Public Board of Directors 6 May 2021 - Items for Board Assurance

Organiser Jacqueline Ryden

Documents for Review

1. Guardian of Safe Working Hours Annual Report

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	6th May 2021
Meeting:	Board of Directors
Title:	Annual report (April'20-March'21) from the Guardian of safe working hours
Author:	Anu Rajgopal
Sponsoring Director:	David Birkenhead
Previous Forums:	none

Actions Requested:
To note

Purpose of the Report

In line with Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016, the purpose of this report is to provide an overview and assurance of the Trust's compliance with safe working hours for junior doctors and to highlight any areas of concern or commendation.

Key Points to Note

1. A commendable response by the junior doctor workforce over the pandemic for their commitment to patient safety and willingness to be flexible and support changes to their rota in response to COVID-19 activity in the Trust.
2. An increase in exception reports submitted mainly by the medical division in quarters 3 and 4 reflecting an increased workload due to higher patient acuity and low staffing due to increase in colleague absences.
3. An increase in educational exceptional reports in Q3 & Q4 by foundation trainees due to lack of access to self-development time.
4. Improved Trust and GOSWH engagement with the junior doctor workforce

EQIA – Equality Impact Assessment

The analysis of exception reporting data has highlighted some differences in ethnicity, gender and disability when compared to the makeup of the junior doctor workforce. These findings will be escalated to the equality groups (BAME, CDAG, LGBTQ).

Recommendation
The Board is requested to: 1. Receive and note the report. 2. Acknowledge the hard work and dedication of our junior doctor workforce over the COVID-19 pandemic

Annual report: (1st April 2020 to 31st March 2021)

Guardian of safe working hours (GOSWH), CHFT

Executive summary

The purpose of the annual report is to provide assurance to the board that junior doctors are safely rostered and enabled to work hours that are safe and in compliant with the Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in Training (England) 2016, version 9.

The period of cover is from April 2020 to March 2021

This year saw our junior doctors alongside other healthcare workers across the country demonstrating extraordinary levels of commitment and willingness to go above and beyond usual expectations in reaction to the COVID-19 pandemic. COVID rotas were created and stepped down a few times in response to the COVID-19 impact at CHFT. All rotas were fully compliant with 2016 contract rules. Usual rules around exception reporting were followed as per the contract. It is important to note that no one suffered a financial detriment because of working these rotas. Increased pay was arranged where applicable and pay protection was put in place in the event that the salary for the escalated rota was less than the 'normal' rota.

Only one immediate safety concern was raised via exception reporting during this period which was dealt with effectively and in a timely manner.

During the COVID rota, there were daily meetings /chats (via Microsoft teams) between the junior doctors, medical education, rota coordinators, medical HR and the deputy medical director to ensure effective communication and resolve any rota issues or concerns in a timely manner.

Significant rota gaps continue in accidents & emergency (A &E), obstetrics & gynaecology (OBGYN), paediatrics and trauma & orthopaedics. There has been success in recruitment to trust grade posts in paediatrics and OBGYN recently which will help support these specialities.

There was increased engagement of GOSWH, DME, Medical HR and divisions with trainees via regular junior doctor meetings to receive timely feedback on rotas and for communicating key messages of the pandemic.

There was a significant increase in the educational exception reports from foundation trainees reflecting the lack of access to self-development time (SDT) in Q3 and Q4

Essential data

Trainee Type	Budget	In Post		Part Time		Vacancies
	FTE	FTE	Headcount	FTE	Headcount	FTE
Core Trainee	39.00	30.19	31	2.19	3	8.81
Foundation Year 1	46.92	45.53	46	1.53	2	1.39
Foundation Year 2	35.17	36.28	37	1.28	2	-1.11
GP Trainees - CHFT Based	35.90	32.61	35	4.61	7	3.29
Specialty Trainee	101.60	94.19	101	17.19	23	7.41

Trainee Type	Budget	In Post		Part Time		Vacancies
	FTE	FTE	Headcount	FTE	Headcount	FTE
GP Trainees - Practice Based	0.00	54.10	62	18.1	26	N/A

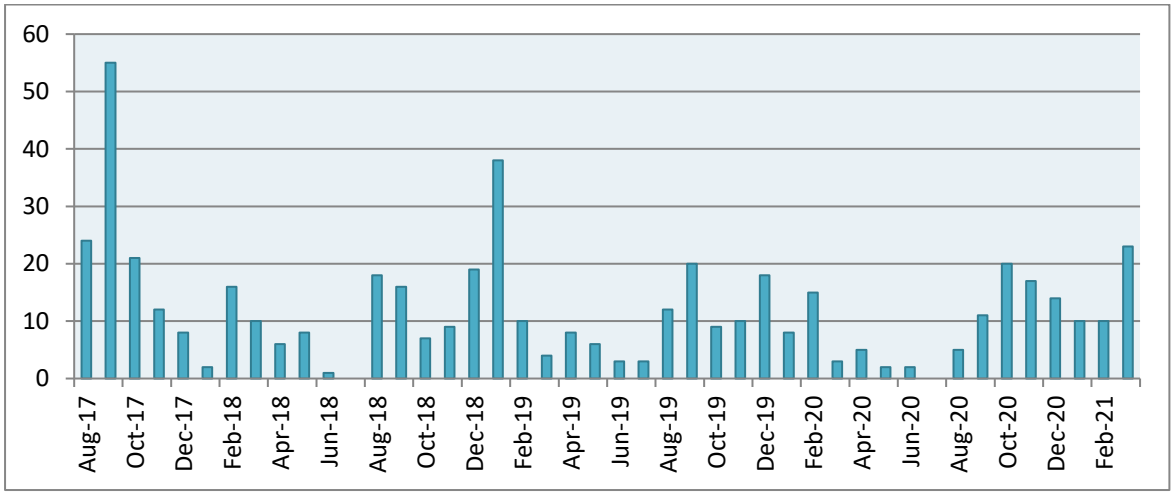
Trust Doctors	Budget	In Post		Part Time		Vacancies
	FTE	FTE	Headcount	FTE	Headcount	FTE
Medical Training Initiative (Royal College Approved	0.00	1.00	1	0.00	0	-1.00
Trust Doctor on 2016 Contract T&Cs	14.72	55.79	58	3.79	6	-41.07

a) Exception Reports (ERs)

Total number of exception reports received per quarter this year

	Immediate safety concerns	Total hours of work and/or pattern	Educational opportunities/ support	Service support available	TOTAL
Q1	0	8	0	0	8
Q2	1	15	0	1	17
Q3	0	47	4	0	51
Q4	0	27	16	0	43
Total	**0**	**98**	**20**	**1**	**119**

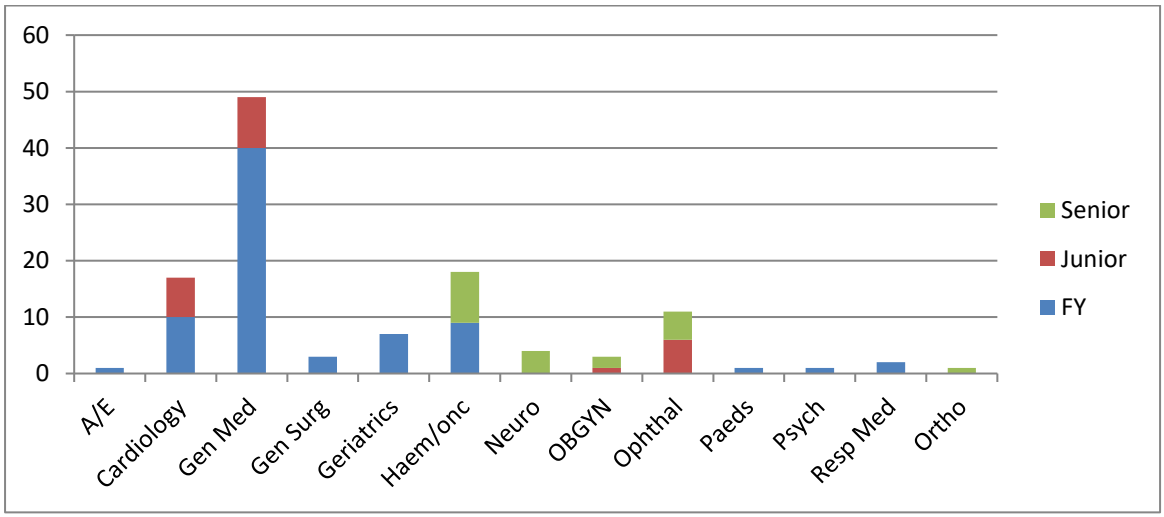
Number of monthly ERs (2017-current)



Trends in exception reporting

There have been a total of 119 exception reports this year, 80% of which were submitted in Q3 and Q4. Whilst the process of exception reporting was available throughout, there was a significant decrease in the reports submitted in Q1.

Majority of ERs were submitted from foundation trainees, similar to previous years but there was a trend of increased ERs from junior and senior trainees. Submission was from a wide variety of specialities, suggesting that the process of exception reporting is embedded across the Trust. There has been a significant decrease in ERs from the surgical division, probably reflecting the decrease in elective surgical activity and the increase in the acuity of medical patients over the COVID-19 pandemic.

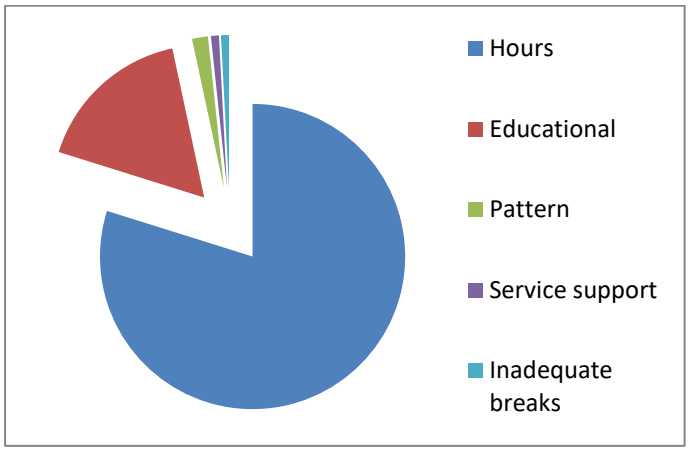


Q3 and Q4 saw a sharp rise in ERs from the Medical division. This was as a result of the second and third pandemic wave and the recurring themes were a higher clinical workload, increased patient acuity and colleague absences.

Oncology and Haematology had an increase in ERs submitted. The main issues raised were: increased referrals and completion of tasks from the oncology help-line, senior medical input later in the day leading to a spill-over of trainee jobs beyond their standard hours and delay in completing ward rounds due to acutely unwell patients. This was escalated to the clinical leads which led to an improvement in managing the help-line and planning ward rounds with early escalation to seniors.

Senior trainees submitting ERs have been mainly in Ophthalmology & oncology. Majority of these were due to over running busy emergency eye clinics and an increase in the oncology helpline referrals with acutely unwell patients.

Type of ERs and outcome:



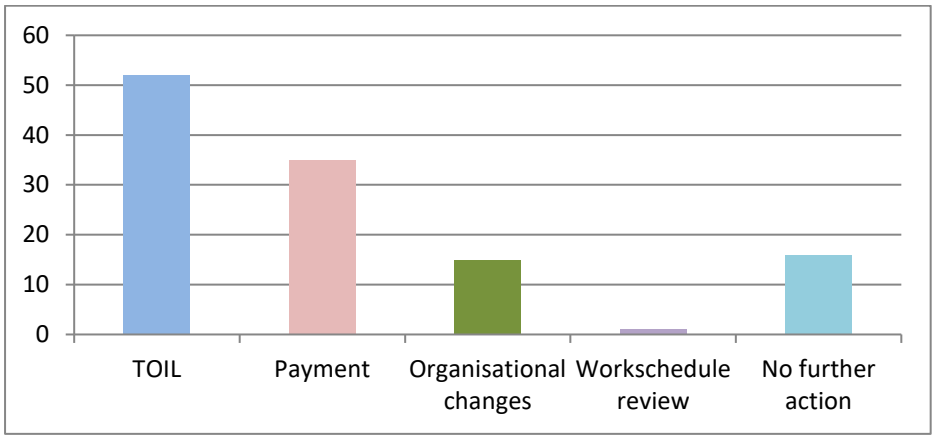
Approximately 80% of ERs submitted this year were as a result of working overtime and this was due to higher patient acuity and poor staffing at times.

There was a trend in ERs submitted in Q3 and Q4 from foundation doctors due to lack of access to self-development time (SDT). This was introduced by the HEE foundation programme in September 2020 and SDT is now a contractual requirement for foundation trainees as per the 2016 TCS. All Divisions, clinical directors, rota coordinators and trainees received the relevant information from medical education and the intention was that it be applied flexibly by the divisions. The surgical and A/E directorates had rostered SDT within the trainee rota and medicine & paediatrics had decided to give it flexibly. However, following concerns raised by trainees and the trend in exception reports, the SDT is now rostered for all trainees who have been encouraged to be proactive in taking it.

Immediate safety concern (ISC)

There has only been one ISC flagged this year. This was in Q2 and submitted by the neurology registrar who does cross-cover on-calls at Leeds teaching hospitals NHS Trust (LTHT). Two acute neurological patients were referred to the multi-speciality assessment area in Leeds which is staffed only by nursing colleagues. The neurology on-call registrar at CHFT was contacted who took time reaching LTHT from CHFT to review these patients. In order to ensure patient safety, this issue was escalated in a timely manner to the neurology day registrar and the ED and Neurology consultant at Leeds. The on-call registrar also datixed the incident at Leeds and emailed the Leeds neuroscience CSU Director. There have been no subsequent incidents reported.

Outcome of ERs



Most ERs have resulted in time off in-lieu or payment. Those that have led to organisational changes have resulted in improved processes for trainee handover, early escalation from trainees for senior medical support in oncology, geriatrics, junior staffing levels in medical wards and a work schedule review for a senior trainee in neurology.

All exception reports have been completed. There remain some which are awaiting trainee agreement and medical HR continues to communicate with trainees to close the report when outcome is agreed.

b) Junior doctor's rota response to the COVID-19 pandemic

At CHFT pooled COVID rotas were created with effect from 13/4/20 to give adequate numbers of all training grade doctors to manage increased acute clinical activity and to facilitate flexible deployment in response to clinical intensity and unpredictable sickness and self-isolation absence. These rotas were fully compliant with EWTD and the 2016 TCS and built to facilitate sufficient rest. The only exception was the frequency of weekend working which was 1:2.5 rather than the 1:3 which is mandated from August 2020. The joint statement from the BMA and NHS Employers allowed for this in response to the first wave of the pandemic. With declining COVID-19 activity, gradual restoration of non-acute services at CHFT, a requirement of trainees to be redeployed back to their specialities and to enable trainees to take annual leave, a decision was taken to suspend the COVID-19 pooled rotas with effect from the 1st June 2020 and communication to that effect was sent out to the trainees. A few trainees raised multiple concerns during the transition back to the pre-COVID rota from June 2020. The main themes were annual leave carry-overs, payment for working extra hours on the COVID rota when compared to their peers and adequacy of rest days over the swap-over period. These were addressed collectively within the Trust and a comprehensive list of FAQs and responses was drafted by medical HR and circulated. No trainee suffered a financial loss as a result of this transition to and from the COVID rota.

All junior doctors in medicine were escalated to the phase 2 response rota in November. The rotas were designed by the trainees following their experience with the initial pandemic

wave in April. All rotas were compliant with the 2016 TCS. The escalation of trainees to this phase coincided with a similar escalation in the medical consultant rotas hence providing increased senior medical support during twilight hours and weekends.

The escalated FY1 Medicine rota commenced 9 November 2020 and was stood down from 22 March 2021.The escalated junior medicine rota (FY2/CT1/2) commenced 9th November 2020 and completed its full cycle on 22 March 2021. The ST3+ Level trainees commenced a 15-week cycle on 23rd November which completed 8 March 2021.

There were a small number of trainees that joined a 'parallel rota' for short period of time in February 2021 when the numbers exceeded the previous peak numbers. This 12 person rota was populated by junior trainees who volunteered to support and were sourced by colleagues from trauma and orthopaedics, general surgery and urology, paediatrics, obstetrics and gynaecology, ENT and ophthalmology. Two weeks' notice was given as per the agreement with the LNC and BMA in January. The rota was only in place for several days and those that joined it mirrored the duties of the FY1 already on duty on the Acute Floor so that they had support and a 'buddy' to work alongside. The rota was stood down as soon as Covid numbers started to reduce as a result of national lockdown measures

All the above rota changes were following junior doctor consultation and included trainees, SAS doctors and physician associates, Guardian of Safe Working, Director of Postgraduate Medicine, Divisional Directors and Medical HR. A Medical Workforce Staffing Group was set up in Jan'21 with the above stakeholders to formulate an ongoing junior doctor rota response to the pandemic.

c) Rota gaps and areas of concern (See Appendix 1)

Specialities with significant rota gaps are Emergency medicine, OBGYN, Paediatrics and Orthopaedics.

Emergency Medicine: There are notable gaps at the ST3+/speciality doctor grade due to maternity leave and recruitment. These are covered by locums and by moving staff across sites. The gaps are likely to persist and concerns have been raised in filling the ST3 rota from August'21. The directorate is looking at solutions. There is a 1.5wte vacancy at the FY2/GPST/CT1 grade which is being filled by a clinical fellow and locums when required.

Paediatrics: Gaps at SHO level covered by a long –term Trust doctor and permanent bank doctor. There may be further gaps at the GPST changeover in August. The directorate has advertised for a further ST1/FY3 post.

OBGYN: Significant vacancies at the registrar grade due to Deanery gaps and maternity leave. These are covered by a new speciality doctor and there is support for the trust SHO to step up to the registrar rota in the near future.

Trauma & Orthopaedics: There was a restructure of the junior establishment over Q1-Q2 2020 with the introduction of new GPST role within T&O. At the ST3+ grade there are 2 deanery gaps from April 2021. The Trust SHO is stepping up into 1 of the gaps, leaving 1 vacancy. However, that leaves 3 on-call SHO vacancies to be covered with ad hoc locum, which is becoming increasingly difficult to cover. ACPs have been pulled to assist with ICU and frailty from November'20 which leaves wards and on-calls covered by junior doctors only.

Surgery: There are a couple of registrar gaps in gen surgery and urology which are covered by locums for on-calls only. The vascular registrar post has been replaced by a SAS gen surgical post following the relocation of vascular services to BRI.

Medicine: A couple of ongoing gaps at the GPST level in geriatrics covered by a Trust doctor and an IMT gap in respiratory, covered by bank locums.

Ophthalmology: Resignation of a speciality doctor has led to loss of some clinical activity and locum cover for the on-call gap.

Anaesthetics: Anticipated HRI one registrar gap from April'21 with locum cover for on-calls only.

d) Work schedule reviews

Trauma and orthopaedics:

Following issues raised previously, registrar work schedules were revised to a new compliant rota prior to the new cohort starting in October 2021. The division will be reviewing this rota 6 monthly to coincide with the registrar rotations.

In Q3, an issue was raised by FY2 trainees in orthopaedics about expected attendance at the post-trauma ward round (PTWR) following a night shift. This would be exception reportable as it is beyond their contracted hours. This was escalated to the clinical director and sector tutor and it was clarified that the FY2 trainees do not need to attend the PTWR.

Stroke Medicine:

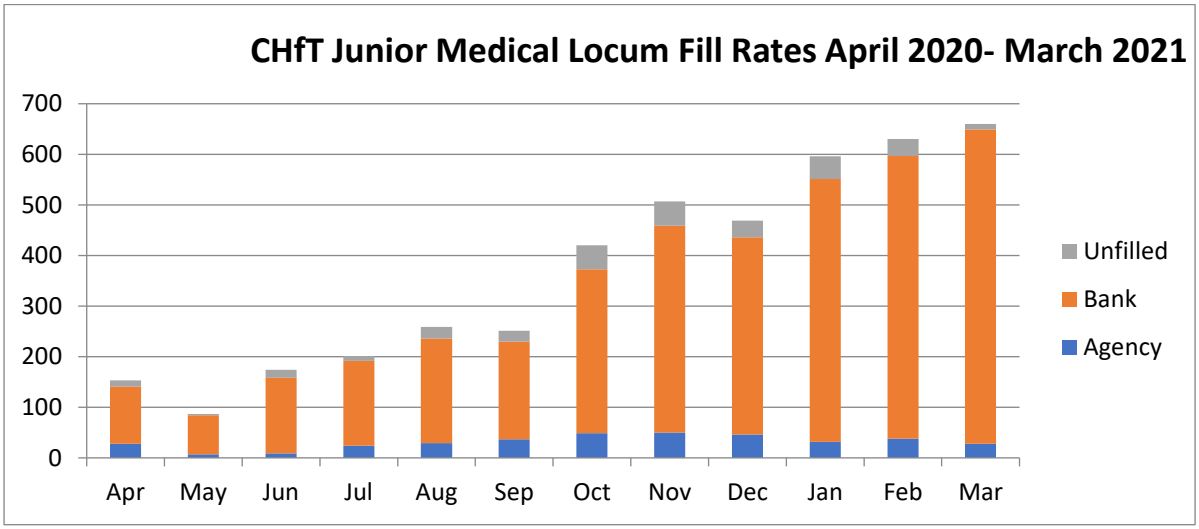
I had requested an FY2 work schedule review following a series of ERs submitted in Q3 due to attendance at the stroke and radiology meeting which was a mandatory teaching session. This has been resolved since.

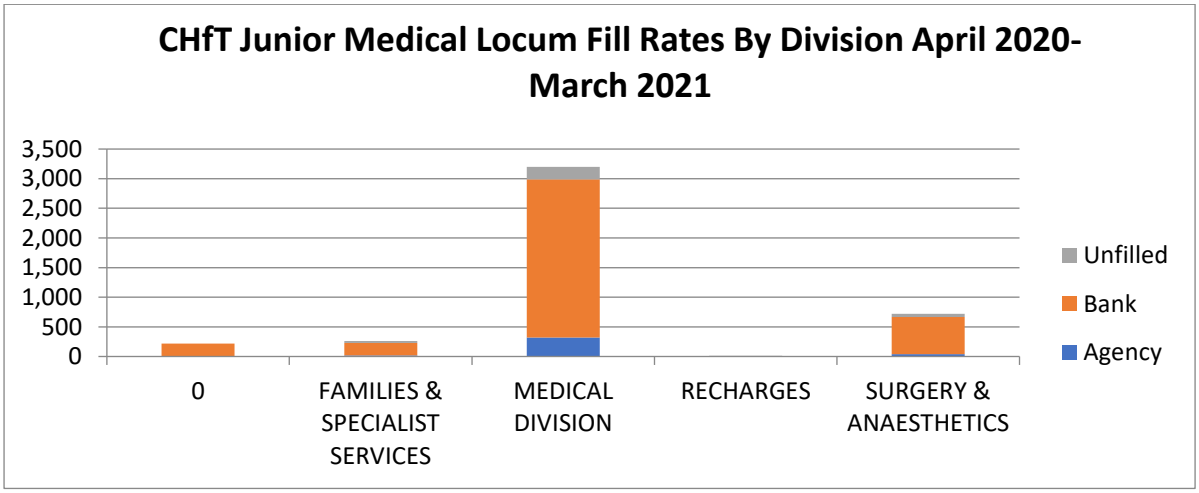
Neurology

ST4 had submitted ERs in Q2 as a result of inadequate rest during non-resident on-call. This was escalated to the clinical director as the supervisor was on leave and resolved by reviewing the work schedule to ensure adequate rest. There since has been a further ER

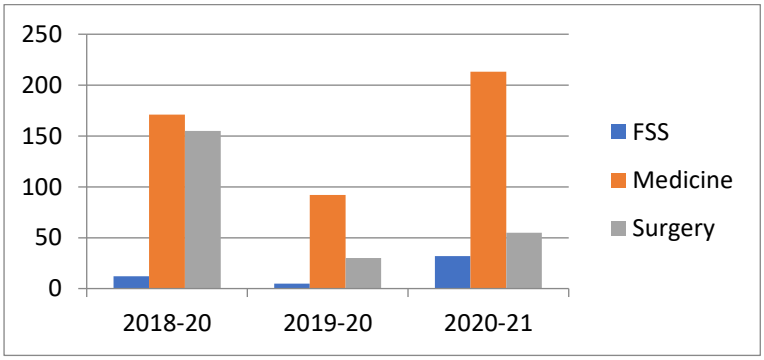
submitted in Q4 due to colleague absences and inadequate rest. The trainee was given subsequent TOIL.

e) Locum bookings





Unfilled locum shifts by division in the last three years



Compared to the previous years, the number of unfilled shifts has increased this year especially in medicine, where it has more than doubled compared to last year. This was mainly seen in Q3 and Q4 which is reflective of wave 2 and wave 3 of the COVID-19

pandemic which led to an increase in staff absences due to sickness and quarantine. Bank shifts have increased relative to agency locums across the divisions which is a positive trend. Better tracking of doctors hours is required when doing bank shifts as it is likely that locum hours will cause breaches in working time if done in addition to normal working hours. Doctors themselves have a responsibility and duty of care for regulating their own hours of working, in addition to the organisation.

f) Fines levied

No fines have been levied this year

g) Junior doctor forum (JDF)

There have been three JDFs held this year as the April meeting was cancelled in response to the first wave of the pandemic. Trainee engagement at the JDF has been better than previous years. The main issues discussed were:

i. Process to access post-shift rest facilities at CHFT was agreed and communicated
ii. A revised process for payment to junior doctors following compensation as a result of exception reporting was drafted by the GOSWH and agreed by medical HR and payroll. This
iii. The newly refurbished doctor's mess on both sites were opened. These facilities had a COVID-19 workplace based risk assessment and were made COVID secure. Each of these facilities included a quiet room for working with IT access.
iv. Lack of access to SDT by foundation trainees was escalated to the divisions and now all areas have rostered it in the work schedules.
v. After feedback from a trainee survey in Q2 and following discussions at JDF, there was improved communication with trainees over the continuing pandemic. There were daily operational medical staffing meetings, weekly medical workforce meetings & fortnightly junior doctor workforce briefings. These were open to all trainees and their representatives. At these meetings any relevant COVID-19 information was communicated and trainees could escalate staffing or other concerns in a timely manner.
vi. Extra laptops made available at each site (20/site) to assist in remote learning via on-line teaching. Additionally, there were areas identified on both sites where trainees could access teaching and IT equipment in a COVID-secure manner.
vii. The Trust has received a one-off payment of £10k to be used for wellbeing initiatives for trainees. Suggestions have been invited from members of the JDF and the trainee via their JDF representatives to agree on how this should be spent.

h) Improved Trust & Guardian engagement with trainees

The use of Microsoft teams, rapidly changing pandemic guidance, need for timely escalation of rota issues, and the need for a timely response to COVID-19 activity in the Trust led to improved engagement with colleagues across the Trust, including the junior doctor workforce.

There are monthly meetings with foundation trainees, workforce briefings with junior doctors, rota meetings, junior doctor's forum and ad hoc meeting with trainee representatives to escalate trainee concerns.

There has been trainee input into specific editorials in the CHFT weekly newsletter to share positive stories and experiences over the pandemic

In February & March 2021, the workforce team organised specific on-line 'Time for you' well-being sessions for all staff, some of which were tailored specifically for medical staff and junior doctors.

Medical HR has also organised monthly meetings with GP training programme directors and the GOSWH to discuss any issues relevant to GP trainees.

I have supported the involvement of trainee representatives in the Trust social distancing & catering work-streams and in improving medical colleague engagement within the Trust.

Along with the Trust colleague engagement advisor, the medical education department and speciality specific college tutors, we are in the process of drafting a junior doctor bulletin with input from trainee representatives.

A couple of JD representatives raised issues to improve junior doctor working lives at CHFT to me directly. These included the trust shuttle bus timings, installation of phones in the doctor's offices, repair of PCs & improved changing room and locker facilities at CRH. This was discussed and supported at the Trust COVID-19 Incident management meeting. There has been progress with these issues and majority are resolved now.

i) Junior doctor awards, CHFT

CHFT's Got Medical Talent 2020 awards were held virtually on 23rd July as part of the Medical Staff Forum weekly COVID-19 update. We received 85 nominations across six categories and we also had 7 highly recommended nominations. The awards were presented by our Medical Director.

The event was a great success and I received extremely positive feedback from our trainees about working at CHFT and how valued they felt as a result of these awards.

The awards for this year are planned again as a virtual event in May 2021.

j) **Trainee Doctors Exceptions Reports EQIA** (Appendix 2)

The junior doctor workforce is highly mobile and constantly changes within the Trust which means that monitoring needs to be regularly reviewed. The exception reports submitted by our junior doctors during this year have been split by ethnicity, gender and disability.

Ethnicity

White colleagues were more likely to have exceptions reported than their BAME counterparts, with 54.55% of exceptions compared to the makeup of junior doctors at 48.00%. There are proportionally more BAME colleagues in the trainee doctor group than the overall Trust (47.20% compared to 18.28%).

Gender

Male colleagues were more likely to have exceptions reported than their Female counterparts, with 50.41% of exceptions compared to the makeup of junior doctors at 43.60%. There are proportionally more Male colleagues in the trainee doctors group than the overall Trust (43.60% compared to 18.03%).

Disability

Proportionally, trainee doctors that did not declare a disability were more likely to have exceptions reported, with 31.40% of exceptions coming from colleagues that did not declare. This is higher than the makeup of trainee doctors where 24.00% did not declare a disability.

Overall there are proportionally less trainee doctors declaring a disability than the rest of the Trust. 3.72% of the Trust declared a disability compared to 2.00% of trainee doctors.

The above analysis of exception reporting data has highlighted differences in ethnicity, gender and disability when compared to the makeup of the junior doctor workforce. These findings will be escalated to the equality groups (BAME, CDAG, LGBTQ) and the guardian will report on any further actions.

k) Support for the GOSWH role at CHFT

Amount of time available in job plan for GOSWH	1 PA/week
Admin support provided to the guardian	provided by medical HR (adhoc)
Amount of job-planned time for educational supervisors:	0.125 PA per trainee
Amount of job-planned time for clinical supervisors:	None

Summary

During the COVID-19 pandemic there has been significant disruption to the training of junior doctors with the cancellation of rotations, reduction in training opportunities and impact on trainee wellbeing. Our junior doctor workforce has worked tirelessly. They should be commended for their commitment to patient safety and their willingness to be flexible during these extraordinary times. The junior doctor rota responses were widely consulted with the relevant stakeholders, adequate notice was given to the trainees and trainee

concerns were clarified in meetings and via a series of FAQs to support the transition between rotas. Feedback from our trainees from the initial COVID surge was considered for phase 2 COVID planning.

Whilst there remain significant rota gaps in emergency medicine, OBGYN and paediatrics, minimal staffing is being managed by locums (mainly bank) and other staff grades like ACPs and Trust grade doctors. There has been significant increase in the number of unfilled shifts in the medical division compared to the previous year. This is seen by the high number of ERs submitted in Q3 and Q4 which reflect the increased workload, mainly in the medical division due to increasing COVID-19 activity, increased patient acuity and decreased staffing seen because of increased colleague absences.

There has been improved engagement by the Trust and GOSWH with the junior doctor workforce last year which has received positive feedback at the JDF.

Recommendation

The Trust Board is requested to receive and note the Guardian of Safe Working Hour's annual report for 2020-21

Anu Rajgopal
Guardian of safe working hours
April 2021

Appendix 1: Rota Gaps

Grade	Speciality	Number of Gaps	Reason for gap	Cover arrangements	Vacancy period	Any anticipated concerns
MEDICINE						
FY1	Acute	1	Training Gap	Bank Cover	Aug-Dec 20	
IMT	Gastro	1	Training Gap	Bank Cover	Aug-Dec 20	IMT Gap for the year
Reg	Respiratory	1	Training Gap	Bank Cover	Aug-Sept 20	
FY1	Elderly	1	Shielding	Bank Cover	Aug-Dec 20	
FY1	Elderly	1	Training Gap	Bank Cover	Dec-April 21	
FY2 on-call gap only	Onc/Haem	1	Health Reasons	Bank Cover	Dec-April 21	
IMT	Gastro	1	Training Gap	Bank Cover	Dec-April 21	IMT Gap for the year
FY1	Respiratory	1	Training Gap	Bank Cover	Dec-April 21	
FY1	FY1	1	Training Gap	Bank Cover	Dec-Jan 21	
IMT	Cardiology	1	Training Gap	Bank Cover	Dec-Feb 21	
FY2	Stroke	1	Training Gap	Bank Cover	Dec-April 21	
FY1	Stroke	1	Training Gap	Bank Cover	Dec-April 21	
FY1	Elderly	1	Training Gap	Bank Cover	April-Aug 21	
GPST	Elderly	1	Left the scheme	Trust Doctor	April-Aug 21	
GPST	Elderly	1	Left the scheme	Trust Doctor	April-Aug 21	
IMT	Respiratory	1	Training Gap	Bank Cover	Apr-Aug 21	IMT Gap for the year
EMERGENCY MEDICINE						
ST3/FY3	A&E	10	Unable to recruit/Deanery gaps/LTFT trainees	Locums if needed	April 2020–Aug 2020	
ST3	A&E	3.5	1 Mat leave, 3 LTFT, 1 Gap	Locums and backfill from ST4 rota when possible. Gaps reduced to 3 at beginning Dec.	Aug 2020-Feb 2021	
ST3	A&E	4.5	3 LTFT, 3 Gaps	Locums and backfill from ST4 rota when possible.	Feb 2021-Aug 2021	Vacancies from Aug'21.
FY1	A&E	0.4	LTFT trainee	Locums if needed	Aug-Dec 2020	None
ST4+/Speciality Doctor	A&E	5.5	Unable to recruit/Deanery gaps	Locums if needed	April 2020-Sept 2020	
ST4+/Speciality Doctor	A&E	3.2	Unable to recruit/Deanery gaps	Locums if needed	Sept 2020-Nov 2020	
ST4+/Speciality Doctor	A&E	3.6	Unable to recruit/Deanery gaps	Locums if needed	Nov 2020-present	Mat leave vacancies
FY2/GPST/CT1	A&E	1.5	2 trust doctors left in Feb	Locums if needed	Feb 2021-Aug 2021	none
SURGERY						
ST3+	Urology	1	Deanery gap	Bank/Agency locum cover for on-calls only	April 2020-March 2021	
ST3+	Urology	40% gap	LTFT Deanery trainee	Bank/Agency locum cover On calls only	Oct 2020-Oct 2021	
FY1	Urology	1	FY1 shielding	Bank/Agency locum cover on calls only	Dec 2020 – April 2021	
CT1-2	Urology	1	Deanery gap	Bank/Agency locum cover on calls only	Feb 2020-Aug 2020	

Grade	Speciality	Number of Gaps	Reason for gap	Cover arrangements	Vacancy period	Any anticipated concerns
FY1	Vasc	1	Deanery gap	Bank/Agency locum cover on calls only	Aug 2020-Dec 2020	
ST3+	Vasc	1	Vasc Trainee, service moved BRI		Oct 2020–Oct 2021	Converted to Gen surg SAS post
ST3+	ENT	1	Deanery gap	Bank/Agency locum cover on calls only	April 2020-Oct 2020	
ST3+	Gen surgery	1	Deanery gap - OOP	Bank/Agency locum cover on calls only	Jan 2021-April 2021	
ST3+	Gen surgery	1	Deanery gap - OOP	Bank/Agency locum cover on calls only	Feb 2021-April 2021	
ANAESTHETICS						
SAS, ST3+	HRI 2nd on call rota	1	Vacancy	Extras/bank staff	April 2021 -	From May 2021 there will be gap
SAS	CRH 2nd on call rota	0.5	SAS doctor not covering any night shifts	Extras	April – present	
PAEDIATRICS						
SHO	Paeds	2 WTE	LTFT trainee and long term sickness	trust Dr & a permanent bank doctor,	April 20-Aug 21	GPST change over in August,
Reg	Paeds	0.8 WTE	LTFT trainees	Trust doctor (covers 60% of the gap), rest covered by bank and agency	March 20-Aug 21	None till sept'21
OBSTETRICS & GYNAECOLOGY						
SHO	O&G	0 WTE		Trust SHO picks up any gaps	Aug 2020 – Sep 2021	.
ST3 +	O&G	4 WTE	Deanery gaps and maternity leave	New speciality doctor employed & Trust SHO to step up	Aug 2020-Ongoing	2 mat leave gaps from Oct'21.
TRAUMA & ORTHOPAEDICS						
CT	T&O	1 WTE	Deanery gap	Nil.	Apr 2020 – Aug 2020	Restructure of JD rota
Trust doctor	T&O	2 WTE	Trust gap	Nil.	Apr 2020 – Aug 2020	Restructure with 2 new appointments
Trust doctor	T&O	1 WTE	Trust gap	ACP's assisting with ward cover, on-call vacancies to be covered with locum.	Aug 2020 – Sep 2020	2 new starters over Aug and Sept'20
ST3 +	T&O	1 WTE	Deanery gap	Junior trust doctor to step up into Reg vacancy in Feb'21.	Oct 2020 – Apr 2021	2 deanery gaps from April 2021. On-calls covered by locums
	T&O				November – Ongoing.	ACPs pulled to assist with ICU and frailty from November. Leaves wards and on-calls covered by junior doctors only.

Grade	Speciality	Number of Gaps	Reason for gap	Cover arrangements	Vacancy period	Any anticipated concerns
CT	T&O	1 WTE	Deanery gap	On-calls and daytime ward cover to be filled with locum.	Feb 2021 – Aug 2021	3 on-call vacancies to be covered with locums
FY2	T&O	0.4 WTE	0.6 WTE LTFT Foundation trainee	Shortfalls for the remaining 0.4 WTE to be covered with locum.	Apr 2021 – Aug 2021	3.4 WTE vacancies on the on-call rota covered by locums.
OPHTHALMOLOGY						
SAS	Ophthal	1 WTE	Specialty doctor resignation	On-call vacancies to be covered with ad hoc locum.	March 2021 – Ongoing.	Locum cover required to backfill on-calls and loss in clinical activity due to resignation of specialty doctor.

Appendix 2: EQIA data analysis for exception reports submitted

Ethnicity	Exceptions	Trainee Doctors	Trust
White	54.55%	48.00%	77.13%
BAME	43.80%	47.20%	18.28%
Unknown	1.65%	4.80%	4.58%

Gender	Exceptions	Trainee Doctors	Trust
Female	49.59%	56.40%	81.97%
Male	50.41%	43.60%	18.03%

Disability	Exceptions	Trainee Doctors	Trust
No	64.66%	74.00%	91.26%
Yes	3.31%	2.00%	3.74%
Not Declared	31.40%	24.00%	4.02%
Unspecified	0.83%	0.00%	0.92%
Prefer Not to Answer	0.00%	0.00%	0.05%

2. CHS Managing Directors Report - April 2021

Calderdale & Huddersfield Solutions Limited (CHS)

MANAGING DIRECTOR'S SHAREHOLDERS REPORT

APRIL 2021

Calderdale and Huddersfield Solutions Ltd
Huddersfield Royal Infirmary · Trust Headquarters ·
Acre Street · Huddersfield · HD3 3EA
Web: www.chs-limited.co.uk
Company registration number 11258001 · VAT number 293 0609 00

1.0 Company Update

Verbal Update

2.0 Service updates

2.1. Estates

2.1.1 Capital Development / Backlog

The Trust / CHS recently received monies addressing Capital Infrastructure Risk increasing the back-log maintenance to £4.6m. This includes demolition of the old nurses' home and learning centre subsequently reducing the back-log maintenance cost at HRI.

The team are now working with the procured principal supply chain partner (PSCP) Integrated Health Partnership (IHP) on all projects across HRI.

The Learning Centre reprovision has been approved for the sub basement floor at HRI and the scheme is currently out to tender with an anticipated start date of Mid May on a 12 week construction programme.

The de-commissiong of the existing Learning Centre and Nurses Home is ongoing with asbestos removal and soft strip currently taking place. The project is due for completion in November 21.

2.1.2 Community

Work to rationalise the estate footprint adjacent to HRI is now coming to an end. The disposal of 62 Acre Street is the last identified disposal. Heads of terms are currently being negotiated with Assura who are working alongside Lindley GP & Greater Huddersfield CCG to develop a new GP Practice on the site.

2.1.3 LED Scheme

The LED scheme continues to progress at HRI albeit with challenges around timescales and delivery. The HRI programme has commenced however now with CV-19 delays with programme end date forecast for Spring 2021.

2.1.4 Fire Safety

Fire safety remains an area of focus at HRI. A draft copy of the HRI technical external audit by Motts has landed from which the Fire officer and Head of Estates are feeding back comments / queries.
The fire property review has now returned in draft which highlighted and overall level of good in terms of compliance albeit with actions to progress to excellent.
The actions are around, community fire door remediation, HRI 30 min compartmentation, fire plans and signage.
A draft trust Fire Strategy is now in circulation for comments and approval.

2.1.5 Portland Stone

The Portland stone cladding panels and windows remain a short and long-term risk at HRI, on-going maintenance and remediation continues to address the immediate risk, CHS estates are undertaking a process of due diligence to resolve the longer-term solution / replacement. This option includes over cladding the existing façade. Precedence has been set at Bristol

Royal Infirmary while Aintree Hospital is currently completing the design stage and about to begin construction. Several “Go See” visits are being organised for members of the Trust to attend.

The Capital plan increase will begin to look at Pre-design investigations into the suitability of an over cladding solution. This will take place within Q4 of the Financial Year.

Risk Mitigation

To mitigate the risk of falling stone panels a 6-month survey is conducted by structural engineers BWB to assess the condition and movement.

Recent Nov 2020 Survey Previous position in May 2020

CLADDING CONDITION SUMMARY

Elevation	Total score on matrix(NHS Estates codes) A	B	C	D	Total No panels
1	0	724	88	0	812
2	0	188	23	0	211
3	0	416	69	0	485
4	0	186	25	0	211
5	0	544	33	0	577
6	0	185	46	0	231
7	0	443	5	0	448
8	0	148	8	0	156
9	0	70	46	0	116
10	0	396	58	0	454
11	0	528	30	0	558
12	0	117	104	0	221
13	0	194	37	0	231
14	0	197	43	0	240
15	0	174	25	0	199
16	0	413	71	0	484
17	0	764	94	0	858
18	0	312	23	0	335
19	0	446	254	0	700
20	0	70	22	0	92
21	0	908	68	0	976
22	0	424	76	1	501
23	0	377	27	0	404
24	0	22	0	0	22
25	0	56	1	0	57
26	0	65	3	0	68
27	0	158	7	0	165
28	0	178	0	0	178
29	0	171	4	0	175
30	0	167	12	0	179
31	0	659	70	0	729
32	0	409	15	0	424
33	0	67	0	0	67
34	0	104	6	0	110
35	0	64	4	0	68
36	0	540	34	0	574
TOTAL	0	10690	1394	1	11952

Table 1: Summary of cladding condition

CLADDING CONDITION SUMMARY

Elevation	Total score on matrix(NHS Estates codes) A	B	C	D	Total No panels
1	0	685	68	0	753
2	0	154	21	0	175
3	0	113	62	1	176
4	0	153	20	2	175
5	0	550	28	1	579
6	0	208	47	0	255
7	0	448	0	0	448
8	0	149	7	0	156
9	0	70	46	0	116
10	0	396	58	0	454
11	0	528	30	0	558
12	0	117	104	0	221
13	0	193	37	0	230
14	0	197	43	0	240
15	0	174	25	0	199
16	0	437	41	6	484
17*	0	765	93	0	858
18	0	317	18	0	335
19	0	446	254	0	700
20	0	70	22	0	92
21	0	908	63	5	976
22	0	425	73	3	501
23	0	377	27	0	404
24	0	22	0	0	22
25	0	56	1	0	57
26	0	65	3	0	68
27	0	158	7	0	165
28	0	178	0	0	178
29	0	171	4	0	175
30	0	167	12	0	179
31	0	659	64	6	729
32	0	408	16	0	424
33	0	67	0	0	67
34	0	104	6	0	110
35	0	64	4	0	68
36	0	540	34	0	574
	0	10346	1301	24	11901

Table 3.3.1: Appendix A -Summary of cladding condition

As can be seen from the table above there is 1 stone cladding panel that has been classified as being significant enough to be classified as being D rating condition i.e. requiring immediate attention as soon as is practically possible.

