South West Yorkshire Partnership NHS Foundation Trust

**Members' Council**
**12.40 – 16.50 on Friday 31 July 2020**
***(pre-meet from 11.30 – 12.25)***
**Virtual meeting**

| Item | Approx. Time | Subject Matter | Lead | | Action | Minutes allotted |
|---|---|---|---|---|---|---|
| | *11.30* | *Governors / Directors pre-meet (to finish at 11:55)* | | | | *25* |
| | *12.00* | *Governors only pre-meet (to finish at 12:25 – 15 minute comfort/food break)* | | | | *25* |
| **1.** | 12.40 | Chairs re-appraisal *(to be held in private - governors only)* | Charlotte Dyson, Deputy Chair | ***Paper*** | To discuss | 25 |
| | *13.05* | *Change from governor only session to Members' Council meeting* | | | | *5* |
| **2.** | 13:10 | Welcome, introductions and apologies | Angela Monaghan, Chair | **Verbal** | To receive | 8 |
| **3.** | 13:18 | Declarations of Interests | Angela Monaghan, Chair | **Verbal** | To receive | 2 |
| **4.** | 13.20 | Poem to be read | Carol Irving, publicly elected governor, Kirklees | **Verbal** | To receive | 5 |
| **5.** | 13:25 | Minutes of the previous meeting held on 1 May 2020 and action log | Angela Monaghan, Chair | **Paper** | To approve | 5 |
| **6.** | 13:30 | Chair's / Chief Executive's update – to include feedback from the Trust board meeting held on 28 July | Angela Monaghan, Chair / Rob Webster, Chief Executive | **Paper Verbal** | To receive | 15 |
| **7.** | **13.45** | **<u>Members' Council business items</u>** | | | | |
| | 13.45 | 7.1 Governor appointment to Members' Council and Trust Board groups and committees | Angela Monaghan, Chair | **Paper** | To approve | 5 |
| | 13.50 | 7.2 Governor Feedback | John Laville, Lead Governor | **Paper** | To receive | 10 |
| | 14.00 | 7.3 Assurance from Members' Council groups and Nominations' Committee | Angela Monaghan, Chair | **Paper** | To receive | 5 |
| | 14.05 | 7.4 Nominations' Committee annual report 2019/20, including update to terms of reference | Angela Monaghan, Chair | **Paper** | To approve | 5 |

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| | 14.10 | 7.5 Members Council Coordination Group Terms of Reference | Angela Monaghan, Chair | **Paper** | To agree | 5 |
| | 14.15 | 7.6 Annual report and accounts 2019/20 | Paul Hewitson, Deloitte, External Auditor | **Presentation** | To receive | 15 |
| | 14.30 | 7.7 Quality report and accounts 2019/20 – progress update and timescale | Tim Breedon, Director of Nursing & Quality | **Paper** | To receive | 5 |
| | 14.35 | 7.8 Customer services annual report 2019/20 | Tim Breedon, Director of Nursing & Quality | **Paper** | To receive | 5 |
| | 14.40 | 7.9 Serious incidents annual report 2019/20 | Tim Breedon, Director of Nursing & Quality | **Paper** | To receive | 5 |
| | 14.45 | 7.10 Consultation / review of Audit Committee terms of reference | Laurence Campbell, Non-Executive Director (Audit Committee Chair) | **Paper** | To agree | 5 |
| | 14.50 | 7.11 Recommendation of appointment of external auditors *(private item)* | Laurence Campbell, Non-Executive Director (Audit Committee Chair) / Bill Barkworth, Deputy Lead Governor | **Paper** | To approve | 10 |
| | 15.00 | *BREAK* | | | | 10 |
| **8.** | **15.10** | **<u>Trust Board appointments</u>** | | | | |
| | 15.10 | 8.1 Reappointment of Chair | John Laville, Lead Governor | **Paper** | To approve | 10 |
| | 15.20 | 8.2 Non-Executive Director appointment | John Laville, Lead Governor | **Paper** | To approve | 10 |
| | 15.30 | 8.3 Review of Chair and Non-Executive Directors' remuneration (process and timescales) | John Laville, Lead Governor | **Paper** | To approve | 10 |
| **9.** | **15.40** | **<u>Members' Council business items (presentations)</u>** | | | | |
| | 15.40 | 9.1 Integrated performance report | Mark Brooks, Director of Finance & Resources / Tim Breedon, Director of Nursing & Quality | **Presentation** | To receive | 30 |

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| | 16.10 | 9.2 Care Quality Commission (CQC) – action plan update and update on our inspection and annual report unannounced/planned visits | Tim Breedon, Director of Nursing & Quality / Subha Thiyagesh, Medical Director | **Presentation** | To receive | 30 |
| **10.** | **16.40** | **<u>Any other business</u>** | | | | |
| | 16.40 | 10.1 Annual Members' Meeting | Andy Lister, Head of Corporate Governance (Company Secretary) | **Verbal** | To receive | 5 |
| **11.** | 16.45 | **<u>Closing remarks, work programme, and future meeting dates</u>**<br>- Work programme 2020/21 (attached)<br>- Members' Council meetings 2020:<br>➢ 30 October 2020 (Joint Trust Board meeting) – Wakefield, 9.30 – 14.30 *TBC*<br>➢ 29 January 2021 – Barnsley, 12.00-4.30pm *TBC* | Angela Monaghan, Chair | **Paper and verbal item** | To receive | 5 |
| | *16.50* | *CLOSE* | | | | |

South West Yorkshire Partnership NHS Foundation Trust

# Minutes of the Members' Council meeting held on 1st May 2020

## Meeting Held Virtually by Skype

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| **Present:** | Angela Monaghan (AM) | Chair |
| | Marios Adamou (MA) | Staff – Medicine and Pharmacy |
| | Kate Amaral (KA) | Public – Wakefield |
| | Bill Barkworth (BB) | Public – Barnsley |
| | Evelyn Beckley (EB) | Appointed – Staff side organisations |
| | Bob Clayden (BC) | Public – Wakefield |
| | Jackie Craven (JC) | Public – Wakefield |
| | Adrian Deakin (AD) | Staff – Nursing (left at 13:00) |
| | Dylan Degman (DD) | Public – Wakefield |
| | Lisa Hogarth (LHo) | Staff – Allied Healthcare Professionals |
| | Tony Jackson (TJ) | Staff – Non-Clinical Support Services |
| | Adam Jhugroo (AJ) | Public – Calderdale |
| | Trevor Lake (TL) | Appointed – Barnsley Hospital NHS Foundation Trust |
| | John Laville (JL) | Public – Kirklees |
| | Cllr Ros Lund | Appointed – Wakefield Council |
| | Tom Sheard (TS) | Public – Barnsley |
| | Phil Shire (PS) | Public – Calderdale |
| | Keith Stuart-Clarke (KSC) | Public – Barnsley |
| | Debs Teale (DT) | Staff – Nursing Support |
| | Tony Wilkinson (TW) | Public – Wakefield |
| **In attendance:** | Carol Harris (CH) | Director of Operations |
| | Mark Brooks (MB) | Director of Finance & Resources |
| | Charlotte Dyson (CD) | Deputy Chair / Senior Independent Director |
| | Rob Webster (RW) | Chief Executive |
| | Laurence Campbell (LC) | Non-Executive Director |
| | Alan Davies (AGD) | Director of Human Resources, Organisational Development & Estates |
| | Kate Quail (KQ) | Non-Executive Director |
| | Laura Arnold (LA) | Administrative Support (observer) |
| | Andy Lister (AL) | Lead Serious Incident Investigator and Company secretary designate (author) |
| | Lucy Auld (LAu) | Personal Assistant (paper presentation) |
| | Jane Wilson (JW) | Personal Assistant (observer) |
| **Apologies:** | <u>Members' Council</u> | |
| | Cllr Bill Armer (BA) | Appointed – Kirklees Council |
| | Paul Batty (PB) | Staff - Social care staff working in integrated teams |
| | Daz Dooler (DD) | Public – Wakefield |
| | Carol Irving (CI) | Public – Kirklees |
| | Ruth Mason (RM) | Appointed – Calderdale and Huddersfield NHS Foundation Trust |
| | Debbie Newton (DN) | Appointed – Mid Yorkshire Hospitals NHS Foundation Trust |
| | Cllr Chris Pillai (CP) | Appointed – Calderdale Council |
| | Jeremy Smith (JS) | Public – Kirklees |
| | Cllr Nicola Sumner (NS)Prof | Appointed – Barnsley Council |
| | Barry Tolchard (BT) | Appointed University of Huddersfield |

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With all of us in mind.

Attendees

| | |
|---|---|
| Tim Breedon (TB) | Director of Nursing & Quality / Deputy Chief Executive |
| Chris Jones (CJ) | Non-Executive Director |
| Sam Young (SY) | Non-Executive Director |
| Erfana Mahmood (EM) | Non-Executive Director |
| Subha Thiyagesh (SThi) | Medical Director |
| Salma Yasmeen | Director of Strategy |
| Sean Rayner | Director of Provider Development |

**MC/20/14 Welcome, introductions and apologies (agenda item 1)**

The Chair, Angela Monaghan (AM) welcomed everyone to the meeting, in particular new governors Tony Wilkinson (TW), Tony Jackson (TJ) and Dylan Degman (DD) who had recently been elected. AM ran through the logistics of how the meeting would be run due to it being conducted remotely through Skype.

Some members reported difficulty in joining the meeting via Skype and had dialled into the meeting by telephone instead. AM gave options to those dialling in as to how best to alert her if they had a question or matter to raise.

The attendance list was double checked due to the complications with the Skype facility.

It was noted that, in response to Covid-19 (Coronavirus), the Trust Chair has taken the decision to suspend non-urgent and non-essential business in line with national guidance and decisions taken through the Trust emergency planning structures.

AM informed the members council that the Chief Executive Rob Webster (RW) would be attending the meeting from around 12:15 due to being on an urgent national conference call.

Apologies were noted as above.

AM explained the logistics of how members would be asked to step out of the meeting at appropriate times due to conflicts of interest and reconnect when contacted by Laura Arnold (LA).

AM stated that for item 5.2 John Laville (JL), Tony Wilkinson (TW) and Bill Barkworth (BB) would need to leave the meeting.

For item 5.3 Keith Stuart-Clarke (KSC) and Dylan Degman (DD) may need to step out of the meeting but AM would ask council members first if this was necessary.

For items 6.1, 6.2 and 6.3 all Non-Executive Directors (including AM) would need to leave the meeting.

**MC/20/15 Declaration of Interests (agenda item 2)**

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

The following declarations of interest for 2020/21 have been made by the Members' Council. *Where no return has been received by the Trust, the current entry on the Register has been included in italics*
:

Current governors (2020/21)

| Name | Declaration |
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| Name | Declaration |
|---|---|
| ADAMOU, Marios<br>Staff elected – Medicine and Pharmacy | Director, Marios Adamou Ltd.<br>Board member, UKAAN.<br>Secondary Care Doctor member, NHS Northumberland Clinical Commissioning Group (CCG). |
| AMARAL, Kate<br>Publicly elected – Wakefield | No interests declared. |
| ARMER, Bill<br>Appointed – Kirklees Council | No interests declared. |
| BARKWORTH, Bill<br>Publicly elected – Barnsley | Director, Barkworth Associates Limited.<br>Senior Associate with Campbell Tickell, a management consultancy partnership specialising in social housing. The partnership does not work with the NHS but may do so at some stage in the future. |
| BATTY, Paul<br>Staff elected – Social care staff working in integrated teams | No interests declared. |
| BECKLEY, Evelyn<br>Appointed – Staff side organisations | No interests declared. |
| CLAYDEN, Bob<br>Publicly elected – Wakefield | Chair, Portobello Community Craft and Camera Group.<br>Occasionally contracted for sessions as freelance artist by Next Generation Artzone.<br>As a freelance artist, may be employed by groups funded or partially funded by the Trust.<br>Member of West Yorkshire & Harrogate Cancer Alliance Community Panel. |
| CRAVEN, Jackie<br>Publicly elected – Wakefield | Board member, Young Lives Consortium, Wakefield.<br>Member, Alzheimer's' Society.<br>Member, Versus Arthritis.<br>Member, Dementia UK.<br>Volunteer, HealthWatch, Wakefield.<br>Volunteer Ambassador, Dementia UK.<br>Parish Councillor, Crigglestone Parish Council.<br>Trustee, Crigglestone Village Institute.<br>Trustee, Hall Green Community Centre.<br>Trustee, 45 Durkar Scouts.<br>Trustee, Worrills Almshouses. |
| CROSSLEY, Andrew<br>Publicly elected – Barnsley (to 30 April 2020) | Shareholder (non-controlling), Liaison Financial Services.<br>Volunteer, Victim Support, Wakefield.<br>Placement Counsellor, Mind, Barnsley & Rotherham |
| *DEAKIN, Adrian*<br>*Staff elected – Nursing* | *No interests declared.* |
| DEGMAN, Dylan<br>Publicly elected – Wakefield (from 1 | No interests declared. |

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| Name | Declaration |
|---|---|
| May 2020) | |
| *DOOLER, Daz*<br>*Publicly elected – Wakefield* | *Chair, S.M.a.S.H Society.*<br>*Seconded position through Nova, Live Well Wakefield Team, South West Yorkshire Partnership NHS Foundation Trust.* |
| HARRISON, Lin<br>Staff elected – Psychological therapies (to 30 April 2020) | Fulltime secondment as Suicide Prevention Project Manager for West Yorkshire and Harrogate Health and Care Partnership (WYHHCP).<br>Member of the Labour party.<br>Volunteer Co-ordinator for sub area of Crookes Mutual Aid Group (COVID-19 Community Support)<br>I commission services for the ICS as Suicide Prevention Project Manager, for example the West Yorkshire and Harrogate Suicide Bereavement Service fulfilled by Leeds Mind.<br>My wife is a Commissioning Manager for Sheffield CCG. |
| HASNIE, Nasim<br>Publicly elected – Kirklees (to 30 April 2020) | Trustee of Voluntary Action Kirklees. |
| HOGARTH, Lisa<br>Staff elected – Allied Healthcare Professionals | Member governor, Salendine Nook High School Huddersfield.<br>Member of the Labour Party. |
| IRVING, Carol<br>Publicly elected – Kirklees | Volunteer Ambassador, Dementia UK. |
| JACKSON, Tony<br>Staff elected – Non-clinical support services (from 1 May 2020) | No interests declared. |
| JHUGROO, Adam<br>Publicly elected – Calderdale | Primary Care Diabetes Team, NAPP Pharmaceuticals.<br>Daughter, Student Nurse / Staff Bank, South West Yorkshire Partnership NHS Foundation Trust<br>Currently in the process of joining of Cygnet Healthcare as a Bank Registered Mental Health Nurse.<br>Full time employment NAPP Pharmaceuticals, currently working in Specialist Drive Primary Care in Diabetes.<br>Recently joined NHS Professionals as a Registered Mental Health Nurse in relation to the Coronavirus outbreak. |
| LAKE, Trevor<br>Appointed – Barnsley Hospital NHS Foundation Trust | Chair, Barnsley Hospital NHS Foundation Trust.<br>Chair, Joint Independent Audit and Ethic Committee, West Yorkshire Police and Crime Commissioners and West Yorkshire Police Force.<br>Director, Six Degrees Consultancy (non NHS work).<br>Chair, Trustees of Barnsley Hospital Charity. |
| LAVILLE, John<br>Publicly elected – Kirklees | Director and Shareholder, EMS (Hartshead) Ltd (dormant company). |

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| Name | Declaration |
|---|---|
| | Member / Carer Representative, Kirklees Mental Health Partnership Board.<br>Trustee and Chair, Popplewell Charity.<br>Patient Representative North Kirklees Primary Care Commissioning Committee |
| LUND, Ros<br>Appointed – Wakefield Council | Wakefield MDC: Deputy Cabinet Member, Adults and Health<br>Member of The Labour Party |
| MASON, Ruth<br>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, Devika<br>Publicly elected – Wakefield (to 30 April 2020) | No interests declared. |
| NEWTON, Debbie<br>Appointed – Mid Yorkshire Hospitals NHS Trust | Director of Community Services, Mid Yorkshire Hospitals NHS Trust. |
| *PILLAI, Chris*<br>*Appointed – Calderdale Council* | *Independent Hospital Manager.* |
| SHEARD, Tom<br>Publicly elected – Barnsley (from 1 May 2020) | Director and Company Secretary of Barnsley TUC Training Ltd.<br>Member of 'Monk Bretton Cares' a voluntary group who organise and provide a Dementia Café in Monk Bretton once per week. This is in conjunction with BIADS Barnsley Dementia Support.<br>Member and Chair of Patient Group at White Rose Medical Practice. |
| SHIRE, Phil<br>Publicly elected – Calderdale | Director, Greenroyd Bowling Club Limited. |
| SMITH, Jeremy<br>Publicly elected – Kirklees | Director, Predictlaw Ltd. |
| STUART-CLARKE, Keith<br>Publicly elected – Barnsley | Volunteer with West Yorkshire and Harrogate NHS trust CCG, in the post with their reduction of suicide project which is based at White Rose House, Wakefield. |
| *SUMNER, Nicola*<br>*Appointed – Barnsley Council* | *No interest declared.* |
| TEALE, Debs<br>Staff elected – Nursing support | No interests declared. |
| TOLCHARD, Professor Barry<br>Appointed – University of Huddersfield | No interests declared. |
| WILKINSON, Tony<br>Publicly elected – Calderdale (from 1 May 2020) | Trustee Board member Healthwatch Kirklees |

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Past governors (who left in 2019/20)

| Name | Declaration |
|---|---|
| ALEXANDER, Neil<br>Publicly elected – Calderdale | No interests declared. |
| WILLIAMS, Paul<br>Publicly elected – Rest of Yorkshire & the Humber | No interests declared. |

No questions or comments were raised in relation to any of the declarations made.

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

**MC/20/16 Minutes and actions of previous meetings held on 31 January 2020 (agenda item 3)**
AM asked for any corrections or amendments to the minutes. No amendments or corrections were noted.

**It was RESOLVED to APPROVE the minutes of the Members' Council meeting held on 31 January 2020 as a true and accurate record.**

AM pointed out that some of the action points had been deferred due to the Covid-19 pandemic and this had been done to reduce the burden on the executive team.

Actions under reference MC/20/03 were amended on this basis as follows:

- PLACE inspection reports – timescale deferred due to Covid-19
- Quality monitoring visits, proposal for raising and addressing issues raised by governors – response deferred to July 2020 due to Covid-19
- Quality monitoring visits, process – this will be reviewed at the next Members' Council Quality Group meeting (May meeting deferred to align with the timescale for production of the Quality Account).

AM confirmed that all entries that followed in the action log, highlighted in blue, were complete.

AM stated that action MC/20/09 had been deferred due to Covid-19.

Bob Clayden (BC) asked about this action and the use of recording devices for meetings. He had noticed that one of the meetings earlier this week had been recorded and asked if today's meeting was being recorded.

Andy Lister (AL) and LA confirmed the meeting was not being recorded.

AM stated that when meetings were going to be recorded it would be made clear at the outset of the meeting.

**Action: Angela Monaghan / Andy Lister**

AM further stated that item reference MC/20/10 would be dealt with by the Members' Council Quality Group at their next meeting.

No further matters were raised.

**MC/20/17 Chair's/Chief Executive's Update (agenda item 4)**

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AM noted that yesterday had been the last day of Jackie Craven's (JC) term of office as lead governor. AM reported JC had completed two terms as a governor and had done a fantastic job and wanted to acknowledge and thank JC for her service as lead governor.

AM was pleased to announce that JC had been re-elected as a governor for the Wakefield area and so would continue to work with the Trust for another three years.

AM described JC as committed, hardworking and caring and highlighted that JC had attended every monthly welcome event held by the Trust, as a volunteer table host, and this demonstrated her level of commitment.

AM advised a certificate of thanks was being sent to JC to pay tribute to her and all the hard work she had done for the Trust as Lead Governor.

AM also wanted to acknowledge and thank governors who had recently retired including Andrew Crossley, Nasim Hasnie, Devika Minocha and Lin Harrison.

AM reported there had been a question and answer (Q&A) session for governors on Tuesday 28 April 2020 following the Trust Board meeting and thanked those that had been able to join and apologised to those who hadn't been able join due to technical difficulties.

AM confirmed that the notes from the Governors Q&A session had now been sent out. She asked members to inform her of any issues the Trust could assist with in preparation for the next session.

AM informed members that the intention was to hold another Q&A session after the next Trust Board in May.

AM advised that the Trust Board meeting had been held on Tuesday 28th April (Business and Risk) and the papers were available on the Trust website for those that hadn't been able to attend. AM advised that seven members of the public had successfully dialled into the meeting, including five governors.

AM updated that the majority of the Trust Board meeting had been held in public and only one risk had been discussed in private due to commercial confidentiality.

The private meeting had also received an update on current serious incident investigations, business developments in our Integrated Care Systems (ICS) including the focus around the Covid-19 response, and an update on our block contracts for 2020/21, which had been discussed in private due to commercial confidentiality.

RW reported that all governors had been receiving the Trust's daily updates about developments in respect of Covid-19.

RW updated that the monthly Brief took place yesterday through the Extended Management Team meeting, which reported that the Trust was in a good position in respect of people, planning and finances, and that this would be shared with governors in due course.

RW reported that, due to the national emergency, the Trust is currently operating through a command and control structure including Bronze, Silver and Gold groups. This structure has allowed the Trust to manage well in response to the impact of Covid-19.

With regard to staffing, we had seen a reduction from 10% to 6% of staff having to self-isolate due to being shielded or themselves/ members of their household being symptomatic. Around 50% of those self-isolating were actually still working at home due to the provision of appropriate technology.

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The Trust has a good wellbeing offer for staff, helping people to stay at work. Services have been maintained and community physical services offered by the Trust have been enhanced. Inpatient services have been able to continue at full capacity.

There has not been an increase in Datix incidents and the Trust has been able to maintain its focus on quality and safety. The Trust has improved its surveillance techniques to continue to monitor this going forward.

RW reported a drop in the number of complaints received by the Trust but commented that there may be an increase in complaints again once things started to return to “normal” or when the consequences of changes to services was felt by more people.

Service levels have been maintained in the areas of safeguarding, child and adolescent mental health services (CAMHS) and psychological therapies, although we had seen a drop in the number of referrals to these areas. .

The financial year 2019/20 had ended with a small surplus resulting in a bonus for the Trust of £900,000 and a total surplus before provider sustainability funding [PSF] of £1 million. There was also a £1.6 million PSF bonus now available to spend on the Trust estate and capital.

There have been recurring themes about testing for Covid-19 and the Trust had enhanced and cleared the backlog of staff that required testing. The statistics were that fewer than 1 in 4 staff tested have proved positive for Covid-19.

There had been a lot of coverage in the press in respect of the lack of Personal Protective Equipment (PPE) and problems with PPE. RW confirmed that the Trust had no problems with PPE and this has not been an issue. The Trust had provided mutual aid to partners during this period.

The Infection, Prevention and Control (IPC) team had been issuing guidance in relation to PPE and its use and had been doing an excellent job.

The impact on Trust staff is acknowledged and the wellbeing offer is substantial and being reinforced every day. The Trust was trying to make sure leaders and managers were being compassionate and kind at all times. The Trust was ensuring staff knew to use Freedom To Speak Up Guardians where there was a need.

In recent days the Trust had acknowledged the disproportionate impact of Covid-19 on Black, Asian and Minority Ethnic (BAME) groups. RW had written to all BAME staff and encouraged them to hold discussions with their line managers based on a four step plan. There had been really positive feedback to this and it was felt to be allaying staff anxieties.

RW reported that, as a Trust, we have responded exceptionally well and were actively engaging with both ICSs in West and South Yorkshire, including collaboration on PPE, testing, finance and reporting.

RW advised there had been a downturn in the number of people dying in hospital and critical care beds that were Covid-19 positive but went on to say that deaths in care homes had only just started being counted and these now accounted for a quarter of all Covid-19 related deaths.

NHS England were now looking towards the second phase. As things were becoming more stable in hospitals and in terms of governance, we need to focus on how care homes and communities are being supported and recognise that the pandemic is not over yet.

NHS England were now looking at reintroducing treatment for cancer patients and those requiring urgent surgery. The Trust were being asked for support with testing and psychological support for staff in all settings.

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RW reported that in summary the Trust was doing well locally and engaging well with processes regionally and nationally.

BC thanked RW for his daily updates stating they had been very interesting and helped him understand the situation. It had also been good to remind staff about the £6 tax rebate a week for working from home.

AM thanked BC for his comments and reported there were more updates on the West Yorkshire & Harrogate ICS in Rob's weekly blogs on the ICS website, and also in the Brief.

RW stated the daily updates had been a really positive step and were a real team effort. They reflected well on the command structure and dedication of the teams.

John Laville (JL) asked about the longer term effect on people's mental health and how as a Trust were we preparing for an increase in demand?

RW advised that national groups were looking at a "recovery and restoration" phase but RW felt this was in danger of suggesting a return to "how we used to do things", which wasn't always as good as it could be, so the Trust was working on retaining what was good from "how we are doing things now" and as such was being pro-active and looking at the future. He preferred the language of "stabilisation and reset".

Debs Teale (DT) asked if there was any way that governors could become involved in this process? RW responded that he would be very happy for governors to be involved and that Salma Yasmeen (SY) was looking to involve as many public viewpoints as possible.

**Action: Salma Yasmeen**

JC stated she had enjoyed reading RW's daily updates but her main concern was that as well as helping with adults, was the Trust also looking at young adults and children in respect of the mental health impact of Covid-19?

RW responded that the Trust was providing mental health services across all ages and targeting younger groups through the use of CAMHS services and campaigns in social media. For the really young the Trust had speech and language therapy teams doing excellent work around their YouTube channel and parent-pointing services to help with speech, language and communication needs.

Child and Adolescent Mental Health Services (CAMHS) had a response into accident and emergency (A&E) units at the moment. Currently, in an emergency, patients would get a response from CAMHS as well as a member of the Psychiatric Liaison Team.

Keith Stuart-Clarke (KSC) thanked RW for involving governors and stated the updates were clear and concise. KSC expressed he would like to be involved in new groups looking into this area because as a single person he would like to be able to reflect how isolation has impacted on him. KSC also wished to thank the Trust for his recent nomination to the quality group.

Marios Adamou (MA) asked RW to explain what was being done about the impact of Covid-19 on staff?

RW advised that staff always had a good Occupational Health offer which has now been enhanced to seven days a week for psychological support. In addition, there is five-day pastoral and faith-based support and a seven day HR helpline.

As Covid-19 had progressed some national support had also become available for psychological help. As the pandemic progressed Alan Davis' (AGD) team brought together a

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hub so that staff had helplines, help for their physical wellbeing and things such as access to food. The latter started with all staff in inpatients being given a hot meal, when the supermarkets were most stressed. This was then enhance with a weekly cold snack box for community staff. From next week, all staff would be able to access a free meal once a week at Kendray and Fieldhead.

Line managers had been given support on coaching and mentoring and daily check-in through the Human Resources team with Operational Management Group input.

DT shared her experience in relation to the staff wellbeing service. She stated that, as an ex-service user, she would speak up if the service wasn't achieving expectations. DT informed members that coronavirus had impacted on her own mental health.

DT stated the Staff Wellbeing Service had been really, really good. It had been very supportive with links, ideas and tips and DT reported she was now feeling well and had only required one session.

DT said the service had suggested she might want to work for them. DT had been making suggestions to RW about how to make things more accessible due to her perspective on services.

DT reported her line manager had been fantastic. DT had felt supported and it had really helped her get back to where she was before. DT stated not all people are fortunate to have access to such a service and as a Trust we needed to be mindful of what might come next.

AM thanked DT for her comments and being so open.

Carol Harris (CH) asked to echo what RW and DT had said. Providing this service was not always straight forward and communication was sometimes hard. CH reported that questions at a service level were getting dealt with very quickly. Bronze to Silver command, got the clarity and support back to the staff quickly to allow them to do their jobs.

**It was RESOLVED to NOTE the Chair and Chief Executive's remarks.**

**MC/20/18 Members Council Business Items (agenda item 5)**
AM noted that the Members' Council business items agenda had been stripped back to essential items, due to Covid-19.

MC/20/18a Members' Council Elections (agenda item 5.1)
AM advised that the Members' Council was being asked to receive the update and hopefully members had had a chance to read this.

AM reported there had been four nominations for two seats in Barnsley, one nomination for one seat in Calderdale, no nominations for three seats in Kirklees and six nominations for two seats in Wakefield.

As a result two governors had been elected uncontested; Tony Wilkinson (TW) for Calderdale, and Tony Jackson (TJ) for non-clinical support staff.

Following voting, Bill Barkworth (BB) had been re-elected and Tom Sheard (TS) newly elected for Barnsley.

Jackie Craven had been re-elected and Dylan Degman (DD) newly elected for Wakefield.

AM noted that, since the start of the election, Paul Williams (PW), the publicly elected Rest of Yorkshire and Humber governor, had moved out of the constituency and was therefore no

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longer eligible to be a member and governor of the Trust. This meant that there were now five vacancies on the Members' Council.

AM advised there would be a further election later in the year after Covid-19 next steps had been established. A further update would be provided at the next Members' Council meeting in July.

**Action: Andy Lister / Aimee Willett**

**It was RESOLVED to RECEIVE the results of the Members' Council elections**

MC/20/18b Appointment of Lead Governor and Deputy Lead Governor (agenda item 5.2)
At the start of this item AM requested that JL, TW and BB leave the meeting due to a conflict of interest in the matters to be discussed.

AM advised for this item we were asking Members' Council to consider and the recommendations from the Nominations' Committee for a lead governor and deputy lead governor. AM reported this was the first time a deputy lead governor had been appointed.

AM stated members had received the papers and then summarised the appointment process.

The recommendations were JL for lead governor, and BB for deputy lead governor. AM informed members the recommendation for appointments was for three years from 1st May 2020 so that the posts fell in line with appointments to other Members' Council groups.

The Nominations' Committee members were AM, JC, Nasim Hasnie (NH), MA, Ruth Mason (RM).

Phil Shire (PS) commented that the governors did not know anything about the candidates as the Nominations' Committee had considered the decision for governors. PS stated it would have been useful to have understood the rationale behind the recommendations that had been made.

AM advised it was fine for the Nominations' Committee members to explain their decisions.

MA explained that he was part of the Nominations' Committee and the process started with an expression of interest from governors. There was then an interview and a robust discussion that followed about suitability, fitness for the role and all decisions were fully supported by the committee as a group.

Each candidate had a statement and statements could be shared with the Members' Council as to why each candidate wanted to take on the role.
The Nominations' Committee thought all candidates would have been fine in the roles. It was noted that TW had very recently been re-elected to the Members' Council but had been governor before.

JL and BB had both been in place as governors for a longer period of time and had given positive statements to the committee, which were well received. AM advised that candidates would be asked for permission to share their statements with the Members' Council.

**Action: Andy Lister / Aimee Willett**

PS said he assumed TW hadn't been selected as he had only recently returned to the Members' Council but agreed it would be good to see candidate statements, to support the decisions that had been made by the Nominations' Committee.

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The Members' Council agreed that John Laville was to be elected as lead governor and Bill Barkworth as deputy lead governor.

JL, TW and BB were then invited back into the meeting.

**It was RESOLVED to APPROVE the recommendations from the Nominations' Committee of John Laville as Lead Governor and Bill Barkworth as Deputy Lead Governor from 1 May 2020 for a period of 3 years, or until they step down as governors, whichever is the shorter.**

MC/20/18c Agreement of governor membership for Nominations Committee and Members Council Quality Group (agenda item 5.3)

AM stated the next item was to consider and agree the appointment of two new members to Members' Council groups. The two governors involved were Dylan Degman (DD) and Keith Stuart-Clarke (KSC).

AM suggested that DD and KSC did not need to leave as, under the appointment process, their appointment was automatic and would not require discussion, but checked with council members first who agreed the proposal.

AM confirmed that all members were content with the recommendations that KSC join the quality group as the publicly elected governor for Barnsley, and DD join the Nominations' Committee as the publicly elected governor.

AM confirmed that the Nominations' Committee would now include JL and BB as newly appointed lead and deputy lead governors, and that they would be invited to future Nominations' Committee meetings. AM noted that there were no nominations for a governor representative at the Trust Board Equality and Inclusion Committee.

Governors would be invited to self-nominate again for any remaining vacancies on groups and committees.

**Action: Aimee Willett / Laura Arnold**

**It was RESOLVED to AGREE the recommendation of Keith Stuart-Clarke as Barnsley representative on the Members' Council Quality Group and Dylan Degman as public governor on the Nominations' Committee.**

MC/20/18d Annual Reports (agenda item 5.4)

AM asked members if there was anything they wished to raise. She reiterated that JC as lead governor had been part of the Co-ordination Group and Quality Group up to now and JL would be taking over and invited to the future meetings.

**Action: Aimee Willett / Laura Arnold**

No comments or questions were raised by the Members' Council.

**It was RESOLVED to RECEIVE the annual reports for 2019/20**

MC/20/18e Members' Council Co-ordination Group (agenda item 5.4.1)

AM asked members if there was anything anybody wished to raise.

PS stated he was unclear on what the ongoing development programme was for governors and what it involved.

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AM responded that the ongoing development plan for the Members' Council is overseen by the Members' Council Co-ordination Group, and covers the development of both the Members' Council as a whole and individual governors. In 2019/20, the development opportunities made available had included the -one-day training sessions on 'Core Skills for Governors' and 'Accountability', both run by NHS Providers Governwell team, which we commissioned in partnership with Leeds & York Partnership Trust and Bradford District Care Trust. We also offered internal development sessions on 'Holding Non-Executive Directors to Account' delivered by appointed governor Ruth Mason, 'Understanding NHS Finance' delivered by Director of Finance and Resources, Mark Brooks, 'Social Prescribing' delivered by staff governor Debs Teale,; and training for governors on conducting PLACE inspections in the Trust. There had also been opportunities offered by outside organisations, which we had shared with governors as appropriate. We plan to run offer similar training and development opportunities this year, when we are able to do so.

We also send one or two governors, usually the Lead Governor, to the annual Governwell national conference for governors, which takes place in London in July. It is expected this will be deferred/postponed this year due to Covid-19.

In addition, AM has 1:1 induction meetings with newly appointed governors, and annual reviews with all governors, which include discussion on any individual development needs. These are recorded and added to the development plan as appropriate. For example, there will be training for new governors appointed to the Nominations' Committee on recruitment and selection.

NHS Providers Governwell training is good but is costly, which is whywe have partnered with other Trusts in West Yorkshire to commission bespoke sessions. We are hoping to do this again in 2020/21, after the Covid-19 emergency.

The Members' Council development plan is reviewed regularly, and is informed by the governor survey and Members' Council review, which used to take place annually but is now biennial. We will repeat this in 2020/21.

PS thanked AM for the update.

There were no further questions.

**It was RESOLVED to APPROVE the updated Terms of Reference**

MC/20/18f Members' Council Quality Group (agenda item 5.4.2)
There were no queries in relation to this item.

**It was RESOLVED to APPROVE the revised Terms of Reference**

MC/20/18g Appointment of external auditor (agenda item 5.5)
AM identified that there had not been a paper circulated in relation to this item but the Members' Council would now receive a verbal update from Mark Brooks (MB).

MB reported it was the responsibility of the Members' Council to invite external auditors to carry out the work.

MB stated the process had commenced with the invitation to tender having been sent out. MB reported that the tender had been fairly prescriptive as to what the Trust wanted. A provisional response had been requested for the 15th May.

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Presentations would be seen from those shortlisted and there would be an aim to propose a recommendation for Members' Council in July.

**Action: Mark Brooks**

MB noted that there had been low levels of response lately from audit firms to other NHS trusts going out to tender and therefore there might not be a huge response.

DD asked if there was a redundancy in place.

MB explained this was not an "employed" role and as such there was no redundancy requirement. MB said the Trust would need a contingency plan for the situation if no bids were received. He also noted the Trust is not under a duty to change the contractor but is under a duty to go out to tender.

BC asked if the Trust should extend the opportunity to respond given the current situation with Covid-19.

MB clarified that due to Covid-19, contractors had been given eight weeks to respond not three.

MB reported that BB was representing the governors on the group managing the tender process, along with Chris Jones (CJ), Laurence Campbell (LC) and MB.

Once tenders rae returned they will be evaluated with invitations sent out for a presentation event, which will need to be conducted virtually.

**It was RESOLVED to RECEIVE the update regarding the process around the appointment of the external auditor.**

**MC/20/19 Trust Board Appointments (agenda item 6)**

AM invited JL and BB, now they had been appointed into their respective roles as Lead Governor and Deputy Lead Governor, to say a few words.

JL stated he wished to reiterate AM's thanks to JC and it was good news that JC was continuing as governor. JL stated he was delighted his nomination had been accepted and wanted to assure the Members' Council that he would do his best to carry out his duties in the best way possible.

JL was delighted for BB and thought they would work well together, and that they had complementary skills.

JL would like to meet everybody as soon as possible. While lockdown continued he would be asking if people can give him e-mail addresses so conversations can continue. JL was keen to understand from Governors what they saw as their role so that he can gain a common perspective.

**Action: Aimee Willett / Laura Arnold**

JL stated it was an eclectic group but a very skilled group and he saw his role as lead governor to coordinate those skills. There were some areas of business that were ok and some areas that could be better. JL identified that there were lots of inactive members that needed activating. JL stated he would seek to achieve the Members' Councils expectations and exceed them.

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BB stated he wished to endorse what JL had said. He stated that they would be calling upon JC's wisdom on matters in the future. BB said he wanted to focus on membership and the membership strategy. He had been shocked at the low voting numbers.

BB reported we have a successful trust that is well valued and well delivered through great staff and volunteers and so queried why members aren't connecting with it more. BB stated that the silver lining in Covid-19 was the massive love and appreciation that had been shown for the NHS, which he felt gave the Members Council a unique opportunity to work on membership.

BB thanked the Members' Council for accepting his nomination.

AM and all NEDs then left the meeting.

JL advised members on the context of the decisions that the Members' Council were being asked to make.

He reported that the governors wouldn't normally be looking at two extensions and one reappointment but due to Covid-19 this was the situation that had presented itself. The Trust would normally be looking at new appointments but this was not a normal situation and two extensions were a reaction to current times.

JL stated it was vital to have continuity in the Trust Board at this time and it needed the right set of skills. It was not sensible for people to be leaving the board at this time.

MC/20/19a Extension of Non-Executive Director – Laurence Campbell (Agenda item 6.1)
JL explained the matter to be agreed was to extend LC's term to November 2020 at his current level of remuneration.

It has been due to end on 31st May and LC had not been looking to seek re-appointment. The Trust was looking to recruit into the position and interviews were set up but had to be postponed.

Four candidates had been shortlisted and were on hold and happy to be interviewed virtually. The target was to have the appointment by the end of June and bring it to the Members' Council by the end of July.

**Action: Andy Lister / Aimee Willett**

It was judicious to extend the term for six months but as referenced in point 6 of the paper LC's activity may be restricted from September 20th 2020 onwards.

JL pointed out that point 9 of the paper referenced an additional payment for £5000 as audit committee chair and this would be paid pro rata to the time in post.

Trevor Lake (TL) asked if it was right that the Trust was going to continue with the appointment process?

JL confirmed that in July's meeting it was possible there would be a new appointment in which case LC would then step down after a short handover

AGD provided an update and stated that the Trust had kept in contact with the four candidates and were happy to continue with a remote process.

It was difficult to coordinate the stakeholder groups section of the process and the facilitating of that but a good solution had now been found. All four candidates were able to participate in the

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process remotely and interviews were to take place at the beginning of June for July's Members' Council.

AGD reported that the process felt to be on track at this time.

**It was RESOLVED to SUPPORT the recommendation from the nominations committee to extend LC's term to November 2020**

MC/20/19b Extension of Deputy Chair / Senior Independent Director – Charlotte Dyson (Agenda item 6.2)

JL pointed out that there a typing error in the paper for this item that read January 2020 when it should be **January 2021**.

The item was the request to extend the term of the deputy chair and senior independent director for six months to 31st January 2021 with the same level of remuneration.

JL reiterated the logic for this item was the same as it had been for the previous one.

JL clarified that it was not CD's term that was in question as her term ran through to 30th April 2021, the extension was for CD's role as deputy chair/senior independent director.

JL reported that the senior independent director had to be drawn from the NEDs but couldn't be the audit committee chair as well and so until LC's replacement was found it was impossible to look at who will be SID hence the request for an extension. CD's remuneration and supplement was to remain unchanged.

TL stated he was really happy to support this. He commented that it was not unusual for chairs of audit committees to be SIDs in his experience but respected the arrangements within the Trust.

AGD stated that the Trust had always adopted this position that the roles should be separate. AGD stated he wasn't sure if this was in the constitution.

TL stated he was happy with this and was just making the point that it was not a legal requirement.

PS asked if the role of deputy chair was an open process where only existing NEDs could apply?

AGD stated the position was opened up for anyone who was a NED to apply for. People put in an expression of interest and what they could offer for the application process.

PS queried if the Trust were therefore waiting for a full NED compliment before this process commenced

AGD confirmed that once all NEDs were in place the matter would be progressed. A progress update will be provided at the Members' Council meeting in July.

**Action: Andy Lister / Aimee Willett**

**It was RESOLVED to SUPPORT the recommendation from the nominations committee to extend CD's term for a period of up to six months from 1 August 2020 to 31 January 2021**

MC/20/19c Reappointment of Non-Executive Director – Kate Quail (Agenda items 6.3)

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JL reported the next item was the re-appointment of KQ as a NED as recommended by nominations committee for a second term.

TL stated he was happy to support this as was BB.

KSC stated he was impressed that people were wanting to carry on in these roles and he thought that should be applauded.

**It was RESOLVED to SUPPORT the recommendation from the nominations committee to extend KQ for second term from 1 August 2020 to 31 July 2023**

**MC/20/20 Closing remarks, work programme, and future meeting dates (agenda item 7)**

AM was brought back into the meeting and reported that anything deferred on the work plan will be picked up later in the year.

JC stated she would like to thank everybody for their kind comments and reported that Covid-19 had made her life very different.

AM reiterated her thanks to JC in her role as lead governor.

AM asked for any comments on the work plan - no comments were made.

AM asked that feedback on the meeting would be sent out electronically, and governors should please let the Trust know if there had been technical issues.

**Action: Aimee Willett / Laura Arnold**

BC reported that he didn't seem to get the work programme in his pack.

AM stated that, for future reference, Members' Council papers can be accessed in the "About us" section on the Trust website and AM confirmed papers would be sent out to BC.

**Action: Aimee Willett/Laura Arnold**

**It was RESOLVED to RECEIVE the work programme for 2020/21**

Members Council Meetings 2020

The dates for the Members' Council meetings in 2020 held in public were noted as follows:

- 31 July 2020 (Calderdale) - 12.30-16.30pm, venue to be confirmed.
- 30 October 2020 (Wakefield) - 9.30am-14.30pm, Large conference room, Wellbeing & learning centre, Fieldhead, Ouchthorpe Lane, Wakefield, WF1 3SP

**Signed:** **Date:**

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NHS
South West Yorkshire Partnership
NHS Foundation Trust

# MEMBERS' COUNCIL 1 MAY 2020 – ACTION POINTS

= completed actions

| Minute ref | Action | Lead | Timescale | Progress |
|---|---|---|---|---|
| **MC/20/16** | Bob Clayden (BC) asked about this action and the use of recording devices for meetings. He had noticed that one of the meetings earlier this week had been recorded and asked if today's meeting was being recorded.<br><br>Andy Lister (AL) and LA confirmed the meeting was not being recorded.<br><br>AM stated that when meetings were going to be recorded it would be made clear at the outset of the meeting. | AM / AL | **October 2020** | **AL to look at recording and update in the Constitution.**<br><br>**If any meeting is to be recorded, it will be declared at the beginning of a meeting.** |
| **MC/20/17** | [Recovery and restoration] Debs Teale (DT) asked if there was any way that governors could become involved in this process? RW responded that he would be very happy for governors to be involved and that Salma Yasmeen (SY) was looking to involve as many public viewpoints as possible. | SY / Dawn Pearson | **June 2020** | **This will be discussed at the May Strategic Board and opportunities for governor involvement will be fed back following this.** |
| **MC/20/18a** | AM advised there would be a further election later in the year after Covid-19 next steps had been established. A further update would be provided at the next Members' Council meeting in July. | AL / AW | **September 2020** | **Review after Covid-19 pandemic, update on progress to July Members' Council meeting.**<br><br>**Update: To now be discussed at Septembers MC Coordination Group Meeting** |

With **all of us** in mind.

