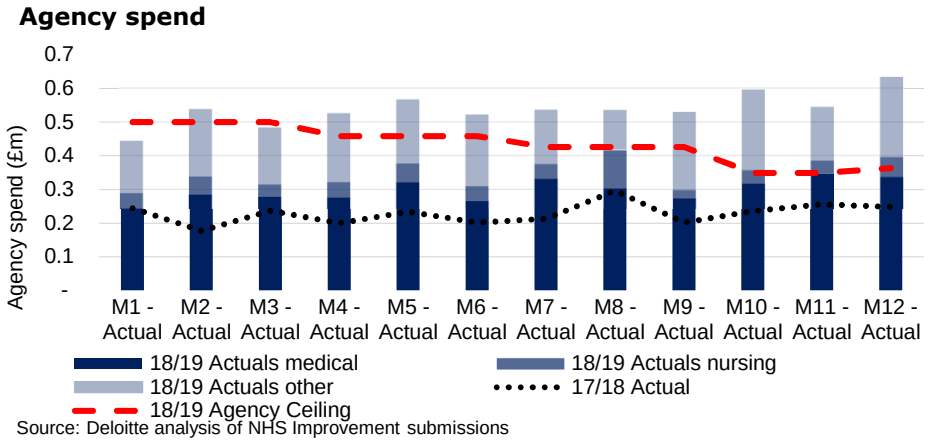
Source: Deloitte analysis of NHS Improvement submissions

Sector benchmarking

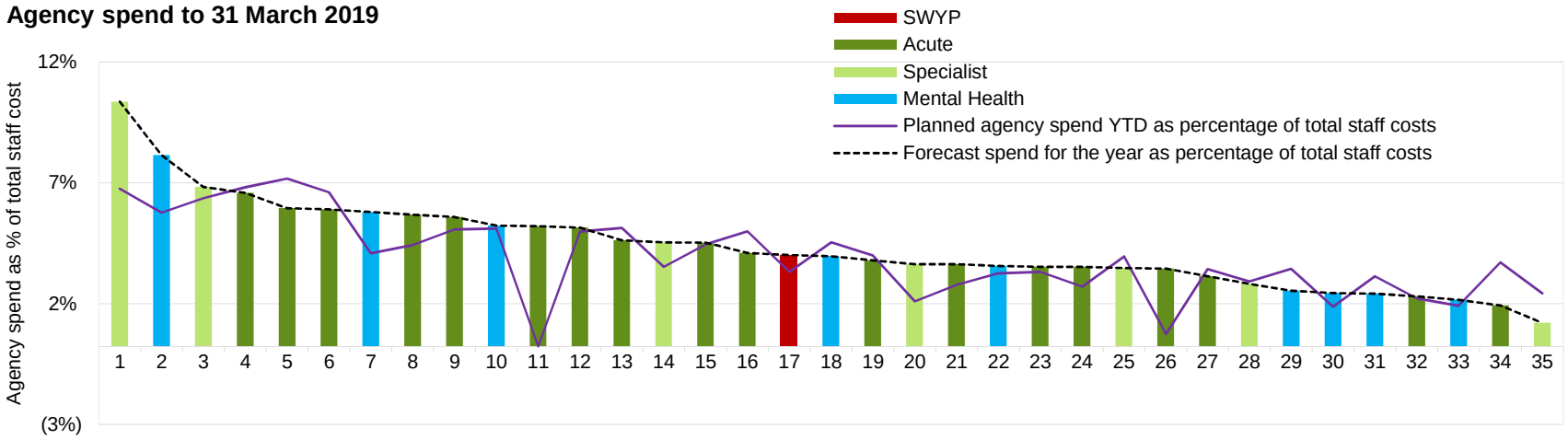
Most trusts have not delivered their planned pay savings. The Trust has achieved 89.1% of planned pay savings.

The main contributor to spending variances nationally are higher than planned pay costs. On average, trusts we audit achieved 76.7% of planned pay efficiencies compared to 89.1% for the Trust.

The Trust's agency costs of £6.5m year to date, compared to plan of £5.2m and an agency ceiling of £5.2m. The Trust's agency spend year to date is 3.8% of staff costs, compared to an average of 4.2% for trusts we audit and 4.0% for other Mental Health trusts.



Source: Deloitte analysis of NHS Improvement submissions



Source: Deloitte analysis of NHSI submissions

Sector benchmarking

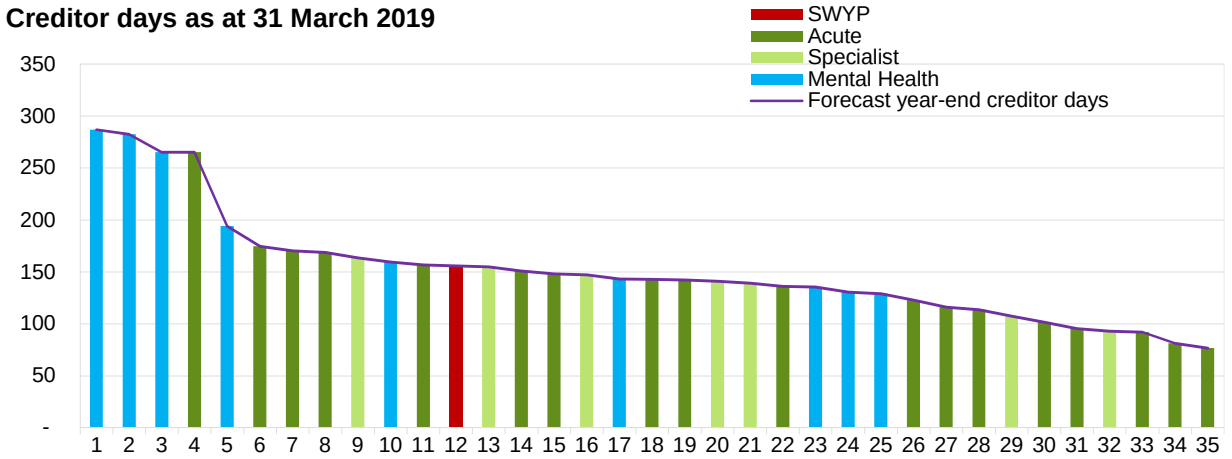
Although the sector has experienced increasing working capital pressures, most cash balances for trusts we audit are ahead of plan.

The charts to below and on the next page, show how the Trust's debtor and creditor days, as well as cash variance to plan, compare to other trusts we audit. The charts on the following page provide additional analysis on debtor aging at 31 March 2019.

The Trust's year-end cash balance was £27.8m, £9.8m above plan of £18m and £1.3m above 31 March 2018 balance of £26.6m. On average mental health trusts were £3.5m ahead of plan, and all trusts we audit were £8.9m ahead of plan.

The Trust debtor days at 31 March 2019 were 18 days compared to an average for mental health trusts of 27 and for all trusts of 37 days (31 March 2018: 35).

The Trust creditor days at 31 March 2019 were 156 days compared to an average for mental health trusts of 186 and for all trusts of 151 days (31 March 2018: 147).

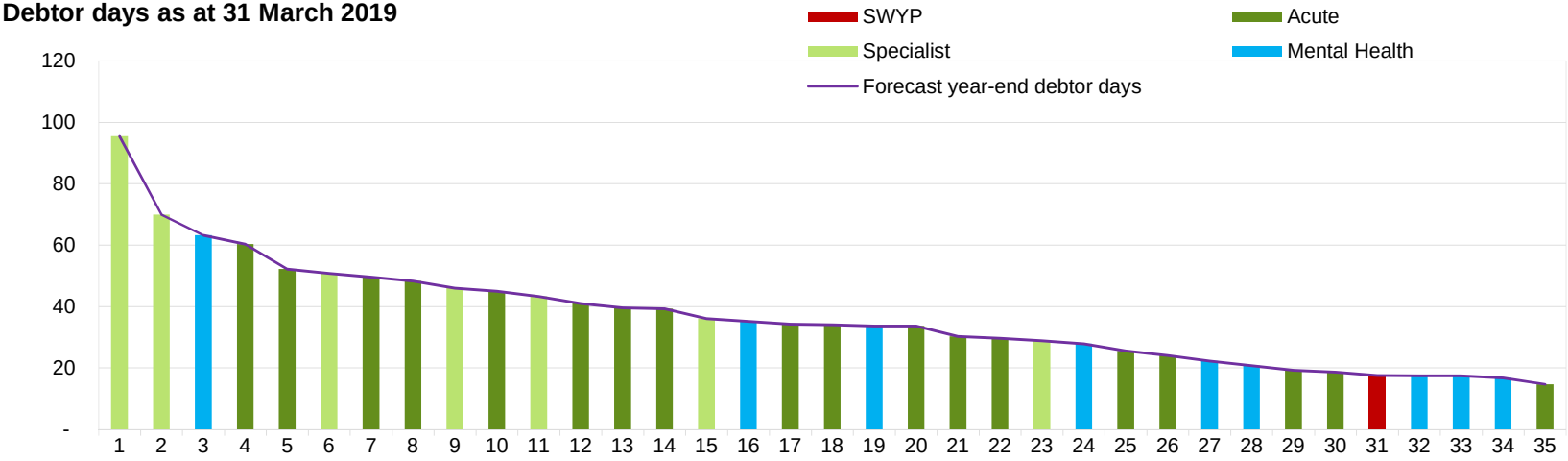


Source: Deloitte analysis of NHSI submissions

Sector benchmarking

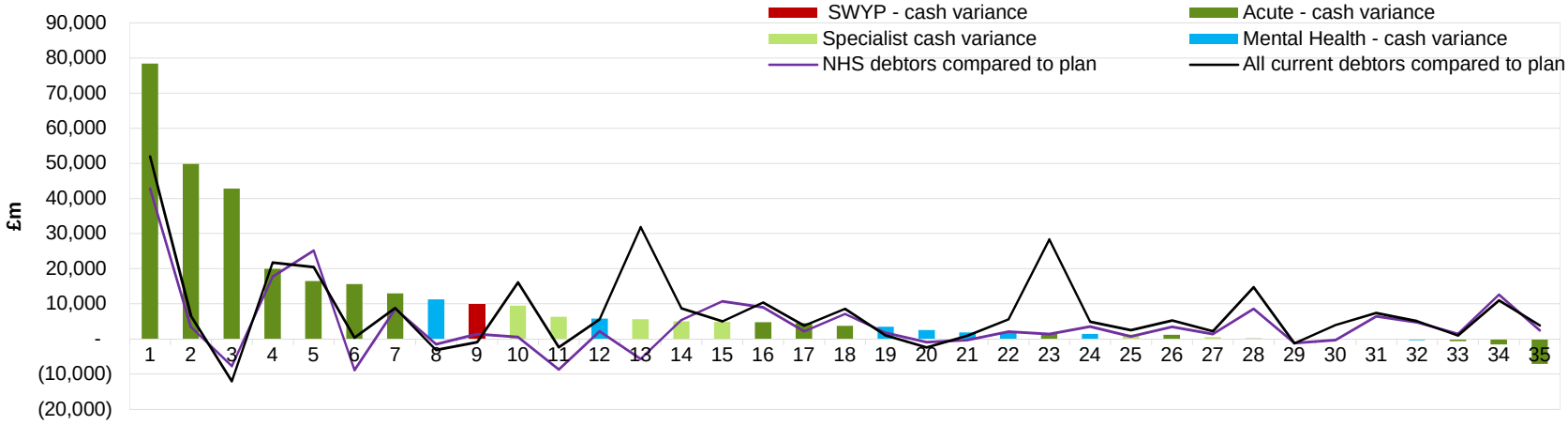
Although the sector has experienced increasing working capital pressures, most cash balances for trusts we audit are ahead of plan.

Debtor days as at 31 March 2019



Source: Deloitte analysis of NHSI submissions

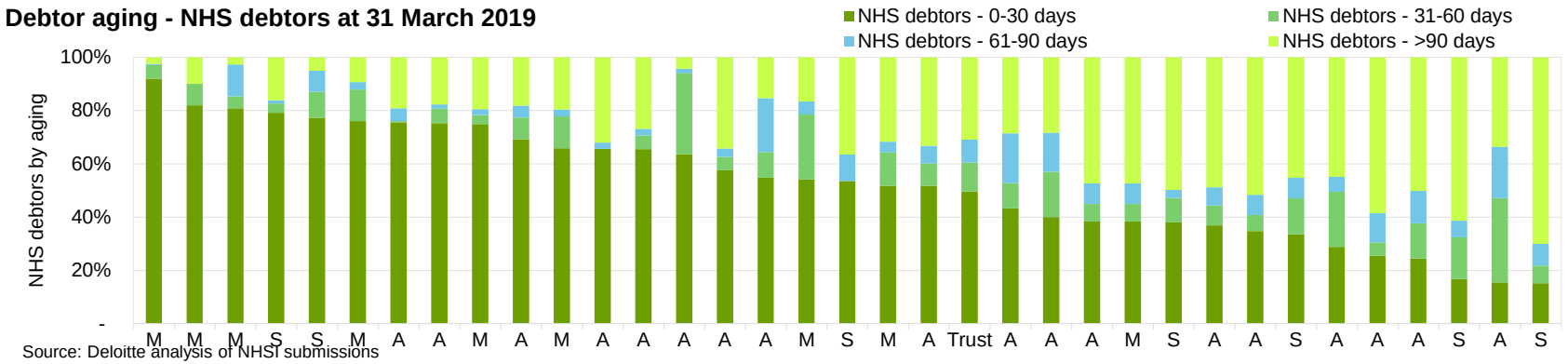
Cash variance to plan as at 31 March 2019



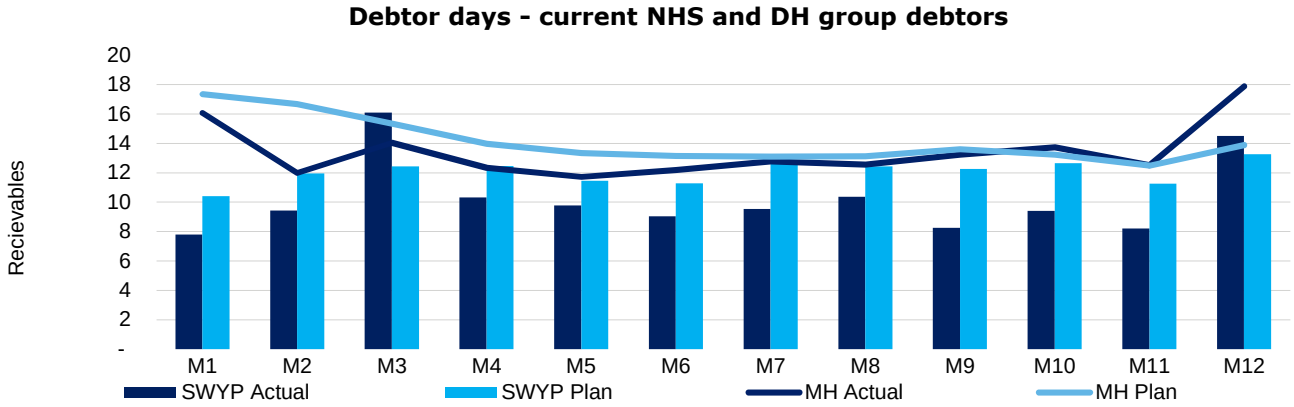
Source: Deloitte analysis of NHSI submissions

Sector benchmarking

Although the sector has experienced increasing working capital pressures, most cash balances for trusts we audit are ahead of plan.



