South Tees Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS (PUBLIC)

Date – 2 April 2024
Time – 13:30
Venue – Room 10, STRIVE James Cook University Hospital

Safety and Quality First

South Tees Hospitals NHS Foundation Trust

MEETING OF THE SOUTH TEES HOSPITALS NHS FOUNDATION TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON TUESDAY 2 APRIL 2024 AT 13:30 IN ROOM 10, STRIVE, JAMES COOK UNIVERSITY HOSPTIAL

AGENDA

	ITEM	PURPOSE	LEAD	FORMAT
CHAIR'S BUSINESS				
1.	Welcome and Introductions	Information	Chair	Verbal
2.	Apologies for Absence	Information	Chair	Verbal
3.	Quorum and Declarations of Interest	Information	Chair	ENC 1
4.	Minutes of the last meetings held on 6 February 2024	Approval	Chair	ENC 2
5.	Matters Arising / action log	Review	Chair	ENC 3
6.	Group Chairman's report	Information	Group Chair	ENC 4
7.	Group Chief Executive's Report	Information	Group Chief Executive	ENC 5
SAFE				
8.	Safer Staffing report	Information	Chief Nurse	ENC 6
9.	Learning from deaths report	Information	Group Chief Medical Officer	ENC 7
EXPERIENCE				
10.	Freedom to speak up report	Information	FTSU Guardian	ENC 8
WELL LED				
11.	Constitution	Approval	Company Secretary	ENC 9
12.	Group Board delegation	Approval	Company Secretary	ENC 10

	ITEM	PURPOSE	LEAD	FORMAT
	DATE OF NEXT MEETING The next meeting of Board of Directors will take place on 17 September 2024.			

South Tees Hospitals NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS - 2 APRIL 2024			
Register of members interests			**AGENDA ITEM: ENC**
Report Author and Job Title:	Jackie White Head of Governance & Company Secretary	**Responsible Director:**	Derek Bell Chairman
Action Required	Approve ☐ Discuss ☐ Inform ☒ (select the relevant action required)		
Situation	The Board of Directors are asked to note interests declared by members of the Committee		
Background	The report sets out membership of the Board of Directors and interests registered by members. Conflicts should be managed in accordance to the Constitution para 32 - 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 other Directors.		
Assessment	There are no specific conflicts identified with the agenda. Members will be reminded at the meeting to raise any if they arise.		
Level of Assurance	Level of Assurance: Significant ☒ Moderate ☐ Limited ☐ None ☐		
Recommendation	The Board of Directors are asked to note the Register of Interest.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Best for safe, clinically effective care and experience ☒	A great place to work ☒	
	Deliver care without boundaries in collaboration with our health and social care partners ☒	Make best use of our resources ☒	
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒		

Board of Directors Register of Interests

Board Member	Position	Relevant Dates From	to	Declaration Details
Ada Burns	Non-Executive Director	2022	Ongoing	Role – Governor and Chair of the Board of Governors, Teesside University
Jackie White	Head of Governance & Company Secretary	March 2013	Ongoing	Registered with IMAS (NHS interim management & support)
		March 2023	Ongoing	Company Secretary of South Tees Healthcare Management Limited - Company number 10166808
Stacey Hunter	Group Chief Executive			No interests declared
Philip Sturdy	Director of Estates, Facilities and Capital Planning			No interests declared
Rachael Metcalf	Director of Human Resources	December 2020	Ongoing	Role of School Governor at High Tunstall College of Science
David Redpath	Non-executive Director	1 January 2021	Ongoing	Director of DGR Consultancy - Company number 10340661
		September 2022	Ongoing	South Tees Healthcare Management Limited - Company number 10166808.
		September 2017	Ongoing	Vice President Senior Executive Partner – Gartner
		July 2022	Ongoing	Deputy Chairman – Seaton Delaval Football Club
Michael Stewart	Chief Medical Officer	1 February 2021	Ongoing	No interests declared
Hilary Lloyd	Chief Nurse	15 February 2021	Ongoing	Visiting Professor at Sunderland – no monetary gain
		May 2023	Ongoing	Chief Nurse for Clinical Research Network NENC
Chris Hand	Chief Finance Officer	2 July 2021	Ongoing	Director of South Tees Healthcare Management Limited - Company number 10166808
				Client Representative ELFS Shared Services Management Board
Samuel Peate	Chief Operating Officer	1 April 2021	Ongoing	No interests declared
Prof Derek Bell	Group Chair	April 2020	Ongoing	Royal Medical Benevolent Fund
		April 2018	Ongoing	Tenovus Scotland (Edinburgh)
		April 2021	Ongoing	Centre for Quality in Governance
		July 2022	Ongoing	NHS South East London (SEL)
		March 2024	Ongoing	Member of the Council for Newcastle University. No remuneration.

Mark Dias	Non Executive Director	2014	Ongoing	Chartered Institute of Personnel & Development (CIPD)
		2014	Ongoing	Professional Code of Conduct Investigator
		20 July 2015	Ongoing	Director of Be The Change HR Ltd – Company No. 9694576
		21 June 2023	Ongoing	Chair – Workforce Committee, Seacole Group
		September 2023	Ongoing	Permanent Deacon in Training (Voluntary Position). Roman Catholic Diocese of Middlesbrough
Miriam Davidson	Non Executive Director	December 2022	Ongoing	Care and Health Improvement Programme (SLI) Advisor Occasional work with Local Government Association (LGA)
		July 2023	Ongoing	Interim Director of Public Health Darlington Council , (Part/time)
Alison Wilson	Non Executive Director	4 January 2022	Ongoing	Civil Partner – Counter Terrorism Policing North East
		2017	Ongoing	Son – Bupa Global and Bupa UK
		September 2022	Ongoing	South Tees Healthcare Management Limited - Company number 10166808.
Kenneth Readshaw	Non Executive Director	2016	Ongoing	Treasurer – Leyburn Community Leisure Club
		2018	Ongoing	Chair – Health Accommodation Trust
		2000	Ongoing	Chair – Horsehouse School Charity - Charity number: 513060
Rudolf Bilous	Associate Non Executive Director			Occasional teacher undergraduate and postgraduate medicine South Tees NHSFT (unremunerated) Data Monitoring Safety Committee for large International multinational Trial – funded by Boehringer via unrestricted grant through University of Oxford (3-4 virtual meetings per year) – Post is remunerated
Alyson Gerner	Associate Non Executive Director	2007	Ongoing	Senior Civil Servant working for a central government department – Department for Education Director of LocatED Property Ltd Member of Audit Committee and Remuneration Committee, Oak National Academy
Manni Imiavan	Digital Director			No interests declared

UNCONFIRMED MINUTES OF THE BOARD OF DIRECTORS MEETING HELD IN PUBLIC ON TUESDAY 6 FEBRUARY 2024 AT 13:30 IN ROOM 10 STRIVE

Present

Professor D Bell	Chairman
Ms A Burns	Non-Executive Director
Mr D Redpath	Non-Executive Director
Ms M Davidson	Non-Executive Director
Mr K Readshaw	Non-Executive Director
Ms A Wilson	Vice Chair / Non-Executive Director
Mr M Dias	Non-Executive Director
Ms S Hunter	Group Chief Executive
Dr M Stewart	Chief Medical Officer
Mr C Hand	Chief Finance Officer
Mrs R Metcalf	Director of HR

Associate Directors – non-voting

Professor R Bilous	Associate Non-Executive Director
Ms A Gerner	Associate Non-Executive Director

Directors – non-voting

Mrs J White	Head of Governance & Company Secretary
Mr M Imiavan	Digital Director
Mr P Sturdy	Director of Estates, Facilities and Capital Planning
Mr S Peate	Chief Operating Officer
Ms L Garcia	Deputy Chief Nurse on behalf of Dr Lloyd

In attendance

Mrs J Crampton	Lead Governor
Ms Roaqah Shaher	Staff side chair
Dr Di Monkhouse	Chair Senior Medical Staff Committee

STAFF STORY

Dr Amy Norrington, Constant Paediatric Anaesthetist and Lead for Paediatric Anaesthesia attended and gave a presentation on anaesthesia for children. Dr Norrington shared some lovely feedback from children, young people and families who had used the services and shared the work she is doing regionally and nationally in this area.

Ms Wilson commented that it was clear from the feedback that Dr Norrington was making a huge difference for patients and asked how the staff were feeling. Dr Norrington advised that the staff love it and are happy with the pathways and plans. She added that retention is high in the team with staff being involved in the changes.

Professor Bilous commented that the presentation was inspirational, and this tells us all about how South Tees is amazing and thanked Dr Norrington for sharing.

The Chairman asked regarding the pathway for emergency admissions and Dr Norrington advised that there is an urgent slot held every day in clinic and patients are seen in that way. She added that referrals come straight into the team and whoever is on call will see the patient. Emergencies is always a challenge as timescale is shorter.

Ms Hunter commented that this was a great story to share with the Board and well done on the work Dr Norrington had undertaken. She asked what will be next in terms of links into education and schools. Dr Norrington advised that the team don't do home visits but do go into schools to see children who will be attending the hospital. They also link with a number of charities and societies.

The Chairman on behalf of the Board of Directors thanked Dr Norrington for attending and sharing her staff story.

BoD/23/093 **WELCOME AND INTRODUCTIONS**

The Chairman welcomed members to the meeting, those in attendance and members of the public and welcomed Ms Hunter who joined the Trust to take forward the Group.

Ms Hunter commented that it had been around 3 months since her appointment, and it always seems a long time coming but it was great to be here. Her induction was going well, and she was managing to get out and about seeing staff and communities and partners. She is looking forward to the future.

BoD/23/094 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Dr Hilary Lloyd, Chief Nurse.

BoD/23/095 **QUORUM**

The meeting was quorate in line with the Constitution paragraph 4.39 "Quorum - No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of the Directors appointed, (including at least one non-executive director and one executive director) are present".

BoD/23/096 **DECLARATION OF INTEREST**

The Chairman referred members to the register of interests and asked members if there were any further declarations to be made not already included.

Mr Mark Dias declared a new interest not relevant for the agenda.

BoD/23/097 **MINUTES OF THE LAST MEETING**

The minutes of the meeting were reviewed and agreed as an accurate record. Mrs White

BoD/23/098 **MATTERS ARISING**

The maters arising were considered and updated.

BoD/23/099 **CHAIRMAN'S REPORT**

The Chair highlighted a number of issues from his written report including formally welcoming Ms Hunter to the Board. He highlighted that the Fit and Proper person test had been concluded and that the two Trusts were ahead in terms of implementing the new processes. The Chairman drew members attention to Maternity services and the CQC report, and that the recommendations will be picked up and monitored by the Quality Assurance Committee. He shared with members that the Council of Governors continue to meet together, and the Constitutions have been aligned across South Tees Hospitals NHS Foundation Trust and North Tees & Hartlepool NHS Foundation Trust. Finally, the Chairman referred to an education event which was scheduled for 21 February 2024 with all Universities who contribute to medical training and education of other colleagues. He added that this was the first time that this group has been brought together to share experiences. Teesside University continue to look at developing a bid for a new medical school on Teesside.

The Chairman took a moment to acknowledge the contribution Mr Harrison had made during the period covering as Chief Executive during January and the handover which was provided to Ms Hunter. He also thanked Ms Page who left in December following 4 years' service at the Trust.

Ms Hunter added that she met with the Deputy Head of Midwifery who described the support from the leadership team as phenomenal and this is testament to colleagues. She also added a thanks to colleagues who are giving up time to support her in her induction and all staff who she has met have been warm and welcoming.

Ms Wilson took the opportunity to update on the work of the Joint Partnership Board advising that it was progressing towards working as a group and the executive team consultation is coming to an initial conclusion and we need to continue to support staff. The other part of this work is the role of the non-executive directors which has just started, reviewing skills and experience and what might the future need to look like and we will do in a more collective way. Other governance work is now beginning to get some traction in terms of establishing the Group Board.

Ms Davidson updated on the CQC maternity inspection and on added that she attended the NENC LMLS meeting post

Ockenden learning event chaired by Sam Allen, which included 5 presentations from the Trust including bereavement suite and maternity voices.

Ms Hunter updated that Sam Allen had recently been appointed as Chair of the Maternity National Group and work is progressing on understanding taking this role forward.

RESOLUTION

The Board of Directors NOTED the Chairman's report.

BoD/23/100 **CHIEF EXECUTIVE'S REPORT**

Dr Stewart on behalf of Ms Hunter took the Chief Executive Report and commented on the maternity services inspection by the CQC specifically commenting on the transparency and accountability in maternity services reported as outstanding. He reminded members that the nomination stage of the nightingale awards is still available for colleagues to nominate. Dr Stewart highlighted that the Trust had received confirmation that it is the 2nd English centre to be awarded the contract for pectus surgery in conjunction with Liverpool Hospital for children and adults and this team has been awarded a research grant to help which children will benefit from this intervention. In addition, the Emergency Department in conjunction with Infection Prevention and Control have introduced a screening programme for treatable infectious diseases with Teesside which they will pilot for next 2 months.

Dr Stewart also gave thanks to Mr Harrison who brought broad based support to the Executive Team which they were all grateful for.

Ms Wilson asked how many patients the Trust would expect to see in the pectus service and Dr Stewart advised the business case was based on around 100 patients a year as it's a national case.

RESOLUTION

The Board of Directors NOTED the Chief Executive's update

BoD/23/101 **BOARD ASSURANCE FRAMEWORK**

Mrs White presented the Board Assurance Framework which had been updated in August following the Board session on strategic objectives, principle risks and risk appetite.

Mrs White highlighted that eight assurance reports were being presented to the Board today.

Ms Burns referring to Principal risk 5 Partnership Working – advised that a risk was emerging around financial health risk around local authority partnerships and impact on social care services and public health services and health and wellbeing and suggested the Trust review the level of risk in terms of partnership working, Ms Hunter concurred and suggested a form of words start to be worked up.

Mr Redpath commented that he was unsure on whether the gaps in assurance were moving in the right direction and that there has been some slippage in terms of dates which may not have been sighted on in terms of Resources Committee. Mrs White advised that there had been some slippage in some areas but that the Committee were sighted on the issues.

Ms Hunter commented on the cycle of business in relation to reviewing the risk appetite of the Trust and principle risks. Mrs White confirmed that there had been a Board development session, and this was discussed, and it is due for a refresh during May. The Chairman concurred and suggested that Digital and Partnership risks needed to be reviewed in more detail.

A number of queries were clarified as part of the discussion including external influences on the BAF risks which will be considered, R&D and education & training which needed further assurances added and further consideration in the Chairs Assurance Reports on how to capture in committee discussion.

The Chairman thanked colleagues for the discussion at Board on this item and agreed to build in further sessions on taking this forward.

RESOULUTION

The Trust Board of Directors NOTED the update

BoD/23/102 **INTEGRATED PERFORMANCE REPORT**

Mr Peate referred members to the Integrated Performance and highlighted the following:

The Trust is now CQC rated Good in all domains: safe, effective, responsive, caring and well led. Trust remains in segment 3, mandated support for significant concerns, due to the historic financial position.

For November, A&E 4-hour standard performance was affected by the early start of winter pressure demand in the region but did improve from October. Subsequently there

were also rises in ambulance handover delays, 12 hour delays following a decision to admit and 12 hour delays from arrival but as a proportion of attendances, the Trust significantly outperformed the regional and national trend.

Challenges within the social care sector continue to be observed with particular delays associated with timely access to domiciliary care.

During October, Elective access (RTT 18-week standard) was maintained and keeps performing ahead of the national trend. Extra focus is being given to reducing the number of patients waiting more than 65 weeks for non-urgent elective treatment, in line with national requirements. Total elective growth continued slightly behind plan but within that 1st OP appt activity was amongst the highest in the ICS.

Performance against the 6 week diagnostic standard showed a further marked improvement resulting from planned extra radiological capacity. The Trust returned to compliance against the national target for 28 day Faster Diagnosis Standard.

The Cancer 62-day accumulation continues to reduce and kept ahead of the planned improvement trajectory. The Cancer 62 day standard performs lower as treatment is prioritised for the longest waiters.

Finally, Mr Peate added that there will be 150 patients beyond 65 weeks waiting at end of financial year.

Dr Stewart commented on the medicine reconciliation and advised that this is the first month the Trust has reported the overall rate and rate in first 24 hours. Ideally this should be first 24 hour and this rate is low at 27%. He reminded colleagues that the service is not funded to do 7 day medicine reconciliation so it's unlikely that the rate will increase significantly. He added that there has been lots of sickness in the department and therefore this has impacted. In terms of pharmacy recruitment there was 40 applications for roles in the Trust which is the highest number of applications and with support from Finance the Trust has partially funded the business case to over recruit on this.

Ms Davidson added that this was discussed in a lot of detail at QAC as it does stand out and its helpful to hear this at Board. Professor Bilous added that the metrics and measurements have altered, and we asked that our pharmacy colleagues made that clear on the graph. We were hoping to see that things will start to pick up despite the change in the metric.

The Chairman asked if there is a quality issue for this in terms of patient risk and Dr Stewart advised that there was and that EPR doesn't help with medicine reconciliation as there is still a manual process. The broader issue on medication is that several metrics in the IPR need a review and comparing historically doesn't make sense and therefore we need a proposal to take this forward.

Mr Readshaw commented on the 12 hour waits on decision to admit which has gone down and Mr Peate added that on 5 December 2023 the Trust introduced the continuous flow model which means we have guaranteed number of beds for ED throughout the day, which was slightly hampered at start of December due to infection issues, but we have seen the impact just recently. Huge change process and further work to do.

The Chairman raised that the CDIF rates were above trajectory and other infections have increased and there is a regional and national picture on this too. Ms Garcia commented that the Trust hasn't had any MRSA reported in December and comparable to this time last year there is a reduction in CDIF. She added that when there has been an outbreak the Trust has contained it well and response rate from teams have been good. The regional picture is the same as ours.

Dr Stewart commented that the Trust is clear that the hospital is overcrowded, and this does affect the rate of infection. Dr Stewart advised that the Trust started a deep clean programme and had to pause during winter as the risk was higher and we intend to return to this from easter onwards, this also enables us to do de-cluttering ward by ward which all contributes. He added that he is concerned around the CDIF, but rate has slowed and that he is more worried about gram negatives as we are at risk of seeing an increase of this.

Ms Wilcon commented on the new NICE guidance on sepsis and if the Trust had had time to consider this and when it will make a change. Dr Stewart advised that the new guidance differentiates sepsis or likely sepsis, and this is one of the KPIs I think we should zero and start again. Dr Stewart added that it is likely that the changes will take 3-4 months to start to implement.

The Chairman commented that as we will be reviewing the IPR shortly we need to pick up the issues we have discussed previously and today with regard to the indicators.

RESOLUTION

The Board of Directors NOTED the update

BoD/23/103 **SAFE STAFFING REPORT**

Ms Garcia on behalf of Dr Lloyd presented the safe staffing report and highlighted that the percentage of shifts filled against the planned nurse and midwifery staffing across the Trust has decreased to 96.6% demonstrating continued good compliance with safer staffing.

Stretch staffing ratios in line with national guidance have been implemented where necessary based on skill mix, acuity, and occupancy levels, all these actions agreed by senior nurses through safe care meetings.

Nursing Turnover for December 23 has increased to 7.69%.

RESOLUTION

The Trust Board of Directors NOTED the update

BoD/23/104 **CONSULTANT APPOINTMENTS**

Dr Stewart updated the Board on the recent starters and leavers as follows:

No leavers

One new starter - Mona Sallam – Anaesthetics

RESOLUTION

The Trust Board of Directors NOTED the update

BoD/23/105 **LEARNING FROM DEATHS REPORT**

Dr Stewart referred members to the previously circulated report and highlighted that there had been159 deaths in October 2023 and 152 deaths in September 2023 – both average for the time of year. Rolling 12 month average mortality rate is 1.27 compared to 1.24 pre-pandemic. The Learning from Deaths dashboard shows that 2,009 of the 2,015 deaths that occurred between November 2022 and October 2023 were reviewed (99.7%).

SHMI at 110 (July 2022 – Jun 2023) is As Expected
560 Mortality Surveillance Reviews were completed in 2022/23. A further 279 reviews have been completed since April 2023 and 192 by the Nurse Reviewer

A number of queries were clarified as part of the discussion. It was noted that Palliative Care patients are not extracted from the SHMI, there is lots of work on coding being undertaken which will be discussed at the next Resources Committee, the themes relating to poor care relate to documentation, communication and coordination with learning being shared

and improvements due to be seen as part of the roll out of clinical noting.

RESOLUTION

The Trust Board of Directors NOTED the report

BoD/23/106 **FREEDOM TO SPEAK UP REPORT**

Mr Bennett, Deputy Director of Quality attended the Board with Ms Imire who has just taken on role as full time FTSU.

Mr Bennett highlighted a number of key issues including the number of concerns raised by colleagues to the FTSU Guardians in Q3 of 2023 was 27. Each concern can have multiple themes, with the top 5 themes identified in the report.

The Guardians team works to improve Speaking Up culture throughout the organisation, raising awareness of FTSU and other routes by which colleagues can raise concerns and continue to maintain strong links with Teesside University and the Regional and Guardians network including establishing links with our new Guardian colleague at North Tees.

Ms Burns, Senior Independent Director and FTSU Board Champion welcomed the appointed of Ms Imire and commented that she had conversations with Ms Scullion who is the Board Champion at North Tees & Hartlepool NHS Trust and advised that they are having a discussion on how to pull their thinking and approach together. Ms Burns also added that in future it would be useful to include how we measure the satisfaction of people who have been through process about the process. Mr Bennet agreed to include this in the next report.

Mr Dias advised members that the report had been considered at People Committee and was pleased to see the EDI element included in the report. He added it was good to see the link between FTUS and EDI from a lesson learnt perspective and feeding this into culture change.

The Chairman drew members attention to the ask for Board colleagues to undertake the FTSU training which is in addition to the Board training previously undertaken.

RESOLUTION

The Trust Board of Directors NOTED the report

BoD/23/107 **ORGAN DONATION REPORT**

Dr Steven Williams Clinical Lead Organ Donation and Rachel Eason Specialist Nurse Organ Donation attended the Board and presented the 6 monthly report on Organ Donation.

Members noted that the Trust had referred 81 patients to NHSBT's Organ Donation Services Team; 33 met the referral criteria and were included in the UK Potential Donor Audit. There was a further 1 audited patient that was not referred. In the first six months of 2023/24, from 8 consented donors the Trust facilitated 7 actual solid organ donors resulting in 16 patients receiving a lifesaving or life-changing transplant. Data obtained from the UK Transplant Registry. In addition to the 7 proceeding donors there was one consented donor that did not proceed.

A SNOD was present for 10 organ donation discussions with families during the first six months of 2023/24. There was 1 occasion where a SNOD was not present. When compared with UK performance, the Trust was average (bronze) for SNOD presence when approaching families to discuss organ donation.

Dr Williams raised with the Board that a Memorial for Dr Steve Bonner had been developed from donor charitable funds and the plans are being worked up with Dr Bonners wife. Dr Stewart thanked Dr Wiliams for bringing this to the attention of the Board which was very welcomed and justified given the contribution Dr Bonner made.

RESOLUTION

The Trust Board of Directors NOTED the report.

BoD/23/108 **FINANCE REPORT MONTH 9**

Mr Hand presented the month 9 finance report and members noted that the national annual planning timetable for 2023/24 was extended, with further submissions required on 4 May 2023. The Trust's plan for the 2023/24 financial year is now a deficit of £31.8m, reflecting the organisation's structural deficit (eg: The James Cook University Hospital PFI scheme) and inflationary pressures.

As part of the system-based approach to planning and delivery, the Trust's plan forms part of the NENC ICB system plan for 2023/24. The NENC ICB is currently planning on the basis of a net deficit of £49.9m for 2023/24.

The Month 9 position includes additional funding announced in November 2023 relating to Industrial Action that took place between April and November 2023. In line with NHSE guidance the month 9 position has applied IFRS16 to the Trust's PFI liabilities.

At Month 9 the reported position is a deficit of £23.5m at a system control-total level, which is in line with the year-to-date plan.

Ms Hunter asked Mr Hand how much of the overspend on pay is strike action and how much is run rate. Mr Hand advised that roughly a pressure of £500k per strike day of which there had been 39 strike days.

Mr Redpath commented that the ICB CIP ask is around 6% so around £45m for this Trust and a sizable increase from this year.

Ms Wilcon asked regarding the non-pay overspend on drug supplies and whether this is this a profile issue, Mr Hand confirmed that it was an element of high cost drugs and variation and demand.

RESOLUTION

The Trust Board of Directors NOTED the report

BoD/23/109 **PEOPLE PLAN**

Mrs Metcalf presented the Board of Directors with the People Plan and shared that this is the Trusts second People Plan, which sets out our approach to developing, strengthening and retaining our workforce over the next two years, 2023 to 2025.

Mrs Metcalf advised that in our first People Plan, we communicated that we wanted our colleagues to feel valued, equipped and empowered to provide the best possible experience and outcome for patients. That has not changed, and we firmly believe that our colleagues are at the heart of everything we do. This People Plan demonstrates how we can build upon the fantastic results we have already achieved to continue our improvement journey and remains critical in further developing our culture and underpinning our values in all that we do.

Our People Plan identifies the themes that will continue to bring out the very best in one another and to make the culture of South Tees Hospitals one that is compassionate and inclusive, whilst addressing our workforce challenges.

Mr Dias commented that he was really pleased with the plan which built on the work and transition and support for colleagues. He added that the People Committee were really pleased to recommend it to Board.

A number of comments were raised including that the Plan was comprehensive and accessible, and the presentation was really useful. The importance of recognising that we are in LGBTplus month, and how we celebrate and recognise this as part of the People Plan. The alignment with North Tees is really important and inevitable there is risk when you bring

two organisations together and how we balance progression and what might be impacting this process. This is one of the things we will need to pay attention to as a Board.

RESOLUTION

The Trust Board of Directors APPROVED the People Plan

BoD/23/110 **FIT AND PROPER PERSON UPDATE**

Mrs White referred members to her report and highlighted the Trust has prepared the documentation that is required to be signed by the Joint Chair and returned to NHSE to confirm the outcomes of the F&PPT guidance for 2023/24.

The Trust is operating under Group arrangements with North Tees & Hartlepool NHS Foundation Trust and the Joint Chair and Joint Chief Executive are hosted by North Tees & Hartlepool NHS Foundation Trust for payrolls and administrative purposed. A letter of confirmation has been sent to the Trust confirming the Joint Chair and Joint Chief Executive are fit and proper persons.

Following the reporting of this outcome to the Board of Directors and to ensure the F&PPT guidance is followed with regards to the governance process, this will be presented to the Council of Governors meeting on 20 February 2024 for information.

Once the required documentation has been signed off by the Joint Chair and submitted to NHSE, the Trust will be able to evidence that the Trust is compliant with Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 5 - people who have director level responsibility for the quality and safety of care, and for meeting the fundamental standards are fit and proper to carry out this important role.

Ms Hunter commented that it is likely the regulation of managers in the NHS will come to a definite point shortly.

RESOLUTION

The Trust Board of Directors APPROVED the Fit and Proper submission

BoD/23/111 **COMMITTEE REPORTS**

The Chairman offered the Chairs of Board Committees the opportunity to raise issues not already covered on the agenda:

QAC – Ms Davidson commented that QAC had received the mental health strategy and 6 month learning disability report.

People – Mr Dias commented that the People Committee had discussed the Gold Award for the Better Health at Work Awards, low uptake on vaccinations, health and wellbeing review into occupational health provision, AHP workforce plan and work on job planning, the increase in sickness absence and local clinical excellence awards.
Resources – Mr Redpath commented that the Committee had noted that CIP was on track with 63% delivered, procurement update and good work.
JPB – Ms Wilson commented that the process for executive colleague appointment had been agreed. Currently working through 1:1s and expectation in terms of phase 1 – statutory group roles appointed will be at the end of February. Phase 2 – further communications on this next week. Ms Hunter thanked colleagues for their engagement and professionalism during this process.

BoD/23/112 **DATE AND TIME OF NEXT MEETING**

The next meeting of the Board of Directors will take place on 2 April 2024.

Signed: …….

Date: ……

Date							
Date	Minute no	Item	Action	Lead	Due Date	Comments	Status (Open or Completed)
05.12.23	BoD/23/083	Safe Staffing Report	Ms Burns requested that the Board may have a staff story from the experience of international nurse	Company Secretary	asap		Open
06.02.24	bod/23/106	FTSU	Satisfaction levels to be included in future reports	Mr Bennett	Apr-24	On agenda	Open

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 2 APRIL 2024			
Joint Chairman's update			**AGENDA ITEM: 6, ENC 4**
Report Author and Job Title:	Jackie White Head of Governance & Company Secretary	**Responsible Director:**	Professor Derek Bell Joint Chairman
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	Joint Chairman's update		
Background	The following report provides an update from the Group Chairman.		
Assessment	The report provides an overview of the health and wider related issues.		
Recommendation	Members of the Trust Board are asked to note the contents of the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Best for safe, clinically effective care and experience ☒	A great place to work ☒	
	Deliver care without boundaries in collaboration with our health and social care partners ☒	Make best use of our resources ☒	
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒		

Group Chairman's Update

1. Introduction

This report provides information to the Board of Directors on key local, regional and national issues.

2. Key Issues and Planned Actions

Group Development and joint working

The Joint Partnership Board met on 21 February 2024 and 20 March 2024. Work is progressing regarding governance arrangements for the Group, and it was agreed to recommend to the statutory Boards delegation of those joint functions which were permissible. Work is progressing on the establishment of the clinical boards with a very good response for in all board positions. Shortlisting has been completed and interviews will take place in early April.

The Digital workstream is continuing with further engagement sessions taking place during March. An action plan is being developed following Community Digital Workshop for immediate priorities.

Finally work continues on engagement and communications for the Group. Dedicated communication messages to all staff centred around Group CEO and recruitment continue.

Group Non Executive roles

A number of discussions have been held with all non-executive and associate non-executive directors on the future group roles. A proposal on the process for appointment has been considered and agreed at a meeting in Common of the Nomination Committees. A recommendation for appointments will be considered at the end of March and recommended to the a meeting of the Council of Governors on 28 March 2024.

NHSE Chairs meeting

I attended the NHSE Chairs meeting and there were a number of key discussion points including productivity, priorities and focus and data. With regard to productivity the main challenge will be looking at productivity in broadest sense. For most Trusts there is a productivity gap with less than 10% of Trusts able to demonstrate increased productivity, most show a decline in productivity even corrected for demand, case mix and sickness absence. Agency costs showing some improvement but bank and temporary staff increasing. For 2024/25 in real terms funding is less, however funding for mental health services will be protected.

The focus on priorities remain 4 hour performance, ambulance handover, elective waiting times, 62 day cancer backlog and faster diagnosis. Latter two are closest to delivery.

Emphasis on intelligent use of data to improve quality of care, flow and performance was discussed including better evidence of use of data at Board level needed.

Other areas discussed including the National Clinical Director for mental health, National team visits to all stroke thrombectomy services, focus on health care acquired infection and bringing Maternity and neonatal services together with a focus on Martha's rules to be introduced by April 2024

NHS ICB chairs meeting

The NHS ICB and Trust Chairs meeting focus on was maintaining and progress on the fair shares principles across region recognising significant financial challenges. Recognising risks around digital and need to improve data sharing and the ICB estates strategy which is planned for end of March.

Engagement meetings

I have continued to meet with colleagues across the Trusts including spending half a day in Tees Community Services with Sarah from the Eston Community Nursing Team and had the opportunity to meet some wonderful patients who were receiving compassionate care from Sarah and other members of the team. I spent some time at Hartlepool One Life and the Friarage visiting the services there.

Education event

I was pleased to be able to host a meeting with the Universities who provide education and training to medical, nursing, allied health professions, science and technology and admin and management colleagues. The event was the first of many to start to look at the types of workforce we will need for the future and what training will be required.

3. Recommendation

The Board of Directors are asked to note the content of this report.

Professor Derek Bell
Group Chair

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 2 April 2024			
Chief Executive update			**AGENDA ITEM: 7 ENC 5**
Report Author and Job Title:	Jackie White Head of Governance & Company Secretary	**Responsible Director:**	Stacey Hunter Group Chief Executive
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	Chief Executive update		
Background	The following report provides an update from the Chief Executive.		
Assessment	The report provides an overview of the health and wider related issues.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of the Trust Board are asked to note the contents of the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Best for safe, clinically effective care and experience ☒	A great place to work ☒	
	Deliver care without boundaries in collaboration with our health and social care partners ☒	Make best use of our resources ☒	
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒		

1. Introduction

This report provides information to the Board of Directors on key local, regional and national issues.

2. National context

2.1 Supporting new standards for board members

Working with system colleagues and wider stakeholders, NHS England have published the new NHS leadership competency framework (LCF) for board level roles. The LCF will help inform the 'fitness' assessment in the FPPT in line with the recommendation made by Tom Kark KC in his Review of CQC Regulation 5: Fit and proper persons: directors, that NHS board members should meet specified standards of competence. It takes account of the NHS Long Term Workforce Plan, NHS People Promise and integrated care board (ICB) formation and will support the development of a diverse range of skilled and proficient leaders to deliver the best outcomes for our patients, workforce, and wider communities.

The LCF comprises a set of leadership competencies incorporating the skills, values and behaviours required in NHS board roles and establishes what good looks like in leadership terms, providing a new and consistent national standard of leadership.

The current NHS Chair appraisal framework (CAF) has been updated to include the new NHS leadership competency framework.

A new NHS board member appraisal framework (BMAF) will also be published, incorporating the LCF, by September 2024. The Trust in conjunction with North Tees & Hartlepool NHS Trust will look to be an early adopters of the framework.

2.2 Spring Budget Statement

The Chancellor of the Exchequer, The Right Honorable Jeremy Hunt MP delivered his Spring Budget statement on 6 March 2024 setting out measures to achieve the stated goal of driving higher growth and in turn, "more opportunity, more prosperity and more funding for our precious public services". The key announcements for health and care included:

- £2.5bn revenue funding in 2024/25 for the NHS to protect current funding levels in real terms and support the NHS to continue reducing waiting times and improve performance;
- £3.4bn capital funding over three years for technological and digital transformation in the NHS;
- £35m over three years to improve maternity safety across England.

