1 May 2025

Chair's Office
Block 7
Fieldhead
Ouchthorpe Lane
Wakefield
WF1 3SP

Any queries in relation to this letter should be directed to Gemma Lockwood or Andrew Lister by email at gemma.lockwood@swyt.nhs.uk
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Dear Governor,

Members' Council meeting – 7 May 2025

The next Members' Council meeting will be held on Wednesday 7 May 2025. The meeting is hybrid, Microsoft Teams link and in-person at the Large Conference Room, Fieldhead Hospital, Ouchthorpe Lane, Wakefield.

The governors pre – meeting will start at 09.30 until 10.05.
The formal meeting will start at 10.05 and finish at 12.45 (public meeting).

The agenda for the meeting and papers for the Members' Council meeting are enclosed.

The meeting will take some items as read and ask for questions to be submitted in advance. These items are:
Item 4 - Matters arising from the previous meeting held on 14 February 2025
Item 5 - Chair's report and feedback from Trust Board
Item 6 - Chief Executive's report
Item 9.4 - Appointment to Members' Council groups
Item 9.5 - Assurance from Members' Council groups and Nominations Committee
Item 9.8 – Integrated Performance Report (IPR)

Please note items 9.9 and 12.1 are presentations that will be provided on the day of the meeting and circulated afterwards.

If you have any questions about any of the above items or issues of clarity in relation to the agenda and papers, it would be appreciated if they could be provided to Gemma

Lockwood, Corporate Governance Manager, on gemma.lockwood@swyt.nhs.uk by 12 noon on Tuesday 6 May 2025.

Please note, if you have requested to receive a hard copy of Members' Council papers, these are on their way to you. Governors are required to bring their copy into the meeting.

I hope you can join us on 7 May 2025.

Yours sincerely

Marie Burnham
Chair

South West Yorkshire Partnership NHS Foundation Trust

Members' Council meeting
7 May 2025 from 10.05 – 13.00

Microsoft Teams/
Large Conference Room, Fieldhead Hospital, Wakefield

Item	Approx. Time	Subject Matter	Lead		Action	Minutes allotted
	09.30	*Governors only pre-meet (30 minutes followed by 5-minute break)*	*John Laville, Lead Governor*			*30*
1.	10.05	Welcome, introductions and apologies	Marie Burnham, Chair	**Verbal**	To receive	2
2.	10.07	Declarations of interests	Marie Burnham, Chair	**Verbal**	To receive	3
3.	10.10	Minutes of the previous Members' Council meeting held on 14 February 2025	Marie Burnham, Chair	**Paper**	To approve	2
4.	10.12	Matters arising from the previous meetings held on 14 February 2025 and action log	Marie Burnham, Chair	**Paper**	To receive	3
5.	10.15	Chair's report and feedback from Trust Board (to be taken as read)	Marie Burnham, Chair	**Paper**	To receive	5
6.	10.20	Chief Executive's comments on the operating context	Mark Brooks, Chief Executive	**Paper**	To receive	10

Item	Approx. Time	Subject Matter	Lead		Action	Minutes allotted
7.	10.30	**Members' Council Business items (including annual items)**				
7.1	10.30	Appointment of Non-Executive Directors	The Chair	**Paper**	To approve	5
7.2	10.35	Appointment of Deputy Lead Governor	The Chair	**Paper**	To approve	5
7.3	10.40	Audit Committee Terms of Reference (annual item)	Andy Lister, Head of Corporate Governance	**Paper**	To receive	5
	10.45	*Break*				*15*
8	11.00	**Focus On item:** Quality Assurance System (QAS)	Darryl Thompson/Liam Redican/Sarah Whiterod	**Presentation**	To receive	30
9	11.30	**Members' Council Business items continued (including annual items**				
9.1	11.25	Quality monitoring visits annual report 23-24 (annual item)	Darryl Thompson, Chief Nurse Director of Nursing, Quality and Professions	**Paper**	To receive	5
9.2	11.30	Care Quality Commission (CQC) action plan	Darryl Thompson, Chief Nurse Director of Nursing, Quality and Professions	**Paper**	To receive	5
9.3	11.35	Quality Account update (annual item)	Darryl Thompson, Chief Nurse Director of Nursing, Quality and Professions	**Paper**	To receive	10
9.4	11.45	Appointment to Members' Council groups (to be taken as read and submit questions in advance)	Andy Lister, Head of Corporate governance	**Paper**	To receive	5

Item	Approx. Time	Subject Matter	Lead		Action	Minutes allotted
9.5	11.50	Members' Council groups and Nominations Committee annual reports (annual item): • Members' Council Co-ordination Group annual report 2024/25 including update to the Terms of Reference • Members' Council Quality Group annual report 2024/25 including update to the Terms of Reference • Nominations Committee annual report 2024/25 update to the Terms of Reference	Marie Burnham, Chair	**Paper**	To receive/ approve	5
9.6	11.55	Members' Council elections – outcome	Andy Lister, Head of Corporate Governance	**Paper**	To receive	5
9.7	12.00	Governor feedback	John Laville, Lead governor	**Verbal**	To receive	10
9.8	12.10	Integrated Performance Report (to be taken as read and questions to be submitted in advance)	Margaret Kitching, Non-executive Director	**Presentation**	To receive	10
9.9	12.20	Governor Capacity	John Laville, Lead governor	**Presentation**	To receive	15
10	12.35	**Closing remarks and annual work programme** Work programme 2025/26	Marie Burnham, Chair	**Paper**	To receive	2
11	12.37	**Any other business**	Marie Burnham, Chair	**Verbal**	To note	3
		Private Meeting (all executives and non-executives to leave)				
12.1	12.40	**Teaching Trust status**	Marie Burnham, Chair	**Presentation**	To receive	5
	12.45	*Close*				

Minutes of the Members' Council meeting
14 February 2025, 10.10 – 12.45

Hybrid meeting
Microsoft Teams and Fieldhead Hospital, Ouchthorpe Lane, Wakefield

Present:	Marie Burnham (MBu)	Chair
	Bob Clayden (BC)	Public - Wakefield
	Cllr Geraldine Carter (GC)	Appointed – Calderdale Council
	Warren Gillibrand (WG)	Appointed – University of Huddersfield
	Adam Jhugroo (AJh)	Public – Calderdale
	Elaine Lane (EL)	Staff – Allied Health Professionals
	John Laville (JLa)	Public – Kirklees (Lead Governor)
	John Lycett (JLy)	Public – Barnsley
	Valentina McParland	Public – Kirklees
	Andrea McCourt (AMc)	Appointed – Calderdale and Huddersfield NHS Foundation Trust
	Natalie McMillan (NMc)	Non-Executive Director/ Deputy Chair
	Reini Schühle (RS)	Public – Wakefield
	Phil Shire (PS)	Public – Calderdale
	Stephen Baines (SB)	Public – Calderdale
	Nesar Rafiq (NR)	Public – Wakefield
	Jacob Agoro (JA)	Staff – Nursing
	Daz Dooler (DD)	Public – Wakefield
	Susan Spencer (SS)	Appointed – Barnsley Hospital NHS Foundation Trust
	Emma Hall (EH)	Appointed – Mid Yorkshire Hospitals NHS Trust
	Keith Stuart-Clarke	Public – Barnsley
In attendance:		
	Mark Brooks (MBr)	Chief Executive
	Gary Ellis (GE)	Non-executive director
	Mike Ford (MF)	Non-executive director
	Izzy Worswick (IW)	Assistant director of corporate governance
	Jon Head (JHe)	Chief People Officer
	Margaret Kitching (MK)	Non-executive director
	Dawn Lawson (DL)	Executive director of strategy and change
	Darryl Thompson (DT)	Chief Nurse and Director of Quality and Professions
	David Webster (DW)	Non-Executive Director
	Adele Fox (AF)	Chief Operating Officer
	Andy Lister (AL)	Head of Corporate Governance / Company Secretary
	Andrew Betteridge (AB)	Corporate governance administrator
	Gemma Lockwood (GL)	Corporate governance manager
	Debbie Beynon-Fisher (DBF)	Corporate Governance Officer (author)
Apologies: Members' Council		
	Bob Morse (BM)	Public - Kirklees

	Claire Den Burger-Green (CDBG)	Public – Kirklees / Deputy governor lead
	Rosie King (RK)	Public – Wakefield
	Ian Grace (IG)	Staff – Medicine and Pharmacy
	Helen Dale (HD)	Staff – Nursing support
	Daniel Goff (DG)	Public – Barnsley
	Leonie Gleadall (LG)	Staff – Non-clinical support
	Sarah Leason – Hurley (SLH)	Staff – Social workers
	Melanie Mott (MM)	Staff – Psychological Therapies
	Anne Magee (AM)	Staff – Staff side
	David Webster (DW)	Non-executive director
	Erfana Mahmood (EM)	Non-executive director
	Fatima Shahzad	Public – Rest of Yorkshire and Humber
Apologies:	Adrian Snarr (AS)	Executive Director of Finance, Estates and Resources
	Sean Rayner (SR)	Director of provider development
	Professor Subha Thiyagesh (ST)	Chief Medical Officer

MC/25/01 Welcome, introductions and apologies (agenda item 1)

Marie Burnham (MBu) formally welcomed everyone to the meeting. Apologies were noted as above. The meeting was quorate and could proceed.

MBu reported that the meeting was being recorded to support minute taking, and that the recording would be deleted once the minutes had been approved (it was noted that attendees of the meeting should not record the meeting unless they had been granted authority by the Trust prior to the meeting taking place). Attendees who were joining virtually were requested to remain on mute, unless speaking.

MBu informed the meeting that David Webster (DW) had made the decision to stand down as non-executive director at the end of April 2025. MBu thanked DW for his hard work over the last 3 years.

MBu also noted that after 7 years as a non-executive director, Erfana Mahmood's (EM) term was coming to an end. Erfana's term was previously extended by 1 year however, in line with the terms set by NHS England, it is not possible to extend the term any further. MBu thanked EM for her outstanding support over the last 7 years. She advised that a process was already in place to support the recruitment to both non-executive director posts.

MBu advised that Claire Den Burger-Green (CDBG) had also announced her plans to stand down as deputy lead governor. MBu thanked Claire for her support and added that Claire will remain as a governor for the Trust. Nominations for the new deputy lead governor will be sought and a communication will be sent out from the Corporate Governance Team. It was noted that the appointment of deputy lead governors is dealt with through the Nominations Committee and Members' Council.

MBu introduced Adele Fox (AF) as the new chief operating officer for the Trust. Adele joined the Trust at the beginning of January and Mbu stated she had already had a positive impact.

MBu also advised that Julie Hall has been seconded to support the integration of Cheswold Park Hospital into the Trust and Izzy Worswick (IW) seconded into the role of assistant director

for corporate governance for the next 15 months and will oversee the Trust Board secretariat and issues related to corporate governance. IW was welcomed to the meeting.

It was RESOLVED to RECEIVE the welcome, introductions and apologies as described above.

MC/25/02 Declarations of interest (agenda item 2)

MBu asked governors if they had any declarations of interests. Governors did not share any additional declarations of interest.

It was RESOLVED to RECEIVE the individual declarations from governors.

MC/25/03 Minutes of the previous Members' Council meeting held on 15 November 2024 and Joint Members' Council and Trust Board meeting held on 15 November 2024 (agenda item 3)

It was noted that the spelling of Valentia McParland's name was incorrect on page 4 and page 19. It was agreed the minutes would be updated with the correct spelling.

Action – Corporate governance team

It was RESOLVED to APPROVE the minutes of the Members' Council meeting on 15 November 2024 and Joint Members' Council and Trust Board meeting held on 15 November 2024 as a true and accurate record.

MC/25/04 Matters arising from the previous meeting held on 15 November 2024 (agenda item 4)

John Laville (JLa) raised a query regarding the wording of action MC/24/87 and the frequency of updates being brought back to Members' Council. Dawn Lawson (DL) explained that the plan was to bring the Equality, Involvement, Communication and Membership (EICM) strategy back to Members' Council before it is finalised and once finalised it will be brought back to the meeting annually. It was agreed to reword the action to make it clearer.

Action – Corporate governance team

Bob Clayden (BC) requested feedback following the changes to the executive summary format. The meeting agreed that the revised format was helpful, and Andy Lister (AL) confirmed that the executive summary will continue to be produced in this format going forward.

It was RESOLVED to RECEIVE the action log of the Members' Council.

MC/25/04 Chair's report and feedback from Trust Board (agenda item 5)

MBu provided a summary of the chair's report and feedback from Trust Board and advised that the report provided a summary of the work undertaken by the chair and non-executive directors every week. MBu thanked the non-executive directors for their hard work and support to the Trust.

Mbu advised that the report also provided a summary of key events that have taken place since the last Members' Council meeting in November 2024 including the Crofton ward carol service attended by non-executive directors and the Fieldhead carol service attended by the chair.

MBu updated that the shadow board programme continues, which is run in conjunction with Leeds and York Partnership NHS Foundation Trust. The shadow board creates a safe learning space for aspirant directors, allowing participants to support their development in the right environment allowing them to flourish and experience what it is like to be a board director. MBu reported that the shadow board experience has proved successful so far.

MBu updated that the Trust is working towards Teaching Trust status, and that further updates would be provided in due course.

It was RESOLVED to RECEIVE the Chairs' report.

MC/25/05 Chief Executive's Report (agenda item 6)

The chief executive's report was taken as read. Mark Brooks (MBr) noted that since the report was written, the NHS planning guidance had been received which details the financial challenge that all NHS organisations will be facing going forward.

BC raised a question around whether the Trust receives any money for reaching a particular level of flu vaccination compliance. MBr confirmed that the Trust no longer receives any performance related payment. Since the pandemic vaccination uptake in general has declined and the Trust position is similar to most other organisations in terms of the numbers of staff receiving the vaccine.

Councillor Geraldine Carter (GC) provided clarification around her previous request at the last meeting for further updates to the chief executive's report as the report is written and shared a week prior to the Members' Council meeting. MBu confirmed that since the report was written the only additional update was in relation to the NHS planning guidance which MBr had provided at the start of the agenda item.

Daz Dooler (DD) queried whether the government's decision to put £22billion into the NHS had eased any of the financial pressure faced by the Trust. MBr advised that the cost of recent pay increases, national insurance changes, cost of new drugs and pension costs is greater than £22billion. Therefore, the Trust will receive 4% less income next year which equates to circa £15-16 million less than this year and the financial pressure faced by the organisation is expected to continue.

Phil Shire (PS) noted that only 53% of frontline staff had received the flu vaccination. MBr stated that the number of staff receiving the vaccination is not as high as previous years and the overall uptake from the general public is lower, however the Trust is not an outlier, and the figures are comparable with other organisations. Mask wearing was reintroduced across inpatient areas over the winter period due to the flu vaccination numbers being lower. The Trust undertake a significant amount of promotion for the vaccine and a review of this is required in order to understand the reasons why staff are not accepting the vaccine.

PS also raised a question in relation to finance, productivity and partnership working and asked whether there is any scope in improving this as it has been noted publicly that the NHS is not as productive as it should be. MBr stated that a productivity review of the Trust's community mental health services has taken place, led by an external organisation as part of the South Yorkshire Integrated Care Plan. MBr noted that the Trust has the lowest number of out of area bed placements across Yorkshire and Humber, which is positive for service users however comes at a cost due to 7 day working, bed flow and management due to additional staffing. Inpatient occupancy levels are currently between 95% and 105% which is a cost premium due to the additional staffing required. MBr gave an example of productivity following a recent visit with a community team and acknowledged that there are opportunities for better productivity. MBu added that the Trust must also ensure that the public purse is being spent

as efficiently as possible and noted that mental health organisations work on contracts where payment is by block and not on activity levels. Therefore, the Trust continue to accept patients. She raised the importance of making sure staff are looked after and supported whilst continuing to provide safe care to service users. The Trust is also reviewing non-essential vacancies across the Trust and this will continue with some difficult conversations and decisions to be made going forward.

DD raised a concern around the amount of pressure faced by the Trust which is being seen in community services and the voluntary sector following a significant increase in the number of referrals received over the last few months. DD suggested that governors need to push back to the government stating that people need time to recover as mental health issues are not solved quickly. MBu agreed and added that there are also ways the Trust can look to be more efficient to support the challenges.

Margaret Kitching (MK) added that the Trust is working hard on improving digital solutions in order to improve productivity and efficiencies for frontline staff and this is key to enabling staff to spend more time on patient care rather than record keeping. Adam Jhugroo (AJh) stated that artificial intelligence (AI) is being used more and more in general practice to support patient consultation and note writing, and this could be used to increase efficiencies and support digital note taking and record keeping. MBu added that consideration should also be given to moving mental health to a preventative model which would result in less people presenting with higher acuity. MBr provided a summary of work that has already taken place in terms of digital solutions. Electronic prescribing medicines administration (EPMA) has been introduced which has had a significant impact in terms of efficiencies and accuracy of prescribing. The Trust also has an electronic patient system (SystmOne) and work has taken place with the SystmOne team to help identify areas to support staff to be more efficient and effective.

In terms of prevention, MBr stated that although demand has been exceptionally high over the last few years, the mental health investment standard has focused on younger people's services with a mental health support team in most schools. The impact of this will take time to be seen but it is hoped that through engagement with young people this may prevent serious challenges later on. DD added that more work is required around prevention and ensuring that people who are referred to services have the right information. Consideration also needs to be given around information that states that mental health issues do not necessarily mean a referral into the services and this will help reduce some of the pressure. It would also be helpful for schools to start explaining mental health and getting the right information out to children and families. MBu agreed and stated that work is ongoing with the voluntary and private sectors working with the NHS to promote avenues of support.

It was RESOLVED to RECEIVE the Chief Executive's report.

Mark Brooks left the meeting

MC/25/05 Members' Council business items (agenda item 7)

MC/25/06 Review of Trust Constitution (SFIs and scheme of delegation) (agenda item 7.1)

Phil Shire (PS) left the meeting

Izzy Worswick (IW) advised that a yearly review of the Trust's Constitution takes place and a recent discussion and review took place at Trust Board in January where it was agreed to recommend that Members' Council approve the changes to the Trust Constitution. IW noted that there have been some statutory and organisational changes which include:

Statutory changes

- Best practice in relation to non-executive director terms and the need for any extension beyond 6 years (2 x 3 year terms) being subject to rigorous review and NHS England approval.
- Monitor references removed and replaced with NHS England where appropriate.

Organisational changes

- An amendment to governor tenure, to allow, by exception, the extension of a governor's final 3 year term by 12 months, subject to approval by the Members' Council.
- The description of the services the Trust offers has been updated to include the provision of adult secure services at Cheswold Park Hospital in South Yorkshire.
- Trust Board committee updates
  - Quality and safety committee - title updated
  - Commissioning committee – title updated

IW advised that the Standing Financial Instructions and Scheme of Delegation had been included in papers for information only. A full review, involving internal and external stakeholders, has been completed to review and update the Trust's Standing Financial Instructions. Any stakeholder feedback has been incorporated.

Members' Council were asked to receive the recommendation from Trust Board to approve the changes to the Trust Constitution and note the changes to the standing financial instructions.

Andy Lister (AL) added that a meeting took place with Bob Clayden (BC) to go through any points of accuracy and AL will make the necessary changes before the documents are published.

GC raised a query regarding the role and function of Members' Council in relation to "*Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied"*. GC stated that there is no information related to the forward plan on the Trust website and requested clarification around the forward plan and what is expected of her in her role as governor. Dawn Lawson (DL) advised that the forward plan is a plan of the work of the Members' Council throughout the year and the role of governors is to bring in the voice of communities to help with decision making and discussion around each item. GC requested a copy of the forward plan to review outside the meeting and present to the health and wellbeing board in order to obtain local feedback from partners. AL stated the Trust strategy is currently going through a transitional phase and the new strategy will be in place from 1 April 2025 along with an updated annual plan that will be added onto the Trust website. DL confirmed that the strategy and annual plan have been written in consultation with partners. More information around the Trust's annual plan is to be added to the Trust website with hyperlinks. An updated annual plan to be shared with governors.

Action – Dawn Lawson

Darryl Thompson (DT) also noted that the annual quality account includes planning and quality priorities for the year ahead and is shared with all partners. This will be presented to the Members' Council Quality Group as well as Members' Council.

GC also noted that the dates of the Members' Council meetings were not listed on the Trust website. Corporate governance team to review and update the Members' Council meeting information, including meeting dates, on the Trust website.

Action – Corporate governance team

It was RESOLVED to APPROVE the Review of Trust Constitution (scheme of delegation).

MC/25/07 Extension of governor final term (agenda item 7.2)

Following the approval to extend governor's final term by 12 months, AL advised that any extension has to be voted through a quorate Members' Council meeting. The meeting today was noted to be quorate. AL stated that as there are a number of governors who are currently in their first 3 year term, a proposal is put forward to extend Phil Shire's (PS) term by 12 months in order to provide additional support to the newer Members' Council governors. AL noted that this has had an impact on the Members' Council elections, in that should the proposal for PS's term to be extended be accepted, this will result in there being one less governor vacancy.

GC declared an interest in that she has known PS for a number of years on a personal level.

Members' Council accepted the proposal to extend PS's term by 12 months.

It was RESOLVED to APPROVE the Extension of governor final term.

MC/25/08 Appointment to Members' Council groups (agenda item 7.3)

PS rejoined the meeting

AL advised that there was a vacancy on the Members' Council Coordination Group and GC has put herself forward to become a member, effective immediately.

AL also noted that following CDBG's decision to stand down as deputy lead chair, there are now vacancies on both the Members' Council Quality Group and Members' Council Coordination Group. Expressions of interest will be sought to fill both these positions in due course.

It was RESOLVED to RECEIVE the appointment to Members' Council groups and Nominations Committee.

MC/25/09 Assurance from Members' Council groups and Nominations Committee (agenda item 7.4)

The assurance from Members' Council groups and Nominations Committee was taken as read.

It was RESOLVED to RECEIVE assurance from Members' Council groups and Nominations Committee.

MC/25/10 Review of Chair and Non-Executive director remuneration (agenda item 7.5)

Jon Head (JH) provided a summary of the review of chair and non-executive director remuneration and advised that the report was for Members' Council to receive and was an

update on remuneration for the chair and non-executive directors in line and in accordance with the national framework arrangements for remuneration. Due to the significant change in the size of the Trust following the acquisition of Cheswold Park Hospital, the Trust is now recognised as being a "large" Trust. The recommended Chair's pay range for the Trust has increased slightly. Renumeration for the audit committee chair and deputy chair, as well as non-executive directors has been set out by the national framework and MBu advised that the Trust is in line with all other NHS organisations. JH also noted that feedback from NHS England has been received stating that they have no intention to revise the levels of remuneration.

GC raised a question around whether there is any flexibility to increase remuneration for non-executive directors as well as the chair as non-executive workloads are also expected to increase along with the increase in the size of the Trust. MBu advised that as a Foundation Trust is it possible to determine the chair and non-executive directors' remuneration however the Trust previously made the decision to follow the guidance from NHS England. MBu acknowledged the significant amount of work that non-executive directors undertake. Mike Ford (MF) added that remuneration reflects wider financial issues and will become more of an issue when recruiting new non-executive directors into the NHS as a whole as well as the Trust due to the amount of work required and the fact that pay has not increased over the last 6 years. Therefore, the Trust may struggle to recruit people with the right level of current experience and skills in areas such as AI, digital and sustainability. MK suggested that recruitment need to be completely honest in terms of expectations when advertising non-executive director roles. MBu agreed and stated that during the last non-executive recruitment process, the requirement was for experienced non-executive directors with specific skills. Nesar Rafiq (NR) stated that the Trust should consider how they recruit non executives from different backgrounds in order to provide a different perspective, in addition to recruiting based on skill set. JLa confirmed that the current non-executive directors are from different areas of industry and not just the NHS. When undertaking recruitment, the Trust will always look for people from different backgrounds and different sectors including non-NHS, and review the skill set of the current Board to consider where there are gaps. MBu thanked Member's Council for their input and comments.

It was RESOLVED to RECEIVE the Review of Chair and Non-Executive director remuneration.

MC/25/11 Care Quality Commission (CQC) action plan updates (agenda item 7.6)

Keith Stuart-Clarke (KSC) joined the meeting.

The CQC action plan update was taken as read. Darryl Thompson (DT) advised that the update has been presented to Trust Board in November 2024 and a further update would be presented to the Quality and Safety Committee in March 2025. DT noted that the CQC actions are under constant review and work are in place to progress them further. DT noted that following a request from Trust Board, an example had been included in the update demonstrating the governance and sign off process for actions and how the Trust maintains confidence that progress is maintained going forward.

Based on the audit, which was carried out in December 2024, JLa queried whether the board of governors was satisfied with the progress made so far and whether the actions should have been completed by now. DT stated that the aim was to close the actions as soon as possible but in a way that ensures that that they have been fully implemented with a plan to embed the actions further going forward. In terms of prone restraint, DT confirmed that the Reducing Restrictive Practice Intervention (RRPI) team are working with care group colleagues to progress this work as soon as possible. DT reported that he is satisfied with the progress

made so far which will help to support a sustained improvement. MK added that the quality and safety committee challenge progress on a regular basis, particularly around prone restraint and RRPI and the committee have scrutinised the evidence across the region and acknowledged that the Trust is doing well in terms of reducing incidents. Where there are issues related to ligatures, non-executive directors also continue to push this issue to ensure that there is a tight grip and the estates plan is prioritised. As a relatively new non-executive director for the Trust, MK stated that her opinion of SWYPFT is that the Trust operates to gold and platinum standards of assurance and the audits demonstrate an acceptable level of assurance. NR also congratulated the executive directors, non-executive directors and staff for their hard work while working under pressure.

BC reported that during a previous quality monitoring visit it was noted that bank staff did not receive the same level of RRPI training as substantive staff and this could lead to a risk that the ward would not have enough adequately trained staff which could potentially be picked up by the CQC. DT confirmed that there are mandatory training expectations for all bank staff, particularly around RRPI training, and only bank staff who are trained and have the right level of clinical skills would be deployed into an inpatient area. There is a clear focus around mandatory training and compliance is monitored to ensure that staff have the required level of expertise.

It was RESOLVED to RECEIVE the CQC action plan updates.

MC/25/12 Chairs' appraisal – process (agenda item 7.7)

The chairs' appraisal paper was taken as read.

AL provided a summary and advised that the process will be led by Nat McMillan (NMc) (deputy chair) and will include executive directors, non-executive directors, governors and internal and external stakeholders who will all be invited to contribute to the appraisal process. A questionnaire was developed last year which was found to be effective and this process will be repeated this year. The lead governor, deputy lead governor and a member of each of the Members' Council groups will be invited to complete the appraisal questionnaire independently before coming together to discuss and agree a resolution. The deadline for the questionnaire is end of June 2025 and updates will be provided throughout the process. There will be an opportunity for governors to have sight of the initial appraisal. The Members' Council approved the process as stipulated within the paper.

It was RESOLVED to RECEIVE the Chairs' appraisal – process.

MC/25/13 Members' Council elections - update (agenda item 7.8)

AL provided an update on the Members' Council elections and advised that the election process was scheduled to begin 2 weeks prior to the meeting but was pending decision today to appoint PS for a further 12 months. He outlined that current vacancies were: 1 vacancy in Wakefield, 2 in Kirklees, 1 in Calderdale and 1 in Barnsley. He advised the "notice of poll" would be issued from Monday 17 February 2025 and added to the Trust website with a link to the website. All the necessary information will be included in all communications through Civica. AL advised that the nomination stage will begin on Monday 17 February 2025 and will be open for a period of 1 month with electoral voting from 7 to 30 April 2025 in order to appoint for 1 May 2025. Therefore, despite the delay, it is expected that the original timeline will be met.

GC queried how vacancies are publicised. AL stated that as the Trust is a membership organisation, applicants need to be a member in order to vote. MBu confirmed that new

members are being sought all the time and members will receive a letter notifying them of the vacancies within their designated constituency. AL confirmed that there are no staff vacancies only public vacancies at this time.

It was RESOLVED to RECEIVE the Members' Council elections – update.

MC/25/14 Governor feedback from virtual meetings (agenda item 7.9)

JLa provided a summary of feedback from virtual meetings and community feedback sessions and advised that in relation to complaints, the feedback received was that the Trust complaints process takes too long and when a response to a compliant is received, it appears to be a standard response stating that the Trust will try to do better with little acknowledgement of lessons learnt while investigating the complaint. JLa queried why, when there has been some learning from a complaint, this cannot be fed back to the individual? MBu stated that the once a compliant process has been completed it is signed off by the chief executive. Over recent years, the complaints process has changed significantly. DT stated that he will pass this feedback to the team but provided assurance that there are no standard responses to complaints and each compliant is reviewed by the executive trio (chief nurse, chief medical officer and chief operating officer) with a focus on the tone of the response as well as to ensure all the elements of the complaint have been addressed and highlight any learning before final sign off by the chief executive. DT stated that he would be keen to understand where this has not been done well enough. DT advised that 18 months previously there had been a large backlog of complaints and the team had worked extremely hard to reduce this. In November it was noted that 100% of complaints received a response within 6 months, which is the national standard. JLa stated that, in his opinion, this needed to improve and that the Trust should be aiming to be outstanding and to respond more quickly. DL added that she was recently involved in the sign off process while the chief executive was on annual leave and 1 particular response was 21 pages long. Therefore, there are complexities when reviewing complaints and the Trust would rather provide a detailed response rather than a quick response which does not get down to the "nitty gritty" detail. DL requested that specific examples be shared with the executive team where the responses were not acceptable in order for the Trust to learn from them.

NR challenged the use of the term "nitty gritty" and provided context to the phrase. Others had not been aware of connotations. DL thanked NR for bringing this to the attention of Members' Council, apologised and stated that this phrase would not be used again.

JLa raised a concern related to patient discharge back to the community and their GP where service users could be discharged back to the community and the care of a GP who has no knowledge of the service user, their condition or mental health medication. Paula Scott-Loftus (quality governance lead) recently joined a group to go through the process of discharge and JLa advised he did not feel the Trust is following the process in all cases. JLa requested an audit of 10 individuals in each of the 4 places to look at the discharge process followed. Adele Fox (AF) advised that she recently joined a carers forum meeting and listened to the experience of individuals who have been referred back to a different GP and found this difficult. AF confirmed that a process is in place where service users must be referred back to primary care and AF agreed to look at this process in more detail in order to ensure that the GP is aware that the service user is back under their care and that they understand the level of support required. AF agreed to review the discharge process for service users back into the community and the care of their GP to ensure that GPs are aware that service users are back under their care and the level of support required. AF to present a paper to the quality and safety committee before bringing it back to Members' Council.

Action – Adele Fox

MBu agreed that a selective audit in 4 localities with 10 service users who have been discharged should take place to check whether the process has been followed. MK suggested undertaking an experience audit of individuals who have been discharged to obtain their experience rather than checking whether the process has been followed. JLa stated that some individuals are reluctant to raise an issue once they have been discharged. JLa agreed to see if there are any service users he was aware of from his discussions who would be willing to talk about their experience.

JLa also raised an issue following the news that a private provider in Bradford has had a negative CQC inspection and asked whether there are any of the Trust's service users placed with that particular provider and if so, what are the Trust's responsibilities to these service users. MBu confirmed that there are no service users from the Trust under the care of the private provider and the only area of responsibility for the Trust would be if the Trust has commissioned that service. MK noted that a poor CQC inspection might mean that the organisation would not be in a position to take any new admissions and this may have an impact on the Trust in terms of additional pressure.

In relation to the Nottinghamshire Healthcare Independent Review, BC requested reassurance that the Trust is intending to review the report in full. MK confirmed that the report has been published in full and is on the government website. It was noted that a paper will be presented to EMT this week and public Trust Board in March.

It was RESOLVED to RECEIVE the Governor feedback from virtual meetings.

MC/25/15 Integrated Performance Report (agenda item 7.10)

Mark Brooks rejoined the meeting.

Gary Ellis (GE) presented a summary of the Integrated Performance Report for quarter 3 and advised that performance metrics (improving health) are all green and above the threshold. The Trust continues to take action around the collection of information related to protected characteristics by codesigning services and ensuring these are representative of the population that the Trust serves.

The number of people with a risk assessment/staying safe plan in place within 24 hours of admission demonstrates an increase for inpatient services with a slight deterioration for community services. GE noted that all service users without a risk assessment are followed up individually within the care group in order to maintain patient safety. The Trust continues to stress the importance of timely risk assessments and continue to look for opportunities to improve the position. The number of service users clinically ready for discharge improved in December however there continue to be a number of service users whose discharge is delayed which may impact future performance. Work is continuing with partners to ensure that people are discharged as soon as possible.

The national target for out of area beds. The Trust has 5 service users currently out of area. This is a largely positive position for service users as well as the Trust's financial position and GE confirmed that the data includes all out of area placements regardless of commissioner. Work continues to ensure service users are cared for close to home. Workforce challenges have led to an increase in temporary staffing, primarily though bank usage and this is expected to continue to be a financial challenge for the Trust.

GE summarised the Trust's financial position and advised that the challenges will continue with the position in December 2024 reporting a £911k deficit against plan which will be a challenge going forward in achieving a breakeven position. There has been additional capital allocation due to the acquisition of Cheswold Park Hospital with a total capital allocation of

£8.1m. One area of spend is the older peoples' transformation and this work has been delayed therefore the teams are working hard to maximise the full allocation.

GE advised that management of the overall workforce continues with a focus on agency spend. There were some significant reductions in the previous financial year (2023/24) and this has continued to fluctuate this year with an increase in spend by £30k compared to last month. However, it was noted that this included the increase in costs associated with Cheswold Park Hospital.