Source: Deloitte analysis of NHSI submissions



Legend:

A = Acute

M = Mental Health

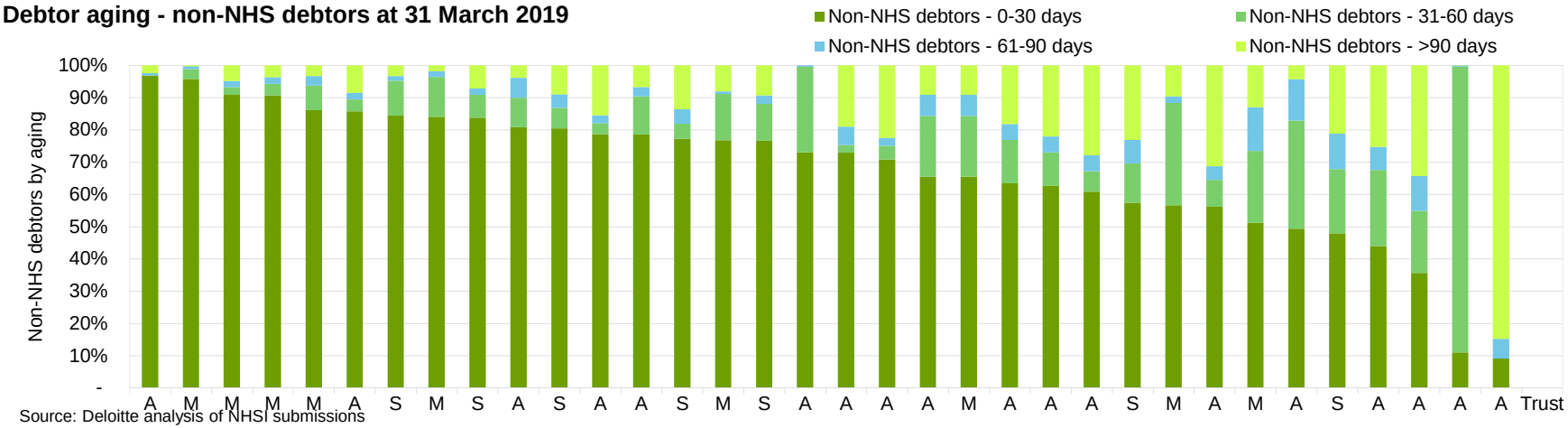
S = Specialist

Source: Deloitte analysis of NHS Improvement submissions. Debtor days calculated on monthly income from patient care activites, which excludes other operating income (including STF income) .

Sector benchmarking

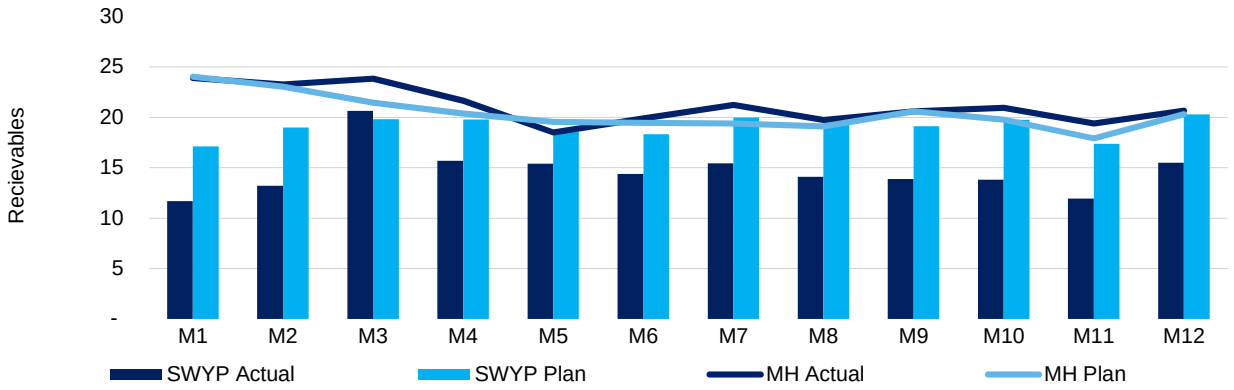
Although the sector has experienced increasing working capital pressures, most cash balances for trusts we audit are ahead of plan.

Debtor aging - non-NHS debtors at 31 March 2019



Source: Deloitte analysis of NHSI submissions

Debtor days - total current trade and other receivables



Legend:

A = Acute

M = Mental Health

S = Specialist

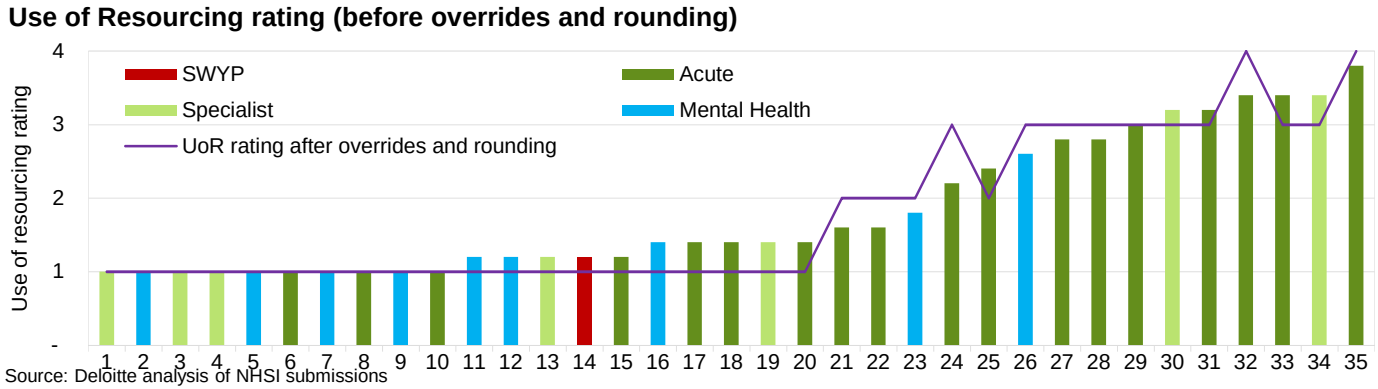
Source: Deloitte analysis of NHS Improvement submissions. Debtor days calculated on monthly income.

Sector benchmarking

Single Oversight Framework Risk Rating

The Trust has a risk rating at 31 March 2019 of 1. The table and chart below show how this compares to other trusts we audit.

Results for year to 31 March 2019	Trust Plan	Trust Actual	Mental Health Actual	All trusts Actual
Capital service cover metric	1.0	1.0	1.3	2.1
Liquidity metric	1.0	1.0	1.3	1.9
I&E Margin metric	2.0	1.0	1.2	1.9
I&E Variance from plan metric		1.0	1.0	1.4
Agency staff use vs provider cap metric		2.0	2.1	1.9
Overall rating (before rounding and overrides)		1.2	1.4	1.8
Rating after overrides		1.0	1.4	1.8



Source: Deloitte analysis of NHSI submissions

Deloitte.

Deloitte LLP is a limited liability partnership registered in England and Wales with registered number OC303675 and its registered office at 2 New Street Square, London, EC4A 3BZ, United Kingdom.

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STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2019

		Group		Trust	
	note	Year Ended 31 March 2019 £000	Year Ended 31 March 2018 £000	Year Ended 31 March 2019 £000	Year Ended 31 March 2018 £000
Operating income from patient care activities	5	207,321	208,032	207,321	208,032
Other operating income	5	17,460	14,848	17,279	14,760
Operating Expenses	6	(230,959)	(215,451)	(230,784)	(215,246)
Operating surplus / (deficit)		**(6,178)**	**7,429**	**(6,184)**	**7,546**
Finance costs:					
Finance income	10	162	66	161	65
PDC Dividends payable		(3,156)	(3,393)	(3,156)	(3,393)
NET FINANCE COSTS		**(2,994)**	**(3,327)**	**(2,995)**	**(3,328)**
Gains/(losses) on disposal of assets	13	500	425	500	425
SURPLUS/(DEFICIT) FOR THE YEAR		**(8,672)**	**4,527**	**(8,679)**	**4,643**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	27	(14,707)	(1,719)	(14,707)	(1,719)
Revaluations	27	0	9,841	0	9,841
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**(23,379)**	**12,649**	**(23,386)**	**12,765**

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 40 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2019	note	Group 31 March 2019 £000	Group 31 March 2018 £000	Trust 31 March 2019 £000	Trust 31 March 2018 £000
Non-current assets					
Intangible assets	14	108	231	108	231
Property, plant and equipment	15	99,737	123,419	99,737	123,419
Investment Property	16	160	160	160	160
Total non-current assets		**100,005**	**123,810**	**100,005**	**123,810**
Current assets					
Inventories	20	259	232	259	232
Trade and other receivables	21	10,785	8,132	10,787	8,134
Non-current assets for sale and assets in disposal groups	17	0	0	0	0
Cash and cash equivalents	22	28,371	27,108	27,823	26,559
Total current assets		**39,415**	**35,472**	**38,869**	**34,925**
Current liabilities					
Trade and other payables	23	(19,844)	(16,917)	(19,817)	(16,882)
Provisions	25	(3,939)	(3,377)	(3,939)	(3,377)
Other liabilities	23	(276)	(670)	(276)	(670)
Total current liabilities		**(24,059)**	**(20,964)**	**(24,032)**	**(20,929)**
Total assets less current liabilities		**115,361**	**138,318**	**114,842**	**137,806**
Non-current liabilities					
Provisions	25	(3,282)	(3,113)	(3,282)	(3,113)
Total assets employed		**112,079**	**135,205**	**111,560**	**134,693**
Financed by					
Taxpayers' equity					
Public Dividend Capital		44,222	44,015	44,222	44,015
Revaluation reserve	27	9,453	24,938	9,453	24,938
Other reserves		5,220	5,220	5,220	5,220
Income and expenditure reserve		52,665	60,520	52,665	60,520
Others' equity					
Charitable fund reserves		519	512	0	0
Total taxpayers' and others' equity		**112,079**	**135,205**	**111,560**	**134,693**

The financial statements on pages 2 to 40 were approved by the Board of Directors and authorised for issue on the 21 May 2019 and signed on their behalf by:

Signed……
Rob Webster Chief Executive Date 23 May 2019

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED		Group		Trust	
31 March 2019		**Year Ended 31 March 2019**	**Year Ended 31 March 2018**	**Year Ended 31 March 2019**	**Year Ended 31 March 2018**
	note	**£000**	**£000**	**£000**	**£000**
Cash flows from operating activities					
Operating surplus/(deficit) from continuing operations		(6,178)	7,429	(6,184)	7,546
Operating surplus/(deficit)		**(6,178)**	**7,429**	**(6,184)**	**7,546**
Non-cash income and expense:					
Depreciation and amortisation	6	4,741	5,853	4,741	5,853
Net Impairments	6	11,856	(613)	11,856	(613)
Income recognised in respect of capital donations (cash and non-cash)		0	0	0	0
(Increase)/Decrease in receivables	21	(2,558)	516	(2,558)	539
(Increase)/Decrease in Inventories	20	(27)	(66)	(27)	(66)
Increase/(Decrease) in Trade and Other Payables	23	3,007	(1,355)	3,007	(1,355)
Increase/(Decrease) in Other Liabilities	23	(394)	(84)	(394)	(84)
Increase/(Decrease) in Provisions	25	731	(1,060)	731	(1,060)
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows		(8)	8	0	0
NET CASH GENERATED FROM/(USED IN) OPERATIONS		**11,170**	**10,628**	**11,172**	**10,760**
Cash flows from investing activities					
Interest received	10	161	65	161	65
Purchase of intangible assets	14	0	(19)	0	(19)
Purchase of Property, Plant and Equipment		(8,367)	(10,019)	(8,367)	(10,019)
Sale of property, plant and equipment and Investment Property		1,296	2,486	1,296	2,486
NHS Charitable Funds - net cash flows from investing activities		1	1	0	0
Net cash generated from/(used in) investing activities		**(6,909)**	**(7,486)**	**(6,910)**	**(7,487)**
Cash flows from financing activities					
Public dividend capital received		207	350	207	350
PDC Dividend paid		(3,205)	(3,437)	(3,205)	(3,437)
Net cash generated from/(used in) financing activities		**(2,998)**	**(3,087)**	**(2,998)**	**(3,087)**
Increase/(decrease) in cash and cash equivalents		**1,263**	**55**	**1,264**	**186**
Cash and Cash equivalents at 1 April		27,108	27,053	26,559	26,373
Cash and Cash equivalents at 31 March		**28,371**	**27,108**	**27,823**	**26,559**

Annual Governance Statement 2018/19

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 2019 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 continuity in the Executive Director team. There have been some changes in posts, with a reduction in the number of Business Delivery Unit (BDU) directors to consolidate all operational matters under a single Director of Operations. A Director of Provider Development has been created to support the substantial changes

occurring across West Yorkshire & Harrogate. These changes reflect the fact that 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 & Bassetlaw and West Yorkshire & Harrogate. 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 continued to operate a strengthened risk management arrangement during 2018/19 with regular reviews of risk at Executive Management team meetings, and the Trust Board, alongside the forums of the Board and its 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 biennially. 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 and is due to be reviewed again in April 2019.

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 30 April 2019.

The Audit Committee assessment was supported by the Trust internal auditors who conducted a survey of Trust Board members for the second consecutive year 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. It was further refined during 2018. 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 2018/19, further work has continued to review risk registers where organisational risks not considered significant (level 15 and above) fall outside the Risk Appetite.

Risk exception reports are used at the relevant committees or fora of the Board setting out the actions being taken and the consequences of managing the risk to a higher risk appetite level. Work continues to take place to further develop risk tolerance and this is a regular item of discussion at Trust Board meetings.

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. At the February strategy meeting of the Board the structure of the BAF was reviewed to assess whether it was sufficiently capturing strategic risks. Some revisions were suggested which will strengthen the focus on strategic workforce risks particularly. The Board will approve the outline of the updated BAF in April 2019.

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 2018/19, personal objectives were set for each director and reflected in the Board Assurance Framework through the strategic objectives assigned to each Director. My objectives were discussed and agreed with the Chair.

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 2018/19 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, development of new roles and establishment reviews Development of staff networks
Acuity and demand pressures	Successfully implemented waiting list initiatives, with more underway. Extra focus on hotspots such as CAMHS and inpatient wards. System-wide reviews Continued focus on serious incident reporting, investigations & learning. Greater partnership working with local partners. Ongoing review with commissioners
Financial sustainability in a changing environment	Financial sustainability plan being developed Maintaining focus on quality improvement. Engagement with West Yorkshire & Harrogate and South Yorkshire & Bassetlaw integrated care systems
Out of area placements	High level of internal focus Engagement of independent support and implementation of recommendations Working closely with commissioners to identify system wide solutions
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.
Tenders and operating environment	Engagement with West Yorkshire & Harrogate and South Yorkshire & Bassetlaw integrated care systems Engagement in all places the Trust operates in Stakeholder engagement plans

Given the strategic context within which we operate, the risks outlined above will continue into 2019/20 with mitigating actions in place. The creation of Integrated Care Systems (ICS) across West Yorkshire & Harrogate and South Yorkshire & Bassetlaw will provide a further mechanism for managing some risks across organisations. As the lead Chief Executive for the ICS in West Yorkshire & Harrogate, I am able to ensure we are closely engaged in the leadership and delivery of these plans. The Director of Provider Development role means we have senior capacity working on the programmes that relate to the Trust. In parallel, as an engaged member of the leadership team of the South Yorkshire & Bassetlaw ICS, I will ensure that the risks inherent in the move to an Integrated Care

System are understood and mitigated. The Board has kept my dual role, as Chief Executive of SWYPFT and lead Chief Executive of the West Yorkshire & Harrogate ICS, under regular review to ensure the arrangement continues to work in the interests of the Trust as well as the ICS.

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 Trust recorded a deficit in 2018/19 prior to the provision of provider sustainability funding. Achievement of our underlying deficit plan resulted in provider sustainability funding of £4.7m being achieved and as such a net surplus is recorded prior to the impact of asset revaluations

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 quality monitoring 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 'Requires Improvement' overall by the CQC. This includes ratings of Good for, Caring, Effectiveness and for being Well-Led. Eleven out of fourteen core service lines are rated 'Good' overall with community based mental health services for adult of working age, specialist community mental health services for children and young people, and acute wards for adults of working age & psychiatric intensive care units being rated as 'Requires Improvement'.

Our ratings chart shows that 86% of the ratings within our service lines were found to be 'Good' or 'Outstanding'. The CQC found that 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 2018 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.

Values 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.

This has been further strengthened in 2018/19 with changes to the appraisal system to focus on objectives and values more explicitly.

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 2018/19, 12,640 incidents were reported, of which 88% resulted in low or no harm to patients and service users, recognising that the Trust has a risk based and good reporting 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. Following the latest Well Led Review by the CQC, the Trust joined the inaugural Mental Health Safety improvement Partnership between the CQC and NHS Improvement. This work looks at balancing the requirements of our regulators on quality and finance with the need to improve services and true value.

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 2018/19, there were 45 serious incidents across the Trust compared to 71 in 2017/18. 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 a regular report to the Operational Management Group, the Executive Management Team and reported through the governance structures to Board. There was one duty of candour breach in the year.

