

Council of Governors Meeting

There will be a meeting of the **COUNCIL OF GOVERNORS** of West Suffolk NHS Foundation Trust on Wednesday **8 February 2017 at 18.00** in the Education Centre, West Suffolk Hospital

Roger Quince, Chairman

Agenda

General duties/Statutory role
(a) To hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. (b) To represent the interests of the members of the corporation as a whole and the interests of the public.
The Council is involved in strategic discussions, appoints the Chairman and Non-Executive Directors, external auditors and assures itself that Trust performance is at the required standard.

18.00 GENERAL BUSINESS		
1.	Apologies for absence To <u>receive</u> any apologies for the meeting	Steve Turpie
2.	Welcome and introductions To <u>welcome</u> governors and attendees to the meeting.	Steve Turpie
3.	Declaration of interests for items on the agenda To <u>receive</u> any declarations of interest for items on the agenda	Steve Turpie
4.	Minutes of the meeting of 16 November 2016 (enclosed) To <u>approve</u> the minutes of the meeting held on 16 November 2016	Steve Turpie
5.	Matters arising action sheet (enclosed) To <u>note</u> updates on actions not covered elsewhere on the agenda	Steve Turpie
6.	Chairman's update (verbal) To <u>receive</u> an update from the Vice Chairman, including decision regarding appointment of External Auditor	Steve Turpie
7.	Chief Executive's report (enclosed) To <u>note</u> a report on operational and strategic matters	Steve Dunn
8.	Governor Issues (enclosed) To <u>note</u> the issues raised and <u>receive</u> any agenda items from Governors for future meetings.	June Carpenter
18.30 DELIVER FOR TODAY		
9.	Summary Quality & Performance Report (enclosed) To <u>note</u> the summary report	Rosie Varley
10.	Summary Finance & Workforce Report (enclosed) To <u>note</u> the summary report	Neville Hounsome

18.50 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
11.	Quality presentation – Due to time constraints the presentation has been deferred.	
12.	e-Care transformation update (enclosed) To <u>note</u> a report on the progress with e-Care	Craig Black
19.00 BUILD A JOINED UP FUTURE		
13.	Community services and Accountable Care Organisation (ACO) (verbal) To <u>receive</u> a brief update ahead of the workshop on 23 February 2017.	Steve Dunn
14.	Annual Quality Report (verbal) To <u>approve</u> nominations for Governors to act as readers and provide comments on the Quality Report	Richard Jones
19.15 GOVERNANCE		
15.	Amendment to Constitution (enclosed) To <u>note</u> amendments to the Constitution	Richard Jones
16.	Register of Interests (enclosed) To <u>note</u> the Register of Governors Interests	Richard Jones
17.	Appointment of Lead Governor (enclosed) To <u>approve</u> the appointment of the Lead Governor	Richard Jones
18.	Nominations Committee (verbal) To <u>elect</u> a governor to the Nominations Committee	Richard Jones
19.	Report from Engagement Committee (enclosed) i) To <u>note</u> a report from the Engagement Committee meeting of 12 January 2017 ii) To <u>review</u> and <u>approve</u> the Engagement Strategy for 1 April 2017-March 2019	Jan Osborne
20.	Lead Governor report (enclosed) To <u>receive</u> a report from the Lead Governor.	June Carpenter
19.40 ITEMS FOR INFORMATION		
21.	Reflections on Meeting To consider whether the right balance has been achieved in terms of information received and questions for assurance versus operational delivery	Steve Turpie
22.	Dates of meetings for 2017 Thursday 11 May Thursday 10 August Thursday 16 November Tuesday 12 September– Annual Members Meeting (Apex, Bury St Edmunds)	Steve Turpie
19.45 CLOSE		

REPORT TO:	Council of Governors
MEETING DATE:	8 February 2017
SUBJECT:	Draft Minutes of the Council of Governors Meeting held on 16 November 2016
AGENDA ITEM:	4
PRESENTED BY:	Steve Turpie, Vice Chairman
FOR:	Approval

DRAFT

**MINUTES OF THE COUNCIL OF GOVERNORS' MEETING
HELD ON WEDNESDAY 16 NOVEMBER 2016 AT 17.30
IN THE EDUCATION CENTRE AT WEST SUFFOLK NHS FOUNDATION TRUST**

COMMITTEE MEMBERS		Attendance	Apologies
Roger Quince	Chairman	•	
Mary Allan	Public Governor	•	
June Carpenter	Public Governor	•	
Jane Chilvers	Staff Governor	•	
Ian Collyer	Public Governor	•	
Justine Corney	Public Governor	•	
Judy Cory	Partner Governor	•	
Jon Eaton	Partner Governor	•	
Nick Finch	Staff Governor		•
David Frape	Public Governor	•	
Jayne Gilbert	Public Governor	•	
Mark Gurnell	Partner Governor		•
Peter Harris	Public Governor	•	
Beccy Hopfensperger	Partner Governor	•	
Jenny McCaughan	Staff Governor	•	
Sara Mildmay-White	Partner Governor	•	
Laraine Moody	Partner Governor		•
Barry Moulton	Public Governor	•	
Janice Osborne	Public Governor	•	
Joe Pajak	Public Governor	•	
Lindsay Pike	Staff Governor	•	
Margaret Rutter	Public Governor	•	
Mick Smith	Public Governor	•	
Liz Steele	Public Governor	•	
Stuart Woodhead	Public Governor	•	
In attendance			
John Benson	Non Executive Director		
Pam Chrispin	Medical Director – agenda item 2 only		
Georgina Holmes	FT Office Manager (<i>minutes</i>)		
Neville Hounsome	Non Executive Director		
Nick Jenkins	Medical Director		
Richard Jones	Trust Secretary & Head of Governance		

Action

GENERAL BUSINESS

16/66 APOLOGIES

Apologies for absence were noted as above.

16/67 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting and introduced Nick Jenkins, who had taken over from Pam Chrispin as Medical Director and Charles Nevitt, who had replaced Steve Ohlsen as a Public Governor.

He also welcomed Pam Chrispin, who had come to say goodbye. She thanked everyone for their support and said that she had enjoyed working with the Governors and wished them all the best for the future.

Agenda item 13, STP update, would be moved forward to after item 7. It was also noted that John Benson would present the quality report and Neville Hounsome would present the finance report.

16/68 DECLARATIONS OF INTEREST

There were no declarations of interest.

16/69 MINUTES OF THE COUNCIL OF GOVERNORS MEETING HELD ON 8 AUGUST 2016

The minutes of the meeting held on 8 August 2016 were approved as a true and accurate record.

Judy Cory referred to item 16/49, page 2 and asked when the proposals for the front of the hospital would be presented to the Board. It was explained that due to a delay this would now be going to the Board in the New Year.

16/70 MATTERS ARISING ACTION SHEET

There were no ongoing actions. The completed actions were reviewed and there were no issues.

16/71 CHAIRMAN'S UPDATE

The Chairman reported that the Trust had been experiencing a very busy period but staff had coped well with the pressure. A&E performance was not as good as it was hoped it would be and WSFT was now fourth in the region for performance. Apart from this overall performance was satisfactory.

16/72 CHIEF EXECUTIVE'S REPORT

June Carpenter asked if the outcome from Perfect Week had continued, or if it had slipped back again. Nick Jenkins explained that Perfect Week had involved people helping in this process who would not normally do so. Although areas for improvement had been identified, it was not possible to address these straight away as these people had to return to their regular jobs. The final report on Perfect Week was going to the Trust Executive Group (TEG) next week.

Judy Cory referred to escalation ward beds and junior doctor cover at night. It was explained that this would be discussed under agenda item 8 (Governor issues).

Liz Steele asked about the low level of uptake from staff for flu vaccination. Nick Jenkins confirmed that he would be addressing this in his presentation (agenda item 11).

Stuart Woodhead asked about the progress of e-Care and if the benefits that the Trust was hoping for were beginning to be realised. Neville Hounsome reported that implementation had gone very well and broadly to plan. However, there continued to be some teething problems, particularly around the production of data, which everyone was very aware of.

Barry Moulton asked this was affecting data that had to be reported to the CCG and other areas for compliance. Neville Hounsome confirmed that this had been addressed with the CCG.

Margaret Rutter referred to the discharge process and said that she was aware of people having to wait on the ward for 3½ hours for their prescriptions to be available.

Jane Chilvers explained that 3½ hours would be the time from a doctor saying that a patient could go home. This did not mean that their prescription was written up immediately. Therefore the time included the wait for a junior doctor to write up their prescription rather than the time for pharmacy to turn around the prescription.

The Chairman explained that waiting for junior doctors to write up prescriptions had been a general problem, as opposed to a delay in pharmacy processing prescriptions. It was proposed that there should be a report to the Council of Governors, with an analysis of discharge times and processing prescriptions.

J Green

Neville Hounsome noted that WSFT had received £10m funding as a Global Digital Exemplar. This would be used to develop IT systems and e-Care further.

West Suffolk had also been rated the best in England for early cancer diagnosis, reflecting the high quality primary and secondary care in the area and how effectively they work together. The Governors commended everyone associated with this achievement.

16/73 GOVERNOR ISSUES

The responses to the issues that were raised were noted.

The Chairman confirmed that information on junior doctors and escalation beds at night would be circulated or come back to the next meeting.

J Green

Richard Jones referred to item 8a, Governor Training, and proposed a follow up session with Clare Lea. He suggested that this could consist of a refresher on the previous session, and then look at accountability, effective questioning and challenge, membership and public engagement.

If Governors agreed with this proposal he would talk to Clare about developing a session on this basis next March.

R Jones

The Council of Governors agreed with this proposal.

The Chairman said that Governors could also have input into anything else that they would like covered.

DELIVER FOR TODAY

16/74 SUMMARY QUALITY & PERFORMANCE REPORT

John Benson explained that A&E performance had been discussed in detail at the Board meeting, particularly the volume coming through the front door and clearing space at the back door.

There were still issues with e-Care around reporting, both internally and externally, but he anticipated that this would improve.

Mortality was looking good compared to other periods when this had caused concern, particularly around elective care. This was a good reflection on the Trust's overall performance.

June Carpenter asked about patient falls. John Benson explained that there had been an increase in falls this month, however these fluctuated month on month and therefore he was not concerned about a single set of figures but we would be monitoring the trend. He added that staffing issues could also have an effect on this.

Nick Jenkins said that this highlighted the fact that hospital was not necessarily a safe place and people were better off in their normal home environment unless they medically needed to be in hospital. People fell more in hospital than they fell at home.

Joe Pajak asked about staffing and if there was any correlation between staffing levels and performance on falls etc. It was explained that there was a relationship between staffing and falls. The organisation had a mechanism for addressing staffing levels but this had an impact on the financial situation.

June Carpenter asked about the React to Red pressure ulcer trial on G8. Neville Hounsome reported that Rowan Procter had been very positive about this at the Board meeting, but as far as he was aware the data was not yet available.

Jane Chilvers explained that there was a pressure ulcer awareness day in the Trust tomorrow. She confirmed that there was definitely a correlation between patient falls and the number of staff available on a ward. However, a ward could have a constant number of staff but pressure ulcers may increase due to skill mix and lack of awareness of what to look for.

David Frape asked how much capacity the IT system had for storing data. The Chairman explained that e-Care was predicated on using data effectively. Richard Jones clarified that that there was a legal requirement for the time that patient records were held.

16/75 SUMMARY FINANCE & WORKFORCE REPORT

Neville Hounsome explained that WSFT had planned for a £5m deficit, which was subject to receiving £6m from Sustainability & Transformation (S&T) funding. However the current position was £1m behind plan, which meant that at the current run rate the Trust would use up its entire contingency by the year end.

Spend on substantive staff was approximately £0.5m more than last year, and there were 96 more staff than last year. However, temporary staff had not reduced in spite of recruiting more substantive staff. He explained that this was due to flow through the organisation and patient acuity. Therefore the initiatives referred to in the performance report were very important in order to manage patient flow and ensure that appropriate people were treated in the community so that the Trust did not have to have 25 unfunded beds open.

Cost improvement plans (CIPs) were back loaded toward the end of the year and the NEDs had been challenging the executive team on how this would be achieved. Discussions had taken place around how to address the financial challenges and the Board was not prepared to compromise patient safety to meet financial challenges. It was therefore very important to ensure that staff were appropriately deployed.

Barry Moulton noted that a third of the CIPs had been delivered in the first two quarters. Therefore the organisation now needed to deliver the other two thirds in the last two quarters, which would be a particular challenge due to winter pressures.

Stuart Woodhead asked what it was thought the final, year-end deficit would be. The Chairman explained that this would partly depend on how much S&T funding the Trust received. Currently the deficit was looking more like £8m than £5m.

Jayne Gilbert asked if the NEDs were satisfied that the Trust was working effectively, considered the number of additional staff. John Benson explained that with the current clinical pressures and winter pressures approaching the organisation needed to be careful not to make decisions that would affect quality of care.

He assured Governors that the NEDs had pushed the executive team to consider whether staff were being used appropriately and effectively.

It was confirmed that S&T funding was not ring fenced. Nick Jenkins explained that S&T funding was only awarded if an organisation was doing well. If it was not doing well, possibly due to lack of finances, it would not receive S&T funding.

Neville Hounsome reported that WSFT was performing well financially compared to other hospitals. However, he stressed that this was still not acceptable.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

16/76 MEDICAL DIRECTOR PRESENTATION

Nick Jenkins thanked the Council of Governors for inviting him to attend this meeting. He said that the welcome and friendliness of everyone had been most overwhelming.

He explained his background as an A&E Consultant, and why he wanted to become a Medical Director. Throughout his career he had particularly focussed on embedding a culture of people being nice to one another and the benefits of doing so.

He considered the Accountable Care Organisation (ACO) to be very exciting. It would assist in making WSFT sustainable for the future as a good performing hospital.

He also considered mortality data to be excellent and stroke and hip fracture performance to be good. However, sustaining this would be a challenge and would only be possible if organisations working in partnership, which would enable the Trust to continue to provide good patient care.

He referred to the question raised by Liz Steele earlier in the meeting about low level of uptake of flu vaccinations and said that he could not understand why this was not mandatory. He firmly believed that this should be the case as staff might not die if they contracted flu but they could pass it on to patients who might die.

It was suggested that communication to staff about having their flu vaccination should focus more on the danger to other people/patients, rather than protecting themselves.

The Chairman thanked Nick Jenkins for his presentation and said that he had high hopes for his future at WSFT.

16/77 CARE QUALITY COMMISSION (CQC) INSPECTION REPORT & ACTION PLAN

The Council of Governors noted and accepted this report and action plan.

BUILD A JOINED UP FUTURE

16/78 SUSTAINABILITY & TRANSFORMATION PLAN (STP) UPDATE

Richard Watson introduced himself and explained that he was the Chief Redesign Officer for the CCG.

Richard Watson explained the background to STP and that the timescales had been very ambitious, with a six month timeframe to submit a plan by the end of October.

The STP would be published tomorrow; however he stressed that this was not a “done deal”, or a contract or new organisation.

He explained that this was a plan and a direction of travel and it had been very helpful to have commitment by all organisations to this process. This included a number of organisations across health and Social Care. This provided the opportunity to share knowledge and benefit from everyone working together, and had enabled a programme of work to be developed from current projects.

The vision set out had been very similar to that within the Health & Wellbeing Strategy, with the main focus being on a review of health and care. The aim was to develop and work with the community to build resilience and look at how to work with statutory services. Another objective was to do more around prevention by working more closely with public health colleagues.

Janice Osborne commented that she was pleased to that prevention was part of this. She referred to the benefits of an ageing population and the contribution that older people could make to the community. However she acknowledged that this would also be a challenge. Richard Watson agreed that this would be a challenge, particularly around the allocation of funding.

They were also trying to work closely with the West on the integration of out of hospital care. However, this was not progressing as well as it could be and required more focus from all the organisations. He explained that there did not appear to be a single factor that was slowing this down.

By October 2017 the existing community services contract will end, and the CCG are currently in a constructive dialogue process with the hospital, working with local alliance partners, rather than going out to procurement.

It was explained that there was no additional funding for STP; this would have to be funded from current funding.

With regard to mental health services, more needed to be done around children. However, an increase in allocation of funding to CCGs would mean an uplift to money spent on mental health.

Primary care was also included in the STP. This was looking at GPs and other organisations working more closely together to the benefit of patients, ie partnering GP practices with care homes.

It was expected that hospital reconfiguration and transformation would initiate the most interest in the process, ie Ipswich & Colchester Hospital partnership. It was stressed that this was not about closing A&E departments etc on these sites, but how the two organisations could work together to the benefit of both.

With regard to WSFT, this was about working in partnership across all organisations as an alliance to transform services in the local area. Collaborative working was being looked at, particularly in terms of back office, eg HR, finance, payroll, and opportunities for sharing functions; this included CCGs.

Richard Watson considered clinical engagement to have been the weakest part of the process. Following the launch of STP tomorrow, a number of engagement events would take place to gain support and help people to understand the detail and plans.

The main focus in the STP for WSFT was alliance working and developing an Accountable Care Organisation.

Dawn Godbold introduced herself as Director of Operations for Community Services. Part of this role was to oversee the delivery of the community services contract on behalf of WSFT.

She explained that the main partners in the ACO were WSFT, Suffolk County Council, the GP Confederation, Primary Care and the Mental Health Trust. This was something that had been talked about for some time but they were now in a position to implement this as contracts were coming to an end.

WSFT had always been keen to work in partnership with other organisations in the system and was now looking at working in a more structured and formal way. She explained the definition of an ACO and that the aim was to build a new model with shared responsibility and shared accountability, with all organisations working together as a responsible shared health and social care partnership. She stressed that conversations were at a very early stage of and they still needed to understand how governance would work and how people would be involved and engaged in this.

The community service contract would finish at the end of September 2017 and this provided an opportunity to move into a different type of arrangement. Therefore the organisations in the ACO were going through a constructive dialogue with the CCG, through a formation of a provider alliance, ie collaborative, multi-agency, partnership service.

Dawn Godbold explained that this would be done through a locality basis, working with all the organisations, so that there was a more rounded view and people would be referred back to the correct services much more quickly and more appropriately. The alliance would be developing a set of principles around how it would operate.

Joe Pajak asked about the principals of this and if there would be an equality impact assessment. Richard Watson explained that within any changes that were undertaken a quality and equality impact assessment would be undertaken.

Janice Osborne requested that people connected with the provision of supported housing should also be a part of this. Dawn Godbold confirmed that this would be case, as well as other organisations in the wider locality, eg police and housing associations.

Mick Smith asked if the voluntary sector had also been considered. Dawn Godbold confirmed that these would be included and discussions had already taken place with Healthwatch.

Barry Moulton asked if there was any other area with a similar model already set up. Richard Watson explained that the national Vanguard programme was set up last year and this was exploring alliance working. Salford was the most ambitious of these and their plans were progressing well.

It was stressed that there was no easy solution to this, as it was very complex.

John Benson agreed and said that the key challenge was to do this despite the commissioning system and including social care.

16/79 NHS IMPROVEMENT PLANNING GUIDANCE

Richard Jones explained that the timescales for this had been brought forward compared to previous years, with the draft plan having to be submitted by 24 November and the final plan by 23 December.

He asked for volunteers to act as readers and comment on the final plan, which would be available early December.

Stuart Woodhead and June Carpenter volunteered.

GOVERNANCE

16/80 REVIEW OF CONSTITUTION AND ROLE OF LEAD GOVERNOR

The Chairman explained that the Constitution had not been significantly reviewed since the organisation became a Foundation Trust on 1 December 2011.

A working group had been set up and had met on 8 November; he thanked those Governors who had been a part of this. It had been a good meeting and this paper reflected their views, as well as Richard Jones's original suggestions.

Stuart Woodhead considered the proposal for a Deputy Lead Governor to be very good but was concerned as to whether it would be possible to find someone to do take on this role.

The Chairman explained that the Deputy Lead Governor would have no formal role, apart from if the Lead Governor stepped down or was not able to attend meetings for some reason. He suggested that Governors might wish to have a discussion about the role of the Lead Governor. He explained that the only role of the Lead Governor laid down in statute was to act as the link between the CoG and the regulator in the event that the Chair could not perform this role. All other functions performed by lead governors were additional and for agreement between the governors themselves and the Trust.

Justine Corney felt that the Lead Governor was very important in the cohesiveness of the Council of Governors and their working together.

Barry Moulton referred to the meeting on 8 November, when the Lead Governor role had been considered. He had understood that the proposal put forward would then be discussed and approved at today's meeting. Richard Jones clarified that this had been the intention.

June Carpenter proposed that this should be discussed at the informal Governors meeting on 26 January 2017.

The Council of Governors approved the recommendations in the paper, subject to further discussions on 26 January 2017.

It was noted that the election process for a Lead Governor would still take place at the Council of Governors meeting on 8 February 2017.

16/81 REPORT FROM NOMINATIONS COMMITTEE

A report had been received and discussions had taken place at the closed session of this meeting.

16/82 REPORT FROM ENGAGEMENT COMMITTEE

June Carpenter read out a report from West Suffolk College on the 'Step into the NHS Event' which had taken place on 2 November. This was considered to have been a great success and Denise Needle was thanked for her enthusiasm and Jan Bloomfield for her support. It was felt that this was the beginning of a much more joined up relationship between West Suffolk College and WSFT.

The Chairman thanked those Governors who had attended this event on behalf of WSFT.

Joe Pajak suggested that the Trust should have a presence at local schools' careers events. John Benson agreed that schools were a good place for promoting careers in the NHS.

June Carpenter referred to the car parking meeting on 10 November which had been attended by several Governors. A paper would be going back to the next Board meeting on this.

16/83 LEAD GOVERNOR REPORT

The Council of Governors received and noted the content of this report.

ITEMS FOR INFORMATION

16/84 REFLECTIONS ON MEETING

No comments received.

The Chairman gave his apologies for the meeting on 8 February 2017. Steve Turpie would be chairing this meeting in his role as Vice Chair of the Council of Governors.

16/85 DATES OF COUNCIL OF GOVERNORS MEETING FOR 2017

Wednesday 8 February 2017

Thursday 11 May 2017

Thursday 10 August 2017

Tuesday 12 September 2017 - Annual Members Meeting

Thursday 16 November 2017

REPORT TO:	Council of Governors
MEETING DATE:	8 February 2017
SUBJECT:	Matters Arising Action Sheet from Council of Governors Meeting of 16 November 2016
AGENDA ITEM:	5
PRESENTED BY:	Roger Quince, Chair
FOR:	Information

The attached details action agreed at previous Council of Governor meetings and includes ongoing and completed action points with a narrative description of the action taken and/or future plans as appropriate.

- Verbal updates will be provided for ongoing action as required.
- Where an action is reported as complete the action is assessed by the lead as finished and will be removed from future reports.

Ongoing action points

None

Completed action points

Ref.	Date of Meeting	Item	Action	Action taken	Action By	Completion date
141	16 Nov 2016	16/72	Clarification to be given to the Council of Governors on the processing time for TTO prescriptions.	<p><u>Report from Simon Whitworth, Chief Pharmacist</u></p> <p>The department target is to turn all TTO's around within 120 minutes with an average of 90 minutes. The last analysis that we did the average was 94 minutes, but that was some time ago. We continue to work on the Pharmacy KPI's. Since the implementation of e-Care there has been a delay in obtaining detailed TTO turnaround time data from the system but we are working with the Trust information team to rectify this, however I cannot give a firm time line for the work.</p> <p>The planned visits to the department will be an opportunity to show the way the ward and dispensary teams work with clinical teams to minimize delays in patient discharges.</p>	J Green	8 Feb 2017

142	16 Nov 2016	16/73	Information on escalation ward/beds and junior doctor cover at night to come back to next CoG meeting.	<p>Junior doctor cover is not provided overnight on a ward basis. Medical cover is provided by the medical on call team, that covers the entire organisation and are supported in this by the Critical Care Outreach Team (CCOT). The CCOT supports wards with specialist advice/tasks and the care of deteriorating patients. The main focus of the medical on call team overnight is the front door, managing new admissions to the hospital.</p> <p>During the day junior doctor cover for the winter escalation ward (G9) has been achieved through the associated moves across G3 and G5 when we were able to reallocate junior doctors so that all three areas were covered. This was supported by the move of 20 beds to Glastonbury Court for which medical cover is provided by GPs.</p>	J Green	8 Feb 2017
143	16 Nov 2016	16/73	Arrange a Governor development session in March based on proposal agreed at CoG meeting of 16 November 2016.	Training/development day arranged for 7 March 2017.	G Holmes	8 Feb 2017

Council of Governors – 8 February 2017

AGENDA ITEM:	Item 7
PRESENTED BY:	Steve Dunn, Chief Executive Officer
PREPARED BY:	Steve Dunn, Chief Executive Officer
DATE PREPARED:	30 January 2017
SUBJECT:	Chief Executive's Report
PURPOSE:	Information

I am conscious of the Governors' role in contributing to strategic decisions of the organisation and in doing this representing the interests of our Members as a whole and the interests of the public. Within this report I have reflected some of the key messages from my report to the Board of Directors but framed to highlight some of the key strategic issues and challenges that the organisation is addressing.

