










# Council of Governors Meeting - 20.4.23

<b>Schedule</b>	Thursday 20 April 2023, 14:00 — 16:00 BST
<b>Venue</b>	MS Teams and Meeting Room 3 and 4, Acre Mill Outpatients
<b>Organiser</b>	Kathy Bray

## Agenda



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|-------|---|---|
| 14:00 | 1. Welcome and Introductions:<br>To Note - Presented by Helen Hirst   |   |
| 14:01 | 2. Apologies for absence:<br>Brian Moore<br>Andrea McCourt<br>Salma Yasmeen<br>Emma Kovaleski<br>Peter Bamber<br>Jonny Hammond<br>To Note - Presented by Helen Hirst  |   |
| 14:02 | 3. Declaration of Interests<br>To Approve   |   |
| 14:03 | 4. Minutes of the last meeting held on<br>26 January 2023<br>To Approve - Presented by Helen Hirst<br><br> APP A - V1 Draft Minutes - Council of Governors Meeting<br>26.01.2023hhcomment.docx | 1 |
| 14:05 | 5. Action Log and Matters Arising<br>To Note - Presented by Helen Hirst<br><br> APP B - Action Log as at 26.01.2023 - Draft.docx   | 9 |
| 14:07 | 6. Update from Chair<br>For Information - Presented by Helen Hirst  |   |
| 14:12 | 7. Brief Update from Governors<br>For Information   |   |



14:17	8. Review of Constitution including Standing Orders of the Council of Governors To Approve - Presented by Victoria Pickles	
	 APP C1 - Constitution Amendment.docx	10
	 APP C2 - G-1C-2017 - CONSTITUTION - UPDATES APRIL 2023.doc	12
14:22	9. Chair Appraisal Process 2022/23 To Approve - Presented by Karen Heaton	
	 APP D- Chair's Appraisal Process Cover Sheet and Paper.docx	122
14:27	10. NED Appraisal Process 2022/23 To Approve - Presented by Helen Hirst	
	 APP E1 - COVER SHEET NED Appraisal 2022 23.docx	126
	 APP E2 - Annual Appraisal Process of the Non-Executive Directors 2022-23.docx	128
14:32	11. Feedback from Finance and Performance Committee  Finance Report and Integrated Performance Report To Note - Presented by Andy Nelson	
	 APP F1 - Month 11 Finance Report.pdf	133
	 APP F2 - Integrated Performance Report (summary version) Feb 23.pdf	151
14:42	12. 2023/24 Annual Plan To Note - Presented by Gary Boothby and Kirsty Archer	
14:52	13. Feedback from Quality Committee To Note - Presented by Denise Sterling	
15:02	14. Quality Account Priorities 2022/23 update / year end position To Note - Presented by Lindsay Rudge	
15:12	15. Quality Account Priorities 2023/24	

## 16. Membership and Engagement

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15:17	a. Update on Membership and Engagement Strategy Action Plan 2020 -23	
	 APP G - Front sheet and summary Membership and Engagement Strategy - 2023-2026.docx	178
	 APP G1 - Membership Strategy 2020-2023 Update_Cover Sheet.docx	181

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15:27	b. 2023 – 2026 Membership and Engagement Strategy	
	 APP G2 - Membership Strategy 2023-2026_Cover Sheet.docx	182
	 APP G3 - Membership and Engagement Strategy for 2023-2026_Action Plan_Year One.docx	183

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## 17. COMPANY SECRETARY REPORT

	 APP H1 - Company Secretary Cover Sheet.docx	188
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15:32	a. Governor Elections 2023 To Note - Presented by Victoria Pickles	
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15:37	b. Procedure for the Appointment of Lead Governor 2023/24 To Approve - Presented by Victoria Pickles	
	 APP H2 - PROCEDURE FOR APPOINTMENT OF LEAD GOVENOR-COUNCILLOR - PROCEDURE AND ROLE.doc	191

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15:42	c. Review Council of Governors Attendance Register for the Annual Report and Accounts 2022/23 To Approve - Presented by Victoria Pickles	
	 APP H3 Attendance Schedule CoG 01.04.22 - 31.03.23 - version 1.docx	197


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15:43	d. Review Council of Governors Declarations of Interest Register To Approve - Presented by Victoria Pickles	
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	 APP H4 - DECLARATIONS OF INTEREST REGISTER - COUNCIL OF GOVERNORS - March 2023.doc	201
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15:44 e. Receive Register of Council of Governors  
To Note - Presented by Victoria Pickles

	 APP H5 - COG REGISTER OF COUNCIL MEMBERS - 2022 23- as at 31.03.2023.docx	207
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15:45 f. Date Future Meetings and date of the Annual Members Meeting 2023  
To Note - Presented by Victoria Pickles

	 APP H6 - Council of Governors Future Dates - 2023.docx	210
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15:46 18. RECEIPT OF MINUTES FROM BOARD SUB COMMITTEES  
For Information


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a. Quality Committee held on 14 November 2022, 16 January, 20 February  
For Information

	 APP IA2 -FINAL Quality Committee minutes & action log - 16.01.23 (Approved Mon 20 Feb 2023).docx	211
	 APP IA1 - DRAFT Quality Committee minutes & action log - 14.11.22.docx	220
	 App IA3 - DRAFT Quality Committee minutes & action log - 20.02.23.docx	229
	 APP ID1 - Approved F&P Minutes 06 DECEMBER 2022.docx	239
	 APP ID2 - Approved F&P Minutes 10 JANUARY 2023.docx	246
	 APP ID3 -Approved F&P Minutes 07 FEBRUARY 2023.docx	254
	 APP ID4 - Approved F&P Minutes 28 FEBRUARY 2023.docx	264

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b. Workforce Committee held on 14 February 2023  
For Information


	 APP J - Workforce Committee Highlight Report 14.2.23..docx	274
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c. Audit and Risk Committee held on 31 January 2023

For Information

-  APP IC - Final DRAFT Audit and Risk Committee Meeting Minutes held on 31 Jan 2023 (2).docx 276
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d. Finance and Performance held on 6 December 2022, 10 January, 7 February, 28 February

For Information

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e. Charitable Funds Committee held on 15 February 2023

For Information

-  APP IE - Charitable Funds Minutes 15 February 2023.docx 288
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## INFORMATION TO RECEIVE

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15:47

19. Highlight Report from Workforce Committee


For Information

-  APP J - Workforce Committee Highlight Report 14.2.23..docx 291
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15:48

20. a. Council of Governors Workplan 2023

For Information

-  APP K - Council of Governors Annual Business Cycle 2023 - v2 DRAFT.docx 293
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15:49

21. Any Other Business

To Receive - Presented by Helen Hirst

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22. DATE AND TIME OF NEXT MEETING:

Date: Thursday 20 July 2023

Time: 2:00 – 4:00 pm (Private meeting 1:00 – 1:45 pm)

Venue: Microsoft Teams

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**DRAFT MINUTES OF THE FOUNDATION TRUST COUNCIL OF GOVERNORS MEETING HELD AT 2:00 PM ON THURSDAY 26 JANUARY 2023 VIA MICROSOFT TEAMS**

<b>PRESENT:</b> Helen Hirst	Chair
<b>PUBLIC ELECTED GOVERNORS</b>	
Christine Mills (CM) Gina Choy (GC) Peter Bell (PB) Stephen Baines Brian Moore (BM) Robert Markless (RM)	Public Elected - Huddersfield Central Public Elected - Calder and Ryburn Valleys Public Elected – East Halifax and Bradford Public Elected - Skircoat and Lower Calder Valley (Lead Governor) Public Elected – Lindley and the Valleys Public Elected - Huddersfield Central
<b>STAFF ELECTED GOVERNORS</b>	
Sally Robertshaw (SR)	Staff Elected – AHPs/HCS/Pharmacist
<b>APPOINTED GOVERNORS</b>	
Dr Sara Eastburn (SE) Abdirahman Duaale Lesley Warner (LW)	University of Huddersfield Calderdale and Huddersfield Solutions Ltd. Kirklees Metropolitan Council
<b>IN ATTENDANCE:</b>	
Karen Heaton (KH) Nigel Broadbent (NB) Denise Sterling (DS) Peter Wilkinson (PW) Tim Busby (TB)  Rob Aitchison Gary Boothby Lindsay Rudge Sharon Cundy Victoria Pickles Andrea McCourt	Non-Executive Director Non-Executive Director Non-Executive Director Non-Executive Director Non-Executive Director  Deputy Chief Executive Director of Finance Chief Nurse Head of Patient Safety and Quality Director of Corporate Affairs (Minute taker) Company Secretary
<b>01/23</b>	<b>WELCOME &amp; INTRODUCTIONS</b>
	The Chair welcomed everyone to the meeting, and in particular Rob Aitchison attending his first Council of Governors meeting.
<b>02/23</b>	<b>APOLOGIES FOR ABSENCE</b>
Andy Nelson John Gledhill Peter Bamber Isaac Dziya Veronica Woollin	Non Executive Director Public Elected – Lindley and the Valleys Public Elected - Calder and Ryburn Valleys Public Elected – South Huddersfield Public Elected – North Kirklees

	<p>Jo Kitchen Emma Kovalski Sandeep Goyal Chris Reeve Karen Huntley Megan Swift Salma Yasmeen</p>	<p>Staff Elected – Ancillary Staff Elected - Management/Admin/Clerical Staff elected – Doctors/ Dentists Locala Healthwatch Calderdale Council South West Yorkshire Partnership Foundation Trust</p>
<b>03/23</b>	<b>DECLARATIONS OF INTEREST</b>	
	<p>There were no declarations of interest. The Chair reminded the Council of Governors and staff colleagues to declare their interests at any point in the agenda.</p>	
<b>04/23</b>	<b>MINUTES OF THE LAST MEETINGS HELD ON 20 OCTOBER 2022</b>	
	<p>It was noted that Stephen Baines apologies should have been recorded.</p> <p><b>OUTCOME:</b> Subject to the above amendment the minutes of the previous meeting held on 20 October 2022 were <b>APPROVED</b> as a correct record.</p>	
<b>05/23</b>	<b>ACTION LOG AND MATTERS ARISING</b>	
	<p>It was noted that all actions on the action log had been completed. Several matters arising were identified:</p> <ul style="list-style-type: none"> <li>- A question was asked about deep dives and how these are followed up. It was confirmed that these are followed up through the Committees and through the performance data within the Integrated Board report</li> <li>- A question was asked about complaints. VP confirmed that as of 23 January 2023, there were 96 open complaints and none were outside of timeframe, which was a significant improvement in position over the previous six months. She added that this required close ongoing monitoring.</li> <li>- A question was asked about patient transport and the numbers of concerns raised. The Chief Nurse responded that very few relate to getting between sites. More are in relation to booked patient transport. She also referenced the shuttle bus and the fact that this is sometimes referenced in patient letters. GC commented that patient transport services are not joined up with what is available in community and that this needs investigating further. VP clarified the position in relation to patient use of the shuttle bus and that the Trust was not licensed nor insured to provide a public service.</li> <li>- A question was asked in relation to moving to the new model of dementia screening. The Chief Nurse explained that due to the pressures over the winter, it had not been possible to roll this out, but this was planned for April.</li> </ul> <p>The Chair confirmed that there were no further matters arising.</p> <p><b>OUTCOME:</b> The Council of Governors <b>NOTED</b> the updates to the action log.</p>	
<b>06/23</b>	<b>CHAIR'S REPORT</b>	
	<p>The Chair confirmed the appointment of Rob Birkett as Chief Digital Officer and Lindsay Rudge as Chief Nurse. The Council of Governors expressed their congratulations on the appointments.</p>	

	<p>The Chair provided feedback from the Organ Donation Committee and explained that the lead Doctor for organ donation, Paul Knight requested an invite to the Council to provide an overview of the work. She added that the Trust had made a contribution towards the funding for a competitor at the World Transplant Games with close links to the Trust and was purchasing two dopplers to record heart beats at end of life.</p> <p>The Chair explained that there had been a West Yorkshire Partnership Board meeting that Governors were invited to watch online. The main agenda items had been health inequalities, colleagues, cost of living and the new Five Year Strategy. VP explained that an email inviting Governors to comment on the Five Year Strategy would be circulated the following week.</p> <p>The Chair reported that work is taking place on a Council of Governors development plan which would be discussed at the meeting on 16 February 2023.</p> <p><b>OUTCOME:</b> The Council of Governors <b>NOTED</b> the update from the Chair.</p> <p>A question was asked regarding industrial action. RA explained that it is secondary issue for the Trust as not experiencing strike action as a Trust currently for any of the staff groups. The Trust will be keeping an eye on the impact on colleagues as a result of any school strike action.</p>
07/23	<p><b>Charitable Funds Committee Update</b></p>
	<p>The Chair provided feedback from the Committee and highlighted the need to update the reserves policy.</p> <p><b>OUTCOME:</b> The Council of Governors <b>NOTED</b> the Charitable Funds Committee Update.</p>
08/23	<p><b>GOVERNANCE</b></p>
	<p><b>Brief Update from Governors</b></p> <p>SB provided feedback on the tour around CRH to look at where the proposed development will be. He commented that it had been a useful and informative exercise. He specifically asked for his thanks to be passed to Helen Barker who provided the tour.</p> <p>RM explained he had attended Greenhead Ward Partnership Group and given a presentation on the role of Governors. He added that he would be doing a follow up one for Crossland Moor and may also do an article for a GP practice newsletter. RM also informed the Council that progress had been made to bring pets as therapy dogs back in to the Trust.</p> <p>SR commented that all new staff get a letter from the staff governors and that there would be drop in sessions via teams for staff to find out about the role.</p> <p>GC highlighted the need to identify more engagement opportunities as all Governors are willing to go participate in community and engagement events.</p> <p>Cllr Warner explained that scrutiny committee are due to attend to visit maternity services at the Trust. Chief Nurse confirmed that this would be on 16 February 2023.</p> <p>HH asked that the minutes of the working group be added to future agendas. <b>ACTION</b></p>

	<p><b>OUTCOME:</b> The Council of Governors <b>NOTED</b> the updates from the Council of Governors members.</p>
<b>09/23</b>	<p><b>Audit and Risk Committee Update</b></p> <p>NB provided an overview of the key areas of review at the last Audit and Risk Committee including a review of core standards, the Board Assurance Framework and a reduction in the health and safety risk score. He highlighted the internal audit reports that had received limited assurance. He explained that at the next meeting, there would be a focus on completing all outstanding recommendations from internal audit reports.</p> <p>It was clarified which Governors attend the meeting.</p> <p><b>OUTCOME:</b> The Council of Governors <b>NOTED</b> the Audit and Risk Committee Update.</p>
<b>10/23</b>	<p><b>PERFORMANCE AND STRATEGY</b></p> <p><b>Feedback from Transformation Programme Board</b></p> <p>PW gave a short presentation on the latest position with the reconfiguration covering the purpose, social value, and progress with the various elements of build. GC asked what the delays are to a decision on the funding for the Calderdale site. PW explained that the delay centres around the approval process from HM Treasury. He added that the Trust Board is formally working with DHSC and HM Treasury to progress this.</p> <p><b>OUTCOME:</b> The Council of Governors <b>NOTED</b> the feedback from the Transformation Programme Board.</p>
<b>11/23</b>	<p><b>Feedback on Areas of Work</b></p> <p>TB provided an update on his eight months in role. He explained that he has two key roles as a NED for the Trust and the Chair of Calderdale and Huddersfield Solutions Ltd. TB reported that he had received a robust induction into both organisations and CHS has restructured how their board meetings run with a development session every other month looking at quality and CQC requirements, recruitment and retention, commercial opportunity, and Model Hospital benchmarking data. TB highlighted the role CHS has played in the reconfiguration plans to date; undertaken a capital plan of renewal; continued to bring services in house including catering; mattress decontamination, and cost savings plans. CHS has also been providing support to the two local hospices and has received high ratings from key audits. TB highlighted that CHS has a key role in the development and implementation of the green plan for the Trust, including a switch to LED lighting across 95% of the Trust and switch to electric vehicles.</p> <p>At this point, VP declared a loyalty interest in this item as Vice Chair of Overgate Hospice.</p> <p>Cllr Warner asked about the services brought in house and whether their terms and conditions were worse as a consequence. HH and TB confirmed that there had been no worsening of terms and conditions. VP explained that it was a different private provider not an NHS service prior to transfer to CHS. Cllr Warner also asked if there remained different sets of terms and conditions in CHS. HH confirmed that there are two sets of terms and conditions that have been in place since CHS was formed. GB highlighted that this was not just an issue at HRI, as these services are provided by ISS and Equans at CRH who are also on different terms and conditions.</p>

	<p>BM asked a question about the cost of energy. GB explained that the Trust is facing a significant cost pressure as previously block arrangements were in place but these are now moving and the scale for the Trust is significant. GB added that the Trust, alongside CHS are also looking at ways to reduce our energy use.</p> <p>GC applauded CHS on the support for the local Hospices.</p> <p><b>OUTCOME:</b> The Council of Governors <b>NOTED</b> the feedback on areas of work.</p>
<b>12/23</b>	<b>2023/2024 Annual Plan Update</b>
	<p>The Director of Finance provided a verbal update and the key points to note were: GB gave a presentation setting out the planning update for 2023/24 and the need to provide a first draft by 14 February into the ICB but currently there are quite a lot of gaps in the information available at a national level. He highlighted that it will be extremely challenging financially, and the Trust would be setting a deficit plan. He explained that he was not in a position to take a plan for approval at this stage as there are too many unknowns.</p> <p>CW asked a question regarding vacancies and how these are budgeted for. GB explained that the expenditure assumes a level of vacancies however many are covered by agency and bank posts. A vacancy factor is applied differentially depending on the area. A vacancy control panel is in place to test whether there are different ways of working.</p> <p>RM asked about the partial payment by results arrangements and where the risk is moving to. GB explained that the financial risk shifts to the Trust as it is based on electives. This money would go back into the ICB, and they would need to find a different mechanism for distributing this funding.</p> <p>RM also asked what planning assumptions are being made with regards to pay. GB responded that the national requirement is to assume 2%. Should an agreement greater than this be made, there would be a requirement for more funding or a greater deficit position.</p> <p>CW asked what would happen if a national agreement on pay was higher. GB responded that there would need to be a national response to this.</p> <p><b>OUTCOME:</b> The Council of Governors <b>NOTED</b> the 2023/2024 Annual Plan Update.</p>
	<b>QUALITY</b>
<b>13/23</b>	<b>2022/23 Quality Account Priorities</b>
	<p>DS gave an update on the progress against the three quality priorities for 2022/23.</p> <ul style="list-style-type: none"> <li>- Recognition and timely treatment of sepsis – it was noted that progress had been made however the Trust was not fully compliant with the requirements.</li> <li>- Reduce the number of HCAs including C19 – reintroduced testing in October due to an increase in cases. Still above the level we would expect. Being closely monitored.</li> <li>- Reducing wait times in ED – due to operational pressures not seen up to date data. The Trust experienced high volumes through ED and put in place a variety of initiatives to support patient flow.</li> </ul>

	<p>HH asked how progress is maintained and monitored going forward once these are no longer the named priorities. LR explained that HCAs remain a key performance indicator and there is a group that looks at infection control reporting into Quality Committee. The sepsis indicator is part of the clinical outcomes group and would also be picked up in the new indicator around care of the acutely ill patient. ED waiting times will be included in performance indicators moving forward.</p> <p>GC expressed disappointment that these had not been achieved.</p> <p><b>OUTCOME:</b> The Council of Governors <b>NOTED</b> the update to the 2022/23 Quality Account Priorities.</p>
<b>14/23</b>	<b>Proposed 2023/24 Quality Account Priorities</b>
	<p>Sharon Cundy, Head of Quality and Risk presented the choices for quality priorities for 2023/24. Governors had been invited to vote for their first, second and third priority choice. LR commented that the two with the most votes are hospital focused and that it would be good to include a third one that is more community focused.</p> <p>CM commented that the patient story at the Board had covered No. 7 and that this was an extremely important service. GC highlighted the need to ensure that the targets are achievable and that they really make a difference.</p> <p>SB felt that alternatives to hospital admission was an important indicator to select as it is important to people.</p> <p>RM highlighted that there would be progress against all of these. He stressed the need to have improvements in stroke performance.</p> <p>LW was interested in the medicines indicator. BM stroke should be the one that we concentrate on as there is poor performance in this area. Patient flow impacts the whole hospital through to discharge.</p> <p>LR reflected that has tried to chose priorities with a clear outcome and which will benefit other initiatives. All have a committee that they are monitored through.</p> <p>PBe highlighted the carers indicator and the benefit of this to patients.</p> <p>VP offer to circulate where you would expect to see these being monitored including the previous three. <b>ACTION</b></p> <p><b>OUTCOME:</b> The Council of Governors <b>SELECTED</b> items <b>1, care of the acutely ill patient, 2 nutrition and hydration and 7, alternatives to hospital admission</b> as the 2023/24 Quality Account Priorities.</p>
<b>15/23</b>	<b>COMPANY SECRETARY REPORT</b>
<b>a)</b>	<p><b>Election Process</b></p> <p>The Council of Governors noted the election process, and the associated communications strategy with the results due on 13 April. There will be 9 public governor and 2 staff governor</p>

	<p>positions available. RM asked what the cut off date is for new members to be able to vote. AMc agreed to provide this information. <b>ACTION</b></p> <p>BM asked if governors will be required to attend events. AMc confirmed that Governors would be very welcomed to be part of this process.</p> <p><b>b) Membership Survey Results</b> The Council of Governors noted the results of the survey. AMc reported that there had been positive feedback and which demonstrated that people are members because they are patients, former staff or interested in the changes. She explained that this is being discussed at the membership group and would be discussed at the workshop on 16 February 2023.</p> <p><b>c) Divisional Reference Group and Estates and Facilities Services Group Meetings 2023</b> The Council of Governors noted the meeting dates for 2023.</p> <p><b>d) Council of Governors Meeting Dates 2023</b> The Council of Governors noted the meeting dates for 2023</p> <p><b>e) Council of Governors Workplan 2023</b> The Council of Governors noted the Workplan for 2023.</p> <p><b>f) Receive Updated Register of Council of Governors</b> The Register was received by the Council of Governors.</p> <p><b>OUTCOME:</b> The Council of Governors <b>NOTED</b> the Election Process, the Membership Survey Results, Divisional Reference Group and Estates and Facilities Services Group Meeting dates, Council of Governors Meeting Dates, the Council of Governors Workplan and the Updated Register of Council of Governors.</p>
<b>16/23</b>	<b>RECEIPT OF MINUTES FROM BOARD SUB COMMITTEES</b>
	<p>The minutes of the following meetings were received:</p> <ul style="list-style-type: none"> <li>• Quality Committee held on 12.09.22, 24.10.22</li> <li>• Workforce Committee held on 11.10.22</li> <li>• Audit and Risk Committee held on 25.10.22</li> <li>• Finance and Performance Committee held on 06.09.22, 07.10.22, 01.11.22</li> <li>• Charitable Funds Committee held on 23.11.22</li> </ul> <p><b>OUTCOME:</b> The Council of Governors <b>RECEIVED</b> the minutes from the above sub-committee meetings.</p>
<b>17/23</b>	<b>INFORMATION TO RECEIVE</b>
	<p><b>Feedback from Finance and Performance Committee</b></p> <p><b>a) Performance Update for information</b></p> <p><b>b) Finance Report for information</b></p> <p>These reports were made available prior to the meeting for information. RM commented on the overview of performance being absent from the report and what would replace this useful overview. HH responded that there will be new performance reporting</p>



	<p>arrangements from April and these will be taken through the Finance and Performance Committee. RA commented that there will be a transitional period to identify the key indicators.</p> <p><b>OUTCOME:</b> The Council of Governors <b>NOTED</b> the Performance Update and the Finance Report for Information.</p>
<b>18/23</b>	<p><b>ANY OTHER BUSINESS</b></p> <p>There were no other items of business.</p>
<b>19/23</b>	<p><b>DATE AND TIME OF NEXT MEETING</b></p> <p>The Chair thanked all for attending the meeting and for their contribution and formally closed the meeting at approximately 4.10pm and invited governors to the next meeting.</p> <p><b>Date:</b> Thursday 20 April 2023  <b>Time:</b> 2:00 – 4:00 pm (Private meeting 1:00 – 1:45 pm)  <b>Venue:</b> Microsoft Teams</p>

DRAFT

## ACTION LOG FOR COUNCIL OF GOVERNORS

<b>Red</b>	<b>Amber</b>	<b>Green</b>	<b>Blue</b>
Overdue	Due this month	Closed	Going Forward

Date discussed at CoG Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
26.01.23 08/23	<b>Governance update</b> Minutes of the working group be added to future agendas	KB	Added to the workplan and will be on the next agenda	April 2023		
26.01.23 14/23	<b>2023/24 Proposed Quality Account Priorities</b> To circulate where you would expect to see these being monitored including the ones from the previous year's meeting	VP		February 2023		
26.01.23 15/23	<b>Company Secretary's Report – Election Process</b> Provide detail of the cut-off date for new members to be able to vote.	AMc				

<b>Date of Meeting:</b>	Thursday 20 April 2023
<b>Meeting:</b>	Council of Governors
<b>Title of report:</b>	Review of the Trust Constitution (including Standing Orders of the Council of Governors)
<b>Author:</b>	Andrea McCourt, Company Secretary
<b>Purpose of the Report</b>	
This report presents updates to the Trust Constitution and Standing Orders of the Council of Governors for approval as required by the Trust Constitution following a review.	
<b>Key Points to Note</b>	
<p>The Trust Constitution sets out the principles and processes that the Directors and Council of Governors follow. Any proposed changes to the Constitution require approval by both the Council of Governors and the Board of Directors as per section 44 of the Trust Constitution.</p> <p>The proposed changes to the Constitution and Standing Orders of the Council of Governors reflect the Health and Care Act 2022 (July 2022) and the NHS England Code of Governance for NHS Provider Trusts which came into effect on 1 April 2023. Updates are also included regarding members and governors in terms of applications, nominations and tenure.</p>	
<b>Summary Changes</b>	
<ul style="list-style-type: none"> <li>• References to the Health and Social Care Act 2022 have been added</li> <li>• Integrated Care Board/Partnership and System has been added</li> <li>• References to Monitor, NHS Improvement and the Trust Development Authority have been removed and replaced with NHS England</li> <li>• Purpose of a Foundation Trust has been updated (paragraph 4)</li> <li>• Disqualification from membership has been updated (paragraph 8)</li> <li>• Tenure for governors has been updated (paragraph 14)</li> <li>• Disqualification and removal of governors has been updated (paragraph 16)</li> <li>• Termination of office and removal of governors has been updated (paragraph 17)</li> <li>• Duties of governors has been updated (paragraph 18)</li> <li>• Board of Directors – general duty - updated (paragraph 23)</li>   <li>• Annex 2 Election Rules – Decisions as to the validity of nomination updated (paragraph 14)</li> <li>• Annex 3 Further Provisions – Termination of membership updated</li> <li>• Annex 5 Roles and Responsibilities of Governors updated</li> <li>• Annex 6 Composition of the Council of Governors updated</li>   <li>• Annex 7 Standing Orders Council of Governors – updated for Health and Care Act 2022, deputy lead governor and nomenclature of Council Member changed to Governor</li> </ul>	
If approved, the updated Constitution will be considered by the Board of Directors on 4 May 2023 for approval.	
<b>Recommendation</b>	

The Council of Governors is asked to:

- **APPROVE** the updates to the Trust Constitution and Standing Orders of the Council of Governors.

**UNIQUE IDENTIFIER NO: G-1C-2017**

**Review Date: April 2026**

**Review Lead: Company Secretary**

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**CONSTITUTION OF THE**

**CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST**

**(A PUBLIC BENEFIT CORPORATION)**

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<b>Version:</b>	<p>2.0 Review and update including:</p> <ul style="list-style-type: none"><li>- Expenses clarification</li><li>- References to Monitor / NHS Improvement</li><li>- Typographical amends</li></ul> <p>2.1 Addition of partner governor May 2019</p> <p>3.0 <i>April 2021</i></p> <p>14.1.5 An elected governor who completes the maximum 6 year tenure may stand for re-election after a period of 2 years has elapsed since the end of their tenure</p> <p>14.3 removal of reserve register</p> <p>Annexe 1 - addition of Rest of England constituency</p> <p>4.0 <i>13 January 2022</i></p> <p>25.4 Change to NED eligibility criteria</p> <p>5.0 July 2022</p> <p>24.0 Change to the Board of Directors composition to increase the number of Non-Executive Directors to up to 7 and the number of Executive Directors to up to 7.</p> <p>6 April 2023</p> <p>Amendments to reflect the Health and Social Care Act 2022, the NHS England Code of Governance for Provider Trusts (October 2022), application for membership and nomination as a governor, voting for removal of a governor.</p>
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## 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 and the Health and Social Care Act 2022.
- 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.
The 2022 Act	means the Health and Social Care Act 2022
Annual Members' Meeting	is defined in paragraph 10 of the constitution.
Appointed Governor Member	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 NHS England
Board of Directors	means the Board of Directors as constituted in accordance with this constitution;
Code of Governance	means the NHS England Code of Governance for NHS Provider Trusts (October 2022)
Director	means a member of the Board of Directors

Non-Executive Directors	means the Chair 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;
Integrated Care Board	An Integrated Care Board is a statutory organisation that brings NHS and care organisations together locally to improve population health and establish shared strategic priorities within the NHS
Integrated Care Partnership	An Integrated Care Partnership is a formal partnership of organisations working together to improve the health and care of the whole population they serve
Integrated Care System	An Integrated Care System (ICS) is a statutory partnership of organisations who plan, buy and provide health and care services in their geographical area. The organisations involved include the NHS, local authorities, voluntary and charity groups and independent care providers.
<del>Monitor</del> NHS England	<del>is the former name for the Trust’s regulator, as provided by Section 61 of the 2012 Act;</del> The Health and Social Care Act 2022 has merged Monitor and the Trust Development Authority into NHS England and is now the Trust’s regulator
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 Calderdale and Huddersfield NHS Foundation Trust t;

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](http://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.
- 4.5. The Trust should be led by an effective and diverse Board that is innovative and flexible and whose role it is to promote the long term sustainability of the Trust as part of the ICS and wider healthcare system in England, generating value for members, patients and the public.

## **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 England 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 divide into four classes as follows with five seats:
- 7.5.1. doctors or dentists (x1);
  - 7.5.2. Allied Health Professionals, Health Care Scientists or Pharmacists (x1);
  - 7.5.3. Management, administration and clerical (x1);
  - 7.5.4. Nurses and midwives (x2).
- 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 When applying to be a member, an online literature review will be undertaken to check that there are no known concerns regarding an individual that would suggest the person would act in a manner detrimental to the interests of the Trust. This decision as to whether an individual is likely to act in a way detrimental to the interests of the Trust will be made by the Council of Governors (as per section 8.2 of the Trust Constitution).

8.2A 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 and 8;
  - 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. 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 Company 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;
  - 14.1.4. cease to hold office if they cease to be a Member of the constituency by which they were elected, or if they are disqualified for any of the reasons set out in this Constitution.
- 14.2. An elected governor who completes the maximum 6 year tenure may not stand for re-election to ensure that they retain the objectivity and independence required to fulfil their roles. 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 cease to be a Member of the constituency by which they were elected, or if they are disqualified for any of the reasons set out in this Constitution.

## **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 Governor, 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. where a vacancy arises within 6 months to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office to fill the seat until the next annual election, at which time the seat will become vacant and subject to election for any unexpired period of the term of office.
  - 15.3.3. If the vacancy arises during the last 6 months of office, the office will remain vacant until it is filled at the next scheduled election term

## **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. their behaviour does not meet the Nolan principles / Standards of Public Life
- 16.1.8. 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 Governors

- 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 elected Governor, they cease to be a member of the constituency by whom they were elected;
  - 17.1.6. in the case of an appointed Governor, the appointing organisation terminates the appointment;
  - 17.1.7. they have failed to undertake any training which the Council of Governors requires all Governors to undertake;
  - 17.1.8. 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;
  - 17.1.9. 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;
  - 17.1.10. they are removed from the Council of Governors under the following provisions.
- 17.2. A Governorr may be removed from the Council of Governors by a resolution approved by a 66% 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.

Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable.

## **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
  - 18.1.3. to form a rounded view of the interests of the “public at large” to support collaboration and system working; this includes the population of the West Yorkshire ICS ;
- 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 – conflicts of interest**

- 21.1. 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 councillor shall disclose that interest to the members of the Council of Governors as soon as they become aware of it.
- 21.2. 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.
- 21.3. The Standing Orders for the Council of Governors are attached at Annexe 7.

## **22. Council of Governors - expenses**

- 22.1. 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.
- 22.2. Expenses claims must be submitted in line with the Trust's expenses policy.
- 22.3. Governors are not to receive remuneration.

## **23. Board of Directors – general duty**

- 23.1. 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.
- 23.2. 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.
- 23.3. The Trust will comply with the statutory requirements of the Code of Governance for NHS Provider Trusts issued by NHS England. Section A of this code details the principles and provisions relating to Board leadership and purpose.

## **24. Board of Directors – composition**

- 24.1. The Trust is to have a Board of Directors. It is to consist of Executive and Non-Executive Directors.
- 24.2. The Board of Directors is to comprise:
  - 24.2.1. a Non-Executive Chair;
  - 24.2.2. up to 7 other Non-Executive Directors;
  - 24.2.3. up to 7 Executive Directors.
- 24.3. One of the Executive Directors shall be the Chief Executive who shall be the Accounting Officer.

- 24.4. One of the Executive Directors shall be the Finance Director.
- 24.5. One of the Executive Directors is to be a registered medical practitioner.
- 24.6. One of the Executive Directors is to be a registered nurse or a registered midwife.

## **25. Board of Directors – appointment and removal of the Chair, Deputy Chair and other Non-Executive Directors**

- 25.1. The Council of Governors shall appoint a Chair of the Trust.
- 25.2. 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 (SINED).
- 25.3. The Chair and Deputy Chair will be the Chair and Deputy Chair of both the Council of Governors and the Board of Directors.
- 25.4. To be eligible for appointment as a Non-Executive Director of the Trust the candidate must demonstrate a commitment to the Trust and the communities it serves and live within reasonable travelling distance.
- 25.5. The Council of Governors at a general meeting shall appoint or remove the Chair of the Trust and the other Non-Executive Directors.
- 25.6. Non-Executive Directors are to be appointed by the Council of Governors using the following procedure:
  - 25.6.1. The Board of Directors will work with the external organisations recognised as expert in non-executive appointments to identify the skills and experience required
  - 25.6.2. Appropriate candidates will be identified by the Board of Directors who meet the skills and experience required
  - 25.6.3. 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.
- 25.7. Removal of the Chair or other Non-Executive Director shall require the approval of three-quarters of the Council of Governors.
- 25.8. The Board of Directors shall appoint one Non-Executive Director to be the Deputy Chair of the Trust.

## **26. Board of Directors – Senior Independent Director**

- 26.1. The Board of Directors will appoint one Non-Executive Director to be the Senior Independent Director.
- 26.2. The Trust has a detailed job description for the Senior Independent Director. The main duties include:

- 26.2.1. 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 Senior Independent Director has the same duties as the other Non-Executive Directors.
- 26.2.2. 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 Senior Independent Director also has a role in supporting the Chair as Chair of the Council of Governors.
- 26.2.3. 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.
- 26.2.4. The Senior Independent Director 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 Senior Independent Director 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.
- 26.2.5. In rare cases where there are concerns about the performance of the chair the Senior Independent Director 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 Senior Independent Director should liaise with the Lead Governor in such circumstances.
- 26.2.6. In circumstances where the board is undergoing a period of stress the Senior Independent Director 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.
- 26.2.7. In the circumstances outlined above, the Senior Independent Director will work with the chair, other directors and/or Governors, to resolve significant issues.

## **27. Board of Directors – tenure of Non-Executive Directors**

- 27.1. The Chair and the Non-Executive Directors are to be appointed for a period of three years.
- 27.2. The Chair and the Non-Executive Directors will serve for a maximum of two terms.

- 27.3. 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.

## **28. Board of Directors – appointment and removal of the Chief Executive and other executive directors**

- 28.1. The Non-Executive Directors shall appoint or remove the Chief Executive.
- 28.2. The appointment of the Chief Executive requires the approval of the Council of Governors.
- 28.3. A committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

## **29. Board of Directors – disqualification**

- 29.1. A person may not become or continue as a Director of the Trust if:
- 29.1.1. they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;
  - 29.1.2. 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;
  - 29.1.3. 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;
  - 29.1.4. they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;
  - 29.1.5. 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;
  - 29.1.6. they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;
  - 29.1.7. in the case of a Non-Executive Director they have failed to fulfil any training requirement established by the Board of Directors; or
  - 29.1.8. 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

## **30. Board of Directors - meetings**

- 30.1. 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.

- 30.2. Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors.
- 30.3. 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.

### **31. Board of Directors – standing orders**

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

### **32. Board of Directors – conflicts of interest of directors**

- 32.1. The duties that a director of the Trust has by virtue of being a director include in particular –
  - 32.1.1. 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.
  - 32.1.2. 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.
- 32.2. The duty referred to in sub-paragraph 31.1.1 is not infringed if –
  - 32.2.1. The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or
  - 32.2.2. The matter has been authorized in accordance with the constitution.
- 32.3. 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.
- 32.4. In sub-paragraph 31.1.2, “third party” means a person other than –
  - 32.4.1. The Trust, or
  - 32.4.2. A person acting on its behalf.
- 32.5. If a director of the Trust has in any way a direct or 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.
- 32.6. If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.
- 32.7. Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.
- 32.8. 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.

- 32.9. A director need not declare an interest –
- 32.9.1. If it cannot reasonably be regarded as likely to give rise to a conflict of interest;
  - 32.9.2. If, or to the extent that, the directors are already aware of it;
  - 32.9.3. If, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered –
    - 32.9.3.1. By a meeting of the Board of Directors, or
    - 32.9.3.2. By a committee of the directors appointed for the purpose under the constitution.
- 32.10. 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:
- 32.10.1. shall not be present except with the permission of the Board of Directors in any discussion of the matter, and
  - 32.10.2. shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).
- 32.11. 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.
- 32.12. 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.
- 32.13. The exceptions which shall not be treated as material interests are as follows:
- 32.13.1. shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange.

### **33. Board of Directors – remuneration and expenses**

- 33.1. 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.
- 33.2. The remuneration and allowances, and the other terms and conditions of office, of the Chair 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.
- 33.3. The remuneration and allowances for Directors are to be disclosed in the annual report.

### **34. Secretary**



- 34.1. 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:
- 34.1.1. acting as Secretary to the Council of Governors and the Board of Directors, and any committees;
  - 34.1.2. summoning and attending all members meetings, meetings of the Council of Governors and the Board of Directors, and keeping the minutes of those meetings;
  - 34.1.3. keeping the register of members and other registers and books required by this Constitution to be kept;
  - 34.1.4. having charge of the Trust's seal;
  - 34.1.5. publishing to members in an appropriate form information which they should have about the Trust's affairs;
  - 34.1.6. preparing and sending to NHS England and any other statutory body all returns which are required to be made;
  - 34.1.7. providing support to the Council of Governors and the Non-Executive Directors;
  - 34.1.8. overseeing elections conducted under this Constitution;
  - 34.1.9. offering advice to the Council of Governors and the Board of Directors on issues of governance and corporate responsibility.
- 34.2. 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.

### 35. Registers

- 35.1. The Trust is to have:
- 35.1.1. 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;
  - 35.1.2. a Register of Members of the Council of Governors;
  - 35.1.3. a Register of Directors;
  - 35.1.4. a Register of Interests of Governors
  - 35.1.5. a Register of Interests of the Directors.
- 35.2. 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.

### 36. Documents available for public inspection

- 36.1. 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.
- 36.1.1. a copy of the current Constitution;
  - 36.1.2. a copy of the current Authorisation;

- 36.1.3. a copy of the latest annual accounts and of any report of the auditor on them;
- 36.1.4. a copy of the report of any other auditor of the Trust's affairs appointed by the Council of Governors;
- 36.1.5. a copy of the latest annual report;
- 36.1.6. a copy of the latest information as to its forward planning;
- 36.1.7. a copy of the Trust's Membership Strategy;
- 36.1.8. a copy of any notice given under section 52 of the 2006 Act (NHS England's notice to failing NHS Foundation Trust).
- 36.1.9. 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.

### **37. Auditors**

- 37.1. The Trust is to have an auditor and is to provide the auditor.
- 37.2. The Council of Governors at a general meeting shall appoint or remove the Trust's auditors.
- 37.3. 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 England standards, procedures and techniques to be adopted.

### **38. Audit and Risk Committee**

- 38.1. 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.

### **39. Accounts**

- 39.1. The Trust must keep proper accounts and proper records in relation to the accounts.
- 39.2. NHS England may, with the approval of the Secretary of State, give directions to the Trust as to the content and form of its accounts.
- 39.3. The accounts are to be audited by the Trust's auditor.
- 39.4. The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.
- 39.5. The following documents will be made available to the Auditor General for examination at their request:
  - 39.5.1. the accounts;
  - 39.5.2. any records relating to them; and
  - 39.5.3. any report of the auditor on them.

- 39.6. 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.
- 39.7. The Trust shall:
  - 39.7.1. lay a copy of the annual accounts, and any report of the auditor on them, before Parliament; and
  - 39.7.2. once it has done so, send copies of those documents to NHS England.

#### **40. Annual report, forward plans and non-NHS work**

- 40.1. The Trust is to prepare an Annual Report and send it to NHS England.
- 40.2. The Trust is to give information as to its forward planning in respect of each financial year to NHS England. 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.
- 40.3. Each forward plan must include information about:-
  - 40.3.1. 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
  - 40.3.2. the income it expects to receive from doing so.
- 40.4. 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:-
  - 40.4.1. 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
  - 40.4.2. notify the directors of the Trust of its determination.
- 40.5. 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.

#### **41. Indemnity**

- 41.1. 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.

#### **42. Seal**

- 42.1. The Trust shall have a seal.

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

### **43. Dispute Resolution Procedures**

- 43.1. Every unresolved dispute which arises out of this Constitution between the Trust and:
- 43.1.1. a Member; or
  - 43.1.2. any person aggrieved who has ceased to be a Member within the six months prior to the date of the dispute; or
  - 43.1.3. any person bringing a claim under this Constitution; or
  - 43.1.4. 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.

### **44. Amendment of the constitution**

- 44.1. The Trust may make amendments of its Constitution only if:-
- 44.1.1. More than half of the members of the Council of Governors of the Trust voting approve the amendments; and
  - 44.1.2. More than half of the members of the Board of Directors of the Trust voting approve the amendments.
- 44.2. 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.
- 44.3. 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)
- 44.3.1. At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment; and
  - 44.3.2. The Trust must give the members an opportunity to vote on whether they approve the amendment.
- 44.4. 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.
- 44.5. Amendments by the Trust of its constitution are to be notified to NHS England. For the avoidance of doubt, NHS England'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.

### **45. Mergers etc. and significant transactions**

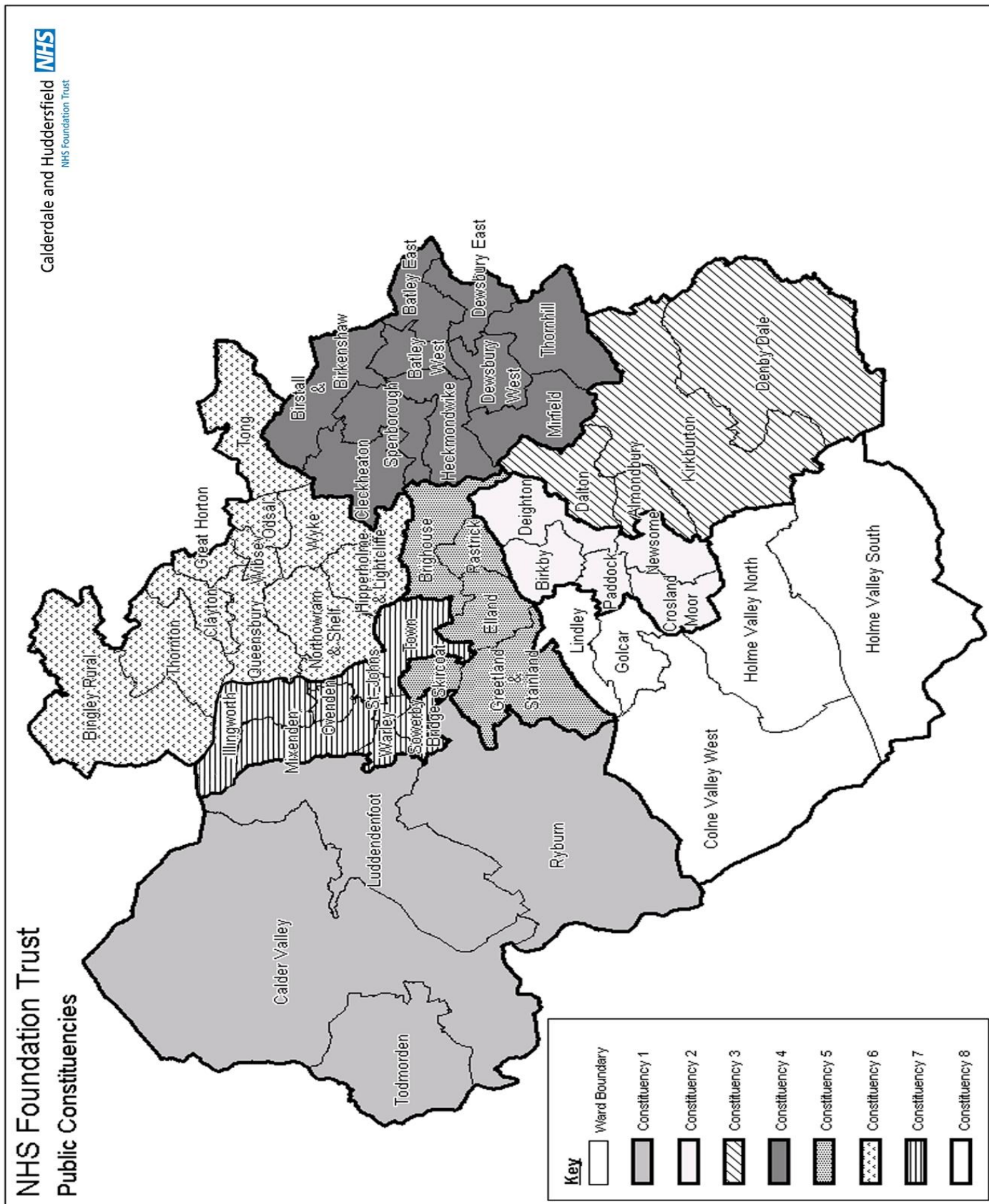
- 45.1. The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

- 45.2. 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.
- 45.3. The constitution does not contain any descriptions of the term 'significant transaction' for the purposes of section 51A of the 2006 Act (Significant Transactions).

#### **46. Dissolution of the Trust**

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

ANNEXE 1 – PUBLIC CONSTITUENCIES (See Map below and Rest of England)





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

Constituency	Wards	Population	Number of Governors to be elected
	Town		
<b>8</b>	Lindley	73,412	2
	Golcar		
	Colne Valley West		
	Holme Valley North		
	Holme Valley South		
<b>9</b>	<b>Rest of England</b> - any other electoral area in England with the exception of the above		<b>2</b>

### 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 8.4.14 (map/constituencies)

UPDATED 20.1.15 (election rules – electronic voting)

UPDATED 14.4.21 (addition of Rest of England constituency)



## **ANNEX 2**

### **ELECTION RULES**

#### **Part 1 Interpretation**

1. Interpretation

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2. Timetable
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4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

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10. Candidate's particulars
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## **Part 9 Death of a candidate during a contested election**

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- 60. Publicity about election by the corporation
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## **Part 11 Questioning elections and irregularities**

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- 64. Secrecy
- 65. Prohibition of disclosure of vote
- 66. Disqualification
- 67. Delay in postal service through industrial action or unforeseen event

## 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:

<b>Proceeding</b>	<b>Time</b>
<b>Publication of notice of election</b>	<b>Not later than the fortieth day before the day of the close of the poll.</b>
<b>Final day for delivery of nomination papers to returning officer</b>	<b>Not later than the twenty eighth day before the day of the close of the poll.</b>
<b>Publication of statement of nominated candidates</b>	<b>Not later than the twenty seventh day before the day of the close of the poll.</b>
<b>Final day for delivery of notices of withdrawals by candidates from election</b>	<b>Not later than the twenty fifth day before the day of the close of the poll.</b>
<b>Notice of the poll</b>	<b>Not later than the fifteenth day before the day of the close of the poll.</b>
<b>Close of the poll</b>	<b>By 5.00pm on the final day of the election.</b>

### 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 Any member who chooses to nominate themselves for the role of governor must meet the Standards of Public Life (Nolan Principles) and sign a declaration at the point of nomination to confirm that they meet these principles of public life.

An online literature review will be undertaken of all members who wish to nominate themselves as a governor. Where this identifies any issues in relation to an individual meeting the standards of public life and / or acting in a way that is detrimental to the interests of the Trust, these concerns regarding a potential nomination will be notified to the Chair, Company Secretary and lead governor. If a recommendation is made that a nomination should not proceed then an extra-ordinary meeting of the Council of Governors should take place to consider the recommendation. The individual/member will be notified of the outcome of the Council of Governors. Consideration should also be given to formal removal of the member in question – see section 8.

14.2 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.

14.3 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.

14.4 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.

14.5 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.

14.6 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**

STV38.1 In 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.

STV41.2 The 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-paragraph of transferred votes which was last received by that candidate into separate sub-paragraphs 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-paragraph of non-transferable votes.

STV44.6 The returning officer is, in accordance with this rule and rule STV45, to transfer each sub-paragraph 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 Chair of the NHS Trust, or
  - (ii) in any other case, to the Chair of the corporation; and
- (c) give public notice of the name of each candidate whom 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 Chair of the NHS Trust, or
  - (ii) in any other case, to the Chair of the corporation, and
- (c) give public notice of the name of each candidate who 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 Chair 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 Chair 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 Chair 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 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 11 Questioning 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 11.04.23. -see version history (electronic voting)

## ANNEX 3 – FURTHER PROVISIONS

(From paragraph 9.2)

### Termination of Membership

1. A Member may be expelled by a resolution approved by not less than 66% of the full Council of Governors present and voting at a meeting of the Council of Governors – this may be either a public or an extra ordinary meeting as appropriate to the timeframe. 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 either a public or extra-ordinary meeting of the Council of Governors.
4. If a resolution to expel a Member is to be considered at either a public or extra-ordinary meeting of the Council of Governors, details of the complaint must be sent to the Member complained of not less than one week 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.

## ANNEX 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 Chair 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 Council of Governor 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 Chair shall decide the outcome.
12. Unless a poll is demanded, the result of any vote will be declared by the Chair 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.

## ANNEX 5 – ROLES AND RESPONSIBILITIES OF GOVERNORS

(from Your Statutory Duties – A reference guide for NHS foundation trust governors / Addendum to your statutory duties 2022) [NHS England » Addendum to your statutory duties – reference guide for NHS foundation trust governors](#)

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. hold Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors;
  - 1.8. represent the interests of the members of the Trust as a whole and the interests of the public at large.
  - 1.9. 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;
  - 1.10. to approve “significant transactions”;
  - 1.11. to approve an application by the Trust to enter into a merger, acquisition, separation or dissolution;
  - 1.12. to respond as appropriate when consulted by the Board of Directors in accordance with this Constitution;
  - 1.13. to approve amendments to the Trust’s Constitution
  - 1.14. Decide whether the Trust’s non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions;
  - 1.15. to undertake such functions as the Board of Directors shall from time to time request;
  - 1.16. 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. If governors are acting outside of the context of a Council of Governors meeting they do so solely as individuals, i.e. outside their statutory role as a governor.
3. 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.

## ANNEX 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 18 Public Governors from 9 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
    - Calderdale Huddersfield Solutions Limited
    - Calderdale Cares Partnership / West Yorkshire Health and Care Partnership
    - Kirklees Health and Care Partnership/ West Yorkshire Health and Partnership

**ANNEX 7 – COUNCIL OF GOVERNORS – STANDING ORDERS**

**AS APPROVED AT COUNCIL OF GOVERNORS APRIL 2021**

**A Public Benefit Corporation**

**STANDING ORDERS**  
**COUNCIL OF GOVERNORS**

<b>Version:</b>	<p>2.0 Review and update including:</p> <ul style="list-style-type: none"> <li>- Expenses clarification</li> <li>- References to NHS England / NHS Improvement</li> <li>- Typographical amends</li> </ul> <p>2.1 Addition of partner governor May 2019</p> <p>3 April 2021          Integrated car system references added          Addition of period after which governors may stand for re-election</p>
<b>Approved by:</b>	Council of Governors / Board of Directors
<b>Date approved:</b>	<p>17 January 2017</p> <p>Version 2 17 October 2019</p> <p>Version 3 22 April 2021          Version 4 20 April 2023          Updates for Health and Care Act 2022 and change from Council Member to Governor</p>
<b>Date issued:</b>	17 October 2019
<b>Next Review date:</b>	In conjunction with the constitution but as a minimum every three years (2026)

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## 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 NHS England 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.

“**Chair**” means the person appointed to be Chair 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 NHS England.

“**Council of Governors**” shall mean the Council of Members as constituted in accordance with the corporation’s constitution.

“**Council of Governors**” shall mean those persons elected or appointed to sit on the Trust’s Council of Governors.

**Deputy Lead Governor** lead governor, act as deputy in the absence of the lead governor and share workload as required and act as a sounding board for the lead governor

“**Director**” shall mean a member of the Board of Directors as defined in section 13 of the constitution.

“**Governor**” shall mean a governor member of the Council of Governors as defined in section 12 of the constitution.

“**Lead Governor**” is the Public Council of Governor selected by the Council of Governors to act as a lead for the Council of Governors and to chair meetings in those circumstances where both the Chair and Deputy Chair have a conflict.

**Integrated Care System (ICS)** - is the West Yorkshire Health and Care Partnership.

“**NHS England**” is the previous name of the Independent Regulator for NHS Foundation Trusts. This changed to NHS Improvement on 1 April 2016 and NHS England on 1 July 2022

“**Motion**” means a formal proposition to be discussed and voted on during the course of a meeting.

~~“**NHS Improvement**” was the 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.

**“Deputy Chair”** means the Deputy Chair of the Trust pursuant to the terms of the constitution who will preside at meetings of the Council of Governors in the Chair’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 Chair (or Deputy 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 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. Meetings may be held virtually or in person.
- 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 Chair, 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 Chair 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 Chair, 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

Chair 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 Council of Governors, 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 (including not less than six Public Governors, not less than two Staff Governors and not less than two Appointed Governors – in line with the Constitution) 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 Chair 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 Chair or the Secretary.

### **5. Chairing of meeting**

- 5.1. The Chair of the Trust or, in his/her absence, the Deputy Chair will chair meetings of the Council of Governors.
- 5.2. The Lead Governor will be appointed from the Public Membership at a general meeting. He/she will act as Chair of the meeting should the Chair and the Deputy Chair be in conflict. The Deputy Chair will hold the casting vote when he/she is acting as Chair.

### **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 Chair, 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 Chair.

## **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 Chair to propose a motion to the same effect within six months, although the Chair 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 Chair of the meeting, the amendment negates the substance of the motion.

## **10. Chair's ruling**

10.1. The decision of the Chair 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 Chair 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 Chair, 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 Chair 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).
- 12.4. The names of the Governors' present at the meeting and those who gave apologies for each meeting shall be recorded in the minutes.
- 12.5. Council of Governor Members' must make every effort to attend meetings of the Council of Governors where appropriate and practicable. Where it's not possible for a Governor to attend apologies should be sent to the Corporate Governance Manager no later than three working days prior to the meeting.

## **SECTION B: COMMITTEES**

### **13. Appointment of Committees**

- 13.1. Subject to paragraph 40 below and such directions as may be given by NHS England, the Council of Governors may and, if directed to do so, shall appoint committees of the Council of Governors, 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 England or the Council of Governors, 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 England (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 England, 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 England 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 Chair, Deputy Chair and Non-Executive Directors**

- 15.1. The Council of Governors shall appoint a Chair of the Trust. 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, also take on the role of SINED (Senior Independent Non-Executive Director). The Council of Governors shall ratify the appointment of the Vice Chair 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 Chair 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) A contract with their Integrated Care Board / Integrated Care System (ICS) held by a Place / ICS governor;
  - d) An employment contract with a Local Authority held by a Local Authority Governor;

- e) An employment contract with any organization listed at paragraph 12.3.5 of the constitution.
- 16.10. If, in relation to 47, the Chair has a conflict of interest, the Deputy Chair will exercise the casting vote. If the Deputy Chair has a conflict of interest, the Deputy Chair 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 as per section 4.1 of Section C of the Code of Governance for NHS Provider Trusts (Composition succession and evaluation)

## SECTION D: TERMINATION OF OFFICE AND REMOVAL OF GOVERNOR

### 17. Termination of office

- 17.1. A person holding office as a Governor on the Council of Governors 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 1 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 Council Governor, they cease to be a Member of the constituency by whom they were elected;
  - d) In the case of an appointed Council 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 Council of Governors 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 Governors;
  - 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 Chair so that the Chair 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 Chair'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.
- 18.6. A Governor whose tenure of office is terminated under paragraph 18 shall not be eligible to stand for re-election. ~~Any re-election would take into account time served as a Governor so that a maximum term would not exceed 6 years.~~

## **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 Chair 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.

**ANNEXE 8 – BOARD OF DIRECTORS – STANDING ORDERS**

**UNIQUE IDENTIFIER NO: G-1A-2010**  
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# STANDING ORDERS

## BOARD OF DIRECTORS

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**TRUST STANDING ORDERS**

<b>Standing Orders for the regulation of the proceedings of Calderdale and Huddersfield NHS Foundation Trust</b>	
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## FOREWORD to Standing Orders

Within their terms of authorisation issued by the 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”) and 2012 Act

These Standing Orders, together with the documents below which form part of these “extended” Standing Orders, are extremely important. They provide a regulatory and governance framework for high standards of personal conduct and corporate conduct of the Trust and support public service values of accountability, probity and openness.

The additional documents which form part of these “extended” Standing Orders are:

- Standing Financial Instructions, which detail the financial responsibilities, policies and procedures to be maintained by the Trust
- Schedule of Decisions reserved to the Board of the Trust Scheme of Delegated Authorities, which sets out delegated levels of authority and responsibility

These documents provide a comprehensive business framework and set out the ground rules within which Board directors and staff must operate in conducting the business of the Trust. Observance of them is mandatory. 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.

All Directors and all members of staff should be aware of the existence of these documents, understand when they should be referred to and, where necessary and appropriate to their role, be familiar with the detailed provisions.

Failure to comply with standing orders is a disciplinary matter which could result in dismissal.

## DEFINITIONS

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, National Health Service Act, 2006 (the 2006 Act) and the Health and Social Care Act, 2012,(the 2012 Act) 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, 2012 Act, the Health and Care Act 2022 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.

Save as permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders. In this the Chair should be advised by the Chief Executive, guided by the Company Secretary, and in the case of Standing Financial Instructions, the Director of Finance.

Any expression to which a meaning is given in the 2006 Act, 2012 Act or 2022 Act in the Regulations or Orders made under the Act shall have the same meaning in this interpretation and in addition:

<b>Accounting Officer</b>	means the NHS 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.
<b>Associate Non-Executive Director</b>	means a development role for potential Non-Executive Directors who is not an Officer of the Trust with no voting rights and who is appointed by the Council of Governors.
<b>Board of Directors</b>	The Board of Directors as constituted in accordance with the Constitution.
<b>Budget</b>	A resource, expressed in financial terms, proposed by the Board and authorised by the Independent Regulator for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.
<b>Chair (of the Board or Trust)</b>	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.

<b>Chief Executive</b>	<b>The chief officer of the Trust</b>
<b>Code of Governance</b>	The Code of Governance for NHS provider trusts in its latest form as published at <a href="http://www.england.nhs.uk">www.england.nhs.uk</a>
<b>Committee</b>	A Committee created and appointed by the Board of Directors functioning as an internal Committee.
<b>Committee members</b>	Persons formally appointed by the Board of Directors to sit on or to chair specific Committees.
<b>Committee in Common</b>	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 with the aim of promoting alignment between the organisations yet reserving to themselves their own decisions.
<b>Company Secretary</b>	A person appointed to act as Trust Secretary or Company Secretary for the purposes of the Code of Governance, to provide advice on corporate governance issues to the Board and Chair and monitor the Trust's compliance with the law, Standing Orders and regulatory guidance
<b>Deputy Chair</b>	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.
<b>Director</b>	A non-voting member of the Board who is an Officer of the Trust
<b>Director of Finance</b>	The chief finance officer of the Trust.
<b>Elected governor member</b>	Those governors Members elected by the public constituency and the staff constituency.
<b>Executive Director</b>	A voting member of the Board who is an Officer of the Trust
<b>Funds held on Trust (Charitable Funds)</b>	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.
<b>Member</b>	A member of the Trust Board unless otherwise stated.
<b>Memorandum of Understanding (MoU)</b>	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.
<b>Motion</b>	A formal proposition to be discussed and voted on during the course of a Trust Board or Committee meeting.
<b>NHS England</b>	Is responsible for the oversight of NHS Trusts
<b>Non-Executive Director</b>	A voting member of the Board who is not an Officer of the Trust
<b>Nominated officer</b>	An Officer charged with the responsibility for discharging specific tasks within the Constitution and the SOs and SFIs.
<b>Officer</b>	An employee of the Trust.
<b>Schedule of Decisions reserved to</b>	Document setting out those powers which only the Board can exercise

<b>the Board</b>	
<b>Scheme of Delegation</b>	Document setting out the detailed delegated levels of authority and responsibility.
<b>SFIs</b>	Standing Financial Instructions.
<b>SINED</b>	Senior Independent Non-Executive Director, the Non-Executive Director appointed to support the Chair in leading the Board of Directors and Council of Governors
<b>SOs</b>	Standing Orders.
<b>Trust</b>	Calderdale and Huddersfield NHS Foundation Trust.
<b>Working Day</b>	Means any day, other than a Saturday, Sunday or legal holiday
<b>WYAAT</b>	The West Yorkshire Association of Acute Trusts

## INTRODUCTION

### Statutory and Regulatory Framework

- I. Calderdale and Huddersfield NHS Foundation Trust (the Trust) is a public benefit corporation which was established in 2006 under the National Health Service Act 2006 (as amended) (“the 2006 Act”) and is governed by Acts of Parliament.
- II. The principal place of business of the Trust is Trust Headquarters, Acre Mill Outpatients, Huddersfield Royal Infirmary, Acre Street, Lindley, Huddersfield, HD3 3EB
- III. The statutory functions conferred on the Trust are set out by Acts of Parliament, mainly the National Health Service Act 2006 and subsequent versions (i.e. Health and Social Care Act 2012 and the Health and Care Act 2022.) The functions of the Trust are conferred by this legislation. 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.
- IV. 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.
- V. As a statutory body, the Trust has specified powers to contract in its own name and act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.
- VI. The Trust also has statutory 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.
- VII. The Trust will be bound by such other statutes and legal provisions which govern the conduct of its affairs. In addition to the statutory requirements NHS England will issue further requirements and guidance. Many of these are contained within the 2006 Act, 2012 Act and 2022 Act and on NHS England’s website. Information is accessible locally via the Corporate Governance Manager.
- VIII. 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.
- IX. The Code of Governance and the Trust Constitution, together with the NHS Provider Licence (and the NHS Foundation Trust Conditions), require that the Trust draws up a schedule of decisions reserved to the Board and publicises which types of decisions are to be taken by Board and by the Council, and ensure that management arrangements



are in place to enable responsibility to be clearly delegated to Committees of the Board and individual Directors.

- X. The Code of Governance for NHS provider Trusts and the Trust 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.
- XI. The Code of Governance sets out arrangements for public access to information on the NHS.
- XII. Trust Boards are encouraged to operate an integrated governance framework to 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 take a holistic view of the Trust and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

### **Collaboration of services across West Yorkshire and the Integrated Care System**

Since the introduction of statutory Integrated Care Boards in July 2022 all NHS Trusts providing acute hospital services have been mandated to be part of a provider collaborative. The West Yorkshire Association of Acute Trusts, part of West Yorkshire Health and Care Partnership, is the acute sector collaborative, which formalises previous voluntary partnership working that was in place across the region to impact on the delivery of efficient 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.

The Trust will also work with local Integrated Care Boards and system partners, having regard to the triple aim of better health for everyone, better care for all and efficient use of NHS resources.

## PART 1 - THE TRUST AND BOARD OF DIRECTORS

### CORPORATE ROLE OF THE TRUST

#### 1. Name and business of the Trust

- 1.1 All business shall be conducted in the name of Calderdale and Huddersfield NHS Foundation Trust ( "the Trust").

The roles and responsibilities of the Board of Directors to be carried out in accordance with the Constitution include:

- 1.1.1 to ensure compliance with the Constitution, mandatory obligations issued by NHS England and relevant statutory requirements;
- 1.1.2 to establish a set of values and standards of conduct which are consistent with the Nolan Principles governing standards in public life;
- 1.1.3 to ensure compliance with the Code of Governance for NHS provider trusts issued by NHS England and report on the Trust's governance arrangements annually;
- 1.1.4 to determine the vision and values of the Trust;
- 1.1.5 to determine the service and financial strategy of the Trust and to monitor the delivery of those strategies;
- 1.1.6 to ensure the financial viability of the Trust;
- 1.1.7 to ensure the clinical quality and safety through a system of clinical governance
- 1.1.8 to provide services in accordance with agreed contracts; to ensure that adequate systems are in place to measure and monitor the Trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery; and
- 1.1.9 to ensure the Trust co-operates with other NHS bodies, Local Authorities and other stakeholders and relevant organisations with an interest in the health economy
- 1.1.10 The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in the Constitution.
- 1.1.11 NHS Foundation Trusts are governed by Acts of Parliament, mainly the National Health Service Act 2006 and subsequent versions.
- 1.1.12. 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 Directors acting on behalf of 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 to the Secretary of State for Health.
- 1.1.13. 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 "Schedules of

Decision Reserved for the Trust Board and have effect as if incorporated into the Standing Orders. Those powers and decisions not reserved to the Board are delegated to Officers and other bodies as described in the Scheme of Delegation and have effect as if incorporated into these Standing Orders.

## **2. Composition of the Trust Board of Directors**

**2.1** 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:

2.1.1. A Non-Executive Chair

2.1.2 Up to 7 other Non-Executive Directors (one appointee will act as the Deputy Chair and one the Senior Independent Non-Executive Director, the same appointee may be appointed to both roles))

### **2.1.3 Up to 7 Executive Directors which shall include:**

- *the Chief Executive (the Chief Officer)*
- *the Director of Finance (the Chief Finance Officer)*
- *a medical or dental practitioner*
- *a registered nurse or midwife*

2.1.4. Other Directors may be appointed to the Board of Directors from time to time but shall have no voting rights.

2.1.5 The Non-Executive Directors and Chair together shall be equal to or greater than the total number of Executive Directors. In the case where the numbers are equal, in the instance of a vote, the Chair will have a casting vote.

2.1.6 Associate Non-Executive Directors: Associate Non-Executive may be appointed to the Board on terms and conditions to be specified by the Board to provide additional advice and expertise to the Board and / or its Committees. Associate Non-Executive Directors will not be Directors of the Trust for the purposes of the National Health Service 2006 Act and thus will be non-voting appointees without executive or delegated executive functions or any power to bind the Trust.

**2.2** Appointment and removal of the Chair, Non-Executive Directors and Associate Non-Executive Directors

The Chair, Non-Executive Directors and Associate 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.

**2.3** Terms of Office of the Chair, Non-Executive Directors and Associate Non-Executive Directors

The provisions setting out the period of tenure of office of the Chair and Non-Executive Directors and the termination or suspension of office are contained in the Constitution, supplemented by the Code of Governance for NHS provider Trusts. The terms and conditions of the office are decided by the Council of Governors, informed by the Code of Governance for NHS provider Trusts.

The terms and conditions relating to the office of Associate Non-Executive Directors are decided by the Council of Governors.

- 2.4 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.

The appointment should be for a period which does not exceed the remainder of the term. 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. The Directors of the Trust may thereupon appoint another Non-Executive Director as Deputy Chair in accordance with these Standing Orders.

- 2.5 Powers of Deputy Chair  
Where the Chair has ceased to hold office or where he/she 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.

- 2.6 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.

Any appointment will be for such a period not exceeding the remainder of his/ her term as a Non-Executive Director agreed by the Council of Governors.

- 2.7 Appointment and Removal of Directors  
The Chief Executive shall be appointed or removed by the Chair and the Non-Executive Directors. The appointment requires the approval of the Council of Governors.

A Committee consisting of the Chair, the Chief Executive and other Non-Executive Directors (as specified in the terms of reference) shall appoint or remove the other Executive Directors and non-voting Directors.

- 2.8 Appointment of Deputy Chief Executive  
The Board may appoint an Executive Member as Deputy Chief Executive.

Any person so appointed may resign at any time from the office of Deputy Chief Executive by giving notice in writing to the Chief Executive. In the event of a resignation, the Board may appoint another Executive Member.

### 2.9.1 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.

Where the office of a Member of the Board is shared jointly by more than one person:

- Either or both of those persons may attend or take part in meetings of the Board
- If both are present at a meeting they should cast one vote if they agree
- In the case of disagreements, no vote should be cast and the presence of either or both of those persons should count as the presence of one person for the purposes of quorum.

### 2.10 Role of Directors

The Board will function as a corporate decision-making body. Executive Directors and Non-Executive Directors will be full and equal Directors. Their role as Directors on the Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions in

accordance with the Code of Governance. The function and role of Directors is described within these Standing Orders and documents incorporated into these Standing Orders.

- 2.11** Executive Directors  
Executive Directors shall exercise their authority within the terms of these Standing Orders, Standing Financial Instructions and the Scheme of Delegation.
- 2.12** Chief Executive  
The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the Accounting Officer for the Trust and shall be responsible for ensuring the discharge of obligations under applicable financial directions and NHS England guidance and in line with the requirements of the NHS Foundation Trust Accounting Officer Memorandum.
- 2.13** Director of Finance  
The Director of Finance is responsible for the provision of financial advice to the Trust and to its Directors and for the supervision of financial control and accounting systems. He/she is responsible along with the Chief Executive for ensuring the discharge of obligations under applicable financial directions and NHS England guidance.
- 2.14** Non-Executive Directors  
The Non-Executive Directors shall not be granted, nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may, however, exercise collective authority when acting as Directors of or when chairing a Committee of the Trust which has delegated powers.
- 2.15** Chair  
The Chair is responsible for the operation of the Board and will chair all Board meetings when present.

The Chair has certain delegated executive powers.

The Chair must comply with the terms of appointment and with these Standing Orders.

The Chair shall liaise with the Council of Governors and the Nominations and Remuneration Committee over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

The Chair shall work in close harmony with the Chief Executive

The Chair shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions

The Chair will ensure that the designation of lead roles or appointments of Board Members as required by NHS England or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement.

- 2.16** 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 Director of Finance. The Secretary shall be accountable to the Chief Executive and their functions shall be as listed in the Constitution.

## **PART 2. MEETINGS OF THE BOARD OF DIRECTORS**

### **3.1 Admission of the Public and the Press**

The public and representatives of the press shall be afforded facilities to attend all ordinary/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).

Business proposed to be transacted when the press and public have been excluded from a meeting as provided for in Standing Order 2.1, shall be confidential to members of the Board.

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.

The provisions of these Standing Orders relating to meetings of the Trust Board shall refer only to formal Trust Board meetings, whether ordinary or extraordinary meetings. The provisions shall not apply to workshops or other meetings attended by members of the Trust Board.

### **3.2 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.

### **3.3 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 information 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 it 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.

### **3.4 Calling Meetings**

Ordinary meetings of the Board of Directors shall be held at regular intervals 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 are eligible to vote, giving 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 of Directors who are eligible to vote may forthwith call a meeting.

### **3.5 Notice of Meetings and Business to be Transacted**

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 by email or equivalent electronic means to every Director, or by post to the usual place of residence of such Director, so as to be available at least three working 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.

No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 2.6 (emergency motions).

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 on the Trust's website at least three working 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

### **3.6 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.

The decision of the Chair of the meeting on questions of order, relevancy, and regularity (including procedure on handling motions and the Chair's interpretation of the Standing Orders shall be final. In this interpretation the Chair shall be advised by the Chief Executive and the Company Secretary and in the case of Standing Financial Instructions the Chair shall be advised by the Director of Finance.

### **3.7 Agenda and Supporting Papers**

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 10 working days before a meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

The agenda will be sent to Directors and Governors five working days before the meeting. Supporting papers, whenever possible, shall accompany the agenda sent to Directors, save in an emergency.

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.

### **3.8 Annual Members' Meeting**

The Trust will publicise and hold an annual members' meeting in accordance with its Constitution.

### **3.9 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 working 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.

### **3.10 Emergency Motion**

Subject to the agreement of the Chair, 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.

### **3.11 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.

### **3.12 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.

### **3.13 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.

### **3.14 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.

### **3.15 Voting**

It is not a requirement for decisions to be subject to a vote. The necessity of a vote shall be indicated by the agreement of at least one third of those attending and eligible to vote. The Chair shall be responsible for deciding whether a vote is required and what form this will take.

Where it is necessary to take a vote to determine an issue, 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.

Where the office of a Director who is eligible to vote is shared jointly by more than one person, see Standing Order 3.17 for voting rules.

Where necessary, a Director may be counted as present when available constantly for discussions through an audio or digital link and may take part in voting on an open basis.

### **3.16 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.

### **3.17 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.

### **3.18 Suspension of Standing Orders**

Except where this would contravene any statutory provision or any direction made by NHS England, 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.

### **3.19 Variation and Amendment of Standing Orders**

These Standing Orders shall be amended only if:

- (a) a notice of motion under Standing Order 3.10 has been given; and
- (b) upon a recommendation of the Chair or Chief Executive included on the agenda for the meeting
- (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 at the meeting where the variation is being discussed; and
- (d) the variation proposed does not contravene a statutory provision or provision of authorisation or of the Constitution.

### **3.20 Record of Attendance**

The names of the Chair and Directors present at the meeting, and others invited by the Chair, 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.

If a Director is not present for the entirety of the meeting, the minutes shall record the items that were considered when they were present.

### **3.21 Quorum**

No business shall be transacted unless six of the Directors are present (including three Executives and three 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 5 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 three Executive Directors to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting.