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. This includes a review of arrangements for managing waiting lists for Child and Adolescent Mental Health

Services (CAMHS), and a recent report on improving the quality of the mortality review process. The Committee routinely monitors infection, prevention and control management of violence, safeguarding, patient safety, health and safety, quality impact assessments and issues identified at the drugs and therapeutic committee. 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.
- Monthly compliance reporting against quality indicators within the Integrated Performance report. Trust Board also receives a quarterly report on complaints through a customer service report.
- 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, Reducing Restrictive Practice Group, Drugs and Therapeutics and policy development.
- Quality Impact assessments are carried out on all Trust cost improvement plans with Medical Director and Director of Nursing & Quality 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 areas within the statement.
- The Freedom to Speak Up Guardians ensure that where staff feel unable to raise concerns through the usual channels, there is a mechanism for doing so. The staff has four Guardians, drawn from the staff governors and a representative of the BAME network. The arrangements surrounding the Guardians have been

strengthened, with a slot at new staff induction, better administrative support, protected time allocated and clearer guidance available.

- The Foundation Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensure that its obligations under the Climate Change Act and the Adaptation

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. The new mental health clinical record system implementation approach ensured that staff were fully engaged during both design and delivery phases.
- 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 with an improved rating in the accreditation process for this year.

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 the implementation of our patient safety strategy and the development of an integrated approach to quality improvement that equips our staff to make improvements for the benefits of our service users and carers..*
- *Operational excellence - focuses on improving patient flow through our systems and making the best use of all our resources including the use of technology to improve clinical care and our productivity through agile working and the implementation of the 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. The Trust Board has 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 networks are a significant part of our approach. The Black, Asian and minority ethnic (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. The Network had its second annual celebration event, which showcased some of their achievements, in October 2018. The Trust has also established a disability staff equality network and a Lesbian, Gay, Bisexual, Transgender, Queer plus (LGBTQ+) network using the same principles of self-determination and support. The networks play an active role in a number of elements of Trust business, including recruitment to senior positions and the development of Freedom to Speak Up Guardians.

The Trust has also established a clinical network, called Race Forward, to reduce bullying and harassment from service users and carers on BAME Staff. The clinical network was established as in the NHS Staff Survey BAME staff reported the highest level of bullying and harassment from services users and carers.

Over the last year, the Board has continued to become more diverse. Appointments at director and non-executive director level have meant a better gender, age and ethnic balance across the Board.

In 2018/19, the Equality and Inclusion Forum received reports on the following:

- *Wellbeing survey results.*

- *Progress against the Workforce Race Equality Standard (WRES) and Disability Equality Standard (DES) reports and action plans*
- *Equality Delivery System (EDS2) report and action plan*
- *The Trust's equality, inclusion and engagement review*
- *Our inclusive leadership and development programmes.*

The Trust has improved in 3 of the 4 Workforce Race Equality Standard indicators published in the NHS Staff Survey.

During the year, the Trust published its gender pay gap audit as required by law, and in addition produced pay gap audits for ethnicity and disability. These showed there is a pay gap on both gender and ethnicity but not disability. An action plan has been agreed and published on the Trust's internet.

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.

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 at 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 successor Integrated Care Systems) 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 the Director of Operations, BDU Deputy 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 revised financial control total of £2.0m deficit by achieving a deficit of £1.6m. This entitled us to receive Provider Sustainability Funding (PSF) of £4.7m. There are various levels of surplus and deficit and the following table provides a reconciliation between the comprehensive expense of £23.4m as shown in our accounts and the £1.6m deficit quoted above:

	£m
Total Comprehensive Income/(Expense)	(23.4)
Impairments and Revaluations	14.7
Net Impairments	11.9
Provider Sustainability Funding (PSF)	(4.7)
Pre PSF Surplus in our management accounts	(1.6)

In total, £10.6m cost savings were delivered against a target of £9.7m (109% delivery). Of the £10.6m, £7.9m was delivered recurrently and a further £2.7m 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 2019.*

Information governance has had continued focus through 2018/19 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. The Audit Committee reviewed progress against all actions; the vast majority of which were completed in 2017/18 with final completion of outstanding actions taking place in early 2018/19. A deep dive of causes of confidentiality breaches was undertaken and reviewed at the Audit Committee in April 2019.

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 2 such incidents reported in 2018/19. This is a reduction compared to the nine reported incidents in 2016/17 and four incidents in 2017/18. They are summarised below together with the actions taken:

- A laptop and diary containing sensitive personal data was stolen from a staff member's car
- Hand written bed management information including patient details was stolen from a ward by a service user

No further action has been taken by the ICO in respect of these incidents.

Good information governance will continue to be a feature of the Trust in 2019/20. The Data Security and Protection Toolkit was submitted that is compliant with the standards.

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 Report 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 oversee 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.
- During the move to a new clinical record system, staff have been fully involved in the development and delivery of templates to ensure quality data is captured and reported. The transition to the new system has been managed with input from ICIG and with significant governance via the programme board, Executive Management Team and Board. A named non-executive director has provided constructive challenge to the process.
- 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.
- During the move to a new clinical record system, staff have been fully involved in the development and delivery of templates to ensure quality data is captured and reported. The transition to the new system has been managed with significant governance via the programme board, Executive Management Team and Board. A named non-executive director has provided constructive challenge to the process.
- 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.
- During the move to a new clinical record system, staff training has been a key consideration of readiness for movement to the next implementation phase of the system. Training in the use of SystmOne for mental health reached levels of 89% registered staff, 88% front line staff and 80% all staff prior to going live and in line with requirements set by the Trust.

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. Internal Audit conducted two reviews of the governance and programme management arrangements of the implementation of the clinical record system. Any recommendations were taken account of and factored into our implementation plans.

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 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. My appraisal is undertaken by the Chair. Non-Executive Director appraisals are undertaken by the Chair of the Trust. The Non-Executives' performance is collectively reviewed by the Members' Council. The appraisal of the Chair is led by the Senior Independent Director and reports to the Members' Council on the outcome.

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. During 2018/19, approximately 98% of staff had an appraisal.

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 2018/19 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.

In respect of the internal audit plan for 2018/19, 11 internal audit reviews have been presented to the Audit Committee. Of these, there were 9 significant assurance opinions and 2 limited assurance opinions in relation to complaints management and phase 1 of the programme management arrangements relating to the implementation of the clinical record system. It should be noted phase 2 of this audit conducted closer to go-live provided significant assurance.

The fieldwork for the three remaining reports from the 2018/19 plan relating to Cost Improvement Projects & transformation, Data Quality framework and Compliance with legislation are in progress with the assurance ratings subject to discussion 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 2018/19 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: 23 May 2019

Deloitte.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

South West Yorkshire Partnership NHS Foundation Trust

Findings and Recommendations from the 2018/19 NHS Quality Report External Assurance Review

Issued 17 May 2019 for the meeting on 21 May 2019

Contents

Executive Summary

We have completed our indicator testing and are finalising the consistency checks and anticipate signing an unmodified opinion.

Status of our work

- We have completed our review, including validation of the reported indicators. We have still to receive the final signed Quality Report and letter of Representation, at which point we will issue our final report to the Governors.
- 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 2018/19".
- We anticipate signing an unmodified opinion for inclusion in your 2018/19 Annual Report.

The Care Quality Commission inspected during the year and graded the Trust as "Requires Improvement".

	2018/19 (draft)	2017/18
Length of Quality Report	74 pages	78 pages
Quality Priorities	19	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 2018/19, all Trusts are required to have testing performed on a local indicator selected by the Council of Governors. The Trust has selected Cardio Metabolic Assessment.
  - 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 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: Early Intervention in Psychosis, Inappropriate Out of Area Placements and Cardio Metabolic Assessment.

Executive Summary (continued)

We have not identified any significant issues from our work.

Content and consistency review

Review content → Document review → Interviews → Form an opinion

We have substantially 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 2019 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)?	TBC

Performance indicator testing

Interviews → Identify potential risk areas → Detailed data testing → Identify improvement areas

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 2019, 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 2018/19".

	Early Intervention in Psychosis	Inappropriate Out of Area Placements	Cardio Metabolic Assessment
Recommendations identified?	✓	✓	✓
Overall Conclusion	B Unmodified Opinion	B Unmodified Opinion	B 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

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: 74 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: 5 Clinical Effectiveness: 5 Patient Experience: 9
• 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")

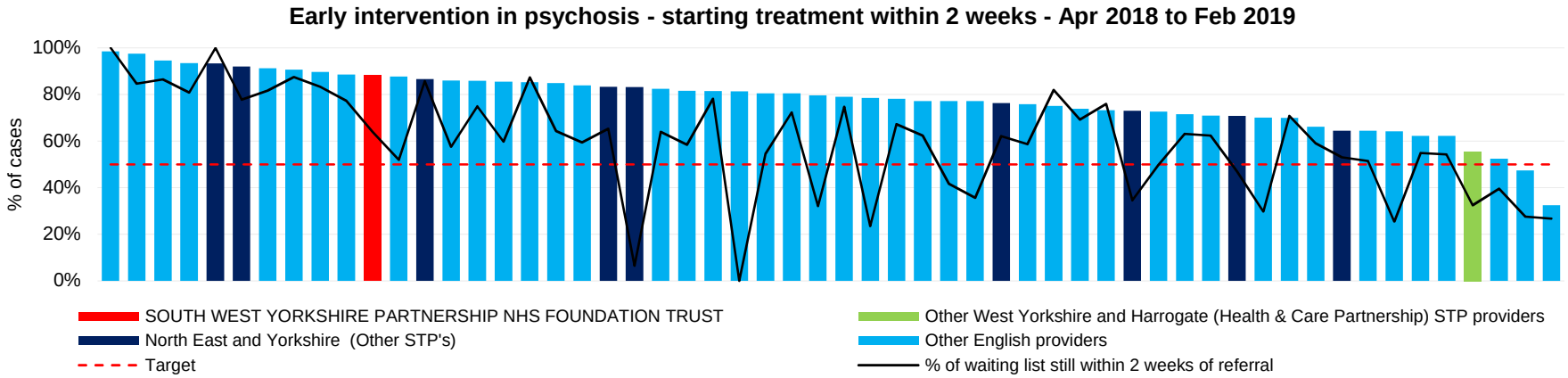
	Trust reported performance	Target	Overall evaluation
2018/19 (average)	88.1%	50%	B
2017/18 (average)	88.2%	50%	B

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 11 months of 2018/19, based on the latest national data available.



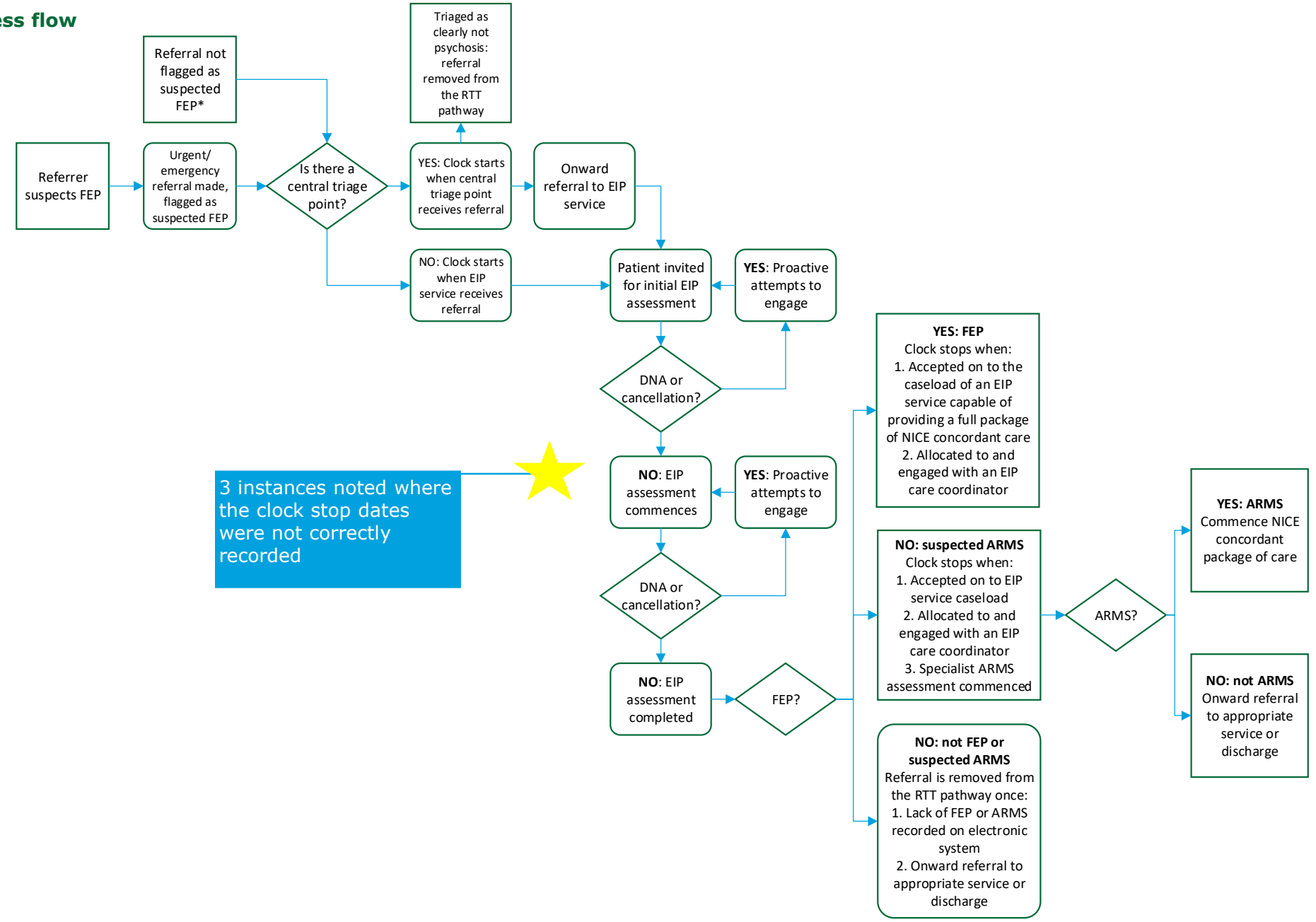
Source: Deloitte analysis of NHS England data. Percentage of waiting list still within 2 weeks of referral calculated as average of month end figures.

National context of data quality

EIP was selected as a national indicator for the first time in 2017/18. Four out of 38 Foundation Trusts with this indicator tested received a qualification (11%).

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 2018 to 31 March 2019 including in our sample a mixture of cases in breach and not in breach of the target. During our work we found 3 errors.
- We agreed our sample of 25 to the underlying information held within RiO and SystmOne.

Findings

- 3 instances where the clock stop dates were incorrect based on the patient notes and information held in RiO and SystmOne however only one sample had an impact upon the indicator, with the other two having no impact.

Deloitte View:

We have completed our testing on this indicator and do not have any issues to report. We anticipate issuing an unmodified opinion in respect of this indicator.

Inappropriate Out of Area Placements

	Trust reported performance	Target	Overall evaluation
2018/19	344 average per month	Progress against trajectory	B
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.

Out of area placements include all placements with other providers, and placements within a provider where usual frequency of contact with the care co-ordinator is not possible.