The Christmas period and January has been difficult at the hospital with unprecedented pressure on our services. First of all I would like to **thank all staff for everything you have done** to pull together as a team and make sure we put patients first. Some of you have gone above and beyond, working overtime during anti-social hours and being willing to do whatever it takes to keep our hospital and patients safe. I know many of you are exhausted and mentally drained by the effort it has taken to get this far.

This month's **performance pack** not only reflects the pressure that are being felt through the hospital and the emergency flow in the run up to the Christmas period but also other operational pressures. As well as failing the A&E 4 hour standard the trust suffered a sharp deterioration in echocardiology 6 week performance that resulted in an overall failure of the diagnostic target after successful delivery in November. Additionally the draft 62 day cancer performance for December is indicating a fail after the November performance was confirmed at 84.7% against the 85% target. We are still facing issues with e-Care and our ability to accurately report data. We are working with Cerner to resolve the technical reporting issues and this will be underpinned by robust procedures to ensure accurate data capture.

The **month 9 financial position** is behind plan by £5.4m year to date which is largely due to increased expenditure on escalation capacity and our failure to achieve our stretch CIP of £2m YTD. Consequently we will only receive £2.9m of the £6.1m Sustainability and Transformation funding we had anticipated in 2016-17, and therefore £1.6m of this shortfall is reflected in the YTD position.

Action within the Trust to increase the number of discharges and make those discharges that do take place earlier in the day is key to delivering both the operational and financial plan. Our future sustainability is dependent on this action, as well as reducing the overall volume of activity, in line with STP plans. The Patient Flow Group, chaired by the medical director, continues to focus on defined workstreams to ensure timely assessment, review and discharge planning for patients in the hospital.

Through my blog I have been emphasising that **Our hospital needs you!** Recognising it's been a busy few months and in preparing for this period we have been putting in place a number of initiatives to support and improve patient flow.

The **SAFER bundle** is a combined set of simple rules for adult inpatient wards. It is designed to improve patient flow and prevent unnecessary waits and is a major focus as the hospital prepares for winter.

- **Senior Review** – a consultant review of all patients by midday every day
- **All patients** will have a Planned Date for Discharge (PDD) and Clinical Criteria for Discharge (CCD)
- **Flow of patients** to commence at the earliest opportunity from the assessment wards with the first patients arriving on the ward by 10am
- **Early Discharge** – 33% of patients will be discharged before midday
- **Review** – a Multi-Disciplinary Team (MDT) review of all patients with an extended length of stay greater than 7 days (also known as stranded patients) with a home first mind set

Go Green – why it's important for patients

Go **Green** this Winter is encouraging us to adapt and change the way we work in order to identify from within where unnecessary patient waiting occurs. We have launched it as a Trust wide campaign because we must do all we can to reduce patients' length of stay and improve processes for discharging them. Patient flow is one of our biggest challenges and when patients don't flow effectively through the hospital we have to manage it.

It is helpful at this stage, as we continue refining our early morning board rounds, identifying **red** and **green** actions for our patients and using the SAFER patient flow bundle as a set of simple rules to support an improvement in patient flow, to remind ourselves who this is ultimately for - our patients. We know unnecessary waiting causes harm to our patients and we recognise that our actions as we care for them must support their journey with us in a value added way. Our job is to make them all well enough to go home as quickly and safely as possible.

We must ensure that every day a patient is in hospital is a **green** day where actions are taken to actively manage and advance their care and treatment. We want to reduce our **red** days where nothing of value happens to the patient. Our goal is to make every day a **green** day for every patient. We are dealing with the needs of an elderly population, people come into our care because they need our support, but hospital is not always the best place to be. Indeed, if you had 1,000 days left to live, how many would you choose to spend in hospital?

The approach is all about creating and delivering expectation for our patients and our colleagues. **Red** to **green** aims to ensure that everyone, especially the person receiving care, knows what the next steps are and knows that the system of care is ensuring there is no waste of their, often precious, time.

When patients remain with us, what happens to them? Studies have found that:

- 10 days in hospital leads to the equivalent of 10 years ageing in the muscles of people over 80 and reconditioning takes twice as long as this de-conditioning
- One week of bed rest equates to 10% loss in strength, and for an older person who is at threshold strength for climbing the stairs at home, getting out of bed or even standing up from the toilet, a 10% loss of strength may make the difference between dependence and independence
- 48% of people over 85 die within one year of hospital admission

I am delighted to say that our commissioners have agreed to support an alliance of organisations in east and west Suffolk as the 'Most Capable Provider' of **community health services**. The decision means that we now have the opportunity to develop a model for providing these services by October 2017 when the current contract ends. I believe this approach is a positive development for staff and patients in west Suffolk because it aims to avoid another fully competitive tender process.

The East and West Suffolk Alliance includes Suffolk GP Federation, Norfolk and Suffolk NHS Foundation Trust, West Suffolk NHS Foundation Trust, The Ipswich Hospital NHS Trust and Suffolk County Council. It is intended that the alliances drive even closer integration of acute, primary care, social care, mental health and community services.

It is with regret that I report that we have declared a **never event** during November. The incident relates to an epidural line being attached to a peripheral line and medication intended to be administered via an epidural being administered via a peripheral cannula. The patient was in the Labour Suite, in labour and neither the mother or her baby came to harm as a result. The patient went on to deliver her baby and following a period of monitoring was returned to the maternity ward. The patient is fully aware of the events that have occurred and has been discharged home. Some initial learning has been identified for immediate implementation and, in accordance with the Trust's incident procedures, a full investigation has been completed and the report is being finalised.

The year-end forecast will not be achieved without considerable remedial action. This will require the delivery of those schemes currently identified along with further initiatives to reduce expenditure. The risks around our I&E position could have a detrimental effect on our cash position. The Trust has in place financing arrangements which mean there is no urgent requirement for cash. However, the requirement to fund the deficit could result in the need to review and potentially reduce the future capital programme.

The challenging financial environment has underpinned our need to increase patient and staff parking charges, at a time when we have made a £2m investment to provide 400 additional car parking spaces on the hospital site.

The '**Sustainability and Transformation Plan**' or 'STP' for Suffolk and north east Essex has now been published. We worked with partners in producing the plan which sets out a range of priorities for the region, including an intention to bring together hospital, community, mental health and social care services in west Suffolk. This supports our existing strategy to join up services and work closely with partners on integrated health and social care provision. By working in collaboration across the west Suffolk system we will be able to tackle the challenge of growing demand for acute hospital care, by focussing on prevention and developing new models of care in different settings including patients' homes. This is vital if we are to put services on a financially sustainable footing for the future. The challenges we face in the NHS and social care are significant and the publication of this plan is an important opportunity for us to commit to changing the way we work and tackle some of the daily pressures we're facing. Our aim is to unite services and deliver excellent value in supporting the people of west Suffolk to lead healthier, happier lives.

Under the **Single Oversight Framework (SOF)**, which is designed to help NHS providers attain, and maintain, Care Quality Commission ratings of 'Good' or 'Outstanding', NHSI will segment providers based on the level of support each provider needs. Shadow (or indicative) segmentation of the sector has now been completed ahead of the first formal segmentation in November 2016. This segmentation is based on performance data and other information gathered before the SOF came into place on 1 October 2016. Some of the data that will help inform future decisions was not available at the time of preparing this shadow segmentation.

NHSI segmented trusts according to the level of support each trust needs across the five themes of quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability. Each trust is segmented into one of the following four categories:

- 1 Providers with maximum autonomy: no potential support needs identified. Lowest level of oversight; segmentation decisions taken quarterly in the absence of any significant deterioration in performance.
- 2 Providers offered targeted support: there are concerns in relation to one or more of the themes. We've identified targeted support that the provider can access to address these concerns, but which they are not obliged to take up. For some providers in segment 2, more evidence may need to be gathered to identify appropriate support.
- 3 Providers receiving mandated support for significant concerns: there is actual or suspected breach of licence, and a Regional Support Group has agreed to seek formal undertakings from the provider or the Provider Regulation Committee has agreed to impose regulatory requirements.
- 4 Providers in special measures: there is actual or suspected breach of licence with very serious and/or complex issues. The Provider Regulation Committee has agreed it meets the criteria to go into special measures.

WSFT has been allocated a **category 2 segmentation**. 15% of providers have been placed in category 1, 45% in category 2, 31% in category 3 and 9% in category 4.

Quarterly performance of the NHS provider sector was discussed at the NHS Improvement Board meeting on 24 November 2016:

- The Q2 net deficit for the sector is £648m, compared to £461m at Q1. This is £968m better than at Q2 2015/16 and £18m worse than at the same time of 2014/15.
- Including the £1.8 billion of sustainability and transformation funding (STF), the sector has forecast to end the year with a deficit of £669m, £89m worse than plan.
- Against forecast, the aggregate deficit at month six is marginally over plan by £22 million. The sector was £5m ahead of plan at Q1. 71 providers reported an adverse variance against plan at Q2. The overall net adverse variance was largely driven by:
 - Cost Improvement Plans that were £92m under forecast delivery
 - Bed days lost due to delayed transfers of care rising by 35% compared to Q2 last year
 - Agency costs exceeding plan by almost 16%
 - Adverse variance of £195 million for non-pay items. In particular, costs of drugs and clinical supplies significantly exceeded plan.

NHS Improvement and the Care Quality Commission (CQC) continue to align their approaches to overseeing providers and understanding where support is needed. As part of this work they are consulting on a new **use of resources assessment** and a new **well-led framework**.

CQC and NHS Improvement have agreed that NHS Improvement will undertake the use of resources assessment in line with an agreed methodology and propose a rating. NHS Improvement will carry out an assessment to determine how effectively providers are using their resources to deliver high quality, including safe, efficient and sustainable care for patients. It will do this by assessing how well they are meeting financial controls, how financially sustainable they are, and how efficiently they use their resources more broadly while still delivering high quality care to patients. NHS Improvement will use this assessment to inform its oversight of trusts.

As part of the further development and alignment of the respective oversight and regulatory regimes, CQC and NHS Improvement have been working on a new well-led framework for trusts, which builds on CQC's current well-led assessment and Monitor's previous well-led framework for governance reviews. The revised approach to well-led for trusts will bring together the existing aligned well-led framework published by CQC, the NHS Trust Development Authority and Monitor in 2015 into a common structure.

The **CQC is also consulting on a new model of inspection** - "*Our next phase of regulation. A more targeted, responsive and collaborative approach*". The changes aim to provide:

- More integrated approach (flexible and responsive to changes in care provision)
- Targeted approach (areas of greatest concern and where there have been improvements in quality)
- Greater emphasis on leadership, including at the level of overall accountability for quality of care
- Closer working and alignment with NHS Improvement / other partners (therefore less duplication)

Key changes include:

- Reduction in the burden of on-site inspection:
 - at least one core area (unannounced)
 - 'Well-led' (announced)
- Provider information request not as detailed
- Some amendments / additions to the prompts within the key lines of enquiry
- Intelligent monitoring replaced with new Insight model
- Strengthened in year relationship management not just around inspection time

- Removal of some elements from definition of 'core services' (Diagnostic imaging and Gynaecology)
- Effective use of accreditation schemes

The document also identifies the need to keep the CQC apprised of any changes to organisational service provision such as changing models of care and complex providers through sustainability and transformation plans, devolution and the new care models programme. The timeframe for implementation of the revised assessment frameworks is April 2017.

It has been confirmed that the **national tariff** will be a two year tariff, running from April 2017 to April 2019. The rationale given is that with the "relative certainty of NHS funding at the current time, the fact that there is no planned revision of CCG allocations until 2018 and the wider planning being undertaken to support the sustainability and transformation plans we believe now is an opportune time to introduce a two-year tariff".

13 national CQUIN indicators have been agreed which aim to improve quality and outcomes for patients:

1. Improving Staff Health and Wellbeing
2. Reducing the impact of serious infections (Antimicrobial resistance and Sepsis)
3. Improving physical healthcare to reduce premature mortality in people with serious mental illness (PSMI)
4. Improving services for people with mental health needs who present to A&E
5. Transitions out of Children and Young People's Mental Health Services
6. Offering Advice and Guidance
7. e-Referrals
8. Supporting proactive and safe discharge
9. Preventing ill health by risky behaviours – alcohol and tobacco
10. Improving the assessment of wounds
11. Personalised care and support planning
12. Ambulance conveyance
13. NHS 111 referrals

Chief Executive blog

<http://staff.wsha.local/Blog/Hospitalunderhighestlevelofpressure%e2%80%93messagefromSteveDun,chiefexecutive.aspx>

DELIVER FOR TODAY

Speedy fix for patients as Trust develops innovative trauma service

Patients attending West Suffolk NHS Foundation Trust with a trauma now benefit from rapid access to day surgery as part of an innovative service. The day surgery trauma list, a new concept in the UK, has been designed to improve the experience of patients who need to have surgery quickly, but who don't need to wait in a hospital bed while they are being scheduled for their operation. The service is helping to manage demand on emergency services, reduce costs, and improve patient experience. When patients attend the emergency department with a trauma and are assessed as needing low-risk surgery as soon as possible they are now scheduled into West Suffolk Hospital's day surgery unit instead of the main operating theatre. This means they can go home rather than wait for their surgery in a hospital bed and are discharged home again on the same day as they have their operation.

Healthcare options this festive season

With winter upon us local people are being reminded of the healthcare options available. Jon Green, chief operating officer at West Suffolk NHS Foundation Trust, said: "Emergency departments come under increasing pressure, particularly over the winter period. It's important that as far as possible we make sure that the people who visit the department really need to be there. There are other services that provide urgent advice and assistance and we are working to encourage local people to use these services when appropriate. Pharmacists, GPs and the 111 telephone service are all geared up to help people who need support, but whose condition is not serious and life-threatening."

Trust tackles mounting car parking issues at West Suffolk Hospital

West Suffolk NHS Foundation Trust has taken steps to address a number of issues with the availability of car parking at its West Suffolk Hospital site. It is due to open an additional 400 spaces at the hospital in early 2017 after making a £2 million investment in this and a range of improvement works.

After liaising with patient representatives, the Trust is amending the tariff for parking in the New Year to make a modest contribution towards the investment that has been made. It is also addressing a regular complaint from patients that short-stay visits are charged at an excessively high rate by introducing a new tariff for a one hour stay. Additional spaces for disabled drivers who carry a Blue Badge are being created, along with specially-designated wheelchair-supported access spaces that provide better access for those unable to walk.

Hospital housekeeping team awarded for commitment to excellence

West Suffolk NHS Foundation Trust's housekeeping team has recently received the CIMS Award for Commitment to Excellence at the British Institute of Cleaning Science's annual awards ceremony. The award recognises the dedication of individuals for their commitment to excellence and the CIMS (Cleaning Industry Management Standard) programme, meeting the requirements of a successful, quality cleaning organisation. Cleanliness is a high priority across the Trust with a particular focus on infection prevention and staff work together to lead the fight against infections such as clostridium difficile, norovirus and MRSA. The Trust has a strong record on keeping infection cases to a minimum, with sustained reductions in c. difficile and no avoidable MRSA bacteraemia cases recorded since May 2013. West Suffolk Hospital was also the UK's first hospital to achieve CIMS certification with honours earlier this year.

New liquid thickener launched

A brand new and improved liquid thickener is being launched across West Suffolk Hospital, Glastonbury Court and Newmarket Hospital from Monday 14 November. Staff are all expected to use the new Thick & Easy CLEAR product, which is far more palatable for patients and will improve patient care and experience. The new product leaves no after taste, will remain at a stable consistency all day and is clear rather than cloudy in appearance. There is evidence that it improves patient compliance – i.e. is more palatable, reducing the need for top up IV fluids and ultimately reducing length of stay because it helps prevent aspiration, chest infections and dehydration. The new thickener is mixed in a different way: powder is distributed into a dry cup first, and then the correct measurement of fluid is added which must quickly be stirred and left to thicken for three minutes.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

West Suffolk top in the east of England for hip fracture care

The National Hip Fracture Database rates West Suffolk NHS Foundation Trust (WSFT) as top in the east of England for the care patients receive when attending with a hip fracture, and sixth nationally, up three places from last year. Hip fracture is the most common serious injury in older people, often resulting in lengthy hospital stays with only a minority of patients regaining their previous abilities and often needing long-term care. An integrated staff team, including specialists from the emergency department, orthopaedics, elderly medicine and physiotherapy, work hard to deliver against best clinical practice guidelines. The team has introduced regular virtual fracture clinics at West Suffolk Hospital, a key part of the care given to patients attending with musculoskeletal injuries, where they assess patient needs together to identify immediate care needs and ensure they see the right specialist at the earliest opportunity.

WSFT achieved 85.1% in the best practice tariff, the highest in the east region, against a national average of 65.6%. Records show that:

- 100% of patients received a bone health assessment (national average 97.2%)
- 88.2% of patients had surgery on the day of, or day after, admission (national average 71.5%)
- 80.2% of patients were mobilised out of bed on the day after surgery (national average 76.1%)
- The average overall length of stay in days was 17 (national average 21.1 days)

Group exercise fun for children with disabilities

An innovative sports health partnership, piloted to offer children with disabilities the chance to exercise together and socialise, has been so successful there are calls for further exercise classes to be established. The partnership, between the children's community physiotherapy team from Suffolk Community Healthcare, Abbeycroft Leisure and Ipswich Borough Council, was developed to bring together the knowledge and expertise of local physiotherapists with the enthusiasm and skill of sports centre staff. Instead of children having to do their exercises on their own in a clinical setting, they have been able to use gym facilities alongside their peers, guided by both physiotherapists and gym staff collaboratively. The piloted sessions were based around strengthening exercises in the gym for children living with developmental conditions such as cerebral palsy, or for those recovering from effects of brain surgery. Exercise and physical therapy is such an important aspect of the rehabilitation of these children with the goal being to maximise control of the body; build strength and improve balance; increase flexibility and, ultimately, independence.

Improved diabetes care in West Suffolk

Partnership working between healthcare professionals has delivered significant improvements to Type 2 diabetes care in west Suffolk. New figures show that more patients than ever before are getting the support they need to control their blood pressure, blood sugar and cholesterol levels. These are the three key indicators measured by the national NHS Quality and Outcomes Framework to identify local levels of diabetes care.

The improvement follows the introduction of a community diabetes service, which sees specialist hospital diabetes nurses working alongside general practice nurses in 19 west Suffolk GP practices to provide enhanced diabetes care to patients closer to home. The service, commissioned by NHS West Suffolk Clinical Commissioning Group (WSCCG), is delivered in partnership with West Suffolk NHS Foundation Trust. The west Suffolk area is now ranked at 81 out of 209 CCGs for diabetes care, with 61% of patients receiving the support they need, a figure which is now higher than the national average of 60%.

Midwives train as hypnobirthers

West Suffolk midwives believe that mums-to-be should have the right to choose where and how they would like to give birth, and want to offer as many different options as possible. The maternity unit already offers three birthing pools, counselling, aromatherapy massage, and a state of the art birthing unit. Recently, 20 midwives, from both West Suffolk and Kings Lynn, came together to learn The Wise Hippo's programme of self-hypnosis, relaxation and massage techniques to help take the fear and anxiety out of giving birth so that couples actually look forward to the experience. Our midwives are excited to start teaching The Wise Hippo birthing programme to enable more pregnant couples access to this life changing education and prepare for birth using the hypnobirthing techniques and in turn achieve a positive birth on the day.

Safeguarding against domestic violence

Over 70 staff from across the Trust recently attended a study day on the sensitive and harrowing topics of domestic abuse, female genital mutilation and honour-based violence. Delivered by local safeguarding and awareness trainers Bal Howard and Cathy Press, two experts who lecture across the UK, the training helps participants build knowledge and understanding of the complex nature of domestic violence and abuse. Bal spoke of her own personal experience of being forced into a marriage at the age of 17. Despite the emotional impact of the issues covered, the day was well received and staff stated they felt more equipped to manage situations that might arise. It is a foundation to build upon with requests for similar training days around the complexities of safeguarding to be held in the future.

BUILD A JOINED-UP FUTURE

Christmas was business as usual for Suffolk healthcare workers

The Early Intervention Team at West Suffolk NHS Foundation Trust worked throughout Christmas to help keep patients at home with their friends and families throughout the west of Suffolk. A multidisciplinary team of support workers, occupational therapists, physiotherapists, nurses and social workers all play a role in assessing and caring for patients in their homes, helping them to

maintain their independence rather than come into hospital when it is unnecessary. Hosted by the Trust, this service is delivered in partnership with Suffolk Community Healthcare, Suffolk County Council, Age UK Suffolk, and Suffolk Family Carers. For the first time this year, occupational therapists and physiotherapists in the Early Intervention Team worked throughout Christmas Day to ensure patient care is not interrupted over the holiday season.

New private physiotherapy service launches

West Suffolk NHS Foundation Trust has launched a new private physiotherapy service to help people recover from injury and enhance their wellbeing. Called West Suffolk Physio, the new service, based in Hillside Road, Bury St Edmunds, is staffed by a team of NHS-trained physiotherapists who also work at West Suffolk Hospital. The innovative new service is a tailor-made private option for people who want to top-up on what can be offered by existing NHS physiotherapy services from the hospital. It also gives more choice for people who want to pay for a service that is quickly accessible and convenient for them. Any income generated by the service will be reinvested into NHS services provided by the Trust. Therapists at West Suffolk Physio can assess and treat a wide spectrum of joint, soft tissue and nerve related problems as well as offering specialist interventions and advice in relation to respiratory conditions, rehabilitation after surgery, continence problems, mobility and falls and pain management. As well as providing treatments at the purpose-built Hillside Road centre, physiotherapists from the service will visit people in their homes if this is more practical for the client rather than coming to the clinic.

REPORT TO:	Council of Governors
MEETING DATE:	8 February 2017
SUBJECT:	Governor issues
AGENDA ITEM:	8
PREPARED BY:	June Carpenter, Lead Governor Richard Jones, Trust Secretary & Head of Governance
PRESENTED BY:	June Carpenter, Lead Governor
FOR:	Information

Response to feedback from June Carpenter, following informal Governors meeting on 26 January 2017.

Items already on the agenda or raised at the January Trust Board:

1. **TPP** – covered in closed session
2. **Finance** – covered as part of main agenda
3. **Were staff governors used in the car parking discussions?** Accepted that while staff side were engaged we can include staff governors in future reviews
4. **Night staff shortages** – covered in action points
5. **The training and retention of HCAs** – The current turnover rate for HCAs (the Trust calls them Nursing Assistants) – 13.45%. This is higher than our average for the total trust which is 10.17%. These posts traditionally had a higher than average turnover. The Trust is currently investigating this and looking to develop retention strategies.

Currently HCAs are interviewed and employed by individual wards/departments or offered positions with NHS Professionals. All newly recruited HCAs must undertake and complete the WSFT induction programme and the nationally recognised Care Certificate programme covering the fundamentals of care. Support is given throughout the 12 week process to complete the induction, programme, workbook and competencies. Action plans will be set in place for those who fail to achieve the requirements in a timely fashion and these are monitored by the ward/department manager with support from the Education Team.

Opportunities are available for continued development via the apprenticeship route. Currently at the WSFT we are able to offer level 2 and 3 clinical apprenticeships in partnership with West Suffolk College. Delivery of these programmes is provided by the Education Team with assessment by the college.

For those HCAs who are interested in further career development the Trust supports the Foundation Degree (FdA) in Healthcare that is run by the University of Suffolk. Completion of this 2 year programme allows HCAs to apply for Band 4 roles within healthcare.

For those Nursing Assistants who have completed a level 5 qualification (FdA degree) a further opportunity exists which provides a 18 month route to become a Registered Nurse. Currently we have 4 nursing assistants who are undertaking this programme.

6. **E care** – covered as part of main agenda

Other items raised :

7. **What is the progress of the CQC action plan?** The action plan is progressing well and regular discussion has taken place with the CQC. A report on progress will be submitted to the March Board meeting.
8. **What is the uncertainty of Brexit having on staff recruiting?** – It is not just the result of Brexit that is having a major negative effect on recruiting nurses from overseas. In 2015, 33 nurses from Portugal/Italy were recruited, whereas during 2016, 5 overseas nurses were recruited via an agency with an additional 4 directly recruited via the 'Introduce a friend scheme'.

There appears to be two main concerns post Brexit that overseas nurses have regarding working in the UK.

- Uncertain economic future, potential changes to free movement of EU nationals and the overall job security.
- Racially aggravated crimes/protests since the referendum vote they see in the media.

In addition, far more stringent language tests (IELTS) are also a major contributory factor affecting recruitment. Overseas applicants now have to achieve a level 7.0 and some staff despite additional support have still not successfully passed and therefore unable to apply for their NMC registration.

Whilst nurses and midwives trained outside the EEA require the IELTS they are also tested for competence through a two-part procedure as part of the NMC registration process. Part one is a computer-based, multiple-choice examination which is accessible by applicants in their home countries, part two - is a practical objective structured clinical examination (OSCE) which is always held in the UK. In addition, nurses outside the EEA require a level 2 tier, certificate of sponsorship

Discussions with international recruitment agencies have advised that the introduction of the OSCE and IELTS has discouraged people from coming to the UK to work within our health.