In total there are 1394 panels or 11.66% that are classified as C condition rating utilising the NHS estates codes that are showing “significant signs of deterioration”. This could be due to the presence of any number of the following defects that require remediation repairs:

• exhibiting signs of minor movement.

• heavy water staining and missing grout,
• hairline cracks present to the face of the stone,
• damaged stone cladding panel
• several open drill holes to stone from historical scaffold fixings that have not been filled etc.
• exhibiting signs of minor movement.

2.1.6 Oxygen
The oxygen infrastructure became critical during the CV-19 peak in particular monitoring of the Vacuum Insulated Evaporator (VIE). Monitoring became twice daily and improvements were made during the peak which ensured the VIE operated as efficiently as possible. Demand peaked to 40% of the overall capacity during the first wave. We are now reporting on less than 18% which is near normal levels.

2.1.7 Ventilation
During the pandemic here has been a focus on ventilation air change rates across health care premises in the management of aerosol generating procedures (AGPs). The resulting work is to ascertain the air change rate per hour (ACH) for every area where patient care may take place across the Trust to assist the Trust in decision making. This work is now complete for HRI. A paper exploring the mitigations and subsequent advice was presented and approved by IMT in February.

2.1.8 ED Development
The new ED development at HRI has now been passed over to estates to run as a P22 scheme. The capital development team are working with Lendlease Consulting who are providing PM & QS services. The scheme is currently working towards RIBA stage 3 (spatial coordination). The team are working on the cost plan and stakeholder engagement.

2.2. Medical Engineering & Decontamination Service

2.2.1 Asset Tracking
Asset tracking system rollout complete in support of the COVID effort and it is working well, this is now being expanded to enable Wards/Departments to better manage their assets, by grouping them into Ward/Department areas from the Favourites menu. Throughout the next year suitable assets will be tagged and added to each area as identified.

2.2.2 Active Temperature Monitoring
Medical Engineering have deployed the active temperature monitoring tags Trust wide, as a soft roll out communications and training are being prepared, we are waiting for the upgrade to the Temperature monitoring system before the SOP and “Go Live” date is agreed.

2.2.3 Training Development
Medical Engineering Training team continue to develop alternative training resources and methods of training delivery in order to adapt to the ever-changing situation, essential to keep up with demand and expand the Digital Training Catalogue.

2.2.4 New Location for Medical Engineering
Expansion of Medical Engineering & Decontamination Service accommodation at HRI in order to facilitate social distancing and working differently under COVID and in the future, is in the planning phase with Estates, the first draft plans have been received, this will be essential to the continuation of service delivery for the Medical Device Training team, with the Learning Centre no longer being available. The Training Team have already made use of part of this

space to deliver urgently needed training to staff. Still awaiting fully costed plans from Estates Department.

2.2.5 Contract Management
Administrative team continue progressing well with contract renewals ahead increasing compliance levels, also managing the maintenance programme for Community Division.

2.2.6 Decontamination and Repair of Mattresses
SOP for new "in house" decontamination and repair process is being written, with Facilities Team to deliver this service, while maintaining support from current provider until staff have been recruited and trained to support this service.

2.2.7 KPI compliance
We have maintained Green compliance for all High-Risk devices but have been unable to do this for Medium and Low Risk device due to lack of staff, as we didn't have recurrent funding to retain the temporary staff, they left to take up permanent positions elsewhere.

2.2.8 Vacancy
In the coming month the following posts will be advertised:

- Grade E Medical Engineer.
- Grade D Apprentice Medical Engineer NVQ Level 4 (3-year apprenticeship) x 2.
- Grade B Apprentice Administrative assistant.
- Grade TBC Decontamination Manager.

2.2.9 Student Placements
The two student placements from Bradford University who have been working with us over the past year, Hasnain Mir and Ammad Mahmood are due to finish their placement in June and have progressed well, this will be offered to the University again for the Clinical Technologist students who will be looking for their placement positions in the Autumn.

2.2.10 Replacement of Patient Monitoring
The upcoming replacement of the Patient monitoring for the following areas on both sites:

- ICU
- ICU Central station
- Theatres
- Induction rooms
- Recovery
- NICU
- A&E

This will be replacing the existing Philips MP70, Fakuda, Mindray & Philips X2 transport monitors with the Fixed installation of GE B450, B650, B850 & Carescape 1 transport monitor, enabling the transfer pathway between all included areas utilising the same monitoring without changing leads. A working group has been set up with all departments represented to ensure as smooth a transition as possible with a target date for Theatres of July. The new system also has the potential to be integrated into our EPR system and is on the Cerner approved Careaware list, which can be explored under the S4S program.

2.3. Facilities

2.3.1 Covid Support

Facilities services have been able to step down some of the additional services which we have been providing over the past 12 months. Where support is still required, variations have been raised and timeframes agreed
Shielders have returned to work which has helped significantly

2.3.2 Laundry Tender

The laundry tender process is now well underway and legal representation has been sought to prevent challenges from either one of the companies who have shown an interest

2.3.3 Retail catering

DSFS have now submitted a draft business case to CHS who are in the process of reviewing and amending as necessary. Compass are now aware that the preferred option of the Trust is that the contract be brought back in house and that CHS will be the provider as of 1 November 2021. Handover meetings will commence once the full business case has been presented at board level

2.3.4 Transport services – Operators licence

The operators licence has been applied for and underway. Everything is satisfactory so far with the only requirement being that the shuttle buses have a dedicated space, with bays, available to them. The transport manager is working with Estates to arrange

2.3.5 Equipment service audit and review

The Calderdale local authority recently carried out an audit on the equipment service, which resulted in the highest score achievable, with no recommendations. It is now 2 years since a full equipment review was carried out by the local authority, which resulted in a new IT system and several actions. CHS was challenged at that point to demonstrate over these last 2 years that we are value for money as well as being effective. A review will take place in May to assess whether or not the service has been successful in achieving what has been asked, or whether the service will be outsourced by the council.

2.3.6 Vehicle fleet

CHS now has a new vehicle fleet which is a mixture of Hybrid and electric. The shuttles are still being built and will be with us towards the end of the year

2.3.7 Switchboard upgrade

CHS saw an upgrade to switchboard server at the beginning of April following several instances of the switchboard system failing. Further upgrades of the software is expected to take place on 27 April.

2.4. Procurement

2.4.1 Materials Management

Although the risk of obtaining PPE stock has reduced, the demand on the team is constant and will remain in place until March 2022 when the provision of free PPE ceases. The PPE Group is planning to stand down over the next month with the recommendations amongst others to IMT that we have a robust supply chain of PPE & QA process. We have scored 100% every week since January in the PPE quality audit where every clinical area visited had the

correct levels of PPE. Recent national guidelines to accompany Phase 2 out of lockdown has also meant we have had to adapt to further demands of PPE provision to ensure safety.
The management and daily distribution of the Lateral Flow (Covid) Tests remains with some staff requesting their second tests but plenty more new staff have requested these tests. There is an issue with significant quantities of tests disappearing so working with ISS & Estates to make the stock holding areas more secure.
Finally, high level plans are being worked through to resource the WYAAT Scan4Safety inventory management system – tentative go live is Sept. This will mean an increase in staff and scope for development opportunities within the team as we progress through the implementation to delivery.

2.4.2 Category Management

All vacancies successfully recruited which included 2 internal promotions. External appointments expected to commence mid May following all relevant checks. End of year spend was extremely hectic with a significant number of 'surprises' and although all activity was delivered and made compliant improved planning will be a focus for 2021/2 As BAU activity begins to return focus is now being put on contract areas which were extended or rolled forward during COVID.

2.4.3 Operational Procurement

The team have engaged with stakeholders to complete a large number of procurement processes in short timeframes relating to year end spend and have managed this effectively. The team continue to work alongside Accounts Payable to reduce outstanding invoice queries and have participated in housekeeping exercises to reduce unnecessary accruals prior to financial year end close down. There is a current focus around updating catalogue data due to large numbers of supplier price updates from 1st April as this also feeds into other areas such as Scan4Safety. The Scan4Safety project continues to progress, we are currently undertaking a review of catalogue data in collaboration with LTH and preparation for Inventory Management continues.

3.0 CHS

3.1. Spotlight Awards

Matthew Boothroyd works in the stores and Chris Allen is an equipment technician. They were nominated by a district nurse, who emailed the Equipment Manager to say “I just wanted to bring to your attention the outstanding commitment that the Loans Store team showed last week with regards to one of our palliative patients.

We have a very young gentleman on who had taken a sudden dip in health and was now being treated as end of life. Equipment was ordered in the usual way as this man was sleeping on the couch.

I contacted Andy to see if he could help me get this done sooner and he arranged for 2 of his staff to go up that afternoon and the bed was delivered within an hour of me phoning him. In order for this to happen one of his drivers sacrificed their health and wellbeing time to enable this to happen which to me shows true compassion.

I just wanted to make you aware of this story as all too often we hear complaints but I feel that we also need be more confident in calling out best practice too.

David Nott David commenced work CHS in November and has become an integral part of the catering team, his caring, compassionate and empathetic approach to patients, especially elderly at ward level, has been recognised by not just us but by ward staff as well. The following email was sent to the head of catering by Amy Emerson, Development Sister on Ward 20, HRI:
"I just wanted to pass on how impressed I was with one of your workers "David Nott". It was lovely to see how he approached the patients on ward 20, he actually took time to ask them what they wanted, and he did not stand over them he bent/knelt down to their level. He had a lovely way when talking to the patients and came across very compassionate and was happy to repeat himself if required. Just thought I would pass this on."

3.2. Finance

In Month Period 12

The in month position shows a £0.38m deficit against a plan of £0.07m with a £0.45m adverse variance. This position results from the over recovery of income (£5.82m) due to an increase in the goods and services being transacted through the company offset by an overspend on pay (£0.10m) (adverse to plan). Pay is overspent by £0.10m due to additional staffing resources required to deliver services in response to COVID 19 and the inclusion of a pay accrual for annual leave carried forward into 2020/21 this is offset by vacancies in Senior Positions. Non pay is overspent by £6.30m due to an increase in goods and services being transacted through the company the majority of which relates to capital. The charitable donation of £0.50m from non-pay to CHFT approved by CHS Board further deteriorates the surplus in month.

Year End

The year-end position is £0.15m surplus against a plan of £0.73m with a £0.58m adverse variance. The adverse variance of £0.58m results from the over recovery of income (£17.54m)

due to additional goods and services being transacted through the company offset by additional expenditure on pay (£0.40m adverse to plan) and non-pay(£17.97m adverse to plan)

Pay is overspent by £0.40m due to additional staffing resources required to deliver services in response to COVID 19 this is offset by vacancies in Senior Positions. Non pay is overspent by £17.97m due to additional goods and services being transacted t through the company the majority of which relates to capital. The £0.58m adverse to plan is a result of the £0.5m charitable donation to CHFT approved by CHS Board in March and deterioration in commercial income from the Compass Contract.

CIP

The CIP for the year was delivered with a favourable position of £6k at the end of the financial year. CIP of £761k has been achieved of which £432k is recurrent. The slippage in recurrent schemes has been offset with non-recurrent savings in B Braun due to reduced theatre activity and senior staff vacancies.

3.3. Workforce

3.3.1 Attendance

CHS Sickness rate for March is 3.77% comprising LTS 2.79% and STS 0.99%.
This compares well with absence in March 2020 was almost 6%.
This reduction is pleasing to note and a significant achievement from colleagues, particularly at the current time.
Stress and Anxiety and Chest/Respiratory infections are the main reason for absence at 23% in each. This is replicated as the top reasons for absence within CHFT.
As soon as circumstances permit it is hoped to increase access to mental health training across CHS by conducting our own sessions, following some 'train the trainer' courses that are currently being sourced.
We welcomed back 18 Clinically Extremely Vulnerable colleagues (CEV) who have been shielding on 1 April 2021, to low-risk areas with support in place to re-integrate into the workplace.

3.3.2 Appraisal and Essential Skills Training

Appraisal and EST KPI's are both excellent at 97%+ and 95% + respectively.

3.3.3 Recruitment

The Deputy Head of Procurement post has been recruited to. Cheryl Gibbons has been appointed and will commence duty on 17 May 2021.
Tom Donaghey an internal colleague has been appointed to the Head of Estates post and is currently undertaking handover with Chris Davies who leaves to take up post as Deputy Director of Estates and Facilities at Bradford Hospitals NHS Trust. Chris's last working day with CHS is 7 May 2021.

3.3.4 Staff Survey

CHS overall response rate is 50% *(212 respondents from an eligible sample of 425 staff),* which is an improvement on last year's rate of 47%.
Results show some good improvement with an increase in our overall engagement score from 6.7 to 7.1 for 2020. An action plan is being developed to look at areas and responses that need special attention.

3.3.5 Customer Service/Values and Behaviours Training
The above face to face training has been developed and is being delivered weekly across the Company in response to staff survey feedback that our staff are not always treated with respect by other colleagues. Whilst only small numbers are allowed in the sessions, due to covid restrictions, these have been well received and will roll out over the next 12 months, with on-line team sessions being available further down the line.

3.3.6 Vaccination position
79.5% of colleagues have received their first vaccination with 59.6% having had both doses.

4.0 KPIs

We continue to deliver a large number of KPIs as 'green', 4 KPIs (from a total of 68) did not achieve Green in March 2021, which were:

Porters - Immediate response time jobs – Red at 77.21%, against a target of over 95%
General Office – Medical Certificates completed appt made with registrar's within 5 days – Red. This was a total of 17 not achieving from a total 91, reasoning beyond CHS control and issues stand with coroners and registrars
Medical Engineering – Medium Risk PPMs – Red 56.99% against a target of over over 70%
Medical Engineering – Low Risk PPMs – Amber 58.36% against a target of over 60%
Issues in regards to increased reactive repairs due to increased purchases and extra national loan kit which are being kept

5.0 Risks

An overview of CHS high level risk register is included within Appendix 1.

The very high / high risks that CHS seek to manage and mitigate are:

- HRI Estates failing to meet minimum condition due to age and condition of the building (20)
- Resus – Collective risk to maintain compliance / upgrade (20)
- ICU – Collective risk to maintain compliance / upgrade (20)
- Medical Engineering - There is a risk of equipment failure from Medical Devices on the current trust asset list (20)
- Fire safety due to breaches in compartmentation, and a lack of compartmentation in some areas, and enough staff trained in fire safety awareness and as fire wardens (in CHFT) (15)
- The façade of HRI (15).

6.0 Recommendation

Shareholders are asked to note the contents of the report.

APPENDIX 1

Risk Register C H Solutions – April 2021

C H Solutions	Number of Risks	Change in Month
Burgundy Very Hi Risks	4	0
Red Risks High	2	0
Amber Risks Moderate	26	+3
Green Risks Low	12	0
Total	47	+3

Risk ref + score	Strategic Objective	Risk	Executive Lead	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	April 21
CHS Risk 6903 (CHFT 7444 (12)	Keeping the base safe	Resus – Collective risk to maintain compliance / upgrade	Managing Director (SS) General Manager Estates (CD)	=20	=20	=20	=20	=20	=20
CHS Risk 7271 (CHFT 7442 (12)	Keeping the base safe	ICU – Collective risk to maintain compliance / upgrade	Managing Director (SS) General Manager Estates (CD)	=20	=20	=20	=20	=20	=20
CHS Risk 5806	Keeping the base safe	Overall condition of the building –There is a risk to areas due to the age, environment and condition of the HRI building.	Managing Director (SS) General Manager Estates (CD)	=20	=20	=20	=20	=20	=20
CHS Risk 7438 (CHFT 7474 (15)	Keeping the base safe	There is a risk of equipment failure from Medical Devices on the current trust asset list of 19,456 Medical Devices due to a very large number (n=5359) of High Risk devices (n=837), Medium and Low Risk devices which are out of service date and have not been seen for extended periods of time.	Manager Director (SS) Head of Medical Engineering (RR)	=16	=16	=20	=20	=20	=20
CHS Risk 7318 (CHFT 7414 (15)	Keeping the base safe	There is a risk to life and building due to the failed / heavily corroded metal ties that hold back the Portland Stone cladding at HRI, particularly Ward Black 1 South Elevation potentially resulting in falling Stone debris.	Managing Director (SS) General Manager Estates (CD)	=15	=15	=15	=15	=15	=15
CHS Risk 5511 (CHFT 7413 (15)	Keeping the base safe	Collective Fire Risk – There is a risk of increased fire spread and delayed evacuation at HRI	Managing Director (SS) General Manager Estates (CD)	=15	=15	=15	=15	=15	=15

The Risk Register has been noted by CHS Board

3. Scheme of Delegation

UNIQUE IDENTIFIER NO: G-3-2010
Review Date: January 2023
Review Lead: Finance Director

Calderdale and Huddersfield
NHS Foundation Trust

SCHEME OF DELEGATION
AND
RESERVATION OF POWERS TO THE BOARD

FOR

Calderdale and Huddersfield NHS Foundation Trust

(Reviewed January 2021)

Document Summary Table		
Unique Identifier Number	G-3-2010	
Status	Approved	
Version	4	
Implementation Date	April 2010	
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Next Formal Review	January 2023	
Sponsor	Director of Finance	
Author	Company Secretary	
Where available	Intranet	
Target audience	All staff	
Ratifying Committee		
Executive Board		
Consultation Committees		
Committee Name	**Committee Chair**	**Date**
Audit and Risk Committee	Andy Nelson	26 January 2021
Trust Board	Philip Lewer	6 May 2021 tbc
Other Stakeholders Consulted		
Deputy Director of Finance		

Does this document map to other Regulator requirements?	
NHS England / Improvement	*NHS Foundation Trust Code of Governance*

Document Version Control	
Version no	*Details of review/alterations, rational for document etc*
2	Update to align with revised Standing Financial Instructions and Director lead changes Addition of scheme of delegation for Mental Health Act 1983
3	Updates to respond to Covid-19 pandemic, non-material job title / organisational title changes
4	Routine review including incorporation of Covid-19 arrangements until further notice

CONTENTS

1.0 INTRODUCTION

This Scheme of Delegation (SoD) details administrative practice and procedure and records the delegations and reservations of powers and functions adopted by the Calderdale and Huddersfield NHS Foundation Trust (referred to as the "Trust"). They should be used in conjunction with the *Constitution* and the *Standing Financial Instructions* which have been adopted by the Trust. The Trust's *Constitution* and the *Foundation Trust Code of Governance* from NHS Improvement (formerly Monitor) requires such a formal document recording the exercise of delegated powers.

The Trust is a Public Benefit Corporation following approval by the Independent Regulator of NHS Foundation Trusts (known as Monitor or NHS Improvement) pursuant to the National Health Service Act 2006 (the "2006 Act"). The Trust is governed by the 2006 Act, as amended by the Health and Social Care Act 2012 (or subsequent statute, its Constitution and the NHS Licence Conditions granted by NHS improvement. The functions of the Trust are conferred by the Regulatory Framework and the Trust is required to comply with the guidance issued by NHS Improvement. This SoD and their content and approval are the sole responsibility of the Board of Directors and are not required to be submitted for approval to any group or organisation including NHS Improvement or the Council of Governors.

The Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee or by the CHAIR or a director or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit". The NHS Code of Accountability for NHS Boards also requires that there should be a formal schedule of matters specifically reserved to the Trust.

The purpose of this document is to detail how those powers may be reserved to the Board - generally matters for which it is held accountable to NHS Improvement, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. However, the Board remains accountable for all of its functions, even those delegated to the CHAIR, individual directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

1.1 The Purpose of the Board

The Board of Directors is a strategic unitary board that has regard to robust arrangements being in place that will deliver strong and high quality patient care and strong financial management. The appropriate role of the Board is to ensure that the governance mechanisms to meet these objectives are in place. This means that the Board takes the view that the experts it employs in each functional field should have the authority to present policies and procedural documents to the operational Executive Board who will give approval. The Board of Directors will be notified of policy and procedural changes for them to scrutinise if they wish but will not do this as part of the normal function of the Board of Directors Meetings.

1.2 Role of the Chief Executive

All powers of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee shall be exercised on behalf of the Board 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 on accountability to the Board.

All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise. As Accounting Officer, the Chief Executive is accountable to NHS Improvement for the funds entrusted to the Trust.

1.3 Caution over the Use of Delegated Powers

Powers are delegated to directors and officers on the understanding that they would not exercise delegated powers in a matter, which, in their judgement was likely to be a cause for public concern.

1.4 Directors' Ability to Delegate their own Delegated Powers

The Scheme of Delegation shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

1.5 Absence of Directors or Officer to Whom Powers have been Delegated

In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent, their delegated powers may be exercised by the designated Deputy Chief Executive. If both the Chief Executive and the Deputy Chief Executive are absent, the Chief Executive's delegated powers may be exercised by a nominated Executive Director acting in the Chief Executive's absence.

2.0 RESERVATION OF POWERS TO THE BOARD

The NHS Code of Accountability which has been adopted by the Trust requires the Board to determine those matters on which decisions are reserved unto itself. These reserved matters are set out below:

2.1 General Enabling Provision

The Board may determine any matter it wishes in full session within its statutory powers.

2.2 Regulation and Control

2.2.1 Approval of Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions (SFIs) for the regulation of its proceedings and business.

2.2.2 Approval of a scheme of delegation of powers from the Board to officers.

2.2.3 Receiving declarations of directors' interests and also the requiring and receiving the declaration of directors' interests which may conflict with those of the Trust and determining the extent to which that director may remain involved with the matter under consideration.

2.2.4 Requiring and receiving the declaration of interests from officers which may conflict with those of the Trust.

2.2.5 Disciplining directors who are in breach of statutory requirements or SOs.

2.2.6 Approval of the disciplinary procedure for officers of the Trust.

2.2.7 Approval of arrangements for dealing with complaints.

2.2.8 Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications there to.

2.2.9 To receive reports from committees including those which the Trust is required by NHS England / Improvement or other regulation to establish and to take appropriate action thereon.

2.2.10 To confirm the recommendations of the Trust's committees where the committees do not have executive powers. To establish terms of reference and reporting arrangements of all sub-committees (and other committees if required).

2.2.11 Notification of any urgent decisions taken by the Chief Executive in accordance with SO 3.1.

2.2.12 Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.

2.3 Appointments

2.3.1 The appointment and dismissal of committees.

2.3.2 The appointment, appraisal, disciplining and dismissal of executive directors (subject to SO2.6).

2.3.3 The appointment of members of any committee/sub committee of the Trust or the appointment of representatives on outside bodies.

2.4 Policy Determination

2.4.1 Having regard to the strategic context that the Board has set for itself and the way it conducts the business of the Trust, it will only deal in determining strategic business. Therefore, policies will be approved by the Executive Board and reported to the next Board of Directors Meeting.

2.5 Strategy and Business Plans and Budgets

2.5.1 Definition of the strategic aims and objectives of the Trust.

2.5.2 Approval of annual business plans.

2.5.3 Approval of annual budgets for the Trust.

2.6 Direct Operational Decisions

2.6.1 Acquisition, disposal or change of use of land and/or buildings of a significant nature (above £300,000.

2.6.2 The introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant if it has a gross annual income or expenditure (that is before any set off) in excess of £1m.

2.7 Financial and Performance Reporting Arrangements

2.7.1 Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees, associate directors and officers of the Trust as set out in management policy statements. All monitoring returns required by Monitor, Care Quality Commission and the Charity Commission shall be reported, at least in summary, to the Trust.

2.7.2 Approval of the opening or closing of any bank or investment account.

2.7.3 Approval of any working capital facility arrangement entered into.

2.7.4 Receipt and approval of a schedule of NHS contracts signed in accordance with arrangements approved by the Chief Executive.

2.7.5 Consideration and approval of the Trust's Annual Report including the annual accounts.

2.7.6 Receipt and approval of the Annual Report(s) for funds held on trust.

2.8 Audit Arrangements

2.8.1 To approve audit arrangements (including arrangements for the separate audit of funds held on trust) and to receive reports of the Audit Committee meetings and take appropriate action.

2.8.2 The receipt of the annual management letter received from the external auditor and agreement of action on the recommendation where appropriate of the Audit Committee.

2.8.3 To receive a report/minutes from the Audit Committee relating to the annual report received from the internal auditors and the agreement of action on any recommendations.

3.0 DELEGATION OF POWERS

3.1 Delegation to Committees

The Board may determine that certain of its powers shall be exercised by Standing Committees. The composition and terms of reference of such committees shall be that determined by the Board from time to time taking into account where necessary the requirements of NHS England / Improvement and or the Charity Commissioners (including the need to appoint an Audit Committee, and a Remuneration and Terms of Service Committee). The Board shall determine the reporting requirements in respect of these committees. In accordance with SO 5.5 committees may not delegate executive powers to sub-committees unless expressly authorised by the Board.

4.0 SCHEME OF DELEGATION TO OFFICERS

4.1 Standing Orders and Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive (CE), the Director of Finance (DoF) and other directors. These responsibilities are summarised below.

Certain matters needing to be covered in the scheme of delegation are not covered by SFIs or SOs or they do not specify the responsible officer. These are:

Area of responsibility	Overall responsibility
General Data Protection Regulation Requirements	Managing Director, Digital Health
Health and Safety Arrangements	Chief Executive

There are two schemes of delegation. The “top level” scheme covers only matters delegated by the Board to directors and certain other specific matters referred to in SFIs (Appendix A).

A more detailed scheme of delegation including financial limits is attached as Appendix B.

APPENDIX A

SCHEME OF DELEGATION FOR CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST IMPLIED BY STANDING ORDERS

SO REF	DELEGATED TO	DUTIES DELEGATED
1.1	CHAIR	Final authority in interpretation of SOs.
3.5	CHAIR	Calling meetings.
3.13	CHAIR	Chair all board meetings and associated responsibilities.
6.8	CE	Register(s) of interests.
9.19	CE	Best value for money is demonstrated for all services provided under contract or in-house.
9.20	CE	Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector.
9.22	CE	Ensure that procedures are in place to manage each contract on behalf of the Trust.
9.23	CE	Ensure that procedures are in place to enter into contracts of employment, regrading staff, agency staff or consultancy service contracts.
9.24	CE	Nominate officers with power to negotiate commissioning contracts with providers of healthcare and other authorities.
10(a)	CE/NOMINATED OFFICER	Determining any items to be sold by sale or negotiation.
12.1	CE	Responsible for ensuring seal is kept in a safe place and a register of sealing is maintained.
12.2	CHAIR/CE OR DEPUTIES	Board delegated powers to seal documents and initial any amendments thereto.
12.3a.	CHAIR/CE/DEPUTIES DOF AND/OR NOMINATED OFFICERS	Board delegated powers to approve the signing and sealing all building, engineering, property or capital documents and initial any amendments thereto.
12.3b	DOF	Board delegated powers to approve building, engineering, property or capital documents and any amendments thereto.

SCHEME OF DELEGATION FOR CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST IMPLIED BY STANDING ORDERS

SO REF	DELEGATED TO	DUTIES DELEGATED
13.1	CE	Approve and sign all documents which will be necessary in legal proceedings
13.2	CE OR NOMINATED OFFICERS	Sign on behalf of the Trust any agreement or document not requested to be executed as a deed.
14.1	CE	Existing Directors and employees and all new appointees are notified of and understand their responsibilities within Standing Orders SFIs.
Annex s2	CE	Designate an officer responsible for receipt and custody of tenders before opening.
Annex s3	TWO SENIOR OFFICERS	Open tenders
Annex s4	CE OR NOMINATED OFFICER	Decide whether any late tenders should be considered.
Annex s5	DOF	Keep lists of approved firms for tenders.

APPENDIX B

SCHEME OF DELEGATION FOR CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
1.3.6	CHIEF EXECUTIVE (CE)	To ensure all employees and directors, present and future, are notified of and understand Standing Financial Instructions.
1.3.7	DIRECTOR OF FINANCE (DOF)	Responsible for: Implementing the Trust's financial policies and coordinating corrective action and ensuring detailed financial procedures and systems are prepared and documented.
1.3.8	ALL DIRECTORS AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
1.3.10	DOF	Form and adequacy of financial records of all departments.
2.1.1	AUDIT & RISK COMMITTEE	Provide independent and objective view on internal control and probity.
2.2	DOF	Carry out all work to counter fraud and corruption in accordance with Directions on Fraud and Corruption and Bribery Act 2010
2.3.1	DOF	Monitor effectiveness of internal financial control, internal audit function and Investigate any suspected cases of irregularity not related to fraud or corruption and not covered by work to counter fraud and corruption.
2.4	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
2.5	AUDIT & RISK COMMITTEE	Ensure cost-effective external audit.
3.1.2	DOF	Submit budgets.
3.1.3	DOF	Monitor performance against budget, submit to Board financial estimates and forecasts.
3.2	CE	Delegate budget to budget holders and submit monitoring returns.

SCHEME OF DELEGATION FOR CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
3.3	DOF	Devise and maintain systems of budgetary control.
4	DOF	Annual accounts and reports.
5	DOF	Banking arrangements.
6	DOF	Income systems.
8 7.3	CE DOF	Ensure adequate and appropriate business arrangements for the provision of patient services. Regular reports of actual and forecast contract expenditure.
9.1 – 9.2 9.4	BOARD REMUN COMMITTEE DIRECTOR/EMPLOYEE	Remuneration & Terms of Service Committee Report in writing to the Board its advice and its bases about remuneration and terms of service of directors and senior employees. Staff, including agency staff, appointments.
9.5	DIRECTOR OF WORKFORCE AND OD	Payroll
10.1	CE	Determine, and set out, level of delegation of non-pay expenditure to budget managers.
10.2.3	DOF	Prompt payment of accounts.
10.2.5	CE	Authorise who may use and be issued with official orders.
10.2.7	DOF	Ensure that Standing Orders are compatible with requirements of NHS Improvement re building and engineering contracts.
11	DOF	Advise Board on borrowing and investment needs and prepare procedural instructions.

SCHEME OF DELEGATION FOR CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
12.1	CE	Capital investment programme
12.1.5	DOF	Monitoring the capital programme.
12.3	CE	Maintenance of asset registers.
12	CE	Overall responsibility for fixed assets.
12.4.4	ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to DoF, and reporting losses in accordance with Trust procedure.
13	DOF	Responsible for systems of control over stores and receipt of goods.
13.8	CE	Identify persons authorised to requisition and accept goods from NHS Supplies stores.
14	DOF	Prepare procedures for recording and accounting for losses and special payments and informing NHS Improvement of all frauds and informing police in cases of suspected arson or theft.
15	DOF	Responsible for accuracy and security of computerised financial data.
16	CE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
17	DOF	Shall ensure each fund held on trust is managed appropriately.
18	CE	Retention of document procedures
19	CE	Risk management programme
19.3	CE	Insurance arrangements

APPENDIX C

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST - DETAILED SCHEME OF DELEGATION

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. **The delegation shown below is the lowest level to which authority is delegated.** Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders.

	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
1.	**Management of Budgets** Responsibility of keeping expenditure within budgets		
a)	At individual budget level (Pay and Non-Pay and non-contracted income)	Budget Manager	SFIs Section 3
b)	For the totality of services covered in a division.	Divisional Director	
2.	**Maintenance / Operation of Bank Accounts**	Director of Finance	SFIS Section 5
3. **a)**	**Non-Pay Revenue and Capital Expenditure/Requisitioning/Ordering/Payment of Goods & Services** Non-Pay expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement. (Subject to the limits specified in the Authorisation Limits in Appendix I of the SFIs		SFIs Section 10 and Appendix 1, Standing Orders section 9
4.	**Capital Schemes**		
a)	Selection of architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations and the Trust tender process	Chief Executive or Director of Finance	SFIs Section 12 and Appendix 1
b)	Financial monitoring and reporting on all capital scheme expenditure	Director of Finance	
c)	Granting, extension and termination of leases for equipment	Director of Finance	

d)	Granting, extension and termination of leases for land and buildings	Director of Finance and Chief Executive	
e)	Approval of business case • Covid-19 related expenditure ▪ £2,500,000and over ▪ Between £2,000,000 and £2,500,000 ▪ Between 50,000 and £2,500,000 ▪ Less than £50,000	*Covid Incident Management team to agree investment up to a value of £100,000 without a business case, any amounts over £100,00 will require a business case* Board of Directors Trust Executive Board Chief Executive and Director of Finance Capital Investment Group	
5. **a)**	**Quotation, Tendering and Contract Procedures for Goods and Services** **Competitive Tenders** **Authorisation limits**	Chief Executive	Refer to the Authorisation Limits in Appendix 1 of the SFIs
b)	**Opening Tenders**	Nominated representative by the Director of Finance	
i.	Receipt and custody of tenders prior to opening (where e-tendering portal being used)	Nominated representative by the Director of Finance	
ii.	Receipt and custody of tenders prior to opening (where the paper-based system used)	Two Trust HQ officers designated by the Chief Executive	
d)	**Waiving of Quotations and Tenders**		
. i.	Tenders – refer to paragraph 7.6 of the Standing Financial Instructions subject to the completion of the relevant Application to Waive Competitive Tenders Procedure form. Quotes – refer to paragraph 7.6 of the Standing Financial Instructions subject to the completion of the relevant Application to Waive Competitive Tenders Procedure form.	Director of Finance (or a nominated representative) (reported to the Audit Committee) Director of Finance (or a nominated representative)	

6.	**Setting of Fees and Charges**		
a)	Private Patient, Overseas Visitors, Income Generation and other patient related services.	Appropriate Director	SFIs Section 6.2
b)	Price of NHS Contracts Charges for all NHS Contracts	Chief Executive or Director of Finance	SFIs Section [8]
7. a) b) c) c) d) e) i. ii iii	**Engagement of Management/Specialist Consultancy (non-medical)** Management or Specialist Consultancy Where total commitment is less than £20,000 Where total commitment is between £20,000 and £100,000. Where total commitment is above £100,000 In accordance with NHS Improvement mandatory guidance the engagement, appointment or commissioning of any consultancy over £50,000 Engagement of Trust's Solicitors • Employment law matters • All other legal matters Booking of Bank or Agency Staff • Nursing Off framework Above 50% wage Bank and Tier 1 Agency cap	 Appropriate Director Two Executive Directors (one of whom must be the Chief Executive, Deputy Chief Executive or Director of Finance Chief Executive and Director of Finance NHS Improvement Director of Workforce and OD Company Secretary Appropriate Director Executive Director Executive Director Deputy Director of Nursing	SFIs Section 9

	• Medical •	(via Nursing Daily staffing meeting)	
8.	**Expenditure on Charitable Funds** For authorisation limits please refer to Appendix 1 of the Standing Financial Instructions and to paragraph 17 for further guidance.	See SFIs - Appendix 1 which lists authorisation limits	SFIs Section 17
a)	Preparation and signature of all tenancy agreements/licences for all staff subject to Trust Policy on accommodation for staff	Director of Finance	
b)	Letting of premises to non NHS organisations.	Chief Executive/ Director of Finance	
c)	Letting of premises to other NHS Organisations	Chief Executive and Director of Finance	
d)	Approval of rent based on professional assessment	Director of Finance	
e)	Sales and purchase of land not exceeding £100	Chief Executive and Director of Finance of Director of Finance	
10.	**Condemning & Disposal**		
a)	Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively (to be recorded in the appropriate Losses Register		SFIs Section 14.1 and SFIs Appendix 2,
	i) all IT equipment with new price <£5,000	Director of Health Informatics	
	ii) all medical equipment with new price <£5,000	Divisional Director	
	iii) all mechanical and engineering plant <5,000	Chief Executive or Director of Finance (as Chair of Capital Investment Group	
	iv) all general equipment with new price <£5,000		
	v) all equipment with new price >£5,000		
11.	**Losses, Write-off & Compensation**		

a)	Losses and Cash due to theft, fraud, overpayment & others Up to £50,000	Chief Executive and Director of Finance	SFIs Section 14.2 and SFIs Appendix 2
b)	Fruitless Payments (including abandoned Capital Schemes) Up to £250,000	Chief Executive and Director of Finance	
c)	Bad Debts and Claims Abandoned. Private Patients, Overseas Visitors & Other Up to £1,000 –Over £1,000	Chief Executive or Director of Finance Audit Committee	
d)	Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to: Culpable causes (e.g. fraud, theft, arson) or other Up to £50,000	Chief Executive or Director of Finance	
e)	Extra Contractual payments to contractors Up to £50,000	Chief Executive or Director of Finance	
f)	Ex-gratia Payments Patients and staff for loss of personal effects Up to £2,500 £2,500 to £100,000	Assistant Director for Patient Safety, Chief Executive or Director of Finance **AND** Medical Director or Director of Nursing	
g)	Payments or admissions of liability for personal injury claims involving negligence where legal advice has been obtained and guidance applied Up to £10,000 for employers liability and Up to £3,000 for public liability (to reflect the excess payment)	Assistant Director for Patient Safety	
h)	Other, except cases of maladministration where there was no financial loss by claimant up to £50,000 **The following safeguards must have been made before payment can be made:** **a. For clinical negligence claims, the claim has been agreed with the NHS Resolution with the appropriate legal advice.** **b. For employee liability and public liability cases, that the claim has been agreed with the insurers with the appropriate legal advice.** **c. Where the level of expenditure is below that**	Chief Executive and Director of Finance	

	which requires either NHS Resolution or our insurers' approval, that legal advice supports the amount and payment of the claim.		
12.	Reporting of Incidents to the Police		
a)	Where a criminal offence is suspected i) criminal offence of a violent nature ii) other than fraud	Duty Manager Appropriate Director	SFIs Section 2 & 14 Fraud Policy & Response Plan
b)	Where a fraud in involved	Director of Finance	
13.	**Petty Cash Disbursements**		
a)	Expenditure up to £40 per item	Manager / Authorised Signatory	SFIs Section10
14.	**Receiving Hospitality, Gifts and Individual Corporate Sponsorship**		Refer to Conflicts of Interests and Standards of Business Policy
a)	Declaring the receipt of gifts and hospitality and/or individual sponsorships for inclusion in the Trust register. (Applies to both individual and collective hospitality / gifts / sponsorship received)	Individual Staff Member Declaration required in Trust's Hospitality Register maintained by Company Secretary	Staff may accept donations during Covid-19 pandemic where such donations are offered to **all** staff which cumulatively may exceed this limit.
b)	In excess of £50.00 per item received. Approving the retention of gifts and receipt of hospitality/sponsorship • For Non-Executive Directors • For all employees	Chair Chief Executive	Any donation which is offered to one specific member of staff must be in line with the £50 limit.
15.	**Implementation of Internal and External Audit Recommendations**	Director of Finance	SFIs Section 2
17.	**Investment of Funds (including Charitable & Endowment Funds)**	Director of Finance	SFIs Section 11 and 17
18.	**Personnel, Pay and Expenses**		
a)	Authority to fill funded post on the establishment with	Director/ Divisional Director of Operations	

	permanent staff.		
b)	Authority to appoint staff to post not on the formal establishment.	Director/Divisional Director of Operations	
d)	Regrading All requests for upgrading/regrading shall be dealt with in accordance with Trust Procedure.	Director of Workforce and Organisational Development/ Divisional Director Operations	
e)	Establishments		
	i. Additional staff to the agreed establishment with specifically allocated finance.	Director/Divisional Director Operations	
	ii. Additional staff to the agreed establishment without specifically allocated finance.	Director/Divisional Director Operations	
f)	Pay		
	i. Authority to complete standing data forms effecting pay, new starters, variations and leavers.	Director of Workforce and Organisational Development/Divisional Director Operations	
	ii. Authority to complete and authorise positive reporting forms.	Line Manager	
	iii. Authority to authorise overtime.	Line Manager	
	iv. Authority to complete and authorise positive reporting forms.	Line Manager	
	v. Authority to authorise travel & subsistence expenses.	Line Manager	
g)	Leave		
	i. Approval of annual leave	Line Manager	See appropriate Trust Policy
	ii. Annual Leave – approval of carry forward of 5 days.	Line Manager	
	iii. Annual Leave – approval of carry over 5 days (to occur in exceptional circumstances only	Line Manager	
	iv. v. Compassionate Leave up to 6 days.	Line Manager	

	vi. Special Leave arrangements • paternity leave • carers leave • adoption leave (to be applied in accordance with Trust Policy	Line Manager Line Manager		
	vii. Leave without pay			
	viii. Medical Staff Leave of Absence • paid and unpaid	Clinical Director/General Manager/Line Manager Line Manager		
	ix. Time off in lieu	Line Manager		
	x. Maternity Leave – paid and unpaid			
h)	<u>Sick Leave</u> i. Extension of sick pay	Director of Workforce and Organisational Development/ Divisional Director Operations		
i)	<u>Study Leave</u> i. Study leave outside the UK	Divisional Director		
	ii. Medical staff study leave (UK)	Clinical Director/General Manager/Line Manager		
	iii. All other study leave (UK)	Line Manager		
j)	<u>Removal Expenses</u> Authorisation of payment of removal expenses	Director/Divisional Director Operations		
k)	<u>Authorised Car & Mobile Phone Users</u>			
	Requests for new posts to be authorised as car users.	Line Manager		
	Requests for new posts to be authorised as mobile telephone users.	Line Manager		

l)	Renewal of Fixed Term Contract	Line Manager	
m)	Redundancy	Director of Workforce and Organisational Development and Director of Finance	
n)	Dismissal inc. Ill Health	Director/Divisional Director Operations	
19.	**Authorisation of New Drugs**	Medicines Management Committee	
20.	**Authorisation of Sponsorship Deals**	Chief Executive, Medical Director	
21.	**Authorisation of Research Projects**	Chief Executive, Medical Director	
22.	**Authorisation of Clinical Trials**	Chief Executive, Medical Director & Deputy and Director of Operations	
23.	**Insurance Policies** **Risk management arrangements** Risk Management Strategy	Director of Finance Director of Nursing	SFIs Section 19
24.	**Patients & Relatives Complaints** a) Overall responsibility for ensuring that all complaints are dealt with effectively b) Responsibility for ensuring complaints relating to a directorate are investigated thoroughly c) Medico – Legal Complaints Co-ordination of their management	 Director of Nursing Director of Nursing Director of Nursing	
25.	**Relationships with Press** a) Non-Emergency General Enquiries • Within Hours • Outside Hours b) Emergency	 Communications Manager Communications Manager	

	• Within Hours • Outside Hours	Chief Executive or Executive Director Communications Manager or On Call Director	
26.	**Infectious Diseases & Notifiable Outbreaks**	On Call Infection Control Team	
27.	**Extended Role Activities** Approval of Nurses to undertake duties / procedures which can properly be described as beyond the normal scope of Nursing Practice.	Director of Nursing	Nurse/Midwives Health Visitors Act Midwives Rules/Code of Professional Conduct
28.	**Patient Services** a) Variation of operating and clinic sessions within existing numbers • Outpatients • Theatres • Other b) All proposed changes in bed allocation and use • Temporary Change • Permanent Change	 General Manager General Manager General Manager Covid Incident Management Team / Divisional Director Operations Chief Operating Officer and Divisional Director	
29.	**Facilities for staff not employed by the Trust to gain practical experience** Professional Recognition, Honorary Contracts, and Insurance of Medical Staff. Work experience students.	 Clinical Directors or Medical Staffing Manager or PGME Director as appropriate Departmental Managers / Personnel Officer	
30.	**Review of fire precautions**	Chief Operating Officer	Fire Safety Policy

31.	**Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations**	Director of Workforce and Organisational Development in conjunction with Director of Finance as appropriate	Health & Safety at Work
32.	**Review of Medicines Inspectorate Regulations**	Clinical Director of Pharmacy	
33.	**Review of compliance with environmental regulations, for example those relating to clean air and waste disposal**	Director of Workforce and Organisational Development, Director of Finance	
34.	**Review of Trust's compliance with the Data Protection Act**	Managing Director Digital Health	
35.	**Monitor proposals for contractual arrangements between the Trust and outside bodies**	Director of Transformation and Partnerships	
36.	**Review the Trust's compliance with the Access to Records Act**	Medical Records Manager	
37.	**Review of the Trust's compliance code of Practice for handling confidential information in the contracting environment and the compliance with "safe haven" practices.**	Managing Director Digital Health	
38.	**The keeping of a Declaration of Interests Register**	Chief Executive/Company Secretary	SOs Section 6
39.	**Attestation of sealings in accordance with Standing Orders**	Company Secretary	SOs Section 12
40.	**The keeping of a register of Sealings**	Company Secretary or Corporate Governance Manager	SOs Section 12
41.	**The keeping of the Hospitality Register**	Company Secretary	
42.	**Retention of Records**	Medical Records Manager	SFIs Section 18

43. Mental Health Act 1983: Scheme of Delegation by the Hospital Managers and Training

Director with responsibility: Director of Nursing **Operational lead: Chief Operating Officer**

FUNCTIONS WHICH CANNOT BE DELEGATED TO OFFICERS OF THE TRUST

Function	Legislative Reference	Code of Practice Reference	Authorised Person / Committee
Review the Trust's operation of the Act, governance arrangements & varying this scheme of delegation		Chapter 37	Board of Directors

FUNCTIONS DELEGATED TO OTHER ORGANISATIONS

The Trust has a Service Level Agreement with South West Yorkshire Partnership Foundation Trust to act as hospital manager for the purpose of reviewing detentions under the Mental Health Act, and administration of the Mental Health Act	Section 23 MHA		South West Yorkshire Partnership Foundation Trust

FUNCTIONS DELEGATED TO OFFICERS

Recording admission For section 5(2) – Form H1	MHA sections 5(2) Regulation 4(1)(g)	Chapter 18: holding powers	H1 Part 1: Medical Practitioner in Charge of Patient or nominated deputy H1 Part 2: the designated authorised hospital manger which is the senior nurse in and out of hours who has received appropriate Mental Health Act receipt and scrutiny training
Formal Receipt and Scrutiny of statutory forms	MHA sections 5(2)	Chapter 18: holding powers	Head of Safeguarding
Provision of information on section 5(2) to patients and their nearest relative	MHA sections 5(2)	Chapter 2	Senior hospital nurse in and out of hours will provide relative letter 5(2) and the rights leaflet S5 (2).
Patient discharged from section 5(2) detention before the expiry of the 72 hours holding period (with clarity over start and finish times of the detention	MHA sections 5(2)	Chapter 18: 18.19, 18.20 & 18.35	Medical Practitioner in Charge of Patient or nominated deputy or Approved Mental Health Practitioner (AMHP).

period)			

TRAINING PROVISION

Programme	Frequency	Course Length	Delivery Method	Trainer(s)	Recording Attendance	Strategic & Operational Responsibility
MCA Level 3	Every three years	31/2 hours	Face to face	Safeguarding team	Training team	Deputy Director of Nursing

*To be reviewed - Medical Staff also receive specific training in the use of the MHA at induction sessions, foundation year programme training and department specific sessions including Emergency Department.