The additional cash for 2024/25, will allow us to make progress on our key recovery priorities and the investment in technology and data offers will help deliver better services for patients and staff.

2.3 Independent Inquiry into the Issues Raised by the David Fuller Case

On 29 February 2024 the Trust received correspondence from the Chair of the Independent Inquiry into the issues raised by the David Fuller case. In November 2021 the Secretary of State for Health and Social Care announced an independent inquiry into the issues raised by the actions of David Fuller, an electrical supervisor who sexually abused the bodies of 101 women and girls in the mortuaries at Kent and Sussex hospital and Tunbridge Wells hospital between 2005 and 2020.

At the end of November, the report on Phase 1 of the Inquiry was published, which focused on matters relating to Maidstone and Tunbridge Wells NHS Trust and its system partners.

Phase 2 of the Inquiry has now been launched which will consider the wider NHS. This will be considering whether procedures and practices in NHS hospital settings across England, where deceased people are kept, are sufficient to safeguard the security and dignity of the deceased and would prevent the inappropriate access and opportunity to abuse the deceased that Fuller had.

The Trust in conjunction with North Tees & Hartlepool NHS Trust have completed a self assessment questionnaire which was considered by the Executive Director team and submitted to the enquiry on 15 March 2024.

2.4 Equality Diversity and Inclusion

Last week I, with lots of NHS colleagues, collectively raised concern at the racist, sexist and violent comments alleged to have been made by the Chief Executive of TPP. I was shocked at these comments and they should not be tolerated.

The last staff survey for the Trust for the key indicators in this theme relate to compassionate culture, compassioned leadership, diversity, equality and inclusion show that our results are marginally higher this year at 7.28 and remain higher than the national average which is 7.2 We are not complacent with this result and continue with our work in this area.

We know that staff agreeing/strongly agreeing that the Trust respects individual differences has risen to 68.3% from 67.8% in 2022 and almost 65% of staff feel that their immediate line manager helps to resolve problems.

Throughout 2023, the Trust implemented ‘rate this shift’, strengthened BAME and disability networks and support and implemented job planning for nurses and allied health professions.

3. Group

3.1 Tees Valley Group Model

Work continues to develop the Group model between North Tees and Hartlepool and South Tees Hospitals NHS Foundation Trusts. Development meetings continue to take place on a regular basis, which reports to the Joint Partnership Board. The Trust has officially signed the partnership agreement with South Tees Hospitals and the North East and North Cumbria ICB. This is a milestone in the formation of our hospital group, which will enable us to deliver better outcomes for our patients and the wider population across the Tees Valley and beyond.

3.2 Group Executive Appointments

At the end of February 2024 the Group interviewed and appointed the following to the Group Executive Team; Neil Atkinson, Group Managing Director; Dr Michael Stewart, Group Medical Director; Dr Hilary Lloyd, Group Chief Nurse; Chris Hand, Group Finance Officer; Dr Susy Cook and Rachael Metcalf as Group Chief People Officers. In addition Ruth Dalton has been appointed as Group Communications Director.

Phase 2 of the consultation process will shortly commence.

3.3 Clinical Services Strategy

The third Clinical Services Strategy Engagement Event was held on 24th January 2024. It was attended by 148 members of staff with multi-professional representation from medical, nursing, midwifery, allied health professionals and operational managers from both Trusts. There was also representation from primary care. The key note speech describing lived experience with leading on service and organisation transformation in Leeds from Sir Julian Hartley, Chief Executive of NHS Providers, which was very well received. The attendees had been allocated seating to enable table top discussions on the Clinical Board development relevant to their area of work. There was interactive communications and post event feedback received which will inform the clinical strategy development and planning for future clinical engagement events. Recruitment to the triumvirate leadership for each of the six Clinical Boards is currently underway and interviews are planned for April 2024.

As Board colleagues will be ware one of the key challenges highlighted by colleagues is the need to improve the access, consistency and interoperability of our digital systems. Our digital leadership team has been holding engagement sessions with a wide variety of clinical, corporate and admin colleagues to capture the detailed feedback from our teams. This will help us both prioritise current interventions and inform the Group digital strategy.

3.4 Clinical Support Worker (Band 2 / Band 3)

The release of updated Agenda for Change national profiles for clinical support workers (in the combined nursing job family), resulted from concerns that the duties and tasks in some clinical support worker (CSW) and maternity support worker (MSW) roles had changed significantly over time and job descriptions may not have been reviewed regularly and updated. As a consequence some banding outcomes

may have become out of date and inconsistent when viewed against other NHS jobs. Work was undertaken in collaboration with care groups and staff side colleagues to review and update as necessary all clinical support worker job descriptions.

Whilst we have offered both an uplift of banding and back pay from July 2021, the Board will know we are in dispute over the back pay element. This resulted in strike action on the 11 March and we have been notified of a 72 hours strike action from 0800hrs on Monday 8 April 2024 to 0759hrs on Thursday 11 March 2024. I will ask the Chief People Officer to provide a verbal update to Board when we meet.

4. Visits and local information

Myself, Professor Bell and Dr Lloyd recently met with Lady Ogden and Gemma Peters, Macmillan Chief Executive at the Sir Robert Ogden Macmillan Centre at the Friarage. Throughout 2023, The Sir Robert Ogden Macmillan Centre in Northallerton has continued to provide crucial support to people living with cancer and their loved ones. The breadth of services available at the Centre, from chemotherapy and haematology treatment, to trusted information and financial support, have helped people diagnosed with cancer to find their best way through at a time when help has never been more needed.

Also, at the Friarage, I visited the Hospital's new surgical hub which is starting to take shape with the first bricks now firmly in place. Rishi Sunak, MP for Richmond (Yorks), had the honour of laying one of the first bricks on Friday 15 March.

The new £35.5m surgical hub, which is due to open in 2025, will enable the Northallerton hospital to more than double the number of planned operations it carries out each year. It will replace the hospital's five existing operating theatres with a modern surgical hub that will include six main operating theatres, two minor operating theatres and a surgical admissions unit and day hub.

Finally as we move into April, the health and wellbeing team will be organising a host of events to mark National stress awareness month. This year's theme is Little By Little, A Little Becomes A Lot.

This is the idea that small consistent actions each day contribute to overall wellbeing as an increasing effect. Colleagues are encouraged to attend one of the sessions and / or speak to the health and wellbeing team and find out more about stress and ways to combat and prevent the condition. There will also be free resources available on the days that will help you de-stress.

4. Recommendation

The Board of Directors is asked to note the content of this report.

South Tees Hospitals NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 2 APRIL 2024			
Safe Staffing Report for February 2024			**AGENDA ITEM:** **[PA insert number]**
Report Author and Job Title:	Debi McKeown Interim NMAHP Workforce Lead	**Responsible Director:**	Dr Hilary Lloyd Chief Nurse
Action Required	Approve ☐ Discuss ☒ Inform ☒		
Situation	This report details nursing and midwifery staffing levels for February 2024 for inpatient wards.		
Background	The requirement to publish nursing & midwifery staffing levels monthly is one of the ten expectations specified by the National Quality Board (2013 and 2016).		
Assessment	The percentage of shifts filled against the planned nurse and midwifery staffing across the trust is 97.6% as per Table 1 demonstrating continued good compliance with safer staffing. Stretch staffing ratios in line with national guidance have been reviewed with Operational Senior Nurses and implemented where necessary based on skill mix, acuity, and occupancy levels, all these actions agreed by senior nurses through safe care meetings. Nursing Turnover for February 24 is 7.82%.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of the Trust Board are asked to Note the content of this report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF risk 5.1 Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit. Threat - Ability to attract and retain good staff resulting in critical workforce gaps in some clinical services and impact on use of resources. Failure to have effective workforce plans that anticipate and prevent shortages arising from retirements, shortfalls in all recruitment and retention plans		

Legal and Equality and Diversity implications	• Care Quality Commission • NHS Improvement • NHS England	
Strategic Objectives	Best for safe, clinically effective care and experience ☒	A great place to work ☒
	Deliver care without boundaries in collaboration with our health and social care partners ☐	Make best use of our resources ☒
	A centre of excellence, for core and specialist services, research, digitally supported healthcare, education, and innovation in the North East of England, North Yorkshire and beyond ☐	

Nursing and Midwifery Workforce Exception Report

February 2024

This report provides a monthly update to the Board on nursing and midwifery staffing. It provides an overall picture of staffing in the inpatient areas as an exception report.

1. Safer Staffing Governance

Safer staffing is maintained through twice daily SafeCare (staffing review) meetings to address any immediate issues (on the day) and put robust plans in place. All elements of safer staffing are discussed at the Workforce Group which meets fortnightly on a Wednesday and are escalated to the Tactical/Strategic Group as required. A look forward to the week ahead on Mondays and the weekend on Fridays takes place with Associate Directors of Nursing, Heads of Nursing and Clinical Matrons.
Staff movement takes place to ensure patient safety with Clinical Matron Huddles and Ward Manager Briefings utilised to ensure full communication of plans and to gain feedback from teams to inform decision making.

Table 1 shows overall planned versus actual across the trust. **Appendix 1** shows a detailed breakdown for each ward.

Table 1 Trust Planned versus Actual

		December 23	January 24	February 24
Overall, Ward Fill Rate	RN/RMs (%) Average fill rate - DAYS	82.6%	87.1%	86.4%
	HCA (%) Average fill rate - DAYS	90.8%	97.8%	97.3%
	NA (%) Average fill rate - DAYS	100.0%	100.0%	100.0%
	TNA (%) Average fill rate - DAYS	100.0%	100.0%	100.0%
	RN/RMs (%) Average fill rate - NIGHTS	93.0%	93.5%	91.9%
	HCA (%) Average fill rate - NIGHTS	106.6%	107.8%	105.5%
	NA (%) Average fill rate - NIGHTS	100.0%	100.0%	100.0%
	TNA (%) Average fill rate - NIGHTS	100.0%	100.0%	100.0%
	Total % of Overall planned hours	**96.6%**	**98.3%**	**97.6%**

Redeployment of staff has taken place on a regular basis to ensure wards are safely staffed with 245 total shifts (2435.92) logged via SafeCare during February which was a decrease on January's hours. Whilst redeployment remains an unpopular option, staff are reassured that every solution is explored prior to any redeployment. The SafeCare Chair is compliant with the aim to redeploy within collaborative. This has been well received by staff and reduced some anxiety around moving to other areas. Ongoing work with the legacy mentors, workforce lead and operational matrons to produce a well being focused redeployment process.

Percentage of overtime has decreased year on year since 2021. The current overtime percentage based on the NHSp vs Overtime report has remained static at 6% but is still considerably lower compared to last year's 11% in February.

Nursing turnover has increased slightly from 7.69% to 7.82%. (**Appendix 4**). The nursing turnover report excludes employee external transfer and flexi-retirement these reasons

however are included in the fortnightly workforce meetings as that is what is reported at Trust level.

2. Nurse Sensitive Indicators

No staffing factors were identified as part of any SI review process in February 2024.

3. Red Flags Raised through SafeCare Live

February has shown a decrease in the number of red flags raised through SafeCare live. There are 21 open red flags relating to workforce, with shortfall in RN time being the most common (19). For red flags for less than 2 RNs, the SafeCare log provides a documented resolution to this red flag, therefore no shifts had less than 2 RNs throughout February. Reminders are sent to ward managers and matrons to review and close red flags this will be further communicated to raise the priority or reviewing and closing solved red flags. This has now been added to the SafeCare log, the SafeCare matron of the day will direct or close open red flags that have been resolved.

4. Datix Submissions

There were 50 Datix submissions relating to staffing in February. The majority of Datix were for staff shortages in Richmond and Thirsk District Nursing. Redeployment decisions were made following safer staffing discussions with ward managers and matron agreement.
The Nursing Workforce Team continues to work closely with HR senior team and the temporary staffing providers (NHSp) to improve fill rates and maintain safe staffing.

5. Vacancy & Turnover

Appendix 2 shows registered nursing and midwifery vacancy rate for February 24. **Appendix 3** shows healthcare assistant vacancy rate for February 24. **Appendix 4** shows the nursing turnover for February 24 Please note **Appendixes 2, 3 & 4** provide information regarding all nurse vacancies including corporate roles and maternity services.

6. Nurse Recruitment and Retention

72 Newly Qualified Nurses have been recently recruited directly from Teesside University. They are now through the recruitment process and have commenced roles across all sites within South Tees.

March 2022 cohort of Registered Nurse Degree Apprenticeships (RNDAs) completed the programme in February , this has provide 18 qualified RNDAs back into the organisation with the majority going back to their substantive ward.

7. RECOMMENDATIONS

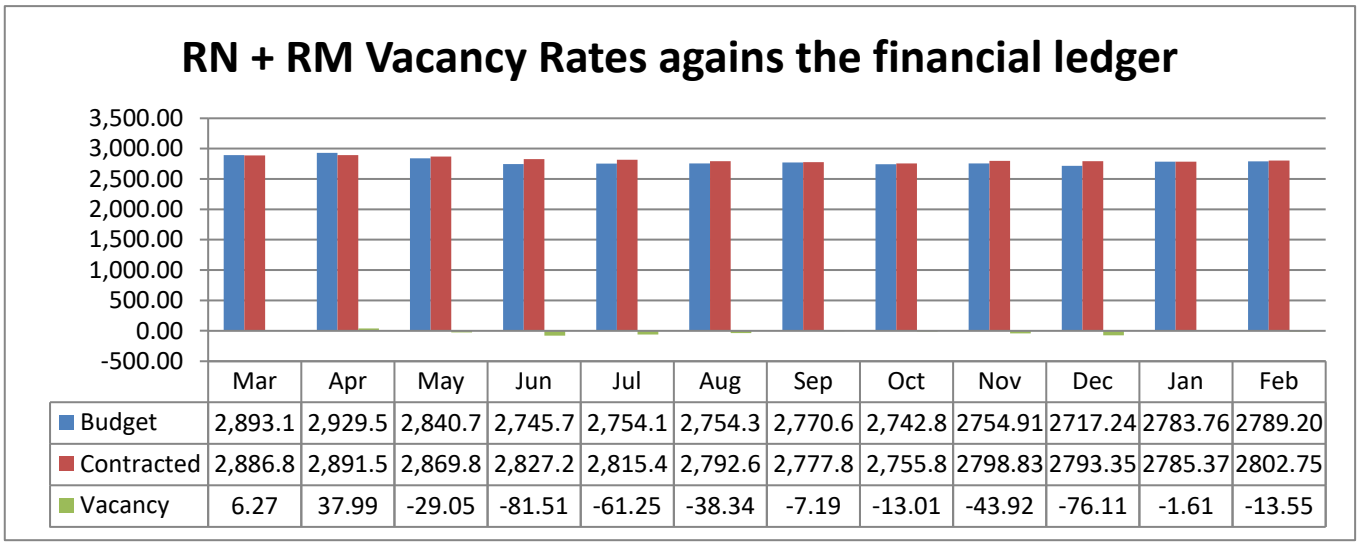
The Board is asked to note this report and the progress in relation to key nursing workforce issues and be assured that arrangements are in place to monitor, support and mitigate any impact of reduced staffing levels or skill mix in relation to patient safety.

Appendix 1 - Nursing and Midwifery Planned Vs Actual hours % and Care Hours Per Patient Day

Wards	Physical Bed Capacity	Open Bed Capacity	Total CHPPD	Occupied Bed No – Feb -24 (at midnight)	Average fill rate - Days RN/ RM (%)	Average fill rate - Days HCA (%)	Average fill rate – Days NA (%)	Average fill rate – Days TNA (%)	Average fill rate - Nights RN/ RM (%)	Average fill rate - Nights HCA (%)	Average fill rate – Nights NA (%)	Average fill rate - Nights TNA (%)	Comments
Ward 1	30	30	788	27	93.0%	116.3%	100.0%	-	88.1%	101.9%	100.0%	-	
Ward 31 (2)	35	35	980	34	89.9%	95.8%	-	100.0%	85.9%	99.2%	-	100.0%	
Ward 3	28	28	779	27	112.5%	122.4%	100.0%	100.0%	99.8%	145.3%	100.0%	100.0%	
Ward 4	24	24	631	22	89.1%	117.8%	-	-	83.9%	126.7%	-	-	
Ward 5	30	30	757	26	82.8%	101.4%	-	100.0%	96.6%	150.0%	-	-	
Ward 6	31	31	879	30	75.8%	128.5%	-	100.0%	101.0%	100.0%	-	-	RN vacancies and Short Term Sickness
Ward 7	31	31	865	30	93.6%	108.7%	-	100.0%	96.6%	97.1%	-	-	
Ward 8	30	30	767	26	84.2%	108.7%	-	100.0%	94.3%	105.4%	-	100.0%	
Ward 9	34	32	927	32	80.1%	171.1%	-	100.0%	95.9%	185.5%	-	-	
Ward 10	27	27	777	27	81.3%	69.9%	-	100.0%	97.7%	130.8%	-	-	
Ward 11	28	28	786	27	79.3%	84.5%	-	100.0%	85.9%	138.0%	-	100.0%	Sickness
Ward 12	30	30	854	29	103.9%	137.2%	-	-	90.7%	168.8%	-	-	
Ward 14	23	23	603	21	89.0%	96.4%	-	100.0%	100.0%	111.5%	-	-	
Ward 24	23	23	602	21	93.6%	120.4%	-	100.0%	96.8%	186.6%	-	-	
Ward 25	21	21	503	17	86.2%	143.2%	-	-	91.3%	127.1%	-	-	
Ward 26	18	19	515	18	100.9%	143.2%	-	-	100.0%	148.3%	-	-	
Ward 27	15	15	177	6	63.2%	65.9%	100.0%	100.0%	102.5%	73.7%	-	100.0%	Low elective pathway usage.
Ward 28	30	30	839	29	84.7%	104.1%	-	-	85.9%	103.0%	100.0%	-	
Ward 29	27	27	716	25	94.4%	85.3%	-	100.0%	98.9%	106.3%	-	100.0%	
Cardio MB	9	9	232	8	99.1%	96.6%	-	-	98.3%	100.0%	-	-	
Ward 32	22	21	574	20	110.8%	108.6%	-	-	100.0%	103.4%	-	-	
Ward 33	23	23	588	20	74.8%	102.6%	-	-	94.5%	102.9%	-	-	3 newly qualified nurses supernumerary status

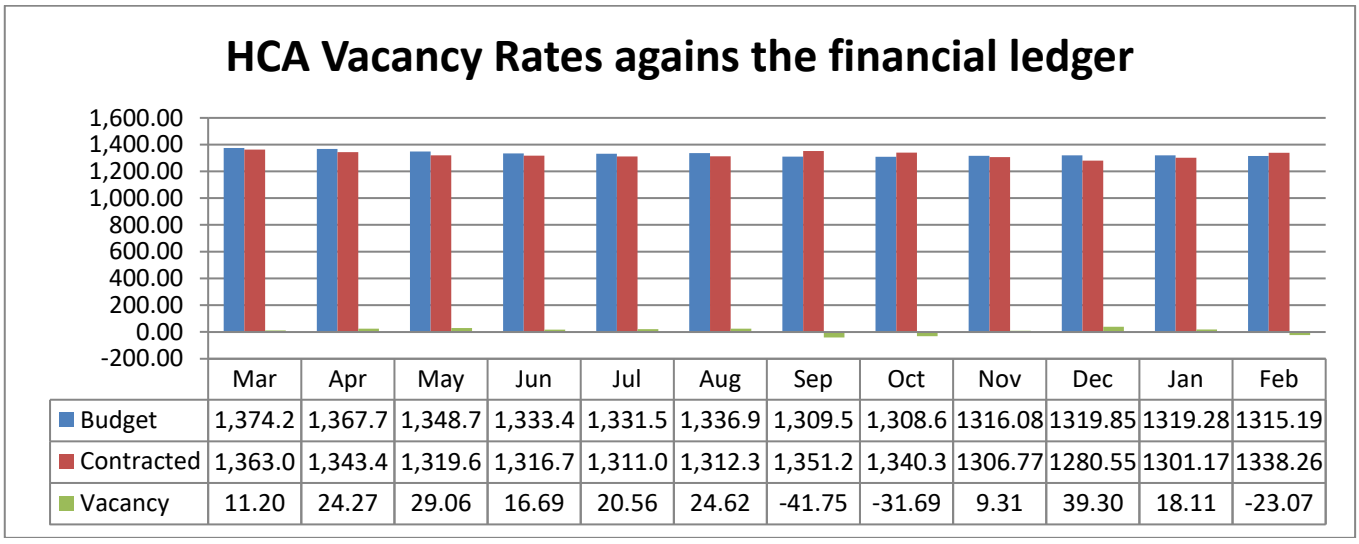
Ward 34	34	34	798	28	78.8%	116.2%	-	100.0%	93.4%	128.6%	-	100.0%	RN vacancies- support other wards within the collaborative on a rotational basis
Ward 35	26	26	625	22	111.1%	111.8%	-	-	110.7%	111.3%	-	-	
Ward 36	34	34	897	31	96.9%	96.0%	100.0%	100.0%	92.1%	112.5%	100.0%	100.0%	
Ward 37 - AMU	30	30	736	25	99.6%	118.6%	100.0%	-	96.1%	101.2%	-	-	
Spinal Injuries	24	24	567	20	89.5%	67.0%	-	100.0%	99.5%	100.0%	-	-	
CCU	14	14	302	10	82.1%	114.1%	-	-	95.5%	-	-	-	
Critical Care	33	33	872	30	90.9%	98.6%	-	100.0%	93.3%	102.8%	-	-	
CICU JCUH	12	10	196	7	77.5%	82.8%	-	-	78.7%	106.9%	-	-	Short term sickness
Cardio HDU	10	10	221	8	90.1%	100.0%	-	-	86.2%	100.0%	-	-	
Ward 24 HDU	8	8	180	6	94.6%	151.2%	-	-	80.4%	196.6%	-	-	
CDU FHN	22	22	445	15	84.5%	94.3%	100.0%	-	82.0%	93.1%	100.0%	-	
Ainderby FHN	27	22	699	24	96.1%	97.1%	100.0%	-	80.4%	100.9%	-	-	
Romanby FHN	26	22	730	25	84.0%	93.2%	-	-	91.7%	96.6%	-	-	
Gara FHN	21	21	237	8	76.7%	93.4%	-	-	98.5%	46.8%	-	-	Low elective pathways due to IA
Rutson FHN	17	17	481	17	71.2%	104.7%	-	100.0%	100.0%	86.3%	-	100.0%	
Friary	18	18	452	16	93.8%	107.3%	-	100.0%	96.5%	92.5%	-	-	
Zetland Ward	31	29	865	30	76.1%	82.5%	100.0%	-	93.1%	105.2%	100.0%	-	
Tocketts Ward	30	26	814	28	84.9%	99.7%	-	100.0%	97.3%	131.5%	-	-	
Ward 21	25	25	532	18	75.9%	108.6%	100.0%	-	78.2%	1.8%	100.0%	-	Sickness
Ward 22	17	17	283	10	63.8%	63.8%	-	-	72.6%	94.8%	-	-	Sickness
Delivery Suite	-	-	338	12	98.5%	98.5%	-	-	95.5%	93.1%	-	-	
Neonatal Unit	35	35	696	24	94.9%	94.9%	-	-	90.4%	-	-	-	
PCCU	6	6	91	3	76.7%	76.7%	-	-	75.9%	13.8%	-	-	Sickness
Ward 17	-	-	267	9	97.1%	97.1%	-	-	100.3%	70.2%	-	-	
Ward 19 Ante Natal	-	-	293	10	100.1%	100.1%	-	-	100.0%	-	-	-	
Maternity Centre FHN	-	-	7	0	67.6%	67.6%	-	-	90.0%	-	-	-	Closure of the unit due to staffing issues

Appendix 2 - Registered Nursing Vacancy Rate January 2024



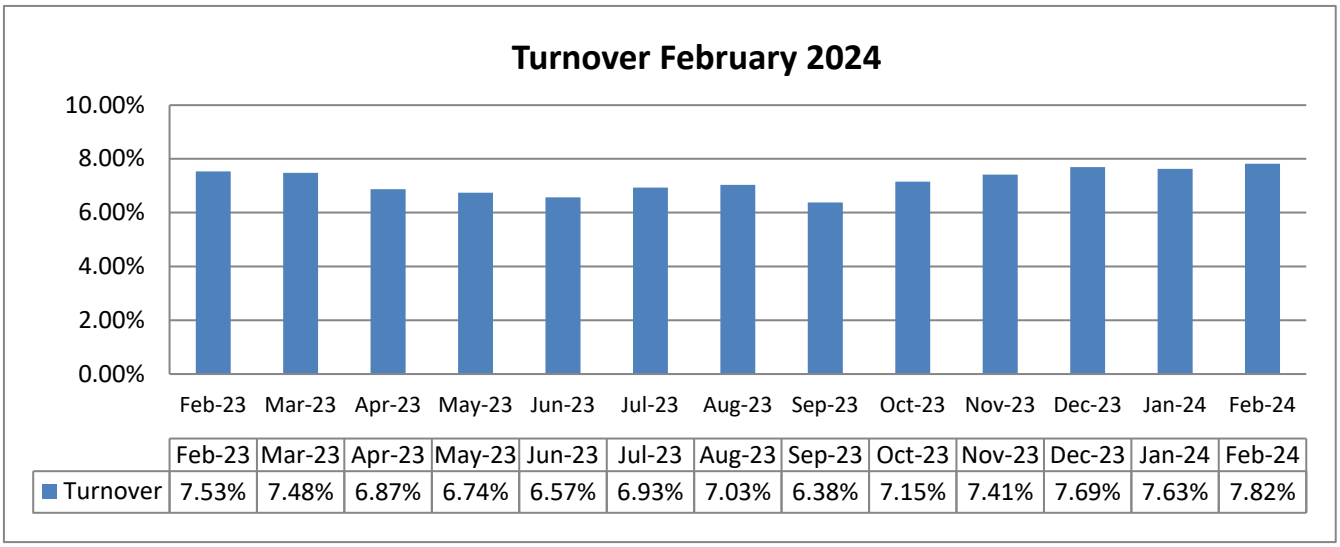
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Budget	2,893.1	2,929.5	2,840.7	2,745.7	2,754.1	2,754.3	2,770.6	2,742.8	2754.91	2717.24	2783.76	2789.20
Contracted	2,886.8	2,891.5	2,869.8	2,827.2	2,815.4	2,792.6	2,777.8	2,755.8	2798.83	2793.35	2785.37	2802.75
Vacancy	6.27	37.99	-29.05	-81.51	-61.25	-38.34	-7.19	-13.01	-43.92	-76.11	-1.61	-13.55

Appendix 3 - Health Care Assistant Vacancy Rate January 2024



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Budget	1,374.2	1,367.7	1,348.7	1,333.4	1,331.5	1,336.9	1,309.5	1,308.6	1316.08	1319.85	1319.28	1315.19
Contracted	1,363.0	1,343.4	1,319.6	1,316.7	1,311.0	1,312.3	1,351.2	1,340.3	1306.77	1280.55	1301.17	1338.26
Vacancy	11.20	24.27	29.06	16.69	20.56	24.62	-41.75	-31.69	9.31	39.30	18.11	-23.07

Appendix 4 - Nursing Turnover February 2024



	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Turnover	7.53%	7.48%	6.87%	6.74%	6.57%	6.93%	7.03%	6.38%	7.15%	7.41%	7.69%	7.63%	7.82%

South Tees Hospitals NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 2 APRIL 2024			
Learning from Deaths December 2023		**AGENDA ITEM:**	
Report Author and Job Title:	Jo Raine, Data Analyst Mortality Surveillance and Tony Roberts, Deputy Director (Clinical Effectiveness)	**Responsible Director:**	Michael Stewart Chief Medical Officer
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	This report provides assurance on the overall quality of care, as measured by hospital mortality and other clinical effectiveness indicators, delivered by the organization and is an extract of the report submitted to the Mortality and Morbidity Group in November 2023.		
Background	Overview of mortality within the Trust including relevant mortality indicators and coverage of the Medical Examiner service and Mortality Surveillance activity including lessons learned and feedback given.		
Assessment	178 deaths were recorded in December 2023, 174 deaths were recorded in November 2023. Rolling 12-month unadjusted mortality rate average is 1.21 back to pre-pandemic levels. The Learning from Deaths dashboard shows that 1,973 of the 1,976 deaths that occurred between January 2023 and December 2023 were reviewed (99.8%) by Medical Examiners. SHMI at 110 (September 2022 – August 2023) is As Expected. 358 Trust Mortality Reviews have been completed since April 2023 and 220 by the Nurse Reviewer.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of the Board are asked to: continue to monitor the Medical Examiner and mortality review processes and all the mortality indicators described in the report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	2.3, 2.4		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Best for safe, clinically effective care and experience ☒	A great place to work ☐	
	Deliver care without boundaries in collaboration with our health and social care partners ☐	Make best use of our resources ☐	

	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☐	

Learning From Deaths December 2023

1. PURPOSE OF REPORT

1.1. The report is consistent with the mortality reporting required by NHS England in December 2015 and is a response to the National Quality Board published in March 2017 *Guidance on Learning from Deaths* (LFD)[1] including the requirement to publish information on preventable deaths on a quarterly basis; the NHS Patient Safety Strategy, published in July 2019, confirmed the importance of Medical Examiners as a source of Insight into patient safety and the value of mortality reviews as part of the Learning from Deaths policy.

2. BACKGROUND

2.1. **Mortality Indicators**: The Trust reports and discusses mortality statistics including counts of deaths, unadjusted mortality rates, the Summary Hospital-level Mortality Indicator (SHMI), which is the NHS's official risk-adjusted hospital mortality statistic, various contextual indicators including quality of clinical coding and palliative care delivery plus a range of population level statistics including Excess Mortality as provided by the Office for National Statistics (ONS), Place of Death statistics and various other public health metrics. Detailed discussion occurs the Trust Mortality and Morbidity Group (TMMG), this report summarises on key metrics and picks up any issues identified there.

2.2. **Learning from Deaths:** The Trust *Responding to Deaths* policy (G163, published Sep 2018, updated Oct 2020 and Oct 2022) sets out how the trust responds to, and learns from, deaths of patients who die under its management and care[2]. The approach is summarised below.

2.2.1. A *Medical Examiner Review* occurs at the time of certification of death. The Medical Examiner Service began in May 2018 and covers around 98% of all deaths in the Trust. The process includes review of the case records, discussion with the attending team and a discussion with the bereaved family.

2.2.2. A *Trust Mortality Review,* is conducted if any potential concerns are identified during the Medical Examiner Review and also for all deaths of patients with learning disabilities, serious mental illness, within 30 days of a surgical procedure or where a 'mortality alert' from a range of sources has occurred, or where a Patient Safety Event or complaint has been reported. A *Patient Safety Incident Investigation* may occur before or after Trust Mortality Review. A *Nurse-led review* may also be completed if potential deficiencies in nursing care has been highlighted.

[1] https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

[2] https://staffintranet.xstees.nhs.uk/resources-guidelines/g163-responding-to-deaths-policy/

3. MORTALITY INDICATORS & LEARNING FROM DEATHS

3.1. **Mortality Indicators**: The dashboard includes the count of deaths from August 2017 to December 2023 (Fig 1). 178 deaths in December 2023 and 174 deaths in November 2023. The unadjusted mortality rate is back to pre-pandemic levels. Rolling 12- month average is 1.21 compared to 1.24 pre-pandemic.