There were 11 RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) incidents in quarter 3 which is greater than quarter 2 but lower than quarter 1. All staff involved in violence and aggression incidents have been supported through recuperation and follow up appointments with occupational health as well as "welcome back" meetings with departmental managers. There were no enquiries from either the Health and Safety Executive or the CQC following the reporting of these incidents in quarter 3. MBu provided clarification that the 11 incidents occurred in 3 areas of the organisation where there are specific challenges related to individual service users.

The percentage of ligature jobs completed within timeframe is currently 100% and all urgent jobs are being actioned within 2 days. GE thanked the estates team for their hard work in keeping up to the work and reaching this position.

In terms of workforce, turnover continues to be positive at 7.6% which highlights that the Trust is successfully retaining staff within the organisation.

Sickness absence has increased in December 2024 to 5.7% due to the increase in the number of cold viruses, flu and gastric illnesses over the colder months. The majority of sickness is related to short term absence and most care groups have seen an increase in December 2024. Hot spots areas continue to be managed within care groups however the increase has led to an increase in bank and agency staff.

It was acknowledged that it is important that staff receive an appraisal. GE noted that there has been an issue with the appraisal system since 16 December 2024 which has led to a delay in the reporting of appraisals for staff, however an alternative reporting system is currently in place. MBu added that the plan is to move away from WorkPal as a reporting system onto the electronic staff record system (ESR) and staff continue to be appraised in the interim.

Mandatory training compliance remains above threshold including RRPI training which is a positive position. E-rostering continue to ensure that wards have access to adequately trained staff at all times. Information governance training is just below the 95% threshold at 93.6% and work will continue over the coming months to ensure that the Trust meets the 95% target.

Incident reporting remains within the expected range.

The Trust continues to perform well against the national metrics. However maximum 6 week wait for diagnostic procedures remains an area of concern with a current position of 49.5% against a target of 99% and is related to staffing issues within the paediatric audiology service. The service has set a trajectory for improvement and is preparing a business case for commissioners following a demand and capacity exercise.

NR raised a question regarding the 80% threshold for the cardiopulmonary and RRPI training and 85% threshold for fire training. NR asked why the thresholds are not set at 100% with an aim to have all staff trained in these areas. DT advised that the Trust will always aim to reach 100% however the metrics take into account where staff are on leave from work and are not

available to undertake the training. The system provides assurance that there are enough adequately trained staff available on each ward at all times. NR queried when the targets were set and requested that the targets be set at 100%. MBu explained that some of the thresholds are set nationally and are predetermined. However executive colleagues undertake a yearly review of targets which are agreed through Trust Board as reasonable thresholds that are practical, appropriate and ambitious.

In terms of financial sustainability and efficiencies, JLa requested more information around how the £22m savings will be achieved and in which areas. MBr advised that Adrian Snarr, (director of finance, estates and resources) would be able to provide the detail however the focus for the Trust this year is around 2 key areas; reduction of out of area bed usage which has been achieved and reduction in the level of vacancies. Further information is included in the financial performance report which is presented to Trust Board. To obtain more detailed financial information around the required £22m savings for the next Members' Council meeting.

Action – Adrian Snarr

CG asked whether agency spend within the overall workforce includes bank usage. CG noted that it had been highlighted in the national press that there has been an increase in the number of adults diagnosed at GP level with ASD/ADHD (Autism Spectrum Disorder/Attention Deficit Hyperactivity Disorder) and asked whether this is having an impact on waiting times in the Trust. MBr confirmed that the agency figures do not include bank usage. He advised that GPs do not diagnose ASD/ADHD but do refer people into service providers, dependant on where they live. There is a different pathway in Calderdale (Right to Choose) compared to Kirklees and Wakefield. Over the last 5 years there has been a 500% increase in the number of referrals into the Trust which has had an impact on access to services as well as increased waiting times. MF advised that the Members' Council Quality Group are also undertaking a deep dive into ADHD.

BC queried whether the carbon impact in terms of business milage is due to undertaking reduced milage or using better vehicles. MBr confirmed that it is down to both factors. The estates vehicle fleet is almost all electric vehicles and mileage claims reduced during the pandemic however there has been an increase over recent months as teams and services undertake more patient visits in the community. MBr noted that the biggest impact is around estates and when any upgrades to the estate take place, the Trust always look at the most up to date technology in order to reduce the Trust's carbon emissions.

NR asked whether the Trust has made a decision to step away from the social media platform "X" (formally known as Twitter) and whether its use aligned to the Trust values. DL confirmed that a discussion has taken place around the use of "X" and other social media platforms. DL advised that to not use "X" would result in the loss of contact with over 9,000 staff and service users. DL added that there are clinical teams that use "X" as a way to engage with service users, therefore no final decision has been made at this time.

NR requested clarification around the 128% fill rate figure. DT provided an explanation stating that this is related to a requirement for extra staffing over establishment in order to keep service users safe. This also comes at an increased cost to the Trust which is an added pressure. MBu confirmed that AF and DT continue to monitor this going forward. PS asked whether when increasing the fill rate figure, there is a detrimental impact on the quality of service when there is not enough registered staff available or whether this is a better use of resources. DT stated that the use of substantive nurses on shift would be the ideal in order to ensure the best outcomes for service users. However, when that is not possible, the service will seek to appoint a registered nurse onto that shift when there is a gap due to sickness or absence. When a registered nurse is not available, a healthcare support worker will be

brought in to maintain a level of safety. PS asked whether there is a percentage of registered staff required as a standard? DT confirmed that there is a core expectation which varies across all inpatient areas dependent on the demands of the ward and how many registered nurses are on each shift. This is the standard that has been set and will be reviewed as part of the establishment review.

It was RESOLVED to RECEIVE the Integrated Performance Report.

MC/25/16 Focus on item: Update to Equality, Inclusion, Communications and Membership Strategy (agenda item 8)

DL presented an update on the equality, diversity and inclusion (EDI) strategy and following feedback received from the Members' Council, this has been taken forward into objective 6. DL provided a summary of the Trust's strategic aims as part of the revised Trust Strategy and requested support from governors to look at ways to engage with communities, particularly communities where there is very little contact. DL requested thoughts and advice on how to interact with communities and governors were asked to contact DL direct with any ideas. MBu added that the Trust has spent a lot of time this year re-establishing what the strategy should look like in order to be in a position to launch the new strategy for the next 5-10 years. Following the launch, a deployment plan will be put in place where executive and non-executive colleagues will be given objectives to deliver the plan for every year of the strategy. MBu asked that governors review the strategy and the slides before they are finalised, after which a deployment plan will be developed. MBu added that EDI is critical to the Trust strategy in order to understand staff and people being able to access the Trust services. AL agreed to send the slides out to governors in order for them to reply with any feedback.

Action – Corporate governance team

NR stated that the actions of the Trust and its staff is the best way to deliver the strategy, treating everyone with dignity and respect. NR suggested adding a statement saying that the EDI is for everyone and suggested that a briefing with governors to explain the benefits of the strategy would be helpful.

JLa advised that a subgroup meeting took place between governors and Sue Barton (Deputy director of strategy, inclusion and change) and Sharon Kennedy (Assistant director of strategy, equality and inclusion) which was a useful meeting for governors to provide input and challenge. An outcome from the meeting was to obtain a list of organisations that the Trust work with so that governors can support engagement with our communities. JLa added that it is also important that more young people are invited to join as governors. It is important that governors share the message around mental health and the work that goes on within the organisation.

It was RESOLVED to RECEIVE the update to Equality, Inclusion, Communications and Membership Strategy.

MC/25/17 Closing remarks and annual work programme 2024/25 (agenda item 9)

Members' Council agreed to approve the work programme for 2024/25.

It was RESOLVED to APPROVE the work programme for 2024/25.

MC/25/18 Any Other Business (agenda item 10)

MBu noted that the meeting was the last meeting for BC and thanked him on behalf of Members' Council and the Trust for his contribution as a governor to the Trust and wished him well for the future. JLa also thanked BC for his support as well as the rest of the Members's Council governors.

It was RESOLVED to NOTE any other business.

MC/25/18 Future meetings of the Members' Council (agenda item 11)

- Wednesday 7 May 2025 (hybrid – venue to be confirmed)

It was RESOLVED to APPROVE the date of the next Members' Council meetings.

Close of public meeting

Members' Council 14 February 2025
Action log

= completed actions

Minutes ref	Action	Lead	Timescale	Progress
Actions from 14 February 2025				
MC/25/03	To update the spelling of Valentina McParland's name in the minutes of the Members' Council meeting of 15 November 2025	Corporate Governance Team	May 2025	Completed. Minutes updated.
MC/25/04	To reword action MC/24/87 to make it clearer	Corporate Governance Team	May 2025	Action updated and annual review of progress against the EDI strategy has now been added to the annual work programme with the first update to be received in May 2026 as agreed by Members' Council.
MC/25/06	More information around the Trust's annual plan against the Trust Strategy to be added to the Trust website and shared with governors.	Dawn Lawson Director of Strategy, Inclusion and Change	August 2025	Priority programmes for 25/26 were agreed by Trust Board on 29 April 2025. The Trust's annual plan can now be confirmed and published.
MC/25/06	Corporate governance team to review and update the Members' Council meeting information, including meeting dates, on the Trust website.	Corporate Governance Team	May 2025	Website update requested for all future meetings for 25/26 including annual members' meeting.
MC/25/14	Adele Fox to review the discharge process for service users back into the community. AF to present a paper to the Quality and Safety Committee before bringing it back to Members' Council	Adele Fox, Chief Operating Officer	August 2025	Paper going to QSC in May and will be presented to the Members' Council in August.

Minutes ref	Action	Lead	Timescale	Progress
MC/25/15	To obtain more detailed financial information around the required £22m savings for the next Members' Council meeting.	Adrian Snarr, Director of Finance, Estates and Resources.	May 2025	Our plan is to deliver £28.3m of efficiencies in 2025/26. We will deliver this through a combination of reductions in temporary staffing (£4m), improvements in productivity (£3m) reductions in corporate roles (£2m, in line with NHSE guidance, growth in corporate roles since 2019 needs to be reduced by 50%), carefully managing vacancies (£10m) and a focus on tight control of non-pay costs. This year's efficiency savings are the toughest yet for the Trust and the Executive and senior leaders are aligned and focused on delivering a break-even position for the Trust.
MC/25/16	Corporate governance team to forward the Equality, Diversity and Inclusion strategy slides to governors to provide feedback direct to Dawn Lawson	Corporate Governance Team	May 2025	Slides sent out. Complete.

Members' Council
7 May 2025
Agenda item 5

Private/Public paper:	**Public**
Title:	**Chair's Report and feedback from Trust Board**
Paper presented by:	**Marie Burnham - Chair of the Trust**
Paper prepared by:	Izzy Worswick, Assistant Director of Corporate Governance
Purpose:	The purpose of this report is to provide Members' Council with an update on the activity of the Chair and Non-Executive Directors and feedback from Trust Board, to enable governors to hold Non-Executive Directors (NEDs) to account for the performance of the Board. This report covers activity from **15 February to 30 April 2025**. In addition, Trust communications including the Headlines, The View and The Brief, are circulated to governors to provide up to date information on the Trust's performance and activities. This report aims to highlight: • Chair and NED activity since the previous report to Members' Council on 14 February 2025. • Key issues discussed at Board meetings in the last quarter; and • Any other current issues of relevance and interest to Governors not covered elsewhere in the agenda.
Executive summary:	To support governors in their role of holding the Chair and NEDs to account, this section of the report highlights the activities NEDs have been engaged in since the previous Chair's report which was presented at the Members' Council meeting held on 14 February 2025. (Please note that NEDs are expected to work around 3 days a month and the Chair around 3 days a week, although in practice most work considerably longer). **<u>Key Events</u>** On 13 March 2025, the Chair at Chief Executive attended a national meeting for chairs and chief executives where it was announced that NHS England would be abolished and absorbed into the Department of Health and Social Care (DHSC). At the same meeting a re-set of the financial regime was outlined. The Chair chaired the last meeting of the Shadow Board programme in March 2025, which was delivered in the Trust in partnership with Leeds and York Partnership Foundation Trust. The Shadow Board creates a safe learning space for aspirant directors, allowing participants to gain experience of what it is like to be a board director in a supportive environment.

The Chair and Board members are looking forward to attending the learning and long service awards in the afternoon of the 1 May which will be followed by the annual excellence awards celebrating staff achievements. A total of 320 nominations were received for our excellence awards. This is our highest number of nominations ever. It is always an excellent evening at which we can recognise the fantastic achievements of our colleagues.

Chair and NED's activities and meetings

The Chair and NEDs continue to attend a wide range of webinars, development events and virtual meetings to keep up to date on policy and governance matters, both nationally and regionally.

Below is a list of their activities:

Our Non-Executive Directors have attended the following from **1 February to 30 April 2025**

Natalie McMillan, Senior Independent Director / Deputy Chair

- Quality & Safety Committee (11 February, 11 March and 8 April 2025)
- One to one meeting with the Chair (11 February 2025, 12 March and 15 April)
- Members' Council (14 February 2025)
- People and Remuneration Committee agenda setting and discussion of risks (18 February 2025)
- EyUp! Annual Trustee Training delivered by Hempsons (6 March 2025)
- Meeting with Assistant Director of Corporate Governance (10 March and 24 March 2025)
- One to one meeting with Specialty Doctor (17 March 2025)
- People and Remuneration Committee (18 March 2025)
- NEDS meeting (25 March 2025)
- Members' Council Coordination Group (26 March 2025)
- Improvement Network (1 April 2025)
- Calderdale Early Intervention in Psychosis (EIP) Consultant Post Interview pre meet, interview and post interview discussion (4 April 2025)
- People and Remuneration Committee Chair/Lead Exec Meeting (14 April 2025)
- Audit Committee (15 April 2025)
- Stakeholder engagement session (24 April 2025)
- Yorkshire & Humber Training Hub Connect Event (26 April 2025)
- Trust Board (25 February, 25 March and 29 April 2025)

Mike Ford, Non-Executive Director

- Disciplinary Appeal Hearing (7 February 2025)
- One to one meeting with the Chair (11 February 2025, 5 March and 15 April)
- Members' Council (14 February 2025)
- Freedom to Speak Up Guardians [6 weekly meetings] (11 February 2025 and 10 March 2025)
- Quality and Safety Committee (11 February, 11 March and 8 April 2025)
- Presentation of Final Grading for Equality Delivery System (14 February 2025)
- Catch up meeting with Gary Ellis and Margaret Kitching (14 February 2025)

	• Complex case meeting report (19 February 2025) • South Yorkshire Audit Committee Chairs Network Meeting (3 March 2025) • Audit Committee agenda setting (5 March 2025) • Charitable Funds Committee (5 March 2025) • Meeting with Assistant Director of Corporate Governance (5 March 2025) • Quality visit to Beckside Court (6 March 2025) • EyUp! Annual Trustee Training delivered by Hempsons (6 March 2025) • West Yorkshire Audit Committee Chairs Network Meeting (10 March 2025) • Equality, Inclusion and Involvement Committee (12 March 2025) • NEDS meeting (25 March 2025) • Catch up meeting with Adrian Snarr, Director of Finance and Resources (15 March 2025) • Audit Committee (15 April 2025) • Trust Board (25 February and 25 March and 29 April 2025) **Erfana Mahmood, Non-Executive Director** • Commissioning Committee (4 February 2025) • Trust Board (25 February 2025) • One to one meeting with the Chair (26 February 2025) • Mental Health Act Committee pre meet (4 March 2025) • Mental Health Act Committee (4 March 2025) • Charitable Funds Committee (5 March 2025) • Meeting with Assistant Director of Corporate Governance (5 March 2025) • EyUp! Annual Trustee Training delivered by Hempsons (6 March 2025) • Mental Health Act Committee Agenda Setting (14 April 2025) • Audit Committee (15 April and 29 April 2025) **David Webster, Non-Executive Director** • Quality visit to Neurological Rehabilitation Unit (11 February 2025) • Finance, Investment & Performance Committee (18 February 2025, 17 March 2025 and 22 April 2025) • Finance, Investment & Performance Committee Agenda Setting (3 March and 10 April 2025) • People Remuneration Committee (18 March 2025) • NEDS meeting (25 March 2025) • One to one meeting with Chair (26 March 2025) • Improvement Network (1 April 2025) • Digital Strategy & Innovation Group Meeting (11 April 2025) • Audit Committee (15 April 2025) • Stakeholder engagement session (24 April 2025) • Trust Board (25 February 2025, 25 March and 29 April 2025) **Gary Ellis, Non-Executive Director** • Clinical Ethics Advisory Group (10 February 2025 and 23 April 2025) • Commissioning Committee (4 February and 1 April 2025) • Meeting to discuss Integrated Performance Report (13 February 2025) • Meeting with Margaret Kitching (14 February 2025) • Members' Council (14 February 2025) • Introductory meeting with Tony Wright, Sustainability Change Manager (18 February 2025)

	• Finance, Investment & Performance Committee (18 February 2025, 17 March 2025 and 22 April 2025) • Mental Health Act Committee (4 March 2025) • Meeting with Assistant Director of Corporate Governance (4 March 2025) • NEDS meeting (25 March 2025) • Quality visit to Cheswold Park (26 March 2025) • Pre meeting regarding Cheswold Park (19 March 2025) • Finance, Investment & Performance Committee agenda setting (10 April 2025) • Audit Committee (15 April 2025) • Stakeholder Panel (16 April 2025) • Stakeholder engagement session (24 April 2025) • CAMHS consultant interview (25 April 2025) • Trust Board (25 February 2025, 25 March 2025, 29 April 2025) **Margaret Kitching, Non-Executive Director** • Cheswold Park Quality Improvement Group (4 February 2025) • Quality Assurance System Update (4 February and 17 February 2025) • One to one meeting with Chair (11 February 12 March and 4 April 2025) • Catch up meeting with Gary Ellis (14 February 2025) • Members' Council (14 February 2025) • Meeting with Chief Nurse/Director of Quality and Professions (11 February 2025 and 11 March 2025) • Merseycare Quality Dashboard demonstration (11 February 2025) • Risk Meeting with Head of Corporate Governance (17 February 2025) • Meeting with Freedom to Speak Up Guardian (19 February 2025) • Meeting re Quality Tool (19 February 2025) • Individual 1:1 meetings (19, 20,21, 26, 27, 28 February and 6, 12,19, 20, 24, 31 March) • Governor Question and Answer Aligned to Quality and Safety Committee (27 February 2025) • Meeting with Assistant Director of Corporate Governance (5 March and 31 March 2025) • Meeting prior to Cheswold Park Quality Improvement Group (5 March 2025) • EyUp! Annual Trustee Training delivered by Hempsons (6 March 2025) • Quality Assurance System Launch Planning Meeting (11 March 2025) • Appeal Hearing (19 March 2025) • Shadow Board hot spot interview (19 March 2025) • Quality visit to Cheswold Park (26 March 2025) • NEDs meeting (25 March 2025) • Data review meeting (31 March 2025) • Trust Board (25 February 2025 and 25 March and 29 April 2025) **Marie Burnham - Chair** • Mid Yorkshire Teaching Trust CEO Recruitment - External Stakeholder Panel (3 February 2025) • Teaching Trust Steering Group (3 February 2025) • Mental Health Chairs Weekly Conference Call (4 February, 27 February, 6 March, 13 March, 26 March, 10 April, 17 April 2025) • NHS System Leads/MP Meeting (7 February 2025) • Monthly one to ones with Mark Brooks, Chief Executive

	• Monthly one to ones with all NEDs • Monthly one to ones with Paul Cartwright, Head of Comms • Monthly Welcome Events • Merseycare Quality Dashboard demonstration (11 February 2025) • Interviews (Topic Advisor) (12 February 2025) • Aspiring Chair Talent Programme - virtual assessment (13 February 2025) • Presentation of Final Grading for Equality Delivery System (14 February 2025) • Members' Council (14 February 2025) • NHS Confederation: Indicator set for Patient and Carer Race Equality Framework (PCREF) and Nottinghamshire Healthcare Report Recommendations (24 February 2025) • Trust Board (25 February and 25 March 2025) • Engaging Membership Group meeting (26 February 2025) • Meeting to discuss Calderdale Memory Service (26 February 2025) • Meeting with Chair of Airedale NHS Foundation Trust (26 February 2025) • Governor Question and Answer (Q&A) Aligned to Quality and Safety Committee (27 February 2025) • Nominations Committee- extraordinary meeting (28 February 2025) • Trust Board agenda setting (4 March 2025) • West Yorkshire Chairs Meeting (4 March 2025) • Catch up with Lead Governor (5 March 2025) • EyUp! Annual Trustee Training delivered by Hempsons (6 March 2025) • South Yorkshire and Bassetlaw Mental Health Learning Disability and Autism (SYMHLA) Provider Collaborative Chairs Meeting (11 March 2025) • Meeting with Canine Befrienders (11 March 2025) • Introductory meeting with Christine Brereton, Director of People (11 March 2025) • Dice face assurance discussion with Programme Director South Yorkshire and Bassetlaw Mental Health Learning Disability and Autism Provider Collaborative (11 March 2025) • Pre appraisal meeting (12 March 2025) • SY MHLDA Provider Collaborative - Chair and Chief Executive informal discussion (12 March 2025) • Equality, Inclusion and Involvement Committee (12 March 2025) • Finance, Investment and Performance Committee (17 March 2025) • People and Remuneration Committee (18 March 2025) • Preliminary Interview North West Ambulance Service NHS Trust Chair (18th March 2025) • Volunteer discussion (19 March 2025) • Update on NED recruitment (19 March 2025 and 26 March 2025 and 8 April) • Engaging Membership (20 March 2025) • Shadow Board (24 March 2025) • Filming for PCREF video (24 March 2025) • Trust Board (25 March 2025) • NEDs meeting (25 March 2025) • Members Council Co-Ordination Group (26 March 2025) • Trust Board Agenda Setting (26 March 2025) • Barnsley Alliance Development Session (26 March 2025) • NICE Annual Conference (27 March 2025)

- Barnsley Place Committee & Partnership Board (27 March 2025)
- Scoping Meeting (Metabolic Dysfunction-Associated Steatotic Liver Disease (28 March 2025)
- Aspiring Chair feedback meeting (10 April 2025)
- Nominations Committee (11 April 2025)
- Call with Andrew Patterson, NHS Confederation (11 April 2025)
- Introductory call with Rebecca Gray, Mental Health Network (16 April 2025)
- Meeting with Chief Nurse/Director of Quality and Professions re Safer Staffing Report (16 April 2025)
- Meeting with Head of Corporate Governance re Board reporting system (16 April 2025)
- Health on the High Street Launch Event (16 April 2025)
- Health on the High Street Executive Group (17 April 2025)
- Introduction with Katy Calvin-Thomas- Executive Place Director (17 April 2025)
- Introductory calls with NED candidates (April 2025)
- Engaging Membership meeting (17 April 2025)
- Visit to Hepworth Ward (23 April 2025)
- Trust Board (25 February 2025 and 25 March and 29 April 2025)

4. Key issues discussed at Board meetings

Since the previous Chair's report, the Board has met three times, and the key items discussed are highlighted below. Papers are available on our website six days before public meetings.

Governors are welcome and encouraged 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. Thank you to those governors who have attended Board meetings.

Standing items at Board:

There are 8 board meetings a year held in public, plus four strategic board meetings held in private.

At every public board meeting, we have a service user, carer or staff story, receive a report from the chief executive, setting out the current context and relevant national developments, discuss the monthly Integrated Performance Report (IPR) including the finance report, receive updates on business developments in our two integrated care systems (West Yorkshire and South Yorkshire), and receive assurance from the Board committees.

In addition, at every *business and risk* meeting (quarterly), the board assurance framework is discussed (which sets out the key risks to the strategic objectives plus corresponding controls and assurance), and the corporate/ organisational risk register.

At every *performance and monitoring* meeting (quarterly), the quarterly serious incident report is discussed.

Additional items at the below meetings were presented as follows in line with the Trust Board work programme:

25 February 2025

	• Trust Board development session **<u>25 March 2025 (performance)</u>** • Patient Safety Oversight Report • Priority Programmes update for 2025/26 • Financial and Operational Planning • Review of risk appetite statement • Infection Prevention and Control (IPC) Board Assurance Framework • Cheswold Park Hospital Update • Nottinghamshire Healthcare Independent Review • Care Quality Commission (CQC) inspection action plan updates • Trust Seal • Internal Governance Framework • Equality, Diversity and Inclusion Strategy • Clinical Strategy **<u>29 April 2025 (business and risk)</u>** • Draft Annual Governance Statement • Quality Account process for 2025 • Cheswold Park update • Freedom to Speak up bi-annual update • PLACE report • Priority Programmes • Financial and Operational Planning • Audit Committee annual report including committee annual reports and terms of reference • Going Concern Statement • Risk Management Governance Framework
Recommendation:	**Members' Council is asked to:** • **NOTE** the report and raise any questions or comments in advance of the meeting.
Mission/values:	We put the person first and in the centre We are respectful, honest, open and transparent We improve and aim to be outstanding We are relevant today and ready for tomorrow
Any background papers / previously considered by:	Chair's report to Members' Council 14 February 2025

Members' Council
7 May 2025
Agenda item 6

Private/Public paper:	**Public**
Title:	**Chief Executive's Report**
Lead Director:	**Mark Brooks - Chief Executive**
Purpose:	To provide an update on the strategic context the Trust is operating in for the Members' Council.
Executive summary:	Since the last meeting of the Members' Council, **significant changes in leadership and structure at NHS England (NHSE) have been announced**. Towards the end of February Amanda Pritchard, chief executive of NHSE, announced her resignation from the role effective from the end of March. Sir Jim Mackey will be interim chief executive for the foreseeable future. Sir Jim was previously the chief executive at Newcastle Hospitals NHS Foundation Trust. **At a national meeting for chairs and chief executives on March 13th it was announced that NHS England would be abolished and absorbed into the Department of Health and Social Care (DHSC).** This reverses the decision made in the 2012 reorganisation of the NHS. At the same meeting a re-set of the financial regime was outlined. The changes outlined to NHSE and DHSC are accompanied by a requirement to generate savings of 50% of the current costs. Similarly, **a process to clarify the roles of Integrated Care Boards (ICB) has been announced, with ICBs asked to make cost savings of 50%. Trusts are expected to have plans to break-even in 2025/26 and any growth in corporate costs since the pandemic, including non-frontline clinical costs need to be reduced by 50%.** The focus on improving productivity needs to be relentless. There has been significant activity taking place in our systems, places, and our Trust on the operating plan for 2025/26. The level of efficiency required to live within the financial resources is approximately double what the NHS has achieved previously. Sir Jim Mackey wrote to all integrated care board (ICB) and provider chief executives on his first day in his role and in this letter, he recognised the progress that has been made on developing operating and financial plans for 2025/26. The letter also confirms that ICBs have a critical role to play in the future as strategic commissioners and this is going to be central to realising the ambitions that will be set out in the 10 Year Health Plan, which is expected to be published in the Spring. Greater clarity is still required on what is meant by strategic commissioning to enable revised structures to be developed. There will also be a reduced ICB role on assurance and oversight. Clearly in the short

term there is focus on reducing ICB costs by 50% by the third quarter of this year and there is recognition this is a very challenging ask. Our ICBs in both South and West Yorkshire are both responding to the requirement to develop new structures by the end of May. Clearly this is causing much concern for many colleagues and the personal impact on individuals cannot be under-estimated.

Some further information is also provided regarding the **requirement for provider organisations to reduce growth in corporate and non-clinical spend**. Within our organisation we are working as an executive team and with Meridian to identify how this ask can best be delivered. Staff-wide communications have taken place, and we are committed to keeping our colleagues updated as the position develops.

During March the Chancellor of the Exchequer, Rachel Reeves, presented her **Spring Statement to Parliament**, accompanied by the main findings from the Office for Budget Responsibility's (OBR) forecast on the UK economy. The economic outlook for the UK has worsened since the Autumn budget, with business and consumer confidence declining. Real Gross Domestic Product (GDP) growth is projected to be 1% in 2025, half of the October 2024 forecast. Inflation is expected to increase from 2.5% in 2024 to 3.2% in 2025. Key announcements impacting on health and care covered:

- The incorporation of NHS England within the Department of Health & Social care (DHSC), with the money saved going directly to improving services for patients.
- A £3.25bn transformation fund to drive fundamental reforms in public services with a particular focus on harnessing the power of digital technology and artificial intelligence
- A revised welfare package which will reduce welfare spending by £4.8 billion by 2029/30.

The statement gives our sector much to consider in terms of the potential impact of welfare benefits changes and the context of limited public spending upon people with mental health conditions, autistic people and people with a learning disability.

Disappointingly the share of the total NHS budget spent on mental health will fall by 0.07% in 2025/26. This follows a reduction in 2024/25 compared to the previous year and comes at a time when demand for services continues to increase and there are considerable inequalities experienced by people with mental illness or a learning disability.

Financially for 2024/25 the Trust has achieved its break-even position, albeit with the significant use of non-recurrent means. Capital expenditure increased in the final quarter of the year to end only £0.5m lower than the original plan. These are both positive achievements in what has been an increasingly challenging time for the NHS. Focus is now very much centred on the development of sustainable plans for 2025/26 and beyond.

