Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING

(conducted electronically via Microsoft Teams)

10:00am on Tuesday 13 December 2022

AGENDA

No	Item	Presenter	Enc.
	OPENING BUSINESS		
1.	Chairman's Welcome and Public Questions	Martin Earwicker, Chair	Verbal
2.	Apologies	Martin Earwicker, Chair	Verbal
3.	Declaration of Any Other Business	Martin Earwicker, Chair	Verbal
4.	Declarations of Interest i. Amendments to the Register ii. Agenda Items	Martin Earwicker, Chair	Verbal
5.1	Minutes of Meeting held on 08 November 2022	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
	QUALITY		
6.0	Patient Story, Community Dental Service	Debbie Fulton, Director of Nursing and Therapies/Helen Pailthorpe, Head of Service, Community Dental Service	Verbal
6.1	Freedom to Speak Up Guardian's Report	Mike Craissati, Freedom to Speak Up Guardian	Enc.
6.2	Quality Assurance Committee – 29 November 2022: a) Minutes of the Meeting b) Learning from Deaths Quarterly Report c) Guardian of Safe Working Quarterly Report	Sally Glen, Chair, Quality Assurance Committee	Enc.
6.3	Neurodiversity Service: Reducing Waiting Times Report	Tehmeena Ajmal, Chief Operating Officer	Enc.
	EXECUTIVE UPDATE		
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
	PERFORMANCE		
8.0	Month 07 2022/23 Finance Report	Paul Gray, Chief Financial Officer	Enc.
8.1	Month 07 2022/23 Performance Report	Paul Gray, Chief Financial Officer	Enc.

No	Item	Presenter	Enc.
STRATEGY			
9.0	People Strategy and Equalities, Diversity and Inclusion Strategy Update Report	Jane Nicholson, Director of People/Amit Popat, Deputy Director, Leadership, Inclusion and Organisational Experience	Enc.
9.1	Quarterly Status Report on Key Trust Initiatives	Alex Gild, Deputy Chief Executive	Enc.
CORPORATE GOVERNANCE			
10.0	Trust Seal Report	Paul Gray, Chief Financial Officer	Enc.
10.1	New Code of Governance for NHS Provider Trusts Compliance Report	Julie Hill, Company Secretary	Enc.
10.2	Trust Constitutional Changes Report	Julie Hill, Company Secretary	Enc.
10.3	Council of Governors Update	Martin Earwicker, Trust Chair	Verbal
Closing Business			
11.	Any Other Business	Martin Earwicker, Chair	Verbal
12.	Date of the Next Public Trust Board Meeting – 14 February 2023	Martin Earwicker, Chair	Verbal
13.	**CONFIDENTIAL ISSUES:** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Martin Earwicker, Chair	Verbal

Berkshire Healthcare
NHS Foundation Trust

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday, 08 November 2022

(Conducted via Microsoft Teams)

Present:	Martin Earwicker	Chair
	Naomi Coxwell	Non-Executive Director
	Mark Day	Non-Executive Director
	Aileen Feeney	Non-Executive Director
	Rajiv Gatha	Non-Executive Director
	Sally Glen	Non-Executive Director
	Mehmuda Mian	Non-Executive Director
	Julian Emms	Chief Executive
	Alex Gild	Chief Financial Officer
	Dr Minoo Irani	Medical Director
	Debbie Fulton	Director of Nursing and Therapies
	Paul Gray	Chief Financial Officer
In attendance:	Julie Hill	Company Secretary
	Kerry Harrison	Senior Physical Health Lead
	Steph Moakes	Staff Health, Wellbeing and Engagement Manager
	Kate Penhaligon	Head of Research and Development
Observers:	Tom Lake	Public Governor
	Steven Gillingwater	Public Governor
	Juliet Armstrong	Non-Executive Director, South-West London and St Georges Mental Health Trust

22/176	**Welcome and Public Questions** (agenda item 1)
	The Chair welcomed everyone to the meeting. The Chair particularly welcomed the observers to the meeting.
22/177	**Apologies** (agenda item 2)
	Apologies were received from: Tehmeena Ajmal, Chief Operating Officer.

22/178	**Declaration of Any Other Business** (agenda item 3)
	There was no other business.
22/179	**Declarations of Interest** (agenda item 4)
	i. **Amendments to Register** – none
	ii. **Agenda Items** – none
22/180	**Minutes of the previous meeting – 13 September 2022** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday 13 September 2022 were approved as a correct record.
22/181	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. **The Trust Board:** noted the action log.
22/182	**Board Story – Physical Health Monitoring for Patients with Serious Mental Illness (**agenda item 6.0)
	The Chair welcomed Kerry Harrison, Senior Physical Health Lead to the meeting. Kerry Harrison gave a presentation and highlighted the following points: • People with a serious mental illness died on average 17-20 years younger than the general population of mainly treatable diseases. People with a serious mental illness were more likely to have higher alcohol consumption, were three times more likely to smoke, had double the risk of obesity and diabetes, had three times the risk of hypertension and had five times the risk of dyslipidaemia • Prior to January 2021 the Trust offered a limited secondary care offer for people with a serious mental illness to access physical health checks. There was a lack of awareness across mental health practitioners and patients about the importance of physical health checks for this cohort of patients. The Trust had a responsibility for undertaking health checks in respect of people who were in the first year of their serious mental illness or if they had come back into the Trust's services in the last year. The Trust's compliance for completed health checks prior to January 2021 was around 14%. • Since January 2021, the Trust had established a Physical Health Team who had responsibility for undertaking the health checks. The Physical Health Team run clinics in seven locations across Berkshire and also operated a home visit service. The Trust's outreach, engagement and flexible offer ensured that access to health checks was made as easy as possible. The Trust's health check compliance rate was now 80% and there was a new improvement target of achieving 95%. Kerry Harrison presented Luke's (not his real name) story to illustrate the work of the Physical Health Team and made the following points:

	• Luke was a 35 year old Paranoid Schizophrenic and an ex-drug users. He had not had a health check for ten years. Luke refused blood tests, was overweight and declined a smoking discussion or intervention. • The Physical Health Team made four attempts to contact Luke before they were finally able to speak to him. Luke agreed to have a physical health check and a blood test (using the new point of care finger prick testing for lipids (blood fats) and diabetes which delivered the test results in a few minutes). • The Physical Health Team's flexible and tenacious approach enabled Luke to have his annual health check including appropriate interventions. The interventions offered included advice around increasing activity, weight loss, how to reduce his high cholesterol and although Luke did not feel ready to stop smoking, he was open to receiving information about smoking cessation. Luke was referred to this GP for his subsequent annual physical health checks. The Chair asked how "serious mental illness" was defined. Kerry Harrison explained that "serious mental illness" was a term applied to people who were required to take anti-psychotic medication. It was noted that side effects of anti-psychotic medication included weight gain which increased the risk of cardiovascular illness. The Chief Executive congratulated Kerry Harrison and her team for their work to significantly increase the health check compliance rate from 14% to 80%. The Chief Executive noted that the Trust's service was responsible for undertaking the health checks of new patients and asked about the Trust's engagement with GPs who would be responsible for undertaking any subsequent health checks. Ms Harrison explained that the Physical Health Team worked closely with primary care as part of the shared care agreement with primary care. Ms Harrison said that the Care Coordinators helped patients to access a GP appointments for their health checks and the Care Coordinators would also accompany patients to their appointment if appropriate. The Chair thanked Kerry Harrison for her presentation and thanked her for the work she and her team did to ensure that patients with serious mental illness received their physical health checks.
22/183	**Health and Wellbeing Update Report** (agenda item 6.1)
	The Chair welcomed Steph Moakes, Staff Health, Wellbeing and Engagement Manager to the meeting. Steph Moakes gave a presentation and highlighted the following points: • The key aims of the Trust's Staff Health and Wellbeing policy was to develop organisational wide health and wellbeing support and to enable staff and teams to look after their own health and wellbeing at work • Staff could access 24/7 support via the Health Assured Employee Assistance Programme, Health Assured. Health Assured provided mental health and wellbeing support, legal and financial advice etc. Staff could also access the Wellbeing Matters Health Hub which was run by the Trust and provided support to all health workers across the Berkshire area

	• The Trust also provided access to a range of other services, such as early intervention physiotherapy support, ergonomics advice, free eye test vouchers and access to the Peppy Menopause App. In addition, the Trust signposted staff to a range of health and wellbeing support, for example, helping staff to access food banks, the Blue Light NHS Staff Discount Card and the Money Helper service which provided financial advice to NHS staff as well as providing links to a range of health and wellbeing online resources etc. Mehmuda Mian, Non-Executive Director said that it was encouraging to hear about the range of health and wellbeing support for staff. Ms Mian asked whether the Trust recorded how many staff accessed the various support/schemes on offer. Ms Moakes said that she had discussed this with Mark Day who was the Non-Executive Director Champion for Staff Health and Wellbeing and had agreed that proving the impact of the various schemes would be helpful where it was feasible to collect the data. This included information about how many staff were accessing the Employee Assistance Programme Service, but it would not be possible to collect data on the number of staff who accessed the external support which the Trust signposted. The Deputy Chief Executive also pointed out that the Trust's NHS Staff Survey results for staff seeing positive action on health and wellbeing was towards the top of the results at 75% of staff seeing positive action on health and wellbeing and that this was a positive indicator of impact of the Trust's work. Naomi Coxwell, Non-Executive Director asked how the Trust was ensuring that staff health and wellbeing was sustainable moving forward. Mark Day reported that he had monthly meetings with Steph Moakes and pointed out that the Health and Wellbeing team were skilled at embedding health and wellbeing initiatives throughout the Trust in a sophisticated and effective way. Mr Day also reported that he attended NHS England's Staff Health and Wellbeing Champion meetings which provided an opportunity to find out what other Trusts were doing to support staff health and wellbeing. Mr Day commented that he thought that the Trust's health and wellbeing offer to staff was over and above what other Trusts were providing. The Deputy Chief Executive reported that the Trust was reviewing the employee engagement Apps this month to create a connection to those ward and community based staff who did not access emails or the intranet. The Chief Executive said that the Trust also re-starting its management training programmes for new managers which had been paused during the COVID-19 pandemic. The Chief Executive said that regular supervision and good staff appraisals played a key role in supporting staff and therefore in preventing staff experiencing stress and anxiety at work. On behalf of the Trust Board, the Chair congratulated Ms Moakes and her team for the work they were doing to improve staff health and wellbeing. **The Trust Board**: noted the report.

22/184	**Patient Experience Quarterly Report** (agenda item 6.2)
	The Director of Nursing and Therapies presented the paper and highlighted the following points: • During this quarter, there were a reported 152,841 patient contacts, this included patient hospital discharges and around 5,300 pieces of feedback received. This equated to around 3.5% feedback. The feedback included 81 formal and locally resolved complaints, 1,119 compliments, 16 MP enquires received and 4,024 (compared with 2,067 responses in quarter 1) responses to our patient experience tool, I Want Great Care • Services were using the feedback from I Want Great Care to make improvements. Some services were publicly displaying the changes they had made to their services in response to patient feedback via the I Want Great Care. Mark Day, Non-Executive Director referred to page 57 of the agenda pack which highlighted the changes and improvements that had been made in response to patient and carer feedback and commented that he found these tangible examples very powerful and asked whether future reports would contain this information. The Director of Nursing and Therapies confirmed that she intended to continue to provide examples of changes and improvements in future reports. Sally Glen, Non-Executive Director complimented the Director of Nursing and Therapies on the comprehensiveness of the Patient Experience Report. Ms Glen asked whether there was a process whereby formal complaints were reviewed to see if they highlighted any systematic issues which needed to be addressed. The Chief Executive reported that he signed off all complaint responses (or in his absence, another executive director would sign of the response) and confirmed that this provided an opportunity to identify any systemic issues and in these cases, he would ask the relevant service for a review of their processes and the complaint response would also include the action that had been taken as result of their complaint. The Director of Nursing and Therapies added that a group of staff reviewed all complaints and that a clinical director would sign off the complaint response before it was forwarded to the Chief Executive for final approval. The Chief Executive asked how quickly services were able to access the I Want Great Care feedback. The Director of Nursing and Therapies reported that the I Want Great Care feedback was available very quickly after it was received and it could be accessed 24/7 via the Tableau information system. The Deputy Chief Executive asked whether in the future, the I Want Great Care feedback could be linked to a patient's clinical record to ensure a more personalised approach to their care. The Director of Nursing and Therapies confirmed that the I Want Great Care feedback was anonymous and was not linked to an individual.

	Naomi Coxwell, Non-Executive Director said that it was positive that the volume of I Want Great Care responses was increasing but asked going forward how the Trust would sustain the momentum to ensure that the response rate did not plateau. The Director of Nursing and Therapies said that those services who were fully engaging with the I Want Great Care tool recognised the benefits and therefore had an incentive to continue to encourage patient feedback but acknowledged that the challenge was around persuading those services who were yet to see the value of using the tool. Aileen Feeney, Non-Executive Director pointed out that promoting the "You Said – We Did" examples may encourage other services to see the benefits of using the I Want Great Care tool to improve their services. Ms Coxwell noted that CAMHS waiting times continued to feature across both formal and informal complaints, local resolution and MP queries and said that this had been an issue for some time. Ms Coxwell acknowledged that this was an issue which required support from the system to resolve but said that the Trust needed to have a plan around what it could do to influence the system. The Director of Nursing and Therapies reported that an external consultant had been engaged to review the Neurodiversity Pathway to ensure that both the internal and external systems and processes were as efficient as possible. The Director of Nursing and Therapies provided assurance that the Trust was working closely with the system to improve CAMHS waiting times. The Chief Executive explained that the biggest waiting times were for ASD and ADHD assessments and said that the Trust had made significant progress in reducing waiting times in this area. The Chief Executive agreed that a report on the Trust's work around reducing ASD and ADHD assessment waiting times would be presented to a future Trust Board meeting. **Action: Chief Operating Officer** The Chair commented that the Trust needed to have real determination to reduce waiting times for ASD/ADHD assessments given the year on year increase in demand. **The Trust Board:** noted the report
22/185	**Six Monthly Safe Staffing Report** (agenda item 6.3)
	The Director of Nursing and Therapies presented the report and said that the paper was structured to support the requirements within the 2016 National Quality Board and the October 2018 NHS Improvement's Developing Workforce safeguards in relation to Board oversight of staffing on the wards. The Director of Nursing and Therapies reported that triangulation of available data including the SafeCare tool had indicated that the number of staff being deployed at Prospect Park Hospital was broadly in line with meeting the needs of the acuity of patients, whilst a high number of temporary staff were used, many of these staff knew the hospital well and staff were deployed around the hospital to ensure that staff were in the right place to meet patient need.

	The Director of Nursing and Therapies reported that there continued to be much higher levels of staff sickness absence on the wards (around 8%) compared with the Trust's overall staff sickness absence at 4.7%. The top reasons in terms of the number of days absent were stress and anxiety related, MSK and respiratory illness. The Director of Nursing and Therapies said that work was ongoing to improve staff retention and to increase the sources of recruitment such as apprenticeships and international recruitment. The Director of Nursing and Therapies referred to the declaration (page 92 of the agenda pack) and confirmed that over the last six months, the wards were considered to have been safe with no significant patient safety incidents occurring. However, during the reporting period, due to the inability to fill all rota gaps due to vacancies, staff absence and temporary staffing availability, shifts when staffing was sub-optimal and as a consequence, there was limited assurance that care was always of a high quality and it was possible that patient experience was compromised. Sally Glen, Non-Executive Director commented that sickness absence at 8% in respect of ward based staff was high. The Director of Nursing and Therapies pointed out that sickness absence sickness amongst ward based staff was always higher than for community based staff because of the speed at which viruses such norovirus and colds etc. spread on the wards. Naomi Coxwell, Non-Executive Director reported that the Director of People had attended the last Finance, Investment and Performance meeting and had updated the meeting on the Trust's staff retention work. Ms Coxwell said that she was surprised to find out that the Trust currently advertised all vacancies externally. It was noted that the Trust was considering changing the policy so jobs would only be advertised externally if there were no suitably qualified internal candidates. The Director of Nursing and Therapies reported that the Trust was piloting an internal rotation scheme so staff did not have to leave the Trust in order to gain experience of working in other area. **The Trust Board:** a) Noted the report b) Noted the safe staffing declaration by the Director of Nursing and Therapies and the Medical Director
22/186	**Research and Development Annual Report** (agenda item 6.4)
	The Medical Director introduced Kate Penhaligon, Head of Research and Development who was observing the meeting. The Medical Director presented the paper and said that the Trust's research and development portfolio was a blend of hosted research projects and Trust sponsored research projects of both observational and interventional research. It was noted that in the last financial year (2021-22), the Trust had delivered 94 research projects and recruited 1,723 participants into 38 National Institute for Health and Care Research Portfolio studies. The Trust was ranked joint seventh out of 48 similar trusts

	(Mental Health and Community Trusts) and was ranked eighth out of 48 similar trusts for the number of participants that the Trust had recruited to national portfolio studies. The Medical Director reported that the in current financial year, the Trust was working on an "opt out" approach to research to make healthcare research more available to patients, more inclusive and representative. The Medical Director said that the report also provided assurance around the Trust's research and development governance processes and pointed out that year on year, the Trust was increasing its research income which covered virtually all expenditure on research and development with the exception of the Head of Research and Development's salary. Sally Glen, Non-Executive Director said that it was clear from the report that the Trust was "punching above its weight" in terms of research and development. Ms Glen also thanked the Medical Director and the Head of Research and Development for taking the time to meet with her to discuss the Trust's research and development work. Ms Glen asked whether the Trust was using learning and development monies to enable clinicians to participate in practitioner research activities. The Medical Director said that the Trust was doing a lot of work around engaging with front line clinicians and practitioners to ensure that they were aware of what research and development opportunities were open to them and to support them through the process. The Medical Director said that was not aware about whether learning and development monies could be used to support research. The Medical Director said that the Trust's approach was around embedding staff with some research time within the various clinical services who were supported by the central Research and Development team and that this model had been successful in attracting research. It was noted that the Head of Research and Development was also starting to work with the Quality Improvement and with the Clinical Audit teams to bring the Trust's research functions together. **The Trust Board noted**: noted the report.
22/187	**Quality and Safety in Inpatient Services Report** (agenda item 6.5)
	The Director of Nursing and Therapies presented the paper which was in response to the Panorama television programme aired on 28 September 2022 which showed patients being abused whilst in the care of an NHS Trust. It was noted that following the programme, Claire Murdock CBE, the National Director for Mental Health wrote to all Mental Health, Learning Disability and Autism provider organisations to explain that urgent consideration was being given to what more could be done nationally with regulators, through the Inpatient Quality and Improvement Programme and with issues such as workforce. Ms Murdock's letter also recognised that poor cultures developed and were prevented locally and that therefore it was local, culture, systems and processes that were most likely to mitigate against these tragic consequences. The Director of Nursing and Therapies commented that concerns around culture were a feature of Sir Robert Francis' investigation into Mid Staffordshire NHS Foundation Trust in

