PART A PAPERS

Countess of Chester Hospital NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS (PART 1, PUBLISHED ITEMS) TUESDAY, 1ST DECEMBER 2020, AT 9:30AM – 12:05PM HELD VIA VIDEO-CONFERENCE, DUE TO THE COVID-19 PANDEMIC RESTRICTIONS.

A G E N D A

In attendance: Helen Ellis, Freedom To Speak Up Guardian

PART A				
FORMAL BUSINESS			Lead:	Decision Required/ purpose:
9:30am	1.	Welcome & Apologies	Chair	
9:30am	2.	Declarations of Interest	Chair	
9:30am	3.	To acknowledge a Patient Story – Tony's Story – experience of Covid-19 *(to be viewed in advance:https://youtu.be/Q_PAErkv6ss)*	Director of Nursing & Quality	To Receive
9:35am	4.	Minutes of the meeting held on 8th September 2020 (attached) ***- Page 4***	Chair	To Approve
9:40am	5.	To consider any matters arising and action log (attached) ***p13***	Chair	To Note
9:45am	6.	Chief Executive Officer's Report – including Covid-19 pressures (attached) ***- page 15***	Chief Executive Officer	To Note
09:55am	7.	Board Assurance Framework progress – Quarter 2, 2020/21 (verbal)	Interim Governance Consultant	To Note
SAFE				
10:00am	8.	Infection Prevention & Control: COVID-19 Board Assurance Framework (attached) ***- page 23***	Director of Nursing & Quality	For Assurance
10:10am	9.	Quality & Safety Committee Chair's Report – 15 September & 10 November 2020 (attached) ***- page 69***	Quality & Safety Committee Chair	For Assurance
EFFECTIVE				
10:20am	10.	Finance & Performance Committee Chair's Report – 22 September &17 November 2020 (attached) ***- page 77***	Finance & Performance Committee Chair	For Assurance
10:30am	11.	Finance Report – Month 7, October 2020 (attached) ***- pg 81***	Director of Finance	For Assurance
10:40am	12.	Integrated Performance Report – October 2020 (attached) ***- page 98***	Chief Operating Officer/ Executives	For Assurance
11:00am - 11:10am COMFORT BREAK				

CARING				
11:10am	13.	North West Black, Asian and Minority Ethnic Strategic Advisory Committee (The Assembly) - (attached) ***- page 140***	Director of HR & Organisation Development	To Note
WELL LED				
11:15am	14.	Freedom to Speak Up (FTSU) Update Report (attached) ***- page 146***	FTSU Guardian	For Assurance
11:25am	15.	Proposed Amended Constitution, including Standing Orders (attached) ***- page 155***	Interim Governance Consultant	To Approve
In the Board's role as Corporate Trustee of Charitable Funds:				
11:35am	16.	Charitable Funds Committee Chair's Report – 24 September 2020 (attached) ***- page 276***	Charitable Funds Committee Chair	For Assurance
		PART B ***(Items 17 a-e are referenced within Chair's reports in Part A. See separate Part B public papers)***		
11:45am	17.	a. Nursing Bi-annual Safe Staffing Assurance Report (January-June 2020)	Chair	To Ratify
		b. Director of Infection Prevention and Control Annual Report 2019/20		To Ratify
		c. Continuous Improvement Strategy (attached)		To Ratify
		d. Quality Accounts (attached)		To Ratify
		e. Council of Governors Report – 1 October 2020 (attached)		To Note
		f. Updated Board business cycle (attached)		To Agree
		g. Finance Report – Month 6, September 2020 (attached)		To Note
11:50am	18.	Minutes for noting and receipt:- <u>*Sent under separate cover*</u>: a. Approved minutes of the Quality & Safety Committee – 15 September 2020 b. Approved minutes of the Audit Committee – September 2020 c. Approved minutes of the Finance & Performance Committee – 22 September 2020 d. Draft minutes of the Charitable Funds Committee – 24 September 2020	Chair	To Note
11:55pm	19.	Any Other Business	Chair	

12:00	20.	Closing remarks and review of the meeting	Chair
		Date & Time of next meeting:	Chair
		The next meeting of the Board of Directors is scheduled for **19 January 2021, at 9:30am, via Teams videoconference**	

NHS
Countess of Chester Hospital
NHS Foundation Trust

MINUTES OF THE PUBLIC BOARD OF DIRECTORS (PART 1, PUBLISHED ITEMS) HELD ON TUESDAY, 8TH SEPTEMBER, 2020, AT 9:30AM-12:30PM, VIA VIDEO-CONFERENCE DUE TO THE COVID-19 PANDEMIC RESTRICTIONS

		Attendance	
Chair	Ms C Hannah	☑	
Non-Executive Director	Mr A Higgins	☑	
Non-Executive Director	Mr D Williamson	☑	
Non-Executive Director	Mr M Adams	☑	
Non-Executive Director	Ms R Fallon	☑	
Non-Executive Director	Ms B Fletcher	☑	
Non-Executive Director	Mr P Jones	☑	
Chief Executive Officer	Dr S Gilby	☑	
Executive Medical Director	Dr D Kilroy	☑	
Director of Finance	Mr S Holden	☑	
Director of Nursing & Quality/Deputy Chief Executive	Mrs A Kelly	☑	
Director of Human Resources and Organisation Development	Mrs A Hall	☑	
Chief Digital Information Officer	Ms C Williams	☑	
Chief Operating Officer	Mr D Coyle	☑	

In attendance:

Mr K Haynes, Interim Governance Consultant
Mrs D Bryce, Lead for Governance Improvement
Ms Sophie Hunter, Equality & Diversity Manager (item B104/09/20)

FORMAL BUSINESS

B93/09/20 **WELCOME AND APOLOGIES**

The Chair welcomed Darren Thorne and Simon Lavery from Facere Melius, as observers of the meeting, as part of governance improvement work. Apologies were received from Ms Andrea Campbell, Associate Non-Executive Director.

B94/09/20 **DECLARATIONS OF INTEREST**

There were no declarations of interest.

B95/09/20 **TO APPROVE THE MINUTES OF MEETING HELD ON 21st JULY 2020**

The minutes of the meeting held on 21st July 2020 were approved.

B96/09/20 **TO CONSIDER ANY MATTERS ARISING AND ACTION LOG**

Action 10/20 – It was raised by Non-Executive Director, Mr Higgins that the action had been discussed with the Chair and there was now an overview of performance and a coherent thread in

finance reporting. In addition, there would be a focus on the people agenda to develop and build the same. It was agreed to close the action.

Action 11/20 – Board Assurance Framework (BAF) development – The Interim Governance Consultant provided an update in relation to the Board Assurance Framework explaining that he was reviewing the format and content of the Board Assurance Framework that had been developed by Facere Mellius. In particular, he was considering whether it was more appropriate to use the more usual layout of the BAF, capturing the initial and residual risk scores. He also felt that the work would benefit from the Board considering its top strategic/corporate risks and it was agreed that this could be achieved in a brief focussed workshop. The intention remained to share a further update of the BAF with the Board.

Following an enquiry from the Chair, the Board noted that the patient story would resume from the next public Board meeting.

As a matter arising, Non-Executive Director, Ms Fletcher referred to the minutes under the CEO verbal update where the sharing of waiting lists across NHS providers was raised and enquired if there had been any further discussion on this. It was reported by the CEO that the cancer patient treatment list was now held by the Cancer Alliance and that sharing of waiting lists will be on case by case basis where organisations have capacity, i.e. mutual aid rather than formal sharing of waiting lists. In relation to this, the Director of Finance made the Board aware that a £50k capital allocation has been received, primarily directed at Endoscopy, to support the linking of units and enabling direction of patients to other centres, if required.

B97/09/20 **CHIEF EXECUTIVE OFFICER'S REPORT**

The Chief Executive presented her report providing details, in particular, of the response to Covid-19 at national, regional and local level. In relation to the successor organisations to Public Health England, the Chief Executive explained that further details were awaited on the national protection service to replace this Public Health England function. The Chief Executive also explained that the Trust's winter preparations were well underway and confirmed that the Trust continued to work hard to restore the Trust to its pre-Covid-19 levels of activity.

The Chief Executive went on to explain that unfortunately the Trust had declared two 'Never Events'. The first involved a dental incident from October 2018 involving an inappropriate extraction of a patient's tooth. The incident had only come to light following the more recent removal of the patient's brace. The second incident involved a complex case in Maternity Services in August 2020, and although the case was clinically well managed with no harm to the patient involved, improvements have been identified in how clinical documentation was completed. The Chief Executive explained that the learning from each of these incidents had been shared with the teams involved and implemented. As ever, further updates if necessary would be reported to the Quality & Safety Committee.

Following an enquiry from Non-Executive Director, Mr Adams for clarification on point 3 regarding the new 90 minute test for care homes, it was noted that this was now not being rolled out, but subject of further research instead.

The Board noted the Chief Executive Officer's report.

SAFE

B98/09/20 **INFECTION PREVENTION & CONTROL COVID-19 UPDATE**

The Director of Nursing & Quality drew the Board's attention to the following within the paper:

- Currently, there have been no further hospital acquired Covid cases.
- The position on the number of Covid-19 cases in hospital continues to be monitored, with one positive Covid-19 patient currently and 16 suspected patients.
- That whilst Page 3 of the report showed a reduced trend of hospital deaths from Covid-19, there has been one death associated with Covid-19 since the report was written.

- Section 3.4 of the paper indicates that progress continues to be made in addressing gaps in assurance regarding the infection prevention and control (IPC) board assurance framework, with six elements completed, seven in progress and three to commence.
- The highest risk element is the Trust's estate and restrictions with providing isolation facilities. The estates team are undertaking a scoping exercise of where potential clinical space is occupied by administrative functions, along with considering solutions for a 1.4 metre social distancing space, including safety curtains.
- The Appendix within the paper provides the report from the Care Quality Commission (CQC) following an IPC assessment engagement call. Evidence was also provided by the Trust, with a pleasing outcome, as shown within the letter.

Non-Executive Director, Ms Fallon made an enquiry about the support available regionally in relation to additional capital funding and what the bed number reduction was in light of the national IPC guidelines. In response, the Director of Nursing & Quality referred to the opportunity taken to submit an estate bid via a clinically based submission, with the key aim to improve isolation and ventilation facilities in certain areas. The Director of Finance confirmed that this formed part of the capital re-submission of capital bids totalling £24.8M associated with the restorative and restoration phase of Covid-19, and identified in the Finance Report at section 7. The Chief Operating Officer confirmed that the expectation was that fewer beds would be reduced and that the intention was to create a stand-alone isolated respiratory unit with adequate ventilation.

In response to an enquiry from Non-Executive Director, Ms Fletcher, regarding enhanced cleaning arrangements, the Director of Nursing & Quality referred to the Facilities Team request for further funding, with the aim to enact this quickly and work to understand roles and responsibilities at ward level further in relation to cleaning, nutrition and hydration to support patients.

In response to an enquiry from the Chair regarding the Surgical Assessment Unit (SAU), the Director of Nursing explained that IPC compliance had been a challenge on SAU and that improvement had been made with the expectation that compliance would be high in this area with close monitoring. Further updates would be reported to the Quality & Safety Committee.

The Board noted the IPC update and the encouraging progress.

B99/09/20 **QUALITY & SAFETY COMMITTEE CHAIR'S REPORT - 30TH JULY 2020 AND RATIFICATION OF ITEMS CONSIDERED BY THE QUALITY & SAFETY COMMITTEE**

Non-Executive Director, Ms Fallon, drew attention to the following within her report:

- The good discussion on the Board Assurance Framework.
- The falls deep dive report, with overall Limited assurance provided, and the action plan in place to address gaps in assurance, with quarterly updates to be received by the Committee on this in future.
- The presentation received on the Ward Accreditation Programme and the work in progress on this, with oversight in place of action plans.
- That bed moves were considered as part of the integrated performance report.
- The Think Family Safeguarding and Complex Care Annual Report was considered.
- The Committee discussed the *First Do No Harm Report* from Baroness Cumberledge, and noted that a gap analysis is being undertaken within the Trust.

The Board noted the Quality & Safety Committee Chair's Report.

(a) THINK FAMILY SAFEGUARDING & COMPLEX CARE ANNUAL REPORT

It was reported that there was a thorough discussion on this report at the Quality & Safety Committee. Non-Executive Director, Mr Jones referred to the binary ratings and values within the report that he had raised at the Committee meeting, e.g. above 90% is green and below 90% is red, which he felt required clarification in the report. In response, the Director of Nursing referred to the note on the cover page of the paper and explained that this had been raised with the Clinical Commissioning Group (CCG) who had subsequently confirmed that the RAG (red, amber, green) rating is out of synchronisation with the data values and are re-considering this to clarify that element of the report, and an update will be provided on the data at the Quality & Safety Committee.

Non-Executive Director, Ms Fletcher referred to page 50 of the agenda papers and the change to deprivation of liberty and sought further information as to when this would occur. In response, the Director of Nursing & Quality referred to this being a key part of national legislation to consider; that Liberty Protection Safeguarding had been deferred to 2022; the Trust will be the authority to sign off any deprivation of liberty to patients in its care; and that adequate training will be required and the safeguarding lead is considering this important issue currently.

The Board:

- **noted the important forthcoming Liberty Protection Safeguarding element;**
- **ratified the Think Family Safeguarding & Complex Care Annual Report, subject to clarification of the RAG data and the detail of this returning to the Quality &Safety Committee, due to the Board's concern; and**
- **agreed that the reference to '2018/19' on page 74 of the agenda papers should be changed to '2019/20'.**

EFFECTIVE

B100/09/20 **THIRD PHASE OF NHS RESPONSE TO COVID-19 - THE TRUST'S SERVICE RECOVERY & RESTORATION PLANNING**

The Chair noted the extended time allocated to this important item.

The Chief Executive Officer referred to the letter of the NHS Chief Executive and Chief Operating Officer of 31 July 2020, and the modelling that the Trust has undertaken and the detailed contents of the report. In particular, the Chief Executive Officer drew the board's attention the following:-

- The letter sets out ambitious stretch targets, highlighting cancer, elective care and diagnostics which present a challenge for the Trust;
- Further work has been undertaken with colleagues across the region to model the trajectory of services recovery/restoration which has been helpful and brings the Trust closer to the required national performance targets;
- Given the significant challenge and impact of Covid-19 on the suspension in Phase 1 of all non-urgent elective activity, the challenge of restoration was likely to go beyond this financial year;
- It was important to note restoration of elective services in the context of the winter plan, which covers the impact of flu and the exacerbation of chronic disease

- The information in the report relates to August 2020 data, without the impact of the section 2.2.3 actions, and expects these to be delivered, with significant progress already made on workforce items since the paper was written, with a cohort of overseas nurses recruited to vacancies.
- The Diagnostic Division is to be commended in the recovery of its activity achieved so far exceeding the ambitious trajectory, in spite of the enhanced IPC measures in place.
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- Despite the current situation, the Executive Team remained firmly committed to delivering the maximum activity practical for the remainder of the financial year.

There were a number of enquiries raised and discussed by the Board, as follows:-

- Non-Executive Director, Mr Adams enquired if the forecasting included the Trusts' Cerner training roll-out impact and also if the forecasts could be shared of what may happen in winter or a later second wave in October-December 2020. The Chief Executive Officer referred to the lack of guidance from SAGE but that modelling was in place; and that for every planned activity Cerner training was being taken into account, with the aim to go live as currently planned.
- In response to an enquiry from Non-Executive Director, Mr Williamson, the Executive Medical Director explained that he did not foresee any changes to the delivery of the five year clinical strategy in relation to Covid-19.
- The potential impact on inpatient and daycase activity from the recently revised IPC guidelines was raised by Non-Executive Director, Ms Fallon. The Chief Operating Officer outlined that the new guidelines were currently under consideration, along with how to maximise theatre and

endoscopy capacity. As the Director of Infection, Prevention and Control, the Director of Nursing stated her intention to ensure that the guidance was followed and also to take a pragmatic approach to its implementation, supported by appropriate risk mitigation.

- Non-Executive Director, Ms Fletcher welcomed the report and queried, in relation to performance against out-turn, if the trajectories identified were submitted to the regulators. The Chief Executive Officer advised they were not. The Director of Finance informed that the financial impact of the activity is contained within the pack but financial penalties are not modelled. However, as explained following further discussion across the region, activity assumptions have now increased and this is being re-modelled.
- Non-Executive Director, Ms Fletcher referred to the small number of theatre suites at the Trust and enquired whether the Endoscopy units would be expanded. The Chief Operating Officer provided details on shortage in workforce, the current maximisation of workforce and insourcing, and advised of the focus on cancer for Colorectal and Cystoscopy with consideration being given to additional out of hours activity.
- Non-Executive Director, Mr Higgins raised concerns about pressures on staff and the availability of outsourcing, due to other organisations facing similar challenges, and enquired as to the oversight and governance of this issue. The Chief Executive Officer advised that the situation is iterative and difficult to report in a prospective way. Significant work was undertaken to develop a plan following the Phase Three letter from NHS England and suggested the integrated performance report is expanded to ensure visibility of what is delivered, in parallel with regular reporting and exception reporting via committees of the Board.
- Non-Executive Director, Mr Jones raised the risk to delivery and queried how an active risk management system will be implemented around this. The Chief Executive Officer informed that it is intended to draw out the necessary information via exception reports, e.g. outsourcing achievement and limitations on services.
- The Chair enquired how benchmarking was undertaken and the Chief Executive Officer noted that growth assumptions and growth in demand are considered, and how the Trust compares to others. With regard to diagnostics, the Trust is performing better than most in activity, although growth in the waiting list remains a risk.

The Director of Finance highlighted that the papers contain details of the Trust's first return and outlines how the Trust compares across Cheshire and Merseyside. With regard to the baseline impact, Covid-19 costs were higher than other organisations and included a number of non-recurrent, one-off, items. However, the Trust's restoration costs are lower than others, although these are likely to increase.

The Chair noted the work in progress and the importance to be agile in planning for the various scenarios, oversight and governance, and felt that as much as possible this critical workstream should be included into business as usual processes and reporting arrangements.

The importance of the new Infection Prevention and Control guidelines and the need to increase the Trust's activity capacity was also noted, and that financial modelling and the clear assumptions and implications of extra capacity in theatres and insourcing had also been discussed. The mutual aid principle across Cheshire & Merseyside was recognised as being important, along with the importance of the Board's need to view the Trust's performance in relation to its peers, and in relation to restoration of activity and its financial impact.

The Board discussed and noted the content of the report, and agreed and supported the solutions to improve the Trust's restoration and reset position.

B101/09/20 **INTEGRATED PERFORMANCE REPORT - JULY 2020**

The Chief Operating Officer provided an overview of the report, with reference to referral to treatment standards (RTT) as the main concern, along with commending the Emergency Department for the July performance position. Reference was made to the recent movement of patients into intermediate care; the concern regarding the challenges ahead; and details were provided on the same day approach to emergency care, with the intention of same day discharge, where possible. However, it was identified that Emergency Department (ED) attendances were normal in July and higher in August, and an increase in some primary care attendances has been seen. However, support is currently being received from the Cheshire West Integrated Care Partnership (ICP).

In response to an enquiry from Non-Executive Director, Ms Fletcher, about how the Board might be able to assist, the Chief Operating Officer felt that there was merit in engagement with the local authority in relation to improved assistance with discharges.

Action agreed: The Chair suggested that Ms Andrea Campbell, Chair of the ICP could potentially assist with related Local Authority issues, and the Chief Operating Officer will discuss this further with Ms Campbell, with detail of further agreed actions to be clarified.

Non-Executive Director, Mr Higgins enquired if the focus had changed and if there was sufficient capacity in the local health system as a whole. In response, the Chief Operating Officer advised that the ICP had enabled more hospital at home capacity and that Better Care Funding had been pledged for the winter.

In relation to the report, the Director of Nursing & Quality drew attention to:-:

- The new maternity continuity of care metric which monitors the complete care of a woman, with a dedicated midwife, in relation to the Better Births policy. A reduction has been experienced with Covid-19, but the model had now been re-established and in August achievement was at 46% against the target of 53%.
- Ward moves were initially being measured by patient moves, bay to bay, rather than ward moves and this had now been simplified to ward moves and is actively being monitored.

It was acknowledged by Non-Executive Director, Ms Fallon that pressure ulcers on admission was over the control limit and she enquired as to what actions were being taken. The links to the deep dive into pressure ulcers, and interrogation of the data to ascertain where in the community the patients were coming from with pre-hospital pressure ulcers was raised by the Director of Nursing & Quality, who noted the work underway locally with the CCG on this matter, noting that the CCG support care homes and nursing homes.

The Executive Medical Director referred to the mortality data within the report and how the HSMR may change during Covid-19, and further remarked on the national medical examiner scheme that the Trust is participating in, and recruiting, to in relation to the priority of ensuring safe patient care. He also referred to sepsis performance and the Trust's top performance in relation to sepsis care at 91%, along with 80% of patients in June receiving the AQuA measure of perfect care.

The Chair acknowledged the significant progress in the Emergency Department measure, noted the move to the same day emergency care model, the further progress on integration needed across the PLACE, and the useful explanations and clarifications received on maternity continuing care, ward moves, pressure ulcers and sepsis.

The Board reviewed and noted the Integrated Performance Report and agreed that the Well Led section should be reinstated, following the Level 4 emergency period when it had been stood down.

B102/09/20 **FINANCE REPORT - MONTH 4, JULY 2020**

The Director of Finance provided an overview of the report and referred to the 'True Up' measures in place, which are likely to extend to the end of October. The Month 4 financial position resulted in a 'True Up' of £1.3m, which brings the cumulative year to date 'True Up' total to £3.8m. Furthermore, activity is showing an underperformance of circa 75,000 units. However, the associated income shortfall is not reflected in the position, as this is not applicable in the current financial regime where payment by results is suspended. In addition, he explained that the Trust had not yet received reimbursement for capital expenditure and had recently been notified of details of Endoscopy, CT and Urgent Care capital funding, details of which would be provided separately to Board of Directors.

Action agreed: A separate Capital paper will be presented at the next meeting of Board, following its presentation at the Finance & Performance Committee.

Details were provided of the letter dated 20 August 2020, received from NHSE/I, setting out the shared goals for the return to near-normal levels of non-Covid health services and the associated incentives and penalties at a system level, although not all activity items were covered in the letter.

Non-Executive Director, Ms Fallon enquired whether, following receipt of the second Phase 3 letter, there was now an indication of the potential financial impact to the Trust. The Director of Finance responded that the Trust had been informed that it should not yet cost the impact of Covid-19, and details were provided on other areas that may potentially impact on costs.

Non-Executive Director, Mr Higgins noted that the run rate on Covid revenue expenditure in certain areas has appeared flat recently and queried whether this could be expected to reduce, going forward. With reference to the table within section 6 of the report, the Director of Finance identified that some expenditure, such as testing, would increase as activity increases.

The Board noted the report and its recommendations.

B103/09/20 **AUDIT CHAIR'S REPORT - 2ND SEPTEMBER 2020**

Non-Executive Director, Mr Higgins referred to the meeting held on 2 September and noted the helpful and encouraging update from the Freedom To Speak Up (FTSU) Guardian in relation to the committee's responsibility around whistleblowing. The Committee had also received a brief update from Mersey Internal Audit Agency (MIAA) highlighting one report with Limited Assurance, regarding the escalation of deteriorating patients, and noted that the follow-up work around this would be the responsibility of the Quality and Safety Committee. The Committee also reviewed the Covid-19 Donations, Gifts, Hospitality and Fundraising Self-Assessment and Covid-19 Governance People Self-Assessment and the high level of assurance around these items was noted.

The Board received the verbal update from the Chair of the Audit Committee.

CARING

B104/09/20 The Chair reminded the Board of the previous discussions in July on the following items, and that the focus for this Board meeting would be scrutiny of the associated action plans.

WORKFORCE RACE EQUALITY STANDARD (WRES) and WORKFORCE DISABILITY EQUALITY STANDARD (WDES)

The Director of Human Resources and Organisation Development referred to the work to develop the action plans and that the Equality and Diversity Manager, Ms Sophie Hunter, , had been working with the BAME network, disability groups and other related parties to engage in the development of the plans. It was noted that the Covid-19 pandemic had escalated the Trust's ability to work more closely on these items, particularly race equality.

The Equality and Diversity Manager provided an overview of the work undertaken and referred to the large increase in staff willing to share their view in order to make improvements, with a WDES workshop held to shape the action plan.

A number of enquiries were raised and discussed by the Board, as follows:

- Non-Executive Director, Mr Jones suggested that, as 5 of the 25 items were rated red and there was no commentary provided against them, that a plan is developed to address this. The Director of Human Resources and Organisation Development advised that the action plan had been recently created and the intention is to carry out a 'deep dive' review into areas of particular concern and add commentary as the work progresses.
- The level of engagement and the insightful comments provided was acknowledged by Non-Executive Director, Ms Fletcher, who further remarked that the test will be to determine whether the action plan addresses the issues identified, with careful monitoring required. She queried whether the Board could do anything further to enhance the action plan. In response, the Director of Human Resources and Organisation Development advised that the Freedom To Speak Up (FTSU) Guardian had been contacted to discuss the willingness of staff to come forward and that the Staff Survey would provide additional feedback. Furthermore, diversity

continues to be a challenging issue, due to the Trust's geographical location, although this is being considered as part of the recruitment processes.

- Non-Executive Director, Mr Williamson raised the challenge of encouraging staff to declare disabilities and queried what actions were being considered in relation this. The Equality and Diversity Manager remarked that this had been considered over the last 12 months and the Disability Network is providing guidance on how to update information on the Electronic Staff Record.
- The above average bullying and harassment score was referred to by Non-Executive Director, Mr Adams who enquired how the organisation benchmarked against other Trusts. The Equality and Diversity Manager responded that further information was being sought in relation to this.

The Board noted the action plans and approved the contents for Publication on the Trust's Website, with the addition of any further comments in relation to the red items on the action plans, where possible. The Board also approved the 2021 submission dates from July to May.

B105/09/20 **ANNUAL ORGANISATIONAL AUDIT FOR REVALIDATION**

The Executive Medical Director referred to the decision to keep revalidation on-going during the Covid-19 pandemic, remarking on the strong appraisal and revalidation system, and recommended the statement of compliance to the Board, for approval.

The Board noted the contents of the report and, satisfied that the Trust is compliant with the relevant regulations, approved the submission of the Statement of Compliance and for the Chief Executive Officer to sign this on behalf of the Board of Directors.

B106/09/20 **HR UPDATE, including:**

(a) NHS NATIONAL PEOPLE PLAN

The Director of Human Resources and Organisation Development referred to the 2020/21 People Plan objectives and the delay in the production of the national one year People Plan. Reference was made to the key themes which will feature within the Trust's plan. It was noted that the PLACE People Plan for Cheshire & Merseyside was absent although it is anticipated that this will be received shortly. Health and wellbeing remains a focus and reference was made to flexible working improvements, changes during Covid-19 and the new policies which will be required, such as the remote working policy which is in draft form. It was noted that the Board workshop scheduled for 1st December would enable a deep dive into the People Strategy, and the executive away day in September would also focus on this area.

The Board noted the content of the update and the intention that the implications of the People Plan and the Trust's local response to it will be subject to a dedicated Board development session.

(b) ANNUAL STAFF SURVEY ACTION PLAN

The Director of Human Resources and Organisation Development referred to the low response rate to the 2019 electronic survey and the development of an engagement programme, which has been impacted by the Covid-19 pandemic. The new staff survey is scheduled to be circulated electronically across the Trust on 14 September 2020, and it is intended to encourage uptake of this to improve the response rate. The survey in 2020 will include a number of bespoke questions, including flexible/remote working and a new initiative on lean working and the continuous improvement model, in order to increase empowerment at a local level. The results from the 2020 survey will be received early in 2021, with subsequent analysis to link to improvement and to the Trust's People Plan.

The Board noted the update on progress on the implementation of the 2019 Staff Survey and the arrangements for the 2020 Staff Survey, and welcomed the intention that the 2019 and 2020 Staff Surveys will be the subject of a dedicated Board development session.

WELL LED

B107/09/20 **COUNCIL OF GOVERNORS REPORT - 24TH JULY 2020**

The Chair referred to the report and provided an update on the smaller group meetings that had been established between governors and non-executive directors to build relationships, the first of which will take place on 9 September. Following the meetings, it is anticipated that a review will be undertaken to determine whether any adaptation is required, going forward.

The Board noted the Council of Governors Report.

B108/09/20 **ITEMS FOR NOTING:**

The Board noted the following:-

- 16a Updated Board business cycle
- 16b – Approved minutes of the Quality & Safety Committee – 9th June 2020
- 16c –Draft minutes of the Quality & Safety Committee – 30th July 2020
- 16d – Draft minutes of the Audit Committee – 7th July 2020
- 16e – Approved minutes of the Finance & Performance Committee – 17th March 2020
- 16f – Draft minutes of the Finance & Performance Committee – 30th June 2020
- 16g – Draft minutes of the Charitable Funds Committee – 16th July 2020

B109/09/20 **ANY OTHER BUSINESS**

There was no other business raised.

B110/09/20 **REVIEW OF THE MEETING**

The chair welcomed comments on the meeting to herself or the Board secretary

B111/09/20 **DATE AND TIME OF NEXT MEETING**

The Chair highlighted that the 6th October 2020 meeting would now be held informally, in private, due to the short interval between the September and October meeting. The future aim will be to hold six meetings in public per year.

The next meeting will be held on **1st December 2020 at 9:30am**, via Teams.

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Board of Directors Public Action Log 2020-21

Action no.	Board date	Allocated to	Action detail	Action update/outcome	Due date	Status
01/20	07.04.20	Interim Governance Consultant	Further consideration should be given to how standards and metrics in the integrated performance report could best be considered by both the Finance & Performance Committee and Quality & Safety Committee to ensure appropriate consideration and scrutiny of the quality and safety impact of all performance indicators. A review should be undertaken when business returns to two committees.	Re-allocated 21.07.20 and status updated. Further subsequent discussion in each of the relevant Committees has clarified the relevance of what might have seemed trajectories outwith the Committees purview and confirmed their purpose.	30.09.20	Closed – 24/11/2020
05/20	07.04.20	Chair	To consider a representative from the Quality & Safety Committee becoming a member of Audit Committee later in the year when normal business resumes and in relation to the timings of Mr Higgins' term of office ending.	Discussed at Audit Committee on 17th November 2020. Chair of Quality and Safety Committee to be invited to attend Audit Committee annually.	31.10.20	Closed
09/20	21.07.20	Chief Operating Officer & Interim Governance Consultant	The Board to receive a brief update in September on winter planning progress and consider how to deal with incorporating strategy elements into next year's business cycle.	Final draft Winter Plan for review and consideration at September 2020 Board (private) prior to system-wide submission and review. Corporate Business Cycle to be presented to January Board.	~~08.09.20~~ 19.01.21	On-going

Action no.	Board date	Allocated to	Action detail	Action update/outcome	Due date	Status
10/20	21.07.20	Chair and Non-Executive Director, Mr Higgins	Discuss the adequate consideration of people matters within the Finance & Performance Committee.		08.09.20	Closed
11/20	21.07.20	Interim Governance Consultant	A Non-Executive Director briefing session to be held in support of the work to develop the BAF further.	Initial assurance sessions held on 8th September 2020. Verbal update to 1st December 2020 Board meeting – confirming update now underway, revised format and updated currently by two Executive Directors. Work also to be supported by an early Board session to identify key strategic risks.	~~30.09.20~~ 31.01.21	On-going
12/20	08.09.20	Chief Operating Officer	Discussion to be held with Ms Andrea Campbell, Chair of the ICP, regarding potentially assisting with related Local Authority issues, with detail of further agreed actions to be clarified.	Discussion to be held.	01.12.20	On-going
13/20	08.09.20	Director of Finance	A separate Capital paper to be presented at the next meeting of Board, following presentation at Finance & Performance Committee.	Paper to Board December (Private) and F&P Committee November 2020	01.12.20	Closed – 24/11/2020

Countess of Chester Hospital NHS Foundation Trust

Meeting	**1st December 2020**		**Board of Directors**					
Report	**Agenda item 6**		**Chief Executive Officer's Report**					
Purpose of the Report	Decision		Ratification		Assurance		Information	x
Accountable Executive	Susan Gilby				Chief Executive Officer			
Author(s)	Susan Gilby				Chief Executive Officer			
Board Assurance Framework	Q1-Q3 P3 E4	Safety, Quality Staff Engagement Access, Waiting times, care pathways and Constitutional standards						
Strategic Aims	-							
CQC Domains	Well Led							
Previous Considerations	N/A							
Summary	The purpose of this report is: • Provide an overview of relevant local regional and national matters which may have impact on the Trust's strategic objectives.							
Recommendation(s)	The Board is asked to**:-** • Note and consider the contents of this report.							
Corporate Impact Assessment								
Statutory Requirements								
Quality & Safety	Covered within the report							
NHS Constitution								
Patient Involvement								
Risk								
Financial impact								
Equality & Diversity								
Communication	Document to be published on Trust's website							

Chief Executive Officer's Report

National issues

1. In October, the Welsh Government introduced a two-week "circuit breaker" lockdown following a sustained growth in the number of regional COVID-19 cases. Subsequently, following a significant increase in the number of COVID-19 cases presenting in England, the UK Government implemented a four-week English lockdown. People were once again asked to work from home wherever possible, and the leisure and hospitality sectors were closed in an effort to suppress the growth in cases. The English lockdown is due to end on 2 December, although Ministers have said that they will be "guided by the facts" when determining whether the lockdown should be extended.

2. In early October, the Prime Minister confirmed that 40 hospitals will be built by 2030 as part of a package worth £3.7bn, with 8 further new schemes invited to bid. New standards will be developed to help standardise the design of new hospitals and make use of modular construction methods to speed up the build. The Health Infrastructure Plan (HIP) was launched last September with a £2.8bn investment that gave 6 new hospitals the funding to go ahead, alongside seed funding for trusts to work up business cases. The trusts that received seed funding will now all be fully funded to deliver 25 new hospitals. A new hospital in Shotley Bridge is also being added to the programme. Health and Social Care Secretary, Rt. Hon Matt Hancock MP said: "We protected the NHS through the peak of COVID-19. Today we recommit to protect the NHS for years to come with the 40 new hospitals we will build over the next decade."

3. In November, there were exciting developments in the effort to defend against the COVID-19 virus. The US company Moderna announced that its vaccine appears to be highly effective, providing perhaps as much as 95% protection which is comparable with the world's most successful vaccines such as measles. This news came on the heels of the equally welcome development that the vaccine being manufactured by Pfizer and BioNTech may provide as much as 90% protection. Subsequently, new data released by Pfizer and BioNTech suggested that their vaccine could provide as much as 94% protection for those in the vulnerable over-65s age group, and findings from the Oxford/AstraZeneca vaccine programme also showed a strong immune response in the elderly.

4. Additionally, the announcement in November of the increasing availability of mass testing with rapid results available within a matter of minutes was very positive and significant news. Rapid mass testing coupled with the roll out of the vaccine offers the possibility of a much safer and sustainable route out of current restrictions than it was the first time around. This programme is already being piloted in Liverpool and at the time of writing is going well and is likely to be extended to other cities in the near future.

5. The NHS in England was placed on its highest alert level in November. The move by NHS England means staff can be moved around the country, while patients may be sent to other regions for treatment if COVID-19 threatens to overwhelm local services. NHS England Chief Executive Sir Simon Stevens said that the pressure on the NHS caused by the virus is already "three times worse than the extra burdens placed on hospitals over winter". Evidence presented at a press briefing in London suggested hospitals could take a maximum of 20,000 COVID-19 patients before other services, such as routine surgery, would be disrupted.

6. It was concerning to note reports that hospital admissions declined by up to 90% for some of the most serious conditions and illnesses during the first wave of the COVID-19 pandemic, leading to fears that the Government's "Protect the NHS" message home may have produced unintended negative consequences. While Britons were told to "Stay Home, Protect the NHS, Save Lives", the number of heart attack checks reduced by almost half. Additionally, consultations for the most common cancers also dropped by up to two thirds.

7. On 17 September we celebrated World Patient Safety Day. This provided us all with an opportunity to reflect on the work we do here to provide safe and high-quality treatment to those patients under our care. We must continue working relentlessly to strengthen the culture of safety at the Trust, ensuring that every patient feels confident and reassured that they will receive both the safest and most effective care and treatment at the Countess.

Regional & local issues

1. It is a continuing source of pride that we are one of only a few Trusts in the North West who have been able to maintain the majority of our elective services and continue the recovery and restoration work which we began in the summer months. However, this is now significantly under pressure due to the rise in COVID-19 hospital admissions, and I fear that some people will experience distressing further delays in their treatment for conditions which are not time critical. Having said this, the hospital, primary care, 111 and other emergency services are still in a position to provide timely emergency and urgent care to those who need it.

2. In November I held a briefing session with local MPs to update them on ongoing workstreams at the Countess, and to provide an update on the neonatal investigation. The MPs were also briefed on our continuing work to restore the hospital's capacity for treating non-COVID-related illnesses and maintaining elective services while continuing to observe strict infection prevention and control measures throughout the Trust.

3. At the time of writing we are hoping to commence a programme of asymptomatic COVID-19 testing at the Trust, open to staff working on site and who work in or pass through patient areas. The lateral flow, self-administered tests give a result within 20 to 30 minutes and are conducted at home. This testing is vital in protecting others, as asymptomatic people can transmit the virus. It's my hope that, through more frequent testing, we will be able to more quickly identify colleagues who may not know that they have the virus and are potentially infectious to others. Taking part in the testing programme is not compulsory but I have encouraged colleagues in areas of our hospitals where they may cross paths with patients to support the testing programme, as doing so will maximise our ability to monitor the virus, better protect our patients and colleagues, while also giving participants greater peace of mind as they interact with patients across the Trust.

4. I also want to mention our plans for the COVID-19 vaccination. We will be offering this to all staff in the coming weeks as soon as it becomes available and plans on how we will do this are well advanced. At the moment this is a very fluid situation as the entire NHS awaits further information regarding the approval of the vaccine and its distribution. We expect the vaccination doses to arrive in early December although this is yet to be confirmed

5. As we move into a period of high pressure and demand for healthcare, it is important to re-emphasise that the wellbeing and mental health of our staff remains one of our key priorities. Ultimately, colleagues will only be able to derive satisfaction from their work and provide the high-quality care which patients expect of the Trust if they feel properly supported. It is absolutely

essential that the resources are in place to ensure that anyone who is struggling or wants to talk can access the resources at the Trust to do so. As we proved through the spring and summer, it will be by working together and supporting one another that we will maintain our resilience and ability to protect each other, our patients and the wider community.

6. We were all delighted by the announcement in September from the Department for Health that the Trust would receive a £7m funding to support and develop urgent and emergency care services. In November a further £8million has been awarded following our submission of plans to develop a new same day emergency care centre. The additional funding will allow us to implement best practice pathways and further improve the experience and timeliness of care for our most urgent patients. In particular, the new funding will allow the Trust to more build on the improved safety standard performance and comprehensively implement plans to rebuild our capacity for non-COVID-19 treatment and care, while also supporting measures to effectively and safely treat new cases of the virus.

7. In an important development, the NHS 111 First service has now launched at the Trust. NHS 111 First will make it easier and safer for patients to get the right advice or treatment when they urgently need it and where appropriate, will be offered a direct appointment/time slots in a service that is right for them. While our initial capacity for providing appointment slots is limited, this will be scaled up over the coming weeks and months. NHS 111 First will play an important role in helping the Trust manage demand at the Emergency Department, particularly as we continue to enforce strict social distancing measures to reduce the risk of COVID-19 transmission at the Trust.

8. On staff engagement, I am very pleased to announce that this year's staff survey received a 42% response rate this year, compared to last year's 29%. This illustrates a greater willingness on the part of staff to engage with the Trust and feedback their experiences and concerns, helping us to shape an increasingly staff-focused strategy as we move forward. However, there is still much room for improvement, and maximising staff engagement will be an important priority in 2021.

9. On Wednesday 11 November, Lucy Letby was charged by Cheshire Police following an extensive investigation over the past two years into a number of baby deaths and non-fatal collapses at the neonatal unit at the Trust in 2015 and 2016. Over the coming months, our priority will be to fully support and respect the legal process. Our thoughts are with the families involved.

Cheshire West Integrated Care Partnership

Cheshire West and Chester Council and the NHS working together

NHS Cheshire West and Chester

Report

Cheshire West Integrated Care Partnership (CWICP) Board – October 22nd 2020

Strategic Discussion: What people want from healthcare?

Alison Lee presented summaries of:

- Community Conversations commissioned from the voluntary sector in 2019
- The GP Patient Survey 2020.

Louise Barry (Healthwatch Cheshire) presented a summary of findings to date of a rolling survey being conducted by Healthwatch to understand people's health and wellbeing during the Covid-19 pandemic.

Community Conversations

The engagement comprised 77 conversations with 569 people with long-term conditions and with their families and carers. The engagement resulted in more than 900 recommendations for the ICP and its nine Care Communities.

Key messages included the importance of treating the whole person, not the disease; fostering support from friends, family, carers and the community; and having consistent signposting to services and support via a single website.

GP Patient Survey 2020

It is an independent annual survey run by Ipsos MORI for NHS England. It is sent out to more than two million people across the UK, and it reveals how people feel about their GP practice. The latest survey was conducted between January and April 2020.

The survey placed 83 per cent of Cheshire West GP practices above the national average and 63 per cent above the average for NHS Cheshire CCG. An analysis of results against the ICP's Primary Care Networks (PCNs) found that satisfaction was generally very high but that there was less satisfaction with contacting the surgery by telephone while relatively fewer patients described their experience of making an appointment as good. These findings were replicated to a large degree when responses were analysed for individual PCNs.

Your Health and Wellbeing during the Coronavirus Pandemic

More than 1,600 people had so far responded to the rolling survey started in May to ask people about access to health and care services, and their mental health and wellbeing. Findings were reported to the local authority, the NHS and third sector to aid their response to the pandemic. The survey had been revised regularly to continue to provide relevant information.

Findings included respondents being generally satisfied with services but not preferring interim arrangements to business as usual. Nearly half the respondents did not feel comfortable making appointments as they did not wish to overburden services. More than two thirds of respondents rated their GP, pharmacy or hospital appointment "good" or "excellent".

People generally felt they were coping well but contended that clearer information, particularly from the Government, would improve physical and mental health. Top concerns for the future included people continuing to observe social distancing, mental and physical health, money and the economy, and education.

The presentations informed a discussion on staff wellbeing and resilience.

Alison said she had attended an informal meeting of the Cheshire West Health and Wellbeing Board on 21st October. She said there had been recognition that the health and social care sector was suffering a collective trauma. Public health directors were not confident that Covid was on a downward trend in Cheshire West. The consensus was that the second wave was likely to put much greater strain on mental health services than the first.

Alison added that the board had received summaries of progress in establishing hot hubs, virtual wards, the Home First service, and addressing food poverty in Care Communities including One Ellesmere Port.

Jeremy Perkins reported that Covid was placing increasing pressure on general practice staffing levels, with more employees self-isolating. Hot Hubs were to be set up in November while protected time for practice staff training was to be reintroduced in October. This would be used to support staff resilience.

Director Updates

Managing Director: Alison Lee
Alison had spent time with the Local Authority and with non-executive directors of Cheshire and Wirral Partnership NHS Foundation Trust and Countess of Chester Hospital NHS Foundation Trust (COCH). She and ICP Medical Director Dr Chris Ritchieson had also had a positive meeting with the Local Medical Committee.

The voluntary sector had appointed a representative to the Directors' Group while Alison had represented Cheshire West at the first meeting of Cheshire and Merseyside Health and Care Partnership's (HCP) ICP Network. The HCP had provided £9,000 of leadership funding that the ICP was using to support an Improvers' Network that was developing a group of transformation and improvement staff across ICP partners.

Membership of the Care Community Steering Groups was nearing completion while COCH had increased staffing at Ellesmere Port Hospital, reducing a service delivery risk that had been escalated. The Health Protection Board had signed off escalation plans to support the "shielded population" considered extremely vulnerable to Covid-19.

The ICP did not have capacity to devote sufficient time to the development of a response to NHS Cheshire CCG's road map for commissioning of the ICP without additional resources from the CCG.

DECISION: It was agreed to ask the CCG to align a senior member of staff from its New Models of Care team to act across the CCG and ICP, ensuring progress was made.

Directors' Group Chair's Report: Alison Lee
Poverty: At the meeting of October 8th, directors were briefed on the Poverty Truth Commission and Advisory Board established by Cheshire West and Chester Council. A member of the ICP Directors' Group was to join the Advisory Board.

Covid-19: A number of Covid outbreaks in non-clinical areas of health and care providers had prompted a back-to-basics focus on mask wearing, hygiene and social distancing.

Care Communities: All but three of Cheshire West's electoral wards were now aligned with Care Communities. The final alignment was expected to have taken place by November's ICP Board meeting.

The PCN managers were providing management support to the Care Community Steering Groups. The third sector had appointed Gareth Phytherch to act as its ICP lead. Gareth was to be invited to join the Directors' Group.

Service delivery: A Hot Hub was now in place in Northwich and Winsford to support GP practices in safely treating patients suspected of having Covid. A second hub was being developed in Chester to support the remaining Care Communities.

COCH and Mid Cheshire Hospitals NHS Foundation Trust were setting up operational resilience groups to oversee winter schemes while the NHS and social care were working together to develop integrated health and social care brokerage systems.

Mental health urgent care: The Directors' Group was providing oversight on issues around the urgent care pathway for mental health.

Medical Directors' Report: Dr Chris Ritchieson

Enhancing community-based services: Recruitment of lead clinicians for Care Communities was underway. Individuals should be in post within a month.

A day of "floor walking" with the REACT team had resulted in resolution of issues around managing some general practice referrals to the service.

Primary care: Work was ongoing to support staff resilience in general practice and address operational issues related to Covid in some practices.

Long-term conditions: Dr Ritchieson had chaired a webinar for GP practices across Cheshire to share learning from a Care Home Practice pilot in Chester.

Transformation: He was working with colleagues to scope the feasibility of establishing a clinician-to-clinician advice service called Consultant Connect.

Covid: A clinical model had been developed for the proposed Chester Hot Hub while managerial and administrative staff had been identified. Work was ongoing to secure a general practice workforce.

Dr Ritchieson was supporting conversations on establishing Covid virtual wards across Cheshire, involving deployment of pulse oximeters to higher-risk patients. He was in the process of convening a virtual meeting of medical directors from across Cheshire West to enable mutual support and joint working on the Covid response.

Primary Care Network Clinical Directors' Meeting: Dr Chris Ritchieson

Dr Ritchieson reported that £200,000 of Primary Care Network development funding had been secured from NHS England to support development of a suite of options co-designed with PCN clinical directors.

First-contact physiotherapy practitioners were now in place across all PCNs. They were employed or provided by the ICP, either alone or with Central Cheshire ICP.

Workforce planning had been completed with all PCNs to inform recruitment to additional roles. Recruitment was now continuing in all areas following delays caused by Covid.

Primary Care Cheshire was supporting PCNs to deliver flu antiviral prophylaxis in areas where this had not already been commissioned.

Transformation Report: Ali Wheeler

Part 1 Transformation Group: Long-Term Planning and Resourcing Plan

Membership of the Transformation Group had been widened and a Priority Programme established to begin from April 2021 under the leadership of the third sector. It had been tasked with co-creating a "Developing Connected Communities" Priority Programme.

The ICP's Long Term Plan was to be presented to Board for approval in November 2020. The ICP would then support partners to take the plan through their governance processes in December 2020/January 2021 for final signoff by ICP Board in January or February 2021.

Part 2 Transformation Group: Programme Development
All programme expenditure was on track, with the exception of £100,000 allocated to "Developing Connected Communities". A potential unallocated £20,000 had been identified. A report confirming this change is being prepared for Cheshire West Place Board

Programme highlights
Care Communities: The first meetings of the Care Community Steering Groups were being arranged. For each group, representatives had been identified from Healthwatch Cheshire, the third sector, adult social care and locality managers.

An ICP director had been aligned with each Care Community.

Enhanced Community-Based Services Programme: The step-up element of the Home First service went live for the NHS on September 1st 2020. A bed-based analysis of the step-down element had been presented to the core operational team for Home First.

Workshops had been completed to enable adult social care to be aligned to the Home First model.

Long-Term Care Programme: The onboarding of care home residents to the Fountains Integrated Care Home Service was ongoing. The commissioning of a digital multifactorial risk assessment tool had been discussed with the Digital Programme.

An Outcomes and Project Plan had been developed for the implementation of a rolling programme of enhanced training for care home staff.

Business Intelligence Programme: Work was ongoing with the Combined Intelligence Population Health Analysis project to receive more timely data from social care to support the Covid response. Some PCN directors had expressed interest in a series of new health management apps that had been built.

Communications: The stakeholder newsletter had been relaunched and a Facebook page created while the ICP's Twitter footprint was growing.

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Meeting	**1st December 2020**		**Board of Directors**					
Report	**Agenda item 8**		**Infection Prevention and Control COVID-19 Board Assurance Framework (update)**					
Purpose of the Report	Decision		Ratification		Assurance	X	Information	
Accountable Executive	Alison Kelly				Director of Nursing and Quality/ Director of Infection Prevention & Control			
Author(s)	Janice Scott Alison Kelly				Interim Associate Director of Nursing (Infection Prevention & Control) Director of Nursing and Quality/ Director of Infection Prevention & Control			
Board Assurance Framework	Q1 Q2, Q3	Safety Quality						
Strategic Aims	To deliver high quality care and treatment							
CQC Domains	Safe, Effective, Caring, Responsive, Well Led							
Previous Considerations	Board of Directors, previous version presented on 21st July 2020							
Summary	This assessment is intended to provide an update on progress with Infection Prevention and Control COVID-19 Board Assurance Framework (BAF). Since the last update to the Board, further updates to the national document have taken place (October 2020). Below is a summary of key points within the BAF document. Areas where progress has been made are as follows: • Full assessments of clinical and non-clinical areas to mitigate risk associated with 2 metre spacing – general themes of these assessments were: requirement for perspex screen partitioning, signage; space utilisation; ventilation- all actioned. • Formalised training in place, Fit testing training model revised. • Formalised governance regarding management of root cause analysis investigations. • Revision of communications and literature Trust wide. • Public facing reception areas have Perspex screens insitu. • Ventilation and engineering assessments undertaken regarding high risk areas – new Respiratory Unit currently being developed with £300k investment regarding ventilation. Areas for further improvement are as follows: • Trust wide **screening** on admission compliance remains at 84% - focused attention on wards and departments lead by Associate Director of Nursing (IPC) with Divisional Associate Directors of Nursing/Lead Nurses. Positively, Acute Medical Unit/Emergency Department has a compliance of 98% (as of 24.11.20), majority of patients are managed through this area.								

	• **Clinical risk assessments** have indicated therefore some areas of high risk in terms of estate restrictions regarding space, Pharmacy and Radiology areas are high risk. A staff outbreak has been declared in Pharmacy (but linked to an outbreak ward) Additional measures, including treating the Pharmacy Dispensary area as a clinical space has been actioned (therefore staff are wearing PPE as required to reduce further risk) • Development of a revised **IPC audit tool** to support additional BAF measures, this will cover Covid and all other elements of IPC practice. • Implementation of **revised cleaning model** – this is a delayed action, it is anticipated that this will be concluded in the next 2 weeks. However, current cleaning compliance score is 98.5% (October data). Once new model is in place, it will meet the required standards of the Covid BAF and better comply with the overarching IPC agenda. • **Patient Movement within wards** – it is clear from the learning from the nosocomial transmission cases highlights frequent moves within ward areas (and across wards) is challenging. A risk based approach is taken when placing patients from a clinical specialty perspective as well as from an IPC perspective. During Oct-Nov, the Trust has been operating between 96-98% occupancy with increased ED attendances and a higher complexity and acuity of patients. • **Increased emergency/urgent activity** across the Trust has meant, despite 'Outbreaks' being declared, whole wards have not been able to close due to pressures in the Emergency department so again, a risk based approach is taken (in liaison with the Infection prevention & Control Team, including the Lead Microbiology Consultant).
Recommendation(s)	The Board is asked to receive this report as **assurance** in articulating this update on the Infection Prevention and Control Board Assurance Framework and **support** the proposed actions going forward. It is acknowledged that a number of actions are in progress and are being taken in response to changing national guidance.
Corporate Impact Assessment	
Statutory Requirements	Meets NHSE/I Guidance Supports compliance with Health & Social Care Act : Code of Practice on Prevention and Control of infections
Quality & Safety	Supports delivery of safe care, CQC and Public Health England requirements
NHS Constitution	Contributes to safety standards
Patient Involvement	Patient input not obtained for this assessment
Risk	Specific COVID-19 Risk Register in place
Financial impact	Financial impact being monitored, especially regarding Capital improvements
Equality & Diversity	N/A
Communication	Document to be published on the website and intranet

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Publications approval reference: 001559 and now joint togther Publications approval reference: 001559

Infection Prevention and Control COVID-19
Board Assurance Framework

(National: 22 May 2020, Version 1.2 Reviewed: 19/10/20 in line with new National document: 22nd July 2020 Version 1.3
National updated version 15th October. Version 1.4 added in red along with new forward and introduction pages)

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May

Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in evidence- based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

Infection prevention and control board assurance framework

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions	Update
Systems and processes are in place to ensure:				
• infection risk is assessed at the front door and this is documented in patient notes	Clinical pathways altered to address triage of symptomatic patients – as per ED pathway; cohort areas commissioned to facilitate COVID-19 and non-covid-19 patients in ED and Haygarth Centre; Children's Respiratory Assessment has identified location; process to assess obstetric patients prior to arrival	Spot check assurance programme identified an overall compliance score of 89% with rapid triage systems	Localised action for improvement within any ward/department with identified gaps in compliance	21.11.20 – Process for screening for COVID-19 for all emergency admissions in place, with rapid screening of suspected cases. Overall Trust compliance with admission screening 85%.
• patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	Local process for clinical teams to escalate any change in condition – appropriate bed allocation managed through Co-ordination Centre (Teletracking). COVID-19 screening results managed through the Coordination Centre 24/7 – communicated to wards, documented on EPR and database of suspected/confirmed cases	Spot check assurance programme identified an overall compliance score of 79% with limiting patient movement	Trust-wide action in progress to minimise the number of patient moves, both between wards and between beds within the same ward – this is inclusive of patients with possible or confirmed COVID-19	24.11.20 – initial learning from outbreak investigation (Bluebell Ward) identifies this to be an on-going challenge due to capacity and operational pressures. Patient moves are monitored very closely via the coronation centre.

	managed through Silver Control			
• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	Discharge/transfer pathway developed, including patient screening programmes prior to discharge to a social care setting	Consider audit of discharge/transfer pathways to incorporate key actions identified within 'Hospital Discharge service Requirements'	Recommendations dependant on audit outcomes	Internal hospital discharge guidance introduced 16/4/20. **No patients discharged to care homes without a negative screen**  Covid 19 care Home discharge guidance 1 System partner escalation call for mutual aid and IPC support Care home webnRs Staff redeployed into CCG team offering practical support on IPC and training on swabbing Close working with PH lead at local authority and Community Infection control team Therapists redeployed according to clinical prioritisation for acute inpatient wok

				Ongoing review of result of pathway and actions implement Ongoing audit against hospital discharge guidance to care homes.
• Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC champions to embed and encourage best practice	21.11.20 – Trust wide roll out of IPC Link Practitioner audit programme with audit tool. IPC team supporting with this.	We will review in two months' time as this programme has been revised		
• staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase	21.11.20 - 7 day system and process for staff screening, Test and Trace established through a multi-disciplinary team collaboration. Programme of staff testing in place in high risk areas. Lateral flow testing to start soon			
• all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that	Staff training, including reminders in practice are continually supported by the IPC Team/ Floorwalker Team, Fit Testing team, daily briefings, posters and screensavers. PPE supplies for individual areas are coordinated	Action in progress to explore if PPE training can be formalised through ESR as a mandatory annual competency	Spot check assurance programme identified an overall compliance score of 100% - current actions to continue to support sustained compliance	21.11.20 – Clinical based staff training, including reminders in practice continues to be supported by the IPC Team/ daily briefings, posters and videos screensavers.

protects them for the appropriate setting and context as per national guidance	through Silver Control and the Supplies team. PPE meeting weekly to assess PPE sustainability, plus daily stock check			
• training in IPC standard infection control and transmission-based precautions are provided to all staff	21.11.20 - Included on IPC mandatory training programme (clinical and non-clinical staff)			
• IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training	21.11.20 - Included on IPC mandatory training programme (clinical and non-clinical staff) and Trust Induction			
• all staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	21.11.20 - Clinical based staff training, in practice continues to be supported by the IPC Team/ daily briefings, posters and screensavers. Also we moved ahead of the recommendation of all patients to wear surgical masks on all wards to reduce the risk of transmission of COVID19. Also we had staff isolate for longer than national recommendation along with staff and patients screening/swabbing.			

• all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	21.11.20 - Clinical based PPE training, continues to be supported by the IPC Team/daily briefings, posters and screensavers. Access to PPE donning and doffing demonstration videos via COVID-19 intranet hub.			
• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	Information received from various national teams through formal routes e.g. CAS alerts, CMO/CNO letters etc.; IPC Team receive automated PHE updates and have escalated to NHS England for a similar process to be enabled for NHSe/i updates – updates communicated via Silver Control and approved Comms routes depending on content/intended audience		Spot check assurance programme identified an overall compliance score of 100% for Floorwalker daily briefings being shared with staff - current actions to continue to support sustained compliance	21.11.20 – local and national updates co-ordinated an disseminated via Silver Control, EPRR and IPC
• changes to guidance are brought to the	Executive Team receive updates directly from national correspondence, or via Silver Control/IPC	Any gaps in assurance will be identified through the BAF and	Current actions to continue to support sustained compliance	21.11.20 – local and national updates co-ordinated an disseminated via Silver

attention of boards and any risks and mitigating actions are highlighted	Team (see above)	ongoing assessment		Control, EPRR and IPC
• risks are reflected in risk registers and the Board Assurance Framework where appropriate	IPC/COVID-19 risk register is under review regularly via Senior Leaders Group & Quality Governance Group	Outcome of spot check assurance programme to inform updates of COVID-19 risk register and BAF	COVID-19 risk register to be updated utilising spot check assurance programme outcomes	21.11.20 – Action – For COVID-19 risk register to be reviewed.
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	Established systems and processes remain in place for non-COVID-19 infections and pathogens, including mandatory reporting requirements	Limitations on single room capacity have resulted in a change to isolation risk assessments , to include COVID-19 criteria and other 'alert' organisms	COVID-19 and other infections are risk assessed and prioritised for single rooms accordingly e.g. suspected COVID-19, C. difficile infection, diarrhoea etc. Confirmed COVID-19 cohort area utilised to full capacity to optimise use of single rooms	21.11.20 – Established IPC risk assessment process remains in place
• That Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in	21.11.20 – Established process in place via Silver Control for daily submission of nosocomial data sitrep. DIPC oversite of all submissions			

a timely manner.				
• ensure Trust Board has oversight of ongoing outbreaks and action plans.	21.11.20 – daily outbreak review meetings established with dissemination of action log to all key stakeholders. Regular updates presented to board.			
1. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.				**2.**
Key lines of enquiry	Evidence	**Gaps in assurance**	**Mitigating actions**	
Systems and processes are in place to ensure:				
• designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	Dedicated team identification for Ward 43 and JDSU/identified elective surgery on identified rotas	Dedicated teams are not routinely assigned in all areas due to workforce limitations - spot check assurance programme identified an overall compliance score of 68%	Implementation of IPC guidelines to minimise the risk of transmission of all micro-organisms, including COVID-19	21.11.20 – Dedicated staff to COVID-19 cohort areas remains an on-going challenge due to workforce limitations, and pressures on capacity and patient flow. Movement of staff risk assessed on an individual basis. Medical staffing team and the central nursing workforce team provide oversite of staff movements.
• designated cleaning teams with appropriate training in required	Domestic Teams cover all ward/department areas regardless of COVID status, in conjunction with	Spot check assurance programme identified an	Implementation of IPC guidelines to minimise the risk of transmission of all micro-organisms, including COVID-19	21.11.20 - Domestic Teams continue to cover all ward/department areas regardless of

techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	appropriate mask fit testing to enable the service to be delivered in higher risk areas	overall compliance score of 86% for designated cleaning teams		COVID status, ensuring compliance with IPC precautions are maintained.
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other	Facilities support terminal cleaning requirements – advised by the Coordination Centre (Note: within limitations of patient remaining in situ if terminal cleaning required due to IPC stepdown)	Terminal cleaning is completed by a separate team who specialise in this bespoke service	Spot check assurance programme identified an overall compliance score of 100% - current actions to continue to support sustained compliance.	21.11.20 – Established Rapid Response domestic service in place to ensure decontamination and terminal decontamination of isolation rooms is undertaken.
• increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	National guidance updated to include patient isolation rooms/cohort areas to be cleaned twice daily (minimum) – currently cleaned on a daily basis with additional wipe downs of frequently touched surfaces	Spot check assurance programme identified an overall compliance score of 36%, due to resource requirement for full implementation of requirements	Facilities have undertaken an assessment of updated guidance and a draft paper has been developed to identify the resources required to meet this requirement – requires progression. This is currently with the Director of |infection Prevention & Control for review before progressing	21.11. Draft paper received by Trust Execs, some re-work currently underway .
• attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found	National guidance updated as above, to include toilet/bathroom and staff areas – toilets/bathrooms currently cleaned as per	Spot check assurance programme identified an overall compliance score of 36%, due	Facilities have undertaken an assessment of updated guidance and a draft paper has been developed to identify the resources required to meet this requirement – requires progression.	21.11.20 – Draft paper received by Trust Execs, some re-work currently underway.

to contaminate surfaces in these areas	frequency within national cleaning standards	to resource requirement for full implementation of requirements (as previous)		
• cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	All environmental and equipment cleaning/disinfection is being undertaken with a combined neutral detergent/chlorine-based disinfectant (1,000ppm available chlorine); 70% isopropyl alcohol wipes as standard disinfectant for more fragile equipment that is physically clean; approved disinfectants for specialist equipment/areas as per standard practice		Spot check assurance programme identified an overall compliance score of 100% - current actions to continue to support sustained compliance	21.11.20 – Established process in place for decontamination of all clinical areas with chlorine based disinfectant (1,000ppm)
• manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant	As per standard disinfectants in use within the Trust – no new products have needed to be introduced for COVID-19	Spot check assurance programme identified an overall compliance score of 97%	Not always sufficient time to allow items to air dry within the Resuscitation area (Emergency Department)	21.11.20 – Roll out of additional patient monitoring equipment undertaken by EBME

solutions/products				
• as per national guidance: o 'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids o electronic equipment, e.g. mobile phones, desk phones, tablets, desktops, and keyboards should be cleaned at least twice daily	Facilities undertake touch point cleaning throughout the day e.g. door/toilet handles, hand rails, toilet door handles and lift call buttons in all public areas, with additional wipe downs of frequently touched surfaces in clinical areas Clinical teams – cleaning/ decontamination communication has been shared and frequently updated via Floorwalker Team and daily briefing messages, plus other team meetings	Spot check assurance programme identified an overall compliance score of 68%	Staff report that decontamination is undertaken; however, there is a gap in compliance as there is no standard/formal method to evidence that decontamination has been undertaken as required – action identified to introduce a monitoring sheet (or similar) to support evidence of compliance with the cleaning that is being undertaken	21.11.20 –environment / equipment cleaning schedules undertaken by Individual departments. Action standardised monitoring tool to be used across clinical areas

o rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	National guidance updated as above, to include rooms where PPE is removed	Spot check assurance programme identified an overall compliance score of 36%, due to resource requirement for full implementation of requirements (as previous)	Facilities have undertaken an assessment of updated guidance and a draft paper has been developed to identify the resources required to meet this requirement – requires progression	21.11.20 – Draft paper received by Trust Execs, some re-work currently underway .
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	As per established linen handling policy	Spot check assurance programme identified an overall compliance score of 90% for the compliance monitoring section relating to linen	Localised action for improvement within any ward/department with identified gaps in compliance, with a particular focus on correctly labelling linen bags (55% overall compliance score achieved for correctly labelling linen bags)	21.11.20 – Linen policy amended to reflect requirement to label linen bags. Policy update disseminated via Trust wide daily briefings.
• single use items are used where possible and according to Single Use Policy	As per established decontamination of medical devices policy	Spot check assurance programme identified an overall compliance score of 97%	Localised action for improvement within any ward/department with identified gaps in compliance	21.11.20 – Established decontamination and medical device policy in place.
• reusable equipment is appropriately	As per established decontamination of medical devices policy and	Spot check assurance programme	A Trust-wide action is currently in progress to assess equipment deficits and provide the required	21.11.20 – Roll out of additional patient monitoring

decontaminated in line with local and PHE and other national policy	supported by Floorwalker Team and daily briefing messages	identified an overall compliance score of 58%, with the gap in compliance identified as insufficient equipment being available in a number of areas to facilitate practice	quantity of equipment to identified areas	equipment/medical devices undertaken by EBME. Migration over to a streamlined process of 2 in 1 cleaning and disinfection wipes.
• review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	Air flow assessment undertaken within ICU and single rooms within the Trust (February 2020) with remedial works progressed in ICU to optimise air flow direction National guidance updated to recommend that local consideration is given to any enhancements that could be made to improve ventilation in healthcare premises	Estates action is in progress to assess how ventilation and cooling measures can be used in support of infection prevention and control	Await the outcome of Estates ventilation assessment and report any requirements for improvement within the BAF Capital monies requested through national process to include improvements n Trust wide ventilation systems.	21.11.20 –Detailed work has been undertaken in the respiratory unit to incorporate isolation rooms with compliant ventilation as a priority. Engineering assessment now has been indicated in specific areas of the Trust e.g. CRV and Spirometry services. The Trust is taking a risk based approach to identified areas of concern ie services that require review as part of our restoration programme.

• ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	21.11.20 – roll out of 2 in 1 cleaning and disinfection wipes across all non-clinical areas			
• there is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants	21.11.20 – Standardised decontamination process across all COVID-19 pathways (using combination of detergent and disinfectants)			
3. **Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance**				**4.**
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**	
Systems and process are in place to ensure: • arrangements around antimicrobial	Established systems and processes remain in place for operational antimicrobial stewardship,	COVID-19 specific 'Start smart then focus' audit completed and	Antimicrobial stewardship is a standing agenda item for the IPC Strategy Group – gaps in assurance can be escalated through this route	21.11.20 – ASC re-established in September 2020 and continues to feed into the IPC Strategy Group**.**

stewardship are maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	including point prevalence assessments as per local programme and mandatory reporting requirements; local COVID-19 antibiotic guidelines have also been developed	results/learning are being shared through medical unit meetings Antimicrobial Stewardship Committee (ASC) is currently paused	pending ASC being reconvened DIPC has discussed on going medical engagement in this agenda with the medical Director	
5. **Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion**				**6.**
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**	
Systems and processes are in place to ensure:				
• implementation of national guidance on visiting patients in a care setting	National guidance for visiting patients has been implemented, with support systems developed to patients, families and friends	Spot check assurance programme identified an overall compliance score of 45% regarding clear signage for visiting restrictions	Action has been taken since the time of this baseline assessment, with appropriate signage indicating visiting restrictions now displayed in all areas	21.11.20 – visiting restrictions remain in place as per NHSE guidelines. Signage in place at key entrances to the Trust.
• areas in which suspected or confirmed COVID-19 patients are being treated are clearly	Signage is in place for wards or identified single rooms; not all areas have restricted access as there is the potential for a	Spot check assurance programme identified an overall compliance	Action has been taken since the time of this baseline assessment, with Trust-wide standardised signage introduced to indicate red/amber/green zones, plus the	21.11.20 – Standardised red/amber/green zone signage in place across the Trust. Central access to signs

marked with appropriate signage and have restricted access	suspected case of COVID-19 to be isolated within any single room in the Trust	score of 70% regarding doors to isolation/cohort rooms/areas being closed with clear signage displayed	requirement for doors to be kept closed is consistently reinforced through ward visits and Floorwalker briefings	available via Trust Shared drive. Requirement to keep door closed continually reinforced by IPC during clinical visits
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	Trust website links to national resources, including easy read versions		Current actions to continue to support sustained compliance	21.11.20 – enhanced COVID-19 intranet hub developed.
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Clinical handover routinely includes infection risk/status, including electronic and ED handover proforma; infection status is also included with e-discharge and transfer of care documentation	Spot check assurance programme identified an overall compliance score of 93% for transfers within COCH 100% compliance with communicating infection status was identified for discharges or transfers to other healthcare or social care providers	Localised action for improvement within any ward/department with identified gaps in compliance Current actions to continue to support sustained compliance	21.11.20 – Established process includes Infection risk/status on handover, transfer documentation.

• there is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	21.11.20 – Enhanced comms, posters and signage in place at key areas across the Trust promoting compliance with 'hands, face and space' advice.			
7. **Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people**				**8.**
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**	
Systems and processes are in place to ensure:				
• screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases.	21.11.20 – Process for triaging patients and screening for COVID-19 for all emergency admissions in place, with rapid screening of suspected cases. Overall Trust compliance with admission screening (w/c 09.11.20) was 84%. High level of compliance (98%) demonstrated from key admission pathway are (AMU).			

• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non-COVID-19 cases to minimise the risk of cross-infection, as per national guidance	Clinical pathways have been altered to address triage of symptomatic patients. This can be found in ED pathway. Segregation areas commissioned to facilitate COVID-19 and non-covid-19 patients in ED (and Haygarth Centre). The Children's Respiratory Assessment area has also been given a separate location; process to assess obstetric patients prior to arrival	Spot check assurance programme identified an overall compliance score of 89%	Localised action for improvement within any ward/department with identified gaps in compliance	21.11.20 – Process for screening for COVID-19 for all emergency admissions in place, with rapid screening of suspected cases. Established 'hot/cold' zones in place within the ED. Overall Trust compliance with admission screening (w/c 09.11.20) was 84%. High level of compliance (98%) demonstrated from key admission pathway are (AMU).
• staff are aware of agreed template for triage questions to ask	21.11.20 – Standardised triage process with the ED with established red and amber zones in place.			
• triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	21.11.20 – Competency assessed locally with ED to ensure staff are trained and competent to undertake patient triage. Manchester triage process implemented			
• face coverings are used by all outpatients and	21.11.20 – Face covering and Face masks available at			

visitors • face masks are available for patients with respiratory symptoms	all Trust entrances and distributed to all staff and visitors entering the Trust			
• provide clear advice to patients on • use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care	21.11.20 – posters and comms distributed on the correct use of facemasks. All patient's continue to be encouraged by staff to use facemasks where tolerated			
• ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	21.11.20 – Trust wide assessment of key reception areas undertaken and led by estates. Areas of 'high traffic' identified and perspex screens in place.			
• mask usage is emphasised for suspected individuals	Local recommendation that all patients wear a surgical face mask, at all times, if tolerated	Spot check assurance programme identified an overall compliance score of 87% with local policy	Localised action for improvement within any ward/department with identified gaps in compliance and consistently reinforced through ward visits and Floorwalker briefings	21.11.20 – posters and comms distributed on the correct use of facemasks. All patient's continue to be encouraged by staff to use facemasks where tolerated
• ideally segregation should be with separate	Some front door areas/departments have a screened reception desk -	Spot check assurance programme	Trust-wide action in progress through Estates, to complete the assessment/installation works	21.11.20 – Trust wide assessment of key reception areas

spaces, but there is potential to use screens, e.g. to protect reception staff	all reception desks, including outpatients require assessment for physical separation options e.g. screens	identified an overall compliance score of 24% with screened reception areas	required for physical separation options	undertaken and led by estates. Areas of 'high traffic' identified and perspex screens in place.
• for patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	Process developed to isolate/cohort patients who develop signs/symptoms of COVID-19 during their admission, or who screen positive for COVID-19 as part of any assessment – this includes routine contact tracing	Spot check assurance programme identified an overall compliance score of 38%, with the gap in assurance identified as limitations for enhanced contact tracing – project in development with Teletracking Team (US) to address this	Interim action has been taken since this baseline assessment was undertaken, to introduce a method of enhanced contact tracing through Meditech data, while awaiting the outcome of the Teletracking project	21.11.20 – patient contact tracing system established utilising teletracking. System under further development with additional resource to ensure robust system of contact tracing is maintained. Senior leadership provided by an consultant.
• patients with suspected COVID-19 are tested promptly	Laboratory capacity supports patient testing for COVID-19	Process to monitor compliance with emergency admission COVID-19 screening, plus screening on day 3 and day 5 of admission, is in	Spot check assurance programme identified an overall compliance score of 100% - current actions to continue to support sustained compliance	21.11.20 – Process for screening for COVID-19 for all emergency admissions in place, with rapid screening of suspected cases. Overall Trust compliance with admission screening 85%.

		development		Process established to monitor compliance with day 1, day 3 and day 5 admission screening.
• patients who test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re- tested and contacts traced	Process developed to isolate/cohort patients who develop signs/symptoms of COVID-19 during their admission, or who screen positive for COVID-19 as part of any assessment – this includes routine contact tracing	Spot check assurance programme identified an overall compliance score of 38%, with the gap in assurance identified as limitations for enhanced contact tracing – project in development with Teletracking Team (US) to address this	Interim action has been taken since this baseline assessment was undertaken, to introduce a method of enhanced contact tracing through Meditech data, while awaiting the outcome of the Teletracking project	21.11.20 – patient contact tracing system established utilising teletracking. System under further development with additional resource to ensure robust system of contact tracing is maintained.
• patients who attend for routine appointments and who display symptoms of COVID-19 are managed appropriately	Only urgent/essential elective/planned services are currently being delivered		Spot check assurance programme identified an overall compliance score of 100% - current actions to continue to support sustained compliance	21.11.20 – Process for COVID-19 screening of all emergency and elective admissions in place. Temperature checking and symptom checking in place at key entrances to the Trust

9. **Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection**				**10.**
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**	
Systems and processes are in place to ensure:				
• Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	21.11.20 – Review of trust entrance/exits being undertaken. Dedicated patient/visitor entrance and exit points in place. No visitor access to staff restaurant.			
• all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	Staff training, including reminders in practice are supported by the IPC Team/ Floorwalker Team, daily briefings, posters and screensavers. PPE supplies for individual areas are coordinated through Silver Control and the Supplies Team.	Action in progress to explore if PPE training can be formalised through ESR as a mandatory annual competency	Spot check assurance programme identified an overall compliance score of 100% - current actions to continue to support sustained compliance	21.11.20 – Clinical based staff training, including reminders in practice continues to be supported by the IPC Team/ Floorwalker Team, daily briefings, posters and screensavers. Action – to formalise training as a mandatory competency
• all staff providing	Staff PPE training is	Action in progress	Spot check assurance programme	21.11.20 – Clinical based

patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it safely	supported by IPC Team, Floorwalker Team, Fit Testing Team, daily briefing messages, posters, screensavers, videos, FFP3 fit testing programme.	to explore if PPE training can be formalised through ESR as a mandatory annual competency	identified an overall compliance score of 100% - current actions to continue to support sustained compliance	staff training, including reminders in practice continues to be supported by the IPC Team/ Floorwalker Team, daily briefings, posters and screensavers. Action – to formalise training as a mandatory competency
• a record of staff training is maintained	Staff FFP3 fit test record is held on ESR	Action in progress to explore if PPE training can be formalised through ESR as a mandatory annual competency	Spot check assurance programme identified an overall compliance score of 100% - current actions to continue to support sustained compliance	21.11.20 – Clinical based staff training, including reminders in practice continues to be supported by the IPC Team/ Floorwalker Team, daily briefings, posters and screensavers. Action – to formalise training as a mandatory competency Strategic and operational management of FFP3 fit testing now led by a collaborative of EPRR and Silver Control. Review of FFP3 staff record database in progress.

• appropriate arrangements are in place that any reuse of PPE in line with the MHRA CAS Alert is properly monitored and managed	Local thresholds developed for when reuse of PPE may need to be considered, this would be monitored/recorded via Silver Control as central control point for PPE; daily stock checks plus PPE Group meets weekly to assess PPE sustainability		Spot check assurance programme identified an overall compliance score of 100% for staff access to the PPE they require - current actions to continue to support sustained compliance Central decontamination processes developed for 3M Jupiter hoods and reuseable eye protection	21.11.20 – Established central process for decontamination of reusable eye protection and powered respirator hoods in place.
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	PPE related incidents would be recorded via incident reporting system (Datix) and actioned accordingly	Gaps in assurance would be identified via Datix reports		21.11.20- established incident reporting system (datix) in place.
• adherence to PHE national guidance on the use of PPE is regularly audited	BAF compliance monitoring process has now been developed to standardise assurance		Spot check assurance programme identified an overall compliance score of 100% with PPE use - current actions to continue to support sustained compliance Action in progress to include IPC COVID-19 spot check assurance programme as part of the ward accreditation rolling programme	21.11.20 – Formal monitoring of compliance with PPE guidance is incorporated into the IPC departmental audit programme and the IPC Link Practitioner audit programme.
• staff regularly undertake hand hygiene and observe standard	As per established hand hygiene compliance monitoring programme		Spot check assurance programme identified an overall compliance score of 100% with hand hygiene	21.11.20 – Established hand hygiene compliance monitoring

infection control precautions			following PPE removal - current actions to continue to support sustained compliance	programme in place.
• hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: **1.** hand hygiene facilities including instructional posters **2.** good respiratory hygiene measures **3.** maintaining physical distancing of 2 meters wherever possible unless wearing PPE as part of direct care **4.** frequent decontamination of equipment and environment in both clinical and non-clinical areas **5.** clear advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas	21.11.20 – hand hygiene facilities available to all patients/staff within clinical areas (hand wash basins, hand sanitizer). Roll out undertaken to ensure hand hygiene instructional posters are displayed in all toilet areas across the Trust. A review of the availability of hand sanitizer identified a requirement for additional wall mounted sanitizer dispensers. Works in progress to fit additional dispensers. Signage promoting physical 2 meter distancing in place across communal (corridors, stairwells). Provision of environmental cleaning materials (2in1) detergent/disinfectant wipes and hand sanitizer distributed to all non-clinical areas. Posters and comms	Availability of wall mounted hand sanitizer dispensers.	Procurement of portable hand sanitizer bottles to be distributed to all staff to ensure access to hand sanitizer.	

	distributed on the correct use of facemasks. All patient's continue to be encouraged by staff to use facemasks where tolerated			
• hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	Use of disposable paper hand towels is standard practice within all clinical areas		Progress check required with Facilities on progress with removing the small number of hand dryers located within some public toilet areas	21.11.20 – Action – Facilities to provide assurance that hand dryers not in use.
• guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff area	Staff information, including reminders in practice supported through staff communication e.g. daily briefings	Spot check assurance programme identified an overall compliance score of 52%, with this gap in assurance relating to displaying	Action required to purchase click frames to appropriately display the national hand hygiene guidance poster within all patient/public bathrooms/toilets – adjacent, or near to hand wash basins for ease of reference	21.11.20 – Collaborative project between estates and IPC. Appropriate posters and click frames procured. Programme now established and works on-going to ensure hand hygiene instructional posters are

		guidance posters as standard in public toilet areas - currently hand hygiene reminders are on display only		displayed in all toilet areas across the Trust.
• staff understand the requirements for uniform laundering where this is not provided for on site	Staff information, including reminders in practice supported by Floorwalker Team and through staff communication e.g. daily briefings	Spot check assurance programme identified an overall compliance score of 94%	Localised action for improvement within any ward/department with identified gaps in compliance	21.11.20 – Established uniform policy. Provision of scrubs to all staff working on COVID-19 cohort areas.
• all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household displays any of the symptoms	Staff information, including reminders in practice are supported by Occupational Health, Floorwalker Team and through staff communication e.g. Intranet resources, daily briefings		Spot check assurance programme identified an overall compliance score of 100% - current actions to continue to support sustained compliance	21.11.20 – Established process/SOP for staff screening. If staff develop COVID-19 symptoms to inform their manager, arrange to be screened via Trust screening service and self-isolate pending screen result.
• a rapid and continued response through ongoing surveillance of rates of infection	21.11.20 – COVID-19 surveillance processes established and maintained by a collaborative of the			

transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals	Business Intelligence and IPC Team. Surveillance process identifies community/hospital cases with escalation/incident reporting process for all hospital onset cases.			
• Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	21.11.20 – Process established for SBAR investigation of all hospital onset COVID-19 cases. All cases linked to a declared outbreak reviewed as part of an enhanced outbreak investigation process.			
• robust policies and procedures are in place for the identification of and management of outbreaks of infection	21.11.20 – Robust surveillance system in place within the IPC service for the identification of outbreaks. Management of outbreaks led by the Associate Director for IPC /Lead Infection Control nurse and IPC Doctor utilising PHE COVID-19 IPC guidance.			

6. Provide or secure adequate isolation facilities				**7.**
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**	
Systems and processes are in place to ensure:				
• restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	21.11.20 – Trust escalation strategy to maintain COVID-19 cohort areas within a dedicated area of the Trust. Including restricted access at entrance/exits of dedicated area.	Standardisation of pathway terminology across the organisation. ('Hot/Cold' zones in the ED).	Established process within the ED for identification and segregation of suspected COVID-19 and non-suspected cases.	
• areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	21.11.20 – Established red/amber/green zones with appropriate door signage in place across inpatient clinical areas.			
• patients with possible or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	Process in place to triage patients who have confirmed COVID-19, are suspected to have COVID-19 (high suspicion or low suspicion), patients who are shielding or vulnerable and patients who have no COVID-19 risk factors, to	Spot check assurance programme identified an overall compliance score of 52% for isolation in a single room with clinical wash hand	Challenges with resources (infrastructure) to achieve compliance – insufficient single rooms with required en-suite Patients are cohorted by identified risk group, single rooms prioritised for immunosuppressed patients, clinically extremely vulnerable	21.11.20 – Action – Estates to provide assurance of Trust strategy for infrastructure/capital refurbishments plans to increase appropriate single room facilities.

	support decision making for bed allocation.	basin and en-suite facilities Other wards with non-COVID-19 bays may have confirmed COVID-19 positive and/or suspected cases in single rooms	patients (shielding) or patients with another increased risk factor	Established process to isolate/cohort suspected COVID-19 cases. Single rooms prioritized for patients assessed as vulnerable – patient status flagged and tracked via teletracking.
• areas used to cohort patients with possible or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	The Trust does not currently have a standard 2m separation between patients in all areas Privacy curtains/screens are not currently used routinely as indicated, as these would obscure patient visibility There is no thoroughfare through any of the identified cohort wards/areas after leaving the main access corridor	Spot check assurance programme identified an overall compliance score of 38% with standard 2m separation Spot check assurance programme identified an overall compliance score of 96%	Action required to consider how the standard 2m separation may routinely be achieved, plus options for alternative screens that will not obscure visibility and will continue to support use of privacy curtains when required for care activity Request for Capital monies through national process submitted to fund separation screens to support this action. Localised action for improvement within any ward/department with identified gaps in compliance	21.11.20 – Action – Estates leading on project to procure and install 'clear' screens across all clinical areas. Recommend process is expedited to provide additional mitigation against the risk of nosocomial transmission of COVID-19.

• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Established systems and processes remain in place for patients with a resistant/alert organism, to ensure risk assessment for the most appropriate placement in conjunction with available resources	A number of resistant/alert organisms are taking a lower priority for isolation in a single room than previously e.g. MRSA, VRE, due to limitations on single room capacity and patients with a higher priority for isolation e.g. COVID-19 or vulnerable patient groups Spot check assurance programme identified an overall compliance score of 80% - with the gap in compliance identified as the requirement for improved documentation of infection risk	Localised action for improvement within any ward/department with identified gaps in compliance	21.11.20 - Established processes in place for patients with a resistant/alert organism, to ensure risk assessment for the most appropriate placement in conjunction with available resources

		within patient records		
8. Secure adequate access to laboratory support as appropriate				**9.**
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**	
There are systems and processes in place to ensure:				
• ensure screens taken on admission given priority and reported within 24hrs	21.11.20 – Process for screening for COVID-19 for all emergency admissions in place, with rapid screening of suspected cases. Monitoring process of screening compliance established with overall Trust compliance for admission screening (w/c 09.11.20) reported as 84%. High level of compliance (98%) demonstrated from key admission pathway are (AMU).			
• regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	21.11.20 – Action – Microbiology Laboratory to provide assurance of result reporting and specimen turnaround times.			
• testing is undertaken by competent and	As per Microbiology Laboratory SOPs and staff training records			21.11.20 - As per Microbiology Laboratory SOPs and staff training records

trained individuals				
• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Laboratory capacity supports patient testing for COVID-19 On-site staff screening process in place for identified staff groups	Process to monitor compliance with emergency admission COVID-19 screening, plus screening on day 3 and day 5 of admission, is in development	Spot check assurance programme identified an overall compliance score of 100% - current actions to continue to support sustained compliance	21.11.20 - Monitoring process of screening (day 1,day 3 and day 5) compliance established with overall Trust compliance for admission screening (w/c Established staff screening service and SOP in place.
• regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	21.11.20 – Action – Microbiology Laboratory to provide assurance of specimen testing and result reporting protocols.			
• screening for other potential infections takes place	Established processes for infection/colonisation screening remain in place		Compliance monitoring via established systems	21.11.20 - Established processes for infection/colonisation screening remain in place
10. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				**11.**
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**	

Systems and processes are in place to ensure that:				
• staff are supported in adhering to all IPC policies, including those for other alert organisms	Established IPC systems and processes remain in place, with these being strengthened by the COVID-19 response; supported by staff information, including reminders in practice by IPC Team /Floorwalker Team and through staff communication e.g. daily briefings	Assurance monitoring supported through established systems plus COVID-19 spot check assurance programme		21.11.20 – Formal monitoring of compliance with IPC policies is incorporated into the IPC departmental audit programme and the IPC Link Practitioner audit programme.
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Information received from various national teams through formal routes e.g. CAS alerts, CMO/CNO letters etc.; IPC Team receive automated PHE updates and have escalated to NHS England for a similar process to be enabled for NHSe/i updates – updates communicated via Silver Control and approved Comms routes depending on content/intended audience		Spot check assurance programme identified an overall compliance score of 100% for Floorwalker daily briefings being shared with staff - current actions to continue to support sustained compliance	21.11.20 – local and national updates co-ordinated an disseminated via Silver Control, EPRR and IPC
• all clinical waste related	All COVID-19 related clinical		Spot check assurance programme	21.11.20 – Action –

to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	waste is disposed of via 'orange' Category B waste stream. Waste is segregated at source and housed in clinical waste containers. Removed from Trust site by approved/licenced waste contractor		identified an overall compliance score of 100% - current actions to continue to support sustained compliance	Facilities to provide assurance of compliance with waste management guidelines.
• PPE stock is appropriately stored and accessible to staff who require it	PPE is appropriate stored and availability to all areas is coordinated through Silver Control and the Supplies Department	Spot check assurance programme identified an overall compliance score of 87% for appropriate storage of PPE, due to a temporary challenge with plastic aprons being supplied via PUSH in flat packs – not able to use usual ward/department based dispensers for these – this has now been resolved	Spot check assurance programme identified an overall compliance score of 100% for accessibility - current actions to continue to support sustained compliance	21.11.20 – Central process and access to PPE maintained and co-ordinated through Silver Control and the Supplies Department.

12. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**13.**
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**	
Systems and processes are in place to ensure:				
• staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	Local risk assessments for staff have been developed, with staff allocated to appropriate areas, guided by risk assessment outcomes	Consistency of application of risk assessment and changes to risk assessment as more national guidance is provided requires regular updating and communication to staff and managers	Regular briefings are provided to staff and work to develop an electronic RA tool will provide central oversight to identify gaps and allow for identification of emerging issues.	21.11.20 – Co-ordination by Workforce Planning of staff risk assessment with staff allocated/redeployed to appropriate areas, guided by risk assessment outcomes.
• that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff	21.11.20 – Co-ordination by Workforce Planning in collaboration with Occupational Health to ensure appropriate staff risk assessment is undertaken with staff allocated/redeployed to appropriate areas, guided by risk assessment outcomes.			

• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	Staff PPE training is routinely supported by the IPC Team, Floorwalker Team, Fit Testing Team, daily briefing messages, posters, screensavers, FFP3 fit testing programme		Reuseable respirators are not currently in standard use; however introduction is planned through a phased programme within identified areas and an associated training programme, including record keeping, is in development to support this (initially within ICU)	
• staff who carry out fit test training are trained and competent to do so	21.11.20 - Strategic and operational management of Centralised FFP3 fit testing service led by a collaborative of EPRR and Silver Control.			
• all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	As above.			
• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation	21.11.20 – A review of the ESR staff fit testing record is being undertaken by Silver Control			
• for those who fail a fit test, there is a record given to and held by	As above - 21.11.20 - A review of the ESR staff fit testing record is being			

trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	undertaken by Silver Control. Strategic and operational management of Centralised FFP3 fit testing service led by a collaborative of EPRR and Silver Control.			
• for members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	As above - 21.11.20 - Strategic and operational management of Centralised FFP3 fit testing service led by a collaborative of EPRR and Silver Control.			
• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health	21.11.20 - Strategic and operational management of Centralised FFP3 fit testing service led by a collaborative of EPRR and Silver Control.			
• following consideration of reasonable adjustments e.g. respiratory hoods,	21.11.20 - Strategic and operational management of Centralised FFP3 fit testing service led by a			

personal re- usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	collaborative of EPRR and Silver Control. Strategy in relation to use of powered respirators and reusable masks in development.			
• boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	As above - 21.11.20 - A review of the ESR staff fit testing record is being undertaken by Silver Control. Strategic and operational management of Centralised FFP3 fit testing service led by a collaborative of EPRR and Silver Control.			
• consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways	For nursing, Centralised Nursing Workforce Team in place. This 'hub' supports safe deployment of staff, tracks movements, staff absences and screening. Medical Staffing team in place to support medical staff deployment.	Spot check assurance programme identified an overall compliance score of 81%	Planned/elective pathways and urgent/emergency pathways established in a number of areas – identified that staff are moved between areas of the Trust as staffing levels do not always support dedicated teams of staff for identified areas – this is risk assessed	21.11.20 - For nursing, Centralised Nursing Workforce Team continue to support and facilitate safe deployment of staff, tracks movements, staff absences and screening. Medical Staffing team

between planned and elective care pathways and urgent and emergency care pathways, as per national guidance				continue to support medical staff deployment.
• all staff adhere to national guidance on social distancing (2metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	Staff information, including reminders in practice supported by Floorwalker Team and through staff communication e.g. daily briefings Staff routinely wear a face mask in all areas of the Trust, both clinical and non-clinical areas, as per updated national guidance	Spot check assurance programme identified an overall compliance score of 90% with social distancing	Localised action for improvement within any ward/department with identified gaps in compliance	21.11.20 – Trust protocol for all staff to wear facemasks at all times (unless in single occupancy office with the door closed). Review of staff rest areas to be expedited to ensure compliance with 2 metre social distancing when staff attend rest areas.
• consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas		Spot check assurance programme identified an overall compliance score of 90% with social distancing	Localised action for improvement within any ward/department with identified gaps in compliance	21.11.20 – Action – A review of staff break times is required to mitigate the density of healthcare workers in specific rest areas
• staff absence and well-being are monitored and staff who are self-	Staff information on wellbeing and how to access testing is supported by managers, Occupational			21.11.20 - Staff wellbeing and how to access testing continually supported by

isolating are supported and able to access testing	Health, Floorwalker Team and through staff communication e.g. Intranet resources, daily briefings Staff absence is routinely monitored through eRoster/ESR			managers, Occupational Health, Workforce Planning and through staff communication e.g. Intranet COVID-19 hub, daily briefings Staff absence is routinely monitored through eRoster/ESR.
• staff that test positive have adequate information and support to aid their recovery and return to work	Staff are routinely signposted to national resources and are supported by their manager and Occupational Health Occupational Health contact individuals directly on receipt of test results and provide advice and guidance as required.			21.11.20 - Staff continue to be guided to national PHE/NHS guidance and are supported by their manager and Occupational Health Occupational Health continue to contact individuals directly on receipt of test results (during office hours) and provide advice and guidance as required. Communication of positive result (out-of hours) is facilitated by the staff test and trace system.

Countess of Chester Hospital NHS Foundation Trust

Meeting	**1st December 2020**		**Board of Directors**					
Report	**Agenda item 9**		**Quality and Safety Committee, Chair's Report**					
Purpose of the Report	Decision		Ratification		Assurance	x	Information	
Author(s)	Ros Fallon				Non Executive Director and Chair of Quality & Safety Committee			
Board Assurance Framework	Q1 Q2	Safety Quality						
Strategic Aims								
CQC Domains	Safe & Well Led							
Previous Considerations	-							
Summary	The purpose of this report is: • To provide an update on the business of the Quality & Safety Committee meetings held on 15 September and 10 November 2020							
Recommendation(s)	The Board is asked to**:** • Note the contents of the Quality and Safety Committee Chair's Report • Ratify the following items considered by the Quality and Safety Committee: o Nursing Bi annual Safe Staffing Assurance Report (January to June 2020) o Director of Infection Prevention and Control Annual Report 2019/20 o Continuous Improvement Strategy o Quality Accounts 2019/20							
Corporate Impact Assessment								
Statutory Requirements	The Quality & Safety Committee is established as a formal committee of the Board of Directors to provide assurance							
Quality & Safety	Improved patient safety							
NHS Constitution								
Patient Involvement								
Risk	Quality &Safety Risks are considered by the Quality & Safety Committee							
Financial impact								
Equality & Diversity								
Communication								

CHAIR'S REPORT
QUALITY & SAFETY COMMITTEE

1. Purpose

The purpose of this report is to provide the Board of the Countess of Chester NHS Foundation Trust with an overview of key items of business discussed at the Quality and Safety Committee on 15 September and 10 November 2020. Due to Covid restrictions the meetings were undertaken via Microsoft Teams.

15th September 2020

2. Outstanding items from previous meetings

- The new Emergency Planning Officer is now in post and will bring regular updates to the Quality and Safety Committee.
- Temperature monitoring – this item was a CQC recommendation. The system hardware has been ordered and is with the supplier however delivery has been delayed due to Covid 19. The Executive Medical Director confirmed he would work with the Chief Digital Information Officer to progress this issue. It was confirmed that discussions had taken place with the CQC assessor who was in agreement with actions being taken. It was suggested that this agreement be confirmed in writing from the CQC.

3. Quality Governance Group (QGG) Chair's Report

The committee received an overview of the report and key items of discussion included:

- Audit of resuscitation trolleys to commence in October
- Patient ward moves will continue to be monitored
- Changes to documentation for NEWS 2 to be communicated across the Trust
- Action plans in place for wards accredited as 'inadequate'
- A programme of work is underway to simplify the referral process to the Safeguarding Team

4. Nursing & Midwifery Safe Staffing Report

The committee received an overview of the report and key items of discussion included:

- Work undertaken to improve staffing levels despite there still being some gaps
- 20 international nurses now in post. This is one of three cohorts that will fill 55 vacant posts.
- 30 aspirant nurses have been retained
- It is anticipated that the Trust will have filled its vacancy gap by April 2021
- There has been investment in five ward areas and in the emergency and urgent care pathway
- People issues to be discussed further at a Board workshop in December.

5. Quality Account & Quality Priorities

The committee received an overview of the report and key items of discussion included:

- 'Sepsis antibiotic administration within 1 hour' and 'reduction in Health Care Acquired Infection' metrics had failed to achieve their target and would be included in the 2020/21 priorities.
- Other improvement priorities for this year included increasing discharges across 7 days, reducing face to face follow up outpatient appointments, an integrated approach to safeguarding, improving the ward accreditation baseline and creating a Lived Experience Panel.

The committee reviewed the 2019/20 Quality Account, accepted the key priorities identified for 2020/21and suggested some refinement to the report. The committee also suggested that the report be returned to the committee prior to submission to the Board of Directors for ratification.

6. Research & Innovation Update

The committee received a verbal update that work is underway to ensure research and innovation is resumed and that Dr Peter Bamford has recently been appointed as the Clinical Research Director.

7. Pressure Ulcers Quarterly Update

The committee received a progress report following the Pressure Ulcers Deep Dive noting that the action plan has been updated with revised timescales. The Cheshire and Merseyside Pressure Ulcer Policy has been launched and audits of compliance are taking place. It was noted that there is some confidence that September timescales will be achieved and it was anticipated that education and training would be completed on schedule. The Deep Dive will be repeated in December to provide assurance that recommendations are embedded in practice.

8. Policy for Listening & Responding to Concerns and Complaints

The committee considered the contents of the policy. It was noted that the mechanism to obtain feedback on the complaints process is still being considered although the mechanism for safeguarding concerns is included as is the mechanism for financial redress. The committee ratified the policy.

9. Annual Decontamination Report

The committee received an overview of the report and assurance was provided on decontamination compliance against national standards. An interim appointment has been made to the role of Associate Director of Infection Prevention and Control and their portfolio would encompass decontamination. Further discussion included:

- The Director of Nursing intends to bring ward based cleaning, facilities work and decontamination within her portfolio of Director of Infection Prevention and Control to ensure that any gaps are identified and resolved.

- Mitigation is in place against the risks although further clarity will be sought

It was noted that the report required some amendments to risk ratings and it was agreed that the report would return to the next committee.

10. Director of Infection Prevention & Control Annual Report 2019/20

The committee received an overview of the report and it was noted that full compliance had not been achieved although the following actions are ongoing:

- Robust programme for audit, surveillance and investigation for early risk identification
- Additional cleaning requirements as a result of Covid 19
- Antimicrobial workstreams
- Accessibility of information for service users and visitors
- Adequate isolation facilities
- Adherence to policies.

Consideration is being given to how compliance assurance will be provided. It is anticipated that risks will be managed appropriately through increased numbers in the Infection Prevention and Control team and strengthened leadership through the Interim Associate Director of Infection Prevention and Control. The Trust contributes to the Cheshire wide work and this also will be strengthened as a result of the new team structure as will roll out of the high impact intervention monitoring.

11. Integrated Performance Report – July 2020

The committee reviewed the same Integrated Performance Report that had previously been reviewed by the Board of Directors however focused on quality and safety matters. Key items for discussion included:

- Harm reviews are scheduled with the Clinical Commissioning Group in relation to cancer patients waiting beyond the constitutional standard
- Reduced referrals that may be due to reticence by the public to come to a care setting
- A trajectory has been developed however there are still concerns for endoscopy, breast, urology and skin. The trust is working with NHSE/I to reduce the trajectory

12. Continuous Improvement Strategy

The committee received the Strategy and key items for discussion included:

- Feedback received from staff engagement sessions focussed on a priority to address lean training and this is due to be rolled out
- Quarterly progress report to be received by the committee with a bi annual report to the Board of Directors
- Resource to deliver the strategy.

13. Review of terms of reference of Quality & Safety Committee and Quality Governance Group

The terms of reference were reviewed and ratified although membership to be considered to ensure the right balance of executive and non executive attendance.

10th November 2020

14. Outstanding items from previous meetings

- EPRR now sits within the portfolio of the Chief Operating Officer. Whilst the work is progressing it was agreed that the update would be deferred to the next meeting.
- Equipment for temperature monitoring for drug fridges is still an outstanding action following the CQC recommendations. There is an issue with coordinating contractors on site with IM&T support during the pandemic. It was agreed that the Director of Pharmacy and Medicines Management would secure an on site date with the contractor and the Executive Medical Director would liaise with the Chief Digital Information Officer to secure IM&T resource. Both actions were due to be implemented within 48 hours. There has been subsequent follow up of this action and the Director of Pharmacy, Executive Medical Director, Director of Nursing & Quality and Chief Digital Information Officer met on 18 November resulting in an agreed action for the Chief Digital Information Officer to make an assessment of when the support for the project will be available, and to identify dates when the work can proceed. The output of this assessment is awaited.

- Whilst the risks within the Annual Decontamination Report had been reviewed by the divisions, the ratings had not been altered within the report. It was noted that the majority of urgent equipment had been procured and awaiting delivery. The risk register will be update to reflect this.

15. Covid-19 Update Report

The committee reviewed the report and key items for discussion included:

- The approach to Infection Prevention and Control and the current Trust and regional position.
- 3% Covid related nurse absence requires balancing on a daily basis.
- Outbreaks within the Trust were at a similar level to other local Trusts.
- Staff across the Trust are working together to make pathways safe
- Daily regional Critical Care calls are in place alongside Trust level Command and Control calls.
- Communication with relatives – families have mostly been accepting of the restrictions and used technology where possible.
- Caring for patients at end of life has been difficult however there has been daily contact and most responses have been positive.

- It was noted the great effort from all staff and thanks to staff were expressed from the committee.
- Death rates from Covid 19 are difficult to assess however the Trust outcomes appear to have a lower death rate compared to national figures. Work is ongoing with Dr Foster and will be reported to the Learning from Deaths Group.

16. Complaints, Litigation, Incidents & Coroners (CLIC) Report

The committee reviewed the report and key items for discussion included:

- Where possible the Trust is responding in normal timeframes
- Coroners cases have been paused since the onset of Covid 19. Work is ongoing to support families and staff through this delay
- Compliments are reported through a 'Greatix' measure on Datix. These are shared widely and reported through Governance Boards
- It was recommended that a more detailed discussion take place within a future Board development session

17. Safe Staffing during Covid-19 In-Hospital Cell

This report set out the minimum safe staffing levels required during the Covid 19 pandemic that has been agreed by all Directors of Nursing across Cheshire and Merseyside. Key discussion items included:

- Whilst the Trust has experienced significant challenges over the last weeks it has not reduced staffing levels to those described in the report
- Current success in recruitment
- Units around the region are flexing in and out of Guidelines for the Provision of Intensive Care Services (GPICS) standards. This is being addressed at the Trust on a shift by shift basis however it is a real team effort and some staff who have previously left Intensive Care have returned
- Current staffing levels on the general wards are at an acceptable level
- Ward Accreditation Programme has been maintained throughout Covid 19. Work is ongoing to monitor metrics alongside staffing levels

18. Integrated Performance Report – Sept 2020

The committee reviewed the report and key items of discussion included:

- Continued improvement in Sepsis screening and treatment alongside improved position with peers. Thanks were expressed to Liz Kanwar, Quality Governance Manager and Dr Michelle Tinker, Clinical Lead for Sepsis.
- HSMR has increased with Covid 19 data although SHMI has remained the same or within the expected range.

- HSMR is usually observed within a peer group however it should be a different peer group for Covid 19. Dr Foster has assisted the Trust in identifying a different peer group for Covid 19 and all trusts within the group are seeing a similar increase. Dr Foster do not consider the Trust as vulnerable. This is an ongoing detailed piece of work and the committee expressed thanks to Dr Michelle Green and the team interrogating the data.
- Whilst all falls increased this month it remains within the control limit however falls with harm were outside the control limit. Work is ongoing to drill down into the data. Audits on risk assessment on admission have shown an improvement however there are still issues with recording lying and standing blood pressure. Monthly data is being shared with the wards. Each ward has its own metrics that are aligned to the Ward Accreditation Programme. There is still work to be done on education and training and a falls group is being re established. All falls investigations are correlated against staffing levels.
- A further Deep Dive into falls is due to take place in December
- Pressure Ulcers on admission whilst still high, appear to have had a reduction. Work has commenced to identify where patients with pressure ulcers have been admitted from, although this has not yet been concluded.
- Internal monitoring of pressure ulcers is ongoing and a group is to be re established. The group will also consider compliance with the Cheshire and Merseyside Policy.
- A reduction in serious incidents was noted possibly due to Covid 19 pressures however this is now improving. Ward Accreditation provides assurance around the safety of care on the wards. Many factors affect incident reporting and it was suggested that a future Board development session could review this in detail.
- The quality of reporting and use of a Just Culture is to be addressed
- Appraisals for Medical Staff is progressing as usual
- Work is underway to strengthen staff induction and mandatory training
- Patients waiting beyond standard waiting times are an area of concern. All patients have been contacted to discuss risks and review. Some patients continue to be reviewed virtually and opportunities for Trust mutual aid are being explored
- No planned activity has been cancelled during the current wave of Covid 19.
- Whilst the Trust has staff capacity and patients willing to attend, then planned activity will continue
- Endoscopy is an area of concern and patients are being contacted to review symptoms

19. Due to operational pressures on 10th November, the following items were deferred:

- Learning From Deaths Update
- Mortality Indicators Report
- Health & Safety Annual Report
- Clinical Audit Annual Report
- Clinical Audit Strategy
- Terms of Reference of Quality and Safety Committee
- Updated business cycle

20. Recommendations

The Board is asked to:

- Note the contents of the Quality and Safety Committee Chair's Report.

- Ratify the following items considered by the Quality and Safety Committee:
    - Nursing Bi annual Safe Staffing Assurance Report (January to June 2020)
    - Director of Infection Prevention and Control Annual Report 2019/20
    - Continuous Improvement Strategy
    - Quality Accounts 2019/20

Meeting	**1st December 2020**		**Board of Directors**					
Report	**Agenda item 10**		**Finance & Performance Committee Chair's Report**					
Purpose of the Report	Decision		Ratification		Assurance	x	Information	
Author(s)	Andrew Higgins				Non-Executive Director			
Board Assurance Framework	People, Effectiveness & Partnership							
Strategic Aims	-							
CQC Domains	Well Led							
Previous Considerations	Finance & Performance Committee meetings, 22nd September & 17th November 2020							
Summary	The purpose of this report is to inform board members of matters discussed by the Finance & Performance Committee and to provide assurance on these matters.							
Recommendation(s)	The Board is asked to note the contents of this report and the matters approved, ratified and discussed by the Committee in its two latest meetings.							
Corporate Impact Assessment								
Statutory requirements	**-**							
Quality & Safety	**-**							
NHS Constitution	**-**							
Patient Involvement	**-**							
Risk	**-**							
Financial impact	The Committee considers the financial position of the Trust							
Equality & Diversity	**-**							
Communication	Paper to be available on the Trusts' website							

NHS
Countess of Chester Hospital
NHS Foundation Trust

1.0 Key items of business discussed

The Finance & Performance Committee met on 22nd September & 17th November, 2020. This report covers both meetings.

2.0 17th September - Major matters arising, key agreements or decisions made

2.1 The Committee approved the minutes of the meeting held on 30th June and reviewed the action log to ensure that actions are receiving appropriate scrutiny.

2.2 The Committee noted the report of the Finance & Performance Working Group, highlighting an update report on the Capital Programme and continuous discussions on the challenges arising in maintaining adequate cyber security.

2.3 The Committee noted the report of the Transformation Group (TG). Attention was drawn to the programme currently underway to embed the Quality Improvement culture throughout the Trust (Lean for Leaders) and the new Space Utilisation Programme being developed. It was also reported that the first draft of the Trust's Corporate Strategy has been completed. Discussion took place around the major programmes being undertaken by the Group and it was agreed to take a presentation on Outpatient Improvement at a future date. **The Committee noted the delivery of the 2020 Transformation Programme to date and the request to give an update on Outpatient improvement at a future Committee meeting.**

2.4 The Integrated Performance Report for July was reviewed, with particular attention on performance on key targets and work currently in hand to maintain cancer performance at the highest levels possible in the current circumstances. Pressures on our workforce were highlighted and the risks presented by a further Covid-19 peak. The Committee also discussed the need to reconcile the competing demands, expectations and messages within the system. The Committee recognised the need for the Board to support Executive Directors in their roles and decision-making, and for the Board to be especially clear about Trust priorities. **The Committee received the July Integrated Performance Report.**

2.5 The Finance report for Month 5 was reviewed, highlighting the increasing medical and nursing costs starting to emerge and the financial impact of performance in the current year compared to 2019/20. Discussion took place on the complexities of the developing financial regime and the new guidance expected in September. It was acknowledged that additional funding is being placed into the system and that this allocated on a top-down basis. Continuing updates will be provided to enable the Board to be aware of emergent pressures and requirements. **The Committee noted the Month 5 Finance Report.**

2.6 The Chief Digital Information Officer (CDIO) provided a verbal update on the EPR programme. Due to constraints arising from the pandemic, the programme was moving into a hibernation phase. Additional resources have been secured and a newly installed programme Director will be assessing the "go/no go" position for 7th October. Extensive discussion took place on key aspects of the programme and risks arising therefrom. Assurance was provided that the Committee and Board will be updated on the "go/no go" position and any high risk items will be escalated as appropriate. **The Committee noted the verbal Electronic Patient Record update.**

2.7 The Equality, Diversity & Inclusion Annual Report was presented and discussed. It was noted that the report indicates the plans needed to support the Trust's future workforce, brings together the Workforce Race Equality Standard (WRES) Report and The Workforce Disability Equality Standard (WDES) Report, includes the Gender Pay Gap Report 2020, and includes patient data and ONS data. The action plans for WRES and WDES address the actions required and were currently being updated following feedback from the last Board of Directors meeting. **The Committee noted the report and approved its publication on the Trust's website.**

2.8 The Director of Human Resources and Organisational Development provided a full update on the 2020/21 Flu Campaign, including the aim of vaccinating 100% of staff. **The Committee approved the flu delivery plan and best practice checklist; considered initiatives to supplement existing activities; and noted that funding and peer vaccinator enablement was covered at last year's expenditure level.**

2.9 The Committee considered the first report from the Director of Medical Education, highlighting the response to the Covid-19 challenge and the decision to stand down traditional education activity at the Trust. **The Committee considered the key points from the report and approved it.**

2.10 The Chief Operating Officer provided an overview of the 2020/21 Winter Resilience Plan and referred to the integrated working arrangements within it, which are deemed to be robust in relation to future EPR and Covid-19 challenges. The plan was discussed and the key risks around it were debated. Advanced Continuing Health Care capacity/placement was identified as a risk, as there has been a significant backlog to resolve and the care home element is providing delays. It was also highlighted that Wales contributes approximately half of the Trust's long term patients, and further discussions were required around this. **The Committee considered and noted the contents of the winter resilience plan.**

3.0 17th November - Major matters arising, key agreements or decisions made

3.1 Because of operational pressures within the hospital, a late decision had been made to reduce the length of the meeting. As a result, the ordering of agenda items was changed; certain items were taken for noting; and certain matters transferred to Audit Committee for further consideration.

3.2 The Integrated Performance Report for September was reviewed, concentrating on the Responsive and Well Led sections. The Chief Operating Officer highlighted the priorities of achieving the optimum diagnostics performance and of improving 31 day cancer performance. Work to achieve phase 3 trajectories was currently being conducted when Covid patient numbers occupy one third of the Trust's bed stock. Discussions were to take place that day with NHSI/E on how they can support improvement in the recovery trajectories achieved. It was emphasised that, among all current pressures, the balance of risks and level of potential harm was under continuous review by clinicians. **The Committee noted and received the September Integrated Performance Report.**

3.3 The Director of Human Resources and Organisational Development presented a report on absence management, May to October 2020. The Committee noted that ordinary absences are running at around 3.4% but that we have a further 3% Covid related absences. Discussion took place on arrangements to support staff in such stressful circumstances and to maintain delivery of services. **The Committee noted the Absence Management Report.**

3.4 The Committee also considered the Urgent Care Business Case, setting the key aspects of providing a Same Day Emergency Care facility adjacent to the Emergency Department. The benefits to safety and quality, efficiency, and patient experience were noted, together with the trust-wide involvement in the project. Above all, it was emphasised that this is a clinically led project. **The Committee welcomed the very positive nature of the business case presented and noted its support of this important project.**

3.5 **The Committee noted the report of the Transformation Group.** Among matters reported were the Trust Clinical Strategy moving to business as usual; progress made on the development of the Trust Corporate Strategy; the implementation of the Trust Continuous Improvement Strategy; an update on the development of the Space Utilisation work stream and process improvement workstreams; and an overview on the potential next steps for the Trust's transformation programme.

3.6 The Finance report for Month 6 was reviewed, accompanied by a verbal update on the financial regime for the second half of the year. The true-up for month 6 was £2.3m, reflecting the recognition of a medical pay award and increasing nursing agency costs (reflecting higher activity levels). The key risks were discussed, in particular the capital programme and future funding of Welsh activity. The Director of Finance (DoF) outlined the regime for the second half year split between deficit, restoration and Covid funding. Given current operational pressures it was recognised that delivery against the Phase 3 plan represented an immense challenge and that meeting planned amounts of restoration and Covid costs was subject to significant uncertainty. It was understood that this is acknowledged centrally and that the key objective was to achieve a "net neutral" position on outturn for the second half. **The Committee noted the Month 6 Finance Report.**

3.7 The DoF also presented a workforce report at month 6 that set out the movements in staffing over the first half of the year and how these relate to the Phase 3 plan submitted. Movements reflected the Nursing Establishment review conducted last year and it was noted that the trust currently has a relatively positive staffing position albeit subject to significant pressures that are constantly monitored. The Committee welcomed the clear connection between workforce and financial data and requested that such reporting be continued to assist in understanding cost pressures arising. **The Committee noted the workforce report.**

3.8 The Chief Digital Information Officer presented a status report on the EPR project that included the "go" decision as the gateway had been successfully passed on 16th October. The overall status of the programme is amber and it was reported that the one red RAG status (Medicines Management) had moved to amber after finalisation of the report. The Committee noted governance now in place over the project and discussed the performance of project partners, contingency and the financial impact of implementation. **The Committee noted the report and the "go" decision.**

3.9 **The Committee noted the Governance Improvement Plan update.**

3.10 The Director of Human Resources and Organisational Development presented Terms of Reference for the Strategic Workforce Group and the Education Governance Group. It was agreed that the Strategic Workforce should be amended to include the group's responsibilities on diversity and inclusion; otherwise, both terms of reference were accepted as presented. **Subject to the amendment noted, the Committee ratified the Terms of Reference.**

4.0 Items for escalation to Board

- The Board is asked to note the contents of this report and the matters approved, ratified and discussed by the Committee in its two latest meetings.

Meeting	**1st December 2020**		**Board of Directors**					
Report	**Agenda item 11**		**Finance Report – Month 07, October 2020**					
Purpose of the Report	Decision		Ratification		Assurance	X	Information	X
Accountable Executive	Simon Holden				Director of Finance			
Author(s)	Simon Holden Clare Barrow				Director of Finance Deputy Director of Finance			
Board Assurance Framework	E1	Underlying Long Term Trust Financial Sustainability						
Strategic Aims	Providing efficient and financially sustainable services.							
CQC Domains	Safe, Caring, Responsive, Effective & Well Led.							
Previous Considerations	n/a							
Summary	**The purpose of this report is:** • To provide details of the Trust's financial position, as at 31st October 2020 (Month 07) and the revised financial regime for months 7-12 2020/21.							
Recommendation(s)	**The Board is asked to note:** 1. The change to the financial regime for Months 7 to 12 (October 2020 to March 2021); including the requirement to not exceed an adjusted outturn deficit position of £5.2m; 2. The requirement to manage the Trust's funding from the three different funding streams (i.e. Underlying Deficit, Covid Monies and Restoration Costs) on a "net neutral" basis; 3. The £0.4m adverse variance reported for October 2020 (Month 07) against the Trust's allocation; 4. The £0.6m favourable variance reported for October 2020 (Month 7) when taking into account the adjusted outturn deficit position of £5.2m for six months, being £1.010m for October alone; 5. That the Elective Incentive Scheme (EIS) has not been accrued for, and if applied will only be applied at a Heath & Care Partnership level 6. The following key risks in not exceeding the adjusted outturn deficit of £5.2m, namely that • Actual expenditure exceeds planned levels, as the Plan was based on the underlying assumption that the reproductive number R=1 • That Restoration activity is controlled within the envelope available,							

	• No Elective Incentive Scheme penalties are applied at a local level, due to activity falling below 90% (noting no accrual made in Month 7 consistent with NHSE/I expectations); and • That Income from Wales is maintained in line with the agreed planning assumptions.
Corporate Impact Assessment	
Statutory Requirements	Meets the Trust compliance with Foundation Trust Status
Quality & Safety	Seeks to address Quality & Safety issues across the Trust.
NHS Constitution	n/a
Patient Involvement	n/a
Risk	There is an overarching risk that the Trust may lose financial control if governance standards are reduced. There is a risk the planned deficit of £5.2m will be exceeded if operational plans are required to change in response to 2nd wave of Covid. There is a risk regarding the uncertainty of income for cross border patient charges, due to the ongoing discussion with NHSE/I and the Welsh authorities at a national level.
Financial impact	Control total of £5.2m challenging due to risk and uncertainty of continuing financial impact of the 2nd wave.
Equality & Diversity	n/a
Communication	This report can be communicated publically.

Financial Performance October 2020 (Month 7)

Executive Summary

The temporary financial regime put in place nationally from 1st April 2020 (Month 01) to 30th September 2020 (Month 06) has now ceased, resulting in a change to the previous "top-up" arrangements.

A revised financial regime based on system level "Control Totals" has effectively been introduced for the remainder of the financial year (Month 7-12); requiring the Trust to operate within a financial envelope delegated by the Cheshire & Merseyside Healthcare Partnership (HCP).

The new financial regime signifies no return to Payment by Results, with block contracts continuing for NHS Providers in England. Funding has been delegated by NHSE/I to local "systems" made up of 3 core elements, plus a variable source of funding linked to Elective Activity performance, namely:

- Block - Deficit funding - (£11.9m)
- Block - Covid funding – (£7.6m)
- Block - Growth funding (including Winter & Restoration) – (£0.9m)
- Variable - Elective Incentive Scheme - a withdrawal, or increase of funding at a marginal rate depending of the level of Elective activity delivered.

The additional funding is based upon expenditure during November 2019 - January 2020 (i.e. Months 8,9 &10 prior year) with Covid and Growth allocated proportionally across the system based on average expenditure for Months 1 to 6 of the current financial year.

Taking the above funding arrangements into account, the Trust submitted a deficit against this plan of £5.2m (M7-12) which it will now be monitored against by the regulator NHS Improvement & England in year. The Plan was based on operational planning assumptions prior to the 2nd wave of Covid, which assumed a reproduction rate of R=1.

The October 2020 (Month 7) position reported to NHSE/I is a favourable variance of £650k against the revised in-month deficit of £1.010m (£5.2m for M7-12). However, this is a further £360k deficit in month when compared to the original planned deficit.

The main cause of the improved position, is lower than expected Restoration & Winter costs.

The Elective Incentive Scheme (EIS) has not been accrued for, and if applicable will be modified at a system level to take account of Covid cases.

There is an underperformance on activity of 100,945 units up to month 7, equating to an income shortfall of £29.8m; However, due to the suspension of PbR Contract performance adjustments will not be made in year. The activity trend graphs show an upward trend for all points of delivery over the last six months, with local trajectories lower than the national expected trajectory;

The Cash funding, & Cash balances held of £34.8m as at 31st October 2020.

A separate paper will be presented to the Trust Board regarding the current Capital position.

Finance Report - October 2020 (Month 07)

1.0 Background

In response to the global pandemic of Covid 19 (and as described previously), the Operational Planning and Contracting Process for 2020/21 and Payment by Results (PbR) mechanism has been formally suspended nationally.

To reiterate, these interim arrangements were put in place to cover the period 1st April to 31st July 2020, but were extended to 30th September 2020.

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The simplified financial arrangements from October 2020 (Month 7) to March 2021 (Month 12) have been released, and are based upon the principles of system allocations, performance and management of risk. There is no return to Payment by Results and block contracts will remain in place for all NHS English providers until the end of the financial year.

For the Trust, this means that NHS funding has been allocated to the Cheshire & Merseyside Health & Care partnership (HCP) with three pots of block funding available and one variable source of funding:

- Block deficit funding (£11.9m allocated)
- Block Covid funding (£7.6m allocated)
- Block growth funding (Including Winter & Restoration) (£0.9m allocated) and
- The withdrawal or increase of funding at a marginal rate (25% underperformance & 75% over performance) depending of the level of Elective activity delivered (Elective Incentive Scheme).

Despite the level of funding allocated to the Trust, based on the latest assumptions, the Trust submitted a deficit plan of £5.2m on 18th November 2020 and it is this figure that the Trust will be monitored against by the regulator NHS Improvement & England. The table below outlines the additional funding sources received from M1-7 which to be managed on 'net neutral' basis:

Funding Category	Original Plan M7-12	Allocation Received/Adjustment	Surplus/(Deficit)
	£000s	£000s	
Underlying Deficit	8,921	11,931	3,010
Covid	9,453	7,638	(1,815)
Growth (Restoration)	5,116	921	(4,195)
Winter	1,371	-	(1,371)
Holiday Pay Accrual*	2,042	1,193	(849)
Total	**26,903**	**21,683**	**(5,220)**

*Holiday Pay Accrual reduced by £1.193m to £849k after applying methodology consistent with C&M HCP Providers

2.0 Financial Summary

The table below shows the October 2020 (Month 7) cumulative financial position under the current interim arrangements as reported to NHSE/I:

Financial Plan as per NHSI/E Template	October	October	October
	NHSI/E Plan	Actual Expenditure	Variance
	£k	£k	£k
Clinical Income	141,511	141,408	(103)
Non Clinical Income	4,330	4,333	3
Total Income	**145,841**	**145,741**	**-100**
Pay Expenditure	116,559	116,048	(511)
Non Pay Expenditure	49,044	48,804	(240)
Total Expenditure	**165,603**	**164,852**	**-751**
Operating Surplus / (Deficit)	**(19,762)**	**(19,111)**	**651**
Finance Income	12	11	(1)
Finance Expense	(444)	(444)	0
PDC	(867)	(867)	0
Total Finance Costs	**(1,299)**	**(1,300)**	**(1)**
Other gains / (losses) inc disposal of assets	(58)	(58)	0
Deficit Prior to Top Up	**(21,119)**	**(20,469)**	**650**
Projected Top Up (M1-M6)	9,660	9,660	0
Projected True Up / Retrospective Top Up (M1-M6)	7,059	7,059	0
Deficit / Growth / Covid Funding (M7-M12)	3,416	3,416	0
Net monthly surplus / (deficit)	**(984)**	**(334)**	**650**
Remove capital donations/grants I&E impact	**(26)**	**(26)**	0
Adjusted Financial Performance	**(1,010)**	**(360)**	**650**

***Please note the above table may contain roundings.*

The table above shows that against a planned deficit of £1,010k as at October 2020, the Trust has delivered a deficit of £360k, therefore performing £650k better than anticipated.

The October 2020 (Month 07) position reported to NHSE/I is a favourable variance of £650k against the revised in-month deficit of £1.010m (£5.2m for M7-12). However, this is a £360k deficit in month against the original planned deficit;

The main cause of the improved position, is lower than expected Restoration & Winter costs.

The Elective Incentive Scheme (EIS) has not been accrued for, and if applicable will only be applied at a system level.