Work on our **2024/25 year-end process is well underway** and draft versions of our annual governance statement and annual report have been developed. This Trust Board meeting also features our comprehensive effectiveness

	reviews of all our Trust Board committees, which as well as providing assurance will be used to identify where further improvements can be made. **Work has taken place to develop our Trust priorities for 2025/26, which will be aligned to our new Trust strategy**. Two Trust strategies were approved at March Trust Board. These are our updated Equality, Diversity & Inclusion strategy and new Clinical strategy. Both have featured considerable engagement and work has taken place to ensure both are fully aligned with our Trust strategy. **A mental health homicide report into the care and treatment of Valdo Calocane at Nottinghamshire Healthcare NHS Foundation Trust was recently published** and is a sobering reminder of the challenges we face within our mental health system. Our thoughts are with the victims, their families, and all those affected. As we do with all such reports, we review them carefully and seek to learn as well as gain assurance. All mental health provider trusts and Integrated Care Boards have been asked to review the findings from the report and update their local action plans for supporting people with a serious mental illness who require intensive and assertive care and treatment. Our initial report was provided to March Trust Board. **Our full staff survey results have now been published and are very similar to last year**. In a challenging year for the NHS this is viewed positively. There remain a number of hotspots across the Trust, and we will continue to engage with colleagues to seek ways to improve. The People and Remuneration Committee will provide oversight of the analysis of and action plans resulting from the staff survey. **A review of place leadership arrangements has taken place in the West Yorkshire (WY) integrated care system**. Further work is to be carried out on this in the coming weeks and months. An underpinning principle is the establishment of more formal place provider partnerships, which increasingly take on delegated responsibility for budgets and transformation. Regarding the three places in which we work of Calderdale, Kirklees and Wakefield (CKW), as the role of the ICB evolves the review has identified there will need to be some sharing and building of capacity to ensure that they can deliver the three shifts identified by the Secretary of State, along with the ICB's core functions and supporting the delivery of high quality care. The Calderdale, Kirklees, and Wakefield place directors will undertake a rapid piece of design work to develop proposals for sharing capacity or moving certain functions to a WY model where this would better meet their needs. Locally to our systems Cathy Elliott, the chair of NHS West Yorkshire Integrated Care Board has resigned from her role to take up an executive position in Cheshire and Merseyside. Brent Kilmurray has been appointed as the new chief executive of Mid Yorkshire Hospitals Teach Trust. Most recently Brent has been chief executive of two mental health providers. **As a Trust we are partnering with other public bodies across Wakefield to develop a single district plan**. Strategic framework outcomes, measures of success and underpinning principles are being jointly developed. We are also

	working closely with colleagues across all four places on the development of neighbourhood care models and there is further information regarding this in the more detailed system and place updates. Along with acute trust partners in West Yorkshire we applied for a place on a **12-month improvement programme sponsored by the NHS Confederation dedicated to supporting teams working at the interface between acute emergency departments and mental health to develop solutions to local issues**. Positively following a very competitive process we have secured a place on this programme which will be led from a SWYPFT perspective by our chief operating officer, Adele Fox. **In 2020 the NHS committed to become the first healthcare system globally to commit to reaching net zero carbon emissions, in response to the health risks posed by climate change.** As a Trust we continue to focus on how we can contribute positively to this, and we have had excellent engagement from staff with 450 expressing an interest to be involved. How we continue to drive environmental improvement during what are challenging times both from a financial and capacity perspective is being assessed. NHS England has released updated guidance on how to develop sustainability green plans for the next three years, which we are reviewing. Good progress continues to be made at **Cheswold Park** with the number of admissions continuing to increase. Particularly of note is the successful implementation of SystmOne as the electronic patient record at Cheswold **A total of 320 nominations were received for our annual excellence awards**. This is our highest number of nominations ever and the judges have had a difficult time filtering down to a shortlist. The awards will take place on Thursday May 1st at The Metrodome in Barnsley. This is always an excellent evening at which we can recognise the fantastic achievements of our colleagues. Given the financial environment we are progressing with a number of ways in which to reduce the cost of the event and to also generate income, as we still very much want to recognise and celebrate the difference colleagues make to people's lives. **Operationally, services continue to be very busy**. Acute providers have experienced continuing demand challenges including higher prevalence of norovirus, and there have been examples of people presenting at emergency departments with mental illness, where there have been twelve-hour breaches given the high levels of demand on our own services. The use of out of area bed placements and non-designated bed areas have both fluctuated in March and seen numbers used increasing compared to recent months. Our colleagues continue to work tirelessly to provide the best possible care. **In recent months we have experienced an increase in the number of people clinically ready for discharge**. The National Housing Federation has reported that mental health patients spent 109,029 days in mental health hospitals waiting to be discharged last year. Their research highlighted that a lack of supported housing was responsible for 20% of all delayed discharges,

	and 73% of all housing-related delayed discharges, from mental health hospitals. We are aware of the **challenges posed by a significant increase in demand for ADHD referrals in recent years** and that a national taskforce led by Professor Anita Thapar has been established to work alongside government, the NHS, voluntary sector and experts by experience to identify ways to improve care for people living with ADHD. The taskforce plans to publish an interim report in Spring 2025 with the intention of setting out a few early principles for the main report that is planned for Summer 2025 Jon Head, chief people officer, has resigned from the Trust for personal reasons. We are fortunate that Chrstine Brereton, an experienced leader and chief people officer has joined us on secondment until May 2026 to lead our people directorate. Sean Rayner, director of provider development is leaving his substantive role at the end of April. Sean has agreed to continue working on a part-time and temporary basis for the Trust as Director of Integrated Care – Wakefield. Sean has been a huge part of SWYPFT for many years and we will really miss his insight and pragmatism in the executive team and at Trust Board. Sean is widely respected across all of our places and has played a lead role in the development of the mental health alliances and development of integrated care. David Webster, Non Executive Director will also be leaving the Trust. David has made a valuable contribution to the Trust these past three years. As ever, there are examples of great work being carried out by our colleagues that are worthy of highlighting in this report. As the operating environment will clearly become more challenging it is important that we continue to recognise the many achievements of our colleagues. • Our stop smoking services were out in the community with pop-up events and clinics, encouraging people to sign up to the 12-week quit programme as part of National No Smoking Day. • Barnsley achieved 100% in smoking screening rates for inpatient admissions in recent months. This accomplishment was recognised by the South Yorkshire Integrated Care Board (ICB), with the QUIT service securing funding in Barnsley. • We held our second annual suicide prevention conference. Delivered by our patient safety team, the successful event featured insightful discussions, expert speakers and valuable resources to help combat suicide • The work undertaken to develop our refreshed Trust strategy is being recognised nationally and will be the focus of a session at the NHS Confed Expo in June. It is entitled ‘Voice counts – engaging with patients and communities in the development of our strategy’. • The Good Mood Football League returned for 2025 with the first fixture of the year. The initiative, in partnership with Creative Minds and West

<table>
<tr><td></td><td>Riding County Football Association, aims to tackle health inequalities and provide physical activity for service users</td></tr>
<tr><td>Recommendation:</td><td>Members' Council are asked to:
NOTE the Chief Executive's report.</td></tr>
<tr><td>Mission/values:</td><td>We put the person first and in the centre
We are respectful, honest, open and transparent
We improve and aim to be outstanding
We are relevant today and ready for tomorrow</td></tr>
<tr><td>Strategic Objectives</td><td><table>
<tr><td>Live Our Values</td><td>✓</td></tr>
<tr><td>Be the best we can be:
• Best quality
• Best partner
• Best value
• Best place to work and learn</td><td>
✓
✓
✓
✓</td></tr>
<tr><td>Be ambitious</td><td>✓</td></tr>
</table></td></tr>
<tr><td>BAF Risk(s):</td><td>All BAF risks</td></tr>
<tr><td>Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships</td><td>The report includes highlights of what is happening in both our systems and places. The Trust regularly reviews that its own objectives are aligned to those of our systems and places as well as taking account of national guidance and requirements</td></tr>
<tr><td>Any background papers / previously considered by:</td><td>A Chief Executive's Report was received by Members' Council on 14th February 2025.
Updates contained within this report to Members' Council were received at 25th March and 29th April Trust Board meetings.</td></tr>
</table>

Members' Council
7 May 2025
Agenda item 7.1

Private/Public paper:	**Public**
Title:	**Non-Executive Director recruitment - appointment**
Paper presented by:	**Christine Brereton, Chief People Officer**
Purpose:	The purpose of this report is to update the Members' Council on the process for the appointment of two Non-Executive Directors and to approve the recommendation from the Nominations Committee.
Executive summary:	**Background** 14 February 2025, the Members' Council approved the Trust progressing an intent to appoint two Non-Executive Director posts. **Recruitment Process** The Nominations Committee agreed for Gatenby Sanderson to conduct the recruitment process for two Non-Executive Director posts with expertise in one for the following areas; • Legal • Artificial Intelligence (AI/Digital) • Housing/Education/Social Care • Environmental Sustainability The following timeline has been followed: • Post advertised nationally by Gatenby Sanderson. • 7 April 2025 – Advert closing date. • 11 April 2025 – Shortlist panel convened. • 11 April 2025 – Shortlist agreed by Nominations Committee. Six shortlisted candidates were invited to meet two stakeholder groups and have a formal interview. • 24 April 2025 – Stakeholder Group Sessions comprising of service users, carers, governors and staff. • 28 April 2025 – Final panel interviews. As part of the recruitment process it was agreed that the Trust will be actively seeking candidates with the right skills and expertise from diverse backgrounds. **Final Panel Interviews**

	The decision-making process was challenging due to the high quality of all the candidates who were all recognised as being appointable. The panel considered the existing skills, membership and diversity of the Trust Board and agreed that all considerations had to be factored into the decision-making process. **Martin Neeson** demonstrated his experience in industry in different facets including housing. The panel was unanimous in its view that he was an outstanding and credible candidate bringing value to the role due to his experience and would effectively challenge the Board. **Rokiya Khan**, demonstrated her excellent connections and networks with the local communities whilst holding a national presence for women's rights. It was agreed she was a very credible candidate who is likely to be strong service user voice on the Board. The panel agreed that from a strong field of candidates Rokiya was the best fit with the Board, complimenting existing knowledge and skills. It was recognised this is her first non-executive director role and support will be put in place to support her induction. The Committee is asked to consider and agree the recommendation from the final interview panel that both Martin Neeson and Rokiya Khan are appointed as a Non-Executive Director.
Recommendation:	**The Members' Council are asked to:** **RECEIVE** the update and **APPROVE** the recommendation from the Nominations Committee to appoint **Martin Neeson** and **Rokaiya Khan** as Non-Executive directors with South West Yorkshire Partnership NHS Foundation Trust for a three-year term from dates to be confirmed, following fit and proper person test completion.
Mission/values:	Good governance supports the Trust to deliver its mission and adhere to its values.
Strategic Objectives	Live Our Values ✓ Be the best we can be: • Best quality ✓ • Best partner ✓ • Best value ✓ • Best place to work and learn ✓ Be ambitious ✓

BAF Risk(s):	All risks
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	Through the utilisation of a thorough and transparent recruitment process the Trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships.
Any background papers / previously considered by:	Nominations Committee 30 April 2025

SOUTHWEST YORKSHIRE NHS FOUNDATION TRUST APPLICATION FOR NED

SUPPORTING STATEMENT – Rokaiya Khan

I am passionate about improving public services. I have spent all of my career working to improve the quality, reach and inclusivity of public services, as the chief executive of a VCSE organisation, school governor and in other roles.

I committed to making a difference, by developing and delivering effective services which build social capital and provide opportunities. I am deeply committed to the provision of high quality, accessible health care services, which are responsive to the needs of patients and the wider community. My commitment is driven by a career delivering services to a range of vulnerable client groups, often with a range of needs from physical and mental health through to wider social and economic disadvantage. I am committed to helping to develop public services which reflect need, which reach into communities, and which involve service users meaningfully in their development and operational delivery. Health care services are central to the well-being of communities and a key element in building active, engaged communities.

I have a good understanding of the financial and operational pressures which NHS systems face and the role that system leaders must fulfil. I am passionately committed to creating a local health system that is accessible, responsive and which provides the best possible health outcomes for diverse populations.

I understand that health needs vary significantly across South Yorkshire and that, as actors in thins system, we need to ensure that we shape services that address inequalities, and which reach effectively into communities.

I am an experienced Chief Executive, with deep experience in the voluntary sectors, along with senior level experience working within sectors including education, housing, public health and social care. I have been CEO of Together Women for over 18 years, following various roles in the public and charity sectors (including Chair of Trustees for a provider of women's refugees and Governor of local school with a lead on SEND). I am experienced at operating at senior board level. I was an adviser to Lord Farmer during his enquiry on women's family ties in the context of the criminal justice system, member of the Prison Reform Trust Transforming Lives Advisory Board and Advisory Board on Female Offenders. I have also contributed to the National Women's Prisons Health and Social Care Review. I am used to operating in advisory roles, across multiple stakeholder constituencies and using my involvement to shape positive outcomes.

I have a range of board-level experience in strategic planning, financial management, risk management, performance management, service development and transformation, in both the public and voluntary sectors. Above all, I am an experienced, inclusive, and determined leader, with a track record of building cross-organisational networks, influencing whole-system development and building alliances.

My strengths include:

• I understand public accountability and am accustomed to working in a regulated environment with high levels of public oversight, for example in the prison and education sectors. Understand the distinction between governance and management and the requirement for Board to focus on strategy, assurance and critical challenge. I have worked

at Board level in the voluntary sector and have a good understanding of appropriate governance systems and behaviours.

• I have built Together Women as the leading charity providing trauma-informed services to vulnerable women in prisons and communities. I understand how to lead and develop organisations in highly sensitive areas and have maintained a resolute focus on improving the lives of our service users.

• I am experienced in building cross-organisational partnerships in complex delivery landscapes. For example, at Together Women I have developed strong working relationships with successive Government Ministers, who have sought our advice and support on a range of issues. Inevitably there is not always agreement, but the strong constructive challenge and evidence-based solution-focussed advice that I provide is vital for effective collective leadership to implement the Government's strategy.

• I understand how to build networks and alliances through influence and soft leadership skills.

• I am politically astute and able to engage, influence and secure commitment to strategies in an environment with a high degree of public and political accountability. For example, I played an active role in shaping the content and aims of the Female Offender Strategy (2018) and have supported the implementation of the extensive work programme to deliver its aims and objectives, including fundraising, securing £1million from the Tampon Tax Fund leading a group of women's centre providers.

• I am an effective leader of people-centred organisations, as evidenced by my track record

leading Together Women.

• I build inclusive and effective teams, which value contributions and which have strong cultures based around mutual respect and clarity of purpose.

In summary: I am an experienced Director. I have well-developed financial and operational management skills, grounded in cross-sectoral experience derived from a range of diverse organizations. I have had significant budget and financial responsibilities, in particular in a contracting environment. I have a deep commitment to the delivery of good public services, across a variety of sectors, and of improving outcomes for people. I am driven by a strong set of personal values, grounded in experience of working with some of the most socially excluded groups in society. I am a people-focused leader, with a proven ability to rally people around a clear strategic vision. I can build consensus and have a track record of effective Board-level delivery. I am deeply committed to shaping public services that improve lives, and I believe my experience, leadership, and strategic oversight would add value to the Trust. I am particularly drawn to this opportunity because of the Trust's commitment to delivering high-quality, inclusive healthcare and tackling inequalities, and I would be honoured to contribute to its vision.

Martin Neeson

Supporting Statement, Non-Executive, South West Yorkshire Partnership NHS Foundation Trust

Thank you for providing the opportunity to apply for the position of non-executive with the South West Yorkshire Partnership NHS Foundation Trust. I have strong connections to Yorkshire, which has been my home since 1988, when I joined Terry's of York as a graduate trainee. In the years that have followed, I have continued to develop my insight into the profile of Yorkshire and have worked extensively in the regional areas served by the Trust. I am committed to the ***values of the Trust and the experience of patients, carers and the community***. I understand the demographics of the area and the challenges this brings in the context of healthcare. I have individuals in my personal life and experience of working with people in my professional life who belong to disadvantaged groups. In deciding to move to a non-executive career I have sought to do this in the region where I live to enable me to give something back to the local community. In this vein I have recently been appointed as property Development Board Advisor to Joseph Rowntree and believe the position of Non-Executive with the Trust further aligns to my community commitment.

A significant part of my executive career has been with an investment development and construction company (Skanska) which is a £1.6bn revenue **large complex organisation** and global industry leader in **environmental sustainability** (*Financial Times" Climate Leader in Europe" for the third year in a row 2024*). As a large global business, Skanska delivers to UK customers in both the public and regulated sectors such as the NHS, defence, energy, transport, education and property development. I have led operations in each of these sectors. I was appointed to Managing Director in 2007 and in 2016 I was promoted to the C-suite role of Executive Vice President (EVP) for operations and to the Skanska Norway board. Success in my career has been attributable to several factors, including ***an ability to accept accountability and probe and challenge constructively***, this being evident in the outcomes of delivering P&L targets in consecutive years as Managing Director and EVP.

My most recent role within Skanska included being the C-suite lead on ***strategy development (balancing needs and constraints)*** customer experience transformation and IT. As the executive responsible for IT, I was the sponsor of the recently implemented Oracle ERP cloud platform. In addition, I was the executive lead for the team that assessed the business cases for all new investments in IT & digital technologies, I pioneered the early assessment and adoption of Artificial Intelligence tools and worked with the CEO as co-leader for cybersecurity.

Being the executive lead for IT and ***digital technologies,*** I was sponsor for the delivery of a new ERP IT technology platform, replacing a twenty-year-old legacy system to Oracle cloud. I successfully led this to being delivered by the 'go-live' date agreed with the Board. The complexity of this transformation project enabled the organisation to adopt world-class processes and access automations that would lead to reduced costs across the core business functions of finance, procurement and commercial management. I was also an early identifier of the business opportunities being presented by the emergence of ***Artificial Intelligence (AI),***engaging with PWC, Microsoft and Salesforce to identify global best-practice applications and their relative ease of application within the organisation, with a view to more efficient business processes and improved user-interfaces.

I am ***committed to quality and delivering excellence.*** As the C-suite executive with responsibility for

operational delivery, this included the geotechnical engineering construction of London City Airport, the construction and upgrades of water treatment works with Anglian Water and the replacement of thousands of kilometres of gas pipeline for National Grid. The respective customers for each of these critical national infrastructure programmes were respectively commended for their engineering excellence and the quality of the service provided.

The Jospeh Rowntree Housing Trust (JRHT) own and operate some 2,500 affordable and social ***housing*** homes and ***care*** homes, primarily within York and North Yorkshire and intend to build a further 1,000 social and affordable homes by 2030. I am responsible to act on behalf of the Board to challenge, support and provide rigour to the Executive in relation to Development. This encompasses making recommendations to the Board for the Development **Strategy and approval of revised strategies,** reviewing and monitoring risk related to development activities and within the built asset portfolio, providing assurances to the Board. Also, to ensure that the principles of Development align with JRHT values & outcomes as well as the approval of Development activity in relation to all new build.

Success in my career both as a C-suite executive and more recently in my transition to the role of Non-Executive Director has required that I have achieved desired outcomes through my ability to apply ***strong relationship management and influencing skills.*** For example, as EVP I led a business-wide transformation programme to improve the Customer Experience. This involved applying customer insights methods and conducting a critical analysis of the level of customer advocacy for strategically important customers, which identified the need for radical change. This required engaging with key stakeholders whilst exploring options to address legacy practices and designing a customer insights capability to deliver clear customer-experience aspirations. This approach gained Board approval resulting in extensive communications and skills training to scale and align the business to deliver against tangible customer outcomes. This resulted in a material improvement in customer feedback and advocacy measures.

I have been a board member of several joint-venture programmes, requiring ***positive and collaborative engagement in Board discussions.*** This approach being especially valuable to ensure successful outcomes in the delivery of large infrastructure projects, such as the @one alliance board with Anglian Water and the gas mains replacement programme for Cadent. I was recently awarded the Financial Times non-executive Director, Level 7 Advanced Professional Diploma part of which assessed that my board room behavioural preferences are to be ‘highly ***collaborating***’ using the ‘Thomas-Kilmann Conflict Mode Instrument, TKI’.

I have a ***strong commitment to promoting equity, inclusion and diversity***. As a senior leader within Skanska, I have personally led in areas that have helped to transform the culture. For example, I initiated a comprehensive review of potential succession candidates, assessing their technical & leadership potential alongside their ambition and executive capability. Having agreed development plans for those candidates identified as high-potential, I personally engaged in mentoring & reverse-mentoring activities, this leading to succession plans being secured for the business and a step-change in inclusion momentum. This was achieved with the intent of creating a more inclusive & diverse culture, leading the leadership team through a series of supportive exercises to enable a psychologically safe space for individuals and the team to experiment with new ideas.

I have previously acted in an ambassador role during my executive career, for example representing Skanska within the railway industry through the transport museum corporate sponsorship programmes and would be happy to be an ***ambassador for the Trust***.

I trust that I have provided you with sufficient insight to enable you to assess my application for the role. I

would be pleased to provide further clarity should this be required.

Yours Faithfully

Martin Neeson

Members' Council
7 May 2025
Agenda item 7.2

<table>
<tr><td>Private/Public paper:</td><td>Public</td></tr>
<tr><td>Title:</td><td>Appointment of Deputy Lead Governor</td></tr>
<tr><td>Paper presented by:</td><td>The Chair</td></tr>
<tr><td>Purpose:</td><td>To consider the recommendation from Nominations Committee to appoint Daz Dooler as Deputy Lead Governor.</td></tr>
<tr><td>Executive summary:</td><td>Background
1. The role of the Nominations' Committee is 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, Non-Executive Directors (NEDs), Associate Non-Executive Directors, Deputy Chair / Senior Independent Director, and the Lead Governor / Deputy Lead Governor.

2. Claire Den Burger Green was appointed as Deputy Lead Governor on 1 May 2023 for three years and has resigned as of 30 April 2025.

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

4. The agreed process is as follows:

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

5. The Corporate Governance Manager wrote to all governors on 20 March 2025 inviting them to self-nominate and a reminder was sent on 27 March 2025. Two self-nominations were received.</td></tr>
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<tr><td></td><td>6. On 11 April 2025, the Nominations Committee considered the self-nominations and made a recommendation to the Members' Council for the appointment of Daz Dooler as deputy lead governor.

7. Details of the role is attached for information along with Daz Dooler's supporting statement.</td></tr>
<tr><td>Recommendation:</td><td>The Members' Council are asked to:
APPROVE the appointment of Daz Dooler to the role of Deputy Lead Governor for appointment for a term of office for three years from the 1 May 2025 to 30 April 2027.</td></tr>
<tr><td>Mission/values:</td><td>Good governance supports the Trust to deliver its mission and adhere to its values.</td></tr>
<tr><td>Strategic Objectives</td><td><table>
<tr><td>Live Our Values</td><td>✓</td></tr>
<tr><td>Be the best we can be:
• Best quality
• Best partner
• Best value
• Best place to work and learn</td><td>
✓
✓
✓
✓</td></tr>
<tr><td>Be ambitious</td><td>✓</td></tr>
</table></td></tr>
<tr><td>BAF Risk(s):</td><td>N/A</td></tr>
<tr><td>Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships</td><td>N/A</td></tr>
<tr><td>Any background papers / previously considered by:</td><td>Nominations Committee 11 April 2025</td></tr>
</table>

Darren Dooler - Expression of Interest for the role of Deputy Lead Governor

I would like to express my interest in the Deputy Lead Governor role.

I feel that my experience as a publicly elected governor has given me the insight and knowledge to be able to support the Lead Governor in their duties and fulfil the role as necessary, and as written in the vacancy responsibilities.

My work within the VCSE sector as a lived experience practitioner gives me first-hand knowledge of mental and emotional health and my role as a C.I.C. Director also gives me some of the necessary knowledge of the governance required to fulfil this role.

I trust that my expression is acceptable.

My very best regards,

Daz

Darren G. Dooler

Public Governor - Wakefield

Deputy Lead Governor arrangements

Approved by Nominations Committee 6 March 2020

Since October 2009, the Trust has been required by its regulator, NHS Improvement (previously Monitor), to appoint a Lead Governor. The role of a nominated lead governor is outlined in Monitor's The NHS Foundation Trust Code of Governance (Appendix B). In addition, following a review of the Trust Constitution in 2019/20, it was agreed to introduce the role of Deputy Lead Governor to support the Lead Governor to fulfil their role and to provide cover for the Lead Governor as required.

The main duties of the Deputy Lead Governor are to:

1. In the absence of the Lead Governor, chair any parts of Members' Council meetings that cannot be chaired by the person presiding (that is, the Chair or Deputy Chair of the Trust) due to a conflict of interest in relation to the business being discussed
2. Be a member of the Nominations' Committee (except when the appointment of the Deputy Lead Governor is being considered)
3. Be involved in the assessment of the Chair and Non-Executive Directors' performance;
4. Deputise as Chair the Co-ordination Group (as required) in the absence of the Lead Governor to assist in the planning and setting of the Members' Council agenda and governor development
5. Support new governors
6. Support the Trust / Members' Council Chair in dealing with governor conduct issues
7. Liaise with the Chair of the Trust / Members' Council.

The individual appointed should be confident they can undertake the duties outlined above. The individual should also:

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

<u>Time commitment - meetings</u>
In addition to attendance at Members' Council meetings (held quarterly), the Deputy Lead Governor may be **required** to:

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

- Be a member of and attend Nominations' Committee (held as required in Fieldhead);
- In the absence of the Lead Governor, act as chair for items at Nominations' Committee meetings where the Chair of the Trust has a conflict of interest;
- Attend and represent the governors at the Annual Members' Meeting (held annually in different locations within the Trust's geography);
- In the absence of the Lead Governor, take part in any Chair or Non-Executive Director (NED) recruitment processes
- Attend an annual one-to-one review meeting with the Chair of the Trust.

Process for appointment

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

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

Members' Council
7 May 2025
Agenda item 7.3

Private/Public paper:	**Public**
Title:	**Consultation / Review of Audit Committee terms or reference**
Paper presented by:	**Andrew Lister – Head of Corporate Governance (company secretary)**
Purpose:	The purpose of this item is to update the Members' Council on the updates to the Audit Committee's Terms of Reference. These updates were approved by the Trust Board at their meeting on 29 April 2025.
Executive summary:	Trust Board Committees are responsible for scrutiny and providing assurance to Trust Board on key issues within their Terms of Reference. Since the last presentation to the Members' Council the Audit Committee Terms of Reference have been updated to reflect the following: • Receipt of a bi-annual update on the Trusts compliance with the accessible information standard (AIS) • Review of the Trust's approach to Freedom to Speak Up including receiving at least 2 reports every year, one of which should be the annual report, from the lead Freedom to Speak Up Guardian. • Receipt of the Freedom to Speak Up Strategy and action plan and review in detail of relevant performance indicators. • Monitoring of clinical audit via the Quality and Safety Committee • In line with the Trust Treasury Management Strategy and Policy receives regular updates to on treasury management and interest receivable to provide assurance of appropriate management. Members' Council should note that the Audit Committee terms of reference align fully to the Healthcare Financial Management Association Model Audit Committee terms of reference released in 2024. Alignment has been tested by 360 Assurance (Trusts internal auditor) and approved by Audit Committee.
Recommendation:	**The Members' Council are asked to:** **RECEIVE** the updates to the Terms of Reference for the Audit Committee.
Mission/values:	Good governance supports the Trust to deliver its mission and adhere to its values.
Strategic Objectives	Live Our Values ✓ Be the best we can be: • Best quality ✓ • Best partner ✓ • Best value ✓

	• Best place to work and learn	✓	
	Be ambitious	✓	
BAF Risk(s):	All risks		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	The Audit Committee provides assurance to Trust Board on matters included in its duties, as part of its terms of reference, so that the Trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the Integrated Care Partnerships and Integrated Care Boards, and place-based partnerships.		
Any background papers / previously considered by:	The Audit Committee 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. Historically provision C.3.2b stated 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 the Code of Governance for NHS Provider Trusts (October 2022) applied in April 2023, this provision has been removed. However, the Assistant Director of Corporate Governance and the Company Secretary believe the Audit Committee's Terms of Reference should continue to be presented to the Members' Council on an annual basis to demonstrate best practice.		

AUDIT COMMITTEE
Terms of Reference
Approved by Trust Board 29 April 2025

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 the code of governance for NHS provider trusts (October 2022) 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 Chair of the Committee is appointed by Trust Board and the Chair of the Committee cannot be the Chair of the Trust. The Chair of the Committee should not be the Deputy Chair or Senior Independent Director.

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. At least one Non-Executive member of the Committee should have recent and relevant financial experience.

Membership as at 1 April 2025
Chair – Non-Executive Director – Mike Ford
Non-Executive Director – David Webster
Non-Executive Director – Nat McMillan.

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 local counter fraud specialist is required to attend a minimum of two meetings a year.

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.

The accounting officer (Chief Executive) should be invited to attend meetings and should discuss at least annually with the audit committee the process for assurance that supports the governance statement. They should also attend when the committee considers the draft annual governance statement and the annual report and accounts.

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 Audit Committee will meet with the External Auditor and Head of Internal Audit in private, on at least one occasion, per year. The Chair of the Committee, External Auditor or Head of Internal Audit may request a meeting if they consider one is necessary. The External Auditor and Head of Internal Audit have the right of direct access to the Audit Committee Chair. There will also be an additional annual 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.

Health and Safety - (moved across from Quality and Safety Committee 1st April 2022)

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 for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, including the NHS Code of Governance and NHS Provider licence
- 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 counter fraud, bribery and corruption as required by the NHSCFA.
- 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.
- These processes reassure individuals raising concerns that they will be protected from potential negative repercussions.

<u>Internal Audit</u>
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.

<u>External audit</u>

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 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 satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.

With regards to the local counter fraud specialist it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports. 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.
- Have a responsibility to refer any suspicions of fraud, bribery and corruption to the NHS Counter Fraud Authority

Management

The committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The committee may also request specific reports from individual functions within the organisation (for example, compliance reviews or accreditation reports).

Financial reporting

The Committee has responsibility for approving accounting policies. It reviews the Trust annual report and financial statements, in order 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, 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.
- Significant adjustments arising from the annual audit.
- The wording in the annual governance statement and other disclosures relevant to the terms of reference of the Committee.
- Unadjusted misstatements in the financial statements.
- Letters of representations.
- Explanations of significance variances.

Committee members will review the Charitable Funds annual report and accounts, prior to submission to the Charitable Funds Committee.

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.
- Reviews the Trust's approach to Freedom to Speak Up including receiving at least 2 reports every year, one of which should be the annual report, from the lead Freedom to Speak Up Guardian.
- Receives the Freedom to Speak Up Strategy and action plan and review in detail relevant performance indicators.
- Receives assurance from the Quality and Safety Committee that clinical audit is receiving sufficient oversight.
- In line with the Trust Treasury Management Strategy and Policy receives regular updates to on treasury management and interest receivable to provide assurance of appropriate management.

Other Compliance
1. To provide assurance that the Trust has effective arrangements for the management of safety and emergency response including through the receipt of assurance reports provided by the Health and Safety TAG.
2. To provide assurance that the Trust has effective arrangements in place to demonstrate compliance with the accessible information standard (AIS) through the receipt of a bi-annual update report.

Other Assurance Functions
The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include any reviews by the Department of Health and Social Care, arms-length bodies, or regulators/inspectors (e.g. Care Quality Commission and NHS England, NHS Resolution, etc) professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

In addition, the committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the audit committee's own areas of

responsibility. In particular, this will include any committees covering safety/quality, for which assurance from clinical audit can be assessed, and risk management.

Governance regulatory compliance
The committee shall review the organisation's reporting on compliance with the NHS Provider Licence, NHS code of governance and the fit and proper person's test.

The committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

Behaviours and Conduct
Trust values
Members will be expected to conduct business in line with the trust values and objectives.

Members of, and those attending, the committee shall behave in accordance with the trust's constitution, standing orders, and standards of business conduct policy.

Equality and diversity
Members must demonstrably consider the equality and diversity implications of decisions they make.

Relationship with the Members' Council
To reflect best practice, 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 chair of the audit committee shall draw to the attention of the board any issues that require disclosure to the full board or require executive action.

- The committee will report to the board at least annually on its work in support of the annual governance statement, specifically commenting on the:
  - fitness for purpose of the assurance framework
  - completeness and 'embeddedness' of risk management in the organisation
  - effectiveness of governance arrangements

    - appropriateness of the evidence that shows that the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.
- This annual report should also describe how the committee has fulfilled its terms of reference and give details of any significant issues that the committee considered in relation to the financial statements and how they were addressed.

An annual committee effectiveness evaluation will be undertaken and reported to the committee and the board.

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.

Secretariat and administration
The committee shall be supported administratively by its secretary. Their duties in this respect will include:

- agreement of agendas with the chair and attendees
- preparation, collation and circulation of papers in good time
- ensuring that those invited to each meeting attend
- taking the minutes and helping the chair to prepare reports to the board
- keeping a record of matters arising and issues to be carried forward
- arranging meetings for the chair: for example, with the internal/ external auditors or local counter fraud specialists
- maintaining records of members' appointments and renewal dates and so on
- advising the committee on pertinent issues/ areas of interest/ policy developments
- ensuring that action points are taken forward between meetings

Approved by Trust Board:
Next review due: 1 April 2026

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

The Quality Assurance System

With **all of us** in mind.

What is the Quality Assurance System

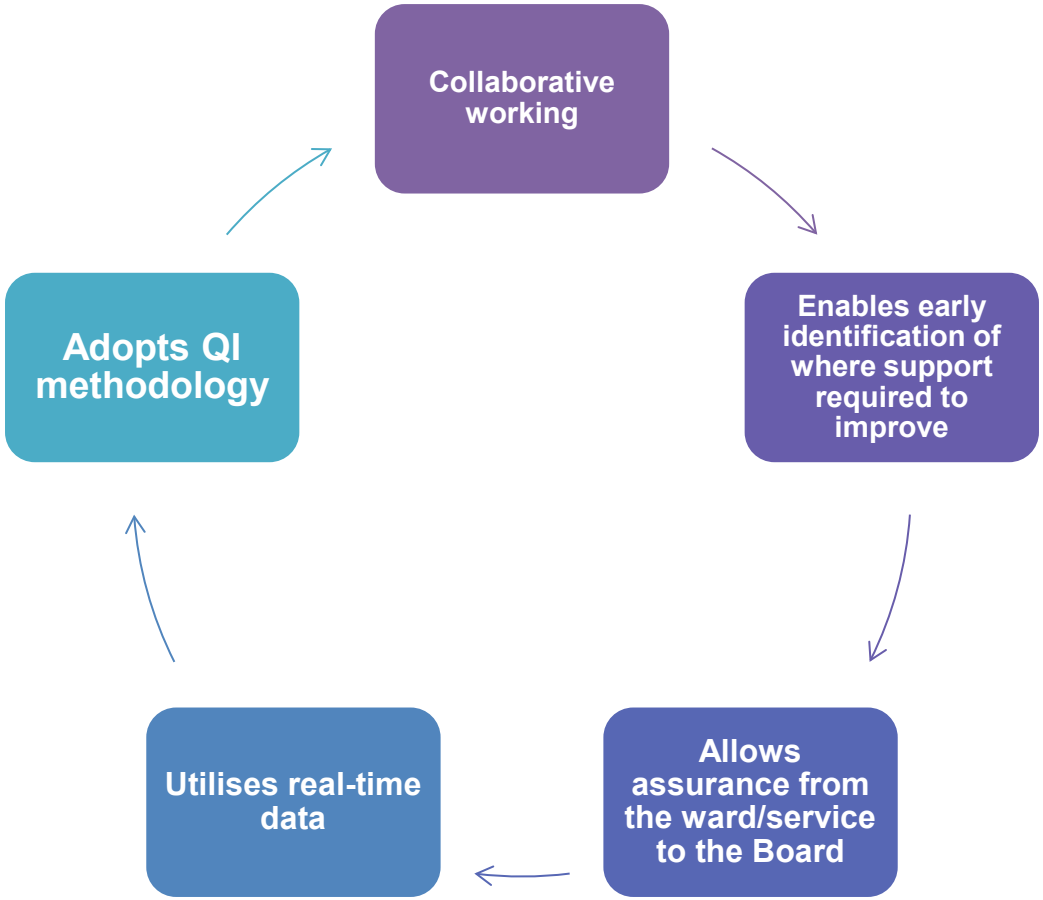
South West Yorkshire Partnership NHS Foundation Trust

The Quality Assurance System (QAS) is a framework that triangulates data, information and feedback to provide an oversight of quality and culture across Trust services.

With **all of us** in mind.

Principles of the QAS

South West Yorkshire Partnership NHS Foundation Trust



With all of us in mind.

The three QAS levels

South West Yorkshire Partnership NHS Foundation Trust

Routine monitoring

- Default position for all services
- Utilises existing monitoring and oversight within Care Groups
- Quality dashboard development
- Routine quality walkaround

Enhanced monitoring

- Where there are persistent or increasing concerns
- Rapid quality review meeting
- Enhanced quality walkaround (more focused visit)
- Quality improvement approach (six-step process)

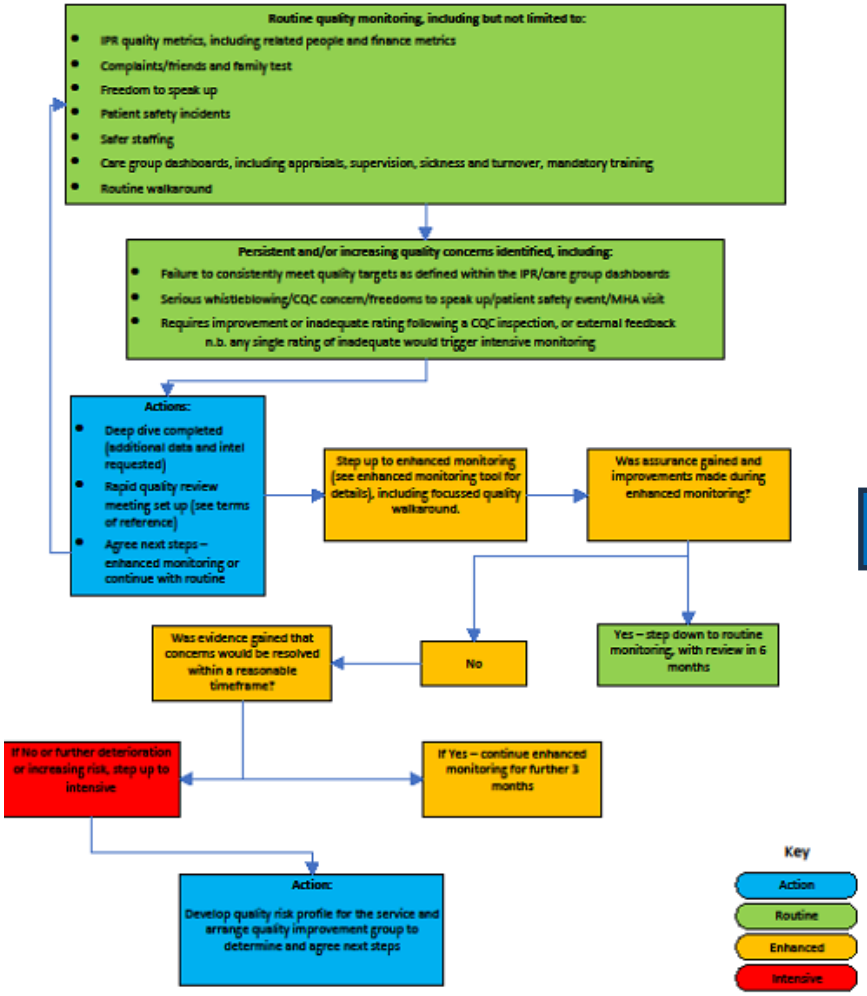
Intensive monitoring

- In exception circumstances on, where there are significant concerns, failure to improve or where a service is rated inadequate
- Quality improvement group
- Intensive quality walkaround
- Quality improvement approach
- Quality risk profile

With **all of us** in mind.

