Council of Governors Meeting - 26.10.17

Schedule	Thursday 26 October 2017, 04:00 PM — 06:00 PM BST
Venue	Large Training Room, Learning & Development Centre, Calderdale Royal Hospital
Organiser	Kathy Bray

Agenda

1. Welcome and introductions:
Mrs Jan Wilson, Non-Executive Director
Karen Heaton, Non-Executive Director

2. Agenda and Apologies for absence: Mr Gary Boothby, Executive Director of Finance – Kirsty Archer to attend Kate Wileman, Public Elected Governor, Charlie Crabtree, Staff Elected Governor

Presented by Andrew Haigh

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Meeting of the CALDERDALE AND HUDDERSFIELD NHS FOUNDATION COUNCIL OF GOVERNORS MEETING

Date: THURSDAY 26 OCTOBER 2017 at 4.00 pm
Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital

AGENDA

REF	ITEM	LEAD	PAPER	PURPOSE OF PAPER/ UPDATE
1	**Welcome and introductions:** Mrs Jan Wilson, Non-Executive Director Karen Heaton, Non-Executive Director	Chair	**VERBAL**	**Note**
2	**Apologies for absence:** Mr Gary Boothby, Executive Director of Finance – Kirsty Archer to attend	Chair	**VERBAL**	**Note**
3	**Declaration of interests**	All	**VERBAL**	**Approve**
4	**Minutes of the meeting held:** Thursday 6 July 2017	Chair	**APP A**	**Approve**
5	**Matters Arising** **a. Discharge Lounge – Presentation from:** **Bev Walker, Associate Director – Urgent Care** **Wendy Brawn, Lead for Age UK and Gill Sutillic, Discharge Sister to attend**	Chair	**VERBAL** **Presentation**	**Information** **Information**
CHAIRMAN'S REPORT				
6	**a. Update from Chairs Information Exchange Meeting – 3.7.17** **b. WYATT Update** **c. Senior Staff Changes**	Chair IW	**VERBAL** **VERBAL**	**Approve**
PERFORMANCE AND STRATEGY				
7	**TRUST PERFORMANCE** **a. Financial Position and Forecast** **b. Performance Report (including Good News Stories)** **c. Winter Plan 2017-18** **d. Medical Services Reconfiguration**	KA HB HB HB	**APP B** **APP C** **APP D** **Presentation**	**Information**
8	**STRATEGIC PLAN & QUALITY PRIORITIES UPDATE** • **Updated Strategic Plan and Priorities 2017-18**	VP	**APP E**	**Information**

9	**Full Business Case Update**	AB	**VERBAL**	**Information**
GOVERNANCE				
10	**Constitutional Amendments**	VP	**APP F**	**Note**
11	**Governors Attendance at Formal Council of Governor Meetings – 2017-2018**	VP	**APP G**	**Approve**
12	**Appointment of External Auditors**	VP	**VERBAL**	**Approve**
13	**Council of Governors Register – Resignations/ Appointments**	Chair	**APP H**	**Approve**
14	**Register of Interests/Declaration of Interest**	Chair	**APP I**	**Approve**
UPDATE FROM BOARD SUB COMMITTEES				
15	**Audit and Risk Committee**	**V Pickles**	**VERBAL**	**Information**
16	**Charitable Funds Committee**	**A Haigh**	**VERBAL**	**Information**
17	**Patient Experience and Caring Group**	**L Moore**	**VERBAL**	**Information**
18	**Nomination and Remuneration Committee (CoG) – Non-Executive Director/Chair Appointments**	**A Haigh**	**VERBAL**	**Approve**
INFORMATION TO RECEIVE				
19	**a. Updated Membership Council Calendar** **b. Extract from Quality Report re Complaints & PALS** **c. Draft BoD/CoG Annual General Meeting Minutes – 20.7.17** **d. Feedback from BoD/CoG Workshop – 18.7.17** **e. EPR and Stabilisation**	Chair BB Chair Chair HB	**APP J** **APP K** **APP L** **APP M** **Presentation**	**Note** **Note** **Approve** **Note** **Note**
20	**Any Other Business**	Chair	**VERBAL**	**Receive**
21	**DATE AND TIME OF NEXT MEETING:** **Date:** Wednesday 17 January 2018 at 4.00 pm. **Venue:** Boardroom, Huddersfield Royal Infirmary			

3. Declaration of interests

To Note

Presented by Andrew Haigh

4. Minutes of the meeting held: Thursday 6 July 2017

To Approve

Presented by Andrew Haigh

Calderdale and Huddersfield NHS Foundation Trust

MINUTES OF THE FOUNDATION TRUST COUNCIL OF GOVERNORS MEETING HELD ON THURSDAY 6 JULY 2017 IN DISCUSSION ROOM 1, LEARNING CENTRE, HUDDERSFIELD ROYAL INFIRMARY

PRESENT:

Andrew Haigh	Chair
Rosemary Hedges	Public elected – Constituency 1
Veronica Maher	Public elected – Constituency 2
Peter Middleton	Public elected – Constituency 3
George Richardson	Public elected – Constituency 5
Annette Bell	Public elected – Constituency 6
Kate Wileman	Public elected – Constituency 7
Lynn Moore	Public elected – Constituency 7
Brian Moore	Public elected – Constituency 8
Bob Metcalfe	Nominated Stakeholder - Calderdale Metropolitan Council
Graham Ormrod	Nominated Stakeholder – University of Huddersfield
Dawn Stephenson	Nominated Stakeholder – South West Yorkshire Partnership FT

IN ATTENDANCE:

Dr David Anderson	Non-Executive Director
Helen Barker	Chief Operating Officer
David Birkenhead	Executive Medical Director
Kathy Bray	Board Secretary
Anna Basford	Director of Transformation and Partnerships
Gary Boothby	Executive Director of Finance
Brendan Brown	Executive Director of Nursing/Deputy Chief Executive
Mandy Griffin	Director of the Health Informatics Service
Ruth Mason	Associate Director of Engagement & Inclusion
Victoria Pickles	Company Secretary
Owen Williams	Chief Executive

34/17 APOLOGIES:

Apologies for absence were received from:

Di Wharmby	Public elected – Constituency 1
Dianne Hughes	Public elected – Constituency 3
Katy Reiter	Public elected – Constituency 2
Grenville Horsfall	Public elected – Constituency 4 (Reserve Register)
Nasim Banu Esmail	Public elected – Constituency 4
Stephen Baines	Public elected – Constituency 5
Brian Richardson	Public elected – Constituency 6
Michelle Rich	Public elected – Constituency 8
Mary Kiely	Staff-elected – Constituency 9
Nicola Sheehan	Staff-elected – Constituency 10
Charlie Crabtree	Staff-elected – Constituency 13
David Longstaff	Nominated Stakeholder – Clinical Commissioning Group
Sharon Lowrie	Nominated Stakeholder – Locala
Lesley Hill	Executive Director of Planning, Estates & Facilities
Ian Warren	Executive Director of Workforce & OD

The Chair welcomed everyone to the meeting. It was noted that the meeting was not quorate:- *Ten Governors (including not less than six Public, not less than two Staff Council Members and not less than two Appointed,)* but that any decisions required would be made subject to confirmation from those absent.

35/17 DECLARATION OF INTERESTS

There were no declarations of interest at the meeting.

36/17 MINUTES OF THE LAST MEETING – 5 APRIL 2017

The minutes of the last meeting held on 5 April 2017 were approved as an accurate record.

37/17 MATTERS ARISING

72/16 – Declaration of Interest - It was noted that the Board Secretary had sent a further reminder to return completed Declaration of Interests forms and these were awaited.

23/17 – Reserve Register – It was noted that eligible Governors had been contacted to express interest on the Council of Governors' reserve register and this would be confirmed once the election results have been received.

23/17- Review of Boundaries – The Company Secretary advised that this would be reviewed at an appropriate time following the Government's review on electoral wards.

OUTCOME: The Council of Governors **RECEIVED AND NOTED** the matters arising.

38/17 CHAIRMAN'S REPORT

a. UPDATE FROM CHAIRS INFORMATION EXCHANGE MEETING – 3.7.17

The Chairman gave a brief update following the discussions at the Chairs Information Exchange held on Monday 3 July 2017. The key issues included:-

- Communication between clinicians and patients
- Levels of Staffing – concerns regarding turnover in Medicine
- Levels of 4th Perinatal tears

OUTCOME: The Council of Governors **RECEIVED AND NOTED** the Chairs Information Exchange Minutes – 21.3.17

b. TRUST RESPONSE TO IMPROVING LIAISON WITH OUR VOLUNTEERS

The Chairman reported that Rachael Pierce, Recruitment Manager had now been allocated the management of the Volunteers Services. Details of the actions undertaken to date were received which included:-

- Contact with 395 volunteers to cleanse data
- Meeting with HRI 'Meet and Greet' volunteers
- Appointment of new Voluntary Co-ordinator Lead at CRH
- Walkarounds to introduce volunteers
- League of Friends (CRH) Meeting scheduled for August
- DBS checks being completed following Saville Enquiry
- Safeguarding Training – on going

Uniforms – It was noted that the volunteers had asked for more investment in uniforms and this would be fedback to Rachael.

Volunteers Accreditation – Dawn Stephenson reported that SWYPFT would be happy to get involved with the Trust Volunteers to learn from each other.

It was agreed that the Company Secretary would contact Rachael accordingly.

ACTION: Company Secretary

OUTCOME: The Council of Governors **SUPPORTED** the Trust's response to improving liaison with Volunteers.

c. TRUST PROPOSALS FOR THE NEW WORKING RELATIONSHIP WITH THE COG AND MEMBERSHIP OFFICE

As reported at the last meeting it was noted that the Associate Director of Engagement and Inclusion, Ruth Mason had taken up the post of Associate Director of OD with effect from 1 June 2017. Arrangements had been made for the Company Secretary, Victoria Pickles to take over the management of the Council of Governors and the administration work would continue to be supported by Vanessa Henderson and Kathy Bray. It was noted that Ruth would continue to have some involvement with the Council of Governors in her new role around training.

OUTCOME: The Council of Governors **NOTED** the new working relationship with the CoG and Membership Office.

d. WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS (WYAAT) Update

The Chairman advised the meeting that he had been appointed Chair of the WYAAT Committee in Common, a position he would hold until February 2018.

It was noted that work continues in the areas of Information Technology and Estates with a view to collaboration across the patch and the creation of a company/organization.

Other areas being developed within the West Yorkshire area included collaboration on the following services, Pharmacy, Vascular, Head and Neck, Finance, Nursing. This was hoped would achieve the expectancies of WYAAT in order to meet the STP ambitions and work was underway around governance arrangements.

PERFORMANCE AND STRATEGY

39/17a FINANCIAL POSITION AND FORECAST

The Executive Director of Finance presented the Month 2 position as at 31 May 2017.

The key issues were:-

- Reported year to date Deficit position in line with agreed control total of £6.14m,
- Capital expenditure is below plan,
- Cash position is in line with plan at £1.90m.
- Delivery of CIP is behind the planned level at £1.31m against a planned level of £1.43m.
- A Use of Resources score of level 3, in line with the plan.

The year to data position was:-

- The year to date deficit is £6.15m versus a planned deficit of £6.12m. This includes £0.02m net benefit excluded for Control Total purposes:
- The I&E impact of Donated Assets (£0.02m).
- The year to date position assumes receipt of the full allocation of Sustainability and Transformation Funding (STF) of £1.01m.
- Activity continued to be behind plan in Month 2, driven by lower than planned Outpatient and Elective activity. In addition to this underlying underperformance, £2.6m of clinical income has been included as an estimate to reflect coding and capture issues linked to EPR implementation.
- Capital expenditure year to date is behind plan at £3.08m against a planned £3.66. plans.
- Cash balance is as planned at £1.90m.
- Trust borrowing in month was slightly below the planned level. Year to date the Trust has borrowed £10.74m to support the deficit and delayed STF funding.
- CIP schemes delivered £1.31m, £0.11m less than the year to date target of £1.43m.
- The revised NHS Improvement performance metric Use of Resource (UOR) stands at 3 against a planned level of 3. Of the five metrics that make up the UOR, all are as planned except the I&E Margin Variance which shows an unfavourable variance - rated as a 2 (planned as 1).

It was noted that:

- The Trust is forecasting to achieve the planned year end Control Total deficit of £15.94m. This excludes a planned £14m impairment and the I&E impact of Donated Assets which are excluded from the deficit for Control Total purposes and therefore have no impact on our STF allocation or UOR metric.
- The forecast assumes full receipt of the allocated £10.1m STF Funding, recovery of £2.6m estimated clinical income and a return to planned activity levels from Month 3.
- The forecast assumes full delivery of the £20m CIP target, of which £5.54m is currently unidentified.
- The Trust cash position is forecast as planned at £1.90m. The total borrowing requirement is £28.76m in this financial year to support both Capital and Revenue plans. The total loan balance by year end is forecast to be £87.62m as planned.
- Capital expenditure is forecast for the full year as planned at £14.39m, supported by the final £8m instalment of an existing Capital Loan facility.

40/17b PERFORMANCE & QUALITY (Including Good News Stories)

The Chief Operating Officer presented the quality and performance report. The key issues from the report included:-

- May's performance score has fallen to 61% for the Trust.
- The SAFE domain remains GREEN although the position for harm free care and pressure ulcers had deteriorated.
- The RESPONSIVE domain remains Amber due to failing to meet the Emergency Care Standard and the two week wait target which was missed for the first time in over 12 months. An improvement was now being seen.
- CARING had deteriorated to RED due to a number of Friends and Family Targets being missed.
- EPR had impacted on the achievement of several indicators this month including 18 weeks admitted and non-admitted, VTE, coding and day case rates. Work was underway with an external data company to develop a recovery plan regarding clinical codings.
- A small increase in C.Diff and MRSA cases had been seen and work was being undertaken to reduce this.

- Green Cross Patients – work continued with social care to reduce the number of patients within the Trust who are medically fit for discharge. Currently 96 patients were on the transfer to care list.
- Mortality rates had fallen.
- The contents of the 'Performance Achievements' report (good news stories) was noted and thanks given to staff for preparing this for the Governors.

41/17 STRATEGIC PLAN AND QUALITY PRIORITIES UPDATE

The Company Secretary reported that the Strategic Plan and Priorities for 2017-18 would be discussed in detail at the BoD/CoG to be held on the 18 July 2017 and this had been circulated in advance to give opportunity for the Governors to review.

42/17 EPR UPDATE

The Director of THIS presented a detail paper following the implementation of the EPR system in May. The key points from the paper included:-

- A high level update in terms of the go-live of the Electronic Patient Record (EPR) at Calderdale and Huddersfield NHS Foundation Trust (CHFT).

- With regard to the overall view of the cutover, go-live and early live support both Cerner and our external Cutover management team have been very complimentary stating that this had been one of the best 'go-lives' in Europe. It was noted that lessons learned would be shared with Bradford prior to their go-live on the 24 September 2017.

- Current work was in progress on data quality and outpatient arrangements to improve appointment bookings.

- The Council of Governors wished to thank all staff for their resilience during this challenging time.

43/17 FULL BUSINESS CASE UPDATE

The Director of Transformation and Partnerships presented an update to the Council of Governors on the development of the full business case (FBC). It was noted that the key benefits of the FBC remained the same but it had been refreshed and reviewed and included:-

- Activity modelling
- Workforce Modelling
- Estate costs
- Funding options
- Commercial/procurement options
- Trust financial model/impact on deficit
- System affordability

The next steps, timetable and sharing of information was discussed. It was noted that the Joint Health Overview and Scrutiny Committee was scheduled to meet on Friday 21 July and discussions with NHS Improvement at the Quarterly Review Meeting would be held on 25 July.

It was noted that this item would be discussed in more detail at the BoD/CoG Workshop to be held on the 18 July 2017.

GOVERNANCE

44/17 CONSTITUTIONAL AMENDMENTS

It was noted that the amended Constitution discussed and agreed at the last meeting had now been approved by the Board of Directors, along with the change of name to 'Council of Governors'.

45/17 COUNCIL OF GOVERNORS CHARTER

The Company Secretary reported that the Charter had been updated in line with the Constitution. She confirmed that there had been no material changes and the revised copy would be circulated to the newly elected Governors.

OUTCOME: The Council of Governors present approved the revised Charter.

46/17 APPOINTMENT OF EXTERNAL AUDITORS

The Company Secretary reported that the contract with the External Auditors was due to complete and arrangements were being made re-tender for the service. A small group of Governors would possibly be required to help with the procurement process which would likely to be during October.

ACTION: Company Secretary

47/17 COUNCIL OF GOVERNORS REGISTER

The updated register of members as at 6 July was received for information. It was noted that this included the governors elected unopposed. The Chairman reported that discussions were taking place with Locala and the CCG regarding attendance of representatives.

OUTCOME: The Council of Governors **NOTED** the updated Register.

48/17 REGISTER OF INTERESTS/DECLARATION OF INTERESTS

The Chairman requested that any amendments be notified to the Board Secretary as soon as possible.

OUTCOME: The Council of Governors **APPROVED** the Register of Interests

49/17 FUTURE COUNCIL OF GOVERNOR MEETING DATES

The future meeting dates for the Council of Governors for 2017/18 was approved.

OUTCOME: The Council of Governors **APPROVED** the CoG future meeting dates

50/17 APPOINTMENT OF LEAD GOVERNOR

It was noted that only one candidate had applied for the post of Lead Governor and therefore Brian Moore had been appointed unopposed with effect from 15 September 2017.

OUTCOME: The Council of Governors **APPROVED** the appointment of Brian Moore as Lead Governor.

51/17 NON-EXECUTIVE DIRECTOR APPRAISAL FEEDBACK

The Chairman presented a paper reporting on the appraisals of the Non-Executive Directors (NEDs) carried out between January and March 2017 by the Chair with input from the Executive team. It was noted that all the Non-Executive Directors were assessed to be carrying out their duties to a satisfactory standard and fulfilling their time commitment to the Trust.

OUTCOME: The Council of Governors **APPROVED** the Chairman's Appraisal of the Non-Executive Directors.

52/17 CHAIR APPRAISAL FEEDBACK

Dr David Anderson, Senior Independent Non-Executive Director/Non-Executive Director gave feedback on the Chair Appraisal Process. It was noted that this was

Andrew's sixth appraisal and was to be his final year in office, but due to the crucial stage of some of the transformation agendas, the Council of Governors had approved an extra year to ensure that a change of Leadership would not disrupt progress.

Overall the appraisal had identified positive feedback:

- He works well with the Chief Executive, the Board and Council of Governors.
- He provides strategic insight and steerage through challenging times.
- The Governors felt engaged and to have status within the Trust which is not necessarily experienced in other Trusts.
- The NEDs felt Andrew was performing strongly and making significant contributions to performance of the Trust in a difficult challenging environment. The board meetings seemed to be more focused, prioritised and strategy more prominent, but a consistent feedback was there still needed to be more concise Board meetings.
- The challenges going forward were noted with new appointments and a challenging strategic agenda

OUTCOME: The Council of Governors **APPROVED** the Chair Appraisal

UPDATE FROM BOARD SUB COMMITTEES

53/17 AUDIT AND RISK COMMITTEE

It was noted that the Annual Report and Accounts were now available on the Trust Website.

54/17 FINANCE AND PERFORMANCE COMMITTEE

It was noted that the next meeting was scheduled for 1 August 2017. The contents of the Finance Report given earlier in the meeting were noted.

55/17 QUALITY COMMITTEE

It was noted that the next meeting was scheduled for 31 July 2017 and the agenda was very inclusive and detailed.

56/17 CHARITABLE FUNDS COMMITTEE

The Chairman reported that arrangements were being made to increase activity with the help of students from Huddersfield University.

57/17 WORKFORCE WELL-LED COMMITTEE

In Rosemary's absence the Company Secretary gave a brief overview of the issues discussed at the last meeting held on the 8 June 2017:-

- Progress with EPR
- E-Rostering "Allocate" system now being used
- Response to 2016 Staff Survey and action plan developed.

58/17 PATIENT EXPERIENCE AND CARING GROUP

Lynn Moore updated the Council of Governors on the issues discussed at the last meeting which included:-

- Communications between clinicians and patients
- Clinical treatment
- Patient care
- Task and finish group to be established
- The 'End of Life' video would be shared with the CoG at the Development Day on the 24 July 2017.

59/17 ORGAN DONATION COMMITTEE

The Chairman reported that the Committee was in the process of appointing a new Medical Lead and work continued with Healthwatch to encourage members of the public to join the register.

OUTCOME: The Council of Governors **RECEIVED** the updates from Sub Committees/Groups.

60/17 INFORMATION TO RECEIVE

The following information was received and noted:

a. Updated Council Calendar – updated calendar received and the contents were noted.

b. Extract from Quarter 4 Quality Report re Complaints and PALs
The Executive Director of Nursing reported that this information had been supplied to the Membership Council for information and offered an overall view of the Trust's management of the current position with regard to complaints and PALs contacts received during Quarter 4.

61/17 ANY OTHER BUSINESS

a. The Chief Operating Officer reported that the Health Visiting Team had transferred to Locala at the end of June.

b. Peter Middleton asked for assurance that the Trust had systems in place to avoid maverick surgeons/staff from committing criminal acts. The Executive Medical Director advised that all doctors go through revalidation and appraisal when complaints and other metrics are scrutinised. Any issues of concern would be brought to the attention of the Medical Director. Scrutiny of any issues would be highlighted through monthly clinical audits and external scrutiny is provided through MDTs.

c. The Chairman reported that as this would be the last formal meeting for a number of Governors including Peter, Grenville, George, Bob, Mary and Dawn he wished to formally place on record his thanks for their help and support.

62/17 DATE AND TIME OF NEXT MEETING

Thursday 26 October 2017 commencing at 4.00 pm in the Large Training Room, Learning Centre, CRH.

The Chair thanked everyone for their contribution and closed the meeting at 6.30 pm.

5. Matters Arising
a. Discharge Lounge – Presentation from: Bev Walker, Associate Director – Urgent Care
Wendy Brawn, Lead for Age UK and Gill Sutillic, Discharge Sister to attend

To Note

6. CHAIRMAN'S REPORT
a.Update from Chairs Information Exchange Meeting – 3.7.17
b.WYATT Update
c.Senior Staff Change

To Note

Presented by Andrew Haigh

7. PERFORMANCE AND STRATEGY
TRUST PERFORMANCE
a.Financial Position and Forecast
b.Performance Report (including Good News Stories)
c.Winter Plan 2017-18
d.Medical Services Reconfiguration

To Note

Presented by Helen Barker

COUNCIL OF GOVERNORS MEETING	
PAPER TITLE: MONTH 5 FINANCIAL REPORT	**REPORTING AUTHOR:** Philippa Russell, Assistant Director of Finance
DATE OF MEETING: 26 October 2017	**SPONSORING DIRECTOR:** Gary Boothby, Director of Finance
STRATEGIC DIRECTION – AREA: • Financial Sustainability	**ACTIONS REQUESTED:** • To note
PREVIOUS FORUMS: Finance and Performance Committee, Board of Directors	
IF THIS IS A POLICY OR A SERVICE CHANGE, HAS IT BEEN EQUIP'd? If so, please provide the unique EQUIP reference number below: **For guidance click on this link:** http://nww.cht.nhs.uk/index.php?id=12474	
EXECUTIVE SUMMARY: (inc. Purpose/Background/Overview/Issue/Next Steps) Summary report on the financial position of Calderdale & Huddersfield NHS Foundation Trust at the end of August 2017.	
FINANCIAL IMPLICATIONS OF THIS REPORT: N/A	
RECOMMENDATION: To note	
APPENDIX ATTACHED: YES	

EXECUTIVE SUMMARY: Trust Financial Overview as at 31st Aug 2017 - Month 5

KEY METRICS

	M5 Plan	M5 Actual	M5 Var	YTD (AUG 2017) Plan	YTD (AUG 2017) Actual	YTD (AUG 2017) Var	Forecast 17/18 Plan	Forecast 17/18 Forecast	Forecast 17/18 Var
	£m	£m	£m	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit) Control Total basis	(£2.37)	(£2.35)	£0.01	(£11.08)	(£11.05)	£0.03	(£15.94)	(£15.94)	(£0.00)
Agency Expenditure	(£1.25)	(£1.24)	£0.02	(£7.60)	(£6.62)	£0.98	(£16.86)	(£14.78)	£2.08
Capital	£1.24	£0.50	£0.74	£9.05	£5.76	£3.29	£14.39	£14.39	£0.00
Cash	£1.91	£1.92	£0.01	£1.91	£1.92	£0.01	£1.91	£1.90	(£0.01)
Borrowing (Cumulative)	£78.76	£79.97	£1.20	£78.76	£79.97	£1.20	£87.62	£88.37	£0.75
CIP	£1.10	£1.05	(£0.06)	£5.44	£3.97	(£1.47)	£20.00	£20.00	£0.00
Use of Resource Metric	3	3		3	3		3	3	

INCOME AND EXPENDITURE SUMMARY

	M5 Plan	M5 Actual	M5 Var	YTD (AUG 2017) Plan	YTD (AUG 2017) Actual	YTD (AUG 2017) Var	Forecast 17/18 Plan	Forecast 17/18 Forecast	Forecast 17/18 Var
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Total Income	**£30.66**	**£30.39**	**(£0.27)**	**£154.93**	**£149.40**	**(£5.53)**	**£374.74**	**£370.17**	**(£4.57)**
Pay	(£20.26)	(£20.23)	£0.03	**(£102.65)**	**(£101.39)**	**£1.26**	**(£241.10)**	**(£239.81)**	**£1.28**
Non Pay	(£10.65)	(£10.84)	(£0.20)	**(£53.01)**	**(£49.02)**	**£3.99**	**(£124.55)**	**(£121.06)**	**£3.49**
Total Expenditure	**(£30.91)**	**(£31.07)**	**(£0.16)**	**(£155.67)**	**(£150.41)**	**£5.25**	**(£365.65)**	**(£360.87)**	**£4.78**
EBITDA	**(£0.25)**	**(£0.68)**	**(£0.43)**	**(£0.74)**	**(£1.02)**	**(£0.28)**	**£9.09**	**£9.30**	**£0.21**
Non Operating Expenditure	(£2.11)	(£2.11)	(£0.00)	(£24.31)	(£10.51)	£13.80	(£38.93)	(£39.68)	(£0.75)
Surplus / (Deficit)	**(£2.36)**	**(£2.79)**	**(£0.43)**	**(£25.04)**	**(£11.52)**	**£13.52**	**(£29.84)**	**(£30.38)**	**(£0.54)**
Less: Items excluded from Control Total	(£0.01)	£0.01	£0.02	£13.96	£0.04	(£13.92)	£13.90	£13.91	£0.01
Less: Loss of STF funding	£0.00	£0.43	£0.43	£0.00	£0.43	£0.43	£0.00	£0.53	£0.53
Surplus / (Deficit) Control Total basis	**(£2.37)**	**(£2.35)**	**£0.01**	**(£11.08)**	**(£11.05)**	**£0.03**	**(£15.94)**	**(£15.94)**	**(£0.00)**

CLINICAL ACTIVITY

	M5 Plan	M5 Actual	M5 Var	YTD (AUG 2017) Plan	YTD (AUG 2017) Actual	YTD (AUG 2017) Var	Forecast 17/18 Plan	Forecast 17/18 Forecast	Forecast 17/18 Var
Elective	678	481	(198)	3,317	2,607	(710)	7,958	6,983	(975)
Non-Elective	3,994	4,035	41	20,938	22,697	1,759	50,873	52,620	1,747
Daycase	3,282	3,238	(43)	15,915	14,489	(1,426)	38,132	36,402	(1,731)
Outpatient	30,707	28,698	(2,009)	149,907	132,874	(17,034)	359,602	335,113	(24,489)
A&E	12,314	12,088	(226)	64,790	63,185	(1,605)	155,414	153,809	(1,605)
Other NHS Non-Tariff	127,438	143,400	15,962	668,748	689,943	21,196	1,622,193	1,705,658	83,465
Other NHS Tariff	11,011	10,363	(649)	55,432	51,056	(4,376)	133,242	122,547	(10,695)
Total	**189,425**	**202,303**	**12,878**	**979,047**	**976,851**	**(2,196)**	**2,367,414**	**2,413,131**	**45,717**

- **Reported year to date deficit position of £11.05m in line with agreed control total of £11.08m;**
- **Delivery of CIP is behind the planned level at £3.97m against a planned level of £5.44m;**
- **Capital expenditure is £3.29 below plan due to revised timescales;**
- **Cash position stands at £1.92m as planned;**
- **A Use of Resources score of level 3, in line with the plan.**

The Month 5 reported position is a deficit in line with the planned £11.08m on a control total basis. However, there is an underlying adverse variance from plan due to the loss of £0.43m Sustainability and Transformation funding (STF) based on A&E performance. The financial position remains extremely precarious with activity and income continuing to be below the planned level and underperformance on CIP starting to impact.

The underlying financial shortfall against the financial plan in the year to date is £7.1m. This is largely driven by the shortfall in activity, offset by the release of five sixths of the Trust's contingency reserves for the year alongside a number of non-recurrent benefits.

M5 position prior to action: adverse variance to plan	**(£7.1m)**
Non-recurrent benefits M2	£1.1m
Non-recurrent benefits M3	£1.5m
Non-recurrent benefits M4	£2.0m
Non-recurrent benefits M5	£0.8m
Release of Contingency Reserves	£1.7m
Month 5 position to report: nil variance to plan	**£0.0m**

The Trust continues to forecast achievement of its Control Total and in so doing would secure the 70% of the STF allocation that is linked to financial performance. The forecast also assumes that the Q3 and Q4 A&E performance related STF funding is secured. However, in order to achieve financial balance, activity would need to return to the planned level from September, with no further EPR related income losses and any costs incurred as a result of the EPR stabilisation plan would need to be offset with additional savings. It is also reliant on finding a further £6.4m CIP that is currently unidentified in order to deliver the full £20m CIP target. The risk of failing to achieve our target deficit of £15.94m therefore remains extremely high and further action is required to stabilise the financial position.

Trust Financial Overview as at 31st Aug 2017 - Month 5

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M5

CLINICAL ACTIVITY

	M5 Plan	M5 Actual	Var
Elective	3,317	2,607	(710)
Non-Elective	20,938	22,697	1,759
Daycase	15,915	14,489	(1,426)
Outpatient	149,907	132,874	(17,034)
A&E	64,790	63,185	(1,605)
Other NHS Non-Tariff	668,748	689,943	21,196
Other NHS Tariff	55,432	51,056	(4,376)
Total	**979,047**	**976,851**	**(2,196)**

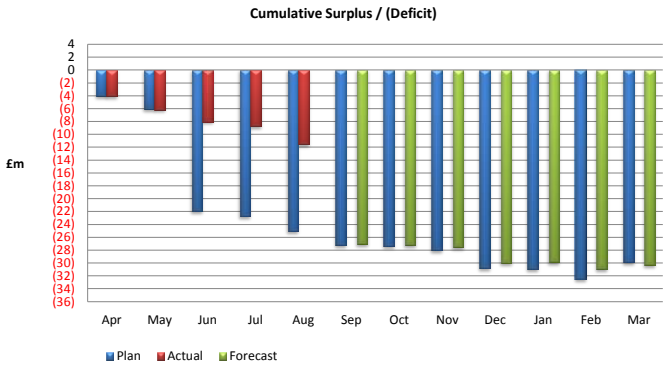
TRUST: INCOME AND EXPENDITURE

	M5 Plan	M5 Actual	Var
	£m	£m	£m
Elective	£9.32	£7.96	(£1.36)
Non Elective	£39.64	£41.14	£1.50
Daycase	£11.06	£10.40	(£0.65)
Outpatients	£17.44	£15.89	(£1.55)
A & E	£8.02	£7.51	(£0.51)
Other-NHS Clinical	£49.40	£46.33	(£3.07)
CQUIN	£2.91	£2.78	(£0.14)
Other Income	£17.14	£17.39	£0.24
Total Income	**£154.93**	**£149.40**	**(£5.53)**
Pay	(£102.65)	(£101.39)	£1.26
Drug Costs	(£14.43)	(£14.34)	£0.09
Clinical Support	(£13.67)	(£12.46)	£1.21
Other Costs	(£19.84)	(£17.15)	£2.69
PFI Costs	(£5.08)	(£5.08)	£0.00
Total Expenditure	**(£155.67)**	**(£150.41)**	**£5.25**
EBITDA	**(£0.74)**	**(£1.02)**	**(£0.28)**
Non Operating Expenditure	(£24.31)	(£10.51)	£13.80
Surplus / (Deficit)	**(£25.04)**	**(£11.52)**	**£13.52**
Less: Items excluded from Control Total	£13.96	£0.04	(£13.92)
Less: Loss of STF funding	£0.00	£0.43	£0.43
Surplus / (Deficit) Control Total basis	**(£11.08)**	**(£11.05)**	**£0.03**

DIVISIONS: INCOME AND EXPENDITURE

	M5 Plan	M5 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	£8.07	£5.07	(£3.00)
Medical	£11.78	£11.50	(£0.28)
Families & Specialist Services	(£0.96)	(£2.49)	(£1.53)
Community	£1.07	£1.33	£0.26
Estates & Facilities	(£10.74)	(£10.96)	(£0.22)
Corporate	(£12.61)	(£12.01)	£0.60
THIS	(£0.09)	(£0.20)	(£0.11)
PMU	£1.11	£1.08	(£0.03)
Central Inc/Technical Accounts	(£21.88)	(£4.84)	£17.05
Reserves	(£1.67)	£0.00	£1.67
Unallocated CIP	£0.88	£0.00	(£0.88)
Surplus / (Deficit)	**(£25.04)**	**(£11.52)**	**£13.52**

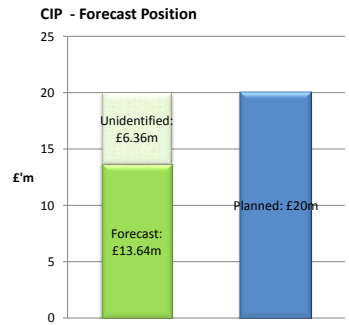
TRUST SURPLUS / (DEFICIT)

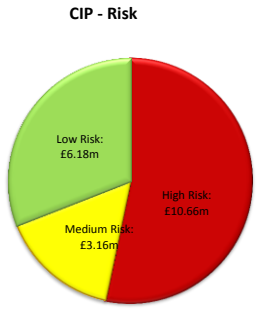


KEY METRICS

	Year To Date			Year End: Forecast		
	M5 Plan	M5 Actual	Var	Plan	Forecast	Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	(£11.08)	(£11.05)	£0.03	(£15.94)	(£15.94)	£0.00
Capital	£9.05	£5.76	£3.29	£14.39	£14.39	£0.00
Cash	£1.91	£1.92	£0.01	£1.91	£1.90	(£0.01)
Loans	£78.76	£79.97	£1.20	£87.62	£88.37	£0.75
CIP	£5.44	£3.97	(£1.47)	£20.00	£20.00	£0.00
	Plan	Actual		Plan	Forecast	
Use of Resource Metric	3	3		3	3	

COST IMPROVEMENT PROGRAMME (CIP)





Total Planned: **£20m**

Total Forecast **£20m**

YEAR END 2017/18

CLINICAL ACTIVITY

	Plan	Actual	Var
Elective	7,958	6,983	(975)
Non-Elective	50,873	52,620	1,747
Daycase	38,132	36,402	(1,731)
Outpatient	359,602	335,113	(24,489)
A&E	155,414	153,809	(1,605)
Other NHS Non- Tariff	1,622,193	1,705,658	83,465
Other NHS Tariff	133,242	122,547	(10,695)
Total	**2,367,414**	**2,413,131**	**45,717**

TRUST: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£22.36	£20.67	(£1.69)
Non Elective	£95.53	£97.02	£1.49
Daycase	£26.51	£25.61	(£0.90)
Outpatients	£41.84	£39.53	(£2.30)
A & E	£19.24	£18.73	(£0.51)
Other-NHS Clinical	£122.22	£120.96	(£1.26)
CQUIN	£6.99	£6.79	(£0.21)
Other Income	£40.05	£40.86	£0.81
Total Income	**£374.74**	**£370.17**	**(£4.57)**
Pay	(£241.10)	(£239.81)	£1.28
Drug Costs	(£35.34)	(£34.62)	£0.70
Clinical Support	(£32.76)	(£30.42)	£2.34
Other Costs	(£44.27)	(£43.61)	£0.65
PFI Costs	(£12.19)	(£12.41)	(£0.22)
Total Expenditure	**(£365.65)**	**(£360.87)**	**£4.78**
EBITDA	**£9.09**	**£9.30**	**£0.21**
Non Operating Expenditure	(£38.93)	(£39.68)	(£0.74)
Surplus / (Deficit)	**(£29.84)**	**(£30.38)**	**(£0.53)**
Less: Items excluded from Control Total	£13.90	£13.91	£0.01
Less: Loss of STF funding	£0.00	£0.53	£0.53
Surplus / (Deficit) Control Total basis	**(£15.94)**	**(£15.94)**	**£0.00**

DIVISIONS: INCOME AND EXPENDITURE

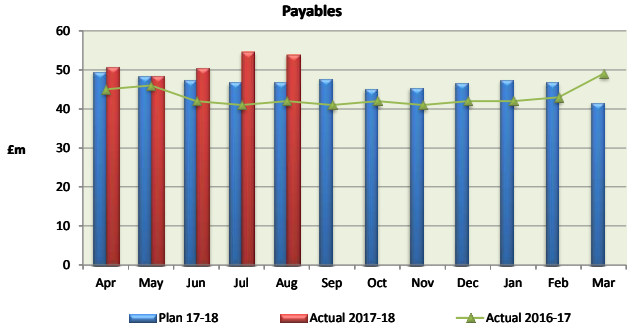
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	£21.22	£20.17	(£1.05)
Medical	£28.75	£28.50	(£0.24)
Families & Specialist Services	(£0.66)	(£1.71)	(£1.05)
Community	£2.36	£2.35	(£0.00)
Estates & Facilities	(£25.65)	(£25.91)	(£0.26)
Corporate	(£30.16)	(£30.16)	£0.00
THIS	£0.03	£0.03	£0.00
PMU	£2.75	£2.75	(£0.00)
Central Inc/Technical Accounts	(£29.77)	(£31.17)	(£1.39)
Reserves	(£2.00)	£0.15	£2.15
Unallocated CIP	£3.30	£4.61	£1.31
Surplus / (Deficit)	**(£29.84)**	**(£30.38)**	**(£0.53)**

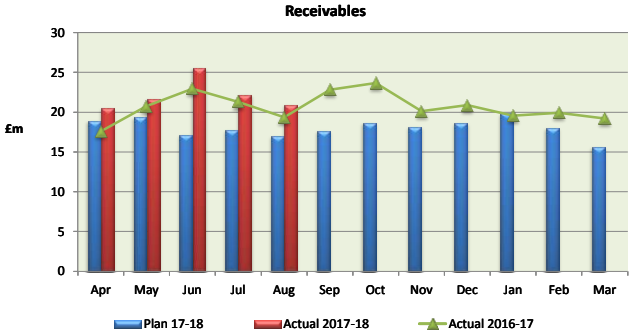
Trust Financial Overview as at 31st Aug 2017 - Month 5

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

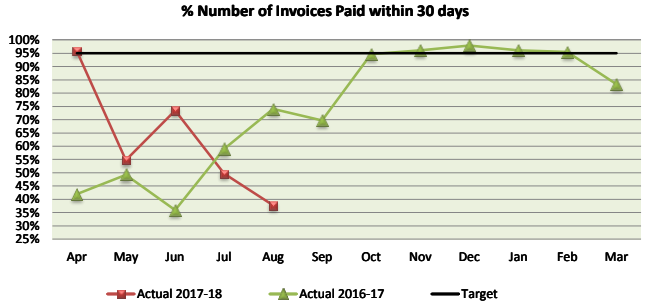
WORKING CAPITAL

	M5 Plan £m	M5 Actual £m	Var £m	M5
Payables	(£46.95)	(£53.83)	£6.88	
Receivables	£16.98	£20.89	(£3.91)	



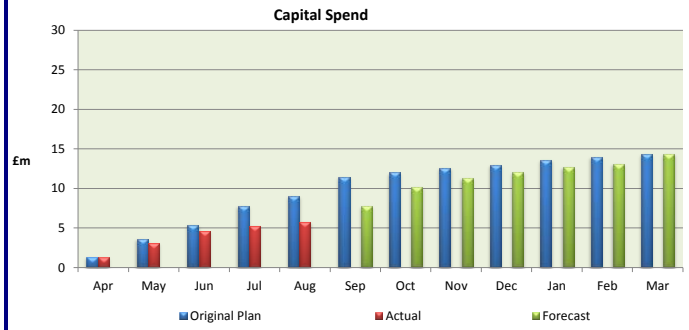


BETTER PAYMENT PRACTICE CODE



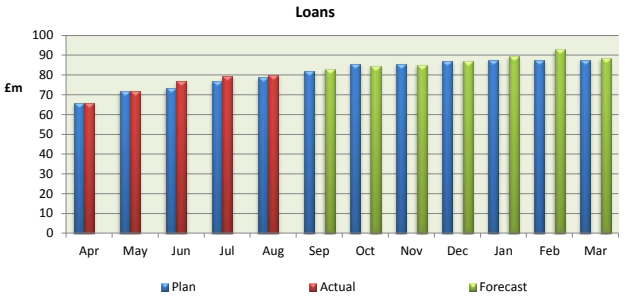
CAPITAL

	M5 Plan £m	M5 Actual £m	Var £m	M5
Capital	£9.05	£5.76	£3.29	

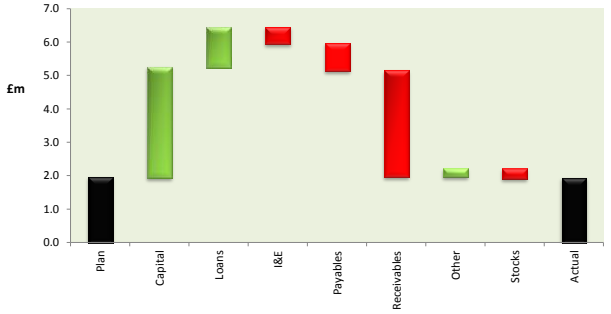


CASH

	M5 Plan £m	M5 Actual £m	Var £m	M5
Cash	£1.91	£1.92	£0.01	
Loans (Cumulative)	£78.76	£79.97	£1.20	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The year to date deficit is £11.52m versus a planned deficit of £25.04m. This £13.52m favourable variance includes £0.43m Loss of STF funding linked to A&E performance, offset by a £13.92m net benefit excluded for Control Total purposes: delayed £14m planned impairment and the I&E impact of Donated Assets (£0.04m).
- The year to date position assumes receipt of Sustainability and Transformation Funding (STF) of £2.43m, £0.43m less than the planned £2.86m, due to A&E performance against the 4 hour target being below trajectory for Month's 1-5.
- Activity continued to be behind plan year to date, with lower than planned Outpatient, A&E, Daycase and Elective activity. In addition to this underlying underperformance, £1.20m of clinical income has been included as an estimate to reflect coding and capture issues linked to EPR implementation.
- Capital expenditure year to date is behind plan at £5.76m against a planned £9.05m.
- Cash balance is £1.92m, in line with above the planned level of £1.91m.
- Trust borrowing is above the planned level. Year to date the Trust has borrowed £13.94m to support the deficit and delayed Q1 STF funding.
- CIP schemes have delivered £3.97m, £1.47m less than the year to date target of £5.33m. The year to date plan includes £0.8m of the £3m stretch target required to bridge between £17m and £20m CIP.
- The revised NHS Improvement performance metric Use of Resource (UOR) stands at 3 against a planned level of 3. Of the five metrics that make up the UOR, all are as planned except the I&E Margin Variance which shows an unfavourable variance - rated as a 2 (planned as 1).

NOTES

- The Trust is forecasting to achieve the planned year end Control Total deficit of £15.93m. This excludes loss of STF Funding of £0.53m, a planned £14m impairment and the I&E impact of Donated Assets which are excluded from the deficit for Control Total purposes and therefore have no impact on the financial performance element of the STF allocation.
- The forecast assumes receipt of the £9.57m STF Funding, £0.53m less than the planned value of £10.1m due to the assumed loss of funding for Quarters 1 and 2 based on A&E four hour performance in the year to date.

The forecast assumes recovery of £1.20m estimated clinical income and a return to planned activity levels from Month 6.

- The forecast assumes full delivery of the £20m CIP target, of which only £13.64m is currently forecast to deliver, leaving a gap of £6.36m to identify.
- The Trust cash position is forecast as planned at £1.90m. The total borrowing requirement is £28.76m in this financial year to support both Capital and Revenue plans. The total loan balance by year end is forecast to be £87.84m, £0.75m higher than planned based on forecast deficit and working capital requirements.
- Capital expenditure is forecast for the full year as planned at £14.39m, supported by the final £8m instalment of an existing Capital Loan facility.

RAG KEY: (Excl: UOR)

- Actual / Forecast is on plan or an improvement on plan
- Actual / Forecast is worse than planned by <2%
- Actual / Forecast is worse than planned by >2%

NB. In addition to the above rules, if Capital expenditure <85% of that planned then Red, (per NHSI risk indicator).