## **PART 3. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION AND COMMITTEES**

Subject to a provision in the authorisation or the Constitution, the Board of Directors may delegate any of its functions to 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, these arrangements shall be subject to such restrictions and conditions as the Board of Directors thinks fit.

### **4.1 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 acting jointly 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.

### **4.2 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.

### **4.3 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.

### **4.4 Schedule of Decisions Reserved to the Trust Board**

The Chief Executive shall prepare a Schedule of Decisions reserved for the Trust Board identifying the matters for which approval is required by the Board of Directors.

The Chief Executive may periodically propose amendment to the Schedule of Decisions Reserved to the Trust Board which shall be considered and approved by the Board of Directors as indicated above; and shall update the schedule after each review.

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 "Schedule of Decisions Reserved to the Trust Board shall have effect as if incorporated in these Standing Orders.

The Schedule of Decisions Reserved for the Trust Board shall take precedence over any terms of reference or description of functions of any committee or sub-committee established by the Trust Board. The powers and functions of any committee or sub-committee shall be subject to and qualified by the reserved matters contained in that schedule.

### **4.5 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 Audit and Risk Committee and Board of Directors for action or ratification. All members of the Board of Directors,

Membership Council and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

#### **4.6 Scheme of Delegated Authorities**

Standing Order (SO) 3 summaries the Board's powers to "arrange for the exercise of any of its functions by:

- an internal Committee or sub-Committee appointed by virtue of SO 4 Committees
- or by a Director or officer of the Trust,

in each case subject to such restrictions and conditions as the Board thinks fit or as NHS England may direct.

The Trust Board shall adopt a Scheme of Delegated Authorities 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.

The Scheme of Delegated Authorities sets out details of the directors and officers of the Trust to whom responsibility has been delegated for deciding particular matters. The Schedule that is current at the date of adoption of these Standing Orders is contained in Appendix A.

Subject to Standing Order 7.4 the Trust Board shall review such Schedule at such times as it considers appropriate; and shall update such Schedule in Appendix A after each review.

The direct accountability, to the Trust Board, of the Chief Finance Officer and other Executive Directors to provide information and advise the Trust Board in accordance with any statutory requirements shall not be impaired, in any way, by the delegations set out in the Scheme of Delegated Authorities.

Wherever the title Chief Executive, Director of Finance or other Officer position is used in these Standing Orders, it will be deemed to include such other employees who have been duly authorised to deputise, such as an employee formally deputising into the post during a period of absence of the substantive post holder or to cover a vacant post, subject to such deputising arrangements being formally documented and signed off appropriately.

#### **4.7 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. Committees will be subject to review by the Trust Board from time to time.

The Committees to be established by the Trust will consist of statutory, mandatory and non-mandatory Committees.

A Committee may appoint sub-committees consisting of wholly or partly of members of the Committee or wholly of persons who are not members of the Committee.

#### **4.8 Joint Committees**

The Trust may appoint a joint Committee by joining together with one or more other health or social care organisations consisting wholly or partly of the Chair and members of the Board of Directors 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 England 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).

#### **4.9 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 'Chair' is to be read as a reference to the Chair 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.

#### **4.10 Terms of Reference**

Each such internal Committee or sub-committee shall have such terms of reference and powers. The Trust Board shall approve the terms of reference of each Board Committee. Committees and sub-committees shall 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 and be subject to regular review by that Committee or sub-committee and the Trust Board as required

#### **4.11 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.

#### **4.12 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.

During a period of incapacity or temporary absence, Non-Executive Directors may nominate another named Non-Executive Director to attend a meeting of a Committee on their behalf. The status of the nominated Non-Executive Director shall be recorded in the minutes

#### **4.13 Minutes**

Minutes, or a representative summary of the issues considered, and decisions taken, of any Committee appointed under this Standing Order are to be formally recorded and submitted for inclusion onto the agenda of the next possible Trust Board meeting. Minutes, or a representative summary of the issues considered, and decisions taken of any sub-committee shall be submitted for inclusion onto the agenda of the next Committee meeting to which it reports.

#### **4.14 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 England and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with the regulations and directions made by NHS England.

### **Statutory and Mandatory Committees**



## 4.15 Mandatory Committees

### **Role of Audit and Risk Committee**

In line with the Code of Governance, the Trust Board shall appoint a Committee of three independent Non-Executive Directors to undertake the role of an Audit & Risk Committee. This role shall include providing the Trust Board with a means of independent and objective review of the financial systems and of general control systems that ensure that the Trust achieves its objectives, the reliability of the financial information used by the Trust and of compliance with law, regulations, guidance and codes of conduct. This Committee will pay due regard to good practice guidance, including, in particular, the NHS Audit Committee Handbook.

The terms of reference of the Audit & Risk Committee shall have effect as if incorporated into these Standing Orders and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

The Council of Governors is responsible for the appointment of external auditors, working in conjunction with members of the Audit and Risk Committee.

### **Role of Nominations and Remuneration Committee of the Board of Directors**

In line with the Code of Governance the Trust Board shall appoint a Committee to undertake the role of a remuneration and nominations Committee. This role shall include providing advice to the Trust Board about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors, as well as advising the Trust Board on the terms of service of other senior officers and ensuring that the policy of the Trust Board on remuneration and terms of service is applied consistently.

The Committee shall advise the Trust Board on the size, structure and membership and succession plans for the Trust Board and maintain oversight of the performance of the Chief Executive and Executive Directors.

The terms of reference of the Nominations and Remuneration Committee of the Board of Directors shall have effect as if incorporated into these Standing Orders and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

A separate Nomination and Remuneration Committee of the Council of Governors for Non-Executive Directors is in place as detailed in the Trust Constitution.

### **Charitable Funds Committee**

The Trust Board, in line with its role as Corporate Trustee, shall appoint a Committee to be known as the Charitable Funds Committee, whose role shall be to advise the Trust on the appropriate receipt, use and security of charitable monies in accordance with any statutory or other legal requirements or best practice required by the Charities Commission and Department of Health and Social Care.

The terms of reference of the Charitable Funds Committee shall have effect as if incorporated into these Standing Orders and shall be recorded in the appropriate minutes of the Trust Board, acting as Corporate Trustee, and may be varied from time to time by resolution of the Trust Board, acting in this capacity.

#### 4.16 Non-Mandatory Committees

The Trust Board shall appoint such additional non-mandatory Committees as it considers necessary to support the business and inform the decisions of the Trust Board

The terms of reference of these Committees shall have effect as if incorporated into these Standing Orders. The approval of the terms of reference shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

The membership of these Committees may comprise Non-Executive Directors or Executive Directors, or a combination of these. The membership and voting rights shall be set out in the terms of reference of the Committee and shall be subject to approval by the Board.

##### **Committees established by the Board**

The current non-mandatory internal Committees established by the Trust Board are:

- Finance and Performance Committee
- Quality Committee
- Workforce Committee
- Joint Liaison Committee
- Transformation Programme Board
  
- West Yorkshire Association of Acute Trusts (WYAAT) Committee in Common

#### 4.17 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 responsible for leading the development of the WYAAT collaborative programme and the workstreams in accordance with the defined key principles, setting overall strategic direction in order to deliver the WYAAT collaborative programme.

The above are subject to change at the discretion of the Trust Board. Such other Committees may be established as required to discharge the Board's responsibilities and will have the same standing and be subject to the same standing orders.

#### 4.18 Confidentiality

Proceedings in Committee meetings are confidential. There is no requirement for meetings of Trust Board Committees and sub-committees to be held in public, or for agenda or records of these meetings to be made public. However, the records of any meetings may be required to be disclosed, should a valid request be made under the rights conferred by the Freedom of Information Act, 2000 and there is no legal justification for non-disclosure.

Committee members should normally regard matters dealt with or brought before the Committee as being subject to disclosure, unless stated otherwise by the Chair of the Committee. The Chair shall determine whether specific matters should remain confidential until they are reported to the Trust Board.

A member of a Committee, or observer of that 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.

#### **4.19 Election of Chair of Committee**

Each Committee shall appoint a Chair; and may appoint a vice-Chair from its membership. The terms of reference of the Committee shall describe any specific rules regarding who the Chair should be. Meetings of the Committee will not be recognised as quorate, if the Chair, or vice Chair, or other suitably qualified, nominated member of the Committee is not present to undertake the role.

Each Committee shall review the appointment of its Chair, as part of the annual review of the Committee's role and effectiveness.

#### **4.20 Special meetings of Committee**

The Chief Executive shall require any Committee to hold a special meeting, on the request of the Chair, or on the request, in writing of any two members of that Committee.

## PART 4

### DUTIES AND OBLIGATIONS ON BOARD MEMEBRS, DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

#### 5. DECLARATIONS OF INTERESTS, REGISTER OF INTERESTS AND COMPLIANCE WITH FIT AND PROPER PERSONS REGULATIONS

Schedule 7 of the 2006 Act, Section 13.20 of the Constitution and the Trust Policy on Conflicts of Interests and Standards of Business Conduct 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.

Statutory requirements relating to pecuniary interests are detailed at SO 5.4

##### 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 organisation 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 organisation, entity or company considering entering in to or having entered into 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 NHS England *Code of Governance* and the Trust's Constitution and Policy on Conflicts of Interests and Standards of Business Conduct 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. Declarations made during the course of a meeting should be recorded in the minutes.

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 5.4 (pecuniary interest), 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 Company 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 an interest. The interests of partner in professional partnerships including general medical practitioners should also be considered.

## **5.2 Register of Interests**

The Company Secretary will ensure that a Register of Interests is established to record formally declarations of interests of Board Directors and officers and is considered by the Board. 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 open to inspection via the Trust website.

## **5.3 Compliance with Fit and Proper Persons Regulations**

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires all Trusts to ensure that all Executive and Non-Executive Director posts (or anyone performing similar or equivalent functions) are filled by people that meet the requirements of the Fit and Proper Persons Regulations ('FPPR'). The definition of Directors includes those in permanent, interim or associate roles, irrespective of their voting rights at Board meetings.

Individuals must be: of good character, have the necessary qualifications, competence, skills and experience for their role, have the appropriate level of physical and mental fitness, have not been party to any serious misconduct or mismanagement in the course of carrying on a regulated activity, and not be deemed unfit under the Regulation provisions

The regulations stipulate that Trusts must not appoint or have in place an Executive Director or a Non-Executive Director unless they meet the standards set out in the Regulations. The guidance issued by the CQC in January 2018 places ultimate responsibility on the Chair to discharge the requirements of the FPPR. The Chair must assure themselves that new applicants and existing post holders meet the fitness checks and do not meet any of the unfit criteria. Responsibility also falls on the Chair to decide whether an investigation is necessary and, at the end of the investigation, to consider whether the Director in questions remains fit and proper. The Chair will be notified by the CQC of any non-compliance with the FPPR and holds responsibility for making any decisions regarding action that needs to be taken.

#### **5.4 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.

The Secretary of State 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 paragraph 233, Part 11 of the NHS Act 2006 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 5.4, 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:

- (a) 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 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
- (b) 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.

## 5.5 Standards of Business Conduct

### 5.5.1. Policy

All members of staff must comply with the national guidance contained in the [NHS England » Standards of Business Conduct Policy](#) and Trust guidance in the Policy on Conflict of Interest and Standards of Business Conduct.

### 5.5.2 Standards of Public Life (Nolan Principles)

The Trust adheres to and expects all staff to abide by the seven principles of public life set out by the Parliamentary Committee on Standards of Public Life.

These are:

- **Selflessness:** Holders of public office should act solely in terms of the public. This version of the Standing Orders can only be guaranteed to be the current adopted version, if it is opened directly from the Trust's intranet library of policies and procedures. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
- **Integrity:** Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

- **Objectivity:** Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
- **Accountability:** Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
- **Openness:** Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
- **Honesty:** Holders of public office should be truthful.
- **Leadership:** Holders of public office should exhibit these principles in their own behaviour and treat others with respect. They should actively promote and robustly support the principles and challenge poor behaviour wherever it occurs.

The following provisions should be read in conjunction with this document.

#### **5.5.3. 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 and declare in a register of interest 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.

#### **5.5.4 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 with, 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.

#### **5.5.5. 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 alleged 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 Counter Fraud Authority 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 'Exclusion 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 £50.
- 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 may be expanded by the Trust's Standards of Business Conduct as from time to time approved by the Board of Directors.



5.

## **PART 5 CUSTODY OF SEAL AND SEALING OF DOCUMENTS**

### **6.1 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.

### **6.2 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.

### **6.3 Register of Sealing**

An entry of every sealing, including the name of the persons who have approved and authorised the document and attested the sealing shall be made and numbered consecutively in a register provided for that purpose.

A report of all sealings shall be made to the Board of Directors bi-annually. 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.

The seal should only be used to execute deeds or where otherwise required by law. Where it is unclear whether the use of the seal is necessary, appropriate legal advice should be sought by the Company Secretary or Officer nominated by the Secretary.

### **6.4 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 or any other Executive Director, 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.



## **PART 6 MISCELLANEOUS**

### **7.1 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. Links to these policies shall be issued by email to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive e-copies where appropriate of SOs.

**7.2** A copy of these Standing Orders will be held, with unrestricted access to all staff, on the Trust's intranet site

### **7.3 Documents having the standing of Standing Orders**

Standing Financial Instructions and Scheme of Delegation shall have the effect as if incorporated into SOs.

### **7.4 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 before a recommendation is made to the Board for adoption.

### **7.5 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.



<b>Date of Meeting:</b>	Thursday 20 April 2023
<b>Meeting:</b>	Council of Governors
<b>Title of report:</b>	Chair's Appraisal Process 2022/23
<b>Author:</b>	Andrea McCourt, Company Secretary
<b>Previous Forums:</b>	N/A
<b>Purpose of the Report</b>	
The purpose of this paper is to outline the annual appraisal process for the Chair for 2022/23	
<b>Key Points to Note</b>	
<p>The Trust is required to ensure a formal and transparent procedure is in place to monitor the performance and undertake the appraisal of the Chair and other Non-Executive Directors and report the outcome of these reviews, initially to the Nominations and Remuneration Committee of the Council of Governors with a summary of the appraisal and outcome to the Council of Governors on an annual basis.</p> <p>The enclosed paper sets out the proposed appraisal process for the Chair relating to the financial year 2022/23, which follows the national guidance issued by NHS England. This includes seeking feedback from governors. The timetable is detailed in the paper and the appraisal is scheduled for completion by 30 June 2023, with the outcome reported to the Council of Governors meeting on 20 July 2023.</p> <p>This process is usually overseen by the Nominations and Remuneration Committee of the Council of Governors on their behalf, however through agreement with the lead governor and Chair, it is being brought directly to the Council of Governors this year. A report will be submitted to the Nominations and Remuneration Committee of the Council of Governors ahead of the update to the Council of Governors.</p>	
<b>EQIA – Equality Impact Assessment</b>	
The attached paper is for information only. Where this information is used to inform changes to services, policies or procedures, an Equality Impact Assessment will first be completed to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.	
<b>Recommendation</b>	
The Council of Governors is asked to <b>APPROVE</b> the Chair's appraisal process for 2022/23.	

## Chair's Appraisal Process 2022/23

An NHS Trust Chair has a pivotal role in creating the conditions for the Board's effectiveness in maintaining a focus on strategy, performance, behaviour and values, stakeholders and accountability and in fostering effective relationships between Non-Executive Directors and the Executive team and between the Board and its internal and external partners.

Annual appraisal is a valuable way of ensuring continuous and supportive dialogue and objective feedback, relating to personal impact and effectiveness and enabling potential support and development needs to be recognised and fully considered.

The Trust process is based on the NHS England 2021 Chair Appraisal Framework for conducting annual appraisal of NHS provider chairs, together with a Provider Chair Competency Framework based around the following five competencies:

1. Strategic
2. Partnerships
3. People
4. Professional acumen
5. Outcomes focus

Further detail on these competencies can be found in the following link and are all included within the Chair assessment template. [Report template - NHSI website \(england.nhs.uk\)](#)

An overview of the NHS Chair Competency Framework is given at Appendix 1.

The Chair's appraisal takes place annually, is a face to face discussion and will be informed by self-evaluation and stakeholder feedback using an Microsoft Teams survey. It will enable identification of a Chair's strengths and any opportunities to increase impact and effectiveness.

The Chair's appraisal process will be undertaken by the Senior Independent Non-Executive Director, referred to as the appraisal facilitator in the NHS Improvement documentation. As a key stakeholder the lead governor will be asked to undertake assessment of the Chair as part of the appraisal process.

The Trust will undertake the Chair's appraisal for 2022/23 in line with the NHS England guidance on conducting chair's appraisal.

The key stages of the appraisal process are:

1. Appraisal Preparation
2. Gathering information - assessment by stakeholders
3. Appraisal discussion / evaluation by Senior Independent Non-Executive Director
4. Formal recording of appraisal
5. Communication - formal reporting of appraisal outcome to NHS England, Nominations and Remuneration Committee of the Council of Governors and a summary of the outcome to the Council of Governors.

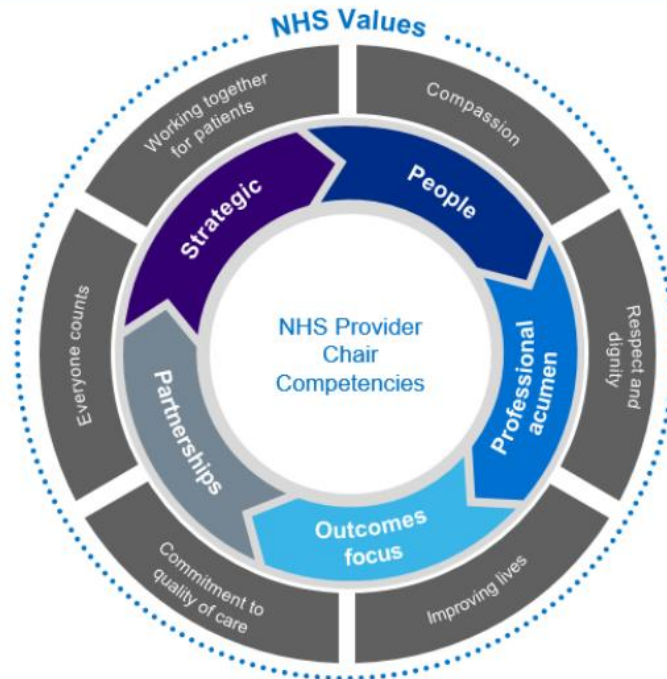
The flowchart below summarises the key steps and proposed timetable.

### Chair's Appraisal Proposed Timeline – 2022/2023

<p><b>Step 1 Appraisal Preparation</b> 2 May 2023</p>	<p>Chair and Senior Independent Non-Executive Director meet with Company Secretary and Corporate Governance Manager to discuss assessment area, areas of focus, stakeholder input and timetable.</p>
<p><b>Stage 2 Gathering Information</b> May 2023</p>	<p>Survey to seek stakeholder input sent (MS Forms).  Chair undertakes self-assessment.</p>
<p><b>Stage 3 Evaluation</b> Early June 2023</p>	<p>Senior Independent Non-Executive Director (SINED) evaluates stakeholder information, seeks any further information and reviews alongside Chair self-assessment.</p>
<p><b>Stage 4 Appraisal Meeting</b> Mid-June 2023</p>	<p>Individual appraisal meetings with SINED and Trust Chair.  2023/24 objectives and areas for personal development agreed.  Appraisal documentation completed and signed by appraiser and appraisee</p>
<p><b>Stage 5 – Communicating the results externally</b> 30 June 2023</p>	<p>Completed appraisal paperwork submitted to NHS England</p>
<p><b>Stage 6 - Communicating the results to Nominations and Remuneration Committee (Council of Governors)</b>  Early July 2023</p>	<p>SINED provides feedback to governors on outcome of appraisal at the meeting.</p>
<p><b>Stage 6 - Communicating the results to Governors</b>  20 July 2023</p>	<p>SINED provides verbal feedback to governors on outcome of appraisal at Council of Governors meeting on 20 July 2023.</p>

Figure 1: Chair's competency framework

# NHS Provider Chair Competency Framework



<b>Date of Meeting:</b>	Thursday 20 April 2023
<b>Meeting:</b>	Council of Governors
<b>Title of report:</b>	Non-Executive Director Appraisal Process 2022/23
<b>Author:</b>	Andrea McCourt, Company Secretary
<b>Previous Forums:</b>	N/A
<b>Purpose of the Report</b>	
To present for approval the appraisal process for Non-Executive Directors for 2022/23	
<b>Key Points to Note</b>	
<p>The Trust is required to ensure a formal and transparent procedure is in place to monitor the performance and undertake the appraisal of the Non-Executive Directors and report the outcome of these reviews to the Council of Governors on an annual basis.</p> <p>This process is usually approved by the Nominations and Remuneration Committee of the Council of Governors, a sub-group of the Council of Governors, however in agreement with the lead governor it has been agreed to bring approval of the process this year to the Council of Governors meeting.</p> <p>The enclosed paper sets out the proposed appraisal process for Non-Executive Directors relating to the financial year 2022/23, which will commence in line with the Trust appraisal season with an aim to complete this by June 2023 and report to governors during July 2023. by this date.</p> <p>A separate process for the Chair appraisal is presented to the Council of Governors for approval.</p>	
<b>EQIA – Equality Impact Assessment</b>	
The attached paper is for information only. Where this information is used to inform changes to services, policies or procedures, an Equality Impact Assessment will first be completed to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.	
<b>Recommendation</b>	
The Committee is asked to <b>APPROVE</b> the appraisal process for Non-Executive Directors for 2022/23.	





## ANNUAL APPRAISAL PROCESS OF THE NON-EXECUTIVE DIRECTORS 2022/23

### 1. PURPOSE OF THIS PAPER

The purpose of this paper is to:

- Set out a process for the annual appraisal of the Non-Executive Directors (NEDs) for approval by the Council of Governors;
- Confirm the timeline for the 2022/23 appraisal of the NEDs.

The paper includes the following appendices:

- Appendix 1 - Appraisal template (2022/23)
- Appendix 2 - Strategic Objectives 2022/23
  - Appendix 3 - NED team appraisal summary 2022/23 template NHS England /

### 2. INTRODUCTION

Appraisal is an important cornerstone of continuous and supportive dialogue and objective informal feedback, relating to personal impact, contribution and effectiveness. Governors of the Trust have a duty to agree the process for evaluating / appraising Non-Executive Directors (NEDs).

The NHS England Code of Governance for NHS Providers (effective from 1 April 2023), Section C: Composition, Succession and Evaluation states that, for NHS foundation trusts, the Council of Governors should take the lead on agreeing a process for the evaluation of the Chair and Non-Executive Directors (NED). The outcome of the appraisals is shared with the Council of Governors.

The Trust appraisal season for 2022/31 takes place between 1 April and 31 December 2023 reflecting on the previous 12 months, financial year 2022/23. Within the Trust's annual report confirmation is given that NED appraisals have been conducted.

The appraisal of the NEDs is undertaken by the Trust Chair and the lead governor, with the assistance of the Company Secretary.

NHS England has requested that NHS Foundation Trusts share the summary outcome of these appraisals with their appointments team to support learning and development of Non-Executive Directors regionally and nationally.

**Principles:** The appraisal process will be guided by the following principles:

- the appraisal process and documentation should be clear, simple and straightforward to administer;
- The appraisal should be based on reliable evidence about performance since the last appraisal;
- where a NED has been in post for less than 12 months at the time of the appraisal process, in place of the full appraisal process, the Chair will undertake a general review of progress within the first six months of the NED appointment;
- the performance of Non-Executives should be appraised against:
  - their role as a member of the Board
  - specific roles that they occupy, eg serving on a Committee of the Board
  - specific objectives that have been agreed for the year in question.
- the appraisal process will set new objectives, taking into account the future strategic organisational needs;
- appraisees will receive constructive feedback on their performance, build on strengths, identify any areas for learning and development relevant to their role and agree any support required for improvement;
- where there is not agreement regarding the appraisal or aspects of the appraisal the Trust Chair's assessment will stand with the Non-Executive Director's disagreement noted.

### 3. NON-EXECUTIVE DIRECTOR'S (NED) APPRAISAL PROPOSED TIMELINE – 2022/2023

<b>Step 1 NED Appraisal Process</b> 20 April 2023	Council of Governors agree Non-Executive Director appraisal process.
<b>Step 2 Gathering Information</b> From lead governor and Executives by mid-June 2023	NEDs to self-assess against the core and individual 2022/23 objectives in preparation for discussion with the Trust Chair.  Chair seeks input from relevant Executive Directors, ie those who work most closely with each NED.
<b>Step 3 Appraisal Meetings</b> June 2023	Individual appraisal meetings with Trust Chair and each NED.  Review 2022/23 objectives Agree 2023/24 objectives and personal development plan agreed for each NED

	<p>Chair to send letter to NED following appraisal conversation.</p> <p>Confirmation in annual report that Board member appraisal is undertaken</p>
<p><b>Step 4 – Completion</b> 30 June 2023</p>	<p>Completion of appraisal paperwork and feedback to lead governor</p>
<p><b>Step 5 Communicating the results</b> July 2023</p>	<p>Summary feedback to the Nominations and Remuneration Committee of the Council of Governors</p> <p>Chair to confirm completion of appraisal to Council of Governors 19 October 2023</p>

#### **4. RECOMMENDATION**

The recommendation is that the Council of Governors approve the appraisal process for the Non-Executive Directors as outlined in the paper.

**Andrea McCourt**  
**Company Secretary**

**6 April 2023**





## EXECUTIVE SUMMARY: Total Group Financial Overview as at 28th Feb 2023 - Month 11

## KEY METRICS

	M11				YTD (FEB 2023)				Forecast 22/23			
	Plan £m	Actual £m	Var £m		Plan £m	Actual £m	Var £m		Plan £m	Forecast £m	Var £m	
<b>I&amp;E: Surplus / (Deficit)</b>	(£1.55)	(£1.67)	(£0.12)	●	(£18.47)	(£22.07)	(£3.60)	●	(£17.35)	(£17.34)	£0.00	●
<b>Agency Expenditure (vs Ceiling)</b>	(£0.65)	(£1.27)	(£0.63)	●	(£6.26)	(£13.00)	(£6.75)	●	(£6.90)	(£14.29)	(£7.39)	●
<b>Capital</b>	£4.09	£6.77	(£2.68)	●	£37.49	£20.59	£16.90	●	£41.99	£30.86	£11.14	●
<b>Cash</b>	£37.83	£44.20	£6.37	●	£37.83	£44.20	£6.37	●	£19.26	£23.38	£4.12	●
<b>Invoices paid within 30 days (%)</b> (Better Payment Practice Code)	95.0%	90.3%	-5%	●	95.0%	91.3%	-4%	●				
<b>CIP</b>	£2.07	£1.73	(£0.34)	●	£17.89	£17.70	(£0.19)	●	£20.00	£20.00	£0.00	●
<b>Use of Resource Metric</b>	3	4		●	3	4		●	3	3		●

## Year to Date Summary

Year to date the Trust is reporting an £22.07m deficit, a £3.60m adverse variance from plan. The in month position is a deficit of £1.67m, a £0.12m adverse variance. The adverse variance is driven by inflationary pressures, the costs of opening additional capacity and the associated premium rate staffing costs. Pressures reduced to some extent in February with the closure of some surge capacity, and some additional funding from System partners.

- Funding for 22/23 is based on an Aligned Payment Incentive (API) approach with a fixed element based on agreed activity levels and a variable element to support recovery of elective services. £12.13m of Elective Recovery Funding (ERF) was assumed in the plan, based on delivery of 104% of 19/20 elective activity. ERF of £10.93m has been assumed in the year to date position in line with plan. It has been confirmed that ERF will not be clawed back for the first half of the year (H1). National guidance suggests that ERF is not likely to be clawed back in the second half of the year, but this has not yet been formally confirmed.
- The Trust has been allocated block funding of £6.0m for the year to support Covid-19 costs by the Integrated Care System (ICS) and subject to approval continues to have access to funding for Covid-19 costs that are considered to be outside of the System Envelope: Vaccinations and Covid-19 Testing. Requirements for additional funding for testing have reduced significantly as national procurement has expanded and the Autumn vaccination programme was funded differently, on a fixed cost per vaccine basis.
- Year to date the Trust has incurred costs relating to Covid-19 of £14.42m, (excluding costs outside of System Envelope), £6.17m higher than planned. Covid-19 activity remains higher than planned and is one of a number of factors driving additional staffing costs and consumables, with extra capacity opened over and above the planned level and ongoing Emergency Department segregation.
- Year to date the Trust has delivered efficiency savings of £17.70m, £0.19m lower than planned.
- Agency expenditure year to date is £13.00m, £6.75m higher than planned. The Integrated Care Board has set the Trust's Agency expenditure ceiling for the full year at £6.9m, and the Trust has already exceeded that ceiling.
- Total planned inpatient activity, for the purpose of Elective Recovery, was 99.6% of the activity planned year to date, (104.1% of 19/20 activity levels).

## Key Variances

- Income is £15.80m above the planned year to date due to: changes to Tariff based funding (£5.66m YTD) to support changes to pay (pay award / National Insurance changes); additional Integrated Care Board (ICB) funding to support increased bed capacity and Depreciation; and income from other local Trusts to support Vascular Services and Non Surgical Oncology. In addition, £0.87m of Covid-19 funded has been reallocated year to date to support operational pressures. Higher than planned NHS Clinical income is offset to some extent by lower than planned funding for 'outside of envelope' Covid-19 due to a reduction in testing costs now that most testing consumables have moved to a national procurement mechanism. Higher than planned Education & Training income of £3.85m includes £2.15m for hosted GP trainees.
- Pay costs are £8.83m above the planned level year to date, including £6.46m relating to the higher than planned Pay Award. Additional funding has been allocated to offset this pressure, although this is not currently sufficient to entirely offset the cost. Excluding pay award, the underlying year to date variance is £2.37m above the planned level, with an adverse variance in Month 11 of £0.55m. In the year to date position the cost of additional capacity and higher than planned Agency and Bank premium rates have been offset to some extent by a combination of vacancies in FSS and Community Divisions and lower than planned Elective Recovery costs.
- Non-pay operating expenditure is £11.39m higher than planned year to date with pressure on consumable costs due to additional capacity requirements, higher than planned insourcing / outsourcing costs associated with Elective Recovery and inflationary pressures in particular on utilities and the PFI contract.

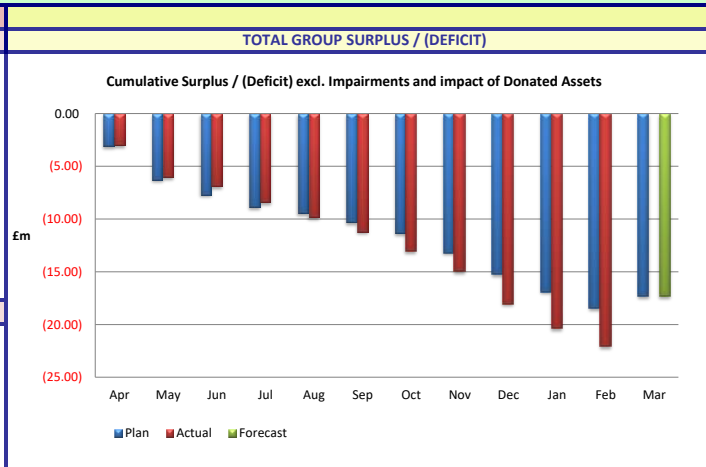
## Forecast

Whilst the reported year end forecast continues to be in line with the planned £17.35m deficit, the underlying position would drive a significantly bigger deficit, which is largely mitigated by additional non recurrent funding, technical flexibilities, and system support. The forecast continues to assume full delivery of the challenging £20m efficiency target and that the Trust will deliver its elective activity plan, delivering 104% of 19/20 activity levels within the planned funding envelope.

Total Group Financial Overview as at 28th Feb 2023 - Month 11

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M11			
CLINICAL ACTIVITY			
	M11 Plan	M11 Actual	Var
Elective	5,238	4,253	(985)
Non-Elective	53,520	49,323	(4,197)
Daycase	45,552	46,313	761
Outpatient	397,944	413,739	15,794
A&E	159,288	159,410	122
Other NHS Non-Tariff	1,696,994	1,809,913	112,919
<b>Total</b>	<b>2,358,535</b>	<b>2,482,951</b>	<b>124,416</b>



YEAR END 22/23			
CLINICAL ACTIVITY			
	Plan	Actual	Var
Elective	5,774	4,736	(1,038)
Non-Elective	58,360	53,930	(4,430)
Daycase	50,173	50,777	604
Outpatient	436,084	453,117	17,033
A&E	170,928	171,589	661
Other NHS Non-Tariff	1,867,647	1,993,590	125,943
<b>Total</b>	<b>2,588,966</b>	<b>2,727,739</b>	<b>138,773</b>

TOTAL GROUP: INCOME AND EXPENDITURE			
	M11 Plan	M11 Actual	Var
	£m	£m	£m
Elective	£20.95	£16.23	(£4.72)
Non Elective	£119.49	£118.57	(£0.92)
Daycase	£31.93	£32.70	£0.76
Outpatients	£36.30	£40.48	£4.18
A & E	£26.76	£28.16	£1.40
Other-NHS Clinical	£160.02	£172.42	£12.40
CQUIN	£0.00	£0.00	£0.00
Other Income	£49.20	£51.90	£2.70
<b>Total Income</b>	<b>£444.66</b>	<b>£460.46</b>	<b>£15.80</b>
Pay	(£294.57)	(£303.40)	(£8.83)
Drug Costs	(£41.92)	(£41.57)	£0.34
Clinical Support	(£31.24)	(£31.10)	£0.14
Other Costs	(£52.74)	(£64.34)	(£11.60)
PFI Costs	(£13.11)	(£13.39)	(£0.27)
<b>Total Expenditure</b>	<b>(£433.57)</b>	<b>(£453.80)</b>	<b>(£20.23)</b>
<b>EBITDA</b>	<b>£11.09</b>	<b>£6.66</b>	<b>(£4.43)</b>
Non Operating Expenditure	(£29.56)	(£28.73)	£0.83
<b>Surplus / (Deficit) Adjusted*</b>	<b>(£18.47)</b>	<b>(£22.07)</b>	<b>(£3.60)</b>

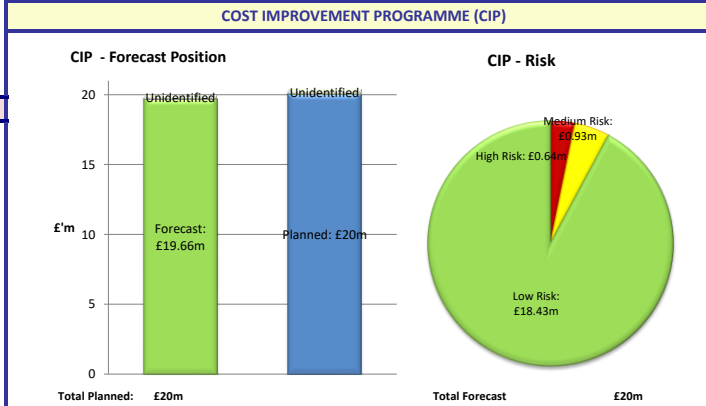
KEY METRICS						
	Year To Date			Year End: Forecast		
	M11 Plan	M11 Actual	Var	Plan	Forecast	Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	(£18.47)	(£22.07)	(£3.60)	(£17.35)	(£17.34)	£0.00
Capital	£37.49	£20.59	£16.90	£41.99	£30.86	£11.14
Cash	£37.83	£44.20	£6.37	£19.26	£23.38	£4.12
Invoices Paid within 30 days (BPPC)	95%	91%	-4%			
CIP	£17.89	£17.70	(£0.19)	£20.00	£20.00	£0.00
Use of Resource Metric	Plan	Actual		Plan	Forecast	
	3	4		3	3	

TOTAL GROUP: INCOME AND EXPENDITURE			
	Plan	Actual	Var
	£m	£m	£m
Elective	£23.08	£18.28	(£4.80)
Non Elective	£123.29	£122.09	(£1.20)
Daycase	£35.10	£36.07	£0.96
Outpatients	£40.60	£44.80	£4.19
A & E	£28.76	£30.22	£1.47
Other-NHS Clinical	£180.77	£198.67	£17.91
CQUIN	£0.00	£0.00	£0.00
Other Income	£53.66	£56.89	£3.23
<b>Total Income</b>	<b>£485.26</b>	<b>£507.02</b>	<b>£21.76</b>
Pay	(£318.79)	(£330.56)	(£11.77)
Drug Costs	(£45.79)	(£45.58)	£0.20
Clinical Support	(£34.28)	(£34.05)	£0.23
Other Costs	(£57.19)	(£70.06)	(£12.87)
PFI Costs	(£14.31)	(£14.60)	(£0.30)
<b>Total Expenditure</b>	<b>(£470.36)</b>	<b>(£494.85)</b>	<b>(£24.49)</b>
<b>EBITDA</b>	<b>£14.90</b>	<b>£12.17</b>	<b>(£2.73)</b>
Non Operating Expenditure	(£32.25)	(£29.52)	£2.73
<b>Surplus / (Deficit) Adjusted*</b>	<b>(£17.35)</b>	<b>(£17.34)</b>	<b>£0.00</b>

\* Adjusted to exclude items excluded for assessment of System financial performance: Donated Asset Income, Donated Asset Depreciation, Donated equipment and consumables (PPE), Impairments and Gains on Disposal

\* Adjusted to exclude all items excluded for assessment of System financial performance: Donated Asset Income, Donated Asset Depreciation, Donated equipment and consumables (PPE), Impairments and Gains on Disposal

DIVISIONS: INCOME AND EXPENDITURE			
	M11 Plan	M11 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	(£93.56)	(£92.59)	£0.97
Medical	(£113.54)	(£120.71)	(£7.16)
Families & Specialist Services	(£82.06)	(£80.01)	£2.05
Community	(£25.56)	(£24.79)	£0.77
Estates & Facilities	£0.00	£0.01	£0.01
Corporate	(£49.12)	(£50.31)	(£1.19)
THIS	£1.15	£1.25	£0.10
PMU	£2.19	£1.45	(£0.74)
CHS LTD	£0.47	£0.21	(£0.27)
Central Inc/Technical Accounts	£340.04	£343.98	£3.94
Reserves	£1.51	(£0.56)	(£2.08)
<b>Surplus / (Deficit)</b>	<b>(£18.47)</b>	<b>(£22.07)</b>	<b>(£3.60)</b>



DIVISIONS: INCOME AND EXPENDITURE			
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	(£102.29)	(£101.47)	£0.82
Medical	(£124.34)	(£132.23)	(£7.89)
Families & Specialist Services	(£89.56)	(£87.32)	£2.23
Community	(£27.88)	(£27.13)	£0.75
Estates & Facilities	£0.00	£0.01	£0.01
Corporate	(£53.58)	(£55.02)	(£1.43)
THIS	£1.25	£1.21	(£0.05)
PMU	£2.39	£1.55	(£0.84)
CHS LTD	£0.54	£0.24	(£0.30)
Central Inc/Technical Accounts	£374.02	£380.34	£6.32
Reserves	£2.09	£2.48	£0.39
<b>Surplus / (Deficit)</b>	<b>(£17.35)</b>	<b>(£17.34)</b>	<b>£0.00</b>

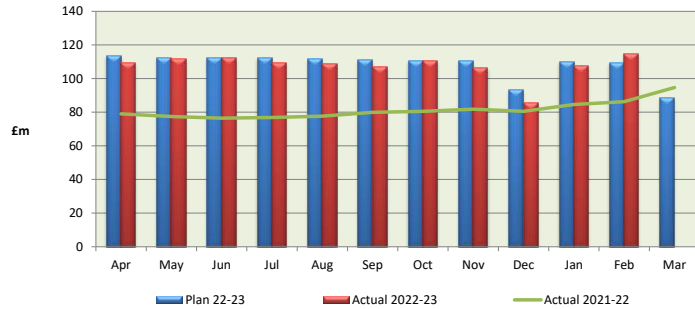
Total Group Financial Overview as at 28th Feb 2023 - Month 11

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

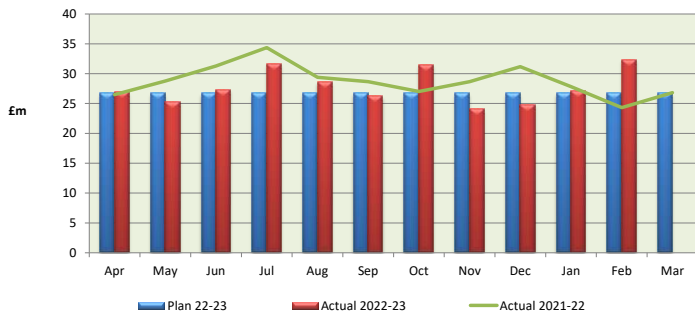
WORKING CAPITAL

	M11 Plan £m	M11 Actual £m	Var £m	M11
Payables (excl. Current Loans)	(£109.39)	(£114.62)	£5.23	●
Receivables	£26.70	£32.29	(£5.59)	●

Payables

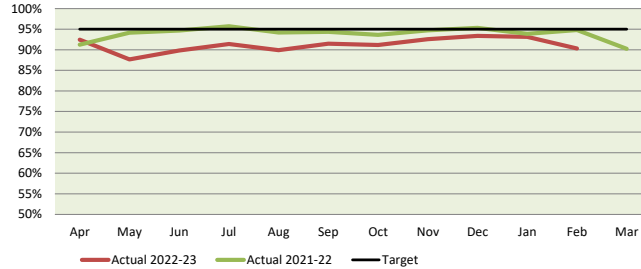


Receivables



BETTER PAYMENT PRACTICE CODE

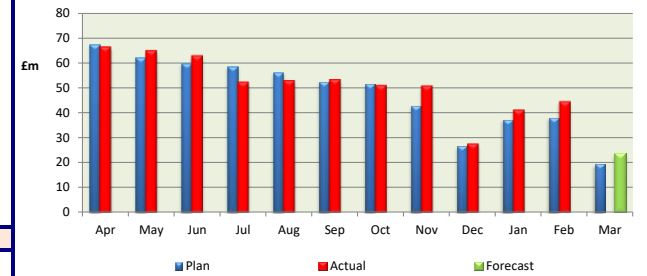
% Number of Invoices Paid within 30 days



CASH

	M11 Plan £m	M11 Actual £m	Var £m	M11
Cash	£37.83	£44.20	£6.37	●
Loans (Cumulative)	£15.46	£15.46	£0.00	●

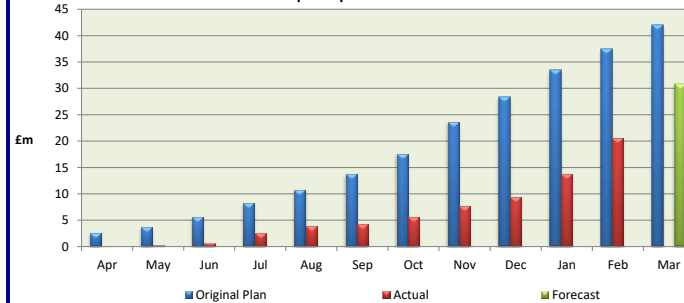
Cash



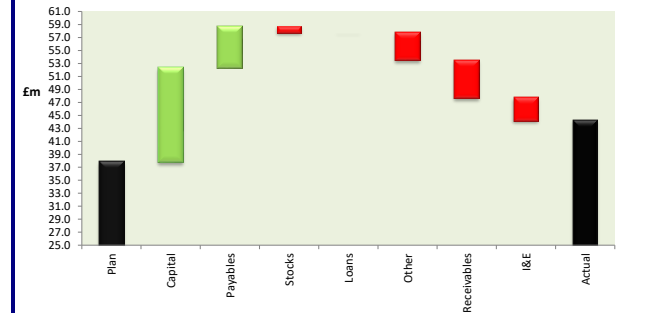
CAPITAL

	M11 Plan £m	M11 Actual £m	Var £m	M11
Capital	£37.49	£20.59	£16.90	●

Capital Spend



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- Year to date the Trust is reporting an £22.07m deficit, a £3.60m adverse variance from plan.
- The adverse variance is driven by inflationary pressures, the cost of opening additional capacity and the associated premium rate staffing costs.
- Funding for 22/23 is based on an Aligned Payment Incentive (API) approach with a fixed element based on agreed activity levels and a variable element to support recovery of elective services. £12.13m of Elective Recovery Funding (ERF) was assumed in the plan, based on delivery of 104% of 19/20 elective activity.
- £10.93m of ERF has been assumed in the year to date position as planned. National guidance suggests that ERF is not likely to be clawed back this year, although this has not yet been formally confirmed.
- Total planned inpatient activity for the purposes of Elective recovery was 99.6% of the activity planned year to date, (104.1% of 19/20 activity levels).
- Year to date the Trust has incurred costs relating to Covid-19 of £14.42m, (excluding testing and vaccination costs funded outside of System envelope), £6.17m higher than planned.
- Capital expenditure is lower than planned at £20.59m against a planned £37.83m. Capital plans now also include any new leases.
- Year to date the Trust has delivered efficiency savings of £17.70m, £0.19m lower than planned.
- NHS Improvement performance metric Use of Resources (UOR) stands at 4, worse than planned, with 2 metrics currently away from plan.

NOTES

- Whilst the reported year end forecast continues to be in line with the planned £17.35m deficit, the underlying position would drive a significantly bigger deficit, which is largely mitigated by additional non recurrent funding, technical flexibilities, and system support.
- The forecast position assumes full delivery of a challenging £20m efficiency target. At the end of February 23, £19.66m of efficiency has been identified and the forecast assumes that mitigation will be found to offset the remaining gap.
- The Trust is forecasting to deliver its elective activity plan and secure £11.72m of Elective Recovery Funding.
- The total loan balance is £15.46m as planned. No further loans are planned for this financial year.
- The Trust is forecasting to spend £30.86m on Capital programmes in this financial year including £0.16m on leases. The £11.14m forecast underspend is due to reduction in expenditure on PDC funded Reconfiguration and leases, offset to some extent by an increase in forecast donated assets (funded through charitable funds) and additional PDC funded expenditure on Endoscopy equipment, Diagnostics Digital Capability and Front Line digitisation.
- The Trust has a cash balance of £44.20m, £6.37m higher than planned.

RAG KEY:	●	Actual / Forecast is on plan or an improvement on plan
(Excl: UOR)	●	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



## Summary of Operating Income

Income category	Year to Date				Forecast Outturn			
	Plan (£'m)	Actual (£'m)	Variance (£'m)	Pay Award Impact net of NI reduction (£'m)	Plan (£'m)	Actual (£'m)	Variance (£'m)	Pay Award Impact net of NI reduction (£'m)
ICB Income ( Exc ERF)	344.97	354.29	9.32	5.41	376.33	388.86	12.54	5.79
NHSE Income ( Exc ERF)	33.39	34.80	1.41	0.25	36.43	37.99	1.56	0.27
System Covid Funding	5.50	6.36	0.86		6.00	7.32	1.32	
Elective Recovery Funding (ERF)	10.93	10.93	0.00		12.12	11.72	(0.40)	
<b>ICB &amp; NHSE Income</b>	<b>394.79</b>	<b>406.38</b>	<b>11.59</b>	<b>5.66</b>	<b>430.88</b>	<b>445.89</b>	<b>15.02</b>	<b>6.06</b>
Other Clinical Income	7.56	10.08	2.53		8.22	12.64	4.42	
<b>Total Clinical Income</b>	<b>402.35</b>	<b>416.47</b>	<b>14.12</b>	<b>5.66</b>	<b>439.10</b>	<b>458.54</b>	<b>19.44</b>	<b>6.06</b>
Out of envelope Covid Funding	3.66	0.37	(3.30)		4.00	0.37	(3.63)	
Other Non-Clinical income	38.65	43.63	4.97		42.17	48.12	5.95	
<b>Total Operating Income</b>	<b>444.66</b>	<b>460.46</b>	<b>15.80</b>	<b>5.66</b>	<b>485.26</b>	<b>507.02</b>	<b>21.76</b>	<b>6.06</b>

## Operating Income:

- The Trust received £388m block contract income from NHSE and ICB in line with 2022/23 plan. This income is inclusive of £5.7m pay award funding which is net of national insurance adjustment.
- ICB Income is above plan due to Bed Capacity Funding and additional Depreciation funding not included in the plan.
- NHSE Income is above plan due to additional High-Cost Drug income, funded on a cost and volume basis plus further non-recurrent funded secured in year.
- Included in monthly block payments is Covid funding via the ICB of an annual value of £6m. A further £1.3m Covid related funding has also been secured from the ICB for Quarter 4, to support operational pressures.
- The Trust has an annual Elective Recovery Funding (ERF) target of £12.1m. To date £10.9m has been reflected in the position in line with plan. ERF will not be clawed back for the first half of the year (H1) with national guidance suggesting that there will be no clawback in H2. This however, has not been fully confirmed and so remains a risk.
- Other clinical income is £2.53m above plan and included in the position is additional Non Surgical Oncology income from Mid Yorks and some additional winter funding that has been secured to offset operational pressures.

## ACTIVITY & CAPACITY (INCLUDING ELECTIVE RECOVERY FUND PERFORMANCE)

### CLINICAL ACTIVITY

#### Activity Summary by Point of Delivery - 2022/23 Plan v Actual

Activity - Point of Delivery	YTD Plan - FEB 2023	YTD Actual - FEB 2023	YTD Variance	% of Plan Delivered	% of 2019/20 Baseline Delivered
Day case	45,552	46,313	761	101.7%	105.7%
Elective	5,238	4,253	- 985	81.2%	89.1%
<b>Sub-total Inpatient Activity</b>	<b>50,789</b>	<b>50,566</b>	<b>- 223</b>	<b>99.6%</b>	<b>104.1%</b>
Outpatient First Attendances	139,220	138,885	- 335	99.8%	106.1%
<b>Sub-total Elective Recovery</b>	<b>190,009</b>	<b>189,451</b>	<b>- 559</b>	<b>99.7%</b>	<b>105.5%</b>
Outpatient Follow-up Attendances	258,724	274,854	16,129	106.2%	111.8%
Non-elective Inpatient	53,520	49,323	- 4,197	92.2%	91.3%
A&E Attendances	159,288	159,410	122	100.1%	110.8%
Other	1,696,994	1,809,913	112,919	106.7%	109.1%
<b>TOTAL</b>	<b>2,358,535</b>	<b>2,482,951</b>	<b>124,416</b>	<b>105.3%</b>	<b>108.8%</b>

#### Plan vs 2022/23 Actual

Activity is being monitored against 2022/23 plan

- In-month planned inpatient activity is 0.9% above plan and 0.4% below plan year-to-date.
- Outpatient First Attendances are 0.2% below plan and non-elective is 7.8% below plan.

#### Elective Recovery Performance

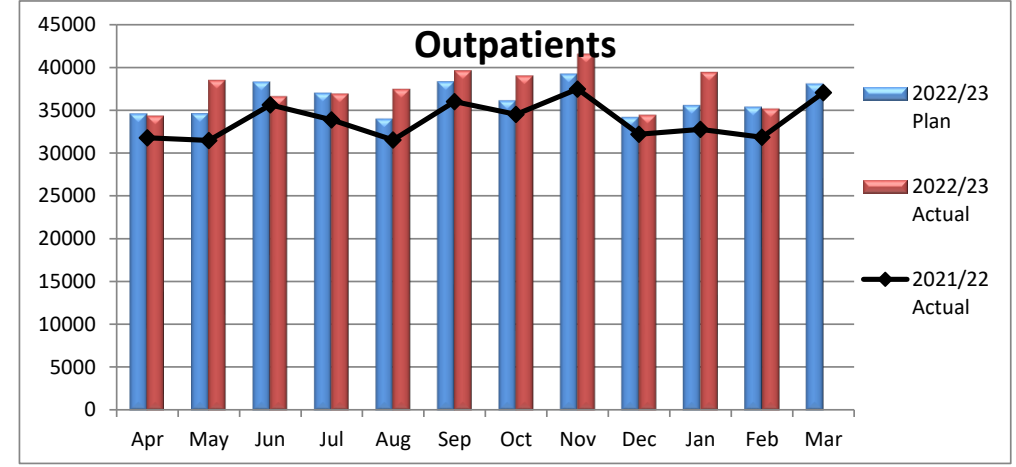
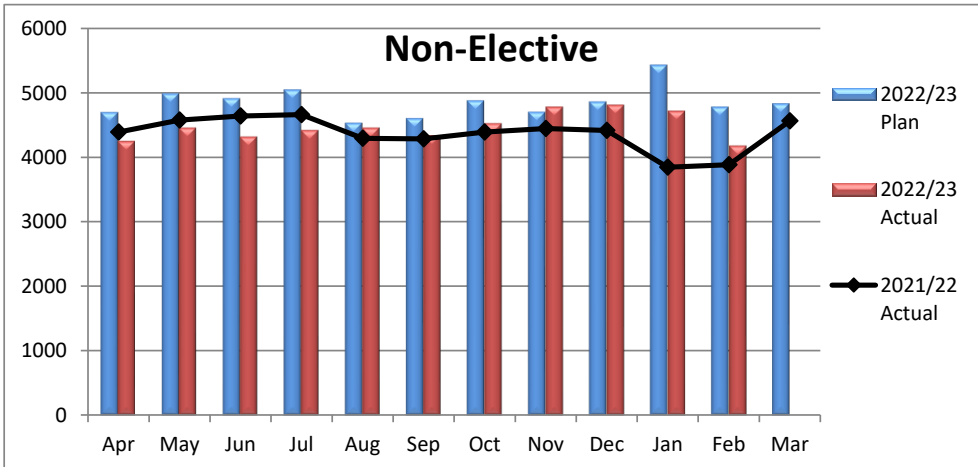
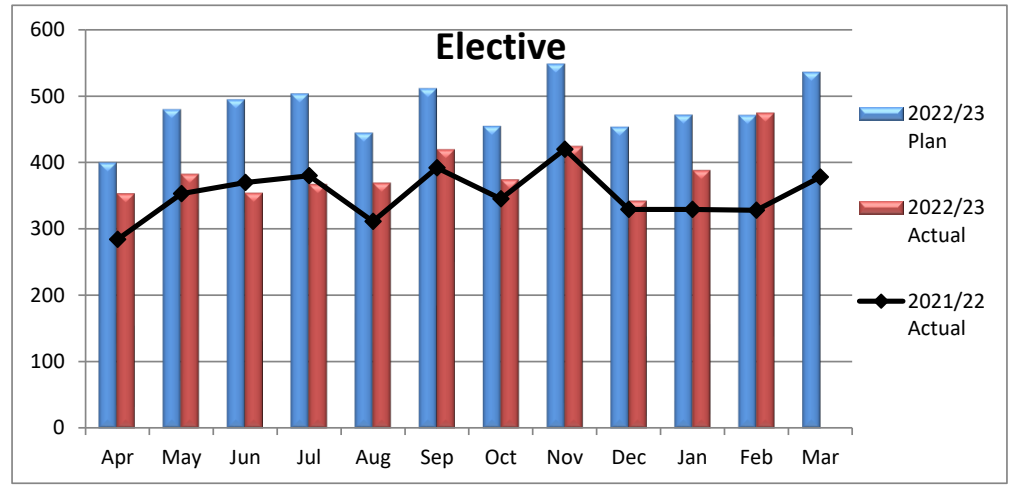
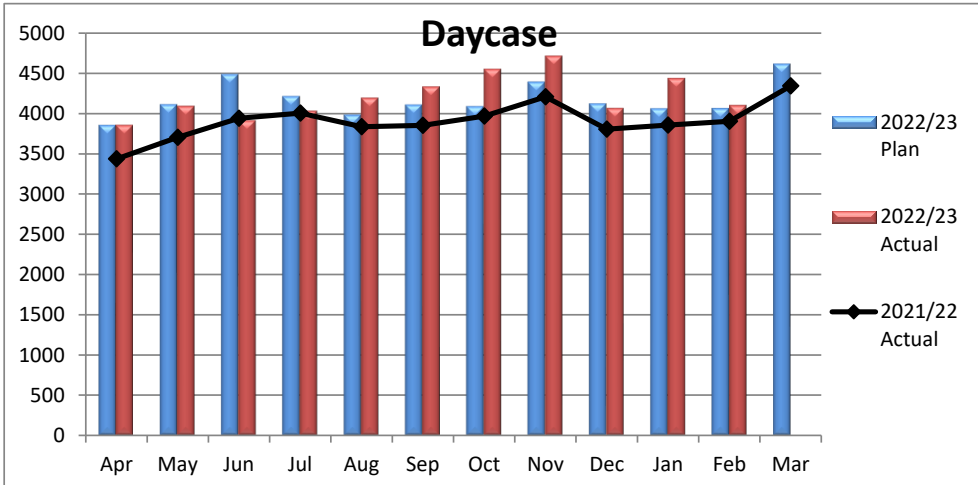
- The Trust achieved 99.7% of its Elective Recovery plan to date that is inclusive of Planned Inpatient and Outpatient First Attendance activity.
- The plan is to achieve 104% of 19/20 activity levels by the end of the year for both planned inpatient (elective and daycase) and outpatient first attendances. Across planned inpatient this is currently at 104.1% of 2019/20 levels and outpatient first activity is at 106.1%.
- The outpatient follow-up target reduction is 25%. The Trust is currently at 111.8% of 19/20 activity.
- The forecast elective recovery position is to achieve 103.6% of 2019/20 levels for planned inpatient and 105.7% of 2019/20 levels for outpatient first attendances.

It should be noted that Elective Recovery Funding is based on the financial value of activity measured against a baseline rather than volume of activity.

### ACTIVITY & CAPACITY (2)

#### CLINICAL ACTIVITY

Activity Trends by Point of Delivery

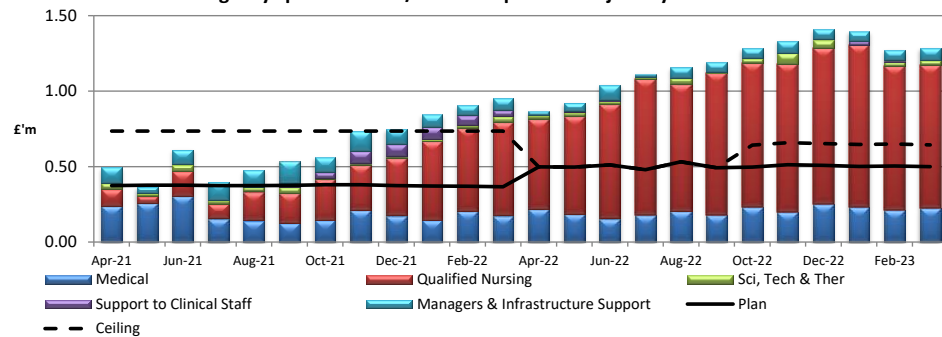


## WORKFORCE

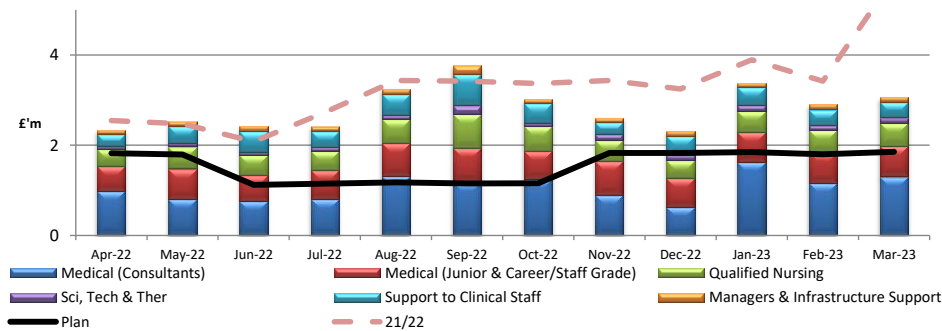
## Vacancies

	Sci, Tech & Ther	Admin & Estates	Medical	Nursing	Support to Clinical	Total
Vacancies (WTE)	75	80	43	163	72	433
Staff in post (WTE)	764	1,539	673	1,741	1,220	5,937
% Vacancies	9%	5%	6%	9%	6%	7%

## Agency spend - Actual/Forecast spend vs Trajectory



## Bank spend - Actual/Forecast spend vs Plan



Cumulative Agency and Bank Spend	Plan	Actual	Var		NHSI Ceiling	Var from Ceiling
	£'m	£'m	£'m		£'m	£'m
Agency Year to Date	(£5.53)	(£13.00)	(£7.47)	●	(£6.26)	(£6.75) ●
Agency Forecast	(£6.03)	(£14.29)	(£8.26)	●	(£6.90)	(£7.39) ●
Bank Year to Date	(£16.68)	(£30.98)	(£14.30)	●		
Bank Forecast	(£18.54)	(£34.05)	(£15.51)	●		

## Vacancies

- Total vacancies: 433 or 7% of baseline establishment, a reduction of 51 WTE compared to Month 10.
- The vacancies include additional capacity linked to Recovery and ongoing Covid-19 costs have been non-recurrently funded in budgets this year resulting in an increase to Establishment - in many cases these will be filled using temporary staffing due to the temporary nature of the staffing requirement.
- Total Staff in Post has increased since Month 11 by 40 to 5,937
- Medical vacancies are static at 6%.
- Nursing vacancies have reduced to 9%.

## Agency Expenditure

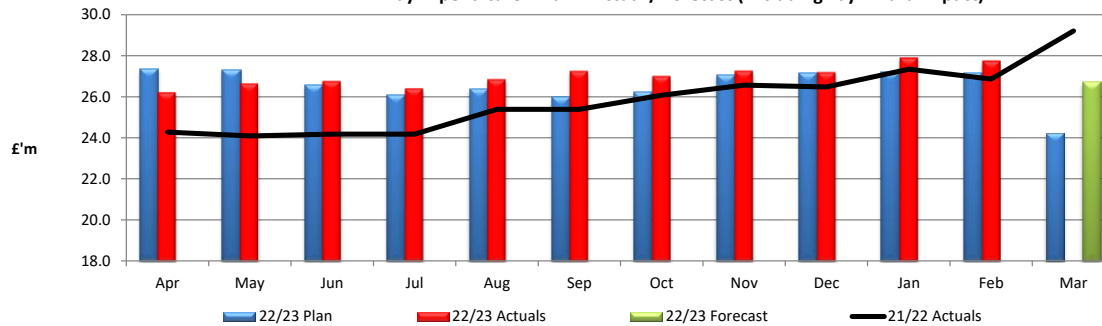
- Agency expenditure year to date is £13.00m; £7.47m higher than planned and above the annual ceiling for the full year.
- The Agency Ceiling for the Trust has been set at £6.90m for the year, slightly higher than the planned level of £6.03m for the year. This represents a 10% reduction compare to 21/22 levels in line with recently revised guidance. As with many targets this year, the ceiling has been set at Integrated Care Board (ICB) level and there is a collective responsibility to achieve the target across the System.
- Higher than planned agency costs due to additional capacity requirements, vacancies and higher than planned levels of staff sickness (Covid-19 and other).
- The use of Agency Healthcare Support Workers has largely been eliminated since April 22 with the exception of some specific ICB funded shifts for 1:1's in Paediatrics.
- Higher Nursing Agency costs are due to an increase in the average hourly rate, due to increasing use of Tier 3 Agencies, as well as an increase in volume required.
- An action plan is now underway to reduce visibility of shifts for Tier 3 agencies with the aim of reducing the cost impact.

## Bank usage

- Expenditure on Bank staff year to date is £30.98m, £14.40m higher than planned.
- The overspend is linked to operational pressures, vacancies and unavailability of staff, and the 50% enhanced pay rates for bank staff that were in place between August and early November, (£1.95m impact), c. £0.70m a month.
- A new more targeted scheme started in November incurring a lower monthly cost of c.£0.30m per month.

## EXPENDITURE - PAY

Pay Expenditure - Plan v Actual / Forecast (Excluding Pay Award Impact)



## Pay Expenditure

- Pay costs were £8.83m higher than the planned level year to date, primarily driven by the higher than planned pay award, for which arrears were paid in Month 6. The change to National Insurance rates that commenced in November, partially offsets this cost. The additional expenditure is funded through an increase in Clinical Contract income, although indications are that there will be a net funding gap of around £0.60m for the year, (across both the Pay Award and NI adjustments). Excluding the impact of the pay award, the underlying pay position is a year to date adverse variance of £2.37m.
- In Month 11, underlying pay costs were higher than planned, with an adverse variance (excluding pay award) of £0.55m. Pay pressures linked to additional bed capacity continued in February, with much higher than planned Bank and Agency costs, offset to some extent by vacancies.
- The Trust continued to experience operational pressures, with higher than planned Covid-19 cases and DTOC levels. The number of additional capacity beds open was slightly lower than the peak seen across December and January. Additional bed capacity funding has been secured to support a proportion of this pressure, but based on the current expenditure rate this is currently insufficient.
- In the year to date position the cost of additional capacity and higher than planned Agency and Bank premium rates have been largely offset by a combination of vacancies in FSS and Community Divisions and lower than planned Elective Recovery costs. Elective Recovery costs are slightly lower than expected year to date and a higher proportion of these costs have been incurred through insourcing and outsourcing arrangements (non pay), rather than through pay expenditure.

Pay Expenditure including Agency

	M11 YTD Budget	M11 YTD Actual						M11 YTD Variance	Impact of higher than planned Pay Award	M11 YTD Variance Excl. Pay Award	
		Total Actual	Substantive Pay	Agency	Bank	Medical Bank / WLI	Overtime / Cost per Case				Additional Basic Pay / Extra Sessions
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m		
<b>Medical &amp; Dental</b>											
Consultants	50.70	48.56	35.56	1.04		11.45	0.41	0.11	-2.14	0.86	-3.00
Career/Staff Grades	12.60	12.42	9.70	0.53		2.06	0.07	0.06	-0.18	0.15	-0.33
Trainee Grades	19.40	26.18	20.24	0.67		5.22	0.01	0.05	6.79	-0.06	6.85
<b>Non Medical - Clinical Staff</b>	0.00	0.00							0.00		0.00
Qualified nursing, midwifery and health visiting staff	85.46	89.97	74.21	9.70	5.39		0.36	0.32	4.51	2.05	2.46
Sci Tech & Ther	38.00	36.01	33.95	0.31	1.15		0.36	0.24	-2.00	0.52	-2.52
Support to Nursing staff	26.21	28.60	23.85	0.06	4.49		0.11	0.09	2.39	1.12	1.28
Support to Other Clinical Staff	11.42	10.06	9.90				0.11	0.05	-1.36	0.34	-1.69
Support to AHP Staff	7.88	7.53	7.39				0.04	0.09	-0.35	0.29	-0.64
<b>Non Medical - Non Clinical</b>	0.00	0.00							0.00		0.00
NHS infrastructure support	41.97	43.84	41.46	0.70	1.23		0.16	0.29	1.87	1.21	0.66
Any Other Spend	-3.40	0.23	0.23						3.64	-0.02	3.65
Pay Reserves	4.34	0.00							-4.34		-4.34
<b>TRUST TOTAL</b>	<b>294.57</b>	<b>303.40</b>	<b>256.49</b>	<b>13.00</b>	<b>12.26</b>	<b>18.72</b>	<b>1.63</b>	<b>1.29</b>	<b>8.83</b>	<b>6.46</b>	<b>2.37</b>

## Nursing Pay Expenditure

- Nursing pay expenditure shows a £3.73m adverse variance year to date (excluding pay award) compared to the planned level.
- Nursing budgets have been impacted by operational pressures due to additional capacity requirements including: Ward 11 operating as a medical ward in April (Surgical Division), Discharge Lounge (Corporate), Acute Floor and Respiratory additional beds, Wards 4d, 6ab and 20, ongoing enhanced segregation models in the Emergency Department (Medical Division) and the occasional use of both the Birth centre and Ambulatory. February saw some retraction from maximum surge capacity, but bed requirements continued to be above funded levels.
- This has been offset to some extent by vacancies in FSS (particularly mid-wife vacancies) and in Community.
- Qualified Nursing Agency costs did reduce slightly in month, totalling £0.96m in February, but remain well above last year's average of £0.32m per month.
- The impact of the 50% Enhanced Bank rates was relatively low, having moved to a targeted model since the 6th of November, and costing c. £0.02m in Month 11.

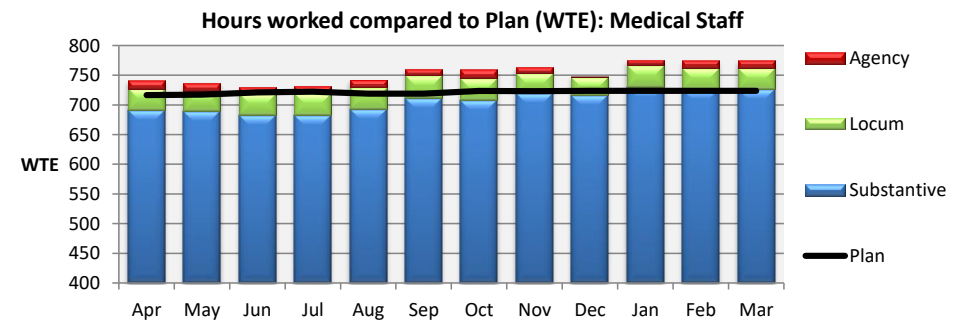
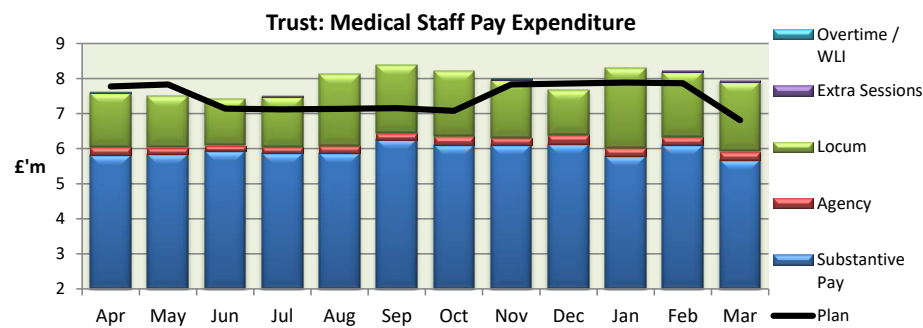
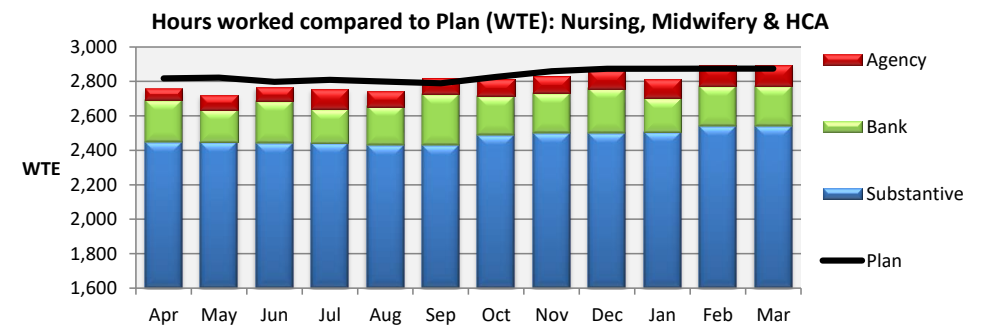
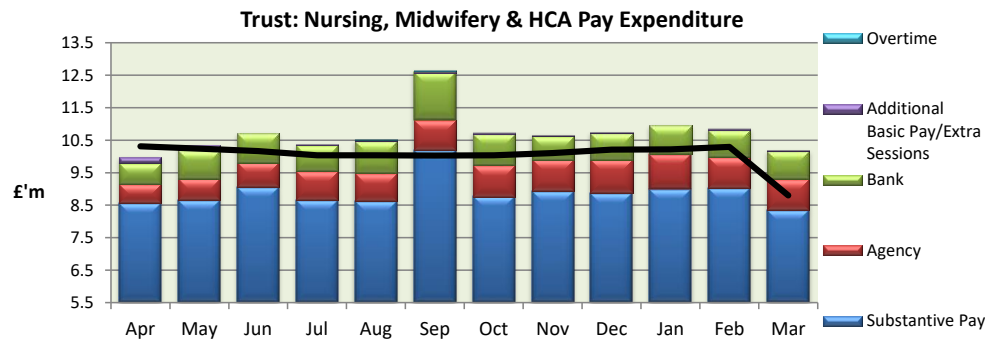
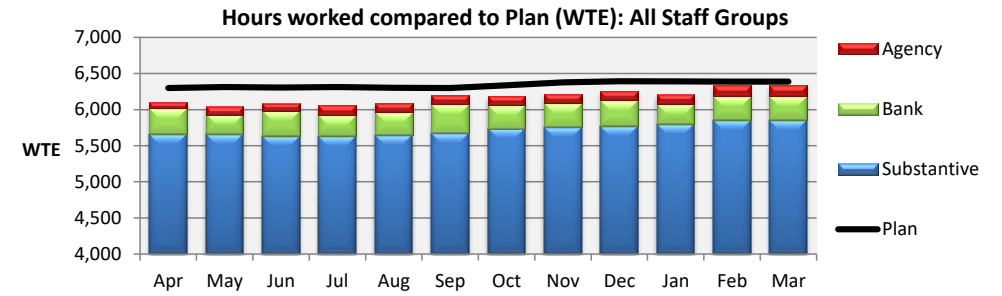
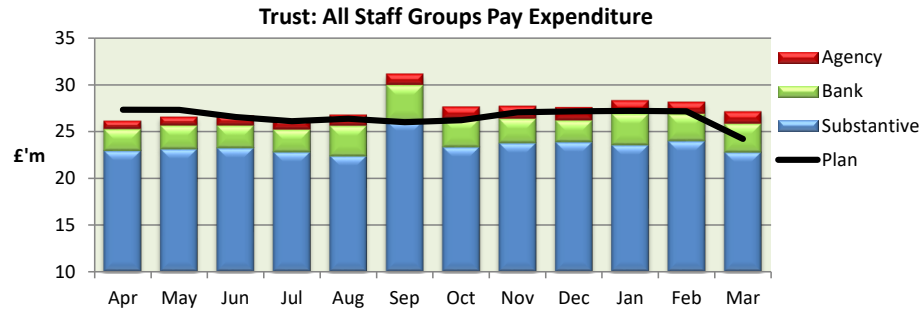
## Medical Pay Expenditure

- Medical pay expenditure shows an adverse variance of £3.52m. (excluding pay award).
- The new medical bank rate is impacting this staff group with an additional monthly cost of c £0.30m per month, although this is a reduction in cost compared to the previous 50% enhanced rate offer.
- The adverse variance shown on Trainee Grades is in part driven by an increase in hosted GP trainees, £2.15m year to date. The cost of which will be offset by additional training income.
- Lower than planned Recovery costs in the first half of the year have been increasingly offset by the impact of additional capacity requirements and Emergency Department pressures.