4. Standing Orders of the Board of Directors

Calderdale and Huddersfield NHS Foundation Trust

UNIQUE IDENTIFIER NO: G-1A-2010
Review Date: January 2023
Review Lead: Company Secretary

STANDING ORDERS

BOARD OF DIRECTORS

Directorate responsible for policy:	Chief Executive's Office
Version:	V4 Section1.1 addition of roles and responsibilities of Board of Directors Section 5.3 addition of section on Compliance with Fit and Proper Persons Regulations
Policy author:	Company Secretary
Responsible Committee:	Audit and Risk Committee
Date written:	April 2017
Date approved:	26 January 2021
Date issued:	26 January 2021
Date of latest review:	January 2021
Next review date:	January 2023

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Review Lead: Company Secretary

FOREWORD

Within the terms of authorization issued by Monitor, the former Independent Regulator, NHS Foundation Trusts are required to demonstrate appropriate arrangements to provide comprehensive governance arrangements in accordance with the need to agree Standing Orders (SOs) and schedules of Reservations of Powers to the Trust and Scheme of Delegation in accordance with their constitutions, their Terms of Authorisation and the requirements of the National Health Service Act 2006 ("the 2006 Act").

This Standing Orders document, together with Standing Financial Instructions and the Reservation of Powers to the Board (Scheme of Delegation), provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

These documents provide a comprehensive business framework. All Directors and all members of staff should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

INTERPRETATION

These Standing Orders are subject to continuous review (and formally reviewed and approved by the Audit and Risk Committee and Board of Directors every 2 years) to ensure that they reflect the obligations to which the Foundation Trust is subject under the Health and Social Care (Community Health and Standards) Act 2003, the Terms of Authorisation and the provisions of its Constitution.

For the avoidance of doubt nothing contained within these standing orders shall be construed in contravention of the Terms of Authorisation and in the event that there is such a contravention, the Terms of Authorisation, the 2006 Act and the Constitution shall take precedence.

Whilst the nature of these Standing Orders is that they are subject to variation, no such variation shall contravene the Terms of Authorisation, the 2006 Act and the Constitution.

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INTRODUCTION

Statutory Framework

Calderdale & Huddersfield NHS Foundation Trust (the Trust) is a public benefit corporation which was established under the National Health Service Act 2006 ("the 2006 Act").

The principal place of business of the Trust is:
Trust Offices, Huddersfield Royal Infirmary, Acre Street, Lindley, Huddersfield, HD3 3EA

The statutory functions conferred on the Trust are set out in the 2006 Act. The Trust also has a constitution ("the Constitution") as required under the 2006 Act, which includes further provisions consistent with Schedule 7 in support of the governance arrangements within the Trust.
It should be noted that the Trust also has in place Standing Orders (SOs) which deal with the Membership Council which may need to be referred to.

The purpose of the Trust (as required by the 2006 Act) is to serve the community by the provision of goods and services for purposes related to the provision of health care in accordance with its statutory duties and the Terms of the Independent Regulator's Authorisation (the "Terms of Authorisation"). The Trust is to have all the powers of an NHS Foundation Trust as set out in the 2006 Act, subject to the Terms of Authorisation.

As a statutory body, the Trust has specified powers to contract in its own name.

The Trust also has powers under section 28A of the NHS Act 1977 as amended by the 2006 Act to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

Regulatory Framework

Under its regulatory framework the Trust must adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions as an integral part of Standing Orders setting out the responsibilities of individuals.

The Trust's Constitution also requires that the Board of Directors draw up a schedule of decisions reserved to that Board and a scheme of delegation to enable responsibility to be clearly delegated to committees of the board and individual directors.

The Constitution also requires the establishment of an Audit Committee and a Remuneration Committee with formally agreed terms of reference. The Constitution requires a register of possible conflicts of interest of members of both the Board of Directors and the Council of Governors and how those possible conflicts are addressed.

In addition to the statutory requirements the Independent Regulator (the office formerly known as Monitor and now known as NHS Improvement) will issue further requirements and guidance. Many of these are contained within the 2006 Act and on NHS Improvement's website. Information is accessible locally via the Corporate Governance Manager.

Arrangements for public access to information are set out in the Code of Practice on Openness in the NHS and in the Trust's publication scheme under the Freedom of Information Act 2000.

Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. Under the Standing Orders relating to the Arrangements for the Exercise of Functions (SO 4) the Board is given powers to make arrangements for the discharge, on behalf of the Trust, of any of its functions by an internal committee or sub-committee appointed by virtue of SO 5 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit or as the Independent Regulator may direct. Delegated Powers are covered in a separate document (Scheme of Delegation) and financial delegation in the Standing Financial Instructions. These documents have effect as if incorporated into the Standing Orders.

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Integrated Governance
Trust Boards are now encouraged to move away from silo governance and develop integrated governance that will lead to good governance and ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance. The Trust Board uses its committee structures to support it in implementing a model of integrated governance.

Collaboration of services across West Yorkshire and Harrogate District
Moving to support the implementation of the Sustainable Transformation Plans (STPs), acute providers are required by NHS Improvement to plan, commission and deliver 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.

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INTERPRETATION

Save as permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he/she should be advised by the Chief Executive).

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

"Accounting Officer" means the Officer responsible and accountable for funds entrusted to the Trust. He/she shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

"Trust" means the Calderdale & Huddersfield NHS Foundation Trust.

"**Board of Directors**" means the Board of Directors as constituted in accordance with the Constitution;

"Budget" shall mean a resource, expressed in financial terms, proposed by the Board 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;

"Chair" is the person appointed in accordance with schedule 7 of the 2006 Act and under the terms of the Constitution to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Deputy Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable or is unable to act as Chair due to a conflict of interest.

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

"Committee" shall mean a committee appointed by the Board of Directors functioning as an internal committee.

"Committee members" shall be persons formally appointed by the Board of Directors to sit on or to chair specific committees.

"Committee in Common" means a collective group or representation from organisations (i.e. the acute provider Trusts in West Yorkshire and Harrogate District), to perform a particular function or duty.

"Deputy Chair" means the non-executive director appointed by the Trust to take on the Chair's duties if the Chair is absent for any reason or is unable to act due to a conflict of interest.

"Director" means a member of the Board of Directors

"Director of Finance" shall mean the chief finance officer of the Trust.

"Elected governor member" means those governors Members elected by the public constituency and the staff constituency.

"Funds held on Trust" (Charitable Funds) shall mean those funds that the Trust as Corporate Trustee holds at the date of authorisation, or receives on distribution by statutory instrument or chooses subsequently to accept. Such funds will be charitable.

"Memorandum of Understanding" (MOU or MoU) is a formal agreement between two or more parties. Companies and organisations can use MOUs to establish official partnerships. MOUs are not legally binding but they carry a degree of seriousness and mutual respect.

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"Monitor" is the former name of the Independent Regulator for NHS Foundation Trusts

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

"NHS Improvement" is the name of the Independent Regulator for NHS Foundation Trusts.

"Nominated officer" means an officer charged with the responsibility for discharging specific tasks within the Constitution and the SOs and SFIs.

"Officer" means an employee of the Trust.

"SFIs" means Standing Financial Instructions.

"SINED" means Senior Independent Non-Executive Director.

"SOs" mean Standing Orders.

"Sustainability and Transformation Plans" are five year plans for the future of health and care services in local areas. STPs represent a very significant change to the planning of health and care services in England.

"WYAAT" means the West Yorkshire Association of Acute Trusts, which includes Harrogate District.

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1. THE TRUST

1.1 All business shall be conducted in the name of the Trust.

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

1.1.1 to ensure compliance with the Constitution, mandatory obligations issued by NHS Improvement and relevant statutory requirements;

1.1.2 to establish a set of values and standards of conduct with are consistent with the Nolan Principles governing standards in public life;

1.1.3 to ensure compliance with the NHS foundation trusts: Code of Governance issued by Monitor and report on the Trust's governance arrangements annually;

1.1.4 to determine the vision, mission 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

The Trust has the functions conferred on it by the 2003 Act and by its Terms of Authorisation.

All funds or property received in trust under section 22 of the 2003 Act shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees under Chapter 5, section 51 of the 2006 Act. Accountability for charitable funds held on trust is in accordance with the relevant arrangements made by the Charity Commission and such other statutory requirements or direction by NHS Improvement as may apply.

The Trust has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in "Reservation of Powers to the Board" and have effect as if incorporated into the Standing Orders.

1.2 Composition of the Board of Directors
In accordance with the 2006 Act, Terms of Authorisation and the Constitution, the Board of Directors of the Trust shall comprise both Executive and Non-Executive Directors as follows:

A Non-Executive Chair
Up to 6 other Non-Executive directors (one of who shall act as the SINED)
Up to 6 Executive directors including:

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

The Non-Executive Directors and Chair together shall be greater than the total number of Executive Directors.

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

1.3 Appointment and removal of the Chair and Non-Executive Directors

The Chair and Non-Executive Directors are appointed and may be removed by the Council of Governors in accordance with Schedule 7 of the 2006 Act and under Paragraph 13 of the Constitution.

1.4 Terms of Office of the Chair and Non-Executive Directors

The Chair and Non-Executive Directors are appointed for a period of office in accordance with Schedule 7 of the 2006 Act and under Paragraph 13 of the Constitution. The terms and conditions of the office are decided by the Council of Governors.

1.5 Appointment of Deputy Chair

For the purpose of enabling the proceedings of the board of directors to be conducted in the absence of the Chair, the directors of the Trust will appoint a non-executive director from amongst them to be Deputy Chair. This individual may, through agreement with the Chair take on the role of Senior Independent Non-Executive Director (SINED), as contained in 12.11 of the Constitution.

Any Non-Executive Director so elected may at any time resign from the office of Deputy Chair by giving notice in writing to the Chair and the Directors of the Trust may thereupon appoint another Non-Executive director as Deputy Chair in accordance with these Standing Orders.

1.6 Powers of Deputy Chair

Where the Chair has ceased to hold office or where he/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.

1.7 Appointment of Senior Independent Director

The Board of Directors shall, following consultation with the Council of Governors, appoint one of the Non-Executive Directors to be their Senior Independent Director using the procedure set out in the Constitution.

1.8 Joint Directors

Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for Executive Directorship or in relation to which an Executive Director is to be appointed, those persons shall become appointed as an Executive Director jointly, and shall count for the purpose of Standing Orders as one person.

1.9 Secretary

The Board of Directors shall appoint the Secretary of the Trust and subject to following good employment practice, may also remove that person. The Secretary may not be a Governor, or the Chief Executive or the Director of Finance. The Secretary shall be accountable to the Chief Executive and their functions shall be as listed in the Constitution.

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2. MEETINGS OF THE BOARD OF DIRECTORS

2.1 Admission of the Public and the Press

The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Board but shall be required to withdraw upon the Board resolving as follows:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).

The Chair shall give such directions, as he/she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press, such as to ensure that the Board's business shall be conducted without interruption and disruption and without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted. The public will be required to withdraw upon the Board resolving as follows:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public (Section 1 (8) Public Bodies (Admission to Meetings) Act 1960).

Nothing in these Standing Orders shall require the Board of Directors to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of the proceedings as they take place without prior agreement of the Board of Directors.

2.2 Observers at Board meetings

The Board of Directors will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board meetings and will change, alter or vary these terms and conditions as it deems fit.

2.3 Public questions

Members of the public wishing to submit questions to the Board of Directors meeting will be required to submit these in writing by close of play the day before the meeting. The Chair will have the discretion to accept questions at the meeting if appropriate. Questions / statements must not relate to any 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 is being raised at a public meeting. The Chair's ruling on the appropriateness of the question / statement is final. The Chair will reserve the right to respond to questions in writing if time does not permit these questions to be answered in the meeting.

2.4 Calling Meetings

Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

Meetings of the Board of Directors may be called by the Secretary or by the Chair at any time. Meetings may also be called by at least one-third of the directors who given written notice to the Secretary specifying the business to be carried out. The Secretary should send a written notice to all directors within seven days of receiving such a request. If the Chair or Secretary refuses to call a meeting after such a request one-third or more directors may forthwith call a meeting.

2.5 Notice of Meetings

Before each meeting of the Board of Directors of the Trust, a notice of the meeting, specifying the business proposed to be transacted at it, shall be delivered to every director, or sent

electronically or by post to the usual place of residence of such director, so as to be available at least three clear days before the meeting.

A notice shall be presumed to have been served one day after posting. Lack of service of the notice on any director shall not affect the validity of the meeting.

In the case of a meeting called by directors in default of the Chair, the notice shall be signed by those directors and no business shall be transacted at the meeting other than that specified in the notice.

Before each meeting of the NHS Foundation Trust a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's offices at least three clear days before the meeting. (required by the Public Bodies (Admission to Meetings) Act 1960 S.I. (4) (a)

The Board of Directors may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting

2.6 Chair of the Meeting

At any meeting of the Board of Directors the Chair, if present, shall preside. If the Chair is absent, the Deputy Chair shall preside. If the Chair and Deputy Chair are absent one of the other Non-Executive Directors in attendance, as chosen by the Board of Directors shall preside.

If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest, the Deputy Chair, if present, shall preside. If the Chair and Deputy Chair are absent, or are disqualified from participating, such Non-Executive director as the directors present shall choose shall preside.

2.7 Setting the Agenda

The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Trust and shall be addressed prior to any other business being conducted.

A director who requires a matter to be included on an agenda should advise the Secretary to the Board prior to the agenda being agreed with the Chair and no less than 5 working days before a meeting.

Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next Board of Directors meeting.

2.8 Annual Members Meeting

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

2.9 Notices of Motion

A director of the Trust wishing to move or amend a motion should advise the Secretary to the Board prior to the agenda being agreed with the Chair and no less than 5 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.

2.10 Emergency Motion

Subject to the agreement of the Chair, and subject to the provision of SO 3.8, a director may give written notice of an emergency motion after the issue of the notice of the meeting and agenda up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision is final.

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2.11 Withdrawal of Motion or Amendments
A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

2.12 Motion to Rescind a Resolution
Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding **six (6)** calendar months shall bear the signature of the director who gives it and also the signature of the majority of the other directors. When any such motion has been disposed of by the Trust, it shall not be competent for any director other than the Chair to propose a motion to the same effect within **six (6)** months, however the Chair may do so if he/she considers it appropriate.

2.13 Motions - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

When a motion is under discussion or immediately prior to discussion it shall be open to a director to move:

(a) An amendment to the motion.
(b) The adjournment of the discussion or the meeting.
(c) That the meeting proceed to the next business. (*)
(d) The appointment of an ad hoc committee to deal with a specific item of business.
(e) That the motion be now put. (*)
(f) A motion under Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960 resolving to exclude the public (including the press).

In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a director who has not previously taken part in the debate.

No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, advised by the Secretary, the amendment negates the substance of the motion.

2.14 Chair's Ruling
Statements of directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting, on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

2.15 Voting
Every question put to a vote at a meeting shall be determined by a majority of the votes of the Chair of the meeting and the directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote. No resolution of the Board of Directors shall be passed by a majority composed only of Executive Directors or Non-Executive Directors.

All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

If at least one-third of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

If a director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

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In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

An officer who has been appointed formally by the Board to act up for an executive director during a period of incapacity or temporarily to fill an executive director vacancy, shall be entitled to exercise the voting rights of the executive director. An officer attending the Board of Directors to represent an executive director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive director. An officer's status when attending a meeting shall be recorded in the minutes.

2.16 Minutes

The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

Minutes shall be circulated in accordance with directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public via the Trust website (required by Code of Practice on Openness in the NHS). A record of items discussed in private will be maintained and approved by the Board of Directors.

2.17 Joint Directors

Where a post of executive director is shared by more than one person

a) Both persons shall be entitled to attend meetings of the Trust
b) If both are present at a meeting they should cast one vote if they agree
c) In the case of disagreement between them no vote should be cast
d) The presence of either or both of those persons shall count as one person for the purposes of SO 3.20 Quorum

2.18 Suspension of Standing Orders

Except where this would contravene any statutory provision or any direction made by Monitor, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board of Directors are present, including two Executive directors and two Non-Executive directors, and that a majority of those present vote in favour of suspension.

A decision to suspend SOs shall be recorded in the minutes of the meeting.

A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the directors.

The Audit and Risk Committee shall review every decision to suspend SOs.

2.19 Variation and Amendment of Standing Orders

These Standing Orders shall be amended only if:

(a) a notice of motion under Standing Order 3.8 has been given; and
(b) no fewer than half the total of the Trust's total Non-Executive directors vote in favour of amendment; and
(c) at least two-thirds of the Directors are present; and
(d) the variation proposed does not contravene a statutory provision or provision of authorisation or of the Constitution

2.20 Record of Attendance

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The names of the Chair and Directors present at the meeting shall be recorded in the minutes. The Secretary shall maintain a record of the number of meetings of the Board of Directors and the attendance of individual directors. This will include those who participate by telephone, video or computer link in accordance with these SOs.

2.21 Quorum

No business shall be transacted unless one-third of the whole number of the Directors are present (including two Executives and two Non-Executives are present), one of whom is the Chair or Deputy Chair and as such has a casting vote.

Any officer in attendance for an executive director but without formal acting up status may not count towards the quorum.

If the Chair or a director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SOs 6 and7) he/she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least two Executive Directors to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting.

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3. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

Subject to a provision in the authorisation or the Constitution, the Board of Directors may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 4.2 below, or by a director or an officer of the Trust in each case subject to such restrictions and conditions as the Board of Directors thinks fit.

3.1 Urgent Decisions

The powers which the Board of Directors has retained to itself within these Standing Orders (SO 2.5) may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

3.2 Delegation to Committees

The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by internal committees or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

3.3 Delegation to Officers

Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Board of Directors.

The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board of Directors as indicated above.

Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Director of Finance or other executive director to provide information and advice to the Board of Directors in accordance with any statutory requirements and the Terms of Authorisation.

The arrangements made by the Board of Directors as set out in the “Scheme of Delegation” shall have effect as if incorporated in these Standing Orders.

3.4 Overriding Standing Orders

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around non-compliance shall be reported to the next formal meeting of the 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.

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4. COMMITTEES

4.1 Appointment of Committees

Subject to the authorisation and the Constitution, the Board of Directors may appoint internal committees of the Trust consisting wholly or partly of the Chair and director of the Trust or wholly of persons who are not directors of the Trust.

Joint Committees

The Trust may appoint a joint committee by joining together with one or more other health or social care organisations consisting wholly or partly of the Chairman and members of the Trust Board or other health service bodies or wholly of persons who are not members of the Trust or other health bodies in question.

Any committee or joint committee appointed under this SO may, subject to such directions as may be given by NHS Improvement or the Board of Directors or other health bodies in question, appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include directors of the Trust) or wholly of persons who are not members of the Trust committee (whether or not they include directors of the Trust).

Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any internal committees or sub-committee established by the Trust. In which case the term 'Chairman' is to be read as a reference to the Chairman of the internal Committee as the context permits, and the term "director" is to be read as a reference to a member of the internal committee also as the context permits. There is no requirement to hold meetings of internal committees established by the Trust in public.

Terms of Reference

Each such internal committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

Delegation of powers by internal Committees to Sub-Committees

Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board of Directors.

Approval of Appointments to Internal Committees

The Board of Directors shall approve the appointments to each of the internal committees which it has formally constituted. Where the Board of Directors determines that persons, who are neither directors nor officers, shall be appointed to an internal committee, the terms of such appointment shall be determined by the Board of Directors. The Board of Directors shall define the powers of such appointees and shall agree the terms of their remuneration and/or reimbursement for loss of earnings and/or expenses subject to approval by the Membership Council.

Appointments for statutory functions

Where the Trust is required to appoint persons to an internal committee and/or to undertake statutory functions as required by NHS Improvement, and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with the regulations laid down by Monitor.

Appointment to the WYAAT Committee in Common

Membership of the Committee in Common will be defined in the Terms of Reference, which will be agreed or amended by all Parties. The Board of Calderdale and Huddersfield NHS

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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 work streams in accordance with the defined key principles, setting overall strategic direction in order to deliver the WYAAT Collaborative Programme.

Committees established by the Board
The Internal Committees and sub-committees established by the Trust are:

- Audit and Risk Committee
- Finance and Performance Committee
- Remuneration and Terms of Service Committee
- Charitable Funds Committee
- Quality Committee
- Workforce Committee
- Joint Liaison Committee
- Transformation Programme Board

The external committee established by the Trust is:

- West Yorkshire Association of Acute Trusts Committee in Common

Such other committees may be established as required to discharge the Board's responsibilities.

4.2 Confidentiality

A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

A Director of the Trust or a member of a committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

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5. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

Schedule 7 of the 2006 Act and Section 13.20 of the Constitution requires all Board directors (including Non-Executive Directors) and any other officers nominated by the Trust to declare interests which are relevant and material to the Board of Directors of which they are a member (including the WYAAT Committee in Common). A register of these interests must be kept by the Trust.

5.1 Declaration of Interests

All existing Directors should declare such interests. Any board directors/officers appointed subsequently should do so on appointment.

Interests may be financial or non-financial (i.e. political or belief-based). Interests which should be regarded as relevant and material and which, for the avoidance of doubt should be included in the register are:

- Any directorship of a company;
- Any interest (excluding holding of shares in a company whose shares are listed on any public exchange where the holding does not exceed 2% of the total issued share capital or the value of such shareholding does not exceed £25,000) or position in any firm of company or business, which in connection with the matter, is trading with the Trust or is likely to be considered as a potential trading partner with the Trust including private healthcare organisations and other foundation trusts;
- Any interest in an organization providing health and social care services to the NHS;
- Position of authority in a charity or voluntary organization in the field of health or social care;
- Any affiliation to a special interest group campaigning on health or social care issues.

To the extent not covered above, any connection with an organization, entity or company considering entering in to or having entered in to financial arrangement with the NHS Foundation Trust, including but not limited to lenders or banks.

WYAAT Committee in Common – the Chair and Chief Executive of Calderdale and Huddersfield NHS Foundation Trust will adhere to declaring interests as described within the Conflict of Interests section 10 of the Memorandum of Understanding.

Reference should also be made to the Monitor *NHS Foundation Trust Code of Governance* and the Trust's Constitution and Declaration of Interests Policy in determining whether other circumstances or relationship are likely to affect, or could appear to affect the director's judgement.

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

At the time board directors' interests are declared, they should be recorded in the board minutes. Any changes in interests should be declared at the next board meeting following the change occurring.

Board directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the board's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

During the course of a meeting of the Board of Directors, if a conflict of interest is established the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt this includes voting on such an issue where a conflict is established. If there is a dispute as to where a conflict does exist a majority vote

will resolve the issue with the Chair having the casting vote. If by inadvertence they do remain and vote, their vote shall not be counted.

There is no requirement in the Code of Accountability for the interest of directors' spouses or partners to be declared. However, in accordance with the Nolan Principles of integrity, accountability and openness, good practice suggests that such declarations are strongly advisable (as are declaring the interests of other immediate family members and co-business partners). SO 6, which is based on these regulations requires that the interests of spouses or partners (if living together) in contracts should be declared. Therefore the interests of spouses or cohabiting partners should also be regarded as relevant.

If Board directors/officers have any doubt about the relevance of an interest, this should be discussed with the Chair or Trust Secretary. Financial reporting standard 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of in interest. The interests of partner in professional partnerships including general medical practitioners should also be considered.

5.2 Register of Interests

The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board directors and officers. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by both board directors and officers, as defined in SO 5.1. The Register shall also contain the names of all members of the Board of Directors including those who have no interests.

These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

The Register will be available to the public and the Secretary will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

5.3 Compliance with Fit and Proper Persons

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.

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.

6. EXCLUSION OF THE CHAIR AND DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

Subject to the following provisions of this Standing Order, if the Chair or a director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he/she shall at the meeting and as soon as practicable after its commencement

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disclose the fact and should withdraw so as not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

NHS Improvement may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health Service that the disability shall be removed.

The Board of Directors may exclude the Chair or a director from a meeting of the Trust while any contract, proposed contract or other matter in which he/she has a pecuniary interest, is under consideration.

Any remuneration, compensation or allowances payable to the Chair or director by virtue of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.

For the purpose of this Standing Order the Chair or a director shall be treated, subject to SO 6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

(a) he/she, or a nominee of his/hers, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

or

(b) he/she is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration; and in the case of persons living together the interest of one person shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

The Chair or director shall not be treated as having a pecuniary interest in any contract proposed contract or other matter by reason only:

(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 connected as mentioned in SO 7.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

Where the Chair or director:

(a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

(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.

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This Standing Order applies to a committee or sub-committee of the Trust as it applies to the Board of Directors and applies to any member of any such committee or sub-committee (whether or not he/she is also a director of the Trust) as it applies to a director of the Trust.

7. STANDARDS OF BUSINESS CONDUCT

7.1 Policy

Staff must comply with the national guidance contained in NHS England's guidance Conflicts of Interest in the NHS – Guidance for Staff and Organisations (June 2017) and contained in the Trust's "Policy of Standards of Business Conduct for NHS Staff". The following provisions should be read in conjunction with this document.

7.2 Interest of Officers in Contracts

If it comes to the knowledge of a Board director or an officer of the Trust that a contract in which he/she has any pecuniary interest not being a contract to which he/she is him/herself a party, has been, or is proposed to be, entered into by the Trust he/she shall, at once, give notice in writing to the Chief Executive of the fact that he/she is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

An officer must also declare to the Chief Executive any other employment or business or other relationship of his/hers, or of a cohabiting spouse or partner, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

7.3 Canvassing of, and Recommendations by, Directors in Relation to Appointments

Canvassing of Board directors or officers of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

A Board director or officer of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

Failure to declare any interest which may conflict 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.

7.4 Relatives of Directors or Officers

Candidates for any staff appointment shall when making application disclose in writing whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

The Directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Foundation Trust any such disclosure made.

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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 Protect and possible prosecution under the Fraud Act 2006.

On appointment, Directors or officers (and prior to acceptance of an appointment in the case of executive directors) should disclose to the Foundation Trust whether they are related to any other director or holder of any office under the Trust.
Where the relationship of an officer or another director to a Board director of the Trust is disclosed, the Standing Order headed `Disability of directors in proceedings on account of pecuniary interest' shall apply.

The key elements of the Trust's Standards of Business Conduct with which directors and officers are required to comply are:

a. refuse gifts and hospitality above the value of £25
b. declaration of Business interests
c. decline offers of preferential treatment
d. permission to undertake outside employment
e. declaration of offers of commercial sponsorship
f. declaration of rewards
g. respect confidentiality of information.

The principles set out in this Standing Order 8.11 may be expanded by the Trust's Code of Business Conduct as from time to time approved by the Board of Directors.

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8. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

8.1 Custody of Seal

It is the responsibility of the Chief Executive to ensure that the Common Seal of the Trust is kept in a secure place.

8.2 Sealing of Documents

The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board of Directors or of a committee thereof or in accordance with any delegation by the Board of its power. The affixing of the Seal shall be attested and signed for by two Executive Directors (not from the originating department) or one Executive Director and the Company Secretary.

Before any building, engineering, property or capital document is sealed the scheme must be approved and authorised and countersigned by the Chief Executive (or an officer nominated by him/her who shall not be within the originating department.)

Contracts for the purchase of goods and services shall be under seal where the aggregate contract value may be reasonably expected to exceed £500,000.

8.3 Register of Sealing

An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealings shall be made to the Board of Directors at least quarterly. The report shall contain details of the seal number, the description of the document and the date of sealing. The book will be held by the Chief Executive or nominated officer.

9. SIGNATURE OF DOCUMENTS

Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

The Chief Executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority.

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10. MISCELLANEOUS

10.1 Standing Orders to be given to Directors and Officers

It is the duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions. Updated email copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive e-copies where appropriate of SOs.

10.2 Documents having the standing of Standing Orders

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

10.3 Review of Standing Orders

Standing Orders and all documents having effect as if incorporated in Standing Orders shall normally be reviewed regularly by the Audit and Risk Committee on behalf of the Board of Directors.

10.4 Non-availability of the Chair / Deputy Chair and Chief Executive / Director of Finance.

Save as expressly provided in these standing orders if the Chair of the Trust is not available for whatever reason to transact the business of the trust expressly or by implication delegated to him/her, then the Deputy Chair shall be empowered to act in his/her place and to exercise all the powers and duties of the Chair until the Chair is again available.

If the Deputy Chair is not available for whatever reason to transact the business of the Trust expressly or by implication delegated to him/her, then any two Non-Executive Directors shall be empowered to act in his/her place and to exercise all the powers and duties of the Deputy Chair in relation to that matter.

If the Chief Executive is not available for whatever reason, then any of the Chief Executive's powers and duties expressly or by implication under these Standing Orders may be exercised on his/her behalf by some other Officer duly authorised by the Chief Executive in writing so to act.

5. Trust Constitution - Reviewed April 2021

Latest review: August 2019
Approved:

UNIQUE IDENTIFIER NO: G-1C-2017
Review Date: April 2024
Review Lead: Company Secretary

CONSTITUTION OF THE

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

(A PUBLIC BENEFIT CORPORATION)

Version:	2.0 Review and update including: - Expenses clarification - References to Monitor / NHS Improvement - Typographical amends 2.1 Addition of partner governor May 2019 3 April 2021 14.3 removal of reserve register Annexe 1 -addition of Rest of England constituency
Approved by:	Council of Governors
Date approved:	17 January 2017 Version 2 17 October 2019 Version 3 22 April 2021 (tbc)
Date issued:	17 October 2019
Next Review date:	As required, as a minimum every three years (2024)

Latest review: August 2019
Approved:

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Calderdale and Huddersfield NHS Foundation Trust

CONSTITUTION FOR THE CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

1. Definitions

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

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

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

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

1.5. In this constitution:

The Accounting Officer	is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.
The 2006 Act	means the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.
The 2012 Act	is the Health and Social Care Act 2012.
Annual Members' Meeting	is defined in paragraph 10 of the constitution.
Appointed Council 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 Monitor
Board of Directors	means the Board of Directors as constituted in accordance with this constitution;
Director	means a member of the Board of Directors
Non-Executive Directors	means the Chair and non-executives on the Board of Directors;

Elected Council Member"	means those Governors elected by the public constituency and the staff constituency;
Financial year	means: (a) a period beginning with the date on which the Trust is authorised and ending with the next 31 March; and (b) each successive period of twelve months beginning with 1 April;
Monitor	is the former name for the Trust's regulator, as provided by Section 61 of the 2012 Act;
Local Authority Council Member	means a Member of the Council of Governors appointed by one or more Local Authorities whose area includes the whole or part of the area of the Trust;
Member	means a Member of the Trust;
Council of Governors	means the Council of Governors as constituted by this constitution and referred to as the Board of Governors/ Council of Governors in the 2006 Act;
The NHS Trust	means the NHS Trust which made the application to become the Trust;
Other Partnership Council Member	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 Council Member	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 Council Member	means a Member of the Council of Governors appointed by the Members of one of the classes of the constituency of the staff membership;
The Trust	means Calderdale & Huddersfield NHS Foundation Trust.

2. Name and status

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

3. Head Office and Website

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

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

4. Purpose

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

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

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

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

4.3.2. the promotion and protection of public health.

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

5. Powers

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

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

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

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

5.5. In particular it may:

5.5.1. acquire and dispose of property;

5.5.2. enter into contracts;

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

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

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

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

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

6. Membership and Constituencies

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

7. Members

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

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

Public Membership

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

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

Staff Membership

7.5. There is one staff constituency for staff membership. It is to 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. A person may not be a member of the Trust if, in the opinion of the Council of Governors, there are reasonable grounds to believe that they are likely to act in a way detrimental to the interests of the Trust.

9. Termination of membership

9.1. A Member shall cease to be a Member if:

9.1.1. they resign by notice to the Company Secretary;

9.1.2. they die;

9.1.3. they are disqualified from Membership by paragraph 7;

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

9.2. Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annexe 3 – Further Provisions.

10. Annual Members' Meetings

10.1. The Trust is to hold an annual meeting of its members. 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 ~~excluding any period on the reserve register (see 14.3 below);~~

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.

14.1.5. 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

14.2. Appointed Governors:

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

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

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

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

14.2.5. cease to hold office if they 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.

14.3. ~~The Foundation Trust will retain a reserve register of Governors who have previously held and completed their elected terms of office with the Foundation Trust as per paragraph 14.1. Access to the Register will be exceptional and for a time limited period. No reserve Council of Governors shall be retained on the reserve list for more than 2 years following completion of their elected terms of office. Governors can apply to be on the reserve register if they are not re-elected following the first term of their elected office. The normal rules of selection and exclusion for Governors will apply to reserve Governors. A majority of the Council of Governors, who are present when the decision is taken, must agree the movement of a reserve Council of Governors from the reserve list onto the Council of Governors. The reserve Governors may only serve on the Council of Governors for a 12 month period. No further terms on the register will be available. The reserve Governors may only cover a vacancy that exists following elections. This may be on the Constituency to which they were previously~~

~~elected and hold terms of office or to a different vacant seat. The rules of good governance will apply at all times and the Board of Directors and Council of Governors will have regard to the need to continually refresh their elected and appointed members, whilst ensuring that the business of the Council of Governors can continue seamlessly using the best available knowledge and experience.~~

15. Council of Governors - vacancies amongst Governors

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

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

15.3. Where the vacancy arises amongst the elected Council Member, 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 Council Member 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 Council Member or Non-Executive Director of another NHS Foundation Trust;

16.1.5. they are under 16 years of age;

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

16.1.7. they are a person whose tenure of office as the Chair or as a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for

non-attendance at meetings, or for non-disclosure of a pecuniary interest;

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

17.1. A person holding office as a Council Member 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 Council Member may be removed from the Council of Governors by a resolution approved by not less than three-quarters of the remaining Governors Members present and voting at a general meeting of the Council of Governors on the grounds that:

17.2.1. they have committed a serious breach of the code of conduct; or

17.2.2. they have acted in a manner detrimental to the interests of the Trust; and

17.2.3. the Council of Governors consider that it is not in the best interests of the Trust for them to continue as a Governor.

18. Council of Governors – duties of Governors

18.1. The general duties of the Council of Governors are:

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

18.1.2. to represent the interests of the members of the Trust as a whole and the interests of the public;

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

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

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

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

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

19.2. Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

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

20. Council of Governors – standing orders

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

21. Council of Governors – 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.

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 (SID).

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 live and/or work within the West Yorkshire and Harrogate area.

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

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 Council Member, 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 Improvement 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 (Monitor'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 Improvement 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 Improvement 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 Improvement.

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

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

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

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 Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

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.

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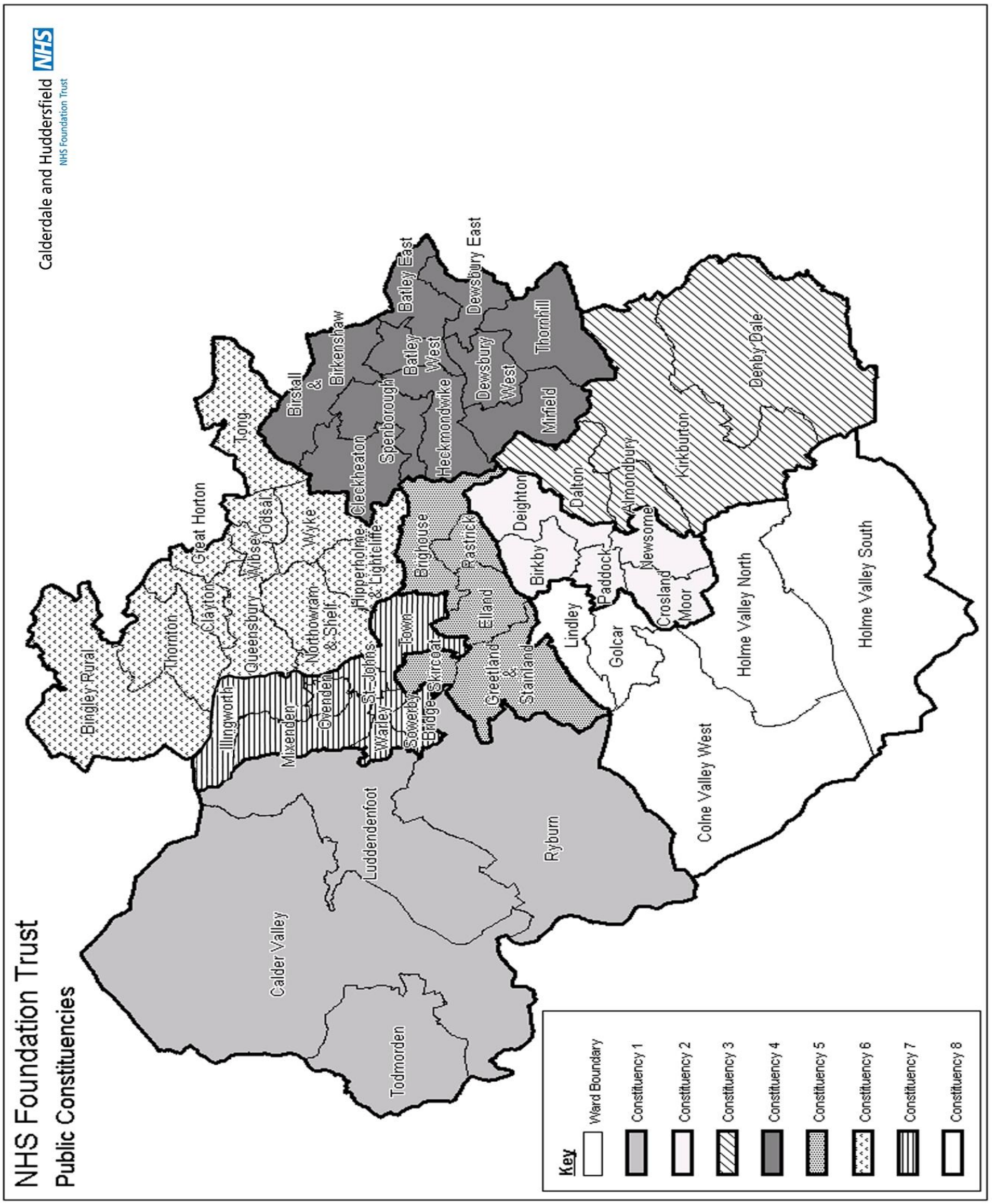
Calderdale and Huddersfield NHS Foundation Trust

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		
	Spenborough		
	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		

Calderdale and Huddersfield NHS Foundation Trust

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

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.

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MODEL ELECTION RULES 2014

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Part 1 Interpretation

1. Interpretation

1.1 In these rules, unless the context otherwise requires:
"corporation" means the public benefit corporation subject to this constitution;
"election" means an election by a constituency, or by a class within a constituency, to fill vacancy among one or more posts on the council of governors;
"the regulator" means the Independent Regulator for NHS foundation Trusts; and
"the 2006 Act" means the National Health Service Act 2006
"e-voting" means voting using either the internet, telephone or text message;
"internet voting system" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;
"method of polling" means voting either by post, internet, text message or telephone
"the telephone voting system" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;
"the text message voting system" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;
"voter ID number" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting.

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

Part 2 Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

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

Computation of time

3.1 In computing any period of time for the purposes of the timetable:
(a) a Saturday or Sunday;
(b) Christmas day, Good Friday, or a bank holiday, or
(c) a day appointed for public thanksgiving or mourning,
shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

Part 3 Returning Officer

4.1 Subject to rule 66, the returning officer for an election is to be appointed by the corporation.
4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff
5.1 Subject to rule 66, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure
6.1 The corporation is to pay the returning officer:
(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,
(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation
7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

Part 4 Stages

8. Notice of election
8.1 The returning officer is to publish a notice of the election stating:
(a) the constituency, or class within a constituency, for which the election is being held,
(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(c) the details of any nomination committee that has been established by the corporation,
(d) the address and times at which nomination papers may be obtained;
(e) the address for return of nomination papers and the date and time by which they must be received by the returning officer,
(f) the date and time by which any notice of withdrawal must be received by the returning officer
(g) the contact details of the returning officer
(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates
9.1 Each candidate must nominate themselves on a single nomination paper.

9.2 The returning officer:
(a) is to supply any member of the corporation with a nomination paper, and
(b) is to prepare a nomination paper for signature at the request of any member of the corporation,
but it is not necessary for a nomination to be on a form supplied by the returning officer and it can, subject to rule 13, be in an electronic format.

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

11. Declaration of interests
11.1 The nomination paper must state:
(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party, and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination paper must include a declaration made by the candidate:
(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,
(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination paper must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:
(a) they wish to stand as a candidate,
(b) their declaration of interests as required under rule 11, is true and correct, and
(c) their declaration of eligibility, as required under rule 12, is true and correct.

14. Decisions as to the validity of nomination

14.1 Where a nomination paper is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:
(a) decides that the candidate is not eligible to stand,
(b) decides that the nomination paper is invalid,
(c) receives satisfactory proof that the candidate has died, or
(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination paper is invalid only on one of the following grounds:
(a) that the paper is not received on or before the final time and date for return of nomination papers, as specified in the notice of the election,
(b) that the paper does not contain the candidate's particulars, as required by rule 10;
(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,
(d) that the paper does not include a declaration of eligibility as required by rule 12, or
(e) that the paper is not signed and dated by the candidate, as required by rule 13.

14.3 The returning officer is to examine each nomination paper as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination paper, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination paper.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:
(a) the name, contact address, and constituency or class within a constituency of each candidate standing, and
(b) the declared interests of each candidate standing,
as given in their nomination paper.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination papers to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination papers

16.1 The corporation is to make the statement of the candidates and the nomination papers supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a person requests a copy or extract of the statement of candidates or their nomination papers, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

Part 5 Contested elections

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide if eligible voters, within a constituency, or class within a constituency, may, subject to rule 19.4, cast their vote by any combination of the methods of polling.

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

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

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

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

20. The ballot paper

20.1 The ballot of each voter is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:
(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) instructions on how to vote by all available methods of polling, including the relevant voters and voter ID number if e-voting is a method of polling,
(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

Action to be taken before the poll

21. List of eligible voters

21.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 26 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

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

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

22. Notice of poll

22.1 The returning officer is to publish a notice of the poll stating:
(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,
(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) the methods of polling by which votes may be cast at the election by a constituency or class within a constituency as determined by the corporation in rule 19 (3).