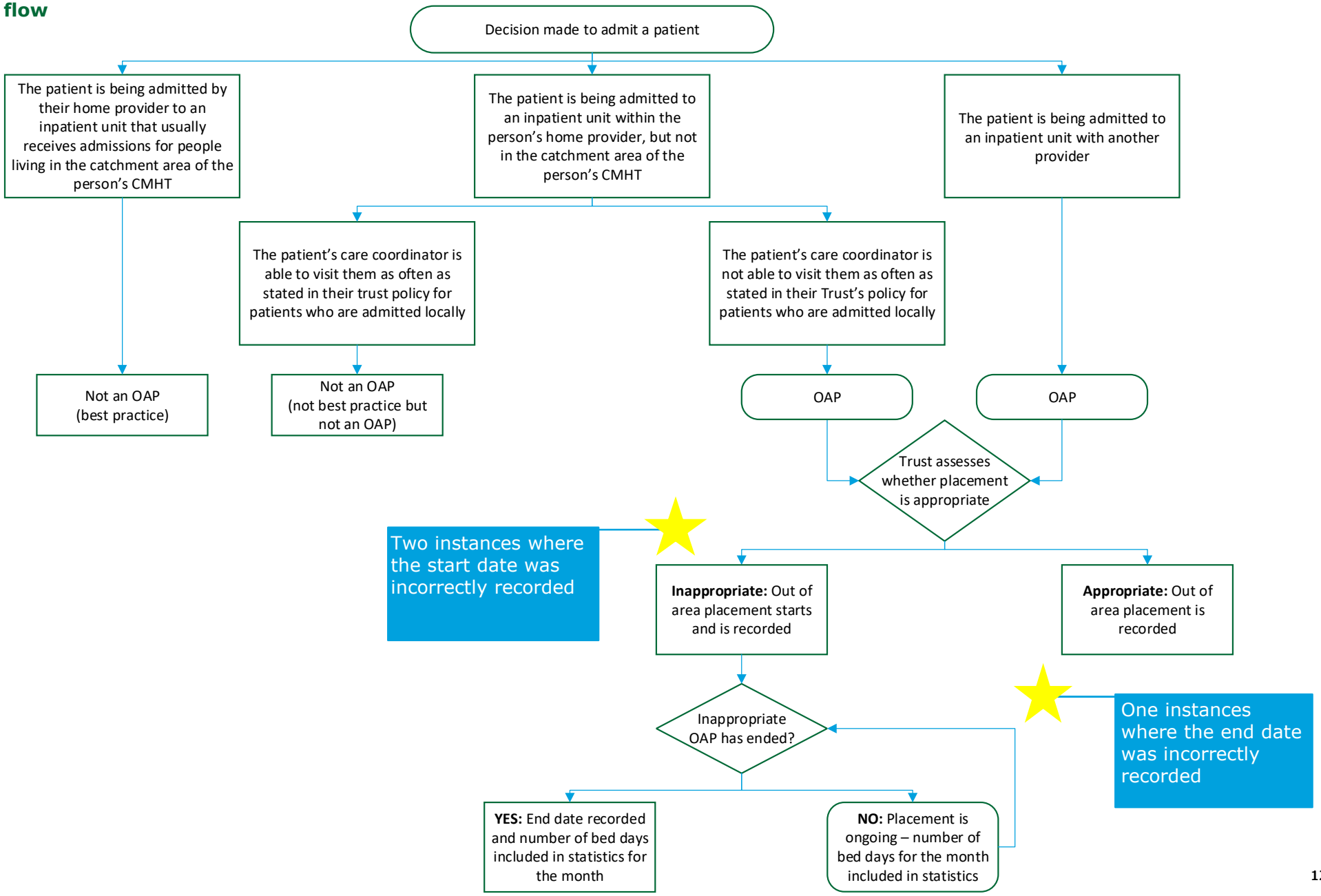
National context

Inappropriate Out of Area Placements was selected as a national indicator for the first time in 2017/18. Three out of 29 Foundation Trusts with this indicator tested received a qualification (10%). For 2017/18, providers had a choice of reporting figures for Quarter 4 only, or for the whole year. The Trust decided to report only Quarter 4 figures, and so the comparative figure is not directly comparable.

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 2018 to 31 March 2019 including both placements with other providers and placements within the Trust. During our work we found 3 errors which affected 2 sample items.
- We agreed our sample of 25 to the underlying information held within RiO and SystmOne.

Findings

- As part of our testing we identified one case where there was an incorrect recording of the start date and a further case where both the start and stop date were incorrectly stated.

Deloitte View:

We have completed our testing on this indicator and do not have any issues to report. We anticipate issuing an unmodified opinion in respect of this indicator.

Local Indicator – Cardio Metabolic Assessment

	Trust reported performance	Target	Overall evaluation
2018/19	TBC	TBC	B
2017/18	TBC	TBC	Not selected for testing

Approach

- We met with the Trust's leads to understand the process surrounding the Cardio Metabolic Assessment. 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 2018 to 31 March 2019. During our work we found 1 error.

Findings

- As part of our testing we identified one case where there was no evidence that an assessment had been completed.

Deloitte View:

We have completed our testing on this indicator, and need to tie our work to the reported position in the Quality Account.

Future changes in reporting requirements

Clinically-led Review of NHS Access Standards

The NHS National Medical Director has issued an interim report on recommendations for updating and supplementing current targets

Issue

In 2018 Professor Stephen Powis, NHS National Medical Director, was asked to carry out a clinical review of standards across the NHS, with the aim of determining whether patients would be well served by updating and supplementing some of the older targets currently in use.

An interim report in March 2019 made a number of recommendations across elective care, urgent care, cancer and mental health, to replace and/or add to the existing clinical access standards. The standards are designed to support:

- shorter waiting times for a wider range of clinical services;
- more emphasis on standards that improve the quality of clinical care and outcomes;
- shorter waiting times for A&E and planned surgery, by tracking the entire wait for every patient; and
- standards that will enable trusts to modernise their care without being penalised.

The new standards are planned to be field-tested during 2019/20 and then implemented during 2020/21, with field testing to consider both the practicalities of adoption and also whether they:

- promote safety and outcomes;
- drive improvement in patient experience;
- are clinically meaningful, accurate and practically achievable;
- ensure the sickest and most urgent patients are given priority;
- ensure patients get the right service in the right place;
- are simple and easy to understand for patients and the public; and
- do not worsen inequalities.

The proposed indicators are set out on the next page. Dependant upon the final changes, this may affect the scope of Quality Report testing in from 2020/21.

Deloitte View

The choice of specific targets to measure often involves trade-offs in what is captured, or not captured, by the indicators selected, and in the behaviours that are incentivised.

There have been a variety of responses to the proposals, reflecting in part the changes in what would be emphasised (and deemphasised) relative to the current targets and indicators.

The intention of the new indicators is to measure what is most important clinically and to patients. As the implementation of new standards progresses, it will be important that organisations do not focus solely upon achievement of performance against the selected metric, and that there is continued focus on the overall quality and timeliness of care provided to service users.

We highlight that the implementation of new metrics will require process and potentially system changes, and it will be important for the Trust to consider controls over data quality as part of implementing any changes.

Clinically-led Review of NHS Access Standards (continued)

The NHS National Medical Director has issued an interim report on recommendations for updating and supplementing current targets

Urgent care

The proposed standards would replace the current 4 hour wait target with a measure of the average waiting time, and a specific measure for treatment of the most critically ill patients.

- Time to initial clinical assessment in Emergency Departments and Urgent Treatment Centres (type 1 and 3 A&E departments). (The report does not include a specific target).
- Time to emergency treatment for critically ill and injured patients (complete a package of treatment in the first hour after arrival for life-threatening conditions).
- Mean waiting time in A&E (all A&E departments and mental health equivalents).
- Utilisation of Same Day Emergency Care. The aim is to complete all diagnostic tests, treatment and care that are required in a single day.
- Call response standards for 111 and 999.

Mental health

A series of new indicators are proposed for testing, which would replace the current Early Intervention in Psychosis and Improving Access to Psychological Therapies targets. These would focus on faster access for mental health crises, with slower but timely targets for other support.

- Expert assessment within hours for emergency referrals; and within 24 hours for urgent referrals in community mental health crisis services.
- Access within one hour of referral to liaison psychiatry services and children and young people's equivalent in A&E departments.
- Four-week waiting times for children and young people who need specialist mental health services.
- Four-week waiting times for adult and older adult community mental health teams.

Cancer

The proposed standards combine existing standards into simplified overall metrics:

- Faster Diagnosis Standard: Maximum 28 day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening.
- Maximum two-month (62-day) wait to first treatment from urgent GP referral (including for breast symptoms) and NHS cancer screening.
- Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

Elective care

The current 18 week RTT target may be revised, and a patient choice standard introduced.

- Maximum wait of six weeks from referral to test, for diagnostic tests (the current standard is to be retained).
- Defined number of maximum weeks wait for incomplete pathways, with a percentage threshold (current 18 week RTT threshold and maximum wait to be reviewed) **OR** Average wait target for incomplete pathways.
- 26-week patient choice offer (patients will be able to choose whether to access faster treatment elsewhere in a managed way).
- 52-week treatment guarantee.

Appendices

Appendix 1: Update on prior year recommendations

Indicator	Prior year finding	Current year status
Early Intervention in Psychosis	**Inappropriate start dates** There should be consistency in terms of the recording of start dates where there is a referral from within the Trust.	There have been no such instances noted in the current year.
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.	There have been no such instances noted in the current year.
Local Indicator	**Completion of the 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.	This has been reviewed as part of training. However, this has not been reviewed in the year.

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
17 May 2019

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 NHS Improvement for their information in connection with this purpose, but as made clear in our engagement letter dated, only the basis that we accept no duty, liability or responsibility to NHS Improvement 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 2019 (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 2019, 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 2019 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:

- board minutes for the period April 2018 to March 2019;
- papers relating to quality reported to the board over the period April 2018 to March 2019;
- feedback from Commissioners, dated 21/05/2019;
- feedback from local Healthwatch organisations, dated 22/05/2019;
- feedback from Overview and Scrutiny Committee, dated 16/05/2019;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2018 (Q1), Oct 2018 (Q2), and Dec 2018 (Q3);
- the national community mental health patient survey 2018;
- the national staff survey 2019;
- Care Quality Commission inspection report, dated July 2018; and

- the Head of Internal Audit's annual opinion over the trust's control environment, dated 21/05/2019.

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.

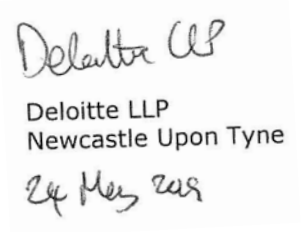
Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

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' and supporting guidance.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by South West Yorkshire Partnership NHS Foundation Trust.

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 2019:

- 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 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.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Report to the Governors
2018/19 audit

July 2019

Scope of our work

Accounts and Annual Report

- Identification and testing of the key risk areas.
- Performance of sample testing and analytical review.
- Testing of the auditable sections of the Remuneration Report.
- Review of the work of relevant regulatory bodies.
- Review of:
  - The Annual Report for consistency with the content of the Financial Statements.
  - The Annual Governance Statement.

Quality Report

- Review and testing of the form and content of the Quality Report.
- Testing of quality indicators

'True and Fair' Opinion on Accounts

Standard 'Limited Assurance' opinion on Quality Report

Value for Money & Going Concern

Consistency of the Consolidation Schedules

Confirmation to National Audit Office over content of WGA schedules

All opinions were unmodified

Key Findings

Audit findings

Accounting Performance

The Trust submitted its draft and audited Annual Report and Accounts ahead of the NHSI timetable.

Regular meetings have been held with management through the year.

The working papers produced to support the draft accounts continue to be of a good standard.

As part of our audit we identified uncorrected misstatements in relation to the valuation of property, plant and equipment. The net impact of this is an increase of £1.59m of net assets and a £1.59m increase in reserves.

Annual governance statement

The review of the Trust's Annual Governance Statement identified no significant issues.

Annual Report

The Trust provided a draft of the annual report which required minimal adjustment from the draft version and incorporated all of the significant changes required.

Accounting policies and financial reporting

We reviewed the Trust's accounting policies and found them to be consistent with sector norms.

We provided comments to the Trust on presentational matters which have been reflected in the financial statements.

Controls findings

We did not raise any control findings from our audit work.

Quality Report Audit

Quality Accounts : content and consistency findings

Key Questions	Assessment
Is the length and balance of the content of the report appropriate?	G
Is there an introduction to the Quality Report that provides context?	G
Is there a glossary to the Quality Report?	G
Is the number of priorities appropriate across all three domains of quality (Patient Safety, Clinical Effectiveness and Patient Experience)?	G
Has the Trust set itself SMART objectives which can be clearly assessed?	G
Does the Quality Report clearly present whether there has been improvement on selected priorities?	G
Is there appropriate use of graphics to clarify messages?	G
Does there appear to have been appropriate engagement with stakeholders (in both choosing priorities as well as getting feedback on the draft Quality Report)?	G
Is the language used in the Quality Report at an appropriate readability level?	G

Quality Accounts : Indicator testing

	Early Intervention in Psychosis	Inappropriate Out of Area Placements	Cardio Metabolic Assessment
Accuracy Is data recorded correctly and is it in line with the methodology.	B	B	B
Validity Has the data been produced in compliance with relevant requirements.	B	G	G
Reliability Has data been collected using a stable process in a consistent manner over a period of time.	B	G	G
Timeliness Is data captured as close to the associated event as possible and available for use within a reasonable time period.	B	G	G
Relevance Does all data used generate the indicator meet eligibility requirements as defined by guidance.	B	G	G
Completeness Is all relevant information, as specific in the methodology, included in the calculation.	B	G	G
Recommendations identified?	-	-	-
Overall Conclusion	B	B	N/A

G No issues noted

A Requires improvement

B Satisfactory – minor issues only

R Significant improvement required

Deloitte.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Members' Council
2 August 2019

Agenda item:	**7.3**
Report Title:	**Governor engagement feedback**
Report By:	Company Secretary on behalf of governors
Action:	To receive

The following events were attended by governors since the last Members' Council meeting on 3 May 2019 up to 15 July 2019 (note, this does not include Members' Council meetings):

Name	Role	Events attended / feedback provided
Marios Adamou	Staff governor - Medicine and pharmacy	➢ Nominations Committee 3 June 2019
Neil Alexander	Public Governor - Calderdale	➢ Members' Council Co-ordination Group 10 June 2019 ➢ WYMHSC Joint Non-Executive Director and Governor Event 24 June 2019
Bill Barkworth	Public Governor - Barnsley	➢ Non-Executive Director (NED) recruitment Governor Stakeholder Group 12 July 2019
Bob Clayden	Public Governor - Wakefield	➢ Members' Council Co-ordination Group 10 June 2019 ➢ Creative Minds collective shortlist meeting 20 June 2019 ➢ WYMHSC Joint Non-Executive Director and Governor Event 24 June 2019 ➢ Non-Executive Director (NED) recruitment Governor Stakeholder Group 12 July 2019
Jackie Craven	Lead Governor (Public Governor - Wakefield)	➢ Members' Council Quality Group 10 May 2019 • Integrated performance report Q4 2018/19 • Care Quality Commission (CQC) Action Plan • Quality Account 2018/19 ➢ Nominations Committee 3 June 2019 ➢ Members' Council Co-ordination Group 20 June 2019 • Members' Council development including Membership on Members' Council groups, Holding Non-Executive Directors to Account - annual session, and Development plan action update. • Future agenda and discussion items for consideration including the draft agenda for Members' Council meeting 2 August 2019, items requested by Governors, items previously suggested by Members' Council Coordination Group, and items deferred at Members' Council meeting on 3 May 2019. • Governor attendance at Members' Council meetings *(continued over)*

Name	Role	Events attended / feedback provided
		➢ WYMHSC Joint Non-Executive Director and Governor Event 24 June 2019 ➢ Non-Executive Director interview panel 12 July 2019 ➢ Nominations Committee 15 July 2019
Dr Nasim Hasnie OBE	Public Governor - Kirklees	➢ Members' Council Quality Group 10 May 2019 ➢ Nominations Committee 3 June 2019 ➢ Non-Executive Director interview panel 12 July 2019 ➢ Nominations Committee 15 July 2019
Lin Harrison	Staff Governor - Psychological therapies	➢ Non-Executive Director (NED) recruitment Governor Stakeholder Group 12 July 2019
Lisa Hogarth	Staff Governor - Allied Healthcare Professionals	➢ Members' Council Co-ordination Group 10 June 2019
Adam Jhugroo	Public Governor - Calderdale	➢ Non-Executive Director (NED) recruitment Governor Stakeholder Group 12 July 2019
John Laville	Public Governor - Kirklees	➢ WYMHSC Joint Non-Executive Director and Governor Event 24 June 2019 ➢ Non-Executive Director (NED) recruitment Governor Stakeholder Group 12 July 2019
Ruth Mason	Appointed Governor - Calderdale & Huddersfield NHS Foundation Trust	➢ Nominations Committee 3 June 2019 ➢ Members' Council Co-ordination Group 10 June 2019 ➢ Non-Executive Director (NED) recruitment Governor Stakeholder Group 12 July 2019 ➢ Nominations Committee 15 July 2019
Phil Shire	Public Governor - Calderdale	➢ Members' Council Quality Group 10 May 2019 ➢ Non-Executive Director (NED) recruitment Governor Stakeholder Group 12 July 2019
Jeremy Smith	Public Governor - Kirklees	➢ Members' Council Quality Group 10 May 2019
Keith Stuart-Clarke	Public Governor - Barnsley	➢ WYMHSC Joint Non-Executive Director and Governor Event 24 June 2019
Paul Williams	Public Governor - Rest of South and West Yorkshire	➢ Members' Council Co-ordination Group 10 June 2019

There were no emails received for governors via the governor email address (Governors@swyt.nhs.uk) since the last Members' Council meeting on 3 May 2019.