9. **Assurance that the contract and standards for physio services at Morton Hall are being looked at** – The Trust's Scrutiny Committee has received an initial service review and will receive a six-month post launch review in April 2017. A Governor visit to the Morton Hall practice is being arranged.
10. **At the Trust board it was decided that because of time constraints departmental presentations would be moved to another forum. As this also applies to the CoG would it be possible for NEDs and governors to have joint presentations?** – the focus and schedule for these presentations is being considered and when appropriate they will be structured as joint sessions or repeated for CoG.

Recommendation:

To note issues raised and responses.

REPORT TO:	Council of Governors
MEETING DATE:	8 February 2017
SUBJECT:	Summary quality & performance report
AGENDA ITEM:	9
PREPARED BY:	Jon Green, Chief Operating Officer Rowan Procter, Chief Nurse Richard Jones, Trust Secretary & Head of Governance
PRESENTED BY:	Rosie Varley - Non-Executive Director
FOR:	Information - To update the Council of Governors on quality and operational performance

The performance for Q3 demonstrates overall **good performance achieving the key national targets** defined by NHS Improvement's (NHSI) Single Oversight Framework with the exception of some key areas. Performance shows the pressure the Trust remains under operationally, in addition we are still facing issues with e-Care and our ability to accurately report data. The Trust remains in regular contact with the CCG and NHS Improvement over our reporting status.

The Trust reported A&E performance of 86.50% for December; an improvement on November but still well below the national target. The Flow Action Group continues to work across all wards in the support of the overall system A&E plan. Having recovered the 6 week diagnostic target this was missed again in December with 94.83% against a 99% target; this was a result of a rapid and sharp deterioration in Cardiac diagnostic performance. The Trust had no 52-week breaches of the 18 week target and achieved all other access and Cancer targets.

1. Performance against local targets and measures

(a) Patient safety dashboard

Within the **patient safety dashboard** 11/35 indicators for which data was available were reported as 'green' throughout Q3, including:

- Infection prevention indicators - Central venous catheter insertion, Peripheral cannula insertion, Urinary catheter insertion, MRSA bacteraemias and total no of C. diff infections: Hospital
- Quarterly Standard principle compliance, Environment/Isolation
- PEWS: documentation and escalation compliance
- Incident reporting and management: Non-SIRI Trust-led RCA investigation not complete more than 60 days, RCA action completion, SIRI reported within two days and final reports due in month submitted and SIRI reports open on STEIS more than 60 days

- Active risk assessments in date and Outstanding actions in date for Red / Amber entries on Datix risk register

Due to reporting limitations we remain unable to report compliance for: MRSA screening, MEWS documentation and escalation compliance , Falls per 1000 bed days VTE: prophylaxis compliance,

A new maternity dashboard is also reported to the board as part of the monthly quality and performance report. This includes more than 60 indicators cover activity, booking clinical outcomes, workforce, risk and patient experience.

The Trust continued to experience a high number of **patient falls** in the quarter (194) compared with 178 in Q2 and 166 in Q1. It needs to be recognised that increased activity in Q3 will impact on the number of falls. When benchmarked the number of falls in the Trust has consistently been below the national average of 6.63 falls per thousand bed days (Royal College of Physicians 2015), however we are not currently able to report this figure. Action being implemented in 2016/17 includes:

- Use e-Care, our new electronic patient record, to improve on
 - Comprehensive medical review for patients at risk of falls
 - Medication review to reduce polypharmacy
 - Lying and standing blood pressure
- Focus on hydration to help reduce confusion in the elderly
- Focus on assessment of spinal injury post fall, in line with NICE guidance.

Changes have been put in place through e-Care to monitor and escalate lying and standing blood pressure monitoring – this allows these to be captured and monitored as clinical tasks. Senior matrons audit compliance with lying and standing BP on a fortnightly basis as part of their quality audits.

Since the launch of the React to Red Campaign we have seen our **Hospital Acquired Pressure incidents (HAPUs)** fall from 30 in the month of April to 16 in September however it has risen again in October/November. A total of 60 HAPUs were reported during Q3, an increased compared to 41 in Q2 (57 in Q1).

Weekly ward walks are being undertaken by Matron lead for PU and the Tissue Viability Lead to educate and support staff. Since October short competency packs have been rolled, out a ward at a time, targeting high incidence areas first. These give staff the skills to grade and treat pressure ulcers appropriately. The Trust target for avoidable pressure ulcers is defined in the quality priority *Maintain the incidence of avoidable pressure ulcers, avoidable inpatient falls and hospital acquired VTE below the baseline for 2014/15*. The target is therefore to ensure the percentage of total pressure ulcers deemed avoidable does not exceed the 2014/15 level (34%) by the end of March 2017.

At the end of December there had been 147 HAPU 2, 3 or 4 reported and currently 47 of these have been classified as avoidable, 90 as unavoidable with another 10 pending confirmation of grading. This puts the Trust currently just above the threshold (at 35%) although it has fallen since the beginning of the year and is anticipated to further improve when review December's incidents is complete. The increase in staff recognising and reporting pressure ulcers together with the 'React to Red' campaign to ensure timely recognition of deep tissue injury is expected to reduce the percentage to below the target before the year end.

The Trust has agreed to provide data on numbers and avoidability to another trust who are coordinating an informal benchmarking exercise following a notable rise in the number of reported pressure ulcers at their trust.

Nutritional assessment and monitoring was red for the quarter. Matrons are redesigning the audit form which currently does not reflect the documentation now on e-Care, it is hoped that this will better reflect the recorded data. We continue to raise awareness of importance of these parameters and this issue will be revisited at the ward managers' meeting in February '17.

RCA actions overdue was red for November and December with 15 outstanding in December. Internal Audit have been asked to review performance in this area to provide assurance regarding the arrangements to monitor and complete actions.

Looked after Children performance is 14.29% against a 100% target with one out of 7 initial health assessments completed within 28 days. However, 100% achieved for an appointment offered within 28 days of all paperwork being received.

(b) Patient experience dashboard

Within the **patient experience dashboard** 20/30 indicators for which data was available were reported as 'green' throughout Q3.

Nine recommender indicators scored 100% for each month in the quarter – short stay, post-natal ward, labour suite, birthing unit, antenatal department, young children, F1 (parent) and stroke. This increased from three areas in Q2.

Being bothered by **noise at night from other patients** flagged consistently as Red in the quarter. Staff are continuing to offer RoseVital trays to patients to aid their sleeping. A task and finish group met in January to review all patient surveys and wording of questions ahead of the new financial year. There is a proposal to reword this question to ensure areas for improvement can more easily be identified.

Performance for patients being **informed of delays in being seen** has remained red, although improved from Q2. Staff have been reminded to ensure patients are being kept informed of delays. We are continuing to explore alternative ways of obtaining feedback in outpatient areas which will assist in understanding the extent of the issue and how to satisfactorily rectify. Areas with poor performance will also be subject to patient experience visits to review progress.

Action has been taken to improve **complaint responses within 25 days or negotiated timescale**. Significant improvement has been achieved during Q3 with 100% compliance in December.

(c) Clinical effectiveness dashboard

Within the **clinical effectiveness dashboard** 6/6 indicators for which data was available were reported as 'green' for each month in Q3.

The Trust's overall reported **SHMI** (summary hospital-level mortality indicator) and **HSMR** (hospital standardised mortality ratio) for the latest reported periods are statistically below the expected levels (87.22 and 85.5 respectively).

(d) Other targets and indicators

Table 1: Performance against national targets

Target or Indicator (per Risk Assessment Framework)	Target	Q4	Q1	Q2	Q3
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	95.2%	96.8%	93%*	92%*
A&E Clinical Quality - Total Time in A&E under 4 hours	95%	91.5%	86.0%	87.3%	85.36%
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	87.0%	85.9%	90.4%	85.70%
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	94.2%	100%	97.5%	100.0%
Cancer 31 day wait for second or subsequent treatment - surgery	94%	100%	100%	100.0%	100.0%
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	99.5%	100%	100.0%	100.0%
Cancer 31 day wait from diagnosis to first treatment	96%	100%	100%	100.0%	99.5%
Cancer 2 week (all cancers)	93%	98.9%	91.4%	94.9%	97.19%
Cancer 2 week (breast symptoms)	93%	96.7%	85.3%	77.80%	98.17%
C.Diff due to lapses in care (YTD)	16	9	1	3	1**

* Estimated data due to reporting issues

** See C difficile section below

We experienced challenges during the quarter with the **A&E 4 hour standard** which suffered a sharp deterioration. As well as the focus to improve flow within the emergency department (ED) the focus is on improving patient flow within and out of the hospital through the SAFER bundle and **red to green**.

The Trust had a total of eight **C. difficile** cases in quarter 3. All of these cases have been reviewed by the CCG which established that one cases was due to lapses in care and one case is pending final decision. Although the Trust is achieving the C. *difficile* ceiling the Board recognises that delivery going forward is a risk.

Stroke performance achieved all targets with the exception of patients spending 90% of their time on a Stroke Unit

The cancer target for **62-day wait** for first treatment has a draft performance of 83.84% against the 85% target, but remains on target to achieve the quarter

The Trust had no 52-week breaches of the **18 week target**, although data reporting remains problematic. All other **access and cancer targets** were achieved.

Recommendation:

To note the summary report.

REPORT TO:	Council of Governors
MEETING DATE:	8 February 2017
SUBJECT:	Summary Finance Report
AGENDA ITEM:	10
PREPARED BY:	Nick Macdonald, Deputy Director of Finance
PRESENTED BY:	Neville Hounsome - Non-Executive Director
FOR:	Information - To update the Council of Governors on Financial Performance

EXECUTIVE SUMMARY:

This report provides an overview of key issues during Q3 and highlights any specific issues where performance fell short of the target values as well as areas of improvement. The format of this report is intended to highlight the key elements of the monthly Board Report.

- The Month 9 YTD position is behind plan by £5,432k.
- The Use of Resources Rating (UoR) (previously Financial Sustainability Risk Rating), is 4 YTD (1 being highest, 4 being lowest)
- The Trust is forecasting an annual deficit of £12.1m before accounting for writing off the tPP investment.

Key risks

- Delivering the cost improvement programme of £12.5m (6%)
- Containing the increase in demand to that included in the plan (2.5%).
- Working across the system to minimise delays in discharge

I&E headlines for December 2016

The reported I&E for December 2016 is a deficit of £3,541k, against a planned deficit of £960k. This results in an adverse variance of £2,581k (£5,432k YTD) which is predominantly due to the stretch CIP and lost Sustainability and Transformation funding.

A significant cause of the deterioration in plan over the last 3 months relates to the underachievement of the stretch CIP, being £650k per month (£1.95m YTD).

As a result of our failure to meet the Q3 financial plan we are not eligible for any Sustainability and Transformation funding in Q3 (£1.525m) and this is reflected in the December position. Furthermore we lost our appeal against our failure to meet the A&E performance target for Q2, which resulted in a further £191k S&T funding being removed this month.

The December position includes a YTD CIP target of £8.0m of which £5.5m has been achieved. The shortfall largely relates to stretch CIP (£1.95m) and DTOCs (£0.3m). The CIP target is £12.5m for the full year.

The forecast has been revised to reflect the performance against the stretch CIP target (£3.9m) and lost Sustainability and Transformation funding (£3.2m) and as a result we now forecast a deficit of £12.1m.

On advice from our auditors, and consistent with the treatment of other shareholding Trusts our forecast now also includes the loss on our investment being £5.15m. This is now included in the forecast as a 'below the line' adjustment which will increase WSFT loss in 2016-17 to £17.3m

1. Use of Resources (UoR) Rating

Following implementation of the Single Oversight Framework (SOF), providers' financial performance will now be formally assessed via five "Use of Resources (UoR) Metrics. The scoring has reversed (compared with the FSRR ratings) so that 1 is now the highest score and 4 is now the lowest. Under the UoR we score a 4 cumulatively to December 2016.

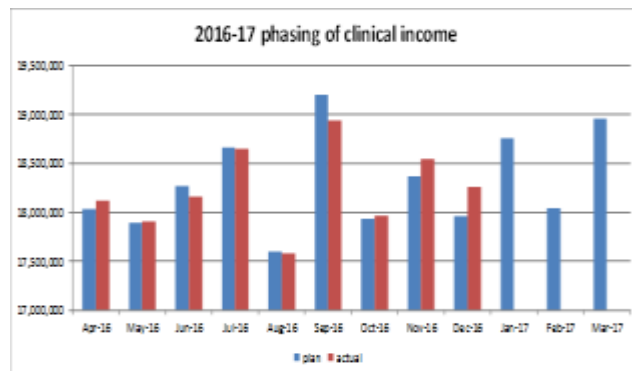
Metric	Value	Score
Capital Service Capacity rating	-2.594	4
Liquidity rating	-16.455	4
I&E Margin rating	-4.93%	4
I&E Margin Variance rating	-2.12%	4
Agency	5.22%	2
Use of Resources Rating after Overrides		4

2. Performance against I & E plan

SUMMARY INCOME AND EXPENDITURE ACCOUNT - December 2016	Dec-16			Year to date			Year end forecast		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m
NHS Contract Income	18.0	18.3	0.3	163.9	164.1	0.2	219.7	220.0	0.3
Other Income	3.4	1.3	(2.1)	26.3	23.1	(3.2)	33.8	32.3	(1.5)
Total Income	21.4	19.6	(1.8)	190.2	187.2	(3.0)	253.5	252.4	(1.1)
Pay Costs	11.8	11.8	(0.0)	105.7	106.6	(1.0)	141.4	142.7	(1.3)
Non-pay Costs	9.8	10.5	(0.7)	82.7	84.1	(1.4)	106.1	110.0	(3.8)
Operating Expenditure	21.6	22.3	(0.7)	188.3	190.7	(2.4)	247.5	252.7	(5.1)
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	2.5	0.0	2.5
EBITDA	(0.2)	(2.7)	(2.5)	1.9	(3.5)	(5.3)	3.5	(0.3)	(3.8)
EBITDA margin	(0.9%)	(13.7%)	(12.8%)	1.0%	(1.8%)	(2.8%)	1.4%	1.4%	0.0%
Depreciation	0.6	0.7	(0.1)	4.4	4.5	(0.1)	6.7	6.8	(0.1)
Finance costs	0.1	0.1	(0.0)	1.3	1.3	0.0	1.7	1.7	0.0
SURPLUS/(DEFICIT)	(1.0)	(3.5)	(2.6)	(3.8)	(9.2)	(5.4)	(5.0)	(8.9)	(3.9)
S&T funding included in Other Income forecast above that is at risk							0.0	(3.2)	(3.2)
Possible SURPLUS / (DEFICIT)							(5.0)	(12.1)	(7.2)
tPP investment write off							0.0	(5.2)	(5.2)
Final SURPLUS / (DEFICIT)							(5.0)	(17.3)	(12.3)

Performance against Income plan

The chart below summarises the phasing of the clinical income plan for 2016-17, including Suffolk Community Health. This phasing is in line with activity phasing and does not take into account the block payment.



Income (£000's)	Current Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	608	693	(15)	6,575	6,466	(110)
Other Services	2,142	2,882	740	19,260	23,239	3,979
CCU/ICU	298	283	(15)	2,743	2,638	(104)
Elective	2,706	2,480	(226)	26,264	23,783	(2,482)
Non Elective	4,781	4,823	42	41,298	42,267	970
Emergency Threshold Adjustment	(236)	(250)	(14)	(2,088)	(2,352)	(264)
Outpatients	2,740	2,626	(114)	26,415	24,834	(1,581)
Community	4,942	4,942	0	44,475	44,475	0
Total	17,960	18,257	297	163,932	164,129	197

3. Performance against Expenditure plan - Workforce

Monthly Expenditure Acute services only				
As at December 2016	Dec-16	Nov-16	Dec-15	YTD 2016-17
	£'000	£'000	£'000	£'000
Budgeted costs in month	10,710	10,635	10,067	96,411
Substantive Staff	9,522	9,561	9,071	84,995
Medical Agency Staff (includes 'contracted in' staff)	160	187	153	1,863
Medical Locum Staff	163	139	87	1,358
Additional Medical sessions	238	249	153	2,147
Nursing Agency Staff	143	139	45	1,479
Nursing Bank Staff	175	167	266	2,095
Other Agency Staff	92	101	93	1,071
Other Bank Staff	127	124	110	1,214
Overtime	78	79	64	691
On Call	47	53	46	448
Total temporary expenditure	1,222	1,239	1,018	12,367
Total expenditure on pay	10,743	10,799	10,089	97,362
Variance (F/A)	(33)	(165)	(21)	(952)
Temp Staff costs % of Total Pay	11.4%	11.5%	10.1%	12.7%
Memo : Total agency spend in month	394	427	291	4,413

Monthly whole time equivalents (WTE) Acute Services only			
As at December 2016	Dec-16	Nov-16	Dec-15
	WTE	WTE	WTE
Budgeted WTE in month	3,016.6	3,012.5	2,925.3
Employed substantive WTE in month	2,730.6	2,713.4	2,677.5
Medical Agency Staff (includes 'contracted in' staff)	12.1	13.0	19.1
Medical Locum	15.8	12.4	13.3
Additional Sessions	22.1	24.4	21.7
Nursing Agency	22.1	21.6	14.8
Nursing Bank	58.0	56.8	91.4
Other Agency	27.0	20.2	24.4
Other Bank	63.7	60.3	58.5
Overtime	36.1	36.9	29.5
On call Worked	8.5	9.2	8.6
Total equivalent temporary WTE	265.4	254.7	281.3
Total equivalent employed WTE	2,996.0	2,968.1	2,958.8
Variance (F/A)	20.6	44.4	(33.6)
Temp Staff WTE % of Total Pay	8.9%	8.6%	9.5%
Memo : Total agency WTE in month	61.3	54.8	58.3
Sickness Rates (October / September)	3.88%	3.88%	3.6%
Mat Leave	2.0%	2.0%	1.9%

Monthly Expenditure Community Service				
As at December 2016	Dec-16	Nov-16	Dec-15	YTD 2016-17
	£'000	£'000	£'000	£'000
Budgeted costs in month	1,080	1,065	968	9,250
Substantive Staff	1,011	1,043	931	8,684
Medical Agency Staff (includes 'contracted in' staff)	(15)	0	17	(15)
Medical Locum Staff	3	3	6	41
Additional Medical sessions	0	0	0	0
Nursing Agency Staff	5	5	0	30
Nursing Bank Staff	8	9	4	52
Other Agency Staff	38	44	3	320
Other Bank Staff	11	14	10	109
Overtime	4	6	2	38
On Call	3	1	1	12
Total temporary expenditure	57	62	44	586
Total expenditure on pay	1,068	1,125	975	9,271
Variance (F/A)	11	(39)	(6)	(21)
Temp Staff costs % of Total Pay	5.4%	7.3%	4.5%	6.3%
Memo : Total agency spend in month	28	49	20	335

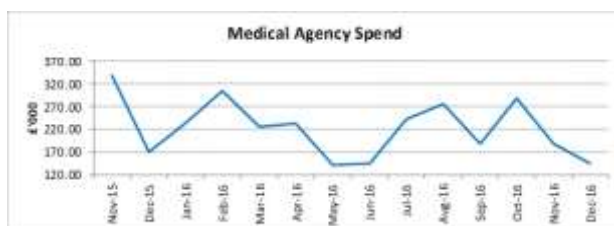
Monthly whole time equivalents (WTE) Community Services			
As at December 2016	Dec-16	Nov-16	Dec-15
	WTE	WTE	WTE
Budgeted WTE in month	369.1	369.2	327.2
Employed substantive WTE in month	337.8	342.9	319.1
Medical Agency Staff (includes 'contracted in' staff)	0.0	0.0	0.7
Medical Locum	0.4	0.4	0.8
Additional Sessions	0.0	0.0	0.0
Nursing Agency	0.7	0.8	0.1
Nursing Bank	2.7	2.7	1.3
Other Agency	9.4	11.6	1.9
Other Bank	3.2	3.9	2.8
Overtime	2.2	3.6	1.2
On call Worked	0.9	(1.0)	0.4
Total equivalent temporary WTE	19.5	22.0	9.1
Total equivalent employed WTE	357.3	364.8	328.2
Variance (F/A)	1.8	(5.6)	(0.9)
Temp Staff WTE % of Total Pay	5.5%	6.0%	2.8%
Memo : Total agency WTE in month	10.1	12.4	2.7
Sickness Rates (October / September)	4.26%	4.26%	
Mat Leave	1.5%	1.5%	

The overall WTE variance for Acute services is now 20.6 WTE below establishment. There are 40 more WTE than in December 2016, although this includes 53 substantive WTEs.

Temporary costs of nursing staff have decreased by £17k month on month. The Trust has incurred expenditure of £143k on agency nursing staff in December, (£139k in November).

The monthly cost of additional sessions decreased by £9k to £238k. These costs are for both Medical and Non-Medical staff

Suffolk Community Services staff numbers have decreased by around 7.5 WTEs during December.



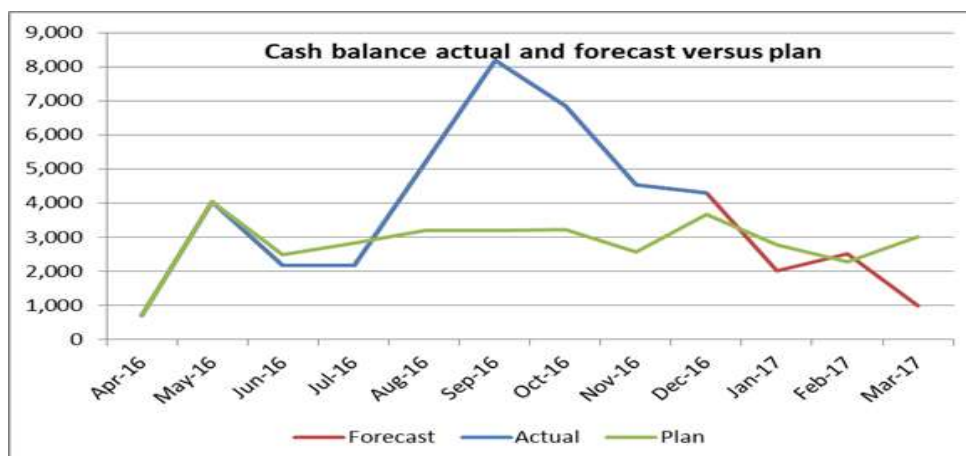
4. Balance Sheet

STATEMENT OF FINANCIAL POSITION

	As at		Plan YTD	As at	Variance YTD
	1 April 2016	31 March 2017			
	£000	£000	£000	£000	£000
Intangible assets	10,876	13,487	13,072	15,059	1,987
Property, plant and equipment	61,923	74,893	69,620	65,345	(4,275)
Trade and other receivables	273	340	340	340	0
Other financial assets	1,888	2,409	2,259	1,909	(350)
Total non-current assets	74,760	91,129	85,292	82,653	(2,638)
Inventories	2,825	2,850	2,950	2,778	(172)
Trade and other receivables	11,191	9,230	9,380	13,130	3,750
Non-current assets for sale	1,400	0	0	0	0
Cash and cash equivalents	2,601	3,007	3,678	4,302	624
Total current assets	18,017	15,087	16,008	20,211	4,203
Trade and other payables	(21,692)	(20,886)	(17,660)	(27,899)	(10,239)
Borrowings	(130)	(130)	(130)	(130)	0
Provisions	(84)	(84)	(84)	(84)	0
Other liabilities	(1,892)	(295)	(476)	(942)	(466)
Total current liabilities	(23,798)	(21,195)	(18,350)	(29,055)	(10,705)
Total assets less current liabilities	68,979	85,021	82,949	73,809	(9,141)
Trade and other payables - Non current	(912)	(1,083)	(1,083)	(1,111)	(28)
Borrowings	(18,205)	(39,075)	(35,640)	(32,064)	3,576
Provisions	(202)	(203)	(211)	(202)	9
Total non-current liabilities	(19,319)	(40,361)	(36,934)	(33,377)	3,557
Total assets employed	49,660	44,660	46,015	40,432	(5,584)
Financed by					
Public dividend capital	59,232	59,232	59,232	59,232	(0)
Revaluation reserve	2,151	2,151	2,151	2,151	0
Income and expenditure reserve	(11,723)	(16,723)	(15,368)	(20,951)	(5,583)
Total taxpayers' and others' equity	49,660	44,660	46,015	40,432	(5,583)

The cash at bank as at the end of December 2016 is £3.7m.

5. Cashflow forecast for the year



6. Capital Progress Report



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	Forecast	2016-17
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
E Care	94	1,262	19	412	625	561	378	705	198	473	473	473	5,672
CSSD	11	37	130	176	281	365	580	1,221	608	1,135	1,577	1,556	7,671
Other Schemes	270	15	426	124	548	806	793	299	819	1,125	1,419	2,300	8,944
Total Actual/Forecast	375	1,313	574	713	1,454	1,732	1,751	2,225	1,620	2,732	3,469	4,329	22,286
Total Plan	359	864	770	1,628	2,012	2,104	2,124	2,101	2,009	2,834	2,459	2,327	21,590

The capital programme for the year is shown in the graph above. The CSSD and E-care schemes are shown separately.