(f) the address for return of the ballot papers, and the date and time of the close of the poll,
(g) the uniform resource locator (url) where, if internet voting is being used, the polling website is located.
(h) the telephone number where, if telephone voting is being used, the telephone voting facility is located,
(i) the telephone number or telephone short code where, if text message voting is being used, the text message voting facility is located,
(j) the address and final dates for applications for replacement voting information, and
(k) the contact details of the returning officer.

23. Issue of voting information by returning officer

23.1 As soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following voting information:
(a) by post to each member of the corporation named in the list of eligible voters and on the basis of rule 21 able to cast their vote by post:
(i) a ballot paper
(ii) information about each candidate standing for election, pursuant to rule 61 of these rules,
(iii) a covering envelope

(b) by e-mail or by post, to each member of the corporation named in the list of eligible voters and on the basis of rule 19.4 able to cast their vote only by an e-voting method of polling:
(i) instructions on how to vote
(ii) the eligible voters voter ID number
(iii) information about each candidate standing for election, pursuant to rule 61 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate.
(iv) contact details of the returning officer.

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

24. The covering envelope

24.1 The covering envelope is to have:
(a) the address for return of the ballot paper printed on it, and
(b) pre-paid postage for return to that address.

25. E-voting systems

25.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

25.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

25.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

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

(b) specify:
(i) the name of the corporation,
(ii) the constituency, or class within a constituency, for which the election is being held

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(v) instructions on how to vote.

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

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

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

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

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

(b) specify:
(i) the name of the corporation,
(ii) the constituency, or class within a constituency, for which the election is being held
(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(iv) instructions on how to vote.

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

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

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

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

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

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

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

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

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

The poll

26. Eligibility to vote

26.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

27. Voting by persons who require assistance

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

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

28. Spoilt ballot papers

28.1 If a voter has dealt with their ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

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

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

28.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):
(a) is satisfied as to the voter's identity, and
(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and
(c) the details of the unique identifier of the replacement spoilt ballot paper.

29. Lost voting information

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

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

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

30. Issue of replacement voting information

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

Polling by internet, telephone or text

31. Procedure for remote voting by internet

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

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

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

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

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

32. Voting procedure for remote voting by telephone

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

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

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

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

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

33. Voting procedure for remote voting by text message

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

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

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

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

34. Receipt of voting documents

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

34.2 The returning officer may open any covering envelope for the purposes of rules 35 and 36, but must make arrangements to ensure that no person obtains or communicates information as to:
(a) the candidate for whom a voter has voted, or
(b) the unique identifier on a ballot paper.

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

35. Validity of votes

35.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll.

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

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

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

36. De-duplication of votes

36.1 Where a combination of the methods of polling are being used, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in an election.

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

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

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

37. Sealing of packets

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

Part 6 Counting the votes

Note: the following rules describe how the votes are to be counted manually but it is expected that appropriately audited vote counting software will be used to count votes where a combination of

methods of polling is being used and votes are contained as electronic e-voting records and ballot papers.

STV38. Interpretation of Part 6

STV38.1In Part 6 of these rules:
"ballot" means a ballot paper, internet voting record, telephone voting record or text voting record.
"continuing candidate" means any candidate not deemed to be elected, and not excluded,
"count" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,
"deemed to be elected" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,
"mark" means a figure, an identifiable written word, or a mark such as "X",
"non-transferable vote" means a ballot:
(a) on which no second or subsequent preference is recorded for a continuing candidate,
or
(b) which is excluded by the returning officer under rule STV46,
"preference" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,
(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and
(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,
"quota" means the number calculated in accordance with rule STV43,
"surplus" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballots from the candidate who has the surplus,
"stage of the count" means:
(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

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

39. Arrangements for counting of the votes

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

40. The count

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

40.2 The returning officer, while counting and recording the number of votes and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or a voter's voter ID number.

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

STV41. Rejected ballot papers

STV41.1 Any ballot paper:
(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,
(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

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

STV41.3 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV41.1

FPP41. Rejected ballot papers

FPP41.1 Any ballot paper:
(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which votes are given for more candidates than the voter is entitled to vote,
(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(d) which is unmarked or rejected because of uncertainty,
shall, subject to rules FPP41.2 and FPP41.3, be rejected and not counted.

FPP41.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP41.3 A ballot paper on which a vote is marked:
(a) elsewhere than in the proper place,
(b) otherwise than by means of a clear mark,
(c) by more than one mark,
is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP41.4 The returning officer is to:
(a) endorse the word "rejected" on any ballot paper which under this rule is not to be counted, and
(b) in the case of a ballot paper on which any vote is counted under rules FPP41.2 and FPP 41.3, endorse the words "rejected in part" on the ballot paper and indicate which vote or votes have been counted.

FPP41.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:
(a) does not bear proper features that have been incorporated into the ballot paper,
(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and
(d) unmarked or rejected because of uncertainty,
and, where applicable, each heading must record the number of ballot papers rejected in part.

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

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

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

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

STV43.2 The result, increased by one, of the division under rule STV43.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

STV43.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV44.1 to STV44.3 has been complied with.

STV44. Transfer of votes
STV44.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballots on which first preference votes are given for that candidate into sub- parcels so that they are grouped:
(a) according to next available preference given on those ballots for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

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

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

STV44.4 The vote on each ballot transferred under rule STV44.3 shall be at a value (“the transfer value”) which:
(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and
(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballots on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV44.5 Where at the end of any stage of the count involving the transfer of ballots, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballots in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:
(a) according to the next available preference given on those ballots for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

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

STV44.7 The vote on each ballot transferred under rule STV44.6 shall be at:
(a) a transfer value calculated as set out in rule STV44.4(b), or
(b) at the value at which that vote was received by the candidate from whom it is now being transferred, whichever is the less.

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

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

STV44.10 Transferable ballots shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:
(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or
(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

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

STV45. Supplementary provisions on transfer

STV45.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballots of the candidate with the highest surplus shall be transferred first, and if:
(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballots of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and
(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballots of the candidate on whom the lot falls shall be transferred first.

STV45.2 The returning officer shall, on each transfer of transferable ballots under rule STV44:
(a) record the total value of the votes transferred to each candidate,
(b) add that value to the previous total of votes recorded for each candidate and record the new total,
(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and
(d) compare:
(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with
(ii) the recorded total of valid first preference votes.

STV45.3 All ballots transferred under rule STV44 or STV45 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot or, as the case may be, all the ballots in that sub-parcel.

STV45.4 Where a ballot is so marked that it is unclear to the returning officer at any stage of the count under rule STV44 or STV45 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot as a non-transferable vote; and votes on a ballot shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or

not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV46. Exclusion of candidates

STV46.1 If:
(a) all transferable ballots which under the provisions of rule STV44 (including that rule as applied by rule STV46.11 and this rule are required to be transferred, have been transferred, and
(b) subject to rule STV47, one or more vacancies remain to be filled,
the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV46.12 applies, the candidates with the then lowest votes).

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

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

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

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

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

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

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

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

STV46.10 The returning officer shall after each stage of the count completed under this rule:
(a) record:
(i) the total value of votes, or
(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with
(ii) the recorded total of valid first preference votes.

STV46.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV44.5 to STV44.10 and rule STV45.

STV46.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV46.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:
(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and
(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV47. Filling of last vacancies
STV47.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV47.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

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

STV48. Order of election of candidates
STV48.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV44.10.

STV48.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV48.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV48.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP48. Equality of votes
FPP48.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

Part 7 Final proceedings in contested and uncontested elections

FPP49. Declaration of result for contested elections

FPP49.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:
(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who they have declared elected:
(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the 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 11Questioning elections and the consequence of irregularities

63. Application to question an election

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

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

63.3 An application may only be made to the Regulator by:
(a) a person who voted at the election or who claimed to have had the right to vote, or
(b) a candidate, or a person claiming to have had a right to be elected at the election.

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

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

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

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

63.8 The determination by the person or persons nominated in accordance with rule 63.7 shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency including all the candidates for the election to which the application relates.

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

Part 12 Miscellaneous

64. Secrecy

64.1 The following persons:
(a) the returning officer,
(b) the returning officer's staff,
must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:
(i) the name of any member of the corporation who has or has not been given voter information or who has or has not voted,
(ii) the unique identifier on any ballot paper,
(iii) the voter ID number allocated to any voter
iv) the candidate(s) for whom any member has voted.

64.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter id number allocated to a voter.

64.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

65. Prohibition of disclosure of vote

65.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

66. Disqualification

66.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:
(a) a member of the corporation,
(b) an employee of the corporation,
(c) a director of the corporation, or
(d) employed by or on behalf of a person who has been nominated for election.

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

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

UPDATED 20.1.15 (electronic voting)

Calderdale and Huddersfield NHS Foundation Trust

ANNEXE 3 – FURTHER PROVISIONS

(From paragraph 9.2)

Termination of Membership

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

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

3. If a complaint is made, the Council of Governors may itself consider the complaint having taken such steps as it considers appropriate to ensure that each Member's point of view is heard and may either:

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

4. If a resolution to expel a Member is to be considered at a general meeting of the Council of Governors, details of the complaint must be sent to the Member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

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

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

7. A person expelled from Membership will cease to be a Member upon the declaration by the Chair of the meeting that the resolution to expel them is carried.

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

Calderdale and Huddersfield NHS Foundation Trust

ANNEXE 4 – ANNUAL MEMBERS' MEETING

(From paragraph 10.2)

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

2. Members' meetings are open to all members of the Trust, members of the Council of Governors and the Board of Directors, representatives of the Trust's financial auditors, but not to members of the public. The Council of Governors may invite representatives of the media, and any experts or advisors, whose attendance they consider to be in the best interests of the Trust to attend a members' meeting.

3. All Members meetings are to be convened by the Secretary by order of the Chair of the Council of Governors or upon a resolution of the Board of Directors.

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

   4.1. arrange for the annual members' meeting to be held in different venues each year;
   4.2. make provisions for a members meeting to be held at different venues simultaneously or at different times. In making such provision the Council of Governors shall also fix an appropriate quorum for each venue, provided that the aggregate of the quorum requirements shall not be less than the quorum set out below.

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

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

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

8. It is the responsibility of the Council of Governors, the Company 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.

Calderdale and Huddersfield NHS Foundation Trust

ANNEXE 5 – ROLES AND RESPONSIBILITIES OF GOVERNORS

(from paragraph 11.3)

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

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

ANNEXE 6 – COMPOSITION OF THE COUNCIL OF GOVERNORS

(from paragraph 12.2)

1. The Council of Governors of the Trust is to comprise:
   1.1. up to 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 Council Member 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
      - NHS Calderdale Clinical Commissioning Group /West Yorkshire and Harrogate Integrated Care System
      - NHS Kirklees Clinical Commissioning Group/West Yorkshire and Harrogate Integrated Care System
      -

Calderdale and Huddersfield NHS Foundation Trust

ANNEXE 7 – COUNCIL OF GOVERNORS – STANDING ORDERS

AS APPROVED AT COUNCIL OF GOVERNORS JANUARY 2017

A Public Benefit Corporation

STANDING ORDERS

COUNCIL OF GOVERNORS

Version:	2.0 Review and update including: - Expenses clarification - References to Monitor / NHS Improvement - Typographical amends 2.1 Addition of partner governor May 2019 3 April 2021 Integrated car system references added Addition of period after which governors may stand for re-election
Approved by:	Council of Governors/ Board of Directors
Date approved:	17 January 2017 Version 2 17 October 2019 Version 3 22 April 2021 (tbc)
Date issued:	17 October 2019
Next Review date:	In conjunction with the constitution but as a minimum every three years (2024)

Calderdale and Huddersfield NHS Foundation Trust

CONTENTS

INTERPRETATION

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

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

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

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

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

"**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 Monitor.

"**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.

"**Council Member**" shall mean a governor member of the Council of Governors as defined in section 12 of the constitution.

"**Director**" shall mean a member of the Board of Directors as defined in section 13 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 and Harrogate Health and Care Partnership

"**Monitor**" is the previous name of the Independent Regulator for NHS Foundation Trusts. This changed to NHS Improvement on 1 April 2016.

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

"**NHS Improvement**" is the 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.

Calderdale and Huddersfield NHS Foundation Trust

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 Council Members. 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 Council members (including two appointed Council Members) who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Council Members 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 Council Members, whichever is the case, shall call such a meeting.

2.4. In the case of a meeting called by Council Members in default of the Chair, the notice shall be signed by those Council Members 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 Council Members 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 Council Member, , 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 Council Members 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 Council Members, not less than two Staff Council Members and not less than two Appointed Council Members – 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 Council Member 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.

Calderdale and Huddersfield NHS Foundation Trust

6. Notices of motion

6.1. A Council Member 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

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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 Council Members who give it and also the signature of four other Council Members, of whom at least two shall be Public Council Members. When any such motion has been disposed of by the Trust, it shall not be competent for any Council Member 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 Council Member 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 Council Member 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 Council Members.

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 Council Members present so request, or the Secretary deems it advisable or necessary.

11.3. If at least one third of the Council Members present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Council Member present voted or abstained.

11.4. If a Council member 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 Council Member 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 Council Members' 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 Council Members' present at the meeting and those who gave apologies for each meeting shall be recorded in the minutes.

12.5. Council Members' must make every eftort to attend meetings of the Council of Governors where appropriate and practicable. Where is it's not possible for a Council Member 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 Improvement, the Council of Governors may and, if directed to do so, shall appoint committees of the Council of Governors, consisting wholly or partly of Council Members. In all cases, each committee shall have a majority of Public Council Members.

13.2. A committee appointed under SO 13.1 may, subject to such directions as may be given by NHS Improvement 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 Council Members, nor directors or officers, shall be appointed to a committee, the terms of such an appointment shall be determined by the Council of Governors subject to the payment of travelling and other allowances being in accordance with such sum as may be determined by the Board of Directors or NHS Improvement (in line with SO 20).

13.7. Where the Council of Governors is required to appoint persons to a committee or to undertake statutory functions as required by NHS Improvement, and where such appointments are to operate independently of the Council of Governors or the Board of Directors, such appointment shall be made in accordance with the any regulations laid down by the Chief Executive or his nominated officer or any directions or guidance issued by NHS Improvement from time to time.

14. Confidentiality

14.1. A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Council of Governors or shall otherwise have concluded on that matter.

14.2. A Council Member 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 Council Members 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 Council Members have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair or the Secretary.

16.2. Any Council Member 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 Council Member 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 Council Member 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 Council Members.

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 Council Member 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 Council Members' 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 Council Member, 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 Council Members;

c) A contract with their Clinical Commissioning Group (CCG) / Integrated Care System (ICS) held by a CCG / ICS governor r;

d) An employment contract with a Local Authority held by a Local Authority Council Member;

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 Council Member 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 Council Member 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 Council members.

16.12. Members of the Council of Governors must meet the requirements of the Fit and Proper persons test.

SECTION D: TERMINATION OF OFFICE AND REMOVAL OF COUNCIL MEMBER

17. Termination of office

17.1. A person holding office as a Council member 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 Council Members 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 Member, they cease to be a Member of the constituency by whom they were elected;

d) In the case of an appointed Council Member, the Appointing Organisation terminates the appointment;

e) They have failed to undertake any training which the Council of Governors requires all Council Members 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 Members/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 Members;

h) They are removed from the Council of Governors under the following provisions.

18. Removal of Council Member

18.1. A Council Member may be removed from the Council of Governors by a resolution approved by not less than three-quarters of the remaining Council Members 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 Council Member.

18.2. Where a person has been elected or appointed to be a Council Member 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 Council Member 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 Council Member. 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 Council Member 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 Council Member.

18.6. A Council Member whose tenure of office is terminated under paragraph 18 shall not be eligible to stand for re-election for a period of 2 years from the date of removal from office or the date upon which any appeal against removal from office is disposed of, whichever is the later except by resolution carried by a majority of the Council of Governors present and voting at a general meeting. 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. Council Members are not to receive remuneration.

20. Payment of expenses

20.1. The return cost of travel from the Council Member'

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 COUNCIL MEMBERS

21. Policy

21.1. In relation to their conduct as a member of the Council of Governors, each Council Member 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. Council Members are expected to be impartial and honest in the conduct of official business.

22. Interest of Council Members in contracts

22.1. If it comes to the knowledge of a Council Member 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 Council Member 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 Council Members and one appointed Council Member, 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 Council Members and one appointed Council Member, and at least half of the Council Members 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.

Latest review: August 2019
Approved:

ANNEXE 8 – BOARD OF DIRECTORS – STANDING ORDERS

UNIQUE IDENTIFIER NO: G-1A-2010
Review Date: January 2023
Review Lead: Company Secretary

STANDING ORDERS

BOARD OF DIRECTORS

Directorate responsible for policy:	Chief Executive's Office
Version:	V4 Section1.1 addition of roles and responsibilities of Board of Directors Section 5.3 addition of section on Compliance with Fit and Proper Persons Regulations
Policy author:	Company Secretary
Responsible Committee:	Audit and Risk Committee
Date written:	April 2017
Date approved:	26 January 2021
Date issued:	26 January 2021
Date of latest review:	January 2021
Next review date:	January 2023

Calderdale and Huddersfield NHS Foundation Trust

FOREWORD

Within the terms of authorization issued by Monitor, the former Independent Regulator, NHS Foundation Trusts are required to demonstrate appropriate arrangements to provide comprehensive governance arrangements in accordance with the need to agree Standing Orders (SOs) and schedules of Reservations of Powers to the Trust and Scheme of Delegation in accordance with their constitutions, their Terms of Authorisation and the requirements of the National Health Service Act 2006 ("the 2006 Act").

This Standing Orders document, together with Standing Financial Instructions and the Reservation of Powers to the Board (Scheme of Delegation), provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

These documents provide a comprehensive business framework. All Directors and all members of staff should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

INTERPRETATION

These Standing Orders are subject to continuous review (and formally reviewed and approved by the Audit and Risk Committee and Board of Directors every 2 years) to ensure that they reflect the obligations to which the Foundation Trust is subject under the Health and Social Care (Community Health and Standards) Act 2003, the Terms of Authorisation and the provisions of its Constitution.

For the avoidance of doubt nothing contained within these standing orders shall be construed in contravention of the Terms of Authorisation and in the event that there is such a contravention, the Terms of Authorisation, the 2006 Act and the Constitution shall take precedence.

Whilst the nature of these Standing Orders is that they are subject to variation, no such variation shall contravene the Terms of Authorisation, the 2006 Act and the Constitution.

INTRODUCTION

Statutory Framework

Calderdale & Huddersfield NHS Foundation Trust (the Trust) is a public benefit corporation which was established under the National Health Service Act 2006 ("the 2006 Act").

The principal place of business of the Trust is:
Trust Offices, Huddersfield Royal Infirmary, Acre Street, Lindley, Huddersfield, HD3 3EA

The statutory functions conferred on the Trust are set out in the 2006 Act. The Trust also has a constitution ("the Constitution") as required under the 2006 Act, which includes further provisions consistent with Schedule 7 in support of the governance arrangements within the Trust.
It should be noted that the Trust also has in place Standing Orders (SOs) which deal with the Membership Council which may need to be referred to.

The purpose of the Trust (as required by the 2006 Act) is to serve the community by the provision of goods and services for purposes related to the provision of health care in accordance with its statutory duties and the Terms of the Independent Regulator's Authorisation (the "Terms of Authorisation"). The Trust is to have all the powers of an NHS Foundation Trust as set out in the 2006 Act, subject to the Terms of Authorisation.

As a statutory body, the Trust has specified powers to contract in its own name.

The Trust also has powers under section 28A of the NHS Act 1977 as amended by the 2006 Act to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

Regulatory Framework

Under its regulatory framework the Trust must adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions as an integral part of Standing Orders setting out the responsibilities of individuals.

The Trust's Constitution also requires that the Board of Directors draw up a schedule of decisions reserved to that Board and a scheme of delegation to enable responsibility to be clearly delegated to committees of the board and individual directors.

The Constitution also requires the establishment of an Audit Committee and a Remuneration Committee with formally agreed terms of reference. The Constitution requires a register of possible conflicts of interest of members of both the Board of Directors and the Council of Governors and how those possible conflicts are addressed.

In addition to the statutory requirements the Independent Regulator (the office formerly known as Monitor and now known as NHS Improvement) will issue further requirements and guidance. Many of these are contained within the 2006 Act and on NHS Improvement's website. Information is accessible locally via the Corporate Governance Manager.

Arrangements for public access to information are set out in the Code of Practice on Openness in the NHS and in the Trust's publication scheme under the Freedom of Information Act 2000.

Delegation of Powers

(a) The Trust has powers to delegate and make arrangements for delegation. Under the Standing Orders relating to the Arrangements for the Exercise of Functions (SO 4) the Board is given powers to make arrangements for the discharge, on behalf of the Trust, of any of its functions by an internal committee or sub-committee appointed by virtue of SO 5 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit or as the Independent Regulator may direct. Delegated Powers are covered in a separate document (Scheme of Delegation)

and financial delegation in the Standing Financial Instructions. These documents have effect as if incorporated into the Standing Orders.

(b)

(c) Integrated Governance

(d) Trust Boards are now encouraged to move away from silo governance and develop integrated governance that will lead to good governance and ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance. The Trust Board uses its committee structures to support it in implementing a model of integrated governance.

(e)

(f) **Collaboration of services across West Yorkshire and Harrogate District**

(g) Moving to support the implementation of the Sustainable Transformation Plans (STPs), acute providers are required by NHS Improvement to plan, commission and deliver efficient and sustainable healthcare services for patients across a footprint for the population of West Yorkshire and Harrogate District.

(h)

(i) 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

(j)

(k) 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.

(l)

(m) INTERPRETATION

Save as permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he/she should be advised by the Chief Executive).

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

"Accounting Officer" means the Officer responsible and accountable for funds entrusted to the Trust. He/she shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

"Trust" means the Calderdale & Huddersfield NHS Foundation Trust.

"**Board of Directors**" means the Board of Directors as constituted in accordance with the Constitution;

"Budget" shall mean a resource, expressed in financial terms, proposed by the Board 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;

"Chair" is the person appointed in accordance with schedule 7 of the 2006 Act and under the terms of the Constitution to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Deputy Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable or is unable to act as Chair due to a conflict of interest.

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

"Committee" shall mean a committee appointed by the Board of Directors functioning as an internal committee.

"Committee members" shall be persons formally appointed by the Board of Directors to sit on or to chair specific committees.

"Committee in Common" means a collective group or representation from organisations (i.e. the acute provider Trusts in West Yorkshire and Harrogate District), to perform a particular function or duty.

"Deputy Chair" means the non-executive director appointed by the Trust to take on the Chair's duties if the Chair is absent for any reason or is unable to act due to a conflict of interest.

"Director" means a member of the Board of Directors

"Director of Finance" shall mean the chief finance officer of the Trust.

"Elected governor member" means those governors Members elected by the public constituency and the staff constituency.

"Funds held on Trust" (Charitable Funds) shall mean those funds that the Trust as Corporate Trustee holds at the date of authorisation, or receives on distribution by statutory instrument or chooses subsequently to accept. Such funds will be charitable.

"Memorandum of Understanding" (MOU or MoU) is a formal agreement between two or more parties. Companies and organisations can use MOUs to establish official partnerships. MOUs are not legally binding but they carry a degree of seriousness and mutual respect.

"Monitor" is the former name of the Independent Regulator for NHS Foundation Trusts

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

"NHS Improvement" is the name of the Independent Regulator for NHS Foundation Trusts.

"Nominated officer" means an officer charged with the responsibility for discharging specific tasks within the Constitution and the SOs and SFIs.

"Officer" means an employee of the Trust.

"SFIs" means Standing Financial Instructions.

"SINED" means Senior Independent Non-Executive Director.

"SOs" mean Standing Orders.

"Sustainability and Transformation Plans" are five year plans for the future of health and care services in local areas. STPs represent a very significant change to the planning of health and care services in England.

"WYAAT" means the West Yorkshire Association of Acute Trusts, which includes Harrogate District.

1. THE TRUST

1.1 All business shall be conducted in the name of the Trust.

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

1.1.1 to ensure compliance with the Constitution, mandatory obligations issued by NHS Improvement and relevant statutory requirements;

1.1.2 to establish a set of values and standards of conduct with are consistent with the Nolan Principles governing standards in public life;

1.1.3 to ensure compliance with the NHS foundation trusts: Code of Governance issued by Monitor and report on the Trust's governance arrangements annually;

1.1.4 to determine the vision, mission 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

The Trust has the functions conferred on it by the 2003 Act and by its Terms of Authorisation.

All funds or property received in trust under section 22 of the 2003 Act shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees under Chapter 5, section 51 of the 2006 Act. Accountability for charitable funds held on trust is in accordance with the relevant arrangements made by the Charity Commission and such other statutory requirements or direction by NHS Improvement as may apply.

The Trust has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in "Reservation of Powers to the Board" and have effect as if incorporated into the Standing Orders.

1.2 Composition of the Board of Directors

In accordance with the 2006 Act, Terms of Authorisation and the Constitution, the Board of Directors of the Trust shall comprise both Executive and Non-Executive Directors as follows:

A Non-Executive Chair
Up to 6 other Non-Executive directors (one of who shall act as the SINED)
Up to 6 Executive directors including:

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

The Non-Executive Directors and Chair together shall be greater than the total number of Executive Directors.

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

1.3 Appointment and removal of the Chair and Non-Executive Directors

The Chair and Non-Executive Directors are appointed and may be removed by the Council of Governors in accordance with Schedule 7 of the 2006 Act and under Paragraph 13 of the Constitution.

1.4 Terms of Office of the Chair and Non-Executive Directors

The Chair and Non-Executive Directors are appointed for a period of office in accordance with Schedule 7 of the 2006 Act and under Paragraph 13 of the Constitution. The terms and conditions of the office are decided by the Council of Governors.

1.5 Appointment of Deputy Chair

For the purpose of enabling the proceedings of the board of directors to be conducted in the absence of the Chair, the directors of the Trust will appoint a non-executive director from amongst them to be Deputy Chair. This individual may, through agreement with the Chair take on the role of Senior Independent Non-Executive Director (SINED), as contained in 12.11 of the Constitution.

Any Non-Executive Director so elected may at any time resign from the office of Deputy Chair by giving notice in writing to the Chair and the Directors of the Trust may thereupon appoint another Non-Executive director as Deputy Chair in accordance with these Standing Orders.

1.6 Powers of Deputy Chair

Where the Chair has ceased to hold office or where he/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.

1.7 Appointment of Senior Independent Director

The Board of Directors shall, following consultation with the Council of Governors, appoint one of the Non-Executive Directors to be their Senior Independent Director using the procedure set out in the Constitution.

1.8 Joint Directors

Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for Executive Directorship or in relation to which an Executive Director is to be appointed, those persons shall become appointed as an Executive Director jointly, and shall count for the purpose of Standing Orders as one person.

1.9 Secretary

The Board of Directors shall appoint the Secretary of the Trust and subject to following good employment practice, may also remove that person. The Secretary may not be a Governor, or the Chief Executive or the Director of Finance. The Secretary shall be accountable to the Chief Executive and their functions shall be as listed in the Constitution.

2. MEETINGS OF THE BOARD OF DIRECTORS

2.1 Admission of the Public and the Press

The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Board but shall be required to withdraw upon the Board resolving as follows:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).

The Chair shall give such directions, as he/she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press, such as to ensure that the Board's business shall be conducted without interruption and disruption and without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted. The public will be required to withdraw upon the Board resolving as follows:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public (Section 1 (8) Public Bodies (Admission to Meetings) Act 1960).

Nothing in these Standing Orders shall require the Board of Directors to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of the proceedings as they take place without prior agreement of the Board of Directors.

2.2 Observers at Board meetings

The Board of Directors will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board meetings and will change, alter or vary these terms and conditions as it deems fit.

2.3 Public questions

Members of the public wishing to submit questions to the Board of Directors meeting will be required to submit these in writing by close of play the day before the meeting. The Chair will have the discretion to accept questions at the meeting if appropriate. Questions / statements must not relate to any 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 is being raised at a public meeting. The Chair's ruling on the appropriateness of the question / statement is final. The Chair will reserve the right to respond to questions in writing if time does not permit these questions to be answered in the meeting.

2.4 Calling Meetings

Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

Meetings of the Board of Directors may be called by the Secretary or by the Chair at any time. Meetings may also be called by at least one-third of the directors who given written notice to the Secretary specifying the business to be carried out. The Secretary should send a written notice to all directors within seven days of receiving such a request. If the Chair or Secretary refuses to call a meeting after such a request one-third or more directors may forthwith call a meeting.

2.5 Notice of Meetings

Before each meeting of the Board of Directors of the Trust, a notice of the meeting, specifying the business proposed to be transacted at it, shall be delivered to every director, or sent electronically or by post to the usual place of residence of such director, so as to be available at least three clear days before the meeting.

A notice shall be presumed to have been served one day after posting. Lack of service of the notice on any director shall not affect the validity of the meeting.

In the case of a meeting called by directors in default of the Chair, the notice shall be signed by those directors and no business shall be transacted at the meeting other than that specified in the notice.

Before each meeting of the NHS Foundation Trust a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's offices at least three clear days before the meeting. (required by the Public Bodies (Admission to Meetings) Act 1960 S.I. (4) (a)

The Board of Directors may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting

2.6 Chair of the Meeting

At any meeting of the Board of Directors the Chair, if present, shall preside. If the Chair is absent, the Deputy Chair shall preside. If the Chair and Deputy Chair are absent one of the other Non-Executive Directors in attendance, as chosen by the Board of Directors shall preside.

If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest, the Deputy Chair, if present, shall preside. If the Chair and Deputy Chair are absent, or are disqualified from participating, such Non-Executive director as the directors present shall choose shall preside.

2.7 Setting the Agenda

The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Trust and shall be addressed prior to any other business being conducted.

A director who requires a matter to be included on an agenda should advise the Secretary to the Board prior to the agenda being agreed with the Chair and no less than 5 working days before a meeting.

Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next Board of Directors meeting.

2.8 Annual Members Meeting

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

2.9 Notices of Motion

A director of the Trust wishing to move or amend a motion should advise the Secretary to the Board prior to the agenda being agreed with the Chair and no less than 5 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.

2.10 Emergency Motion

Subject to the agreement of the Chair, and subject to the provision of SO 3.8, a director may give written notice of an emergency motion after the issue of the notice of the meeting and

agenda up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision is final.

2.11 Withdrawal of Motion or Amendments

A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

2.12 Motion to Rescind a Resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding **six (6)** calendar months shall bear the signature of the director who gives it and also the signature of the majority of the other directors. When any such motion has been disposed of by the Trust, it shall not be competent for any director other than the Chair to propose a motion to the same effect within **six (6)** months, however the Chair may do so if he/she considers it appropriate.

2.13 Motions - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

When a motion is under discussion or immediately prior to discussion it shall be open to a director to move:

(a) An amendment to the motion.
(b) The adjournment of the discussion or the meeting.
(c) That the meeting proceed to the next business. (*)
(d) The appointment of an ad hoc committee to deal with a specific item of business.
(e) That the motion be now put. (*)
(f) A motion under Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960 resolving to exclude the public (including the press).

In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a director who has not previously taken part in the debate.

No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, advised by the Secretary, the amendment negates the substance of the motion.

2.14 Chair's Ruling

Statements of directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting, on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

2.15 Voting

Every question put to a vote at a meeting shall be determined by a majority of the votes of the Chair of the meeting and the directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote. No resolution of the Board of Directors shall be passed by a majority composed only of Executive Directors or Non-Executive Directors.

All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

If at least one-third of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

If a director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

An officer who has been appointed formally by the Board to act up for an executive director during a period of incapacity or temporarily to fill an executive director vacancy, shall be entitled to exercise the voting rights of the executive director. An officer attending the Board of Directors to represent an executive director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive director. An officer's status when attending a meeting shall be recorded in the minutes.

2.16 Minutes

The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

Minutes shall be circulated in accordance with directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public via the Trust website (required by Code of Practice on Openness in the NHS). A record of items discussed in private will be maintained and approved by the Board of Directors.

2.17 Joint Directors

Where a post of executive director is shared by more than one person

a) Both persons shall be entitled to attend meetings of the Trust
b) If both are present at a meeting they should cast one vote if they agree
c) In the case of disagreement between them no vote should be cast
d) The presence of either or both of those persons shall count as one person for the purposes of SO 3.20 Quorum

2.18 Suspension of Standing Orders

Except where this would contravene any statutory provision or any direction made by Monitor, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board of Directors are present, including two Executive directors and two Non-Executive directors, and that a majority of those present vote in favour of suspension.

A decision to suspend SOs shall be recorded in the minutes of the meeting.

A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the directors.

The Audit and Risk Committee shall review every decision to suspend SOs.

2.19 Variation and Amendment of Standing Orders

These Standing Orders shall be amended only if:

(a) a notice of motion under Standing Order 3.8 has been given; and
(b) no fewer than half the total of the Trust's total Non-Executive directors vote in favour of amendment; and
(c) at least two-thirds of the Directors are present; and
(d) the variation proposed does not contravene a statutory provision or provision of authorisation or of the Constitution

2.20 Record of Attendance

The names of the Chair and Directors present at the meeting shall be recorded in the minutes. The Secretary shall maintain a record of the number of meetings of the Board of Directors and the attendance of individual directors. This will include those who participate by telephone, video or computer link in accordance with these SOs.

2.21 Quorum

No business shall be transacted unless one-third of the whole number of the Directors are present (including two Executives and two Non-Executives are present), one of whom is the Chair or Deputy Chair and as such has a casting vote.

Any officer in attendance for an executive director but without formal acting up status may not count towards the quorum.

If the Chair or a director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SOs 6 and7) he/she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least two Executive Directors to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting.

3. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

Subject to a provision in the authorisation or the Constitution, the Board of Directors may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 4.2 below, or by a director or an officer of the Trust in each case subject to such restrictions and conditions as the Board of Directors thinks fit.

3.1 Urgent Decisions

The powers which the Board of Directors has retained to itself within these Standing Orders (SO 2.5) may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

3.2 Delegation to Committees

The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by internal committees or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

3.3 Delegation to Officers

Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Board of Directors.

The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board of Directors as indicated above.

Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Director of Finance or other executive director to provide information and advice to the Board of Directors in accordance with any statutory requirements and the Terms of Authorisation.

The arrangements made by the Board of Directors as set out in the “Scheme of Delegation” shall have effect as if incorporated in these Standing Orders.

3.4 Overriding Standing Orders

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around non-compliance shall be reported to the next formal meeting of the 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. COMMITTEES

4.1 Appointment of Committees

Subject to the authorisation and the Constitution, the Board of Directors may appoint internal committees of the Trust consisting wholly or partly of the Chair and director of the Trust or wholly of persons who are not directors of the Trust.

Joint Committees

The Trust may appoint a joint committee by joining together with one or more other health or social care organisations consisting wholly or partly of the Chairman and members of the Trust Board or other health service bodies or wholly of persons who are not members of the Trust or other health bodies in question.

Any committee or joint committee appointed under this SO may, subject to such directions as may be given by NHS Improvement or the Board of Directors or other health bodies in question, appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include directors of the Trust) or wholly of persons who are not members of the Trust committee (whether or not they include directors of the Trust).

Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any internal committees or sub-committee established by the Trust. In which case the term 'Chairman' is to be read as a reference to the Chairman of the internal Committee as the context permits, and the term "director" is to be read as a reference to a member of the internal committee also as the context permits. There is no requirement to hold meetings of internal committees established by the Trust in public.

Terms of Reference

Each such internal committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

Delegation of powers by internal Committees to Sub-Committees

Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board of Directors.

Approval of Appointments to Internal Committees

The Board of Directors shall approve the appointments to each of the internal committees which it has formally constituted. Where the Board of Directors determines that persons, who are neither directors nor officers, shall be appointed to an internal committee, the terms of such appointment shall be determined by the Board of Directors. The Board of Directors shall define the powers of such appointees and shall agree the terms of their remuneration and/or reimbursement for loss of earnings and/or expenses subject to approval by the Membership Council.

Appointments for statutory functions

Where the Trust is required to appoint persons to an internal committee and/or to undertake statutory functions as required by NHS Improvement, and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with the regulations laid down by Monitor.

Appointment to the WYAAT Committee in Common

Membership of the Committee in Common will be defined in the Terms of Reference, which will be agreed or amended by all Parties. The Board of Calderdale and Huddersfield NHS

Foundation Trust has not agreed to delegate any of its statutory functions to the Committee in Common. The scope of the Committee in Common will be responsible for leading the development of the WYAAT Collaborative Programme and the work streams in accordance with the defined key principles, setting overall strategic direction in order to deliver the WYAAT Collaborative Programme.

Committees established by the Board

The Internal Committees and sub-committees established by the Trust are:

- Audit and Risk Committee
- Finance and Performance Committee
- Remuneration and Terms of Service Committee
- Charitable Funds Committee
- Quality Committee
- Workforce Committee
- Joint Liaison Committee
- Transformation Programme Board

The external committee established by the Trust is:

- West Yorkshire Association of Acute Trusts Committee in Common

Such other committees may be established as required to discharge the Board's responsibilities.

4.2 Confidentiality

A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

A Director of the Trust or a member of a committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

5. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

Schedule 7 of the 2006 Act and Section 13.20 of the Constitution requires all Board directors (including Non-Executive Directors) and any other officers nominated by the Trust to declare interests which are relevant and material to the Board of Directors of which they are a member (including the WYAAT Committee in Common). A register of these interests must be kept by the Trust.

5.1 Declaration of Interests

All existing Directors should declare such interests. Any board directors/officers appointed subsequently should do so on appointment.

Interests may be financial or non-financial (i.e. political or belief-based). Interests which should be regarded as relevant and material and which, for the avoidance of doubt should be included in the register are:

- Any directorship of a company;
- Any interest (excluding holding of shares in a company whose shares are listed on any public exchange where the holding does not exceed 2% of the total issued share capital or the value of such shareholding does not exceed £25,000) or position in any firm of company or business, which in connection with the matter, is trading with the Trust or is likely to be considered as a potential trading partner with the Trust including private healthcare organisations and other foundation trusts;
- Any interest in an organization providing health and social care services to the NHS;
- Position of authority in a charity or voluntary organization in the field of health or social care;
- Any affiliation to a special interest group campaigning on health or social care issues.

To the extent not covered above, any connection with an organization, entity or company considering entering in to or having entered in to financial arrangement with the NHS Foundation Trust, including but not limited to lenders or banks.

WYAAT Committee in Common – the Chair and Chief Executive of Calderdale and Huddersfield NHS Foundation Trust will adhere to declaring interests as described within the Conflict of Interests section 10 of the Memorandum of Understanding.

Reference should also be made to the Monitor *NHS Foundation Trust Code of Governance* and the Trust's Constitution and Declaration of Interests Policy in determining whether other circumstances or relationship are likely to affect, or could appear to affect the director's judgement.

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

At the time board directors' interests are declared, they should be recorded in the board minutes. Any changes in interests should be declared at the next board meeting following the change occurring.

Board directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the board's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

During the course of a meeting of the Board of Directors, if a conflict of interest is established the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt this includes voting on such an

issue where a conflict is established. If there is a dispute as to where a conflict does exist a majority vote will resolve the issue with the Chair having the casting vote. If by inadvertence they do remain and vote, their vote shall not be counted.

There is no requirement in the Code of Accountability for the interest of directors' spouses or partners to be declared. However, in accordance with the Nolan Principles of integrity, accountability and openness, good practice suggests that such declarations are strongly advisable (as are declaring the interests of other immediate family members and co-business partners). SO 6, which is based on these regulations requires that the interests of spouses or partners (if living together) in contracts should be declared. Therefore the interests of spouses or cohabiting partners should also be regarded as relevant.

If Board directors/officers have any doubt about the relevance of an interest, this should be discussed with the Chair or Trust Secretary. Financial reporting standard 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of in interest. The interests of partner in professional partnerships including general medical practitioners should also be considered.

5.2 Register of Interests

The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board directors and officers. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by both board directors and officers, as defined in SO 5.1. The Register shall also contain the names of all members of the Board of Directors including those who have no interests.

These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

The Register will be available to the public and the Secretary will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

5.3 Compliance with Fit and Proper Persons

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.

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.

6. EXCLUSION OF THE CHAIR AND DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

Subject to the following provisions of this Standing Order, if the Chair or a director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he/she shall at the meeting and as soon as practicable after its commencement disclose the fact and should withdraw so as not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

NHS Improvement may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health Service that the disability shall be removed.

The Board of Directors may exclude the Chair or a director from a meeting of the Trust while any contract, proposed contract or other matter in which he/she has a pecuniary interest, is under consideration.

Any remuneration, compensation or allowances payable to the Chair or director by virtue of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.

For the purpose of this Standing Order the Chair or a director shall be treated, subject to SO 6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

(a) he/she, or a nominee of his/hers, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

or

(b) he/she is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration; and in the case of persons living together the interest of one person shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

The Chair or director shall not be treated as having a pecuniary interest in any contract proposed contract or other matter by reason only:

(n) of his/her membership of a company or other body, if he/she has no beneficial interest in any securities of that company or other body;

(b) of an interest in any company, body or person with which he/she is connected as mentioned in SO 7.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

Where the Chair or director:

(a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

(o) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he/she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

This Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

This Standing Order applies to a committee or sub-committee of the Trust as it applies to the Board of Directors and applies to any member of any such committee or sub-committee (whether or not he/she is also a director of the Trust) as it applies to a director of the Trust.

7. STANDARDS OF BUSINESS CONDUCT

7.1 Policy

Staff must comply with the national guidance contained in NHS England's guidance Conflicts of Interest in the NHS – Guidance for Staff and Organisations (June 2017) and contained in the Trust's "Policy of Standards of Business Conduct for NHS Staff". The following provisions should be read in conjunction with this document.

7.2 Interest of Officers in Contracts

If it comes to the knowledge of a Board director or an officer of the Trust that a contract in which he/she has any pecuniary interest not being a contract to which he/she is him/herself a party, has been, or is proposed to be, entered into by the Trust he/she shall, at once, give notice in writing to the Chief Executive of the fact that he/she is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

An officer must also declare to the Chief Executive any other employment or business or other relationship of his/hers, or of a cohabiting spouse or partner, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

7.3 Canvassing of, and Recommendations by, Directors in Relation to Appointments

Canvassing of Board directors or officers of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

A Board director or officer of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

Failure to declare any interest which may conflict 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.

7.4 Relatives of Directors or Officers

Candidates for any staff appointment shall when making application disclose in writing whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

The Directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Foundation Trust any such disclosure made.

Any 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 Protect and possible prosecution under the Fraud Act 2006.

On appointment, Directors or officers (and prior to acceptance of an appointment in the case of executive directors) should disclose to the Foundation Trust whether they are related to any other director or holder of any office under the Trust.
Where the relationship of an officer or another director to a Board director of the Trust is disclosed, the Standing Order headed `Disability of directors in proceedings on account of pecuniary interest' shall apply.

The key elements of the Trust's Standards of Business Conduct with which directors and officers are required to comply are:

a. refuse gifts and hospitality above the value of £25
b. declaration of Business interests
c. decline offers of preferential treatment
d. permission to undertake outside employment
e. declaration of offers of commercial sponsorship
f. declaration of rewards
g. respect confidentiality of information.

The principles set out in this Standing Order 8.11 may be expanded by the Trust's Code of Business Conduct as from time to time approved by the Board of Directors.

8. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

8.1 Custody of Seal

It is the responsibility of the Chief Executive to ensure that the Common Seal of the Trust is kept in a secure place.

8.2 Sealing of Documents

The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board of Directors or of a committee thereof or in accordance with any delegation by the Board of its power. The affixing of the Seal shall be attested and signed for by two Executive Directors (not from the originating department) or one Executive Director and the Company Secretary.

Before any building, engineering, property or capital document is sealed the scheme must be approved and authorised and countersigned by the Chief Executive (or an officer nominated by him/her who shall not be within the originating department.)

Contracts for the purchase of goods and services shall be under seal where the aggregate contract value may be reasonably expected to exceed £500,000.

8.3 Register of Sealing

An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealings shall be made to the Board of Directors at least quarterly. The report shall contain details of the seal number, the description of the document and the date of sealing. The book will be held by the Chief Executive or nominated officer.