RAG KEY: UOR

- All UOR metrics are at the planned level
- Overall UOR as planned, but one or more component metrics are worse than planned
- Overall UOR worse than planned

Calderdale and Huddersfield NHS Foundation Trust

COUNCIL OF GOVERNORS	
PAPER TITLE: **QUALITY & PERFORMANCE REPORT/PERFORMANCE ACHIEVEMENT SLIDES**	**REPORTING AUTHOR: P Keogh**
DATE OF MEETING: 26th October 2017	**SPONSORING DIRECTOR: H Barker**
STRATEGIC DIRECTION – AREA: • Keeping the base safe • A workforce for the future • Financial Sustainability	**ACTIONS REQUESTED:** • To note
PREVIOUS FORUMS: Executive Board, Quality Committee, Finance and Performance Committee, Board of Directors	
IF THIS IS A POLICY OR A SERVICE CHANGE, HAS IT BEEN EQUIP'd? If so, please provide the unique EQUIP reference number below: **For guidance click on this link:** http://nww.cht.nhs.uk/index.php?id=12474	
EXECUTIVE SUMMARY: August's Performance Score stands at 60% for the Trust, an 8 point improvement in-month. The RESPONSIVE domain has improved to AMBER following achievement of Cancer 2 week wait target and both Cancer 62 day targets. Finance domain has improved to Amber with variance from plan and agency expenditure on plan in-month. All domains have improved performance with the exception of WORKFORCE which is now RED due to short-terms sickness YTD and 4 out of 5 Mandatory Training areas missing target.	
FINANCIAL IMPLICATIONS OF THIS REPORT: N/A	
RECOMMENDATION: To note the contents of the report and the overall performance score for August.	
APPENDIX ATTACHED: YES	

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Board Report

August 2017

Report Produced by : The Health Informatics Service

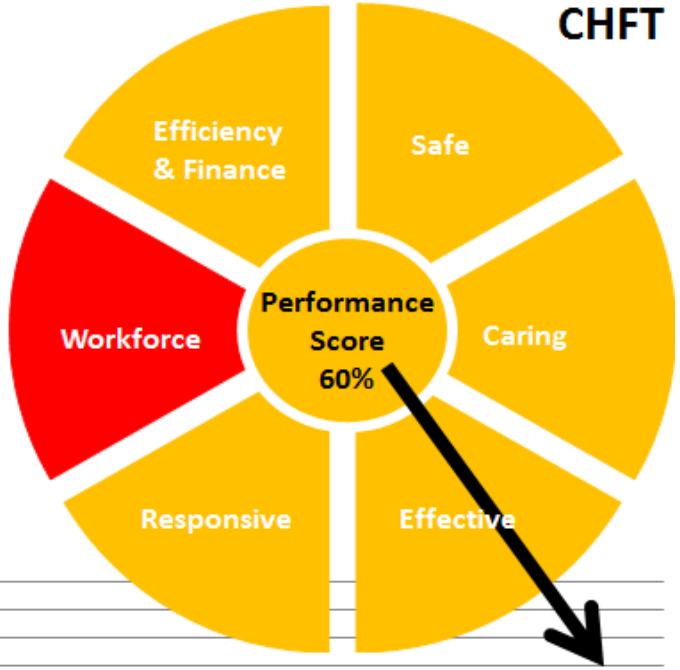
DataSource : various data sources syndication by VISTA

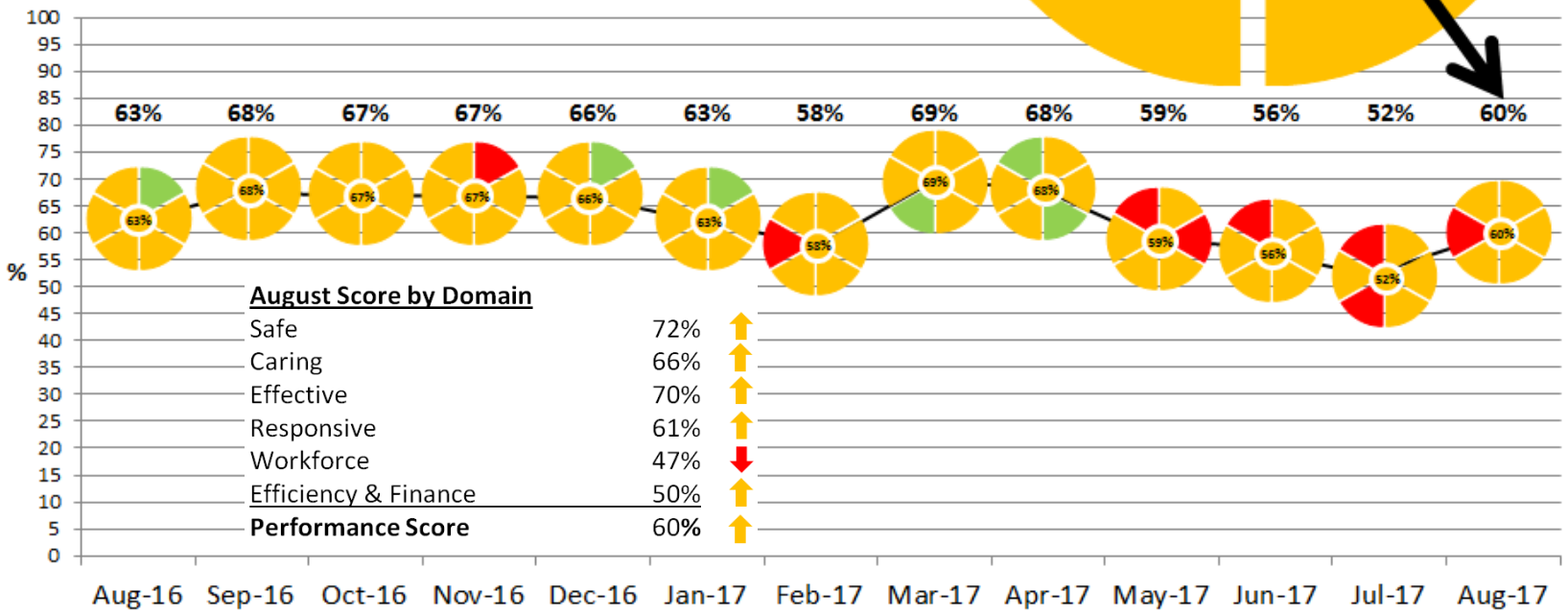
Performance Summary

August

RAG Movement

August's Performance Score stands at 60% for the Trust, an 8 point improvement in-month. The RESPONSIVE domain has improved to AMBER following achievement of Cancer 2 week wait target and both Cancer 62 day targets. Finance domain has improved to Amber with variance from plan and agency expenditure on plan in-month. All domains have improved performance with the exception of WORKFORCE which is now RED due to short-terms sickness YTD and 4 out of 5 Mandatory Training areas missing target.





August Score by Domain

Safe	72%
Caring	66%
Effective	70%
Responsive	61%
Workforce	47%
Efficiency & Finance	50%
Performance Score	60%

SINGLE OVERSIGHT FRAMEWORK

SAFE	Emergency C-Section Rate
VTE Assessments	Never Events
CARING	FFT A&E
FFT Community FFT OP	FFT Maternity FFT IP
Mixed sex accommodation breaches	% Complaints closed
EFFECTIVE	
CDiff Cases	Avoidable Cdiff
MRSA	SHMI
HSMR	HSMR - Weekend
Emergency Readmissions GHCCG	Emergency Readmissions CCCG

RESPONSIVE	Diagnostics 6 weeks
RTT Incomplete Pathways	ECS 4 hours
Cancer 62 day Screening to Treatment	Cancer 62 day Referral to Treatment
FINANCE	
Variance from Plan	Use of Resources
WORKFORCE	
Proportion of Temporary Staff	Sickness
Staff turnover	Executive Turnover

Safe | Caring | Effective | Responsive | Workforce | Efficiency/Finance | Activity | CQUIN

Carter Dashboard

		Current Month Score	Previous Month	Trend	Target
CARING	Friends & Family Test (IP Survey) - % would recommend the Service	97.2%	96.1%	↑	96.3%
	Inpatient Complaints per 1000 bed days	1.8	2.1	↓	TBC
EFFECTIVE	Average Length of Stay - Overall	4.70	4.77	↑	5.17
	Delayed Transfers of Care	4.54%	3.32%	↓	5%
	Green Cross Patients (Snapshot at month end)	104	107	↑	40
	Hospital Standardised Mortality Rate (1 yr Rolling Data)	93.24	95.83	↑	100
	Theatre Utilisation (TT) - Trust	81.6%	83.0%	↓	92.5%
RESPONSIVE	% Last Minute Cancellations to Elective Surgery	0.69%	1.05%	↑	0.6%
	Emergency Care Standard 4 hours	93.59%	93.45%	↑	95%
	% Incomplete Pathways <18 Weeks	92.12%	92.63%	↓	92%
	62 Day GP Referral to Treatment	91.5%	83.3%	↑	85%
SAFE	% Harm Free Care	93.18%	94.27%	↓	95.0%
	Number of Outliers (Bed Days)	547	491	↓	495
	Number of Serious Incidents	7	9	↑	0
	Never Events	0	0	↔	0

MOST IMPROVED

Improved: Hospital Standardised Mortality Rate (HSMR) continues to improve with latest 12 month figure at 93.24.

Improved: Crude Mortality Rate in August is at its lowest rate since September 2016.

Improved: Two Week Wait From Referral to Date First Seen/38 Day Referral to Tertiary - 2 week waits recovered well from last 3 months' performance and 38 day referral to tertiary at its highest position in 12 months at 62.5%.

MOST DETERIORATED

Deteriorated: Mandatory Training and Appraisals. Across the divisions Appraisals are below target. 4 out of 5 elements in focus are behind plan within Mandatory Training with only Fire Safety on plan.

Deteriorated: Theatre Utilisation - Main Theatres - % utilisation on both sites is lowest level in last 12 months.

Deteriorated: Emergency C-Section Rate - August rate is the highest in the last 12 months at 16.6%.

TREND ARROWS:
Red or Green depending on whether target is being achieved
Arrow upwards means improving month on month
Arrow downwards means deteriorating month on month.

ACTIONS

Action: Appraisal training sessions with the HR Business Partners have taken place with further sessions scheduled in September. Where appraisal compliance is below the planned trajectory there has been direct intervention from General Managers and/or Matrons and recovery plans devised with Line Managers, which involve rescheduling of appraisals to ensure all are completed before 31st October. All line managers have been sent mandatory training lists for their teams, which show compliance across the 9 elements and mandatory training profilers have been created for Divisions to plan dates for the 5 elements in focus.

Action: Task and Finish group established to review cancelled operations and reasons. Anticipated impact is a reduction in on-day cancellations and a corresponding improvement in touchtime.

Action: A detailed analysis has commenced that will look at specific factors, impact on outcomes and compliance with guidance and theatre Standard Operating Procedures.

Arrow direction count ↔ 1 ↑ 10 ↓ 8

PEOPLE, MANAGEMENT & CULTURE: WELL-LED	Current Month Score	Previous Month	Trend	Target
Doctors Hours per Patient Day				
Care Hours per Patient Day	7.8	7.6	↑	
Sickness Absence Rate	4.13%	4.14%	↑	4.0%
Turnover rate (%) (Rolling 12m)	13.16%	13.13%	↓	12.3%
Vacancy	400.11	374.98	↓	NA
FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q1	81.2%	Different division sampled each quarter. Comparisons not applicable		
FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly) Q1	62.8%	Different division samples each quarter. Comparisons not applicable		

OUR MONEY	Current Month Score	Previous Month	Trend
Income vs Plan var (£m)	-£5.53	-£5.27	🔴
Expenditure vs Plan var (£m)	£5.25	£5.42	🟢
Liquidity (Days)	-30.94	-28.09	🔴
I&E: Surplus / (Deficit) var - Control Total basis (£m)	£0.03	£0.02	🟢
CIP var (£m)	-£1.47	-£1.41	🔴
UOR	3	3	🟡
Temporary Staffing as a % of Trust Pay Bill	12.37%	13.16%	🔴

Executive Summary

The report covers the period from August 2016 to allow comparison with historic performance. However the key messages and targets relate to August 2017 for the financial year 2017/18.

Area	Domain
Safe	• **% Harm Free Care** - Performance remains within normal variation, declining slightly in-month to 93.18%. All divisions below target with the exception of FSS with Medicine worst position at 90.86%. • **Number of Category 4 Pressure Ulcers Acquired at CHFT** - 2 Category 4 pressure ulcers within Medicine. An investigation and action plan is currently being worked through.
Caring	• **Complaints closed within timeframe** - Of the 37 complaints closed in July, 47% were closed within target timeframe. The overall percentage for complaints closed within target timeframe last year (2016-17) was 45%. • **Friends and Family Test Outpatients Survey - % would recommend the Service** - Performance is still not achieving target. The task and finish group has identified areas for testing improvements. • **Friends and Family Test A & E Survey - Response Rate** - has fallen slightly to 11.7% in-month. Leads have been identified on both sites who will drive the FFT completion through the minors stream. • **Friends and Family Test A & E Survey - % would recommend the Service** - still just below 86.5% target. CRH is performing well whilst HRI needs to improve. Some focused work on communication and customer care has been identified. • **Friends and Family Test Community Survey** - Community FFT reported 86% would recommend the service against a 96% national average. A new server has been installed meaning that the web form can be used predominantly to collect FFT.
Effective	• **Stillbirths Rate and Neonatal Deaths** - There were 3 still births and 1 early neonatal death in August. • **Mortality Reviews** - The new Learning from Deaths policy was approved in August which describes the ambition to perform initial screening reviews on all deaths plus Structured Judgment Reviews (SJR) on selected cases from September. Expect improvements to be visible in the data from October, an additional measure will appear to record the % of applicable cases undergoing SJR. • **% Sign and Symptom as a Primary Diagnosis** - Since EPR go live the % Sign and Symptom has increased. This is due to documentation within Power Chart and the admitting primary diagnosis not being updated to the diagnosis at discharge. Communication is to go out from the Medical Director's office to clinical teams to highlight the issue and impact of the increase on HSMR and income. • **Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge** - August's performance improved to 76%. CHFT has changed the process so there is better visibility of all Trauma patients which should improve the planning generally and improve the hip fracture patients having surgery in a timely way.

Background Context

The CQC preparedness has continued across the Trust in August with the collation of evidence for self assessment.

EPR deployment stabilisation continues with improved inpatient utilisation both medical and nursing. Issues remain with booking and outpatient services with a direct impact on efficiency and productivity.

Work has continued in August to ensure clinical activity is recorded and captured accurately.

Counting and coding is improving but has still not returned to pre-EPR levels with recovery plans managed through a Data Quality Board. The services of an external data quality team remain on site.

Whilst ECS performance has not been sustained at 95% the Trust remains on an upward trajectory. Delivery of the ECS has been challenging throughout August during the evenings and nights at HRI. The Urgent Care action plan has been developed and is key to getting long standing issues back on track.

Work on reconfiguring Cardiology, Respiratory and Elderly Services has continued with details being finalised in the business case.

Work continues to assess IPC compliance and standards of cleanliness with a deep cleaning plan in progress across the HRI site.

Executive Summary

The report covers the period from August 2016 to allow comparison with historic performance. However the key messages and targets relate to August 2017 for the financial year 2017/18.

Area	Domain
Responsive	• **Emergency Care Standard 4 hours improved again to 93.6**% for August - The ECS recovery and sustainability Plan actions continue to be worked through and implemented. • **% Diagnostic Waiting List Within 6 Weeks -** just missed the 99% target again with Medicine Echocardiograms underperforming. Longest waiters will be addressed by the end of the month. • **Two Week Wait From Referral to Date First Seen: Breast Symptoms -** missed the 93% for the 3rd month running. There is a new Oncoplastic Surgeon in post. The new outpatient clinic templates will ensure enough capacity for 2 week waits. • **38 Day Referral to Tertiary** - significant improvement in-month to 62.5% - best performance in last 12 months.
Workforce	• **Mandatory Training and Appraisals**. Across the divisions Appraisals are below target. 4 out of 5 elements in focus are behind plan within Mandatory Training with only Fire Safety on plan. A number of activities are taking place between HR Business Partners and divisions to try and improve performance.
Finance	• Finance: Reported year to date deficit position of £11.05m in line with agreed control total of £11.08m; • Delivery of CIP is behind the planned level at £3.97m against a planned level of £5.44m; • Capital expenditure is £3.29m below plan due to revised timescales; • Cash position stands at £1.92m as planned; • A Use of Resources score of level 3, in line with the plan. The Month 5 reported position is a deficit in line with the planned £11.08m on a control total basis. However there is an underlying adverse variance from plan due to the loss of £0.43m Sustainability and Transformation funding (STF) based on ECS performance. The financial position remains extremely precarious with activity and income continuing to be below the planned level and underperformance in CIP starting to impact. The underlying financial shortfall against the financial plan in the year to date is £7.1m. This is largely driven by the shortfall in activity, offset by the release of five sixths of the Trust's contingency reserves for the year alongside a number of non-recurrent benefits. M5 position prior to action: adverse variance to plan (£7.1m) Non-recurrent benefits M2 £1.1m Non-recurrent benefits M3 £1.5m Non-recurrent benefits M4 £2.0m Non-recurrent benefits M5 £0.8m Release of Contingency Reserves £1.7m Month 5 position to report: nil variance to plan £0.0m The Trust continues to forecast achievement of its Control Total and in so doing would secure the 70% of the STF allocation that is linked to financial performance. The forecast also assumes that the Q3 and Q4 ECS performance related to STF is secured. However, in order to achieve financial balance activity would need to return to the planned level from September, with no further EPR related income losses and any costs incurred as a result of the EPR stabilisation plan would need to be offset with additional savings. It is also reliant on finding a further £6.4m CIP that is currently unidentified in order to deliver the full £20m CIP target. The risk of failing to achieve the target deficit of £15.94m therefore remains extremely high and further action is required to stabilise the financial position.

Background Context

Consultant vacancies remain a challenge in Medical specialties particularly AED, Elderly Care and Respiratory which have been further compounded by sickness in Cardiology. Within Surgery there has been an increase in the casemix and length of stay of some patient groups. This has impacted on patient flow even with the lower levels of elective activity. There still remain a number of issues affecting the Division's ability to ensure Outpatient capacity is fully utilised and these require additional resources which will be in place by November. The same process is being followed for Ophthalmology. Ophthalmolgy and General Surgery have been identified as priority areas for the EPR Outpatient workflow review which will help with capacity. Further training is required to support booking staff for the Breast Screening service.

The Community division continues to work collaboratively with primary and social care.

The dressings pathway has been completed and is due to be launched in November with primary care. The launch will coincide with some training for practice nurses by the tissue viability nurse. A phlebotomy pathway is the next pathway to be worked up.

Focus continues to be on developing community models around rehabilitation at home. Once the pathway has been agreed with commissioners this will enable patients who have low level rehabilitation needs to leave hospital earlier.

In recent months there has been significant pressure within Hysteroscopy services following capacity issues relating to the fire within Endoscopy. Recovery plans are now in place and additional sessions will be taking place during the next 2 months.

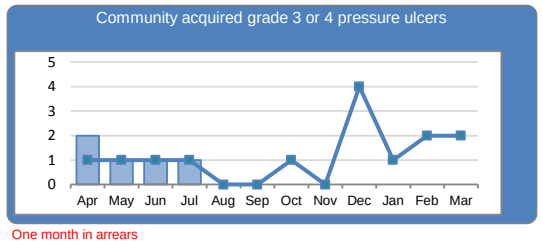
Safe, Effective, Caring, Responsive - Community Key messages

Area	Reality	Response	Result
Safe	Grade 3/4 pressure ulcers The Community division is maintaining a low prevalence of grade 3/4 pressure ulcers with one grade 3 being reported in July.	Grade 3/4 pressure ulcers Continued work is progressing with tissue viability. One senior nurse has been released to focus more dedicated time on wound care and pressure ulcers.	Grade 3/4 pressure ulcers Continue to maintain and improve performance in this area By when: Review October 2017 Accountable: ADN
Effective	Number of hospital admissions avoided There has been an increase in the number of hospital admissions recorded as being avoided this month.	Number of hospital admissions avoided Working with teams to inform them of the importance of recording admission avoidance as an outcome of care will help to demonstrate the effectiveness of community service delivery.	Number of hospital admissions avoided Increased % of interventions recorded as impacting on admission avoidance. By when: November 2017 Accountable: Matron Community Nursing services
Caring	Friends and Family Test The Friends and Family test for community services has consistently shown a poor level of patients who are satisfied with the service where the individual feedback received to services suggests many patients are happy with the service they receive. The current method of collecting FFT is not providing a true reflection of patient opinion and does not help to identify where services could improve their offer in relation to patient feedback.	Friends and family test. A new server has been installed meaning that the web form can be used predominantly to collect FFT. This provides a more robust data collection tool and also provides more accurate and timely feedback to services. It is important to note that response rates will be impacted by changing the methodology.	Friends and family Test An expected improvement FFT will be seen by November 2017 By when: Review November 2017 Accountable: Head of Therapies
Responsiveness	Physiotherapy waiting times Physiotherapy waiting times have improved significantly in August and now stand at 6 weeks compared with 16 week wait in July.	Physiotherapy waiting times The physiotherapy service has commenced a telephone assessment service. This is intended to reduce the number of people requiring face to face contact by a physiotherapist in order to reduce the waiting times and enable that people in need of hands on therapy can receive this in a timely manner. The physiotherapy band 5 new graduates have commenced in post and are being inducted.	Physiotherapy waiting times Physiotherapy waiting times to return to an acceptable performance level by the end of September. By when: September 2017 Accountable: Head of Therapies

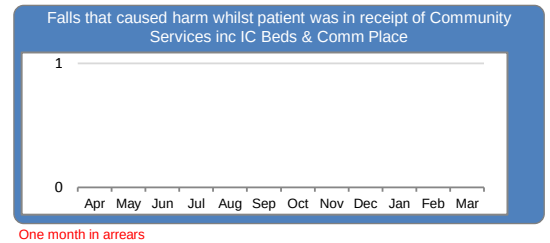
Dashboard - Community

Bar Chart = 17/18 figures Line graph = 16/17 figures

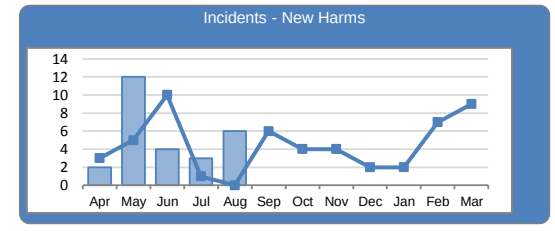
Safe

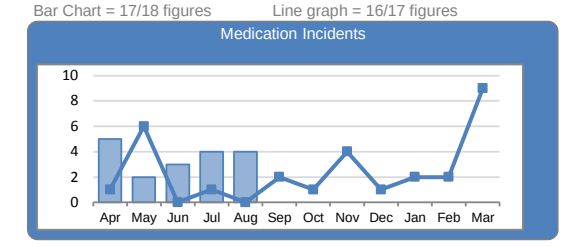


One month in arrears



One month in arrears





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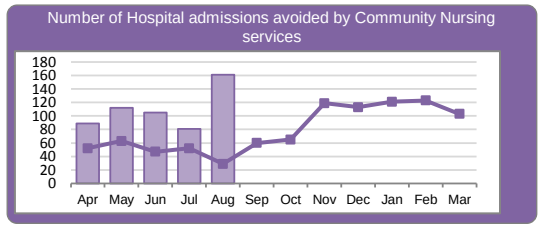
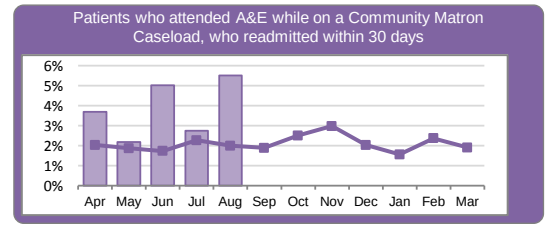
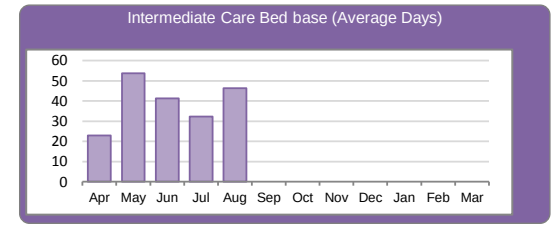
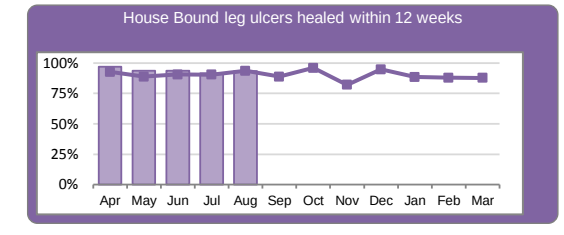
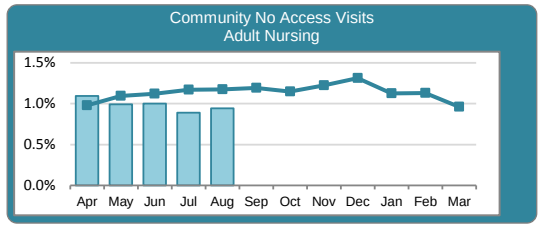


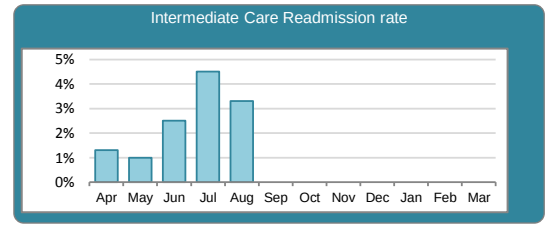


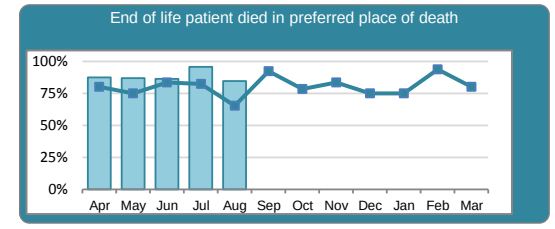


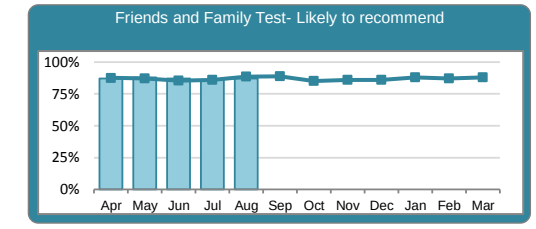


Caring

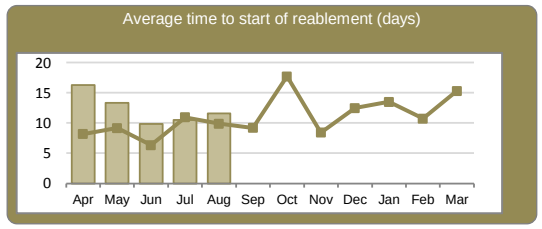


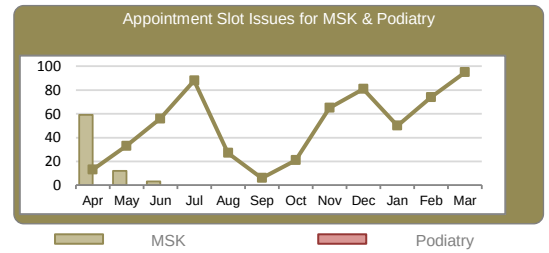


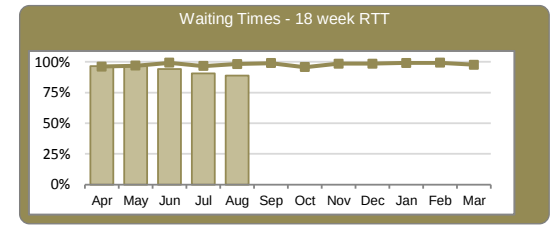


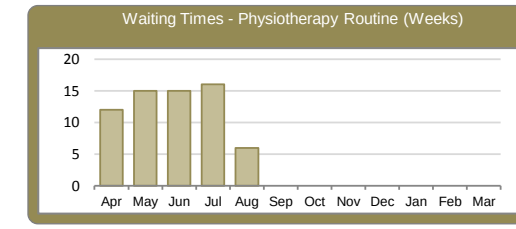


Responsive

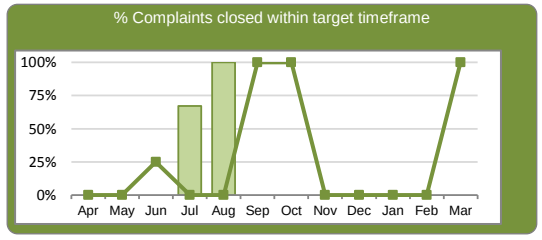


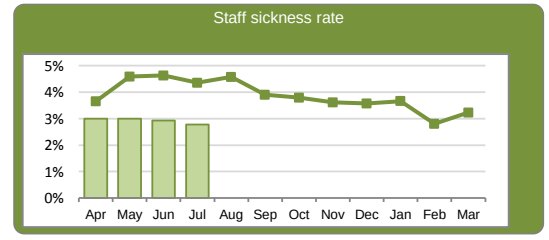




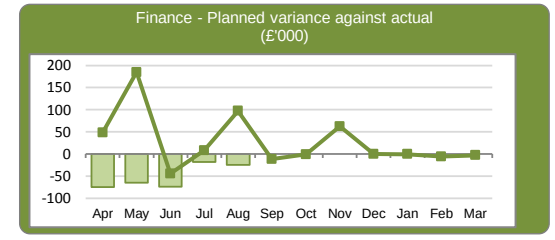


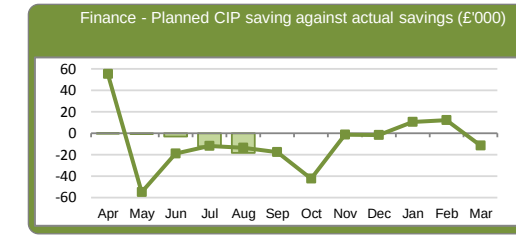
Well Led



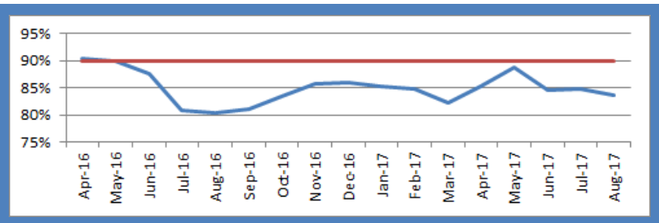
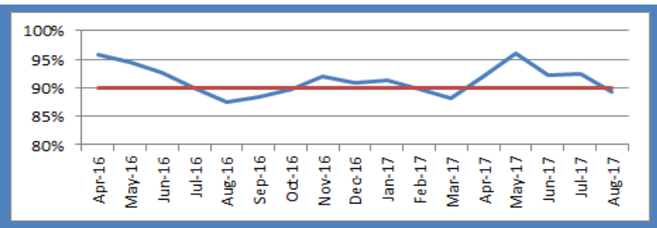
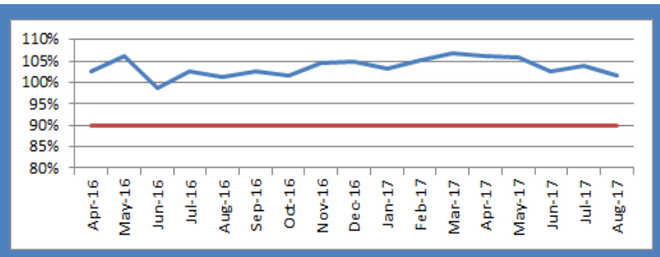
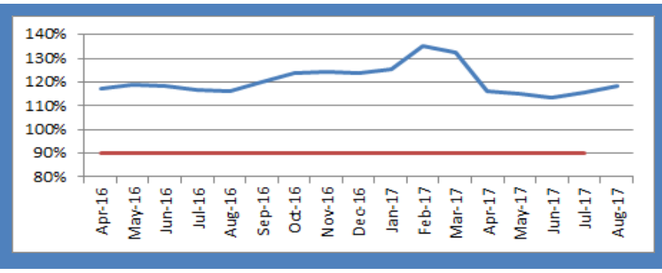


One month in arrears





Hard Truths: Safe Staffing Levels

	Description	Aggregate Position	Trend	Variation	Result
Registered Staff Day Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	83.58% of expected Registered Nurse hours were achieved for day shifts.		Staffing levels at day <75% -WARD 6D : 71.1% -WARD 7BC : 70.3% -WARD 17 : 59.3% -WARD 21 : 69.6%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. This is managed & monitored within the divisions by the matron & senior nursing team to ensure safe staffing against patient acuity & dependency is achieved. The low fill rates reported in August 2017 are attributed to a level of vacancy.
Registered Staff Night Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	89.40 % of expected Registered Nurse hours were achieved for night shifts.		Staffing levels at night <75% -WARD 8 : 68.8% -WARD 8AB : 63.6% -WARD 8D : 72.6% -WARD 10 : 66.7%	The overall fill rates across the two hospital sites maintained agreed safe staffing thresholds. This is managed & monitored within the divisions by the matron & senior nursing team to ensure safe staffing against patient acuity & dependency is achieved. The low fill rates reported in August 2017 are attributed to a level of
Clinical Support Worker Day Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.	101.63 % of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at day <75% -WARD 7BC : 70.7% - WARD 8AB: 58.0% - WARD LDRP : 54.4% - WARD NICU : 51.9%	The low HCA fill rates in August are attributed to flucuating bed capacity & a level of HCA vacancy within the FSS division. This is managed on a daily basis against the acuity of the work load. Recruitment plans are in place for all vacent shifts. Fill rates in excess of 100% can be attributed to supporting 1-1 care requirements; realisation of supervisory time for band 7 registered nurses and for care staff supporting reduced fill rate of registered nurse hours.
Clinical Support Worker Night Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.	118.24 % of expected Care Support Worker hours were achieved for night shifts.		Staffing levels at night <75% -WARD 7BC: 60.0%	The low HCA fill rates in August are attributed to flucuating bed capacity. Fill rates in excess of 100% can be attributed to supporting 1-1 care requirements; realisation of supervisory time for band 7 registered nurses and for care staff supporting reduced fill rate of registered nurse hours.

Hard Truths: Safe Staffing Levels (2)

Staffing Levels - Nursing & Clinical Support Workers

Ward	Main Specialty on Each Ward	DAY						NIGHT					
		Registered Nurses		Care Staff		Average Fill Rate - Registed Nurses (%)	Average Fill Rate - Care Staff (%)	Registered Nurses		Care Staff		Average Fill Rate - Registed Nurses(%)	Average Fill Rate - Care Staff (%)
		Expected	Actual	Expected	Actual			Expected	Actual	Expected	Actual		
CRH MAU	GENERAL MEDICINE	2511	1919.5	1674	1325	76.4%	79.2%	1364	1357	1023	1045	99.5%	102.2%
HRI MAU	GENERAL MEDICINE	2046	1892	1209	1820	92.5%	150.5%	1364	1633	1023	1320	119.7%	129.0%
WARD 2AB	GENERAL MEDICINE	1845	1481.4	1170	1664	80.3%	142.2%	1364	1293	682	1045	94.8%	153.2%
HRI Ward 5 (previously ward 4)	GERIATRIC MEDICINE	1674	1343	1209	1636	80.2%	135.3%	1023	1012	1023	1441	98.9%	140.9%
HRI Ward 11 (previously Ward 5)	CARDIOLOGY	2083.5	1729.45	1014	957	83.0%	94.4%	1364	1320	682	682	96.8%	100.0%
WARD 5AD	GERIATRIC MEDICINE	2139	1764	1581	2143.5	82.5%	135.6%	1364	1333	1364	1458	97.7%	106.9%
WARD 5C	GENERAL MEDICINE	1069.5	1004.5	837	821.5	93.9%	98.1%	682	682	341	407	100.0%	119.4%
WARD 6	GENERAL MEDICINE	1674	1507.5	1209	1126	90.1%	93.1%	1023	968	682	682	94.6%	100.0%
WARD 6BC	GENERAL MEDICINE	1674	1513.5	1209	1196.5	90.4%	99.0%	1364	1311.5	682	746	96.2%	109.4%
WARD 5B	GENERAL MEDICINE	1209	992	744	1281	82.1%	172.2%	682	660	682	1045	96.8%	153.2%
WARD 6A	GENERAL MEDICINE	976.5	815	976.5	743	83.5%	76.1%	682	677	341	358	99.3%	105.0%
WARD CCU	GENERAL MEDICINE	1674	1352.5	372	294.5	80.8%	79.2%	1023	985.5	0	12	96.3%	-
WARD 6D	GENERAL MEDICINE	1674	1191	837	919	71.1%	109.8%	1023	852.25	682	638	83.3%	93.5%
WARD 7AD	GENERAL MEDICINE	1674	1390.3	1581	1759.6	83.1%	111.3%	1023	1012	1023	1210	98.9%	118.3%
WARD 7BC	GENERAL MEDICINE	1674	1176.5	1581	1117	70.3%	70.7%	1023	814	1023	613.5	79.6%	60.0%
WARD 8	GERIATRIC MEDICINE	1441.5	1138.5	1209	1928	79.0%	159.5%	1023	704	1023	1644	68.8%	160.7%
WARD 12	MEDICAL ONCOLOGY	1674	1379	837	832	82.4%	99.4%	1023	877	341	678	85.7%	198.8%
WARD 17	GASTROENTEROLOGY	2046	1213.3	1209	1146	59.3%	94.8%	1023	773	682	685	75.6%	100.4%
WARD 21	REHABILITATION	1209	841	976.5	1245.3	69.6%	127.5%	682	682	682	1001	100.0%	146.8%
ICU	CRITICAL CARE	4030	3433	821.5	677	85.2%	82.4%	4278	3384	0	0	79.1%	-
WARD 3	GENERAL SURGERY	945.5	882.5	761.5	819	93.3%	107.6%	713	719.5	356.5	552	100.9%	154.8%
WARD 8AB	TRAUMA & ORTHOPAEDICS	1072	871.5	979	568	81.3%	58.0%	977.5	621.5	264.5	402.5	63.6%	152.2%
WARD 8D	ENT	821.5	792	821.5	679	96.4%	82.7%	713	517.5	0	218.5	72.6%	-
WARD 10	GENERAL SURGERY	1302	1136	761.5	932.5	87.3%	122.5%	1069.5	713	356.5	713	66.7%	200.0%
WARD 15	GENERAL SURGERY	1569.5	1404.5	1256	1119.5	89.5%	89.1%	1069.5	724.5	356.5	866.5	67.7%	243.1%
WARD 19	TRAUMA & ORTHOPAEDICS	1643	1312.5	1178	1369.4	79.9%	116.2%	1069.5	1015.5	1069.5	1081	95.0%	101.1%
WARD 20	TRAUMA & ORTHOPAEDICS	1999.5	1529.1	1410.5	1555.5	76.5%	110.3%	1069.5	1035	1069.5	1035	96.8%	96.8%
WARD 22	UROLOGY	1178	1384.5	1178	1100.8	117.5%	93.4%	713	713	713	701.5	100.0%	98.4%
SAU HRI	GENERAL SURGERY	1830	1489.5	943	883	81.4%	93.6%	1380	1306	345	367	94.6%	106.4%
WARD LDRP	OBSTETRICS	4278	3607	945.5	514.5	84.3%	54.4%	4278	3499.5	713	632.5	81.8%	88.7%
WARD NICU	PAEDIATRICS	2247.5	1817	930	482.5	80.8%	51.9%	2139	1748	713	632.5	81.7%	88.7%
WARD 1D	OBSTETRICS	1242	1099.5	356.5	339	88.5%	95.1%	713	699.8	356.5	333.5	98.1%	93.5%
WARD 3ABCD	PAEDIATRICS	2435	2427.5	1208	722	99.7%	59.8%	2070	2054.5	345	333.5	99.3%	96.7%
WARD 4C	GYNAECOLOGY	713	706.5	465	429.5	99.1%	92.4%	713	713	356.5	310.5	100.0%	87.1%
WARD 9	OBSTETRICS	1069.5	866	356.5	334.3	81.0%	93.8%	713	713	356.5	356.5	100.0%	100.0%
WARD 18	PAEDIATRICS	793.5	697	138	51	87.8%	37.0%	713	666.8	0	0	93.5%	-
Trust		**61137.5**	**51099.55**	**35945**	**36531.4**	**83.58%**	**101.63%**	**44511**	**39790.4**	**21352.5**	**25246.5**	**89.40%**	**118.24%**

Hard Truths: Safe Staffing Levels (3)

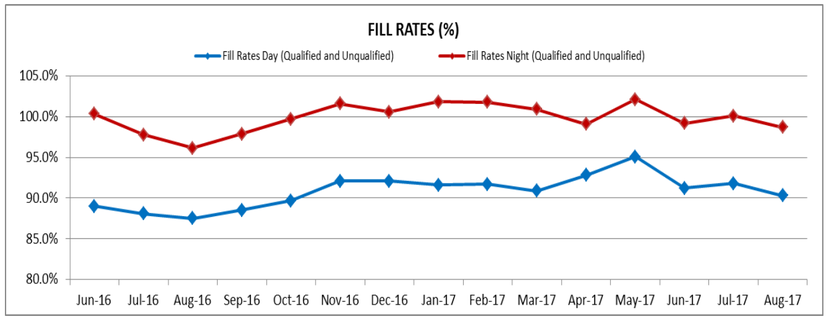
Care Hours per Patient Day

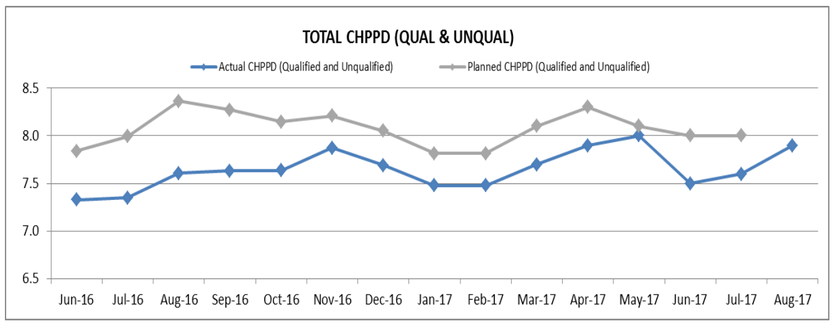
STAFFING - CHPPD & FILL RATES (QUALIFIED & UNQUALIFIED STAFF)

	Jun-17	Jul-17	Aug-17
Fill Rates Day (Qualified and Unqualified)	91.20%	91.80%	90.30%
Fill Rates Night (Qualified and Unqualified)	99.20%	100.10%	98.70%

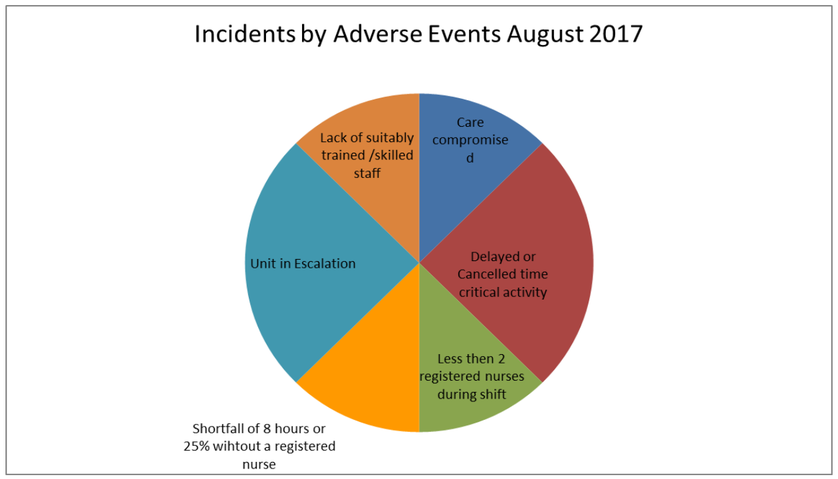
Planned CHPPD (Qualified and Unqualified)	8.0	8.0	8.4
Actual CHPPD (Qualified and Unqualified)	7.5	7.6	7.9

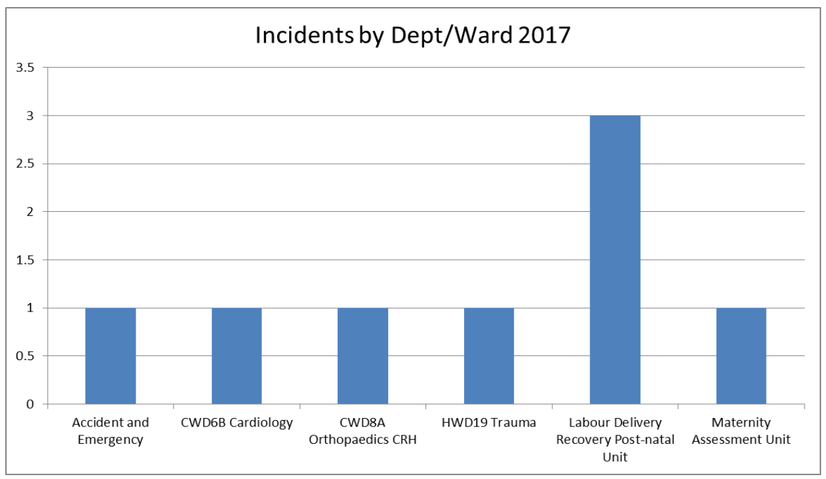
A review of Augusts 2017 CHPPD data indicates that the combined (RN and carer staff) metric resulted in 25 clinical areas of the 37 reviewed had CHPPD less than planned. 2 areas reported CHPPD as planned. 10 areas' reported CHPPD slightly in excess of those planned. Arears with CHPPD more than planned was due to additional 1-1's requested throughout the month due to patient acuity in the departments.





RED FLAG INCIDENTS





Red flagged events:

A Red Flag Event occurs when fewer Registered Nurses than planned are in place, or when the number of staff planned is correct but the patients are more acutely sick or dependent than usual requiring a higher staffing level (NICE 2015). In total there were **8 Trust Wide Red shifts** declared in **August 2017** . The Red flagged shifts were resolved within the Divisions and support for areas where staffing levels had fallen below planned levels was provided across the floor & by the duty night sister/site co-ordinator.

Hard Truths: Safe Staffing Levels (4)

Conclusions

Conclusions
The Trust remains committed to achieving its nurse staffing establishments. A range of actions are being developed and undertaken to recruit and retain the nursing workforce, and to develop data collection and reporting to support the nursing workforce.

On-going activity:
1.The proactive recruitment initiatives have been successful for the recruitment of the local graduate workforce. Focused recruitment continue forspecific area.
2. Recruitment fairs are planned for October 2017 & march 2018.
2. Applications from international recruitement projects are progressing well and the first nurses are expected in Trust October 201.
3. CHFTis a fast follower pilot for the Nursing Associate (NA) role and has 5 NA who started in post in April 2017.
4. A new comprehensive preceptorship document has been developed in line with national guidance to support the recruitment & retention of the graduate workforc. This is been further enhanced by the development of a year long perceptorship programme to support & develop new starters.
5. A new module of E roster called safecare will be introduced, benefits will be better reporting of red flag events, real-time data of
acuity and responsive deployment of staff.

Council of Governors Meeting – Performance Achievements Thursday 26th October 2017

Significant Improvements

Hospital Standardised Mortality Rate (HSMR) continues to improve with latest 12 month figure at 93.24.

Crude Mortality Rate in August is at its lowest rate since September 2016.

Two Week Wait From Referral to Date First Seen/38 Day Referral to Tertiary - 2 week waits recovered well from last 3 months' performance and 38 day referral to tertiary at its highest position in 12 months at 62.5%.

Community Division

Our Virtual Noticeboard has been well received by staff and the second edition has been published.