Quality Assurance and Quality Improvement

South West Yorkshire Partnership NHS Foundation Trust



With **all of us** in mind.

Things to celebrate

South West Yorkshire Partnership NHS Foundation Trust

- Developed a **draft Toolkit** to support people with all levels of the QAS
- Implementation of **quality walkarounds**, from April 2024.
  - These have included enhanced and intensive walkarounds
  - To date there have been 36 quality walkarounds completed
- Adoption of the **enhanced monitoring process** and collaborative working with three teams who have been on enhanced monitoring.
  - This has included action plan development, ownership by the services and improvements made and evidenced Lots of improvements at a local level have been made
- Pilot of **intensive monitoring** at Cheswold Park, including a quality improvement group chaired by a non-exec director
- Quality oversight dashboard is in development
- Reviewed and update our '15 step challenge' template

Quality Walkaround data for 2024/2025	
How many Exec's	6
How many NED's	7
How many Gov's	6
How many staff	34
How many walkarounds	36
How many revisits	4

With **all of us** in mind.

South West Yorkshire Partnership NHS Foundation Trust

*The Quality Walkabout team were **very professional**, and the Community mental health team found them approachable and overall, a **positive experience.***

*Initially the team were apprehensive about the walkabout which I was able to share prior knowledge of the process with them, **however an email about the process/ purpose that could be shared with the team prior to the visit would be beneficial**.*

*The team appreciated the feedback given and how that was from the wider Trust which gave them a **sense of being valued** further than the local senior managers.*

We were fortunate in terms of not having any identified actions for the team from the visit but more trust and building issues which the team addressed promptly and were resolved and hopefully they will take further at a higher level.

Judith Megson, Team Manager, Older Peoples Services

With **all of us** in mind.

Feedback

South West Yorkshire Partnership NHS Foundation Trust

A survey of people who have been part of a visit team for a quality walkaround to date has included the following feedback:

91% of respondents felt supported prior to the walkaround

91% of respondents felt they had enough information to complete the walkaround

100% of respondents felt that the quality walkarounds are beneficial to the services and the Trust

With all of us in mind.

Feedback

South West Yorkshire Partnership NHS Foundation Trust

Feedback from staff who have experienced a walkaround within their team/service:

69% of respondents felt the walkaround was what they expected

93% of respondents felt that the notification timeframe to teams/services of approx. 3 weeks was adequate

100% of respondents felt that the quality walkarounds are beneficial

With all of us in mind.

Feedback continued

NHS
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The following question was asked as part of the survey:
We are continuously looking to improve the process, what are your thoughts/ideas?

- When I supported a quality walk around, I noted that other members of the visit team were not complaint with policy in terms of dress & IPC (bare below the elbow etc.) which doesn't demonstrate leadership by example.
- I hope that those on the walkaround are kept informed on the progress against issues / actions raised.
- To ensure there are rooms available to speak privately.
- Brief explanation of the process and how it is undertaken which can be shared with the team to reduce anxieties and concerns over the process.
- Coproduction/expert by experience on the panel.

With **all of us** in mind.

Next Steps

South West Yorkshire Partnership NHS Foundation Trust

April 2025: Launch the developmental Quality Assurance System Toolkit across the Trust

May 2025 onwards: Develop Implementation Group with key operational teams and stakeholders

April – October 2025: Develop quality dashboard with performance and business intelligence and integrated change team. Then test the use of this October – March 2026

Ongoing: Work with the Research Team to evaluate and measure impact

March 2026: Finalise and publish the toolkit- March 2026.

With **all of us** in mind.

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South West Yorkshire Partnership
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With **all of us** in mind.

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Members' Council
7 May 2025
Agenda item 9.1

Private/Public paper:	**Public**
Title:	**Annual Report for Quality Monitoring Visits 2023/24**
Paper presented by:	**Darryl Thompson, Chief Nurse and Director of Quality and Professions**
Purpose:	The purpose of the paper is to provide an overview on quality monitoring visits which were completed during 2023/24. This paper was presented to Quality and Safety Committee in September 2024. The paper also includes oversight of the new quality oversight, monitoring and support system (QOMSS), which has since been renamed at the Quality Assurance System and a separate presentation regarding this is being shared with members. Of note, this report was previously titled annual report of announced and unannounced visit. It has been clarified with the corporate governance team that going forward, the report that will best meet the original intention of that title will be the Quality Assurance System annual report. This report for last year is presented to Members Council for completeness.
Executive summary:	The quality monitoring visit (QMV) programme has been a well-established internal quality governance framework for many years, within the Trust. QMVs were developed to serve a specific purpose and to align with the care quality commission (CQC) inspection regulatory process at the time. During 2024, CQC launched the single assessment framework and made changes to the way it inspects and regulates organisations. In order to ensure our internal processes, align with new ways of working and to strengthen internal governance and oversight processes, a new system, the Quality Assurance System (referred to as the quality oversight, monitoring and support system (QOMSS in the paper) was developed during 2023/24 and was launched in early 2024. The QMV programme for 2023/24 was developed based on learning from the 2022/23 programme and review. The approach was adopted to be more flexible, allowing for visits to be more focussed and to take place at short notice if urgent concerns were raised. During 2023/24 sixteen QMVs were completed, and these identified a number of positive areas of practice and some areas for improvement. The areas for improvement largely align with findings from the recent CQC inspections and

	already identified priority programmes of work which are in place across the Trust. **Learning from QMVs** Below is a summary of themes identified. Not all are relevant to all wards/services and further detail is contained within the report. A number of positive themes were identified during the visits and these included: • Staff found to be welcoming and have a positive commitment to provide the best service possible • Good or improved multi-disciplinary team working • Good safeguarding practices • Improvements noted in physical health monitoring and understanding (from previous years) Some areas for improvement were also identified and these included: • Use of bank and agency staff • Mandatory training compliance • Recording of supervision • Involvement of carers and families in service user care Any service specific concerns which required immediate escalation were shared at the time of the visit with the senior leadership team for immediate review and action. Trust-wide themes: • Monitoring and use of lone working devices • Issues with panic alarm availability • Recording of observation levels on SystmOne • Wi-fi issues on inpatient units **Monitoring, oversight and link with key work programmes** Each clinical area produces a quality improvement plan following a QMV. This is monitored through each of the Care Group Quality and Governance Groups. Updates and themes from QMVs are shared through the regular Quality and Regulatory Oversight paper which is presented to the Quality and Safety Committee on a monthly basis. A number of areas for improvement, identified during QMVs are related to or contribute to ongoing programmes of work, including: • Improving access to care – focus on waits for community learning disability services, CAMHS, psychological therapies

<table>
<tr><td></td><td>
CQC inspection reports MUST and SHOUL DO actions and action plans which are in place following the CQC inspections in May 2023
Next steps
The QMV programme has now finished and has been replaced by a wider and more robust system, known as the quality assurance system (referred to as quality oversight, monitoring and support system (QOMSS) in the paper). This was introduced in a phased way from April 2024 and continues to evolve and develop. This includes quality walkarounds. This new process aims to triangulate information from across the trust, link with and not duplicate actions and work already happening and provide a lighter touch approach. This is in line with the new CQC regulatory process where services will be required to undertake self-assessment and provide information and assurance to the CQC.
A separate presentation is being shared with members regarding the quality assurance system.
An annual report for the quality assurance system will be produced in September 2025.
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<tr><td>Mission/values:</td><td>The report demonstrates commitment to all the Trust’s values, which are fundamental to delivering safe and high quality health care:
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Best value
Best place to work and learn</td><td>✓

✓</td></tr>
<tr><td>Be ambitious</td><td>✓</td></tr>
</table>
</td></tr>
<tr><td>BAF Risk(s):</td><td>1.1 Measures are not taken to identify and address discrimination across the Trust resulting in poor patient care and staff experience.
1.2 Compassionate and diverse leadership and a values-based inclusive culture is not delivered resulting in a poor workforce and service user experience.
2.3 Failure to create a learning environment leads to lack of innovation and to repeat incidents.</td></tr>
</table>

	2.4 Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care and service user outcomes.
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	Delivering safe and effective services is a priority of all health and social care providers. This is a shared priority across the Integrated Care System, Integrated Care Board, Place based partnerships and is a regular feature of our shared objectives and actions. Being part of the Integrated Care System allows for opportunity to share learning, findings and best practice to ensure services are delivered to the highest standard. Understanding our current position, areas of strength and areas for improvement supports us to be an engaged member of the integrated care systems support and consider opportunities for economies of scale.
Any background papers / previously considered by:	The Quality Monitoring Annual report for 2022/23 was shared with Quality and Safety Committee in September 2023. This paper was shared with Quality and Safety Committee in September 2024. Overview of quality monitoring visits and new quality walkarounds have been provided monthly within the quality and regulatory oversight paper. A bi-monthly paper on the quality assurance system is shared with the Quality and Safety Committee and the executive management team.

Members Council
May 2025
Annual Report for Quality Monitoring Visits 2023/24

1. Background

The quality monitoring visit (QMV) programme has been a well-established internal quality governance framework for many years within the Trust. QMVs were developed to serve a specific purpose and to align with the care quality commission (CQC) inspection regulatory process at the time. In the last year, the CQC have launched the single assessment framework and made changes to the way it inspects and regulates organisations. In order to ensure our internal processes align with new ways of working and to strengthen internal governance and oversight processes, a new system, the quality oversight, monitoring and support system (QOMSS) was developed during 2023/24 and was launched in early 2024.

This report will look back at the previous year's QMVs and outline any themes and learning. Information about the new QOMSS approach is also included and future annual reports will align with this new system.

The QMV programme for 2023/24 was developed based on learning from the 2022/23 programme and review. The approach was adopted to be more flexible, allowing for visits to be more focussed and to take place at short notice if urgent concerns were raised.

The main aims of the quality monitoring visit programme for 2023/24 were:

- To undertake visits to both inpatient and community-based teams. This included teams and services who had not had a QMV for a number of years and those where issues had been highlighted through CQC enquiries, serious incidents or by other means
- To undertake at least two QMVs per month, to allow for thorough planning in advance and collection of all relevant data to make the visit meaningful and relevant to that particular service.

2. 2023/24 Visit schedule

During 2023/24 (April to March) sixteen visits were completed. These visits covered a wide range of services across inpatient settings and community services. The aim at the start of the year was to undertake two QMVs per month (excluding the Christmas and New Year period). This would be around 20 to 22 QMVs in the year. The following impacted on these all being completed:

- CQC inspections of forensic and secure services, and acute mental health and psychiatric mental health services (PICU), which was unannounced and took place in May 2023. As a result two QMVs were postponed.
- The focus on the factual accuracy checking process following receipt of the CQC reports in late September 2023. This impacted the availability of the QMV lead and colleagues involved in the process so two further QMVs were postponed.

In order to decide where a QMV should take place the following criteria were used:

- Potential concerns around quality and safety on a ward or in a community setting, based on local intelligence (internal assurance monitoring)
- If concerns existed that may trigger a CQC inspection visit e.g., the team was having an increasing number of serious incidents/CQC enquiries
- Where services had asked for an independent review

Table 1 below provides detail on where QMVs were completed during 2023/24:

Service	Teams	Rationale for inclusion
Learning Disability (LD) inpatient services	• Horizon Centre	• Re-visit following previous serious concerns from a QMV
Adult community mental health	• Barnsley West Enhanced Team • Barnsley East Enhanced Team • Barnsley Core Team	• Potential concerns raised. • Potential concerns raised. • Request from team
Adult inpatient mental health and psychiatric intensive care unit (PICU)	• Elmdale Ward • Ward 18 • Clark Ward • Melton PICU • Walton Ward	• Concerns raised. • Re-visit following previous serious concerns from a QMV. • Concerns raised • Concerns raised • Potential concerns
Forensics inpatients	• Waterton Ward • Bronte Ward • Newhaven	• Re-visit following previous serious concerns from a QMV. • Concerns raised from CQC MHA visit • Lack of recent visit
Forensics community teams	• FOCUS CAMHS • LD & Autism Forensic Outreach Liaison Service • Specialist Community Forensic Team	• Request of service senior management team. • Request of service senior management team. • Request of service senior management team.
Child and adolescent mental health services (CAMHS)	• Wakefield CAMHS	• Potential concerns.

3. Scope of the reviews

At each QMV the following were assessed/reviewed (this is consistent with previous years):

- Service/team improvement plans, including any previous CQC actions related to the service
- Previous QMV findings (if applicable)
- Local intelligence gathered from complaints, CQC enquiries, staff surveys etc.
- Risk assessments, to check for compliance with standards and policies.

- Care planning, to check for compliance with standards and policies.
- Safeguarding practices
- Infection prevention and control practices
- Medication management
- Indicators of culture within the service

4. Visiting team representation

A member of the Quality Governance Team (QGT), which at the time was known as the Quality Improvement and Assurance team (QIAT), oversaw the QMV programme throughout the year. This included planning and facilitating visits with support from two project leads.

The QMV programme was supported by a pool of staff who requested to actively participate with QMVs. The visit team is designed to consist of people with appropriate knowledge and skills and some knowledge of the team being visited and the service user group. This enables the visit to be both team and person-centred and ensures that the oversight of quality is robust.

Each visit team consists of four to six people including:

- Matrons / Quality Governance Leads / Practice Governance Coaches
- Allied Health Professionals
- Nurses
- Therapists
- Medics
- Infection Prevention Control team
- Mental Health Act team
- Safeguarding team
- Pharmacy
- Non-Executive Directors
- Governors

5. Learning from QMVs

The QMV process provided the visit team with the opportunity to feedback good practice to the teams receiving a visit. Team managers, service managers and general managers are often the people who receive the initial feedback following a visit and are appreciative of this feedback. There is an acknowledgement across teams that continuous improvement in services is required and the feedback provided can help to establish or contribute to already established improvement programmes. In some cases, where serious concerns were identified, immediate escalation to senior leadership team was completed.

Following initial feedback to the teams and addressing any immediate concerns, reports are completed and shared with the service within two weeks of the visit. From this report and feedback, teams are required to produce an action/improvement plan outlining the actions they will be taking to address areas for improvement. The action/improvement plan is monitored through their own governance and assurance systems e.g., Care Group Governance meeting. The Nursing, Quality and Professions Directorate provide support to teams to make improvements.

5.1. Summary of positive themes from visits

Common positive themes found throughout the QMVs for 2023/24 included:

- Staff found to be welcoming and have a positive commitment to provide the best service possible

- Good or improved multi-disciplinary team working
- Good safeguarding practices
- Improvements noted in physical health monitoring and understanding (from previous years)

The following table summarises the positive findings from QMVs, shared by service line.

Service Line	Common themes
Learning Disability inpatient service (only one service visited)	• Staff were welcoming and showed commitment to providing the best service possible. • Risk assessment information was generally of good standard. • Communication between team members was good. • Incidents were well recorded and properly managed. • Staffing recruitment had improved. • More focus on person centred care than seen in previous QMVs. • Introduction of primary care teams. • Better monitoring of physical health needs. • Reduction in number of incidents with more focus on de-escalation. • Improved range of activities on offer. • More effective multi-disciplinary team (MDT) working, including strengthening the role of the medic within this. • Stronger safeguarding practices. • Improvements in hygiene and cleanliness standards. • Environmental improvements to more suit the needs of the service user group. • Better oversight and governance of improvement plans.
Working age adult community mental health services	• Staff were welcoming, open and transparent. • Good collaborative teamworking within MDTs. • Service users fedback that they felt listened to and involved in their care. • There had been improvements in managing waiting lists. • Risks were regularly discussed within MDT and FACT (flexible assertive community treatment) meetings. • Care was person centred. • Service users' physical health needs were assessed. • Staff understood and followed robust safeguarding practices. • There were safe medication practices. • Staff followed good infection prevention and control practices.

	• Professional development was encouraged.
Working age adult inpatient mental health services	• Despite staffing challenges, staff showed a determined commitment to providing good quality care. • Improvements in recruitment of new staff although staffing remains a challenge. • Service users reported they felt safe on the wards. • Risk assessment information was generally good. • Induction for new staff. • Physical health care monitoring and care. • Multi-Disciplinary Team (MDT) working was effective. • Psychology access and input into teams. • Links with advocacy agencies. • Safeguarding practices. • Incident reporting was mostly good. • Staff development. • Staff and manager support. • Student placement feedback was positive.
Forensic inpatients	• Risk documentation was good. • Care plans were person centred and included the service users' voice. • Teams showed a recovery focussed approach to delivering care. • New staff were well inducted. • Service users had physical health care monitoring and care plans in place to meet any identified needs. • Staff complied with requirements within the Mental Health Act (MHA) code of practice. • Teams had good links with advocacy services. • Safeguarding practices were good. • Incidents were reported and reviewed. • Staff received regular supervision. • Quality improvement initiatives had been undertaken and put into practice. • There was comprehensive and useful information on display boards.
Forensic Community Services	• Comprehensive risk assessment and care planning documentation. • Good physical health monitoring and care. • Documentation captured the service user's voice. • Strong teamworking, including the MDT approach. • Robust safeguarding practices. • Good incident reporting cultures. • Positive carer feedback about services. • Strong management and leadership support. • Valued Trio support. • Good governance systems.

CAMHS (only one team visited)	• Good person-centred care. • Effective communication and information sharing. • Good engagement strategies for service users having difficulty accessing clinics. • Effective management of waiting lists. • Focus on discharge planning. • Manageable caseload sizes. • Good MDT working and interaction with other agencies. • Robust safeguarding practices. • Good incident reporting culture. • Good service user and carer feedback about the service. • Quality improvement initiatives had been undertaken and put into practice. • Well trained staff. • Staff have annual appraisals. • Good staff and management support.

5.2. Summary of common themes where improvements were needed.

Common areas for improvement found during QMVs included:

- Use of bank and agency staff
- Mandatory training compliance
- Recording of supervision
- Involvement of carers and families in service user care

The following table summarises areas of learning/for improvement, provided by service line:

Service Line	Areas for improvement
Learning Disability inpatient service	• High use of bank and agency staff. • Need for clarity around professional standards, lines of accountability and boundaries within decision-making. • Carer involvement and information available to carers. • Service user involvement in care planning needed strengthening. • Seclusion records around food and fluid intake. • Clearer explanation within care records of de-escalation techniques to be used. • Gaps in assurance checks. • Training figures. • Supervision uptake. • Appraisal rates.
Community mental health services	• Caseloads were higher than would be expected. • Risk assessments not always fully completed and up to date. • Inconsistencies in the quality-of-care planning records. • Access to psychology waiting times. • Some delays in returning service user calls and cancellation of visits not always communicated to the service user.

	• Not all supervision was captured and recorded so uptake figures were below expected Trust targets. • Mandatory training levels not meeting Trust targets. • Appraisal rates below expected targets.
Working age adult inpatient mental health services	• Staffing shortfalls that led to high use of bank and agency staff and impacted on 1:1 time with service users, activities on offer and staff morale. • Lack of personalisation in care records. • Lack of information for carers. • Observation care plans did not always accurately reflect the observations being conducted. • Incomplete seclusion records. • Mandatory training figures fell short of expected Trust targets. • Supervision not always captured and recorded. • Assurance checks were not always identifying or addressing issues found. • Staff felt valued by their own management team but not by the wider Trust senior management team.
Forensic inpatients	• Mandatory training figures were not meeting Trust targets. • Some carers said they would welcome better communication with staff. • Whilst some improvements had been made around the availability of activities, further work was needed. • Where environmental issues had been reported to the estates team, there was sometimes delays in addressing these. • Staff felt valued by their own management team but not by the wider Trust senior management team.
Forensic Community services	• Supervision was not always captured and recorded (not all services). • Waiting list for interventions (in one service).
Child and Adolescent Mental Health Services (CAMHS)	• More clarity around the assessment process and different roles within this. • Screening and initial assessments undertaken by telephone only. • Staff clarity around the referral process and pathways. • Long waits to access services. • There were eight different teams within the service. Staff described working in ‘silos’ and felt they had no connection with the wider CAMHS teams. • Carers said they had limited opportunities to speak with staff without their relative’s presence. • Staff lacked clarity around the management structure and lines of accountability. • Staff felt valued by their own management team but were not as positive about their wider senior management team.

5.3. Summary of specific service concerns that were immediately escalated.

Where there were specific concerns that required an urgent response from the service leadership team, these are escalated immediately rather than waiting for the publication of the report, so that appropriate action could be taken.

Service Line	Specific service concerns that were escalated
Working age adult inpatient mental health services	• Continuing concerns from a previous QMV around the leadership and management of the ward (Ward 18). • Inconsistencies in details on the handover sheet (Walton ward).
Forensic inpatients	• A damaged seclusion room on Newhaven that required resin fitting to prevent picking and further damage. This had been reported to the estates team but was still awaiting action.
Forensic Community services	• One service user who had been identified for discharge from the team caseload required their risk assessment updating as the referral remained open to the team.

5.4. Trust-wide themes:

From the above information gathered during QMVs the following trust wide themes have been identified:

Theme	Current actions underway
Monitoring use of lone working devices.	There was inconsistent monitoring and use of lone working devices.
Panic alarms	One team did not have panic alarms within their building. Another team lacked panic alarms in two areas and had an issue that alarms could not always be heard when sounding on different floors.
Recording of observation levels on SystmOne	There were some issues around recording of observation levels onto the electronic system that were being flagged up by matrons.
Wi-Fi issues	Service users described difficulties in being able to use their mobile phones on wards due to inadequate signal strength.

These concerns were escalated at the time with the relevant teams to support with any improvement work that was needed.

6. Improvement actions, reporting and monitoring.

Each clinical area produces a quality improvement plan following a QMV. This is monitored through each of the Care Group Quality and Governance Groups.

Updates and themes from QMVs are shared through the regular Quality and Regulatory Oversight paper which is presented to each Quality and Safety Committee.

A number of areas for improvement which were identified during the QMV programme are related to or contribute to ongoing programmes of work. This includes the following priority programme:

- Improving access to care – focus on waits for community learning disability services, CAMHS, psychological therapies

In addition, and following the Trust receipt of the CQC reports following the two inspections into mental health acute and PICU services and Forensics and secure services, the MUST and SHOULD DO actions have supported improvement work, which link with the finding from QMVs, in the following areas:

- Reducing the use of bank and agency staff
- Improving carer and family involvement in service user care. This also links with the triangle of care programme of work
- Improving compliance with mandatory training
- Improving appraisal rate for staff

This improvement work is monitored and overseen through Care Group governance groups and through the CQC action plan assurance meetings. A process for monitoring the embedding of changes and sustainability of changes is currently being developed.

6.1. Care Group oversight of actions from QMVs

Each Care group is responsible for the oversight and monitoring of individual actions which are developed as a result of a QMV. Where possible, these are incorporated into existing improvement plans and work that is ongoing within each Care Group as outlined above.
The action plans from QMVs are no longer reported on centrally to the QIAT team as robust arrangements are in place across Care Groups.

7. Assurance

The QMV programme has supported the Trust's governance system for the oversight and assurance of the quality of services for a number of years. Alongside the QMVs, other assurance processes are in place within Care Groups. These include:

- matron weekly and monthly assurance checks, utilising Tendable (a recently commissioned electronic system) to record these within acute inpatient settings
- Infection prevention and control teams complete regular visits to wards
- Patient Led Assessments of the Care Environment (PLACE) are completed in line with the national programme and requirements
- Ad hoc visits by Directorate of Nursing, Quality and Professions to wards and services

8. Next Steps

8.1. Quality oversight, monitoring and support system (QOMSS)

A new system for supporting the oversight of quality and culture within services has been developed and was launched across the Trust from April 2024. This new system is aimed at developing a new way of oversight, monitoring and support that is more closely aligned with the changes to the CQC regulatory model. Whilst the previous QMV model provided some assurances to the Trust board, the benefits of the previous model have been limited and we have found that:

- QMVs have been intensive to organise in terms of resources required.
- They are also time intensive in terms of planning, organising, conducting, and reporting on visits.
- It has been challenging to evidence the quality improvement impact of QMVs and the sustainability of this improvement.

- Care Groups have now developed their own more robust improvement plans, including quality improvement initiatives to address must and should do actions from CQC report findings.

The quality oversight monitoring and support system (QOMSS) is based on evidence, research and learning from other trusts, our existing processes and feedback from across our services.

- QOMSS has been co-produced with Care Group colleagues
- QOMSS will aim to triangulate:
    - data and information available through dashboards, reporting and monitoring which give an indicator of quality
    - 'softer' intelligence' such as a 15-step challenge, culture surveys and freedom to speak up
    - quality and safety walkarounds
- There are three categories of oversight and monitoring:
- 1. **Routine QOMSS** (standard position)
- 2. **Enhanced QOMSS**
- 3. **Quality Improvement Group**

Routine QOMSS

The routine level is the default position for all services.
This level will utilise the following information, which provide an oversight of quality and culture such as:

- Care Group dashboards and team level dashboards (developing)
- Ward assurance checks using Tendable (inpatients only)
- Community service standards
- CQC cases (formally enquiries) / external whistleblowing
- Datix and safety incidents and links with PSIRF themes and learning
- Freedom to Speak Up Guardian intelligence
- Complaints and compliments
- CQC Mental Health Act visit finding

- A dashboard is in development which brings together available data
- As well as monitoring of data and evidence, there will be a 'light touch' and a more informal approach to monitoring teams and services
- The Quality and Safety Walkaround (QSW) will have more emphasis in listening to what service users, carers and staff say about the service and less focus on reviewing documentation such as care records

The Quality and safety walkaround

- This is a proven quality intervention that focusses on open and transparent communication.
- It looks at systems and processes rather than individuals and supports 'Board to ward' involvement.
- It enables service users, staff and others to work together to identify improvements and overcome any barriers to this.
- It encourages conversation around:
    - Service user and staff safety
    - Culture
    - Equipment

- Tasks
- Environment
- Organisation
- Service user engagement

Enhanced QOMSS (stage 2)

In cases where a team or service is identified as an outlier through metrics, soft intelligence or a walkaround, the following actions will be taken:

- An extraordinary meeting will be set up with key stakeholders e.g. a matron for the service, assistant director, specialist advisors etc.
- Any further evidence will be gathered and reviewed
- A follow-up meeting will be organised within 48 hours to review the intelligence and agree next steps

The type of additional support and/or next steps will be based on need and could include for example, specialist support or a quality improvement initiative. The agreed actions will be monitored through:

- The Care Group reporting into their respective Care Group Governance meeting and provide assurance to the Clinical Governance Group meeting
- A further QSW or a quality monitoring visit (QMV) will also be planned for 12 weeks (or an agreed timeframe) after the agreed action plan offer commences
- After the QSW follow-up, another extraordinary meeting will be held to review all evidence and to decide if the team can return to routine monitoring or if further action is needed
- Some improvement would be expected after 3 months but it is acknowledged it might take up to 6 months to embed changes

Quality improvement group (stage 3)

At the time of writing, this stage is still under development. In the event of teams not making suitable improvements and actions following enhanced monitoring then they may be moved to stage 3. This would be in exceptional circumstances only. This is likely if there are 6 months with no improvement.

This would mean:

- Further discussions and agreement with senior leaders from the Care Group.
- Reporting into the Quality and Safety Committee via the highlight report for an agree period.

9. Summary

During 2023/24 sixteen QMVs were completed, and these identified a number of positive areas of practice and some areas for improvement. The areas for improvement largely align with findings from the recent CQC inspections and already identified priority programmes of work which are in place across the Trust.

The QMV programme has now finished and has been replaced by a wider and more robust system, known as the quality oversight, monitoring and support system (QOMSS). This was introduced in a phased way from April 2024 and continues to evolve and develop. This new process aims to triangulate information from across the trust, link with and not duplicate actions and work already happening and provide a lighter touch approach. This is in line with the new CQC regulatory process where services will be required to undertake self-assessment and provide information and assurance to the CQC.

Members' Council
7 May 2025
Agenda item 9.2

Private/Public paper:	**Public**
Title:	**Care Quality Commission Inspection Reports - Action plan update for Must and Should Do Actions**
Paper presented by:	**Darryl Thompson, Chief Nurse / Director of Quality and Professions**
Purpose:	The purpose of the paper is to provide Members Council with an update and assurance regarding the Trust's approach to addressing recommendations from CQC inspections carried out on mental health and forensic inpatient services in 2023, and to outline our internal process of assurance that the identified actions are being responded to in an improvement-focused and timely manner.
Executive summary:	On Wednesday 6 December 2023 the reports were published for the Care Quality Commission (CQC) inspections into the core services of acute wards for working age adults and psychiatric intensive care units (PICU), and forensic inpatient and secure wards. These inspection reports were presented to Trust Board in January 2024. This report contains an update on the Trust's progress with regards to the action plans against the 'must do' and 'should do' actions within the CQC inspection reports. The Care Groups have identified that some 'should do' actions are being approached with a clear expectation of completion. Actions are signed off as completed at Care Group level before final sign off by the Chief Nurse / Director of Quality and Professions, where the evidence of assurance is reviewed. The Chief Operating Officer joined the last review of evidence sign off on 4 March, providing a helpful perspective on analysis of data over time to evidence embeddedness. Of note, this report is a live document under a process of continual review and update. A review meeting at Cheswold Park Hospital (CPH) took place on 18 March 2025, and going forward the progress against the CQC actions for CPH will be included in this report in the same format. In the interim, a summary position of CPH actions can be found in Section 10 of this report. There are a number of broader issues outlined within the report, and these are being approached on a Trust-wide basis rather than solely at Care Group level. These include: • Monitoring of essential to job role training. • Oliver McGowan training, for staff working with people with a learning disability and autistic people, and access to the webinar to complete Part 1 of the training. • Appraisal recording given the system changes.

	• Roll out of alternative exit to seclusion and use of alternative injection sites. • Supervision of courtyards/outside spaces. **Current progress** **Sixteen Acute and PICU MUST DO actions:** • Ten are now complete. • Two are complete and awaiting further evidence from the Care Group to enable them to be signed off as embedded. • One action is on track for completion. • Three actions are now amber and off track for completion. Two of these actions relate to care planning and these are off track due to the development and roll out of new person-centred care plans across all SWYPFT mental health services. This has meant a delay in being able to gather evidence and provide quantitative assurance. As the new care plans embed, close monitoring against these actions is taking place and evidence of compliance and embedding will be provided by the Care Group. The third of these actions relates to reducing prone restraint and there is a focus on collaborative work with the RRPI (reducing restrictive physical interventions) team and inpatient wards to roll out training on alternative exit from seclusion and alternative injection sites. As of the 1 April 2025 alternative seclusion exits will be taught as part of both the four-day initial training and 2-day refresher training for Reducing Restrictive Physical Interventions training. In addition to this, focused training regarding alternative seclusion exits will also take place with individual wards. As each individual ward reaches 80% compliance they will go live on alternative exit and cease prone based seclusion staff exit use. **Twelve Acute and PICU SHOULD DO actions:** • All 12 are now complete. **Seven Forensic service MUST DO actions:** • Four actions are now complete. • Two are complete but awaiting further evidence from the Care Group to enable them to be signed off as embedded. • One action is off track, related to Trust-wide work on reducing prone restraint. **Seven Forensic service SHOULD DO actions:** • Four of these are complete. • One is complete but is awaiting further evidence to enable sign off as embedded. • Two are off track. One of these relates to the use of blanket restrictions and outside spaces. A review of all Trust outside spaces has been completed and an urgent meeting is being held to review and audit compliance with new guidance from the CQC around the use of blanket restrictions and outside spaced. Recommendations and actions will be agreed at this meeting. The other action is awaiting evidence upload of activities across wards. The Trust continues to take an improvement focused approach to these actions, with prioritisation around completion where there were clear safety concerns. The evidence sign-off process is underpinned by both a review of the evidence, and a review of the plan to embed going forward, and the commitment to embed these improvements into practice, with a clear governance process to oversee

<table>
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✓
✓</td></tr><tr><td>Be ambitious</td><td>✓</td></tr></table></td></tr>
<tr><td>BAF Risk(s):</td><td>This report has links to many of the Trust's strategic risks. In particular:
1.3 Lack of or ineffective communication and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve
2.2 Failure to create a learning environment leading to lack of innovation and to repeat incidents.
2.3 Increased demand for services and acuity of service users exceeds supply and resources available leaving to a negative impact on quality of care
4.2 Failure to deliver compassionate and diverse leadership and a values-based inclusive culture impacts on retention, recruitment and poor workforce experience meaning sub-optimal staffing and not everyone in the Trust is able to contribute effectively.</td></tr>
<tr><td>Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships</td><td>Each provider Trust within the Integrated Care System is governed by regulatory bodies. It is important that regulatory activity is monitored, learning is taken from feedback, and action is taken to remedy any findings. Regulatory bodies also identify areas of strength and good practice. Being part of the Integrated Care System allows for opportunity to share learning, findings and best practice to ensure services are delivered to the highest standard. Understanding our key areas of strength and improvement and any barriers supports us to engage with integrated care systems, learn from others and share good practice across the system. The progress described in this report and the completion of these actions contributes directly to the quality and safety objectives of the integrated care systems.</td></tr>
</table>

Any background papers / previously considered by:	Previous versions of this paper have been shared with the Executive Management Team (EMT), the Quality and Safety Committee, Members Council and Trust Board. EMT and the Quality and Safety Committee received this report in March 2025 and Trust Board in April 2025.