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| **MC/20/18b** | JL and BB had both been in place as a governor for a longer period of time. AM advised that candidates would be asked for permission to share their statements with the Members' Council. | AL / AW | **June 2020** | **Corporate Governance team will request permission to share statements and circulate to governors.** |
| **MC/20/18c** | AM confirmed that the Nominations Committee would now include JL and BB as newly appointed lead and deputy lead governors, and that they would be invited to future Nominations Committee meetings. | AW / LA | **June 2020** | **JL and BB will be added to the future Nominations Committee meetings.** |
| **Mc/20/18d** | AM asked members if there was anything they wished to raise. She reiterated that JC as lead governor had been part of the Co-ordination Group and Quality Group up to now and JL would be taking over and invited to the future meetings. | AW / LA | **June 2020** | **JL will be added to the future Group meetings.** |
| **MC/20/18g** | Presentations would be seen from those shortlisted and there would be an aim to propose a recommendation for Members' Council in July. | MB | **July 2020** | **Update to be provided to July Members' Council meeting** |
| **MC/20/19** | JL would like to meet everybody as soon as possible. While lockdown continued he would be asking if people can give him e-mail addresses so conversations can continue so that all members can understand what their role was and what the governors role were so they can move forward. | AW / LA | **June 2020** | **Corporate Governance team has requested permission to share contact details and will share with JL.** |
| **MC/20/19a** | Four candidates were happy they were on hold and happy to be interviewed virtually. The target was to have the appointment by the end of June and bring it to the Members' Council by the end of July. | AL / AW | **June / July 2020** | **AW working with HR to set interview dates. Recommendation will be made to Members' Council for approval dependent upon that process.** |
| **MC/20/19b** | [Appointment of Deputy Chair / Senior Independent Director] PS queried if the Trust were therefore waiting for a full NED compliment before this process commenced<br><br>AGD confirmed that once all NED's were in place the matter would be progressed. A progress update will be provided at the Members' Council meeting in July. | AL / AW | **July 2020** | **An update will be brought to the July Members' Council meeting, dependent upon the NED recruitment process.** |
| **MC/20/20** | AM asked that feedback on the meeting would be sent out electronically, and governors should please let the Trust know if there had been technical issues. | AW / LA | **May 2020** | **Survey circulated to governors and the Corporate Governance team will work to improve this where possible.** |

**Outstanding actions from 31 January 2020**

| Minute ref | Action | Lead | Timescale | Progress |
|---|---|---|---|---|
| **MC/20/03Minutes and actions of previous meetings held on 11 November 2019 (agenda item 4)** | MC/19/38 Governor engagement feedback (agenda item 7.4)<br>Phil Shire (PS) referred to the matter he had raised at the 11 November 2019 meeting regarding opportunities to feedback on PLACE inspection visits and where the reports went. AM replied that Alan Davis (AD) would know the answer to that and he would come back with a response. | Alan Davis | **May 2020** | **Timescale deferred due to Covid-19 (Coronavirus) pandemic.**<br>**PLACE inspection reports shared with relevant governors in March 2020.** |
| | PS added that he had been involved in some of the quality monitoring visits that were held in December, and that there were wider issues raised. He questioned whether more feedback should be provided from the findings of those visits, which were just a sample, together with any action points. AM advised that discussions had begun with the Trust engagement team, and she would report back via the Members' Council Co-ordination Group with a proposal with regard to a process for raising, addressing and issues raised by governors. | Angela Monaghan / Co-ordination Group | **July 2020** | **This has been picked up by Dawn Pearson and our Involving People team, who are developing a supported mechanism for governors to raise issues and comments, and will feedback at a future meeting.**<br>**Timescale deferred due to Covid-19 (Coronavirus) pandemic.** |
| | JL advised that he had attended a quality monitoring visit, the previous day. It was part of the new process. He felt that, potentially, more could have come out of the process, eg, more involvement from the staff would provide richer discussions (which tended to be at "arms-length"), and potentially reduce some of the bureaucracy. AM advised that this new process was a pilot, linked to the quality improvement framework, and was being developed. TB would know more about the process. She suggested that this be discussed further with the Members' Council Quality Group. | Tim Breedon / Quality Group | **August 2020** | **This will be included on the August Quality Group agenda – May meeting deferred to June with a reduced agenda due to Covid-19.** |

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| | <u>Use of recording devices for meetings</u><br>The following suggestions were made and acknowledged:<br>• the definition of a meeting be made clear.<br>• any objections to use of recording devices to be acknowledged<br>• should different protocols be developed for public and private meetings?<br>• consider live streaming<br>• be mindful of social media | Aimee Willett | **July 2020** | **Timescale deferred due to Covid-19 (Coronavirus) pandemic.**<br>**Superseded by May action.** |
| **MC/20/10 Performance Report Quarter 3 (agenda item 8.1)** | With regard to safer staffing, Adrian Deakin (AD) had concerns that quality could be compromised by using bank and agency staff. He was assured that safety to patients was always the top priority. Deep dive investigations were carried out, as required, to ensure the correct skill mix was in place. AM suggested that this subject could be discussed further by the Quality Group, if required. | Tim Breedon | **August 2020** | **This will be included on the August Quality Group agenda – May meeting deferred to June with a reduced agenda due to Covid-19.** |

**Outstanding actions from 1 November 2019**

| Minute ref | Action | Lead | Timescale | Progress |
|---|---|---|---|---|
| **MC/19/34** | In respect of the recommendation relating to fixing the chair's salary for three years upon appointment it was agreed to ask the nominations committee to re-look at the flexibility of this approach and to recommend a modified proposal. This recommendation is to be brought back to the members' council. TL noted he was abstaining from voting on this proposal as he is conflicted. | Nominations Committee | **July 2020** | **Process and timescale to be agreed at July Members Council meeting.** |
| **MC/19/38** | AM introduced this agenda item and referred to the paper which summarised events attended by governors and any feedback provided. DT asked for clarification on who needed to be informed regarding events governors attend. AM explained that a request is made and governors respond with what they think should be included in the report. JL asked if there are meetings that are fixed can as much notification as possible be | Company Secretary | **Complete** | **It is noted that governors are given as much notice as it possible for attending meetings / events.** |

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| | provided as some governors may have other commitments. AM agreed to this. | | | |
| **MC/19/38** | In addition to items included in the paper Lisa Hogarth (LHo) noted she had attended an annual BAME event. KSC added that he attended a Barnsley mental health forum. At that meeting a question was asked why they were not invited to SWYPFT meetings anymore. The Company Secretary will be asked to make sure they are in future. KSC was also asked for details of bereavement support groups in Barnsley. | | | **KSC provided with bereavement support groups in Barnsley and nationally. NB the SWYPFT meeting in question is unable to be identified at this time. If further information comes to light a new action with be logged.** |

South West Yorkshire Partnership NHS Foundation Trust

# Members' Council
# 31 July 2020

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| **Agenda item:** | **6** |
| **Report Title:** | **Chair's Report** |
| **Report By:** | **Chair of the Trust and Members' Council** |
| **Action:** | **For information** |

**Purpose**

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

- Chair and NED activity since the previous Members' Council meeting;
- issues discussed at Board meetings in the last quarter; and
- any other current issues of relevance and interest to Governors.

**Recommendation**

**Governors 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.**

## 1. Chair and Non-executive Director activity since 1 May 2020

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 held on 1 May 2020. Please note that NEDs are expected to work around 3 days a month and the Chair around 3 days a week.

**Response to Covid-19:**

Due to the Covid-19 pandemic, a level-4 incident was declared in the NHS at the end of January. This led to command and control governance structures being established, with gold, silver and bronze command meetings taking place frequently across the Trust and in each place we operate, and the suspension of all non-essential activity. All governance and operational activity during this



With all of us in mind.

period has been focused on Covid-19.

Since lockdown was established in mid-March, the Chair and Non-executive directors have been working largely from home. This means they have been able to carry out the core part of their roles, but have had only limited opportunity to engage with service users, carers and staff.

Since early April, there has been a weekly Covid-19 meeting of the Chair and NEDs with the Chief Executive and Director of Finance and Resources. At this meeting, the log of governance decisions arising from the command and control structures has been reviewed, along with newly emerging risks.

The board and committees have continued to meet normally, albeit virtually and with reduced agendas, with the exception of the Workforce & Remuneration Committee, which suspended its activities for a short period (now resumed). During this time, oversight of workforce matters was undertaken by the board. A new committee has been set up in response to Covid-19, the Interim Clinical Ethics Advisory Group (CEAG).

Three Covid-19 question and answer sessions have taken place between governors and the Chair and Chief executive, and governors have received the Chief executive's daily coronavirus update, now produced weekly (87 editions to date).

There have been weekly Covid-19 briefing sessions taking place between NHS/ council health system leads and MPs for Wakefield and North Kirklees, chaired by SWYPFT chair Angela Monaghan. These have now reduced to every 3 weeks.

The Chair and NEDs have attended numerous webinars and virtual meetings to keep up-to-date on policy and governance matters, nationally and regionally.

**Governance meetings – Chair and NEDs:**
In the last quarter, the Chair and NEDs have prepared for and attended three Board meetings (see below for further details), plus the following committees and governance groups:

- Audit Committee (2 June and 14 July 2020) – Laurence Campbell (chair), Sam Young, Chris Jones
- Clinical Governance and Clinical Safety Committee (9 June 2020) – Charlotte Dyson (chair), Angela Monaghan, Kate Quail
- Finance, Investment and Performance Committee (26 May, 23 June and 27 July 2020) – Chris Jones (chair), Sam Young, Kate Quail

- Workforce and Remuneration Committee (21 July 2020) – Sam Young (chair), Charlotte Dyson, Angela Monaghan
- Mental Health Act Committee (12 May 2020) – Kate Quail (chair), Laurence Campbell, Erfana Mahmood
- Equality and Inclusion Committee (2 June 2020) – Angela Monaghan (chair), Erfana Mahmood, Chris Jones
- Charitable Funds Committee (9 June 2020) – Erfana Mahmood (chair), Charlotte Dyson, Angela Monaghan
- West Yorkshire & Harrogate Mental Health, Learning Disability & Autism Services Collaborative Committees in Common (23 July 2020) – Angela Monaghan
- Nominations' committee (23 June 2020) – Angela Monaghan (chair)
- CRS Programme steering group (Sam Young)
- Barnsley Integrated Care Partnership Group (28 May, 25 June and 30 July 2020) – Angela Monaghan
- West Yorkshire & Harrogate Health & Care Partnership Board (2 June 2020) – Angela Monaghan
- Members' Council Coordination Group (8 June 2020) – Angela Monaghan, Charlotte Dyson
- Interim Clinical Ethics Advisory Group (7 May, 19 May, 1 June and 8 July 2020 – Angela Monaghan

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

- monthly meetings with the Lead Governor and Deputy Lead Governor.
- 1:1 induction meetings with all new governors, and annual review meetings with existing governors.
- monthly Trust Welcome Events for new staff and volunteers - these were suspended, but started again (virtually) in July
- 1:1 meetings with chief executive, Rob Webster (weekly)
- 1:1 meetings with Deputy Chair (monthly)
- Reciprocal mentoring programme (monthly)
- Virtual perinatal mental health team meeting
- SWYPFT silver command meeting
- Non-executive director recruitment interviews
- Consultant recruitment interviews

**Chair attendance at external meetings and events:**

- Monthly meetings with NHS mental health provider chairs in west Yorkshire
- NHS Confederation weekly governance webinars
- NHS Providers chairs' and chief executives' network meeting (virtual)
- NHS Providers' roundtable meeting on race equality

- Webinar on Covid-19 and BAME staff

**Additional NED activity:**

- NEDs' quarterly meeting (all)
- Kirklees Learning Disability service virtual team meeting and Makaton signing session (Kate Quail, Charlotte Dyson)
- Meeting with Freedom to Speak Up Guardians (Charlotte Dyson)
- Kirklees Mental Health Carers' Forum (Kate Quail)
- National Covid-19 webinars (Kate Quail, Charlotte Dyson)
- SWYPFT silver command meeting (Erfana Mahmood, Charlotte Dyson)
- Chair's interim appraisal (Charlotte Dyson)
- Non-executive director recruitment interviews (Charlotte Dyson, Chris Jones)
- Consultant recruitment interviews (Charlotte Dyson)

## 2. Issues discussed at Board meetings

Since the previous Chair's report, the Board has met three times (virtually) and the key items discussed are highlighted below. May I please remind Members' Council that all governors are welcome to attend all public Board meetings (virtually at present) and there is the opportunity to raise questions and comments at the end of each meeting, which are recorded in the minutes. 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.

**Standing items:**

There are 8 public board meetings a year. At every public board meeting, we start the meeting with a **service user, carer or staff story**, discuss the monthly **Integrated Performance Report (IPR),** which includes the finance report, receive updates on **business developments** in our two integrated care systems (West Yorkshire & Harrogate and South Yorkshire & Bassetlaw), and receive **assurance from our board committees**.

In addition, at every *business and risk* meeting (quarterly), we discuss the **board assurance framework** (which sets out the key risks to our strategic objectives plus corresponding controls and assurance), and the **corporate risk register**. And at every *performance and monitoring* meeting (quarterly), we discuss the quarterly **serious incident report.**

Additional items at each meeting are as set out in the annual board work programme, which is received at every board meeting.

- **May – private and strategic meeting:**

Strategic board meetings take place in private and enable the board to discuss

and develop policy and strategy, as well as undertake board development.

At this meeting, the board discussed the final draft annual report and accounts, and received performance and risk updates in relation to Covid-19. The board then discussed planning for recovery and restoration from Covid-19 and the Board Assurance Framework (BAF) and strategic risks for 2020/21.

- **June – performance and monitoring meeting:**
  In addition to the standing items, the public Board:
  - received the annual serious incident report for 2019/20;
  - approved the Covid-19 risk report;
  - approved a trust-wide Covid-19 equality impact assessment;
  - discussed Covid-19 recovery and restoration planning;
  - approved the revised internal governance framework and a number of annual governance documents; and
  - confirmed submission of the Trust's annual report and accounts to Parliament, the first NHS Trust in the country to do so this year.

  There were no questions from members of the public at this meeting.

  In **private session,** the board heard the lived experiences of several members of the black, Asian and minority ethnic (BAME) staff equality network, supported by the chair of the network, Cherill Watterston. Their stories highlighted that, whilst the Trust is a good place to work, we still have a lot to do to ensure that there is genuine race equality and eliminate all bullying and racism in the workplace. Race equality is a priority for the chair, NEDs and board as a whole.

  There was also a meeting of the **Corporate Trustee** in June. This is the governing body for SWYPFT's four linked charities – EyUp!, Creative Minds, Spirit in Mind, and Mental Health Museum.

- **July – business and risk:**
  The July meeting is taking place just prior to the Members' Council on 28 July, and I will be able provide a verbal update at the Members' Council meeting.

**Angela Monaghan**
**Chair**

South West Yorkshire Partnership NHS Foundation Trust

**Members' Council**
**31 July 2020**

| | |
|---|---|
| **Agenda item:** | **7.1** |
| **Report Title:** | **Governor appointment to Members' Council and Trust Board groups and committees** |
| **Report By:** | Corporate Governance Manager |
| **Action:** | To agree |

**Purpose**

The purpose of the paper is to support the appointment of governors to the Members' Council groups, Nominations' Committee and Trust Board Equality & Inclusion Committee.

**Recommendations**

**The Members' Council is asked to CONSIDER and AGREE the recommendations as outlined below.**

Background

At the Members' Council meeting on 2 November 2018, a process was approved regarding how governors become members of its sub-groups (attachment 1) 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

The Corporate Governance Team wrote to all governors seeking self-nominations for available vacancies on groups. The following self-nominations were requested to be put forward for the vacancies:

| Group | Vacancy | Self-nominations received |
|---|---|---|
| Co-ordination Group | 1 x Public governor – Barnsley<br>1 x Public governor – Kirklees<br>1 x Public governor – Rest of Yorkshire and the Humber *(note, this seat is currently vacant)* | - Keith Stuart-Clarke, Barnsley |



With all of us in mind.

| | | |
|---|---|---|
| Quality Group | 1 x Public governor – Kirklees<br>1 x Public governor – Rest of Yorkshire and the Humber *(note, this seat is currently vacant)*<br>1 x Appointed governor | Nil |
| Trust Board Equality & Inclusion Committee | 1 x Public governor | - Dylan Degman, Publicly elected – Wakefield<br>- Daz Dooler, Publicly elected – Wakefield |

Outcome

The members of the Co-ordination Group discussed the nominations received and agreed to make the recommendation to the Members' Council to appoint Keith Stuart-Clarke to the Members' Council Co-ordination Group and Daz Dooler to the Trust Board Equality & Inclusion Committee.

Supporting statements for each self-nomination are attached.

The remaining vacancies will continue to be promoted.

*Co-ordination Group members: Angela Monaghan, Charlotte Dyson, John Laville, Bill Barkworth, Bob Clayden, Lisa Hogarth, Adam Jhugroo, Ruth Mason.*

South West Yorkshire Partnership NHS Foundation Trust

**Governor appointment to Members' Council groups and committee**

*Approved by Members' Council 2 November 2018*

## 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.<br>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 (as at 2 November 2018) 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.



With **all of us** in mind.

South West Yorkshire Partnership NHS Foundation Trust

**Members' Council Co-ordination Group**

**Monday 8 June 2020**

**Self-nomination statement**

**Keith Stuart-Clarke – Members' Council Co-ordination Group**

Please accept my self nomination for the vacant post on the co-ordination council group, for the Barnsley constituency.

I have been a member of the council for just over a year, and am enjoying the work that I am able to do as a publicly elected governor, and especially am very proud to be able to say, that I enjoy being part of a valued and enthusiastic team who are prepared to be an active representative and voice for the benefit of people in their constituents where they live.

I believe that as a member of the coordination group I would be able to use my past and future learned life skills and experience, to try to ensure that the people of Barnsley are given a strong voice and represented as equally as other members council governors constituents are?

I know that as a veteran (and a very proud Yorkshireman) I have the unique knowledge of military service life and of many of the special needs and problems of veterans have, that non-veterans will never know or understand about ?

If elected I would be able to represent people both as a veteran, and civilian equally and promise to work hard for everyone in all that I do connected with being a publicly elected governor as I have done in the past

Kind regards Keith D Stuart-Clarke

Publicly elected governor for Barnsley

South West Yorkshire Partnership NHS Foundation Trust

**Members' Council Co-ordination Group**

**Monday 8 June 2020**

**Self-nomination statement**

**Dylan Degman – Trust Board Equality & Inclusion Committee**

I would like to put myself forward to be nominated onto the equality and inclusion committee. Please see statement below.

"I am equal and inclusive by nature and i believe i can reflect this quality into the Trust equality and inclusion mission. I Have previously been the secretary for the LGBT+ staff network so have experience in dealing with E&I matters. I also have thorough knowledge of the goings on of different cultures and backgrounds. I am also a volunteer for the trust and have dealt with many of the services strategies and focuses that are about inclusion into the Trust and have strong emphasis on treating everyone the same and giving everyone the same opportunities.
I know this Trust is strongly focused on E&I and i would like the opportunity to continue providing the fantastic support the Trust provides, as well as improving and strengthening Equality and Inclusion for all where i can."

I hope you will consider me

Kindest Regards

**Dylan Degman**

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

**Members' Council Co-ordination Group**

**Monday 8 June 2020**

## Self-nomination statement

## Daz Dooler – Trust Board Equality & Inclusion Committee

Please accept this mail as my application for the role of 'Trust Board Equality & Inclusion Committee' member. The reason for my willingness to apply for said role is that I am passionate about removing the injustices of prejudice at all levels of society. It is my firm belief that to ensure that we have equality and inclusion we need to change the idea's, opinions, and incorrect/inappropriate thought processes of people within our communities.

I believe that it is vitally important that change is driven through, not just by policy from the top of the management structure but, by a change of ideation from the 'bottom'. Having personally been someone who when in my 'worst place' has looked for someone to blame for my problems, and often pointed the finger at the easy target of those that are different to the perceived majority of us, when ultimately blame is not to be apportioned. It should not even exist at these times, my energy should have been focussed on improving my life, with the helping hand of everyone in my community, not just the ones who looked the same as me.

My personal experiences have shown me that it is those of us in greater need often apportion blame to those of us who are labelled different, when actually it is those exact same people that are most like to be supportive of us, particular when in need. These are the realities of the matter and therefore need to be identified and highlighted.

It is my belief that change needs to happen for the good of all of us, because we ultimately break away from the misconception that people who are different because of their colour, race, faith, physical/mental attributes etc. and that ultimately our differences are personal to us and therefore we should be proud of them. Not, therefore, something that we should be held accountable for by our peers and/or fellow people. By reaching this point we all benefit, every single one of us.

The district that I am proud to be the elected Governor for is not necessarily the most culturally diverse area in the country, but I have many colleagues who are from varying backgrounds, ethnicities and differences, and would be honoured to be able to work on breaking down the barriers that unfortunately exist within our communities. By doing so I believe that we can create a more harmonious society that will organically remove the unfortunate prejudices that exist within our communities.

I hope that this makes my case for the role clear, please advise if you require any further information and clarification.

My very best regards, please stay safe and well.

South West Yorkshire Partnership NHS Foundation Trust

**Members' Council**
**31 July 2020**

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|---|---|
| **Agenda item:** | **7.2** |
| **Report Title:** | **Governor engagement feedback** |
| **Report By:** | Corporate Governance Manager on behalf of governors |
| **Action:** | To receive |

The following events were attended by governors since the last Members' Council meeting on 18 January 2020 up to 17 July 2020 (note, this does not include Members' Council meetings). This report includes engagement since January 2020 as the item was deferred in May 2020 due to Covid-19:

| Name | Role | Events attended / feedback provided |
|---|---|---|
| Marios Adamou | Elected – staff medicine and pharmacy | • 06.03.20 Nominations Committee<br>• 14.04.20 Nominations Committee<br>• 23.06.20 Nominations Committee |
| Kate Amaral | Public Governor – Wakefield | |
| Bill Armer | Appointed – Kirklees Council | |
| Bill Barkworth | Public Governor – Barnsley (Deputy Lead Governor) | • 02.03.20 Co-ordination Group<br>• 14.04.20 Co-ordination Group<br>• 08.06.20 Co-ordination Group<br>• 26.06.20 Quality Group<br><br>• 28.04.20 Q&A Governor Session with Rob Webster and Angela Monaghan<br>• 12.05.20 Recruitment training<br>• 22.05.20 Q&A Governor Session with Rob Webster and Angela Monaghan<br>• 27.05.20 Governor stakeholder panel for Non-Executive Director recruitment<br>• 01.07.20 Q&A Governor Session with Rob Webster and Angela Monaghan<br>• 16.07.20 SWYPFT Key Strategy messages meeting<br>• 29.07.20 Governors Training Workshop |
| Paul Batty | Staff Governor – social care staff working in integrated teams | |
| Evelyn Beckley | Appointed Governor– Staff | • 02.03.20 Co-ordination Group |



With all of us in mind.

| Name | Role | Events attended / feedback provided |
|---|---|---|
| | side organisations | • 28.04.20 Q&A Governor Session with Rob Webster and Angela Monaghan<br>• 22.05.20 Q&A Governor Session with Rob Webster and Angela Monaghan<br>• 27.05.20 Governor stakeholder panel for Non-Executive Director recruitment |
| Bob Clayden | Public Governor - Wakefield | • 02.03.20 Co-ordination Group<br>• 14.04.20 Co-ordination Group<br>• 08.06.20 Co-ordination Group<br><br>• 03.02.20 - Company secretary interviews<br>• 28.04.20 Q&A Governor Session with Rob Webster and Angela Monaghan<br>• 22.05.20 Q&A Governor Session with Rob Webster and Angela Monaghan<br>• 27.05.20 Governor stakeholder panel for Non-Executive Director recruitment<br>• 14.07.20 Virtual Governor Workshop - NHS Providers. |
| Jackie Craven | Public Governor - Wakefield | • 06.03.20 Nominations Committee<br>• 02.03.20 Co-ordination Group<br>• 10.02.20 Quality Group<br>• 14.04.20 Co-ordination Group<br>• 14.04.20 Nominations Committee<br><br>• 03.02.20 Company Secretary interviews<br>• 01.07.20 Q&A Governor Session with Rob Webster and Angela Monaghan |
| Adrian Deakin | Staff Governor - Nursing | • 10.02.20 Quality Group<br>• 26.06.20 Quality Group<br><br>• 28.04.20 Q&A Governor Session with Rob Webster and Angela Monaghan |
| Daz Dooler | Public Governor - Wakefield | • 10.02.20 Quality Group<br>• 02.03.20 Co-ordination Group<br>• 26.06.20 Quality Group<br><br>• 22.05.20 Q&A Governor Session with Rob Webster and Angela Monaghan<br>• 01.07.20 Q&A Governor Session with Rob Webster and Angela Monaghan |
| Lisa Hogarth | Staff Governor - Allied Healthcare Professionals | • 14.04.20 Co-ordination Group<br>• 08.06.20 Co-ordination Group |
| Carol Irving | Public Governor – Kirklees | |
| Tony Jackson | Staff Governor – non clinical | • 28.04.20 Q&A Governor Session with Rob Webster |

| Name | Role | Events attended / feedback provided |
|---|---|---|
| | support | and Angela Monaghan<br>• 22.05.20 Q&A Governor Session with Rob Webster and Angela Monaghan<br>• 01.07.20 Q&A Governor Session with Rob Webster and Angela Monaghan |
| Adam Jhugroo | Public Governor - Calderdale | • 08.06.20 Co-ordination Group<br>• Trust in-house improvement program.<br>• 27.05.20 Governor stakeholder panel for Non-Executive Director recruitment<br>• 01.07.20 Q&A Governor Session with Rob Webster and Angela Monaghan |
| Trevor Lake | Appointed Governor– Barnsley Hospital NHS Foundation Trust | |
| John Laville | Public Governor – Barnsley (Lead Governor) | • 02.03.20 Co-ordination Group<br>• 14.04.20 Co-ordination Group<br>• 08.06.20 Co-ordination Group<br>• 26.06.20 Quality Group<br>• 23.06.20 Nominations Committee<br>• 21.01.20 North Kirklees Patient Reference Group network meeting<br>• 22.01.20 Kirklees Time to Change Hub<br>• 28.01.20 SWYPFT Board meeting<br>• 30.01.20 Kirklees Mental Health Alliance meeting<br>• 07.04.20 Kirklees MH Alliance meeting<br>• 09.04.20 Time to Change Hub<br>• 21.04.20 Time to Change Hub<br>• 28.04.20 Q&A Governor Session with Rob Webster and Angela Monaghan<br>• 12.05.20 Recruitment training<br>• 13.05.20 North Kirklees Primary Care Commissioning Committee<br>• 22.05.20 Q&A Governor Session with Rob Webster and Angela Monaghan<br>• 08.06.20 Kirklees MH Carers Forum<br>• 10.06.20 Interview panel for Non-Executive Director recruitment<br>• 24.06.20 North Kirklees CCG Engagement Event<br>• 01.07.20 Q&A Governor Session with Rob Webster and Angela Monaghan<br>• 08.07.20 North Kirklees Primary Care Commissioning Committee<br>• 16.07.20 SWYPFT Key Strategy messages meeting |

| Name | Role | Events attended / feedback provided |
|---|---|---|
| | | • 23.07.20 Kirklees MH Partnership Board<br>• 29.07.20 Governors Training Workshop<br>• 30.07.20 North Kirklees Patients Reference Group Network Meeting<br>• Various Dates June – July, One to one chats with governors. |
| Ros Lund | Appointed Governor– Wakefield Council | • 20.02.20 – visit to Unity Centre and the Horizon Centre, Fieldhead |
| Ruth Mason | Appointed Governor- Calderdale and Huddersfield NHS Foundation Trust | • 14.04.20 Nominations Committee<br>• 08.06.20 Co-ordination Group<br>• 23.06.20 Nominations Committee |
| Debbie Newton | Appointed Governor – Mid-Yorkshire Hospitals NHS Trust | |
| Chris Pillai | Appointed Governor- Calderdale Council | |
| Tom Sheard | Public Governor – Barnsley | • 08.06.20 Co-ordination Group |
| Phil Shire | Public Governor - Calderdale | • 10.02.20 Quality Group<br>• 26.06.20 Quality Group<br>• 28.04.20 Q&A Governor Session with Rob Webster and Angela Monaghan<br>• 22.05.20 Q&A Governor Session with Rob Webster and Angela Monaghan<br>• 01.07.20 Q&A Governor Session with Rob Webster and Angela Monaghan |
| Jeremy Smith | Public Governor - Kirklees | • 22.05.20 Q&A Governor Session with Rob Webster and Angela Monaghan |
| Keith Stuart-Clarke | Public Governor - Barnsley | • 10.02.20 Quality Group<br>• 02.03.20 Co-ordination Group<br>• 26.06.20 Quality Group<br>• 22.05.20 Q&A Governor Session with Rob Webster and Angela Monaghan<br>• 01.07.20 Q&A Governor Session with Rob Webster and Angela Monaghan |
| Nicola Sumner | Appointed Governor – Barnsley Council | • 22.05.20 Q&A Governor Session with Rob Webster and Angela Monaghan |

| Name | Role | Events attended / feedback provided |
|---|---|---|
| Debs Teale | Staff Governor – Nursing Support | • 28.04.20 Q&A Governor Session with Rob Webster and Angela Monaghan<br>• 22.05.20 Q&A Governor Session with Rob Webster and Angela Monaghan |
| Barry Tolchard | Appointed Governor– University of Huddersfield | |
| Tony Wilkinson | Public Governor – Calderdale | • 28.04.20 Q&A Governor Session with Rob Webster and Angela Monaghan<br>• 22.05.20 Q&A Governor Session with Rob Webster and Angela Monaghan<br>• 01.07.20 Q&A Governor Session with Rob Webster and Angela Monaghan |

There were no emails received for governors via the governor email address (Governors@swyt.nhs.uk) since the last Members' Council meeting on 1 May 2020.

South West Yorkshire Partnership NHS Foundation Trust

# Members Council 31 July 2020

## Agenda Item 7.3 Assurance from Members' Council groups and Nominations Committee

### Members' Council Co-ordination Group

| | |
|---|---|
| **Date** | 8 June 2020 |
| **Presented by** | Angela Monaghan, Chair of the Trust |
| **Key items to raise at Members' Council** | • Recommendations regarding the appointment of governors to vacancies on the Members' Council groups, and Trust Board Equality & Inclusion Committee (on agenda).<br>• Members' Council Coordination Group revised terms of reference (on agenda).<br>• Reviewed Members' Council development plan.<br>• Reviewed attendance of governors at Members' Council meetings.<br>• Received the updated governors' induction pack.<br>• Discussed the development of the Involving People Strategy with Dawn Pearson (Marketing, communications, engagement and inclusion lead). |
| **Approved Minutes of previous meeting/s for receiving** | • Notes of the meeting held on 14 April 2020 attached. |

### Members' Council Quality Group

| | |
|---|---|
| **Date** | 26 June 2020 |
| **Presented by** | Tim Breedon, Director of Nursing, Quality and Deputy Chief Executive (Chair of Committee) |
| **Key items to raise at Members' Council** | • The headlines of the IPR report for the covid-19 section<br>• Not to delay the start-up of services which are currently on hold due to covid-19<br>• Reiterate the positive work that has been done, reflecting on PS previous comment.<br>• Revised change to the quality account timeline<br>• To note that it is great to keep in touch with all virtually, although this is not suited to all. |
| **Approved Minutes of previous meeting/s for receiving** | • Notes of the meeting held on 10 February 2020 attached. |

## Nominations' Committee

| | |
|---|---|
| **Date** | 23 June 2020 |
| **Presented by** | Angela Monaghan, Chair of the Trust (Chair of Committee) |
| **Key items to raise at Members' Council** | • Appointment of New Non-Executive Director (on agenda).<br>• Chair re-appointment (on agenda).<br>• Terms of Reference and Annual report (on agenda).<br>• Reviewed cross section of skills across the Trust Board. Key items can be raised to Trust Board |
| **Approved Minutes of previous meeting/s for receiving** | • Minutes of the Committee meeting held on 14 April 2020 attached. |

South West Yorkshire Partnership NHS Foundation Trust

# Action Notes of the Members' Council Co-ordination Group held on 14 April 2020 at 1.15 pm Skype meeting

**Present:**
Bill Barkworth (BB)
Bob Claydon (BC)
Jackie Craven (Chair) (JC)
Lisa Hogarth (LH)
John Laville (JL)
Angela Monaghan (AM)

**In attendance:**
Maria Steeples (MS) – note taker
Laura Arnold (LA)

**Apologies – members:**
Charlotte Dyson (CD)
Adam Jhugroo (AJ)
Ruth Mason (RM)

Due to the difficulties associated with holding the meeting virtually, and it being the first time that Jackie Craven (JC) had chaired a meeting in this way, Angela Monaghan (AM) supported JC in the chairing of the meeting.

| No. | Item | Action |
|---|---|---|
| 1. | **Welcome and Introductions**<br>Jackie Craven (JC) welcomed all to the meeting. Apologies, as above, were noted. | |
| 2. | **Declaration of Interests**<br>There were no declarations of interest. | |
| 3. | **Action Notes and Action Points from previous Co-ordination Group meeting**<br>The Action Notes were approved as a correct record.<br><br>The Action Points were recorded / updated on a separate log. | |
| 4. | **Self-nomination for vacancies on Trust Board and Members' Council groups and committees**<br>Angela Monaghan (AM) outlined the purpose of the item. Governors, including newly-appointed ones, had been invited to self-nominate for vacancies on the Members' Council Groups, Nominations Committee and the Trust Board Equality & Inclusion Committee, and to provide a brief statement about why they were putting themselves forward. The closing date had been 3 April 2020.<br><br>It was noted that, at the meeting of the Co-ordination Group on 2 March 2020, it had been agreed to recommend to the Members' Council that Keith Stuart-Clarke be appointed as public governor (Barnsley) on the Members' Council Quality Group.<br><br>No nominations had been received in respect of the following vacancies:<br><br>Members' Council Quality Group –<br>• public governor, Kirklees<br>• public governor, rest of Yorkshire and the Humber (seat vacant) | |

| No. | Item | Action |
|---|---|---|
| | • appointed governor<br><br>Members' Council Co-ordination Group -<br>• Public governor, rest of Yorkshire and the Humber (seat vacant)<br><br>Trust Board Equality & Inclusion Committee –<br>• public governor<br><br>Dylan Degman, newly-appointed governor for Wakefield, had self-nominated for the position of public governor to the Nominations Committee. As this was the only nomination received for that position, it would automatically be recommended for approval by the Members' Council, at its next meeting.<br><br>**It was RESOLVED to AGREE to:**<br><br>• recommend to Members' Council the appointment of Dylan Degman to the position of public governor on the Nominations Committee.<br><br>• confirm the recommendation to Members' Council of the appointment of Keith Stuart-Clarke to the position of public governor (Barnsley) on the Members' Council Quality Group.<br><br>It was noted that the next meeting of the Members' Council may need to be deferred, in order to get in place the appropriate technology for it to be held virtually.<br><br>The Group discussed the difficulties experienced with holding a meeting by telephone. In particular, it was difficult if the papers had to be accessed from the same phone from which the call was being made. AM advised that various options were currently being explored within the Trust. Due to the majority of staff having to work from home, during the current emergency, it had not been possible to send out paper copies for this meeting. However, AM would consider whether this could be resumed. If not possible, she would look at options for making the papers easier to read on-line. | |
| **5,** | **Any Other Business**<br>There was no further business. | |
| **6.** | **Date of next Co-ordination Group meeting**<br>The next meeting was scheduled for Monday 8 June 2020, 10.00 am to 12 noon. However, this may change, dependent upon the date of the next Members' Council meeting. | |

South West Yorkshire Partnership NHS Foundation Trust

# Action Notes of the Members' Council Quality Group held on 10 February 2020 at 2pm in Training Room 5, Wellbeing & Learning Centre, Fieldhead, Wakefield.

**Present:**
Tim Breedon (TB)
Jackie Craven (JC)
Adrian Deakin (AD)
Darren Dooler (DD)
Nasim Hasnie (NH) – from item 5 onwards
Phil Shire (PS)

**In attendance:**
Karen Batty (KB)
Carmain Gibson-Holmes (CGH) – up to and including item 5
Ashley Hambling (AH) – up to and including item 6
Devika Minocha (DM)
Maria Steeples (MS) (note taker)
Keith Stuart-Clarke (KSC)

**Apologies – members:**
Paul Williams (PW)

**Apologies – in attendance:**
None

| No. | Item | Action |
|---|---|---|
| 1. | **Welcome, introductions and apologies**<br>Tim Breedon (TB) welcomed everyone to the meeting. The apologies, as above, were noted. | |
| 2. | **Declarations of Interest**<br>There were no further declarations over and above those made previously. | |
| 3. | **Notes from the meeting held on 14 November 2019**<br>The notes were agreed.<br><br>With regard to the action to go through the work programme with a view to suggesting how best to cover everything, TB had not yet had an opportunity to action this, but would be in touch with Keith Stuart-Clarke (KSC) and Lisa Hogarth (LH) to take this forward. | |
| 4. | **Integrated Performance Report (IPR) Q3 2019/20**<br>It was highlighted that the IPR had not been discussed in detail at the 31 January 2020 Members' Council meeting. There had been a Performance & Finance update presentation. TB invited members to raise any issues that they particularly wished to discuss.<br><br>Jackie Craven (JC) highlighted that there had been a discussion around agency spend. TB advised that a lot of work had been undertaken around two years ago to reduce agency spend, but unfortunately it had risen again due to recruitment difficulties. The Trust was close to reaching the cap for agency spends, which would result in close scrutiny. Whilst trying to contain the numbers of agency staff, the safety of patients was the main priority.<br><br>Carmain Gibson Holmes (CGH) added that using agency staff had actually assisted in the CAMHS recruitment strategy, as some agency staff had joined the organisation as permanent members of staff. In response to a question about | |

| No. | Item | Action |
|---|---|---|
| | registered nurses, it was noted that there were two levels, bands 4 and 5.<br><br>In response to an enquiry from Phil Shire (PS) regarding Friends & Family test responses, TB advised that the results were based only on the responses we receive, and was not therefore necessarily representative, if the response rate was low. Unlike acute trusts, mental health trusts were not required to provide a percentage response rate. The emphasis was more around providing responses to feedback received.<br><br>PS advised that, within some of his other roles, he had encountered some dissatisfaction around CAMHS services. Karen Batty (KB) was able to respond that the negativity tended to be around waiting times, but service users were generally satisfied with the services they received.<br><br>PS referred to the reported challenges which exist in single point of access (SPA) in terms of coping with a high rate of referrals. He enquired as to whether each BDU had its own SPA, rather than the Trust just having one. He questioned whether pooling resources would increase efficiency, as advice could be given from anywhere if it was not a face-to-face service. TB advised that the Trust was moving towards place-based SPAs. As there were so many disparate services, no one person or team could have sufficient knowledge on every service.<br><br>KSC highlighted that road-shows used to be held where advice was given on, amongst other things, becoming a governor and self-referrals. JC added that there is an annual governors meeting but they tended to be attended by people from the local area only. TB acknowledged that this was an interesting point, which he would pass on to colleagues in the Communications and Membership teams. | **TB** |
| **5.** | **Focus on – CAMHS**<br>PS referred to a particular issue he had encountered that quite a lot of lower level children's mental health problems were left for schools to address, and he queried how decisions were made around thresholds. CGH replied that, generally, schools and / or social workers would deal with low level problems, e.g., sleep, hygiene, safety. With regard to the next level (2), e.g., anxiety, stress, SWYPFT endeavour to provide advice to social workers, teachers, police and parents to help them to feel confident in providing support to children and young people. On-line counselling was available in some Wakefield schools.<br><br>TB advised that the Trust provided level 3 support and also level 2, in some areas. Service level agreements were in place with some schools in respect of what they could do to help the Trust provider appropriate services.<br><br>PS asked how people are made aware of what is available and how to access the various services. CGH advised that mapping was being undertaken in Wakefield to create something as part of the Future in Mind roll-out. There are multi-disciplinary teams in schools who can advise the best way forward. SWYPFT was looking to expand the service with other partners. Children who are not in school can access services via the SPA or their GP.<br><br>Services may not necessarily have the same names, dependent upon the individual commissioner. The number of SPAs could also vary, according to individual commissioners.<br><br>In response to a query from Darren Dooler (DD) regarding access to autism services, CGH advised that the Trust was working towards reducing waiting times for assessment. Commissioners were applying for additional funding for support teams to prevent crisis. TB added that a lot of services were looking at neuro- | |

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| | diversity to avoid having to be re-referred and therefore avoiding extended waiting times.<br><br>CGH added that waiting times for ASD services varied from area to area. Currently, the wait in Wakefield for above and below 14-year olds was 26 weeks. Calderdale and Kirklees were to receive funding to reduce waiting times. SWYPFT did not provide this service in Barnsley; it was provided by Barnsley District Hospital NHS Foundation Trust.<br><br>CGH added that learning from successful initiatives (e.g., early intervention of group / sharing of patient experiences) was shared across the Trust.<br><br>KSC expressed concern that some parents may try to encourage an inappropriate diagnosis for financial gain.<br><br>With regard to referral to treatment times, PS asked what percentage of patients was seen within the 18 weeks deadline, and what was being done to prioritise. CGH replied that the Trust had historically been under-funded. Demand and capacity work had been undertaken in Barnsley and Wakefield. Calderdale and Kirklees districts were seeing more patients within the 18 weeks threshold. TB added that there was now a programme of improvement around this work which was jointly funded with the commissioners, as it was recognised as a provider / commissioner / system-wide issues. A secondment post had been put in place for this. | |
| **6.** | **Focus on – Bullying and Harassment**<br>Ashley Hambling (AH) reported that this was one of the Trust's workforce priorities. AH and Alan Davis (Director of Human Resources and Workforce Development) were addressing colleague-to-colleague bullying. A separate piece of work around bullying by service users/carers was being led by Sue Threadgold, Deputy Director.<br><br>The latest staff survey results had shown that the Trust was slightly lower than the national average in this area. The policy had been revised 2 years ago.<br><br>Last year, work had been undertaken to build on staff feedback. Between April and July 2019 HR managers went out to speak to staff about to improve their work experience.<br><br>Most staff had said that their team was supportive. Only a few had reported issues.<br><br>In 2019, a framework for the prevention of bullying had been launched, which stated that identifying bullying and harassment was the responsibility of all staff, and staff guides had been produced.<br><br>A number of bullying and harassment advisors had been identified, who offer a confidential listening service, along with Freedom to Speak Up Guardians.<br><br>More work on this area was planned, during 2020. This would include asking the communications team to spread the message, undertaking a specific campaign, including it within the Great Place to Work forum.<br><br>PS asked how much was reported to advisors. AH replied that there were a small number of reports per year to HR. It was hoped to increase the number of advisors, who would be asked to collect anonymised data.<br><br>DD queried whether debate was stifled, in that someone may misinterpret a challenge raised in a meeting. AH replied that staff should feel confident to | |

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| | challenge, without fear, in a respectful manner.<br><br>PS was concerned at the level of bullying and harassment from service users and carers. It was acknowledged that a higher incidence was directed at BAME staff. This was being dealt with by the team led by Sue Threadgold. | |
| **7.** | **Quality Account – local indicator**<br>KB advised that, from the three local indicators put forward by TB, the care and treatment for people who have pressure ulcers had received the most votes form Members of the Quality Group. This had been approved by Members' Council, at its meeting held on 31 January 2020. Deloitte had therefore been asked to test our processes at the beginning of April 2020, following which they would put forward their recommendations. | |
| **8.** | **Members' Council Quality Group Annual Report and review of Terms of Reference**<br>TB invited members to consider the amended Terms of Reference, and let him know, in due course, of any amendments they felt were required. It was, however, agreed that KB's title be changed to Associate Director of Nursing and Quality.<br><br>The Group considered the draft Annual Report for 2019/20.<br><br>It was suggested that it include issues that the Quality Group had considered in detail, e.g., CAMHS and Bullying and Harassment. In addition, a suggestion was made that details on visits that governors had undertaken, e.g., quality monitoring and PLACE visits, be included in the report. | **TB/KB** |
| **9.** | **Items to raise at Members' Council / Trust Board**<br>There were no items. | |
| **10.** | **Any other business**<br>Darren Dooler (DD) reported that he had heard positive comments about caring within the Wakefield Five Town initiative.<br><br>AD raised an issue around commissioners in the various BDUs having different opinions and priorities, and it would be useful to know more about any challenges that that presented to the Trust in providing the same level of service in each geographical area. TB advised that a piece of work had been undertaken around differentials in commissioning arrangements in minimising unnecessary variations in quality of care. | |
| **11.** | **Members Council Quality Group Annual Work Programme 2020**<br>TB confirmed that he would arrange a meeting with KSC and LH to go through the work programme, with a view to considering how to best to cover all items.<br><br>It was noted that the discussions around the Quality Account had commenced at the November 2019 meeting, and it was agreed that this item should be moved to November rather than February on the Annual Work Programme.<br><br>With regard to the Care Quality Commission (CQC) Action Plan, KB highlighted that it was marked for discussion at every meeting, and queried whether this was appropriate, as it was not necessarily discussed at every meeting.<br><br>KB also added that, from April 2020, there would be an enhanced section in the Integrated Performance Report on customer services / patient experience. There would no longer be a separate report to the group. | **MS** |

| No. | Item | Action |
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| | PS felt that it would be helpful for this Group to have sight of the reports from the PLACE visits. He also highlighted that the quality monitoring visits were an opportunity for the Trust to get a good insight into how services were delivered, and for governors to share their experiences of visits.<br><br>KB advised that these were linked to the CQC visits, and an annual report was produced on them. A pilot on 2 standards had been undertaken. TB suggested that these be added to the Work Programme and that feedback on visits be provided as a standing item. | **TB/MS** |
| **12.** | **Date of Next Meeting(s) and agreement of agenda items**<br>It was agreed that the Quality Account be the main agenda item for the next meeting.<br><br>The next meeting would be held on Monday 6 May 2020, 2.00-4.00 pm in Room 1, Block 7, Fieldhead.<br><br>It was agreed that, generally, meetings would be held on the second Monday of the month, between 2.00 and 4.00 pm. The August and November meetings would therefore be:<br><br>Monday 10 August<br>Monday 9 November | |

South West Yorkshire Partnership NHS Foundation Trust

# Minutes of the Nominations Committee held on 14 April 2020 at 2.00 pm Virtual meeting via Skype

| | | |
|---|---|---|
| **Present:** | Angela Monaghan (AM) | Chair of the Trust (Chair of the Committee) |
| | Marios Adamou (MA) | Staff elected governor (Medicine and Pharmacy) |
| | Jackie Craven (JC) | Lead Governor (Publicly elected governor, Wakefield) |
| | Ruth Mason (RM) | Appointed governor (Calderdale & Huddersfield NHS Foundation Trust) |
| **Apologies:** | Members | |
| | Nasim Hasnie (NH) | Publicly elected governor (Kirklees) |
| | Attendees | |
| **In attendance:** | Alan Davis (AD) | Director of Human Resources, Organisational Development & Estates |
| | Rob Webster (RW) | Chief Executive |
| | Maria Steeples (MS) | Personal Assistant (author) |

## NC/20/20 Welcome, introduction and apologies (agenda item 1)

The Chair welcomed everyone to the meeting. The apologies, as above, were noted.