We have developed an employee engagement plan for the division and are inviting staff members to join our engagement group

We have submitted our service information into the National Community Benchmarking programme

We have currently 7 applications for Celebrating success and are planning a divisional celebration event on 20th December to recognise applications within the division

Medicine Division

4 consecutive months of complaints and harm incidents reducing

New starters in diabetes and respiratory

Retraction of ward 4 additional capacity

FSS Division

Radiology – Planning a new Band 7 Leadership Development Programme for Radiology Team Leaders
Pathology – Welcome to our new CD Gavin Boyd, and thanks to our outgoing CD Karen Mitchell
Outpatients – Focused work to improve OP FFT continues with cross Divisional work with CDs, GM's and Matrons. Great example of WTGR – thank you for your commitment to improvement
Women's – 'go see' to UHMB provided new insights and validated so of the work we are doing with service users around using patient feedback to improve patient experience
Children's – please take a look at our brilliant new video made with children for children explaining what might happen to them when they come to hospital.
NICU – improvements and refurbishment to facilities for parents completed. This area now provides a restful space for parents caring for sick babies

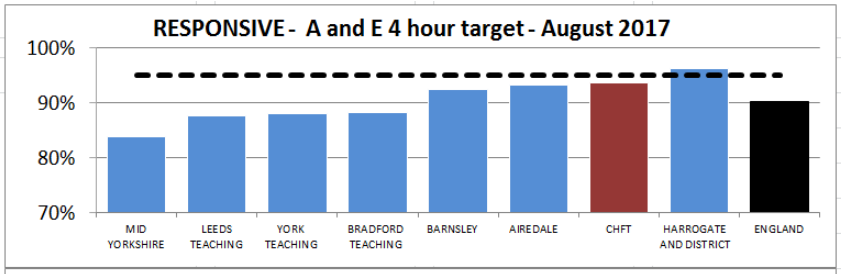
Surgery Division

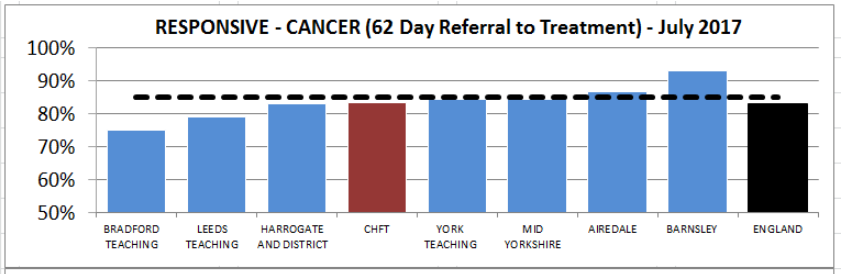
CD appointments:

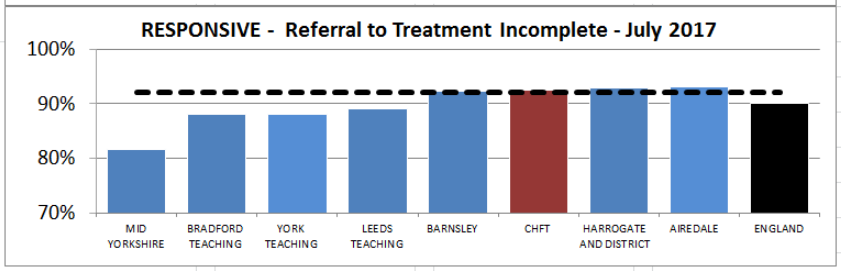
- Jonathan Cowley appointed to General and Specialist Surgery CD post
- PNT in post in Head and Neck

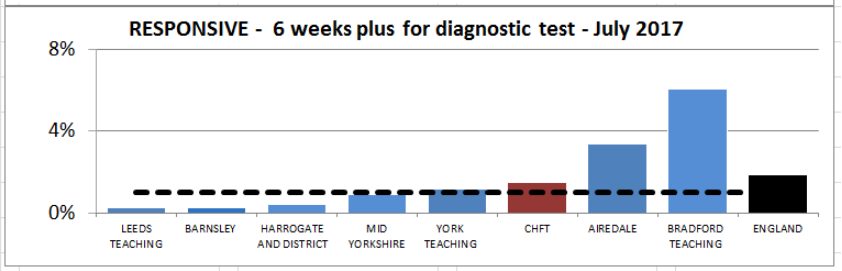
Feedback from the National Team Triple A was positive

Benchmarking Selected Measures









Calderdale and Huddersfield NHS Foundation Trust

COUNCIL OF GOVERNORS	
PAPER TITLE: **WINTER PLAN 2017-18**	**REPORTING AUTHOR: H Barker**
DATE OF MEETING: 26th October 2017	**SPONSORING DIRECTOR: H Barker**
STRATEGIC DIRECTION – AREA: • Keeping the base safe	**ACTIONS REQUESTED:** • To note
PREVIOUS FORUMS: Board of Directors – September 2017	
IF THIS IS A POLICY OR A SERVICE CHANGE, HAS IT BEEN EQUIP'd? If so, please provide the unique EQUIP reference number below: **For guidance click on this link:** http://nww.cht.nhs.uk/index.php?id=12474	
EXECUTIVE SUMMARY: The Winter Plan describes the structure within which operational pressures, during the winter period, will be anticipated and managed. It provides the framework for Managers and Clinicians in the Trust to work together, and with other organisations.	
FINANCIAL IMPLICATIONS OF THIS REPORT: N/A	
RECOMMENDATION: To note the contents of the report.	
APPENDIX ATTACHED: YES	

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

Calderdale and Huddersfield NHS
NHS Foundation Trust

Winter Plan 2017/18

Version 1

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

Document Summary Table	
Unique Identifier Number	
Status	Draft 1
Version	1
Implementation Date	October 2017
Current/Last Review Dates	October 2016
Next Formal Review	June 2018
Author	Associate Director of Urgent Care
Where available	Preparing for Emergencies Section of the Trust Intranet.
Target audience	Executive Directors, On-call General Managers, Directors on-call, Duty Matrons, Senior ward & department staff, Estates and procurement.

Ratifying Committees	
Weekly Executive Board	September 2017

Consultation Committees		
Committee Name	**Committee Chair**	**Date**
Board of Directors		
A&E Delivery Board	Matt Walsh	

Does this document map to other Regulator requirements?	
Care Quality Commission	Outcomes 4B, 6D, 10E and 14A

Document Version Control	
V1	Updated for Winter 2017/18

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

Contents

Appendices

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

Introduction

The winter plan describes the structure within which operational pressures during the winter period will be anticipated and managed. It provides the framework for managers and clinicians in the Trust to work together and with other organisations.

The winter period is normally defined as being from early November to late March with specific emphasis on the 'Critical Period' early December to the end of January. However NHS England expectations of Trusts to implement improvements as described below do not and cannot be achieved if just focused on planning through the winter but must be the focus throughout the year.

Purpose

The objectives of the Plan are as follows:

- To support existing plans by increasing the operational focus on winter as an issue that challenges the resilience of the Trust.
- To provide a framework for the management of the winter response
- To provide a framework for the development of other plans
- To provide the basis for agreement and working with other partners & organisations
- To provide reference material for use in the Trust
- To set out the information systems to be used to manage the response.

NHS England has reiterated that trusts are expected to respond appropriately to the demands of winter through attention to the following areas:

- Reducing Delayed Transfer of Care
- Reducing variation in best practice (Improving patient flow and effective discharge planning)
- Demand and capacity planning
- Planning for Peaks in demand over weekends and Bank Holidays.

1. Definitions

Critcon - The status report that is used to manage intensive care capacity across the network

Elective restarts - This is the point at which elective surgery is restarted, either completely or in part, following the planned stopping of it during a period of acute workload pressure.

ImmForm - The monthly report on take up of influenza vaccination in staff.

Organisational resilience - The ability to adapt and respond to disruptions to deliver organisationally-agreed critical activities

Sitrep - A daily report to Monitor which highlights pressures in Trusts' capacity. Sign off will be required by 11:00, Monday-Sunday from the beginning of November until the end of March 2018. THIS will support the reporting of the Sitrep on a daily basis and the Associate Director of Urgent care or deputy will complete the sign off, a rota will be created.

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2. Duties (roles and responsibilities)

Director of Estates and Facilities

- Reportable officer at executive level for Winter Planning

Chief Operating Officer

- Will represent Trust on the A&E Delivery Board

Associate Director of Urgent Care

- Chair the Winter Planning Group
- Represent the Trust on the Joint Surge and Escalation Teleconferences
- Compile a situation report for the Joint Surge and Escalation Teleconferences
- Cascade the situation report from the Joint Surge and Escalation Teleconferences / Update the winter planning group and divisional leads of the situation across the local healthcare system
- Respond to requests for assurance from the CCG and NHS England
- Benchmark and share good practice from partner organisations
- Ensure that winter plans are aligned with the Trust Emergency Management Arrangements and associated emergency plans
- Collate departmental plans for the Christmas and New Year period and ensure they are accessible to staff on-call and on-duty over the period
- Ensure that contingency plans that are in place for surge in emergency demand for inpatient capacity, severe winter weather and outbreaks of winter infectious diseases are appropriate and will deliver safe patient care and experience and organisational resilience.
- Ensure that the Trust Winter Plan aligns with those across the local health & social care system.

Divisional Directors

- Ensure adherence to the Emergency Care Standard action plan as agreed at Executive Board
- Ensure each Division takes responsibility for securing sufficient capacity to meet out of hours demands on a daily basis
- Ensure collaboration across Divisions to ensure compliance with Patient First principles
- Ensure each Division has robust arrangements for escalation and any associate bronze and silver meetings

Winter Planning Group (Division Winter Leads)

- Ensure that appropriate plans are in place to manage an increase in activity through the winter period within the division
- Ensure that divisional plans are joined up across the organisation
- Ensure that contingency plans are in place for surge in emergency demand for inpatient capacity, severe winter weather and outbreaks of winter infectious diseases.
- Ensure that key staff groups are aware of the risks and response arrangements for winter

Estates, Clinical Site Commanders and Night Matrons

- Liaise with Local Council Highways departments to clear roads for urgent patient transport requirements
- Contact alternative transport providers if required

Estates and Facilities

- Ensure that there is sufficient supplies of salt/grit for clearing car parks, pathways and roads on site
- Liaise with contractors to arrange access to 4X4 vehicles for transport services if required
- Ensure that additional staff accommodation is available if required
- Cascade weather updates throughout the year including winter.

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3. The Trust's Winter Strategy

The winter plan is based on the following strategic aims;

- To continue to provide high quality health and social care to the communities of Calderdale and Kirklees.
- To ensure that patients receive treatment in the most appropriate environment at the time most beneficial to their needs
- To work collaboratively with other health and social care providers to effectively manage capacity
- To assess risks to continued service provision and put plans in place to mitigate those risks
- To put in place a communications strategy that assists the public in gaining access to appropriate health and social care services.
- To ensure optimum occupancy and staffing levels over the winter period to minimise the risk of harm
- To ensure patients do not wait in any part of the system unless clinically appropriate

Winter planning arrangements

The Trust Lead for winter planning is the Associate Director of Urgent Care in collaboration with the Divisional Senior Management Teams.

The A&E Delivery Board has overall responsibility for ensuring that the health and social care service in Calderdale and Huddersfield is adequately prepared to manage an expected increase in activity and acuity over the winter period. The CHFT Winter Planning Group reports to the A&E Delivery Board and, in addition to internal escalation arrangements, is responsible for ensuring that the Trust has plans in place for severe winter weather, seasonal infectious disease outbreaks and Christmas and New Year bank holidays.

Command, control and coordination

During the period 1 November – 29 February, a daily SitRep (Mon-Fri) will be completed for submitting to NHS England by the Health Informatics Service. The Monday SitRep will include details from the preceding weekend. SitReps will be signed off by the Associate Director of Urgent/Director of Operations after high level validation with fully validated data submitted monthly. Arrangements will be confirmed to ensure that there is adequate cover in case of absence.

The National Escalation Framework

4 Hour Emergency Care Standard Performance is one measure of a whole health and social care system experiencing pressure, but it is not the only one. An Emergency Department (ED) could be experiencing isolated difficulties but the rest of the system is coping well; there are sufficient beds available and there is good flow through the system. Alternatively, an ED could be managing well whilst the rest of the hospital, and the wider system; community beds, community services and social care are experiencing high pressures due to a lack of capacity.

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Escalation triggers at each level

Local A&E Delivery Boards should align their existing systems to the escalation triggers and terminology used below, and adds to the triggers listed as appropriate. The escalation criteria detailed over the following pages are not an exhaustive list of triggers, nor do they constitute a rigid system where criteria must be met sequentially for escalation to take place. **Not all parts of the system need to meet all triggers in order to escalate – escalation can be service specific if agreed locally.**

Local A&E Delivery Boards should be able to demonstrate that appropriate triggers have been met to warrant escalation. NHS England and NHS Improvement sub-regional and regional teams will also use the framework to moderate and challenge in discussions with local systems.
National terminology (OPEL) has now been adopted and has been used within the Trust throughout 2017.

To ascertain the OPEL status of acute hospitals within Yorkshire the Clinical Site Commanders will be contacted by Yorkshire Ambulance Service twice daily either by phone or email. The Clinical Site Commanders will be contacted at 09:00 each morning for the new national escalation level (OPEL) status for inpatient capacity and any associated comments noted by hospitals on the Daily Bed Alert Status Report.

Operational Pressures Escalation Levels	
OPEL 1	The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. The Local A&E Delivery Board area will take any relevant actions and ensure appropriate levels of commissioned services are provided. Additional support is not anticipated.
OPEL 2	The local health and social care system is starting to show signs of pressure. The Local A&E Delivery Board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation. Enhanced co-ordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible. Local systems will keep NHS E and NHS I colleagues at sub-regional level informed of any pressures, with detail and frequency to be agreed locally. Any additional support requirements should also be agreed locally if needed.
OPEL 3	The local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are now required across the system by all A&E Delivery Board partners, and increased external support may be required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. National team will also be informed by DCO/Sub-regional teams through internal reporting mechanisms
OPEL 4	Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the Local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally, and will be actively involved in conversations with the system. Where multiple systems in different parts of the country are declaring OPEL 4 for sustained periods of time and there is an impact across local and regional boundaries, national action may be considered.

Figure 1

OPEL-Winter command and control arrangements (internal)

Operational Pressures Escalation Level (OPEL) 1 when operating within normal parameters. At OPEL 1 and 2, we would anticipate operations and escalation to be delegated to the relevant named individuals in each organisation across the A&E Delivery Board. At OPEL 3 and 4

however, it would be expected that there would be more executive level involvement across the A&E Delivery Board, as agreed locally.

A second assessment of capacity alerts will be made at 16:00 and the capacity status for each hospital again reported.

The three hourly SAFER Patient Flow Hospital Meetings chaired by the Clinical Site Commanders involving the patient Flow Team and Divisional Managers of the day, Matrons and on call managers/Matron of the day will monitor activity on each site and determine operational actions using a standard operating procedure and escalation policy to manage capacity issues. The level (OPEL) at which the hospitals are working within will be determined at these meetings. The Associate Director of Urgent Care will report direct into the partner organisations involved in the Joint Surge and Escalation Plan.

The Associate Director of Urgent Care for Calderdale and Huddersfield Foundation Trust is responsible for representing the Trust at the Calderdale, Kirklees and Wakefield Joint Surge and Escalation meetings where situation reports are shared and healthcare system-wide actions to manage demand and capacity are determined.

Each division and department is responsible for the successful implementation of their escalation plans. In the event that significant pressures are identified the Associate Director of Urgent Care or the Divisional Directors of Operations will decide to implement the Trust Emergency Management Arrangements (Strategic (Gold) and Tactical (Silver) and Operational (Bronze).

Workforce

Staffing levels

Agreed workforce plans and skill mix are in place for all inpatient areas and community services over the 7 day period. These will be used to assess the risk of reduced staffing due to absence and to assist in the redeployment of staff if necessary. Nurse rosters are signed off by Divisional Matrons to ensure robust cover an arrangement especially over the Xmas and New Year period and to ensure annual leave is managed appropriately over this period. Staffing gaps should be identified and mitigated by Divisional teams in hours, only last minute absences will be actioned by on-call, out of hours teams

> **For Xmas & New Year a further review will be completed weekly from the beginning of December with a final sign off and escalation of any risks with mitigation plans by the 12th December 2017.**

Vaccination

The CQUIN target for this year for Calderdale and Huddersfield is to achieve at least 75% of frontline staff. The emphasis will be on staff in clinical and clinical support roles, but the vaccine will be available to all staff. The campaign this year has been well communicated and information on scheduled sessions, ‘myth busting’ and league tables of performance have been advertised on the intranet. Additional groups of staff have been trained to administer the vaccine so that it can be more accessible to staff. District nursing services provide flu vaccination to patients on their caseload as well as working with GPs to ensure that all vulnerable people are offered the vaccine.

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Personal Winter Plan/Engagement Plans

All members of staff have a personal responsibility to ensure that they are available for work and that they have alternative arrangements for carer responsibilities and journeys to work. All staff will be reminded of preparations they should make for winter – seasonal flu vaccination, checking public transport alternative routes, vehicle preparation as well as contingency plans. This will continue to be reinforced through the business continuity management system and staff communications strategy. In severe weather conditions staff in District nursing will report to their nearest team to their home not necessarily where they usually work. The Trust's attendance management, carer leave and adverse weather policies will be used to support staff and to maintain service levels.

Strengthened Operational Management

Daily support for patient flow from the Clinical Divisions is already in place, additional senior support is provided by the Associate Director of Urgent Care or a Director of Operations as point of escalation and chair of the critical 12pm Patient Flow Meeting. From the beginning of December 2017 until the end of January 2018 that will increase to the 9am and 3pm patient flow to ensure any surge in activity above expected levels are acted upon immediately and provide additional assurance that good control and command is in place.

Lead Nurse-Patient Flow

Clinical Site Commander
The Clinical Site Commander will effectively manage the Trusts bed capacity, ensuring the patient's journey is safe and their experience is good. This is in conjunction with the Divisional operational teams. They will be the point of escalation if surge is being experienced.

Divisional Operational Teams
There will be a Divisional manager and Matron of the day who will support the patient's journey, ensuring safe effective admissions, transfers and discharge. They will work to a standard operating procedure.

"On call/site manager of the day"
There is an on call manager designated on site daily.

Duty Matron
There will be a duty matron on site daily.

Reducing admissions
Ambulatory Care in medicine and Medical Admission avoidance will be available on each hospital site to prevent avoidable medical admissions. Surgical Ambulatory will be available on the HRI site with dedicated additional surgical registrars on specific days over the x-mas and new year period and Gynaecology Ambulatory will be available on the CRH site.

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Reducing delayed discharges to support length of stay reduction
SAFER Patient Flow Transformational Programme is supporting initiatives to improve flow, prevent avoidable admissions, reduce LOS, improving discharges at the weekend by introducing additional medical staff to focus on discharge and completing of TTOs and occupancy levels, reduce patients on a green cross pathway and find alternatives for patients who do not require acute hospital services.

A fortnightly senior management meeting for all partners to ensure robust discharge plans are in place for all patients on a green cross pathway.

With the introduction of Nervecentre Task Management there is an improved communication and joint working across all specialities. This will support earlier discharge throughout the winter period by prioritising tasks associated with discharge and liaising with the appropriate professionals to ensure that the task is completed timely.

Pharmacy
Will ensure that flexible capacity wards are stocked with appropriate medicines, a regular clinical pharmacy visit will be established and maximise the use of pharmacist prescribers to assist with medicines reconciliation and transcribing TTOs.

Ward based ATOs will be targeted to high turnover areas to assist with transferring medicines.

Pharmacy staff will work with medical and nursing staff to prioritise supply of medicines for discharge.

Wards should identify patients due for discharge on all ward areas as soon as possible, and e-discharge should be sent to pharmacy in a timely manner so that these can be processed quickly. Where possible, discharge prescriptions for patients who have monitored dosage systems (MDS) should be sent to pharmacy the day before discharge.

Pharmacy and nursing staff should identify patients who already have sufficient supplies of medicines at home before a request is made for a supply for discharge, which will enable pharmacy to dispense items which are genuinely required more quickly.

Winter Inpatient Flexible Capacity Plan

CHFT's Divisional teams have prepared their winter plans through analysing their expected demand, tracking assumptions against their business plans and understanding the impact transformational work is having.

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Medical Divisional Plans

The Medical Division will have completed the alignment of all elderly, cardiology and respiratory wards which will provide improvements in how patients with needs that require a specialist assessment and ongoing review are cared for. There will be an introduction of more specialist weekend reviews. All wards will have a daily ward round. The Medical Division has developed specific plans to provide escalation capacity to meet the expected increased demand on inpatient capacity. With the improvements seen in reducing the longest lengths of stay within the hospital these plans will be operationalised **only** if a surge in activity described in figure 1 impact on operational performance and patient safety.

Acute Medical Care

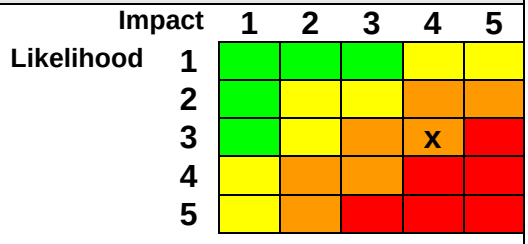
Hot clinics:

Diabetes & Endocrine: Consultant to work with DNS team in identifying patients to be discharged from the wards with a view to returning to clinic before the weekend. This prevents patients then having a weekend stay where they will require work-up on a Monday and subsequent discharge planning.

Acute Medical Unit/General Medicine*:* This will be delivered from the Ambulatory Assessment Unit (AAU) on a daily basis by the Acute Medical team. AAU will be extended to provide ambulatory care until 10pm daily on each hospital site Monday to Friday. An Emergency Floor planned will be opened on the Calderdale Royal Site to extend the ambulatory care offer.

Care of the Elderly*:* This will be delivered by the Care of the Elderly team with support from the Frailty team in AAU or 6 bedded frailty area on the Acute Medical Unit at HRI and a designated elderly ward.
A Frailty Team will be in place at the Calderdale Royal from September 2017 onwards.

Surge in Non-Elective Demand

Overview	
Impact	
• Unpredicted increase activity in ED's, SAUs and MAUs • Increase in bed occupancy across the Trust • Increased pressure on community healthcare services to support discharges above predicted • Potential of the need to outlie patients into another speciality. • Greater potential for inpatient outbreaks of infection and outbreaks in nursing homes preventing discharges	
Proactive strategy- Actioned by the Director of Operations	
• Identify flexible beds that can be opened in the short term to support increased admissions and staffing requirements • Trigger escalation	

Reactive strategy		
• Use of winter strategy & plan • Implement the joint surge and escalation plan- Silver & gold • Activate business continuity plans and escalation plans • Increase inpatient capacity by opening flexible beds		
Trigger	**Received by**	**Immediate action**
ED reporting of increased activity	Emergency department matron/manager	• Reallocate junior medical/nursing staff to support the Emergency Department • Establish additional trauma lists as required • Review the availability of trauma surgery equipment • Move from elective beds to trauma as demand dictates • Use of flexible capacity- short term • Surge & Escalation plan actions to be followed
YAS reporting of increased activity	Emergency department. Patient flow team	
Low temperatures Met Office - proactive	Emergency Planning Officer	• Prepare for increased attendance by patients in the at-risk groups
Community nursing workload	General Manager – Adult Community Nursing	• Review community case load to prioritise at risk patients • Trigger business continuity plans
Assess bed capacity issues in line with regional plan	Director Of Operations	• Implement the escalation policy. • Implement joint partner surge & escalation plan
Requirement to expedite discharge	Clinical Site Commander Discharge Matron/Discharge Team.	• Liaise with YAS to agree priority order for patient movement. • Initiate spot purchasing agreements • Start discharges with medicines to follow. (Use of taxis of transportation of medicines post discharge.) • Use of day rooms and discharge lounges to facilitate expedite discharge.

Figure 1

Escalation Capacity

Division	Flexible Capacity	Trigger & Action	Lead
Medicine	24 escalation beds are planned.	Triggered through SAFER Hospital Meetings using demand management data/daily predicted discharges after all other admission avoidance has been exhausted. **Risk assessments must be completed.**	Divisional Manager/Matron/Clinical Site Commander. Director of Operations

	Gynaecology Assessment Unit x 6 beds.	Daily tracking will be in place and Senior Divisional Team will monitor winter demand. A robust nurse staffing plan will be developed and signed off by the Chief Nurse. The identified ward to be opened will have an inventory of equipment/medicines/essential consumables/linen & pillows available and stored in a secure facility (appendix 2) It will also be EPR ready. Plan to flex these beds as required (overnight). Staffing Plan developed to provide flexible capacity overnight.	Associate Directors of Nursing

Figure 2

Emergency Department

The Emergency Department (ED) will have;

- Surge triggers developed for ED Consultants will be implemented to extend the working hours of the consultant until midnight.
- Additional assessment capacity will be created, adjacent to the ED to ensure **all** ambulance and ambulatory major's patients even at times of surge are seen through EDIT/WEDIT. This will be managed by the ED team but supported through triggers and escalation (described in the Surge & Escalation Plan) by the hospital matrons providing the required staff.
- Daily analysis of 'reasons for breaches' shared with Specialty colleagues for learning and action to prevent, monthly review meeting will be in place to ensure ownership of actions and improvements being made, chaired by the Associate Director of Urgent Care.
- Daily representation at Patient Flow Meetings with consultant attendance at critical pressure points. Actions fed back to the department and two-way communication in place.
- Robust internal Escalation Plans are in place to manage surges in demand.
- In order to improve communication between AMU, ED and site management team, the ED team will strengthen communication via bed management team by providing an ED update at each SAFER Patient Flow Meeting.
- Planned increased medical staffing over the X-mas and New Year period as mitigation against the expected increase in demand especially over the out of hours period .
- The Senior Lead Nurse B7 for each department will be supernumery
- Each department will have trackers to support the internal flow and escalation within each department.
- The Frailty Team will work closely with the ED team to ensure all opportunities to support avoidable admissions are taken.

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

Surgical Divisional Plans

The Surgical Division has developed plans to mitigate increased non-elective demand whilst planning for a reduction in elective activity.

- In addition to current planned trauma lists (17) all additional demand will be delivered by following the Trauma Surge Pathway (Figure 3).
- There will be the ability to provide patients with a fractured neck of femur surgery over the x-mas and New Year period.
- Current medical workforce on SAU will be increased with an additional middle grade to minimise impact on patient flow. Improved timely access to theatre will reduce pre-op bed days and overall LOS for some Minor/intermediate and complex trauma. Performance will continue be monitored regarding delays to theatre.

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

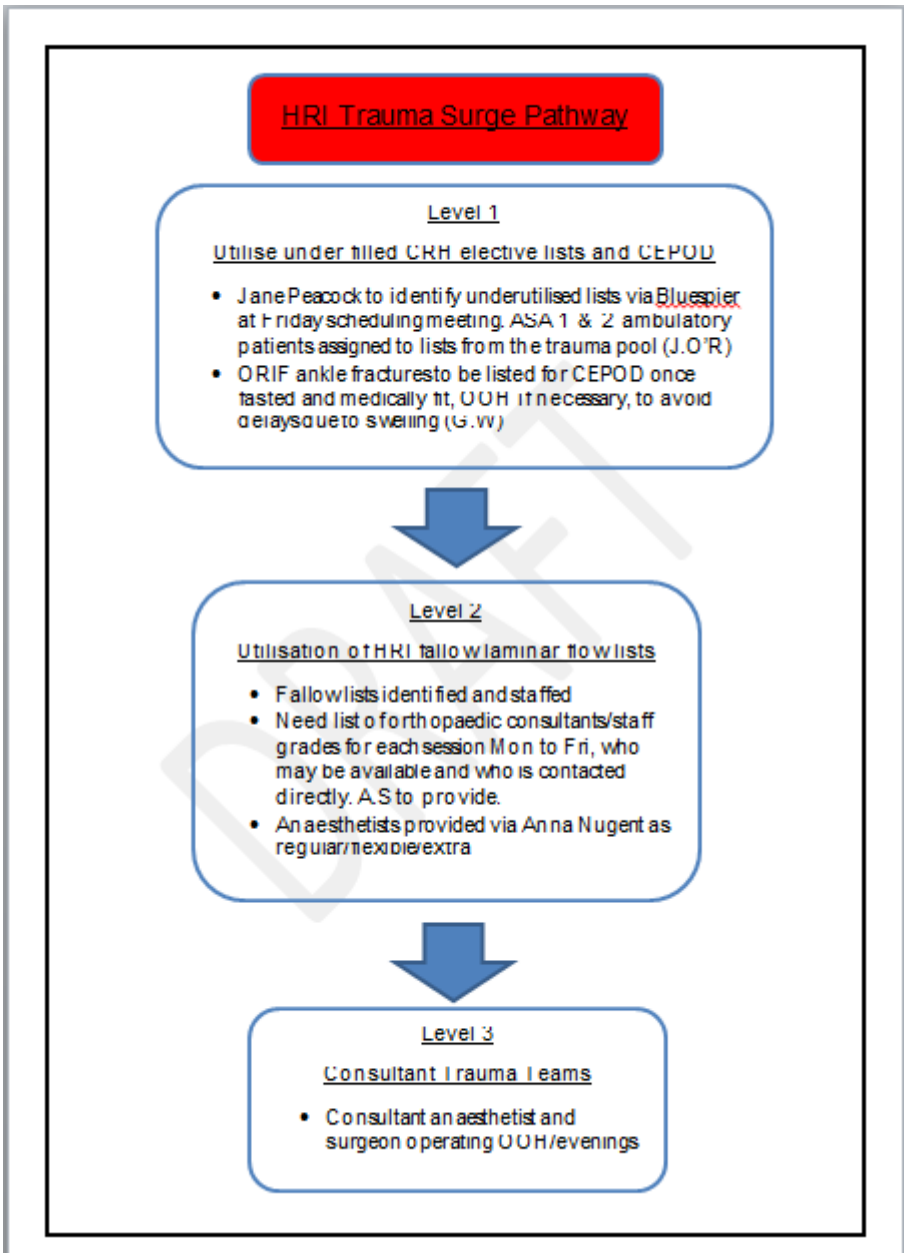


Figure 3

Reduction in elective Orthopaedic activity

The surgical division will reduce elective orthopaedic surgery providing additional inpatient capacity for the peak periods from Mid-December to the end of February. If additional beds are not required the staff will be redeployed as directed by the ADN.

From January 3 the Surgical Division will introduce additional Laparoscopy Cholecystectomy lists that reflect the Upper GI Surgeon on CEPOD week. This will improve the scheduling of acute/emergency patients with cholecystitis based on clinical urgency, over and above the CEPOD list. This will improve LOS for these patients, prevent readmission and improve patient experience.

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

The Division have progressively moved more work to day-case this year and from 5 December will open a 5 day ward are exploring options to develop this further which may include a short stay unit, thereby reducing the risk of elective cancellations over the winter period?

Central Operations (COT)

Lead Nurses for the COT will provide cross site cover into the Patient Flow Team over the x-mas and New Year period

Discharge Coordinators

- A daily huddle will be introduced to focus resource of the team when triggers on any specific pending delays occur this must be without reducing the robust management of the complex discharges. Working hours will be reviewed daily as part of the huddle and extended as required. Staff will work flexibly to support the service.
- A process for linking GP practices with MDTs will be introduced to ensure primary care support for complex discharges.
- Weekly 'stranded patient' meeting will be in place to prevent any clinical delays.

Patient Flow Team

- There will an Operations centre developed on each acute hospital site to be the hub for all Patient Flow Meetings and as required for escalation meetings using learning from EPR go live.
- A twice weekly Cross Divisional Business Meeting will be chaired by the Associate Director of Urgent Care/Associate Director of Nursing for FSS to gather intelligence, share information on divisional issues/risks affecting patients flowing through the hospital in a safe and effective way. To then agree solutions and implement supplemental actions to address these.
- A cross divisional QIA Panel will be in place to review all x-mas and New Year rosters. Panel consisting of Deputy Chief Nurse, Associate Directors of Nursing for each division and the Associate Director of Urgent Care. A weekly Nurse Staffing Assurance Panel will then be in place to monitor.

Discharge Planning

- Implement the 8 High Impact Changes to improving Patient flow and discharge.
- Continue to roll out the 'Supported consultant ward round/MDT initiative'

Family & Specialist Services

Paediatrics

- Escalation Plan (Appendix 5)
- Continued support paediatric stream in the EDs with PNPs during surge in both EDs and planned at Huddersfield Royal Infirmary (Appendix 6).

Maternity

- Escalation Plan (Appendix 7)

Diagnostics
Daily attendance in Patient Flow meetings of Operational management from FSS to support flow, support prioritisation of diagnostics during increased demand.

Community Division

CHFT Community Division accesses on-call support via the Trust on-call rota.

For Winter 2017, a Community Division on-call rota will be implemented to support community services out-of-hours in a more formal and routine way.

The community division on-call manager will be the first point of contact for Community staff and staff escalating a concern about responsiveness of community services out-of-hours and the on-call divisional manager will escalate to the Trust on-call manager and on-call Director for support if the situation cannot be managed locally.

On-call staff can be accessed by contacting Calderdale switchboard on **01422 357171.** All staff are made aware of the route to access on-call staff.

Priority 1 Clinical Services

The following services have been deemed as **Priority 1 Clinical Services:-**

- District Nursing priority one patients
- Blocked catheters
- Administration of medications including IV therapy
- Support for discharge out of hospital
- Palliative Care
- Crisis Intervention Team
- Intermediate Care bed base
- IV Therapy priority one patients
- Palliative care priority one patients
- Gateway to Care
- Quest Matron support to Care Homes
- Community Respiratory Service
- Community Heart Failure Service

Community Services Available

Gateway to Care

The service supports the co-ordination of intermediate care services and prevention of hospital admissions. The service accepts patient referrals from GPs, community clinicians, Social Workers and patients.

Referral should be made to Gateway to Care for the following services:-

- Crisis Intervention Team
- Support and Independence Team including Stroke early Supported Discharge Team, Falls Prevention Team
- Intermediate Care Beds
- Heatherstones

Hours of Operation	8.45am-5.30pm Monday to Thursday and 8.45am-5.00pm Friday
Contact Details	01422 393000

Intermediate Care

The intermediate care service is delivered by an integrated partnership of health and independent care home provider, ensuring a multi-disciplinary approach to care. Care is provided in one of our bed bases i.e.

Brackenbed View (32 beds) or Ferney Lea (12 beds) and Heatherstones (12 apartments)

The Service Aims to:-
- Promote a faster recovery from illness
- Prevent unnecessary presentation and admission to an acute hospital bed
- Prevent premature and unnecessary admission to long term care
- Maintain independence as long as possible

Service Criteria:
- Service user/patient must be over 18 years of age
- Medically stable
- A resident of Calderdale or Registered with a Calderdale GP
- Consent to rehabilitation

Hours of Operation	24 hours a day, 7 days a week
Referrals Accepted	Via Gateway to Care (in-hours) and via Crisis Intervention Team (weekends)
Lead Manager	Claire Folan
Contact Details	07879 447218 (for IMC Beds)

Heatherstones provides temporary accommodation for adults for up to 6 weeks and facilitates early discharge, or prevents the need for admission to hospital, residential or respite care. The service is most appropriate for people who want to live independently but need short-term alternative accommodation or short-term help and support to achieve this.

The service aims to reduce individuals' dependency and reliance on direct services and prevent their level of need from increasing with people returning to their own home with the confidence and

level of care required to enable them to cope long term. Residents are expected to cook their own meals and do their own shopping and laundry. Reablement assistants provide support where needed.

Hours of Operation	Monday to Sunday 8.00am – 9.45pm 7 day service
Lead Manager	June Warman
Contact Details	01422 392229

Community Place

This is a partnership arrangement between CHFT and Calderdale Council and operates from Ward 4B at Calderdale Royal Hospital.

The service assists in early identification of patients appropriate for discharge from hospital who can be supported by Community services upon discharge and require a step down goal focussed approach. There is an expectation that the individual can focus and be involved in higher level of rehabilitation functioning up to 6 times per day through goal led functional rehabilitation and a transition to self-care.

The ethos of the Community Place is self-management and individualised care planning within an MDT approach (Therapy, Support workers and Social Workers) with a view to maximising independence and returning home as planned with the most appropriate and proportionate care services that reduce continuing dependency on care and support services. This serves to prevent prolonged hospital stays and premature admissions to long term residential care.

Personalisation and community are the key building blocks of the Community Place service, community membership, living in their own homes, maintaining or gaining employment and making a positive contribution to the communities they live in.

Hours of Operation	24 hours a day, 7 days a week
Lead Manager	Alistair Mirfin
Contact Details	01422 223406

Reablement

The reablement service provides therapeutic care and support; with therapy care plans provided by CHFT community therapy team and then delivered by social care reablement staff. Access to reablement is via Gateway to Care following an assessment by a social worker.

Reablement is offered for up to 4 visits a day for a period of 6 weeks with the aim to increase function and reduce dependence. If care is required following a period of reablement, a care package will be commissioned and a means test assessment will be undertaken to determine what financial contribution will be required by the individual.

Hours of Operation	8.00am-9.00pm, 7 day service
Lead Manager	Tracey Proctor
Contact Details	07748 797896

Reablement Team	Allocator	Contact number
Lower Valley	Julia Green	01484 728943
Upper Valley	Stephanie Brooks	01422 264640
Central	Jo-Anne Rice	01422 383584

Crisis Intervention Team

Crisis Intervention Team will provide support to someone in crisis in their own home for up to 72 hours. For example if someone is struggling in their own home after a fall, or discharge from hospital where packages of care cannot start immediately. They also assess suitability for intermediate care beds. They are a responsive service and will assess within 2 hours for urgent referrals and 24-48 hours for routine referrals.

The team consists of nurses and a physiotherapist who undertakes assessments and set care plans. Rehabilitation assistants in the team offer up to 4 visits a day for a period of 72 hours with the aim to increase function and reduce dependence. If further reablement is required after 72 hours, the locality reablement teams continue the care.

Hours of Operation Assessors	8.00am–7.00pm 7 days a week
Reablement Service Work	8.00am-9.00pm 7 days a week
Lead Nurse	Susan Johnson
Contact Details	01422 307333/07917 106263

End of Life Out-of-Hours Crisis Team

This is collaboration between Overgate Hospice, Marie Curie and CHFT. This small team provide crisis support to people out of hours who are near the end of their life. The Specialist Palliative Nurse supports the person with symptom control, physical and emotional support and works with a Marie Curie Support Worker. They provide support to the person, carers and families.

Hours of Operation	7 day service
Lead Nurse	Abbie Thompson
Contact Details (9am-5pm Mon-Fri)	01422 310874
Contact Details (Out-of-Hours)	07917 106263 Out-of-Hours Service/ 01422 379151

OPAT/ IV Therapy

This team provides antibiotic intravenous therapy to patients in their own homes. Patients remain under the care of their Physician or Consultant. This prevents some admissions and certainly reduces the LOS for many more.

- Patients have to be medically stable. Need to be under consultant referrals
- Commissioned for 12 administrations a day
- Compatible drugs need to be administered within 30 minutes

Hours of Operation	7 day/24 hour service
Lead Nurse	Jayne Woodhead
Contact Details	07795 825106

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

Community Nursing Services

District Nurses visit housebound patients that have complex health care needs. Patients that are able to be transported are expected to attend treatment rooms.

Hours of Operation	7 day/24 hour service
Contact Details Core Hours (8am-6pm)	07917 106263
Contact Details Evening/Night (6pm-8am)	07917 106263

Only **priority 1/urgent patients** are seen at night i.e. palliative care requiring symptom management, blocked catheters and patients requiring prescribed medication at agreed intervals.

Quest for Quality Service

CHFT have established a multi-disciplinary team consisting of Community Matrons, pharmacist, therapist and consultant Geriatrician who caseload residents in all Residential and Nursing Homes in Calderdale. This scheme's main role is to reduce the number of calls made to General Practitioners to prevent avoidable admissions. They use Telecare and Tunstall Telehealth to promote health and wellbeing to the residents within the Care Homes.

The team have a responsive function to the Care Homes dealing with calls that would have been received by a GP and managing the residents. They also provide support to the care home staff to better manage their residents through training and education.

The pharmacist role has greatly helped with reviewing patient medication, reduction in poly-pharmacy and education and training of care home staff.

Hours of Operation	9am-6pm, 7 days a week
Lead	Liz Morley
Contact Details	07917 086450

Community Matron Service

Community Matrons provide a service to people with Long Term Conditions (LTC) who have complex health and social care needs which without effective case management are likely to result in the individual having repeated and avoidable hospital admissions and increased lengths of stay in hospital and frequent contact with primary care services.

They are based in localities with District Nursing Teams.

Hours of Operation	8.30am-4.30pm, Mon-Fri
Lead	Andrea Beevers

Locality	Base	Matron	Contact Details
Upper Valley	Todmorden Health Centre	Jenny Dyson/Vacancy	07795 252396

Lower Valley	Church Lane Surgery Rastrick	Rachel Clegg/ Andrea Beevers Mandy Kazmieski	07795 801112 07795 825037 07795 825084
South Halifax		Sheila Kalanovic/Vacancy	07795 825139
North Halifax		Julie Norris/Vacancy	07770 734748
Halifax Central		Sheryl McGinn/Louise Watson	07769 365247 07717 347547

Specialist Nursing

There are a range of specialist nursing services that support people in community settings.

Service Area	Hours of Operation	Lead Nurse	Contact Details
Continence	7.00am-4.30pm Mon-Fri	Sharon Holroyd	01422 252086
Respiratory	8.30am-4.30pm 7 days/Week	Sue Scriven	01422 307328
Heart Failure **Cardiac Rehab**	9.30am-5.30pm Mon-Fri 7.30am-4.30pm Mon-Fri	Ian Ormerod Caroline Lane	07500 553892 01422 224260/ 07713 739144
Parkinson's	9.00am-5.00pm Mon-Fri	Paula Roberts	01484 712515
TB	9.00am-5.00pm Mon-Fri	Mary Hardcastle Dale Richardson	07824 343770 07795 825070 01422 307307
Lymphoedema	9.00am-5.00pm Mon-Fri	Sarah Wilson	01422 350755

Respiratory Team

This team provides 7 day admission avoidance in the community to patients and early supported discharge from hospital. GPs, practice nurses and patients known to the service can refer via the Respiratory Single Point of Access.

Hours of Operation	8.30am-4.30pm 7 days a week
Lead Nurse	Sue Scriven
Contact Details	01422 307328

Early Supported Discharge for Stroke

This team provides support to enable patients who have had a stroke to be supported at home to reduce length of stay and increase function by facilitating people to be as active as possible.

Hours of Operation	8.30am-5.00pm Mon-Fri
Lead Therapist	Sally Grose
Contact Details	01422 358146

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

Elective Orthopaedic Rehabilitation

The EOR service facilitates a smooth discharge home from the orthopaedic unit at Calderdale Royal Hospital. Most people are medically fit and safely mobile enough to return home within a few days following joint surgery to replace a hip or knee. Rehabilitation is started on the ward by EOR and continues following discharge home. EOR assess, advise and offer treatment, enabling a timely recovery and return to independence. This includes an exercise programme to gain improvement with walking, both indoors and out. Any equipment previously supplied is assessed to ensure it is still appropriate and if required, new equipment is provided.

Hours of Operation	8.00am-4.00pm, 7 day service
Lead Manager	Joanne Vaughan
Contact Details	01422 306723

Community Falls Service

The Falls Prevention Team is part of the Support and Independence Team who assess and advise people over the age of 50 who have had a fall or who are worried about their balance and frightened of falling. The team raise public awareness of falls and how to prevent them, identify older people who are at risk of falling using a simple five question screening tool, undertake detailed falls risk screening and refer patients to appropriate services to help, manage the risk of falling, provide education and advice to older people including advice on physical activity, diet, footwear and environmental hazards. The team provide strength and balance groups in local settings and /or tailored exercises in older people's homes.

Hours of Operation	8.30am-5.00pm, 5 day service
Lead Therapist	Claire Folan
Contact Details	01422 307323

Senior Managers in Community Division

Senior Managers on-call rota, contact Calderdale Royal Switchboard on **01422 357171.**

The Community senior manager on-call rota is available here Z:\Annual Leave\on call rota.xlsx

Senior manager contact details are as follows:-

Name	Role	Work mobile
Karen Barnett	Director of Operations	07785 416708
Nicola Ventress	Assistant Director of Finance/ Deputy Director of Operations	07765 306617
Andrea Dauris	Associate Director of Nursing	07920251715

Nicola Sheehan	Head of Therapies and Service Manager for OP and Children's Therapies	07917 234931
Liz Morley	Matron for Community Nursing	07747630989
Debbie Wolfe	Service Manager for Community Therapies	07825 902363
Mandy Gibbons-Phelan	Service Manager for Specialist Nursing	07795 825137
Suzie Dore	Service Manager for Intermediate Tier Services	07584 612950

Transportation and 4X4 Vehicles in Severe Weather

Roads that are impassable to cars due to ice or heavy snow are sometimes accessible to four-wheel-drive vehicles. The Estates Department have access to a 4X4 vehicle. The Hospital Transport Service can also arrange to hire 4X4 vehicles through their vehicle contractor, Arrow.

The following voluntary organisations in Yorkshire and the Humber have access to 4X4 vehicles:

- St John's Ambulance
- British Red Cross
- Yorkshire 4X4 club (4X4 Response)
- Age UK

It is essential that community nursing teams are able to travel to visit service users in their homes. The adult community nursing team managers maintain a list of staff with 4X4 vehicles and ensure that the nursing teams have access to 4X4 vehicles in instances of severe winter weather.

The adult community nursing teams also work closely with Calderdale Council Adult Social Care to make best use of resources.

Equipment Ordering and Provision

Patients in the community may require equipment to keep them safe, assist daily living skills and improve mobility/function in their own home.

Physiotherapists, Occupational Therapists, Nursing Teams and the Crisis Intervention Team are regular referrers to access equipment. Equipment is arranged via the Loan Stores for Calderdale Royal Hospital patients based at the Community Support Centre, Salterhebble.

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

Loan Stores Hours of Operation	8.00am-4.30pm Monday-Friday 8.00am-12.00pm Saturday
Lead Manager	Andrew Mould
Contact Details	01422 306725

Escalation plans and business continuity plans

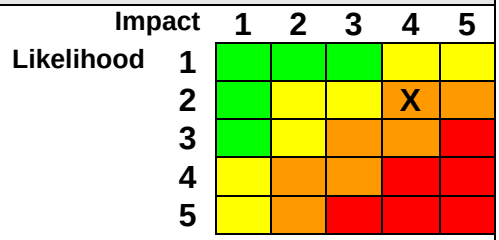
There are escalation plans that have been developed to support operations across all divisions. All escalation plans are found on the intranet, the ED and Paediatric escalation plan will be included in the On Call Managers Pack.

Each clinical division has identified the critical patient services they provide. Directorates have undertaken business impact analysis to identify what service functions can be reduced or suspended and have developed business continuity plans that describe the process for reducing non-critical activity and using the capacity generated to sustain critical patient services.

Cancer Pathway and Elective Pathway

The cancer agenda and targets will be maintained throughout winter. Elective surgery and cancer have rarely been cancelled due to bed pressures previously and this will continue to be the standard we adhere too. Attendance at MDT's and performance will be maintained over Christmas time and throughout winter. This will be managed by authorisation/monitoring of the number of Consultants that are off at any one time over this period.