Agenda item 8i
Focus on
Suicide Prevention

Members' Council

2 August 2019

South West Yorkshire Partnership NHS Foundation Trust

West Yorkshire and Harrogate Health and Care Partnership

Suicide Prevention Strategy Governor's Focus Session

Member's Council Meeting August 2nd 2019

Dr. Michael Doyle Suicide Prevention Lead,
West Yorkshire & Harrogate Integrated Care System

Lin Harrison Suicide Prevention Project Manager,
West Yorkshire and Harrogate Integrated Care System

Objectives:

West Yorkshire and Harrogate Health and Care Partnership

NHS

Suicide prevention
Five year strategy 2017-2022

Annual Report 2018

- How can we prevent suicide and why do we need a strategy?
- Background to the West Yorkshire & Harrogate (WY&H) Integrated Care System (ICS) strategy
- Update on progress to date
- Recent funding developments and plans for 2019/2020

Background

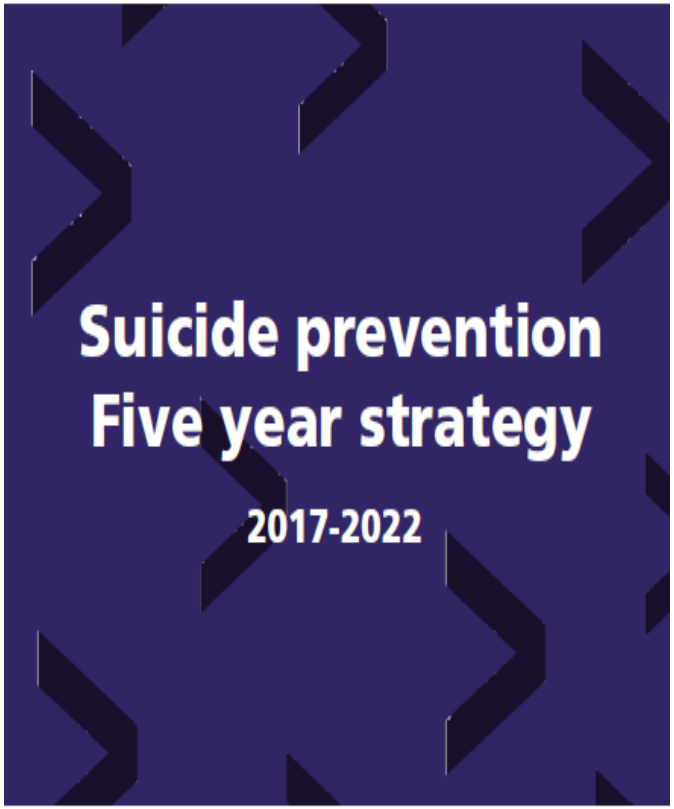
- Death by suicide accounts for more deaths worldwide than war and natural disasters combined with 800,000 deaths globally each year
- In 2017, 4451 people are recorded as having died by suicide in England, roughly 10 per 100k
- Suicide is the biggest cause of premature death in men under 50 and the biggest killer of young people aged under 35 in the UK
- The rates of suicide have steadily risen in England since 2007 but reduced in males by 4.8% in 2017
- In 2015, the Yorkshire and Humber region had the highest suicide rate in England

Why should we work strategically on suicide prevention?

- Our SWYPFT staff work with individuals to reduce their suicide risk on a daily basis
- Strategic community wide initiatives are a much needed support in this work
- Research shows that strategic responses to suicide save lives – e.g. changes to tablet packaging, barriers on bridges, training for staff/public, restrictions on buying multiple medications at any one time etc.
- This is how we build ‘suicide safer communities’
- A balance of linked regional/national initiatives and local place based projects are needed

West Yorkshire and Harrogate Health and Care Partnership

NHS



Suicide Prevention Strategy

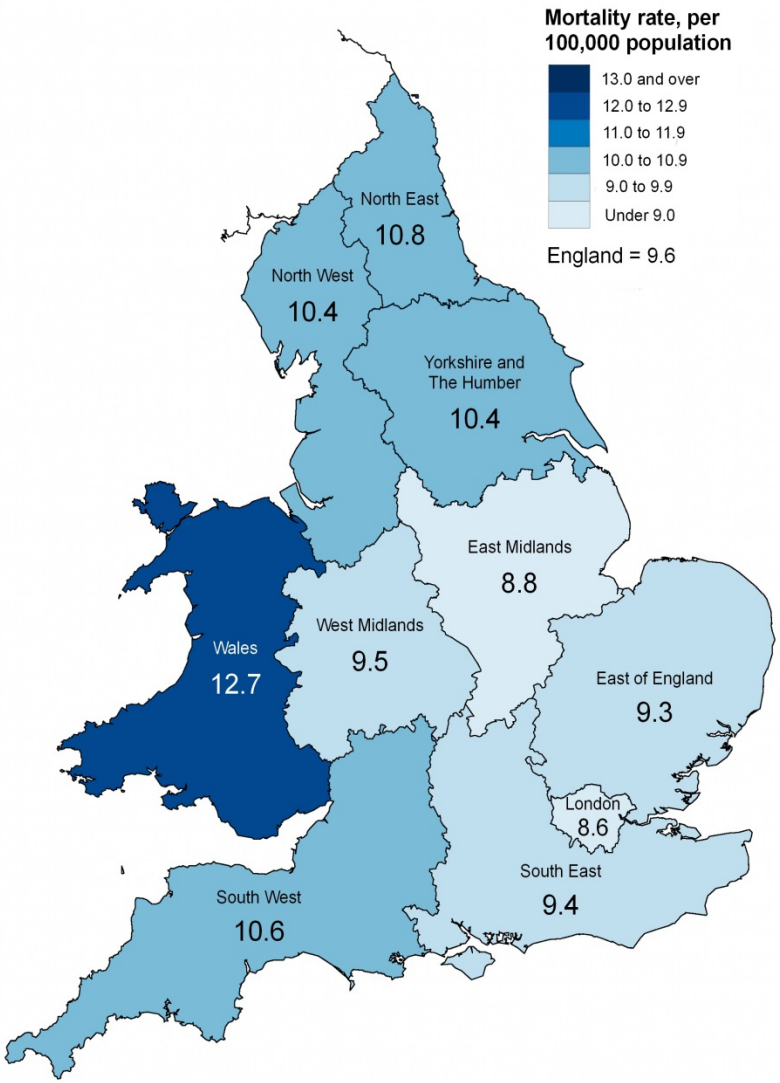
Aim

"To develop working relationships between partner agencies to provide an evidence-based but practical framework across the WY region to help reduce the frequency of suicide and minimise the associated human, collateral and financial costs"

West Yorkshire & Harrogate ICS

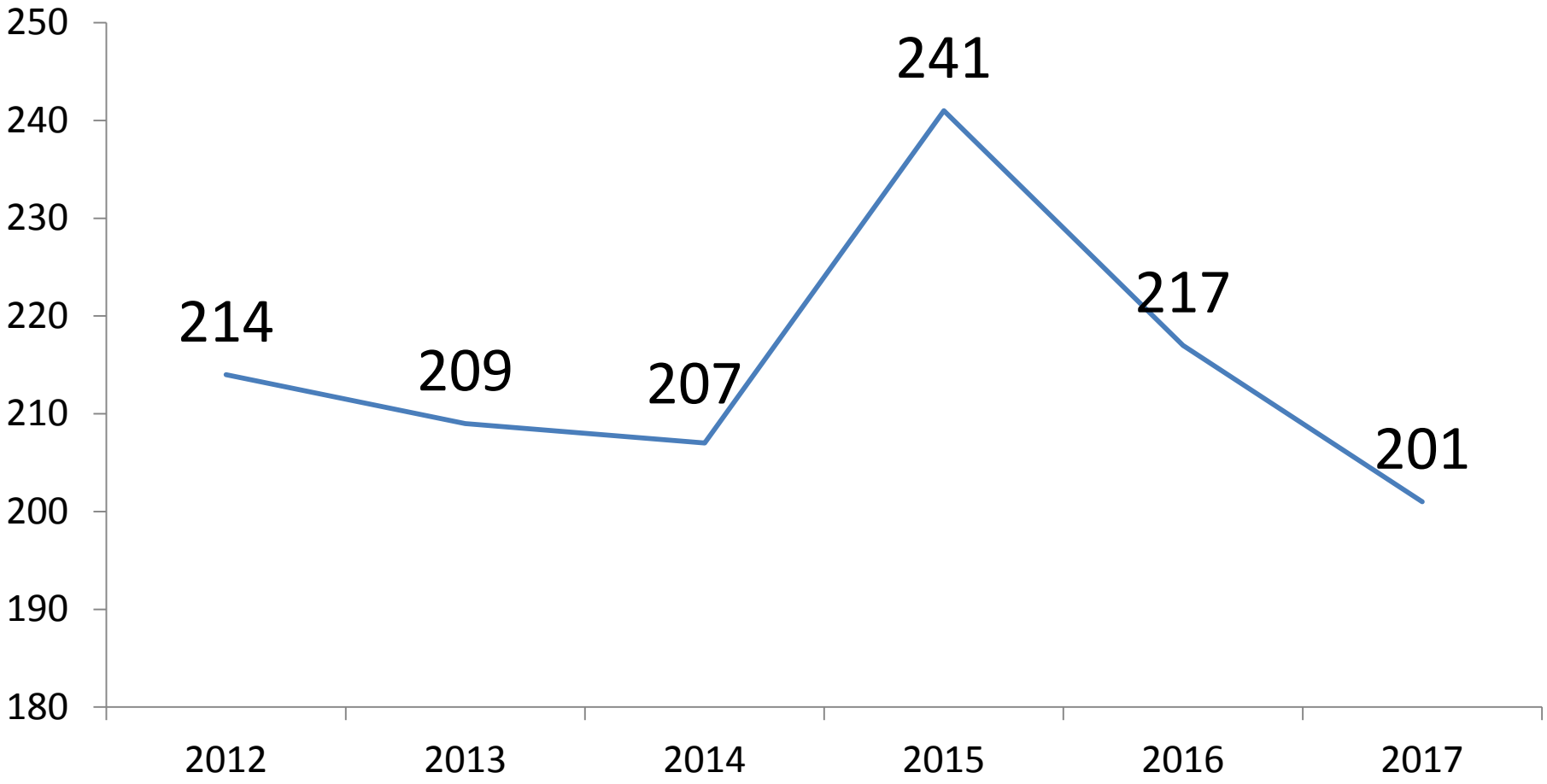
Figure 1
West Yorkshire Health and Care Partnership

Number of deaths and age-standardised suicide rates by regions of England, rolling three year aggregates, 2015-17

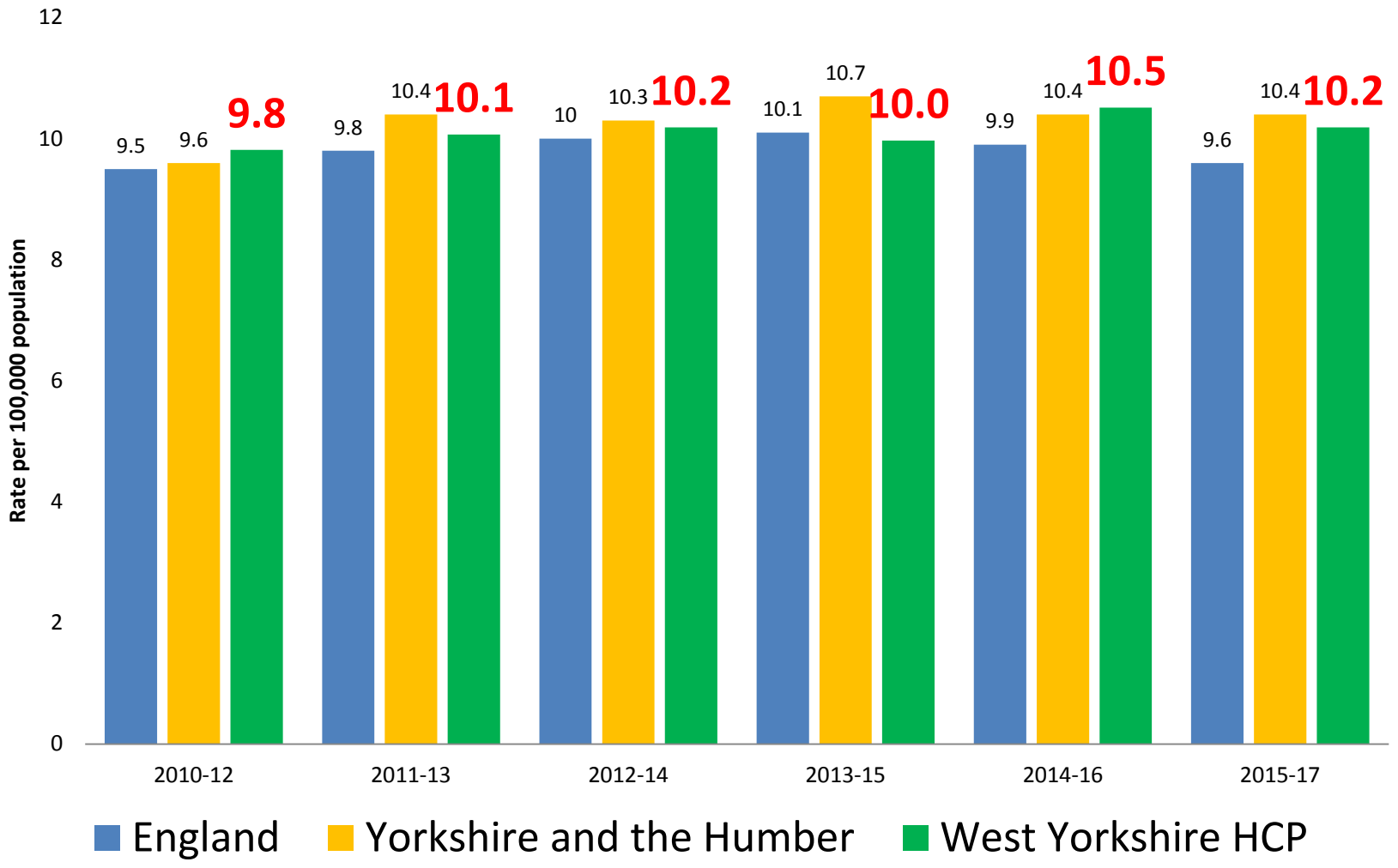


Region	No.	Rate
North East	739	10.8
North West	1,969	10.4
Yorkshire and the Humber	1,475	10.4
East Midlands	1,092	8.8
West Midlands	1,423	9.5
East of England	1,488	9.3
London	1,883	8.6
South East	2,230	9.4
South West	1,547	10.6
Wales	1,032	12.7

WY&H ICS: number of suicides 2012-17



WY&H ICS 3-year rolling suicide rates per 100k



Progress 2018

- ✓ Partnership working improved
  - Suicide Prevention Advisory Network (SPAN)
- ✓ New links made including Network Rail, British Transport Police, Papyrus, Highways England, Military
- ✓ Experts by experience engaged e.g. 'Messages of hope'
- ✓ Train-the-Trainer for ASIST and SafeTALK
- ✓ Real-time surveillance model developed with West Yorkshire Police
- ✓ Bereavement by suicide developments
- ✓ Removing *access to means* guidance drafted
- ✓ Presentation at national & international conferences
- ✓ Staff employed to lead on this work

Progress 2019 to date

- Military Veteran Campaign
  - Scope the extent of the demand
  - Develop working relationships
  - Build campaign to publicise support
  - Monitor uptake of services by veterans
  - Identify critical times for veterans
  - Evaluate future needs and develop proposal based on needs

- Real time intelligence
  - Info sharing agreement developed across WY&H
  - Early identification of risks to family or significant others
  - Any early lessons to learn and prompt action
  - Trends themes and contagion
  - Allowing us to make real time referrals for suicide bereavement support

Progress 2019 to date continued.

- Postvention funding approved - £173,000

  Bereavement by suicide postvention service

  - Expanding the well established and evaluated Leeds Suicide Bereavement Service across WY&H
  - Launching real time referrals via WY Police

- Trail blazer funding approved - £114,000

  Support pathway for males who are vulnerable and at risk

  - Establish pathway for men to access support services
  - Facilitate peer support groups and networks based on the State of Mind *Offload* programme
  - Develop social media and online support materials
  - Provide training and supervision to partner agencies and stakeholders

In SWYPT….

MANCHESTER 1824
The University of Manchester

HQIP
Healthcare Quality Improvement Partnership

Plans for our Trust

SOUTH WEST YORKSHIRE PARTNERSHIP NHS PARTNERSHIP TRUST

Suicide Prevention Improvement Plan to include:

- Introduce new systems to determine safe staffing levels
- Create a Clinical Environment Safety Group (CESG)
- Develop a standard MDT recording template for SystmOne
- Implement new SystmOne formulation-based risk assessment
- Develop specific suicide prevention training plan
- Improve our shared learning by considering new ways of learning
- Pilot self-harm and self-harm/burns pathways
- Review CPA policy and launch new version
- Standardised approach for bereavements and work with families
- Deliver 72 hour follow-up target as part of CQUIN delivery
- Monitor progress in reducing Out Of Area placements

South West Yorkshire Partnership NHS Foundation Trust

West Yorkshire and Harrogate Health and Care Partnership

Thank you

Michael Doyle, RMN, PhD

Deputy Director of Nursing & Quality

michael.doyle@swyt.nhs.uk

University of Manchester: michael.doyle@manchester.ac.uk

Lin Harrison

Suicide Prevention Project Manager, Senior Psychotherapist and Staff Governor

lin.harrison@swyt.nhs.uk

South West Yorkshire Partnership NHS Foundation Trust

West Yorkshire and Harrogate ICS

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Agenda item 8
Performance & Finance Update
Quarter 1 2019/20

Members' Council

2 August 2019

With **all of us** in mind.