Overall the slippage on the 2016-17 Capital Programme is £2.2 million to the end of December. This is mainly due to re-phasing of larger projects such as the CSSD building and the Cath Lab. Whilst these are forecast to continue to underspend in 2016-17 the overall capital programme is forecast to overspend by £0.7m due to increasing expenditure on e-Care.

The CSSD build has commenced and will incorporate two additional floors to facilitate future clinical development in the hospital core. Expenditure is £0.4 million behind plan in December and £3 million behind plan YTD.

Slippage on the Cath Lab in 2016-17 is anticipated to be £2.256 million by the end of the year and largely relates to a delay with the Mortuary move. Enabling works have been identified for G6 and F12 and are due to commence in mid-February. Build works have also been tendered with commencement due in mid-March. Phase 1 E-Care went live at the beginning of May and the Capital Programme assumes Phase 2 of the original business case will be completed within this financial year. Expenditure on e-Care is £4.253 million at the end of December, (against a total plan for 2016-17 of £3.44 million.)

The outcome of the Global Digital Excellence (GDE) bid has not been taken into consideration in the M9 forecast since it is yet to be determined when the funding will arrive and it is still subject to formal Treasury sign-off. However, the E-Care programme budget is currently being reviewed to take account of the increased scope associated with this funding.

Recommendation:

To note the summary report.

e-Care

Reflecting back and looking forwards



Jan/Feb 2017

Putting you *first*

What we will cover



Reflecting back – looking back at our journey so far



Taking stock - of where we are now

Looking forwards – what to expect over next two years



THIS IS A LONG JOURNEY!



NINE MONTHS AGO!

e-Care
Quality through Technology

PLEASE BE PATIENT TODAY...

We are introducing a new electronic patient record called e-Care which will transform the way we care for you.

However, all new systems take a bit of getting used to and we know there will be a few teething problems.

We may seem busier and doctors and nurses may take a little longer to carry out their duties, so your patience during your visit today will be appreciated.

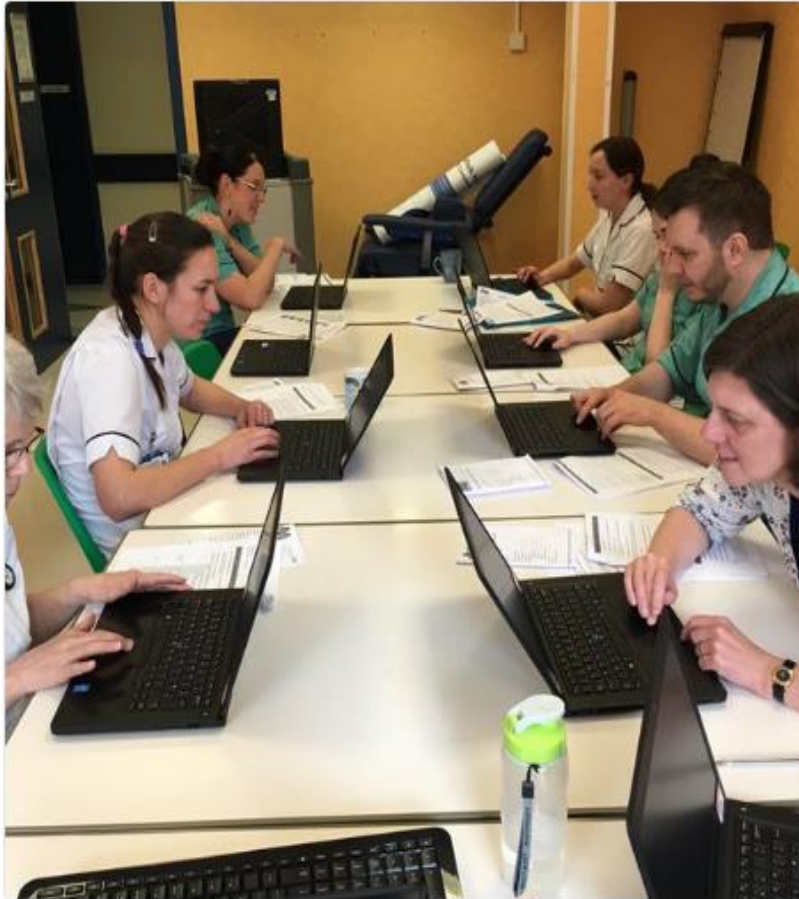
Thank you for your patience.

e-Care is about putting our patients - their safety, outcomes and experience - first

West Suffolk **NHS**
NHS Foundation Trust



WSH Physio Dept @WSHPhysio · Mar 23
Busy on the eCare play domain in Therapies today @beckhelen1
@Stephen_P_Dunn



← 3 ❤️ 7 ...

STAFF WORKED INCREDIBLY HARD TO GET READY FOR GO LIVE

More than **2000** hours of
classroom training attended

Peak of **250** users on play
domain at same time

12,000 hits on website in April
for people accessing training
materials

Prof Dr Stephen Dunn @Stephen_P_Dunn · May 4
Floorwalker huddle this morning at the start of another busy day



Prof Dr Stephen Dunn @Stephen_P_Dunn · 1 May 2016
Go G5 transcription #eDay #GoLive



Dermot O'Riordan @dermotor · May 1
Full marks to @WestSuffolkNHS CEO @Stephen_P_Dunn dishing out tea to patients & staff #eCare #TaggingHimBack



21 40

Prof Dr Stephen Dunn @Stephen_P_Dunn · May 1
Good to see Ian Coe hard at it seeing all the preparation of the last few weeks being put into action



2 6

Delivering high quality, safe care, together

THANK YOU!

And now every day

- **1000+ users are on system**
- **2272 drugs are prescribed**
- **5,400 drugs are administered**
- **2,400 powernotes are written**
- **4,700 documents are signed**
- **61 new patients are registered**
- **1005 appointments are made**

Average for every day in last month

But how does it feel?

There are things that you like....

Accessible from anywhere

Single log on

Up to date information

Drugs administration faster –
no more “chart in pharmacy”

Legible

Powerchart

Visit summary

Helps prioritise workload

Everything in one place

Able to personalise

Click through to Evolve

No more missing notes!

Easy to find my patients

But how does it feel?

There are things that you don't like....

Secretarial workflow

Handover

Some interfaces clunky – IMPAX etc

Reporting

Logs me out too quickly

Pharmacy dispensing slow

**Word functionality –
spell check etc**

I can't remember how to do the things I don't do very often

Things take longer

Need more help to personalise

Encounter driven – cumbersome!

We are making progress

Since go live you have raised 19685 issues with the helpdesk

We have closed more than 19291 of these including

- EPARs workflow
- Doctor and nursing handover tools
- New nursing assessments and invasive devices added
- Improvements to fluid balance
- Improvements to admission assessment workflow

However

.... we still have some significant “hotspots” to resolve and we have plans for these



Ordercomms
launching end of
March



- Interim improvements
- New logical template coming (M Page)
- Requires behaviour change



- New PAS (RPAS) will simplify processes
- Small improvements to sec workflow
- Continue to seek long term solution

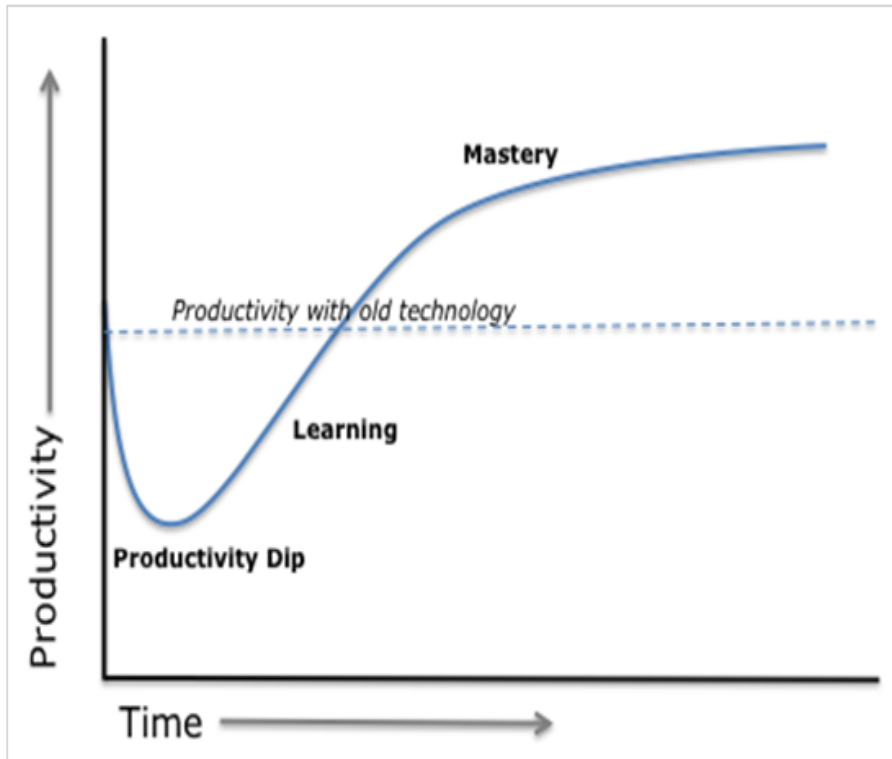


- Upgrade to reporting software will fix many issues
- Improved report requesting function
- Reporting team now at full strength



We are where we would expect to be at this stage

The “productivity paradox”



“The lag between the adoption of technology and the realisation of productivity gains”

Erik Brynjolfsson, MIT

“You can see the computer age everywhere but in the productivity statistics”

Robert Solow, Nobel Laureate Economics

“Technology never reaches its full potential at the very beginning”

Bob Wachter, Digital Doctor

We have ways to help you now

Only 6.7% of staff are currently placing orders using “favourites”

We can increase productivity by helping people to work more smartly

Average time to place an order on e-Care is 60 seconds

However we know some people taking much longer. We can target support to these staff

Cerner evaluation planned in February

Will identify other areas for improvement

COMING SOON!!!

AT THE ELBOW “COACHING” SUPPORT TO HELP YOU WORK SMARTER



GETTING THE BALANCE RIGHT

TRANSFORMATION

Empowering people to transform how they work in light of the new opportunities that e-Care offers

INSTRUCTIONS

Things we need people to do now to ensure safe working i.e. mandating use of message centre

One Vision

TO DELIVER THE BEST QUALITY AND SAFEST CARE FOR OUR COMMUNITY



Three Priorities

Deliver for today

Invest in quality, staff and clinical leadership

Build a joined-up future



Seven Ambitions



1
Deliver personal care



2
Deliver safe care



3
Deliver joined-up care



4
Support a healthy start



5
Support a healthy life



6
Support ageing well



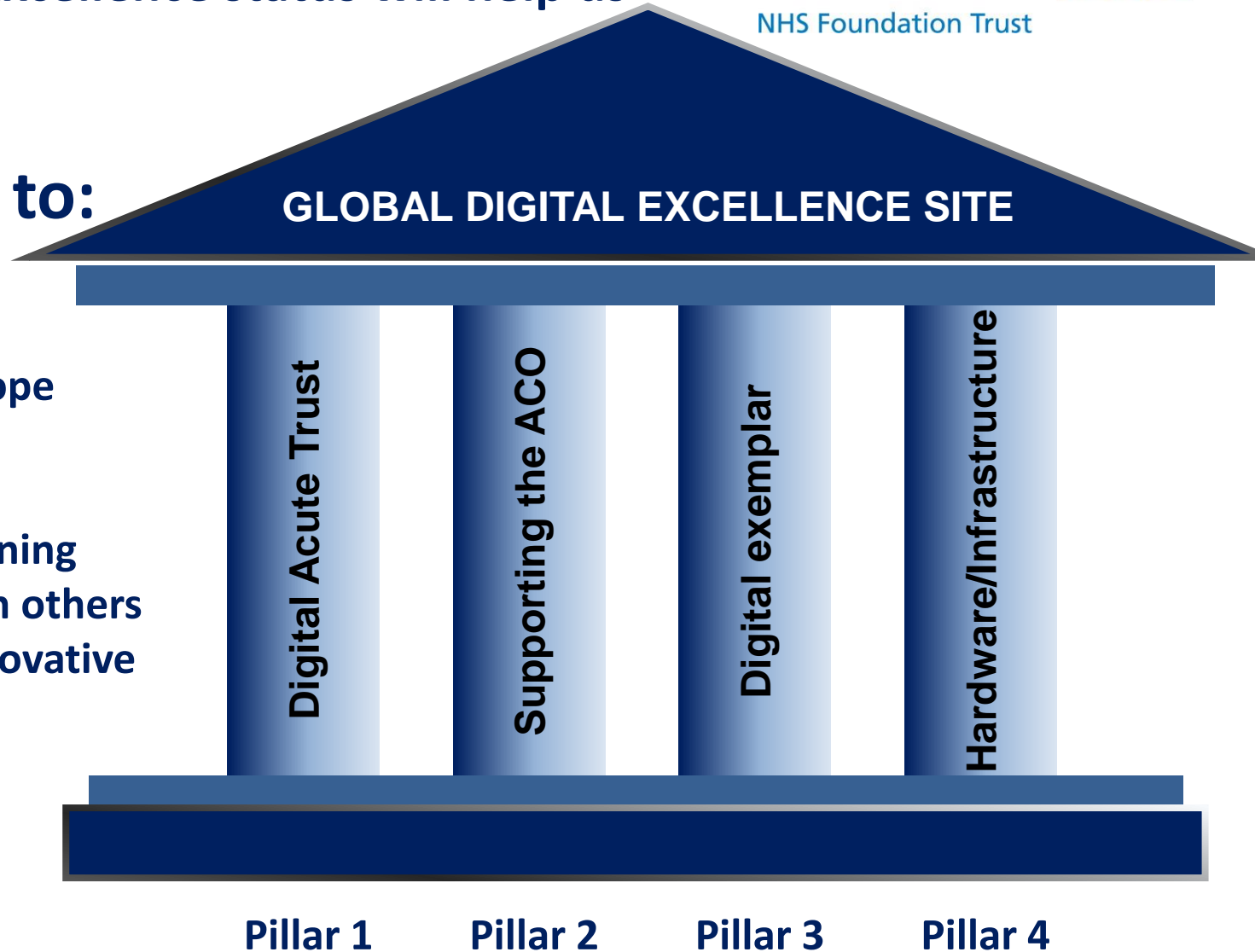
7
Support all our staff

e-Care will provide us with a single patient record so we can transform how we care for our patients

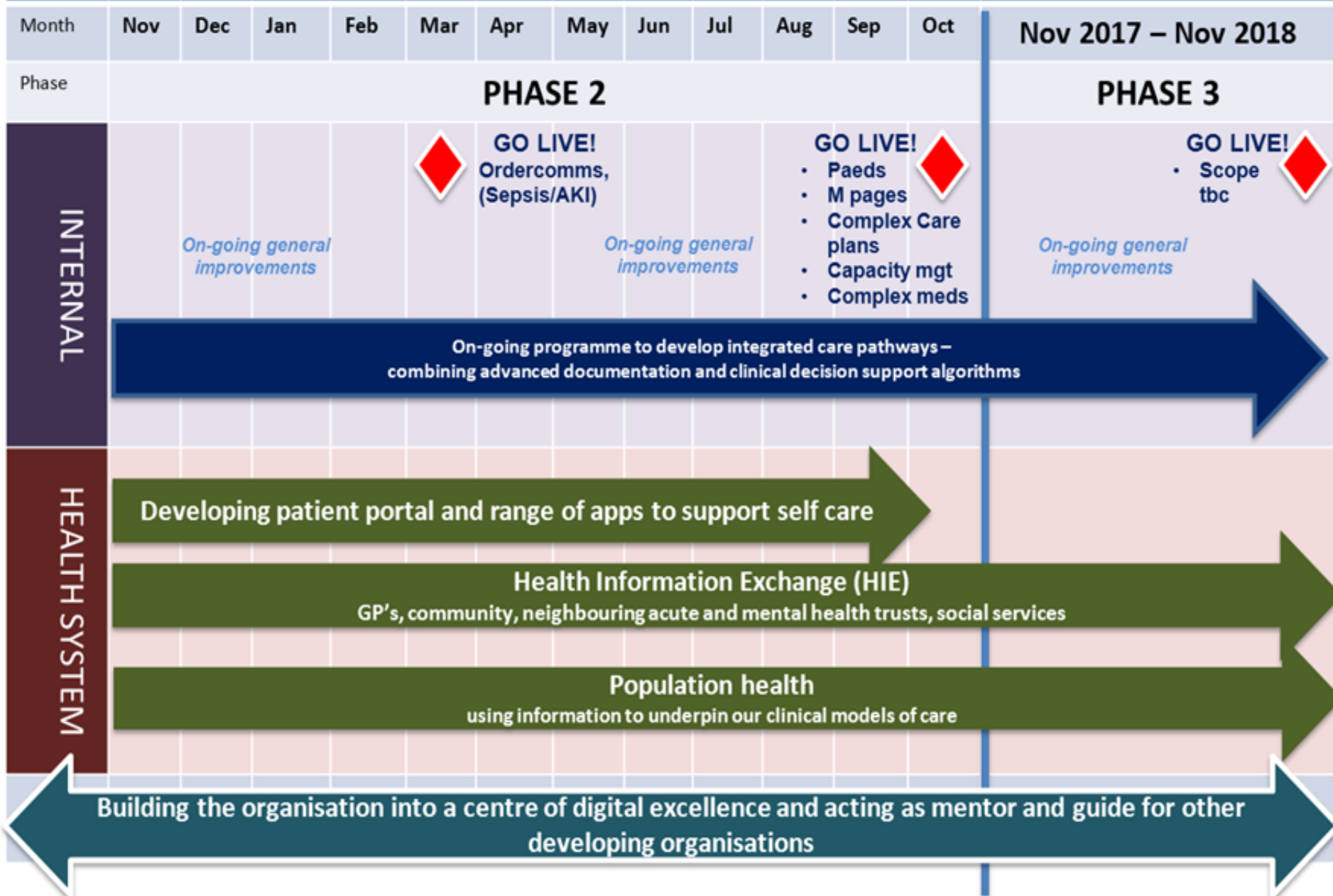
Deliver personal care	<ul style="list-style-type: none"> • All staff with access to the same comprehensive patient record at the time they need the information • All care plans in one place ensuring co-ordinated approach to care • Ability to prescribe and deliver care in a more timely way meaning reduced lengths of stay
Deliver safe care	<ul style="list-style-type: none"> • Early identification of patients at risk and early intervention of care (falling, pressure ulcers etc) • Reduction in adverse drug events • Prevention of acute kidney injury and sepsis through early identification and flags
Deliver joined-up care	<ul style="list-style-type: none"> • Ability to monitor and improve performance through access to reliable data – we will know where we are getting it wrong and where we can improve • Ability to build best practice into e-Care (such as care bundles) • Ability to give 24hr access and share in real time care plans across wards, services and externally to GPs, social care, community services and to patients and their carers
Support a healthy start	<ul style="list-style-type: none"> • Bring patients to the heart of their care planning and management in using a Patient Portal supporting patients to take more control of their own health (gives patients access to their own clinical data and for them to record their own observations and data for the health professionals to see) • Integrated data that allows identification of patient with complex care needs (i.e. multiple drug therapy, co-morbidities) • Ability to focus on prevention • Releasing time to care • Access to single source of Truth for every patient
Support a healthy life	
Support ageing well	
Support all our staff	

Enables us to:

- Go faster
- Extend our scope
- Improve our hardware
- Share our learning and learn from others
- Work with innovative digital leaders



e-Care 2017 – current plan



QUESTIONS

A reminder - coming very soon!!



ORDERCOMMS

- Launching at end of March
- We will all be using e-Care to order, collect and review pathology samples
- Make sure you have booked yourself onto training (see our intranet pages)



SEPSIS AND ACUTE KIDNEY INJURY (AKI) ALERTS

Council of Governors – 8 February 2017

AGENDA ITEM:	Item 15
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	30 January 2017
SUBJECT:	Review of the Trust's constitution
PURPOSE:	Approval

EXECUTIVE SUMMARY:

At its meeting on 30 September 2016 the Board of Directors agreed to the principle of extending the Trust's membership area to include the east of the county. As part of the constitutional review to enact this change a small working group including Governors was established and has made the following recommendations for updates to the constitution. Based on the work of this group at the Council of Governors meeting on the 16 November 2016 the following areas were agreed for change within the constitution:

1. Extend **public membership area** to include whole of Suffolk – enacted through change in Annex 1, page 26
2. Update **quorate definition for Council of Governors** - a less prescriptive form of words is proposed '*one-third of the whole number of the Governors are present, the majority of whom from the public constituency*' (Annex 7, para 3.34 page 87)
3. Make provision for **remote attendance at Board of directors** meetings - it would not be expected that this provision would often be implemented but may be useful in exceptional circumstances. This provision means that if a Director attends a meeting remotely that they are considered to be included in the quorum and therefore are entitled to vote (Annex 8 para 3.19 pages 101)
4. Make provision for a **Deputy lead governor** position - enacted through change which indicates that the deputy only takes-up function in absence of lead governor (Annex 7, para 9 page 91)
5. **Situational conflicts** for directors - legal advice indicated that the constitution did not adequately cater for conflicts of interest and this has caused some difficulties for FTs elsewhere (para 34.2.2). Appropriate wording has been included in the constitution to manage 'situational conflicts' for circumstances such as joint ventures or other vehicles which place the directors of WSFT on another legal entity.

The proposed changes were approved by the Board of Directors at their meeting on 27 January 2017 and the constitution with tracked changes is attached for approval by the Council of Governors. Following this approval the amendments to the constitution are effective immediately and the updated constitution will be submitted to NHSI for information.

Linked Strategic objective (link to website)	6. To deliver and demonstrate rigorous and transparent corporate and quality governance
Issue previously considered by: (e.g. committees or forums)	Board of Directors (September 2016 and 27 January 2017) Council of Governors (November 2016)
Risk description:	
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Legal opinion from Bevan Brittan confirms that changes and updated constitution are legal and valid against the relevant Acts
Legislation / Regulatory requirements:	Compliance with National Health Service Act 2006 and Health and Social Care Act 2012.
Other key issues:	
Recommendation: The Council of Governors approves the recommended changes to the constitution.	

West Suffolk NHS Foundation Trust

Constitution

| February 2017

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1. Name

The name of the foundation trust is West Suffolk NHS Foundation Trust (the trust).

2. Principal purpose

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

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

3. Other purposes and powers

3.1 The trust may provide goods and services for any purposes related to:

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

3.1.2 the promotion and protection of public health.

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

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

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

3.5 Any of these powers may be delegated to a committee of Directors or to an Executive Director.

4. Membership and constituencies

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

4.1 the public constituency or

4.2 the staff constituency

5. Application for membership

An individual who is eligible to become a Member of the trust may do so on application to the trust.

6. Public Constituency

- 6.1** An individual who lives in the area specified in Annex 1 as the area for a public constituency may become or continue as a Member of the trust.
- 6.2** Those individuals who live in the area specified for a public constituency are referred to collectively as the Public Constituency.
- 6.3** The minimum number of Members in the Public Constituency is specified in Annex 1.

7. Staff Constituency

- 7.1** An individual who is employed by the trust under a contract of employment with the trust may become or continue as a member of the trust provided:
 - 7.1.1** he is employed by the trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or
 - 7.1.2** he has been continuously employed by the trust under a contract of employment for at least 12 months.
- 7.2** Individuals who exercise functions for the purposes of the trust, otherwise than under a contract of employment with the trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months. For clarity this does not include individuals who exercise functions for the purposes of the trust on a voluntary basis.
- 7.3** The Trust Secretary must have regard to Chapter 1 of Part 14 of the Employment Rights Act 1996 for the purposes of determining whether an individual has been continuously employed by the Trust, or has continuously exercised functions for the purposes of the Trust.
- 7.4** Those individuals who are eligible for membership of the trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

- 7.5 The minimum number of members in the Staff Constituency is specified in Annex 2.

Automatic membership by default – staff

- 7.6 An individual who is:

7.6.1 eligible to become a Member of the Staff Constituency, and

7.6.2 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 informs the trust that he does not wish to do so.

8. Restriction on membership

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

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

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

8.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the trust are set out in Annex 10 – Further Provisions.

9. Annual Members' Meeting

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

10. Council of Governors – composition

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

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

10.3 The aggregate number of public Governors is to be more than half the total membership of the Council of Governors.

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

11. Council of Governors – election of governors

11.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election–Rules_for Elections.

11.2 The Model Election–Rules_for Elections as published from time to time by the Department of Health form part of this Constitution. The Model Election–Rules_for Elections current at the date ~~of the trust's Licence–this constitution is approved~~ are attached at Annex 4. Elections for elected members of the Council of Governors shall be conducted using the first past the post system. Thus, where appropriate, the alternative rules marked "FPP" (First Past the Post) should be used.