9. SIGNATURE OF DOCUMENTS

Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

The Chief Executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority.

10. MISCELLANEOUS

10.1 Standing Orders to be given to Directors and Officers

It is the duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions. Updated email copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive e-copies where appropriate of SOs.

10.2 Documents having the standing of Standing Orders

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

10.3 Review of Standing Orders

Standing Orders and all documents having effect as if incorporated in Standing Orders shall normally be reviewed regularly by the Audit and Risk Committee on behalf of the Board of Directors.

10.4 Non-availability of the Chair / Deputy Chair and Chief Executive / Director of Finance.

Save as expressly provided in these standing orders if the Chair of the Trust is not available for whatever reason to transact the business of the trust expressly or by implication delegated to him/her, then the Deputy Chair shall be empowered to act in his/her place and to exercise all the powers and duties of the Chair until the Chair is again available.

If the Deputy Chair is not available for whatever reason to transact the business of the Trust expressly or by implication delegated to him/her, then any two Non-Executive Directors shall be empowered to act in his/her place and to exercise all the powers and duties of the Deputy Chair in relation to that matter.

If the Chief Executive is not available for whatever reason, then any of the Chief Executive's powers and duties expressly or by implication under these Standing Orders may be exercised on his/her behalf by some other Officer duly authorised by the Chief Executive in writing so to act.

6. Board Sub-Committee Minutes

• Finance and Performance Committee held on 11.01.21, 01.02.21, 01.03.21

• Workforce Committee held on 08.02.21, 08.03.21

• Quality Committee held on 22.02.21, 22.03.21, 19.04.21

• Covid-19 Oversight Committee held on 26.03.21

• Audit and Risk Committee held on 12.04.21

• Charitable Funds Committee minutes of meeting held 23.02.21

NHS
Calderdale and Huddersfield
NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on
Monday 11 January 2021, 11.00am – 1.45pm
Via Microsoft Teams

PRESENT

Anna Basford	Director of Transformation & Partnerships
Helen Barker	Chief Operating Officer
Gary Boothby	Director of Finance
Richard Hopkin	Non-Executive Director (CHAIR)
Owen Williams	Chief Executive
Peter Wilkinson	Non-Executive Director

IN ATTENDANCE

Andrea McCourt	Company Secretary
Betty Sewell	PA to Director of Finance (Minutes)
Kirsty Archer	Deputy Director of Finance
Lindsay Rudge	Deputy Director of Nursing and Infection Prevention and Control
Peter Keogh	Assistant Director of Performance
Stephen Baines	Governor representative
Stuart Baron	Associate Director of Finance

ITEM

001/21 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

The Chair also noted his concerns regarding the late arrival of a number of papers accepting the unprecedented circumstances but stressing the need to avoid a recurrence.

002/21 APOLOGIES FOR ABSENCE

There were no apologies to note.

003/21 DECLARATIONS OF INTEREST

Declarations of Interest were noted for Stuart Baron as a Director of CHS.

004/21 MINUTES OF THE MEETING HELD 30 NOVEMBER 2020

The Minutes of the Public meeting were APPROVED as an accurate record subject to the following amends: -

Agenda items 155/20 and 159/20 – the word 'good' should be removed to read "IPR - overall performance at October was at 70%."

The Minutes of the Private meeting held 30 November 2020 were also APPROVED as an accurate record.

005/21 ACTION LOG AND MATTERS ARISING

The Action Log was reviewed as follows:

115/20: Business Better Than Usual (BBTU) – The Director of Transformation & Partnerships updated the Committee that a detailed report showing the progress

being made around the delivery programme will be shared with Finance & Performance Committee at the next meeting – **AB, 1/2/21**

149/20: Community Stroke model – The Chief Operating Officer reported that the Community element of Stroke is part of the recovery work in terms of 'Phase 4' which will be built into the annual planning process over the next few months.

153/20: NHSI Benchmarking – For context the Chair explained that a paper had been presented to Committee which identified potential savings opportunities which came out of the benchmarking process. The Chair questioned whether we had been assured that we had explored all the opportunities and how this can be concluded. The Director of Finance commented that we still need to agree how this can be pulled together, although it was noted that this could be included in the 2021/22 Planning process.

The Director of Finance confirmed that CIP for next year will be discussed with Divisional Directors this week to try to identify how we frame the future finance challenges/opportunities. It was noted that CIP will be re-branded and that meetings this week will try to find a way to engage with clinical colleagues – **Post meeting note –** the CIP process will be discussed and progressed outside F&P

009/21: Use of Resources (UOR) External Review – The Director of Finance explained that this item had been an on-going action and that the Committee had asked for an external review. It was noted that a request to under-go a 'mock assessment' had been made to NHSI/E and that their response was that this would have limited value and that capacity is not currently available. It was also noted that a similar request had been made to WYAAT who had provided the same response. The Director of Finance reported on the positive internal work which had been undertaken and with no robust data available at the moment questioned what an external review would look like. Following discussions with other DoFs it was agreed that a review of our governance around some of the decisions taken could be useful. GB, therefore, proposed to undertake a review of some of our governance to provide assurance to the Finance & Performance Committee.

The Committee discussed the view of whether this would be 'marking our own homework'. It was also highlighted that with the latest COVID lockdown and the focus nationally, the new financial regime in April 2021 is likely to be deferred. The idea that the UoR assessment as it stands may not be relevant going forward, in light of planned changes to the ICS role and commissioning arrangements, was also raised. It was also noted that our fiscal position is better than it was when the initial UoR assurance was undertaken in 2018.

The Chair acknowledged the various comments regarding the changes to the finance regime and that the position 2 years ago is going to be different going forward. However, the Committee has an obligation to assess the progress made since the 'Requires Improvement' rating in 2018 and as a minimum would require a further update on the feedback on the working groups, with a re-assessment of our latest financial position against the original assessment. It was noted that when a clearer picture is available a decision can be made as to whether we need an external view in the future.

ACTION: To provide the Committee with a brief paper summarising the scope, process, involvement, and the timescales of the review to enable the Committee to decide when the time would be right to produce this and discuss further – **GB/KA, 1/2/21**

138/20: Stroke Timelines - The Assistant Director of Performance provided an update to the Committee regarding the timelines which were requested against the actions outlined within the paper discussed at the Finance & Performance Committee in November. It was noted that the only key recommendation not to have been implemented due to the current bed pressures was the protection of beds. It was also noted that recommendations 5 and 7 have been implemented and are discussed at the Daily Tactical meeting.

The Committee acknowledged the action plan and timescales and that several of the recommendations have been implemented.

ACTION: To review improvement of the Stroke Indicators at Finance & Performance Committee again later in the year – **PK/HB, 4/10/21**

156/20: BAF Risks – The Director of Finance apologised for the late arrival of papers which will be discussed at Audit & Risk Committee on the 26 January 2021. The following actions were noted: -

- BAF risks 14/19, 15/19 and 18/19 have been updated to reflect the comments at the last meeting regarding the Capital score.
- The action to align the target score of risks 18 and 14 has been completed as part of the update process.
- Directors are currently reviewing all risks (including the allocation) therefore the question of which Committee will be reviewing the COVID risk is part of the update process.

The Committee **APPROVED** the updates of the Finance Risks on the BAF.

The Company Secretary explained that the sequencing of Committees is slightly out of order and that the following is the latest position: -

Risk 8/19 – is in the process of being updated.
Risk 9/19 – this risk has been reviewed in detail by GB and Stuart Sugarman and it has been agreed not to change the risk description but there will be a routine update.

The Chair asked for it to be made clear, when reporting to Audit & Risk Committee and Board, that F&P have not reviewed Risk 8/19 in detail.

Matters Arising
The Chief Executive asked for an update regarding the significant number of 12-hour trolley breaches within October and November.

The Chief Operating Officer commented that a paper will be going to Quality Committee at the end of January in relation to the 'harm' element.

The Director of Transformation & Partnerships provided an overview in terms of process and the role of the Outer Core group. It was noted that it had been recognised, prior to Christmas, that there had been a total of 58 12-hour breaches in waiting time within ED, and the Outer Core group requested a detailed report from the Incident Management Team (IMT). A report was prepared which detailed the work undertaken around the processes at that time and a view of the decision making that had occurred. It also detailed work undertaken to develop a standard operating procedure and training to be provided to all on-call consultants, managers, and directors. Following receipt of the initial response by the Outer Core group they went back for further clarification around the rationale used in the decision making around the risk assessment in terms of patients remaining in ED as opposed to utilising additional bed capacity on wards. The conclusion was that with the greater stability of the workforce within ED, on balance, it seemed a lower risk for patients to remain on beds (not trollies) within ED. Further clarification was also given around the planned training going forward. It was also noted that the reports have also been reviewed by the Oversight Committee who requested further detail to be presented to the Quality Committee, as above.

The Outer Core group subsequently had further discussions and asked for clarification that of the 58 incidents how many investigations have completed and what assessment of harm has been concluded in addition to key learnings.

In terms of assurance for the Finance & Performance Committee, it was noted that there has been a considerable amount of governance and assurance provided at a very difficult time operationally.

The Committee acknowledged the amount of time and effort put into the investigations around the decision making and the reasons for the actions, any further incidents will be picked up through the IPR where the Finance & Performance have visibility. Regarding the 58 incidents, the Committee agreed that they are comfortable for those to be picked up through the Quality Committee and Board.

ACTION: To provide the report going to Quality Committee on the 25 January 2021 along with the outcome of their discussions following that meeting for information to this Committee – **HB/BS, 1/3/21**

150/20: Diagnostic variances – The Deputy Director of Finance confirmed that it was an error in the description of the Re-set Plan, the Plan was understated and did not include all the elements so, therefore, there was a mis-match between the Plan and the actual and the Plan has since been rectified.

FINANCE & PERFORMANCE

006/21 INTEGRATED PERFORMANCE REVIEW – NOVEMBER 2020

The Assistant Director of Operations reported that the Trust's performance for November 2020 was 65.7% showing some deterioration in month. The following key points were highlighted: -

- SHMI has just gone above 100 for the last 12 months, this is being looked at with the Mortality Review Group
- 3 out of 4 stroke targets have been missed.

- For the first time we have been unable to reschedule an Outpatient appointment within 28 days due to the second Covid outbreak.
- We have seen further 12-hour trolley waits in month (included in the 58 referred to above) although processes have been put in place to resolve this issue.
- Long-term sickness absence has now tipped into Red with a peak of 2.77% for the last 12 months.
- Diagnostics 6-week waits have continued to improve.

It was also noted that final Appraisal results are due and there is a potential that this may go into an AMBER position.

In terms of the 38-day referral to tertiary it was noted that we are reliant on other organisations and their capacity.

With regard to Complaints, this is still an issue, however, there is more focus with the new members of the team who are working to progress complaints in a timely manner and we hope to see some improvements over the next few months. It was added that the Complaints Improvement Group, Chaired by Andy Nelson, Non-Executive Director will monitor those improvements.

The Committee **NOTED** the contents of the November IPR.

007/21 PATIENT BACKLOG UPDATE

The Chief Operating Officer highlighted the themes of the presentation as follows: -

<u>New Referrals</u>

CHFT closed to referrals for a short period of time during April/May. We made a system decision to open (earlier than other Trusts) due to the concern of patients being 'lost' across the system which allowed us to understand the true nature of any backlog. This will have an impact on overall waiting numbers and potentially on the number of 52week waits. Overall referrals have not returned to pre COVID levels, this will be a mixture of reduced attendance at GPs, new pathways and other pathway redesign. For example, increased use of Advice and Guidance (A&G). These requests have doubled in 2020 compared to previous years.

Appointment Slot Issues (ASIs) is not in a good place due to the fact that we are accepting referrals, however, they are not being booked in directly but are going through several of the clinical assessment services. A slide showing some of the specialties where we have more of a concern than others was highlighted as an example.

The Chief Executive asked if the GP leadership looking at this information would recognise and be supportive of it? The Director of Transformation & Partnership confirmed that Outpatient Transformation Board meetings have continued with representation from both LMCs, PCMs and CCGs and there is a mixed picture but that there is a greater sense of positivity and a shared buy-in to the changes in these pathways.

<u>Follow Ups</u>

The trend analysis shows that the overall volume on the waiting list is reducing, however, this may not be an entirely positive picture. In terms of learning from this, some specialties are looking at virtual solutions with Gastroenterology being the first

to lead in this area. It was noted that we have started to clinically prioritise patients were clinicians assign a priority and it is understood that we are the only Trust who have started an outpatient prioritisation. It was also noted that we have also included clinical validation directly into EPR which will make it easier for clinicians to complete.

In terms of the profile of the priority outpatient status, the 'P' value, this has been broken down with the majority in P3 to P5 but what is not available is how far past that date have patients had to wait, this information will be provided going forward.

The Trust are also piloting 'buddies', staff who will be in regular contact with patients who are waiting. The buddies will work proactively with clinical teams to communicate the outcome of clinical review to patients/GPs so that our patients are kept informed and can highlight any clinical concerns. The EPR Buddy form has now been built and ready to input patient contacts.

Referral To Treatment (RTT)
From an RTT perspective there is a large waiting list with a significant number of >52 weeks. It was noted that work within surgery around consistency of the profiling at P2 has started. It was also noted that we have started to look at the index of multiple deprivation and the priority values. Discussions took place regarding what 'P' value we should look at in more detail and what should be our focus. It was noted that it is important to track those cohorts of patients within the backlog who will have a recurrence of treatment.

Cancer
In terms of Cancer referrals, they are back to pre-COVID levels in most specialties. It is a positive story for the Trust as we have continued to deliver pathways in the same time as pre-COVID and quite a different picture to other organisations.

The Chair thanked the Chief Operating Officer for a very thorough summary of the position. It was noted that it is good to see that we are starting to understand health inequalities, however, it was noted that there is still work to do. From the Committee's point of view, the Chair asked Helen to highlight the 3 areas of major concern to which she called out the following 3 areas of prioritisation:

1. need to clear and retain a good position on the P2s waiting for theatre
2. 6-week element of Endoscopy
3. new patients who have gone through the clinical assessment service but need face to face appointments.

ACTION: To take discussions off-line to identify KPIs and how progress is measured going forward - **RH/HB**

The Committee **NOTED** the content of the detailed presentation and the importance for greater detailed understanding of the Outpatient Backlog for both Executives and Non-Executive Directors.

008/21 MONTH 8 FINANCE REPORT

The Director of Finance highlighted the key points reported at Month 8: -

- The original £1.4m risk within the plan has been covered.
- Forecasting to deliver the Plan of a £1.9m deficit which is a similar position across the ICS.

- Since Month 8, it is assumed that all material costs relating to the vaccination programme which we are hosting at the John Smiths' stadium will be covered and that this will have no financial impact for the Trust.
- Risk relating to the Elective Incentive Scheme has reduced and the impact to Month 8 is £108k which will not impact our overall year-end position.

The Committee were asked to note that the total cost of COVID in the year to date has been £21m which has been reimbursed up to recent times.

The Committee **NOTED** the Month 8 Finance Report with costs still running below plan.

009/21 PLANNING UPDATE

The Deputy Director of Finance provided a paper to the Committee which summarised the latest position. It was noted that National Guidance and timescales have still not been issued, however, correspondence was received prior to Christmas which gave a 'financial steer' not guidance.

It was also noted that a couple of points from that correspondence have been used to inform the assumptions for our early planning which is showing a sizeable financial gap, however, as in past years, there is always the possibility of reducing that pressure through a review period. With the present-day scale of the unknown there is understandably a level of caution built in which could inflate the figure.

The next steps for further refinement will be as follows:

- Review the pressures and developments and facilitate cross-Divisional dialogue.
- Divisional PRMs for January will be used for engagement and review.
- To agree the CIP target – session will be held with Divisional leadership
- To engage with system partners
- Await the publication of the National Guidance and to develop plans on the back of that guidance.

In terms of reporting back to this Committee, it is proposed that a further Update/Draft Plan will be presented at the next meeting with a further update in March and hopefully to progress with a full Plan which can go to Board, acknowledging that there are both internal and external factors which play into this timescale.

The Chief Operating Officer commented that it is important that there is an informed decision-making process of planning and that all potential needs are identified, using risk scoring etc., to get to a final prioritised list. It was noted budget holders are still very much involved in the process.

The Committee **RECEIVED** the Planning Update.

010/21 PHASE 3 ADDITIONAL STAFFING

The Director of Finance introduced the paper which detailed the additional staffing required to cover Phase 3 both on a recurrent and non-recurrent basis. The paper shows that an extra 248 staff were requested which will increase our run rate by an additional £5m of which £3.9m relates to nursing and support to nursing posts**.** The paper goes onto describe that this was the case for Months 7 to 9 but that the impact

was lower than the plan and for qualified nursing the pay bill was fairly consistent which showed that the number of unfilled posts were increasing.

The Deputy Director of Nursing and Infection Prevention and Control went on to give assurance to the Committee of how we are mitigating this risk and providing care for our patients. It was noted that a number of colleagues have been re-deployed, bank and agency staff are also being used and this has slowly increased over the last few months. There are additional controls in place to mitigate the safety aspect which include a daily nursing workstream meeting, a twice daily staffing review, we also have increased our leadership capacity to ensure a Matron is on both sites 7 days a week, in addition, there are different on-call arrangements and therapy staff are deployed who are ward based. Work is on-going with NHSI/E in terms of increasing our Health Care Support (HCS) workers who are also being used to mitigate some of the risk.

The Director of Finance added that the costs included within the Business Case for extra staff which had been approved at Commercial Investment & Strategy Committee had not filtered through due to the challenges with recruitment. Work continues to look at the 'new' normal staffing models which will be looked at within the planning process.

The pressure on staff was also highlighted along with the importance of the Wellbeing Hour, levels of staffing will continue to be monitored closely especially with the possibility of the next surge.

The Committee **NOTED** the strong controls and the various mitigations put in place with regard to the staffing issue which will continue to be monitored by the Committee.

011/21 2021/22 CAPITAL PLAN REVIEW

The Associate Director of Finance highlighted that the Capital Plan had been through the Commercial Investment & Strategy Committee and the Capital Planning Group with a further review at Board. The key points to note are that the Trust has limited capital resource. The Capital Planning Day has prioritised the available resource through presentation of the requirement to the Capital Panel. The Panel propose a capital programme that is within the available resource, has a contingency in place to manage any emerging risks in 2021/22 and proposes utilisation of some of the remaining contingency from 2020/21.

It was noted that the paper going to Board will have an additional paragraph in relation to the nurses' accommodation which was part of the 2020/21 Plan and funded through the critical infrastructure risk, this resource is being managed by bringing forward some schemes from next year into this year as the building is awaiting a bat survey before it can be demolished.

The Committee **APPROVED** the 2021/22 Capital Plan noting the additional paragraph to be included in the paper for Board.

012/21 WEST YORKSHIRE & HARROGATE (WY&H) ICS FINANCIAL RISK

The Director of Finance shared with the Committee the principles which had been agreed by the ICS Directors of Finance should there be a risk to the overall plan.

The Committee **NOTED** the contents of the paper.

GOVERNANCE

013/21 DRAFT MINUTES FROM SUB-COMMITTEES

The following Minutes and summaries thereof were received by the Committee:

- Draft Minutes from the Commercial Investment & Strategy Committee held 26 November 2020
- Draft Minutes from the Capital Planning Group held 15 December 2020
- Draft THIS SLA Contract Review held 15 December 2020
- Draft CHFT/SPC Quarterly Meeting held 16 December 2020
- THIS Executive Board held 23 December 2020

The Committee **RECEIVED** and **NOTED** the key points of escalation from the Sub-Committees.

014/21 WORK PLAN 2020/21

The Work Plan was discussed and the number of items for the February agenda will be reviewed.

The Work Plan was **NOTED** by the Committee.

015/21 MATTERS TO CASCADE TO THE BOARD

The following points will be cascaded to Board: -

- UoR position discussed – scoping document to be produced
- BAF Risks reviewed
- IPR - overall monthly performance at 66% with key challenges noted
- Patient Backlog - key priorities identified
- Staffing – challenges of the staffing model discussed; mitigation measures are in place to address risks
- Finance – At Month 8, £1m underspend and planning to achieve the full-year plan
- Planning process outlined
- The Capital Plan for 21/22 was approved by the Committee

016/21 REVIEW OF MEETING

It was noted that the extensive agenda had provided good discussions with a useful deep dive into the outpatient backlog.

017/21 ANY OTHER BUSINESS

There were no further items raised under AOB.

DATE AND TIME OF NEXT MEETING:
Monday 1 February 2021, 11am – 1pm, via Microsoft Teams

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on
Monday 01 February 2021, 11.00am – 14.00pm
Via Microsoft Teams

PRESENT

Anna Basford	Director of Transformation & Partnerships
Helen Barker	Chief Operating Officer
Gary Boothby	Director of Finance
Richard Hopkin	Non-Executive Director (CHAIR)
Owen Williams	Chief Executive

IN ATTENDANCE

Andrea McCourt	Company Secretary
Betty Sewell	PA to Director of Finance (Observing)
Kirsty Archer	Deputy Director of Finance
Peter Keogh	Assistant Director of Performance
Rhianna Lomas	Finance Secretary (Minutes)
Stephen Baines	Governor representative
Stuart Baron	Associate Director of Finance

ITEM

018/21 WELCOME AND INTRODUCTIONS
The Chair welcomed attendees to the meeting.

019/21 APOLOGIES FOR ABSENCE
Apologies were received and noted for Peter Wilkinson.

020/21 DECLARATIONS OF INTEREST
Declarations of Interest were noted for Stuart Baron as a Director of CHS.

021/21 MINUTES OF THE MEETING HELD 11 JANUARY 2021
The Minutes of the Public and Private meetings held 11 January 2021 were APPROVED as an accurate record.

022/21 ACTION LOG AND MATTERS ARISING
The Action Log was reviewed as follows:

125/20 – IPR – July 2020 & Outpatient Improvement Work: It was agreed to defer this action until the 29 March.

149/20 – Stroke Deep-Dive: The stroke indicators review will be seen later in year and the stroke recovery item will be covered in the planning process.

153/20 - NHSI Benchmarking Network: This will be covered in the financial planning process; the Director of Finance and the Chair will discuss this further outside of the meeting. CIP is being discussed outside of the meeting and will continue to be progressed. This will be reported on at a future meeting once a plan has been decided.

005/21 – Matters Arising: The 12-hour trolley waits report went to Quality Committee and the minutes from that meeting will be circulated once available.

The closed items on both the public and private action log were noted by the Committee.

115/20: Business Better Than Usual (BBTU) – The Director of Transformation and Partnerships informed the Committee that the update report included in the papers has previously been submitted to the Transformation Programme Board and the Quality Committee. It was noted that through the involvement of colleagues, partner organisations and members of the public 12 learning themes were identified during June and July 2020 where there was agreement that new ways of working implemented during the pandemic have potential long-term benefit and should be sustained and amplified.

The recommendations within the report were to undertake more work now regarding the initial set up costs to take forward some of the work and to produce more detailed work regarding measurable benefits that CHFT can monitor progress against in the year ahead. This work is now in progress and will come back as a further update in March to the Transformation Programme Board with the aim of taking forward implementation through 2021/22. The enthusiasm of the theme leads was noted, many of whom are clinical colleagues or from partner organisations. They have been keen to take forward the new ways of working despite the pressures they currently face due to Covid.

The Chair spoke on behalf of Peter Wilkinson asking two questions; how are we ensuring no one is left behind on digitalisation due to age or material deprivation? Secondly, how will the health inequalities data affect the prioritisation of patients? Anna Basford assured the Committee that the risk of widening inequalities through digital exclusion has been noted and work is being done with both Kirklees and Calderdale Council to prevent this. CHFT are also reaching out to the local community through listening events so that barriers and solutions can be identified. Regarding patient prioritisation, data is now available on Knowledge Portal Plus that could indicate which groups are being impacted most by waiting times and work is being done to increase awareness from this information. It may be that we undertake action to address the longest waiters in a revised priority order to close gaps. Helen Barker added that focus groups are being conducted with staff to look at the health inequality data as this knowledge will aid recovery however it was noted that recovery will be a long process.

The Chair asked how initial stakeholders will be communicated with going forward? And secondly, will this Committee and others be involved with any of the twelve areas or will it primarily sit with the BBTU group and the Transformation Programme Board? It was noted that updates have been given to the initial stakeholders regarding current progress and an internal newsletter has been circulated. Theme leads are also ensuring they regularly communicate internally with the colleagues in their departments. In March more deliberate communication will be done regarding the benefits. In response to the second question it was noted that each committee should continue to receive updates however the leadership and direction of the project sits with the Transformation Programme Board. The Chair highlighted that this Committee are happy to provide support if necessary.

109/21: Use of Resources (UOR) Scoping Document – The Director of Finance summarised the scoping document. The initial scope would be to look at the key governance forums and describe the decision-making process taken at Incident Management Team (IMT), Capital Management Group (CMG), Commercial Investment & Strategy Group (CI&SG) and our agency discussions. The other area to consider is our staffing resource, a significant amount of CHFT's expenditure relates to staff therefore how much do we want the scope to consider this resource? It was noted that this review could be used to analyse how we have allocated people over the last twelve months and from that, work out what opportunities this gives us for the future. It was noted that the Director of Finance and the Chief Executive had a previous discussion outside of the meeting in which it was decided that it may be useful to gain an external view, therefore Adrian Ennis who has worked with CHFT previously, has been contacted to explore whether he could help.

It was asked if due to a full external review not being undertaken whether we include an independent element. Discussions took place and it was agreed that the Non-Executive Directors will sponsor the work and regularly be involved outside of the meeting. The Chair suggested that the work be linked back to the original assessment and the areas for improvement that were identified. It was also noted that colleagues are working at full capacity due to Covid and work needs to be prioritised. Regarding the scope, the Chief Operating Officer also wanted to ensure that when the expenditure over the last twelve months is assessed, the decisions made at forums other than IMT are reviewed also.

The Director of Finance responded to the various comments by agreeing to summarise early in the report the original position. A governance review combined with the staffing resource considerations will test the latest position against these actions.

The Committee **SUPPORTED** the general scope and the possible external input in relation to staffing reporting back to this Committee in May

ACTION: To report back to this Committee in May – **GB, 5/5/21**

FINANCE & PERFORMANCE

023/21 MONTH 9, FINANCE REPORT INCLUDING HIGH LEVEL RISKS

The Director of Finance highlighted the key points reported at Month 9: -

- The year to date position is favourable by £110k. We are forecasting to deliver the deficit position plan.
- There is a potential risk of being £1m away from the plan therefore conversations have been held with CCG partners and the Mental Health Trust to cover this risk between the organisations. The risk was caused by the decision to increase the annual leave provision at year end due to Covid preventing many colleagues from taking leave. CHFT have in writing from NHSI that increasing our deficit due to this would not affect our overall performance however we are confident that this can be avoided. In summary we are confident of delivering the plan even after covering the additional annual leave provision which would have been an allowable adverse variance.

- Across the Integrated Care System (ICS) at Month 9 we struggled to deliver the target activity however all are forecasting £15m ahead of plan. Discussions are in place regarding what will be done with the surplus. It was noted that it could pose an opportunity to cover a provision related to the Flowers court case and this option is being explored.
- Overall a good position as CHFT and ICS are on target to deliver the plan.

Discussions took place with regard to the cost of agency staff required to cover colleagues taking annual leave. It was suggested that we could buy leave from colleagues at lower cost but this could impact colleagues wellbeing. This requires a full and inclusive debate before a final decision is made.

It was highlighted that Finance have achieved the Better Payment Practice Code due to reaching the 95% target. Finance and Operational colleagues were thanked for their involvement in this.

The Chief Executive suggested that information should be included in the Finance report to better articulate what the CIP information is trying to convey. The Chair also suggested a review of the report as a whole to assess whether it is all still required.

ACTION – To amend the Finance report going forward to either reduce the information being provided or better clarify why it is being provided, even if there is no longer an external reporting requirement. **– KA, 01/03/21**

The Chair queried whether the capital underspending will affect us hitting our revised target of capital spend for the year? It was noted that the Capital plan will be achieved, each scheme is being analysed to ensure orders are in place and on track. It was asked why the aged debt position had increased? The Committee were reminded that the aged debt position had been suppressed by a £1.5m credit to a CCG, this has now been transacted and therefore the position has changed. A second element related to SWYFT, they have moved to processing their invoices through SPS and an error occurred where our invoices were not reaching them. This has now been resolved and will be reflected in the next quarter.

It was noted that a BBTU workstream has been created within Finance and one of these groups will be looking at income and debt. The Director of Finance agreed to share the KPMG benchmarking report as this shows how CHFT compare to other organisations positively regarding aged debt.

ACTION – To circulate the KPMG benchmarking report **– GB, 01/03/21**

Discussions took place regarding the high-level risks, the Committee agreed to reduce the risk relating to this year's Financial Plan from 12 to a 9. The Director of Finance agreed to assess the risk scores of the remaining high-level finance risks noted in the report outside of the meeting and amend them in time for the next finance report.

ACTION: To amend the risk scores of the high-level finance risks in time for the next Committee meeting **– GB, 01/03/21**

The Committee **NOTED** the Month 9 finance report and agreed the change to the risk rating for the 2021 financial plan.

024/21 PLANNING UPDATE

The Deputy Director of Finance briefly explained that clarification has been received regarding the national position for next year and the existing regime will continue in Q1 (potentially into Q2.) Further operational planning guidance will be available from the centre in April. The planning timetable has been revised slightly and the changes can be seen in the papers. Finance continue to plan and the upcoming round of PRMs will be dedicated to planning and will form a key part of the process. Further updates will continue to be received by this Committee. Helen Barker added that the backlog recovery has been separated and this will aid planning and increase focus.

The Committee **RECEIVED** the updated position on the latest national planning guidance and the revised planning time table.

025/21 INTEGRATED PERFORMANCE REVIEW – DECEMBER 2020

The Chief Operating Officer reported that the Trust's performance for December 2020 was 65.7%The following key points were highlighted: -

- The way complaints performance is reported has changed therefore Rachel White will meet with Helen Barker and the DoPs to explain what this means and investigate why performance is low.
- A 10% improvement has been seen regarding stroke admissions.
- Cancer performance is positive, more operating sessions are taking place. However some patients needed subsequent treatment, and this was slightly late. In general CHFT should be proud of how the service has continued. The fast track conversion rate is down, national direction says more patients should be referred however it appears we have a delay regarding routine outpatients therefore this continues to be assessed.
- Long term sick leave is increasing however this is not related to Covid sickness. This will be picked up by the Workforce Committee.
- Regarding the mortality rate, SHMI has increased for 'out of hospital' deaths. There are alerts in place for several specialities therefore this is being discussed with David Birkenhead and Cornelle Parker in order to understand the data further.
- Readmission rates are increasing therefore the work done to reduce this will be relaunched. It was noted that this could be linked to Covid as some pathways like pneumonia and acute bronchitis are more affected by the pandemic. David Birkenhead is reviewing the data.
- Regarding frailty, last December 950 people attended A&E to which 50% were admitted however this December we have seen 900 attend and only 29% be admitted. This shows improvement and has saved the Trust around 1300 bed days. The readmissions for this cohort have also stayed static. This project will be taken to the CI&SC next month to demonstrate the KPIs against the investment.

The Chief Executive questioned whether SHMI needed to be approached with more purpose for example, creating a specific report to be shared with the Quality and Performance WEB in February, which the Chief Operating Officer agreed to create.

ACTION: To develop a SHMI report to go to Quality and Performance WEB in February **– HB, 01/03/21**

The Chair said on behalf of Peter Wilkinson that thanks were to be noted for Peter Keogh for his time spent on the performance management and accountability framework. He also questioned why the complaints performance was particularly low in December, Helen Barker agreed to investigate this and report back next month.

ACTION: To understand why complaints were so low in December and report back the findings at the next Committee meeting **– HB, 01/03/21**

It was queried why head and neck cancer is red when the others are not. It was noted that this is a national pattern as it is a more complex pathway and the bulk of the treatment would go to a tertiary provider of which many are at full capacity.

The Chair asked if the length of the IPR could be reduced. The Chief Operating Officer accepted the challenge; however she is reluctant to take anything out therefore it may be rearranged rather than reduced. Peter Keogh added that we need to bear in mind quality priorities moving forward.

The Committee **NOTED** the contents of the December IPR.

GOVERNANCE

026/21 F&P SELF-ASSESSMENT OF THE COMMITTEE'S EFFECTIVENESS – DEADLINE FOR RESPONSES 01/03/21

The deadline of 1 March was noted, and all were encouraged to send their responses to Betty Sewell. The responses will be reviewed at the 29 March meeting.

027/21 DRAFT MINUTES FROM SUB-COMMITTEES

The following Minutes and summaries thereof were received by the Committee:

- Draft Minutes from the CHFT/CHS Joint Liaison Committee Meeting held 5 January 2021
- Draft Minutes from the Capital Planning Group held 14 January 2021
- Draft Minutes from the CCG A&E Delivery Board held 8 December 2020

The Committee **RECEIVED** and **NOTED** the key points of escalation from the Sub-Committees recognising the achievement of colleagues, both CHS and Trust, to complete Ward 18 in record time to improve patient care.

028/21 WORK PLAN 2020/21

The Work Plan was **NOTED** by the Committee.

A number of items for March have been deferred and the agenda will be reviewed outside of the meeting.

029/21 MATTERS TO CASCADE TO THE BOARD

The following points will be cascaded to Board: -

- An update was given regarding BBTU, further reports will be received in the Spring following discussions at Transformation Board.

- The UOR scoping document was approved. The review will be largely done by the Director of Finance and his team and non-executive input will be given. An external review will potentially be done regarding staffing. Report due early May.
- Month 9 finance report noted. CHFT are on plan despite the annual leave provision. The ICS is also on plan.
- Updated planning guidance has been received however the existing regime will continue in Q1 at least. Further formal guidance will be available from the centre in April. Our plan will be shown at the March 1 Committee meeting.
- IPR showed an overall performance of 65.7%, the following areas for concern were noted regarding complaints performance, increase in long-term sick and increase in SHMI. However, positives were noted regarding, cancer, stroke and frailty performance.
- The impact of our involvement with the vaccine rollout was noted and the John Smith Stadium contract will be reviewed at the March 1 Committee meeting.

030/21 REVIEW OF MEETING

All agreed that the Business Better than Usual and Use of Resources items had been useful.

031/21 ANY OTHER BUSINESS

The vaccine centre contract position in relation to the John Smith Stadium will be shared with the Committee at the next meeting.

ACTION: Review the John Smith Stadium contract at the next Committee meeting **– GB, 01/03/21**

DATE AND TIME OF NEXT MEETING:

Monday 1 March 2021, 11am – 1pm, via Microsoft Teams

NHS
Calderdale and Huddersfield
NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on
Monday 01 March 2021, 11.00am – 13.00pm
Via Microsoft Teams

PRESENT

Anna Basford	Director of Transformation & Partnerships
Helen Barker	Chief Operating Officer
Gary Boothby	Director of Finance
Peter Wilkinson	Non-Executive Director
Richard Hopkin	Non-Executive Director (CHAIR)
Owen Williams	Chief Executive

IN ATTENDANCE

Andrea McCourt	Company Secretary
Betty Sewell	PA to Director of Finance (Observing)
Kirsty Archer	Deputy Director of Finance
Mandy Griffin	Managing Director – Digital Health (Item 040/21)
Peter Howson	Commercial Director, THIS (Item 040/21)
Peter Keogh	Assistant Director of Performance
Philip Lewer	Chair
Rhianna Lomas	Finance Secretary (Minutes)
Stephen Baines	Governor representative
Stuart Baron	Associate Director of Finance

ITEM

032/21 WELCOME AND INTRODUCTIONS
The Chair welcomed attendees to the meeting.

033/21 APOLOGIES FOR ABSENCE
There were no apologies to note.

034/21 DECLARATIONS OF INTEREST
Declarations of Interest were noted for Stuart Baron as a Director of CHS.

035/21 MINUTES OF THE MEETING HELD 1 FEBRUARY 2021
The Minutes of the Public meeting held 1 February 2021 were APPROVED as an accurate record.

036/21 ACTION LOG AND MATTERS ARISING
The Action Log was reviewed as follows:

025/21 – IPR, December 2020: The Chief Operating Officer confirmed that a presentation was given at Quality & Performance Weekly Executive Board (WEB) regarding SHMI. Following that an action was given to investigate the driving factors and assess why SHMI was deteriorating pre-Covid. Data from other organisations will be gained for benchmarking purposes. This information will be submitted back to WEB.

005/21 – 12 Hr Trolley Waits: The Committee noted the circulated papers. The Chief Operating Officer informed all that she is working with Ellen Armistead, the Executive Director of Nursing, to formulate a response. It was questioned whether protected characteristics had been recorded along with ethnicity. The Chief Operating Officer agreed to investigate this.

ACTION: To investigate whether all protected characteristics had been recorded regarding the 12 Hr Trolley Waits **– HB, 29/03/21**

The Chair queried why in some cases there was limited information to which it was understood that busier departments have found updating the Electronic Patient Record (EPR) challenging. It was noted that the Department Matron now has an assurance process in place for regular checks and intentional rounding. There has been limited feedback from the regulators however they did acknowledge that the incidents were out of character for CHFT as an organisation. It was highlighted that other Trust Boards are also seeing breaches however they are not placing as much focus on it. Due to having dealt with the situation we can now identify it quicker and there have been no further incidents. A report was submitted to the Data Quality Board however this has been sent back for further assurance.

The Chief Operating Officer was not aware of any response from the relatives involved therefore she agreed to investigate this with the complaints team. It was acknowledged that a letter was issued to address the long wait time in the Emergency Department. The death that occurred is being dealt with by the Serious Incident Panel therefore this could not be commented on yet.

ACTION: To investigate with the Complaints Team whether there has been a response from relatives regarding the 12 Hour waits **– HB, 29/03/21**

It was noted that colleagues on call have seen this issue receive much greater focus and escalation. The Chair summarised that the incident was out of character for the Trust and work has been done to investigate the situation and it will continue to be monitored.

131/21 – John Smiths Stadium Vaccine Centre Contract: The modelling suggests that the vaccination programme will run until September 2021. The total financial impact could be as high as £14.5m. All reasonable costs will be reimbursed. When costs are more stable it is believed the process will move to a cost per jab structure however this would be on an optional sign up basis so the risk would be mitigated. There is a risk regarding efficiency as this has decreased recently however this has been seen regionally. Costs to date at the end of January are £450k across our programme and the John Smiths Stadium Contract.

The Chief Operating Officer highlighted that some staff are choosing to work vaccination centre shifts rather than ward shifts and this could create an agency staffing cost. This challenge was noted. The Company Secretary is looking for an appropriate Committee to regularly review the governance. The Leeds contract will be sent today, and the schedule will be amended soon as section four and six in the contract are out of date. The financial impact of the programme will continue to be documented in the monthly finance report submitted to the Finance & Performance Committee.

FINANCE & PERFORMANCE

037/21 INTEGRATED PERFORMANCE REVIEW – JANUARY 2021

The Chief Operating Officer reported that the Trust's performance for January 2021 was 64.7%. The following key points were highlighted:

- Overall, there has been a slight deterioration in performance however most domains remain amber and green. Finance and efficiency are improving and caring remains the same but all other categories have deteriorated.
- Complaints were 25% last time however this was due to an error in the data therefore the percentage was in the forties. Complaints will now be reported a month in arrears to ensure the data is accurate. There has been capacity allocated divisionally which has left a gap in the core team which is being assessed. A new dashboard was implemented, Rachel White and the Directors of Operations have met to look at this and they will seek to improve it.
- Emergency care standards have steadily improved however breaches continue to increase in the twilight hours. Due to Covid we effectively have two Emergency Departments (ED) on each site. Work is being done to improve ED care within the Covid recovery plan.
- There have been three outbreaks of Covid on the Stroke Unit therefore focus work has been done to assess the outbreaks and this has affected performance. The Chief Operating Officer will be reviewing the Sentinel Stroke National Audit Programme (SSNAP) data with the Medicine Division.
- The readmissions task and finish group has been re-established as this is also deteriorating.
- The main area for concern regards the responsive domain which relates heavily to the backlogs. The reset modelling is being reviewed and the parameters are being assessed.
- Diagnostic performance is low, and breaches are high. DEXA scanning is driving the backlog therefore Sarah Clenton, General Manager in Diagnostic and Therapy Services (DATS) will investigate this. Endoscopy is also a challenge and the routine backlog is a concern as the pathway can lead to a cancer diagnosis. We are in discussions regarding gaining a qualified provider for the system.
- Data shows our length of stay is the best regionally for 7,14 and 21 days despite being red in the seven day section. A fortnightly executive meeting has been set up with Calderdale colleagues to address long waits and look at strategic decision making. We now have 58 patients on the transfer of care list.

The Chief Executive added that it will be strategically important to be confident about SSNAP data and what it is tells us when we look at the clinical strategy. The Assistant Director of Performance continued the item by informing the Committee that the friends and family test data was reintroduced in December however response rates will not be monitored. A national benchmark will be provided soon. The indicators have been split into two categories - key and standard. 1/3 of the indicators are key. In January, 12 of the key targets were missed therefore we must be wary that this standard does not become the norm.

The Committee questioned whether there were any emerging themes related to long term sickness. The reasons were not known therefore more information will be

gained from Suzanne Dunkley, Executive Director of Workforce and OD so a narrative can be included next month. It was agreed that the IPR will be better triangulated going forward.

ACTION: To gain information from Suzanne Dunkley, Executive Director of Workforce and OD regarding long term sickness in order to include a narrative going forward **– HB, 29/03/21**

The Director of Finance questioned whether there will be a risk created by not monitoring the family and friend's response rates as it could only be given to select patients therefore gaining only positive feedback. It was understood that this will have been considered when the national guidance was produced however it will be noted going forward. The Chair highlighted that cancer performance decreased in January, and falls have increased also. It was understood that CHFT had to reduce theatre activity which created a cancer backlog however the Chief Operating Officer will ensure that this does not continue into February and work is being done to assess the 104 day wait. It was highlighted that the rise in falls and pressure ulcers reflects the staffing levels and bed pressures. Due to Covid many community patients are declining access to healthcare professionals therefore when access is gained, they are in a worse position. The Committee **NOTED** the contents of the January IPR. At the next Committee meeting the outcome based indicators will be reviewed and feedback will be gained from the outpatient improvement work. It was agreed to socialise the updated performance management framework and IPR before it is reviewed at this Committee.

038/21 MONTH 10, FINANCE REPORT INCLUDING HIGH LEVEL RISKS

The Director of Finance highlighted the key points reported at Month 10:

- Year to date deficit of £300k which is £0.5m better than planned.
- Forecasting a £3.6m deficit which is £1.7m worse than plan however it is an allowable deterioration due to the increased annual leave provision. In reality the position is £1.5m better than plan as CHFT have absorbed the Flowers case provision into our position. If we deliver this plan it will be deemed by the regulators as a success.
- Regarding capital we are forecasting to deliver the majority of the plan. The externally funded schemes are delayed but we will not lose the funding. By year end we will have significant capital creditors.
- CIP is being reported despite no requirement for external monitoring. It is being monitored as the impact of under delivery in 20/21 will be played out into 21/22.
- The risk scores have been amended as agreed at the last Committee meeting.
- Overall, the position is good and the main risks are regarding further underspend, the vaccine rollout costs and COVID testing costs.

The Deputy Director of Finance informed the Committee about 21/22 planning. It has been confirmed that the current financial regime will continue into Q1, NHSI are in talks with the government about extending it into Q2 also but this has not been confirmed as yet. Performance review meetings have been held with each clinical division. Following these meetings, it has been agreed to simplify the budget setting process for Q1 and use a normalised budget as a starting point. Due to the planning time being extended we will take longer to consider pressures and recovery requirements. A paper describing this staged process will be going

to Board next week. The Chief Operating Officer added that the backlogs must be kept in mind whilst planning. The baseline budget will be presented at the next Committee meeting.

ACTION: To present the baseline budget at the next Finance & Performance Committee meeting **– GB/KA, 29/03/21**

The Committee **NOTED** the Month 10 finance report.