Agenda

South West Yorkshire Partnership NHS Foundation Trust

- Summary Performance Metrics
- Quality
- NHS Improvement Targets
- Workforce
- Finance

With **all of us** in mind.

Summary Performance Metrics

South West Yorkshire Partnership NHS Foundation Trust

KPI	Threshold	Sept Q2	Dec Q3	Mar Q4	Jun Q1
Single Oversight Framework	2	2	2	2	2
Children & Younger People in adult inpatient wards	0	2	1	1	3
% SU on CPA Followed up Within 7 Days of Discharge	95%	98.4%	95.4%	98.2%	100%
Physical health – cardiometabolic assessment	Community 75% Inpatient 90%	84.1%	83.8%	88.1%	87.1%
% LD referrals with assessment, care package and commenced service delivery within 18 weeks	90%	84.6%	84.2%	82.8%	tbc
Inappropriate Out of Area Bed days	<300 days	1,410	842	691	705
Friends & Family Test – Mental Health	85%	88%	90%	95%	86%
Friends & Family Test - Community	98%	98%	99%	99%	97%
Delayed Transfers of Care	3.5%	1.5%	1.7%	1.6%	0.6%

SU – service users
CPA – care programme approach
LD – learning disability

With **all of us** in mind.

Summary Performance Metrics

South West Yorkshire Partnership NHS Foundation Trust

KPI	Threshold	Sept Q2	Dec Q3	Mar Q4	Jun Q1
Patient & Safety Incidents involving moderate or severe harm or death (quarter)		68	85	92	96
Proportion of people detained under Mental Health Act who are black, asian & minority ethnic	**Trend monitor**	14.1%	13.0%	16.6%	14.5%
IG confidentiality breaches	**<24**	**45**	**45**	**32**	**26**
CAMHS referral to treatment < 18 weeks	**Trend monitor**	37.0%	33.4%	24.3%	32.7%
Surplus/(deficit)	**(£0.2m) – full year**	**£160k**	**£5k**	**(£770k)**	**(£1.3m)**
Agency spend	**£5.3m (full year)**	**£1.6m**	**£1.6m**	**£1.8m**	**£1.9m**
Cost Improvement Programme delivery	**£8.3m**	**£2.5m**	**£2.3m**	**£3.8m**	**£2.0m**
Financial risk in forecast	**0**				**(£2.8m)**
Sickness absence	**4.5%**	**4.6%**	**5.0%**	**5.0%**	**4.8%**
Staff Turnover	**10%**	**12.8%**	**12.0%**	**11.9%**	**12.0%**
Actual level of vacancies	**Trend monitor**				10.7%

IG – information governance
CAMHS – child & adolescent mental health services

With **all of us** in mind.

Quality Update 2019/20 – Q1

South West Yorkshire Partnership NHS Foundation Trust

CQUIN Income (Quality Indicators)

- 2019/20 CQUIN income target of £2.3m
- Currently working on 2019/20 Q1 submission
- Overall value of scheme has reduced to 1.25% of contract value with the difference now included in the core contract

With **all of us** in mind.

Quality Update 2019/20 – Q1

South West Yorkshire Partnership NHS Foundation Trust

Safer Staffing

- Not one ward has fallen below the 90% overall fill rate.
- Overall fill rate all staff – 115.7%
- Registered On Days (Trust total 85.1%).
- Registered On Nights (Trust total 99%).
- **Overall fill rates remain positive, significant pressures remain on wards due to increased acuity and demand**.
- Safer Staffing decision support tool utilised to ensure that safe levels of staffing maintained.
- Establishment review is now being finalised with an implementation plan.

Overall Fill Rate	Month-Year		
Unit	Apr-19	May-19	Jun-19
Specialist Services	119%	118%	118%
Barnsley	117%	107%	110%
C & K	110%	114%	115%
Forensic	112%	108%	106%
Wakefield	143%	147%	140%
Overall Shift Fill Rate	**118%**	**117%**	**116%**

With **all of us** in mind.

Quality Update 2019/20 – Q1

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Patient Experience – Friends and Family Test (FFT)

- 90% of respondents would recommend Trust services
- The number of responses increased by 119% in June (732) from the previous month (May 334) and 52% compared to June 18 (481)
- Returns have increased due to the number of returns from the community services, the text message service recommencing and the use of volunteers collecting feedback on acute wards
- Text messages provided 30% of responses in June
- The number of responses for acute wards increased by 52%
- Areas under development are Carers survey, CAMHs, Learning Disabilities and Recovery Colleges.

With **all of us** in mind.

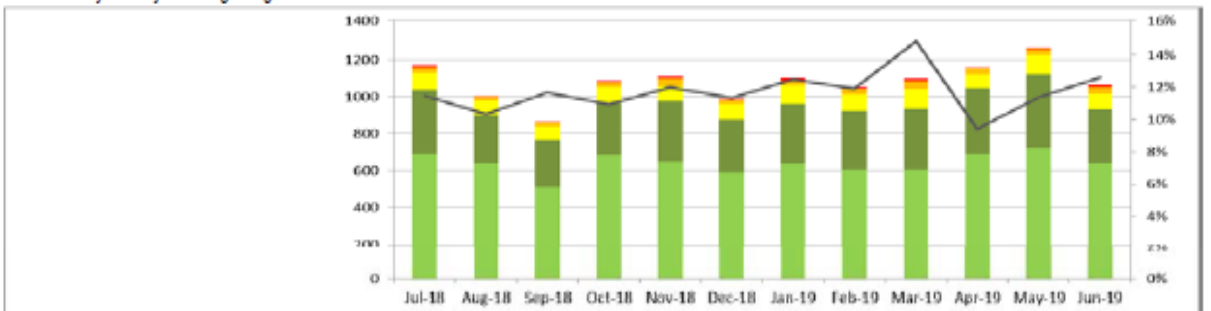
Quality Update 2019/20

South West Yorkshire Partnership NHS Foundation Trust

- All serious incidents investigated using route cause analysis techniques.
- Weekly risk panel scans for themes.
- No never events reported in June 2019.
- 12.6% of incidents were in red, amber and yellow categories. This is a slight increase and will be reviewed.
- Restraint incidents currently under close review as part of restricting physical interventions programme

Summary of Incidents since June 2018

Incidents may be subject to re-grading as more information becomes available



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Red (should not be compared with SIs)	10	5	6	10	15	3	14	7	11	6	8	14
Amber	28	21	21	24	42	23	23	30	44	30	32	33
Yellow	96	78	74	85	76	86	100	88	108	73	104	87
Green	345	263	252	281	328	287	328	317	327	357	401	292
Green no harm	689	637	511	685	648	587	633	607	606	691	720	637
Total	1168	1004	864	1085	1109	986	1098	1049	1096	1157	1265	1063
Percentage of total that are Red/Amber/Yellow *	11.5%	10.4%	11.7%	11.0%	12.0%	11.4%	12.5%	11.9%	14.9%	9.4%	11.4%	12.6%

** A high level of incident reporting, particularly of less severe incidents is an indication of a strong safety culture (National Patient Safety Agency, 2004: Seven Steps to Patient Safety). The distribution of these incidents shows 86% are low or no harm incidents.*

With **all of us** in mind.

NHS Improvement Compliance

South West Yorkshire Partnership NHS Foundation Trust

Single Oversight Framework Risk Rating

- Actual Rating of 2 – targeted support
- Ratings of 1 – 4, with 1 being the best

Performance against mandated standards of access and outcomes:

- Performing above target for vast majority of national indicators

With **all of us** in mind.

NHS Improvement

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Access standards and Outcomes – Trust Performance

KPI	Threshold	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20
Max time of 18 weeks from point of referral to treatment – Incomplete pathway	92%	97.2%	99.3%	97.2%	98.9%
% Admissions Gatekept by CRS Teams	95%	97.9%	98.9%	96.8%	99.7%
% SU on CPA Followed up Within 7 Days of Discharge	95%	97.1%	97.1%	99.2%	97.8%
IAPT - Treatment within 6 weeks of referral *	75%	94.3%	94.4%	88.7%	84.8%
IAPT - Treatment within 18 weeks of referral *	95%	99.6%	99.6%	99.2%	98.9%
Early Intervention in Psychosis – 2 weeks (NICE approved care package) Clock Stops	50%	90.3%	92.6%	80.5%	84.2%
Maximum 6 week wait for diagnostic procedures	99%	100%	92.9%	100.0%	99.6%
IAPT – Proportion of people completing treatment who move to recovery *	50%	51.1%	52.4%	55.4%	55.0%

* to May 2019

IAPT - Improving access to psychological therapies
CPA - Care programme approach
SU - Service user
NICE - National Institute for Clinical Excellence
CRS - Community recovery service

With **all of us** in mind.

Workforce

South West Yorkshire Partnership NHS Foundation Trust

- The Trust sickness rate in June was 5.2% and is 4.8% cumulatively.
- Appraisal rate is above 66.2% from band 6 and above. Time lag on recording appraisal completion so expected improvement by the end of July.
- All mandatory training is above 80% required compliance level.
- Staff turnover rate relatively consistent at 12%.

With **all of us** in mind.

Financial Performance

South West Yorkshire Partnership NHS Foundation Trust

Key Performance Indicators

Performance Indicator		Year To Date	Forecast
1	NHS Improvement Finance Rating	3	2
2	Normalised Deficit (excl PSF)	(£1.3m)	(£0.2m)
3	Agency Cap	£1.9m	£7.4m
4	Cash	£25.2m	£25.7m
5	Capital	£1.1m	£7m
6	Delivery of CIP	£2.1m	£10.6m
7	Better Payment	99%	

Red	Variance from plan greater than 15%
Amber	Variance from plan ranging from 5% to 15%
Green	In line, or greater than plan

With **all of us** in mind.

Financial Performance – Highlights

South West Yorkshire Partnership NHS Foundation Trust

- £1.3m deficit for the first quarter. Includes £0.7m non-recurrent pay increases made in April.
- Expenditure of £0.7m on out of area bed placements. 39% lower than Q1 last year
- Agency staffing costs of £1.9m. 41% higher than our cap.
- Actual performance is better than plan, but requires £1.1m surplus over last 9 months of the year to achieve our plan.
- Full year target of £0.2m deficit. Achievement enables access to £1.8m of provider sustainability funding.
- High level of demand and pressure continues in many inpatient wards leading to an overspend on staff in these areas. Offset by vacancies in other areas.
- Cash balance of £25.2m.
- Capital spend of £1.1m mainly on Fieldhead re-development. Capital plan for the year reduced by £1m as national capital over-subscribed.
- Financial risk rating of 3 due to size of Q1 deficit.

With **all of us** in mind.


With all of us in mind.

South West Yorkshire Partnership NHS Foundation Trust

Agenda item 9 Customer Services & Incident Management Annual Update

Members' Council

2 August 2019

With **all of us** in mind.

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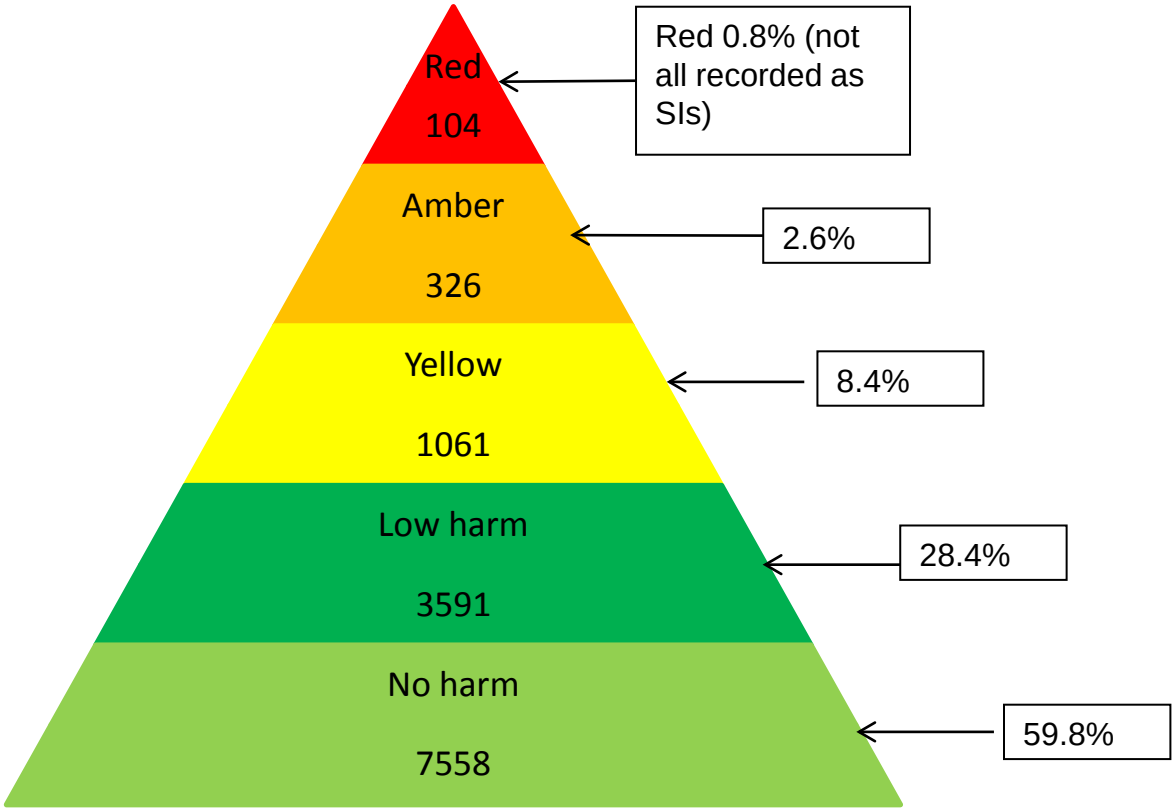
Incident Management Annual Update

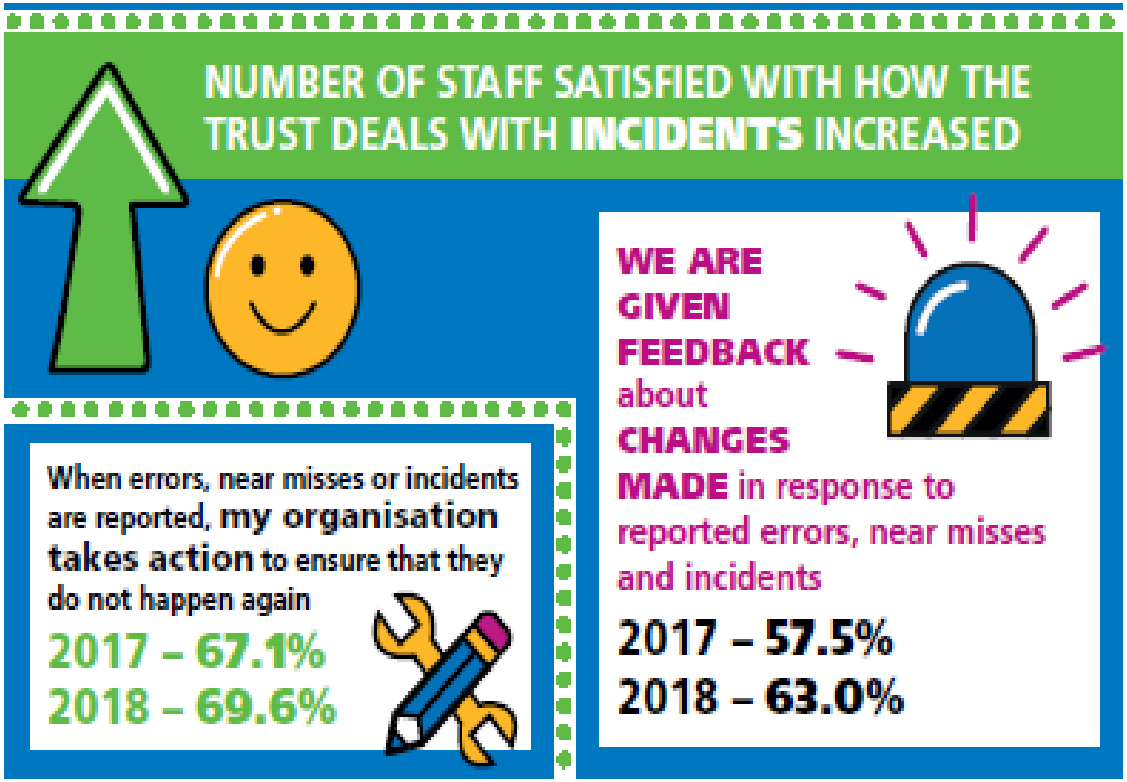
With **all of us** in mind.