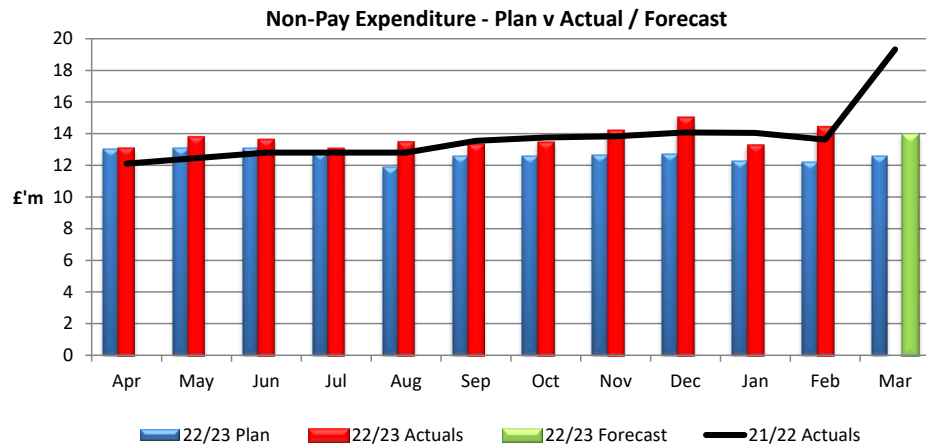
### EXPENDITURE - PAY

#### Actual & Forecast Pay Expenditure

#### Actual & Forecast Staffing WTE



## EXPENDITURE - NON PAY



- Non-pay operating expenditure year to date is £11.39m higher than planned year to date.

**Drug costs**

- Expenditure on drugs is £0.34m below the planned level year to date.
- Includes £0.71m higher than planned expenditure on High Cost Drugs.
- The underlying underspend is driven by lower than planned expenditure of £1.57m within the Pharmacy Manufacturing Unit, (offset by lower than planned commercial income), offset to some extent by inflationary pressures in operational areas.

**Clinical Support**

- Expenditure is £0.14m below the planned level year to date.
- An adverse variance of £3.40m due to inflationary pressures on clinical supplies and additional consumables costs due to unplanned additional non-elective capacity.
- Offset by an underspend of £3.54m on Covid-19 Testing costs due to the transition of the majority of testing costs to a National procurement mechanism. These costs were funded as 'Outside of Envelope' Covid-19 costs and the reduction is also reflected in lower than planned income.

**Other Costs**

- Expenditure is £11.87m above the planned level year to date.
- Expenditure on insourcing and outsourcing (largely for Elective Recovery) is £2.65m higher than planned, but is offset by lower than planned pay related Recovery costs.
- £2.89m of the overspend is linked to VAT cost recovery which is offset to some extent by underspends in other cost categories.
- The Trust is also seeing a cost pressure on the cost of premises of £4.38m as a result of inflationary uplifts, including utilities and pressure on the PFI contract, (planned at 7.5% but March RPI was higher at 9%).

**Non-operating Items**

- Non-operating expenditure is £0.83m lower than planned year to date, due to a favourable variance on PDC Dividend and higher than planned income from interest due to the increase in interest rates.

	M11 Plan £m	M11 Actual £m	Var £m	
Drug Costs	(£41.92)	(£41.57)	£0.34	●
Clinical Support	(£31.24)	(£31.10)	£0.14	●
Other Costs*	(£52.74)	(£64.34)	(£11.60)	●
PFI Costs	(£13.11)	(£13.39)	(£0.27)	●
<b>Total Operating Expenditure</b>	<b>(£139.01)</b>	<b>(£150.40)</b>	<b>(£11.39)</b>	●
Non Operating Expenditure*	(£29.56)	(£28.73)	£0.83	●
<b>Total Non Operating Expenditure</b>	<b>(£29.56)</b>	<b>(£28.73)</b>	<b>£0.83</b>	●
<b>Total Expenditure</b>	<b>(£168.57)</b>	<b>(£179.13)</b>	<b>(£10.57)</b>	●

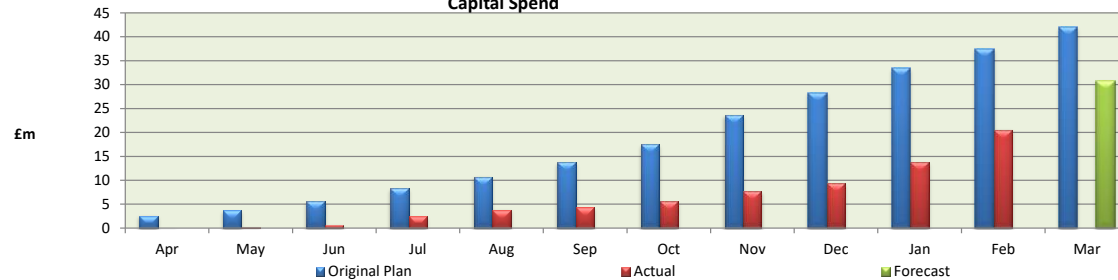
\*Excluding donated asset depreciation, donated consumables and impairments

## CAPITAL

## CAPITAL - TOTAL

	M11 Plan £m	M11 Actual £m	Var £m	M11
Capital	£37.49	£20.59	£16.90	●

## Capital Spend



- The Trust's 22/23 Capital plan as agreed with the ICS is £41.99m, this includes £2.92m in relation to leases, which due to the adoption of IFRS 16 are now treated as Capital expenditure, these sit outside of the ICS Capital plan.

- The Trust total Capital expenditure YTD is £20.59m vs plan of £37.49m.

## Variances:

- Capital expenditure was underspent by £14.05m in Month 11 with lower than expected expenditure on Reconfiguration, IT and Equipment.
- Lease expenditure was underspent by £2.75m in Month 11 with lower than expected expenditure on leases, due to new leases not being entered into as planned.

The overall Capital forecast is now forecast to be below plan, due to a reduction in planned expenditure in 22/23 on Reconfiguration, offset to some extent by: the capital expenditure funded through Charitable Funds, forecast to be greater than planned; £162k of approved PDC funding support in relation to Endoscopy for Equipment and a Training Simulator; £1.66m approved Diagnostics Digital Capability; £100k Front Line digitisation funding; £100k Community Diagnostics Centre and £50k for Waiting list validation support. The lease forecast has been revised at Month 10, due to new leases not being expected to be entered into as planned by 31st March 23.

## CAPITAL - BY SCHEME

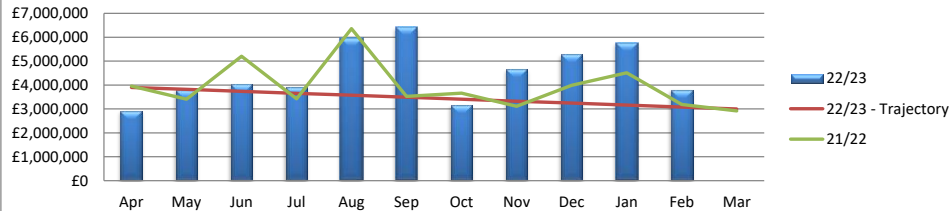
	Year To Date			Forecast		
	M11 Plan £m	M11 Actual £m	Var £m	Plan £m	Forecast £m	Var £m
<b>Internally Funded - Capital</b>						
IT	£1.46	£0.99	£0.46	£1.46	£1.71	(£0.26)
Built Environment	£1.49	£2.87	(£1.38)	£1.49	£3.07	(£1.58)
Equipment	£4.22	£1.17	£3.06	£4.60	£4.14	£0.47
Car Park	£0.85	£0.27	£0.57	£1.00	£0.30	£0.70
Contingency	£6.26	£3.07	£3.19	£7.67	£7.08	£0.60
<b>Total - Internally Funded Capital</b>	<b>£14.27</b>	<b>£8.37</b>	<b>£5.90</b>	<b>£16.22</b>	<b>£16.29</b>	<b>(£0.07)</b>
<b>Externally Funded - Capital</b>						
Reconfiguration Business case	£19.47	£9.75	£9.73	£21.84	£10.90	£10.94
Scan4Safety	£0.75	£0.64	£0.11	£0.87	£0.87	£0.00
Critical cybersecurity infrastructure risks	£0.00	£0.00	£0.00	£0.06	£0.06	£0.00
Endoscopy - Equipment and Simulator	£0.00	£0.06	(£0.06)	£0.00	£0.16	(£0.16)
Diagnostics Digital Capability	£0.00	£1.21	(£1.21)	£0.00	£1.66	(£1.66)
EPR digital noticeboards	£0.00	£0.10	(£0.10)	£0.00	£0.10	(£0.10)
Community Diagnostics Centres	£0.00	£0.10	(£0.10)	£0.00	£0.10	(£0.10)
Waiting List Validation - support	£0.00	£0.00	£0.00	£0.00	£0.05	(£0.05)
Donated Assets	£0.08	£0.30	(£0.22)	£0.09	£0.50	(£0.42)
<b>Total Externally Funded - Capital</b>	<b>£20.30</b>	<b>£12.16</b>	<b>£8.15</b>	<b>£22.86</b>	<b>£14.40</b>	<b>£8.45</b>
<b>Leases</b>	<b>£2.92</b>	<b>£0.16</b>	<b>£2.75</b>	<b>£2.92</b>	<b>£0.16</b>	<b>£2.75</b>
<b>Total Capital</b>	<b>£37.49</b>	<b>£20.69</b>	<b>£16.80</b>	<b>£41.99</b>	<b>£30.86</b>	<b>£11.13</b>



## CASH

## AGED DEBT

## Total Outstanding Invoices over 30 days



Data shown above is as at 31st March 22

## CASH FLOW

Cash flow variance from plan		Variance £m
Operating activities	Surplus /(Deficit) including impairments	(3.47)
	Non cash flows in operating deficit	(0.96)
	Other working capital movements	1.79
<b>Sub Total</b>		<b>(2.64)</b>
Investing activities	Capital expenditure	14.46
	Movement in capital creditors / Other	(1.52)
<b>Sub Total</b>		<b>12.94</b>
Financing activities	Net drawdown of external DoH cash support	0.00
	Other financing activities	(3.93)
<b>Sub Total</b>		<b>(3.93)</b>
<b>Grand Total</b>		<b>6.37</b>

## KEY METRICS

## RECEIVABLES:

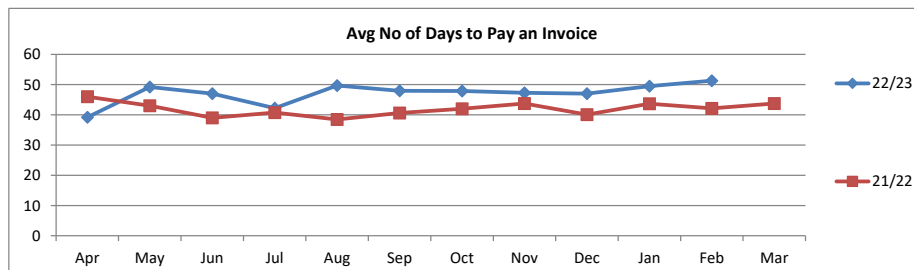
As at Month 11 22/23 aged Debt was as follows

Days	30-60	61-90	91-120	121-180	180-360	360+	Total
HPS	33,096	78,316	71,171	834,576	88,351	78,808	1,184,318
THIS	414,978	9,231	55,157	46,558	74,484	50,724	651,131
Other	247,000	190,880	213,571	104,051	228,684	985,926	1,970,112
£ Value	695,073	278,427	339,899	985,185	391,519	1,115,458	3,805,562
No Invoices	184	146	162	265	477	1,653	2,887

Bad Debt Provision: £1.540k

## PAYABLES:

For Invoices paid in February the average numbers of days taken to pay was 51 days ( 49 days January 2023)



Data shown above is as at 25th October 22

- At the end of February 2023 the Trust had a cash balance of £44.20m, £6.37m higher than planned.

## Operating activities

- Operating activities - adverse variance of £2.64m against the plan.
  - Deficit position, a £3.47m adverse variance from plan (excluding impact of donated assets).
  - £0.96m adverse variance on non-cash items (PDC and Interest receivable).
  - £1.79m favourable working capital variance. Deferred income was £6.38m higher than planned and payables were £2.21m higher than planned. These favourable variances were offset by higher than planned receivables of £4.44m, higher than planned inventories of £0.96m and higher than planned prepayments of £1.40m.

## Investing activities (Capital)

- Capital expenditure was £14.46m lower than planned (excluding planned donated assets and leases)
- Capital creditors are £2.12m lower than planned.
- £0.61m favourable variance on Interest Receivable.

## Financing activities

- includes lower than planned PDC of £4.08m due to delays in delivering the Capital programme, (timing difference).

## Aged Debt

Aged Debt is £3.80m, £1.97m lower than in Month 10, but remains above the trajectory to meet this year's target level of £3m. Debt over 30 days relating to HPS, the Pharmacy Manufacturing Unit (HPS), has reduced by £0.07m, and the debt relating to the Health Informatics Service has reduced significantly by £1.07m this month. Outside of these Divisions, debt has reduced overall by £0.83m, with no individual supplier owing more than £0.16m.  
Note: HPS (Huddersfield Pharmacy Specials), THIS (The Health Informatics Service)

## Borrowing

The Trust is not been required to borrow so far during this financial year due to changes in the cash regime and System Top Up payments / Elective Recovery funding.

## Better Payment Practice Code

Performance was 90.3% in month, below the target level of 95% of invoices paid within 30 days, and a slight worsening compared to Month 10.

## Use of Resource Metric

### Capital Service Cover

	Plan YTD	Actual YTD
Revenue Available for Capital Service	11.11	7.56
Capital Service	20.28	20.08
<b>Capital Service Cover metric</b>	0.55	0.38
<b>Capital Service Cover rating</b>	<b>4</b>	<b>4</b>

### Liquidity

Working Capital balance	(47.07)	(40.33)
Operating Expenses within EBITDA, Total	(433.57)	(453.80)
<b>Liquidity metric</b>	<b>(35.83)</b>	<b>(29.33)</b>
<b>Liquidity rating</b>	<b>4</b>	<b>4</b>

### I&E Margin

Surplus/(Deficit) adjusted for donations and asset disposals	(18.47)	(22.07)
Total Operating Income for EBITDA	444.66	460.46
<b>I&amp;E Margin</b>	<b>(4.15%)</b>	<b>(4.79%)</b>
<b>I&amp;E Margin rating</b>	<b>4</b>	<b>4</b>

### I&E Margin Variance From Plan

<b>I&amp;E Margin</b>	<b>(4.15%)</b>	<b>(4.79%)</b>
<b>I&amp;E Margin Variance From Plan</b>	<b>0.00%</b>	<b>(0.64%)</b>
<b>I&amp;E Margin Variance From Plan rating</b>	<b>1</b>	<b>2</b>

### Agency

<b>Agency staff, total</b>	<b>(6.26)</b>	<b>(13.00)</b>
<b>Agency Ceiling</b>	<b>(6.26)</b>	<b>(6.26)</b>
<b>Agency rating</b>	<b>1</b>	<b>4</b>

### Overall Use of Resource score

<b>Plan YTD</b>	<b>3.00</b>	<b>4.00</b>
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### Compliance regime - Single Oversight Framework

The Single Oversight Framework (SOF) considers 5 themes: Quality of Care; Finance and Use of Resources; Operational performance; Strategic change; Leadership and improvement capability.

The Finance element of this system is the Use of Resources score and the constituent parts of this measure are described below. A score of 1 is the most favourable and 4 the least favourable. The UOR score for the Trust stands at a level 4.

- **Liquidity:** days of operating costs held in cash or cash-equivalent forms (cash in the bank less payables plus receivables, on the presumption these can be immediately converted into cash)
- **Capital servicing capacity:** the degree to which the organisation's generated income covers its financing obligations (a measure of the Trust's ability to afford its debt - in this sense payments against debts include PDC payments, interest and loan repayments and PFI interest, PFI contingent rent and PFI capital repayments.)
- **Income and expenditure (I&E) margin:** the degree to which the organisation is operating at a surplus/deficit (measured on a Control Total basis which excludes impairments and donated assets)
- **Variance from plan in relation to I&E margin:** variance between a trust's plan and its actual I&E margin within the year, (excludes impairments and donated assets)
- **Agency:** measurement of actual agency usage against the agency ceiling set by NHSI at the planning stage. A distance from target of greater than 50% results in the lowest rating of 4 against this metric.

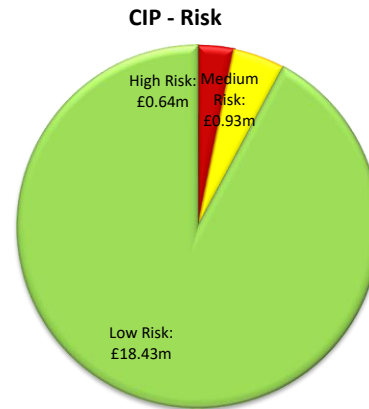
### Trust Performance

The Trust's year to date performance on the overall UOR and the individual metrics is shown. On a weighted average basis the overall UOR stands at level 4, based upon the average of the scores against the metrics above rounded to the nearest whole number and calculated as follows:  $4 + 4 + 4 + 2 + 4 = 18 / 5 = 4.0$ .

If any one metric is scored at a level 4, the maximum overall performance is capped at level 3.

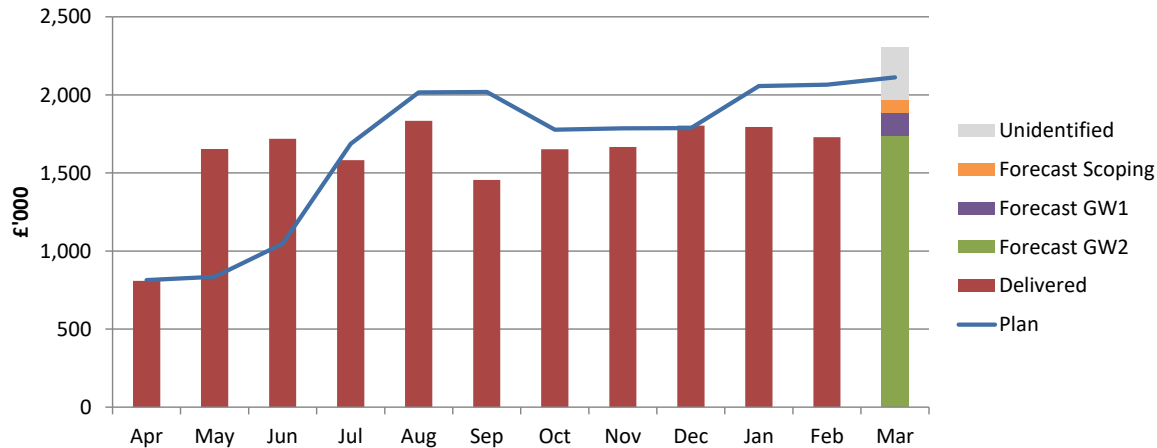
## COST IMPROVEMENT PROGRAMME

22/23 CIP						
Division	Plan <sup>1</sup>	Forecast				
	Total £'m	Rec £'m	Non Rec £'m	Total £'m	FYE £'m	WTE
Corporate Services	2.25	0.56	1.62	2.18	0.78	22.70
Health Informatics	0.40	0.40	0.10	0.50	0.40	0.00
Medicine	3.24	0.79	2.57	3.36	0.83	0.00
PMU	0.00	0.00	0.00	0.00	0.00	0.00
Surgery & Anaesthetics	1.63	0.67	1.25	1.92	1.21	0.00
Families & Specialist Services	0.86	0.02	1.28	1.31	0.53	4.04
Community	0.26	0.04	0.39	0.43	0.04	2.00
CHS Ltd	0.89	0.56	0.04	0.60	0.58	0.00
Technical Accounting	2.02	0.00	2.51	2.51	0.00	0.00
Central Income & Trust Reserves	8.45	1.33	5.86	7.19	1.38	4.00
<b>Grand Total</b>	<b>20.00</b>	<b>4.38</b>	<b>15.62</b>	<b>20.00</b>	<b>5.75</b>	<b>32.74</b>



- The Trust is planning to deliver £20m a challenging level of efficiency savings in 22/23.
- Turnround Executive (TE), an Executive led group with responsibility for financial sustainability and the delivery of efficiencies, provides the oversight and leadership to deliver this plan.
- At the end of February 23, £19.66m of efficiency has been identified and is forecast to deliver.
- Year to date the Trust has delivered £17.70m of efficiencies, £0.19m lower than planned.
- Of the schemes identified, only £4.38m of recurrent savings are expected to be delivered, with a full year effect to carry into 23/24 of £5.75m. Whilst this is of concern, because non-recurrent savings do not reduce the Trust's underlying deficit position, the level of non-recurrent expenditure in the financial plan is also very high, and in many cases it is this non-recurrent spend (including Covid-19 and Recovery costs) that is being targeted for efficiency.
- Change Control Notices for two schemes that were not delivering as expected were received and accepted by TE in February. This has increased the efficiency gap to £0.34m and work is underway to close this remaining gap by the end of the financial year. The current likely case remains that the full £20m of efficiency will be identified and delivered.

## CIP Profile by Month



Note: Planned CIP, is shown as a blue line on the graph to the left and reflects the plan submitted to NHSI in April. Bars show the current forecast for future months. Schemes not yet at GW2 also represent a risk to delivery.

CIP 22/23	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
<b>Plan (£'000)</b>	814	835	1,047	1,686	2,016	2,019	1,777	1,786	1,787	2,056	2,065	2,112	<b>20,000</b>
Delivered	809	1,654	1,718	1,582	1,834	1,456	1,651	1,666	1,803	1,794	1,729	-	<b>17,695</b>
Forecast GW2	-	-	-	-	-	-	-	-	-	-	-	1,739	<b>1,739</b>
Forecast GW1	-	-	-	-	-	-	-	-	-	-	-	148	<b>148</b>
Forecast Scoping	-	-	-	-	-	-	-	-	-	-	-	80	<b>80</b>
Unidentified	-	-	-	-	-	-	-	-	-	-	-	338	<b>338</b>
<b>Total Actual / Forecast</b>	<b>809</b>	<b>1,654</b>	<b>1,718</b>	<b>1,582</b>	<b>1,834</b>	<b>1,456</b>	<b>1,651</b>	<b>1,666</b>	<b>1,803</b>	<b>1,794</b>	<b>1,729</b>	<b>2,305</b>	<b>20,000</b>

## PLACE / INTEGRATED CARE SYSTEM (ICS) - INCOME &amp; EXPENDITURE POSITION

## YEAR TO DATE

Integrated Care System (ICS) Organisation	YTD FEB 2023			
	Plan £m	Surplus / (Deficit) £m	Expected allocn adj £'m	Reported Variance £m
WY ICB - Bradford	(1.9)	0.7	(2.5)	0.0
WY ICB - Calderdale	0.5	0.9	(0.4)	0.0
WY ICB - Kirklees	1.5	1.0	0.5	0.0
WY ICB - Leeds	(5.1)	(8.7)	3.6	0.0
WY ICB - Wakefield	(0.4)	(0.5)	0.1	0.0
WY ICB - West Yorkshire	4.0	4.0	(0.0)	(0.0)
<b>WY ICB Total</b>	<b>(1.3)</b>	<b>(2.5)</b>	<b>1.2</b>	<b>0.0</b>
Airedale NHS Foundation Trust	0.0	(1.7)		(1.7)
Bradford District Care NHS Foundation Trust	0.1	0.1		0.0
Bradford Teaching Hospitals NHS Foundation Trust	0.0	0.0		0.0
Calderdale And Huddersfield NHS Foundation Trust	(18.5)	(22.1)		(3.6)
Leeds and York Partnership NHS Foundation Trust	1.0	1.2		0.2
Leeds Community Healthcare NHS Trust	1.0	1.2		0.2
Leeds Teaching Hospitals NHS Trust	2.5	1.1		(1.4)
Mid Yorkshire Hospitals NHS Trust	0.0	0.0		0.0
South West Yorkshire Partnership NHS Foundation Trust	3.1	3.7		0.7
Yorkshire Ambulance Service NHS Trust	0.0	0.0		0.0
<b>Providers Total</b>	<b>(10.8)</b>	<b>(16.5)</b>	<b>0.0</b>	<b>(5.7)</b>
<b>West Yorkshire ICS Total</b>	<b>(12.1)</b>	<b>(19.0)</b>	<b>1.2</b>	<b>(5.7)</b>

Kirklees & Calderdale Place Organisation	YTD FEB 2023		
	Plan £m	Surplus / (Deficit) £m	Variance £m
Calderdale And Huddersfield NHS Foundation Trust	(18.5)	(22.1)	(3.6)
Mid Yorkshire Hospitals NHS Trust (30%)	0.0	0.0	0.0
WY ICB - Kirklees	1.5	1.5	0.0
WY ICB - Calderdale	0.5	0.5	0.0
South West Yorkshire Partnership NHS Foundation Trust (60%)	1.8	2.2	0.4
<b>Total Kirklees and Calderdale Place</b>	<b>(14.7)</b>	<b>(17.9)</b>	<b>(3.2)</b>

## FORECAST

Plan £m	Surplus / (Deficit) £m	Expected allocn adj £'m	Variance £m
2.9	2.3	0.6	0.0
(0.2)	(0.2)	0.0	0.0
(1.7)	(2.7)	1.0	0.0
6.4	4.6	1.8	0.0
0.5	0.3	0.2	0.0
(3.5)	(3.5)	(0.0)	0.0
<b>4.4</b>	<b>0.8</b>	<b>3.6</b>	<b>0.0</b>
0.0	0.0		0.0
0.0	0.0		0.0
0.0	0.0		0.0
(17.4)	(17.3)		0.0
1.1	1.1		0.0
1.0	1.0		0.0
7.6	7.6		0.0
0.0	0.0		0.0
3.2	3.2		0.0
0.0	0.0		0.0
<b>(4.4)</b>	<b>(4.4)</b>	<b>0.0</b>	<b>0.0</b>
<b>(0.0)</b>	<b>(3.6)</b>	<b>3.6</b>	<b>0.0</b>

Plan £m	Surplus / (Deficit) £m	Expected allocn adj £'m	Variance £m
(17.4)	(17.3)		0.0
0.0	0.0		0.0
(1.7)	(2.7)	1.0	0.0
(0.2)	(0.2)	0.0	0.0
1.9	1.9		0.0
<b>(17.4)</b>	<b>(18.3)</b>	<b>1.0</b>	<b>0.0</b>

- A summary of the West Yorkshire ICS position combined at Month 11 is shown.
- Adjustments have been made to ICB allocations to rephase the Quarter 1 underspend (CCG). £1.2m overspend rephased into Month 11.
- The ICB forecast assumes allocations of £3.6m of Discharge Funding will be received. This will bring the ICB forecast to a £4.4m surplus, offsetting the £4.4m forecast Provider deficit.
- Against the 22/23 ICS agency ceiling of £99.3m, the ICS is forecasting is to spend £119.3m, £20.0m more than planned.

### FORECAST POSITION 22/23

#### 22/23 Forecast (31 Mar 23)

#### Statement of Comprehensive Income

	Plan <sup>2</sup> £m	Forecast £m	Var £m	
Income	£485.35	£507.35	£22.01	●
Pay expenditure	(£318.79)	(£330.56)	(£11.77)	●
Non Pay Expenditure	(£151.58)	(£164.29)	(£12.72)	●
Non Operating Costs	(£32.68)	(£30.05)	£2.63	●
<b>Total Trust Surplus / (Deficit)</b>	<b>(£17.69)</b>	<b>(£17.55)</b>	<b>£0.15</b>	●
Deduct impact of:				
Impairments (AME) <sup>1</sup>	£0.00	(£0.00)	(£0.00)	
Donated Asset depreciation	£0.43	£0.53	£0.11	
Donated Asset income (including Covid equipment)	(£0.08)	(£0.33)	(£0.25)	
Net impact of donated consumables (PPE etc)	£0.00	£0.00	£0.00	
Gain on Disposal	£0.00	£0.00	£0.00	
<b>Adjusted Financial Performance</b>	<b>(£17.35)</b>	<b>(£17.34)</b>	<b>£0.00</b>	●

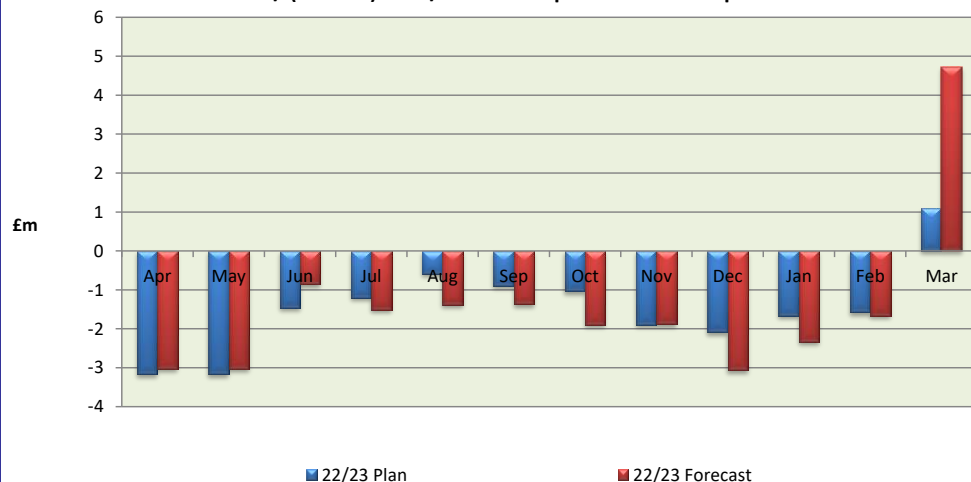
Notes:

1. AME - Annually Managed Expenditure - spend that is unpredictable and not easily controlled by departments

- The Trust is forecasting to deliver the revised plan of a £17.35m deficit.
- Whilst forecasting to deliver this planned deficit, the underlying position would drive a significantly bigger deficit. Additional capacity requirements remained high in February and continue to be above the planned level due to higher than planned Emergency attendances, Covid-19 & Flu activity, Delayed Transfers of Care and other operational pressures. This continues to drive additional costs, particularly in relation to bank and agency expenditure.
- The additional funding for inflation was required to flow in full to improve the Trust overall financial position and assumed that plans included sufficient funding to cover any pressures. The increase in RPI since March 22 is driving additional inflationary pressures over and above the planned level, particular in relation to Energy costs and the PFI contract. It is also impacting on the ability to achieve planned procurement savings.
- The forecast assumes full delivery of a challenging £20m efficiency target. Some slippage in month 11 has left a gap of £0.34m for which full mitigation is yet to be identified. The expectation is that closing the remaining gap is feasible and full delivery of the target is expected.
- The Pharmacy Manufacturing Unit has not delivered the planned surplus in the year to date and is forecasting an adverse forecast variance of £0.84m by year end, although this is an improved position compared to last month's forecast.
- Vacancies have driven underspends in Community and FSS Divisions in the year to date, mitigating the operational pressures described above to some extent.
- Indications are that the forecast £11.73m of Elective Recovery Funding is secure, although formal confirmation from NHS England that funds will not be reallocated has not yet been received.
- A significant amount of non recurrent mitigation has been identified to offset the Divisional pressures described above through a combination of additional non recurrent funding, technical flexibilities and system support, and the current 'likely case' forecast as reported to the Integrated Care Board is delivery of the planned financial position.

#### MONTHLY SURPLUS / (DEFICIT)

SURPLUS / (DEFICIT) 2022/23 - excl. impairments and impact of Donated Assets



#### Risks and Potential Benefits

- There is a risk that the Junior Doctors Strike will adversely impact on the Month 12 financial position due to the requirement to backfill with senior medical staff and the potential knock on impact on the delivery of Elective Recovery.
- The forecast assumes full delivery of the £20m efficiency target, although there is a gap to mitigate and a few schemes that remain high risk.
- The combined impact of the funded pay award and the changes to National Insurance rates is a £0.60m shortfall in funding.
- The forecast assumes that current levels of additional capacity remains open in March. A further retraction of the bed base would lead to a reduction in costs.
- There is a risk that the revised scheme for Bank enhancements proves more expensive than expected or an expansion of the scheme is required due to operational pressures.
- Opportunities to reduce Agency costs are being pursued including a scheme to retract from Tier 3 Nursing Agency rates.
- It is expected that the requirements for the Maternity Incentive Scheme (Clinical Negligence Scheme for Trusts (CNST)), will be met, securing the £0.86m rebate.

**COVID-19 & Recovery**

<b>Covid-19 Expenditure YTD FEB 2023</b>	<b>Pay £'000</b>	<b>Non-Pay £'000</b>	<b>Total £'000</b>
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	863	0	863
Remote management of patients	185	0	185
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	0	73	73
Segregation of patient pathways	11,513	510	12,023
Existing workforce additional shifts	202	0	202
Decontamination	0	6	6
Backfill for higher sickness absence	0	0	0
Remote working for non patient activities	0	0	0
PPE - other associated costs	0	0	0
Sick pay at full pay (all staff types)	0	0	0
Enhanced PTS	0	363	363
COVID-19 virus testing - rt-PCR virus testing	182	85	267
COVID-19 virus testing - Rapid / point of care testing - all other locally procured devices	36	0	36
COVID-19 - Vaccination Programme - Provider/ Hospital hubs	0	0	0
COVID-19 - Vaccination Programme - Vaccine centres	96	0	96
NIHR SIREN testing - antibody testing only	16	3	20
<b>Total Reported to NHSI</b>	<b>13,095</b>	<b>1,041</b>	<b>14,136</b>
COVID-19 - Vaccination Programme - Vaccine centres (Locally Funded)	54	0	54
COVID-19 - Vaccination Programme - Provider/ Hospital hubs (Locally funded)	84	0	84
PPE - locally procured	0	-16	-16
Other COVID-19 virus / antibody (serology) testing (not included elsewhere)	552	0	552
Support for stay at home models	0	26	26
Internal and external communication costs	0	-1	-1
<b>Grand Total</b>	<b>13,785</b>	<b>1,051</b>	<b>14,836</b>

<b>Recovery Costs YTD FEB 2023</b>	<b>Pay £'000</b>	<b>Non-Pay £'000</b>	<b>Total £'000</b>
Independent Sector	10	6,307	6,318
Additional Staffing - Medical	2,219	0	2,219
Additional Staffing - Nursing	448	0	448
Additional Staffing - Other	1,083	0	1,083
Non Pay	0	2,068	2,068
Enhanced Payment Model - Medical	0	0	0
Enhanced Payment Model - Nursing	838	0	838
<b>Total</b>	<b>4,599</b>	<b>8,375</b>	<b>12,973</b>

**Covid-19 Costs**

Year to date the Trust has incurred £14.84m of expenditure relating to Covid-19. Excluding Covid-19 costs that were outside of System envelope and for which funding can be claimed retrospectively, the year to date cost is £14.42m versus a plan of £8.25m, an adverse variance of £6.17m. This overspend was driven by higher than planned Covid-19 related activity leading to higher staffing and consumables costs and contributing to the requirement for additional Medical capacity, although it is becoming increasingly difficult to separately identify the impact of Covid-19 from other operational impacts on capacity, (e.g. Flu). Outside of envelope costs are highlighted in the table to the left and total £0.42m year to date.

The Autumn Covid-19 vaccination programme is now complete and funding has been provided on a fixed cost per vaccine basis.

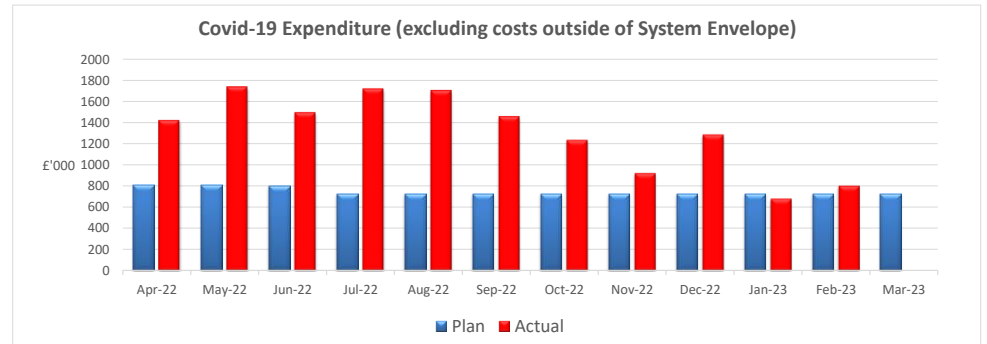
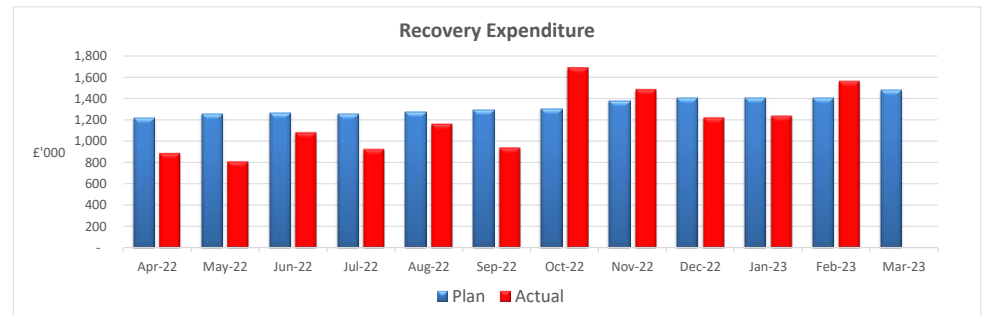
**Covid-19 Funding**

The Trust was allocated block funding by the ICS to cover any ongoing Covid-19 costs and associated impacts totalling £6.00m for the year (£5.50m year to date). A further £1.3m of additional funding has been allocated in Quarter 4 (£0.87m YTD), to support operational pressures.

**Recovery**

- Year to date Recovery costs are £12.97m, £1.52m lower than planned.
- Total planned Recovery costs for the year are £15.97m to deliver the required 104% of 19/20 activity.
- Funding of £11.72m of Elective Recovery Funding (ERF) is forecast, receipt of which should be reliant on the Trust achieving its activity targets as planned. £10.93m of ERF has been assumed in the year to date position as planned, (profiled in line with activity plans). Funding has been secured for H1 and National guidance suggests that ERF is not likely to be clawed back in the second half of the year, although there is a local agreement to return £0.40m of the planned ERF to the Integrated Care Board (ICB) to support Independent Sector overspends in Kirklees Place.

Note: Both Covid-19 and recovery plans assumed that associated CIP schemes would be delivered in full.



**RISKS**

**Financial Risks 22/23**

**Risk description**

**Score**

**Risk of not achieving the Full Year 2022/23 Financial Plan:**  
 The Trust is planning a deficit position of £17.35m for 22/23, (revised June 22). There is a risk that the Trust fails to achieve this plan due to:  
 - a challenging efficiency requirement of £20m, which equates to 4.8% of operating expenditure.  
 - ongoing cost of Covid-19 and the potential for a Winter surge.  
 - Recovery costs in excess of planned levels, or the Trust does not deliver sufficient activity to secure planned Elective Recovery Funding.  
 - Inflationary pressures exceed planned levels.

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**Risk that the Trust will have insufficient funding available to complete its capital programme for 2022/23:**  
 The Trust has planned capital expenditure for 21/22 of £39.08m of which £22.86m are expected to be externally funded through Public Dividend Capital. Internally funded capital plans are £16.22, £5.12m more than available internally generated funds of £11.1m. Cash Reserves of £5.1m will be required to cover the shortfall.

6

**Risk that the Trust will not be able to pay suppliers, staff, and loans due to cash flow timing or an overall shortfall of cash:**  
 resulting in external scrutiny, significant reputational damage and possible inability to function as going concern.

6

**I&E**

Year To Date the Trust is reporting a deficit of £22.07m, a £3.60m adverse variance to plan. The Trust is forecasting to deliver the planned deficit of £17.35m by the year end. Whilst there remains a risk to delivery of this forecast due to the ongoing impact of inflationary pressures, the Pay Award funding shortfall, additional capacity requirements and Bank and Agency staffing pressures, non recurrent mitigations have been identified to offset the majority of these overspends. The I&E risk is assessed to have reduced compared to previous months and the score was reduced from 20 to 16 as agreed at Finance and Performance Committee on the 7th of February.

As at the end of February, £19.66m of efficiencies (£0.34m below the target level) have been identified. Work is underway to close this remaining gap by the end of the financial year and the current likely case remains that the full £20m of efficiency will be identified and delivered.

Additional NHS funding to support inflation allowed an improvement to the planned deficit position of £2.75m, a revised full year deficit of £17.35m. Regardless of this funding, inflationary costs continue to drive an underlying pressure that is higher than the value funded through contract income, in particular in our PFI contract value which is 1.5% higher than planned, but also utilities and other key external contracts. Covid-19 costs remain higher than planned year to date. Covid activity was planned at a low level throughout the year as advised by national guidance and some efficiency plans rely on the Trust's ability to close Covid-19 capacity and exit from some of these costs. Capacity requirements continue to be above the planned level due significant operational pressures including higher than planned Covid-19 and Flu activity, but also Delayed Transfers of Care and a significant increase in Emergency department attendances. This is driving additional costs, particularly in relation to bank and agency expenditure.

Indications are that the forecast £11.73m of Elective Recovery Funding is secure, although formal confirmation from NHS England that funds will not be reallocated has not yet been received.

**Capital**

The Trust submitted a Capital plan to NHSI for 22/23 that was within the agreed ICS Capital envelope and comprised internally funded capital of £16.22m to support key Trust priorities, combined with external Public Dividend Capital totalling £22.86, subject to final approval by the Department of Health prior to the release of funds.

The overall Capital forecast is currently forecast to be below plan by £11.14m, due to a reduction in PDC supported expenditure on Reconfiguration and lower than planned expenditure on new leases, offset to some extent by: the capital expenditure funded through Charitable Funds is forecast to be greater than planned; £0.16m of PDC funding for Endoscopy equipment and a training simulator; £1.66m approved Diagnostic Capability funding; and £0.1m of Front Line digitalisation funding.

**Cash**

The risk of not having sufficient cash is assessed to be moderate. The Trust starts the year with a healthy cash balance and should have sufficient funds this year to support the planned deficit without requiring additional external revenue support. The carried forward cash balance was boosted by a higher than average level of accrued costs which will result in cash payments at some point over the next 12-18 months. Working Capital is expected to reduce by at least £11m over this period.

- The NHS cash regime for 22/23 sees block payments paid mid month in the month to which they relate.
- Covid costs that are outside of the System financial envelope will only be paid once funding is approved, which will be in arrears, but are now minimal.
- Payment has been received in cash terms for planned Elective Recovery Funding and is secure for H1, but the mechanism for any required claw back in H2 remains unclear.
- Funding for the backdated pay award has been received.
- The Trust does not expect to require any revenue support via PDC for this financial year.

**Risk Scoring Matrix**

Impact	5	4	3	2	1	0	Likelihood
>£5m	5	10	15	20	25		>50%
>£1m	4	8	12	16	20		21-50%
>£0.5m	3	6	9	12	15		6-20%
>£0.1m	2	4	6	8	10		1-5%
<£0.1m	1	2	3	4	5		<1%
	0	1	2	3	4	5	Rare
							Unlikely
							Possible
							Likely
							Almost Certain

Score	Risk Level
1-3	Low Risk
4-6	Moderate Risk
8-12	High Risk
15-25	Extreme Risk

# Integrated Performance Report

February 2023



## Key Indicators

	21/22	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	YTD	Performance Range			
<b>SAFE</b>																			Green	Amber	Red
Never Events	2	0	0	0	1	0	1	1	1	0	0	0	0	1	1	0	5	0	>=1		
<b>CARING</b>																			Green	Amber	Red
% Complaints closed within target timeframe	63.61%	70.73%	37.50%	44.44%	29.41%	27.08%	48.98%	28.57%	44.64%	55.32%	45.45%	49.12%	66.67%	78.05%	93.94%	<b>86.96%</b>	<b>54.56%</b>	100%	86% - 99%	<=85%	
Friends & Family Test (IP Survey) - % Positive Responses	96.91%	97.35%	97.10%	97.36%	96.36%	97.57%	97.14%	97.62%	98.23%	98.23%	98.40%	98.00%	97.94%	97.82%	98.50%	<b>in arrears</b>	<b>97.91%</b>	>=90% / >=95% from	September	<=79%	
Friends and Family Test Outpatients Survey - % Positive Responses	92.16%	93.02%	93.20%	92.15%	93.71%	91.82%	92.24%	90.33%	92.13%	90.49%	91.88%	91.94%	92.44%	93.80%	93.83%	<b>in arrears</b>	<b>92.05%</b>	>=90% / >=93% from	September	<=79%	
Friends and Family Test A & E Survey - % Positive Responses	82.76%	84.40%	86.40%	84.69%	76.52%	83.18%	81.09%	79.94%	79.63%	83.09%	84.64%	76.40%	80.20%	76.73%	83.91%	<b>in arrears</b>	<b>80.92%</b>	>=80% / >=85% from	September	<=69%	
Friends & Family Test (Maternity) - % Positive Responses	94.64%	98.33%	92.30%	91.00%	95.12%	96.74%	97.92%	95.92%	93.09%	93.75%	93.33%	94.24%	93.20%	97.98%	93.18%	<b>in arrears</b>	<b>94.84%</b>	>=90% / >=95% from	September	<=79%	
Friends and Family Test Community Survey - % Positive Responses	92.44%	93.68%	95.50%	91.21%	98.32%	94.79%	94.52%	88.96%	93.81%	95.31%	92.81%	96.79%	98.21%	87.50%	89.27%	<b>in arrears</b>	<b>93.42%</b>	>=90% / >=95% from	September	<=79%	
<b>EFFECTIVE</b>																			Green	Amber	Red
Number of MRSA Bacteraemias – Trust assigned	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	2	0	>=0		
Preventable number of Clostridium Difficile Cases	5	1	1	0	0	2	1	1	1	0	0	0	0	0	0	0	8	<3	>=3		
Local SHMI - Relative Risk (1 Yr Rolling Data)	106.36	106.36	104.79	104.38	104.58	105.39	107.98	107.85	108.15	106.05	105.86	104.66	103.84				<b>103.84</b>	<=100	101 - 109	>=110	
Hospital Standardised Mortality Rate (1 yr Rolling Data)	102.2	99.27	102.20	102.64	104.59	105.86	106.69	107.31	107.98	106.74	103.66	102.26	99.98	100.19			<b>100.19</b>	<=100	101 - 109	>=111	
<b>RESPONSIVE</b>																			Green	Amber	Red
Emergency Care Standard 4 hours	78.99%	72.95%	75.70%	73.92%	74.05%	72.64%	75.85%	72.97%	72.52%	73.27%	75.44%	68.44%	66.37%	60.34%	70.85%	<b>67.51%</b>	<b>70.52%</b>	>=95%	81% - 94%	<=80%	
% Stroke patients admitted directly to an acute stroke unit within 4 hours of arrival	36.71%	23.19%	16.67%	15.79%	25.45%	25.53%	28.81%	13.33%	24.60%	19.18%	33.30%	26.15%	31.30%	36.07%	30.56%	<b>17.39%</b>	<b>25.74%</b>	>=90%		<=85%	
Two Week Wait From Referral to Date First Seen	98.38%	97.96%	98.39%	98.35%	97.56%	97.76%	98.46%	98.03%	97.76%	97.79%	96.19%	96.73%	98.28%	95.77%	98.50%	<b>98.81%</b>	<b>97.65%</b>	>=93%	86% - 92%	<=85%	
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.53%	96.00%	93.84%	97.25%	93.50%	96.92%	96.27%	98.20%	97.83%	100.00%	100.00%	98.56%	99.32%	98.20%	100.00%	<b>97.93%</b>	<b>98.49%</b>	>=93%		<=92%	
31 Days From Diagnosis to First Treatment	98.21%	99.37%	98.35%	99.39%	98.31%	97.58%	98.86%	99.00%	99.46%	97.85%	98.91%	99.03%	99.12%	98.88%	98.01%	<b>98.73%</b>	<b>98.67%</b>	>=96%		<=95%	
31 Day Subsequent Surgery Treatment	95.43%	100.00%	93.33%	96.55%	94.44%	96.00%	100.00%	100.00%	100.00%	96.97%	97.37%	97.30%	94.59%	100.00%	87.18%	<b>92.31%</b>	<b>96.58%</b>	>=94%		<=93%	
31 day wait for second or subsequent treatment drug treatments	99.51%	100.00%	95.45%	98.63%	100.00%	100.00%	100.00%	100.00%	100.00%	98.75%	98.86%	100.00%	98.67%	98.86%	100.00%	<b>100.00%</b>	<b>99.53%</b>	>=98%		<=97%	
38 Day Referral to Tertiary	50.00%	37.93%	35.00%	66.67%	30.77%	55.17%	64.71%	40.74%	33.33%	24.00%	35.71%	54.55%	44.00%	84.21%	34.62%	<b>66.67%</b>	<b>47.50%</b>	>=85%		<=84%	
62 Day GP Referral to Treatment	90.62%	87.32%	89.59%	86.82%	89.71%	91.63%	87.70%	90.69%	85.32%	85.55%	86.09%	90.69%	92.28%	89.86%	89.45%	<b>85.11%</b>	<b>88.64%</b>	>=85%	81% - 84%	<=80%	
62 Day Referral From Screening to Treatment	59.47%	81.25%	62.50%	50.00%	96.30%	92.59%	73.68%	70.37%	87.88%	88.89%	88.89%	72.41%	82.35%	92.86%	58.62%	<b>90.00%</b>	<b>81.18%</b>	>=90%		<=89%	
Faster Diagnosis Standard: Maximum 28-day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening	74.31%	76.82%	76.50%	83.12%	79.54%	77.76%	76.91%	74.06%	75.88%	73.65%	77.32%	78.10%	77.24%	76.79%	74.10%	<b>79.84%</b>	<b>76.46%</b>	>=75%		<=70%	
<b>WORKFORCE</b>																			Green	Amber	Red
Sickness Absence rate (%) - Rolling 12m - Non-Covid related	4.83%	4.58%	4.66%	4.63%	4.83%	4.90%	4.91%	4.88%	4.82%	4.77%	4.73%	4.71%	4.73%	4.80%	4.73%	<b>4.83%</b>	-	<=4.75%	<5.25%	>=5.25%	
Long Term Sickness Absence rate (%) -Rolling 12m - Non-Covid related	3.21%	3.12%	3.15%	3.17%	3.21%	3.24%	3.23%	3.20%	3.15%	3.10%	3.06%	3.06%	3.08%	3.09%	3.08%	<b>3.10%</b>	-	<=3.0%	<3.25%	>=3.25%	
Short Term Sickness Absence rate (%) -Rolling 12m - Non-Covid related	1.62%	1.46%	1.52%	1.57%	1.62%	1.66%	1.68%	1.69%	1.68%	1.67%	1.66%	1.65%	1.65%	1.71%	1.65%	<b>1.73%</b>	-	<=1.75%	<2.00%	>=2.00%	
Overall Essential Safety Compliance	92.90%	93.28%	92.50%	92.57%	92.90%	92.54%	92.94%	92.61%	92.63%	91.89%	90.46%	91.68%	92.38%	92.74%	92.76%	<b>93.20%</b>	-	>=90%	>=85%	<85%	
Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth)	82.43%	70.31%	72.91%	74.86%	82.43%	82.31%	81.50%	82.97%	83.79%	83.15%	82.47%	76.57%	76.57%	74.79%	75.86%	<b>76.99%</b>	-	>=95%	>=90%	<90%	
Appraisal (1 Year Refresher) - Non-Medical Staff	69.06%	61.72%	63.51%	65.54%	69.06%	0.64%	2.79%	5.94%	9.36%	17.18%	48.64%	59.23%	66.77%	74.47%	68.39%	<b>64.78%</b>	-	>=95%	>=90%	<90%	
<b>FINANCE</b>																			Green	Amber	Red
I&E: Surplus / (Deficit) Var £m YTD	2.27	0.17	0.02	-0.06	-0.11	0.11	0.11	0.59	-0.34	-0.83	-0.51	-0.88	-0.02	-1.01	-0.69	<b>-0.12</b>	<b>-3.60</b>				

## SWOT Analysis

Strengths	<ul style="list-style-type: none"> <li>• Agreed Recovery Framework.</li> <li>• Continuing to focus on Trust agreed priorities for elective patients, e.g. ensuring we prioritise patients with learning disabilities and long waiters (104 weeks).</li> <li>• Ongoing comprehensive theatre staff engagement and workforce development programme.</li> <li>• Progressing installation of two new permanent MRI scanners which are being ramped and shimmed which is the process by which the main magnetic field is made more homogenous.</li> <li>• Community Pharmacist roles continue to add significant value in Quality Improvement (identifying and managing medication incidents), supporting effective assessment and care planning across nursing and therapy services and helping manage some of the discharge based risks and issues with handover of medicines management.</li> <li>• Continue to support Mid Yorkshire Hospital Trust with Non-Surgical Oncology care for Breast and Lung cancer and also now providing some in-reach support to Bradford.</li> <li>• Focus on recruitment in both clinical and admin roles to support Recovery. Using alternative roles and thinking differently for hard to recruit areas. Also exploring risks and benefits to over recruitment to minimise bank and agency spend.</li> <li>• Insourcing arrangements in place for ENT (OP &amp; Surgery), Orthopaedics (CHOP LLP) and Ophthalmology (OP, diagnostics &amp; Surgery) to help tackle elective backlogs.</li> <li>• CMDU programme started 17th January in collaboration with Locala and Mid Yorkshire to reduce hospital attendances. This funding has now been extended for the whole of 2022/23.</li> <li>• Improving AHP workforce planning capability through extension of project roles to deliver outputs of initial review findings.</li> <li>• E-Job rollout almost complete for AHP and next for specialist nursing.</li> </ul>
Weaknesses	<ul style="list-style-type: none"> <li>• Bed pressures continue to be significant.</li> <li>• The staffing position continues to be extremely challenging across all divisions in particular among nursing teams.</li> <li>• Theatre lists still not up to pre-covid numbers but pipeline staffing showing a positive position over the next few weeks and months.</li> <li>• Issue retaining Community Pharmacists in Quest due to conflicting demands with PCN Pharmacists.</li> <li>• Disparity with availability of clinical educators into Therapy services to support staff retention and education.</li> </ul>
Opportunities	<ul style="list-style-type: none"> <li>• The SAFER programme continues to pull together existing workstreams and those stopped during the Covid period.</li> <li>• The Plan for Every Patient roll-out programme is underway with further resource allocated to increase pace and buy-in.</li> <li>• Using Myosure in Gynaecology to see and treat patients in an ambulatory setting where previously they would have needed theatre. Supports capacity and improved patient experience.</li> <li>• Development of workforce plan including ODP apprentices, Nurse Associate role.</li> <li>• Opportunity to work with NHSE as a part of the pathfinder pilot looking at hospital patient transport (HTCS) for both inpatients and outpatients.</li> <li>• Patient appliance trustwide budget is to be consolidated into the community division, this will come with a cost pressure but streamlines operational pressures and improves patient pathways.</li> <li>• Virtual wards - CKW working groups have been established for virtual wards to ensure pathways are streamlined across the CKW footprint. Initial focus pathways are Frailty and Respiratory. The first VW beds went live in November.</li> <li>• CHFT Community have agreed to work as a pilot site for developing a community currency tool with NHSE.</li> <li>• The Community division are currently working up a number of business cases with external partners to maximise some system money earmarked for innovation. In addition we are submitting a business case to Parkinson's UK for some pump primed funding to enhance the Calderdale Parkinson's service.</li> <li>• IC Beds current provision extended for a further 12 months under the existing contract but on reduced beds (now 15 in total) and will be re looked at through 3CPB.</li> <li>• The school aged Immunisations tender has been released to start a new contract from 1st September 2023. Community division are looking at submitting a collaborative tender with Locala for CHFT to continue to provide this service.</li> </ul>
Threats	<ul style="list-style-type: none"> <li>• We continue to see the significant and sustained increase in demand for both our emergency departments which continues to create pressure at the front door and driving ongoing increased staffing.</li> <li>• Deterioration of Head and Neck service in terms of consultant cover and Speech and Language Therapy, started some WYAAT conversations re: a regional response.</li> <li>• Community services are increasingly seeing more complex and acute presentation with impacts on wider anticipatory care and Long Term Condition (LTC) management.</li> <li>• Patients are presenting with increased acuity and complexity which is resulting in a longer length of stay and challenges around timely discharge into the community.</li> <li>• Staff fatigue due to ongoing pressures and frustration due to prolonged changing and increasing workloads.</li> <li>• Significant cost pressure due to Private Ambulance costs over and above CCG YAS commissioned service. This service moved to the corporate division from May 2022.</li> <li>• Risk around long term funding of Virtual ward, this comes with 1 year pump priming, 1 year match funding and should be sustained through existing resource from 2024/25. Community are working in collaboration with other CHFT divisions as well as across CKW for longer-term efficiencies.</li> <li>• Risk around recruitment to virtual ward posts as initial plans support recruitment of circa 150 WTE posts across the West Yorkshire footprint.</li> <li>• We are still not clear on the match funding requirements for virtual ward in 2023/24, we continue to submit our forecast costs for 2022/23 and have submitted a plan for 2023/24 to NHSE and await further guidance.</li> <li>• Health and safety risks due to ageing estate across the Trust. Working with stakeholders to mitigate risks and explore permanent solutions that align with wider Trust reconfiguration plans.</li> <li>• There is currently an ongoing exercise to understand procurement options for Intermediate Care Beds in Calderdale. There is a significant risk to the stability of wider</li> </ul>

## 104% Elective Recovery – Position to February and Forecast

Point of Delivery	YTD Performance Against 2019/20 and 104% Target			
	2019/20 Baseline YTD	2022/23 Actual YTD	Variance YTD	% of 2019/20 Baseline Delivered YTD
Daycase	43,825	46,313	2,488	105.7%
Elective	4,771	4,253	- 518	89.1%
<b>Sub-total Planned Inpatient</b>	<b>48,596</b>	<b>50,566</b>	<b>1,970</b>	<b>104.1%</b>
<b>Outpatient First Attendances*</b>	<b>130,940</b>	<b>138,885</b>	<b>7,945</b>	<b>106.1%</b>
Outpatient Follow-ups	245,796	274,854	29,058	111.8%

Performance Against 2022/23 Plan			
2022/23 Plan YTD - activity	2022/23 % of 2019/20 baseline	Variance YTD - activity	Variance YTD - % of 2019/20 baseline
50,739	104.4%	- 173	-0.4%
139,220	106.3%	- 335	-0.3%
258,724	105.3%	16,129	6.6%

Forecast Performance Against 2019/20 and 104% Target			
2019/20 Baseline Full Year	2022/23 Actual Forecast	Variance Forecast	% of 2019/20 Baseline Forecast
48,300	50,777	2,477	105.1%
5,285	4,736	- 549	89.6%
53,585	55,513	1,928	103.6%
143,668	151,787	8,119	105.7%
270,804	301,330	30,526	111.3%

\* actual outpatient first activity includes an estimate of 821 attendances for Pioneer (ENT, Ophthalmology & Neurology) not yet input into EPR for January & February

- Planned inpatient spells**
  - Currently delivering **104.1% of 2019/20 levels**
  - Forecasting to deliver **103.6% of 2019/20 levels** and therefore 0.4pp (215 spells) below 104% target.
  - The revised elective recovery trajectory agreed at Month 8 was 103.3% and so the Trust is forecasting to exceed this.
- Outpatient first attendances**
  - Currently delivering **106.1% of 2019/20 levels**.
  - Forecasting to deliver **105.7% of 2019/20 levels** and therefore 1.7pp (2,372 attendances) above 104% target
  - The revised elective recovery trajectory agreed at Month 8 was 105.6% and so the Trust is on track to achieve this.
- It should be noted that the Junior Doctor strike remains a risk in the delivery of the above forecast.

# Summary

		As of 29/03/2023	Current Trajectory as	Variance to trajectory	Variance against trajectory				Main areas above Trajectory
					Medical	Surgical	FSS	Community	
Elective Backlogs	104 Weeks RTT	0	0	0	0	0	0	-	-
	78 Weeks RTT	4	8	-4	0	-4	0	-	-
	52 Weeks RTT	141	2,053	-1912	-299	-1471	-142	-	Max Fax and ENT
	Total ASI's	13,491	4,563	8928	1567	6071	1178	112	ENT
	ASIs over 22 weeks	608	6	602	188	401	11	2	Neurology, Max Fax, T&O and ENT
	Holding List overdue	25,722	345	25377	13919	9701	1645	112	Urology, Cardiology, Dermatology, Gastro, Neurology, Respiratory Med, T&O, Ophthalmology and Gynaecology

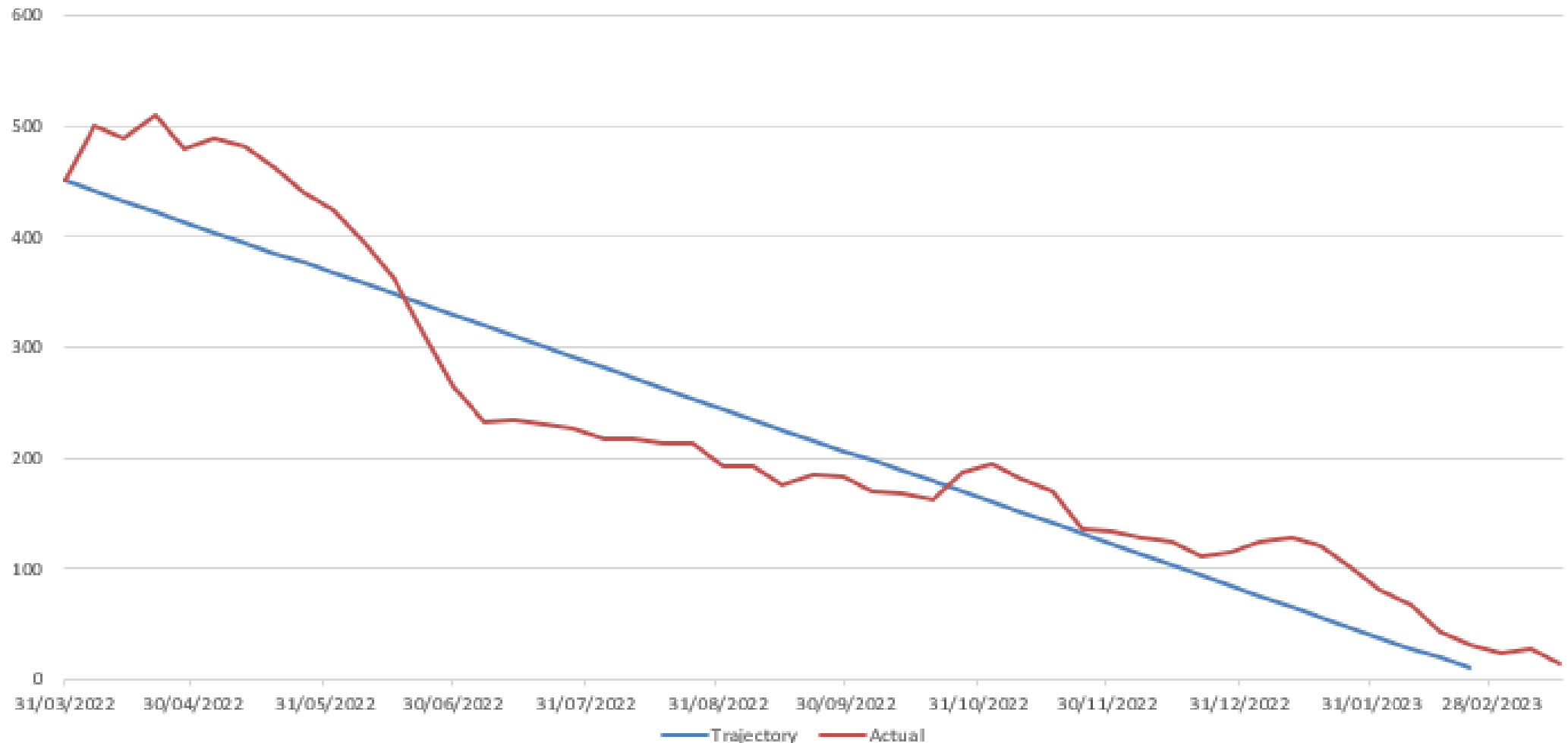
## Current 104 week wait Position

- As of the 21<sup>st</sup> March 2023 , we currently have 0 patients waiting over 104 weeks.
- Next longest waiting patient is currently at 98 weeks (has a TCI Date)

Specialty	Current total number of 78+ww	Current number of 78+ww patients on a non-admitted pathway	Current number of 78+ww who have a TCI date
ENT	1		1
General Surgery	1		1
Ophthalmology	1		1
Urology	1		1
<b>Grand Total</b>	<b>4</b>	<b>0</b>	<b>4</b>

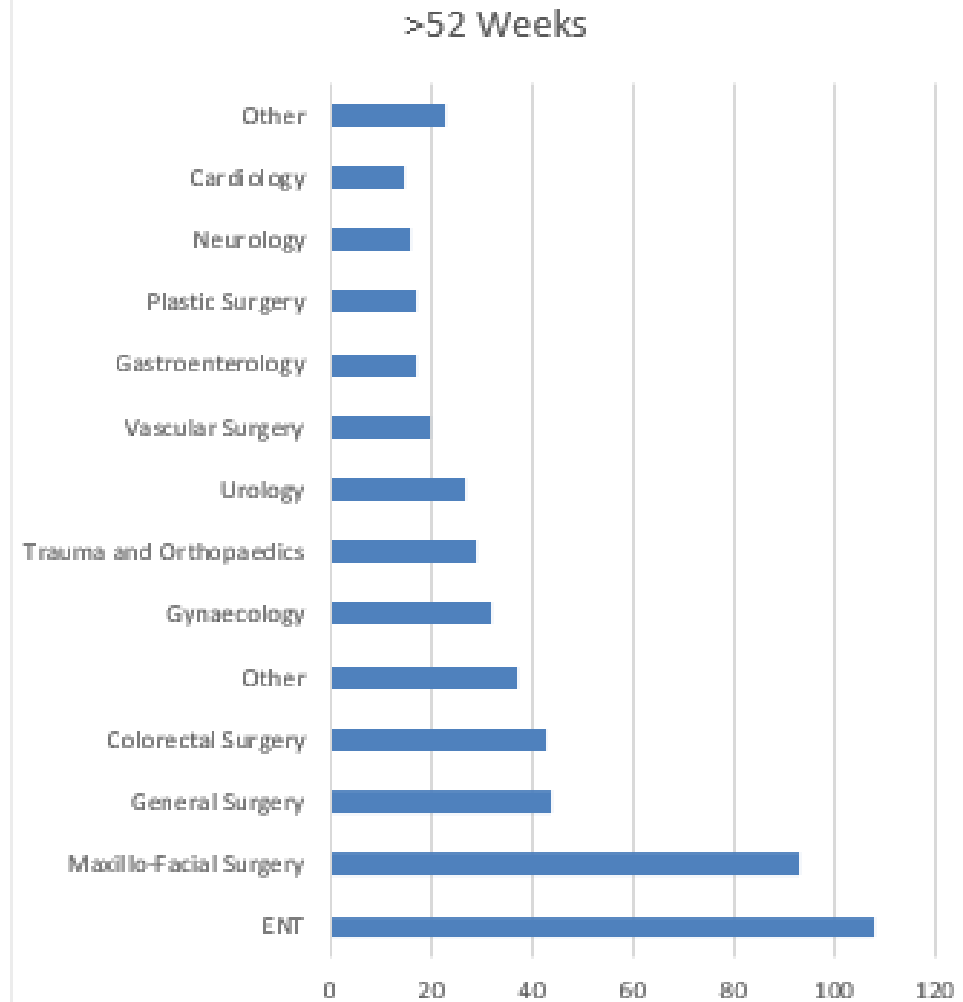
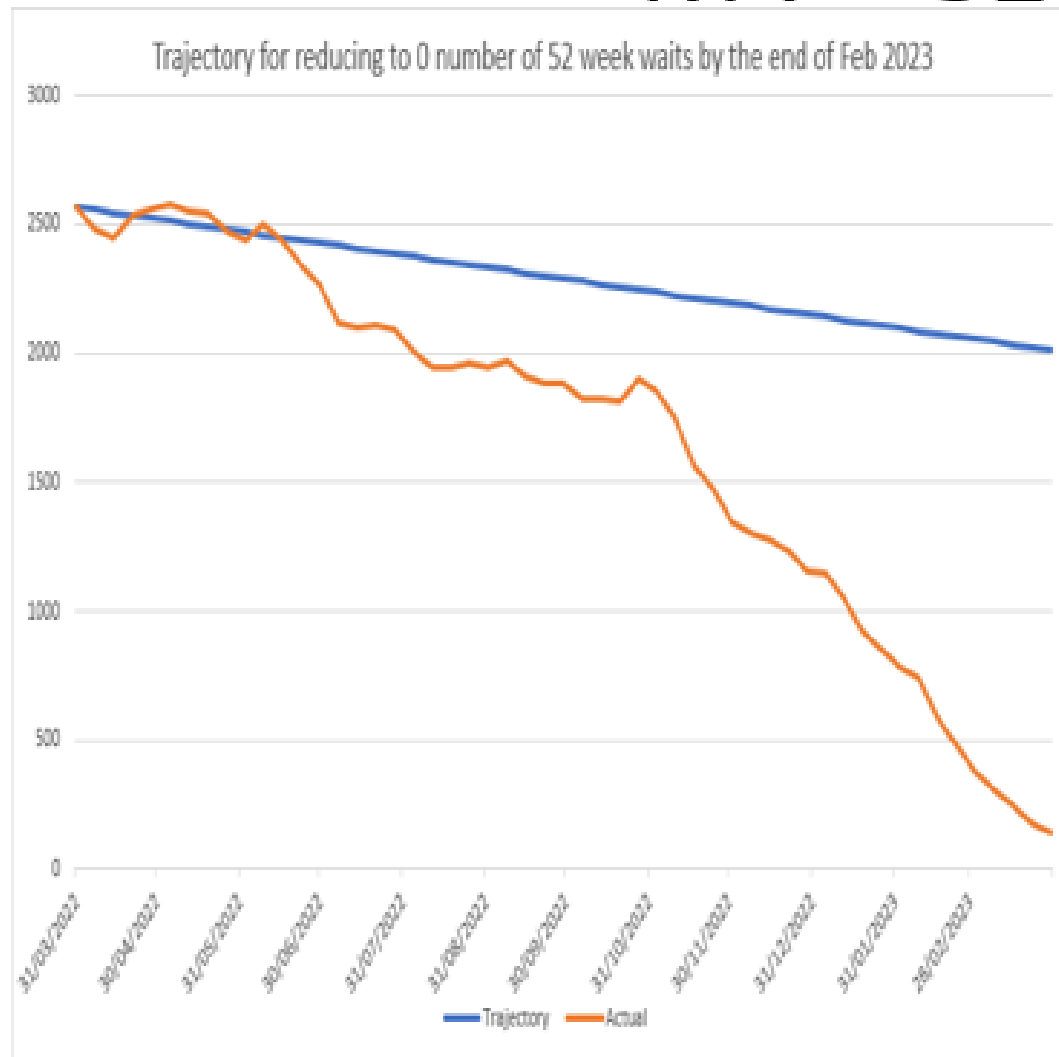
# RTT – 78 Weeks

Trajectory for reducing to 0 number of 78 week waits by the end of March 2023



National expectation to be at zero by end of March 2023, on track to deliver by end of March 2023

# RTT – 52 Weeks

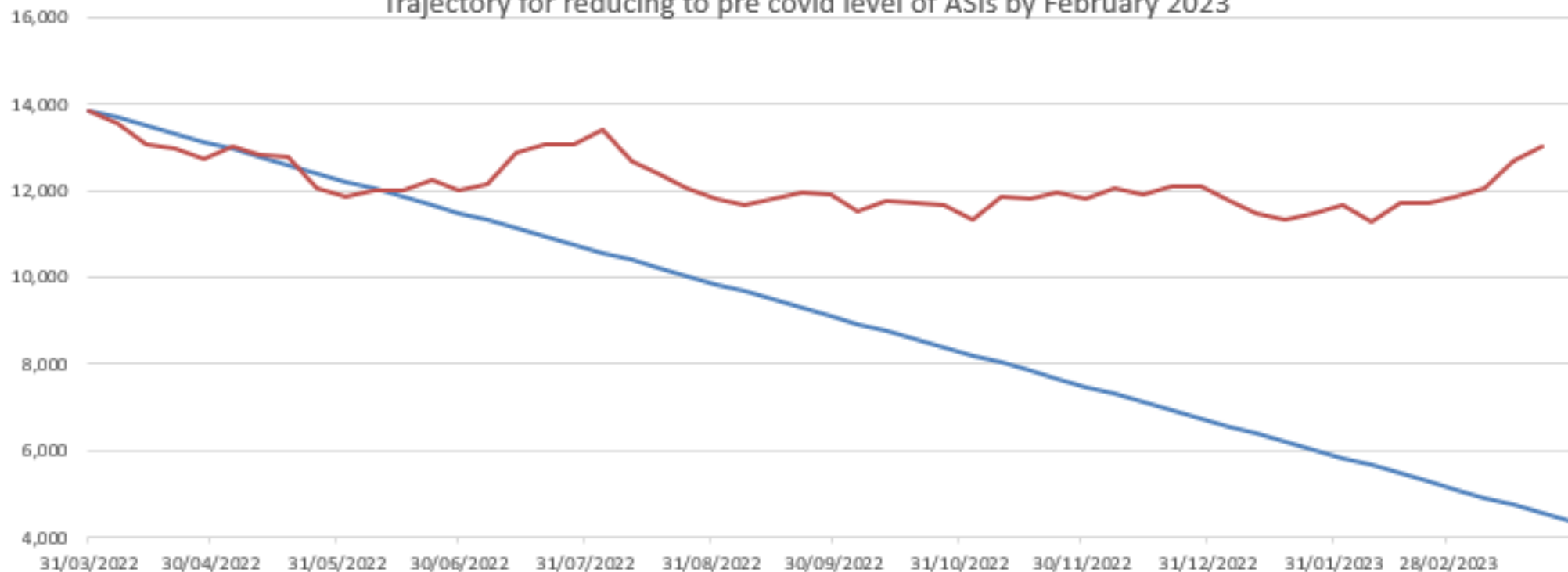


National expectation to be at zero by end of March 2025, on track to deliver NHS E/I trajectory.