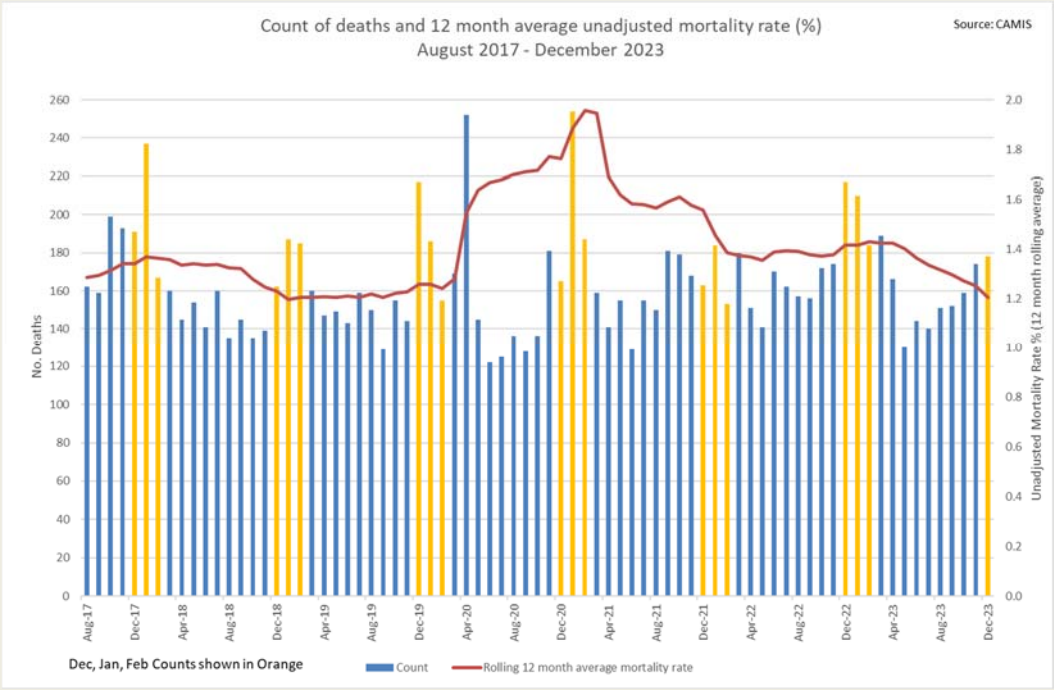


Fig 1. Count of deaths and Mortality Rate
Source: South Tees Hospitals NHS Foundation Trust

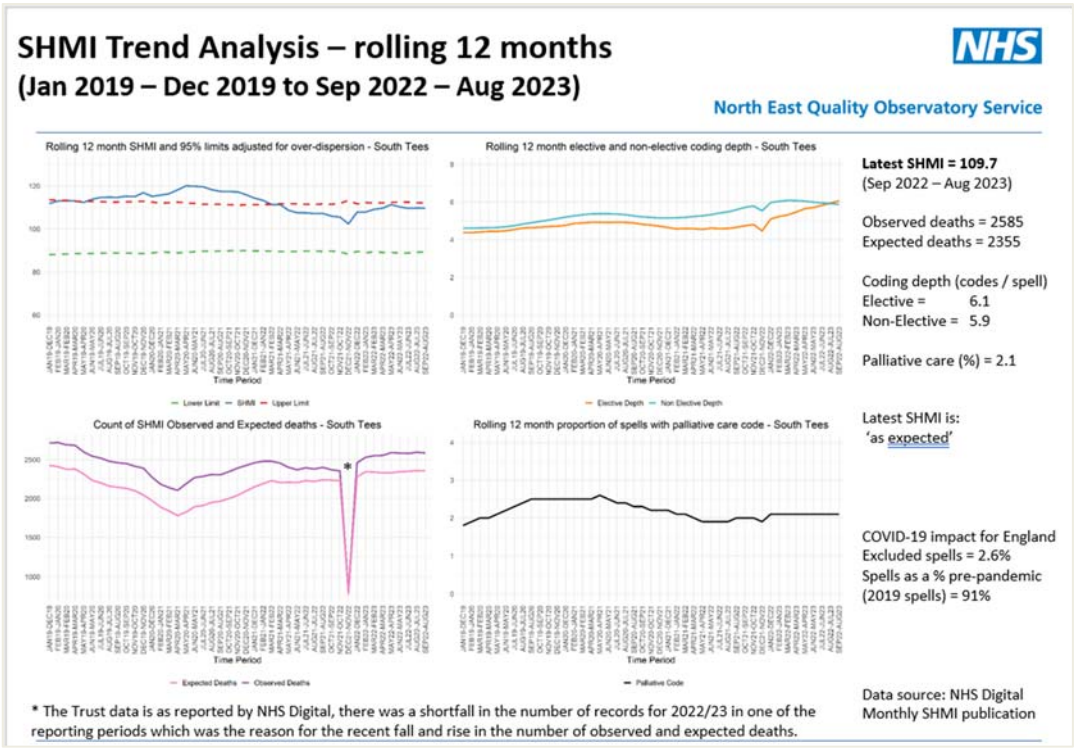


Fig 2. SHMI Trend Analysis Rolling 18 month trend analysis.
Source: NHS Digital/NEQOS

3.2. **Summary Hospital-level Mortality Indicator, Comorbidity and Palliative Care Coding: (Fig 2)** includes all in-hospital deaths plus deaths within 30 days of discharge. It is published on a quarterly basis by NHS Digital and is an official government statistic. The SHMI is the ratio of observed mortality rate/expected mortality rate (based on a statistical estimate of expected mortality). Latest SHMI 110 (September 2022 – August 2023) – As Expected. NHS Digital are removing any spell containing a COVID-19 Confirmed or Suspected code. For the current period there is a total fall of ~10% in the number of spells used to calculate SHMI. The comorbidity count matters because of its impact on the risk adjustment used in modelling mortality. Coding depth for elective spells is 6.1, for non-elective 5.9. Implementation of electronic patient records is known to reduce coding initially, although improves coding as systems become refined and embedded in delivery of care. It is likely that SHMI will be adversely affected in the short term, reflecting the roll out of Clinical coding in the autumn of 2023. 2.1% of spells had a palliative care code. Palliative care coding is provided as a key contextual indicator.

3.3. Work on producing statistics by **Collaborative Group** is currently being developed. 55.2% of deaths were in Medicine and Emergency Care Services and 11.5% in Growing the Friarage and Community Services: Friarage Medical Services (Fig 3).

Fig 3: Deaths in South Tees Hospitals NHS Foundation Trust by collaborative

Deaths in South Tees Hospitals NHS Foundation Trust: Jan - Dec 2023					
Collaborative	Survived	Died	Total	Unadjusted Mortality Rate	% all deaths
Cardiovascular Care services	6220	153	6373	2.4%	7.7%
Clinical Support Services	1046		1046	0.0%	0.0%
Digestive Diseases, Urology and General Surgery services	32208	203	32411	0.6%	10.3%
Head and Neck, Orthopaedic and Reconstructive services	24631	88	24719	0.4%	4.4%
James Cook Cancer Institute and Speciality Medicine services	28082	166	28248	0.6%	8.4%
Medicine and Emergency Care services	29991	1093	31084	3.5%	55.2%
Neurosciences and Spinal Care Services	4425	67	4492	1.5%	3.4%
Perioperative and Critical Care Medicine Services	1818	187	2005	9.3%	9.4%
Women and Children services	34670	23	34693	0.1%	1.2%
Grand Total	**163091**	**1980**	**165071**	**1.2%**	**100.0%**

Deaths in South Tees Hospitals NHS Foundation Trust: Jan - Dec 2023					
Collaborative	Survived	Died	Total	Unadjusted Mortality Rate	% all deaths
Growing the Friarage and Community services: Community Services	321	24	345	7.0%	1.2%
Growing the Friarage and Community services: Primary Care Hospitals	639	41	680	6.0%	2.1%
Growing the Friarage and Community services: Friarage Medical Services	24070	228	24298	0.9%	11.5%

3.4. **Medical Examiners:** In 2022/23, of the 2,392 deaths that occurred in hospital and in A&E or were very recent discharges from hospital and referred to the Medical Examiner (including 184 GP/Community deaths included in the Medical Examiner system since September 2021), 2,361 were reviewed by the Medical Examiner service – 98.7% of all such deaths. (Fig 4). Since April 2023 ME scrutiny was provided in 1,763 cases out of a total of 1,773 in-hospital, A&E or community deaths referred to the medical examiner service – 99.4% of all deaths.

3.4.1. Minor concerns were raised about 130 of the deaths and Major concerns raised about 35 deaths. 169 deaths were referred for Trust Mortality Review (TMR) of which 149 have taken place.

3.4.2. Of the 203 deaths recommended for TMR in 2022/23, 168 have now been completed. The waiting list of cases (currently 55 cases) needing review by Mortality Surveillance from this, and the previous year, are currently being addressed.

Fig 4: Medical Examiner Service Statistics

Medical Examiner Service Statistics: Month of Death	No. In-Hospital Deaths	A&E Deaths	Community Deaths	Other Deaths	ME Review	% Review	Rec'mend TMR	Received TMR	Specialty Review	Discussed with Coroner	Noted as Coroner Case
May 2018 - Mar 2019	1698	25		19	1432	82.2%	230	230	265	275	137
April 2019 - March 2020	1902	92		46	1822	89.3%	192	192	393	381	296
April 2020 - March 2021	1994	73		39	2041	96.9%	153	153	224	330	279
April 2021 - March 2022	1936	109	40	11	2034	97.0%	174	174	103	297	333
April 2022 - March 2023	2083	125	184	0	2361	98.7%	203	168	115	301	409

Medical Examiner Service Statistics: Month of Death Apr 2023 -Mar 2024	No. In-Hospital Deaths	A&E Deaths	Community Deaths	Other Deaths	ME Review	In hospital % Review	Rec'mend TMR	Received TMR	Specialty Review	Discussed with Coroner	Noted as Coroner Case
Apr-23	166	10	27	0	202	99.5%	16	16	11	27	31
May-23	130	8	30	0	166	98.8%	17	12	11	26	21
Jun-23	144	9	20	0	173	100.0%	17	15	7	18	29
Jul-23	140	10	24	0	174	100.0%	14	14	4	21	32
Aug-23	151	11	17	0	178	99.4%	24	23	9	16	34
Sep-23	152	5	30	0	187	100.0%	15	15	7	20	21
Oct-23	159	4	33	0	195	99.5%	18	18	13	18	28
Nov-23	174	5	62	0	243	100.0%	25	24	8	17	32
Dec-23	178	12	62	0	245	97.2%	23	12	12	40	37
	1394	74	305	0	1763	99.4%	169	149	82	203	265
	11007	498	529	115	11453	94.3%	1121	1066	1182	1787	1719

3.5. Mortality Surveillance Reviews: The review team currently consists of four consultant reviewers. 560 reviews were completed in 2022/23 and 372 reviews completed by the consultant review team since April 2023 with an additional 220 cases reviewed by our nurse reviewer. These additional cases had some indications of problems in care but did not definitively fall into the categories that automatically lead to second review. After review, 22 were referred back to the consultant mortality surveillance team for second review. Cases are graded for preventability and using the NCEPOD grading system[3] (Figs 5 & 6).

3.5.1. 62% of the 372 case reviews were judged to show good practice with no preventability. 22% showed room for improvement in care but with no preventability, 9% showed both preventability and room for improvement in care and 2% (7 reviews) showed strong preventability and/or less than satisfactory care.

Fig 5 No. of Reviews Apr 2021 to date

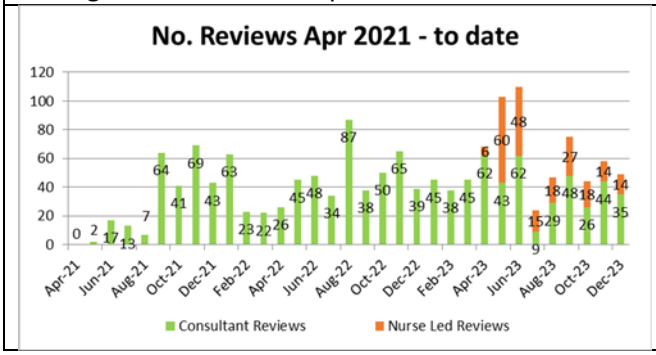
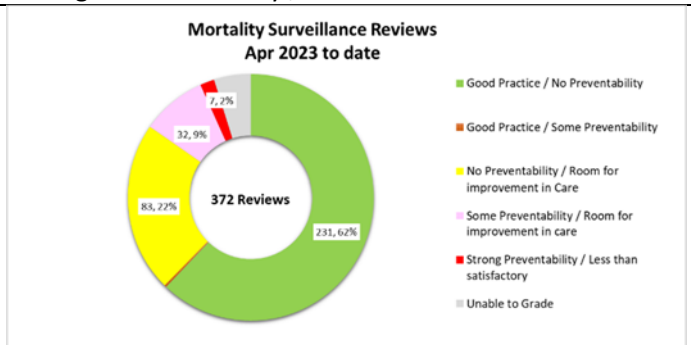


Fig 6 Preventability / Good Practice



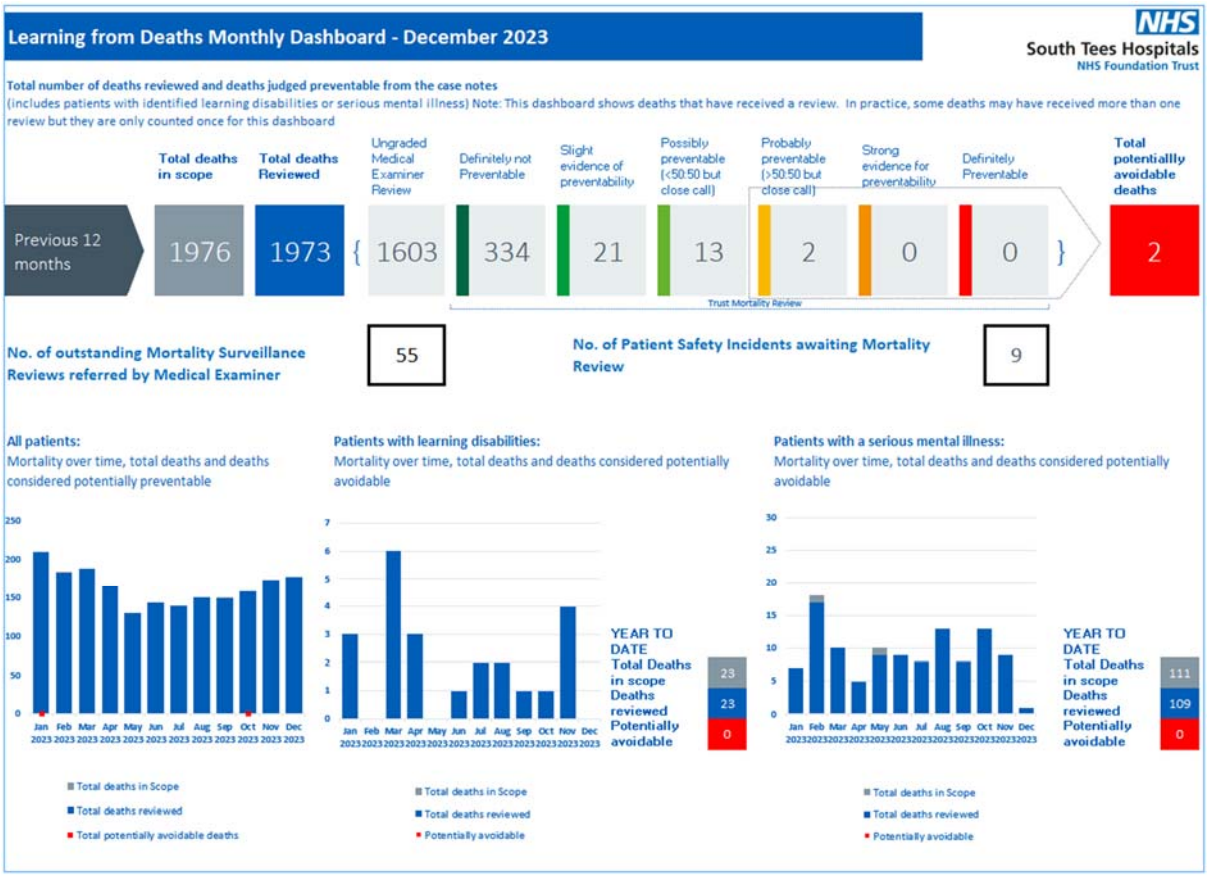
[3] National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Grading system

3.5.2. Cases are also judged to be expected or unexpected and assessed using an overall quality of care scale. 83% of deaths were Expected, 16% Unexpected. Care in 64% of cases was graded Good-Excellent. 21 (6%) cases were judged to have received poor care and one very poor care.

3.5.3. In the last month, 3 reviews mentioned lessons learned from good care, including good communication with families.

3.5.4. In the last month, 14 reviews identified learning from problems in care including poor quality of clinical care, lack of senior input and advanced decision making, delays in tests being undertaken or reported on, medication errors and problems with unverified DNACPRs.

3.5.5. The Nurse Reviewer has completed 220 reviews since April 2023. This role fulfils a dual purpose of screening the backlog and providing support to the reviewers from a nursing perspective and providing feedback and lessons learned to wards and clinical areas on key areas such as accurate completion of NG tube LOCSSIP and fluid balance charts.



3.6. The **Learning From Deaths Dashboard** reports the number of deaths, the number of Medical Examiner Reviews, the number of deaths with a Trust Level Mortality Review or investigation and the number of those deaths judged to show evidence of preventability. Numbers are reported separately for patients with learning disabilities and known serious mental health illnesses. For the year to end of December 2023 there were 1,976 deaths, of which 1,973 (99.8%) received a review or investigation and 2 deaths were considered to be

potentially avoidable. In the same period 100% of deaths in patients with a learning disability and 98% of cases where the patient had a pre-existing serious mental health condition were reviewed with no deaths considered potentially avoidable.

4. MORTALITY INDICATORS & LEARNING FROM DEATHS

Medical Examiner scrutiny and Mortality Reviews identify aspects of good care and potential or actual problems in care. Where these are specific to a particular clinical team, feedback is provided by the ME or reviewer directly to the team and this will often prompt review and action in the department, specialty or Collaborative: it is not currently possible to collate this centrally. More general themes are collated and areas of focus include:

- **End of Life Care**. Actions are coordinated through the End of Life Care Group, which receives information on EoLC themes and cases from ME scrutiny and mortality reviewers and the EoLC G reports through the governance structure to QAC. The DNACPR and other end of life documentation audit work continues as part of the Health Care Records Audit and audit of end-of-life care at the Friary hospital continues.

- **Documentation** in the medical records. This issue is addressed through the STACQ accreditation and Health Care Records Audit audits, although the longer-term solution is implementation of electronic patient records. Progress on this work is reported to the Miya Programme Board through Trust Committees to Board level. A communications campaign called “Documenting for great CARE” remains available on the Trust intranet (Documenting for great CARE – South Tees Hospitals NHS Foundation Trust), highlighting the issue and with hints, tips, advice, and guidance to help clinicians ‘keep the chain going’. The campaign is shared through the Trust’s usual channels. This includes what good documentation looks like and how clinicians can support improvement in the clinical coding of the care they have delivered.

- **Coordination of care** between specialities. This is not easily identified in medical records as it relies on notes being made of conversations and telephone calls between colleagues. This will improve with implementation of Miya and is reported through the Miya Board. There have been recent discussions at the Miya Clinical Working Group on developments in this field.

- **Transfer of patients from other hospitals**. Information about patients prior to, and at the time of, referral is currently in the medical record, usually in a summary form (it currently relies on the doctor accepting referral to make this summary). Newcastle upon Tyne Hospitals NHS FT have led procurement of a single electronic system for all Trusts in the North East & North Cumbria and Patient Pass (https://www.patientpass.co.uk/) has been chosen with completion of contracts in process currently. An implementation plan for cardiac, renal, vascular, orthopaedic and other specialty services will follow.

5. RECOMMENDATIONS

- The unprecedented pattern of deaths, unadjusted and risk adjusted mortality rates during the pandemic has made these measures difficult to interpret. The Trust should continue to monitor these statistics but accept that their use for assurance is diminished and thus the importance of non-statistical approaches to mortality are of greater importance than was the case before covid. The volume of spells used to calculate SHMI is gradually returning to pre-pandemic levels is currently at 90%.

- The Trust should continue to engage with national and regional efforts to understand hospital mortality within the wider context of mortality in all settings and particularly in relations to disparities (inequalities) in the populations served by the trust.

- SHMI at 110 remains ‘as expected’ however there is a small reduction in the rolling 12 month depth of non-elective comorbidity coding coinciding with the implementation of electronic patient records. Although comorbidity coding will improve as the system is refined and becomes embedded in the delivery of care in the short term SHMI may be adversely affected and the trust should remain focused on this issue.

- The Medical Examiner team coverage of mortality continues to be in excess of 98% of all deaths. Scrutiny is being extended to out of hospital settings and the trust should continue to support the development of this service.

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 2 APRIL 2024			
Freedom to Speak Q4 2023/24 Update			**AGENDA ITEM: ENC**
Report Author and Job Title:	Jim Woods and Philippa Imrie Freedom to Speak Up Guardians Ian Bennett Deputy Director of Quality and Lead Freedom to Speak up Guardian.	**Responsible Director:**	Dr Hilary Lloyd Chief Nurse
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	This report provides an update on the work of the Freedom to Speak Up (FtSU) Guardians during Quarter 4 of 2024 (01 January 2024 to date 21 March 2024)		
Background	The Freedom to Speak Up Guardian role was created following recommendations from the Francis review of the Mid Staffordshire Hospitals with the aims of helping to protect patient safety and quality of care, to improve the experience of workers and promote organisational learning and improvement. At South Tees we achieve this by supporting colleagues to speak up about concerns, remove barriers to speaking up and by ensuring issues raised are used as opportunities for feedback, learning and improvement. Our current FtSU model has now been in place for over 3 years, with 75 hours dedicated to providing a speak up service to the organisation.		
Assessment	The number of concerns raised by colleagues to the FtSU Guardians in Q4 of 2023/24 was 37. The themes identified from the 37 concerns raised during the quarter include: Inappropriate attitudes/Behaviours 60 Pt safety/Quality 48 Worker Safety or Wellbeing 18 Bullying and Harassment 10 The Guardians Team continues to improve FtSU culture throughout the organisation with proactive work taking place to raise awareness of FtSU and other routes colleagues can use to raise concerns. We are maintaining our strong links with Teesside University, the Regional and national Guardians networks and have recently started		

	working in closer collaboration with our Guardian colleague at North Tees with a as part of the Joint Group Model.	
Level of Assurance	Level of Assurance: Significant ☒ Moderate ☐ Limited ☐ None ☐	
Recommendation	Members of the Board of Directors are asked to Note the content of the paper and emerging themes.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	All risks associated with this presentation are recorded on the risk register. BAF alignment: 5.1, 5.2	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives	Best for safe, clinically effective care and experience ☒	A great place to work ☒
	Deliver care without boundaries in collaboration with our health and social care partners ☒	Make best use of our resources ☒
	To create a Centre of Excellence, for all services, research, digitally supported healthcare, education and innovation in the Northeast of England, North Yorkshire and beyond ☒	

Freedom to Speak Up Q4 2023/24 Update

PURPOSE OF REPORT

The purpose of the report is to update the Board of Directors on progress made by the Freedom to Speak Up Guardians (FtSUG) since the submission of the previous report submitted in January 2024.

The report provides an overview of the themes and issues raised between the 1st of January 2024 to date 21 March 2024.

BACKGROUND

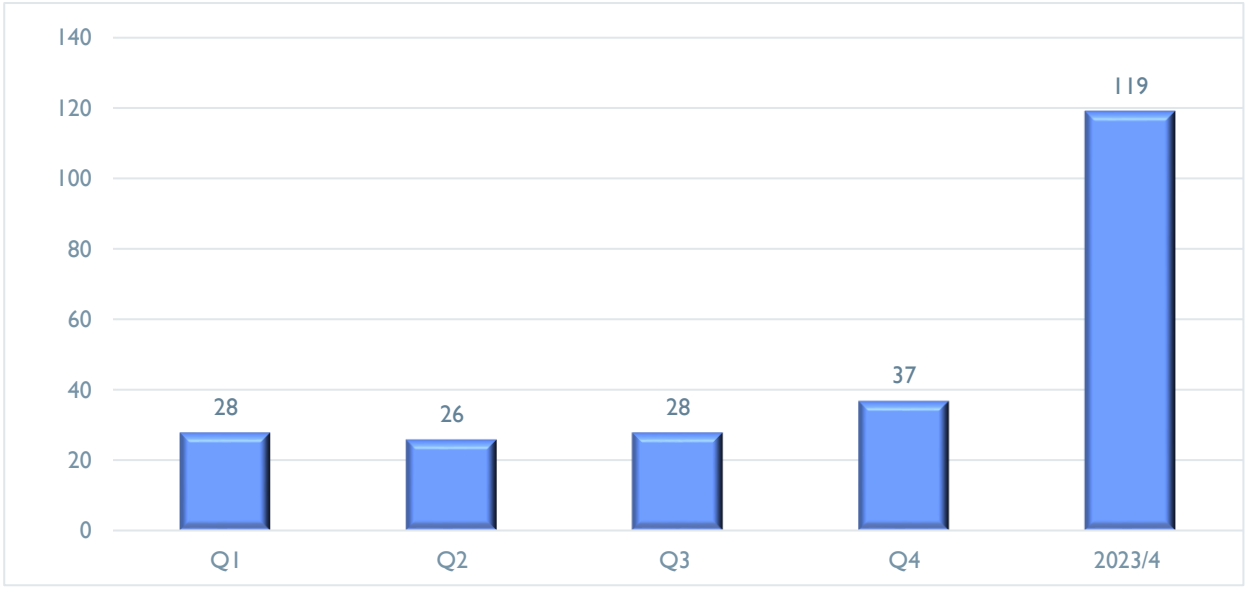
Following recommendations from the Francis Report, Freedom to Speak Up (FtSU) Guardians were created with the aim of helping to protect patient safety and quality of care, improve the experience of workers and promote learning and improvement.

At South Tees we achieve this by supporting colleagues to speak up about concerns, remove barriers to speaking up and by ensuring issues raised are used as opportunities for feedback, learning and improvement.

The current FtSU model employed in the Trust has now been in place for over 3 years with 3 part time guardians working 2.0 WTE hours covering the organisation. Due to recent changes and an ongoing service review, we were temporarily reduced to 1.0 WTE but after successful recruitment of 2 new Guardians in January 2024 we will be returning 75 hours from the start of April.

DETAILS

During Q4 of 2023/4, the FtSU Guardians received 37 new concerns set out in Graph 1, below. This brings the total number of concerns received in this financial year to 119.

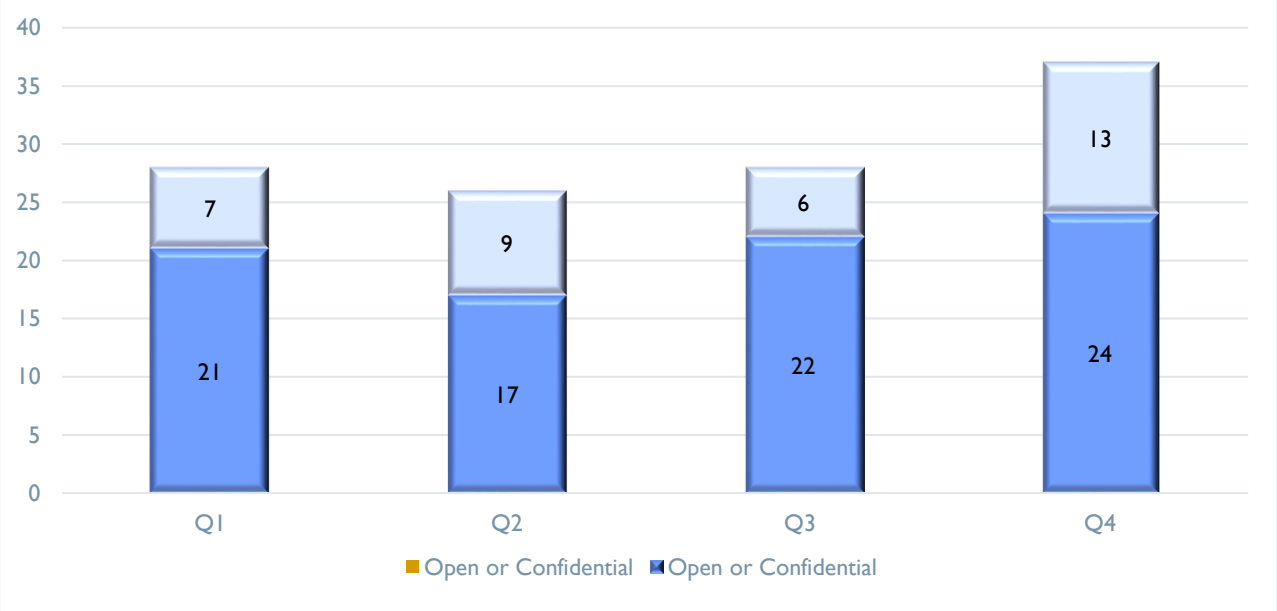


Graph 1

There was an increase in the number of cases raised during January 2024 compared to other quarters in the financial year. 17 of the 37 cases raised in Q4 were raised in by staff in one department, with similar themes being highlighted by the concern raisers. A focused piece of work has been carried out in this area to investigate the concerns raised which included engagement meetings held alongside staff and senior leaders, FtSU drop-in sessions within the department and proactive walkabouts. More recently discussions have taken place between FtSU guardians, Strive and psychology services in relation to what opportunities there are to support staff in this department.

In Q4 there was an increase in the proportion of concerns being reported anonymously although a large number of these were from one department, that we had received multiple concerns during January. This meant that for Q4, 13 concerns (35%) were raised anonymously which runs counter to the trend of a slow reduction in anonymous reporting that we had been seeing over the last 3 years.

Graph 2 below shows the rate of anonymous to open or confidential concerns received by quarter. Table 1 shows the year on year of decline in anonymous concerns since the new model was introduced.



Graph 2

Anonymous concerns received by year			
Year	2021/2	2022/3	2023/4
Total concerns	107	97	119
Anonymous concerns	46	32	32
% of total	43%	33%	27%

Table 1

Themes

When a concern is raised, themes are assigned to it by the Guardian depending on the content of the concern. A count of the Q4 themes is illustrated in Graph 3, below.

Graph 3

In the last bimonthly meeting with the Executive and Non-Executive directors of FtSU, there was a discussion about the themes reported by the FtSU Guardians at South Tees not matching the national picture taken from the National Guardian Office data.

The team has now concluded that conveying a count of themes may not be the most appropriate way to report these data. As a single concern can have many different themes assigned to it, and with each of these themes having an equal weight, reporting a simple count of themes may not be representing a true picture of what people are speaking up about to the Guardians at STH.

In the last NGO national report, data about FtSU concern themes was presented using 4 broad thematic groups:

- Patient safety or quality of patient care
- Inappropriate behaviours
- Bullying and Harassment
- Worker safety or wellbeing

When the Guardians assigned these broad categories to the South Tees thematic data, they found that in Q4:

35.3% of concerns related to patient safety,
44.1% related to inappropriate behaviours,
13.2% related to worker safety and wellbeing
7.4% related to bullying or harassment.

When this approach is applied Trust data from the full year, it shows that:

31.7% of concerns related to patient safety,
45.1% related to inappropriate behaviours,
13.7% related to worker safety and wellbeing
9% related to bullying or harassment.

The charts below show the proportion of themes reported in Q4 (Chart 1), the proportion of themes across the fiscal year (Chart 2) and a comparison with the National Guardians office data as of Q3 of 2023/24 [(1)].

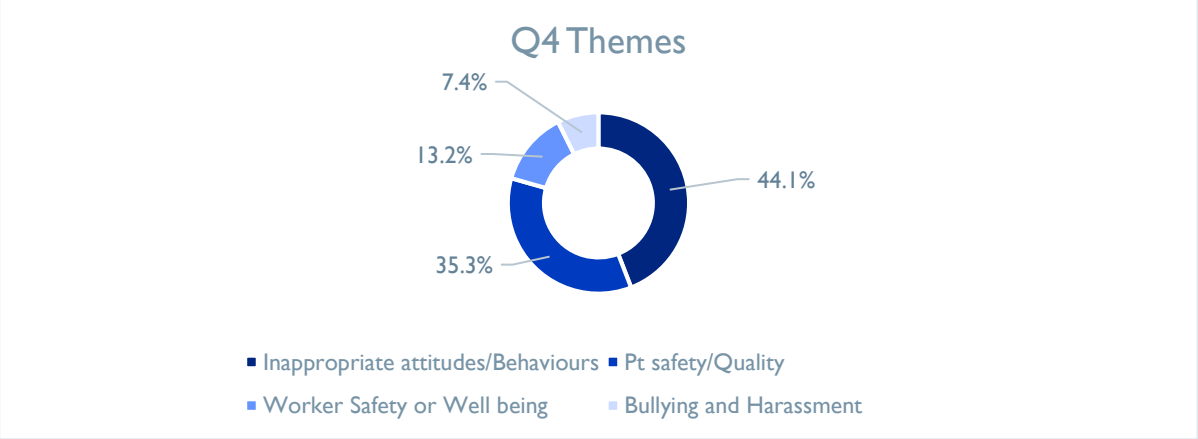


Chart 1

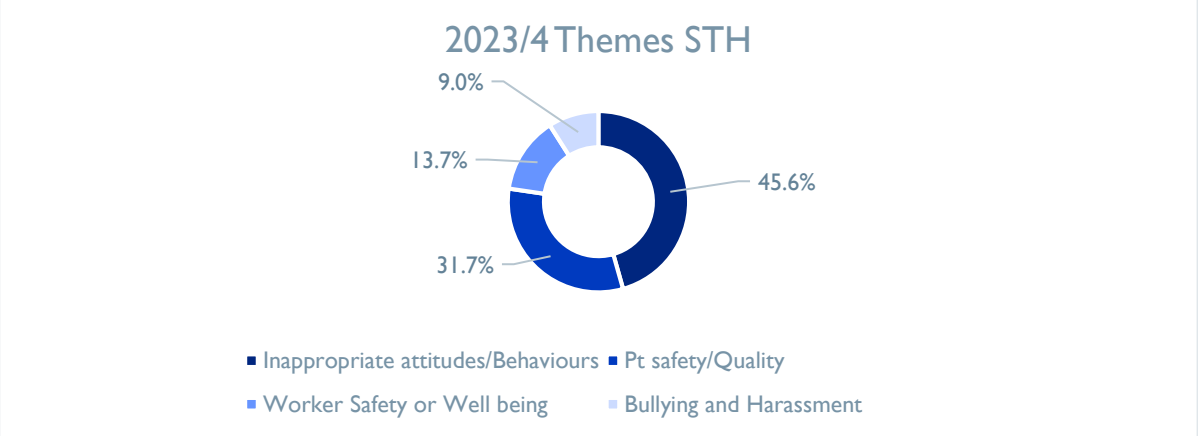


Chart 2

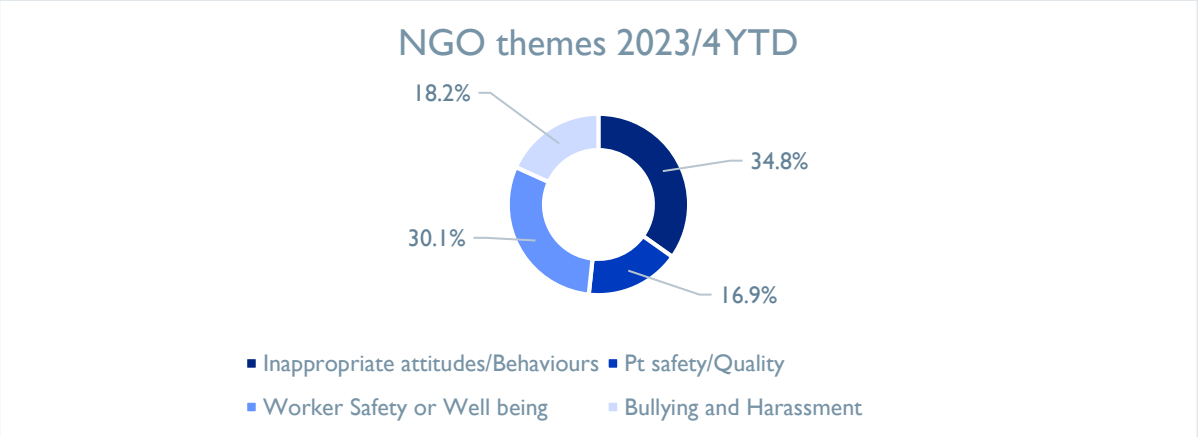


Chart 3

(1) *https://nationalguardian.org.uk/learning-resources/speaking-up-data/*

When applying this methodology of categorisations and comparing the national FtSU data, year to date, with the Trust's full year data it shows that the Trust is:

- Reporting a higher proportion (+10.8 percentage points) of behavioural themes concerns
- Reporting a much higher proportion (+14.8 percentage points) of patient safety and quality themed concerns
- Reporting a lower proportion (-9.2 percentage points) of bullying and harassment themed concerns
- Reporting a much lower proportion (-16.4 percentage points) of worker safety and well-being themed concerns

Staff Groups Speaking Up

Table 2 shows the staff groups who have spoken up in Q4.