Severe Winter Weather

Overview	
Business Impact	
• Absence of staff because they cannot get to work • Difficulty for staff and patients to travel around and between sites • Difficulty for community staff to access patienst homes • Increase in minor injuries from slips, trips and falls • Reduced patient transport service • Difficulty discharging patients because reduced public transport, patient transport or impassable roads to their homes or other healthcare facilities • Difficulty for suppliers to get supplies to hospital	
Proactive strategy	
• Adverse winter weather plan in place and reviewed. • Weather forecasts and gritting information published on the local authority websites. • Stockpile of salt/grit for car parks and access ways to Hospital sites. • Access roads to CRH and HRI are on Local Council Highways Priority Gritting Routes. • Yorkshire Ambulance Service winter plan. • Secure contingency 4x4 vehicles through voluntary services to transport staff to and from their place of work. • Community staff advised to work to nearest location to their homes	
Reactive strategy	
• Implement flexible working arrangements where possible (adult community nursing) • Implement the joint surge and escalation plan • Contact Local Council Highways to request roads are gritted for essential appointments and	

discharges (this will not always be possible).
• Provide accommodation for essential staff who cannot get home from work
• Request that the hospital transport service collect essential staff and bring them to work (this will not always be possible)

Trigger	Received by	Immediate action
Met Office Cold Weather Alert	Estates/Associate Director of Urgent Care	• Cold weather alerts will be forwarded to members of the winter (surge) planning group for onward circulation to departments. • Clinical Site Commanders will assess the consequences for discharges • The Estates Department and VLL (CRH) have a planned process for maintaining the Hospital grounds. • Review by the outpatients and surgical management teams of impact on performance.
YAS PTS notification that journeys are affected or have been stopped	Clinical Site Commander	
Significant number of out-patient DNA	Outpatient manager	
Staff absence reporting	Department managers	• All members of staff should make an early assessment of travel plans during inclement weather. It is the responsibility of staff to exhaust every potential transport arrangement that will enable then to attend for duty. • Staff accommodation for inclement weather will be supported by the Trust as in previous years via the Accommodation Manager • All service areas will maintain up-to-date contact lists for all their staff • Managers will use the Trust's adverse weather policy and the carer leave policy to manage staff absence. • Staff will be reallocated according to service need.

Cold Weather Alerts

Alert trigger	Trust Actions
Level 1 Winter Preparedness	• Work with partner agencies to co-ordinate cold weather plans • Work with partners and staff on risk reduction awareness • Plan for a winter surge in demand for services • Identify those at risk on your caseload
Level 2 Alert and readiness (60% risk of severe weather)	• Communicate public media messages • Communicate alerts to staff and make sure that they are aware of winter plans • Implement business continuity plans • Identify those most at risk • Check client's room temperature when visiting
Level 3 Severe Weather Action	• Communicate public media messages • Activate plans to deal with a surge in demand for services • Communicate with those at risk regularly • Ensure that staff can help and advise clients • Signpost clients to appropriate benefits

	• Maintain business continuity
Level 4 Emergency Response Exceptionally severe weather of threshold temperatures breached >6days	• Activate emergency management arrangements • Communicate public media messages • Activate plans to deal with a surge in demand for services • Communicate with those at risk regularly • Ensure that the hospital sites are kept clear and accessible • Maintain business continuity

Road Clearance

In the event of severe winter weather requiring roads to be cleared of snow and ice Kirklees Council will clear the pavement outside HRI to the boundary of the hospital site as part of its planned snow clearance operations. Acre Street and Occupation Road are on priority gritting routes. The access roads to CRH (Dryclough Lane, Godfrey Road, Dudwell Lane and Huddersfield Road) are all on priority gritting routes. Information on the priority gritting routes can be found at –

http://www2.kirklees.gov.uk/winterUpdates/default.aspx
http://www.calderdale.gov.uk/transport/highways/winter-service/index.html

There may be occasions in severe winter conditions where the hospital requires urgent deliveries such as medical gases and the site road access is impassable. In these situations the Local Councils may assist with road clearance where possible.

Kirklees Council will be operating “gritter twitter” this winter which gives real time information on the council’s response to the winter forecast. This information can be used to plan journeys and has been used by schools to assess whether or not to open. The link to twitter is can be found at the Kirklees Council weblink above. Calderdale Council regularly update their website with information about planned gritting routes during periods of severe weather.

Kirklees Council will do what is possible to help ambulances with gaining access to patients that require urgent treatment / transport to outpatient appointments and hospital discharges. Examples of urgent outpatient treatments include renal dialysis and administration of drugs for life threatening conditions. Any assistance will be on the basis that the hospital confirms that the situation is urgent. Kirklees Council Highways can be contacted 24hours a day on 0800 7318765. Any Trust patient phoning the council to ask for help will be directed to contact the relevant hospital department. The hospital department will inform the patient flow team who will be responsible for liaising with Kirklees Council Highways.

Calderdale Council Highways commit to responding to requests from the emergency services only but may be able to assist in the event of an urgent request from the Hospital to grit a particular highway. The Calderdale Council Highways can be contacted via the Street Care / Customer Care number 0845 2457000.

Transportation and 4X4 vehicles

The following voluntary organisations in Yorkshire and the Humber have access to 4X4 vehicles:

- St John's Ambulance
- British Red Cross
- Yorkshire 4X4 club (4X4 Response)
- Age UK

It is essential that community nursing teams are able to travel to visit service users in their homes. The adult community nursing team managers maintain a list of staff with 4X4 vehicles and ensure that the nursing teams have access to 4X4 vehicles in instances of severe winter weather. The adult community nursing teams also work closely with Calderdale Council adult social care to make best use of resources.

Managing absence

The Trust Adverse Winter Weather Policy will be followed at all times to ensure that there is consistency across the organisation in the event that severe winter weather causes staff to be later, absent or work excess hours.

In the event that essential have difficulty getting to work and there are no alternate travel options including car sharing or public transport it may be possible for the hospital transport team to collect staff from their homes. Where staff have difficulty getting home from work and there are no other options hospital provided transportation is also an option. It may also be possible to provide additional staff overnight accommodation. Requests for additional hospital transport services or accommodation should be made by a matron or general manager to the General Manager of Operations and Facilities.

The adult community nursing team work flexibly in winter. Healthcare workers visit patients closest to their home address and are able to work from an alternative location that is closer to their home address.

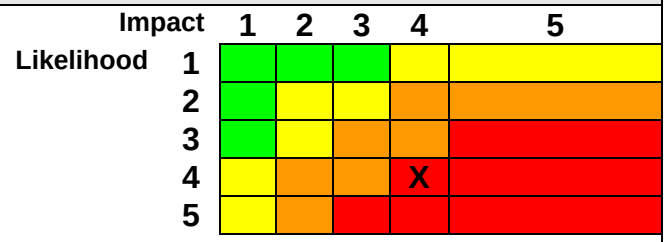
Useful contact information

Organisation	Contact Name	Telephone / Email
4X4 Response	24hr call out number	Available in patient flow office
British Red Cross		
Calderdale Council Highways		01422 288002
		OOH 01422 288000
Calderdale Council Emergency Planning Team		01422 393134
CHFT Accommodation		Via General Office
CHFT Hospital Transport Service		Via help desk
Kirklees Council Emergency Planning Team		01484 221000
Kirklees Council		01484 414818

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

Highways		
St John Ambulance		
	24hr pager	Via switchboard

Seasonal influenza

Overview		
Business Impact		
• Absence of staff due to influenza illness • Spread of the virus to staff due to ineffective use of personal protective equipment • Lack of available supplies of personal protective equipment • Increase costs of delivering care because of requirement of FFP3 masks and fit testing in some clinical areas • Lack of available side rooms to isolate infectious patients • Lack of available capacity on intensive care units to treat flu patients with serious illness • Closure of ward areas and loss of bed days due to outbreaks of infection • Increased monitoring and reporting requirements for flu-related activity		
Proactive strategy		
• Immunise staff for seasonal flu • Community staff continue support people to stay at home • Restate the risks and infection control requirements for managing flu patients • Key messages reinforced by community staff • Purchase additional supplies of face masks, gowns and goggles • Create and manage a stockpile of FFP3 masks • Fit test staff who may be required to use FFP3 face masks (medical, nursing and physiotherapy staff working in A&E, ICU, Respiratory and MAU)		
Reactive strategy		
• Promote key flu messages for patients (if you've got flu, stay at home) • Follow standard infection control precautions for managing flu patients • Reassign or redeploy staff in high-risk groups as appropriate • Implement the joint surge and escalation plan • Implement the escalation plan for critical care if required		
Trigger	**Received by**	**Immediate action**
DH reporting - proactive	DIPC	• Alert forwarded by email rule to Director of Operations, Director of Nursing, Director of Infection Prevention and Control. • Staff in the Emergency Departments and out patient departments will remind relevant patients to have their flu jabs if they have not already done so. • Implement management of flu arrangements.
Surge in flu related activity	ED matron/CD	
Surge in flu admissions	Infection control team	

Infection Control

Patients that require admission with suspected or confirmed influenza should be nursed in a side room with the door closed. A respiratory isolation sign should be displayed (further information on isolation of patients is available in the isolation policy section K). All staff must wear personal protective clothing (PPE) when entering the side room. When performing aerosolising procedures staff must wear an FFP3 mask and eye protection. Transfer and movement of patients around the hospital should be kept to a minimum.

In the event that there are number of admissions with confirmed or suspected influenza it may become appropriate to cohort patients in a single bed bay or ward area.

Some members of staff will be at greater risk from flu because of a pre-existing medical condition or pregnancy. The risks to staff should already have been identified and managed through existing occupational health protocols.

Personal Protective Equipment

Wards and departments should ensure that they have sufficient supplies of personal protective equipment including gloves, plastic aprons and surgical masks.

A central stockpile of surgical masks, gowns and eye protection will be established on each site. The stockpile will be managed by the materials management team and accessible to the relevant wards and departments.

FFP3 masks, gowns and eye protection are only required by staff performing cough inducing procedures for patients with suspected or confirmed influenza. FFP3 respirators must be used as an alternative to a surgical face mask when performing the following procedures.

- intubation and related procedures, e.g. manual ventilation and ET tube suctioning
- cardiopulmonary resuscitation
- bronchoscopy
- surgery and post-mortem procedures in which high-speed devices are used.

Staff performing these types of procedures will include A&E medical staff, Anaesthetists and Intensivists, respiratory physicians, medical physicians, physiotherapists (chest) and some nursing staff in ICU, respiratory and MAU. Other wards and departments should not routinely stock these masks.

FFP3 masks are held on wards 1, 6, 11, 18, ICU, SAU, Emergency Department at HRI; wards 2AB, MAU, 3, 5, ICU and Emergency Department at CRH); A central stockpile of FFP3 masks will also be established on each site but will be managed by the infection control team. The site coordinator can be contacted out-of-hours if FFP3 masks are required.
A central stockpile of FFP3 masks will also be established on each site but will be managed by the infection control team. The site coordinator can be contacted out-of-hours if FFP3 masks are required.

Fit Testing For FFP3 Masks

Prior to using a face mask respirator the user must first test that an air-tight seal can be attained. Face masks come in various shape sizes so users can determine the most effective.

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

There are fit test kits on all ward areas within the Trust. Fit test kits will be used to fit test initially. It is the responsibility of leads in each of the areas identified to fit test their staff, that perform aerosolizing procedures, and to record the type of mask that they require. For those staff that have been fit tested need adding onto the equipment training database to ensure an accurate training record is maintained.

Where a member or staff does not successfully fit test with the mask in the central stock areas (wards 1, 5, 6, 18, ICU, SAU, Emergency Departments at HRI; wards 2AB, MAU, 3, CCU, ICU and Emergency Department at CRH); or a reusable mask held by the ward or department, each management team must put in place appropriate risk mitigation measures to protect the member of staff from contracting the flu virus at work. This may involve:

- Purchasing an alternative model of mask (if available)
- Reassigning to an alternative task
- Redeploying to a different area where they will not be required to perform aerosolising procedures with flu patients

FFP3 portable hood systems have been purchased for use in the emergency departments on both sites. Training is being undertaken in both ED's in the use of the FFP3 hood systems.

Critical Care Escalation Plan

The Local Critical Care Network has developed a critical care network escalation plan that includes triggers and escalation levels (see appendix 2). The Trust Critical Care Escalation Plan details the arrangements for increasing level 3 capacity in the event of a surge in demand.

Christmas and New Year Bank Holidays

Staffing

The clinical divisions will have arrangements in place to ensure staff cover on the bank holidays over the Christmas, New Year period and the during this period when there is anticipated surge in emergency/acute demand. There will be senior divisional management cover over the Christmas and New Year period.

Reduced services

The Christmas and Bank Holiday arrangements for different services will be shared in the on callpack which will be available in each Patient Flow office. Copies of the operational arrangements for theatres and clinical support services over the Christmas and Bank Holiday period will be again available for the on call teams over the Christmas and New Year period.

Partner organisations

The Christmas and New Year cover arrangements for primary care, social care and safeguarding will be shared with the on call teams for the Christmas and New Year period and stored in the patient flow offices on both CRH and HRI sites.

Communications

The communications team will issue media statements during winter to reinforce key health messages.

When there is a community outbreak of diarrhoea and vomiting a press release will be issued promoting basic hand hygiene and asking the public to stay away from hospital if possible because they risk passing on an infection to vulnerable patients.

Prior to the Christmas and New Year period a press release will be issued reminding the public them when it is appropriate to use primary care services rather than accident and emergency departments and to stock of home medicines cabinets prior to the holiday.

In the event of a significant infection outbreak the Trust communications team will work with Calderdale and Greater Huddersfield CCG to implement a media and communications strategy utilising key messages which will include advice for visitors.

Training and Implementation of the Winter Plan

The winter planning group is overall responsible for ensuring that those with identified roles in the plan are familiar with the protocols set out in this document. This will be achieved by;

- Involvement of leads from each division in winter planning group
- Discussion at the appropriate divisional committees
- Cascade of messages to key staff groups through email circulation and Trust news;
- Publication of related documents on the Preparing for Emergencies section of the staff intranet;
- Publication of the plan on the Trust intranet; and,
- **Winter Plan briefings for Managers, Directors, Matrons, Ward/department sisters from September 2017.**

Equality Impact Statement

Calderdale and Huddersfield NHS Foundation Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender, race, disability, age, sexual orientation, religion or religious/philosophical belief or marital status.

Monitoring Compliance with this procedural document

The winter planning group is responsible for the successful implementation and monitoring of the winter plan. The winter planning group will continue monitor the plan (October 2017 to March 2017) to review its effectiveness and update the document where appropriate.

Review Date: June 2017
Review Lead: Associate Director for Urgent Care

Associated Documents/Further Reading- Intranet

The Trust has a number of policies and plans that would be used in dealing with problems caused by winter conditions. They are both clinical and non-clinical and some are season-specific and others are for general use.

a. Adverse weather policy
b. Pandemic influenza
c. Major Outbreak of infection Policy
d. Emergency Management Arrangements
e. Escalation guidelines for the maternity units
f. Discharge policy/Transfer of Care policy

There are also some whole system plans that will be implemented as appropriate:

g. Joint Surge and Escalation Plan

Appendix 1

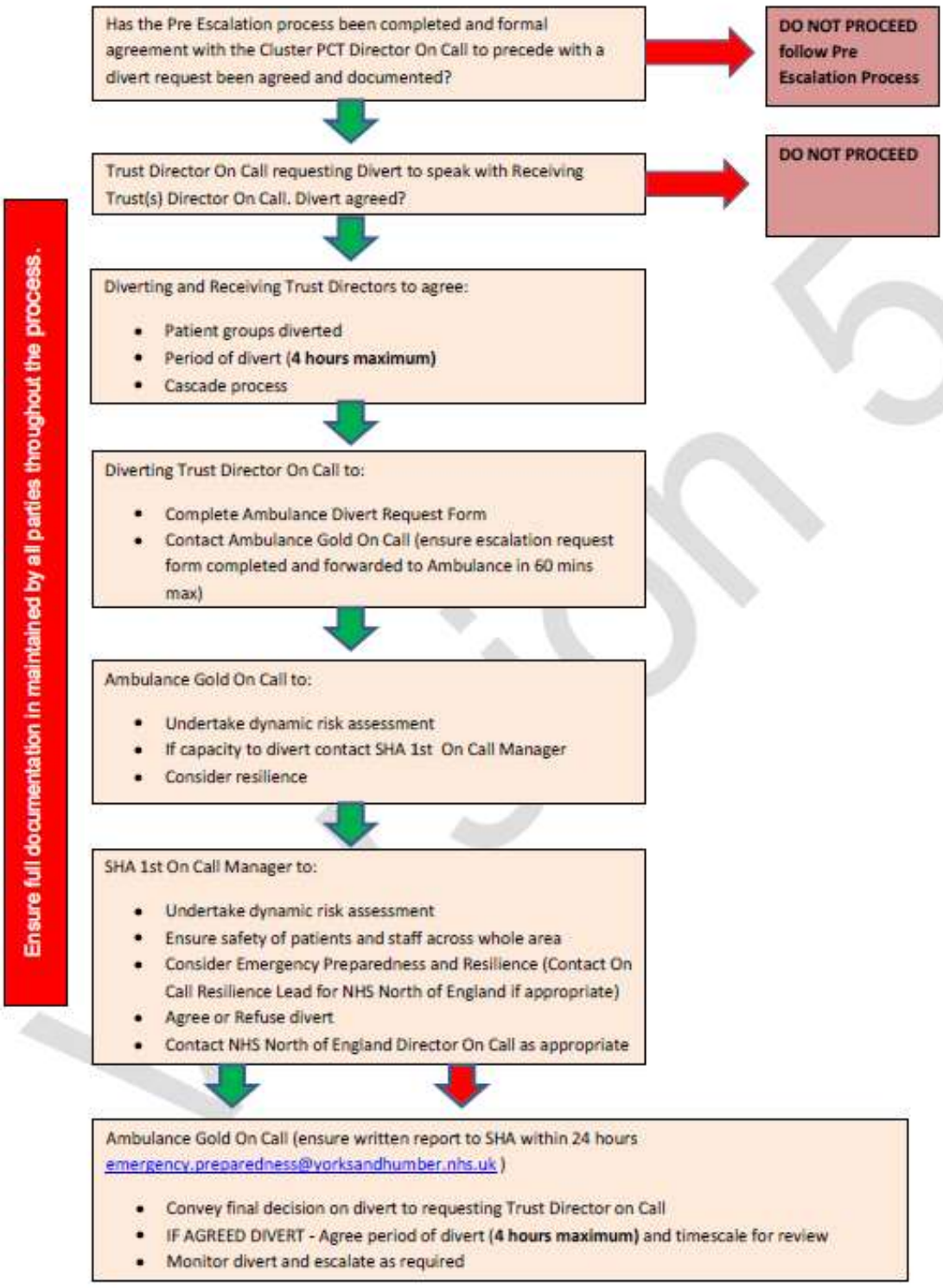
SECONDARY CARE (including Acute, Specialist & Foundation Trusts etc)	
DEFINITION	**STATUS**
NORMAL	
'Business as usual' • Normal, able to meet all critical care needs, without impact on other services. • Current status as 'normal' for season	**CRITCON 0 (FLUCON 0)**
LOW SURGE	
'Swine Flu impacting beyond 'normal' winter pressures' • May include limited local expansion, elective cancellation, and/or non-clinical patient transfers.	**CRITCON 1 (FLUCON 1)**
MEDIUM SURGE	
'Unprecedented' • Level of pressure on critical care which is previously unseen in most organisations. • May include significant expansion into non-ICU areas, and/or use of adult facilities for paediatric critical care. • Staff working outside normal areas, or at increased patient:nurse ratios. • Significant critical care transfers (clinical and non-clinical). • Trusts beginning mutual aid and phased reduction of elective work as necessary to support critical care needs, by local decision. • No triage (refusal or withdrawal of critical care due to resources). • When a significant proportion of Trusts in Yorkshire and The Humber are reporting CRITCON 2 the SHA will assume command and control arrangements	**CRITCON 2 (FLUCON 2)**
HIGH SURGE	
'Full stretch' • Maximum expansion for mutual aid with extensive impact on services. • SHA instruction for all critical care units in region to double capacity (so all organisations in SHA move to CRITCON 3 in one step). • Trusts at or near maximum physical capacity (may be more than double in some cases). • Elective operating reduced to lifesaving surgery only. • Elective medical and other procedures similarly prioritised to free staff, space, or equipment. • No triage (refusal or withdrawal of critical care due to resources).	**CRITCON 3 (FLUCON 3)**
TRIAGE	
'Last resort' • SHA will declare CRITCON 4 for all of region when region is unable to meet all critical care needs despite full surge capacity in place. • Triage processes for accessing critical care will be instigated. This will result in adverse outcomes to one or more flu or non-flu patients due to resource limits caused by the pandemic. • Will be reviewed every 12 hours.	**CRITCON 4 (FLUCON 3)**

Appendix 2: Criteria and SOP for open and referral to flexible capacity

Checklist on opening additional beds.docm

Appendix 3

Escalation Request Flow – NHS North of England Yorkshire and the Humber Footprint



Appendix 4

CRITERIA FOR MEDICAL TRANSFERS TO: - THE GYNAECOLOGY AREAS

Prior to transferring to ward 4C or GAU the patient must be assessed against essential criteria as outlined below.

If the criteria to outlie are not met please escalate to the Matron for Gynaecology, On Call Duty Matron or Night Matron as appropriate.

- No acute delirium, confusion, disorientation
- Patient is not on the End of Life Care Pathway
- Minimal risk of falling
- For patients requiring re-ablement, intermediate or 24 hour care section 2 physio and OT referrals must have been completed
- NEWS within expected limits
- Patient does not require specialist nursing skills i.e. Nippy, peg feeds, unstable cardiac symptoms, unstable diabetic, active seizures, probable CVA
- Patient with a known ongoing complaint/ grievance must have Senior review to assure that a move is in the best interest of the patient
- Patient has not been admitted with a diagnosis of long term substance misuse (e.g. alcohol or drugs)

Paediatric Escalation Plan, Advanced Paediatric Nurse Practitioner Escalation Plan and Maternity Escalation Policy

Appendices 5, 6 and 7

2016__Feb__-_Paediatric_Escalation_-_v3

2016__Sept__-_APNP_escalation_process

Escalation Policy (Maternity).pdf

8. STRATEGIC PLAN & QUALITY PRIORITIES UPDATE

•Updated Strategic Plan and Priorities 2017-18

To Note

Presented by Victoria Pickles

QUALITY COMMITTEE	
PAPER TITLE: 2017/18 Plan on a Page	**REPORTING AUTHOR:** Victoria Pickles, Company Secretary
DATE OF MEETING: 26 October 2017	**SPONSORING DIRECTOR:** Victoria Pickles, Company Secretary
STRATEGIC DIRECTION – AREA: • Keeping the base safe • Transforming and improving patient care • A workforce for the future • Financial Sustainability	**ACTIONS REQUESTED:** • For comment • To approve • To note
PREVIOUS FORUMS: Board of Directors	
IF THIS IS A POLICY OR A SERVICE CHANGE, HAS IT BEEN EQUIP'd? If so, please provide the unique EQUIP reference number below: N/A **For guidance click on this link: http://nww.cht.nhs.uk/index.php?id=12474**	
EXECUTIVE SUMMARY: Last year the Board approved the 5 Year and 1 Year plan on a page. During 2016/17 the Board received quarterly updates on the progress made against the objectives described in the plan and at its meeting in March, received the end of year position. At its meeting in June, the Board approved the objectives for 2017/18. Both the Council of Governors and the Board received a progress report against these in July. This is the second update for the year and will also be presented to Board in November.	
FINANCIAL IMPLICATIONS OF THIS REPORT: None	
RECOMMENDATION: The Council of Governors is asked to NOTE and COMMENT on the 2017/18 plan on a page.	
APPENDIX ATTACHED: YES ~~/ NO~~	

Calderdale and Huddersfield NHS Foundation Trust
Annual Plan Year ending 2018 - Progress Report July 2017

Introduction

The Trust's vision is:
Together we will deliver outstanding compassionate care to the communities we serve.

In June 2017, the Board of Directors agreed the refreshed 1 year plan for year ending 2018. The plan describes the four goals of the Trust:

- Transforming and improving patient care
- Keeping the base safe
- A workforce fit for the future
- Financial sustainability

These goals are underpinned by the four behaviours:

- We put the patient first
- We go see
- We work together to get results
- We do the must dos

The plan sets out the key areas of delivery to support the achievement of each of the goals described in the table below. The risks of not delivering our goals have been assessed and are included in the Board Assurance Framework. The risks associated with each area of delivery have also been assessed and are included in the corporate risk register. The identified risks are reviewed and escalated as appropriate in line with the Trust's risk management arrangements.

Year Ending 2018				
Our Vision	*Together we will deliver outstanding compassionate care to the communities we serve*			
Our behaviours	We put the patient first / We go see / We do the must dos / We work together to get results			
Our goals (The result)	Transforming and improving patient care	Keeping the base safe	A workforce for the future	Financial sustainability
Our response	Submit a full business case to NHS Improvement to secure approval of capital funding and agreement to implement	Maintain a Single Oversight Framework rating of 3 or better	Implement the 5 year workforce strategy	Deliver a robust financial plan for 2018 including CIP
		Strengthen patient and public engagement in particular learning from incidents, complaints process, and in listening events	Develop and deliver an organisational development plan	Refresh the commercial strategy in light of current economic climate
	Delivery of 17/18 SAFER (patient flow) programme objectives	Implement the actions resulting from the findings of the CQC inspection in readiness for the new-style inspection.	Create and deliver an engagement strategy that ensures colleagues have a voice	Continue to proactively contribute to WYAAT and the WYSTP.
	To work as an early adopter toward the implementation of selected 7 day NHS England standards (2,5,6 and 8) in agreed specialties	Develop the Quality Strategy and implement the local quality priorities (see separate page)	Develop workforce roles and service models that enable the Trust to deliver care within planned resources and minimise use of agency & temporary staffing	Lead on the development of the IM&T and Estates schemes and progress these to full business case.
	Realise the benefits and transformational change opportunities from the new EPR	Implement year 3 of the health and safety action plan; develop and deliver robust emergency planning and business continuity arrangements	Deliver a leadership and succession planning development programme	Develop a clear plan to meet the organisations capital requirements
			Deliver a programme of workforce information systems modernisation	

Purpose of Report

The purpose of this report is to provide an update for Trust Board members of the progress made against the four goals described in the Trust's 1 year plan 2017/18.

Structure of Report

The report is structured to provide an overview assessment of progress against key deliverables responses and this is rated using the following categories:
1. Completed (blue)
2. On track (green)
3. Off track – with plan (amber)
4. Off track – no plan in place (red)

For each area of delivery there is also a summary narrative of the progress and details of where the Board will receive further assurance.

Summary

This report highlights that of the 20 deliverables:
- None are rated red
- Seven are rated amber
- 13 are rated green
- None have been fully completed

This is an expected position at this point in the year.

Recommendation

Trust Board Members are requested to:
- Note the assessment of progress against the 2017/18 goals.
- Discuss and agree the future action and assurance that may be required

Goal: Transforming and improving patient care

Deliverable	Progress rating	Progress summary	Assurance route
Submit a full business case to NHS Improvement to secure approval of capital funding and agreement to implement.	**On track (green)**	The Trust has developed the draft Business Case and this has been submitted to NHS Improvement. The Commissioners agreed their support at the Governing Body meetings in October. Awaiting decision from SoS regarding referral to Independent Reconfiguration Panel.	**Lead: AB** Hospital Services Programme Board Board NHS I Quarterly Review Meeting
Delivery of 17/18 SAFER (patient flow) programme objectives	**On track (green)**	SAFER programme in place and seeing some impact on key indicators. Ambulatory Care and Community Place are running and having an impact. Frailty Service commenced at HRI and plans to expand. Building on the work undertaken by WYAZ.	**Lead: HB** Reported to Weekly Executive Board and Quality Committee.
To work as an early adopter towards the implementation of selected 7 day NHS England standards (2,5,6 and 8) in agreed specialties	**On track (green)**	Compliance with 7-day services now included as an indicator in the Single Oversight Framework for Trusts. Most recent benchmarking report received and being reviewed to identify gaps and any further actions required.	**Lead: DB** Quality Committee Weekly Executive Board
Realise the benefits and transformational change opportunities from the new EPR	**Off track – with plan (amber)**	Cut-over and go-live took place as scheduled over the weekend from 28 April. Number of outstanding issues identified and being addressed through managed process overseen by Operational Board and Weekly Executive Board. Business as usual team in place.	**Lead: MG / HB** Monthly to Board and Finance and Performance Committee Sponsoring Group Executive Board

Goal: Keeping the base safe			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Maintain a Single Oversight Framework (SOF) rating of 3 or better	**On track (green)**	The Trust is currently achieving a SOF rating of 3.	**Lead: VP** Progress Review Meeting feedback to Board Audit and Risk Committee
Strengthen patient engagement particularly in learning from incidents, complaints and in listening events	**Off track – with plan (amber)**	We are introducing patient readers into the complaints process and have patients working with maternity colleagues looking at serious incidents. HealthWatch colleagues are also attending Calderdale Royal each month to talk to patients about health services. A plan that describes the actions already taken and further steps is being pulled together and will go to Quality Committee for approval.	**Lead: BB** Monitored through Quality Committee
Implement the actions resulting from the findings from the CQC inspection in readiness for the new-style inspection	**On track (green)**	Response to CQC report – actions complete, but testing on embeddedness of actions taken to date continues. 'Mock' inspections of targeted areas completed CHFT hosting Ted Baker, Chief Inspector of Hospitals in a Regional Leadership Event for Clinicians in response to the new CQC inspectorate regime Self-assessment against PIR underway – further testing against self-assessment scheduled Test site for NHS Improvement Board development for continuous improvement programmes - linked to the policy framework *'Developing People – Improving Care'*	**Lead: BB** Monitored through Quality Committee, Weekly Executive Board and Board of Directors
Develop the Quality Strategy and implement the local quality priorities	**On track (green)**	A Quality Improvement Strategy has been drafted and shared with Quality Committee for review prior to approval by the Board.	**Lead: BB** Quality Committee

Implement year 3 of the health and safety action plan; develop and deliver robust emergency planning and business continuity arrangements	**On track (green)**	Progress has been made on delivery of year three of the health and safety action plan. Business continuity plans were refreshed in preparation for EPR and were tested during go live and early live support. The learning from this is being built into the plans. Emergency planning and counter terrorism training in place. A lockdown plan has been developed. Security adviser from Leeds is providing support to the Trust. Taking part in exercises.	**Lead: LH** Monitored through Health and Safety Committee to Quality Committee and reported six-monthly to the Board.

Goal: A workforce fit for the future			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Implement the 5 Year workforce strategy	**On track (green)**	Workforce Strategy and implementation plan approved by the Board in January 2017. Implementation of the plan being monitored through the Well Led Workforce Committee.	**Lead: JE** Well Led Workforce Committee
Develop and deliver an organisational development plan	**Off track – with plan (amber)**	A draft OD approach and plan has been written. OD partners appointed. First two cohorts in CLIP programme. Mentoring for BME in place.	**Lead: JE** Well Led Workforce Committee.
Create and deliver an engagement strategy that ensures colleagues have a voice	**Off track – with plan (amber)**	The proposed plan has been discussed with the Colleague Engagement Network. The Trust has been working with Wrightington Wigan and Leigh NHS FT to adopt the 'Go Engage' programme. A small task and finish group of members of the colleague engagement network has been set up to develop an implementation plan for Go Engage. The BME network continues to meet and is well attended.	**Lead:JE** Well Led Workforce Committee.
Develop workforce roles and service models that enable the Trust to deliver care within planned resources and minimise use of agency and temporary staffing	**Off track – with plan (amber)**	Work underway using Calderdale Framework. Have made significant improvements in recruitment of different staff groups – particularly medical staff. Agency spend is below planned levels. Work on strengthening the bank, including weekly pay arrangements in place.	**Lead: JE** Well Led Workforce Committee.

Develop a leadership and succession planning development programme	**On track (green)**	Compassionate Leadership in Practice (CLIP) programme launched on 27 June with the first two cohorts delivered by HealthSkills for current and future leaders. Programmes being developed to provide management skills for clinical leaders, coaching and financial management skills.	**Lead: JE** Well Led Workforce Committee.
Deliver a programme of workforce information systems modernisation	**On track (green)**	A paper was presented to the Well Led Workforce Committee in January. Purchased Allocate software to provide multi-specialty e-rostering and job planning for medics.is ESR upgraded and work being done to improve use of functionality. Strengthened system in place for e-expenses.	**Lead: JE** Well Led Workforce Committee

Goal: Financial sustainability			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Deliver a robust financial plan including CIP for YE 2018	**Off track – with plan (amber)**	The Month 5 position is a deficit of £13.91m on a control total basis, in line with plan. This excludes year to date Sustainability and Transformation funding (STF) of £2.43m.This financial position is challenging and a number of actions have been put in place as part of a recovery plan including tighter controls around non-pay spend; vacancies; and additional hours. Briefings are planned for all parts of the organisation to encourage greater control and generate ideas for efficiency savings.	**Lead: GB** Weekly progress monitored through Turnaround Executive. Reported to Finance & Performance Committee
Refresh the commercial strategy in light of current economic climate	**Off track – with plan (amber)**	The Commercial Strategy is being refreshed.	**Lead: AB** Finance and Performance Committee
Continue to proactively contribute to WYAAT and WYSTP	**On track (green)**	The WYAAT Committee in Common governance arrangements are in place and Chairing responsibility currently sits with CHFT. West Yorkshire network agreed for vascular services looking at on call, sub specialisation teams and shared workforce approaches. A model for pathology services has been set out. Other workstreams looking at provision of estates and facilities; single radiology imaging system and pharmacy stores business cases.	**Lead: AB** Finance & Performance Committee
Lead on the development of	**On track (green)**	Estates and Facilities and THIS schemes are progressing	**Lead: MG / LH**

schemes and progress these to full business case		to the next stage.	Business cases rev by Board and WYAAT Committee in Common
Develop a clear plan to meet the organisation's capital requirements	**On track (green)**	Prioritised plan approved.	**Lead: GB** Capital Management Group Weekly Executive Board

9. Full Business Case Update

To Note

Presented by Anna Basford

GOVERNANCE

MEMBERSHIP COUNCIL	
PAPER TITLE: CONSTITUTION AMENDS	**REPORTING AUTHOR:** Victoria Pickles, Company Secretary
DATE OF MEETING: 26 October 2017	**SPONSORING DIRECTOR:** Andrew Haigh – Chairman
STRATEGIC DIRECTION – AREA: • Keeping the base safe • Transforming and improving patient care • A workforce for the future • Financial Sustainability	**ACTIONS REQUESTED:** • For comment • To approve • To note
PREVIOUS FORUMS: Council of Governors – April 2017	
IF THIS IS A POLICY OR A SERVICE CHANGE, HAS IT BEEN EQUIP'd? If so, please provide the unique EQUIP reference number below: **For guidance click on this link:** http://nww.cht.nhs.uk/index.php?id=12474	

EXECUTIVE SUMMARY:

The Trust's Constitution, along with the standing orders for the Membership Council and the Board of Directors, sets the rules for the governance of the Trust and should be periodically reviewed for any changes or updates in legislation.

Following the last significant review in April 2017, a number of minor amendments have been identified and are presented here for approval:

- Removal of the Clinical Commissioning Groups' Stakeholder Governor place and replacing this with HealthWatch Calderdale and Kirklees.
- Amendment to quoracy to not specify make up of attendance, purely the need for 10 governors.
- Clarification of what happens when an elected governor moves constituencies during their term
  14.1.4 who relocate from the constituency to which they were elected to a different constituency where there is a vacancy are eligible to represent that constituency until the next election;
- Re-reviewed to ensure all references to Membership Council have been updated to Council of Governors.

FINANCIAL IMPLICATIONS OF THIS REPORT:

None

RECOMMENDATION:
The Council of Governors is asked to REVIEW and APPROVE the Constitution.

APPENDIX ATTACHED: YES ~~/ NO~~

Latest review October 2017
Approved October 2017

UNIQUE IDENTIFIER NO: G/1/2017c
Review Date: April 2019
Review Lead: Company Secretary

CONSTITUTION OF THE

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

(A PUBLIC BENEFIT CORPORATION)

TABLE OF CONTENTS

CONSTITUTION FOR THE CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

1. Definitions

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

1.2. References in this constitution to legislation include all amendments, replacements, or re-enactments made.

1.3. Headings are for ease of reference only and are not to affect interpretation.

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

1.5. In this constitution:

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.
The 2006 Act	means the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.
The 2012 Act	is the Health and Social Care Act 2012.
Annual Members' Meeting	is defined in paragraph 10 of the constitution.
Appointed Governor	means those Governors appointed by the Appointing Organisations;
Appointing Organisations	means those organisations named in this constitution who are entitled to appoint Governors;
Areas of the Trust	the areas specified in Annexe 1;
Authorisation	means an authorisation given by Monitor
Board of Directors	means the Board of Directors as constituted in accordance with this constitution;
Director	means a member of the Board of Directors
Non-Executive Directors	means the Chairman and non-executives on the Board of Directors;
Elected Governor	means those Governors elected by the public constituency and the staff constituency;

Financial year	means: (a) a period beginning with the date on which the Trust is authorised and ending with the next 31 March; and (b) each successive period of twelve months beginning with 1 April;
Monitor	is the former name for the Trust's regulator, as provided by Section 61 of the 2012 Act;
Local Authority Governor	means a Member of the Council of Governors appointed by one or more Local Authorities whose area includes the whole or part of the area of the Trust;
Member	means a Member of the Trust;
Council of Governors	means the Council of Governors as constituted by this constitution and referred to as the Board of Governors/ Council of Governors in the 2006 Act;
The NHS Trust	means the NHS Trust which made the application to become the Trust;
Other Partnership Governor	means a Member of the Council of Governors appointed by a Partnership Organisation other than a Primary Care Trust or Local Authority;
Public Constituency	means those individuals who live in an area specified as an area for any public constituency;
Public Governor	means a Member of the Council of Governors elected by the Members of the public constituency;
Secretary	means the Board Secretary of the Trust or any other person appointed to perform the duties of the Secretary;
Staff Constituency	means those individuals who are eligible for Trust membership by reason of 8.5-8.9 of this Constitution are referred to collectively as the Staff Constituency;
Staff Governor	means a Member of the Council of Governors appointed by the Members of one of the classes of the constituency of the staff membership;
The Trust	means Calderdale & Huddersfield NHS Foundation Trust.

2. Name and status

2.1. The name of this Trust is “Calderdale and Huddersfield NHS Foundation Trust”.

3. Head Office and Website

3.1. The Trust’s head office for the purpose of this Constitution is at Trust Offices, Huddersfield Royal Infirmary, Acre Street, Lindley, Huddersfield, HD3 3EA, or any other address decided by the Council of Governors.

3.2. The Trust will maintain a website, the address of which is www.cht.nhs.uk or any other address decided by the Council of Governors.

4. Purpose

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

4.2. 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.

4.3. The Trust may provide goods and services for any purposes related to:-

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

4.3.2. the promotion and protection of public health.

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

5. Powers

5.1. The powers of the Trust are set out in the 2006 Act.

5.2. All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

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

5.4. The Trust may do anything which appears to it to be necessary or desirable for the purposes of or in connection with its functions.

5.5. In particular it may:

5.5.1. acquire and dispose of property;

5.5.2. enter into contracts;

5.5.3. accept gifts of property (including property to be held on Trust for the purposes of the Trust or for any purposes relating to the health service);

5.5.4. employ staff.

5.6. Any power of the Trust to pay remuneration and allowances to any person includes the power to make arrangements for providing, or securing the provision of pensions or gratuities (including those payable by way of compensation for loss of employment or loss or reduction of pay).

5.7. The Trust may borrow money for the purposes of or in connection with its functions, subject to the limit published by NHS Improvement from time to time.

5.8. The Trust may invest money (other than money held by it as Trustee) for the purposes of or in connection with its functions. The investment may include investment by:
5.8.1. forming, or participating in forming bodies corporate;
5.8.2. otherwise acquiring membership of bodies corporate.

5.9. The Trust may give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its function.

6. Membership and Constituencies

6.1. The Trust shall have members, each of whom shall be a member of one of the following constituencies:
6.1.1. A public constituency
6.1.2. A staff constituency

7. Members

7.1. The Members of the Trust are those individuals whose names are entered in the register of members. Every Member is either a Member of one of the public constituencies or a Member of the staff constituency.

7.2. Subject to this Constitution, Membership is open to any individual who:
7.2.1. is over 16 years of age;
7.2.2. is entitled under this Constitution to be a Member of the public constituencies, or staff constituency; and
7.2.3. completes or has completed a membership application form in whatever form the Council of Governors approves or specifies.

Public Membership

7.3. There are eight public constituencies corresponding to the areas served by the Trust as set out in Annexe 1. Members of each constituency are to be individuals:
7.3.1. who live in the relevant area of the Trust;
7.3.2. who are not eligible to be Members of the staff constituency; and
7.3.3. who are not Members of another public constituency.

7.4. The minimum number of members of each of the public constituencies is to be 50.

Staff Membership

7.5. There is one staff constituency for staff membership. It is to divided into five classes as follows:
- 7.5.1. doctors or dentists;
- 7.5.2. Allied Health Professionals, Health Care Scientists and Pharmacists;
- 7.5.3. Management, administration and clerical;
- 7.5.4. Ancillary staff;
- 7.5.5. Nurses and midwives.

7.6. Members of the staff constituency are to be individuals:
- 7.6.1. who are employed under a contract of employment by the Trust and who either:
  - 7.6.1.1. are employed by the Trust under a contract of employment which has no fixed term or a fixed term of at least 12 months, or
  - 7.6.1.2. who have been continuously employed by the Trust for at least 12 months; or
- 7.6.2. who are not so employed but who nevertheless exercise functions for the purposes of the Trust, and have exercised the functions for the purposes of the Trust for at least 12 months.

7.7. Individuals entitled to be Members of the staff constituency are not eligible to be Members of the public constituency.

7.8. The Secretary is to decide to which class a staff member belongs.

7.9. The minimum number of members in each class of the staff membership is to be 20.

Automatic membership by default – Staff

7.10. An individual who is:
- 7.10.1. Eligible to become a member of the Staff Constituency, and
- 7.10.2. Invited by the Trust to become a member of the Staff Constituency,

Shall become a member of the Trust as a member of the Staff Constituency without an application being made, unless he / she informs the Trust that he / she does not wish to do so.

8. Disqualification from membership

8.1. A person may not be a member of the Trust if, in the opinion of the Council of Governors, there are reasonable grounds to believe that they are likely to act in a way detrimental to the interests of the Trust.

9. Termination of membership

9.1. A Member shall cease to be a Member if:
- 9.1.1. they resign by notice to the Company Secretary;
- 9.1.2. they die;
- 9.1.3. they are disqualified from Membership by paragraph 7;

9.1.4. they cease to be entitled under this Constitution to be a Member of any of the public constituencies or the staff constituency.

9.2. 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 Annexe 3 – Further Provisions.

10. Annual Members' Meetings

10.1. The Trust is to hold an annual meeting of its members meeting. The Annual Members Meeting shall be open to members of the public.

10.2. Further provisions about the Annual Members' Meeting are set out in Annexe 4 – Annual Members' Meeting.

11. Council of Governors - composition

11.1. The Trust is to have a Council of Governors which shall comprise both elected and appointed governors.

11.2. The composition of the Council of Governors is specified in Appendix 6 – Composition of the Council of Governors.

11.3. The composition of the Council of Governors, subject to the 2006 Act, shall seek to ensure that:

11.3.1. the interests of the community served by the Trust are appropriately represented;

11.3.2. 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.;

12. Council of Governors – elections of Governors

12.1. Public Governors are to be elected by Members of the public constituencies, and Staff Governors by Members of the staff constituency.

12.2. The Election procedures including the arrangements governing nominations, the advertisement of candidates, rules regarding canvassing voting, and the election of reserves to fill casual vacancies are to be determined by the election rules, set out in Annexe 2 – Election Rules.

13. Council of Governors - appointed Governors

13.1. Local Authority Governors

The Secretary, having consulted each Local Authority whose areas includes the whole or part of the area of the Trust is to adopt a process for agreeing the appointment of Local Authority Councils Member with those Local Authorities.

13.2. Partnership Governors

The Secretary, having consulted each partnership organisation is to adopt a process for agreeing the appointment of Partnership Governors with those partnership organisations.

14. Council of Governors - tenure for Governors

14.1. Elected Governors:

14.1.1. shall hold office for a period of three years commencing immediately after the annual members meeting at which their election is announced;

14.1.2. subject to the next sub-paragraph are eligible for re-election after the end of that period;

14.1.3. may not hold office for more than six consecutive years or two terms excluding any period on the reserve register (see 14.3 below);

14.1.4. who relocate from the constituency to which they were elected to a different constituency where there is a vacancy are eligible to represent that constituency until the next election;

14.1.5. cease to hold office if they are disqualified for any of the reasons set out in this Constitution.

14.2. Appointed Governors:

14.2.1. shall hold office for a period of 3 years commencing immediately after the annual members meeting at which their appointment is announced;

14.2.2. subject to the next sub-paragraph are eligible for re-appointment after the end of that period;

14.2.3. may not hold office for longer than 6 consecutive years;

14.2.4. shall cease to hold office if the Appointing Organisation terminates their appointment.

14.2.5. cease to hold office if they are disqualified for any of the reasons set out in this Constitution.

14.3. The Foundation Trust will retain a reserve register of Governors who have previously held and completed their elected terms of office with the Foundation Trust as per paragraph 14.1. Access to the Register will be exceptional and for a time limited period. No reserve governor shall be retained on the reserve list for more than 2 years following completion of their elected terms of office. Governors can apply to be on the reserve register if they are not re-elected following the first term of their elected office. The normal rules of selection and exclusion for Governors will apply to reserve Governors. A majority of the Council of Governors, who are present when the decision is taken, must agree the movement of a reserve governor from the reserve list onto the Council of Governors. The reserve governor may only serve on the Council of Governors for a 12 month period. No further terms on the register will be available. The reserve Governor may only cover a vacancy that exists following elections. This may be on the Constituency to which they were previously elected and hold terms of office or to a different vacant seat. The rules of good governance will apply at all times and the Board of Directors and Council of Governors will have regard to the need to continually refresh their elected and appointed members, whilst ensuring that the business of the Council of Governors can continue seamlessly using the best available knowledge and experience.

15. Council of Governors - vacancies amongst Governors

15.1. Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply.

15.2. Where the vacancy arises amongst the Appointed Governors, the Secretary shall request that the Appointing Organisation appoints a replacement to hold office for the remainder of the term of office.

15.3. Where the vacancy arises amongst the elected Governors, the Council of Governors shall be at liberty either:

15.3.1. to call an election within three months to fill the seat for the remainder of that term of office, or

15.3.2. to invite any elected reserve Governors or 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 annual election, at which time the seat will become vacant and subject to election for any unexpired period of the term of office.