	2013 and in all subsequent health related national investigations. The Director of Nursing and Therapies said that the paper was designed to provide assurance to the Trust Board around the Trust's systems and processes and work around maintaining an open culture. Mark Day, Non-Executive Director thanked the Director of Nursing and Therapies for her comprehensive response to the Panorama television programme. Mr Day commented that undertaking the unannounced 15 Step Visits to services may be a better way of assessing culture than through the announced Non-Executive Director service visits. Mr Day asked whether there was merit in undertaking visits outside of normal working hours. The Director of Nursing and Therapies confirmed that she undertook unplanned out of hour visits to wards and said that she would be very happy for individual Non-Executive Directors to accompany her on these visits. The Chair said that the Trust Board was fully committed to creating an open culture where all staff were confident around speaking up. **The Trust Board**: noted the report.
22/188	**Executive Report** (agenda item 7.0)
	The Executive Report had been circulated. The following items were discussed further: **a) Trust Stakeholder Survey 2022** The Chief Executive reported that the full results of the Trust Stakeholder 2022 Survey 2022 including attributable comments had been presented to the September 2022 In Committee Trust Board meeting. The Public Trust Board version had been anonymised. **b) Staff COVID-19 and Flu Vaccination Campaign** Aileen Feeney, Non-Executive Director expressed disappointment by the low staff take up rate of the COVID-19 booster and flu vaccination given the steps the Trust had taken to make it easy for staff to receive the vaccination. The Director of Nursing and Therapies shared Ms Feeney's disappointment and pointed out that the Trust's low staff vaccination take up rate was reflected nationally. The Director of Nursing and Therapies said that part of the issue was that COVID-19 was no longer being covered by the media and for the last two years, the prevalence of flu had been relatively low. The Director of Nursing and Therapies said that the Trust was continuing to run vaccination clinics, including offering a mobile service via the Heath Bus. **The Trust Board**: noted the paper.
22/189	**Month 06 2122-23 Finance Report** (agenda item 8.0)
	The Chief Financial Officer presented the report and highlighted the following points: • The Trust was continuing to report better than planned financial performance with a £0.1m surplus against a year to date deficit plan of £0.7m. This included

	the impact of the 2022/23 pay award in respect of back-payment and associated additional funding as agreed with the Integrated Care systems. • The Trust had completed a mid-year forecast and was holding to a forecast at year end of a deficit of £0.9m in line with the financial plan. • The Finance, Investment and Performance Committee had discussed three scenarios in respect of the financial forecast for year end. The key variables in relation to the financial forecast were Out of Area Placements and the extent of any further workforce growth against core allocations. • The Trust's cash position remained strong with a closing balance as at 30 September 2022 of £59.4m. • The number of full time staff equivalents had increased in month which was normal for September and was in line with the financial plan profile. • The Trust was continuing to offset substantive vacancies with higher levels of temporary staffing. • Non Pay spend was £6.8m in month, which was slightly above plan and was linked to higher than planned expenditure on Out of Area Placements. The Trust had extended some of its block bed booking arrangements with suppliers. • The Trust had spent £0.8m of capital against a year end capital plan of £3.3m. The Trust fully expected to recover this slippage in year and expected to spend to the capital plan by year end. • Both the Trust's Integrated Care Systems were in deficit financial positions at the moment and were well behind their financial plans. Sally Glen, Non-Executive Director referred to the Placement Costs section of the report (page 144 of the agenda pack) and commented that she was delighted to read that the Community Enhance Rehabilitation Service business case had now been approved and that this would support the work on the psychosis pathway, providing an alternative to bed based provision and both a step up/step down offer. Ms Glen asked whether there was an option to increase social care capacity by contracting with the voluntary sector. The Chief Financial Officer confirmed that the Trust was looking at a range of options including some non-recurrent investment in the voluntary sector in order to ease the pressure on in-patient beds because of the support required in the Community teams around discharging patients. The Chair said that it was likely that the service demands and financial pressures across the health and social care sector were likely to increase over the next years and therefore it was important that the Trust was open minded and was creative in its thinking around how it was going to meet the financial challenges. The Chief Financial Officer reported that the Trust had started to work on the financial plan 2023-24 and would present an early draft to the December 2022 Trust Board meeting. **Action: Chief Financial Officer** Naomi Coxwell, Non-Executive Director commented that in her experience, most non-public sector organisations tended to develop their three to five year strategies and then consider what was required to fund that strategy. **The Trust Board**: noted the report.

22/190	**Month 06 2122-23 "True North" Performance Scorecard Report** (agenda item 8.1)
	The Chief Financial Officer presented the paper and reported that and highlighted the following points: • There was a slight increase in the number of falls on Community and Older Adult Mental Health Inpatient wards this month (29 falls against a target of 25 falls). No falls had resulted in moderate or severe harm. Jubilee and Henry Tudor wards had no falls and a contributory factor was the newly implemented falls technology • There were 69 self-harm incidents on Mental Health Inpatient wards (excluding the Learning Disability ward) against a revised target of 67. Four patients accounted for 44 of the incidents. • The I Want Great Care compliance response rate was at 3.4% against a target of 10% which was an improvement on the previous month which was at 2.2%. • Staff turnover was at 16.98% against a target of less than or equal to 16%. The Trust had held a two-day Rapid Improvement event at Prospect Park Hospital and had identified a number of counter measures which were being worked up. • The number of inappropriate Out of Area Placements was 524 against a quarter 2 target of 276. Due to the high volume of delayed discharges of care, there remained significant pressures on beds despite a number of pre-commissioned beds available. **The Trust Board**: noted the report.
22/191	**Finance, Investment and Performance Committee** (agenda item 8.2)
	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee reported that in addition to the standing items, the Committee had discussed the increase (around 60 posts) in the number of management and administrative posts over the last 18 months. It was noted that the Committee was assured that there were robust recruitment processes in place that these posts were largely to support the Trust's digital and recruitment functions. Ms Coxwell said that the Committee would continue to keep a watchful eye on the growth in management and administrative posts. Ms Coxwell reported that the Committee had received an update on the Trust's Human Resources case work and was particularly pleased to note that the number of formal disciplinaries had reduced and that Black, Asian and Minority Ethic staff were not over-represented in the number of disciplinaries. Ms Coxwell reported that the Director of People had attended the meeting and had updated the Committee on the Trust's staff recruitment and retention work which included making it easier for internal staff to apply for internal jobs. The Chair thanked Naomi Coxwell for her update.
22/192	**Audit Committee Meeting – 26 October 2022** (agenda item 9.0)
	Minutes of the Audit Committee meeting held on 26 October 2022 had been circulated.

	Rajiv Gatha, Audit Committee Chair reported that in addition to the standing items, the Audit Committee had received an update on the Trust's new Emotionally Unstable Personality Disorder (EUPD) Pathway. Mr Gatha said that the EUPD pathway was now business as usual and therefore the Committee would no longer receive regular updates on the implementation of the pathways. Mr Gatha reported that the Committee had discussed the volume and contract values of the single waiver tenders between July to the end of September 2022 and had noted that a number of the waivers were contract extensions to provide time for the Trust to complete its procurement processes for new contracts. Mr Gatha said that although the number of single waivers during the reporting period was higher than normal, this was not due to any systemic control issues. The Chair thanked Rajiv Gatha for his update. **The Trust Board:** noted the minutes.
22/193	**Trust Seal Report** (agenda item 9.1)
	The Chief Financial Officer reported that the Trust's Seal had been added to a lease for London House, Bracknell which would serve as the Trust's new headquarters. The Trust's Seal had also been added to lease in order to relocate the MSK Physiotherapy team from Dedworth Clinic. **The Trust Board**: noted the report.
22/194	**Council of Governors Update** (agenda item 10.1)
	The Chair reported that the Governors had appreciated an opportunity to contribute the Strategy refresh process at the strategy review meeting on 25 October 2022. The Chair reported that a group of Governors had volunteered to support the Company Secretary in reviewing the proposed changes to the Trust's Constitution. The proposed changes to the Constitution would be presented to the Council of Governors and Trust Board meetings in December 2022 for approval. The Chair reported that the Governors valued the small group informal discussions with the Non-Executive Directors at the joint meetings.
22/195	**Any Other Business** (agenda item 10)
	There was no other business.
22/196	**Date of Next Public Meeting** (agenda item 12)
	The next Public Trust Board meeting would take place on 13 December 2022.
22/197	**CONFIDENTIAL ISSUES:** (agenda item 12)

	The Board resolved to meet In Committee for the remainder of the business on the basis that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.

I certify that this is a true, accurate and complete set of the Minutes of the business conducted at the Trust Board meeting held on 08 November 2022.

Signed……. Date 13 December 2022

(Martin Earwicker, Chair)

NHS
Berkshire Healthcare
NHS Foundation Trust

Trust Board - Patient Story

Physical Health Checks for people with Serious Mental illness

'LUKE'

Kerry Harrison
Senior Physical Health Lead
8th November 2022

Why are physical health checks important?

Berkshire Healthcare NHS Foundation Trust

People with a serious mental illness die on average 17-20 years younger than the general population of mainly preventable or treatable diseases.

Risk factors:

- likely to have higher alcohol consumption
- 3 times more likely to smoke
- double the risk of obesity and diabetes
- 3 times the risk of hypertension
- 5 times the risk of dyslipidaemia

Accessing physical health checks

pre 2021

NHS
Berkshire Healthcare
NHS Foundation Trust

- Limited secondary care offer
- Patients identified through ‘CPA’ status
- Mainly accessed through GP
- Reliant on patient to book or health care professional to facilitate
- Lack of parity between physical and mental health
- Lack of awareness across mental health practitioners *AND* patients
- Trust compliance for completed health checks was **14%**

Accessing physical health checks

since January 2021

Berkshire Healthcare NHS Foundation Trust

- Physical health team based in Berkshire Healthcare
- A reliable data system to identify patients appropriately
- Clinics in 7 locations and a home visit service
- Outreach, engagement & flexible offer – making access easy
- Education and awareness training for all mental health staff

Introducing Luke

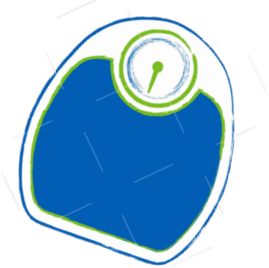
Berkshire Healthcare NHS Foundation Trust

- 35 year old man
- Paranoid **schizophrenia**
- Ex intravenous drug user
- Limited social contacts & unable to work
- Does his own cooking and shopping
- Well supported by family
- Enjoys computer games
- **Smokes** 10 cigarettes / day
- Last physical health check **ten years ago**

Physical health *for Luke* in 2021

Berkshire Healthcare NHS Foundation Trust

- Identified through Tableau for a Physical Health Check in BHFT
- Luke refused blood tests so no lipids or HbA1C
- Overweight – BMI 28
- Other physical parameters normal
- Healthy eating & activity advice given
- Declined a smoking discussion or intervention
- GP asked to provide ongoing annual PHC



Physical health *for Luke* in 2022

Berkshire Healthcare NHS Foundation Trust

- New finger prick blood tests for lipids (blood fats) and HbA1C (diabetes screen) now available
- Noted that Luke had not attended GP for his annual PHC this year
- Four attempts to contact him and finally spoke to him
- Agreed to a home visit to have blood test and a PHC

2022 continued

NHS
Berkshire Healthcare
NHS Foundation Trust

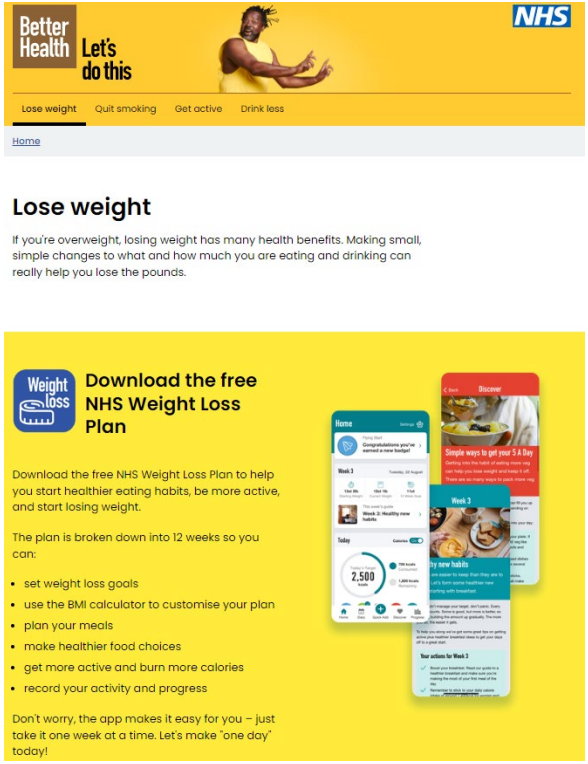
- Home visit at a time that suited Luke
- BMI now 26 – improved but still over weight
- Blood pressure was a healthy 104/78mmHg
- Point of care blood test with results in 7 minutes at home
  - HbA1c 39mmol/mol (healthy range)
  - Lipids – cholesterol was high
- Smoking – still does not feel ready to stop but open to information

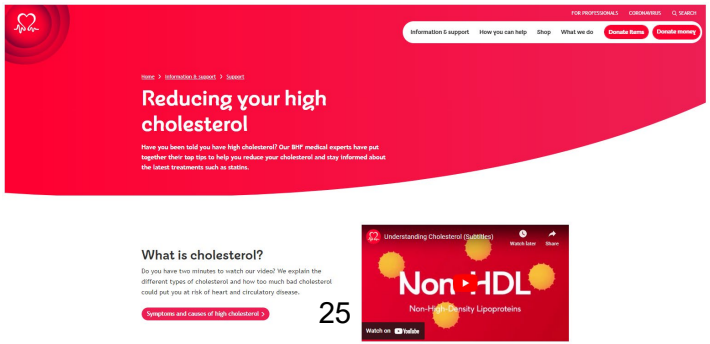
Interventions offered *to reduce risk and improve physical health*

Berkshire Healthcare NHS Foundation Trust

- Praised for weight loss so far and discussed how to maintain this
- Lipids – referred to GP for review and discussed what Luke can do to help reduce cholesterol
- Smoking – when ready, local services will support for 12 weeks and provide free nicotine replacement therapy. E-cigs may help to cut down
- Moving more and getting active – helps all elements of physical and mental health

Helpful resources for Luke





NHS
Berkshire Healthcare
NHS Foundation Trust

Sport In Mind

October 2022

Reading

"We are Sport in Mind – the charity that uses sport and physical activity to improve the lives of people experiencing mental health problems". Our sessions take place every week, all year around.
To find out more about sessions near you, check out our Activity Map on sportinmind.org or contact Claire on 0118 947 9762!

Reading Sessions

Day	Time	Activity	Instructor	Venue
Mon	11-12PM	Walk	Calum	Christchurch Meadows, Caversham, Reading RG4 8BY, meet in the middle of Christchurch Foot Bridge
Mon	2-3PM	Yoga	Julie	Meadway Sports Centre, Conwy Cl, Reading RG30 4BZ
Mon	6.30-7.15PM	Jog & Walk	Calum	Prospect Park, Liebenrood Road, RG30 2ND, meet nr changing rooms at car park
Tues	11.30-12.30PM	Dance	Josie	The Royal Suite, South Reading Leisure Centre, Northumberland Ave, RG2 8DH
Tues	2-3PM	Football	Ashley	Football Courts, Prospect Park, Liebenrood Road, RG30 2ND
Weds	1-2PM	Yoga	Ann	Meeting Room, Reading University Students Union, Shinfield Rd, RG2 7BW
Weds	12-1PM	Badminton & Table Tennis	Gill	Sports Hall, Rivermead Leisure Centre, Richfield Avenue, Reading, RG1 8EQ
Weds	3.30-4.30PM	Tai Chi	Steve	Museum of English Rural Life, 6 Redlands Road, RG1 5EX
Thurs	12-1PM	Tennis	Gill	Meet next to outdoor Tennis Courts, Reading Uni, Shinfield Rd, RG2 7BW
Thurs	6.30-7.15PM	Jog & Walk	Laura	Meet near statue, Palmer Park, RG6 1LF

Woodley Sessions

Day	Time	Activity	Instructor	Venue
Mon	12-1PM	Badminton & Table Tennis	Gill	Woodford Park Leisure Centre, Haddon Drive, Woodley, RG5 4LY
Tues	11-1PM	Allotment	Carolyn / Kev	Woodley Allotments, Reading Road, RG5 3AA (meet by the gates)

@sportinmind info@sportinmind.org www.sportinmind.org 01189479762

Supported by the Thriving Communities Fund, made possible thanks to
ARTS COUNCIL ENGLAND Historic England NHS SPORT ENGLAND
Attendee Sign-Up

In summary

NHS
Berkshire Healthcare
NHS Foundation Trust

- Luke had not had a health check for **ten years**
- The Physical Health Team enabled Luke to have his **annual health check** and **appropriate interventions**
- Interventions offered address the real **cardiometabolic risks** associated with serious mental illness that Luke faced
- Luke **engaged** with his health check with good humour and thanks
- Tenacious approach to engage and flexible appointments with plenty of time allows a meaningful health check that can support lifestyle changes
- Trust compliance is now **80%** with a target to achieve 95%

Thank you

questions…

Berkshire Healthcare NHS Foundation Trust

BOARD OF DIRECTORS MEETING 13.12.22

Board Meeting Matters Arising Log – 2022 – Public Meetings

Key:

Purple - completed
Green – In progress
Unshaded – not due yet
Red – overdue

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
13.09.22	22/150	Performance Report	The Performance Report to re-introduce the information about the number of individuals who made up the self-harm incidents.	Feb 2023	**PG**	There is an ongoing technical problem around linking the patient's NHS number to the self-harm incidents reported on the DATIX (online incident reporting system). The Trust is trying to resolve the issue by having a new	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						data feed from the DATIX system.	
13.09.22	22/150	Performance Report	The Finance, Investment and Performance Committee to receive an update on the project on reducing the average length of stay for mental health patients	Jan 2023	**TA**		
08.11.22	22/184	Patient Experience Report	The Chief Operating Officer to present a report on the Trust's work to reduce ASD/ADHD assessment waiting lists to a future Trust Board meeting.	Dec 2022	**TA**	On the agenda for the meeting.	
08.11.22	22/189	Finance Report	The Chief Financial Officer to present an early draft of the Trust's Financial Plan 2023-24 to the December 2022 In Committee Trust Board meeting.	Dec 2022	**PG**	On the agenda for the In Committee meeting.	

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	Tuesday 13th December 2022
Title	**Freedom to Speak Up Report**
	ITEM FOR NOTING
Purpose	To update the Trust Board on the work of the Freedom to Speak Up Guardian over the last 6 months.
Business Area	Corporate
Author	Freedom to Speak Up Guardian – Mike Craissati
Relevant Strategic Objectives	To strengthen our highly skilled and engaged workforce and provide a safe working environment
CQC Registration/Patient Care Impacts	The Care Quality Commission assesses Trust's Speaking Up Culture as part of its Well-Led Inspection
Resource Impacts	None
Legal Implications	All UK NHS Provider organisations are required to appoint a Freedom to Speak Up Guardian
Equality and Diversity Implications	Good links with the 3 Staff Networks have been maintained during the period, the Freedom to Speak Up Guardian has promoted the concept of Freedom to Speak Up and has supported network members for any concerns they may have had around EDI issues. The Guardian has forged close ties with EDI Leads & Network Chairs and contributes to various EDI Groups or Committees.
SUMMARY	This is a 6 monthly report for Trust Board covering July 2022 – December 2022 and contains data for Q1 21/22 – Q3 22/23 **For brevity, key points for the Board to note are contained within the Executive Summary.** The paper includes: • a summary of communication activity being undertaken by the FTSUG • data from the most recent reports to the National Guardians Office • Feedback received from those who have raised concerns during the period • key points about improving FTSU culture • recommendations from the Freedom to Speak Up Guardian
ACTION REQUIRED	The Trust Board is asked: • to note the contents of this report by the Freedom to Speak Up Guardian; and • to provide support for the Guardian's recommendations detailed in this report

Report to the Meeting of the Berkshire Healthcare NHS Foundation Trust Board of Directors

Freedom to Speak up Report for July 2022 – Dec 2022

Executive Summary

- **Detriment –** A key element within the FTSU process is that workers wishing to raise a concern should be able to do so without fear of detriment (being harmed, threatened, singled out or a feeling of having to change role or employer). For the majority of concerns that revolve around patient safety issues, processes or other such concerns such as environmental issues etc this is not a problem. The issue arises for those cases that come under the "behavioural" banner, where the main concern is how staff are being treated and how they treat others. Generally, this type of behaviour is within a Team or Service, and it is very difficult for someone to feel empowered to speak up without being singled out, especially if their concern revolves around how they themselves are being treated. Data shows that a significant proportion of cases raised contain an element of bullying & harassment, this, coupled with a fear of detriment or what is the outcome of speaking out about this type of behaviour makes it a very difficult decision for staff.