Staff Groups	Q4
Nurses	11
Doctors	3
Allied Healthcare Professionals (other than pharmacists)	3
Administrative / clerical staff	3
Healthcare Assistants	2
Other/Not specified	15

Table 2

Professional Level Data

The FtSU team continue to receive concerns from all levels of staff within the organisation. Table 3 shows the professional levels of all staff who have spoken up in Q4.

Professional level	Q4
Worker 2-6	9
Manager 6-8d	14
Senior Leader/Consultant	8
Do not wish to disclose/Unknown	6

Table 3

EDI Data

Tables 4 and 5 reflect the equality and diversity of staff members who spoke up in Q4. Work is underway with the Equality and Diversity Lead to triangulate the data we gather and identify opportunities for key learning and development from the high-level themes.

EDI Information					
Male	2	Female	22	Prefer not to say /Not given	13
Ethnic Origin of Concern Raisers					
White					12
Asian					1
Mixed					0
Black					0
Not Stated					16

Prefer not to say	9
Sexuality of Concern Raiser	
Heterosexual	12
Gay	0
Bisexual	0
Prefer not to say	9
Do you consider yourself to have a disability?	
Yes	14
No	17
Prefer not to say/not stated	6

Table 4

Concerns linked to reported protected characteristics			
No. of concern raisers who self-reported being from a BAME background	1	No. of BAME staff who raised concerns related to ethnicity or racism	0
No. of Concern Raisers who self-reported having a disability	14	No. of staff who raised concerns related directly to disability	2
No. of Concern Raisers who self-reported being from the LGBTQ+ community	0	No. of staff who raised concerns related directly to sexuality or gender identity	1

Table 5

The team have noted the high numbers of people either not stating their ethnicity, sexuality or disability or selecting “prefer not to say” for these options. Some of this missing data can be accounted for by concerns being raised through other channels, rather than the online reporting tool, where the team may not routinely ask this information unless ethnicity, disability is mentioned in the concern. The team are working with the EDI lead and the system administrator to examine ways that we can improve the capturing of this data whilst not adding additional barriers to those wishing to raise concerns to the FtSUGs.

Of the 37 cases recorded over the quarter, 13 remain open, and 24 have been closed. Of these 6 were closed within 7 days, 10 within 30 days and 8 within 60 days. The median time for new concerns to be open is 18.5 days, as shown in Table 5 below.

Concerns raised during reporting period	Concerns Closed	Average No of Days Open (median)	Concerns Open from current period	Total Open Concerns
37	24	18.5	13	21

Table 5

Feedback and Follow up

Of the 37 concerns opened in this period, 24 have been closed and feedback forms sent where an email address has been supplied. To data we have not yet received any feedback from the concerns closed in this quarter which may be explained by the fact that 46% of the concerns raised and closed so far this in this period were anonymous. Open and confidential concerns have only recently been closed so feedback has yet to be returned.

There was discussion both at the regional FtSUG meeting and between the Guardians at South and North Tees about developing a mechanism to collect feedback from cases, not just when a case is closed, but up to 1 year after. It was agreed that collecting feedback about historical cases would allow Guardians to see whether any improvements made as the result of staff speaking up had been enduring and as a way of determining if concern raisers had suffered any long-term detriment as a result of raising their concerns.

As a result of these discussions, from Q1 2024, the Guardians will start to ask all concern raisers their permission to contact after concerns have been closed. The concern raised will be contacted through their preferred media at 3-, 6- and 12-month intervals after the cases had been closed.

Staff Survey and FTSU Questions

The staff survey results were published in early March. Table 6 below shows the responses to the Freedom to Speak Up Questions asked in the NHS Staff Survey for 2023. Three questions have remained above the national average, with question *Q20b "I am confident that my organisation would address my concern"* dropping slightly below the national benchmark.

NHS Staff Survey 2023 – Responses to the Freedom to Speak Up Questions	2023
% of staff "agreeing" or "strongly agreeing" I would feel secure raising a concern about unsafe clinical practice	71.05%
% of staff "agreeing" or "strongly agreeing" I am confident that my organisation would address my concerns	54.08 %
% of staff "agreeing" or "strongly agreeing" I feel safe to speak up about anything that concerns me in this organisation	62.82 %
% of staff "agreeing" or "strongly agreeing" If I spoke up about something that concerned me, I am confident my organisation would address my concern	48.69 %

Table 6

Table 7 below shows the changing scores to the FTSU questions over the last 3 years. Whilst the overall percentages have declined, this mirrors the national picture, with the Trust remaining above, or close to the national comparator benchmarking data. This will be an area that is closely monitored over the next 12 months with proactive work taking place using the trust scores breakdown as a guide to focus education and awareness of the FtSU service.

Staff Survey Question	2021/22 results	2022/23 results	2023/24 national results	2023/24 STH results
Q20a I would feel secure raising concerns about unsafe clinical practice.	76.9%	74.14%	70.24%	71.05% ↑
Q20b I am confident that my organisation would address my concern.	60.7%	58.3%	55.90%	54.08% ↑

Q25e, I feel safe to speak up about anything that concerns me in this organisation.	64.62%	63.10%	60.89%	62.82% ⬆
Q25f If I spoke up about something that concerned me, I am confident my organisation would address my concern	49.83%	48.15%	48.65%	48.69% ⬆

Table 7

ICB Audit

In November 2023, our colleagues at the ICB asked us to provide evidence for their regional audit of current FtSU procedures in the wake of the Lucy Letby Investigation, also known as the Thirwell Inquiry.

The ICB asked each trust in the region to undertake and submit to the ICB an audit of two retrospective cases to ensure that trusts are operating using suitable and similar FtSU processes. Our team completed this work in December and the ICB will share the full results of the audit once they have finished visiting all the sites within their remit. The ICB have advised us that the timescale for this is currently mid-April.

As North and South Tees come together in the group model, we have been working collaboratively as FtSU Guardians across both Trust and undertaken a GAP analysis on our respective FtSU self-assessments and of any recommendations which have been published as a result of recent national enquiries. This will be presented to the first group Board of Directors in April.

Staffing Changes

After our colleague Afshan Ali left in September 2023 and Rick Betts retired in January 2024, the FtSU team have recruited 2 new Guardians. Philippa Imrie, who has already joined us on 2 days a week will be moving to full time hours in April and a new colleague from County Durham and Darlington will be coming to work 4 days a week also in early April. This will mean that the team is once again up to full capacity.

Future Plans

Over the next twelve months the guardians have identified several opportunities, including:

- Embedding the freedom to speak up model which include the implementation of the updated Freedom to Speak Up policy.
- Using the data from the staff survey to identify areas that scored below the trust average for the 4 FtSU questions and focus our proactive work in these collaboratives and departments.
- Using data from the staff survey to identify areas that scored above the trust average for the 4 FtSU questions and develop collaborative relationships with departments in these areas to identify any areas of best practice related to speaking up.
- To develop training for staff as to what detriment is and how it can be tackled and prevented with the delivery of detriment workshops for managers and senior managers.

- To continue Identifying the barriers to speaking up and developing opportunities to overcome these including closer work with Equality and Diversity Inclusion groups and EDI lead.
- Recruitment and expansion of new and existing FtSU Champions from diverse backgrounds, with regular “lunch & learn” webinars and meetings, in addition to more formal training twice a year.
- Present joint GAP analysis on FtSU model to Group Board of Directors.

Recommendations

Members of the Board of Directors are asked to:

- Note the content of the paper and emerging themes.
- Receive assurance that the FtSU model continues to be effective and supports the Trust’s aims and objectives to improve culture and safety.
- Note the future opportunities identified as focus for the guardians over the next 12 months

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 2 April 2024			
Review of the Trust's Constitution			**AGENDA ITEM:** **[PA insert number]**
Report Author and Job Title:	Jackie White Head of Governance & Company Secretary	**Responsible Director:**	Jackie White Head of Governance & Company Secretary
Action Required	Approve ☒ Discuss ☐ Inform ☐ (select the relevant action required)		
Situation	The purpose of the report is to highlight the key changes made to the Trust's constitution to reflect updated guidance and group working with North Tees & Hartlepool NHS Foundation Trust and to seek final approval from the Board of Directors		
Background	In line with good governance practice, the Trust's Constitution should be reviewed every 3 years to ensure it remains up to date and reflects current practice, unless there is a significant change prompting earlier review. Following progress with the group model with North Tees & Hartlepool NHS Trust, it was agreed to review both Constitutions with a view of alignment where possible and to ensure that both documents incorporated any changes to legislation and guidance, including a focus on system working.		
Assessment	Both Constitutions have now been reviewed and are predominantly aligned, with key changes summarised below, with full details provided in the attached report; • Update to the principal purpose in line with the Health and Care Act 2022. • Update to election of lead governor. • Update to the detail of the Board of Directors – Composition • The addition of the statutory appointment of the Company Secretary. • Proposed replacement of CCG appointed governors with 1 x ICB governor and 1 x voluntary organisation governor (to be agreed) and increase to 6 staff governors from 3. • Amendment to state that in the event the Trust has governor vacancies, following an election process, a further election will take place. This replaces the process to have temporary arrangements. The proposed changes were presented approved by the Council of Governors meeting on 20 February 2024.		
Level of Assurance	Level of Assurance: Significant ☒ Moderate ☐ Limited ☐ None ☐ (select the relevant assurance level)		

Recommendation	Members of the Trust Board are asked to approve the Constitution	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This paper relates to all aspects of the Board Assurance Framework.	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Best for safe, clinically effective care and experience ☒	A great place to work ☒
	Deliver care without boundaries in collaboration with our health and social care partners ☒	Make best use of our resources ☒
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒	

South Tees Hospitals
NHS Foundation Trust

FOUNDATION TRUST CONSTITUTION

ISSUE DATE	February 2013
DATE REVIEWED	February 2024 in conjunction with North Tees & Hartlepool NHS Foundation Trust
APPROVAL PROCESS	Subject to Board of Director and Council of Governor Agreement
LEAD OFFICER(S)	Chief Executive and Chair

Revisions:

During 2018 - to meet the requirements of the NHS 2012 Health Act amendments

Approved:
Council of Governors on 8 May 2018
Board of Directors on 5 June 2018
Annual Members Meeting on 2 October 2018

June 2019 – to ensure document is gender neutral

March 2020 – to make provisions for meeting to be held using video/telephone/digital technologies

August 2020 – to amend names of the Clinical Commissioning Groups

January 2024 – to meet the requirements of the NHS Health and Care Act 2022; to adhere to the code of governance for NHS provider trusts 2022; to incorporate revised statutory duties: system working and collaboration: role of foundation trust councils of governors

Introduction

South Tees Hospitals NHS Foundation Trust and North Tees and Hartlepool NHS Foundation Trust approved arrangements to establish a group model to support increased joint working and collaboration between the two organisations and wider system, in line with the powers set out in the Health and Care Act 2022 and with approval from NHS England and North East North Cumbria Integrated Care Board (NENC ICB).

To support the joint working, a joint chair and a joint chief executive have been appointed, however, in line with current legislation both trusts remain as individual statutory organisations with individual constitutions. Therefore, for the purposes of this document references to the chair and chief executive will remain singular and not 'joint' or 'group'.

TABLE OF CONTENTS

[once the content is agreed, the page and paragraph numbers will be corrected throughout the document]

1. Name

The name of the foundation trust is South Tees Hospitals 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 service for any other purposes.

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

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

2.3.2 the delivery of safe, effective care and the effective use of resources; and

2.3.3 the promotion and protection of public health; and

2.3.4 the contribution to the objectives of the integrated care system (ICS); and

2.3.5 the collective responsibility with partners for delivery of high quality and sustainable services across system (ICS) and place based footprints.

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

2.5 The trust is required to comply with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all and sustainable use of NHS resources.

2.6 The trust will also be required to engage consistently and constructively in shared planning and decision making with partners in system, place based partnerships, provider collaboratives and any other relevant forums.

2.7 The trust will consistently take responsibility for delivery of improvements and decisions agreed through system and place based partnerships, provider collaboratives or any other relevant forums.

3. Powers

3.1 The powers of the trust are set out in the 2006 Act, updated in the 2012 Health and Social Care Act and the 2022 Health and Care Act.

3.2 The powers of the trust shall be exercised by the Board of Directors on behalf of the trust.

3.3 The powers of the Board of Directors, may be delegated to a committee of directors or to an executive director.,

4. Membership and constituencies

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

4.1.1 a public constituency; and
4.1.2 a staff constituency; and
4.1.3 a patient and/or carers constituency
4.1.4 a rest of England 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 an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the trust.

6.2 Those individuals who live in an area specified as an area for any public constituency are referred to collectively as the public constituency.

6.3 The minimum number of members in each area for the public constituency is specified in Annex 1.

6.4 For the avoidance of doubt, individuals who solely fulfil an unpaid voluntary role with the trust shall form part of the public constituency.

7. Patient/Carer Constituency

7.1 A patient/carer constituency eligibility is an individual who has, within the last 10 years, attended any of the trust's hospitals as either a patient or as the carer of a patient. They may become a member of the trust, provided that they live within the trust's public constituency areas.

8. Staff constituency

8.1 An individual who is employed by the trust and / or a subsidiary organisation, under a contract of employment may become or continue as a member of the trust provided:

8.1.1 they are employed by the trust and / or a subsidiary organisation under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 they have been continuously employed by the trust and / or a subsidiary organisation, under a contract of employment for at least 12 months.

8.2 Individuals, who exercise functions for the purposes of the trust (which for the avoidance of doubt shall not include non-executive directors), 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.

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

8.4 The minimum number of members in the staff constituency is specified in Annex 2.

9 Automatic membership by default – staff

9.1 An individual who is:

9.1.1 eligible to become a member of the staff constituency, and

9.1.2 invited by the trust to become a member of the staff constituency.

9.1.3 shall become a member of the trust as a member of the staff constituency and without an application being made, unless they inform the trust that they do not wish to do so.

10. Restriction on membership

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

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

10.3 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 8 – Further Provisions.

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

11. Council of Governors – composition

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

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

11.3 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 1 and Annex 3.

12. Council of Governors – election of governors

12.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the model rules for elections, as may be varied from time to time by NHS Providers or its successor body.

12.2 The model rules for elections, as may be varied from time to time by NHS Providers or its successor body, form part of this constitution and those current at the date of the trust's authorisation are attached at Annex 4.

12.3 A subsequent variation of the model rules for election by NHS Providers or its successor shall not constitute a variation of the terms of this constitution.

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

12.5 Election of lead governor

12.5.1 The Council of Governors will elect a lead governor from among their number, who shall on any occasion when direct contact with the Regulator is required, facilitate that contact between the governors and the Regulator.

12.5.2 If a lead governor ceases to hold the office for any reason, the company secretary shall send out nominations forms for appointment as lead governor. Each nomination shall be made in writing by the governor seeking appointment and must be returned to the company secretary.

12.5.3 If there are two or more nominations a ballot shall be held. Nominees may not vote.

12.5.4 This appointment shall be made from the public governors.

12.5.5 This appointment shall be for the remaining term of office of the governor elected.

12.5.6 The lead governor may resign from the office at any time by giving written notice to the company secretary, and shall cease to hold the office if they cease to be a governor.

12.5.7 The duties of the lead governor are as defined in the NHS foundation trust code of governance.

12.6 Election of deputy lead governor

12.6.1 The Council of Governors will elect a deputy lead governor from among their number.

12.5.2 Upon a vacancy arising, the company secretary shall send out nominations forms for appointment as deputy lead governor. Each nomination shall be made in writing by the governor seeking appointment and must be returned to the company secretary.

12.5.3 If there are two or more nominations a ballot shall be held. Nominees may not vote.

12.5.4 This appointment shall be made from the public governors.

12.5.5 This appointment shall be for the remaining term of office of the governor elected.

12.5.6 The deputy lead governor may resign from the office at any time by giving written notice to the company secretary, and shall cease to hold the office if they cease to be a governor.

12.5.7 The duties of the lead governor are:

i) The deputy lead governor plays an important role in deputising for the lead governor and to share the lead governor's workload which includes taking ownership of particular work streams and leading on certain areas of work on behalf of the Council of Governors.

ii) The role receives ongoing support from the Chair, Company Secretary and the Corporate Services Officer and has access to training and development and required.

13. Council of Governors – tenure

Subject to the provisions of paragraph 14:

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

13.2 An elected governor shall be eligible for re-election at the end of their term and shall serve no more than 3 consecutive terms of office, resulting in a maximum of 9 years tenure.

13.3. An elected governor shall cease to hold office if they cease to be a member of the constituency or class by which they were elected.

13.4 An appointed governor shall cease to hold office if notified by the appointing organisation.

13.5 An appointed governor shall be eligible for re-appointment at the end of their term and shall serve no more than 3 consecutive terms of office, resulting in a maximum of 9 years' tenure.

14. Council of Governors – disqualification and removal

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

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

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

14.1.3 a person who within the preceding 5 years has been convicted in the UK or Europe of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than 3 months (without the option of a fine) was imposed on them;

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

14.2 In addition to those criteria listed above, 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.

14.3 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

14.4 Where a governor becomes ineligible to continue holding the office of a governor, and thus disqualified, they must notify the company secretary in writing. Upon receipt of this notification the governor's tenure of office will be terminated.

14.5 If it comes to the notice of the company secretary that a governor is disqualified, the governor will be immediately declared disqualified and notified to this effect.

15. Council of Governors – Duties of Governors

15.1 The general duties of the Council of Governors are:

15.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, in the context of the system as a whole in the wider provision of health and social care; and

15.1.2 the Board of Directors decision making process to comply with the triple aim duty; and

15.1.3 to represent the interests of the members of the trust ,the public and the wider health system; and

15.1.4 approving 'significant transactions', mergers, acquisitions, separations or dissolutions.

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

16. Council of Governors – meetings of governors

16.1 The chair of the trust (that is, the chair of the Board of Directors, appointed in accordance with the provisions of paragraph 25) or, in their absence the vice chair (appointed in accordance with the provisions of paragraph 26 below), shall preside at meetings of the Council of Governors. The Council of Governors should meet at least 4 times per year.

16.2 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 including

16.2.1 during the consideration of any material or discussion in relation to a named person employed by or proposed to be employed by the trust;

16.2.2 during the consideration of any material or discussion in relation to a named person who is or has been or is likely to become a patient of the trust or a carer in relation to such patient;

16.2.3 during the consideration of any matter which, by reason of its nature, the Council is satisfied should be dealt with on a confidential basis;

16.2.4 those matters which would be deemed to be confidential for the purposes of the Freedom of Information Act 2000.

17. Council of Governors – standing orders

17.1 The standing orders for the practice and procedure of the Council of Governors, as may be varied from time to time, are attached at Annex 6.

18. Council of Governors – Referral to the Panel

18.1 In this paragraph, the Panel means a panel of persons appointed by NHS England to which a Governor of an NHS Foundation Trust may refer a question as to whether the Trust has failed or is failing;

18.1.1 to act in accordance with its constitution, or

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

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

19. Council of Governors - conflicts of interest of governors

19.1 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.

20. Council of Governors – travel expenses

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

21. Council of Governors – further provisions

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

22. Board of Directors – composition

22.1 The trust shall have a Board of Directors, which shall comprise both executive and non-executive voting directors.

22.2 The Board of Directors is to comprise:

22.2.1 a non-executive chair

22.2.2 a minimum of 5 other non-executive directors; and

22.2.3 a minimum of 5 executive directors.

22.4 One of the executive directors shall be the chief executive.

22.5 The chief executive shall be the Accounting Officer.

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

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

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

23. Board of Directors – General Duty

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

23.2 The Board of Directors should promote the long-term sustainability of the trust as part of the ICS and wider healthcare system.

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

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

24.2 They are a member of the public constituency of the trust, and

24.3 They meet the fit and proper persons requirements outlined within Regulation 5: Fit and Proper Persons: Directors of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 including all future amendments to the regulation; and

24.4 They are not disqualified by virtue of paragraph 29 below.

25. Board of Directors – appointment and removal of chair and other non-executive directors

25.1 The Council of Governors has the responsibility to appoint or remove the chair and other non-executive directors. The Council of Governors will request that the nominations committee undertakes such activities, and provide a recommendation for the whole of the Council of Governors to consider and agree, this would be undertaken at a general meeting of the Council of Governors.

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

253 The appointment of the chair and non-executive directors will be for an initial term of 3 years, further extensions for the chair and non-executive directors will be taken to the nominations committee. Chairs or non-executive directors should not remain in post beyond nine years from the date of their first appointment in line with the code of governance for NHS provider trusts.

25.4 The Council of Governors has the power to appoint associate non-executive directors in a non-voting capacity as deemed necessary to support the work of the Board of Directors. The appointment process will be delegated to the nominations committee.

26. Board of Directors – appointment of vice chair and senior independent director

26.1 The Board of Directors shall recommend to the Council of Governors, at a general meeting of the Council of Governors, that one of the non-executive directors is appointed as a vice chair.

26.2 Any non-executive director so appointed may at any time resign from the office of vice chair by giving notice in writing to the chair.

26.3 Where the chair of the trust has ceased to hold office, or they are unable to perform their duties owing to illness or any other cause, the vice chair shall act as chair until a new chair is appointed or the existing chair has resumed their duties. References to the chair in this constitution shall, so long as there is no chair able to perform the relevant duties, be deemed to include references to the vice chair.

26.4 Following consultation with the Council of Governors the Board of Directors shall inform the Council of Governors, at a general meeting of the Council of Governors, that one of the non-executive directors is appointed as a senior independent director.

26.5 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 chair.

27. Board of Directors - appointment and removal of the chief executive and other executive directors

27.1 The non-executive directors shall appoint or remove the chief executive. All appointments must satisfy the requirements of Regulation 5: Fit and Proper Persons: Directors of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 including all future amendments to the regulation.

27.2 The appointment of the chief executive shall require the approval of the Council of Governors.

27.3 A committee consisting of the chair, the chief executive and the other non-executive directors shall appoint or remove the other executive directors. All appointments must satisfy the requirements of Regulation 5: Fit and Proper Persons: Directors of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 including all future amendments to the regulation.

28. Board of Directors – appointment and removal of the Company Secretary

28.1 The Board shall appoint or remove the Company Secretary.

29. Board of Directors – disqualification

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

29.1.1 A person who has within the preceding 2 years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

29.1.2 An undischarged bankrupt, or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged;

29.1.3 The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;

29.1.4 A person whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40).

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

29.1.6 A person who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986.

29.1.7 The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.

29.1.8 The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

29.1.9 A person who within the preceding 5 years has been convicted in the United Kingdom and/or the European Union of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than 3 months (without the option of a fine) was imposed on them or been convicted elsewhere of any offence which if committed in any of the United Kingdom would constitute an offence.

29.1.10 A person has been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England would be a regulated activity.

29.1.11 A non-executive director who is no longer a member of the public constituency.

29.1.12 A person who is unable or unwilling to sign an annual declaration that they continue to meet the requirements within Regulation 5: Fit and Proper Persons: Directors of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 including all future amendments to the regulation;

29.1.13 A person who has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

29.2 The trust may suspend or agree leave of absence in the event of any investigation into matters associated with an executive director.

30. Board of Directors – Meetings

30.1 The practice and procedure for meetings of the Board of Directors are attached at Annex 7.

31. Board of Directors – standing orders

31.1 The standing orders for the practice and procedure of the Board of Directors, as may be varied from time to time, are attached at Annex 7.

32. Board of Directors - conflicts of interest of directors

32.1 Each director has 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. This duty is not infringed if the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or if the matter has been authorised in accordance with this constitution.

32.2 Each director has 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. This duty is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

32.3 If a director is aware that they have in any way a direct or indirect interest in a proposed transaction or arrangement with the trust, they shall disclose the nature and extent of that interest to the other directors as soon as they are aware of it and in all cases, before the trust enters into the transaction or arrangement. If any declaration proves to be or becomes inaccurate or incomplete, the director shall make a further declaration.

32.4 A director need not declare an interest:

32..1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

32..2 if, or to the extent that, all the directors are already aware of it;

32..3 if, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered;

(a) by a meeting of the Board of Directors; or

(b) by a committee of the directors appointed for that purpose under this constitution.

32.5 The Board of Directors shall adopt standing orders specifying the arrangements for excluding directors from discussion or consideration of the contract or other matter as appropriate.

33. Board of Directors – remuneration and terms of office

33.1 The Council of Governors has the responsibility to review the remuneration and allowances, and the other terms and conditions of office, of the chair and other non-executive directors, but shall delegate this responsibility to the nominations committee, who will report back to the whole of the Council of Governors for final approval at a general meeting of the Council of Governors.

33.2 The trust shall establish a remuneration committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the chief executive and other executive directors.

34. Registers

34.1 The trust shall have:

34.2 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;

34.3 a register of members of the Council of Governors;

34.4 a register of interests of governors;

34.5 a register of directors; and

34.6 a register of interests of the directors.

35. Admission to and removal from the Registers

35.1 The Trust's Company Secretary will be responsible for the maintenance of, admission to and removal from the registers under the provisions of this constitution.

35.2 Each director and governor shall advise the Company Secretary as soon as practicable of anything which comes to their attention or which they are aware of which might affect the accuracy of the matters recorded in any of the registers referred to in paragraph 34.

35.3 Members will be removed from the Register of Members if:

35.3.1 the member is no longer eligible or is disqualified; or

35.3.2 the member dies.

36. Registers – inspection and copies

36.1 The trust shall make the registers specified in paragraph 34 available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

36.2 The trust shall not make any part of its registers available for inspection by members of the public which shows details of:

36.2.1 any member of the trust, if the member so requests.

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

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

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

36.4 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.

37. Documents available for public inspection

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

37.1.1 a copy of the current constitution;

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

37.1.3 a copy of the latest annual report;

37.2 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:

37.2.1 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;

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

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

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

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

37.2.6 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 (Regulator's decision), 65KB (Secretary of State's response to Regulator'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;

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

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

37.2.9 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; and

37.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

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

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. Auditor

38.1 The trust shall have an auditor.

38.2 The Council of Governors shall appoint or remove the auditor to the trust. The Council of Governors will request that the governor external audit working group undertake this activity, and provide a recommendation to the whole Council of Governors to consider and agree at a general meeting of the Council of Governors.

39. Audit committee

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

40. Accounts

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

40.2 The Regulator may with the approval of the Secretary of State give directions to the trust as to the content and form of its accounts.

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

40.4 The trust shall prepare in respect of each financial year annual accounts in such form as the Regulator may with the approval of the secretary of state direct.

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

40.6 The trust shall:

40.6.1 lay a copy of the annual accounts, and any report of the auditor on them, before Parliament;

40.6.2 send copies of those documents to the Regulator within such period as the Regulator may direct; and

40.6.3 send copies of any accounts prepared pursuant to paragraph 40.4, and any report of an auditor on them to the Regulator within such period as the Regulator may direct.

41. Annual report, forward plans and non NHS work

41.1 The trust shall prepare annual reports and send them to the Regulator and parliament.

41.2 The trust shall give information as to its forward planning in respect of each financial year to the Regulator. The trust's annual forward plan will be aligned with the joint system plan.

41.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors who in doing so shall have regard to the views of the Council of Governors.

41.4 The forward planning information must include information about –

41.4.1 the activities other than the provision of goods and services for the purposes of the health service in England that the trust proposes to carry on, and

41.4.2 the income it expects to receive from doing so.

41.5 Where the forward planning information contains a proposal that the trust carry on an activity of a kind mentioned in sub-paragraph 41.4.1 the Council of Governors must –

41.5.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the trust of its principal purpose or the performance of its other functions, and

41.5.2 notify the directors of the trust of its determination.

41.6 Where the trust 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 purpose of the health service in England may implement the proposal only if more than half of the members of the Council of Governors of the trust voting approve its implementation.

42. Presentation of the annual accounts and reports to the governors and members

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

42.1.1 the annual accounts;

42.1.2 any report of the auditor on them;

42.1.3 the annual report.

42.2 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. The trust may combine a meeting of the Council of Governors convened for the purposes of paragraph 42.1 with the Annual Members' Meeting.

42.3 Where an amendment has been made to this constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the trust), at least one governor shall attend the next Annual Members' Meeting to be held, at which the governor shall present the amendment and the members shall be entitled to vote on whether they approve the amendment.

42.4 If more than half the members voting to approve the amendment, the amendment shall continue to have effect; otherwise it shall cease to have effect and the trust shall take such steps as are necessary as a result.

43. Acquisition, Merger, Separation and Dissolution

43.1 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.

44. Significant Transactions

44.1 South Tees Hospitals NHS Foundation Trust may enter into a significant transaction only if more than half of the members of the Council of Governors voting approve entering in to the transaction. The threshold for a significant transaction differs depending upon whether the transaction relates to UK or non UK healthcare investment or disinvestment.

44.2 There are three types of transactions that may trigger the significant transaction threshold:

44.2.1 investment/disinvestment in income – Where the income attributable to the asset or the contract associated with the transaction is greater than 25% when divided by the income of the trust. (For non-healthcare/international transactions the threshold is reduced by 50% for investments only).

44.2.2 acquisition or disinvestment of assets of the business – Where the gross assets subject to the transaction is greater than 25% when divided by the gross assets of the trust.

44.2.3 investment of a capital nature - Where the gross capital of the company or business being acquired/divested is greater than 25% when divided by the total capital of the trust following completion of the effects on the total capital of the trust resulting from the transaction.

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.

45.3 The seal shall be kept by the company secretary.

45.4 Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two senior managers of the trust duly authorised by the chief executive and not also from the originating department or directorate, and shall be attested by them.

45.5 The chief executive shall keep a register in which they, or another manager of the trust authorised by them, shall enter a record of the sealing of every document.

45.6 A report of all sealing shall be made to the Board of Directors at least quarterly. The report shall contain the description of the document and the date of sealing.

45.7 In land transactions, the signing of certain supporting documents may be delegated to managers as set out clearly in the scheme of delegation. Such delegation shall not include the main or principal documents effecting the transfer (for example, the sale/purchase agreement, lease, contracts for construction works and main warranty agreements) or any document which must be executed as a deed.

46. Interpretation and definitions

46.1 Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 and amended by the Health and Social Care Act 2012 and updated Health and Care Act in 2022

46.2 In the case of a dispute in relation to the interpretation of this constitution, the chair's decision will be final.

the 2006 Act is the National Health Service Act 2006.

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

the 2022 Act is the Health and Care Act 2022.

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

Board of Directors means the board of directors as constituted in accordance with the terms of this constitution.

Constitution means this constitution and all annexes to it.

Council of Governors means the council of governors as constituted in accordance with the terms of this constitution.

Integrated Care Boards (ICBs) are statutory NHS organisations responsible for planning and commissioning health services for the local population within each ICS geographical area as part of the ICP's integrated care strategy.

Integrated Care Partnership (ICP) is a statutory joint committee between members of the ICS and the ICB which is responsible for the development of an integrated care strategy setting out how the health and care needs of the local population will be met.

Integrated Care System (ICS) is a statutory partnership of organisations, which include the NHS, local authorities, social care, voluntary groups and independent care providers to provide health and care services in a designated geographical area.

Place Based Partnerships are a partnership of organisations which include the NHS, local authorities, social care, voluntary and other groups that design and deliver integrated services for individual geographical 'places' within the ICS such as towns or boroughs.

Provider Collaboratives are a partnership of NHS provider trusts working across a number of places with the shared purpose to plan, deliver and transform local services.

The Regulator is the body corporate known as NHS England, as provided by section 33 of the Health and Care Act 2022 or its successor.

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

47. Amendment to constitution

47.1 The trust may make amendments to this constitution only if:

47.1.1 more than half the members of the Council of Governors voting, approve the amendments.

47.1.2 more than half the members of the Board of Directors voting, approve the amendments.

47.2 Amendments take effect as soon as the conditions in paragraph 47.1 are satisfied, but an amendment shall have no effect in so far as the constitution would, as a result of the amendment, not accord with Schedule 7 of the 2006 Act.

47.3 The trust shall inform the Regulator of amendments to the constitution.

47.4 If an amendment relates to the powers or duties of the Council of Governors (or is otherwise with respect to the role that the Council of Governors has as part of the trust), paragraphs 42.3 and 42.4 the constitution shall apply.

48. Law and guidance

This constitution must be read in conjunction with all relevant law and any relevant guidance issued by the Regulator or the Secretary of State for Health.

49. Indemnity

49.1 Governors and directors who act honestly and in good faith and not recklessly 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 Council of Governors or Board of Directors functions. Any such liabilities will be liabilities of the trust.

49.2 The trust may make such arrangements it considers appropriate for the provision of indemnity insurance or similar arrangement for the benefit of the trust, the Council of Governors, the Board of Directors, and the Company Secretary.

ANNEX 1

THE PUBLIC CONSTITUENCY

Area	Name of Constituency	Minimum Number of Members	Number of Governors
Area A	Middlesbrough (defined by local authority boundaries)	5	x
Area B	Redcar and Cleveland (defined by local authority boundaries)	5	x
Area C	Hambleton and Richmondshire (defined by the boundaries of Hambleton District Council and Richmondshire District Council)	5	x
Area D	Rest of England (defined as any area of England other than those in area A, B and C)	1	x
Area E	Patient and/or Carers (defined as any of the public constituencies /Rest of England in areas A, B, C and D a patient and/or Carer of the Trust)	2	x

ANNEX 2

THE STAFF CONSTITUENCY

The Staff Constituency will not be divided into classes.

There will be a minimum of 30 members in the Staff Constituency.

Individuals, who exercise functions for the purpose for 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 a contract of employment for a period of at least 12 months.