3.0 Variance Analysis

3.1 Divisional / Departmental Variances (to budget)

In the absence of the completion of the 2020/21 financial planning process, the Trust has adopted the NHSE/I Financial Plan, outlined above. The table below shows the Divisional / Departmental performance comparing actual expenditure to the 2019/20 recurrent budget inflated, for the pay award, and is provided as a comparator only. It does not currently include any adjustments for activity over, or under, performance:

Divisional Variances		OCT YTD Var	CRS YTD Var	Pressure YTD exc CRS & PBR
		£000s	£000s	£000s
Planned Care	Favourable	(1,507)	1,494	(3,001)
Urgent Care	Adverse	3,402	694	2,708
ICP	Favourable	(116)	249	(365)
D&I	Adverse	1,185	604	581
Nurse Management	Adverse	329	54	275
Corporate Services	Adverse	2,667	235	2,432
Central Services	Adverse	1,085	(932)	2,017
Covid	Adverse	12,439		12,439
Exclude Donated Asset Transactions		0		0
Total		**19,484**	**2,398**	**17,086**
Top Up M1-M6		(9,659)		
True Up M1-M6		(7,059)		
Deficit / Growth / Covid Funding (From M7)		(3,416)		
Revised Total		(650)		

***Please note the above table may contain roundings.*

The data above is line with expectation:

- Planned Care underspend due to the elective programme being largely paused;
- Urgent Care overspend due to the operational pressures felt largely within this division;
- Diagnostic and Infrastructure overspend due to loss of car parking, and Staff Restaurant income;
- Additional £12.4m costs incurred due to Covid-19 to date, further details can be found in section 4.0; and

3.2 Subjective variances (comparison of Month 06 to Month 07 expenditure)

The table below, whilst not intended to be an exhaustive list, is intended to highlight a number of the material movements in actual expenditure between September (Month 6) and October (Month 7).

Variance Analysis - selected significant movements between September 2020 and October 2020

Code	Description	M1 Actual	M2 Actual	M3 Actual	M4 Actual	M5 Actual	M6 Actual	M7 Actual	Movement M6-M7	Rationale	M1-7 YTD
		£	£	£	£	£	£	£	£		£
BE025	Medical Staff	4,564,995	4,733,488	4,522,987	4,215,367	4,385,245	4,847,935	4,431,069	(416,866)	CEAs (full annual amount) paid in M2. Medical pay award for consultant & middles grades paid in M6 relating to M1-6 £420k	31,701,085
BE060	Nursing/ Midwifery Staff	6,019,370	6,319,197	6,317,959	5,998,595	6,065,176	6,013,656	6,008,465	(5,191)		42,742,418
BE110	Admin & Clerical Staff	1,948,242	1,992,494	2,172,335	2,039,508	2,021,952	2,033,459	1,965,531	(67,928)		14,173,521
BE150	Medical (Non Nhs)	145,579	220,310	163,204	137,264	201,455	111,711	217,226	105,515		1,196,749
BE154	Nursing & Midwifery (Non Nhs)	87,494	116,300	186,066	141,079	199,227	234,568	247,321	12,753		1,212,056
Total Salaries & Wages		**16,225,684**	**16,876,487**	**16,912,363**	**16,115,921**	**16,387,328**	**16,787,042**	**16,743,464**	**(43,578)**		**116,048,289**
CE302	Drugs (Including Gases)	1,438,007	1,514,434	1,621,076	1,647,069	1,472,290	1,664,985	1,702,371	37,386		11,060,232
CE305	Med & Surg Equip - Purchases	693,910	672,917	776,107	672,255	720,664	1,388,044	1,036,723	(351,321)		5,960,620
CE312	Lab Equipment - Purchases	443,465	506,735	424,780	445,989	472,553	421,407	348,789	(72,618)		3,063,717
CE322	Contract Hotel Services	41,882	41,143	80,160	52,393	39,539	49,299	50,491	1,192		354,907
CE324	Uniforms & Clothing	409,616	98,746	142,139	377,139	(16,814)	100,859	90,983	(9,876)	PPE purchases	1,202,668
CE362	Furniture, Office & Computers	551,727	726,525	546,316	540,779	910,424	518,695	598,925	80,230		4,393,391
CE366	Building & Eng Materials	90,672	60,300	62,061	105,584	98,922	43,621	138,335	94,714		599,495
CE367	Building & Eng Contractors	123,772	75,382	65,668	159,207	109,063	99,956	47,565	(52,391)		680,614
CE368	Estates - Maint Contracts	23,764	46,798	16,992	26,443	70,612	31,869	18,461	(13,408)	Fire alarm maintenance contract payment in M5	234,938
CE390	Ext Staffing/ Consultancy Fees	161,654	139,397	253,181	173,949	103,697	285,532	333,935	48,403		1,451,344
CE396	Services Received	154,759	129,951	107,172	511,664	413,914	253,218	223,574	(29,644)		1,794,254
Total Non Pay Expenditure		**6,440,220**	**6,509,542**	**6,558,647**	**7,207,171**	**6,953,132**	**7,587,150**	**7,606,233**	**19,083**		**48,862,095**
TOTAL TRUE UP & TOP UP		**(1,896,000)**	**(2,528,000)**	**(2,953,000)**	**(2,944,000)**	**(2,515,000)**	**(3,883,000)**				**(16,719,000)**
DEFICIT / GROWTH / COVID FUNDING (From M7)								**(3,416,000)**			**(3,416,000)**

4.0 Covid Revenue Costs

The Trust is required, where possible, to identify the costs incurred as a result of Covid-19 and report it to NHS E/I. The costs identified must be “proportionate and reasonable”, and each Trust will be subject to external scrutiny. To aid this process the Trust has set up a Covid-19 specific cost centre, and by the end of October 2020 had identified £12.4m cumulative year to date expenditure as detailed in the table below:

Sum of YTD act	Column Labels		
Description	Non Pay	Pay	Grand Total
Decontamination	£ 146,306		£ 146,306
Enhanced PTS	£ 492		£ 492
Existing workforce additional shifts		£7,206,180	£ 7,206,180
Expanding medical / nursing / other workforce	£ 88,740	£ 987,279	£ 1,076,019
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	£ 1,111,111		£ 1,111,111
Other	£ 4,440	-£ 5	£ 4,435
Plans to release bed capacity	£ 803,081		£ 803,081
Remote management of patients	£ 189,297		£ 189,297
Remote working for non patient activites	£ 424,549		£ 424,549
Segregation of patient pathways	£ 21,000		£ 21,000
Testing non included in outside envelope categories	£ 410,319		£ 410,319
PPE - locally procured	£ 1,041,646		£ 1,041,646
PPE - other associated costs	£ 4,772		£ 4,772
Grand Total	**£ 4,245,752**	**£8,193,454**	**£ 12,439,207**

** *Please note the above table may contain roundings*

Please also note that costs of £1.17m relating to the hibernation of Cerner PAS implementation for the period April to August that had previously been identified against Covid have been recoded to IM&T as requested by NHSE/I.

5.0 Capital Expenditure

Due to the increasing complexity of Capital funding this year, a separate paper has been written to accompany the Board Report outlining the current position. The Trust has recently been informed that the Public Dividend Capital application for urgent and emergency spend, of £5.5m, has been approved by the Department of Health & Social Care.

6.0 Cash

In response to the Covid-19 pandemic and the interim financing arrangements, Trusts were paid one twelfth of the block income on 1st April 2020, and a further one twelfth on the 15th April thus securing Trust balances to eliminate potential cash flow issues and enable swift payments to be made to suppliers. A further one twelfth has been received monthly with a cash balance of £34.8m held as at the 31 October 2020. There is no clarity yet for the second half of the year, but NHSEI have confirmed that Trusts will be given at least two months' notice of any proposed change.

7.0 Activity Monitoring

The table below is provided for information only and compares the cumulative activity for April to October 2020, to April to October 2019 and associated income. The information is provided for comparative purposes to assist in understanding the impact Covid-19 has had on Trust activity levels. Please note due to the block contract arrangements in place during 2020/21 there will be no contract performance adjustments in year mitigating the financial loss summarised in the table below:

Point of Delivery	October 2019 YTD Activity	October 2020 YTD Activity	Activity Variance	October 2019 YTD Value at 19/20 Tariffs	October 2020 YTD Value at 19/20 Tariffs	Value Variance
Daycases	21,046	10,319	(10,727)	£13,435,458	£6,461,445	(£6,974,013)
Elective Inpatients	2,495	1,288	(1,207)	£7,196,039	£3,433,293	(£3,762,747)
Non-Elective Inpatients (exc Maternity)	18,042	14,261	(3,781)	£38,357,267	£32,733,919	(£5,623,348)
Non-Elective Inpatients - Maternity	1,495	1,484	(11)	£3,949,200	£3,930,883	(£18,317)
First Outpatients	45,567	23,239	(22,328)	£7,153,616	£3,768,031	(£3,385,584)
Follow Up Outpatients	112,988	83,838	(29,150)	£8,776,688	£6,642,595	(£2,134,093)
Outpatient Unbundled & Procedures	47,231	24,430	(22,801)	£5,573,204	£2,418,508	(£3,154,696)
Maternity	5,644	5,136	(508)	£3,385,190	£3,292,518	(£92,673)
A&E Attendances	43,599	36,439	(7,160)	£4,982,210	£4,707,165	(£275,045)
Best Practice Adj'ts	0	0	0	£414,911	£290,238	(£124,674)
AMD	3,953	209	(3,744)	£3,462,981	£191,697	(£3,271,283)
Adult Critical Care	2,449	2,656	207	£3,692,656	£4,315,485	£622,829
Neonatal Critical Care	1,500	1,765	265	£986,622	£1,052,504	£65,882
Other Non PBR & CQUIN	0	0	0	£27,345,596	£25,706,689	(£1,638,907)
PBR & Non PBR Variance	**306,009**	**205,064**	**(100,945)**	**£128,711,638**	**£98,944,969**	**(£29,766,669)**

NB. Discussions continue between NHSE/I with NHS Wales regarding cross border activity charges which may result in a change in income from Betsi Cadwaladr as outlined in the risk section below.

In response to the Phase 3 Recovery requirements from NHS England & Improvement, the Trust submitted activity trajectories for all elective points of delivery in September 2020.

The ambition was to achieve a monthly incremental improvement in elective activity performed with the ultimate ambition to get back to delivering 90% of 2019/20 elective activity levels.

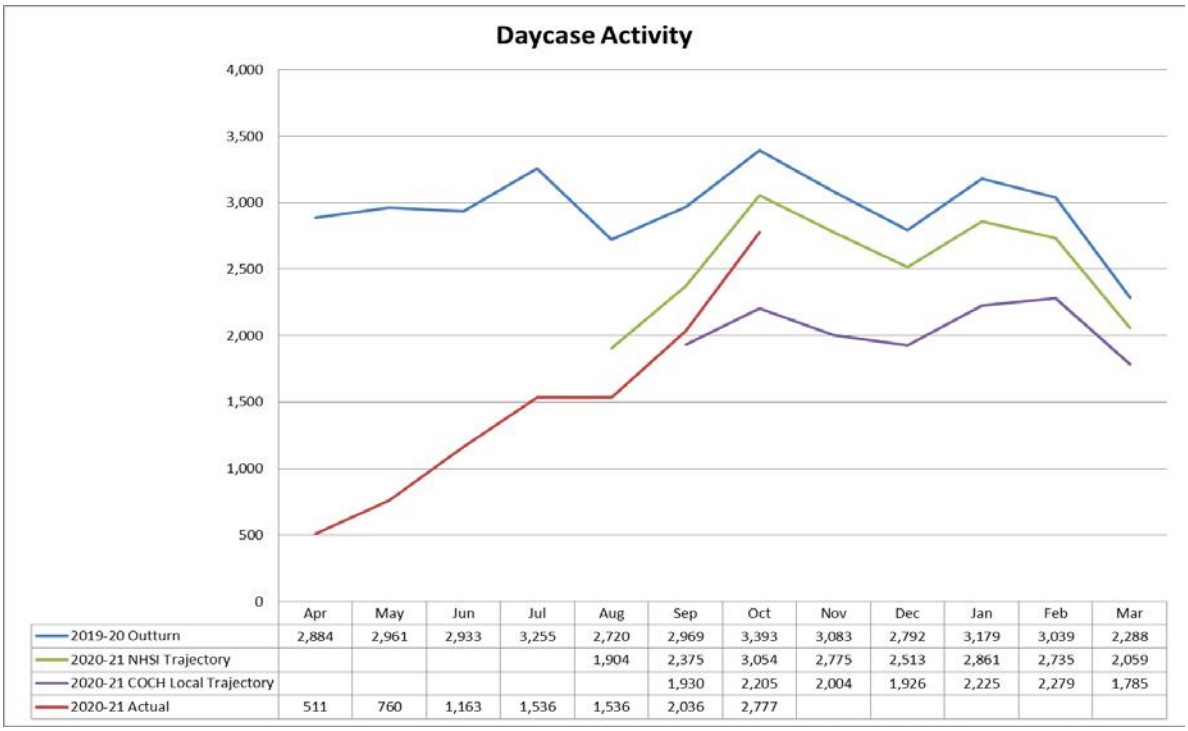
The requirement from the regulator was to achieve the following phased performance for all elective points of delivery:-

Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
70%	80%	90%	90%	90%	90%	90%	90%

In addition to these aspirant levels of activity, NHSE/I introduced an Elective Incentive Scheme (EIS), which was intended to reward systems that over delivered, and penalised others where performance was below these levels. However, whilst this scheme has not formally been withdrawn, the Trust has been told to not accrue for any potential penalties in any financial forecasts (with the expectation that this scheme will either be withdrawn, or modified to take account of Covid cases within systems).

The graphs and tables in this report show that the month on month trend in activity delivered by point of delivery, compared to performance for the same period in 2019/20, the COCH trajectory and the national target for the Covid recovery phase by Point of Delivery.

7.1 Daycase Activity

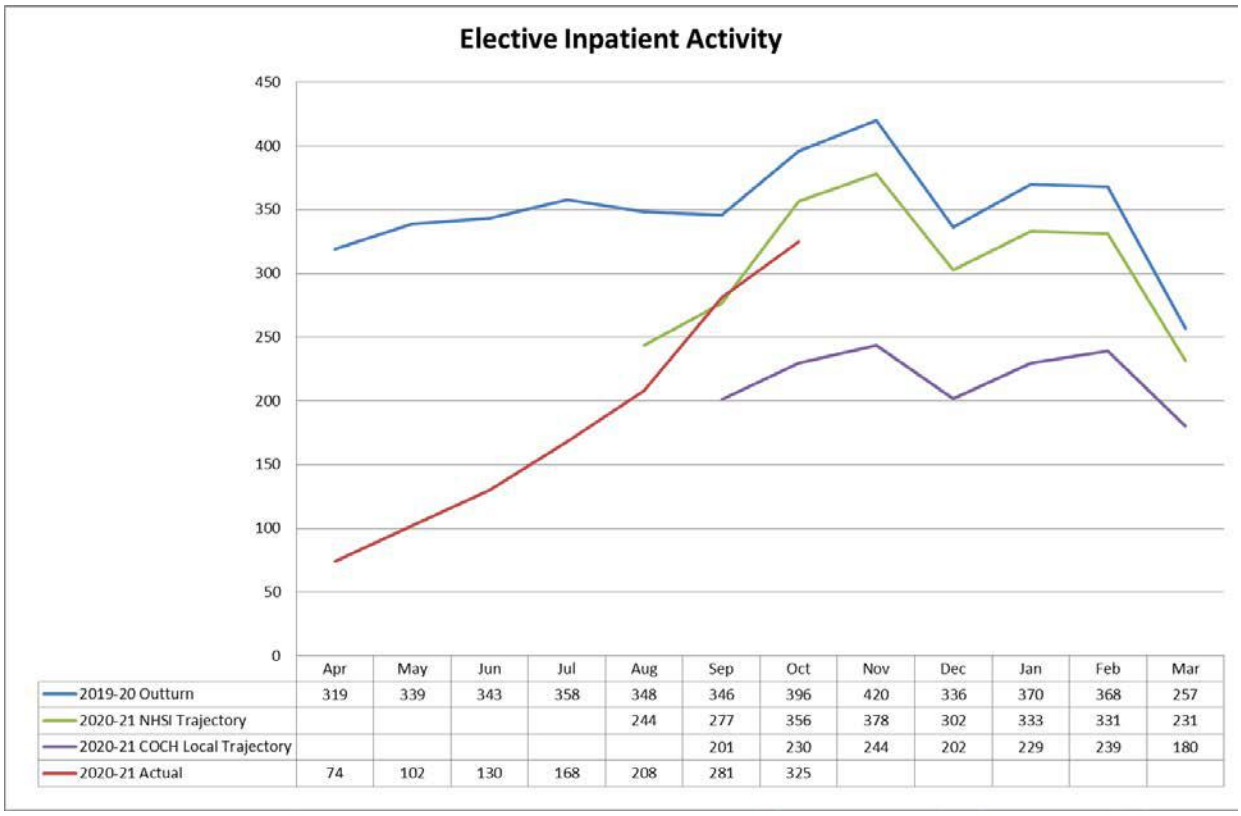


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019-20 Outturn	2,884	2,961	2,933	3,255	2,720	2,969	3,393	3,083	2,792	3,179	3,039	2,288
2020-21 NHSI Trajectory					1,904	2,375	3,054	2,775	2,513	2,861	2,735	2,059
2020-21 COCH Local Trajectory						1,930	2,205	2,004	1,926	2,225	2,279	1,785
2020-21 Actual	511	760	1,163	1,536	1,536	2,036	2,777					

Daycases	Sep	Oct
19/20 Outturn	100%	100%
NHSI Trajectory	80%	90%
COCH Local Trajectory	65%	65%
Actual Activity	69%	82%
% Variance against NHSI Trajectory	-11%	-8%
% Variance against Local COCH Trajectory	4%	17%

The graph and tables above show that Daycase activity in September was at 69% of 19/20 activity and therefore exceeded the Trust trajectory of 65%. Activity in October was at 82% and therefore above the local target of 65%.

7.2 Elective Inpatient Activity

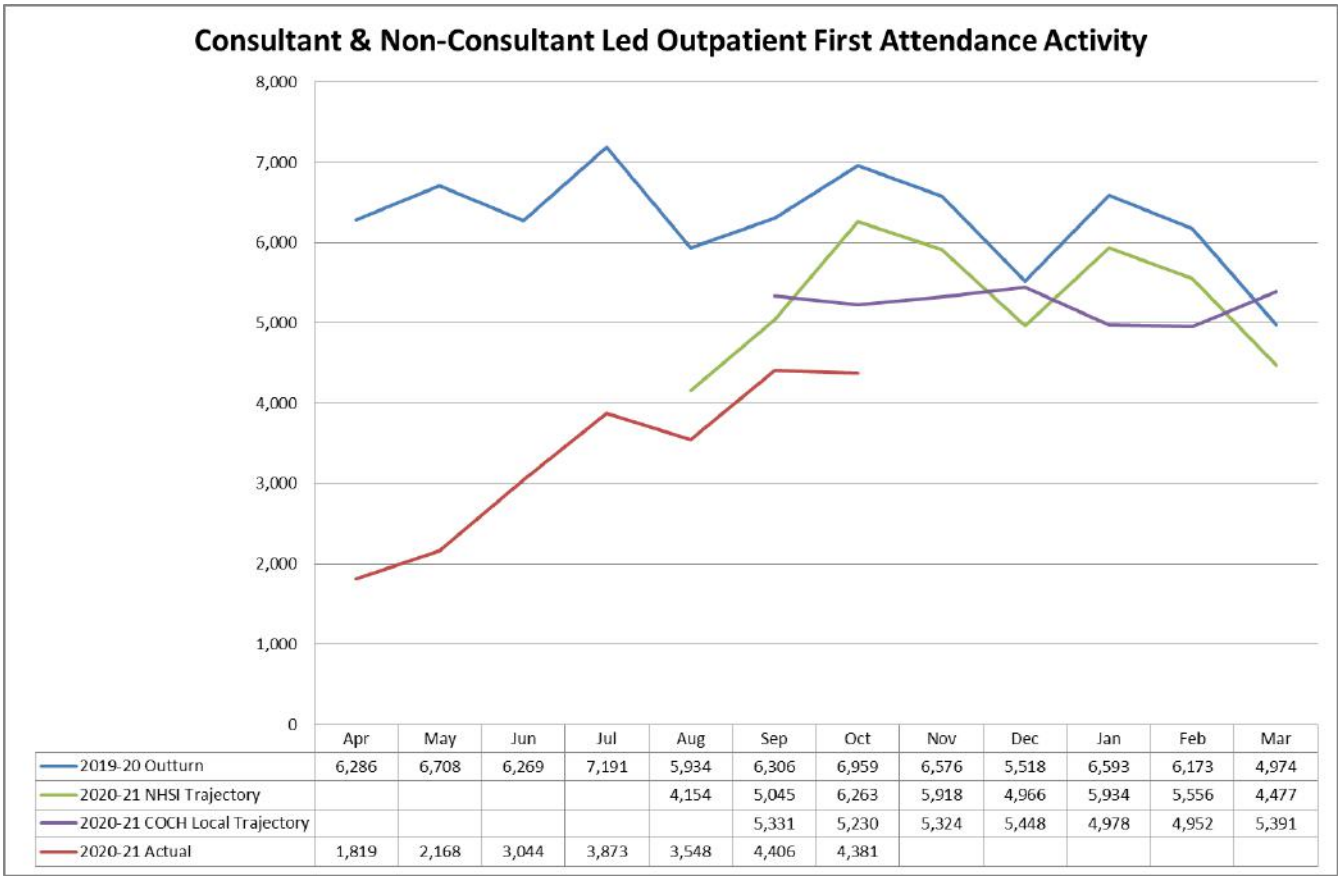


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019-20 Outturn	319	339	343	358	348	346	396	420	336	370	368	257
2020-21 NHSI Trajectory					244	277	356	378	302	333	331	231
2020-21 COCH Local Trajectory						201	230	244	202	229	239	180
2020-21 Actual	74	102	130	168	208	281	325					

Elective Inpatients	Sep	Oct
19/20 Outturn	100%	100%
NHSI Trajectory	80%	90%
COCH Local Trajectory	58%	58%
Actual Activity	81%	82%
% Variance against NHSI Trajectory	1%	-8%
% Variance against Local COCH Trajectory	23%	24%

The graph and tables above show that elective inpatient activity in September was at 81% of 19/20 activity and therefore exceeded the Trust trajectory of 58% and the NHSI trajectory of 80%. Activity in October was at 82% and therefore above the local target of 58%.

7.3 Outpatient First Attendances

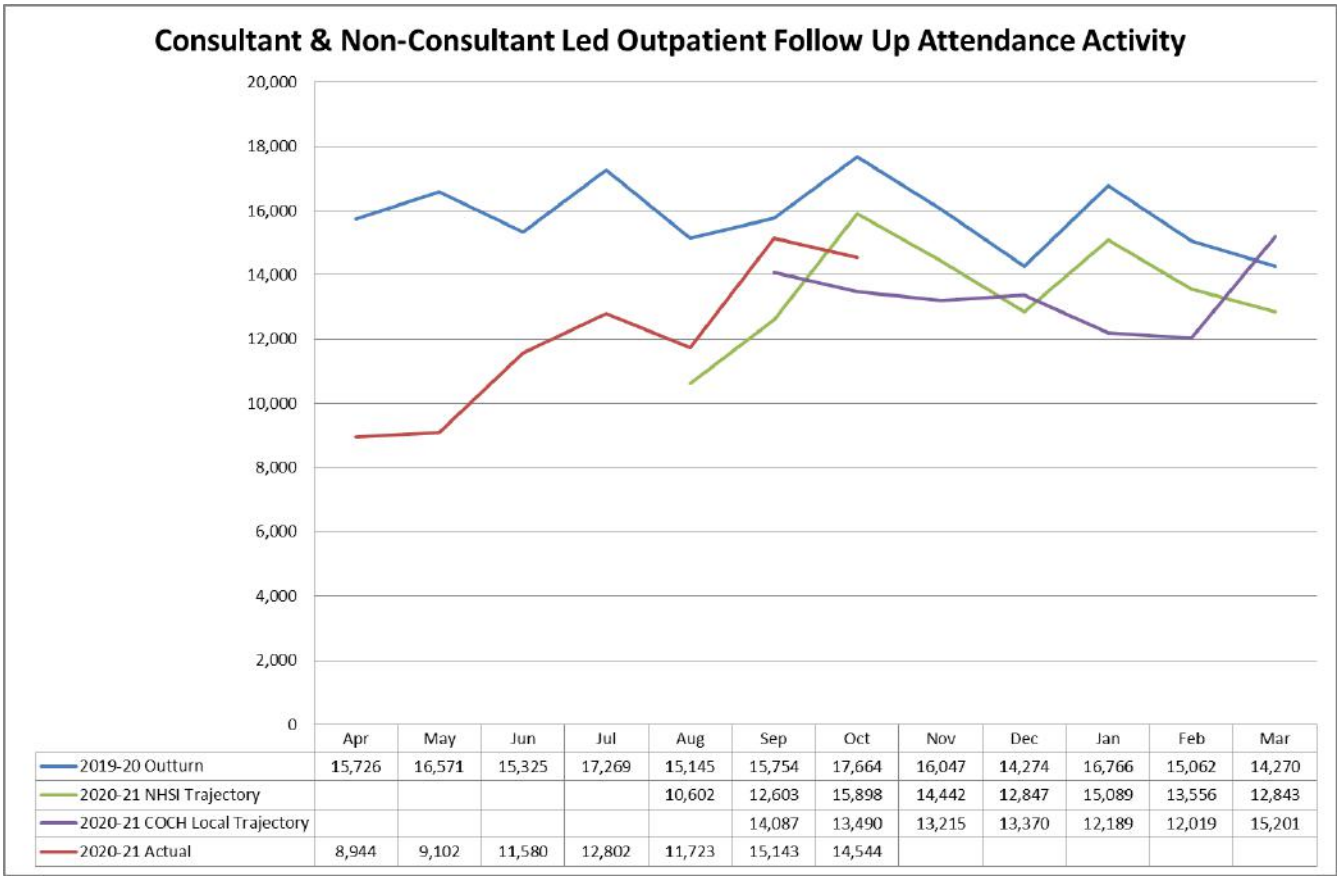


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019-20 Outturn	6,286	6,708	6,269	7,191	5,934	6,306	6,959	6,576	5,518	6,593	6,173	4,974
2020-21 NHSI Trajectory					4,154	5,045	6,263	5,918	4,966	5,934	5,556	4,477
2020-21 COCH Local Trajectory						5,331	5,230	5,324	5,448	4,978	4,952	5,391
2020-21 Actual	1,819	2,168	3,044	3,873	3,548	4,406	4,381					

First Outpatient Appointments	Sep	Oct
19/20 Outturn	100%	100%
NHSI Trajectory	80%	90%
COCH Local Trajectory	85%	75%
Actual Activity	70%	63%
% Variance against NHSI Trajectory	-10%	-27%
% Variance against Local COCH Trajectory	-15%	-12%

The graph and tables above show that first outpatient attendance activity in September was at 72% of 19/20 activity and therefore below the Trust trajectory of 85% and the NHSI trajectory of 80%. Activity in October was at 63% and therefore below the local target of 75%.

7.4 Outpatient Follow Up Attendances

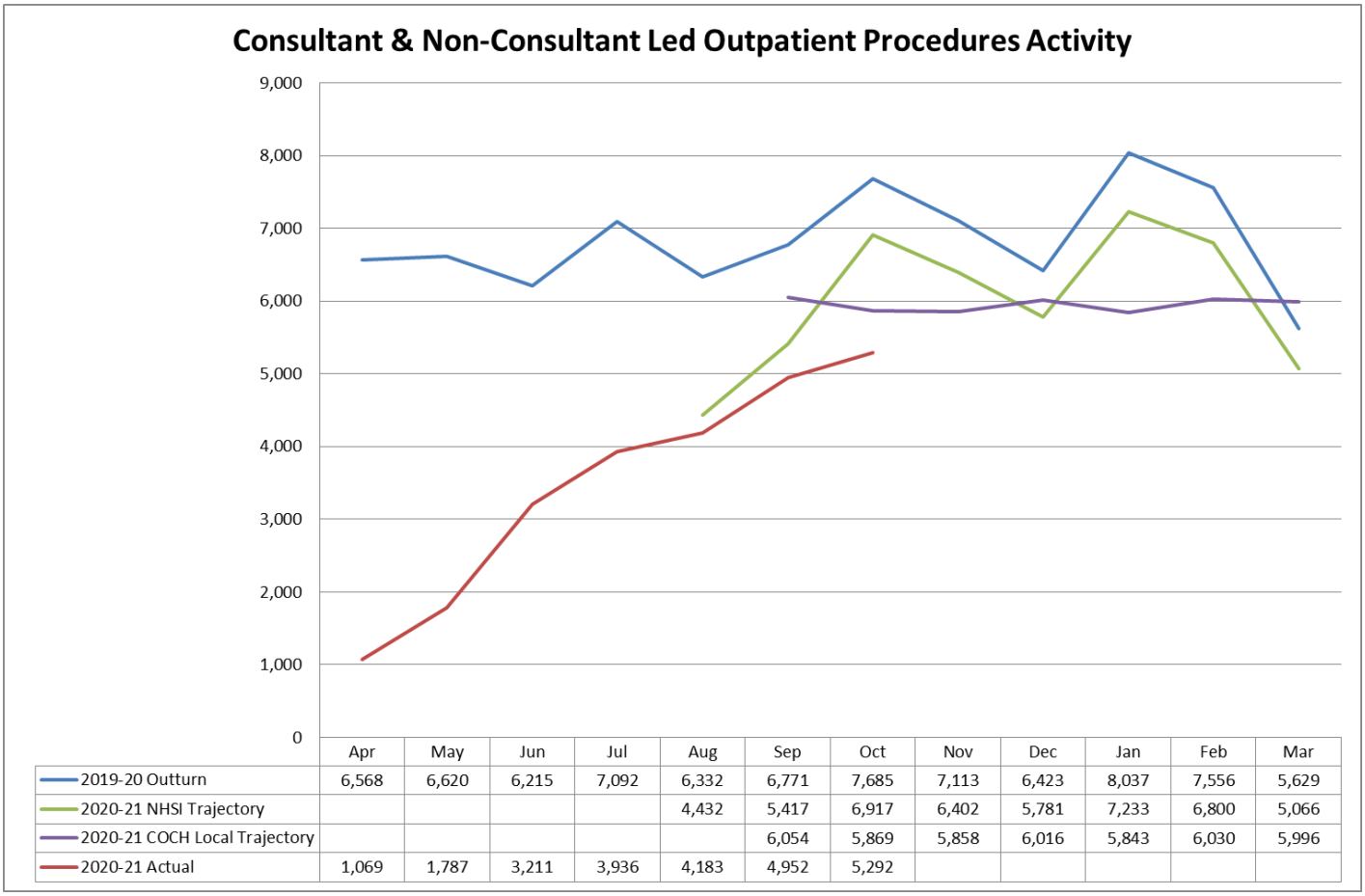


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019-20 Outturn	15,726	16,571	15,325	17,269	15,145	15,754	17,664	16,047	14,274	16,766	15,062	14,270
2020-21 NHSI Trajectory					10,602	12,603	15,898	14,442	12,847	15,089	13,556	12,843
2020-21 COCH Local Trajectory						14,087	13,490	13,215	13,370	12,189	12,019	15,201
2020-21 Actual	8,944	9,102	11,580	12,802	11,723	15,143	14,544					

Follow Up Outpatient Appointments	Sep	Oct
19/20 Outturn	100%	100%
NHSI Trajectory	80%	90%
COCH Local Trajectory	89%	76%
Actual Activity	96%	82%
% Variance against NHSI Trajectory	16%	-8%
% Variance against Local COCH Trajectory	7%	6%

The graph and tables above show that follow up outpatient attendance activity in September was at 94% of 19/20 activity and therefore exceeded the Trust trajectory of 89% and the NHSI trajectory of 80%. Activity in October was at 82% and therefore above the local target of 75%.

7.5 Outpatient Procedures



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019-20 Outturn	6,568	6,620	6,215	7,092	6,332	6,771	7,685	7,113	6,423	8,037	7,556	5,629
2020-21 NHSI Trajectory					4,432	5,417	6,917	6,402	5,781	7,233	6,800	5,066
2020-21 COCH Local Trajectory						6,054	5,869	5,858	6,016	5,843	6,030	5,996
2020-21 Actual	1,069	1,787	3,211	3,936	4,183	4,952	5,292					

Outpatient Unbundled & Procedures	Sep	Oct
19/20 Outturn	100%	100%
NHSI Trajectory	80%	90%
COCH Local Trajectory	89%	76%
Actual Activity	73%	69%
% Variance against NHSI Trajectory	-7%	-21%
% Variance against Local COCH Trajectory	-16%	-8%

The graph and tables above show that unbundled and procedure outpatient attendance activity in September was at 74% of 19/20 activity and therefore was below the Trust trajectory of 89% and the NHSI trajectory of 80%. Activity in October was at 69% and therefore below the local target of 76%.

7.6 Summary

The summary position for October 2020 is further outlined below:

	Daycase	Elective In Patients	Outpatient First Attendances	Outpatient Follow Up Attendances	Outpatient Procedures
Target October 2020	90%	90%	90%	90%	90%
Actual October 2020	82%	82%	63%	82%	69%
Variance October 2020	-8%	-8%	-27%	-8%	-21%

8.0 Key Risks and Mitigations

The key risks and mitigations identified previously under the M1-6 finance regime remain, namely:

- The potential failure to secure full reimbursement for capital expenditure incurred – the Trust is fully compliant with the processes in place to secure capital despite guidance changing frequently;
- The potential failure to secure full reimbursement for revenue expenditure up to September 2020 - the Trust is fully compliant with the processes in place to secure revenue expenditure with clear auditable information for costs identified;
- The potential failure to secure sufficient block funding for the period October 2020 to March 2021 to cover the ongoing costs of Covid, and the delivery of the required restoration of the Trusts Elective activity program;
- The potential costs incurred in response to 2nd wave and the resultant pressure on maintaining elective activity;
- The Trust holds a significant contract circa £27m with Betsi Cadwaladr NHS Trust. Contracting rules continue to be different in Wales to England, however currently there is a commitment from Wales to apply the “spirit” of the national English approach for cross border commissioning during this unprecedented time. There is, however, a risk this could change as discussions continue to take place between Welsh Government and NHSE/I;
- Given the urgency of some of the spending, and also given the resources available to the Trust, there is a heightened risk of fraud. – The Trusts Counter Fraud Service has been kept Informed throughout the Covid process, with proactive pieces of work undertaken (including raising awareness with the staff, and also targeted investigations);
- The NHS as a whole is mindful of the urge to “bend rules” during this reimbursement phase, and hence costs need to be proportionate and reasonable (in accordance with the new rules) – The NHS centrally has stated that there will be an Audit of Trust expenditure and returns, to ensure that rules have been applied consistently across all providers; and
- The impact on the Trust’s underlying recurring revenue position as a resultant of some significant capital investments (to support expansion), namely:
    - Additional CT Scanner, Ellesmere Port Hospital (£1,000,000)
    - Additional Endoscopy Suite, Countess of Chester Hospital (£300,000)
    - Expansion Critical Care 7 beds, Countess of Chester Hospital (£500,000)

9.0 Recommendations

The Board is asked to note:

1. The change to the financial regime for Months 7 to 12 (October 2020 to March 2021); including the requirement to not exceed an adjusted outturn deficit position of £5.2m;

2. The requirement to manage the Trust's funding from the three different funding streams (i.e. Underlying Deficit, Covid Monies and Restoration Costs) on a "net neutral" basis;

3. The £0.4m adverse variance reported for October 2020 (Month 07) against the Trust's allocation;

4. The £0.6m favourable variance reported for October 2020 (Month 7) when taking into account the adjusted outturn deficit position of £5.2m for six months, being £1.010m for October alone;

5. That the Elective Incentive Scheme (EIS) has not been accrued for, and if applied will only be applied at a Heath & Care Partnership level

6. The following key risks in not exceeding the adjusted outturn deficit of £5.2m, namely that
   - Actual expenditure exceeds planned levels, as the Plan was based on the underlying assumption that the reproductive number R=1
   - That Restoration activity is controlled within the envelope available,
   - No Elective Incentive Scheme penalties are applied at a local level, due to activity falling below 90% (noting no accrual made in Month 7 consistent with NHSE/I expectations); and
   - That Income from Wales is maintained in line with the agreed planning assumptions.

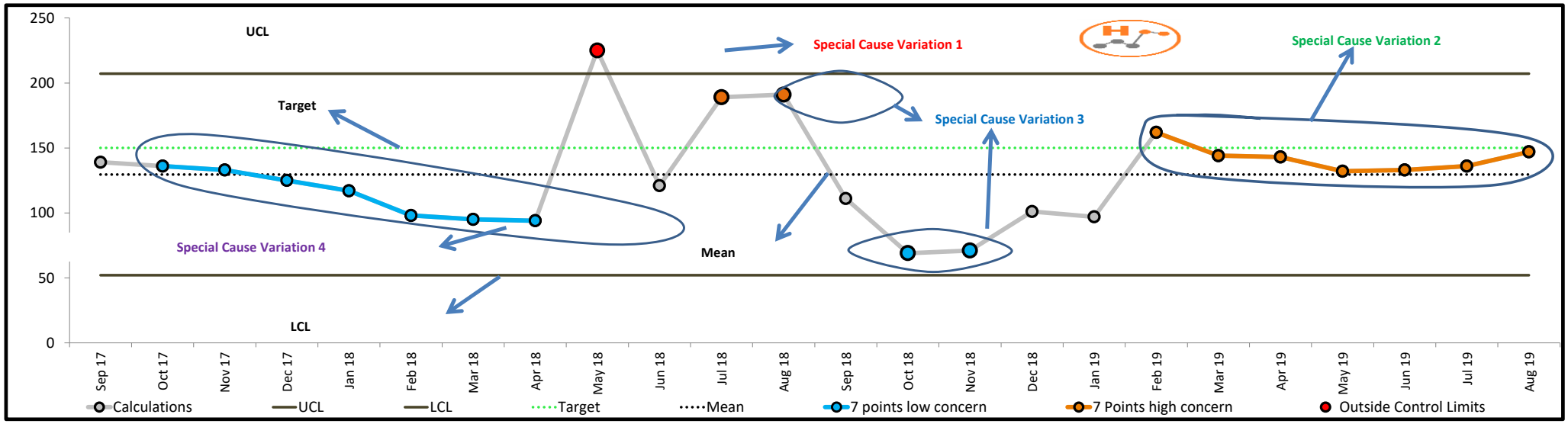
Meeting	**1st December 2020**		**Board of Directors**					
Report	**Agenda item 12**		**Integrated Performance Report – October 2020**					
Purpose of the Report	Decision		Ratification		Assurance	**x**	Information	
Accountable Executive	David Coyle				Director of Clinical Operations			
Author(s)	Denise Wood				Head of Information & Performance			
Board Assurance Framework	E2	Access, Waiting times, care standards and constitutional standards						
Strategic Aims	Providing efficient and financially sustainable services. To deliver high quality care and treatment.							
CQC Domains	Safe/Effective/Caring/Responsive & Well Led							
Previous Considerations	-							
Summary	The purpose of this report is to: • Summarise the key performance Indicators • Assure the Board of the monthly oversight of trust priorities against agreed targets • Highlight areas of high or low performance for operational, quality, safety, workforce or financial metrics							
Recommendation(s)	The Board is asked to: • Review and note the report							
Corporate Impact Assessment								
Statutory Requirements	Meets the Trust compliance with Foundation Trust Status							
Quality & Safety	Monitors patient safety issues							
NHS Constitution	Monitors performance against key targets							
Patient Involvement	-							
Risk	Risk to achievement of targets included on corporate risk register							
Financial impact	-							
Equality & Diversity	-							
Communication	-							

COUNTESS OF CHESTER

Performance Report Oct-20

Countess of Chester Hospital NHS
NHS Foundation Trust

The integrated performance report has been reviewed and the use of Statistical process control (SPC) charts has been introduced. This method plots data over time to show how much the data varies naturally and guides us to take the most appropriate action based on alerts where a situation may be deteriorating, or if a situation is improving. SPC also shows how capable a system is of delivering a standard or target. This method of reporting is actively encouraged by NHSI for Board reporting to improve decision making.



A SPC chart is a time series graph which is used in order to monitor the performance of metrics over time. We aim to use a rolling 24 months worth of data from which the mean and moving averages are calculated. Then - from these - we can create our Upper Control Limit (UCL) and Lower Control Limit (LCL). Various tests are then performed on this data to see whether the process is in statistical control, if a process is 'Out of Control' it means it has broken one of the SPC rules below.

Special Cause Variation Criteria:

Special Cause Variation 1 - If one or more of the data points are above or below the control limits.

Special Cause Variation 2 - If a sequence of seven or more of the data points are above or below the mean.

Special Cause Variation 3 - When 2 out of 3 data points in a row are close to hitting the control limits, the point will become larger.

Special Cause Variation 4 - If a sequence of 7 or more points are all showing either a positive or negative trend.

The graphs are then summarised using the summary icons to the right, one for Variation - which demonstrates whether a metric is improving or failing - and one for Assurance, which states whether or not we are on target. The variation icon only considers the last 6 months of data.

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and failing short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

COUNTESS OF CHESTER

Performance Report Oct-20

Countess of Chester Hospital NHS
NHS Foundation Trust

SAFE

Indicator	This Month	Target	Trend	Assurance	20/21 YTD	20/21 Target	20/21 Assurance
Hospital Standard Mortality Rate (HSMR)	116.2	Within Expected Range		Outside Expected Range	117.5	Within Expected Range	Outside Expected Range
CHPPD Compliance	7.0	8.2	H	P	8.3	8.2	P
Serious Incidents Level 1	5	Within Expected Range		Within Expected Range	16	Within Expected Range	Within Expected Range
Serious Incidents Level 2	1	Within Expected Range	L	Within Expected Range	1	Within Expected Range	Within Expected Range
Incident Reporting: No Harm	484	Within Expected Range		Within Expected Range	2135	Within Expected Range	Within Expected Range
Incident Reporting: Low Harm	86	Within Expected Range		Within Expected Range	392	Within Expected Range	Within Expected Range
Incident Reporting: Moderate Harm	72	Within Expected Range	H	Outside Expected Range	285	Within Expected Range	Outside Expected Range
Incident Reporting: Severe Harm	5	Within Expected Range	H	Within Expected Range	27	Within Expected Range	Within Expected Range
Incident Reporting: Death	1	Within Expected Range		Within Expected Range	6	Within Expected Range	Within Expected Range
Serious Incidents Never Events	0	Within Expected Range	H	Within Expected Range	2	Within Expected Range	Within Expected Range
All Falls Rate	7.4	7.0		P	6.6	7.0	P
Falls With Harm Rate	0.1	0.3	H	P	0.2	0.3	P
Hospital Acquired Pressure Ulcers	1.6	Within Expected Range		Within Expected Range	2.6	Within Expected Range	Within Expected Range
Pressure Ulcers On admission	3.9	Within Expected Range	H	Within Expected Range	5.6	Within Expected Range	Within Expected Range

SAFE

Indicator	This Month	Target	Trend	Assurance	20/21 YTD	20/21 Target	20/21 Assurance
Midwife Continuity of Care	45.0%	35%	H	P	30%	35%	P
Reducing Term Admissions to NNU	4.1%	5.0%	H	P	4%	5.0%	P
Nurse Retention Rates	93.1%	90%	H	P	92%	90%	P
Infection Control -C-Difficile	7	TBA		F	14	TBA	P
Infection Control -MRSA	0	0	L	P	0	0	P
Hospital Onset Covid	29	0	L	F	155	0	F

EFFECTIVE

Indicator	This Month	Target	Trend	Assurance	20/21 YTD	20/21 Target	20/21 Assurance
SEPSIS-Screening	100%	75%		P	98.8%	75%	P
SEPSIS-Treatment	78%	75%	H	P	72.4%	75%	F
Emergency Response Calls	11	Within expected range	L	Within Expected Range	71	Within expected range	Within Expected Range
Bed Moves	99.5%	95%	L	P	97.9%	95%	P

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and failing short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

COUNTESS OF CHESTER

Performance Report Oct-20

Countess of Chester Hospital NHS
NHS Foundation Trust

RESPONSIVE

Indicator	This Month	Target	Trend	Assurance	20/21 YTD	20/21 Target	20/21 Assurance
ED 4 Hour Wait Standard %	81.1%	95%	H	F	91.5%	95%	F
RTT Incomplete Pathways %	47.6%	92%	L	F	48.5%	92%	F
RTT Total Incomplete Pathways	25220	Covid Related Delay	H	To be agreed	25220	Covid Related Delay	To be agreed
RTT Incomplete Pathways 0 - 18 Weeks	12010	Covid Related Delay	L	To be agreed	12010	Covid Related Delay	To be agreed
RTT Incomplete Pathways 18+ Weeks	13210	Covid Related Delay	H	To be agreed	13210	Covid Related Delay	To be agreed
RTT Incomplete Pathways 40+ Weeks	5392	Covid Related Delay	H	To be agreed	5392	Covid Related Delay	To be agreed
Diagnostic 6 wks Standard %	31.0%	1%	H	F	46.3%	1%	F
Cancer Treatment - 62 Day Standard %	57.3%	85%	L	F	64.4%	85%	F
Cancer Treatment -31 Day Standard %	73%	96%	L	F	79.8%	96%	F
Cancer Treatment - 14 Day Standard %	74.7%	93%	L	F	85.9%	93%	F

WELL LED

Indicator	This Month	Target	Trend	Assurance	20/21 YTD	20/21 Target	20/21 Assurance
Sickness Absence	4.0%	3.65%		P	3.7%	3.65%	P
Mandatory Training	81.8%	95%	L	F	83%	95%	F
Annual Appraisal	68.9%	95%	L	F	75%	95%	F
Staff Turnover %	8.9%	10%	L	P	9%	10%	P
M&D Over Cap Rates	166	> Last Year		No Target	1364	> Last Year	P
N&M Over Cap Rates	395	> Last Year	H	No Target	2578	> Last Year	F
Other Over Cap Rates	60	> Last Year		No Target	303	> Last Year	P
Medical Agency £	217000	> Last Year		No Target	1343k	> Last Year	P
Nursing Agency £	247000	> Last Year		No Target	1212k	> Last Year	F
Total within Budget	123001	Meet Plan		P	1202k	Meet Plan	P

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Performance Report Oct-20

Countess of Chester Hospital NHS
NHS Foundation Trust

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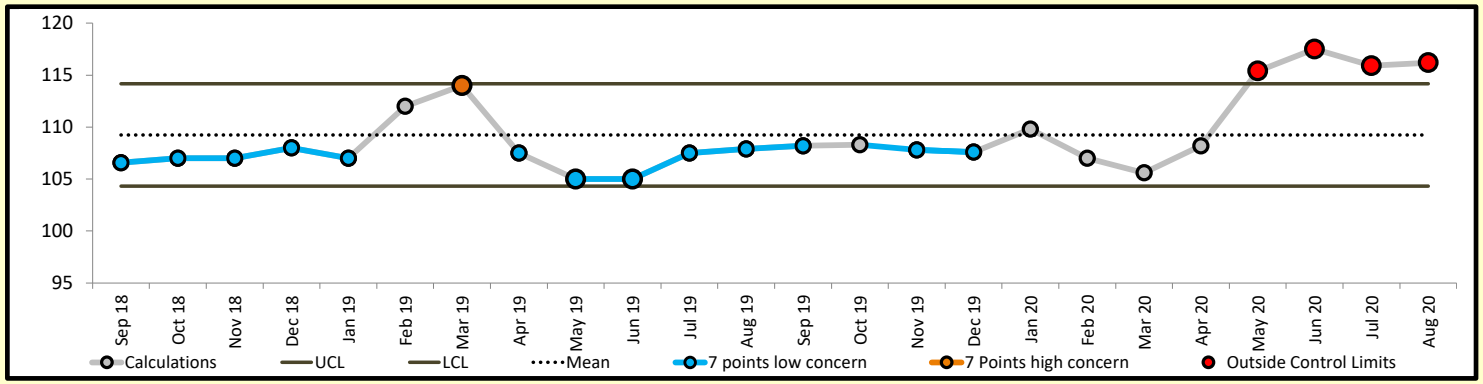
Hospital Standard Mortality Rate (HSMR)



The HSMR measures the rate of observed deaths divided by predicted deaths (based on the diagnoses which most commonly result in death)

Target: Within Expected Range

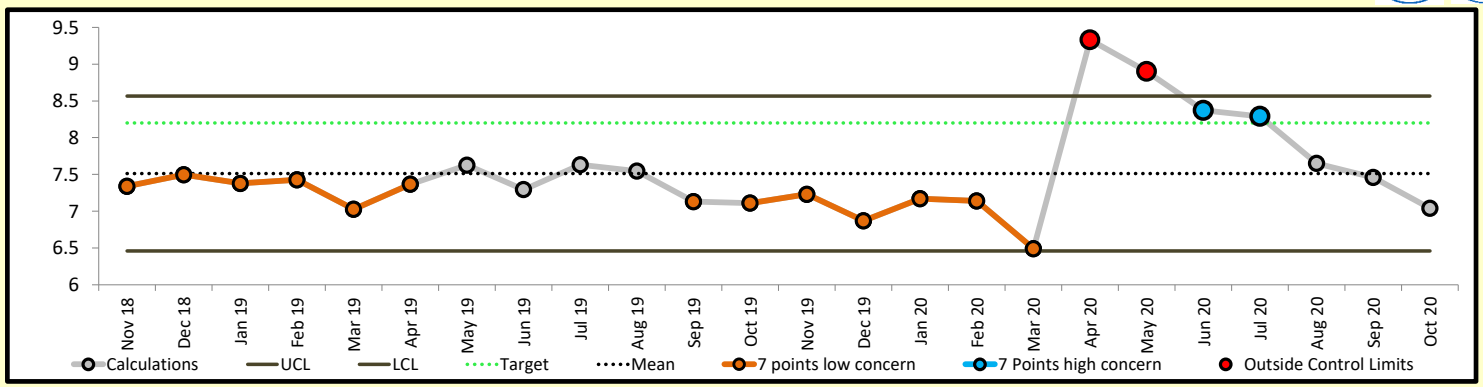
Mean: 109.2

This Month's Figure: 116.2

Executive Comments:

The metric reflects challenges to HSMR previously highlighted to Board in line with Wave 1 COVID. A detailed action and mitigation plan sits behind this metric.

Care Hours Per Patient per Day (CHPPD) Compliance



(Hours of registered clinical ward-based staff + Hours of non-registered clinical ward based staff) / Total number of inpatients at midnight

Target: 8.2

Mean: 7.51

This Month's Figure: 7.04

Executive Comments:

As activity has slowly increased over the past month to reflect national expectations, previously redeployed staff have returned to their substantive positions, therefore illustrating an overall decline in the Trusts CHPPD position. Nurse staffing levels continue to be monitored by a shift by shift basis via the Centralised Nursing Workforce Team, ensuring wards and departments are operating within safe staffing levels, with escalation processes in place as required.

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Countess of Chester Hospital NHS
NHS Foundation Trust

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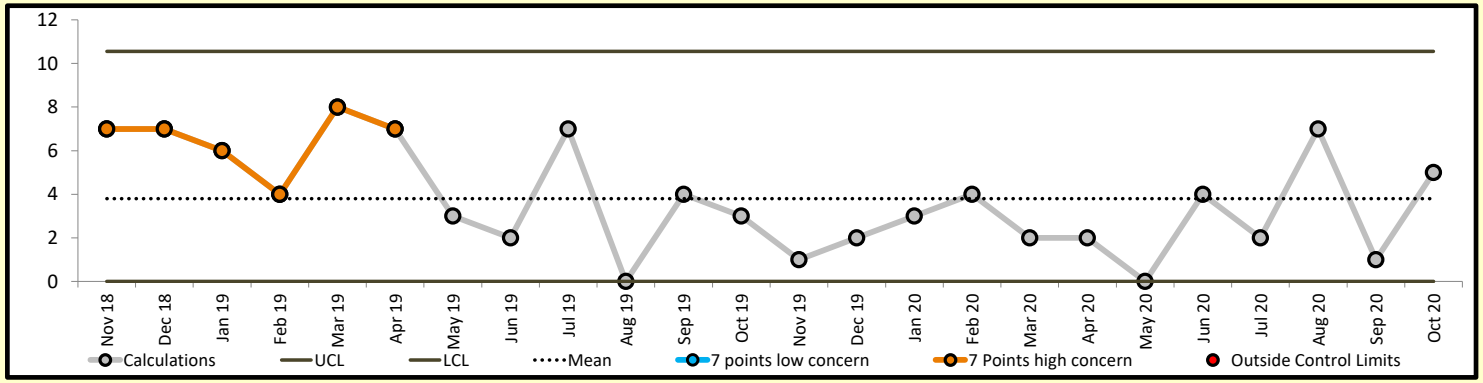
Serious Incidents - Level 1



The number of Serious Incidents reported at Level 1

Target: Within Expected Range

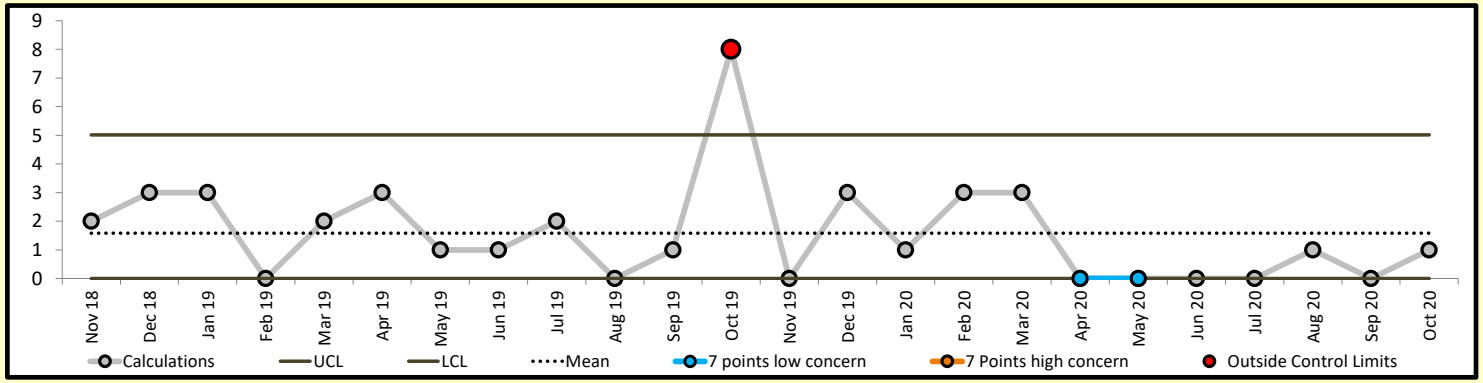
Mean: 3.79

This Month's Figure: 5

Executive Comments:

The data illustrates performance remains within the expected range. During October there were 5 Level 1 incidents declared, these incidents were in relation to COVID-19 outbreaks in the following areas; Appointments Hotline Office (Staff), Ward 51 (Patients), Breast Unit (Staff), Ward 53 (Patients), Bluebell Ward (Patient) outbreak investigations are underway and the relevant external reporting completed.

Serious Incidents - Level 2



The Number of Serious Incidents reported at Level 2

Target: Within Expected Range

Mean: 1.58

This Month's Figure: 1

Executive Comments:

There was 1 Level 2 Serious Incident Investigations commissioned by the Serious Incident Panel during October that pertains to a patient death in ED following a fall. We remain within the trust target to be within the boundaries of the control limit.

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Countess of Chester Hospital NHS
NHS Foundation Trust

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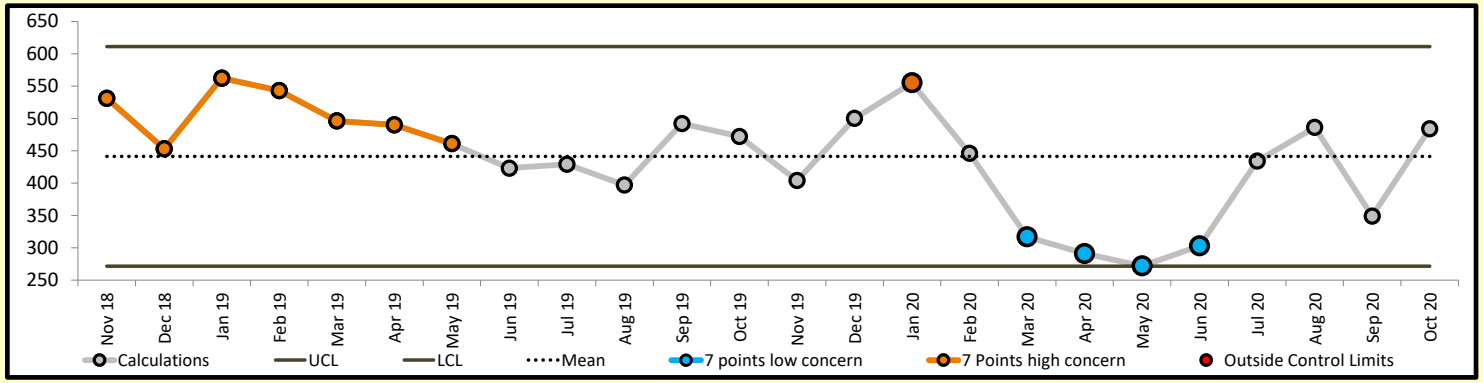
Incident Reporting: No Harm



The number of incidents where no harm was caused

Target: Within Expected Range

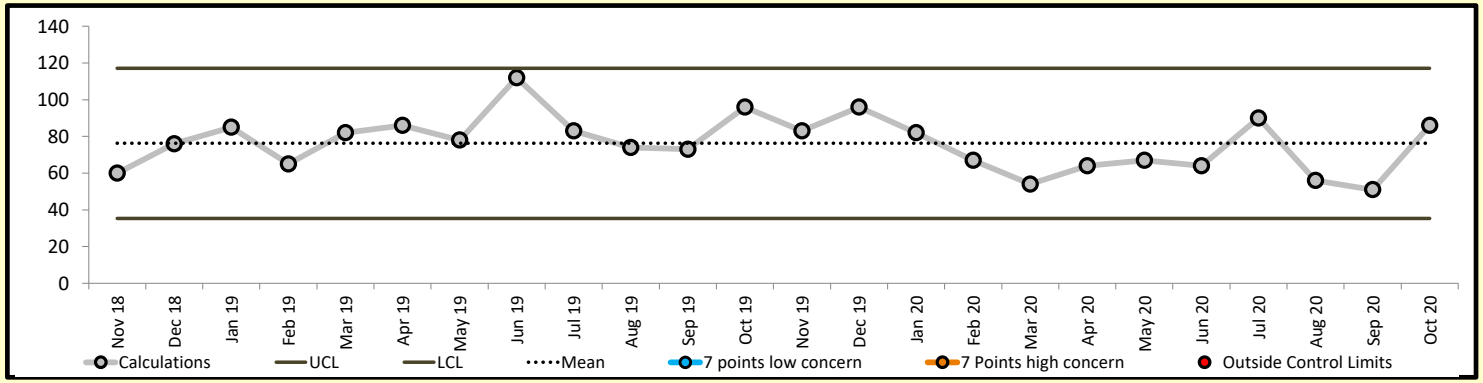
Mean: 441.25

This Month's Figure: 484

Executive Comments:

There has been an increase in month for no harm incidents. However, as part of the overarching review into the redesign of the Quality Governance Team there will be a piece of work conducted in relation to the grading of incidents to ensure that staff are recording the correct level of harm. Communication is in place with divisional teams to emphasise the importance of reporting in order to identify any themes or trends in issues, where proactive action can be taken to prevent a significant event.

Incident Reporting: Low Harm



The number of incidents where low harm was caused

Target: Within Expected Range

Mean: 76.25

This Month's Figure: 86

Executive Comments:

There has been an increase in the number of low harm reported incidents. The increased low harm incident reporting may be attributed to the increase in activity within the hospital in month. Communication is in place with divisional teams to emphasise the importance of reporting in order to identify any themes or trends in issues, where proactive action can be taken to prevent a significant event.