Care Quality Commission Inspection Reports
Action plan update for Must and Should Do Actions
Members Council May 2025

1. Executive Summary

This paper provides an updated position on progress against the Must and Should do actions which were highlighted within the two CQC inspection reports, published on the 6 December 2023.

A review meeting of outstanding actions and evidence took place on 4 March 2025 and the new Chief Operating Officer was in attendance. A review meeting at Cheswold Park Hospital (CPH) is scheduled for 18 March 2025, after which point the CQC actions for CPH will be included in this report in the same format. A summary position of CPH actions can be found in section 10.

Acute/Psychiatric intensive care unit (PICU)

There were sixteen Must do actions, of which 10 are now complete, 2 are complete and awaiting further evidence form the Care Group to enable them to be signed off. One action is on track for completion and three actions are now amber as they are off track for completion. Two of these actions relate to care planning and these are off track due to the development and roll out of new person-centred care plans across all SWYPT mental health services. This has meant a delay in being able to gather evidence and provide quantitative assurance at this point due to timescales. As the new care plans embed close monitoring against these actions is being monitored and evidence of compliance and embedding will be provided by the Care Group. The third of these actions relates to reducing prone restraint and there is a focus on collaborative work with the reducing restrictive physical interventions teams (RRPI) team and inpatient wards to roll out training on alternative exit from seclusion and alternative injection sites. As of the 1 April 2025 alternative seclusion exits will be taught as part of both the four day initial training and 2 day refresher training for Reducing Restrictive Physical Interventions training. In addition to this focused training regarding alternative seclusion exits will also take place with individual wards. As each individual ward reaches 80% training compliance they will go live on alternative exit and cease prone based seclusion staff exit use.

There were 12 Should do actions, all of these are now complete.

Forensic and secure services

There were seven Must do actions, of which four are now complete. Two are complete and awaiting further evidence from the Care Group to enable them to be signed off. Once action is off track, this is related to Trust wide work on reducing prone restraint.

There were seven Should do actions. Four of these are complete, one complete and awaiting further evidence from the Care Group to enable them to be signed off and two are off track. One of the actions which is off track relates to the use of blanket restrictions and outside spaces. A review of outside spaces across the Trust has been completed and shared with the Executive Management Team (EMT). An urgent meeting has been convened to review the new guidance from the CQC regarding blanket restrictions and outside spaces against Trust current practice, with recommendations and actions to be agreed at this meeting.

2. Purpose of the paper

This paper provides an updated position on progress against the Must and Should Do actions which were highlighted within the two CQC inspection reports, published on 6 December 2023 It also includes monitoring arrangements to ensure that any actions are embedded in practice going forward.

Of note, this is a live document. Later versions of this report are in development and will be reviewed by the Executive Management Team and the Quality and Safety Committee prior to submission to Trust Board. Therefore, some dates due for completion might be in the past tense in the data in this report. Face to face meetings to review the evidence that underpins progress continue to be held regularly, chaired by the Chief Nurse / Director of Quality and Professions. The most recent review of action progress took place on 4 March 2025.

3. Background

Following receipt of the initial feedback from the inspections in May 2023 and on receipt of the draft reports in September 2023 the Care Groups (Acute and psychiatric intensive care units (PICU) and Forensic Services) several improvement actions were put into place. Some of these actions were already in progress in existing improvement work and others were added to plans.

On 21 December 2023 two action plans were submitted to the CQC, one for each of the inspection reports. These action plans detailed how each core service plans to address the Must Do actions / regulatory breaches, along with timescales and action owners. (See Section 8 of this report for action plans).

Within the inspection reports are the following:

Forensic service – seven MUST DO and seven SHOULD DO actions
Acute and PICU service – sixteen MUST DO and twelve SHOULD DO actions

4. Action plans, oversight and assurance

The overarching Trust wide action plan and detail summarised below is held in an excel spreadsheet and this contains further detail. This spreadsheet is updated during monthly update and assurance meetings and is also used to provide updates to our Trust CQC inspector at monthly local engagement meetings.

The CQC actions and progress against them is being overseen and assured in the following way:

5. Sign off of actions

- Forensic actions

This is completed in line with a detailed process within the Forensic Care Group process, with explicit governance arrangements.

- Acute/PICU actions

Sign off of the actions for acute/PICU is through the inpatient performance and quality oversight meeting with Director of Service approval.

Bi-monthly assurance meetings are chaired by the Chief Nurse (Darryl Thompson). Progress against actions is shared as part of the meetings, following which final sign off takes place once actions are completed and evidence embedded.

A SharePoint site captures changes and information which provides assurance around completion of actions and embedding of these actions into practice. Evidence is uploaded and reviewed as part of the meetings with the Chief Nurse. The quality governance manager (Liam Redican) is meeting regularly with each Care Group to review and add any additional evidence onto SharePoint.

- Evidence review meetings

In addition to the meetings with Care Group leads that have been taking place to receive updates around progress against actions, from August 2024, face to face meetings have taken place with the Chief Nurse / Director of Quality and Professions and other colleagues from the nursing, quality and professions (NQ&P) directorate, to review in detail the evidence which has been submitted to SharePoint, to provide assurance against completion of the actions.

The purpose of these evidence review meetings is:

- To review the uploaded evidence against the actions and to decide whether it provides robust assurance of action completion.
- To review where further work is needed or further evidence required to provide required assurance.
- To agree where actions cannot be completed or where there is Trust wide improvement work which is in progress or is needed to support delivery of the action (see below for examples).

Any escalations will be shared through EMT and Quality and Safety Committee.

6. Monitoring of the embedding of changes and improvements as a result of actions

Action completion is being monitored through the above process. There is a need to ensure that any changes or improvements made as a result of actions are embedded into practice long term and any learning shared more widely if required.

Alongside the review of the actions and evidence, an additional column has been added to the main table in Appendix 1, which outlines where reporting and monitoring is held as actions become business as usual. This column is still being completed and is designed to provide oversight of ensuring that improvements continue to be monitored.

7. Trust wide issues

Following the most recent review of actions, there are several Trust wide or system-based issues which need to be resolved. In the following cases the Care Groups have taken action to improve but are unable to fully implement improvements due to wider issues. These include:

- Monitoring of completion of essential to job role training. The Trust does not currently have a reporting system which allows for completion of essential to job role training to be monitored on a regular basis. Work is underway with collection of data regarding essential to job role training through electronic staff records (ESR) with Learning and Development and Care Group colleagues to ensure the both the right alignment of training to job roles and robust recording through ESR.
- Oliver McGowan training. Within both reports this is highlighted as a must do action and compliance with the e-learning part of Level 1 is now high across the Care Groups (Acute and PICU – 96.1%, Forensic Care Group – 89.2%). A trajectory is being developed to clarify when the required 10% of Trust staff will have completed the webinar aspect (and so have achieved full Level 1 compliance). Currently there is little progress across the region in the development of the webinar and therefore services are not able to progress against this action. Alternative arrangements are being explored by the associate director of nursing, quality and professions.

- Appraisals. The Care Groups have undertaken work to improve completion of appraisals and this continues to be closely monitored. This has been strengthened by the Care Group since the CQC inspection and oversight is maintained on a monthly basis with escalation to individual wards and ward managers if any reduction in compliance is noted. However, some concerns have been raised about the target of 95% being unachievable. Feedback indicates this relates to a particular issue with staff that have transitioned from being bank to substantive, and the need for an appraisal to be completed with them immediately when they start substantively, or they will show as being in breach. In addition, there were system issues with appraisals which have now been addressed and recording of appraisals is now through ESR which is enabling robust oversight and monitoring by individual teams and senior leadership. The concerns regarding the 95% compliance have been escalated to the executive management team.
- With regards to Reducing Restrictive Physical Interventions (RRPI), in particular the aim to reduce the use of prone restraint, pilot sites are still being supported to ensure robust learning around alternatives to seclusion exit and alternative injection sites for rapid tranquilisation (the two most frequent reasons for the use of prone restraint). As of the 1st April 2025 alternative seclusion exits will be taught as part of both the four day initial training and 2 day refresher training for Reducing Restrictive Physical Interventions training. In addition to this focused training regarding alternative seclusion exits will also take place with individual wards. As each individual ward reaches 80% compliance they will go live on alternative exit and cease prone based seclusion staff exit use.
- A review of restrictions within courtyard/garden areas across the trust and the use of individual risk assessments and blanket restrictions will be completed. A conversation has been had with the CQC MHA (Mental Health Act) inspector around this subject as this is raised within MHA inspections.
- A review of how emergency equipment, including defibrillators is completed in acute wards, to support this work within Forensic wards.
- Information about automated e-seclusion reporting to be sought to support reporting on seclusion checks.

8. Trust wide developments

There are several CQC actions which are supported by Trust wide programmes of work. Whilst there are specific actions for each Care Group, detailed in the tables below, some actions are progressing on a larger scale. These actions cover several of the MUST DO actions and include:

- Regulation 12 – safe care and treatment
    - Reduction in prone restraint, use of alternative injection sites, strategies for exit from seclusion and use of safety pods
- Regulation 9 – person centred care
    - Care plan and risk assessment improvement group and the introduction of a new care plan from January 2025
- Regulation 17 – good governance
    - Use of e-seclusion

Reporting of progress of these larger scale improvement plans occurs regularly through the Quality and Safety Committee, operational management group and executive management team.

9. Care Group action plan oversight and summary

The progress of actions is measured using a blue, red, amber, green (BRAG) key. These are defined as the following:

Blue	Action complete and assurance of improvement
Blue Green	Action reported as complete by Care Group, awaiting evidence sign off
Red	Action not started
Amber	In progress but off track from expected
Green	On track for completion by date

Full details of action pans can be seen in appendix 1. Below is a high-level summary which outlines where there are outstanding actions to be competed against the actions.

Acute/PICU

Sixteen Must do actions

Blue	10
Blue Green	2
Green	1
Amber	3
Red	0

CQC requirement	Status	Outstanding actions	Embedded by target date
9.1 and 9.2- person centred care – care planning and service user and carer voice in care planning (2 actions)		Review of data for 7 months. This will be reviewed in July 25 and reported in August update. • Slippage due to roll out of new care plans.	31/03/25
12.1 – safe care and treatment – prone restraint reduction		• Roll out of training on alternative seclusion exits to reduce prone restraint underway but some challenges due to release of staff • Trust wide rollout longer term plan. Trajectory required.	Aligned with Trust wide work
12.2 and 12.3 – safe care and treatment			
15.1 – premises and equipment			
15.2 and 15.3 – premises and equipment			
17.1 and 17.2 – good governance			

17.3 – good governance – reviews when a person is in seclusion			• Processes in place and improvements made • Will continue to monitor for 7 months, review in July and report in August	31/03/25
18.1 – staffing – sufficient numbers of appropriately qualified staff			• Date for activities to be uploaded for Feb and March and then action will be complete	31/03/25
18.2 - staffing				
18.3 – staffing – use of bank and agency (reducing this)			• Establishment review completed and agreed which will support the reduction in use of bank and agency.	31/03/25
18.4 and 18.5 – staffing				

Twelve Should do actions

Blue	12
Blue Green	0
Green	0
Amber	0
Red	0

CQC action	Status	Outstanding actions	Embedded by target date
Training on door top alarms			
Information for agency staff on medicines management			
Records of medicines management training			
Records of when section 17 leave has been cancelled due to staffing			
Access to medical care as quickly as possible			
Physical health monitoring following medication start			
Blanket restrictions around access to certain areas of the wards			
Care plans for those at risk of deliberate self harm			

Planning meals which take into account dietary and cultural needs of patients	
Access to hot and cold drinks and snacks at all times	
Consider amending the cleaning records or The dales and Priestley unit	
Making the seclusion policy more accessible for staff to use in practice	

Forensics
Seven Must do actions

Blue	4
Blue / Green	2
Green	0
Amber	1
Red	0

CQC regulation	Status	Outstanding actions	Embedded by target date
09 – person centred care – people who require them have positive behavioural support plans		• Clarification of roles and responsibilities and screening tool to be shared and uploaded to share point then action will be complete.	31/03/25
10 – dignity and respect			
12 – safe care and treatment – Part 1			
12 – safe care and treatment – Part 2 – checking of emergency equipment		• Part 2 – Good processes in place for monitoring and oversight. Data required to demonstrate compliance for 7 months	31/03/25
13 – safeguarding service users from abuse and improper		• Trust wide training on alternative seclusion exit and alternative injection site to support reducing restraint. See acute action regarding use of prone restraint. Trust wide action.	Trust wide work timescales to be confirmed.

treatment – proportionate use of restraint, and use of prone restraint only as a last resort			
17 – good governance			
20 – duty of candour			
18 – staffing			

Seven Should do actions

Blue	4
Blue / Green	1
Green	0
Amber	2
Red	0

CQC action	Status	Outstanding actions	Embedded by target date
Range of activities across wards		Complete once data uploaded to Sharepoint	31/10/24
Section 17 leave supported, particularly when attending medical appointments			
Consider options for improving the provision of food for patients			
Staff wearing scrubs when escorting patients on leave			
One page profiles are easily accessible for staff			
Involvement of carers in loved one's care		• Audit data to demonstrate where carers have been given the opportunity to be involved	
Restrictions should be individually assessed and that restrictions are proportionate to the risks posed		• Trust wide work to understand restrictions for outside areas on each of our units and review where individual risk assessments are appropriate	30/09/24

10. Summary

The CQC actions, outlined above, are progressing across the two Care Groups and on a Trust wide basis (where applicable). These actions vary in complexity, and the timescale for completion also varies depending on this complexity.

There are systems in place for the Chief Nurse / Director of Quality and Professions to maintain oversight and be provided with assurance and updates on progress, which in turn will allow assurance to be provided to the Board. Monthly meetings with the Care Group leads are established and challenge is provided where required.

Monitoring of the sustainability of improvements will be monitored through Care Group processes and through clinical governance group on a six-monthly basis. The embedded by dates will allow for monitoring of how the actions have impacted and supported change across each Care Group and across the Trust.

11. Cheswold Park Hospital (CPH) CQC Action Plan:

The CPH Leadership Team report the following progress with the action plan:

Blue	Action complete and assurance of improvement	0
Blue Green	Action reported as complete by Care Group, awaiting evidence sign off	9
Green	On track for completion by date	7
Amber	In progress but off track from expected	3
Red	Action not started	0

The Cheswold Park Hospital leadership team continues to focus on the CQC report and action plan through internal governance meetings. The introduction of Trust Policies will further support the improvement of patient care and family and carer involvement. An evidence review meeting is scheduled with the leadership team on Tuesday 18 March to review the evidence against each action, decide on sign off / rating and agree next steps. Further detail will be provided in the next update.

Appendix 1: Full detail and updates

Acute and PICU MUST DO actions (evidence reviewed on 4 March 25)

16 Must do actions

- Blue and complete = ten
- Blue/green = two
- Green, on track and progressing = one
- Amber and off track = three
- Evidence is regularly uploaded to SharePoint to provide assurance about action progress and completion

Regulation	How the regulation was not being met	Person responsible	Action completion date	Evidence	Status (BRAG)	Further evidence requested	Embedded by date	Ongoing monitoring
09 - Person centred care	9.1 The Trust must ensure that people have care plans in place to meet their needs and minimise any risks relating to their care, taking into account best practice guidance relating to their diagnosis and their individual circumstances including any protected characteristics (Regulation 9(1) and (3))	Care group senior leadership team NQ&P directorate	In line with Care plan and risk assessment group and priority programme	4/3/25 – Care Plan programme (trust wide) timings slipped. New care plan now implemented from beginning of Jan. For 12 months – consistently over 90%. In Jan 25 – dip to 87.3%, due to changes in Care plan and roll out of new care plans. Feb – increase to 92% Metric on Tendable – considers care plan after 7 days. 1st person – SU voice.		Review of data for 7 months. This will be reviewed in July 25 and reported in August update. .	31/03/2025	KPI within Care Group – through performance meeting. IPR monitoring.

09 - Person centred care	9.2 The Trust must ensure that people (and, where relevant their relatives and/or carers) have the opportunity to be meaningfully involved in their care, are supported to access independent advocacy and are offered a copy of their care plans, unless this is not possible due to the person's individual circumstances (Regulation 9(1) and (3))	Care Group senior leadership team and NQ&P directorate	In line with care plan and risk assessment group	4/3 – KPI moving forward 25/26 – questions about how the care plan has been developed collaboratively. Quality dip sample through the matron checks. Carer champions on wards. New care plan monitoring and recording as above. Evidence: Benchmarking for Triangle of Care (ToC) and action plan Carers newsletter Advocacy monitoring on inpatient whiteboard and Tendable checks – weekly results Completion of the carer FFT Care planning – as above with patient voice and involvement. Copy of care plan – on SystmOne – recent Business Intelligence dashboard and working on embedding.		Similar to above action. Increase in compliance on S1 on sharing of care plans	31/03/2025 Align with previous action.	

				Compliance increasing – to embed over next 6 months. Delivered preceptorship training and a specific session about care planning.				
12 - Safe care and treatment	12.1 The Trust must ensure that action is taken to reduce the number of restraints in the prone position which are taking place on the acute and PICU wards, in line with the Mental Health Act Code of Practice and national clinical best practice guidance (Regulation 12(2)(b))	Care Group senior team and NQ&P directorate	September 2024	4/3 – training being rolled out slowly on wards regarding seclusion exit and injection sites. 2 hour training – barrier due to ward acuity. RRPI team to visit wards to deliver training. This will be picked up by nursing team around trajectory and working closely with wards to deliver training locally.		Alternative exit from seclusion has been rolled out on Walton. awaiting 100% team trained – Feb 25. Trust wide longer-term plan for roll-out. A range of factors are influencing the speed of roll-out, including ward acuity to release staff and arranging training spaces ahead of roster confirmation. Alterative injection sites – looking at adopting a train the trainer approach. Additional RRPI training identified to support.	Aligned with Trust wide work	

12 - Safe care and treatment	12.2 The Trust must ensure that monitoring checks are carried out in line with national guidance to the greatest extent possible on each occasion following the administration of rapid tranquilisation and when patients are secluded (Regulation 12(2)(b))	Care Group senior team and NQ&P directorate	October 2024 with interim dates to submit progress against specific actions	Matron weekly Tendable checks as a baseline and to monitor against moving forwards. Changes to paperwork. Monitoring checks initiated and completed. Posters displayed in seclusion A-E document re-vamped Exploring using NEWS2 for rapid tranquilisation monitoring Metrics: Tendable Compliance audits for May, June, July – completed and demonstrated considerable improvement.		Oversight – reviewed quarterly through Care group governance. Adding in NEWS2 as monitoring post rapid tranq.	31/12/2024	
12 - Safe care and treatment	12.3 The Trust must ensure that staff receive regularly updated training on cardiopulmonary resuscitation and responding to violence and aggression (Regulation 12(2)(c))	Care Group senior team and NQ&P directorate	September 2024 with interim dates to submit progress against specific actions	CPR and RRPI training figures. Care group performance dashboards for monitoring. Metrics – overall performance for the care group Ward compliance RRPI – 83.5% overall in September Resus –			31/12/2024	

				ILS – 90.9% BLS – 90.2%				
15 - Premises and equipment	15.1 The Trust must ensure that action is taken to address the patient flow issues impacting on bed occupancy rates and admissions, particularly at Kendray Hospital, to reduce the reliance on leave beds for new admissions and prevent the need to admit patients to non-bedroom areas (Regulation 15(1)(c))	Care Group Senior Leadership Team, Estates Team, Executive Management Team (EMT) (capital allocation and sign off)		4/3 – evidence paper submitted. Local operating procedure. Clear governance process in place, including comms to SU, oversight by senior manager, ensuring risk assessments, ligature risks, privacy and dignity.			In line with CC2H programme	Normal routine business as usual. Robust processes and monitored through CCTH and Care group reporting and monitoring.
15 - Premises and equipment	15.2 The Trust must ensure that the planned refurbishment works at Kendray Hospital, Priestley Unit and The Dales are progressed as quickly as possible to ensure patients on these wards	Care Group Senior Leadership Team, Estates Team, EMT (capital allocation and sign off)		Clear dates for work completion to be determined and monitored until completion.			N/A	

	have access to a care environment which meets their needs, including those relating to any protected characteristic, and where they are not subject to avoidable restrictions on their freedom of movement within the ward (Regulation 15(1)(c))							
15 - Premises and equipment	15.3 The Trust must ensure that the care environment on all wards supports patients' privacy and dignity, particularly when wards are overlooked by areas accessed by patients of another gender or the general public (Regulation 15(1)(c))	Care Group Senior Leadership Team, Estates Team, EMT (capital allocation and sign off)	June 2024	Evidence review complete. This includes: Confirmation of installation of Integrated Blinds and statement regarding care planning when necessary to utilise specific bedrooms and Trust-wide bed base if required			N/A	

17 - Good governance	17.1 The Trust must ensure that, when a patient's capacity to consent to their treatment or to make another important decision is assessed, a record of this assessment and the outcome is kept within their care records (Regulation 17(2)(c))	Care Group Senior Leadership Team, Mental Health Act (MHA) Team, Directorate of Nursing, Quality and Professions		Tendable shows capacity assessments for individual decisions (finance etc.) Data collected by MHA office around capacity assessment completion. 2 metrics: • Consent to treatment – MHA colleagues – metrics reported in MHA Committee • Decision specific capacity assessments A manual audit has been completed and demonstrates assurance >90% that both capacity to consent to treatment and decision specific capacity assessments are undertaken and recorded. Routine monitoring is part of the weekly Matron Tendable check which includes a question about decision specific capacity assessments being documented if clinically indicated			31/03/25	
17 - Good governance	17.2 The Trust must ensure that record keeping	Care Group Senior Leadership	March 2024	Tendable data demonstrates 100%			30/09/24	

	in relation to environmental risks is kept up to date and is available for ward staff to refer to when needed. (Regulation 17(2)(b))	Team, MHA Team, Directorate of Nursing, Quality and Professions		compliance in April and May.				
17 - Good governance	17.3 The Trust must ensure that, when patients are secluded, they receive observations and medical, nursing and multi-disciplinary team reviews at the intervals stated in the Mental Health Act Code of Practice and clear records are kept to evidence this (Regulation 17(2)(c))	Care Group Senior Leadership Team, MHA Team, Directorate of Nursing, Quality and Professions	October 2024 in line with e-seclusion developments	4/3 – audits completed – good compliance. Junior medics within 1 hour completed. Independent review led by a medic – considerable improvement following discussions and training. Now sits with medical secretaries who organise independent review. E-seclusion audit.			Process implemented. Now evidencing embedding – until July. Data for Feb. Non-compliance with independent review but showing improvements (Jan and Feb). Will continue to review until July – for review in Aug	31/03/25	Monitored by care group performance meeting. Can we automate e-seclusion audits.
18 - Staffing	18.1 The Trust must ensure that sufficient numbers of appropriately qualified staff are available to meet	Care Group Senior Leadership Team and Directorate of Nursing, Quality and	November 2024 - (in line with annual workforce plan). This will be reviewed each month.	4/3 – evidence enough staff to facilitate leave – since May 24, <1% of cancelled leave due to staffing. Therapeutic activities – Sept-Jan – 13%			Feb and March data to be uploaded and then action will be complete – by end March.	31/03/2025	Reported into MHA Committee and the MHA office. Monitor in quality and

	people's holistic needs during their admission, including the provision of regular meaningful and therapeutic activities for patients both on the wards and away from the hospital if the patient is granted leave (Regulation 18(1))	Professions, People's directorate		Sept cancelled due to staffing, reducing month on month and Jan 3.5%. Reflecting successful recruitment into posts and improved staffing on wards.				performance meeting.
18 - Staffing	18.2 The Trust must ensure that there are sufficient numbers of registered nurses on each shift to meet patients' needs and provide an appropriate level of support to unqualified staff, in line with the established staffing ratios for each ward (Regulation 18(1))	Care Group Senior Leadership Team and Directorate of Nursing, Quality and Professions, People's directorate	November 2024 - (in line with annual workforce plan). This will be reviewed each month.	4/3 – monthly summary regarding safer staffing. Last 6 months data– shows meeting staffing rations for RN's. Trust target 80% - consistent over 80%.			31/3/25	Monitored through IPR monthly. Quality and performance meeting.
18 - Staffing	18.3 The Trust must ensure that action is taken to	Care Group Senior Leadership	November 2024 - (in line with annual	4/3 – continued high use of bank staffing due to acuity.			31/3/25	Weekly assurance meeting

	address the current high rates of bank and agency staff working on the acute and PICU wards and to ensure that the use of agency and bank workers does not negatively impact on the quality of patient care (Regulation 18(1))	Team and Directorate of Nursing, Quality and Professions, People's directorate	workforce plan). This will be reviewed each month.	Establishment review completed and agreed which will support the reduction in use of bank and agency.				around use of bank and agency.
18 - Staffing	18.4 The Trust must ensure that staff receive regular appraisals in line with the requirements of the trust's appraisal policy (Regulation 18(2)(a))	Care Group Senior Leadership Team and Directorate of Nursing, Quality and Professions, People's directorate	August 2024	4/3 – Now migrated across to ESR. Working on new process for documenting. Target threshold being reviewed to reduce to 90%. Ward level data through Care group dashboards. Not consistently >95% Alert system in place. Monitored through performance oversight 3 months of appraisal data to provide assurance.		Looking to review reporting threshold – PRC and Board	30/09/2024	Trust wide action now – not for the Care Group. Appraisals monitored through OMG, IPR and Care Group performance group.
18 - Staffing	18.5 The Trust must ensure that staff receive training on	Care Group Senior Leadership Team and	New completion date of March 2025 in line	4/3 – continue to sustain		Update regarding availability of webinar for part	To be aligned with Trust wide work	

	meeting the needs of people with a learning disability and autistic people at a level appropriate to their role (Regulation 18(2)(a))	Directorate of Nursing, Quality and Professions, People's directorate	with Oliver McGowan training programme	e-learning element of Level 1 now above 80% compliance for all wards. Awaiting rollout of webinar element of Level 1		1 of Oliver McGowan training and exploration of alternative options		

Acute and PICU SHOULD DO actions:

Blue and complete = ten

Green and on track = two

The Should Do action	Person responsible	Action completion date	Evidence	Status (BRAG)	Ongoing monitoring and oversight
The Trust should ensure that staff complete their training on door top alarms so these can be implemented across all acute and PICU wards as soon as possible	Care group leadership team	May 2024	Plan for door top alarm go live Implementation of door top alarm sign off		
The Trust should ensure that written information for agency workers at Kendray Hospital is reviewed and updated to include accurate information on the Trust's medicines management system	Care group leadership team	May 2024			
The Trust should ensure that more accessible records are kept of medicines management training and staff competency assessment to provide high level assurance that all staff who	Directorate of NQ&P, Pharmacy	31/03/24	4/3 – using e-rostering to record when staff have done medicines with respect oral and IM. This		Monitor quarterly in Quality and

require these training updates are receiving them			allows a report to be pulled and monitored. Face to face training.		performance meeting. Dashboard development around essential to job role training – review of training – mandatory training.
The Trust should ensure that clear records are kept on all wards of instances where Section 17 leave is cancelled due to staffing pressures and that action is taken to address any concerns identified from this data	Directorate of NQ&P	31/07/24	Data for monitoring of completion of section 17 leave and record of any cancelled leave and reasons		
The Trust should ensure that patients are able to access medical care as quickly as possible when this is needed, including out of hours	Care group leadership team	31/07/24	Ongoing process of monitoring incidents.		
The Trust should ensure that all patients who meet the criteria for enhanced physical health monitoring due to their medication start receiving these checks as soon as possible following the prescription of the medication	Care group leadership team, Pharmacy	31/12/24	Specific high dose anti-psych monitoring form. On tenable as a question. Data June-Oct 100% physical health monitoring. Monitoring and oversight added.		
The Trust should ensure that the restrictions on patients' access to certain areas of the wards at Kendray Hospital are kept under review and kept to the minimum level of restriction	Care group leadership team	30/09/24	Completion of works related to Clark ward		

necessary to keep people safe from avoidable harm					
The Trust should ensure that care plans for people at risk of deliberate self-harm include guidance for staff on how to support the person to minimise the risk of them resorting to self-harming behaviour as well as guidance on how to support them if self-harm does occur	Care group leadership team	30/04/24	4/3 – good practice guide. Weekly matron checks. Data for 7 months demonstrates good compliance. New care plan will enhance this.		
The Trust should ensure that patient feedback on the availability of food to meet dietary and cultural needs is taken into account when menus are planned for all wards	Catering Team	30/09/24	Terms of reference for nutrition steering group. Patient experience feedback on food Community meeting minutes where food was discussed.		
The Trust should ensure that patients are able to access hot and cold drinks and snacks at all times on all acute and PICU wards unless this has been individually risk assessed as unsafe	Care group leadership team	30/09/24	Confirmation of access to hot and cold drinks and snacks on acute wards		
The Trust should consider amending the cleaning records template for The Dales and Priestley Unit to align with the other Trust services and provide assurance that specific areas of the ward are being regularly cleaned in line with the Trust policies	Estates and Facilities	31/12/24	Cleaning reports from The Dales and Priestley unit		

The Trust should consider reviewing the seclusion policy to make this more accessible for staff to use in practice	Care group leadership team, Directorate of NQ&P	31/12/24	Update to seclusion policy which has been agreed at clinical policy group. Full review of policy due in 2025.		