ANNEX 3

COMPOSITION OF COUNCIL OF GOVERNORS

1. Council of Governors structure

1.1 The Council of Governors of the trust shall include:

1.1.1 15 public governors selected by the public constituency;

1.1.2 1 Rest of England public governor elected by the public constituency;

1.1.3 2 patient carer governors elected by the public constituency;

1.1.4 6 staff governors elected by the staff constituency;

1.1.5 10 partnership Governors appointed by stakeholders comprising;

1.1.5.1 3 representatives from regional universities;
1.1.5.2 1 NENC ICB representative
1.1.5.3 3 local authority representatives;
1.1.5.4 1 Healthwatch representative;
1.1.5.5 1 carers organisation;
1.1.5.6 1 strategic organisation;
1.1.5.7 1 voluntary organisation

2. Appointed Governors

2.1 The following organisations ("Partnership Organisations") are specified for the purposes of sub-paragraph 9(7) of Schedule 7 to the 2006 Act and may each appoint one member of the Council of Governors:

3. Partnership organisations

3.1 The organisations which are partnership organisations are the;

3.1.1 University of Newcastle;
3.1.2 University of Durham;
3.1.3 University of Teesside.

3.2 Partnership governors will be appointed pursuant to a process agreed by those organisations and the trust.

4. ICB representative governors

4.1 The following ICB may appoint one representative:

4.1.1 NENC ICB; and

4.2 This governor will be appointed in accordance with a process to be agreed between the trust and the ICB.

5. Local authority governors

5.1 The following local authorities may each appoint one Local Authority governor:

5.1.1 Middlesbrough Council;

5.1.2 Redcar and Cleveland Council; and

5.1.3 North Yorkshire County Council.

6. Healthwatch governors

6.1 The following healthwatch organisation may appoint one Healthwatch governor:

6.1.1 Healthwatch South Tees

7. System Health and Care representatives

7.1 The following health and care system organisation may appoint one governor.

ANNEX 4

THE MODEL RULES FOR ELECTIONS

South Tees Hospitals NHS Foundation Trust (Council of Governors)

Rules for the Conduct of Elections for Public and Staff Governors

The poll

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

PART 6: COUNTING THE VOTES

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

PART 8: DISPOSAL OF DOCUMENTS

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

PART 10: ELECTION EXPENSES AND PUBLICITY

Expenses

Publicity

PART 11: QUESTIONING ELECTIONS AND IRREGULARITIES

PART 12: MISCELLANEOUS

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution;

"*council of governors*" means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance NHS England December 2013 or any later version of such code.

"deputy lead governor" means the governor nominated by the corporation to deputise for the lead governor and to provide the Trust with a point of contact for the Council of Governors in the event that the lead governor is unbailable for a period of time or has a conflict of interest.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*The Regulator*" means the corporate body known as the Regulator or any successor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

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

2. Timetable

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

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

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

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

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

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

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail

address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

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

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

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

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

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

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

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

16. Inspection of statement of nominated candidates and nomination forms

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

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

17. Withdrawal of candidates

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

18. Method of election

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

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

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

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

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

19. Poll to be taken by ballot

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

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

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

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

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an

electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters

in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate,

(d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

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

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

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

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

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

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

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

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

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

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

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

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

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

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

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

The poll

27. Eligibility to vote

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

28. Voting by persons who require assistance

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

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

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

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been

returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

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

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

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

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

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

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

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

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

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

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

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

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

41. Interpretation of Part 6

41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule 49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule 46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination

of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules 47.4 or 47.7.

42. Arrangements for counting of the votes

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

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:
  (i) the use of such software for the purpose of counting votes in the relevant election, and
  (ii) a policy governing the use of such software, and
(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:
  (iii) ballot papers that have been returned; and
  (iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and
(b) count the votes according to the provisions in this Part of the rules and/or the

provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

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

44. Rejected ballot papers and rejected text voting records

44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

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

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

44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

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

44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule 44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule 44.3.

45. First stage

45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

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

45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

46. The quota

46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

46.2 The result, increased by one, of the division under rule 46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules 47.1 to 47.3 has been complied with.

47. Transfer of votes

47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule 47.1.

47.3 The returning officer is, in accordance with this rule and rule 48, to transfer each sub-parcel of ballot documents referred to in rule 47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

47.4 The vote on each ballot document transferred under rule 47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

47.6 The returning officer is, in accordance with this rule and rule 48, to transfer each sub-parcel of ballot documents referred to in rule 47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

47.7 The vote on each ballot document transferred under rule 47.6 shall be at:

(a) a transfer value calculated as set out in rule 47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

47.8 Each transfer of a surplus constitutes a stage in the count.

47.9 Subject to rule 47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

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

48. Supplementary provisions on transfer

48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

48.2 The returning officer shall, on each transfer of transferable ballot documents under rule 47:

(a) record the total value of the votes transferred to each candidate,

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

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

48.3 All ballot documents transferred under rule 47 or 49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

48.4 Where a ballot document is so marked that it is unclear to the returning officer at

any stage of the count under rule 47 or 49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

49. Exclusion of candidates

49.1 If:

(a) all transferable ballot documents which under the provisions of rule 47 (including that rule as applied by rule 49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule 50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule 49.12 applies, the candidates with the then lowest votes).

49.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule 49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

49.3 The returning officer shall, in accordance with this rule and rule 48, transfer each sub-parcel of ballot documents referred to in rule 49.2 to the candidate for whom the next available preference is given on those ballot documents.

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

49.5 If, subject to rule 50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule 49.1 into sub- parcels according to their transfer value.

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

49.7 The vote on each transferable ballot document transferred under rule 49.6 shall be at the value at which that vote was received by the candidate excluded under rule 49.1.

49.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule 49.1.

49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

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

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

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules 47.5 to 47.10 and rule 48.

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

49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

50. Filling of last vacancies

50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

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

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

51. Order of election of candidates

51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule 47.10.

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

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

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

52. Declaration of result for contested elections

52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the South Tees Hospitals NHS Foundation Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule 44.1,

(f) the number of rejected text voting records under each of the headings in rule 44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared

elected.

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with "rejected in part",

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

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

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that the Regulator has declared that the vote was invalid.

59. Countermand or abandonment of poll on death of candidate

59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to the Regulator under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

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

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

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

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to the Regulator for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

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

66.3 An application may only be made to the Regulator by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. The Regulator will refer the application to the independent election arbitration panel appointed by The Regulator.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

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

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

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

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

68. Prohibition of disclosure of vote

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

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

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

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 5

ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

1 A person may not vote at an election for a public governor unless within the specified period they have made a declaration in the specified form stating the particulars of their qualification to vote as a member of the constituency for which an election is being held. It is an offence to knowingly or recklessly to make such a declaration which is false in a material particular.

2. Partnership governors (including all organisations in the wider health and care system), as the case may be, shall cease to hold office where the relevant appointing organisation notifies the company secretary of the withdrawal of their appointment of them.

3. Subject to paragraph 3A below and in addition to those criteria listed in paragraph 12.1 of the constitution a person may not become or continue as a governor of the trust if:

3.1 They have within the preceding 2 years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body.

3.2 They are a person whose tenure of office as the chair or as a member or director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest.

3.3 They are or have been an executive or non-executive director of the trust, or a non-executive director, chair or chief executive or executive director of another NHS organisation.

3.4 They have been removed from membership of a professional body or from a list of registered medical, dental, nursing or other health care practitioners as a result of disciplinary action or any conclusion that the continued inclusion of that person's name on any such list or membership of any such professional body would be prejudicial to the efficiency of the services to which the professional body or list relates and has not subsequently been re-instated to membership or such a list.

3.5 They are incapable by reason of mental disorder, illness or injury of managing and administering their property and affairs.

3.6 The Council of Governors reasonably considers that they are unfit to discharge the functions of a governor.

3.7 They have been disqualified from membership of their profession by the professional or regulatory body.

3.8 They bring the trust into disrepute or their actions are detrimental to the interests of the trust.

3.9 They have had their name placed on the registers of Schedule 1 offenders pursuant to the Sex Offenders Act 1977 and/or the Children's and Young Person's Act 1993.

3.10 They fail to confirm acceptance of the Council of Governors code of conduct, and/or a breach of the code of conduct.

3.11 They are a member of parliament.

3A. Further to paragraph 3, a person may not become or continue as a public governor if they are a governor in another NHS organisation.

3B. Where a person has been elected or appointed to be a governor and they become disqualified for appointment under paragraph 12.1 of the constitution and/or paragraph 3 or 3A above they shall notify the company secretary in writing of such disqualification.

3C. If it comes to the notice of the trust at the time of their appointment or later that the governor is so disqualified, the trust shall immediately declare that the person in question is disqualified and notify them in writing to that effect.

3D. Upon receipt of any such notification, that person's tenure of office, if any, shall be terminated and they shall cease to act as a governor.

3E. The nominations committee on behalf of the Council of Governors will decide whether a governors position should be terminated in the event of any of the above actions occurring or a breach of the Council of Governors code of conduct has occurred. The sub-committee shall subsequently call a general meeting of the Council of Governors to approve their decision for the removal of a governor.

3F A staff governor who is suspended from staff duties for any reason will also be suspended from their role as a governor for the duration of their suspension. Whilst a staff governor is under investigation, they cannot attend meetings of the Council of Governors in any capacity, but missing any meetings of the Council of Governors will not count as failure to attend for the purpose of 4.2 below.

4. Termination of Tenure

4.1 A governor may resign from office at any time during the term of that office by giving notice in writing to the company secretary.

4.2 If a governor fails to attend for 3 consecutive meetings of the Council of the Governors their tenure of office is to be immediately terminated unless the other governors are satisfied that:

4.2.1 the absence was due to a reasonable cause; and

4.2.2 they will be able to start attending meetings of the Council of Governors again within such a period as they consider reasonable.

4.3 In the event that the governor failed to attend further meetings they may be terminated after consideration by the nominations committee.

5. Managing Vacancies

5.1 The validity of any act of the trust is not affected by any vacancy among the governors or by any defect in the appointment of any governor.

5.2 In the event that the trust has Governor vacancies remaining following an election process, a further election will take place.

6. Roles and responsibilities of Council of Governors at a general meeting

6.1 In addition to those powers contained elsewhere in this constitution the roles and responsibilities of the governors at a general meeting are:

6.2 To approve the remuneration and allowances, and the other terms and conditions of office, of the non-executive directors.

6.3 To appoint or remove the trust's auditor.

6.4 To both consider and be presented with the annual accounts, any report of the auditor on them, and the annual report at the annual general meeting of the trust.

6.5 To give the views of the Council of Governors to the directors for the purposes of the preparation (by the directors) of the document containing information as to the trust's forward planning in respect of each financial year to be given to the Regulator.

6.6 To respond as appropriate when consulted by the directors in accordance with this constitution.

6.7 Such other duties as may be agreed with the directors from time to time.

6.8 A governor elected to the Council of Governors by the public constituency or the staff constituency may not vote at a meeting of the Council of Governors unless, within one month of election or by the date of the next Council of Governors Meeting after their election (whichever is the sooner) they have made a declaration in the form found at Annex 4 that they are a member of the public constituency, or the staff constituency and are not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 to the 2006 Act or is otherwise prevented under this constitution.

6.9 Committees and Sub-Committees

6.9.1 the Council of Governors may appoint committees consisting of its members to assist it in carrying out its functions. A committee appointed under this paragraph may appoint a sub-committee.

6.9.2 these committees or sub-committees may, where appropriate and reasonable, call upon outside advisers to help them in their tasks

6.10 Code of conduct

The Council of Governors shall at all times comply with the provisions of the trust's Council of Governors code of conduct as varied by the Board of Directors from time to time.

ANNEX 6

STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

1. Meetings of the Council of Governors

1.1 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 resolving as follows:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting because the confidential nature of the business to be transacted is such that publicity would be prejudicial to the public interest".

1.2 The chair (or vice chair) shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Council of Governors' business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Council of Governors resolving as follows:

"That in the interests of public order the public withdraw from the meeting for (the period to be specified) to enable the Council of Governors to complete business without the presence of the public".

1.3 Nothing in these standing orders shall require the Council of Governors to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Council of Governors.

1.4 Calling meetings - ordinary meetings of the Council of Governors shall be held at such times and places as determined by the trust. Meetings may be held virtually by means of digital technology.

1.5 The chair may call a meeting of the Council of Governors at any time. If the chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of governors, has been presented to them, or if, without so refusing, the chair does not call a meeting within 7 days after such requisition has been presented to them, at the trust's headquarters, such one third or more governors may forthwith call a meeting.

1.6 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 chair or by an officer of the trust authorised by the chair to sign on their behalf shall be delivered to every governor, or sent by post to the usual place of residence of such governor, so as to be available to them at least 6 days before the meeting.

1.7 Lack of service of the notice on any governor shall not affect the validity of a meeting.

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

1.9 Failure to serve such a notice on more than 3 governors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post, and by electronic means.

1.10 Setting the agenda - The Council of Governors may determine that certain matters shall appear on every agenda for a meeting of the Council of Governors 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.

1.11 A governor desiring a matter to be included on an agenda shall make their request in writing to the chair at least 14 days before the meeting, subject to standing order 1.8. Requests made less than 8 days before a meeting may be included on the agenda at the discretion of the chair, and if agreed would be taken under any other business.

1.12 Chair of meeting - At any meeting of the trust, the chair, if present, shall preside. If the chair is absent from the meeting the vice chair, if there is one and they are present, shall preside. If the chair and vice chair are absent, the senior independent director or the lead governor shall preside.

1.13 If the chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the vice chair, if present, shall preside. If the chair andvice chair are absent, or are disqualified from participating, the senior independent director or the lead governor shall preside.

1.14 Notices of motion - A governor of the trust desiring to move or amend a motion shall send a written notice there of at least 10 days before the meeting to the chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being in compliance with these standing orders. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to standing order 1.8.

1.15 Withdrawal of motion or amendments - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the chair.

1.16 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 6 calendar months shall bear the signature of the governors who gives it and also the signature of 3 other governors. When any such motion has been disposed of by the trust, it shall not be competent for any governor other than the chair to propose a motion to the same effect within 3 months; however the chair may do so if he considers it appropriate.

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

1.19 When a motion is under discussion or immediately prior to discussion it shall be open to a governor 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.

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

1.20 Chair's ruling - Statements of governors made at meetings of the trust shall be relevant to the matter under discussion at the material time and the decision of the chair of the meeting on questions of order, relevance, regularity and any other matters shall be observed at the meeting.

1.21 Voting - Save where all public governors present are unanimous in opposing a motion, every question at a meeting shall be determined by a majority of the votes of the governors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote. In the event that a motion is opposed by all public governors present, that motion shall not be passed.

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

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

1.24 If a governor so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

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

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

1.27 No discussion shall take place upon the minutes except upon their accuracy or where the chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the meeting subsequent to the meeting to which the minutes relate.

1.28 Where providing a record of a public meeting the minutes shall be made available to the public (required by the code of practice on openness in the NHS).

1.29 Suspension of standing orders - Except where this would contravene any statutory provision any one or more of the standing orders may be suspended at any meeting, provided that at least two-thirds of the Council of Governors are present, including one staff governor and one public governor, and that a majority of those present vote in favour of suspension.

1.30 A decision to suspend standing orders shall be recorded in the minutes of the meeting.

1.31 A separate record of matters discussed during the suspension of standing orders shall be made and shall be available to the governors.

1.32 No formal business may be transacted while standing orders are suspended.

1.33 The audit committee shall review every decision to suspend standing orders.

1.34 Variation and amendment of standing orders - These standing orders shall be amended only if:

- a notice of motion under standing order 1.15 has been given;
- no fewer than half the total of the trust's public governors vote in favour of amendment;
- at least two-thirds of the governors are present; and
- the variation proposed does not contravene a statutory provision.

1.35 Record of attendance - The names of the governors present at the meeting shall be recorded in the minutes.

1.36 Quorum - No business shall be transacted at a meeting of the Council of Governors unless at least one-third of the whole number of the governors are present, including at least 4 public governors.

1.37 If a governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see standing order 4.5) they 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.

1.38 The Council of Governors will receive, discuss and approve any proposed amendments to the constitution presented to them at a general meeting of the Council of Governors.

2. Committees

2.1 Appointment of committees - The Council of Governors may appoint committees of the Council of Governors, consisting wholly or partly of governors.

2.2 A committee appointed under standing order 2.1 may appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include governors).

2.3 These standing orders, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committees established by the Council of Governors.

2.4 Each such committee or sub-committee shall have such terms of reference and powers in relation to the business of the Council of Governors, and be subject to such conditions (as to reporting back to the Council of Governors), as the Council of Governors shall decide. Such terms of reference shall have effect as if incorporated into the standing orders.

2.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Council of Governors.

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

2.7 A governor or a member of a committee shall not disclose any matter reported to the Council of Governors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or committee shall resolve that it is confidential.

3. Declarations of interests and register of interests

3.1 Declaration of interests - The trust's constitution requires governors to declare interests which are relevant and material to the Council of Governors of which they are a member. All governors should declare such interests, and are required to review these each year.

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

3.2.1 directorships, including non-executive directorships held in public or private limited companies (with the exception of those of dormant companies);

3.2.2 ownership or part-ownership of public or private limited companies, businesses, majority or controlling share holdings in organisations or consultancies likely or possibly seeking to do business with the NHS;

3.2.3 a position of authority in a charity or voluntary organisation in the field of health and social care;

3.2.4 any connection with a voluntary or other organisation contracting for NHS services.

3.2.5 any family connections with any of the above or any other NHS, voluntary, public or private body which provides services to the trust.

3.4 If governors have any doubt about the relevance of an interest, this should be discussed with the chair.

3.5 At the time governors' interests are declared, they should be recorded in the Council of Governors minutes of the relevant meeting. Any changes in interests should be declared at the next Council of Governors' meeting following the change occurring.

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

3.7 During the course of a Council of Governors' meeting, if a conflict of interest is established, the governor concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

3.8 For the purposes of this standing order 3 there is no requirement for the interests of governors' spouses or partners to be declared. Note that standing order 4 which is based on the Health Authorities (Membership and Procedure) Regulations 1996 requires that the interest of governors' spouses, if living together, in contracts should be declared.

3.9 Register of interests - The chief executive will ensure that a register of interests is established to record formally declarations of interests of governors. In particular the register will include details of all directorships and other relevant and material interests which have been declared by governors, as defined in standing order 3.2.

3.10 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 12 months will be incorporated.

3.11 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 the local population and to publicise arrangements for viewing it. To view the register, contact should be made to the company secretary.

4 Role and Responsibilities of the Council of Governors

4.1 The Council of Governors shall:

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

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

4.2 The roles and responsibilities of the governors are at a general meeting or otherwise to:

4.2.1 give the views of the Council of Governors to the directors for the purposes of the preparation (by the directors) of the document containing information as to the trust's forward planning in respect of each financial year to be given to the Regulator;

4.2.2 require one or more directors to attend a meeting of the Council of Governors for the purpose 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); and/or

4.2.3 respond as appropriate when consulted by the directors.

4.3 The governors also have the specific role and function of:

4.3.1 providing views to the Board of Directors on the strategic direction of the trust;

4.3.2 developing membership; and

4.3.3 representing the interests of the members.

4.4 If the Regulator has appointed a panel for advising governors, a governor may refer a question to that panel as to whether the trust has failed or is failing to act in accordance with this constitution or Chapter 5 of the 2006 Act. A governor may only refer a question under this paragraph if more than half of the members of the Council of Governors voting approve the referral.

4.5 The trust will take steps to ensure that governors are equipped with the skills and knowledge they require in their capacity as governors of this trust.

5. Dispute Resolution

5.1 The chair, or vice chair (if the dispute involves the chair) of the Board and the Council of Governors, shall first endeavour through discussion with members of the Council of Governors and directors or, to achieve the earliest possible conclusion, appropriate representatives of them to resolve the matter to the reasonable satisfaction of both parties.

5.2 Failing resolution under 5.1 above then the Board and the Council of Governors, shall, at its next formal meeting, approve the precise wording of a Disputes Statement setting out clearly and concisely the issue or issues giving rise to the dispute.

5.3 The chair, or vice chair (if the dispute involves the chair) of the Board and the Council of Governors, shall ensure that the Disputes Statement, without amendment or abbreviation in any way, shall be an Agenda Item and Agenda Paper at the next formal meeting of the Board or Council of Governors as appropriate. That meeting shall agree the precise wording of a Response to Disputes Statement.

5.4 The chair, or vice chair (if the dispute involves the chair) of the Board and the Council of Governors, shall immediately or as soon as is practicable, communicate the outcome to the other party and deliver the Response to Disputes Statement. If the matter remains unresolved or only partially resolved then the procedure outlined in 5.1 above shall be repeated.

5.5 If, in the opinion of the chair, or vice chair (if the dispute involves the chair) and the Board or the Council of Governors, and following the further discussion prescribed in 5.4, there is no further prospect of a full resolution or, if at any stage in the whole process, in the opinion of the chair or vice chair, as the case may be, there is no prospect of a resolution (partial or otherwise) then they shall advise the Council of Governors and the Board accordingly.

5.6 On the satisfactory completion of this disputes process the Board shall implement agreed changes.

5.7 On the unsatisfactory completion of this disputes process the view of the Board shall prevail.

5.8 Nothing in this procedure shall prevent the Council of Governors, if it so desires, from informing the Independent Regulator of NHS Foundation Trusts that, in the Council of Governors' opinion, the Board has not responded constructively to concerns of the Council of Governors that the Trust is not meeting the Terms of its Authorisation.

<

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

CONTENTS

<

<

1. INTRODUCTION

The principal place of business of the trust is The James Cook University Hospital, Marton Road, Middlesbrough.

NHS Foundation Trusts are governed by a Regulatory Framework that confers the functions of the Trust and comprises: Acts of Parliament and in particular the National Health Service Act 2006 ('the 2006 Act'); their constitutions; and the terms of their authorisation granted by the Independent Regulator of NHS Foundation Trusts ('the Independent Regulator').

The Regulatory Framework requires the Board of Directors to adopt Standing Orders for the practice and procedure of the Board of Directors. The Board of Directors will conduct its business in as open a way as possible and will:

a) Observe the Nolan principles of Public Life of selflessness, integrity, objectivity, accountability, openness, honesty andleadership;
b) At all times seek to comply with the NHS Foundation Trust Code of Governance; and
c) At all times seek to comply with the Combined Code on Corporate Governance 2003. Everything done by the Trust should be able to stand the test of scrutiny, public judgment on propriety, and professional codes of conduct.

These Standing Orders (SOs) are for the regulation of the Board of Directors' proceedings and business.

2. INTERPRETATION

2.1 Save as permitted by law, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders on which he/she should be advised by the Company Secretary, Chief Executive and Director of Finance.

2.2 Any expression to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts shall have the same meaning in this interpretation and inaddition:

a) **ACCOUNTABLE OFFICER** shall be the officer responsible and accountable for funds entrusted to the Trust. He shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

b) **BOARD** means the Board of Directors, formally constituted in accordance with this Constitution and consisting of a Chairman, and Non-executive Directors, appointed by the Council of Governors and the Executive Directors, appointed by the Non-executive Directors and (except for his/her own appointment) by the Chief Executive.

<

c) **BUDGET** shall mean a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

d) **CHAIRMAN** is the person appointed by the Council of Governors as a Non-Executive Chairman to lead the Board of Directors and Council of Governors to ensure it successfully discharges its overall responsibility for the Trust as a whole.

e) **CHIEF EXECUTIVE** shall mean the accountable officer of the Trust.

f) **COMMITTEE OF THE COUNCIL** means a committee formed by the Council of Governors with specific Terms of Reference, chair and membership.

g) **COMMITTEE OF THE BOARD** means a committee formed by the Board with specific Terms of Reference, Chair and Membership.

h) **COUNCIL** means the Council of Governors, formally constituted in accordance with this Constitution meeting in public and presided over by the Chairman.

i) **COUNCIL MEMBER** means a person elected or appointed to the Council of Governors.

j) **DIRECTOR** means a person appointed to the Board of Directors

k) **DEPUTY CHAIRMAN** means the Non-Executive Director appointed by the Council of Governors to take on the Chairman's duties if the Chairman is absent for any reason.

l) **DIRECTOR OF FINANCE** shall mean the Chief Finance Officer of the Trust who will ensure compliance with Standing Financial Instructions.

m) **FUNDS HELD ON TRUST** shall mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Schedule 3 and 4 para 14.1c National Health Service Act 2006. Such funds may or may not be charitable.

n) **MEMBER** means a person registered as a member of one of the constituencies of the Trust as outlined in this Constitution.

o) **MONITOR or TRUST REGULATOR** is the body corporate known as Monitor, referred to in Section 61 of the 2012 Act which operates with National Health Service Trust Development Authority as NHSE/I.

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

<

q) **NOMINATED OFFICER** means an officer charged with the responsibility for discharging specific tasks within Standing Orders in line with the 2006 Act.

r) **NON-EXECUTIVE DIRECTOR** is a person appointed by the Council of Governors to be a member of the Board of Directors. Initially Non executives of the applicant NHS Trust will become Non-executives of the Foundation Trust, unless they choose not do so. This includes the chairman of the Trust.

s) **OFFICER** means an employee of the Trust

t) **SOs** means Standing Orders

u) **SFIs** means Standing Financial Instructions

v) **TRUST** means South Tees Hospitals NHS Foundation Trust.

w) **COMPANY SECRETARY** this role will act as independent advice to the Board and monitor the Trust's compliance with its terms of authorisation and constitution.

3. THE BOARD OF DIRECTORS – ITS COMPOSITION, APPOINTMENTS AND INDEMNITY ARRANGEMENTS

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

3.2 All funds received in Trust shall be in the name of the Trust as corporate trustee. In relation to funds held on Trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

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

3.4 The Board of Directors has resolved that certain powers and decisions may only be exercised or made by the Board. These powers and decisions are set out in "Reservation of Powers to the Board" and have effect as if incorporated into the Standing Orders. The Board of Directors must adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities ofindividuals.

3.5 Composition of the Board of Directors

The composition of the Board of Directors will be:

- The Chairman of the Trust (Non-Executive Director as required by Schedule 7 of the NHS Act 2006)
- Within the range of 5-8 other Non-Executive Directors

<

- Within the range of 5-8 Executive Directors including:
- One of the executive Directors shall be the Chief Executive.
- The Chief Executive shall be the Accounting Officer.
- One of the executive Directors shall be the Finance Director.
- One of the executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).
- One of the executive Directors is to be a registered nurse or registered midwife.
- The Company Secretary to the Board of Directors will be in attendance at all Board meetings.

3.6 Terms of Office of the Chairman and Members of the Board

3.6.1 Guidance relating to the period of tenure of office of the Chairman and Non-executive Directors and the termination or suspension of office of the Chairman and Directors is contained in the Foundation Trust Code of Governance.

3.6.2 Non-Executive Directors including the Chairman will be appointed by the Council of Governors for a period of 3 years and subject to re-appointment thereafter at intervals of 3 years. Any term beyond six years for a Non-executive Director will be subject to rigorous review by the Council of Governors. Non-Executive Directors may serve more than nine years subject to an annualre-appointment.

3.7 Appointment of the Chairman and Non-executive Directors

The Chairman and Non-executive Directors are to be appointed/removed by the Council of Governors in accordance with the constitution.

3.8 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.

<

3.9 Any Non-executive Director so elected may at any time resign from the office of Deputy Chairman by giving notice in writing to the Chairman. The Council of Governors may thereupon appoint another Non-executive Director as Deputy Chairman in accordance with the Constitution.

3.10 Powers of Deputy Chairman

Where the Chairman of the Trust has died or has otherwise ceased to hold office or where he/she has been unable to perform his/her duties as Chairman owing to illness, absence or any other cause, references to the Chairman in the Standing Orders shall, so long as there is no Chairman able to perform his/her duties, be taken to include the DeputyChairman.

3.11 **Senior Independent Director** – The Chairman shall, following consultation with the Council of Governors appoint one of the Non- executive Directors as a "Senior Independent Director".

3.12 In accordance with the Constitution the Non-executive Directors shall appoint the Chief Executive (which appointment shall be approved by the Council of Governors) and a committee consisting of the Chairman, Chief Executive and the other non-executive directors shall appoint or remove the other Executive Directors.

3.13 The Board shall nominate a Company Secretary, who, under the direction of the Chairman and Chief Executive, shall ensure good information flows within the Board and Council of Governors and their Committees, between Directors and members of the Council of Governors, and between senior management and the Board. The Company Secretary shall also advise the Board and Council of Governors on all governance matters and shall facilitate induction and professional development as required. The appointment and removal of the Company Secretary will be carried out jointly with the Chief Executive and Chairman.

3.14 A Director of the Trust, who has acted honestly and in good faith will not have to meet out his or her own personal resources any personal civil liability which is incurred in the execution or purported execution of his or her functions as a Director save where the Director has acted recklessly. On behalf of the Directors and as part of the Trust's overall insurance arrangements the Board of Directors shall put in place appropriate insurance provision to cover such indemnity and the discretion of the Trust.

3.15 Non-executive Directors may, at the Trust's expense, seek external advice or appoint an external adviser on any material matter of concern provided the decision to do so is a collective one by the majority of Non- executive Directors. Approval of any such expenses will be done in conjunction with the allocated budget and financial procedure.

<

3.16 Disqualification and removal of Directors:

Over and above the legal minimum, a person may not become or continue as a Director if they:

- Are a Governor of the Trust;
- Are the subject of a disqualification order made under the Company Directors Disqualification Act 1986
- Have had their name removed by a direction under S.46 of the 1977 Act from any list prepared under Part II of that Act, and have not subsequently had their name included in such a list;
- Are no longer a member of one of the public constituencies (Non-Executive Directors only)
- Have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body.
- Have had a tenure of office as a Chairman or as a member or director of a health service body terminated on the grounds that their appointment is not in the interests of the health service, for non attendance at meetings or for non-disclosure of a pecuniary interest;
- Have refused without reasonable cause to fulfill any training requirement established by the Board of Directors;
- Have refused to sign and deliver a statement in the prescribed format confirming acceptance of a Code of Conduct for Directors.

4. MEETINGS OF THE BOARD OF DIRECTORS

4.1 Admission of the Public and the Press

Meetings of the Board of Directors shall be open to members of the public or representatives of the press. Members of the public may be excluded from a meeting (whether for the whole or part of such meeting) for special reasons as determined by the Chairman in conjunction with the Board of Directors, which may include, but are not limited to, the following reasons:

- Publicity would be prejudicial to the public interest by reasons of the confidential nature of the business to be transacted; or
- There are special reasons stated in the resolution and arising from the nature of the business of the proceedings.

The Chairman may exclude any member of the public from the meeting of the Board of Directors if they are interfering with, or preventing the reasonable conduct of the meeting.

4.2 Confidentiality

Directors and Officers and any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Board of Directors meeting, without the express permission of the Board of Directors. This

<

prohibition shall apply equally to the content of any discussion during the Board of Directors' meeting which may take place on such reports or papers.

4.3 **Calling Meetings** - Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors maydetermine.

4.4 The Chairman of the Trust may call a meeting of the Board of Directors 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 Directors, has been presented to him/her, or if, without so refusing, the Chairman does not call a meeting within seven days after such requisition has been presented to him/her at the Trust's Headquarters, such one third or more Directors may forthwith call ameeting.

4.5 **Notice of Meetings** - Before each meeting of the Board of Directors, 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/her behalf shall be delivered to every Director, or sent by post to the usual place of residence of such Director, so as to be available to him/her at least five clear days before themeeting.

4.6 Want of service of the notice on any Director shall not affect the validity of a meeting.

4.7 In the case of a meeting called by Directors in default of the Chairman, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice or emergency motions allowed under these Standing Orders. Failure to serve such a notice on more than three Directors will invalidate the meeting. A notice shall be presumed to have been served one day after posting.

4.8 Agendas will wherever possible be sent to Directors at least five clear days before the meeting and supporting papers, wheneverpossible.

4.9 The Company Secretary will ensure that a notice of a meeting of the Board of Directors is publicised to the public and papers made available on the Trust's website.

4.10 **Setting the Agenda**

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

4.11 A Director desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman at least 10 clear days before the meeting. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of theChairman.

<

4.12 **Chairman of Meeting** - At any meeting of the Board of Directors, the Chairman of the Board of Directors, if present, shall preside. If the Chairman is absent from the meeting the Deputy-Chairman, if there is one and he/she is present, shall preside. If the Chairman and Deputy- Chairman are absent such Director (who is not also an officer of the Trust) as the Directors present shall choose shall preside.

4.13 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 absent, or are disqualified from participating, such non-executive director as the Directors present shall choose shall preside. If any matter for consideration at a meeting of the Board of Directors relates to the interests of the Chairman, the Chairman shall not preside over the meeting during which the matter is under discussion.

If any matter for consideration at a meeting of the Board of Directors relates to the interests of the Non-executive Director, the Non-Executive Directors shall not preside over the meeting during which the matter is under discussion.

4.14 The Directors (excluding the Chairman and the other non-executive Directors) shall elect one of their numbers to preside during that period and that person shall exercise all the rights and obligations of the Chairman including the right to exercise a second or casting vote where the number of votes for and against a motion is equal.

4.15 **Annual Members Meeting**

The Trust will publicise and hold an Annual Members Meeting that is open to members of the public and representatives of the press.

4.16 **Notices of Motion** - A Director desiring to move or amend a motion shall send a written notice thereof at least 10 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, subject to Standing Order 4.6.

4.17 **Withdrawal of Motion or Amendments** - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

4.18 **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 6 calendar months shall bear the signature of the Director who gives it and also the signature of 4 other Directors. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any Director other than the

<

Chairman to propose a motion to the same effect within 6 months; however the Chairman may do so if he/she considers it appropriate.

4.19 **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.

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

4.21 An amendment to the motion.
4.22 The adjournment of the discussion or the meeting.
4.23 That the meeting proceed to the next business. (*)
4.24 The appointment of an ad hoc committee to deal with a specific item of business.
4.25 That the motion be now put. (*)
4.26 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 Director 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.

4.21 **Chairman's Ruling** - Statements of Directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be final. In this interpretation he/she shall be advised by the Company Secretary on standing orders and the case of Standing Financial instructions by the Director of Finance.

4.22 **Voting** - Every question put to a vote at a meeting shall be determined by a majority of the votes of the Directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chairman of the meeting shall have a second or casting vote.

4.23 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 Directors present so request.

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

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

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

<

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

4.28 **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 atit.

4.29 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.