11.3 A subsequent variation of the Model Election–Rules_for Elections by the Department of Health shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 46 of the Constitution (amendment of the constitution).

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

11.5 Where a vacancy arises for an elected Governor the trust may, instead of holding a by-election, fill the vacancy by appointing the highest polling unsuccessful candidate at the most recent election of governors for the constituency or class in respect of which the vacancy has arisen. Any person so appointed shall hold office for the unexpired term of office of the retiring Governor.

12. Council of Governors - tenure

12.1 An elected Governor may hold office for a period of up to 3 years.

12.2 An elected Governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

12.3 Subject to Paragraph 12.4 below, an elected Governor shall be eligible for re-election at the end of his term.

12.4 An elected Governor may not hold office for longer than 9 years or be re-elected if, by virtue of this paragraph 12.4, he would not be able to remain in office for the full three year period.

- 12.5 An appointed Governor may hold office for a period of up to 3 years.
- 12.6 An appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him.
- 12.7 An appointed Governor shall be eligible for re-appointment at the end of his term, but may not hold office for more than nine years.

13. Council of Governors – disqualification and removal

- 13.1 The following may not become or continue as a member of the Council of Governors:
- 13.1.1 a person who has been ~~adjudged-made~~ bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
 - 13.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;
 - 13.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.
- 13.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.
- 13.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 5.

14. Council of Governors – Termination of tenure

- 14.1 A Governor may resign from that office at any time during the term of that office by giving notice in writing to the Secretary to the trust.
- 14.2 If a Governor fails to attend any meeting of the Council of Governors, for a period of one year or three consecutive meetings (whichever is the shorter) his tenure of office is to be immediately terminated unless the other Governors agree by a majority vote that:
- 14.2.1 the absence was due to a reasonable cause; and
 - 14.2.2 he will be able to start attending meetings of the Council of Governors again within such a period as they consider reasonable.

- 14.3** Where a person has been elected or appointed to be a Governor and he becomes disqualified for appointment under paragraph 13, he shall notify the Secretary in writing of such disqualification.
- 14.4** If it comes to the notice of the Secretary at the time of his appointment or later that the Governor is so disqualified, he shall immediately declare that the person in question is disqualified and notify him in writing to that effect.
- 14.5** Upon receipt of any such notification, that person's tenure of office, if any, shall be terminated and he shall cease to act as a governor.

15. Council of Governors – Vacancies

Where membership of the Council of Governors ceases, Public and Staff Governors shall be replaced in accordance with paragraph 11.5, and appointed Governors shall be replaced in accordance with processes agreed with their appointers.

16. Council of Governors – duties of governors

- 16.1** The general duties of the Council of Governors are –
- 16.1.1** to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and
 - 16.1.2** to represent the interests of the members of the trust as a whole and the interests of the public.
- 16.2** The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

17. Council of Governors – meetings of governors

- 17.1** The Chairman of the trust (i.e. the Chairman of the Board of Directors, appointed in accordance with the provisions of paragraph 26.1 or paragraph 27.1 below) or, in his absence the Deputy Chairman (appointed in accordance with the provisions of paragraph 28 below), shall preside at meetings of the Council of Governors.
- 17.2** Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons. The Chairman may also exclude any member of the public from a meeting of the Council of Governors if he is interfering with or preventing the proper conduct of the meeting.
- 17.3** For the purposes of obtaining information about the trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the trust's or

Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

18. Council of Governors – standing orders

The standing orders for the practice and procedure of the Council of Governors, as may be varied from time to time in accordance with paragraph 46, are attached at Annex 7.

19. Council of Governors – referral to the Panel

19.1 In this paragraph, the Panel means a panel of persons appointed by Monitor to which a governor of an NHS foundation trust may refer a question as to whether the trust has failed or is failing—

19.1.1 to act in accordance with its Constitution, or

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

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

20. Council of Governors - conflicts of interest of governors

If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. 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 consideration of the matter in respect of which an interest has been disclosed.

21. Council of Governors – travel expenses

The trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the trust.

22. Council of Governors – further provisions

Further provisions with respect to the Council of Governors are set out in Annex 5 and Annex 10.

23. Board of Directors – composition

23.1 The trust is to have a Board of Directors, which shall comprise both Executive Directors and Non-Executive Directors.

23.2 The Board of Directors is to comprise:

23.2.1 a Non-Executive Chairman;

23.2.2 5 other Non-Executive Directors; and

23.2.3 5 Executive Directors.

23.3 One of the Executive Directors shall be the Chief Executive.

23.4 The Chief Executive shall be the Accounting Officer.

23.5 One of the Executive Directors shall be the Finance Director.

23.6 One of the Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

23.7 One of the Executive Directors is to be a registered nurse or a registered midwife.

24. Board of Directors – general duty

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

25. Board of Directors – qualification for appointment as a non-executive director

A person may be appointed as a Non-Executive Director only if –

25.1 he is a member of the Public Constituency, or

25.2 where any of the trust's hospitals includes a medical or dental school provided by a university, he exercises functions for the purposes of that university, and

25.3 he is not disqualified by virtue of paragraph 31 below.

26. Board of Directors – appointment and removal of chairman and other non-executive directors

26.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chairman of the trust and the other Non-Executive Directors.

26.2 Removal of the Chairman or another Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors.

26.3 The initial Chairman and the initial Non-Executive Directors are to be appointed in accordance with paragraph 27 below.

27. Board of Directors – appointment of initial chairman and initial other non-executive directors

27.1 The Council of Governors shall appoint the chairman of the applicant NHS Trust as the initial Chairman of the trust if he wishes to be appointed.

27.2 The power of the Council of Governors to appoint the other Non-Executive Directors of the trust is to be exercised, so far as possible, by appointing as the initial Non-Executive Directors of the trust any of the Non-Executive Directors of the applicant NHS Trust (other than the Chairman) who wish to be appointed.

27.3 The criteria for qualification for appointment as a Non-Executive Director set out in paragraph 25 above (other than disqualification by virtue of paragraph 31 below) do not apply to the appointment of the initial Chairman and the initial other Non-Executive Directors in accordance with the procedures set out in this paragraph.

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

28. Board of Directors – appointment of deputy chairman

The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Non-Executive Directors as a Deputy Chairman.

29. Board of Directors - appointment and removal of the Chief Executive and other executive directors

29.1 The Non-Executive Directors shall appoint or remove the Chief Executive.

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

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

29.4 A committee consisting of the Chairman, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

30. Board of Directors – appointment and removal of initial Chief Executive

30.1 The chief officer of the applicant NHS Trust shall be appointed as the initial Chief Executive of the trust if he wishes to be appointed.

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

31. Board of Directors – disqualification

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

31.1 a person who has been ~~adjudged~~ made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

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

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

31.4 a person who, in the case of a Non-Executive Director other than the initial Non-Executive Directors, no longer satisfies paragraph 25.1 or 25.2 (if applicable).

31.5 a person whose tenure of office as a chairman or as a member or director of a national health service body has been terminated on the grounds that his appointment is not in the interests of public service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest.

31.6 a person who has had his name removed from a list maintained under regulations pursuant to sections 91, 106, 123, or 146 of the 2006 Act, by a direction or has otherwise been disqualified or suspended from any healthcare profession, and has not subsequently had his name included in such a list or had his qualification re-instated or suspension lifted (as applicable).

- 31.7 a person who has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a national health service body.
- 31.8 a person who has failed to agree (or having agreed, fails) to abide by the value of the trust's principles as set out in Annex 9.
- 31.9 a person does not meet the criteria set out in Regulation 5(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (including any modification or re-enactment).

32. Board of Directors – meetings

- 32.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.
- 32.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

33. Board of Directors – standing orders

The standing orders for the practice and procedure of the Board of Directors, as may be varied from time to time in accordance with paragraph 46, are attached at Annex 8.

34. Board of Directors - conflicts of interest of directors

- 34.1 The duties that a Director of the trust has by virtue of being a Director include in particular –
 - 34.1.1 A duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the trust (a "Conflict").
 - 34.1.2 A duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.
- 34.2 The duty referred to in sub-paragraph 34.1.1 is not infringed if –
 - 34.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or
 - 34.2.2 The matter has been authorized in accordance with the Constitution.

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

34.4 In sub-paragraph 34.1.2, “third party” means a person other than –

34.4.1 The trust, or

34.4.2 A person acting on its behalf.

34.5 If a Director of the trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the trust, the Director must declare the nature and extent of that interest to the other Directors.

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

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

34.8 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.

34.9 A Director need not declare an interest –

34.9.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

34.9.2 If, or to the extent that, the Directors are already aware of it;

34.9.3 If, or to the extent that, it concerns terms of the Director’s appointment that have been or are to be considered –

34.9.3.1 By a meeting of the Board of Directors, or

34.9.3.2 By a committee of the Directors appointed for the purpose under the Constitution.

34.10 A matter shall have been authorised for the purposes of paragraph 34.2.2 above if:

34.10.1 The Directors, in accordance with the requirements set out in this paragraph 34.10, authorise any matter or situation proposed to them by any Director which would, if not authorised, involve a Director (an "Interested Director") breaching his duty under paragraph 34.1.1 above to avoid Conflicts:

34.10.1.1 the matter in question shall have been proposed by any Director for consideration in the same way that any other matter may be proposed to the Directors under the provisions of this Constitution;

34.10.1.2 any requirement as to the quorum for consideration of the relevant matter is met without counting the Interested Director or any other Interest Director; and

34.10.1.3 the matter was agreed to without the Interested Director voting or would have been agreed to if the Interested Director's and any other Interested Director's vote had not been counted.

34.10.2 Any authorisation of a Conflict under this paragraph 34.10 may (whether at the time of giving the authorisation or subsequently):

34.10.2.1 extend to any actual or potential conflict of interest which may reasonably be expected to arise out of the Conflict so authorised;

34.10.2.2 provide that the Interested Director be excluded from the receipt of documents and information and the participation in discussions (whether at meetings of the Directors or otherwise) related to the Conflict;

34.10.2.3 impose upon the Interested Director such other terms for the purposes of dealing with the Conflict as the Directors think fit;

34.10.2.4 provide that, where the Interested Director obtains, or has obtained (through his involvement in the Conflict and otherwise than through his position as a Director of the Trust) information that is confidential to a third party, he will not be obliged to disclose that information to the Board of Directors, or to use it in relation to the Trust's affairs where to do so would amount to a breach of that confidence; and

34.10.2.5 permit the Interested Director to absent himself from the discussion of matters relating to the Conflict at any meeting of the Directors and be excused from reviewing papers prepared by, or for, the Directors to the extent they relate to such matters.

34.11 Where the Directors authorise a Conflict, the Interested Director will be obliged to conduct himself in accordance with any terms imposed by the Directors in relation to the Conflict.

34.12 The Directors may revoke or vary such authorisation at any time, but this will not affect anything done by the Interested Director, prior to such revocation or variation in accordance with the terms of such authorisation.

34.13 A Director is not required, by reason of being a Director, to account to the Trust for any remuneration, profit or other benefit which he derives from or in connection with a relationship involving a Conflict which has been authorised by the Directors (subject in each case to any terms, limits or conditions attaching to that authorisation) and no contract shall be liable to be avoided on such grounds.

34.1034.14

35. Board of Directors – remuneration and terms of office

35.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other Non-Executive Directors.

35.2 The trust shall establish a committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors; (or, pending the establishment of such a committee, in accordance with the terms and conditions decided by the remuneration committee of the applicant NHS Trust).

36. Registers

The trust shall have:

36.1 a register of Members showing, in respect of each Member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;

36.2 a register of members of the Council of Governors;

36.3 a register of interests of Governors;

36.4 a register of Directors; and

36.5 a register of interests of the Directors.

37. Registers – inspection and copies

- 37.1** The trust shall make the registers specified in paragraph 36 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.
- 37.2** The trust shall not make any part of its registers available for inspection by members of the public which shows details of any Member of the trust, if the Member so requests.
- 37.3** So far as the registers are required to be made available:
- 37.3.1** they are to be available for inspection free of charge at all reasonable times; and
- 37.3.2** a person who requests a copy of or extract from the registers is to be provided with a copy or extract.
- 37.4** If the person requesting a copy or extract is not a Member of the trust, the trust may impose a reasonable charge for doing so.

38. Documents available for public inspection

- 38.1** The trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:
- 38.1.1** a copy of the current Constitution;
- 38.1.2** a copy of the latest annual accounts and any report of the auditor on them; and
- 38.1.3** a copy of the latest annual report;
- 38.2** The trust shall also make the following documents relating to a special administration of the trust available for inspection by members of the public free of charge at all reasonable times:
- 38.2.1** a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.
- 38.2.2** a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.
- 38.2.3** a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

- 38.2.4** a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.
- 38.2.5** a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act.
- 38.2.6** a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.
- 38.2.7** a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.
- 38.2.8** a copy of any final report published under section 65I (administrator's final report),
- 38.2.9** a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.
- 38.2.10** a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

38.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

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

39. Auditor

39.1 The trust shall have an auditor.

39.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

40. Audit committee

The trust shall establish a committee of Non-Executive Directors as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate.

41. Accounts

- 41.1** The trust must keep proper accounts and proper records in relation to the accounts.
- 41.2** Monitor may with the approval of the Secretary of State give directions to the trust as to the content and form of its accounts.
- 41.3** The accounts are to be audited by the trust's auditor.
- 41.4** The trust shall prepare in respect of each financial year annual accounts in such form as Monitor may with the approval of the Secretary of State direct.
- 41.5** The functions of the trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

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

- 42.1** The trust shall prepare an annual report and send it to Monitor.
- 42.2** The trust shall give information as to its forward planning in respect of each financial year to Monitor.
- 42.3** The document containing the information with respect to forward planning (referred to above) shall be prepared by the Directors.
- 42.4** In preparing the document, the Directors shall have regard to the views of the Council of Governors.
- 42.5** Each forward plan must include information about:
 - 42.5.1** the activities other than the provision of goods and services for the purposes of the health service in England that the trust proposes to carry on, and
 - 42.5.2** the income it expects to receive from doing so.
- 42.6** Where a forward plan contains a proposal that the trust carry on an activity of a kind mentioned in sub-paragraph 42.5.1 the Council of Governors must:
 - 42.6.1** determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfillment by the trust of its principal purpose or the performance of its other functions, and
 - 42.6.2** notify the Directors of the trust of its determination.

42.7 A trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of health service in England may implement the proposal only if more than half of the members of Council of Governors of the trust voting approve its implementation.

43. Presentation of the annual accounts and reports to the Governors and Members

43.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

43.1.1 the annual accounts

43.1.2 any report of the auditor on them

43.1.3 the annual report.

43.2 The documents shall also be presented to the Members of the trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

43.3 The trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 43.1 with the Annual Members' Meeting.

44. Indemnity

The Secretary of the trust and members of the Council of Governors and Board of Directors 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, and the trust may also take out and maintain at its own cost insurance against such risks, both for its own benefit and for the benefit of such persons.

45. Instruments

45.1 The trust shall have a seal.

45.2 The seal shall not be affixed except under the authority of the Board of Directors.

46. Amendment of the constitution

46.1 The trust may make amendments of its Constitution only if:

46.1.1 More than half of the members of the Council of Governors of the trust voting approve the amendments, and

46.1.2 More than half of the members of the Board of Directors of the trust voting approve the amendments.

46.2 Amendments made under paragraph 46.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act

46.3 Where an amendment is made to the Constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the trust):

46.3.1 At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

46.3.2 The trust must give the Members an opportunity to vote on whether they approve the amendment.

46.4 If more than half of the Members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the trust must take such steps as are necessary as a result.

46.5 Amendments by the trust of its Constitution are to be notified to Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

47. Mergers etc. and significant transactions

47.1 [The trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

47.2 The trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the trust voting approve entering into the transaction.

47.3 "Significant transaction" means a transaction which meets the definition set out in Table 1 below:

Table 1: Significant transaction

Ratio	Description	Significant
Assets	The gross assets* subject to the transaction, divided by the gross assets of the trust	>25%

Income	The income attributable to assets or contract associated with the transaction, divided by the income of the trust	>25%
Consideration to total NHS foundation trust capital	The gross capital** of the company or business being acquired/divested, divided by the total capital*** of the trust following completion or the effects on the total capital of the trust resulting from a transaction	>25%

- * Gross assets is the total of fixed assets and current assets
- ** Gross capital equals the market value of the target's shares and debt securities, plus the excess of current liabilities over current assets
- *** Total capital of the foundation trust equals taxpayers' equity

48. Interpretation and definitions

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this Constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

References to statutory provisions shall be deemed to include references to any provision amending, re-enacting or replacing them and to such provisions as amended from time to time.

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

the 2006 Act is the National Health Service Act 2006.

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

Accounting Officer means the Officer responsible and accountable for discharging the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act, which shall be the Chief Executive.

Adviser means a person formally appointed by resolution of the Council of Governors to advise the Council of Governors at meetings of the Council of Governors in an advisory and non-voting capacity.

Annual Members Meeting is defined in paragraph 9 of the constitution.

Audit Committee means a committee whose functions are concerned with the arrangements for providing the Board with an independent and objective review on its financial and risk systems, financial information and compliance with laws, guidance, and regulations governing the NHS and with the arrangements for the

monitoring and improving the quality of healthcare for which the trust has responsibility.

Board of Directors (“the Board”) means the Executive and Non-Executive Directors including the Chairman as constituted in accordance with the Constitution as the Board of Directors.

Chairman is the person appointed by the Council of Governors to lead the Council of Governors and Board of Directors and to ensure that they successfully discharge their overall responsibility for the trust as a whole. The expression “the Chairman of the trust” shall be deemed to include the Deputy Chairman of the trust if the Chairman is absent from the meeting or is otherwise unavailable.

Chief Executive means the accounting officer of the trust.

Committee members means in the context of a Committee persons formally appointed by the Council of Governors or Board of Directors to be members of the Committee.

Council of Governors means the elected and appointed Governors of the trust collectively as a body, as constituted in accordance with the Constitution.

Constitution means this constitution and all annexes to it.

Deputy Chairman means the Non Executive Director appointed by the Council of Governors to take on the Chairman duties if the Chairman is absent for any reason.

Director means a Member of the Board.

Executive Director means a Member of the Board who holds an executive office of the trust.

Finance Director means the Chief Financial Officer of the trust.

Governor means a person who is a member of the Council of Governors.

Licence issued by Monitor the Licence sets out a range of conditions that the Trust must meet.

Member means any person registered as a member of the trust, and authorised to vote in elections to select Governors.

Monitor is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act.

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

Non Executive Director means a member of the Board of Directors who is not an

Executive Director of the trust.

Officer means employee of the trust or any other person holding a paid appointment or office with the trust.

Secretary means a person who may be appointed to act independently of the Council of Governors to provide advice on corporate governance issues to the Council of Governors, and the Chairman and monitor the trust's compliance with the law, Standing Orders and guidance of the Monitor.

SFIs means Standing Financial Instructions.

SOs mean Standing Orders.

Voluntary Organisation is a body, other than a public or local authority, the activities of which are not carried on for profit.

ANNEX 1 – THE PUBLIC CONSTITUENCY

The trust shall have a single Public Constituency. The area of the Public Constituency will be made up of the wards specified below and the minimum number of Members in the Public Constituency shall be 100.

Babergh:	<u>Alton, Berners, Boxford, Brett Vale, Brook, Bures St Mary, Chadacre, Dodnash, Glemsford and Stanstead, Great Cornard (North Ward), Great Cornard (South Ward), Hadleigh (North Ward), Hadleigh (South Ward), Holbrook, Lavenham, Leavenheath, Long Melford, Lower Brett, Mid Samford, Nayland, North Cosford, Pinewood, South Cosford, Sudbury (East Ward), Sudbury (North Ward), Sudbury (South Ward), Waldingfield.</u>
Braintree:	Bumpstead, Hedingham and Maplestead, Stour Valley North, Stour Valley South, Upper Colne, and Yeldham
Breckland:	Conifer, East Guiltcross, Harling and Heathlands, Mid Forest, Thetford-Abbey, Thetford-Castle, Thetford-Guildhall, Thetford-Saxon, Watton, Wayland, Weeting, and West Guiltcross
East Cambridgeshire:	Bottisham, Burwell, Cheveley, Dullingham Villages, Fordham Villages, Isleham, Soham North, Soham South, and The Swaffhams
Forest Heath:	<u>All Saints, Brandon East, Brandon West, Eriswell & the Rows, Exning, Great Heath, Icen, Lakenheath, Manor, Market, Red Lodge, St Marys, Severals, South.</u>
<u>Ipswich</u>	<u>Alexandra, Bixley, Bridge, Castle Hill, Gainsborough, Gipping, Holywells, Priory Heath, Rushmere, St John's, St Margaret's, Sprites, Stoke Park, Westgate, Whitehouse, Whitton.</u>
King's Lynn and: West Norfolk	Denton
Mid Suffolk:	<u>Bacton & Old Newton, Badwell Ash, Barking & Somersham, Bramford & Blakenham, Claydon & Barham, Debenham, Elmswell & Norton, Eye, Fressingfield, Gislingham, Haughley & Wetherden, Helmingham & Coddenham, Hoxne, Mendlesham, Needham Market, Onehouse, Palgrave, Rattlesden, Rickinghall & Walsham, Ringshall, Stowmarket Central, Stowmarket North, Stowmarket South, Stowupland, Stradbroke & Laxfield, The Stonhams, Thurston & Hessett, Wetheringsett, Woolpit, Worlingworth.</u>

South Norfolk: Bressingham and Burston, Diss and Roydon
St Edmundsbury: Abbeygate, Bardwell, Barningham, Barrow, Cavendish, Chedburgh, Clare, Eastgate, Fornham, Great Barton, Haverhill East, Haverhill North, Haverhill South, Haverhill West, Horringer and Whelnetham, Hundon, Ixworth, Kedington, Minden, Moreton Hall, Northgate, Pakenham, Risby, Risbygate, Rougham, Southgate, St Olaves, Stanton, Westgate, Wickhambrook, ~~and~~ Withersfield

Suffolk Coastal Aldeburgh, Deben, Felixstowe East, Felixstowe North, Felixstowe South, Felixstowe West, Framlingham, Fynn Valley, Grundisburgh, Hacheston, Kesgrave East, Kesgrave West, Kirton, Leiston, Martlesham, Melton, Nacton & Purdis Farm, Orford & Eyke, Peasenhall & Yoxford, Rendlesham, Saxmundham, The Trimleys, Tower, Wenhaston & Westleton, Wickham Market, Woodbridge.

Waveney Beccles North, Beccles South, Blything, Bungay, Carlton, Carlton Colville, Gunton & Corton, Halesworth, Harbour, Kessingland, Kirkley, Lothingland, Normanston, Oulton, Oulton Broad, Pakefield, Southwold & Reydon, St Margaret's, The Saints, Wainford, Whitton, Worlingham, Wrentham.

ANNEX 2 – THE STAFF CONSTITUENCY

The Staff Constituency will comprise a single class. The minimum number of Members in the Staff Constituency shall be 100.

ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

A. Elected Governors - public members	14
B. Elected Governors - staff members	5
C. Appointed Governors:	
(a) Local Authority Governors:	
i. Suffolk County Council	1
ii. St Edmundsbury Council in consultation with Babergh, Braintree, Breckland, East Cambridgeshire, Forest Heath, <u>Ipswich</u> , King's Lynn and West Norfolk, Mid Suffolk, and <u>South Norfolk, Suffolk Coastal and Waveney</u> councils	1
(b) University of Cambridge Governor	1
(c) Other appointing organisations: (specified for the purposes of sub-paragraph 9(7) of Schedule 7 of the 2006 Act)	
i. Friends of West Suffolk Hospital	1
ii. Community Action Suffolk	1
iii. University Campus Suffolk (UCS) in consultation with West Suffolk College	1
Or in each case such other organisations as may be the successors to their functions.	

ANNEX 5 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

A person may not become or continue as a Governor of the trust if –

- (a) he, in the case of a staff Governor or public Governor, ceases to be a Member of the constituency he represents;
- (b) he, in the case of a appointed Governor, has his sponsorship withdrawn by their sponsoring organisation;
- (c) he has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a national health service body;
- (d) his tenure of office as the chairman or as a member or director of a national health service body has been terminated on the grounds that his appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;
- (e) he is an Executive Director or Non-Executive Director of the trust, or a governor, non executive director, chairman, chief executive officer of an organisation the nature of whose business is to give rise to potential conflicts of interest of a personal or prejudicial nature to such a degree as to prevent the person from the proper exercise of their duties as a Governor of this Trust. This may include other NHS Foundation Trusts;
- (f) a person who has had his name removed from a list maintained under regulations pursuant to sections 91, 106, 123, or 146 of the 2006 Act, by a direction or has otherwise been disqualified or suspended from any healthcare profession, and has not subsequently has his name included in such a list or had his qualification re-instated or suspension lifted (as applicable).
- (g) he is incapable by reason of mental disorder, illness or injury of managing and/or administering his property and/or affairs;
- (h) he has been declared, by a sub-committee of the Council of Governors, to be a vexatious complainant; or
- (i) he has failed to agree (or having agreed, fails) to abide by the Code of Conduct for Governors as set out in Annex 6 and the value of the trust's Principles as set out in Annex 9.