# Outpatients – New (total ASIs)

Trajectory for reducing to pre covid level of ASIs by February 2023

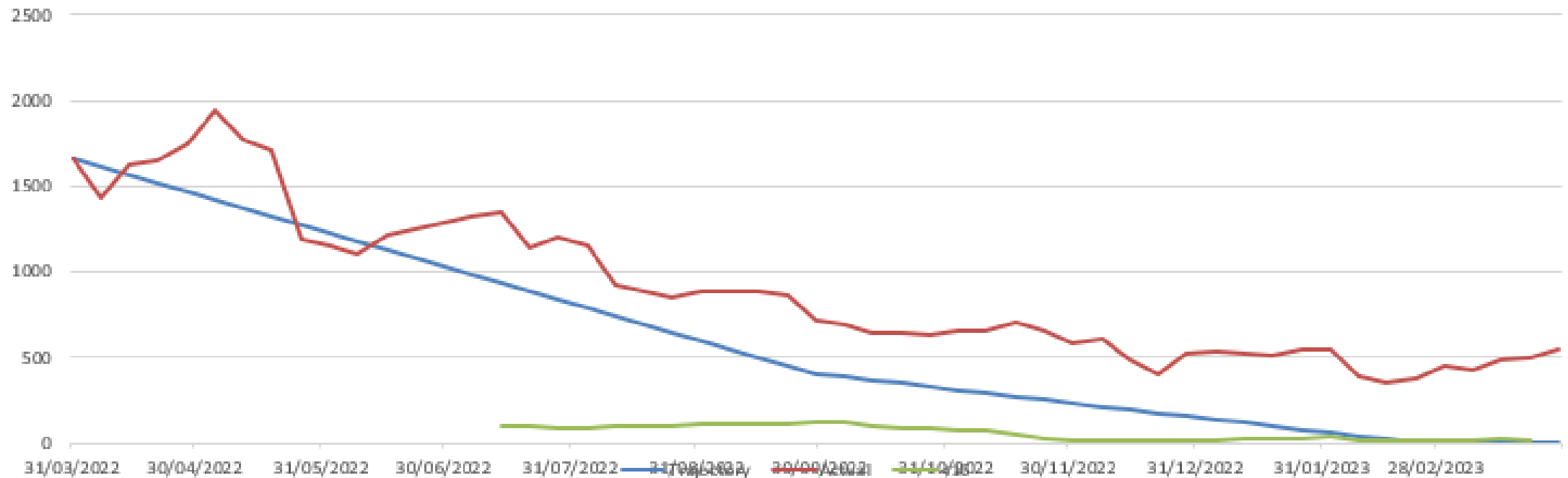


- No external target and no requirement to report centrally. Internal target to get back to pre-covid levels.
- Current ASIs had reduced but increasing again particularly in ENT
- Risk of not addressing is on overall length of RTT pathways



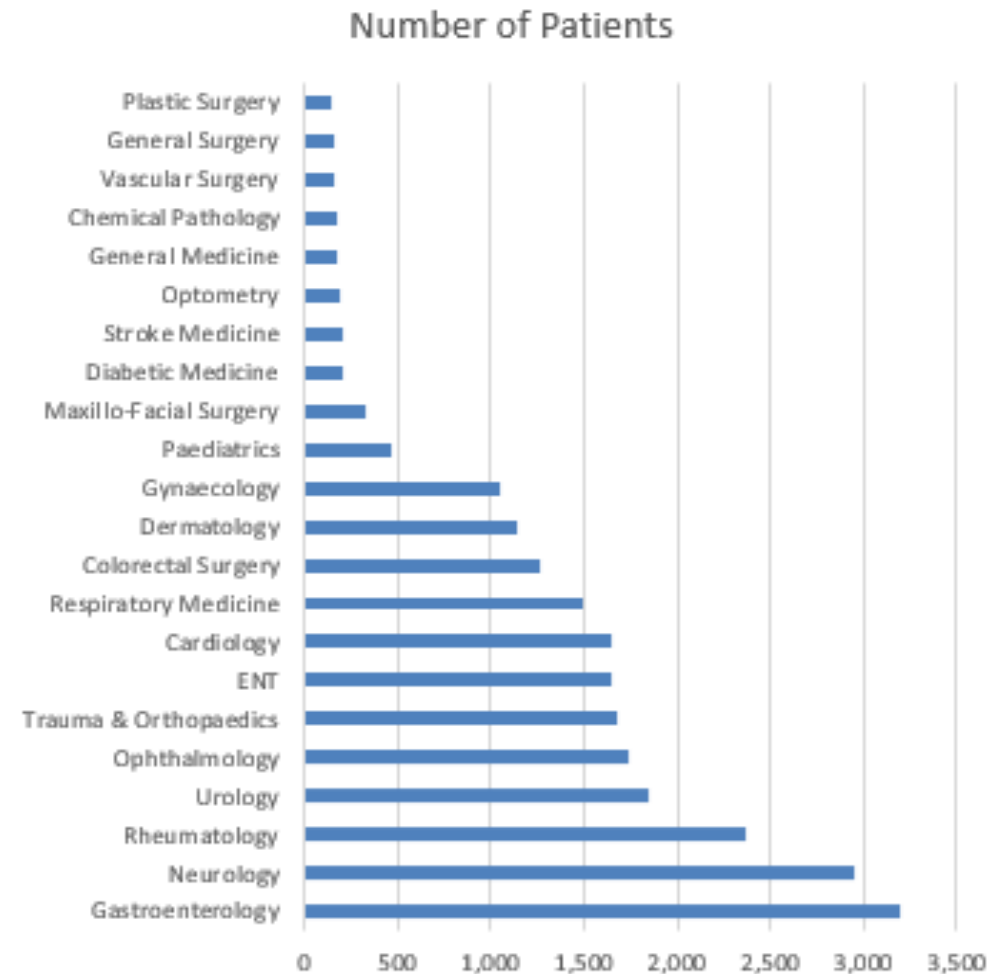
# Outpatients – New (ASI > 22 weeks)

Trajectory for reducing to 0 number of ASI over 22 weeks by the end of February 2023)



- Our trajectory is a locally set target that will help achieve a reduction in 52/78 week RTT Waits.
- Of the 545 Remaining ASIs over 22 weeks:
  - 48 in Neurology
  - 94 in ENT
  - 132 in Max Fax
  - 93 in Trauma & Orthopaedics

# Outpatients – Follow Up

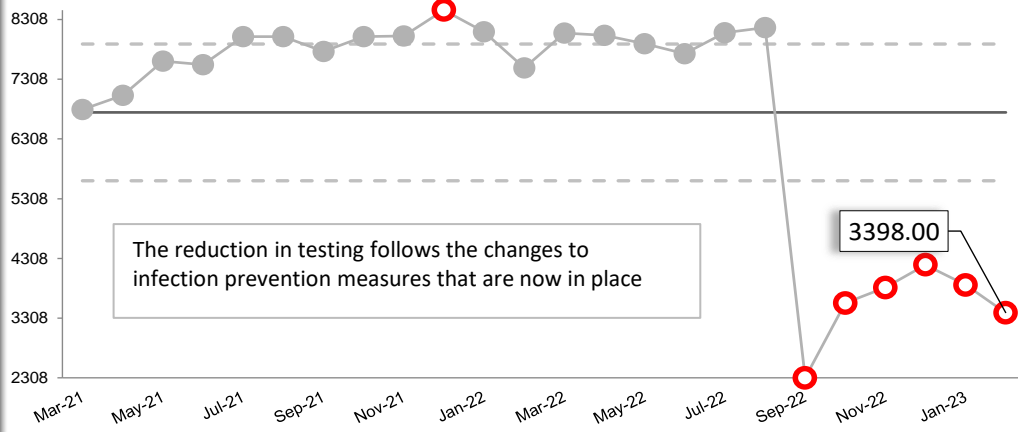


- No external target or requirement to report externally
- Internal target to reduce to 0

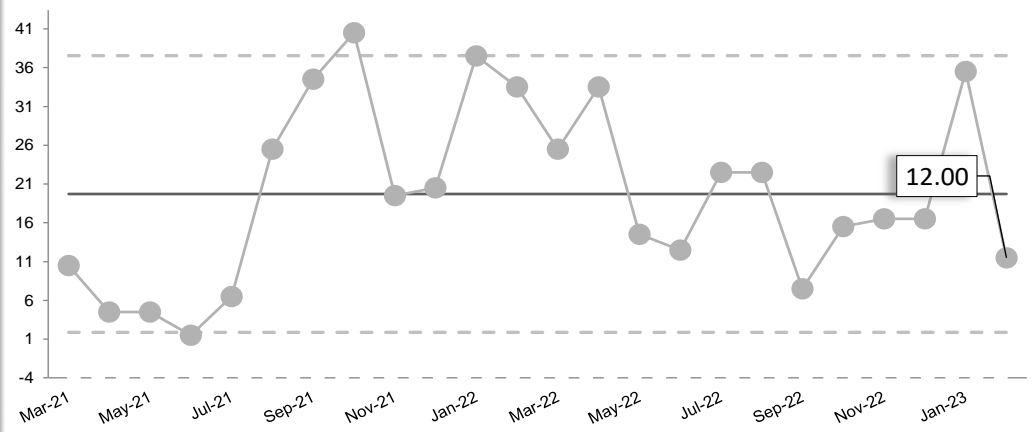
# Covid-19 - Charts

○ Critical 
 ● Activity 
 ○ On Target 
 ○ Trend 
 — Target Line 
 — Average Line 
 - - - Control Line 
 → Last 6 Points Directional Flow 
   Last Data Point

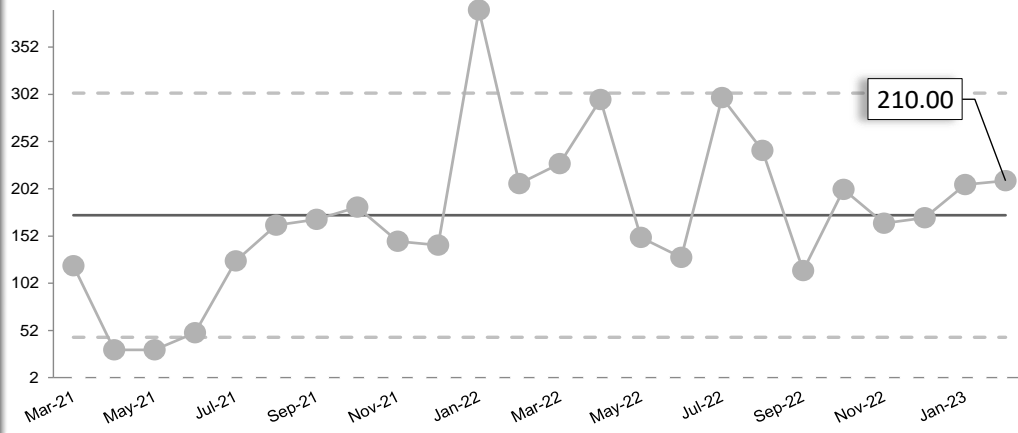
### Number of Patients Tested for Covid-19



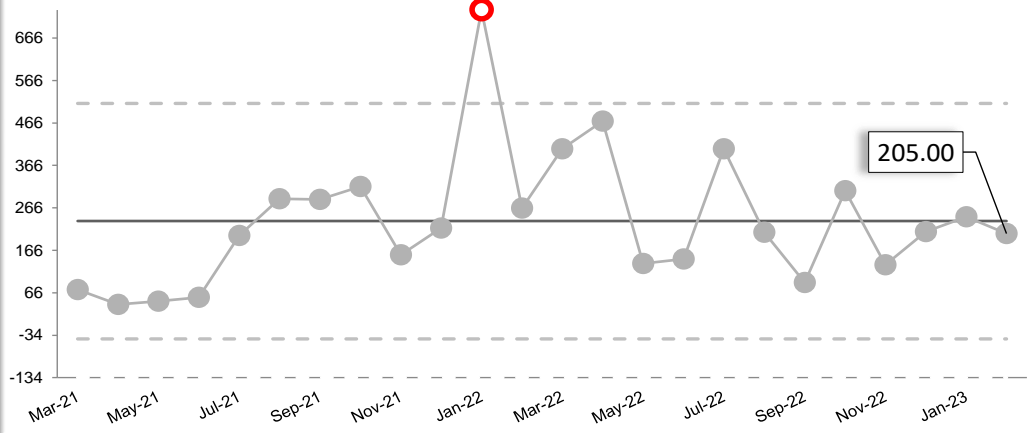
### Number of Covid+ Deaths



### Number of Covid+ Patients Discharged Well

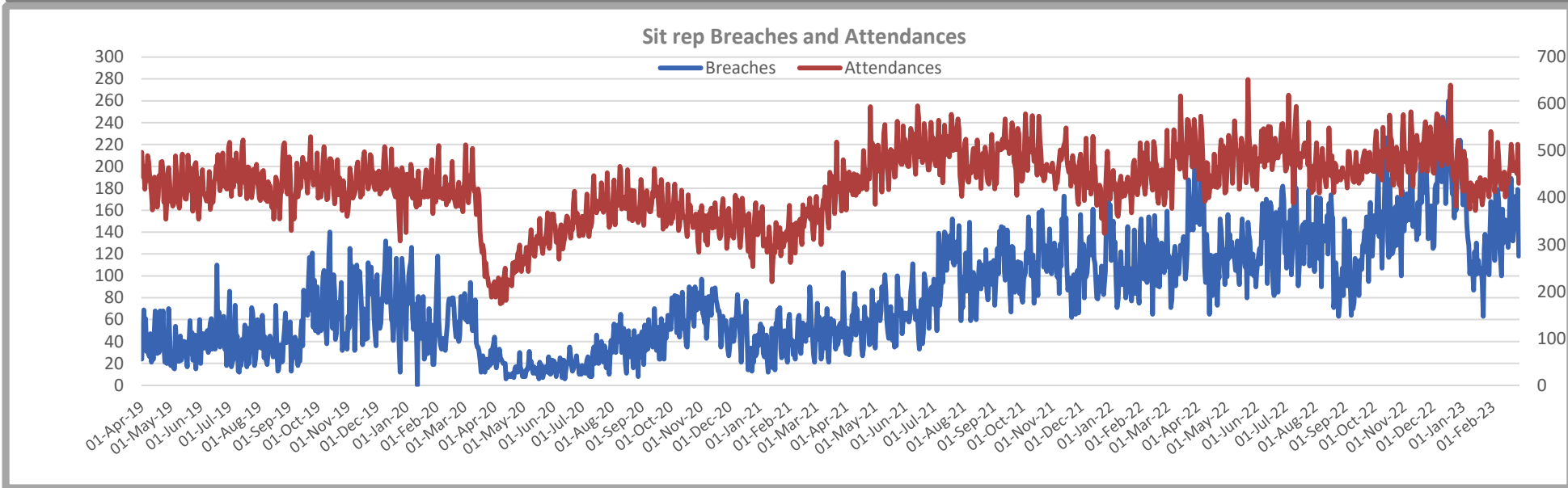
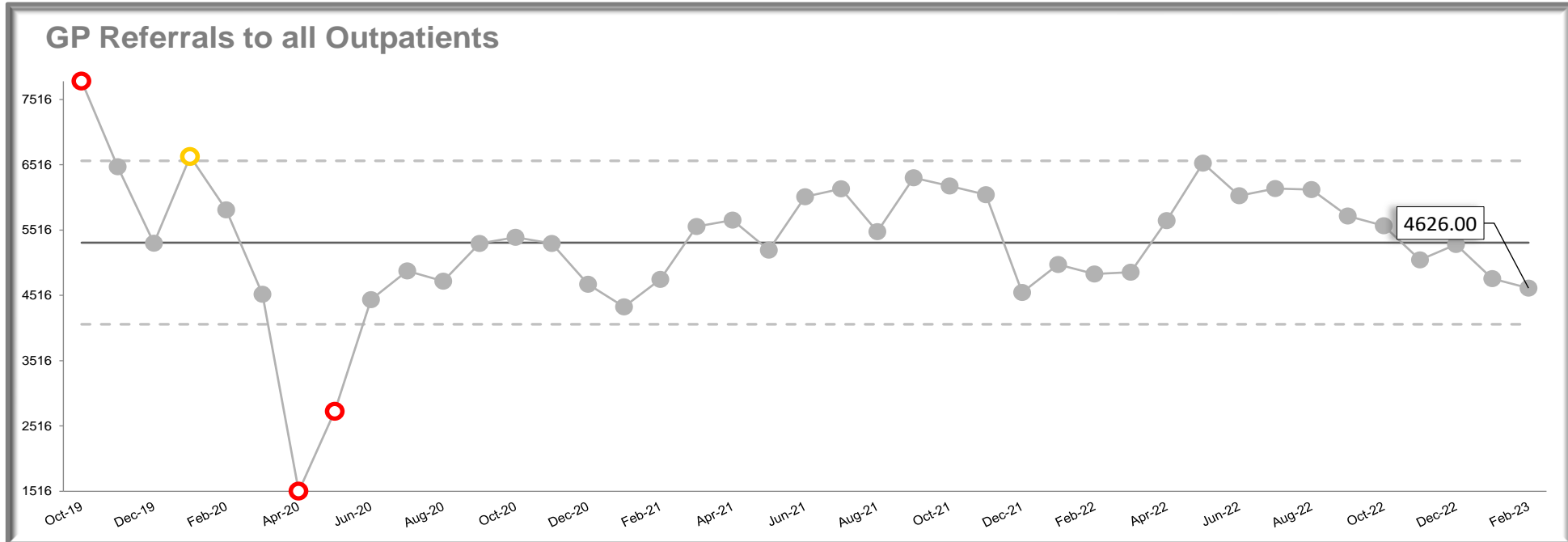


### Number of New Covid+

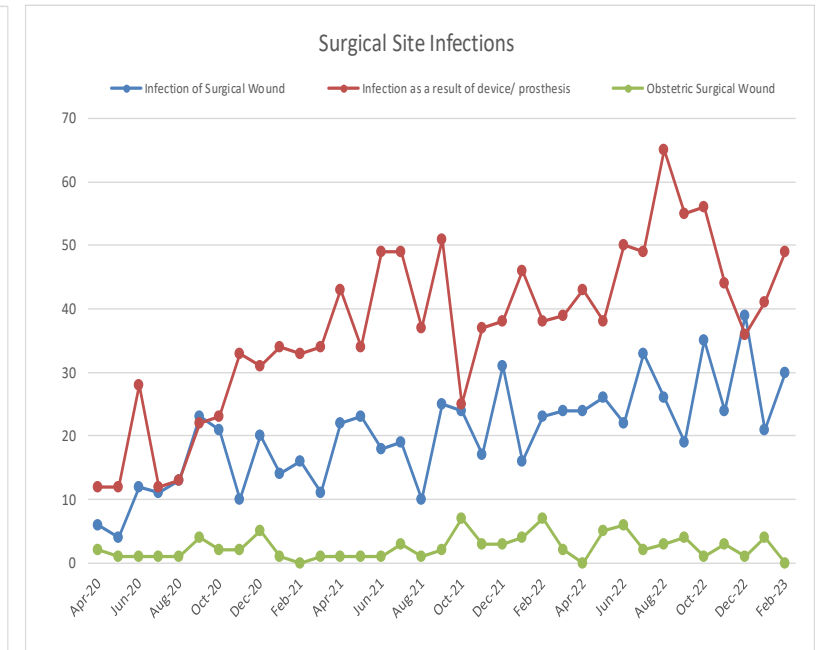
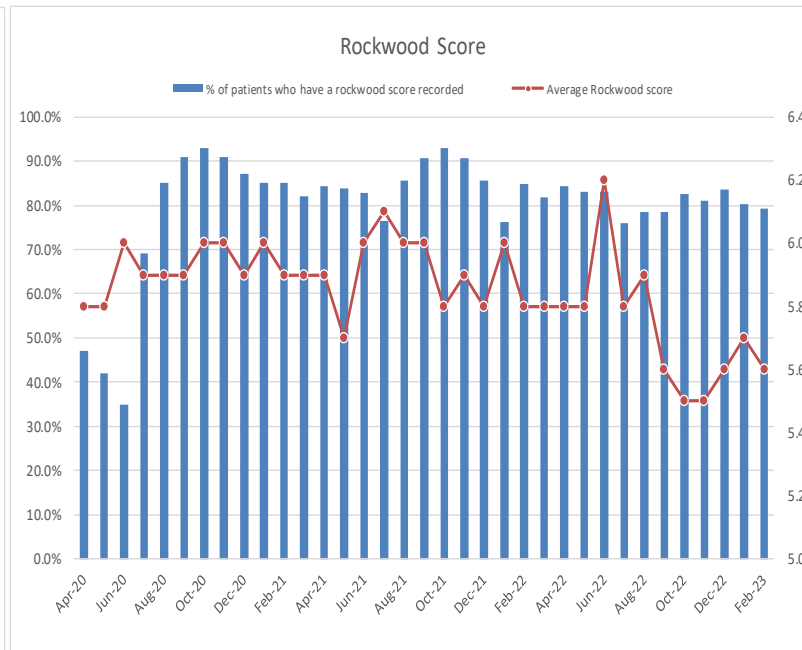
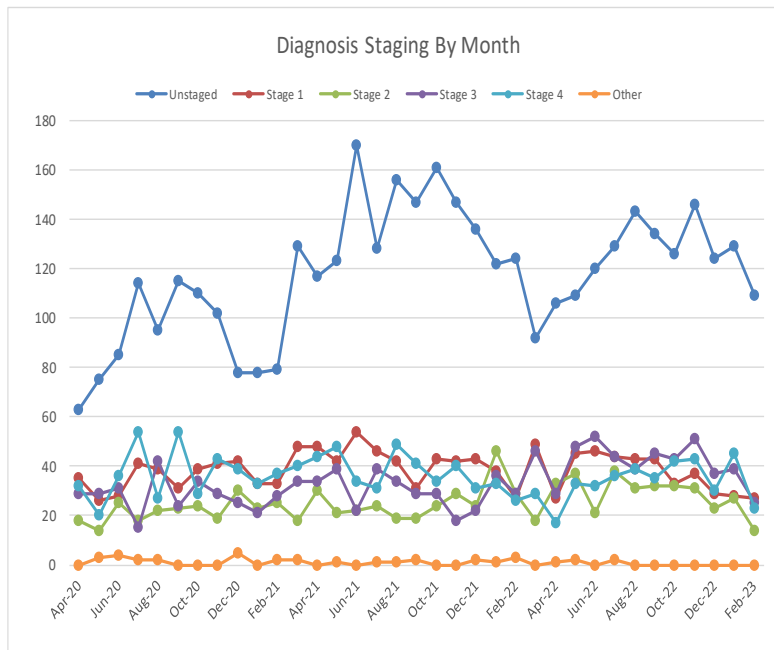
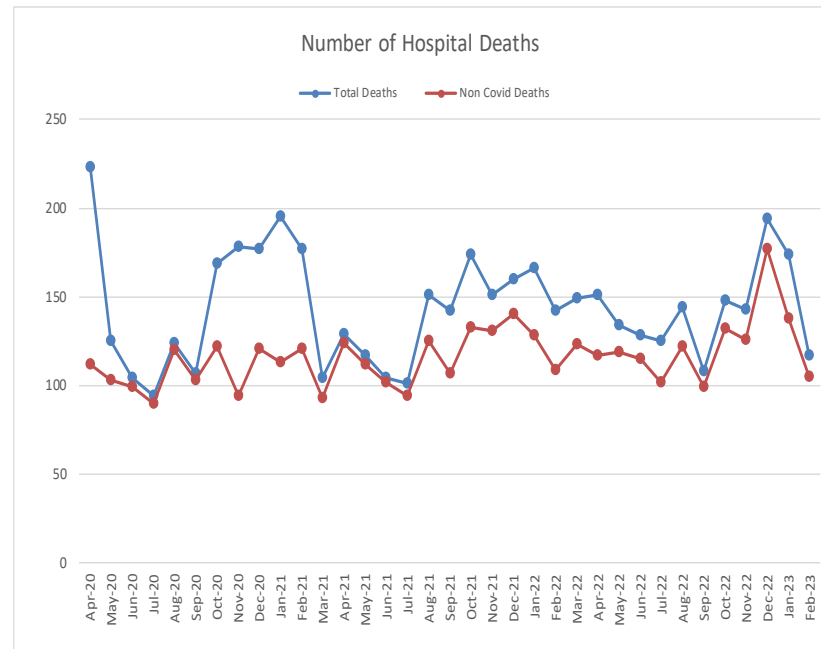
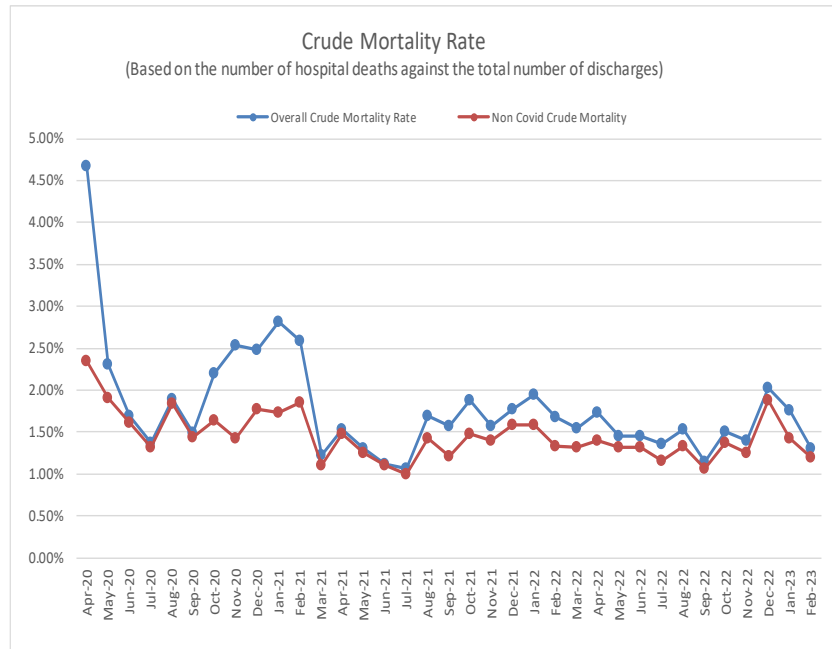


# Capacity and Demand

○ Critical ● Activity ○ On Target ○ Trend — Target Line — Average Line - - - Control Line → Last 6 Points Directional Flow □ Last Data Point



# Outcome Measures



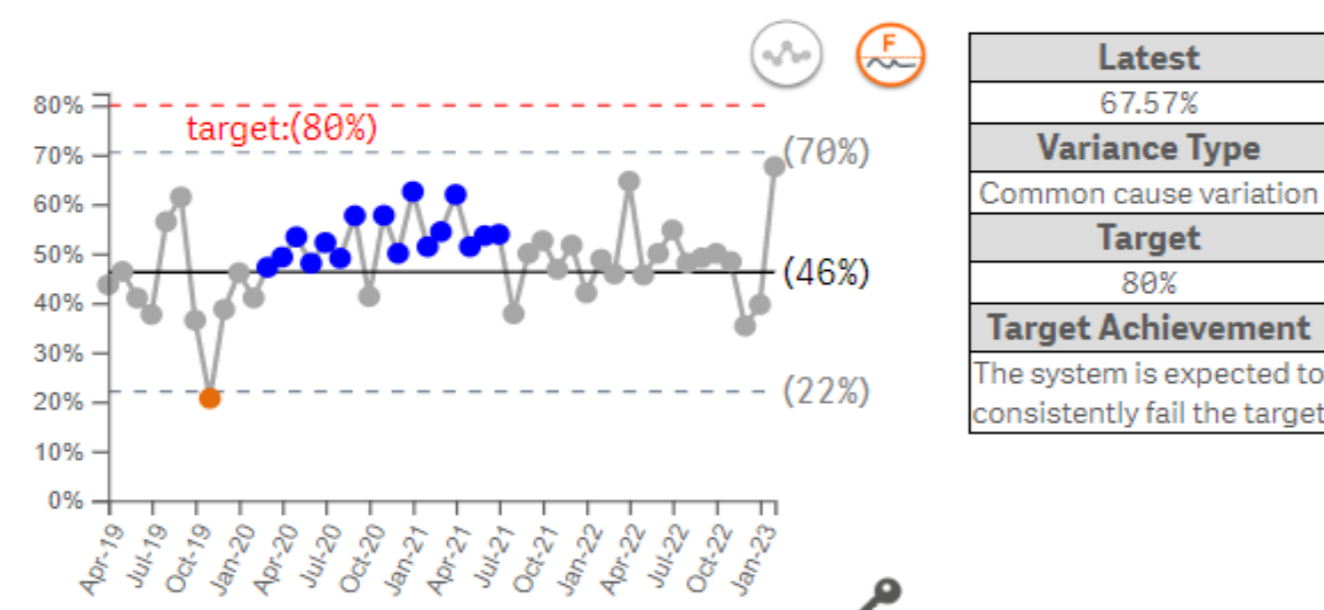
Graphs produced by the Quality Performance Team



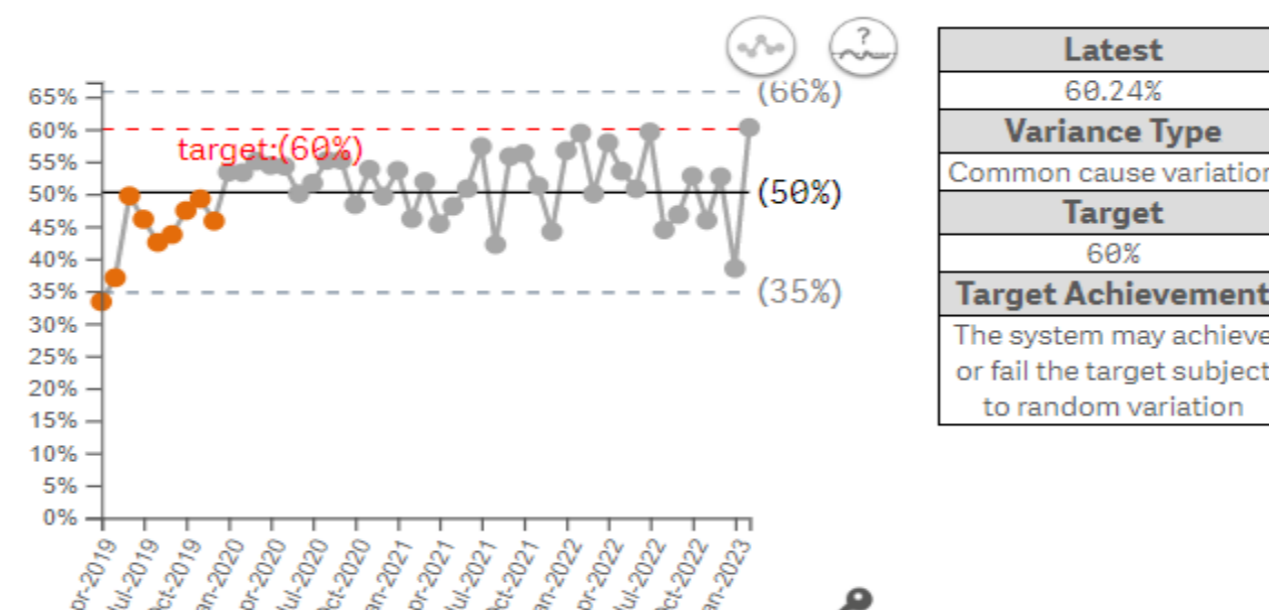
# Quality Priorities - Quality Account Priorities

**Priority 1**  
Recognition and timely treatment of Sepsis

**% of ED patients that had antibiotics <1hr of red flag trigger**  
Adult patients coded with Sepsis that triggered red flag sepsis

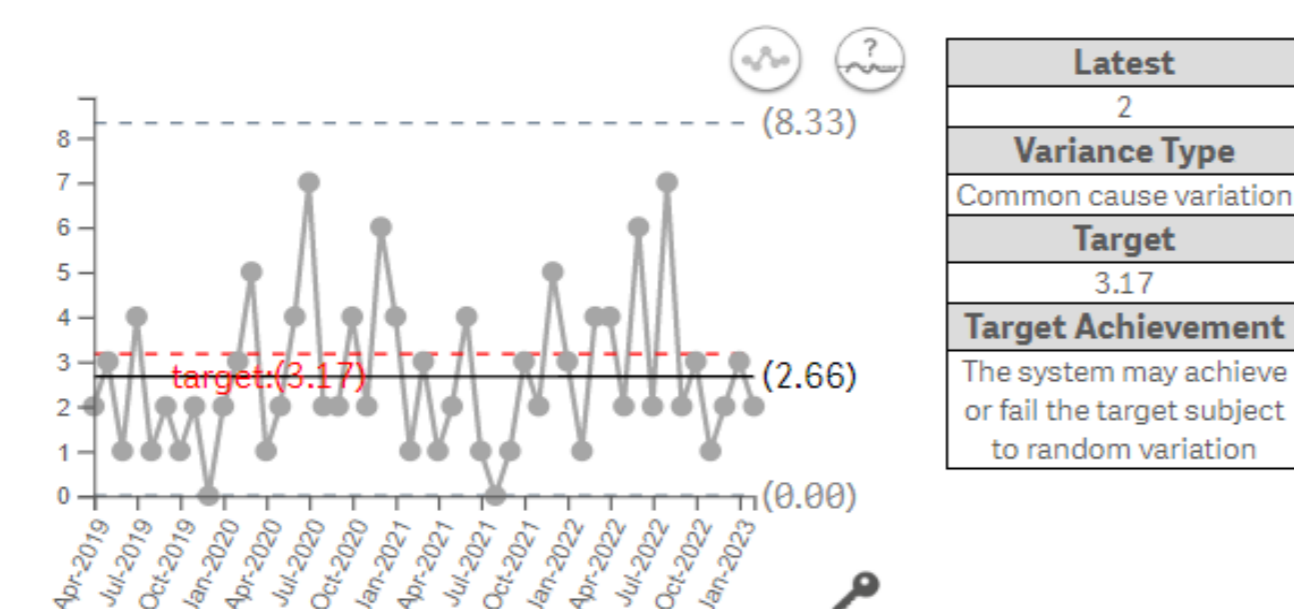


**BUFALO Bundle Total Compliance (%)**  
Adult patients coded with Sepsis

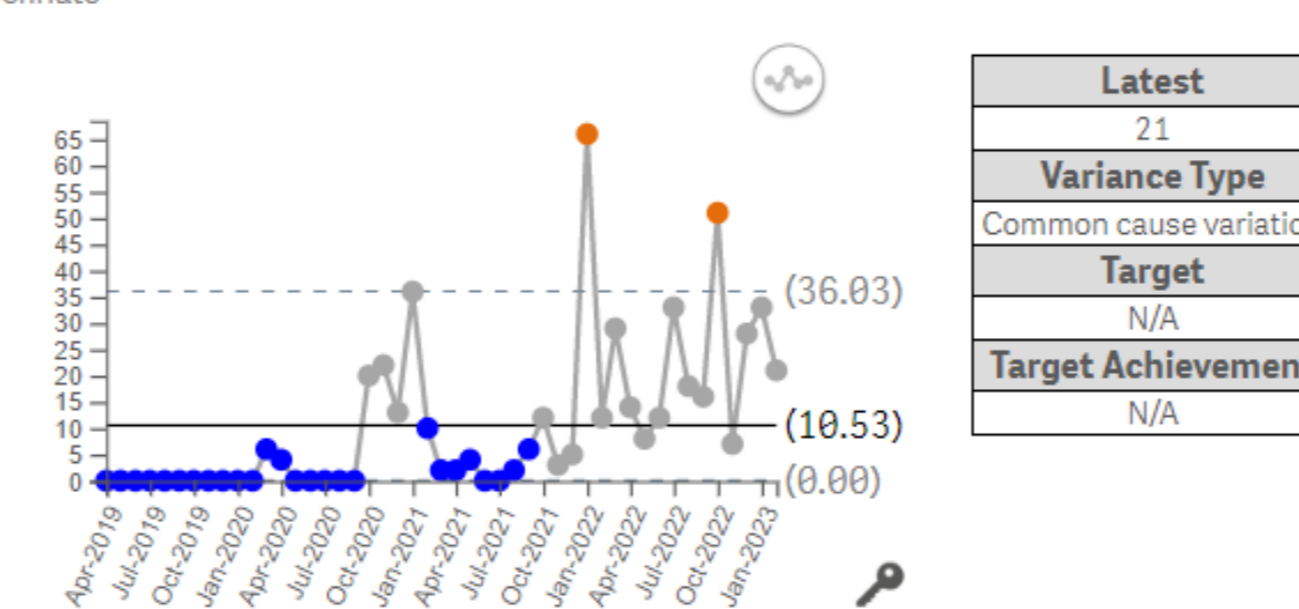


**Priority 2**  
Reduce number of hospital acquired infections including COVID-19

**No. of CDiff**  
Trust Assigned

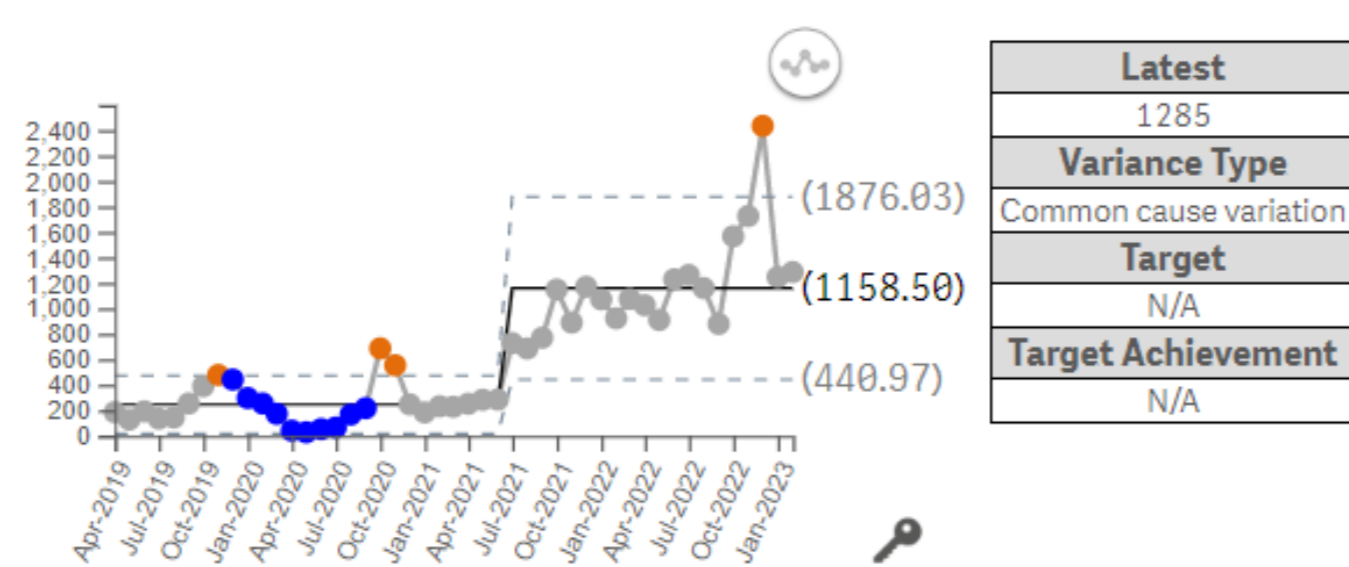


**No. of Hospital Onset Covid Infection**  
Definate

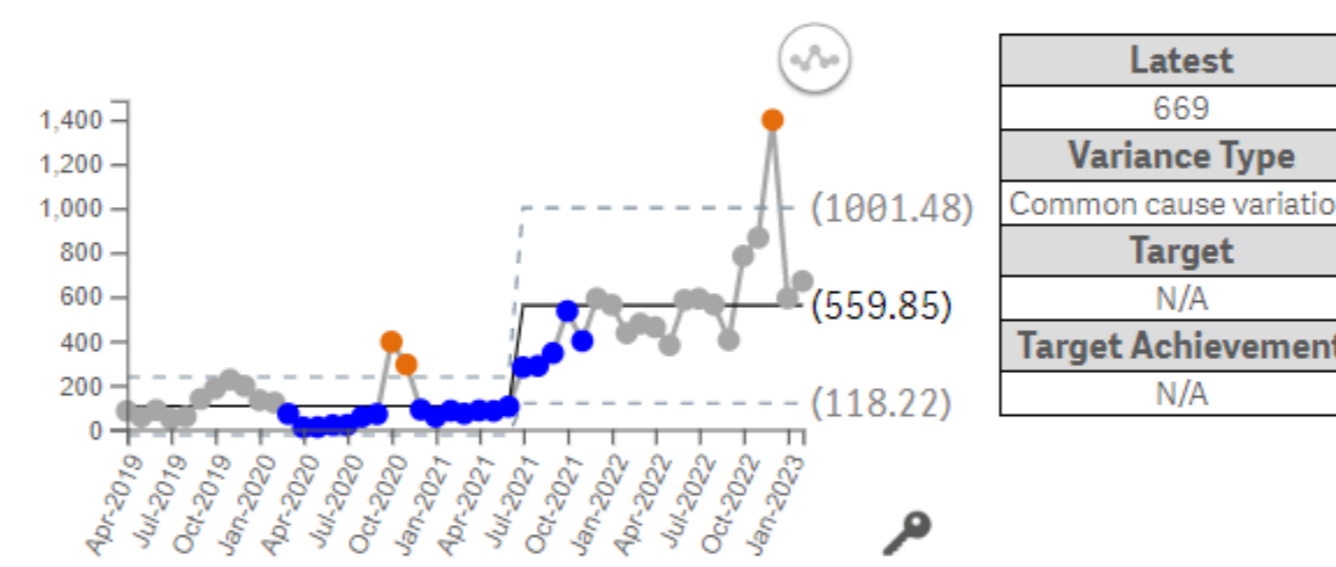


**Priority 3**  
Reduce waiting times for individuals in the Emergency Department

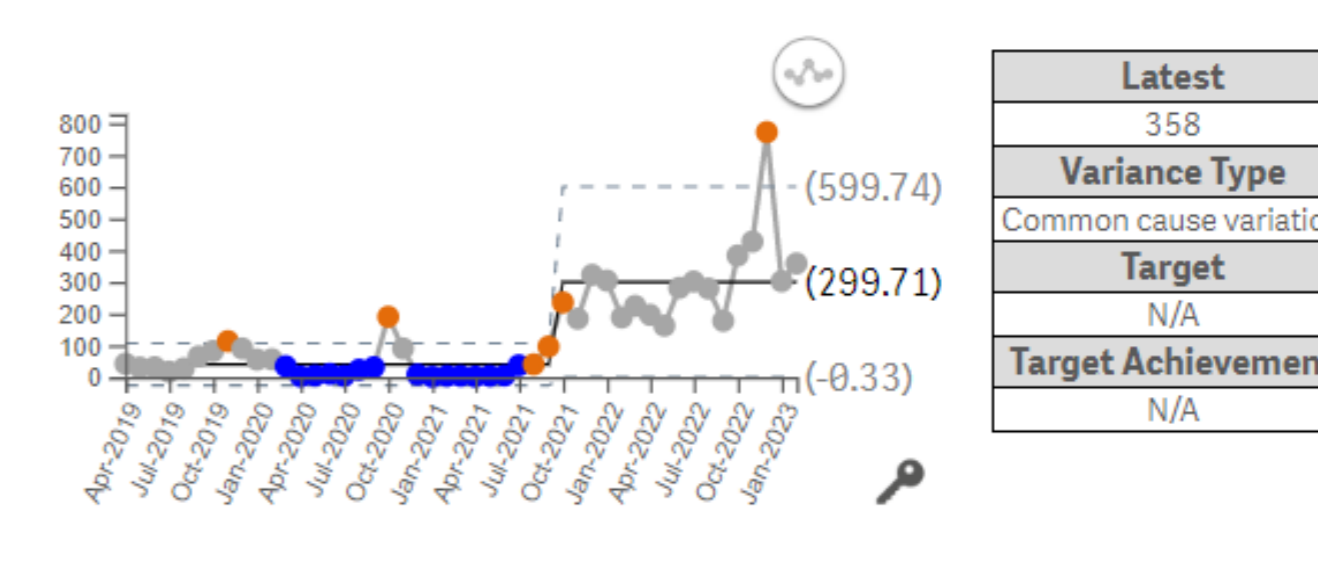
**8 Hour A&E Breaches**



**10 Hour A&E Breaches**



**12 Hour A&E Breaches**



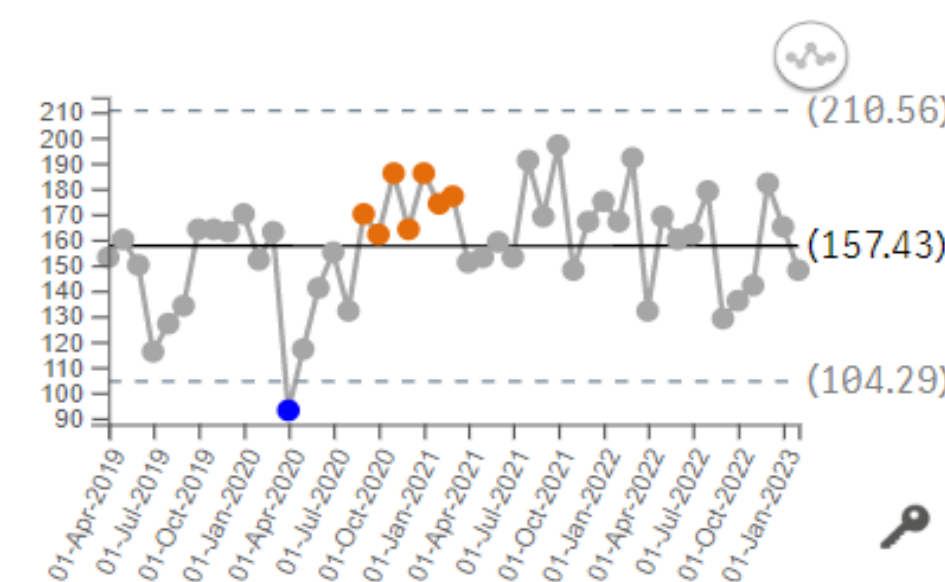
Graphs produced by the Quality Performance Team



### Quality Priorities - Focused Priorities

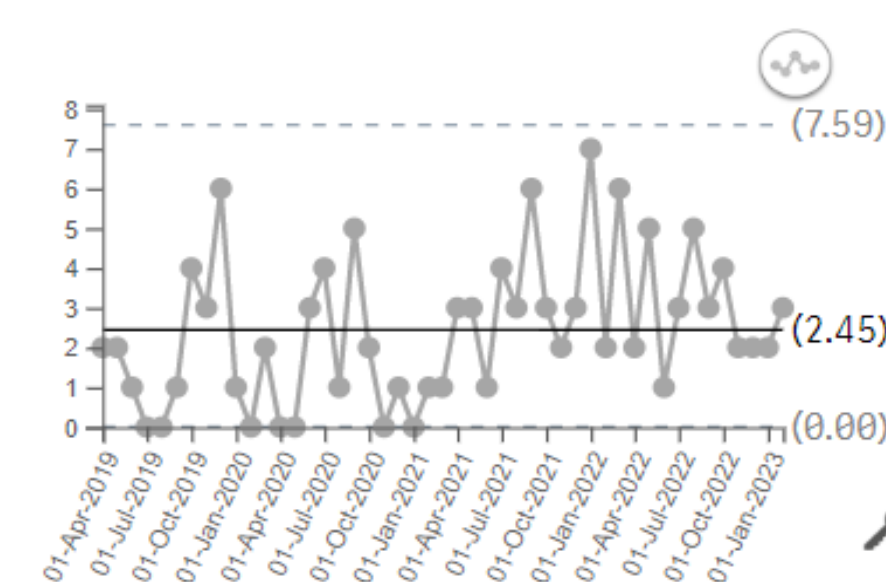
**Priority 1**  
Reducing the number of falls resulting in harm

No. of Falls



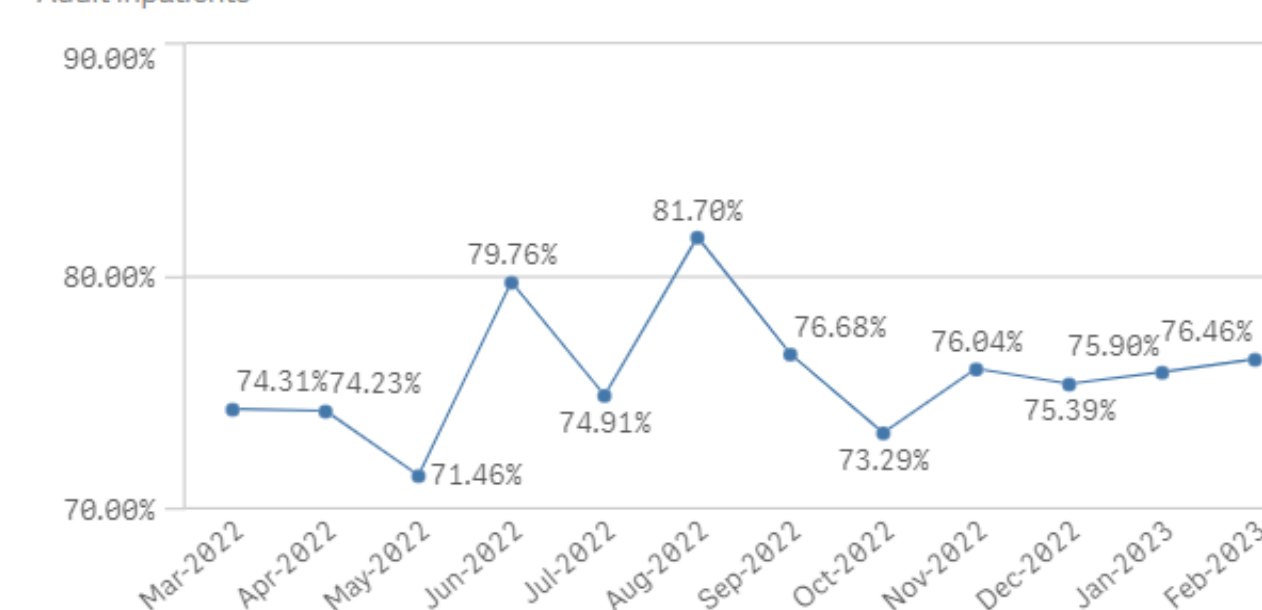
Latest	148
Variance Type	Common cause variation
Target	N/A
Target Achievement	N/A

No. of Harm Falls



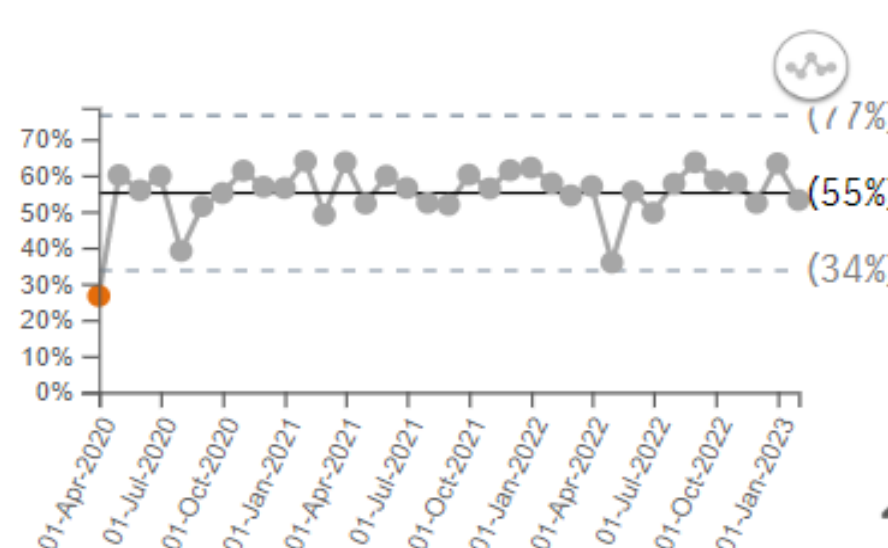
Latest	3
Variance Type	Common cause variation
Target	N/A
Target Achievement	N/A

% of pts that had a falls risk assessment on adm/trans to the ward  
Adult inpatients



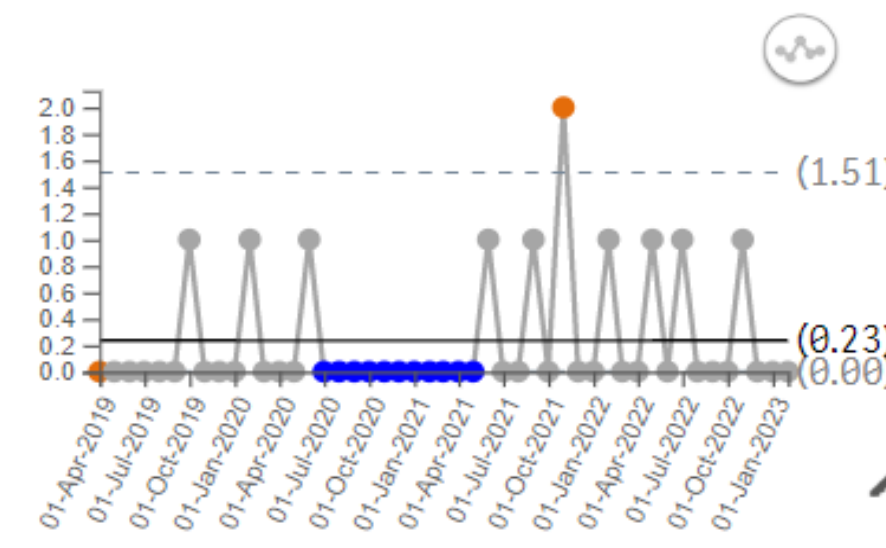
**Priority 2**  
End of Life Care

% of patients that had Last Days of Life Documentation (LULD)  
of those that died in hospital



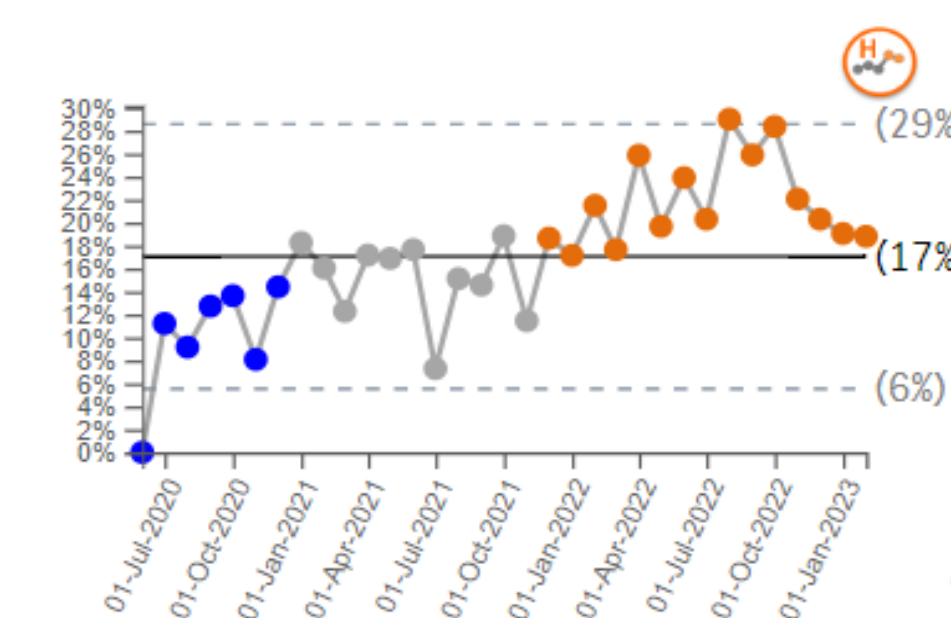
Latest	0
Variance Type	Common cause variation
Target	N/A
Target Achievement	N/A

Number of complaints relating to end of life care  
Where EOLC is in the subject (primary or secondary)



Latest	0
Variance Type	Common cause variation
Target	N/A
Target Achievement	N/A

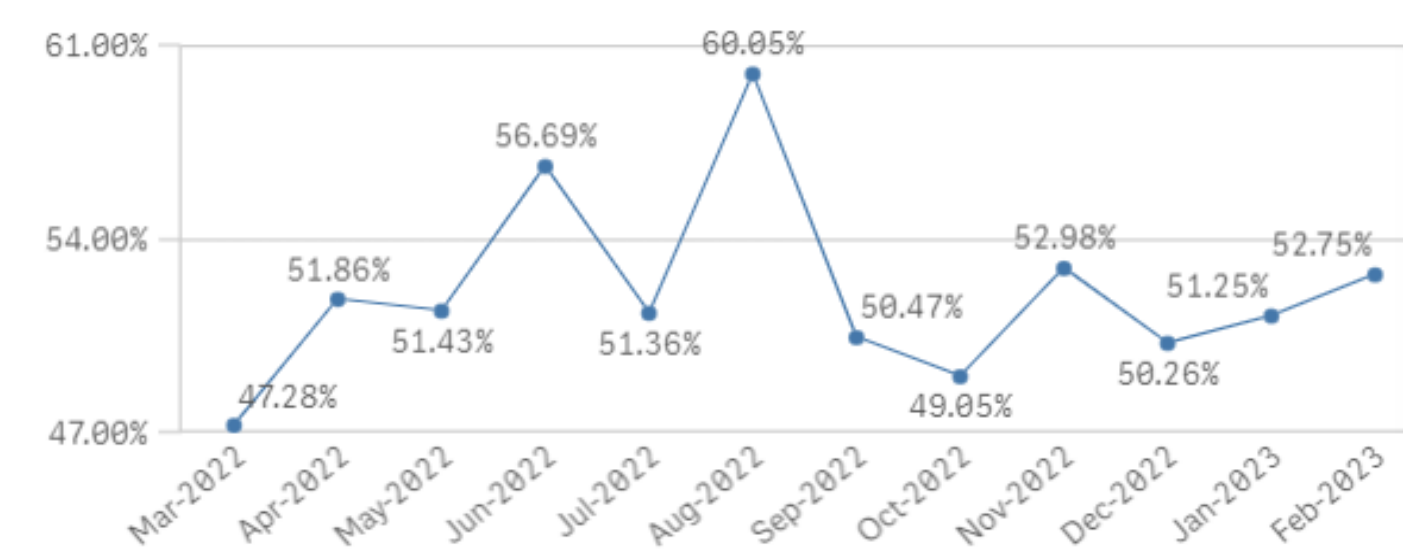
% of patients referred to HSPCT that died or were discharged before seen



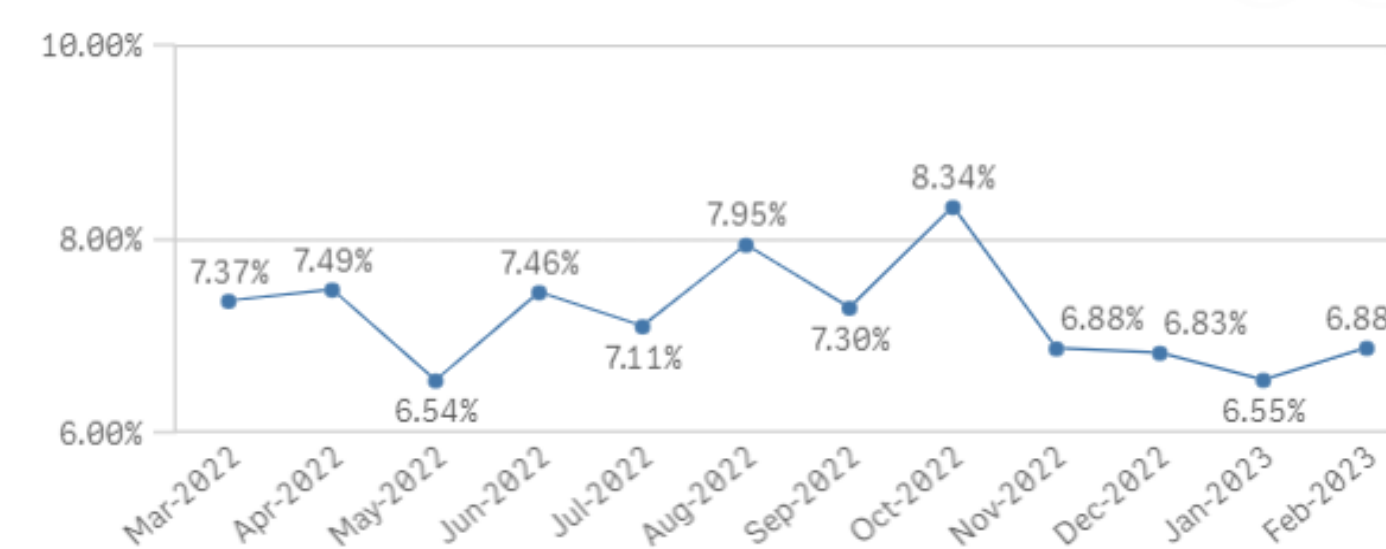
Latest	18.80%
Variance Type	Special cause variation - cause for concern (indicator where high is a concern)
Target	N/A
Target Achievement	N/A

**Priority 3**  
Clinical Documentation

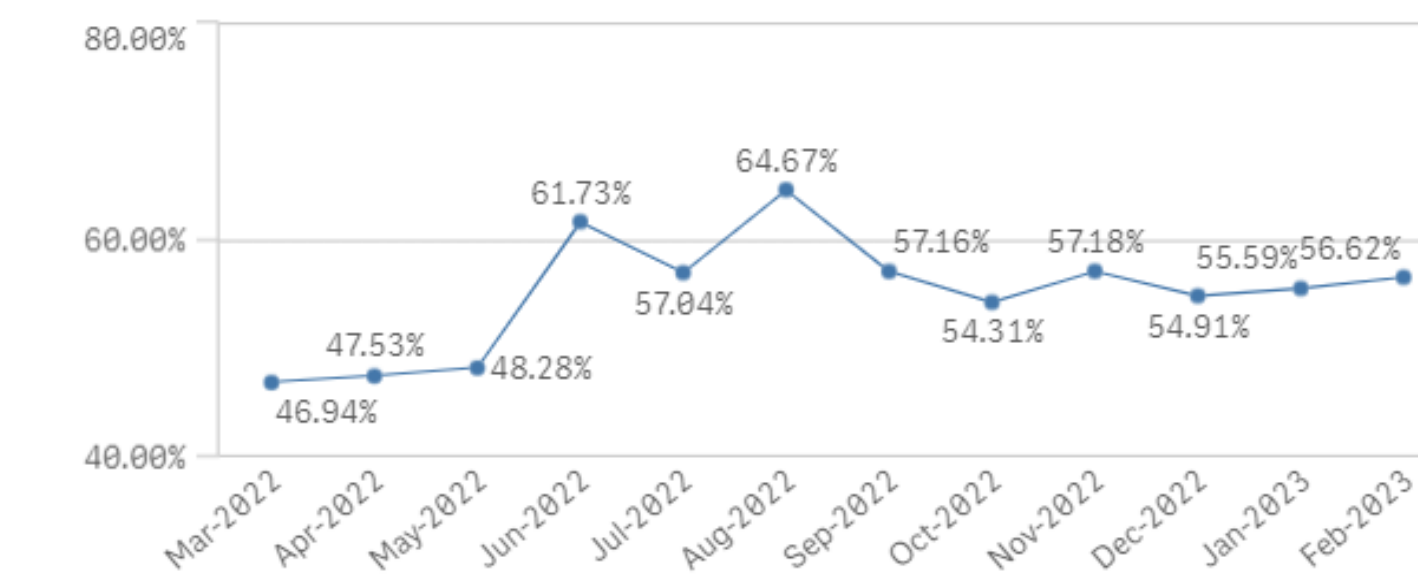
Ward Assurance Overall



Ward Assurance Elimination



Ward Assurance Pressure Ulcers



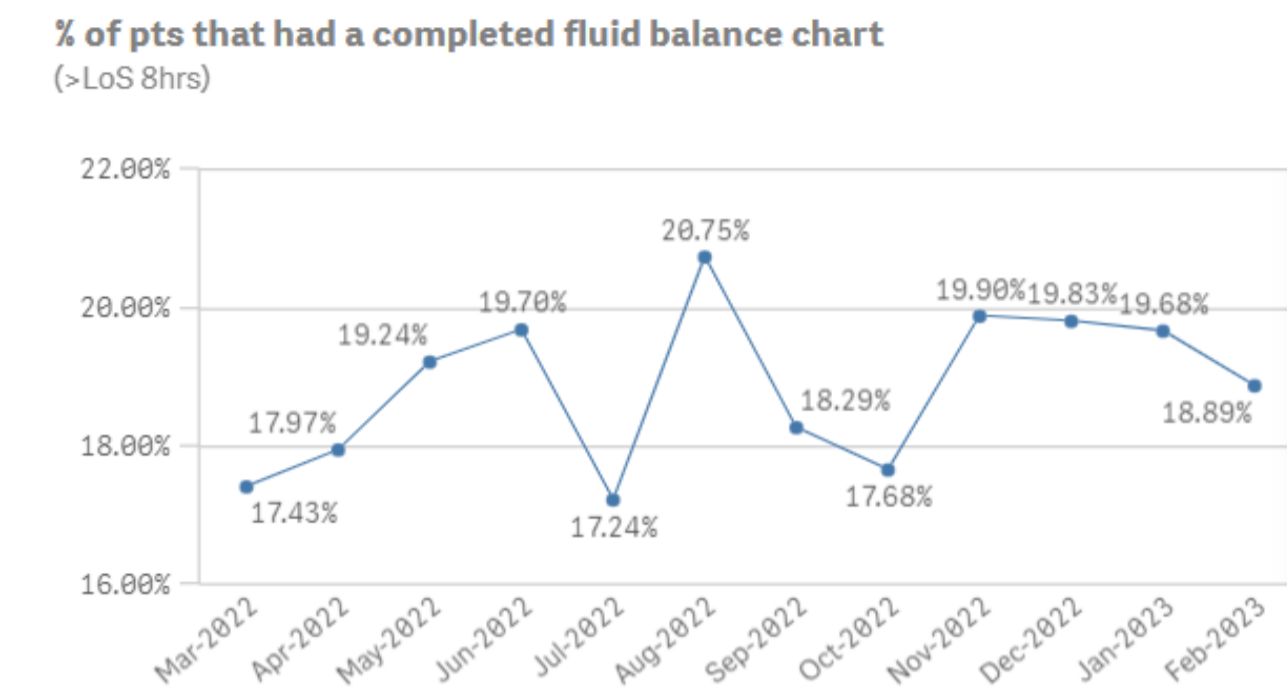
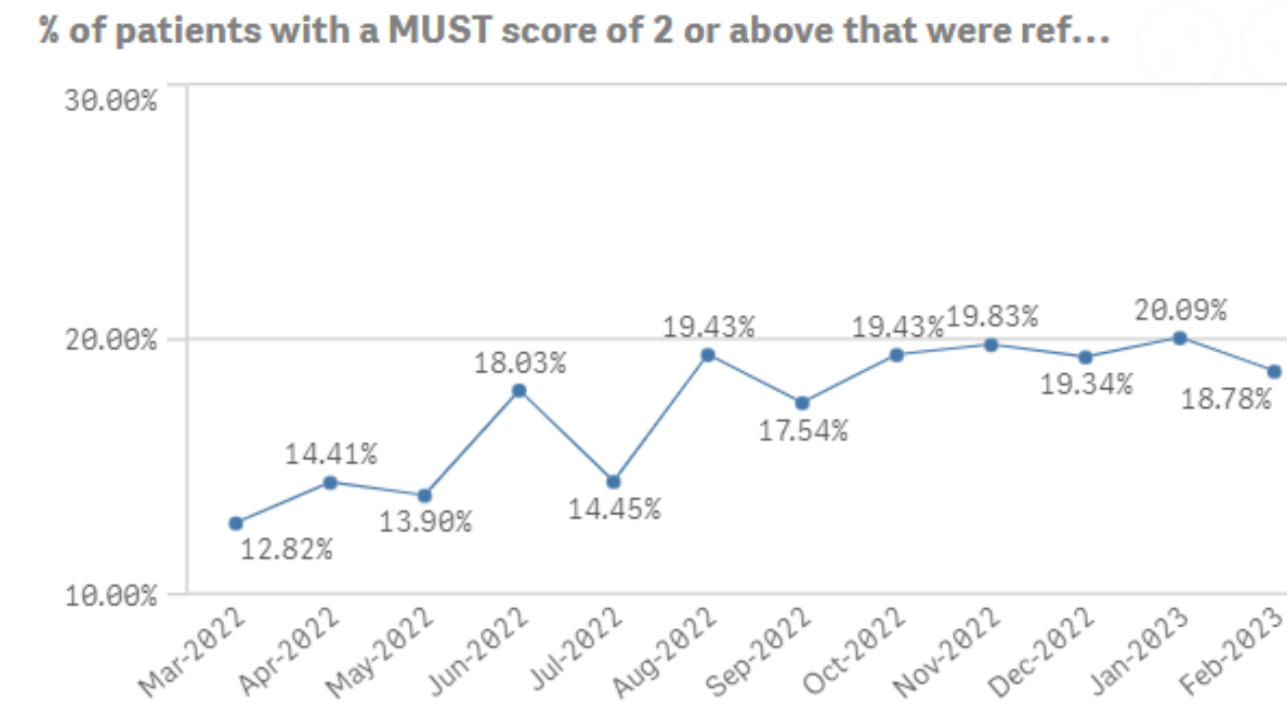
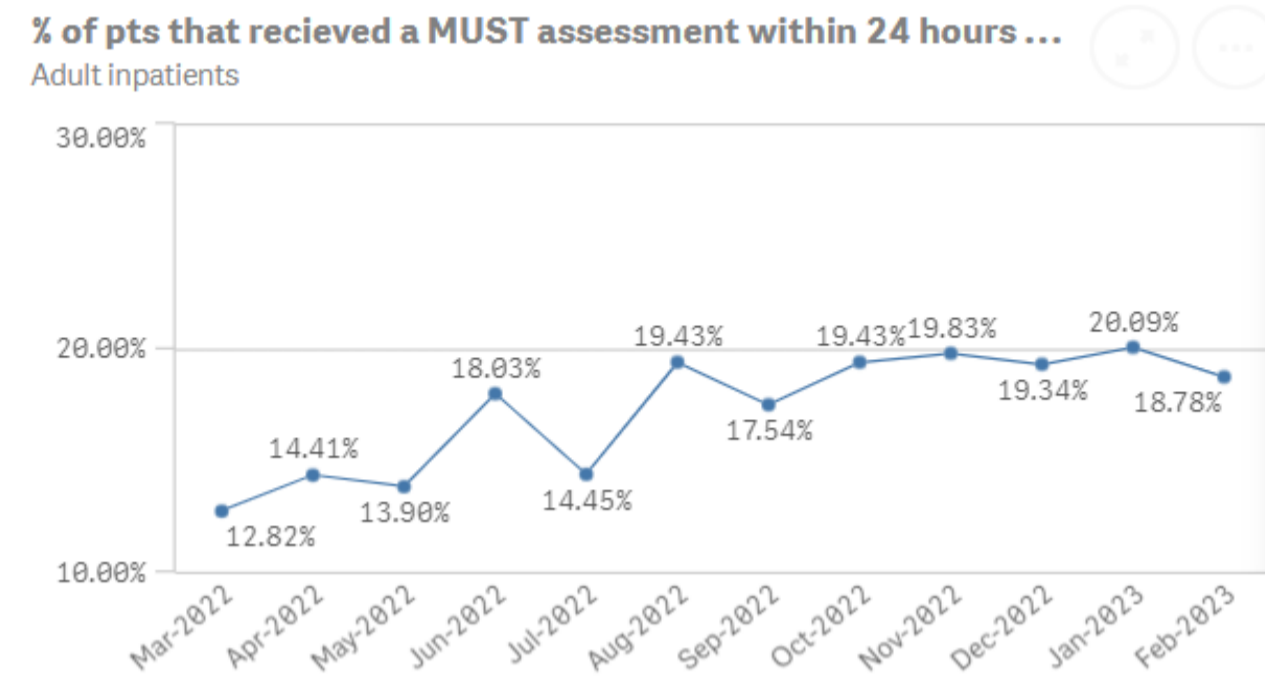
**Priority 4**  
Clinical Prioritisation

Not Available

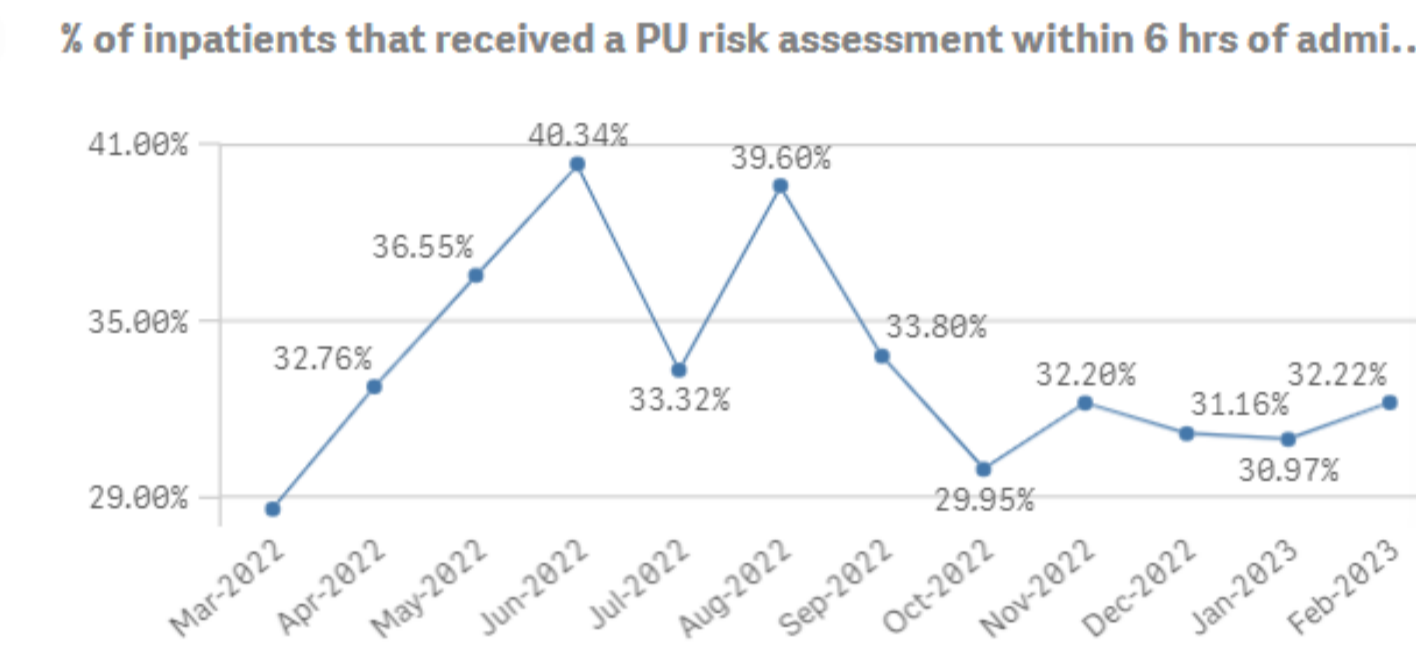
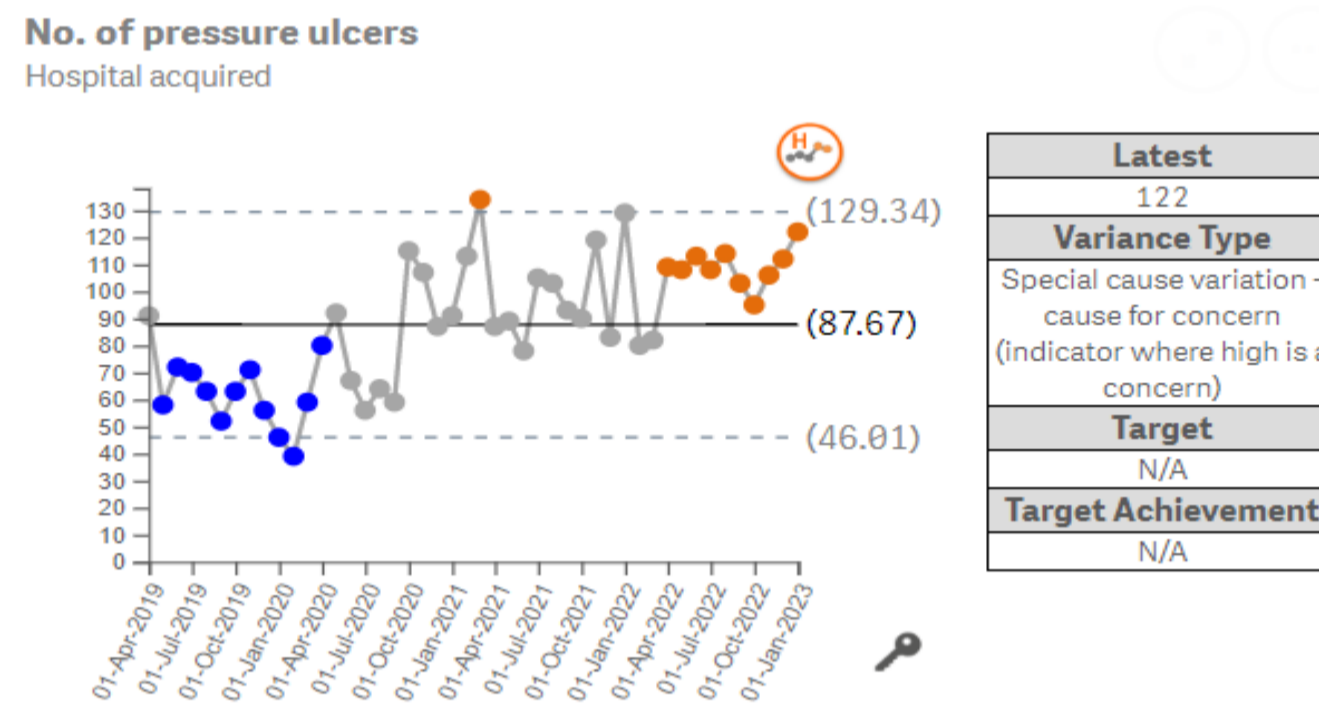
Graphs produced by the Quality Performance Team

### Quality Priorities - Focused Priorities

#### Priority 5 Nutrition and Hydration



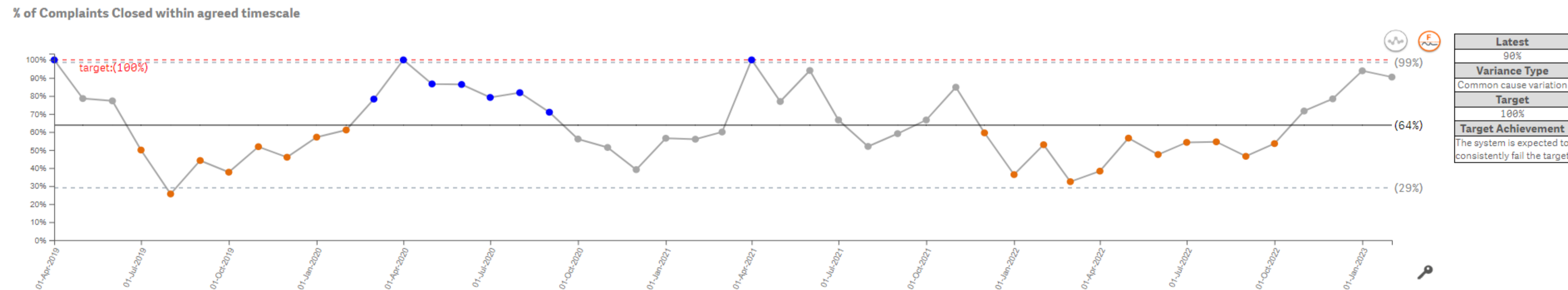
#### Priority 6 Reduction in the number of CHFT acquired pressure ulcers



95% of staff\* will have completed PU training in last 2 years.  
\*(RNs, Nursing Associates and HCAs)

# Trust Compliance 86.80%

#### Priority 7 Making complaints count



Graphs produced by the Quality Performance Team



## CQUIN - Key Measures

Indicator Name	Description	Top 5	Target	Apr-22	May-22	Jun-22	Q1	Jul-22	Aug-22	Sep-22	Q2	Oct-22	Nov-22	Dec-22	Q3	Jan-23	Feb-23	Mar-23	Q4		
<b>CCG1: Flu vaccinations for frontline healthcare workers</b>	Achieving 90% uptake of flu vaccinations by frontline staff with patient contact.	N	Min 70%, Max 90%	Data collection starts in Q3					Data collection starts in Q3				50.2%			50.2%					
<b>CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+</b>	Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment.	Y	Min 40%, Max 60%	57.00%				57.00%	59.00%				59.00%	63%			63%				
<b>CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions</b>	Achieving 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation (T0) and time of clinical response (T1) recorded.	Y	Min 20%, Max 60%	100.0%	84.6%	75.0%	84.4%	100.0%	42.9%	100.0%	66.7%	100.0%	72.3%	100.0%	92.5%						
<b>CCG4: Compliance with timed diagnostic pathways for cancer services</b>	Achieving 65% of referrals for suspected prostate, colorectal, lung and oesophago-gastric cancer meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways	N	Min 55%, Max 65%	8.04%	4.84%	4.21%	5.60%	7.15%	7.24%	9.75%	8.00%	11.20%	16.10%	12.60%	13.40%						
<b>CCG5: Treatment of community acquired pneumonia in line with BTS care bundle</b>	Achieving 70% of patients with confirmed community acquired pneumonia to be managed in concordance with relevant steps of BTS CAP Care Bundle.	N	Min 45%, Max 70%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%						
<b>CCG6: Anaemia screening and treatment for all patients undergoing major elective surgery</b>	Ensuring that 60% of major elective blood loss surgery patients are treated in line with NICE guideline NG24.	N	Min 45%, Max 60%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%						
<b>CCG7: Timely communication of changes to medicines to community pharmacists via the discharge medicines service</b>	Achieving 1.5% of acute trust inpatients having changes to medicines communicated with the patient's chosen community pharmacy within 48 hours following discharge, in line with NICE Guideline 5, via secure electronic message.	N	Min 0.5%, Max 1.5%	16.00%	15.70%	12.60%	14.90%	14.60%	15.50%	15.60%	15.20%	14.40%			14.40%						
<b>CCG8: Supporting patients to drink, eat and mobilise after surgery</b>	Ensuring that 70% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending.	Y	Min 60%, Max 70%	83.33%	54.84%	96.30%	78.00%	88.00%	90.00%	88.89%	89.00%	78.00%			88.00%						
<b>CCG9: Cirrhosis and fibrosis tests for alcohol dependent patients</b>	Achieving 35% of all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.	Y	Min 20%, Max 35%	12.90%	4.23%	3.77%	6.99%	4.29%	6.17%	1.75%	4.33%	7.25%	4.82%	1.79%	4.81%						
<b>CCG14: Assessment, diagnosis and treatment of lower leg wounds</b>	Achieving 50% of patients with lower leg wounds receiving appropriate assessment diagnosis and treatment in line with NICE Guidelines.	Y	Min 25%, Max 50%	28.40%				28.40%	43.50%				43.50%	35.82%			35.82%				

## CQUIN - Key Measures

Indicator Name	Reality	Response	Result
<b>CCG4: Compliance with timed diagnostic pathways for cancer services</b>	In Q3 we achieved 13.40% compliance, which is a small improvement from the previous quarters but still well below the 65% target.	This data is taken to a monthly collaborative meeting to assess current position. Assessment of the response of the 5 tumour sites is ongoing.	Achieving 65% of referrals for suspected prostate, colorectal, lung and oesophago-gastric cancer meeting timed pathway milestones as set out in the rapid cancer diagnostic
<b>CCG5: Treatment of community acquired pneumonia in line with BTS care bundle</b>	For the third quarter we are achieving 0.00%, this may be due to monitoring rather than an actual reflection of achievement	The low compliance is not a true reflection of current practice, there needs to be a means of recording the care bundle in EPR. This may be a quality improvement project for a junior doctor in the team.	Achieving 70% of patients with confirmed community acquired pneumonia to be managed
<b>CCG9: Cirrhosis and fibrosis tests for alcohol dependent patients</b>	Performance for Q3 is 4.81% which is below the 35% target.	Response not yet available	Achieving 35% of all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.
<b>CCG14: Assessment, diagnosis and treatment of lower leg wounds</b>	As of the third quarter we are achieving 35.82% compliance, which is below the target of 50%	Data collection framework is in place with a meeting set to take place every 4 weeks to sense check the data.	Achieving 50% of patients with lower leg wounds receiving appropriate assessment diagnosis and treatment in line with NICE Guidelines.