  Work is currently in progress to review the processes around FTSU to try and minimise the risk of detriment, these processes currently do not fully support the pledges or commitment made by the Executive or Board and staff can be left feeling vulnerable or exposed. The aspiration is to formulate a manageable and workable contract which is available to staff, that outlines to processes when a concern of this type is taken forward and might involve some form of formal review. It will also hold the Organisation to account should timelines slip, for example.

- **Supporting BAME staff –** There has been a significant effort during the period to engage with and support BAME colleagues. Staff with protected characteristics are vulnerable to poor behaviours, microaggressions and racially motivated bullying. Data from various sources supports this, however it is also evident that BAME colleagues do not tend to use the FTSU process to raise concerns. Discussions with Race Equality Network (REN) members shows the following main reasons behind this:
  - **Culture –** Within certain cultures, the expectation is that issues are internalised and not spoken about.
  - **Language –** This is also linked to Culture, there is a perception that raising a concern (especially if it is about how the person is being treated or what they are experiencing) is essentially complaining. Also, there is an issue around nuances of language and being understood in the wider sense.

- **Past Experience** – Previous endeavours to raise concerns have not been properly taken up and followed through, lack of feedback. This links to detriment and a feeling of exposure or vulnerability. Experience of peers.
- **Confidentiality/Anonymity** – There's a feeling that whatever is promised at the outset, confidentiality is not adhered to and that staff names will be exposed to senior leaders inc CEO & Exec. This ties in with the perception of complaining.
- **Burden of proof** – As many concerns relate to personal experience and can be subjective in nature (bullying, microaggressions etc) staff are worried that they need proof to back up their claims so as to be believed.

Whilst someone's Cultural norms may not be within the remit of FTSU to effect change, the other reasons for not speaking up can be addressed by the Organisation.

Recommendations are on the final page of this report.

Background

A Freedom to Speak up Guardian (FTSUG) within every Trust was a key recommendation made by Sir Robert Francis QC in the Freedom to Speak Up review 2015. FTSU has also become part of the CQC Well Led inspection component since October 2016.

A standard integrated FTSU policy for the NHS issued in April 2016 is the basis of the Trust's Raising Concerns policy. This national policy has been reviewed with an update published in Q2 22/23.

In line with the above and as part of our regular policy review process, the FTSU policy is being reviewed by the FTSUG pending consideration by Human Resources colleagues and out Joint Staff Consultative Committee.

The National Guardian's office (NGO) was established in October 2016 at the same time as it became a contractual obligation for every NHS Provider Organisation to have appointed a FTSU Guardian.

The Role of the Freedom to Speak Up Guardian

"The Freedom to Speak Up Guardian will work alongside Trust leadership teams to support the organisation in becoming a more open and transparent place to work, where all are actively encouraged and enabled to speak up safely." (NGO 2018)

The FTSUG is independent and impartial. The Guardian reports directly to the Chief Executive and has access to anyone in the organisation. There are two main elements to the role.

- To give independent, confidential advice and support to members of staff who wish to speak up that have an impact on patient and staff safety or issues around malpractice,

wrongdoing and fraud. This is not exclusive to permanent members of staff but extends to temporary or agency staff, trainees or students, volunteers and trust governors.

- To promote a culture where members of staff feel safe to raise concerns and do not fear adverse repercussions or detriment as a consequence of doing so.

Debbie Fulton, Director Nursing and Therapies is Executive Lead for Freedom to Speak Up and Mark Day, Non-Executive Director, is nominated Non-Executive Director for Freedom to Speak Up.

Communication

It is crucial that the FTSU role is visible and accessible to all staff. The communications plan outlines how this is achieved.

The plan includes the following (Showing progress on plans and relevant target dates):

- Raising Concerns presence on Nexus
- Presentations and attendance at management/team meetings (ongoing)
- Production and dissemination of posters, leaflets and cards etc (ongoing)
- Virtual F2F presence at Corporate Induction, Junior Doctor's Induction & Student's Induction via MS Teams
- Supporting all EDI/Staff Networks as an Ally.
- Membership of the Safety Culture Steering Group, Strategic People Group, Diversity Steering Group amongst others

Contribution to the Regional and National Agenda

The Guardian is Chair of the Southeast Regional FTSU Guardian Network consisting of all NHS Trusts and private providers (including Primary Care) this numbers some 180 Guardians representing 113 Organisations and provides input to quarterly meetings between the NGO & regional Chairs.

Quarterly submissions to the National Guardian's Office (NGO)

The NGO requests and publishes quarterly speaking up data.

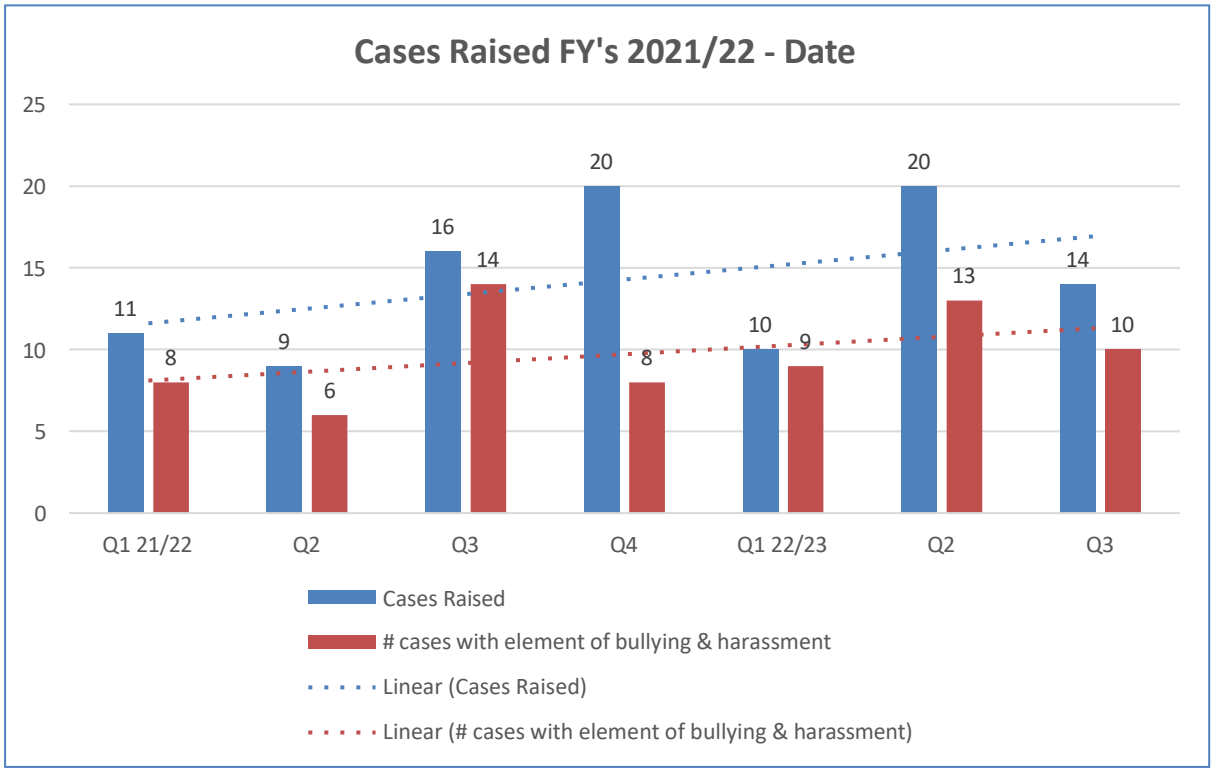
Contacts are described as "enquiries from colleagues that do not require any further support from the FTSUG".

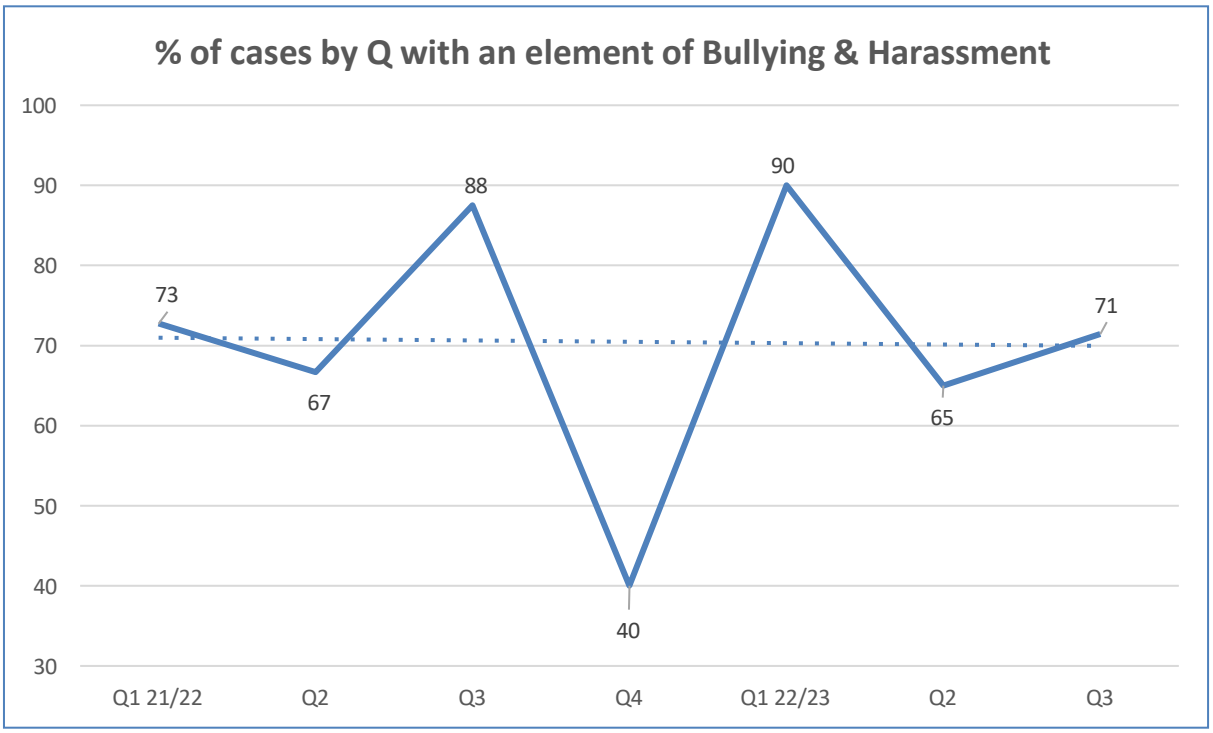
Cases are described as "those concerns raised which require action from the FTSUG".

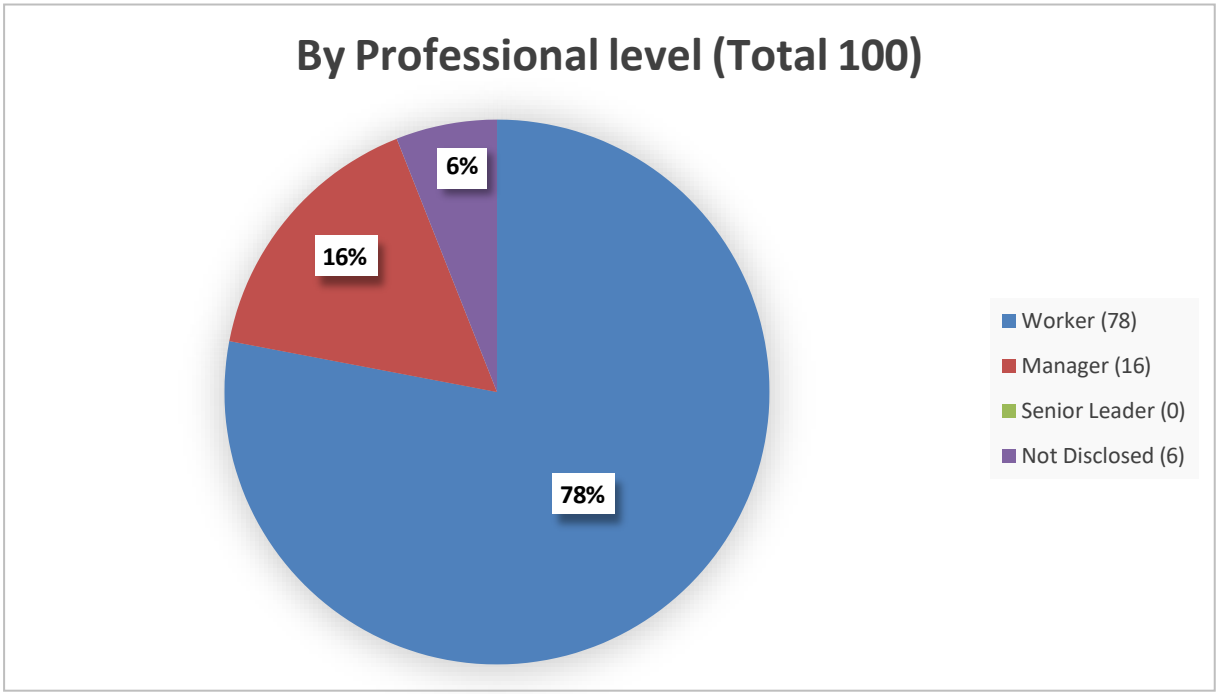
Outlined below are Berkshire Healthcare's submissions to the NGO for Q1 FY 2021/22 to date (Q3 FY 2022/23).

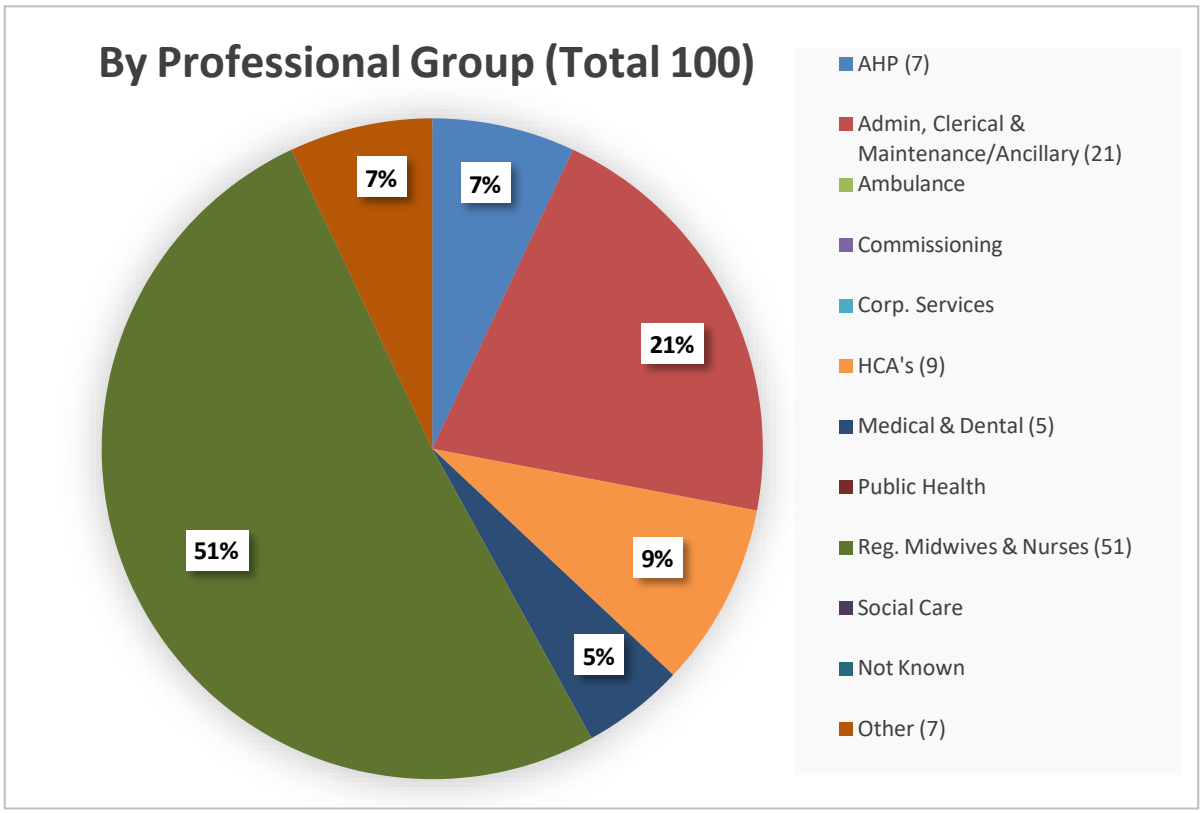
It's difficult to make comparisons with other similar organisations as the data does not provide a narrative regarding how many guardians or champions there are, how many days a week they work and if they have recorded both cases and contacts. All cases and contacts at Berkshire Healthcare are reported.

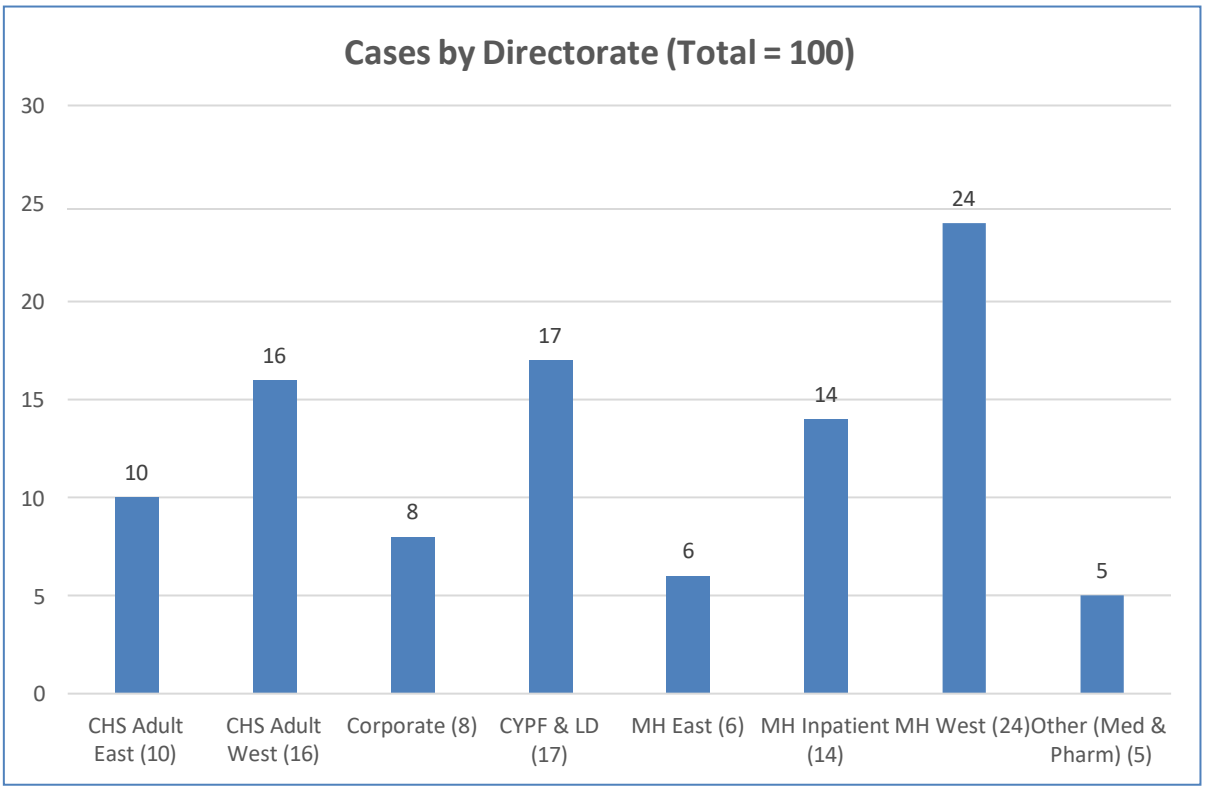
The total number of cases raised for FY 2021/22 plus Q1-Q3 2022/23 = 100