ANNEX 6 - CODE OF CONDUCT FOR GOVERNORS

Introduction

- 1 This Code seeks to outline appropriate conduct for Governor, and addresses both the requirements of office and their personal behaviour. Ideally any penalties for non-compliance would never need to be applied; however a Code is considered an essential guide for Governors, particularly those who are newly elected.
- 2 The Code seeks to expand on or complement the Constitution. Copies will be made available for the information of all Governors and for those considering seeking election to the Council of Governors.

Qualifications for office

- 4 Members of the Council of Governors must continue to comply with the qualifications required to hold elected office throughout their period of tenure as defined in the Constitution. The Secretary should be advised of any changes in circumstances, which disqualify the Governor from continuing in office. An example of this would be a public Governor becoming an employee of the trust, given that the number of employees sitting on the trust's elected bodies is limited.

Role and functions

- 5 Governors should:
 - a) adhere to the trust's rules and policies and support its objectives, in particular those of retaining Foundation Trust status and developing a successful trust.
 - b) act in the best interests of the trust at all times.
 - c) contribute to the workings of their Council of Governors in order for it to fulfill its role and functions.
 - d) recognise that their role is a collective one. They exercise collective decision making in the meeting room, which is recorded in the minutes. Outside the meeting room a Governor has no more rights and privileges than any other member.
 - e) note that the functions allotted to the Council of Governors are not of a managerial nature.

Confidentiality

- 6 All Governors are required to respect the confidentiality of the information they are made privy to as a result of their membership of the Council of Governors.

Conflict of interests

- 7 Governors should act with the utmost integrity and objectivity and in the best interests of the trust in performing their duties. They should not use their position for personal advantage or seek to gain preferential treatment. Any Governor who has a material interest in a matter as defined by the Constitution, shall declare such interest to the Council of Governors and:

- shall not vote on any such matters.
- Shall not be present except with the permission of the Council of Governors in any discussion of the matter.

If in any doubt they should seek advice from the Secretary. It is important that conflicts of interest are addressed and are seen to be actioned in the interests of the trust and all individuals concerned.

- 8 Any Governor who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so be a majority of the remaining Governors.

Council of Governors meetings

- 9 Governors have a responsibility to attend meetings of the Council of Governors. When this is not possible they should submit an apology to the Secretary in advance of the meeting.
- 10 In accordance with the Constitution, absence from the Council of Governors meetings without good reason established to the satisfaction of the Council of Governors is grounds for disqualification. If a Governor fails to attend for a period of one year or three consecutive meetings (whichever is the shorter) of the Council of Governors, his tenure of office is to be immediately terminated unless the other Governors are satisfied that the absence was due to a reasonable cause and he will be able to start attending meetings of the trust again within such a period as they consider reasonable.
- 11 Governors are expected to attend for the duration of the meeting.

Personal conduct

- 12 Governors are required to adhere to the highest standards of conduct in the performance of their duties. In respect of their interaction with others, they are required to:
- a) adhere to good practice in respect of the conduct of meetings and respect the views of their fellow elected governors
 - b) be mindful of conduct which could be deemed to be unfair or discriminatory
 - c) treat the trust's executives and other employees with respect and in accordance with the trust's policy
 - d) recognise that the Council of Governors and management have a common purpose, i.e. promote the success of the trust, and adopt a team approach
 - e) Governors should conduct themselves in such a manner as to reflect positively on the trust. When attending external meetings or any other events at which they are present, it is important for Governors to be ambassadors for the trust.

Accountability

- 13 Governors are accountable to the membership and should demonstrate this by attending Members' meetings and other key events, which provide opportunities to interface with their electorate in order to best understand their views.

Induction and development

- 14 Training is essential for Governors, in respect of the effective performance of their current role. Governors are required to adhere to the trust's policies in all respects and undertake identified training and develop to allow them to effectively undertake their role.

Visits to trust Premises

- 15 Where Governors wish to visit the premises of the trust in a formal capacity as opposed to individuals in a personal capacity, the Council of Governors should liaise with the Secretary to make the necessary arrangements.

Non-compliance with the Code of Conduct

- 16 Non-compliance with the Code may result in action being taken as follows:-

- a) Where misconduct takes place, the Chairman shall be authorised to take such action as may be immediately required, including the exclusion of the person concerned from a meeting.
 - b) Where such misconduct is alleged, it shall be open to the Council of Governors to decide, by simple majority of those in attendance, to lay a formal charge of misconduct.
 - c) notifying the Governor in writing of the charge/s, detailing the specific behaviour, which is considered to be detrimental to the trust, and inviting and considering their response within a defined timescale.
 - d) inviting the Governor to address the Council of Governors in person if the matter cannot be resolved satisfactorily through correspondence;
 - e) deciding, by simple majority of those present and voting, whether to uphold the charge of conduct detrimental to the trust;
 - f) imposing such sanctions as shall be deemed appropriate. Such sanctions will range from the issuing of a written warning as to the member's future conduct and consequences, non-payment of expenses to the removal of the Governor from office.
- 17 A Governor may be removed from the Council of Governors for non-compliance with the Code of Conduct by a resolution approved by not less than two-thirds of the remaining Governors present and voting at a general meeting of the Council of Governors.
- 18 This Code of Conduct does not limit or invalidate the right of the Governors or the trust to act under the Constitution.

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

1. INTERPRETATION

- 1.1 Save as otherwise permitted by law, at any meeting the Chairman of the trust shall be the final authority on the interpretation of Standing Orders (of which he should be advised by the Chief Executive or Secretary).
- 1.2 Any expression to which a meaning is given in the National Health Service Act 2006 (“2006 Act”) or in the Constitution shall have the same meaning in these Standing Orders.

2. THE COUNCIL OF GOVERNORS

- 2.1 **Composition of the Council of Governors** - The composition of the Council of Governors shall be in accordance with the Constitution.
- 2.2 **Appointment of the Chairman and members** – The Chairman is appointed by the Council of Governors, as set out in the Constitution.
- 2.3 **Terms of Office of the Chairman and members**- The regulations setting out the period of tenure of office of the Chairman and members and for the termination or suspension of office of the Chairman and members are contained in the Constitution.
- 2.4 **Appointment and Powers of Deputy Chairman** – subject to Standing Order 2.5 below; members of the Council of Governors may appoint one of the Non-Executive Directors, to be Deputy Chairman for such period, not exceeding the remainder of his term as a Non-Executive Director of the trust, as they may specify on appointing him.
- 2.5 Any Non-Executive Director so appointed may at any time resign from the office of Deputy Chairman and the Council of Governors may thereupon appoint another Non Executive Director as Deputy Chairman in accordance with the provisions of Standing Order 2.4.
- 2.6 Where the Chairman of the trust has died or has ceased to hold office or where he has been unable to perform his duties as Chairman owing to illness or any other cause, the Deputy Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes his duties, as the case may be, and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform his duties, be taken to include references to the Deputy Chairman.

3. MEETINGS OF THE COUNCIL OF GOVERNORS

- 3.1 *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 Council of Governors but shall be required to withdraw upon the Council of Governors (including a majority of the public Governors present at the meeting) 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”

- 3.2 The Chairman (or Deputy Chairman) shall give such directions as he 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 trust’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 Council of Governors (including a majority of the public Governors present at the meeting) resolving 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”

- 3.3 Nothing in these Standing Orders shall require the trust 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 proceedings as they take place, without the prior agreement of the Council of Governors.
- 3.4 **Calling Meetings** – Meetings of the Council of Governors shall be held at such times and places as the Council of Governors may determine.
- 3.5 The Council of Governors will hold at least four meetings each year, one of which is the Annual Members Meeting.
- 3.6 The Chairman of the trust may call a meeting of the Council of Governors at any time. If the Chairman refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of members of the Council of Governors, has been presented to him or her, or if, without so refusing, the Chairman does not call a meeting within seven days after such requisition has been presented to him at the trust’s headquarters, such one-third or more members may forthwith call a meeting.
- 3.7 **Notice of Meetings** - Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chairman or by an officer authorised by the Chairman to sign on his behalf shall be delivered to every Governor, or sent by post to the usual place of residence of each Governor, so as to be available to him at least three days before the meeting.
- 3.8 Want of service of the notice on any Governor shall not affect the validity of a meeting.
- 3.9 In the case of a meeting called by Governors in default of the Chairman, the notice shall be signed by those Governors and no business shall be transacted at the meeting other than that specified in the notice.
- 3.10 Agendas will be sent to Governors five days¹ before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be

¹ See 3.7 the Notice should be sent before the Agenda.

dispatched no later than three days before the meeting, save in emergency. A notice shall be presumed to have been served one day after posting.

- 3.11 Before each meeting of the Council of Governors 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 office at least three days before the meeting.
- 3.12 **Setting the Agenda** - The Council of Governors may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted. (Such matters may be identified within these Standing Orders or following subsequent resolution shall be listed in an Appendix to the Standing Orders).
- 3.13 A Governor desiring a matter to be included on an agenda shall make his request in writing to the Chairman at least ten clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chairman.
- 3.14 **Petitions** - where a petition has been received by the trust the Chairman of the Council of Governors shall include the petition as an item for the agenda of the next Council of Governors meeting.
- 3.15 **Chairman of Meeting** - At any meeting of the Council of Governors, the Chairman, if present, shall preside. If the Chairman is absent from the meeting the Deputy Chairman, if there is one and he is present, shall preside. If the Chairman and Deputy Chairman are absent another Non Executive Director as the members present shall choose who shall preside.
- 3.16 If the Chairman is absent temporarily on the grounds of a declared conflict of interest the Deputy Chairman, if present, shall preside. If the Chairman and Deputy Chairman are disqualified from participating, such Governor from the Public Constituency as the Governors present shall choose by majority vote who shall preside.
- 3.17 **Notices of Motion** – A member of the Council of Governors desiring to move or amend a Motion shall send a written notice thereof at least ten clear days before the meeting to the Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any Motion being moved during the meeting, without notice on any business mentioned on the agenda.
- 3.18 **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 consent of the Chairman.
- 3.19 **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 calendar months shall bear the signature of the member who gives it and also the signature of four other Governors. When any such Motion has been disposed of by the Council of Governors, it shall not be competent for any Governor other than the Chairman to propose a Motion to the same effect within six months however the Chairman may do so if he considers it appropriate.

3.20 **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.

3.21 When a Motion is under discussion or immediately prior to discussion it shall be open to a member to move:

- An amendment to the Motion,
- The adjournment of the discussion or the meeting
- That the meeting proceed to the next business (*)
- The appointment of an ad hoc committee to deal with a specific item of business
- That the Motion be now put (*)
- A Motion 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 member who has not previously taken part in the debate and who is eligible to vote.

No amendment to the Motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the Motion.

3.22 **Chairman's Ruling** - Statements of members of the Council of Governors made at meetings of the Council of Governors shall be relevant to matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

3.23 **Voting** - every question at a meeting shall be determined by either a majority of the votes of the Governors present, qualified to vote on the issue and voting on the question unless the Constitution requires otherwise. In the case of the number of votes for and against a Motion being equal, the Chairman of the meeting, or the person presiding over that issue if the Chairman is absent, shall have a second or casting vote.

3.24 All questions put to the vote shall, at the discretion of the Chairman 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 Governors present so request.

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

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

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

3.28 A person attending the Council of Governors to represent a Governor during a period of incapacity or temporary absence without formal appointment as a Governor may not exercise the voting rights of the Governor. A person's status when attending a meeting shall be recorded in the minutes.

- 3.29 **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.
- 3.30 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.
- 3.31 Minutes shall be circulated in accordance with Governors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public as required by Code of Practice on Openness in the NHS.
- 3.32 **Variation and Amendment of Standing Orders** – will be undertaken in accordance with paragraph 46 of the Constitution.
- 3.33 **Record of Attendance** – the names of the Chairman and Governors present at the meeting shall be recorded in the minutes.
- 3.34 **Quorum** – No business shall be transacted at a meeting unless at least one third of the whole number of the Governors are present, ~~the majority of whom are from the public constituency, including at least five Public Governors, two Staff Governors and two appointed Governors~~. If at any meeting there is no quorum within 30 minutes of the time fixed for the start of the meeting, the meeting shall stand adjourned for 7 days and upon reconvening, those present shall constitute a quorum.
- 3.35 If the Chairman or Governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Orders 6 or 7) he 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. The meeting must then proceed to the next business.

4. ARRANGEMENTS FOR DELEGATION

- 4.1 **Committees** – The Council of Governors shall agree from time to time to the delegation of matters for consideration by committee, or sub-committees which it has formally constituted in accordance with the Constitution. The constitution and terms of reference of these committees or sub-committees and their specific powers shall be approved by the Council of Governors. Such committees and subcommittees shall be advisory only and not decision-making.
- 4.2 **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 the non-compliance, shall be reported to the next formal meeting of the Council of Governors for action or ratification. All members of the Council of Governors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chairman as soon as possible.

5. COMMITTEES

- 5.1 Subject to any guidance or best practice advice as may be issued by Monitor, the Council of Governors may and, if directed by Monitor, shall appoint committees of

the Council of Governors to assist it in the proper performance of its functions, consisting wholly or partly of the Chair, Governors, and others, including Advisers.

- 5.2 A committee appointed under Standing Order 5.1 may, subject to such directions as may be given by the Council of Governors, appoint sub-committees consisting wholly or partly of members of the committee.
- 5.3 These Standing Orders, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council of Governors with the terms "Chairman" to be read as a reference to the Chairman of the committee, and the term "Governor" to be read as a reference to a member of the committee as the context permits. There is no requirement to hold meetings of committees, established by the Council of Governors in public.
- 5.4 Each such committee shall have such terms of reference and powers and be subject to such conditions as the Council of Governors shall decide and shall be in accordance with the 2006 Act, the Constitution, and any best practice advice and/or guidance issued by Monitor, but the Council of Governors shall not delegate to any committee any of the powers or responsibilities which are to be exercised by the Council of Governors at a formal meeting.
- 5.5 Where committees are authorised to establish sub-committees they may not delegate their powers to the sub-committee unless expressly authorised by the Council of Governors.
- 5.6 Any committee or sub-committee established under this Standing Order 5.1 may call upon outside advisers to assist them with their tasks including any Advisers, subject to the advance agreement of the Board of Directors.
- 5.7 The Council of Governors shall approve the appointments to each of the committees which it has formally constituted.
- 5.8 Where the Council of Governors is required to appoint persons to a committee to undertake statutory functions, and where such appointments are to operate independently of the Council of Governors, such appointments shall be made in accordance with applicable statute and regulations and with best practice advice and/or guidance issued by Monitor.
- 5.9 Where the Council of Governors determines that persons who are neither Governors, nor Directors or Officers of the Trust, shall be appointed to a committee, the terms of such appointment shall be determined by the Council of Governors subject to the payment of travelling expenses and other allowances being in accordance with such sum as may be determined by the Board of Directors.
- 5.10 The Council of Governors may appoint members to serve on joint committees with the Board of Directors or committees of the Board of Directors on the request of the Chair.
- 5.11 The Secretary or his deputy will attend all meetings of the Committees in support of them.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

- 6.1 **Declaration of interests** – The Constitution and the trust’s Code of Conduct requires Governors to declare interests which are relevant and material to the Council of Governors of which they are a member. All existing Governors should declare such interests. Any Governors appointed subsequently should do so on appointment.
- 6.2 Interests which should be regarded as “relevant and material” are:
- 6.2.1 Directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies).
 - 6.2.2 Ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
 - 6.2.3 Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.
 - 6.2.4 A position of trust in a charity or Voluntary Organisation in the field of health and social care
 - 6.2.5 Any connection with a voluntary or other organisation contracting for NHS services
 - 6.2.6 To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the NHS Foundation Trust, including but not limited to, lenders or banks.
 - 6.2.7 Any other commercial interest in the decision before the meeting
- 6.3 At the time Governors’ interests are declared, they should be recorded in the Council of Governors minutes. Any changes in interests should be declared at the next Council of Governors meeting following the change occurring.
- 6.4 Governors’ directorships of companies likely or possibly seeking to do business with the trust should be published in the Council of Governors Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.
- 6.5 During the course of a Council of Governors meeting, if a conflict of interest is established, the member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.
- 6.6 There is no requirement in the Code of Conduct for the interests of Governors’ spouses or partners to be declared. However Standing Order 7 requires that the interest of members’ spouses, if living together, in contracts should be declared. Therefore the interests of Governors’ spouses and cohabiting partners should also be regarded as relevant.
- 6.7 If Governors have any doubt about the relevance of an interest, this should be discussed with the Chairman. Financial Reporting Standard No 8 (issued by the Accounting Standards Council) specifies that influence rather than the immediacy

of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

- 6.8 **Register of Interests** – The Secretary will ensure that a register of interests is established to record formally declarations of interests of members. In particular the register will include details of all directorships and other relevant and material interests which have been declared by both elected and appointed members.
- 6.9 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.
- 6.10 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.

7. DISABILITY OF CHAIRMAN AND MEMBERS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

- 7.1 Subject to the following provisions of this Standing Orders, if the Chairman or a Governor 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 shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.
- 7.2 The Council of Governors may exclude the Chairman or a member of the Council of Governors from a meeting of the Council of Governors while any contract, proposed contract to other matter in which he has a pecuniary interest, is under consideration.
- 7.3 Any remuneration compensation or allowances payable to the Chairman or a member of the Council of Governors by virtue of the Constitution shall not be treated as a pecuniary interest for the purpose of this Standing Order.
- 7.4 For the purpose of this Standing Order the Chairman or a member of the Council of Governors shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:
 - a. He, or a nominee of his, 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 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 married persons living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

- 7.5 The Chairman or a member shall not be treated as having a pecuniary interest in any contract, proposed contract or any other matter by reason only:
- a. of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body; or
 - b. of an interest in any company, body or person with which he is connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a member in the consideration or discussion of or in voting on, any question with respect to that contract or matter.
- 7.6 Where the Chairman or a member of the Council of Governors 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 the total nominal value of these securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company body, whichever is the less, and if the share capital is of more than one class, the total nominal value of shares of any one class in which he has 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 duty to disclose his interest.
- 7.7 The Standing Order applies to a committee or sub-committee as it applies to the trust.

8. SENIOR INDEPENDENT DIRECTOR

- 8.1 The Council of Governors is entitled to be consulted by the Board of Directors on the appointment of the Trust's Senior Independent Director.
- 8.2 The role of the Senior Independent Director is as set out in the Trust's "Senior Independent Director Role Specification" as amended from time to time. For the avoidance of doubt the "Senior Independent Director Role Specification" does not form part of the Constitution.

9. LEAD GOVERNOR AND DEPUTY LEAD GOVERNOR

~~9.1 The Council of Governors will appoint a public Governor as the Lead Governor.~~

9.1 The appointment of the Lead Governor and Deputy Lead Governor will be made from those Governors who have been elected as Governors from the Public Constituency.

9.2 The role of the Lead Governor is as set out in the Trust's "Lead Governor Role Specification" as amended from time to time. For the avoidance of doubt the "Lead Governor Role Specification" does not form part of the Constitution.

9.3 The Deputy Lead Governor will take up the role and responsibilities of the Lead Governor on a temporary basis, in the event the Lead Governor is absent for any reason.

ANNEX 8 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

SECTION A

INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

SECTION B – STANDING ORDERS

1. INTRODUCTION
2. THE BOARD
3. MEETINGS OF THE TRUST
4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES
5. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION
6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS
7. DUTIES AND OBLIGATIONS OF DIRECTORS UNDER THE STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS
8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

SECTION A

1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

- 1.1 Save as otherwise permitted by law, at any meeting the Chairman of the trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive or Secretary to the Board).
- 1.2 All references in these Standing Orders to the masculine gender shall be read as equally applicable to the feminine gender and vice-versa.

SECTION B – STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

The trust is a public benefit corporation which was established under the 2006 Act on 1 March 2009.

- 1.1.1 The powers of the trust are set out in the 2006 Act subject to any restrictions in the Constitution or the License.
- 1.1.2 The Constitution requires the Board to adopt Standing Orders for the regulation of its proceedings and business. The trust must also adopt Standing Financial Instruction (SFIs) as an integral part of Standing Orders setting out the responsibility of individuals.
- 1.1.3 The trust will also be bound by such other statute, legal provisions and binding guidance from Monitor which governs the conduct of its affairs.
- 1.1.4 As a statutory body, the trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable.

1.2 Delegation of Powers

- 1.2.1 The powers of the trust shall be exercised by the Board of Directors on behalf of the trust.
- 1.2.2 Any of those powers may be delegated to a committee of Directors or to an Executive Director. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO 5) the trust is given powers to "make arrangements for the exercise, on behalf of the trust of any of their functions by a committee or subcommittee, or by an Officer of the trust, in each case subject to such restrictions and conditions as the trust thinks fit. Delegated Powers are covered in a separate document (Reservation of Powers to the Board and Delegation of Powers). This document has effect as if incorporated into the Standing Orders. Delegated Powers are covered in a separate document entitled – 'Schedule of Matters reserved to the Board and Scheme of Delegation' and have effect as if incorporated into the Standing Orders and Standing Financial Instructions.

2. THE BOARD

2.1 Composition of the Board

The composition of the Board shall be in accordance with the Constitution.

2.2 Appointment and Powers of Deputy Chairman

2.2.1 In accordance with paragraph 28 of the Constitution and subject to Standing Order 2.2.2 below, the Council of Governors may appoint a Non Executive Director, to be Deputy Chairman, for such period, not exceeding the remainder of his term as a member of the Board, as they may specify on appointing him.

2.2.2 Any Non Executive Director so appointed may at any time resign from the office of Deputy Chairman by giving notice in writing to the Chairman (in the Chairman's capacity as Chairman of the Board and the Council of Governors). The Council of Governors may thereupon appoint another Non Executive Director as Chairman in accordance with the provisions of Standing Order 2.2.1.

2.2.3 Where the Chairman of the trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chairman owing to illness or any other cause, the Deputy Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes their duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform those duties, be taken to include references to the Deputy Chairman.

2.3 Appointment and Powers of Senior Independent Director

2.3.1 Subject to Standing Order 2.3.2 below, the Board of Directors (in consultation with the Council of Governors) may appoint any Member of the Board, who is also a Non Executive Director, to be the Senior Independent Director, for such period, not exceeding the remainder of his term as a Member of the Board, as they may specify on appointing him. The Senior Independent Director shall perform the role set out in the Trust's "Senior Independent Director Role Description", as amended from time to time by resolution of the Board.

2.3.2 Any Non-Executive Director so appointed may at any time resign from the office of Senior Independent Director by giving notice in writing to the Chairman. The Chairman (in consultation with the other Non Executive Directors and the Council of Governors) may thereupon appoint another member of the Board as Senior Independent Director in accordance with the provisions of Standing Order 2.3.1.

2.4 Appointment and Powers of Deputy Chief Executive

The Chairman and Chief Executive may jointly appoint or remove one of the Executive Directors as the deputy chief Executive. The powers of the Deputy chief executive are defined in the Board's Scheme of Delegation.

2.5 Role of Directors

The Board will function as a corporate decision making body and Non Executive and Executive Directors will be full and equal Board members. Their role as members of the Board will be to consider the key strategic and managerial issues facing the trust in carrying out its statutory and other functions. In exercising these functions, the Board will consider guidance from Monitor "The NHS Foundation Trust Code of Governance" as amended from time to time.

2.6 Corporate role of the Board

2.6.1 All business conducted by the trust shall be conducted in the name of the trust.

2.6.2 All funds received in trust shall be held in the name of the trust as corporate trustee.

2.6.3 The powers of the trust established under statute subject to the License shall be exercised by the Board in private session except as otherwise provided for in Standing Order 3.

2.7 Schedule of Matters reserved to the Board and Scheme of Delegation

2.7.1 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to Officers and other bodies are contained in the Scheme of Delegation.

2.8 Lead Roles for Directors

2.8.1 The Chairman will ensure that the designation of Lead roles as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Director with responsibilities for Infection Control or Child Protection Services etc).

3. MEETINGS OF THE TRUST

3.1 Calling meetings

3.1.1 Meetings of the Board shall be held at regular intervals at such times and places as the Board may determine.

3.1.2 The Chairman may call a meeting of the Board at any time.

3.1.3 One third or more Directors of the Board may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the Directors signing the requisition may forthwith call a meeting.

3.2 Notice of Meetings and the Business to be transacted

3.2.1 Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every Director, or sent by

post to the usual place of residence of each Director, so as to be available to Directors at least three days before the meeting. The notice shall be signed by the Chairman or by an Officer authorised by the Chairman to sign on their behalf. Want of service of such a notice on any Director shall not affect the validity of a meeting.

3.2.2 In the case of a meeting called by Directors in default of the Chairman calling the meeting, the notice shall be signed by those Directors.

3.2.3 No business shall be transacted at the meeting other than that specified on the agenda, or emergency Motions allowed under Standing Order 3.6.

3.2.4 A Director desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman at least 15 days before the meeting. The request should include appropriate supporting information. Requests made less than 15 days before a meeting may be included on the agenda at the discretion of the Chairman.