4.30 Minutes shall be circulated in accordance with Directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

4.31 **Joint Directors** - Where the office of a Director is shared jointly by more than one person:

a) either or both or any of those persons may attend or take part in meetings of the Board of Directors:
b) if both/any are present at a meeting they should cast one vote if they agree:
c) in the case of disagreements no vote should be cast;
d) the presence of either/any or both/any of those persons should count as the presence of one person for the purposes of Standing Order 4.40 (Quorum).

4.32 **Suspension of Standing Orders** - Except where this would contravene any provision of the constitution or any direction made by the Independent Regulator of NHS Foundation Trusts, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two- thirds of the Directors are present, including one executive director and one non-executive director, and that a majority of those present vote in favour of suspension.

4.33 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

4.34 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Directors.

4.35 No formal business may be transacted while Standing Orders are suspended.

<

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

4.37 **Variation and Amendment of Standing Orders** - These Standing Orders shall be amended only if:

4.37.1 a notice of motion under Standing Order 4.17 has been given; and
4.37.2 no fewer than half the total of the Trust's non-executive directors vote in favour of amendment; and
4.37.3 at least two-thirds of the Directors are present; and
4.37.4 the variation proposed does not contravene a statutory provision or a direction made by the Regulator of NHS Foundation Trusts and
4.37.5 the amendment is approved by the Independent Regulator of NHS Foundation Trusts.

4.38 **Record of Attendance** - The names of the Directors present at the meeting shall be recorded in the minutes.

4.39 **Quorum** - No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of the Directors appointed, (including at least one non-executive director and one executive director) are present.

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

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

The above requirement for at least one executive director to form part of the quorum shall not apply where the executive Directors are excluded from a meeting (for example when the Board of Directors considers the recommendations of the Remuneration and Terms of Service Committee). The above requirement for at least one non-executive Director to form part of the quorum shall not apply where the Non- Executive Directors are excluded from a meeting.

4.41 **Adjournment of Meetings -** The Board of Directors may, by resolution, adjourn any meeting to some other specified date, place and time and such adjourned meeting shall be deemed a continuation of the original meeting. No business shall be transacted at any adjourned meeting which was not included in the agenda of the meeting of which it is an adjournment.

<

4.42 When any meeting is adjourned to another day, other than the following day, notice of the adjourned meeting shall be sent to each Director specifying the business to be transacted.

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

5. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

5.1 The Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 5.1 or 5.2 below or by a Director of the Trust in each case subject to such restrictions and conditions as the Board thinks fit.

5.2 **Emergency Powers** – The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised jointly by the Chief Executive and the Chairman after having consulted at least two other Non-executive Directors. The exercise of such powers by the Chief Executive and the Chairman shall be reported to the next formal meeting of the Board for ratification.

5.3 **Delegation to Committees** – The Board shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees of Executive Directors, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board and in accordance with Schedule 7 of the Act.

The Board shall agree and regularly review the setting up of committees to assist and advise the Board in fully discharging its duties as a healthcare organisation.

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

5.5 The Chief Executive shall prepare a Scheme of Decisions Reserved to the Board and Schedule of Decision/Duties Delegated by the Board, identifying their proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of

<

Delegation which shall be considered and approved by the Board as indicated above.

5.6 Nothing in the Schedule of Decision/Duties Delegated by the Board shall impair the discharge of the direct accountability to the Board of the Director of Finance or other Director to provide information and advise the Board in accordance with any statutoryrequirements.

5.7 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 members of the Board and officers have a duty to disclose any non compliance with these Standing Orders to the Chief Executive as soon aspossible.

6. COMMITTEES

6.1 **Formation of Committees** – The Board may form committees of the Trust, consisting wholly or partly of members of the Board of Directors or wholly of persons who are not members of the Board ofDirectors.

6.2 Where the Board delegates a function or power to a committee this committee shall be formed of Directors solely and may not establish sub committees, in accordance with Schedule 7 of theAct.

6.3 Where the Board agrees to the setting up of committees consisting of other persons, this committee may not be delegated a function or any power of the Board of Directors but will advise the Board to assist in the Board effectively discharging its duties. Sub Committees of any such committees may be agreed.

6.4 The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee formed by the Trust.

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

6.6 The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines that persons, who are neither Non-executive Directors nor Directors, shall be appointed to a committee, the terms of such appointment shall be defined by the Board and the terms of reference of that committee. Those appointed would not constitute formal members of the committee and preside in an attendance capacityonly.

<

6.7 Where the Trust is required to appoint persons to a committee and/or to undertake statutory functions and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with the regulations and directions laid down by the Board of Directors.

6.9 All committees and sub committees of the Board of Directors will be subject to an annual review to ensure best practice and fitness for purpose in conducting and governing the Trusts business.

6.10 Confidentiality

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

7 DECLARATIONS OF INTERESTS AND REGISTER OFINTERESTS

7.1 **Declaration of Interests** If a director has a pecuniary, personal or family interest, whether the 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 Board of Directors, the director shall disclose that interest to the members of the Board of Directors as soon as he becomes aware of it.

7.2 Interests which may be declared may include but are not exclusive to:

a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);
b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;
c) Shareholdings in organisations likely or possibly seeking to do business with the NHS.
d) A position of Trust in a charity or voluntary organisation in the field of health and social care;
e) Any connection with a voluntary or other organisation contracting for NHS services;
f) Any other commercial interest in the decision the committee or Board meeting may be considering

7.3 If Board members have any doubt about the relevance of an interest, this should be discussed with the Chairman.

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

<

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

7.6 During the course of a Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion (unless the Board decides otherwise) or decision.

7.7 The interests of Board members' spouses or cohabiting partners should be declared.

7.8 If Board members 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 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.

7.9 Register of Interests

In accordance with paragraph 34 of the Constitution, the Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board members. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by both Director and Non-executive Directors, as defined in Standing Order 7.2.

7.10 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.

7.11 The Register will be available for inspection by members of the public.

8 DISABILITY OF CHAIRMANMAN AND DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

8.1 Subject to the following provisions of this Standing Order, if the Chairman or any member of the Board of Directors has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board of Directors at which the contract or other matter is the subject of consideration, he/she shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter, without the Chairman of the meeting's agreement, or vote on any question with respect to it.

8.2 The Board of Directors shall exclude the Chairman or a Director from a meeting of the Board of Directors while any contract, proposed contract or

<

other matters in which he/she has a pecuniary interest, is under consideration.

8.3 Any remuneration, compensation or allowances payable to a member by virtue of paragraph 11 of Schedules 3 and 4 to the National Health Service Act 2006 shall not be treated as a pecuniary interest for the purpose of this Standing Order.

8.4 For the purpose of this Standing Order the Chairman or a Director shall be treated, subject to SO 7.1 and SO 8.5, as indirectly having a pecuniary interest in a contract, proposed contract or other matter, if:

a) he/she, or a nominee of him/her, 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 matters under consideration; or

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

8.5 The Chairman or a member shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only because:

a) of their membership of a company or other body, if he/she has no beneficial interest in any securities of that company or other body;

b) of an interest in any company, body or person with which he/she is connected as mentioned in SO 8.4 above 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.

8.6 Where the Chairman or a Director:

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

b) the total nominal value of those securities does not exceed one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he/she has a beneficial interest does not exceed one hundredth of the total issued share capital of that class, this Standing Order shall not prohibit him/her from taking part in

<

the consideration or discussion of the contract or other matter from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

8.7 Standing Order 8 applies to a committee or sub-committee of the Board of Directors as it applies to the Board of Directors and applies to any member of any such committee or subcommittee (whether or not they are also a member of the Board of Directors) as it applies to a member of the Board of Directors).

9 STANDARDS OF BUSINESS CONDUCT

9.1 Policy

Staff must comply with the Trust's detailed Standards of Business Conduct and Capability policy documents.

9.2 Interests of Officers in Contracts

If it comes to the knowledge of a Director of the Trust that a contract is which he/she has any pecuniary interest not being a contract to which he/she is himself/herself a party, has been, or is proposed to be, entered into by the Trust he/she shall, at once, give notice in writing to the Chief Executive of the fact that he/she is interested therein.

9.3 An officer must also declare to the Chief Executive any other employment or business or other relationship of him/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. The Trust requires interests, employment or relationships so declared by staff to be entered in a register of interests of staff.

9.4 Canvassing of, and recommendations by, Members in relation to Appointments

Canvassing of members of the Board of Directors or members of any committee of the Board of Directors directly or indirectly for any appointment by the Trust shall disqualify the candidate from 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.

9.5 A member of the Board of Directors shall not solicit for any person any appointment by the Board of Directors or recommend any person for such appointment, but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Board of Directors.

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

<

9.7 Relatives of Members of the Board ofDirectors

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

9.8. The Chairman, and every Director of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that the Chairman, members or Director is aware. It shall be the duty of the Chief Executive or nominated Director to report to the Board of Directors any such disclosure made.

9.9 On appointment, the Chairman and members of the Board (and prior to acceptance of an appointment in the case of Directors) should disclose to the Board of Directors whether they are related to any other member or holder of any office under the Trust.

9.10 Where the relationship of a Director or another member of the Board or another member of the Trust is disclosed, the Standing Order headed (SO 8) shall apply (Disability of Directors in proceedings on account of pecuniary interest).

10 RESOLUTION OF DISPUTES WITH THE COUNCIL OFGOVERNORS

10.1 The Council of Governors has three main roles:

a) Advisory – Communicating to the Board the wishes of members of the Council of Governors and the wider community
b) Guardianship – Ensuring that the Trust is operating in accordance its Terms of Authorisation. In this regard it acts in a trustee role for the welfare of the organisation.
c) Strategic – Advising on a longer term direction to help the Board effectively determine itspolicies.

10.2 The Board of Directors has overall responsibility for running the affairs of the Trust. Its role is to:

a) Note advice from, and consider the views of the Council of Governors
b) Set the strategic direction and leadership of theTrust
c) Ensure the Terms of Authorisation are complied with
d) Set organisational and operational targets
e) Assess, manage and minimise risk
f) Assess achievement against the above objectives
g) Ensure that action is taken to eliminate or minimise, as appropriate, adverse deviations from objectives
h) Ensure that the highest standards of Corporate Governance are applied throughout the organisation

<

10.3 The disputes resolution procedure recognises the different roles of the Council of Governors and the Board as described above.

10.4 The Chairman, or Deputy Chairman (if the dispute involves the Chairman) of the Board and the Council of Governors, shall first endeavour through discussion with members of the Council of Governors and Directors or, to achieve the earliest possible conclusion, appropriate representatives of them to resolve the matter to the reasonable satisfaction of both parties.

10.5 Failing resolution under 10.4 above then the Board and the Council of Governors, shall, at its next formal meeting, approve the precise wording of a Disputes Statement setting out clearly and concisely the issue or issues giving rise to the dispute.

10.6 The Chairman, or Deputy Chairman (if the dispute involves the Chairman) of the Board and the Council of Governors, shall ensure that the Disputes Statement, without amendment or abbreviation in any way, shall be an Agenda Item and Agenda Paper at the next formal meeting of the Board or Council of Governors as appropriate. That meeting shall agree the precise wording of a Response to Disputes Statement.

10.7 The Chairman, or Deputy Chairman (if the dispute involves the Chairman) of the Board and the Council of Governors, shall immediately or as soon as is practicable, communicate the outcome to the other party and deliver the Response to Disputes Statement. If the matter remains unresolved or only partially resolved then the procedure outlined in 10.4 above shall be repeated.

10.8 If, in the opinion of the Chairman, or Deputy Chairman (if the dispute involves the Chairman) and the Board or the Council of Governors, and following the further discussion prescribed in 10.7, there is no further prospect of a full resolution or, if at any stage in the whole process, in the opinion of the Chairman or Deputy Chairman, as the case may be, there is no prospect of a resolution (partial or otherwise) then they shall advise the Council of Governors and the Board accordingly.

10.9 On the satisfactory completion of this disputes process the Board shall implement agreed changes.

10.10 On the unsatisfactory completion of this disputes process the view of the Board shall prevail.

10.11 Nothing in this procedure shall prevent the Council of Governors, if it so desires, from informing the Independent Regulator of NHS Foundation Trusts that, in the Council of Governors' opinion, the Board has not responded constructively to concerns of the Council of Governors that the Trust is not meeting the Terms of its Authorisation.

<

11 NOTIFICATION TO INDEPENDENT REGULATOR OF FOUNDATION TRUSTS AND COUNCIL OF GOVERNORS

The Board shall notify the Independent Regulator of Foundation Trusts and the Council of Governors of any major changes in the circumstances of the Trust which have made or could lead to a substantial change to its financial wellbeing, healthcare delivery performance, or reputation and standing or which might otherwise affect the Trust's compliance with the terms of Authorisation. The need to notify the independent regulator and Governors will also apply in situations where amendments are proposed to the Constitution or its annexes.

12 BOARD PERFORMANCE

The Chairman, with the assistance of the Company Secretary, shall lead, at least annually, a performance assessment process for the Board. This process should act as the basis for determining individual and collective professional development programmes for Directors.

13 TENDERING AND CONTRACT PROCEDURE

The procedure set out in the Trusts Standing Financial Instructions should be adhered to in conjunction with the implementation of these Standing Orders for all tendering and contract procedures.

14 CUSTODY OF SEAL AND SEALING OF DOCUMENTS

14.1 Custody of Seal

The Common Seal of the Trust shall be kept by the Chief Executive or nominated person in a secure place.

14.2 Sealing of Documents

The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or of a committee thereof or where the Board has delegated itspowers.

14.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by any two as delegated by the Board – Chairman, Chief Executive, Director of Finance or Chief Operating Officer (or a nominated officer who shall not be from within the originating directorate).

14.4 The form of the attestation of documents shall be "The Common Seal of the South Tees Hospitals NHS Foundation Trust was hereto affixed in the presence of ……".

14.5 Register of Sealing

An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who

shall have approved and authorised the document and attested the seal. A report of all sealing shall be made to the next Board of Directors meeting. (The report shall contain details of the seal number, the description of the document and date of sealing).

15 SIGNATURE OF DOCUMENTS

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

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

16 DISSEMINATION OF STANDING ORDERS

The Chief Executive is responsible for ensuring all existing Directors and officers, and all new appointees are notified of, an understand their responsibility within the Standing Orders.

<

ANNEX 8

FURTHER PROVISIONS

1. **Disqualification for membership**

1.1 A person may not be a member of the trust if they:

1.1.1 are under the age of 16 years;

1.1.2 have been convicted of any offence of violence against or dishonesty in relation to a member of the trust's staff or the trust itself or;

1.1.3 if the Council of Governors reasonably considers that they:

1.1.3.1 are unable or unfit to discharge the functions of a member;

1.1.3.2 may bring the trust into disrepute; and

1.1.3.3 has habitually and persistently and without reasonable grounds instituted complaints against the trust and is classified as a vexatious complainant under the terms of the trust policy.

and the Council of Governors so resolves at a general meeting. No person who has been prevented or expelled from membership under this paragraph 1.1.3 shall be readmitted except by a resolution carried by the votes of two-thirds of the Council of Governors present and voting at a general meeting.

1.1.4 It is the responsibility of the 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. Members must be proactive and notify the trust immediately upon becoming aware of any issues concerning their or any member's eligibility.

2. **Termination of membership**

2.1 A member shall cease to be a member if they:

2.1.1 resign by notice to the company secretary;

2.1.2 fulfil any of the criteria set out at 1.1 above.

3. **Board of Directors' termination of tenure and disqualification**

3.1 A non-executive director may resign from that office at any time during their term of office by giving notice to the company secretary.

<

3.2 A director shall cease to be a director if:

3.2.1 in the case of a non-executive director, they are no longer a member of the public constituency;

3.2.2 they are a person whose tenure of office as a chair or as a member of or director of a health service body has been terminated on the grounds that their appointment is not in the interests of public service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

3.2.3 they have been removed from membership of a professional body or from a list of registered medical, dental, nursing or other health care practitioners as a result of disciplinary action or any conclusion that the continued inclusion of that person's name on any such list or membership of any such professional body would be prejudicial to the efficiency of the services to which the professional body or list relates and has not subsequently been re-instated to membership or such a list;

3.2.4 they have within the preceding 2 years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

3.2.5 they fail to meet the fit and proper persons requirements outlined within Regulation 5: Fit and Proper Persons: Directors of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 including all future amendments to the regulation;

3.2.6 they become a member of the Council of Governors.

4. **Indemnity**

4.1 Members of the Council of Governors, the Board of Directors and the Company Secretary who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred and in the execution or purported execution of their board functions, save where they have acted recklessly. Any costs arising in this way will be met by the trust.

5 Compliance – Other Matters

5.1 Members of the Council of Governors must behave in accordance with the seven Nolan principles of behaviour in Public Life, and both the Trust's and Council of Governors Code of Conduct as amended from time to time:

- **Selflessness**

Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends

- **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

- **Objectivity**

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit

- **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

- **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

- **Honesty**

Holders of public office have a duty to declare any private interest relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest

- **Leadership**

Holders of public office should promote and support these principles by leadership and example

END OF DOCUMENT

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 2 April 2024			
Group Board Delegation Proposal			**AGENDA ITEM:** **[PA insert number]**
Report Author and Job Title:	Jackie White Head of Governance & Company Secretary	**Responsible Director:**	Stacey Hunter Group Chief Executive
Action Required	Approve ☒ Discuss ☐ Inform ☐ (select the relevant action required)		
Situation	To request the unitary Board of Directors of South Tees Hospitals NHS Foundation Trust, to delegate authority to the Group Board for jointly exercised functions, in accordance with the Health & Care Act 2022 and NHS England guidance.		
Background	North Tees & Hartlepool NHS Foundation Trust (NTHFT) and South Tees Hospitals NHS Foundation Trust (STHFT) established and agreed a Memorandum of Understanding in May 2021, in support of working collaboratively. This resulted in the formation of a Joint Strategic Board (JSB), with no delegated functions as committees in common. This was renamed to Joint Partnership Board (JPB) in October 2021, with membership extended on 15 June 2022 and Terms of Reference were updated in July 2022. The JPB was established under the new Health & Social Care Act ('the Act') in 2022 as a Single Joint Committee (enabling it to make legally binding decisions) supported by the Integrated Care Board on 19 October 2022. Updated TOR and Schedule 1 (detailing the delegated matters from each unitary Board) were agreed. The Partnership Agreement between NTHFT and STHFT, NHS England (NHSE) NHS North East and North Cumbria Integrated Care Board (ICB) was agreed in November 2023 and officially signed February 2024.		
Assessment	The Trusts made the decision from the outset to ensure there was sufficient, knowledgeable and experienced governance resource in place to support the journey to Group arrangements, including the temporary retention of the respective Company Secretaries of each Trust A Group Risk Management Workshop was held with relevant stakeholders in March 2024 and this included the Audit Committee chairs of each Trust, internal audit and external audit representation and the legal advisor. During the meeting, it was acknowledged that the Group and each Trust would be reliant upon the independent assurance provided by respective internal and external auditors and feedback would continue to be sought. It was agreed that an audit would be included in the annual internal audit plan for each Trust in 2024/25 to obtain independent assurance on governance arrangements.		

	At the last meeting of the JPB on 20 March 2024, it was agreed to support the decision to proceed to seek approval from the unitary Board of Director meetings on 2nd April 2024 (South Tees Hospitals NHS Foundation Trust) and 4th April 2024 (North Tees & Hartlepool NHS Foundation Trust) to delegate authority to the Group Board, note that the first meeting of the Group Board will be 17 April 2024.	
Level of Assurance	Level of Assurance: Significant ☒ Moderate ☐ Limited ☐ None ☐ (select the relevant assurance level)	
Recommendation	Members of the Trust Board are asked to : • Consider and approve to delegate authority to the Group Board for jointly exercised functions, in accordance with the Health & Care Act 2022 and NHS England guidance. • Approve the carry forward of the strategic objectives of the Trust for 2024/25 and the supporting Board Assurance Frameworks; and • Note that the first meeting of the Group Board will be 17 April 2024.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This paper relates to all aspects of the Board Assurance Framework.	
Legal and Equality and Diversity implications	Legal issues have been addressed within the context of the report.	
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Best for safe, clinically effective care and experience ☒	A great place to work ☒
	Deliver care without boundaries in collaboration with our health and social care partners ☒	Make best use of our resources ☒
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒	

Group Board Delegation Proposal

1. Introduction/Background

1.1 North Tees & Hartlepool NHS Foundation Trust (NTHFT) and South Tees Hospitals NHS Foundation Trust (STHFT) established and agreed a Memorandum of Understanding in May 2021, in support of working collaboratively. This resulted in the formation of a Joint Strategic Board (JSB), with no delegated functions as committees in common. This was renamed to Joint Partnership Board (JPB) in October 2021, with membership extended on 15 June 2022 and Terms of Reference were updated in July 2022.

1.2 The JPB was established under the new Health & Social Care Act ('the Act') in 2022 as a Single Joint Committee (enabling it to make legally binding decisions) supported by the Integrated Care Board on 19 October 2022. Updated TOR and Schedule 1 (detailing the delegated matters from each unitary Board) were agreed. The Partnership Agreement between NTHFT and STHFT, NHS England (NHSE) NHS North East and North Cumbria Integrated Care Board (ICB) was agreed in November 2023 and officially signed February 2024.

2. Main content of report

2.1 Attached at **Appendix A** to this report is the signed Partnership Agreement. It was recognised that the Partnership Agreement would be an evolving document and the attached version contains a slight amendment, based on legal advice which will reflect the required content of the Partnership Agreement, subject to approval. Proposed amendments are shows with tracked changes in the document.

2.2 This provides the basis of the signed and formal agreement of both Trusts to work in group arrangements. The document will be continue to be subject to change and should the need arise for further amendments, they would need to be formally agreed and approved.

2.3 Attached as **Appendix B** are the Terms of Reference of the Group Board, which includes Schedule 1. This states that all functions that can be jointly exercised by the Group Board will be delegated and the items that cannot be delegated to the Group Board and must remain at unitary Board level, is explicitly stated. This is in accordance with NHSE Guidance Arrangements for Delegation and Joint Exercise of Statutory Functions – Schedule F.

2.4 Items that cannot be delegated, will be presented to meetings of the unitary Board of Directors meetings of each Trust and this will be included in the annual cycle of business and annual schedule of meetings.

2.5 To provide clarity to the Group Board and unitary Board of Directors meetings, a new cover sheet template will confirm delegated authority.

Corporate Documents

2.6 The Constitutions of each Trust have recently been aligned as much as possible, with the exception of necessary differences e.g. constituency details etc. and were approved by the respective Council of Governors in February 2024. The Constitution is a separate agenda item for Board approval.

2.7 The extant Scheme of Delegation and Standing Financial Instructions of each Trust will be adopted by the Group Board and requests seeking future approval from the Group Board will need to be compliant with both versions. Over the next 12 months, an exercise will be undertaken to align these documents.

Conflict of Interest

2.8 As part of Group arrangements, careful consideration has been given to the risk that directors may have conflicts of interest by reason of being jointly appointed directors of both Trusts. Under Group arrangements and by delegating jointly exercised functions, there are a number of reference points permitting this to occur;

- Overall NHS legal and policy framework for collaboration
- Specific statutory provisions for managing conflicts
- NHS best practice
- Authorisation of joint director roles

2.9 The focus of attention will not be whether there is a conflict of interest, instead the focus will be on ensuring robust processes are in place to provide all relevant information to support informed and robust decision making in the best interest of patients and the population the Group serves.

Assurance

2.10 The Trusts made the decision from the outset to ensure there was sufficient, knowledgeable and experienced governance resource in place to support the journey to Group arrangements, including the temporary retention of the respective Company Secretaries of each Trust.

2.11 Board Assurance Frameworks and risk management processes will remain in place for each Trust, with a view to ensuring standardisation and consistency in a controlled and managed approach. Governance arrangements below committee level will remain in place to ensure assurance and escalation processes continue to operate effectively.

2.12 Further underpinning this process has been the provision of legal advice from the outset and throughout the process, as and when required, which has been acknowledged by the auditors of both Trusts.

2.13 A Group Risk Management Workshop was held with relevant stakeholders in March 2024 and this included the Audit Committee chairs of each Trust, internal

audit and external audit representation and the legal advisor. During the meeting, it was acknowledged that the Group and each Trust would be reliant upon the independent assurance provided by respective internal and external auditors and feedback would continue to be sought. It was agreed that an audit would be included in the annual internal audit plan for each Trust in 2024/25 to obtain independent assurance on governance arrangements.

2.14 At the last meeting of the JPB on 20 March 2024, it was agreed to support the decision to proceed to seek approval from the unitary Board of Director meetings on 2nd April 2024 (South Tees Hospitals NHS Foundation Trust) and 4th April 2024 (North Tees & Hartlepool NHS Foundation Trust) to delegate authority to the Group Board, note that the first meeting of the Group Board will be 17 April 2024.

Unitary Board Strategic Objectives

2.15 The strategic objectives of South Tees Hospital NHS Foundation Trust are proposed to be carried forward into 2024/25 and will be considered in light of the strategic objectives of North Tees & Hartlepool NHS Foundation Trust and the development of a vision, mission statement and strategic objectives of the Group in early 2024/25. The strategic objectives of both Trusts are set out below;

North Tees & Hartlepool NHS Foundation Trust	South Tees Hospitals NHS Foundation Trust
• Putting Patients First • Valuing Our People • Transforming Our Services • Health & Wellbeing	• Best for safe, clinically effective care and experience. • A great place to work. • A centre of excellence, for core and specialist services, research, digitally supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond. • Deliver care without boundaries in collaboration with our health and social care partners. • Make best use of our resources.

2.16 A draft timescale of October 2024 has been set for a review of strategic objectives of each Trust, to allow embedding of group arrangements, completion of group development sessions and to compare them to draft strategic objectives of the Group.

Group Board Formation

2.17 Following a recent exercise to appoint to jointly appoint into Group Executive Director roles and jointly appoint Non-Executive Directors, the Group Board has now been formed and was approved by the Remuneration Committee, Nominations Committee and Council of Governors respectively during March 2024.

3. Key issues, significant risks and mitigations

3.1 The risks in relation to the formation of the Group Board related to delays in forming the Group Board and potential regulatory or legal action, linked to group proposals. This has been mitigated throughout the process by ensuring appropriate resource has been in place to support the associated work, sourcing legal advice from the outset and effective engagement with the auditors of both Trusts. There has also been extensive stakeholder engagement (internal and external) throughout the process.

4. Conclusion/Summary/Next steps

4.1 Due to timing issues of writing this paper and to ensure consistency across each Trust, a proposal to seek delegated authority from STHFT Board of Directors will be sought on 2 April 2024 and NTHFT on 4 April 2024.

4.2 The Group Board has now been formed and allows the unitary Board of Directors of South Tees Hospitals NHS Foundation Trust to delegate authority to the Group Board, ahead of the first planned meeting on 17 April 2024.

5. Recommendation

5.1 The Board of Directors is asked to;

- Consider and approve to delegate authority to the Group Board for jointly exercised functions, in accordance with the Health & Care Act 2022 and NHS England guidance.
- Approve the carry forward of the strategic objectives of the Trust for 2024/25 and the supporting Board Assurance Frameworks; and
- Note that the first meeting of the Group Board will be 17 April 2024.

Jackie White
Head of Governance & Company Secretary

Partnership Agreement

1. Overview and Introduction

1.1 This partnership agreement is a formal statement of commitment on behalf of three parties: North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust; and NHS North East and North Cumbria Integrated Care Board (ICB). It builds on considerable work over a number of years to strengthen collaboration between the Trusts on a range of activities with the aim of improving care and outcomes for patients and the wider communities which the Trusts serve. The Trusts have now agreed to adopt a group model working within the wider health system of the Integrated Care System for North East and North Cumbria and this Agreement is key to defining the implementation of that model. The Agreement's purpose is:

1. To set out the design of the operating model for the Group and a plan for the governance and resourcing arrangements which will enable its success;
2. To agree the priorities to be progressed during the coming months and a roadmap for the implementation and launch of the group model;
3. To signal a willingness to continue to strengthen the collaboration through further collaborative working, recognising that the development and implementation of the group model will need to be an iterative process.

1.2. All parties agree that there are major benefits from the effective implementation of greater collaboration to help to address deep-rooted health issues in the population served by the Trusts. The Tees Valley has a higher than average prevalence of chronic disease and the high demand for services to tackle these issues is likely to be exacerbated by a demographic shift over the period to 2040, through which the over 65 population of the Tees Valley increases while the under 65 population decreases in absolute terms[1].

1.3 High levels of deprivation and major social and economic variations including a scarcity of quality employment for some in the area drive health inequalities and demand for services in the Tees Valley and parts of County Durham and North Yorkshire. All Tees Valley local authorities are more deprived than the national average and there are stark differences across the Tees Valley and within individual boroughs. Given that there is a clear link between higher levels of deprivation and higher levels of poor health and preventable mortality, these overall levels of deprivation and the variation across the Tees Valley and beyond create a complex pattern of demand for hospital and community services.

1.4 By working collaboratively the parties will be better able to address these high and varied levels of demand and the Trusts' ability to meet the needs of the shared population will improve. The principle of the Trusts working together is already well established over a number of years and across many specialties.

1.5 The group model will enable the parties to develop the capability and capacity to deliver a significant strategic transformation and realise the benefits of collaboration. The benefits of deepening collaboration include, but are not limited to:

- Better tackling endemic health issues by collaborating on solutions;

[1] ONS quoted in the Tees Valley Economic Assessment 2022

- An unwavering focus on quality (by which we mean patient safety, clinical effectiveness and patient experience) supported by joining up our practices and systems;
- Delivering high quality and sustainable services, improving through learning and increasing resilience;
- Creating a stronger single and coherent voice for communities which is more influential regionally and nationally;
- Maintaining and enhancing local access to key services by making the most of the whole estate and greater integration with partners;
- Maximising the collective power of the existing and future workforce and providing enhanced career possibilities for our staff;
- Growing and developing our own health care workforce (doctors, nurses, AHPs, managers etc.) by close working with local secondary and tertiary education providers, and strengthening our research capacity;
- Addressing disparities in care by adopting joint models to ensure better outcomes; and
- More efficient and resilient corporate services.

1.6. In determining the best structure to enable enhanced collaboration, a range of potential models were considered and the Trusts agreed to adopt a group model, in which each organisation retains its statutory accountabilities, but there is a shared leadership structure, with shared clinical services, culture and practices. This reflects a new stage of maturity in the collaboration between the parties as it has evolved and the critical factor in the decision has been to adopt the structure which can best benefit patient care and the wider population. The Trusts also recognise their key role as leaders across the health care system within the Integrated Care System and believe this too can best be delivered through the adoption of a group model. The group operating model is described in more detail in 2.1 below.

1.7 This Partnership Agreement builds on several years of progressively greater collaboration between the parties which has been reflected in governance changes. A Memorandum of Understanding setting up a Joint Strategy Board, later renamed the Joint Partnership Board (JPB) was signed in May 2021; and a Joint Chair was appointed across the two Trusts. In October 2022 the JPB was established as a Single Joint Committee able to make legally binding decisions; and a revised Terms of Reference was agreed, delegating specific matters from the Trust Boards. In late 2022 the North East and North Cumbria ICB commissioned an external independent strategic review to take stock of progress on collaboration and this review made recommendations on how to deepen the collaboration. In 2023 the JPB agreed to adopt a group model and to push forward with a programme of work to deliver that model. The JPB has been renamed the Group Board and any references in this Partnership Agreement to the JPB or Joint Partnership Board now mean the Group Board..

1.8 Since the agreement to move forward with a group model, work has been underway to design the specific form of that model for the Trusts. During this phase there has been engagement with clinical leaders and external partners, recognising that a joint clinical strategy lies at the heart of the success of the group model and that effective outcomes often rely on joint working with external partners. That level of engagement will intensify throughout the programme through:

- Multi-channel communications with our staff to seek input;
- Ongoing discussions with partners in other NHS Trusts, in particular County Durham and Darlington NHS Foundation Trust and Tees, Esk and Wear Valleys

NHS Foundation Trust; primary care; local authorities; and the voluntary sector; and

- Regular two-way feedback with patients and the wider population, including via the Councils of Governors.

1.9 With the approval of this Agreement the priorities for action within the next phase of the Group's development will be initiated. Subject to progress with these key priorities in the coming months, these will enable the Group to be established during quarter 1 2024/25. It is proposed that the JPB regularly reviews progress in the delivery of the priorities during the mobilisation phase to determine the specific timeline for launch of the group model. We recognise that the programme of work will be an iterative process and we will continue to look for more opportunities to strengthen and deepen our collaboration.

1.10 The parties have agreed a set of principles which define the work of the Group:

- The very best care for everyone
- Equity of access for services[2]
- Respect, compassion and dignity in everything we do
- Learning from all, everyone counts
- Improving lives by working together across Tees Valley and parts of North Yorkshire and areas of County Durham – Peterlee, Easington and Sedgefield
- Using all possible resources effectively and efficiently

These principles both describe the shared values which we expect all staff to demonstrate and also the objectives we hold in delivering the programme.

2. Group Operating Model

2.1 The Trusts shall implement their group operating model by exercising their powers under sections 65Z5 and 65Z6 of the National Health Service Act 2006 to extend the functions that are exercisable jointly with each other and to authorise their Joint Partnership Board (being a joint committee) to exercise such functions in accordance with updated terms of reference that they shall each approve. The group operating model will provide the organisational structures and governance necessary for the Group to operate efficiently and effectively and deliver the Group's strategic ambitions for patients and the wider population. It will also ensure that we maintain proper accountability for our performance and finances, both at a Group level, and where it remains necessary, at a Trust level.

2.2 The Trusts shall report and be accountable operationally and financially as follows:

- The Trusts shall continue to report and be accountable operationally and financially as separate corporate bodies
- Additionally the Trusts will commence reporting in shadow form on a Group basis
- Subsequently, subject to the agreement of the ICB and NHS England, the Trusts will move to a position where they report on a Group basis and are accountable operationally and financially at a Group level rather than as individual Trusts.

2.3 The Trusts have agreed the following key components of the group operating model:

[2] Including compliance with the Equalities Act 2010 and associated legal framework

- Group leadership: board arrangements and executive capacity/capability;
- Clinical teams to develop clinical strategy and transformation;
- Site leadership teams responsible for operational delivery; and
- Corporate services supporting the Group, site and clinical leadership.