16. Council of Governors – disqualification and removal

16.1. A person may not become a Governor of the Trust, and if already holding such office will immediately cease to do so if:

16.1.1. they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

16.1.2. they have made a composition or arrangement with, or granted a Trust deed for, their creditors and have not been discharged in respect of it;

16.1.3. they have within the preceding five years, been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them.

16.1.4. they are a Director or Company Secretary of this Trust, a Director of another NHS Trust or a Governor or Non-Executive Director of another NHS Foundation Trust;

16.1.5. they are under 16 years of age;

16.1.6. they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

16.1.7. they are a person whose tenure of office as the Chair or as a member or Director of a health service 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 non-disclosure of a pecuniary interest;

17. Council of Governors - termination of office and removal of Governor

17.1. A person holding office as a Governor shall immediately cease to do so if:

17.1.1. they resign by notice in writing to the Secretary;

17.1.2. they fail to attend two meetings in any 12 month period, unless the other Governors are satisfied that:

17.1.3. the absences were due to reasonable causes; and

17.1.4. they will be able to start attending meetings of the Trust again within such a period as they consider reasonable.
17.1.5. in the case of an appointed governor, the appointing organisation terminates the appointment;
17.1.6. they have failed to undertake any training which the Council of Governors requires all Governors to undertake;
17.1.7. they have failed to sign and deliver to the Secretary a statement in the form required by the Council of Governors confirming acceptance of the code of conduct for Governors;
17.1.8. they refuse to sign a declaration in the form specified by the Council of Governors that they are a member of a specific public constituency and are not prevented from being a member of the Council of Governors. This does not apply to staff members;
17.1.9. they are removed from the Council of Governors under the following provisions.

17.2. A Governor may be removed from the Council of Governors by a resolution approved by not less than three-quarters of the remaining Governors Members present and voting at a general meeting of the Council of Governors on the grounds that:
17.2.1. they have committed a serious breach of the code of conduct; or
17.2.2. they have acted in a manner detrimental to the interests of the Trust; and
17.2.3. the Council of Governors consider that it is not in the best interests of the Trust for them to continue as a governor.

18. Council of Governors – duties of Governors

18.1. The general duties of the Council of Governors are:
18.1.1. to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors;
18.1.2. to represent the interests of the members of the Trust as a whole and the interests of the public;

18.2. The Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such.

18.3. The Council of Governors shall appoint at a general meeting one of its public members to be Lead Governor of the Council of Governors.

18.4. The specific roles and responsibilities of the Council of Governors are set out in Annexe 5 – Roles and Responsibilities.

19. Council of Governors – meetings of the Council of Governors

19.1. The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed with the provisions of paragraph 26 below) or, in his absence the Deputy Chair (appointed in accordance with the provisions of paragraph 26 below), shall preside at meetings of the Council of Governors.

19.2. 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.

19.3. For the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their duties, the Council of Governors may require one or more of the directors to attend a meeting.

20. Council of Governors – standing orders

20.1. The standing orders for the practice and procedure of the Council of Governors and its meetings are included in a separate document which is attached at Annexe 8.

21. Council of Governors – referral to the Panel

21.1. In this paragraph, the Panel means a panel of persons appointed by NHS Improvement to which a governor of an NHS foundation Trust may refer a question as to whether the Trust has failed or is failing:

21.1.1. to act in accordance with its constitution, or

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

21.2. A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

22. Council of Governors – conflicts of interest

22.1. If a Council of Governors has a pecuniary, personal or family interest, whether that interest is actual or potential, or 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 as soon as they become aware of it.

22.2. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or the consideration of the matter in respect of which an interest has been disclosed. This should be in line with the NHS England guidance on Conflicts of Interest.

22.3. The Standing Orders for the Council of Governors are attached at Annexe 7.

23. Council of Governors - expenses

23.1. The Trust may pay travelling and other expenses to Governors at such rates as it decides. These are set out in the Standing Orders for the Council of Governors at Annexe 7 and are to be disclosed in the annual report.

23.2. Expenses claims must be submitted in line with the Trust's expenses policy.

23.3. Governors are not to receive remuneration.

24. Board of Directors – general duty

24.1. The business of the Trust is to be managed by the Board of Directors, who (subject to this Constitution) shall exercise all the powers of the Trust. 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 as to maximise the benefits for the members of the Trust as a whole and for the public.

24.2. A third party dealing in good faith with the Trust shall not be affected by any defect in the process by which Directors are appointed or any vacancy on the Board of Directors.

25. Board of Directors – composition

25.1. The Trust is to have a Board of Directors. It is to consist of executive and non-executive directors.

25.2. The Board of Directors is to comprise:

- 25.2.1. a non-executive Chair;
- 25.2.2. up to 7 other non-executive directors;
- 25.2.3. up to 7 executive directors.

25.3. One of the executive directors shall be the Chief Executive who shall be the Accounting Officer.

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

25.5. One of the executive directors is to be a registered medical practitioner.

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

26. Board of Directors – appointment and removal of the Chairman, Deputy Chair and other non-executive directors

26.1. The Council of Governors shall appoint a Chair of the Trust.

26.2. The Board of Directors will appoint one non-executive director to be Deputy Chair of the Trust. This individual may, through agreement with the Chair, take on the role of Senior Independent Non-Executive Director (SID).

26.3. The Chair and Deputy Chair will be the Chair and Deputy Chair of both the Council of Governors and the Board of Directors.

26.4. To be eligible for appointment as a non-executive director of the Trust the candidate must live and/or work within the West Yorkshire and Harrogate area.

26.5. The Council of Governors at a general meeting shall appoint or remove the Chairman of the Trust and the other non-executive directors.

26.6. Non-Executive Directors are to be appointed by the Council of Governors using the following procedure:

26.6.1. The Board of Directors will work with the external organisations recognised as expert in non-executive appointments to identify the skills and experience required

26.6.2. Appropriate candidates will be identified by the Board of Directors who meet the skills and experience required

26.6.3. A sub-committee of the Council of Governors (not exceeding four persons) including the Chair, will interview a short list of candidates and recommend a candidate for appointment by the Council of Governors.

26.7. Removal of the Chairman or other non-executive director shall require the approval of three-quarters of the Council of Governors.

26.8. The Board of Directors shall appoint one non-executive director to be the Deputy Chair of the Trust.

27. Board of Directors – Senior Independent Director

27.1. The Board of Directors will appoint one non-executive director to be the Senior Independent Director.

27.2. The Trust has a detailed job description for the SID. The main duties include:

27.2.1. Being available to members of the Foundation Trust and to the Council of Governors if they have concerns that contact through the usual channels of Chair, Chief Executive, Finance Director and Company Secretary has failed to resolve or where it would be inappropriate to use such channels. In addition to the duties described here the SID has the same duties as the other Non-Executive Directors.

27.2.2. A key role in supporting the Chair in leading the Board of Directors and acting as a sounding board and source of advice for the Chair. The SID also has a role in supporting the Chair as Chair of the Council of Governors.

27.2.3. While the Council of Governors determines the process for the annual appraisal of the chair, the senior independent director is responsible for carrying out the appraisal of the chair on its behalf.

27.2.4. The SID should maintain regular contact with the Governors and attend meetings of the Council of Governors to obtain a clear understanding of Council of Governors views on the key strategic performance issues facing the Foundation Trust. The SID should also be available to Governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the chair; chair's appraisal or setting the chair's objectives for example.

27.2.5. In rare cases where there are concerns about the performance of the chair the SID should provide support and guidance to the Council of Governors in seeking to resolve concerns or in the absence of a resolution in taking formal action. Where the foundation Trust has appointed a lead governor the SID should liaise with the lead governor in such circumstances.

27.2.6. In circumstances where the board is undergoing a period of stress the SID has a vital role in intervening to resolve issues of concern. These might include unresolved concerns on the part of the Council of Governors regarding the chair's performance; where the relationship

between the chair and the chief executive is either too close or not sufficiently harmonious, where the Foundation Trust's strategy is not supported by the whole Board or where key decisions are being made without reference to the Board or where succession planning is being ignored.

27.2.7. In the circumstances outlined above, the SID will work with the chair, other directors and/or Governors, to resolve significant issues.

28. Board of Directors – tenure of non-executive directors

28.1. The Chair and the Non-Executive Directors are to be appointed for a period of three years.

28.2. The Chair and the Non-Executive Directors will serve for a maximum of two terms.

28.3. In exceptional circumstances a Non-Executive Director (including the Chair) may serve longer than six years (two three-year terms). Any subsequent appointment will be subject to annual re-appointment. Reviews will take into account the need to progressively refresh the Board whilst ensuring its stability. Provisions regarding the independence of the Non-Executive Director will be strictly observed.

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 requires the approval of the Council of Governors.

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

30. Board of Directors – disqualification

30.1. A person may not become or continue as a Director of the Trust if:

30.1.1. they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

30.1.2. they have made a composition or arrangement with, or granted a Trust deed for, their creditors and have not been discharged in respect of it;

30.1.3. they have within the preceding five years been convicted in the British Islands of any offence, and a sentenced of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them;

30.1.4. they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

30.1.5. they are a person whose tenure of office as a Chair or as a member or Director of a health service 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 non-disclosure of a pecuniary interest;

30.1.6. they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;
30.1.7. in the case of a Non-Executive Director they have failed to fulfil any training requirement established by the Board of Directors; or
30.1.8. they have failed to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for Directors and fit and proper persons test; or

31. Board of Directors - meetings

31.1. Meetings of the Board of Directors shall be open to members of the public unless the Board of Directors decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other proper grounds. The Chair may exclude any member of the public from a meeting of the Board of Directors if they are interfering with or preventing the proper conduct of the meeting.

31.2. Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors.

31.3. 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.

32. Board of Directors – standing orders

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

33. Board of Directors – conflicts of interest of directors

33.1. The duties that a director of the Trust has by virtue of being a director include in particular –
33.1.1. 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.
33.1.2. 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.

33.2. The duty referred to in sub-paragraph 31.1.1 is not infringed if –
33.2.1. The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or
33.2.2. The matter has been authorized in accordance with the constitution.

33.3. The duty referred to in sub-paragraph 31.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

33.4. In sub-paragraph 31.1.2, “third party” means a person other than –
33.4.1. The Trust, or
33.4.2. A person acting on its behalf.

33.5. If a director of the Trust has in any way a direct of indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.

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

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

33.8. 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.

33.9. A director need not declare an interest –
- 33.9.1. If it cannot reasonably be regarded as likely to give rise to a conflict of interest;
- 33.9.2. If, or to the extent that, the directors are already aware of it;
- 33.9.3. If, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered –
  - 33.9.3.1. By a meeting of the Board of Directors, or
  - 33.9.3.2. By a committee of the directors appointed for the purpose under the constitution.

33.10. Any Director who has a material interest in a matter as defined below shall declare such interest to the Board of Directors and it shall be recorded in a register of interests and the Director in question:
- 33.10.1. shall not be present except with the permission of the Board of Directors in any discussion of the matter, and
- 33.10.2. shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

33.11. Any Director who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining Directors.

33.12. A material interest in a matter is any interest (save for the exceptions referred to below) held by a Director or their spouse or partner in any firm or company or business which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust, including private healthcare organisations and other foundation Trusts.

33.13. The exceptions which shall not be treated as material interests are as follows:
- 33.13.1. shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange.

34. Board of Directors – remuneration and expenses

34.1. The Board of Directors shall appoint an executive remuneration committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and Executive Directors.

34.2. The remuneration and allowances, and the other terms and conditions of office, of the Chairman and Non-Executive Directors shall be decided by the Council of Governors at a general meeting. The Council of Governors may take advice from independent pay advisors whose Terms of Reference will be established and ratified by the Board of Directors and the Council of Governors.

34.3. The remuneration and allowances for Directors are to be disclosed in the annual report.

35. Secretary

35.1. The Trust shall have a Secretary who may be an employee. The Secretary may not be a Governor, or the Chief Executive or the Finance Director. The Secretary shall be accountable to the Chief Executive and their functions shall include:

35.1.1. acting as Secretary to the Council of Governors and the Board of Directors, and any committees;
35.1.2. summoning and attending all members meetings, meetings of the Council of Governors and the Board of Directors, and keeping the minutes of those meetings;
35.1.3. keeping the register of members and other registers and books required by this Constitution to be kept;
35.1.4. having charge of the Trust's seal;
35.1.5. publishing to members in an appropriate form information which they should have about the Trust's affairs;
35.1.6. preparing and sending to NHS Improvement and any other statutory body all returns which are required to be made;
35.1.7. providing support to the Council of Governors and the Non-Executive Directors;
35.1.8. overseeing elections conducted under this Constitution;
35.1.9. offering advice to the Council of Governors and the Board of Directors on issues of governance and corporate responsibility.

35.2. 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. Minutes of meetings will be included on the agenda of the next meeting.

36. Registers

36.1. The Trust is to have:

36.1.1. a Register of Members showing, in respect of each Member, the name of the member, the constituency to which they belong and, (where the Council of Governors has decided that the Membership of the Public, or Staff constituencies shall be sub-divided for election purposes) any sub-division of that constituency to which they belong;
36.1.2. a Register of Members of the Council of Governors;
36.1.3. a Register of Directors;
36.1.4. a Register of Interests of Governors
36.1.5. a Register of Interests of the Directors.

36.2. The Secretary shall add to the Register of Members any individual who becomes a Member of the Trust or remove from the Register of Members the name of any

Member who ceases to be entitled to be a Member under the provisions of this Constitution.

37. Documents available for public inspection

37.1. The following documents of the Trust are to be available for inspection by members of the public. If the person requesting a copy or extract under this paragraph is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

37.1.1. a copy of the current Constitution;

37.1.2. a copy of the current Authorisation;

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

37.1.4. a copy of the report of any other auditor of the Trust's affairs appointed by the Council of Governors;

37.1.5. a copy of the latest annual report;

37.1.6. a copy of the latest information as to its forward planning;

37.1.7. a copy of the Trust's Membership Strategy;

37.1.8. a copy of any notice given under section 52 of the 2006 Act (Monitor's notice to failing NHS Foundation Trust).

37.1.9. The register of Members shall be made available for inspection by members of the public. Article 2(b) of the Public Benefit Corporation (Register of Members) Regulations 2004 allows for members to request their details are not published as part of the Register of Members.

38. Auditors

38.1. The Trust is to have an auditor and is to provide the auditor.

38.2. The Council of Governors at a general meeting shall appoint or remove the Trust's auditors.

38.3. The auditor is to carry out his duties in accordance with Schedule 7 to the 2006 Act and in accordance with any directions given by NHS Improvement standards, procedures and techniques to be adopted.

39. Audit and Risk Committee

39.1. The Trust shall establish a committee of non-executive directors as an Audit and Risk Committee to perform such monitoring, reviewing and other functions as are appropriate.

40. Accounts

40.1. The Trust must keep proper accounts and proper records in relation to the accounts.

40.2. NHS Improvement may with the approval of the Secretary of State, give directions to the Trust as to the content and form of its accounts.

40.3. The accounts are to be audited by the Trust's auditor.

40.4. The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

40.5. The following documents will be made available to the Auditor General for examination at their request:
- 40.5.1. the accounts;
- 40.5.2. any records relating to them; and
- 40.5.3. any report of the auditor on them.

40.6. The annual accounts, any report of the auditor on them, and the annual report are to be presented to the Council of Governors at a General Meeting.

40.7. The Trust shall:
- 40.7.1. lay a copy of the annual accounts, and any report of the auditor on them, before Parliament; and
- 40.7.2. once it has done so, send copies of those documents to NHS Improvement.

41. Annual report, forward plans and non-NHS work

41.1. The Trust is to prepare an Annual Report and send it to NHS Improvement.

41.2. The Trust is to give information as to its forward planning in respect of each financial year to NHS Improvement. The document containing this information is to be prepared by the Directors, and in preparing the document the Board of Directors shall have regard to the views of the Council of Governors.

41.3. Each forward plan must include information about:-
- 41.3.1. 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
- 41.3.2. the income it expects to receive from doing so.

41.4. Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 39.3.1 the Council of Governors must:-
- 41.4.1. 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
- 41.4.2. notify the directors of the Trust of its determination.

41.5. 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 voting to approve its implementation.

42. Indemnity

42.1. Members of the Council of Governors and the Board of Directors and the Secretary who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred 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 the benefit of members of the Council of Governors and Board of Directors and the Secretary.

43. Seal

43.1. The Trust shall have a seal.

43.2. The Trust is to have a seal, but this is not to be affixed except under the authority of the Board of Directors.

44. Dispute Resolution Procedures

44.1. Every unresolved dispute which arises out of this Constitution between the Trust and:

44.1.1. a Member; or

44.1.2. any person aggrieved who has ceased to be a Member within the six months prior to the date of the dispute; or

44.1.3. any person bringing a claim under this Constitution; or

44.1.4. an office-holder of the Trust;

is to be submitted to an arbitrator agreed by the parties. The arbitrator's decision will be binding and conclusive on all parties.

45. Amendment of the constitution

45.1. The Trust may make amendments of its Constitution only if:-

45.1.1. More than half of the members of the Council of Governors of the Trust voting approve the amendments; and

45.1.2. More than half of the members of the Board of Directors of the Trust voting approve the amendments.

45.2. Amendments made under paragraph 43.1 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.

45.3. 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)

45.3.1. At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment; and

45.3.2. The Trust must give the members an opportunity to vote on whether they approve the amendment.

45.4. 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.

45.5. 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.

46. Mergers etc. and significant transactions

46.1. 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.

46.2. 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.

46.3. The constitution does not contain any descriptions of the term 'significant transaction' for the purposes of section 51A of the 2006 Act (Significant Transactions).

47. Dissolution of the Trust

47.1. The Trust may not be dissolved except by order of the Secretary of State for Health, in accordance with the 2006 Act.

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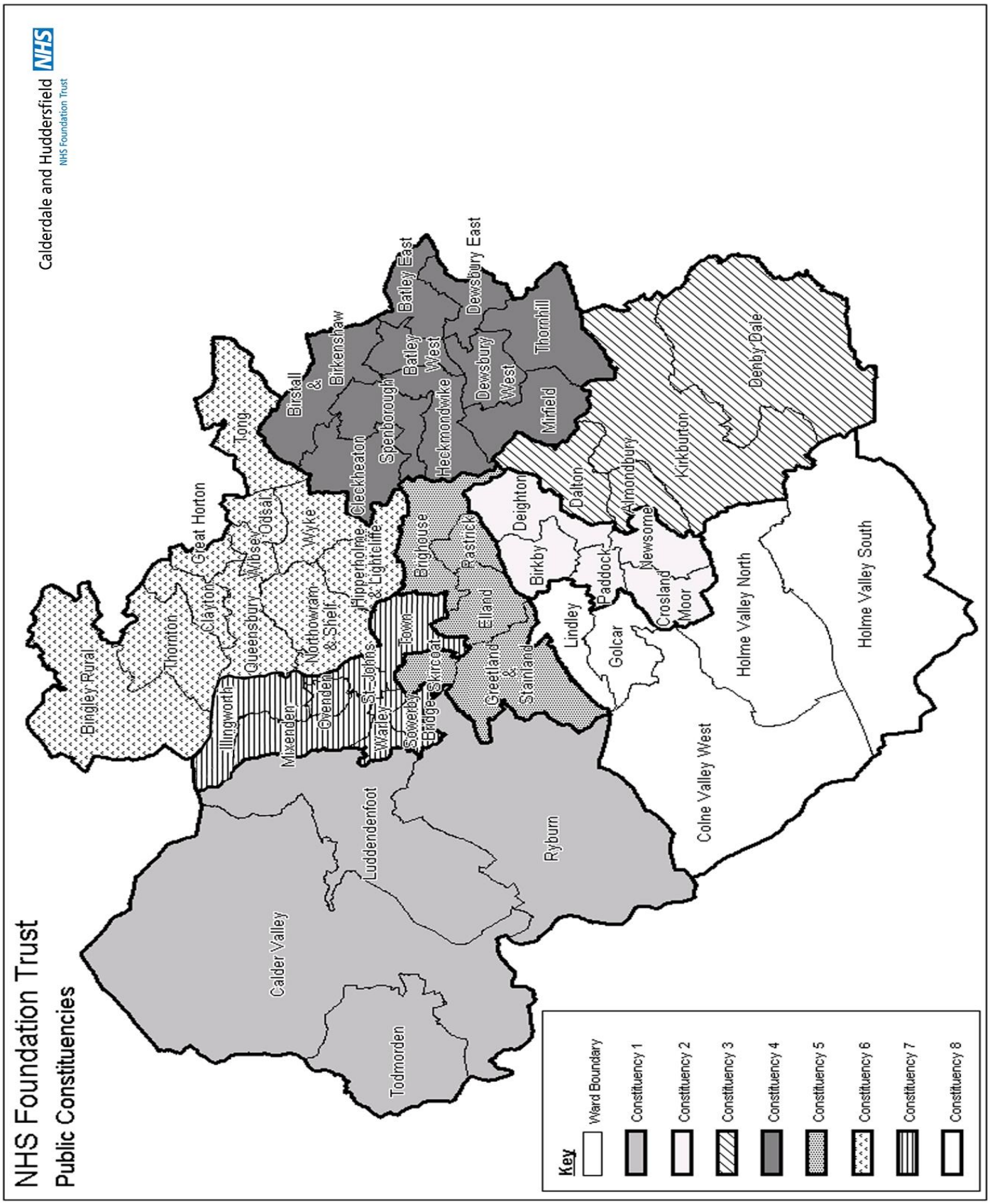
ANNEXE 1 – PUBLIC CONSTITUENCIES



Constituency	Wards	Population
1	Todmorden	37,487
	Calder Valley	
	Luddendenfoot	
	Ryburn	
2	Birkby	62,501
	Deighton	
	Paddock	
	Crosland Moor	
	Newsome	
3	Dalton	56,161
	Almondbury	
	Kirkburton	
	Denby-Dale	
4	Cleckheaton	144,794
	Birstall & Birkenshaw	
	Spenborough	
	Heckmondwike	
	Batley West	
	Batley East	
	Mirfield	
	Dewsbury West	
	Dewsbury East	
	Thornhill	
5	Skircoat	47,727
	Greetland & Stainland	
	Elland	
	Rastrick	
	Brighouse	
6	Northowram & Shelf	150,326
	Hipperholme & Lightcliffe	
	Bingley Rural	
	Thorton	
	Clayton	
	Queensbury	
	Great Horton	
	Wibsey	
	Oddsall	
	Wyke	
	Tong	
7	Illingworth & Mixenden	63,407
	Ovenden	
	Warley	
	Sowerby Bridge	
	St Johns	
	Town	
8	Lindley	73,412
	Golcar	

Constituency	Wards	Population
	Colne Valley West	
	Holme Valley North	
	Holme Valley South	

Note on Constituencies

Population data and indices of deprivation have been used to formulate the eight constituencies. Constituencies are as close as possible to one eighth of the population of Calderdale and Kirklees, though attempts to reflect Local Authority boundaries and areas of similar deprivation levels mean there is some variation. Constituencies 4 and 6 are noticeably larger because persons in these constituencies mostly use services provided by other NHS Trusts. Each Constituency comprises of several electoral areas for local government elections.

/KB/CONSTITUTION-MARCH 2006
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UPDATED 20.6.06
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UPDATED 12.11.07
REVIEW DATE: September 2008
DRAFT – 29,7.10
UPDATED 24.10.13
UPDATED 8.4.14 (map/constituencies)
UPDATED 20.1.15 (election rules – electronic voting)

ANNEX 2

MODEL ELECTION RULES 2014

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2.Timetable
3. Computation of time

Part 3 Returning officer
4. Returning officer
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6. Expenditure
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Part 1 Interpretation

1. Interpretation

1.1 In these rules, unless the context otherwise requires:
"corporation" means the public benefit corporation subject to this constitution;
"election" means an election by a constituency, or by a class within a constituency, to fill vacancy among one or more posts on the council of governors;
"the regulator" means the Independent Regulator for NHS foundation Trusts; and
"the 2006 Act" means the National Health Service Act 2006
"e-voting" means voting using either the internet, telephone or text message;
"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;
"method of polling" means voting either by post, internet, text message or telephone
"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.

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

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 papers 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.**

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

4.1 Subject to rule 66, 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 66, 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

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 papers may be obtained;
(e) the address for return of nomination papers 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 Each candidate must nominate themselves on a single nomination paper.

9.2 The returning officer:
(a) is to supply any member of the corporation with a nomination paper, and
(b) is to prepare a nomination paper 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 it can, subject to rule 13, be in an electronic format.

10. Candidate's particulars
10.1 The nomination paper must state the candidate's:
(a) full name,
(b) contact address in full, and
(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests
11.1 The nomination paper 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 paper 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 paper 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.

14. Decisions as to the validity of nomination

14.1 Where a nomination paper 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 paper 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 paper 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 papers, 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
(e) that the paper is not signed and dated by the candidate, as required by rule 13.

14.3 The returning officer is to examine each nomination paper 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 paper, 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 paper.

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, 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 paper.

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 papers to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination papers

16.1 The corporation is to make the statement of the candidates and the nomination papers 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 person requests a copy or extract of the statement of candidates or their nomination papers, 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 if eligible voters, within a constituency, or class within a constituency, may, subject to rule 19.4, cast their vote by any combination of the methods of polling.

19.4 The corporation may decide if eligible voters, within a constituency or class within a constituency, for whom an e-mail mailing address is included in the list of eligible voters may only cast their votes by, one or more, e-voting methods of polling.

19.5 If the corporation decides to use an e-voting method of polling then they and the returning officer must satisfy themselves that:

(a) if internet voting is being used, the internet voting system to be used for the purpose of the election is configured in accordance with these rules and that it will accurately record the internet voting record of any voter who chooses to cast their vote using the internet voting system.

(b) if telephone voting is being used, the telephone voting system to be used for the purpose of the election is configured in accordance with these rules and that it will accurately record the telephone voting record of any voter who choose to cast their vote using the telephone voting system.

(c) if text message voting is being used, the text message voting system to be used for the purpose of the election is configured in accordance with these rules and that it will accurately record the text voting record of any voter who choose to cast their vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter 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 voters and voter ID number if e-voting is a method of polling,
(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.

Action to be taken before the poll

21. List of eligible voters

21.1 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 26 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

21.2 The list is to include, for each member, a postal mailing address and if available an e-mail address, where their voting information may be sent.

21.3 The corporation may decide if the voting information is to be sent only by e-mail to those members, in a particular constituency or class within a constituency, for whom an e-mail address is included in the list of eligible voters.

22. Notice of poll

22.1 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) the methods of polling by which votes may be cast at the election by a constituency or class within a constituency as determined by the corporation in rule 19 (3).
(f) the address for return of the ballot papers, and the date and time of the close of the poll,
(g) the uniform resource locator (url) where, if internet voting is being used, the polling website is located.

(h) the telephone number where, if telephone voting is being used, the telephone voting facility is located,
(i) the telephone number or telephone short code where, if text message voting is being used, the text message voting facility is located,
(j) the address and final dates for applications for replacement voting information, and
(k) the contact details of the returning officer.

23. Issue of voting information by returning officer

23.1 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 voting information:
(a) by post to each member of the corporation named in the list of eligible voters and on the basis of rule 21 able to cast their vote by post:
(i) a ballot paper
(ii) information about each candidate standing for election, pursuant to rule 61 of these rules,
(iii) a covering envelope

(b) by e-mail or by post, to each member of the corporation named in the list of eligible voters and on the basis of rule 19.4 able to cast their vote only by an e-voting method of polling:
(i) instructions on how to vote
(ii) the eligible voters voter ID number
(iii) information about each candidate standing for election, pursuant to rule 61 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.
(iv) contact details of the returning officer.

23.2 The documents are to be sent to the mailing address or e-mail address for each member, as specified in the list of eligible voters.

24. The covering envelope

24.1 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. E-voting systems

25.1 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").

25.2 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”).

25.3 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”).

25.4 The provision of the polling website and internet voting system, will:
(a) require a voter, to be permitted to vote, to enter his voter ID number;

(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.

(c) prevent a voter voting for more candidates than he is entitled to at the election;

(d) create a record ("the internet voting record") that is stored in the internet voting system in respect of each vote cast using the internet of-
(i) the voter ID number used by the voter;
(ii) the candidate or candidates for whom he has voted; and
(iii) the date and time of his vote, and

(e) if their vote has been cast and recorded, provide the voter with confirmation

(f) prevent any voter voting after the close of poll.

25.5 The provision of a telephone voting facility and telephone voting system, will:
(a) require a voter to be permitted to vote, to enter his voter ID number;

(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.

(c) prevent a voter voting for more candidates than he is entitled to at the election;

(d) create a record ("the telephone voting record") that is stored in the telephone voting system in respect of each vote cast by telephone of-
(i) the voter ID number used by the voter;
(ii) the candidate or candidates for whom he has voted; and
(iii) the date and time of his vote

(e) if their vote has been cast and recorded, provide the voter with confirmation;

(f) prevent any voter voting after the close of poll.

25.6 The provision of a text message voting facility and text messaging voting system, will:
(a) require a voter to be permitted to vote, to provide his voter ID number;

(b) prevent a voter voting for more candidates than he is entitled to at the election;

d) create a record ("the text voting record") that is stored in the text messaging voting system in respect of each vote cast by text message of:
(i) the voter ID number used by the voter;
(ii) the candidate or candidates for whom he has voted; and
(iii) the date and time of his vote

(e) if their vote has been cast and recorded, provide the voter with confirmation;

(f) prevent any voter voting after the close of poll.

The poll

26. Eligibility to vote

26.1 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.

27. Voting by persons who require assistance

27.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

27.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as they consider necessary to enable that voter to vote.

28. Spoilt ballot papers

28.1 If a voter has dealt with their 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.

28.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if they can obtain it.

28.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless satisfied as to the voter's identity.

28.4 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) is satisfied as to the voter's identity, 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 spoilt ballot paper.

29. Lost voting information

29.1 Where a voter has not received their voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

29.2 The returning officer may not issue replacement voting information for lost voting information unless they:
(a) are satisfied as to the voter's identity,
(b) have no reason to doubt that the voter did not receive the original voting information.

29.3 After issuing replacement voting information, the returning officer shall enter in a list ("the list of lost ballots"):
(a) the name of the voter
(b) the details of the unique identifier of the replacement ballot paper, and
(c) if applicable, the voter ID number of the voter.

30. Issue of replacement voting information

30.1 If a person applies for replacement voting information under rule 28 or 29, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 28.3 or 29.2, they are also satisfied that that person has not already voted in the election.

Polling by internet, telephone or text

31. Procedure for remote voting by internet

31.1 To cast their vote using the internet the voter must gain access to the polling website by keying in the url of the polling website provided in the voting information,

31.2 When prompted to do so, the voter must enter their voter ID number.

31.3 If the internet voting system authenticates the voter ID number the system must give the voter access to the polling website for the election in which the voter is eligible to vote.

31.4 To cast their vote the voter may then key in a mark on the screen opposite the particulars of the candidate or candidates for whom they wish to cast their vote.

31.5 The voter must not be able to access the internet voting facility for an election once their vote at that election has been cast.

32. Voting procedure for remote voting by telephone

32.1 To cast their vote by telephone the voter must gain access to the telephone voting facility by calling the designated telephone number provided on the voter information using a telephone with a touch-tone keypad.

32.2 When prompted to do so, the voter must enter their voter ID number using the keypad.

32.3 If the telephone voting facility authenticates the voter ID number, the voter must be prompted to vote in the election.

32.4 When prompted to do so the voter may then cast his vote by keying in the code of the candidate or candidates, allocated in accordance with rule 61 of these rules, for whom they wish to vote.

32.5 The voter must not be able to access the telephone voting facility for an election once their vote at that election has been cast.

33. Voting procedure for remote voting by text message

33.1 To cast their vote by text the voter must gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided on the voter information.

33.2 The text message sent by the voter must contain their voter ID number and the code for the candidate or candidates, allocated in accordance with rule 61 of these rules, for whom they wish to vote.

33.3 The text message sent by the voter must be structured in accordance with the instructions on how to vote contained in the voter information.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

34. Receipt of voting documents

34.1 Where the returning officer receives a:
(a) covering envelope, or
(b) any other envelope containing a ballot paper,
before the close of the poll, that officer is to open it as soon as is practicable; and rules 35 and 36 are to apply.

34.2 The returning officer may open any covering envelope for the purposes of rules 35 and 36, 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.

34.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers.

35. Validity of votes

35.1 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.

35.2 Where the returning officer is satisfied that rule 35.1 has been fulfilled, the ballot paper is to be put aside for counting after the close of the poll.

35.3 Where the returning officer is not satisfied that rule 35.1 has been fulfilled, they should:
(a) mark the ballot paper "disqualified",
(b) record the unique identifier on the ballot paper in a list (the "list of disqualified documents"); and
(c) place the document or documents in a separate packet.

35.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet, telephone or text voting record has been received by the returning officer before the close of the poll.

36. De-duplication of votes

36.1 Where a combination of the methods of polling are being used, 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 an election.

36.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in an election they shall:
(a) only accept as duly returned the first vote received that contained the duplicated voter ID number
(b) mark as "disqualified" all other votes containing the duplicated voter ID number

36.3 Where a ballot paper is "disqualified" under this rule the returning officer shall:
(a) mark the ballot paper "disqualified",
(b) record the unique identifier and voter id number on the ballot paper in a list (the "list of disqualified documents"); and
(c) place the ballot paper in a separate packet.

36.4 Where an internet, telephone or text voting record is "disqualified" under this rule the returning officer shall:
(a) mark the record as "disqualified",
(b) record the voter ID number on the record in a list (the "list of disqualified documents".
(c) disregard the record when counting the votes in accordance with these Rules.

37. Sealing of packets

37.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 35 and 36, the returning officer is to seal the packets containing:
(a) the disqualified documents, together with the list of disqualified documents inside it,
(b) the list of spoilt ballot papers,
(c) the list of lost ballots
(d) the list of eligible voters, and
(e) complete electronic copies of records referred to in rule 25 held in a device suitable for the purpose of storage.

Part 6 Counting the votes

Note: the following rules describe how the votes are to be counted manually but it is expected that appropriately audited vote counting software will be used to count votes where a combination of methods of polling is being used and votes are contained as electronic e-voting records and ballot papers.

STV38. Interpretation of Part 6

STV38.1In Part 6 of these rules:

"ballot" 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:
(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 STV46,
"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 STV43,
"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 ballots 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 on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,
"transferred vote" means a vote derived from a ballot on which a second or subsequent preference is recorded for the candidate to whom that ballot has been transferred, and
"transfer value" means the value of a transferred vote calculated in accordance with rules STV44.4 or STV44.7.

39. Arrangements for counting of the votes

39.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

40. The count

40.1 The returning officer is to:
(a) count and record the number of votes that have been returned, and
(b) count the votes according to the provisions in this Part of the rules.

40.2 The returning officer, while counting and recording the number of votes 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 a voter's voter ID number.

40.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV41. Rejected ballot papers

STV41.1 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.

STV41.2The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV41.3 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 STV41.1

FPP41. Rejected ballot papers

FPP41.1 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 FPP41.2 and FPP41.3, be rejected and not counted.

FPP41.2 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.

FPP41.3 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.

FPP41.4 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 FPP41.2 and FPP 41.3, endorse the words "rejected in part" on the ballot paper and indicate which vote or votes have been counted.

FPP41.5 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.

STV42. First stage
STV42.1 The returning officer is to sort the ballots into parcels according to the candidates for whom the first preference votes are given.

STV42.2 The returning officer is to then count the number of first preference votes given on ballots for each candidate, and is to record those numbers.

STV42.3 The returning officer is to also ascertain and record the number of valid ballots.

STV43. The quota
STV43.1 The returning officer is to divide the number of valid ballots by a number exceeding by one the number of members to be elected.

STV43.2 The result, increased by one, of the division under rule STV43.1 (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”).

STV43.3 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 STV44.1 to STV44.3 has been complied with.

STV44. Transfer of votes
STV44.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballots 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 ballots for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV44.2 The returning officer is to count the number of ballots in each parcel referred to in rule

STV44.3 The returning officer is, in accordance with this rule and rule STV45, to transfer each sub-parcel of ballots referred to in rule STV44.1(a) to the candidate for whom the next available preference is given on those papers.

STV44.4 The vote on each ballot transferred under rule STV44.3 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 ballots on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV44.5 Where at the end of any stage of the count involving the transfer of ballots, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballots 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 ballots for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV44.6 The returning officer is, in accordance with this rule and rule STV45, to transfer each sub-parcel of ballots referred to in rule STV44.5(a) to the candidate for whom the next available preference is given on those ballots.

STV44.7 The vote on each ballot transferred under rule STV44.6 shall be at:
(a) a transfer value calculated as set out in rule STV44.4(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.

STV44.8 Each transfer of a surplus constitutes a stage in the count.

STV44.9 Subject to rule STV44.10, the returning officer shall proceed to transfer transferable ballots until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV44.10 Transferable ballots 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.

STV44.11 This rule does not apply at an election where there is only one vacancy.

STV45. Supplementary provisions on transfer

STV45.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballots 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 ballots 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 ballots of the candidate on whom the lot falls shall be transferred first.

STV45.2 The returning officer shall, on each transfer of transferable ballots under rule STV44:
(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.

STV45.3 All ballots transferred under rule STV44 or STV45 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 or, as the case may be, all the ballots in that sub-parcel.

STV45.4 Where a ballot is so marked that it is unclear to the returning officer at any stage of the count under rule STV44 or STV45 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot as a non-transferable vote; and votes on a ballot 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.

STV46. Exclusion of candidates
STV46.1 If:
(a) all transferable ballots which under the provisions of rule STV44 (including that rule as applied by rule STV46.11 and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV47, one or more vacancies remain to be filled,
the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV46.12 applies, the candidates with the then lowest votes).

STV46.2 The returning officer shall sort all the ballots on which first preference votes are given for the candidate or candidates excluded under rule STV46.1 into two sub-parcels so that they are grouped as:
(a) ballots on which a next available preference is given, and
(b) ballots on which no such preference is given (thereby including ballots on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV46.3 The returning officer shall, in accordance with this rule and rule STV45, transfer each sub-parcel of ballots referred to in rule STV46.2 to the candidate for whom the next available preference is given on those ballots.

STV46.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV46.5 If, subject to rule STV47, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballots, if any, which had been transferred to any candidate excluded under rule STV46.1 into sub- parcels according to their transfer value.

STV46.6 The returning officer shall transfer those ballots in the sub-parcel of transferable ballots with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballots (thereby passing over candidates who are deemed to be elected or are excluded).

STV46.7 The vote on each transferable ballot transferred under rule STV46.6 shall be at the value at which that vote was received by the candidate excluded under rule STV46.1.

STV46.8 Any ballots on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV46.9 After the returning officer has completed the transfer of the ballots in the sub-parcel of ballots with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballots with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV46.1.

STV46.10 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 non-transferable 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.

STV46.11 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 STV44.5 to STV44.10 and rule STV45.

STV46.12 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.

STV46.13 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.

STV47. Filling of last vacancies
STV47.1 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.

STV47.2 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.

STV47.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV48. Order of election of candidates
STV48.1 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 STV44.10.

STV48.2 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.

STV48.3 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.

STV48.4 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.

FPP48. Equality of votes
FPP48.1 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

FPP49. Declaration of result for contested elections
FPP49.1 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 they have 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 chairman of the NHS Trust, or
(ii) in any other case, to the chairman of the corporation; and
(c) give public notice of the name of each candidate whom they have declared elected.

FPP49.2 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 FPP41.5,
available on request.

STV49. Declaration of result for contested elections
STV49.1 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 they have 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 chairman of the NHS Trust, or
(ii) in any other case, to the chairman of the corporation, and
(c) give public notice of the name of each candidate who they have declared elected.

STV49.2 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 STV41.1,
available on request.

50. Declaration of result for uncontested elections
50.1 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 they have declared elected to the chairman of the corporation, and
(c) give public notice of the name of each candidate who they have declared elected.

Part 8 Disposal of documents

51. Sealing up of documents relating to the poll
51.1 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,
(b) the ballot papers endorsed with “rejected in part”,
(c) the rejected ballot papers, and
(d) the statement of rejected ballot papers.
(e) the complete electronic copies of records referred to in rule 25 held in a device suitable for the purpose of storage.

51.2 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,
(c) the list of lost ballots,
(d) the list of eligible voters, and
(e) the complete electronic copies of records referred to in rule 25 held in a device suitable for the purpose of storage.

51.3 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.

52. Delivery of documents

52.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 51, the returning officer is to forward them to the chair of the corporation.

53. Forwarding of documents received after close of the poll

53.1 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 voter information is made too late to enable new ballot papers to be issued,
The returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

54. Retention and public inspection of documents

54.1 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 regulator, cause them to be destroyed.

54.2 With the exception of the documents listed in rule 55.1, 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.

54.3 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

55. Application for inspection of certain documents relating to an election

55.1 The corporation may not allow the inspection of, or the opening of any sealed packet containing –
(a) any rejected ballot papers, including ballot papers rejected in part,
(b) any disqualified documents, or the list of disqualified documents,
(c) any counted ballot papers, or
(d) the list of eligible voters,
(e) the complete electronic copies of records referred to in rule 25 held in a device suitable for the purpose of storage by any person without the consent of the Regulator.

55.2 A person may apply to the Regulator to inspect any of the documents listed in rule 55.1, and the Regulator 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.

55.3 The Regulator'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.

55.4 On an application to inspect any of the documents listed in rule 55.1:
(a) in giving its consent, the regulator, and
(b) making the documents available for inspection, the corporation, must 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 their vote was given, and
(ii) that the regulator has declared that the vote was invalid.

Part 9 Death of a candidate during a contested election

FPP56. Countermand or abandonment of poll on death of candidate
FPP56.1 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.

FPP56.2 Where a new election is ordered under rule FPP56.1, 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.

FPP56.3 Where a poll is abandoned under rule FPP56.1(a), rules FPP56.4 to FPP56.7 are to apply.

FPP56.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 35 and 36, and is to make up separate sealed packets in accordance with rule 37.

FPP56.5 The returning officer is to:
(a) count and record the number of ballot papers that have been received, and
(b) seal up the ballot papers into packets, along with the records of the number of ballot papers.
(c) seal up the electronic copies of records that have been received referred to in rule 25 held in a device suitable for the purpose of storage.

FPP56.6 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.

FPP56.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP56.4 to FPP56.6, the returning officer is to deliver them to the chairman of the corporation, and rules 54 and 55 are to apply.

STV56. Countermand or abandonment of poll on death of candidate

STV56.1 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) ballots 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) ballots 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.

STV56.2 The ballots which have preferences recorded for the candidate who has died are to be sealed with the other counted ballots pursuant to rule 51.1(a).

Part 10 Election expenses and publicity

57. Election expenses

57.1 Any expenses incurred, or payments made, for the purposes of an election which to the regulator under Part 11 of these rules.

58. Expenses and payments by candidates

58.1 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.

59. Election expenses incurred by other persons

59.1 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 their family any money or property (whether a 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.

59.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 60 and 61.

Publicity

60. Publicity about election by the corporation

60.1 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.

60.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 61, 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, the expense of the electoral prospects of one or more other candidates.

60.3 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.

61. **Information about candidates for inclusion with voting information**

61.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 23 of these rules.

61.2 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 polling method, the numerical voting code, allocated by the returning officer, to each candidate, for the purpose of recording votes on the telephone voting facility or the text message voting facility, and
(c) a photograph of the candidate.

62. Meaning of "for the purposes of an election"

62.1 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.

62.2 The provision by any individual of their own services voluntarily, on their own time, and free of charge is not to be considered an expense for the purposes of this Part.

Part 11Questioning elections and the consequence of irregularities

63. Application to question an election

63.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to the regulator.

63.2 An application may only be made once the outcome of the election has been declared by the returning officer.

63.3 An application may only be made to the Regulator 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.

63.4 The application must:
(a) describe the alleged breach of the rules or electoral irregularity, and
(b) be in such a form as the Regulator may require.

63.5 The application must be presented in writing within 21 days of the declaration of the result of the election.

63.6 If the Regulator requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

63.7 The Regulator shall delegate the determination of an application to a person or persons to be nominated for the purpose of the Regulator.

63.8 The determination by the person or persons nominated in accordance with rule 63.7 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.

63.9 The Regulator may prescribe rules of procedure for the determination of an application including costs.

Part 12 Miscellaneous

64. Secrecy

64.1 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 voter 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.

64.2 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.

64.3 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.

65. Prohibition of disclosure of vote

65.1 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.

66. Disqualification

66.1 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.

67. Delay in postal service through industrial action or unforeseen event

67.1 If industrial action, or some other unforeseen event, results in a delay in:
(a) the delivery of the documents in rule 23, or
(b) the return of the ballot papers and declarations of identity,
the returning officer may extend the time between the publication of the notice of the poll and the close of the poll, with the agreement of the Regulator.

UPDATED 20.1.15 (electronic voting)

ANNEXE 3 – FURTHER PROVISIONS

(From paragraph 9.2)

Termination of Membership

1. A Member may be expelled by a resolution approved by not less than three quarters of the full Council of Governors present and voting at a general meeting. The following procedure is to be adopted.

2. Any Member may complain to the Company Secretary that another Member has acted in a way detrimental to the interests of the Trust.

3. 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:

   3.1. dismiss the complaint and take no further action; or
   3.2. arrange for a resolution to expel the Member complained of to be considered at the next general meeting of the Council of Governors.

4. 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 of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

5. At the meeting the Council of Governors will consider evidence in support of the complaint and such evidence as the Member complained of may wish to place before them.

6. If the Member complained of fails to attend the meeting without due cause the meeting may proceed in their absence.

7. 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.

8. No person who has been expelled from Membership is to be re-admitted except by a resolution carried by the votes of three quarters of the Council of Governors present and voting at a general meeting.

ANNEXE 4 – ANNUAL MEMBERS' MEETING

(From paragraph 10.2)

1. All Members meetings, other than annual meetings, are called special members meetings.

2. Members' meetings are open to all members of the Trust, members of the Council of Governors and the Board of Directors, representatives of the Trust's financial auditors, but not to members of the public. 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. All Members meetings are to be convened by the Secretary by order of the Chair of the Council of Governors or upon a resolution of the Board of Directors.

4. The Council of Governors may decide where a members' meeting is to be held and may also for the benefit of Members:

   4.1. arrange for the annual members' meeting to be held in different venues each year;
   4.2. make provisions for a members meeting to be held at different venues simultaneously or at different times. In making such provision the Council of Governors 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.

5. At the Annual Members' Meeting the Council of Governors shall present to the Members:
   5.1. the annual accounts;
   5.2. any report of the auditor;
   5.3. any report of any other auditor of the Trust's affairs;
   5.4. forward planning information for the next financial year;
   5.5. a report on steps taken to secure that (taken as a whole) the actual membership of its constituencies is representative of those eligible for such membership;
   5.6. the progress of the Membership Strategy;
   5.7. any proposed changes to the policy for the composition of the Council of Governors and of the Non-Executive Directors.
   5.8. the results of the election and appointment of Council of Governors Members will be announced.