Performance Report Oct-20

Countess of Chester Hospital NHS
NHS Foundation Trust

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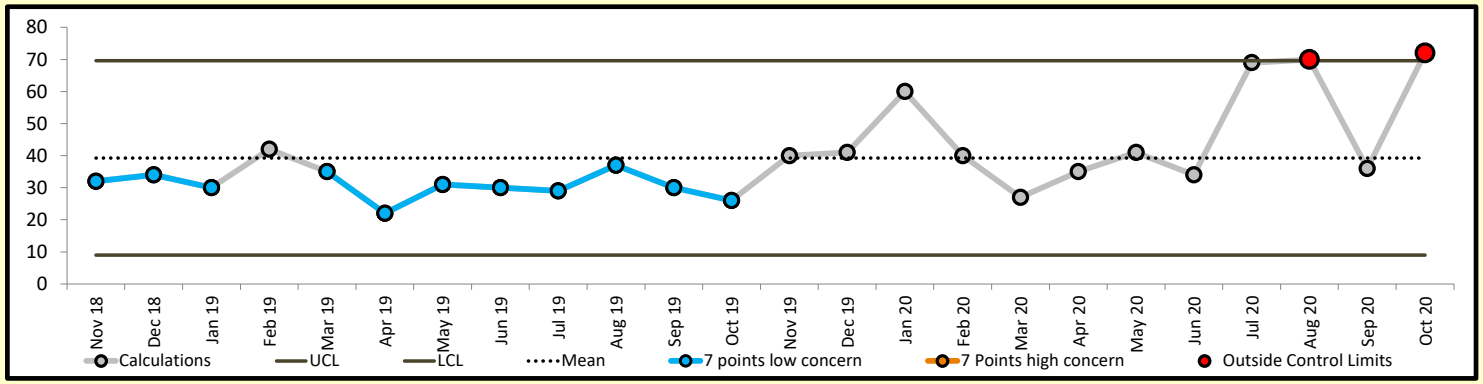
Incident Reporting: Moderate Harm



The number of incidents where moderate harm was caused

Target: Within Expected Range

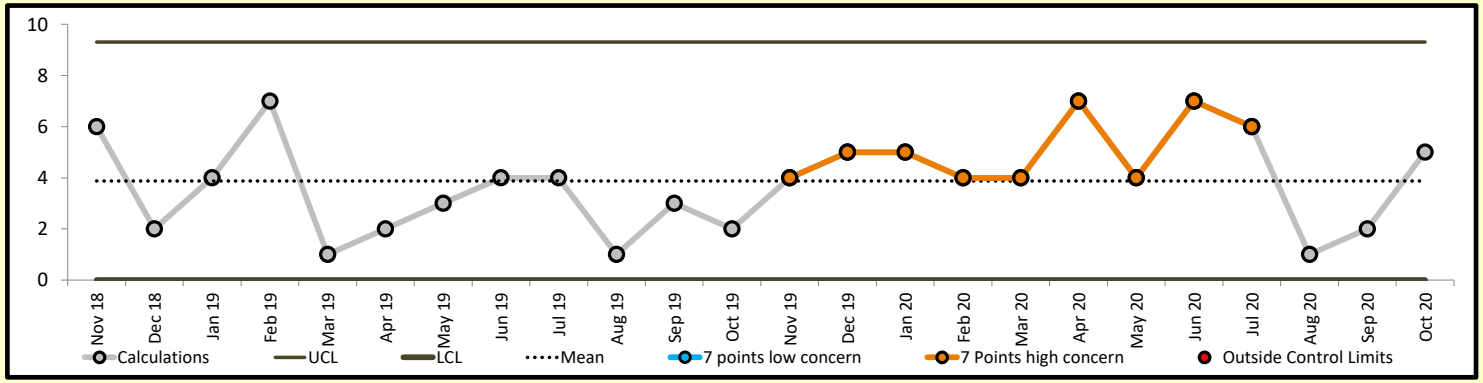
Mean: 39.29

This Month's Figure: 72

Executive Comments:

There has been a significant increase in the number of Moderate Harm incidents reported in month. This increase is due to the infection control related incidents linked to the reported hospital onset COVID outbreaks. Immediate reviews have been completed prior to the full investigation to ensure that there are no Patient Safety issues and to extract learning.

Incident Reporting: Severe Harm



The number of incidents where severe harm was caused

Target: Within Expected Range

Mean: 3.88

This Month's Figure: 5

Executive Comments:

There number of Severe Harm incidents reported in month remains the same as the previous month with 5 severe harm incidents being reported in October. There are no trends or themes in relation to the severe harm incidents and all are undergoing investigation.

Performance Report Oct-20

Countess of Chester Hospital NHS
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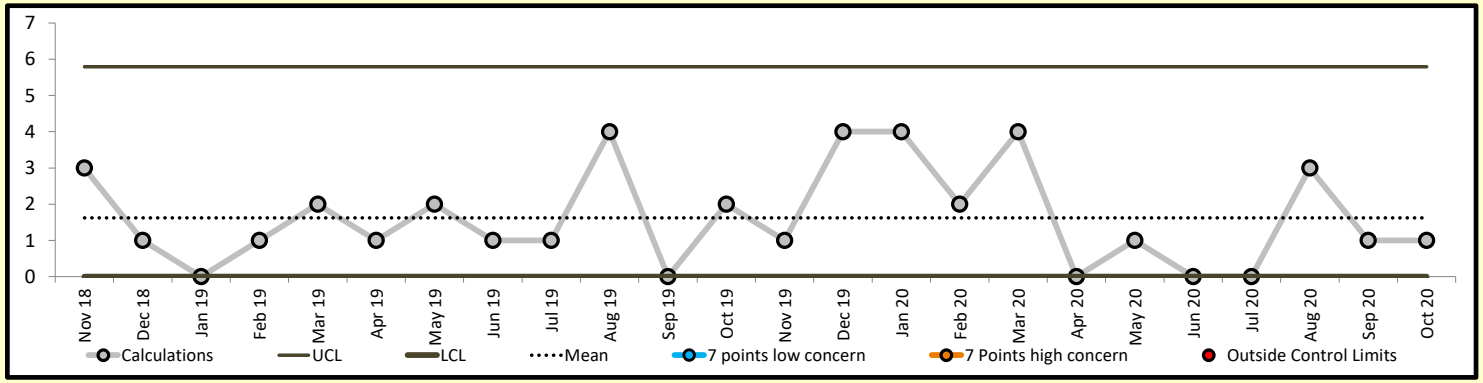
Incident Reporting: Death



The number of incidents where death was caused

Target: Within Expected Range

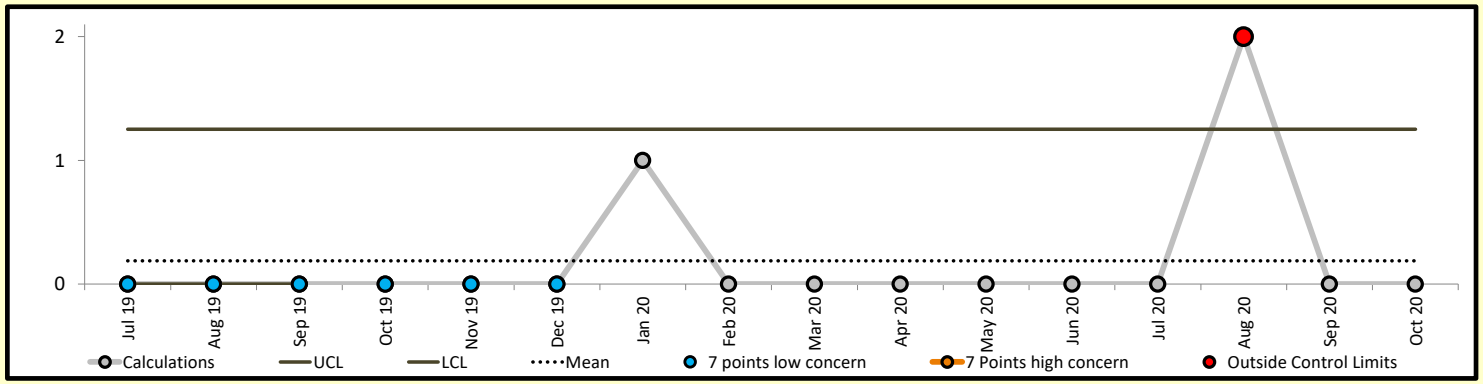
Mean: 1.63

This Month's Figure: 1

Executive Comments:

This metric was brought in to coincide with National Reporting and Learning System standards, our aim is to improve the trusts ranking nationally. Our trust target is to remain within the boundaries of the control limits

Serious Incidents - Never Events



Number of reported Never Events

Target: Within Expected Range

Mean: 0.19

This Month's Figure: 0

Executive Comments:

There have been 0 Never Events in October. The previously reported Never Events; 1 in Women's and Children's in August relating to a retained swab and 1 in Orthodontics in October 2018 but reported when the incident came to light in August 2020 of a wrong tooth extraction are currently under investigation with preliminary learning shared.

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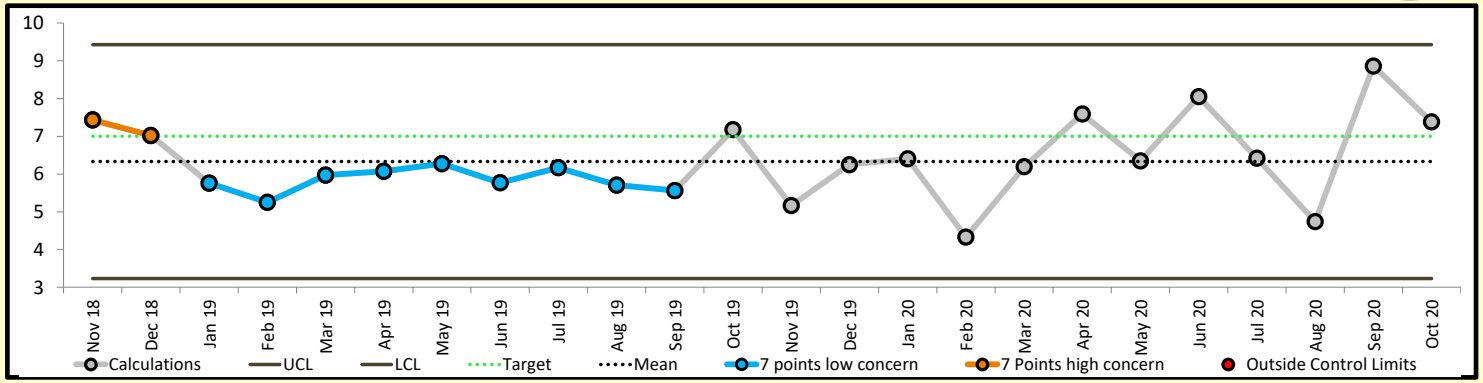
Falls



Rate of all falls per 1000 bed days

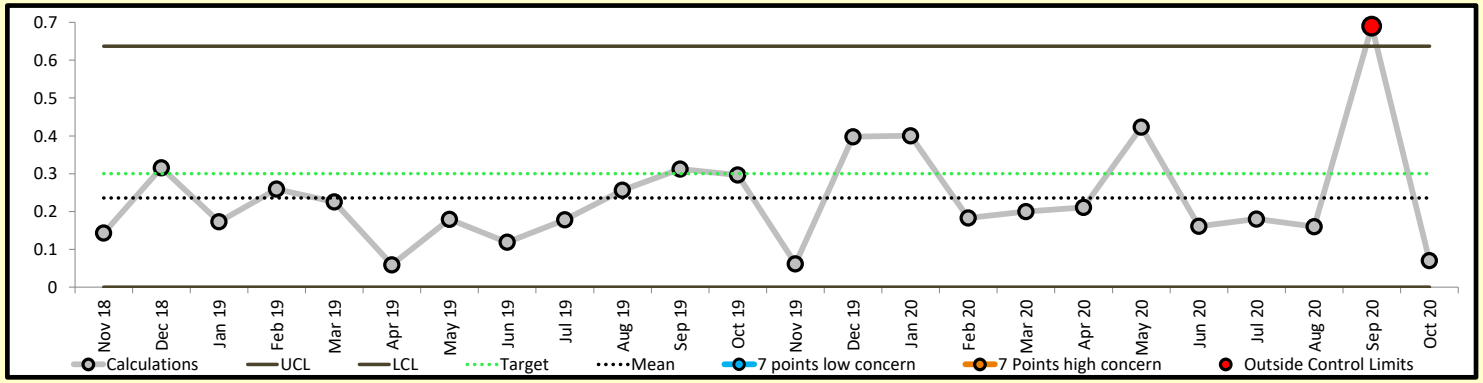
Target: 7 | **Mean: 6.33**

This Month's Figure: 7.38

Executive Comments:

This remains within expected range and is below the upper control limit. The falls dashboard has been built and is providing intelligence to progress improvement work. Falls 'unwitnessed in bays' is the main theme identified. Staffing metrics and compliance against the Enhanced Supervision Policy are being assessed at the Nursing & Midwifery Performance and Assurance Group. Promotion is to take place of the local policy in the Assessment, Prevention and Management of Inpatients at Risk of Slips, Trips and Falls.

Falls with harm rate



Rate of falls with harm per 1000 bed days

Target: 0.30 | **Mean: 0.24**

This Month's Figure: 0.07

Executive Comments:

This has dramatically reduced since the previous month and is now well within the control limits set. October's data is representative of the figures that had previously been reported in year.

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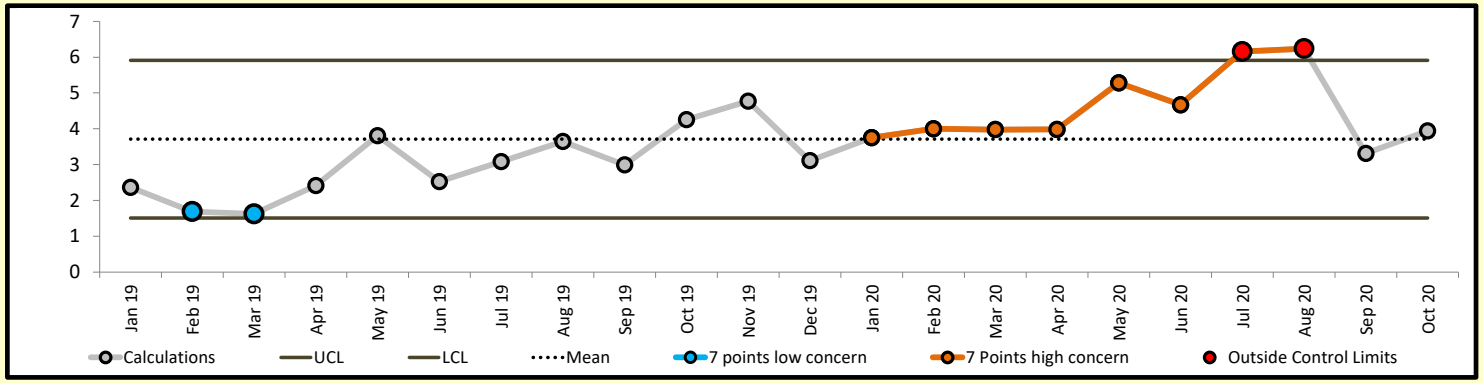
Present on Admission Pressure Ulcers



Rate of all present on admission Pressure Ulcers per 1000 bed days

Target: Within Expected Range

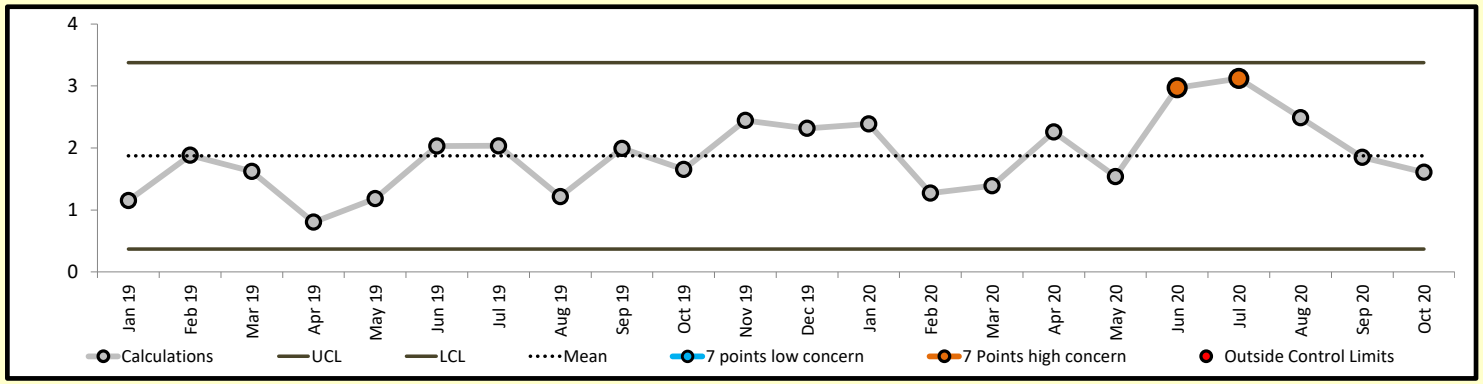
Mean: 3.71

This Month's Figure: 3.9

Executive Comments:

The most recent data indicates that there has been a slight increase in the number of community/out of hospital acquired pressure ulcers but we are still within the control limits. Work is still being undertaken within the Datix system to determine the source of these pressure ulcers so that further work can be progressed with CCG and community colleagues in reducing and monitoring this prevalence.

Hospital Acquired Pressure Ulcers



Rate of all hospital acquired Pressure Ulcers per 1000 bed days

Target: Within Expected Range

Mean: 1.87

This Month's Figure: 1.6

Executive Comments:

The number of Hospital Acquired Pressure Ulcers we have reported has been in statistical control throughout the reporting period and we have seen a continuous decline in the overall numbers for the past 3 months.

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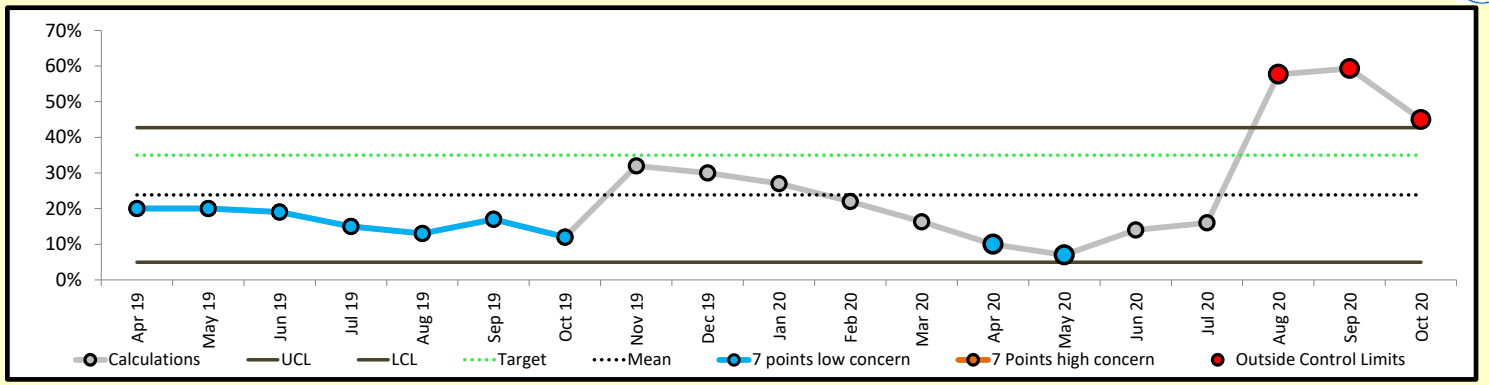
Women and Children's Continuity Of Care



The percentage of pregnancies where the patient had a consistent midwife/midwife team throughout their pregnancy

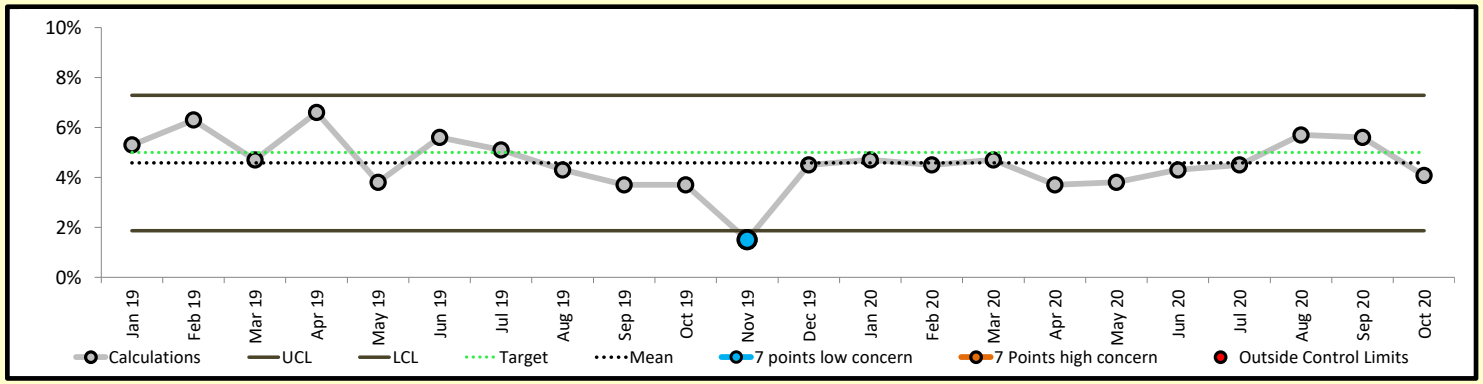
Target: 35% | **Mean: 23.8%**

This Month's Figure: 45.0%

Executive Comments:

Women are being booked onto a low risk pilot model led by the community midwife team Sept-Jan. The increase is due to the change in our covid recovery plan; Community Midwives and their buddies offer care through homebirth, early labour home assessments and following their women to the Blossom midwifery led unit.

Women and Children's - Reducing NNU Term Admissions



The percentage of term admissions to the Neonatal Unit (NNU)

Target: 5% | **Mean: 4.6%**

This Month's Figure: 4.1%

Executive Comments:

This metric is now slightly above the target of 5% but remains within the control limits.

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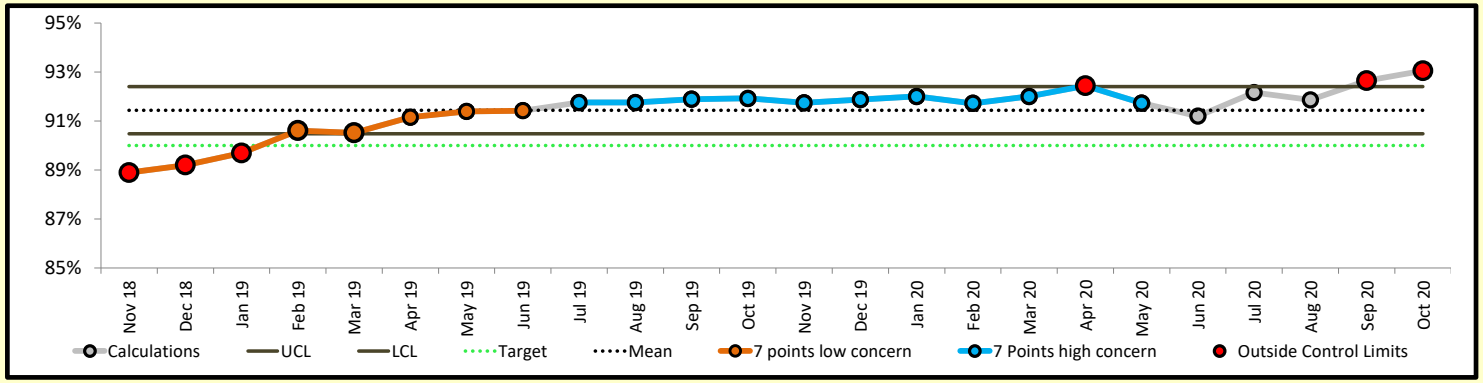
Nurse Retention Rates



The % of nurses being retained

Target: 90%

Mean: 91.4%

This Month's Figure: 93.1%

Executive Comments:

The trust continues to show a sustained improvement against this standard.

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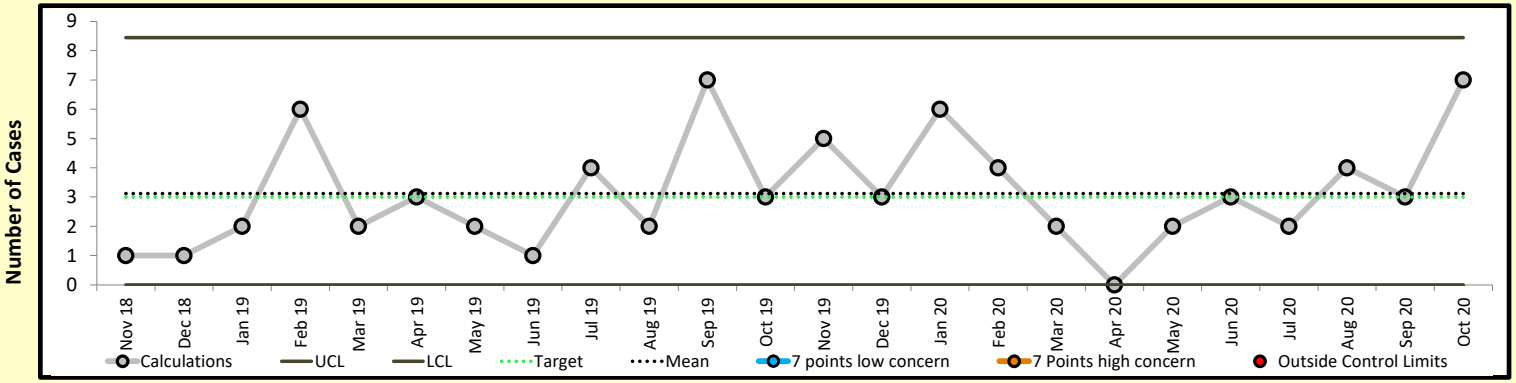
Infection Control - Rate of C.Difficile



Cases of hospital acquired C. Difficile bacteraemia

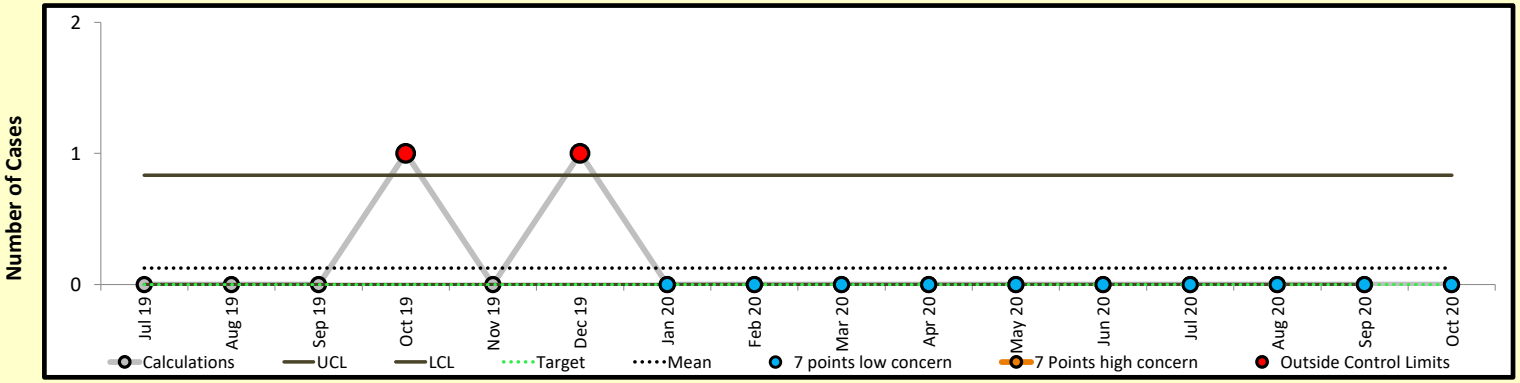
Target: 3 | **Mean: 3.13**

This Month's Figure: 7

Executive Comments:

The October monthly total of 7 cases is the highest monthly figure within the 2020/21 period. There are no direct links between any of the cases (7 cases from 7 different clinical areas). 4 of the cases were identified as positive on admission, but Trust assigned due to previous discharge from the Trust in the previous 28 days. Full root cause analysis investigation has been completed for 2 of the cases which identified no lapses in care. Full IPC department audits have also been completed across 3 of the departments to benchmark standards of IPC practice.

MRSA



Cases of hospital acquired MRSA(Methicillin-resistant Staphylococcus aureus) bacteraemia

Target: 0 | **Mean: 0.13**

This Month's Figure: 0

Executive Comments:

The Trust continues to report zero cases of MRSA bacteraemia, with the last case of this infection reported in December 2019.

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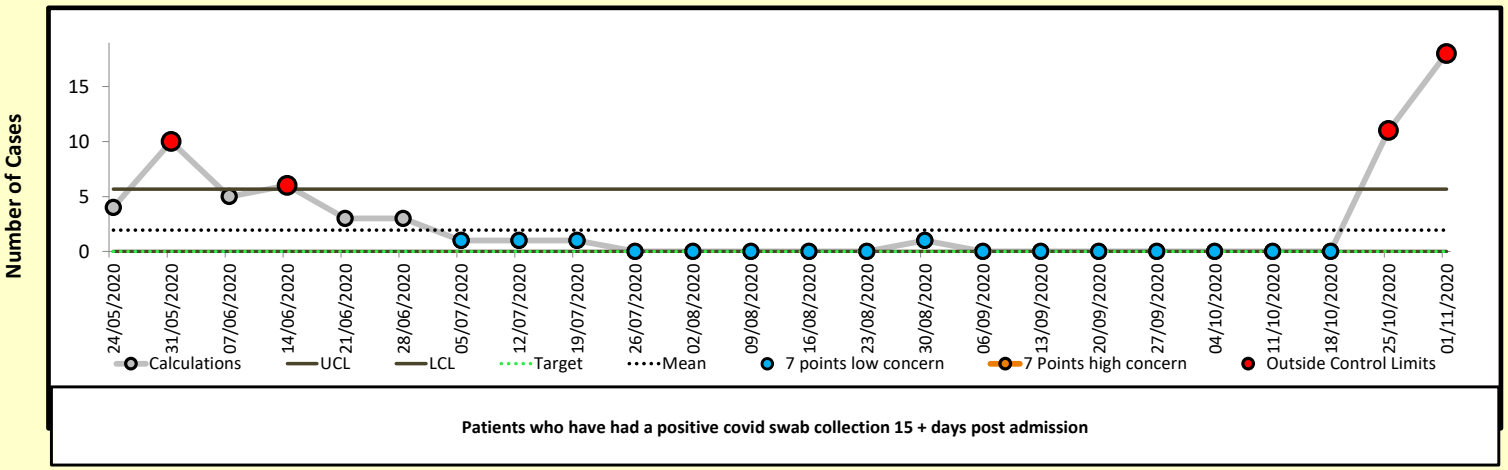
Hospital Onset Covid



Patients who have had a positive covid swab collection 15 + days post admission

Target: To Be Agreed

Hospital Onset Total:
Onset Within 15 Days Admission Total:

Executive Comments:

29 cases of hospital onset COVID-19 infection (HOCI) (positive 15 days +post admission) were reported during October 2020. During October the Trust declared outbreaks of COVID-19 infection within 3 clinical areas. 28 of the 29 cases were related to these outbreak areas. Investigations into all reported HOCI cases have been undertaken with any learning/themes to be disseminated.

Exception Report Oct-20

Planned Actions:

Actions to mitigate risk includes:
On identification of each outbreak, appropriate control measures were implemented –
Implementation of a regime of COVID-19 screening inclusive of all patients and staff from each area
Enhanced levels of environmental and equipment decontamination
Enhanced IPC presence and engagement across each area
Restricting transfer of patients to the affected areas
Daily reporting and analysis continues to be submitted nationally in liaison with the NHSE/I infection prevention & control Lead

An update of COVID-19 Board Assurance Framework has also been undertaken, which includes-

- Enhanced monitoring of IPC practices through the implementation of IPC Link Practitioner audit programme
- Development of COVID-19 staff test and trace service
- IPC induction training focusing upon appropriate measures in relation to COVID-19
- Robust central system of PPE provision via Silver Control, with correct PPE use reinforced through continued programme of comms and clinical based IPC support
- Roll out of designated hand hygiene technique signage across all toilet areas throughout the organisation

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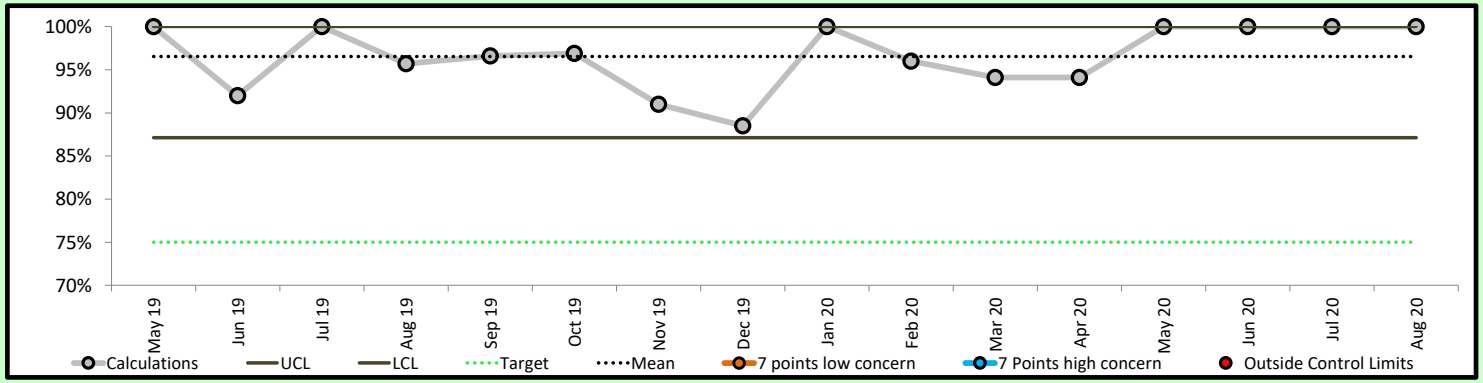
Sepsis Screening



Advancing Quality NEWS2 (National Early Warning Score) recorded within 1 hour of hospital arrival

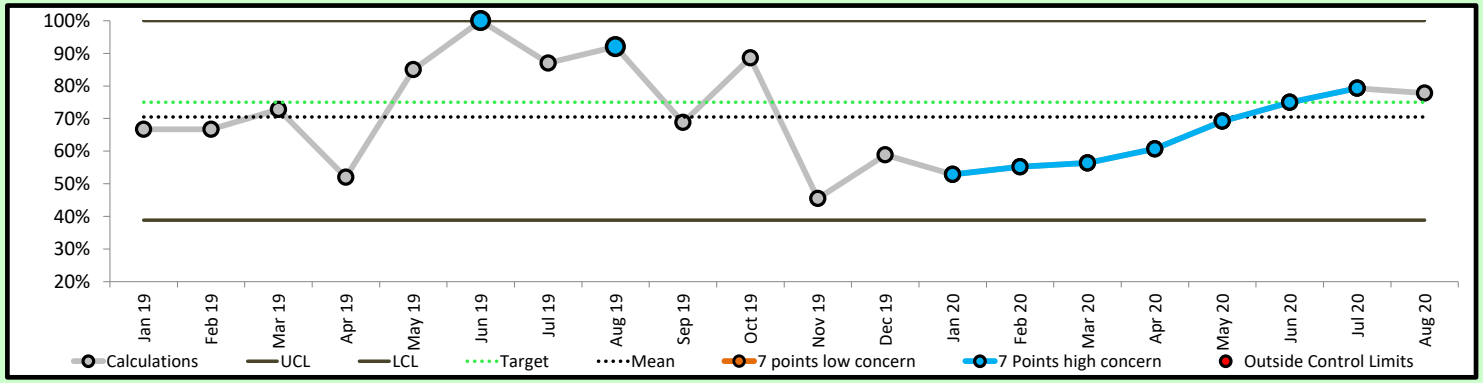
Target: 75% | **Mean: 96.56%**

This Month's Figure: 100%

Executive Comments:

This measure is within the expected variation and remains above the Advancing Quality (AQ) target. This is reported 2 months in arrears. Focus remains on training to ensure consistent performance.
The detailed work being carried out to underpin sustainable improvement in this key area of practice is reflected in the month on month improvements in this metric.

SEPSIS Treatment



Advancing Quality IV - Antibiotics administered within 1 hour of sepsis diagnosis

Target: 75% | **Mean: 70.53%**

This Month's Figure: 78%

Executive Comments:

This measure has remained above the Advancing Quality (AQ) target .
This is reported 2 months in arrears

Exception Report Oct-20

Countess of Chester Hospital NHS Foundation Trust

AQ - SEPSIS NEWS Performance

What do the charts tell us?

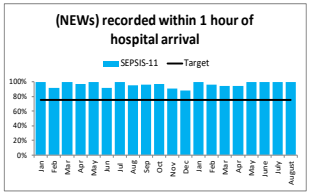
The SPC Sepsis charts report the sepsis screening and antibiotics administration timing as part of the Advancing Quality Sepsis bundle. The target for 2020 is 75% Composite Process Score for care delivery. As the population is generated through ICD10 codes from clinical coding there is a delay in reporting.

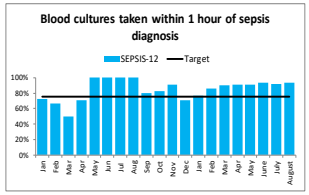
Planned Actions:

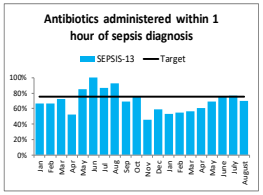
Data: The trust continues to achieve above the cumulative CPS target of 75%. Recent analysis to understand the impact of COVID19 has been undertaken; this has demonstrated that despite patients presenting with ? COVID it has not had a direct impact on sepsis screening or antibiotic administration times.

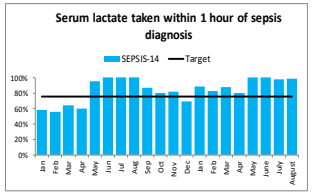
Education: E learning education module in finals stages of development. This will be available to all staff and linked to the ESR system.

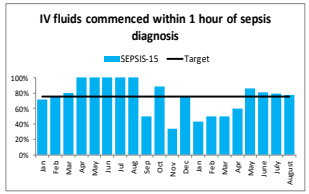
Documentation: The trust has implemented a revised sepsis screening / treatment pathway which has a greater emphasis on senior review/ decision maker. This has been well received across the organsiation.

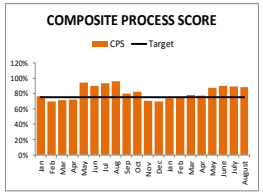


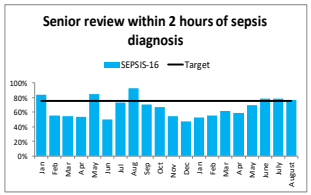


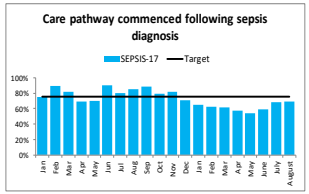


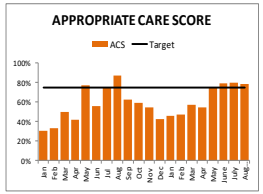












SepsisNEWS			SEPSIS-11	SEPSIS-12	SEPSIS-13	SEPSIS-14	SEPSIS-15	SEPSIS-16	SEPSIS-17	CPS	ACS	
Code Provider		Target	National early warning score (NEWS2) recorded within 1 hour of hospital arrival	Blood cultures taken within 1 hour of sepsis diagnosis	Antibiotics administered within 1 hour of sepsis diagnosis	Serum lactate taken within 1 hour of sepsis diagnosis	IV fluids commenced within 1 hour of sepsis diagnosis	Senior review within 2 hours of sepsis diagnosis	Care pathway commenced following sepsis diagnosis	COMPOSITE PROCESS SCORE	APPROPRIATE CARE SCOR	Number of measures passing out of 6 (excl. data collection measures)
REM	Liverpool Uni Hospital	80.8%	100.0%	85.9%	82.3%	87.2%	97.4%	87.3%	38.0%	89.5%	63.9%	6
RW6	Pennine Acute	78.3%	97.3%	78.4%	84.6%	92.3%	88.1%	81.7%	63.5%	88.8%	75.9%	6
RJR	Countess of Chester	75.0%	100.0%	93.4%	70.3%	98.4%	77.8%	76.6%	68.8%	88.3%	78.1%	5
RRF	WWL	69.0%	100.0%	40.7%	85.2%	70.4%	73.3%	70.4%	77.8%	75.8%	57.1%	5
REN	Clatterbridge	75.0%	100.0%	72.3%	84.6%	81.5%	85.7%	52.3%	67.7%	79.1%	25.0%	4
RBT	Mid Cheshire	67.1%	96.7%	63.9%	72.9%	68.9%	68.2%	26.2%	27.9%	68.6%	41.3%	4
RXN	Lancashire Teaching	67.4%	98.2%	53.8%	57.5%	80.0%	84.0%	46.3%	14.6%	70.8%	37.5%	3
RBL	Wirral	83.6%	98.3%	83.3%	85.5%	92.3%	77.8%	76.1%	48.3%	87.3%	64.2%	3
RJN	East Cheshire	77.7%	85.2%	78.9%	65.0%	65.0%	60.0%	55.0%	45.0%	69.5%	40.7%	2
RVY	Southport and Ormskirk	78.1%	100.0%	54.8%	76.1%	60.3%	80.0%	53.4%	46.6%	71.0%	30.7%	2
RBN	St Helens & Knowsley Tr	75.0%	63.1%	65.4%	83.3%	73.1%	82.9%	74.4%	55.8%	72.8%	28.6%	2
RWW	Warrington and Halton	75.0%	94.8%	49.1%	55.4%	56.1%	86.7%	57.9%	17.5%	65.2%	10.3%	2
All North West			95.4%	71.2%	77.6%	79.9%	82.2%	66.3%	48.1%	79.7%	53.2%	

Ownership:

Lead: Dr Santokh Singh
Executive Lead: Darren Kilroy, Medical Director
Improvement Objective: Achieve targets in all Sepsis graphs
Improvement Timescale: To be agreed

Exception Report Oct-20

Countess of Chester Hospital NHS
NHS Foundation Trust

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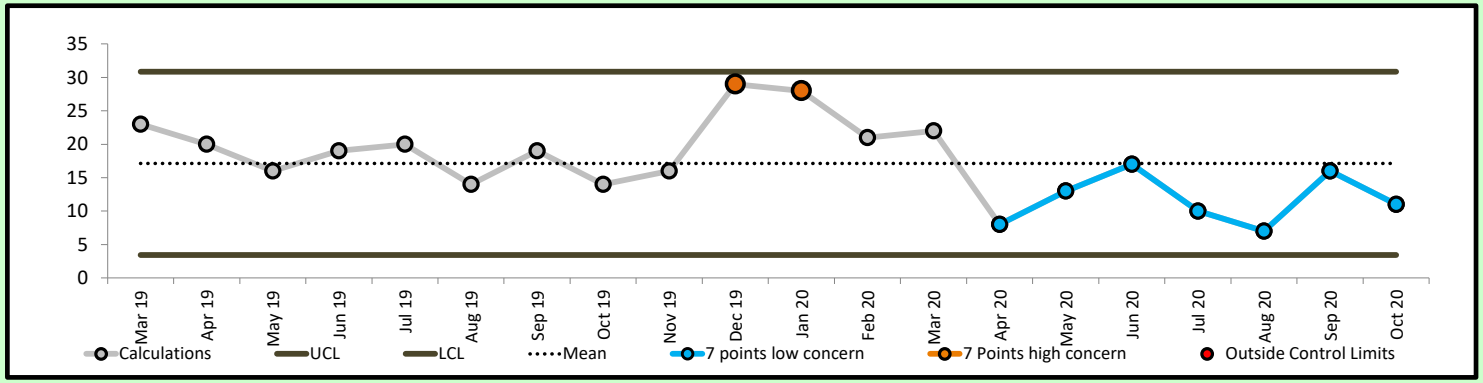
Emergency Response Calls - 2222



Calls received from emergency 2222 number from hospital areas

Target: Within Expected Range

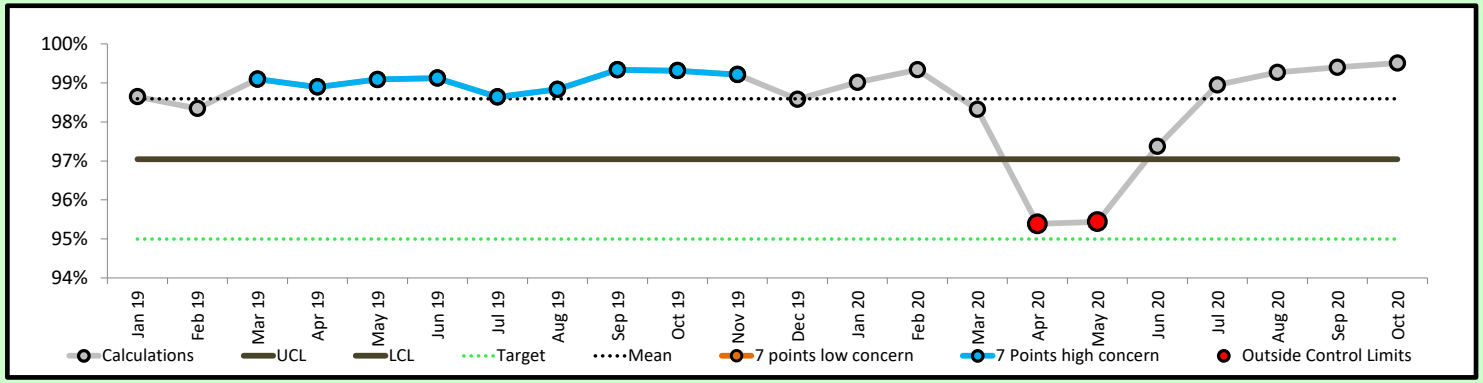
Mean: 17.15

This Month's Figure: 11

Executive Comments:

This metric is being reported to understand and monitor the level of deterioration of patients within the hospital environment. More detailed data relating to this metric will be collected from June 2020 to understand any themes and trends and allow the organisation to respond in a timely way to patients deterioration.

Inpatient Ward Moves



The % of patients having fewer than or equal to 3 Ward moves during their Inpatient spell

Target: 95%

Mean: 98.60%

This Month's Figure: 99.51%

Executive Comments:

This metric is being reported to understand and monitor the number of times patients move under our care in the Trust. It would not be expected that any patient should move more than 3 times during their inpatient stay.

Performance Report Oct-20

Countess of Chester Hospital NHS
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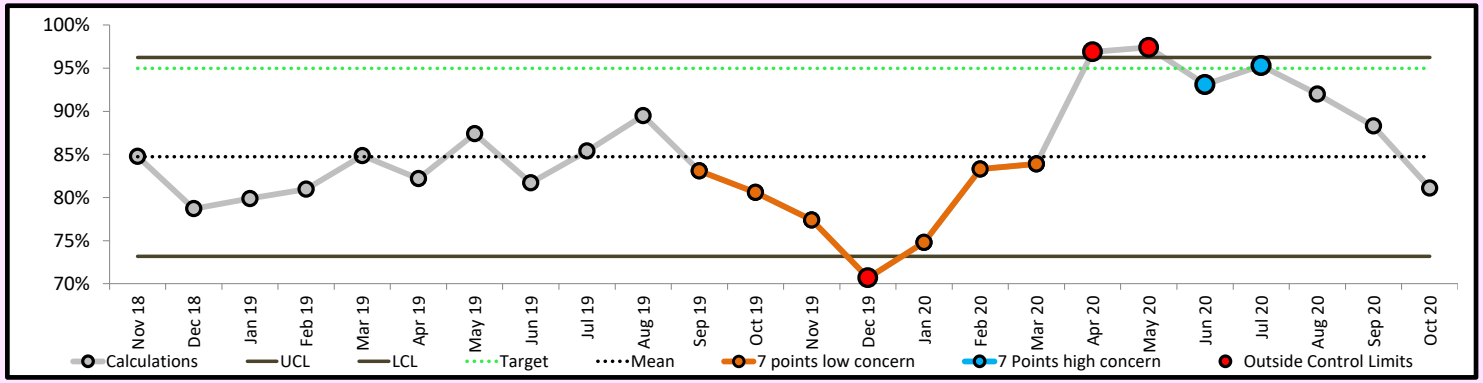
ED 4 Hour Wait Standard



% of A&E attendances that were seen within 4 hours of arrival

Target: 95% | **Mean: 84.72%**

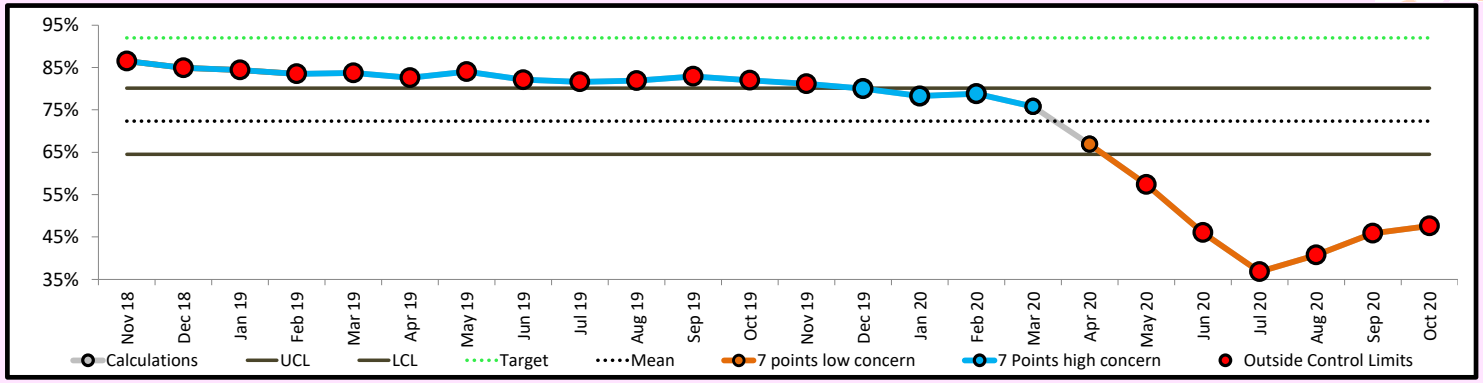
This Month's Figure: 81.10%

Executive Comments:

Nationally, 84.4% of the total attendances were seen within 4 hours. National type 1 performance was 77.6%, CoCH was 79.4%, whilst National Type 3 performance was 99.4% compared to the trusts score of 99.6%

An exception report is provided.

18 Weeks Referral To Treatment (RTT) Incomplete Pathways



The % of incomplete pathways for English patients within 18 weeks

Target: 92% | **Mean: 72.31%**

This Month's Figure: 47.62%

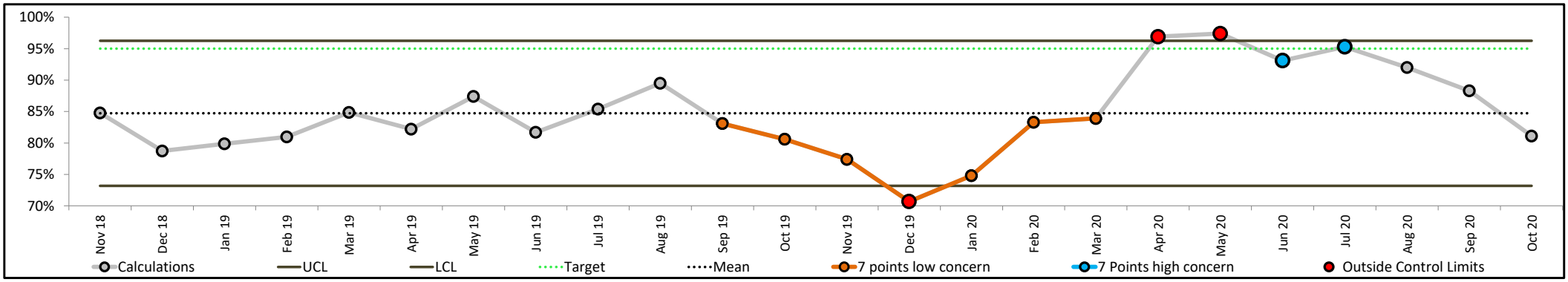
Executive Comments:

This metric identifies the percentage of patients who are still on an 18 week pathway, for example the figure for October shows that 48% of patients are currently waiting under 18 weeks at month end. The latest national figure for this indicator is 60.6% (September 2020). An exception report is provided.

Supplementary ED Information

Countess of Chester Hospital NHS
NHS Foundation Trust

ED 4 Hour Wait Standard



What does the chart tell us?

This month's 4 hour wait standard has returned to pre-covid levels . Persistent higher compliance over the prior 6 months lead to a run of 7 points below the mean from September 2019 to March 2020.

Ownership:

Primary Lead: David Coyle, Chief Operating Officer

Improvement Objective: Remain above national standard

Improvement Timescale: Ongoing

Updates:

Attendances and admission activity at levels pre-COVID - bed occupancy remains high. ED department performance has been stable however overall performance against 4 hour standard has fluctuated due to the rising prevalence of C19 and associated bed waits based on how we allocate the bed base to support patient cohorts which can impact the flow of admitted patients from ED

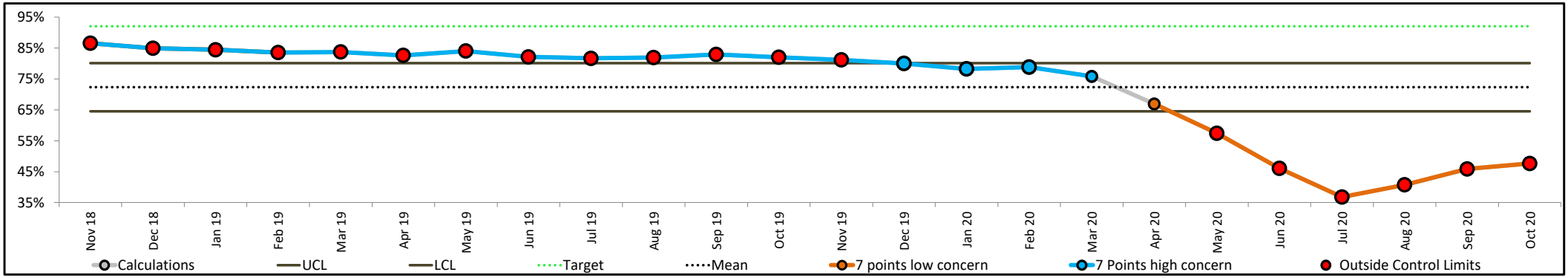
The Trust has been functioning at 95%+ occupancy for over four weeks now and this is having a significant impact on exit block in ED. The ED team remain motivated and energetic in ensuring that patients receive safe and timely care.

Isolation cubicle works completed both GPU & ED in November which will provide greater flexibility for flow across urgent and emergency pathways

Exception Report Oct-20

Countess of Chester Hospital NHS
NHS Foundation Trust

18 Weeks Referral To Treatment (RTT) Incomplete Pathways



What does the chart tell us?

The RTT figure is currently out of the expected range.
The Covid-19 pandemic has caused a rapid decline as a result of significant reduction in both our elective and outpatient ability and the fact that patients have not wanted to come onto the hospital site.

Due to Covid-19, trajectories will be set for the remainder of the financial year as early as possible.

Ownership:

Lead: Divisional Directors
Primary Lead: David Coyle, Chief Operating Officer
Improvement Objective: Once Covid restoration is in place, progress will be agreed
Improvement Timescale: To be agreed

Planned Remedial Actions:

The focus continues to be on cancer and urgent work. All new referrals continue to be clinically triaged. Patients continue to exercise their personal choice to delay appointments and treatments so patient choice as a reason for delaying treatment has increased and this is increasing on a monthly basis.

The Trust continues to conduct the Clinical Validation exercise where extended clinic consultation has been required on all urgent, fast-track and over 30 week waiting patients on RTT pathways.

Following a conversation with NHSI regarding the challenges we are facing in terms of estates, workforce, IPC guidance and behaviours, we have requested support from ECIST in order to gain support and insight on how we can increase our productivity.

Performance Report Oct-20

Countess of Chester Hospital NHS
NHS Foundation Trust

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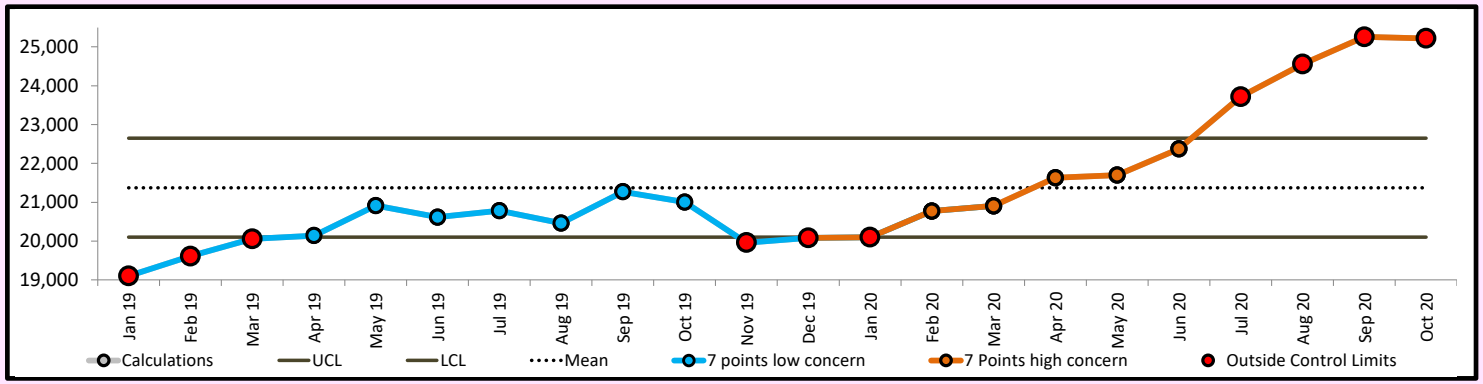
Total number of 18 Weeks Referral To Treatment (RTT) Incomplete Pathways



The total number of incomplete pathways for English patients

Target: To be agreed

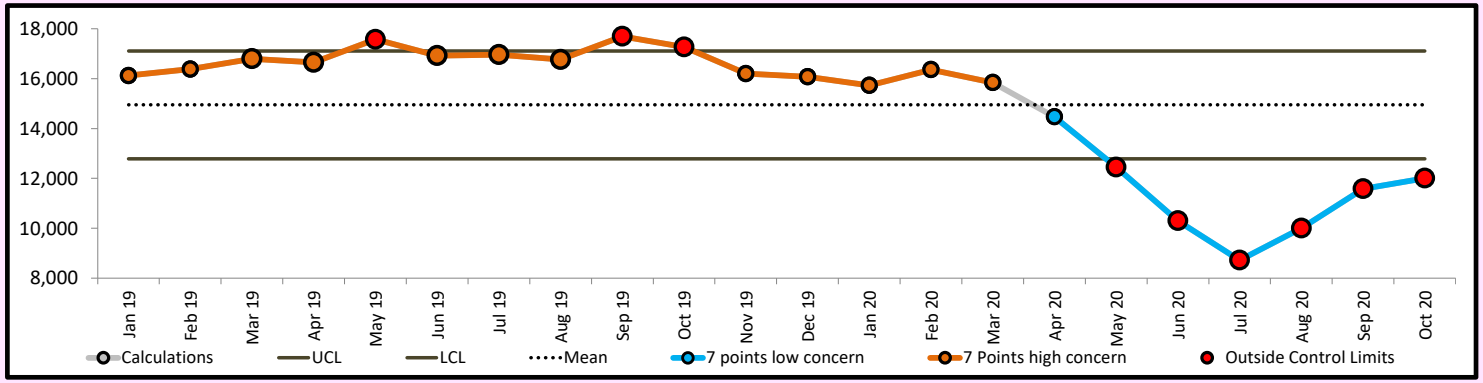
Mean: 21375

This Month's Figure: 25220

Executive Comments:

This metric has been added to give additional clarity to our Referral To Treatment metric.

Referral To Treatment (RTT) Incomplete Pathways of patients waiting between 0 - 18 weeks



The total number of incomplete pathways for English patients between 0 - 18 weeks

Target: To be agreed

Mean: 14949

This Month's Figure: 12010

Executive Comments:

This metric has been added to give additional clarity to our Referral To Treatment metric.

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Countess of Chester Hospital NHS
NHS Foundation Trust

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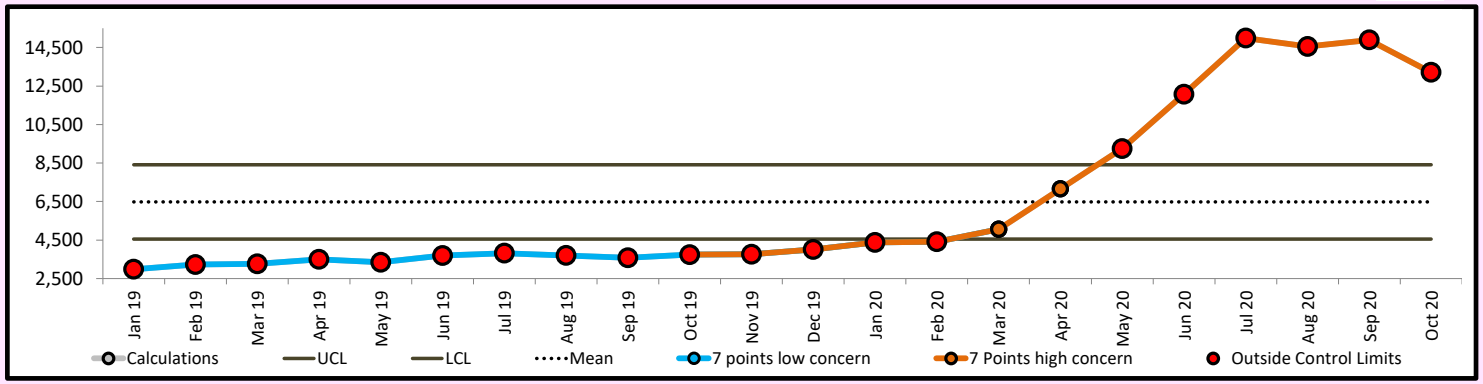
Referral To Treatment (RTT) Incomplete Pathways of patients waiting over 18 weeks



The total number of pathways for English patients exceeding the 18 week RTT target

Target: To be agreed

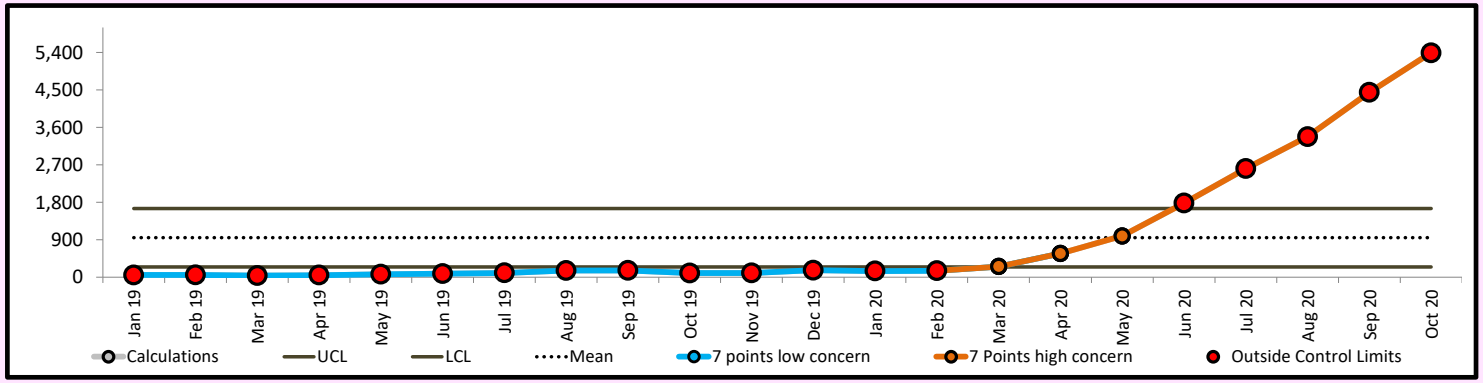
Mean: 6481

This Month's Figure: 13210

Executive Comments:

This metric has been added to give additional clarity to our Referral To Treatment metric.