## NC/20/21 Declarations of interest (agenda item 2)

There were no declarations of interest.

## NC/20/22 Minutes of and matters arising from previous meetings held on 6 March 2020 (agenda item 3)

**It was RESOLVED to APPROVE the Minutes from the meeting held on 6 March 2020.**

Any matters arising were on the agenda.

## NC/20/23 Update on NED recruitment process (agenda item 4)

Alan Davis (AD) provided a verbal update on the NED recruitment process.

Sandy Stones, Human Resources Manager, had continued to keep in contact with the four short-listed candidates, who had all agreed to take part in a virtual interview, and the suitability of their own technology was being ascertained. A date had not yet been agreed for the interviews, but they were likely to be held around end May / early June.

Sandy had been in touch with IT services to establish which would be the best system to use for this purpose. Microsoft Teams was the system of choice. Sandy was looking into how the stakeholder groups could be involved remotely and was arranging a trial within HR, the following week. The members of the Committee were comfortable with this course of action. The Chair stated that the Committee would be guided by AD, and added that further information would be forwarded to Committee members, once the internal trial had taken place.



With all of us in mind.

## NC/20/24 Re-appointment of Deputy Chair / Senior Independent Director (SID) (agenda item 5)

The current term of office of Charlotte Dyson (Deputy Chair / Senior Independent Director (SID)) was due to end on 31 July 2020. Charlotte had not intended to seek re-appointment. However, in order to ensure continuity and maintain strong governance during the current health emergency caused by Covid-19, Charlotte had agreed to extend her appointment for up to 6 months to help the Trust in these difficult times.

AD highlighted the recent changes in remuneration arrangements by NHS Improvement, which suggested that the maximum additional payment to Deputy Chairs be £2,000 per annum, and it had previously been agreed to put this to the Members' Council. Charlotte Dyson was currently being paid an additional £5,000 per annum, and AD sought the views of the Committee on whether this should be reduced.

The Chair highlighted that Charlotte's performance had been strong, and she had fulfilled her duties very well.

The Committee discussed and considered the matter. Bearing in mind Charlotte's strong performance and the fact that, in agreeing to the extension to her appointment, she was providing help and support to the Trust in difficult circumstances, the Committee agreed to recommend to Members' Council that the additional remuneration she receives for these two role be retained at £5,000 per annum.

**It was RESOLVED to AGREE to support the recommendation to the Members' Council to re-appoint Charlotte Dyson as Deputy Chair / SID for a period of up to 6 months from 1 August 2020 to 31 January 2021, and to recommend the retention of her additional remuneration at £5,000 per annum for the duration of the extension of her appointment.**

## NC/20/25 Re-appointment of Non-Executive Director – Laurence Campbell (agenda item 6)

The current term of office of Laurence Campbell as Non-Executive Director (NED) was due to end on 31 May 2020, and it had not been his intention to seek re-appointment. Due to the restrictions around Covid-19, the interviews for his replacement have had to be postponed. Following discussion with the Chair, Laurence had indicated his willingness to extend his term of office for a period of 3 months, in order to support the Trust, and also to extend it for a further 3 months to 30 November 2020 if necessary but stated that his availability may be restricted from September 2020 due to other commitments. He would be happy to support the induction of his successor, if required. Laurence had extensive financial expertise and would contribute to, among other things, the close down of the annual accounts, should his appointment be extended. He was also Chair of the Audit Committee.

As in the case of Charlotte Dyson, Laurence Campbell was currently paid an additional £5,000 per annum in recognition of his role as Chair of the Audit Committee. The Chair stated that Laurence had given excellent performance both as a NED and as Chair of the Audit Committee.

The Committee discussed and considered the matter. Bearing in mind Laurence's strong performance and the fact that, in agreeing to the extension to his appointment, he was providing help and support to the Trust in difficult circumstances, the Committee agreed to recommend to Members' Council that the additional remuneration he receives be retained at £5,000 per annum.

**It was RESOLVED to AGREE to support the recommendation to the Members' Council to re-appoint Laurence Campbell for a period of up to 6 months from 1 June 2020 to 3**

**November 2020, and to recommend the retention of his additional remuneration at £5,000 per annum for the duration of the extension of his appointment.**

## NC/20/26 Appointment of Lead Governor and Deputy Lead Governor (agenda item 7)

The term of office of the current Lead Governor was due to end on 30 April, and two self-nominations had been received for the position from publicly-elected governors. Two self-nominations had also been received for the newly-formed position of Deputy Lead Governor from publicly-elected governors. Each candidate had submitted a brief written explanation of why they were putting themselves forward, and evidencing how they would be able to fulfil the role. They were each invited to join the meeting, individually, to give a brief verbal presentation and to answer any questions on their submission.

Before the presentations were given, the Chair invited any questions on the process from members of the Group, and also invited any questions on the individual written submissions before each applicant joined the meeting.

Each of the candidates was then invited to address the committee in turn for up to five minutes, in support of their self-nomination, and committee members were invited to ask questions of each of them.

After each candidate had addressed the committee, the committee members discussed the self-nominations and considered which of the candidates best met the requirements of the role at this time.

**Following discussion, it was RESOLVED to AGREE to recommend to the Members' Council the following appointments to the roles of Lead Governor and Deputy Lead Governor:**

**Lead Governor – John Laville**
**Deputy Lead Governor – Bill Barkworth**

AM offered to provide feedback to each candidate on their applications.

## NC/20/27 Revised 2020/21 Work Plan to take account of Covid-19 (agenda item 8)

The Chair advised that a revised Work Plan would be produced in liaison with the Corporate Governance team. Meeting dates for the rest of the year would be arranged.

## NC/20/28 Issues and items to bring to the attention of Members' Council and Trust Board (agenda item 9)

The Chair advised that the recommendations, as outlined above in minute numbers NC/20/24, NC/20/25, NC/20/26 would be put to the Members' Council at their next meeting.

The Chair also advised that a report would be submitted to the Trust Board that no nominations had been received for vacancies on the Trust Board Equality & Inclusion Committee. Nominations would be sought again, in due course.

## NC/20/29 Any other business (agenda item 10)

RM highlighted an error in Appendix B of Item 7, where reference was made to "Monitor". This should be "NHS Improvement".

**NC/20/30 Date of next meeting (agenda item 11)**

The date of the next meeting would be arranged, once the process around the NED recruitment had been agreed.

AM thanked members for their attendance, and acknowledged the difficulties in holding the meeting remotely, with no paper copies. She would endeavour to arrange for paper copies to be sent out, in future, while the restrictions were in place. Other methods of virtual meetings were still being explored.

South West Yorkshire Partnership NHS Foundation Trust

**Members' Council**
**31 July 2020**

| | |
|---|---|
| **Agenda item:** | **7.4** |
| **Report Title:** | **Nominations Committee Annual Report 2019/20 including update to the Terms of Reference** |
| **Report By:** | Corporate Governance Manager on behalf of the Nominations Committee |
| **Action:** | To receive / agree |

**EXECUTIVE SUMMARY**

Purpose

The purpose of this paper is to provide assurance to the Members' Council that their Nominations Committee is fulfilling its remit and meeting its terms of reference through their annual report.

Recommendation

**The Members' Council is asked to RECEIVE the annual report for 2019/20 and APPROVE the updated Terms of Reference for the Nominations' Committee.**

Background

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

The attached annual report provides assurance to the full Members' Council that the Committee is meeting its terms of reference and outlines the work undertaken for the period 1 April 2019 to 31 March 2020. The Terms of Reference have also been reviewed with amendments made to reflect the current membership and attendance, to ensure consistency between the terms of reference of other committees.

These documents were reviewed and supported for approval by the Nominations Committee on 23 June 2020.

*Nominations Committee members: Angela Monaghan, Marios Adamou, Bill Barkworth, Dylan Degman, John Laville, Ruth Mason*

*NB. This report relates to 2019/20 before the Deputy Lead Governor role was approved and introduced. This role will be reflected in the 2020/21 report.*



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NHS
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Yorkshire Partnership
NHS Foundation Trust

# Nominations Committee Annual Report 2019/20

## 1. Purpose of report

The purpose of the report is to provide a summary of the Committee's activities during the financial year 2019/20 to provide assurance and evidence to the Members' Council of its effectiveness and impact through compliance with its Terms of Reference.

## 2. Background

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

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

The duties of the Committee are:

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



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

Changes to Committee terms of reference

In 2020, the terms of reference were reviewed and some changes made in relation to membership and attendance, to be approved by the Committee on 23 June 2020. These will be presented to the Members' Council for formal approval.

Reporting to Trust Board

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

Membership

The Committee is made up of Non-Executive Directors and Governors and members from 1 April 2019 to 31 March 2020 were:

| **Name / role** | **Attendance 2019/20** |
|---|---|
| Angela Monaghan, Chair of the Trust - Committee chair | 6/ 7 |
| Jackie Craven, Lead Governor (public) | 7/ 7 |
| Nasim Hasnie, Governor (public) | 6/ 7 |
| Marios Adamou, Governor (staff) | 3/ 7 |
| Ruth Mason, Governor (appointed) | 4/ 7 |

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

## 3. Review of Committee activities

The activities during 2019/20 have been cross-referenced to the purpose of the Committee as outlined in the Terms of Reference below:

| | **Progress** |
|---|---|
| Regularly review the structure, size and composition (including the skills and experience) of Trust Board and make recommendations to the Board and Members' Council regarding any changes and appropriate processes. | The Committee reviewed the structure, size and composition of the Trust Board as part of the following items:<br>- Review of skills and Non-Executive Director structure – April 2019<br>- Non-Executive Director recruitment – June 2019, July 2019 and January 2020<br>- Non-Executive Director reappointment – March 2020 |
| Ensure there is a formal, rigorous and transparent procedure for the appointment of the | The Committee oversaw the recruitment process for one Non-Executive Director in 2019 including |

| | Progress |
|---|---|
| Chair and Non-Executive Directors of the Board, which fits the criteria set out by the Committee as a result of its regular review and meets the requirements of a confidential recruitment process. | the recommendation for appointment at its meeting in July 2019 which was approved by Members' Council in August 2019.<br>The further recruitment process began in January 2020. |
| Give full consideration to succession planning in respect of the Chair and Non-Executive Directors of the Board, taking account of the challenges and opportunities facing the Trust and the skills and expertise required by the Board. | The Committee considered succession planning in respect of Non-Executive Directors, including expertise required, as part of the oversight of the recruitment process for Non-Executive Directors in July 2019 and in January 2020. |
| Make recommendations to the Members' Council on the appointment of the Chair and Non-Executive Directors ensuring all information, such as job descriptions, person specifications and process, are available to Council Members to make an informed decision. | The Committee oversaw the recruitment process for one Non-Executive Director in 2019 including the recommendation for appointment at its meeting in July 2019 which was approved by Members' Council in August 2019.<br>The Committee also oversaw the recruitment process for one Non-Executive Director which began in January 2020, and the reappointment of a Non-Executive Director in March 2020. |
| Make recommendations to the Members' Council regarding any uplift to the Chair's remuneration based on benchmarking information as applicable and the pay spine point, and dependant on the outcome of Chair appraisal process through the Members' Council. | The Committee reviewed the Chair's remuneration based on benchmarking information at its meeting in October 2019 and made a recommendation to the Members' Council in November 2019. Progression along the pay scale was discussed as part of the Chair appraisal process, which was reported to and agreed by the Members' Council at the January 2020 meeting. |
| Make recommendations to the Members' Council regarding any uplift to Non-Executive Directors' remuneration based on benchmarking information as applicable. | The Committee reviewed the Non-Executive Directors' remuneration based on benchmarking information at its meeting in September 2019 and made a recommendation to the Members' Council in November 2019. |
| Ensure there is a formal, rigorous and transparent procedure for the appointment of the Deputy Chair and Senior Independent Director of the Board, which fits the criteria set out by the Committee as a result of its regular review (as above). | Not applicable in 2019/20. |
| Ensure there is a formal, rigorous and transparent procedure for the appointment of the Lead Governor for the Members' Council, which fits any criteria set out by the Committee and meets the requirements of a confidential recruitment process. | The Committee considered a self-nomination received at its meeting in July 2019 in accordance with the process agreed by Members' Council and made a recommendation to the Members' Council in July 2019. The process for appointment of Lead Governor and Deputy Lead Governor began in March 2020, for approval in May 2020. |

## 4. Review of Committee administrative arrangements

The Committee met seven times in 2019/20 and has been quorate at each meeting. The requirement to send papers out five working days in advance has been met throughout the year. There have been some instances where individual papers have, with agreement, been sent out after the five-day requirement.

South West Yorkshire Partnership NHS Foundation Trust

# NOMINATIONS COMMITTEE
## Terms of Reference
*To be approved by Members' Council 31 July 2020*

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

The Nominations Committee was established in May 2009. It has no executive powers. The authority of the Nominations Committee is limited to those powers specifically delegated to it in these terms of reference and, as appropriate, by the Members' Council. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

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

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

*Membership as at 1 May 2020*
Chair – Angela Monaghan (Chair of the Trust)
John Laville (Lead Governor) – governor term ends 30 April 2022
Bill Barkworth (Deputy Lead Governor) – Deputy Lead Governor term ends 30 April 2023
Marios Adamou (Staff Elected Governor) – governor term ends 30 April 2021
Ruth Mason (Appointed Governor) – governor term ends 7 November 2020
Dylan Degman (Publicly Elected Governor) – term ends 30 April 2023

## Attendance
The Head of Corporate Governance (Company Secretary) is in attendance at meetings. The Chief Executive and the Director of Human Resources, Organisational Development and Estates (or a member of his team) may also be asked to attend meetings to offer specialist



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or expert advice to the Committee. Administrative support is provided by the Corporate Governance team.

## Quorum

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

## Frequency of meetings

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

## Authority

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

## Duties

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

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

## Reporting to the Members' Council

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

**Approved by Members' Council: 31 July 2020**
**Next review due: May 2021**

DRAFT

South West Yorkshire Partnership NHS Foundation Trust

# MEMBERS' COUNCIL CO-ORDINATION GROUP
## Terms of Reference
*To be approved by Members' Council 31 July 2020*

The Members' Council Co-ordination Group was set up by Members' Council in July 2008, initially as the Members' Council Development Group with the overall aim to co-ordinate the work and development of the Members' Council.

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

## Membership
- Membership consists of governors including the Lead Governor (with representation from at least one from each public constituency, one staff, and one appointed), plus the Chair and Deputy Chair of the Trust / Senior Independent Director.
- A Governor's term of office on the Group is determined by their term of office as a Governor. If an individual resigns or is not re-elected onto the Members' Council, the individual taking their seat does not automatically take the place on the Group.

*Membership as at 1 May 2020:*
Chair – John Laville, Lead Governor (publicly elected governor, Kirklees)
Bill Barkworth, Deputy Lead Governor (publicly elected governor - Barnsley)
*Vacant (publicly elected governor – Barnsley)*
Adam Jhugroo (publicly elected governor - Calderdale)
*Vacant (publicly elected governor – Kirklees)*
Bob Clayden (publicly elected governor - Wakefield)
*Vacant (publicly elected governor - Rest of Yorkshire & the Humber)*
Lisa Hogarth (staff elected governor)
Ruth Mason (appointed governor)
Angela Monaghan (Chair of the Trust)
Charlotte Dyson (Deputy Chair of the Trust / Senior Independent Director)

## Attendance
All governors are welcome to attend meetings of the Co-ordination Group, even if they are not formal members. The Head of Corporate Governance (Company Secretary) is in attendance at meetings. The Chief Executive, Directors, and relevant officers will be invited to attend as appropriate. Administrative support is provided by the Corporate Governance team.

## Quorum
The quorum will be three Members' Council representatives (including the Lead Governor or Deputy Lead Governor as Chair of the Group) plus a member of Trust Board. Members are expected to attend all meetings. In the unusual event that the Chair of the Group is absent from the meeting, the Deputy Lead Governor will chair the meeting.

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With all of us in mind.

## Frequency of meetings

The Group will meet four times per year approximately six weeks prior to formal Members' Council meetings. Additional meetings will be arranged as needed.

## Duties

a) In conjunction with the Chair of the Trust, develop and agree the agendas for Members' Council meetings.
b) Work with the Trust to develop an appropriate development programme for governors both as ongoing development and as induction for new governors.
c) Act as a forum for more detailed discussion of issues and opportunities where the Trust seeks the involvement of the Members' Council.
d) Consider advice and feedback from other Members' Council working groups as appropriate.

## Reporting to the Members' Council

The Group will report to the Members' Council on any issues it feels should be escalated to the full Members' Council and will provide an annual report on its activities each year.

**To be approved by Members' Council: 31 July 2020**
**Next review due: May 2021**

DRAFT

South West Yorkshire Partnership NHS Foundation Trust

**Members' Council**
**31 July 2020**

| | |
|---|---|
| **Agenda item:** | **7.6** |
| **Report Title:** | **Annual Report and Accounts 2019/20** |
| **Report By:** | Director of Finance and Resources |
| **Action:** | To receive |

**EXECUTIVE SUMMARY**

Purpose and format

- To confirm the submission of the 2019/20 Annual Accounts and Annual Report.
- To explain the process undertaken to generate these submissions and provide assurance regarding the governance of the process.
- To publically table the reports generated by the external auditors Deloitte LLP following their annual audit.

**Recommendation**

**The Members' Council is asked to RECEIVE the Annual Report and accounts for 2019/2020.**

Background

- Given the impact of the Covid-19 pandemic on the NHS, the deadline for submission of the Annual Report and Accounts was extended to 25 June 2020. Trust Board delegated authority for approval to the Trust Chair and Chief Executive at its meeting on 21 May 2020.
- The draft Annual Governance Statement was reviewed and agreed by the Trust Board on 28 April 2020 with the final draft reviewed and approved at Trust Board on 21 May 2020. The final draft was included in the Annual Report reviewed by the Audit Committee on 2 June 2020 and approved by the Trust Chair and Chief Executive on 3 June 2020.
- The draft Annual Report had input from executive directors and other senior managers and stakeholders, and was shared with four non-executive directors including the Trust Chair for comment and feedback. The final draft was reviewed by the Audit Committee on 2 June 2020 and approved by the Trust Chair and Chief Executive on 3 June 2020.
- The Annual Accounts were reviewed in detail by the Director of Finance & Resources and the two qualified accountants on the Audit Committee. The



With all of us in mind.

Annual Accounts were then reviewed in full and recommended for approval by the Audit Committee on 2 June 2020 and approved by the Trust Chair and Chief Executive on 3 June 2020.

- A separate paper was provided to the Trust Board on 21 May and Audit Committee on 2 June explaining the change in process and extended timescales for completion of the Quality Account.
- In accordance with Department of Health and Social Care Group Accounting Manual 2019/20, the Annual Report and Accounts was to be published until the document was laid before parliament which took place on 8 June 2020.
- It will be formally presented at the Annual Members' Meeting on 28 September 2020.
- All documents were submitted to NHS England & Improvement ahead of the submission deadline.
- Each document was subject to significant Board scrutiny and oversight.
- With regard to the accounts, Deloitte issued 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.

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

- the Director of Finance's report on the year end process and submissions for 2019/20;
- 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 Trust's Annual Report and accounts for 2019/20 are being published on the Trust's website on 17 July 2020 under **About us > Our Performance > Annual report** (http://www.southwestyorkshire.nhs.uk/about-us/performance/annual-report/)

South West Yorkshire Partnership NHS Foundation Trust

# 2019/20 Annual Report, Annual Accounts and Quality Account

## Introduction

In line with statutory requirements the Trust has submitted an annual report and its annual accounts to parliament and to NHS England & Improvement (NHSE&I). Each of these has been subject to internal scrutiny and governance, and to external audit. The documents become publicly available documents once laid before parliament, which normally occurs in July, but this year was completed in June 2020. They will be formally presented at the Annual Members' Meeting in September 2020. This document explains the process undertaken and provides the external audit reports.

Given the impact of Covid-19 timescales for the submission of these documents was extended this year. The annual report and accounts needed to be completed and submitted by 25 June and the quality account needs to be submitted by 15 December. Given the timings of the year-end, required time to audit the accounts and report remotely delegated authority was given by the Trust Board on 21 May for the Trust Chair and Chief Executive to approve the annual report and annual accounts.

## Annual Governance Statement

The Annual Governance Statement (AGS) was produced in line with guidance and instructions provided by NHSE&I based on Treasury requirements. The draft AGS was approved by the Trust Board on 28 April and the final draft was further reviewed and approved by Trust Board on 21 May. The final version was reviewed and recommended for approval by the Audit Committee on 2 June before being approved by the Trust Chair and Chief Executive on the 3 June 2020. The AGS contained the Head of Internal Audit overall opinion of significant assurance.

## Annual Accounts

The annual accounts were produced in line with international accounting standards (IFRS) and followed guidance and instruction provided by NHSE&I. The draft accounts were shared with the members of the Audit Committee (which includes two qualified accountants) for comment and feedback. Responses were provided to all questions raised and where appropriate amendments were made to the accounts (typically within the notes to the accounts). They were also shared with members of the Executive Management Team (EMT) for comment and feedback.

The accounts were subject to audit by Deloitte LLP and to a review at the Audit Committee on 2 June. The Audit Committee recommended them for approval and they were subsequently approved by the Trust Chair and Chief Executive on 3 June 2020. Electronic

signature took place on 3 June. A log was kept of all adjustments made from version to version. The accounts were then submitted to parliament and NHSE&I three weeks ahead of the required deadline.

**Annual Report**

The production of the annual report was co-ordinated by the head of business development 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 annual report was reviewed at the Trust Board on 21 May and then at the Audit Committee on 2 June. The Audit Committee recommended the annual report for approval and it was approved by the Trust Chair and Chief Executive on 3 June 2020. Electronic signature again took place on 3 June 2020. The report was then submitted to parliament and to NHSE&I

**Quality Account**

As a result of Covid-19 there is no requirement to complete an external audit of the 2019/20 quality account. In addition the deadline for submission has been extended to 15 December 2020.

**Conclusion and Recommendation**

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

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

Deloitte.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

# South West Yorkshire Partnership NHS Foundation Trust

Report to the Audit Committee on the 2019/20 audit

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# Contents

## 01 Final report



## 02 Appendices




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# Director introduction
## The key messages in this report

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

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

I have pleasure in presenting our final report to the Audit Committee for the 2019/20 audit.
I would like to draw your attention to the key messages within this paper:

| | |
|---|---|
| **Status of the audit** | Our audit is complete.<br>Our Independent Examination of EyUp! Is underway and we have agreed a timetable with management to have these ready for signing for the September Charitable Funds meeting. |
| **Conclusions from our testing** | • The key judgements in the audit process related to the Modern Equivalent Asset Valuation Alternate Site design (page 8);<br>• We have issued an unmodified audit opinion on the financial statements with the inclusion of a key audit matter on property valuations referring to a material uncertainty identified by your property valuers (page 8);<br>• We have identified a finding in respect to our work regarding management override of controls (page 9);<br>• We did not identify any significant audit adjustments or disclosure deficiencies; and<br>• We have not identified any inconsistencies between the financial statements and the TACs (Trust Accounts Consolidation schedules). |
| **Financial sustainability and Value for Money** | • The Trust reported a surplus for the year of £8.5m before other comprehensive income and expenditure, which is ahead of the planned surplus of £1.5m. This includes £1.8m of payment from the Provider Sustainability Fund (PSF) notified at the year-end.<br>• CIP (Cost Improvement Plan) delivery was £10.6m against a £10.6m target, meaning that the Trust has achieved the target in year. This comprised of £5.5m in recurrent CIP, an underachievement of £1.8m (plan £7.3m), offset by an overachievement of £1.8m in non-recurrent CIP (plan £3.2m v actual £5m).<br>• The Trust has a Use of Resources rating of 1 and a Single Oversight Framework segmentation of 1 which are in line with the planned rating. It is not currently subject to any regulatory action from either NHSI (NHS Improvement) or the Care Quality Commission (CQC).<br>• Our response to Value for Money is set out on page 10. |


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# Director 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.

| | |
|---|---|
| **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. |
| **Impact of Covid-19** | • The impact of Covid-19 has led to a material uncertainty being identified by the Trust's property valuer regarding the valuation of properties (page 12). This is described as follows:<br>*The outbreak of the Novel Coronavirus (COVID-19), declared by the World Health Organisation as a "Global Pandemic" on 11 March 2020, has impacted global financial markets. Travel restrictions have been implemented by many countries.*<br>*Market activity is being impacted in many sectors. As at the valuation date, we consider that we can attach less weight to previous market evidence for comparison purposes, to inform opinions of value. Indeed, the current response to COVID-19 means that we are faced with an unprecedented set of circumstances on which to base a judgement.*<br>*Our valuation(s) is / are therefore reported on the basis of 'material valuation uncertainty' as per VPS 3 and VPGA 10 of the RICS Red Book Global. Consequently, less certainty – and a higher degree of caution – should be attached to our valuation than would normally be the case. Given the unknown future impact that COVID-19 might have on the real estate market, we recommend that you keep the valuation of this property / these properties under frequent review.*<br>The above material uncertainty statement is based on guidance from RICS. As a result we expect to refer to this in our opinion in the key audit matter on property valuations.<br>• There are no other significant impacts of Covid-19 on the Trust's Accounts and Annual Report identified at this time. |
| **Accounting performance** | • The finance team have been proactive in raising matters for audit consideration during the year. The quality of working papers to support the financial statements audit has been of a very high standard as in previous years. We would like to take this opportunity to thank management for their assistance during the audit. |

Paul Hewitson
Audit Director


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# Our audit explained

## We tailor our audit to your business and your strategy

**Identify changes in your business and environment**

In our planning report we identified the key changes in your business and articulated how these impacted our audit approach. We have not identified any subsequent changes which have impacted our audit approach.

**Scoping**

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

**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 page 13 of this report.


**Determine materiality**

When planning our audit we set our Group materiality at £4.506m based on approximately 2% of forecast income. Materiality has increased slightly since our planning assessment to £4.857m (PY: £4.269m) as total income for the year has increased against the plan. We report to you in this paper all misstatements above £243k (PY: £225k).

**Significant risk assessment**

In our planning report and update reports we explained our risk assessment process and identified significant audit risks in relation to Management Override of Controls and the Modern Equivalent Asset Valuation alternate site assumptions. 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 income are appropriate.

**Our audit report**

We have issued 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.


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# Central Funding – Provider Sustainability Funding (PSF)

The Trust had a planned allocation of PSF of £1.8m, with a control total of £1.5m, or £(0.2)m before PSF income.

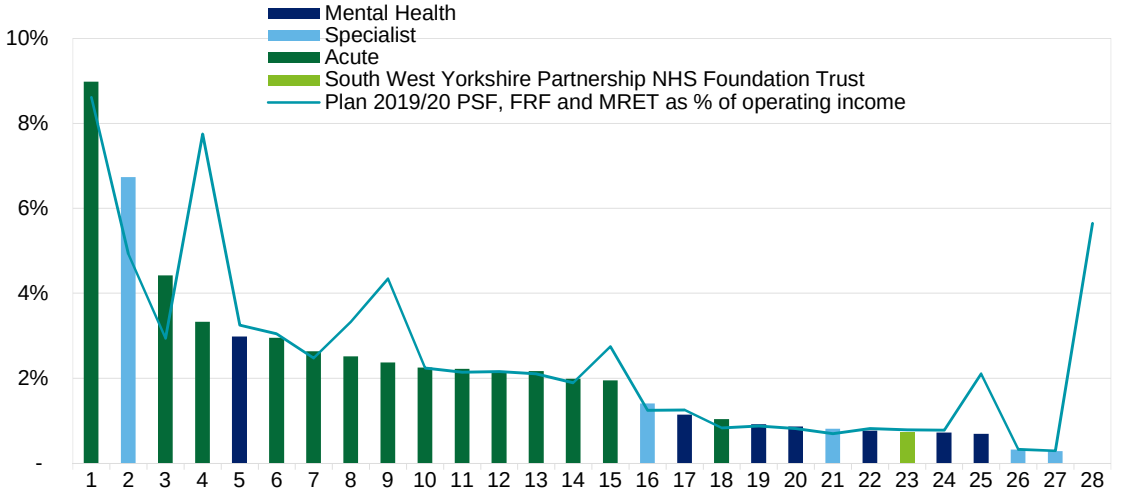
The Trust has recognised £1.8m of PSF income, in line with plan.

The Trust exceeded its underlying control total by £1.3m.

On average, trusts we audit received 96.1% of planned PSF, FRF and MRET income, and £0.3m of additional 2018/19 income allocated in 2019/20.

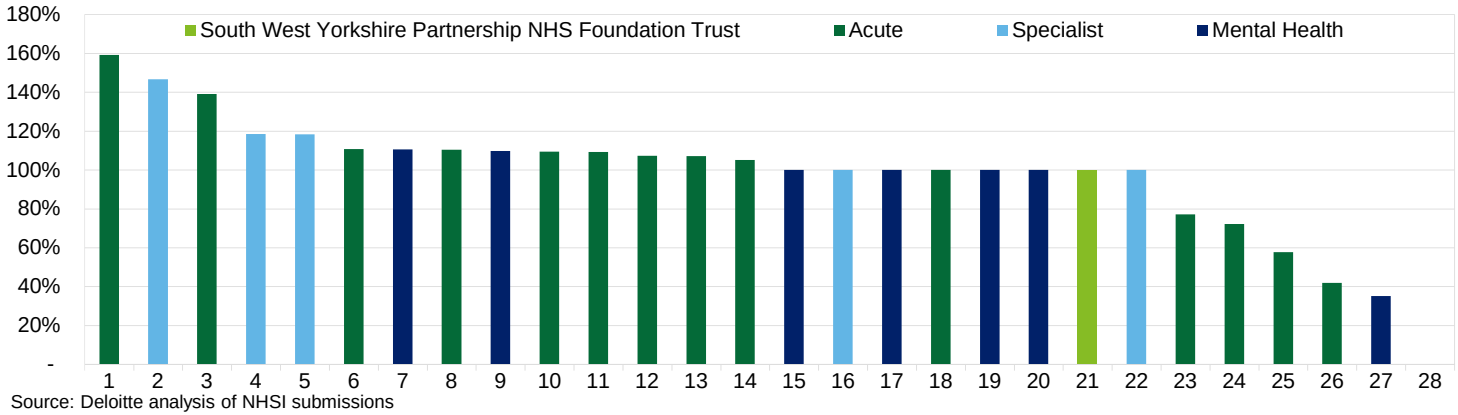
These income streams were 0.7% of the Trust's operating income for the year, compared to an average of 2.3% for all trusts we audit and 1.0% for Mental Health trusts.

**PSF, FRF and MRET funding as a percentage of operating income**




Source: Deloitte analysis of NHSI submissions

**PSF, FRF and MRET as a percentage of plan**




Source: Deloitte analysis of NHSI submissions



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# Significant risks
## Dashboard

| Risk | Fraud risk | Planned approach to controls | Controls conclusion | Consistency of judgements with Deloitte's expectations | Expected to be a key audit matter in our audit report | Slide no. |
|---|---|---|---|---|---|---|
| Modern Equivalent Asset Design | ✓ | DI | Satisfactory | ● | ✓ | 8 |
| Management Override of Controls | ✓ | DI | Weakness identified | ● | ✗ | 9 |

Overly prudent, likely to lead to future credit

Overly optimistic, likely to lead to future debit.

**Controls approach adopted**

- DI Assess design & implementation
- OE Test operating effectiveness of relevant controls
- S Involvement of IT specialists


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# Significant audit risks (continued)
## Modern Equivalent Asset Valuation Alternate Site design

| | |
|---|---|
| **Risk identified** | Under Auditing Standards there is a rebuttable presumption that the fraud risk from revenue recognition is a significant risk. In line with the prior year, we do not consider this it be a significant risk for South West Yorkshire Partnership NHS Foundation Trust, as there is unlikely to be an incentive to fraudulently recognise revenue. Therefore, we consider the fraud risk to be focussed on management's judgements in respect of the Modern Equivalent Asset Valuation – Alternate Site (MEAV-AS) design and its appropriateness in view of any service changes and any changes to the Trusts capital programme, as this could impact the Trust's Public Dividend Capital and depreciation charges.<br><br>In 2018/19 the Trust commissioned the District Valuer (DV) to perform a full revaluation of the estate and to implement amendments to the previous MEAV-AS design. For 2019/20, our discussions with management indicated that the Trust planned to use the existing MEAV-AS design to procure a desktop valuation for the current year. There is judgement in relation to the use of the MEAV-AS design should this not accurately reflect the current service potential and future estate's strategy for the Trust. |
| **Deloitte response** | • We have examined the preparation of MEAV-AS assumptions and the management controls within the Trust surrounding the review and communication of the MEAV-AS assumptions;<br>• We have reviewed the MEAV-AS assumptions used by management and validated that these are the same as the ones adopted in the 2018/19 valuation;<br>• We have tested a sample of the MEAV-AS assumptions to the Trust's current estates strategy and also the current service potential of assets; and<br>• We have reviewed minutes of the Estates TAG and Trust Board meetings to check for any changes to the Trust's estate that has not been reflected in the MEAV-AS design.<br><br>No significant issues have been identified as a result of the testing performed. |
| **Audit report findings** | We included 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.<br><br>We included in our audit report a key audit matter due to the material uncertainty identified by the DV in relation to the valuations as at 31 March 2020 due to the impact of Covid-19 on the property market. |


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# Significant audit risks (continued)
## Management override of controls

| | |
|---|---|
| **Risk identified** | In accordance with ISA 240 (UK) 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.<br>We consider that in the current year there is a heightened risk across the NHS that management may override controls to fraudulently manipulate the financial statements or accounting judgements or estimates. This is due to the increasingly tight financial circumstances of the NHS and the incentives to meet or exceed control totals to receive PSF funding. |
| **Deloitte response** | • We have risk assessed journals and selected a sample of items for detailed follow up testing. The journal entries were selected using data analytics to focus our testing on higher risk journals with characteristics of audit interest.<br>• We have tested the appropriateness of journal entries recorded in the general ledger, and other adjustments made in the preparation of financial reporting.<br>• We have reviewed accounting estimates for biases that could result in material misstatements due to fraud.<br>• We have obtained an understanding of the business rationale of significant transactions that we become aware of that are outside of the normal course of business for the entity, or that otherwise appear to be unusual, given our understanding of the entity and its environment. |
| **Conclusion** | We have not identified any significant bias in the key judgements made by management.<br>We have raised an insight in respect to the review of journals, on page 13. |
| **Audit report findings** | We did not 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. |


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# Value for money

**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. Value for money 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 value for money conclusion, and perform further testing where risks are identified.

**Key judgements**

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

| | Actual 2019/20 | Plan 2019/20 | Variance | Prior year 2018/19 |
|---|---|---|---|---|
| Surplus (before impairments) | £8.5m | £1.5m | £7.0m | £3.2m |
| EBITDA margin (as a % of related income) | 4.7% | 4.2% | 0.5% | 4.4% |
| CIP target and identified to date | £10.6m | £10.6m | (£0.0m) | £10.6m |
| Single Oversight Framework segmentation (finance rating) | 1 | | | 1 |
| CQC report conclusions | Good | | | Good |

The Trust reported a surplus for the year of £8.5m before other comprehensive income and expenditure, which is ahead of the planned surplus of £1.5m. This includes £1.8m of payment from the Provider Sustainability Fund (PSF) notified at the year-end. CIP (Cost Improvement Plan) delivery was £10.6m against a £10.6m target, meaning that the Trust has overachieved the target in year. This comprised of £5.5m in recurrent CIP, an underachievement of £1.8m (plan £7.3m), offset by an overachievement of £1.8m in non-recurrent CIP (plan £3.2m whereas actual £5m).

**Deloitte response**

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

- Review of high level forecasts and CIP plans;
- Consideration of the Trust's year end and forecast cash position;
- High level interviews with management;
- Review of the Trust's draft Annual Governance Statement;
- Consideration of issues identified in our audit work;
- Consideration of the Trusts' financial results, including CIP delivery, and the 2019/20 plan;
- Review of any Care Quality Commission Reports issued in the year;
- Review of NHSI's risk ratings;
- Benchmarking of the Trust's performance.

**Draft audit report findings**

We have identified no specific risks in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.


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# Area for monitoring in relation to our Value for Money Conclusion

| | |
|---|---|
| **Area of monitoring** | As part of our planning work and discussions with the Trust we noted the delivery of the CIP programme as an area for monitoring that may potentially have been relevant to our Value for Money conclusion. |
| **Conclusion** | We monitored this area throughout the year, and based on our work, did not consider that this crystallised into a specific risk and therefore there are no issues identified that would have an impact on the Value for Money conclusion. |


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# Coronavirus (Covid-19) outbreak

## Impact on the annual report and audit

The current crisis is unprecedented in recent times. The NHS is most directly exposed to the practical challenges and tragedies of the pandemic, and is undergoing major, rapid operational changes in response.

The uncertainties and changes to ways of working also impact upon the reporting and audit processes, and present new issues and judgements that management and Audit Committees need to consider. NHS Improvement has issued *"NHS providers: COVID-19 related considerations for 2019/20 annual reports and accounts disclosures"* to assist in making relevant disclosures. We summarise below the key impacts on reporting and audit:

| Impact on Trust annual report and financial statements | Impact on our audit |
|---|---|
| The Trust need to consider the impact of the outbreak on the annual report and financial statements including:<br>• Principal risk disclosures;<br>• Change in the funding regime for 20/21;<br>• Waiting list backlog;<br>• Property valuation material uncertainty;<br>• Impairment of non-current assets;<br>• Allowance for expected credit losses;<br>• Fair value measurements based on unobservable inputs;<br>• Onerous contracts and any potential provisions;<br>• Going concern; and<br>• Events after the end of the reporting period. | Covid-19 has fundamentally changed the way we have conducted our audit this year including:<br>• Teams are primarily working remotely with workarounds needed in respect to accessing 'physical' documentation and on site access to Trust staff.<br>• The teams have had regular status updates to discuss progress and facilitate the flow of information.<br>• Consideration of impacts on the areas of the financial statements and annual report listed has been included as part of our audit work in the current year and comments have been included where appropriate within this report.<br>• In conjunction with the Trust, we will continue to consider any developments for potential impact up to the finalisation of our work in June 2020. |


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# Internal control and risk management

## Findings

During the course of our audit we have one internal control and risk management finding, which we have included below for information.

| Area | Observation | Priority |
|---|---|---|
| Journal review | During the year we note, in line with Internal Audit findings, that the review of journals ceased and there is no review of journals completed. Deloitte recommend that journals are reviewed at least on a monthly basis, or journals with specific characteristics or a random selection of journals are reviewed. | High |

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


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# 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 | June 2020


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# Sector Developments



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# COVID-19 implications for 2019/20 Annual Report and Accounts

## There are a number of areas where the current crisis and related uncertainties will impact on the 2019/20 reporting process.

**Issue**

The current crisis is unprecedented in recent times. The NHS is most directly exposed to the practical challenges and tragedies of the pandemic, and is undergoing major, rapid operational changes in response.

The uncertainties and changes to ways of working also impact upon the reporting and audit processes, and present new issues and judgements that management and Audit Committees need to consider. NHS Improvement has issued *"NHS providers: COVID-19 related considerations for 2019/20 annual reports and accounts disclosures"* to assist in making relevant disclosures.

- **Timetable:** NHS Improvement has given providers the option to delay submission of draft accounts to a choice of either 27 April or 11 May (compared to original deadline of 24 April), with signed accounts due by 25 June rather than 29 May.
- **Financing and funding**: The Government has undertaken to provide the NHS with the funding required to address the current crisis. All providers have moved to block contracts for at least the first four months of 2020/21, with additional funding for the incremental costs of COVID-19 and an undertaking to ensure that where this does not cover costs additional funding will be provided to ensure providers achieve break-even. Unlike many other organisations, this removes short-term uncertainty over finances and going concern, income is significantly below normal. Trusts will still need to assess the appropriateness of the going concern assumption for at least 12 months from the signing of the financial statements, and we understand that the Department and NHS Improvement will be issuing guidance on assumptions that providers should make about the remainder of 2020/21 and start of 2021/22.
- **Valuation**: The Royal Institute of Chartered Surveyors have issued guidance to valuers, highlighting that the uncertain impact of COVID-19 may cause a valuer to conclude there is a material valuation uncertainty. This does not preclude a valuer giving an opinion on value, but highlights additional uncertainty over the valuation. Our understanding is that at 31 March 2020 most, if not all, valuations will include a "material valuation uncertainty" paragraph. NHS Improvement have given guidance, both for trusts with 2020 valuations and for those not undertaking valuations in year, that this should be disclosed in the Key Sources of Estimation Uncertainty note, with the disclosure reflecting specific circumstances of the Trust. Where this is the case, then this will also be expected to need to be referred to in the audit opinion. The Trust's valuation included a material valuation uncertainty paragraph.
- **Reporting requirements:** The Quality Accounts no longer need to be prepared alongside the Annual Report and have to be submitted by 15 December 2020, and independent assurance from the auditor is no longer required. The requirement to include a performance analysis section in the Annual Report has been removed, as has the requirement to disclose sickness absence data.
- **Annual Report:** NHS Improvement have suggested areas where disclosures are likely to need to refer to COVID-19, albeit with the main focus of the Annual Report on 2019/20 as a whole. This would include: forward looking disclosures; discussion on finances, operational performance and work force; the annual governance statement and how the trust responded to this (including any required changes in control environment or business continuity issues; and risk and uncertainties disclosures.
- **Inventory:** In some cases, trusts were unable to perform planned inventory counts, or to have these audited. There may also be circumstances where unusual stock levels have occurred around year-end, some items may be impaired (due to reductions in some services) or judgements may be needed over the ownership of centrally procured stock. The Trust's stock balance is immaterial, as such this has not presented an issue for the 2019/20 audit.
- **Financial instruments:** The wider impact of the crisis may impact on measurement or disclosure of financial instruments, for example by changing expected credit loss provisions.