- **12640** incidents reported
- **2.7%** increase in reporting on 2018/19
- **88%** of incidents resulted in no/low harm
- **45** Serious incidents reported
- No Never Events
- Serious Incidents account for **0.36%** of reported incidents
- High reporting rate with high proportion of no/low harm is indicative of a positive safety culture[1]


Red
104
Amber
326
Yellow
1061
Low harm
3591
No harm
7558
Red 0.8% (not all recorded as SIs)
2.6%
8.4%
28.4%
59.8%

- 45 Serious incidents reported
- Serious incidents account for 0.36% of all incidents
- Reduction on total from 2017/18 (71)
- No homicides reported
- No Never Events

- Improvement in some key findings from staff survey for incident reporting
- Internal audit result for serious incidents requiring investigation was significant assurance with minor improvement opportunities
- Internal audit result for learning from healthcare deaths was significant assurance
- Positive feedback from Care Quality Commission (CQC) on our serious incident and mortality review process
- Positive outcomes from the patient safety strategy
- Achievement of Sign up to Safety targets


NUMBER OF STAFF SATISFIED WITH HOW THE TRUST DEALS WITH INCIDENTS INCREASED
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again
2017 – 67.1%
2018 – 69.6%
WE ARE GIVEN FEEDBACK about CHANGES MADE in response to reported errors, near misses and incidents
2017 – 57.5%
2018 – 63.0%

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Customer Services Annual Update

With **all of us** in mind.

Summary

South West Yorkshire Partnership NHS Foundation Trust

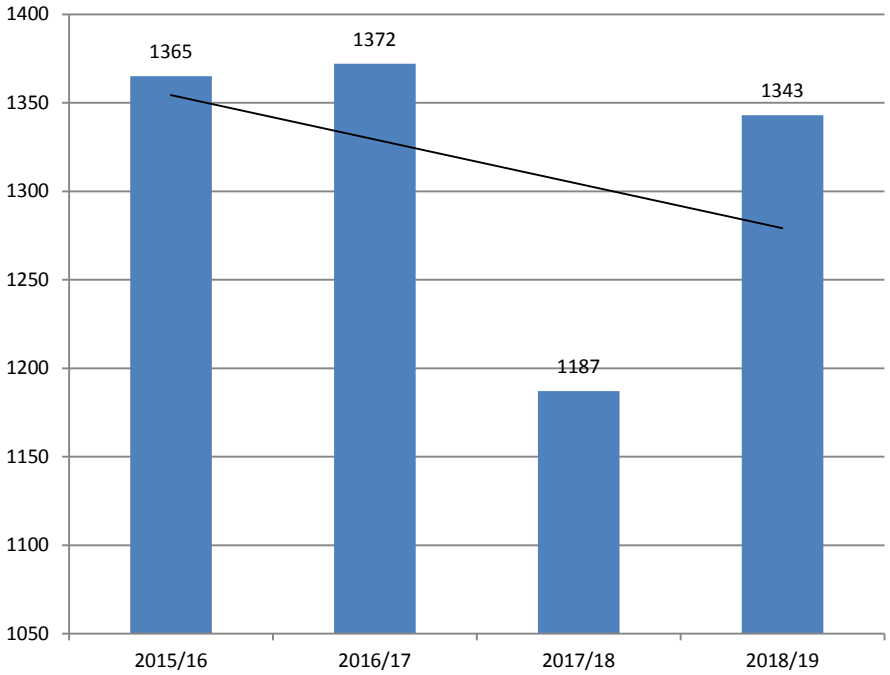
- The Trust received 1343 items of feedback in the form of complaints, concerns, comments and compliments in 2018/19. This is an increase in the previous year when feedback totalled 1187.
- 119 formal complaints were received, a decrease on the previous year of 185.
- 78 formal complaints were closed.
- 614 comments/concerns were received in 2018/2019 (578 received in the previous year).
- 610 compliments were received in 2018/19 (430 in 2017/18).
- 875 general enquires were responded to in the period
- Sign-posting to Trust services was the most frequent enquiry. 1162 telephone contacts were recorded.
- Access to treatment and drugs was identified as the most frequently raised negative issue (146). This was followed by communications (124), values and behaviours (96), admission and discharge (57), and appointments (45). Most complaints contained a number of themes.

With **all of us** in mind.

Feedback overview

South West Yorkshire Partnership NHS Foundation Trust

Total number of complaints, concerns, comments & compliments received into the Trust via customer services



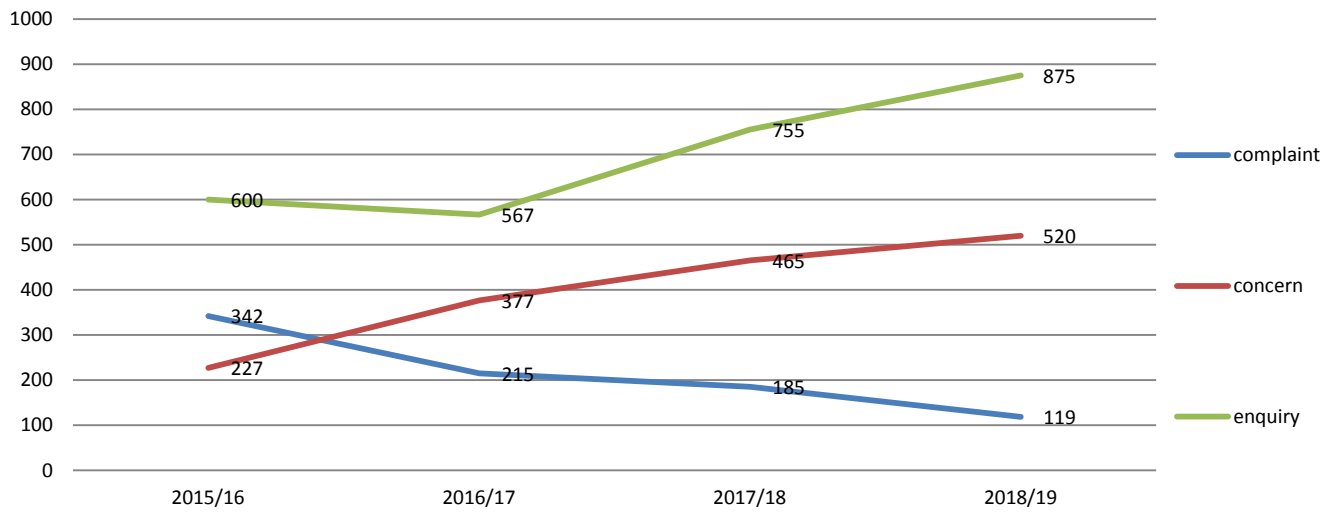
Overall, the total number of complaints, concerns, comments and compliments that that have been received within the Trust since 2015/16 is on a downward trend, with an average total of 1316 per year.

With **all of us** in mind.

Complaints activity

South West Yorkshire Partnership NHS Foundation Trust

Number of formal complaints, concerns and enquiries into customer services per quarter



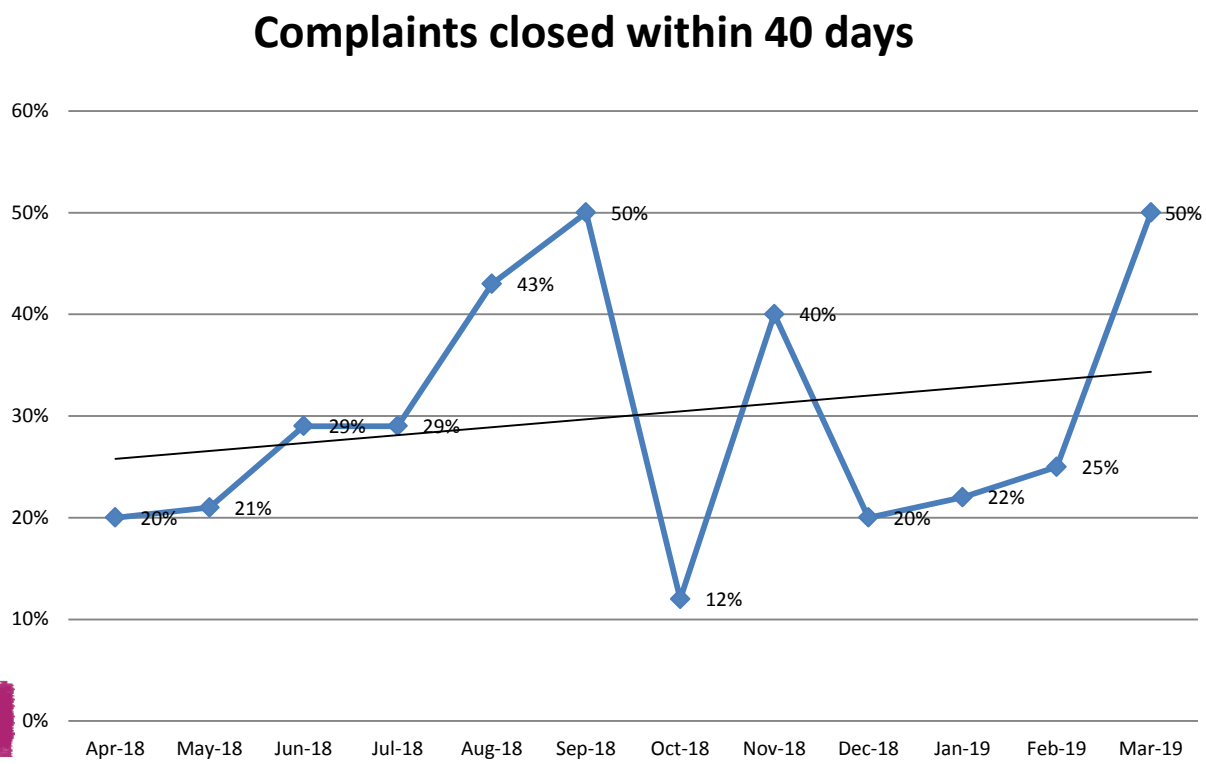
- Overall the number of formal complaints received into the Trust, since 2015/16 continues to decline. This can be explained by an actual reduction in people making complaints and the Trusts approach to complaint management, i.e. when people contact customer service we are proactive in seeking an early resolution to the issues raised within 48 hours. In line with this the number of concerns has increased as expected.
- The number of general enquiries into customer services has increased from 2015/16.

With **all of us** in mind.

Complaints Key Performance Measure

South West Yorkshire Partnership NHS Foundation Trust

In the Trust we have a Key Performance Measure's (KPI) related to complaints: Close 80% of formal complaints within 40 working days:



Slow progress is being made against this internal target. Work remains ongoing to improve our performance.

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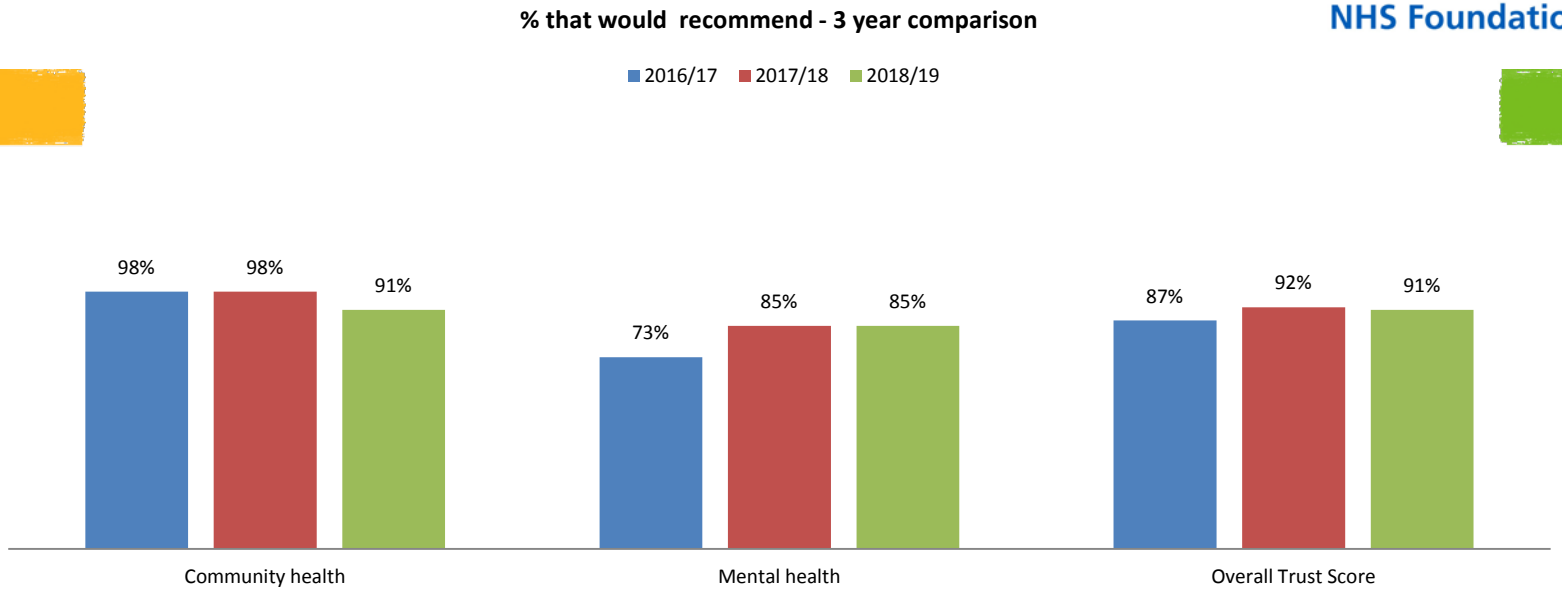
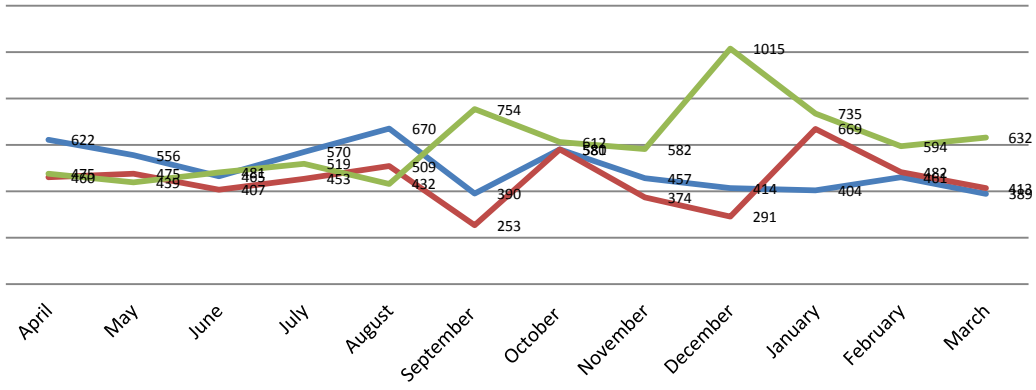
Friends & Family Feedback

South West Yorkshire Partnership NHS Foundation Trust





With **all of us** in mind.

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South West Yorkshire Partnership NHS Foundation Trust

Members' Council
2 August 2019

Agenda item:	**10**
Report Title:	Holding Non-Executive Directors to account - annual session
Report By:	Company Secretary
Action:	Interactive session

EXECUTIVE SUMMARY

Introduction

The duty to hold Non-Executive Directors (NEDs) to account for the performance of Trust Board is a key part of the governor role. This discussion item is designed to help governors find out more about their NEDs, the role they play in the Trust and how they perform their role as a member of the Trust's unitary board effectively.

The format of this session follows the successful 'speed dating' format used since 2015, which the Members' Council Co-ordination Group agreed should be repeated.