Hard Truths: Safe Staffing Levels

TRUST - CHPPD & FILL RATES (REGISTERED & NON REGISTERED CLINICAL STAFF)

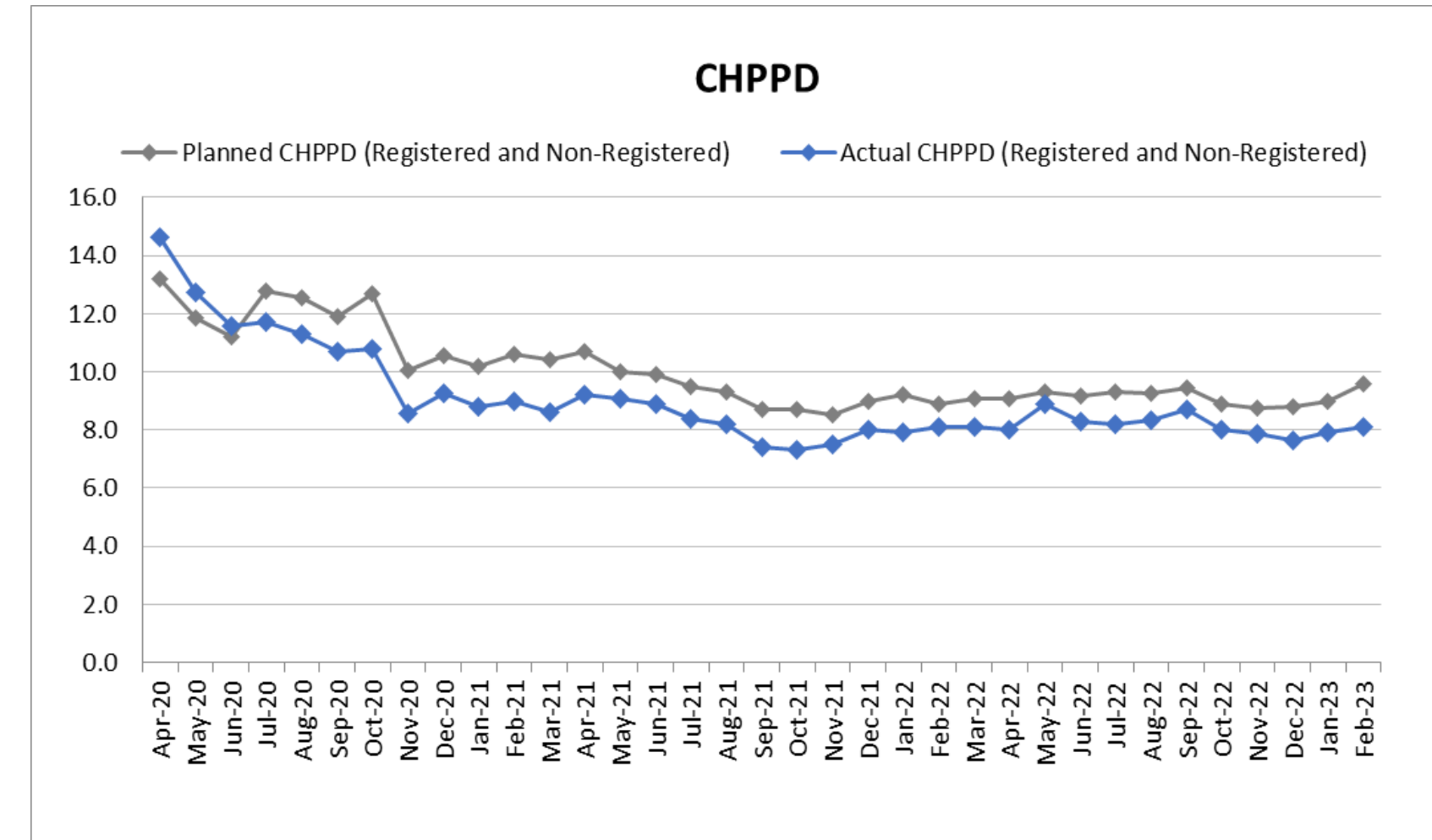
	Dec-22	Jan-23	Feb-23
FILL RATES - DAY (REGISTERED & NON REGISTERED CLINICAL STAFF)	88.6%	84.0%	84.0%
FILLRATES - NIGHT (REGISTERED & NON REGISTERED CLINICAL STAFF)	92.7%	93.8%	93.8%

	Dec-22	Jan-23	Feb-23
PLANNED CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF)	8.8	9.0	9.6
ACTUAL CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF)	7.6	7.9	8.1

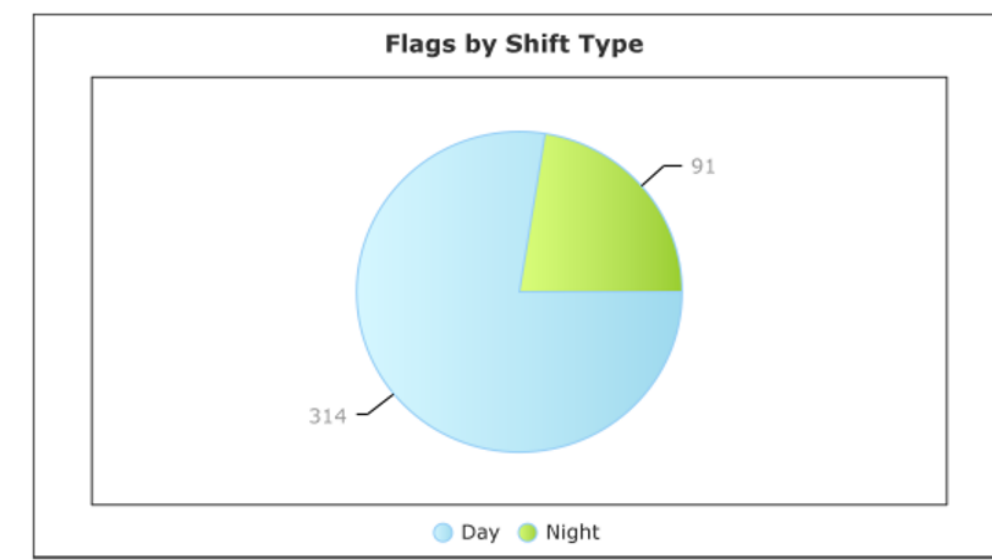
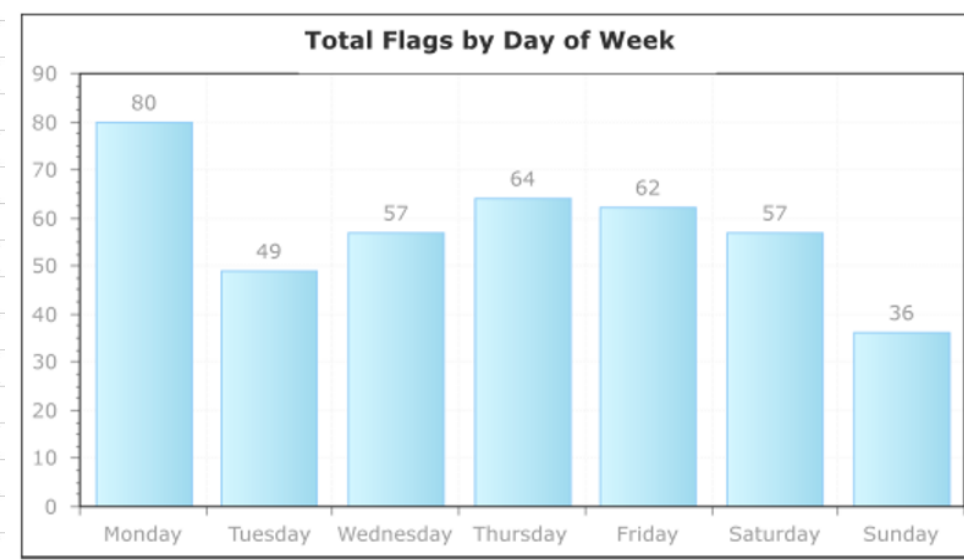
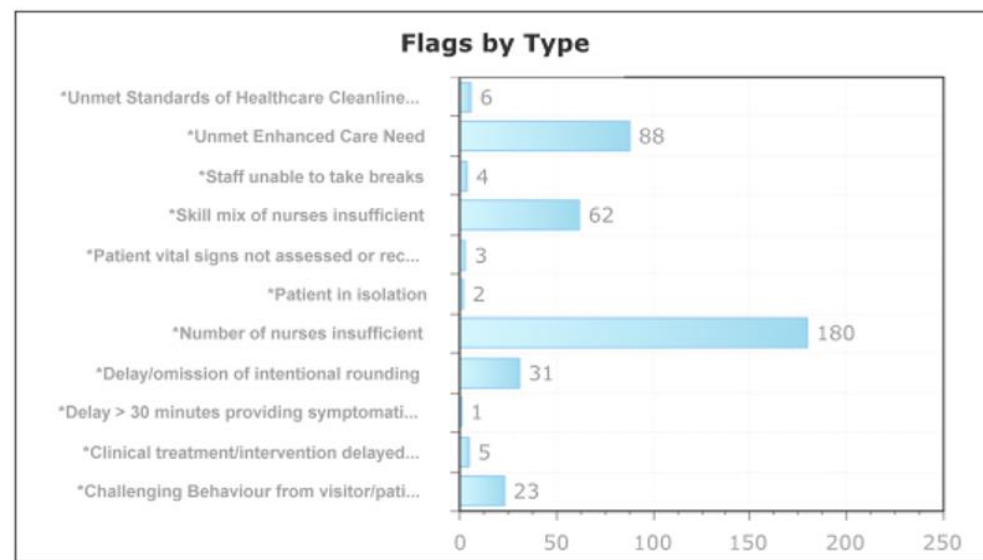
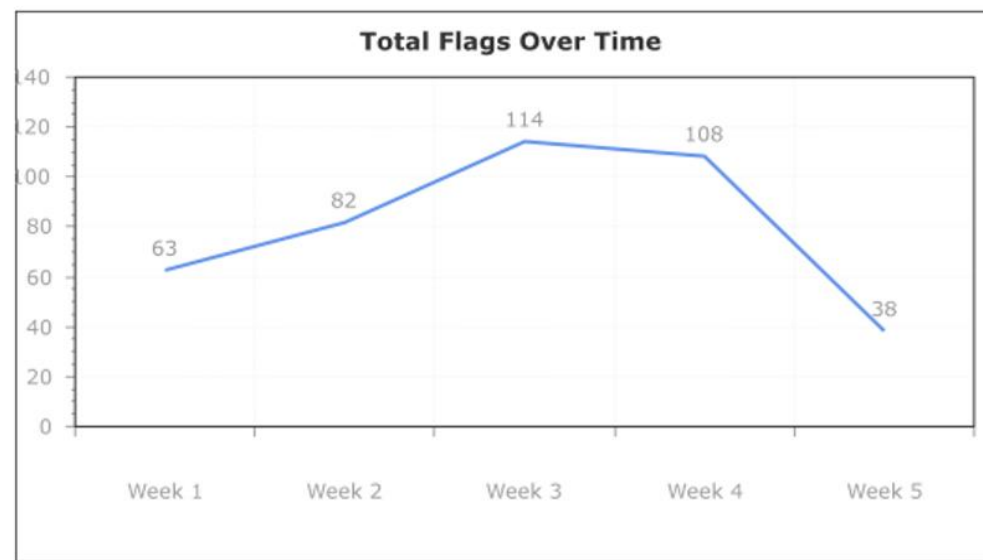
CHPPD provides a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatient wards. CHPPD is not a stand alone measure and is be used alongside clinical quality and safety outcome measures.

A review of February 2023 data indicates that the combined RN and non-registered clinical staff metrics resulted in 24 of the 28 clinical areas having fewer CHPPD than planned, with a total deficit of 1.5 CHPPD across the Trust. This apparent widening of the gap between planned and actual results from the inclusion of those shifts which were planned but above the normal workforce model, to provide care for patients in the additional capacity beds (e.g. Acute Floor and Stroke). The planned CHPPD now also includes the enhanced support worker shifts required to care for patients requiring 1:1 care. The impact of this change is also reflected in the recorded shift fill percentage, which is more representative of the clinical reality, whereas previous reports showed an apparent over staffing (<100%) in some areas.

A review of the nurse sensitive indicators demonstrates incidence of falls to be within normal variation. The apparent rise in pressure ulcers on the Medical division SPC chart is as a result of reporting actual numbers, rather than prevalence per 1,000 bed days. The increase in actual number of pressure ulcers correlates to the increased number of medical inpatients sustained since the summer of 2022. Future reporting will reflect prevalence rather than actual numbers for more consistent comparison.



STAFFING RED FLAG INCIDENTS



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). As part of the escalation process staff are asked to record any staffing concerns through safe care live. These are monitored daily by the divisions and monthly through the Nursing workforce strategy group.

The Red Flags are reviewed as part of the daily staffing meetings and immediate mitigate put in place as required.



### Hard Truths: Safe Staffing Levels (2)

Aggregate Position

Trend

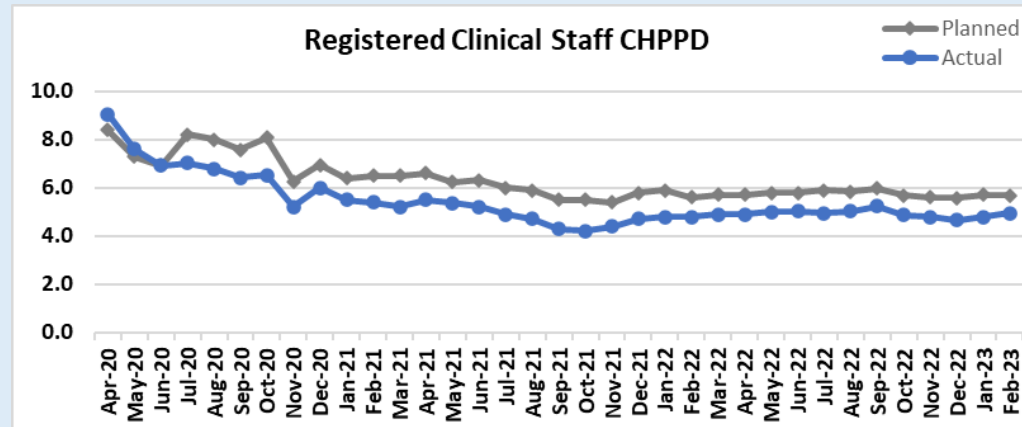
Result

#### CHPPD BY STAFF TYPE

##### Registered Clinical Staff

Monthly hours (day and night combined) divided by average patient count at midnight

CHPPD was 5.7 for planned and 5.0 for actual for Registered Clinical Staff

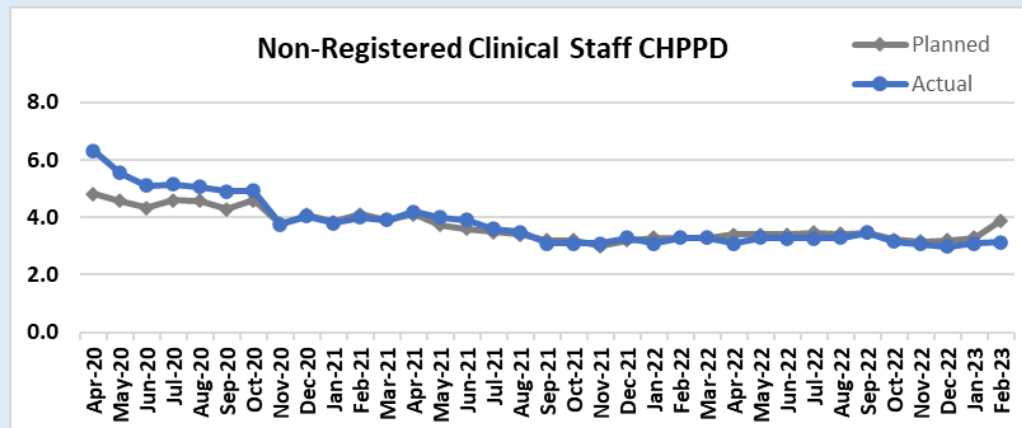


Overall there was a shortfall of 0.7 CHPPD against an overall requirement of 5.7 CHPPD provided by registered staff. Professional judgement informs decision-making at the twice daily staffing meetings to mitigate the risk across the clinical areas, and staff are redeployed to optimise safety. The number of falls within month for both the Medical and Surgical divisions is within normal common cause variation as is the number of pressure ulcers within Surgery. The number of pressure ulcers in the Medical division was reported above the mean for the 7th consecutive month, potentially triggering the need for further exploration to identify any special cause variation. However, these are absolute numbers, not prevalence per 1,000 bed days and thus the increased number of medical in-patients since July 2022 would explain the increase in the number of pressure ulcers.

##### Non-Registered Clinical Staff

Monthly hours (day and night combined) divided by average patient count at midnight

CHPPD was 3.9 for planned and 3.1 for actual for Non-Registered Clinical Staff



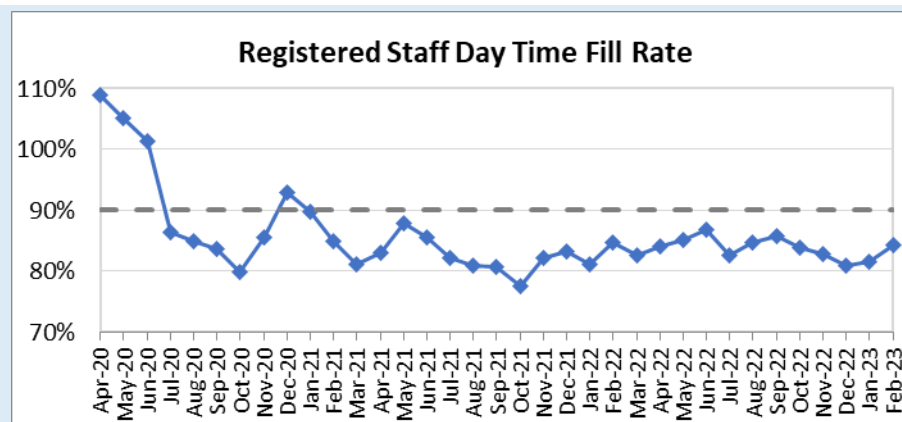
There was a shortfall in the planned CHPPD of 0.8 provided by non-registered clinical staff. This apparent step change between planned and actual represents the shortfall in availability to meet the 1:1 care allocation to patients who require that level of care. Previous reports have only included workforce model shifts in the 'planned' hours, whereas this report now also includes the 1:1 care requirements in the planned CHPPD. The apparent significant drop in HCSW shift fill rates largely represents the unfilled 1:1 shifts not previously reported, and is more representative of the clinical reality.

#### FILL RATES BY STAFF AND SHIFT TYPE

##### Registered Clinical Staff Day

Monthly expected hours by shift versus actual monthly hours per shift only. Day shift only.

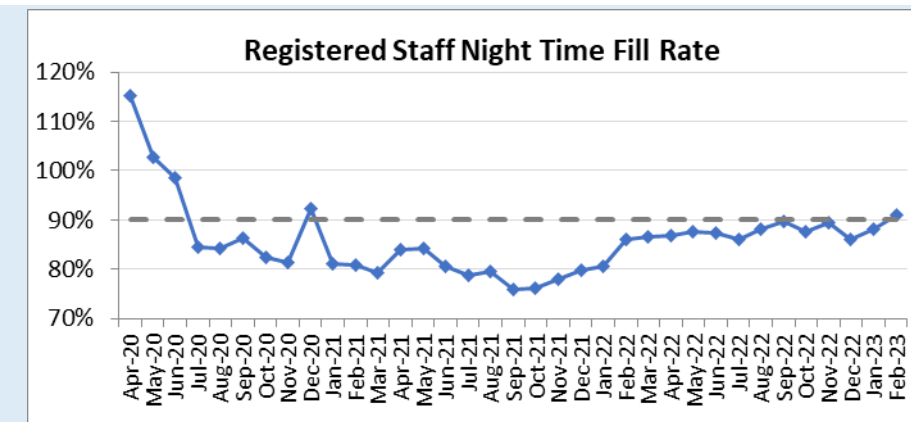
84.25% of expected Registered Clinical Staff hours were achieved for day shifts.



##### Registered Staff Night

Monthly expected hours by shift versus actual monthly hours per shift only. Night shift only.

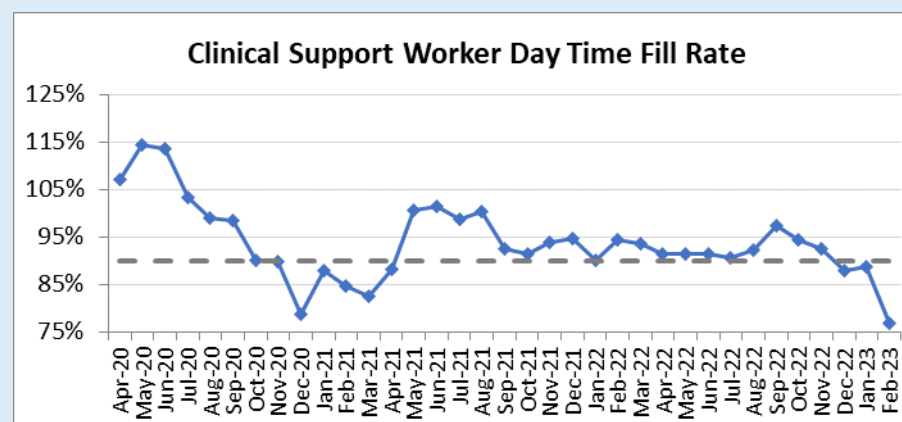
90.96% of expected Registered Clinical Staff hours were achieved for night shifts.



##### Non-Registered Clinical Staff Day

Monthly expected hours by shift versus actual monthly hours per shift only. Day shift only.

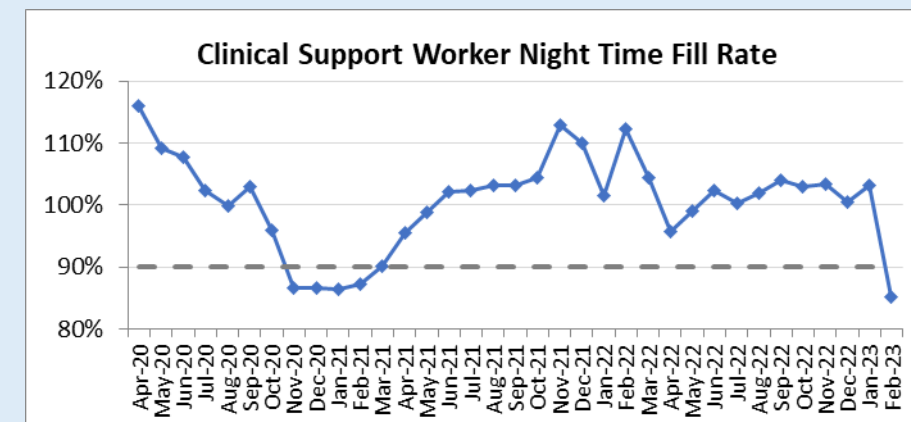
76.78% of expected Non-Registered Clinical Staff hours were achieved for Day shifts.



##### Non-Registered Clinical Staff Night

Monthly expected hours by shift versus actual monthly hours per shift only. Night shift only.

85.18% of expected Non-Registered Clinical Staff hours were achieved for night shifts.



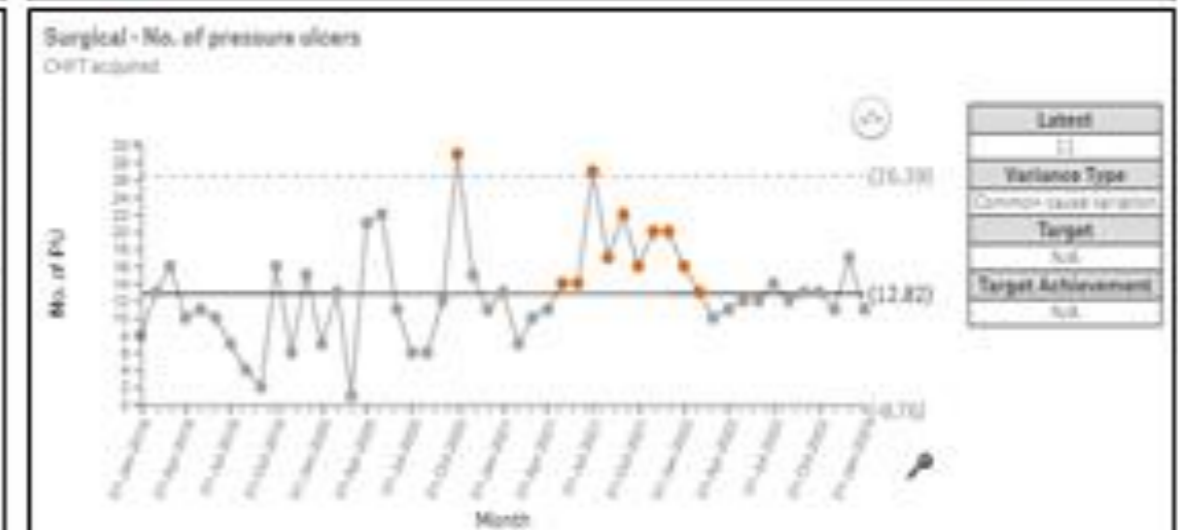
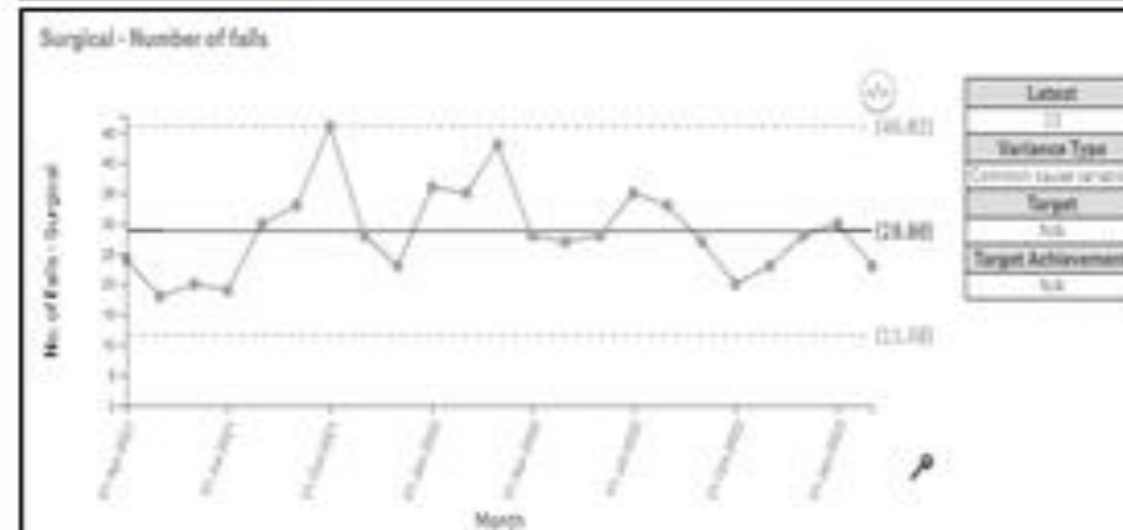
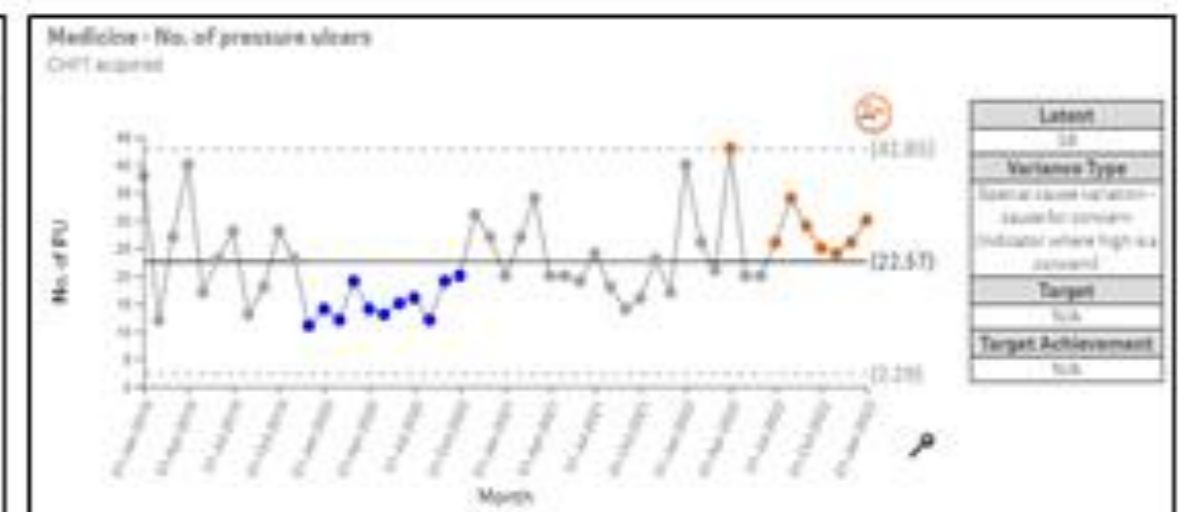
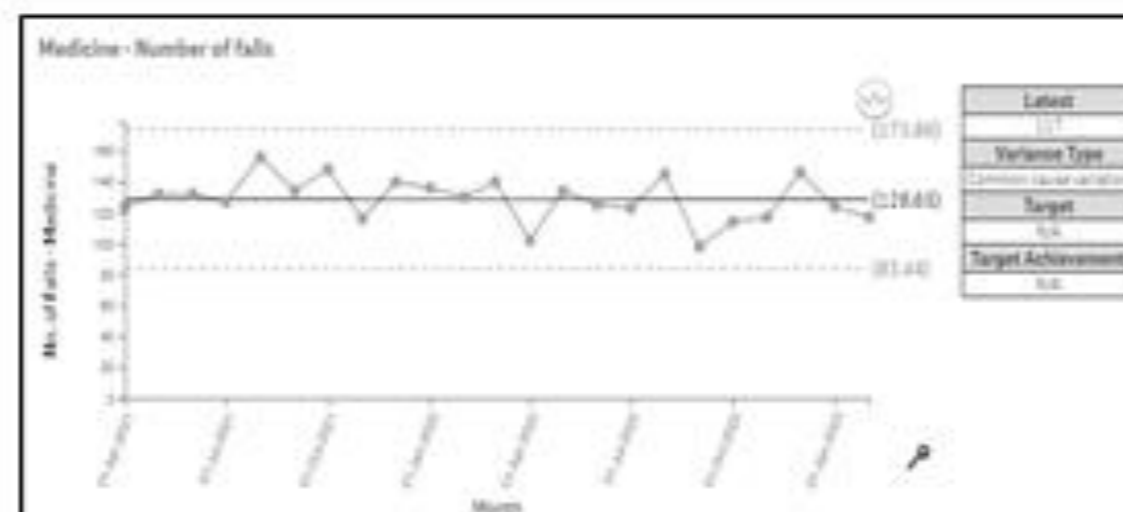
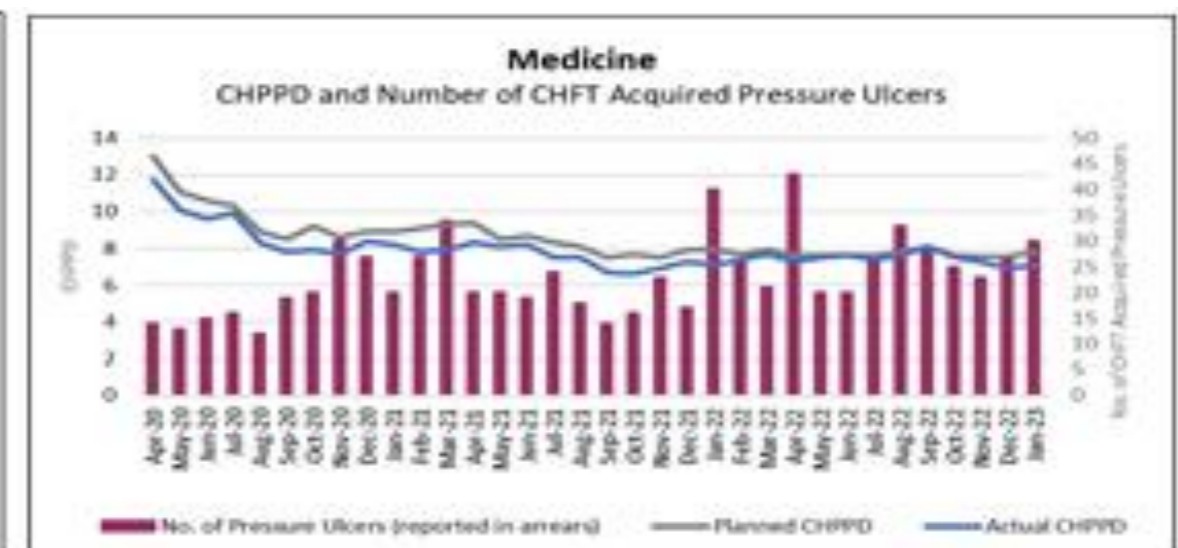
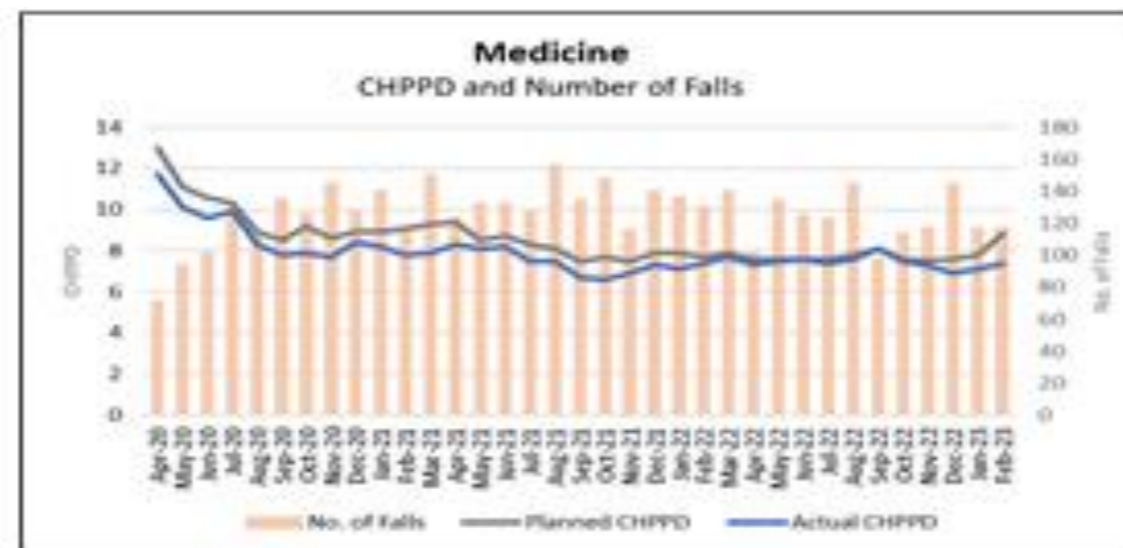


Hard Truths: Safe Staffing Levels (3)

NURSING QUALITY INDICATORS AND FILLRATES BY WARD AND DIVISION

Ward	Average Fill Rates				CHPPD	
	DAY - Registered Clinical Staff (%)	DAY - Non Registered Clinical Staff (%)	NIGHT - Registered Clinical Staff (%)	NIGHT - Non Registered Clinical Staff (%)	Total PLANNED CHPPD	Total ACTUAL CHPPD
CRH ACUTE FLOOR	90.8%	79.8%	100.4%	86.6%	8.6	7.8
HRI ACUTE FLOOR	95.5%	85.8%	100.7%	92.0%	8.9	8.3
RESPIRATORY FLOOR	66.4%	71.7%	89.9%	74.9%	9.6	7.2
WARD 5	86.2%	76.0%	99.7%	89.4%	8.0	6.9
WARD 6	81.1%	52.9%	100.0%	100.0%	4.2	3.4
WARD 6C	85.9%	60.6%	104.5%	65.6%	16.6	12.6
WARD 6AB	85.9%	60.6%	104.5%	65.6%	9.0	6.8
WARD CCU	76.0%	56.7%	93.2%		8.8	7.2
STROKE FLOOR	90.8%	65.6%	98.7%	77.1%	8.8	7.3
WARD 12	99.5%	76.0%	96.6%	88.0%	7.2	6.4
WARD 15	84.1%	81.4%	93.1%	85.8%	9.8	8.3
WARD 17	83.5%	79.0%	96.5%	95.6%	7.7	6.7
WARD 18	96.0%	76.6%	65.5%	106.0%	11.4	9.7
WARD 20	87.0%	93.4%	95.6%	95.7%	7.0	6.5
<b>Medicine</b>	<b>84.41%</b>	<b>73.88%</b>	<b>96.03%</b>	<b>83.15%</b>	<b>8.8</b>	<b>7.4</b>
WARD 21	84.9%	81.0%	95.8%	82.6%	8.7	7.4
WARD 22	92.8%	87.2%	92.4%	89.7%	7.7	7.0
ICU	78.2%	66.7%	79.8%	51.8%	49.8	37.8
WARD 8A	84.7%	46.5%	76.6%	82.1%	10.8	7.7
WARD 8C	99.2%	75.2%	98.1%	96.4%	8.1	7.4
WARD 10	82.0%	85.4%	87.5%	95.7%	7.7	6.7
WARD 14	89.1%	89.1%	100.0%	100.0%	7.6	7.1
WARD 19	89.5%	88.3%	97.6%	96.5%	8.0	7.4
SAU HRI	98.3%	83.1%	99.8%	94.1%	8.1	7.7
<b>Surgical</b>	<b>86.6%</b>	<b>79.4%</b>	<b>89.3%</b>	<b>87.5%</b>	<b>10.3</b>	<b>8.8</b>
WARD LDRP	88.7%	79.2%	82.2%	97.7%	22.9	19.7
WARD NICU	84.9%	63.1%	89.6%	41.4%	13.8	11.5
WARD 3ABCD	77.4%	84.5%	80.0%	90.7%	13.6	11.0
WARD 4ABC	71.7%	84.2%	80.5%	69.6%	6.4	4.9
Ward 1D	101.1%	69.5%	98.7%	77.3%	8.6	7.8
<b>FSS</b>	<b>81.5%</b>	<b>80.8%</b>	<b>82.8%</b>	<b>80.4%</b>	<b>12.7</b>	<b>10.4</b>
<b>TRUST</b>	<b>84.25%</b>	<b>76.78%</b>	<b>90.96%</b>	<b>85.18%</b>	<b>9.6</b>	<b>8.1</b>

Nursing Quality Indicators



KEY: >100% 100-96% 95-85% <85%

## Hard Truths: Safe Staffing Levels (4)

### Conclusions and Recommendations

#### Conclusions

The Trust remains committed to achieving its nurse and midwifery staffing establishments to provide safe and compassionate care to patients.

Ongoing activity:

1. The dashboard aligns the workforce position to an agreed suite of nurse sensitive indicators and is reviewed weekly at the Monday Safer Staffing Meeting, for which terms of reference are being revised to include a greater focus on quality metrics.
2. The Nursing, Midwifery and AHP Workforce Steering Group is progressing work to understand the detail of the vacancy position and aligning this to the recruitment/training strategy in partnership with the local HEI, as well as high impact retention strategies.
3. A review of the current Nursing and Midwifery workforce plans is underway, supported by Workforce Business Intelligence, reviewing directorate specific pressures to inform recruitment and retention strategies. The Safer Nursing Care Tool (Acuity/Dependency Scoring) has been used on inpatient wards and the emergency departments to collect data to inform the next bi-annual review in May 2023.
4. The International recruitment project continues to progress. CHFT have been successful in a bid for funding from NHSE to support recruitment of a further 30 International Nurses to arrive before the end of November 2023.
5. Trainee Nursing Associate apprenticeships and Registered Nurse Apprenticeships continue to be supported to assist the RN workforce recruitment strategy.
6. There is a strong commitment, with associated operational plans, to retract from Agency spending, commencing with the high cost agencies.



# Workforce Metrics

March 2023



Target:  
Vacancies (NHSi  
submitted position)  
– 230.08 FTE

## Workforce

Headcount	↑	<b>6264</b>
Actual FTE	↑	<b>5571.31</b>
Establishment FTE	↑	<b>5988.05</b>
Vacancies FTE	↓	<b>416.74</b>

### Most Vacancies:

Nursing and Midwifery (163.28 FTE)  
Admin & Clerical (73.92 FTE)  
Additional Clinical Services (70.86 FTE)



Target:  
EST - 90%  
Appraisal – 95%

## Essential Safety Training & Appraisal

Overall EST Compliance	↑	<b>93.20%</b>
Appraisal Compliance*	↑	<b>76.99%</b>

\*74.476% at the end of appraisal season 2022/2023.

### Lowest EST Core Suite Elements:

Fire Safety (88.28%)  
Safeguarding (90.30%)



Target:  
Overall - 4.75%  
Long Term – 3.0%  
Short Term – 1.75%

## Non Covid- Sickness Absence

Rolling 12 month	↑	<b>4.83%</b>
In-month	↓	<b>5.06%</b>
FTE days lost per FTE (Rolling)	↓	<b>20.93</b>

### Main Reason (in-month):

Anxiety, stress, and depression (26.19%)

### Highest Staff Groups (in-month):

Estates & Ancillary (10.78%)  
Additional Clinical Services (7.42%)



Targets:  
Advised by WYATT  
Streamlining  
1 8 days  
2 45 days  
3 3 days

## Recruitment

Vacancy approval to advert placement <sup>1</sup>	↓	<b>9.2</b>
Interview to conditional offer <sup>2</sup>	↑	<b>2.7</b>
Unconditional offer to acceptance <sup>3</sup>	↓	<b>0.0</b>



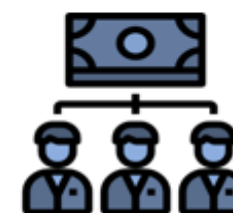
Target:  
Rolling – 11.5%

## Turnover

Rolling 12 month	↓	<b>8.70%</b>
In-month	↓	<b>0.49%</b>
Leavers FTE	↑	<b>27.01</b>

### Highest Staff Groups:

Estates & Ancillary (13.83%)  
Allied Health Professionals (11.44%)  
Administrative & Clerical (10.99%)



Forecast Budget (YTD):  
Substantive – £272.36M  
Bank – £16.68M  
Agency – £5.53M

## Spend (YTD)

Substantive	<b>£259.41M</b>
Bank	<b>£30.98M</b>
Agency	<b>£13.00M</b>

### Highest Agency Spend:

Medical and Dental (£2.2M)  
Nursing and Midwifery (£9.9M)

# Directorate Health Heatmap

Directorate	Division	NHS SS Response Rate 2022	Engagement Score 2022	EST (Mar 2023)	AfC Appraisal 2022-23 (Mar 2023)	Sickness (Non-Covid) (12m) (Feb 2023)	Annual Leave Usage (Apr 2022 - Feb 2023)	Turnover (12m) (Feb 2023)	Vacancy Rate (Feb 2023)	Health Score
Finance	Corporate	86.7%	8.0	99.5%	97.6%	1.21%	85.46%	4.6%	-5.3%	88.9%
Workforce and Organisational Development	Corporate	87.1%	7.7	97.1%	95.7%	3.18%	85.94%	12.5%	-5.8%	77.8%
Community Management	Community	66.7%	7.4	98.0%	89.6%	2.97%	89.32%	2.1%	-2.1%	72.2%
FSS Management	Families & Specialist Services	56.7%	7.8	93.8%	96.6%	4.87%	74.19%	9.2%	0.9%	72.2%
Information	Health Informatics	86.8%	7.6	98.7%	94.1%	2.34%	83.46%	4.3%	0.1%	72.2%
Community Therapies	Community	54.4%	6.8	95.4%	90.9%	4.83%	93.57%	11.5%	6.0%	72.2%
General Surgery	Surgery & Anaesthetics	37.1%	7.4	92.6%	90.0%	4.31%	90.39%	5.7%	4.3%	66.7%
Critical Care	Surgery & Anaesthetics	56.9%	6.7	98.0%	74.0%	9.06%	89.44%	7.7%	-8.2%	66.7%
Corporate & Operations	Health Informatics	68.2%	7.3	94.8%	90.6%	2.35%	76.83%	14.0%	8.0%	61.1%
Outpatients & Records Services	Families & Specialist Services	62.6%	6.5	98.7%	97.5%	5.94%	92.75%	15.0%	11.3%	61.1%
Corporate Services	Corporate	71.6%	7.8	92.2%	64.9%	2.33%	62.98%	16.8%	-4.8%	61.1%
Radiology	Families & Specialist Services	44.8%	6.4	97.8%	92.4%	3.58%	58.68%	10.0%	9.4%	61.1%
Surgical Divisional Support	Surgery & Anaesthetics	73.3%	7.3	92.3%	71.0%	4.82%	45.73%	7.5%	9.8%	56.3%
Head & Neck	Surgery & Anaesthetics	42.4%	7.2	94.7%	91.3%	5.40%	91.59%	12.2%	7.8%	55.6%
Quality	Corporate	62.2%	7.1	93.0%	59.2%	6.33%	83.79%	9.4%	-2.8%	55.6%
Medical Divisional Management	Medical	57.6%	7.0	91.9%	80.0%	6.83%	47.88%	5.5%	-1.8%	55.6%
Pharmacy	Families & Specialist Services	51.8%	6.8	97.0%	90.6%	4.85%	87.44%	14.4%	8.7%	50.0%
Community Nursing	Community	34.7%	7.0	93.7%	84.6%	7.25%	91.14%	5.0%	-6.0%	50.0%
Operating Services	Surgery & Anaesthetics	33.8%	5.9	91.6%	79.4%	6.39%	92.73%	7.6%	0.0%	44.4%
Pathology	Families & Specialist Services	40.8%	6.4	97.3%	91.0%	6.68%	85.86%	10.9%	9.1%	44.4%
Service Delivery	Health Informatics	-	-	98.8%	85.7%	10.30%	63.40%	30.8%	-6.7%	42.9%
Surgical Medical Secretaries	Surgery & Anaesthetics	62.2%	6.7	97.7%	71.4%	5.73%	85.45%	8.9%	11.1%	38.9%
Childrens	Families & Specialist Services	43.2%	6.9	92.0%	74.9%	5.37%	82.77%	5.8%	8.2%	38.9%
Womens	Families & Specialist Services	48.4%	6.6	94.4%	75.9%	6.48%	86.31%	6.9%	12.7%	38.9%
Integrated Medical Specialties	Medical	31.0%	6.7	91.8%	69.8%	5.94%	83.82%	8.9%	6.6%	33.3%
Acute Medical	Medical	29.6%	6.5	90.3%	71.2%	7.86%	81.43%	6.2%	14.7%	33.3%
Medical Specialties	Medical	34.1%	6.4	91.0%	44.7%	5.33%	70.76%	7.5%	12.9%	27.8%
Resilience, Acute Flow and Transformation	Corporate	30.8%	6.1	93.2%	52.8%	9.96%	89.47%	10.4%	12.7%	27.8%
Pharmacy Manufacturing Unit	Pharmacy Manufacturing Unit	69.5%	5.9	96.8%	93.1%	5.99%	81.45%	23.0%	10.8%	27.8%
Emergency Care	Medical	29.3%	6.2	90.5%	88.3%	6.62%	83.42%	4.1%	7.2%	27.8%
Orthopaedics	Surgery & Anaesthetics	26.5%	6.0	88.9%	66.0%	5.65%	86.21%	9.8%	8.5%	16.7%

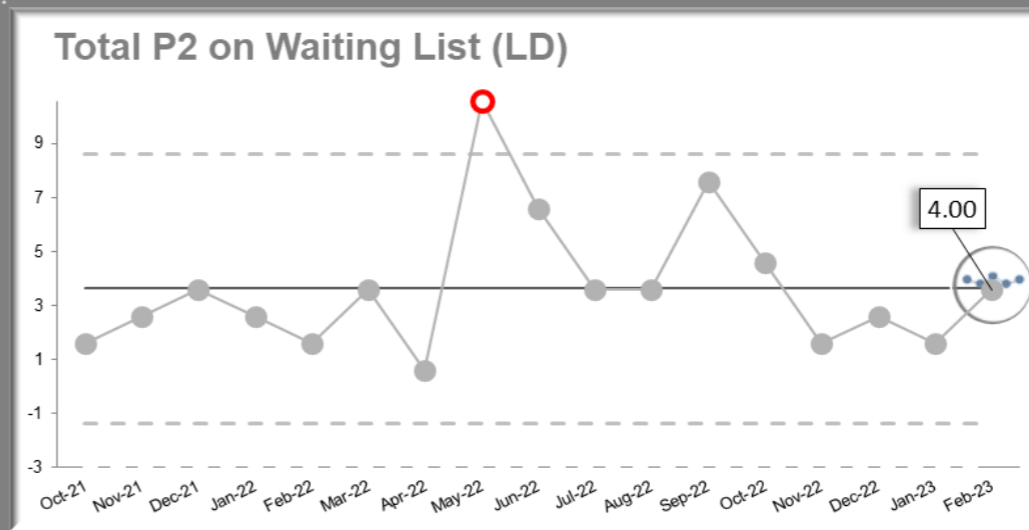
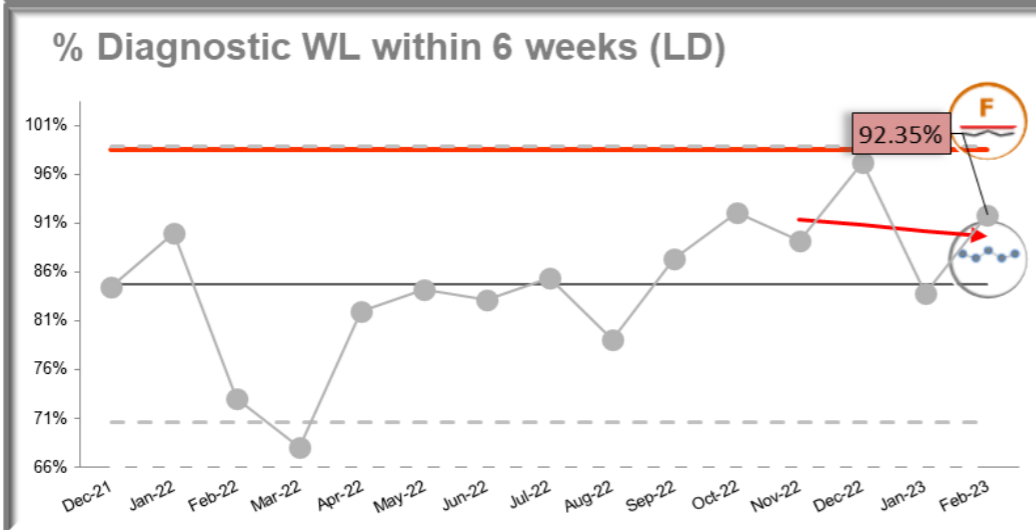
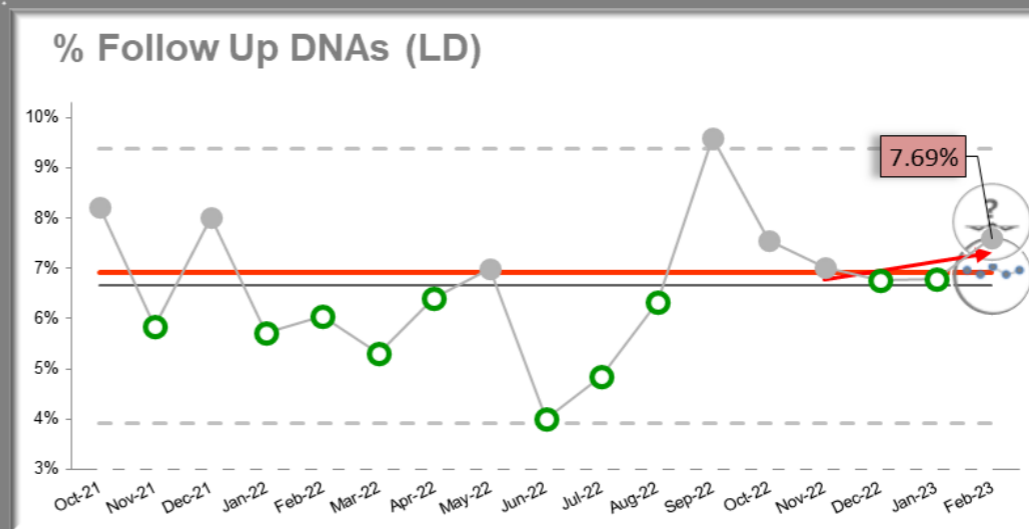
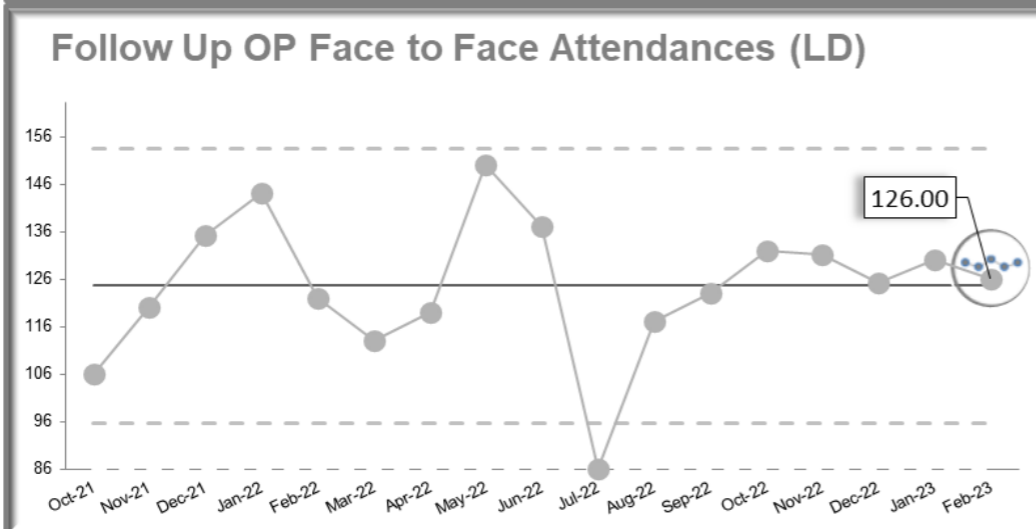
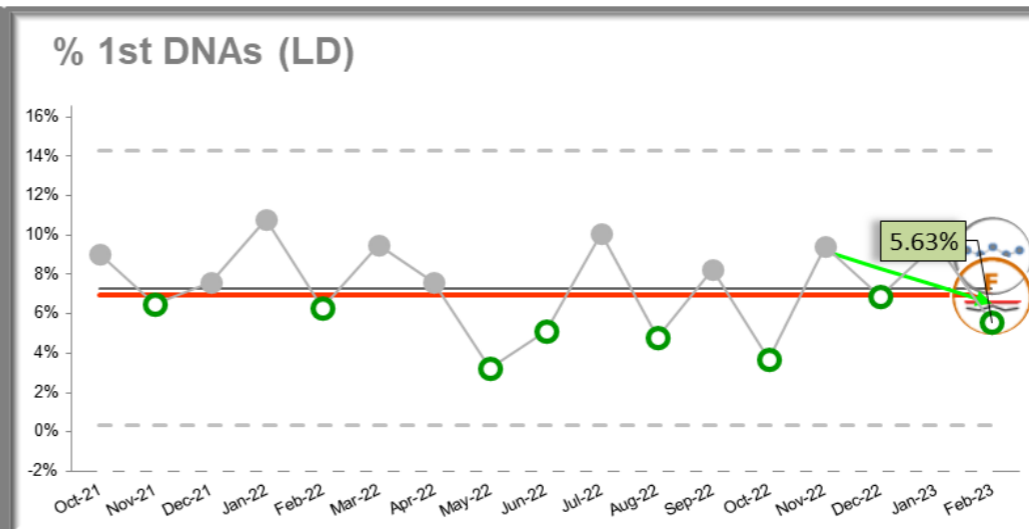
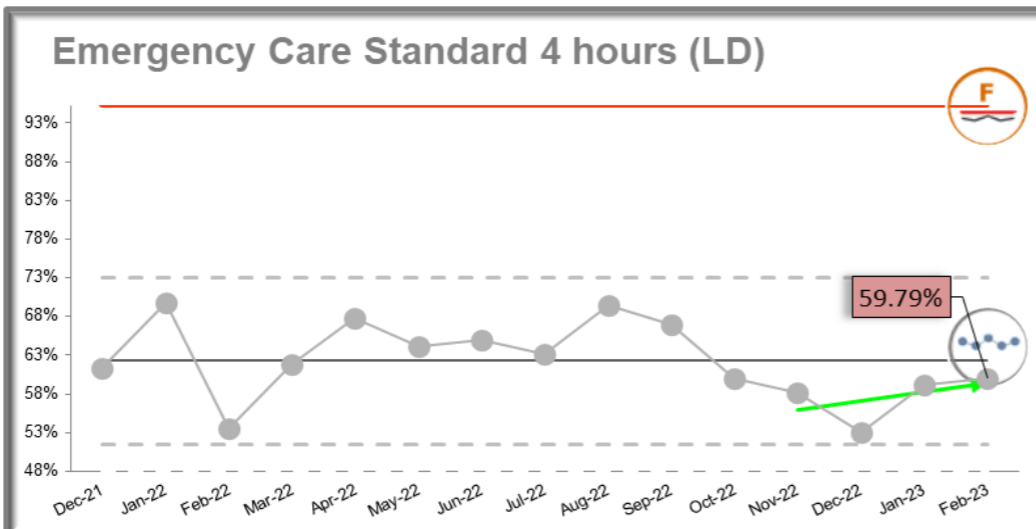


## LD - Key measures

	21/22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	YTD	Performance Range		
<b>Recovery</b>																Green	Amber	Red
Total P2 on Waiting List (LD)	32	2	4	1	11	7	4	4	8	5	2	3	2	4	4	No target		
Total P3 on Waiting List (LD)	119	11	11	15	17	13	10	11	11	12	7	8	15	13	13	No target		
Total P4 on Waiting List (LD)	58	1	1	2	3	4	4	2	2	3	4	3	2	5	5	No target		
<b>Emergency Care</b>																		
Emergency Care Standard 4 hours (LD)	65.74%	53.33%	61.62%	67.52%	63.93%	64.66%	62.89%	69.23%	66.67%	59.68%	57.97%	52.74%	58.97%	59.79%	61.85%	>=95%		<95%
<b>Waiting Times</b>																		
18 weeks Pathways >=26 weeks open (LD)	569	63	54	50	48	55	41	35	37	35	33	35	21	22	22	0		>=1
RTT Waits over 52 weeks Threshold > zero (LD)	409	47	38	10	8	8	5	4	6	5	3	4	1	1	1	0		>=1
% Diagnostic Waiting List Within 6 Weeks (LD)	83.63%	0.7354	0.6848	82.40%	84.64%	83.68%	85.80%	79.51%	87.80%	92.61%	89.63%	97.76%	84.24%	92.35%	86.66%	>=99%		<=98%
<b>Cancer</b>																		
Two Week Wait for Referral to Date First Seen (LD)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	>=93%	86% - 92%	<85%
31 Days From Diagnosis to First Treatment (LD)	100.00%	not applicable	not applicable	100.00%	not applicable	100.00%	not applicable	not applicable	100.00%	100.00%	100.00%	not applicable	not applicable	not applicable	100.00%	>=96%		<95%
31 Day Subsequent Surgery Treatment (LD)	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	>=94%		<93%
38 Day Referral to Tertiary (LD)	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	>=85%		<84%
62 Day GP Referral to Treatment (LD)	100.00%	not applicable	not applicable	not applicable	not applicable	100.00%	not applicable	not applicable	100.00%	not applicable	not applicable	not applicable	not applicable	not applicable	100.00%	>=85%	81% - 84%	<80%
62 Day Referral From Screening to Treatment (LD)	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	100.00%	not applicable	not applicable	not applicable	not applicable	100.00%	>=90%		<89%
<b>Activity - Number of Attendances</b>																		
New Outpatient Attendances - Face to Face (LD)	366	24	31	38	40	41	40	48	59	38	50	30	46	34	464	No target		
New Outpatient Attendances - Non Face to Face (LD)	256	16	18	11	20	15	9	13	16	18	14	17	15	17	165	No target		
Follow up Outpatient Attendances - Face to Face (LD)	1426	122	113	119	150	137	86	117	123	132	131	125	130	126	1376	No target		
Follow up Outpatient Attendances - Non Face to Face (LD)	845	56	67	57	62	61	42	48	50	55	74	44	51	51	595	No target		
<b>Activity - % DNAs</b>																		
% 1st DNAs (LD)	7.22%	6.35%	9.59%	7.69%	3.33%	5.19%	10.14%	4.88%	8.33%	3.75%	9.47%	6.94%	9.64%	5.63%	6.85%	<=7.0%	7.1% - 7.9%	>=8.0%
% Follow Up DNAs (LD)	5.72%	6.13%	5.39%	6.50%	7.09%	4.07%	4.93%	6.41%	9.70%	7.63%	7.10%	6.84%	6.87%	7.69%	6.87%	<=7.0%	7.1% - 7.9%	>=8.0%

# LD - Charts

● Critical 
 ● Activity 
 ○ On Target 
 ○ Trend 
 — Target Line 
 — Average Line 
 - - - Control Line 
 → Last 6 Points Directional Flow 
 F RAG Rated Last Data Point



# Membership and Engagement Strategy 2023 – 2026



"I signed up to be a member after working at the Trust on a student placement during the pandemic. I saw some of the amazing efforts staff went to for patients, so thought it would be a small way of giving something back."



"I signed up to be a member to show my support as I've had so much help with a health condition for many years. Also, having been a carer for my mum and uncle, I have a vested interest in having a say in the Trust's services."



## Our membership and engagement strategy for 2023-2026

This strategy outlines what we will do over the next three years to achieve our vision for membership and engagement, which is that *we will be directly accountable to local people and colleagues by making the best use of our membership communities*. It describes the methods we intend to use to create and maintain a representative membership and strengthen engagement and communication with members over the three-year period.

CHFT became a Foundation Trust in 2006, and as such, we are required to have a membership community. A fundamental part of being a NHS Foundation Trust is the way the organisation is structured, based upon the involvement of local people, patients, carers, partner organisations and staff employed by the Trust.

There are three main components to the way a NHS Foundation Trust is structured:

- A membership community made up of local people, patients, carers and staff employed by the Trust
- A Council of Governors consisting of public and staff governors elected from the membership community and also appointed representatives from the Trust's key partners in health and social care
- A Board of Directors made up of a chairman and non-executive directors

One of the greatest benefits of being a NHS Foundation Trust is that the structure helps us to work much more closely with local people and service users to help us respond to the needs of our communities.

We encourage membership applications from all sectors of our communities, to develop a wide and diverse membership, and we try to provide different ways for the people we serve to contribute to the success of our organisation. Through this strategy we aim to build on our existing membership to develop an active and engaged membership community that helps us with our forward plans.

The core benefit of becoming a member is that members have a voice and can be involved in shaping the way services are provided and contribute to the future direction of the organisation. Our strategy describes a number of ways in which we will develop in this area.

You can find out more about membership and how you can become a member via our website: <https://www.cht.nhs.uk/about-us/membership-and-the-council-of-governors/>

Our governors provide the link between members and the Trust and it is the role of the Council of Governors to represent the interests of members and hold the non-executive directors to account for the performance of the Board. It is crucial that governors have the skills and opportunities to engage with members, and our strategy has a particular focus on this area also.

The strategy is summarised in table form below and is supported by a full action plan that has been co-created by the Membership Office and the Membership and Engagement Working Group. The strategy was approved at the meeting of the Council of Governors on 20 April 2023.