Forensic service MUST DO actions

- Seven must do actions
- Blue and complete = four
- Blue/green = two
- Amber and off track = one
- Evidence is regularly uploaded to SharePoint to provide assurance about action progress and completion

Regulation	How the regulation was not being met	Person responsible	Action Completion date	Evidence	Current status (BRAG)	Further evidence requested	Embedded by date	
09 - person-centred care	The Trust must ensure patients, who require them, have relevant behavioural support plans that enable staff to meet their needs and provide person centred care. Regulation 9 (3)(a)(b)	Clinical manager, lead matron and NQ&P directorate	August 2024	4/3/25 – screening tool in T&F group. Do people need a PBS plan? Still being developed, waiting for this to go on a template. All existing patients have been. As people are admitted this will be done. Psychology screening may include this. Screening tool on S1 now. All LD service users screened. Still developing process for other service users on other wards		Clarity on roles and responsibilities being developed. Who's responsible for screening on non-LD forensic wards? Timeframes from admission to receive PBS screening. To update with above info then action will be complete.	31/03/25	

				to identify who require PBS.				
10 – dignity and respect	The Trust must ensure confidential spaces where service users share sensitive information are private and that conversations cannot be overheard by others. Regulation 10(1)(2)(a)	Senior estates manager Forensic care group managers	January 2024	Uploaded to SharePoint: • One email thread around the strips being completed and any improvement noted • One email around increasing staff vigilance to areas where confidential information can be heard. • Copy of revised environment check paperwork • Audit work completed to check for noises in confidential spaces.			November 2024	
12 – safe care and treatment 12- safe care and treatment **part 2**	The Trust must ensure ligature risk assessments are up to date and accessible for all staff Regulation12(d)(e)	Clinical lead for security Ward managers/governance team Clinical environment safety group	March 2024	Uploaded to SharePoint: • QI Action plan • Risk summary document • Ligature photos • All induction checklists • Bank leaflet • Risk handover document				

				• Security update slide set • Ligature audit • Copy of yellow folder				
	That all equipment used has been checked to ensure it is safe to use.	As above	As above	4/3 – Processes in place to support oversight and governance. Upload 3/12 reporting to Sharepoint. Review completed. This is reviewed in governance meeting. Reporting shows >80% currently.		Requires 7 months evidence of compliance. Processes in place for oversight and monitoring of this. Wider work looking at the policy and when checks are completed.	31/03/25	Forensic governance meeting review report.
13 – safeguarding service users from abuse and improper treatment	The Trust must ensure that the use of restraint is proportionate to the risks posed. This includes ensuring person centred attempts at de-escalation have been attempted in line with patients' care and positive behavioural support plans prior to restraint. The Trust must also ensure prone	Care Group leadership team and NQ&P directorate	September 2024 – with interim updates to submit progress against specific actions	4/3 – same as acute discussion. Low prone Uploaded to SharePoint: • Blank highlight report • FISC March agenda • FISC March presentation • FISC March minutes - draft • Analysis of highlight reports so we can develop a report of themes		Trust wide training on alternative seclusion exit and alternative injection site to support reducing restraint. Timescales for this work being identified.	December 2024. Timescales currently being updated to ensure pace and focus.	Security committee. Governance meeting. Ward managers highlight report.

	restraint is only used as a last resort and is carried out safely. Regulation 13 (4)(b)			at the end of July and end of September.				
17 – good governance	The Trust must ensure that it is accurately monitoring and managing the quality and safety of all wards and ensure it has effective oversight of the use of prone restraint and is managing this appropriately. Regulation 17(1)	Senior managers NQ&P directorate	September 2024, with interim dates to submit progress against specific actions	Uploaded to SharePoint: • Inpatient highlight report template • FISC Minutes Jan, March & May 2024 • FISC March presentation • FCG Governance framework • Forensic management structure • TOR for security committee. • TOR for inpatient governance. • Flow of FISC minutes into FCG - agenda		Summary piece on governance process (Care Group Governance Minutes to CGG, summary in IPR – rotating focus)	December 24	
20 – duty of candour	The Trust must ensure that all staff understand the duty of candour and follow this correctly. Staff must send a letter following a verbal	Lead Matron	December 2023 – complete	Uploaded to SharePoint: • Inpatient quality governance report template • Incident monitoring agenda			31/12/25	

	apology. Regulation 20			• DoC incidents Jan-May 24				
18 – staffing	The Trust must ensure all staff are receiving the required level of supervision and training in accordance with trust policy. The Trust must ensure all staff receive appropriate training to enable them to meet the needs of people with a learning disability and autistic people. 18(2)a	Senior management team NQ&P directorate	March 2024 New completion data: March 2025 – in line with target completion date for OM training	4/3 – Uploaded to SharePoint: • Highlight report template, • Minutes from management team meeting, • 2 x Oliver McGowan training compliance • Copy of dashboard to show uptake and stats. • 23-24 Q4 commissioner highlight report (adult secure inpatient) • Supervision and training stats from dashboard		Trust wide action regarding webinar element. Care group maintain compliance with part 1 learning.	31/03/25	

Forensic service SHOULD DO actions

- Seven should do actions
- Blue and complete = four
- Blue/green = one
- Amber and off track = two

The Should Do action	Person responsible	Completion date	Evidence	Status (BRAG)	
The Trust should ensure that patients are able to engage in a range of activities across all wards	Care group leadership team	31/10/24	4/3 – 25 hours activity. 100% compliance for few years. Activities on board, record who's taken part and who's declined. IT training on induction. To send highlight report with data.	To turn blue once data received.	Forensic KPI – reported to commissioners.
The Trust should ensure patients are supported to take Section 17 leave, particularly when this involves patients attending medical appointments	Care group leadership team	31/07/24	Section 17 leave recording of completed and cancelled leave		
The Trust should consider its options for improving the provision of food for patients	Care group leadership team and Catering Team	31/10/24	Catering meeting minutes Forensic care group process You said we did poster		
The Trust should ensure patients privacy and dignity is considered when staff accompany them on section 17 leave in relation to wearing of scrubs	Care group leadership team	31/10/24	Auditing of staff escorting service users whilst wearing scrubs June and September 24		
The Trust should ensure that all patient's one-page profiles are easily accessible for all staff	Care group leadership team	30/04/24	One page profile template and review of completed profiles		

The Trust should ensure where appropriate carers have opportunities to be involved in their loved one's support	Care group leadership team	30/09/24 S1 template to record carer involvement.	Carers bags Carers involvement Carers noticeboard Triangle of care action plan			To send data.
The Trust should ensure that restrictions are individually assessed and blanket restrictions are a proportionate response to risks posed	Care group leadership team	4/3 – review of blanket restrictions and how these are recorded. Including a review of the use of restrictions in courtyard/outside spaces. For discussion at EMT. Blanket restrictions are reviewed monthly. Review dates being updated to add into recording template. Patients are individually risk assessed 30/09/24 Evidence uploaded to SharePoint	Forensic blanket restrictions information and community meeting minutes			

Understanding the impact of changes

A number of the actions are part of ongoing improvement work across Care groups and Trust wide. The impact of changes made as a result of these improvement programmes is reviewed on an ongoing basis and using the following data and intelligence:

- Complaints/concerns raised – for example this is being monitored as the Triangle of Care work progresses and through the dashboard that is reviewing the impact of this work on carers experience
- Friends and family test, service line patient experience surveys and carers feedback
- A reduction in the use of prone restraint through the improvement work on exit strategies from seclusion, safety pods and alternative injection sites. This is reported on a monthly basis through RRPI trust action group and within the integrated performance report
- The number of ligature related incidents monitored and reviewed through clinical environment safety group
- Staff culture and retention of staff, reported through Care group quality and governance meetings, annual staff survey, leavers surveys and oversight of supervision recording, mandatory training compliance and appraisal completion are monitored through Care Group dashboards reviewed at operational management group
- Improvement in the quality-of-care plans, monitored through audit processes within the service
- Reduction of the use of out of area beds and the provision of care closer to home. Monitoring and reporting of this will include understanding how this reduction has impacted on the holistic care, pathway and journey of the individual patients. This programme monitored and reported on through mental health inpatient performance and quality oversight group
- Improved seclusion experience for patients through the development of and improvement to the use of e-seclusion, monitored through audits of seclusion records, patient experience information and reduction in Datix incidents

Sarah Whiterod – Associate Director of Nursing, Quality and Professions

Liam Redican – Quality Governance Manager

Glossary of terms

Acronym	Full version
BLS	Basic Life Support Training
BRAG	Blue Red Amber Green
CC2H	Care Closer to Home
CPR	Cardiopulmonary Resuscitation
CQC	Care Quality Commission
DoC	Duty of Candour
EMT	Executive Management Team
EPMA	Electronic Prescribing and Medicines Administration
FISC	Forensic Inpatient Security Committee
FCG	Forensic Care Group
ILS	Immediate life support training
LD	Learning Disability
MCA	Mental Capacity Act
MHA	Mental Health Act
NEWS2	National Early Warning Score 2 – a tool to identify physical health deterioration
NQ&P	Nursing, Quality and Professions
OM	Oliver McGowan training for people with a learning disability and autistic people
OMG	Operational Management Group
OPP	One Page Plan
PBS	Positive Behaviour Support planning (a therapeutic approach for learning disability)
PICU	Psychiatric Intensive Care Unit
PSOG	Patient Safety Oversight Group
RRPI	Reducing Restrictive Physical Interventions
SOP	Standard Operating Procedure
SPC	Statistical Process Control
TBC	To Be Confirmed
ToC	Triangle of Care
ToR	Terms of Reference
QI	Quality Improvement

Members' Council
7 May 2025
Agenda item 9.3

Private/Public paper:	**Public**
Title:	**Quality Account update 2024/25**
Paper presented by:	**Darryl Thompson, Chief Nurse/Director of Quality and Professions**
Purpose:	The purpose of the paper is to provide the Members Council with an update on the progress of the development of the Trust's Quality Account 2024/25, which is due for publication by 30 June 2025.
Executive summary:	Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce Quality Accounts if they deliver services under an NHS Standard Contract, have staff numbers over 50 and NHS income greater than £130k per annum. The Trust's Quality Account is required to be published for the previous financial year by 30 June. The Quality Account is produced annually and in line with the guidance from NHS England, focuses on the quality of services by looking at: • Patient safety • Clinical effectiveness • Patient experience A description of future areas for improvement and achievements against previous year's quality priorities is included in Part 2 of the Quality Account. Part 3 covers a review of quality performance and also looks back at historic performance to identify any trends. Examples will be included as required in line with the three bullet points above. The Trust's Quality Account for 2024/25 is near to completion, and a timeline is included in this report. As part of this, the next draft will be reviewed by Quality and Safety Committee members on 13 May prior to external consultation with partners across the integrated care systems. The final draft will be reviewed by Quality and Safety Committee members on 10 June 2025, prior to recommendation for approval by the Trust Board on 29 June. There are no challenges expected with regards to our ability to meet the expectations of the timeline in this report. The Quality Account will meet statutory requirements set out by NHS England, will provide a view of quality across the Trust for 2024/25 and will be ready for publication on the Trust's website as required by 30 June 2025.
Recommendation:	**Members' Council are asked to:**

<table>
<tr><td></td><td>RECEIVE the update on the Quality Account for 2024/25.</td></tr>
<tr><td>Mission/values:</td><td>The report demonstrates the Trust’s commitment to all the Trust’s values, which are fundamental to delivering safe and high quality health care:
We put the person first and in the centre
We know that families and carers matter
We are respectful, honest, open and transparent
We improve and aim to be outstanding
We are relevant today and ready for tomorrow</td></tr>
<tr><td>Strategic Objectives</td><td><table><tr><td>Live Our Values</td><td>✓</td></tr><tr><td>Be the best we can be:
Best quality
Best partner
Best value
Best place to work and learn</td><td>
✓
✓
✓
✓</td></tr><tr><td>Be ambitious</td><td>✓</td></tr></table></td></tr>
<tr><td>BAF Risk(s):</td><td>The Quality Account content is aligned with all areas of BAF risks.</td></tr>
<tr><td>Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships</td><td>Each provider trust within an Integrated Care System is governed by regulatory bodies, and production of a Quality Account is a formal requirement of each trust. It is important that regulatory activity is monitored, learning is taken from feedback, and action is taken to remedy any findings. Quality of care is a key priority for our Integrated Care Boards and the places within which we work. The information provided in the Quality Account supports and describes the delivery of quality care and the improvements made across services over the last 12 months</td></tr>
<tr><td>Any background papers / previously considered by:</td><td>Members Council members received the Quality Account for 2023/24 during the consultation period in May 2024. Trust Board received and approved the Trust’s Quality Account for 2023/24 and previous years. An early draft version of the Quality Account for 2024/25 was shared with member of the Quality and Safety Committee and executive management team in March 2025.</td></tr>
</table>

Quality Account update 2024/25
Members Council
7 May 2025

1. Purpose of the paper

This paper is intended to provide an interim update to members of Trust Board on progress of the development of the Trust Quality Account for 2024/25, including quality initiatives for inclusion. The report shows a clear timeline of the review and sign off process. The Quality Account will be presented to Trust Board for final approval following internal review and external stakeholder engagement. This will be during June 2025 and prior to the deadline of 30 June.

2. Background

Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce Quality Accounts if they deliver services under an NHS Standard Contract, have staff numbers over 50 **and** NHS income greater than £130k per annum. The Trust's Quality Account is normally expected to be published for the previous financial year by 30 June.

There has been no update from NHS England on the requirements for the Quality Account for 2024/25, and so this year's version will follow the guidance shared in previous years.

3. Development of the Quality Account

The Quality Account is produced annually and in line with the guidance from NHS England, focusses on the quality of services by looking at:

- Patient safety
- Clinical effectiveness
- Patient experience

A description of future areas for improvement and achievements against the previous year's quality priorities is included in Part 2 of the Quality Account. This includes data and information around clinical audit, patient safety, data security, data quality, learning from deaths and reporting against core indicators, such as follow up within 72 hours of discharge, readmission rates and patient experience. Quality Priorities for 2025/26 are being based on the priorities identified as part of the development of the Trust Strategy.

Part 3 of the Quality Account covers the locally decided review of quality performance and can also look back at historic performance to highlight trends. This focusses on the three domains of quality: patient safety, clinical effectiveness and

patient experience, and allows the Trust to showcase quality initiatives and developments.

4. Timeline for the development of the Quality Account

The following timeline has been developed and agreed to support the completion of the Quality Account. There is a requirement for 28 days consultation with external stakeholders, including the integrated care boards (ICBs) and overview and scrutiny panels.

Date	Task
13/01/24	Initial discussion held to plan construction of Quality Account and first draft started and work started on Part 2 – priorities for improvement
04/02/25	Planning meeting held with the Chief Nurse / Director of Quality and Professions
17/02/25	Emails sent to relevant parties with request for updates to sections in preparation for year-end (sections on quality)
03/03/25	Emails sent to relevant parties with request for updated data at year end
10/03/25	Work on draft to continue
27/03/25	Update and early draft presented to the executive management team
01/04/25	Follow up email sent as above with return date by 19 April 2025
08/04/25	Update and early draft presented to the Quality and Safety Committee
21/04/25	Returned data and content to be written into the Quality Account
21/04/25	Draft sent for proof reading and review by comms team
22/04/25	Update and early draft presented to the Members' Council Quality Group
25/04/25	Review of updated draft by Chief Nurse / Director of Quality and Professions
29/04/25	Update paper presented to Trust Board
07/05/25	Review of updated draft in Operational Management Group
13/05/25	Review of updated draft in the Quality and Safety Committee
14/05/25	Comments received and draft updated. Final draft of Quality Account for external stakeholder consultation finalised.
15/05/25	Review of final Draft in executive management team
19/05/25	Share final draft with members council quality group and external stakeholders with a return date for comments of within 28 days
20/05/25	Review of final draft in Clinical Governance Group
20/05/25	Final Draft to Trust Board
13/06/25	Comments received; any final changes/updates made
24/06/25	Final updates to Quality Account prior to publishing
29/06/25	Trust Board – receive final version
30/06/25	Publish Quality Account on external website

5. Examples of work to include in the Quality Account 2024/25

As part of the overall Quality Account, the Trust is required to publish progress against at least three indicators for patient safety, at least three indicators for clinical effectiveness and at least three indicators for patient experience. Examples of work that are in the current working draft of the report are as follows:

Patient safety

- Patient safety – an update on continued work towards the delivery of patient safety workstreams
- Suicide prevention – review of the suicide prevention strategy and progress against the national suicide prevention strategy
- Reducing restrictive physical interventions improvement work – the continuing reduction of the use of prone restrain against the Trust's ambition of zero use, and reducing incidences of seclusion
- Ligature audits – improvement work on streamlining the procedures for conducting community and inpatient ligature audits.

Clinical effectiveness

- Improving access to child and adolescent mental health services, including waiting times and providing care in the right place
- Care closer to home priority programme progress
- Falls improvement work with a focus on reducing falls related patient safety events
- Making data count – maximising opportunities to present and use data more effectively
- Improvement of mental health screening for children with epilepsy

Patient experience

- Triangle of care – progress with improving the experience for carers across the Trust
- Friends and family test – achieving targets for patient experience
- Complaint closure and resolution times – improving on the delivery of providing timely feedback to complaints and concerns

In addition, we report on progress against the three quality priorities and included are the following examples:

- **Safe and responsive care**
    - Learning disability service improvements – reducing waits and supporting GPs
    - Urgent community response – out of hours integration with Barnsley Metropolitan Borough Council night service
    - Kirklees 0-18 children and young people primary care network service
    - Electronic prescribing and medicines administration – progress on the roll out and benefits
    - Personalised care and support planning for adult and older adult community mental health services update
    - Quality assurance system development
    - Clinical record keeping – improvement work
- **Equality, inclusion and equity**
    - Culture of care – quality improvement, ward manager development and staff care and development

    - Embedding a trauma informed approach (April 2024 – March 2025)
- **Health, wellbeing and experience of staff**
    - Staff survey improvements
    - Staff wellbeing developments

Other examples of quality and innovation will be shared, including:

- Domestic abuse – embedding learning from domestic homicide reviews and domestic abuse related death reviews
- Nutrition and hydration – nutrition and hydration week focus on 'reinforce, focus and energise'
- West Yorkshire Paths – maternal mental health service development
- Improvements in emergency red bags – making bags easier for staff to maintain and simplification of the checking process

6. Summary

The Trust's Quality Account for 2024/25 is in development and near to completion, with a clear timeline, and an early draft has been shared with members of the executive management team, the Quality and Safety Committee and the Members Council Quality Group. The Quality Account will meet statutory requirements set out by NHS England, will provide a view of quality across the Trust for 2024/25 and will be ready for publication on the Trust website as required by 30 June 2025.

Paper prepared by:
Sarah Whiterod
Associate Director of Nursing, Quality and Professions

Members' Council
7 May 2025
Agenda item 9.4

<table>
<tr><td>Private/Public paper:</td><td>Public</td></tr>
<tr><td>Title:</td><td>Governor appointments to the Members' Council and Trust Board Groups and Committees.</td></tr>
<tr><td>Lead Director:</td><td>Andy Lister – Head of Corporate Governance (company secretary)</td></tr>
<tr><td>Purpose:</td><td>The purpose of the paper is to support the appointment of governors to the Members' Council groups, Nominations Committee and Trust Board Equality, Inclusion and Involvement Committee (EIIC).</td></tr>
<tr><td>Executive summary:</td><td>
Background
1. The Members' Council has the following process for appointing governors to the Members' Council groups and committees (full process is attached):

<table>
<tr><td>Step 1</td><td>When a vacancy arises, governors are invited to self-nominate, supported by a brief verbal or written statement about why they are putting themselves forward.
If only one self-nomination is received, they will automatically fill the vacancy, otherwise the process will move to Step 2.</td></tr>
<tr><td>Step 2</td><td>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.</td></tr>
</table>

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. It is noted that the one group rule does not apply to the Lead Governor, Deputy Lead Governor and the representative for the Rest of Yorkshire and the Humber representatives.

There is currently one governor vacancy in Members' Council subgroups.

<u>Members' Council Co-ordination Group</u>
One vacancy (Wakefield Public Governor)

<u>Members' Council Quality Group</u>
No vacancies

<u>Nominations Committee</u>
</td></tr>
</table>

	No vacancies <u>Equality, Involvement and Inclusion Committee</u> No vacancies
Recommendation:	**Not applicable.**
Mission/values:	Good governance supports the Trust to deliver its mission and adhere to its values.
Strategic Objectives	Live Our Values ✓ Be the best we can be: • Best quality ✓ • Best partner ✓ • Best value ✓ • Best place to work and learn ✓ Be ambitious ✓
BAF Risk(s):	N/A
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	N/A
Any background papers / previously considered by:	Quarterly updates to the Members' Council

Members' Council
7 May 2025
Agenda item 9.5

<table>
<tr><td>Private/Public paper:</td><td>Public</td></tr>
<tr><td>Title:</td><td>Members' Council Groups and Nominations Committee Assurance and Annual Reports for 2024/25</td></tr>
<tr><td>Paper presented by:</td><td>The Chair</td></tr>
<tr><td>Purpose:</td><td>The purpose of this paper is to provide assurance to the Members' Council that their Co-ordination Group, Quality Group and the Nominations Committee are fulfilling their remit and meeting their terms of reference through the quarterly assurance update (below).</td></tr>
<tr><td>Executive summary:</td><td>Members' Council Co-ordination Group (MCCG)
The Co-ordination Group co-ordinates the work and development of the Members' Council and:
• with the Chair, develops and agrees the agendas for Members' Council meetings.
• Works with the Trust to develop an appropriate development programme for governors both as ongoing development and as induction for new governors.
• Acts as a forum for more detailed discussion of issues and opportunities where the Trust seeks the involvement of the Members' Council.

<table>
<tr><td>Date</td><td>26 March 2025</td></tr>
<tr><td>Presented by</td><td>John Laville, Lead Governor (Chair)</td></tr>
<tr><td>Key items for Members' Council to note</td><td>• The group received an update for governor attendance at Members' Council meetings.
• The group approved the governor training schedule.
• The group received the action log of the Members' Council Biennial Evaluation.
• The group received a verbal and paper update of the progress against Members' Council Objectives.
• The group received updates from governors only meetings.
• The group discussed and approved the Members' Council agenda for 7 May 2025.
• The group received the quarterly schedule for QAS visits.</td></tr>
<tr><td>Approved notes of previous meeting/s to be received</td><td>Approved notes of the meeting held on 11 December 2024.

Please note these notes may be redacted if they contain personal, sensitive or confidential information.</td></tr>
</table>
</td></tr>
</table>

Review of annual report, terms of reference and workplan	The group reviewed the Members' Council Co-ordination Group annual report, terms of reference and workplan for 2025/26 and recommended them for approval by the Members Council.

Members' Council Quality Group (MCQG)

The Quality Group supports the Trust in its approach to quality through the Trust's quality priorities and:

- has high-level discussions on quality of care (using the quality performance report to lead the discussion).
- monitors the quality of care and facilitates discussion on patient experience, patient safety and clinical effectiveness.
- supports the production of the Trust's Quality Account.

Date	**22 April 2025**
Presented by	Phil Shire, Public Governor Calderdale (Chair)
Key items for Members' Council to note	• The group received and discussed the Integrated Performance Report (IPR). • The group received an update on Care Quality Commission (CQC) • The group received an oversight report on Quality Assurance System (QAS). • The group received an update for the plan for the Quality Account. • The group received a presentation from a deep dive into Cheswold Park Hospital. • The group received an update on the Quality Strategy.
Approved Minutes of previous meeting/s to be received.	Approved notes of the meeting held on 3 February 2025. *Please note these notes may be redacted if they contain personal, sensitive or confidential information.*
Review of annual report, terms of reference and workplan	The group reviewed the Members' Council Quality Group annual report, terms of reference and workplan for 2025/26 and recommended them for approval by the Members Council.

Nominations Committee

The Nominations Committee ensures the right composition and balance of the Board and oversees the process for the:

- identification, nomination and appointment of the Chair and Non-Executive

<table>
<tr><td></td><td>
Directors of the Trust.
• identification, nomination and appointment of the Deputy Chair and Senior Independent Director of the Board.
• identification, nomination and appointment of the Lead Governor and Deputy Lead Governor of the Members' Council.
<table>
<tr><td>Dates</td><td>11 April 2025 and 30 April 2025</td></tr>
<tr><td>Presented by</td><td>Marie Burnham, Chair</td></tr>
<tr><td>Key items for Members' Council to note</td><td>11 April 2025
• The Committee discussed the shortlisting for two new non-executive directors.
• The Committee made a recommendation to the Members' Council for the appointment of a new Deputy Lead Governor.
30 April 2025
• The Committee discussed the appointment of two new non-executive directors, recommended this for approval at Members' Council.</td></tr>
<tr><td>Approved Minutes of previous meeting/s for receiving</td><td>Approved notes of the meeting held on 15 January 2025.

Please note these notes may be redacted if they contain personal, sensitive or confidential information.</td></tr>
<tr><td>Review of annual report, terms of reference and workplan</td><td>The Committee reviewed the Nominations Committee annual report, terms of reference and workplan for 2025/26 and recommended them for approval by the Members Council.</td></tr>
</table>
</td></tr>
<tr><td>Recommendation:</td><td>The Members' Council are asked to:
• RECEIVE the assurance and approved notes/minutes from the Members' Council Co-ordination Group, Members' Council Quality Group and Nominations Committee.
• APPROVE the annual report, terms of reference and workplans for the:
  • Members Council Coordination Group
  • Members Council Quality Group
  • Nominations Committee</td></tr>
<tr><td>Mission/values:</td><td>Good governance supports the Trust to deliver its mission and adhere to its values.</td></tr>
<tr><td>Strategic Objectives</td><td>
<table>
<tr><td>Live Our Values</td><td>✓</td></tr>
<tr><td>Be the best we can be:
• Best quality
• Best partner</td><td>
✓
✓</td></tr>
</table>
</td></tr>
</table>

	• Best value • Best place to work and learn	✓ ✓	
	Be ambitious	✓	
BAF Risk(s):	N/A		
Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships	N/A		
Any background papers / previously considered by:	Previous quarterly and annual reports to the Members' Council		

Notes of the Members' Council Co-ordination Group
11 December 10.30 – 12:30
Meeting held virtually by Microsoft Teams

Present:	John Laville (JL)	Public Governor – Kirklees (Lead Governor) Chair of the Group
	Marie Burnham (MBu)	Chair of the Trust
	Bob Clayden (BC)	Public Governor - Wakefield
	Bob Morse (BM)	Public Governor - Kirklees
	John Lycett (JLy)	Public Governor - Barnsley
	Adam Jhugroo (AJh)	Public Governor – Calderdale
In attendance:	Andy Lister (AL)	Head of Corporate Governance (Company Secretary)
	Gemma Lockwood (GL)	Corporate Governance Manager
	Deborah Beynon-Fisher	Corporate Governance Officer
	Andrew Betteridge (AB)	Corporate Governance Administrator (author)
Apologies (members):	Leonie Gleadall (LG)	Staff Governor – Non-clinical support
	Natalie McMillan (NMc)	Non-Executive Director
	Fatima Shahzad (FS)	Public Governor - Rest of Yorkshire and the Humber. Cumbria, Durham, Lancashire, Greater Manchester, Derbyshire, Nottinghamshire, and Lincolnshire
	Claire Den Burger-Green (CDBG)	Deputy lead governor/ publicly elected governor – Kirklees
	Nesar Rafiq (NR)	Public Governor - Wakefield
Apologies (in attendance):		

1. Welcome, introductions and apologies (agenda item 1)
John Laville (JL) welcomed everyone to the meeting. Introductions were made and apologies, as above, were noted. The meeting was noted at quorate.

2. Declarations of interest (agenda item 2)
There were no declarations of interest.

3. Notes of the previous meeting held on 9 October 2024 (agenda item 3)
The notes of the meeting which was held on 9 October 2024 were agreed as a true and accurate record.

4. Action log from previous Co-ordination Group meetings (agenda item 4)
The group reviewed the outstanding and completed actions. The completed actions had been removed from the list, because of this AL went through those for the group.

Action 5.3 (09/10/2024) – Concerns regarding the PLACE visits and the short notice given to get governors involved. Andy Lister (AL) will also investigate PLACE visits, and QOMSS visits arranged by the Quality Team.

JL updated the group that we now have an up-to-date calendar of events that is updated and sent out regularly. AL stated this is updated and monitored by Corporate Governance and will become part of the Members' Council Co-ordination Group agenda.

Action 5.4 (09/10/2024) - Bob Clayden raised the question on will governors be able to change anything when the equality, inclusion, membership and communication strategy arrives at Members Council. John Laville echoed this question. Andy Lister stated he believes governors will be able to make amendments, but he will investigate this. This will be raised in governor feedback.

Action 5.6 (09/10/2024) - John Laville has spoken with Claire Den Burger-Green, and they both agree that we need a calendar of events for the year of involvement. Andy Lister agrees and will look at getting something together. Bob Clayden (BC) confirmed that this calendar would be for Governor events within the Trust and not in the wider community. JL confirmed this.

Action: Corporate Governance Team

5. Members' Council Development (agenda item 5)

5.1. Governor appointments to the Members' Council and Trust Board Groups and Committees (agenda item 5.1)

AL updated the group on vacancies in Members' Council groups and committees;

- Members' Council Co-ordination Group – One vacancy

No nominations have been received for this group. AL stated that although we have vacancies this is looking very well for the teams. AL did raise that Phil Shire is coming to the end of his third term at the end of April and as he currently sits at the head of the Members Council Quality Group we will need to look at his replacement.

5.2. Governor attendance at Members' Council meetings (agenda item 5.2)

AL informed the group that no issues were raised but Governors who do not attend and there is no contact with will be followed up with. JL is disappointed with the engagement of some governors, Marie Burnham (MBu) would like to take an assessment of those governors within the Trust who are not attending to follow up with them to see if we can assist moving forward.

Action: Corporate Governance Team

5.3. Governor training - update (agenda item 5.3)

AL presented the paper highlighting changes to the training guide. BC asked if sufficient notice would be given before training is booked. AL stated that he would be contacting the training providers to confirm dates and times, once confirmed these will be circulated.

JL has concerns about the governor completion of training and would like to see some visibility of training completed. BC and JL agree that some governors struggle due to timings and availability. AL this is raised with new governor induction.

5.4. Members' Council Co-ordination Group action log from the Biennial Evaluation and Members' Council engagement session (agenda item 5.4)

AL presented the paper highlighting certain points that are not completed and will take the paper as read for those that are, unless questions are raised.

AL Point 6 - Governors have had sufficient information and opportunity to ask questions in relation to the review of the Trust's Membership Strategy. Engagement session held with November

Members' Council meeting and to be presented in February 2025. The final draft will be formally approved by Trust Board in March 2025.

JL did raise some feedback on the session in November. There were some technical issues, the group breakout sessions felt rushed, and the strategy refresh felt completed rather than changeable. MBu agreed that it did feel rushed on the day. AL will look at reviewing the joint meeting to ensure everyone gets the best out of it.

Action: Corporate Governance Team

AL Point 14 - Staff governors are working towards creating networks within the group for feedback and insight.

AL Point 20 – Governors with a disability felt this was a barrier for them attending Members' Council meetings. All Trust and council buildings are fully accessible. BC does not feel that this covers all disabilities. AL will pick this up with BC.

AL Point 21 - Governors would like to see the Members' Council being held in different places. The corporate governance team to review different options.
Fieldhead – available
Barnsley – available
Calderdale – Laura Mitchell now has MS Teams facilities but isn't big enough to accommodate NED's/Execs and governors.
Kirklees – site isn't big enough for a hybrid meeting (Folly Hall)
AL wants to have the best quality of meeting possible, and the smaller sites will not offer the same experience.

5.5. Members' Council Objectives 2023 – 2025 - update (agenda item 5.5)

JL gave an update on the presented paper Members Council Objectives, pointing out the following.
1.4 - Actively encourage young people to become members and governors of the Trust. This will need a push to continue this improvement especially with the upcoming elections.

1.6 - Further develop governor effectiveness by increasing participation in the regular virtual governor meetings by area. To utilise the involving people feedback process through governor insight. Positive feedback from first meeting.

1.7 - Work with our communities and the Trust to identify and feedback areas of health inequalities both by community and location. Sara Javid (SJ) is doing great work on this area, but this has been paused due to staffing changes.

2.3 - To develop governor networks with the wider Integrated Care System (ICS) partners and ensure that all Trust activities have a positive impact on the wider system and enhance the holistic offering in line with the "Social Responsibilities and Sustainability Plan". JL has been involved with other lead governors from other Trusts and JL felt positive about the experience. JL would like to look at a network for the Integrated Care System (ICS).

MBu agrees with the governor network but does point out that this would only include Foundation Trusts. This is something that needs to be investigated with the hope of moving forward.

AL informed the group that after a conversation with BC, objective 1.5 & 3.2 have been clarified and the wording has been cleared up. AL also asked the group to agree that the timeline on these objectives can be changed to 3 years (one lead governor term). This is agreed by the group.

Action: Corporate Governance Team

5.6. Governor feedback – issues emerging from governor forums (agenda item 5.6)
JL updated the group on the feedback from the governor virtual meetings.

The staff governor meeting focused on two themes. The ongoing tight budget of the Trust and concerns that this will influence resources and confidence. The second was concerns about staff governors being involved in the new Cheswold site, and how do they make an inroad into this site.

Public and Elected governors raised, public involvement with surveys and how they feel like they are being asked the question and give the answers, but nothing ever changes. Also raised that some of the creative activities on wards have been changed and managed, it has moved from group work to one to one. BC informed that it is becoming difficult to access creative and cultural activities due to restrictions on Forensic wards. AL will look into if any process has changed around activities.

Action: Corporate Governance Team

AL informed the group that in regards to Cheswold a news email like the Headlines and the View will be sent out to their emails. This is until they move onto the NHS email system and this will be built upon. BC asked if this transition had started. AL this is an ongoing piece of work.

6. Members' Council agenda, discussion items for consideration (agenda item 6)
AL presented the draft Members' Council meeting agenda for the February 2025 meeting.

BC asked about Item 6 on why it was now a paper and not verbal update. AL stated that Mark Brooks will give a written report with a verbal update to any changes. AL will discuss this with Mark Brooks.

JL asked about having a focus on the £22 million on the cost improvement programme to show where we are making these cost cuttings. Also an update on the Cheswold site would be great for governors. Adam Jhugroo (AJh) believed that Cheswold might me worth pushing back to the following meeting giving them time to settle down.

BC raised concerns over how much time we give to the engagement section as this is a wide area. MBu agrees that this needs to be clarified that this is a very wide net to throw. It's needs to be looked at who we target and in what areas.

7. Members' Council Co-ordination group work programme 2024 – 2025 (agenda item 7)
AL presented the work programme, nothing raised on this area.

8. Members' Council Elections (agenda item 8)
AL presented the Members' Council Elections and asked for the paper to be taken as read.

JL raised that we need to discuss the amount of commitment that is expected from new governors. BC agreed that it needs looking at as the website only states four meetings. Bob Morse (BM) raised that we need to identify what the Trust needs from its governors and what we would need to do to engage and get the right applicants. JL stated that until decisions are made, we need to choose our words carefully to encourage more than the four meeting minimal attend. MBu agrees with the points raised and would like us to get the correctly skilled governors. MBu raised the possibility of looking at some kind of podcast to talk about what is required as a governor. AL raises the concerns regarding remaining timeline but does agree with the positive promotion of being a governor and the additional opportunities.

9. Any other business (agenda item 9)
Nothing raised.

10. Date of future Co-ordination Group meetings for 2025 (agenda item 10)

- 26 March 2025, 09.30 – 11.30, virtual, MS teams
- 4 June 2025, 10.00 – 12.00, virtual, MS teams
- 8 October 2025, 10.00 – 12.00, virtual, MS teams
- 3 December 2025, 10.00 – 12.00, virtual, MS teams

JL closed the meeting.

Notes of the Members' Council Quality Group
Held on 03 February 2025 from 10:00 to 11:40
Virtual meeting *on Microsoft Teams*

Present:	Phil Shire (PS)	Public Governor – Calderdale (Chair)
	Darryl Thompson (DT)	Chief Nurse and Director of Quality and Professions
	Bob Morse (BM)	Governor (publicly elected Kirklees)
	Elaine Lane (EL)	Governor (Staff elected Allied Health Professionals)
	Susan Spencer (SS)	Governor (Appointed Barnsley Hospital NHS foundation trust)
	Nesar Rafiq (NR)	Public governor - Wakefield
	Sarah Whiterod (SW)	Associate Director of nursing, quality and professions
	Melanie Wood (MW)	Head of Performance & Business Intelligence
In attendance:	John Laville (JL)	Lead Governor / Public governor (Kirklees)
	Izzy Worswick (IW)	Associate Director of Corporate Governance
	Gemma Lockwood (GL)	Corporate governance manager
	Deborah Beynon-Fisher (DBF)	Corporate Governance Officer
	Andrew Betteridge (AB)	Corporate governance Administrator (author)
Apologies (members):	Emma Cox (EC)	Associate Director of Nursing, Quality and Professions
	Daniel Goff (DG)	Public Governor – Barnsley
	Claire Den Burger-Green (CDBG)	Public Governor – Kirklees (Deputy Lead Governor)
	Fatima Shahzad (FS)	Governor (publicly elected Rest of Yorkshire and the Humber)
	John Lycett (JLy)	Governor (Public elected Barnsley)
Apologies: Attendance	Anne Magee (AM)	Governor (Appointed Staff side organisations)

1. Welcome, introductions and apologies (agenda item 1)
Phil Shire (PS) welcomed everyone to the meeting. Introductions were made and the apologies, as above, were noted. The meeting was noted to be quorate.