Referral To Treatment (RTT) Incomplete Pathways of patients waiting over 40 weeks



The total number of pathways for English patients exceeding 40 weeks from Referral To Treatment (RTT)

Target: To be agreed

Mean: 946

This Month's Figure: 5392

Executive Comments:

This metric has been added to give additional clarity to our Referral To Treatment metric.

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Countess of Chester Hospital NHS
NHS Foundation Trust

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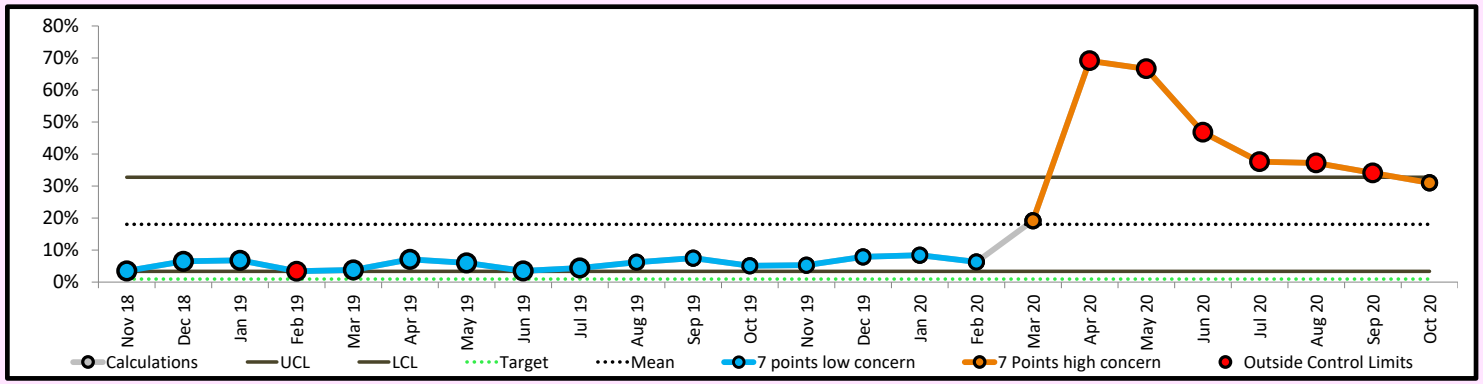
Diagnostic Tests Exceeding 6 Weeks Waiting Time(DM01)



The % of Diagnostic tests that have currently not been carried out within 6 weeks of the request being received

Target: 1% | **Mean: 18.05%**

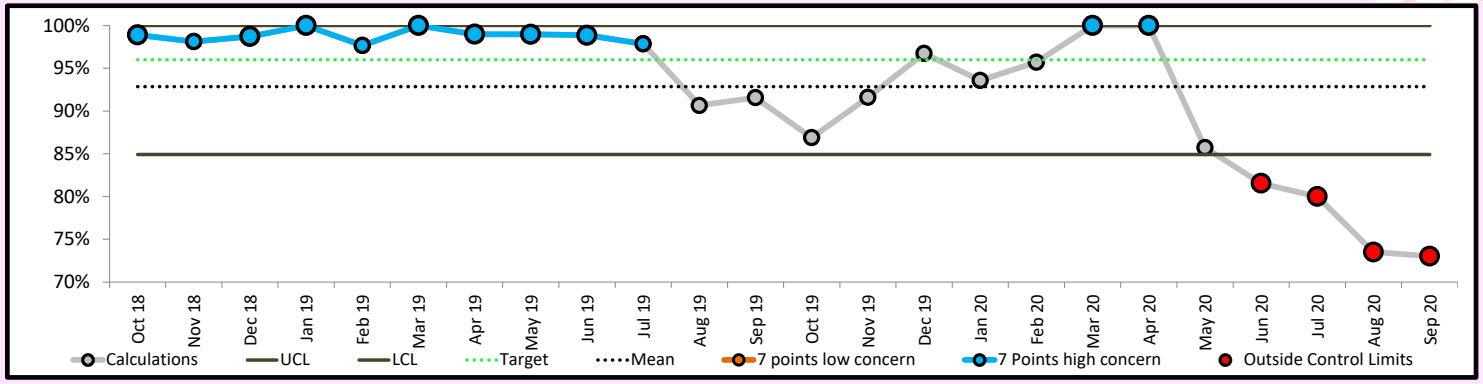
This Month's Figure: 31.00%

Executive Comments:

The latest national figure for this indicator is 33.0% (September 2020).

An exception report is provided.

Cancer Treatments: 31 Day Standard



The number of patients who received their first definitive cancer treatment within 1 month of being diagnosed

Target: 96% | **Mean: 92.86%**

This Month's Figure: 73.00%

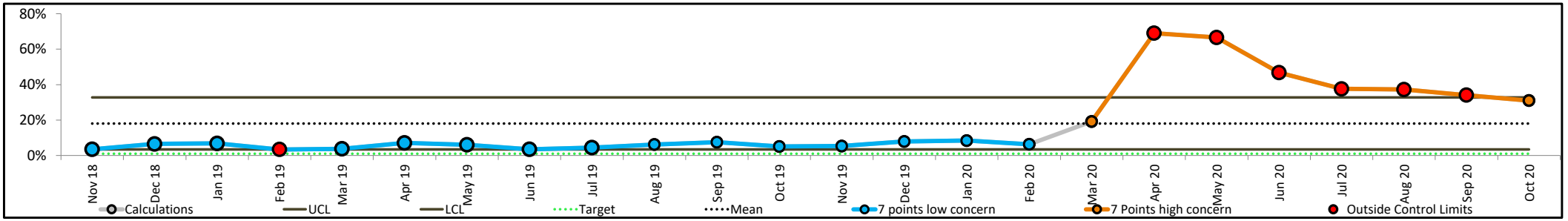
Executive Comments:

Performance has again dropped and remains below target at 73%. The latest national provisional figure for this metric is 94.5% (September 2020). This indicator is reported one month in arrears.

Exception Report Oct-20

Countess of Chester Hospital NHS
NHS Foundation Trust

Diagnostic Tests Exceeding 6 Weeks Waiting Time(DM01)



Month End Snapshot	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Magnetic Resonance Imaging		2	13	20	19	117	527	476	239	98	32	7	2
Computed Tomography	11	26	49	52	29	20	213	212	110	69	88	76	68
Non-obstetric ultrasound						380	1524	1099	482	218	68		
CRV - Vascular						15	111	151	165	149	54		
Barium Enema						2	9	14	2				
Audiology - Audiology Assessments	15	9	44	45	30	91	239	286	286	265	289	307	271
Cardiology - echocardiography			3	4		44	237	220	156	89	99	7	5
Respiratory physiology - sleep studies						3	17	38	25	19	19	12	12
Colonoscopy	53	45	49	40	20	21	179	216	223	145	254	231	168
Flexi sigmoidoscopy	4	7	8	12	9	35	93	106	117	132	144	127	98
Cystoscopy	66	78	107	125	140	171	309	348	429	469	469	454	341
Gastroscopy	137	145	155	152	119	125	414	456	487	517	574	606	547
Total patients waiting	5601	5837	5390	5330	5797	5326	5601	5437	5812	5764	5617	5362	4885
Total breaches	286	312	428	450	366	1024	3872	3622	2721	2170	2090	1827	1512
% > Threshold	5.1%	5.3%	7.9%	8.4%	6.3%	19.2%	69.1%	66.6%	46.8%	37.6%	37.2%	34.1%	31.0%

Ownership:

Primary Lead: David Coyle, Chief Operating Officer
Lead: Divisional Directors
Improvement Objective: Achieve Target
Improvement Timescale: Once Covid restoration is in place, progress will be agreed

Due to COVID-19, performance has decreased in the previous 5 months and now lies above the upper control limit. The previous 5 months figures have caused a run of 18 points below the mean.

Planned Remedial Actions:

Endoscopy:

In October 997 patients were treated in Endoscopy and the overall waiting list reduced. This is evident in the numbers for DM01 where we now have less patients waiting more than 6 weeks. This has been largely down to insourcing which will continue until mid-Feb, however, in order to maintain that position going forwards, extra capacity will be required within Endoscopy.

The team continues to work hard to maximise every session, however the current swabbing process and isolation period hampers any opportunity to back-fill leaving some lists under-utilised due to patient cancellations prior and on the day, along with patient failure to attend for both swab and procedure. Endoscopy continue to be short of one scoping room due to equipment malfunction but a replacement has been confirmed which means that all five rooms will be functional in January. Acceptance rates have fallen to 63% meaning we cannot always target the patients we need to come in.

Radiology :

Performance has been maintained with Ultrasound at 100%, MRI at 99% and CT at 89%. All CT breeches are related to cardiac imaging for which there is a shortage of highly specialised consultant staff. We have investigated the possibility of utilising cardiac imaging in private hospitals, however there still remains a lack of cardiac imaging specialists so there is no additional availability. Additional capacity continues to be used within the private sector. The department continues to see very high demand for urgent and cancer diagnostics which challenges the depleted workforce.

Performance Report Oct-20

Countess of Chester Hospital NHS
NHS Foundation Trust

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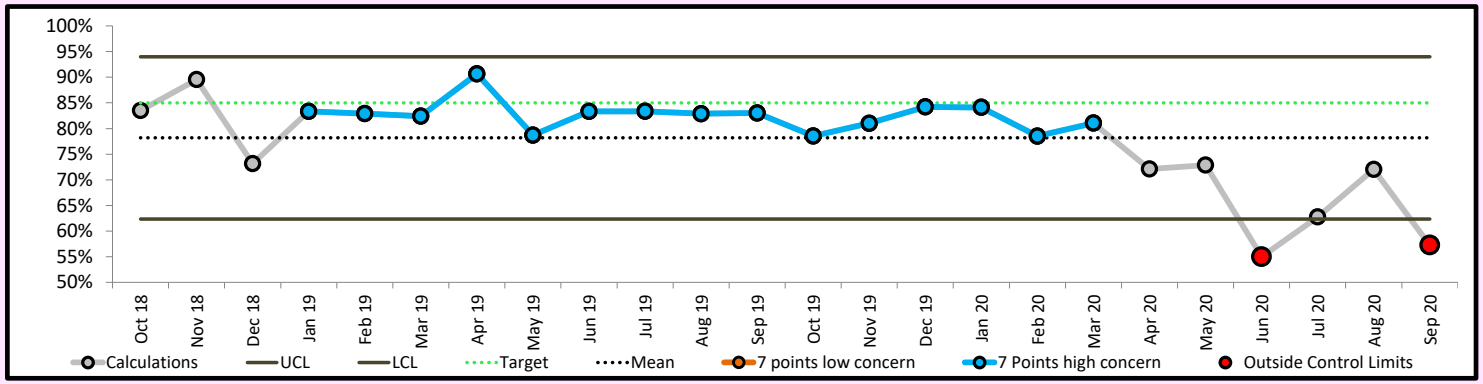
Cancer Treatments: 62 Day Standard



The percentage of patients having their first treatment for cancer within 62 days of an urgent referral through the GP 2 week referral route

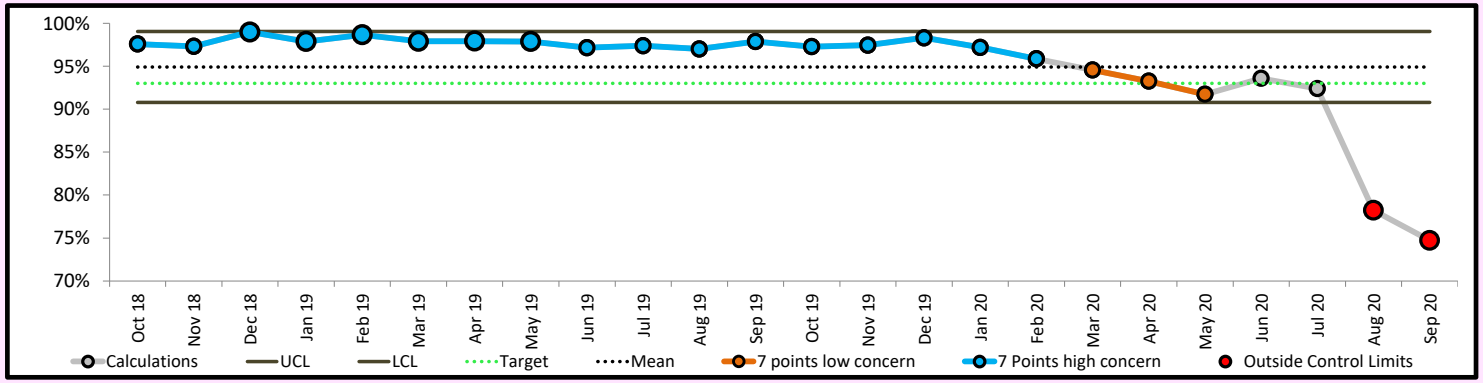
Target: 85% | **Mean: 78.18%**

This Month's Figure: 57.26%

Executive Comments:

Performance has now returned above the Lower Control Limit but is still below target. This indicator is reported one month in arrears.
The latest national provisional figure for this indicator is 74.7% (September 2020).

Cancer Treatments: 14 Day Standard



The number of patients referred from their GP with suspected cancer should have their first appointment within 14 days

Target: 93% | **Mean: 94.93%**

This Month's Figure: 74.71%

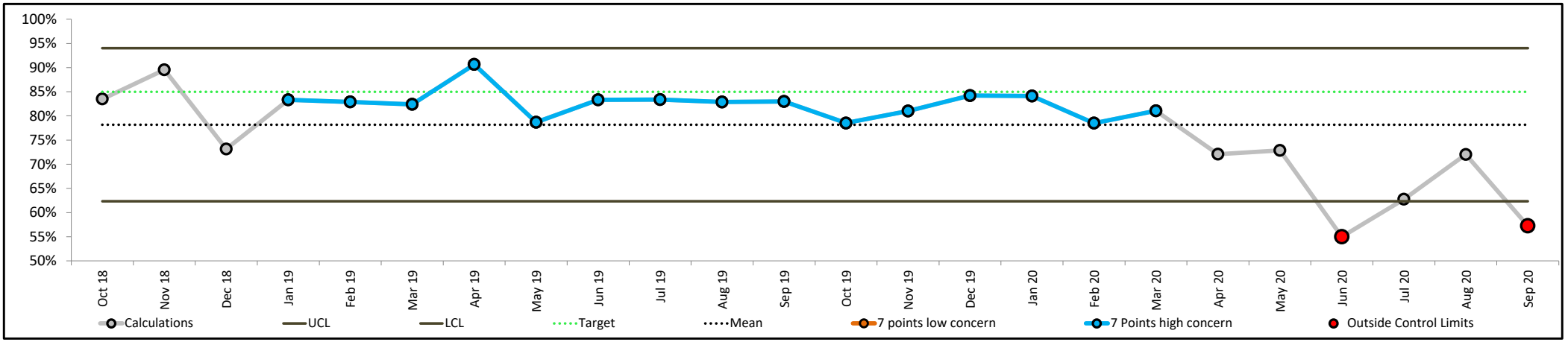
Executive Comments:

Performance is now outside the Lower Control Limit. The latest national provisional figure for this indicator is 87.8% (September 2020). This indicator is reported one month in arrears. 14 day performance has been affected this month due to reduced number of patients seen and a high number of breaches particularly in Breast and Colorectal, following triage of referrals and appointments booked based on clinical priority.

Exception Report Oct-20

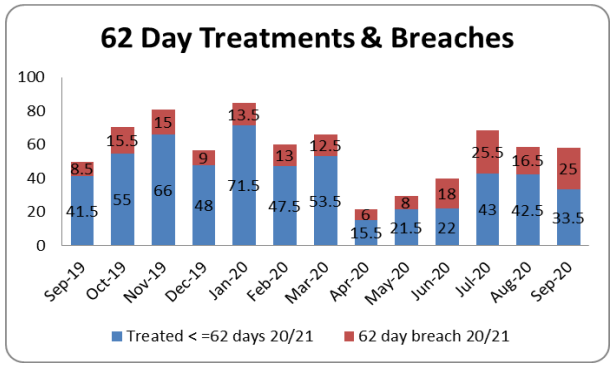
Countess of Chester Hospital NHS
NHS Foundation Trust

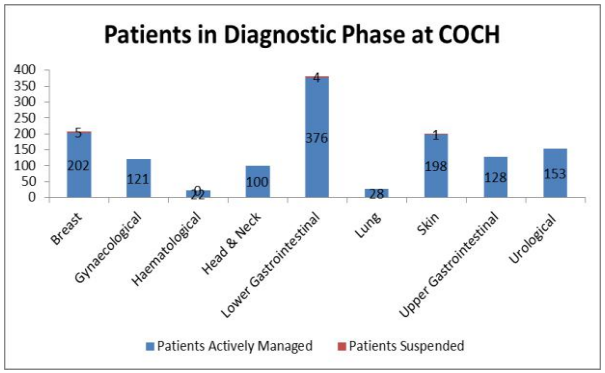
Cancer Performance - 62 Days



What does the chart tell us?

This month's Cancer Performance - 62 Days score returned within the boundaries of the control limits, but remains under target.





Breakdown of CoCH Patients on the PTL for over 100 days

	AWAITING DATE	DATED
OPA	1	4
OTHER DIAGNOSTICS	2	1
ENDOSCOPY	15	6
RADIOLOGY	1	1
TCI TREATMENT	12	14

	OTHER UPDATES
AWAITING CLINIC LETTER	1
AWAITING CLINICAL DECISION	3
AWAITING HISTOLOGY	4
AWAITING RADIOLOGY REPORT	1
CLINICAL TEAM TO ORDER INVESTIGATION	1
PATIENT DELAY	6
MDT REVIEW	1

Exception Report Oct-20

Countess of Chester Hospital NHS Foundation Trust

Planned Remedial Actions:

Endoscopy

The Colorectal, Upper GI and Urology have all been impacted with no access to Endoscopy during the pandemic. The numbers continue to reduce for both Colorectal and Upper GI. Urology is still a concern with a high number of patients awaiting Flexi Cystoscopy. The insourcing contract is addressing this.

Endoscopy work continues at Grosvenor Nuffield Hospital (GNH).

Validation continues between Endoscopy and clinical teams to review patients who are still unwilling to engage for their diagnostic test.

Insourcing for Endoscopy has commenced for Colonoscopy (Colorectal) and Flexi Cystoscopy (Urology) and is continuing through November and December with a pause at Christmas. There are plans to continue this work into January.

A total of 8 Colonoscopies and 58 Flexi Cystoscopies have been completed on weekend lists during October. The planned capacity up to Christmas is 48 Colonoscopies, 48 Flexi Cystoscopies and 16 OGD's.

Theatres

Theatre activity has continued across all specialities with designated blocks of time for operating, which is supporting GA diagnostics and treatment surgery.

Work has continued to outsource Skin (Plastics) patients to Whiston NHS Trust for surgical procedures, due to volume of undated patients on the waiting list. Theatre sessions continue at the Grosvenor Nuffield Hospital for these patients. As previously a request has been made to ECIST to ask for support in terms of theatre productivity and reduced waiting times.

First Outpatients

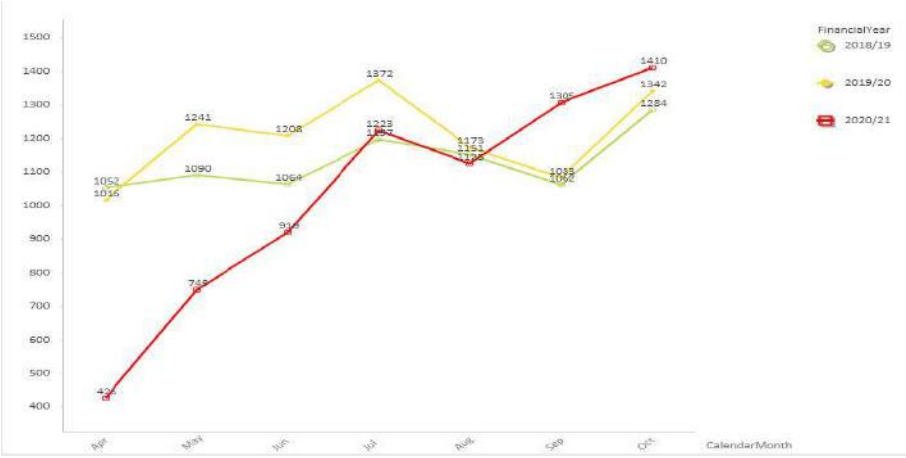
There has been pressure in Colorectal, Gynae and Breast resulting in an underachievement of the two-week target for September.

The Breast service has been triaging appointments during the pandemic only seeing patients (face-to-face) who are deemed most at risk for cancer. Additional clinics have taken place through September, which has resulted in a large number of breaches. The provisional position for October does show an improvement, although it is anticipated that the service will continue to underachieve for a few months.

Referrals

The Trust has continued to see a high number of referrals and for both September and October, both months are above the number received in previous years for this period.

Cancer Referrals per month from April 2016



Ownership:

Primary Lead: David Coyle, Director of Clinical Operations
Improvement Objective: Achieve Target
Improvement Timescale: Currently under review

Patients waiting over 100 days by location

	APH	CCC	COCH	LHCH	RLUH	SALFORD	UHA	WHIS	Grand Total
Breast			7						7
Colorectal			18						18
Gynaecology			1						1
Head and Neck			2						2
Lung		1	1	2					4
Skin			17					1	18
Upper GI			6		1		3		10
Urology	2		26		1	1			30
Grand Total	**2**	**1**	**78**	**2**	**2**	**1**	**3**	**1**	**90**

Performance Report Oct-20

Countess of Chester Hospital NHS
NHS Foundation Trust

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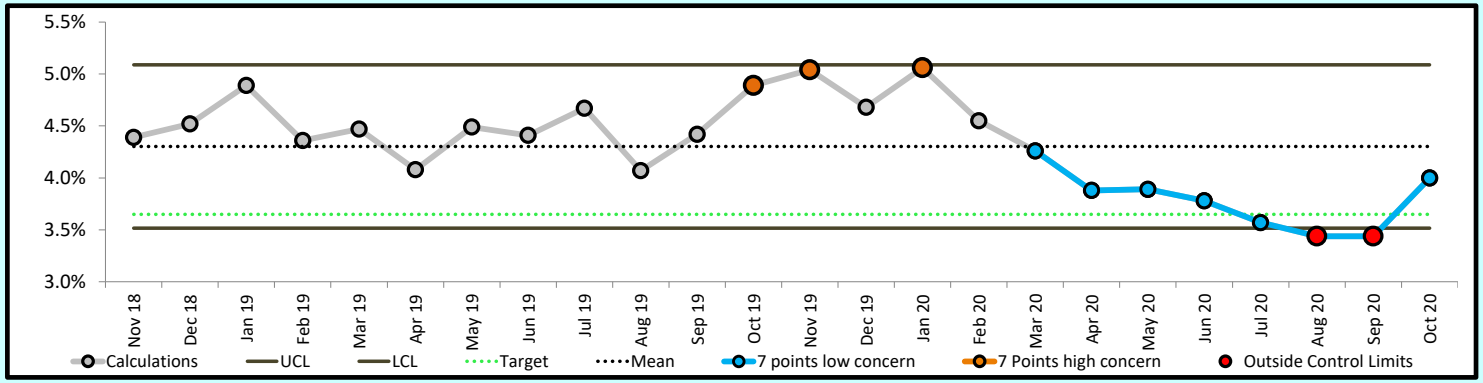
Sickness Absence



The % of monthly sickness absence, excluding comfort zone (café) and bank staff

Target: 3.65% | **Mean: 4.30%**

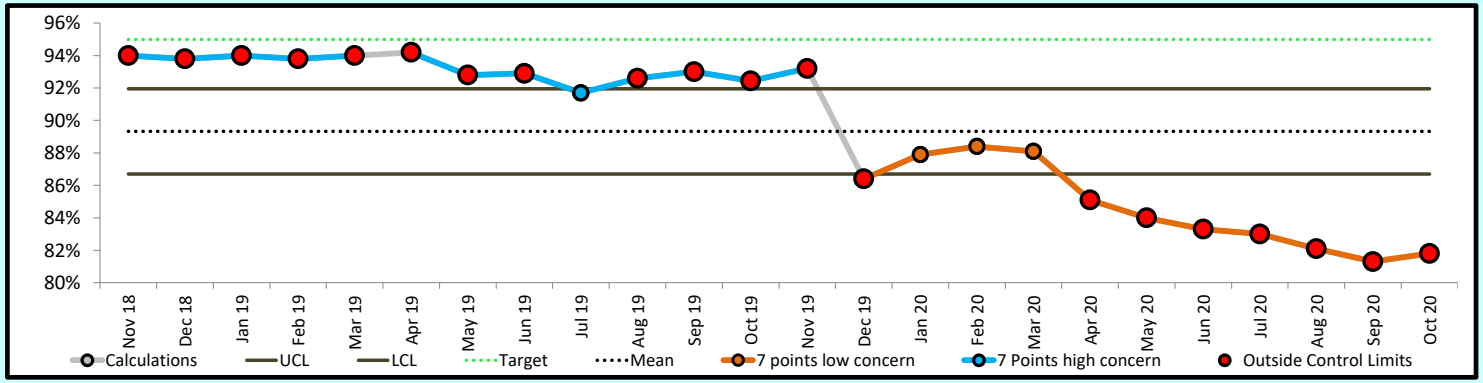
This Month's Figure: 4.00%

Executive Comments:

The October Sickness absence rate is 4.00%. Exception report provided. Performance is above target.

COVID ABSENCE – 2.91%

Mandatory Training Compliance



The % of Mandatory Training Compliance, excluding Comfort Zone (Café) and bank staff, as well as staff on Maternity leave/lon g term sickness

Target: 95% | **Mean: 89.33%**

This Month's Figure: 81.80%

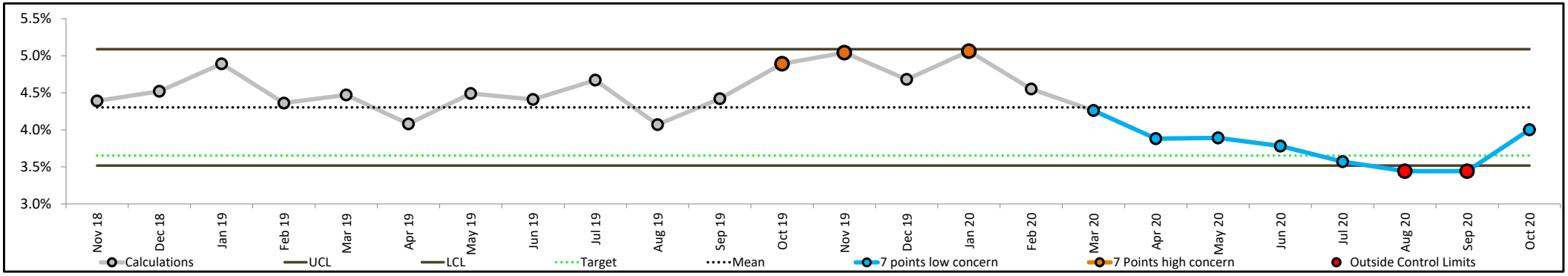
Executive Comments:

Mandatory Training compliance continues to remain below target. Exception Report provided.

Exception Report Oct-20

Countess of Chester Hospital NHS Foundation Trust

Sickness Absence



What does the chart tell us?

Since January 2020, sickness absence levels have continued to fall with the last 3 months absence rates falling below the Trust's target of 3.65%. However, these figures do not include the Covid-19 related absences which are reported separately as per Government guidelines. When the Covid-19 absence rate (currently reported as being 2.91%) the overall absence level within the Trust is 6.56% and therefore above target.

Ownership:

Lead: Dee Appleton-Cairns, Deputy Director of People and OD
Executive Lead: Alyson Hall
Improvement Objective: Achieve Target
Improvement Timescale: To be agreed

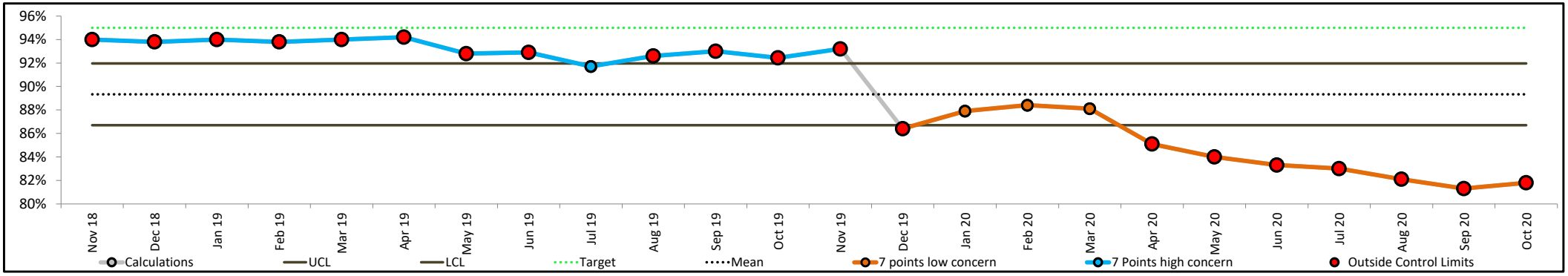
Proposed Actions:

Following the cessation of the National Staff-side Partnership Agreement requiring all Trust's to suspend the processing of any absence cases without the agreement of the individual or Trade Union representative the Trust is now working locally to Staff-side colleagues to review all open cases. Covid-19 related absences are monitored on daily basis with Staff Testing and risk assessments taking place regularly to facilitate staff returning to work at the earliest opportunity. Further testing is expected to commence over the coming weeks together with the launch of the NHS national vaccination programme.

Exception Report Oct-20

Countess of Chester Hospital NHS Foundation Trust

Mandatory Training Compliance



Changes to this metric:

Trust compliance remains below target at 81.8%.Compliance for Mandatory training in October remains significantly below target, due in part to increased pressures and availability of training since the start of the COVID 19 pandemic. All non-essential training was stood down for March, April & May to focus of critical training and Mask Fit Testing.
As of June 2020 face to face training was restarted with reduced course capacity in line with social distancing protocols. Clinical and Medical Mandatory Training have now been combined and reduced to the practical sessions of Resus, Manual Handling, Fire Evacuation and End of Life Care.
All other elements of Statutory and Mandatory Training will now be completed solely by e-learning – all non-clinical will be completed by e-learning. Local Induction continues to remain below the Trust target at 53.7%.

Ownership:

Lead: Dee Appleton-Cairns, Deputy Director of People and OD
Executive Lead: Alyson Hall
Improvement Objective: Achieve Target
Improvement Timescale: To be agreed

Planned Remedial Actions:

A trajectory will be put together to understand the amount of training sessions that will be required to clear the backlog and improve compliance figures. Potential changes in Covid regulations and social distancing will assist in allowing for more capacity. Increasing the offering of training via E-Learning will support this improvement.

Mandatory Training Table October 2020

Position	Division	Compliance
1	Finance & Performance	91.3%
2	HRWBS	91.3%
3	Diagnostics and Pharmacy	86.3%
4	Human Resources	86.8%
5	Estates & Facilities	85.1%
6	Integrated Care Partnership	82.9%
7	Corporate Non - Clinical	81.1%
8	Planned Care	81.3%
9	Urgent Care	78.8%
10	Nurse Management	68.7%
	Total	81.8%

Local Induction Table October 2020

Position	Division	Compliance
1	Estates & Facilities	76.9%
2	Finance & Performance	75.0%
3	Corporate Non - Clinical	66.7%
4	Integrated Care Partnership	65.7%
5	Diagnostics and Pharmacy	61.3%
6	Planned Care	53.7%
7	Urgent Care	51.1%
8	Human Resources	50.0%
9	HRWBS	33.3%
10	Nurse Management	20.9%
	Total	53.7%

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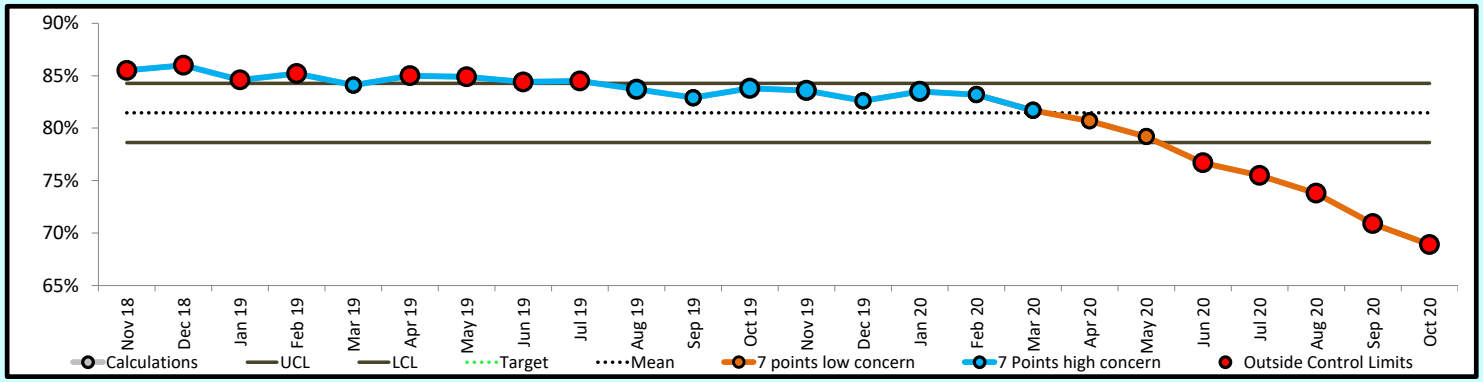
Annual Appraisal Compliance



Annual Appraisal Rate, again excluding Bank staff and long term absentees, staff with < 1 years service also excluded

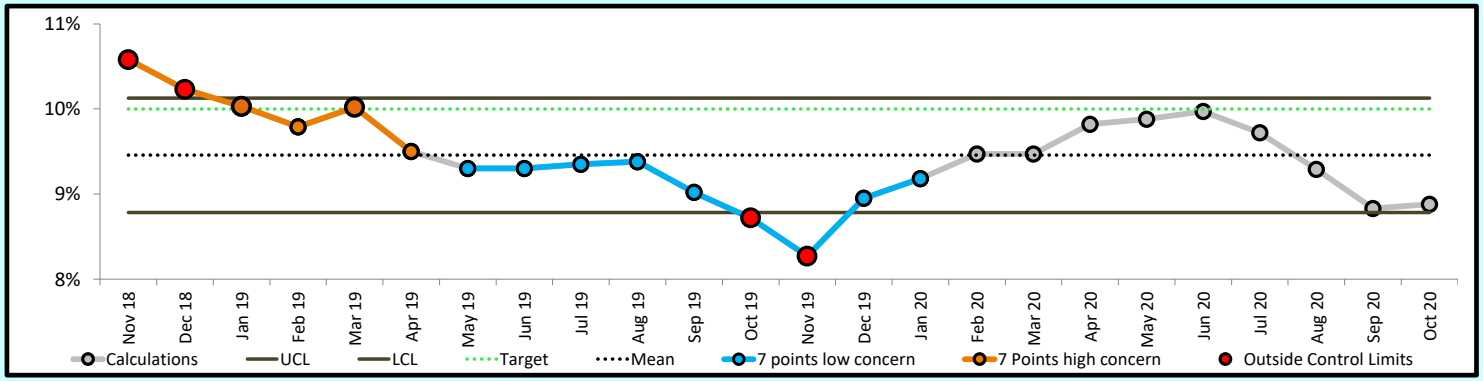
Target: 95% | **Mean: 81.45%**

This Month's Figure: 68.90%

Executive Comments:

Appraisal compliance decreased in October. Exception report provided.

Staff Turnover



The staff turnover rate is based on headcount in the previous 12 months and is comprised of only permanent staff

Target: 10% | **Mean: 9.46%**

This Month's Figure: 8.88%

Executive Comments:

Performance is inside target at 8.88%.

Performance Report Oct-20

Countess of Chester Hospital NHS
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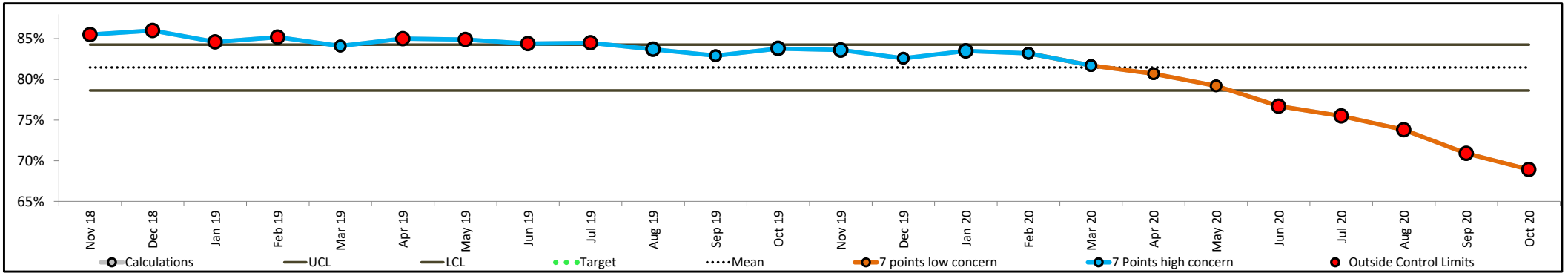
Annual Appraisal Compliance



What does the chart tell us?

Appraisal compliance has decreased in October to 68.9%, this remains below our corporate target of 95%. Much of the decrease can be attributed the increase pressures during the winter period and then futher impacted duing the COVID pandemic.

Proposed Actions:

HR Business Partners continue to escalate the compliance rate in the monthly divisional reports & at governance boards, stressing the importance of completing appraisals on a timely basis. Guides to inputting appraisals via ESR have also been sent out monthly to ensure the input is accurate and timely. Development of the new electronic PDR system is continuing with further discussions taking place to support the system to be ready later in the year. From this month we will be analysing appraisals overdue after 14 months to ensure that we are not over reporting but, this has seen no statistically significant change. Following feedback from the Staff Survey and CQC, we will also be reviewing the perceived value and quality of appraisals to support staff to undertake their roles.

Ownership:

Lead: Dee Appleton-Cairns, Deputy Director of People and OD
Executive Lead: Alyson Hall
Improvement Objective: Achieve Target
Improvement Timescale: By March 2020

Appraisal Table October 2020

Position	Division	Compliance
1	Diagnostics and Pharmacy	74.6%
2	Planned Care	74.0%
3	Estates & Facilities	71.9%
4	Urgent Care	71.4%
5	Finance & Performance	67.6%
6	Integrated Care Partnership	53.4%
7	Human Resources	50.0%
8	Corporate Non - Clinical	44.1%
9	Nurse Management	43.8%
10	HRWBS	4.2%
	Total	68.9%

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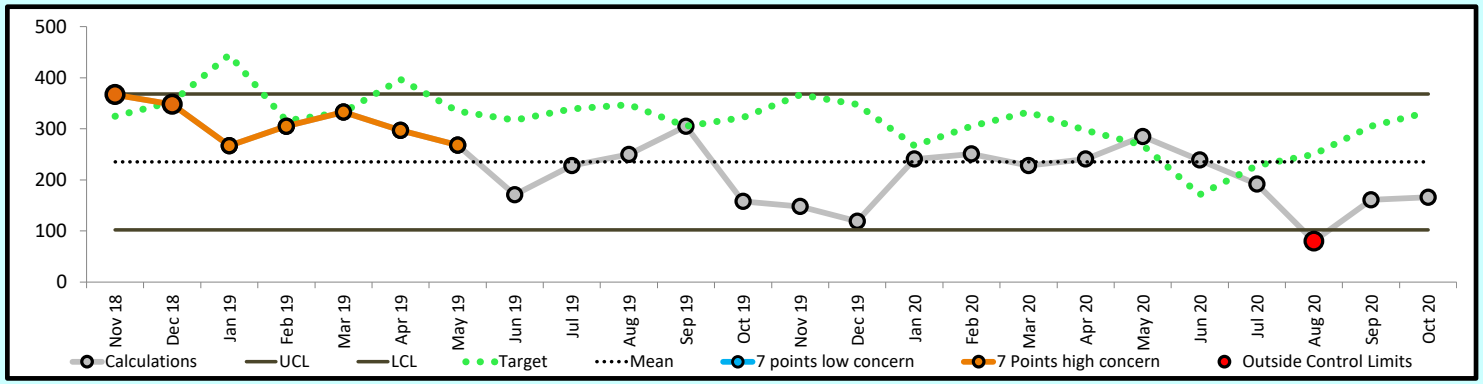
Medical & Dental Reduction in Agency Shifts over Cap Rates



Reducing agency shifts over the cap rates

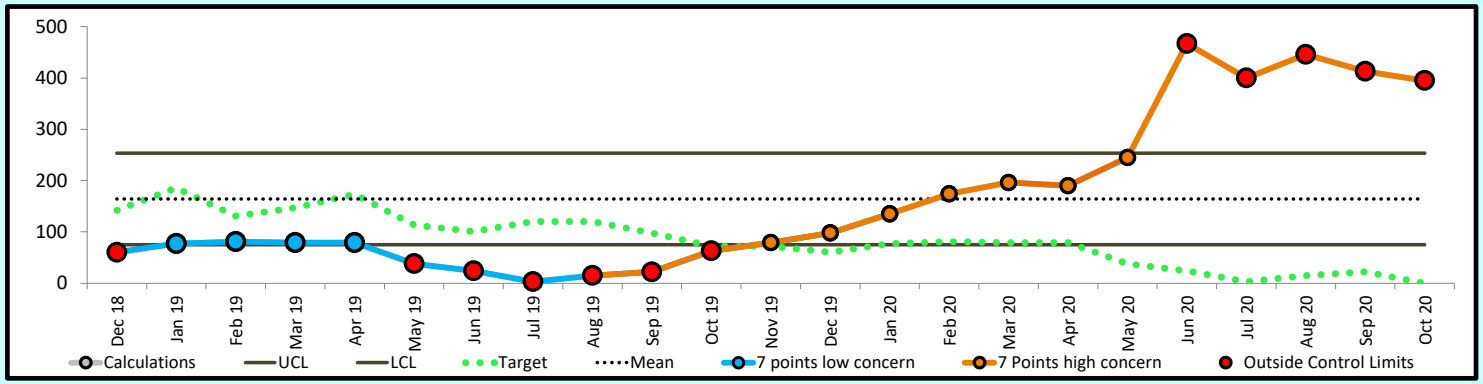
Target: Last Year

This Month's Difference: 167

Executive Comments:

Month 7 shows an increase in shifts above the cap, with 166 Medical shifts above cap rates. A difference of +8 from the previous year.

Nursing & Midwifery Reduction in Agency Shifts over Cap Rates



Reducing agency shifts over cap rates

Target: Green Line

Mean: 164.30

This Month's Difference: 373

Executive Comments:

In relation to Nursing shifts, 395 shifts were approved above cap rates in Month 7.
A difference of +332 from the previous year.

Performance Report Oct-20

Countess of Chester Hospital NHS
NHS Foundation Trust

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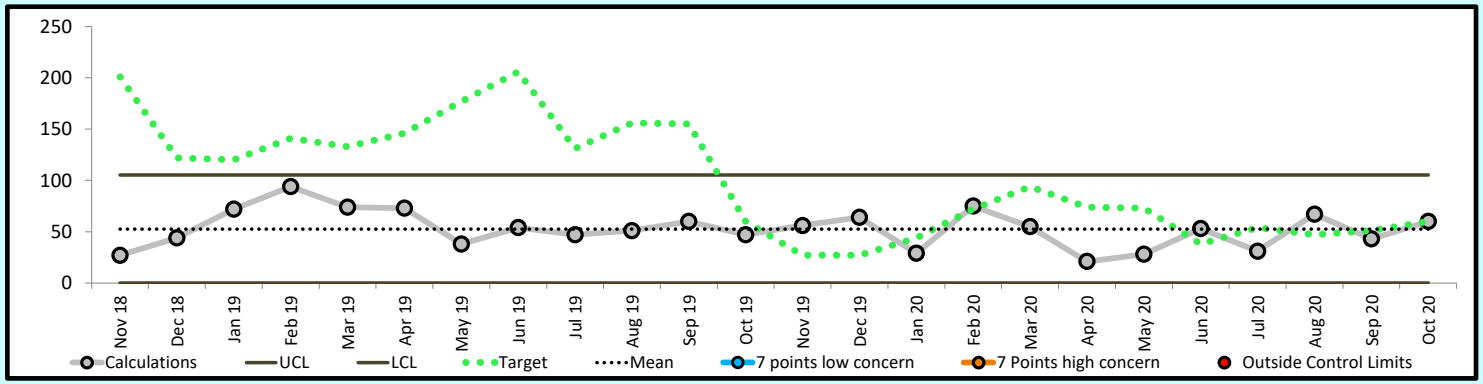
Other Reduction in Agency Shifts over Cap Rates



Other reductions are comprised of Care Packages, Sonographers, Theatres and the CRV Dept

Target: Green Line

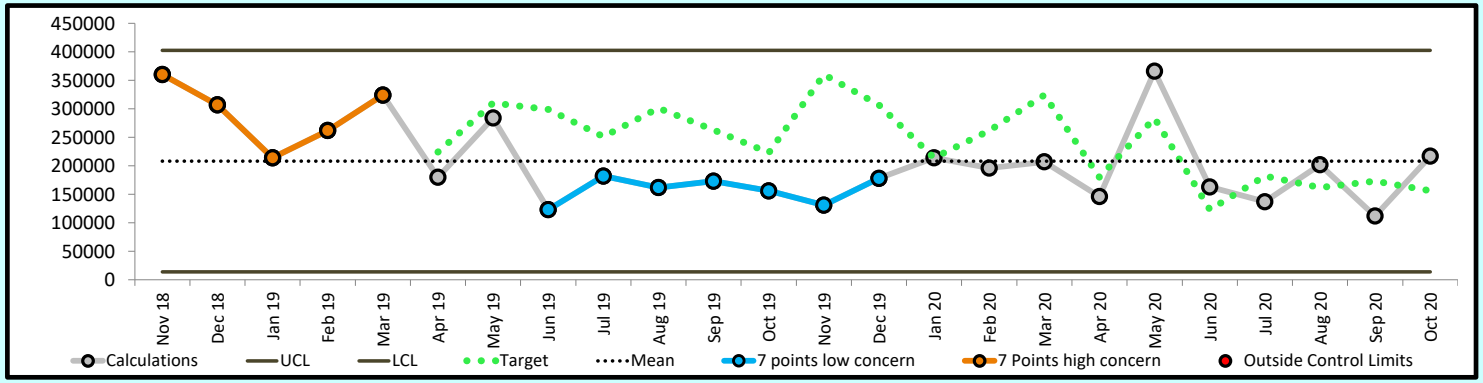
Mean: 52.63

This Month's Difference: 39

Executive Comments:

In relation to Other shifts 43 were approved over the cap. A difference of -16 from the previous year.

Medical Agency Spend



Planning improvements in productivity and efficiency

Target: Green Line

Mean: £208167

This Month's Difference: 61000

Executive Comments:

Agency medical expenditure is £1,197k (4% of the total medical spend).

Performance Report Oct-20

Countess of Chester Hospital NHS
NHS Foundation Trust

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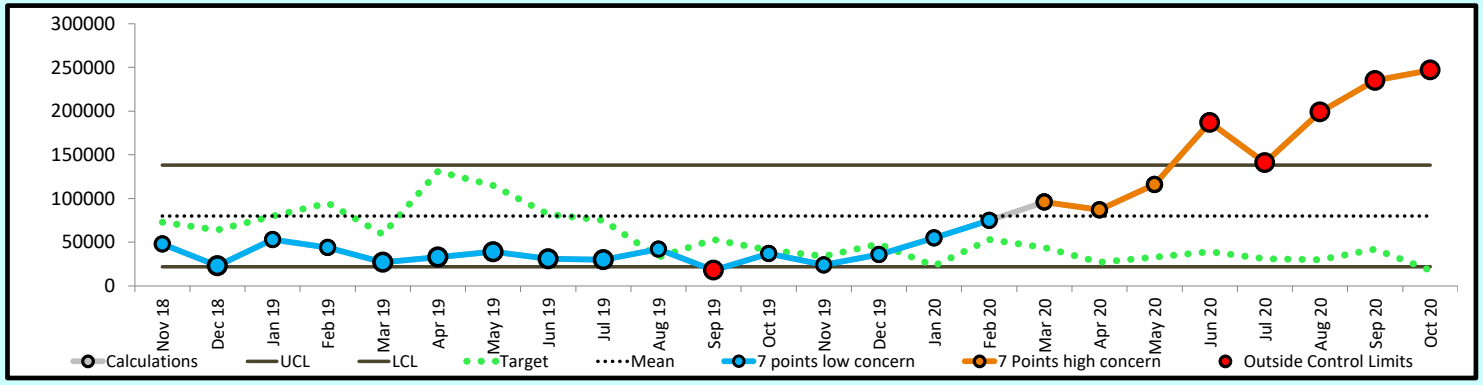
Nursing Agency Spend



Planning improvements in productivity and efficiency

Target: Green Line

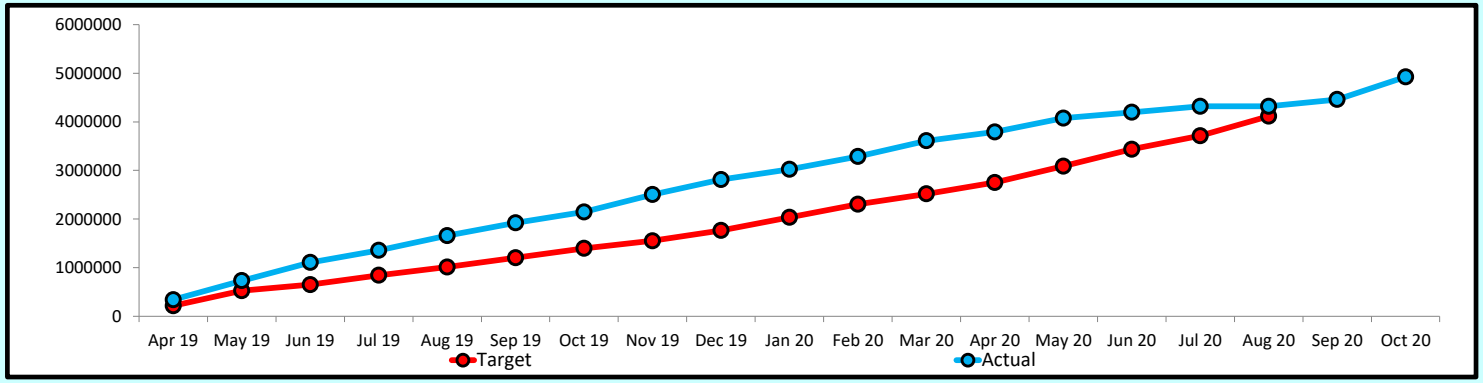
Mean: £80125

This Month's Difference: 229000

Executive Comments:

Agency nursing expenditure is £1,212k which is 4% of total trained nursing spend.

Total Agency Spend within Budget



Total Agency Spend within Budget

Target: Plan

This Month's Difference:

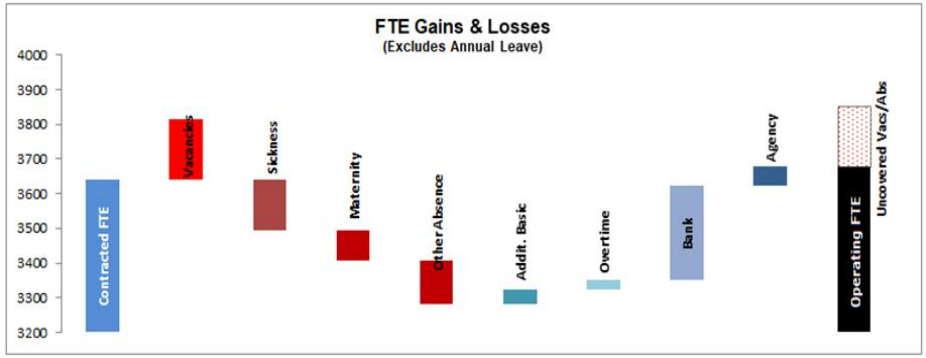
Executive Comments:

Total Agency spend for M1-7 is £2,521k. (£1,628k was spent during the same period last year).

Exception Report Oct-20

Countess of Chester Hospital NHS
NHS Foundation Trust

Agency Spend



Agency Spend by Staff Group	14/15	15/16	16/17	17/18	18/19	19/20	20/21	20/21 Annual Straight Line Projection
Admin & Clerical	£ 119,858	£ 163,219	£ 180	£ 85,760	£ 88,172	£ 58,632	£ 57,980	£ 99,395
Medical	£ 2,531,112	£ 3,911,032	£ 2,743,172	£ 3,268,433	£ 3,339,110	£ 2,186,354	£ 1,196,751	£ 2,051,572
Nursing	£ 830,776	£ 642,734	£ 380,679	£ 747,847	£ 662,413	£ 420,670	£ 1,212,056	£ 2,077,810
Allied Health Professional	£ 177,384	£ 218,871	£ 75,470	£ 171,820	£ 222,289	£ 175,607	£ 38,681	£ 66,310
Health Care Scientists	£ 115,743	£ 161,736	£ 252,863	£ 99,009	£ 110,124	£ 133,831	£ 15,718	£ 26,945
Total	£ 3,774,873	£ 5,097,592	£ 3,452,004	£ 4,372,869	£ 4,422,108	£ 2,975,094	£ 2,521,185	£ 4,322,032

Performance Issue

To not exceed £4.576m agency expenditure ceiling.
Agency medical expenditure is £980k (3% of the total medical spend). Agency nursing expenditure is £965k which is 4% of total trained nursing spend. Total Agency spend for M1-6 is £2,044k. (£1,406k was spent during the same period last year).

Proposed Actions:

The above is being reviewed in terms of presentation in conjunction with the variable Pay group to focus on key metrics to ensure comparison across other organisations. For further actions see actions proposed under Variable Pay.