3.2.5 In the event that a meeting of the Board is to be held in public pursuant to paragraph 3.17.1, 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 principal offices at least three days before the meeting.

3.3 Agenda and Supporting Papers

3.3.1 The Agenda will be sent to Directors five days² before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three days before the meeting, save in emergency.

3.4 Petitions

Where a petition has been received by the trust the Chairman shall include the petition as an item for the agenda of the next meeting.

3.5 Notice of Motion

3.5.1 Subject to the provision of Standing Orders 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to rescind a resolution', a Director of the Board wishing to move a Motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chairman.

3.5.2 The notice shall be delivered at least 10 clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any Motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

² See SO 3.2.1 and 3.2.5; the Notice should precede the Agenda.

3.6 Emergency Motions

3.6.1 Subject to the agreement of the Chairman, and subject also to the provision of Standing Order 3.7 'Motions: Procedure at and during a meeting', a Director of the Board may give written notice of an emergency Motion after the issue of the notice of 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 trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include the item shall be final.

3.7 Motions: Procedure at and during a meeting

3.7.1 Who may propose

A Motion may be proposed by the Chairman of the meeting or any Director present. It must also be seconded by another Director.

3.7.2 Contents of Motions

The Chairman may exclude from the debate at their discretion any such Motion of which notice was not given on the notice summoning the meeting other than a Motion relating to:

- the reception of a report;
- consideration of any item of business before the trust Board;
- the accuracy of minutes;
- that the Board proceed to next business;
- that the Board adjourn;
- that the question be now put.

3.7.3 Amendments to Motions

A Motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to Motions shall be moved relevant to the Motion, and shall not have the effect of negating the Motion before the Board.

If there are a number of amendments, they shall be considered one at a time. When a Motion has been amended, the amended Motion shall become the substantive Motion before the meeting, upon which any further amendment may be moved.

3.7.4 Rights of reply to Motions

- a) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original Motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) Substantive/original Motion

The Director who proposed the substantive Motion shall have a right of reply at the close of any debate on the Motion.

3.7.5 Withdrawing a Motion

A Motion, or an amendment to a Motion, may be withdrawn.

3.7.6 Motions once under debate

When a Motion is under debate, no Motion may be moved other than:

- an amendment to the Motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business;
- that the question should be now put;
- the appointment of an 'ad hoc' committee to deal with a specific item of business;
- that Director be not further heard;

In those cases where the Motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a Director of the Board who has not taken part in the debate and who is eligible to vote.

If a Motion to proceed to the next business or that the question be now put, is carried, the Chairman should give the mover of the substantive Motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.8 Motion to Rescind a Resolution

3.8.1 Notice of Motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director who gives it and also the signature of three other Directors, and before considering any such Motion of which notice shall have been given, the trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

3.8.2 When any such Motion has been dealt with by the trust Board it shall not be competent for any Director other than the Chairman to propose a Motion to the same effect within six months. This Standing Order shall not apply to Motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Chairman of meeting

3.9.1 At any meeting of the trust Board the Chairman, if present, shall preside. If the Chairman is absent from the meeting, the Deputy Chairman (if the Board has appointed one), if present, shall preside.

3.9.2 If the Chairman and Deputy Chairman are absent, such Director (who is not also an Executive Director of the trust) as the Directors present shall choose shall preside.

3.10 Chairman's ruling

The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling Motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.11 Quorum

3.11.1 No business shall be transacted at a meeting unless at least one-third of the whole number of the Chairman and Directors (including at least one Executive Director and one Non Executive Director) is present.

3.11.2 An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.11.3 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see Standing Order 7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.12 Voting

3.12.1 Save as provided in Standing Orders 3.13 - Suspension of Standing Orders and 3.14 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of Directors present and voting on the question. In the case of an equal vote, the person presiding (i.e.: the Chairman of the meeting) shall have a second, and casting vote.

3.12.2 At the discretion of the Chairman all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chairman directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

3.12.3 If at least one third of the Directors present so request, the voting on any question may be recorded so as to show how each Director present voted or did not vote (except when conducted by paper ballot).

3.12.4 If a Director so requests, their vote shall be recorded by name.

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

3.12.6 A manager who has been formally appointed by the Board to act up for a Director during a period of incapacity or temporarily to fill a Director vacancy as an Acting Director or Interim Director under paragraph 4 and 5 respectively of Annex 10 of the constitution shall be entitled to exercise the voting rights of the Director.

3.12.7 A manager attending the Board meeting to represent a Director during a period of incapacity or temporary absence who is not an acting Director or an interim Director for the purposes of the Constitution may not exercise the voting rights of the Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.13 Suspension of Standing Orders

3.13.1 Except where this would contravene any provision in the Constitution, the License, any statutory provision, any binding guidance issued by Monitor, or the rules relating to the Quorum (Standing Order 3.11), any one or more of the Standing Orders may be waived at any meeting, provided that at least two-thirds of the whole number of the Directors are present (including at least one Executive Director and one Non Executive Director) and that at least two-thirds of those Directors present signify their agreement to such suspension. The reason for and decision to waive shall be recorded in the trust Board's minutes.

3.13.2 A separate record of matters discussed during the waiver of Standing Orders shall be made and shall be available to the Chairman and Directors of the trust.

3.13.3 The Audit Committee shall review every decision to suspend Standing Orders.

3.14 Variation and amendment of Standing Orders

3.14.1 These Standing Orders shall only be varied in accordance with paragraph 46 of the Constitution.

3.15 Record of Attendance

The names of the Chairman and Directors present at the meeting shall be recorded.

3.16 Minutes

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

No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate.

3.17 Admission of public and the press

3.17.1 Board meetings shall be held in public but the whole or any part of a meeting may be held in private if the Board so resolves.

3.17.2 In that event members of the public and the press will be excluded from all or part of a Board meeting.

3.17.3 General disturbances

In the event that the public and press are admitted to all or part of a Board meeting pursuant to paragraph 3.17.1 and 3.17.2 above, the Chairman (or Deputy Chairman if one has been appointed) or the person presiding over the meeting shall give such directions as he thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the trust's business shall be conducted without interruption and disruption and, the public and/or press maybe required to withdraw from a Board meeting at any time and for any reason whatsoever.

3.17.4 Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the trust or Committee thereof. Such permission shall be granted only upon resolution of the trust.

3.18 Observers at trust meetings

The trust 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's meetings and may change, alter or vary these terms and conditions as it deems fit.

3.19 Meetings: electronic communication

3.19.1 In this SO, "electronic communication" means a communication transmitted (whether from one person to another, from one device to another or from a person to a device or vice versa): (a) by means of an electronic communications network; or (b) by other means but while in an electronic form.

3.19.2 A Director in electronic communication with the Chairman and all other parties to a meeting of the Board of Directors or of a committee or sub-committee of the Directors shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting he has the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

3.19.3 A meeting at which one or more of the Directors attends by way of electronic communication is deemed to be held at such a place as the Directors shall at the said meeting resolve. In the absence of such a

resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the Directors attending the meeting are physically present, or in default of such a majority, the place at which the Chairman of the meeting is physically present.

3.19.4 Meetings held in accordance with this SO are subject to SO 3.11 (Quorum). For such a meeting to be valid, a quorum must be present and maintained throughout the meeting.

3.19.5 The minutes of a meeting held in this way must state that it was held by electronic communication and that the Directors were all able to hear each other and were present throughout the meeting.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Subject to the Constitution, the Board shall appoint committees of the Board, consisting wholly of Directors.

4.2 Appointment of Committees

Subject to the Constitution, the trust Board may appoint committees of the trust.

The trust shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees.

4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the trust. In which case the term "Chairman" is to be read as a reference to the Chairman of other committee as the context permits, and the term "member" is to be read as a reference to a member of other committee also as the context permits. (There is no requirement to hold meetings of committees established by the trust in public.)

4.4 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.5 Delegation of powers by Committees to Sub-Committees

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board.

4.6 Approval of Appointments to Committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that

persons, who are neither members nor Officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.7 Committees established by the trust Board

The committees and sub-committees established by the Board may vary from time to time as per operational requirements, legislation and best practice. Their terms of reference may be obtained from the Secretary to the trust.

4.8 The Board of Directors may appoint persons to serve as members on joint committees with the Council of Governors or committees of the Council of Governors on the request of the Chairman.

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

5.1 Delegation of Functions to Committees, Officers or other bodies

Subject to the Constitution and License and such guidance as may be given by Monitor, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of Standing Order 4, or by an Officer of the trust, in each case subject to such restrictions and conditions as the trust thinks fit.

5.2 Emergency Powers and urgent decisions

The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 2.7) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two non-Executive Directors. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the trust Board for noting.

5.3 Delegation to Committees

The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or subcommittees, which it has formally constituted in accordance with the Constitution, the License, binding guidance issued by Monitor and the 2006 Act. The Constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board in respect of its sub-committees.

5.4 Delegation to Officers

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

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Finance Director to provide information and advise the Board in accordance with the Constitution, License and any statutory requirements, or provisions required by Monitor.

5.5 Schedule of Matters Reserved to the trust and Scheme of Delegation of powers

The arrangements made by the Board as set out in the "Scheme of Reservation and Delegation" of powers shall have effect as if incorporated in these Standing Orders.

5.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

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 the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All Directors of the trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy statements: general principles

The trust Board will from time to time agree and approve Policy statements/procedures which will apply to all or specific groups of staff employed by the trust. The decisions to approve such policies and procedures will be recorded in an appropriate trust Board minute and will be deemed where appropriate to be an integral part of the trust's Standing Orders and Standing Financial Instructions.

6.2 Specific Policy statements

Notwithstanding the application of Standing Order 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the Standards of Business Conduct policy for trust staff;
- the staff Disciplinary and Appeals Procedures adopted by the trust both of which shall have effect as if incorporated in these Standing Orders.

6.3 Standing Financial Instructions

Standing Financial Instructions adopted by the trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4 Specific guidance

Notwithstanding the application of Standing Order 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other binding guidance issued by Monitor:

- Caldicott Guardian 1997;
- Human Rights Act 1998;
- Freedom of Information Act 2000.

7. DUTIES AND OBLIGATIONS OF DIRECTORS UNDER THESE STANDING ORDERS

7.1 Declaration of Interests

7.1.1 Requirements for Declaring Interests and applicability to Board Directors

- (a) All existing Board Directors should declare any relevant and material interests. Any Director appointed subsequently should do so on appointment.

7.1.2 Interests which are relevant and material

- (a) Interests which should be regarded as "relevant and material" are defined under paragraph 34 of the Constitution.
- (b) Any Director who comes to know that the trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Director shall declare his/her interest by giving notice in writing of such fact to the trust as soon as practicable.

7.1.3 Advice on Interests

If Board Directors have any doubt about the relevance of an interest, this should be discussed with the Chairman or with the Secretary.

Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.1.4 Recording of Interests in trust Board minutes

At the time Directors' interests are declared, they should be recorded in the trust Board minutes.

Any changes in interests should be declared at the next trust Board meeting following the change occurring and recorded in the minutes of that meeting.

7.1.5 Publication of declared interests in Annual Report

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

7.1.6 Conflicts of interest which arise during the course of a meeting

During the course of a Board meeting, 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.

7.2 Register of Interests

7.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board or Committee Directors. In particular the Register will include details of all directorships and other relevant and material interests (as defined in SO 7.1.2) which have been declared by both executive and non-executive trust Board Directors.

7.2.2 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.

7.2.3 The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

7.3 Exclusion of Chairman and Directors in proceedings on account of pecuniary interest

7.3.1 Definition of terms used in interpreting 'Pecuniary' interest

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

- (a) "spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);
- (b) "contract" shall include any proposed contract or other course of dealing.
- (c) "Pecuniary interest"

Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-

- (i) he/she, or a nominee of his/her, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or

- (ii) he/she is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

(d) Exception to Pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract if:-

- (i) neither he/she or any person connected with him/her has any beneficial interest in the securities of a company of which he/she or such person appears as a member, or
- (ii) any interest that he/she or any person connected with him/her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract, or
- (iii) those securities of any company in which he/she (or any person connected with him/her) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (iii) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.1.2 (ii).

7.3.2 Exclusion in proceedings of the trust Board

- (a) Subject to the following provisions of this Standing Order, if a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.
- (b) The Board may exclude a Director from a meeting of the Board while any contract, proposed contract or other matter in which he has a pecuniary interest is under consideration.
- (c) Any remuneration, compensation or allowance payable to a Director.
- (d) This Standing Order applies to a committee or subcommittee as it applies to the trust.

7.4 Standards of Business Conduct

7.4.1 Trust Policy

All trust staff and Directors must comply with the trust's Standards of Business Conduct Policy. This section of standing orders shall be read in conjunction with this document.

7.4.2 Interest of Officers in Contracts

- (a) Any Officer or employee of the trust who comes to know that the trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 7.3) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or trust's Secretary as soon as practicable.
- (b) An Officer should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the trust.
- (c) The trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7.4.3 Canvassing of and Recommendations by Directors in Relation to Appointments

- (a) Canvassing of Directors or 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.
- (b) Directors 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.

7.4.4 Relatives of Directors or Officers

- (a) Candidates for any staff appointment under the trust shall, when making an application, disclose in writing to the trust 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 liable to instant dismissal.
- (b) The Chairman and every Director and Officer of the trust shall disclose to the Board any relationship between himself and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the trust Board any such disclosure made.
- (c) On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the trust whether they are related to any other Director or holder of any office under the trust.

- (d) Where the relationship to a Director/Officer of the Trust is disclosed, the Standing Order headed 'Disability of Chairman and Directors in proceedings on account of pecuniary interest' (Standing Order 7) shall apply.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 Custody of Seal

The common seal of the trust shall be kept by the Chief Executive or a nominated Officer by him/her in a secure place.

8.2 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two Directors or a Director and the Secretary duly authorised by the Board.

8.3 Register of Sealing

The Chief Executive shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document.

8.4 Signature of documents

Where any document will be a necessary step in legal proceedings on behalf of the trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents will be delegated to Officers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

ANNEX 9 – STATEMENT OF TRUST PRINCIPLES

The West Suffolk NHS Foundation Trust will operate within a governance framework which reflects best practice within the NHS. In particular it will adopt the seven principles of public life, determined by the Nolan Report. It will also from time to time develop mission statements, corporate values, codes of conduct and other governance statements.

Nolan Principles: - the seven principles of public life

1. **Selflessness:** Holders of public office should take decisions solely in terms of the public interest. They should not do so to gain financial or other material benefit for themselves, their family or their friends.
2. **Integrity:** Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.
3. **Objectivity:** In carrying out public business, including making public appointments, awarding contracts or recommending individuals for rewards and benefits, holders of public office should make choice on merit.
4. **Accountability:** Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
5. **Openness:** Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
6. **Honesty:** Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
7. **Leadership:** Holders of public office should promote and support these principles by leadership and example.

ANNEX 10 – FURTHER PROVISIONS

1. Trust Secretary

- 1.1 The trust shall have a Secretary who may be an employee. The Secretary may not be a Governor, or the Chief Executive or the Finance Director.
- 1.2 Minutes of every meeting of the Council of Governors and of every meeting of the Board of Directors are to be kept by the Secretary.
- 1.3 The Secretary is to be appointed and removed by the Chairman and Chief Executive acting jointly.

2. Vacancy of Governor or Director position

- 2.1 The validity of any act of the trust is not affected by any vacancy among the Directors or the Governors or by any defect in the appointment of any Director or governor.

3. Absent Director

- 3.1 If:
 - 3.1.1 an Executive Director is temporarily unable to perform his/her duties due to illness or some other reason (the "Absent Director"); and
 - 3.1.2 the Board of Directors agree that the duties of the Absent Director need to be carried out;then the Chairman (if the Absent Director is the Chief Executive) or the Chief Executive (in any other case) may appoint an acting Director as an additional Director to carry out the Absent Director's duties temporarily.
- 3.2 For the purposes of paragraph 3.1 of this Annex, the number of Directors appointed under paragraph 23.2.3 of the Constitution shall be relaxed accordingly.
- 3.3 The acting Director will vacate office as soon as the Absent Director returns to office or, if earlier, the date on which the person entitled to appoint him under this paragraph notifies him that he is no longer to act as an acting Director.
- 3.4 The acting Director shall be an Executive Director for the purposes of the 2006 Act. He shall be responsible for his/her own acts and defaults and he shall not be deemed to be the agent of the Absent Director.

4. Vacant Positions

- 4.1 If:
 - 4.1.1 an Executive Director post is vacant ("Vacant Position"); and
 - 4.1.2 the Board of Directors agree that the Vacant Position needs to be filled by an interim postholder pending appointment of a permanent postholder, then the Chairman (if the Vacant Position is the Chief Executive) or the

Chief Executive (in any other case) may appoint a Director as an interim Director (“Interim Director”) to fill the Vacant Position pending appointment of a permanent postholder.

4.2 The Interim Director will vacate office on the appointment of a permanent postholder or, if earlier, the date on which the persons entitled to appoint him under this paragraph notifies him that he is no longer to act as an Interim Director.

4.3 The Interim Director shall be an Executive Director for the purposes of the 2006 Act.

5. Title of “Director”

5.1 The trust may confer on senior staff the title “Director” as an indication of their corporate responsibility within the trust but such persons will not be Directors of the trust for the purposes of the 2006 Act (“statutory Directors”) unless their title includes the title “Chief” or “Executive” or “Non Executive Director” or “Chair” or “Chairman” and will not have the voting rights of statutory Directors or any power to bind the trust.

6. Disqualification of membership

6.1 An individual may not become or continue as a member of the Trust if:

6.1.1 the individual has been specifically excluded in writing from any of the Trust’s premises or other facilities in whole or in part following a decision of the Board of Directors that such a course of action is necessary because, for example, the individual concerned has been violent, aggressive or has committed an act of gross misconduct; or

6.1.2 the Board of Directors considers that an individual has or is likely to cause harm or detriment to the Trust and after the Trust has consulted with or made reasonable efforts to consult with the individual about the concerns of the Board and the Board notifies the individual about his disqualification accordingly.

6.2 Notwithstanding anything contained in this Constitution, no person who ceases to be a member of the Trust pursuant to paragraph 6.1.1 or 6.1.2 above shall be re-admitted to membership except by a decision of the Board of Directors.

6.3 It is the responsibility of Members to ensure their eligibility and not the trust, but if the trust is on notice that a Member may be disqualified from membership, they shall carry out all reasonable enquiries to establish if this is the case.

7. Termination of membership

7.1 A member shall cease to be a member if that member:

7.1.1 resigns by notice to the Secretary or the Chief Executive;

7.1.2 ceases to fulfill the requirements of paragraph 6 or 7 of the Constitution;

7.1.3 is disqualified under any other provision of this constitution;

7.1.4 dies; or

7.1.5 the Council of Governors, having made reasonable enquiries, determines that the member no longer wishes to be a member or he ceases to be eligible as a member for whatever reason.

TO:	Council of Governors
MEETING DATE:	8 February 2017
SUBJECT:	Register of Governors' Interests
AGENDA ITEM:	16
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	2 February 2017
FOR:	Review

1. Introduction

The Register of Governors' Interests should be formally reviewed and updated on an annual basis.

At each Council of Governors meeting declarations are also received for items to be considered as part of the agenda.

Confirmation of interests are outstanding for:-

Margaret Rutter

2. Recommendation

The Council of Governors receives and notes the updated Register of Governors' Interests.

Individual Governors are reminded of their responsibility to inform the Chairman or Trust Secretary of any changes to their defined interests.

REGISTER OF GOVERNORS' INTERESTS

The register of governors' interests is constructed and maintained pursuant to the National Health Service Act 2006. All governors should declare relevant and material interests. Any changes in interests should be declared at the next Council of Governors meeting following the change occurring.

Signed copies of individual governor's declarations are held by the Foundation Trust office.

Interests which should be regarded as "relevant and material" are:

1. Directorships, including Non Executive Directorships held in private companies or public limited companies (with the exception of those of dormant companies).
2. Ownership, part-ownership or Directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
3. Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.
4. A position of trust in a charity or voluntary organisation in the field of health and social care
5. Any connection with a voluntary or other organisation contracting for NHS services
6. To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the NHS Foundation Trust, including but not limited to, lenders or banks.
7. Any other commercial interest in the decision before the meeting

Supplementary Information:

In the case of spouses and cohabiting partners the interest of the spouse/partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

	Declared Interest	Date Reviewed
Trust Chairman		
Roger Quince	Non-Executive Director, SQW Group Ltd (subsidiaries are SQW Ltd and IO Services) Chair, Theatre Royal Bury St Edmunds Management Committee Trustee, Emmaus Ipswich Ltd	8 February 2017
Staff Governors		
Jane Chilvers	Nil	8 February 2017
Nick Finch	Nil	8 February 2017
Peter Harris	Nil	8 February 2017
Jenny McCaughan	Nil	8 February 2017

	Declared Interest	Date Reviewed
Lindsay Pike	Nil	8 February 2017
Nominated Partner Governors		
Judy Cory	Vice Chairman, Friends of West Suffolk Hospital Trustee, Friends of West Suffolk Hospital	8 February 2017
Jon Eaton – resigned from CoG 02/02/2017	Team Leader – Communities at Community Action Suffolk, Brightspace, Hadleigh Road, Ipswich IP2 0HH	9 February 2016
Dr Mark Gurnell	Council member – UK Society for Endocrinology	8 February 2017
Cllr Rebecca Hopfensperger	Suffolk County Councillor Suffolk County Council – Cabinet member responsible for Adult Care – this involves health and social care Husband – Paul Hopfensperger is Director of Body & Mind Studio Ltd, The Wellness Centre, 16 Risbygate Street, Bury St Edmunds, IP33 3AA	8 February 2017
Laraine Moody	Governor of Connect Education Business in Ipswich (charity)	8 February 2017
Cllr Sara Mildmay-White	St Edmundsbury Borough Councillor	8 February 2017
Public Governors		
Mary Allan	Nil	8 February 2017
June Carpenter	Member of Bildeston Health Centre Patient Participation Group	8 February 2017
Jean Cawrse – resigned from CoG 19/03/2016	Nil	9 February 2016
Ian Collyer	I am a volunteer car driver for East of England Ambulance Service, who has a contract with West Suffolk Hospital to take patients to and from the hospital. This includes patients for OPD, Day Surgery, admissions and discharges	8 February 2017
Justine Corney	Directorships: Lavenham Community Council Lavenham Community Land Trust	8 February 2017
Dr David Frape	Managing Editor of the International Scientific Review Journal – voluntary, no financial gain	8 February 2017

	Declared Interest	Date Reviewed
Jayne Gilbert	Nil	8 February 2017
Barry Moult	Director East Anglian Association of Grace Baptist Churches Employee at Colchester Hospital University Foundation Trust	8 February 2017
Charles Nevitt	Nil	8 February 2017
Steve Ohlsen – resigned from CoG 21/07/2016	<p>Managing Director and joint owner (with my wife) of Abbot Health Solutions Ltd (AHS) – a small consultancy company, providing healthcare companies with advice and key opinion leader contacts in the areas of public health, cardiology, cancer and behaviour change.</p> <p>I own and manage Abbot Health Solutions Ltd – a healthcare consultancy that may do business with the NHS if approached by local authorities, CCGs or Trusts – but I am more likely to be working for medical diagnostic, pharmaceutical or occupational health providers.</p> <p>Consultancy work with Alere Ltd (Medical Diagnostic supplier) and AXA PPP (occupational health services)</p>	9 February 2016
Janice Osborne	Babergh District Councillor	8 February 2017
Joe Pajak	<p>I am a Director of Flexpace Limited – which provides education leadership and governance consultancy and advice to charities, schools, colleges and local authorities.</p> <p>I act as an education leadership and governance adviser/consultant and currently have a professional relationship with Livability (a national disability charity) http://www.livability.org.uk/.</p> <p>My consultancy services are on occasions contracted through other providers; in particular, through Veredus and Capita (interim management services).</p>	8 February 2017
Margaret Rutter	Treasurer – Thetford Friends of St Nicholas Hospice Care	9 February 2016
Mick Smith	Nil	8 February 2017
Liz Steele	Nil	8 February 2017
Stuart Woodhead	Director and owner of Pope Woodhead Property Ltd.	8 February 2017

REPORT TO:	Council of Governors
MEETING DATE:	8 February 2017
SUBJECT:	Appointment of Lead Governor
AGENDA ITEM:	17
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	30 January 2017
FOR:	Approval

1. Background

It was agreed at the Council of Governors meeting on 16 November 2016, that the election of a Lead Governor would take place at the meeting on 8 February 2017.

In accordance with the process agreed at that meeting nominations were invited from the Public Governors for the role, the closing date for these being 27 January 2017.

2. Nominations

Only one nomination statement (maximum 100 words) was received from June Carpenter:-

An important role of the lead governor is to encourage dialogue between the governors, CEO, Chair, NED's, staff and patients to ensure that WSH maintains its excellent standard of care. Working with these groups takes time, patience and commitment.