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# COVID-19 implications for 2019/20 Annual Report and Accounts (continued)

## There are a number of areas where the current crisis and related uncertainties will impact on the 2019/20 reporting process.

**Next steps**

- Our Foundation Trust Annual Reporting Manual and DHSC Group Accounting Manual checklist which we have shared with management includes specific considerations for matters highlighted by NHS Improvement and other interested bodies, which have been considered in reviewing the Annual Report and Accounts.
- We have reviewed key areas of impact with management as part of our year-end audit work.
- The Trust are progressing in line with plan to sign their accounts and annual report by the 25 June 2020 deadline.


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# Respond – Recover – Thrive: Governing NHS boards through COVID-19

## How is your board coping?

Overview by the Deloitte Board Advisory Practice

Over the last few weeks the COVID-19 crisis has unfolded at extraordinary pace, causing everyone to fundamentally rethink priorities and to redefine ways of working. The Boards of NHS provider organisations are no exception and have responded with urgency. From our discussions with a number of providers around the country, it is clear that there has been a rapid response to bring about new ways of working during these unprecedented times.

Commonly adopted initiatives include: moving to video-conferencing for board and committee meetings, along with defining revised protocols for board etiquette; revisiting agendas and forward plans to determine what is absolutely necessary; minimising the number of additional attendees/presenters invited to the meetings, and in some instances redefining meeting quoracy; and revising Standing Financial Instructions (SFIs) and Standing Orders (SOs) to ensure they enable sufficient autonomy to the executive team at a time when pace is key.

### Sharing Best Practice

Despite the commonly adopted initiatives described above, it is apparent from our discussions with NHS provider boards, as well as those in other sectors, that there is no blueprint for governance in these times. As a result, providers are developing a number of innovative approaches devised to increase flexibility, whilst also maintaining rigour. Outlined below is a brief overview of these approaches.

1. **Board led change:** A number of providers have formally set out the options for changing governance arrangements during COVID-19 in a paper to their board for discussion and approval.
2. **Consent Agenda**: Under this approach, some of the board papers are placed onto a separate section of the agenda ("the Consent Agenda") with a working assumption that they will not be subject to any detailed debate during the meeting unless specifically requested.
3. **Meeting efficiency:** There are a number of ways in which efficiency can be improved. Examples include: inviting board members to submit questions in advance of board or committee meetings and holding a preparatory call with Non-Executive Directors (NEDs) a few days in advance.
4. **Post-board briefings:** Some are endeavouring to publish a summary of the key matters on their website immediately after the board meeting to maintain communication with the public, patients, governors, and stakeholders.
5. **NED briefings**: We are aware of providers who have placed a lot of emphasis on this. Examples include: NED/Executive Director (ED) buddy systems; weekly virtual meetings between each committee chair and their relevant ED, with a summary of pertinent points shared by the committee chairs
6. **COVID-19 Risk Register**: Risk management continues to play a crucial role in managing the current crisis, and many have moved to maintaining a COVID-19 Risk Register and updating their Board Assurance Framework (BAF) for COVID-19 related strategic risks, including reputational risk.
7. **Consolidating committee meetings:** Many providers have moved to consolidate or reduce meeting frequency, balancing the time input required with ensuring that key issues are regularly reviewed.
8. **Decision Logs:** Trusts are maintaining a list of significant operational and strategic decisions taken during these revised measures, which can subsequently be shared with their board to ensure that visibility and transparency is maintained.
9. **Ethics Committees:** many trusts are establishing board level Ethics Committees (or modifying the Terms of Reference of existing forums).
10. **Board visibility:** Board visibility is more important than ever to boost the morale of staff that are under constant pressure, as well as to provide visible leadership to external stakeholders, and many have turned to technology based solutions.


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# Respond – Recover – Thrive: Governing NHS boards through COVID-19 (continued)

## How is your board coping?

| Next steps |
| --- |
| • It is vital that boards take time to plan ahead for the "new normal", given the wide ranging implications for patients, staff and finances beyond the current situation. The full article can be found here: https://www2.deloitte.com/uk/en/pages/public-sector/articles/governing-nhs-boards-through-covid-19.html**. We will be arranging a number of future webinars around these aspects**. If you would like to be included in these sessions, please contact: **Jane Taylor, Lead Director,** jataylor@deloitte.co.uk or **Lucy Bubb, Associate Director,** lbubb@deloitte.co.uk **from the Deloitte Board Advisory Practice**. |


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# National Audit Office updated Code of Audit Practice

## The National Audit Office has issued the new Code of Audit Practice applicable for 2020/21 audits onwards

**Issue**

The National Audit Office issued the new Code of Audit Practice for 2020/21 onwards. The Code is applicable to NHS Trusts and Foundation Trusts, CCGs, and Local Authorities.

The Code remains aligned (where relevant) with generally accepted auditing standards, with the intention that this will allow the Code to adapt to any changes arising as a result of the wider debate within the audit profession (such as the Brydon Review and the Redmond Review).

The most significant changes are around Value for Money (the arrangements to secure economy, efficiency, and effectiveness in the use of resources), which:

- Change the approach away from the auditor performing a risk assessment, and then only performing further work if a significant risk were identified, to specifying procedures that will need to be undertaken in each of three areas. This will require a minimum level of work at every local public body, with additional risk based work where relevant.
- Moving the focus of reporting to providing public narrative commentary on each of criteria considered for all bodies. This will be included in a separate "Annual Auditor's Report", which will be a public narrative report, which for NHS bodies will be issued alongside the audit opinion.
- The audit opinion will continue to include reporting by exception where the auditor is not satisfied in respect of arrangements in place (which is a change from the initial proposals consulted upon).

The three criteria that would be considered in Value for Money work would be:

- **Financial sustainability:** How the body plans and manages its resources to ensure it can continue to deliver its services.
- **Governance:** How the body ensures that it makes informed decisions and properly manages its risks and finances.
- **Improving economy, efficiency and effectiveness:** How the body uses information about its costs and performance to improve the way it manages and delivers its services.

Where the auditor identifies significant weaknesses in VfM arrangements, the Code includes an expectation that the auditor will issue recommendations to the audited body, and considers whether to do so when identified.

Other proposed changes include:

- Giving the NAO the ability to specify whether auditors should issue 'enhanced' auditor reports (as is already done for NHS Foundation Trusts);
- Clarifying expectations on reporting by introducing key principles for effective reporting, so that auditors ensure that any reporting is as effective and transparent as possible and promotes local improvement.

We note that the changes are likely to increase the scope of work required for audits, both in required procedures on Value for Money and in the need for an additional public report each year.

The NAO will now move forward in developing supporting guidance on the detail of what will be required.


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# Appendices



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# 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 Auditing standard on Auditing (UK). The net impact of these is a decrease of £0.131m in the deficit for the period.

| | | Debit/ (Credit) income statement £m | Debit/ (Credit) in Net Assets £m | Debit/ (Credit) in reserves £m |
|---|---|---|---|---|
| **Misstatements identified in current year** | | | | |
| Revaluation – update to valuation | [1] | | 0.273 | (0.273) |
| **Aggregation of misstatements individually < £0.243m** | | | | |
| Misstatements less than £0.243m | | (0.131) | 0.131 | |
| **Total** | | **(0.131)** | **0.404** | **(0.273)** |

(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 £1.099m and on income and expenditure there is a margin of uncertainty of £2.555m. 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.


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# Audit adjustments (continued)

## 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 |
|---|---|---|
| We have not identified any significant disclosure deficiencies in the financial statements and the deficiencies identified have been corrected by management. | | |


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# 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 / you have disclosed to us all information in relation to fraud or suspected fraud that you are aware of and that affects the entity or group.

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

**Audit work performed:**

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

During course of our audit, we have had discussions with management and those charged with governance, as well as with Local Counter Fraud and Internal Audit.

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


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# 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 that we comply with FRC Ethical Standards for Auditors and that, in our professional judgement, we and, where applicable, all Deloitte network firms are independent 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 Ethical Standards for Auditors 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 2019/20. |
| Relationships | We have no 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 2019 to 31 March 2020 are as follows:

| | Current year | Prior year |
|---|---|---|
| Audit of Trust (including WGA) | £46,672 | £46,672 |
| **Total audit** | **£46,672** | **£46,672** |
| Quality Accounts (1) | 2,500 | £5,000 |
| Independent Examination of the Charity | £828 | £828 |
| **Total fees** | **£50,000** | **£52,500** |

(1) The quoted fee for the Quality Accounts work was £5,000. NHSI in response to the covid-19 pandemic removed the requirement for auditors to complete the limited assurance procedures. However, prior to this announcement, a substantial amount of the indicator work had already been undertaken. We have agreed with management that the fee for the work undertaken will be £2,500.


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# Our audit report

## We will provide an overview of our audit approach

Here we discuss the items that we intend to comment on in our audit report. Our audit report includes comment on materiality and scoping, including how this has changed from last year. We also comment on the key audit matters which have been the focus of our time and efforts on the audit.

**Materiality**

We will disclose materiality, and the basis for how we determined it. We will also provide our reporting threshold and the component materiality ranges used in the audit.

**Key audit matters**

Key audit matters are those which were of most significance in the audit. We have indicated in the slides above which significant risks and other matters we determined to be key audit matters.

**Irregularities and fraud**

We will explain the extent to which we considered the audit to be capable of detecting irregularities, including fraud.

In doing so, we will describe the procedures we performed in understanding the legal and regulatory framework and assessing compliance with relevant laws and regulations. We will discuss the areas identified where fraud may occur and any identified key audit matters relating to fraud.

**Material uncertainty related to going concern**

We have not identified a material uncertainty related to going concern and will report by exception regarding the appropriateness of the use of the going concern basis of accounting.


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# Sector benchmarking

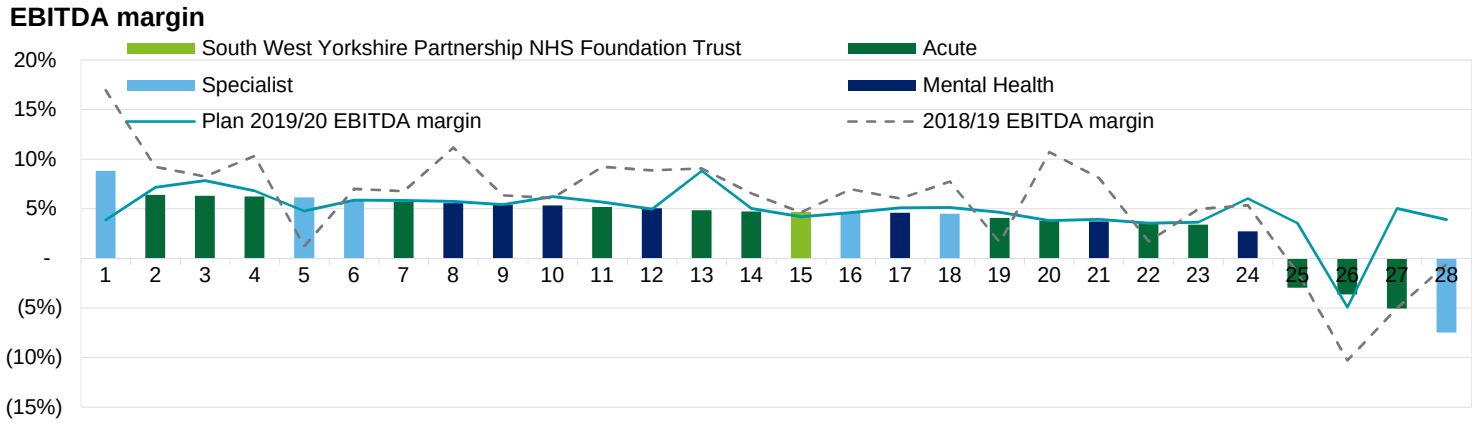
## We have reviewed the Trust's performance to 31 March 2020.

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 below some of the comparisons we have performed as part of our concluding analytical procedures, comparing the Trust's performance to 31 March 2020 to other trusts we audit.

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

| (£m) | Trust Actual | Trust Plan | Trust Variance | Mental Health Trusts average Actual | All Trusts average Actual |
|---|---|---|---|---|---|
| Operating income | 243.0 | 225.3 | 17.7 | 211.8 | 473.2 |
| EBITDA | 11.4 | 9.5 | 0.1 | 10.0 | 17.2 |
| EBITDA margin (%) | 4,7% | 4.2% | 0.5% | 4.7% | 3.6% |
| Surplus / (deficit) | 8.5 | 1.5 | 7.0 | (2.3) | (5.7) |
| Performance against control total | 2.8 | 1.5 | 1.3 | 1.8 | (3.8) |

The chart below shows EBITDA margin for trusts we audit, compared to plan. The Trust's EBITDA of £11.4m compared to plan of £9.5m gives an EBITDA margin of 4.7%. This compares to an average margin for mental health trusts of 4.7% and all types of trust of 3.6%




Source: Deloitte analysis of NHSI submissions



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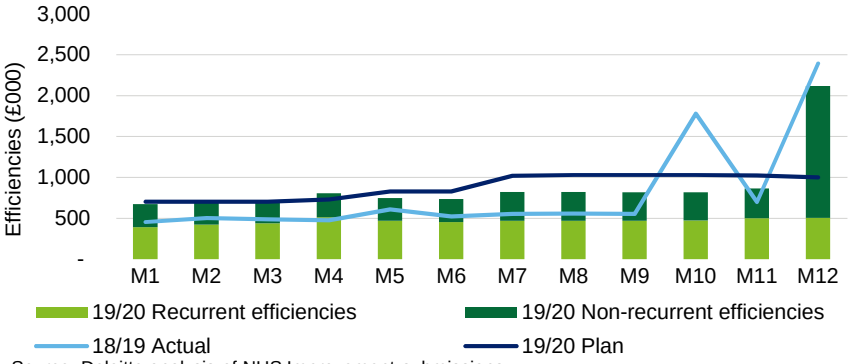
# Sector benchmarking (continued)

## The sector is behind plan on delivery of efficiency savings. The Trust is £0.2m behind the planned level of savings for the year and has a high level of non-recurrent savings.

Nationally, providers delivered £1.1 billion of savings through efficiency savings (cost improvement programmes (CIPs) and revenue generation schemes) during the first two quarters of the year. Overall, the sector forecast to finish the year £135m behind plan with £3.1bn of savings (95.9% of plan), an increase on the first two quarters.

**Efficiencies**

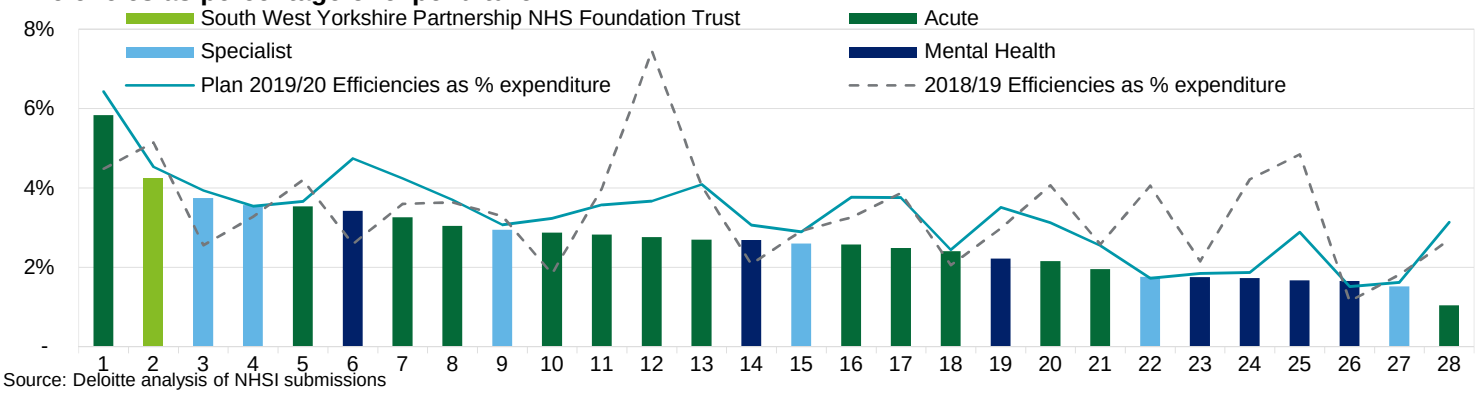



Source: Deloitte analysis of NHS Improvement submissions

| Efficiencies (including revenue generation schemes) %/£m | Trust 2019/20 | *Mental Health* 2019/20 | All Trusts 2019/20 |
|---|---|---|---|
| Planned efficiencies | 10.6 | 6.7 | 15.4 |
| Actual efficiencies | 10.6 | 6.1 | 13.5 |
| Actual as % of plan | 100.0% | 90.1% | 87.5% |
| | | | |
| Recurrent efficiencies as % of total | 52.2% | 51.8% | 69.0% |
| | | | |
| Planned efficiencies as % of operating expenses | 4.5% | 3.4% | 3.3% |
| Actual efficiencies as % of operating expenses | 4.2% | 2.8% | 2.7% |
| | | | |
| Pay efficiencies as % total | 39.7% | 48.6% | 31.1% |
| Non pay efficiencies as % total | 40.4% | 37.3% | 38.0% |
| Income efficiencies as % total | 19.9% | 14.0% | 31.0% |

On average, the trusts reviewed had planned to achieve efficiencies of 3.3% of operating expenses in 2019/20 (the Trust planned savings of 4.5%). Actual average savings have been below this at 2.7% (the equivalent of £1.9m higher spend). The Trust has achieved efficiencies of 4.2% of operating expenses, in line with plan.

**Efficiencies as percentage of expenditure**




Source: Deloitte analysis of NHSI submissions



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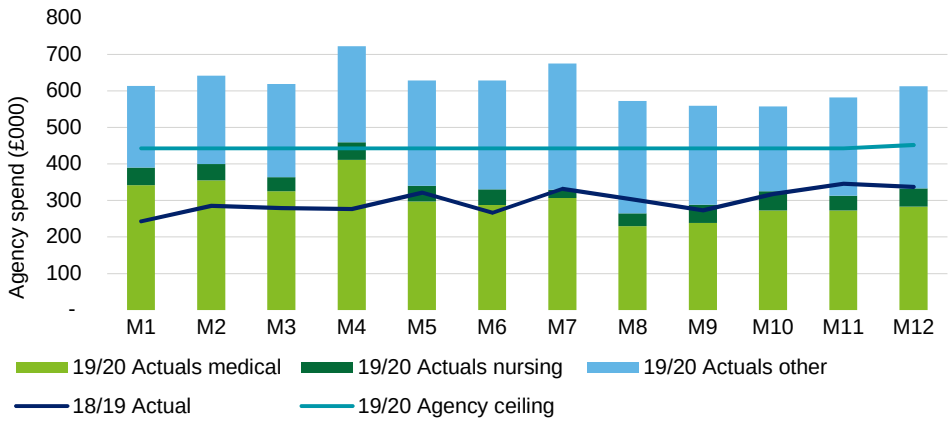
# Sector benchmarking (continued)

## Most trusts have not delivered their planned pay savings. The Trust has achieved 72.1% of planned pay savings.

The main contributor to spending variances nationally are higher than planned pay costs. On average, trusts we audit achieved 83.7% of planned pay efficiencies compared to 72.1% for the Trust (£4.2m achievement of plan of £5.9m).

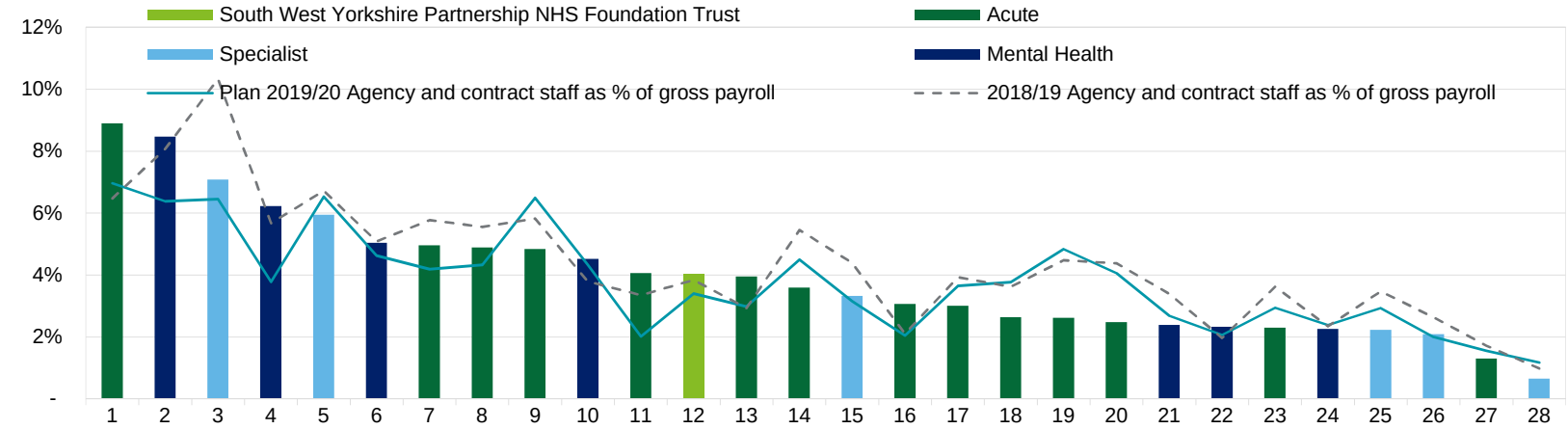
The Trust's agency costs of £7.4m year to date compared to an agency ceiling of £5.3m and plan of £(5.9)m (126.5% of plan). On average Mental Health trusts we reviewed spent 124.7% of plan (all trusts 98.5% of plan).

**Agency spend**




Source: Deloitte analysis of NHS Improvement submissions

**Agency and contract costs as a percentage of gross payroll costs**




Source: Deloitte analysis of NHSI submissions



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# Sector benchmarking (continued)

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

The Trust's year-end cash balance was £36.4m, £17.5m above plan of £18.9m and £8.6m above 31 March 2019 balance of £27.8m.

Although the sector has experienced increasing working capital pressures, on average Mental Health trusts were £5.3m behind plan, and all trusts we reviewed were £11.1m ahead of plan.

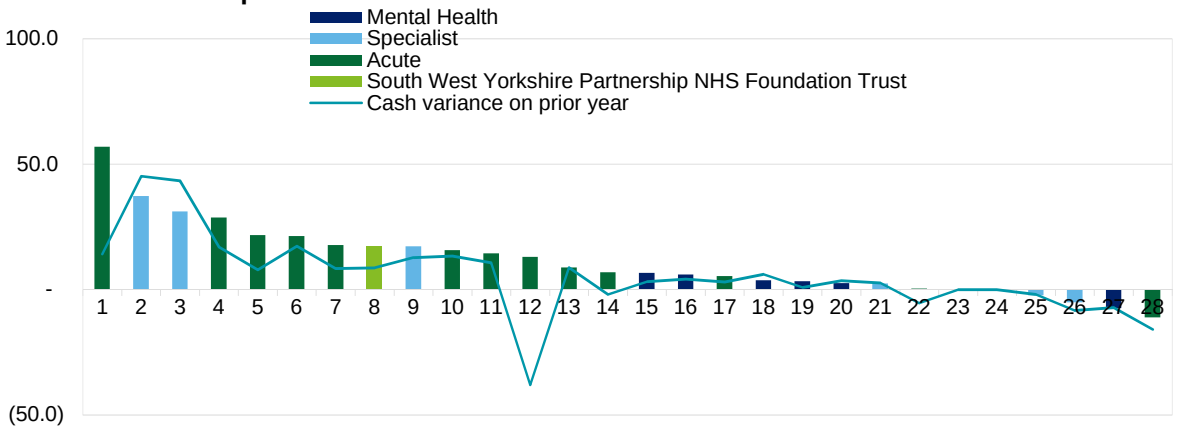
The Covid-19 funding changes have reduced working capital pressures for early 2020/21.

The Trust debtor days at 31 March 2020 were 18 days compared to an average mental health trusts of 20.2 and for all trusts reviewed of 31.8 days.

The Trust creditor days at 31 March 2020 were 167 days compared to an average for mental health trusts of 186.9 and for all trusts reviewed of 152.3 days.

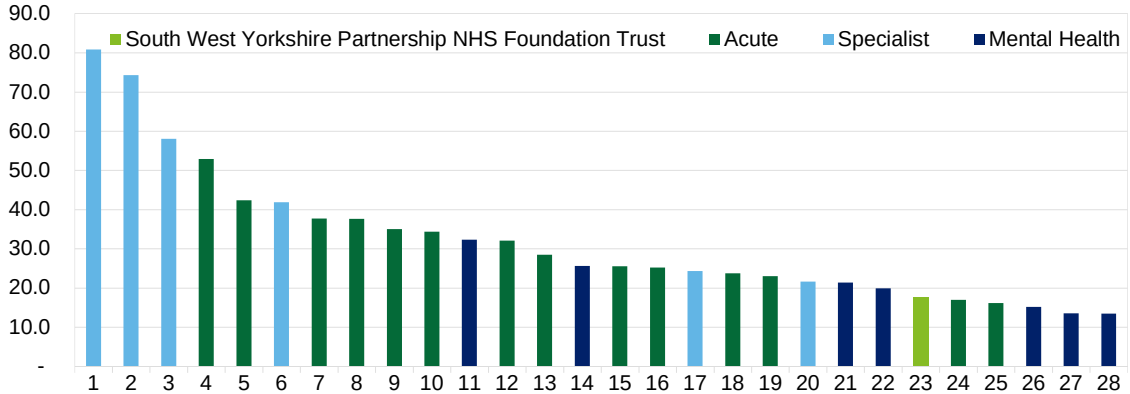
*Debtor and creditor days figures are using NHS Improvement's calculation methodology.*

**Cash variance to plan**




Source: Deloitte analysis of NHSI submissions

**Debtor days**

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# Sector benchmarking (continued)

## The Use of Resources risk rating for the Trust reflects the Trust's overall compliance with the key NHS Oversight Framework metric targets.

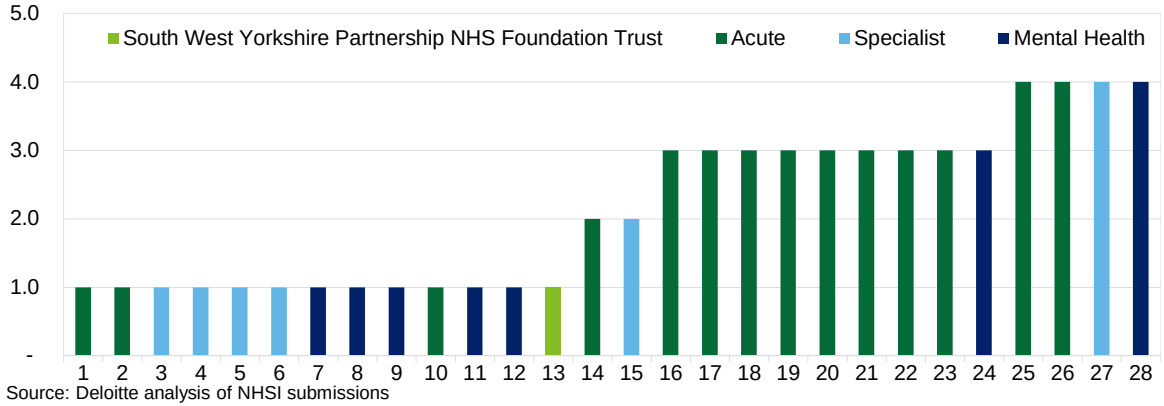
### NHS Oversight Framework Risk Rating

The Trust has a risk rating at 31 March 2020 of 1. The table and chart below show how this compares to other trusts we audit.

Use of Resources

| Single Oversight Framework Use of Resources metrics<br>As at 31 March 2020 | Trust<br>Plan | Trust<br>Actual | *Mental Health*<br>*Actual* | *All Trusts*<br>*Actual* |
|---|---|---|---|---|
| Capital service cover metric | 1.0 | 1.0 | 1.9 | 2.1 |
| Liquidity metric | 1.0 | 1.0 | 1.6 | 2.1 |
| I&E Margin metric | 2.0 | 1.0 | 1.6 | 2.0 |
| I&E Variance from plan metric | | 1.0 | 1.4 | 1.8 |
| Agency staff use vs provider cap metric | | 3.0 | 2.6 | 2.0 |
| **Overall rating (before overrides)** | | **1.4** | **1.8** | **2.0** |
| **Rating after overrides** | | **1.0** | **1.6** | **2.1** |

**Use of Resources Risk rating**

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# Annual Governance Statement 2019/20

### 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 Accountable 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 Statement also reflects the unique circumstances of the Covid-19 Pandemic.

### 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 2020 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 is a

balance of directors with internally and externally focused roles. Director portfolios are continually reviewed to ensure appropriate balance and capacity is in place to meet the needs of the Trust. This has been visible in the last year with the effectiveness of the Director of Provider Development and Director of Strategy roles in ensuring appropriate links into enhanced partnership arrangements; the development of an Executive clinical/operational trio in securing a ward to board approach; and good support from other corporate directors.

**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.** This has been materially impacted further by the Coronavirus pandemic.

**The Trust operates within a strategic framework that includes a Vision, Mission and Values, supported by four 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, at time outs with the full Executive and 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 predominantly in Calderdale, Kirklees, Wakefield, Barnsley and the Integrated Care Systems 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 2019/20 with regular reviews of risk at Executive Management team meetings, and the Trust Board, alongside the committees of the Board. This recognises the dynamic nature of the environment in which we operate and the need to constantly focus, assess and manage risk. As 2019/20 came to a close the level and nature of risk in the Trust was significantly impacted by the rapid increase in prevalence of the Covid-19 pandemic and our risk register has been modified to reflect this.

Risk management training for the Trust Board is undertaken biennially. The training needs of staff are assessed through a formal training needs analysis and this was completed in 2019/20. All staff receives 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 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 in April 2020.

**The Audit Committee assessment was supported by the Trust internal auditors who conducted a survey of Trust Board members for the third 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. Given the exceptional circumstances brought about by Covid-19 the March Trust Board meeting was held virtually and in by necessity in private. Minutes and papers from the meeting have been made available to the public.

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 Committee in Common with West Yorkshire & Harrogate partners reports in line with other Committees of the Board.

**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 and was further refined during 2018. It was confirmed in April 2019 when the risk policy was updated and approved by the Board.

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 2019/20, further work has continued to review risk registers where organisational risks not considered significant (level 15 and below) 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 four 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. In 2019/20, the fourth strategic objective 'Make SWYPFT a great place to work' was added following significant engagement with staff and strategic risks realigned.

**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 2019/20, 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 and shared across the Trust.

**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 main risks at the end of 2019 have been separated into two sections. These are the risks that have been focused on during the course of the year and those that have emerged towards the end of the year as a consequence of the Covid-19 pandemic.

**The Trust's main risks at the end of 2019/20 that have been an area of focus for all or the majority of the year can be summarised as follows:**

| **Area of focus** | **Sample of actions completed or underway** |
|---|---|
| Data and information: cyber-crime and information governance (IG) | The Trust has completed its third year of the data centre infrastructure investment programme focusing on replacement of core equipment and application availability.<br>Activities have progressed to support full cyber essentials certification.<br>Cyber and IG awareness campaigns refreshed and phishing exercise conducted.<br>Targeted approach and advice/support provided to 'hot-spot' areas. |
| Workforce pressures | Safer staffing levels for inpatient services updated for adult acute services. Further review of forensics and older people's services underway<br>Refresh of workforce plans as part of operational planning process.<br>Development of new roles including advanced nurse practitioners<br>Dedicated recruitment resource to review and focus on target areas with the greatest recruitment issues/high agency use.<br>Marketing the Trust as an employer of choice.<br>Delivery of Workforce Race / Disability Equality and EDS2 action plans.<br>Development of action plan to tackle bullying and harassment from service users and families.<br>Relaunch pilot of safer staffing judgement tool within community teams |

| | |
|---|---|
| Quality of care | CAMHS Improvement Group established to focus on improvements<br>Quality improvement focus and training<br>Informed risk assessment training plan and introduction of enhanced risk assessment process<br>Waiting list initiatives in services where required<br>CQC improvement action plans implemented.<br>Suicide prevention strategy |
| Financial sustainability in a changing environment | Implementation of longer term financial sustainability plan including productivity and benchmarking<br>Development of external engagement and links to priority programmes.<br>Engagement with West Yorkshire and South Yorkshire & Bassetlaw integrated care systems.<br>Focus on service and income growth in line with the long term plan for mental health and community health services |
| Out of area placements | Continued implementation of actions identified following independent review of bed management processes.<br>Development and implementation of local plans for change activity for reducing admission, length of stay and PICU bed use.<br>Working across our ICSs to identify system-wide solutions and areas of best practice.<br>Work with commissioners to prioritise areas of expenditure. |
| Fire safety | New builds and developments fitted with sprinklers.<br>Smoking group established to review policy and trial e-cigarettes.<br>Reinforcement of rules and fire safety message |

**The Trust's main risks at the end of 2019/20 relating to the Covid-19 pandemic year can be summarised as follows:**

| **Area of focus** | **Sample of actions underway** |
|---|---|
| Risk of harm to staff, service users and carers whilst in our care | Updating of policies & procedures<br>Publication of guidance and regular communications<br>Provision of appropriate personal protective equipment<br>Self-isolation and social distancing guidance<br>Testing of staff |
| Impact on core Trust service provision | Updating of business continuity plans<br>Risk panel review process<br>Retain focus on key performance metrics and intelligence<br>Development of a post Covid-19 recovery plan |
| Staffing and workforce | Safer staffing policies<br>Staff redeployment plan<br>Training and support |

| | |
|---|---|
| | Upgrading the staff health & wellbeing offer |
| Ability of staff to work remotely | Increasing provision of laptops and other devices<br>Capital works to strengthen band-width<br>Introduction of digital solutions including video consultations<br>Provision of increased virtual private network (vpn) connections and application licences |

**Given the strategic context within which we operate, the risks outlined above will continue into 2020/21 with mitigating actions in place.** The ongoing Covid-19 pandemic means that we are operating in a dynamic context for risk. As a novel virus, the impact and progression of Covid-19 is still emerging.

The instigation of command and control mechanisms through the Department of Health & Social Care (DHSC) and the Ministry of Housing, Communities and Local Government (MHCLG) help to manage the risks of Covid-19. We play a full and active role in these, through direct Emergency Planning Response and Resilience arrangements through NHS England/Improvement and as a partner in Local Resilience Fora. The response to Covid-19 brings subsequent risks due to the withdrawal of personal freedoms and of treatments to some members of the public.

The creation of Integrated Care Systems (ICS) across West Yorkshire & Harrogate and South Yorkshire & Bassetlaw provides a further mechanism for managing some risks across organisations. Both of our ICSs have refocused their capacity and resources to ensure that actions to mitigate the impact of Covid-19 are prioritised. This includes critical care, integrated community services and mutual aid on PPE, testing and staffing.

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

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). The Trust continues to assess its compliance with CQC registration requirements on a regular basis through our Quality Assurance & Improvement Team. To support our assessment we have developed a quality assurance and improvement 'self-governing' assessment model, which provides a philosophy, process, and a set of tools for improving quality for clinical teams. As a philosophy and process, the model provides a

context for a dialogue on self-governance and self-evaluation. As a series of methods and tools, it helps map the relationships between quality assurance and quality improvement and will be a continual source of evidence for teams to inform them how well they are performing (in relation to quality).

The aim is to foster each team's sense of responsibility for its own quality outcomes and engender optimism that the quality of service delivery can continually be improved. As part of this initiative we have developed an accreditation scheme that will be underpinned by quality measures and a quality monitoring system to recognise teams that are delivering high quality care and reward them for their efforts.

We are very pleased that the Care Quality Commission (CQC) has rated our Trust as Good in 2019, recognising the improvements we have made since their last inspection in 2018 and the strength and quality of the services we provide. We delivered on the actions from the last report, which has led to four of the five overall domains now being rated as Good. We are also pleased that our mental health community services have improved and are now rated Good.

Overall, we are now rated Good for being responsive, caring, well led and effective, and Requires Improvement for being safe. This means that overall we have been rated Good as a Trust.

They found that **12 of our 14** core services are rated Good. Over **87%** of our individual domains have been rated as Good or Outstanding. In summary:

- The vast majority of our services are rated as Good or Outstanding.
- Our community based mental health services for working age adults have improved and are now rated Good.
- Acute wards for adults of working age and psychiatric care units have improved
- We have improved and are now rated as Good for being Responsive
- 93% of our services were rated as Caring and Responsive
- Staff were kind and caring towards service users, with positive relationships that demonstrated we knew them well
- The values of the organisation were understood and respected by both leaders and those working in core services.
- Our strategy, vision and values were all identified as being patient centred.

There are still areas where the Trust requires improvement, in particular in our inpatient mental health and Child and Adolescent Mental Health services. These, alongside targeted improvements in a number of areas, are the subject of the CQC action plan, signed off and overseen by the Trust Board.

The Trust assesses itself annually against the NHS Constitution. A report was presented to Trust Board in January 2020 which set out how the Trust meets the rights and pledges of the NHS Constitution.

The Foundation Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the foundation trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of interests in the NHS' guidance.

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 pre-requisite 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 2019/20 with changes to the appraisal system to focus on objectives and values more explicitly. A successful E-Appraisal pilot has been conducted with the aim to reduce the paperwork involved to allow staff and managers to focus on the conversation. This will be rolled out in 2020/21.

**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.

**The Trust works closely with safety teams in NHS England/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 England & Improvement (NHSE&I. This work looks at balancing the requirements of our regulators on quality and finance with the need to improve services and true value to our service users.

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. In 2019/20, there were 13,206 incidents reported (a 4% increase on 2018/19), of which 87% resulted in low or no harm to patients and service users, recognising that the Trust has a risk based and good reporting culture.

During 2019/20, there were 47 serious incidents across the Trust compared to 45 in 2018/19. 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 an essential part of our culture, linked to our values of being open, honest, respectful and transparent. 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 were no duty of candour breaches recorded 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 quality improvement initiatives. The Committee routinely monitors infection, prevention and control, reducing restrictive practice interventions, 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. This takes place weekly and reports directly into the EMT at every meeting.

**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 well led, safe, caring, responsive, 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. QIAs can also be invoked in year where concerns trigger the requirement to do so.
- 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 Trust has four Guardians, drawn from the staff governors and a representative of the BAME staff 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. Over the year xx concerns were raised through this mechanism and reporting was shared with the Office of the National Guardian.
- 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 of reporting requirements are complied with.

**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 Trust members, service users, patients, carers and the public.
- Ongoing facilitated engagement events for service users and carers, staff and stakeholders in support of the Trust's priority programmes. For example, the new mental health clinical record system implementation ensured that staff were fully engaged during both design and delivery phases. This has continued during the optimisation phase for the delivery of the new Mental Health Care Plan and risk assessments.
- Quantitative and qualitative local and national surveys undertaken on a regular basis and actions taken.
- The principle of co-production being promoted throughout the Trust, such as co-production of training in Recovery Colleges and new resources being secured to strengthen this further.

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. This is backed by priority programmes and associated structures. The priority programmes help to address the strategic risk of having insufficient capacity and help to prioritise our efforts.

- For 2019/20 the Trust Board agreed 12 priority areas of work, some of these are strategic and emergent; others are priority programmes of change. In year, we have added two additional priority areas so by January 2020 we had 14 priority programmes of change that provide the framework for driving improvements. These include:
- Working with our local system partners: in each of the places to join up care in our communities. This includes our four Districts where we provide services as well as the two integrated systems in South Yorkshire & Bassetlaw and West Yorkshire & Harrogate.
- Providing safe care every time in every service: focusing 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.
- Programmes of work to improve our use of resources covering reducing waste and improving financial sustainability. We have also delivered a programme to provide all care as close to home as possible: focusing on improving patient flow through our systems and reducing the number of people who are placed outside our area.
- Making the Trust a great place to work: supporting staff wellbeing, improving staff engagement and reducing bullying and harassment.

This is underpinned by our values and our approach to leadership with a culture of improvement and inclusive change. Each programme has a Director sponsor and clinical lead, and is supported by robust project and change management arrangements through the central 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 the development of a recovery approach with recovery colleges across our districts. Alongside this we host Altogether Better, a national initiative which supports development of community champions. This is all complemented by our charity EyUp! and linked charities Creative Minds, Spirit in Mind and the Mental Health Museum.

**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. During the year this has included further installation of energy efficient LED lighting across our estate and we have signed up to the NHS Single-Use Plastics Reduction Campaign which aims to eliminate avoidable single use plastics across the Trust.

**Equality and Diversity**

**The Trust sees Diversity as strength and embraces its duties under the Equalities legislation.** Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Leadership and governance vehicles are also in place to ensure the value of diverse thinking and staffing is secured. This is facilitated through Trust policies, training and audit processes. The Equality and Inclusion Committee was established to act on behalf of the Board and ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does.

The Committee oversees the implementation of the Equality Strategy to improve access, experience and outcomes for people from all backgrounds and communities. This includes 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 staff to achieve their potential and maximise their contribution in delivering the Trust's Mission, Values and Strategic Objectives. The Network had its third annual celebration event, which showcased some of their achievements, in October 2019. The Trust has an 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 staff from BAME backgrounds. The clinically managed network meets bi-monthly to support staff and liaises with the Police and other Trusts to tackle the issue and create positive change.

The Board believes it should represent the workforce and population it serves. Over the last year a good level of diversity has been retained across the Board with a good balance of gender, age and ethnicity.

In 2019/20, the Equality and Inclusion Committee 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 all 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 gender but not on ethnicity or 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 covers the period 2017-2020 (and will be merged with the involving people strategy from 2020 onwards). 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.

The strategy is due for review early 2020/21 and a significant staff engagement and listening exercise was undertaken during June 2019 involving over 800 staff and focused on 4 areas:

- Improving Staff Health and Wellbeing
- Improving Staff Appraisal
- Preventing Bullying and Harassment
- Improving Staff Engagement

This led to staff developing the key themes which in their view would make South West Yorkshire a Great Place to Work and these will be the basis of the new Workforce Strategy for 2020-2023

- Feeling Safe
- Working in a Supportive Team
- Positive Support to keep me fit and well
- Developing my potential
- My voice counts

As part of making SWYPFT a Great Place to Work a senior leadership forum was created involving senior managers, clinicians and corporate service to develop local actions plans in response to the key themes above in line with “Developing Workforce Standards”, 2018.

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 branded NHS England/NHS Improvement) Code of Governance and further information is included in the Trust’s annual report.

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 a Finance, Investment and Performance Committee was introduced in November 2019. This replaced a Financial Oversight Group which was chaired by a non-executive director and had executive and non-executive representation.

The Executive Management Team has a robust governance structure ensuring monitoring and control of the efficient and effective use of the Trust’s resources. This is subject to oversight by the governance mechanisms described in the previous paragraph.

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, such as the Model Hospital, 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 the local commissioning intentions and local health and wellbeing plans. Increasingly we are ensuring that 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. During the year the Trust contributed to the five year plans for the two Integrated Care Systems it works with. This process was conducted in the final quarter of 2019/20. The impact of Covid-19 is such that the planning process for 2020/21 has been paused with revised temporary arrangements in place for the first four months of the year.

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. Cost improvement planning has been paused in the final stages of 2019/20 and into 2020/21 in to enable focus on our response to the Coronavirus pandemic.

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 a position ahead of its financial control total. The control total was for a £0.2m deficit. On a like for like basis this position was improved by £0.3m to a small surplus of £0.1m. Additional income has been provided to providers of mental health services towards the end of the year. This amounted to £0.9m and increases the Trust surplus to £1.0m. This entitled us to receive Provider Sustainability Funding (PSF) of £1.8m. There are various levels of surplus and deficit and the following table provides reconciliation between the comprehensive income of £11.9m as shown in our accounts and the £0.1m surplus quoted above:

| | £m |
|---|---|
| Total Comprehensive Income/(Expense) | 11.9 |
| Impairments and Revaluations | (3.4) |
| Net Impairments | (5.7) |
| Provider Sustainability Funding (PSF) | (1.8) |
| Pre PSF Surplus in our management accounts | 1.0 |
| Allocation of additional income to providers of mental health services | (0.9) |
| Pre PSF Surplus on same basis as control total | 0.1 |

In total, £10.7m cost savings were delivered against a target of £10.6m (101% delivery). Of the £10.7m, £5.6m was delivered recurrently and a further £5.1m 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 more than achieved the target of 95% of staff completing training on information governance by 31 March 2020 with 98% of staff recorded as completing the training.