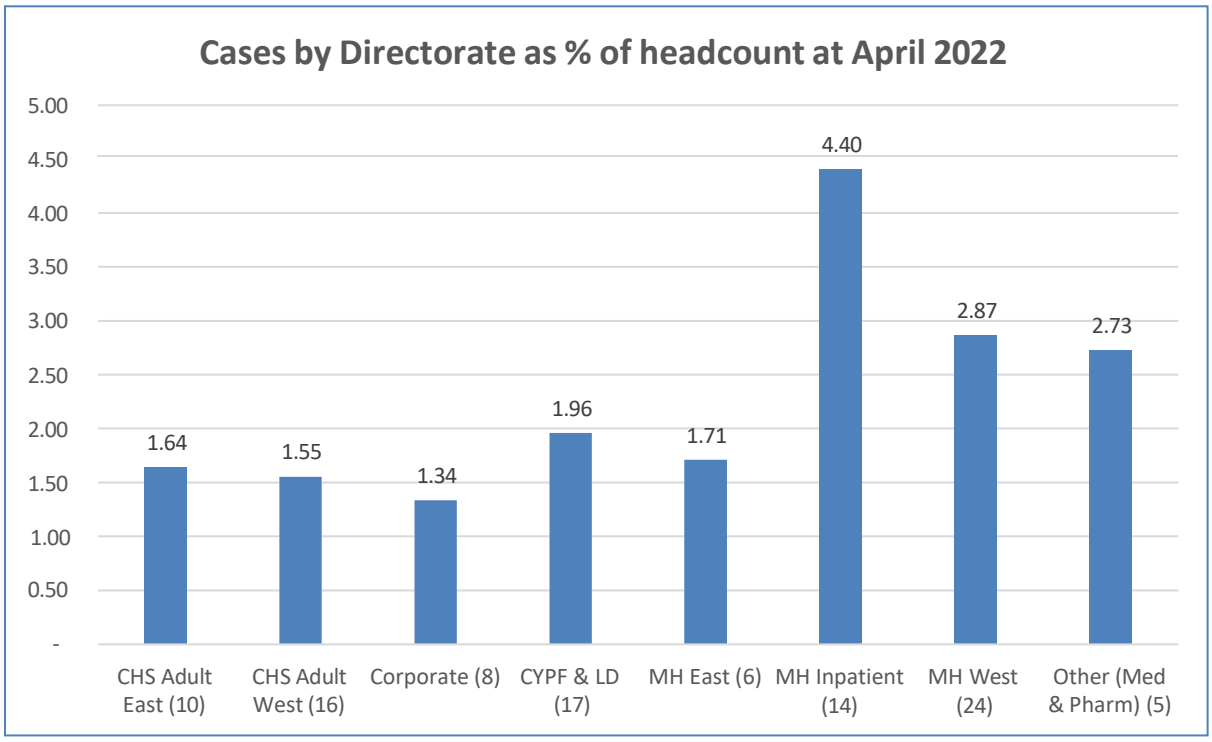


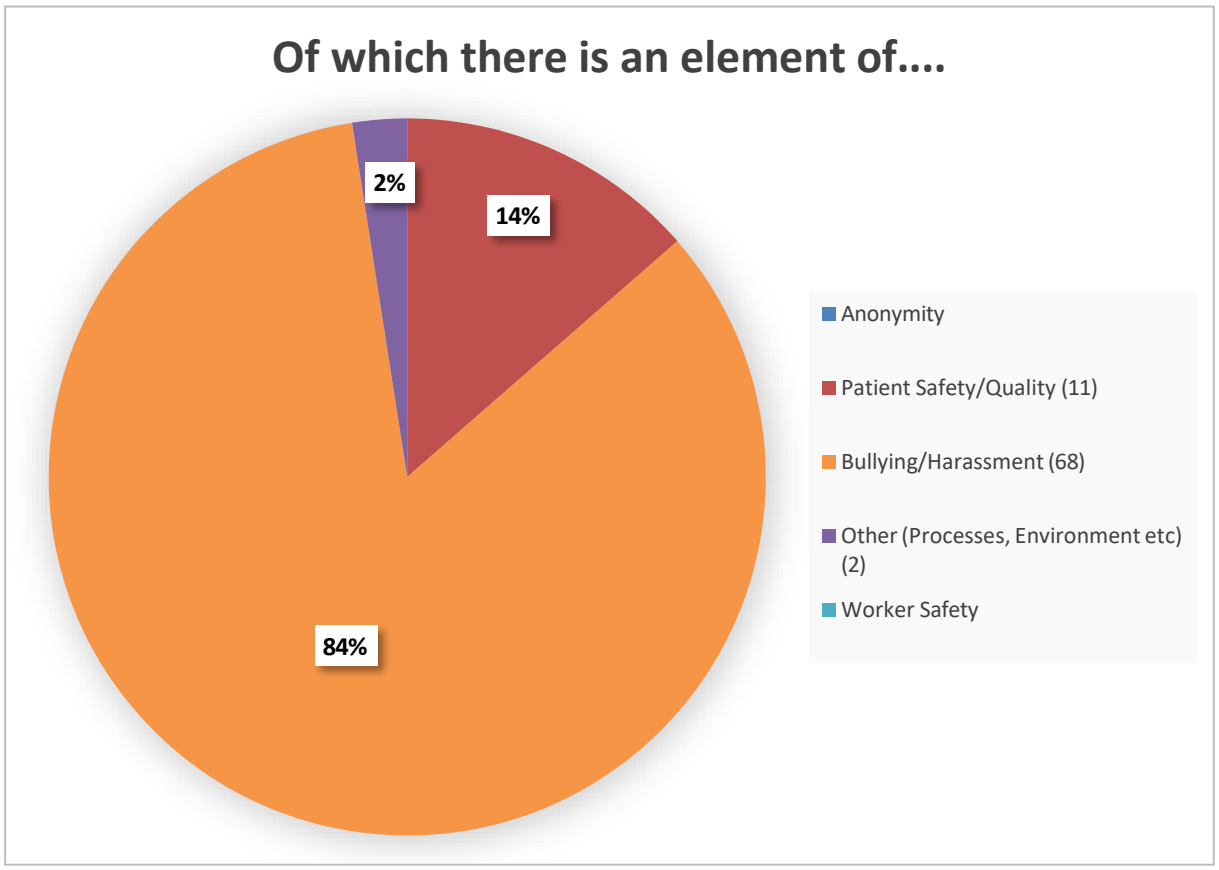

% of cases by Q with an element of Bullying & Harassment
100
90
80
70
60
50
40
30
73
67
88
40
90
65
71
Q1 21/22
Q2
Q3
Q4
Q1 22/23
Q2
Q3


By Professional level (Total 100)
6%
16%
78%
Worker (78)
Manager (16)
Senior Leader (0)
Not Disclosed (6)


By Professional Group (Total 100)
7%
7%
21%
9%
5%
51%
AHP (7)
Admin, Clerical & Maintenance/Ancillary (21)
Ambulance
Commissioning
Corp. Services
HCA's (9)
Medical & Dental (5)
Public Health
Reg. Midwives & Nurses (51)
Social Care
Not Known
Other (7)


Cases by Directorate (Total = 100)
30
25
20
15
10
5
0
10
16
8
17
6
14
24
5
CHS Adult East (10)
CHS Adult West (16)
Corporate (8)
CYPF & LD (17)
MH East (6)
MH Inpatient (14)
MH West (24)
Other (Med & Pharm) (5)


Cases by Directorate as % of headcount at April 2022
5.00
4.50
4.00
3.50
3.00
2.50
2.00
1.50
1.00
0.50
-
1.64
1.55
1.34
1.96
1.71
4.40
2.87
2.73
CHS Adult East (10)
CHS Adult West (16)
Corporate (8)
CYPF & LD (17)
MH East (6)
MH Inpatient (14)
MH West (24)
Other (Med & Pharm) (5)


Of which there is an element of....
2%
14%
84%
Anonymity
Patient Safety/Quality (11)
Bullying/Harassment (68)
Other (Processes, Environment etc) (2)
Worker Safety

Assessment of Issues

- The number and type of cases raised fit into the general pattern of cases from previous periods and could be considered the norm.
- Returns show 11 cases were raised via FTSU which contain an element of patient safety, the Board can be assured that any other patient safety issues are raised via other routes, handovers etc.
- A high proportion of cases raised are done so where the person raising the concern wishes some form of anonymity or confidentiality having spoken to the Guardian.
- During the period the Guardian received no anonymous concerns.
- A significantly high proportion of cases are around the “staff experience” and specifically from staff who are stating the cause is bullying & harassment (B&H) from fellow staff members (no cases have been received where B&H has been reported as coming from patients of the public at large – this would normally be highlighted via Datix).

Improving FTSU Culture

Creating a culture where all staff feel able to speak up and feel valued for doing so is dependent on the organisation showing it is listening and taking their concerns seriously. Giving feedback is one important way the Trust can demonstrate it values staff that speak up. The importance of this stage of the process is not always recognised by managers. Staff who speak up to the FTSUG fear suffering detriment as a result and this can present a barrier.

From personal observations and feedback from those who have spoken up, the following is highlighted:

- To achieve an open culture around speaking up, all elements of good, effective communication need to be included in the process. Speaking Up is only part of this and is relatively easy to address.
- An effective process is only achievable if the other elements are addressed, namely improving the Listening Up Culture, and removing barriers to communication.
- Part of the Listening Up process should include improved feedback to those who raise concerns, including timescales, expectations around outcomes.

Learning and Improvement

The FTSU Status Exchange between the FTSUG, Chief Executive, Director of Nursing and Therapies and Deputy Director of People continues to provide a good forum for a structured information exchange, triangulation of information, and ensuring action is completed regarding concerns raised. A regular meeting between the FTSUG and the Deputy Director

of People & Senior HR Managers continues as a standard piece of to enable direct communication about case work in a confidential manner.

The Guardian now also meets on a six-monthly basis with the nominated Non-Executive Director lead.

The Guardian ensures that any learning from cases raised is communicated to the Organisation through this status exchange, through regular 1:1's with the Executive lead for Freedom to Speak Up. All cases are audited on a quarterly basis to ensure any learning is taken into account and actioned.

Those who raise concerns are offered continual feedback on any investigation work undertaken as a result of speaking up and are supported throughout the whole process, the Guardian also obtains feedback from those who raise concerns on their views of the process and this learning is reviewed and considered by the Guardian.

On occasions where reports of case reviews undertaken by the National Guardian's Office are published, the Guardian will review these reports and communicate recommendations to the Organisation.

The National Guardian's Office have released a series of E-Learning packages, there are 3 packages aimed at various levels within the Organisation.

All three modules are available for staff on the Trust Nexus e-learning platform, Totara.

- **Speak Up** – Core training for all workers, volunteers, students and trainees, aimed at giving all staff an understanding what speaking up is, how to do so and what to expect when they do so.
- **Listen Up** – Aimed at all line managers, raising awareness of the barriers that can exist when staff wish to speak up and how to minimise them.
- **Follow Up** – For Senior Management groups and Trust Executives, ensuring the Organisation acts on concerns raised, learns from them and uses feedback to help create an open & just culture where all workers are actively encouraged to use their voices to suggest improvements or raise concerns.

National Guardian's Office

- The National FTSU Policy has been under review and the revised policy has just been published. The Berkshire Healthcare Raising Concerns policy will be reviewed and updated in Q4 FY 2022/23 to reflect changes in the national policy.

Learning – Some follow up actions from cases raised

- All cases are audited on a quarterly basis to ensure any learning is actioned.
- Where appropriate Services now have the support of an MDT/Organisational Development team. This includes representatives from HR, OD, Psychological Services, FTSU, Patient Safety, EDI leads. Concerns raised from staff within these services have helped to highlight some dysfunctionality or friction within the service. The aim of the MDT is to assist Heads of Service with improving morale, behaviours and efficiency of the service.
- In several cases where the standard of management may be in question, support will be given on a more individual basis to improve management techniques.
- It has been highlighted that with larger more complex cases where there may have been a collective concern or group of concerns that, due to the time taken to investigate these concerns, that staff concerned should get better and more frequent feedback. This is being addressed with HR colleagues to align the FTSU process with HR processes.

Examples of non-implementation of learning from concerns raised:

During the period there were no examples where learning from concerns raised (from cases that have been closed) had not been fully implemented.

Recommendations from the FTSU Guardian

The Trust Board is asked to support the following:

- Support and encourage initiatives to address “Staff Experience” concerns, specifically those that include an element of bullying & harassment and those concerns that may affect Network members.
- Support and encourage initiatives to minimise the risk of detriment.
- Support and encourage initiatives to improve a Listening Up culture, so that all staff will feel more able to challenge in a positive way, to encourage positive suggestions that may improve ways of working, the patient experience or efficiencies. In turn this will make raising more traditional FTSU concerns easier and more a part of the culture.
- Assist in minimising those barriers to communication that may prevent those wishing to speak up (in any way) from doing so.

Author and Title:

Mike Craissati - Freedom to Speak Up Guardian

December 2022

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13 December 2022
Title	**Quality Assurance Committee – 29 November 2022**
	ITEM FOR NOTING
Purpose	To receive the unconfirmed minutes of the meeting of the Quality Assurance Committee of 29 November 2022
Business Area	Corporate
Author	Julie Hill, Company Secretary for Sally Glen, Committee Chair
Relevant Strategic Objectives	To provide good outcomes from treatment and care.
CQC Registration/Patient Care Impacts	Supports ongoing registration
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equalities and Diversity Implications	N/A
SUMMARY	The unconfirmed minutes of the Quality Assurance Committee meeting held on 29 November 2022 are provided for information. Attached to the minutes are the following reports which were discussed at the Quality Assurance Committee meeting and are presented to the Trust Board for information: • Learning from Deaths Quarterly Report • Guardians of Safe Working Hours Quarterly Report
ACTION REQUIRED	The Trust Board is requested to: a) receive the minutes and the quarterly Guardians of Safe Working Hours and Learning from Deaths Reports and to seek

	any clarification on issues covered.

Berkshire Healthcare
NHS Foundation Trust

Minutes of the Quality Assurance Committee Meeting held on Tuesday, 29 November 2022

(the meeting was conducted via MS Teams)

Present:	Sally Glen, Non-Executive Director (Chair) Mark Day, Non-Executive Director (deputising for Aileen Feeney) Julian Emms, Chief Executive Minoo Irani, Medical Director Debbie Fulton, Director of Nursing and Therapies Guy Northover, Lead Clinical Director Amanda Mollett, Head of Clinical Effectiveness and Audit
In attendance:	Julie Hill, Company Secretary Daniel Badman, Deputy Director of Nursing Jodie Holtham, Deputy Director of Allied Health Professionals (present for agenda item 5.0) Dr Emma Bingham, Consultant, Diabetes (present for agenda item 6.0) Sara Fantham, Clinical Director (present for agenda item 6.0) Jan Durrant, Head of Community Diabetes Services (present for agenda item 6.0)

Opening Business

1 Apologies for absence and welcome

Apologies were received from: Aileen Feeney, Non-Executive Director, Mehmuda Mian, Non-Executive Director and Tehmeena Ajmal, Chief Operating Officer.

The Chair welcomed everyone to the meeting.

2. Declaration of Any Other Business

There was no other business declared.

3. Declarations of Interest

There were no declarations of interest.

4.1 Minutes of the Meeting held on 30 August 2022

The minutes of the meeting held on 30 August 2022 were confirmed as an accurate record of the proceedings.

4.2 Matters Arising

The Matters Arising Log had been circulated.

The action log was noted.

Patient Safety and Experience

5.0 Breakthrough Objective: Falls Reduction

The Chair welcomed Jodie Holtham, Deputy Director of Allied Health Professionals to the meeting.

Jodie Holtham gave a presentation and highlighted the following issues:

- The Trust embarked upon its Quality Improvement Programme in 2016. Inpatient Falls Reduction was identified as a True North Objective. Following a successful implementation, the number of falls reduced and the target of 20 falls per month was achieved.
- During the pandemic there was a sharp increase in the number of falls. A variety of reasons were given to account for the rise in the number of falls, including an increase in the acuity of patients.
- A Community Inpatient Falls Rapid Improvement Event was held in November 2021 to review the data, current root causes and to identify new countermeasures. Each of the nine Community Inpatient wards identified the "3 Cs" (concerns, causes and countermeasures) for their respective wards. Patients were invited to contribute to the process and provided useful insights. Each ward agreed their own individual target for reducing falls to ensure that the targets provided stretch but were realistic and achievable.
- Oakwood ward had consistently met their target over an eight month period and had agreed to reduce their individual target to provide more stretch.
- Prospect Park Hospital Older Adults Inpatient wards undertook a similar exercise to identify their "3 Cs". The countermeasures included environmental factors such as changing the flooring to better meet the needs of people with dementia.
- Using the Quality Improvement Programme methodology has led to a number of successes including:
    - Falls reduction was now seen as everyone's responsibility rather than leaving it to a Falls Champion.
    - The Safety Huddles provided an opportunity to daily review safe staffing and the care needs of new and potential admissions.
    - Cohorting patients requiring supportive observation (known as "Baywatch") meant that staff had "eyes on the patient"
    - Improved triage processes – for example, working with the acute hospitals to get information about patients being transferred before they were admitted so that patients individual risks could be reviewed
    - Using technology to support falls reduction. The Trust had trialled two different systems but had settled on the Rambleguard Bond system which was on a wireless solution.
- The National Audit of Inpatient Falls highlighted that the Trust was below the national average for community health wards (there was no comparable national audit for mental health inpatient falls).
- The most important issue was that by reducing the number of falls, the Trust had prevented serious harm to patients.

The Chair thanked Jodie Holtham for her presentation. The Chair added that it was an impressive piece of work which highlighted the value of using Quality Improvement methodology to achieve sustainable performance improvements.

Mark Day, Non-Executive Director commented that the presentation had also illustrated how the trust-wide Quality Improvement Programme was implemented at the very local level. Mr Day said that it was heartening to hear how the individual wards had been empowered to identify and develop their own individual countermeasures which had led to an overall reduction in the number of falls. Mr Day asked how the learning from the individual wards was shared.

Jodie Holtham said that there was a monthly Falls meeting which provided an opportunity to share learning.

The Chief Executive said that it was important to view the Trust's fall reduction work within the context that the Trust was already a high performer in terms of the number of inpatient falls and therefore to reduce falls even more was a significant achievement. The Chief Executive added that providing central authority but de-centralised decision-making was a characteristic of high performing organisations.

The Chief Executive reported that there would be an opportunity to discuss the Trust's Quality Improvement work at the January 2023 Trust Board Discursive meeting.

The Committee noted the presentation

5.1 Quality Concerns Status Report

The Director of Nursing and Therapies presented the paper and highlighted the following points:

- Since the Quality Concerns Register was last presented to the Committee two concerns have been added:
    - Quality Concern No 14: - Heart Function Team
    - Quality Concern No 15: - Community Mental Health Teams
- There was an overlap between Quality Concern No 4: Common Point of Entry, Crisis Resolution Home Treatment Team and Community Mental Health Team interfaces; Quality Concern No 9: Record Keeping in Mental Health Services particularly in relation to risk and safety planning and Quality Concern No 15: Community Mental Health Teams and that a new concern would be framed to capture all three into one Quality Concern
- Dental waits had been removed since the Register was last submitted to the Committee due to improvement work leading to decreased wait times and improved processes.
- At the November 2022 Quality and Performance Executive Group, it was agreed that Speech and Language Therapy would come off the Register as a result of stability over last few months.
- CAMHs Rapid Response had been successful at recruitment but would remain on the Register for three months to ensure stability.

The Chair referred to the Coroner's request for the Trust to review the role and appointment of Care Coordinators and asked whether the Community Mental Health Teams should be a focus for the Committee.

The Director of Nursing and Therapies reported that the Chief Operating Officer was reviewing the Community Mental Health Team framework as part of her review of the

Operational Structure. The Director of Nursing and Therapies proposed that an update report would be presented to the May 2023 meeting.

Action: Chief Operating Officer

The Lead Clinical Director added that work was also underway to support the Community Mental Health Teams in the short term to ensure a safe service until the Trust moved to a better model.