There will, therefore, be six 'speed dates' between governors and NEDs. These are:

- Angela Monaghan, Chair of the Trust
- Charlotte Dyson, Deputy Chair of the Trust / Senior Independent Director
- Laurence Campbell, Non-Executive Director
- Erfana Mahmood, Non-Executive Director
- Kate Quail, Non-Executive Director
- Sam Young, Non-Executive Director

Each NED 2019 Board profile has been included to provide some background information:

- an outline of what they believe they bring to the Trust, their individual experience, skills and areas of expertise;
- why they became a NED and why this Trust;
- for established NEDs, what they've achieved and, for newly appointed, what they would like to achieve;
- their role in the Trust (Committee membership, etc.).

Also provided is a brief description of the NEDs' role and that of an Executive Director within the unitary Board.

The purpose of the background information is to allow the group sessions at the meeting to focus on governor and NED questions and answers.

Governors and members of Trust Board will be randomly allocated to a table when

they arrive at the meeting. It is the intention that all governors will have the opportunity to meet all NEDs so there will be ten minutes for each group of governors with each NED. This is intended to be a two-way interactive process with governors given the opportunity to ask questions.

Non-Executive Director role description

1. General

Non-Executive Directors play a crucial role in bringing an independent perspective to Trust Board in addition to any specific knowledge and skills they may have. Non-Executive Directors have a duty to uphold the highest standards of integrity and probity and to foster good relations with Trust Board colleagues. They should apply similar standards of care and skill in their role as a Non-Executive Director of the Trust as they would in similar roles elsewhere.

Non-Executive Directors, including the Chair, have a particular role in helping and supporting the Members' Council to hold them to account for the performance of Trust Board.

Non-Executive Directors are expected to participate fully as members of Trust Board Committees to which they are appointed and to take the role of Committee Chair when so appointed.

Non-Executive Directors will meet periodically with the Chair, without the Executive Directors present, to discuss issues of interest or concern.

Non-Executive Directors will meet at least once a year with the Senior Independent Director, without the Chair present, to participate in the Chair's appraisal and the setting of objectives for the Chair. In exceptional circumstances, they may be asked to meet with the Senior Independent Director to attempt to resolve issues concerning the Chair's performance or to take action in that respect.

2. The Non-Executive Director role

Non-Executive Directors have a responsibility to:

- support the Chair, Chief Executive and Executive Directors in promoting the Trust's values;
- support a positive culture throughout the Trust and adopt behaviours that exemplify the Trust's culture;
- constructively challenge the proposed decisions of Trust Board and ensure that appropriate challenge is made in all circumstances;
- help develop proposals on priorities;
- help develop proposals on risk mitigation;
- help develop proposals on values and standards;
- contribute to the development of strategy.

Non-Executive Directors have a duty to:

- scrutinise the performance of the Executive Management Team in meeting agreed goals and objectives;
- satisfy themselves as to the integrity of financial, clinical and other information;
- satisfy themselves that financial and clinical quality controls and systems of risk management and governance are sound and that they are used;
- commission and use external advice where necessary;
- ensure they receive adequate information in the form that they specify and to monitor the reporting of performance.

Non-Executive Directors are responsible (acting in the appropriate Committees) for:

- determining appropriate levels of remuneration for Executive Directors;
- participating in the appraisal of Executive Directors, fellow Non-Executive Directors and the Chair;
- appointing the Chief Executive (with the approval of the Members' Council);

- appointing other Executive Directors along with the Chief Executive;
- where necessary, removing Executive Directors;
- succession planning for key executive posts;
- relations with the Members' Council.

Non-Executive Directors should:

- attend meetings of the Members' Council with sufficient frequency to ensure they understand the views of governors on key strategic and performance issues facing the Trust;
- take into account the views of governors and other members to gain a different perspective on the Trust and its performance;
- have an ongoing dialogue with the Members' Council on the progress made in delivering the Trust's strategic objectives, the high level financial and operational performance of the Trust;
- receive feedback from the Members' Council regarding performance and ensure the Trust Board is aware of this feedback.

Executive Director role description

1. Trust Board role

In addition to and separate from their management duties, as Trust Board members, Executive Directors have the same duties and responsibilities as Non-Executive Directors. The Executive Director's role as a Trust Board member covers all the business of Trust Board, not just their management specialism. Executive Directors share Trust Board's collective and individual responsibility for its decisions. Executive Directors, as Trust Board members, share the same legal liabilities as Non-Executive Directors. Executive Directors are expected to 'own' Trust Board decisions and act in accordance with collective decisions.

2. Appropriate challenge

While Executive Directors are likely to have the most detailed knowledge of their particular area of professional expertise, they should understand and welcome the need for constructive challenge from both Non-Executive Directors and their Executive Director colleagues. They should be open to having their proposals and reports tested in the light of different managerial expertise of their Executive Director colleagues and the broader experience that Non-Executive Directors bring to Trust Board.

3. Information

Executive Directors have a particular responsibility for ensuring that the information provided to Trust Board is accurate, timely, of high quality and is presented in the form required by Trust Board. Executive Directors also have a particular responsibility to ensure that the Members' Council is provided with accurate, timely and high quality information in the form required by governors.

4. Accountability

Although legislation specifies that governors hold Non-Executive Directors to account for the performance of Trust Board, Executive Directors will need to provide support in facilitating good accountability relationships. In practice, this will mean, for example, that Non-Executive Directors may require timely information from Executive Directors to support their dialogue with the Members' Council (to enable the Members' Council to form a view of Trust Board's performance).

South West Yorkshire Partnership NHS Foundation Trust

Trust Board profile 2019

Angela Monaghan

Date of appointment: ***1 August 2017 Non-Exec Director***
1 December 2017 Chair

SUMMARY OF RELEVANT QUALIFICATIONS	➢ BA Hons, Economics
CURRENT AREAS OF INTEREST IN THE TRUST, INCLUDING COMMITTEE MEMBERSHIP	Areas of interest: All aspects of the Trust's work, with a particular interest in: ➢ Staff, service user and carer engagement ➢ service improvement ➢ partnerships with the voluntary and community sectors ➢ equality and inclusion ➢ leadership ➢ governance ➢ strategic developments (including ICSs) Trust Committee membership: ➢ Chair of Equality and Inclusion Forum ➢ Member of Clinical Governance and Clinical Safety Committee ➢ Member of Workforce and Remuneration and Committee ➢ Member of Charitable Funds Committee ➢ Chair of Members' Council ➢ Member of Members' Council Co-ordination Group ➢ Chair of Nominations' Committee Partnership Group Membership ➢ Chair of West Yorkshire Mental Health, Learning Disability and Autism Collaborative ➢ Member of West Yorkshire & Harrogate Health and Care Partnership Board ➢ Member of Barnsley Integrated Care Partnership Board
SUMMARY OF EXPERIENCE/AREAS OF INTEREST TO SUPPORT DEVELOPMENT OF FT	➢ Over 20 years' experience of leading charities and social enterprises at both regional and national level (14 of those as a Chief Executive) and NHS bodies. ➢ Former Chief Executive of a children's hospice. ➢ Former Non Executive Director and Chair of an NHS Primary Care Trust. ➢ Significant experience of non executive roles in a wide range of voluntary and community sector organisations.
KEY DEVELOPMENT AREAS OVER THE NEXT 12 MONTHS	➢ Broaden understanding and knowledge of the Trust's services and the needs of our service users and carers. ➢ Build positive relationships with staff, service users, carers and partners across the Trust. ➢ Leadership skills.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board profile 2019

Charlotte Dyson

Date of appointment: 1 May 2015

SUMMARY OF RELEVANT QUALIFICATIONS	➢ BA Hons (Law and Economics) 2:1
CURRENT AREAS OF INTEREST IN THE TRUST, INCLUDING COMMITTEE MEMBERSHIP	Areas of interest: Improving quality of care for our patients Strategic development Marketing and communications Committee membership: ➢ Deputy Chair and Senior Independent Director ➢ Chair, Clinical Governance and Clinical Safety Committee ➢ Chair, Charitable Funds Committee ➢ Member, Workforce and Remuneration Committee
SUMMARY OF EXPERIENCE/AREAS OF INTEREST TO SUPPORT DEVELOPMENT OF FT	➢ Marketing Consultant ➢ Formerly Non-Executive Director for Calypso Soft Drinks ➢ Formerly Non-Executive Director Leeds Teaching Hospital ➢ Particular area of expertise in strategic brand marketing. ➢ Lay member for RCS of Edinburgh and chair for AAC's for LTHT o Member of the National and Local Advisory committee for Clinical Excellence awards
KEY DEVELOPMENT AREAS OVER THE NEXT 12 MONTHS	➢ Focus on patient centred care for our community ➢ Build stakeholder strategy and engagement ➢ Enhance Marketing and Communications ➢ Continue to develop financial understanding ➢ Develop knowledge of ACS (WY&H and SY&B)

South West Yorkshire Partnership NHS Foundation Trust

Trust Board profile 2019

Laurence Campbell

Date of appointment: 1 June 2014

SUMMARY OF RELEVANT QUALIFICATIONS	➢ MA Oxon (Natural Sciences) ➢ Fellow of the Institute of Chartered Accountants
CURRENT AREAS OF INTEREST IN THE TRUST, INCLUDING COMMITTEE MEMBERSHIP	Areas of interest: ➢ Finance ➢ Strategy ➢ Risk Committee membership: ➢ Chair of Audit Committee ➢ Member of Mental Health Act Committee
SUMMARY OF EXPERIENCE/AREAS OF INTEREST TO SUPPORT DEVELOPMENT OF FT	➢ 20 years' experience as Finance Director of large corporate businesses including two Public Limited Companies, all with significant international operations. Very interested in the development and implementation of strategy, and the balance between risk and opportunity. ➢ Treasurer and Trustee of Kirklees Citizens Advice and Law Centre.
KEY DEVELOPMENT AREAS OVER THE NEXT 12 MONTHS	➢ Safe and effective management of resources in a period of significant financial pressure and change; ➢ Focus on sustainability; ➢ Input into the strategic role of the trust and its application in the two Strategic Transformation Plans.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board profile 2019

Erfana Mahmood

Date of appointment: 3 August 2018

SUMMARY OF RELEVANT QUALIFICATIONS	➢ LLB (HONS) ➢ Qualified Solicitor
CURRENT AREAS OF INTEREST IN THE TRUST, INCLUDING COMMITTEE MEMBERSHIP	Areas of interest: ➢ Commitment to putting individuals at the heart of service provision ➢ and improving patient care ➢ Strategic development ➢ Governance Committee membership: ➢ Member, Audit Committee ➢ Member, Mental Health Act Committee ➢ Member, Equality & Inclusion Forum
SUMMARY OF EXPERIENCE/AREAS OF INTEREST TO SUPPORT DEVELOPMENT OF FT	➢ Experience in the housing sector. ➢ Non-Executive Director for Chorley and District Building Society ➢ Non-Executive Director for Plexus/Omega Housing (part of the ➢ Mears Group).
KEY DEVELOPMENT AREAS OVER THE NEXT 12 MONTHS	➢ Focus on delivering improved patient care ➢ Enhance development of governance and compliance. ➢ Support engagement with diverse communities.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board profile 2019

Kate Quail

Date of appointment: 1 August 2017

SUMMARY OF RELEVANT QUALIFICATIONS	➢ MA Public Health ➢ Managing Health and Social Care Services - Cert ➢ Registered General Nurse ➢ B.A. (Hons.) Psychology
CURRENT AREAS OF INTEREST IN THE TRUST, INCLUDING COMMITTEE MEMBERSHIP	Current areas of interest include: ➢ Developing SWYPFT's place in & contribution to the Integrated Care Systems and Place based plans - developing robust partnership arrangements & relationships. ➢ Ensuring role/ involvement of carers and service users. ➢ Creative Minds; Recovery Colleges; Social prescribing; VCS links Committee membership: ➢ Chair, Mental Health Act Committee ➢ Member, Clinical Governance & Clinical Safety Committee ➢ Member, Charitable Funds Committee
SUMMARY OF EXPERIENCE/AREAS OF INTEREST TO SUPPORT DEVELOPMENT OF FT	➢ Experienced, qualified Public Health professional with deep understanding of social determinants of health & wellbeing & the range of challenges many people face. Developed prevention & early intervention initiatives, using strength-based approaches to create strong resilient connected communities & support people to build fulfilling lives. ➢ Previously Head of two Department Health National Support Teams including one for Children and Young People's Emotional Wellbeing and Mental Health. ➢ Experienced in putting people with learning disability and/ or autism and/ or mental health problems & their families and carers at the centre. For example: o Member of Advisory Group to Improving Health and Lives Learning Disability Observatory (Public Health England until March 2019). o Original national Transforming Care steering group member, working to support people in their communities & prevent admission to hospital. o Expert for Care and Treatment Reviews and Care Education and Treatment Reviews ➢ Extensive experience of working in partnership across whole systems.

	➢ Experienced in building strong partnerships between commissioners & providers across health & care, including GPs & voluntary and community sector, citizens, patients and service users. ➢ In-depth experience of working in and with large complex organisations, from national & local charities and local community organisations, to Local Authorities, health organisations and Whitehall Departments.
KEY DEVELOPMENT AREAS OVER THE NEXT 12 MONTHS	➢ Continue to develop relationships with Members' Council ('Associate') Hospital Managers, a broader range of staff and service user and carer groups. ➢ Deeper understanding of operational areas of Trust, as relevant and also how service users & carers are meaningfully involved in planning and developing the Trust's services. ➢ Further develop the Mental Health Act Committee and all aspects of compliance with the Mental Health Act.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board profile 2019

Sam Young

Date of appointment: 3 August 2018

SUMMARY OF RELEVANT QUALIFICATIONS	➢ BA Hons (Business Studies) 1st ➢ MSc IT and Management ➢ ILM (L5) & EMCC Foundation – Coaching and Mentoring
CURRENT AREAS OF INTEREST IN THE TRUST, INCLUDING COMMITTEE MEMBERSHIP	Areas of interest: ➢ Organisational culture. ➢ Technology and digital development. ➢ Transformation and digital transformation and optimisation programmes. Committee membership: ➢ Chair, Workforce and Remuneration Committee. ➢ Member, Audit Committee. ➢ Member, Equality and Inclusion Forum.
SUMMARY OF EXPERIENCE/AREAS OF INTEREST TO SUPPORT DEVELOPMENT OF FT	➢ Runs 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. Previous 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. ➢ Non-Executive Director at Great Places Housing Group.
KEY DEVELOPMENT AREAS OVER THE NEXT 12 MONTHS	➢ Further develop knowledge of trust activities, and wider NHS systems. ➢ Focus on strategic opportunities and plans for service user centred digital optimisation and transformation. ➢ Enhance transformation planning. ➢ Focus on service user experience through an engaged, inclusive, motivated workforce. ➢ Continue to develop NHS financial understanding.

South West Yorkshire Partnership NHS Foundation Trust

Members' Council annual work programme 2019

Agenda item/issue	Feb	May	Aug	Nov
Standing items				
Declaration of interests	✘	✘	✘	✘
Minutes and matters arising	✘	✘	✘	✘
Chair's and Chief Executive's report and feedback from Trust Board	✘	✘	✘	✘
Governor engagement feedback	✘	✘	✘	✘
Integrated performance report	✘	✘	✘	✘
Trust Board appointments				
Appointment/Re-appointment of Non-Executive Directors *(if required)*	✘	✘	✘	✘
Ratification of Executive Director appointments *(if required)*	✘	✘	✘	✘
Review of Chair and Non-Executive Directors' remuneration (process and timescales)			✘	
Annual items				
Evaluation / Development session (to follow main meeting)	✘			
Local indicator for Quality Accounts	✘			
Annual report unannounced/planned visits		✘		
Care Quality Commission (CQC) action plan		✘		
Private patient income (against £1 million threshold)		✘		
Annual report and accounts			✘	
Quality report and external assurance			✘	
Customer services annual report			✘	
Serious incidents annual report			✘	
Strategic meeting with Trust Board				✘
Trust annual plans and budgets, including analysis of cost improvements				✘

Agenda item/issue	Feb	May	Aug	Nov
Members' Council Business				
Members' Council elections	✘	✘		
Chair's appraisal	✘			✘
Consultation / review of Audit Committee terms of reference		✘		
Members' Council Co-ordination Group annual report		✘		
Members' Council Quality Group annual report		✘		
Appointment of Lead Governor		✘	✘	
Holding Non-Executive Directors to account			✘	
Review and approval of Trust Constitution				✘
Members' Council meeting dates and annual work programme				✘
Review and approval of Membership Strategy *(next review due April 2020)*				
Appointment of Trust's external auditors *(next due in August 2020)*				
Members' Council objectives *(next due in November 2020)*				
Other items				
Priority programme update		✘		✘
Other agenda items to be discussed and agreed at Co-ordination Group meetings to ensure relevant and topical items are included.	✘	✘	✘	✘