**Information governance has had continued focus through 2019/20** 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. Information governance had a continuous and high profile in the Brief, cascaded monthly to all staff.

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

**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 no such incidents reported in 2019/20.

**Good information governance will continue to be a feature of the Trust in 2020/21.** The Data Security and Protection Toolkit was submitted on time and 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 England/ 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*. Following the outbreak of Covid-19 the Quality Accounts will not be subject to external audit for 2019/20. In addition the deadline for completion of the Quality Accounts has been extended to December 2020

We have fully compiled our Annual Report with the updated guidance issued in response to the Covid-19 pandemic. The requirements for Quality Account reporting for 2019/20 have been reduced and the Trust will meet these requirements in line with the revised timetable identified.

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 & Resources, 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 were fully involved in the development and delivery of templates to ensure quality data is captured and reported. The transition to the new system and into our system optimisation programme has been managed with input from the Improving Clinical Information and Information Governance Group (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 (Caldicott Guardian) and Director of Finance & Resources (SIRO) 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 & 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 ICIG with reports to the Audit and Clinical Governance and Clinical Safety Committees on data quality.

## Systems and processes

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

## People and skills

- Behaviours that reflect the Trust values and the necessary skills are essential elements 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 (SystmOne and a small number of additional systems) with the

provision of targeted training and support to ensure responsible staff have the necessary capacity and skills.

## Data use and reporting

- Data provision is reviewed regularly to ensure it is aligned to the internal and external needs of the Trust through the 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 ICIG 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. Following the impact of Covid-19 national guidance is that the 2019/20 Quality Report will not be subject to external audit. Internal Audit conducted three reviews covering data quality in year relating to the testing of manual data transfer to SystmOne, compliance with the General Data Protection Requirements (GDPR) and core Data Quality.

## Review of effectiveness

As Accountable 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 information provided in 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 me in my roles as 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 2019/20, approximately 95% of staff had an appraisal. Following the Covid-19 outbreak, appraisals for 2019/20 have been deferred in line with national guidance.

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. Areas of development identified in the last Audit Committee annual report have been acted upon.

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 2019/20 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 2019/20, 13 internal audit reviews have been conducted and presented to the Audit Committee. Of these, there were 8 significant assurance opinions, 3 were advisory audits with no rating provided and the other 2 provided benchmarking information.

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. Completion of recommended actions is tracked by the Audit Committee and over the course of the year 74% of actions were completed within the original time frame specified and 96% of all recommendations have been completed

The Head of Internal Audit's overall opinion for 2019/20 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. I can confirm that my review has concluded there are no significant control issues have been identified. 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.

During the final months of the year, the Covid-19 outbreak meant changes to the operations of the Trust. These were conducted in line with the Trust constitution, its Standing orders and SFIs. The system of governance was adhered to, with decision making always in line with powers of delegation and authority. Weekly assessments of the decision made through the Gold Command structure were appraised by non-executive members of the Board each week.

As we enter 2020/21, the progression of the Covid-19 pandemic remains unclear. The peak of the outbreak has not been reached and may be longer than previously thought. The recovery phase will require a change in the business of the trust and developing risks in our systems. We will continue to ensure that the principles of good governance and effective controls are maintained throughout.

Rob Webster
Chief Executive Date: 3 June 2020

| | | Group | | Trust | |
|---|---|---|---|---|---|
| **STATEMENT OF FINANCIAL POSITION** | | **31 March 2020** | **31 March 2019** | **31 March 2020** | **31 March 2019** |
| **AS AT 31 March 2020** | **note** | **£000** | **£000** | **£000** | **£000** |
| **Non-current assets** | | | | | |
| Intangible assets | 14 | 170 | 108 | 170 | 108 |
| Property, plant and equipment | 15 | 107,332 | 99,737 | 107,332 | 99,737 |
| Investment Property | 16 | 115 | 160 | 115 | 160 |
| Receivables | 21 | 528 | 0 | 528 | 0 |
| **Total non-current assets** | | **108,145** | **100,005** | **108,145** | **100,005** |
| **Current assets** | | | | | |
| Inventories | 20 | 238 | 259 | 238 | 259 |
| Trade and other receivables | 21 | 11,175 | 10,785 | 11,177 | 10,787 |
| Cash and cash equivalents | 22 | 37,021 | 28,371 | 36,417 | 27,823 |
| **Total current assets** | | **48,434** | **39,415** | **47,832** | **38,869** |
| **Current liabilities** | | | | | |
| Trade and other payables | 23 | (21,650) | (19,844) | (21,607) | (19,817) |
| Provisions | 25 | (3,990) | (3,939) | (3,990) | (3,939) |
| Other liabilities | 23 | (1,462) | (276) | (1,462) | (276) |
| **Total current liabilities** | | **(27,102)** | **(24,059)** | **(27,059)** | **(24,032)** |
| **Total assets less current liabilities** | | **129,477** | **115,361** | **128,918** | **114,842** |
| **Non-current liabilities** | | | | | |
| Provisions | 25 | (4,733) | (3,282) | (4,733) | (3,282) |
| **Total assets employed** | | **124,744** | **112,079** | **124,185** | **111,560** |
| **Financed by** | | | | | |
| **Taxpayers' equity** | | | | | |
| Public Dividend Capital | | 44,972 | 44,222 | 44,972 | 44,222 |
| Revaluation reserve | 27 | 12,397 | 9,453 | 12,397 | 9,453 |
| Other reserves | | 5,220 | 5,220 | 5,220 | 5,220 |
| Income and expenditure reserve | | 61,596 | 52,665 | 61,596 | 52,665 |
| **Others' equity** | | | | | |
| Charitable fund reserves | | 559 | 519 | 0 | 0 |
| **Total taxpayers' and others' equity** | | **124,744** | **112,079** | **124,185** | **111,560** |

The financial statements on pages 2 to 39 were approved by the Board of Directors and authorised for issue on the 3 June 2020 and signed on their behalf by:

Signed……
Rob Webster Chief Executive Date 3 June 2020

South West Yorkshire Partnership NHS Foundation Trust

**Members' Council**
**31 July 2020**

| | |
|---|---|
| **Agenda item:** | **7.7** |
| **Report Title:** | **Quality Account proposal for 2019/20, in context of Covid-19 impact** |
| **Report By:** | Director of Nursing & Quality / Deputy CEO |
| **Action:** | To receive |

## EXECUTIVE SUMMARY

Purpose

The quality account report is an annual report that focuses on how we perform against a set of quality priorities that we set for ourselves and a range of mandated items as identified by NHS Improvement. The purpose of this paper is to describe the revised quality account proposal taking account of national guidance.

Recommendation

**The Members' Council is asked to RECEIVE the update on the 2019/20 Quality Account.**

Background

**NHS ENGLAND (23 March 2020) announced that** 'Given the current and estimated impact of COVID-19 we have worked with the Department of Health and Social Care (DHSC) to amend arrangements for year-end accounts for 2019/20'.

For the **Quality accounts and quality reports 2019/20 this means:**

- **Quality accounts preparation:** the deadline of 30 June is specified in Regulations. DHSC has sought approval from Ministers to amend the Regulations and this date has been extended to December 2020.

- **Quality report preparation for NHS foundation trusts**: given the expectation of change for quality accounts, there is no longer a requirement for a quality report to be included in the annual report. NHS foundation trusts are encouraged to include the additional quality report content in their quality account.

- **Assurance work on quality accounts and quality reports** should cease, and no limited assurance opinions are expected to be issued in 2019/20. Where auditors have completed interim work or early testing on indicators, auditors should consider whether value can be derived from work already completed, such as a narrative report being provided to the trust, or governors at a NHS foundation trust. For NHS foundation trusts, there is no formal requirement for a



With all of us in mind.

limited assurance opinion or governors' report.

- Provider organisations will no longer be required to submit any hard copy documents to NHS Improvement for the annual report and accounts.

- Deloitte (External auditors) have confirmed that they will not be reviewing the quality report for audit purposes and they will not be undertaking a review of local or mandated indicators or statements of assurance, as these are not a mandated requirement of the report for 2019/20.

Based on the above the following recommendations were made and approved by Trust Board:

**In line with national guidance we will include the following in the report:**

- Chief Executive and Chair's welcome
- Priorities for improvement
    - Our approach to quality improvement
    - Our approach to quality governance
    - Quality priorities- summary of performance 2019/20
    - Quality risks
    - Quality priorities for 2020/21
    - Care Quality Commission inspection
- Our performance against quality initiatives 2019/20
    - Performance against our quality priority key measures of performance for 2019/20. SAFE, EFFECTIVE, CARING, RESPONSIVE & WELL LED.

**In line with national guidance we will exclude the following from the report:**

- Statements of assurance from the board
    - Review of services
    - Participation in clinical audit
    - National clinical audit programme
    - National confidential inquiry

- Local clinical audit
- Participation in clinical research
- Goals we agreed with our commissioners
- Care Quality Commission
- NHS number and general medical practitioner code validity
- Data security and protection toolkit (formally Information governance toolkit attainment)
- Clinical coding accuracy
- Quality of data
- Patients on Care programme Approach who were followed up in seven days
- Percentage of admissions to acute wards for which crisis resolution home treatment teams acted as gatekeeper
- Readmission rates
- Patient experience of community mental health services
- The number and percentage of such patient incidents that resulted in severe harm or death
- Learning from healthcare deaths
- Guardian of Safe Working Hours

**In line with our Trust values we will maintain the governance framework of the report:**

- Maintain the internal governance process for report sign off, i.e. Members' Council quality group, CGCSC, EMT & Trust Board
- Request our stakeholder partners to make comment on the report and provide us with feedback.
- Complete this process by the end of August with a view for submission to the September Board this is subject to review in light of changing circumstances.

South West Yorkshire Partnership NHS Foundation Trust

**Members' Council**
**31 July 2020**

| | |
|---|---|
| **Agenda item:** | **7.8** |
| **Report Title:** | **Patient Experience – Annual Report 2019/20** |
| **Report By:** | Director of Nursing & Quality / Deputy CEO |
| **Action:** | To receive |

**EXECUTIVE SUMMARY**

Purpose

To provide a summary of feedback on experience of using Trust services received via the Customer Services function during 2019/20. To note also the summary Friends and Family Test results and comments.

Recommendation

**The Members' Council is asked to RECEIVE the Patient Experience Annual Report 2019/20.**

Background

**Patient experience feedback – Annual Report 2019/20**

This report provides a summary of feedback on experience of using Trusts services as received via the Trusts complaints and friends and family test (FFT) systems. In total the Trust received 1165 items of feedback in the form of complaints, concerns, comments and compliments in 2019/20. This is an increase in the previous year when feedback totalled 1187. In addition 8339 responses were received from the FFT system.

**Complaints process**

Extensive development work on the complaints pathway has been undertaken in 2019/20 to improve both the complaints pathway, process and data quality. We are adopting a continuous quality improvement approach to our complaints process to ensure we have a contemporary service that is fit for purpose and can respond efficiently & effectively to issues people raise.

There were 166 formal complaints in the year, 332 compliments and 667 comments and concerns were raised. Access to treatment and drugs was identified as the most frequently raised negative issue. This was followed by communications, values and behaviours, clinical treatment and appointments. Most complaints contained a number of themes.



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**Key areas to note:**

- For the financial year 2019/20 the customer services team received and dealt with 1165 items of feedback in the form of complaints, concerns, comments (excluding compliments). This is a 15% reduction compared to 2018/19 when the Trust received 1371 items of feedback.
- The customer services team dealt with 166 formal complaints in 2019/20 compared to 120 in 2018/19 which is a 38% increase.
- Complaints typically contain a number of different themes and issues and anecdotally complaints have become more complex in nature with complainant's expectations about what can be achieved through the complaints process increased.
- This is also reflected by the increase in reopened complaints which has gone up four fold from 3 in 2018/19 to 12 in 2019/20.
- 667 comments/concerns were received in 2019/20 which is an increase of 4% from 2018/19 where 639 comments/concerns were received.
- 332 compliments were received in in 2019/20 which is a significant decrease of 46% compared to 612 in 2018/19. The number of compliments does fluctuate and depends on how regularly clinical services send these in for customer services to record. The Trust promotes the importance of submitting compliments so that they can be monitored, used to boost staff morale and to share best practice.
- Customer services monitors the progression of formal complaints against the Trust's internal target of providing a response within **40 working days** from the date that consent has been provided and the scope of the complaint investigation agreed. This is considerably quicker than the guidance set out in the NHS Complaints (England) Regulations 2009 which details that a response should be provided within 6 months from the date that a complaint is received.
- Proactive partnership working between customer services and clinical services to mitigate against complaint process delays has made a positive impact on achieving the Trust's internal target that 80% of formal complaints should be closed within 40 working days. The total number of complaints closed within 40 days steadily increased throughout 2019/20.

**Friends and family test (FFT)**

- In 2019/20 a total of 8339 responses were received, with 91% recommending Trust services. This is a 15% increase (18/19 7270 - 19/20 8339) on the previous year's returns.
- In 2019/20 there was a 38% increase (18/19 3934 – 19/20 5440) in the number of returns received for mental health service and there was a 20% decrease (18/19 3336 – 19/20 2674) in responses received for community services.
- Text messaging contributed 33% of the returns for the Friends and Family Test

in 2019/20.

- Friends and Family Test comments and text message free text is reviewed daily by the QIA Team and address concerns with services / teams immediately when service users expressed intentions of harm to either themselves or others.

This information, from both complaints process and FFT is shared with BDUs for review. Responding to feedback and ensuring changes in practice is monitored through BDU governance processes.

Development work for focus in 2020:

- Learning lessons from complaints.
- Review of complex complaints.
- Review of process to manage persistent complainants.
- Review of process for reopened complaints.
- Continue work on response times.
- Update of complaint policy.
- Review of reports to meet commissioner requirements.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

# Patient Experience (including complaints) Annual Report 2019/20

With **all of us** in mind.

# Summary

**Annual update:**

- For the financial year 2019/20 the customer services team received and dealt with 1165 items of feedback in the form of complaints, concerns, comments (excluding compliments). This is a 15% reduction compared to 2018/19 when the Trust received 1371 items of feedback.
- The customer services team dealt with 166 formal complaints in 2019/20 compared to 120 in 2018/19 which is a 38% increase.
- Complaints typically contain a number of different themes and issues and anecdotally complaints have become more complex in nature with complainant's expectations about what can be achieved through the complaints process increased.
- This is also reflected by the increase in reopened complaints which has gone up four fold from 3 in 2018/19 to 12 in 2019/20.
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- Proactive partnership working between customer services and clinical services to mitigate against complaint process delays has made a positive impact on achieving the Trust's internal target that 80% of formal complaints should be closed within 40 working days. The total number of complaints closed within 40 days steadily increased throughout 2019/20.

# Summary

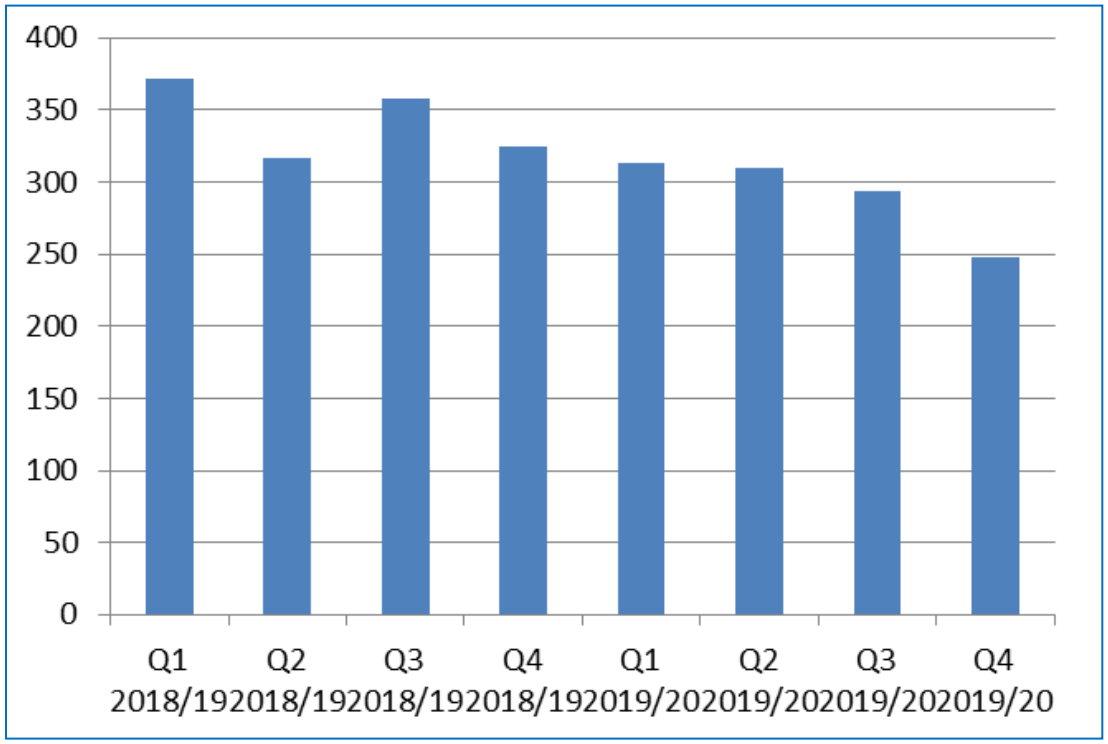
- All complaints are risk assessed on arrival in the Trust using the Trust's Risk Matrix. In the first instance, this is undertaken by the customer services manager or their Deputy. In addition, complex complaints are discussed with both the Associate director of nursing and quality and the Assistant director of legal services.
- Work is continuing to improve our customer services process to make sure that the Trust always responds in ways that ensure learning and becomes more responsive where service issues arise. This will mean services will see the issues first, with a robust process in place to support them.

**Risks**

- Complaints are often complex and longstanding in nature and require thorough investigation to resolve the issues raised. Complainants expectations of what can be achieved through the complaints process can be unachievable.
- Resources allocated to habitual or vexatious complainants has increased and requires a consistent and coordinated approach across the Trust.
- Anecdotally the biggest delays in the complaint process appear to be the time for the completed investigation to be returned to customer services. This is being scrutinised further to generate further discussions with clinical services about the specific challenges they face in responding to complaints i.e. resource, and how these can be overcome to improve the Trust's response timeframes.

# Feedback overview

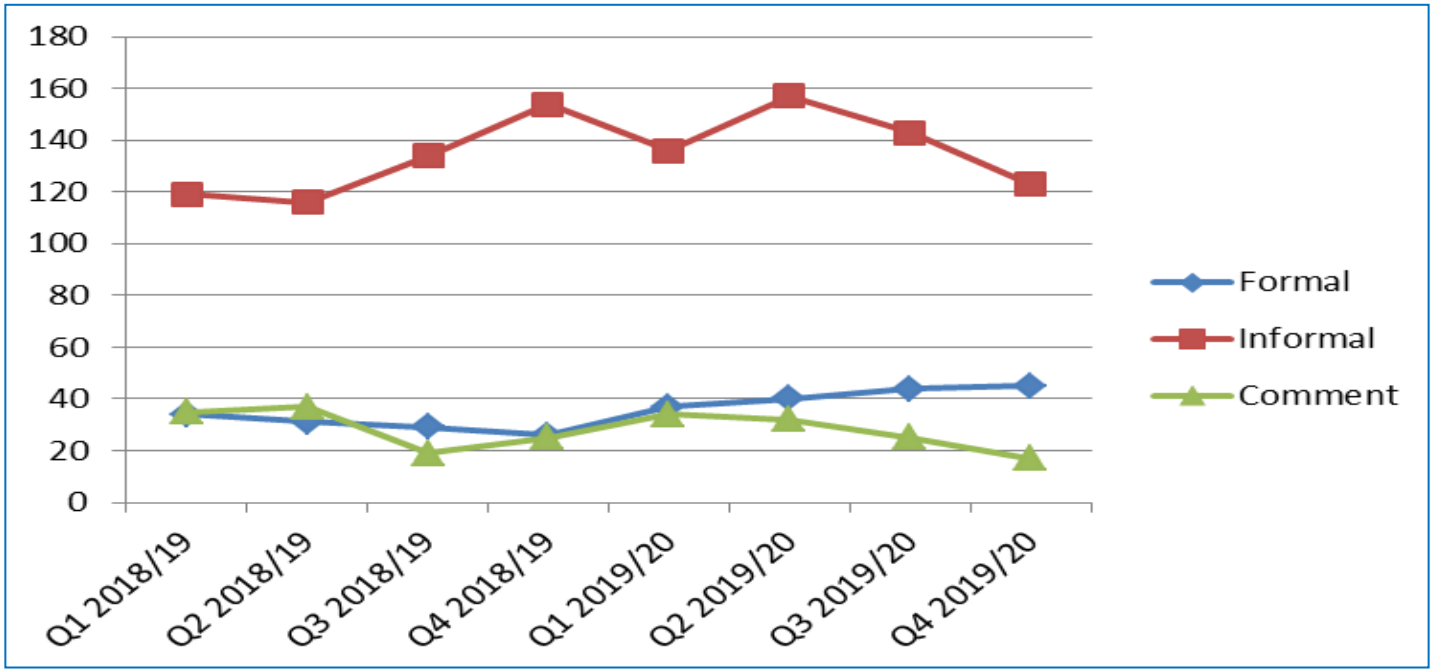
## Total number of complaints, concerns, comments & compliments received into the Trust via customer services




There has been a consistent decline in feedback since Q1 2018/19. However, the biggest reduction in feedback type is for compliments which had a record high of 184 in Q1 2018/19 to a record low of 63 in Q4 2019/20 which is a 66% decrease.

# Complaints activity

## Number of formal complaints, informal concerns and comments made into customer services per quarter




- Overall, the number of formal complaints has gradually increased since Q4 2018/19 with a quarterly average of 36.
- There is a less consistent pattern for informal concerns and this has been gradually decreasing since Q2 2019/20.
- There has been a significant reduction in informal concerns (14%) and comments (32%) for Q4 2019/20 although formal complaints have slightly increased to an all-time high of 45.

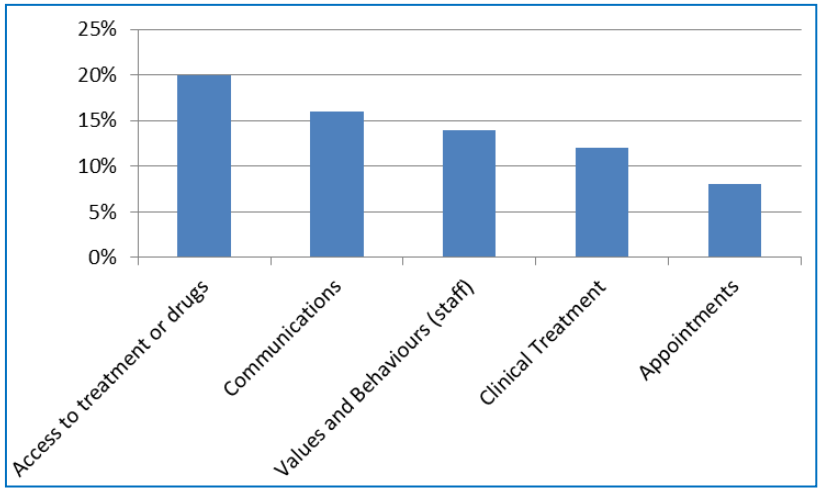
# Regulation: Parliamentary Health Service Ombudsman

During 2019/20 the Trust received 6 requests for information from the PHSO. All requests have been responded to and information shared with the PHSO to enable them to review and investigate complaints at stage 2 of the Complaints process.

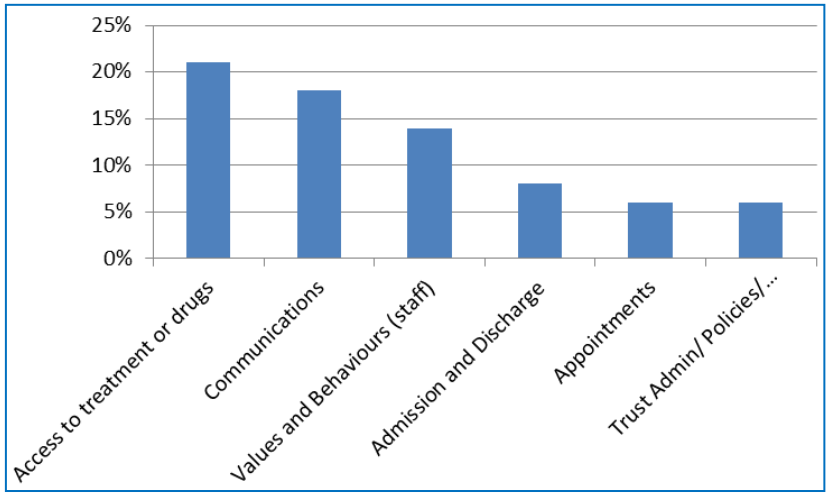
- The Trust had 5 cases open with the PHSO at the end of the financial year 18/19
  - The Trust received notification that 2 cases had closed with no further action and 3 cases were partially upheld; of these 3 cases, 2 cases involved Barnsley Mental health services with both requesting further actions and an apology and in addition in 1 of these 2 cases was to be awarded financial redress; and, 1 Community Services –Kirklees requesting further actions and an apology and awarded financial redress.
  - 2 cases were closed that had been requested and reviewed in 19/20 with no further actions
  - The Trust is still waiting for the outcome of the PHSO's investigation on 4 cases at the end of 19/20.

# Top 5 themes for complaints

## 2019/20




## 2018/19

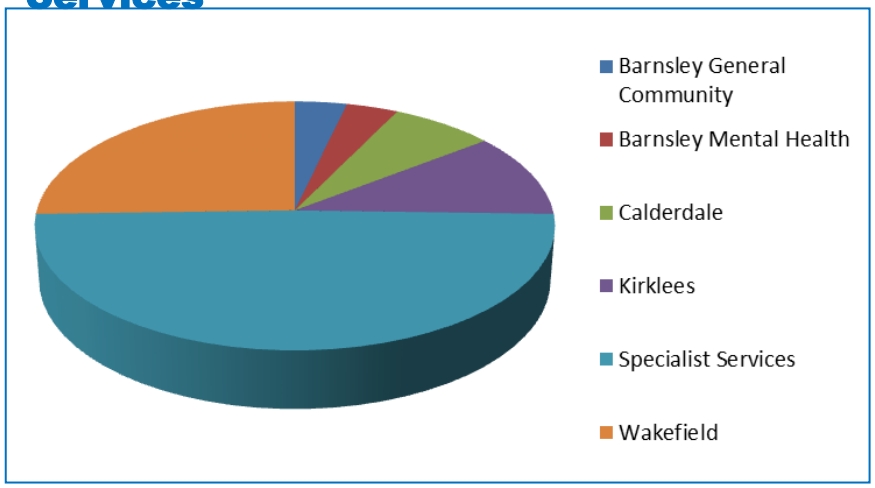



- Complaints typically contain multiple themes/issues
- The top 3 primary subjects for complaints has remained consistent across both years, including by rank order
- Access to treatment is the most common theme for complaints about CAMHS

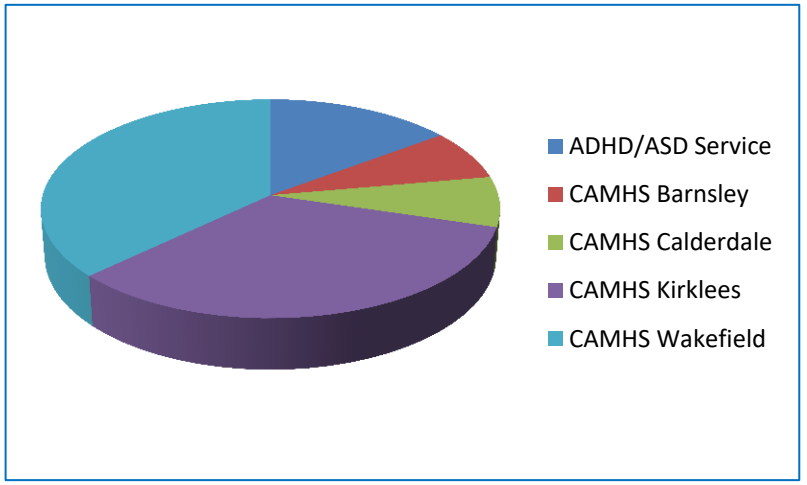
# MP Contacts

- During 2019/20 the customer services team received 55 MP contacts compared to 68 MP contacts in 2018/19 which is a 19% decrease.
- 25 of the 55 MP (45%) contacts received, including those received across Specialist Services, were for Wakefield from MP Yvette Cooper.
- Even excluding Specialist Services there are considerably more MP contacts for Wakefield than any other BDU.
- Overall the service line which receives the most MP contacts is CAMHS with 42%.

**MP contacts by BDU Services**

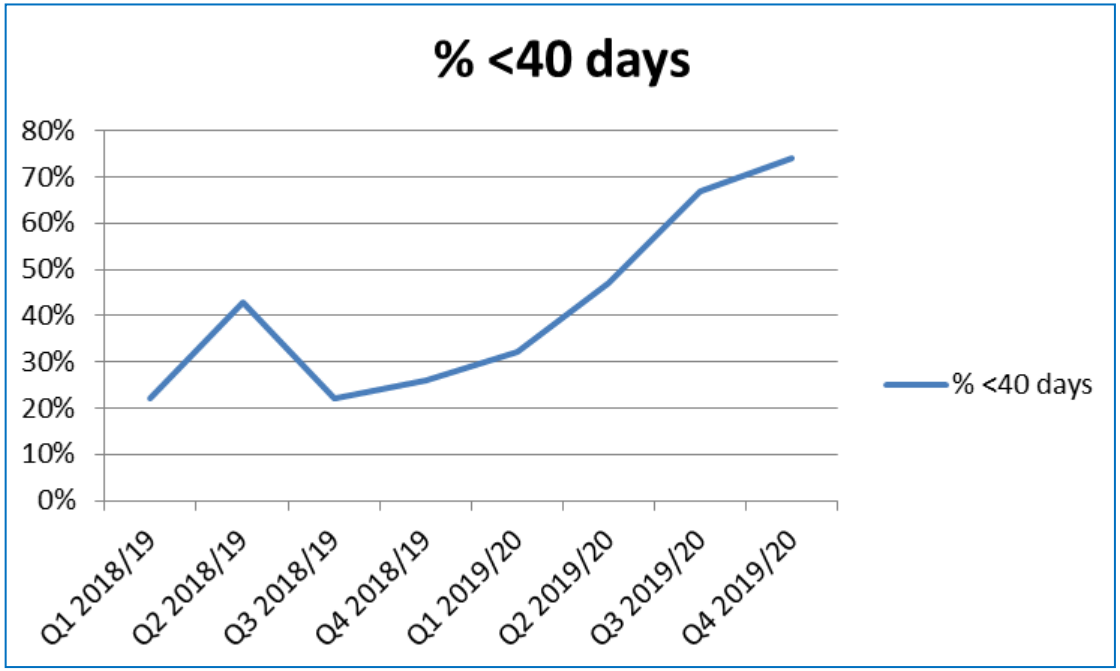



**MP contacts for Specialist**



# Complaints Key Performance Indicators (KPIs)

## The Trust's KPI is to close 80% of formal complaints within 40 working days




From Q3 2018/19 there has been a steady month-on-month increase in the percentage of formal complaints closed within 40 working days. Historically this figure was calculated using the date consent was received. However, from Q3 2019/20 customer services have calculated 40 working days using the date consent was received AND the scope of the complaint investigation agreed. This further improves performance figures from 47% of complaints in Q2 2019/20 closed within 40 days to 67% in Q3 2019/20 and 74% in Q4 2019/20.

In December 2019 and February 2020 we achieved the target of closing 80% of complaints within 40 days.

# Reopened complaints

During 2019/20 we reopened 9 formal complaints.

Once the individual has received the Trust's response to a complaint further or outstanding issues should be raised within a reasonable time – a guideline is twelve months from receipt of the response, though it very much depends on individual circumstances. In such cases, the complaint file is reopened and further investigation will take place to ensure that the Trust has addressed all of the issues raised and a further response is sent to the individual with the findings. In some cases a second opinion or clinical advice will be sought. The Trust will endeavour to resolve re-opened complaints through local resolution, however, once it is considered by the Trust this is completed the individual is advised of their right to refer their case to the PHSO.

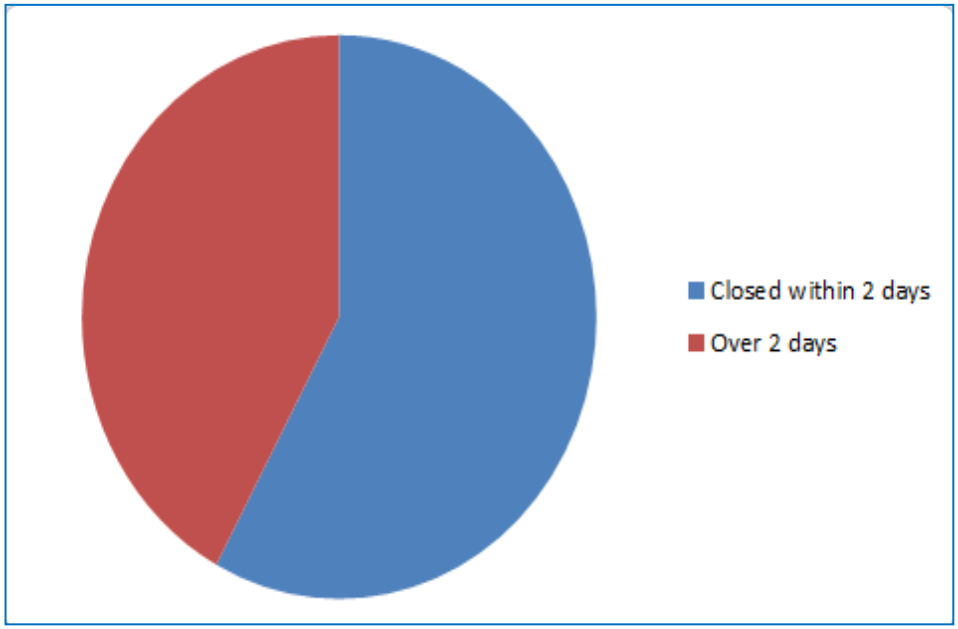
Analysis of reopened complaints is complex. The reported figures are those that were reopened within a particular time frame, regardless of when the complaint was initially responded to. Complainants coming back to tell us they are not satisfied with their response is a positive indicator they have not lost faith in our organisation's ability to resolve their concerns as they have actively chosen to come back to us rather than approach the Parliamentary Health Service Ombudsman (PHSO) directly.

In line with the NHS Complaints (England) Regulations 2009, issues that the Trust has already responded to and is unable to provide any further meaningful comments will not be reopened or re-investigated.

We are currently developing a reporting function on DATIX to better capture the reason why complaints are reopened. This will enable us to monitor any themes and trends.

# Response times for informal concerns

## Informal concerns closed against 2 day target




The Trust's complaints process supports Local Resolution in the first instance and contact with the service provider to resolve concerns directly at source.

This revised approach means we are dealing with significantly more informal concerns – 530 informal concerns were dealt with in 2019/20. Of these, 60% were closed within 2 working days.

The customer services team ensures that all feedback is provided and responded to by services within a target of 2 working days for resolution or with agreement from the complainant that the timeframe can be extended.

The figures on the chart are the percentage (%) compliance rates, by BDU, for responses to informal concerns within 48 hours.

This is a new measure, hence this is a benchmark rate. Compliance goals are being agreed with senior directors.

# Improvements in sign off process

- Customer services worked hard in 2019 to clear the backlog of outstanding complaint responses. We now have weekly team meetings hosted by the Customer Services Office Manager (CSOM) where we track active complaints progress and report on responses that are at 30 working days to ensure that these are being managed proactively and flagged as required.
- Sign off process has been streamlined and the internal clock for the 40 working day target now starts when we have received consent from the service user **AND** agreed the scope of what will be investigated with the complainant. Previously there were issues outside of the Trust's control when we had received consent but there were difficulties agreeing the scope with the complainant to allow the investigation to proceed which negatively impacted on our response times.
- Since 2018 responses are reviewed by the CSOM for quality at the start of the sign off process and prior to final progression to the Deputy Chief Executive. Quality improvement work on the complaint process has resulted in there being very few amends received in the latter stages of the sign off process which demonstrates that the quality of complaint responses has improved.
- Customer services have completed several reviews working alongside Business Delivery Units. As part of these reviews it was identified that we needed to understand and identify what challenges the operational teams face when they are asked to respond to a concern or complaint within the established timeframes set above i.e. 48 hours for a concern and in the current complaint pathway 15 working days are allocated to operational services to investigate a formal complaint (time from when toolkit is sent to manager to the date toolkit is retuned to CS team). Questionnaires were sent out to the services and the information returned was reviewed and recommendations implemented.
- Customer services response figures continue to improve and 80% of complaints in December 2019 and February 2020 achieved the Trust's internal target of being closed within 40 working days.

**Risks**

- The current most common delays in responding to complaints are related to the investigation process and customer services are reliant on the findings from clinical services to draft a response.
- The Trust's processes for responding to feedback may need to further consider the complexity of the complaint and the number of concerns which necessarily impact on our timescales for investigating and responding.

# Listening to and learning lessons from feedback and experience

Anyone making a complaint under the NHS complaints procedure is entitled to three things:

1. A full and complete explanation of what happened and why, given in terminology that the complainant can understand
2. An apology if there was an error or omission on behalf of the staff
3. If an error or omission has occurred the complainant should be given information about the action that the Trust has taken, or is proposing to take, to try to prevent it happening again

- As a result of feedback raised, learning points have been implemented regarding staff to always consider the trigger factors involved in a service users care and treatment which should enable a more individual approach to be delivered. Staff to ensure that positive coping strategies, resources and safety advice is always shared with service users and their families where appropriate .

**Specialist services (excluding CAMHS)**

- Service to create written information in the form of a Frequently Asked Questions (FAQ) fact sheet to be included in the initial appointment letter, which will provide clear explanation regarding the upcoming assessment process . ***Adult Autism Service***

- Staff reminded of the importance of clearly communicating key information and decisions relating to service users care and treatment and documenting the service users understanding. ***Adult Autism Service***

# Listening to and learning lessons from feedback and experience

## Barnsley General Community Services

Acknowledged that appropriate end of life care measures were not implemented in a timely fashion and there were number of areas where this could be improved. Should have referred to District Nursing Service upon discharge from hospital to home with terminal diagnosis. Should have ensure pre-emptive medications were available at home for when condition deteriorated. Services should have recognised deterioration more quickly to ensure appropriate support provided to family at such a difficult time. ***Palliative care team***

Service resolved informally directly with service user. Apologised on behalf of the service and explained that the clinician was trying to establish whether clinically urgent and to ensure that they were seen in the most appropriate place. It transpired some of the things the GP had written on the referral were not accurate so the urgency was not clear cut. Complainant agreed to an appointment with a different clinician, which has been arranged and seemed happy with the outcome. ***Physiotherapy/Musculoskeletal***

## Child and Adolescent Mental Health Services (CAMHS)

Customer services raised feedback with clinical service concerned for their contact with young person to be reviewed internally and to ensure any further appropriate action was taken. **CAMHS Barnsley**

# Listening to and learning lessons from feedback and experience

## Calderdale & Kirklees

Customer services spoke with clinical lead for psychology service and advised general waiting times for individual therapy and that some groups are available depending on assessed needs and whether appropriate. Provided general response to MP office as no consent to share specific details of individual case. ***Calderdale Psychology Service***

Health records reviewed which documented numerous discussions with service user prior to planned transfer to specialist placement. Acknowledged that they consider relationship with care coordinator has irretrievably broken down and team manager has allocated a new care coordinator. Explained that specialist placement funding is provided by local Clinical Commissioning Group and when mental health is more stable there will be plans to move service user closer to home area. ***Enhanced Team 2, South Kirklees***

Service are writing to the family to summarise the meeting held and hoped that they had addressed the family's concerns however they would be happy to cooperate with any formal procedures should the family wish to take it further. ***Kirklees Intensive Support Team***

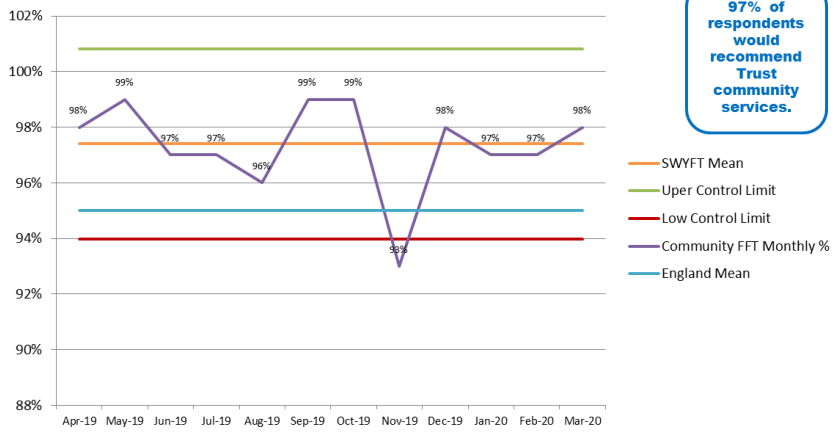
Customer services have provided a written explanation about why service user was incorrectly discharged from services following previous verbal explanation and apology. Agreed that there should have been clarification as to which service they wished to be discharged from as discharge from one service effectively discharged their whole episode of care. Also acknowledged that details should have been provided to the GP to inform them of the discharge and ensure there was a clear plan in place in the event of a deterioration in mental health or specialist advice required***. Calderdale Core Team***

## Wakefield

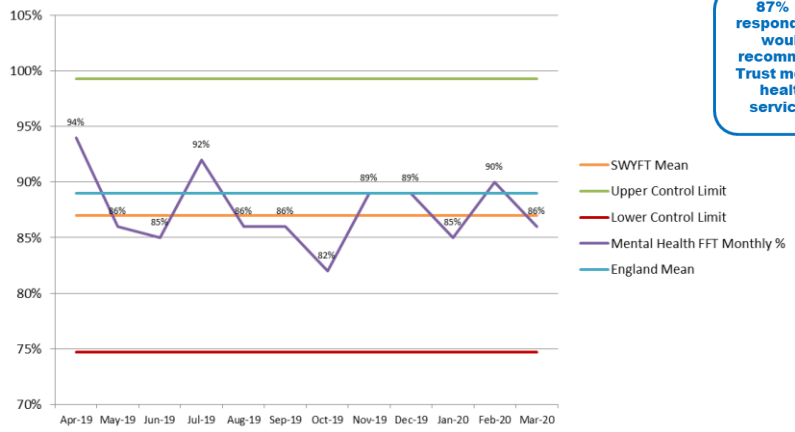
The senior management team  will now hold a formal debrief in order to ensure that learning is implemented into clinical services and appropriate support is given when patients are transferred to another health care provider for treatment – **Poplars unit (OPS)**

# Friends & Family Test Feedback

## % of respondents who would recommend Trust service by month

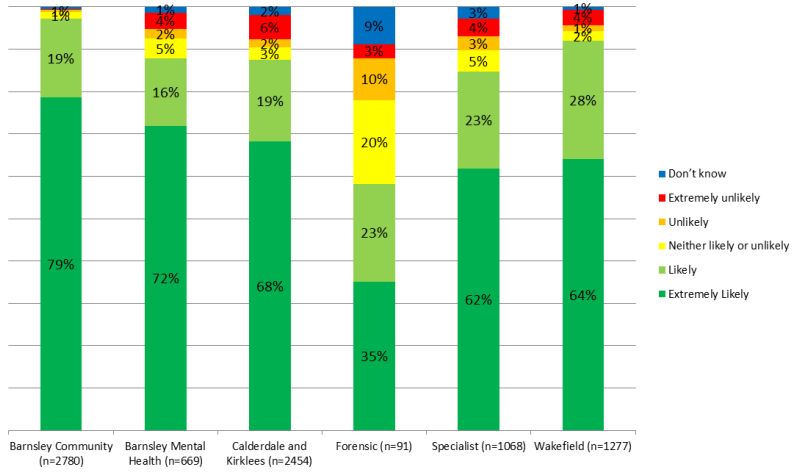



**97% of respondents would recommend Trust community services.**




**87% of respondents would recommend Trust mental health services.**

## % of respondents who would recommend Trust service by BDU




## Top three themes

**Comments; positive:**

- **Communication comments include:** *very good at keeping staff and family in loop, very clear communication, the communication from both practitioners was excellent, communication superb, good communication and staff were contactable.*
- **Staff attitude comments include:** *all the staff were warm, knowledgeable and supportive, staff courteous and efficient, Nurse and Doctors were very thorough and extremely helpful, great staff who are kind and caring.*
- **Access comments include:** *Appointment on time, appointment was executed in a friendly and compassionate manner, punctual appointments, quick appointment, easy accessible appointments and appointments arranged within reasonable waiting times.*

**Comments; negative:**

- **Communication comments include:** *Serious lack of communication from staff, extremely poor communication staff who fail to listen to patients, experienced poor communication between departments and not enough communication.*
- **Staff attitude comments include:** *Night staff to be more helpful, better reception staff, poor attitudes from many staff and staff have an ignorant attitude when approached.*
- **Access comments include:** *Four consecutive appointments cancelled, waiting time for appointment, takes a long time to get an appointment, quicker appointment from referral and length of time between appointments.*

South West Yorkshire Partnership NHS Foundation Trust

**Members' Council**
**31 July 2020**

| | |
|---|---|
| **Agenda item:** | **7.9** |
| **Report Title:** | **Incident management annual report 2019/20** |
| **Report By:** | Director of Nursing and Quality |
| **Action:** | To receive |

**EXECUTIVE SUMMARY**

Purpose and format

The purpose of the paper is to provide assurance to Members' Council that robust incident management arrangements are in place and to provide an overview of all incidents that take place within the Trust.