# 2023-2026 Membership and Engagement Strategy on a page

## Our vision:

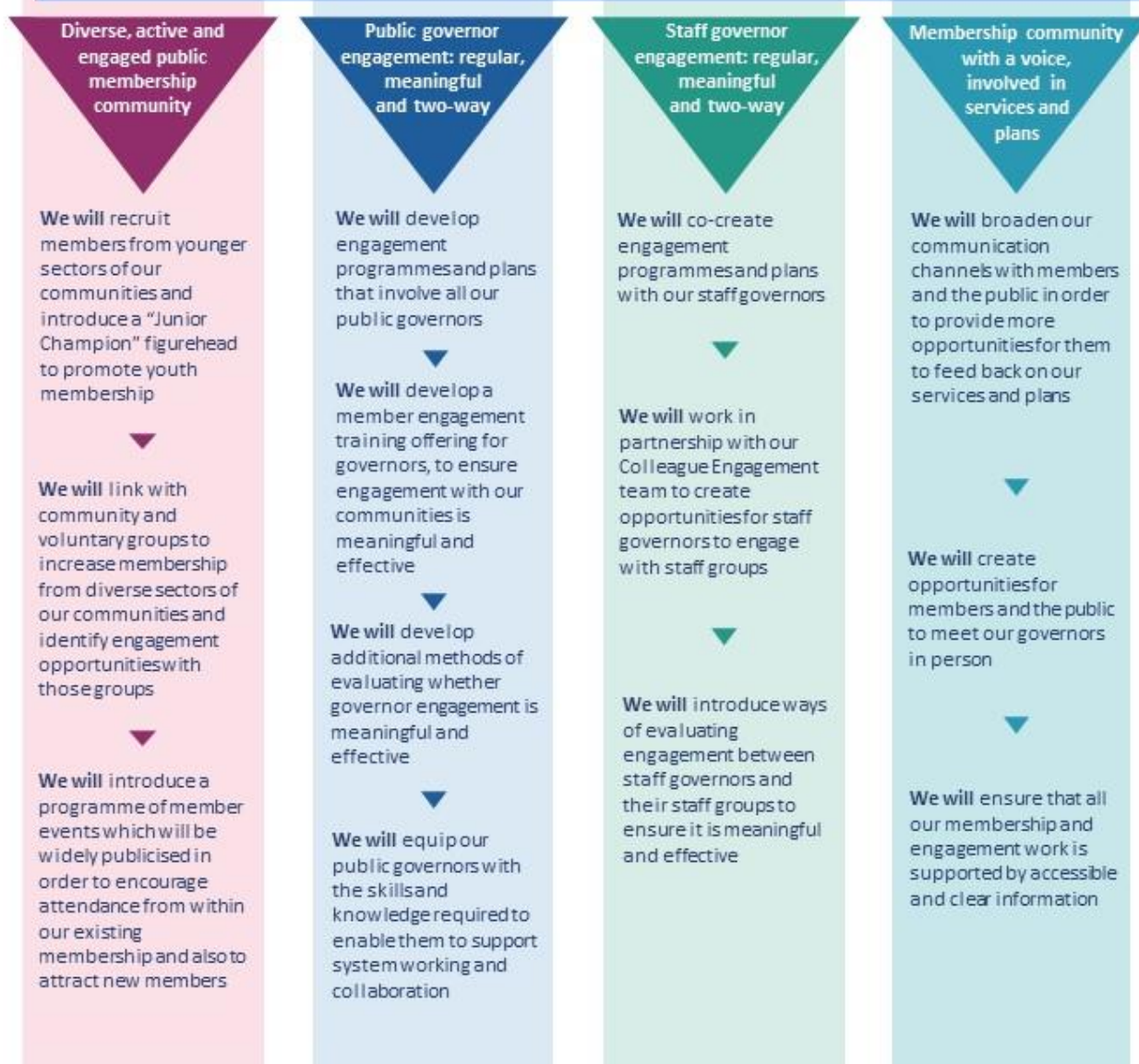
Together with partners we will deliver outstanding compassionate care to the communities we serve

## Our values and behaviours:

- We put patients and people first
- We 'go see'
- We work together to get results
- We do the 'must dos'
- We care for ourselves and each other in the same way we care for our patients through 'one culture of care'

## Our goals and results:

We will be directly accountable to local people and colleagues by making the best use of our membership communities



<b>Date of Meeting:</b>	<b>20 April 2023</b>
<b>Meeting:</b>	<b>COUNCIL OF GOVERNORS</b>
<b>Title of report:</b>	<b>Membership and Engagement Strategy: Update on strategy for 2020-2023</b>
<b>Author:</b>	<b>Vanessa Henderson, Membership and Engagement Manager</b>
<b>Previous Forums:</b>	<b>N/A</b>
<b>Actions Requested:</b>	
<ul style="list-style-type: none"> <li>To note</li> </ul>	
<b>Purpose of the Report</b>	
This report provides a final progress report on the work undertaken to achieve the goals from the Membership and Engagement Strategy 2020-2023.	
<b>Key Points to Note</b>	
<p>Over the three-year period there has been significant progress against the goals of the strategy, due in part to the relaxing of restrictions caused by the pandemic which has allowed governors and the Membership Office team to set up more external activities/events and also to the establishment of the Membership and Engagement Working Group (MEWG).</p> <p>The MEWG has met five times since it was set up in March 2022 and in conjunction with the Membership Office, has co-created a number of activities and initiatives which has enhanced membership recruitment and engagement.</p> <p>The following are examples of the progress that has been made since the strategy was agreed in 2020:</p> <ul style="list-style-type: none"> <li>The level of engagement between public and staff governors and members has increased due to the introduction of regular e-mail updates to members from governors. Feedback has shown that the e-mails are well received.</li> <li>Public engagement events have taken place in a variety of settings, to share general information about the Trust and the Council of Governors and also specific information relating to the A&amp;E development at HRI.</li> <li>Governors have received engagement training commissioned from NHS providers. An in-house training offering is to be developed and offered to all governors going forward.</li> <li>The staff governor profile has risen due to successful communications activities including 'e-meet your governor' sessions and 'welcome emails' which are now sent by governors to all new starters in their staff groups.</li> <li>Feedback from the annual survey of public members has shown that members are, in the main, satisfied with the level of engagement with governors.</li> <li>A programme of members' events has been developed and is due to start in the spring of 2023.</li> </ul>	
<b>Recommendation</b>	
The Council of Governors is asked to <b>NOTE</b> the progress made over the period 2020-2023 to increase and enhance membership recruitment and engagement in line with the action plan from the Membership and Engagement Strategy.	

<b>Date of Meeting:</b>	<b>20 April 2023</b>
<b>Meeting:</b>	<b>COUNCIL OF GOVERNORS</b>
<b>Title of report:</b>	<b>Membership and Engagement Strategy for 2023-2026</b>
<b>Author:</b>	<b>Vanessa Henderson, Membership and Engagement Manager</b>
<b>Previous Forums:</b>	<b>Membership and Engagement Working Group meeting – 11 April 2023</b>
<b>Actions Requested:</b>	
<ul style="list-style-type: none"> <li>To note and approve</li> </ul>	
<b>Purpose of the Report</b>	
<p>This report presents the draft refreshed Membership and Engagement Strategy for the period 2023-2026.</p>	
<b>Key Points to Note</b>	
<p>The refreshed Membership and Engagement Strategy for the period 2023-2026 has been co-produced between the Membership Office and the Membership and Engagement Group (MEWG) and builds on the progress that has been made during the last three years under the Membership and Engagement Strategy for 2020-2023.</p> <p>The MEWG agreed that for 2023-2026 the emphasis should be on “quality over quantity”, ie enhancing engagement with members rather than increasing membership numbers overall. The strategy continues, however, to focus on increasing membership numbers from under-represented groups, ie younger people, males and Asian/Asian British communities.</p> <p>The refreshed strategy also places more emphasis on staff governors in an attempt to facilitate more engagement between them and their staff groups.</p> <p>The strategy – attached – is depicted in the same format as the Trust’s 2023-24 strategic plan on a page and is supported by a full action plan for Year One, 2023-2024. Both were approved by the MEWG at its meeting on 11 April 2023.</p> <p>An annual update on progress will be presented to the Council of Governors at the April meeting.</p>	
<b>Recommendation</b>	
<p>The Council of Governors is asked to <b>NOTE</b> the focus of the refreshed Membership and Engagement Strategy for the period 2023-2026 and to <b>APPROVE</b> the strategy and the action plan for Year One.</p>	



GOAL	ACTION	RESPONSIBLE	DUE BY	STATUS	NOTES/OUTCOME
1) A diverse and representative public membership community which is active and engaged	1a) Recruiting members from younger sectors of our communities				
	Set up a series of membership recruitment events at local colleges	M&E Manager/ M&E Assistant	First event – May-23	In progress	First event at Calderdale College 09-May-23
	Set up process whereby college students who request work placements are encouraged to join as members	M&E Manager	Sep-23		Rebecca Armitage – WOD
	Set up a programme of membership recruitment events at the University of Huddersfield	M&E Manager/ M&E Assistant	First event – May-23	In progress	First event 25-Apr-23
	Draft a role description for a “Junior Champion” figurehead and a process for appointing a younger member to the role	M&E Manager	Sep-23		
	Explore possibility of promoting membership with younger patients via Jo Kitchen (Patient Advocate, Children’s Diabetes Team/staff governor)	M&E Manager/ M&E Assistant	Jun-23		
	Establish links with Liam Whitehead, Widening Participation Lead, to promote membership amongst his contacts	M&E Manager	Apr-23	Ongoing	Initial meeting held Jan-23 and LW agreed to promote widely; To follow up quarterly
	Establish whether Youth Forum has been reinstated and if so, explore ways of linking in with group to connect with younger patients	M&E Manager	May-23		
	Establish links with Youth Carers Groups in Calderdale and Kirklees via Healthwatch to identify recruitment and engagement opportunities	M&E Manager/ Healthwatch Gov	Jul-23		
	1b) Linking with community and voluntary groups to increase membership and identify engagement opportunities				
Develop a focused plan for member recruitment from Asian/Asian British groups	M&E Manager/ M&E Assistant	Jul-23			

GOAL	ACTION	RESPONSIBLE	DUE BY	STATUS	NOTES/OUTCOME
	Explore feasibility of routinely signing up volunteers as members	M&E Manager	May-23		Stevie Cheesman – WOD
	If feasible, set up process for routinely signing up volunteers as members	M&E Manager	Jun-23		
	Look into possibility of producing membership poster in other languages	M&E Manager/ M&E Assistant	Oct-23		
	1c) Introducing a programme of member events, “Health Matters”				
	Set up programme of events for 2023/4, with expert speakers and tours of Trust departments where possible	M&E Manager/ M&E Assistant	Apr-23	In progress	
	Develop a communications plan to ensure Health Matters events are publicised widely using a variety of platforms in order to encourage attendance from non-members as well as members	M&E Manager	Apr-23	In progress	
	Invite students from local secondary schools, colleges and Huddersfield University to events	M&E Manager/ M&E Assistant/ University Gov	Apr-23	In progress	
2) Public governors from diverse sectors of our communities who have regular, meaningful, two-way engagement with our membership	2a) Developing engagement programmes and plans involving public governors				
	Develop a plan to involve governors in Healthwatch engagement events	M&E Manager/ Healthwatch Gov	Jul-23		
	Develop a programme of engagement activities from opportunities identified through Kirklees Council’s Ward Based Partnership meetings	M&E Manager/ M&E Assistant/ Governors	Jun-23		
	Identify opportunities to reach community groups in Calderdale through similar arrangements as in Kirklees, ie through Ward Based Partnership meetings	M&E Manager/ Governors	May-23		Ward Based Partnerships do not exist in Calderdale

GOAL	ACTION	RESPONSIBLE	DUE BY	STATUS	NOTES/OUTCOME
communities and members of the public	2b) Developing a member engagement training offering for governors				
	Develop a member engagement training session for delivery at new governors' induction programme	M&E Manager	May-23	In progress	
	Expand the member engagement session developed for the induction programme and incorporate it into the governor training programme for the year to open it up to all governors	M&E Manager	Sep-23		
	2c) Evaluating whether engagement activities are meaningful and effective				
	Devise system for evaluating effectiveness of engagement activities, eg whether they generated new members; whether any feedback from communities was received etc	M&E Manager/ M&E Assistant	Apr-23		
	Build mechanism into engagement activities to obtain direct feedback from groups/participants	M&E Manager/ M&E Assistant	May-23		
	2d) Equipping our governors with the skills and knowledge they need to support collaboration between organisations				
	Incorporate an introduction to partnership working/governor duties under the ICS into the new governors' induction programme	Company Sec	May-23		
	Develop a training session on partnership working/governor duties under the ICS to be offered to governors as part of the governor training programme for the year	M&E Manager/ Deputy CEO, Exec Director of Transformation and Partnerships	Nov-23		
	Explore local accountability arrangements in the two local places and how governors interact with these to support system working and collaboration	Company Sec/ Lead Governor	Mar-24		

GOAL	ACTION	RESPONSIBLE	DUE BY	STATUS	NOTES/OUTCOME
3) Staff governors who are active and take part in regular, meaningful, two-way engagement with colleagues in their staff groups	3a) Co-creating engagement event programmes and plans with staff governors				
	In conjunction with current staff governors, agree a programme of engagement events for the year, based on previous successful events, eg e-Meet Your Governor drop-in sessions	M&E Manager/ M&E Assistant/ Staff Governors	Jun-23		
	Devise new ways of raising the profile of our staff governors	M&E Manager/ M&E Assistant/ Staff Governors	Jun-23		Staff induction?
	3b) Working in partnership with our Colleague Engagement Team				
	Re-visit plans for staff governors to attend staff networks meetings with view to more regular involvement of governors	M&E Manager/ Colleague Engmnt Advisor	Oct-23		Majority of staff networks not currently meeting due to operational pressures
	Set up mechanism by which staff governors are automatically invited to participate in any events/activities arranged by the Colleague Engagement Team	M&E Manager/ Colleague Engmnt Advisor	Aug-23		
	3c) Evaluating the effectiveness of engagement between our staff governors and their staff groups				
	Design and issue a survey to all staff to obtain their views on engagement with their staff governor(s)	M&E Manager/ Comms Manager/ MEWG	Nov-23		
4) A membership community that has a voice and opportunities to get involved and contribute to the organisation, our services	4a) Broadening communication channels with members and the public				
	Set up a dedicated page on the trust's website to: <ul style="list-style-type: none"> <li>- Share information about services and plans;</li> <li>- Share surveys;</li> <li>- Gather members' and the public's views</li> </ul>	M&E Manager/ Comms Manager	Nov-23		
	Look into using on-line platforms, eg Nextdoor, to share information with members and the public and provide opportunities for feedback	M&E Manager/ Comms Manager	Nov-23		

GOAL	ACTION	RESPONSIBLE	DUE BY	STATUS	NOTES/OUTCOME
and our plans for the future	Establish cost of writing to all public members for whom we do not have an e-mail address to encourage them to provide one (budget dependent)	M&E Manager/ M&E Assistant	Jul-23		
	If deemed cost-effective, write to public members to request e-mail addresses	M&E Manager	Aug-23		
	4b) Creating opportunities for members and the public to meet our governors in person				
	Develop a plan to trial a face-to-face 'Meet Your Governor' event in one of the Trust's public constituencies, including a mechanism to evaluate the success of the event	M&E Manager/ MEWG	Jun-23		
	Host the trial 'Meet Your Governor' event	M&E Manager	Aug-23		
	Explore possibility of incorporating a 'Meet Your Governor' slot into the Annual Members Meeting	M&E Manager	Jun-23		
	4c) Ensuring all our membership and engagement work is supported by accessible and clear information				
	Explore the feasibility of producing membership publicity material in different languages	M&E Manager	Jun-23		
	Set up system with Communications Team for evaluating the accessibility of any information shared with members and the public	M&E Manager/ Comms Manager	Apr-23		

<b>Date of Meeting:</b>	Thursday 20 April 2023
<b>Meeting:</b>	Council of Governors
<b>Title of report:</b>	Company Secretary’s Report – Governance
<b>Author:</b>	Andrea McCourt, Company Secretary

**Purpose of the Report**

This report brings together the following items for receipt, noting and approval by the Council of Governors in April 2023.

**Key Points to Note**

**a) Governor Elections 2023**

As notified to the Council of Governors at its meeting of 26 January 2023, governor elections have been underway, taking place slightly earlier than usual due to the number of vacancies. The outcome of the elections is as follows:

Public Constituency	Elected governor
South Huddersfield	John Richardson
North Kirklees	Hollie Hampshaw
	1 x remaining vacancy
Skircoat and Lower Calder Valley	Diane Cothey
	Lorraine Wolfenden
Lindley and the Valleys	Pam Robinson
North and Central Halifax	Kathleen Wileman
	Anthony Wilkinson
East Halifax and Bradford	2 x remaining vacancies

Staff Groups	Elected governor
Nurses/midwives	Emma Karim
AHPs/Health Care Scientists/ Pharmacists	Jonathan Drury

The Council of Governors is asked to **NOTE** the outcome of the 2023 Governor Elections.

**b) Process for Appointment of Lead Governor 2023/24**

The Council of Governors is asked to approve the process for the election of the Lead Governor.

The papers attached include:

- Procedure for the appointment of Lead Governor
- Proposed timeline for 2023
- Role of lead governor

Subject to approval, the process will begin after the Council of Governors’ meeting on 20 April 2023. The voting process closes on 27 June 2023 and a formal announcement will

be made at the Annual Members Meeting to be held on 25 July 2023, the date from which the appointment will become effective. This process is detailed at Appendix J2.

Governors are also requested to consider the introduction of a deputy governor role, which is widely used in other Foundation Trusts. This would support the lead governor, act as deputy in the absence of the lead governor and share workload as required and act as a sounding board for the lead governor. The deputy lead governor would also support the lead governor in engaging with the Board of Directors and the constituencies from which governors are elected.

The proposed process for the appointment of a deputy lead governor is by invitation to all governors to self-nominate and explanation as per the process for the lead governor role, with consideration of the candidates by the Nomination and Remuneration Committee of the Council of Governors.

The Council of Governors is asked to **APPROVE** the procedure for the appointment of the lead governor and **DECIDE** on the establishment of a deputy lead governor role and process for this.

**c) Review Council of Governors Attendance Register for the Annual Report and Accounts 2022/23**

The Council of Governors is asked to check the record of attendance at Council of Governor meetings and advise of any discrepancies before 30 April 2023, following which they will be published in the Annual Report in June 2023. This is detailed at Appendix J3.

**d) Date of the 2023 Annual Members Meeting**

The Council of Governors is advised that the joint Board of Directors/Council of Governors' Annual Members Meeting will be held in person on 25 July 2023. The event will take place at Calderdale Royal Hospital from 5:00 pm - 7:00 pm.

**e) Review of Council of Governors Declarations of Interest Register**

The Council of Governors declarations of interest register is attached at Appendix J4 for review. All governors must ensure they have submitted an annual declaration of interest. Any changes to current declarations are to be notified to Kathy Bray, Corporate Governance Manager by 30 April 2023, including request form to submit a declaration. A link to the Council of Governors Declarations of Interest Register is included in the 2022/23 Annual Report.

The Council of Governors is asked to **RECEIVE** and **NOTE** the current Council of Governors Declarations of Interest.

**f) Receive Register of Council of Governors**

The current Register of Council of Governors as of 31 March 2023 is attached at Appendix J5 for information.

The Council of Governors is asked to **RECEIVE** and **NOTE** the Register of Council of Governors as of 31 March 2023.

**Recommendation**

The Council of Governors is asked to **APPROVE** the:

- Process for appointment of lead governor for 2023/24 and decide on the establishment of a deputy lead governor role
- Council of Governors Attendance Register for the Annual Report and Accounts 2022/23
- Council of Governors Declarations of Interest Register

The Council of Governors is asked to **NOTE** the:



- Outcome of the 2023 Governor Elections
- Date of the 2023 Annual Members Meeting
- Register of Council of Governors as of 31 March 2023

## **PROCEDURE FOR THE APPOINTMENT OF LEAD GOVERNOR OF THE COUNCIL OF GOVERNORS' – 2023-24**

### **1. Purpose**

- 1.1 A new election for the role of Lead Governor is now due to take place which will be ratified at the Council of Governors meeting on 20 July 2023 and the new appointment will be announced at the Annual Members Meeting on 25 July 2023.
- 1.2 To provide the Council of Governors with the timetable (Appendix 1), appointment criteria and process for election to the post of lead governor which will be effective from the Annual Members Meeting on 25 July 2023 for a period of 12 months.
- 1.3 The lead governor's current term expires when the governor elections for 2023 are concluded and an election process will take place as outlined below.
- 1.4 The current lead governor will be asked to attend the Annual Members Meeting (AMM) of the Trust on 25 July 2023 and provide an annual account of governor activities during 2022/23.

### **2. Constitutional Context**

- 2.1 Under the Constitution, the Council of Governors is required to nominate a lead governor to facilitate direct communication between NHS England, the regulator, and the Council of Governors in limited circumstances where it may not be appropriate to communicate through the normal channels. Further information on this is provided in Appendix 2.
- 2.2 In accordance with the Constitution, the lead governor will act as Deputy Chair of the Council of Governors' when the Chair and the Deputy Chair of the Board of Directors are not available or have a declaration of interest in an agenda item.
- 2.3 Section 18.3 of the Trust Constitution states that any of the governors are eligible to fill the lead governor role, this includes public, staff or appointed governors. This is in line with the Code of Governance for NHS Provider Trusts, Appendix B, Council of Governors and role of the nominated lead governor, which states:  
  
"The lead governor may be any of the governors."
- 2.4 The new lead governor will start their office from the Annual Members Meeting on 25 July 2023 for a period of 12 months, or until the expiry of

their Council of Governor tenure, whichever is the sooner. The usual length of tenure of a lead governor is 12 months.

- 2.5 The Council of Governors re-elects the lead governor on an annual basis. Any governor can serve as lead governor for three terms i.e. three years, linked to their Council of Governor tenure.

### **3. Responsibilities of the Lead Governor**

An indicative outline of the responsibilities of the lead governor is provided below.

- 3.1 To act as the point of contact between NHS England and the Council of Governors where it is decided by the governors or NHS England that the usual channel, which in most cases will be through the Chair or Company Secretary, is not warranted.
- 3.2 To act as a point of contact for the Governors with the Care Quality Commission (CQC).
- 3.3 To chair any parts of Council of Governors meetings in circumstances where it may not be considered appropriate for the Chair, Deputy Chair or another one of the Non-Executive Directors to lead (e.g. chairing a meeting to discuss the appointment of a new Chair or a conflict of interest in relation to the business being discussed).
- 3.4 To assist the Chair in facilitating the flow of information between the Trust Board and the Council of Governors.
- 3.5 To liaise with the Trust / Council of Governors Chair and/or the Senior Independent Non-Executive Director.
- 3.6 To be involved in the appraisal of the performance of the Chair and Non-Executive Director's performance
- 3.7 To provide support dealing with governor conduct issues.
- 3.8 To contribute to the agenda setting of the Council of Governors meetings.
- 3.9 To be a member of the Nomination and Remuneration Committee of the Council of Governors and involved in the process for appointing the Chair and Non-Executive Directors.
- 3.10 To attend the Annual Members Meeting (AMM) of the Trust and provide an annual account of governor activities.

#### **Time Commitment**

In addition to attendance at Council of Governors meetings, held quarterly, the lead governor will be required to:

- Attend one-to-one meetings with the Chair of the Trust
- Act as Chair for items at Council of Governors meetings where the Chair of the Trust has a conflict of interest
- Attend Council of Governors agenda setting meetings with the Chair and Company Secretary
- Ask Governors for any additional items for the Council of Governors agenda
- Co-ordinate responses from Governors to questions from the Board
- Be a member of the Nomination and Remuneration Committee of the Council of Governors
- Take part in any Chair or Non-Executive Director recruitment processes
- Attend and represent the governors at the Annual Members Meeting (AMM) held annually
- Be actively involved in governor engagement activities, e.g. Divisional Reference Groups (DRGs)

#### **4. Criteria**

4.1 Governors wishing to undertake the role of lead governor should be confident they can undertake the duties outlined above to undertake this role. They should also:

- have the confidence of the governors and Trust Board;
- be able to commit the time necessary for the role, to attend meetings and for any other matters should the need arise, which may be at short notice;
- have excellent communication skills, including the ability to influence and negotiate;
- be committed to the values and behaviours of the Foundation Trust and support its goals and objectives;
- be able to act as an ambassador for the Council of Governors and the Trust;
- be able to work with others as a team and encourage participation from less-experienced governors;
- have effective time management skills;
- demonstrate an understanding of the Trust's Constitution.

4.2 Desirable personal qualities for a lead governor include:

- Previous experience of chairing meetings within a formal setting i.e. local authority, education, independent sector businesses, preferably involving participants from a variety of backgrounds;
- the ability to deal with potential conflicts;
- the ability to command the respect, confidence and support of their governor colleagues;
- the ability to represent the views of governor colleagues.

## 5. Process for the appointment to the role of lead governor

- 5.1 An election for the role of Lead Governor is now due to take place which will be ratified at the Council of Governors meeting on 20 July 2023 announced at the Annual Members Meeting on 25 July 2023.
- 5.2 Any governor will need to demonstrate, by way of written expression of interest, experience in all areas of the person specification. In the event that there is no evidence of experience in two or more categories, the expression of interest will not be able to proceed to voting stage. Letters of support from **four** existing governors will be required. Governors can nominate a governor to be the lead governor and should ideally discuss this with the proposed nominated governor before making a nomination.
- 5.3 Candidates or governors submitting a nomination will need to provide a paragraph by way of a supporting statement which can be circulated to the Council of Governors as part of the lead governor voting paper.
- 5.4 Governors may **not** vote for more than one candidate.
- 5.5 In the event of a tie the Chair will have casting vote.
- 5.6 The timescale for the process is detailed in Appendix 1.
- 5.7 The appointment of the lead governor will take place at a meeting of the Council of Governors on 20 July 2023.

### **Recommendation:**

The Council of Governors is asked to:

- **Approve** the process for the election of the lead governor which will be ratified at the Council of Governors meeting on 20 July 2023 and effective from the Annual Members Meeting on 25 July 2023.

Enclosed:

Appendix 1 - Timeline for the Appointment of Lead Governor'

Appendix 2 - The role of the nominated lead governor with NHS England

### References:

Constitution of Calderdale and Huddersfield NHS Foundation Trust

Code of Governance for NHS Provider Trusts

Standing Orders – Council of Governors'

## Appendix 1

### DRAFT TIMELINE FOR THE APPOINTMENT OF LEAD GOVERNOR 2023/24

DATE	ACTION
Thursday 20 April 2023	Procedure for appointment of lead governor approved at the Council of Governors meeting on 20 April 2023.
Friday 19 May 2023	Deadline for governors to email their expressions of interest or nominations for the role of lead governor to the Corporate Governance Manager (kathy.bray@cht.nhs.uk)
Friday 2 June 2023	Deadline for receipt of Candidate Supporting Statements (up to 250 words max) to Kathy Bray on their suitability for the post of lead governor with letters of support from three governors.
Tuesday 13 June 2023	Candidate Supporting Statements and voting papers for the lead governor role will be issued to all governors.
14 June – 26 June 2023	Voting <b>OPEN</b> for the lead governor appointment – only 1 vote per governor.
Tuesday 27 June 2023	Voting <b>CLOSED</b> for the lead governor appointment and votes are counted.
Thursday 13 July 2023	Declaration of Result shared with the Council of Governors papers for the meeting on 20 July 2023.
Thursday 20 July 2023	Council of Governors to ratify the results of the lead governor appointment which will be effective for a period of 12 months and announced at the Annual Members Meeting on 25 July 2023.

## **Appendix 2**

### **The role of the nominated lead governor with NHS England**

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

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

The main circumstances where NHS England will contact a lead governor are where they have concerns about the Board leadership provided to an NHS foundation trust, and those concerns may in time lead to the use by NHS England of their formal powers to remove the chair and non-executive directors. The Council of Governors appoints the chairperson and non-executive directors, and it will usually be the case that NHS England will wish to understand the views of the governors as to the capacity and capability of these individuals to lead the Trust, and to rectify successfully any issues, and also for the governors to understand NHS England's concerns.

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

The other circumstance where NHS England may wish to contact a lead governor is where, as the regulator, they have been made aware that the process for the appointment of the chair or other members of the Board, or elections for governors, or other material decisions, may not have complied with the NHS Foundation Trust's constitution, or alternatively, whilst complying with the Trust's constitution, may be inappropriate. In such circumstances, where the chair or other members of the Board of directors or the Trust Secretary may have been involved in the process by which these appointments or other decisions were made, a lead governor may provide a point of contact for NHS England.



Attendance	✓	Apologies	✘	Not elected/in post	
				Did not attend	

## COUNCIL OF GOVERNORS AND BOARD OF DIRECTORS ATTENDANCE AT COUNCIL OF GOVERNOR MEETINGS – 1 APRIL 2022 – 31 MARCH 2023

MEETING DATES		13.04.22 (Extra-ordinary)	21.04.22	27.06.22 (Extra-ordinary)	14.07.22	20.10.22	26.01.23	TOTAL
1 – Calder & Ryburn Valleys	Peter Bamber (from 28.07.21)	✓	✓	✘	✓	✓	x	4 / 6
	Gina Choy (from 28.07.21)	✘	✓	✓	✓	✓	✓	5 / 6
2 – Huddersfield Central	Christine Mills	✓	✓	✓	✘	✓	✓	5 / 6
	Robert Markless (from 28.07.21)	✓	✓	✓	✓	✓	✓	6 / 6
3 – South Huddersfield	Isaac Dziya (from 28.07.21)		✓				x	1 / 6
4 – North Kirklees	Veronica Woollin		✓	✓	✓		x	3 / 6
5 – Skircoat & Lower Calder Valley	Stephen Baines	✓	✓	✓	✓		✓	5 / 6
	Nicola Whitworth (from 28.07.21)	✘	✓	✘	✘	✓		2 / 6
6 – East Halifax & Bradford	Peter Bell (from 28.07.21)			✓	✓		✓	3 / 6
7 – North and Central Halifax	Alison Schofield	✓	✓		✓			3 / 6
8 - Lindley & The Valleys	John Gledhill			✓	✓	✓	x	3 / 6
	Brian Moore (from 28.07.21)	✓	✓	✓	✓	✓	✓	6 / 6
9 – Staff – Drs/Dentists	Sandeep Goyal (from 28.07.21)						x	0 / 1
10 – Staff - AHPs/HCS/Pharmacists	Sally Robertshaw			✓	✘			1 / 6
11 – Staff – Management / Admin	Emma Kovaleski (from 28.07.21)	✓	✘		✓	✓	x	3 / 6
12 – Ancillary	Jo Kitchen (from 28.07.21)	✘	✓			✓	x	2 / 6

<b>13 – Staff – Nurses / Midwives</b>		Liam Stout (from 28.07.21)	✓	✓	✓	✓	✓		<b>5 / 6</b>
		Jason Sykes (from 28.07.21)							
		Sally Robertshaw						✓	<b>1 / 6</b>
<b>Stakeholder Governors (Appointed)</b>	<b>University of Huddersfield</b>	Prof Joanne Garside	x	x		x			<b>0 / 3</b>
	<b>University of Huddersfield</b>	Dr Sara Eastburn				✓	✓	✓	<b>3 / 3</b>
	<b>Calderdale Metropolitan Council</b>	Cllr Megan Swift						x	<b>0 / 6</b>
	<b>Calderdale and Huddersfield Solutions Ltd.</b>	Abdirahman Duaale	✓	x	✓	✓	✓	✓	<b>5 / 6</b>
	<b>Kirklees Metropolitan Council</b>	Cllr Lesley Warner		x	x	x	✓	✓	<b>2 / 6</b>
	<b>Healthwatch Kirklees / Calderdale</b>	Karen Huntley	x	x	x	✓	x	x	<b>1 / 6</b>
	<b>Locala</b>	Chris Reeve	x	x		x	x	x	<b>0 / 6</b>
	<b>South West Yorkshire Partnership NHS Foundation Trust</b>	Salma Yasmeen	✓	x	x	x	x	x	<b>1 / 6</b>

<b>DIRECTORS / NON-EXECUTIVE DIRECTORS</b>	<b>13.04.22 (Extra-ordinary)</b>	<b>21.04.22</b>	<b>27.06.22 (Extra-ordinary)</b>	<b>14.07.22</b>	<b>20.10.22</b>	<b>26.01.23</b>	<b>TOTAL</b>
Philip Lewer (Chair)	✓	✓	✓				
Helen Hirst (Chair)		✓		✓	✓	✓	
Alastair Graham, Non-Executive Director							
Andy Nelson, Non-Executive Director				✓		x	

Andrea McCourt, Company Secretary	x	✓	x	✓	✓	✓	
Anna Basford, Director of Transformation and Partnerships		✓		✓	x	x	
Karen Heaton, Non-Executive Director		✓			✓	✓	
Richard Hopkin, Non-Executive Director		✓		✓			
Lindsay Rudge, Chief Nurse				✓	✓	✓	
Denise Sterling, Non-Executive Director					✓	✓	
Peter Wilkinson, Non-Executive Director						✓	
Nigel Broadbent, Non-Executive Director				✓	✓	✓	
Tim Busby, Non-Executive Director					✓	✓	
David Birkenhead, Medical Director		✓				x	
Gary Boothby, Director of Finance		✓		✓		✓	
Kirsty Archer, Acting Director of Finance					✓		
Helen Barker, Chief Operating Officer							
Jonathan Hammond, Interim Chief Operating Officer					✓	x	
Jo Fawcus, Chief Operating Officer (from 11.21)		✓		✓			
Ellen Armistead, Director of Nursing		✓					
Brendan Brown, Chief Executive (from 04.01.22)	✓	✓	✓	x	✓	x	
Robert Birkett, Managing Director Digital Health					✓	x	
Suzanne Dunkley, Director of Workforce and OD	✓		✓			x	

Stuart Sugarman, Managing Director, CHS	x			✓		x	
Victoria Pickles, Director of Corporate Affairs			x	✓		✓	
Rob Aitchison, Deputy Chief Executive						✓	
Sharon Cundy, Head of Patient Safety and Quality						✓	

**DECLARATION OF INTERESTS REGISTER – COUNCIL OF GOVERNORS  
AS AT MARCH 2023**

The following is the current register of the Council of Governors of Calderdale and Huddersfield NHS Foundation Trust and their declared interests. The register is maintained by the Foundation Trust Corporate Office who keeps a copy of the original signed declaration forms. These are available for inspection by contacting the office on 01484 355933.

DATE OF SIGNED DEC.	NAME	COUNCIL OF GOVERNORS 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
<b>PUBLIC GOVERNORS</b>								
25.03.21	Stephen BAINES	Public Elected - Skircoat and Lower Calder Valley	-	-	-	Councillor Calderdale MBC  Calderdale Health and Well-being Board member  West Yorkshire Joint Health and Scrutiny Committee	-	Councillor Calderdale MBC
25.08.21	Peter BAMBER	Public Elected – Calder and Ryburn Valleys	-	-	-	-	-	Self-employed humanist funeral celebrant, accredited by Humanists UK  Member of the BMA  Member of Anaesthesia UK  Registered with the General Medical Council (GMC), without a licence to practice

DATE OF SIGNED FORM	NAME	COUNCIL OF GOVERNORS 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
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25.08.21	Gina CHOY	Public Elected – Calder and Ryburn Valleys	-	-	-	-	-	Childline Counsellor (Voluntary)
26.08.21	Isaac DZIYA	Public Elected - South Huddersfield	Isaacs Cons Trading Ltd	Isaacs Cons Trading Ltd	Isaacs Cons Trading Ltd	Board Member Housing Kirklees Council	-	Calderdale Council
14.10.21	John B GLEDHILL	Public Elected – Lindley and the Valleys	Chairman and Director of Yorks WR Masonic Activities Limited  Former Director of Interaction and Community Academy Trust at Castle Hill School, Newsome, Huddersfield	-	-	-	-	-
31.08.21	Robert MARKLESS	Public Elected - Huddersfield Central	-	-	-	-	-	-
15.03.21	Christine MILLS	Public Elected - Huddersfield Central	-	-	-	-	-	-
23.08.21	Brian MOORE	Public Elected – Lindley and the Valleys	-	-	-	-	-	-
06.04.21	Alison SCHOFIELD	Public Elected - North and	-	Owner and founder of	-	Soon to be Trustee of	-	-

DATE OF SIGNED FORM	NAME	COUNCIL OF GOVERNORS 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
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		Central Halifax		Disability Roadmap.co.uk		Imagineer Foundation		
24.08.21	Nicola WHITWORTH	Public Elected - Skircoat and Lower Calder Valley	-	-	-	-	-	-
15.03.21	Veronica WOOLLIN	Public Elected - North Kirklees	-	-	-	-	-	-

**STAFF GOVERNORS**

19.09.21	Sandeep GOYAL	Staff Elected - Drs/Dentists	-	-	-	-	-	Registered with the General Medical Council (GMC)
07.09.21	Jo KITCHEN	Staff Elected - Ancillary	-	-	-	-	-	Nutrition Association Membership
3.09.21	Emma KOVALESKI	Staff Elected - Admin/Clerical	-	-	-	Charity Manager, Calderdale and Huddersfield NHS Charity	Charity Manager, Calderdale and Huddersfield NHS Charity	-



<b>DATE OF SIGNED FORM</b>	<b>NAME</b>	<b>COUNCIL OF GOVERNORS STATUS</b>	<b>DIRECTORSHIP</b>	<b>OWNERSHIP</b>	<b>CONTROLLING SHAREHOLDING</b>	<b>AUTHORITY IN A CHARITY /BODY</b>	<b>VOLUNTARY OR OTHER CONTRACTING FOR NHS SERVICES</b>	<b>OTHER EMPLOYMENT (PAID OR NON-PAID) &amp; MEMBER OF PROFESSIONAL ORGAN'S</b>
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26.3.21	Sally ROBERTSHAW	Staff Elected – AHPs/HCS/ Pharmacists	-	-	-	-	-	Membership HCPC (professional registration)  Member of the Chartered Society of Physiotherapy
01.09.21	Liam STOUT	Staff Elected – Nurses/Midwives	-	-	-	-	-	Member of the Association for Perioperative Practice (AEPP)  Member of the Faculty of Perioperative Care Edinburgh (MFPCEd)

DATE OF SIGNED FORM	NAME	COUNCIL OF GOVERNORS 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
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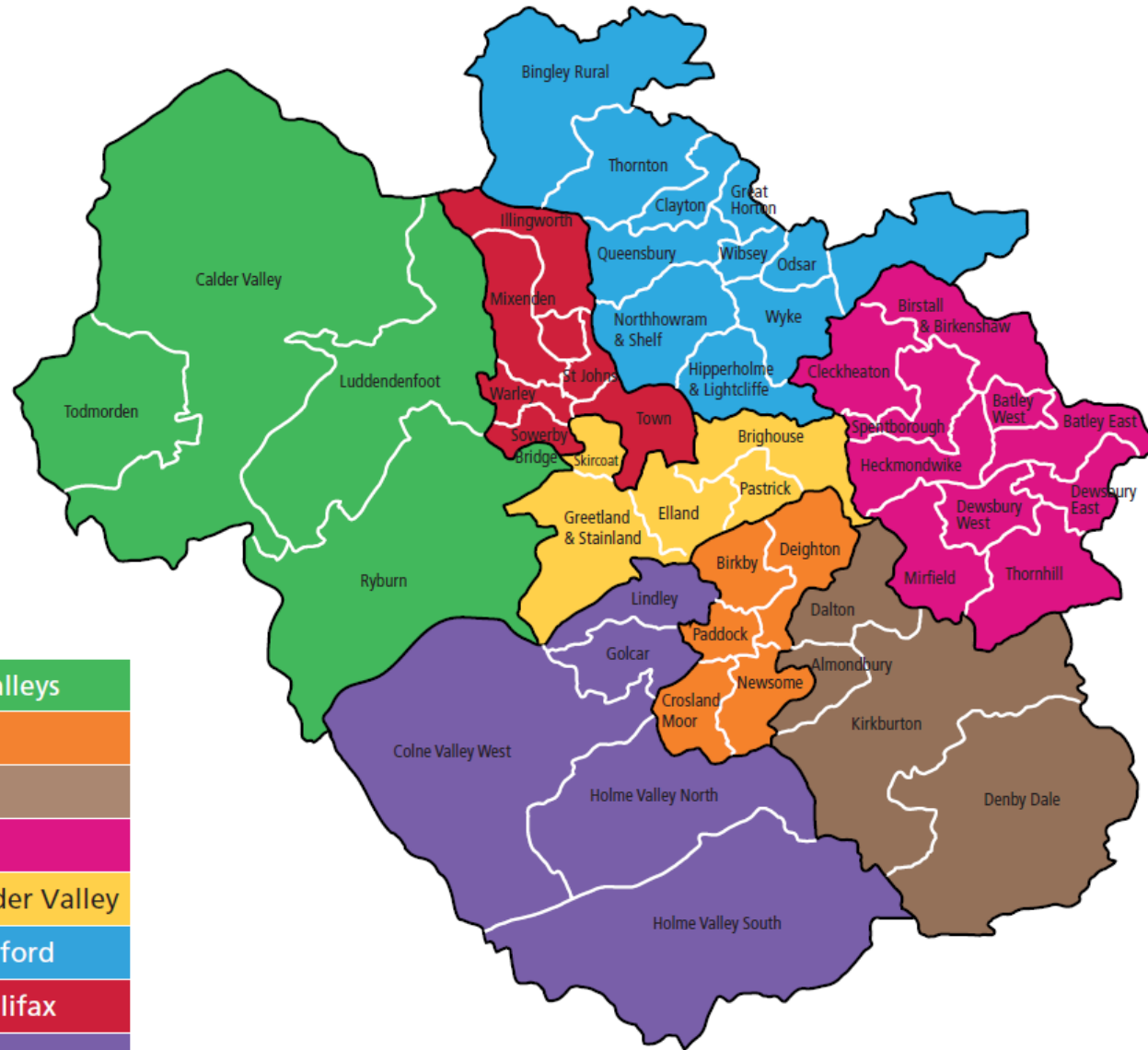
APPOINTED GOVERNORS - STAKEHOLDERS								
03.05.22	Abdirahman DUAALE	Calderdale and Huddersfield Solutions Ltd.	-	-	-	-	-	-
28.07.22	Sara EASTBURN	University of Huddersfield	-	-	-	-	-	Registered with the Health and Care Professions Council and the Chartered Society of Physiotherapy
15.07.22	Karen HUNTLEY	Healthwatch	-	-	-	Director of Healthwatch Calderdale	-	-
22.4.21	Chris REEVE	Locala	Company Secretary – Locala Community Partnerships CIC	-	-	-	Co-opted governor of Calderdale College	-
22.4.21	Megan SWIFT	Calderdale Metropolitan Council	-	-	-	Trustee - Health Trust Trustee – Mixenden Parents Resource Centre	-	Councillor – Calderdale MBC
16.3.21	Salma YASMEEN	South West Yorkshire Partnerships NHS Foundation Trust	Director – South West Yorkshire Partnerships NHS FT	-	-	-	-	Registered with the Nursing and Midwifery Council

DATE OF SIGNED FORM	NAME	COUNCIL OF GOVERNORS 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
22.4.21	Cllr Lesley WARNER	Kirklees Metropolitan Council	-	-	-	-	-	Councillor – Kirklees Metropolitan Council

### COUNCIL OF GOVERNORS REGISTER AS AT 31 MARCH 2023

CONSTITUENCY	NAME	DATE APPOINTED	TERM OF TENURE	ELECTION DUE
<b>PUBLIC – ELECTED</b>				
1 – Calder and Ryburn Valleys	Peter Bamber	28.07.21	3 years	2024
1 – Calder and Ryburn Valleys	Gina Choy	28.07.21	3 years	2024
2 – Huddersfield Central	Christine Mills	19.07.18 28.07.21	3 years 3 years	2021 2024
2 – Huddersfield Central	Robert Markless	28.07.21	3 years	2024
3 – South Huddersfield	Isaac Dziya	28.07.21	3 years	2024
3 – South Huddersfield	Vacancy			
4 – North Kirklees	Veronica Woollin	15.09.16 17.07.19 Extended	3 years 3 years 1 year	2019 2022 2023
4 – North Kirklees	Vacancy			
5 – Skircoat and Lower Calder Valley	Stephen Baines	15.09.16 17.07.19 Extended	3 years 3 years 1 year	2019 2022 2023
5 – Skircoat and Lower Calder Valley	Vacancy			
6 – East Halifax and Bradford	Vacancy			
6 – East Halifax and Bradford	Vacancy			
7 – North and Central Halifax	Vacancy			
7 – North and Central Halifax	Vacancy			
8 – Lindley and the Valleys	John Gledhill	17.07.19 Extended	3 years 1 year	2022 2023
8 - Lindley and the Valleys	Brian Moore	28.07.21	3 years	2024

CONSTITUENCY	NAME	DATE APPOINTED	TERM OF TENURE	ELECTION DUE
<b>STAFF – ELECTED</b>				
9 - Drs/Dentists	Sandeep Goyal	28.07.21	3 years	2024
10 - AHPs/HCS/ Pharmacists	Sally Robertshaw	17.7.19 Extended	3 years 1 year	2022 2023
11 - Mgmt/Admin/ Clerical	Emma Kovalski	28.07.21	3 years	2024
12 – Ancillary	Jo Kitchen	28.07.21	3 years	2024
13 – Nurses/Midwives	Liam Stout	28.07.21	3 years	2024
13 – Nurses/Midwives	Vacancy			
<b>APPOINTED GOVERNORS</b>				
University of Huddersfield	Dr Sara Eastburn	02.08.22	3 years	2025
Calderdale Metropolitan Council	Cllr Megan Swift	3.10.17 Extended 3.10.20	3 years 1 year 2 years	2020 2021 2023
Calderdale and Huddersfield Solutions Ltd (CHS)	Abdirahman Duaale	31.03.22	3 years	2025
Kirklees Metropolitan Council	Cllr Lesley Warner	14.6.19	3 years 1 year	2022 2023
Healthwatch Kirklees and Healthwatch Calderdale	Karen Huntley	20.12.21	3 years	2024
Locala	Chris Reeve	21.11.17 21.11.20	3 years 3 years	2020 2023
South West Yorkshire Partnership NHS FT	Salma Yasmeen	18.10.17 18.10.20	3 years 3 years	2020 2023



- Calder and Ryburn Valleys
- Huddersfield Central
- South Huddersfield
- North Kirklees
- Skircoat & Lower Calder Valley
- East Halifax and Bradford
- North and Central Halifax
- Lindley and the Valleys

## Council of Governors Meetings Dates - 2023

Date	Time	Location
<b>Thursday 20 April 2023</b>	1:00 – 1:45 pm (Private) 2:00 – 4:0 pm (Public)	Microsoft Teams or Acre Mill Meeting Rooms 3 & 4
<b>Thursday 20 July 2023</b>	1:00 – 1:45 pm (Private) 2:00 – 4:0 pm (Public)	Medium Training Room, Learning Centre, Calderdale Royal Hospital
<b>Thursday 19 October 2023</b>	1:00 – 1:45 pm (Private) 2:00 – 4:0 pm (Public)	Microsoft Teams

### Joint Council of Governors and Non-Executive Directors Informal Workshops

Date	Time	Location
<b>Thursday 21 September 2023</b>	2:00 – 4:00 pm	Microsoft Teams or Acre Mill Meeting Rooms 3 & 4

### Joint Council of Governors and Board of Directors Workshops

Date	Time	Location
<b>Tuesday 16 May 2023</b>	1:00 – 4:00 pm	Microsoft Teams Acre Mill Meeting Rooms 3 & 4
<b>Tuesday 14 November 2023</b>	1:00 – 4:00 pm	Microsoft Teams Or alternate sites TBC

#### Bank Holidays 2023

Monday 1 May 2023 (Early May Bank Holiday)  
Monday 29 May 2023 (Spring Bank Holiday)  
Monday 28 August 2023 (Summer Bank Holiday)  
Monday 25 December 2023  
Tuesday 26 December 2023



## QUALITY COMMITTEE

Monday, 16 January 2023

### STANDING ITEMS

#### 01/23 WELCOME AND INTRODUCTIONS

##### Present

Denise Sterling (DS)	Non-Executive Director ( <a href="#">Chair</a> )
Dr David Birkenhead (DB)	Medical Director
Mr Neeraj Bhasin (NB)	Deputy Medical Director
Gina Choy (GC)	Public Elected Governor
Sharon Cundy (SC)	Head of Quality and Safety
Richard Dalton (RD)	Head of Risk and Compliance
Jason Eddleston (JE)	Deputy Director of Workforce & Organisational Development
Jonathan Hammond (JH)	Deputy Chief Operational Officer
Karen Heaton (KH)	Non-Executive Director
Joanne Middleton (JMidd)	Deputy Chief Nurse
Victoria Pickles (VP)	Director of Corporate Affairs
Lindsay Rudge (LR)	Chief Nurse
Kim Smith (KS)	Assistant Director for Quality and Safety
Elisabeth Street (ES)	Clinical Director of Pharmacy
Michelle Augustine (MA)	Governance Administrator ( <a href="#">Minutes</a> )

##### In attendance

Helen Barker (HB)	Operations Director - Reconfiguration ( <a href="#">item 07/23</a> )
Laura Douglas (LDou)	Deputy Head of Midwifery ( <a href="#">for Diane Tinker and item 08/23</a> )
Dr Elizabeth Loney (EL)	Associate Medical Director ( <a href="#">item 06/23</a> )
Lucy Raine (LRa)	Student Nurse on Placement ( <a href="#">Observing</a> )
Debbie Winder (DW)	Deputy Director of Quality – NHS West Yorks ICB ( <a href="#">for LD</a> )
Tracy Wood (TW)	Interim Research and Development Lead ( <a href="#">item 10/23</a> )

##### Apologies

Rob Aitchison (RA)	Deputy Chief Executive
Lucy Dryden (LD)	Quality Manager for Calderdale Integrated Care Board
Jo Kitchen (JK)	Staff Elected Governor
Diane Tinker (DT)	Director of Midwifery

Lindsay Rudge was congratulated on her appointment in the substantive role as Chief Nurse.

Jonathan Hammond and Joanne Middleton were welcomed to their first meeting of the Quality Committee.

#### 02/23 DECLARATIONS OF INTEREST

There were no declarations of interest.

#### 03/23 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday, 14 November 2022 were approved as a correct record.

The scheduled meeting for Wednesday, 22 December 2022 was cancelled.

The action log can be found at the end of these minutes.

## 04/23 MATTERS ARISING

### Care Quality Commission (CQC) Action Plan Review

Victoria Pickles presented the action plan as circulated at appendix B.

A detailed review of the original 'must do' and 'should do' CQC actions was undertaken with divisions to ensure actions were still progressing. The report shows the current position of the 63 actions and details how the seven progressing actions (one 'must do' and six 'should do') will be monitored going forward.

**VP** also noted the restructuring of the CQC and compliance Group, which have now been separated. The CQC Group will focus on the preparedness for any CQC inspection and ongoing levels of quality and safety and any required trustwide actions.

**KH** asked for clarification on the critical care action (MD 8) which states that it is embedded, and also in progress. **VP** clarified that the embedded rating was carried out before the detailed review, and the in progress rating is the current position.

**JE** asked whether the CQC are aware of the internal position and appreciative of the work delivered or ongoing, in order to attain compliance or mitigate risks when not fully compliant. **VP** stated that the Trust is clear with the CQC of our current position, and will be on-site for a deep dive into Critical Care on 1 February 2023. There is honest dialogue on the position, and are aware that some actions will take place post-reconfiguration. **LR** also added that a number of deep dives have taken place with the CQC during normal relationship meetings and also through wanting to look at key services. **LR** suggested that the presentations which took place with the Emergency Department (ED), Children's Services and End of Life Care are shared with the Committee to clarify what has been shared with the CQC, and feedback received.

**Action:** Presentations from previous deep dives to be shared with the Committee.

**OUTCOME:** **VP** was thanked for the update, and the Quality Committee noted the report.

## SPECIFIC REPORTS

### 05/23 QUALITY AND SAFETY STRATEGY

Kim Smith provided an update on the Quality and Safety strategy as circulated at appendix C.

**KH** asked if there was an opportunity for Governors to be referenced as setting the quality priorities; and in relation to the quality ambitions, it was asked if there is an intention to have milestones set against those ambitions. **KS** stated that governors can be referenced, and milestones will be included.

**ES** asked how the Commissioning for Quality and Innovation (CQUINs) fit into the strategy. **KS** stated that the 2023/24 CQUINs are still being discussed and not yet been agreed, but will be part of the strategy. There has been some challenge on which CQUINs are chosen and work has taken place across the integrated care board looking at shared quality priorities and CQUINs.

**DS** asked about the implementation of the revised strategy. **KS** stated that it would be a soft launch with feedback at early stages. The implementation of the effectiveness of the strategy will also need to be monitored throughout the year with regular reports back to the Committee on progress. **LS** stated that the measurement framework within the dashboard needs to be clear, relevant and match national metrics.

**OUTCOME:** **KS** was thanked for the update and the Quality Committee approved the timeline.

## **06/23 HOSPITAL STANDARDISED MORTALITY RATIO UPDATE**

Dr Elizabeth Loney was in attendance to provide a verbal update.

**EL** reported that both the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI) have improved. The HSMR data up to the end of October 2022 was at 102.26 and previously at 103.96. The SHMI data up to the end of September 2022 shows an improvement from 106.65 to 105.86. Nationally, CHFT is ranked 48th and within the green section of the chart. Some of the improvement in the HSMR is due to an increased number of palliative care discharges. Looking at the data between now and October 2022, the crude in-hospital mortality increased, and the out-of-hospital mortality reduced in December. The first question is whether people have been dying in hospital because they have not been able to go back out into the community, and secondly, whether the spike in Emergency Department (ED) mortality of 25 deaths, had anything to do with the increase in number of patients in ED, delayed transfers of care, patients not being able to get a bed, patients who were not expected to die in the ED, etc. This data does not count toward CHFT's HSMR or SHMI, therefore, an audit has been requested. There have been no new alerts.

**JH** mentioned some work done with the Health Informatics Team on demand through the EDs over the last three to four weeks, as well as acuity information of patients, which will be shared with **EL**.

**DW** stated that it is important to learn from deaths and how the ICB can support with any learning outside of the organisation to ensure a place-based approach.

OUTCOME: **EL** was thanked for the update.

## **07/23 REVIEW OF FOLLOW-UP APPOINTMENT CONCERNS REPORT**

Helen Barker was in attendance to present the above report as circulated at appendix D.

In summary, **HB** stated that there is not a systemic issue with the Electronic Patient Record (EPR), however, there are improvements which can be made to the functionality of the EPR to provide assurance on the follow-up pathway management. **HB** thanked the members of the task and finish group on the amount of work achieved in six weeks.

It was suggested that the Quality Committee receive an update on the recommendations on a quarterly basis, which have been agreed by the Executive Board.

**DS** asked about the EPR training, what needs to change, and whether this is part of ongoing work. **JH** stated that EPR training is available, however, there is an opportunity to see how effective it is. This is being led by Neil Staniforth.

**NB** stated that generic baseline training is provided, however, the nuances of what to do for which speciality when in clinic regarding the different surveillance is required, and would benefit from the additional training. It was also noted that Jonathan Cowley (Chief Clinical Information Officer) and Louise Croxall (Chief Nursing Information Officer) will be picking up some of this work regarding awareness around the optimisation of the training and how to most effectively use EPR.

OUTCOME: **HB** was thanked for the update and the Quality committee noted the rapid response to concerns and process entered.

**08/23 MATERNITY REPORT AND MATERNITY INCENTIVE SCHEME SUBMISSION**

Laura Douglas was in attendance to provide an update on the Maternity report as circulated at appendix E1, highlighting:

- Maternity Transformation Plan – Monthly confirm and challenge meetings continue to review the plan, with the current position table included in the report. A weekly maternity improvement huddle also takes place, which the plan is fed into.
- Maternity Incentive Scheme – the additional paper provided with the report as circulated at appendix E2 details the 10 safety actions and progress against them. In preparation for the submission, there have been divisional check and challenge meetings to review the actions and evidence. As a result, it was agreed that nine out of the 10 safety actions were compliant. Work is ongoing with the one outstanding safety action - action six - which relates to the Saving Babies' Lives care bundle. The action has two elements; one is the percentage of women where Carbon Monoxide (CO) measurement at booking is recorded, and the other element is percentage of women where CO measurement at 36 weeks is recorded. An update on the compliance figure within the report was provided. As of December 2022, there was an overall average of 88%.
- Healthcare Safety Investigation Branch (HSIB) Investigations – At the time of the report, there were two active ongoing cases, with a summary provided for each.
- Maternity incidents – The summary of a maternal death which occurred in December 2022 was provided.

**LR** reported that the Board of Directors accepted the Maternity Incentive Scheme position last Thursday.

**LR** also commented on the incident data and the higher reporting around postpartum haemorrhage and term admission to the neonatal unit, and asked whether any deep dives have been carried out on both to look for any reasons or mitigations that can be put in place. **LDou** stated that postpartum haemorrhage is monitored on the dashboard and if there are consecutive months where it is an outlier, then a deep dive would be carried out. In terms of admissions to the neonatal units, a deep review is done as part of the ATAIN (Avoiding Term Admissions Into Neonatal units) work, audited and presented to the ATAIN meetings within the Local Maternity System. **LR** stated that it would be helpful to appendix the maternity dashboard to this report in order for the Committee to see local data and benchmarks.

**LR** also asked about the significant increase in delays to emergency caesarean sections between the November and December's positions. **LDou** stated that the November data was noted as a partial review, however, all delays in caesarean sections are reviewed through the weekly governance meeting. **LDou** asked for a review of December's data regarding the delays and whether any harm occurred. It was also suggested that this is added to a dashboard in order to see data over time.

**DS** stated that in previous reports, reference has been made to work being done on a national and regional level with teams on new trajectories and plans in regard to maternity continuity of carer, and asked about the progress of this. **LDou** stated that the formal outcome and recommendations from the Ockenden 2 and East Kent reports are being awaited, therefore a confirmed trajectory or target dates are not yet known.

**DW** stated that the planning guidance around maternity is expected in January to pull together those action plans. In relation to the governance of the Maternity Incentive Scheme, there is a requirement for a Place assurance and a statement that it has been signed off by the ICS accountable officer. **DW** is working through the evidence with **DT** to be able to support the collation in a timely manner.

OUTCOME: **LDou** was thanked for the update.

## **09/23 TRUST PATIENT SAFETY AND QUALITY BOARD REPORT**

Kim Smith provided an update on the above report as circulated at appendix F.

**KS** reported on the lengthy narrative in the report, and asked that the Quality Committee supports the work going forward into the new financial year, that there is a process for oversight and scrutiny from divisional level into Trust Patient Safety and Quality Board for increased level of assurance into Quality Committee. The process will link into work around the Quality Strategy, Quality Priorities and outcome measures.

**DS** mentioned the items for escalation to Quality Committee and asked if there was any actions expected of the Committee. **KS** stated that terms of references of both the Trust PSQB and sub-groups have been reviewed, and that there have been challenges from the last few months with acuity and operational issues, however, once there is a change in focus and reports are in a more robust place, it may be easier for attendance.

**LR** asked that it be referenced that during the time of the reporting, CHFT was fluctuating between Opel 3 and 4, and the organisation took the decision to stand a number of meetings down, which may have impacted on attendance.

OUTCOME: **KS** was thanked for the update.

### **WELL-LED**

## **10/23 RESEARCH AND INNOVATION COMMITTEE REPORT**

Tracy Wood was in attendance to provide an update on the above report as circulated at appendix G.

**KH** commented on the R&D department's success story which goes from strength to strength. **LD** thanked **TW** for putting CHFT on the map with the national nursing lead who recently visited CHFT.

**DS** commented on how the Quality Committee can assist in getting more coverage for the R&D department. **NB** stated that alternatives have been sought, and thanked **JH** for allowing the R&D team to present at the Wednesday morning leadership briefings. There is an aspiration to go into new services, specialties, or forums to potentially look at job plans to attract and recruit Physician Associates, nurses and Allied Health Professionals to have an element of research, therefore any suggestions on areas where research can be championed were welcomed.

OUTCOME: **TW** and **NB** were thanked for their update.

### **RESPONSIVE**

## **11/23 QUALITY REPORT**

Kim Smith provided an update on the above report as circulated at appendix H.

**KS** noted that the majority of CQUINs are on track, however, the report shows two amber and one red CQUIN: CCG2 – Appropriate antibiotic prescribing for UTI in adults aged 16+; CCG9 – Cirrhosis and fibrosis tests for alcohol dependent patients, and CCG14 – Assessment, diagnosis and treatment of lower leg wounds.

**ES** commented that although CCG7 – Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service - was not prioritised for the organisation, it was very specific to pharmacy around referrals to community pharmacy when patients have several medication changes, to ensure they are informed. The target was 1.5% of all discharges, and Pharmacy achieved 3.19% for the latest quarter, and the highest

performing Trust in North East and Yorkshire. It is hoped that this carried through into the final quarter.

In relation to the expected CQC maternity services inspection, **KH** commented on the incredible work undertaken in the service on their thorough and detailed action plan, and good feedback from the assurance visit last year.

**DS** commented on the ED quality priority and the increasing numbers of patients in ED who are breaching the eight, 10 and 12 hour targets, however, was pleased to see that no patients were coming into any harm, however, the pressure ulcer data states that there is an increase in hospital acquired Pressure Ulcers due to long waits and time spent on trollies. **DS** asked how reviews in ED are linking to ward level. **LR** stated that it cannot be said that patients are not coming to any harm on the long waits, as there are some serious incidents regarding delay in treatment. It was suggested that a review of the incidents related to ED over the Christmas period is carried out.

**Action:** Report of a review of incidents relating to the ED over the Christmas period to return to a future meeting, and triangulating data of increased acuity and admissions into the bed base as discussed at item 06/23.

OUTCOME: **KS** was thanked for the update.

### **12/23 INTEGRATED PERFORMANCE REPORT**

David Birkenhead presented an update to the report as circulated at appendix I, highlighting key points and noting the cancer performance which remains really positive and good progress made on the long waiters.

There has been significant pressure with the organisation being in Opel 4 through much of December and the first part of January.

OUTCOME: The Quality Committee noted the report.

## **ITEMS TO RECEIVE AND NOTE**

### **13/23 CLINICAL OUTCOMES GROUP MINUTES**

A copy of the minutes were available at appendix J.

**KH** noted from the minutes of the lack of a report from the End of Life Care Group.

**DB** reported following this up as a report has been expected and awaiting a response. **LR** stated that for assurance, **JM** will now be chairing the Group and having a stronger assurance role.

OUTCOME: **DB** was thanked for the update.

### **14/23 MINUTES FROM KIRKLEES PLACE**

A copy of the minutes were available at appendix K for information.

**DS** asked if there are any queries from the Quality Committee, how will these be fed back? **LR** stated that a report by exception would be completed. It was noted that an issue has been raised on the need for a risk register representative of Place. As of yet, a quality dashboard has not yet been agreed, however, at the last integrated care board quality committee, a range of quality metrics were discussed and it is hoped that a review of the dashboard can take place with agreed metrics, and a sub-group for risk which reviews the risk register.

### **15/23 ANY OTHER BUSINESS**

**DS** mentioned the notification of the change of dates to the Quality Committee from April 2023, to ensure alignment with other Board sub-committees. It was acknowledged that some members may now be unable to attend Quality Committee due to conflicting commitments, however, this will be managed throughout the year.

**DS** also mentioned discussions about the length of Board sub-committee meetings. There may be recommendations to extend the meetings by 30 minutes in order to get through the agenda and to ensure there is appropriate time given to agenda items and time for discussions to take place.

### **16/23 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

**DS** mentioned changes at Board level in terms of how sub-committee Chairs report, therefore, this will now be a broader report provided to the Board, which will include most of the Quality Committee agenda.

### **17/23 QUALITY COMMITTEE ANNUAL WORK PLAN**

The workplan was available at appendix L for information.

There is still some work to be done on the workplan, and the finalised agreed workplan will hopefully be able to be shared by March 2023 at the latest.

## **POST MEETING REVIEW**

### **18/23 REVIEW OF MEETING**

A good overview of quality from all aspects of the organisation, and acknowledgement of challenges, not just assurances.

## **NEXT MEETING**






Monday, 20 February 2023  
3:00 – 5:00 pm  
Microsoft Teams



# QUALITY COMMITTEE ACTION LOG

Following meeting on Monday, 16 January 2023

Overdue    New / Ongoing    Closed    Going Forward

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	RAG RATING
<b>NEW / ONGOING ACTIONS</b>				
14.11.22 (193/22)	BAF Risk 4/20 – CQC		At the last CQC meeting, a complete review of all the must-do and should-do actions from the last inspection took place to create a more realistic position. <b>Action:</b> Report detailing review of all must and should-do actions to be submitted to the next Quality Committee for sign-off. <b>Update Jan 2023:</b> See agenda item 04/23	<b>DUE FOR CLOSURE</b>
16.01.23 (04/23)	CQC action plan review		<b>Action Jan 2023:</b> Presentations from previous deep dives to be shared with the Committee (also see end of combined pack for full presentations)     EoLC Focus CQC VisitFINAL JSS Vaccination Maternity Services - MASTER Template.pCentre CQC TMA PresCQC presentation.ppt    Medicine CQC Slides Patient FIRST - May 2022 final.pptx Presentation V5.pptx	
16.05.22 (80/22)	Split Paediatric Service	J Mellor / S Riley- Fuller / S Cartwright	<b>Action 16 May 2022:</b> That the original escalation process is revisited. <b>Update:</b> Options to return to Quality Committee in September and October have been provided and awaiting response from division. <b>Update Oct 2022:</b> See item 168/22 <b>Action 24.10.22:</b> A focus on the children and young people standards to return to Quality Committee.	
20.06.22 (84/22)	Annual Patient Experience Report	Nicola Greaves	<b>OUTCOME:</b> To be deferred <b>Update:</b> The report is awaiting approval at the Patient Experience and Caring Group before ratification at Quality Committee <b>Update Oct 2022:</b> Deferred to a future meeting – date TBC	<b>See agenda item 35/23</b>
<b>UPCOMING ACTIONS</b>				
16.01.23 (1/23)	Quality Report	Kim Smith	DS commented on the ED quality priority and the increasing numbers of patients in ED who are breaching the eight, 10 and 12 hour targets, however, was pleased to see that no patients were coming into any harm, however, the pressure ulcer data states that there is an increase in hospital acquired Pressure Ulcers due to long waits and time spent on trolleys. DS asked how reviews in ED are linking to ward level. LR stated that it cannot be said that patients are not coming to any harm on the long waits, as there are some serious incidents regarding delay in treatment. It was suggested that a review of the incidents related to ED over the Christmas period is carried out. <b>Action 16.01.23:</b> A report of a review of incidents relating to the ED over the Christmas period to return to a future meeting, and triangulating data of increased acuity and admissions into the bed base as discussed at item 06/23.	<b>March 2023</b>
16.05.22 (80/22)	Split Paediatric Service	Lindsay Rudge	LR commented on the risk relating to the APNP model at Huddersfield, which is at a score of 16 on the risk register, stating that Simon Riley-Fuller (ADN in FSS) has been asked to review this. It was also noted that the Emergency Department (ED) are also looking at the impact of any incidents or near misses that have occurred as a result of the described risk, the results of which can be returned to a future Quality Committee for oversight and assurance to ensure that the risk is not tolerated. <b>Action 24.10.22:</b> For any results of the review of the risk and impact of incidents and near misses to be returned to the Quality Committee	<b>TBC</b>
24.10.22 (171/22)	Integrated Performance Report	Lindsay Rudge	LR also stated that it would be helpful to bring a presentation on the data to see the broader impact of all the increased activity and that expanded bed base to see what that means in terms of harm and incidence. <b>Action:</b> Presentation to be requested for Quality Committee	<b>TBC</b>

**CLOSED ACTIONS**

<p>24.10.22 (176/22)</p>	<p><b>Medical Gases and Non-Invasive Ventilation (NIV) Group</b></p>	<p><b>Lindsay Rudge / Nicholas Scriven</b></p>	<p>LR asked if there were any solutions to the issues raised or whether any support was required from the Committee. <b>NSc</b> stated that in terms of attendance at the meeting, divisional representation has been sought, however, this is challenged due to turnover, and not being certain on who the correct representative is, therefore any help would be appreciated on identifying the correct people to target to attend the meeting.</p> <p><u>Action 24.10.22:</u> LR agreed to meet with <b>NSc</b> outside of the meeting to logically go through the issues raised.</p> <p><u>Update:</u> Vanessa Dickinson met with <b>NSc</b> and Lis street on 16 November 2022 to discuss the various issues regarding the NIV/O2/Medical gases meeting and lack of divisional representation, the following were agreed:</p> <ul style="list-style-type: none"> <li>• NIV/O2 and Medical Gases will be split into two separate meetings again – (identified by all parties that joining them has increased the problems)</li> <li>• Pull sub-groups back into the main meeting to reduce number of meetings and increase divisional representation</li> <li>• Vanessa has introduced a buddy system in medicine for the medical matrons regarding all meetings, which should also improve attendance and is happy to share with other divisions.</li> </ul>	<p align="center"><b>CLOSED Jan 2023</b></p>
<p>16.05.22 (80/22)</p>	<p><b>Split Paediatric Service</b></p>	<p><b>David Birkenhead</b></p>	<p>The Chair also mentioned the key risk in regard to staffing and asked if there was any business planning taking place or a business case, and whether this would be a long-term risk.</p> <p><u>Action 24.10.22:</u> <b>DB</b> agreed to liaise with Venkat Thiyagesh for further detail on the above and feedback to the Quality Committee.</p> <p><u>Update:</u> The Division produced an options paper to manage the risk. This went to Weekly Executive Board, and the option to move Paediatric A&amp;E patients to CRH in line with the reconfiguration model was supported.</p> <p><u>Update Jan 2023:</u> <b>DB</b> reported that a paper was taken through to the Weekly Executive Board for consideration. There were a number of options, including moving to a model where most children would be cared for in Calderdale. This has since moved on and now potentially looking to recruit additional paediatric nurses for the HRI site. This will return to the WEB this week, with plans to mitigate the risks</p>	<p align="center"><b>CLOSED</b></p>

## QUALITY COMMITTEE

Monday, 14 November 2022

### STANDING ITEMS

#### 182/22 WELCOME AND INTRODUCTIONS

##### Present

Denise Sterling (DS)	Non-Executive Director (Chair)
Rob Aitchison (RA)	Deputy Chief Executive
Gina Choy (GC)	Public Elected Governor
Sharon Cundy (SC)	Head of Quality and Safety
Richard Dalton (RD)	Head of Risk and Compliance
Andrea Dauris (AD)	Deputy Chief Nurse
Karen Heaton (KH)	Non-Executive Director
Victoria Pickles (VP)	Director of Corporate Affairs
Lindsay Rudge (LR)	Chief Nurse
Elisabeth Street (ES)	Clinical Director of Pharmacy
Michelle Augustine (MA)	Governance Administrator (Minutes)

##### In attendance

Helen Hirst (HH)	CHFT Chair (Observing)
Richard Hill (RH)	Head of Health and Safety (item 185/22)
Lucy Dryden (LD)	Quality Manager for Calderdale Integrated Care Board
Helen Rees (HR)	Director of Operations – Medical Division (item 185/22)
Nicola Greaves (NG)	Quality Improvement Manager - Patient Experience (item 189/22)
Christopher Roberts (CR)	Deputy Director of Operations – Medical Division (item 185/22)
Diane Tinker (DT)	Director of Midwifery (item 175/22)
Debbie Winder (DW)	Deputy Director of Quality – NHS West Yorks ICB (item 186/22)

##### Apologies

Mr Neeraj Bhasin (NB)	Deputy Medical Director
Dr David Birkenhead (DB)	Medical Director
Jason Eddleston (JE)	Deputy Director of Workforce & Organisational Development
Jonathan Hammond (JH)	Chief Operational Officer
Jo Kitchen (JK)	Staff Elected Governor
Kim Smith (KS)	Assistant Director for Quality and Safety

Rob Aitchison was welcomed to his first Quality Committee meeting as Deputy Chief Executive.

#### 183/22 DECLARATIONS OF INTEREST

There were no declarations of interest.

#### 184/22 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday, 24 October 2022 were approved as a correct record, with the exception that an action is made in conjunction with the last paragraph of item 176/22 in relation to the Medical Gases and Non-Invasive Ventilation (NIV) Group. The action log can be found at the end of these minutes.

## **185/22 MATTERS ARISING**

### **Stroke Deep Dive**

Christopher Roberts was in attendance to present the update as circulated at appendix B.

The Sentinel Stroke National Audit Programme (SSNAP) allows for CHFT to monitor performance against national targets for stroke, and historically, CHFT have performed at a rating of 'A', however, during COVID and over more recent months, there has unfortunately been a deteriorating position. The current performance of a 'C' rating is due to a number of challenges, one of which is the closure of nine beds prior to COVID, with a view to delivering increased care in the community. This took place with an early supported discharge service which increased capacity, however, there was also a significant increase of stroke patients presenting at the Emergency Department (ED), as well as increased acuity and dependency, which has led to increased outliers with patients not being seen as quickly by the Stroke team, which in turn led to increased lengths of stay.

Some of the challenges have been mitigated, with nurse vacancies now being fully recruited to, and other actions taken have seen a continued improvement in the SSNAP scores, with increases from 'C' to 'A' ratings in some of the individual measures in the last couple of months. Further actions completed and ongoing actions were also detailed in the presentation.

The stroke service are aware of the challenges and have addressed them as much as possible, however, an ongoing challenge is the medical workforce and not able to successfully recruit into those posts.

**KH** commented on the increase in the number of patients being seen and asked if there was anything specific around this. **CR** stated that COVID and an aging population have impacted on the increase, and also mentioned that there tends to be a pattern of an increase of stroke patients every six weeks or so into the bed base, and trying to understand this is also a challenge. **LR** stated that the issue of the increase in stroke patients was taken to the Clinical and Professional forums at Calderdale, and one of the responses were people not accessing their regular screenings throughout COVID as normal, and there is an expectation that this impact will continue. **KH** asked how CHFT's performance compares to others in the region. **CR** stated that CHFT is not a significant outlier.

**LR** asked if there was any harm or outcomes being seen as a result of not being able to meet the SSNAP and performance targets. **CR** stated that the prevention of harm is the main focus. Practice was changed during COVID to facilitate early discharge, and the outcomes are now being seen on the ongoing quality of life, as not being able to rehabilitate patients as quickly and challenges with therapy staffing.

**VP** stated that a decision was made at a point in time to remove beds from the acute stroke ward, and asked what would trigger a different decision to put the capacity back in. **CR** stated that it is believed that there is a cohort of patients that could be rehabilitated in the community bed base and this is being worked towards. In terms of triggers to open up additional capacity, this would be determined on the number of outliers, and the number of attendances in a day which require the additional beds being opened. The biggest trigger is at what point, for example, ten outliers are reached, and to also understand the impact on the wider Trust, as staffing also needs to be considered.

**LR** stated being involved in the stroke task and finish groups, and understood from an integrated care board perspective, that there was a commitment to fund additional inpatient beds to cope with demand. It was asked if this is still the case. **HR** stated that as part of the winter funding, four additional beds have been supported, as well as support for early supported discharge.

**ES** mentioned enhanced roles for pharmacists and Advanced Clinical Practitioners, and asked if there was anything which the service could provide, in terms of workforce support. **CR** welcomed the support and agreed to follow this up with **ES** outside of the meeting.

**LR** stated that clarity is required on which forum this item will be monitored, Finance and Performance or Quality Committee, to ensure there is no duplication.

**OUTCOME:** CR was thanked for the update and would be kept informed of which forum any follow-ups would be required.

### **Health and Safety Assurance Report**

Richard Hill was in attendance to provide an update on health and safety assurances, as circulated at appendix C, in light of changes made to the Quality Committee terms of reference for the Committee being cited on employee safety issues.