I have developed an understanding of the responsibilities and requirements of this interesting role and try to encourage governors to participate in all the training and activities available to understand the success and challenges faced by the Trust in providing first class care for the patients who using our successful hospital.

3. Recommendation

Governors are asked to approve the appointment of June Carpenter as Lead Governor for the remainder of the vacated term (until November 2018). This is subject to the Lead Governor standing and being re-elected as a public governor in November 2017.

REPORT TO:	Council of Governors
MEETING DATE:	8 February 2017
SUBJECT:	Report from Engagement Committee Meeting held on 12 January 2017
AGENDA ITEM:	19(i)
PRESENTED BY:	Jan Osborne, Chair of Engagement Committee
FOR:	Information

The attached minutes summarise discussions that took place at the Engagement Committee meeting on 12 January 2017.

Recommendation

Governors receive the minutes for information.

DRAFT

MINUTES OF THE COUNCIL OF GOVERNORS

ENGAGEMENT COMMITTEE

HELD ON THURSDAY 12 JANUARY 2017, 5.00pm

IN THE COMMITTEE ROOM AT WEST SUFFOLK HOSPITAL

COMMITTEE MEMBERS		Attendance	Apologies
Janice Osborne (JO) - Chair	Public Governor	•	
June Carpenter (JC)	Public Governor (Interim Lead Governor)	•	
Ian Collyer (IC)	Public Governor		•
Jayne Gilbert (JG)	Public Governor		•
Laraine Moody	Partner Governor	•	
Margaret Rutter (MR)	Public Governor		•
In attendance			
Ali Bailey	Head of Communications		
Georgina Holmes (GH)	FT Office Manager		
Richard Jones (RJ)	Trust Secretary / Head of Governance		

17/01 APOLOGIES

Apologies for absence were noted as above. The Committee sent their best wishes to Margaret Rutter who was currently an inpatient at WSH.

17/02 MINUTES OF MEETING HELD ON 13 OCTOBER 2016

The minutes of the meeting held on 13 October 2016 were agreed as a true and accurate record.

17/03 MATTERS ARISING ACTION SHEET

Ongoing actions:-

Ref 16 – feedback from West Suffolk College event. Laraine Moody reported this had been a great success and a number of students had shown an interest in health and wellbeing as well as signing to be volunteers. It had also provided a good opportunity to develop links between the college and NHS. A further event was being planned; Jan Osborne suggested that this should have even more focus on health and wellbeing and prevention.

Ref 29 – suggestion that Public Governors should attend staff engagement sessions to be followed up. June Carpenter had discussed this with Nick Finch and Peter Harris who felt that this could be useful occasionally, but not regularly.

Ref 36 – topics and speakers for AMM on 12 September to be discussed with Executive Directors. Richard reported that this had been discussed at the Executive Directors meeting yesterday and it was also on the agenda for their meeting tomorrow. One proposal was that Mr Sam Parsons, Orthopaedic Consultant should give a similar talk to the one he gave to the Board in November 2016, based on orthopaedics and frailty

Action

The completed actions were reviewed and there were no issues.

17/04 REVIEW OF ENGAGEMENT STRATEGY

It was agreed that the engagement objectives (1.2) should be linked with the objectives in the Trust's strategic framework. These would also link with the work plan of the Engagement Committee.

It was proposed that the wording should be amended to say "...the challenges faced by Trust and the local health and care services". There should also be more focus on health prevention and wellbeing.

The target membership by March 2017 (5500) had been exceeded and was currently 5946. It was agreed that it was not necessary for this figure to increase significantly and therefore the target membership to be achieved by March 2019 should be 6000. The target for under 50s (1100) had also been exceeded and was currently 1176. It was proposed that this should be increased to 1250 by March 2019.

Richard Jones would amend the strategy for approval by the Council of Governors on 8 February and the Board on 3 March 2017.

R Jones

17/05 PUBLIC & MEMBER ENGAGEMENT

a) Communicating with the Public

Ali Bailey explained that the three year communication strategy would be going to the Trust Board meeting on 27 January. She reported that the media office had received a large number of enquiries recently, particularly about parking and bed pressures. The aim was to be very pro-active in high profile local media using positive stories around clinical excellence based on patient experiences.

Ali Bailey was asked to keep Governors informed of media coverage, eg TV and radio interviews. It was confirmed that Governors already received copies of press releases.

A Bailey

Laraine Moody proposed that students at West Suffolk College on health and social care courses should be encouraged to sign up as members and a membership form should be included in their induction pack. Ali Bailey suggested producing a membership form that was designed specifically for younger people. She also proposed reviewing the current membership form to make it quick and easy for people to complete. It was noted that NHSI required specific information on members, eg gender, age, ethnicity, disability.

A Bailey

b) Feedback from Courtyard Café

The feedback from Courtyard Café was reviewed and there were no major concerns. Comments continued to be very positive, with car parking spaces being the main issue.

17/06 ITEMS FOR INFORMATION ONLY

i) Membership Numbers

The membership numbers were reviewed and it was agreed that the focus should remain on increasing the number of members in the 16-50 age group. It was noted that currently there were over 1000 more female than male members, therefore it was agreed that there should also be a focus in increasing the number of male members.

ii) Draft Minutes of Patients and Carers Experience Group meeting – 22 December 2016

As Jayne Gilbert had given her apologies for today's meeting it was requested that the draft minutes should be circulated by email to members of this committee.

G Holmes

17/07 ISSUES FOR ESCALATION TO THE COUNCIL OF GOVERNORS

There were no issues for escalation.

17/08 ANY OTHER BUSINESS

Richard Jones explained that the structure of Quality Walkabouts was being changed so that fewer people took part and they were not so intrusive to areas visited. Governors taking part in Environmental Walkabouts had been reintroduced as an alternative.

It was also proposed that group visits to specific areas of the hospital should be reintroduced/arranged.

G Holmes

17/09 DATE OF NEXT MEETING

The next meeting would take place on Wednesday 29 March 2017 at 5.00pm.

COUNCIL OF GOVERNORS

ENGAGEMENT COMMITTEE – WORK PLAN

Proposal	Progress and detailed action	Lead	Timescale	Comments/Update
1. Communications with Members	<ul style="list-style-type: none"> • Members' Newsletter <ul style="list-style-type: none"> - Published two or three times a year, governors to provide input into content. - Topic driven engagement, eg quality accounts – include questionnaires, surveys etc in Members' Newsletter - Include item of interest for young people, eg profile of a role • Member Events <ul style="list-style-type: none"> - AGM/Talk– Apex, BSE - Medicine for Members – (2 or 3) <ul style="list-style-type: none"> - Cardiology – Stowmarket - Other topic & area to be agreed • Electronic Communication with Members <ul style="list-style-type: none"> - Utilisation of email 	Comms G Holmes G Holmes	Ongoing 12 Sept 2017 Ongoing	Governors to provide suggestions for content of newsletter Topic to be agreed Members encouraged to indicate if happy to receive information via email.
2. Other engagement approaches	<ul style="list-style-type: none"> • Courtyard Café - short questionnaire used to gain information on the public's expectations/ experiences of WSFT. Results fed back to FT Engagement Committee and Patient & Carers Experience Committee. <p>Issues or trends escalated to relevant Manager/department for response.</p>	G Holmes	Ongoing	Sessions booked for Jan-June 2017

Proposal	Progress and detailed action	Lead	Timescale	Comments/Update
	<ul style="list-style-type: none"> • Attend pre-organised events, eg Probus/U3A • Talk/presentation to WSC staff • Programme to support elections to ensure nominations for public and staff Governors • Encourage governors to consider other areas for engagement and recruitment • Include Membership leaflet specifically designed for young people in WSC induction packs for careers related to health and social care 	<p>G Holmes</p> <p>L Moody</p>		
3. Staff Engagement	<ul style="list-style-type: none"> • Staff governors to engage with staff members within their allocated area • Staff governors to communicate to staff via 'Green Sheet' 	Staff Governors	Ongoing	
4. Networking with other organisations to establish best practice in membership engagement, eg NHS Providers and other NHS FTs	<ul style="list-style-type: none"> • Networking at NHS Provider events 	Governors	Ongoing	

REPORT TO:	Council of Governors
MEETING DATE:	8 February 2017
SUBJECT:	Review of Engagement Strategy – April 2017 to March 2019
AGENDA ITEM:	19 (ii)
PRESENTED BY:	Jan Osborne – Chair of Engagement Committee
DATE PREPARED:	1 February 2017
FOR:	Approval

Introduction

The previous Engagement Strategy covered the period from April 2015 to March 2017. The strategy is reviewed annually and was last updated by the Council of Governors in February 2016.

The Engagement Committee of the Council of Governors reviewed the strategy at its meeting on 12 January 2017. The Committee agreed a number of updates to the strategy in order to ensure that the document was fit for purpose and reflected the FT membership recruitment and engagement strategies being used by the Trust.

The key changes to the document were:

- Linking the engagement objectives (1.2) with the objectives in the Trust's strategic framework. These would also link with the work plan of the Engagement Committee.
- A greater focus on health prevention and wellbeing.
- Updated membership targets for 2019
- The public constituency of the Trust (Appendix 1) has been amended to reflect the expansion of its membership area.

These revisions have been accepted by the Engagement Committee.

Recommendation

The Council of Governors receives this report and notes the revised strategy (attached) prior to submission to the Board of Directors. Implementation of the strategy will be driven through the work of the Engagement Committee.

Engagement Strategy

April 2017 to March 2019

Engagement Strategy

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1. Introduction

West Suffolk Hospital NHS Foundation Trust is committed to being a successful membership organisation and strengthening its links with the local community.

We recognise that we need to commit significant resources both in time and effort to developing our membership and engaging with the public and this strategy sets out the actions that we will take in support of this.

1.1 Purpose of strategy

This strategy outlines our vision and the methods we intend to use to maintain and build a representative and engaged public and staff membership. It also outlines our future plans in terms of recruitment and engagement and how we will measure the success of our membership and future engagement.

Delivery of the future plans set out in this strategy will be achieved through an agreed development plan with defined responsibilities and timescales for delivery.

This is an evolving strategy and will be subject to change as lessons are learnt.

1.2 Engagement objectives

Our vision for engagement within the Trust must underpin the organisational vision, priorities and ambitions. We should support the organisation in achieving the Trust's strategy with our aspirations for engagement.

Deliver for today

- Increase understanding amongst the public and members of the Trust's strategy and the range of services offered by it, including current changes in health services and the challenges the Trust and local health and care services are facing
- Maintain our existing membership base and ensure that it reflects the diversity of our local communities

Invest in quality, staff and clinical leadership

- Actively engage with the public and members to understand their views and aspirations for the Trust, including how it can develop and improve
- Through our representative membership learn from, respond to and work more closely with our patients, public, staff and volunteers to develop and improve our services

Build a joined up future

- Deliver a range of engagement events and activities to focus on engaging on and communicating the strategic plans for the Trust
- Through the range of events and contacts promote wellbeing

Through these objectives the Trust will develop a thriving and influential Council of Governors which is embedded in the local community, is responsive to the aspirations and concerns of the public and members, and works effectively with the Board of Directors.

2.0 The membership

Our Membership allows us to develop a closer relationship with the community we serve. It provides us with an opportunity to communicate with our members on issues of importance about our services.

We recognise that for the membership to be effective and successful, we must provide benefits and reasons for people to join us.

Our members will:

- be kept up to date with what is happening at the Trust by receiving the quarterly members' newsletter;
- be able to stand for election as a governor;
- have the opportunity to vote in the elections to the Council of Governors;
- be able to learn more about our services by attending member events, including Council of Governor meetings;
- have the opportunity to be included in consultation events on hospital and service developments – both internally for staff and externally for our patients and public;
- have the opportunity to pass on their views and suggestions to governors;
- be invited to attend the Annual Members' Meeting.

Membership is free and there is no obligation for members to get involved apart from receiving the quarterly newsletter.

2.1 Becoming a member

Our potential members can be drawn from the following:

- public, including patients who live within our membership area (**public members**)
- staff members and volunteers at the Trust (**staff members**)

An individual who satisfies the criteria for membership of the staff constituency may not become or continue as a member of the public constituency. Members can join more than one foundation Trust.

All members must be 16 years of age or over.

A person can become a member by:

- completing a membership application form, which is available on our website, by request from the membership office or from the hospital's main reception;
- joining 'online' via the Trust's website at www.wsh.nhs.uk;

- e-mailing membership. foundationtrust@wsh.nhs.uk;
- calling the membership office on 0370 707 1692.

2.2 Defining our membership

2.2.1 Public

Patients and members of the public who reside in the following areas are eligible to join our public constituency: Babergh (all wards); Braintree (selected wards); Breckland (selected wards); East Cambridgeshire (selected wards); Forest Heath (all wards); Ipswich (all wards); Kings Lynn and West Norfolk (selected wards); Mid Suffolk (all wards); South Norfolk (selected wards); St Edmundsbury (all wards); Suffolk Coastal (all wards) and Waveney (all wards).

Appendix 1 provides a detailed breakdown of eligible wards for our public constituency. Public members are recruited on an opt-in basis.

As we continue to develop and provide more services in out-of-hospital settings the Trust recognises that this may mean that services grow beyond the current boundaries of the organisation. Therefore the Trust expanded its membership area in 2016/17 and will continue to review this on an annual basis to ensure it is representative of the area served by the Trust.

2.2.2 Staff

To be eligible to be a staff member, people must either:

- be employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or have been continuously employed by the Trust under a contract of employment for at least 12 months; or
- exercise functions for the purposes of the Trust, without a contract of employment, continuously for a period of at least 12 months. For clarity this does not include individuals who exercise functions for the purposes of the Trust on a voluntary basis.

All staff automatically become members unless they choose to opt-out of the scheme.

3.0 Recruitment of members

We wish to encourage and develop a strong sense of community involvement with the membership. Therefore, we will continue to actively recruit new members.

Our aim is to have a membership that is informed and engaged in our activities and members who feel part of our organisation.

3.1 Methods of recruitment

Our initial membership recruitment drive began as an integral part of our consultation process.

While we undertook some direct mail recruitment campaigns in the early days, more recently we have found that the most effective method of recruitment is face to face. This can be done internally within hospital or out in the community.

Methods of recruitment used in the past include:

- attending public meetings and events including festivals, stands in sports & healthy living events and recruitment fairs;
- targeted recruitment of staff members' friends and family;
- using local newspapers;
- on-line recruitment through the Trust's website;
- through a mail-shot to all households in the membership area;
- in-house , eg Courtyard Café, Friends shop and outpatients

3.2 Who is responsible for recruiting members?

The Board of Directors has overall responsibility for the membership strategy.

The Engagement Committee of the Council of Governors advises on where the Trust should focus its effort on recruitment to ensure we have a balanced membership, and it is the responsibility of all governors and the FT Office Manager to actively recruit members.

Staff and volunteers are also encouraged to recruit members; for example family members, friends or patients and members of the public visiting the Trust.

3.3 Recruitment plan

We aim to recruit new members year on year to maintain our public membership at the current numbers of engaged members. As part of the recruitment plan experience has shown that engaging with the public is a very effective way of recruiting new members and gaining their views on West Suffolk Hospital.

3.3.1 Public members

Direct recruitment plan

- active engagement and recruitment within the hospital and other healthcare environments e.g. courtyard café, out-patient clinics and healthy living centres
- membership form with out-patient appointment letters
- providing literature to staff working in out-of-hospital settings to share with service users and their families
- public education events e.g. "medicine for members"

- voluntary organisations – ensuring inclusion from ethnic and marginalised groups of people
- education facilities e.g. school talks and college events
- local non-NHS patient groups e.g. support groups
- sports organisations e.g. leisure centres, rugby and football clubs
- PALS office
- Work with partner organisations to establish best practice in membership recruitment e.g. NHS Providers and other NHS FTs.
- Encourage former staff members to become public members on leaving the Trust

Indirect recruitment plan

- website
- consider inclusion with other patient information e.g. bedside lockers for inpatient areas
- posters and leaflets in clinic and outpatient areas
- posters in GP surgeries, dentists, opticians and pharmacists

Media coverage

- membership newsletter
- local newspaper coverage e.g. the Bury Free Press and East Anglian Daily Times (EADT)
- local radio e.g. Radio Suffolk, Radio West Suffolk
- community newsletter coverage, including Parish Council and local Council information/resource guides

3.3.2 Staff

Staff are automatically members unless they choose to opt-out. New members to the Trust will receive information from HR in their induction pack explaining the benefits of membership. An individual who satisfies the criteria for membership of the staff constituency may not become or continue as a member of the public constituency.

We will seek to ensure that no more than 1% of staff opt-out of membership.

4.0 Engaging with public and members

Engagement with our members is as important as recruitment, to ensure that we have an effective and active membership.

4.1 Members' newsletter

The membership newsletter is distributed to all members.

Staff are able to access the newsletter via a link which is included in weekly staff bulletin (Green Sheet) when it is published on the website.

Hard copies are also available in key staff areas including Time Out and in patient waiting areas.

The newsletter provides an opportunity to communicate key issues and developments, including news and “dates for the diary”.

4.2 Public and Member events

It is proposed to hold regular events for the public and members. Suggestions for topics will be based on the most popular areas of interest of the members and by the views of governors. Subjects may also be chosen from topical issues, such as quality accounts.

These events will be advertised in the members’ newsletter and on the website. They will also be advertised in the weekly staff bulletin (“Green Sheet”) and by posters displayed within the Trust.

Members who have expressed an interest in a particular service or area of interest will be invited to relevant activities.

4.3 Staff involvement

Staff members will be encouraged to take part in public and member events, as it is an opportunity for departments to raise awareness of the services they provide, to highlight benefits of being treated at the Trust and to answer questions from members. It will also be a chance for us to receive valuable feedback from the public and our members.

4.4 Engagement plan

Positive engagement with our members is extremely important. The Engagement Committee of the Council of Governors have considered how we can most effectively engagement with our membership.

As described member recruitment and engagement are often most effective when undertaken together. Therefore the direct recruitment plans set out in section 3.3.1 will also in effect provide effective engagement activities. Future engagement plans with our members will also include:

- the members’ newsletter to be distributed to all members;
- regular member events with suggestions from governors of recommendations from their members for future member events e.g. “medicine for members”
- staff governors holding staff member engagement sessions
- staff governors to communicate to staff via the “Green Sheet”
- greater use of electronic communication with members
- the annual members’ meeting – this is an opportunity for members to hear more about the Trust’s achievements plus the opportunity to ask questions
- working with partner organisations to establish best practice in membership engagement e.g. NHS Providers and other NHS FTs

- using a short questionnaire to gain information on the public's expectations and/or experiences of West Suffolk Hospital; the results of which will be fed back to the Patient & Carers Experience Committee.

In addition we are developing an active campaign to engage with a range of local groups and forums. Presentations at these forums will allow governors to communicate the Trust's vision, priorities and ambitions as described in our "Together strategy" and engage with the public to gain an understanding of their views.

The Trust also has a role to play in promoting prevention and a healthy lifestyle. This will be done by working with our partners to engage with the public in promoting prevention and a healthy lifestyle.

5.0 The membership register

We maintain a register of staff and public members and this is available to the public. All members are made aware of the existence of the public register and have the right to refuse to have their details disclosed (Data Protection Act).

The public register is maintained on our behalf by Capita and contains details of the member's name and the constituency to which they belong. Eligible members of the public constituency who complete a membership application form will be added to the register of members.

The staff register is maintained by the Trust's HR department. Eligible staff will automatically be added to the register, unless they 'opt out'.

The public register is validated prior to any mailing to ensure that it remains accurate. Details of members who have moved away or died are removed from the register.

6.0 Monitoring success

The membership strategy will be monitored on behalf of the Board of Directors by the Engagement Committee of the Council of Governors.

The FT Office Manager and the Engagement Committee will also undertake a key role in leading and managing the implementation of this strategy and its future development.

An annual review of the strategy will take place by the Engagement Committee.

6.1 How will the success be measured?

The success of the strategy will be measured by the following criteria:

Criteria	Current Jan 2017	Target (Mar 2019)
1. Achievement of the recruitment target: a. Total number of Public members b. Staff opting out of membership	5946 <1%	6000 <1%
2. Achieve a representative membership for our membership area, Priorities for action: a. Age – recruitment of under 50s b. Engagement and recruitment events in all market towns of Membership area (Thetford, Newmarket, Stowmarket, Haverhill and Sudbury)	1176 20%	1250 100%
3. An engaged membership measured by: a. number of member events held April 2015 – March 2017 b. member attendance – total all events c. annual members' meeting attendance (each year)	5 (+1 cancelled) 880 261	6 600* 200

* Includes people attending Annual Members' Meeting, does not include 57 who would have attended cancelled event

A review of the membership recruitment targets will be take place each year as part of the annual plan submission to Monitor.

Appendix 1

PUBLIC CONSTITUENCY OF THE TRUST

Babergh:	Alton, Berners, Boxford, Brett Vale, Brook, Bures St Mary, Chadacre, Dodnash, Glemsford and Stanstead, Great Cornard (North Ward), Great Cornard (South Ward), Hadleigh (North Ward), Hadleigh (South Ward), Holbrook, Lavenham, Leavenheath, Long Melford, Lower Brett, Mid Samford, Nayland, North Cosford, Pinewood, South Cosford, Sudbury (East Ward), Sudbury (North Ward), Sudbury (South Ward), Waldingfield.
Braintree:	Bumpstead, Hedingham and Maplestead, Stour Valley North, Stour Valley South, Upper Colne, Yeldham
Breckland:	Conifer, East Guiltcross, Harling and Heathlands, Mid Forest, Thetford-Abbey, Thetford-Castle, Thetford-Guildhall, Thetford-Saxon, Watton, Wayland, Weeting, West Guiltcross
East Cambridgeshire:	Bottisham, Burwell, Cheveley, Dullingham Villages, Fordham Villages, Isleham, Soham North, Soham South, The Swaffhams
Forest Heath:	All Saints, Brandon East, Brandon West, Eriswell & the Rows, Exning, Great Heath, Icen, Lakenheath, Manor, Market, Red Lodge, St Marys, Severals, South.
Ipswich	Alexandra, Bixley, Bridge, Castle Hill, Gainsborough, Gipping, Holywells, Priory Heath, Rushmere, St John's, St Margaret's, Sprites, Stoke Park, Westgate, Whitehouse, Whitton.
King's Lynn and: West Norfolk	Denton
Mid Suffolk:	Bacton & Old Newton, Badwell Ash, Barking & Somersham, Bramford & Blakenham, Claydon & Barham, Debenham, Elmwell & Norton, Eye, Fressingfield, Gislingham, Haughley & Wetherden, Helmingham & Coddensham, Hoxne, Mendlesham, Needham Market, Onehouse, Palgrave, Rattlesden, Rickinghall & Walsham, Ringshall, Stowmarket Central, Stowmarket North, Stowmarket South, Stowupland, Stradbroke & Laxfield, The Stonhams, Thurston & Hissett, Wetheringsett, Woolpit, Worlingworth.
South Norfolk:	Bressingham and Burston, Diss and Roydon
St Edmundsbury:	Abbeygate, Bardwell, Barningham, Barrow, Cavendish, Chedburgh, Clare, Eastgate, Fornham, Great Barton, Haverhill East, Haverhill North, Haverhill South, Haverhill West, Horringer and Whelnetham, Hundon, Ixworth, Kedington, Minden, Moreton Hall, Northgate, Pakenham, Risby, Risbygate, Rougham, Southgate, St Olaves, Stanton, Westgate, Wickhambrook, Withersfield

Suffolk Coastal

Aldeburgh, Deben, Felixstowe East, Felixstowe North, Felixstowe South, Felixstowe West, Framlingham, Fynn Valley, Grundisburgh, Hacheston, Kesgrave East, Kesgrave West, Kirton, Leiston, Martlesham, Melton, Nacton & Purdis Farm, Orford & Eyke, Peasenhall & Yoxford, Rendlesham, Saxmundham, The Trimleys, Tower, Wenhaston & Westleton, Wickham Market, Woodbridge.

Waveney

Beccles North, Beccles South, Blything, Bungay, Carlton, Carlton Colville, Gunton & Corton, Halesworth, Harbour, Kessingland, Kirkley, Lothingland, Normanston, Oulton, Oulton Broad, Pakefield, Southwold & Reydon, St Margaret's, The Saints, Wainford, Whitton, Worlingham, Wrentham.

REPORT TO:	Council of Governors
MEETING DATE:	8 February 2017
SUBJECT:	Report from Lead Governor
AGENDA ITEM:	20
PRESENTED BY:	June Carpenter, Lead Governor
FOR:	Information

As Governors of West Suffolk Hospital we are very lucky to have many opportunities available for us to learn and observe the workings of the trust but sadly these opportunities have a poor take up rate. Without participation in as many as possible of these events it can be difficult to make sense of the items raised at the CoG.

Training put on by the Trust is expensive so can I urge all governors to try and support these events.

Quality Walkabouts, Environmental Walkabouts, sessions in the Courtyard Cafe, attending members meetings and departmental visits are free and an excellent way of seeing the Trust at work and talking to those who use it.

Let's continue to help support the excellent working of our Trust.