The Chair noted that there were pressures in relation to the Campion Unit due to workforce related issues and delayed discharges and commented that this was a particularly vulnerable cohort of patients.

The Director of Nursing and Therapies said that the Chief Executive, Medical Director and herself regularly visited the Campion Unit.

The Chair referred to the Quality and Performance Executive Group minutes which had referred to the Trust's Pharmacy Review and asked whether medication errors were a cause for concern.

The Medical Director confirmed that the Trust had very few medication errors which originated in the Trust and the majority were of minor significance. The Director of Nursing and Therapies said that there was a serious incident due to issues with the Electronic Prescribing and Medication Administration system where a patient had missed their medication but said that this was an isolated case.

The Committee noted the report.

5.2 Serious Incidents Report

The Director of Nursing and Therapies presented the paper and highlighted the following points:

- During quarter 2, there were a total of 13 Serious Incidents initially reported, with 1 downgraded during the quarter. There were also 12 incidents investigated through internal learning reviews.
- The Trust had been involved in 14 inquests during the quarter. There were no Preventing Future Death reports issued to the Trust following these.
- The Coroner had asked during the summing up of one inquest in September 2022 for the Trust to review their position and the criteria for appointment of Care Coordinators. The Trust had forwarded a response to the Coroner but at this time, the Trust had not received any further correspondence in relation to this.
- The report now included an expanded section on the learning from incidents.

The Chair asked the Director of Nursing and Therapies whether she was aware of a recommendation from the review into Maternity Services at East Kent around using statistical process control charts when reporting serious incidents.

The Director of Nursing and Therapies said that the Trust was using statistical process control charts as part of the True North Breakthrough Objective reporting but confirmed that she was not aware of this recommendation and pointed out that the implementation of the National Patient Safety Strategy would require changes to the reporting of Serious Incidents from September 2023 and agreed to consider the use of statistical process control charts as part of this process.

Action: Director of Nursing and Therapies

The Committee noted the report.

5.3 Learning from Deaths Quarterly Report

The Medical Director presented the paper and highlighted the following points:

- During quarter 2, 98 deaths had met the criteria to be reviewed further
- All 98 deaths were reviewed by the Executive Mortality Review Group and the outcomes were as follows:
    - 54 were closed with no further action
    - 37 required “second stage” reviews (using an initial finding review/structured judgement review methodology)
    - Of the 37 deaths requiring further review, 4 were classified as Serious Incidents requiring investigation and 7 cases were awaiting further information
- During quarter 2, the Trust Mortality Review Group had received the findings of 33 second stage review reports of which 13 related to patients with a learning disability
- There were “no lapses in care” identified from the quarter 2 reviews which were undertaken
- There were 2 deaths in quarter 2 where a patient had died within 28 days of a positive COVID-19 result and therefore met the criteria for national reporting. COVID-19 was not stated on the Medical Certificate of Cause of Death and both cases were closed at the first stage review
- Learning from the reviews of death had been shared with the relevant services by the Clinical Directors through their Patient Safety and Quality Group meetings. Any key learning themes will also be disseminated across the Trust via the staff Circulation electronic newsletter after quarter 4.

The Chair referred to six unexpected deaths due to ill health deterioration where the patients were transferred to an acute hospital and died within 7 days and asked for further information.

The Medical Director pointed out that these deaths had occurred following transfer from the community health wards and commented that it was not always possible to prevent the deaths of very elderly patients even after transfer to an acute hospital. The Medical Director said that the staff on community health wards had undertaken a lot of training around the identification of the deteriorating patient.

Mark Day, Non-Executive Director said that it was reassuring to read that there had been no deaths identified due to a lapse in care this quarter and asked how the Trust’s performance compared with other trusts.

The Medical Director said that the acute trusts were mandated to submit data nationally but unfortunately mental health and community trusts were not required to submit data nationally which could then be benchmarked. The Medical Director said that the Trust’s Learning from Deaths quarterly reports were submitted to the local Integrated Care Systems Mortality Group along with the reports from other NHS provider organisations. The Medical Director added that the Trust was rigorous in reviewing all deaths and was upfront around declaring any lapses in care.

Mark Day, Non-Executive Director reminded the meeting that he was the Non-Executive Director lead for Freedom to Speak Up and commented that he was encouraged that the Trust had an open, transparent and learning culture which did not shy away from identifying any lapses in care.

The Committee noted the report.

5.4 National Patient Safety Strategy Implementation Report

The Director of Nursing and Therapies said that the paper provided an update on the current national and local position regarding the implementation of the National Patient Strategy. The paper included a summary of the ongoing implementation plans and an update specifically on the Patient Safety Incident Response Framework which was launched in August 2022.

The Director of Nursing and Therapies reported that the Deputy Director of Nursing and the Trust's two Patient Safety Specialists would be giving a presentation on the Trust's Patient Safety Strategy at the January 2023 Trust Board Discursive meeting.

The Director of Nursing and Therapies reported that work was ongoing both nationally and locally to support Coroners in the move away from the traditional serious incident investigation reports.

It was noted that the Deputy Director of Nursing was involved in a national piece of work around making families count to ensure that the Duty of Candour systems and processes were operating effectively.

The Chair commented that it was clear from the report that the Trust had already undertaken a significant amount of work to prepare for the implementation of the National Patient Strategy.

The Chair noted that at the national level, the Learning from Patient Safety Incidents would replace the current national Reporting Learning Scheme by the end of March 2023 (with the option to extend the deadline until September 2023) and that there were several risks identified associated with this nationally mandated change especially as the release of the software to support the transition had been delayed..

The Director of Nursing and Therapies reported that the Trust's Risk Team and Patient Safety Team were working closely together and within the wider network groups to evaluate the potential risks, to benchmark and were possible to mitigate any organisational risks.

The Deputy Director of Nursing commented that there were different options around the implementation of the National Patient Safety but the most important aspect was around developing a safety and improvement culture with patients and families at the very centre.

Mark Day, Non-Executive Director asked whether during the transition phase to the new arrangements whether there were any areas that could leave patients and their families exposed in terms of deficiencies in the new arrangements.

The Deputy Director of Nursing said that if the new Patient Safety Incident Response Framework was poorly implemented that could potentially put patients at risk. The Deputy Director of Nursing said that this why it was so important to ensure that the needs and views of families took centre stage rather than focusing on the incident.

The Director of Nursing and Therapies added that the Trust's bigger challenge was around making sure staff understood the changes and the different approach away from old style investigations to identifying and disseminating learning. The Director of Nursing and Therapies said that the Trust had been preparing for this change for quite a while and had already undertaken a lot of training with staff. It was noted that staff would also need to be supported to understand the changes to the DATIX online incident reporting system.

Mark Day, Non-Executive Director said that it would be helpful if learning from incidents could be highlighted in future reports.

The Director of Nursing and Therapies said that further work was needed to develop a new reporting template for providing assurance around the Trust's patient safety work and confirmed that the new report would include a section on learning from incidents.

Action: Director of Nursing and Therapies

The Chair commented that a lot of the national patient safety guidance was skewed towards the acute sector.

The Director of Nursing and Therapies agreed and reported that the Trust had been involved in some national calls via the system and that this had raised the profile of the issues relating to community and mental health services.

The Chair agreed and said that the Trust Board had a key role to play in setting the right culture and said that she pleased that the whole Trust Board would have an opportunity to be updated about the implementation of the National Patient Safety Strategy at the Trust Board Discursive meeting in January 2023.

The Committee noted the report.

5.5 Reducing Restrictive Practices Update Report

The Deputy Director of Nursing reported that the National Patient Safety Strategy had identified delivery of the Mental Health Safety Improvement Programme which included reducing restrictive practice as one of its key improvement aims.

The Deputy Director of Nursing presented the paper and highlighted the following points:

- There had been no confirmed cases of inappropriate use of force in quarter 2
- There had been one upheld complaint relating to the inappropriate use of force relating to an incident that had occurred during quarter 1
- Snowdrop Ward had been identified as an outlier ward for use of Rapid Tranquilisation. An internal Deep dive into this was underway
- Changes to blanket restrictions during the quarter were:
    - Supervised access to kitchen area revised to enable all patients on Phoenix access unless a risk assessment indicated that this was not safe
    - Access to the snack area on Campion ward was revised
- A range of improvement activity was being taken forward as detailed in the report

The Deputy Director of Nursing reminded the meeting that following the Panorama programme into care and treatment of patients at Edenfield Centre, Manchester, an assurance paper, including additional measures being taken to mitigate the risk of closed and poor cultures developing on the Trust's Mental Health and Learning Disability inpatient wards was presented to full Trust Board in November 2022. The paper also proposed that a combined paper to include updates against this as well as actions following Ockenden report and the Care Quality Commission's Who Cares Report would be presented to the Committee at the February 2023 meeting.

Action: Director of Nursing and Therapies/Company Secretary

The Chair commented that she found the "Avoided Use of Force" section particularly helpful as she had not seen this reported in this format elsewhere.

The Deputy Director of Nursing said that this data was part of the new mandated Use of Force Dashboard and commented that it provided some balance especially as

some of the highest users of restraint often had the highest incidence of avoided restraint as well.

The Chair asked about the governance processes around the use of mechanical restraints.

The Medical Director explained that in terms of governance, he was the responsible person for the new Use of Force Act. The Medical Director said that the Deputy Director of Nursing was responsible for managing the Restrictive Practices Interventions Oversight Group.

The Medical Director confirmed that he was no aware of the Trust using mechanical restraints but said that the Trust's PMVA Specialist had trained several staff on PICU in the use of mechanical restraints which were being considered in respect of one patient. It was noted that in the event, mechanical restraints were not used. The Medical Director said that the Trust had clear systems and processes in relation to the decision making around whether or not the use of mechanical restraints would be appropriate and confirmed that mechanical restraints would never be used without a rigorous assessment which would require either approval from himself as the Responsible Person or from the Deputy Responsible Person.

The Medical Director added that if mechanical restraints were ever used, this would be reported to the Mental Health Act Governance Board (the minutes of which were presented to the Committee).

The Chair thanked the Medical Director for clarifying the governance systems and processes and commented that it was reassuring that there was a robust process in place in relation to the use of mechanical restraints.

Mark Day, Non-Executive Director said that the report provided assurance about a very sensitive subject especially in light of the Panorama programme and other media reports. Mr Day added that the paper was inevitably produced to reflect reported data and asked about the leadership team's confidence around under reporting around the use of restraint.

The Medical Director said that this was part of the Trust's work around promoting an open and learning culture. This included visits to the wards and frontline services to talk to staff and patients, including out of hours unannounced visits, the work of the Freedom to Speak Up Guardian and the reviewing complaints around the use of restraint. The Medical Director reported that he had written to staff at Prospect Park Hospital to inform them that in his capacity as the Responsible Person for the Use of Force, he would be randomly selecting CCTV footage to review as part of the triangulation of data.

The Director of Nursing and Therapies added that patients and/or their families could also refer any concerns to the Care Quality Commission.

The Chair commented that it was important that the Trust was not complacent and continued to rigorously triangulate information from different sources in order to ensure there was an open culture across the Trust.

The Committee noted the report.

5.6 Quarterly Infection Prevention and Control Report

The Quarterly Infection Prevention and Control Report had been circulated.

The Committee noted the report.

5.7 Safeguarding Self-Assessment Framework Report

The Director of Nursing and Therapies presented the paper and said that the NHS England Safeguarding Accountability and Assurance Framework (2022) was designed to strengthen the NHS commitment to promoting the safety, protection and welfare of children, young people and adults.

It was noted that the framework which had been developed in partnership with multi-agency organisations and professional bodies was updated in July 2022 to provide clarify of roles and responsibilities of commissioners and providers in relation to system working and safeguarding.

The Director of Nursing and Therapies reported that the Trust had conducted a self-assessment against the framework to provide assurance that the relevant policies and processes required to align with the requirements of the framework were in place.

The Director of Nursing and Therapies reported that a key area of focus for the Trust was in relation to preparation for the introduction of the new Liberty of Protection Safeguards (LPS) which would be replacing the current Deprivation of Liberty Safeguards (DoLS). It was noted that this was not likely to be before October 2023. The Director of Nursing and Therapies reported that the Trust had employed a Mental Capacity Act Liberty Protection Safeguards Lead to support with preparing for the new safeguards and also to support improvement to the current Mental Capacity Act understanding and application.

The Committee noted the report.

Clinical Effectiveness and Outcomes

6.0 Clinical Audit Report

The Medical Director presented the paper and reported that four national clinical audit reports had been received since the last meeting of the Committee and had been presented to the Clinical Effectiveness Group:

- National Clinical Audit of Psychosis: National Recommendations
- The National Diabetes Audit: three national level reports from the 2020/21 audit data collection
- National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP)
- National Audit of Care at End-of-Life 2021/22: National recommendations

a) National Clinical Audit of Psychosis: National Recommendations

The Medical Director explained that the Trust level results were published in March 2022 and reported to the Clinical Effectiveness Group and to the Committee in June 2022 alongside a detailed action plan for improvement. The current report was a review of the national findings released in July 2022.

The Medical Director reported that the Early Intervention in Psychosis service had completed a comprehensive review of the national recommendations and one additional action had been added to the action plan which would allow the team to review gender and ethnicity data to ensure the equitable access recommendation

was met. All other recommendations in the national report were covered where relevant in the service's current action plan.

b) The National Diabetes: three national level reports from the 2020/21 audit data collection

The Chair welcomed Dr Emma Bingham, Diabetes Consultant, Sara Fantham, Clinical Director and Jan Durrant, Head of Community Diabetes Services to the meeting.

The Medical Director reported that an area to note was the treatment targets for Type 2 diabetes which were significantly below the national benchmark.

Dr Emma Bingham, Consultant Diabetes said that the Trust's Community Diabetes service was unusual in that the Trust was commissioned to provide Type 1 and complex Type 2 specialist Diabetes care. Dr Bingham said that in her view, Diabetes care like many other long term conditions was best delivered in the community.

Dr Bingham explained that the Trust's Diabetes service only accepted referrals for type 2 patients with poor control and that this may skew the Trust's results in comparison to other organisations. Once the patient had improved and was stable, they were then discharged back to primary care.

Dr Bingham said that the latest clinical audit had indicated that the percentage of patients with Type 1 and Type 2 receiving blood tests for glucose control continued to be high (94% & 97% respectively) well above the national average as well as the number of Type 1 diabetics meeting the treatment target was continuing to improve and was now also above the national average.

Dr Bingham reported that the Trust's performance in relation to the number of patients attending Diabetes education events had also improved since the previous clinical audit and that Trust's performance was now above the national average.

Dr Bingham said that plans were being developed for an education 'roadshow' where she would visit each GP Practice with a Diabetes Specialist Nurse and deliver some education on core points of care from the Diabetes Crib Card which was developed at Frimley Park hospital. This would start once the Trust had sufficient Diabetic Specialist Nurses in place within the service to support this.

Jan Durrant, Head of Community Diabetes Service said the service had made significant changes in the past 18-24 months in terms of data collection and recording, which would enable an accurate reflection of the quality of care and outcomes being delivered and should positively influence results of future audits. It would also give the Diabetes service the ability to monitor their own activity more effectively from a service perspective and support effective quality improvement where applicable.

The Chief Executive thanked Dr Bingham and Jan Durrant for providing some helpful context around the clinical audit results and said that the value of clinical audit process was not around scoring highly for the sake of it but to do the right things in terms of service delivery. The Chief Executive said that the action plan was focussed on the right things for patients.

The Chair thanked Emma Bingham, Jan Durrant and Sara Fantham for attending the meeting.

c) National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP)

The Medical Director reported that the Berkshire Healthcare's Berkshire West Cardiac and Respiratory Specialist Services had met 4 out of the 6 national key performance indicators (KPI) with a further 2 not applicable to the service.

The "not applicable" KPIs were because the Trust did not offer a home-based Pulmonary Rehabilitation programme as this was challenging with staffing capacity. However, patients who were unable to attend a group were seen at home by a Physio/Integrated Assistant for a "home exercise programme". The Trust also did not use a "Six Minute Walk Test" to measure exercise capacity but instead used the Incremental Shuttle Walking Test" which was a validated measure of exercise capacity.

d) National Audit of Care at End-of-Life 2021/22: National recommendations

It was noted that there were six national recommendations from the End-of-Life national audit report for Acute and Community Trusts and three National recommendations highlighted from the Mental Health End-of-Life spotlight national report. Three out of the six National recommendations for acute and community trusts directly related to the key performance standards audited in the national audit, two were in relation to 'Individual Plan of Care' and one recommendation in relation to 'Needs of Families and Others'. The Trust met both performance standards higher than the national average.

The Committee noted the report.

6.1 Quality Accounts 2022-23 Quarter 2 Report

The Quality Accounts 2022-23 quarter 2 report had been circulated. The Medical Director reminded the meeting that the Quarter 3 version of the Quality Accounts would be shared with the Trust's stakeholders.

The Head of Clinical Effectiveness and Audit presented the report and said that the performance information had been previously reported to the Trust Board and/or to the various Committees.

The Chair commented that Non-Executive Directors found the Quality Accounts Reports very helpful as it provided a useful overview of the Trust's quality related work and performance over a twelve month period.

The Chair asked whether the Quality Accounts should explain more about how the Trust was actively managing waiting lists.

The Head of Clinical Effectiveness and Audit agreed to review the information about waiting lists.

Action: Head of Clinical Effectiveness and Audit

Mark Day, Non-Executive Director commented that a recent Trust Board meeting had noted that there was an increase in the number of pressure ulcers but the Quality Accounts made reference to there being only one grade two and zero grade three or four pressure ulcers.

The Director of Nursing and Therapies said that there had been a run of three pressure ulcers related to the management of deteriorating patients but confirmed that overall, she was not concerned about the number of pressure ulcers. The Director of Nursing and Therapies agreed to review the section on pressure ulcers.

Action: Director of Nursing and Therapies

The Committee noted the report.

Update Items for Information

7.0 Guardian of Safe Working Hours Quarterly Report

The Guardian of Safety Working Hours report had been circulated.

The Medical Director presented the paper and reported that during the reporting period (3 August 2022 to 31 October 2022) the Trust had not received any exception reports.

It was noted that the Guardian of Safe Working Hours had provided assurance to the Trust Board that no unsafe working hours had been identified and there were no other patient safety issues requiring escalation.

The Committee noted the report.

7.1 Minutes of the Mental Health Act Governance Board

The minutes of the Mental Health Act Governance Board meeting held on 17 August 2022 had been circulated.

The Chair commented that the minutes were very informative and comprehensive.

The Medical Director reported that the Mental Health Act Governance Board had received a presentation from the Quality Improvement team on the Trust's work around reducing health inequalities in relation to the Mental Health Act detentions of black individuals. The Medical Director reported that he was keen that this work progressed at pace and had therefore requested that an update be presented to the February 2023 Mental Health Act Governance Board meeting.

The Medical Director reported that the practice of using the side rooms near the Reception area at Prospect Park Hospital to assess patients when the Place of Safety was full had been discontinued because of concerns about safety.

The Committee noted the minutes.

8.5 Quality and Performance Executive Group Minutes – August 2022, September 2022 and October 2022

The minutes of the Quality and Performance Executive Group minutes for August 2022, September 2022 and October 2022 had been circulated.

The Committee noted the minutes.

8.6 Council of Governors Quality Assurance Group – Visits to Services

Copies of the Governor visit reports to the Phoenix Unit had been circulated.

The Chair thanked the Governors for their detailed reports.

The Committee noted the Governors' service visit reports.

Closing Business

9.0 Quality Assurance Committee Horizon Scanning

The Director of Nursing and Therapies reported that she would present a paper to the February 2023 meeting on the Trust's Safety Culture work.

Action: Director of Nursing and Therapies

The Director of Nursing and Therapies proposed that the Chief Operating Officer reports to the May 2023 meeting on the Trust's work around the Community Mental Health Teams.

Action: Chief Operating Officer

The Medical Director said that he would present a paper to the November 2023 meeting on the reforms to the Mental Health Act which were currently going through Parliament.

Action: Medical Director

9.1. Any Other Business

There was no other business.