Ownership:

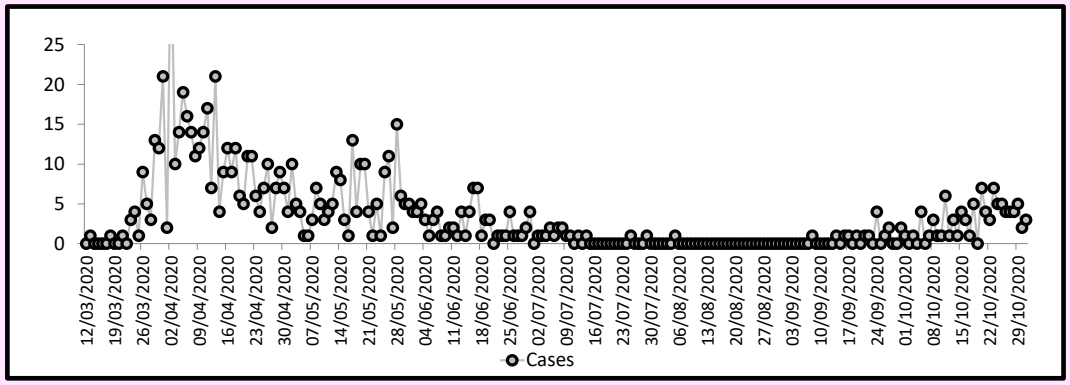
Lead: Steve Bridge, Planning & Partnerships
Executive Lead: Alyson Hall
Improvement Objective: Achieve Plan
Improvement Timescale: By March 2020

NHSI - See Further down for summary table	
Total Registered Nursing, Midwifery and Health Visiting Staff Vacancy WTE	**23.26**
Of which Registered Midwife Vacancy WTE	0.82
Of whichRegistered Health Visitor Vacancy WTE	0.00
Of which Advanced Care Practitioner Vacancy WTE	0.00
Total Qualified AHP Vacancy WTE	**14.89**
Of which Qualified Physiotherapist Vacancy WTE	0.00
Of which Qualified Occupational Therapist Vacancy WTE	3.36
Qualified Art / Music/ Drama Therapy Vacancy WTE	0.00
Qualified Chiropody/Podiatry Vacancy WTE	0.00
Qualified Dietetics Vacancy WTE	0.14
Qualified Operational Department Practitioners Vacancy WTE	2.36
Qualified Orthoptics/Optics Vacancy WTE	0.01
Qualified Prosthetics and Orthotics Vacancy WTE	0.00
Qualified Radiography (Diagnostic) Vacancy WTE	7.04
Qualified Radiography (Therapeutic) Vacancy WTE	0.00
Qualified Speech & Language Therapy Vacancy WTE	1.78
Of which Qualified Paramedic Vacancy WTE	0.20
Total Medical/Dental Vacancy WTE	**24.31**
Of which Medical/Dental Consultant Vacancy WTE	10.00
Support to Clinical Staff Vacancy WTE	**22.81**
Of which Support to Nursing Vacancy WTE	22.81
NHS Infrastructure Vacancy WTE	**88.35**
Total Vacancies	**173.61**
Budgeted FTE Total	3972.01
Trust Vacancy Rate	**4.37%**

Covid 19 Appendix

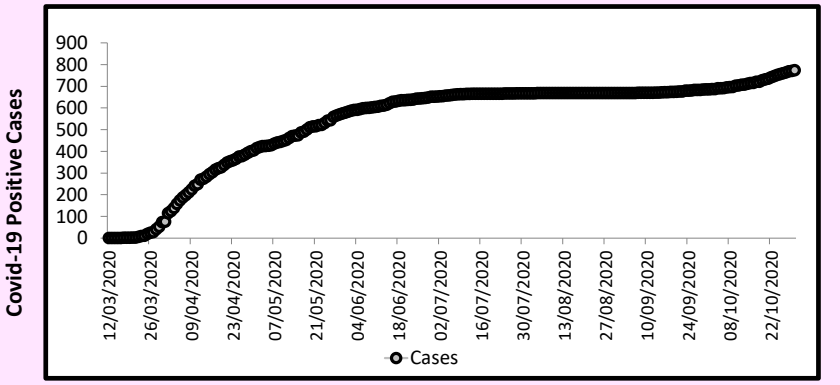
Countess of Chester Hospital NHS
NHS Foundation Trust

Covid-19 Confirmed Cases



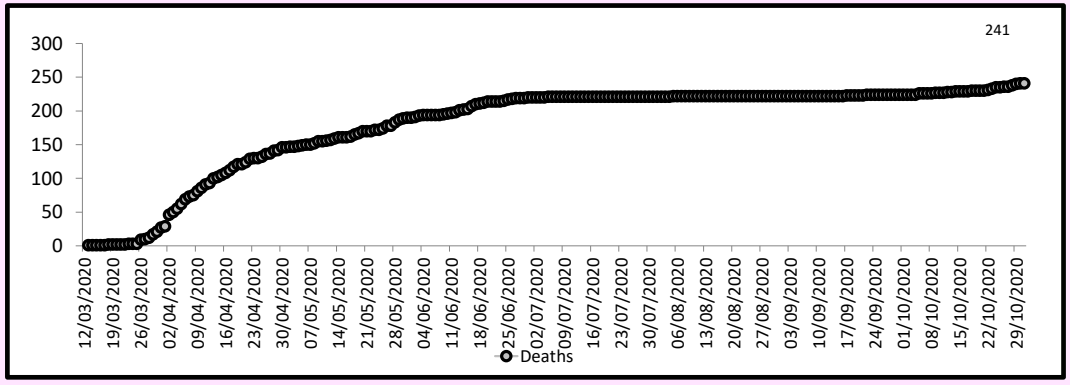
The number of patients who had their first Covid-19 confirmed result on that day

Covid-19 Confirmed Cases



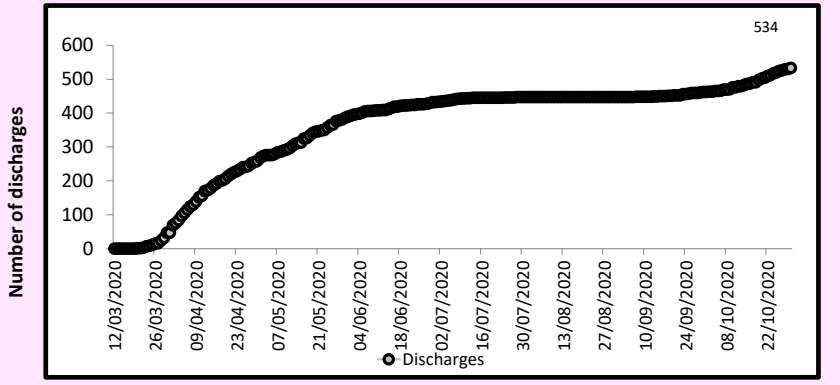
The number of patients who were Covid-19 confirmed cumulative from April

Covid-19 positive - patient deaths



Of those who tested positive for Covid-19, this graph shows cumulatively how many were deceased

Covid-19 positive - discharges

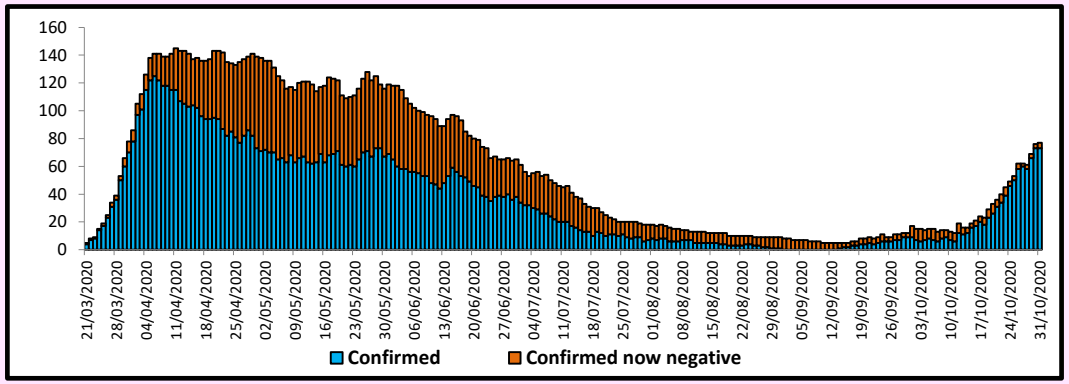


Of those who tested positive for Covid-19, this graph shows how many were discharged

Covid 19 Appendix

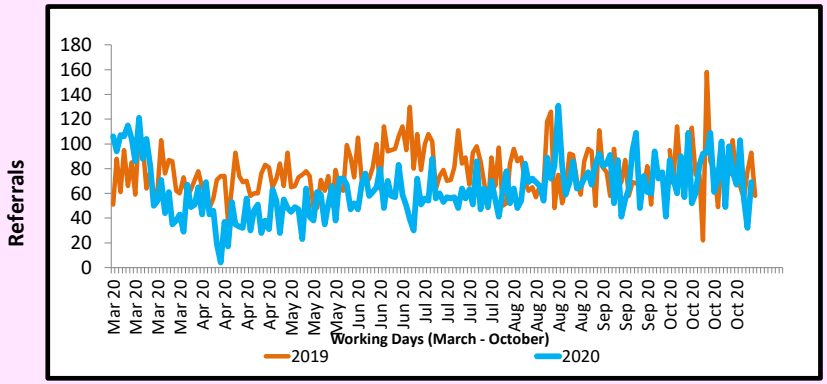
Countess of Chester Hospital NHS
NHS Foundation Trust

Covid-19 cases in a bed that day



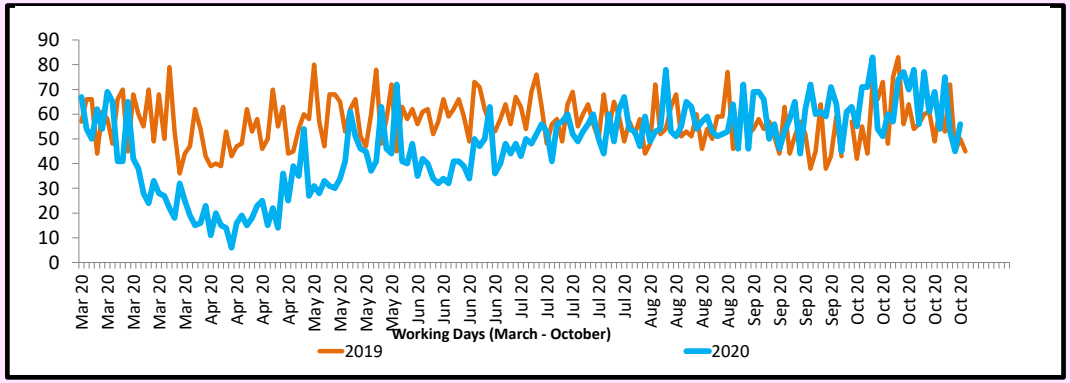
Patients in a bed who were Covid-19 confirmed or were confirmed but now negative

GP Referrals



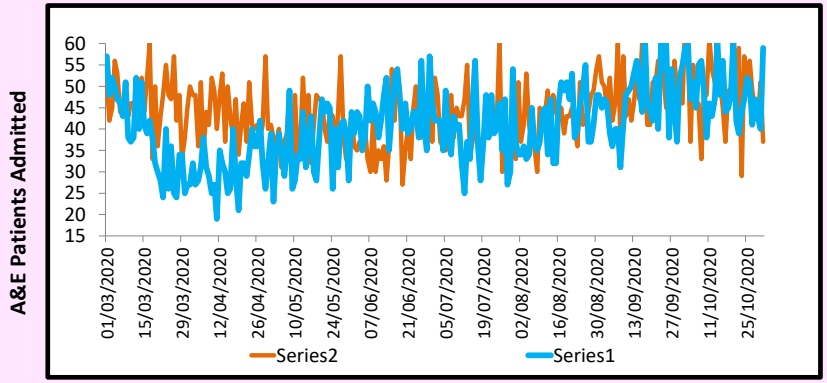
The number of referrals per working day where the referral source is from a GP

Cancer Referrals Per Day



The number of referrals that day where the referral indicates that Cancer is suspected

A&E Conversion to Inpatient Numbers

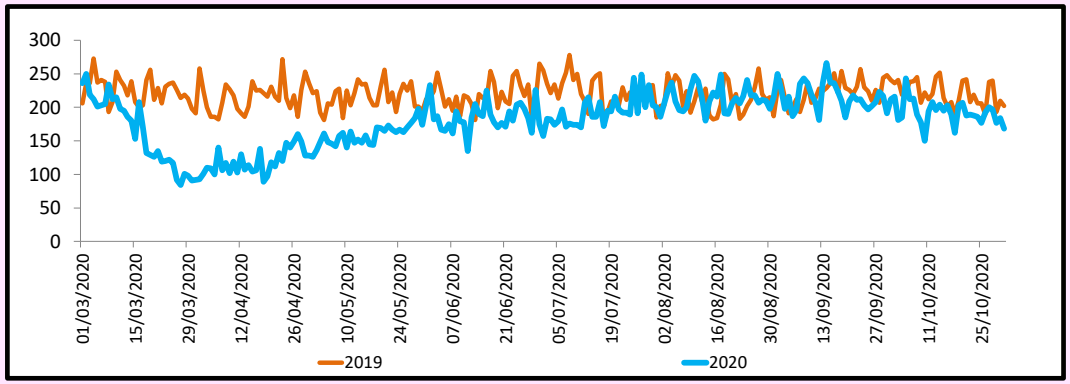


The number of patients who were admitted after being seen in A&E

Covid 19 Appendix

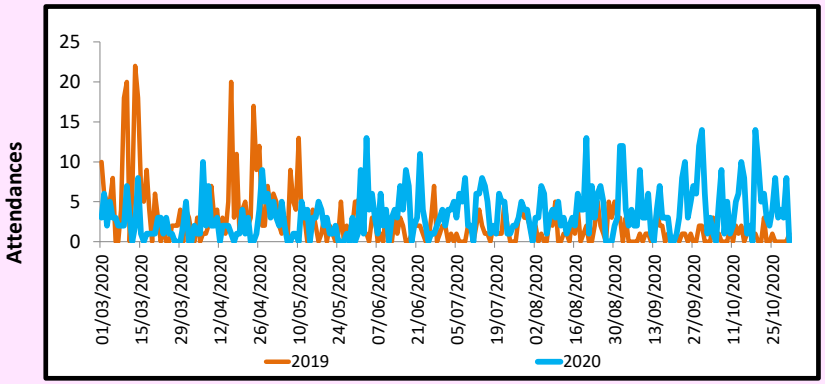
Countess of Chester Hospital NHS
NHS Foundation Trust

A&E Attendances



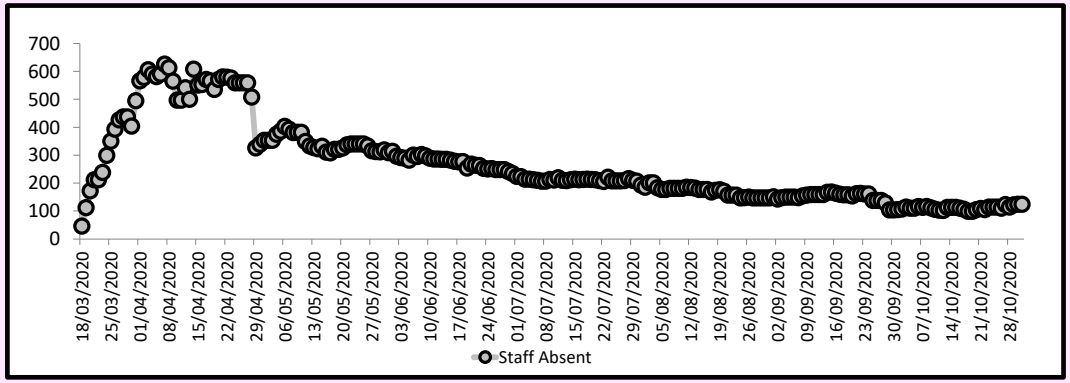
The number of patients who were seen in A&E on that specific day

A&E Attendances from GP



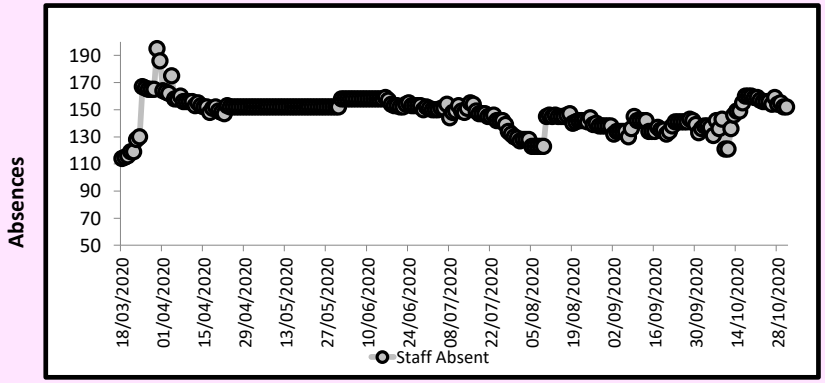
The number of patients attending A&E with a referral source of GP

Covid-19 Related Absences



The number of staff who were absent due to Covid-19 related issues

Other Absences



The number of staff who were absent due to non Covid-19 related issues

Covid 19 Appendix

Countess of Chester Hospital NHS
NHS Foundation Trust

HR Recruitment Figures

Split by normal and fast track recruitment for the reporting period (23/03/2020 - 31/08/2020)

Recruitment Update **31/07/2020**

Normal Recruitment

Recruitment Activity	Applications received	Rejected after initial screen by HR team	Presented for Shortlisting	Interviews held	Offers made	Available to work
Registered Nurse & Nursing Assistant Bank	264				257	257
HEE Student Nurses	151				148	148
HEE Student Midwives	15				15	14
HEE Allied Health	35				27	25
Total	465				447	444

Fast track recruitment

Recruitment Activity	Applications received	Rejected after initial screen by HR team	Presented for Shortlisting	Interviews held	Offers made	Available to work
Admin & Clerical	347	192	155	72	73	65
Non-clinical support staff	223	129	94	29	27	19
Registered Nursing	30	1	30	23	23	19
Nursing Assistants	188	17	173	110	101	69
AHP	15	0	15	0	13	7
Fast track total	803	339	467	234	237	179

Elective Activity Attributed to the Countess

Elective Activity at COC	Month							
Location	Apr	May	Jun	Jul	Aug	Sep	Oct	Grand Total
COCH								
Day Case	500	666	961	1334	1279	1782	2544	9066
Ordinary Admission	97	133	159	188	207	308	329	1421
Other	1		2	1			2	6
NUFFIELD								
Day Case		89	180	221	252	248	225	1215
Ordinary Admission		1		2	3	10	8	24
Grand Total	598	889	1302	1746	1741	2348	3108	11732

COUNTESS OF CHESTER

Glossary of terms

Countess of Chester Hospital NHS
NHS Foundation Trust

Metric Explanation

Hospital Standard Mortality Rate (HSMR)	The Hospital Standard Mortality Rate plays a role in learning about and improving the quality of patient care. The HSMR measures the rate of observed deaths divided by predicted deaths (based on the diagnoses which most commonly result in death) to give a measure of mortality rates and to aid in the reduction of this rate
CHPPD Compliance	Care hours per patient per day has become the principle measure of nursing within the NHS and is a measure of workforce deployment that can be used at ward level, service level and can also be aggregated to trust level
Serious Incidents: Level 1, Level 2 and Never Events	An Incident is classified as Serious when there are major consequences to patients, families, carers or staff. Serious incidents are split into Level 1, Level 2 and Never Events dependent on the severity of the incident
Incident Reporting	As a trust, we report all incidents to the National Reporting and Learning System (NRLS), again these incidents are classified differently depending on the severity of the incident. The different levels of harm we report on are: No Harm, Low Harm, Moderate Harm, Severe Harm and Death
All Falls Rate	Every month, the total number of patient falls recorded from our systems are aggregated against the number of bed days during the month.
Falls With Harm Rate	This metric is similar to the 'All Falls Rate', every fall is categorised differently (no harm, low harm, moderate harm and severe harm). This metric focuses solely on those categorised as moderate harm or above
Pressure Ulcers	Similar to 'All Falls Rate', we measure the number of reported Pressure Ulcers against the total number of bed days. Pressure ulcers are categorised into those 'Present on Admission(PoA)' and 'Hospital Acquired'
Infection Control -C-Difficile (cumulative)	The number of patients presenting with Clostridium difficile - an easily transferred infection commonly affecting the bowels - per month
Infection Control -MRSA	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium that causes infections in different parts of the body. It is difficult to treat due to the bacterium being resistant to the commonly used antibiotics
Hospital Acquired Covid	Patients entering the hospital are now tested on admission as well as throughout their stay. As a trust, we have been identified as an outlier for 'Hospital Acquired' Covid, meaning people are catching Covid while in the hospital. We have provided a new metric detailing how many of these patients we have compared to those classified as 'Community Onset'
Emergency Calls - 2222	The number of emergency 2222 phonecalls from hospital areas
SEPSIS-Screening	One of the Sepsis assessments we undertake is recording the number of patients who have their National Early Warning Score (NEWS2) recorded within 1 hour of arriving at the hospital
SEPSIS-Treatment	One of the Sepsis assessments we undertake is recording the number of patients who antibiotics administered within 1 hour of being diagnosed with Sepsis
Bed Moves	During Covid when rates of infection have been high, there has been pressure to reduce transmission whenever possible. One area we have looked into is the number of times a patients moves beds during their spell. If a patients moves frequently and has the virus, it means there is a higher chance of it spreading round the hospital.
ED 4 Hour Wait Standard %	A patient is considered a breach if they are waiting in A&E for over 4 hours without being seen, the operational standard is that at least 95% of patients attending A&E should be admitted, transferred or discharged within four hours.
RTT Incomplete Pathways %	Every event recorded on the patients letter from their referral to their treatment is considered their pathway, this metric reports on what % of these pathways are considered to be complete after 18 weeks has passed since their referral
Diagnostic 6 weeks Standard %	A Patients waiting time for various diagnostic tests are recorded, our aim is to provide all patients with their required test within 6 weeks, this metric details the % of tests which are not completed in this time frame
Cancer Treatment - 62 Day Standard %	The 62 day Cancer target measures the % of patients who began their first definitive Cancer treatment within 62 days of having an urgent GP referral
Cancer Treatment -31 Day Standard %	The 31 day Cancer target measures the % of patients who began their first definitive Cancer treatment within 31 days of receiving their associated diagnosis
Cancer Treatment - 14 Day Standard %	The 14 day Cancer target measures the % of patients who were seen by a specialist within 2 weeks of their urgent suspected Cancer referral
RTT Total Incomplete Pathways	Our main Referral to Treatment metric details the % of completed pathways, the completion of all these pathways are commonly categorised into those completed between 0 and 18 weeks, over 18 weeks, over 40 weeks and occasionally over 52 weeks. All these metrics were created to provide more clarity for the main Referral to treatment metric

Acronym Explanation

Bed Days	Bed days are days during which a person is confined to a hospital bed and the patient stays overnight.
CHPPD	Care Hours Per Patient per Day
C-Diff	Clostridium difficile
ED/A&E	Emergency Department / Accident & Emergency
MRSA	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium that causes infections in different parts of the body.
NEWS	National Early Warning Score
RTT	Referral to Treatment
YTD	Year to date, a measure of performance from the start of the financial year to the latest reporting month

Meeting	**1st December 2020**		**Board of Directors**					
Report	**Agenda item 13**		**North West Black, Asian and Minority Ethnic Strategic Advisory Committee (the Assembly)**					
Purpose of the Report	Decision	**x**	Ratification		Assurance		Information	**x**
Accountable Executive	Alyson Hall				Director of HR & OD			
Author(s)	Alyson Hall				Director of HR & OD			
Board Assurance Framework	People							
Strategic Aims	Our service involves and treats people with compassion, kindness, dignity and respect							
CQC Domains	Caring & Well Led							
Previous Considerations	-							
Summary	The Board is asked to read the attached letter and supporting information from the North West Black, Asian and Minority Ethnic Strategic Advisory Committee prepared by Evelyn Astante-Mensah, Chair, Pennine Care NHS Foundation Trust and Bill McCarthy, Executive Regional Director (North West) and consider their request. Formal responses are to be prepared and submit to the Assembly by 22nd December 2020. The work will be led by the Director of Human Resources & Organisation Development, supported by the Equality & Diversity Manager. A discussion will also take place at the next meeting of the Chair's Forum to be held at the end of November.							
Highlights of requirements	In summary, the requirements are: 1. To consider the attached statement and prepare a response from the Trust, setting out the Board's commitment to supporting the Assembly's vision, mission and objectives. The Trust is also asked as part of its response to describe the Board's aspirations in terms of tackling racism and inequalities and action it proposes to take to tackle this;							

	2. Use the statement provided as a catalyst to have further discussions with staff about the issues of racism and inequality and complete the feedback form capturing the views of staff to inform the Trust's response to the above; 3. Share the information provided about the Assembly with staff, specifically: • Share a link to a short film; • Publish the suggested content on the Trust's staff intranet site, bulletins and staff newsletters; • Promote discussion using a slide deck provided to guide conversations with staff. To support the discussion at the forthcoming Chair's Forum the Board is also asked to provide an overview of how the Trust: • is planning to share the statement with staff and engage them in conversations about racism and inequalities; • plans to link with the Assembly and its members, to support the development of the trusts response to the statement • plan to build on the work already done within the Trust, and by others, on promoting the health and wellbeing of our staff and the outcomes from the risk assessments carried out so far, particularly in relation to the roll out of the Covid vaccination programme.
Recommendation(s)	The Board is asked to: 1. Note the letter and further actions required; and 2. Provide support from members to formulate the Trust's response and the Board's aspirations in this matter.
Corporate Impact Assessment	
Statutory Requirements	Meet Trust's obligations under Public Sector Equality Duty and EA 2010
Quality & Safety	
NHS Constitution	The NHS aspires to the highest standards of excellence and professionalism
Patient Involvement	
Risk	
Financial impact	
Equality & Diversity	Meet Workforce Race Equality Standards obligations set by NHS England
Communication	Document to be published on Trust's website

Ref BMc EA KMcB 2020-11-18

Bill McCarthy
North West Region
5th Floor
3 Piccadilly Place
Manchester
M1 3BN

E: bill.mccarthy@nhs.net

TO ALL NHS CHAIRS, CHIEF EXECUTIVES AND ACCOUNTABLE OFFICERS FOR THE NORTH WEST

By email

18 November 2020

Dear Colleagues

During this second wave of Covid-19, it is important that we learn the lessons from earlier in the pandemic for our communities and the impact on the services we provide, in order to minimise the disproportionate effect the virus has on our BAME colleagues and communities. The North West continues to be one of the regions which is most affected by the high levels of community transmission of COVID. Fourteen out of the fifteen local authority areas with the highest COVID prevalence in over 60 years are in the region: and it is not therefore surprising that hospital admissions are high and growing and pressure remains intense in all parts of our systems, including primary, community, mental health and social care.

Black History Month provided us all with an opportunity to reflect on the progress that has been taken to confront racism within our organisations and wider society and to shine a light of the contribution of our BAME colleagues to the NHS. We are clear that racism has no place in our NHS and as leaders in our organisations and our systems, we must all make sure that equality is intrinsic in everything we do. We want our NHS in the North West to be clearly and unashamedly anti-racist, which means working to dismantle the structures that mean it is difficult for our BAME communities to access services and to enter the NHS workforce and progress.

Many colleagues are tired of and frustrated by the repeated pattern they see in how the NHS approaches the issue of BAME inequalities. Action rather than just talk is an imperative. Committing consistent attention and action over the long period of time is needed to tackle the deep-rooted issues behind inequalities is a must.

As an Assembly, we want to work with our North West organisations to develop action plans that leverage the collective power of the region acting together, to make a lasting change. Our members are a group of senior BAME leaders, with invaluable collective knowledge and experience, who can provide advice and guidance on the vital steps needed to tackle the deep-rooted issues behind inequalities.

The Assembly has now developed its vision, mission and identified its priorities. We ask that you:

1. Consider the attached statement from the Assembly and provide us with a response from your organisation, setting out your commitment to supporting our vision, mission and objectives. As part of your response, describe your aspirations in terms of tackling racism and inequalities and the actions you will take. The Assembly will consider these plans and identify areas where we can focus additional support (please complete the template provided).

2. Use the statement as a catalyst to have further discussions within your own staff about the issues of racism and inequality and to inform the development of your organisation's response. We know that many of our colleagues from all backgrounds across the region want to engage and stand up to racism but are sometimes fearful of saying the wrong thing and causing offense. It is only by encouraging safe space conversations that we can shine a light on the experiences of BAME staff.
3. Share information provided about the Assembly with your staff. To support this, we have provided the following:

    - A link to a short film, which can be shared with staff
    - Content for your staff intranet sites and bulletins
    - A set of slides to guide conversations with staff

We will have a discussion on this topic at the next meeting of the Chairs' forum at the end of November. It would be good if you could come prepared to give an overview of the following:

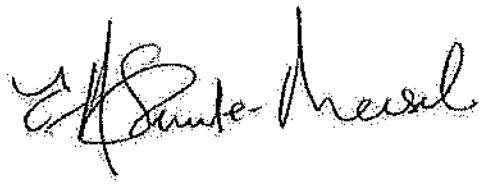
- How you are planning to share the statement with your staff and engage them in conversations about racism and inequalities
- How you plan to link with the Assembly and its members, to support the development of your response to our statement
- How you plan to build on the work already done in your own organisation – and by others – on promoting the health and wellbeing of your staff and the outcomes from the risk assessments carried out so far, particularly in relation to the roll out of the COVID vaccination programme

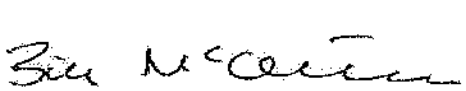
We would ask that you return your responses to our statement with us by close of play on Tuesday 22 December. We will be pulling responses from all NHS organisations together in a report for the Assembly to consider at its next meeting in January.

In the meantime, if you want to discuss anything further about our agenda, please either of us as co-chairs of the Assembly, Anthony Hassall or Raj Jain, who are also supporting the Assembly.

May we also take this opportunity to thank you for the leadership and ongoing commitment you and your teams have demonstrated to tackling inequalities. It is only through working collaboratively together as a region that we will be able to confront racism to become anti-racist and reduce health inequalities.

Yours sincerely,





Evelyn Asante-Mensah
Co-Chair, North West Black, Asian and Minority Ethnic Strategic Assembly and Chair Pennine Care NHS Foundation Trust

Bill McCarthy
Co-Chair, North West Black, Asian and Minority Ethnic Strategic Assembly and Executive Regional Director (North West)

North West Black, Asian and Minority Ethnic

Strategic Advisory Committee

Response to the Assembly Statement

Please use the questions below, to help frame your response to the Assembly's statement.

1. **The Assembly has set out its vision, mission and objectives, to support the NHS in the North West to be anti-racist; please describe your own organisation's commitment to achieving this**

2. **Please share the key points from feedback you have had from staff within your organisation, which has helped you to shape this commitment**

3. **Please give an overview of what you are going to do differently as a senior leadership team, in order to put this commitment in to action**

4. **Given where we are with the second wave of the pandemic, please give an overview of how you are going to focus on some immediate challenges facing our BAME colleagues and communities i.e.:**

    - The health and wellbeing of staff, in particular building on risk assessments for BAME staff
    - Support for your BAME staff networks and effective communications with them in general
    - The take up of the flu and the Covid vaccines by staff in particular BAME staff
    - Ensuring BAME communities are not disproportionately impacted by any temporary changes to services; and that as services are brought back on line, health inequalities are not made worse

5. **What are you proud of; what initiatives or programmes in place to tackle health inequalities and take positive action against racism**

Meeting	**1st December 2020**		**Board of Directors**					
Report	**Agenda item 14**		**Freedom to Speak Up Update Report**					
Purpose of the Report	Decision		Ratification		Assurance	x	Information	x
Accountable Executive	Dr Susan Gilby				Chief Executive Officer			
Author(s)	Helen Ellis				Freedom to Speak Up Guardian			
Board Assurance Framework	Q1 Q2 P3	Safety Quality Staff engagement						
Strategic Aims	To deliver high quality care and treatment							
CQC Domains	Well Led							
Previous Considerations	Quarterly data reported to Audit Committee – 2 September 2020							
Summary	This report is intended to provide an update on the activity within the Freedom to Speak Up (FTSU) agenda April-September 2020, including the quarter 4 2019/20 and quarter 1 2020/21 data. It includes data on concerns raised which demonstrates an overall continuation in the increase of concerns raised from previous years. In addition activity undertaken by the Guardian locally, regionally and national will be outlined. The National Guardians Office published a second Index report in June 2020 using evidence from the 2019 NHS staff survey to demonstrate Trust performance in relation to FTSU.							
Recommendation(s)	The Board is asked to receive and note the information contained within this report, and support proposed actions.							
Corporate Impact Assessment								
Statutory Requirements	Yes							
Quality & Safety	Yes							
NHS Constitution	-							
Patient Involvement	-							
Risk	-							
Financial impact	-							
Equality & Diversity	**-**							
Communication	**-**							

Freedom to Speak Up

NHS
Countess of Chester Hospital
NHS Foundation Trust

Freedom to Speak Up Update Report To Board of Directors

1.0 Executive Summary

The purpose of this report is to provide an update to the Board on the Freedom to Speak Up agenda. It will articulate updates on resources, policy, communication and engagement and national and local data. The impact of the pandemic on continued progress and the introduction of new activities to further embed the national agenda will be outlined.

2.0 Progress to Date

2.1 Data Submission to National Database

As previously articulated in the last Board update, the Trust is required to submit speaking up data to the National Guardians Office (NGO) on a quarterly basis for national publication. The Trust's submissions for Quarter 4 2019/20 and Quarter 1 2020/21 are as follows:

Quarter 4, 2019/20

- Number of cases raised (this equates to the number of members of staff involved) – 7
- Number of cases raised anonymously – 1
- Number of cases with element of patient safety / quality – 2
- Number of cases with element of bullying / harassment – 4
- Number of cases where the person speaking up may have suffered some form of detriment – 1
- An additional concern regarding attitudes and behaviours was also reported

Quarter 1, 2020/21

- Number of cases raised (this equates to the number of members of staff involved) – 5
- Number of cases raised anonymously – 0
- Number of cases with element of patient safety / quality – 3
- Number of cases with element of bullying / harassment – 0
- Number of cases where the person speaking up may have suffered some form of detriment – 0
- An further 2 concerns regarding attitudes and behaviours were also reported

Although there was a significant reduction in the number of concerns raised with the guardian during March and April in line with similar sized Trusts throughout England, the data still reflects a continual increase from the same periods last year. In Q1 there is a reduction in the

number of concerns raised that involved an element of bullying and harassment, again as seen nationally. This may be due to the pressures of the pandemic when staff were focused on the work they need to undertake, possibly due to the increase in health and wellbeing provision or that staff felt that raising concerns of this nature would not be viewed as a positive thing to do under the current circumstances. There was initially an increase in concerns relating to PPE and redeployment, the perceived inequalities for opportunities to work from home and inconsistencies in advice given regarding sickness absence allowances. From May these significantly reduced, again it is difficult to pin point why but the daily update briefs from senior leaders, information posted on the intranet and the understanding of Silver Control could have had a part to play. Currently there has seen a steady rise in the number of concerns relating to risk assessments particularly from staff from within the BAME community.

2.2 FTSU Board Self-Review Tool

Work on this assessment is still required from the Board. The national guidance and self - review tool were re-circulated to the Board in March 2020. There is an expectation that progress should be shared with the Guardian half yearly.

2.3 National Case Reviews

A further review was published by the National Guardians Office in June 2020. The Guardian has developed an action plan that reflects the recommendations of that review. To date there has been no progress other than that undertaken by the Guardian in relation to the recommends from previous reviews for over 12 months. *See attached for information:* ***Appendix 1***

2.4 North West Regional FTSU Guardians Network

The North West Network for Freedom to Speak Up Guardians provides regional support where learning and best practice is shared, enabling the recommendations of the Frances Report on speaking up to be consistently and effectively implemented. It aims to:

- Provide support to Freedom to Speak Up Guardians
- Support consistency in the approach to the delivery of the guardian's role
- Provide a platform for shared learning that supports continuous improvement
- Act as a source of intelligence on Freedom to Speak Up matters
- Actively engage with local and national FTSU debate
- Maintain open and effective channels of communication with the National Guardians Office.

From April 2020 the FTSU Guardian at Chester has taken the role of Co-Chair for this group, providing further opportunities for personal learning and development whilst providing a greater platform to influence decision making within the National Guardians Office. *See Terms of Reference:* ***Appendix 2***

2.5 Freedom to Speak Up: Mandatory Training

The National Guardians Office has published their recommendations for learning in regards to FTSU with E-learning packages shortly to be available on the national ESR framework. Work to include this subject area within the Trust's mandatory training framework had commenced with an original date of April 2020 for implementation. Due to the pandemic this has been delayed.

2.6 National Guardians Office Index Report

The National Guardians Office (NGO) has published its second FTSU Index Report, which monitors 'speaking up culture' in the NHS based on four questions from the 2019 NHS staff survey. The purpose is to enable trusts to see how their FTSU culture compares with others and promote the sharing of good practice.

The Countess of Chester scored 78.1%, an increase of 3.1% from the previous year. This means that we are now in line with the national average for Acute Trusts. *See summary paper:* ***Appendix*** *3.*

The NGO has agreed that the questions in the survey do not wholly reflect FTSU but all concerns and incidents and are currently looking to include additonal questions in the next staff survey. This will provide improved accuracy for reporting on FTSU matters.

2.7 The Trust's FTSU Key Priorities Moving Forward:

- Delivery of the FTSU strategy
- Develop, distribute and review findings of a COCH staff survey on FTSU
- Development of a robust mechanism for sharing learning to all staff
- Inclusion of Freedom to Speak Up in the mandatory training portfolio for all staff
- Consideration for a network of FTSU / Cultural Ambassadors
- Development of a method for anonymously raising concerns direct from the FTSU intranet page.

2.8 Conclusion and Recommendations

The Board is asked to receive and note the information contained within this report, and support proposed actions. It is clear that this agenda continues to be very significant and is increasing. Our continued focus on this agenda supports and compliments the work already underway within the Trust in ensuring we have a culture that is open and transparent to reflect our Trust values of Safe, Kind and Effective.

Prepared by:

Helen Ellis
Freedom to Speak Up
Guardian
September 2020

Freedom to Speak Up: National Case Reviews 2020

Countess of Chester NHS Foundation Trust Action Plan: July 2020

Whittington June 2020

Recommendation	Action	Timeframe	Responsible Lead	Evidence (Where possible embed documents)	RAG Status
The FTSU Guardian should receive regular supervision to support them with their wellbeing	One to one monthly support and supervision with CEO, Quarterly with Chair. Open door approach				
The FTSU Guardian and Human Resources Business Partners should establish regular meeting to promote understanding and trust	For consideration: Discuss with AH				
FTSU Guardians should liaise with other NHS Trusts/ Regional Networks to support learning and development	NW Regional Network: Co-Chair				
Organisations should provide adequate resources for the FTSU Guardian role	Done				
All Trusts policies relating to speaking up must be in accordance with the National Standard Integrated Policy	Done				
The FTSU policy should be published on the trust intranet and signposting for staff should be made clear to ensure staff have clear guidance on what to do around Speaking Up.	Done				

The trust should use the NHS staff survey data and local pulse surveys to get staff feedback on the effectiveness of communication of the FTSU Guardian role.	Survey ready to send out.				
A Communication Strategy should include activities necessary to improve the understanding of the FTSU Guardian role.	Guardian to consider				
Staff should be aware of the role and function of FTSU and receive appropriate training in line with the NGO guidance	Planned				
An annual review of the Boards Self-Assessment in relation to FTSU should be undertaken	Aware that this needs doing: shared document with board members				
Trusts should undertake a gap analysis against case reviews produced by the National Guardian	Done following each National Case review publication				
Internal audits for Freedom to Speak Up should not be included in other trust audits but be audited separately.	Audit Team and Guardian				
Workers who speak up should be meaningfully thanked, regardless of the issues raised.	Done				
Workers should receive meaningful feedback to provide assurance the organisation has listened to them and taken action.	Done				
The trust should take appropriate steps to ensure grievance cases are addressed within the time frames set out in its policies and procedures.	HR and Audit				

The Trust should to follow national guidance on training and provide training on speaking up for all those who deal with speaking up cases	Done				
The trust should ensure that exit interviews and questionnaires are offered to all staff and include a question regarding FTSU/raising concerns. The FTSU Guardian should be informed when the feedback references the role.	HR				

Appendix 2

North West Regional Guardians Network
Terms of Reference

Purpose	The North West Network for Freedom to Speak Up Guardians provides regional support where learning and best practice is shared, enabling the recommendations of the Frances Report on speaking up to be consistently and effectively implemented.
Priorities and Objectives	o Provide support to Freedom to Speak Up Guardians o Support consistency in the approach to the delivery of the guardian's role. o Provide a platform for shared learning that supports continuous improvement o Act as a source of intelligence on Freedom to Speak Up matters o Actively engage with local and national FTSU debate o Maintain open and effective channels of communication with the North West Regional Liaison Lead and the National Guardians Office.
Responsibilities	o Establish local arrangements for shared learning and development o Provide opportunities for buddying, mentorship and supervision for guardians at different stages of their development o Provide regional representation to the National Guardians Office o Nominate a chair/co-chair on an annual/six monthly basis o Proactively contribute in network meeting o Facilitate the resolution of local issues raised by its members, referring to the National Guardian's Office as and when required.
Membership	North West Freedom to Speak Up Guardians registered with the National Guardians Office. Co-opted members and /or guest speakers may be invited to attend for specific agenda items as and when required. A chair and a co-chair shall be agreed by network members on a 6 monthly basis or in line with future recommendations by the NGO.
Attendance Requirements	Members should attend as many meetings as possible. If unable to attend apologies should be submitted in advance.
Quorum	In order for network based decisions to be valid, the meeting must be quorate. A quorum will consist of at least ten members including either the chair or co-chair.
Organisation	Meetings will be held quarterly. Additional meetings may be arranged as and when required as agreed by this group. Agenda items will be submitted to the chair/co-chair no later than two weeks in advance of a meeting. Agenda and papers will be circulated no later than 5 days in advance of meetings. Action points and meeting notes will be circulated within two weeks of a meeting.
Review	Terms of Reference will be reviewed annually as a minimum.

Freedom to Speak Up
Improving Patient Care & Staff Experience
NGO: Index Report 2020

Appendix 3

Introduction / Summary

The National Guardians Office (NGO) has published its second **FTSU Index Report**, which monitors **'speaking up culture'** within the NHS. The findings are based on four questions from the 2019 NHS staff survey. The purpose is to enable trusts to see how their **FTSU culture compares with others** and promote the **sharing of good practice.**

'The Four Questions' form the NHS Annual Staff Survey

% of staff responded 'agreeing' or 'strongly agreeing' that their organisation **treats staff who are involved in an error, near miss or incident fairly**

% of staff responded 'agreeing' or 'strongly agreeing' that their organisation **encourages them to report errors, near misses or incidents**

% of staff responded 'agreeing' or 'strongly agreeing' that if they **were concerned about unsafe clinical practice they would know how to report it.**

% of staff responded 'agreeing' or 'strongly agreeing' that **they would feel secure raising concerns about unsafe clinical practice**

What we still need to do?

1. Develop improved mechanisms for **triangulating data**
2. Improve **communication** that shares **good practice** and **learning**
3. Better promote **zero tolerance** in relation to **bullying and harassment**
4. Identify, train and support FSTU **Ambassadors** from within the **workplace** that reflects diversity and promotes inclusion

What have we done already?

1. Increased the number of concerns raised from **11** in **2017-18** to **28** during **2019-20**.
3. Distributed FTSU **Information folders** to **every** ward and department
4. Agreed to include FSTU on the **mandatory training** platform for all staff
5. Developed a 5 year FTSU **Strategy**

Summary of Results

Overview of the percentage index score over the last **three years**

Trust Type	2017 %	2018 %	2019 %
Acute Specialist	79	82	81
Acute Trusts	76	77	78
Ambulance	69	74	74
Combined Acute and Community	77	78	79
Mental Health/LD / Community Trusts	79	80	80
Community Trusts	81	83	84
Mental Health &LD	77	79	79

Summary of Results

Overall the North West Region showed an increase from 78.5 – 79.1% the previous year

The highest index percentage score was **86.6%**

The Countess of Chester scored **78.1%** an **increase of 3.1%** from the previous year. This means that we are now in line with the national average for Acute Trusts.

Countess of Chester Hospital NHS Foundation Trust

Meeting	**1 December 2020**		**Board of Directors**					
Report	**Agenda item 15**		**Proposed Amended Constitution, including Standing Orders**					
Purpose of the Report	Decision	X	Ratification		Assurance		Information	
Accountable Executive	Keith Haynes				Interim Governance Consultant			
Author(s)	Keith Haynes Debbie Bryce				Interim Governance Consultant Governance Improvement Lead			
Board Assurance Framework		N/A						
Strategic Aims	-							
CQC Domains	Well Led							
Previous Considerations	Council of Governors – 1 October 2020 Governor Forum – 20 November 2020 Audit Committee – 18 November (in relation to Standing Orders of the Board of Directors)							
Summary	1. A detailed review of the Trust's current Constitution (including Standing Orders) has been undertaken, together with Hill Dickinson Solicitors LLP. As a result, it was considered that the Constitution would benefit from updating and a greater alignment with the model constitution adopted by many trusts. 2. Consequently, the Trust's Constitution has been updated in line with the model constitution and a number of proposed amendments have been made. The opportunity has also been taken to include a number of provisions which the Governors and the Trust Board wished to make – e.g. residency requirements for Non-Executive Directors, provision for Associate Non-Executive Directors, clarification of terms of office for Non-Executive Directors which better aligns with good governance practice, etc. 3. A detailed schedule of each of the Constitution amendments is attached. These have been reflected in red in the draft amended Trust Constitution. 4. In accordance with relevant provisions within the NHS Act 2006, and now incorporated as a proposed amendment to the Constitution (paragraph 460), amendments to the Trust's Constitution can only be made if more than half of the members of the Council of Governors and Board of Directors approve the amendments. 5. Given that there are a number of proposed amendments (some more material than others) and the need for Governors to give proper consideration to them, a small "task and finish" group of governors was established to review the detail of the amendments ahead of consideration and formal approval at the							

	December meeting of the Council of Governors. The outcome of the task and finish group deliberations of 29 October is attached and have been incorporated into the second updated version of the proposed Constitution. The Lead Governor and Deputy Lead Governor term of office was further discussed at the Governor Forum meeting held on 20th November 2020.
Recommendation(s)	The Board is asked to: • Approve the amended Constitution, including Standing Orders. • Note that approval will be sought from the Council of Governors on 11 December 2020, it being a requirement that both the Trust Board and Council of Governors need to approve amendments to the Constitution.
Corporate Impact Assessment	
Statutory Requirements	The Constitution is in line with statutory requirements
Quality & Safety	
NHS Constitution	
Patient Involvement	
Risk	
Financial impact	
Equality & Diversity	
Communication	Once approved by Board and Council of Governors, the amended Constitution will be placed on the Trust's website.

Page number	Paragraph number	Description of amendment	Rationale for amendment
Throughout document	Throughout document	Trust constitution and standing orders (latest version September 2019) re-structured and re-formatted to reflect Monitor's FT model core constitution and best practice – document now consists of constitution and annexes. Duplication and slight inconsistencies between Trust's constitution and standing orders now removed/corrected.	To bring the Trust's constitution in line with the model core constitution (as adopted by most, if not all, foundation trusts). To make the document easier to read and more user-friendly so that it is easier for the Trust to apply and ensure compliance. To remove duplication and slight inconsistencies between the Trust's constitution and standing orders.
5	5	Removal of reference to Staff Associates within constitution.	There appears to be no benefit to being a Staff Associate if you can be a member of the Public Constituency instead. The trust currently has no Staff Associates.
5	5.2 and 5.3	Addition of Youth Associates and slight tweak to current wording.	To confirm that individuals can apply to be Youth Associates but are not members of the trust. Current wording tweaked slightly to provide clarity on the Youth Associate role.
6	9	Provisions re: automatic membership by default added for staff members.	Permitted by statute, but not a statutory requirement. However, it is part of the model core constitution and means that the Trust does not have to process applications for staff members.
6	10.3	Reference to an individual being over 16 years of age to be a member changed to 'at least 16 years'.	Youth Associates are individuals over 11 and less than 16 so 16 year olds were previously excluded from membership. This amendment ensures that those aged 16 years and above are eligible for membership.
7 22	13.2 Annex 4	Reference to model election rules being part of the constitution. Rules included at Annex 4.	To reflect the model core constitution and to ensure that the rules form part of the constitution so that it is clear what rules are being applied from time to time. Both First Past the Post (FPP) and Single Transferable Vote (STV) provisions left in the

			model rules so that the trust can use either method when conducting elections.
8 68	14.3 and 14.6 Annex 5 paragraphs 1.1.1 and 1.4.1	Removed reference to a governor not being eligible for re-election if already held office for more than 6 consecutive years.	To reflect statute – that a governor's term of office can be up to three years – and to give some flexibility to a governor being able to remain in office for longer than 6 years but no more than 9 consecutive years.
9	17.1	Added provision for Lead Governor to chair Council meetings if person presiding has a conflict of interest.	Allows some flexibility in case of conflict and reflects part of suggested role of a Lead Governor.
9	19	Added provisions for governors to receive support and advice (from the trust or commissioned by the trust) to replace the governors' panel.	The governors' panel is still mentioned in statute, but has now been disbanded and no longer exists. This wording enables the governors to ask the trust to commission support and advice where required for the purposes of exercising their duties under the constitution.
10	23.10	Added provisions re: Associate NEDs.	To enable the trust to appoint Associate NEDs should it wish to do so.
14	38.1 and 38.2	Slightly amended wording as to making the registers available for public inspection except for in the circumstances set out in the paragraph or as otherwise prescribed, and to clarify that a member can request that their details in the register of members are not made public.	Wording amended to reflect the Public Benefit Corporation (Register of Members) Regulations 2004. This wording also means that the trust can determine that certain details in the registers eg. the conflicts of interest registers need not be publicised in exceptional circumstances where, for example, data protection law would mean that it was not fair or lawful to do so [this reflects the guidance in NHSE's guidance on conflicts of interest in the NHS (guidance June 2017 paragraph 6.6].
15	40	Slightly amended provisions on auditor.	To reflect provisions of NHS Act 2006. The Act sets out provisions as to who can be appointed as an auditor and how the auditor's functions are carried out. Rather than repeat

			them here, it is simpler to refer to the statutory provisions.
17	46	Amended provisions re: amending the constitution to clarify that more than half of the members of the Council of Governors and of the Board of Directors of the trust voting must approve the amendments. Also to clarify that members must be given the opportunity to vote on amendments that relate to the powers or duties of the Council of Governors or the role that the Council of Governors has as part of the trust.	To reflect the statutory provisions (section 37 and paragraph 27A of Schedule 7 of the NHS Act 2006).
17	47.3	Added in definition of 'significant transaction'.	Whilst a trust can determine that it is not defining a significant transaction and will determine from time to time what a significant transaction is, for clarity and corporate governance purposes, it makes sense to agree a definition as a trust. The suggested definition is used by many FTs and uses the definition in NHS Improvement's Transactions Guidance (November 2017) which is the guidance to be followed by NHS bodies when a significant transaction is planned.
19	Annex 1	Amended to reflect the geographical areas of the four public constituencies based on electoral areas.	Under the NHS Act 2006, the four public constituencies each need to be an electoral area or consist of two or more electoral areas.
20	Annex 2	Amended to clarify what is meant by AHP.	To confirm AHPs are those who are recognised in the NHS as being AHPs (as regulated by the Health and Care Professions Council or the General Osteopathic Council) – 14 AHP professions currently recognised in the NHS.
21	Annex 3 paragraph 2.3	To be amended to either retain or delete referenceto commissioners being partnership organisations who may appoint a governor. To consider further amendments to those organisations who may appoint a governor.	There is no statutory requirement for the local CCG or commissioner to appoint a governor.

68	Annex 5 paragraph 2.1	Amended and added to disqualification criteria for governors.	To update disqualification criteria to reflect statute and to reflect disqualification criteria adopted by other FTs which seem appropriate to have in place.
70	Annex 5 paragraph 3.1.2	Amendment so that governor has to fail to attend 3 consecutive meetings of the Council (rather than 2) before they shall cease to hold office.	Reflects process adopted by other FTs and makes it more manageable for the trust ie. failing to attend 2 consecutive meetings could happen more often than not and cause an issue in terms of the application of this provision.
70	Annex 5 paragraph 5	Addition of provisions re: the formation of a working group to consider concerns about a governor and make a recommendation to the Council that they be removed from office.	To clarify the process to be followed should there be concerns about a governor and should the trust wish to consider use of the provisions enabling removal of a governor. Establishes a fair and transparent process.
71	Annex 5 paragraph 6.3.3	Added provision to enable the trust to leave a governor seat vacant until the next election should it wish to do so.	Reflects the provisions of other FT constitutions and provides some flexibility should a governor seat become vacant.
71 and 72	Annex 5 paragraphs 8 and 9	Insertion of provision re: Lead Governor and Deputy Lead Governor.	To reflect the Lead Governor role outlined by Monitor in its Code of Governance. Many FTs have also nominated a deputy.
73	Annex 5 paragraph 10	Insertion of provisions re: communications from governors.	Provisions adopted by many FTs to clarify when and how governors may send communications to the members as a whole and the trust's role in facilitating such communications.
74	Annex 6 paragraph 1	Additional provisions inserted re: role of Council of Governors nominations committee and process for nominating candidates for Chair and NED roles.	To clarify role of nominations committee and process for nominating candidates for Chair and NED roles.
75	Annex 6 paragraph 3.1	Amended and added to disqualification criteria for directors.	To update disqualification criteria to reflect statute and to reflect disqualification criteria adopted by other FTs which seem appropriate to have in

	Annex 6 paragraph 3.1.2	Amended to remove reference to being a director of another NHS body from disqualification criteria for directors.	place. Amendment allows joint appointments (an individual holding a director post at 2 trusts) and the introduction of an associate NED who may also be a director at another NHS body (Associate NEDs are not directors of the Trust and therefore are not strictly bound by the directors' disqualification criteria in the trust's constitution, but they should be treated in the same way as directors in this regard).
75	Annex 6 paragraph 4.2	References in the constitution and annexes to Chairman amended to 'Chair'. This provision clarifies that references to 'Chair' in this constitution and annexes means the same as statutory references to Chairman.	To clarify that references to 'Chair' in this constitution and annexes means the same as statutory references to Chairman.
77	Annex 7 paragraph 3.1.6	Amended to the Council meeting at least 4 times each financial year to reflect the Code of Governance.	Monitor's Code of Governance states typically the Council would be expected to meet at least four times a year.
80	Annex 7 paragraph 3.8.6	Added to reflect current provisions of constitution which allow governors to amend standing orders without approval from the Board. Whilst this provision makes clear that any such variation shall not constitute an amendment to the constitution for the purposes of paragraph 46, it is suggested that the number of governors required to approve such a variation is the same as the number required to approve an amendment to the constitution, for consistency. Amendment also clarifies that such an amendment to the standing orders does not constitute an amendment to the constitution for the purposes of paragraph 46, except where the procedure in 46.3 and 46.4 applies.	To clarify that the Council can amend its own standing orders without approval from the board to reflect trust's current constitution.

80	Annex 7 paragraph 3.10.1	Removed reference to the minutes being signed by the Chair.	To reflect fact that minutes are approved at the next meeting but are not physically signed.
80	Annex 7 paragraph 3.11.1	Suggested alternative wording to change quorum for Council meetings to be based on percentage of governors in post rather than number of specified governors.	To make it easier for quorum to be achieved for Council meetings.
83	Annex 7 paragraph 7.8	Additional wording to refer to trust's conflicts of interest policy.	To confirm that governors must comply with the trust's conflicts of interest policy.
83 and 84	Annex 7 paragraphs 8.4 and 8.5	Additional provisions re: governors' compliance with Code of Governance, any other guidance issued by Monitor and Nolan principles.	To confirm that governors must comply with Code of Governance, any other guidance issued by Monitor and Nolan principles.
85	Annex 7 paragraph 9	To add provisions for a process to manage disputes between the Council and Board.	Provisions adopted by many FTs and provides a clear process to be followed in the case of any disputes. Monitor's Code of Governance states that the trust should have a process for the resolution of any disagreements between the Council and Board.
85	Annex 7 paragraph 10.1	Added provisions re: a performance assessment for the Council.	To ensure that there is a process for performance assessment of the Council as referred to in Monitor's Code of Governance.
87 and 88	Annex 8 paragraph 3.1	Added provisions re: the term of office of the Chair and NEDs.	To confirm that if a NED holds office for longer than 6 consecutive years, their re-appointment is subject to strict criteria and annual re-appointment as per Monitor's Code of Governance. To confirm that NEDs cannot hold office for longer than 9 consecutive years.
89	Annex 8 paragraph 3.4.1.6	Inserted provisions re: senior independent director.	To reflect the role set out in Monitor's Code of Governance.
90	Annex 8 paragraph 4.1.8	Inserted provisions to enable individuals who are not members of the Board to attend Board meetings, have access to Board papers and participate in discussions.	Added to allow others to participate in Board meetings including interim directors, senior management and any other individuals at the discretion of the Board. Provision clarifies they are not

			Board members.
93	Annex 8 paragraph 4.12.1	Removed reference to the minutes being signed by the Chair.	To reflect fact that minutes are approved at the next meeting but are not physically signed.
93	Annex 8 paragraphs 4.13.6 and 4.13.7	Added to reflect current provisions of constitution which allow directors to amend standing orders without approval from the Council. Whilst this provision makes clear that any such variation shall not constitute an amendment to the constitution for the purposes of paragraph 46, it is suggested that the number of directors required to approve such a variation is the same as the number required to approve an amendment to the constitution, for consistency. Ability to amend standing orders on an emergency basis also included but subject to subsequent approval by the Board.	To clarify that the Board can amend its own standing orders without approval from the Council to reflect trust's current constitution.
96	Annex 8 paragraph 6.6.1.1	Amendment to composition of audit committee to clarify that all non-executive director members of the committee must be independent NEDs.	To reflect latest version of Monitor's Code of Governance.
98	Annex 8 paragraph 7.8	Additional wording to refer to trust's conflicts of interest policy.	To confirm that directors must comply with the trust's conflicts of interest policy.
98	Annex 8 paragraphs 9.2 and 9.3	Additional provisions re: directors' compliance with Code of Governance and Nolan principles.	To confirm that directors must comply with Code of Governance and Nolan principles.
99 and 100	Annex 8 paragraphs 9.6.2 and 9.6.3	Provisions added re: gifts and hospitality and reference to trust's policy.	To clarify that directors must comply with the trust's policy on gifts and hospitality (contained in the conflicts of interest policy).

Countess of Chester Hospital NHS Foundation Trust

Constitution Task & Finish Group Meeting –

Outcome of meeting held on 29th October, 2020 at 3:30pm-5:00pm

Present:

Chris Hannah, Trust Chair

Peter Folwell, Lead Governor

Russel Jackson, Deputy Lead Governor

Caroline Stein, Public Governor

Keith Haynes, Interim Governance Consultant

Debbie Bryce, Lead for Governance Improvement.

	Section reference	Amendments agreed by Governor Task & Finish Group in relation to the proposed Constitution
1	19.1 and 19.2, page 9	In relation to the reference to 'a governor' in section 19.1, update section 19.2 to add: 'based on a majority decision from governors', i.e. 'As such a panel does not presently exist, the trust must take steps to secure that the governors (*based on a majority decision from governors)* are able to access support and/or advise…'
2	26, 27 and 30, page 11, plus contents page on page 2	Remove references to 'initial' in relation to Chair, NEDs and CEO (as this relates to the initial Foundation Trust appointments within the Model Constitution). Delete the whole of section 27, delete 26.3 and 29.3 and delete the whole of section 30. Also update this on the contents page.
3	Annex 3, 2.3, page 21	Update text in relation to CCG appointed governor to '*organisation with strategic responsibility for commissioning NHS provider services*'. Also re-draft narrative in relation to partnership governors to enable more flexibility and to update partners list and draw from a range of organisations. Plus, add 'review on an annual basis'. Suggest that narrative is added, as follows: *In the event that partnership governor appointments are not taken up, the Council of Governors shall at its discretion consider the appointment of other appropriate partnership governors, subject to the overall limit of six appointed partnership governors. The partnership governor position should be reviewed on an annual basis.*
4	Annex 6, 1.3, page 75	Bring section 1.3 in line with recent Governor Nomination Committee Terms of Reference, as follows: 'The (governor) nominations committee will comprise the Chair of the trust (or, when a chair is being appointed, the Vice Chair *+/- the Senior Independent Director* unless he/she is standing for appointment, in which case another non-executive director), *four* elected governors (*comprising Lead Governor, Deputy*

		Lead Governor and one staff governor) and one appointed partnership governor.'
5	Annex 6, Page 75	Following section 1.5, include a paragraph regarding the Governor Nominations Committee responsibility for NED remuneration, as follows (from terms of reference): *Review and make recommendations to the Council of Governors to ensure that the Trust Chair and Non-Executive Directors are fairly rewarded for their contribution to the organisation, having proper regard to the organisation's circumstances and performance and to the provisions of any appropriate guidance and/or legislation.*
6	Annex 7, page 79	Further to the point in section 3.1.4, add the ability to use video conferencing by agreement as an additional point after point 3.2.1 (calling meetings), as follows: *'The Council of Governors may agree that its members can participate in its meetings via electronic means (video, telephone or computer link). Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.'*
7	Annex 7, 3.2.3, page 78 and 4.1.4, page 91	Add 'additional', so it reads '*Additional* meetings of the Council of Governors shall be called…' Also add 'Additional' at the start of section 4.1.4 in Annex 8 (page 91) for Board of Directors, to reflect the same here.
8	Annex 7, 3.11.1, page 81	Remove 1st sentence and retain second sentence to accept the suggestion that quorum for Council of Governors is based on half of governors in post to transact business. i.e. delete the sentence starting: 'No business shall be transacted at the meeting of the Council of Governors unless at least twelve governors are present…'
9	1.2.10, page 4	Change reference from 'Monitor' to 'Monitor or successor body' within Interpretations and definitions'.

	Subsequent implications raised for further consideration	**Lead**
a	Follow up with Human Resources regarding communication of automatic staff membership for new starter process.	Trust Secretary
b	Consideration required by Council of Governors regarding recruitment to Youth Associates (section 8.10, page 6).	Council of Governors
c	Liaise with Civica Engage regarding new membership boundaries alignment on Trust's membership database.	Trust Secretary
d	Consider section 10, page 74, implications regarding communications from governors (Annex 5, section 10, page 74).	Council of Governors
e	Consider Lead Governor appointment/renewal every 12 months (Annex 5, section 8.1, page 73).	Council of Governors
f	Review Council of Governors effectiveness annually (Section 10.1).	Chair
g	Share updated constitution with NHSE/I once approved by Board (1st December) and Council of Governors (11th December). (Also to be considered by Audit Committee on 18th November).	Trust Secretary

	Section reference	Subsequent amendments proposed by/to Governor Task & Finish Group in relation to the proposed Constitution (November 2020)
10	Annex 5, section 8.1, 8.2, 9.1 and 9.2, page 73	Change the period of the Lead Governor and Deputy Lead Governor role from 12 months to 24 months.
11	23.2.2 and 23.2.3, page 10	Update the Board of Directors composition to: 'no more than 7 other non-executive directors' and 'no more than 7 executive directors'.

CONSTITUTION OF COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

1 INTERPRETATION AND DEFINITIONS

1.1 Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

1.2 Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

1.2.1 **the 2006 Act** is the National Health Service Act 2006.

1.2.2 **the 2012 Act** is the Health and Social Care Act 2012.

1.2.3 **the Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

1.2.4 **Annual Members' Meeting** is defined in Paragraph 11 of the constitution.

1.2.5 **Appointed Governor** means a governor appointed by one of the appointing organisations listed in paragraph 2.3 of Annex 3.

1.2.6 **the Board** means the Board of Directors.

1.2.7 **Constitution** means this constitution and all annexes to it.

1.2.8 **Lead Governor** means the governor appointed by the Council of Governors to fulfil the role described at Paragraph 8 of Annex 5.

1.2.9 **Deputy Lead Governor** means the governor appointed by the Council of Governors to fulfil the role described at Paragraph 9 of Annex 5.

1.2.10 **Monitor** is the corporate body known as Monitor (or successor body), as provided by Section 61 of the 2012 Act.

Comment [DB1]: Updated following governor review

1.2.11 **NHS Commissioning Board** is the body corporate established pursuant to Section 1H of the 2006 Act, known as NHS England.

1.2.12 **NHS England** is the NHS Commissioning Board.

1.2.13 **Partnership Organisation** means an organisation specified in paragraph 2.3 of Annex 3 who may appoint an 'Appointed Governor'.

1.2.14 **Public Governor** means a governor elected by the members of one of the Public Constituencies.

1.2.15 **Staff Governor** means a governor elected by the members of one of the classes of the Staff Constituency.

1.2.16 the **trust** means the Countess of Chester Hospital NHS Foundation Trust.

1.2.17 **Trust Secretary** means the secretary of the Trust or any other person appointed to perform the duties of the secretary including a secretarial assistant.

2 NAME

2.1 The name of the foundation trust is the Countess of Chester Hospital NHS Foundation Trust.

3 PRINCIPAL PURPOSE

3.1 The principal purpose of the trust is the provision of goods and services for the purposes of the health service in England.

3.2 The trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The trust may provide goods and services for any purposes related to –

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order to better carry on its principal purpose.

4 POWERS

4.1 The powers of the trust are set out in the 2006 Act.

4.2 All the powers of the trust shall be exercised by the Board of Directors on behalf of the trust.

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

4.4 The trust is required to comply with its authorisation, as granted by Monitor, and its provider licence.

5 MEMBERSHIP AND CONSTITUENCIES

Comment [ES2]: Staff associates could also be included here if the Trust wishes to retain them, but what is the benefit if you can be a member of the Public Constituency?

5.1 The trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1.1 a public constituency;

5.1.2 a staff constituency.

5.2 Youth Associates may also become involved with the trust. Youth Associates are individuals who are at least 11 years of age, but less than 16 years of age, who, apart from their age, are otherwise entitled to become a member of one of the public constituencies and apply to the trust to become a Youth Associate by completing an application form in whatever form the Trust Secretary determines from time to time.

5.3 Youth Associates shall not be members of the trust and shall not have a right to vote, but they shall be permitted to attend members meetings and receive any members newsletter or other literature that is distributed to members from time to time, at the discretion of the Council of Governors.

Comment [ES3]: Youth associates added here but wording slightly amended.

6 APPLICATION FOR MEMBERSHIP

6.1 Subject to paragraph 9 below, an individual who is eligible to become a member of the trust may do so on application to the trust.

7 PUBLIC CONSTITUENCY

7.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the trust.

7.2 Those individuals who live in an area specified for a public constituency are referred to collectively as a Public Constituency.

7.3 The minimum number of members in each Public Constituency is specified in Annex 1.

8 STAFF CONSTITUENCY

8.1 An individual who is employed by the trust under a contract of employment with the trust may become or continue as a member of the trust provided:

8.1.1 he/she is employed by the trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 he/she has been continuously employed by the trust under a contract of employment for at least 12 months.

8.2 Individuals who exercise functions for the purposes of the trust, otherwise than under a contract of employment with the trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months. For the avoidance of doubt, this does not include those who assist or provide services to the trust on a voluntary basis.