**RH** stated that there were five projects:

- NHS Workplace Health and Safety Standards – Compliance is being demonstrated against the majority of the required legislation, with those partially demonstrated due to be fully compliant by December 2022.
- Management of the most common risk of injuries:
  - slips, trips and falls injuries are the most frequent type of injury, and has been on a steady decline since 2017. Over the last 12 months, **RH** has been working with PFI partners and CHS to review the risk assessments, policies, procedures and method statements. The majority of injuries are connected to the cleaning processes and winter weather conditions.
  - Needlestick injuries are the second most frequent type of injury, and several improvement plans are taking place. In the next 4-6 months, a further measure of incidents will take place to reflect on the work which has been done.
  - Moving and handling injuries – since 2017, there has been a steady decline in the number of injuries, due to the work of the moving and handling team.
- Handling and control of exposure to hazardous chemicals – a review of the 8000 assessments on the database has been done, and a review of current users is taking place in December 2022.
- Controlling the risk to new and expectant mothers – a review of the maternity assessment content has taken place, with a planned implementation of the refreshed assessment due in November 2022.
- Direct working arrangements between the Head of Health and Safety and Occupational Health Team – Work undertaken by **RH** is closely aligned with Occupational Health and Human Resources, and over the next six months, meetings will take place to review issues on work-related loss-time injuries; stress management; DSE referrals and needlestick injury referrals, and some measures put in place to reduce where there are increases in those areas.

**RH** stated that these areas of work have been represented over the last six months, with much more work which will be included in the end of year report to the Board of Directors.

**KH** asked about the progress of the assessment for controlling the risk to new and expectant mothers. **RH** stated that this was completed four weeks ago.

**ES** asked about a refresh of the Control of Substances Hazardous to Health (COSHH) training. **RH** stated that within the employee staff record (ESR), there are different types of health and safety modules and a PowerPoint presentation on COSHH will be added at the beginning of next year. **DS** asked if there have been any incidents relating to COSHH. **RH** stated that there have not been any incidents at the moment.

**DS** asked about the Display Screen Assessments, response rates so far, and what was coming through in relation to colleagues working from home, and the plans to address any issues. **RH** started the assessments are based on office-based colleagues, and assessments for homeworking colleagues is work in progress through Human Resources and agile working. There are currently 120 desk-based users with 80% compliance of completing the assessment, with around 12 colleagues who have raised issues relating to the ergonomics and position and setup of chairs; aches, pains, back injuries and historic medical conditions. **RH** has been working with a company in Sowerby Bridge who are DSE specialists, who will be giving a free of charge in-depth assessment for those individuals.

OUTCOME: RH was thanked for the update.

## AD HOC REPORTS

### 186/22 PLACE-BASED ARRANGEMENTS FOR QUALITY ASSURANCE

Debbie Winder was in attendance to provide an update on the integrated quality framework for Place-based arrangements, as circulated at appendix D.

The framework contains the principles of how quality oversight, surveillance and assurance will take place in Calderdale in an integrated way and the opportunities for quality improvement.

The relationships between the Integrated Care Board place and the programmes of work was highlighted at appendix 1 within the paper. The proposed principles for the Calderdale Place Integrated Quality Group (IQG) was also highlighted, and the proposed IQG model for delivery.

In relation to the governance structure within appendix 1, **VP** asked whether the structure was the same for both Kirklees and Calderdale places, and how duplication and consistency of information is managed, as Trusts do not have representation on the system quality group in terms of membership. It was also asked how this feeds into the Quality integrated care board Committee. **DW** stated that this is an emergent process, and that the current arrangement is that Penny Woodhead as the Executive Lead represents and takes information into the high-level committee, in agreement with partners. In terms of duplication, **DW** stated that this is something which is being mindful of, but does not have a definitive answer as yet. **VP** asked how CHFT will be appropriately represented, and how data that is being used is accurately reflective. **LR** stated that there is further work to be done on the data that is represented, and requested that data is brought through the CHFT Quality Committee before being submitted externally. **KH** asked about the role of the CHFT Quality Committee into the structure, and how it would receive and have the opportunity to feed information into. **DW** stated again that this is an emergent process, and hopes that definitive answers will be available soon, and is happy to return to update.

**LR** assured the Quality Committee that it was recognised at the Kirklees place that further work is needed on the risk register. A sub-group will be set up to work through what would be expected on the register, and it was agreed that this is fast-tracked through this Committee, as well as the minutes from the meetings.

OUTCOME: DW was thanked for the update and the Quality Committee noted the report.

### 187/22 SAFER STAFFING REPORT

Andrea Dauris was in attendance to present the report as circulated at appendix E, which provided an overview of Nursing, Midwifery and Allied Health Professional (AHP) staffing capacity and compliance within CHFT in line with the National Institute for Excellence (NICE) Safe Staffing, National Quality Board (NQB) and the NHS Improvement Workforce



Safeguards guidance. The report has previously been through the Workforce Committee and also the Board of Directors.

The key points to note were highlighted.

**GC** noted speech and language therapists, and concerns about whether or not there is capacity in the Community for this to be delivered. **LR** stated that work has been done with Jenny Clark, Associate Director of Therapy Services, to support speech and language therapists, by creating some nurse specialist roles around dysphagia management and screening, which will provide more capacity. This is a hard to recruit service, however, there are things which can be done differently which will remove some of the tasks which can be performed by another professional.

OUTCOME: AD was thanked for the update and the Quality Committee noted the report.

## **188/22 EXTERNAL REVIEWS REPORT**

Sharon Cundy presented an update as circulated at appendix F.

Three external reviews had not yet started, one review completed and one review in progress. One review not yet started was the onsite Healthcare Safety Investigation Branch inspection, where the final report is still awaiting publication. The other review not yet started was the Ockenden regional maternity team assurance visit, where a mock inspection has been carried out with positive feedback received. One of the recommendations was that Julie Mellor's role is reviewed, as she is the only lead nurse for children in the organisation. **LR** stated that this is to ensure that Julie has the correct capacity to carry out her role across the organisation, with further matron roles being put into paediatrics.

**LR** stated that from a Quality Committee perspective, there is a commitment to carry out a development session with Board members around the children and young people's strategies, which will be taken forward over the next couple of months.

**VP** asked about the status columns within the update which state 'not yet started'. **SC** agreed to come back to **VP** with a response, as the template was not populated by herself.

OUTCOME: SC was thanked for the update and the Quality Committee noted the report.

## **CARING**

### **189/22 LEARNING FROM PATIENT STORY**

Nicola Greaves was in attendance to share a patient story as circulated at appendix G on motor neurone disease (MND), with an opportunity for the Committee to look at the learning.

The presentation highlighted the patient voice, the initiating of the MND steering group, the reality, response and result of the steering group, and benefits of the learning.

**VP** agreed that this was something which the community requires, however, was not clear on the learning from the presentation. The benefits of having an MND nurse and the steering group were evident, however, the learning as an organisation, on how patients' voices are listened to, about the service developments that may be required within the organisation were not outlined. **NG** stated that work on an engagement toolkit will refine more about the listening to voices, and learn about when it is appropriate and how to make that judgement of putting the steering group in place.

**DS** asked where the information is captured from patients and carers who are stating that their needs are not met. **NG** stated that Friends and Family Test results, appreciations and complaints are now being triangulated, with some themes emerging, especially within maternity. A specific patient experience group has been set up to look at the issues.



In terms of carers, work is ongoing and increasing awareness such as the John's campaign, with better conversations with dementia carers, and targeting the carers' lanyard across more carers. There are also good mechanisms for engaging with carers once they have been provided with a lanyard, and working with carers' agencies across the health economy about carers being signposted for additional support.

OUTCOME: NG was thanked for the update and the Quality Committee noted the report.

## SAFE

### 190/22 MATERNITY REPORT

Diane Tinker provided a brief update on the report as circulated at appendix H, highlighting the key points, including the publication of the East Kent report. The report identified six areas for concern, which were submitted to the Board of Directors for discussion.

**DS** asked about the complaints, which are not seeing an increase in the numbers, although, with the additional scrutiny within maternity, it was asked if any changes were noted in the themes coming through. **DT** was not concerned about any themes, but stated that a piece of work on themes and relating to clinical incidents is being carried out as well as triangulating that with the maternity scorecard, which will be part of next months' report.

**LR** stated that following agreement at Board, a more detailed report on the East Kent report will also be submitted to the Quality Committee.

OUTCOME: **DT** was thanked for the update and the Committee noted the report.

## EFFECTIVE

### 191/22 CLINICAL OUTCOMES GROUP MINUTES AND DASHBOARD

Sharon Cundy briefly presented an update from the Clinical Outcomes Board, as circulated at appendix I, which included items for escalation to Quality Committee of:

- ReSPECT (Recommended Summary Plan for Emergency Care) update, which will hopefully be rolled out in early 2023
- Concerns from the Care of the Acutely Ill Patient (CAIP) Programme included sepsis and the administration of antibiotics in ED within 60 minutes; the percentage of stroke patients spending 90% of their length of stay on a dedicated stroke unit; and the AKI business case not progressing as expected due to the interface between Cerner and Electronic Patient Record, and the risk of losing funding.
- Mental Health Strategy to be ratified at the Clinical Outcomes Group before submission to the Quality Committee, and a Mental Health Nurse in now in post.
- Maternity is being removed from the risk assessment compliance data for pressure ulcers, KP+ and Datix are generating different data. Data is being captured on Athena instead
- The COG dashboard shows that the administration of antibiotics for in the ED for sepsis has decreased; in harm falls have decreased, and a positive is that hospital mortality ratio is at its lowest since the start of the pandemic.

OUTCOME: SC was thanked for the update, and the Committee noted the minutes.

## RESPONSIVE

### 192/22 INTEGRATED PERFORMANCE REPORT

Lindsay Rudge presented an update to the report as circulated at appendix J.

It was noted that there is an improvement in the Quality Priority for 'Recognition and timely treatment of Sepsis' with challenges for the remaining quality priorities for 'Reduction in the number of hospital-acquired infections including COVID-19' due to continued COVID waves and 'Reducing waiting times for individuals attending the Emergency Department' due to continued ED positions.

The surgical site infection data looks to be increasing, with a possible update required going forward on the actions being taken and what it means in practice.

LR also noted that at the last weekly executive board (WEB) meeting, there was a deep dive into the Hospital Standardised Mortality Ratio.

OUTCOME: LR were thanked for the update and the Quality Committee noted the report.

## WELL-LED

### 193/22 BOARD ASSURANCE FRAMEWORK (BAF) RISK 4/20 – CQC RATING

Victoria Pickles presented the report as circulated at appendix K.

Key points to note were:

- The Trust continues to make good progress in assessing key service areas
- All board members recently took part in a 'well led' conversation individually with an external assessor. Feedback from this will be shared and actions to address any areas of development put in place.
- The learning from recent and upcoming webinars on the new approach to inspection to understand how this will affect us will be shared
- Children's services recently had an independent assessment by external facilitator. Report due in December 2022.
- The rating for the risk remains the same at a score of 12.

It was noted that the CQC and Compliance Group is now being restructured to only focus on CQC, which will be included on the new governance structure. The compliance element of the meeting will be monitored elsewhere. At the last CQC meeting, a complete review of all the must-do and should-do actions from the last inspection took place to create a more realistic position.

**Action:** Report detailing review of all must and should-do actions to be submitted to the next Quality Committee for sign-off.

## ITEMS TO RECEIVE AND NOTE

### 194/22 QUALITY COMMITTEE ANNUAL REPORT ACTION PLAN

A copy of the Quality Committee Annual Report action plan was available at appendix L for information. There were no questions from the Committee in relation to the action plan.

### 195/22 MEDICINES MANAGEMENT COMMITTEE MINUTES

A copy of the Medicines Management Committee minutes were available at appendix M for information. There were no questions from the Committee in relation to the minutes.

**196/22 ANY OTHER BUSINESS**

Integrated Care Board report

LD asked the Committee if there was anything of focus for the report, which is due to be drafted this week. Any comments which would like to be added, to be emailed to LD.

**197/22 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

In terms of the Chair’s highlight report to the Board of Directors, the Quality Committee will note receipt of:

- Productive conversation with Debbie Winder in terms of place working arrangements
- Health and Safety highlight report with good assurance on appropriate processes and systems in place for patient and employee safety
- External Reviews Report
- Surgical Site Infections
- Safer Staffing Report

**198/22 QUALITY COMMITTEE ANNUAL WORK PLAN**

The workplan was available at appendix N for information.

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**POST MEETING REVIEW**

**199/22 REVIEW OF MEETING**

This item was not taken due to time constraints.

**NEXT MEETING**

Monday, 16 January 2023  
3:00 – 5:00 pm  
Microsoft Teams

The meeting scheduled for Wednesday, 21 December 2022 was cancelled.

## QUALITY COMMITTEE ACTION LOG

### Following meeting on Monday, 14 November 2022

Overdue
New / Ongoing
Closed
Going Forward

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	RAG RATING
<b>NEW / ONGOING ACTIONS</b>				
14.11.22 (193/22)	<b>BAF Risk 4/20 – CQC</b>	<b>Victoria Pickles</b>	<p>At the last CQC meeting, a complete review of all the must-do and should-do actions from the last inspection took place to create a more realistic position.</p> <p><b>Action:</b> Report detailing review of all must and should-do actions to be submitted to the next Quality Committee for sign-off.</p>	<b>Due 16 January 2023</b>
24.10.22 (176/22)	<b>Medical Gases and Non-Invasive Ventilation (NIV) Group</b>	<b>Lindsay Rudge / Nicholas Scriven</b>	<p>LR asked if there were any solutions to the issues raised or whether any support was required from the Committee. <b>NSc</b> stated that in terms of attendance at the meeting, divisional representation has been sought, however, this is challenged due to turnover, and not being certain on who the correct representative is, therefore any help would be appreciated on identifying the correct people to target to attend the meeting.</p> <p><b>Action 24.10.22:</b> LR agreed to meet with <b>NSc</b> outside of the meeting to logically go through the issues raised.</p> <p><b>Update:</b> Vanessa Dickinson met with <b>NSc</b> and Lis street on 16 November 2022 to discuss the various issues regarding the NIV/O2/Medical gases meeting and lack of divisional representation, the following were agreed:</p> <ul style="list-style-type: none"> <li>• NIV/O2 and Medical Gases will be split into two separate meetings again – (identified by all parties that joining them has increased the problems)</li> <li>• Pull sub-groups back into the main meeting to reduce number of meetings and increase divisional representation</li> <li>• Vanessa has introduced a buddy system in medicine for the medical matrons regarding all meetings, which should also improve attendance and is happy to share with other divisions.</li> </ul>	
16.05.22 (80/22)	<b>Split Paediatric Service</b>	<b>David Birkenhead</b>	<p>The Chair also mentioned the key risk in regard to staffing and asked if there was any business planning taking place or a business case, and whether this would be a long-term risk.</p> <p><b>Action 24.10.22:</b> <b>DB</b> agreed to liaise with <b>Venkat Thiyagesh</b> for further detail on the above and feedback to the Quality Committee.</p> <p><b>Update:</b> The Division produced an options paper to manage the risk. This went to Weekly Executive Board, and the option to move Paediatric A&amp;E patients to CRH in line with the reconfiguration model was supported.</p>	
<b>UPCOMING ACTIONS</b>				
16.05.22 (80/22)	<b>Split Paediatric Service</b>	<b>Lindsay Rudge</b>	<p>LR commented on the risk relating to the APNP model at Huddersfield, which is at a score of 16 on the risk register, stating that Simon Riley-Fuller (ADN in FSS) has been asked to review this. It was also noted that the Emergency Department (ED) are also looking at the impact of any incidents or near misses that have occurred as a result of the described risk, the results of which can be returned to a future Quality Committee for oversight and assurance to ensure that the risk is not tolerated.</p> <p><b>Action 24.10.22:</b> For any results of the review of the risk and impact of incidents and near misses to be returned to the Quality Committee</p>	<b>TBC</b>
24.10.22 (171/22)	<b>Integrated Performance Report</b>	<b>Lindsay Rudge</b>	<p>LR also stated that it would be helpful to bring a presentation on the data to see the broader impact of all the increased activity and that expanded bed base to see what that means in terms of harm and incidence.</p> <p><b>Action:</b> Presentation to be requested for Quality Committee</p>	<b>TBC</b>
16.05.22 (80/22)	<b>Split Paediatric Service</b>	<b>J Mellor / S Riley-Fuller / S Cartwright</b>	<p><b>Action 16 May 2022:</b> That the original escalation process is revisited.</p> <p><b>Update:</b> Options to return to Quality Committee in September and October have been provided and awaiting response from division.</p> <p><b>Update Oct 2022:</b> See item 168/22</p> <p><b>Action 24.10.22:</b> A focus on the children and young people standards to return to Quality Committee.</p>	<b>Due 20 February 2023</b>
20.06.22 (84/22)	<b>Annual Patient Experience Report</b>	<b>Nicola Greaves</b>	<p><b>OUTCOME:</b> To be deferred</p> <p><b>Update:</b> The report is awaiting approval at the Patient Experience and Caring Group before ratification at Quality Committee</p> <p><b>Update Oct 2022:</b> Deferred to a future meeting – date TBC</p>	

## QUALITY COMMITTEE

Monday, 20 February 2023

### STANDING ITEMS

#### 19/23 WELCOME AND INTRODUCTIONS

##### Present

Denise Sterling (DS)	Non-Executive Director (Chair)
Dr David Birkenhead (DB)	Medical Director
Mr Neeraj Bhasin (NB)	Deputy Medical Director
Gina Choy (GC)	Public Elected Governor
Sharon Cundy (SC)	Head of Quality and Safety
Jason Eddleston (JE)	Deputy Director of Workforce & Organisational Development
Alison Edwards	
Jonathan Hammond (JH)	Deputy Chief Operational Officer
Karen Heaton (KH)	Non-Executive Director
Joanne Middleton (JMidd)	Deputy Chief Nurse
Victoria Pickles (VP)	Director of Corporate Affairs
Kim Smith (KS)	Assistant Director for Quality and Safety
Elisabeth Street (ES)	Clinical Director of Pharmacy
Michelle Augustine (MA)	Governance Administrator (Minutes)

##### In attendance

Gemma Hinchliffe (GH)	Quality Manager – NHS West Yorks ICB (for LD and DW)
Dr Tim Jackson (TJ)	Lead Medical Examiner (item 27/23)
Dr Elizabeth Loney (EL)	Associate Medical Director (item 06/23)
Julie Mellor (JM)	Student Nurse on Placement (Observing)
Liz Pepper (LP)	Senior Medical Examiner Officer (item 27/23)
Diane Tinker (DT)	Director of Midwifery (item 29/23)

##### Apologies

Rob Aitchison (RA)	Deputy Chief Executive
Lucy Dryden (LD)	Quality Manager for Calderdale Integrated Care Board
Lindsay Rudge (LR)	Chief Nurse
Debbie Winder (DW)	Deputy Director of Quality – NHS West Yorks ICB

#### 20/23 DECLARATIONS OF INTEREST

There were no declarations of interest.

#### 21/23 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday, 16 January 2023, circulated at appendix A1, were approved as a correct record. The action log can be found at the end of these minutes.

#### 22/23 TERMS OF REFERENCE

A copy of the terms of reference were circulated at appendix A2 for revision and approval by the Quality Committee, prior to submission to the next Trust Board.

Changes made during the last year have been incorporated into the revised terms of reference. It was asked that the organogram within the terms of reference is amended to highlight changes to chairs of sub-group meetings.

**Action:** The organogram to be updated, and the amended terms of reference to be re-circulated.

## SPECIFIC REPORTS

### 23/23 CQC CHILDREN AND YOUNG PEOPLE SURVEY ACTION PLAN

Julie Mellor was in attendance to present the above, circulated at appendix B.

**JM** assured the Committee that the action plan has now been built into the overarching transformation plan, which will continue to be presented to the Committee.

**KH** asked about the timeframe for having volunteers in place. **JM** stated that confirmation from Infection Control is needed for the additional volunteers who will be actively involved in play sessions with children. This is being worked through by matrons at this time and envisaged to be in place in the next four weeks.

**SC** asked whether the clinical governance board is a divisional or trustwide initiative. **JM** stated that is a staff-facing board which was developed locally, and not in the public domain. It is a board in the medicines room with readily available information.

**DS** commented that it was encouraging to see the amount of work completed since the last Quality Committee update, and asked that thanks are conveyed to the key individuals who have been pushing this work forward.

OUTCOME: **JM** was thanked for the update and the Quality Committee noted the report.

## WELL-LED

### 24/23 GETTING IT RIGHT FIRST TIME (GIRFT)

Mr Neeraj Bhasin presented the above report, circulated at appendix C.

**DS** commented on the tracking of the benefits of GIRFT across the organisation and asked how this will be done, due to the team not yet being at full complement. **NB** stated that the reason for the new team composition is to try to enable that. One of the difficulties is double counting, as some of the benefits from the urology work, for example, are also captured in the outpatient transformation programme and divisional plans. One of the areas which needs to be more rigorous in capturing the benefits, is the refreshed reporting system. The GIRFT reports are monitored through the Performance Review Meetings, however, there should also be a view to quality, via Patient Safety and Quality Board meetings, in order for divisions to have an oversight and understanding of GIRFT in order to facilitate it.

**KH** reported that this continues to be a good story with a good track record, and looking forward to the new team being established quickly in order to not lose the successful momentum, as this is now embedded in the Trust and continues to be useful and helpful.

**JH** mentioned the benefits of GIRFT and trying to embed it as business as usual in divisions and directorates. An example of this is through the elective transformation programme, and trying to build on work already done, particularly around outpatients, and bring to the forefront by using the GIRFT outpatient recommendations as a menu of what each specialty could do if they followed the GIRFT process, with a structured approach and support from the GIRFT team.

**DS** commented on positive feedback received in terms of the training provided to increase colleagues' awareness of GIRFT.

OUTCOME: **NB** was thanked for the update, and the Quality Committee noted the report.

## **25/23 BOARD ASSURANCE FRAMEWORK (BAF) RISK 3/19 – SEVEN-DAY SERVICES**

Mr Neeraj Bhasin presented the above report, circulated at appendix D.

**NB** noted that this is particularly around the medical staffing and medical reviews defined by NHS England audit, rather than the broader provision of seven-day services, which is an operational and Multi-disciplinary Team approach.

OUTCOME: **NB** was thanked for the update, and the Quality Committee noted the report.

### **EFFECTIVE**

## **26/23 LEARNING FROM DEATH (Lfd) REPORT**

Dr Elizabeth Loney was in attendance to present the above report, circulated at appendix E.

**EL** reported on highlights not included in the report, including community services now being part of the electronic initial screening review process; work ongoing on a new tool to bring the emergency department to electronic initial screening reviews, and then finally working with critical care to bring them online to use standardised initial screening review templates.

**EL** commented that the Hospital Standardised Mortality Ratio has gone below 100 for the first time in some time, and dropped to 99.98%. The Summary Hospital-level Mortality Indicator has dropped from 105.86 to 104.66.

**ES** asked about the three medicine-related incidents identified via the structured judgement reviews process, and queried whether the medication safety officers were cited on them, as part of the process. **EL** stated that one of the problems is that once the incidents go into the Datix process, they are lost sight of within the Mortality Surveillance Group, unless a colleague goes back into the individual Datix incident to get the feedback. **EL** reported liaising with the Risk Management department in order to join up the process, however, a response is yet to be received.

**DS** asked how we ensure that outcomes and messages are shared widely across the divisions, as necessary. **EL** stated that as part of the mortality review process, many specialties have a mortality/morbidity meeting, where their specialty mortalities are discussed. The surgery and anaesthetic division does this particularly well, however, there is room for improvement at better sharing learning from deaths, and an opportunity to link with the acute medical team to provide some learning sessions for junior doctors. Learning is circulated through different routes, for example, through Patient Safety and Quality Board meetings, however, more joined up learning, linking complaints, incidents, etc is required, which may be further improved with the introduction of Patient Safety Incident Response Framework, which will be reviewing themes.

On behalf of the Committee, **DS** thanked **EL** for her contributions over the last three years, which have always been positively received. This was the last meeting for **EL** as Associate Medical Director.

OUTCOME: **EL** was thanked for the update, and the Quality Committee noted the report.

## **27/23 MEDICAL EXAMINER REPORT**

Dr Tim Jackson and Liz Pepper were in attendance to present the above report, circulated at appendix F.

**DS** thanked **TJ** for the comprehensive update on the work of the Medical Examiners' Office and good to see the service moving forward, despite the challenges. In terms of the planned national rollout of Medical Examiner (ME) scrutiny to include community deaths, **DS** asked whether the ME Office will be in a position to do so by April 2023. **TJ** stated that between all



the services in the region, lead Medical Examiners are not in a position to 100% complete the community rollout.

**JE** commented on the helpful paper and comprehensive data sets which show impressive performance, and asked that future reports highlight where CHFT are in relation to partners in the West Yorkshire footprint. **TJ** stated that previous reports included regional data, however, data was not forthcoming for this report due to instability in the regional leadership team. **TJ** agreed to include comparative data in future reports.

OUTCOME: **TJ** and **LP** were thanked for the update, and the Quality Committee noted the report.

## **28/23 CLINICAL OUTCOMES GROUP REPORT**

Dr David Birkenhead presented the above report, circulated at appendix G.

It was also noted that the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process is being rolled out with CHFT and Mid-Yorks collaboratively, and across the health economy.

OUTCOME: **DB** was thanked for the update.

## **SAFE**

### **29/23 MATERNITY SAFETY REPORT**

Diane Tinker presented the above report, circulated at appendix H.

The report also includes sections requested at the last meeting on the maternity dashboard, a review of the December 2022 cases postpartum haemorrhage and delay in emergency caesarean sections.

**DT** asked for comments on how the Perinatal Mortality Review Tool updates are reported. It was suggested that once the cases are reported as green, they are then taken off the subsequent report and a summary at the end of the year states the amount. **DT** also noted that through doing the Perinatal Mortality Review, there was an increase in neonatal deaths from 10 in 2021, to 25 in 2022, and a thematic review is being undertaken, with a view that the results are reported at a later meeting.

**KH** commented on the comprehensive report and good to see the progress against the detailed transformation plan. In terms of recruitment, **KH** also asked how many international midwife posts were expected to be filled. **DT** stated that there will be an over-offer of 10 posts, in order to recruit to five.

OUTCOME: **DT** was thanked for the update, and the Quality Committee noted the report.

### **30/23 SAFEGUARDING BI-ANNUAL REPORT**

Alison Edwards presented the above report, circulated at appendix I.

**DS** thanked **AE** for the comprehensive report and asked what the biggest challenge for the team was at the moment. **AE** stated that there have been several vacancies, and recruitment into safeguarding is difficult, with a lack of staff with appropriate skills to fill vacancies. One of the biggest challenges is in relation to the Mental Capacity Act (MCA) and colleagues' understanding. The audit results were of concern, and targeted work is planned over the next few months to address and improve colleague confidence in relation to their understanding, as the transition to the Liberty Protection Safeguard (LPS) will not be achieved.

**DS** asked whether there is enough support in place in order to deliver what is required. **AE** stated that there is support from the Safeguarding Team, the Learning Disability matron and the new lead for mental health, and will also look at having some MCA champions to get learning embedded within departments in the organisation.

OUTCOME: **AE** was thanked for the update, and the Quality Committee noted the report.

### **31/23 Q3 INFECTION PREVENTION AND CONTROL REPORT**

Dr David Birkenhead presented the above report, circulated at appendix J.

The Infection Prevention and Control Board Assurance Framework self-assessment was also appended to the report, which was rated with reasonable assurance.

**JE** asked that given CHFT have breached the Clostridium difficile ceiling, what are the regulatory implications and/or sanctions that flow from that, if any. **DB** stated that there are no sanctions, however, there is a visit from the regional Infection Prevention and Control team to review what is being done at CHFT, however, it is not anticipated that there will be anything suggested which is not already being carried out. With breaching the Clostridium difficile ceiling, there may be some attention from a CQC point of view, however, there are no particular concerns around the numbers, and CHFT is performing well in relation to peer Trusts.

OUTCOME: **DB** was thanked for the update, and the Quality Committee noted the report.

## **CARING**

### **32/23 PATIENT EXPERIENCE AND CARING GROUP REPORT**

Kim Smith presented the above report, circulated at appendix K.

In relation to the 52 complaints, **DS** asked how representative were the category of complainants. **KS** stated that there was good representation across the demographic, however, the challenge is that people who have responded well were those who were likely to respond anyway.

**VP** stated that equality data is not collected well enough about complainants and who make complaints, which can be done better. This is difficult, as it involves going back to complainants to ask to complete a form, which they are not always willing to do. The data is currently as representative as it can be, based on what is already known about complainants at this time, however, there is more which can be done. **KS** also stated that it is also around how the questions are asked, and also the timeliness of the questions.

**DS** commented on the principles of John's campaign being used in other areas.

OUTCOME: **KS** was thanked for their update, and the Quality Committee noted the report.

## **RESPONSIVE**

### **33/23 QUALITY REPORT**

Sharon Cundy presented the above report, for the period of January 2023, circulated at appendix L.

**DS** noted that an end of year summary for all the quality priorities is hoped to be brought to a next meeting, as some are still recording as amber or red. **KS** stated that this would need to be done in April, as the end of March 2023 data will be required to do a close-off summary. The introduction of the new quality priorities can also be done at the same time.

**VP** queried the Friends and Family Test, and asked whether there was a decline in the number of people completing, or a decline in the scores. **SC** stated that there was a decline in the number of people completing, as the process is partly done electronically, and partly done on paper, and those being completed on paper, are not being filled in.

**VP** commented on being interested in what the Friends and Family Test results were saying rather than the numbers being completed. **SC** stated that this was rather difficult to determine at the moment, as the Patient Safety Incident Response Framework task and finish group is currently looking at various types of data to ascertain what themes and trends would be in order to choose the Patient Safety Incident Response Framework categories, however, the Friends and Family Test data has so many elements to it, that it is hard to collate. The Health Informatics Team are currently working on a report; however, the majority of results say that good care is being provided. The difficulty is currently in the theming of the results. **KS** stated that the feedback that is being received is genuinely positive, however, due to the numbers being received, it is difficult to analyse.

**JMidd** shared that there may be a system to easily pull the themes from the Friends and Family Test systems, and agreed to liaise with **SC** outside of the meeting.

OUTCOME: **SC** was thanked for the update, and the Quality Committee noted the report.

### **34/23 QUALITY ACCOUNTS TIMELINE**

Kim Smith presented the above report, circulated at appendix M, which outlined the timeline and requirements to ensure the Quality Account for April 2022 to March 2023 are prepared and submitted to the Quality Committee.

The date of 2 March 2023 was confirmed as to when the Trust Board would be agreeing delegated authority to Quality Committee for sign off the Quality Accounts.

OUTCOME: **KS** was thanked for the update, and the Quality Committee noted and were agreement to the timeline.

### **35/23 INTEGRATED PERFORMANCE REPORT**

Dr David Birkenhead presented the above report, circulated at appendix N.

**VP** mentioned a previous deep dive into stroke services; however, figures continue to be low, and asked when it was expected that actions would begin to make a difference. **DB** stated that it is challenging, with things not improving at this point in time, and in some ways, the pressures are increasing with staffing. Medical Directors of the Integrated Care Board raised the issue of stroke performance across CHFT and the ICBs, and whether the Stroke network can help in terms of stroke performance overall. **JH** stated that workforce challenges became more significant over the last couple of months, despite using outside agencies, looking across the country and abroad for additional Consultants. Two locum consultants have been agreed in order to ensure that the service is covered, however, this is fragile. From a workforce perspective, this is not limited to the medical workforce, this also applies to the therapy workforce, with challenges around therapy provision, particularly in occupational therapy and speech and language therapy. Business cases have been worked up looking at the pathway, which was prohibitively expensive, and broken down, and the community division plan to take the case through the Business Case Approvals Group, looking at an extended early supported discharge (ESD) service. Further work is required to understand the benefits. **JH** also added that some actions have been taken over the last couple of months to expand the stroke ward to manage patients at the front end as opposed to having outliers. Ward 7A has been opened up using nurses from across the stroke floor to staff the ward, however, this is not without challenge, in terms of a staffing position.

**DS** stated discussion took place at a previous Quality Committee regarding further investigation into long trolley waits and further information and assurance that patients had

not come to harm, particularly during the December 2022 and January 2023 timeframes of being in Opel 4. **JMidd** stated that Thomas Ladlow (ED Head Nurse) has started to review this, which can hopefully be brought to the next meeting.

OUTCOME: The Quality Committee noted the report.

## ITEMS TO RECEIVE AND NOTE

### 36/23 SUB-GROUP TERMS OF REFERENCE

Copies of the Quality Committee sub-groups' terms of reference were circulated at appendix O, for ratification, as part of recommendations from the Quality Structure Internal Audit. These included Research and Development; Mental Health Operational Group; Medical Gases and Non-invasive Ventilation Group; Trust Patient Safety and Quality Board and Clinical Effectiveness and Audit Group.

OUTCOME: All terms of reference were signed off by the Quality Committee.

### 37/23 ANNUAL PATIENT EXPERIENCE REPORT

A copy of the annual patient experience report 2021-2022 was circulated at appendix P for information.

OUTCOME: The Quality Committee noted the report.

### 38/23 MEDICINES MANAGEMENT COMMITTEE MINUTES

A copy of the above minutes were circulated at appendix Q for information. No comments were made.

### 39/23 ANY OTHER BUSINESS

There was no other business.

### 40/23 MATTERS FOR ESCALATION TO THE TRUST BOARD

The reports received include:

- Children and Young People Survey and Action plan
- Getting It Right First Time
- Board Assurance Framework – Seven-Day Services
- Learning from Deaths Report
- Medical Examiner Report

### 41/23 QUALITY COMMITTEE ANNUAL WORK PLAN

A copy of the above was available at appendix R for information.

## POST MEETING REVIEW

### 42/23 REVIEW OF MEETING

- Good reports
- Briefing to presenters to only provide highlights of reports
- One of the recommendations from the internal audit report was to review the reporting structure below the Quality Committee. **LR, VP, KS, SC** and **JMidd** met a few weeks ago, and are in the process of finalising what that structure may look like, and will return to a future Quality Committee meeting. Alongside that, the Committee needs to receive highlight reports from sub-groups rather than minutes, to either provide assurance or no assurance.

**NEXT MEETING**


Monday, 20 March 2023  
2:30 – 5:00 pm  
Microsoft Teams

Draft

## QUALITY COMMITTEE ACTION LOG

### Following meeting on Monday, 20 February 2023

Overdue
New / Ongoing
Closed
Going Forward

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	RAG RATING
<b>NEW / ONGOING ACTIONS</b>				
20.02.23 (22/23)	<b>Quality Committee terms of reference</b>	All	<p>A copy of the terms of reference were circulated at appendix A2 for revision and approval by the Quality Committee, prior to submission to the next Trust Board.</p> <p>Changes made during the last year have been incorporated into the revised terms of reference. It was asked that the organogram within the terms of reference is amended to highlight changes to chairs of sub-group meetings.</p> <p><b>Action 20 Feb 2023:</b> The organogram to be updated, and the amended terms of reference to be re-circulated.</p> <p><b>Update:</b> The revised terms of reference were re-circulated on 20 February 2023, with a deadline for comments to be received by 23 February. Comments received were incorporated into the final copy of the terms of reference, which were submitted to Trust Board on 2 March 2023 and approved.</p>	<p><b>DUE FOR CLOSURE</b></p>  <p>2023 (Feb) - Quality Committee Terms of F</p>
<b>UPCOMING ACTIONS</b>				
16.01.23 (1/23)	<b>Quality Report</b>	Kim Smith/ Jonathan Hammond / THIS	<p><b>DS</b> commented on the ED quality priority and the increasing numbers of patients in ED who are breaching the eight, 10 and 12 hour targets, however, was pleased to see that no patients were coming into any harm, however, the pressure ulcer data states that there is an increase in hospital acquired Pressure Ulcers due to long waits and time spent on trolleys. <b>DS</b> asked how reviews in ED are linking to ward level. <b>LR</b> stated that it cannot be said that patients are not coming to any harm on the long waits, as there are some serious incidents regarding delay in treatment. It was suggested that a review of the incidents related to ED over the Christmas period is carried out.</p> <p><b>Action 16.01.23:</b> A report of a review of incidents relating to the ED over the Christmas period to return to a future meeting, and triangulating data of increased acuity and admissions into the bed base as discussed at item 06/23.</p> <p><b>Update:</b> Information to be triangulated with the more detailed analysis carried out in relation to demand. This will help frame the improvement work in ED.</p> <p><b>March Update:</b> To be presented at the April meeting.</p>	Monday, 17 April 2023
24.10.22 (168/22)	<b>Split Paediatric Service</b>		<p><b>LR</b> commented on the risk relating to the APNP model at Huddersfield, which is at a score of 16 on the risk register, stating that Simon Riley-Fuller (ADN in FSS) has been asked to review this. It was also noted that the Emergency Department (ED) are also looking at the impact of any incidents or near misses that have occurred as a result of the described risk, the results of which can be returned to a future Quality Committee for oversight and assurance to ensure that the risk is not tolerated.</p> <p><b>Action 24.10.22:</b> For any results of the review of the risk and impact of incidents and near misses to be returned to the Quality Committee</p> <p><b>March Update:</b> Followed-up with <b>SRF</b> as to whether the risk reviews have taken place, and also with the Risk Management Team as to whether there have been any reports from ED in relation to the impact of incidents or near misses as a result of the above risk. Awaiting responses on both.</p>	TBC
24.10.22 (171/22)	<b>Integrated Performance Report</b>	Lindsay Rudge	<p><b>LR</b> also stated that it would be helpful to bring a presentation on the data to see the broader impact of all the increased activity and that expanded bed base to see what that means in terms of harm and incidence.</p> <p><b>Action:</b> Presentation to be requested for Quality Committee</p> <p><b>Update:</b> Charlotte Anderson (Performance and Intelligence Lead) will attend the April meeting to present.</p>	Monday, 17 April 2023
<b>CLOSED ACTIONS</b>				
14.11.22 (193/22)	<b>BAF Risk 4/20 – CQC</b>		<p>At the last CQC meeting, a complete review of all the must-do and should-do actions from the last inspection took place to create a more realistic position.</p> <p><b>Action:</b> Report detailing review of all must and should-do actions to be submitted to the next Quality Committee for sign-off.</p> <p><b>Update Jan 2023:</b> See agenda item 04/23</p> <p><b>Action Jan 2023:</b> Presentations from previous deep dives to be shared with the Committee (also see end of combined pack for full presentations)</p>	CLOSED
16.01.23 (04/23)	<b>CQC action plan review</b>			CLOSED

16.05.22 (80/22)	<b>Split Paediatric Service</b>		<p><b>Action 16 May 2022:</b> That the original escalation process is revisited.  <b>Update:</b> Options to return to Quality Committee in September and October have been provided and awaiting response from division.  <b>Update Oct 2022:</b> See item 168/22  <b>Action 24.10.22:</b> A focus on the children and young people standards to return to Quality Committee.  <b>Update:</b> See agenda item 23/23</p>	<b>CLOSED</b>
20.06.22 (84/22)	<b>Annual Patient Experience Report</b>		<p><b>OUTCOME:</b> To be deferred  <b>Update:</b> The report is awaiting approval at the Patient Experience and Caring Group before ratification at Quality Committee  <b>Update Oct 2022:</b> Deferred to a future meeting – date TBC  <b>Update:</b> See agenda item 37/23</p>	<b>CLOSED</b>

Draft



**Minutes of the Finance & Performance Committee held on  
Tuesday 6<sup>th</sup> December 2022, 13.00pm – 15.00pm  
Via Microsoft Teams**

**PRESENT**

Andy Nelson	Non-Executive Director (Chair)
Nigel Broadbent	Non-Executive Director
Kirsty Archer	Acting Director of Finance

**IN ATTENDANCE**

Andrea McCourt	Company Secretary
Rochelle Scargill	PA to Director of Finance (Minutes)
Brian Moore	Public Elected Governor
Robert Markless	Public Elected Governor
Peter Keough	Assistant Director of Performance
Philippa Russell	Acting Deputy Director of Finance
Isaac Dziya	Public Elected Governor
Adam Matthews	Business Manager - HR
Jonathan Hammond	Acting Chief Operating Officer
Lisa Whiteley	HR Business Partner- Medicine
Helen Rees	Acting Director of Operations - Medicine
Rob Aitchison	Deputy Chief Executive

**ITEM**

**191/22 WELCOME AND INTRODUCTIONS**

The Chair welcomed attendees to the meeting.

**192/22 APOLOGIES FOR ABSENCE**

Apologies were received from Vicky Pickles, Gary Boothby and Anna Basford

**193/22 DECLARATIONS OF INTEREST**

There were no declarations of interest.

**194/22 MINUTES OF THE MEETING HELD 1<sup>st</sup> NOVEMBER 2022**

The minutes of the last meeting were approved as an accurate record.

**195/22 MATTERS ARISING**

**196/22 ACTION LOG**

The Action Log was reviewed as follows:

Change actions marked as JF to JH.

180/21 The new format IPR will not be in draft form by January. There is a substantial change to the format including using some of the layout used by Leeds. Once the draft is in an acceptable position it will be brought to this committee.

133/22 The minutes for all meetings have now been received and summary sheets have been requested from the administrators.

144/22 Terms of reference to be brought to January committee for approval.

Workforce deep dives will no longer take place at this committee as this is covered by the workforce committee. Adam Matthews will be regularly attending this meeting to answer any workforce questions raised.

For any deep dives the HR business partner for that division will also be invited to attend.

#### **197/22 TERMS OF REFERENCE**

To avoid too much restriction a suggestion to change Executive Directors to Directors. This would provide more flexibility as some attendees are Directors but not Executive directors.

Section 4.3 – Relating to Business and Commercial Development – There is a historic reference to Treasury Management which is no longer applicable.

The Commercial Investment and Strategy group is referenced but no longer exists and has been replaced with the Business Case Approvals Group.

Clarity required on which meetings report to this committee and for what purpose to be reviewed.

**ACTION:** A separate meeting to take place between AN, AM, KA and PR to review the Terms of Reference and agree the changes to be made.

#### **198/22 ED DEEP DIVE**

A clear definition of the information required within deep dives has been discussed for future deep dives.

The Acting Director of Operations for Medicine presented. 2019/20 has been used a base year for data as it was the last year pre-covid. Towards the end of the year covid cases started to impact.

The average daily attendance in ED across both sites this financial year is 473 compared to 422 in 2019/20. There have been days in November where the number has been above 600 with one day reaching 652. Four-hour breeches have increased in 2022/23 with the average per day being 133. This compares to 53 in 2019/20.

Performance year to date is 74.74% for Calderdale and 69.36% for Huddersfield. The overall performance is at 72.1% which is a decrease from 80.39%. Twelve-hour breeches used to be rare except for Winter. Since August 2021 there have been a substantial number with 420 in November and 424 in October.

The increase in number of attendances has not been reflected in the number of admissions from ED. The increase in attendances is expected to be partially due to patients who would have attended Primary Care, being unable to obtain a GP appointment and presenting at ED instead. There is now an Urgent Care Hub in place. The flipside are patients presenting who are more acutely ill due to delays in seeking care.

Ambulance handovers prior to covid, anything over 60minutes was minimal. However, there was an increase in Summer 2021 which reduced towards the end of the year. There are measures in place. Benchmarked against other Trusts in the region, CHFT is not an outlier and benchmarks well. The RAG rating which

was received after the presentation was put together, shows an increase of 26% in ambulance attendances. CHFT were rating as Green for ambulance handovers of over 30 minutes at 4.59%.

Benchmarking - Comparing ED performance over the last two months with other Trusts in the region, CHFT is one of the best performing Trusts in the area for ED even taking into account the dip in performance.

Patients treated by a doctor within 60 minutes reached 49% and patients who are treated and admitted or discharged within 12 hours was scored at 97%. The national picture shows a deterioration.

Average unit of price of direct costs (no overheads) has increased from an average of £109 per attendance in 2019/20 to £138 per attendance in 2022/23. Average unit cost has increased by 27% driven primarily by use of agency staff but also extra staffing to minimise ambulance handover times. .

ED reduction in performance is due to the following:

- Increased attendances
- Reduced access to primary care
- Acuity of patients
- Workforce capacity
- Space
- Flow into hospital for admissions – bed availability.

Plans are in place to improve performance including, the mapping of the medical workforce staffing to cover peak attendance times and recruitment of 3 speciality doctors and one Trust doctor which will reduce the reliance on agency and bank staff. The new ED from Summer 2023 is expected to assist with recruitment, as colleagues choose to work in a modern, purpose-built facility as well as being designed to be a more efficient and effective space in which to work.

Workforce – Sickness absence is consistently over 7%. HR are working closely with the team to put preventative measures in place.

## **FINANCE & PERFORMANCE**

### **199/22 MONTH 7 FINANCE REPORT (Including High Level Risks and Efficiency Performance)**

The Acting Deputy Director of Finance presented the Month 7 Finance Report. Year to date the trust is reporting a £13.10m deficit, a £1.76m adverse variance from plan. The in-month position is a deficit of £1.90m, a £0.88, adverse variance. The adverse variance in month is driven by inflationary pressures and staffing costs, in particular the impact of Enhanced Bank rates, (£0.83m in Month 7), high cost Agency staff, and the HPS loss of contribution from wholesaling.

In the first part of the year the variance was offset by the underspend on recovery costs. These are now back on track. There have been a high number of vacancies in FSS and Community divisions which are partially offsetting the pressures.

£820k was spent on the enhanced bank rate in month. The scheme ended on the 6<sup>th</sup> November and became a more targeted approach which will hopefully reduce costs.

CIP – Still ahead of plan year to date with just under £11m delivered which is £550k better than planned. Forecast is to deliver the full £20m and there is a small gap of £220k to be identified but this is achievable. Agency costs continue to be a concern and showing no sign of reducing. Activity reached 99% for inpatient activity which equates to 103% against 19/20 levels.

Use of Resources score is currently at level 4 which is the lowest level due to the adverse variance to plan and agency spend. Cash currently at £50m and slightly below plan. There has been an improvement in aged debt which has reduced by £3m and is back on trajectory. Capital is underspent at £5.7m against a plan of £17.6m on plan. Forecasting to be above plan by the end of the year which will be a challenge.

Achieving plan is reliant on a number of items. Withdrawal of the 50% enhanced bank rate. The super surge capacity is constantly being used which costs money and could affect recovery performance. The ICB could retain recovery funding if targets were not met.

At the point of reporting month 7 the forecast was officially on plan with a likely risk of £5.5m. Since that point there have been two or three positive moves and CHFT are working with system partners looking to share risk. There is potential for some system support to help our position. We are now looking to report the position as on plan and flag a risk of £1.5m.

Conversation is taking place within CHFT, around moving back to a turnaround approach which has happened in the past. This is in initial discussions and more details to come. This will move away from the weekly ERG held currently and help to prepare for expected further scrutiny. The 2023/24 position is expected to be more challenging. The turnaround executive would build on what we are currently doing with 70-80% of existing projects to continue.

Agency spend is being monitored on the ICB, not individual Trusts. Currently there is an adverse variance to the £99.3m overall agency target. The ICB Director of Finance asked all sectors to report into the ICS forecast forum listing the issues and drivers behind the spend and what is being done to improve. This was done on a sector basis to identify themes which are all very similar.

The Committee **RECEIVED** the Month 7 Financial Update.

## **200/22 FINANCIAL RECOVERY UPDATE**

A guidance document has been issued, which specifies the protocol for any changes to financial forecasts. A copy was included within the meeting papers in the Convene Reading Room. If anyone is to report an overall financial position which has an adverse variance from their original plan which was signed off for the year, then additional measures will be put in place.

This includes additional approval limits put in place. If an organisation went off plan in forecast terms, then ICB approval will be required for any investment over £50k. This effectively equates to one post. If the whole ICB goes off plan, a national approval system will come into place for investments over £100k.

The crucial point will be month 9. The guidance makes clear that it is expected that any changes to forecast will have gone through a rigorous process before being declared. Any adverse plan declarations would reflect badly on the organisation. The ICB DoF has encouraged CHFT to enact the rigour discussed within the document. This ties in with the decision to move to the Turnaround Executive process.

The new workforce enhancement scheme has had very few applications so far. A task and finish group has been created to help us move away from use of Tier 3 agencies. It is a challenge to recruit from the agencies who pay a lower rate of pay.

A Joint Financial Recovery group has been created which includes all system partners and aims to drive efficiencies across the whole system.

The Committee **RECEIVED** the Financial Recovery Update

## **201/22 INTEGRATED PERFORMANCE REVIEW – OCTOBER 2022**

The Assistant Director of Performance gave an update.

Key headlines – Reporting on the October position. There has been deterioration overall compared to September. Unusually in month we had the first MRSA case for some time.

Safe domain - indicators have seen their best position this year.

Caring domain - has improved with 2 of the 5 friends and family tests (Inpatients and Community) achieving target. Complaints have had a lot of work to improve the position. Only a small improvement has been seen against targets, but we have closed the most complaints within month this financial year. Dementia screening not performing well as required but plans have been put in place. MRSA occurrence in medicine, the investigation has been completed and an action plan circulated. Fractured neck of femur still struggling to meet target and further work going on.

Responsive domain – Continued to achieve key cancer targets. Struggling to maintain improvement in stroke due to fluctuation in month, those scanned and thrombolysed within 1 hour of arrival has improved. ED performance was at 68.44 which is lowest performance ever by CHFT. This had an impact on 12 hour waits which were also the highest in month. There is still a high level of attendances.

The percentage of diagnostics seen within 6 weeks has improved and at 95.82% was the best performance in over 12 months. 52 week waits for treatment have not reduced in month for the first time since December 2021.

None covid related short term sickness is at its highest since January. Lot of work being done around Return to Work interviews which at its lowest position since December.

The Committee **NOTED** the Integrated Performance Review.

## **202/22 RECOVERY UPDATE**

The Assistant Director of Performance gave an update covering activity (including delivery against the 104% trajectory), risk areas and mitigations, standards and diagnostics.

Currently delivering 103.1% of 2019/20 activity versus a plan of 102.9% for planned inpatient spells and 103.7% of 2019/20 activity versus a plan of 104.5% for Outpatient first attendances.

Some areas are overperforming against the planned 104% performance, but this needs to be maintained to support the areas that are not yet on plan. The main area exceeding plan are Medical Oncology and Chemotherapy who are reaching 120% of 2019/20 levels. The main area below plan is Gynaecology at 89% of 2019/20 levels. Key targets now need to be hit on a monthly basis.

CHFT is performing well in comparison with other organisations. Focussing extra effort on 52 week waits to mitigate the risk of breaching 78 week targets.

Each speciality has plans in place, and when CHFT is benchmarked against local trusts it is the only Trust reducing its waiting lists across all wait times.

ASI's – Internal target and no requirement to report centrally. Not seeing a reduction in overall numbers. Further work is being done including a lot of triage to transfer some back to GP's.

Cardiology and Gastroenterology ASI's. Waiting for paper for detailed plans. Will need further funding and external support which needs to be agreed.

Follow ups no great reduction.

Harm Review process and task and finish group created looking at clinical validation work.

Diagnostics lot more positive and at their highest level of performance for 12 months of 95.82%. ECHO, Neurophysiology and MRI have all improved following previous backlogs. MRI to be removed from future updates as they are now back on track.

The Committee **NOTED** the Recovery Update for October

**203/22 ONE CULTURE OF CARE (OCOC)**

Chairs highlight report will refer to any items linked to one culture of care.

**204/22 DRAFT MINUTES FROM SUB-COMMITTEES**

The following minutes and summaries thereof were received by the Committee:

- THIS Executive Board
- Access Delivery Group
- Capital Management Group

The Committee **RECEIVED** and **NOTED** the key points from the Sub-Committees.

**205/22 WORKPLAN – 2022/23**

The workplan for 2022/23 was reviewed.

- Deep dives to be reviewed if any follow up is required – AN / JH
- The financial plan for 2023/24 needs to be brought to F&P. A planning update to be brought to the January meeting with more detail in February when the guidance has been issued.

The Committee **APPROVED** the Workplan for 2022/23

**206/22 ANY OTHER BUSINESS**

Deep dives take a substantial amount of time and going forward the assumption will be that the presentation has been read and key highlights and questions will be covered in the meeting.

**207/22 MATTERS TO CASCADE TO BOARD**

The financial position remains challenging but has seen some improvement. Performance recovery positive although the scale of the backlogs on ASIs and Follow-Up Appointments remains a concern – will it lead to greater pressure on 52-week waits.

**DATE AND TIME OF NEXT MEETING:**

Tuesday 10<sup>th</sup> January 2023, 10:00 – 12.00 MS Teams



**Minutes of the Finance & Performance Committee held on  
Tuesday 10<sup>th</sup> January 2023, 10.00am – 12.00noon  
Via Microsoft Teams**

**PRESENT**

Andy Nelson	Non-Executive Director (Chair)
Nigel Broadbent	Non-Executive Director
Kirsty Archer	Acting Director of Finance

**IN ATTENDANCE**

Andrea McCourt	Company Secretary
Rochelle Scargill	PA to Director of Finance (Minutes)
Brian Moore	Public Elected Governor
Robert Markless	Public Elected Governor
Peter Keogh	Assistant Director of Performance
Philippa Russell	Acting Deputy Director of Finance
Adam Matthews	Business Manager - HR
Jonathan Hammond	Acting Chief Operating Officer
Lisa Whiteley	HR Business Partner- Medicine
Stuart Baron	Associate Director of Finance
Rob Birkett	Managing Director, The Health Informatics Service
Anna Basford	Director of Transformation and Partnerships
Vicky Pickles	Director of Corporate Affairs
Maureen Overton	Lead Cancer Manager

**ITEM**

**001/23 WELCOME AND INTRODUCTIONS**

The Chair welcomed attendees to the meeting.

**002/23 APOLOGIES FOR ABSENCE**

Apologies were received from, Gary Boothby

**003/23 DECLARATIONS OF INTEREST**

Stuart Baron registered his Declaration of Interest as a Director of CHS.

**004/23 MINUTES OF THE MEETING HELD 6<sup>th</sup> December 2022**

The minutes of the last meeting were approved as an accurate record.

**005/23 MATTERS ARISING**

**006/23 ACTION LOG**

The Action Log was reviewed as follows:

133/22 The minutes for all meetings have now been received and summary sheets have been requested from the administrators. Action to be closed.  
The Urgent Emergency Care Delivery Group is currently under review and will relaunch in February.

## 007/23 TERMS OF REFERENCE

AN, AM, KA and PR met to review the terms of reference. These had been updated and were brought to this meeting for approval.

The governance schedule has also been aligned.

**ACTION:** The workplan needs to be reviewed to match the ToR's.

The committee **APPROVED** the Terms of Reference

## 008/23 CANCER DEEP DIVE

AN has had discussions with Denise Sterling (chair of Quality Committee) and Karen Heaton (chair of Workforce Committee) and agreed this committee will take the lead on deep dives into specialities. In February there will be one on Elective Recovery and in March a follow-up review of the actions from the previous deep dives into Stroke and Neck of Femur.

The Lead Cancer Manager gave a presentation on the Trust cancer performance. Data presented was from October 2022. A comparison was shown between local Trusts all of which are struggling with screening. CHFT doing well in comparison. Where the tumour is sited can mean targets are harder to meet and therefore some have quicker pathways than others.

CHFT introduced the 28-day tracked target in 2019 but this became a national target from last year. This target is when a patient has to be told within 28days if they have cancer. Some tumour sites never meet this but most do. For example Lower GI is difficult to meet due to the diagnostics involved.

Treatment by day 31 target is achieved constantly, except for a dip in October 2021. Treatment by day 62 has consistently met target even during Covid but the Lead Cancer Manager emphasised the focus remains on patients and not targets.

CHFT does struggle to meet the 62day screening target although it was achieved last month. The numbers of patients that come through screening are low and the target is 90% unlike others which are at 85%. One breach and the target is not reached. The screening team are doing everything that it is possible to meet this target.

Best practice time pathways are national initiatives that have been brought in and look at how quickly each stage of the pathways are completed. For example: an ultrasound in Gynae should be completed by day 7. Conversations are taking place with all teams to find the best way to implement these. For example Radiology are looking into the possibility of being able to refer patients for CT directly instead of back to the GP for them to refer. All of this feeds into national outcomes but nothing specific to CHFT. AN asked if it was possible to have some overall outcome measures for Cancer. The Lead Cancer Manager made clear that the aim is to see and treat patients as soon as possible as research

shows this leads to better outcomes – hence the use and focus on the measures we have today. However, the Acting Chief Operating Officer agreed it would be worth looking at to see if some outcome measures could be developed.

CHFT is leading the way in Prehabilitation work. This is providing support when patients have just received the diagnosis. There is also a non-site specific team where patients can be referred when the diagnosis might not be a cancer. Working closely with GP's to highlight the services on offer. Not everyone can afford to travel to reach the GP or have a blood test.

NCPES – Is a national report around quality improvement and initiatives. Patients feedback on their experience but the survey responses are 18 months out of date once received. CHFT did not receive good feedback for providing long-term support. Work is being done to improve these areas.

Looking to the future – Currently for Dysphagia patients are referred straight to test. It may be possible to roll this out to other groups of patients who meet certain criteria. Succession planning has commenced as a number of senior nurses are expected to retire in next few years.

A Cancer app is now available for patients to use. Created by the service improvement person. The average reading age for the region is 8-9 years old, in line with the UK as a whole, so the app contains lots of animation for patients so they can see what to expect.

## **FINANCE & PERFORMANCE**

### **009/23 INTEGRATED PERFORMANCE REVIEW – NOVEMBER 2022**

The Assistant Director of Performance gave an update.

November was a difficult month for performance due to pressures which are continuing in December. Very high numbers of patients are presenting at ED. It is fortunate that to date, this had not impacted the recovery programme which continues to perform well and we are still seeing excellent cancer performance.

Safe domain – Still performing well but continue to see patients with Category 4 pressure ulcers. Actions have been put in place to improve this.

Caring domain – Now seeing the impact of work carried out by colleagues around complaints with an improvement in month. Best performance in response to complaints since December 2021 and the number complaints closed is the highest number in over 12 months. Two of the five areas for the friends and family test are now meeting target. Dementia screening is still not improving.

Effective domain – Work to be done around HSMR/ SHMI, MRSA screening and Neck of Femur. Changing the way that HSMR and SHMI updates are issued to Trusts. Nationally CHFT is ranked 77<sup>th</sup> out of 123 so there is more work to be done. More work going on around specific diagnosis looking at coding.

Responsive domain – Overall Cancer targets are being reached. In month Cancer 31 Day Subsequent Surgery Treatment target was missed for the first time

since January. For stroke patients 3 out of 4 targets were missed in November. ED performance at 66.37% was the lowest monthly performance seen at CHFT which has also meant the highest number of 12 hour waits in the department. We are also continuing to see a small number of 12-hour trolley waits from Decision to Admit. Compared to others CHFT is in a relatively good position.

New planning guidance has been issued with the 4-hour target now set at 76% (down from 95%) and to be achieved by the end of 2023-24.

Percentage of Diagnostics seen within 6 Weeks has improved again and at 96.9% it was its best performance in over 12 months. Numbers waiting over 52 weeks for treatment continue to reduce as part of our Recovery Programme.

Workforce - Non covid absence, highest since December.

Recovery in general 104, 78 and 52 weeks in a good position. Respiratory medicine has seen a 47% increase in non-elective admissions since pre-Covid.

**ACTION:** PK to do an update on new targets against existing targets.

Ambulance wait times. Figures for CHFT quite good. Going forward we are moving to a different template for the IPR, examples of which were included in the papers for the meeting, which will use SPC charts and will include ambulance wait times.

The Committee **NOTED** the Integrated Performance Review.

## **010/23 RECOVERY UPDATE**

The Assistant Director of Performance gave an update covering activity (including delivery against the 104% trajectory), risk areas and mitigations, standards, and diagnostics.

Activity has increased in some areas and reduced in others. Plan is to review the action plans created in October. At the end of month 8 we are forecasting to deliver by year end 103.3% of 2019 activity for day cases and elective work and 105.6% for outpatients.

The Access Delivery Group is scheduled to meet next week and will review to see if that end-year forecast position can be improved to meet the overall 104% target. Doing well against the 104, 78, 52-week targets. Stretch target is to reach zero for 52-week waiters by the end of 2022/23 versus the national target is to reach zero by March 2025. CHFT is currently planning to have circa 1000 patients over 52weeks at the end of March 2023. Benchmarking against other Trusts CHFT compares very well, and are currently the only trust improving all time bands over 18 weeks.

Total ASI's there is not as much movement as we would like although 22- week waits are seeing a reduction. Neurology have 133 patients on the 22-week list

whereas other specialities are around the 30 mark. Looking at weekend work and external support for neurology.

Diagnostics – We are now seeing improvements from the action plans put in place. MRI, ECHO and Neurophysiology are all improving, with the expectation they will be back on target by the end of March.

Included in the pack is a detailed medicine action plan. Surgery are working on doing the same. These will continue to be reviewed by speciality at the Access Delivery Group.

The Committee **NOTED** the Recovery Update for November

### **011/23 MONTH 8 FINANCE REPORT (Including High Level Risks and Efficiency Performance)**

The Acting Deputy Director of Finance presented the Month 8 Finance Report.

Year to date the Trust is reporting a £14.99m deficit, a £1.78m adverse variance from plan. The in-month position is a deficit of £1.89m, a £0.02m adverse variance. The adverse variance is driven by inflationary pressures, the costs of opening additional capacity and the associated premium rate staffing costs, in particular the impact of the revised medical bank rates and high cost agency staff.

Some mitigation was deployed in Month 8 to reach this position. Note that the underlying run rate is still around a £3-£3.5m deficit per month.

Agency spend has bypassed the ceiling of £6.9m currently at £8.9m which was a variance from plan of £4.9m year to date. The bank premium in its previous form ended on 6th November which reduced bank spend in month to just an additional £0.02m. There is a new agreement with medical staffing which will incur additional cost.

Increased pay expenditure is also offset by some significant vacancies in maternity and community.

CIP slightly above plan year to date with £12.5m delivered and we are on track to achieve £20m. There was a £170k shortfall in month 8 shortfall but hoping this won't be an issue. Capital spend is significantly behind plan but still forecasting to achieve the full year plan.

Cash balance is £7.77m above plan at £50.5m primarily due to lower capital spend.

Aged debt increased in month 8 by £1.42m taking it to £4.68m versus a plan of £3m with the biggest movement around THIS SLA agreements related to the ICB. Some old invoices not paid and new ones not paid. Outside a block agreement. There is also an increase related to Calderdale council who are not paying in as timely a manner as they have previously.

Use of Resources score still at level 4 which is the worst position it can be driven by agency overspend and variance from the overall financial plan. Still forecasting to achieve level 3.

Forecasting to deliver the revised plan of £17.5m deficit. There are risks and potential benefits to deliver this.

- Forecast assumes achievement of the requirements for the Maternity Incentive Scheme for Trusts (CNST).
- Enhanced pay being agreed only on an exceptional basis.
- ICB as a whole planning to break even.
- Non pay inflation around £3.6m mainly from PFI contracts and utilities, but now starting to see other inflationary pressures.
- The pay award created a funding gap. National insurance decision reversed.
- Additional capacity is forecast at £8.6m for full year. Includes ED and flow pressures.
- Huddersfield Pharmacy Specials has not delivered the planned surplus in the year to date and is forecasting an adverse variance of £1.57m.

Most of positive variances are non-recurrent. Some of negative ones are recurrent. Some challenges in current year will become a bigger challenge for next year.

The Committee **RECEIVED** the Month 8 Financial Update.

## **012/23 2023 / 2024 FINANCIAL PLANNING**

The National planning guidance was issued on the Friday before Christmas. The timetable is compressed at both sides as we are awaiting allocations information from the ICB. Plans must be submitted to the ICB prior to national submission so will need to allow time for this extra stage.

The timetable was anticipated, and preparatory work had commenced prior to receiving the guidance. Board approval for the plan needs to be obtained before final submission at the end of March, but the board meeting is scheduled for early March so there may be a need to delegate approval authority for any final changes before submission to a sub-group of the Board. A near final/complete plan will be ready for board to review early March and prior to this F&P will have had the chance to review early versions of the plan at its meetings in February.

There are three key tasks:

- Recovering our core services and productivity
- Making progress in delivering the key ambitions in the long term plan
- Continue transforming the NHS for the future.

These have then been broken down into more specific KPI's some of which have been covered elsewhere in the meeting.

Note - the target of financial balance is at a system/ICB level rather than an organisational level. Some organisations will need to plan for a surplus to level out those who are planning for a deficit.

Elective recovery funding – each Commissioner will be set an individual activity target as opposed to a blanket target for every organisation. Re-introduction of a payment by results scheme (cost per case) instead of block payments. More detail required to understand fully the impact of this change.

Planning guidance has some detail but the detail will be clearer once the system allocations are known. An NHS Payment Scheme (NHSPS) efficiency factor of 1.1% has been set but the overall efficiency requirement is expected to be higher but is to be achieved outside of NHSPS.

Likely to see some pressure against inflationary funding. Currently running higher than the figures within the guidance. The PFI for example is based on the retail price index. Funding will not specifically allow for this.

Commenced some work ahead of guidance to create a picture of the financial challenge. This year there was a reliance on non-recurrent solutions. An initial view of the challenge for 2023/24 is that we are forecasting to be circa £62m above break even.

This does not include new developments and will limit our ability to take on new developments. This figure assumes Elective Recovery Funding is equal to activity with no assumption of gain or loss until more information is available. Significant work will be required to mitigate this funding gap. The Use of Resources group has been replaced with a Turnaround Executive with a heightened level of focus on efficiency. Stretch targets have been set at for the 2023/24 CIP at £32m and split against individual portfolios. This still leaves a deficit based on initial figures.

Capital and Cash – Capital position is currently unknown until ICB have allocated. CHFT have some pre commitments to specific schemes such as the multi storey car park. Will wait for allocation before firming up any plans.

There appears to be a change in the guidance around cash with a new facility to allow for cash transfers between system partners. Some organisations have significant cash balances and others have deficits. Transfer would allow cash rich partners to transfer cash to the ICB to be reallocated to a trust who is struggling. CHFT are planning for a £20m cash balance at the beginning of the year, but with a deficit plan this would soon be consumed. More technical guidance expected this week and local decisions to be made.

The Committee **RECEIVED** the 2023 /2024 Financial planning information and noted the scale of the potential efficiency requirement.



**013/23 HUDDERSFIELD PHARMACY SPECIALS BOARD REPORT**

HPS Board report included within the papers. Two elements included, 2021 /2022 and current year. The report flagged financial challenges in the current year particular relating to wholesale activity and inflationary pressures.

Revised updated HPS Commercial strategy will be brought to this committee in February.

**014/23 ONE CULTURE OF CARE (OCOC)**

Chairs highlight report will refer to any items linked to one culture of care.

**015/23 DRAFT MINUTES FROM SUB-COMMITTEES**

The following minutes and summaries thereof were received by the Committee:

- Access Delivery Group
- Business Case Approvals Group
- Capital Management Group
- CHFT / CHS Joint Liaison Committee
- THIS Executive Board
- Urgent and Emergency Care Group
- THIS Contract Review Meeting

The Committee **RECEIVED** and **NOTED** the key points from the Sub-Committees.

**016/23 WORKPLAN – 2022/23**

The workplan for 2022/23 was reviewed.

The Committee **APPROVED** the Workplan for 2022/23

**017/23 ANY OTHER BUSINESS**

None.

**018/23 MATTERS TO CASCADE TO BOARD**

Cancer review – Positive story. Learn from their success.

Performance – Challenging times but seeing improvements.

Finance – Continuation of previous months performance in terms of pressures and gains. More confident that the adverse variance can be closed by year end.

2023/24 Planning – Very early days but there is a risk with the degree of stretch in the plan.

**DATE AND TIME OF NEXT MEETING:**

Tuesday 7<sup>th</sup> February 2023, 9:30 – 12.00 MS Teams

**Minutes of the Finance & Performance Committee held on  
Tuesday 7<sup>th</sup> February 2023, 09.30am – 12.00noon  
Via Microsoft Teams**

**PRESENT**

Andy Nelson (AN)	Non-Executive Director (Chair)
Nigel Broadbent (NB)	Non-Executive Director
Gary Boothby (GB)	Director of Finance

**IN ATTENDANCE**

Kirsty Archer (KA)	Director of Finance
Andrea McCourt (AM)	Company Secretary
Rochelle Scargill (RS)	PA to Director of Finance (Minutes)
Brian Moore (BM)	Public Elected Governor
Robert Markless (RM)	Public Elected Governor
Peter Keogh (PK)	Assistant Director of Performance
Philippa Russell (PR)	Deputy Director of Finance
Adam,Matthews (AMa)	Business Manager - HR Associate Director of Finance
Stuart Baron (SB)	Director of Operations – Surgery – Present for deep dive only.
Thomas,Strickland (TS)	

**ITEM**

**019/23 WELCOME AND INTRODUCTIONS**

The Chair welcomed attendees to the meeting.

**020/23 APOLOGIES FOR ABSENCE**

Apologies were received from, Rob Aitchison, Jonathan Hammond, Vicky Pickles, Anna Basford, Rob Birkett.

**021/23 DECLARATIONS OF INTEREST**

Stuart Baron registered his Declaration of Interest as a Director of CHS.

**022/23 MINUTES OF THE MEETING HELD 10<sup>th</sup> January 2023**

AN to clarify what was suggested re regarding outcome measures post the cancer deep dive. Subject to this point (which was addressed after the meeting) the minutes of the last meeting were approved as an accurate record.

**023/23 MATTERS ARISING**

**024/23 ACTION LOG**

The Action Log was reviewed as follows:

007/22 The workplan has been updated in line with the changes to the Terms of Reference. Close the action.

## 025/23 RECOVERY DEEP DIVE

Presented by the Director of Operations for Surgery (TS), the key points to note were:

- CHFT continues to reduce the elective backlog faster than all the Trusts in WYAAT.
- Going beyond national targets in terms of 52 weeks and making good progress vs CHFT internal target. Working to reach zero, if possible, by 31<sup>st</sup> March 2023.
- Vacancies in theatres post Covid have been filled.
- Cancer targets, CHFT is the second-best performing trust in the country.
- CHFT has been chosen to be one of 8 trusts taking part in the national getting it right first time (GIRFT) surgical hub accreditation pilot.
- Regarding theatre activity and the measure capped utilisation CHFT reached 85% in December making it a top 10 performer nationally.
- Challenges on Appointment Slot Issues (ASI's), Follow-up backlogs and Harm review process, and in some specialities including Maxillofacial, Gastroenterology, Neurology, General and Colorectal Surgery. Within Ophthalmology there are currently medical vacancies.
- Making some good progress on validation with admin validation reducing the pressure on clinical validation. Developing a more effective harm review process
- As of December 2022 the Trust was achieving 103.5% against a national target of 104% for day case and inpatient. For outpatients we were achieving 105.3%.
- This performance has come at a cost which will need to be considered as part of the planning process for 2023/24.
- Referral to Treatment (RTT) - The national standard states that by the 31<sup>st</sup> March 2023 there will be zero 78 week waiters. These are being managed at individual patient level to meet this target. 52 weeks are also reducing. Wait time is monitored from the patient being referred by their GP.
- Diagnostics have a national target of 99% of patients should have their diagnostic procedure within 6 weeks. MRI, CT and Endoscopy are around the target. Neurophysiology however are at 61%. Both Neurophysiology and Echocardiography had action plans in place but were impacted by specific issues over the Xmas period. Echocardiography is now back on target. Plans are in place to improve Neurophysiology performance.

AN questioned if there are extra actions in place to improve the areas that have been challenging this year to a point where they revert back to a more standard way of working. The internal targets are much tighter than the national ones. TS stated that the planning assumption for 23/24 is that a 40-week target will be implemented alongside a maximum 18 week wait for outpatients, but decisions will need to be made around balancing this with the financial pressures.

RM asked what the timescale is for the new community diagnostic centre (CDC) is and what the plan is for staffing it. GB said the plan is to have the CDC up and running by 2025 and funding has been awarded for this. This timeline allows time

for recruitment and working alongside the university. The idea is to have services located in areas where people are not accessing them. SB currently exploring the possibility of putting some interim capacity arrangements in place before 2025.

## **FINANCE & PERFORMANCE**

### **026/23 INTEGRATED PERFORMANCE REVIEW – DECEMBER 2022**

The Assistant Director of Performance (PK) gave an update. The key points to note were:

- December was a very challenging month in ED particularly the three weeks around the 10<sup>th</sup>.
- Patients were very unwell which contributed to the acuity of the patients and impacted length of stay.
- Moved to OPEL 4 at the end of December along with all West Yorkshire acute trusts. This did not prevent CHFT from treating clinically urgent patients.
- Ambulance handovers were better in CHFT than some other areas. This was due in part to a significant number of actions put in place at Place level which were used to manage demand. A full list of these actions are available within the report.
- All cancer targets were achieved in December despite the operational pressures.
- Peaks were seen in 12,10 and 8 hour emergency department waits which led to a small number of 12 hour trolley waits. These were kept to a minimum. We have also had a mixed sex breach, another MRSA outbreak and seen our 4th Never Event of the financial year.
- Non-Covid staff sickness both long and short term peaked in December which resulted in more bank and agency staff being used.
- There are still a number of areas where we have action plans in place and are yet to see some traction in terms of performance improvement including stroke, neck of femur and dementia screening.
- December also saw a peak in the number of non-Covid deaths and crude mortality reflecting the acuity of the patients presenting at CHFT. There is a deep-dive planned to look at mortality within the Trust including (Summary Hospital Level Mortality Indicator (SHMI) and Hospital Standardised mortality Ratios (HSMR) although we did see an improvement in the 12-month position for HSMR to October.
- Significant work has gone into improving our Complaints system and yet again we have seen this come to fruition with our best performance in responding to complaints within timeline since November 2021.
- Currently in the middle of the annual planning process for 2023/24. Will be confirming some of the targets covered in the deep dive.

NB noted the good news on theatres and surgery. Within the meeting pack, it is shown that for elective surgery there has been a dip in the number of theatre sessions completed. PK responded that during the Christmas period elective work is at a minimum. This is a seasonal fluctuation.

RM asked if mortality rates are in line with national figures? PK – SHMI has been on a gradual increase since covid, comparatively to other organisations we have been in a worse position. For IMD 1's and 2's (Indices of multiple deprivation) we are an outlier. More work needs to be done to understand the reasons why better. There are 20-25% more sicker patients post Covid particularly in respiratory.