9.2. Date of the Next Meeting

The next meeting is scheduled to take place on 28 February 2023 at 10am.

These minutes are an accurate record of the Quality Assurance Committee meeting held on 29 November 2022.

Signed:-_____

Date: - 28 February 2023_____

Berkshire Healthcare
NHS Foundation Trust

QAC Meeting/Trust Board	29 November 2022
Title	**Learning from Deaths Quarter 2 Report 2022/23**
Purpose	To provide assurance to the Trust Board that the Trust is appropriately reviewing and learning from deaths
Business Area	Clinical Trust Wide
Authors	Head of Clinical Effectiveness and Audit
Relevant Strategic Objectives	1 – To provide accessible, safe, and clinically effective services that improve patient experience and outcomes of care
Equality Diversity Implications	A national requirement is that deaths of patients with a learning disability & Autism are reviewed to promote accessibility to equitable care. This report provides positive assurance of learning from these deaths.
Summary	98 deaths met the criteria to be reviewed further and were submitted on Datix for review. All 98 were reviewed by the Executive Mortality Review Group (EMRG) and the outcomes were as follows: • 54 were closed with no further action • 37 required 'second stage' review (using an initial finding review (IFR)/ Structured Judgement Review (SJR) methodology). • Of the 37 deaths requiring further review, 4 were classed as Serious Incident Requiring Investigation (SI) • 7 cases were awaiting further information During Q2, the trust mortality review group (TMRG) received the findings of 33 2nd stage review reports, of which 13 related to patients with a learning disability. **Lapse in care (LIC)** A lapse in care is defined as greater than 50% likelihood that problems in care of the patient could have contributed to the death of the patient. No lapse in care was identified from the Q2 reviews which were undertaken. **COVID 19 Inpatient Deaths.** We had 2 deaths in Q2 where the patient died within 28 days of a positive covid result and therefore met the threshold for national reporting. Covid 19 was not stated on the Medical Certificate of Cause of Death (MCCD) and both cases were closed at 1st stage review. Learning from review of deaths is further shared with services by the Clinical Directors through their patient safety and quality groups (PSQs).
ACTION REQUIRED	The committee is asked to receive and note the Q2 learning from deaths.

Figure 1. Summary of Deaths and Reviews completed in 2022/23.

Figure 1	20/21 total	21/22 total	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Total 22/23
Total deaths screened (Datix) 1st stage review	510	467	119	**98**			
Total number of 2nd stage reviews requested (SJR/IFR/RCA)	269	209	48	**37**			
Total number of deaths reported as serious incidents	48	35	9	**4**			
Total number of deaths judged > 50% likely to be due to problems with care (lapse in care)	1	4	0	**0**			
Number of Hospital Inpatient deaths reported (Including patients at the end of life and unexpected deaths following transfer)	185	156	43	**39**			
Total number of deaths of patients with a Learning Disability (1st stage reviews)	53	51	7	**6**			
Total number of deaths of patients with LD judged > 50% likely to be due to problems with care	0	0	0	**0**			

Note: The date is recorded by the month we receive the form which is not always the month the patient died

1.1 Total Deaths Screened (1st stage review)

98 deaths were submitted by services through the trust Datix reporting system for a first stage review by the EMRG. Of these 98 deaths reviewed, EMRG advised closing 54 cases, 37 were referred for a second stage review of which 4 were referred for SI investigation. 7 cases require additional information at first stage review.

1.2. 2nd Stage Reviews Completed

The Trust-wide mortality review group (TMRG) meets monthly and is chaired by the Medical Director; 33 second stage reviews have been received and considered by the group in Q2. Figure 2 details the service where the review was conducted.

Figure 2: 2nd Stage Reviews Completed in Q2

July 2022	14 SJR 1 IFR **15 Total**	Learning Disabilities: 5 SJR West Mental Health: 1 SJR, 1IFR West Physical Health: 8 SJR
August 2022	10 SJR 1 IFR **11 Total**	Learning Disabilities: 7 SJR East Mental Health: 1 IFR West Physical Health:2 SJR Children Young People Families (Adult EDS): 1 SJR
September 2022	6 SJR 1 IFR **7 Total**	Learning Disabilities: 1 SJR East Mental Health: 1 IFR Mental Health Inpatients: 1 SJR West Physical Health: 3 SJR East Physical Health: 1 SJR

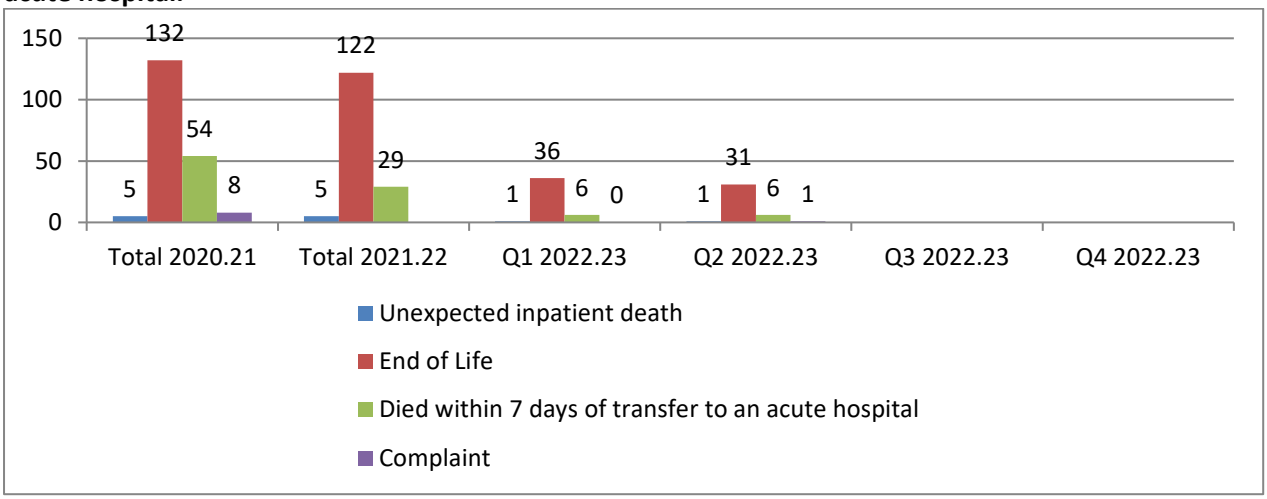
2. Concerns or Complaints

In Q2, 2 new complaints in total were received from families following the death of a relative, 2nd stage reviews were requested for both. None of the complaint related SJR reviews at TMRG raised concern that the quality of care provided would have contributed to the patient's death.

3.1 Deaths of patients (including palliative care) on Community Health Inpatient Wards

For community health inpatients we require all deaths to be reported on the Datix system including patients who are expected to die and receiving palliative care. Figure 3 details these.

Figure 3: Deaths occurring on the community health inpatients wards or following deterioration and transfer to an acute hospital.



In Q2 there were 39 deaths reported by Community Inpatient Wards, of which:

- 31 were expected deaths and related to patients who were receiving end of life care (EOLC).
- 6 unexpected deaths due to ill health deterioration where they were transferred to an acute hospital and died within 7 days
- 1 unexpected inpatient death
- 1 new complaint (inpatient)

Of the 31 EOLC deaths reviewed by the EMRG, 30 were closed at 1st stage review and 1 was referred for 2nd stage review.

Of the 6 unexpected deaths, 2nd stage reviews were requested for all.

3.2 Covid-19 Inpatient deaths.

From the deaths noted above, 2 patients died within 28 days of having tested positive for Covid 19, of these:

- Both were closed at first stage review, the patients were admitted for end-of-life care and were positive for covid 19 on or prior to admission, Covid 19 was not stated on medical certificate of cause of death (MCCD).

3.3 Medical Examiner

Nationally, Acute Trust Medical Examiner's Offices are required to put in place measures to extend Medical Examiner scrutiny of deaths across all non- acute sectors so that all deaths are scrutinised.

RBFT provide this service for the Trust and all BHFT inpatient deaths (since December 2022) have been scrutinised through the RBFT Medical Examiner's Office.
Subject to parliamentary process this will become a statutory requirement in April 2023.

All 32 inpatient deaths have been independently scrutinised by a Medical Examiner. In 31 cases, the medical certificate of cause of death (MCCD) was agreed and processed. 1 case was referred to the coroner, this has gone to inquest (due to diagnosis of mesothelioma).

The ME process allows for the Medical Examiner to also recommend cases for structured judgement review and notify us of any family concerns, no cases were identified for review in Q2 by the ME.

4. Deaths of Children and Young People

In Q2, 6 deaths were submitted as a Datix for 1st stage review. 5 cases were closed at EMRG following 1st stage review. Cause of death was either extreme prematurity or complex disability in most cases. 1 case was identified for 2nd stage

review as an IFR. All deaths of children and young people are reviewed by the Berkshire Child Death Overview Panel (CDOP).

5. Deaths of adults with a learning disability

In Q2 the Trust Mortality Review Group (TMRG) reviewed a total of 13 deaths of adults with learning disabilities who had received services from Berkshire Healthcare in the 12 months prior to their death. The Structured Judgement Review methodology was used for all reported deaths with these reviews appraised by the LD Clinical Review Group (CRG) prior to review and sign off by the TMRG.

Of these 13 deaths there were no identified lapses in care provided by Berkshire Healthcare.

The deaths were attributed to the following causes:

Immediate cause of death	Number of deaths
Diseases of the respiratory system*	5
Infections	3
Diseases of the digestive system	2
Cancer	1
Other	2

**Number of COVID related deaths:1*

Demographics:

Gender:

Female	6
Male	7

Age:

The age at time of death ranged from 38 to 76 years of age (median age: 67 yrs.)

Severity of Learning Disability:

Mild	2
Mild to Moderate	1
Moderate	4
Severe	5
Not Known	1

Ethnicity:

White British	12
Other Ethnic Group - Arab	1

Engagement and feedback with family members

The Learning Disability Service makes contact with the family and/or staff team following the reported death of a person with a learning disability. There have been no responses received to date from those contacted in this quarter.

6. Deaths categorised as Serious Incidents

In Q2, 4 deaths were reported as serious incidents (See SI Q2 report for details).

7. Lapse in Care

A lapse in care is defined as greater than 50% likelihood that problems in care of the patient could have contributed to the death of the patient. No lapse in care was identified from the Q2 reviews which were undertaken.

8.Learning from Deaths

Learning from Serious Incidents is summarised in Q2 SI report.

Immediate learning from all deaths is shared by Clinical Directors and Governance Leads through locality governance and quality meetings. Where the need for more substantial learning is identified from initial review, an Internal Learning Review is facilitated by the Patient Safety Team.

Thematic learning from mortality reviews will be summarised after Q4 for the trust clinical Circulation brief to all staff.

9.Conclusion

During Q2, the trust mortality review group (TMRG) received the findings of 33 2nd stage review reports. All hospital inpatient deaths were reviewed by a medical examiner.

No lapse in care were identified.

Two inpatients tested positive for Covid 19 within 28 days of death, both were closed at first stage review, the patients were admitted for end-of-life care and were positive for covid 19 on or prior to admission, Covid 19 was not stated on medical certificate of cause of death (MCCD).

Learning from review of deaths is further shared with services by the Clinical Directors through their patient safety and quality groups, the Trust clinical 'Circulation' brief and the ICS mortality review group for system learning.

Berkshire Healthcare NHS Foundation Trust

Quality Assurance Committee Paper

Meeting Date	29 November 2022
Title	Guardian of Safe Working Hours Quarterly Report (August to October 2022)
Purpose	To assure the Trust Board of safe working hours for junior doctors in BHFT
Business Area	Medical Director
Author	Dr Marjan Ghazirad, Ian Stephenson
Relevant Strategic Objectives	1 – To provide accessible, safe, and clinically effective services that improve patient experience and outcomes of care
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and safe patient care
Resource Impacts	Currently 1 PA medical time
Legal Implications	Statutory role
Equalities and Diversity Implications	N/A
SUMMARY	This is the latest quarterly report for consideration by Trust Board from the Guardian of Safe Working. This report focusses on the period 3rd August to 31st October 2022. Since the last report to the Trust Board, we have received no exception reports. We do not foresee any problems with the exception reporting policy or process; neither do we see a significant likelihood of BHFT being in frequent breach of safe working hours in the next quarter.
ACTION REQUIRED	The QAC/Trust Board is requested to: Note the assurance provided by the Guardian.

Berkshire Healthcare
NHS Foundation Trust

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

This report covers the period 3rd August to the 31st of October 2022

Executive summary

This is the latest quarterly report for consideration by Trust Board from the Guardian of Safe Working.

This report focusses on the period the period 3rd August to 31st October 2022. Since the last report to the Trust Board, we have received no '*hours & rest'* exception reports and no '*education*' report.

We do not foresee any problems with the exception reporting policy or process; neither do we see a significant likelihood of BHFT being in frequent breach of safe working hours in the next quarter.

Introduction

The current reporting period covers the first half of a six-month CT and GPVTS rotation.

High level data

Number of doctors in training (total): 48 (FY1 – ST6)

Included in the above figure are 2 MTI (Medical Training Initiative) trainees.

Number of doctors in training on 2016 TCS (total): 48

Amount of time available in job plan for guardian to do the role: 1PA

Admin support provided to the guardian (if any): Medical Staffing

Amount of job-planned time for educational supervisors: 0.25 PAs per trainee

a) **Exception reports (with regard to '*hours & rest*' and education)**

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	0	0	0	0
Sexual Health	0	0	0	0
Total	0	0	0	0

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY1	0	0	0	0
CT	0	0	0	0
ST	0	0	0	0
Total	0	0	0	0

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	0	0	0	0

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
FY1	0	0	0	0
CT1-3	0	0	0	0
ST4-6	0	0	0	0
Total	0	0	0	0

In this period, we have received no '*hours and rest'* exception reports where the trainees' worked hours in excess of their work schedule. Exception reporting is a neutral action and is encouraged by the Guardians and DME. We continue to promote the use of exception reporting by trainees, and make sure that they are aware that we will support them in putting in these reports.
It is the opinion of Medical Staffing and the Guardian of Safe Working that "time off in lieu" (TOIL) is the most appropriate action following an exception report to minimize the effects of excessive work.

There have been no systemic concerns about working hours, within the definitions of the 2016 TCS.

We remain mindful of the possibility of under-reporting by our trainees, whilst having no evidence of this. Trainees are strongly encouraged to make reports by the Guardian at induction and at every Junior Doctor Forum.

b) Work schedule reviews

There have been no work schedule reviews in this period. The Medical Staffing department has created Generic Work Schedules. The DME, working with tutors, the School of Psychiatry and Clinical Supervisors, has developed Specific Work Schedules. These are both required by the contract.

Work schedule reviews by grade	
CT1-3	0
ST4-6	0

Work schedule reviews by department	
Psychiatry	0
Dentistry	0
Sexual Health	0

c) **Gaps**

(All data provided below for bookings (bank/agency/trainees) covers the period 3rd August to 31st October 2022)

Psychiatry	Number of shifts requested	Number of shifts worked	Number of shifts worked by:			Number of hours requested	Number of hours worked	Number of hours worked by:		
			Bank	Trainee	Agency			Bank	Trainee	Agency
	73	73	35	38	0	724.5	724.5	351.5	373	0

Reason	Number of shifts requested	Number of shifts worked	Number of shifts worked by:			Number of hours requested	Number of hours worked	Number of hours worked by:		
			Bank	Trainee	Agency			Bank	Trainee	Agency
Gap	34	34	23	11	0	355	355	239.5	115.5	0
Sickness	39	39	12	27	0	369.5	369.5	112	257.5	0
Maternity	0	0	0	0	0	0	0	0	0	0
Total	73	73	35	38	0	724.5	724.5	351.5	373	0

d) **Fines**

Fines levied by the Guardians of Safe Working should be applied to individual departments, as is the intent of the contract. No fines have been levied in this quarter.

Fines by department		
Department	Number of fines levied	Value of fines levied
None	None	None
Total	0	0

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£0	£0	£0	£0

Qualitative information

The OOH rota is currently operating at 1:14 and our system for cover continues to work as normal, with gaps generally being quickly filled. Our bank doctors continue to be an asset, and we continue to increase this pool.

No immediate patient safety concerns have been raised to the guardian in this quarter.

Issues arising

Exception reporting remains at a level consistent with previous GOSW Board reports. The current level of exception reporting suggests that Junior Doctors are not working unsafe hours, and this is confirmed by the qualitative information from the Junior Doctors Forum. However, it is possible that there may be under-reporting of small excess hours worked.

Actions taken to resolve issues

Next report to be submitted February 2023.

Summary

All work schedules are currently compliant with the Contract Terms and Conditions of Service. No trainee has breached the key mandated working limits of the new contract.

The Guardian gives assurance to the Trust Board that no unsafe working hours have been identified, and no other patient safety issues requiring escalation have been identified.

We remain mindful of the possibility of under-reporting by our trainees, whilst having no evidence of this. Trainees are strongly encouraged to make reports by the Guardian at induction and at every Junior Doctor Forum. Junior Doctors are assured that it is a neutral act and asked to complete exceptions so that the Guardian of Safe Working can understand working patterns in the Trust.

Questions for consideration

The Guardian ask the Board to note the report and the assurances given above.

The Guardian make no recommendations to the Board for escalation/further actions.

Report compiled by Dr Marjan Ghazirad, GOSW, & Ian Stephenson, Medical Workforce Manager.

Appendix A: Glossary of frequently used terms and abbreviations

Guardian of Safe working hours: A new role created by the Junior Doctors Contract that came into effect for the majority of trainees in BHFT in February 2017. The Guardian has a duty to advocate for safe working hours for junior doctors and to hold the board to account for ensuring this.

FY – Foundation Years – Doctors who are practicing usually in the first two years after completing their medical degrees.

CT – Core Trainee – The period usually following FY where a junior doctor is specializing in a particular area of medicine (in BHFT this is primarily for Psychiatry or General Practice). Typically, 3 years for psychiatry trainees.

ST- Speciality Trainee – The period following Core training where a junior doctor sub-specializes in an area of medicine, for example Older Adult Psychiatry. Typically, 3 years for psychiatry trainees.

Work Schedule – A work schedule is a new concept for junior doctors that is similar to a Job Plan for Consultants. A work schedule sets out the expectations of the clinical and educational work that a Junior Doctor will be expected to do and have access to. Before entering each post, the Junior Doctor will have a “Generic Work Schedule” that the Clinical Supervisor and Medical Staffing feels sums up the expectations and opportunities for the that post. At the initial meeting between Clinical Supervisor and trainee this will be personalized to a “Specific Work Schedule” giving the expectations of that trainee in that post. If exception reporting or other information indicates a need to change the work schedule this is called a work schedule review. The new policy indicates the procedures for this process and appeal if it is not considered satisfactory.

Junior doctors’ forum – A formalized meeting of Junior Doctors that is mandated in the Junior Doctors Contract. The Junior Doctors under the supervision of the Guardians are amalgamating other pre-existing fora under this meeting so it will be the single forum for Junior Doctors to discuss and formally share any concerns relating to their working patterns, education or patient safety. The Junior Doctor Forum includes representation from the Guardians, Director of Medical Education and others as required to ensure these concerns can be dealt with appropriately.

Fines – If doctors work over the hours in their Specific Work Schedule they are entitled to pay or to time back in lieu for that time. In this trust we are looking for trainees to have time back as the preference. However if the doctor works so many hours as to further breach certain key mandated working limits the trust will be fined with the fine going into a separate fund managed by the Guardians to be used for educational purposes for the trainees.

Appendix B

Factsheet: Safety limits and rest

The below table highlights the changes to the safety limits and rest provisions between the 2016 terms and conditions and the 2018 contract refresh. For full details please refer to schedule 3 of the terms and conditions of service (TCS).