2.4 In the process of developing the group operating model a range of design principles have been applied:

- A clinically-driven "Patient First" ethos whereby patients are at the heart of what we do;
- Strategic decision-making which reflects the overall benefit of the Group rather than its component parts;
- A capable distributed leadership model to enable clinical transformation;
- A need to ensure statutory and regulatory requirements continue to be met;
- Form follows function in the design of structures;
- We should start from existing organisational structures in order to retain stability and talent within the Trust structure;
- We avoid duplication and ensure efficiency through clarity of roles;
- We provide enough capacity at Group level to drive strategy;
- A matrix structure in which all senior roles have responsibility and accountability for Group strategy and performance;
- We retain a place-based focus into the communities we serve; and
- Cost effectiveness and potential for efficiencies.

Board Arrangements

2.5 The aim of the group leadership structure will be to provide effective strategic leadership, accountability and oversight of the group model. It will be headed by the Joint Chair, a role which has been in place since 2021. The Trusts have recruited a Joint Group Chief Executive to lead the executive team.

2.6 The Trusts are standardising their committee structures and as part of the move to a group model have agreed to adopt a Group Board structure with all decisions and accountability that can be delegated flowing through the Group Board and its joint committees. The Trusts intend to review and revise their constitutions as necessary to allow these changes during the mobilisation phase, subject to the approval of the Councils of Governors.

2.7 Where joint committees are not currently permitted by legislation and a separate committee is required for each Foundation Trust (for Audit, Remuneration and Charitable Funds) these committees will meet as Committees in Common.

2.8 The composition of the Group Board will ensure that it meets all statutory requirements and the principles of good governance while being as efficient as possible.

2.9 The intention wherever possible will be for Non-Executive roles to be held jointly with both organisations making simultaneous appointments. Non-Executive roles will hold responsibility for engagement with specific place-based communities.

2.10 There will be a transition plan in place to move to a revised Group Board structure during the mobilisation phase and ahead of the formal launch of the Group, subject to the agreement of NHS England and the ICB.

2.11 With their agreement the intention is that the Councils of Governors for each Trust will normally meet as Committees in Common, with separate meetings by exception, and the nominations committees will also do so. The Councils of Governors has a key role in many of the proposed changes, for example in having approved the appointment of the Group CEO and in appointing and continuing to hold Non-Executive directors to account.

Clinical Leadership

2.12 Clinical leadership will play a key role in the emerging Group – both to drive clinical strategy and ensure delivery of high quality clinical services. Clinical leadership will be provided by a series of clinical boards which will be responsible for leading transformational change in a range of agreed specialities. The proposed clinical boards and a Clinical Strategy Council will sit centrally in the group operating model, with the Clinical Strategy Council reporting directly to the Group Executive and clear delegated accountabilities. It is vital that there is a strong connection between senior clinicians leading clinical transformation, the Group Executive and the Group Board.

2.13 Clinical boards will be led by triumvirates (Medical, Nursing or Allied Healthcare Professional, and General/Operational Manager) and chaired by a clinician; all drawn from the two Trusts. Clinical boards may also include external clinical expertise for example drawn from primary care. Clinical boards will have dedicated support from corporate services including HR and business intelligence which is aligned across the Group to support effective decision-making and operation.

2.14 The Clinical Strategy Council (chaired by the Chief Medical Officer) will oversee and drive the development of the overarching clinical strategy and ensure coherence across clinical boards as well as wide engagement with clinical leaders. This is critical to ensure that the strategy can then be translated into local operational implementation. This Council will draw its membership from clinical leaders across both organisations, the Group Executive and site leadership teams and be accountable to the Group Executive.

2.15 To realise the benefits of working as a Group, we need to ensure a safe transition. We are therefore, initially at least, keeping the current Care Group structure at North Tees and the Collaboratives structure at South Tees.

2.16 The clinical strategy is described in more detail at 3.1.

Group and Site Leadership Teams

2.17 Group and Site Leadership teams, each with clearly defined responsibilities, will together provide the strategic, oversight and operational capabilities to drive improvement. The Group director team (led by the Group CEO) will develop a range of enabling strategies (including quality, people, estates, digital, finance and communications) to support delivery of the clinical strategy. It will hold executive accountability for the Group on behalf of both Trusts and will be responsible for driving performance across the Group. The Group director team will also be the 'guiding mind' to ensure that effective executive governance arrangements are in place and working well.

2.18 It is proposed that in place of executive director posts for each Trust the following executive posts will be at Group level and sit as members of the Board:

- Group CEO

- Chief Medical Officer
- Chief Nursing Officer
- Chief Finance Officer
- Managing Director North Tees and Hartlepool
- Managing Director South Tees
- Chief People Officer
- Chief Strategy Officer

2.19 The following roles will also sit at group level but will not be members of the Board:

- Director of Estates
- Chief Information and Technology Officer
- Director of Communications
- Board Secretary

There may be further roles designated as Group roles in due course.

2.20 Site leadership teams will be responsible for delivery (quality, performance, operations and finance). Site leadership teams will need to work effectively within agreed group governance arrangements and will contribute significantly to strategic development and delivery. These teams will initially reflect existing Trust arrangements in order to maintain stability, but the roles will both be responsible for their own areas and expected to make a wider contribution to the Group. Each site team will be led by a Managing Director, who will be a voting member on the Group Board and will also be personally accountable for a Group-wide strategic activity or function.

2.21 There will be site director roles reporting to the site Managing Director. These will consist of medical, nursing, allied health and operations leadership roles. Proposals for specific site director roles will be developed and will reflect the operational requirements of each site. Site leadership teams will also play a key role in working with local system partners in local place-based partnerships and in our communities.

2.22 Clinicians will be involved in due course to assess the feasibility of alignment of collaborative/ clinical directorate structures and leadership arrangements in each site. This will evolve over time to determine how best to connect Group and site clinical leadership arrangements in an effective matrix structure.

2.23 In the next phase of detailed design of the executive governance structures, roles and responsibilities, it will be critical to articulate the respective functions of the Group and site arrangements. There will need to be clarity about the value of the Group Executive structure, that there is no duplication in roles and that the aggregate value of the matrix (Group and site) is capable of addressing the significant strategic agenda ahead as well as ensuring effective operational delivery.

Corporate Services

2.24 Effective corporate services are needed to support the Group to achieve its goals, with each service being designed to provide capable leadership operating at scale and working effectively within Group and site structures.

2.25 All corporate services will move towards joint service provision with a single strategy and single responsible director. Each Group director will be responsible for the developing plans for the transformation of corporate services and we will instigate an overarching programme for the work to be taken forward.

2.26 The delivery model will vary between these enabling services, with a combination of centralised Group functions designed to benefit from economies of scale; business partnering from embedded teams using an agreed framework; and functions devolved to a trust level but with professional oversight at a group level.

2.27 The delivery strategies setting out initial plans for the transformation of each corporate service are described in more detail in 4.1.

Further development

2.28 These outline proposals for the group operating model will inform the development of the detailed governance arrangements and operating structures during the mobilisation phase. We envisage that these detailed proposals will be developed by January 2024 subject to the feasibility of the Group CEO engaging in this prior to starting in role. Their input will be crucial in finalising these proposals. This will then be followed by a formal consultation period and agreement to a firm implementation plan and timescales.

Exercise of joint functions

2.29 Subject to Clause 2.32 from a date to be agreed by both Trusts' Boards:

- The Trusts shall jointly exercise their joint functions as set out in Schedule 1
- The Group Board shall exercise for the Trusts all their joint functions in accordance with Group Board Terms of Reference that both Trusts' Boards have approved
- The Group Board may appoint one or more sub-committees of it
- The Group Board may authorise one of the Trusts to contract with a third party on behalf of itself alone or both Trusts jointly and/or severally subject to compliance with the Trusts' standing orders and standing financial instructions.

2.30 If the Group Board appoints a sub-committee, then

- The Group Board may authorise the sub-committee to exercise joint functions that the Group Board subdelegates to the sub-committee in its ToR
- The members of a sub-committee of the Group Board may comprise or include individuals who are or are not members of the Group Board

2.31 Both Trusts agree that in the exercise of their joint working arrangements, members of either Trust's or both Trusts' workforce may be line managed by duly authorised officers of either Trust or both Trusts.

2.32 Subject to Clause 2.33, the Trusts agree that they, the Group Board and its sub-committees, and directors and officers must always comply with this Agreement and with each of the Trust's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation when they are exercising joint functions.

2.33 The proceedings of the Group Board shall not be invalidated by any vacancy in its membership or by any defect in the appointment of a member of the Group Board.

Exercise of reserved functions

2.34 Both Trusts shall continue to exercise separately their reserved functions as set out in Schedule 2.

2.35 The Trusts agree that the Group Board shall not at any time exercise their reserved functions.

3. Clinical Strategy

3.1 The joint clinical strategy is at the heart of this Partnership Agreement. Its clear aim is to improve patient care and the health outcomes for the wider population through the transformation of clinical practice by both Trusts working together in a single integrated model. It will be developed by our experienced clinical teams of doctors, nurses, Allied Health Professionals and scientists in conjunction with our patients and colleagues in primary care, local authorities and the voluntary sector.

3.2 Key transformation priorities will be to ensure we deliver high quality and accessible services; to reduce unwarranted variation in outcomes; to make our Group a great place to work and address workforce challenges; and to achieve financial efficiency.

3.3 In delivering this transformation we will adhere to the following principles:

- The primacy of quality in all we do;
- Care will be provided as close to home as possible, whilst ensuring it is clinically effective and appropriate to local population needs;
- Prevention and early intervention must be supported across health and social care;
- We will support partners to ensure every child has the best possible start in life;
- The maintenance of strong community services focussed on prevention, admission avoidance and early discharge; and the specific needs of frail elderly;
- Mental health and well-being must be considered equal to physical health needs;
- There should be strong collaboration across health and social care, including sharing information;
- Evidence-based and best practice healthcare provision, avoiding unnecessary duplication, to promote a consistent standard of access across the Tees Valley;
- Single, unified referral, treatment and discharge planning;
- Equity of access and outcomes across the Tees Valley; and
- Provision of high quality specialist and tertiary services for the local and regional population which we serve.

3.4 Our joint clinical strategy will be strongly aligned to the ICB clinical strategy as it is developed and we will play a full role in helping to develop the strategy for the wider system. The clinical strategy sees the system as whole and looks widely across the Tees Valley and beyond and to partners as well as the Trusts. There are three key supply-side drivers:

- The need to establish clinical sustainability, given the increased demand and increased complexity;
- Improving recruitment, retention and career routes for our staff, and tackling shortage areas, by making our Group an employer of choice; and

- Ensuring long-term financial sustainability by making our Group's practices efficient while demonstrating the impact we can have with a fair share of funding allocation.

3.5 The strategy will be a live document which will evolve and develop over time so that more specialties are brought within a truly collaborative model.

3.6 While the ultimate aim of the clinical strategy is that it will cover all specialties, our initial proposal is that we will focus on the following strategic priority areas where we can drive rapid service transformation:

- Medicine – with a focus on optimising operation pathways and Urgent and Emergency Care flow;
- Urgent and Emergency Care – given the key drivers of the national focus on the new 4 hour target and ambulance handover delays, and the local development of a revised UTC model in our Group;
- Community Services and virtual ward – as a key plank of our winter plan and support for acute hospital decompression as well as an enabler of further acute service design;
- Surgery and elective recovery – as a key national target with a major clinical need along with the potential financial benefits of bringing work back from the independent sector;
- Women and children's services – with the major national focus on maternity services and the clinical benefits of paediatric service redesign; and
- Diagnostics, including the development of the joint Community Diagnostic Centres.

3.7 For each of these strategic priorities (and in due course extending to all clinical areas), a clinical board will be formed and appointments made via an open and transparent process to the triumvirate leadership roles (Medical, Nursing or Allied Healthcare Professional, and General/Operational Manager) with a chair appointed from among that triumvirate. The clinical board will have responsibility for developing strategy in each clinical area and identifying the clinical pathways for initial review, with subsequent proposals for service transformation. Where appropriate boards will involve external partners (e.g. the Community Services board could include representatives from primary care, social care and the voluntary sector). The intention is for the six priority clinical boards to be operational by Q4 2023/24.

3.8 The Clinical Strategy Council will be responsible for the development of the clinical strategy and will oversee the work of the clinical boards. It will also ensure that there is a strong connection between senior clinicians leading clinical transformation, the Group executive and the Group Board. This distributed leadership model will ensure that the clinical transformation is successful.

3.9 The clinical boards will delegate operational responsibility for subsequent delivery of any agreed pathway changes to relevant clinical teams (Collaborative Boards and Care Groups) and site teams, but have a continued oversight and assurance role for programme.

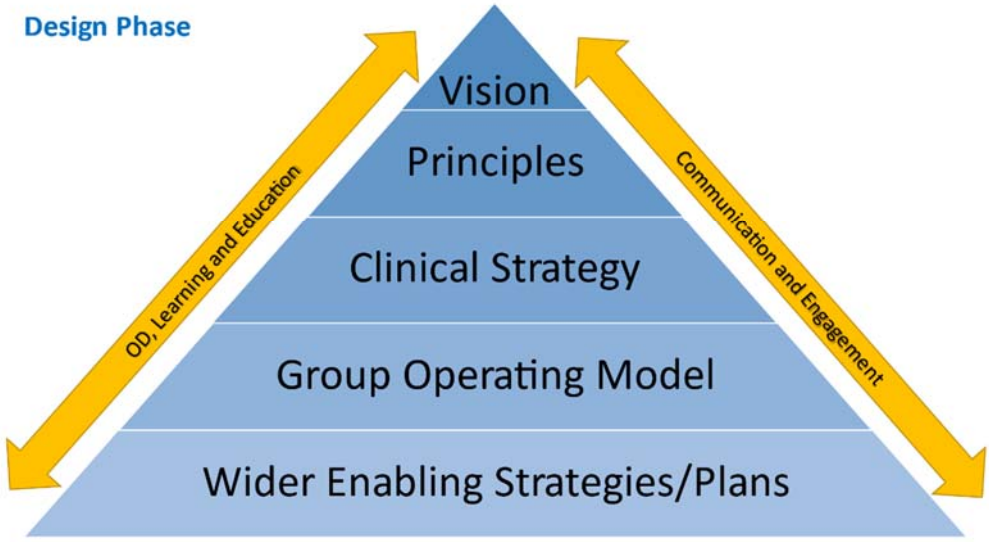
3.10 There is a high level of interdependence between the clinical strategy and corporate services which will support clinical transformation. In principle the requirements of the clinical strategy drive the transformation of corporate services, although a review of corporate services may create additional opportunities which had not been envisaged. For example, the availability of spare clinical estate may mean that the transformation

of certain clinical services are prioritised. We will continue to map and work through these interdependencies throughout the delivery of the programme.

4. Delivery Strategies

4.1 The Group will need to develop a suite of strategies to enable delivery of the clinical strategy, to secure greater coherence for the Group and to maximise the use of all available resources so that they drive efficient and effective services. These strategies will include quality, people, estates, digital, finance and communications.

A visual representation of this approach is set out below.



4.2 These enabling strategies will set out the ambition to be delivered in the coming 3-5 year period and will identify priority programmes of work required to progress the strategic goals. They will be informed by the emerging priorities of the clinical strategy and by an appraisal of strategic challenges and opportunities facing the Group.

4.3 Group directors (when appointed) will be responsible for the development of these strategies.

4.4 As they take forward these strategic priorities, Group directors will also lead the work to develop plans for the integration of corporate services across the Group and will ensure that these arrangements provide the capacity and capability required to develop and deliver these enabling strategies in the future.

4.5 Set out below is an initial description of the purpose of the specific delivery strategies. These strategic goals will continue to iterate in the coming months, together with greater clarity on priority programmes of work that will be needed and also opportunities for more immediate 'just do it' actions to be agreed.

Quality Strategy
To ensure that our patients, across the Tees Valley and beyond, receive the same standard of high quality and safe care, no matter which care setting they attend. We will achieve this through the development of a collective quality strategy, delivered

through joint governance arrangements. The emphasis will be on ensuring that the care and treatment we provide is founded on best practice and evidence with a focus on excellence in patient safety and experience, leading to optimal outcomes for our patients.

People Strategy
To develop the future workforce necessary to deliver the clinical strategy and enable the Group to be an employer of choice (through innovative and inclusive HR practice). It will focus on substantive recruitment (reducing reliance on temporary staffing and addressing key shortfalls); developing the Group training and education 'offer' and creating the conditions for an inclusive culture to thrive through a unified approach to organisational and leadership development. Policies will be aligned and will reflect best practice.

Estates Strategy
To develop ambitious plans for improving the condition and utilisation of the estate; specifically developing plans for the North Tees hospital site (in view of the existing infrastructure challenges). It will initially review utilisation of the estates and develop future plans, aligned to the priorities of the clinical strategy.

Digital Strategy
To unify the digital infrastructure across the Group to enable the delivery of high quality patient care across all clinical services. Plans will be developed to secure interoperability across existing EPRs in the short term pending delivery of the long term single digital solution.

Finance Strategy
To create financial sustainability for the Group. There will be close alignment with the clinical strategy and the enabling strategies to assess the opportunities for best use of financial resources, reduce duplication and secure inward investment (e.g. capital resources and resources linked to structural debt).

Communications & Engagement
To ensure that an intensive and ongoing communications and engagement approach is in place with the local population, patients, staff and stakeholders that demonstrates an open and inclusive culture and places value on partnerships.

4.6 In the engagement sessions we have held with clinicians and wider staff groups two priority areas were clear. First, making progress on a Group digital strategy so that barriers to working across sites and sharing necessary clinical data were reduced; and second the importance of considering workforce issues. As a result of this feedback, these strategies will be accelerated.

5. Roadmap to the launch of the group model

5.1 The outputs of the initial design phase of the group model have been incorporated into this partnership agreement. Progress has been made in developing the outline group operating model, plans for clinical leadership arrangements to lead the clinical strategy and transformation and proposals for the further development of key enabling strategies. This has been achieved by the Joint Partnership Board, clinical leaders and the ICB working together to shape the future of the group model and agree early priorities.

5.2 This section of the partnership agreement describes how further progress will be made during this next 'mobilisation' phase. Subject to progress in the coming months, it will be feasible for the group to be launched in the early part of 2024/25. A small core team is in place to direct the development programme, led by the Associate Director of Group Development. Joint resources are already committed to the programme and should specific priorities require further resourcing, proposals will be brought to the JPB for approval. Executive directors and their teams are also working together increasingly on agreed joint priorities.

5.3 The Group development team brings executive directors and ICB representation together to provide executive leadership and is co-chaired by the Managing Directors. The JPB provides board direction and oversight and also includes ICB representation. These arrangements will continue through the mobilisation phase and will in due course be superseded by the new group governance model.

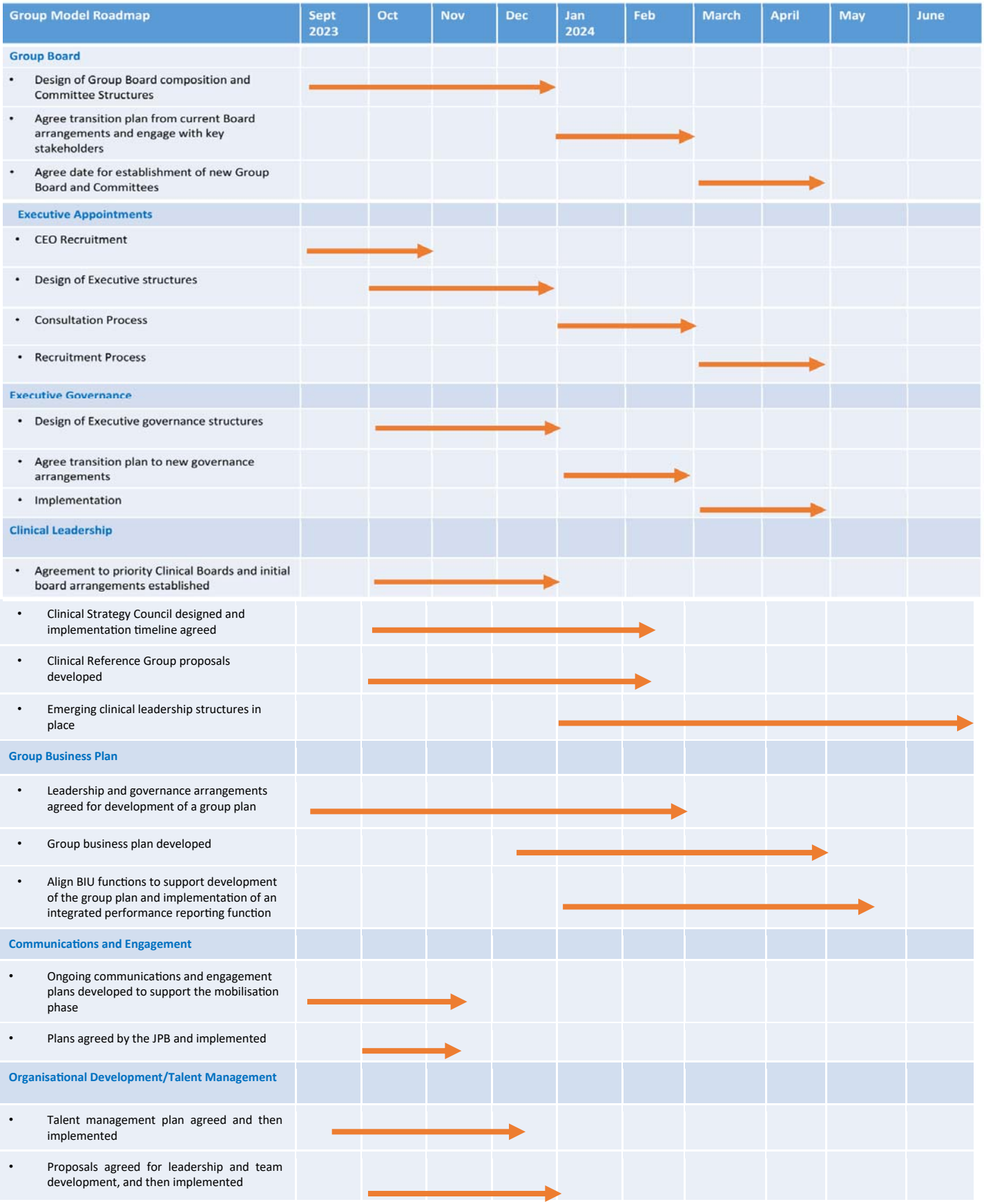
5.4 It is proposed that the following components of the operating model should, as a minimum, be in place ahead of the launch of the Group. These combine to provide a coherence to the Group and ensure that the necessary leadership and governance arrangements are established to lead strategic transformation and ensure robust operational delivery.

- New Group board and committee arrangements in place
- Key Group and site directors appointed following recruitment of Group CEO
- Executive governance arrangements in place
- Priority clinical boards and clinical strategy council established
- A Group business plan for 2024/25 in place

5.5 These key priorities inform the Group development programme in its mobilisation phase. This is set out in the roadmap below, which outlines the forward plans over the coming months and will be reviewed regularly by the JPB. A communications and engagement plan will be developed to ensure that the development programme progresses in an inclusive and transparent way, involving all key stakeholders. An effective organisational development plan will also be needed, focused on ongoing leadership and team development and talent management i.e. coaching support for staff impacted by these organisational changes.

5.6 Roadmap

Fig 1: Roadmap to the launch of the Group Model



6. Conclusion

6.1 This Partnership Agreement sets out a formal commitment by all parties to work towards the launch of a group operating model in Q1 24/25 to deliver the many benefits for our patients, staff and the wider population the Trusts serve. It has been developed through the dedication of staff, who have often been doing this work alongside other priorities; the boldness shown by the Boards of both Trusts in driving towards a new future; and the engagement of all our partners who are critical to the success of the transformation envisaged. The Trusts are grateful to the ICB for their support and direction throughout.

6.2 All parties recognise that circumstances are very likely to mean changes to the specifics of the Agreement but this does not dilute the clarity of vision and determination to deliver the benefits of the collaborative approach. Following the approval of the Agreement we will move to initiate the changes, and accelerate those changes already underway. Alongside that we will intensify our efforts to listen to our staff, patients and external partners to ensure that the clinical transformation the heart of this Agreement is successful.

6.3 As well as the initiation of change, the mobilisation phase will also include full programme planning with an increased level of detail and documentation. The Joint Partnership Board will continue to review progress on the implementation of the Agreement on a monthly basis and hold action owners to account to ensure that the programme is delivered.

6.4 While it is clear that there is much to do, we believe firmly that the future health of the people of Tees Valley and beyond will be transformed by the path this Partnership Agreement sets out.

This Agreement is signed on behalf of the three parties:

Professor Derek Bell OBE
Joint Chair
South Tees Hospitals NHS Foundation Trust
North Tees and Hartlepool NHS Foundation Trust

Professor Sir Liam Donaldson
NHS North East and North Cumbria ICB[3]

[3] As host ICB for North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust

North Tees and Hartlepool NHS Foundation Trust

South Tees Hospitals NHS Foundation Trust

Group Board of Directors
Terms of Reference

1. Purpose

The following Parties have entered a Partnership Agreement for provider collaboration and agreed to establish a Joint Committee which will be known as the Group Board. The Parties are:

North Tees and Hartlepool NHS Foundation Trust (NTHT); and
South Tees Hospitals NHS Foundation Trust (STHT).

The purpose of the Group Board will be to provide the formal, strategic leadership of the partnership arrangements between the two Parties. It will be responsible for overseeing, coordinating and ensuring delivery of the strategic intent of the partnership to secure the future of high quality, safe and sustainable healthcare across the Tees Valley and North Yorkshire.

It will provide a forum for both Parties:

- To build agreement across the Parties to drive action around a shared vision and strategic intent

- To exercise their joint functions (including delegated decision-making) in accordance with the Partnership Agreement.

2. Scope

The Parties will work collectively and collaboratively as a Group Board to develop solutions that support the future delivery of safe and sustainable health and care services across the population of the Tees Valley and North Yorkshire.

The shared objectives and priorities are identified in the Partnership Agreement.

3. Appointment of the Group Board as a Joint Committee

The Parties have agreed in their Partnership Agreement to appoint the Group Board as a joint committee in accordance with these terms of reference.

4. Group Board Membership

The voting members of the Group Board comprise the Group Chairman and the voting Board of Director members of NTH and STH Trust Statutory Boards.

The Company Secretaries from both Trusts will be in attendance.

Co-opted non-voting members will join the Group Board according to subject matter expertise as required by the nature of business on each agenda.

5. Quorum

The Group Board will be quorate when at least one-third of the whole number of the Directors appointed by each Trust, (including at least one non- executive director and one executive director from each of the Trust Statutory Boards) are present.

6. Delegated authority

The Parties have delegated authority for the exercise of joint functions (including relevant decision-making) to the Group Board in the terms set out in Schedule 1 scheme of delegation.

7. Decision making

The Group Board will generally operate on the basis of forming a consensus on all issues considered, taking account of the views expressed by all members. It will look to make decisions on a 'best for the Tees Valley and North Yorkshire' basis. The Group Chair will seek to ensure that any lack of consensus is resolved amongst members.

If the Group Board is unable to reach a consensus on an issue, the Group Chair may put the issue to a vote. The vote will be carried if:

- A majority of voting members present and voting are in favour (and in the event of a tied vote the Group Chair shall have a casting vote), and

- The voting members in favour include not less than half the NTHT voting directors present and not less than half the STHT voting directors present.

8. Accountability and reporting

The Parties agree that members of the Group Board will use all reasonable endeavours to translate its recommendations and decisions into actions through their respective Boards.

The Group Board has a key role within the wider governance and accountability arrangements of individual organisations. The minutes, and a summary of key messages will be submitted to all Parties after each meeting.

9. Conduct and Operation

The Group Board will meet on a frequency agreed to carry out its business but this will be no less than bi monthly. Members should be in attendance for at least 75% of meetings over any 12 month period.

Extraordinary meetings may be called for a specific purpose at the discretion of the Group Chair. Where possible, a minimum of seven working days' notice will be given when calling any extraordinary meeting.

The agenda and supporting papers will be sent to members and attendees no less

than five working days before any meeting. The Chair will give notice in the agenda whether the meeting will be in public or private. Urgent papers will be permitted in exceptional circumstances at the discretion of the Group Chair.

Both the NTH and STH Board of Directors' Standing Orders will apply to the conduct and operation of the Group Board insofar as these terms of reference do not provide otherwise.

10. Managing Conflicts of Interest

Each member must abide by all policies of the organisation it represents in relation to conflicts of interest.

Where any Group Board member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Group Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member may participate in meetings (or parts of meetings) in which the relevant matter is discussed.

Where the Group Chair decides to exclude a member, the relevant organisation represented by that member may send a deputy to take the place of the conflicted member in relation to that matter,

11. Secretariat

The secretariat function for the Group Board will be provided by the Corporate Office. The Company Secretaries will be responsible for arranging meetings, recording notes and actions from each meeting, preparing agendas, and agreeing these with the Group Chair.

12. Review

These terms of reference will be reviewed at least annually by the Statutory Boards of each Trust. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the partnership.

North Tees and Hartlepool NHS Foundation Trust

South Tees Hospitals NHS Foundation Trust

Terms of Reference Schedules

South Tees Hospitals NHS Foundation Trust

North East and North Cumbria

North Tees and Hartlepool NHS Foundation Trust

Terms of Reference Schedules

Schedule 1 – Joint Functions

Schedule 2 – Reserved Functions

Schedule 1 Joint functions

1. Joint functions of the Trusts are any functions of the Trusts which are not reserved functions as set out in Schedule 2.

2. Joint functions include but are not limited to:

   2.1. Each of the Trust's functions to provide goods and services, namely hospital accommodation and services and community health services, for the purposes of the health service

   2.2. All the Trusts' functions that NHS England has categorised as 'Open to Joint Exercise of Functions' in *Arrangements for delegation and joint exercise of statutory functions* as reproduced in the table set out in Paragraph 3 below (excluding references to legislation that is applicable to or in force in Wales only).