8.3 Those individuals who are eligible for membership of the trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.4 The Staff Constituency shall be divided into 4 descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

9 AUTOMATIC MEMBERSHIP BY DEFAULT – STAFF

9.1 An individual who is:

9.1.1 eligible to become a member of the Staff Constituency, and

9.1.2 invited by the trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

shall become a member of the trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless he/she informs the trust that he/she does not wish to do so.

Comment [ES4]: Permitted by statute, but not a statutory requirement but part of the model core constitution and means that the Trust does not have to process applications for staff members.

10 RESTRICTION ON MEMBERSHIP

10.1 An individual who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

10.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

10.3 An individual must be at least 16 years old to become a member of the trust.

Comment [ES5]: Changed to 16 years old rather than over 16. Youth Associates are individuals over 11 and less than 16 so 16 year olds were previously excluded from membership.

10.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the trust are set out in Annex 9 (Further Provisions – Members).

11 ANNUAL MEMBERS' MEETING

11.1 The Trust shall hold an annual meeting of its members (**Annual Members Meeting**). The Annual Members Meeting shall be open to members of the public.

11.2 Further provisions about the Annual Members Meeting are set out in Annex 9.

12 THE COUNCIL OF GOVERNORS – COMPOSITION

12.1 The trust is to have a Council of Governors, which shall comprise both elected and appointed governors.

12.2 The composition of the Council of Governors is specified in Annex 3.

12.3 The composition of the Council of Governors shall seek to ensure that the interests of the community served by the trust are appropriately represented and that the level of representation of the Public Constituencies, the Staff Constituency and the partnership organisations strikes an appropriate balance having regard to their legitimate interest in the trust's affairs. To this end, the Council of Governors shall:

12.3.1 at all times maintain a policy for the composition of the Council of Governors which takes account of the membership strategy; and

12.3.2 from time to time, and not less than every three years, review the policy and, where appropriate, propose amendments to it and amendments to this constitution.

12.4 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

13 THE COUNCIL OF GOVERNORS – ELECTION OF GOVERNORS

13.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules.

13.2 The Model Election Rules as published from time to time by NHS Providers form part of this constitution. The 2014 version of the Model Election Rules is attached at Annex 4.

13.3 A subsequent variation of the Model Election Rules by NHS Providers shall not constitute a variation of the terms of this constitution for the purposes of paragraph 46 of the constitution (amendment of the constitution).

13.4 An election, if contested, shall be by secret ballot.

13.5 A member may not vote at an election for a Public Governor unless within the specified period he/she has made a declaration in the specified form that he/she is a member of the Public Constituency and stating the particulars of his/her qualification to vote as a member of that Public Constituency for which an election is being held. It is an offence knowingly or recklessly to make such a declaration which is false in a material particular.

13.6 The form and content of the declaration and the period for making such a declaration for the purposes of paragraph 13.5 above shall be specified and published by the trust from time to time and shall be so published not less than 14 days prior to an election.

14 COUNCIL OF GOVERNORS - TENURE

14.1 An elected governor may hold office for a period of up to 3 years.

14.2 An elected governor shall cease to hold office if he/she ceases to be a member of the constituency or class by which he/she was elected.

14.3 An elected governor shall be eligible for re-election at the end of his/her term, but may not hold office for longer than nine consecutive years.

Comment [ES6]: Removed reference to not being eligible for re-election if already held office for more than 6 consecutive years. Same at 14.6.

14.4 An appointed governor may hold office for a period of up to 3 years.

14.5 An appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him/her.

14.6 An appointed governor shall be eligible for re-appointment at the end of his/her term, but may not hold office for longer than nine consecutive years.

14.7 Further provisions as to the tenure of governors are contained in paragraph 1 of Annex 5 of this constitution.

15 COUNCIL OF GOVERNORS – DISQUALIFICATION AND REMOVAL

15.1 The following may not become or continue as a member of the Council of Governors:

15.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

15.1.2 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

15.1.3 a person who has made a composition or arrangement with, or granted a trust deed for, his/her creditors and has not been discharged in respect of it;

15.1.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her.

15.2 Governors must be at least 16 years of age at the closing date for nominations for their election or appointment.

15.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors and provision for the removal of Governors in certain circumstances are set out in Annex 5.

16 COUNCIL OF GOVERNORS – DUTIES OF GOVERNORS

16.1 The general duties of the Council of Governors are:

16.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors; and

16.1.2 to represent the interests of the members of the trust as a whole and the interests of the public.

16.2 The trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

17 COUNCIL OF GOVERNORS – MEETINGS OF GOVERNORS

17.1 The Chair of the trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 26.1 or paragraph 27.1 below) or, in his/her absence the Vice Chair (appointed in accordance with the provisions of paragraph 28 below), or in his/her absence one of the non-executive directors shall preside at meetings of the Council of Governors. If the person presiding at any such meeting has a conflict of interest in relation to the business being discussed, the Lead Governor will chair that part of the meeting.

17.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons in accordance with Standing Order 3.1.2 of Annex 7.

17.3 For the purposes of obtaining information about the trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

18 COUNCIL OF GOVERNORS – STANDING ORDERS

18.1 The standing orders for the practice and procedure of the Council of Governors are attached at Annex 7.

19 COUNCIL OF GOVERNORS – SUPPORT/ADVICE

19.1 Paragraph 39A of the 2006 Act provides Monitor with the ability to appoint a panel of persons to which a governor of an NHS foundation trust may refer a question as to whether the trust has failed or is failing:

19.1.1 to act in accordance with its constitution; or

19.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

19.2 As such a panel does not presently exist, the trust must take steps to secure that the governors *(based on a majority decision from governors)* are able to access support and/or advice, as and where necessary, to enable them to fulfil the duties set out at paragraph 16.1 above.

Comment [DB7]: Section added following governor review

20 COUNCIL OF GOVERNORS - CONFLICTS OF INTEREST OF GOVERNORS

20.1 If a governor, or their spouse or partner, has a relevant and material interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the appropriate management of any conflicts of interest.

21 COUNCIL OF GOVERNORS – EXPENSES

21.1 The trust may reimburse governors for travel costs and any other costs and expenses at such rates as the trust may determine.

21.2 Governors are not to receive remuneration for their role.

22 COUNCIL OF GOVERNORS – FURTHER PROVISIONS

22.1 Further provisions with respect to the Council of Governors are set out in Annex 5.

23 BOARD OF DIRECTORS – COMPOSITION

23.1 The trust is to have a Board of Directors, which shall comprise both executive and non-executive directors.

23.2 The Board of Directors is to comprise:

23.2.1 a non-executive Chair;

23.2.2 at least 7 ~~6~~ other non-executive directors; and

23.2.3 at least 7 ~~6~~ executive directors.

Comment [DB8]: To reflect a balanced Board of Directors and current composition

23.3 At least half of the Board of Directors, excluding the Chair, shall be comprised of non-executive directors.

23.4 If, at any time, there is an equal number of executive directors and non-executive directors (including the Chair) on the Board then the Chair shall have an additional and casting vote.

23.5 One of the executive directors shall be the Chief Executive.

23.6 The Chief Executive shall be the Accounting Officer.

23.7 One of the executive directors shall be the finance director.

23.8 One of the executive directors is to be a registered medical practitioner or registered dentist (within the meaning of the Dentists Act 1984).

23.9 One of the executive directors is to be a registered nurse or registered midwife.

23.10 The trust may appoint individuals to be Associate Non-Executive Directors. For the avoidance of doubt, individuals appointed to this role are not members of the Board of Directors and have no voting rights. However, they shall be permitted to attend meetings of the Board of Directors, receive relevant papers and participate in discussions at meetings, at the discretion of the Board of Directors.

Comment [ES9]: Associate NED provision inserted.

24 BOARD OF DIRECTORS – GENERAL DUTY

24.1 The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the trust so as to maximise the benefits for the members of the trust as a whole and for the public.

25 BOARD OF DIRECTORS – QUALIFICATION FOR APPOINTMENT AS A NON-EXECUTIVE DIRECTOR

25.1 A person may be appointed as a non-executive director only if –

25.1.1 he/she is a member of a Public Constituency; and

25.1.2 he/she is not disqualified by virtue of paragraph 31 below.

26 BOARD OF DIRECTORS – APPOINTMENT AND REMOVAL OF CHAIR AND OTHER NON-EXECUTIVE DIRECTORS

26.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the trust and the other non-executive directors.

26.2 Removal of the Chair or another non-executive director shall require the approval of three-quarters of the members of the Council of Governors.

26.3 ~~The initial Chair and the initial non-executive directors are to be appointed in accordance with paragraph 27 below.~~

26.4 Further provisions relating to the appointment and removal of the Chair of the trust and the other non-executive directors are set out in paragraphs 1 and 2 of Annex 6 to this constitution and paragraph 3.1 of Annex 8.

27 ~~BOARD OF DIRECTORS – APPOINTMENT OF INITIAL CHAIR AND INITIAL OTHER NON-EXECUTIVE DIRECTORS~~

27.1 ~~The Council of Governors shall appoint the Chair of the applicant NHS Trust as the initial Chair of the trust, if he/she wishes to be appointed.~~

27.2 ~~The power of the Council of Governors to appoint the other non-executive directors of the trust is to be exercised, so far as possible, by appointing as the initial non-executive directors of the trust any of the non-executive directors of the applicant NHS Trust (other than the Chair) who wish to be appointed.~~

27.3 ~~The criteria for qualification for appointment as a non-executive director set out in paragraph 26 above (other than disqualification by virtue of paragraph 31 below) do not apply to the appointment of the initial Chair and the initial other non-executive directors in accordance with the procedures set out in this paragraph.~~

27.4 ~~An individual appointed as the initial Chair or as an initial non-executive director in accordance with the provisions of this paragraph shall be appointed for the unexpired period of his term of office as Chair or (as the case may be) non-executive director of the applicant NHS Trust; but if, on appointment, that period is less than 12 months, he/she shall be appointed for 12 months.~~

28 BOARD OF DIRECTORS – APPOINTMENT OF DEPUTY CHAIR

28.1 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the non-executive directors as a deputy Chair. The deputy Chair shall be called the "Vice Chair".

29 BOARD OF DIRECTORS - APPOINTMENT AND REMOVAL OF THE CHIEF EXECUTIVE AND OTHER EXECUTIVE DIRECTORS

29.1 The non-executive directors shall appoint or remove the Chief Executive.

29.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

29.3 ~~The initial Chief Executive is to be appointed in accordance with paragraph 30 below.~~

29.4 A committee consisting of the Chair, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors.

30 ~~BOARD OF DIRECTORS – APPOINTMENT AND REMOVAL OF INITIAL CHIEF EXECUTIVE~~

30.1 ~~The non-executive directors shall appoint the chief officer of the applicant NHS Trust as the initial Chief Executive of the trust, if he/she wishes to be appointed.~~

30.2 ~~The appointment of the chief officer of the applicant NHS trust as the initial Chief Executive of the trust shall not require the approval of the Council of Governors.~~

31 BOARD OF DIRECTORS – DISQUALIFICATION

31.1 The following may not become or continue as a member of the Board of Directors:

31.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

Comment [DB10]: Relates to initial FT appointments. Deleted following governor review

Comment [DB11]: Relates to initial FT appointments. Deleted following governor review

Comment [DB12]: Relates to initial FT appointment. Delete following governor review

Comment [DB13]: Relates to initial FT appointment.

31.1.2 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

31.1.3 a person who has made a composition or arrangement with, or granted a trust deed for, his/her creditors and has not been discharged in respect of it;

31.1.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her.

31.2 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Board of Directors are set out in Annex 6.

32 BOARD OF DIRECTORS – MEETINGS

32.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons in accordance with Standing Order 4.16 of Annex 8.

32.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors. Agendas and minutes of public meetings will be available on the trust's website. Minutes shall be published in approved form.

33 BOARD OF DIRECTORS – STANDING ORDERS

33.1 The standing orders for the practice and procedure of the Board of Directors are attached at Annex 8.

34 BOARD OF DIRECTORS - CONFLICTS OF INTEREST OF DIRECTORS

34.1 The duties that a director of the trust has by virtue of being a director include in particular:

34.1.1 a duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the trust;

34.1.2 a duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

34.2 The duty referred to in paragraph 34.1.1 is not infringed if:

34.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or

34.2.2 the matter has been authorised in accordance with the constitution.

34.3 The duty referred to in paragraph 34.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

34.4 In paragraph 34.1.2, "third party" means a person other than:

34.4.1 the trust; or

34.4.2 a person acting on its behalf.

34.5 If a director, or their spouse or partner, has a relevant and material interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the trust or Board of Directors,

the director shall disclose that interest to the other directors. The Standing Orders for the Board of Directors contains further provision on the disclosure of interests and arrangements for the appropriate management of any conflicts of interest.

34.6 Any interest that is disclosed by a director pursuant to this constitution shall be recorded in a register of interests of directors maintained by the Trust Secretary.

34.7 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

34.8 Any declaration required by this paragraph must be made before the trust enters into the transaction or arrangement.

34.9 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

34.10 A director need not declare an interest:

34.10.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

34.10.2 if, or to the extent that, the directors are already aware of it;

34.10.3 if, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered –

35.9.3.1 by a meeting of the Board of Directors; or

35.9.3.2 by a committee of the directors appointed for the purpose under the constitution.

34.11 A matter shall have been authorised for the purposes of paragraph 34.2.2 if it has previously been approved by the Board of Directors at a meeting and the minutes of the meeting shall be conclusive evidence of such approval having been given.

35 BOARD OF DIRECTORS – REMUNERATION AND TERMS OF OFFICE

35.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other non-executive directors, subject to the provisions on terms of office contained in paragraph 3.1 of Annex 8 of this constitution.

35.2 The trust shall establish a committee of non-executive directors (the **Remuneration and Nominations Committee**) to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

36 REGISTERS

36.1 The trust shall have:

36.1.1 a register of members showing, in respect of each member, the constituency to which he/she belongs and, where there are classes within it, the class to which he/she belongs;

36.1.2 a register of members of the Council of Governors;

36.1.3 a register of interests of governors;

36.1.4 a register of directors; and

36.1.5 a register of interests of the directors.

37 ADMISSION TO AND REMOVAL FROM THE REGISTERS

37.1 The Trust Secretary shall be responsible for establishing registers and for keeping these registers up-to-date.

37.2 The Council of Governors shall review the registers listed at Paragraphs 36.1.1 to 36.1.3 (inclusive) at least annually.

37.3 The Board of Directors shall review the registers listed at Paragraphs 36.1.4 to 36.1.5 (inclusive) at least annually.

37.4 The removal of any member from the register of members shall be undertaken in accordance with the provisions of paragraph 2 of Annex 9 to this constitution.

38 REGISTERS – INSPECTION AND COPIES

38.1 The trust shall make the registers specified in paragraph 36 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed.

38.2 The trust shall not make any part of its register referred to in paragraph 36.1.1 available for inspection by members of the public which shows details of any member of the trust, if he/she so requests.

Comment [ES14]: Wording reflects the Public Benefit Corporation (Register of Members) Regulations 2004.

38.3 So far as the registers are required to be made available:

38.3.1 they are to be available for inspection free of charge at all reasonable times; and

38.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

38.4 If the person requesting a copy or extract is not a member of the trust, the trust may impose a reasonable charge for doing so.

39 DOCUMENTS AVAILABLE FOR PUBLIC INSPECTION

39.1 The trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

39.1.1 a copy of the current constitution;

39.1.2 a copy of the latest annual accounts and of any report of the auditor on them;

39.1.3 a copy of the latest annual report.

39.2 The trust shall also make the following documents relating to a special administration of the trust available for inspection by members of the public free of charge at all reasonable times:

39.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act;

39.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act;

39.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act;

39.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act;

39.2.5 a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act;

39.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act;

39.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;

39.2.8 a copy of any final report published under section 65 I (administrator's final report) of the 2006 Act;

39.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act;

39.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

39.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

39.4 If the person requesting a copy or extract is not a member of the trust, the trust may impose a reasonable charge for doing so.

40 AUDITOR

40.1 The trust shall have an auditor.

40.2 A person may only be appointed as the auditor if he/she meets the requirements referred to in paragraph 23 of Schedule 7 to the 2006 Act.

40.3 The auditor is to carry out their duties in accordance with the provisions of the 2006 Act, in particular Schedule 10 to the 2006 Act, and in accordance with any directions given by Monitor on standards, procedures and techniques to be adopted.

40.4 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

Comment [ES15]: Schedule 7 to the 2006 Act contains provisions re: the auditor.

41 AUDIT COMMITTEE

41.1 The trust shall establish a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

42 ACCOUNTS

42.1 The trust must keep proper accounts and proper records in relation to the accounts.

42.2 Monitor may with the approval of the Secretary of State give directions to the trust as to the content and form of its accounts.

42.3 The accounts are to be audited by the trust's auditor.

42.4 The trust shall prepare in respect of each financial year annual accounts.

42.5 In preparing its annual accounts, the trust must comply with any directions given by Monitor with the approval of the Secretary of State as to the methods and principles according to which the accounts must be prepared and the content and form of the accounts.

42.6 The functions of the trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

43 ANNUAL REPORT, FORWARD PLANS AND NON-NHS WORK

43.1 The trust shall prepare an annual report and send it to Monitor.

43.2 The trust shall give information as to its forward planning in respect of each financial year to Monitor.

43.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

43.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

43.5 Each forward plan must include information about:

43.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the trust proposes to carry on, and

43.5.2 the income it expects to receive from doing so.

43.6 Where a forward plan contains a proposal that the trust carry on an activity of a kind mentioned in paragraph 43.5.1 the Council of Governors must:

43.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the trust of its principal purpose or the performance of its other functions, and

43.6.2 notify the directors of the trust of its determination.

43.7 A trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the Council of Governors of the trust voting approve its implementation.

44 PRESENTATION OF THE ANNUAL ACCOUNTS AND REPORTS TO THE GOVERNORS AND MEMBERS

44.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

44.1.1 the annual accounts;

44.1.2 any report of the auditor on them;

44.1.3 the annual report.

44.2 The documents shall also be presented to the members of the trust at the Annual Members Meeting by at least one member of the Board of Directors in attendance.

44.3 The trust may combine a meeting of the Council of Governors convened for the purposes of paragraph 44.1 with the Annual Members Meeting.

45 INSTRUMENTS

45.1 The trust shall have a seal.

45.2 The seal shall not be affixed except under the authority of the Board of Directors.

46 AMENDMENT OF THE CONSTITUTION

46.1 The trust may make amendments of its constitution only if:

46.1.1 more than half of the members of the Council of Governors of the trust voting approve the amendments; and

46.1.2 more than half of the members of the Board of Directors of the trust voting approve the amendments.

46.2 Amendments made under paragraph 46.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with Schedule 7 of the 2006 Act.

46.3 Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the trust):

46.3.1 at least one member of the Council of Governors must attend the next Annual Members Meeting and present the amendment; and

46.3.2 the trust must give the members an opportunity to vote on whether they approve the amendment.

46.4 If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the trust must take such steps as are necessary as a result.

46.5 Amendments by the trust of its constitution are to be notified to Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

Comment [ES16]: New paragraph regarding amendments to the constitution to reflect the statutory provisions (section 37 and paragraph 27A of Schedule 7 of the NHS Act 2006).

47 MERGERS ETC AND SIGNIFICANT TRANSACTIONS

47.1 The trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

47.2 The trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the trust voting approve entering into the transaction.

47.3 For the purposes of paragraph 47.2:

47.3.1 a transaction is an investment or disinvestment; and

47.3.2 a transaction is significant if it falls within the definition of a 'significant transaction' as set out in NHS Improvement's Transactions Guidance (November 2017) calculated with reference to the trust's opening balance sheet for the financial year in which approval is being sought.

47.4 For the avoidance of doubt, for the purposes of paragraph 47.2, the term 'transaction' shall not include the renewal of an existing contract with a commissioning organisation for the provision of services for the purposes of the health service in England and Wales.

47.5 If more than half of the members of the Council of Governors voting decline to approve a significant transaction or any part of it, the Council of Governors must approve a written Statement of Reasons for its rejection, to be provided to the Board of Directors.

47.6 Nothing in this paragraph 47 shall prevent the Board of Directors from engaging with the Council of Governors, as it sees fit, about any other transaction or arrangement which the trust may enter into, which does not constitute a “significant transaction” within the meaning of this paragraph.

ANNEX 1 – THE PUBLIC CONSTITUENCIES

Name of the Public Constituency	Area of the Public Constituency (confirmation of electoral area or areas)	Minimum number of members	Number of governors to elect
Ellesmere Port and Neston	The following electoral wards within Cheshire West & Chester Local Authority, England: Parkgate Neston Little Neston Willaston & Thornton Netherpool Ledsham & Manor Strawberry Sutton Villages Whitby Groves Whitby Park Central & Grange Westminster Wolverham.	4	4
Chester and rural Cheshire	The electoral wards within the Cheshire West & Chester Local Authority boundary not listed within the Ellesmere Port and Neston constituency (above).	4	8
Flintshire	The electoral wards within the unitary authority of Flintshire, Wales.	4	3
Rest of England and Wales	All electoral areas in England not covered by the other public constituencies in this Annex, and the country of Wales	4	1
Total		16	16

Comment [ES17]: Areas need to be defined based on electoral area. The four public constituencies each need to be an electoral area or consist of two or more electoral areas.

Comment [DB18]: Now added

ANNEX 2 – THE STAFF CONSTITUENCY

Staff classes within the Staff Constituency	Individuals eligible for membership of the relevant class	Minimum number of members	Number of governors to elect
Medical staff	Those members of staff employed by the trust who are registered with a medical regulatory body to practise	4	1
Nursing and midwifery staff	Those members of staff employed by the trust who are registered nurses or midwifes	4	2
Allied health professionals and technical/scientific staff	Those members of staff who are recognised in the NHS as being AHPs (as regulated by the Health and Care Professions Council or the General Osteopathic Council) and technical and scientific staff who hold recognised technical or scientific qualifications (with the exception of those with recognised medical or nursing/midwifery qualifications)	4	1
Other	Anyone who is eligible for membership of the Staff Constituency but does not fall within any of the other 3 classes	4	1
Total		16	5

In the case of any query as to which class of the Staff Constituency a member of staff is eligible to be a member of, the Trust Secretary shall be responsible for determining which one of the four classes of the Staff Constituency, shown in this Annex, the member of staff is eligible to be a member of. If any member of staff is eligible to be a member of more than one class of the Staff Constituency, he/she shall select one class to be a member of or, where he/she fails to do so (including where he/she fails to notify the Trust Secretary of his/her selection), the Trust Secretary shall determine the class that the member of staff shall be a member of and shall notify the member of that determination in writing.

ANNEX 3 – COMPOSITION OF THE COUNCIL OF GOVERNORS

The composition of the Council of Governors shall be as follows-

COMPOSITION

1 The aggregate number of Public Governors is to be more than half of the total number of members of the Council of Governors.

2 The Council of Governors shall be comprised of the following governors:

2.1 16 Public Governors from the following public constituencies:

2.1.1 Chester and rural Cheshire – 8 Public Governors

2.1.2 Ellesmere Port and Neston – 4 Public Governors

2.1.3 Flintshire – 3 Public Governors

2.1.4 Rest of England and Wales – 1 Public Governor.

2.2 5 Staff Governors from the following classes of the Staff Constituency:

2.2.1 Medical staff – 1 Staff Governor

2.2.2 Nursing and midwifery staff – 2 Staff Governors

2.2.3 Allied health professionals and technical/scientific staff – 1 Staff Governor

2.2.4 Other – 1 Staff Governor.

2.3 6 Appointed Governors (Partnership Governors) who may be appointed by the following partnership organisations – 1 Appointed Governor to be appointed by each partnership organisation:

2.3.1 Betsi Cadwaladr University Health Board;

2.3.2 Chester University;

2.3.3 Cheshire West and Chester Council;

2.3.4 North Wales Community Health Council – Local Flintshire Committee;

2.3.5 Council for Voluntary Services;

2.3.6 ~~Cheshire Clinical Commissioning Group~~ Organisation with strategic responsibility for commissioning NHS provider services

The Partnership Governors are to be appointed by the partnership organisations in accordance with a process agreed with the Trust Secretary. In the event that partnership governor appointments are not taken up, the Council of Governors shall at its discretion consider the appointment of other appropriate partnership governors, subject to the overall limit of six appointed partnership governors. The partnership governor position should be reviewed on an annual basis.

Comment [ES19]: The statutory requirement is that at least one governor must be appointed by one or more qualifying local authorities, which are a local authority for an area which includes the whole or part of an area specified in the constitution as the area for a public constituency.

There is no statutory requirement for the local CCG or commissioner to appoint a governor. This can therefore be removed from your constitution if you so wish. However, there is nothing preventing a CCG from being a partnership organisation, if you so wish, and appointing an individual to the Council of Governors (although a CCG's GB lay member cannot be a governor of a FT as well as a lay member of a GB). Conflicts of interest can be managed in the same way as usually managed.

Comment [DB20]: Updated following governor review

Comment [DB21]: Added following governor review

ANNEX 4 – THE MODEL ELECTION RULES

PART 1 Interpretation

1. Interpretation

PART 2 Timetable for election

2. Timetable

3. Computation of time

PART 3 Returning officer

4. Returning officer

5. Staff

6. Expenditure

7. Duty of co-operation

PART 4 Stages common to contested and uncontested elections

8. Notice of election

9. Nomination of candidates

10. Candidate's particulars

11. Declaration of interests

12. Declaration of eligibility

13. Signature of candidate

14. Decisions as to validity of nomination forms

15. Publication of statement of nominated candidates

16. Inspection of statement of nominated candidates and nomination forms

17. Withdrawal of candidates

18. Method of election

PART 5 Contested elections

19. Poll to be taken by ballot

20. The ballot paper

21. The declaration of identity (public and patient constituencies)

PART 1 - INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution;

"*council of governors* " means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code*" means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"the telephone voting system " means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting;

"*voting information*" means postal voting information and/or e-voting information.

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2 - TIMETABLE FOR ELECTION

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

a) a Saturday or Sunday;
b) Christmas day, Good Friday, or a bank holiday, or
c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3 – RETURNING OFFICER

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

a) any expenses incurred by that officer in the exercise of his or her functions under these rules,
b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4 – STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

a) the constituency, or class within a constituency, for which the election is being held,
b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
c) the details of any nomination committee that has been established by the corporation,
d) the address and times at which nomination forms may be obtained;
e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,
f) the date and time by which any notice of withdrawal must be received by the returning officer
g) the contact details of the returning officer
h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

a) is to supply any member of the corporation with a nomination form, and
b) is to prepare a nomination form for signature at the request of any member of the corporation, but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

a) full name,
b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and
c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

a) any financial interest that the candidate has in the corporation, and
b) whether the candidate is a member of a political party, and if so, which party, and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

a) they wish to stand as a candidate,
b) their declaration of interests as required under rule 11, is true and correct, and
c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

a) decides that the candidate is not eligible to stand,
b) decides that the nomination form is invalid,
c) receives satisfactory proof that the candidate has died, or
d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,
b) that the paper does not contain the candidate's particulars, as required by rule 10;
c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11, (d) that the paper does not include a declaration of eligibility as required by rule 12, or
d) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and
b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and
b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

PART 5 – CONTESTED ELECTIONS

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

   (i) configured in accordance with these rules; and
   (ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

   (i) configured in accordance with these rules; and
   (ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

   (i) configured in accordance with these rules; and
   (ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

a) the name of the corporation,
b) the constituency, or class within a constituency, for which the election is being held,
c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,
f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

a) what the voter is the person:

(i) to whom the ballot paper was addressed, and/or
(ii) to whom the voter ID number contained within the e-voting information was allocated,

b) that he or she has not marked or returned any other voting information in the election, and

c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared

Action to be taken before the poll invalid.

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

a) a postal address; and,
b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

a) the name of the corporation,
b) the constituency, or class within a constituency, for which the election is being held,
c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,
d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,
f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,
g) the address for return of the ballot papers,
h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;
i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,
j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,
k) the date and time of the close of the poll,
l) the address and final dates for applications for replacement voting information, and
m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

a) a ballot paper and ballot paper envelope,

b) the ID declaration form (if required),
c) information about each candidate standing for election, pursuant to rule 61 of these rules, and
d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

a) instructions on how to vote and how to make a declaration of identity (if required),
b) the voter's voter ID number,
c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate,
d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

a) only be sent postal voting information; or
b) only be sent e-voting information; or
c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an email address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

a) the address for return of the ballot paper printed on it, and
b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

a) the completed ID declaration form if required, and
b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

a) require a voter to:
   (i) enter his or her voter ID number; and
   (ii) where the election is for a public or patient constituency, make a declaration of identity;

   in order to be able to cast his or her vote;

b) specify:

   (i) the name of the corporation,
   (ii) the constituency, or class within a constituency, for which the election is being held,
   (iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
   (iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
   (v) instructions on how to vote and how to make a declaration of identity,
   (vi) the date and time of the close of the poll, and
   (vii) the contact details of the returning officer;

c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter's vote,

e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and
(ii) where the election is for a public or patient constituency, make a declaration of identity;

b) specify:

(i) the name of the corporation,
(ii) the constituency, or class within a constituency, for which the election is being held,
(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(iv) instructions on how to vote and how to make a declaration of identity,
(v) the date and time of the close of the poll, and
(vi) the contact details of the returning officer;

c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter's vote

e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

a) require a voter to:

(i) provide his or her voter ID number; and
(ii) where the election is for a public or patient constituency, make a declaration of identity; in order to be able to cast his or her vote;

b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

c) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter's vote

d) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

e) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

a) is satisfied as to the voter's identity; and
b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

a) the name of the voter, and
b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and
c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

a) the name of the voter, and
b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and
c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

a) is satisfied as to the voter's identity,
b) has no reason to doubt that the voter did not receive the original voting information,
c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

a) the name of the voter
b) the details of the unique identifier of the replacement ballot paper, if applicable, and
c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

a) the name of the voter,
b) the unique identifier of any replacement ballot paper issued under this rule;
c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

a) a covering envelope, or
b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

a) the candidate for whom a voter has voted, or
b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to: and other documents.

a) put the ID declaration form if required in a separate packet, and
b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

a) mark the ballot paper "disqualified",
b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,
c) record the unique identifier on the ballot paper in a list of disqualified documents (the "list of disqualified documents"); and
d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",
b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and
c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

a) mark the ID declaration form "disqualified",
b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and
c) place the ID declaration form in a separate packet.

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and
b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

a) mark the ballot paper "disqualified",
b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,
c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;
d) place the document or documents in a separate packet; and
e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",
b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;
c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and
d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

a) the disqualified documents, together with the list of disqualified documents inside it,
b) the ID declaration forms, if required,
c) the list of spoilt ballot papers and the list of spoilt text message votes,
d) the list of lost ballot documents,
e) the list of eligible voters, and (f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6 – COUNTING THE VOTES

STV41. Interpretation of Part 6

41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"count" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document: (a) on which no second or subsequent preference is recorded for a continuing candidate, or (b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,

(b) the transfer of a surplus of a candidate deemed to be elected, or (c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transfer red vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and
(ii) a policy governing the use of such software, and

b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

a) count and record the number of:

(i) ballot papers that have been returned; and
(ii) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique

identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,
c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,
b) on which anything is written or marked by which the voter can be identified except the unique identifier, or
c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
b) on which votes are given for more candidates than the voter is entitled to vote,
c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

a) elsewhere than in the proper place,
b) otherwise than by means of a clear mark,
c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and
b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

a) does not bear proper features that have been incorporated into the ballot paper,
b) voting for more candidates than the voter is entitled to,
c) writing or mark by which voter could be identified, and
d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

a) on which votes are given for more candidates than the voter is entitled to vote,
b) on which anything is written or marked by which the voter can be identified except the voter ID number, or
c) which is unmarked or rejected because of uncertainty,
d) shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

a) otherwise than by means of a clear mark,
b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and
b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

a) voting for more candidates than the voter is entitled to,
b) writing or mark by which voter could be identified, and
c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

a) according to next available preference given on those ballot documents for any continuing candidate, or
b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each subparcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and
b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

a) according to the next available preference given on those ballot documents for any continuing candidate, or
b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each subparcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

a) a transfer value calculated as set out in rule STV47.4(b), or
b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or
b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

a) record the total value of the votes transferred to each candidate,
b) add that value to the previous total of votes recorded for each candidate and record the new total,
c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and
d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a nontransferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

b) subject to rule STV50, one or more vacancies remain to be filled,

i. the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV49.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two subparcels so that they are grouped as:

a) ballot documents on which a next available preference is given, and
b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each subparcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV49.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the subparcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1

STV49.10 The returning officer shall after each stage of the count completed under this rule:

a) record:
   (i) the total value of votes, or
   (ii) the total transfer value of votes transferred to each candidate,

b) add that total to the previous total of votes recorded for each candidate and record the new total,
c) record the value of non-transferable votes and add that value to the previous nontransferable votes total, and
d) compare:
   (i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with
   (ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest

candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7 – FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or

(ii) in any other case, to the Chair of the corporation; and

c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

a) the total number of votes given for each candidate (whether elected or not), and
b) the number of rejected ballot papers under each of the headings in rule FPP44.5,
c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,
b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or

(ii) in any other case, to the Chair of the corporation, and

c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

a) the number of first preference votes for each candidate whether elected or not,
b) any transfer of votes,
c) the total number of votes for each candidate at each stage of the count at which such transfer took place,
d) the order in which the successful candidates were elected, and
e) the number of rejected ballot papers under each of the headings in rule STV44.1,
f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

a) declare the candidate or candidates remaining validly nominated to be elected,
b) give notice of the name of each candidate who he or she has declared elected to the Chair of the corporation, and
c) give public notice of the name of each candidate who he or she has declared elected.

PART 8 – DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

a) the counted ballot papers, internet voting records, telephone voting records and text voting records,
b) the ballot papers and text voting records endorsed with "rejected in part",
c) the rejected ballot papers and text voting records, and
d) the statement of rejected ballot papers and the statement of rejected text voting records,
e) and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

a) the disqualified documents, with the list of disqualified documents inside it,
b) the list of spoilt ballot papers and the list of spoilt text message votes,
c) the list of lost ballot documents, and
d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

a) its contents,
b) the date of the publication of notice of the election,
c) the name of the corporation to which the election relates, and
d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, returning officer is to forward them to the Chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

a) any voting documents are received by the returning officer after the close of the poll, or

b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the Chair of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the Chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

a) the inspection of, or the opening of any sealed packet containing – (i) any rejected ballot papers, including ballot papers rejected in part, (ii) any rejected text voting records, including text voting records rejected in part, (iii) any disqualified documents, or the list of disqualified documents, (iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or (v) the list of eligible voters, or

b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

a) persons,
b) time,
c) place and mode of inspection,
d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

a) in giving its consent, and
b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and
(ii) that Monitor has declared that the vote was invalid.

PART 9 – DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

a) its contents,
b) the date of the publication of notice of the election,
c) the name of the corporation to which the election relates, and
d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the Chair of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

a) publish a notice stating that the candidate has died, and
b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10 – ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

a) personal expenses,
b) travelling expenses, and expenses incurred while living away from home, and
c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

a) compile and distribute such information about the candidates, and
b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

a) objective, balanced and fair,
b) equivalent in size and content for all candidates,
c) compiled and distributed in consultation with all of the candidates standing for election, and
d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be

64.2 The information must consist of:

a) a statement submitted by the candidate of no more than 250 words,

b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

c) a photograph of the candidate. distributed by the returning officer pursuant to rule 24 of these rules.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11 – QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor.

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

a) a person who voted at the election or who claimed to have had the right to vote, or
b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

a) describe the alleged breach of the rules or electoral irregularity, and
b) be in such a form as Monitor may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election.

66.6 If Monitor requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the person or panel of persons nominated in accordance with rule 66.7 shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 Monitor may prescribe rules of procedure for the determination of an application including costs.

PART 12 - MISCELLANEOUS

67. Secrecy

67.1 The following persons:

a) the returning officer,
b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,
(ii) the unique identifier on any ballot paper,
(iii) the voter ID number allocated to any voter,
(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

a) a member of the corporation,
b) an employee of the corporation,
c) a director of the corporation, or
d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

a) the delivery of the documents in rule 24, or
b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 5 - ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

1 TENURE FOR GOVERNORS

Appointed governors

1.1 An appointed governor:

1.1.1 shall hold office for a period of up to three years commencing immediately after the Annual Members Meeting at which his/her appointment is announced save where such term of office commences pursuant to the exercise of paragraph 6.2 of this Annex 5 below on the occasion of a vacancy, in which case the relevant term of office shall commence on the date of such appointment and shall expire on the expiry of the remainder of the term of office of the governor who has vacated the seat;

1.1.2 shall be eligible for re-appointment at the end of his/her term of office;

1.1.3 may not hold office for longer than nine consecutive years.

1.2 For the purposes of these provisions concerning terms of office for appointed governors, "year" means a period commencing on the date the appointed governor took office and ending twelve (12) calendar months later.

1.3 An appointed governor shall cease to hold office if the organisation which appointed him/her terminates his/her employment or contract for services or withdraws its sponsorship of him/her.

Elected Governors

1.4 An elected governor:

1.4.1 shall hold office for a period of up to three years commencing on the date notified to him/her by the trust following the election process save where such term of office commences pursuant to the exercise of paragraph 6.3 of this Annex 5 below on the occasion of a vacancy, in which case the relevant term of office shall commence on the date of such appointment and shall expire on the expiry of the remainder of the term of office of the governor who has vacated the seat;

1.4.2 shall be eligible for re-election at the end of his/her term of office;

1.4.3 may not hold office for longer than nine consecutive years.

1.5 For the purposes of these provisions concerning terms of office for elected governors, "year" means a period commencing on the date the elected governor took office and ending twelve (12) calendar months later.

1.6 An elected governor shall cease to hold office if they cease to be a member of the constituency or class of the constituency by which they were elected.

2 FURTHER PROVISIONS AS TO ELIGIBILITY TO BE A GOVERNOR

2.1 A person may not become a governor of the trust, and if already holding such office will immediately cease to do so, if:

2.1.1 they are a Director of the trust or a director or governor of any other NHS body (unless they are appointed by an appointing organisation which is an NHS body);

2.1.2 they are the spouse, partner, parent or child of a member of the Board of Directors of the trust;

2.1.3 they are a member of a local authority's scrutiny committee covering health matters;

2.1.4 they are a director (or equivalent) of the trust's Local Healthwatch (unless they are appointed by such an organisation);

2.1.5 they have previously been removed as a governor pursuant to paragraph 4 or 5 of this Annex 5;

2.1.6 they are under 16 years of age at the closing date for nominations for their election or appointment;

2.1.7 they refuse to sign a declaration in the form specified by the Trust Secretary confirming that they are not prevented by this constitution from being a member of the Council of Governors;

2.1.8 they fail to sign and deliver to the Trust Secretary a statement in the form required by the Trust Secretary confirming acceptance of the code of conduct for governors;

2.1.9 they have previously been or are currently subject to a sex offender order and/or required to register under the Sexual Offences Act 2003 or have committed a sexual offence prior to the requirement to register under current legislation;

2.1.10 they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with an NHS body;

2.1.11 they are a person whose tenure of office as the chair or as a member or governor or director of an NHS body has been terminated on the grounds that their appointment is not in the interests of the health service, reasons including non-attendance at meetings or for non-disclosure of a pecuniary interest;

2.1.12 on the basis of disclosures obtained through an application to the Disclosure and Barring Service, they are not considered suitable by the trust's director responsible for human resources;

2.1.13 they are a person who has had his/her name removed or been suspended from any list (including any performers list maintained by NHS England) prepared under the 2006 Act or under any related subordinate legislation or who has otherwise been suspended or disqualified from any healthcare profession, and has not subsequently had his/her name included in such a list or had his/her suspension lifted or qualification reinstated;

2.1.14 Monitor has exercised its powers to remove that person as a governor of an NHS foundation trust or has suspended him/her from such office or has disqualified him/her from holding office as a governor for a specified period or Monitor has exercised any of those powers concerned at any time;

2.1.15 he/she lacks capacity within the meaning of the Mental Capacity Act 2005;

2.1.16 they are an unfit person within the meaning of the trust's provider licence, save where Monitor has provided approval in writing to them becoming or continuing as a governor.

2.2 The Trust Secretary shall, at his/her entire discretion, determine whether an individual is eligible to become or continue as a governor under the provisions of paragraph 2.1 above.

3 TERMINATION OF OFFICE AND REMOVAL OF GOVERNORS

3.1 A person holding office as a governor shall immediately cease to do so if:

3.1.1 they resign by notice in writing to the Trust Secretary;

3.1.2 they fail to attend three consecutive meetings of the Council of Governors, unless a majority of the other governors are satisfied that:

3.1.2.1 the absences were due to reasonable causes; and

3.1.2.2 they will be able to start attending meetings of the Council of Governors again within such a period as the other governors consider reasonable;

3.1.3 they have refused without reasonable cause to undertake any training which the Council of Governors requires all governors to undertake;

3.1.4 they have failed to sign and deliver to the Trust Secretary a statement in the form required by the Trust Secretary confirming acceptance of the code of conduct for governors;

3.1.5 they are removed from the Council of Governors under the provisions of paragraphs 4 or 5 of this Annex 5;

3.1.6 they are expelled from membership of the trust or in the case of any elected governor cease to be a member of the trust for any other reason.

Comment [ES22]: May make this more manageable rather than 'fail to attend two consecutive meetings'.

4 TERMINATION OF OFFICE AND REMOVAL OF GOVERNOR – FAILURE TO DISCLOSE A DECLARABLE INTEREST

4.1 Any governor who fails to disclose any interest required to be disclosed under this constitution must permanently vacate their office if required to do so by a majority of the remaining governors.

5 TERMINATION OF OFFICE AND REMOVAL OF GOVERNORS – PROCESS FOR REMOVAL BY THE COUNCIL OF GOVERNORS

5.1 A governor may be removed from the Council of Governors by a resolution approved by not less than three quarters of the remaining governors present and voting at the meeting on grounds including but not limited to that:

5.1.1 they have committed a material breach of any code of conduct for governors; or

5.1.2 they have acted in a manner detrimental to the interests of the trust; or

5.1.3 the Council of Governors considers that it is not in the best interests of the trust for them to continue as a governor;

and there is a recommendation from a working group formed under paragraph 5.2 below for them to be removed from office.

5.2 There shall be a working group of the Council of Governors whose function shall be to receive and consider concerns about the conduct of any governor and to make recommendations to the Council of Governors. The working group shall be made up of two governors from the Public Constituencies, one governor from the Staff Constituency and one Appointed Governor. Each member of the working group shall be appointed by the Council of Governors and shall serve until they are otherwise removed or resign. The quorum of the working group shall be three (3) governors. No governor may consider any concern of which they are the subject.

5.3 If any governor, director or member of the trust has concerns about the conduct of any governor, including but not limited to where such conduct involves:

5.3.1 a breach of any governors' code of conduct;

5.3.2 causing disruption to meetings of the Council of Governors, Board of Directors, members meetings, any working group of the Council of Governors or any committee of the trust;

5.3.3 threatening any individual;

5.3.4 jeopardising the health or welfare of any patient;

5.3.5 causing disruption to the operations of the trust; or

5.3.6 causing damage to the reputation of the trust;

he/she may make a complaint in writing about that governor to the working group of governors established pursuant to paragraph 5.2 above, which shall investigate the complaint and make recommendations to the Council of Governors as to any action the working group considers necessary, which may include a recommendation that a governor is removed from office pursuant to paragraph 5.1 above.

5.4 A governor may resign from office by giving notice in writing to the Trust Secretary, to take effect immediately or following such period of notice as may be specified in the notice. For the avoidance of doubt, any such resignation does not need to be accepted by the Trust Secretary to be effective.

6 VACANCIES AMONGST GOVERNORS

6.1 Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply.

6.2 Where the vacancy arises amongst the appointed governors, the Trust Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office.

6.3 Where the vacancy arises amongst the elected governors, the Trust Secretary shall, having consulted the Chair, either:

6.3.1 call an election within three months to fill the seat for the remainder of that term of office; or

6.3.2 invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat until the next election, at which time the seat will fall vacant and subject to election; or

6.3.3 leave the seat vacant until the next elections are held provided that during such period, the Council of Governors will continue to meet the requirement at paragraph 1 of Annex 3 of this constitution and can continue to meet the quorum requirements at paragraph 3.11 of Annex 7 of this constitution.

7 GOVERNORS' CODE OF CONDUCT

7.1 The trust may from time to time publish a governors' code of conduct and each governor shall be required, on his/her appointment, to provide written confirmation that he/she will abide by any such code of conduct.

7.2 The Trust Secretary, in consultation with the Chair, shall draw up any code of conduct for approval by the Board of Directors. Any amendment to the code of conduct shall be made using the same process.

8 LEAD GOVERNOR

Comment [ES23]: Role suggested by Monitor.

8.1 The Council of Governors shall appoint one of the governors as the Lead Governor. Subject to paragraphs 8.2 and 8.3 below, such governor shall fulfil the role of the Lead Governor for a period of ~~12~~ 24 months.

8.2 The Council of Governors may reappoint a governor to the position of Lead Governor at the end of any ~~12~~ 24 month period, if he/she wishes to be so reappointed for a further 24 month period, subject to a continuing term of office.

8.3 If the Lead Governor notifies the Council of Governors, prior to the end of his/her term in office, that he/she no longer wishes to be the Lead Governor then the Council of Governors shall appoint another governor as the Lead Governor.

8.4 The role and responsibilities of the Lead Governor will be determined by the trust and set out in a written role description. They shall include but not be limited to:

8.4.1 leading the Council of Governors where it would be inappropriate for the Chair or Vice Chair to do so, such circumstances to be determined by the senior independent director;

8.4.2 providing input to the senior independent director, on behalf of the Council of Governors, in respect of the evaluation of the Chair; and

8.4.3 liaising with Monitor where it would be inappropriate for the Chair to do so.

8.5 The Lead Governor will act in accordance with the written role description for the Lead Governor produced by the trust, as may be updated from time to time.

8.6 The Lead Governor shall lead the Council of Governors in the event that:

8.6.1 neither the Chair or Vice Chair is present at a meeting; or

8.6.2 both the Chair and the Vice Chair are disqualified from voting by virtue of a conflict of interest.

9 DEPUTY LEAD GOVERNOR

9.1 The Council of Governors shall appoint one of the governors as the Deputy Lead Governor. Subject to paragraphs 9.2 and 9.3 below, such governor shall fulfil the role of the Deputy Lead Governor for a period of ~~12~~ 24 months.

9.2 The Council of Governors may reappoint a governor to the position of Deputy Lead Governor at the end of any ~~12~~ 24 month period, if he/she wishes to be so reappointed for a further 24 month period, subject to a continuing term of office..

9.3 If the Deputy Lead Governor notifies the Council of Governors, prior to the end of his/her term in office, that he/she no longer wishes to be the Deputy Lead Governor then the Council of Governors shall appoint another governor as the Deputy Lead Governor.

9.4 The role and responsibilities of the Deputy Lead Governor will be determined by the trust and are set out in a written role description for the Lead Governor for whom they will be deputising. They shall include but not be limited to:

9.4.1 in the absence of the Lead Governor, leading the Council of Governors where it would be inappropriate for the Chair or Vice Chair to do so, such circumstances to be determined by the senior independent director;

9.4.2 in the absence of the Lead Governor, providing input to the senior independent director, on behalf of the Council of Governors, in respect of the evaluation of the Chair; and

Comment [DB24]: Changed in response to governor consideration

Comment [DB25]: Changed to 24 months in response to governors subsequently considering this

Comment [DB26]: Period of re-appointment added, 20.11.20.

Comment [DB27]: Changed in response to governor consideration

Comment [DB28]: Changed in response to governor consideration of this

Comment [DB29]: Period of re-appointment added 20.11.20.

9.4.3 in the absence of the Lead Governor, liaising with Monitor where it would be inappropriate for the Chair to do so.

9.5 The Deputy Lead Governor will act in accordance with the written role description for the Lead Governor / Deputy Lead Governor produced by the trust, as may be updated from time to time.

9.6 In the absence of the Lead Governor, the Deputy Lead Governor shall lead the Council of Governors in the event that:

9.6.1 neither the Chair or Vice Chair is present at a meeting; or

9.6.2 both the Chair and the Vice Chair are disqualified from voting by virtue of a conflict of interest,

and

9.6.3 where paragraphs 9.6.1 and 9.6.2 apply and the Lead Governor is in attendance but the Lead Governor themselves are disqualified from voting by virtue of a conflict of interest.

10 COMMUNICATIONS FROM GOVERNORS

10.1 Any communications to the members as a whole from individual governors shall be approved by the Council of Governors or, where such communication is requested between meetings of the Council of Governors, the communication may be approved by the Chair.

10.2 Any communications which are approved in accordance with paragraph 10.1 above, shall be distributed to the members by the trust acting through the Trust Secretary.

10.3 The trust shall facilitate communications between a governor and the members in his constituency on no more than two (2) occasions per annum. Any such communications shall be distributed by the trust acting through the Trust Secretary.

10.4 Any communication produced by a governor for the purposes set out above, must make clear that the views or opinions expressed therein are those of that governor and not necessarily those of the trust. The Trust Secretary shall have the right to insert such a provision in any communication where such a provision is lacking.

10.5 Individual governors may, by making a request to the Chair, request that the trust circulates information to the other governors. Subject to paragraph 10.6 below, the Chair shall circulate the requested information to the governors, via the Trust Secretary, where the Chair considers that the information relates to the business of the Council of Governors.

10.6 The Chair or Trust Secretary may decline to circulate the information requested to be circulated under the provisions of this paragraph 10 for reasons including but not limited to:

10.6.1 the volume of information to be circulated;

10.6.2 the frequency of such requests;

10.6.3 the nature of the information to be circulated; or

10.6.4 the administrative cost to the trust of circulating such information.

10.7 For the avoidance of doubt, the trust shall not provide to any governor the contact details of any member who has requested that his details, as recorded in the register of members, are not available for inspection by the public.

ANNEX 6 - ADDITIONAL PROVISIONS – BOARD OF DIRECTORS

1 APPOINTMENT AND REMOVAL OF CHAIR AND OTHER NON-EXECUTIVE DIRECTORS

1.1 A nominations committee of the Council of Governors with external advice, as appropriate, shall be responsible for the identification and nomination of non-executive directors.

1.2 The Council of Governors will maintain a policy for the composition of the non-executive directors which takes account of the membership strategy, and which they shall review from time to time and not less than every three years.

1.3 The (governor) nominations committee will comprise the Chair of the trust (or, when a chair is being appointed, the Vice Chair *+/- the Senior Independent Director* unless he/she is standing for appointment, in which case another non-executive director), ~~two~~ *four* elected governors *(comprising Lead Governor, Deputy Lead Governor and one staff governor)* and one appointed governor. The chair of another foundation trust may be invited to act as an independent assessor to the nominations committee but shall not be a member of such committee.

1.4 The nominations committee may work with an external organisation recognised as expert at appointments to identify the skills and experience required for non-executive directors.

1.5 The nominations committee shall regularly review the structure, size and composition of the Board of Directors and make recommendations for change in relation to non-executive directors, where appropriate.

1.6 Review and make recommendations to the Council of Governors to ensure that the Trust Chair and Non-Executive Directors are fairly rewarded for their contribution to the organisation, having proper regard to the organisation's circumstances and performance and to the provisions of any appropriate guidance and/or legislation.

1.7 The nominations committee shall prepare a description of the role and capabilities required for any new non-executive director appointment and an assessment of the time commitment required. The nominations committee shall take into account the views of the Board of Directors on the qualifications, skills and experience required for the position.

1.8 Suitable candidates (not more than five for each vacancy) will be identified by the nominations committee through a process of open competition. Once suitable candidates have been identified, the nominations committee shall make recommendations to the Council of Governors.

2 THE REMOVAL OR RESIGNATION OF THE CHAIR AND OTHER NON-EXECUTIVE DIRECTORS

2.1 Any proposal for removal of the Chair or another non-executive director must be proposed by a governor and seconded by not less than ten governors including at least two elected governors and two appointed governors.

2.2 Written reasons for the proposal shall be provided to the non-executive director in question, who shall be given the opportunity to set out his/her position in response.

2.3 In making any decision to remove the Chair or another non-executive director, the Council of Governors shall take into account the most recent annual appraisal carried out in respect of the Chair or other non-executive director.

2.4 Removal of the Chair or any other non-executive director shall require the approval of three-quarters of the members of the Council of Governors. If any proposal to remove a non-executive director is not approved at a meeting of the Council of Governors, no further proposal can be put forward to remove such non-executive director based upon the same reasons within twelve months of the meeting.

Comment [ES30]: Additional provisions suggested.

Comment [DB31]: Updated following governor review: sections in italics added/updated

Comment [DB32]: Added as new paragraph, following governor review. Numbering of previous 1.6 and 1.7 has therefore changed.

2.5 The Chair or any other non-executive director may resign from office by giving notice in writing to the Chief Executive, to take effect immediately or following such period of notice as may be specified. For the avoidance of doubt, any such resignation does not need to be accepted by either the Chief Executive or the Council of Governors to be effective.

3 FURTHER PROVISIONS AS TO ELIGIBILITY TO BE A DIRECTOR

3.1 A person may not become or continue as a director of the trust if:

3.1.1 they are a member of the Council of Governors;

3.1.2 they are a governor of another NHS body;

3.1.3 they are the spouse, partner, parent or child of a member of the Board of Directors of the trust;

3.1.4 they are a member of a local authority's scrutiny committee covering health matters;

3.1.5 they are a person whose tenure of office as a chair or as a member or director of an NHS body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for the non-disclosure of a pecuniary interest;

3.1.6 they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with an NHS body;

3.1.7 they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

3.1.8 in the case of a non-executive director, they are no longer a member of one of the Public Constituencies;

3.1.9 in the case of a non-executive director they have refused without reasonable cause to fulfil any training requirement for members of the Board of Directors;

3.1.10 they have refused to sign and deliver to the Trust Secretary a statement in the form required by the Board of Directors confirming acceptance of any code of conduct for directors;

3.1.11 on the basis of disclosures obtained through an application to the Disclosure and Barring Service, they are not considered suitable by the trust's director responsible for human resources;

3.1.12 they are a person who has had their name removed or been suspended from any list (including any performers list prepared under the 2006 Act or under any related subordinate legislation) or who has otherwise been suspended or disqualified from any healthcare profession, and has not subsequently had their name included in such a list or had their suspension lifted or qualification reinstated;

3.1.13 they are a person who fails to satisfy the fit and proper persons requirements for directors as detailed in Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as may be amended from time to time; or

3.1.14 they have previously been or are currently subject to a sex offender order and/or required to register under the Sexual Offences Act 2003 or have committed a sexual offence prior to the requirement to register under current legislation.

4 REFERENCES TO THE CHAIR

Comment [ES33]: Removed reference to being a director of another NHS body to allow joint appointments (an individual holding a director post at 2 trusts) and to enable the introduction of associate NEDs if the associate NED is already a director of another NHS body.

4.1 Where the Vice Chair or a non-executive director appointed under a paragraph of this constitution to deputise for the Chair, are performing any deputising role then any relevant reference to the Chair in this constitution shall be deemed to include the Vice Chair or the non-executive director so appointed.

4.2 For the avoidance of doubt, the “Chairman” in the 2006 Act and other applicable legislation and guidance is referred to in this constitution and its annexes as the “Chair”.

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

1 INTERPRETATION

1.1 Subject to Standing Order 3.6.2 of this Annex 7, save as permitted by law, the Chair shall be the final authority on the interpretation of these Standing Orders (on which they shall be advised by the Chief Executive and Trust Secretary).

1.2 References to any statute, statutory provision, statutory instrument or guidance in these Standing Orders include reference to that statute, provision, instrument or guidance as replaced, amended, extended, re-enacted or consolidated from time to time.

2 GENERAL INFORMATION

2.1 The purpose of these Standing Orders is to ensure that the highest standards of corporate governance and conduct are applied to all Council of Governors meetings.

2.2 The roles and responsibilities of the Council of Governors which are to be carried out in accordance with this constitution include:

2.2.1 to respond as appropriate when consulted by the Board of Directors in accordance with this constitution;

2.2.2 to undertake such functions as the Board of Directors shall from time to time request;

2.2.3 to prepare and from time to time review the trust's membership strategy and the policy for the composition of the Council of Governors and of the non-executive directors;

2.2.4 when appropriate to make recommendations for the revision of the constitution.

3 MEETINGS OF THE COUNCIL OF GOVERNORS

3.1 **Meetings held in public**

3.1.1 Meetings of the Council of Governors shall be open to the public subject to Standing Order 3.1.2 below.

3.1.2 The Council of Governors may resolve to exclude members of the public from any meeting or part of a meeting on the grounds that:

3.1.2.1 publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or

3.1.2.2 there are special reasons stated in the resolution and arising from the nature of the business of the proceedings.

3.1.3 The Chair may exclude any member of the public from the meeting of the Council of Governors if he/she is interfering with or preventing the proper conduct of the meeting.

3.1.4 Nothing in these Standing Orders shall be construed as permitting the introduction by any person of any recording, transmitting, video or similar apparatus into meetings of the Council of Governors.

3.1.5 Where the public have been excluded from a meeting in accordance with Standing Order 3.1.2 above then the matters dealt with following such exclusion shall be confidential to the governors and directors of the trust. No governor, director, officer or employee of the trust in attendance at such meeting shall reveal or disclose any

information concerning such matters to any other person or disclose the contents of any papers presented to such meeting or minutes taken of such a meeting to any other person.

3.1.6 Meetings of the Council of Governors shall be held regularly and at least four times each financial year.

Comment [ES34]: Code of Governance states typically Council would be expected to meet at least four times a year.

3.1.7 Notwithstanding paragraph 17.3 of the constitution, the Council of Governors may invite the Chief Executive, or any other director, or a representative of the auditor to attend any meeting of the Council of Governors to enable governors to raise questions about the trust's affairs. For the avoidance of doubt, any such attendee shall not have the right to vote at such a meeting.

3.1.8 The Chief Executive and/or any other member of the Board of Directors may attend and address any meeting of the Council of Governors but shall not have the right to vote at such meetings.

3.2 **Calling meetings**

3.2.1 Without prejudice to Standing Order 3.2.3 below, meetings of the Council of Governors shall be called by the Trust Secretary, or in the Trust Secretary's absence, by the Chair and shall be held on such dates and at such times and such places as he/she shall determine.

3.2.2 The Council of Governors may agree that its members can participate in its meetings via electronic means (video, telephone or computer link). Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

Comment [DB35]: Added as new paragraph, following governor review. Previous reference to 3.2.2 and 3.2.3 has therefore changed, as numbering updated

3.2.3 Save in the case of emergencies or the need to conduct urgent business, the Trust Secretary shall give to all governors at least 14 days written notice of the date and place of every meeting of the Council of Governors. In the event of an emergency or the need to conduct urgent business the Trust Secretary may reduce the period of notice given to such period as he/she, having consulted where possible with the Chair, deems reasonable in the circumstances. Notice will be published on the trust's website.

3.2.4 Additional meetings of the Council of Governors shall be called by the Trust Secretary on the written request of at least 10 governors (including at least 2 elected governors and 2 appointed governors) who shall specify the business to be carried out. The Trust Secretary shall call a meeting of the Council of Governors on at least fourteen but not more than twenty-eight days written notice to discuss the specified business. If the Trust Secretary fails to call such a meeting within fourteen days of receipt of the written notice then the relevant governors may call such a meeting on not less than fourteen days written notice to all governors.

Comment [DB36]: Added following governor review

3.3 **Notice of meetings**

3.3.1 The notice for each meeting of the Council of Governors shall:

3.3.1.1 specify the business proposed to be transacted at the meeting;

3.3.1.2 be signed by the Chair, or by an officer of the trust authorised by the Chair to sign on his behalf; and

3.3.1.3 be delivered in person to each governor, sent by post to the usual place of residence of each such governor or sent by electronic mail to the address provided by any governor for such purposes.

3.3.2 The lack of service of notice on any governor shall not affect the validity of a meeting subject to Standing Order 3.3.3.

3.3.3 In the case of a meeting called by governors in default of the Trust Secretary pursuant to Standing Order 3.2.3 above, the notice shall be signed by those governors calling the meeting and no business shall be transacted at the meeting other than that specified in the notice. Failure to serve such a notice on more than three quarters of governors will invalidate the meeting.

3.4 **Setting the agenda**

3.4.1 The Council of Governors may determine that certain matters shall appear on every agenda for meetings of the Council of Governors and shall be addressed prior to any other business being conducted.

3.4.2 Subject to Standing Order 3.4.1 of this Annex 7, the Trust Secretary shall be responsible for producing the agenda for meetings in conjunction with the Chair. The Chair shall determine the order of items on the agenda and the expression of such items, including any agenda items requested pursuant to Standing Order 3.4.4 below.

3.4.3 Save in the case of an emergency or the need to conduct urgent business, the agenda for each meeting of the Council of Governors shall be sent to all governors no later than 7 days before the meeting. Supporting papers shall accompany the agenda.

3.4.4 A governor desiring a matter to be included on an agenda shall make his request in writing to the Chair at least 10 days before the meeting. The governor should indicate whether the item of business is to be transacted in the presence of the public and should provide the appropriate paper, document or supporting information. Where a request for an item of business to be included on an agenda is made less than 10 days but more than 5 days before a meeting such item of business may, at the discretion of the Chair, be included on the agenda and shall be tabled as an agenda item at the commencement of the relevant meeting.

3.5 **Notices of motions**

3.5.1 A governor desiring to move or amend a motion shall send a written notice thereof at least 10 days before the meeting to the Chair, who shall insert it into the agenda for the meeting. This Standing Order 3.5.1 shall not prevent any motion or amendment being moved during the meeting, without notice, on any business mentioned on the agenda for that meeting.