2016 terms and conditions	2018 contract refresh
Maximum of 72 hours work in any 7 consecutive day period.	Maximum of 72 hours work in any 168-hour consecutive period.
46-hours rest required after 3-4 consecutive night shifts.	46-hours rest required after any number of rostered nights.
Doctors paid at nodal point 2 are exempt from the requirements that no doctor shall be rostered for work at the weekends greater than 1 week in 2 for one placement during their foundation year.	No doctor shall be rostered for work at the weekend at a frequency of more than 1 week in 2.
No doctor shall be rostered for work at the weekend at a frequency of greater than 1 week in 2.	All reasonable steps should be taken to avoid rostering trainees at a frequency of greater than 1 in 3 weekends.
Where 8 shifts of any length are rostered or worked on 8 consecutive days, there must be a minimum 48-hours rest rostered immediately following the conclusion of the eighth and final shift.	Maximum of 7 shifts of any length can be rostered or worked on 7 consecutive days. Where a shift contains hours of work across more than one day, the work on each day will be counted independently toward the total number of consecutive days*.
No more than 5 long shifts shall be rostered or worked on consecutive days. Where 5 long shifts are rostered on consecutive days, there must be a minimum 48-hour rest period rostered immediately following the conclusion of the fifth long shift.	No more than 4 long shifts shall be rostered or worked on consecutive days. There must be a minimum 48-hour rest period rostered immediately following the conclusion of the final long shift*.
A doctor must receive: • at least one 30 minute paid break for a shift rostered to last more than 5 hours, and • a second 30 minute paid break for a shift rostered to last more than 9 hours.	A doctor must receive: • at least one 30 minute paid break for a shift rostered to last more than 5 hours • a second 30 minute paid break for a shift rostered to last more than 9 hours • A third 30-minute paid break for a night shift as described in paragraph 15 of Schedule 2, rostered to last 12 hours or more.

*As soon as reasonably practicable from August 2019, and in any event as soon as possible before 5 August 2020, the employer will consult with doctors and agree to alter existing rotas.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13 December 2022
Title	**CYPF Neurodiversity: reducing waiting times December 2022 update to the Trust Board**
	Item for Noting
Purpose	Updating the Trust Board on Project approach to reducing waiting times and current and future actions.
Business Area	CYPF and LD
Author	Garry Nixon, Karen Cridland, Mary Jane Stroud
Relevant Strategic Objectives	Improving access and flow Delivering integrated and sustainable services
CQC Registration/Patient Care Impacts	CQC – Trust and both former CCGs have a compliance notice to improve waiting times in children's neurodiversity services
Resource Impacts	Additional investment provided by former CCGs to reduce waiting times and further investment provided by Berkshire Healthcare Additional resources for automation
Legal Implications	None
Equality and Diversity Implications	None
SUMMARY	This report sets out the current situation and action taken and forward plan to address the waiting lists within the Neurodiversity Service. A Programme Team has been established with an overall objective to address the number of children and young people waiting more than 2 years for assessment by the end of March 2023. The Formal Executive is provided a monthly update describing progress and the key data relating to rolling waiting times, future monthly numbers of children and young people that will breach 2+ year waiters and the establishment and vacancies.

ACTION	The Trust Board is requested to note the report.

Berkshire Healthcare
Children, Young People and Families services

CYPF Neurodiversity: reducing waiting times. December 2022 update to the Trust Board

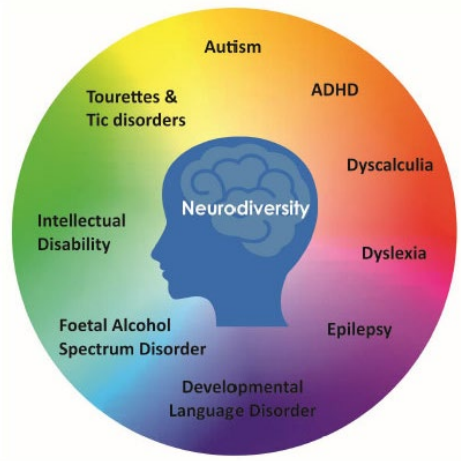
Section 1: Introduction

This report sets out the current situation and action taken and forward plan to address the waiting lists within the Neurodiversity Service.

A Programme Team has been established with an overall objective to address the number of children and young people waiting more than 2 years for assessment by the end of March 2023.

The Formal Executive is provided a monthly update describing progress and the key data relating to rolling waiting times, future monthly numbers of children and young people that will breach 2+ year waiters and the establishment and vacancies.

Section 2: Berkshire Healthcare Neurodiversity Service



Neurodiversity is the fact that all human beings vary in the way our brains work. We

- Take in information in different ways
- Process it in different ways
- Thus behave in different ways

Most people are **neurotypical,** meaning that the brain functions and processes information in the way society expects. However it is estimated that around one in seven people (more than 15 per cent of people in the UK) are **neurodivergent,** meaning that the brain functions, learns and processes information differently.

Berkshire Healthcare Neurodiversity Service is a Berkshire wide service (within the Trust's Children's, Young People, BEDS and Learning Disability Division) that sits alongside but is separate to CAMHS. It comprises two teams:

Autism Assessment Team

- Provides diagnostic assessment for Under 5 (Berkshire West) and 5-18y (across Berkshire). (Diagnostic assessment for under 5s in East Berkshire is provided by the community paediatricians and speech and language therapy services owing to historical commissioning arrangements.)
- Partnership working with private provider (Healios) who offer routine online assessment for 7-18y on our behalf. Contract in place since Feb 2020, with proof-of-concept pilot prior to this.

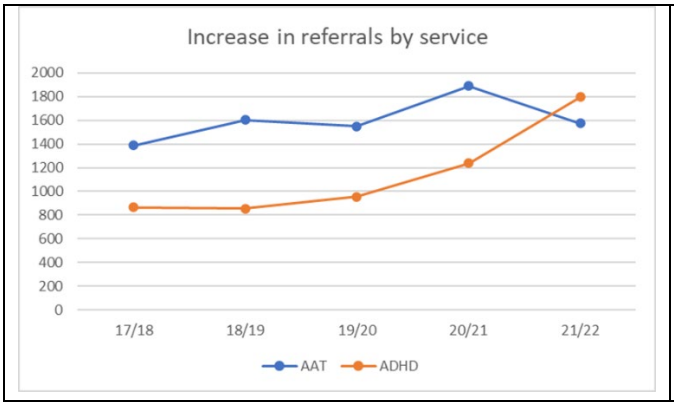
ADHD Team

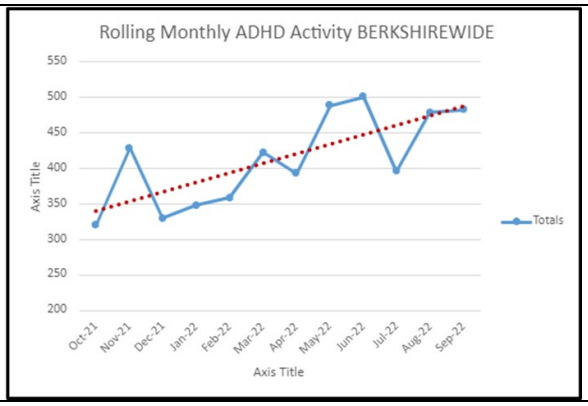
- Provides diagnostic assessment and treatment for 6-18y.
- Partnership working with private provider: PSYCHIATRY-UK who offer online assessment and where clinically indicated initiation/titration/review of medication. Fixed term contract in place from November 2021.

See Appendix 1 for more detailed overview.

Section 3: How has ADHD and AAT need changed

Between 2017/2018 and 2021/2022 there have been significant increases in referrals for ADHD and for Autism Assessment. Additionally, approximately 90% ADHD referrals require ongoing interventions, typically medication initiation, titration and ongoing monitoring and review of medication. This means the ADHD team has to accommodate an ever-growing caseload. (see below).

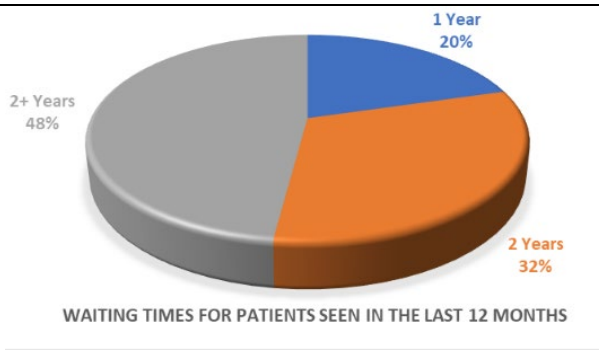




The above pattern of increasing referrals is consistent with services across England.

Currently there are 6,463 children and young people waiting for assessment within the Neurodiversity Service, of these there is 630 who have been waiting more than 2 years.

Not all children and young people wait over 2 years. Approximately 20% are seen within the first year due to the individual level of urgency and a further 32% are seen within 1-2 years.



Establishment: Currently there is a vacancy rate of 20% in ADHD, 37% in AAT and 25% in the administration team. There is a challenge to recruit to critical posts that are vital to complete assessment. The service is currently utilising skill mix i.e. recruiting additional Assistant Psychologists to further support assessments. Other initiatives are shown in section 7.

Section 4: Addressing the waiting list

During the Summer of 2022 the initial project plan was to complete the following:

1. Detailed Process Mapping

- Describing current tasks to be completed, who, how, products, timescales and checking mechanisms.
- Transfer processes between teams, team functions, third parties, providers and families.
- Mapping of administrative tasks and dependencies throughout process and consider opportunities for further digitalisation.
- Identify real and potential delays within the current system.
- Identify unrequired repetition and areas that have potential for simplification and/or lean process.

2. Data Mapping & Review

- Map out the detailed data and data input points across each part of the AAT & ADHD (and shared) pathways.
- Review the current detail data and data quality.
- Identify any staff learning needs and support to enable effective and timely data entry.
- Identify data lines available and critical to reporting.
- Review the current level of timing of compliance of data entry.
- Identify data available for potential use in clinical and managerial to support the projects aim and objectives.

3. Networking with other Organisations

- Network and collaborate with other providers to share ideas and "bench mark."
- Link with local "downstream" organisations and consider potential patient experience improvements.

The outputs from all of the above included:

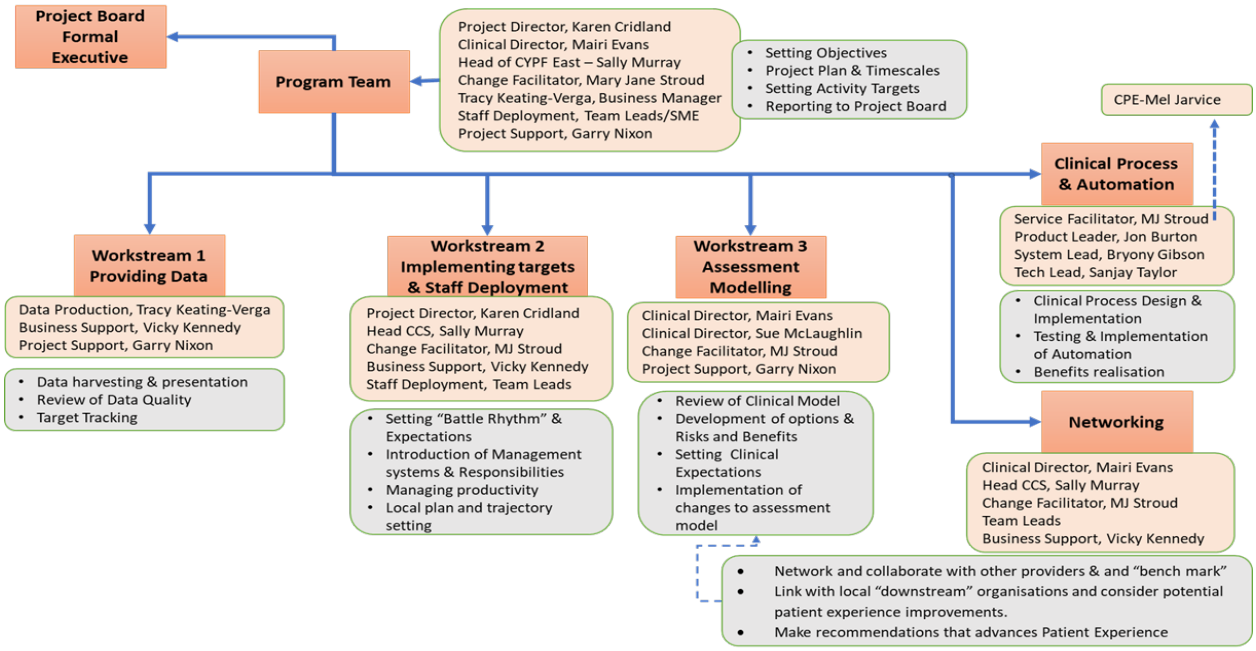
- Opportunties to improve effeciciency and family experience and release capacity identified.
- Changes to some processes e.g. timing of request for assessment information from schools and families to streamline, scope opportunties for automation of processes, submit business case for automation and undertake work to prepare for this.
- Development of additional management data report e.g. HCP dashboard (health care professional) showing capacity and activity supporting individual and team caseload capacity calculations.
- Work undertaken across BOB and Frimley ICS to work together on the shared challenges and opportunities to share learning and innovation across the region. This included a comparison of autism assessment models across Berkshire, Oxfordshire Buckinghamshire and Surrey (tasks/time allocated/skill mix)

At the end of the summer 2022 the Programme structure was updated and continues to be led by the Director of CYPF Services, reporting monthly to the Formal Executive. It has 5 workstreams.

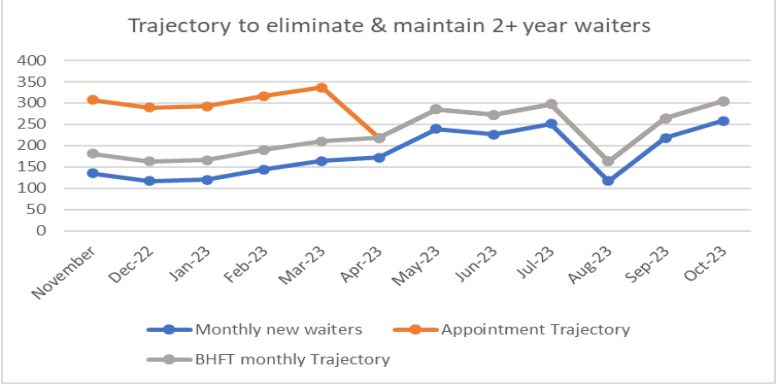
1. Providing regular data and ensuring data quality.
2. Managing system efficiencies and operational targets
3. Review of the clinical model of care, benchmarking and identifying efficiencies
4. Introduction of automation to release clinician time and improve family experience
5. Networking and collaboration with other Neurodiversity services and Berkshire partners

The Programme Board and workstreams 1-3 meet 2 weekly to maintain the momentum and level of urgency.

See below:



A Trajectory has been developed which identifies a monthly activity profile required to reduce and maintain that no children are waiting for more than 2 years. It includes activity for priority appointments the numbers of children who will breach the 2 year target each month and shows the short term additional activity required from contracted 3rd party providers (see below).



Commentary

At the end of October there are currently 630 children and young people waiting more than 2 years. The contracts with 3rd sector providers (900 assessments) will be sufficient to clear the current backlog and provide a further 270 assessment capacity. This will provide a potential "buffer" for the planned Neurodiversity service efficiencies to meet the "Run Rate" required to maintain and improve the level of waiting times.

Month		November	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	**Totals**
Urgent Monthly		46	46	46	46	46	46	46	46	46	46	46	46	**552**
Current 2+ Waiters	**630 Total**	**126**	**126**	**126**	**126**	**126**		0	0	0	0	0	0	**630**
Monthly new waiters		135	117	120	144	164	172	239	226	251	117	218	258	**2161**
Appointment Trajectory		**307**	**289**	**292**	**316**	**336**	**218**	**285**	**272**	**297**	**163**	**264**	**304**	**3343**
BHFT monthly "Run Rate" Trajectory		181	163	166	190	210	218	285	272	297	163	264	304	**2713**

Section 5: Current Programme Focus

Workstream 1 - Data: focus over the past month has been data quality assurance.

Working with IM&T to develop Tableau dashboard for the service to enable routine availability, and reduce time taken to compile data reporting. The aim is to ensure that reported data is reliable, reproducible and correctly reflects waiting times, volumes and clinical activity.

Workstream 2 - Workforce and targets:

- **Management tool in development** to support close monitoring of performance against key metrics: appointments required to prevent 2y+ waits, available appointments with current establishment, appointments offered, appointments attended.
- **Ongoing work to increase available appointments through weekend/additional clinics** with staff in the Neurodiversity Service. This will also include an email to all CYPF staff to identify any staff in the division who can do additional hours (weekdays or weekends) and NHSP/agency adverts have been updated to include weekend shifts.
- **ADHD individual and team caseload capacity** calculations to monitor additional assessment capacity, support prompt transfer of cases e.g. Band 7 to Band 6, Band 6 to Band 5 – this is currently being quality assured.

Workstream 3 – Autism/ADHD Assessment and ADHD medication review transformation: Review of assessment models, timing and skill mix completed across BHFT, Oxford, Bucks and Surrey (including specific time allocated to face to face and associated activities and skill mix). A similar review will take place at a later stage for ADHD assessment and treatment. Comparison of assessment models indicated that BHFT model is 2nd most efficient of the 4 models (with the most efficient model triggering debate around compliance with NICE Guidance).

There is two further workstreams (Networking & Clinical Process Automation)

See Appendix 2 for more detailed overview on the workstreams.

Section 6: Quick Wins & Medium-Term Initiatives

Quick Wins:

A series of Rapid Improvement events have been completed within both ADHD and AAT teams to generate improvement idea, which have all been through a PICK chart to select those to progress immediately. These include:

1. ADHD routine medication reviews: introducing 12-month review with 6-month physical observation clinic (initially using Band 5 nurses but with skills mix options under review). This will reduce the number of clinician medication review appointments required by removing the need for clinicians to see CYP who are stable on medication and where there are no significant concerns for them or their family. This will in turn increase the capacity of the service to see new children and young people.
2. ADHD assessment: ensuring clinicians with sufficient caseload capacity are offering 2 new assessments per week.
3. ADHD assessment: change of booking process to ensure Conners questionnaires (parent/teacher/self) have been returned prior to booking the appointment. This will ensure optimum efficiency by supporting prompt diagnostic decision making, making most efficient use of the time allocated for assessment and reducing the risk of additional appointments being required to complete assessment.
4. ADHD assessment: reviewing assessment reports and clinic letters to ensure effective use of editable report templates to reduce clinical time allocated to these tasks.
5. Autism assessment: change of booking process to ensure developmental histories are booked first. This may identify a small number of children who do not require an ADOS-2 assessment and also reduce failed appointments by giving the clinician a better opportunity to identify a CYP who may not be able to engage with ADOS-2 and allow for a more bespoke assessment process to be put in place.
6. Autism assessment: embedding checks at the time of booking to identify children and young people who may not require further assessment appointments.
7. 3rd Party Providers
    - Agreement in place with Healios (Autism) for an increase of 135 autism assessments, bringing the 2022/23 total to 400. To date 719 have been triaged, 349 invited, 200 of which have opted-in to date and been transferred.
    - Extension of contract with *Psychiatry-UK (ADHD)* to allow for up to 500 ADHD assessments from now until the end of March 2023, with initiation and titration of medication when clinically indicated. To date 420 have been triaged, 257 invited, 132 of which have opted-in to date and been transferred.

Medium term plans will include some larger scale projects including:

1. **Tiered assessment model** (abbreviated/ standard/complex), joint autism and ADHD assessments, implementing changes to the titration model to release some clinical capacity, supporting ADHD physical observations at home. Phase 2 will also include the use of recently developed ADHD connected care dashboard to support efficiency e.g. by identifying CYP not collecting medication prescriptions from GP.