AN commented that he has spoken to Denise Sterling regarding the Quality Committee looking at mortality rates and the results of the deep dive – this is something there are planning to do. A follow up deep dive is due next month at this committee on Neck of Femur

AN asked AMa if sickness levels have increased and all the pressures within the Trust, how is this being reflected in staff wellbeing? AMa responded that there are hotspots for stress, anxiety and depression. The wellbeing team have gone out to those areas and offered support. Availability of staff is showing an improvement at the end of January and beginning of February.

The Committee **NOTED** the Integrated Performance Review.

#### **027/23 MONTH 9 FINANCE REPORT (Including High Level Risks and Efficiency Performance)**

The Deputy Director of Finance presented the Month 9 Finance Report.

Year to date position at month 9, the Trust is reporting an 18.06m deficit which is a £2.8m adverse variance from plan. The in-month position is a deficit of £3.07m, a £1m adverse variance. These figures are a result of operational pressures in month 9 plus inflationary and agency costs which increased in month due to working at OPEL 4 status and all available surge capacity being open. Agency spend reached over £1m in month and year to date is now reached over £10m which is an adverse variance of £5.4m. Month 9 saw a reduction in bank costs following the decisions made around enhanced bank rates. There are still a number of vacancies in some areas particularly Community and Maternity which is partially offsetting the pressures and recovery costs. There have been lower than planned pay costs in elective recovery but outsourcing in elective recovery has increased.

CIP is still on track with £14.17m of savings delivered year to date which is a favourable variance of £400k. On track to deliver the full £20m CIP with a small gap to close before year end. Use of Resources (UoR) at level 4 which is the lowest level. Two metrics are off track, agency spend and the fact that we are off plan. Neither of these two things are going to change until month 12 when we are expected to be back on track in terms of financial plan which will lead to a UoR score of 3.

Still forecasting a £17.4m deficit as planned. At the point of reporting a worsening in the divisional forecast position was seen as the in month position was worse than expected. At that point there was a gap of £2.7m unidentified mitigation, but month 10 appears to have been less pressured and some of the gap has closed. The gap is now expected to be nearer £1-1.5m maximum. Some non-recurrent support has been received from one of our system partners.

There has been a reduction in the Capital forecast which is now down to £34.5m which is £7.5m lower than planned. The biggest change is in the reconfiguration forecast which is now forecast to be £9.9m lower than planned. This has been offset by some additional funding for diagnostic, digital capability funding and frontline digitisation.

Cash was at £27.2m which is slightly above plan. The reduction on previous months is because of the faster closedown process which meant that the reporting is completed before payroll goes out of the system. In months 9 and 12 a full accounting process takes place so the closedown is later, the difference is due to timing. The ICB has moved to paying CHFT on the 1st of the month which is beneficial as it will enable us to pay less in PDC dividend.

Aged debt has increased in month to £5.3m. The majority is within THIS and relates to ICB invoices, which were delayed, so this is not considered high risk.

NB asked if there is a level of confidence that the agency costs will decline over the remainder of the year as forecasted. Secondly is there a level of confidence that the capital allocation will have been spent before year end.

PR – Regarding agency spend, there is little confidence that the forecast will come to fruition. However, as divisions have been optimistic on the amount of recruitment they intended to do this will hopefully offset the agency costs and not massively impact the bottom line overall. KA commented that the CHFT target for agency spend was low based on previous good performance. Currently, while our agency spend target has been exceeded, we are in a very comparable position with similar sized organisations.

SB – The report covers month 9 but since we are currently in month 10 the capital forecast is already reducing. Reconfiguration will reduce by a further £1m as a result of the delays in terms of approval. The CDC spend of £3m that was forecast has been pushed back. A significant amount of spend on new HRI Emergency Department is imminent. Currently in the process of man marking each capital scheme to follow up that orders are in place for every line item. This is giving assurance that we will spend to latest forecast. Some of the additional monies for additional schemes have been released very late in the year which has not helped with forward planning.

RM asked where we are we up to with treasury approval for the reconfiguration? Approval has not been received as yet. Everyone is aware of the impact of the delay which will mean the end of the programme is delayed.

AN asked why the pay expenditure is set so low in month 12. This is the assumption around the annual leave accrual. Part of the plan was that

colleagues have been taking more annual leave this year to use up their excess that has been carried over due to Covid. The full detail of this will not be available until month 12.

GB stated that one of the risks on the BAF relates to achieving the 22/23 financial plan. This has been given a score of 20. As the year is coming to an end there is confidence that the score on this can now be reduced to 15/16.

The Committee agreed the score can now be reduced.

The Committee **RECEIVED** the Month 8 Financial Update.

#### **028/23 REVIEW TREASURY MANAGEMENT**

Most of the current treasury information is included in the month 9 report. A complete report will return to this meeting once the planning for 2023/24 has been completed.

**ACTION:** Report for the end of April

#### **029/23 TURNAROUND EXECUTIVE**

Majority already covered. Plan to achieve £20m CIP. This consists of a significant amount of non-recurrent savings.

#### **030/23 2023 / 2024 FINANCIAL PLANNING**

Slides were shared by KA at the meeting due to the tight planning deadlines. A detailed review of divisional plans for 23/4 has taken place through the Divisional Performance Review Meetings. That information has been collated into this presentation and underpins the current draft 23/4 plan.

An informal submission to the ICB had taken place this week with a full draft submission to the ICB due on the 15<sup>th</sup> February. The draft plan will then be submitted to NHSE on the 23<sup>rd</sup> February. This leaves a very short window between the submission on the 23<sup>rd</sup>, the next meeting of this committee on the 28<sup>th</sup> and the following board meeting on the 2nd March. Dependent on any feedback from the ICB, it may be necessary to request board approval outside of the board timetable, closer to the late March deadline for the final plan to NHSE.

**ACTION:** Update on timetable and approval schedule at next meeting.

The financial plan and the operational plan are interlinked as the operational assumptions affect the financial planning. Key points to note against National targets:

- Bed occupancy is to be reduced to 92% or below – CHFT are currently at 98-99%. In order to reduce to 92% we would be required to increase our bed base by 29 beds. This would be a challenge from both a financial point of view and workforce. The plan is to perform better on other metrics, such as length of stay, and achieve 96% bed occupancy



- Electives – performance has been strong this year. The current trajectory is to have minimal waits over 52 weeks by the end of March. The National target is to have no waiters over 65 weeks by March 2024. Our plan assumes no waits over 40 weeks
- The recovery target which was set at 104% of 19/20 performance for this year, has been set at 108% for the ICB. CHFT is currently modelling at less than 108% but delivering no waits over 40 weeks. Target to be confirmed but may have a bearing on any recovery funding if 108% is not achieved.
- Plan to achieve Cancer and diagnostics targets based on the strong performance seen this year.
- Draft plan to be submitted will be a deficit plan which is against the national target to deliver a balanced plan. Other trusts in West Yorkshire are having similar challenges.

Non-elective activity has been modelled on the current run rate of around 98% occupancy with an average of 95 transfer of care patients in beds. The plan does not assume extra beds to achieve the target. Currently there is no bed capacity funding available for next year. The plan does allow for the same level of beds seen this year to continue into next year. The extra bed capacity comes at a cost of £10.8m before seeking to address through efficiencies. There will be a focussed programme to target efficiencies through the Turnaround Executive.

Elective activity – Overall target for ICB of 108% of pre covid levels however, chemotherapy will not be measured as part of the recovery unlike this year. Instead, chemotherapy cases will be paid on a cost per case basis outside of these percentage targets. Other changes to the way procedures are measured and coded mean that instead of the 103.4% performance we are planning for, 100.5% would be the plan.

Financial plan – Elective Recovery Funding (ERF) will be different to this year. Nationally each commissioner will be set an individual activity target. Providers will be paid on a level of activity delivery. Further work to be done to understand the detail around this. The ICB have submitted a proposal for them to take a different approach on the national plan and use the funding in a more targeted way around waiting time targets. No response as yet from NHSE on this.

The NHS's overall efficiency requirement will be higher, to be achieved through measures outside of the NHS Payment Scheme and allocative efficiency / productivity gains:

- Covid-19 funding for ICB reduced by c.90%
- ICB Convergence adjustment -0.71%, plus potential for further local adjustment.

At the draft submission stage, the ICB have asked for plans to be submitted excluding elective recovery, growth, covid and bed capacity funding. Therefore, there are some significant areas of expenditure not currently covered by funding.

Growth funding is a risk as there is no guarantee that funding will be allocated in full.

**ACTION:** Slides to be shared after the meeting – complete.

All of this leaves CHFT with a proposed deficit plan of £43m after achieving a £25m proposed efficiency target (CIP). Due to the funding streams, such as elective recovery, from the ICB being unconfirmed, a further £25m will need to be deducted which would leave a proposed deficit of £68m.

Capital and Cash - Working on an allocation of £16.2m which would be the CHFT “fair share” of the ICB funding. This would bring the total capital plan to just below £32m. From this some projects have been pre-committed.

Cash is forecast to have an opening balance of £20m. The current planned deficit position will affect this and currently exceeds £20m. This would result in a requirement for additional funding from the Public Dividend Capital which is non-repayable but would incur an annual interest charge of 3.5%.

Recommendations to this committee is for approval of the draft plan for submission, noting our position against performance targets, the challenging efficiency requirement, and the residual deficit position. Consider the timing implications mentioned previously for the final submission.

NB – Asked for clarification of the bed base plan for next year? KA stated that in the plan it has been assumed a continuation of the average beds seen this year including a seasonal allowance. The Turnaround Executive will look at the bigger picture which may or may not result in a reduction of beds.

NB – Risk on ERF in plan based on ERF activity. What are the risks to CHFT if the ICB decide to remove funding due to not reaching 108% target? KA stated that conversations still to be had, but CHFT are unable to deliver 108% as we do not have the volume of patients to achieve 108%. Questions may be around why should CHFT have funding to reduce to waits to 40 weeks when others haven't yet reached 52 weeks.

PK – Diagnostics are heading toward 99% and have reached this target in most areas. The plan is suggesting reducing the target to 95%. So far there has not been a conversation around the change of performance. Do we intend to continue as are with a target of 99% and the known costs associated with achieving this? GB stated the ICB so far have focussed on financial performance and not overall performance. Ideally, CHFT would not want to reduce our performance but discussions may need to take place if performance can be maintained financially.

AN commented that it was helpful to see what had driven the performance this year. What is being assumed for next year around Covid, flu levels etc. It would be useful to see these assumptions in future plan submissions and when talking about extra activity versus extra capacity to know what this means. PR responded that additional capacity talks about the bed base. Additional beds opened or extra ED requirements to support an increased number of patients.

Activity is where certain specialities are doing more. More to do with the volume of patients rather than beds.

With the high CIP target it is difficult to know which areas to target until some of the funding decisions are clearer. The vacancy factor also needs more work.

**ACTION:** Approval of final plan and deadlines to be discussed at board.

The Committee **APPROVED** the 2023 /2024 draft financial plan and noted the scale of the potential efficiency requirement.

### **031/23 BAF Risks**

The Company secretary explained that this is the third and final update of the BAF risks for this year. All of the risks for review by this committee have been updated by the directors.

Risk 5/20 is due to be audited as part of the testing of the Board Assurance Framework (BAF).

Performance risk 5/20 and 8/19, the thought is that these two are converging. In the next financial year, in line with new guidance, they will be combined into one risk.

Recovery and long term financial sustainability risks remain at a score of 16.

7/19 compliance with NHS England. This risk has been left on the BA register but will be reviewed in the new year when the new targets are available. 2023/24 will there be different targets.

AN - Commercial one risk. Leave the score as is. HPS are not hitting their targets but performance in THIS and CHS are performing better.

AN – Long term financial sustainability is a score of 16 still correct? KA responded that it used to be higher. It was reduced when we reached a stage of approval for the reconfiguration business case. Status remains so reasonable to leave the score as is. Once the wider context for next year is understood look at this one again.

**ACTION:** AM to take ensure key points from this discussion are presented to Board

The Committee **APPROVED** the changes to the BAF risks.

### **032/23 ONE CULTURE OF CARE (OCOC)**

Chairs highlight report will refer to any items linked to one culture of care.

### **033/23 DRAFT MINUTES FROM SUB-COMMITTEES**

The following minutes and summaries thereof were received by the Committee:

- Access Delivery Group
- Business Case Approvals Group
- Capital Management Group

The Chair sent an email to the chairs of the sub committees asking for consistency on how the cover sheets are put together. Capital Planning Group and Capital Management Group are used interchangeably. Capital Management Group is the correct name. On Capital AN requested that a review of the capital plan and how it has been spent is presented to F&P at a future meeting.

**ACTION:** review of 2023/24 capital to come to a future F&P meeting

The Committee **RECEIVED** and **NOTED** the key points from the Sub-Committees.

#### **034/23 WORKPLAN – 2022/23**

The workplan for 2022/23 was reviewed.

The layout has been updated to separate out the different areas or review and assurance the committee undertakes.

**ACTION:** More time on the next agenda for the 23/24 plan

The Committee **APPROVED** the Workplan for 2022/23

#### **035/23 ANY OTHER BUSINESS**

None.

#### **036/23 MATTERS TO CASCADE TO BOARD**

- Despite operational pressures performance remaining strong in most areas
- Elective recovery on track to meet or exceed all national targets
- On track to deliver this year's financial plan
- The financial plan for 2023/4 is very challenging with a projected deficit plan of £43m

#### **DATE AND TIME OF NEXT MEETING:**

Tuesday 28<sup>th</sup> February 2023, 9:30 – 12.00 MS Teams

**Minutes of the Finance & Performance Committee held on  
Tuesday 28<sup>th</sup> February 2023, 10.00am – 12.00noon  
Via Microsoft Teams**

**PRESENT**

Andy Nelson (AN)	Non-Executive Director (Chair)
Nigel Broadbent (NB)	Non-Executive Director
Kirsty Archer (KA)	Director of Finance

**IN ATTENDANCE**

Andrea McCourt (AM)	Company Secretary
Rochelle Scargill (RS)	PA to Director of Finance (Minutes)
Brian Moore (BM)	Public Elected Governor
Robert Markless (RM)	Public Elected Governor
Peter Keogh (PK)	Assistant Director of Performance
Philippa Russell (PR)	Deputy Director of Finance
Adam Matthews (AMa)	Business Manager - HR
Thomas Strickland (TS)	Director of Operations – Surgery – Present for deep dive only.
Christopher Roberts (CR)	Deputy Director of Operations - Medicine
Rob Aitchison (RA)	Deputy Chief Executive
Vicky Pickles (VP)	Director of Corporate Affairs
Helen Rees (HR)	Director of Operations - Medicine
Rob Birkett (RB)	Managing Director of Digital Health

**ITEM**

**037/23 WELCOME AND INTRODUCTIONS**

The Chair welcomed attendees to the meeting.

**038/23 APOLOGIES FOR ABSENCE**

Apologies were received from, Anna Basford and Gary Boothby.

**039/23 DECLARATIONS OF INTEREST**

**040/23 MINUTES OF THE MEETING HELD 7<sup>th</sup> February 2023**

The minutes were approved as an accurate record.

**041/23 MATTERS ARISING**

**042/23 ACTION LOG**

The Action Log was reviewed as follows:

190/21 and 126/22 IPR – Timeline for the new format IPR is in place and the format has been agreed. The format has received positive feedback and is largely based on the report used by Leeds Trust. THIS have been particularly helpful in producing the data for the new format as the data required has proved more challenging to access. The plan is to complete the draft IPR by 10<sup>th</sup> March, share it with the Executives and Non-Executives and go live in April. The first report in the new

format will be at the May meeting showing April data. “Making data count” training sessions are running in support. The next sessions are for Executives and Non-Executives. Training has also been planned for the governors further down the line.

009/23 IPR compare targets – This will be done as part of the new IPR looking at the oversight and planning guidance for 2023/24. Close Action.

030/23 2023/2024 Financial Planning – Update on the timetable is on the agenda. Close Action.

030/23 2023/2024 Financial Planning – Approval of final plan and deadlines from board discussion included on the agenda. Close Action.

034/23 Workplan – Bring to next meeting at beginning of April as a full workplan for 2023/24.

#### **043/23 STROKE DEEP DIVE – FOLLOW UP**

The Medical Deputy Director of Operations covered the key points from the stroke deep dive. The full deep dive was shared with the committee in October 2022.

- There was a downwards trend in performance during 2021/22. This was due in part to Covid but also staffing challenges.
- The most recent SSNAP performance is from January 2023. The majority of the performance charts are moving in the right direction.
- There was a recap of the actions and key challenges for the Stroke service as presented in October 2022.
- The SSNAP position for the 1<sup>st</sup> and 2<sup>nd</sup> quarter of 2022 were presented to show the direction of travel. The 3<sup>rd</sup> quarter results have not yet been published. The overall SSNAP score has shown improvement from a rating of C in the 1<sup>st</sup> quarter to a rating of B in the 2<sup>nd</sup>.
- Multidisciplinary team working has also improved from C to B but there is still a challenge with therapy staff with a 40% vacancy rate currently. Changes to ways of working have made a significant impact.
- There has been an increased demand on the stroke service with a 42% increase presenting compared with figures prior to covid. January 2023 saw the highest number of ED attendances for stroke at 184, which when compared to 2018 data shows an increase of 70 per month.
- Increased length of stay is gradually coming down. Additional workforce in the form of ACP’s leading on ward 7D is having a significant impact. Also managed to reinforce the stroke medical workforce. Jan 22 – Mar 22 started to reduce the length of stay despite the numbers presenting at ED. Recently opened 7A to reduce bed pressures which has also contributed to this improvement, along with additional work in the community.
- The increased numbers attending are diluting the improvements made.
- Summary of challenges, the biggest challenge is managing the acute demand. Work continues to try to recruit suitable candidates. A registrar has

been recruited which will enable us to build the workforce and plan for retirements in one years' time.

- Actions completed – The vacancy rate in stroke consultants made it difficult to achieve the SSNAP targets. We have now managed to recruit so reach 5 stroke consultants however some of these are locum posts.
- With the support of radiology a deep dive has taken place looking at where we were failing to complete CT scans within one hour. Two easy fixes that came out of that were, when the CT scans are requested, they are not being identified as potential stroke. This has now been addressed. The second fix is that physically transferring patients from ED to the CT scanner was incurring delays. This is being flagged.
- A nurse consultant job description is currently going through a matching panel.
- Fully recruited to the thrombolysis team to safeguard and improve resilience of timely access 7days / week.
- Recruited a registrar to ensure succession planning.

HR commented that the service had been able to provide a better response with the extra bed base on ward 7A. a lot of work has been done around modernising the workforce and how we can work differently. Currently working with Community around what the community bed base will look with an aim of reducing length of stay.

JH Mentioned that work was being done to put a business case together, that looked at the whole pathway. The overall case became very expensive to put a stroke hub in at the same time as enhancing the stroke department. Discussions have taken place and Michael Folan is bringing the case to be reviewed alongside other cases at Business Case Approvals Group. Medicine and Community to work together on KPI's. All must be triangulated so that the information is clear in the case. Actions have been put in place which have improved the service, including an improved therapy provision. To be noted that there are still challenges around speech therapy.

Discussion was held with the Committee on the content of the deep dive report.

#### **044/23 NECK OF FEMUR DEEP DIVE – FOLLOW UP**

The key points presented by the Director of Operations for Surgery were: -

- Jane Peacock attended this committee last year and presented an update on the Neck of Femur (NoF). The key issue was around patients access to theatres within the 36 hour standard and the action plan that was put in place, which included putting a new Trauma only Consultant post in place.
- The Consultant Trauma post was self-funded within division and as part of the business case, very clear KPI's were requested. One of these was to improve the 36 hour standard.
- The performance against the target is not yet consistently above 70% with full year performance in 2022 of 60.64% for 2022 compared to 57.03% in 2021.
- Continue to see an increase year on year on the number of admissions with NoF or Fractures where the best practice tariff applies, with an increase in the number of admissions of around 33% since 2019.

- Mortality is positive with a reduction to 5.5% which means CHFT remain below the national average and has one of the best performances in the region.
- 36 hours standard – whilst this improved in 2022 to just over 60% from 57% in 2021 that is not where we were intending to be. The target was set at 70% with a stretch of 85%.
- In the presentation last year there was reference to investigating the possibility of creating a fracture liaison service (FLS) which is in place with some other trusts. The fracture liaison service is the gold standard for DXA scanning for osteoporosis which can highlight the risk of NoF. However, the cost of this is £1m.
- Conversations with directorate colleagues revolve around increased demand and the need for more staff and theatre capacity. While this would help, conversations within division have been very clear that there is a need to look at other things. Agreed to re-orientate our approach and not just focus on more theatre capacity.
- Agreed as a division to set up a trauma improvement programme commencing March 2023 to look at improving performance. There are a number of workstreams which will look at plans to reduce length of stay. Will also look at theatre utilisation and improving productivity.
- Over the next three months, three “Go Sees” have been arranged to visit other trusts that have been having more success. What are they doing that CHFT can learn from?

AN asked how do we benchmark against others? What does good look like? Is there a national target.

TS The CHFT target is 70-85%. There is no national standard.

AN Are staffing levels a problem?

TS More capacity would be useful, but the go sees are about facts. Will be looking at other factors than capacity.

NB questioned if the “Go See” visits include a mixture of those who have a fracture liaison service and those who don’t to see if it makes a difference?

TS Approximately 50% of services have a fracture liaison service. For the “Go see” visits the preference is that they don’t have an FLS as that will be seen as the solution.

JH FLS would be a System commissioning discussion not just CHFT, and we would expect to see a reduction in NoF. It is worthwhile seeing what others do with the resources available then see what can be used within CHFT. Explore all other options then revisit LFS if required.

## **FINANCE & PERFORMANCE**

### **045/23 MONTH 10 FINANCE REPORT (Including High Level Risks and Efficiency Performance)**

The Deputy Director of Finance presented the Month 10 Finance Report



## Key points

- Year to date the Trust is reporting a deficit of £20.4m which is a £3.48m adverse variance from plan. The in month position is a £2.33 deficit in month 10 which is a adverse variance of £0.69m.
- A lot of operational pressures at the beginning of January and remained at OPEL 4 for a number of weeks in month 10 which resulted in some high levels of bank and agency pay.
- Agency spend year to date is £11.73m which is £6.12m higher than planned. The ICB set the Trusts agency expenditure at £6.9m for the full year. We are still seeing a continued high level of nursing agency.
- Overall pay costs had a underlying variance of £600k in month. This is despite recovery costs being below plan and vacancy factors in FSS and Community etc still high.
- There was a slight improvement in non-pay spend in Month 10 following a spike December however, it is still above plan. There are some significant inflationary pressures which are having an impact.
- On track to deliver CIP with £15.97m delivered year to date. This is heavily reliant on non-recurrent benefits.
- Capital – year to date we have delivered £13.8m of our £33.4m plan. The forecast plan has now changed to deliver £30.6m this is due in part to slippage in reconfiguration plans.
- Cash on track with a £40.8m balance at the end of the month which was higher than planned but is linked to the capital underspend.
- Aged debt currently above the target but this is in relation to THIS system contracts so is deemed low risk.

A waterfall diagram showing the forecast variances was shared.

- Items which are driving the variances from a negative perspective include, Non-pay inflation which is now over £6m. Additional capacity is over £7m, though now the approach has been changed some of the pay enhancements have reduced. HPS is an ongoing pressure. Most will continue into the new financial year.
- Items with a positive variance include a lot of non-recurrent mitigation. Bed capacity funding received this year has not been confirmed for next year. Additional funding has been secured from the ICB. Elective recovery costs are lower than planned. This has also been reflected in the plan for 2023/24. Technical benefits are £1m less than expected following receipt of a full valuation, which adds some risk to month 12. The level of vacancy has reduced since the beginning of the year.

KA The aged debt referenced above, related in part to Bradford Place. This has been escalated and has been resolved. The delay related to a misunderstanding as to what was billed outside the block.

RB Notes that support from KA and GB has been important in resolving some of the aged debt.

AN Is there confidence that Capital will reach the forecast plan by the end of March?

PR A verbal update this week has state that in month capital spend was £5m. The normal spend is around the £1m mark. So progress is being made.

AN The finance report and the IPR are showing different figures for agency spend.

PR This is more than likely a typo. IPS shows £17.73m which should read £11.73m.

**ACTION:** AM asked to raise with Mark Bushby.

The Committee **RECEIVED** the Month 10 financial report.

#### **046/23 TURNAROUND EXECUTIVE**

Most of the detail covered in the financial report. TE are still monitoring this year's CIP but the focus is now the identification of schemes for the new year.

#### **047/23 2023 / 2024 FINANCIAL PLANNING**

Slides were shared by KA at the meeting. Key points to note;

- Crucial decisions are still awaited so there are minimal changes on the presentation from last month.
- Operational and financial assumptions remain the same.
- Governance and sign off process – It was hoped sign off would be possible at Board this week but the funding information has still not come through so an additional exceptional meeting has been arranged towards the end of March for sign off. This will allow the maximum time possible to achieve the most developed plan.
- There has been an addition to the planning timetable which now includes a deep dive session from the ICB. An additional slide in the pack which shows the overall ICB financial position. All the Places are currently presenting a deficit position. Each Place is being challenged and the CHFT session is scheduled for tomorrow as part of the Kirklees Place.
- Still awaiting further information on funding from the ICB. It is not clear how some funding streams will be allocated. There are some conversations around growth funding and what the levels of allocation will be. There is a challenge from providers that the funding needs to flow.
- There is a national change to elective recovery funding. The West Yorkshire ICB has submitted a counter proposal to focus more on waiting times as the key measure of performance as opposed to volumes and to fix the funding on that basis. The feedback to this seems to be positive with the possibility of the West Yorkshire ICB and one other ICB trialling this.  
For CHFT this would be a positive as it would lead to funding being allocated. An agreed wait target would most likely a positive as would get funding. Currently CHFT is assuming a reduction to a 40 week wait but the national target is 65 weeks.
- Capital plan was previously described as £30.9m plan but is now £37.1m due to the inclusion of leases which ow have to be included in Capital to comply

with the IFRS standard. Capital allocation is in excess of what current plans would require so conversations are ongoing with both Place and ICB.

- Cash as described last month as plans currently stand, CHFT would require cash support next year. Again conversations are taking place with the ICB.

AM asked if prior to the meeting to the 28<sup>th</sup> March if any delegation was required from next week's board meeting for the annual plan sign off

KA / AN To provide clarity this will need to be arranged.

NB asked what the ICB deep dive were expected to challenge CHFT on.

KA The email invite talks about clarity on additional investment, consistency checking, assurance, and an opportunity to highlight opportunities where support is required. Brendan has suggested using the opportunity to ask for more clarity and pace around funding decisions.

NB How fixed is the agency plan mentioned on one of the slides? Currently suggesting £1.5m less than has been spent in this financial year. Would this affect CIP for example?

PR The plan is to stick to the 3.7% target given which seems reasonable. Plans need to be put in place to achieved this. There are also some specific CIP plans to reduce Tier 3 agency spend. This year's costs have been driven by price rather than just volume. Working through a strategy including negotiating with the agencies.

The Committee **NOTED** the Financial Planning update

## **048/23 INTEGRATED PERFORMANCE REVIEW – JANUARY 2023**

The Assistant Director of Performance (PK) gave an update. The key points to note were:

- January saw an improvement in emergency pressures with less attendances at both EDs resulting in better 4-hour performance, shorter ambulance handovers, less patients spending over 12 hours in ED and smaller numbers of 12-hour trolley waits.
- We must achieve the 76% target for ED 4-hour performance by March 2024. We have not achieved this since 2021 in any month. Starting to see more pressures in February and attendances have increased.
- Ambulance waits during early December were up with 30 over 60 minutes at HRI and 21 waits over 60 minutes at CRH. In January this was reduced to 1 at CRH and 1 at HRI.
- Bed occupancy is still high at 98%. The bed base was reduced in January.
- Unusually three cancer targets were missed. 28 day faster diagnosis, 31 day subsequent surgery and 62 day referral from screening to treatment. Regularly have good results but still have some tumour sites that struggle to meet them. Ongoing work with those specialities.
- Another never event in January.
- Dementia screening has an action plan in place which is a work in progress

- HSMR decreased in November to below 100 for the first time in over 12 months. HSMR and SHIMI work on going.
- Following significant work, 94% of complaints were responded to in January. Which is the best performance in a number of years.

JH Decision has been made operationally in planning for 2023/24 not to aim for the recommended bed plan of 92% CHFT going for a more realistic 96% but there is work to be done around patient flow and length of stay to get to that point. Today there are 145 transfer of care patients which is double what the target was. There has not been less than 120 for last 10 days.

VP Two challenges in regards to complaints, maintain existing performance and learning from the complaints. Have looked at the themes of the complaints which are very broad. There is a need to look at the detail which is currently underway.

The Committee **NOTED** the Integrated Performance Review.

### **049/23 RECOVERY UPDATE**

The Assistant Director of Performance (PK) gave an update. The key points to note were:

- Reiterate the excellent work that has been done in the organisation to get to the current position on waitlists, which is better than our peers.
- 104 waits currently have zero. One patient currently at 103 weeks but has a date to attend.
- RTT 78 weeks are now at minimal numbers. ENT have the most with 9 patients.
- RTT 52 weeks internal target to reach zero by March 2023. Consistently reducing and will achieve target in most specialities. Planning to reduce to below 40 weeks next year.
- Outpatients ASI's small reduction overall. Three main specialities now have patients waiting over 22 weeks.
- The main concern is around follow-ups. The harm review process will be in place moving forward. These are covered as a regular agenda item at PRM's and the access delivery group.
- Diagnostics - Echocardiography and neurophysiology have had a dip in performance but plans are in place and confident they will be back on track.
- Overall excellent position with some concern over follow ups.

AN Commented that overall, it was a good news story in terms of what has been achieved. The positive result is due several different actions.

PK Excellent data has been provided from THIS that is shown in all meetings.

JH Follow ups are challenging. ASI's are also challenging. The closer we can get to the waiting times seen pre Covid, it will allow us to reassess new patient and follow up appointments. There have been some good conversations around transformation work which will help to manage our patients differently. The outpatient transformation group is relaunching in the new financial year which will draw in the GIRFT recommendations.

The Committee **NOTED** the Recovery update

## **050/23 HPS COMMERCIAL STRATEGY**

The Deputy Chief Executive as Chair of the HPS Board, highlighted the points of note:

- The plan for 2022/23 was for HPS to make a £2.9m contribution.
- HPS have ceased wholesaling within this year which has impacted the amount of contribution.
- The commercial strategy reflects a decrease in contribution of under £1m.
- Ongoing risks which could affect the contribution, include a drug which could become licensed which would prevent HPS from manufacturing it. This is a £300k contribution risk on a single product.
- Aged debt - £780k over 60 days from a wholesale customer. Speaking to the customer involved.
- From the commercial strategy are two main streams of business the manufacture of specials medicines and repacking and labelling of tablets. Considerable time is being dedicated to developing products that HPS can licence and therefore become the exclusive manufacturer of.
- Conversations taking place at HPS board around Investment versus payoff. Further development plan for 2033/24. Any business cases which are submitted must be rigorous. There is a need to balance risk and opportunity.

KA To be noted that there is a planned reduction in contribution from this year to next year, but that follows a reduction in contribution from last year to this year. Overall reduction is important to note since overall compared to pre-pandemic there has been an overall reduction in contribution of over £2m.

VP Asked that since HPS is not the only NHS pharmacy manufacturing unit, would it be possible for them to perform “Go sees” and visit other units?

The Committee **RECEIVED** the HPS Commercial Strategy.

## **051/23 DRAFT MINUTES FROM SUB-COMMITTEES**

The following minutes and summaries thereof were received by the Committee:

- Access Delivery Group
- Business Case Approvals Group – The group will not be approving cases at this time. They will be picked up as part of the broader planning. Developments on the table current at £11-£12m but only £2m has been set aside as a contingency.
- Capital Management Group – Asked for end of year review at the May meeting.
- Cash Committee

- CHFT / SPC Quarterly Meeting

The Committee **RECEIVED** and **NOTED** the key points from the Sub-Committees.

**052/23 WORKPLAN – 2022/23**

The workplan for 2022/23 was reviewed.

Work through and bring an updated version for 2023/24 to the next F&P meeting.

The Committee **APPROVED** the Workplan for 2022/23

**053/23 ANY OTHER BUSINESS**

None.

**054/23 MATTERS TO CASCADE TO BOARD inc. ONE CULTURE OF CARE**

- Follow up deep dives. Positives and challenges.
- Confidence we will deliver the 2022/23 plan.
- 2023/24 Planning update
- IPR key headlines
- Recovery – challenges next year but YTD great story.

**DATE AND TIME OF NEXT MEETING:**

Tuesday 4<sup>th</sup> April 2023, 9:30 – 12.00 MS Teams

## CHAIR'S HIGHLIGHT REPORT to the Council of Governors

<b>Committee Name:</b>	Workforce Committee
<b>Committee Chair:</b>	Karen Heaton.
<b>Date(s) of meeting:</b>	14 February 2023
<b>Date of meeting presented to the Council of Governors</b>	20 April 2023

### ACKNOWLEDGE

The following points are to be noted by the Board following the meeting of the Committee meeting on 14 February 2023.

- Failure to meet target for EST on Fire Safety remains a concern. Issues with ESR were highlighted with an action agreed to remedy this. System issues preventing updating the module contributed and action is underway to remedy this. There needs to be a balance between face to face and on- line training . The Committee agreed a targeted approach was to be made to those areas failing to meet the target , together with a review of the length and frequency of the module. An update to be presented to the next meeting of the Committee in April.
- IPR- concern remains over the level of short-term sickness absence and the number of return-to-work interviews remains below target with further work planned to improve this. Completion of appraisals was improving , turnover remains high in Estates and amongst AHP colleagues, starters overall exceeded leavers , however nursing vacancies remains high. Agency and bank costs remain high and the Trust has now ceased to work with the most expensive agency.
- The Committee undertook a deep dive into vacancies and continued action is in place to reduce the number of vacancies , some of which are national shortage areas. It was noted that there is a significant difference between actual and planned vacancies, this is partly due to the increase in expanding the number of beds. The Committee raised the need for a more concerted effort from the Centre on a national recruitment campaign.

### ASSURE

- The Committee received a detailed update report on progress against the actions flowing the sickness absence audit with progress being made on a significant number of the actions.
- The disability and BAME network Groups presented and the Committee was encouraged by their plans, ideas and level of enthusiasm.
- The Trust has much stronger, well designed and more cohesive development plans and programmes in place ;this showed real commitment , energy and drive to develop and grow the potential of our colleagues.
- Overall the staff survey results were positive and the Board will receive a more detailed presentation in due course.
- The Board Assurance Framework covering Medical Staffing was discussed and whilst it was recognised the score hadn't changed and the environment

remained challenging the actions to mitigate the risk gave the Committee assurance this was being well managed.

- The internal audit report covering medical revalidation prompted no recommendations and an absolute credit to the Medical Director and his team.

## **AWARE**

- Staffing levels continue to remain a challenge alongside turnover. Although recruitment has been going well and in particular international recruitment.
- The Committee is revising its approach to include presentations from Divisions on a themed approach which will provide a better overview of the actions and progress taking place against the People Strategy themes.
- There will be an additional meeting of the Committee in May to look more deeply at Diversity, Inclusion and Health Inequalities.

## **ONE CULTURE OF CARE**

- One Culture of Care considered as part of the workforce reports and in discussions.



**Draft Minutes of the Audit and Risk Committee Meeting held on Tuesday 31 January 2023 commencing at 10:00 am via Microsoft Teams**

**PRESENT**

Nigel Broadbent (The Chair)	Chair, Non-Executive Director
Denise Sterling (DS)	Non-Executive Director
Peter Wilkinson (PW)	Non-Executive Director

**IN ATTENDANCE**

Andrea McCourt	Company Secretary
Kirsty Archer	Director of Finance
Shaun Fleming	Local Counter Fraud Specialist, Audit Yorkshire
Leanne Sobratee	Internal Audit Manager, Audit Yorkshire
Liam Stout (LS)	Staff Elected Governor
Kim Smith	Assistant Director of Patient Safety
Chris Boyne	Audit Yorkshire
Philippa Russell	Acting Deputy Director of Finance
Richard Lee	KPMG
Heather Moore	Audit Yorkshire
Richard Hill	Head of Health and Safety – from 11am

**01/23 WELCOME AND INTRODUCTIONS**

The Chair welcomed everyone to the Audit and Risk Committee.

**02/23 APOLOGIES FOR ABSENCE**

There were no apologies received.

**03/23 DECLARATIONS OF INTEREST**

The Chair reminded Committee members to declare any items of interest.

**04/23 MINUTES OF THE MEETING HELD ON 25 OCTOBER 2022**

The minutes of the meeting held on 25 October 2022 were approved as a correct record.

**OUTCOME:** The Committee **APPROVED** the minutes of the previous meeting held on 25 October 2022.

**05/23 MATTERS ARISING AND ACTION LOG**

The action log was reviewed and updated accordingly. It was noted that the action relating to item 52/22 internal audit follow up report regarding delegated consent was on the agenda.

**OUTCOME:** The Committee **NOTED** the updates to the Action Log.

**06/23 EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS**

**1. Review of Losses and Special Payments**

The Director of Finance presented a report summarising the losses and special payments for quarter 3 2022/23 totalling £142K. The increase in quarter 3 compared to the prior

quarter, quarter 2 was noted, which it was confirmed relates primarily to the write off of bad debts at circa £60K. The losses of patient property, including cash, was noted in terms of poor patient experience which is likely impacted by recent capacity challenges with Matrons taking a special interest to reduce these incidents.

DS commented that she was pleased to note that there was not an acceptance of the increase in loss of patient items and steps were being taken to reduce these and monitor it. The Director of Finance highlighted a change in how such costs are allocated previously the losses were charged centrally but are now being charged to the service area where the loss was incurred to highlight the issue operationally.

NB questioned the financial thresholds within the Standard Financial Instructions, that determines what is reported to this Committee. The Director of Finance responded that everything over £1000, the limit of bad debt that can be written off at the discretion of the Director of Finance is reported to the Committee. Each transaction is reviewed individually, rather than aggregated across the quarter.

**OUTCOME:** The Committee **NOTED** the Review of Losses and Special Payments report.

## 2. Review of Waiving of Standard Orders

The Director of Finance presented the quarter report showing 138 waivers during quarter 3, 2022/23 at a total cost of £8,715,468.45.

The report reflects several changes within Procurement Contract Regulations and procurement. The new electronic system Atamis is tracking in more sophisticated ways and reporting different categories.

It was noted there had been a focus on single source tenders over the allowable threshold where there was no competition. Only one single source waiver was reported as being over the threshold which was a contract value of £120K for radiation protection services. Investigations as to whether this service can be brought in house to CHS are underway.

Single source tenders were reported under the threshold total at a value of £329K, which were made up of smaller values. Of the single source tenders £202K were in-house, ie exempt from the regulations, such as contracts between CHFT and other NHS Trusts.

**OUTCOME:** The Committee **NOTED** the updated Waiving of Standing Orders report for quarter 3, 2022/23.

## 3. Debts Proposed for Write Offs

The Director of Finance noted that having fully exhausted options around debt recovery, the debt identified in this paper totalling £134.6k was now recommended for write-off, with provision made in the Trust's financial statements, with the exception of the payroll overpayments which were included in the Trust's pay position in 2021/22.

The Director of Finance gave the history relating to an old debt of circa £100K for one overseas visitor who had spent an extended time in ICU, which had been previously brought to the Committee. The patient was complying with a monthly payment plan until their death, and there is no estate to claim from. It had been initially planned to write off this debt at the end of 2021/22 as the patient was deceased. However a cautious approach was taken and checks were made at a national level to see if a threshold had been breached which required the amount to be reported nationally. It had been

confirmed that £300K was the threshold for national level reporting and this applied only to special payments, not a bad debt such as this one. This bad debt was presented once again to this Committee to seek approval to write off this debt.

There is a further £26k of overseas debt spread across nine invoices. Circumstances are similar in that patients are deceased or destitute.

The proposed debts to write off relating to payroll were very specific cases where four apprentices were overpaid with full details given in the report.

PW requested clarification that overseas debt is beyond the control of CHFT and we are not able to prevent such instances. The Director of Finance gave assurances that systems are in place to seek payment for elective procedures via the Overseas Visitors team and that bad debts usually relate to non-elective procedures. It was noted that the volumes of overseas visitors are low compared to other Trusts. Non-payment can be escalated to the level of the patient being prevented from entering the UK if deemed necessary.

In terms of the apprentice overpayments, NB asked if there is a general policy in regard to salary overpayment and whether the write off was consistent with the policy. The Director of Finance confirmed there is a policy in place. In the first instance CHFT would usually seek to reclaim the overpayment from the individual. The policy allows for discretion if individuals would be in hardship as a result of repaying the overpay. This case is unusual in that it was not the fault of individuals, rather CHFT by using the incorrect start point. The colleagues concerned are paid at a low rate which would create financial hardship if deductions were to be made.

**OUTCOME:** The Committee **APPROVED** the debt right off as set out in the paper

#### **4. Final Accounts Process and Plans**

The Director of Finance noted that the 2022/23 final accounts will follow the same process and timeline as previous years. Dates for the 2022/23 audit cycle and timetable are published in the KPMG audit planning paper which was on the agenda. Two colleagues have attended a two-day accounts planning workshop in preparation.

**OUTCOME:** The Committee **NOTED** the Final Accounts Process and Plans.

#### **07/23 Local Counter Fraud:**

The Local Counter Fraud Specialist, SF from Audit Yorkshire, presented the Local Counter Fraud progress report and provided an update on current investigations. The key points to note were:

- Newsletter is sent out on a monthly basis.
- QR code to be added to posters and leaflets for further information to encourage engagement.
- Presentations made to Finance team and Freedom to Speak Up guardians since the last meeting.
- 12 scams of Christmas document sent out, highlighting potential scams at both home and work.
- Fraud prevention masterclass sessions have been delivered covering a selection of topics.
- Survey of all attendees of masterclasses to gauge the effectiveness
- There have been various fraud alerts with a theme of mandate fraud usually cyber enabled.

- The National Fraud Initiative (NFI) exercise that takes place every two years has commenced. The data has been downloaded and matches are coming out in next few months
- In the hold to account section, there are two investigations. One from last year relating to vaccinations is now closed as the evidence asked for was not available. A new investigation which began just before Christmas is ongoing regarding an employee and secondary working whilst on sick leave.
- Referral benchmarking across all Trusts for quarter 3 2022/23 is the same as usual, with two main themes of staff and computer fraud noted.
- Strategic Governance - over the next few months work on a compliance exercise on performance against national counter fraud standards will commence. 124 fraud risks have been reviewed and risk assessed. These will be shared with the risk owners and measures put in place to alleviate the risk. This should enable an improved rating of amber for requirement 3, first introduced in 2021/22, regarding risk assessment methodology
- Progress with the 2022/23 Counter Fraud Plan is on target. There have been more referrals and investigations this year indicating improving awareness of fraud.

PW asked if there was any data showing the benefits of the colleague training, eg by increased referrals. SF noted that it was difficult to assess as increased referrals show greater awareness. SF noted work continues to increase more awareness via face to face training. There has been a low response rates to previous surveys, but results have always shown a good level of awareness.

The Director of Finance commented that training to increase awareness is targeted to areas where colleagues may spot potential fraud.

AM, as the counter fraud champion for CHFT, queried if there had been activity nationally regarding this role and SF advised nothing has been done centrally since the initial guidance was issued, with individual organisations to communicate how this role should work.

DS commented on the positive news around training resulting in awareness and queried the level of take up of training compared to other Trusts and whether more promotion is needed. SF replied that CHFT engagement is on the low side but the Trust is in the same position as other comparative Trusts. The training is constantly advertised. New subjects might encourage colleagues to take up.

NB noted that this Committee could have a role in promoting to the right audience the masterclasses, newsletter and encourage engagement with the survey and training as he would like CHFT to be on a par with the best of the other Trusts.

**OUTCOME:** The Committee **NOTED** the Local Counter Fraud Progress Report.

## **08/23 INTERNAL AUDIT**

### **1. Internal Audit Follow Up Report**

The Internal Audit Manager presented an update to the circulated Follow-Up Report which covers the period Q3 2022/23

It was noted that Internal Audit had completed and finalised 12 audit reports within the last quarter as follows:

- 2 High assurance reports

- 7 Significant assurance reports
- 1 No opinion report
- 2 Limited assurance reports

A total of 268.5 days have been delivered; this represents 72% of planned audit days. The team is currently on track to complete work on the plan by 30 April 2023, with the 2023/24 plan commencing on 1 May 2023.

## 2. Internal Audit Progress Report

The Internal Audit Manager, LS, presented a report which details the progress made by Internal Audit in completing the Internal Audit Plan for 2022/23.

It has not been possible to start two audits as yet: the implementation of a new stock system in theatres has been delayed so will now be scheduled in the 2023/24 plan and a system upgrade at HPS has also been delayed and is under discussion as to whether it will form part of the 2023/24 plan.

The Quality Governance audit which had received a limited assurance opinion was discussed, noting that structures and escalations channels were found to be in place. KS commented that the report was helpful in reviewing ward to Board assurance and that the intention is to complete all recommendations by the end of this week, with terms of reference having been updated with the correct names of Committees.

DS asked whether audits relating to “Medical” had been cancelled or were on hold as only 15 of the 40 planned days for such audits had taken place. LS advised the dementia screening audit had been cancelled as the responsibility for the screening is moving from doctors to nurses and the Safer Procedures (LOCSSIPS) audit was underway but had been delayed as in-house work had been needed prior to the audit commencing.

The Sickness Absence audit report which had received a limited assurance opinion was discussed, noting there had been issues with members of staff and line managers recording sickness, in terms of not always following the process when trigger points are reached. It was noted there is work to do to complete return to work interviews within 72 hours and make sure triggers are being monitored.

AM advised the report should be shared with the Workforce Committee and progress monitored through there.

**ACTION:** DS to take to workforce committee.

**OUTCOME:** The Committee **NOTED** the Internal Audit Follow Up Report and Progress Report.

## 3. Follow up of Internal Audit Recommendations.

LS presented the outstanding recommendations report for the period 20 January 2022 – 19 January 2023. At the time of issue of Committee papers, the report stated there were 27 outstanding recommendations. As of 31 January 2023 that position has improved with 22 outstanding. Of the 22, two are overdue and 20 have been given a revised target date. In total 106 recommendations have been completed in the last 12 months with 45 which are due before 31 March 2023 and work is required to make sure as many of these have been closed as possible.

A full list of the outstanding actions will be shared with NB. LS advised that individual responsible officers will receive their next reminders from the audit system on 3 February 2023.

LS has been training some of the secretarial PA's on the system so they can assist Directors with signing off actions.

AM requested it be noted that the actions are on the Executive Directors radar. It has been agreed that some colleagues can email through their responses rather than using the system which is helpful.

NB commented that there are good processes in place and recommend that the Executive Board (WEB) continue the process to support completion of as many recommendations as possible by the end of March 2023.

DS asked if some of the significantly overdue actions had been closed. LS advised that some recommendations from 2019/20 have been closed, however, there is one from 2018 relating to the study leave policy which remains open. The policy has been written but not enacted due to ongoing discussions with Local Negotiating Committee. As study leave was cancelled for the last few years due to the pandemic this has not been deemed a risk.

In terms of the delegated consent audit it was noted that CHFT has implemented a new electronic system for e-consent but it does not have all the functionality expected which is impacting on completing the recommendations.

**ACTION:** LS circulate the updated report post meeting - Complete

**ACTION:** Update required on long standing actions from responsible officers with commitment to achieve the revised dates. NB to follow up with Brendan.

**OUTCOME:** The Committee **NOTED** the Internal Audit Follow Up Report and Progress Report.

## **09/23 EXTERNAL AUDIT**

### **1. Sector Update**

RL presented the sector update for information and noted the general theme in the paper regarding the changes from Clinical Commissioning Groups to Integrated Care Boards in light of statutory changes.

The following were highlighted: financial reporting, guidance around the deterioration of the financial position in the context of system working, updated code of governance and duties for governors around roles and responsibilities in a system working arrangement.

PW commented the sector update was well put together.

**OUTCOME:** The Committee **NOTED** the External Audit Report.

### **2. Draft External Audit Plan**

The draft audit plan was presented by RL. Audit planning and risk assessment has been undertaken for 2023 and risks have been identified where KPMG will focus their work.

- Page 4 shows a summary of the initial assessment of risk.

- The risk assessment for 2023 is stable compared to the previous year.
- A specific risk assessment relating to value for money will be brought to this Committee at the next meeting.
- Materiality – as the Trust is continuing to forecast expenditure and income around the £500m threshold this puts CHFT on the radar of an AQR (Audit Quality Review) scope audit, where the Financial Reporting Council (FRC) and audit quality review team review the audits performed. This results in additional procedures for KPMG, particularly around documentation, and a second level review takes place before the issue of audit opinions.
- the headline materiality threshold has been increased because of some of the challenge through the audit review process. Headline materiality based on revenue and income of the Trust is between 0.5% and 3%, a prudent level within a stable environment. Any misstatements identified above £300k will be reported to this Committee.
- KPMG will continue to audit Calderdale and Huddersfield Solutions whose timeline will be in line with the Trust annual accounts sign off. A new audit team from KPMG with greater experience of the NEP ledger system is now in place with more on site audit planned.
- Risk around expenditure were noted, including cost improvement programmes (CIP). Valuations of land and buildings was highlighted as a risk, as this is subject to judgement. This year is a full valuation year for land and buildings at CHFT; this was last done in 2018.
- The impact of the new auditing standards ISA 315 revised was highlighted with an enhanced planning and risk assessment approach which reflects an increasing dependence by organisations on digital systems. Further work by KPMG's digital team will be done to understand the processes around key risks.
- The audit cycle and timetable was shown, with finalisation of accounts in June. The plan is for the subsidiaries audit work to be signed off earlier this year than last.
- The proposed fees for 2022/23 were shared which are based on contract, inflation and impact of ISA 315 revised. NB questioned the allowance for inflation and when the fee for ISA315 would be determined. The final fees will be agreed with the Director of Finance before these are charged.

PW queried if the risk re land and property valuation was due to the valuation exercise and not market movement. RL confirmed this was correct as the risk was due to the value of land and buildings (£130M) and reliance on a third party valuer. RL commented that a full valuation is usually more accurate and can significantly impact on the accounts.

The Director of Finance detailed the significant amount of work in the Trust undertaken for the Value For Money (VFM) process and noted that good progress has been made in last few weeks with supporting evidence shared with KPMG, much of which crosses over with evidence provided for the financial sustainability checklist. In regard to the new ISA 315 revised, CHFT use the same ledger system as most Trusts in WYAAT and if we are unable to answer questions, we would have support from those Trusts and the supplier NEP.

The Director of Finance noted that further conversations are to be had around fees, given the considerable increase in fees at the start of the renewed contract with KPMG in 2021/22.

The Committee formally delegated further discussion of fees to the Director of Finance.

## 10/23 BOARD ASSURANCE FRAMEWORK (BAF)

The Company Secretary presented the 2022/23 third and final version of the BAF update.

The top three risks are consistent with previous reports. The workforce nurse staffing risk continues to be the biggest risk. The risk details are to be audited as part of internal audit testing of the Board Assurance Framework. The second risk is around progression of the reconfiguration, which at present is outside of the control of CHFT.

The only risk to have its score changed is Health and Safety risk to reduce from a score of 9 to 6 based on the advice of the Head of Health and Safety, who commented that the plan is to reduce the risk score further over the next 6-12 months towards the target risk score of 3.

AM noted the new deputy CEO has taken the Director lead on the health inequalities risk and refreshed this.

NB asked if the sickness report limited assurance should be referenced in the BAF. AM agreed to review this in relation to workforce risks prior to the paper going to the Board.

NB queried if the Board is satisfied that any new risks around Place or systems sustainability are reflected in the framework. AM feedback that a desktop review of some other BAFS highlighted that some Trusts had one individual system risk on the BAF but that it had been concluded that this was not helpful. AM advised that specific BAF risks had PLACE/ system references where appropriate to the risk, which was more meaningful than having a separate overarching systems risk. Further national guidance regarding BAFs and system risks is awaited.

PW Commented that the top three risks are not obvious within the BAF report. AM agreed to review the presentation of the paper with a view to adding a summary page for the top three risks for the next Board report.

**OUTCOME:** The Committee noted the reduced risk score for risk 16/19 health and safety and **APPROVED** the updated BAF and **RECOMMEND** this to the Board.

## 11/23 COMPANY SECRETARY'S BUSINESS

### 1.1 Review Standing Orders

AM advised that a scheduled review had taken place and updates mainly include legislation and guidance updates which reflect system working. Definitions had been added to, more information had been included on Director roles and a revision to give the Chair the casting vote in the event of an equal result. Information has been added to clarify which are mandatory Committees, and which are non-mandatory. Reference to the Standards of Public Life are now included.

NB advised that he would raise minor points on the Standing Orders with AM outside of meeting.

**OUTCOME:** The Committee **APPROVED** the updated Standing Orders and **RECOMMEND** this to the Board.



## 1.2 Standing Financial Instructions (SFIs)

PR advised that there had been a number of updates to the SFIs as part of this regular review, none of which were major. Future proofing terms had been added e.g. using “regulator” instead of a specific organisation named. Additions include budget holders to sign off budgets at the beginning of the financial year. This is required and any non-compliance will be reported to this Committee. The Online banking section had been updated. The biggest change was in the procurement section which the Head of Procurement and Supplies has rewritten. Reference to EU guidelines has been removed and updated. A paragraph has been added in section 14 with reference to the HM Treasury managing public money guidance.

PR noted a further piece of work is required to update the two appendices which are around authorisation limits.

**ACTION:** Bring back review of Appendices to July Committee meeting.

**OUTCOME:** The Committee **APPROVED** the updated Standing Financial Instructions and **RECOMMEND** this to the Board.

## 1.3 Scheme of Delegation

AM presented this item and noted this was a scheduled review with housekeeping and amends to reflect new Director roles and changed portfolios. The material change relates to delegated authority to the Charitable Funds Committee to approve the charities annual report on annual accounts.

Should the updated appendices of the SFIs impact the scheme of delegation, then this will be returned to this Committee at the same time.

**OUTCOME:** The Committee **APPROVED** the revised Scheme of Delegation and **RECOMMEND** this to the Board.

## 1.4 Self-Assessment of Committee Effectiveness

AM advised this would be circulated for completion and return by Word version to be distributed. Checklist one is only to be completed by the meeting Chair and Director of Finance. The form should be returned by 17 February 2023 and will be feedback with an action plan to the April meeting.

## 1.5 Draft Annual Accounts Timetable

AM advised that the official Foundation Trust accounting manual for 2022/23 has not yet been issued. The timetable is based on the two key dates known. The draft annual accounts are due for submission on 27 April 2023, Trust sign off date is planned for the 27 June 2023 with final submission of accounts planned for 30 June 2023

NB noted sufficient time was needed to review the accounts in advance of the Committee meeting reviewing the accounts and asked if these could be shared at the earliest opportunity.

**ACTION:** Director of Finance and Zoe Quarmby to arrange a meeting with NB after the draft submission and after audit have completed a significant part of their review.

**OUTCOME:** The Committee **NOTED** the annual accounts timetable for 2022/23.

## 1.6 Audit and Risk Committee Workplan 2023

Risk management review deferred to the next meeting.

**OUTCOME:** The Committee **NOTED** the Audit and Risk Workplan for 2023.

## 12/23 APPROVAL OF STRATEGY AND POLICIES

### 1. Health and Safety Strategy 2023 – 2028

RH presented this noting the alignment towards the NHS workplace safety, health and safety standards. The Trust's ambition is to achieve the requirements of ISO 45001 which is the gold standard of assurance. The strategy has been written with these points in mind and is now at the review stage. For the next five years focus will be on monitoring those standards to make sure CHFT continues to meet them.

Other work to be done involves networking with third party organisations and better sharing of information between occupational health and the moving and handling team. This strategy has been to the Health and Safety Committee.

**OUTCOME:** The Committee **APPROVED** the health and safety strategy.

### 2. Health and Safety Policy

RH advised the policy has been reviewed by the Health and Safety Committee. Key points:

- Signature from the current Chief Executive added.
- New polices have been created over the last two years with new risks around ligature, which are now cross referenced in the policy.
- Re-written to make it easier to read and for the reader to access associated information.

NB asked whether it is clear that health and safety is everyone's responsibility. The statement of intent lists the Chief Executive and Board responsibility. RH responded that key responsibilities are noted in the paper at senior levels, which is an NHS requirement. Further down the structures there is less specific detail, but re-iterated health and safety is everyone's responsibility.

**OUTCOME:** The Committee **APPROVED** the Health and Safety Policy.

### 3. Conflicts of Interests Policy

AM presented the revised policy following a routine scheduled review. The main changes highlighted were that the nil return process has been made clearer for decision making staff. CHFT have a lower threshold of decision making staff, at band 7, than the national requirement of band 8 and above. AM advised that NHS Contracts guidance required the Trust to publish details of decision -makers that had not made a nil return. The counter fraud contacts have been updated.

**OUTCOME:** The Committee **APPROVED** the Conflicts of Interest Policy

### 4. Treasury Management Policy

The Director of Finance and PR had to leave the meeting The updated policy within the meeting pack was approved with any comments to PR.

**ACTION** Any comments sent to KA and PR copy in NB.

**OUTCOME:** The Committee **APPROVED** the Treasury Management policy.

## **13/23 REVIEW OF SUB-COMMITTEE TERMS OF REFERENCE**

### **1. Health and Safety Committee**

RH advised that over the last 18 months new subgroups have been created to tackle some of the key issues. These have now been reflected in terms of reference. The membership of the committee has been updated.

NB commented that there was no section detailing quoracy of the meetings. RH advised the meeting must have 75% attendance to achieve quoracy. RH agreed to add quoracy information to the terms of reference

AM highlighted a correction under escalation – the name of this Committee is Audit and Risk Committee and advised that the terms of reference should state that the Audit and Risk Committee also provide health and safety assurance.

**OUTCOME:** The Committee **APPROVED** the updated terms of reference.

### **2. Compliance Group**

KS advised that the terms of reference were presented as the Compliance Group has been separated out from the CQC and Compliance group. The Director of Corporate Affairs is chairing both meetings and taking the Director lead. The terms of reference have been re-written to show clear lines of accountability. The new meetings allow them to be clear about the appropriateness of the membership and are able to focus on separate agenda items and give more scrutiny to those items.

### **3. Risk Group**

KS advised the Risk Group terms of reference had been reviewed.

### **4. Information Governance and Records Strategy Group**

No colleague present to discuss.

**OUTCOME:** The Committee **RATIFIED** the Terms of Reference for the above sub-groups.

## **14/23 SUMMARY REPORTS**

A summary report of work undertaken since April 2022 was provided for the following sub-committees and minutes of these meetings were made available in the review room:

- Risk Group
- Information Governance and Records Strategy Group
- Health and Safety Committee
- Data Quality Board
- CQC and Compliance Group – Stood down due to operational pressures.

**OUTCOME:** The Committee **NOTED** the summary reports for the above sub-groups.

**15/23 ANY OTHER BUSINESS**

No other business was raised.

**16/23 MATTERS TO CASCADE TO BOARD OF DIRECTORS**

- Policies and strategies approved. Referred to Board on Standing Orders, Standing Financial Instructions and Scheme of Delegation.
- Promoting counter fraud awareness programme
- Follow up of internal audit actions.
- Refer to BAF update.

**17/23 DATE AND TIME OF THE NEXT MEETING**

Tuesday 24 April 2023 10:00 – 12:15 pm Microsoft Teams

**ACTION:** Two deep dives on agenda, consider deferring one. Arrange agenda so that items requiring formal approval are at the top of agenda for next meeting. AM

**18/23 REVIEW OF MEETING**

The meeting closed at approximately 12.15.



**Minutes of the Charitable Funds Committee meeting held on  
Wednesday 15 February 2023, 11.30 – 1.00pm  
via Microsoft Teams**

**PRESENT**

Helen Hirst (HH)	Chair
Gary Boothby (GB)	Executive Director of Finance
David Birkenhead (DB)	Medical Director
Lindsay Rudge (LR)	Executive Director of Nursing
Nigel Broadbent (NB)	Non-Executive Director
Peter Wilkinson (PW)	Non-Executive Director
Adele Roach (AR)	REN Staff Representative

**IN ATTENDANCE**

Vicky Pickles (VP)	Director of Corporate Affairs
Emma Kovaleski (EK)	Charity Manager
Carol Harrison (CH)	Charitable Funds Manager (Minutes)
Lyn Walsh (LW)	Finance Manager
Carol Gregson (CG)	Lead Nurse, Quality, Corporate (for item 6)
Nigel Murphy (NM)	Waste Management Officer, Estates (for item 6)

**1. DECLARATION OF INDEPENDENCE**

At the beginning of the meeting the Charitable Funds Committee members made their Declaration of Independence.

**2. APOLOGIES FOR ABSENCE**

Apologies were received from Jo Kitchen.

**3. MINUTES OF MEETING HELD ON 23 NOVEMBER 2022**

The minutes of the meeting held on 23 November 2022 were approved as an accurate record.

EK gave an update on the General Purpose bids that were approved by email outside of the last meeting in November 2022.

**4. ACTION LOG**

The action log was reviewed and it was agreed to close the following actions:

24.05.21 – 7

08.02.22 – 1

23.11.22 – 8

**ACTION: CH** to amend Action Log re closed items – **15.02.23 - 1**

## **5. CHARITY MANAGER'S REPORT**

EK presented this report.

GB queried the CRM and Accounting package elements of the Development Grant award. EK informed the Committee that these had been identified as part of the self-assessment required by NHS Charities Together to access the Grant. It was agreed that EK would bring a paper to the next meeting setting out the Options Appraisal re the top three CRM providers, an overview from the Financial Comparison Survey undertaken internally and the benefits of having a CRM.

HH gave a 'well done' to the Team on overachieving on some of the KPIs and trialling new things.

**ACTION: EK** to bring CRM paper to next meeting – **15.02.23 - 2**

### **CHARITY 2 YEAR PLAN**

EK highlighted the first year of the plan under the headings of the strategic objectives.

EK agreed to circulate the results of the survey which will be carried out by Standout Media regarding the Brand Refresh.

PW asked about the (untapped) area of the private sector and corporate partnerships. EK explained that there were some business partnerships already developed but recognised there was more to do on this area. She explained that the work of the team had been prioritised and that she would be focussing on corporate partnerships and business development going forward.

EK highlighted the Big Hospital Walk planned to take place on 9<sup>th</sup> July as part of the NHS75 celebrations. Questions were asked around about the scale of the event to maximise potential, linking to 75 years of Windrush and also with the Charity being the Mayor's Charity this year. It was agreed that a Task and Finish group should be set up to consider the scope and make recommendations to the Committee. LR volunteered to be part of this group.

AR and HH felt that this event could be an opportunity to meet some goals around Equality, Diversity and Inclusion.

GB said that if this has the potential to be a big winner in terms of awareness and raising funds, it may be worth putting some of the other planned fundraising events on the back burner.

It was agreed to approve the plan and the indicative operational budget of £10,660.

**ACTION: EK** to circulate survey results – **15.02.23 - 3**

**ACTION: EK** to set up a Task and Finish group and circulate its proposals re Hospital Walk– **15.02.23 - 4**

### **SOD and STEERING GROUP SIGN OFF**

EK presented this report and its contents were approved.

**ACTION: EK** to implement new SOD and amend current operations/forms where necessary – **15.02.23 - 5**

**ACTION: EK** to set up Steering Group and its Terms of Reference – **15.02.23 – 6**

## **6. FUNDING AND NEW FUND REQUESTS**

### **General Purpose Bids**

All bids were approved with the exception of Hospital Radio where further information was requested to understand the scope, listenership and potential for advertising.

CG presented the bid for soft close waste bins in person and mentioned that it had BCAG approval. She outlined how it would be tied into a broader quiet hospitals programme.

The charge boxes were approved in principle. GB/LW will seek CMG approval and EK will seek Estates sign off outside of the meeting.

**ACTION: CH** to set up all approvals – **15.02.23 - 7**

**ACTION: GB/LW** to arrange CMG approval for Charge Boxes – **15.02.23 - 8**

**ACTION: EK** to get Estates sign off for Charge Boxes – **15.02.23 - 9**

**ACTION: EK** to discuss with Hospital Radio bidder to better understand the audience and whether we bring it back to the next meeting – **15.02.23 – 10**

### **New fund requests**

Both new fund requests were approved.

**ACTION: CH** to set up new funds – **15.02.23 - 11**

## **7. FINANCE REPORT to end December 2022**

The contents were NOTED.

Age Concern Todmorden's second payment was approved.

**ACTION: CH** to arrange payment to Age Concern Todmorden – **15.02.23 - 12**

## **8. RESERVES POLICY – annual review**

The amended policy was approved.

## **9. MINUTES OF STAFF LOTTERY COMMITTEE MEETING 13 DECEMBER 2022**

These papers are for information only and their contents were NOTED.

## **10. ANY OTHER BUSINESS**

There was no other business to be discussed.

## **DATE AND TIME OF NEXT MEETING:**

10 May 2023, 11am.

## CHAIR'S HIGHLIGHT REPORT to the Council of Governors

<b>Committee Name:</b>	Workforce Committee
<b>Committee Chair:</b>	Karen Heaton.
<b>Date(s) of meeting:</b>	14 February 2023
<b>Date of meeting presented to the Council of Governors</b>	20 April 2023

### ACKNOWLEDGE

The following points are to be noted by the Board following the meeting of the Committee meeting on 14 February 2023.

- Failure to meet target for EST on Fire Safety remains a concern. Issues with ESR were highlighted with an action agreed to remedy this. System issues preventing updating the module contributed and action is underway to remedy this. There needs to be a balance between face to face and on- line training . The Committee agreed a targeted approach was to be made to those areas failing to meet the target , together with a review of the length and frequency of the module. An update to be presented to the next meeting of the Committee in April.
- IPR- concern remains over the level of short-term sickness absence and the number of return-to-work interviews remains below target with further work planned to improve this. Completion of appraisals was improving , turnover remains high in Estates and amongst AHP colleagues, starters overall exceeded leavers , however nursing vacancies remains high. Agency and bank costs remain high and the Trust has now ceased to work with the most expensive agency.
- The Committee undertook a deep dive into vacancies and continued action is in place to reduce the number of vacancies , some of which are national shortage areas. It was noted that there is a significant difference between actual and planned vacancies, this is partly due to the increase in expanding the number of beds. The Committee raised the need for a more concerted effort from the Centre on a national recruitment campaign.

### ASSURE

- The Committee received a detailed update report on progress against the actions flowing the sickness absence audit with progress being made on a significant number of the actions.
- The disability and BAME network Groups presented and the Committee was encouraged by their plans, ideas and level of enthusiasm.
- The Trust has much stronger, well designed and more cohesive development plans and programmes in place ;this showed real commitment , energy and drive to develop and grow the potential of our colleagues.
- Overall the staff survey results were positive and the Board will receive a more detailed presentation in due course.
- The Board Assurance Framework covering Medical Staffing was discussed and whilst it was recognised the score hadn't changed and the environment



remained challenging the actions to mitigate the risk gave the Committee assurance this was being well managed.

- The internal audit report covering medical revalidation prompted no recommendations and an absolute credit to the Medical Director and his team.

## **AWARE**

- Staffing levels continue to remain a challenge alongside turnover. Although recruitment has been going well and in particular international recruitment.
- The Committee is revising its approach to include presentations from Divisions on a themed approach which will provide a better overview of the actions and progress taking place against the People Strategy themes.
- There will be an additional meeting of the Committee in May to look more deeply at Diversity, Inclusion and Health Inequalities.

## **ONE CULTURE OF CARE**

- One Culture of Care considered as part of the workforce reports and in discussions.

ANNUAL COUNCIL OF GOVERNORS BUSINESS CYCLE 2023

**THE STATUTORY FUNCTIONS OF THE COUNCIL OF GOVERNORS**

**Under National Health Service Act 2006:**

- To appoint and, if appropriate, remove the Chair
- To appoint and, if appropriate, remove the other non-executive directors
- To decide the remuneration and allowances, and other terms and conditions of office, of the Chair and other NEDs
- To approve the appointment of the Chief Executive
- To appoint and, if appropriate, remove the NHS Foundation Trust’s external auditor
- To receive the NHS Foundation Trust’s annual accounts, any report of the auditor on them and the annual report

In preparing the NHS Foundation Trust’s forward plan, the Board of Directors must have regard to the views of the Council of Governors.

**Under Health and Social Care Act 2012:**

- To hold the non-executive directors individually and collectively to account for the performance of the Board of Directors
- To represent the interests of the members of the Trust as a whole and of the public
- To approve “significant transactions” as defined within the constitution
- To approve any applications by the Trust to enter into a merger, acquisition, separation or dissolution
- To decide whether the FT’s private patient work would significantly interfere with its principal purpose, i.e. the provision of goods and services for the health service in England or the performance of its other functions
- To approve any proposed increase in private patient income of 5% or more in any financial year
- Jointly with the Board of Directors, to approve amendments to the FT’s constitution

	26 Jan 2023	20 Apr 2023	20 July 2023	September 2022 AGM	19 Oct 2023	COMMENTS
<b>STANDING AGENDA ITEMS</b>						
<b>Introduction and apologies</b>	✓	✓	✓	✓	✓	
<b>Declaration of Interests</b>		✓ Receive updated Register of Declarations of Interest			✓ Receive updated Register of Declarations of Interest	
<b>Minutes of previous meeting</b>	✓	✓	✓		✓	Upload approved minutes to public website
<b>Matters arising</b>	✓	✓	✓		✓	
<b>Chair’s Report</b>	✓	✓	✓		✓	

	26 Jan 2023	20 Apr 2023	20 July 2023	September 2022 AGM	19 Oct 2023	COMMENTS
Update from Governors					✓	*Opportunity for Governors to feedback on their constituencies.
Register of Council of Governors and Review of Election Arrangements	✓ Review Register	✓ Review Register		✓ Receive Register	✓ Receive updated Register of CoG	Updates as required and amendments to website
Verbal Update from Board Sub-Committees: - - Audit and Risk Committee - Finance and Performance Committee - Quality Committee - Workforce Committee - Nomination and Remuneration Committee - Charitable Funds Committee - Organ Donation Committee	✓ Receive update – as appropriate	✓ Receive update – as appropriate	✓ Receive update – as appropriate		✓ Receive update from Non-Executive Director	<u>Private meetings:</u> <ul style="list-style-type: none"> <li>• Feedback from Divisional Reference Group (DRG) meetings</li> <li>• Feedback from private Board meetings</li> <li>• Feedback from questions</li> </ul>
Finance Summary Report	✓ Receive an update from DOF	✓ Receive an update from DOF	✓ Receive an update from DOF	✓ Receive and approve Annual Accounts	✓ Receive an update as part of Finance and Performance Report	
Integrated Performance Report (Quality)	✓ Receive an update from COO	✓ Receive an update from COO	✓ Receive an update from COO		✓ Receive an update as part of Finance and Performance Report	
Quality Account Priorities	✓	✓ Including confirmation of	✓ including quarterly update		✓ including quarterly update 3 QA priorities 22/23	

	26 Jan 2023	20 Apr 2023	20 July 2023	September 2022 AGM	19 Oct 2023	COMMENTS
		new 22/23 QA detail Year end 21/22 quality accounts - Q4	3 QA priorities 22/23			
<b>Updated Council of Governors Calendar</b>	✓ Receive	✓ Receive	✓ Receive		✓ Receive	
<b>REGULAR ITEMS</b>						
<b>Election Process</b>	✓ Agree proposed timetable for election	✓ Progress on elections report		✓ Ratify appointment of newly elected members		
<b>Nominations and Remuneration of Chair and Non-Executive Directors</b>	✓ Receive update on tenures (as required)	✓ Ratify decisions of Nom & Rem Committee Meeting	✓ Ratify decisions of Nom & Rem Committee Meeting		✓ Ratify decisions of Nom and Rem Committee Meeting	
<b>Appointment of Chair</b>		✓				
<b>Strategic Plan &amp; Quality Priorities</b>	Receive update: <ul style="list-style-type: none"> <li>Notes from BOD/COG Workshop</li> <li>Quality Accounts</li> </ul>	✓ Receive update on progress		✓ Receive updated plan and priorities	✓ Workshop	Review as required
<b>ANNUAL ITEMS</b>						
<b>Annual Plan Submission</b>	✓ Annual Plan Discussions	✓ Receive Annual Plan				<b>Details of annual plan review and</b> sign off to be planned once guidance for 2022/23 received – may

	26 Jan 2023	20 Apr 2023	20 July 2023	September 2022 AGM	19 Oct 2023	COMMENTS
						require extra-ordinary COG meeting or COG workshop)
<b>Appointment of Lead Governor</b>		✓ Paper to be presented to discuss election process		✓ Appointment confirmed		
<b>Chair/Non-Executive Director Appraisal</b>		✓ Approve Chair appraisal process	✓ Receive informal report			April – Approve process July – Receive report
<b>Constitutional Amendments</b>		✓ Review amendments				Review as required
<b>External Auditors to attend AGM to present findings from External Audit and Quality Accounts</b>				✓ Receive presentation from audit on Accounts and Quality Accounts		
<b>Future Council of Governors Meeting Dates</b>	✓ meeting dates agreed		✓ Draft – meeting dates agreed		✓	
<b>Council of Governors Sub Committees</b>					✓ Review allocation of members on all Committees following elections NB – Chairs to be reviewed annually	
<b>Council of Governors Self Appraisal of Effectiveness</b>			✓		✓ Self-Appraisal feedback / outcome	✓ Self-Appraisal process to commence July / August 2022
<b>Review Annual Council of Governors Meetings Workplan (this document)</b>		✓ Review			✓ Review any amendments / additions	Review as required

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<b>Review of Council of Governors Formal Meeting Attendance Register</b>		✓ Receive register prior to insertion in Annual Report				
<b>Quality Accounts</b>	✓ Receive update on Quality Account Priorities		✓			Approval of local indicator for QA agreed at December COG Workshop
<b>Review details of 2022/23 Annual Members Meeting</b>		✓ Review April	✓			
<b>ONE OFF ITEMS</b>						
<b>Review Tender arrangements for Administration of Election Service</b>						As required
<b>Appointment of Auditors</b>						Re-tendering of external auditors to be reviewed in 3 years
<b>Review progress with annual plan for Membership Strategy</b>		✓			✓ Review	Review as required and no less than every 3 years
<b>Review of Standing Orders – Council of Governors</b>		✓ Review				Annually
<b>Risk Register</b>	✓	✓				