3.5.2 A motion or amendment, once moved at a meeting of the Council of Governors, may be withdrawn by the proposer with the consent of the Chair.

3.5.3 Only the Chair may propose a motion to amend or rescind any resolution or the general substance of any resolution, which has been passed within the preceding 6 calendar months by the Council of Governors.

3.5.4 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

3.5.5 When a motion is under discussion or immediately prior to discussion it shall be open to a governor to move:

3.5.5.1 an amendment to the motion;

3.5.5.2 the adjournment of the discussion or the meeting;

3.5.5.3 the appointment of an ad hoc committee to deal with a specific item of business;

3.5.5.4 that the meeting proceed to the next business;

3.5.5.5 that the motion be now put; or

3.5.5.6 a motion resolving to exclude the public, including the press.

Such a motion shall be disposed of before the motion which was originally under discussion or about to be discussed. No amendment to the original motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the original motion. In the case of motions under 3.5.5.4 and 3.5.5.5, to ensure objectivity, motions may only be put by a governor who has not previously taken part in the debate on the original motion.

3.6 **Chair's ruling**

3.6.1 Statements of governors made at meetings of the Council of Governors must be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevance, regularity and any other matters shall be final and observed at the meeting.

3.6.2 Without prejudice to Standing Order 1.1, save as permitted by law, at any meeting the person presiding shall be the final authority on the interpretation of these Standing Orders in relation to that meeting.

3.7 **Voting**

3.7.1 No governor may vote at a meeting of the Council of Governors unless, prior to attending the meeting, they have made a declaration in the form specified by the Trust Secretary confirming that they are not prevented by this constitution from being a member of the Council of Governors. Each governor shall be deemed to have confirmed this declaration upon attending any subsequent meeting of the Council of Governors, and every agenda for meetings of the Council of Governors will draw this to the attention of the governors.

3.7.2 Decisions at meetings shall be determined by a majority of the votes of the governors present and voting. In the case of any equality of votes, the person presiding as Chair shall have a second or casting vote.

3.7.3 No resolution of the Council of Governors shall be passed if it is opposed by all of the Public Governors present.

3.7.4 All decisions put to the vote shall, at the discretion of the person presiding as Chair, be determined by oral expression or by a show of hands. A paper ballot may be used if a majority of the governors present so request.

3.7.5 If at least one-third of the governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each governor present voted or abstained.

3.7.6 If a governor so requests, his/her vote (other than by paper ballot) on any question shall be recorded by name.

3.7.7 In no circumstances may an absent governor vote by proxy. Absence is defined as being absent at the time of the vote.

3.8 **Suspension and Variation of Standing Orders**

3.8.1 Except where this would contravene any statutory provision, any direction made by Monitor or any term of this constitution any one or more of these Standing Orders may be suspended at any meeting, provided that at least two-thirds of the members of the Council of Governors are present and that a majority of those present vote in favour of suspension.

3.8.2 A decision to suspend any Standing Order shall be recorded in the minutes of the meeting.

3.8.3 A separate record of matters discussed during the suspension of any Standing Order shall be made and shall be available to the directors and governors.

3.8.4 No formal business may be transacted while any Standing Orders are suspended.

3.8.5 The trust's audit committee shall review every decision to suspend any Standing Order.

3.8.6 Except where this would contravene any statutory provision, any direction made by Monitor, or any provision of this constitution, any one or more of these Standing Orders may be varied, provided that more than half of the members of the Council of Governors of the trust who are present at the meeting at which the variation is being discussed vote in favour of the variation. A variation of any Standing Order in accordance with this paragraph shall not constitute an amendment to the constitution for the purposes of paragraph 46, save for the procedure set out in paragraphs 46.3 and 46.4 shall apply where the variation is in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the trust).

Comment [ES37]: Added to reflect current provisions of constitution which allow governors to amend standing orders without approval from the Board. Whilst this provision makes clear that any such variation shall not constitute an amendment to the constitution for the purposes of paragraph 46, it is suggested that the number of governors required to approve such a variation is the same as the number required to approve an amendment to the constitution, for consistency.

This wording reflects the same provisions in respect of amendments to the Board's standing orders (Annex 8 paragraph 4.13.6).

3.9 **Record of attendance**

3.9.1 The names of the governors present at each meeting shall be recorded in the minutes.

3.10 **Minutes**

3.10.1 The minutes of the proceedings of each meeting of the Council of Governors shall be drawn up and presented for agreement at the next meeting of the Council of Governors. The approved minutes will be conclusive evidence of the events of that meeting. Subject to Standing Order 3.10.4, the minutes shall be maintained as a public record once agreed.

3.10.2 No discussion shall take place at a Council of Governors meeting regarding the minutes except upon their accuracy or where the Chair considers discussion appropriate, at his/her sole discretion. Any agreed amendment to the minutes of a preceding meeting shall be recorded in writing.

3.10.3 Minutes shall be circulated to the governors in draft form within two weeks of the date of the meeting.

3.10.4 The minutes of meetings of the Council of Governors shall be made available to the public except for minutes relating to the business conducted when members of the public have been excluded from the meeting pursuant to Standing Order 3.1.2 of these Standing Orders.

Comment [ES38]: Removed reference to the minutes being signed by the Chair. However, there must still be some way of the Trust confirming that the minutes are agreed/approved. Probably the easiest way of doing this is to note the approval in the minutes of the meeting at which they are approved.

3.11 **Quorum**

3.11.1 ~~No business shall be transacted at a meeting of the Council of Governors unless at least twelve governors are present (including not less than four Public Governors, not less than one Staff Governor, and not less than two Appointed Governors).~~ [No business shall be transacted at a meeting of the Council of Governors unless at least half of the Governors in post on the date of the meeting (as determined by the Trust Secretary) are present].

Comment [DB39]: Alternative wording accepted by governors.

Comment [ES40]: Possible alternative wording if quorum is based on percentage of governors.

3.11.2 If a governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest he/she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that

matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.11.3 Subject to Standing Order 3.11.2 above, if the Council of Governors is quorate at the start of a meeting in accordance with Standing Order 3.11.1 above, the Council of Governors shall be regarded as quorate for the duration of the meeting and shall be able to transact business accordingly, even if governors subsequently leave the meeting.

3.11.4 The Council of Governors may agree that governors can participate in its meeting by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

3.11.5 For the avoidance of any doubt, the Chair of the Trust (who usually presides at a meeting of the Council of Governors) shall not count towards the quorum for the meeting.

4 ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 The Council of Governors may not delegate any of its powers to a committee or sub-committee, but it may appoint committees, working groups and/or sub-groups consisting of members of the Council of Governors, directors, and/or other persons to assist it in carrying out its functions. The Council of Governors may, through the Trust Secretary, request that advisers assist it or any committee, working group or sub-group it appoints in carrying out its duties.

5 COMMITTEES AND WORKING GROUPS

5.1 These Standing Orders, as far as they are applicable, shall as appropriate apply to meetings of any committees or working groups established by the Council of Governors.

5.2 Each such committee, working group or sub-group shall have such terms of reference and remit and be subject to such conditions (as to reporting back to the Council of Governors) as the Council of Governors shall decide. Such terms of reference shall have effect as if incorporated into these Standing Orders.

5.3 The Council of Governors shall approve the membership of all committees, working groups and sub-groups that it has formally constituted and shall appoint the chair of each such committee, working group or sub-group.

6 CONFIDENTIALITY

6.1 Subject to Standing Order 6.3 below no governor or member of any committee or working group of the Council of Governors or attendee at a meeting of the Council of Governors or any committee or working group shall disclose details of any matter dealt with by, or brought before, the Council of Governors or a committee or working group of the Council of Governors without the permission of the Council of Governors or the relevant committee or working group (as applicable) until such matter has been concluded or until the committee or working group has reported to the Council of Governors.

6.2 The Council of Governors and any committee or working group of the Council of Governors shall make governors, the members of any committee or working group and any other attendees at meetings of the Council of Governors and/or its committees or working groups aware of the confidential nature of the business being transacted and their duty of confidentiality as set out at Standing Order 6.1.

6.3 No governor or attendee at any meeting of the Council of Governors or any committee or working group of the Council of Governors shall disclose any matter dealt with by the Council of Governors or the committee or working group (as applicable), notwithstanding that the matter has been

reported or action has been concluded, if the Council of Governors or committee or working group resolves that it is confidential.

7 DECLARATION OF INTERESTS AND REGISTER OF INTERESTS

7.1 Without prejudice to the generality of paragraph 20.1 of this constitution, each governor shall disclose to the Council of Governors any relevant and material interests (as defined below) held by them, their spouse or partner. Any interest that is disclosed by a governor pursuant to this constitution shall be recorded in a register of interests of governors maintained by the Trust Secretary.

7.2 The responsibility for declaring an interest is solely that of the governor concerned and shall be declared to the Trust Secretary:

7.2.1 within 14 days of election or appointment; or

7.2.2 if arising later, as soon as the governor becomes aware of the interest.

7.3 Subject to the exceptions in Standing Order 7.4 below, a relevant and material interest is:

7.3.1 any directorship of a company;

7.3.2 any interest or position in any organisation (including any charitable or voluntary organisation) which has, is likely to have or which is proposing to enter into a trading or commercial relationship with the trust;

7.3.3 any interest in an organisation providing (or seeking to provide) health and social care services to the National Health Service;

7.3.4 any position of authority in any organisation (including a charity or voluntary organisation) in the field of health and social care; or

7.3.5 any connection with any organisation considering entering into a financial arrangement with the trust including but not limited to lenders or banks.

7.4 The exceptions which shall not be treated as relevant and material interests for the purposes of these provisions are as follows:

7.4.1 shares held in any company whose shares are listed on any public exchange not exceeding 2% of the total number of shares issued;

7.4.2 an employment contract with the trust held by a Staff Governor;

7.4.3 an employment contract with or other position of authority within a partnership organisation held by an Appointed Governor.

7.5 Any governor who has an interest in a matter to be considered by the Council of Governors and who is present at a meeting at which that matter is to be the subject of consideration shall declare such interest to the Council of Governors at that meeting and as soon as practicable after its commencement and;

7.5.1 shall withdraw from the meeting and play no part in the relevant discussion or decision; and

7.5.2 shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted); and

7.5.3 details of the interest shall be recorded in the minutes of the meeting.

7.6 Any governor who fails to disclose any interest required to be disclosed under this constitution must permanently vacate their office if required to do so by a majority of the remaining governors.

7.7 If a governor has any doubt about the relevance of an interest, he/she should discuss it with the Chair who shall advise him/her whether or not to disclose the interest.

7.8 A governor shall comply with any Conflicts of Interest policy that the trust may have in place from time to time.

8 COMPLIANCE – OTHER MATTERS

8.1 All decisions taken in good faith at a meeting of the Council of Governors or of any committee or working group shall be valid even if there is any vacancy in its membership or it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the governors attending the meeting.

8.2 Governors shall comply with standing financial instructions prepared by the Director of Finance and approved by the Board of Directors for the guidance of all staff employed by the trust.

8.3 Governors shall act at all times in accordance with the trust's schedule of reservation and delegation of powers.

8.4 Governors must conduct themselves at all times in accordance with the NHS Foundation Trust Code of Governance and any other guidance issued by Monitor in relation to the role and functions of the governors of a foundation trust, as may be in force from time to time. Governors must:

8.4.1 actively support the vision and aims of the trust in developing as a successful NHS Foundation Trust;

8.4.2 contribute to the work of the Council of Governors in order for it to fulfil its role as defined in the trust's constitution, including as set out in these Standing Orders;

8.4.3 recognise that the Council of Governors has no managerial role within the trust;

8.4.4 value and respect governor colleagues, and all members of staff of the trust they come into contact with;

8.4.5 respect the confidentiality of information they receive in their role as a governor;

8.4.6 act in the best interests of the trust, at all times without any expectation of personal benefit;

8.4.7 attend meetings of the Council of Governors and all training events for governors, on a regular basis;

8.4.8 conduct themselves in a manner that reflects positively on the trust, acting as an ambassador for the trust;

8.4.9 abide by the trust's policies and procedures;

8.4.10 recognise that the trust is an apolitical organisation and act in an apolitical way in their role as governor;

8.4.11 if they are a member of any trade union, political party or other organisation, recognise that they do not, in their role as governor, represent those organisations (or the views of those organisations) but represent the interests of the constituency that elected them;

8.4.12 be honest and act with integrity and probity at all times;

8.4.13 respect and treat with dignity and fairness, members of the public, patients, relatives, carers, NHS staff and partners in other agencies;

8.4.14 accept responsibility for their own actions;

8.4.15 show their commitment to working as a team member by working with all their colleagues in the NHS and the wider community;

8.4.16 ensure that the trust's membership and its partner organisations receive appropriate information about the work of the Council of Governors and that their views are fed back to the Council of Governors;

8.4.17 ensure that no one is discriminated against because of their religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social and economic status or national origin;

8.4.18 respect the confidentiality of individual patients;

8.4.19 not make, permit or knowingly allow to be made, any untrue or misleading statement relating to their own duties or the functions of the trust;

8.4.20 ensure that the best interests of the public and patients/clients are upheld in decision making and that decisions are not improperly influenced by gifts or inducements; and

8.4.21 support and assist the Chief Executive of the trust in his/her responsibility to answer to NHS Improvement, commissioners and the public in terms of declaring and explaining the use of resources and the performance of the trust.

8.5 Each governor must uphold the seven principles of public life as detailed by the Nolan Committee:

8.5.1 Selflessness

Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

8.5.2 Integrity

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

8.5.3 Objectivity

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

8.5.4 Accountability

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

8.5.5 Openness

Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

8.5.6 Honesty

Holders of public office have a duty to declare any private interest relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

8.5.7 Leadership

Holders of public office should promote and support these principles by leadership and example.

9 RESOLUTION OF DISPUTES WITH THE BOARD OF DIRECTORS

9.1 Should a dispute arise between the Council of Governors and the Board of Directors then the disputes resolution procedure set out below shall be utilised.

9.1.1 The Chair, or Vice Chair (if the dispute involves the Chair) shall first endeavour through discussion with appropriate representatives of the governors and the directors to achieve the earliest possible resolution of the matter in dispute to the reasonable satisfaction of both parties.

9.1.2 Failing resolution under Standing Order 9.1.1 above then the Board of Directors or the Council of Governors, as appropriate, shall at its next formal meeting approve the precise wording of a disputes statement setting out clearly and concisely the issue or issues giving rise to the dispute.

9.1.3 The Chair or Vice Chair (if the dispute involves the Chair) shall ensure that the disputes statement produced in accordance with Standing Order 9.1.2 above, without amendment or abbreviation in any way, shall be an agenda item and agenda paper at the next formal meeting of the Board of Directors or Council of Governors as appropriate (i.e. the body that does not issue the disputes statement). That meeting shall agree the precise wording of a response to the disputes statement.

9.1.4 The Chair or Vice Chair (if the dispute involves the Chair) shall immediately or as soon as is practical, communicate the outcome to the other party and deliver the written response to the disputes statement. If the matter remains unresolved or only partially resolved then the procedure outlined in Standing Order 9.1.1 above shall be repeated.

9.1.5 If, in the opinion of the Chair or Vice Chair (if the dispute involves the Chair), and following the further discussions prescribed in Standing Order 9.1.1, there is no further prospect of a full resolution or, if at any stage in the whole process, in the opinion of the Chair or Vice Chair (as the case may be), there is no prospect of a resolution (partial or otherwise) then he/she shall appoint a special committee comprising equal numbers of directors and governors to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute.

9.1.6 On the satisfactory completion of this disputes process the Board of Directors shall implement any agreed changes.

9.1.7 If the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Chair may refer the dispute to an external mediator as he/she considers appropriate.

9.2 Nothing in this procedure shall prevent the Council of Governors, if it so desires, from informing Monitor that, in the Council of Governors' opinion, the Board of Directors has not responded

constructively to concerns of the Council of Governors that the trust is not meeting the terms of its licence.

10 COUNCIL OF GOVERNORS PERFORMANCE

10.1 The Chair shall, at least annually, lead a performance assessment process for the Council of Governors to enable the Council of Governors to review its roles, structure, composition and procedures taking into account emerging best practice.

11 AVAILABILITY OF STANDING ORDERS

11.1 The Trust Secretary shall ensure that on appointment all governors are notified of their responsibilities as set out in these Standing Orders.

ANNEX 8 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

FOREWORD

These Standing Orders together with the trust's Standing Financial Instructions and Scheme of Delegation and Reservation of Powers (that provide respectively further detail of administrative practice and procedure, and record delegations and reservations of powers and functions, but do not form part of this constitution), provide a governance framework for the conduct of business by the trust. All directors and all staff should be aware of the existence of these documents and, where necessary, be familiar with their detailed provisions to the extent required for the proper conduct of their duties.

1 INTERPRETATION AND DEFINITIONS

1.1 Save as otherwise permitted by law, at any meeting the Chair of the trust shall be the final authority on the interpretation of these Standing Orders (on which he/she shall be advised by the Chief Executive and Trust Secretary).

2 STATUTORY FRAMEWORK

2.1 The principal place of business of the trust is the Countess of Chester Health Park, Liverpool Road, Chester, Cheshire, CH2 1UL.

2.2 An NHS Foundation Trust is governed by a regulatory framework that confers the functions and powers of the Trust and comprises: Acts of Parliament and in particular the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), its authorisation, constitution and its licence as granted by Monitor.

2.3 The Board of Directors is responsible for ensuring compliance by the trust with its authorisation, its licence, this constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations.

2.4 As a statutory body the trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role the trust is accountable to the Charity Commission for those funds deemed to be charitable.

3 THE BOARD

3.1 **Terms of office**

Comment [ES41]: To reflect Monitor's Code of Governance.

3.1.1 The Chair and the non-executive directors will:

3.1.1.1 serve terms of office of no longer than three (3) years;

3.1.1.2 be eligible for re-appointment at the end of a term of office provided that service of a further term is consistent with Standing Order 3.1.3 below; but

3.1.1.3 shall not hold office for longer than nine consecutive years.

Comment [ES42]: To confirm maximum of nine years for a NED to be in post.

3.1.2 For the avoidance of doubt the number of years service as a non-executive director of the applicant trust will not count towards the total number of years of service as a non-executive director of the trust.

3.1.3 Where the Council of Governors wishes to re-appoint the Chair or a non-executive director for a term of office that would mean that such individual's total years of office will exceed six (6) years or where such individual's total years of office already exceeds six (6) years at the time of such re-appointment, then the Council of Governors may do so where in reaching such a decision they:

3.1.3.1 take into account the current skill set requirements of the Board of Directors;

3.1.3.2 take into account the annual performance of the applicant non-executive director;

3.1.3.3 take into account the need for the progressive refreshing of the Board of Directors;

3.1.3.4 take into account the need to maintain at least half of the Board of Directors (excluding the Chair) as independent non-executive directors; and

3.1.3.5 consider that there are exceptional circumstances justifying such a term of office;

provided that any such term of office must be subject to annual re-appointment by the Council of Governors in accordance with this Standing Order 3.1 at the end of each year of an individual's term of office where such individual's total years in office exceeds six (6) years or will exceed six (6) years during the next year of that individual's term of office, and must be subject to paragraph 3.1.1.3 above.

3.1.4 The Chief Executive and the other executive directors will normally hold non time limited contracts of employment.

3.2 **Vice Chair**

3.2.1 If the Chair is unable to discharge his office as Chair of the trust, the Vice Chair shall be acting Chair of the trust.

3.2.2 Any member of the Board of Directors (the "Board") so appointed may at any time resign from the office of Vice Chair by giving notice in writing to the Chair. The Council of Governors shall thereupon appoint another non-executive director as Vice Chair in accordance with this constitution.

3.3 **Joint Board Members**

3.3.1 Where more than one person is appointed jointly as a member of the Board, those persons shall count for the purpose of Standing Order 4.11 (voting) as one person.

3.3.2 Where the office of a member of the Board is shared jointly by more than one person:

3.3.2.1 Either or both those persons may attend or take part in meetings of the Board;

3.3.2.2 If both are present at a meeting they should cast one vote if they agree;

3.3.2.3 In the case of disagreements no vote should be cast;

3.3.2.4 The presence of either or both those persons should count as the presence of one person for the purpose of Standing Order 4.15 (quorum).

3.4 **Role of Board Members**

3.4.1 The Board will function as a corporate decision-making body. Executive and non-executive directors will be full and equal members. Their role as director will be to consider the key strategic and managerial issues facing the trust in carrying out its statutory and other functions.

3.4.1.1 Executive Directors - executive directors shall exercise their authority within the terms of these Standing Orders, the trust's Standing Financial Instructions and Scheme of Delegation and Reservation of Powers.

3.4.1.2 Chief Executive - the Chief Executive shall be responsible for the overall performance of the executive functions of the trust. He/she is the accounting officer for the trust and shall be responsible for ensuring the discharge of obligations under any relevant guidance from Monitor.

3.4.1.3 Director of Finance - the Director of Finance shall be responsible for the provision of financial advice to the trust and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under any relevant guidance from Monitor.

3.4.1.4 Non-Executive Directors - the non-executive directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the trust which has delegated powers.

3.4.1.5 Chair - the Chair shall be responsible for the operation of the Board and chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of his/her appointment and with these Standing Orders. The Chair shall liaise with the Council of Governors over the appointment of non-executive directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance. The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

3.4.1.6 Senior Independent Director - the Chair shall, following consultation with the Council of Governors, appoint one of the non-executive directors to be the senior independent director. The senior independent director shall make himself available to directors and governors who have concerns that they do not feel they can raise with the Chair or any executive director of the trust. Recourse to the senior independent director shall not replace the right to instigate the dispute resolution procedures at Annex 7 and 10 of this constitution. The senior independent director shall, at least annually, lead a process to evaluate the performance of the Chair.

3.5 **Corporate role of the Board**

3.5.1 All business shall be conducted in the name of the trust.

3.6 **Charitable Funds**

3.6.1 All charitable funds shall be held in the name of the trust as corporate trustee. In relation to funds held on trust, powers exercised by the Board in discharge of the trust's responsibilities as corporate trustee shall be exercised separately and distinctly from those powers exercised as the Board of the trust.

3.6.2 The Board shall discharge the trust's responsibility to act as corporate trustee to administer charitable funds received by the trust and for which the trust is accountable to the Charity Commission.

4 MEETINGS OF THE BOARD

4.1 **Calling a meeting**

4.1.1 The Board of Directors shall meet sufficiently regularly to discharge its duties effectively and shall meet at least six (6) times in public in each financial year. Ordinary meetings of the Board shall be held at such times and places as the Board may determine.

4.1.2 Meetings of the Board of Directors shall be called by the Trust Secretary, or in the Trust Secretary's absence, by the Chair.

4.1.3 Save in the case of emergencies or the need to conduct urgent business, the Trust Secretary shall give to all directors at least fourteen days written notice of the date and place of every meeting of the Board of Directors. In the event of an emergency or the need to conduct urgent business, the Trust Secretary may reduce the period of notice given to such period as he/she, having consulted where possible with the Chair, deems reasonable in the circumstances.

4.1.4 Additional meetings of the Board of Directors shall be called by the Trust Secretary on the written request of at least four directors who shall specify the business to be carried out. The Trust Secretary shall call a meeting of the Board of Directors on at least fourteen but not more than twenty-eight days' notice to discuss the specified business. If the Trust Secretary fails to call such a meeting within fourteen days of receipt of the written notice then the relevant directors may call such a meeting on not less than fourteen days written notice to all directors.

Comment [DB43]: Added following governor review

4.1.5 Meetings of the Board shall be open to members of the public unless the Board decides otherwise in accordance with Standing Order 4.16.

4.1.6 Nothing in these Standing Orders shall require the Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than in writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Board.

4.1.7 The Board may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

4.1.8 Meetings of the Board shall be open to those employed or engaged by the trust, who are not members of the Board of Directors, and any other individuals whose presence at a meeting is deemed by the Board or by the Trust Secretary to be necessary or desirable in view of the matters to be discussed at the meeting. Individuals attending meetings in this capacity may be given access to meeting papers, and shall be permitted to participate in discussions, but, for the avoidance of doubt, shall not be deemed to be members of the Board of Directors and shall not have any right to vote.

Comment [ES44]: Added to allow others to participate in Board meetings including interim directors, senior management and any other individuals at the discretion of the Board. The position re: Associate NEDs is already covered in paragraph 23.10 of the constitution.

4.2 **Notice of meetings**

4.2.1 The notice for each meeting of the Board shall:

4.2.1.1 specify the business to be transacted at the meeting;

4.2.1.2 be signed by the Chair or by an officer authorised by the Chair to sign on his behalf; and

4.2.1.3 shall be delivered to each Board member to the usual place of residence of such Board member, or sent by electronic mail to any address provided by such member for such purposes.

4.2.2 In the case of a meeting called by Board members in default of the Trust Secretary, the notice shall be signed by those Board members calling the meeting pursuant to

Standing Order 4.1.4 above, and no business shall be transacted at the meeting other than that specified in the relevant notice.

4.3 **Agenda**

4.3.1 Agendas will be sent to members at least five clear days before the meeting. Supporting papers shall accompany the agenda, save in an emergency.

4.3.2 The Board shall use its annual reporting cycle, annual business cycle and actions arising from previous Board meetings to determine the main content of the agenda.

4.3.3 Subject to Standing Order 4.3.2 above, the Trust Secretary shall be responsible for producing the agenda for board meetings in conjunction with the Chair. The Chair shall determine the order of items on the agenda and the expression of such items, including any agenda items requested under Standing Order 4.3.4 below.

4.3.4 A Board member desiring other matters to be included on an agenda shall make his request known to the Chair in writing at least fourteen days before the meeting. The Board member should indicate whether the item of business is to be transacted in the presence of the public and should provide the appropriate paper, document or supporting information. Where a request for an item of business to be included on an agenda is made less than fourteen days but more than five days before a meeting such item of business may, at the discretion of the Chair, be included and shall be tabled as an agenda item at the commencement of the relevant meeting.

4.4 **Petitions**

4.4.1 Where a petition has been received by the trust the Chair shall include it as an item for the agenda of the next Board meeting.

4.5 **Chairing of meetings**

4.5.1 The Chair of the trust or, in his absence, the Vice Chair is to chair meetings of the Board. If both the Chair and the Vice Chair are absent, the Board members present shall choose a non-executive director who is present to chair the meeting.

4.5.2 If the Chair stands down temporarily, on the grounds of a declared conflict of interest, the Vice Chair, if present, shall chair that part of the meeting. If the Chair and Vice Chair are both absent, or disqualified from participating on the grounds of a declared conflict of interest, the Board members present shall choose a non-executive director who is present to chair the meeting.

4.6 **Notices of motion**

4.6.1 A member of the Board desiring to move or amend a motion shall send a written notice thereof at least ten days before the meeting to the Chair. The Chair shall insert in the agenda for the meeting all notices so received. This Standing Order 4.6 shall not prevent any motion or amendment being moved during the meeting, without notice, on any business mentioned on the agenda.

4.7 **Withdrawal of motion or amendments**

4.7.1 A motion or amendment once moved may be withdrawn by the proposer with the consent of the Chair.

4.8 **Motion to rescind a resolution**

4.8.1 Only the Chair may propose a motion to amend or rescind any resolution or the general substance of any resolution, which has been passed within the preceding six calendar months by the Board.

4.9 **Motions**

4.9.1 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.9.2 When a motion is under discussion, or immediately prior to discussion, it shall be open to a Board member to move:

4.9.2.1 an amendment to the motion;

4.9.2.2 the adjournment of the discussion or the meeting;

4.9.2.3 the appointment of an ad hoc committee to deal with a specific item of business;

4.9.2.4 that the meeting proceed to the next business;

4.9.2.5 that the motion be now put; or

4.9.2.6 a motion resolving to exclude the public, including the press.

Such a motion shall be disposed of before the motion which was originally under discussion or about to be discussed. No amendment to the original motion shall be admitted if, in the opinion of the chair of the meeting, the amendment negates the substance of the original motion. In the case of motions under Standing Order 4.9.2.4 and Standing Order 4.9.2.5, to ensure objectivity motions may only be put by a Board member who has not previously taken part in the debate on the original motion.

4.10 **Chair's ruling**

4.10.1 Statements of directors made at meetings of the Board must be relevant to the matter under discussion at the material time and the decision of the chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final and observed at the meeting.

4.11 **Voting**

4.11.1 Subject to the following provisions of this Standing Order 4.11, questions arising at a meeting of the Board shall be decided by a majority of votes.

4.11.2 In case of an equality of votes, the person presiding as chair shall have a second and casting vote.

4.11.3 No resolution of the Board shall be passed if it is opposed by all of the non-executive directors present or by all of the executive directors present.

4.11.4 All questions put to the vote shall, at the discretion of the chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may be used if a majority of the Board members present so request.

4.11.5 If at least one-third of the Board members present so request, the voting (other than by paper ballot), on any question may be recorded to show how each member present voted or abstained.

4.11.6 If a Board member so requests, his vote (other than by paper ballot) on any question shall be recorded by name.

4.11.7 In no circumstances may an absent Board member vote by proxy. Absence is defined as being absent at the time of the vote.

4.11.8 An officer who has been appointed formally by the Board to act up for an executive director of the Board during his absence, or to cover a vacant executive director post, shall be entitled to exercise the voting rights of the executive director. An officer attending the Board to represent an executive director without formal acting up status may not exercise the voting rights of the executive director. An officer's status when attending a meeting shall be recorded in the minutes.

4.12 **Minutes**

4.12.1 Minutes of every meeting of the Board must be kept by the Trust Secretary. Minutes of meetings will be presented at the next meeting for approval. The approved minutes will be conclusive evidence of the events of that meeting.

4.12.2 No discussion shall take place regarding the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes of a preceding meeting shall be recorded in writing.

4.12.3 Minutes shall be circulated to Board members in draft form within two weeks of the date of the meeting. The minutes of the meeting shall be made available to the public except for minutes relating to business conducted when members of the public are excluded under the terms of Standing Order 4.16.

4.13 **Suspension and Variation of Standing Orders by the Board**

4.13.1 Except where this would contravene any statutory provision, any direction made by Monitor, or any provision of this constitution, any one or more of these Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board are present, including at least two executive directors and two non-executive directors, and that a majority of those present vote in favour of suspension.

4.13.2 A decision to suspend any Standing Order shall be recorded in the minutes of the meeting.

4.13.3 A separate record of matters discussed during the suspension of any Standing Orders shall be made and shall be available to the Chair and members of the Board.

4.13.4 No formal business may be transacted while Standing Orders are suspended.

4.13.5 The audit committee shall review every decision to suspend any Standing Orders.

4.13.6 Except where this would contravene any statutory provision, any direction made by Monitor, or any provision of this constitution, any one or more of these Standing Orders may be varied, provided that more than half of the members of the Board of Directors who are present at the meeting at which the variation is being discussed vote in favour of the variation. A variation of any Standing Order in accordance with this paragraph shall not constitute an amendment to the constitution for the purposes of paragraph 46.

4.13.7 Should the emergency powers in paragraph 5.2.1 of these Standing Orders be exercised to vary any one or more of these Standing Orders, the variation must be subsequently approved in accordance with paragraph 4.13.6 above. If the variation is not so approved, the variation shall cease to have effect.

4.14 **Record of Attendance at Board Meetings**

Comment [ES45]: As with minutes of the Council of Governors meetings, removed reference to the minutes being signed by the Chair. However, there must still be some way of the Trust confirming that the minutes are agreed/approved. Probably the easiest way of doing this is to note the approval in the minutes of the meeting at which they are approved.

Comment [ES46]: Added to reflect current provisions of constitution which allow directors to amend standing orders without approval from the Council. Whilst this provision makes clear that any such variation shall not constitute an amendment to the constitution for the purposes of paragraph 46, it is suggested that the number of directors required to approve such a variation is the same as the number required to approve an amendment to the constitution, for consistency.

This wording reflects the same provisions in respect of amendments to the Council's standing orders (Annex 7 paragraph 3.8.6).

Also made reference to emergency powers to vary, but any such variation should be approved as per paragraph 4.13.6.

4.14.1 The names of the chair, the Board members present, and individuals in attendance at each Board meeting shall be recorded and this record shall be made available to the Council of Governors upon its request.

4.15 **Quorum**

4.15.1 Four (4) Board members, including not less than two (2) executive directors, one of whom must be the Chief Executive or another executive director nominated by the Chief Executive, and not less than two (2) non-executive directors, one of whom must be the Chair or the Vice Chair, shall form a quorum.

4.15.2 An officer in attendance for an executive director but without formal acting up status shall not count towards the quorum.

4.15.3 If the Chair or any other member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest, he/she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The requirement at 4.15.1 for at least two executive directors to form part of the quorum shall not apply where the executive directors are excluded from a meeting, or part of a meeting; for example when the Board considers the recommendations of the remuneration committee.

4.16 **Admission of public to board meetings**

4.16.1 The Board may resolve to exclude members of the public from any meeting or part of a meeting on the grounds that:

4.16.1.1 publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or

4.16.1.2 there are special reasons stated in the resolution and arising from the nature of the business of the proceedings.

4.16.2 The Chair may exclude any member of the public from a meeting of the Board if they are interfering with or preventing the proper conduct of the meeting.

4.16.3 Nothing in these Standing Orders shall be construed as permitting the introduction by any person of any recording, transmitting, video or similar apparatus into meetings of the Board or of a committee or sub-committee of the Board.

4.16.4 Where the public have been excluded from a meeting in accordance with Standing Order 4.16.1 above then the matters dealt with following such exclusion shall be confidential to the directors of the trust. No director, officer or employee of the trust in attendance at such meeting shall reveal or disclose any information concerning such matters to any other person or disclose the contents of any papers presented to such meeting or minutes taken of such a meeting to any other person.

5 ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

5.1 Subject to such directions or guidance as may be given by Monitor, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions:

5.1.1 by a committee appointed by virtue of Standing Order 6.1 below; or

5.1.2 by an executive director of the trust;

in each case subject to such restrictions and conditions as the Board thinks fit.

5.2 **Emergency powers**

5.2.1 The powers which the Board has retained to itself within these Standing Orders may, in emergency, be exercised by the Chief Executive and the Chair, after having consulted with at least two non-executive directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the board in public session for ratification.

5.3 **Delegation to committees**

5.3.1 The Board may agree, from time to time, to the delegation of executive powers to committees, formally constituted in accordance with Standing Order 6.1. The constitution and terms of reference of these committees or sub-committees and their specific executive powers shall be approved by the Board.

5.4 **Delegation to officers**

5.4.1 Those functions of the trust which have not been retained as reserved by the Board or delegated to a committee shall be exercised on behalf of the trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to assist him in undertaking and discharging the remaining functions for which he/she will still retain accountability to the Board. For the avoidance of doubt whilst the Chief Executive can nominate officers to assist him/ her in undertaking and discharging any functions, the Chief Executive can only delegate functions to one or more executive directors.

5.4.2 The Chief Executive shall prepare a scheme of delegation identifying his proposals, which shall be considered and approved by the Board, subject to any amendments agreed during the discussion. The Chief Executive may periodically propose amendments to the scheme of delegation that shall also be considered and approved by the Board.

5.4.3 Nothing in the scheme of delegation shall impair the discharge of the direct accountability to the Board of the Director of Finance to provide information and advise the Board in accordance with any statutory requirements and any requirements of Monitor.

5.5 **Non-compliance with Standing Orders**

5.5.1 If for any reason these standing orders are not complied with, full details of the non-compliance, any justification for non-compliance and the circumstances surrounding the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these standing orders to the Chief Executive as soon as possible.

6 COMMITTEES

6.1 **Appointment**

6.1.1 Subject to such directions or guidance as may be given by Monitor, the Board may establish committees, reporting to the Board, composed of members of the Board.

6.1.2 A committee appointed under Standing Order 6.1.1 above may appoint sub-committees consisting wholly or partly of members of the committee or wholly of persons who are not members of the committee but who are members of the Board to assist and support the relevant committee with the discharge of its functions, but it may not delegate any function to such sub-committee.

6.1.3 The Board may appoint committees consisting wholly or partly of persons who are not executive directors or non-executive directors of the trust for any purpose that is calculated or likely to contribute to or assist it in the exercise of its powers but it may not delegate the exercise of any of its powers to any such committee.

6.1.4 The Board shall have the power to dismiss the members of any committee or sub-committee that is established under Standing Orders 6.1.1 to 6.1.3 inclusive above.

6.2 **Applicability of standing orders**

6.2.1 The standing orders of the trust, so far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Board and to the meetings of any sub-committee, in which case the term Chair is to be read as a reference to the chair of the committee as the context permits, and the term member is to be read as a reference to a member of the committee also as the context permits. There is no requirement for committees or sub-committees to hold meetings in public.

6.3 **Terms of reference**

6.3.1 Each committee established by the Board and each sub-committee shall have such terms of reference and powers and be subject to such conditions, such as to reporting back to the Board, as the Board shall decide and shall act in accordance with any legislation and any regulation or direction issued by Monitor. Such terms of reference shall have effect as if incorporated into these Standing Orders.

6.4 **Delegation of powers to sub-committee**

6.4.1 Where committees established by the Board are authorised to establish sub-committees they may not delegate functions to the sub-committee.

6.5 **Approval of appointments**

6.5.1 The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines that persons who are neither members of the Board nor officers shall be appointed to a committee, the Board shall define the powers of such appointees and may agree allowances for such appointees, including reimbursement for loss of earnings, and/or expenses.

6.6 **Committees Established by the Board**

6.6.1 The committees to be established by the Board shall include the following:

6.6.1.1 Audit Committee - an audit committee comprised of non-executive directors will be established and constituted to provide the Board with an independent and objective review of its financial systems, financial information and compliance with relevant laws and guidance. The Terms of Reference will be approved by the Board and reviewed on a periodic basis. The non-executive directors appointed to the committee shall all be independent non-executive directors and at least one shall have significant, recent and relevant financial experience.

6.6.1.2 Remuneration and Nominations Committee - a remuneration and nominations committee will be established and constituted by the Board. The committee shall be comprised exclusively of non-executive directors, including at least three independent non-executive directors. The committee shall nominate candidates for executive director posts in accordance with its terms of reference and decide the remuneration and allowances, and the other terms and conditions of office, of the executive directors.

Comment [ES47]: To reflect the requirements of Monitor's updated Code of Governance. There is some ambiguity as to whether this provision has changed in the Code – the beginning of the Code explains the requirement has changed to require all NED members of the committee to be independent, but then the Code itself doesn't seem to reflect this change. I have adopted the change on the basis that it is likely in any event that the NEDs are deemed independent.

6.7 **Confidentiality**

6.7.1 Subject to Standing Order 6.7.3 below, no director of the trust or member of any committee or sub-committee of the Board or attendee at a meeting of the Board or any such committee or sub-committee shall disclose any matter dealt with by, or brought before the Board or committee or sub-committee without the permission of the Board or the relevant committee or sub-committee (as applicable) until such matter has been concluded or, in the case of a committee or sub-committee, until the committee or sub-committee has reported to the Board.

6.7.2 The Board and any committee or sub-committee of the Board shall make the directors of the trust, the members of any committee and sub-committee and any other attendees at meetings of the Board and/or its committees or sub-committees aware of the confidential nature of the business being transacted and their duty of confidentiality as set out in this Standing Order 6.7.

6.7.3 No director of the trust or member of any committee or sub-committee or attendee at any meeting of the Board or any committee or sub-committee of the Board shall disclose any matter reported to the Board or otherwise dealt with by the Board or the committee or sub-committee (as applicable) notwithstanding that the matter has been reported or action has been concluded if the Board or committee or sub-committee resolves that it is confidential.

7 DECLARATIONS OF INTERESTS AND REGISTERS OF INTERESTS

7.1 Each director of the trust shall declare any interests that he/she is required to declare under paragraph 34 of the constitution.

7.2 The responsibility for declaring an interest is solely that of the director concerned and shall be declared to the Trust Secretary:

7.2.1 within 14 days of appointment; or

7.2.2 if arising later, as soon as the director becomes aware of the interest.

7.3 Subject to the exception in Standing Order 7.4 below, a relevant and material interest is:

7.3.1 any directorship of a company;

7.3.2 any interest or position in any organisation (including any charitable or voluntary organisation) which has, is likely to have or which is proposing to enter into a trading or commercial relationship with the trust;

7.3.3 any interest in an organisation providing (or seeking to provide) health and social care services to the National Health Service;

7.3.4 any position of authority in any organisation (including a charity or voluntary organisation) in the field of health and social care; or

7.3.5 any connection with any organisation considering entering into a financial arrangement with the trust including but not limited to lenders or banks.

7.4 The exception which shall not be treated as a relevant and material interest for the purposes of these provisions is shares held in any company whose shares are listed on any public exchange not exceeding 2% of the total number of shares issued.

7.5 Any director who has a relevant and material interest in a matter to be considered by the Board and who is present at a meeting at which that matter is to be the subject of consideration shall

declare such interest to the Board at that meeting and as soon as practicable after its commencement, and:

7.5.1 shall withdraw from the meeting and play no part in the relevant discussion or decision;

7.5.2 shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted); and

7.5.3 details of the interest shall be recorded in the minutes of the meeting.

7.6 Any director who fails to disclose any interest required to be disclosed under this constitution must permanently vacate their office if:

7.6.1 in the case of a non-executive director, he/she is required to do so by a resolution made pursuant to paragraph 26 of this constitution; and

7.6.2 in the case of an executive director, he/she is required to do so by a resolution made pursuant to paragraph 29 of this constitution.

7.7 If a director has any doubt about the relevance of an interest, this should be discussed with the Chair.

7.8 A director shall comply with any Conflicts of Interest policy that the trust may have in place from time to time.

8 DEFECTS IN PROCESS OR APPOINTMENT

8.1 All decisions taken in good faith at a meeting of the Board of Directors or of any committee or sub-committee shall be valid even if there is any vacancy in its membership or it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the directors attending the meeting.

9 STANDARDS OF BUSINESS CONDUCT POLICY

9.1 Directors of the trust shall comply with standing financial instructions prepared by the Director of Finance and approved by the Board for the guidance of all staff employed by the trust.

9.2 Directors of the trust must conduct themselves at all times in accordance with the NHS Foundation Trust Code of Governance, as may be in force from time to time.

9.3 Each director will uphold the seven principles of public life as detailed by the Nolan Committee:

9.3.1 Selflessness

Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

9.3.2 Integrity

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

9.3.3 Objectivity

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

9.3.4 Accountability

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

9.3.5 Openness

Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

9.3.6 Honesty

Holders of public office have a duty to declare any private interest relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

9.3.7 Leadership

Holders of public office should promote and support these principles by leadership and example.

9.4 **Canvassing of and recommendations by members of the Board in relation to appointments**

9.4.1 Canvassing of members of the Board or of any committee or sub-committee of the Board, either directly or indirectly, for any appointment under the trust shall disqualify the candidate for such appointment. The contents of this Standing Order 9.4 shall be included in application forms or otherwise brought to the attention of applicants.

9.4.2 A member of the Board shall not solicit for any person any appointment under the trust or recommend any person for such appointment. This Standing Order 9.4 shall not, however, preclude a member of the Board from giving written testimonial of a candidate's ability, experience or character for submission to the trust.

9.4.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

9.5 **Relatives of members of the board or officers of the trust**

9.5.1 Candidates for any appointment under the trust shall, when making an application, disclose in writing to the trust whether they are related to any member of the Board or the holder of any office under the trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

9.5.2 The Chair and every member of the Board and officer of the trust shall disclose to the Chief Executive any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the board any such disclosure made.

9.5.3 Prior to acceptance of an appointment, members of the Board should disclose to the Board whether they are related to any other member of the Board or holder of any office in the trust.

9.6 **Gifts and hospitality**

9.6.1 Members of the Board and officers of the trust are expected to maintain high standards of personal conduct in all work related business. Under the Bribery Act 2010 they must not accept from any organisation, firm or individual any inducement or reward which

might influence them to make a decision that is not in the best interests of the trust. Any breach of the Act renders any employee liable to instant dismissal.

9.6.2 Any gifts received from or offer of gifts by a contractor or potential contractor must be declined and reported immediately in accordance with the trust's policy on gifts and hospitality, which is contained in the trust's Conflicts of Interest policy, as may be in place from time to time. Contractor means any supplier of goods, and/or services to the trust.

9.6.3 All members of the Board and officers of the trust must comply with relevant NHS guidance in force from time to time in relation to gifts and hospitality and the trust's policy on gifts and hospitality.

10 CUSTODY OF SEAL AND SEALING OF DOCUMENTS

10.1 Custody of seal

10.1.1 The common seal of the trust shall be kept by the Trust Secretary in a secure place.

10.2 Sealing of documents

10.2.1 The seal of the trust shall not be affixed to any document unless the sealing has been authorised by a resolution of the Board or of a committee established by the Board where the Board has delegated its powers to such a committee to authorise the application of the trust's seal.

10.2.2 Before any building, engineering, property or capital document is sealed it must be approved by the director of finance, or an officer nominated by him/her, with such approval being evidenced in writing and authorised in writing by the chief executive, or an officer nominated by him who shall not be within the originating directorate.

10.2.3 All deeds entered into by the trust and all documents conveying an interest in land must be executed by the application of the trust's seal.

10.3 Register of sealing

10.3.1 A record of the sealing of every document shall be made and numbered consecutively in a register established for that purpose, and shall be signed by the persons who have approved and authorised the document and those who attested the seal. A report of all sealings shall be made to the Board at least annually. The report shall contain details of the seal number, the description of the document and date of sealing.

11 SIGNATURE OF DOCUMENTS

11.1 Where any document becomes a necessary step in legal proceedings involving the trust, it shall be signed by the Chief Executive or any executive director nominated by the Chief Executive.

11.2 The Chief Executive or any executive director nominated by the Chief Executive shall be authorised, by resolution of the Board, to sign on behalf of the trust any agreement or other document not required to be executed as a deed, the subject matter of which has been approved by the Board or any committee established by the Board with delegated authority.

12 MISCELLANEOUS

12.1 Standing orders to be given to members of the board and officers of the trust

12.1.1 It is the duty of the Chief Executive to ensure that existing Board members and officers of the trust and all new appointees are notified of and understand their responsibilities

within the Standing Orders, Standing Financial Institutions, Scheme of Reservation and Delegation of Powers.

12.2 **Review of standing orders**

12.2.1 These Standing Orders shall be reviewed periodically by the Board. The requirement for review extends to all documents having effect as if incorporated in the Standing Orders.

ANNEX 9 – FURTHER PROVISIONS - MEMBERS

1 DISQUALIFICATION FROM MEMBERSHIP

1.1 An individual may not become, or continue to be, a member of the trust if:

1.1.1 they are under 16 years of age; or

1.1.2 within the last five (5) years they have been involved as a perpetrator in a serious incident of physical or verbal aggression at any of the trust's sites or facilities or against any of the trust's employees or other persons who exercise functions for the purposes of the trust, or against any registered volunteer.

2 TERMINATION OF MEMBERSHIP

2.1 A member shall cease to be a member if:

2.1.1 they resign by notice to the Trust Secretary;

2.1.2 they die;

2.1.3 they are expelled from membership under this constitution;

2.1.4 they cease to be eligible under this constitution to be a member of any of the Public Constituencies or of any classes of the Staff Constituency;

2.1.5 it appears to the Trust Secretary that they no longer wish to be a member of the trust, and after enquiries made in accordance with a process approved by the Council of Governors, they fail to demonstrate that they wish to continue to be a member of the trust.

2.2 A member may be expelled by a resolution approved by not less than two thirds of the governors present and voting at a meeting of the Council of Governors. The following procedure is to be adopted.

2.2.1 Any member may complain to the Trust Secretary that another member has acted in a way that is detrimental to the interests of the trust;

2.2.2 If a complaint is made, the Council of Governors may itself consider the complaint, having taken such steps as it considers appropriate to ensure that each member's point of view is heard and may either:

2.2.2.1 dismiss the complaint and take no further action; or

2.2.2.2 for a period not exceeding twelve months suspend the right of the member complained about to attend members meetings and vote under this constitution; or

2.2.2.3 arrange for a resolution to expel the member complained about to be considered at the next general meeting of the Council of Governors.

2.2.3 If a resolution to expel a member is to be considered at a general meeting of the Council of Governors, details of the complaint must be sent to the member complained about not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

2.2.4 At the meeting the Council of Governors will consider evidence in support of the complaint and such evidence as the member complained about may wish to place before them.

2.2.5 If the member complained about fails to attend the meeting without due cause the meeting may proceed in their absence.

2.3 A person expelled from membership will cease to be a member upon the declaration by the chair of the meeting that the resolution to expel them is carried.

2.4 No person who has been expelled from membership is to be re-admitted except by a resolution carried by the votes of two thirds of the Council of Governors present and voting at a general meeting.

3 MEMBERS MEETINGS

3.1 The trust is to hold a members meeting (the **Annual Members Meeting**) within nine months of the end of each financial year.

3.2 Any members meetings other than Annual Members Meetings shall be called Special Members Meetings.

3.3 The Annual Members Meeting shall be open to members of the public. Special Members Meetings are open to all members of the trust, governors and directors, and representatives of the auditor, but not to members of the public unless the Council of Governors decides otherwise. The Council of Governors may invite representatives of the media and any experts or advisors whose attendance they consider to be in the best interests of the trust to attend a members meeting.

3.4 All members meetings are to be convened by the Trust Secretary.

3.5 The Trust Secretary shall decide where a members meeting is to be held and may also for the benefit of members:

3.5.1 arrange for the Annual Members Meeting to be held in different venues each year;

3.5.2 make provision for a members meeting to be held at different venues simultaneously or at different times. In making such provision the Trust Secretary shall also fix an appropriate quorum for each venue, provided that the aggregate of the quorum requirements shall not be less than the quorum set out below.

3.6 At the Annual Members Meeting:

3.6.1 the Board of Directors shall present to the members:

3.6.1.1 the annual accounts;

3.6.1.2 any report of the auditor;

3.6.1.3 forward planning information for the next financial year;

3.6.2 the Council of Governors shall present to the members a report on:

3.6.2.1 steps taken to secure that (taken as a whole) the actual membership of:

3.6.2.1.1 the Public Constituency; and

3.6.2.1.2 the classes of the Staff Constituency;

is representative of those eligible for such membership;

3.6.2.2 the progress of the membership strategy and any changes proposed; and

3.6.2.3 any proposed changes to the policy for the composition of the Council of Governors and of the non-executive directors;

3.6.3 the results of the election and appointment of governors and the appointment of non-executive directors will be announced.

3.7 Notice of a members meeting is to be given by the Trust Secretary:

3.7.1 by written notice to all members;

3.7.2 by notice prominently displayed at the trust's head office and at all of the trust's places of business;

3.7.3 by notice on the trust's website; and

3.7.4 is to be given in writing to the Council of Governors and the Board of Directors, and to the auditor;

at least 14 days before the date of the meeting. The notice must:

3.7.5 state whether the meeting is an Annual Members Meeting or a Special Members Meeting;

3.7.6 give the time, date and place of the meeting; and

3.7.7 indicate the business to be dealt with at the meeting.

3.8 The lack of service of notice on any member shall not affect the validity of any meeting.

3.9 Before a members meeting can do business there must be a quorum present. Except where this constitution says otherwise a quorum is one member present from each of the trust's constituencies.

3.10 The trust may make arrangements for members to vote by post, or by using electronic communications.

3.11 It is the responsibility of the Council of Governors, the chair of the meeting and the Trust Secretary to ensure that at any members meeting:

3.11.1 the issues to be decided are clearly explained; and

3.11.2 sufficient information is provided to members to enable meaningful discussion to take place.

3.12 The Chair, or in their absence the Vice Chair, or in their absence one of the other non-executive directors shall chair all members meetings. If neither the Chair nor the Vice Chair nor another non-executive director is present, the members of the Council of Governors present at the meeting shall elect one of their number to be chair and if there is only one governor present and willing to act they shall be chair. If no governor is willing to act as chair or if no governor is present within fifteen minutes after the time appointed for the start of the meeting, the members present and entitled to vote shall choose one of their number present to be chair.

3.13 If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Trust Secretary, having consulted with the Chair, shall determine. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of members present during the meeting is to be a quorum.

3.14 A resolution put to the vote at a members meeting shall be decided by a majority of votes of those members present and voting.

3.15 Every member present and every member who has voted by post or using electronic communications is to have one vote. In the case of an equality of votes the chair of the meeting is to have a second and casting vote.

3.16 The result of any vote will be declared by the Chair and entered in the minutes. The minutes will be conclusive evidence of the result of the vote.

4 DECISIONS ON ELIGIBILITY FOR MEMBERSHIP

4.1 It is the responsibility of each member to ensure his/her eligibility to become or continue as a member of a constituency or class of a constituency at all times and not the responsibility of the trust to do so on his/her behalf. A member who becomes aware of his/her ineligibility shall inform the trust as soon as practicable and that person shall thereupon be removed forthwith from the register of members and shall cease to be a member.

4.2 Where the trust has reason to believe that a member is ineligible for membership or may be disqualified from membership, the Trust Secretary shall carry out reasonable enquiries to establish if this is the case.

4.3 Where the Trust Secretary considers that there may be reasons for concluding that a member or an applicant for membership may be ineligible or be disqualified from membership he/she shall advise that individual of those reasons in summary form and invite representations from the member or applicant for membership within 28 days or such other reasonable period as the Trust Secretary may in his/her absolute discretion determine. Any representations received shall be considered by the Trust Secretary and he/she shall make a decision on the member's or applicant's eligibility or disqualification as soon as reasonably practicable and shall give notice in writing of that decision to the member or applicant within 28 days of the decision being made.

4.4 If no representations are received within the said period of 28 days or such longer period (if any) permitted under the preceding paragraph, the Trust Secretary shall be entitled nonetheless to proceed and make a decision on the member's or applicant's eligibility or disqualification notwithstanding the absence of any such representations from him/her.

4.5 Any decision to disqualify a member or an applicant for membership may be referred by the member or applicant concerned to the dispute resolution procedure described in Annex 10.

ANNEX 10 – FURTHER PROVISIONS

1 REPRESENTATIVE MEMBERSHIP

1.1 The trust shall at all times strive to ensure that taken as a whole its actual membership is representative of those eligible for membership. To this end the trust shall at all times have in place and pursue a membership strategy which shall be approved by the Council of Governors, and shall be reviewed by them from time to time, and at least every three years.

2 TRUST SECRETARY

2.1 The trust shall have a Trust Secretary who may be an employee. The Trust Secretary may not be a governor, or the Chief Executive or the Director of Finance. All directors and governors will have access to the advice and services of the Trust Secretary. The Trust Secretary's functions shall include:

2.1.1 acting as secretary to the Council of Governors, the Board of Directors and any committees, giving independent advice on governance and always acting in the best interests of the trust;

2.1.2 ensuring good information flows between the Board of Directors and its committees and between the Board of Directors, the Council of Governors and senior management;

2.1.3 calling and attending all members meetings, meetings of the Council of Governors and of the Board of Directors, and taking the minutes of those meetings;

2.1.4 being available to give advice and support to individual directors and governors, particularly in relation to the induction of new directors and governors and assistance with professional development;

2.1.5 keeping the register of members and other registers and books required by this constitution to be kept;

2.1.6 keeping the trust's seal;

2.1.7 publishing to members in an appropriate form information which they should have about the trust's affairs;

2.1.8 preparing and sending to Monitor and any other statutory body all returns which are required to be made.

2.2 Minutes of every members meeting, of every meeting of the Council of Governors and of every meeting of the Board of Directors are to be kept by the Trust Secretary.

2.3 The Trust Secretary shall be responsible for making any determination required on the interpretation of this constitution (having sought and received legal advice if required) where any query as to the interpretation of this constitution is raised by any governor, director or member.

2.4 A determination made in accordance with paragraph 2.3 above shall be binding on the Council of Governors, the Board of Directors and the members.

2.5 The Trust Secretary is to be appointed and removed by the Board of Directors.

2.6 The Board of Directors of the applicant NHS trust shall appoint the first secretary of the trust.

3 INDEMNITY

3.1 Members of the Council of Governors and of the Board of Directors and the Trust Secretary who act honestly and in good faith will not have to meet out of their personal resources the cost associated with any personal civil liability which accrues to them in the execution or purported execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the trust. The trust may purchase and maintain insurance against this liability for its own benefit and for the benefit of members of the Council of Governors and of the Board of Directors and of the Trust Secretary.

4 DISPUTE RESOLUTION PROCEDURES

4.1 Every unresolved dispute which arises out of this constitution between the trust and:

4.1.1 a member; or

4.1.2 an applicant for membership; or

4.1.3 any person aggrieved who has ceased to be a member within the six months prior to the date of the dispute; or

4.1.4 any person bringing a claim under this constitution; or

4.1.5 an office-holder of the trust;

is to be submitted to an arbitrator agreed by the parties or in the absence of agreement to be nominated by the Chair. The arbitrator's decision will be binding and conclusive on all parties, including as to cost.

4.2 Any person bringing a dispute must, if required to do so, deposit with the trust a reasonable sum (not exceeding £250) to be determined by the Council of Governors and approved by the Trust Secretary. The arbitrator will decide how the costs of the arbitration will be paid and what should be done with the deposit.

5 NOTICES

5.1 Any notice required by this constitution to be given shall be given in writing or shall be given using electronic communications to an address for the time being notified for that purpose. "Address" in relation to electronic communications includes any number or address used for the purposes of such communications.

5.2 Proof that:

5.2.1 in the case of a notice sent by post, the envelope containing the notice was properly addressed, prepaid and posted; and

5.2.2 in the case of a notice sent by electronic communication, the electronic communication was dispatched to the correct address;

shall be conclusive evidence that the notice was given. A notice shall be treated as delivered 2 days after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 1 day after it was sent.

Meeting	**1 December 2020**		**Board of Directors**					
Report	**Agenda item 16**		**Charitable Funds Committee Chair's Report, 24th September 2020**					
Purpose of the Report	Decision		Ratification		Assurance	x	Information	
Author(s)	Paul Jones				Non-Executive Director			
Board Assurance Framework	-							
Strategic Aims	-							
CQC Domains	Well Led							
Previous Considerations	Charitable Funds Committee – 24th September 2020							
Summary	The purpose of this report is to inform Board members of matters discussed and approved by the Charitable Funds Committee and to provide assurance on these matters.							
Recommendation(s)	The Board is asked to**:-** • Note the contents of the report							
Corporate Impact Assessment								
Statutory Requirements	The Charitable Funds Committee is a statutory committee of the Board of Directors							
Quality & Safety	-							
NHS Constitution	-							
Patient Involvement	-							
Risk	-							
Financial impact	-							
Equality & Diversity	-							
Communication	-							

Countess of Chester Hospital NHS Foundation Trust

Charitable Funds Committee
Chairs Report

1.0 Key items of business discussed

The Charitable Funds Committee met on 24th September, 2020 and the following agenda items were covered:

- A Fundraising Update
- A review of the investments, and bank balances
- A overview of the various individual Charitable Funds performance (income & expenditure per fund)
- A discussion about the NHS Charities Together (bids and expenditure), also known as "Captain Tom's money"; and
- A review of governance and business cycle

2.0 Major matters arising, key agreements or decisions made

- The Head of Fundraising explained that the Trust is now at the point of submitting the Stage three application for NHS Charities Together Grants for £99k

- The Head of Fundraising updated the Committee that the Blue Skies Appeal, for the Intensive Care Unit balcony, has currently reached £500k, 17% of the target. It was agreed that the head of Fundraising would endeavour to share an Artist Impression of this scheme, with the next Charitable Funds Committee (in December 2020).

- A discussion surrounding the staffing of the Fundraising Department took place, acknowledging the changed environment as a result of the pandemic. It was agreed that the situation would be monitored, and that the issues would be revisited in March 2021. It was reiterated that any potential changes within the Charitable Funds Team would require the support of Human Resources Department. It was also agreed to look at benchmark data from similar Trusts to understand relevant performance of fundraising, how they perform in relation to team members (and their associated income and expenditure levels).

- A report was presented on the performance of the Charitable Fund investments, currently held in the M&G Charitable Fund, and it was noted that the M&G Fund had recovered slightly in April 2020 but unfortunately there has since been a further downward trend. Overall M&G have stated that they will have to cut their annual distribution for 2020 by an estimated 20-30%, although they have committed to using some of their reserves to keep the yield up. The total returns M&G Charitable Fund is currently equal 9th in the league table shared, which was considered to be disappointing. It was agreed to meet with M&G

Charifund in advance of the next meeting, and produce a feedback report to the Committee as well as exploring the following two options in parallel

a. Run a procurement exercise to evaluate other Investment Funds from this sector.
b. Engage in an Independent Advisor to re- evaluate the Charitable Funds Committee's aims and to advise on the best vehicle to achieve them

- The Committee also received an update on the performance of individual Funds, noting that two funds had now been closed, with monies redistributed. The committee accepted this recommendation.

3.0 Items for escalation to Board

- The Interim Governance Consultant to provide an update on the revised Charitable Funds Terms of Reference to the next Charitable Funds Committee (in December 2020).

- The Interim Governance Consultant and the Director of Finance would arrange Board Training, on the roles and responsivities of the Corporate Trustees, in the first quarter of 2021 (January 2021 to March 2021); and

- The positive position with regards to funds raised being raised for the Intensive Care Unit, Blue Skies appeal, noting that that 17% of the total has been achieved; and

- M&G Charitable Investment Fund, is being kept under review with an update being requested for the next Charitable Funds Committee, whilst in parallel will go out and look at the option of getting independent advice also.