039/21 BOARD ASSURANCE FRAMEWORK (BAF) RISKS

The Company Secretary informed the Committee that this is the last update of the Board Assurance Framework (BAF) risks for this financial year and it will be presented to the Board on Thursday. The scores for the risks this Committee have oversight on have remained the same and there have been no new risks added. It was noted that the updates are shown in red on the circulated paper. The Board Committee chairs reviewed the allocation of risks and there was a concern from the Chair that this Committee oversee a high volume of risks therefore risk 919 regarding the estate has been moved to the Transformation Programme Board and the references to capital have been removed. It was agreed that the Covid capacity risk does sit with the Finance & Performance Committee.

The current version of the commercial growth risk was missing from the paper therefore this will be circulated after the meeting. It was noted that there are six risks not five as Risk 7/19 regarding NHSI compliance should be included also. There are existing gaps on the paper between actual risk scores and the risk appetite however this is likely to remain as the target risk reflects the risk appetite.

The Board **NOTED** the BAF risks. Final approval will be given at Board.

040/21 THIS COMMERCIAL STRATEGY

Peter Howson, Commercial director for the Health Informatics Service, presented THIS Commercial Strategy to the Committee. The following key facts were noted:

- The overall income stands at £18.57m. 44% of the total income is from external customers and contracts (£8.25m.) 71% of this income (£5.85m) is on a contractual basis ranging from one to seven year contracts. The remaining income (£2.39m) is being achieved through adhoc work.
- THIS operate a margin of 25-30%.
- NPEx has created 149 contracts with every NHS pathology Lab/Trust in England and Scotland. Work is underway to move into Wales and Ireland.
- There are 57 other contracts across primary, secondary and third sector organisations.
- 83% of the total income is generated by the top four contracts.
- Adhoc income is created by procuring equipment on behalf of customers, the setup and implementation fees for NPEx, one off pieces of work for existing customers, one off new customer projects e.g. North East prisons deployment and consultancy services/training.

The Commercial Director continued to note the achievements from 2020/21.

- Last year's income was the highest in THIS history. This year is on target to be even better.
- Successful on boarding of Bradford CCG.

- Roll out to nine North East prisons with Spectrum.
- NPEx being mandated by NHS X for Covid 19 testing, moving from 100K tests per month to 750K per day and now potentially one million tests per hour.
- Supporting customers through Covid vaccine adaptations and roll outs.

It was understood that various challenges have been encountered. Mid Yorks and Leeds have given notice on their service desk agreements for 2021-22. Due to the success of NPEx, Xlab have served notice on the partnership for 2022/23. Covid restrictions could continue to limit delivery of both contractual and adhoc work. Finally, the ICS/CCG restructure could be an opportunity or a risk.

Strategies regarding growth were then presented. The top five contracts will be maintained and improved. They aim to increase in contract values by offering new products and implementing account management. Growth will occur through the existing base by cross selling the current services to the other 17% of contractors. There will be further expansion of the commercial collaboration portfolio - ICS, National Pathology Imaging Collaborative, ISOEC Virtual Smartcards. Overall, the aim is to create new recurrent business from new customers.

These goals will be achieved by ensuring there is a performance management framework for all areas in order to manage by results. The core strengths will be built on. THIS will identify the future of technology for its customers e.g. end user computing, cyber and cloud adoption. Training and support will be given for new core offerings as we adapt. The services and digital position of THIS will be proactively promoted. They will also continue to have a regional presence and be prepared for ICS opportunities.

A new marketing company have been onboarded on a retainer basis. Promotion strategies have been implemented e.g. pay per click, search engine optimisation and public relations. The unique selling points of THIS are being promoted and the current footprint is being reviewed in order to expand. The introduction of Dynamic 365 has begun and this will create tools for customer management, lead generation and conversion. Costs are being controlled and capacity is being measured against performance in order to understand the current utilisation position. Teams are being trained in new areas and there has been a realignment/restructure in order to align the new priorities. In conclusion the two main aims for the next three years are to create a 10% growth in income and continue to contribute to CHFT in excess of £2m per annum.

Further discussion highlighted that the upcoming CCG restructure will also create opportunities for THIS. The Associate Director of Finance noted the successful move of the THIS office to Elland in the last twelve months. It was questioned why NHSIE frequently promote the North East Commissioning Unit and due to this what are they doing that THIS could implement also. It was noted that they are a main competitor along with Daisy Communications. When measured against them it is clear they offer services THIS currently do not, like HR and Finance support. The Managing Director of Digital Health added that these competitors also provide business intelligence, and THIS are not able to bid for some of that work due to the current framework.

Peter Wilkinson, Non-Executive Director, queried why we are not spread further geographically considering the majority of work will be remote. Secondly, could THIS have a larger presence within the private sector. It was noted that THIS do aim to widen their geographic footprint however there are instances where a physical engineer is necessary therefore the opportunity is being explored whilst remaining aware of the potential cost increase. It was understood that the private sector has been investigated and the licensing set up was discovered as a barrier therefore the overall model would need to be adapted for the private sector. This possibility has not been ruled out.

The Chief Executive questioned how THIS see the role of business intelligence (BI) in widening our business offer and opportunities going forward. It was noted that THIS have a capable BI Team however to move this forward as a product we would need to question its transferability to other organisations and whether the team would be confident to interpret and present it to clients. It was agreed that THIS could be missing a key opportunity to profit from giving advice regarding existing systems as this would be a low cost piece of business that creates a high margin. It was explained that consultancy has been offered however to market this as a product resources would need to be committed and this could involve a high set up cost.

The Director of Finance noted that business has been lost with Leeds and Mid Yorks due to the service provided being expensive therefore how will THIS reduce their costs in order to remain competitive going forward. Secondly, due to the success of NPEx, how does the future £2m contribution to CHFT compare to the current contribution. It was understood that work is being done to assess the current costs and reduce them where possible. Regarding the contribution it was noted that it will be lower than normal, and this creates a broader Trust wide cost pressure going forward. The Assistant Director of Performance questioned whether a risk is created by three key individuals driving the Knowledge Portal to which it was explained that work is being done to expand the knowledge base and expertise however at this moment THIS do carry some risk.

The Chair questioned what the key barriers for growth are and what could be done by this Committee and the Board to help break them. It was identified that the ICS/CCG restructure could pose risks or opportunities therefore any information the Board gain on this subject would be appreciated. Expanding the customer network is key therefore if Board members could share their contacts from other organisations this would be helpful also.

The THIS Commercial strategy will go to Board in June. The Committee **SUPPORTED** the strategy and hope to revisit its progress throughout the year.

ACTION: To circulate the THIS Commercial Strategy presentation – **PH, 29/03/21**

GOVERNANCE

041/21 DRAFT MINUTES FROM SUB-COMMITTEES

The following Minutes and summaries thereof were received by the Committee:

- CCG A&E Delivery Board held 12 January 2021
- Draft Cash Committee held 21 January 2021

- HPS Board held 25 January 2021
- THIS Executive Board held 27 January 2021
- Capital Planning Group held 16 February 2021
- CHFT THIS Contract Review Meeting held 16 February 2021

The Committee **RECEIVED** and **NOTED** the key points of escalation from the Sub-Committees. The Chair highlighted the value of the summary report page.

042/21 WORK PLAN 2020/21

The Work Plan was **NOTED** by the Committee.

It was noted that the Chair and Rhianna Lomas (minutes) will prepare the 2021/22 workplan this month. The Chief Operating Officer noted that reset and business better than usual will be discussed next month however there will be no need to do this monthly going forward, the frequency will therefore be reviewed.

043/21 MATTERS TO CASCADE TO THE BOARD

The following points will be cascaded to Board:

- Health Informatics Commercial Strategy Presentation provided by Mandy Griffin & Peter Howson
- Reports reviewed on 12 Hour Trolley Waits as submitted to Outer Core and Quality Committee
- Details of Covid Vaccination Programme Contractual Obligations and Costs
- IPR - overall performance for Jan at 64.7%, with concerns over Complaints performance, SHMI, Stroke indicators (including data quality), Readmissions, DTOC and Diagnostics
- M10 Financial Performance – on track to deliver full year plan, with potential for underspend
- 2021/22 Planning Update – existing regime to continue for Q1 and possibly Q2; CHFT plan to be developed in stages, with initial 'baseline budget' for 29/3 F&P
- Update BAF Risks assigned to F&P reviewed and agreed

044/21 REVIEW OF MEETING

All agreed that the THIS Commercial Strategy presentation was useful. Overall a number of topics were discussed in depth and noted/approved at this meeting.

045/21 ANY OTHER BUSINESS

The Director of Finance noted that Project Echo is to be discussed rather than approved at the Joint Investment forum therefore further delays are expected. It has also been raised that the financial impact will be covered by the ICS therefore conversations will be held with them. It was suggested at the meeting with regulators that the multi-storey car park may need to be funded rather than by the gain share. The proposal paper will be rephrased, and the Director of Finance will have oversight of this before it is circulated. This paper will document the timeline. The Chief Executive will discuss Project Echo further with the Director of Finance and the Associate Director of Finance to agree tactics going forward.

It was noted that this is Betty Sewell, PA to Director of Finance, last Finance & Performance Committee. The Committee members thanked her for her support and wished her a happy retirement.

DATE AND TIME OF NEXT MEETING:
Monday 29 March 2021, 11am – 2pm, via Microsoft Teams

Appendix A

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE – DEEP DIVE

Held on Monday 8 February 2021, 3pm – 5pm
VIA TEAMS

PRESENT:

David Birkenhead	(DB)	Medical Director
Gary Boothby	(GB)	Director of Finance
Mark Bushby	(MB)	Workforce Business Intelligence Manager
Suzanne Dunkley	(SD)	Director of Workforce and Organisational Development
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Jude Goddard	(JG)	Governor
Karen Heaton	(JH)	Non-Executive Director (Chair)
Andrea McCourt	(AMc)	Company Secretary

IN ATTENDANCE:

Leigh-Anne Hardwick	(LAH)	HR Business Partner (for item 08/21)
Nikki Hosty	(NH)	FTSU/ED&I Manager (for item 11/21)

01/21 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

02/21 **APOLOGIES FOR ABSENCE:**

Ellen Armistead, Deputy Chief Executive/Director of Nursing
Helen Barker, Chief Operating Officer
Denise Sterling, Non-Executive Director

03/21 **DECLARATION OF INTERESTS:**

There were no declarations of interest.

04/21 **MINUTES OF MEETING HELD ON 9 DECEMBER 2020:**

The minutes of the Workforce Committee meeting held on 9 December 2020 were approved as a correct record.

05/21 **ACTION LOG – FEBRUARY 2021**

The action log was reviewed and updated accordingly.

06/21 **MATTERS ARISING**

Hot House Topics
Committee members had been given opportunity to express their preference of topic choices, in preference order these are:-

1. Management skills required in a post COVID world
2. Inclusion and Health Inequalities
3. Review of The Cupboard, including how our workforce strategy is aligned with the NHS People Plan
4. One Culture of Care meets Time to Care – how the two strategies work together

Four 2021 Hot House dates are scheduled. The first Hot House date (8 March) is dedicated to NHS Staff Survey – Divisional Trust plans and Trust wide plans, therefore number 4 above will be the subject of a Workforce Committee Deep Dive meeting.

Hot Houses will continue via Teams for the present time and when safe to do so will take place face to face along with Teams option to support attendance.

JG noted an experience where she had felt her attendance at an event not appropriate and asked how Hot House events were managed to ensure all participants feel included. SD recognised that pre-briefings for facilitators and appropriate introductions, along with careful planning of break-out groups/networking opportunities is critical to empowering colleague participation and contribution.

OUTCOME: The Committee **RECEIVED** and **AGREED** the approach to Hot House events.

At this point KH asked if an overview of the NHS People Plan would be provided to the Committee. SD reported that a gap analysis had been carried out to identify how CHFT matched against the national priorities and agreed to circulate the report to the Committee and this item will be added to the March Committee agenda for discussion.

Action: Circulate CHFT actions against NHS People Plan (SD).

Workforce Committee Self-Assessment Action Plan 2019/2020
JE presented the action plan developed to improve consensus and address comments made by Committee members in the self-assessment. The Committee noted four key areas of focus:

- Have in our minds the Committee workplan
- Core member attendance
- Core member participation across agenda items during meetings
- Divisional input to agenda items.

Progress on actions will be reviewed alongside the commencement of the next self-assessment exercise which is due to commence in April in order for the 2020/2021 Workforce Committee Annual Report to be submitted to the July Audit and Risk Committee.

OUTCOME: The Committee **RECEIVED** and **SUPPORTED** the actions to improve Committee feedback and respond to comments.

07/21 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) – JANUARY 2021**

MB presented the report.

Summary
Performance on workforce metrics continues to be high and the Workforce domain increased to 71.2% in December 2020. This is the second month in 19 where the domain score is 'Amber'. 5 of the 15 current metrics that make up the Workforce domain score are not achieving target – 'Return to Work interviews recorded', 'Sickness Absence Rate (rolling 12 month)' 'Long term sickness absence rate (rolling 12 month)' 'Short term sickness absence rate (rolling 12 month), and Data Security Awareness EST compliance. Medical appraisals are on hold due to the current Covid-19 pandemic.

Workforce – December 2020
The Staff in Post increased by 70.46 FTE, which, is also due, in part, to 8.33 FTE leavers in December 2020. There has also been a decrease of 2.42 FTE in the Establishment figure, along with student nurses leaving.

Turnover increased to 7.47% for the rolling 12 month period January 2020 to December 2020. This is a slight increase on the figure of 7.24% for November 2020.

Sickness absence – December 2020
Sickness absence reporting has been revised and now reports on the previous month compared to 2 months behind as previously.

The in-month sickness absence decreased to 5.04% in December 2020. The rolling 12 month rate increased marginally for the fifteenth consecutive time in 25 months, to 4.46%. Anxiety/Stress/Depression remains the highest reason for sickness absence, accounting for 32.02% of sickness absence in December 2020, increasing from 29.81% in November 2020.

The RTW completion rate decreased to 51.61% in November 2020.

Essential Safety Training – December 2020
Performance has improved in 5 of the core suite of essential safety training. With all 9 above the 90% target with 4 achieving the 95% 'stretch' target. Data security awareness target has been amended to fall in line with national guidelines and is now 95%. Overall compliance decreased to 95.16% and is above the stretch target again following last month's increase and is above the stretch target for the fifth time since July.

Workforce Spend – December 2020
Agency spend increased by £0.17M, whilst bank spend also decreased by £1.32M.

Recruitment – December 2020
4 of the 5 recruitment metrics reported (Vacancy approval to advert, Shortlisting to interview, Interview to conditional offer, Pre employment to unconditional offer) deteriorated in November 2020. The time for Unconditional offer to Acceptance in December 2020 increased and was just under 2 days.

KH noted the low compliance in RTW interviews acknowledging this item is for further discussion in a separate agenda item.

Covid vaccinations were noted at approximately 75% with a further 5% to be validated. JG asked what the position is regarding colleagues not wishing to have the vaccine. DB confirmed that whilst the vaccine is not mandatory, infection control measures must be adhered to. Some colleagues choose not to have the vaccine believing they are already protected having had Covid. Midwifery colleagues are working to address fertility concerns. A campaign is underway to reassure BAME colleagues. Some colleagues have been unable to receive the vaccine due to having Covid infection in last 4 weeks.

KH raised the matter of the Trust's workforce age profile noting in particular the over 55s position.

Action: Provide analysys of CHFT age profile at next meeting (MB).

The Committee noted an inconsistency in agency/bank spend. Figures would be reviewed and confirmed.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

08/21 **RETURN TO WORK INTERVIEWS**

LAH provided an updated on the compliance position for return to work interviews and described the steps being taken to improve compliance.

The compliance rate for return to work interviews has seen an ongoing decline since the end of 2019. Seeing its lowest compliance figures in 2020. The metric has not achieved its 95% target in the last 24 months. There had been confusion about which system to record the date for areas that have transferred to the Healthroster system. Managers outline a good understanding of the process, purpose and benefits of completing the interviews, this is not reflected in the compliance data. The HR team has implemented a series of focussed actions to support improvements. Internal compliance will ensure the target of 95% is achieved by 1 April 2021. NH added that the role profile of the two new Wellbeing Advisors includes support to the HR BPs.

Action: RTW compliance position to be reported at May Committee meeting (LAH).

OUTCOME: The Committee **NOTED** the actions to support improvements.

09/21 **PAY ANOMALIES**

JE presented a report which provides information about an exercise to examine payments made to employees in the Trust that fall outside nationally agreed and locally implemented terms and conditions of employment. The report explained pay, terms and conditions arrangements in the Trust are governed by nationally determined agreements for all staff groups. National agreements are largely prescriptive in terms of the what and why though there are some areas where principles have been agreed for local negotiation to determine the appropriate response and limited flexibilities for employers in respect of local pay schemes. Whilst giving consideration to pay arrangements in the context of the Covid pandemic a number of historical pay arrangements operating outside of national terms and conditions were identified

It has been agreed that these arrangements should be reviewed to determine their appropriateness. A review of the payments will be led by the operational HR team in conjunction with service leads. The timeframe for completing the review is 30 April 2021. GB commented on the degree of input to progress the work required once the review is complete. On completion of the review the recommendations will be presented to Executive Board. An updated will be provided to the May Committee meeting.

Action: Review outcome to be presented to May Committee meeting (JE)

OUTCOME: The Committee **NOTED** and **SUPPORTED** the review exercise on pay arrangements.

10/21 **2020 NHS STAFF SURVEY**

NH informed the Committee the indicative results had been received, embargoed until 11 March 2021. The Committee noted CHFT response rate increased from 45.7% in 2019 to 50.1% in 2020. NH provided an overview of the results. Initial indications show an overall improved engagement score. NH outlined the Trust's strategy response which comprises:-

- Development of a Trust wide action plan focusing on key priorities with progress against actions monitored at Workforce Committee
- Development of Division action plans with progress reported at Performance Review Meetings
- Focus on key teams, areas, staffing groups and themes

Aligning to the NHS People Plan, trust-wide key priorities have been identified as follows:-

- Health and Wellbeing
- Leadership Development
- Development opportunities for all

- Inclusion
- I am a member of Team CHFT

GB queried if all areas are developing action plans and NH confirmed that HR BPs are working closely with all divisions and directorates to support production of detailed action plans.

DB asked if more detail was available in terms of respondents' age groups. JE advised that whilst we are able to do some analysis on the indicative results, more detail will be available once the embargo is lifted on 11 March.

KH was pleased to see so many positive results particularly during the pandemic period. KH commented that annual surveys don't always allow the time to respond and measure differences. JE advised NHSE/I is giving consideration to the use of quarterly pulse surveys in addition to the annual survey.

OUTCOME: The Committee **NOTED** the initial results and the positive news.

11/21 **BOARD ASSURANCE FRAMEWORK (BAF)**

AMc presented the BAF. The BAF risks were reviewed at the Audit and Risk Committee on 26 January 2021 and will be presented to the Trust Board on 4 March 2021.

AMc confirmed three of the risks have been updated with the fourth (medical staffing) in progress. Updates will be provided to the Board. The Committee noted that colleague engagement risk (risk 12/19) is one of three risks being reviewed by Internal Audit as part of its end of year Head of Internal Audit Opinion on internal controls which informs the 2020/21 annual report.

On review at the Audit and Risk Committee, it was proposed the Workforce Committee should be asked to consider the change of risk appetite category for risk 10a, 10b and 11/19 to the workforce category. Following discussion members agreed to retain the existing categories.

OUTCOME: The Committee **APPROVED** the BAF.

12/21 **ANY OTHER BUSINESS**

No other business was discussed.

13/21 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

Hot House topics
NHS People Plan
Analysis of workforce age profile
Staff Survey
Return to Work Interviews
BAF

14/21 **EVALUATION OF MEETING**

SD supports HS attendance as maps across staff side issues. GB and DB participation in terms of cross over. JG contributes to patient insight. JG pleased to see good introductions and welcomes seeing people on camera during the meeting.

15/21 **DATE AND TIME OF NEXT MEETING:**

8 March 2021:

9.30am-11.30am: Workforce Committee Hot House – Divisional Presentations of Staff Survey Action Plans

11.45am-12.45pm: Review of Quality & Performance Report (Workforce)

Appendix A

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE – DEEP DIVE

Held on Monday 8 March 2021, 11.45am – 12.45pm
VIA TEAMS

PRESENT:

Ellen Armistead	(EA)	Deputy Chief Executive/Director of Nursing
Mark Bushby	(MB)	Workforce Business Intelligence Manager
Suzanne Dunkley	(SD)	Director of Workforce and Organisational Development
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Karen Heaton	(JH)	Non-Executive Director (Chair)
Andrea McCourt	(AMc)	Company Secretary
Linzi Smith	(LS)	Governor
Denise Sterling	(DS)	Non-Executive Director

IN ATTENDANCE:

Nikki Hosty	(NH)	FTSU/ED&I Manager (for item 24/21)
Philip Lewer	(PL)	Chair

16/21 **WELCOME AND INTRODUCTIONS**

The Chair welcomed members to the meeting.

17/21 **APOLOGIES FOR ABSENCE**

Helen Barker, Chief Operating Officer
Gary Boothby, Director of Finance
Helen Senior, Staff Side Chair

18/21 **DECLARATION OF INTERESTS**

There were no declarations of interest.

19/21 **MINUTES OF MEETING HELD ON 8 FEBRUARY 2021**

The minutes of the Workforce Committee meeting held on 8 February 2021 were approved as a correct record.

20/21 **ACTION LOG – MARCH 2021**

The action log, updated on 2 March 2021, was received.

21/21 **MATTERS ARISING**

CHFT Workforce Age Profile Analysis

MB presented the Trust's current position. The Trust has 5,936 substantive employees, 929 (15.7%) aged over 55. Based on the current profile approximately 25% of 51-55 age group could leave the Trust by age 60, 65% by age of 65 and 95% by age 70. The average age of a doctor is 40 (9.5% of doctors are over age 55). The average age of a nurse is 42 (14% of nurses are over age 55). The average age of a BAME colleague is 38 and average age of a white colleague is 43. There is a higher proportion of white colleagues in the 46-65 age range.

SD advised that the changes to the arrangements in special class status will see fewer colleagues leaving at the age of 55. KH noted the increase in younger BAME colleagues. KH asked if there are any specific concerns in terms of workforce stability. SD feels that the last 12 months may have an effect on people's life choices. The Committee noted the Trust's low turnover over previous years. JE referred to the NHS People Plan which built in mid year career reviews for professional groups giving opportunity to gain clearer insight into people's career choices.

OUTCOME: The Committee **RECEIVED** and **NOTED** the position.

22/21 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) – FEBUARY 2021**

MB presented the report.

Summary
Performance on workforce metrics continues to be amber and the Workforce domain decreased to 65.4% in January 2021. This is the third month in 20 'where the domain score is 'Amber'. 5 of the 15 current metrics that make up the Workforce domain score are not achieving target – 'Return to Work interviews recorded', and 'Sickness Absence Rate (rolling 12 month)' and 'Long term sickness absence rate (rolling 12 month)' and 'Short term sickness absence rate (rolling 12 month), and Data Security Awareness EST compliance. Medical appraisals are currently postponed due to the current Covid-19 pandemic.

Workforce – January 2021
The Staff in Post decreased by 20.78 FTE, which, is also due, in part, to 32.80 FTE leavers in January 2021. There has also been a decrease of 28.89 FTE in the Establishment figure, along with student nurses leaving. Turnover increased to 7.54% for the rolling 12 month period February 2020 to January 2021. This is a slight increase on the figure of 7.47% for December 2020.

Sickness absence – January 2021
Sickness absence reporting has been amended to be for the previous month compared to 2 months behind previously. The in-month sickness absence increased to 5.11% in January 2021. The rolling 12 month rate increased marginally for the sixteenth consecutive time in 26 months, to 4.53%. Anxiety/Stress/Depression remains the highest reason for sickness absence, accounting for 28.88% of sickness absence in January 2021, decreasing from 32.02% in December 2020.

The RTW completion rate increased to 62.97% in January 2021.

Essential Safety Training – January 2021
Performance has decrease in 8 of the core suite of essential safety training. With 9 above the 90% target and 4 achieving the 95% 'stretch' target. Data security awareness target has been amended to fall in line with national guidelines and is now 95%. Overall compliance decreased to 95.02%, and following last month's decrease is a decrease for the third month. However, it is above the stretch target for the seventh time since July.

Workforce Spend – January 2021
Agency spend increased by £0.18M, whilst bank spend increased by £1.75M.

Recruitment – January 2021
2 of the 5 recruitment metrics reported (Vacancy approval to advert, and Unconditional offer to acceptance) deteriorated in January 2021. The time for Unconditional offer to Acceptance in January 2021 increased and was just over 3 days.

KH questioned what the driver was for the overall domain decrease. MB advised the heavily weighted rolling sickness absence dropped the score significantly. KH asked for more information on the international recruitment campaign. EA advised we hope to recruit approximately 70 new starters over a 12 month period with potentially a further campaign in the summer. LS questioned where the new staff would be deployed and EA confirmed the campaign will offset the running vacancy of approximately 140 registered nurses and a number of non registered staff.

DS asked if sickness absence due to anxiety was linked to any particular area. MB confirmed this is general across the Trust. DS also asked if we're seeing the impact on effectiveness of wellbeing packages. SD advised that removing Covid related sickness the position is 4.2% sickness absence which benchmarks well against North East and West Yorkshire. A deep dive is currently being conducted and a reported at a future Committee meeting. Sickness absence is expected to decrease as we enter spring/summer.

DS asked about the position on 5th year students.

Post meeting note: In response to the pandemic, year 5 medical students have been engaged via the Trust's bank to work on the acute floor on each site for up to 12 hours in any one week. As the students don't have GMC registration, remuneration is equivalent to A4C band 3. The students have shadowed FY1 trainees enabling hands on experience with education support and clinical supervision provided. Feedback has been positive with considerable interest in undertaking shifts.

KH queried the zero average number of days to close harassment cases.

Post meeting note: The sentence in the report 'The average number of days to close harassment cases is zero ……' should be ignored. The sentence formed part of a previous report and was included in error.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

23/21 **OUR PEOPLE STRATEGY AND NHS PEOPLE PLAN**

JE presented an update on a review of the Trust's people strategy, The Cupboard, and progress in taking action on NHS provider specific NHS People Plan activities.

A strategy review was initiated in October 2020 of The Cupboard content and concept. The review has been impacted by a focus on Covid19 activity, the first phase has ended with an assessment against the original review ask identifying partial completion. The next phase of activity will concentrate on:-

- changing the strategy content so it is fresh and importantly up to date, ensuring the workforce priorities for the 2021/2022 service year are incorporated and capturing NHS People Plan themes and required actions
  amending the strategy concept so the focus is always on the content ie what we do to deliver one culture of care
  building broader and deeper colleague/stakeholder engagement
- NHS England/Improvement published a 2020/2021 people plan in August 2020 setting out actions for the NHS
- A Trust action plan has been developed capturing the obligations/responsibilities placed on NHS employing organisation

An assessment shows good progress against the employer actions.

The Committee is asked to note the content of the paper and to consider:-

- next step activity for the Trust's people strategy
- progress in actioning NHS People Plan activity.

KH noted the feedback on The Cupboard is largely positive with collegues finding it useful. DS was interested in the actual number of responses and JE confirmed a higher number of responses was anticipated and advised work is progressing to further explore colleagues' assessment of the Trust's people strategy. The Committee noted the December 2021 Hot House will focus on CHFT people strategy and the NHS People Plan.

JE advised that the NHS People Plan had built in specific covid learning and that the Trust's activity plan maintains that link both within its people plan and people strategy.

JE commented on the development of our recruitment approach and future investment in widening participation. AMc asked how this fits across the patch and JE confirmed both Calderdale and Kirklees were considered in developing our response submitted to create the West Yorkshire and Harrogate people plan.

OUTCOME: The Committee **NOTED** and **SUPPORTED** the progress to action activity in both the Trust's People Strategy and the NHS People Plan.

24/21 **PROGRESS UPDATE ON WRES AND WDES ACTION PLANS**

NH presented an overview of activities supporting progress against WRES and WDES action plans.

WRES

- BAME Community Engagement Partner – Tahliah Kelly Martin
- BAME colleagues supporting Equality Impact Assessments
- Lived Experience Videos
- Anti Bullying Week Campaign
- Anti Discrimination posters placed around the hospital
- Empower (Inclusive Personal Development Programme)
- Overseas Community Engagement

WDES

- Colleague Disability Action Group just finding its feet
- CDAG colleagues supporting Equality Impact Assessments
- Lived Experience Videos being Produced
- Anti Bullying Week Campaign / Anti Discrimination posters placed around the hospital
- Dedicated Wellbeing Support for CEV's
- Initial indications highlight home working benefitting some disabled colleagues

To do:

- Leadership Engagement –developing a disability awareness programme to add to the leadership development platform
- 'Celebrating our identity' campaign
- Clear Pathways for colleagues to access support
- Reasonable Adjustment Process Review with input from CDAG
- Management Toolkit – managing a colleague with a disability

LS expressed support for toolkits acting as enablers particularly in dealing with difficult conversations. DS thought the lived experience videos an excellent idea, a powerful way of communicating.

KH commended the significant progress made noting the positive impact across both WRES and WDES.

OUTCOME: The Committee **NOTED** and **SUPPORTED** the progress activity.

25/21 **WORKFORCE COMMITTEE WORKPLAN**

The workplan was received and reviewed.

26/21 **ANY OTHER BUSINESS**

No other business was discussed.

27/21 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

Age profile analysis
Sickness absence/RTW
Progress on People Strategy/NHS People Plan
Progress on WRES/WDES

28/21 **EVALUATION OF MEETING**

DS commented on the comprensive, high quality reports received at the meetings and expressed thanks to the authors.

29/21 **DATE AND TIME OF NEXT MEETING:**

10 May 2021: Workforce Committee Deep Dive, 2.00pm – 4.00pm

QUALITY COMMITTEE

Monday, 25 January 2021

Calderdale and Huddersfield NHS Foundation Trust

STANDING ITEMS

1/21 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Ellen Armistead **(EA)**	Executive Director of Nursing
Doriann Bailey **(DBy)**	Assistant Director for Patient Safety
Dr David Birkenhead **(DB)**	Medical Director
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Karen Heaton **(KH)**	Non-Executive Director / Chair of Workforce Committee
Christine Mills **(CM)**	Public-elected Governor
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Gareth Webb **(GW)**	Interim Senior Risk Manager
Rachel White **(RW)**	Assistant Director for Patient Experience
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Helen Barker **(HB)**	Chief Operating Officer **(item 7/21 only)**
Anna Basford **(AB)**	Director of Transformation and Partnerships **(item 5/21 only)**
Andrea Dauris **(AD)**	Associate Director of Nursing – Corporate **(item 6/21 only)**
Rebecca Sharpe **(RS)**	Project Management Office (PMO) Manager **(item 5/21 only)**
Lucy Walker **(LW)**	Quality Manager, NHS Calderdale / NHS Greater Huddersfield / NHS North Kirklees CCGs

This meeting has adopted the use of a 'reading room' approach for the first time, whereby any reports which are for information, are stored either in the review room on Convene, or in the files section on Microsoft Teams, and not presented during the meeting. It is expected that all meeting attendees read these papers beforehand and any questions or issues relating to the reports can be asked at the meeting.

2/21 APOLOGIES

Lindsay Rudge **(LR)**	Deputy Director of Nursing

3/21 DECLARATIONS OF INTEREST

There were no declarations of interest.

4/21 MINUTES OF THE LAST MEETING, ACTION LOG AND MATTERS ARISING

The minutes of the last meeting held on Wednesday, 30 December 2020 were approved as a correct record.

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

QUALITY PRIORITY UPDATES

5/21 IMPACT OF BUSINESS BETTER THAN USUAL

Anna Basford (Director of Transformation and Partnerships) and Rebecca Sharpe (Project Management Office (PMO) Manager) were in attendance to provide an update on the focussed quality priority for impact of business better than usual, as detailed at appendix B.

Through the involvement of colleagues, partner organisations and members of the public, 12 learning themes were identified during June and July 2020, where there was agreement by the Trust Board that the new ways of working implemented during the pandemic, have potential long-term benefit and should be sustained and amplified. Each theme has a lead, and a detailed 'blueprint' which sets out the vision and ambition of the theme.

This progress report, which has previously been discussed at the Transformation Programme Board, includes a blueprint for each theme and an aggregated report which shares the key benefits identified. The report was positively received at the Transformation Programme Board and noted that work is yet to be done between now and the end of March 2021 to fully clarify any enabling costs. The aim is that the programme will move forward into 2021-2022 around the delivery programme which will be monitored against those benefits identified in the blueprint.

The frequency of reporting into the Quality committee was discussed, and it was suggested that a quarterly update will be provided, as this is not just about the themes and what they deliver, but also includes the engagement of colleagues, and the way the Trust works with partners and the public, and doing that in a different way. EA stated that one of the reasons why this was included as a focussed quality priority was to ensure that the new ways of working were not having a negative impact on service users, and to ensure that the new ways of working do not have an adverse effect to either colleagues or patients.

The Chair thanked AB and RS for the comprehensive update.

OUTCOME: The Committee noted the report and agreed to the quarterly reporting.

AD HOC REPORTS

6/21 POSITION STATEMENT FROM PERSONAL AND PROTECTIVE EQUIPMENT (PPE) GROUP

Andrea Dauris (Associate Director of Nursing – Corporate) was in attendance to provide an update on appendix C regarding the work undertaken by the PPE Strategic Group, which was established in response to the pandemic. It also forms an element of the focused quality priority on nosocomial infections.

At the start of the pandemic, there was an interrupted PPE supply chain and a rapid piece of work was undertaken to provide assurance and continued supply of PPE to clinical areas. Through the membership of the Group, a daily stock position of PPE was established across the organisation, as well as the development of an escalation plan which described what should be done in the event of a shortage of PPE supplies. It was noted that during the pandemic and continuing, these responses have not been mobilised.

The PPE Group also established a quality assurance process whereby any piece of PPE brought into the organisation, there was a team who would review the equipment to ensure it met with specifications and quality required.

FFP3 was another workstream that the Group had oversight of, which refreshed and approved a new strategy in response to the fluidity of the masks and moved to changing the supply of FFP3 masks in clinical areas. Investment was also made in the supply of positive pressure

hoods. At the beginning of the pandemic, there were approximately 15 hoods in the Trust as part of the response to aerosol generating procedures (AGPs), and this has now been increased to 82 hoods. This put the organisation in a good position regarding the number of hoods, a supply or reusable FFP3 masks and a supply of disposable FFP3 masks. The provision of training in clinical areas for those pieces of equipment was also reviewed.

The PPE Group also responded to rapid changes to national guidance, which led to the development of the 'Trust Greeter' service that was at the main entrances of the hospitals which directly responded to changes in national guidance, but it was also a meet and greet service that reminded people about PPE and responded to any concerns.

The report also describes the health and wellbeing taskforce that was established in response to anxiety in relation to PPE, which consisted of registered nurses who checked with staff regarding PPE supplies, reinforcing good practice, etc. It worked well and dispelled myths in clinical areas and fed back into the PPE Group of actions which were required next.

It was noted that the report links to the nosocomial quality priority, and the key point to make is that an interruption to the supply chain was note experienced and continued to deliver the correct PPE to the right places at the right time, and the work of the Group has now been stood down to a weekly meeting that is building further resilience to clinical areas.

The Chair commented on the excellent report outlining the amazing work done at pace by the Group which had to be extremely responsive as situations changed. The Chair also noted the engagement made with staff to seek their views and feedback and asked if there was a group of staff who struggled with wearing masks and how they were supported. AD stated that the wearing of the FFP3 masks did cause problems for staff particularly in the critical care areas where they wore the masks for a period of time, with noticeable markings across the skin areas of their faces, and part of that feedback from staff led to the development of the rapid pathway from the Tissue Viability team to support the skin damage and to support staff to keep them safe with wearing the devices and looked after their skin. A specific pathway was also developed for the dermatology service.

RW commented on the good report and alerted the Quality Committee to how the role of volunteers will be developed in the future. Following the 'Trust Greeter' service being stood down, and the receipt of concerns into the organisation from the public, this informed the application made to the Winter Volunteering Service for funding, and to look at moving that service forward and supported by volunteers.

EA thanked AD for her stewardship of the PPE Strategic Group.

DBy asked whether there is an improvement with the maintenance of the hoods as there were some previous challenges. AD stated that work is ongoing with the contracting process to ensure there is clear ongoing maintenance of hoods going forward. In addition, the Infection Prevention and Control (IPC) team now have additional resource looking at the FFP3 broad agenda, which includes the hoods and ongoing maintenance.

OUTCOME: The Committee noted the report.

7/21 12-HOUR TROLLEY BREACHES

Helen Barker (Chief Operating Officer) was in attendance to present appendix D, which provides highlights following the review of 12-hour breaches in the Emergency Departments (ED).

The paper describes the situation which arose in quarter 3, during wave 2 of Covid-19, where there was an increase in attendances from positive-Covid and non-Covid admissions, combined with a significant management change in the ED and nurse staffing gaps on the inpatient wards.

Patients were waiting longer for beds and there was discussion regarding the opening up of additional capacity, however, it was felt that this could not be done in relation to safe staffing and it would be safer for patients to be bedded and wait in the ED. There were concerns that this was rapidly becoming normalised, with a high volume of patients waiting longer than 12 hours from a decision to admit, in particular at HRI due to the majority of admissions with a dependency on elderly care facilities being on the HRI site.

A paper was provided for the outer core group that described the decision-making process, and the outcome of the review of those patients. The review has provided assurance in 49 of the 60 cases, that the extended wait in the ED did not appear to have impacted patient outcome. For the remaining 11 cases, a further clinical review was recommended, with three patients needing a more detailed investigation, which is currently ongoing. The actual outcome of those three investigations will need to return to the Quality Committee.

It was noted that the patients in ED were all placed on beds for comfort; where there should have been an intentional rounding and observation on the whole, these were undertaken, however, the Committee cannot be assured that every patient received every bit of intentional rounding and observation, and an action plan has been developed in the ED to ensure that policies are adhered to.

It was also noted that there was one patient who died in the ED who had exceeded the 12 hour wait, and it was suggested that the wait contributed to the patient's demise. EA stated that this case is being taken through as a separate serious incident investigation and is being progressed.

EA stated that the organisation has had a clear position to not move to a 'full capacity protocol' to avoid 12-hour breaches. The protocol would mean moving a patient out of the ED and they would be housed along the corridor in a ward area. It has been made clear that this is not safe or a good experience for the patients.

It was asked that the following elements from the Outer Core Group are incorporated in the paper:

- *an additional recommendation that going forward all patients experiencing a 12-hour delay to their treatment in ED will receive a timely written communication from the Trust apologising for this* - HB noted that the process for apology letters has been restarted via the PALS / Complaints team

- *An explanation / view of why the number of breaches experienced was significantly higher at HRI than CRH* – HB noted that a response to the HRI / CRH split has been provided and allocating timeline and leads for all actions and will be managed through the Performance Review Meeting (PRM) process.

- *For each recommendation a named lead / owner responsible for implementing the recommendation and a target timescale for completion of the action*

- *The report includes that an annual review will be undertaken by the Quality Committee to ensure the actions have been completed and embedded. The use of a 'BRAG' (i.e. blue, red, amber, green) scoring system should be utilised to indicate progress – with blue confirming actions related to each recommendation are fully embedded in practice* – HB suggested that the annual review is done at the end of quarter 4 so it covers the winter period.

Due to the Quality Committee now having responsibility for the overview and monitoring of this, further updates will not be required to be submitted to the Outer Core Group.

The Chair asked how frequently a report or update should be provided to the Quality Committee, and it was suggested that a verbal monthly update on any further 12-hour

breaches could be provided, with a quarterly paper against the KPIs and the annual formal report.

OUTCOME: The Committee noted and agreed the recommendations in the report and the quarterly reporting.

8/21 QUALITY AND SAFETY STRATEGY

Ellen Armistead (Executive Director of Nursing) briefly presented appendix E, which has previously been to the Quality Committee. EA reminded the Committee of the purpose of the Strategy, the links to the visions, values and pledges; the one- and ten-year strategy; the governance framework; the quality account priorities and focused priorities and next steps.

The Committee were asked to acknowledge the amendment of the sub-group reporting structure for the Quality Committee and to agree the next steps going forward.

KH commented on the good document and asked whether this strategy would be communicated to the Council of Governors for information. EA stated that the quality account priorities within the strategy will be discussed with the Governors.

OUTCOME: The Committee noted and approved the Strategy.

CARING

9/21 PATIENT EXPERIENCE REPORT

Rachel White (Assistant Director for Patient Experience) presented appendix F, highlighting ~~work ongoing with complaints service users to gather their feedback in relation to complaints, and work ongoing to recruit for the improvement collaborative~~ ongoing work to develop a survey aimed at gathering service users feedback in relation to the complaints service and to recruit members to an advisory group that will work alongside the improvement collaborative and on co-production projects.

Matters for escalation included:

- The Committee being asked to grant devolved responsibility to the Making Complaints Count Improvement Collaborative in order to sign off on the Service Survey to expedite its use by the Trust.
- The cancellation of the monthly Patient Experience and Caring Group with essential business being carried out via an interim arrangement of revised escalation / modified reporting directly into the Quality Committee.
- The trust being alerted to a risk in relation to commitment to carers. Work is ongoing within the Commitment to Carers workstream to mitigate the risk.

A query was raised on the attached project plan which related to restricted visiting and PPE supply. The key point was that certain groups within the Trust have an agreed approach to support carers being part of the care delivery team for people with particular needs, and there are clear guidelines and support in terms of PPE supply, and how it should be used. However, should the Trust move to a place where wider groups of carers are considered as part of the care delivery team (e.g. carers for people with learning disabilities, autism and dementia), then extra consideration is needed to ensure that PPE match will be available for them.

OUTCOME: The Committee noted the update and were in support of devolving responsibility Making Complaints Count Improvement Collaborative in order to sign off on the Service Survey.

SAFE

10/21 PATIENT SAFETY GROUP REPORT

The Patient Safety Group report was available in the reading room at appendix G.

The Chair raised concerns regarding the lack of future improvement work listed in the report in relation to the Pressure Ulcer Collaborative, and the non-attendance of a representative from the collaborative at the Patient Safety Group. DBy stated that these observations have been noted, and EA noted that following the Board of Directors meeting, Judy Harker (Lead Tissue Viability Nurse) has been asked to undertake a deep dive into pressure ulcers, which will be presented at the next Quality Committee meeting, as there is a definitive link between the operational pressures and pressure ulcer development. Early feedback from the deep dive has shown that there are various pockets of good work being undertaken, however, a focused effort on action planning is now needed. It was also agreed that a dedicated monthly report is required from the Collaborative at the Quality Committee.

The Chair also noted from the report that the last update received from the Resuscitation Group into the Patient Safety Group was in October 2019. DBy stated that an update report was received in December 2020 with queries returned to the leads requesting reassurance on an action plan following an audit, however, representation from the Resuscitation Group has not been present at the Patient Safety Group due to one of the two Resuscitation Officers being off for a period of time. Pressures within the service are recognised, however reassurance is still required from the Resuscitation Group, which will hopefully be provided at the next Patient Safety Group meeting in February 2021.

OUTCOME: The Committee noted the report.

11/21 MEDICATION SAFETY AND COMPLIANCE GROUP REPORT

The Medication Safety and Compliance Group report was available in the reading room at appendix H.

In terms of medical gases, the Chair was pleased to see progress in terms of completing the occupational testing for staff and asked if a company has now been commissioned to carry this out. ES reported that the most cost-effective company was chosen, and checks are being made to ensure they meet the appropriate standards required.

The Chair also showed an interested in the development of the electronic controlled drugs (CD) registers and asked how long the development phase would take. ES stated that meetings are booked over the next three to four weeks with key members of the Trust to review the IT needed, and a product can potentially be ready in the next three months to trial.

ES reported on a noted improvement with the collection of oxygen cylinders, and also noted that following the work carried out with purchasing and installing an active temperature monitoring system in Trust fridges, there is still a concern on what the escalation process will be during out of hours if areas go out of range, and a safe method is still to be decided by the Trust.

DBy also thanked ES for the work done on getting the polymer gel patient safety alert signed off and systems in place to monitor these through pharmacy audits.

OUTCOME: The Committee received and noted the report.

12/21 INFECTION PREVENTION AND CONTROL BOARD REPORT

The Infection Prevention and Control report was available in the reading room at appendix I, highlighting the position of the Healthcare Associated Infections (HCAIs) during quarter 3 in 2020.