3. The table referred to in paragraph 2.2 is as follows:

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 43 NHS Act 2006	(2) An NHS foundation trust may provide goods and services for any purposes related to— (a) the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and (b) the promotion and protection of public health. (2A) An NHS foundation 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) [An] NHS foundation trust may also carry on activities other than those mentioned in [subsection (2)][...] for the purpose of making additional income available in order better to carry on its principal purpose.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 44 NHS Act 2006	(6) According to the nature of its functions, an NHS foundation trust may, in the case of patients being provided with goods and services for the purposes of the health service, make accommodation or further services available for patients who give undertakings (or for whom undertakings are given) to pay any charges imposed by the NHS foundation trust in respect of the accommodation or services. (7) An NHS foundation trust may exercise the power conferred by subsection (6) only to the extent that its exercise does not to any significant extent interfere with the performance by the NHS foundation trust of its functions.	COMMISSIONING	Yes
Section 47 NHS Act 2006	(1) An NHS foundation trust may do anything which appears to it to be necessary or expedient for the purpose of or in connection with its functions. (2) In particular it may– (a) acquire and dispose of property, (b) enter into contracts, (c) accept gifts of property (including property to be held on trust for the purposes of the NHS foundation trust or for any purposes relating to the health service), (d) employ staff. (3) Any power of the NHS foundation trust to pay remuneration and allowances to any person includes power to make arrangements for providing, or securing the provision of, pensions or gratuities (including those payable by way of compensation for loss of employment or loss or reduction of pay). (4) “The purposes of the NHS foundation trust” means the general or any specific purposes of the trust (including the purposes of any specific hospital at or from which services are provided by the trust).	ANCILLARY FUNCTION	Yes
Section 47A NHS Act 2006 as inserted by section 64 of the Health and Care Act 2022	Joint exercise of functions An NHS foundation trust may enter into arrangements for the carrying out, on such terms as the NHS foundation trust considers appropriate, of any of its functions jointly with any other person.	CORPORATE	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 56 NHS Act 2006	(1) An application may be made jointly by– (a) an NHS foundation trust, and (b) another NHS foundation trust or an NHS trust [established under section 25], to the regulator for [the dissolution of the trusts and the establishment of a new NHS foundation trust.] (1A) An application under this section may be made only with the approval of more than half of the members of the council of governors of each applicant (that is an NHS foundation trust). (2) The application must– (a) be supported by the Secretary of State if one of the parties to it is an NHS trust, (b) specify the property and liabilities proposed to be transferred to the new NHS foundation trust,[and][...] (d) be accompanied by a copy of the proposed constitution of the new trust [.][...] (4) The regulator must grant the application if it is satisfied that such steps as are necessary to prepare for the dissolution of the trusts and the establishment of the proposed new trust have been taken.[...] (11) [On the grant of the application], the proposed constitution of the NHS foundation trust has effect, but the directors of the applicants may exercise the functions of the trust on its behalf until a board of directors is appointed in accordance with the constitution.	CORPORATE	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 56A NHS Act 2006	56A Acquisitions (1) An application may be made jointly by— (a) an NHS foundation trust (A), and (b) another NHS foundation trust or an NHS trust established under section 25 (B), to the regulator for the acquisition by A of B. (2) An application under this section may be made only with the approval of more than half of the members of the council of governors of each applicant (that is an NHS foundation trust). (3) The application must— (a) be supported by the Secretary of State if B is an NHS trust, and (b) be accompanied by a copy of the proposed constitution of A, amended on the assumption that A acquires B. (4) The regulator must grant the application if it is satisfied that such steps as are necessary to prepare for the acquisition have been taken. (4A) Where the regulator proposes to grant the application, it may by order make provision for the transfer of employees of B to A on the grant of the application. (5) On the grant of the application, the proposed constitution has effect, but where a person who is specified as a director of A in the constitution has yet to be appointed as such, the directors of A may exercise that person's functions under the constitution.	CORPORATE	Yes
Section 63 NHS Act 2006	An NHS foundation trust must exercise its functions effectively, efficiently and economically.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 63A NHS Act 2006	(1) In making a decision about the exercise of its functions, an NHS foundation trust must have regard to all likely effects of the decision in relation to— (a) the health and well-being of the people of England; (b) the quality of services provided to individuals— (i) by relevant bodies, or (ii) in pursuance of arrangements made by relevant bodies, for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England; (c) efficiency and sustainability in relation to the use of resources by relevant bodies for the purposes of the health service in England.	ANCILLARY FUNCTION	Yes
Section 65Z5 NHS Act 2006 as inserted by Section 71 of the Health and Care Act 2022	Joint working and delegation arrangements (1) A relevant body may arrange for any functions exercisable by it to be exercised by or jointly with any one or more of the following— (a) a relevant body (b) a local authority (within the meaning of section 2B); (c) a combined authority. (2) In this section "relevant body" means— (a) NHS England, (b) an integrated care board, (c) an NHS trust established under section 25, (d) an NHS foundation trust, or (e) such other body as may be prescribed.	CORPORATE	Yes
Section 65Z6 NHS Act 2006 as inserted by Section 71 of the Health and Care Act 2022	Joint committees and pooled funds (1) This section applies where a function is exercisable jointly (by virtue of section 65Z5 or otherwise) by a relevant body and any one or more of the following— (a) a relevant body; (b) a local authority (within the meaning of section 2B); (c) a combined authority. (2) The bodies by whom the function is exercisable jointly may— (a) arrange for the function to be exercised by a joint committee of theirs; (b) arrange for one or more of the bodies, or a joint committee of the bodies, to establish and maintain a pooled fund.	CORPORATE	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 72 NHS Act 2006	(1) It is the duty of NHS bodies to co-operate with each other in exercising their functions.	ANCILLARY FUNCTION	Yes
Section 82 NHS Act 2006	In exercising their respective functions NHS bodies (on the one hand) and local authorities (on the other) must co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.	ANCILLARY FUNCTION	Yes
Section 223L NHS Act 2006	(1) NHS England may set joint financial objectives for integrated care boards and their partner NHS trusts and NHS foundation trusts. (2) An integrated care board and its partner NHS trusts and NHS foundation trusts must seek to achieve any financial objectives set under this section.	CORPORATE	Yes
Section 223LA NHS Act 2006	(1) An integrated care board and its partner NHS trusts and NHS foundation trusts must exercise their functions with a view to ensuring that their expenditure in a financial year (taken together) does not exceed the aggregate of any sums received by them in the year.	CORPORATE/ ANCILLARY	Yes
Section 223M NHS Act 2006	(1) Each integrated care board and its partner NHS trusts and NHS foundation trusts must exercise their functions with a view to ensuring that, in respect of each financial year— (a) local capital resource use does not exceed the limit specified in a direction by NHS England; (b) local revenue resource use does not exceed the limit specified in a direction by NHS England.	CORPORATE/ ANCILLARY	Yes
Section 242 NHS Act 2006	(1B) Each relevant English body must make arrangements, as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved (whether by being consulted or provided with information, or in other ways) in– (a) the planning of the provision of those services, (b) the development and consideration of proposals for changes in the way those services are provided, and (c) decisions to be made by that body affecting the operation of those services.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 249 NHS Act 2006	(1) In exercising their respective functions, NHS bodies (on the one hand) and the prison service (on the other) must co-operate with one another with a view to improving the way in which those functions are exercised in relation to securing and maintaining the health of prisoners.	ANCILLARY FUNCTION	Yes
Criminal Justice Act 2003, Section 325(3)	In establishing those arrangements [for the purpose of assessing and managing risks posed by relevant sexual and violent offenders &c], the responsible authority [i.e. the chief officer of police, the local probation board for that area [or (if there is no local probation board for that area) a relevant provider of probation services] and the Minister of the Crown exercising functions in relation to prisons, acting jointly] must act in co-operation with the persons specified in subsection (6); and it is the duty of those persons to co-operate in the establishment by the responsible authority of those arrangements, to the extent that such co-operation is compatible with the exercise by those persons of their [relevant functions]. [NHS trusts are included among persons in sub-s (6)(h).]	ANCILLARY FUNCTION	Yes
Mental Health (Care and Treatment) (Scotland) Act 2003, Section 31	(1) Where it appears to a local authority that the assistance of a Health Board, a Special Health Board or a National Health Service trust– (a) is necessary to enable the authority to perform any of their duties under section 25 or 26 of this Act [i.e. relating to provision of care and support services and services designed to promote well-being and independence]; or (b) would help the authority to perform any of those duties, the authority may request the Health Board, Special Health Board or National Health Service trust to co-operate by providing the assistance specified in the request. (2) A Health Board, a Special Health Board or a National Health Service trust receiving a request under subsection (1) above shall, if complying with the request– (a) would be compatible with the discharge of its own functions (whether under any enactment or otherwise); and (b) would not prejudice unduly the discharge by it of any of those functions, comply with the request.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
National Health Service Trust (Scrutiny of Deaths) (England) Order 2021, article 3	(1) An NHS trust in England may scrutinise the death of any person who has died in England where— (a) a senior coroner is not under a duty to investigate the death under section 1 of the Coroners and Justice Act 2009, or (b) it is unclear whether the death is one which a registered medical practitioner would be required to notify to the relevant senior coroner under the Notification of Deaths Regulations 2019.	ANCILLARY FUNCTION	Yes
Social Workers Regulations 2018, reg 7	(1) The persons specified for the purposes of section 53(1)(d) of the Act [i.e the Children and Social Work Act 2017, which requires Social Work England ("the regulator") to cooperate with, among others, any person specified in regulations made by the Secretary of State] are—[...] (d) any NHS trust established under section 25 of the National Health Service Act 2006,	ANCILLARY FUNCTION	Yes
Children Act 2014, s11(2); (4)	(2) Each person and body to whom this section applies [which includes NHS Trusts by ss(1)] must make arrangements for ensuring that– (a) their functions are discharged having regard to the need to safeguard and promote the welfare of children; and (b) any services provided by another person pursuant to arrangements made by the person or body in the discharge of their functions are provided having regard to that need. (4) Each person and body to whom this section applies must in discharging their duty under this section have regard to any guidance given to them for the purpose by the Secretary of State.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Children Act 2014, Section 25(5) [Applicable in Wales only]	(1) Each local authority in Wales must make arrangements to promote co-operation between– (a) the authority; (b) each of the authority's relevant partners [which includes NHS Trusts by ss(4)(e)]; and (c) such other persons or bodies as the authority consider appropriate, being persons or bodies of any nature who exercise functions or are engaged in activities in relation to children in the authority's area. (2) The arrangements under subsections (1) and (1A) [not reproduced here] are to be made with a view to— (a) improving the well-being of children within the authority's area, in particular those with needs for care and support; (b) improving the quality of care and support for children provided in the authority's area (including the outcomes that are achieved from such provision); (c) protecting children who are experiencing, or are at risk of, abuse, neglect or other kinds of harm (within the meaning of the Children Act 1989). (5) The relevant partners of a local authority in Wales must co-operate with the authority in the making of arrangements under this section.	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 25(6) [Applicable in Wales only]	(6) A local authority in Wales and any of their relevant partners may for the purposes of arrangements under this section– (a) provide staff, goods, services, accommodation or other resources; (b) establish and maintain a pooled fund [as defined by ss(7)].	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 25(8) [Applicable in Wales only]	(8) A local authority in Wales and each of their relevant partners must in exercising their functions under this section have regard to any guidance given to them for the purpose by the Welsh Ministers.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Children Act 2014, Section 27(3) [Applicable in Wales only]	(3) An NHS trust to which section 25 [see lines above] applies must– (a) appoint an executive director, to be known as the trust's "lead executive director for children and young people's services", for the purposes of the trust's functions under that section; and (b) designate one of the trust's non-executive directors as its "lead non-executive director for children and young people's services" to have the discharge of those functions as his special care.	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 28(2) [Applicable in Wales only]	(2) Each person and body to whom this section applies [including an NHS trust all or most of whose hospitals, establishments and facilities are situated in Wales, by ss(1)(c)] must make arrangements for ensuring that– (a) their functions are discharged having regard to the need to safeguard and promote the welfare of children; and (b) any services provided by another person pursuant to arrangements made by the person or body in the discharge of their functions are provided having regard to that need.	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 28(4) [Applicable in Wales only]	(4) The persons and bodies referred to in subsection (1)(a) to (c) and (i) must in discharging their duty under this section have regard to any guidance given to them for the purpose by the Assembly.	ANCILLARY FUNCTION	Yes
Domestic Violence, Crime and Victims Act 2004, Section 9(2), (3)	(3) It is the duty of any person or body within subsection (4) establishing or participating in a domestic homicide review (whether or not held pursuant to a direction under subsection (2)) to have regard to any guidance issued by the Secretary of State as to the establishment and conduct of such reviews.	ANCILLARY FUNCTION	Yes
Mental Health Units (Use of Force) Act 2018, s2(1) [Not in force]	(1) A relevant health organisation [which includes NHS trusts by s13] that operates a mental health unit must appoint a responsible person for that unit for the purposes of this Act.	ANCILLARY FUNCTION	Yes
Mental Health Units (Use of Force) Act 2018, s3(1) [Not in force]	(1) The responsible person for each mental health unit must publish a policy regarding the use of force by staff who work in that unit.	ANCILLARY FUNCTION	Yes
Mental Health Units (Use of Force) Act 2018, s11(2) [Not in force]	(2) In exercising functions under this Act, responsible persons and relevant health organisations [which includes NHS Trusts by s13] must have regard to guidance published [by the SoS by ss(1)] under this section.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s4(3) [In force in Wales only]	(3) The following persons must, when exercising functions under this Part, have regard to any relevant guidance contained in the code [on additional learning needs issued by the Welsh Ministers by ss(1)]— […] (h) an NHS trust;	ANCILLARY FUNCTION	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s20 [In force in Wales only]	(4) If a matter is referred to an NHS body [which includes an NHS Trust by s99(1)] under this section, the NHS body must consider whether there is a relevant treatment or service [as defined by ss(6)] that is likely to be of benefit in addressing the child's or young person's additional learning needs. (5) If the NHS body identifies such a treatment or service, it must— (a) secure the treatment or service for the child or young person, (b) decide whether the treatment or service should be provided to the child or young person in Welsh, and (c) if it decides that the treatment or service should be provided to the child or young person in Welsh, take all reasonable steps to secure that the treatment or service is provided in Welsh.	COMMISSIONING	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s21 [In force in Wales only]	Various duties (not set out in full here) consequent on the NHS body identifying (or not identifying) a relevant treatment or service per s20	COMMISSIONING	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s64 [In force in Wales only]	(1) This section applies where a health body mentioned in subsection (2) [which includes an NHS Trust], in the course of exercising its functions in relation to a child who is under compulsory school age and for whom a local authority is responsible, forms the opinion that the child has, or probably has, additional learning needs. (3) The health body must inform the child's parent of its opinion and of its duty in subsection (4). (4) After giving the parent an opportunity to discuss the health body's opinion with an officer of the body, the health body must bring it to the attention of the local authority that is responsible for the child or, if the child is looked after, to the attention of the local authority that looks after the child, if the health body is satisfied that doing so would be in the best interests of the child. (5) If the health body is of the opinion that a particular voluntary organisation is likely to be able to give the parent advice or other assistance in connection with any additional learning needs that the child may have, it must inform the parent accordingly.	REGULATORY	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s65 [In force in Wales only]	(1) Subsection (2) applies if a local authority requests a person mentioned in subsection (4) [which includes NHS Trusts] to exercise the person's functions to provide the authority with information or other help, which it requires for the purpose of exercising its functions under this Part. (2) The person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person that decides not to comply with a request under subsection (1) must give the local authority that made the request written reasons for the decision.	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s76 [In force in Wales only]	(1) The Education Tribunal for Wales may, in relation to an appeal under this Part,— (a) exercise its functions to require an NHS body to give evidence about the exercise of the body's functions; (b) make recommendations to an NHS body about the exercise of the body's functions. (3) An NHS body to whom a recommendation has been made by the Tribunal must make a report to the Tribunal before the end of any prescribed period beginning with the date on which the recommendation is made. [ss(4) specifies the contents of the report.]	REGULATORY	Yes
Regulation and Inspection of Social Care (Wales) Act 2016, s178 [in force in Wales only]	(2) A regulatory body [i.e. the Welsh Ministers and SCW, by s176(1)] must, in the exercise of its relevant functions, seek to co-operate with a relevant authority [which includes, by s177(1)(e) an NHS Trust] if the regulatory body thinks such co-operation— (a) will have a positive effect on the manner in which the body exercises its functions, or (b) will assist the body in achieving its general objectives.	REGULATORY	Yes
Regulation and Inspection of Social Care (Wales) Act 2016, s178 [in force in Wales only]	(3) Where a regulatory body requests the co-operation of a relevant authority under subsection (2) the authority must comply with the request unless the authority— (a) is prevented from co-operating in the manner requested by any enactment or other rule of law, (b) thinks that such co-operation would otherwise be incompatible with its own functions, or (c) thinks that such co-operation would have an adverse effect on its functions.	REGULATORY	Yes
Regulation and Inspection of Social Care (Wales) Act 2016, s178 [in force in Wales only]	(4) If a relevant authority requests the co-operation of a regulatory body, the body must comply with that request unless the body— (a) is prevented from co-operating in the manner requested by any enactment (including this Act) or other rule of law, (b) thinks that such co-operation would otherwise be incompatible with the regulatory body's own functions, or (c) thinks that such co-operation would have an adverse effect— (i) on the body's functions, or (ii) on achieving the body's general objectives.	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Well-being of Future Generations (Wales) Act 2015, Parts 2 and 3	Not reproduced in full here, the Act confers various duties on public bodies to do things in pursuit of the economic, social, environmental and cultural well-being of Wales in a way that accords with the sustainable development principle and to require public bodies to report on such action. "Public bodies", by section 6, includes NHS Trusts.	REGULATORY	Yes
Counter-terrorism and Security Act 2016, s26	(1) A specified authority [which includes, by Schedule 6, and NHS Trust] must, in the exercise of its functions, have due regard to the need to prevent people from being drawn into terrorism.	ANCILLARY FUNCTION	Yes
Counter-terrorism and Security Act 2016, s38	(1) The partners [which include NHS Trusts by Schedule 7] of a panel [i.e. a panel established by a LA by s36] must, so far as appropriate and reasonably practicable, act in co-operation with— (a) the panel in the carrying out of its functions; (b) the police [and local authorities] in the carrying out of their functions in connection with section 36.	CORPORATE	Yes
Counter-terrorism and Security Act 2016, s38	[By ss(3) the duty of a partner of a panel to act in co-operation with the panel includes the giving of information (subject to ss(4)) and extends only so far as the co-operation is compatible with the exercise of the partner's functions under any other enactment or rule of law.]	CORPORATE	Yes
Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, reg 4(1)	(1) Each public authority listed in Schedule 2 [which includes NHS Trusts] to these Regulations must publish information to demonstrate its compliance with the duty imposed by section 149(1) of the Act [i.e. the public sector equality duty of the Equality Act 2010]. [See further regs 4(2) onwards and reg 6 for requirements as to publication and exemption for authorities with fewer than 150 employees]	REGULATORY	Yes
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 6(1)	(1) Where an NHS trust or an NHS foundation trust supplies a drug or appliance to a patient for the purpose of treatment, the NHS trust or the NHS foundation trust (as the case may be) must, subject to paragraphs (3) to (6), make and recover from the patient for the supply of [continues as to charges to be made in respect of particular items] [See further reg 6 for exemptions]	COMMISSIONING	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 7(1)	(1) Where drugs or appliances are supplied to a patient, including during the out of hours period, for the purpose of treating that patient, by a prescriber at a walk-in centre, the NHS trust, NHS foundation trust or other person responsible for the management of the centre, must, subject to paragraphs (3) to (5), make and recover from that patient for the supply of [continues as to charges to be made in respect of particular items] [See further reg 7 for exemptions]	COMMISSIONING	Yes
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 10(1)	(9) Where a claim to an exemption has been made but is not substantiated, and in consequence of the claim a charge has not been recovered, if—[…] (b) the drugs or appliances were supplied by an NHS trust or an NHS foundation trust as mentioned in regulation 6, then that NHS trust or NHS foundation trust must recover that charge from the person concerned […]	COMMISSIONING	Yes
National Health Service (Charges to Overseas Visitors) Regulations 2015	The Regulations place various duties (not set out in full here) on "relevant bodies" (which includes NHS Trusts, by reg 2) to make and recover charges for the provision of relevant services to overseas visitors. Further, NHS Trusts, in meeting their obligations to make and recover charges from overseas visitors, must (by reg 3A) enter certain specified information against record against the overseas visitor's consistent identifier.	COMMISSIONING	Yes
National Health Service (Optical Charges and Payments) Regulations 2013, reg 2(2)	(2) Where a charge is payable by virtue of paragraph (1) [a charge for such amount for glasses and contact lenses as determined by the SoS], the NHS trust or NHS foundation trust, or other person on its behalf, that supplies or is to supply the glasses or contact lenses must– (a) on arranging to supply the glasses or contact lenses, make the charge, and (b) on supplying the glasses or contact lenses or having them available for supply, recover the charge from the person supplied or to be supplied (if the charge has not previously been paid).	COMMISSIONING	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
National Health Service (Optical Charges and Payments) Regulations 2013, reg 10(1)	(1) An NHS trust or NHS foundation trust which, following a sight test, issues a prescription for an optical appliance to a person who— (a) has indicated that they are an eligible person; or (b) is an eligible person by virtue of regulation 8(5), must issue to that person a voucher relating to the optical appliance prescribed. [See further reg 10(2) for requirements on issuing a voucher]	COMMISSIONING	Yes
Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013/218, reg 23	This provision imposes consultation duties (not set out in full here) on a "responsible person" ("R") (which may be a "service provider", a definition which by reg 23(14) includes an NHS Trust) where R has under consideration any proposal for a substantial development of the health service. This is subject to reg 23(12) which sets out the circumstances in which the functions in reg 23 are to be carried out by a responsible commissioner in the place of a service provider.	ANCILLARY FUNCTIONS	Yes
NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012, reg 4	(1) This regulation applies where a clinical commissioning group, NHS trust or NHS foundation trust and a local authority propose to designate a body as a Care Trust under section 77(1) of the 2006 Act, or propose to revoke such designation. (2) Where this regulation applies, the body and the local authority must, before designating or revoking the designation, as the case may be, consult jointly such persons as appear to them to be affected by the proposed designation or revocation.	REGULATORY	Yes
Care Act 2014, s6	(1) A local authority must co-operate with each of its relevant partners [which, by ss(7) includes each NHS body in the authority's area, defined in turn by ss(8) as NHS trust or NHS foundation trust which provides services in the authority's area], and each relevant partner must co-operate with the authority, in the exercise of— (a) their respective functions relating to adults with needs for care and support, (b) their respective functions relating to carers, and (c) functions of theirs the exercise of which is relevant to functions referred to in paragraph (a) or (b).	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Social Services and Well-being (Wales) Act 2014, s17	(5) A Local Health Board or an NHS Trust providing services in the area of a local authority must, for the purposes of this section [which imposes a duty on Welsh LAs to secure the provision of information, advice and assistance], provide that local authority with information about the care and support it provides in the local authority's area.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s118	(2) Where a child who is accommodated in Wales—[…] (g) in any accommodation provided by or on behalf of an NHS Trust or by or on behalf of an NHS Foundation Trust, ceases to be so accommodated after reaching the age of 16, the person by whom or on whose behalf the child was accommodated or who carries on or manages the home or hospital (as the case may be) must inform the local authority or local authority in England within whose area the child proposes to live. [subject to ss(3) which provides that the duty if the accommodation has been provided for a consecutive period of at least three months.]	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s120	(1) Subsection (2) applies where a child is provided with accommodation in Wales by a Local Health Board, an NHS Trust or a local authority in the exercise of education functions ("the accommodating authority")— (a) for a consecutive period of at least 3 months, or (b) with the intention, on the part of that authority, of accommodating the child for such a period. (2) The accommodating authority must notify the appropriate officer [as defined by ss(4)] of the responsible authority [as defined by ss(3)]— (a) that it is accommodating the child, and (b) when it ceases to accommodate the child.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s134	Not reproduced in full here, this section makes provision for "Safeguarding Boards" and regulations governing them. By ss(2)(d) an NHS Trust is designated as a partner of a Safeguarding Board.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Social Services and Well-being (Wales) Act 2014, s161B	(1) The Welsh Ministers may require a person falling within subsection (2) [which includes an NHS Trust] to provide them with— (a) any documents, records (including medical or other personal records) or other information— (i) which relate to the exercise of a social services function of a local authority, and (ii) which the Welsh Ministers consider it necessary or expedient to have for the purposes of a review under section 149A or 149B; (b) an explanation of the content of— (i) any documents, records or other information provided under paragraph (a), or (ii) any documents or records provided to an inspector conducting an inspection of premises under section 161 in connection with a review under section 149B. [Subject to ss(3) which provides that a person is not required to provide documents, records or other information under subsection (1) if the person is prohibited from providing them by any enactment or other rule of law.]	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Social Services and Well-being (Wales) Act 2014, s162(6)	(1) A local authority must make arrangements [with a view to promoting the matters specified in ss(3)] to promote co-operation between— (a) the local authority, (b) each of the authority's relevant partners [including, by ss(4)(f) an NHS Trust providing services in the area of the authority] in the exercise of— (i) their functions relating to adults (ii) their other functions the exercise of which is relevant to the functions referred to in sub-paragraph (i), and (c) such other persons or bodies as the authority considers appropriate, being persons or bodies of any nature who or which exercise functions or are engaged in activities in relation to— (i) adults within the authority's area with needs for care and support, or (ii) adults within the authority's area who are carers. (6) The relevant partners of a local authority must co-operate with the authority in the making of arrangements under this section.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s162(7); (9)	(7) A local authority and any of its relevant partners may for the purposes of arrangements under this section— (a) provide staff, goods, services, accommodation or other resources; (b) establish and maintain a pooled fund [defined at ss(7)]; (c) share information with each other.	COMMISSIONING	Yes
Social Services and Well-being (Wales) Act 2014, s162(7); (9)	(9) A local authority and each of its relevant partners [including, by ss(4)(f) an NHS Trust providing services in the area of the authority] must, in exercising their functions under this section, have regard to any guidance given to them for the purpose by the Welsh Ministers.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Social Services and Well-being (Wales) Act 2014, s164(1), (3)	(1) If a local authority requests the co-operation of a person mentioned in subsection (4) [includes an NHS Trust] in the exercise of any of its social services functions, the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.	REGULATORY	Yes
Social Services and Well-being (Wales) Act 2014, s164(2); (3)	(2) If a local authority requests that a person mentioned in subsection (4) [includes an NHS Trust] provides it with information it requires for the purpose of the exercise of any of its social services functions, the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.	REGULATORY	Yes
Social Services and Well-being (Wales) Act 2014, s164(5)	(5) A local authority and each of those persons mentioned in subsection (4) [includes an NHS Trust] must in exercising their functions under this section have regard to any guidance given to them for the purpose by the Welsh Ministers.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Social Services and Well-being (Wales) Act 2014, s164A(1), (3)	(1) If a local authority requests the co-operation of a person mentioned in subsection (4) [includes NHS Trusts] in the exercise of its functions mentioned in subsection (5) [relating to functions under Children Act 1989 &c], the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.	REGULATORY	Yes
Social Services and Well-being (Wales) Act 2014, s164A(2), (3)	(2) If a local authority requests that a person mentioned in subsection (4) [includes NHS Trusts] provides it with information it requires for the purpose of the exercise of any of its functions mentioned in subsection (5) [relating to functions under Children Act 1989 &c], the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.	REGULATORY	Yes
Children and Families Act 2014, s28	(1) A local authority in England must co-operate with each of its local partners [which includes, by ss(2)(m), an NHS Trust or NHS Foundation Trust which provides services in the authority's area, or which exercises functions in relation to children or young people for whom the authority is responsible], and each local partner must co-operate with the authority, in the exercise of the authority's functions under this Part.	ANCILLARY FUNCTIONS	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Children and Families Act 2014, s31	(1) This section applies where a local authority in England requests the cooperation of any of the following persons and bodies in the exercise of a function under this Part—[…] (g) an NHS trust or NHS foundation trust. (2) The person or body must comply with the request, unless the person or body considers that doing so would— (a) be incompatible with the duties of the person or body, or (b) otherwise have an adverse effect on the exercise of the functions of the person or body. (3) A person or body that decides not to comply with a request under subsection (1) must give the authority that made the request written reasons for the decision.	ANCILLARY FUNCTIONS	Yes
Children and Families Act 2014, s77	(4) The persons listed in subsection (1) [including at ss(1)(l) NHS Trusts] must have regard to the [Code of Practice issued by the SoS pursuant to ss(1)] in exercising their functions under this Part.	ANCILLARY FUNCTIONS	Yes
Equality Act 2010 c. 15	Refers to all functions under this Act	CORPORATE	Yes
Health Act 2009 c. 21	Refers to entire Act.	REGULATORY	Yes
Health and Social Care Act 2008 c. 14	All duties of an NHS Trust under this Act	REGULATORY	Yes
Local Government and Public Involvement in Health Act 2007 c. 28	All duties of an NHS Trust under this Act	REGULATORY	Yes
Health Act 2006 c. 28	Refers to entire Act.	REGULATORY	Yes
Health and Social Care (Community Health and Standards) Act 2003 c. 43	Refers to entire Act.	REGULATORY	Yes
Mental Capacity Act 2005 c. 9	Refers to entire Act.	REGULATORY	Yes
Health and Social Care Act 2008 c. 14	All functions of a Trust under this Act.	REGULATORY	Yes
Local Audit and Accountability Act 2014 c. 2	Refers to entire Act.	REGULATORY	Yes

Schedule 2 Reserved functions

1. Reserved functions are any functions of the Trusts that they cannot lawfully delegate or jointly exercise or otherwise are functions that NHS England has categorised as not 'Open to Joint Exercise of Functions' in *Arrangements for delegation and joint exercise of statutory functions* as reproduced in the table set out in under paragraph 2 below.

2. The table referred to in paragraph 1 is as follows:

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 27A NHS Act 2006	(1) A public benefit corporation must hold an annual meeting of its members. (2) The meeting must be open to members of the public. (3) At least one member of the board of directors of the corporation must attend the meeting and present the following documents to the members at the meeting— (a) the annual accounts, (b) any report of the auditor on them, (c) the annual report. (4) Where an amendment is made to the constitution in relation to the powers or duties of the council of governors of a public benefit corporation (or otherwise with respect to the role that the council has as part of the corporation)— (a) at least one member of the council of governors must attend the next meeting to be held under this paragraph and present the amendment, and (b) the corporation must give the members an opportunity to vote on whether they approve the amendment. (5) 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 corporation must take such steps as are necessary as a result.	CORPORATE	**No**
Section 37 NHS Act 2006	(1) An NHS foundation trust may make amendments of its constitution only if— (a) more than half of the members of the council of governors of the trust voting approve the amendments, and (b) more than half of the members of the board of directors of the trust voting approve the amendments.	CORPORATE	**No**
Section 42B (6) NHS Act 2006 as inserted by section 62 of the Health and Care Act 2022	Limits on capital expenditure (6) A trust that is the subject of an order under this section must not exceed the capital expenditure limit imposed by the order during the financial year to which it relates.	CORPORATE / REGULATORY	**No**
Section 43 NHS Act 2006	(1) The principal purpose of an NHS foundation trust is the provision of goods and services for the purposes of the health service in England.	CORPORATE	**No**
Section 43 NHS Act 2006	(3D) An NHS foundation trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the council of governors of the trust voting approve its implementation.	CORPORATE	**No**

Section 46 NHS Act 2006	(1) An NHS foundation trust may borrow money for the purposes of or in connection with its functions. [...] (4) An NHS foundation trust may invest money (other than money held by it as trustee) for the purposes of or in connection with its functions. (5) The investment may include investment by– (a) forming, or participating in forming, bodies corporate, (b) otherwise acquiring membership of bodies corporate. (6) An NHS foundation trust may give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its functions.	CORPORATE / ANCILLARY	**No**
Section 50 NHS Act 2006	An NHS foundation trust must pay to the regulator such fee as the regulator may determine in respect of its exercise of functions under— (a) section 39; (b) section 39A.	REGULATORY	**No**
Section 51A NHS Act 2006	(1) An NHS foundation 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. (2) “Significant transaction” means a transaction or arrangement of such description as may be specified in the trust's constitution. (3) If an NHS foundation trust does not wish to specify any descriptions of transaction or arrangement for the purposes of subsection (2), the constitution of the trust must specify that it contains no such descriptions.	CORPORATE	**No**
Section 56B NHS Act 2006	(1) An application may be made to the regulator by an NHS foundation trust for the dissolution of the trust and the establishment of two or more new NHS foundation trusts. (2) An application under this section may be made only with the approval of more than half of the members of the council of governors of the applicant. (3) The application must, by reference to each of the proposed new trusts— (a) specify the property and liabilities proposed to be transferred to it; (b) be accompanied by a copy of its proposed constitution. (4) The regulator must grant the application if it is satisfied that such steps as are necessary to prepare for the dissolution of the trust and the establishment of each of the proposed new trusts have been taken. (5) On the grant of the application, the proposed constitution of each of the new trusts has effect but, in the case of each of the new trusts, the proposed directors may exercise the functions of the trust on its behalf until a board of directors is appointed in accordance with the constitution.	CORPORATE	**No**

Section 57A NHS Act 2006	57A Dissolution (1) An application may be made by an NHS foundation trust to the regulator for dissolution. (2) An application under this section may be made only with the approval of more than half of the members of the council of governors of the applicant.	CORPORATE	**No**
Section 61 NHS Act 2006	(1) An NHS foundation trust must take steps to secure that (taken as a whole) the actual membership of any public constituency and (if there is one) of the patients' constituency is representative of those eligible for such membership.	CORPORATE	**No**
Chapter 5A NHS Act 2006	Trusts Special Administration.	REGULATORY	**No**
Domestic Violence, Crime and Victims Act 2004, Section 9(2), (3)	(2) The Secretary of State may in a particular case direct a specified person or body within subsection (4) [including NHS trusts established under section 25 of the National Health Service Act 2006 or section 18 of the National Health Service (Wales) Act 2006 by ss(4)(a)] to establish, or to participate in, a domestic homicide review [as defined by ss(1)].	ANCILLARY FUNCTION	**No**
Charities Act 2011, ss149; 152	Various provisions as to the audit/examination of the accounts of an "English NHS charity" (which would include a charitable trust, the trustees of which are an NHS Trust), including requirements as to the auditor/independent examiner and the giving of guidance by the Charities Commission	REGULATORY	**No**
Policing and Crime Act 2017, s1	(1) A collaboration agreement [as defined by ss(3)] may be made by— (a) one or more persons within a paragraph of subsection (2), and (b) one or more persons within another paragraph of that subsection. (2) Those persons are— (a) an ambulance trust in England, (b) a fire and rescue body in England, and (c) a police body in England. [See further sections 3 and 4 regarding collaboration agreements]	CORPORATE	**No**
Investigatory Powers Act 2016, Part 3	Not reproduced in full here, this part of the Act contains provision for applications by "relevant public authorities" to the Investigatory Powers Commissioner for authorisations to obtain communications, and the granting of authorisations by a designated officer in a relevant public authority in specific circumstances. "Relevant public authority" includes (by Schedule 4) ambulance trusts.	REGULATORY	**No**
Immigration Act 1999, s20A	Not reproduced in full here, this provision confers a duty on NHS Trusts to supply a "nationality document" at the direction of the SoS, if the SoS has reasonable grounds for believing is lawfully in the possession of an NHS Trust.	REGULATORY	**No**

Network and Information Systems Regulations 2018	Not reproduced in full here, the regulations make provision for the identification of "operators of essential services" (OES) (where they provide an essential service as specified in Schedule 2 of the regs and where they (a) rely on network and information systems; and (b) satisfy a threshold requirement described for that kind of essential service. NHS Trusts are specified in Schedule 2. An OES is subject to duties relating to notification of their status to a designated competent authority and take appropriate and proportionate technical and organisational measures to manage risks posed to the security of the network and information systems on which their essential service relies.	CORPORATE	**No**
Housing Act 1996, s213B	NHS Trusts are included among the public authorities specified by Homelessness (Review Procedure etc) Regulations 2018 (see reg 10 and Schedule) for the purposes of this provision: (1) This section applies if a specified public authority considers that a person in England in relation to whom the authority exercises functions is or may be homeless or threatened with homelessness. (2) The specified public authority must ask the person to agree to the authority notifying a local housing authority in England of— (a) the opinion mentioned in subsection (1), and (b) how the person may be contacted by the local housing authority. (3) If the person— (a) agrees to the specified public authority making the notification, and (b) identifies a local housing authority in England to which the person would like the notification to be made, the specified public authority must notify that local housing authority of the matters mentioned in subsection (2)(a) and (b).	REGULATORY	**No**
Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, reg 5(1)	(1) Each public authority listed in Schedule 2 [which includes NHS Trusts] to these Regulations must prepare and publish one or more objectives it thinks it should achieve to do any of the things mentioned in paragraphs (a) to (c) of section 149(1) of the Act. [See further regs 5(2) onwards and reg 6 for requirements as to publication.]	CORPORATE	**No**
Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, Schedule 1(2)	Not reproduced in full here, a relevant public authority is subject to a duty to publish annual information relating to gender pay gap information relating to employees.	CORPORATE	**No**
Controlled Drugs (Supervision of Management and Use) Regulations 2013	The Regulations place various duties (not set out in full here) on "designated bodies" (which includes NHS Trusts, by reg 7) in relation to the supervision, management and use of controlled drugs	REGULATORY	**No**

Children and Families Act 2014, s23	(1) This section applies where, in the course of exercising functions in relation to a child who is under compulsory school age, a clinical commissioning group, NHS trust or NHS foundation trust form the opinion that the child has (or probably has) special educational needs or a disability. (2) The group or trust must— (a) inform the child's parent of their opinion and of their duty under subsection (3), and (b) give the child's parent an opportunity to discuss their opinion with an officer of the group or trust. (3) The group or trust must then bring their opinion to the attention of the appropriate local authority in England. (4) If the group or trust think a particular voluntary organisation is likely to be able to give the parent advice or assistance in connection with any special educational needs or disability the child may have, they must inform the parent of that.	ANCILLARY FUNCTIONS	**No**
Mental Health Act 1983	Refers to entire Act.	REGULATORY	**No**
Mental Capacity Act 2005	Refers to entire Act.	REGULATORY	**No**
Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008/1858	Refers to entire Regulations.	REGULATORY	**No**
Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008/1184	Refers to entire Regulations.	REGULATORY	**No**