**Recommendation**

**The Members' Council is asked to RECEIVE and comment on the annual report on incident management and to NOTE the next steps identified.**

Background

The Trust Board has received quarterly Incident Management reports, which have also been considered by the Clinical Governance and Clinical Safety Committee. This report will be considered in detail at the next Members Council Quality Group.

This report has been produced in a shortened version in the context of our revised governance arrangements during the Covid-19 response. The patient safety support team will be preparing two further reports. The first, 'Our Learning Journey' report which will present the ongoing work across the trust in terms of sharing and implementing the learning from serious incident investigations. The second report to be prepared is the 'Apparent Suicide Report'. This will be available in September 2020.

The annual report key headlines follow;

- The Trust showed a 4% increase in incidents reported on the previous year.
- 87% of all incidents reported resulted in no harm or low harm. A high level of incident reports, particularly of less severe incidents is an indication of a strong safety culture (NPSA Seven Steps to Safety).
- The number of incidents reported across the Trust (13206) has increased and the number of serious incidents (47) has slightly increased on last year. However the reporting threshold in Forensic services has changed during the year, increasing the number of Forensic SIs. A number of amber incidents were classed as

serious incidents and investigated by the service. The overall proportion of serious incidents is about the same (0.35) compared to previous years.

- During 19/20 there have been no 'never events'.
- There has been one homicide.
- We have reviewed 286 deaths that were in our learning from healthcare deaths scope. This is comparable with 2018/19 (270). The reviews ranged from accepting the death certification, case record reviews through to investigations, in line with the National Quality Board levels.

**The report was scrutinised at the Clinical Governance and Clinical Safety Committee 9 June 2020 where the following comments were made:**

- The National Reporting and Learning System report, published in March 2020, shows no evidence of potential under reporting and that our reporting rate per 1000 bed days remains consistent. Our reporting timeliness has improved.
- Our current internal 360 audit report (awaiting formal internal sign off) shows significant assurance and includes positive comments on our learning from incidents approach.
- Highest incident category is apparent suicide which affirms our focus on suicide prevention – this is the subject of a report due in September 2020.
- The production of the report by the patient safety team, given current circumstances, was noted.
- The report provides important assurance which will be considered again alongside the apparent suicide annual report at the next meeting.
- The committee noted that the current Covid-19 incident monitoring and review of learning disability deaths (discussed during the Covid-19 response section of the agenda) will be included in future quarterly reports.

**Risk appetite**

- Risk identified –the trust continues to have a good governance system of reporting and investigating incidents including serious incidents and of reporting, analysing and investigating healthcare deaths.
- This report covers assurance for compliance risk for health and safety legislation and compliance with CQC standards for incident reporting. This meets the risk appetite –low and the risk target 1-6.
- The clinical risk –risk to service user/public safety and risk to staff safety which is again low risk appetite and a risk target of 1-6.
- Financial or commercial risks -Reputational risks, negative impact on perceptions of service users, staff, commissioners. Risk appetite Cautious / Moderate 4-6

The incident management process supports the drive to reduce harm and learn from incidents to reduce risk and prevent recurrence in the future. For learning from healthcare deaths, we continue to meet the national guidance, and make revisions as needed. We publish our quarterly data on deaths on the internet page.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

# Incident Management Annual Report

## April 2019 to March 2020

Patient Safety Support Team

2 June 2020

With all of us in mind.

## Executive Summary

This report provides an overview of **all** the incidents reported in the Trust during 2019/20. It also includes further analysis of Serious Incidents, and analysis of action themes arising from completed Serious Incident investigations submitted to commissioners for the period of 1 April 2019 to 31 March 2020 (data as at 03/04/2020).

This report does not cover the work of the BDUs in terms of implementing the learning; a report on this will be available here separately.

- **13206** incidents reported
- **4%** increase in reporting on 2018/19
- **87%** of incidents resulted in no/low harm
- **47** Serious incidents reported
- No Never Events
- One homicide reported
- Serious Incidents account for **0.35%** of reported incidents
- High reporting rate with high proportion of no/low harm is indicative of a positive safety culture[1]

The Trust reported **13206** incidents during the year; a slight increase on the previous year. A high level of incident reporting, particularly of less severe incidents is an indication of a strong safety culture (NPSA: Seven Steps to Patient Safety[1]). The distribution of these incidents is in line with an established reporting process showing a triangle with **87%** of incidents resulting in no/low harm.

There were **47** serious incidents reported during the year accounting for 0.35% of all incidents. The highest overall category of serious incident is apparent suicide of service users in current contact with community teams (24) consistent with the figure in 2018/19 (23).

**No 'Never Event'** incidents were reported by SWYPFT in 2019/2020. The last Never Event reported by the Trust was in 2010/11. Never Events is a list (DOH) of serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Further detailed analysis of all apparent suicides occurring in 2019/20 will be available in September 2020 in the apparent suicide report.

[1] NPSA. (2004). Seven Steps to Patient Safety

# Contents

## Introduction

This incident management annual report focusses on incidents and serious incidents reported within the Trust during 2019/20.

This report provides an overview of all incidents reported and does not include detail of specific incident types. Specialist advisors produce separate annual reporting for this purpose. The report does not cover incidents that are managed through other processes such as safeguarding (including Serious Case Reviews (now known as Safeguarding Child Practice Reviews), Domestic Homicide Reviews) or whistleblowing (staff survey). The information is this report is high level, and further breakdown is possible on Datix. Further information can be provided on request.

The patient safety support team will be preparing two further reports. Firstly, we will prepare 'Our Learning Journey' report which will present the work of the BDUs in terms of implementing learning and learning from serious incident investigations. At the present time (May 2020) this is delayed due to the impact of Covid -19. The second report to be prepared is the 'Apparent Suicide Report'. This will be available in September 2020.

The report does not include broader patient safety work which will be updated on separately when possible.

The report is structured into the following sections:

**Section 1** includes a summary of all reported incidents occurring from 1 April 2019 to 31 March 2020. It should be noted that this report provides only an overview; detailed reports are produced on a quarterly basis for Business Delivery Units and many specialist advisors run/analyse incident reports.

**Section 2** focusses on incidents reported as Serious Incidents during 2019/20. The first part looks at what these incidents were, and secondly provides more details on the different types of serious incidents that were reported.

**Section 3** sets out an analysis of the serious incident investigations that have been completed and sent to commissioners during 2019/20. It includes an analysis of the themes arising from serious incident recommendations.

**Section 4** focusses on reported deaths in line with the Learning from health care deaths policy. It includes figures on deaths that were reported as serious incidents.

**Section 5** Overview of incident management plans for 2020/21.

# Section 1 - Incident Reporting Analysis

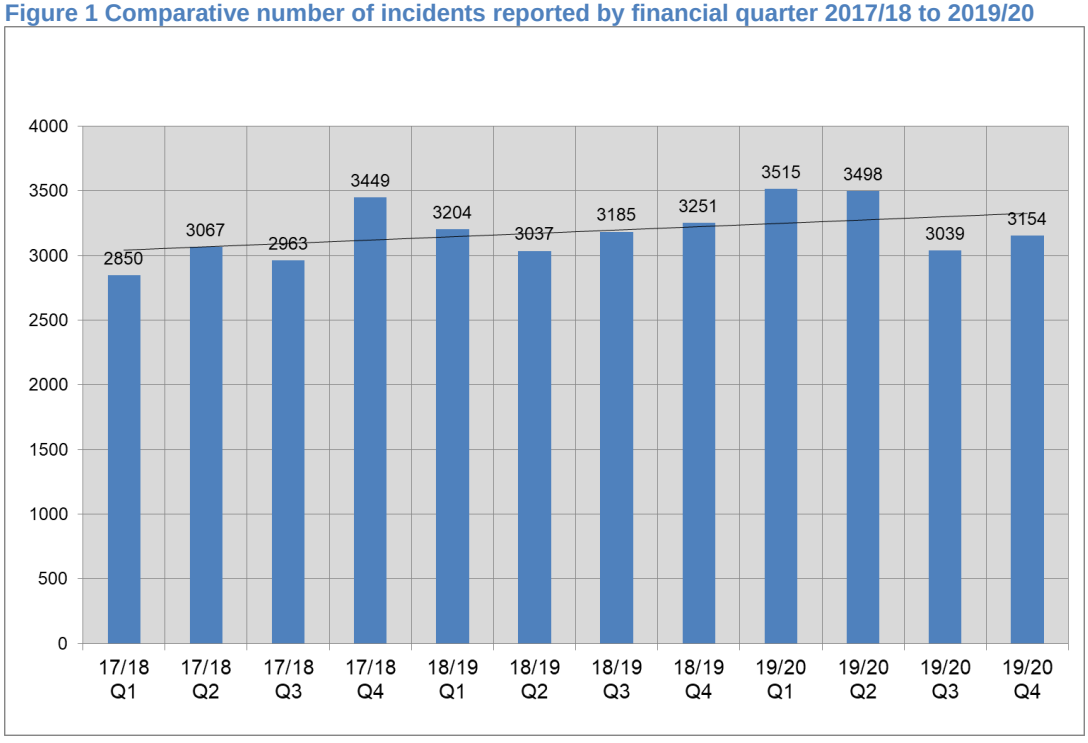
## Headlines

The Trust reported **13206** incidents of all severity during the year, a 2.7% increase on 2018/19 (**12640**). The average number of incidents reported per financial year over a 3 year period is 12737 incidents.

- **13206** incidents reported
- **4%** increase in reported incidents compared with 2018/19
- **87%** of incidents resulted in **no/low harm**
- **47** Serious incidents reported (0.35% of all incidents)
- High reporting rate with high proportion of no/low harm is indicative of a positive safety culture

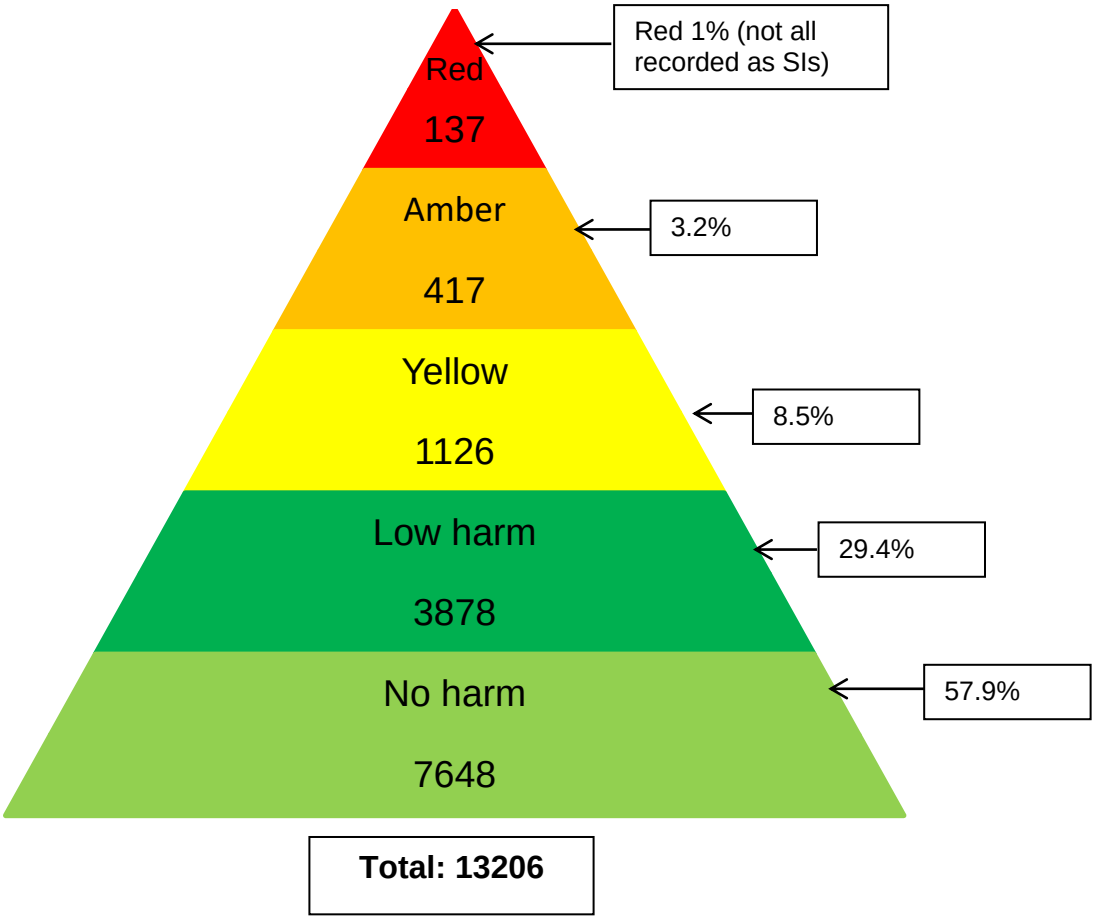
Figure 1 below shows the pattern and number of incidents reported by quarter in the Trust over the last 3 financial years, and indicates the average is stable, with natural fluctuations each quarter. It should be noted that direct comparisons should be viewed with caution due to the changing profile of service provision.

**Figure 1 Comparative number of incidents reported by financial quarter 2017/18 to 2019/20**



The distribution of these incidents in terms of severity is pyramid-shaped, with red incidents being fewest in number; and most incidents being graded green (87%) resulting in no/low harm, as illustrated in Figure 2. The proportion of no/low harm incidents has remained consistent with previous years. An organisation with a high reporting rate, particularly with a high proportion of no/low harm is indicative of a positive safety culture where staff are encouraged to report incidents and near misses.

**Figure 2 Incidents reported by severity 2019/20**



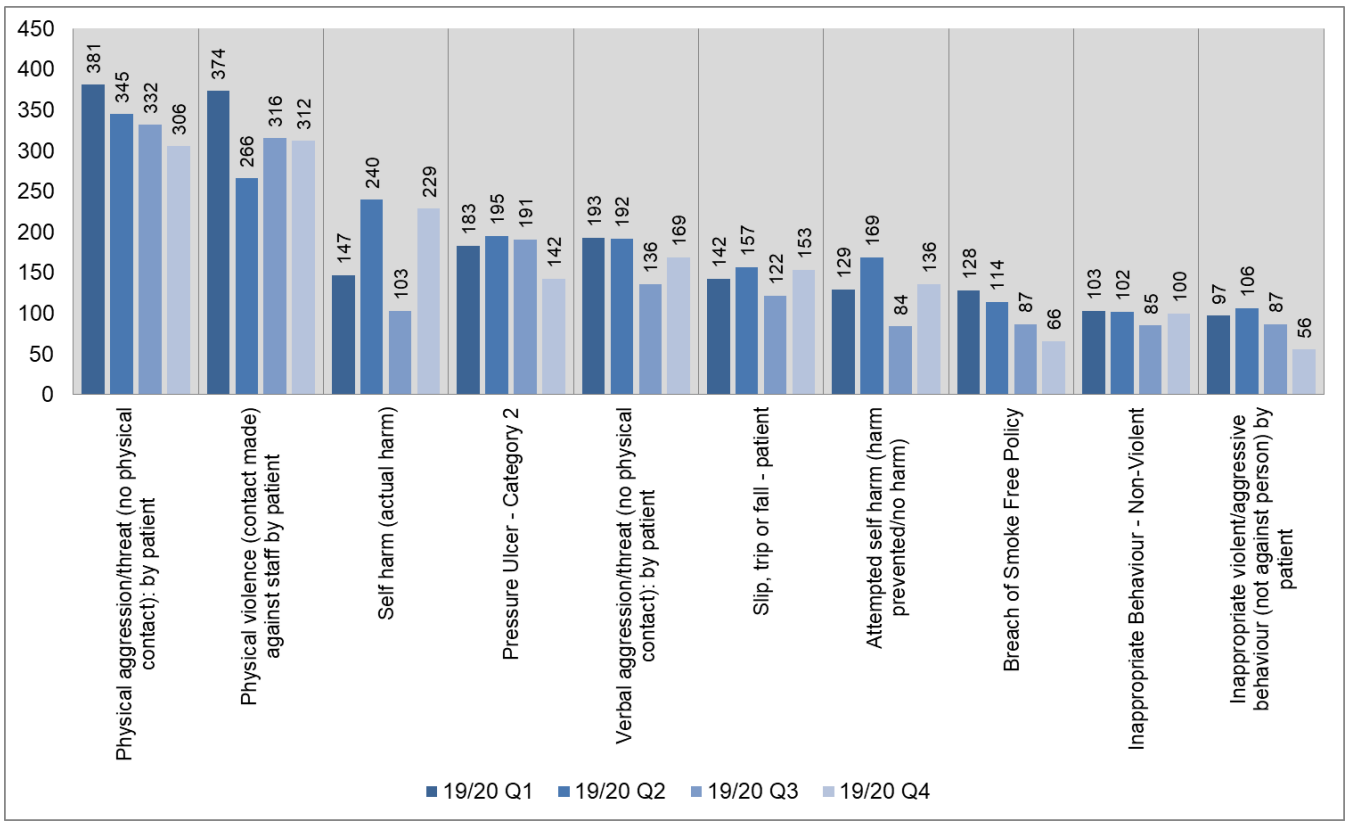

*Note: The red incidents in this chart are based on the date when the incident occurred, which is often different to the date it was reported on the Strategic Executive Information System (StEIS) as a Serious Incident (SI) figures use the date reported on StEIS. Not all Red incidents are reported as SIs.*

## Type and Category of incidents

All incidents are coded using a three tier method to enable detailed analysis. 'Type' is the broadest grouping, with Type breaking into 'categories', and then onwards into 'subcategories'.

Figure 3 shows the top 10 highest reported categories of incidents across the Trust during 2019/20. During 2019/20 incidents were reported against 153 different categories of incident. The top 10 categories account for 53% of all incidents reported, which is consistent the proportion in 2018/19.

**Figure 3 Trust-wide Top 10 most frequently reported incident categories in year 2019/20**




'Physical aggression/threat (no physical contact): by patient' was the highest reported incident category in 2019/20 with a total of 1364 incidents, accounting for 10% of all incidents reported. This is an increase on 2018/19 (1212) but this has remained the top reported category in both years. This includes incidents such as threatening behaviour against others or where physical violence was prevented.

There are three other categories of violence and aggression related incidents appearing in the top 10; 'Physical violence against staff by patient (where contact was made)', 'Verbal aggression/threat (no physical contact): by patient', and 'Inappropriate violent/aggressive behavior (not against person) by patient'. All four categories have appeared in the top 10 in the last 3 years.

In relation to incidents of violence and aggression, like 2018/19, we have continued to see an increase in acuity across certain areas. Some of these incidents also feed into the other sections of the report as contributing factors, e.g. Breach of smoke free policy and self-harm. This is due to a large increase in actual and attempted self-harm within areas and the need for staff's intervention. The Reducing Restrictive Intervention Team continued to push the need for consistent and precise reporting of all incident of both physical and verbal aggression. The consistently improving reporting of verbal aggression is to be commended as this can be used by staff to identify changes or increasing levels of aggression with a service user's presentation, and also show that there are many incidents (near misses) where staff have been confronted by an angry aggressive individual and through the de-escalation skills employed, have limited the incident to verbal aggression. During 2019/20, the Reducing Restrictive Physical Intervention (RRPI) team worked with the Datix team to further improve recording of incidents in-line with the National Data set.

The third highest category of incident is 'Self harm (Actual)' with 'attempted self harm' also appearing in the top 10. In 2019/20 there were 719 actual self harm incidents. The figures for self-harm fluctuate through the year and numbers are closely affected by individual service user presentation.

'Pressure ulcer – category 2' appears in the top 10. It should be noted that these are incidents that are generally identified by staff in the general community services and many are attributable to other agencies. The Datix system is used to capture the identification and actions taken by our staff.

Patient falls appears in the top 10, as it has done in previous years. The reporting remains at a fairly consistent through the year, and is similar to previous years.

Breach of Smoke Free policy incidents have continued to reduce during 2019/20 compared with 2018/19.

## External Review

### Reporting to National Reporting and Learning System

The Trust captures the severity of all incidents locally on Datix using the risk matrix which scores incidents ranging from green through to red (see Figure 2). This includes actual and potential harm of all incidents and near misses (i.e. psychological harm, potential risks).

The Trust uploads patient safety incidents[2] (which are a subset of all incidents reported) from Datix to the National Reporting and Learning System (NRLS) on a weekly basis and has done so since 2004. Local information on Datix is mapped to the national system in the background. The National Reporting and Learning System shares patient safety incidents with the Care Quality Commission (CQC). The CQC may then contact the Trust to enquire further about specific incidents.

Patient Safety incidents do not include non-clinical incidents, or where staff was the affected party (e.g. violence against staff incidents). These are not reportable to NRLS as the harm was not to a patient. The NRLS scores the **actual** degree of harm caused, as opposed to including potential harm as collected locally.

The NHS Patient Safety Strategy [3] published in July 2019 sets out plans for a new national reporting and learning system which will combine NRLS and the Strategic Executive Information System (for reporting serious incidents). The launch date is awaited.

### National Reporting and Learning System reports

Patient Safety Incidents are uploaded to the National Reporting and Learning System (NRLS) when they have been through the internal management review and governance processes. This ensures that the data uploaded externally is as accurate as it can be. Data can also be refreshed if details change. Incidents are exported to NRLS when these reviews have been completed, which results in a natural delay in uploading patient safety incidents to the NRLS.

NHS Improvement publishes data from the NRLS system on a six monthly basis. These reports are designed to assist NHS trust boards to understand and improve their organisation's patient safety culture and reporting of patient safety incidents to the NRLS. The reports have changed over time, but now encourage organisations to compare against themselves over periods of time, rather than with other organisations which may not be comparable for a number of reasons.

The published reports are added to the NRLS intranet page when released.

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[2] A patient safety incident is defined as any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

[3] https://improvement.nhs.uk/resources/patient-safety-strategy/

The latest NRLS Summary Report published in March 2020, covers the period 01 April 19 to 30 September 19 compares the Trust's data for the same period in 2018. The areas compared are:

**Reporting culture and reporting patterns**

- No evidence of potential under-reporting
- Our reporting rate per 1,000 bed days remains consistent

**Has the timeliness of your incident reporting improved?**

- Our reporting timeliness improved in April 2019 to September
- 2019 compared with the previous year due to focussed quality improvement time on reviewing incidents internally. This improved the speed with which incidents were uploaded to NRLS. Further work to protect time for this continues.

**Are you improving the accuracy with which you report degree of harm?**

- There are some small variations in comparative data by degree of harm. The Patient Safety Support Team quality check local data against provisional data from NRLS on a monthly basis and amendments are made as needed. The actions recommended in the report are in place.

**Do you understand your most frequently reported incident types?**

- The incident types reported on from the national system do not direct correlate with those collected locally. Work takes place every 3 years to confirm our mapped data with NHS Improvement. It is anticipated this will next be reviewed as part of the new national reporting system.

**Have the care settings of your incidents changed?**

- There are very small variations in comparative data by care setting but this would be as expected.

In 2019/20, the Trust uploaded a total of 6278 patient safety incidents to the NRLS (at 22/4/20), compared with 5487 reported in 2018/19 Quality Accounts. 95% of the 6278 incidents resulted in no harm or low harm.

The Trust reported a total of 53 severe harm and patient safety related death incidents in 2019/20, compared to 58 incidents in 2018/19.

In relation to the total number of incidents uploaded, the percentage of severe harm incidents has decreased to 0.38% when compared with 0.47% in 2018/19. The percentage number of patient safety related deaths (uploaded to NRLS) has continued to decrease to 0.46% when compared to previous years and last year which was 0.58%.

## Internal Audit

During Winter 2019/20, 360 Assurance undertook an internal audit of our incident reporting and associated processes. The Trust received Significant Assurance. A number of actions have been identified and an action plan is in development. The actions are summarised below and focus on clarifying:

- Responsibilities for completion of the degree of harm field and timeliness of reviewing incidents
- Policy terminology and definitions to ensure they align with Datix (egg closed date, near miss definition, Green1 (no harm) severity)
- Investigation timescales for incidents of all grades, and where relevant, how we manage investigation extensions.
- Level of performance information in Clinical Risk Reports for Operational Management Group

## Royal College of Psychiatrists Serious Incident Review Accreditation Network (SIRAN)

The Trust was been involved in the pilot of Serious Incident Investigation standards during 2018/19 and 2019/20. These have now been agreed and a network officially launched in January 2020. The next phase will involve a self-review process and a peer review visit which is anticipated to be around September 2020. We will need to upload evidence that supports our Serious Incident processes.

## Duty of Candour

Duty of Candour applies to all patient safety incidents that result in moderate harm or above. The Trust has been following the principles of Being Open since 2008 and had a policy in place since that time. The NHS contract includes Duty of Candour for patient safety incidents with moderate harm and above and the Trust has been reporting on this since April 2014. In November 2014 this was strengthened when this became a statutory CQC regulation[4] to fulfil the Duty of Candour requirement.

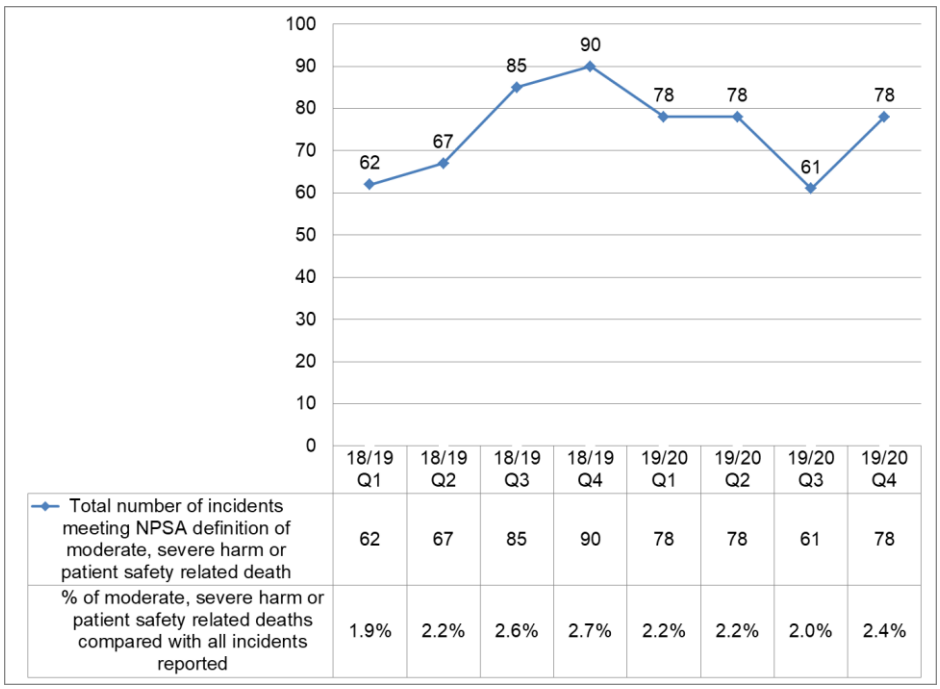
Failure to comply with the contractual requirements could result in recovery of the cost of the episode of care or £10,000 if the cost of the episode of care is unknown (NHS Contract) and/or it is a criminal offence to fail to provide notification of a notifiable safety incident and/or to comply with the specific requirements of notification. On conviction a health service body would be liable to a potential fine of £2,500.
The data contained in this section of the report was correct at the time of reporting (13/5/20). The data is extracted from a live system, and is subject to change. The degree of harm (moderate, severe or death) is initially recorded by the Patient Safety Support Team based upon the potential harm, and is subject to change as further information becomes available e.g. when actual injuries or cause of death are confirmed.

During 2019/20, there were 295 potentially applicable patient safety incidents (2.2% of all incidents reported). The number of patient safety incidents meeting the NRLS definition of moderate or severe harm or death steadily rose in 18/19, however has fallen slightly in 19/20 as shown in Figure 4. The percentage of Duty of Candour applicable incidents against the total number of incidents reported each quarter has remained fairly similar. Some data is still subject to change.

It should be noted that the figures included in this section of the report regarding Duty of Candour will not match the number of incidents reported to the National Reporting and Learning System (NRLS) as some incidents where Duty of Candour applies, are not reportable to NRLS, e.g. apparent suicide of a discharged community patient.

**Figure 4 Total number of patient safety incidents with moderate or severe harm or death between 2018/19 and 2019/20**

[4] Care Quality Commission. Duty of Candour guidance




| | 18/19 Q1 | 18/19 Q2 | 18/19 Q3 | 18/19 Q4 | 19/20 Q1 | 19/20 Q2 | 19/20 Q3 | 19/20 Q4 |
|---|---|---|---|---|---|---|---|---|
| Total number of incidents meeting NPSA definition of moderate, severe harm or patient safety related death | 62 | 67 | 85 | 90 | 78 | 78 | 61 | 78 |
| % of moderate, severe harm or patient safety related deaths compared with all incidents reported | 1.9% | 2.2% | 2.6% | 2.7% | 2.2% | 2.2% | 2.0% | 2.4% |

Figure 5 shows the degree of harm (moderate, severe or death) from patient safety incidents over a three year period. The average for each degree of harm has been added.

**Figure 5 Duty of Candour applicable incidents by degree of harm and month 1/4/2018 – 31/3/2020**

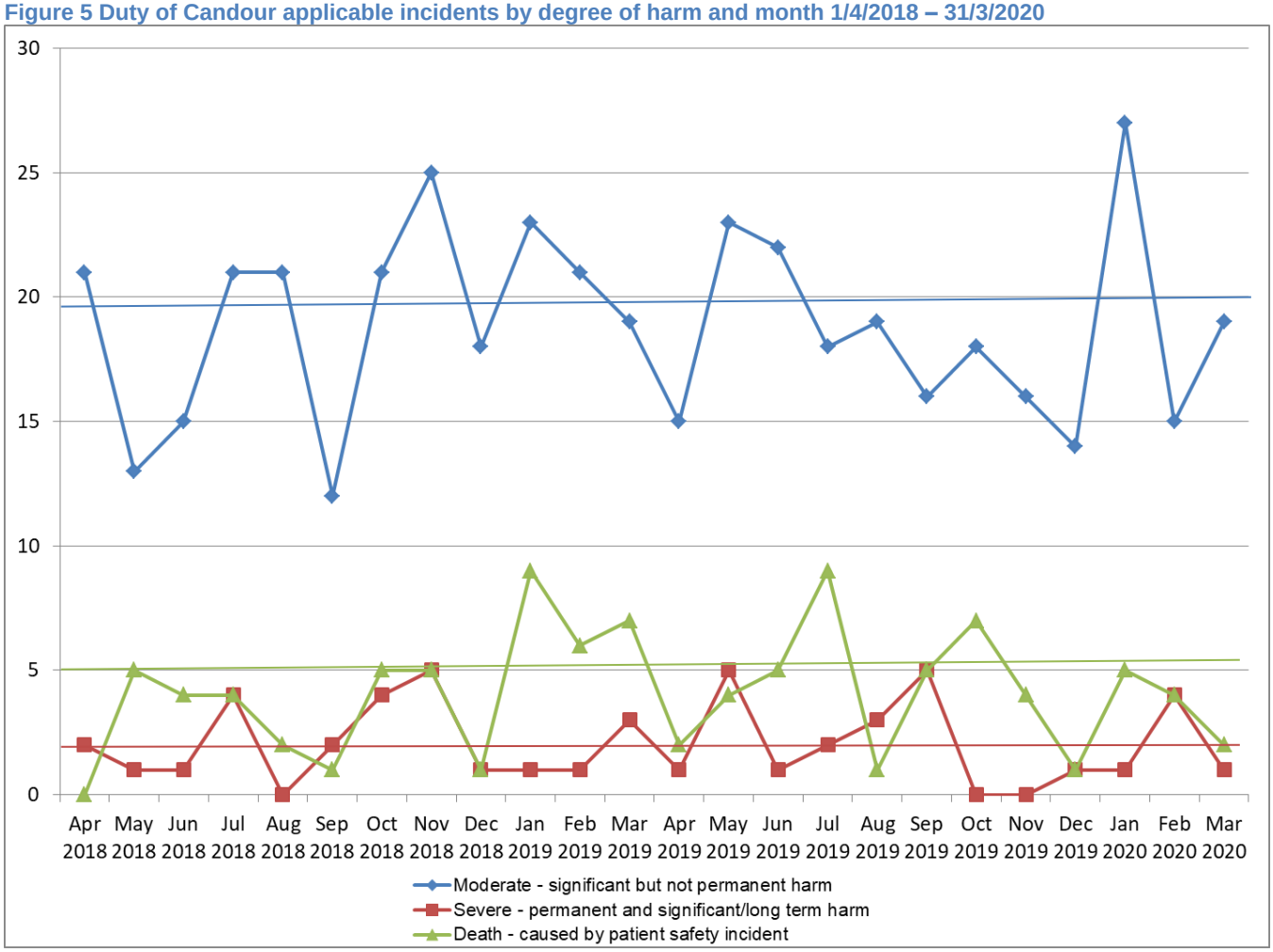



Figure 6 shows the highest number of applicable incidents is in Barnsley General Community Services with 152 incidents. This is an increase of 2 in comparison to 2018/19. A high proportion of these were pressure ulcers, category 3 (moderate harm), and category 4 (severe harm).

**Figure 6 Duty of Candour applicable incidents in 2019/20 by BDU and financial quarter**

| | Barnsley General Community | Barnsley Mental Health | Calderdale | Kirklees | Wakefield | Forensic Service | Specialist Services | **Total** |
|---|---|---|---|---|---|---|---|---|
| 19/20 Q1 | 36 | 2 | 9 | 8 | 22 | 1 | 0 | **78** |
| 19/20 Q2 | 36 | 7 | 7 | 14 | 11 | 2 | 1 | **78** |
| 19/20 Q3 | 37 | 4 | 6 | 7 | 5 | 0 | 2 | **61** |
| 19/20 Q4 | 43 | 6 | 5 | 13 | 9 | 2 | 0 | **78** |
| **Total** | **152** | **19** | **27** | **42** | **47** | **5** | **3** | **295** |

## *Compliance with Duty of Candour*

Each BDU has an identified lead who is responsible for reviewing their BDU's compliance with Duty of Candour. The Patient Safety Support Team provides data on a monthly basis to the Operational Management Group to support BDUs with monitoring their compliance with Duty of Candour. Figure 7 shows the monitoring position which breaks down as below:

- In 77% of cases (228), a verbal conversation has happened with the patient and/or family within 10 days of the incident occurring or being identified (as per the contract).
- There were 20 cases where Duty of Candour was not completed but exception reasons were given (6%). The number of exceptions has stayed the same as in 2018/19 (6%).
- There were three cases where Duty of Candour was underway.
- There were 44 (14%) cases where the Duty of Candour monitoring was not completed by the BDU, these could include possible breaches.

**Figure 7 Duty of Candour compliance 2019/20**

| | Barnsley General Community | Barnsley Mental Health | Calderdale | Kirklees | Wakefield | Forensic Service | Specialist Services | **Total** |
|---|---|---|---|---|---|---|---|---|
| Stage 1 Duty of Candour - underway | 1 | 0 | 0 | 1 | 0 | 0 | 0 | **2** |
| Stage 1 Duty of Candour - awaiting further clarification from manager | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **1** |
| Stage 1 Duty of Candour - verbal apology completed within 10 days | 132 | 10 | 15 | 30 | 41 | 0 | 0 | **228** |
| Stage 1 Duty of Candour verbal apology not given following MDT decision (exception) | 0 | 1 | 7 | 1 | 1 | 0 | 0 | **10** |
| Stage 1 Duty of Candour - not completed (exception) | 0 | 0 | 2 | 4 | 4 | 0 | 0 | **10** |
| Awaiting BDU monitoring | 19 | 8 | 3 | 6 | 1 | 5 | 2 | **44** |
| **Total** | 152 | 19 | 27 | 42 | 47 | 5 | 3 | **295** |

Exception reasons include verbal apology not being given following MDT decision due to clinical presentation or being detrimental to patient's wellbeing. In other cases Duty of Candour was not

possible with the patient as they were too unwell. In some cases, particular where patients had died, there were no family contact details known to enable us to make contact with family members.

# Section 2 - Serious Incidents reported during 2019/20

## Background context

Serious incidents are defined by NHS England as;

> "…events in health care where the potential for learning is so great, or the consequences to patients, families and corers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare." [5]

There is no definitive list of events/incidents. However, there is a definition in the Serious Incident Framework which sets out the circumstances in which a serious incident must be declared:

Serious incidents are incidents requiring investigation and are defined as an incident that occurred in relation to NHS funded services and care resulting in one of the following:

- the unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- serious harm to one or more patients, staff, visitors or members of the public or where outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm (this includes incidents graded under the NPSA definition of severe harm)
- a scenario that prevents, or threatens to prevent, a provider organisation's ability to continue to deliver health care services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment. IT failure or incidents in population programmes like screening and immunisation where harm potentially may extend to a larger population
- allegations of abuse
- adverse media coverage or public concern for the organisation or the wider NHS one of the core set of *Never Events*[6].

## Investigations

Investigations are initiated for all serious incidents in the Trust to identify any systems failure or other learning, using the principles of root cause and systems analysis. The Trust also undertakes a range of reviews to identify any themes or underlying reasons for any peaks. Most serious incidents are graded amber or red on the Trust's severity grading matrix, although not all amber/red incidents are classed as serious incidents and reported on the Strategic Executive Information System (StEIS). Some incidents are reported, investigated and later de-logged from StEIS following additional information. Conversely, some incidents are reported as Serious Incidents on StEIS after local investigation.

## Headlines

During 2019/20, 47 Serious Incidents were reported to the relevant Clinical Commissioning Group (CCG) via the NHS England Strategic Executive Information System (StEIS). This compares with 45 in 2018/19.

[5] NHS England. Serious Incident Framework. March 2015
[6] NHS Improvement. Never Event policy and framework 2018

- 47 Serious incidents reported
- Serious incidents account for 0.35% of all incidents
- Highest incident category is 'apparent suicide of service users in current contact with community teams' (24)
- One homicide reported
- No Never Events

**No 'Never Event'** incidents were reported by SWYPFT in 2019/2020. The last Never Event reported by the Trust was in 2010/11. Never Events is a list (DOH) of serious, largely preventable patient safety incidents where national safety alerts/procedures are in place to prevent occurrence. These events should not occur if the available preventative measures have been implemented. Examples of Never Events relevant to SWYPFT include failure to install functional collapsible shower or curtain rails in mental health settings; and in all settings, overdose of insulin due to abbreviations or incorrect device; falls from poorly restricted windows; chest or neck entrapment in bed rails; scalding of patients; unintentional connection of a patient requiring oxygen to an air flowmeter. There is specific guidance for circumstances of each Never Event.

Never Events[7] are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There were **no 'never event'** incidents reported by SWYPFT in 2019/20. The last Never Event reported by the Trust was in 2010/11. A revised list of Never Events came into effect on 1 February 2018. This is available on the Trust intranet.

There was one **homicide** reported in 2019/20.

## Serious Incident Analysis

Figures 8 and 9 below shows all serious incidents reported on StEIS between 1 April 2015 and 31 March 2020, with figure 8 showing breakdown by financial quarter.

**Figure 8 Breakdown of serious incidents reported each financial year by financial quarter 2015/16- 2019/20**

| | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 |
|---|---|---|---|---|---|
| Quarter 1 | 18 | 13 | 15 | 8 | 12 |
| Quarter 2 | 23 | 13 | 18 | 9 | 12 |
| Quarter 3 | 15 | 15 | 26 | 10 | 8 |
| Quarter 4 | 20 | 23 | 12 | 17 | 15 |
| **Total** | **76** | **64** | **71** | **44** | **47** |

[7] NHS Improvement. Never Event policy and framework 2018

**Figure 9 Total number of Serious Incidents reported by financial year 2015/16 to 2019/20**

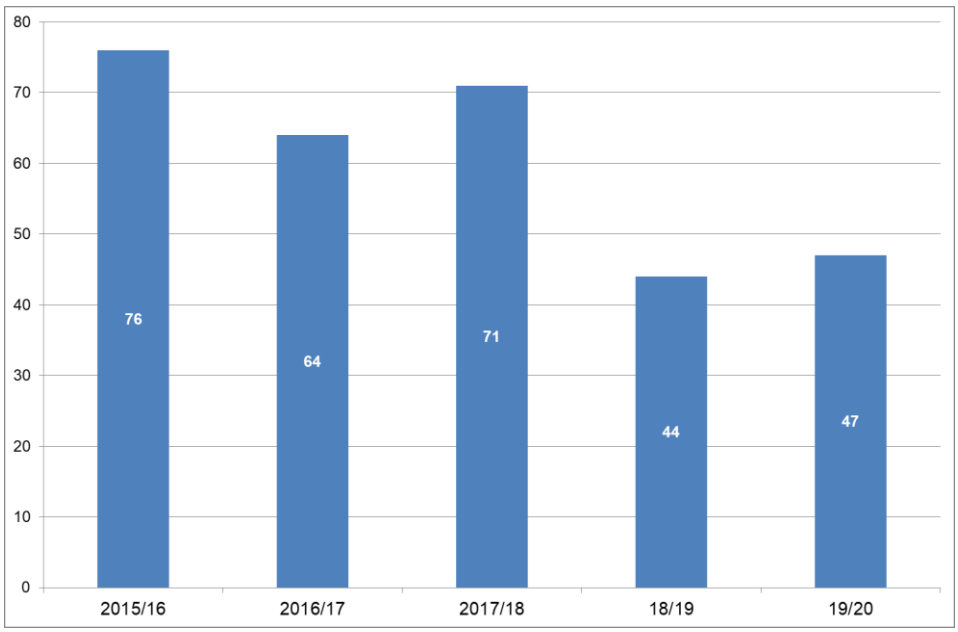
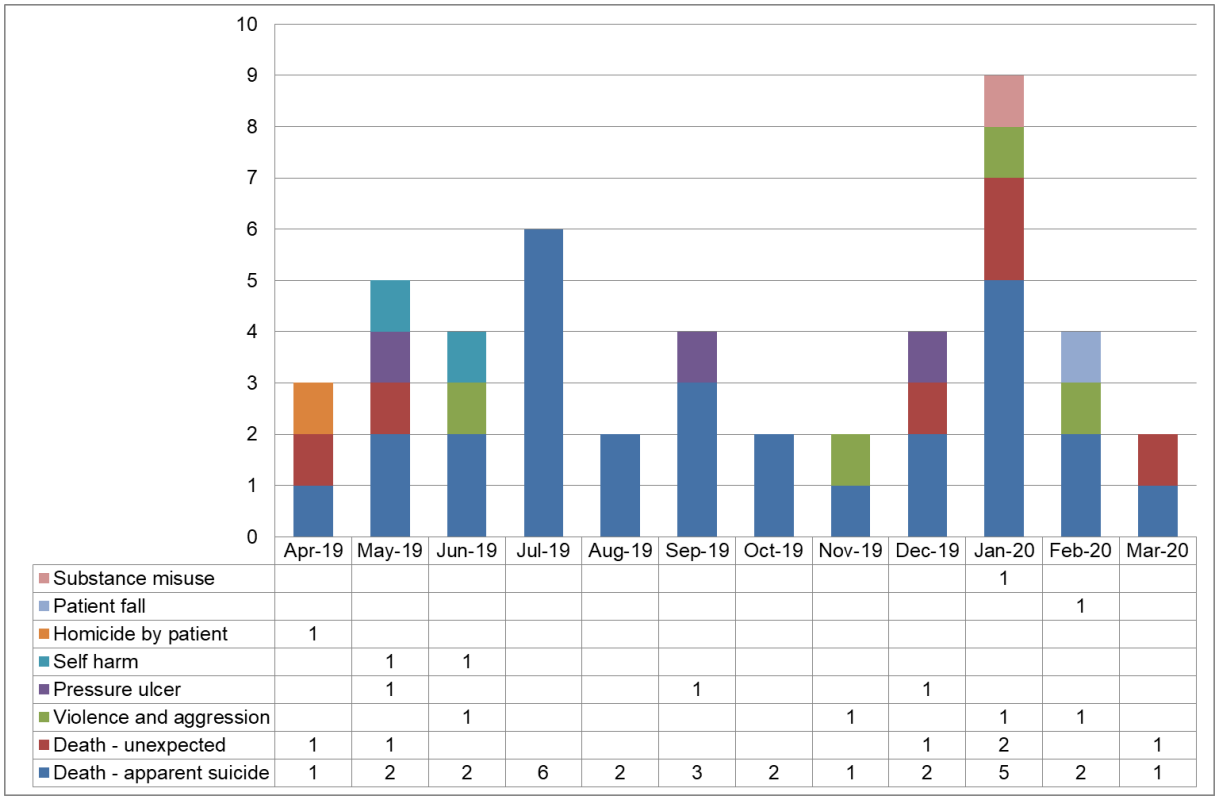



Figure 10 shows a breakdown of the 47 serious incidents reported during 2019/20 by the type of incident and month reported.