6. Notice of a Members' meeting is to be given:
   6.1. by notice on the Trust's website at least 14 clear days before the date of the meeting
   6.2. by notice emailed to all those members for whom we hold an email address
   6.3. included within the Trust's members newsletter
   6.4. be given to the Council of Governors and the Board of Directors, and to the auditors;

7. The notice of the member's meeting must:
   7.1. state whether the meeting is an annual or special members' meeting;
   7.2. give the time, date and place of the meeting; and
   7.3. indicate the business to be dealt with at the meeting.

8. It is the responsibility of the Council of Governors, the Company Chairman of the meeting and the Secretary to ensure that at any members meeting:
   8.1. the issues to be decided are clearly explained;
   8.2. sufficient information is provided to members to enable rational discussion to take place;
   8.3. where appropriate, experts in relevant fields or representatives of special interest groups are invited to address the meeting.

9. The Chair of the Trust or, in their absence, the Deputy-Chair or, in their absence, the Lead Governor is to chair members' meetings.

10. Subject to this Constitution, a resolution put to the vote at a members' meeting shall, except where a poll is demanded or directed, be decided upon by a show of hands.

11. On a show of hands or on a poll, every member present is to have one vote. On a poll, votes may be given either personally or by proxy under arrangements laid down by the Council of Governors, and every member is to have one vote. In case of an equality of votes the Chairman shall decide the outcome.

12. Unless a poll is demanded, the result of any vote will be declared by the Chairman and recorded in the minutes. The minutes will be conclusive evidence of the result of the vote.

13. A poll may be directed by the Chair or demanded either before or immediately after a vote by show of hands by not less than one-tenth of the members present at the meeting. A poll shall be taken immediately.

ANNEXE 5 – ROLES AND RESPONSIBILITIES OF GOVERNORS

(from paragraph 11.3)

1. The roles and responsibilities of the Governors are:
   1.1. at a general meeting, to appoint or remove the Chair and the other Non-Executive Directors;
   1.2. at a general meeting, to approve an appointment (by the Non-Executive Directors) of the Chief Executive;
   1.3. at a general meeting, to decide the remuneration and allowances, and the other terms and conditions of office, of the Non-Executive Directors;
   1.4. at a general meeting, to appoint or remove the Trust's auditor;
   1.5. at a general meeting, to be presented with the annual accounts, any report of the auditor on them and the annual report;
   1.6. at a general meeting, to appoint or remove any auditor appointed to review and publish a report on any other aspect of the Trust's affairs;
   1.7. to provide their views to the Board of Directors when the Board of Directors is preparing the document containing information about the Trust's forward planning in respect of each financial year;
   1.8. to respond as appropriate when consulted by the Board of Directors in accordance with this Constitution;
   1.9. to undertake such functions as the Board of Directors shall from time to time request;
   1.10. to prepare and from time to time to review the Trust's Membership Strategy, its policy for the composition of the Council of Governors and of the Non-Executive Directors.

2. A third party dealing in good faith with the Trust shall not be affected by any defect in the process by which Members of the Council of Governors are appointed or any vacancy on the Council of Governors.

ANNEXE 6 – COMPOSITION OF THE COUNCIL OF GOVERNORS

(from paragraph 12.2)

1. The Council of Governors of the Trust is to comprise:
   1.1. up to 16 Public Governors from 8 public constituencies (2 members from each constituency) set out in Annexe 1

   1.2. up to six Staff Governors from 1 Staff Constituency from the following classes:
      1.2.1. doctors and dentists (1 member);
      1.2.2. Allied Health Professionals, Health Care Scientists and Pharmacists (1 member);
      1.2.3. Management, Administration and Clerical (1 Member);
      1.2.4. Ancillary Staff (1 Member);
      1.2.5. Nurses and Midwives (up to 2 members);

   1.3. Two Local Authority Governors, one to be appointed by each of: Calderdale Metropolitan Borough Council and Kirklees Metropolitan Council;

   1.4. Up to six Governors appointed by partnership organisations. The partnership organisations shall appoint a Governor to represent their organisation on the Council of Governors. The partnership organisations are identified as:
      - Huddersfield University,
      - South West Yorkshire Partnership NHS Foundation Trust
      - Locala Community Interest Company
      - Healthwatch Calderdale and Kirklees

ANNEXE 7 – COUNCIL OF GOVERNORS – STANDING ORDERS

AS APPROVED AT COUNCIL OF GOVERNORS OCTOBER 2017

A Public Benefit Corporation

STANDING ORDERS

COUNCIL OF GOVERNORS

Version:	3.0 Changes to stakeholder governors
Approved by:	Council of Governors
Date approved:	XX October 2017
Date issued:	XX October 2017
Next Review date:	April 2019

CONTENTS

- **INTERPRETATION**

In these Standing Orders, the provisions relating to interpretation in the Constitution shall apply and the words and expressions defined in the Constitution shall have the same meaning and, in addition:

"**The Act**" shall mean the National Health Service Act 2012.

"**Terms of Authorisation**" shall mean the Authorisation of the Trust issued by Monitor with any amendments for the time being in force.

"**Corporation**" means Calderdale & Huddersfield NHS Foundation Trust, which is a public benefit corporation.

"**Board of Directors**" shall mean the Board of Directors as constituted in accordance with the Trust's constitution.

"**Chairman**" means the person appointed to be Chairman of the Trust under the terms of the constitution.

"**Chief Executive**" shall mean the chief officer of the Trust.

"**Constitution**" shall mean the constitution attached to the Authorisation with any variations from time to time approved by Monitor.

"**Council of Governors**" shall mean the Council of Governors as constituted in accordance with the corporation's constitution.

"**Deputy Chair"** (also known as Lead Governor) is the Public Governor selected by the Council of Governors to act as a lead for the Governors and to chair meetings in those circumstances where both the Chairman and Vice-Chair have a conflict.

"**Director**" shall mean a member of the Board of Directors as defined in section 13 of the constitution.

"**Governor"** shall mean those persons elected or appointed to sit on the Trust's Council of Governors.

"**Monitor**" is the previous name of the Independent Regulator for NHS Foundation Trusts. This changed to NHS Improvement on 1 April 2016.

"**Motion**" means a formal proposition to be discussed and voted on during the course of a meeting.

"**NHS Improvement**" is the new Independent Regulator for NHS Foundation Trusts which came into being on 1 April 2016 formed from Monitor and the NHS Trust Development Authority.

- "**Officer**" means an employee of the Trust.

"**Vice-Chairman**" means the Vice-Chairman of the Trust pursuant to the terms of the constitution who will preside at meetings of the Council of Governors in the Chairman's absence.

"**Secretary**" means the Board Secretary of the Trust or any other person appointed to perform the duties of the Secretary to the Board of Directors.

SECTION A: CONDUCT OF MEETINGS

1. Admission of the Public and the Press

1.1. The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Council of Governors but shall be required to withdraw upon the Council of Governors resolving as follows:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with 12.24 of the Constitution."

1.2. The Chairman (or Vice-Chairman) shall give such directions as he/she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Council of Governors' business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on the grounds of the confidential nature of the business to be transacted, the Council of Governors may resolve as follows:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Council of Governors to complete business without the presence of the public in accordance with 12.24 of the Trust's Constitution."

1.3. Nothing in these Standing Orders shall require the Council of Governors 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 prior agreement of the Council of Governors.

2. Calling and notice of meetings

2.1. The Council of Governors is to meet at least three times in each financial year. Meetings shall be determined at the first meeting of the Council of Governors or at such other times as the Council of Governors may determine and at such places as they may from time to time appoint.

2.2. Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least **ten working** days written notice of the date and place of every meeting of the Council of Governors to all Governors. Notice will also be published on the Trust's website.

2.3. Meetings of the Council of Governors may be called by the Secretary, by the Chairman, by the Board of Directors or by eight Governors (including two appointed Governors) who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Governors as soon as possible after receipt of such a request giving at least **ten working days'** notice to discuss the specified business. If the Secretary fails to call such a meeting then the Chairman or four Governors, whichever is the case, shall call such a meeting.

2.4. In the case of a meeting called by Governors in default of the Chairman, the notice shall be signed by those Governors and no business shall be transacted at the meeting other than that specified on the notice.

2.5. All meetings of the Council of Governors are to be general meetings open to members of the public unless the Council of Governors decides otherwise in relation to all or part of the meeting for reasons of commercial confidentiality or on other proper grounds. The

Chairman may exclude any member of the public from a meeting of the Council of Governors if they are interfering with or preventing the proper conduct of the meeting

2.6. The Council of Governors may invite the Chief Executive or through the Chief Executive any other member or members of the Board of Directors, or a representative of the Trust's auditors or other advisors to attend a meeting of the Council of Governors. The Chief Executive and any Executive of the Trust nominated by the Chief Executive shall have the right to attend any meeting of the Council of Governors provided that they shall not be present for any discussion of their individual relationship with the Trust

2.7. The Council of Governors 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.

2.8. All decisions taken in good faith at a meeting of the Membership Council, or of any of its committees, shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Governors attending the meeting.

2.9. Following notice of the meeting (as set out in SO 2.3) an agenda for the meeting, specifying the business proposed to be transacted at it shall be sent to every Governor, so as to be available to him/her at least **five working** days before the meeting.

2.10. The agendas will include all supporting papers available at the time of posting. Further supporting papers will be received no later than **three (3)** working days before the meeting.

2.11. Lack of service of the notice on any one person above shall not affect the validity of the meeting, but failure to serve such a notice on more than six Governors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

3. **Quorum**

3.1. Ten Council of Governors members present in person or by proxy under arrangements approved by the Council of Governors shall form a quorum

4. **Setting the agenda**

4.1. A Governor desiring a matter to be included on an agenda shall make the request in writing to the Chairman at least **ten working** days before the meeting. Requests made less than fourteen clear days before a meeting may be included on the agenda at the discretion of the Chairman or the Secretary.

5. **Chairmanship of meeting**

5.1. The Chairman of the Trust or, in his/her absence, the Vice-Chairman, or in his/her absence the Deputy Chairman will chair meetings of the Council of Governors.

5.2. The Deputy Chairman/Lead Governor will be appointed from the Public Membership at a general meeting. He/she will act as Chairman of the meeting should the Chairman and the Vice-Chairman be in conflict. The Deputy Chairman will hold the casting vote when he/she is acting as Chairman.

6. **Notices of motion**

6.1. A Governor desiring to move or amend a motion shall send a written notice thereof at least **ten working** days before the meeting to the Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to preceding provisions.

7. **Withdrawal of motion or amendments**

7.1. A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

8. **Motion to rescind a resolution**

8.1. Notice of motion to amend or rescind any resolution (or general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Governors who give it and also the signature of four other Governors, of whom at least two shall be Public Governors. When any such motion has been disposed of by the Trust, it shall not be competent for any Governor other than the Chairman to propose a motion to the same effect within six months, although the Chairman may do so if he/she considers it appropriate.

9. **Motions**

9.1. The mover of a motion shall have the right of reply at the close of any discussions on the motion or any amendment thereto.

9.2. When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:

a) An amendment to the motion.

b) The adjournment of the discussion or the meeting.

c) That the meeting proceed to the next business. (*)

d) The appointment of an ad hoc committee to deal with a specific item of business.

e) That the motion be now put. (*)

1. [*In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Governor who has not previously taken part in the debate.]

9.3. No amendment to the motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

10. **Chairman's ruling**

10.1. The decision of the Chairman of the meeting on the question of order, relevancy and regularity shall be final.

11. **Voting**

11.1. Questions arising at a meeting of the Council of Governors requiring a formal decision shall be decided by a majority of votes. In case of an equality of votes the Chairman shall

decide the outcome. No resolution of the Council of Governors shall be passed if it is unanimously opposed by all of the Public Governors.

11.2. All questions put to the vote shall, at the discretion of the Chairman, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request, or the Secretary deems it advisable or necessary.

11.3. 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.

11.4. If a Governor so requests his vote shall be recorded by name upon any vote (other than by paper ballot).

11.5. In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

12. **Minutes**

12.1. The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting

12.2. No discussion shall take place upon the minutes, except upon their accuracy, or where the Chairman considers discussion appropriate. Any amendments to the minutes shall be agreed and recorded at the next meeting.

12.3. Minutes shall be circulated in accordance with Governors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public via the Trust Website (required by the Code of Practice of Openness in the NHS).

SECTION B: COMMITTEES

13. **Appointment of Committees**

13.1. Subject to paragraph 40 below and such directions as may be given by NHS Improvement, the Council of Governors may and, if directed to do so, shall appoint committees of the Membership Council, consisting wholly or partly of Governors. In all cases, each committee shall have a majority of Public Governors.

13.2. A committee appointed under SO 13.1 may, subject to such directions as may be given by NHS Improvement or the Membership Council, appoint sub-committees consisting wholly or partly of members of the committee.

13.3. These Standing Orders, as far as it is applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Council of Governors.

13.4. Each such committee or sub-committee shall have such terms of reference and powers 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.

13.5. Committees may not delegate their powers to a sub-committee unless expressly authorised by the Council of Governors.

13.6. The Council of Governors shall approve the appointments to each of the committees which it has formally constituted. Where the Council of Governors determines that persons who are neither Governors, nor directors or officers, shall be appointed to a committee, the terms of such an appointment shall be determined by the Council of Governors subject to the payment of travelling and other allowances being in accordance with such sum as may be determined by the Board of Directors or NHS Improvement (in line with SO 20).

13.7. Where the Council of Governors is required to appoint persons to a committee or to undertake statutory functions as required by NHS Improvement, and where such appointments are to operate independently of the Council of Governors or the Board of Directors, such appointment shall be made in accordance with the any regulations laid down by the Chief Executive or his nominated officer or any directions or guidance issued by NHS Improvement from time to time.

14. **Confidentiality**

14.1. A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Council of Governors or shall otherwise have concluded on that matter.

14.2. A Governor or a member of a committee shall not disclose any matter reported to the Council of Governors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or committee shall resolve that it is confidential.

14.3. In relation to patient confidentiality, the provisions at paragraphs 42 and 43 above for disclosure of information by Governors or members of committees established by the Council of Governors shall not apply, and such information shall not be disclosed under any circumstances.

15. **Appointment of the Chairman, Vice-Chairman and Non-Executive directors**

15.1. The Council of Governors shall appoint a Chairman of the Trust. The Board of Directors will appoint one Non-Executive Director to be Vice-Chairman of the Trust. This individual may, through agreement with the Chair, also take on the role of SINED (Senior Independent Non-Executive Director). The Council of Governors shall ratify the appointment of the Vice Chairman at a general meeting.

15.2. Non-Executive Directors are to be appointed by a sub-committee (not exceeding four persons) of the Council of Governors using the procedures set out under paragraph 13 of the constitution.

SECTION C: REGISTER AND DISCLOSURE OF INTERESTS

16. **Register and disclosure of interests**

16.1. If Governors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chairman or the Secretary.

16.2. Any Governor who has a material interest in a matter as defined below and in the constitution shall declare such an interest to the Council of Governors and it shall be recorded in a register of interests and the Governor in question:

a) Shall not be present except with the permission of the Council of Governors in any discussion of the matter, and

b) Shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

16.3. Any Governor who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining Governors.

16.4. At the time the interests are declared, they should be recorded in the minutes of the Council of Governors. Any changes in interests should be officially declared at the next meeting as appropriate following the change occurring.

16.5. It is the obligation of a Governor to inform the Secretary in writing within seven days of becoming aware of the existence of a relevant or material interest. The Secretary will amend the register upon receipt within three working days.

16.6. The details of Governors' interests recorded in the register will be kept up to date by the Secretary, and reviewed at each meeting of the Council of Governors.

16.7. Subject to the requirements of the Public Benefit Corporation (Register of Members) Regulations 2006 and the Data Protection Act 1998, the register will be available for inspection by the public free of charge and will be published on the Trust's website.

16.8. Copies or extracts of the register must be provided to members of the Trust free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the register.

16.9. A material interest in a matter is any interest (save for the exceptions referred to below) held by a Governor, or their spouse or partner, in any firm or business which, in connection with the matter, is trading with the trust, or is likely to be considered as a potential trading partner with the trust. The exceptions which shall not be treated as material interests are as follows:

a) Shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange;

b) An employment contract held by staff Governors;

c) An employment contract with HealthWatch or a local authority held by a HealthWatch Governor;

d) An employment contract with a Local Authority held by a Local Authority Governor;

e) An employment contract with any organisation listed at paragraph 12.3.5 of the constitution.

16.10. If, in relation to 47, the Chairman has a conflict of interest, the Vice-Chairman will exercise the casting vote. If the Vice-Chairman has a conflict of interest, the Deputy Chairman will preside and exercise the casting vote, the nomination to be approved by a majority vote of those present at the meeting.

16.11. An elected Governor may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the Council of Governors Charter as specified by the Council of Governors as to the basis upon which they are entitled to vote as a member. The Constitution provides guidance. An elected Governor shall be deemed to have confirmed the 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 elected Governors.

16.12. Members of the Council of Governors must meet the requirements of the Fit and Proper persons test.

SECTION D: TERMINATION OF OFFICE AND REMOVAL OF GOVERNOR

17. **Termination of office**

17.1. A person holding office as a Governor shall immediately cease to do so if:

a) They resign by notice in writing to the Secretary;

b) They fail to attend two meetings in any Financial Year, unless the other Governors are satisfied that the absences were due to reasonable causes, and they will be able to start attending meetings of the trust again within such a period as they consider reasonable;

c) In the case of an elected Governor, they cease to be a Member of the constituency by whom they were elected;

d) In the case of an appointed Governor, the Appointing Organisation terminates the appointment;

e) They have failed to undertake any training which the Council of Governors requires all Governors to undertake;

f) They have failed to sign and deliver to the Secretary a statement in the form required by the Council of Governors confirming acceptance of the Code of Conduct for Governors/gGovernor's Charter;

g) They refuse to sign a declaration in the form specified by the Council of Governors that they are a Member of a specific public constituency and are not prevented from being a Member of the Council of Governors. This does not apply to Staff Members;

h) They are removed from the Council of Governors under the following provisions.

18. **Removal of Governor**

18.1. 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 a general meeting of the Council of Governors on the grounds that:

a) They have committed a serious breach of the Code of Conduct; or

b) They have acted in a manner detrimental to the interests of the Trust; and

c) The Council of Governors considers that it is not in the best interests of the Trust for them to continue as a Governor.

18.2. Where a person has been elected or appointed to be a Governor and he/she becomes disqualified for appointment, under SO 17.1 above, he/she shall notify the Secretary in writing of such disqualification.

18.3. If it comes to the notice of the Secretary that a person elected or appointed to be a Governor may be disqualified, under SO 17.1 above, from holding that office and the Secretary has not received a notice, under paragraph 59, from that person, the Secretary will make such inquiries as he/she thinks fit and, if satisfied that the person may be so disqualified, the Secretary will advise the Chairman so that the Chairman can make a recommendation for disqualification to the Council of Governors. The recommendation will either be made to a general meeting or to a meeting called specifically for the purpose.

18.4. The Secretary shall give notice in writing to the person concerned that the Trust proposes to declare the person disqualified as a Governor. In this notice, the Secretary shall specify the grounds on which it appears to him/her that the person is disqualified and give that person a period of fourteen days in which to make representations, orally or in writing, on the proposed disqualification.

18.5. The Chairman's recommendations and any representations by the Governor concerned shall be made to the Council of Governors. If no representations are received within the specified time, or the Council of Governors upholds the proposal to disqualify, the Secretary shall immediately declare that the person in question is disqualified and notify him/her in writing to that effect. On such declaration the person's tenure of office shall be terminated and he/she shall cease to act as a Governor.

SECTION E: REMUNERATION AND PAYMENT OF EXPENSES

19. **Remuneration**

19.1. Governors are not to receive remuneration.

20. **Payment of expenses**

20.1. The return cost of travel from the Governor
a) The actual bus or rail fare using the most direct route.

b) Travel by private car or taxi at the Trust's usual pence per mile rate (currently 28p per mile) using the most direct route.

c) Necessary parking charges.

20.2. Governors claiming expenses may be required to provide tickets, receipts or other proof of expenditure alongside a completed and signed expenses form.

20.3. Expenses will be authorised through the Secretary's office and details of all expenses claimed by Governors will be recorded and published in the Trust's Annual Report and Accounts.

SECTION F: STANDARDS OF CONDUCT OF GOVERNORS

21. **Policy**

21.1. In relation to their conduct as a member of the Council of Governors, each Governor must comply with the same standards of business conduct as for NHS staff. In particular, the Trust must be impartial and honest in the conduct of its business and its office holders and staff must remain beyond suspicion. Governors are expected to be impartial and honest in the conduct of official business.

22. **Interest of Governors in contracts**

22.1. If it comes to the knowledge of a Governor that a contract in which he/she has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust, he/she shall, at once, give notice in writing to the Secretary of the fact that he/she has such an interest.

22.2. A Governor shall not solicit for any person any appointment in the Trust.

22.3. Informal discussions outside appointment committees, whether solicited or unsolicited, should be declared to the committee.

SECTION G: MISCELLANEOUS PROVISIONS

23. **Suspension of Standing Orders**

23.1. Standing Orders may be suspended at any general meeting provided that:

a) at least two-thirds of the Council of Governors are present, including at least six elected Governors and one appointed Governor, and

b) the Secretary does not advise against it, and

c) a majority of those present vote in favour.

23.2. But Standing Orders cannot be suspended if to do so would contravene any statutory provision, or the Trust's Terms of Authorisation, or the Trust's constitution.

23.3. A decision to suspend Standing Orders shall be recorded in the minutes of the meeting and any matters discussed during the suspension of Standing Orders shall be recorded separately and made available to all members of the Council of Governors.

23.4. No formal business may be transacted while Standing Orders are suspended.

24. **Variation and amendment of Standing Orders**

24.1. Standing Orders may only be varied or amended if:

a) the proposed variation does not contravene any statutory provision, or the Trust's Terms of Authorisation, or the Trust's constitution;

b) unless proposed by the Chairman or the Chief Executive or the Secretary, a notice of motion under paragraph 19 has been given;

c) at least two-thirds of the Council of Governors are present, including at least six elected Governors and one appointed Governor, and at least half of the Governors present vote in favour of amendment.

25. **Review of Standing Orders**

25.1. Standing Orders shall be reviewed bi-annually by the Council of Governors. The requirement for review shall extend to all and any documents having effect as if incorporated in Standing Orders.

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ANNEXE 8 – BOARD OF DIRECTORS – STANDING ORDERS

UNIQUE IDENTIFIER NO: G/1/2010
Review Date: April 2019
Review Lead: Company Secretary

STANDING ORDERS

BOARD OF DIRECTORS

Directorate responsible for policy:	Chief Executive's Office
Version:	V2
Policy author:	Company Secretary
Responsible Committee:	Audit and Risk Committee
Date written:	April 2017
Date approved:	April 2017
Date issued:	April 2017
Review date:	April 2019

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FOREWORD

Within the terms of authorization issued by Monitor, the former Independent Regulator, NHS Foundation Trusts are required to demonstrate appropriate arrangements to provide comprehensive governance arrangements in accordance with the need to agree Standing Orders (SOs) and schedules of Reservations of Powers to the Trust and Scheme of Delegation in accordance with their constitutions, their Terms of Authorisation and the requirements of the National Health Service Act 2006 ("the 2006 Act").

This Standing Orders document, together with Standing Financial Instructions and the Reservation of Powers to the Board (Scheme of Delegation), provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

These documents provide a comprehensive business framework. All Directors and all members of staff should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

INTERPRETATION

These Standing Orders are subject to continuous review (and formally reviewed and approved by the Audit and Risk Committee and Board of Directors every 2 years) to ensure that they reflect the obligations to which the Foundation Trust is subject under the Health and Social Care (Community Health and Standards) Act 2003, the Terms of Authorisation and the provisions of its Constitution.

For the avoidance of doubt nothing contained within these standing orders shall be construed in contravention of the Terms of Authorisation and in the event that there is such a contravention, the Terms of Authorisation, the 2006 Act and the Constitution shall take precedence.

Whilst the nature of these Standing Orders is that they are subject to variation, no such variation shall contravene the Terms of Authorisation, the 2006 Act and the Constitution.

INTRODUCTION

Statutory Framework

Calderdale & Huddersfield NHS Foundation Trust (the Trust) is a public benefit corporation which was established under the National Health Service Act 2006 ("the 2006 Act").

The principal place of business of the Trust is:
Trust Offices, Huddersfield Royal Infirmary, Acre Street, Lindley, Huddersfield, HD3 3EA

The statutory functions conferred on the Trust are set out in the 2006 Act. The Trust also has a constitution ("the Constitution") as required under the 2006 Act, which includes further provisions consistent with Schedule 7 in support of the governance arrangements within the Trust.
It should be noted that the Trust also has in place Standing Orders (SOs) which deal with the Council of Governors which may need to be referred to.

The purpose of the Trust (as required by the 2006 Act) is to serve the community by the provision of goods and services for purposes related to the provision of health care in accordance with its statutory duties and the Terms of the Independent Regulator's Authorisation (the "Terms of Authorisation"). The Trust is to have all the powers of an NHS Foundation Trust as set out in the 2006 Act, subject to the Terms of Authorisation.

As a statutory body, the Trust has specified powers to contract in its own name.

The Trust also has powers under section 28A of the NHS Act 1977 as amended by the 2006 Act to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

Regulatory Framework

Under its regulatory framework the Trust must adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions as an integral part of Standing Orders setting out the responsibilities of individuals.

The Trust's Constitution also requires that the Board of Directors draw up a schedule of decisions reserved to that Board and a scheme of delegation to enable responsibility to be clearly delegated to committees of the board and individual directors.

The Constitution also requires the establishment of an Audit Committee and a Remuneration Committee with formally agreed terms of reference. The Constitution requires a register of possible conflicts of interest of members of both the Board of Directors and the Council of Governors and how those possible conflicts are addressed.

In addition to the statutory requirements the Independent Regulator (the office formerly known as Monitor and now known as NHS Improvement) will issue further requirements and guidance. Many of these are contained within the 2006 Act and on NHS Improvement's website . Information is accessible locally via the Board Secretary.

Arrangements for public access to information are set out in the Code of Practice on Openness in the NHS and in the Trust's publication scheme under the Freedom of Information Act 2000.

Delegation of Powers

(a) The Trust has powers to delegate and make arrangements for delegation. Under the Standing Orders relating to the Arrangements for the Exercise of Functions (SO 4) the Board is given powers to make arrangements for the discharge, on behalf of the Trust, of any of its functions by an internal committee or sub-committee appointed by virtue of SO 5 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit or as the Independent Regulator may direct. Delegated Powers are covered in a separate document (Scheme of Delegation)

and financial delegation in the Standing Financial Instructions. These documents have effect as if incorporated into the Standing Orders.

Integrated Governance
Trust Boards are now encouraged to move away from silo governance and develop integrated governance that will lead to good governance and ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance. The Trust Board uses its committee structures to support it in implementing a model of integrated governance.

Collaboration of services across West Yorkshire and Harrogate District
Moving to support the implementation of the Sustainable Transformation Plans (STPs), acute providers are required by NHS Improvement to plan, commission and deliver efficicient and sustainable healthcare services for patients across a footprint for the population of West Yorkshire and Harrogate District.

Therefore the following Trusts:
- Airedale NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Calderdale and Huddersfield NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Leeds Teaching Hospitals NHS Trust
- Mid Yorkshire Hospitals NHS Trust

will collaborate to oversee a comprehensive system-wide programme to deliver the objective of acute provider transformation. Collectively they will share obligations agreed by all Parties, set out in a Memorandum of Understanding (MOU) and hold each other to account via a Committee in Common, with all Parties agreeing to its Terms of Reference.

(b) INTERPRETATION

Save as permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he/she should be advised by the Chief Executive).

Any expression to which a meaning is given in the 2006 Act or in the Regulations or Orders made under the Act shall have the same meaning in this interpretation and in addition:

"Accounting Officer" means the Officer responsible and accountable for funds entrusted to the Trust. He/she shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

"Trust" means the Calderdale & Huddersfield NHS Foundation Trust.

"**Board of Directors**" means the Board of Directors as constituted in accordance with the Constitution;

"Budget" shall mean a resource, expressed in financial terms, proposed by the Board anauthorised by the Independent Regulator for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

"Chair" is the person appointed in accordance with schedule 7 of the 2006 Act and under the terms of the Constitution to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Deputy Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable or is unable to act as Chair due to a conflict of interest.

"Chief Executive" shall mean the chief officer of the Trust.

"Committee" shall mean a committee appointed by the Board of Directors functioning as an internal committee.

"Committee members" shall be persons formally appointed by the Board of Directors to sit on or to chair specific committees.

"Committee in Common" means a collective group or representation from organisations (i.e. the acute provider Trusts in West Yorkshire and Harrogate District), to perform a particular function or duty.

"Deputy Chair" means the non-executive director appointed by the Trust to take on the Chair's duties if the Chair is absent for any reason or is unable to act due to a conflict of interest.

"Director" means a member of the Board of Directors

"Director of Finance" shall mean the chief finance officer of the Trust.

"Elected Governor**"** means those Governors elected by the public constituency and the staff constituency.

"Funds held on Trust" (Charitable Funds) shall mean those funds that the Trust as Corporate Trustee holds at the date of authorisation, or receives on distribution by statutory instrument or chooses subsequently to accept. Such funds will be charitable.

"Memorandum of Understanding" (MOU or MoU) is a formal agreement between two or more parties. Companies and organisations can use MOUs to establish official partnerships. MOUs are not legally binding but they carry a degree of seriousness and mutual respect.

"Monitor" is the former name of the Independent Regulator for NHS Foundation Trusts

"Motion" means a formal proposition to be discussed and voted on during the course of a meeting.

"NHS Improvement" is the name of the Independent Regulator for NHS Foundation Trusts.

"Nominated officer" means an officer charged with the responsibility for discharging specific tasks within the Constitution and the SOs and SFIs.

"Officer" means an employee of the Trust.

"SFIs" means Standing Financial Instructions.

"SINED" means Senior Independent Non-Executive Director.

"SOs" means Standing Orders.

"Sustainability and Transformation Plans" are five year plans for the future of health and care services in local areas. STPs represent a very significant change to the planning of health and care services in England.

"WYAAT" means the West Yorkshire Association of Acute Trusts, which includes Harrogate District.

1. THE TRUST

1.1 All business shall be conducted in the name of the Trust.

The roles and responsibilities of the Board of Directors are set out in Appendix X of the Trust's Constitution.

The Trust has the functions conferred on it by the 2003 Act and by its Terms of Authorisation.

All funds or property received in trust under section 22 of the 2003 Act shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees under Chapter 5, section 51 of the 2006 Act. Accountability for charitable funds held on trust is in accordance with the relevant arrangements made by the Charity Commission and such other statutory requirements or direction by NHS Improvement as may apply.

The Trust has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in "Reservation of Powers to the Board" and have effect as if incorporated into the Standing Orders.

1.2 Composition of the Board of Directors

In accordance with the 2006 Act, Terms of Authorisation and the Constitution, the Board of Directors of the Trust shall comprise both Executive and Non-Executive Directors as follows:

A Non-Executive Chair
Up to 7 other Non-Executive directors (one of who shall act as the SINED)
Up to 6 Executive directors including:

- *the Chief Executive (the Chief Officer)*
- *the Director of Finance (the Chief Finance Officer)*
- *a medical or dental practitioner*
- *a registered nurse or midwife*

The Non-Executive Directors and Chair together shall be greater than the total number of Executive Directors.

Other Directors may be appointed to the Board of Directors from time to time but shall have no voting rights.

1.3 Appointment and removal of the Chair and Non-Executive Directors

The Chair and Non-Executive Directors are appointed and may be removed by the Council of Governors in accordance with Schedule 7 of the 2006 Act and under Paragraph 13 of the Constitution.

1.4 Terms of Office of the Chair and Non-Executive Directors

The Chair and Non-Executive Directors are appointed for a period of office in accordance with Schedule 7 of the 2006 Act and under Paragraph 13 of the Constitution. The terms and conditions of the office are decided by the Council of Governors.

1.5 Appointment of Deputy Chair

For the purpose of enabling the proceedings of the board of directors to be conducted in the absence of the Chair, the directors of the Trust will appoint a non-executive director from amongst them to be Deputy Chair. This individual may, through agreement with the Chair

take on the role of Senior Independent Non-Executive Director (SINED), as contained in 12.11 of the Constitution.

Any Non-Executive Director so elected may at any time resign from the office of Deputy Chair by giving notice in writing to the Chair and the Directors of the Trust may thereupon appoint another Non-Executive director as Deputy Chair in accordance with these Standing Orders.

1.6 Powers of Deputy Chair

Where the Chair has ceased to hold office or where he has been unable to perform his/her duties as Chair owing to illness, absence or any other cause, references to the Chair shall, so long as there is no Chair able to perform those duties, be taken to include references to the Deputy Chair.

1.7 Appointment of Senior Independent Director

The Board of Directors shall, following consultation with the Council of Governors, appoint one of the Non-Executive Directors to be their Senior Independent Director using the procedure set out in the Constitution.

1.8 Joint Directors

Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for Executive Directorship or in relation to which an Executive Director is to be appointed, those persons shall become appointed as an Executive Director jointly, and shall count for the purpose of Standing Orders as one person.

1.9 Secretary

The Board of Directors shall appoint the Secretary of the Trust and subject to following good employment practice, may also remove that person. The Secretary may not be a Governor, or the Chief Executive or the Finance Director. The Secretary shall be accountable to the Chief Executive and their functions shall be as listed in the Constitution.

2. MEETINGS OF THE BOARD OF DIRECTORS

2.1 Admission of the Public and the Press

The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Board but shall be required to withdraw upon the Board resolving as follows:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).

The Chair shall give such directions, as he/she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press, such as to ensure that the Board's business shall be conducted without interruption and disruption and without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted. The public will be required to withdraw upon the Board resolving as follows:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public (Section 1 (8) Public Bodies (Admission to Meetings) Act 1960).

Nothing in these Standing Orders shall require the Board of Directors to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of the proceedings as they take place without prior agreement of the Board of Directors.

2.2 Observers at Board meetings

The Board of Directors will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board meetings and will change, alter or vary these terms and conditions as it deems fit.

2.3 Public questions

Members of the public wishing to submit questions to the Board of Directors meeting will be required to submit these in writing by close of play the day before the meeting. The Chair will have the discretion to accept questions at the meeting if appropriate. Questions / statements must not relate to any defined as confidential under Section 1 (2) of the Public Bodies (Admissions to Meetings) Act 1960, unless the matter relates to a person's personal circumstances where that person has given their consent to is being raised at a public meeting. The Chair's ruling on the appropriateness of the question / statement is final. The Chair will reserve the right to respond to questions in writing if time does not permit these questions to be answered in the meeting.

2.4 Calling Meetings

Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

Meetings of the Board of Directors may be called by the Secretary or by the Chair at any time. Meetings may also be called by at least one-third of the directors who given written notice to the Secretary specifying the business to be carried out. The Secretary should send a written notice to all directors within seven days of receiving such a request. If the Chair or Secretary refuses to call a meeting after such a request one-third or more directors may forthwith call a meeting.

2.5 Notice of Meetings

Before each meeting of the Board of Directors of the Trust, a notice of the meeting, specifying the business proposed to be transacted at it, shall be delivered to every director, or sent electronically or by post to the usual place of residence of such director, so as to be available at least three clear days before the meeting.

A notice shall be presumed to have been served one day after posting. Lack of service of the notice on any director shall not affect the validity of the meeting.

In the case of a meeting called by directors in default of the Chair, the notice shall be signed by those directors and no business shall be transacted at the meeting other than that specified in the notice.

Before each meeting of the NHS Foundation Trust a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's offices at least three clear days before the meeting. (required by the Public Bodies (Admission to Meetings) Act 1960 S.I. (4) (a)

The Board of Directors 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

2.6 Chair of the Meeting

At any meeting of the Board of Directors the Chair, if present, shall preside. If the Chair is absent, the Deputy Chair shall preside. If the Chair and Deputy Chair are absent one of the other Non-Executive Directors in attendance, as chosen by the Board of Directors shall preside.

If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest, the Deputy Chair, if present, shall preside. If the Chair and Deputy Chair are absent, or are disqualified from participating, such Non-Executive director as the directors present shall choose shall preside.

2.7 Setting the Agenda

The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Trust and shall be addressed prior to any other business being conducted.

A director who requires a matter to be included on an agenda should advise the Secretary to the Board prior to the agenda being agreed with the Chair and no less than 7 days before a meeting.

Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next Board of Directors meeting.

2.8 Annual Members Meeting

The Trust will publicise and hold an annual members meeting in accordance with its Constitution.

2.9 Notices of Motion

A director of the Trust wishing to move or amend a motion should advise the Secretary to the Board prior to the agenda being agreed with the Chair and no less than 7 days before a meeting. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda.

2.10 Emergency Motion

Subject to the agreement of the Chair, and subject to the provision of SO 3.8, a director may give written notice of an emergency motion after the issue of the notice of the meeting and

agenda up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision is final.

2.11 Withdrawal of Motion or Amendments

A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

2.12 Motion to Rescind a Resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding **six (6)** calendar months shall bear the signature of the director who gives it and also the signature of the majority of the other directors. When any such motion has been disposed of by the Trust, it shall not be competent for any director other than the Chair to propose a motion to the same effect within **six (6)** months, however the Chair may do so if he/she considers it appropriate.

2.13 Motions - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

When a motion is under discussion or immediately prior to discussion it shall be open to a director to move:

(a) An amendment to the motion.
(b) The adjournment of the discussion or the meeting.
(c) That the meeting proceed to the next business. (*)
(d) The appointment of an ad hoc committee to deal with a specific item of business.
(e) That the motion be now put. (*)
(f) A motion under Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960 resolving to exclude the public (including the press).

In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a director who has not previously taken part in the debate.

No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, advised by the Secretary, the amendment negates the substance of the motion.

2.14 Chair's Ruling

Statements of directors made at meetings of the Board of Directors shall 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 observed at the meeting.

2.15 Voting

Every question put to a vote at a meeting shall be determined by a majority of the votes of the Chair of the meeting and the directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote. No resolution of the Board of Directors shall be passed by a majority composed only of Executive Directors or Non-Executive Directors.

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 also be used if a majority of the directors present so request.

If at least one-third of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

If a director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

An officer who has been appointed formally by the Board to act up for an executive director during a period of incapacity or temporarily to fill an executive director vacancy, shall be entitled to exercise the voting rights of the executive director. An officer attending the Board of Directors to represent an executive director during a period of incapacity or temporary absence 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.

2.16 Minutes

The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

Minutes shall be circulated in accordance with directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public via the Trust website (required by Code of Practice on Openness in the NHS). A record of items discussed in private will be maintained and approved by the Board of Directors.

2.17 Joint Directors

Where a post of executive director is shared by more than one person

a) Both persons shall be entitled to attend meetings of the Trust
b) If both are present at a meeting they should cast one vote if they agree
c) In the case of disagreement between them no vote should be cast
d) The presence of either or both of those persons shall count as one person for the purposes of SO 3.20 Quorum

2.18 Suspension of Standing Orders

Except where this would contravene any statutory provision or any direction made by Monitor, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board of Directors are present, including two Executive directors and two Non-Executive directors, and that a majority of those present vote in favour of suspension.

A decision to suspend SOs shall be recorded in the minutes of the meeting.

A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the directors.

The Audit and Risk Committee shall review every decision to suspend SOs.

2.19 Variation and Amendment of Standing Orders

These Standing Orders shall be amended only if:

(a) a notice of motion under Standing Order 3.8 has been given; and
(b) no fewer than half the total of the Trust's total Non-Executive directors vote in favour of amendment; and
(c) at least two-thirds of the Directors are present; and
(d) the variation proposed does not contravene a statutory provision or provision of authorization or of the Constitution

2.20 Record of Attendance

The names of the Chair and directors present at the meeting shall be recorded in the minutes. The Secretary shall maintain a record of the number of meetings of the Board of Directors and the attendance of individual directors. This will include those who participate by telephone, video or computer link in accordance with these SOs.

2.21 Quorum

No business shall be transacted unless one-third of the whole number of the Directors are present (including two Executives and two Non-Executives are present), one of whom is the Chair or Deputy Chair and as such has a casting vote.

Any officer in attendance for an executive director but without formal acting up status may not count towards the quorum.

If the Chair or a director 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 (see SOs 6 and7) 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 above requirement for at least two Executive Directors to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting.

3. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

Subject to a provision in the authorization or the Constitution, the Board of Directors may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 4.2 below, or by a director or an officer of the Trust in each case subject to such restrictions and conditions as the Board of Directors thinks fit.

3.1 Urgent Decisions

The powers which the Board of Directors has retained to itself within these Standing Orders (SO 2.5) may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

3.2 Delegation to Committees

The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by internal committees or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

3.3 Delegation to Officers

Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Board of Directors.

The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board of Directors as indicated above.

Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Director of Finance or other executive director to provide information and advice to the Board of Directors in accordance with any statutory requirements and the Terms of Authorisation.

The arrangements made by the Board of Directors as set out in the “Scheme of Delegation” shall have effect as if incorporated in these Standing Orders.

3.4 Overriding Standing Orders

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around non-compliance shall be reported to the next formal meeting of the Board of Directors for action or ratification. All members of the Board of Directors, Council of Governors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

4. COMMITTEES

4.1 Appointment of Committees

Subject to the authorisation and the Constitution, the Board of Directors may appoint internal committees of the Trust consisting wholly or partly of the Chair and director of the Trust or wholly of persons who are not directors of the Trust.

Joint Committees

The Trust may appoint a joint committee by joiung together with one or more other health or social care organisations consisting wholly or partly of the Chairman and members of the Trust Board or other health service bodies or wholly of persons who are not members of the Trust or other health bodies in question.

Any committee or joint committee appointed under this SO may, subject to such directions as may be given by NHS Improvement or the Board of Directors or other health bodies in question, appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include directors of the Trust) or wholly of persons who are not members of the Trust committee (whether or not they include directors of the Trust).

Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any internal committees or sub-committee established by the Trust. In which case the term 'Chairman' is to be read as a reference to the Chairman of the internal Committee as the context permits, and the term "director" is to be read as a reference to a member of the internal committee also as the context permits. There is no requirement to hold meetings of internal committees established by the Trust in public.

Terms of Reference

Each such internal committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

Delegation of powers by internal Committees to Sub-Committees

Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board of Directors.

Approval of Appointments to Internal Committees

The Board of Directors shall approve the appointments to each of the internal committees which it has formally constituted. Where the Board of Directors determines that persons, who are neither directors nor officers, shall be appointed to an internal committee, the terms of such appointment shall be determined by the Board of Directors. The Board of Directors shall define the powers of such appointees and shall agree the terms of their remuneration and/or reimbursement for loss of earnings and/or expenses subject to approval by the Council of Governors.

Appointments for statutory functions

Where the Trust is required to appoint persons to an internal committee and/or to undertake statutory functions as required by NHS Improvement, and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with the regulations laid down by Monitor.

Appointment to the WYAAT Committee in Common

Membership of the Committee in Common will be defined in the Terms of Reference, which will be agreed or amended by all Parties. The Board of Calderdale and Huddersfield NHS

Foundation Trust has not agreed to delegate any of its statutory functions to the Committee in Common. The scope of the Committee in Common will be respondible for leading the development of the WYAAT Collaborative Programme and the work streams in accordance with the defined key principles, setting overall strategic direction in order to deliver the WYAAT Collaborative Programme.

Committees established by the Board

The Internal Committees and sub-committees established by the Trust are:

- Audit and Risk Committee
- Finance and Performance Committee
- Remuneration and Terms of Service Committee
- Charitable Funds Committee
- Quality Committee
- Workforce Well Led Committee

The external committee established by the Trust is:

- West Yorkshire Association of Acute Trusts Committee in Common

Such other committees may be established as required to discharge the Board's responsibilities.

4.2 Confidentiality

A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

A Director of the Trust or a member of a committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

5. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

Schedule 7 of the 2006 Act and Section 13.20 of the Constitution requires all Board directors (including Non-Executive Directors) and any other officers nominated by the Trust to declare interests which are relevant and material to the Board of Directors of which they are a member (including the WYAAT Committee in Common). A register of these interests must be kept by the Trust.

5.1 Declaration of Interests

All existing Directors should declare such interests. Any board directors/officers appointed subsequently should do so on appointment.

Interests may be financial or non-financial (i.e. political or belief-based). Interests which should be regarded as relevant and material and which, for the avoidance of doubt should be included in the register are:

- Any directorship of a company;
- Any interest (excluding holding of shares in a company whose shares are listed on any public exchange where the holding does not exceed 2% of the total issued share capital or the value of such shareholding does not exceed £25,000) or position in any firm of company or business, which in connection with the matter, is trading with the Trust or is likely to be considered as a potential trading partner with the Trust including private healthcare organisations and other foundation trusts;
- Any interest in an organization providing health and social care services to the NHS;
- Position of authority in a charity or voluntary organization in the field of health or social care;
- Any affiliation to a special interest group campaigning on health or social care issues.

To the extent not covered above, any connection with an organization, entity or company considering entering in to or having entered in to financial arrangement with the NHS Foundation Trust, including but not limited to lenders or banks.

WYAAT Committee in Common – the Chair and Chief Executive of Calderdale and Huddersfield NHS Foundation Trust will adhere to declaring interests as described within the Conflict of Interests section 10 of the Memorandum of Understanding.

Reference should also be made to the Monitor *NHS Foundation Trust Code of Governance* and the Trust's Constitution and Declaration of Interests Policy in determining whether other circumstances or relationship are likely to affect, or could appear to affect the director's judgement.

Any director who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining directors.

At the time board directors' interests are declared, they should be recorded in the board minutes. Any changes in interests should be declared at the next board meeting following the change occurring.

Board directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the board's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

During the course of a meeting of the Board of Directors, if a conflict of interest is established the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt this includes voting on such an

issue where a conflict is established. If there is a dispute as to where a conflict does exist a majority vote will resolve the issue with the Chair having the casting vote. If by inadvertence they do remain and vote, their vote shall not be counted.

There is no requirement in the Code of Accountability for the interest of directors' spouses or partners to be declared. However, in accordance with the Nolan Principles of integrity, accountability and openness, good practice suggests that such declarations are strongly advisable (as are declaring the interests of other immediate family members and co-business partners). SO 6, which is based on these regulations requires that the interests of spouses or partners (if living together) in contracts should be declared. Therefore the interests of spouses or cohabiting partners should also be regarded as relevant.

If Board directors/officers have any doubt about the relevance of an interest, this should be discussed with the Chair or Trust Secretary. Financial reporting standard 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of in interest. The interests of partner in professional partnerships including general medical practitioners should also be considered.

5.2 Register of Interests

The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board directors and officers. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by both board directors and officers, as defined in SO 5.1. The Register shall also contain the names of all members of the Board of Directors including those who have no interests.