David Birkenhead (Medical Director) noted that the report focuses heavily on Covid, however, other infections are still occurring at CHFT. The increase in clostridium difficile cases needs to be monitored and MRSA screening needs to improve. Covid is currently the greatest challenge, particularly in relation to the new variants, the increase in hospital acquired Covid cases and outbreaks over the last few weeks.

There are also a number of challenges regarding the estate - ward designs and ventilation - which are being mitigated.

OUTCOME: The Committee received and noted the report.

WELL LED

13/21 BOARD ASSURANCE FRAMEWORK (BAF) RISK – 4/19: PATIENT AND PUBLIC INVOLVEMENT

Ellen Armistead (Executive Director of Nursing) presented appendix J, providing the outcome of a review of the patient and public involvement BAF risk and a level of assurance in terms of mitigation.

The risk articulation and impact remain the same. The key controls have been reviewed and considered to be relevant and an accurate reflection, however, the BAF has been updated to state that the a Health Inequalities group has been set up to add challenge around the extent to which health inequalities drive service planning. In relation to the gaps in control, and while some activity has been progressed, understandably divisions and teams have had a number of competing priorities to manage against a backdrop of Covid-related staff shortages, and the BAF has been updated to reflect this. Another significant challenge to mitigating the risk is a result of relative visiting restrictions. This has resulted in missed opportunities to gain the views of patients' family and friends in assessing how well the Trust is delivering patient centred care. The BAF has also been amended to reflect this.

The risk rating has been reviewed and given the impact of managing the current phase of the pandemic, the current score has been increased to 16.

The Chair noted that this has been a comprehensive review and noted that the risk score has increased to 16, as well as the list of ongoing positive assurances, in spite of all the challenges.

OUTCOME: The Committee noted and approved the recommendations and updated BAF.

14/21 BOARD ASSURANCE FRAMEWORK (BAF) RISK – 6/19: COMPLIANCE WITH QUALITY AND SAFETY STANDARDS

Ellen Armistead (Executive Director of Nursing) presented appendix K, providing the outcome of a review of the compliance with quality and safety standards risk.

There has been very little in the way of external reviews during the pandemic, which was a deliberate strategy of the arms-length bodies to reduce the burden on organisations, however, making a judgment on the overall effectiveness of mitigating actions becomes more challenging to assess. The CQC and Compliance Group has continued to meet and the should and must do's following the last CQC visit have been resolved and are due to be closed.

Internal monitoring has continued throughout the pandemic and ward / service level assessments have been further developed.

The risk articulation and impact remain the same. Key controls have been updated to reflect a refresh of the risk management strategy, a review of the Quality Governance structure and the agreement of the Learning and Improving: Quality and Safety Strategy. The positive assurances remain relevant, however, with no new external reports, the external validation becomes difficult. The gaps in controls remain a risk, in relation to the capacity of serious incident investigators to undertake a review in a timely manner. Work to develop a strategy to resolve this is underway. The risk rating has been reviewed and remains the same, and the gaps in assurance reflects the move away from non-essential activity by regulators.

The Chair asked how the further work which needs to be developed to understand the impact on care standards as a result of the pandemic response, clinical prioritisation and staff shortages will be done and taken forward. EA reported that clinical prioritisation is now a focused quality priority and a key issue in assessing whether there have been any deficits in care as a result of how the Trust has had to operate throughout the pandemic, so this is ongoing. In relation to the staff shortages, there are several good systems and processes in place which have been better utilised to respond to staff shortages as a result of the pandemic, however, nationally, it is not known how long it will be before this is resolved.

OUTCOME: The Committee noted and approved the recommendations and updated BAF.

15/21 QUALITY COMMITTEE TERMS OF REFERENCE

The Committee's terms of reference have now been updated to includes the Assistant Director of Patient Experience to the membership, and were available in the reading room at appendix L.

OUTCOME: The Committee noted and approved the change to the terms of reference.

RESPONSIVE

16/21 ANNUAL LEGAL SERVICES REPORT

The annual legal services report was available in the reading room at appendix M, highlighting the claims and inquests during 2020.

OUTCOME: The Committee noted the report.

POST MEETING REVIEW

17/21 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

The Quality Committee received:

- The final quality and safety strategy
- The 12-hour trolley breaches report and noted that the Committee is taking over the responsibility for the monitoring of progress in regard to the recommendations
- The deep dive into the Board Assurance Framework risk for Patient & Public Involvement (4/19), which has been increased to a score of 16
- The deep dive into the Board Assurance Framework risk for Compliance with quality and safety standards (6/19)

18/21 REVIEW OF MEETING

What went well….

- The revised way of separating the reports for background reading, which allows members to have pre-formed questions and contributions ready for those reading materials and not spending unnecessary attention where not needed.

19/21 ANY OTHER BUSINESS

There was no other business.

ITEMS TO RECEIVE AND NOTE

20/21 CQC AND COMPLIANCE GROUP TERMS OF REFERENCE

The CQC and Compliance Group terms of reference were available in the reading room at appendix N.

OUTCOME: The Committee noted and ratified the terms of reference.

21/21 QUALITY COMMITTEE ANNUAL WORK PLAN

The workplan was available at appendix O for information, and the Chair noted that the workplan is due to change once the revised sub-committee reporting as noted at item 8/21 is in place.

NEXT MEETING

Monday, 22 February 2021 at 3:00 – 4:30 pm on Microsoft Teams

QUALITY COMMITTEE ACTION LOG FOLLOWING MEETING ON MONDAY, 25 JANUARY 2021

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
OPEN ACTIONS				
30.12.20 (205/20)	**BAF Risk 3/19: seven-day services**	David Birkenhead / Cornelle Parker	DB stated that every effort will be made to complete the audit to provide the Quality Committee with a level of assurance in relation to compliance. **Action 30.12.20**: DB to follow this up with CP, DBy and RW regarding resources needed to complete the audit **Update: Completion of audit to be confirmed**	
26.10.20 (184/20)	**Bi-monthly report**	Gill Harries, Louise Croxall, Julie Mellor	**Action 26.10.20:** Gill Harries and Louise Croxall to be invited to a future Quality Committee to discuss their plans to manage the risk of a split-site paediatric service. **Update: see agenda item 26/21**	**See agenda item 26/21**
FORTHCOMING ACTIONS				
5.2.20 (21/20) 28.9.20 (154/20) 30.12.20 (matters arising)	**Outpatients improvement plan**	Helen Barker	**Update 30.12.20:** In relation to the update received from the outpatients' action plan, EA noted that reference to the risk register is made in relation to a closed risk on outpatient delays, however, the risk relates to a new risk on COVID-related delays. Due to the change in circumstances due to the delays as a result of COVID, could HB attend QC to provide updates on all outpatient risks that have been included in the COVID-related risks, as there have now been changes. **Action 30.12.20:** That Helen Barker attends to provide update on outpatient COVID-related risks	**DUE Monday, 22 March 2021**
26.10.20 (181/20)	**Medical examiner update**	Dr Tim Jackson	Following a verbal update from CP, it was agreed that Dr Tim Jackson is invited to the next Medical Examiner's update in April 2021 **Action 26.10.20**: Dr Tim Jackson (Lead Medical Examiner) to be invited to the Quality Committee meeting to provide the next update in six months' time.	**DUE Monday, 19 April 2021**
CLOSED ACTIONS				
30.12.20 (199/20)	**Superabsorbent polymer gels**	Doriann Bailey	In relation to areas that use Vernagel super absorbent sachets, but do not stock controlled drugs therefore, will not be audited by pharmacy as part of their safe storage of controlled drugs audit, DBy asked how it will be assured that there are no missed opportunities in the monitoring and auditing of those areas. EA stated that this should form part of the matron's audit, and that a spot-check audit takes place in six months' time to ensure compliance in dermatology CRH, angiography CRH and radiography HRI, as outlined in the appendix of the report. **Action 30.12.20**: DBy to contact Jean Robinson (Senior Infection Control nurse) to add the superabsorbent polymer gel check to the frontline ownership (FLO) audit. **Update: JR agreed to add compliance checks to the FLO audit.** **DBy also reported that she had met with Richard Hill (Head of Health and Safety), who will be adding the three areas above to the Health and Safety monthly checks going forward.**	**CLOSED 25 January 2021**
30.12.20 (201/20)	**Quality Account priority – learning lessons to improve patient experience**	Rachel White	Rachel White (Assistant Director for Patient Experience) presented appendix E, which was detailed in the report provided at item 200/20. RW summarised that previous work has taken place in relation to the learning portal, and further discussions are needed on what this work entailed. **Action 30.12.20**: Further update to be provided once this is known. **Update: See matters arising – Work on this priority had paused this month in light of a focus on the Making Complaints Count Collaborative & associated activities. This priority now sits within the Making Complaints Count Improvement Collaborative workplan.**	**CLOSED 25 January 2021**
30.12.20 (206/20)	**FSS Terms of Reference**	FSS Division	The terms of reference of the division's Patient Safety and Quality Board meetings were also circulated for ratification from the Quality Committee, and it was noted that the administrative support on the terms of reference would need to be revised, as well as the addition of divisional patient experience and quality support leads on the membership of the PSQBs. **Action 30.12.20**: The terms of reference to be returned to the division for the relevant amendments to be made and returned to the Quality Committee for ratification. **Update: Action forwarded to division**	**CLOSED 25 January 2021**
2.9.20 (133/20)	**Quality priority – falls resulting in harm**	Denise Sterling	**Action 2.9.20**: HH to take comments back to the Falls Collaborative to reconsider the 10% reduction target and to provide further assurance to the Quality Committee **Action 2.9.20**: The equality impact assessment to be completed. **Action 2.9.20**: Benchmarking data from other Trusts to be added to the monthly falls dashboard. **Update 26.10.20:** Reminders sent on 1 October and 20 October – no response received as yet. Further update to be requested from the Falls Collaborative. **Update November:** Deadline date provided for update **Update 30.12.20:** Update received from Falls Collaborative as attached. Discussion ensued on the response received and it was agreed that it should be referred to the Clinical Director for the medical division. The Chair noted that the response did not provide assurance on the safety of patients in terms of falls. It was also noted that complex complaints of repeated falls are currently taking place and could be avoided if a robust falls programme is in place. In relation to IT support and provision of fall sensors, it was agreed that these risks are highlighted in a paper for from the Falls Collaborative and escalated to the Quality Committee. **Action 30.12.20**: DS to follow this up with the Clinical Director for the medical division. **Update: Chair actioned with Clinical Director, who will address the concerns raised**	**CLOSED 25 January 2021**
1.7.19 (120/19) 2.3.20 (41/20)	**Serious incidents deep dive**	Senior Risk Manager	**Action 1.7.19**: OW to be invited to a future meeting to present next steps. **Update 29.7.19:** Work is ongoing to review systems and processes, with an action plan being pulled together. **Update 30.9.19:** A three-month update was provided – see item 176/19 **Action 30.9.19**: Further update to be provided in six months' time, and maybe earlier if improvement and sustained change is not noted. **Update 2.3.20:** Following discussion on target timescales of between 25 to 40 working days for responding to complaints, it was queried why the same timescale cannot be delivered for serious incidents. **Action 2.3.20: Deep dive into serious incidents to take place.** **Update September: MT reported that a conversation with the new Assistant Director for Patient Safety will need to take place regarding plans going forward with serious incident investigation capacity. This item to be deferred.** **Update: Audit Yorkshire is in the process of commencing a deep dive of the incident management process.**	**CLOSED 25 January 2021**
30.12.20 (203/20)	**Infection prevention and control board report**	David Birkenhead	**Action 30.12.20**: Report to be submitted to the next meeting. **Update: See agenda item 12/21**	**CLOSED 25 January 2021**

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Monday, 22 February 2021

STANDING ITEMS

22/21 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Ellen Armistead **(EA)**	Executive Director of Nursing
Doriann Bailey **(DBy)**	Assistant Director for Patient Safety
Dr David Birkenhead **(DB)**	Medical Director
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Karen Heaton **(KH)**	Non-Executive Director / Chair of Workforce Committee
Christine Mills **(CM)**	Public-elected Governor
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Gareth Webb **(GW)**	Interim Senior Risk Manager
Rachel White **(RW)**	Assistant Director for Patient Experience
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Mr William Ainslie **(WA)**	Clinical Director - Surgical Division
Gemma Berriman **(GB)**	Associate Director of Nursing – Medical Division **(item 30/21)**
Dr Abhijit Chakraborty **(AC)**	Consultant in Elderly Care - Medical Division **(item 34/21)**
Louise Croxall **(LC)**	ED Matron – Medical Division **(item 26/21)**
Andrea Dauris **(AD)**	Associate Director of Nursing – Corporate
Gill Harries **(GH)**	Deputy Director of Operations – FSS Division **(item 26/21)**
Judy Harker **(JH)**	Lead Tissue Viability Nurse **(item 27/21 only)**
Julie Mellor **(JM)**	Lead Nurse for Paediatrics – FSS Division **(item 26/21)**
Elizabeth Morley **(EM)**	Associate Director of Nursing – Community **(item 30/21)**
Dr Cornelle Parker **(CP)**	Deputy Medical Director
Rachel Rae **(RR)**	Associate Director of Nursing – Surgical Division **(item 30/21)**
Karen Spencer **(KS)**	Associate Director of Nursing – FSS Division **(item 30/21)**
Vicky Thersby **(VT)**	Head of Safeguarding **(item 28/21)**
Lucy Walker **(LW)**	Quality Manager, NHS Calderdale / NHS Greater Huddersfield / NHS North Kirklees CCGs

23/21 APOLOGIES

Elisabeth Street **(ES)**	Clinical Director of Pharmacy

24/21 DECLARATIONS OF INTEREST

There were no declarations of interest.

25/21 MINUTES OF THE LAST MEETING, ACTION LOG AND MATTERS ARISING

The minutes of the last meeting held on Monday, 25 January 2020 were approved as a correct record, with the exception that the first paragraph of item 9/21 reads:

'Rachel White (Assistant Director for Patient Experience) presented appendix F, highlighting ongoing work to develop a survey which is aimed at gathering service users' feedback in relation to the complaints service and to recruit members to an advisory group that will work alongside the improvement collaborative and on co-production projects'

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

AD HOC REPORTS

26/21 MANAGING THE RISK OF A SPLIT-SITE PAEDIATRIC SERVICE

Gill Harries, Louise Croxall and Julie Mellor were in attendance to present appendix B, providing an overview of recent cross-divisional work regarding split-site working and describing the risks and current mitigations. A slide pack was also included with the paper outlining the work undertaken to review current pathways for children and young people.

CP asked about the staff perspective on this proposal, and it was stated that from a paediatric medical workforce, this model of care would be welcomed, as oversight of the current model is difficult to manage across both sites. From a nursing perspective, and the fact that it fits with longer-term plans around the reconfiguration of children's services, it was felt that it is right to centralise as much of the inpatient and Emergency Department (ED) services on the Calderdale site. The paediatric workforce has been flexible and worked cross-site tirelessly to keep safe staffing levels on both sites, and it was also noted that ED staff are keen to get some stability in the paediatric ED.

EA enquired about the funding business case for this, and whether there was a clear risk mitigation and how close it was to being delivered. GH stated that cross-divisional work has taken place, and costings have been carried out and due to be reviewed. EA stated that a timescale is needed to mitigate the risk.

LW queried about the equality impact assessment and GH stated that this will need further work. RW also mentioned the equality impact assessment and recommended engaging with communities. JM stated that there is currently an established social media route to families asking for their feedback, not just on the reconfiguration, but on the service as a whole.

CM asked about provisions being made for families with no access to transport, as the services will be on the opposite site. GH stated that this would need to be looked into and discussed with the public, to ensure that this does not disadvantage families in the surrounding areas.

In summary, the Committee were asked to approve the next steps and the funding recommendations, however, further work is needed on risk mitigation, the equality impact assessment and further community engagement.

It is noted that the Quality Committee support the preferred option of working for paediatric surgical patients on the HRI site and a Paediatric Emergency Department on the CRH site, and support the progression of a business case, however, the Committee is not in a position to support the funding recommendations.

GH, JM and LC were thanked for the report and asked to return to the Committee at a future date to provide an update on progress being made.

27/21 PRESSURE ULCER DEEP DIVE

Judy Harker was in attendance to present appendix C, to provide a detailed overview on the performance of pressure ulcers, highlighting key challenges posed by COVID-19, and assurance in relation to actions taking place to mitigate the ongoing risks to patient care.

Following the presentation, DBy queried about the increases in pressure ulcers and the potential duplication of reporting. JH stated that double counting is a risk, as patients who are in the Community could potentially come into hospital and their pressure ulcer could be counted on multiple occasions. This issue has been escalated, and the data is cleansed at the end of each month to avoid the double-counting of CHFT acquired pressure ulcers. It was stated that there is a need for greater administrative support to assist with the workload of these incidents.

DBy asked about the increase in pressure ulcer figures in April, the significant decrease with the addition of unstageable and deep tissue injuries, then a further increase in October. JH stated that the pressure ulcer figures decreased during the Summer and peaked in October, however, it is not known why this happened, nevertheless, the data will continue to be interrogated to ensure that errors have not been made. JH noted that it has been a difficult year with COVID-19 as well as the changes in the way that pressure ulcers are reported, however, it is important to be aligned with the recommendations from NHSI.

DBy also asked about opportunities to liaise with other trusts regarding surges, how they are dealing with patients that are declining support and if we could adapt any work that they are using. JH stated that work is taking place around patient concordance, and engagement has taken place with local trusts, along with safeguarding colleagues, who have created a framework to support community colleagues.

CP asked about the 20% unstageable pressure ulcers. JH stated that not all unstageable pressure ulcers are necessarily category 4 pressure ulcers, and that many may be superficial lesions, however, as CHFT are now following NHSI guidance, those pressure ulcers need to be categorised as unstageable. JH was confident that staff are following the categorisation more appropriately, and seeing less category 3 and 4 pressure ulcers, and more unstageable pressure ulcers and deep tissue injuries.

CP commented on benchmarks against other organisations and asked whether what is being described with pressure ulcers, is a surrogate quality marker as to what might be happening to patients. JH stated that benchmarking is not currently taking place, however, liaisons with colleagues and other organisations are due to be done, and this will be fed back. LR stated that it is difficult for organisations to benchmark against pressure ulcers, however, the team have spent a considerable amount of time categorising the grading of pressure ulcers to allow appropriate care plans to be instigated once pressure ulcers are recognised. LR noted that a getting it right first time (GIRFT) review in relation to COVID is due to be undertaken and felt that this pressure ulcer data will be important in forming a broader clinical quality aspect of that review.

LW noted the number of pressure ulcers present on admission and asked if colleagues are being more aware and doing more skin checks, or whether more people are coming into hospital with pressure ulcers. JH stated that the data is difficult to assess as it may include duplicate reporting, however, the number of pressure ulcers present on admission is due to increased training, awareness and pressure ulcers being reported. JH also noted that prior to April 2020, this data was not included in the dashboard, which is now a good thing going forward. JH stated that the data needs to be reviewed to understand what proportion of pressure ulcers are coming from care homes, and LW asked about any mechanisms for feeding learning back to care homes. JH stated that all care homes are now included in the link practitioner system, and themes, trends and learning from root cause analyses are automatically fed back to care homes. JH noted that relationships are being formed with care homes and will be strengthened over time. LW also offered her support with this.

EA noted the peaks and troughs in performance and stated that now is the right time to concentrate on getting into a much better position and to have a brand-new invigorated strategy. JH stated that the service is very committed to this.

JH and her team were thanked for the report and the work they undertake, and JH was invited to attend the Committee in three months' time to provide a progress report.

OUTCOME: The Committee noted the report.

SAFE

28/21 SAFEGUARDING COMMITTEE REPORT

Vicky Thersby was in attendance to present appendix D, highlighting the work of the Safeguarding Committee during the year.

There was a significant reduction in the number of attendances during March and April for children and adults, however work continued to be maintained with safeguarding multi-agency partners. There was an increase in discharge-related issues toward the end of the year which was proactively responded. There was a COVID-19 prioritisation of services with instructions to halt the review of safeguarding adults' reviews and serious case reviews, however safeguarding has been maintained throughout the pandemic.

The report highlighted the work provided by the safeguarding team on Prevent; Safeguarding and COVID; Hidden harms; Mental Capacity Act and Deprivation of Liberty Safeguards; Mental Capacity Bill and Liberty Protection Safeguards; Adult Safeguarding; Children's Safeguarding; Mental Health Act, and Children Looked After Service.

A case study was also included in the report in relation to a young person that the Children Looked After team were involved in.

VT was thanked for the report, and also thanked for the excellent work in supporting the Committee and also in her role as Head of Safeguarding. VT will be leaving the Trust for pastures new, and the Committee wished her all the best for the future.

29/21 HIGH LEVEL RISK REGISTER

Gareth Webb presented appendix E, the high-level risk register as at 27 January 2021, highlighting one new risk - 7930: *Ophthalmology – delays in treatment,* and one increased risk 7769: *Progression of eye pathology and sight loss*.

It was noted that during the last Risk Group meeting on 10 February 2021, there was a discussion on whether the two above similar risks should be combined, however, it was agreed that they should remain as individual risks, due to the differences in controls and actions.

There was one reduced risk 2827: *over-reliance on locum middle grade doctors in the emergency department,* and one risk overdue for review – 7796: *impact on staffing due to track and trace system*. The overdue risk was raised as a COVID risk, however, following discussion with Helen Barker (Chief Operating Officer) and Suzanne Dunkley (Director of Workforce and Organisational Development), it is hoped that this risk will be taken off the high-level risk register.

OUTCOME: The Committee noted the report.

30/21 DIVISIONAL PATIENT SAFETY AND QUALITY BOARD REPORTS

Families and Specialist Services (FSS) Division

Karen Spencer was in attendance to present appendix F, providing a brief overview of patient safety issues from the division in the last quarter:

- Risk – the provision of appropriate admissions and bed spaces for young CAMHS (Child and Adolescent Mental Health Service) patients. There has not been a particular increase in young patients admitted throughout the COVID pandemic, however, there has been a slight increase in young people being admitted with eating disorders. This was reflected nationally from NHS England in the last week, who mandated that mental health providers

increase tier 4 provision nationally for young people with eating disorders. CHFT now have a daily multi-disciplinary team (MDT) meeting with CAMHS, Social Care and any CAMHS patients on CHFT paediatric wards to ensure they receive the best possible treatment while waiting for specialist beds.

- Maternity - One of the developments that is being brought into the maternity services is working with Sheffield Children's Hospital to introduce MRI post-mortems as an option for parents who have suffered a pregnancy loss, and hoping that will increase uptake of parents consenting for their babies to have a post-mortem.

- Paediatrics - In quarter 3, the division developed the lead nurse for children role across CHFT, which Julie Mellor was appointed to, to support children across the wider organisation, with a focus on play and distraction for children.

- Microbiology teams have worked extended hours throughout COVID and also introduced point of care testing for COVID, which has helped patient flow and length of stay.

- The Appointments team, who are currently under pressure with outpatient appointments, have supported the appointment system for the COVID vaccination programme for staff.

- From a virtual perspective, the Children's Community nursing team introduced a virtual consultation for parents and were finalists in the Nursing Times Awards; virtual time to care is a model developed for virtual examinations within paediatrics; and Clinical pearls is a virtual way of shared learning for junior medical and nursing staff.

- Outpatient Recover – Teams are working with clinicians and directorates across the organisation to re-introduce outpatient activity as we move out of COVID, with particular emphasis on the environment, in terms of size and suitability for social distancing.

- Ockenden Report – Maternity services submitted a response to the 12 urgent clinical priorities in December 2020, and a further seven immediate and essential actions.

- Healthcare Safety Investigation Branch (HSIB) – Maternity services have had their quarterly meeting and the good relationship that CHFT maternity services have with HSIB was noted. CHFT are a positive outlier in the region, and as a result of the good relationship with HSIB and families, no families at CHFT have refused a HSIB investigation.

- Good news – Dr Marilyn Rogers, long-standing lactation Consultant at CHFT, was awarded an MBE in the Queen's New Year's Honours List for her work in supporting breast-feeding and infant feeding families across Calderdale and Huddersfield.

DS asked about one of the risks relating to the in-house library filing system, and asked how temporary the solution would be. KS reported that the temporary system has now been tested and was a success, therefore IT have now assured that this can be a permanent solution. This has allowed the risk to be lowered.

DS also commented on the division's excellent performance in the Trust Clinical Audit competition, and that three of the four audits presented were from the division, with two going forward to be presented nationally - this is a great achievement.

<u>Medical Division</u>

Gemma Berriman was in attendance to present appendix G, providing an update on the division's patient safety issues:

- The division has been pressured during the pandemic, therefore the October Patient Safety and Quality Board meeting was stood down and the subsequent November and December meetings were shortened, although they did go ahead. Some of the division's biggest challenges and risks around patient safety have been around the increasing bed

base, and the reduction in staff, giving a significant increased pressure and risk, which has been mitigated across the organisation by working together to cover the gaps and providing safety guardians in areas affected. Band 7 staff and ward managers are not getting the non-clinical time they would ordinarily get to review yellow and green incidents, resulting in learning not being circulated in a timely manner. A concerted effort has been placed on closing those incidents to share the learning with the teams.

- The Emergency Departments have now been segregated on both sites creating a significant staffing gap.

- Outbreaks - There has been a considerable amount of hospital onset COVID infections throughout the organisation, which all need a root cause analysis. The backlog of those is being worked through via daily gold meetings to share the learning reasonable quickly. The division has also seen an increase in clostridium difficile (c.diff) infections, and extra work is being done to reduce these figures. This may be due to people using hand gels more frequently and not washing their hands as such.

- There has been a never event in dermatology with the wrong site surgery and the investigation has now been completed, and the actions are now being worked through.

- Positives – Dermatology have started a one-stop clinic, which has allowed them to see patients quickly. Stroke team have had no hospital acquired pressure ulcers between October and December. Whilst the stroke area has achieved this, some of the ward areas in the division are seeing an increase in pressure ulcers, with work being done with the tissue viability team, particularly on the deep tissue injuries.

- Falls – The division has seen a steady increase in falls since April 2020 and want to reignite the quality and safety strategy within the division and looking at work to develop mini-strategies within the directorates.

- CQC – a provider collaboration review was carried out in ED in October 2020. A second collaboration has taken place around a document for 'patient first', predominantly around EDs in the COVID pandemic and trying to find ways for EDs to keep patients safe.

- The division are just below compliance with appraisals, safeguarding and manual handling, all reporting just below 90%, and work is ongoing to improve.

There were no questions for GB, who was thanked for the report.

Community Healthcare Division

Elizabeth Morley was in attendance to present appendix H, reporting on patient safety issues in the division:

- Staffing – this was the biggest challenge in quarter 3, with a shift from COVID-related staff absence, to absences relating to stress and anxiety.

- There is a gap in the Parkinson's service, with mitigation in place to help close the gap. The division is looking at succession planning within the Parkinson's service, and also in other small or single-handed teams.

- Pressure ulcers – the division saw a surge in community-acquired pressure ulcers, and felt that the increase was due to COVID, as well as a difference in the way that pressure ulcers are reported.

- Incidents – the division saw an increase in discharge-related incidents and has welcomed the Discharge Quality Group which has been reinstated, and includes a whole-system approach to discharge and the monitoring of the quality of discharges.

- The division are also exploring the need for a Community Diabetic Specialist, that will enable people to be seen within their own homes.

- Community nurses have helped support the vaccination programme across the community.

- Success - The division had a recruitment drive into the Community Palliative Care Team, to help ensure that the division is responding to increases in referrals into the Palliative Team, and that patients' needs can be met in their own homes without a conveyance into hospital.

There were no further questions for EM, who was thanked for the report.

CARING

31/21 OBSERVE AND ACT FRAMEWORK

The Chair provided an update further to the circulated report at appendix I.

At the end of last year, the non-executive directors discussed how to improve their visibility and engage with patients. A robust tool was developed, validated and proposed to be introduced either as a stand-alone module or be aligned to the focused support framework. It will be piloted and tested for use at CHFT and rolled out gradually.

The Committee is being asked to approve the introduction of the model, which is intended to be used with a train the trainer method, and the 80/20 approach, with 80% of individuals involved being public-facing, e.g. volunteers, governors and non-executives, and 20% being Trust staff and clinical leads who would support the development and roll-out. The tool has been developed by Shropshire Community Health NHS Trust, who agreed to share with other organisations to adopt. CHFT would be the first Trust in the country to introduce this as a virtual tool.

CP asked where the output from this would be disclosed, and DS stated that this will be to the Quality Committee. Training of the first cohort of staff will start next week, followed by piloting work, then aligning to the focused support framework, which will be reintroduced in May 2021. The feedback and the reports from Observe and Act will be fed back into the Quality Committee.

DBy also commented that there may be opportunities for this to be fed into the CQC and Compliance Group moving forward.

OUTCOME: The Committee approved the introduction and implementation of the Observe and Act toolkit.

QUALITY ACCOUNT PRIORITY UPDATES

32/21 IMPROVE STAFF HANDOVERS TO ENSURE THEY ROUTINELY REFER TO THE PSYCHOLOGICAL AND EMOTIONAL NEEDS OF PATIENTS, AS WELL AS THEIR RELATIVES / CARERS

Lindsay Rudge provided an update on appendix J, with the key headline that this has been piloted and used on the Acute Floor at CRH, and now in a position to embed across the organisation.

33/21 IMPROVE RESOURCES FOR DISTRESSED RELATIVES / BREAKING BAD NEWS RELATING TO END OF LIFE CARE (EOLC)

Lindsay Rudge tabled an update on the above quality priority and reported that work has continued to be progressed around supporting patients and their families through the pandemic, against a background of limited visiting into the organisation. A team consisting of matrons, end of life facilitators, lead cancer nurse and palliative care have been working closely to support a number of areas across the Trust and implement some expanded visiting guidance, following a review of feedback from relatives.

FOCUSED QUALITY PRIORITY UPDATES

34/21 FALLS RESULTING IN HARM

Dr Abhijit Chakraborty was in attendance to present appendix L, providing an update on inpatient falls at CHFT, with a focus on harmful falls.

Most people think of hospital as a place of safety, so it can come as a shock to discover that more the 240,000 falls are reported in hospitals across England each year. Harmful falls will cause serious injuries and distress, for example, fractures and intracranial haemorrhages. A fall can result in an inpatient staying in hospital for longer and undermine a patient's confidence and cause them to worry about falling again.

Fortunately, many of the falls at CHFT are preventable. There was a national audit of inpatient falls that the Trust took part in which provided good advice in preventing falls.

The total number of falls in 2020 was 1772, which was a reduction from 2019 when there were 1963 falls. In terms of harmful falls, from March to December 2019, there were 25 harmful falls, whereas in 2020, there were 28. This may not be a true reflection due to COVID, as there was a reduction in admission during the early part of 2020, after which there was an increase in admissions of patients where there were increased falls due to complications of COVID.

The Falls Collaborative are in the process of developing post-fall review guidelines; a quick reference flow chart, in line with the national NAIF (National Association for Inpatient Falls) guidelines. The results from the audit show:

CHFT - 58% compliance against a national average of 71% in 'checking signs of injury before moving a patient from the floor'
CHFT - 75% compliance against a national average of 78% in the 'Use of safe manual handling method to move patient from the floor'
CHFT – 92% compliance against a national average of 71% in medical assessment within 30 minutes of fall.

An issue that the Falls Collaborative have noted is that when a patient has a fall in hospital which results in a hip fracture, the level of harm recorded in Datix should be severe harm, regardless of the circumstances of the fall. In some cases, it has been noted that some are classed as moderate harm, which is amended.

Falls leaflets are being updated in line with the national NAIF (National Association for Inpatient Falls) guidelines for patients and their families, and the Slips, Trips and Falls policy is to be reviewed through the Falls collaborative to ensure it is also updated in line with NAIF Guidance. This will include parameters for ensuring multi-factorial falls assessments are done for new patients rather than just an assessment of their falls risk – e.g. to include vision, continence, mobility, cognition etc.

A research study is to start in October 2021 in conjunction with Huddersfield University – 'Practice of Falls Risk Assessment and Prevention in Acute Hospital Settings' funded by the National Institute for Health Research (NIHR). Dr Chakraborty is the collaborator for the study, supporting PHD students.

A plan for 2021 is to pursue work with Falls link Practitioners, Commissioning for Quality and Innovation (CQUIN) targets and Falls Workshops. It was noted that it has been difficult to progress some of this work in 2020 due to the COVID pandemic, however, work is continuing through the falls collaborative.

It was noted that there was an increase in falls in December 2019, with seven harmful falls, as a result of the movement of the Acute Floor from Ward 1 to ward 8 and 9 at HRI. The layout, staffing issues and winter pressures all contributed. It was noted that this is not a true reflection of falls and once the COVID-19 pandemic has subsided, it is hoped that there will be a better understanding of the direction of inpatient falls.

DBy mentioned that due to CQUINs being on hold, what assurance does the falls collaborative have around the maintenance of the lying and standing blood pressure being maintained, as it is a fundamental part of the assessment in ensuring that patients are being monitored. AC stated that CQUIN targets state that there should be at least one lying and standing blood pressure taken after admission, and CHFT have a frailty team which carry out comprehensive geriatric assessments on all patients coming through the ED. LR stated that during the pandemic, we have been working differently with clinical teams integrated at ward level and would be a good opportunity for therapy colleagues to carry out lying and standing blood pressures, while they do mobility assessments. AC stated that therapy colleagues have been assisting with lying and standing blood pressures, however, agreed that further support will be sought from the multi-professional team of therapists.

DS mentioned the move away from the use of bundles to a multi-factorial assessment and asked if there was a tool being used across different areas. AC stated that within EPR, there is a system of scoring moderate or high risk of falls, but the multi-factorial guidelines is a new assessment, and that the slips, trips and falls pathways are being updated to indicate that this is a multi-factorial issue.

LR mentioned anecdotally, some patients are presenting in a more deconditioned state as they come into hospital and asked if that is contributing to some falls in those patients and if it is something that needs to be focused on and raise awareness of. AC agreed and stated when frail and deconditioned patients started coming back into hospital, it caused an increased number of falls and in the hospital, there were patients with complications of COVID, which has contributed to the increase of falls. It is not known how to address this at this moment in time, as previously, medically fit patients waiting to be discharged had physiotherapy to check this deconditioning, however, it is not known if this can still be done, but it will stop people from falling. LR stated that this would assist with the recovery and reset challenges going forward.

AC was thanked for the update and asked to return to the Committee at a future date to provide a further update.

35/21 CLINICAL DOCUMENTATION

Lindsay Rudge presented appendix M on progress of clinical documentation.

A paper was submitted to the digital board which described a compliance gap around various aspects of how we recorded into the clinical document, and ability to evidence the quality of care provided. Some background work has taken place around extracting more accurate data through a deployment of digital whiteboards. The digital team procured some resource to carry this out and are looking to test on the Surgical Assessment Unit (SAU) and the Acute Floor, building on work from medical colleagues and linking with documentation on key safety metrics.

Some programme work has been identified which should help extract the data into a more valid dashboard. This work needs to now be done at pace, due to delays from the pandemic, and need to provide assurance that documentation is taking place in the clinical records and that patient safety is maintained and not affecting quality of care.

36/21 END OF LIFE CARE

Lindsay Rudge updated on this quality priority at appendix N, reporting on some of the work being undertaken in the community, ensuring that the needs of both patients and their families / carers do not vary in quality due to their characteristics. It was noted that there is a matron for end of life care in the community who has been overseeing and driving the improvements across the services.

Work on the anticipatory care planning for all frail people was also shared, ensuring there is focused and advanced care planning and documenting into a shared digital record that can be accessed across the system for improving care.

RESPONSIVE

37/21 BI-MONTHLY QUALITY REPORT

Doriann Bailey presented appendix O, providing an update on the quality and patient experience outcomes, including dementia; CQC; Central Alert System; Sepsis; Incidents; Pressure Ulcers; Nutrition and hydration; Complaints; Venous Thromboembolism and the Ockenden Review.

38/21 INTEGRATED PERFORMANCE REPORT

Ellen Armistead briefly presented appendix P, reporting on complaints, and Dr Cornelle Parker provided an update on the Summary Hospital-level Mortality Indicator (SHMI) position.

It was reporting that Dr Sree Tumula (Associate Medical Director) will be submitting a paper to the Quality and Performance meeting this Thursday around SHMI, which is a major reviewed metric, which has been deteriorating for a number of months and now risen above the median position of 100. Around five months ago, CHFT were in the same position with another metric, the Hospital Standardised Mortality Ratio (HSMR). Both metrics look at mortality, with the Summary Hospital-level Mortality covering the 30 days post discharge and unlike HSMR, does not adjust for palliative care coding or deprivation. The majority of our deteriorating trend relates to deaths in the community over the last seven or eight months and is more of an issue in Huddersfield than it is in Calderdale. It was stated that if there was an adjustment for palliative care coding, that would abolish the deterioration in trend, however, that would not be statistically legitimate. It was found that there are a set of conditions, particularly stroke and sepsis, which are coming under some scrutiny, due to alerts being received on those two conditions due to higher volume deaths. This is being reviewed to understand this better.

It was noted that the outcomes of this work will report through the Mortality Surveillance Group, into the reinstated Clinical Improvement Group and into Quality Committee.

WELL LED

39/21 BOARD ASSURANCE FRAMEWORK (BAF)

Andrea McCourt briefly presented appendix Q, the draft Board Assurance Framework which will be submitted to the Board of Directors in March. This is the final update against this year's strategic objectives for 2020/2021. All the risks have been updated and highlighted on the report. The Quality Committee have been diligent in reviewing the risks which it has oversight for, and that is reflected in the updates.

AMcC asked whether the Quality Committee needed to continue receiving the overarching BAF report, as it was presented to the Committee at the time when the individual risks were not being reviewed. It was agreed that some thought would be given to this query outside of the meeting.

It was also noted that the non-executives discussed the BAF risks and suggested that committees may also want to review the high-level risks which they have oversight for. It was stated that this is already covered at the Risk Group and did not want to detract from the role of that Group and possibly duplicating work. The leads of all the high-level risks are held to account at the Risk Group, and a high-level risk report submitted to this Committee.

40/21 BOARD ASSURANCE FRAMEWORK (BAF) RISK – 4/20: CARE QUALITY COMMISSION RATING

Ellen Armistead (Executive Director of Nursing) presented appendix R, providing the outcome of a review of the CQC rating risk.

It was recommended that the risk score is increased as a result of the change in the way CQC is currently operating and the scaling back of internal CQC preparation and assessment activity in response to pandemic response priorities.

OUTCOME: The Committee noted and approved the increased risk score.

POST MEETING REVIEW

41/21 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

The Quality Committee received:

- The paediatric split-site service update. The Quality Committee support the recommended model, but there is further work to be undertaken in terms of current mitigation and other development work going forward
- The pressure ulcer deep dive which was flagged as a concern at a previous Board meeting. Further development work is underway.

42/21 REVIEW OF MEETING

What went well….

- The meeting over-ran, however, very important discussions were held on important agenda items
- The agenda is beginning to link with the Quality and Safety Strategy, which is a positive
- The focus on the deep dive's areas of concern

What could be better….

- More time gibe to key agenda items, to enable meaningful discussions.

43/21 ANY OTHER BUSINESS

There was no other business.

ITEMS TO RECEIVE AND NOTE

44/21 QUALITY COMMITTEE ANNUAL WORK PLAN

The workplan was available at appendix S for information.

NEXT MEETING

Monday, 22 March 2021 at 3:00 – 4:30 pm on Microsoft Teams

QUALITY COMMITTEE ACTION LOG FOLLOWING MEETING ON MONDAY, 22 FEBRUARY 2021

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
OPEN ACTIONS				
30.12.20 (205/20)	**BAF Risk 3/19: seven-day services**	David Birkenhead / Cornelle Parker	DB stated that every effort will be made to complete the audit to provide the Quality Committee with a level of assurance in relation to compliance. **Action 30.12.20**: DB to follow this up with CP, DBy and RW regarding resources needed to complete the audit **Update: Completion of audit to be confirmed**	
5.2.20 (21/20) 28.9.20 (154/20) 30.12.20 (matters arising)	**Outpatients improvement plan**	Helen Barker	**Update 30.12.20:** In relation to the update received from the outpatients' action plan, EA noted that reference to the risk register is made in relation to a closed risk on outpatient delays, however, the risk relates to a new risk on COVID-related delays. Due to the change in circumstances due to the delays as a result of COVID, could HB attend QC to provide updates on all outpatient risks that have been included in the COVID-related risks, as there have now been changes. **Action 30.12.20:** Helen Barker to attend to provide update on outpatient COVID-related risks	**See item 51/12 on agenda**
FORTHCOMING ACTIONS				
26.10.20 (181/20)	**Medical examiner update**	Dr Tim Jackson	Following a verbal update from CP, it was agreed that Dr Tim Jackson is invited to the next Medical Examiner's update in April 2021 **Action 26.10.20**: Dr Tim Jackson (Lead Medical Examiner) to be invited to the Quality Committee meeting to provide the next update in six months' time.	**DUE Monday, 19 April 2021**
CLOSED ACTIONS				
26.10.20 (184/20)	**Bi-monthly report**	Gill Harries, Louise Croxall, Julie Mellor	**Action 26.10.20:** Gill Harries and Louise Croxall to be invited to a future Quality Committee to discuss their plans to manage the risk of a split-site paediatric service. **Update: see agenda item 26/21.** **GH, JM and LC were asked to return to the Committee at a future date to provide an update on progress being made. This will be added to the workplan.**	**CLOSED Monday, 22 February 2021**

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Monday, 22 March 2021

STANDING ITEMS

45/21 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Ellen Armistead **(EA)**	Executive Director of Nursing
Doriann Bailey **(DBy)**	Assistant Director for Patient Safety
Dr David Birkenhead **(DB)**	Medical Director
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Karen Heaton **(KH)**	Non-Executive Director / Chair of Workforce Committee
Christine Mills **(CM)**	Public-elected Governor
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Rachel White **(RW)**	Assistant Director for Patient Experience
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Helen Barker **(HB)**	Chief Operating Officer **(item 51/21)**
Clare Beecher **(CB)**	Named nurse - Children Looked After & Care leavers **(item 52/21)**
Dr Cornelle Parker **(CP)**	Deputy Medical Director
Salim Patel **(SP)**	Interim Quality Governance Lead for Surgery **(observing)**
David Sullivan **(DS)**	Interim Head of Complaints **(observing)**
Lucy Walker **(LW)**	Quality Manager, NHS Calderdale / NHS Greater Huddersfield / NHS North Kirklees CCGs

46/21 APOLOGIES

Lindsay Rudge **(LR)**	Deputy Director of Nursing

47/21 DECLARATIONS OF INTEREST

There were no declarations of interest.

48/21 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday, 22 February 2020 were approved as a correct record, with the exception that the work ‘patinets’ is amended to ‘patients’ in the heading of item 32/21.

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

49/21 MATTERS ARISING

12-hour breaches follow-up

Ellen Armistead (Executive Director of Nursing) presented appendix B, updating on the reviews of the final cases and progress on delivery of the action plan.

The action plan includes recommendations which have been completed, and some which are ongoing. In terms of assurance, it was noted that the leads on the action plan need to demonstrate how this links to future audit, to ensure that any learning and any positive changes to service delivery have been embedded. It was noted that there have been no further 12-hour breaches.

CP asked about the health inequalities aspect and if this information would be captured going forward. EA stated that this will be captured going forward, and that a retrospective review can be carried out..

DBy also highlighted the possibility of this linking into a future quality priority to ensure that some of the areas addressed in the action plan have been taken forward, to see demonstrable improvements further to the 12-hour breaches.

OUTCOME: The Quality Committee noted the report and await further information to be reported.

FOCUSED QUALITY PRIORITIES UPDATES

50/21 NOSOCOMIAL SPREAD

Dr David Birkenhead (Medical Director) presented appendix C, highlighting the progress with the nosocomial spread quality priority.

It was stated that the quality priority needs to refocus away from COVID-19 and to broaden ongoing work on other nosocomial infections, such as gram negative sepsis, Methicillin-resistant staphylococcus aureus (MRSA) and clostridium difficile (C.Diff), of which there has been an increase of this year. There is a well-developed action plan which looks at hygiene, cleaning, antibiotic usage, and it was proposed that this is all combined, along with the COVID-19 work, into a single action plan for infection control and reduction of nosocomial spread.