**Figure 10 Types of All Serious Incidents reported in 2019/20 by date reported on StEIS**



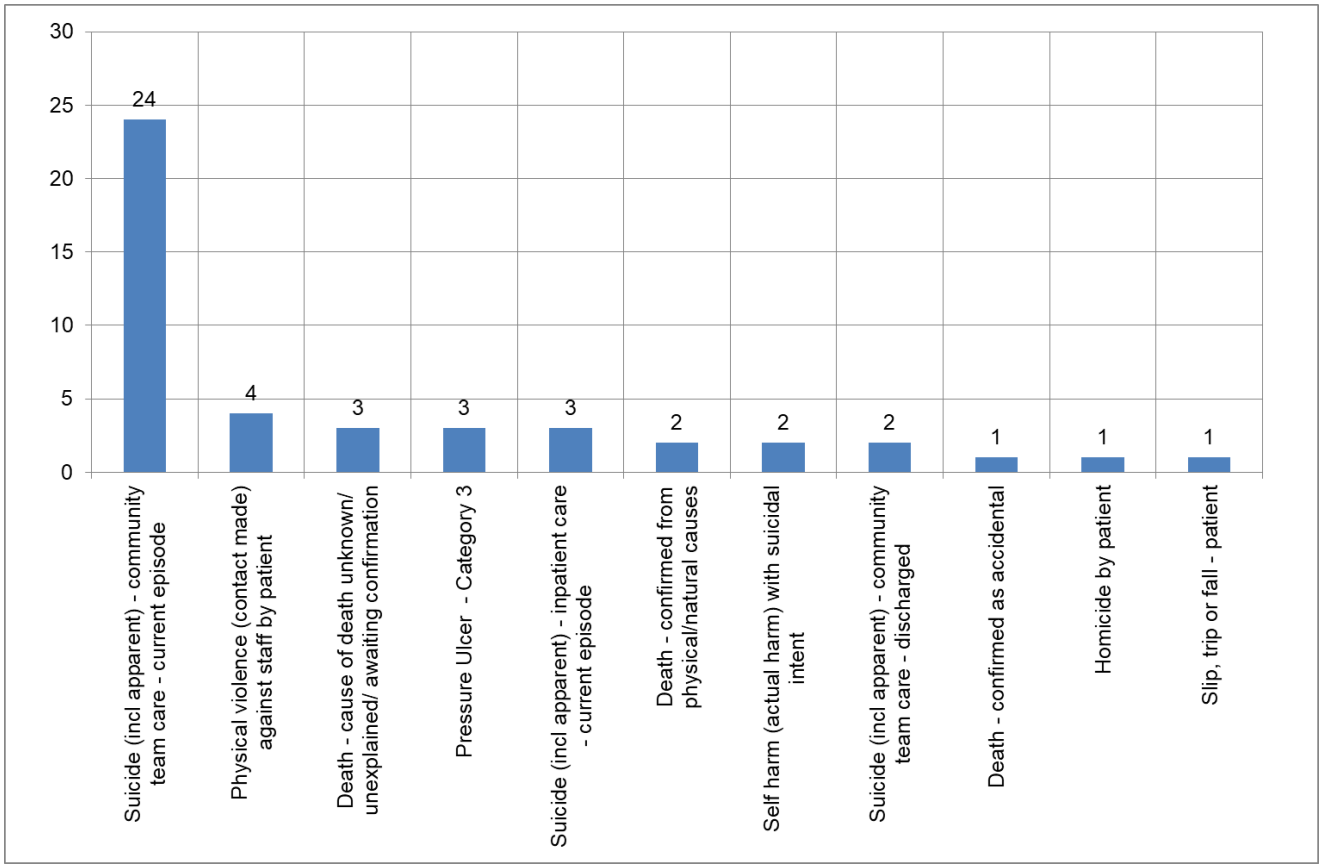

| | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Substance misuse | | | | | | | | | | 1 | | |
| Patient fall | | | | | | | | | | | 1 | |
| Homicide by patient | 1 | | | | | | | | | | | |
| Self harm | | 1 | 1 | | | | | | | | | |
| Pressure ulcer | | 1 | | | | 1 | | | 1 | | | |
| Violence and aggression | | | 1 | | | | | 1 | | 1 | 1 | |
| Death - unexpected | 1 | 1 | | | | | | | 1 | 2 | | 1 |
| Death - apparent suicide | 1 | 2 | 2 | 6 | 2 | 3 | 2 | 1 | 2 | 5 | 2 | 1 |

As in previous years, the highest type of serious incident is death of a service user (35) including death by apparent suicide or unexpected death.

Figure 11 shows a breakdown of the reported serious incidents by category. The category of incident (a subset of 'type', as shown in Figure 10) provides more detail of what occurred. It shows that apparent suicide of service users in current contact with community teams is the highest reported category with 24 (compared with 2018/19 [23]; 2017/18 [34]). There are a further five

incidents relating to apparent suicide. These include three deaths where the patient was under the care of inpatient services at the time of death; two deaths where the service user was discharged from Intensive Home Base Treatment Team (IHBTT) at the time of their death.

**Figure 11 Serious Incidents reported during 2019/20 by reported category**




As Figure 12 shows, during 2019/20, the area with the highest number of SIs reported was Kirklees with 15 serious incidents, the same as 2018/19. Fourteen of the 15 cases were death of service users. Two were apparent suicides of inpatients on leave from wards (not the same ward) at the time of death; a third was an unexpected death of inpatient on leave from the ward. Wakefield has also shown an increase with 11 serious incidents in 2019/20 compared with eight in 2018/19. Ten of Wakefield SIs were deaths.

Forensics has had an increase in serious incidents with 7 reported across the service. This included three inpatient deaths, one of which was apparent suicide in hospital ward. In 2018/19 there were no serious incidents reported. This increase follows a change in Forensic commissioning reporting guidance and thresholds that was implemented in November 2019. This has resulted in some amber incidents now being classed as serious incidents.

Barnsley General Community has reported four SIs in 2019/20 which remains consistent with reporting figures in 2018/19.

A number of BDU's have seen a reduction in the number of serious incidents reported compared with 2018/19 figures. Calderdale's figure reduced from nine in 2018/19 to six in 2019/20. Barnsley Mental Health had four serious incidents in 2019/20 compared with 10 in 2018/19.

There were no serious incidents reported in CAMHS or Learning Disability services.

**Figure 12 2019/20 Reported Serious incidents by BDU and category**

| | Barnsley General Community | Barnsley Mental Health | Calderdale | Kirklees | Wakefield | Forensic Services | Total |
|---|---|---|---|---|---|---|---|
| Suicide (incl apparent) - community team care - current episode | 0 | 3 | 5 | 7 | 9 | 0 | 24 |
| Physical violence (contact made) against staff by patient | 0 | 0 | 0 | 0 | 1 | 3 | 4 |
| Death - cause of death unknown/ unexplained/ awaiting confirmation | 0 | 0 | 0 | 3 | 0 | 0 | 3 |
| Pressure Ulcer - Category 3 | 3 | 0 | 0 | 0 | 0 | 0 | 3 |
| Suicide (incl apparent) - inpatient care - current episode | 0 | 0 | 0 | 2 | 0 | 1 | 3 |
| Death - confirmed from physical/natural causes | 0 | 0 | 0 | 0 | 1 | 1 | 2 |
| Self harm (actual harm) with suicidal intent | 0 | 1 | 1 | 0 | 0 | 0 | 2 |
| Suicide (incl apparent) - community team care - discharged | 0 | 0 | 0 | 2 | 0 | 0 | 2 |
| Death - confirmed as accidental | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Homicide by patient | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| Slip, trip or fall - patient | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Substance misuse | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Total | 4 | 4 | 6 | 15 | 11 | 7 | 47 |

Figure 13 shows all reported serious incidents by reporting team (primary involvement at time of the incident) and financial quarter. It should be noted that some incidents involve several other teams.

**Figure 13 Serious Incidents reported by Team and financial quarter**

| **Team** | Q1 2019/20 | Q2 2019/20 | Q3 2019/20 | Q4 2019/20 | Total |
|---|---|---|---|---|---|
| Enhanced Team South 2 - Kirklees | 1 | 1 | 0 | 3 | 5 |
| Assessment and Intensive Home Based Treatment Team / Crisis Team - Calderdale | 2 | 1 | 0 | 1 | 4 |
| Intensive Home Based Treatment Team (Kirklees) | 1 | 2 | 1 | 0 | 4 |
| Intensive Home Based Treatment Team (IHBTT) - Wakefield | 0 | 1 | 1 | 1 | 3 |
| Core Team West - Wakefield | 1 | 1 | 0 | 0 | 2 |
| Enhanced Team West - Kendray, Barnsley | 2 | 0 | 0 | 0 | 2 |
| Priestley Ward, Newton Lodge | 0 | 0 | 1 | 1 | 2 |
| Sandal Ward (Bretton Centre) | 0 | 0 | 0 | 2 | 2 |
| Appleton, Newton Lodge, Forensic BDU | 1 | 0 | 0 | 0 | 1 |
| Ashdale Ward (based at The Dales, Kirklees BDU) | 0 | 0 | 0 | 1 | 1 |
| Core Team - Calderdale | 0 | 1 | 0 | 0 | 1 |
| Core Team East - Wakefield | 0 | 1 | 0 | 0 | 1 |
| Core Team North - Kirklees | 0 | 0 | 1 | 0 | 1 |
| Criminal Justice Liaison Team, Barnsley | 0 | 0 | 1 | 0 | 1 |
| Early Intervention Service (Insight) - Kirklees | 1 | 0 | 0 | 0 | 1 |
| Enhanced Lower Valley Team - Calderdale | 0 | 0 | 1 | 0 | 1 |
| Enhanced Team East - Wakefield | 0 | 0 | 0 | 1 | 1 |
| Enhanced Team South 1 - Kirklees | 0 | 1 | 0 | 0 | 1 |
| Enhanced Team West - Wakefield | 0 | 1 | 0 | 0 | 1 |
| Hepworth Ward, Newton Lodge, Forensic | 0 | 0 | 0 | 1 | 1 |

| Team / continued | Q1 2019/20 | Q2 2019/20 | Q3 2019/20 | Q4 2019/20 | Total |
|---|---|---|---|---|---|
| Intensive Home Based Treatment Team (IHBTT) - Barnsley | 0 | 1 | 0 | 0 | 1 |
| Neighbourhood Team - North (Barnsley) | 0 | 1 | 0 | 0 | 1 |
| Neighbourhood Team - Penistone (Barnsley) | 1 | 0 | 0 | 0 | 1 |
| Neighbourhood Team - South (Barnsley) | 0 | 0 | 1 | 0 | 1 |
| Neuro Rehab Unit - Barnsley | 0 | 0 | 0 | 1 | 1 |
| Single Point of Access, (Wakefield) | 1 | 0 | 0 | 0 | 1 |
| Stanley Ward (Trinity 2) | 1 | 0 | 0 | 0 | 1 |
| Thornhill Ward (The Bretton Centre) | 0 | 0 | 1 | 0 | 1 |
| Ward 18, Priestley Unit | 0 | 0 | 0 | 1 | 1 |
| Ward 19 - Priestley Unit (OPS) | 0 | 0 | 0 | 1 | 1 |
| Total | 12 | 12 | 8 | 15 | 47 |

## *Demographic comparison of Serious Incidents reported*

The numbers in Figure 12 must be considered by BDU population sizes and service configuration.

**Population**
When serious incidents are viewed against population size (Figure 14) it shows a decrease in the number of serious incidents reported per 100,000 population in Barnsley and Calderdale. Kirklees has remained about the same rate, and Wakefield shows a small increase.

**Figure 14 BDU population estimates and serious incident figures (STEIS reported) per 100,000 population**

| Geographical district | Population estimates Mid 2019 (ONS) | Serious Incident figures per 100,000 population for 2018/19 (based on population figures from 2017) | Serious Incident figures per 100,000 population for 2019/20* |
|---|---|---|---|
| **Barnsley** | 245,199 | 4.55 | 3.26 |
| **Calderdale** | 210,082 | 4.29 | 2.86 |
| **Kirklees** | 438,727 | 3.43 | 3.41 |
| **Wakefield** | 345,038 | 2.64 | 3.18 |
| **Total** | 1,230,730 | 3.57 | 3.81 |

*7 Forensic SIs have been excluded from the geographical calculations but are included in the overall Trust wide total

## Breakdown of all Serious Incidents

## *Deaths (apparent suicides and unexpected deaths)*

Of the 47 serious incidents reported, 35 related to the death of a service user as mentioned earlier. Please note this is not all deaths that were reported on Datix and reviewed, only those reported on StEIS.

Figure 15 shows the apparent category of death. This is extracted from Datix and was correct at the time of writing, based on information known at the time. This is subject to change as more information comes to light or inquest conclusions are received. Apparent suicide is based on the circumstances of death.

**Figure 15 Breakdown of all deaths reported as SIs 2019/20 by category of death and BDU**

| | Barnsley General Community Services | Barnsley Mental Health | Calderdale | Kirklees | Wakefield | Forensic Service | Total |
|---|---|---|---|---|---|---|---|
| Suicide (incl apparent) - community team care - current episode | 0 | 3 | 5 | 7 | 9 | 0 | 24 |
| Death - cause of death unknown/ unexplained/ awaiting confirmation | 0 | 0 | 0 | 3 | 0 | 0 | 3 |
| Suicide (incl apparent) - inpatient care - current episode | 0 | 0 | 0 | 2 | 0 | 1 | 3 |
| Death - confirmed from physical/natural causes | 0 | 0 | 0 | 0 | 1 | 1 | 2 |
| Suicide (incl apparent) - community team care - discharged | 0 | 0 | 0 | 2 | 0 | 0 | 2 |
| Death - confirmed as accidental | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Total | 0 | 3 | 5 | 14 | 10 | 3 | 35 |

### Death - confirmed from physical/natural causes

Deaths of service users where the cause of death appears to be natural or physical cause would not usually be reported as Serious Incidents unless there were significant concerns about the care provided or it met external reporting requirements. During 2019/20, there was one death which has since been confirmed from a physical cause (pneumonia). This was reported as a serious incident as it was the unexpected death of Forensic Services patient, which are reportable as serious incidents under their revised contract.

There are a further two cases where the cause of death was not confirmed at the time of reporting the serious incident. One related to a patient who died following a choking incident. The second was a patient who was found deceased in Scotland. The cause of death has since been received as being related to physical health. The investigation for both has continued.

### Death – other causes

There were 3 serious incidents reported relating to the unexpected death of service users. This figure includes two unexpected deaths related to service users who died in house fires at home. A third incident involved the death of an informal patient on leave from a ward. At the time of reporting cause of death was not known.

It can take a significant amount of time for the cause of death to be identified through the coroner's office. However, irrespective of the outcome, this does not prevent the investigation being completed.

### Apparent Suicide

Of the 35 deaths reported as serious incidents, 29 were apparent suicides. Three of these occurred whilst under the care of inpatient settings, one on a ward (Forensic low secure) and two whilst on leave from wards. Further detailed analysis of all apparent suicides in 2019/20 will be available in September 2020.

## Violence and Aggression

During 2019/20 there were four violence and aggression incidents, the same figure as 2018/19. All four incidents involved violence by patients against staff members using weapons. Three of the cases occurred in Forensic BDU (two in low secure, one in medium secure care) resulting in staff

injuries. The fourth case occurred in an acute inpatient ward and also resulted in injuries to a staff member.

### Homicide by a service user

During 2019/20 there was one homicide by a service user reported as a serious incident. This incident involved a service user under the care of an Enhanced Team. The service user was charged in connection with the death of a member of the public following a stabbing. The investigation for this case was led by an externally appointed investigator on behalf of the Trust. The individual is awaiting trial.

### Pressure ulcers

During 2019/20, a total of three category three pressure ulcers were reported as Serious Incidents on StEIS. This compares with four in 2018/19. All were reported by Neighbourhood teams in Barnsley General Community Services. Two of the three patients affected were male.

### Self-harm/attempted suicide

During 2019/20 there were two serious self-harm incidents. Both cases involved service users falling from bridges, resulting in significant injuries. These occurred whilst under the care of different teams; Intensive Home Based Treatment Team in Calderdale and Enhanced Team West in Barnsley.

### Inpatient fall

During 2019/20 there was one incident where an inpatient in Neuro Rehabilitation unit in Barnsley fell, resulting in a fractured neck of femur.

### Substance misuse

During 2019/20 there was one incident in Forensic medium secure services, where an inpatient was found to be unresponsive, suspected to have injected illegal substances. After treatment, the patient returned to the ward the following day.

## Section 3 - Findings from Serious Incident Investigations completed during 2019/20

This section of the report focusses on the **43** serious incident investigation reports were completed and submitted to the relevant commissioner during the period 1 April 2019 to 31 March 2020. Please note this is not the same data as those reported in this period (see Section 3) as investigations take a number of months to complete. The term 'completed' is used in this section to describe this.

- 43 serious incident investigations completed
- 174 associated actions
- All investigations include a recommendation to share learning
- Top 3 action themes:
  1) Staff education, training and supervision
  2) Record keeping
  3) Joint between Risk Assessment and Communication

### Headline data

Of the 43 serious incidents investigation reports completed and submitted to the relevant commissioner between 1 April 2019 and 31 March 2020, there were 174 actions made.

A standard recommendation to share learning and the outcome of the investigation with staff involved and wider is now in place. All 43 serious incident reports completed had a recommendation to share learning. This increases the number of actions. 44 of the 174 actions were related to sharing learning.

One incident investigation can generate a high number of actions. The breakdown by BDU and team type is shown in figures 16 and 17.

**Figure 16 Breakdown of the number of Serious Incidents completed in 2019/20 per BDU, compared with the number of actions**

| BDU | Number of SIs completed | Number of SI actions |
|---|---|---|
| Barnsley General Community Services | 5 | 20 |
| Barnsley Mental Health | 6 | 21 |
| Calderdale | 6 | 26 |
| Kirklees | 15 | 63 |
| Wakefield | 9 | 31 |
| Specialist Services | 1 | 6 |
| Forensic Services | 1 | 7 |
| **Total** | 43 | 174 |

**Figure 17 Breakdown of the number of Serious Incidents completed in 2019/20 per team type, compared with the number of actions**

| | Number of SIs completed | Number of SI actions |
|---|---|---|
| Enhanced Pathway | 9 | 26 |
| Core pathway | 8 | 27 |
| Crisis/IHBTT (Adult) | 8 | 28 |
| District Nursing | 5 | 20 |
| Acute Inpatients (Adult) | 4 | 33 |
| Early Intervention Services | 2 | 7 |
| 136 Suite (Adult) | 1 | 3 |
| Child and Adolescent Mental Health Services, Wakefield | 1 | 6 |
| Dual Diagnosis (Adult) | 1 | 4 |
| Inpatient Service (OPS) | 1 | 4 |
| Forensic Learning Disability Inpatient units | 1 | 7 |
| Mental Health Liaison Services | 1 | 6 |
| Single Point of Access (SPA) | 1 | 3 |
| Total | 43 | 174 |

Over the last three years the highest numbers of actions have arisen from apparent suicide incidents. This correlates with this being the largest type of Serious Incident reported. During 2019/20 completed serious incident investigations for apparent suicides resulted in 120 actions (69%).

It is important to understand that in undertaking an investigation of an incident, the Trust takes the view that all areas for learning or improvement should be identified and lead to a recommendation being made. These are often care delivery issues, and not considered to have been the direct root cause of the incident.

A majority of the recommendations from serious incident investigations apply directly to the team or BDU involved. Each BDU lead investigator works closely working with the practice governance coaches and BDUs to produce a report on learning from recommendations where further information/breakdown about each BDU and the lessons learnt is presented. This is called ‘Our learning journey from incidents’. This will be available separately.

## Categorisation of actions

In order to analyse actions, each action is given a theme to capture the issue/theme that best matches from a pre-designed list of approximately 20 themes. We also try to add a sub-theme to group similar issues together. In an attempt to gain consistency, this is undertaken by the Lead Serious Incident Investigators. The recording of themes and sub-themes is subjective and isn’t always straightforward to identify which theme/sub-theme an action should be given. Some don’t easily fit into any one theme, and could be included under more than one.

**Figure 18 Ordinal list of action themes from 2019/20 compared with position in 2018/19**

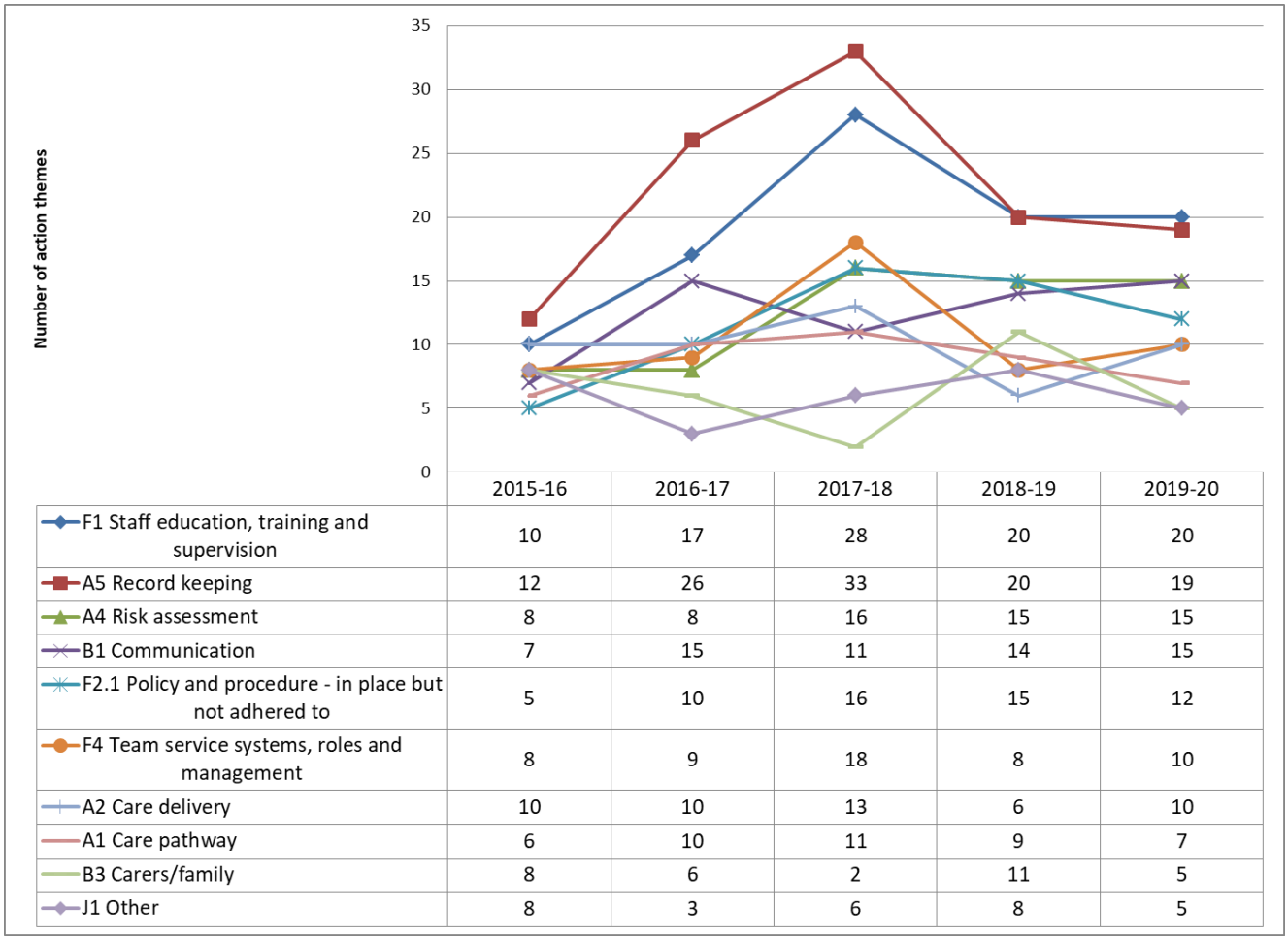
| Top 6 Recommendation types | 2019/20 | 2018/19 |
|---|---|---|
| F1 Staff education, training and supervision | 1st | Joint 1st |
| A5 Record keeping | 2nd | Joint 1st |
| A4 Risk assessment | Joint 3rd | Joint 3rd |
| B1 Communication | Joint 3rd | 5th |
| F2.1 Policy and procedure - in place but not adhered to | 5th | Joint 3rd |
| F4 Team service systems, roles and management | 6th joint | Joint 3rd |
| A2 Care delivery | 6th joint | Not in top 6 |

The types of SIs completed in the year affects the action themes, for example, an Information governance serious incident, is more likely to have actions related to Organisational systems, increasing that figure.

Figure 18 illustrates the ranking of the most common themes this year in comparison to last year. The top 3 themes are the same as last year.

The top 10 action themes have also been reviewed over the last five financial years for comparison. As shown in Figure 19, Record keeping and Staff education, training and supervision have remained the two commonest themes.

**Figure 19 Top 10 action themes in the 5 years between 1/4/2015 and 31/3/20**




| | 2015-16 | 2016-17 | 2017-18 | 2018-19 | 2019-20 |
|---|---|---|---|---|---|
| F1 Staff education, training and supervision | 10 | 17 | 28 | 20 | 20 |
| A5 Record keeping | 12 | 26 | 33 | 20 | 19 |
| A4 Risk assessment | 8 | 8 | 16 | 15 | 15 |
| B1 Communication | 7 | 15 | 11 | 14 | 15 |
| F2.1 Policy and procedure - in place but not adhered to | 5 | 10 | 16 | 15 | 12 |
| F4 Team service systems, roles and management | 8 | 9 | 18 | 8 | 10 |
| A2 Care delivery | 10 | 10 | 13 | 6 | 10 |
| A1 Care pathway | 6 | 10 | 11 | 9 | 7 |
| B3 Carers/family | 8 | 6 | 2 | 11 | 5 |
| J1 Other | 8 | 3 | 6 | 8 | 5 |

In 2019/20 the top three most common action themes were 'Staff education, training and supervision', 'Record keeping', and joint third 'Risk assessment' and 'Communication'. These are generally consistent with top 3 themes in previous years. Below is a summary of some of the issues identified within these themes; where possible these have been grouped together (called subthemes). There is natural overlap between themes and subthemes.

## *1) Staff education, training and supervision (#1):*

Staff education, training and supervision has remained within the top 3 action themes in the last seven years. During 2019/20, there were 20 actions relating to staff education, training and supervision. Where possible these have been grouped by broad sub-theme:

| | Barnsley General Community Services | Barnsley Mental Health | Kirklees | Calderdale | Forensic Service | Specialist Services | Total |
|---|---|---|---|---|---|---|---|
| Physical health | 0 | 0 | 3 | 0 | 2 | 0 | 5 |
| Supervision | 0 | 0 | 1 | 0 | 1 | 2 | 4 |
| Risk assessment | 1 | 1 | 0 | 1 | 0 | 0 | 3 |
| Incident reporting | 0 | 0 | 1 | 1 | 0 | 0 | 2 |
| MDT working | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| CPA policy | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Training - other | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Dual diagnosis | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| Care pathway | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Support for staff | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| **Total** | **3** | **3** | **6** | **3** | **3** | **2** | **20** |

Below is a summary of the actions identified:

### Physical health

- Review the effectiveness of training programmes in building competence and confidence in carrying out resuscitation, and consider with Service Managers what further steps can be taken to ensure staff proficiency under pressure.
- Ensure that staff have up to date awareness and knowledge of physical health problems that are known to shorten life expectancy for patients with long-term mental illnesses.
- Ensure that staff are able to recognise the link between aspiration pneumonia and coughing when eating and drinking.
- Improve education and support to staff in understanding and managing risks associated with dysphagia, including ensuring dissemination of recent relevant guidance and prioritising relevant Trust training programmes on food and nutrition for attendance.
- Consider what changes if any are needed to ensure first aid techniques available to staff are as effective as possible for all patients including bariatric patients.

### Risk assessment and formulation

- The IHBTT should re-establish psychology led supervision sessions with a focus on risk formulation and understanding risk for individuals with a personality disorder and where non-suicidal self-injury and suicidal intentions are present.
- Review the knowledge and skills of the Neighbourhood Nursing Service relating to the factors which affect the Waterlow score.
- Caseload supervision should include checks of the current risk assessment and management plans recorded on the clinical system.

### Care pathway

- Embed the moisture lesion pathway within the Neighbourhood Nursing Service by providing further training and support.

### Dual diagnosis

- Provide training in dual diagnosis for clinical staff as per Trust policy.

### Supervision

- The service should review the current procedures for the delivery of clinical supervision to ensure that they are robust.
- The service needs to provide assurance that clinical supervision is being completed in line with Trust policy.
- Improve the access staff have to on-going supervision and support when they are relying on the Mental Capacity Act for treatment and care of vulnerable patients, particularly where they are concerned that such patients are making unwise decisions.
- The systems of clinical and management supervision on the ward require a review to ensure that both types of supervision meet the requirements of the policy.

### Support for staff

- The Occupational Health Department guidance for managers supporting staff following a critical incident should be reviewed to include advice to be followed immediately on the day of an incident including one-to-one support and for making arrangements for staff affected to go home where appropriate.

### CPA policy

- Thorough handover to take place when transferring care. The meeting must fully involve the service user and all key individuals involved in the persons care as per Care Programme Approach and Care co-ordination policy and procedural guidance.

### MDT working

- All new service users to the enhanced teams must be reviewed by medical staff as part of the multi-disciplinary assessment/review

### Training – other

- Neighbourhood Nursing Service Employees (SWYPFT) involved in the incident will have knowledge, skills, and training reviewed and further training identified

### Incident reporting system

- Ward staff should ensure when allegations of abuse, or violence are made against staff during their working practice, that these are uploaded to the Datix system to enable the Trust to understand what may be going wrong and where, so that action can be taken to avoid this happening again and improve patient and staff safety.
- The Team manager should ensure that staff are provided with initial support at the uploading of Datix incidents to ensure that tasks are not lost where additional advice and information is required.

## *2) Record keeping (#2):*

Record keeping has remained within the top 3 action themes in the last six years. There were 19 actions relating to record keeping. Where possible these have been grouped by broad sub-theme:

| | Barnsley Mental Health | Calderdale | Forensic Service | Kirklees | Wakefield | Total |
|---|---|---|---|---|---|---|
| Clinical decision making | 1 | 0 | 0 | 1 | 1 | 3 |
| Communication with other agencies | 0 | 1 | 0 | 0 | 0 | 1 |
| Contemporaneous recording | 2 | 0 | 0 | 1 | 3 | 6 |
| Care plan | 0 | 1 | 1 | 1 | 0 | 3 |
| Risk assessment | 0 | 1 | 0 | 1 | 0 | 2 |
| Crisis/contingency plan | 0 | 0 | 0 | 1 | 0 | 1 |
| MDT | 1 | 0 | 0 | 1 | 1 | 3 |
| **Total** | **4** | **3** | **1** | **6** | **5** | **19** |

Below is a summary of the actions identified:

### Clinical decision making

- During telephone consultations by the Intensive Home Based Treatment Team with the service user there was no clear documentation of an opinion on his capacity to consent to assessment and treatment, and how this decision provided a rationale for his capability to refuse.
- Document all decisions for the deferment of treatment
- Where there is a difference in clinical opinion as to the acceptance of a referral from enhanced into the IHBTT the decision should be reviewed by the team consultant and senior practitioner/manager as part of the FACT meeting and full rationale/discussion documented within the clinical notes by both teams.

### Communication with other agencies

- There is no uniform practice across the Trust for AMHP reports following assessment. Some AMHPS provide a hand written summary and some don't. This depends on the area.

### Contemporaneous recording

- The Triage Nurse did not make an entry in the progress notes to say that the plan of contact between the Kirklees Intensive Home Based Treatment Team and the Acute Assessment Unit had been changed. This meant that the last entry in the progress notes was misleading because it said that the team would ring daily for an update on discharge plans.
- Services were contacted by family on two occasions, no recorded entry of calls made re concerns over deteriorating mental state. Service user had stated she was not consenting.
- Document contact from service user's family members expressing concern
- Individual's mental state to be recorded following each visit to clozapine clinic
- All discussions and pertinent information must be recorded within the care record
- Changes regarding leave conditions should be recorded contemporaneously and must include informal service users. The practice of leaving these changes to night staff must stop immediately.

### Care plan

- The initial plan of care was not transferred into a formal care plan and the care plan and crisis and contingency plan had not been provided to the service user.
- Care plans need to ensure they are current, easy to follow, provide evidence of the patient's involvement, are being implemented, and are being reviewed if they are not meeting service users' needs

- Breach of operational CPA policy and procedure by the lack of the presence of a clear care plan to support CPA care delivery

### Risk assessment

- The team should ensure that risk assessments are updated and accurate at the point of referral, when there are significant changes to risk and at least annually
- Lack of risk assessment at the point of ward discharge, lack of risk assessment at the point of acceptance on to Core HCP Caseload, Lack of clarification on understanding risk factors in progress notes to support clinical decision making in to moving from 24 hour follow-up. Inconsistencies in clinical communication of risk across teams.

### Crisis/contingency plan

- A team response should be included in the actions in a Crisis Care Plan.

### MDT

- When service users red, amber, green rating is changed within the IHBTT MDT meeting, the rationale for the grading change should be fully recorded within the electronic record.
- Timely and comprehensive documentation including outcome of MDT case discussions and follow up arrangements.
- The team is recommended to ensure that multi-disciplinary clinical decision making and outcomes for care and treatment is recorded in the service user's clinical notes.

## *3) Risk Assessment issues (joint #3):*

Risk assessment issues have been in the top 6 in the last two years. There were 15 actions relating to risk assessment. These have been grouped by broad sub-theme:

| | Barnsley General Community Services | Barnsley Mental Health | Calderdale | Kirklees | Specialist Services | Wakefield | Total |
|---|---|---|---|---|---|---|---|
| Monitoring compliance | 1 | 0 | 1 | 4 | 1 | 1 | 8 |
| Changes in risk | 0 | 1 | 0 | 1 | 0 | 1 | 3 |
| Inadequate exploration of risk | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| Transitions in care | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Training | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Record keeping | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| **Total** | **2** | **1** | **2** | **6** | **1** | **3** | **15** |

Below is a summary of the actions identified:

### Changes in risk

- Risk assessments must be updated with any new relevant risk information with instances of increased risk or attempted harm being shared with the team via the morning meeting.
  The risk assessment was not updated to reflect reported incidents of self-harm
  The family were not involved in care planning including risk assessment and formulation of risk
  There was limited communication with the family at points of transition and when changes in the plan of care had been made
- Ensuring risk assessments are updated when risks change

### Monitoring compliance

- That the Trust considers how it could be assured through audit or other means, that risk assessment and management plans are effectively communicated and implemented when patient care is transferred.

- That the Trust considers through audit or other means how comprehensive, up to date and accurate risk assessment and management plans are with regard to physical or environmental problems, and whether these are fully implemented.
- The service needs to provide assurance that all service users are discharged from the acute ward with a review of existing level two risk assessments having taken place.
  It is acknowledged that the Trust is currently reviewing all risk assessment processes. It is recommended that this review makes reference to in-patient stays of short duration where it is not possible to convene a multi-disciplinary team to discuss and review level two risk assessments.
- There must be a clinical audit on the ward (and possibly wider) to review the current state of risk assessments
- The service needs to provide assurance that risk assessments are being completed in line with Trust policy.
- All services should ensure that level 2 risk assessments are updated in accordance to operational policy and procedure and that risk assessments are closed to future editing at the time of completion.
- Monitoring of completion of Waterlow Risk assessments
- Systems used to monitor completion of risk assessments and care plans (including crisis and contingency plan) remain up to date.

### Record keeping

- The system of having risk assessment forms prepopulated with the last risk information should be reviewed in order to ensure the risk of inaccurate information being perpetuated is minimised and to ensure that there is a robust assessment of current risk.

### Training

- Provide further training to staff members in Waterlow risk scoring to ensure that staff members has an understanding of how Long term conditions (LTC) in can impact on Waterlow scores and decisions in the provision of pressure relieving equipment.
- Moisture Lesion Pathway: Ensuring at appropriate Risk assessments are carried out when pressure damage of any grade / treatment is identified.

### Transitions in care

- Risk management plans should be completed prior to ward transfers and where possible personal behaviour support plans.

### Inadequate exploration of risk

- Where service users have overdosed on medications, the risk assessment should extend to understanding the origins of the medications and whether additional access to other medications is a considered risk. Reducing the access to additional means to self-poison/deliberately overdose should be considered a care action as part of the assessment.

## *4) Communication (joint #3):*

Communication has been in the top 6 in the last two years. There were 15 actions relating to risk assessment. These have been grouped by broad sub-theme:

| | Barnsley General Community Services | Calderdale | Kirklees | Wakefield | Total |
|---|---|---|---|---|---|
| Communication with other agencies | 0 | 0 | 1 | 2 | 3 |
| MDT | 2 | 0 | 0 | 0 | 2 |
| Care delivery | 0 | 1 | 0 | 0 | 1 |
| Communication - service contact details to patient | 0 | 0 | 0 | 1 | 1 |
| Communication between colleagues in team | 0 | 1 | 0 | 0 | 1 |
| Communication not completed following discharge | 0 | 0 | 1 | 0 | 1 |
| Dual diagnosis | 0 | 1 | 0 | 0 | 1 |
| Record keeping | 0 | 0 | 0 | 1 | 1 |
| Team roles | 0 | 0 | 0 | 1 | 1 |
| Specialist advice | 0 | 0 | 0 | 1 | 1 |
| Poor sharing of information between services | 0 | 0 | 0 | 1 | 1 |
| Inadequate transfer of information between services, including discharge summaries from ward | 0 | 1 | 0 | 0 | 1 |
| **Total** | **2** | **4** | **2** | **7** | **15** |

Below is a summary of the actions identified:

### Care delivery

- Where other agencies are involved the Intensive Home Based Treatment Team to ensure effective joint working with them is evidenced throughout a service user's episode of care.

### Communication - service contact details to patient

- Ensure service users are aware of how to contact the service whilst awaiting access to groups.

### Communication between colleagues in team

- Check that notifications go to an administrator/duty worker to ensure the message is picked up and actioned in a timely way

### Communication not completed following discharge

- The Intensive Home Based Treatment Team (IHBTT) needs to provide assurance that discharges from their service is being documented in line with Trust policy

### Communication with other agencies

- The Psychiatric Liaison Team practitioners will ensure that when making a referral for a Mental Health Act assessment that they will call the Intensive Home Based Treatment team to advise them of this action.
- Where partnership working is identified across other organisations, all efforts should be made to approach investigations jointly to optimise information sharing and learning
- The Intensive Home Based Treatment Team should seek to strengthen the connections with the external agencies for reduction in harmful alcohol use. A review of the tools in use in this area should be conducted and the team should seek to mirror the use of such tools when creating care actions and interventions for those people where alcohol misuse is identified.

### Dual diagnosis

- Review links with Recovery Steps as per Trust's Dual Diagnosis Policy

### Record keeping

- Letter templates to be signed from a named professional to support effective engagement and provide a point of contact with the service.

### Team roles

- A written management/contingency plan should be provided to the acute trust department by the Psychiatric Liaison Team detailing onward referral, management of risks and the need to refer back where risks have changed

### Specialist advice

- When the transfer/admission of a service user with a violent history occurs, where clinically indicated staff should as soon as possible seek advice from the Reducing Restrictive Practice and Interventions team on how to manage the service user.

### MDT

- Outcome of the learning event to include a plan of how the teams can develop a MDT approach to care to ensure joint working and improved communication
- The Patient Safety Strategy BDU action plan to include specific actions around MDT working and a flexible workforce to improve communication and patient experience
- Poor sharing of information between services
- The Single Point of Access team to discuss communication issues with the Turning Point Talking Therapies in the interface meeting.

### Inadequate transfer of information between services, including discharge summaries from ward

- Medics discharge summaries should be opened and updated to reflect current patient presentation with a plan for ongoing treatments including medication arrangements and made available to General Practitioners within 24 hours as per operational policy and procedure.

## Implementation of recommendations and actions

Work to ensure monitoring and implementation of all Serious Incident action plans continues through the Operational management group and BDU Serious incident meetings.

BDUs ensure that recommendations and resulting actions are SMART and that evidence is collected against each action to demonstrate implementation. BDUs are asked to develop actions that will result in change when creating their plans.

Some Business Delivery Units hold regular learning lessons events that look at the themes of learning and have presentations on key topics. All BDUs are supported to hold these events and feedback from the events run have been very positive.

A Trust wide event was held in June 2019 which brought the opportunity for BDUs to share their learning more widely. The Patient Safety Support Team share learning from serious incidents in the learning library by sharing Executive summaries.

A common question asked is if investigations and recommendations change practice. This is difficult to answer. Over the number of years we have been analysing action themes, the top 6 themes have remained fairly similar. The type of incidents and teams involved will affect this. We are developing methods of thematic review through the Clinical Mortality Review Group which focuses attention on an individual theme to extract the common messages for particular incident types, with the intention to share these messages across the Trust. This work is being developed and will evolve over time

beyond deaths. One challenge is not losing sight of the original incident and retaining the meaning behind the action.

Anecdotally, we know the investigation process is valued by individuals and teams and we know the quality of reports is generally high from the Commissioners' reviews and the Trust processes are well regarded.

# Section 4 Learning from healthcare deaths

## Introduction

Scrutiny of healthcare deaths has been high on the government's agenda for some time. In line with the National Quality Board report published in 2017, the Trust has had Learning from Healthcare Deaths policy in place since September 2017 that sets out how we identify, report, investigate and learn from a patient's death. The Trust has been reporting and publishing our data on our website since October 2017.

Most people will be in receipt of care from the NHS at the time of their death and experience excellent care from the NHS for the weeks, months and years leading up to their death. However, for some people, their experience is different and they receive poor quality care for a number of reasons including system failure.

The Five Year Forward View for Mental Health identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people. Therefore, it is important that organisations widen the scope of deaths which are reviewed in order to maximise learning.

The Confidential Inquiry into premature deaths of people with learning disabilities showed a very similar picture in terms of early deaths.

The Trust has worked collaboratively with other providers in the North of England to develop our approach. The Trust will review/investigate reportable deaths in line with the policy. We aim to work with families/carers of patients who have died as they offer an invaluable source of insight to learn lessons and improve services.

All deaths that are in scope are reported to Trust Board each quarter. The latest reports are published on the Trust website.