These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

The Register will be available to the public and the Secretary will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

6. EXCLUSION OF THE CHAIR AND DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

Subject to the following provisions of this Standing Order, if the Chair or a director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he/she shall at the meeting and as soon as practicable after its commencement disclose the fact and should withdraw so as not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

NHS Improvement may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health Service that the disability shall be removed.

The Board of Directors may exclude the Chair or a director from a meeting of the Trust while any contract, proposed contract or other matter in which he/she has a pecuniary interest, is under consideration.

Any remuneration, compensation or allowances payable to the Chair or director by virtue of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.

For the purpose of this Standing Order the Chair or a director shall be treated, subject to SO 6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

(a) he/she, or a nominee of his/hers, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

or

(b) he/she is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration; and in the case of persons living together the interest of one person shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

The Chair or director shall not be treated as having a pecuniary interest in any contract proposed contract or other matter by reason only:

(c) of his/her membership of a company or other body, if he/she has no beneficial interest in any securities of that company or other body;

(b) of an interest in any company, body or person with which he/she is connected as mentioned in SO 7.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

Where the Chair or director:

(a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

(d) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he/she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

This Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

This Standing Order applies to a committee or sub-committee of the Trust as it applies to the Board of Directors and applies to any member of any such committee or sub-committee (whether or not he/she is also a director of the Trust) as it applies to a director of the Trust.

7. STANDARDS OF BUSINESS CONDUCT

7.1 Policy

Staff must comply with the national guidance contained in HSG(93)5 "Standards of Business Conduct for NHS Staff and contained in the Trust's "Policy of Standards of Business Conduct for NHS Staff". The following provisions should be read in conjunction with this document.

7.2 Interest of Officers in Contracts

If it comes to the knowledge of a Board director or an officer of the Trust that a contract in which he/she has any pecuniary interest not being a contract to which he/she is him/herself a party, has been, or is proposed to be, entered into by the Trust he/she shall, at once, give notice in writing to the Chief Executive of the fact that he/she is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

An officer must also declare to the Chief Executive any other employment or business or other relationship of his/hers, or of a cohabiting spouse or partner, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

7.3 Canvassing of, and Recommendations by, Directors in Relation to Appointments

Canvassing of Board directors or officers of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

A Board director or officer of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

Failure to declare any interest which may conflict itwh, or compromise, any employee's Trust duties and obligations in respect of the award, operation or administration of a Trust / NHS contract may result in a potential breach of the Bribery Act 2010 and necessitate further investigation by the Trust's counter fraud specialist.

7.4 Relatives of Directors or Officers

Candidates for any staff appointment shall when making application disclose in writing whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

The Directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Foundation Trust any such disclosure made.

Any allaged false representation contained on any application to the Trust, or failure to disclose any information when required to do so, may also result in investigation by the Trust's counter fraud specialist and / or NHS Protect and possible prosecution under the Fraud Act 2006.

On appointment, Directors or officers (and prior to acceptance of an appointment in the case of executive directors) should disclose to the Foundation Trust whether they are related to any other director or holder of any office under the Trust.

Where the relationship of an officer or another director to a Board director of the Trust is disclosed, the Standing Order headed `Disability of directors in proceedings on account of pecuniary interest' shall apply.

The key elements of the Trust's Standards of Business Conduct with which directors and officers are required to comply are:

a. refuse gifts and hospitality above the value of £20
b. declaration of Business interests
c. decline offers of preferential treatment
d. permission to undertake outside employment
e. declaration of offers of commercial sponsorship
f. declaration of rewards
g. respect confidentiality of information.

The principles set out in this Standing Order 8.11 may be expanded by the Trust's Code of Business Conduct as from time to time approved by the Board of Directors.

8. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

8.1 Custody of Seal

It is the responsibility of the Chief Executive to ensure that the Common Seal of the Trust is kept in a secure place.

8.2 Sealing of Documents

The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board of Directors or of a committee thereof or in accordance with any delegation by the Board of its power. The affixing of the Seal shall be attested and signed for by two Executive Directors (not from the originating department) or one Executive Director and the Company Secretary.

Before any building, engineering, property or capital document is sealed the scheme must be approved and authorised and countersigned by the Chief Executive (or an officer nominated by him/her who shall not be within the originating department.)

Contracts for the purchase of goods and services shall be under seal where the aggregate contract value may be reasonably expected to exceed £500,000.

8.3 Register of Sealing

An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealings shall be made to the Board of Directors at least quarterly. The report shall contain details of the seal number, the description of the document and the date of sealing. The book will be held by the Chief Executive or nominated officer.

9. SIGNATURE OF DOCUMENTS

Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

The Chief Executive or nominated officers 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 committee or sub-committee to which the Board has delegated appropriate authority.

10. MISCELLANEOUS

10.1 Standing Orders to be given to Directors and Officers

It is the duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions. Updated email copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive e-copies where appropriate of SOs.

10.2 Documents having the standing of Standing Orders

Standing Financial Instructions and Scheme of Delegation shall have the effect as if incorporated into SOs.

10.3 Review of Standing Orders

Standing Orders and all documents having effect as if incorporated in Standing Orders shall normally be reviewed regularly by the Audit and Risk Committee on behalf of the Board of Directors.

10.4 Non-availability of the Chair / Deputy Chair and Chief Executive / Director of Finance.

Save as expressly provided in these standing orders if the Chair of the Trust is not available for whatever reason to transact the business of the trust expressly or by implication delegated to him/her, then the Deputy Chair shall be empowered to act in his/her place and to exercise all the powers and duties of the Chair until the Chair is again available.

If the Deputy Chair is not available for whatever reason to transact the business of the Trust expressly or by implication delegated to him/her, then any two Non-Executive Directors shall be empowered to act in his/her place and to exercise all the powers and duties of the Deputy Chair in relation to that matter.

If the Chief Executive is not available for whatever reason then any of the Chief Executive's powers and duties expressly or by implication under these Standing Orders may be exercised on his/her behalf by some other Officer duly authorised by the Chief Executive in writing so to act.

MEMBERSHIP COUNCILLORS AND BOARD OF DIRECTORS ATTENDANCE AT FORMAL MC MEETINGS 1 APRIL 2017 TO 31 MARCH 2018

MEETING DATES		5.4.17	6.7.17	20.7.17 AGM	26.10.17	17.1.18	TOTAL ATTENDANCE
PUBLIC – ELECTED							
1	Mrs Rosemary Claire Hedges	√	√	**x**			**/5**
1	Mrs Di Wharmby	√	**x**	**x**			**/5**
2	Mrs Veronica Maher	√	√	√			**/5**
2	Mrs Katy Reiter	**x**	**x**	**x**			**/5**
3	Mr Peter John Middleton	√	√	√	**Tenure ceased 14.9.17**	**-**	**3/3**
3	Mr John Richardson	**-**		**x** Tenure commenced 15.9.17			**/3**
3	Ms Dianne Hughes	√	**x**	√			**/5**
4	Mrs Nasim Banu Esmail	**x**	**x**	**x**			**/3**
4 (RESERVE REGISTER from 15.9.16)	Mr Grenville Horsfall	**x**	**x**	**x**	**Tenure ceased 14.9.17**	**-**	**/5**
4 (RESERVE REGISTER Cons 4 from 15.9.17 Previously Cons 5)	Ms Kate Wileman	√	√	√			**/5**
5	Mr George Edward Richardson	√	√	√	**Tenure ceased 14.9.17**	**-**	**3/3**
5	Stephen Baines	√	**x**	**x**			**/5**
5	Mr Brian Richardson	**x**	**x**	√			**/5**

6	Mrs Annette Bell	√	√	√			**/5**
6	Mr Paul Butterworth			**x** Tenure commenced 15.9.17			**/2**
7	Mrs Lynn Moore	√	√	√			**/5**
7	Miss Alison Schofield			**x** Tenure commenced 15.9.17			**/2**
8	Mrs Michelle Rich	**x**	**x**	**x**			**/5**
8	Mr Brian Moore	**x**	√	√			**/5**
STAFF – ELECTED							
9 - Drs/Dentists	Dr Mary Kiely	**x**	**x**	**x**			**0/5**
9 - Drs/Dentists	Dr Peter Bamber			**x** Tenure commenced 15.9.17			**/2**
10 - AHPs/HCS/Pharm's	Mrs Nicola Sheehan	**x**	**x**	**x**			
11 - Mgmt/Admin/Clerical	Mrs Linzi Smith	**-**	**-**	**x** Tenure commenced 15.9.17			**/2**
12 - Ancilliary	Theodora Nwaeze	**-**	**-**	**x** Tenure commenced 15.9.17			**/2**
13 - Nurses/Midwives	Sian Grbin	**-**	**-**	x Tenure commenced 15.9.17			**/2**

13 - Nurses/Midwives	Charlie Crabtree	**x**	**x**				
NOMINATED STAKEHOLDER							
University of Huddersfield	Dr Cath O'Halloran	**x**	**- Tenure ceased 14.6.17**	-	**-**	**-**	**0/1**
University of Huddersfield	Graham Ormrod		√ **Tenure commenced 15.6.17**	**x**			**/4**
Calderdale Metropolitan Council	Cllr Bob Metcalfe	√	√	√	**Tenure ended 3.10.17**	**-**	**3/3**
Calderdale Metropolitan Council	Cllr Megan Swift			Tenure commenced 3.10.17			**/2**
Kirklees Metropolitan Council	Vacant Post	**-**	**-**	-			
Clinical Commissioning Group	Mr David Longstaff	**x**	**x**	**x**	**Tenure ended 2.10.17**		**0/3**
Locala	Mrs Sharon Lowrie	**x**	**x**	**x**			**0/5**
South West Yorkshire Partnership NHS FT	Vacant Post						
South West Yorkshire Partnership NHS FT	Mrs Dawn Stephenson	**x**	√	**x Tenure ceased 6.7.17**	**-**	**-**	**1/2**
Healthwatch Kirklees	Mr Rory Deighton			**Tenure commenced 2.10.17**			**/2**
BOARD OF DIRECTORS							
Mr Andrew Haigh	Chairman	√	√	√			**/5**

Mrs Jan Wilson	Non-Executive Director	-	-	√			/4
Dr David Anderson	Non-Executive Director	-	√	√			/4
Mrs Karen Heaton	Non-Executive Director	-	-	√			/2
Mr Richard Hopkin	Non-Executive Director	-	-	√			/2
Mr Phil Oldfield	Non-Executive Director	-	-	x			/1
Dr Linda Patterson	Non-Executive Director	-	-	√			/2
Mr Andy Nelson	Non-Executive Director			Tenure commenced 1.10.17			/2
Prof Peter Roberts	Non-Executive Director	√	-	x			/2
Mr Owen Williams	Chief Executive	x	√	√			
Dr David Birkenhead	Exec Medical Director	x	√	√			
Mr Brendan Brown	Exec Director of Nursing	√	√	√			
Mr Ian Warren	Exec Director of Workforce & OD	√	x	Tenure ceases 10.7.10	-	-	1/2
Jason Eddleston	Interim Director of Workforce and OD	-	-	√			
Mr Gary Boothby	Deputy and Exec Director of Finance	√	√	√			
Mandy Griffin	Director of THIS	√	√	√			
Lesley Hill	Exec Director of Planning, Perform., Estates & Facilities Ms	x	x	√			
Helen Barker	Associate Director of Community Services & Operations	x	√	√			
Anna Basford	Director of Transformation and Partnerships	√	√	√			
OTHERS							
Kathy Bray	Board Secretary	√	√	√			
Ruth Mason	Associate Director of Engagement & Inclusion	√	√	√			
Alastair Newall	Senior Manager – KPMG External Auditors	-	-	√			
Victoria Pickles	Company Secretary	x	√	√			
Lindsay Rudge	Deputy Director of	-	-	√			

	Nursing						
Philippa Russell	Acting Director of Finance	-	-	-			
Juliette Cosgrove	Assistant Director for Quality	√	-	-			

Calderdale and Huddersfield NHS Foundation Trust

MEMBERSHIP COUNCIL REGISTER
AS AT 18 OCTOBER 2017

CONSTITUENCY	NAME	DATE APPOINTED	TERM OF TENURE	ELECTION DUE
PUBLIC – ELECTED				
1	Mrs Rosemary Claire Hedges	17.9.15	3 years	2018
1	Mrs Di Wharmby	17.9.15	3 years	2018
2	Mrs Veronica Maher	15.9.16	3 years	2019
2	Mrs Katy Reiter	15.9.16	3 years	2019
3	Ms Dianne Hughes	19.9.13 15.9.16	3 years 3 years	2016 2019
3	Mr John Richardson	15.9.17	3 years	2020
4	Ms Nasim Banu Esmail	15.9.16	3 years	2019
4 (Reserve Register)	Ms Kate Wileman	15.9.17 (Reserve Register Cons. 4)	1 Year	2018
5	Mr Stephen Baines	15.9.16	3 years	2019
5	Mr Brian Richardson	18.9.14	3 years **3 years**	2017 **2020**
6	Mrs Annette Bell	17.9.15	3 years	2018
6	Mr Paul Butterworth	15.9.17	3 years	2020
7	Mrs Lynn Moore	18.9.14	3 years **3 years**	2017 **2020**
7	Miss Alison Schofield	15.9.17	3 years	2020
8	*Mr Brian Moore* ***(Lead MC from 15.9.17)***	17.9.15	3 years 1 year	2018 July 2018
8	Mrs Michelle Rich	15.9.16	3 years	2019
STAFF – ELECTED				
9 - Drs/Dentists	Dr Peter Bamber	15.9.17	3 years	2020
10 - AHPs/HCS/Pharm's	Mrs Nicola Sheehan	15.9.16	3 years	2019

CONSTITUENCY	NAME	DATE APPOINTED	TERM OF TENURE	TERM DATE DUE
11 - Mgmt/Admin/Clerical	Mrs Linzi Jane Smith	15.9.17	3 years	2020
12 - Ancilliary	Mrs Theodora Nwaeze	15.9.17	3 years	2020
13 - Nurses/Midwives	Mrs Charlie Crabtree	15.9.16	3 years	2019
13 – Nurses/Midwives	Sian Grbin	15.9.17	3 years	2020
NOMINATED STAKEHOLDER				
University of Huddersfield	Graham Ormrod	15.6.17	3 years	2020
~~Calderdale Metropolitan Council~~	~~Cllr Bob Metcalfe~~	~~18.1.11~~ TP 3.10.17	~~3 years~~ 3 years	~~2014~~ 2017
Calderdale Metropolitan Council	Cllr Megan Swift	3.10.17	3 years	2020
Kirklees Metropolitan Council	VACANT POST			
~~Clinical Commissiong Group~~	~~Mr David Longstaff~~	~~18.9.14~~	~~3 years~~	~~2017~~
Healthwatch Kirklees	Mr Rory Deighton	2.10.17	3 years	2020
Locala	Mrs Sharon Lowrie	22.1.16	3 years	2019
South West Yorkshire Partnership NHS FT	Ms Salma Yasmeen	18.10.17	3 years	2020

RED = CHANGES TO REGISTER

MC-REGISTER MC – 2.10.17

Calderdale and Huddersfield NHS Foundation Trust

DECLARATION OF INTERESTS – MEMBERSHIP COUNCIL
AS AT 18.10.17

The following is the current register of the Membership Council of the Calderdale & Huddersfield NHS Foundation Trust and their declared interests. The register is maintained by the Foundation Trust Office, and holds the original signed declaration forms. These are available for inspection by contacting the office on 01484 355933.

DATE OF SIGNED DEC.	NAME	MEMBERSHIP COUNCIL STATUS	DIRECTORSHIP	OWNERSHIP	CONTROLLING SHAREHOLDING	AUTHORITY IN A CHARITY /BODY	VOLUNTARY OR OTHER CONTRACTING FOR NHS SERVICES	OTHER EMPLOYMENT (PAID OR NON-PAID) & MEMBER OF PROFESSIONAL ORGAN'S
13.2.13	Kate WILEMAN	Public-elected Constituency 7	-	-	-	-	-	Member of Cancer Partnership Group at St James' Leeds
29.10.13	Dianne HUGHES	Public-elected Constituency 3	-	-	-	-	Civil Funeral Celebrant	Sheffield Teaching Hospitals NHS Trust RCN and Midwifery Council. Marie Curie Nursing Services.
29.9.14	Lynn MOORE	Public-elected Constituency 7	-	-	-	-	-	-
1.11.14	Brian RICHARDSON	Public-elected Constituency 5	-	-	-	-	Locala Members' Council Healthwatch Calderdale Programme Board. Practice Health Champion PRG member at Beechwood Medical Centre	-

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29.9.15	Annette BELL	Public-elected Constituency 6	-	-	-	-	-	-
2.10.15	Brian MOORE	Public-elected Constituency 8	-	-	-	-	-	-
4.11.15	Di WHARMBY	Public-elected Constituency 1	-	-	-	-	-	-
29.10.15	Rosemary HEDGES	Public-elected Constituency 1	-	-	-	-	-	Secretary – Calderdale 38 Degrees Group
14.9.16	Nasim Banu ESMAIL	Public-elected Constituency 4	-	-	-	-	-	-
12.10.16	Veronica MAHER	Public-elected Constituency 2	-	-	-	-	-	-
13.10.16	Michelle RICH	Public-elected Constituency 8	-	-	-	-	-	Kirklees College
10.10.16	Katy REITER	Public-elected Constituency 2	Managing Director Treefrog Communications	-	-	-	-	Mentoring via own business. Care Quality Commission
6.10.16	Stephen BAINES	Public-elected Constituency 5	-	-	-	Trustee – Halifax Opportunities Trust	-	Calderdale MBC
12.11.16	David LONGSTAFF	Nominated Stakeholder – CCG	-	-	-	-	Mental Health Reviews	Audit Chair Calderdale CCG and Audit Chair Greater Huddersfield CCG
21.7.17	John RICHARDSON	Public-elected Constituency 3	-	-	-	-	-	Club Steward
11.8.17	Alison K SCHOFIELD	Public-elected Constituency 7	-	Owner and founder of Diability Roadmap.co.	-	Soon to be Trustee of Imagineer Foundation	-	-

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				uk				
30.8.17	Paul BUTTERWORTH	Public-elected Constituency 6	Chairman Bradford Bulls Supporters Trust	-	-	-	-	-
23.8.17	Graham ORMROD	Nominated Stakeholder – University of Huddersfield						Director of Health Partnerships, University of Huddersfield

Please notify Kathy Bray, Board Secretary immediately of any changes to the above declaration:- 01484 355933 or Kathy.bray@cht.nhs.uk or return the attached with amendments.

Status:- AWAITING RETURNS FROM:–
NICOLA SHEEHAN, Staff Elected
SHARON LOWRIE, Nominated Stakeholder, Locala
DR PETER BAMBER, Staff Elected
LINZI SMITH, Staff Elected
THEORDORA NWAEZE, Staff Elected
SIAN GRBIN, Staff Elected
RORY DEIGHTON, Nominated Stakeholder – Healthwatch Kirklees
MEGAN SWIFT, Nominated Stakeholder – Calderdale Council
SALMA YASMEEN, Nominated Stakeholder - SWYPFT

Calderdale and Huddersfield NHS Foundation Trust

DECLARATION OF INTERESTS – MEMBERSHIP COUNCIL
AS AT 3.10.17

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12.10.16	Veronica MAHER	Public-elected Constituency 2	-	-	-	-	-	-
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THEORDORA NWAEZE, Staff Elected
SIAN GRBIN, Staff Elected
RORY DEIGHTON, Nominated Stakeholder
MEGAN SWIFT, Nominated Stakeholder

10. Constitutional Amendments

To Approve

Presented by Victoria Pickles

11. Governors Attendance at Formal Council of Governor Meetings – 2017-2018

To Note

Presented by Victoria Pickles

12. Appointment of External Auditors

To Approve

Presented by Victoria Pickles

13. Council of Governors Register – Resignations/ Appointments

To Note

Presented by Andrew Haigh

14. Register of Interests/Declaration of Interest

For Comment

Presented by Andrew Haigh

UPDATE FROM BOARD SUB COMMITTEES

To Note

Presented by Andy Nelson

15. Audit and Risk Committee

To Note

Presented by Victoria Pickles

16. Charitable Funds Committee

To Note

Presented by Andrew Haigh

17. Patient Experience and Caring Group

18. Nomination and Remuneration Committee (CoG) – Non-Executive Director/Chair Appointments

To Approve

Presented by Andrew Haigh

INFORMATION TO RECEIVE

Presented by Andrew Haigh

19. a.Updated Membership Council Calendar
b.Extract from Quality Report re Complaints & PALS
c.Draft BoD/CoG Annual General Meeting Minutes – 20.7.17
d.Feedback from BoD/CoG Workshop – 18.7.17
e....

To Note

Presented by Andrew Haigh

COUNCIL OF GOVERNORS CALENDAR OF ACTIVITY - OCTOBER TO DECEMBER 2017

OCTOBER 2017

DATE	MEETING	TIME	LOCATION	PLEASE ATTEND
16 Oct	CoG Induction Day 1	9.00 – 4.30	Discussion Room 1, LC, HRI	AS, JR, LS, GO, TN, SG, PB
19 Oct	External Audit Tender Meeting	9.30 - 10.30	Acre Mill OP Building	BM, LM, DW
20 Oct	CoG Induction Day 2	9.00 – 4.30	Large Training Room, LC, CRH	AS, JR, LS, GO, TN, SG, PB
26 Oct	CoG/Chair Informal meeting (from 9 Nov)	3.00 – 4.00	Large Training Room, LC, CRH	All
26 Oct	Members Public meeting (CoG Formal meeting) (from 9 Nov)	4.00 – 6.00	Large Training Room, LC, CRH	All

NOVEMBER 2017

DATE	MEETING	TIME	LOCATION	PLEASE ATTEND
13 Nov	Medical DRG meeting (from 20 Nov)	1.00 – 3.00	Medium Training Room, LC, CRH	NE, TN, KR, AS, DW, KW, SG
15 Nov	BOD/CoG Workshop (CoG AM only)	9.00 – 12.30	Board Room, sub-basement, HRI	Any
28 Nov	Community DRG meeting (from 23 Nov)	2.00 – 4.00	Multipurpose Room, St John's Health Centre	SB, AB, LM, BR, JR, LS
29 Nov	FSS DRG meeting (from 22 Nov)	11.00 – 1.00	DATs meeting room, South Drive, HRI	PBa, AB, RH, DH, VM, LM, KR
30 Nov	CoG Training Session: Understanding Quality in the NHS	10.30-12.30	Small Training Room, LC, CRH	Any
30 Nov	Surgical/Anaesthetics DRG meeting (from 27 Nov)	2.00 – 4.00	Board Room, sub-basement, HRI	AB, CC, NE, VM, BM, JR, KW

DECEMBER 2017

DATE	MEETING	TIME	LOCATION	PLEASE ATTEND
4 Dec	E&F DRG meeting	1.00 – 3.00	Meeting Room 3, 3rd floor, Acre Mills OP	SB, PBu, BM, BR, AS, LS, KW
13 Dec	CoG Development Session	12.30 – 4.30	Large Training Room, LC, CRH	Any
13 Dec	Chairs' Information Exchange (from 18 Dec)	10.00-12.00	Large Training Room, LC, CRH	TBC (New chairs) + CC, TN, SG, PBa, LS (11.00-12.00)

Calderdale and Huddersfield NHS Foundation Trust

Patient Advice & Complaints
Quarter 1, 2017/18
Report

Contents

1. Introduction

In the vast majority of cases patients, relatives and carers are satisfied with the care, treatment and service they receive. On the occasions where a patient, relative or carer is dissatisfied, it is important that they feel comfortable in raising their concerns so that the Trust can resolve any misunderstandings or, if failings have occurred, ensure that learning and improvements take place. Complaints are a vital source of information for the Trust, helping to identify where the quality and safety of services and care require improvement for service users.

In accordance with NHS Complaints Regulations (2009), this report sets out a detailed analysis of the nature and number of complaints and contacts with Patient Advice and Complaints at Calderdale and Huddersfield NHS Foundation Trust during 2016/17using information held on the Trust's Patient Advice and Complaints database.

2. Executive Summary

2.1 Summary of key points for Q1 2017/18

- A decrease of 8.17% in the number of complaints received in Q1 2017/18 compared to Q1 2016/17.
- The majority of complaints in Q1 2017/18 49% were graded as Amber, which is classed as a high complaint.
- Communication, Patient Care (including nutrition / hydration) and Clinical Treatment are the main subjects of complaints; this was the same as the subjects reported in Q1 2016/17.
- Appointments (including delays and cancellations) remain the main subject of concern received.
- Medicine is the division with the highest number of complaints; however, it is also the largest division and the number of complaints reflects its size.

2.2 Key Performance Indicators

Complaints 2017/18	Q1
Number of new complaints received	146
% increase / decrease on 2016/17	↓ 8.17% (159)
Number of complaints closed	155
% complaints upheld	48%
% complaints partially upheld	39%
% complaints not upheld	17%

Number of complaints re-opened following final response	23
Number of complaints received from Ombudsman for investigation	2
Number of complaints upheld by Ombudsman (includes partially upheld)	1
Number of complaints not upheld by Ombudsman in quarter	2

3. Formal Complaints

3.1 National Benchmarking

NOTE: At the time of reporting quarter 1 figures for 2016/17 were not available; therefore this section uses data for complaints from 2016/17.

The most recent national figures on complaints from NHS Digital (KO41 returns), relating to 2016/17, shows the total number of complaints received at the end of 2016/17 for the region (Yorkshire & Humber) was 12,134; the Trust represented 5% of this total, this was a decrease of 1% from 2015/16

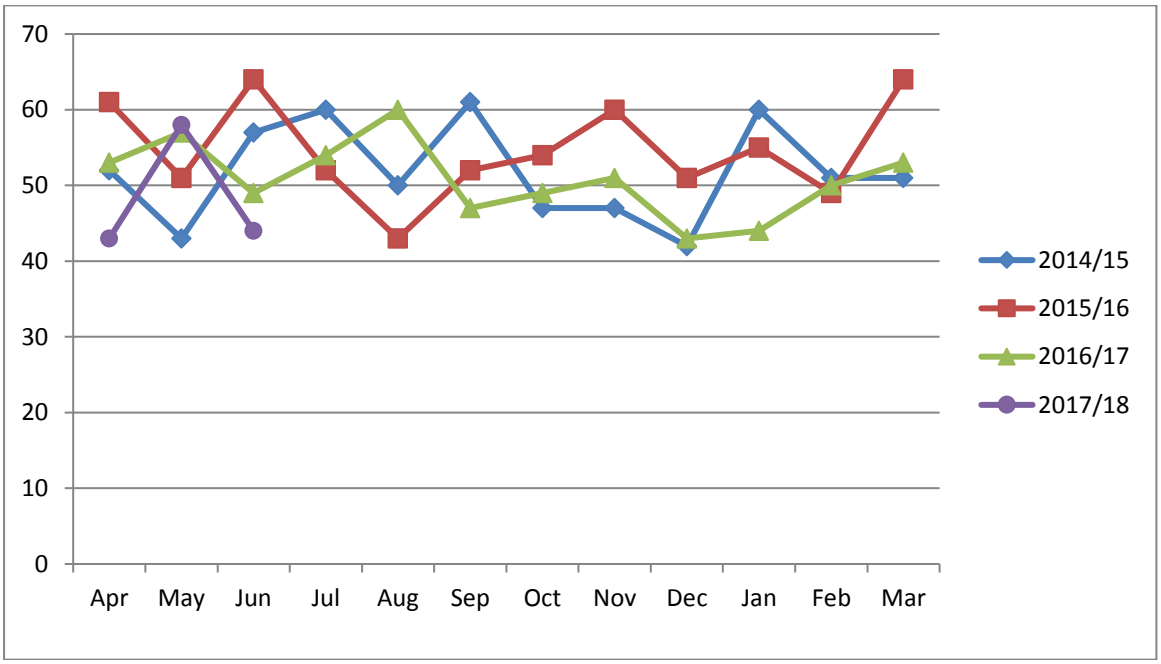
Total numbers of complaints at the end of 2016/17 for neighbouring Trust are as follows:

NHS Hospital Trust	Number of Complaints	% increase / decrease on 2015/16
Airedale NHS Foundation Trust	73	↓ 15%
Bradford Teaching Hospitals NHS Foundation Trust	617	↑ 13%
Calderdale and Huddersfield NHS Foundation Trust	**580**	↓ **7%**
Harrogate and District NHS Foundation Trust	234	↑ 10%
Hull and East Yorkshire Hospitals NHS Trust	627	↓ 1%
Leeds Teaching Hospitals NHS Trust	697	↓ 3%
Mid Yorkshire Hospitals NHS Trust	1,662	↑ 10%

At the end of 2016/17 we have seen a decrease in the total number of complaints received, as well as Airedale NHS Foundation Trust, Hull and East Yorkshire Hospitals NHS Trust and Leeds Teaching Hospitals NHS Trust. This is not in line with the region where an increase of 6% was seen.

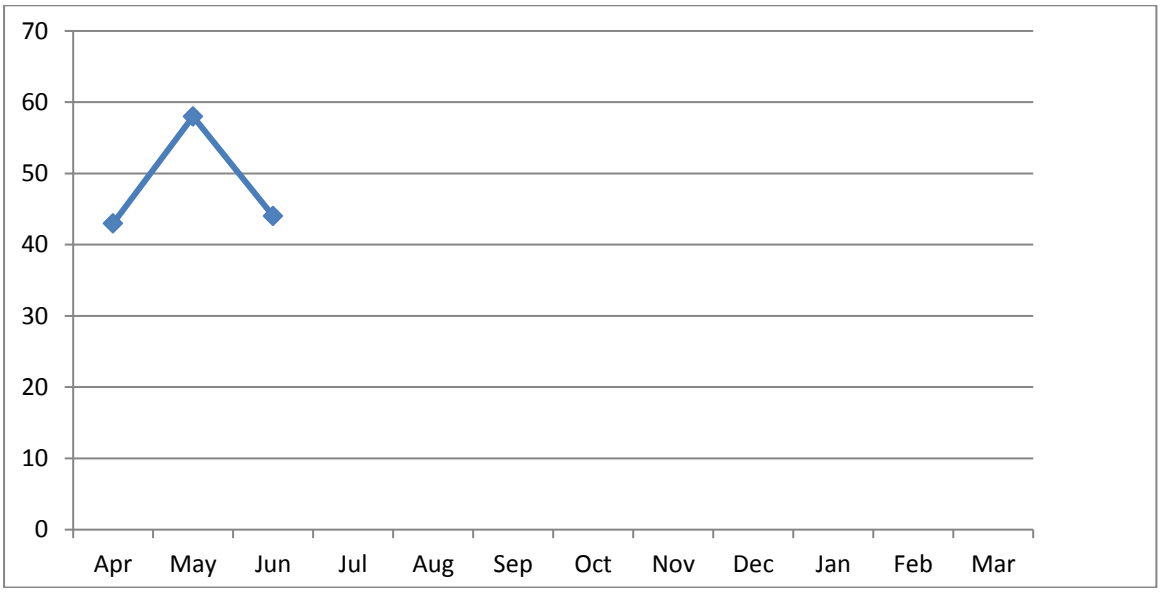
3.2 Comparison of complaints from 2014/15 to 2017/18 (to date)

Below is a graph reflecting the trends in the number of complaints for the past four years – including numbers for this quarter.



3.3 Complaints Received

At the end of Q1 2017/18 the Trust received a total number 146 complaints, this is a decrease of 8.17% from Q1 2016/17 and also a decrease of 17% from 2015/16. Below is a monthly breakdown of the complaints received in Q1 2017/18.



The average number of complaints received by the Trust in Q1 2017/18 was 48. The Trust received the highest number of complaints in May. This was similar to Quarter 1 of 2016/17 were there was a peek of complaints in the month of May.

3.3.1 Number of Complaints received measured against Trust activity

Inpatient admissions	**Q1 2015/16**	**Q1 2016/17**	**Q1 2017/18**
Number of inpatient complaints	53	45	43
Number of inpatient admissions	31,778	29,608	27,382
Complaints per 1,000 admissions	1.67	1.52	1.57
Outpatient attendances	**2015/16**	**2016/17**	**2017/18**
Number of outpatient complaints	48	54	51
Number of outpatient attendances	107,653	114,986	99,909
Complaints per 1,000 attendances	0.45	0.47	0.51

Whilst the number of hospital admission has decrease from Q1 of 2015/16 to Q1 of 2017/18 the number of complaints per 1,000 hospital admission remains around 1.58. However, while the number of outpatient attendances has decreased from Q1 of 2015/16 to Q1 of 2017/18 the number of complaints per 1,000 attendances has had an increase of 13%.

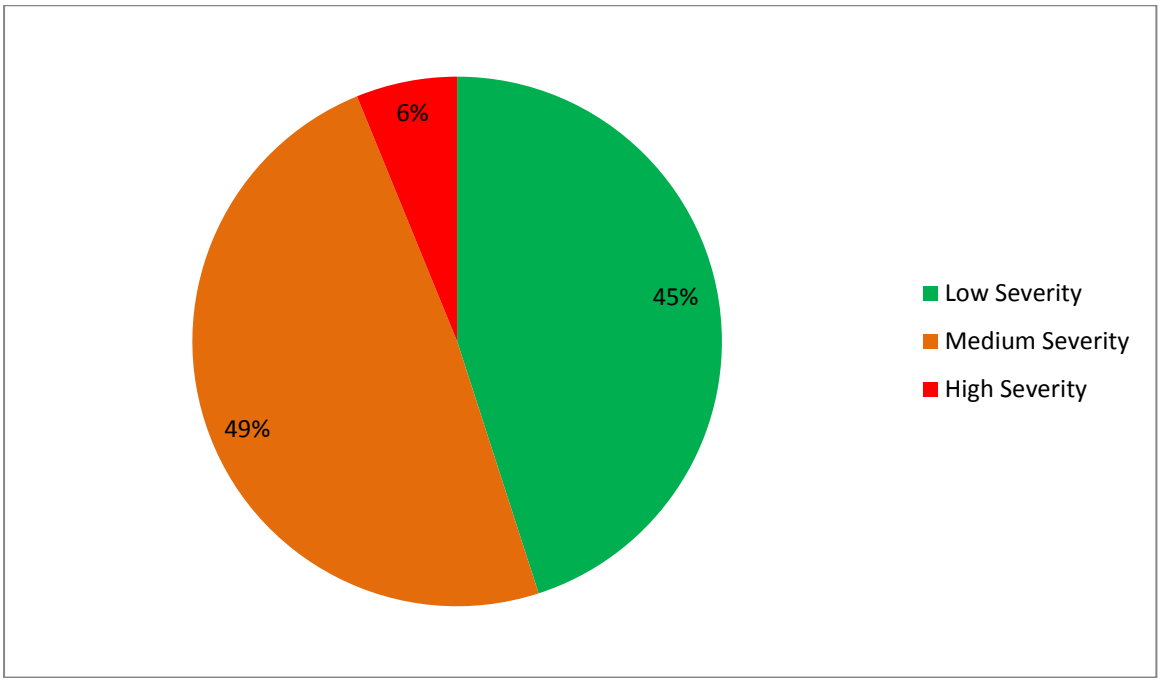
3.3.2 Severity of Complaints Received

Complaints are triaged and graded on receipt for severity. The initial grading is determined by the Patient Advice and Complaints Department based on the content of the complaint. In 2017/18 the Trust changed its grading of complaints from a 4 tiered severity to a three tiered severity, moving away from rating complaints on harm (which is used in incidents) and looking at consequence and likelihood of recurrence. This Trust's new grading matrix is below.

CONSEQUENCE	**LIKELIHOOD OF RECURRENCE**				
	Frequent	**Probable**	**Occasional**	**Uncommon**	**Remote**
Serious	**HIGH**	**HIGH**	**HIGH**	**MEDIUM**	**MEDIUM**
Major	**HIGH**	**HIGH**	**MEDIUM**	**MEDIUM**	**MEDIUM**
Moderate	**HIGH**	**MEDIUM**	**MEDIUM**	**MEDIUM**	**LOW**

Minor	**MEDIUM**	**MEDIUM**	**LOW**	**LOW**	**LOW**
Minimum	**LOW**	**LOW**	**LOW**	**LOW**	**LOW**

The majority of complaints received in Q1 2017/18 were graded as amber, medium severity (49%). 45% were graded as green, low severity and 6% complaints received were graded red, high severity, this is a 2% increase from the same quarter of 2016/17.



Key: Green – Low Severity
Amber – Medium Severity
Red – High Severity

3.3.2.1 Red Complaints Data

A red complaint is a case where there have been moderate to serious consequences and there is a frequent to occasional likelihood of recurrence. It is important to note consequence is not synonymous with harm, although harm maybe a factor. It is also important to note that consequence is taken from the complainant and/or patient's point of view.

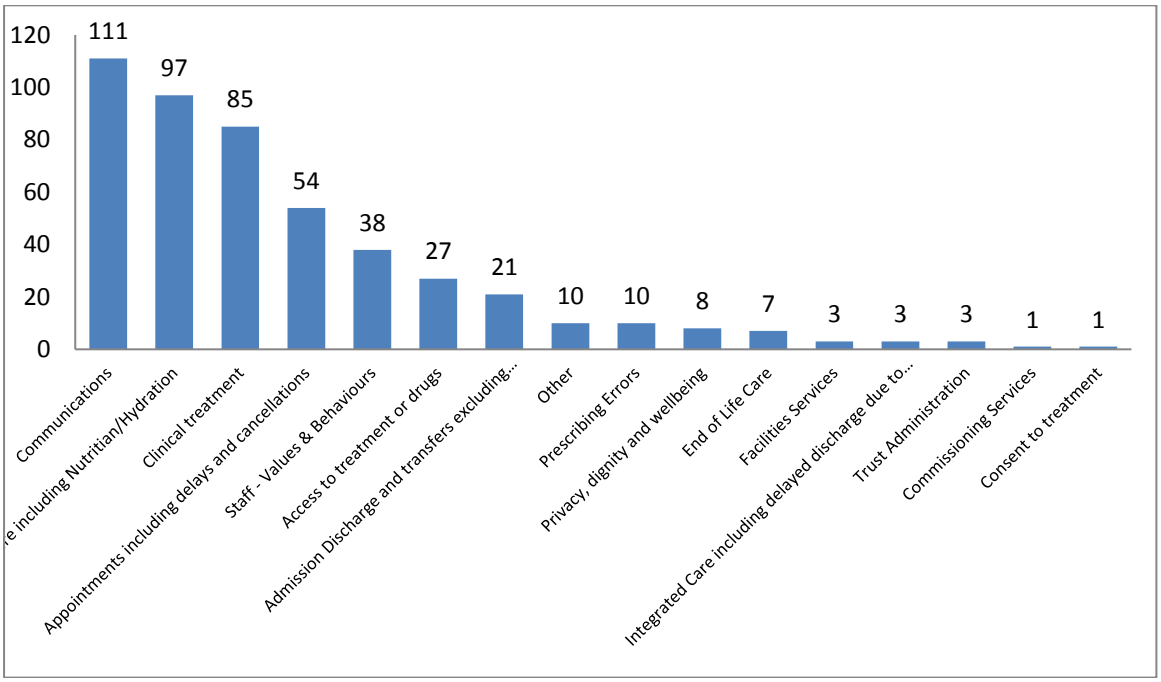
Complaints that are triaged as red are reviewed at a red panel meeting and are linked to an incident where appropriate.

In Q1 2017/18 the Trust received a total of 9 Red complaints. This is a 2% increase from the same quarter in 2016/17; however, the new grading matrix of complaints means that the Red severity rating for complaints is wider.

3.3.3 Analysis of Complaints by Theme

Complaints are analysed below by primary subjects, within each complaint subject there will be a number of different sub categories with more detail relating to the

complaint. There are often a number of issues logged for a single complaint, which is way the number of primary subjects differs from the total number of complaints received.



The top three subjects of complaints for the Trust are as follows:

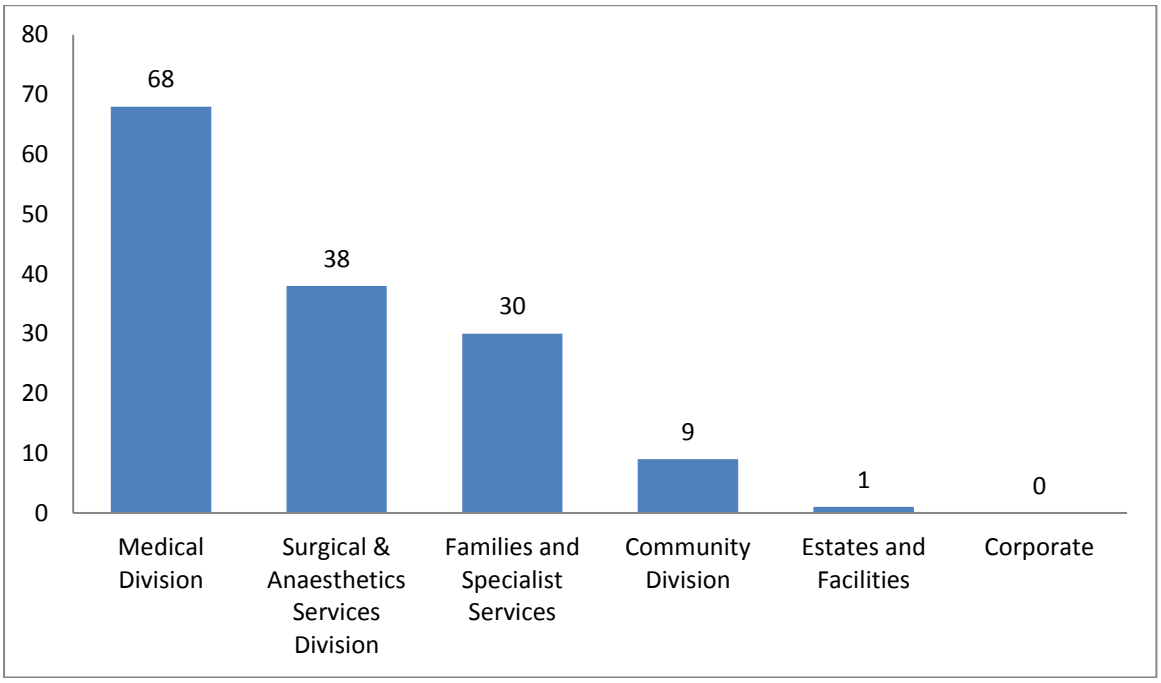
Subject	Percentage	Increase /decrease from 2016/17
Communication	23%	↓ 1%
Patient Care (including nutrition / hydration)	15%	↑9%
Clinical Treatment	14%	↓5%

The top three complaint subjects have remained the same; however, there has been an increase in Patient Care (including nutrition / hydration) complaints and a decrease in Clinical Treatment complaints.

3.3.4 Acknowledgement Time

98% of the complaints received in Q1 2017/18 were acknowledged within three working days.

3.4 Divisional Breakdown of Complaints



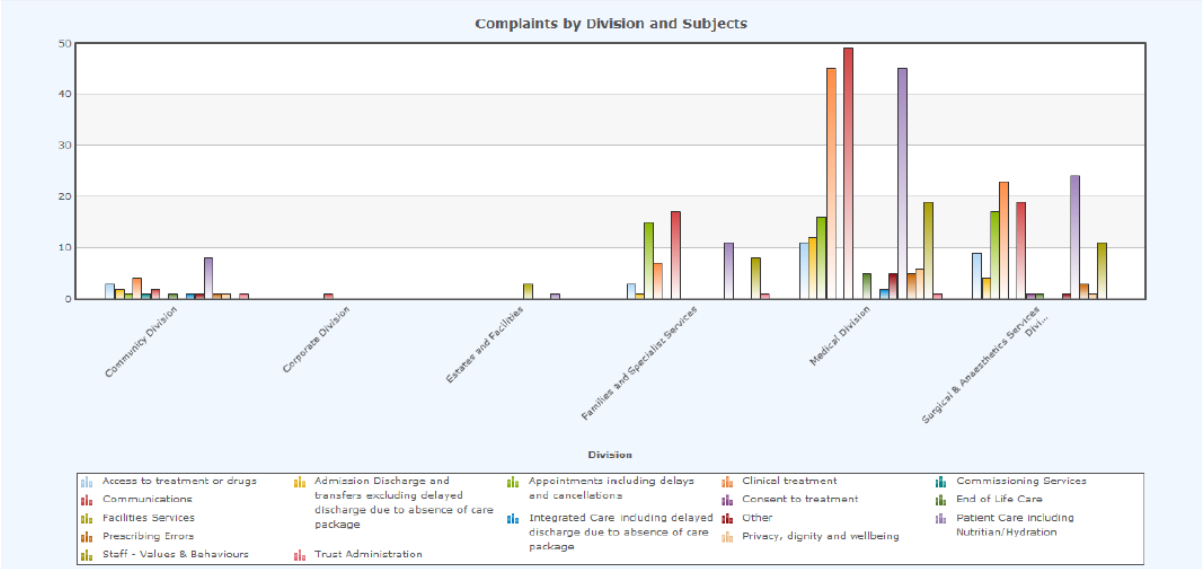
47% of complaints received related to the division of Medicine, which is the largest division with Emergency Department services. There is a 0% increase from 2016/17. The Emergency Network was the directorate within Medicine with the highest number of complaints, receiving a total of 19. Medical Specialties Directorate a total of 18, Acute Medical received a total of 19, and Integrated Medical a total of 12 complaints.

26% complaints received related to the division of Surgery and Anaesthetic Services (SAS). This is a 1% increase from 2016/17. General and Specialist Surgery was the directorate within SAS with the highest number of complaints, receiving a total of 20. Head and Neck received a total of 11 complaints, Orthopaedic a total of 7, Operating Services a total of 0, and Critical Care received a total of 0.

23% complaints received related to the division of Family and Support Services (FSS). This is a 1% increase from Q1 2016/17. Woman's Services was the directorate within FSS with the highest number of complaints, receiving a total of 15. Radiology received a total of 4 complaints, Children's Services a total of 1, Appointments and Records a total of 7, Outpatients a total of 2, Pathology a total of 1, and Pharmacy received a total of 0.

6% complaints received related to the division of Community, which was decrease of 2% from Q1 2016/17. Intermediate and Community was the directorate within Community with the highest number of complaints, receiving a total of 9, and Families Directorate received 0.

3.4.1 Complaints received by Division and Primary Subject



*Appendix One to Complaints

The top subjects of complaint for Medicine were Communication, representing 72% of all complaint subjects received for Medicine in Q1 2017/18. Clinical Treatment represented 66% and patient care (including nutrition and hydration) 66%.