2. Declarations of interest (agenda item 2)
Nothing Declared.

3. Notes and actions of previous meeting held on 15 October 2024 (agenda item 3)
The notes were agreed as a true and accurate record of the meeting.

The group reviewed the action log noting that the action log has been completed. John Laville (JL) noted a missing action from the log and Andrew Betteridge (AB) will update.

Nesar Rafiq (NR) asked for papers to be re-sent to him as he was unable to locate them and AB emailed papers out to NR.

4. Integrated Performance Report (IPR) (agenda item 4)

PS opened the discussion on the IPR as all governors' have been sent a copy of the report. PS started with the headlines on page 5 asking the group if anyone has any questions.

NR asked what the Trust means when using metric, surplus, capitol spend and total cost, is this managing the budget. PS confirmed that this is the budget. PS then clarified that within the Members' Council Quality Group we focus on the quality of work being carried out and not budgets as this area is discussed at Members Council meetings. NR believes that finances are an important part of quality. Looking through this report NR cannot find any reference to how many people we cannot see due to budgets constraints. NR asked for it to be noted regarding his concerns regarding financial constraints within the Trust and how it impacts the services we supply. PS recommends that NR brings any question to the group so the team can answer these questions.

Darryl Thompson (DT) hopes that the report does represent the reality of the Trust and does show where supply and demand are struggling. There is a staffing and financial link to how we supply services. DT reminded the group that with the upcoming budget restraint, the Trust will be going through a difficult time.

PS asked about single point of access to the Trust and that it seems to be struggling to cope. DT stated that we have several points of access, and these areas have their own individual difficulties. In the area of Calderdale and Kirklees this is down to staffing in this area. Melanie Wood (MW) confirms that this is in the mental health single point in Calderdale and Kirklees. DT confirmed that this is mainly down to admin staff vacancies to support nursing and doctors and there is an NHS wide reluctance to take on new admin staff. JL raised the point about the 130% increase in Calderdale and Kirklees in the requirement on Mental Health services. PS would like to look at a possible deep dive topic about the massive increase with the requirement of Mental Health services. Looking at wait times around ADHD services. Bob Morse (BM) agrees that this topic deserves a deep dive as this service will continue to evolve and increase.

Action: Future Deep Dive into ADHD service

PS raised that the number of violence and aggression incidents towards staff on mental health wards involving race has increased as shown in the strategic objectives and priorities section. BC also agreed with these concerns and asked if the increase is linked to drug and alcohol misuse. DT stated that the majority of these incidents occurred on inpatient wards in which the service users do not have access to drugs and alcohol. There has been a change within the Datix reporting system which has a specific field that allows to add the aspect of the incident like racism, sexism, and homophobia. This is new and will take time to see if there are any trends within this area.

NR made the suggestion that as the IPR is such a large report could governors send questions in advance as there is limited time on this report in this meeting. PS agrees that this is a good idea as long as we don't overload departments with questions. PS raised an action point that if governors have any questions that they didn't have time to ask in the meeting they can be sent to the Corporate Governance team.

Action: Questions to be sent in regarding IPR

DT stated that the IPR goes through the executive management team and has been to public Trust board. DT also stated that if governors would like to send questions into the group before the Members' Council Quality Group meeting this would allow them to be focused on. PS likes this idea and would like to see if the IPR can be sent out earlier to allow governors time to review it. JL raised that he had concerns that questions and answers would not be shared with the group allowing the group to discuss this in the open forum of the Members' Council Quality Group. NR stated that there are those with health issues would feel more confident to raise questions via email and requested a draft version in advance of the meeting. Izzy Worswick (IW) agrees that

getting questions before hand is a good idea as long as they are raised within the meeting for all members to discuss. MW is happy to look at what the group has raised in today's meeting for the next IPR meeting.

5. Care Quality Commission (CQC) update (agenda item 5)

DT gave a verbal update on where the Trust is in regards to the CQC. DT stated that the Trust is continuing to review progress against the action plans and is confident that the changes are embedded and will be reviewed in 6 months. Sarah Whiterod (SW) and her team will bring them to the Executive Management Team and Equality and Safety Committee.

PS asked if service users can be admitted into Cheswold Park. DT stated that Cheswold has been open to admissions since 1 October but there has been various blockers. The Trust has ensured that staff and facilities are up to working standards before admitting service users. DT stated that the first service user was admitted to Cheswold in January. Susan Spencer (SS) asked about capacity at the Cheswold and DT confirmed that there are 112 beds at Cheswold, however there has been some fundamental challenges on the site with some wards been closed. Izzy Worswick (IW) confirmed that the focus will be on current available beds and then looking at the closed wards once closer to capacity and will be looked at over the next 18 months.

6. Quality Account – update (agenda item 6)

DT gave a verbal update stating that there is a publishing date with a draft version going to the Executive Management Team and Quality and Safety Committee with a plan to publish on the 30 June 2025. SW's team will create an easy read version of this as requested by the governors which will be shared with the group outside of the main meeting.

7. Quality Assurance System (agenda item 7)

SW presented the paper and opened the floor to questions.

PS raised that it states over the 12 months 31 visits will have been completed. PS asked how the visits are selected. SW stated that visits are currently planned for areas where the Trust has received negative or concerning feedback. If there are no areas of concern, areas that have not received a visit in the past 12 months will be visited.

SS asked if the inpatient areas use the Tendable audits system like Barnsley Trust. SW confirmed that Mental Health inpatient areas currently use Tendable, but Forensic inpatients have a selection of audits.

NR is impressed with this system; it asks detailed questions and links in the CQC. NR feels that comes across as a very friendly approach which is how a Mental Health Trust should work.

JL asked for clarification on what the acronyms are for current visits, as this has changed several times in the last 12 months. SW stated that QAS or Quality Assurance System is the system and the Quality Walkarounds are part of the system.

JL raised concerns that the new walk arounds do not seem as in depth as previous visits and he didn't feel like there was as much focus on the cleanliness and maintenance of the areas they visited. SW stated that this is because there are audits and checks within these areas on cleanliness and maintenance. In the routine visits areas would not be the focus of the visit, but if the site is having an enhanced or intensive monitoring then these areas will be looked at. SS confirmed there are audits aimed at cleanliness and maintenance and SW added that the Trust does have audits around this within Estates. JL raised concerns in regards to the limited range of standard audits. PS agrees there should be a way of raising concerns while on the standard visit.

SW confirmed that governors are still able to do these checks, and that they will be followed up. DT stated that to complete more visits, they have been streamlined from previous visits and do not stop visitors from raising concerns.

NR explained he has been involved in visits outside of the Trust and believes there should be no

fear and blame culture within departments and asked if there is a robust process for reporting cleanliness and maintenance issues. DT stated there is a robust process for reporting via estates and each request is dealt with and prioritised. NR stated that this is great, and staff need to be included in communications, so they are kept updated.

JL raised the data around lone working and how it shows that staff are not taking their lone working devices with them and failing to log out at the end of the day. DT reported that there is a piece of work being undertaken to look at this area.

NR asked if the changes to National Insurance will affect services. DT advised that this area will be discussed at the next Members' Council meeting.

PS raised the summary of walkaround improvements at the end of the report where there are a lot of areas that have not been addressed including IT issues with systems not talking to each other. DT stated that there is very robust data sharing within the Trust and allow access, where appropriate, between organisations. As Caldicott Guardian, DT will review specific issues raised and there is also the Improvement Clinical Information Group where this can be taken for further discussion.

7.1 Deep dive process visits at Barnsley (agenda item 7.1)
PS asked the group regarding interest in this visit to Barnsley community services which will be with staff rather than service users. JL and SS showed interest in this visit and AB will circulate dates and times to governors when confirmed.

7.2 Cheswold Park deep dive for April (agenda item 7.2)
PS is proposing to have the April MCQG meeting at Cheswold Park Hospital, which will include a deep dive of the service and a visit. PS encouraged governors to attend the April meeting in person.

8. Members' Council Quality Group Work Programme 2025/26 (agenda item 8)
PS gave an overview of the paper sent to governors and PS confirmed some changes to the work programme with for 2025/26.

9. Any other business (agenda item 9)
None.

10. Items to raise at Members' Council meetings (agenda item 10)
JL would like to have governors updated on the new terminology around visits to reduce confusion.

Action: Sarah Whiterod confirmation around terminology

11. Future dates for 2024/25 (agenda item 11)
- 13.00 - 16 April 2025 (hybrid – Cheswold Park Hospital) TBC
- 14 July 2025 (hybrid –Hospital)
- 15 October 2025 (hybrid –Hospital)

PS closed the meeting.

Extraordinary Nominations Committee
15 January 2025 14:00
Virtual meeting via Microsoft Teams

Present: Marie Burnham (MBu) - Trust Chair (Chair)
Mark Brooks (MBr) – Chief Executive
Jon Head (JH) – Chief People Officer
John Laville (JL) - Lead Governor, Publicly Elected Governor, Kirklees Governor
Phil Shire (PS) – Public Governor – Calderdale
Andrea McCourt (AMc) - Appointed Governor – Calderdale and Huddersfield NHS Foundation Trust

Apologies: Claire Den Burger Green (CDBG) – Deputy Lead Governor, Publicly Elected – Kirklees
Jacob Agoro (JA) – Staff governor – Nursing support

In attendance: Andy Lister (AL) - Head of Corporate Governance (Company Secretary)
Gemma Lockwood (GL) – Corporate Governance Manager
Andrew Betteridge (AB) – Corporate Governance Administrator
Debbie Beynon-Fisher (DBF) – Corporate Governance Officer (Author)

NC/25/01 Welcome, introductions and apologies (agenda item 1)
Marie Burnham (MBu) introduced herself and welcomed everyone to the meeting. Introductions were made, apologies were noted and the meeting was declared to be quorate and could proceed.

NC/25/02 Declarations of Interests (agenda item 2)
None.

NC/25/03 Minutes of the previous Nominations Committee meetings held on 9 October 2024 (agenda item 3)

It was RESOLVED to APPROVE the minutes as a true and accurate record of the meeting held on 9 October 2024

NC/25/04 Action log and matter arising from the meeting on 9 October 2024 (agenda item 4)
It was noted that there were no outstanding actions.

It was RESOLVED to RECEIVE the action log.

NC/25/05 Review of skills and expertise required on the Board, including Chair and Non-Executive Director terms of office (agenda item 5)
Andy Lister (AL) advised that 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 (NEDs), Deputy Chair / Senior Independent Director, and the Lead Governor / Deputy Lead Governor.

AL advised that there are two NEDs who are due to reach the end of their terms in 2025. David Webster's first 3-year term is due to end on 30 April 2025 and a separate paper will be presented to the Nominations Committee (agenda item 6).

Erfana Mahmood has completed her second 3-year term and AL advised that when a NED wishes to extend their term beyond 2 terms (six years), approval from NHS England (NHSE) and the Integrated Care Board (ICB) Chair is required. This process was followed in 2024, and Erfana's term was extended by 1 year and is due to end on 2 August 2025.

The Committee were asked to note that since June 2024 there have been a number of changes to Trust Board:

- Jon Head (JH) joined as Chief People Officer in September 2024
- Adele Fox joined as Chief Operating Officer in January 2025.
- Mandy Rayner (NED) and Kate Quail (NED) were replaced by Margaret Kitching and Gary Ellis in October 2024.

Marie Burnham (MBu) advised that she had raised concerns regarding Board stability and diversity and had asked that a request be put forward to NHSE to extend Erfana Mahmood's term by a further 2 years, beyond the 1 year already approved. She advised Erfana had confirmed that she would be happy to remain in post for a further 2 years and the relevant paperwork had been completed and submitted to the NHSE regional office for consideration.

It was advised by Mbu that she continues to consider the value of the role of Associate Non-Executive to the Trust, however, as part of the progression of the Trust to Teaching Trust status, it is now confirmed that an associate non-executive director position will be available to a staff member of Leeds University, once the process reaches completion.

Committee were asked to note the contents of the report and support the proposal to extend Erfana Mahmood's term by a further 2 years.

John Laville (JL), Phil Shire (PS) and Andrea McCourt (AMc) confirmed that they were happy to endorse the extension to Erfana's term.

Mark Brooks (MBr) added that Erfana adds great value to the Trust, has a wealth of experience including a legal background, provides diversity in terms of thinking and background, is an expert on equality, diversity and inclusion and conducts herself well and in line with Trust values. MBr therefore agreed to endorse the proposal provided it meets the NHSE code of governance.

The Committee agreed to approve the extension and present the proposal to Members' Council for final approval.

Andy Lister (AL) to complete the paperwork and send to Cathy Elliot (Chair of the ICB) and the NHSE regional office, before presentation at Members' Council in May 2025.

Action: Andy Lister

It was RESOLVED to APPROVE the review of skills and expertise required on the Board, including Chair and Non-Executive Director terms of office

NC/25/07 Review of Chair, Non-Executive Director remuneration (agenda item 7)
Jon Head (JH) advised that the report set out the governance arrangements for the chair and NED remuneration, which follows NHSE guidelines and details who are responsible for the decision.

The report also sets out the national framework for NED pay, which is standardised, and explains the arrangements for Chair remuneration which is heavily influenced by the size of the organisation.

Since the change to the size of the Trust following the acquisition of Cheswold Park Hospital, there is a statutory increase in pay for the Chair. Committee are therefore asked to receive the update in relation to the remuneration and support the recommendation to Members Council.

PS asked for clarification around whether the Chair will move onto the upper quartile due to the Trust becoming a “large” Trust.

AL confirmed that this has already taken place as a result of the acquisition of Cheswold Park Hospital which took place on 1 October 2025. Approval from the Nominations Committee was not required for this change as this is a stipulated pay band for a chair of a “large” Trust, as part of the NHSE framework.

PS raised a question regarding the NHS decision to freeze remuneration since 2019 and the rationale behind it as this has resulted in the posts no longer being attractive to the right calibre of candidate.

Mbu reported this has been picked up by Chairs nationally and that SWYPFT (South West Yorkshire Partnership NHS Foundation Trust) agreed to align with the national guidelines in 2019.

AL confirmed he has spoken with NHSE around the lack of review of chair and NED remuneration noting the issue around attracting future NEDs. NHSE advised that there is no current timeline for a review to take place.

The Nominations Committee agreed to support the recommendation to take the update forward to Members Council.

It was RESOLVED to RECEIVE the review of Chair, Non-Executive Director remuneration

NC/25/08 Work programme for 2024/25 (agenda item 8)

AL confirmed that the work programme is a standard programme which will be presented to the Nominations Committee in April once the annual report and effectiveness has been completed.

It was RESOLVED to RECEIVE the work programme for 2024/25

NC/25/09 Any other business (agenda item 9)
No further business.

NC/25/10 Issues and items to bring to the attention of Trust Board / Members’’ Council (agenda item 10)
Nil

NC/25/11 Dates of future Nominations Committee Meetings (agenda item 11)

11 April 2025, 10.00 – 12.00

Members' Council Co-ordination Group
Members' Council Co-ordination Group Annual Report 2024/25
To be approved by Members' Council 7 May 2025

Purpose of the Report

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

Overall aim

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

Duties

The Co-ordination Group will:

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.

Membership

Membership consists of governors (with representation from public, staff and appointed governors) plus the Chair and Deputy Chair of the Trust. The Head of Corporate Governance (Company Secretary) and Deputy Lead Governors also attends meetings of the Co-ordination Group.

The Members' Council policy is that the term of office for any new members of the Group is three years to allow for consistency of membership. If a governor wishes to stand down from the group or is not re-elected/re-appointed as a governor on the Members' Council during the three years, the individual taking their seat does not automatically take the place on the Group.

The membership of the Co-ordination Group from 1 April 2024 to 31 March 2025 was as follows:

- Chair of the Trust – Marie Burnham
- Deputy Chair of the Trust – Mandy Rayner (until 31 October 2024)
- Deputy Chair of the Trust – Nat McMillan (from 1 November 2024)
- Lead Governor (publicly elected, Kirklees) – John Laville (Chair)
- Governor (publicly elected, Barnsley) – John Lycett
- Governor (publicly elected, Calderdale) – Adam Jhugroo
- Governor (publicly elected, Kirklees) – Bob Morse
- Governor (publicly elected, Wakefield) – Bob Clayden
- Governor (publicly elected, publicly elected Rest of Yorkshire and the Humber. Cumbria, Durham, Lancashire, Greater Manchester, Derbyshire, Nottinghamshire, and Lincolnshire) – Fatima Shahzad
- Governor (staff elected) – Leonie Gleadall
- Governor (appointed) – Geraldine Carter (14 February 2025)

All governors continue to be welcome to attend meetings of the Co-ordination Group, even if they are not formal members.

What the Co-ordination Group has done

Agenda setting

The Co-ordination Group has met on a regular basis throughout the year, approximately six weeks prior to each Members' Council meeting and has worked with the Chair of the Trust to develop and agree the agenda for Members' Council meetings. This has allowed sufficient time for agenda planning and given the opportunity for members to suggest items for inclusion. The Co-ordination Group has also reviewed and inputted to the Members' Council work programme and also considered what discussion topics to focus on, including consideration of items suggested by governors.

In agreeing the Members' Council agenda for each meeting, the Co-ordination Group takes the following into account:

- Feedback received from governors on the last Members' Council meeting and from governor forums
- Items from the Members' Council work programme
- Items from the Members' Council Quality Group
- Items from the Nominations' Committee
- Items from the Trust Board and committees
- Items requested by individual governors
- Items deferred from previous Members' Council meetings

Members' Council and governor development

The Co-ordination Group has:

- Monitored and contributed to the development of the governor training programme.
- Monitored and reviewed actions from the biennial evaluation session in 2023.
- Reviewed and made recommendations to the Members' Council for membership on Members' Council groups.
- Reviewed governor attendance at Members' Council meetings and identified if and where additional support was required to enable governor attendance.
- Agreed the Members' Council Objectives for 2023 – 2025 and recommended to Members' Council for approval. They continually reviewed progress against their objectives.
- Proactively ensured governor engagement in Trust strategies including the Trust strategy refresh and the new equality, diversity and inclusion strategy (including membership)
- Received summaries and issues emerging from governor forums
- Contributed to the development and update of the governor handbook.
- Contributed to the work plan of governors holding non-executive directors to account
- Contributed to the planning of the Annual Members' Meeting.
- Discussed the consultation process with governors in regard to Members' Council workplan, Members' Council meeting days, face to face meetings and hybrid meetings.
- Received updates regarding the Members' Council election process

Forum for discussion

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

- Worked in conjunction with the Company Secretary to consistently review ~~re-design~~ the Members' Council work programme to ensure statutory business items are included and discussion items are included .
- The workplan prioritises focus items for discussion by taking items as read on a rotational basis. The Co-ordination Group takes decisions on priority areas for forthcoming focus on presentations in the Members' Council meetings.
- Continued to promote opportunities for governors to observe Trust Board Committees, following their approved guide.
- Played a key role in the continuing development and update of the Trust website in relation to the Members' Council including providing videos of their experience as a governor on the Members' Council and updating the webpage information relating to governors elections~~.~~

How have we done

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

The Co-ordination Group is supported effectively by the Corporate Governance Team, who prepare agendas and papers, take, and distribute minutes, organise governor training sessions, enable the setting up and running of governor forums, maintain effective communications with and between governors, and answer queries. The Co-ordination Group would like to thank the Corporate Governance Team for their professional support throughout the year.

The Co-ordination Group's sincere thanks are also extended to previous members for both for their support and contribution.

To be approved: Members' Council 7 May 2025
Next review due: May 2026

Members' Council Co-ordination Group
Terms of Reference
To be approved by Members' Council on 7 May 2025

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

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.

Membership
Membership consists of:
- Eight governors: the Lead Governor, one representative from each public constituency, one staff governor, and one appointed governor.
- The Chair
- Deputy Chair

Governors are appointed to the Co-ordination Group by the Members' Council, on the recommendation of the Members' Council Co-ordination Group. The normal term of office is three years. If an individual resigns or is not re-elected / re-appointed onto the Members' Council during the three-year period, the seat becomes vacant and the individual taking their governor seat does not automatically take the place on the Group.

Governors are invited to self-nominate to vacancies on the group on a quarterly basis.

Membership at 1 April 2025:
John Laville, Lead Governor (publicly elected governor – Kirklees) (Chair of the group)
John Lycett (publicly elected governor – Barnsley)
Adam Jhugroo (publicly elected governor – Calderdale)
Bob Morse (publicly elected governor – Kirklees)
Bob Clayden (publicly elected governor – Wakefield)
Fatima Shahzad (publicly elected governor – Rest of Yorkshire and the Humber. Cumbria, Durham, Lancashire, Greater Manchester, Derbyshire, Nottinghamshire, and Lincolnshire)
Leonie Gleadall (Staff elected governor)
Geraldine Carter (appointed governor)
Marie Burnham (Chair of the Trust)
Nat McMillan (Deputy Chair / Senior Independent Director of the Trust)

In attendance:
Andy Lister, Head of Corporate Governance (Company Secretary)
Deputy Lead Governor

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) and Deputy Lead Governor are 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

Meetings are chaired by the Lead Governor. In the unusual event that the Lead Governor is absent from the meeting, the Deputy Lead Governor will chair the meeting.

The quorum will be a minimum of 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.

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.

Reporting to the Members' Council

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

To be approved by Members' Council: 7 May 2025
Next review due: May 2026

Members' Council Coordination Group annual work programme 2025/26

Agenda item/issue	19 Mar 2025	04 Jun 2025	08 Oct 2025	03 Dec 2025
Standing items				
Welcome, introductions and apologies	✘	✘	✘	✘
Declarations of interest	✘	✘	✘	✘
Notes of previous Co-ordination Group meeting	✘	✘	✘	✘
Action log from previous Co-ordination Group meeting	✘	✘	✘	✘
Members' Council Co-ordination Group Work programme	✘	✘	✘	✘
Any other business	✘	✘	✘	✘
Date of future Co-ordination Group meetings	✘	✘	✘	✘
Members' Council development				
Membership on Members' Council groups (if required)	✘	✘	✘	✘
Governor attendance at Members' Council meetings	✘	✘	✘	✘
Governor Training - update	✘	✘	✘	✘
Members' Council biennial evaluation – action log update	✘	✘	✘	✘
Members' Council objectives 2023 - 2025	✘	✘	✘	✘
Governor feedback	✘	✘	✘	✘
Governor Handbook - annual update	✘			
Future Members' Council agenda and discussion items for consideration:				
Draft agenda for next Members' Council meeting, with consideration given to: - Action log from previous Members' Council meetings - Feedback received from governors on last Members' Council meeting - Action log from previous Members' Council meeting - Feedback received from governors on last Members' Council meeting - Items from Members' Council work programme - Items from the Members' Council Quality Group - Items from Nominations' Committee - Items from Trust Board and committees	✘	✘	✘	✘

Agenda item/issue	19 Mar 2025	04 Jun 2025	08 Oct 2025	03 Dec 2025
- Items requested by Governors Items deferred from previous Members' Council meetings				
Scheduled items				
Members' Council Coordination Group Annual Report	✘			
Review of Members' Council Coordination Group Terms of Reference and effectiveness	✘			
Process for appointment of Lead Governor / Deputy Lead Governor (if required)				
Members' Council work plan				✘
Annual Members' Meeting (AMM) planning update		✘		
Involving People Strategy - annual action plan update (to be included in AMM presentation)		✘		
Governor Advisory Committee (NHS Providers) – reminder of forthcoming nomination process		✘		
Draft agenda for Joint Trust Board and Members' Council meeting			✘	
Members' Council Elections		✘ **(mid year election update)**		✘
Members' Council Declaration of Interest policy review (May 2027)				
Members' Council Expenses Guidance (May 2027)				
PLACE visits schedule for September – November 2025		✘		
QAS visits quarterly schedule	✘	✘	✘	✘

Members' Council Quality Group
Members' Council Quality Group Annual Report 2024/25
To be approved by Members' Council on 7 May 2025

Purpose of the Report

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

Overall aim

The Members' Council Quality Group's primary purpose is to support the Trust in its approach to quality through the Trust's quality priorities.

Duties

The Quality Group will:

a) Review the content of the Trust's performance report to gain a more in depth understanding of the quality and safety of services and provide high level scrutiny on behalf of the Members' Council.
b) Support the Trust in developing its annual Quality Accounts.
c) Raise any concerns with the Trust, through the Deputy Director Corporate Governance, who is responsible for the production of the performance report.
d) Invite Executive Directors and or Senior Officers of the Trust to provide greater understanding of quality items identified by the group.
e) To support the Members' Council with an understanding of system working and how it impacts on quality of care.
f) Support governors to visit services as appropriate.

The Members' Council Quality Group will help to implement the following Members' Council Objectives:

- Endeavour to ensure continuous improvement throughout the Trust by providing feedback and constructive challenge from the communities that they serve.
- Increase Governor opportunities to see the Trust at work through planned visits to services, Quality Improvement and Care Groups (CG) visits in order to gain a wider perspective, understanding and knowledge of the Trust's services and that they are appraised of actions and follow up.
- Have access to patient experience intelligence and insight and to understand corrective action and follow up.
- The Groups objectives will be reviewed annually to reflect any changes to Members' Council Objectives.

Membership

Membership consists of:

- Eight governors: one representative from each public constituency, Deputy Lead Governor, one staff governor, and one appointed governor.
- The Deputy Director of Corporate Governance (to December 2025)
- Head of Performance and Business Intelligence (from January 2025)
- Chief Nurse and Director of Quality and Professions

The Members' Council Quality Group is chaired by a publicly elected governor.

The Members' Council policy is that the term of office for any new members of the Group is three years to allow for consistency of membership. If a governor wishes to stand down from the group or is not re-elected/re-appointed as a governor on the Members' Council during the three years, the individual taking their seat does not automatically take the place on the Group.

The Quality Group membership from 1 April 2024 to 31 March 2025:

Member	**Attendance for 2024-25**
Phil Shire Governor (publicly elected, Calderdale) – Co-chair of the group	4/4
Darryl Thompson - Chief Nurse and Director of Quality and Professions (Lead Director and co-chair)	3/4
Claire Den Burger Green - Deputy Lead Governor (publicly elected, Kirklees)	0/3
Daniel Goff - Governor (publicly elected, Barnsley)	0/4
Bob Morse - Governor (publicly elected, Kirklees)	4/4
Daz Dooler - Governor (publicly elected, Wakefield) (to June 2024)	0/2
Nesar Rafiq - Governor (publicly elected, Wakefield) (from November 2024)	2/2
Fatima Shahzad - Governor (publicly elected, Rest of Yorkshire & the Humber)	0/4
Elaine Lane - Governor (staff elected) (from June 2024)	3/3
Susan Spencer - Governor (appointed)	3/4
Deputy Director of Corporate Governance	0/3
Head of Performance and Business Intelligence	1/4

In attendance:

- Associate Director for Nursing, Quality and Professions – Sarah Whiterod
- Lead governor and public governor for Kirklees – John Laville

All governors continue to be welcome to attend meetings of the Group, even if they are not formal members.

What the Quality Group has done

The Quality Group has met on a regular basis throughout the year to consider quality issues and other issues relevant to the Members' Council. The following examples give an indication of the range of discussion. The Quality Group has:

- Reviewed the content of the Trust's quality performance report (Integrated Performance Report) at all meetings of the Quality Group and provided high level scrutiny on behalf of the Members' Council.
- Supported the Trust in developing its annual Quality Accounts.
- Raised and discussed any areas of quality concerns with the Chief Nurse and Director of Quality and Professions, including review of the annual patient experience report, the Incident Management Annual Report, and the Care Quality Commission (CQC) action plans. It has also followed up specific quality issues raised by governors.
- Continued to discuss updates for the quality assurance system (formerly quality monitoring visits), including visits from April 2024 to March 2025. The Quality Group have emphasised

the importance of reviewing feedback from the quality assurance system and the messages the process conveys about quality as a whole.

- The Quality Group has also received presentations as follows:
  - Burnt Bridges report (a thematic review of the deaths of five men on the streets of Halifax during Winter 2018/19)
  - People Directorate presentation relating to sickness absence
  - Independent review of Greater Manchester Mental Health NHS Foundation Trust
  - Updates on the Quality Strategy
- The group has received presentations on and / or undertaken site visits to the Trust's eating disorder team in Wakefield, and Barnsley Community Health Team ~~Newton~~. ~~These S~~site visits have enabled the group to deep dive and gain a more in-depth insight into these services. This initiative for the group site visits continues and depends on members attending meetings in person and the capacity of services to accommodate visits.

How have we done

The Quality Group considers that it has carried out its remit over the past year effectively, as demonstrated by the activity outlined above. Meetings have been held either virtually via Microsoft Teams or Hybrid. However, it has proved difficult to achieve sufficient attendance from governor colleagues, particularly in relation to offering the opportunity to visit services as part of the meetings. The Quality Group is aware that other governors may wish to comment on the work undertaken and suggest further issues the Quality Group could focus on.

The Quality Group's thanks are extended to previous members for both for their support and contribution.

To be approved: Members' Council 7 May 2025

Members' Council Quality Group
Terms of Reference
To be approved by Members' Council on 7 May 2025

Purpose

The Members' Council Quality Group's prime purpose is to support the Trust in its approach to quality through the Trust's quality priorities.

Duties

The Quality Group will:

a) Review the content of the Trust's performance report to gain a more in depth understanding of the quality and safety of services and provide high level scrutiny on behalf of the Members' Council.
b) Support the Trust in developing its annual Quality Accounts.
c) Raise any concerns with the Trust, through the Deputy Director Corporate Governance, who is responsible for the production of the performance report.
d) Invite Executive Directors and or Senior Officers of the Trust to provide greater understanding of quality items identified by the group.
e) To support the Members' Council with an understanding of system working and how it impacts on quality of care.
f) Support governors to visit services as appropriate.

The Members' Council Quality Group will help to implement the following Members' Council Objectives:

- Endeavour to ensure continuous improvement throughout the Trust by providing feedback and constructive challenge from the communities that they serve.
- Increase Governor opportunities to see the Trust at work through planned visits to services, Quality Improvement and Care Groups (CG) visits in order to gain a wider perspective, understanding and knowledge of the Trust's services and that they are appraised of actions and follow up.
- Have access to patient experience intelligence and insight and to understand corrective action and follow up.
- The Groups objectives will be reviewed annually to reflect any changes to Members' Council Objectives.

Membership

Membership consists of:

- Eight governors: Deputy Lead Governor, one representative from each public constituency, one staff governor, and one appointed governor.
- The Deputy Director of Corporate Governance
- Chief Nurse and Director of Quality and Professions

The Members' Council Quality Group is chaired by a publicly elected governor.

Governors are appointed to the Quality Group by the Members' Council, on the recommendation of the Members' Council Co-ordination Group. The normal term of office is three years. If an individual resigns or is not re-elected / re-appointed onto the Members' Council during the three-year period, the seat becomes vacant and the individual taking their governor seat does not automatically take the place on the
Group.

Governors are invited to self-nominate to vacancies on the group on a quarterly basis.

Membership as at 1 April 2025:

Darryl Thompson, Chief Nurse and Director of Quality and Professions (Lead Director)
Phil Shire, Governor (publicly elected Calderdale) (Chair of the group)
Vacancy, (Deputy Lead Governor)
Daniel Goff, Governor (publicly elected, Barnsley)
Bob Morse (publicly elected, Kirklees)
Nesar Rafiq, Governor (publicly elected, Wakefield)
Fatima Shahzad, Governor (publicly elected Rest of Yorkshire and the Humber, Cumbria, Durham, Lancashire, Greater Manchester, Derbyshire, Nottinghamshire, and Lincolnshire)
Elaine Lane, Governor (staff elected)
Sue Spencer, Governor (appointed)
Mel Wood, Head of Performance and Business Intelligence

In attendance:

John Laville, Lead Governor (publicly elected Kirklees
Associate Director for Nursing, Quality and Professions
Executive Directors, Non-Executive Directors and or Senior Officers to be in attendance as required by workplan.

Attendance

All governors are welcome to attend meetings of the Quality Group, even if they are not formal members. Executive Directors, Non-Executive Directors and or Senior Officers are to be in attendance as required by workplan to ensure the Members' Council responsibilities in relation to the Quality Accounts are met. Administrative support is provided by the Corporate Governance team.

Quorum

Meetings are chaired by a governor. In the unusual event that the chair is absent from the meeting, another governor will be asked to chair the meeting.

The quorum will be a minimum of three Members' Council representatives, plus the Deputy Director of Corporate Governance (performance) and Chief Nurse and Director of Quality and Professions. Members are expected to attend all meetings. In the unusual event that the Deputy Director Corporate Governance (performance) and/or Chief Nurse and Director of Quality and Professions are absent from the meeting, a deputy will be in attendance.

Frequency of meetings

The Group will meet four times per year prior to formal Members' Council meetings. Additional meetings will be arranged as needed to ensure the timescales for approval of the Quality Accounts are met.