DBy commented on the quality account priority which has been agreed for 2021-2022 around reducing the number of hospital-acquired infections including COVID-19, and supported the opportunity to broaden this quality priority and move it into the next stage in terms of how nosocomial infections are reviewed across the Trust.

DB reported that in relation to the work which has been ongoing throughout the year, and at the peak of COVID-19 through December 2020 and January 2021, there was an excess of people with hospital onset COVID infections (HOCIs). Other ongoing work on PPE usage, social distancing, enhanced cleaning, ventilation, the vaccination programme, and a general reduction in incidents of COVID in the Community, have all contributed to a reduction in HOCIs. There will be a retrospective look back into work done, and the ongoing work yet to be done to continue to reduce other nosocomial infections.

OUTCOME: The Quality Committee noted the report.

51/21 CLINICAL PRIORITISATION INCLUDING OUTPATIENT RISKS RELATING TO COVID-19

Helen Barker (Chief Operating Officer) was in attendance to present an update on outpatient risks related to COVID-19, clinical prioritisation and buddy system (presentation to be circulated following the meeting – see end of minutes).

Following the presentation, EA reiterated the importance of the clinical prioritisation 'buddies' and the good example of one culture of care. CP asked why clinicians were not keen on the buddy idea and HB stated that clinicians were anxious that the role of the medical secretary was being taken away and that administrative staff would be making decisions on patients' clinical presentation, as opposed to what the extra capacity was intending to do - making contact with patients, and if there was a concern, that the clinical conversation would then take place.

The Chair referenced using the independent sector and asked if there was focus on any particular specialties. HB reported that up until this point, CHFT have been able to use it for specialties which were needed. However, from 1 April 2021, due to the move to the new independent sector contract, we can only use it for specialties and clinicians where they already have practising privileges, which is a restriction, as there are some specialties where we would like to use more of the independent sector, and now cannot do so, as they do not offer the clinician or specialty. CHFT have been maximising the use of Optegra, an

ophthalmology service. The funding arrangements are not yet known, however, work has been undertaken with finance, and identified and committed to some independent sector capacity for the first three months of next year.

OUTCOME: The Quality Committee noted the report.

AD HOC REPORT

52/21 CHILDREN LOOKED AFTER AND CARE LEAVERS ANNUAL REPORT

Clare Beecher (Named nurse for children looked after and care leavers) was in attendance to present the annual report at appendix D.

The Chair commented on the complexity of the case studies, and asked about capacity issues, which relate to around 60% more assessments being done for out-of-area authorities and asked what is being done to address this. CB stated that the issue of increasing the hours of the service is being raised with the Clinical Commissioning Group (CCG), and also stated that any local authority which places a child in our area and requires an assessment taking place, is charged, and that some of that revenue is hoped to be put back into the service.

The Chair also asked what is being done in relation to the backfill required for the designated doctor. CB reported that this is also being raised by the CCG, and that a new designated nurse is now in post. Work is also ongoing to liaise with Kirklees' designated doctor.

KH commented on the resource and volume and one of the key challenges of the impact of COVID-19 being that three members of the team were redeployed. CB reported that staff who were redeployed from the service have now all returned.

OUTCOME: The Committee noted and approved the report.

CARING

53/21 WINTER VOLUNTEERING AND SAFETY GUARDIANS PROJECT

Rachel White (Assistant Director for Patient Experience) presented appendix E, on the Patient and Carers: experience, participation, and equalities - CHFT transformation programme.

The purpose of the update was to provide some background into the winter volunteering service, progress and next steps.

Following the presentation, the Chair asked what engagement had taken place with local communities. RW reported that the capacity has not been available to explore this as yet, and is dependent on getting the co-ordinators in post. There have been challenges and delays with recruitment processes, etc, but have been fortunate to have two redeployed members of staff who have been assisting and supporting the team, and credit was made to them. RW reported that once the co-ordinators are in post, their first job would be to working with communities.

OUTCOME: The Committee noted the report.

WELL-LED

54/21 RESEARCH AND INNOVATION REPORT

Dr Cornelle Parker (Deputy Medical Director) presented the research and innovation annual report at appendix F.

It was noted that this has been an incredible year for research at CHFT. In March 2020, the COVID-19 pandemic started, and the Trust were directed by the National Institute of Health and Research (NIHR) to stand down a number of studies in favour of urgent public health studies.

CHFT opened nine COVID research studies, which produced important outcomes for the treatment of patients and gave them early access to treatments that benefit COVID-19. The Trust was an early recruiter to the Randomised Evaluation of COVID-19 Therapy (RECOVERY) Trial – the largest randomised trial in the world, and to date have recruited 478 patients, and remained in the top 10 recruiting Trusts nationally and the highest recruiting Trust across Yorkshire and Humber. A huge effort was seen from clinical colleagues throughout the year in supporting the research, with over 40 medical colleagues undertaking training and recruiting patients.

Additional in-year Clinical Research Network (CRN) funding was also successful, drawing in a further £121,390 to support the COVID research delivery, and in November 2020 the research department were the proud winners of the UK Nursing Times Award in the category for Clinical Research Nursing.

Next steps are to restart the main interventional studies over the next few weeks and refocus on commercial activity as it provides financial stability and scope to expand beyond the NIHR, who is currently the primary funding source. CHFT are also looking to use successes as a launch pad to develop a research hub which will be an on-site research facility where patients can be managed in a research-dedicated environment.

Several comments were made on this excellent, impressive news story and credit and thanks were conveyed to all involved.

OUTCOME: The Committee noted the report.

55/21 SELF-ASSESSMENT OF COMMITTEE'S EFFECTIVENESS & 2019-20 ACTION PLAN

The Chair reported on the completion of the annual self-assessment of the Quality Committee's effectiveness which took place last year, which identified some areas for improvement. An action plan was compiled, but due to the pressures of the agenda, was not previously submitted. The action plan is now available at Appendix G, and questions for the 2020-2021 self-assessment will be forwarded to members of the Committee for completion following this meeting.

RESPONSIVE

56/21 INTEGRATED PERFORMANCE REPORT

Ellen Armistead (Executive Director of Nursing) presented appendix H, reporting on the complaint's performance, and stated that there will be a step change at the end of March 2021, as divisions have done an amazing job on their complaints backlog.

Dr Cornelle Parker provided an update on the Summary Hospital-level Mortality Indicator (SHMI) position, which looks at all inpatient deaths and all deaths within 30 days of discharge from hospital. It excludes COVID, as it is not felt that comparisons can be made in relation to COVID. There is a national increase in SHMI, which indicates that patients are dying from causes other than COVID once they leave hospital. within 30 days of discharge. CHFT are in the process of reviewing this, but have not found an explanation, but can identify the conditions where there is an issue. The agreed approach is to review the five conditions contributing to SHMI and carry out a deep dive through structured judgement reviews (SJRs), speciality input, and community reviews of deaths. CP also reported that the Care of the Acutely Ill Patient (CAIP) programme will be restarting. It was noted that this is an incredibly complex and significant piece of work which will remain under scrutiny and feed through the Mortality Surveillance Group, into the newly convened Clinical Outcomes Group and into Quality Committee.

POST MEETING REVIEW

57/21 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

The Quality Committee received:

- The follow-up to the 12-hour trolley breaches, in terms of the review of the cases and the action plan, with a number of actions completed
- An update on the nosocomial quality priority and the plan to broaden this out to the next stage for infection prevention in the organisation
- The children looked after and care leavers annual report and confirmed that the team have discharged all their statutory and legal responsibilities. This report was also approved.
- The Research and Innovation annual report
- An update on the development underway with the volunteer service

58/21 REVIEW OF MEETING

What went well….

- The timekeeping of the meeting
- The meeting feeling 'normal' again
- Emphasising quality priorities on the agenda

What could be better….

- Getting reports submitted by the deadline date in order for timely circulation.

59/21 ANY OTHER BUSINESS

Ellen Armistead informed the Committee of the CQC transitional monitoring assessment (TMA) of maternity services which took place last week. Positive feedback was received, and it was noted that the team did a phenomenal job.

The next TMA will be of the vaccination centre at the John Smith's Stadium.

ITEMS TO RECEIVE AND NOTE

60/21 TRANSPORTATION OF MEDICINES – INTERNAL AUDIT

Elisabeth Street (Clinical Director of Pharmacy) presented the internal audit for CHFT transportation of medicines at appendix I.

This is a positive report with some amber actions which need improvement. These actions are monitored at the Pharmacy Board and the Medication Safety and Compliance Group, ensuring there is an audit plan for spot-checking and including the transportation of medicine; to ensure that a risk is added to the Pharmacy risk register that includes transport of medicines and the mitigations in place; and a training needs analysis to ensure that the relevant people have required training with regard to transport of medicines.

OUTCOME: The Quality Committee noted the report.

61/21 QUALITY COMMITTEE ANNUAL WORK PLAN

The workplan was available at appendix J for information.

NEXT MEETING

Monday, 19 April 2021 at 3:00 – 4:30 pm on Microsoft Teams

QUALITY COMMITTEE ACTION LOG FOLLOWING MEETING ON MONDAY, 22 MARCH 2021

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
OPEN ACTIONS / ACTIONS DUE THIS MONTH				
30.12.20 (205/20)	**BAF Risk 3/19: seven-day services**	David Birkenhead / Cornelle Parker	DB stated that every effort will be made to complete the audit to provide the Quality Committee with a level of assurance in relation to compliance. **Action 30.12.20**: DB to follow this up with CP, DBy and RW regarding resources needed to complete the audit **Update:** Completion of audit to be confirmed **Update March 2021:** It was noted that this is still being worked through and aware of.	DUE FOR CLOSURE OR KEEP ON ACTION LOG?
26.10.20 (181/20)	**Medical examiner update**	Dr Tim Jackson	Following a verbal update from CP, it was agreed that Dr Tim Jackson is invited to the next Medical Examiner's update in April 2021 **Action 26.10.20**: Dr Tim Jackson (Lead Medical Examiner) to be invited to the Quality Committee meeting to provide the next update in six months' time.	**See agenda item 72/21**
CLOSED ACTIONS				
5.2.20 (21/20) 28.9.20 (154/20) 30.12.20 (matters arising)	**Outpatients improvement plan**	Helen Barker	**Update 30.12.20:** In relation to the update received from the outpatients' action plan, EA noted that reference to the risk register is made in relation to a closed risk on outpatient delays, however, the risk relates to a new risk on COVID-related delays. Due to the change in circumstances due to the delays as a result of COVID, could HB attend QC to provide updates on all outpatient risks that have been included in the COVID-related risks, as there have now been changes. **Action 30.12.20:** Helen Barker to attend to provide update on outpatient COVID-related risks **Update March 2021:** See item 51/21	**CLOSED Monday, 22 March 2021**

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Covid-19 Oversight Committee
Friday 26 March 2021 - 11.00 am – 12.00 pm
Microsoft Teams

PRESENT

Denise Sterling – Chair (DS)	Non-Executive Director
Karen Heaton (KH)	Non-Executive Director
Andy Nelson (AN)	Non-Executive Director

IN ATTENDANCE

Anna Basford (AB)	Director of Transformation and Partnerships
Andrea McCourt (AM)	Company Secretary
Linda Cordingley (LC)	Minutes

16/21 APOLOGIES FOR ABSENCE

There were no apologies for absence.

17/21 NOTES OF THE LAST MEETING

The notes of the meeting on 22 February 2021 were approved.

18/21 UPDATES

The following updates were received:

Covid-19 Vaccination Programme – CHFT commenced 2nd dose vaccinations on 8 March 2021 and was making good progress.

Waiting List - Buddying Arrangements – these arrangements were to support those patients who had been referred but not yet seen, to monitor their condition and escalate if required. The arrangements had not yet been fully optimised and some modifications were required. The nature of the relationship with buddies and clinical colleagues had not developed in a way to be effective in all areas. Work was being taken forward with the team and further progress reports would be made to the Quality Committee and then to the Oversight Committee.

Learning from 12-hour Breaches – it was noted that the improvements and learning would be managed through the Quality Committee going forward. The Outer Core had discussed the need for broader system learning from breaches and requested members of the IMT to provide further information about which forums received lessons learned briefings and communication methods used to provide assurance that learning had been embedded. KH advised that the Quality Committee had been assured that there had been no further breaches and a detailed action plan had been shared, with further updates on the action plan being planned. It was noted that a number of audits were ongoing eg nursing documentation. AM advised that there would be scrutiny from governors as part of their focus on quality account priorities.

Mixed Sex Breaches – it was noted that when the 12hour breaches investigation was undertaken there was reference made to a higher volume of mixed sex breaches during peaks in the pandemic. The Outer Core had asked for further information regarding trends on numbers, actions taken to prevent breaches and the current position. The Outer Core had received the existing mixed sex breach policy, but the requested information was awaited.

Mortality – it was noted that there had been an increase in SHMI mortality rates for deaths out of hospital within 30 days of discharge. Work was ongoing to identify the reasons, looking at the alerting system and the specialty categories. A paper was received by the Executive Board with a request that clear recommendations and actions taken to reverse the trend of rising SHMI scores be brought back to the Executive Board. This would then be presented to the Outer Core and the Oversight Committee. It was noted that an update on the analysis of the five conditions had been received by the Quality Committee with a further progress report scheduled once the work had been completed. It was recognised that significant progress had previously been made by the Care of the Acutely Ill Patient (CAIP) Programme, therefore this programme would be reintroduced. Work would be undertaken with wider partners for out of hospital mortality (which excluded Covid deaths). It was noted that our HSMR rate was not an outlier in relation to in hospital deaths therefore the focus would be on out of hospital deaths in problem areas.

19/21 OUTER CORE REGISTER OF DECISIONS

The Register of Decisions from the Outer Core Group was received.

Recovery plan – approved by Executive Board on 25 March 2021. It would be presented to the Board of Directors in May. It was noted that elective surgery would be commencing shortly.

Birth Centre – update awaited.

Wellbeing Hour – a proposal would be presented to the Executive Board in July and to the Board of Directors in September 2021. AB would clarify the timeline for feedback to the Oversight Committee on progress.

Suspension of Surgery – update awaited. It was noted that the EQIA/QIA on the impact of the suspension of surgery had been completed.

Prioritisation of Waiting Lists – it was noted that this formed part of the recovery plan with the use of clinical priorities against deprivation, learning disabilities and ethnicity factors.

Wave 2 planning – Testing of Asymptomatic Staff – AB would check the position with David Birkenhead.

20/21 DATE AND TIME OF NEXT MEETING

The next meeting would be provisionally scheduled in April, if required, or updates provided virtually.

Calderdale and Huddersfield NHS Foundation Trust

Draft Minutes of the Audit and Risk Committee Meeting held on Monday 12 April 2021 commencing at 1:00 pm via Microsoft Teams

PRESENT

Andy Nelson (AN)	Chair, Non-Executive Director
Richard Hopkin (RH)	Non-Executive Director
Denise Sterling (DS)	Non-Executive Director

IN ATTENDANCE

Andrea McCourt	Company Secretary
Gary Boothby	Director of Finance
Kirsty Archer	Deputy Director of Finance
Helen Kemp-Taylor	Head of Internal Audit, Audit Yorkshire
Leanne Sobratee	Internal Audit Manager, Audit Yorkshire
Shaun Fleming	Local Counter Fraud Specialist, Audit Yorkshire
Mandy Griffin	Managing Director, Digital Health
Clare Partridge	Partner, KPMG
Amber Fox	Corporate Governance Manager (minutes)
Richard Hill	Head of Health and Safety **(for item 34/21)**
Helen Barker	Chief Operating Officer **(for Deep Dive and item 28/21)**
Peter Keogh	Assistant Director of Performance **(for Deep Dive and item 28/21)**
Julian Bates	Director of Information **(for Deep Dive and item 28/21)**
Stephen Baines	Public Elected Governor – Skircoat and Lower Valley - Lead Governor

23/21 APOLOGIES FOR ABSENCE

Apologies were received from John Gledhill and Steve Moss.

The Chair welcomed everyone to the Audit and Risk Committee meeting and introductions were made. Helen Barker, Peter Keogh and Julian Bates were all welcomed to the meeting who were in attendance to present a Data Quality Deep Dive.

24/21 DECLARATIONS OF INTEREST

The Chair reminded Committee members to declare any items of interest at any point in the agenda.

25/21 MINUTES OF THE MEETING HELD ON 26 JANUARY 2021

The minutes of the meeting held on 26 January 2021 were approved as a correct record subject to the following amendment.

RH asked for clarity on the wording under the External Audit Sector Update section 14.21 'The funding will be reviewed at year end and reflected accurately as things change'. It was agreed that this sentence would be removed as it could not be clarified.

AN asked the Managing Director for Digital Health for a progress update on the actions relating to inappropriate access to records. The Managing Director for Digital Health confirmed the final document is scheduled for the next Information Governance Records Strategy Group with an update on the action plan with only two actions remaining open. A report will be presented at the next Audit and Risk Committee which will include one of the open actions relating to outstanding audits from the first investigation in July. She confirmed that the alerting system is working well and shared a good news story where a recent audit confirmed only appropriate access took place.

OUTCOME: The Committee **APPROVED** the minutes of the previous meeting held on 26 January 2021 subject to the amendment above.

26/21 ACTION LOG AND MATTERS ARISING

The action log was reviewed, and all actions were complete.

OUTCOME: The Committee **NOTED** the updates to the Action Log.

27/21 DATA QUALITY DEEP DIVE

The Chief Operating Officer (COO) introduced the Data Quality annual review deep dive and explained the Data Quality Board terms of reference have been reviewed and updated as part of the deep dive. The presentation included the history of the Data Quality Board, standing and adhoc agenda items, the ten year strategy and draft 21/22 plan on a page. The key points to note were:

- Meetings were stopped for 6 months due to Covid-19 from March 2020 to August 2020 but were continued through waves 2 and 3
- Data Quality Policy has been written and signed off – this needs testing
- Data Quality Maturity Index is good, but an improvement plan is underway which assesses 6 data sets externally, the Director of Information reported 4 of the 6 are good; however, further work is required on maternity and community data sets
- Incorrect encounters in EPR often being used and lots of work has taken place to understand the importance of encounters. This is still a risk but much improved and a further improvement plan is in place. The Managing Director for Digital Health added that the new EPR PAS system will eliminate use of the wrong encounter
- Activity capture under correct clinician – a focused piece of work took place through the Data Quality Board to ensure activity is against the correct clinician which included the coding team, acute floor and the A&E team to embed this into operational practice, bringing service users and reporters together
- Mpage embedded into EPR allows clinicians to clinically validate their follow up backlogs. This is a big fix and plays a big role in the health inequalities agenda; this was previously a manual spreadsheet
- Draper and Dash external review provided good assurance on data quality in 2019
- Pandemic issues solved – e.g. impact of non-face to face CAS services, Covid testing data etc.
- 2021/22 draft plan on a page will go to the next Data Quality Board for further discussion.

RH asked if there are any areas of concern raised by the CCIO or CNIO at the Data Quality Board. The COO explained there is nothing new being raised, the main issue is regarding encounters. She added that Graham Walsh the CCIO is active in the education around this.

RH highlighted the Trust are in a fairly good position on data for health inequalities compared to other Trusts and asked what further work the Trust are doing with this data. The COO agreed the Trust are ahead of other organisations on the quality of its data and presentation in Knowledge Portal and confirmed there is a small Clinical Reference Group with Consultants who are helping look at this. The Trust have not yet reached where they want to be for completeness of ethnicity capture which is at around 94%. The Data Quality Board will review this and see what other actions can be taken. Frailty and learning disabilities are a flag in the system and a learning piece is taking place on young people with a learning disability as the coding is more complex.

RH asked if clinical coding is now in a better position. The Director of Information responded that a few years ago there were considerable concerns; however, the Director of Finance invested in this and the team was strengthened and restructured. There is a Clinical Coding Steering Group which meets monthly with clinicians.

Performance is in the upper quartile and has been in a good position over the last few years. The Managing Director for Digital Health added there has been better performance on all indicators over the last 12 months which will be kept under review as the hospital gets busier with more activity.

The Managing Director for Digital Health explained as part of the health inequalities work, she is working with West Yorkshire Integrated Care System (ICS) to look at how to bring common data together on health inequalities, particularly around BAME and deprivation. A meeting has been arranged with West Yorkshire colleagues this afternoon to look at a Yorkshire wide picture. The position at CHFT is unique as a result of the work that has taken place on the Knowledge Portal. A comparison will take place across the whole region.

Peter Keogh referred to the summary from the Data Quality Board highlighting there has been better input from the quality team and more work is taking place for the team to highlight any areas from Datix incidents.

DS asked for clarity on whether the maternity and community data sets are doing well or need more focus. The Director of Information clarified these areas need more work, the maternity key field is not working and a few fields for community services need to be reviewed in more detail and an action plan is in place.

AN asked if there were any surprises following the green deep dives. The COO confirmed there have been some surprises, for example, the Trust had to work on a definition of an 'urgent operation' with a clear sign off process for urgent cancelled operations.

AN pointed out that benchmarking had been paused and asked when this will be re-started as there is great value in this. The COO responded that the Trust are continuing with 'Getting if Right First Time' (GIRFT) benchmarking with better clinical engagement. The Trust will commit resources as we get them into the GIRFT Programme and Clinical Improvement Programme.

AN asked if the Trust have learned from data quality dipping during the pandemic early on and asked if this was related to the number of staff being re-allocated and requiring training. The Director of Information explained the way activity was being captured changed and keeping on top of this was a challenge e.g. clinical assessment services, non-face to face activity, keeping on top of changes to how services were being delivered took time. He added it was more about the pace that needed to be acted upon rather than lack of knowledge. The COO shared an example of non-face to face activity in that the receptionist would usually capture the ethnicity check; however, a SOP had to be written for the clinician completing the check-in process and the admin pathway needed to be written from a data quality perspective.

OUTCOME: The Committee **NOTED** the details provided in the Data Quality Deep Dive presentation.

28/21 REVIEW OF TERMS OF REFERENCE

1. **Data Quality Board Terms of Reference**
   The COO confirmed the updates to the terms of reference include the frequency of meetings and quorum and the agenda does not change. AN asked how data quality throughout the whole organisation is covered at this meeting. The Chief Operating Officer confirmed all areas are covered in the membership of the Data Quality Board and the Directors of Operations and Corporate teams are represented.

2. Information Governance and Records Strategy Committee Terms of Reference
The terms of reference have been previously approved at the Information Governance and Records Strategy Committee.

AM highlighted the bottom of page one which refers to the Board and asked if this was referencing THIS Board or CHFT Board. The Managing Director for Digital Health clarified this is referring to weekly Executive Board (WEB) and agreed to make this clearer in the terms of reference and confirm which policies the group can approve which would automatically go to WEB. AN suggested including the wording 'as needed to the Audit and Risk Committee'.

The Managing Director for Digital Health asked if the terms of reference should be in a standard template format which AN agreed; however, this is not currently the case.

AN highlighted some of the Divisions names need to be corrected and the Managing Director for Digital Health agreed that there should be representation from the Community Division.
Action: MD for Digital Health to include which policies are approved at this Committee, clarify they go to weekly Executive Board, include the wording 'as needed to the Audit and Risk Committee' and update the Division names

OUTCOME: The Committee **APPROVED** the terms of reference for the Data Quality Board and the Information Governance and Records Strategy Committee subject to the changes above.

34/21 HEALTH AND SAFETY POLICY

Brought forward

Richard Hill, Head of Health and Safety highlighted the main changes to the policy which were:

- Introduction – change to statement of intent to be signed by Owen Williams electronically or hard copy and displayed across the Trust
- Section 2 Roles and Responsibilities – the role 'Head of Health and Safety' now included
- Framework – more sub-groups are included and added as part of the governance process e.g. Slips, Trips and Falls Group
- Four Pillars of the Trust are referenced within the policy and the 'five year strategy'

AN pointed out CHS is mentioned without the full acronym and asked if the role of CHS could be more explicit in the introduction. AN pointed out the Appendix says, 'Quality Audit and Risk' which should be corrected to 'Audit and Risk'. AN asked who the Non-Executive Champion is for health and safety. The Director of Finance confirmed this was Karen Heaton.
Action: Head of Health and Safety to include the role of CHS in the introduction of the policy and update the appendix to say 'Audit and Risk'

RH highlighted section 5.1 which states the role of the Non-Executive Director and suggested this section is removed as it is a Unitary Board responsibility for health and safety. The Company Secretary agreed as the Non-Executive role is covered adequately in section 5.2.
Action: Head of Health and Safety to remove section 5.1

RH pointed out the Policy refers to HPS as a partnership company and subsidiary; however, confirmed HPS is not a subsidiary, it is a Division.

Action: Head of Health and Safety to confirm HPS is a Division and correct the policy

OUTCOME: The Committee **APPROVED** the Health and Safety Policy subject to the changes above.

29/21 EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS

1. Review of Losses and Special Payments

The Deputy Director of Finance presented a report summarising the losses and special payments in the final quarter. The key figures are £248k losses for the full year which is lower than last year. The biggest line for the quarter is just over £40k for pharmacy losses. In addition to the losses noted, £260k was fully expensed in the first half of 2020/21 for stocks of Noradrenaline manufactured by HPS at the request of NHSE/I for use by the NHS in the Covid pandemic.

RH highlighted the Trust is not showing anything in year for bad debt and asked if a further review will take place as part of the year end process. The Deputy Director of Finance clarified the Trust are constantly reviewing bad debt provision and chasing up debt. No debt has been written off in year. The Trust are receiving clinical income payments directly on block payment as opposed to raising invoices. A Business Better than Usual workstream is in place in finance to look at processes and chase debt.

OUTCOME: The Committee **NOTED** the Q4 review of losses and special payments.

2. Review of Waiving of Standard Orders

The Deputy Director of Finance presented the final quarter report showing a total of 22 waivers of standing orders totalling just over £1m. The Deputy Director of Finance clarified a separate schedule was presented for Q1 and Q2 for items bought for Covid; however, these items for the second half of the year were received through a national procurement. The report includes the covid spend that isn't covered in this process i.e. sanitation stations in the Trust entrances.

AN raised his concern in the number of waivers which includes the rationale 'timescale excludes seeking competition'. The Deputy Director of Finance explained this is reflected in the overall value for the quarter, some of this can be contributed to the covid requirements and need for the pace of meetings. The Director of Finance clarified that guidance and funding was issued at short notice which resulted in decisions being taken quickly with a challenge to build them into the forecast. The Trust were reusing suppliers that have been used previously. The Deputy Director of Finance explained more than one company came in to provide demos and provide prices for falls monitors; however, it had not gone through the full formal procurement process. RH explained he understands the practicalities of this as funding became available; however, highlighted it is not good in ensuring value for money and would not want to see this on a recurring basis. The Deputy Director of Finance agreed.

OUTCOME: The Committee **NOTED** the waiving of standing orders report for the final quarter.

3. Receive Treasury Management Annual Report

The Treasury Management Annual Report was circulated which previously went to the Finance and Performance Committee. The proposal going forward is that the treasury management updates will report into the Finance and Performance Committee.

The content of the year end report refers to significant changes seen in the cash position including the write off of historical debt of £140m. However, the Trust will pay a public dividend capital percentage on this which is higher than the interest charge; therefore, there will be a slight pressure to the revenue position although it will show a healthier balance sheet.

As a result of the Covid pandemic and financial regime, the Trust have been receiving block funding for clinical income a month in advance which has resulted in healthy cash balances all year. The cash balance was at £68.4m at the end of February.

There has been a significant improvement on performance for better payment practice code with a target of 95% payment within 30 days. The graph in the report shows that the Trust were significantly beneath this with a tight cash position in the previous year. The Trust have been in excess of 92% compliance since November 2020 due to much higher cash balances. The measures in place to manage cash are still in place such as the Cash Committee and Senior Account Managers for chasing debt. Cash management is a key part of business continuity plans.

The home working model has supported staff availability and lowered staff sickness rates which is a contributor to some of these metrics.

The Trust were in receipt of extra elements of capital funding during the course of the year which have been put towards new projects and will be spent by year end in line with the forecast. The Trust have also successfully closed sales on several buildings during the pandemic.

AN asked if there is an investment policy in terms of the cash position not to invest. The Deputy Director of Finance confirmed this is covered in the Treasury Management Policy to only invest in institutions with the highest credit rating where the interest rate may not be favourable.

RH re-assured the Committee that the cash management position is reviewed in detail at Finance and Performance Committee and he agreed that treasury management updates should report to the Finance and Performance Committee moving forward.

The Senior Manager KPMG highlighted the external audit benchmarking report is linked to this.

OUTCOME: The Committee **NOTED** the Treasury Management Annual Report and **NOTED** that future reports will go to the Finance and Performance Committee.

30/21 INTERNAL AUDIT

Internal Audit Follow Up Report

The Internal Audit Manager presented the follow up report which is now an automated process went live at the end of February 2021. All leads assigned responsibility for an action now automatically receive a notification the third calendar day of each month. The next updates will be requested in May 2021 and a further update will go back to the weekly Executive Board in July 2021.

The Director of Finance highlighted the Chief Executive is aware of how long some of these have been outstanding and is keen to challenge that these are closed off and delivered as agreed e.g. updating the policy for car parking to reflect the current position. AN is pleased the Chief Executive is challenging this and agreed the Trust need to work on closing these off.

DS reported she is pleased with the new approach and monthly update and would like to see more dates which gives an indication when some work will progress, for example, the study leave policy states there was no further progress this year and asked if further action will be taken in the first quarter of next year. The Internal Audit Manager agreed and confirmed more information will be added to the new system and included in the next report.

RH raised his disappointment in the number of overdue recommendations and asked if there needs to be another formal review forum before the end of May given it could impact on the Head of Internal Audit opinion. The Internal Audit Manager explained a total of 14 majors are overdue, of which 9 relate to death certificates and end of life care audits which are taking place now. The death certificates recommendation was previously a limited assurance report and the Internal Audit Manager expects a significant assurance report next time.

Internal Audit Progress Report
The Internal Audit Manager reported at the last Committee a number of audits were identified to not take place; however, the Internal Audit Manager has met with individual Executives seeking confirmation where audits would be cancelled and a few originally identified to be cancelled are now taking place. Of the few that have been cancelled, direct discussions have taken place and most of these have gone into next years plan.

There has been an agreement to cancel 82.5 days which will be offset by additional days in the plan e.g. audits that were not in the plan and some directly related to Covid-19. The reality will be closer to delivering roughly 400 days.

AN highlighted infection control audits have been dropped altogether and asked the rationale for this. The Internal Audit Manager explained this was due to resource pressures and explained as there is a high focus on this elsewhere in other forums, an audit is not required; however, it can be added back in if necessary. The Company Secretary confirmed the Board Assurance Framework has had a focus on infection control.

The Internal Audit Manager summarised the five must do's, two have been completed (Board Assurance Framework review and financial systems) and three are in progress (death certificates, end of life care and data protection security tool). All the critical audits are complete in order to complete a Head of Internal Audit Opinion at the end of the year.

The Head of Internal Audit confirmed the Trust are in a far better position than reported at the last Committee and asked to formally thank the operational staff and the audit team for their focus and hard work. The key risks and control issues have been identified. The Head of Internal Audit confirmed the Trust will receive a meaningful Head of Internal Audit Opinion at end of year and any areas not covered are in the planning for next year.

RH highlighted the good achievement to get closer to 400 days given the circumstances and the Trust aiming for a positive internal audit opinion on the back of this.

The Committee noted thanks to the Director of Finance and Deputy Director of Finance and the Audit Yorkshire team for their efforts to achieve this.

The Internal Audit Manager provided an update on the Delegated Consent audit limited assurance report which was not on the plan and was an additional audit from February

last year which did not take place due to Covid. The Trust are currently awaiting GMC guidance which has recently been released and the Consent to Examination or Treatment policy will need to be updated. The Internal Audit Manager confirmed this is in the 2021/22 internal audit plan for a follow up.

Internal Audit Plan 2021/22
The Internal Audit Manager explained that due to Covid-19, the internal audit plan for 2021/22 is a one-year recovery plan which is normally a three-year strategic plan. The three-year refresh will begin next year. She explained the plan includes audits that have not taken place this year, benchmarking audits, audits focused on Covid-19 recovery and NHS Phase 3 letter and mandated and core audits. The Internal Audit Plan focuses on Covid-19 recovery as opposed to business as usual audits.

OUTCOME: The Committee **APPROVED** the Internal Audit Follow Up Report, Progress Report, Internal Audit Plan for 2021/22 and **RECEIVED** the limited assurance report and the Insight reports for January 2021 and March 2021.

31/21 LOCAL COUNTER FRAUD PROGRESS REPORT
Shaun Fleming, Local Counter Fraud Specialist presented the Local Counter Fraud progress report and workplan. The key points to note were:

- National Fraud Initiative (NFI) new exercise has started
- Hold to Account – No formal fraud referrals have bene received since the last Audit and Risk Committee
- Government Functional Standard for Counter Fraud came out in February and is similar to the current Functional Standard
- There are 13 components three of the components will not achieve a green or amber rating which is a national problem and the Counter Fraud authority agreed on this. These are:
    - *Component 2* – the Counter Fraud Bribery and Corruption Strategy has not been released yet
    - *Component 3* – Fraud Bribery and Corruption Risk Assessment - the guidance on certain methodology has not been received yet
    - *Component 6* – Outcome-based metrics – the suggested metrics will be adapted to the organizational requirements which have been quality assessed immediately with no time to put the new metrics in place
- The NHSCFA recognises there will be non-compliance against these 3 components and that returns for May 2021 will represent a baseline assessment

Counter Fraud Workplan 2020/21
The counter fraud workplan aligns with the new standards that have been released and will report in a different way. The Local Counter Fraud Specialist explained this will be a fresh approach as the old standards were in place for at least ten years.

AN asked the Director of Finance if he sees any key challenges in the plan. The Director of Finance asked the Local Counter Fraud Specialist to be clear in what the ask is to understand if we will comply. The Local Counter Fraud Specialist provided assurance that the Trust will not be in a different position to anyone else and the new standards will be worked through.

OUTCOME: The Committee **RECEIVED** the Local Counter Fraud Progress Report and **APPROVED** the Anti-Fraud, Bribery and Corruption Plan for 2020/21.

32/21 EXTERNAL AUDIT SECTOR UPDATE
Updated External Audit Plan for 2020/21

Clare Partridge, Partner KPMG explained the only change in the plan approved at the previous Audit and Risk Committee is the Value For Money (VFM) risk assessment which is summarised on page 24 of the plan. She confirmed planning work has taken place on this which is currently showing green. The Trust are currently red against financial sustainability with the breach on the well-led review.

The Partner KPMG confirmed they have no concerns with the Trust making quick decisions regarding Covid-19 spend and ensuring the correct governance arrangements were in place.

RH expressed disappointment that the Trust are red against financial sustainability; however, added that it is not unexpected. He added that the Trust are in a good position with the exception of the deficit. RH asked if there will still be a separate VFM opinion. The Partner KPMG responded that the guidance is that there will be a separate report made publicly available; however, this has still not been finalised.

Sector Update
The Partner KPMG explained the statutory changes for the ICS and the CCGs which are expected and where the funding flows, explaining that lots is happening in the background for governance in the sector.

RH highlighted the reflections around Leicester in the papers and the review from Audit Yorkshire on this topic. RH feels the Trust are in a good place on the issues encountered at Leicester e.g. culture of reporting, accounts preparation, policy; however, it is good to keep them under review. The Partner KPMG was in agreement.

AN asked external audit If they had a perspective on the HMFA report and challenges of recruiting external auditors. The Partner KPMG explained it is extremely challenging and agreed that some Trusts struggle to recruit auditors as there are not enough.

Q3 PRF Benchmarking Report
The Director of Finance stated the benchmarking report is helpful for the Trust and feels that the Trust are benchmarking well for use of resources. AN added there is a good validation of work taking place at the Trust which is a positive story.

OUTCOME: The Committee **APPROVED** the External Audit Plan for 2020/21 and **RECEIVED** the sector update and PFR Benchmarking Report Q3 20/21.

33/21 COMPANY SECRETARY'S BUSINESS

Annual Accounts Reporting and Process
The Company Secretary reported the NHS accounts timetable and year-end arrangements were presented to the Committee on 26 January 2021. An updated timetable is enclosed which confirms the final review dates of the annual report and accounts for 2020/21. The Committee meeting to undertake this sign off is scheduled for 10 June 2021.

OUTCOME: The Committee **NOTED** the annual report and accounts timetable for 2020/21 and request to the Board of Directors for delegation of authority to the Audit and Risk Committee to approve the 2020/21 annual report and accounts.

Annual Governance Statement
As part of the annual reporting arrangements, Committee members are asked to review the draft 2020/21 annual governance statement which has been developed in line with the 2020/21 Foundation Trust Annual Reporting Manual guidance from NHS England / Improvement.

The draft statement has been reviewed by the Chief Executive, the Executive team and the Audit and Risk Committee Chair.
Action: RH to share his comments with the Company Secretary

OUTCOME: The Committee **NOTED** the draft Annual Governance Statement.

Review Code of Governance Compliance
Within the annual report the Trust must provide a specific set of disclosures regarding application of the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. Those required to be disclosed are detailed in the annual reporting manual.

The Trust is compliant with all provisions of the code of governance. The paper detailed the Trust position in relation to the application of the code and references key sources of evidence, including the well-led development governance review completed during 2020/21.
Action: RH and AN to share their comments with the Company Secretary

OUTCOME: The Committee **NOTED** the Trust's compliance with the Code of Governance.

Self-Assessment of Committee Effectiveness Action Plan
The 2020/21 self-assessment summary of responses and action plan were shared. The Company Secretary thanked all members for completing their returns which has resulted in a total of 9 actions in the action plan. There is further work needed in some areas.

The Company Secretary reported that Board Committee Chair highlight reports to the Board of Directors are being introduced which was flagged by the AqUA well-led review which will be in place from 6 May 2021.

AN asked the Director of Finance if he would support the action to invite action leads to the Committee where there are limited assurance reports. The Director of Finance was in support of this and is hoping to see an improved position following the challenge from the Chief Executive and at the weekly Executive Board.

OUTCOME: The Committee **NOTED** the outcome of the Audit and Risk Committee self-effectiveness review for 2020/21 and the areas of continued improvement for 2021/22 in the action plan.

Declaration of Interest Update
The Company Secretary highlighted the improvement on declaration of interest compliance since the last meeting which has increased from 20% at the beginning of February 2021 to 83% as at 31 March 2021. Lots of work has taken place to improve this position.

OUTCOME: The Committee **NOTED** the improved compliance position on declarations of interest by decision makers as at 31.03.21.

Review Audit and Risk Committee Workplan
The annual workplan for the Audit and Risk Committee was submitted for approval.

OUTCOME: The Committee **APPROVED** the Audit and Risk Committee 2021 workplan.

Audit and Risk Committee Attendance Register
The attendance register of the Audit and Risk Committee from 1 April 2020 to 31 March 2021 was submitted for any comment or corrections. The attendance of the Non-Executive Directors will be published in the annual report and accounts for 2020/21.

The Managing Director for Digital Health highlighted she was not invited to the October meeting and asked to check when she became a permanent member of the Committee.
Action: Company Secretary to confirm when the MD for Digital Health became a member of the Committee and update the attendance register.

OUTCOME: The Committee **NOTED** the Audit and Risk Committee attendance register for 2020/21.

35/21 SUMMARY REPORTS AND MINUTES TO RECEIVE
A summary report of work undertaken since January 2021 was provided for the following groups and minutes were circulate for assurance:

- Risk Group – no questions were raised.
- Information Governance and Records Strategy Group – The Managing Director for Digital Health confirmed all access measures for records are now a standing agenda item. She explained a total of 250 plus alerts were last reported and only six needed a further review and none went to HR. She confirmed that password compliance is now at 95% following a hard stop that took place in March 2021. This includes 200 students who only attend the Trust infrequently; therefore, compliance would be higher.
- Health and Safety Committee – no questions were raised.
- Data Quality Board – no questions were raised.
- CQC and Compliance Group – no questions were raised.

OUTCOME: The Committee **NOTED** the summary reports for the above groups.

36/21 ANY OTHER BUSINESS
There was no other business.

37/21 MATTERS TO CASCADE TO BOARD OF DIRECTORS

- Encouraging work on data quality
- Highlight report will be submitted to the Board
- Internal audit remaining a concern on overdue major recommendations albeit this is now getting greater Executive focus
- Approved the 2020/21 Internal Audit and Counter Fraud plans

38/21 DATE AND TIME OF THE NEXT MEETING
Extra-Ordinary Audit and Risk Committee to sign off the Annual Report and Accounts
Thursday 10 June 2021
2:30 – 4:00 pm
Microsoft Teams

Wednesday 21 July 2021
10:00 – 12:15 pm
Microsoft Teams

39/21 REVIEW OF MEETING
The meeting closed at approximately 3:00 pm.

Agenda Item 3
Appendix A

Calderdale and Huddersfield NHS Charity

Minutes of the Charitable Funds Committee meeting held on Tuesday 23 February 2021, 1.30pm – 3.00pm via Microsoft Teams

PRESENT

Philip Lewer (PL)	Chair
Gary Boothby (GB)	Director of Finance
David Birkenhead (DB)	Medical Director
Ellen Armistead (EA)	Director of Nursing/Deputy Chief Executive
Peter Wilkinson (PW)	Non-Executive Director
Sheila Taylor (ST)	Council of Governors' Representative
Adele Roach (AR)	BAME Representative

IN ATTENDANCE

Emma Kovaleski (EK)	Fundraising Manager/Ops Sub Committee Rep
Carol Harrison (CH)	Charitable Funds Manager (Minutes)
Lyn Walsh (LW)	Finance Manager
Zoe Quarmby (ZQ)	ADF Financial Control

AR was welcomed to the meeting and brief introductions were made.

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 and noted for Richard Hopkin.

3. MINUTES OF MEETING HELD ON 25 NOVEMBER 2020
The minutes of the meeting held on 25 November 2020 were approved as an accurate record.

4. ACTION LOG AND MATTERS ARISING
EK gave an update on the action log and this was NOTED.

5. RESERVES POLICY
GB presented this draft policy which was reviewed and approved. It was agreed to review again in twelve months.
ACTION: CH to put on agenda for Feb 2022 meeting **23.02.21 – 1**.

6. ETHICAL INVESTMENT
ZQ presented this paper recommending that, after a meeting with CCLA and some members of this committee, the Charity moves its investment portfolios from the Charities Investment Fund to the Charities Ethical Investment Fund, both within CCLA. DB raised a concern regarding the estimated costs of

£10,800 mentioned in the paper but it was likely that these would be much lower in practice. The exact costs are dependent on the number of clients who take up the offer to move in Spring 21 and so will not be known until nearer that time. *After this meeting, the invitation letter was received and it states that the costs would be nearer 0.01% rather than the 0.40% used in the paper, resulting in the likely cost being nearer to £300. As the Ethical Fund was a better performing fund, the move would quickly pay for itself. GB agreed that there were no concerns with these costs.*

The recommendation to move to the Ethical Fund was approved and the Committee now awaits the invitation from CCLA in the Spring 2021 (now received).
ACTION: CH to commence transfer process with CCLA. **23.02.21 – 2**.

7. QTR 3 2020/21 INCOME & EXPENDITURE SUMMARY (inc. SOFA & BS)
EK presented the key points in this very comprehensive paper and its contents were NOTED.

8. CHARITY KPI UPDATE
EK presented this paper and its contents were NOTED.

9. RISK REGISTER - REVIEW
EK presented this paper and the recommendation to reduce two risk ratings was accepted. EK will amend.
The Risk Register was NOTED. This is a live document which is reviewed at each meeting and then updated if necessary.
ACTION: EK to amend the Risk Register as agreed. **23.02.21 – 3**.

10. NHS CHARITIES TOGETHER UPDATE
EK gave a verbal presentation around the different stages, deadlines for applications and discussions with CHFT and community colleagues. This was NOTED.

11. MINUTES OF STAFF LOTTERY COMMITTEE MEETING 14 DECEMBER 2020
The paper is for information only and its contents were NOTED.

12. A ORMEROD – AGE CONCERN TODMORDEN FUNDING
The papers were presented to show how our monies had been spent over the last two years. The Charity has now made its third of three annual payments of £15,000. The contents were NOTED.

13. ANY OTHER BUSINESS
There was no other business to report.

DATE AND TIME OF NEXT MEETING:
Monday, 24 May 2021, 9 – 10.30am, via Microsoft Teams