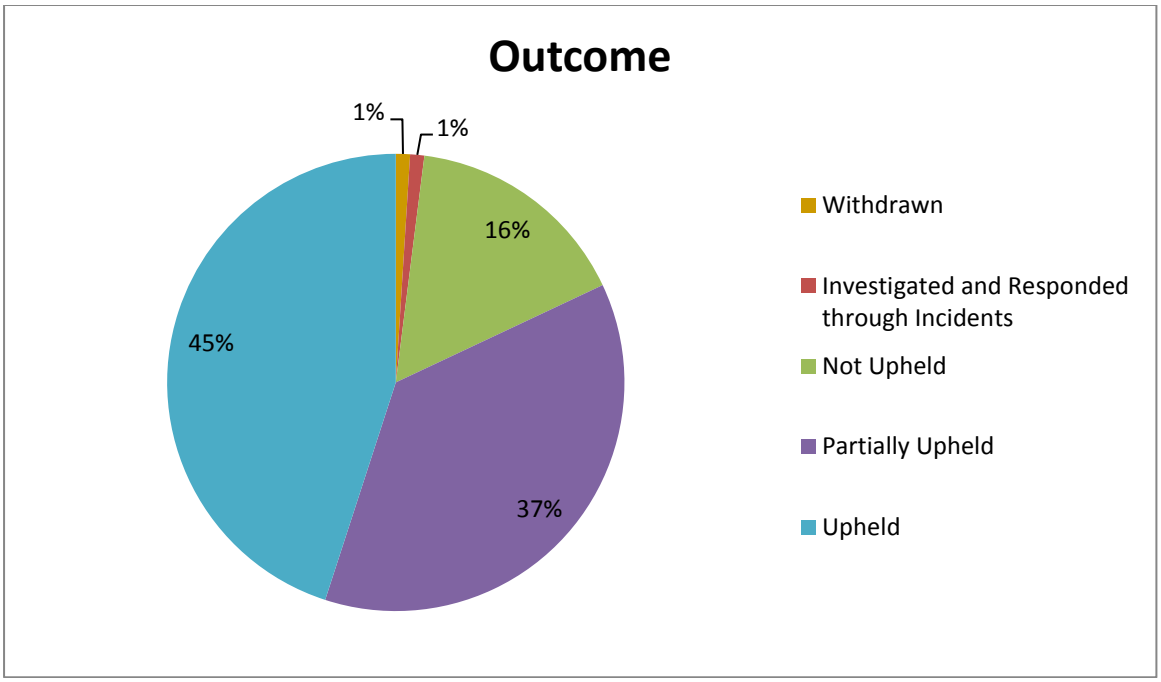
The top subjects of complaint for SAS was patient care (including nutrition and hydration), representing 63% of all complaint subjects received for SAS in Q1 2017/18. Clinical Treatment represented 61% and Communication represented 50% and 16%.

The top subjects of complaint for FSS was Communications, representing 57% of all complaint subjects received for FFS in Q1 2017/18. Appointments (including delays and cancellations) represented 50% and Patient Care (including Nutrition and Hydration) 37%.

The top subjects of complaint for Community was Patient Care (including Nutrition and Hydration), representing 89% of all complaint subjects received for Community in Q1 2017/18. Clinical Treatment represented 44% and Access to treatment or drugs represented 33%.

3.5 Complaints Closed

The Trust closed a total of 155 complaints in Q1 2017/18; this is a decrease of 9% from Q1 2016/17. Of the 155 complaints closed, 45% were upheld, 37% were partially upheld (NHS Digital counts partially upheld complaints as upheld complaints so if looked at in this way the figure is 82%), and 16% were not upheld



Red Complaints closed

The Trust closed 10 Red Complaints in Q1 2017/18; of these 30% were upheld and 20% were investigated as a serious incident.

3.6 Re-Opened Complaints

The Trust will re-open a complaint for one of the following three reasons.

i. Response failed to address all issues and concerns
ii. New issue and concern
iii. Parliamentary and Health Service Ombudsman Investigation

The Trust re-opened a total of 22 complaints in Q1 2017/18. This is a 38% increase from Q1 2016/17.

3.7 Timeliness of Complaints Responses

The total number of overdue complaints at the end of Q1 2017/18 was 29. There has been significant work undertaken by the Trust in 2017/18 to improve the

timeliness of complaints responses.

Processes have been put in place to closely monitor timescales and escalate any delays in response to ensure that all complainants receive a timely response.

3.8 Parliamentary and Health Service Ombudsman Complaints

The Parliamentary and Health Service Ombudsman (PHSO) investigate complaints where an organisation has not been able to resolve the complaint at a local level. The PHSO have broadened their review process and have considerably increased the numbers of cases that they consider.

Below is a table with the figures relating to the Trust's PHSO complaints:

	Q1 2017/18
Number of Complaints Received by PHSO	1
Number of Complaints accepted for investigation by the PHSO	1
Number of Complaints the PHSO Upheld or Partly Upheld	1
Number of Complaints not upheld	3

1 case was accepted for PHSO investigation between April and June 2017. During this period the PHSO also concluded 4 complaints against the Trust, of these 4, 3 complaints were not upheld and 1 was upheld /partially upheld.

4. Concerns

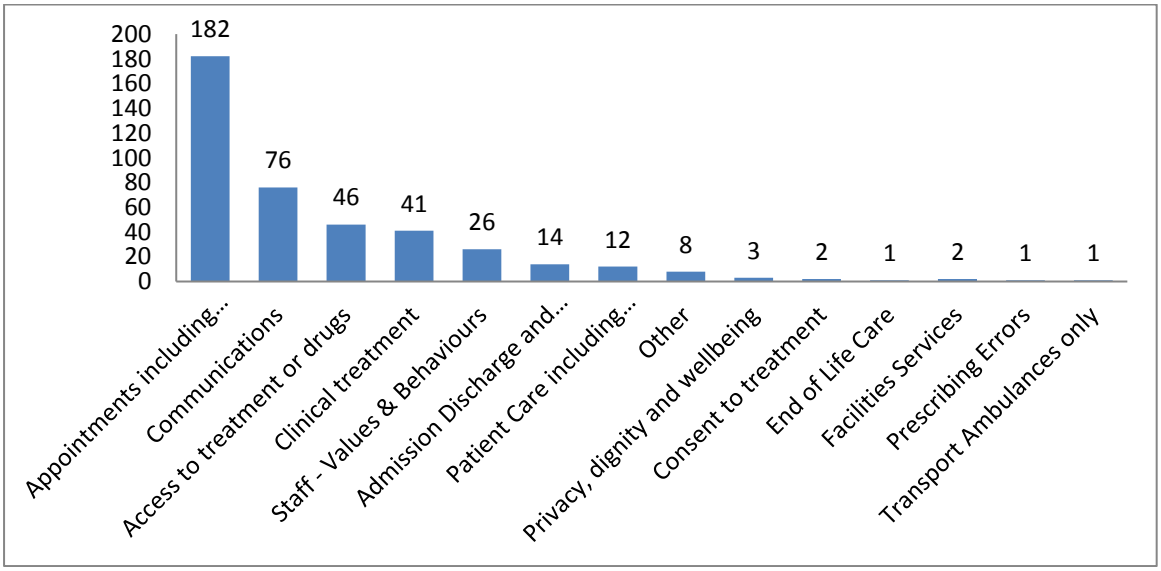
The Patient Advice Service offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

A Concern is an issues raised by patients, their families and their carers to the Patient Advice Team which can be resolved within 72 hours of receipt.

4.1 Concerns Received

The Trust received a total number of 458 concerns in Q1 2017/18; this is a dramatic increase of 119% from Q1 2016/17 (211 concerns). The substantial increase in concerns relate to the changeover to the Trust's new electronic patient record system, and the concerned regarding appointments.

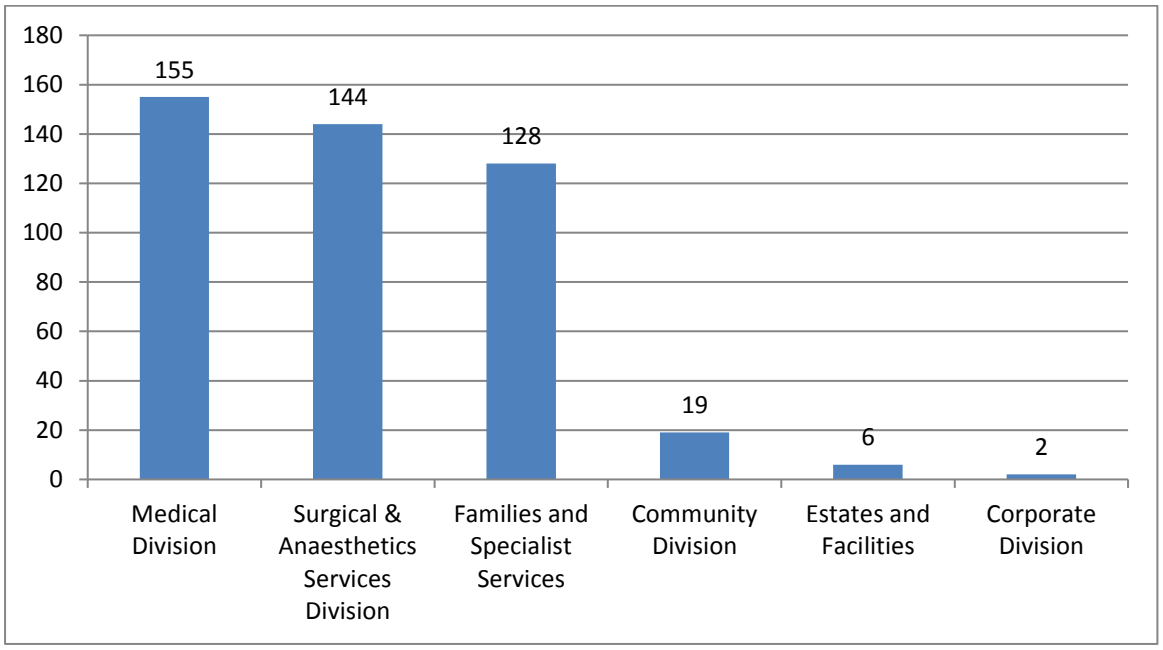
4.1.1 Analysis of Concerns by Theme



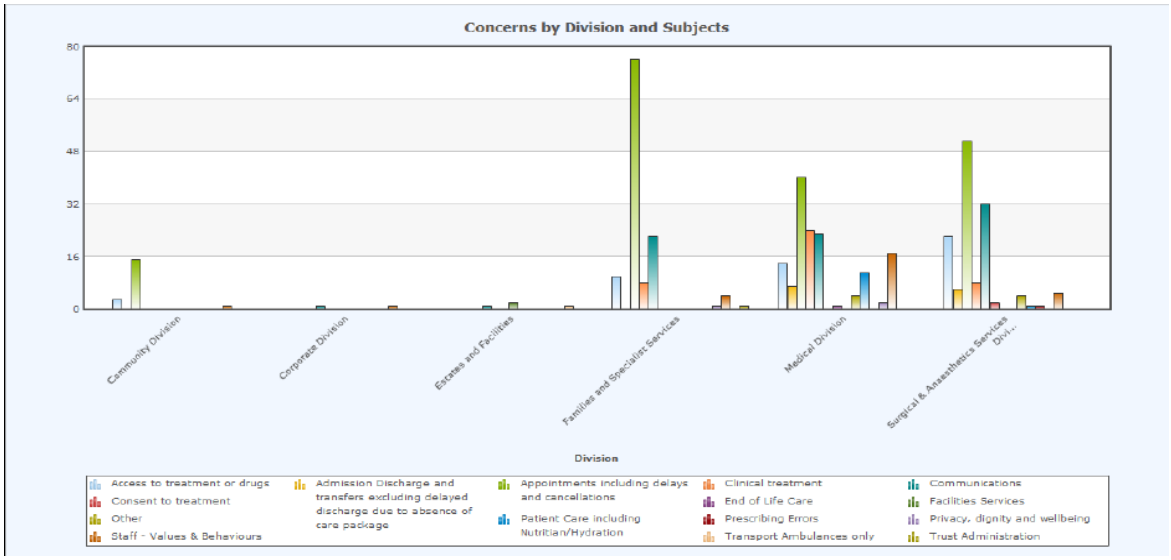
Appointments and Appointments including delays and cancellations was the top subject of concern in Q1 2017/18 representing 44%. This was an increase of 10% from Q1 2016/17, which is indicative of the overall increase in concerns received. The second highest subject of concern was Communication representing 18% and the third highest subject was Access to Treatment or Drugs representing 11% of all concerns in Q1 2017/18.

Whilst Appointments including Delays and Cancellations is the top subject of concern in Q1 2017/18 this is not translated into the complaints figures, which would suggest that the majority of these issues are resolved through the Patient Advice Service. However, Communication figures prominently in Complaints and Concerns.

4.2 Divisional Breakdown of Concerns



34% of concerns received related to the Division of Medicine, 31% related to SAS, 28% related to FSS and 4% related to Community.



*Appendix Two to Complaints

- The top subject of concern for Medicine was Communication, representing 27% of all concerns received for Medicine in Q1 2017/18. Clinical Treatment was the second highest representing 25% and Appointments (including delays and cancellations) was the third highest subject of concern, representing 13%.

- The top subject of concern for SAS was Appointments (including delays and cancellations), representing 40% of all concerns subjects received for SAS in Q1 2017/18. Communication was the second highest representing 22%, and

Clinical Treatment was the third representing 16%.

- The top subject of concern for FSS Appointments (including delays and cancellations), representing 61% of all concerns subjects received for FSS in Q1 2017/18. Communication was the second highest representing 16% and Clinical Treatment was the third representing 8%.

- The top subject of concern for Community was Appointments (including delays and cancellations), representing 67% of all concerns subjects received for Community in Q1 2017/18. Patient Care (including Nutrition and Hydration, was the second highest representing 17% and Access to Treatment or Drugs was the third representing 17%.

5. Learning from Complaints

The feedback we receive from complaints gives the Trust a wealth of information that can be used to improve services as an individual complaint provides detailed insight into a patient's experience.

As an organisation we aim to ensure that we learn from complaints so that we can:

- Share good practice
- Increase patient safety
- Improve the patient experience
- Reduce the number of complaints

Our complaints process includes identifying learning from each complaint and sharing this and each service and division is required to be clear:

- How the services records learning from complaints
- How this learning is disseminated within the service / directorate / division
- How it can point to changes arising from learning from complaints

Complaints data and learning from complaints is reported quarterly to the Trust's Patient Experience Group to ensure that learning is shared across the Trust.

5.1 Divisional & Parliamentary and Health Service Ombudsman

Information on learning from complaints for each division is given below.

Learning:

Medicine		
Issue:	Findings:	Learning:
Attitude of Staff: Poor attitude of a Sonographer. The Sonographer was rude to a patient's daughter whilst attending an appointment. The Sonographer would not allow daughter to go in with mother for the scan even though daughter tried explaining that the carer was going to leave the room allowing space for the daughter to stay.	The Sonographer offered her sincere apologies for the distress caused and appreciated she should have offered the opportunity of the daughter swapping places with the carer. .	The Sonographer has reflected on her behaviour and attitude, and in future will ensure that she gives the opportunity to ensure that the appropriate person remains in the room to support the patient. The standard letter template will be revised to inform patients that only one escort can stay in the room with the patient during the procedure and signs erected in the room informing patients of the one escort policy.
FSS		
Issue:	Findings:	Learning:
Appointments: Patient arrived for his appointment only to be told this has been cancelled and an earlier appointment sent to him which he did not attend. Patient was unaware of the earlier appointment. Patient should be reviewed by Urology every 6 months. By the patient's July appointment it will be 9/10 months since his last review.	Patient's appointment was booked incorrectly. Appointment issues caused by newly implemented EPR system.	No learning as this complaint was in relation to the first couple of weeks after going live with the EPR system. These issues have now been resolved.

PHSO		
Issue:	Findings:	Learning:
Clinical Treatment : The patient complained to the PHSO that the Trust had failed to carry out a CT scan after sustaining a head injury. As a result of this failing the patient says he was left untreated for a subdural haemorrhage which became extensive over time. he also stated that this failing had resulted in the loss of his memory and altered his sleep pattern.	The PHSO decided to partly uphold the complaint. The PHSO found that on the balance of probabilities the Trust failed to carry out a CT scan, however this failure they did not find that this failure resulted in the patient being left untreated for a subdural haemorrhage.	This learning from this case was discussed at the Junior Doctors teaching facilitators meeting, which included extended clinical discussions. The "2014 Head Injury NICE Guideline algorithms for selection of adults & children for CT head scans" was also discussed for awareness.

5.2 Featured Learning

A patient was admitted and diagnosed with a brain haemorrhage, this progressed well for 48 hours. However, on the third day the treatment was withdrawn. The family were worried that the patient was mistaken with another patient of same first name. Upon speaking with the consultant the family were told that the patient had not suffered a further bleeding and full care was reinstated.

The withdrawal of treatment had lasted for 20 hours, which family believe led to the early death of the patient. Another scan was ordered but the patient was not well enough to have it.

It was confirmed that the Trust did not mistake the patient for another, and that treatment was stopped because it was believed that patient had suffered a further bleed. The Trust apologised that we did not provide the family with the necessary information to ensure you they fully aware of the decisions being made about the patient and that this meant they were not fully appreciative of how unwell she was and left the family with doubts about the care provided.

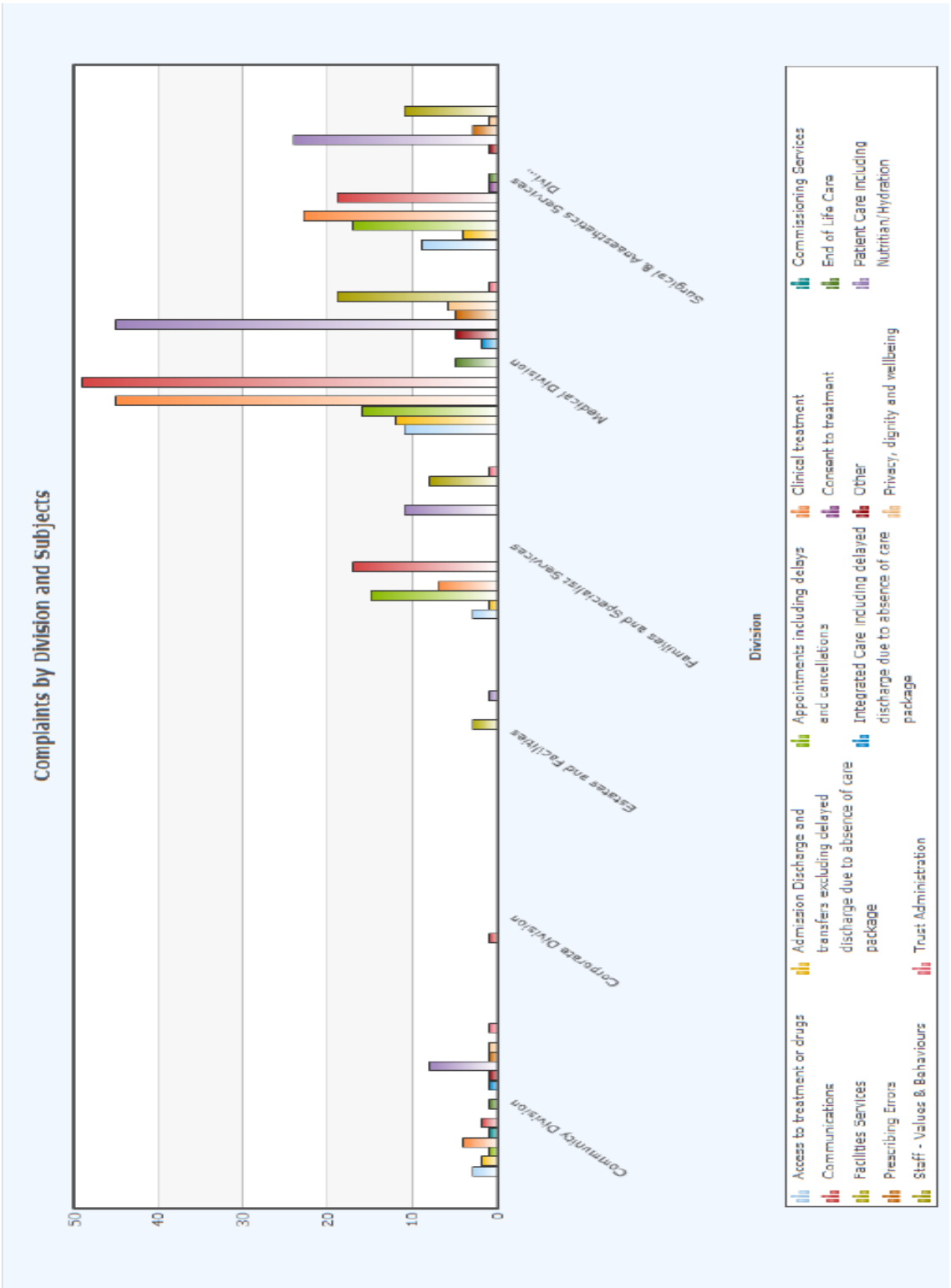
As a result of this complaint, a Consultant is to discuss with the Clinical Director of Radiology, the feasibility of Radiologists incorporating further information in their reports, for example, to include an explanation for the reason or cause of deterioration in a patient's condition, to assist when communicating the findings with patients and their family.

6. Areas for Improvement

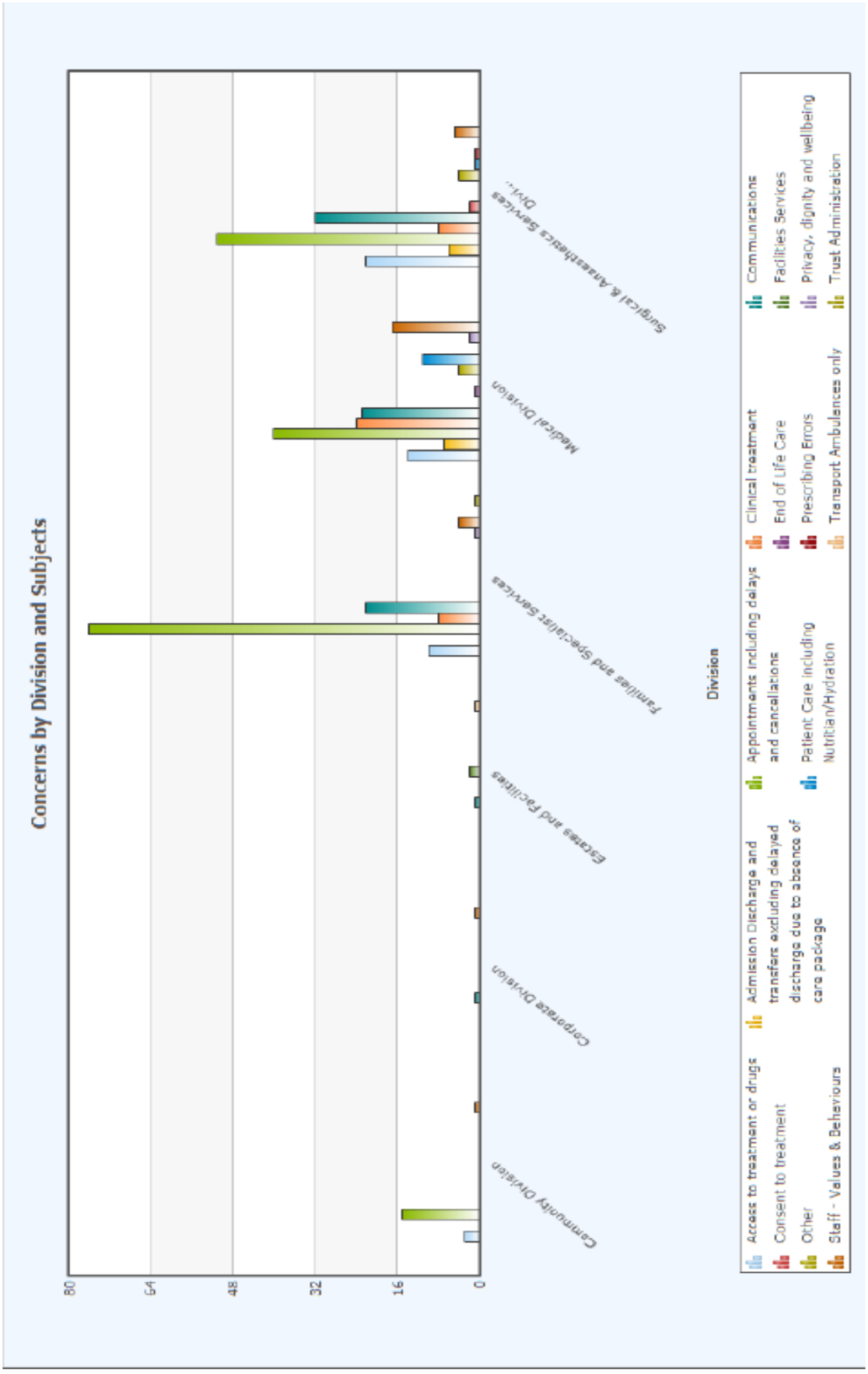
An update against the key priorities for 2017 -18 for the complaints and patient advice service are:

- Sustain timely responses to complainants
- Undertake a 'go see' visit to an acute Trust to learn from their Complaints processes, and implement improvements
- Delivering complaints training to complaints investigators to improve the quality of investigations and support staff in the effective management of complaints
- Continue to focus on quality responses that address all aspects of complaints and analyse reasons for any re-opened complaints
- Improve learning from complaints, which is one of the three Trust's quality improvement priorities for 2017/18
- Improve identification of sharing and learning from complaints within the Trust learning from adverse events framework
- implement recommendations made from internal report on complaints
- Develop reporting of PALS concerns

Appendix One: Complaints by Division & Subject


Complaints by Division and Subjects
50
40
30
20
10
0
Community Division
Corporate Division
Estates and Facilities
Families and Specialist Services
Medical Division
Surgical & Anaesthetics Services Divi...
Division
Access to treatment or drugs
Communications
Facilities Services
Prescribing Errors
Staff - Values & Behaviours
Admission Discharge and transfers excluding delayed discharge due to absence of care package
Appointments including delays and cancellations
Integrated Care including delayed discharge due to absence of care package
Trust Administration
Clinical treatment
Consent to treatment
Other
Privacy, dignity and wellbeing
Commissioning Services
End of Life Care
Patient Care including Nutrition/Hydration

Appendix Two: Concerns by Division & Subject


Concerns by Division and Subjects
80
64
48
32
16
0
Surgical & Anaesthetics Services Div...
Medical Division
Families and Specialist Services
Estates and Facilities
Corporate Division
Community Division
Division
Access to treatment or drugs
Consent to treatment
Other
Staff - Values & Behaviours
Admission Discharge and transfers excluding delayed discharge due to absence of care package
Appointments including delays and cancellations
Patient Care including Nutrition/Hydration
Clinical treatment
End of Life Care
Prescribing Errors
Transport Ambulances only
Communications
Facilities Services
Privacy, dignity and wellbeing
Trust Administration

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Minutes of the Calderdale & Huddersfield NHS Trust Board of Directors and Council of Governors Annual General Meeting held on Thursday 20 July 2017 at 6.00 pm in Meeting Room 3 & 4, 3rd Floor, Acre Mill Outpatient Building, Huddersfield Royal Infirmary

PRESENT

Speakers
Mr Andrew Haigh, Chairman
Dr David Birkenhead, Executive Medical Director
Mr Gary Boothby, Executive Director of Finance
Mr Brendan Brown, Executive Director of Nursing/Deputy Chief Executive
Mr Peter Middleton, Publicly Elected Member-Lead Governor
Mr Alastair Newall, Senior Manager – KPMG External Auditors
Mr Owen Williams, Chief Executive

Others present:
Board of Directors
Dr David Anderson, Non-Executive Director
Mrs Helen Barker, Chief Operating Officer
Mrs Anna Basford, Director of Transformation & Partnerships
Mr Jason Eddleston, Executive Director of Workforce & OD
Mrs Mandy Griffin, Director of THIS
Mrs Karen Heaton, Non-Executive Director
Mr Richard Hopkin, Non-Executive Director
Ms Lesley Hill, Executive Director of Planning, Estates & Facilities
Dr Linda Patterson, Non-Executive Director
Mrs Jan Wilson, Non-Executive Director
Mrs Victoria Pickles, Company Secretary

Governors
Mrs Annette Bell
Mrs Dianne Hughes
Mrs Veronica Maher
Mr Bob Metcalfe
Mr Brian Moore
Mrs Lynn Moore
Mr Brian Richardson
Mr George Richardson
Ms Kate Wileman

1. CHAIR'S OPENING STATEMENT AND INTRODUCTIONS

The Chairman opened the meeting by welcoming people to the Acre Mills Outpatient Building. He introduced the speakers and noted that other members of the Board of

Directors and Council of Governors were also present in the audience. The Chairman highlighted the divisional displays showcasing their developments during the year and on behalf of the Board and Governors thanked staff for their support.

2. APOLOGIES
Apologies were received from:

Board of Directors
Mr Philip Oldfield, Non-Executive Director
Prof. Peter Roberts, Non-Executive Director
Mrs Clare Partridge, Engagement Lead – KPMG

Governors
Mr Grenville Horsfall
Dr Mary Kiely
Mr David Longstaff
Mrs Sharon Lowrie
Dr Cath O'Halloran
Graham Ormrod
Mrs Dawn Stephenson

3. ANNUAL REPORT 2016/17
The Chairman reported that the Membership Council had recently agreed a change of title and were now the 'Council of Governors'. He gave thanks to all staff and patients involved in the recent implementation of the Electronic Patient Record (EPR). It was recognised that the implementation had been successful however there had obviously been some difficulties encountered along the way.

He mentioned that the Trust was in the top 20% of Trusts in the country for recognising the contribution our staff make to improving care in this year's annual NHS Staff Survey. The Trust was now in its second year of awarding monthly Star Awards and nominations are being received from colleagues of all disciplines.

The Chairman reported that 2017 would see the finalisation of the full business case for the reconfiguration of hospital services, outlining how healthcare will be provided in our hospitals and community into the future.

The Chairman commented that the NHS financial position is challenging and will continue to be in the future. He thanked the Council of Governors who had completed their tenures along with thanks to the Board, Volunteers and League of Friends for their support throughout the year.

4. ANNUAL ACCOUNTS – APRIL 2016 TO MARCH 2017
Gary Boothby, Executive Director of Finance presented the Annual Accounts, full details of which were available in the Annual Report. It was noted that the details of these had been discussed at the Board of Directors Meeting and these were approved as a correct record.

The key areas were noted:

Planned 2016/17 Position
The Executive Director of Finance explained the planned 2016/17 position with the introduction of control totals and Sustainability and Transformation Fund (STF) which resulted in a planned deficit position of £16.1m.

Financial Context
Over the year the Trust had seen:
- 120,000 inpatients – elective, non-elective and day cases
- 459,000 outpatients
- 151,000 A&E attendances
- 310,000 community contacts

In addition the Trust has a turnover of £375m, the majority of which is spent on staffing with 6,000 colleagues employed by the Trust. There is property and equipment over two hospital sites with a combined value of £234m. The Trust, like others, is facing a challenging financial and operational landscape.

The Trust's Performance in 2016/17 compared to 2015/16:
- 1% more non elective inpatients were treated
- 2.5% more activity was seen in A&E
- 5.1% increase across planned day case and elective activity combined, with a shift towards more day case delivery.

Key Financial Pressures
- High levels of clinical staffing vacancies and national recruitment pressures
- High levels of agency staffing costs
- Commissioner affordability
- Junior Doctors strike action
- CRH Endoscopy Department fire
- EPR Implementation costs

2016/17 Financial Performance

	Plan	**Actual**
Income and Expenditure	(16.15m)	(16.06m)
Capital Expenditure	28.22m	24.09m
Cash Balance	1.95m	1.94m
Loans	67.87m	61.78m
CIP	14.00m	14.98m
Use of Resources	3	3
Unqualified External Audit Opinion	√	√

2016/17 Capital
Total capital expenditure of £24.1m, invested in:

Theatre refurbishment	£2.0m
Other estates	£4.5m
Electronic Patient Record	£7.4m
Other IT	£4.6m
Equipment	£3.4m

Other £2.2m

The Future
The Executive Director of Finance explained that the NHS faces unprecedented financial challenges both locally and nationally. Locally the Trust has seen an increased demand for services which will require closer joint working with other organisations across West Yorkshire. He concluded that there were no short term solutions to CHFT's financial deficit.

5. QUALITY REPORT

Brendan Brown, Executive Director of Nursing along with Dr David Birkenhead, Executive Medical Director presented the Quality Report. The presentation highlighted the quality priorities for 2016/17 and their progress:-

- Quality Priorities for 2016/17:– Falls – introduction of Safety Huddles
  Implementation of Hospital Out of Hours (HOOP)
  Understanding the Community Experience
- CQC Progress since inspection
- Mortality – fall in HSMR and SHMI cases
- Quality Priorities 2017/18 – Strategic aims:-
  - Care of the Acutely Ill Patient Programme
  - End of Life Care Strategy
  - Safe Care
  - Improving Community Service
  - Demonstrate Engagement and Co-Design
- Continued improvement in delivery of national standards and national Reporting data sets
- Continue to be an organisation that is research active and have exceeded targets for recruiting onto the clinical trials.
- Improving Patient Experience – PRASE Study, noise at night project, true patient and service user engagement
- Infection Prevention and Control – rate of c.difficile reduced.
- Engagement and Co-Design – developing a quality improvement network, Quality enthusiasts to underpin approach and methodologies using wide range of QI expertise within and outside of organisation.
- 3 Key Priorities for 2017/18 – sepsis screening, discharge planning, learning from Complaints
- What's next:-
  - Introduction of a Ward Assurance Tool
  - Roll out of a Peripatetic Nursing Team
  - Targeted recruitment
  - Instillation of 'Reminiscence Pods'
  - Introduction of a CHFT safety manual
  - Delivery of a Quality Improvement Strategy

6. EXTERNAL AUDIT OPINION ON ANNUAL REPORT/QUALITY ACCOUNTS

Alastair Newall, Senior Manager from KPMG gave a presentation outlining the work undertaken by the external auditors on the Annual Report and Accounts and the Quality Accounts. He explained the areas focussed on within the Audit were:-

- Financial Statements Audit
- Use of resources
- Review Annual Report and Annual Governance Statement
- Quality Report

Financial Statements and Annual Report

It was noted that within the financial accounts an unqualified audit opinion had been issued. There were no unadjusted audit differences although a few minor amendments were required – none with an impact on the Trust's reported position. There had been recommendations relating to controls operating within some financial systems but no material concerns.

Use of Resources

The Senior Manager for KPMG explained that the audit had concluded that the Trust had:-

- Qualified 'except for' conclusion on the Use of Resources which reflects the breach of licence that the Trust has been in through 2016/17
- Improvements made in many areas and has delivered its financial 'control total' in 2016/17 and exceeded its planned savings for the year.

Review of Annual Report and Annual Governance Statement

The Annual Report and Annual Governance Statement was consistent with financial statements and complied with the FT Annual Reporting Manual (ARM). Some minor amendments and improvements had been suggested.

Quality Report

The content of the Quality report complied with the FT Annual Reporting Manual requirements. Some minor amendments had been suggested and a qualified opinion had been issued with 'except for' the opinion on the basis of the results of the indicator testing.

Three indicators had been tested – including two national priority indicators mandated by NHS Improvement and one locally selected priority:

- A&E 4 hour wait - % of patients with a total time in A&E of 4 hours or less from arrival to admission, transfer or discharge;
- 18 week incomplete pathways - % of incomplete pathways within 18 weeks for patients on incomplete pathways
- Stroke ward admissions - % of stroke patients admitted to a stroke ward within 4 hours.

The conclusion from the testing was:-

- A&E 4 hour wait – no issues identified
- 18 week incomplete pathways – cases had been included in the indicator which were not pathways, one recommendation made, and a qualified assurance opinion given.

- Stroke ward admissions – cases reported as not being admitted within 4 hours but testing indicated that had been, would always lead to an underreporting of performance and quality checking is only focussed on cases that failed, two recommendations made.

7. FORWARD PLAN

Owen Williams welcomed everyone and thanked staff, volunteers and Governors for their work and commitment in caring for patients. He also wished to thank the Board of Directors for their commitment and challenge over the past year throughout the reconfiguration of services consultation.

Looking ahead the Chief Executive reported that the Trust would continue to use the 4 pillars of behaviour to achieve compassionate care:

- we put the patient first
- we work together to get results
- we do the must do's
- we go see

The Chief Executive set out the key areas of work for the Trust over the next year:

- Reconfiguration – he explained that the full business case would be submitted to the commissioners and regulators and that the Joint Overview and Scrutiny Committee was scheduled for the next day.
- Cost Improvement Programme – Work continued both within the Trust and across West Yorkshire to develop a Sustainability and Transformation Plan. These were also being impacted upon by national discussions around the financial challenges in the NHS.
- Electronic Patient Record (EPR) – the Trust had implemented a whole new EPR which was key to ensuring better patient care and help to provide efficient services in the future.
- Care Quality Commission – The Trust's ambition was to keep improving services and to deliver the actions which had been developed following the inspection.

The Chief Executive emphasised that the care given by all staff clinical and non-clinical should not be recognised and thanked all colleagues for their help and support.

He shared a patient story which highlighted the views of a patients relative on their personal experience who had shared information with the Chief Executive so that the organisation could learn from the feedback.

He encouraged the public to continue to keep fighting for services to be retained on the patch and assured everyone present that the Trust would be fighting hard to retain services as locally as possible.

The Chief Executive wished to give particular thanks was given to Andrew Haigh, Chairman whose tenure on the Board was due to finish in Spring 2018.

The Chairman thanked everyone for their contributions and reinforced that it was clear that this current year was going to be just as challenging as 2016/17.

8. ELECTION RESULTS AND APPOINTMENTS

The Chair reported that the second half of the meeting would concentrate on the Membership Council AGM.

a. Council Members

The Chairman reported the results of the elections run by the Electoral Reform Services on behalf of the Trust over the period 20 April to 6 July 2017. This had resulted in five public and 4 staff seats being filled.

It was noted that Brian Moore had been appointed as Lead Governor to take over from Peter Middleton on the 15 September 2017. The Chair thanked Peter for his support as Membership Councillor for the six years and latterly as Lead Governor for the Council of Governors since 2016.

The Chairman extended a welcome to the newly elected and re-elected members along with Kate Wileman who had agreed to stay on for another year on the Reserve Register.

All these appointments could be seen on the Register of Members which was available within the packs. The ballot turnout rate this year was around 12% which was comparable to other trusts.

The Chairman wished to thank the other retiring members who included:- Grenville Horsfall, George Richardson, Mary Kiely, Linda Dawn Salmons and Eileen Hamer Five Stakeholder representatives had also ended their tenures – Cllr Carole Pattison, Dr Cath O'Halloran, Dawn Stephenson, Bob Metcalfe and David Longstaff.

b. Board of Directors – Non Executive Directors

The Chairman reported that the Nomination and Remuneration Sub Committee (Membership Council) had met on the 18 October 2016 and 8 March 2017 to agree my extension until the Spring of 2018 and to consider three Non- Executive Directors whose tenures were due to expire this year. The Committee had agreed that the tenures of Dr David Anderson should be extended for a further one year period and arrangements were in hand to recruit to the other two positions later in the year.

Those present formally ratified the aforesaid appointments and the new members to the Council of Governors.

9. MEMBERSHIP COUNCIL FORMERLY COUNCIL OF GOVERNOR UPDATE – OVERVIEW OF THE MEMBERSHIP COUNCIL CONTRIBUTION DURING 2015/16

Peter Middleton, Lead Governor gave an overview of the work of the Membership Council during 2016/17. The presentation included:-

- Composition of the Council of Governors
- Governors' Involvement in improving patient experience and outcomes through various forums at Board and Divisional level
- Council of Governors involvement with the Trust in improving quality
- Getting involved with patient and users, feeding back to the Trust and making a difference by seeing improvements.

- Workshops with the Board and Non Executive Directors to enable exchange of views.
- Thanks from the Council of Governors to the volunteers, clinicians, nursing staff, admin staff and management for their hard work and honesty and openness and lastly to Ruth Mason who had taken on a new role at the Trust.

10. QUESTIONS AND ANSWERS

The Chairman gave opportunity for those present to raise any general questions of the Board or Membership Council.

Q Why is there a vacancy for Kirklees Council on Council of Governors?
A We are in talks with them to find a replacement. The position has only been vacant for last three or four months.

Q How has Brexit impacted on recruitment?
A There is anxiety amongst international nurses and we are doing everything in our power to support them in their roles providing care for local people

Q What are your hopes for Joint Overview and Scrutiny Committee tomorrow?
A We welcome the conversation and the scrutiny by local people and will respect the decision.

Q We seem to be changing plans. First Calderdale Royal Hospital (CRH) then Huddersfield Royal Infirmary (HRI) A&E to go, then beds drop. Can you guarantee there will be a hospital at HRI at the end?
A The HRI building is at the end of its life but no one wants to see diminishing services. We have a £16m deficit and we have to make it work given the resources we have. If we don't, then someone else will do it. It is also about clinical safety and lack of doctors in emergency departments. Safety says we must change, finances determine how we change.

Q Primary care is stretched and it's the worst I have known it for 30 years what are the Sustainable Transformation Plans about?
A Not just about HRI and CRH it is about looking at whole of West Yorkshire to provide quality care for the whole population of the area. If we stand still and not let local people decide the change it will be made for us. David Birkenhead said the way forward was better, more joined up working, with GPs, secondary and tertiary care.

Q Elderly people in Meltham are worried they will die if they are ill and need to go further to hospital - to CRH - and are very worried about the proposals. For note.
A Care starts from the time the ambulance arrives. In many cases it is not always beneficial to go to the nearest hospital but to the most suitable hospital.

Q We are trying to mount a legal challenge. We deserve a hospital here in Huddersfield. Eg A 70-year-old man collapsed at the Scarecrow event and waited 1.5 hours in the road for an ambulance. I can see your intentions are honourable (to Owen Williams)
A No-one is flippant about how people feel. Explaining why initially it was CRH A&E to close a few years ago….The context has changed in recent years and money is now a consideration.

11. DATE AND TIME OF NEXT MEETING

It was noted that a provisional date had been set for the next Annual General Meeting - Thursday 19 July 2018. The time and venue would be confirmed nearer the date.

The Chairman thanked everyone for attending and closed the formal meeting at approximately 7.45 pm.

/KB/AGM2017-MINS

BOD/COUNCIL OF GOVERNORS WORKSHOP – 18 JULY 2017 – BOARDROOM, HUDDERSFIELD ROYAL INFIRMARY

PRESENTATIONS:-

KEEPING THE BASE SAFE (Single Oversight Framework – way in which we are oversee by NHS Improvement)

1. Health and Safety – still work to do. Training
2. Emergency Planning – emergency lockdown and anti-terrorism procedures
3. Fire safety – alarms, compartmentalising
4. Business Continuity
5. Health and Safety Executive visit following whistleblowing on water safety.

QUALITY

1. PPI – listening events across different groups – getting patients involved in the processes for complaints and social services
2. CQC Inspection – not yet clear what it will look like. Areas of 'good' will be announced. Well-led Review. Mock Inspections. Whole new team from August.
3. Quality Improvement strategy – using enthusiasts.

WORKFORCE

1. OD and leadership
   - Workforce ↑
   - Appraisal ↑
   - Turnover ↓
   - Sickness ↓
2. Engagement
3. Health and Wellbeing
4. Attendance Management
5. Engagement – rewards and recognition, health and wellbeing, engagement.

TRANSFORMING CARE

1. **Full Business Case** being finalised
2. **Safer programme** – 3 areas :- bed avoidance, bed efficiency, bed alternatives
3. **7 day services**
   10 standards – not all for CHFT. Focus on 4
   70-85% compliance
   Generally meet standard for consultant review
   Don't meet weekend consultant review for stable patients
   Diagnostics and report. Partially meet for critically ill except MRI
   Not able to report xrays within 24 hours.
   Reconfiguration is key. HOOP team. Physicians Associates.
   Tackle medical vacancies.
4. **EPR**
   Deployed 2 May – 12 weeks in
   Now about benefits realisation
   Still issues – outpatient areas in particular
   Bradford Go-live 24.9.17.

FINANCIAL SUSTAINABILITY

1. Submitted a plan = £16m deficit - £20m CIP (5.2%)
2. STF = £10m - 30% based on ED performance
   - ½ based on streaming
   - ½ on performance
3. CIP forecast is £17m. Significant risk
4. Commercial opportunities with Pharmacy Manufacturing Unit/THIS – lab to lab messaging. CRM
5. Capital funding reducing
6. STP is getting funding that we can access
7. Activity is down = c£4m

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DISCUSSIONS:-

KEEPING THE BASE SAFE

1. Is the new approach to patient and public engagement having an impact?
2. Is the feedback from hospital → GP happening and adding value?
3. What/how are we going to measure?
4. Are we using the right methods and tools to capture the data/information?
5. When or is there going to be a review, is it effective?
6. What does improvement look like? Across Quality and Engagement.
7. What are we doing to manage messages especially around the reconfiguration – media has taken a negative approach – how will this interfere with keeping the base safe.

WORKFORCE

1. Friends and Family – staff
2. What's the cost of 12% turnover
3. How are we going to reduce it to (5%)
4. What differences will/are happen(ing) after engagement – how monitored and assessed → action?
5. How do we work to remove the barriers?
6. Is succession planning at all levels?
7. How do we take staff with us over these changes?
8. How do we work together to put patient first? Internal, external?
9. How do we get feedback from whole system – e.g. social services, SWYFT
10. What are the issues with different staff group – e.g. consultants?
11. What involvement with unions?
12. How do we keep our workforce healthy e.g. stress, manual handling – what offers do we have to help staff maintain personal health?
13. Training
14. How contact MPs?

TRANSFORMING AND IMPROVING PATIENT CARE

1. How do we engage, when do we engage, and are our broader communities represented?
2. What is the feedback mechanism(s) to governors and the public on the FBC?
3. How is frailty measured? This is an example of a question re equity.
4. How do we transform thinking around whistleblowing?
5. How do we measure the success of our wider engagement? :- 3rd party agencies, transformation of care, integration of care
6. How do we measure and influence the wider benefits of EPR? How do we lead in this agenda?

FINANCIAL SUSTAINABILITY

1. Each activity needs target – measure progress
   - Some have well developed) use mechanisms for quick response
   - Some to be quantified)
   - Some/many high risk)
   - New income streams)
2. How to get new plans to replace others proved to be non-feasible
3. How to get started (ahead of FBC)
4. How to maintain patient experience/quality with reducing resources
5. Solve agency/workforce challenges
6. Challenge numbers of staff required by department – productivity
7. Timescale to deliver transformational change across WYAAT:-
   - Reconfiguration
   - Capacity
   - Commitment
8. Community resource – inputs/outputs under control
9. Maintain/recover activity targets.

/kb/BOD17-BOD-COGWORKSHOP18.7.17

20. Any Other Business

21. DATE AND TIME OF NEXT MEETING:
Date:
Wednesday 17 January 2018 at 4.00 pm.
Venue:
Boardroom, Huddersfield Royal Infirmary