Reporting to the Members' Council

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

To be approved by Members' Council: 7 May 2025
Next review due: May 2026

Members' Council Quality Group annual work programme 2025/26

Agenda item/issue	16 April 2025	14 Jul 2025	15 Oct 2025	2 Feb 2026
Standing items				
Welcome, introductions and apologies	✘	✘	✘	✘
Declarations of interest	✘	✘	✘	✘
Notes and actions of previous meeting	✘	✘	✘	✘
Integrated performance report	✘	✘	✘	✘
Care Quality Commission (CQC) update	✘	✘	✘	✘
Update on Quality Assurance System (to include information extracted from Quality and Safety Committee as a quarterly update)	✘	✘	✘	✘
Work programme	✘	✘	✘	✘
Any other business	✘	✘	✘	✘
Items to raise at Members' Council	✘	✘	✘	✘
Date of next meeting and agreement of agenda items	✘	✘	✘	✘
Scheduled items				
Quality Account – update	✘	✘	✘ *2026 plan	✘
Sickness and Absence statistics –to include latest statistics and how the Trust is working with services (20 mins) *Deputy Chief People Officer to present this item.*	✘			
Quality Strategy update	✘		✘	
Incident Management Annual Report		✘		
Patient-Led Assessment of the Care Environment (PLACE) visits report				✘
Culture of care response to national learning – Edenfield enquiry			✘	
Patient Experience report – annual report		✘		
Members' Council Quality Group Annual Report				✘
Older people's service (OPS) transformation – update (to be confirmed)				

Agenda item/issue	16 April 2025	14 Jul 2025	15 Oct 2025	2 Feb 2026
Review of Members' Council Quality Group Terms of Reference and effectiveness review				✘
Deep Dives topics – 16 April 2025 - To Be Confirmed (TBC) 14 July 2025 – TBC 15 October 2025 – TBC 2 February 2026 – TBC	✘	✘	✘	✘

Nominations Committee
Nominations Committee Annual Report 2024/25
To be approved by Members' Council on 7 May 2025

Purpose of report

The purpose of the report is to provide a summary of the Committee's activities during the financial year 2024/25 to provide assurance and evidence to the Members' Council of its effectiveness and impact through compliance with its Terms of Reference.

Background

The Nominations Committee was established in May 2009 to allow Members' Council to exercise its statutory duties. These include the appointment of:

- The Chair of the Board
- Non-Executive Directors of the Board
- Associate Non-Executive Directors of the Board
- Deputy Chair of the Board
- Senior Independent Director
- Lead Governor of the Members' Council
- Deputy Lead Governor of the Members' Council

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

Overall aim

The Nominations Committee's purpose is to ensure the right composition and balance of the Board and to oversee the process for the identification, nomination and appointment of the following roles stated above.

Duties

The Nominations Committee will:

a) 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.
b) Ensure there is a formal, rigorous and transparent procedure for the appointment of the Chair, Non-Executive Directors and Associate Non-Executive Directors of the Board, which fit the criteria set out by the Committee as a result of its regular review and meets the requirements of a confidential recruitment process.
c) Give full consideration to succession planning in respect of the Chair, Non-Executive Directors and Associate Non-Executive Directors of the Board, taking account the challenges and opportunities facing the Trust and the skills and expertise required by the Board.
d) Make recommendations to the Members' Council on the appointment of the Chair, Non-Executive Directors and Associate Non-Executive Directors ensuring all information, such as job descriptions, person specifications and process, are available to Members' Council to make an informed decision.
e) Make recommendations to the Members' Council regarding any uplift to the Chair's

remuneration, in line with NHSE England framework and the pay spine point. Progression through the spine points is dependent on the outcome of the Chair appraisal process through the Members' Council.

f) Make recommendations to the Members' Council regarding any uplift to Non-Executive Directors' remuneration based on the NHS England framework. Associate Non-Executive Directors remuneration will based on national benchmarking information.
g) 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.
h) 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.

Changes to Committee terms of reference

From the 1 April 2024 until the 31 March 2025, changes to the Terms of Reference included membership details. The terms of reference include reference to alignment to the NHS England framework for the Chair's and Non-Executive directors' remuneration.

Reporting to Members Council

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

Membership

Membership consists of governors (with representation from public, staff and appointed governors) and the Chair of the Trust.

Regular attendees are the Head of Corporate Governance (Company Secretary), the Chief Executive and the Chief People Officer.

The Members' Council policy is that the term of office for any new members of the Committee is three years to allow for consistency of membership. If a governor wishes to stand down from the Committee or is not re-elected/re-appointed as a governor on the Members' Council during the three years, the individual taking their seat does not automatically take their place on the Committee.

The Nominations Committee membership from 1 April 2024 to 31 March 2025:

Name / role	**Attendance 2024/25**
Chair of the Trust – **Marie Burnham**	6/7
Lead Governor (publicly elected, Kirklees) – **John Laville**	7/7
Deputy Lead Governor (publicly elected, Kirklees) – **Claire Den Burger – Green** (ended February 2025)	3/7
Governor (Appointed - Calderdale and Huddersfield NHS Foundation Trust) **Andrea McCourt**	5/7
Governor (publicly elected, Calderdale) – **Phil Shire**	5/7
Governor (Staff – nursing support) **Laura Habib** (ended 30 April 2024)	1/7
Governor (Staff – nursing) **Jacob Agoro** (from 14 August 2024)	4/7

Review of Committee activities

The activities during 2024/25 have been cross-referenced to the purpose of the Committee as outlined in the Terms of Reference below:

Activities	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: The recruitment of two Non-Executive Directors in April and July 2024. Re-appointment of the Chair in August 2024. Review of Chair and NED remuneration in January 2025. Reviewed the skills and expertise required on the Board, including Chair and Non-Executive Director terms of office in January and February 2025.
Ensure there is a formal, rigorous and transparent procedure for the appointment of the Chair, Non-Executive Directors and Associate 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 Committee oversaw the process for the re-appointment of two Non-Executive Directors in April 2024 which were approved by Members' Council on 15 May 2024. The Committee oversaw the recruitment process for two new Non-Executive Directors. The shortlist meeting was held in June 2024 and the recommendation for appointment was made to the Members' Council and approved in August 2024. The Committee oversaw the process for the re-appointment of the Chair in July 2024 which was recommended to the Members' Council and approved in August 2024. The Committee oversaw the process for the appointment of the Deputy Chair and Senior Independent Director in October 2024. This appointment was approved by the Members' Council in November 2024.
Give full consideration to succession planning in respect of the Chair, Non-Executive Directors and Associate 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.	Succession planning was fully considered by the Committee through the following items: The re-appointment of two Non-Executive Director in April 2024 which were approved by Members' Council on 15 May 2024. The recruitment of two Non-Executive

Activities	Progress
	Directors in April and July 2024. Re-appointment of the Chair in August 2024. Reviewed the skills and expertise required on the Board, including Chair and Non-Executive Director terms of office in January and February 2025.
Make recommendations to the Members' Council on the appointment of the Chair, Non-Executive Directors and Associate 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 made the following recommendations to the Members' Council which were duly approved: Re-appointment of two Non-Executive Directors approved May 2024 Appointment of two new Non-Executive Directors approved August 2024 Re-appointment of the Chair approved August 2024 Appointment of the Deputy Chair/Senior Independent Director approved November 2024.
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 Chairs remuneration is aligned to the NHSE framework (2019). The Trust Chair is now at the top level of the framework for remuneration. As the Trust has agreed alignment to the NHSE framework any change to the Chair's remuneration will be subject to guidance from NHSE.
Make recommendations to the Members' Council regarding any uplift to Non-Executive Directors' and Associate Non-Executive Directors remuneration based on benchmarking information as applicable.	Non-Executive remuneration is broadly aligned to the NHSE framework (2019). As the Trust has agreed alignment to the NHSE framework any change to the NED remuneration will be subject to guidance from NHSE.
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).	The Committee recommended to continue to combine the roles of Deputy Chair and Senior Independent Director in the recommendation to appoint the new Deputy Chair and Senior Independent Director process which was approved by the Members' Council in November 2025.
Ensure there is a formal, rigorous and transparent procedure for the appointment of the Lead Governor for the Members' Council,	The lead governor remains in post at the time of the writing of this report. The deputy lead governor stepped down early in 2025

Activities	Progress
which fits any criteria set out by the Committee and meets the requirements of a confidential recruitment process.	and a recruitment process is underway to appoint a new deputy lead governor.

Review of Committee administrative arrangements

The Committee met **seven** times in 2024/25 and has been quorate at each meeting. The requirement to send papers out five working days has been met throughout the year in the main. There have been some instances where individual papers have been submitted outside of this timeframe due to the timescales relating to recruitment processes.

To be approved by Members' Council: 7 May 2025
Review: May 2026

Nominations Committee
Terms of Reference

To be approved by Members' Council 7 May 2025

Purpose

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 with exercising their statutory duties to appoint the Chair, Non-Executive Directors and Associate Non-Executive Directors of the Board, to appoint the Deputy Chair, 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.

Duties

a) 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.
b) Ensure there is a formal, rigorous and transparent procedure for the appointment of the Chair, Non-Executive Directors and Associate 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.
c) Give full consideration to succession planning in respect of the Chair, Non-Executive Directors and Associate 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.
d) Make recommendations to the Members' Council on the appointment of the Chair, Non-Executive Directors and Associate Non-Executive Directors ensuring all information, such as job descriptions, person specifications and process, are available to Council members to make an informed decision.
e) Make recommendations to the Members' Council regarding any uplift to the Chair's remuneration, based on the NHS England framework (2019), and dependant on the outcome of the Chair appraisal process through the Members' Council.
f) Make recommendations to the Members' Council regarding any uplift to Non-Executive Directors' and Associate Non-Executive Directors remuneration, based on the NHS England framework (2019).
g) 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.

h) 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.

Membership

Membership consists of:

- Five governors: the Lead Governor, Deputy Lead Governor, one publicly elected governor, one staff governor, and one appointed governor.
- The Chair

Governors are appointed to the Nominations Committee by the Members' Council, on the recommendation of the Members' Council Co-ordination Group. The normal term of office is three years. If an individual resigns or is not re-elected / re-appointed onto the Members' Council during the three-year period, the seat becomes vacant and the individual taking their governor seat does not automatically take the place on the Committee.

Governors are invited to self-nominate to vacancies on the Committee on a quarterly basis.

Membership as at 1 April 2025:
Marie Burnham, Chair of the Trust (Chair of the Committee)
John Laville, Lead Governor (publicly elected governor – Kirklees)
Current vacancy, (Deputy Lead Governor)
Phil Shire, Governor (publicly elected – Calderdale)
Jacob Agoro, Governor (staff – Nursing)
Andrea McCourt, Governor (appointed - Calderdale and Huddersfield NHS Foundation Trust)

In attendance:
Andrew Lister, Head of Corporate Governance (Company Secretary)
Mark Brooks, Chief Executive
Jon Head, Chief People Officer

Attendance

The Head of Corporate Governance (Company Secretary) is in attendance at meetings. The Chief Executive and the Chief People Officer (or Deputy) may also be asked to attend meetings to offer specialist or expert advice to the Committee. Administrative support is provided by the Corporate Governance team.

Quorum

The Nominations Committee is chaired by the Chair of the Trust.
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, Non-Executive Director, Associate Non-executive Director, Deputy Chair / 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.

Reporting requirements into the Committee

The Nominations Committee receives reports on and discusses the skill mix and expertise of the Board, Board recruitment planning and processes, and remuneration for the Chair, Non-Executive Directors, Associate on-Executive Directors and recruitment.

Reporting to the Members' Council

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

Approved by Members' Council: 7 May 2025
Next review due: May 2026

Nominations Committee annual work programme 2025/26

Agenda item	**15 Jan 2025**	**11 Apr 2025**	**9 Jul 2025**	**1 Oct 2025**
Standing items at each meeting				
Welcome, introduction and apologies	**x**	**x**	**x**	**x**
Declarations of interest	**x**	**x**	**x**	**x**
Minutes of previous meeting	**x**	**x**	**x**	**x**
Matters arising from previous meetings (action log)	**x**	**x**	**x**	**x**
Work programme	**x**	**x**	**x**	**x**
Any other business	**x**	**x**	**x**	**x**
Issues and items to bring to the attention of Trust Board/ Members' Council	**x**	**x**	**x**	**x**
Date of next meeting	**x**	**x**	**x**	**x**
Annual items				
Review of committee annual report		**x**		
Review of terms of reference		**x**		
Review of skills and expertise required on the Board, including Chair and Non-Executive Director terms of office (also to take place before any NED recruitment)				**x**
Standing items as required				
Non-executive director recruitment and appointment *(as required)*	**x**	**x**		
Non-Executive director re-appointment *(as required)*	**x**	**x**		
Lead Governor and Deputy Lead Governor re-appointment process *(required for 1 May 2026)*				
Associate Non-Executive recruitment / re-appointment *(as required)*				
Deputy Chair and Senior Independent Director appointment *(as required)*				
Chair recruitment or re-appointment *(1 December 2027)*			**x**	

Review of Chair, Non-Executive Director and Associate Non-Executive Director remuneration (if any update from NHSE)				**X**
Other scheduled items				

Members' Council
7 May 2025
Agenda item 9.6

<table>
<tr><td>Private/Public paper:</td><td>Public</td></tr>
<tr><td>Title:</td><td>Members' Council Elections – outcome</td></tr>
<tr><td>Paper presented by:</td><td>Andy Lister, Head of Corporate Governance</td></tr>
<tr><td>Purpose:</td><td>The purpose of this paper is to update the Members' Council on the outcome of the election process for 2025.</td></tr>
<tr><td>Executive summary:</td><td>
Background
When the Trust was working towards Foundation Trust status, a decision was made by the Trust Board to stagger the terms of office for the governors elected in the first elections to the Members' Council to ensure that not all left at the same time. The Trust, therefore, holds elections every year during the spring for terms of office starting on 1 May each year.

The election process was presented to the Members' Council meeting on 15 November 2024 and an update provided at the meeting on 14 February 2025.

<u>Election process</u>
Civica Election Services (CES) manages the election process on behalf of the Trust. This is to make sure that the elections are managed impartially and fairly and that the process is independent and transparent. Elections are held in accordance with the Model Election Rules which are included as an appendix within the Trust's Constitution.

The Nominations process opened on 18 February 2025 and closed on 17 March 2025. Nominations were received as follows:

<table>
<tr><th><u>Constituency</u></th><th><u>Number of vacancies</u></th><th><u>Number of nominations</u></th></tr>
<tr><td>Public, Kirklees</td><td>2</td><td>4</td></tr>
<tr><td>Public, Wakefield</td><td>1</td><td>1</td></tr>
<tr><td>Public, Calderdale</td><td>1</td><td>0</td></tr>
<tr><td>Public, Barnsley</td><td>1</td><td>1</td></tr>
</table>

<u>Outcome</u>
As a result of the nominations process, the following were elected unopposed from 1 May 2025 for a period of three years. (See uncontested report attached from CES).

<table>
<tr><th>Constituency</th><th>Elected Governor/s</th></tr>
<tr><td>Public, Wakefield</td><td>Amaina Elzoubir</td></tr>
<tr><td>Public, Barnsley</td><td>Keith Stuart-Clarke</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td></td><td>The election process took place between 8 April 2025 and 30 April 2025. The results of the election are as follows (report of voting attached):

<table><tr><th>Constituency</th><th>Elected Governor/s</th></tr><tr><td>Public, Kirklees</td><td>John Laville
Farida Ali</td></tr></table>
As no nominations were received for Calderdale, a mid-year election will be held to fill the post.

Melanie Mott has resigned as governor for Psychological Therapies and will stand down from 27 May 2025. The Trust's constitution allows a number of options to deal with this vacancy and these options will be discussed with the Chair and Lead Governor.</td></tr>
<tr><td>Recommendation:</td><td>The Members' Council are asked to:
RECEIVE the update.</td></tr>
<tr><td>Mission/values:</td><td>Good governance supports the Trust to deliver its mission and adhere to its values.</td></tr>
<tr><td>Strategic Objectives</td><td><table><tr><td>Live Our Values</td><td>✓</td></tr><tr><td>Be the best we can be:
• Best quality
• Best partner
• Best value
• Best place to work and learn</td><td>
✓
✓
✓
✓</td></tr><tr><td>Be ambitious</td><td>✓</td></tr></table></td></tr>
<tr><td>BAF Risk(s):</td><td>N/A</td></tr>
<tr><td>Contribution to the objectives of the Integrated Care System/Integrated Care Board/Place based partnerships</td><td>N/A</td></tr>
<tr><td>Any background papers / previously considered by:</td><td>Previous elections outcome papers</td></tr>
</table>

CLOSE OF VOTING: 5PM ON 30 APRIL 2025

CONTEST: Public: Kirklees

The election was conducted using the single transferable vote electoral system.
The following candidates were elected (in order of election):

ELECTED
John Laville
Farida Ali

Number of eligible voters		3,007
Votes cast by post:	59	
Votes cast online:	39	
Total number of votes cast:		98
Turnout:		3.3%
Number of votes found to be invalid:		3
Total number of valid votes to be counted:		95

The result sheet for the election form the Appendix to this report. It details:-

- the quota required for election
- each candidate's voting figures, and
- the stages at which the successful candidates were elected.

Civica Election Services can confirm that, as far as reasonably practicable, every person whose name appeared on the electoral roll supplied to us for the purpose of the election:-

a) was sent the details of the election and

b) if they chose to participate in the election, had their vote fairly and accurately recorded

The elections were conducted in accordance with the rules and constitutional arrangements as set out previously by the Trust, and CES is satisfied that these were in accordance with accepted good electoral practice.

All voting material will be stored for 12 months.

Ciara Hutchinson
Returning Officer
On behalf of South West Yorkshire Partnership NHS Foundation Trust

CLOSE OF NOMINATIONS: 5PM ON 17 MARCH 2025

Further to the deadline for nominations for the above election, the following constituencies are uncontested:

PUBLIC: BARNSLEY 1 TO ELECT
The following candidate is elected unopposed: Keith Stuart-Clarke

PUBIC: WAKEFIELD 1 TO ELECT
The following candidate is elected unopposed: Amaina Elzoubir

Ciara Hutchinson
Returning Officer
On behalf of South West Yorkshire Partnership NHS Foundation Trust

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report Quarter 4 - 2024/25

Members' Council

7 May 2025

With all of us in mind.

Agenda

South West Yorkshire Partnership NHS Foundation Trust

- Summary Performance Metrics
- Quality
- National metrics
- Workforce
- Finance

With **all of us** in mind.

Summary Performance Metrics – Improving Health

South West Yorkshire Partnership NHS Foundation Trust

Improving health				
Metrics	**Threshold**	**Jan-25**	**Feb-25**	**Mar-25**
Percentage of service users who have had their equality data recorded - ethnicity	90%	96.6%	96.6%	96.4%
Percentage of service users who have had their equality data recorded - disability	50%	54.2%	53.3%	52.0%
Percentage of service users who have had their equality data recorded - sexual orientation		59.0%	58.3%	57.0%
Percentage of service users who have had their equality data recorded - deprivation (postcode)	90%	99.5%	99.5%	99.5%
Timely completion of equality impact assessments (EIAs) in services and for policies	Service - 75% Policy - 95%	93.1% Service	95.6% Service	94.9% Service
Completion of equality mandatory training	>=80%	96.3%	96.3%	93.3%
Carbon Impact (tonnes CO2e) - business miles	76	61	71	60
Smoking Quit rates for patients seen by SWYPFT Stop Smoking services (4 weeks)	55%	Due May 25 Q3 was 71.6%		

With **all of us** in mind.

Summary Performance Metrics – Improving Care

NHS South West Yorkshire Partnership NHS Foundation Trust

Improve Care				
Metrics	**Threshold**	**Jan-25**	**Feb-25**	**Mar-25**
The number of people with a risk assessment/staying safe plan in place within 24 hours of admission - Inpatient	95% Improvement trajectory Jan 92.5% Feb 95%	87.3%	92.3%	*94.1%*
The number of people with a risk assessment/staying safe plan in place within 7 working days of first contact - Community		67.1%	76.3%	*75.5%*
% Service users on care programme approach (CPA) offered a copy of their care plan	85%	99.7%	99.7%	99.6%
Inappropriate out of area bed placements (days)	July - 155 Aug - 155 Sept - 150	106	92	128
% service users clinically ready for discharge	<=3.5%	5.2%	5.2%	6.0%

* Figures in italics are provisional

With **all of us** in mind.

Summary Performance Metrics – Improving Resources

NHS South West Yorkshire Partnership NHS Foundation Trust

Improve resources				
Metrics	**Threshold**	**Jan-25**	**Feb-25**	**Mar-25**
Surplus/(deficit) against plan (cumulative)	Breakeven	(£1,898k)	(£567k)	£245k
Capital spend against plan (cumulative)	£8.1m	£2,988k	£4,132k	£7,520k
Agency spend managed within the overall workforce (Monthly)	3.5% £6.7m	£684k	£499k	£422k
Financial sustainability and efficiencies delivered over time (monthly)	£22m	£1,230k	£1,626k	£4,046k
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	0	10		
Estates Urgent Response Times - Service Level Agreement	95%	96.8%	95.8%	96.7%
Statutory Compliance	100%	100.0%	100.0%	100.0%
% of ligature jobs completed within timeframe	100%	100.0%	100.0%	100.0%

With **all of us** in mind.

Summary Performance Metrics – Making SWYPFT a great place to work

NHS South West Yorkshire Partnership NHS Foundation Trust

Make SWYPFT a great place to work				
Metrics	**Threshold**	**Jan-25**	**Feb-25**	**Mar-25**
Turnover external (12 month rolling)	>12% - 13%<	7.8%	7.7%	8.6%
Registered workforce	0% 2024/25	2.3%		
Sickness absence - rolling 12 months	<=5%	5.3%	5.3%	5.2%
Workpal appraisals - rolling 12 months	Projected Compliance: Jan - 78.3% Feb - 82.3% Mar - 84.9%	82.5%	82.6%	83.7%
Mandatory training - Cardiopulmonary	80%	80.9%	81.3%	79.7%
Mandatory training - Reducing restrictive	80%	81.5%	80.1%	79.6%
Mandatory training - Fire	85%	90.6%	90.9%	88.9%
Mandatory training - Information governance	95%	93.5%	93.1%	91.1%

With **all of us** in mind.

Quality Update 2024/25 – Quarter 4

South West Yorkshire Partnership NHS Foundation Trust

Patient Experience – Friends and Family Test (FFT)

- 93% of respondents in March 2025 would recommend community health services
- 91% of respondents in March 2025 would recommend mental health services
- We continue to explore other creative ways of gaining feedback on our services

Out of area placements

- Continued use of out of area beds but at a lower level than last year. Reasons for continued use include staffing pressures across the wards, increased acuity, outbreaks and challenges to discharging people in a timely way.
- The inpatient improvement programme continues to work through impacting issues including workforce challenges.
- The Trust had 5 people placed in out of area beds at the end of March 2025 due to increased acuity and challenges to timely discharge.

With **all of us** in mind.

Quality Update 2024/25 – Quarter 4

NHS South West Yorkshire Partnership NHS Foundation Trust

Safer Staffing (inpatient wards)

• The overall fill rate had a decrease of 4.1% to 128.7%. The day fill rate for registered nurses decreased by 1.6% to 100.6%. Despite the decrease in both the registered and overall fill rate, safer staffing levels were maintained at all times.

The fill rate figures (%) for March 2025:

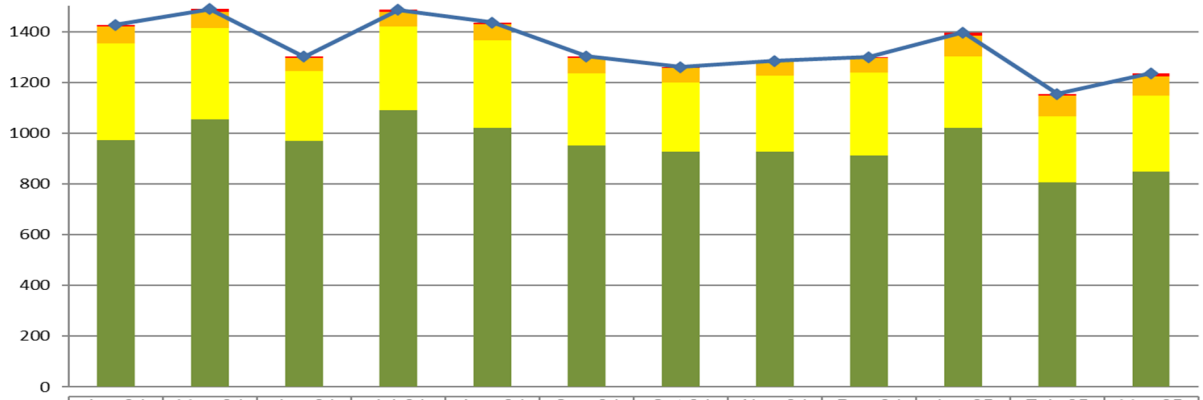
- Registered staff – Days 100.6%
- Registered staff - Nights 115.6%
- Registered average fill rate – Days and nights 101.1%
- Overall average fill rate all staff – 128.7%
- Fill rate does not provide blunt assurance as it might not reflect acuity.
- Where gaps cannot be filled by registered staff, we will utilise unregistered colleagues where possible to maintain safety.
- These fill rates reflect the acuity and challenges that clinical areas are facing

With **all of us** in mind.

Quality Update 2024/25 – Quarter 4

South West Yorkshire Partnership NHS Foundation Trust

Incident Reporting



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Red (should not be compared with SIs)	6	11	6	8	5	6	4	5	5	11	6	14
Amber	66	62	50	57	65	61	57	54	57	83	82	74
Yellow	383	362	275	331	344	285	271	300	326	280	260	299
Green	971	1053	970	1089	1021	951	928	926	912	1022	807	849
Total	1426	1488	1301	1485	1435	1303	1260	1285	1300	1396	1155	1236

- All serious incidents investigated using route cause analysis techniques.
- The weekly risk panel scans for themes that require further review or enquiry.
- No ‘Never Events’ reported in March 2025.
- 95% of incidents reported in March 2025 resulted in no harm or low harm or were not under the care of SWYPFT.
- At the time of report writing the number of red incidents was 14, these may be subject to regrading as more information becomes available.
  This will be updated in next month's report.

With **all of us** in mind.

National metrics

South West Yorkshire Partnership NHS Foundation Trust

Access standards and Outcomes – Trust Performance

KPI	Threshold	Q1 24/25 (June 24)	Q2 24/25 (Sept 24)	Q3 24/25 (Dec 24)	Q4 24/25 (Mar 25)
Maximum time of 18 weeks from point of referral to treatment – Incomplete pathway	**92%**	99.9%	99.5%	98.2%	97.0%
% Admissions Gatekept by Crisis Response Teams	**95%**	95.6%	97.5%	100.0%	100.0%
% Service Users followed up within 72 hours of discharge	**80%**	89.0%	94.2%	94.0%	83.8%
NHS Talking Therapies - Treatment within 6 weeks of referral	**75%**	98.7%	99.0%	97.8%	99.6%
NHS Talking Therapies - Treatment within 18 weeks of referral	**95%**	100.0%	100.0%	100.0%	100.0%
Early Intervention in Psychosis – 2 weeks (NICE approved care package) Clock Stops	**50%**	92.3%	90.3%	96.6%	100.0%
Maximum 6 week wait for diagnostic procedures	**99%**	66.7%	41.9%	49.5%	81.8%
NHS Talking Therapies – Proportion of people completing treatment who move to recovery	**50%**	51.2%	54.0%	52.5%	53.4%
Community health services two hour urgent response standard	**70%**	89.9%	91.6%	89.2%	92.6%

With **all of us** in mind.

Workforce

NHS
South West Yorkshire Partnership
NHS Foundation Trust

- Our Turnover for March 2025 has increased slightly but remains low at 8.6%
- There was sustained reduction in agency spend in 2023/24. Agency spend has continued to fluctuate during 2024/25 around an average run rate level. Spend is £77k less than the previous month.
- Registered workforce growth to end March 2025 remained at 2.3% for the year to date.
- The sickness absence rate for the month of March 2025 was 4.6% and 5.2% for the rolling 12-month period.

Financial Performance

South West Yorkshire Partnership NHS Foundation Trust

Key performance indicators

Performance Indicator		2024/25 Outturn	Narrative
1	Surplus / (Deficit)	£0.2m	The Trust financial target for 2024 / 25 is breakeven. This has been achieved with a small unaudited surplus of £245k.
2	Agency Spend	£6.4m	Agency expenditure run rate has continued to fluctuate but throughout the year has remained lower than the national target (3.2% of total pay expenditure). Spend in March 2025 is £422k which is £77k lower than February. Overall Quarter 4 expenditure is £200k less than Quarter 3. Sustained run rate reductions are required for 2025 / 26 in order to meet internal and external targets.
3	Financial sustainability and efficiencies	£20.6m	The Trust financial sustainability programme for 2024 / 25 has a target of £22.0m to achieve the breakeven target. Overall £20.6m has been achieved which is £1.4m behind plan (6.4%). Throughout the year the main driver is within the workforce optimisation scheme with more worked whole time equivalents (WTE) than planned. This has been partially mitigated in the final position through non-recurrent mitigations.
4	Cash	£55.7m	Cash has continued to reduce month on month throughout 2024 / 25. This has stabilised in Quarter 4 and despite the payment of Public Dividend Capital (PDC) of £2.2m in March has maintained at a similar level. It is expected to reduce further in April / May 2025 as outstanding invoices are paid although this will be partially offset by recovery of accrued income.
5	Capital	£7.5m	The Trust has received a number of capital allocations within the year and a breakdown is provided within the capital detail page in the Finance appendix. Against the original core allocation (£8.1m) expenditure is £7.5m which is £0.6m less than planned (7%). This has been offset by additional expenditure within the IFRS 16 (leases) allocation. For 2025 / 26 this will be a singular allocation covering all capital expenditure.
6	Better Payment Practice Code	99%	This performance is based upon a combined NHS / Non NHS value. The target is that 95% of all valid invoices have been paid within 30 days of receipt. Our performance demonstrates compliance with this target.


With all of us in mind.

Members' Council annual work programme 2025/26

Key
O – take as read submit questions in advance
✘ - statutory item
- deferred

	Strategy	Business	Strategy	Annual Members' Meeting	Joint Members' Council and Trust Board meeting	Strategy
Agenda item/issue	**14 Feb 2025**	**7 May 2025**	**13 Aug 2025**	**17 Sept 2025**	**14 Nov 2025**	**13 Feb 2026**
Declaration of interests	✘	✘	✘		✘	✘
Minutes of the previous Members' Council meeting	✘	✘	✘		✘	✘
Matters arising from the previous meeting and action log	✘	✘	✘		✘	✘
Chair's report and feedback from Trust Board	O	✘	O		✘	O
Chief Executive's comments on the operating context	✘	✘	✘		✘	✘
Governor feedback and appointment to groups and Committees	O	✘	O		✘	O
Assurance from Member's Council groups and Nominations	O	O	O		O	O

	Strategy	Business	Strategy	Annual Members' Meeting	Joint Members' Council and Trust Board meeting	Strategy
Agenda item/issue	**14 Feb 2025**	**7 May 2025**	**13 Aug 2025**	**17 Sept 2025**	**14 Nov 2025**	**13 Feb 2026**
Committee						
Integrated performance report	✘	✘	✘		✘	✘
Appointment / Re-appointment of Non-Executive Directors and Associate Non-Executive Directors *(if required)*		✘				
Ratification of Chief Executive appointment *(if required)*						
Review of Chair and Non-Executive Directors' remuneration (subject to NHSE guidance and appraisal)	✘					✘
Evaluation / Development session *(will take place outside MC meetings through the year)*						
Annual report unannounced / planned visits		✘				
Care Quality Commission (CQC) action plan - update		✘	✘		✘	✘
Private patient income (against £1 million threshold) *not required if under threshold						
Annual report and accounts				✘		
Quality account and external assurance		✘				
Freedom to Speak Up – Annual survey results and planning tool					✘	

	Strategy	Business	Strategy	Annual Members' Meeting	Joint Members' Council and Trust Board meeting	Strategy
Agenda item/issue	**14 Feb 2025**	**7 May 2025**	**13 Aug 2025**	**17 Sept 2025**	**14 Nov 2025**	**13 Feb 2026**
Patient Experience annual report					✘	
Incident Management annual report					✘	
Strategic meeting with Trust Board					✘ **PM**	
Annual update against the Trust Equality, Inclusion and Diversity Strategy (next update May 2026)						
Trust annual plans and budgets, including analysis of cost improvements						
Fit and Proper Person Test (FPPT) for Board members (annual – May)		✘				
Members' Council elections	✘ *update	✘ *outcome	✘ (mid year election – process)		✘ *process	✘ *update
Chair's appraisal	✘ *process	✘ Appraisal input from governors (private)	✘ Final appraisal (private)			✘ *process

	Strategy	Business	Strategy	Annual Members' Meeting	Joint Members' Council and Trust Board meeting	Strategy
Agenda item/issue	**14 Feb 2025**	**7 May 2025**	**13 Aug 2025**	**17 Sept 2025**	**14 Nov 2025**	**13 Feb 2026**
Biennial evaluation (2023) *Next evaluation will be scheduled for autumn 2025 with results to be presented in Feb 2026.*						✘
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		✘				
Appointment of Lead Governor (every three years)		✘				
Appointment of Trust's external auditor – to review 2025						
Review of Members' Council objectives (three yearly due Autumn 2025)					✘	
Review of Members' Council declaration and register of interests (including gifts and hospitality policy) (review May 2027)						
Members' Council meeting dates and annual work programme	✘					✘
Focus on items to be discussed and agreed at Co-ordination	✘	✘	✘		✘	✘

	Strategy	Business	Strategy	Annual Members' Meeting	Joint Members' Council and Trust Board meeting	Strategy
Agenda item/issue	**14 Feb 2025**	**7 May 2025**	**13 Aug 2025**	**17 Sept 2025**	**14 Nov 2025**	**13 Feb 2026**
Group meetings to ensure relevant and topical items are included.	**(1 item)**	**(1 item)**	**(2 items)**		**(1 item)**	**(2 items)**