## Scope

The Trust has systems that identify and capture the known deaths of its service users on its electronic patient administration system (PAS) and on its Datix system where the death requires reporting.

The Trust introduced our Learning from healthcare deaths policy in 2017. Staff report deaths where there are concerns from family, clinical staff or through governance processes and where the Trust is the main provider of care. This is what we refer to as 'in scope deaths' (further details are available in the Learning from Healthcare Deaths policy). The policy has continued to be reviewed and updated to reflect national guidance.

## Learning from Healthcare Deaths reporting

During 2019/20, 3262 deaths (row one in Figure 20) were recorded on our clinical systems (figure correct at 15/5/20). This figure relates to deaths of people who had any form of contact with the Trust within 180 days (approx. 6 months) prior to death, identified from our clinical systems through Business Intelligence software. This includes services such as end of life, district nursing and care home liaison services. Of note is that for a large number of cases, the Trust was not the main provider of care at the time of death.

**Figure 20 Summary of 2019/20 Annual Death reporting by financial quarter***

| | Quarter 1 2019/20 | Quarter 2 2019/20 | Quarter 3 2019/20 | Quarter 4 2019/20 | 2019/20 total |
|---|---|---|---|---|---|
| 1) Total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death | 778 | 700 | 902 | 882 | 3262 |
| 2) Total number of deaths reported on Datix by staff (by reported date, not date of death) | 74 | 78 | 95 | 108 | 355 |
| 3) Total number of deaths reviewed | 74 | 78 | 95 | 108 | 355 |
| 4) Total Number of deaths which were in scope | 63 | 61 | 80 | 82 | 286 |
| 5) Total Number of deaths reported on Datix that were not in the Trust's scope | 4 | 15 | 12 | 21 | 52 |
| 6) Total Number of reported deaths which were rejected following review, as not reportable or duplicated. | 7 | 2 | 3 | 5 | 17 |

*Data extracted from Business Intelligence Dashboards and Datix risk management systems. Data is refreshed each quarter so figures may differ from previous reports. Data changes where records may have been amended or added within live systems. Dashboard format and content as agreed by Northern Alliance group

Not all these deaths were reportable as incidents on Datix. Row 2 in Figure 20 shows that 355 deaths were reported on Datix in the year, with the quarterly breakdown. The yearly total is an increase on 2018/19 (307).

All deaths reported on Datix are reviewed by the patient safety support team to ensure they meet the scope criteria. For 2019/20, 286 deaths were in scope and subject to one of the 3 levels of scrutiny the Trust has adopted in line with the National Quality Board guidance (figure 21):

**Figure 21 National Quality Board Levels of mortality scrutiny**

| **In scope deaths should be reviewed using one of the 3 levels of scrutiny:** | | |
|---|---|---|
| Level 1 | Death Certification | Details of the cause of death as certified by the attending doctor. |
| Level 2 | Case record review | Includes:<br>(1) Managers 48 hour review (first stage case note review)<br>(2) Structured Judgement Review |
| Level 3 | Investigation | Includes:<br>Service Level Investigation<br>Serious Incident Investigation (reported on STEIS)<br>Other reviews e.g. Learning Disability Review Programme (LeDeR), safeguarding. |

Each quarter, there are a number of reported deaths that do not meet the Learning from Healthcare Deaths reporting criteria which receive no further review. These are not in scope and are not included in data report, although the record remains on Datix.

For the purpose of this section, the date of reporting on Datix is used rather than the date of death. This is to ensure all deaths are systematically reviewed. The figures may differ from other sections of the report.

Figure 22 shows the 286 in scope deaths reported by the service areas.

**Figure 22 In scope deaths reported by financial quarter and service type**

| | Mental Health Community | Mental Health Inpatient | General Community | General Community Inpatient | Learning Disability | CAMHS and ADHD | Forensic Services | Total Number of Deaths reviewed |
|---|---|---|---|---|---|---|---|---|
| Quarter 1 | 45 | 3 | 3 | 0 | 12 | 0 | 0 | **63** |
| Quarter 2 | 40 | 4 | 3 | 0 | 14 | 0 | 0 | **61** |
| Quarter 3 | 65 | 5 | 0 | 0 | 9 | 0 | 1 | **80** |
| Quarter 4 | 61 | 5 | 3 | 1 | 11 | 0 | 1 | **82** |
| **Year total** | **211** | **17** | **9** | **1** | **46** | **0** | **2** | **286** |

The 286 in scope deaths were reviewed in line with the National Quality Board levels of scrutiny as outlined in Figure 21. Figure 23 shows the in scope deaths by financial quarter they were reported in, against the review level and process. Figures 24 and 25 show the deaths BDU and category.

**Figure 23 Learning from Healthcare Deaths during 2019/20 by financial quarter and mortality review process**

| Financial quarter | Level 1 | Level 2 | | Level 3 | | | | Total |
|---|---|---|---|---|---|---|---|---|
| | Death certified | Manager's 48 hour review | Structured Judgment Review (SJR) | Service Level Investigation | Serious Incident Investigation | Learning Disability Mortality Review (LeDeR) | Other investigation | |
| Quarter 1 | 23 | 8 | 8 | 0 | 9 | 14 | 1 | 63 |
| Quarter 2 | 13 | 15 | 8 | 1 | 10 | 14 | 0 | 61 |
| Quarter 3 | 35 | 16 | 9 | 2 | 8 | 8 | 2 | 80 |
| Quarter 4 | 34 | 16 | 6 | 1 | 10 | 13 | 2 | 82 |
| **2019/20 total** | 105 | 55 | 31 | 4 | 37 | 49 | 5 | 286 |

**Figure 24 Reported In scope deaths by financial quarter (date reported) and BDU 2019/20**

| | Barnsley General Community Services | Barnsley Mental Health | Calderdale | Kirklees | Wakefield | Forensic Service | Specialist Services | Total |
|---|---|---|---|---|---|---|---|---|
| 19/20 Q1 | 3 | 8 | 15 | 14 | 11 | 0 | 12 | 63 |
| 19/20 Q2 | 3 | 6 | 11 | 11 | 16 | 0 | 14 | 61 |
| 19/20 Q3 | 0 | 11 | 12 | 26 | 21 | 1 | 9 | 80 |
| 19/20 Q4 | 4 | 11 | 8 | 19 | 28 | 1 | 11 | 82 |
| **Total** | **10** | **36** | **46** | **70** | **76** | **2** | **46** | **286** |

**Figure 25 Reported deaths by category and BDU reported during 2019/20**

| | Barnsley General Community Services | Barnsley Mental Health | Calderdale | Kirklees | Wakefield | Forensic Service | Specialist Services | Total |
|---|---|---|---|---|---|---|---|---|
| Death - confirmed from physical/natural causes | 5 | 18 | 26 | 34 | 51 | 1 | 30 | 165 |
| Death - cause of death unknown/ unexplained/ awaiting confirmation | 5 | 10 | 8 | 14 | 7 | 0 | 10 | 54 |
| Suicide (incl apparent) - community team care - current episode | 0 | 5 | 6 | 9 | 13 | 0 | 1 | 34 |
| Death - confirmed from infection | 0 | 1 | 0 | 0 | 3 | 0 | 5 | 9 |
| Suicide (incl apparent) - community team care - discharged | 0 | 0 | 4 | 4 | 1 | 0 | 0 | 9 |
| Death - confirmed related to substance misuse (drug and/or alcohol) | 0 | 0 | 2 | 5 | 1 | 0 | 0 | 8 |
| Suicide (incl apparent) - inpatient care - current episode | 0 | 0 | 0 | 2 | 0 | 1 | 0 | 3 |
| Death - confirmed as accidental | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 2 |
| Death of service user by homicide (alleged or actual) | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 2 |
| Total | 10 | 36 | 46 | 70 | 76 | 2 | 46 | 286 |

Understanding the data around the deaths of our service users is a vital part of our commitment to learning from all deaths. We will continue to develop this over time, for example by looking into some areas in greater detail and by talking to families about what is important to them. We will also learn from developments nationally as these occur.

## Deaths reported as SIs

Of the 286 in scope deaths reported on Datix between 1 April 2019 and 31 March 2020, 37 were reported as serious incidents. Three of these cases were later withdrawn as serious incidents after the investigation revealed that care was as it should have been and no learning was identified. This is in agreement with commissioners.

Please note this figure will not necessarily match those reported in the Serious Incident section of this report due to the use of different dates for different processes (Serious incident reporting uses date reported on STEIS; mortality uses date reported on Datix).

## Apparent suicides

The apparent suicides will be reported on further in the Apparent Suicide annual report which will be available later in the year. The figures will be based on the live data, so may not match figures in this report.

## Learning from Deaths findings

Learning from deaths report is prepared quarterly and included in the Quarterly Incident reports. On six monthly basis, an analysis report is prepared to consider our findings.

## Section 5 - Key Actions and Areas for Development in 2020/21

Recent years have seen substantial developments in mortality processes, processes supporting the review, investigation, management and learning from incidents in the Trust along with the ongoing development of staff within the patient safety support team. This provides a secure platform from which to develop further.

Plans for 2020/21 include:

- Implementation of actions identified in a recent 360 Assurance report following an audit Incident reporting and associated processes.
- Review of policies:
    - Incident Reporting and Management (including Serious Untoward Incidents) policy
    - Investigating and analysing incidents, complaints and claims to learn from experience policy.
- There are two major changes anticipated arising from the NHS Patient Safety Strategy relating directly to Incident reporting and management. This will include:
    - Work to connect Datix to the new Patient Safety Incident Management System (PSIMS) which will replace NRLS and StEIS systems. Timescales will be given by NHS Improvement.
    - Implementation of the new Patient Safety Incident Response Framework (PSIRF) which will replace the Serious Incident Framework. Full implementation is anticipated by July 2021.
- Work to realign Datix with new BDU structures. It is acknowledged that this work is outstanding from Q4 2019/20 but has been delayed during Covid 19 period.
- Review operational interconnectivity within Patient Safety Support Team alongside strengthening governance arrangements with BDUs.
- Partake in Royal College of Psychiatrists Serious Incident Review Accreditation Network (SIRAN), expected September 2020.

Patient Safety Support Team
2/6/2020

South West Yorkshire Partnership NHS Foundation Trust

**Members' Council**
**31 July 2020**

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| **Agenda item:** | **7.10** |
| **Report Title:** | **Review of Audit Committee Terms of Reference** |
| **Report By:** | Audit Committee Chair on behalf of the Audit Committee |
| **Action:** | To receive |

Purpose

The purpose of this item is to consult with the Members' Council on the updates to the Audit Committee's Terms of Reference. The updates were approved by the Trust Board at their meeting on 28 April 2020. It is noted that the update to Members' Council was deferred to the July meeting due to a reduced agenda at the previous meeting on 1 May 2020 due to Covid-19.

**Recommendation**

**The Members' Council is asked to NOTE and CONSIDER the updates to the Terms of Reference for the Audit Committee.**

Background

In 2015, at the request of the Audit Committee, the Committee received a presentation from Deloitte on audit committee effectiveness and best practice. The Committee compared well against best practice and a number of actions were identified for further development. These were agreed with the Chair of the Committee and included a small number of suggested revisions to the Committees terms of reference. The terms of reference continue to be reviewed on an annual basis to ensure they remain fit for purpose as part of the Committee's annual report to Trust Board, which is presented in April each year.

One of the actions suggested by Deloitte and agreed with the Chair to take forward was consultation with the Members' Council on the Audit Committee's Terms of Reference. This reflects provision C.3.2b in NHS Improvement / Monitor's Code of Governance for foundation trusts that "*The council of governors should be consulted on the terms of reference, which should be reviewed and refreshed regularly*". In accordance with the Members' Council work programme any updates to the Audit Committee's Terms of Reference are presented for the Members' Council to consider.

In 2020, some minor updating has been incorporated within the Audit Committee's Terms of Reference which include updating the authority section to obtain 'external' legal or independent professional advice, previously 'outside'; replacement of

references to ‘Monitor’ with ‘NHS England & Improvement’; and replacement of ‘NHS Protect’ with ‘NHS Counter Fraud Authority’.

The proposed amendments were considered by the Audit Committee on 14 April 2020 who supported their formal approval by Trust Board on 28 April 2020.

South West Yorkshire Partnership NHS Foundation Trust

# AUDIT COMMITTEE
## Terms of Reference
*To be approved by Trust Board 28 April 2020*

All Trust Board Committees are responsible for the scrutiny, monitoring and provision of assurance to Trust Board on key issues set out in their terms of reference and / or allocated to them by the Board. Agendas are set to enable Trust Board to receive assurance that scrutiny and monitoring processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Audit Committee was established in June 2002. The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role, any changes to other committees and revised membership. The Audit Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by Trust Board. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

## Purpose
The Audit Committee's prime purpose is to keep an overview of the systems and processes that provide controls assurance and governance within the organisation as described in the Annual Governance Statement on behalf of Trust Board and that these systems and processes used to produce information taken to Trust Board are sound, valid and complete. This includes ensuring independent verification on systems for risk management and scrutiny of the management of finance. On behalf of the Trust Board, it will have an oversight of related risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

## Membership
Taking guidance from Monitor (referred to as NHS England & Improvement) and the Department of Health into consideration, neither the Chair of the Trust or the Chief Executive attends this Committee unless invited to do so. The Committee is always chaired by a Non-Executive Director of the Trust and the membership consists of a minimum of two other Non-Executive Directors.

*Membership as at 1 April 2020*
Chair – Non-Executive Director - Laurence Campbell
Non-Executive Director - Chris Jones
Non-Executive Director - Sam Young.

## Attendance
The Director of Finance and Resources is in attendance (as lead Director) at meetings. The Company Secretary also attends meetings. Representatives of internal and external audit are also invited and expected to attend. The Chair of the Trust, the Chief Executive, other Directors, and relevant officers attend the Audit Committee by invitation. Administrative support is provided by the Personal Assistant to the Director of Finance and Resources



With all of us in mind.

## Quorum

The quorum will be two Non-Executive Director members. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair.

## Frequency of meetings

The Committee will meet a minimum of four times per year to reflect best practice. The Chair of the Committee, External Auditor or Head of Internal Audit may request a meeting if they consider one is necessary. There will also be an additional meeting to approve the annual report, accounts and Quality Accounts.

It is the responsibility of the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation, and to agree these with the Chair of the Committee.

## Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed by Trust Board to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain external legal or other independent professional advice and to secure the attendance of external bodies or individuals with relevant experience and expertise if it considers this necessary.

## Sub-committees

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-committees.

## Duties

<u>Governance, risk management and internal control</u>

The Committee shall review the establishment and maintenance of effective systems and processes that provide internal control within the organisation. In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements, in particular, the Annual Governance Statement and declarations of compliance with value for money assessments together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by Trust Board;
- the underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of management of principal risks and the appropriateness of the above disclosure statements. This includes assessing the fitness for purpose of the assurance framework including risk appetite and providing assurance that action plans are in place to address significant control issues;
- the policies and processes for ensuring compliance with relevant regulatory, legal and code of conduct requirements, including the NHS England & Improvement risk assessment framework;
- the systems for internal control including the risk management strategy, risk management systems and the risk register;

- the policies and procedures for all work related to fraud and corruption as set out in the Secretary of State's directions and as required by the Counter Fraud and Security Management Service;
- the work of other committees whose work can provide relevant assurance regarding the effectiveness of controls and governance arrangements.

In carrying out its work, the Committee will primarily utilise the work of Internal and External Audit; however, it will not be limited to these audit functions. It will also seek reports and assurances from Directors and managers concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness. The Committee will use the Trust's Assurance Framework to guide its work and that of the audit and assurance functions reporting to it.

The Committee will also review arrangements that allow Trust staff (and other individuals where relevant) to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The Committee will ensure that:

- arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action;
- ensure safeguards for those who raise concerns are in place and that these safeguards operate effectively;
- such processes enable individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations and to ensure valid concerns are promptly addressed; and
- these processes reassure individuals raising concerns that they will be protected from potential negative repercussions.

Internal Audit

The Committee shall consider the appointment of the Internal Auditor (for approval by Trust Board) and ensure there is an effective internal audit function established by management that meets Public Sector Internal Audit Standards, that provides appropriate independent assurance to the Audit Committee, Chief Executive, Chair and Trust Board. This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation or dismissal;
- review and approval of the Internal Audit approach, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
- consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between internal and external auditors to optimise audit resources;
- ensure the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
- annual review of the effectiveness of internal audit.

External audit

The Committee shall review the work and findings of the External Auditor appointed by the Members' Council and consider the implications and management's responses to its work. This will be achieved by:

- consideration of the appointment and performance of the External Auditor, as far as NHS England & Improvement's rules permit;

- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the annual audit plan and ensure co-ordination, as appropriate, with other external auditors in the local health economy;
- discussion with the External Auditors of its local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;
- review of External Audit reports, including agreement of the annual audit letter before submission to Trust Board and any work carried on outside of the annual audit plan, together with the appropriateness of management responses;
- Review of each individual provision of non-audit services by the External Auditor in respect of its effect on the appropriate balance between audit and non-audit services.

The Committee will also advise the Members' Council with regard to the appointment and removal of the Trust's external auditors and, to inform this advice, carry out a market testing exercise for the appointment of the external auditor at least every five years.

Counter fraud

The Committee shall review the work and findings of the Local Counter Fraud Specialist as set out in the NHS Counter Fraud Authority Standards for Providers and as required by the NHS Counter Fraud Authority. In particular:

- consider the appointment of the Trust's Local Counter Fraud Specialist, the fee and any questions of resignation or dismissal;
- review the proposed work plan of the Trust's Local Counter Fraud Specialist ensuring that it promotes a pro-active approach to counter fraud measures;
- receive and review the annual report prepared by the Local Counter Fraud Specialist;
- receive update reports on any investigations that are being undertaken.

Financial reporting

The Committee has responsibility for approving accounting policies. It also has delegated authority from Trust Board to review the annual report and financial statements, both for the Trust and for charitable funds, and the Quality Accounts/Report on its behalf and to make a recommendation to the Chair and Chief Executive on the signing of the accounts and associated documents prior to submission to NHS England & Improvement, Trust Board and the Members' Council. In particular, the Committee shall focus on:

- changes in, and compliance with, accounting policies and practices;
- major judgemental areas; and
- significant adjustments arising from the annual audit.

The Committee also ensures that the systems for, and content of, financial reporting to Trust Board, including those of and for budgetary control, are subject to review so as be assured of the completeness and accuracy of the information provided to Trust Board.

The Committee also:

- reviews proposed changes to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation before these are laid before Trust Board;
- examines the circumstances associated with each occasion Standing Orders are waived;
- reviews schedules of losses and compensations on behalf of Trust Board.

## Relationship with the Members' Council

To reflect best practice and NHS England & Improvement's Code of Governance, Trust Board will consult with the Members' Council annually on the Audit Committee's terms of reference. At the discretion of the Chair of the Committee and / or the Chair of the Trust, governors may be invited to attend meetings of the Committee to support the Members' Council in meeting its duty to hold Non-Executive Directors to account for the performance of the Board.

## Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to Trust Board.

## Reporting to Trust Board

Trust Board will receive the minutes of Committee at the Trust Board meeting following the Committee meeting. The Committee will also report to the Board annually on its work and include commentary on its support of the Annual Governance Statement, the effectiveness of assurance systems, the work of internal and external audit and the annual accounting process.

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups.

**To be approved by Trust Board: 28 April 2020**
**Next review due: April 2021**

South West Yorkshire Partnership NHS Foundation Trust

**Members' Council**
**31 July 2020**

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| **Agenda item:** | **8.1** |
| **Report Title:** | Re-appointment of the Chair |
| **Report By:** | Head of Corporate Governance (Company Secretary) and Corporate Governance Manager on behalf of the Nominations Committee |
| **Action:** | To approve |

Purpose and format

For the Members' Council to consider the proposal from the Nominations Committee to re-appoint Angela Monaghan as Chair of the Trust for a further three year term from 1 December 2020, with a review after 12 months. The Chair's profile and role description are attached with this paper for consideration. The Members' Council is also asked to consider the proposal from the Nominations Committee regarding the review of the Chair's remuneration.

**Recommendation**

**The Members' Council is asked to:**

- **CONSIDER and AGREE to the recommendation from the Nominations Committee of re-appointment of Angela Monaghan as Chair from 1 December for a three year term. In the initial period she will remain on her current remuneration.**

- **CONSIDER and AGREE to the recommendation that a remuneration review takes place at the Nomination Committee following approval of the interim appraisal. Any recommendation for progression to the top of the pay range will be made to the Members Council for approval in October 2020 with a view to being implemented on 1st December 2020.**

Background

Following a recruitment process and approval at Members' Council on 3 November 2017, Angela Monaghan was appointed at Chair of the Trust from 1 December 2017 to 30 November 2020.

Process

Following indication from the Chair that she would be willing to be considered for re-appointment for a three year term (with a review after 12 months), the Nominations Committee considered the Chair's reappointment at the meeting held on 23 June



With all of us in mind.

2020. The committee considered the Chair's appraisal completed in January 2020 and subsequent mid-year appraisal taking into consideration the impact of Covid-19 on the Chair's performance and objectives. The mid-year appraisal took place to bring the chairs appraisal in line with other NED's.

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 / Deputy Lead Governor.

In accordance with the Trust's Constitution under the Standing Orders for the Practice and Procedure of the Trust Board (within the Trust's Constitution), section 3.8 states: *"The Chair and Non-Executive Directors will be appointed by the Members' Council for an initial period of three years or as determined by the Nominations Committee… Non-Executive Directors may be re-appointed for a further three years (up to a maximum of nine years), subject to approval by the Members' Council following confirmation by the Chair that they have performed effectively and remain committed to the role. Appointments beyond six years will be subject to annual review."*

Remuneration

The Members' Council agreed to adopt the NHS Improvements and England's (NHSI&E) recommended pay range for Chairs on either reappointment or a new appointment. Previously the Chair was on a locally agreed incremental scale developed with external professional guidance (£42,420 p.a. - £45,450 p.a. - £47,975 p.a. - £50,500 p.a. - £53,025 p.a.) where progression up the scale was based on the annual appraisal.

The NHSI&E recommended pay range is £44,100pa (minimum) - £47,100pa (median) - £50,00pa (maximum). The Members' Council also agreed that the Chair's remuneration could progress along the pay range up to the maximum during their term of office.

The current remuneration of the Chair is £47,974pa, which is within the new pay range. The Chair moved to this incremental point on the 1 December 2019 the anniversary of her appointment following a review by the Nominations Committee and agreement by the Members' Council.

Under the old arrangements the Chair, subject to satisfactory performance, would have progressed to £50,500pa with effect from 1 December 2020. This will be considered by the Nominations Committee and a recommendation made to Members' Council in October 2020.

*Nominations Committee members: Charlotte Dyson, Marios Adamou, Bill Barkworth, Dylan Degman, John Laville, Ruth Mason*

South West Yorkshire Partnership NHS Foundation Trust

## Trust Board profile 2020

**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:<br>All aspects of the Trust's work, with a particular interest in:<br>➢ Staff, service user and carer engagement<br>➢ service improvement<br>➢ partnerships with the voluntary and community sectors<br>➢ equality and inclusion<br>➢ leadership<br>➢ governance<br>➢ strategic developments (including ICSs)<br><br>Trust Committee membership:<br>➢ Chair of Equality and Inclusion Forum<br>➢ Member of Clinical Governance and Clinical Safety Committee<br>➢ Member of Workforce and Remuneration and Committee<br>➢ Member of Charitable Funds Committee<br>➢ Chair of Members' Council<br>➢ Member of Members' Council Co-ordination Group<br>➢ Chair of Nominations' Committee<br><br>Partnership Group Membership<br>➢ Member of West Yorkshire Mental Health, Learning Disability and Autism Collaborative<br>➢ Member of West Yorkshire & Harrogate Health and Care Partnership Board<br>➢ 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.<br>➢ Former Chief Executive of a children's hospice.<br>➢ Former Non Executive Director and Chair of an NHS Primary Care Trust.<br>➢ Significant experience of non executive roles in a wide range of voluntary and community sector organisations. |
| **KEY DEVELOPMENT AREAS OVER THE NEXT 12 MONTHS** | ➢ Continue to strengthen knowledge and understanding of mental health, with a particular focus on autism.<br>➢ Complete Institute for Healthcare Improvement (IHI) Programme.<br>➢ Complete Board development programme.<br>➢ Reciprocal mentoring programme. |

South West Yorkshire Partnership NHS Foundation Trust

# The Chair role description

NHS trusts and foundation trusts are primarily responsible for delivering safe, high quality services and outcomes for patients, service users and the wider community.

**The chair has a unique role in leading the NHS trust board.** The role combines the duty to lead effective governance, consistent with the Nolan principles and NHS values, with securing a long-term vision and strategy for the organisation.

Fundamentally, the chair is responsible for the effective leadership of the board (and in foundation trusts, the council of governors). They are pivotal in creating the conditions necessary for overall board and individual director effectiveness.

Central to the chair's role are five key responsibilities:

1. **strategic**: ensuring the board sets the trust's long-term vision and strategic direction and holding the chief executive to account for achieving the trust's strategy

2. **people**: creating the right tone at the top, encouraging diversity, change and innovation, and shaping an inclusive, compassionate, patient-centred culture for the organisation

3. **professional acumen**: leading the board, both in terms of governance and managing relationships internally and externally

4. **outcomes focus**: achieving the best sustainable outcomes for patients/ service users by encouraging continuous improvement, clinical excellence and value for money

5. **partnerships**: building system partnerships and balancing organisational governance priorities with system collaboration; this role will become increasingly more important as local organisations move to delivering integrated care, prioritising population health in line with the NHS Long Term Plan.[1]

[1] www.longtermplan.nhs.uk

**The relationship between the chair and the trust's chief executive is key to the role's success.** The chair must cultivate an effective working relationship with the chief executive. Many responsibilities in the role description will be discharged in partnership with the chief executive. It is important that the chair and chief executive are clear about their individual and shared roles, and their respective responsibilities towards the unitary board.

The fundamental difference between these roles is that the chair leads the board and is responsible for the non-executive directors' effectiveness and the board as a whole. The chief executive leads the organisation and is responsible for managing the executive directors. In foundation trusts, the chair also chairs the council of governors. This special relationship between the chair and the chief executive sets the tone for the whole organisation.

# Role description

To carry out their role effectively, the chair must cultivate a strong, collaborative relationship with the chief executive. Many responsibilities in this role description will be discharged in partnership with the chief executive. It is important the chair and the chief executive are clear about their individual and shared roles, and their respective responsibilities towards the unitary board.

Together, the chair and the chief executive set the tone for the whole organisation. They are ultimately responsible for ensuring that the population the trust serves and the wider system in which the organisation sits receive the best possible care in a sustainable way.

# Responsibilities of the chair

This detailed description of the chair's role has been aligned with the competency framework's five domains. While each set of responsibilities has been aligned with the competency domain most relevant to discharging that element of the role, **a good chair will demonstrate competence in all five domains across all their responsibilities**, maintaining, for example, an outcomes focus while discharging their role as the board's facilitator.

1. **Strategic**

1.1. In their **strategic leadership** role, the trust chair is responsible for:

- ensuring the whole board of directors plays a full part in developing and determining the trust's **vision, values, strategy and overall objectives** to deliver organisational purpose and sustainability (and for foundation trusts, having regard to the council of governors' views)

- ensuring the trust's strategy aligns with the principles guiding the NHS and the NHS values

- ensuring the board identifies the key risks the trust faces in implementing its strategy; determines its approach and attitude to **providing effective oversight** of those risks and ensures there are **prudent controls** to assist in managing risk

- holding the chief executive to account for delivering the strategy and performance.

## 2. People

2.1. In their role **shaping organisational culture** and setting the right tone at the top, the trust chair is responsible for:

- providing visible leadership in developing a **healthy, open and transparent patient-centred culture for the organisation**, where all staff have equality of opportunity to progress, the freedom to speak up is encouraged, and ensuring that this culture is reflected and modelled in their own and in the board's behaviour and decision-making

- leading and supporting a **constructive dynamic** within the board, enabling grounded debate with contributions from all directors

- promoting the highest standards of **ethics**, **integrity, probity and corporate governance** throughout the organisation and particularly on the board

- demonstrating **visible ethical, compassionate and inclusive personal leadership** by modelling the highest standards of personal behaviour and ensuring the board follows this example

- ensuring that **constructive relationships based on candour, trust and mutual respect** exist between executive and non-executive directors (and for foundation trusts between elected and appointed members of the council of governors and between the board and the council)

- developing **effective working relationships** with all the board directors, particularly the chief executive, providing support, guidance and advice.

2.2. In their role **developing the board's capacity and capability**, the trust chair is responsible for:

- ensuring the board sees itself as a team, has the **right balance and diversity of skills, knowledge and perspectives**, and the confidence to challenge on all aspects of clinical and organisational planning; this includes:
  - regularly **reviewing the board's composition and sustainability** with the chief executive and the nominations committee
  - considering **succession planning** (and for foundation trusts, remuneration) for the board, including attracting and developing future talent (working with the board, council of governors and nominations and remuneration committees as appropriate)
  - considering the **suitability and diversity** of non-executive directors who are assigned as chairs and members of the board's committees, such that as far as possible they reflect the workforce and respective communities served by the board
  - where necessary, leading in seeking the removal of non-executive directors and giving counsel in the removal of executive directors
- leading on **continual director (and for foundation trusts, governor) development** of skills, knowledge and familiarity with the organisation and health and social care system, to enable them to carry out their role on the board/council effectively, including through:
  - induction programmes for new directors/governors
  - ensuring **annual evaluation** of the board/council's performance, the board's committees, and the directors/governors in respect of their board/council contribution and development needs, **acting on the results** of these evaluations and supporting personal development planning

  - taking account of their **own development needs** through, for example, personal reflection, peer learning and mentoring/reverse mentoring as part of the wider NHS provider chair community

- developing a board that is genuinely connected to and assured about staff and patient experience, as demonstrated by appropriate feedback and other measures, including the Workforce Race Equality Standard (WRES); Workforce Disability Equality Standard (WDES); and Equality Delivery System (EDS).

## 3. Partnerships

3.1. In their role as an **ambassador**, leading in developing **relationships** and **partnership working**, the chair is responsible for:

- promoting an **understanding of the board's role**, and the role of non-executive and executive directors

- representing the organisation externally, developing and facilitating strong partnerships, and promoting **collaborative, whole-system working** through engagement with:

  - patients and the public

  - members and governors (foundation trust)

  - all staff

  - key partners across public, private and voluntary sectors

  - regulators

  - other chairs in the system and the wider NHS provider chair community, including where appropriate, through:

    - integrating with other care providers

    - identifying, managing and sharing risks

    - ensuring decisions benefit the local population, prioritising the needs of the citizens served by the organisation at a system level

- ensuring that **effective communication with stakeholders** creates board debate encompassing diverse views, and giving sufficient time and consideration to **complex, contentious or sensitive issues**

- for foundation trusts, facilitating the council of governors' work on **member engagement,** so the governors can carry out their statutory duty to represent the interests of trust members and the general public to the trust

- for foundation trusts, ensuring that governors have the dialogue with directors they need to hold the non-executive directors (which includes the trust chair), individually and collectively to account for the board's performance.

## 4. Professional acumen

4.1. In their role as **governance lead** for the board **(and for the council of governors, in foundation trusts)**, the chair is responsible for:

- making sure the board/council operates effectively and understands its own **accountability** and compliance with its approved procedures – for example, meeting statutory duties relating to annual reporting

- personally **doing the right thing**, ethically and in line with the NHS values, demonstrating this to and expecting the same behaviour from the board

- leading the board in **establishing effective and ethical decision-making processes**

- **setting an integrated board/council agenda** relevant to the trust's current operating environment and taking full account of the **important strategic issues and key risks** it faces (and for foundation trusts, aligned with the annual planner for council of governors meetings, developed with the lead governor)

- ensuring that the board/council receives **accurate, high quality, timely and clear information**, that the related assurance systems are fit for purpose and that there is a good flow of information between the board, its committees, the council and senior management

- ensuring board committees are properly constituted and effective

- for foundation trusts: leading the board in being accountable to governors and leading the council in holding the board to account.

4.2. In their role as **facilitator** of the board (and of the council of governors for foundation trusts), the chair is responsible for:

- providing the environment for agile debate that considers the big picture
- ensuring the board/council collectively and individually applies **sufficient challenge**, balancing the ability to seize opportunities while retaining robust and transparent decision-making
- facilitating the **effective contribution** of all members of the board/council, drawing on their individual skills, experience and knowledge and in the case of non-executive directors, their independence
- working with and supporting the **trust board secretary** in establishing and maintaining the board's annual cycle of business
- for foundation trusts: liaising with and consulting the **senior independent director** (it is an expectation that all NHS trusts, that have not yet done so, will also seek to appoint a senior independent director in the short-medium term).

## 5. Outcomes focus

5.1. In their role as a **catalyst for change**, the chair is responsible for:

- ensuring all board members are well briefed on **external context** – eg policy, integration, partnerships and societal trends – and this is reflected in board/council debate
- fostering a **culture of innovation and learning**, by being outward-looking, promoting and embedding innovation, technology and transformation through the board/council's business and debate
- promoting **academic excellence and research** as a means of taking health and care services forward
- ensuring performance is accurately measured against constitutional and Care Quality Commission 'well-led' standards

- ensuring performance on equality, diversity and inclusion for all patients and staff is accurately measured and progressed against national frameworks, including WRES, WDES and EDS

- above all, ensuring the board maintains an unrelenting interest in and focus on the continuous improvement and self-assessment of patient safety, experience and clinical outcomes.

South West Yorkshire Partnership NHS Foundation Trust

**Members' Council**
**31 July 2020**

| | |
|---|---|
| **Agenda item:** | **8.2** |
| **Report Title:** | Non-Executive Director (NED) appointment |
| **Report By:** | Corporate Governance Manager and Company Secretary on behalf of the Nominations Committee |
| **Action:** | To approve |

## EXECUTIVE SUMMARY

Purpose and format

The purpose of this report is to update the Members' Council on the appointment of a Non-Executive Director (NED) to replace Laurence Campbell who is retiring from the Trust Board shortly. Governors will be asked to approve the recommendation from the Nominations Committee.

**Recommendation**

**The Members' Council is asked to RECEIVE the update and APPROVE the recommendation from the Nominations Committee to appoint of Mike Ford as a new Non-Executive Director.**

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 / Deputy Lead Governor.

Process

The Nominations Committee agreed the recruitment process to a Non-Executive post with the requirement that they are a qualified accountant. The timetable for recruitment was as follows:

- Post advertised nationally on a number of online recruitment websites the week commencing 27 January 2020.
- An Information event for potential candidates was held at Fieldhead.
- Closing date – 27 February 2020.
- Shortlist agreed by Nomination Committee – 6 March 2020.

Please note at this point the recruitment process was delayed due to the coronavirus and until such time a safe and effective method of recruitment could be agreed.

- 3 Stakeholder Group Sessions: Service Users / Carers; Governors; Staff – 27

May 2020.

- Final panel interviews – 10 June 2020.

The Nominations Committee met on 23 June 2020 and discussed and agreed the recommendations for appointment from the final interview panel. The attached paper outlines the recruitment process and panel decision.

During the Committee meeting a discussion took place around what had been asked of Mike Ford in relation to his values and the values of the Trust. It was reported that Mike spoke of wanting to use his skills to give something back, especially to Yorkshire, and he had admiration for the NHS and the important contribution it made. Mike had been involved in diversity work with the BBC and when asked questions by the panel his responses were authentic and credible.

His values of equality and inclusivity came across strongly during interview and it was clear that he had conducted a lot work around understanding the Trust and its values. While other candidates had to be asked, Mike was forthcoming with this information and he drew good comparisons about public funding and scrutiny from his work with the BBC.

On behalf of the Nominations Committee, the Chair is making the following recommendation to the Members' Council: **to APPOINT Mike Ford as Non-Executive Director for a period of three years from 1 September 2020.**

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# Non-Executive Director Recruitment 2020

## Candidate attraction

The Nominations Committee agreed the recruitment process for the Non-Executive Director (NED) vacancy following Laurence Campbell's decision not to seek reappointment. Taking account of the skills and experience of NEDs on the Board it was agreed to seek someone who was a qualified accountant. The position was advertised nationally through a combination of online recruitment websites including: Yorkshire Post On-Line, LinkedIn, NHSI/E public appointments and a number of other public sector appointment sites. In support of the recruitment process prospective applicants were able to have an informal discussion with the Chair and / or Deputy Chair and / or the Chief Executive and a drop-in event was held at Fieldhead.

The post was advertised week beginning 27 January 2020 with a closing date of the 27 February 2020.

## Shortlisting

Following the closing date, 11 applications were received. All the applications received were carefully reviewed by the Chair, Deputy Chair, Chair of the Finance, Performance and Investment Committee and Director of Human Resources, Organisational Development and Estates, and graded in one of four categories as shown below:

Grade 1 - Recommended for interview

Grade 2 - Strong Marginal for discussion

Grade 3 - Marginal for discussion

Grade 4 - Not recommended

The outcome of the review was that the 11 applications received were graded as follows:

Grade 1: 4
Grade 2: 1
Grade 3: 5
Grade 4: 1



With all of us in mind.

A detailed report was prepared for the Nominations Committee on the 6 March 2020 recommending a shortlist of the four candidates graded 1 for the final interviews. The report provided an overview of the background and relevant experience of all the candidates who applied with the reasons for either shortlisting or not.

The Nominations Committee agreed the four candidates to go forward to the final assessment.

**Final assessment**

The final assessment process was delayed due to the coronavirus and until such time a safe and effective assessment process could be arranged in line with Government guidance. In consultation with the shortlisted candidates and the interview panel, arrangements for the stakeholder sessions and the final interviews were agreed using Microsoft Teams.

The four shortlisted candidates selected for final assessment met using Microsoft Teams with the three focus group discussions on 27 May 2020 with:

- Governors
- Service users / carers
- Staff

The final interviews were held on 10 June 2020.

The interview panel members were:

- Angela Monaghan – Chair
- John Laville – Lead Governor
- Charlotte Dyson – Deputy Chair / Senior Independent Director
- Chris Jones – Non-Executive Director
- Cherill Watterston – Chair of the BAME Staff Equality Network

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

The panel asked a common set of questions to all candidates, covering the eight competencies set out in the person specification. They also asked follow-up questions of individual candidates, as appropriate, that took account of any areas for further testing identified by the three stakeholder groups. Each candidate was scored on a scale of 0-5 against the eight areas of competency.

Following all interviews, the candidate with the highest score, by a considerable margin, was Mike Ford. He was also the highest scoring candidate for each individual panel member, again by a considerable margin.

The panel were impressed with Mike's understanding of the role, in spite of not having previously worked in the NHS, and felt confident that he would be able to translate his experience and expertise successfully. He performed strongly across all competencies; in particular, they felt he demonstrated a clear understanding of and commitment to the values of the Trust, and gave a strong response to the questions on equality, diversity and inclusion. He is a clear thinker and an effective communicator, with a positive, approachable, engaging style. He showed good understanding and experience of service user engagement. He had clearly done his research on the trust and the role.

Overall, the panel felt that Mike's skills, expertise and experience strongly met the requirements and would strengthen the board.

**Panel Decision**

Following the interview process and feedback from the focus groups the unanimous decision of the panel was to recommend to the Nominations' Committee that Mike Ford is appointed as a NED with effect from 1 September 2020. The final recommendation for appointment will need to go the Members' Council on 31 July 2020.

**Term of office and remuneration**

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

The remuneration for the role is £13,584 per annum (as agreed by the Members' Council at its meeting on 1 November 2019).

**Recommendation**

**The Members' Council is asked to APPROVE the recommendation from the final interview panel and the Nominations Committee to appoint Mike Ford to the role of Non-Executive Director with South West Yorkshire Partnership NHS Foundation Trust for an initial three year term, with effect from the 1 September 2020.**

South West Yorkshire Partnership NHS Foundation Trust

**Members' Council**
**31 July 2020**

| | |
|---|---|
| **Agenda item:** | **8.3** |
| **Report Title:** | **Review of Chair and Non-Executive Director remuneration - process and timescales** |
| **Report By:** | Corporate Governance Manager 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 remuneration, and NOTE the changes to Non-Executive Director (NED) remuneration agreed in November 2019.**

Background

The Members' Council is responsible for determining and reviewing the remuneration arrangements for the Chair and Non-Executive Directors.

In November 2019, the Director of HR, OD and Estates updated the Members' Council in relation to a document published by NHS Improvement and NHS England titled 'Structure To Align Remuneration for Chairs and Non-Executive Directors of NHS Trusts and NHS Foundation Trusts'.

This document, which was published in September 2019 makes recommendations to NHS Foundation Trusts on levels of payments for Chairs and Non-Executive Directors. Whilst the statutory responsibility for determining the remuneration of the Chair and Non-Executive Directors remains with the Members Council, NHS Improvement and NHS England are expecting NHS Foundation Trusts to follow their structure and if not, explain the reasons why.

The structure sets out a flat rate of £13,000 per annum for a Non-Executive Director role. At the meeting on 1 November 2019, the Members' Council agreed to freeze current Non-Executive director remuneration and use the new structure for appointments or re-appointments but not increase remuneration until the national guidance rate was uplifted.



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The Members' Council also agreed to the new lower supplement of up to £2,000 per annum in recognition of designated extra responsibilities e.g. Chair of the Audit Committee, Senior Independent Director, upon appointment or reappointment.

The Members' Council agreed to adopt the recommended pay range of £44,100pa (minimum) - £47,100pa (median) - £50,00pa (maximum) for Chairs on either reappointment or a new appointment.

The current remuneration of the Chair is £47,974pa, which is within the new pay range. The Chair moved to this incremental point on the 1 December 2019 the anniversary of her appointment, following a review by the Nominations Committee and agreement by the Members' Council.

Under the old arrangements the Chair, subject to satisfactory performance, would have progressed to £50,500pa with effect from 1 December 2020. This will be considered by the Nominations Committee and a recommendation made to Members' Council in October 2020.

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# Members' Council annual work programme 2020/2021

**! – item amended to focus on Covid-19 and business continuity**
**# - item deferred**

| Agenda item/issue | 31 Jan 2020 | 1 May 2020 | 31 Jul 2020 | 30 Oct 2020 | 29 Jan 2021 |
|---|---|---|---|---|---|
| **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 | ✘ *recommend-dation for Chair's remuneration | |
| **Annual items** | | | | | |
| Evaluation / Development session | | | | | ✘ |
| Local indicator for Quality Accounts | ✘ | | | | ✘ |
| Annual report unannounced / planned visits | | # | | ✘ | |
| Care Quality Commission (CQC) action plan | | # | ✘ | | |
| Private patient income (against £1 million threshold) | | # *not required as under threshold | | | |
| Annual report and accounts | | | ✘ | | |
| Quality report and external assurance | | | ✘ | | |
| Customer services annual report | | | ✘ | | |



With all of us in mind.

| Agenda item/issue | 31 Jan 2020 | 1 May 2020 | 31 Jul 2020 | 30 Oct 2020 | 29 Jan 2021 |
|---|---|---|---|---|---|
| Serious incidents annual report | | | ✘ | | |
| Strategic meeting with Trust Board | | | | ✘ | |
| Trust annual plans and budgets, including analysis of cost improvements | | | | ✘ | |
| Members' Council Training & Development - Understanding NHS Finance | | | # *a separate session TBA | | |
| **Members' Council Business** | | | | | |
| Members' Council elections | ✘ *update | ✘ *outcome | | ✘ *process | ✘ *update |
| Chair's appraisal | ✘ | | ✘ *mid-year appraisal | | ✘ *process |
| Review and approval of Trust Constitution | ✘ | # | | | ✘ |
| Consultation / review of Audit Committee terms of reference | | # | ✘ | | |
| Members' Council Co-ordination Group annual report | | ✘ | | | |
| Members' Council Quality Group annual report | | ✘ | | | |
| Nominations' Committee annual report[1] | | # | ✘ | | |
| Appointment of Lead Governor | | ✘ | | | |
| Appointment of Trust's external auditors | | ✘ | | | |
| Holding Non-Executive Directors to account | | | # | ✘ | |
| Review of Members' Council objectives | | | | ✘ | |
| Members' Council meeting dates and annual work programme | | | | ✘ | |
| **Other items** | | | | | |
| Other agenda items to be discussed and agreed at Co-ordination Group meetings to ensure relevant and topical items are included. | ✘ | ✘ | ✘ | ✘ | ✘ |