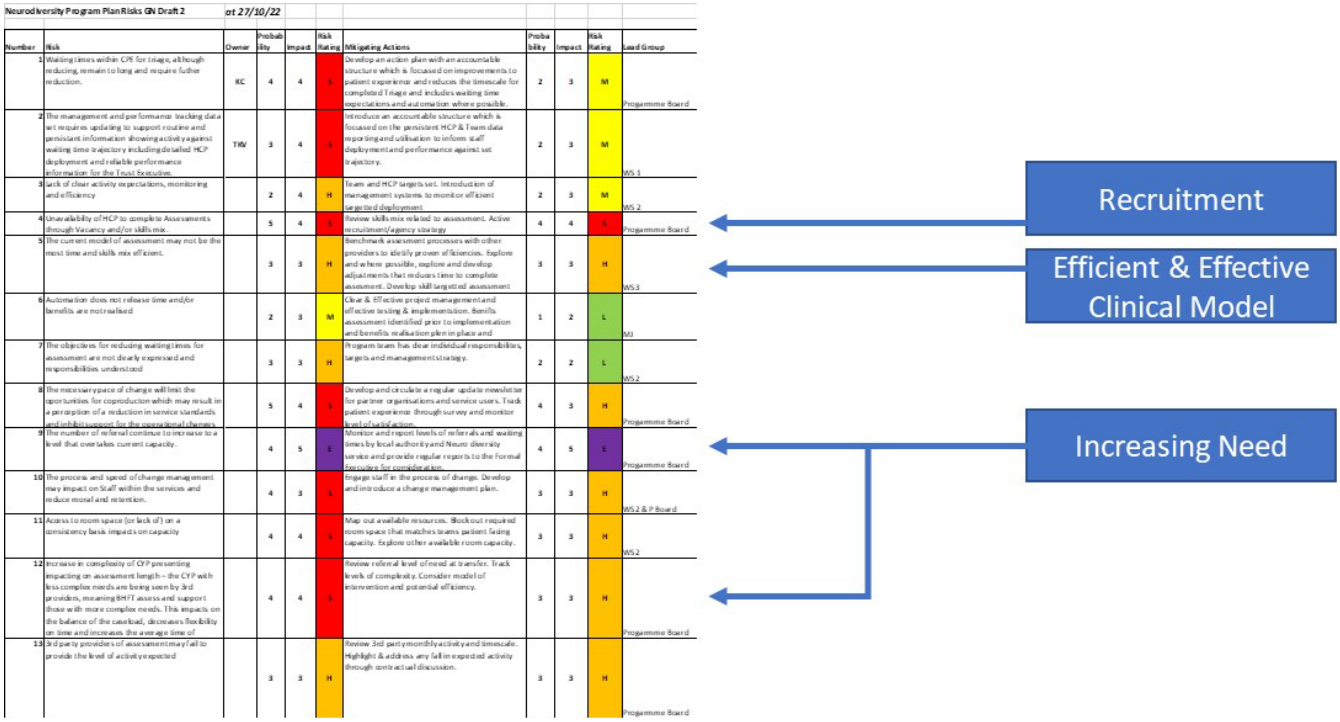
2. **West Under 5 autism:** Additional paediatrician capacity (0.4 wte) will be provided by RBFT from Feb 2023 onwards, who have now confirmed they can provide additional interim weekend clinics.

3. **Recruitment and retention:** The service currently has 15.6 wte vacancy and maternity leave, which is an increase on last month. There is a national shortage of qualified staff and we are working on a recruitment strategy refresh with HR partners which will include an online recruitment event

Section 8: Risks & Mitigation

The programme risks are reviewed each month. The most significant risks are:

1. The possibility of increasing need at the continued levels of the last 5 years
2. The difficulty in recruitment with need rising across all local services
3. Developing an assessment model that maintains clinical effectiveness whist releasing capacity to meet rising need.



Neurodiversity Program Plan Risks GN Draft 2 at 27/10/22

Number	Risk	Owner	Probability	Impact	Risk Rating	Mitigating Actions	Probability	Impact	Risk Rating	Lead Group
1	Waiting times within CPE for triage, although reducing, remain to long and require futher reduction.	KC	4	4	S	Develop an action plan with an accountable structure which is focussed on improvements to patient experience and reduces the timescale for completed Triage and includes waiting time expectations and automation where possible.	2	3	M	Progamme Board
2	The management and performance tracking data set requires updating to support routine and persistant information showing activity against waiting time trajectory including detailed HCP deployment and reliable performance information for the Trust executives.	TMV	3	4	S	Introduce an accountable structure which is focussed on the persistent HCP & Team data reporting and utilisation to inform staff deployment and performance against set trajectory.	2	3	M	WS 1
3	Lack of clear activity expectations, monitoring and efficiency		2	4	H	Team and HCP targets set. Introduction of management systems to monitor efficient targeted deployment	2	3	M	WS 2
4	Unavailability of HCP to complete Assessments through Vacancy and/or skills mix.		5	4	S	Review skills mix related to assessment. Active recruitment/agency strategy	4	4	S	Progamme Board
5	The current model of assessment may not be the most time and skills mix efficient.		3	3	H	Benchmark assessment processes with other providers to identify proven efficiencies. Explore and where possible, explore and develop adjustments that reduces time to complete assessment. Develop skill targeted assessment	3	3	H	WS 3
6	Automation does not release time and/or benefits are not realised		2	3	M	Clear & Effective project management and effective testing & implementation. Benifits assessment identified prior to implementation and benefits realisation plan in place and	1	2	L	MJ
7	The objectives for reducing waiting times for assessment are not clearly expressed and responsibilities understood		3	3	H	Progam team has clear individual responsibilities, targets and management strategy.	2	2	L	WS 2
8	The necessary pace of change will limit the opportunities for coproduction which may result in a perception of a reduction in service standards and inhibit support for the operational changes		5	4	S	Develop and circulate a regular update newsletter for partner organisations and service users. Track patient experience through survey and monitor level of satisfaction	4	3	H	Progamme Board
9	The number of referral continue to increase to a level that overtakes current capacity.		4	5	E	Monitor and report levels of referrals and waiting times by local authority and Neuro diversity service and provide regular reports to the Formal Executive for consideration.	4	5	E	Progamme Board
10	The process and speed of change management may impact on Staff within the services and reduce moral and retention.		4	3	S	Engage staff in the process of change. Develop and introduce a change management plan.	3	3	H	WS 2 & P Board
11	Access to room space (or lack of) on a consistency basis impacts on capacity		4	4	S	Map out available resources. Blockout required room space that matches teams patient facing capacity. Explore other available room capacity.	3	3	H	WS 2
12	Increase in complexity of CYP presenting impacting on assessment length – the CYP with less complex needs are being seen by 3rd providers, meaning BHFT assess and support those with more complex needs. This impacts on the balance of the caseload, decreases flexibility on time and increases the average time of		4	4	S	Review referral level of need at transfer. Track levels of complexity. Consider model of intervention and potential efficiency.	3	3	H	Progamme Board
13	3rd party providers of assessment may fail to provide the level of activity expected		3	3	H	Review 3rd party monthly activity and timescale. Highlight & address any fall in expected activity through contractual discussion.	3	3	H	Progamme Board

Appendix 1: BHFT Service Detail & Available Support.

The process for both ADHD & AAT is as follows:

- **Common Point of Entry (CPE)** online referral form with clear guidance on website (to maximise chances of appropriate referral); also accept internal referrals. CPE triage for risk, to determine if appropriate to transfer to the team/s and to identify if anything else needed as well/instead of autism and/or ADHD assessment.
- **Open referral** anyone can refer but we encourage referrals from schools (particularly for ADHD) or professionals who know the child/young person best.
- **Holistic assessment** which includes consideration of differential and/or co-occurring conditions. Assessment report with focus on recommendations for support (regardless of whether the child or young person receives a diagnosis) and diagnostic feedback includes psychoeducation component.
- **Assessments across the age and ability range** including complex and second opinion assessments.
- **Standardised assessment process** with a great deal of information collected ahead of the assessment to streamline the process.
- **Partnership working with external providers –** where we provide wrap around care for the partnership to ensure consistency and equity of experience for families.
- **Feedback** from service users collected and reviewed to inform actions.

Support available for young people and their families

- **Early help based on presenting needs:** the service also works hard to promote a culture of needs-led support that does not rely on diagnosis, assessment or referral. In Berkshire we are fortunate to be in a position where much of the same support and advice that is available after a diagnosis is also available before an assessment. This includes autism and ADHD support services commissioned by the NHS and delivered in partnership with local charities. No referral is needed and, at any point in their journey, families can access a wide range of support including advice, home visits, workshops and courses.
- **Wider service support:** Children and young people can also receive help from the services as needed e.g. health visiting, school nursing, speech and language therapy, CAMHs, Getting help Service, school mental health support teams etc
- **Online 24/7 support:** Support is also available to parents and carers via our digital support platform SHaRON (Support, Hope and Resources Online Network). This is offered prior to assessment (as well as following a diagnosis) and enables parents to connect with the service and other parents and carers, to receive advice and support from health and other professionals and charity organisations as well as access to a comprehensive library of self-help resources.
- **Care of People Waiting/Helpline telephone support:** advice/support/signpost/make onward referrals and consider if assessment needs to be prioritised. NB Where there is risk or urgency this will supported by Specialist CAMHS or Rapid Response Team.
- **Qualified and Trainee Children's Wellbeing Practitioners:** offer brief evidence-based interventions for children and young people or their parents/carers for anxiety, low mood, and emotional regulation difficulties.
- **Comprehensive online resource:** All families are signposted to our comprehensive online resource with help and advice on a wide range of developmental, emotional/neurodevelopmental /mental health etc concerns.

Appendix 2: Further Detail - Workstreams

Data Quality

To assure data quality the following is required:

- Team clinical activity promptly entered onto RIO following the agreed process
- Data dashboards will be developed/updated on Tableau following an agreed specification.
- The developed/updated Tableau reports will be quality assured and Risk Rated
- The developed Tableau reports and other similar reports provided for other purposes will be compared and quality assured so that data reported is consistent

All key metrics will each have an individual written specification that identifies the data output and source of data from within RIO, with a 3-step quality assurance process:

- Data entered by clinical teams is correctly captured in RIO and missing/incorrect data entry is identified and corrected
- A routine comparison between data held on RIO is the same as that presented in associated Tableau reports.
- The data within the developed reports will be compared with similar output for other organisational purposes

Developing efficiencies

- **ADOS-2 skill mix pilot:** training Assistant Psychologists to administer the ADOS-2 assessment; training and support underway which will release additional capacity for new assessments.
- **Ongoing skill mix review** e.g. how increasing Assistant Psychology posts can further support with assessments, introducing Healthcare Assistant roles
- **Rapid Improvement events:** Both teams have participated in sessions to generate improvements idea, which have all been through a PICK chart to select those to progress immediately.

Associated project - Networking:

- A six-month programme now in place (with project manager time from SCW commissioning support unit) with four task and finish groups to identify improvements (Referral/pre-assessment information gathering/assessment models and delivery/diagnostic feedback and reports)
- Linking with Oxford Health and ASHN to scope role of Artificial Intelligence in triage and assessment
- Bimonthly online newsletter aimed at key stakeholders, including families waiting for assessments, schools (teachers/SENCO network), health visitors, school nurses and other professionals, GPs/PCNs etc. Schedule agreed Jan/March/May/July/September/November with first edition in Jan 2023

Associated project - Clinical Process and automation:

- *Automation of ADHD medication reviews:* good progress has been made with the first automation project although this will now need to be paused due to the December RiO upgrade affecting coding behind the automation. Work continues in the background to ensure the automation can be completed as quickly as possible once the upgrade has happened. This automation is expected to release at least one day per wte clinician per month, thus increasing clinical capacity.

- *Automation of Neurodiversity triage within CPE:* Consequently, work will begin earlier than anticipated on the second project to automate Neurodiversity triage within CPE with the aim to

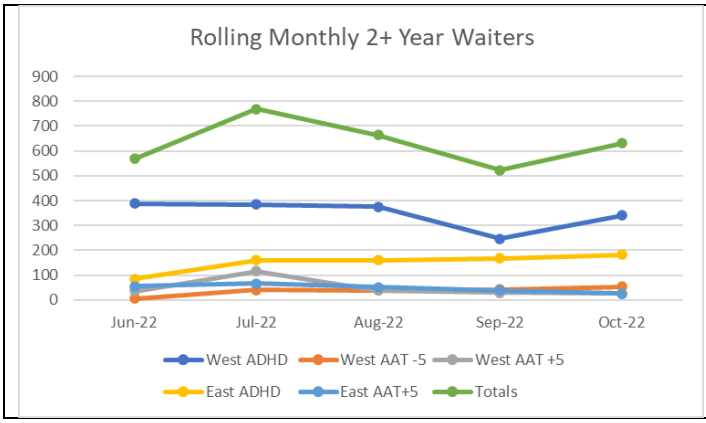
reduce numbers waiting and length of wait at this stage, improve family experience, ensure faster access to Getting Help now resources and release staff time. Development of the whole CYPF hub has been identified as an important project and automation would benefit the whole CYPF referral management system, therefore consideration will need to be taken of this whole system whilst accelerating the implementation within neurodiversity service.

Appendix 3: Data

The following data is provided, together a commentary on each data set. The rolling data shows the trend over the most recent 12 months.

1. Rolling Monthly 2 Year Waiters
2. Rolling Monthly First Appointments (BHFT and 3rd Party Providers)
3. Rolling Monthly Volumes within CPE and waits for Triage
4. Rolling Monthly Referrals
5. Rolling Monthly ADHD caseload (Non Assessment) Activity
6. Current Establishment and Skills Mix

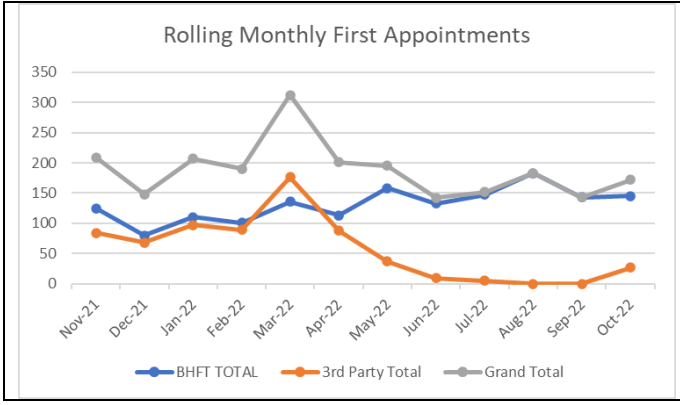
1. Rolling Monthly 2 Year Waiters



Commentary

This shows the historical and up to date waiters as the project proceeds.
There has been an increase in those waiting 2y+ which reflects 281 children and young people who became 2y+ waiters in October.

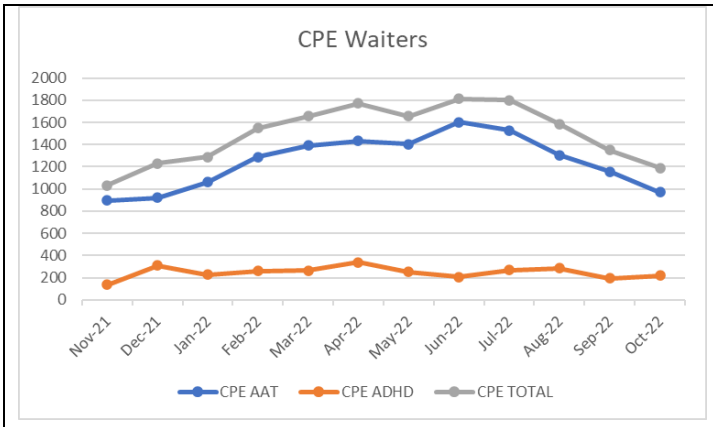
2. Rolling Monthly First Appointments (BHFT and 3rd party)



Commentary

This shows the total first appointments offered for children and young people directly by the Neurodiversity service, and on our behalf by Healios and Psychiatry-UK. 3rd party outcome activity (27) has started to be recorded, with 606 invited so far and 332 transferred to date.

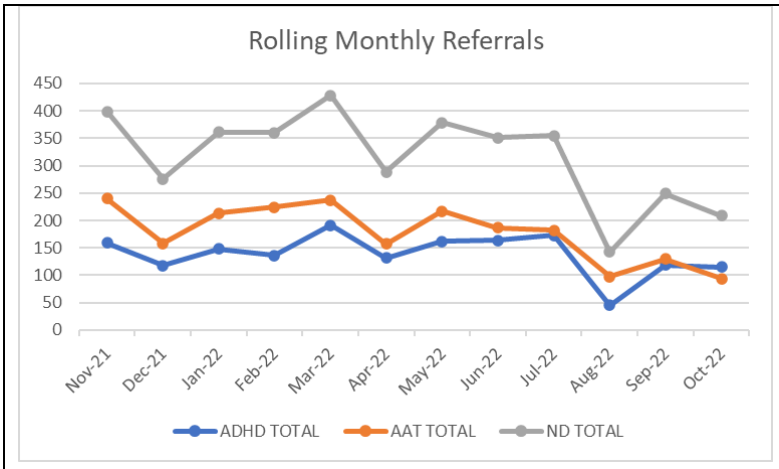
3. Rolling Monthly Volumes within CPE and waits for Triage



Commentary

The total number in CPE pending transfer to the Neurodiversity service in October was 1190. The number has risen to 1334 (as of 29.112022).
Referrals are transferred to the service with their original date of referral, and the monthly referral data updates retrospectively to reflect this.
The longer-term solution is the planned automation of CPE triage which will clear the backlog and prevent this recurring.

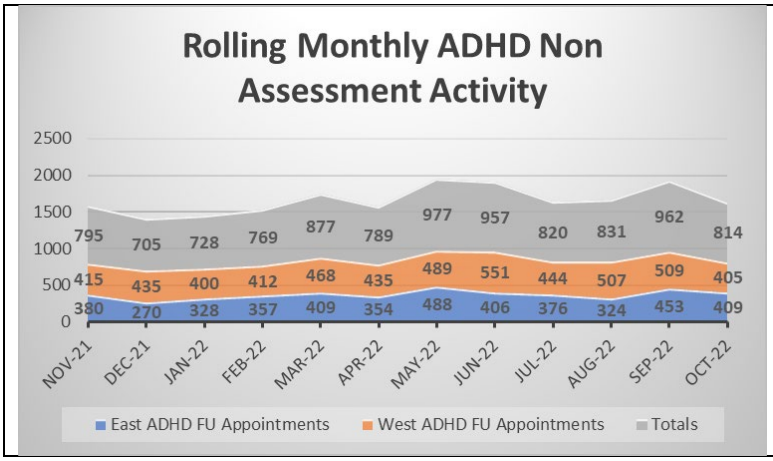
4. Rolling Monthly Referrals



Commentary

This represents the transfer to the AAT and ADHD teams only and does not include CPE data. Referrals to the service continue to increase, and the apparent reduction is due to the numbers pending completion of triage in CPE. The increasing demand on CPE for all types of referrals means that there is a lag in the Neurodiversity referral data due to the amount of time it takes to complete CPE triage. Neurodiversity referrals in CPE are shown in section 4 (above).

5. Rolling Monthly ADHD Casload (Non Assessment) Activity



Commentary

The ADHD service, once assessment has been completed, have an ongoing follow up (typically 6 monthly medication review).

The data reported in this report shows higher volumes than that reported in the November's report due to previous poor data quality.

6. Current Establishment & Skills Mix

ADHD Service — Current Staff

Post	Band	Establishment	Vacancy/Mat Leave	Available
Assistant Psychologists	4	3.2	0.8	2.4
Specialist Nurse	5	6	2	4
CWP	5	0.5	0	0.5
Senior Specialist Nurse	6	11.8	3	8.8
Advanced Specialist Nurse	7	3.8	0	3.8
Specialty Doctor	Medical	2.6	0	2.6
Consultant Psychiatrist	Medical	1.8	0.4	1.4
Team Lead	8a	1	0	1
Totals		**30.7**	**6.2**	**24.5**

AAT Service

Post	Band	Establishment	Vacancy/Mat Leave	Available
Assistant Psychologist	4	3.8	1.2	2.6
CWP	5	0.5	0	0.5
MH Practitioner/SLT	7	14.16	6.4	7.72
Consultant Paediatrician	Medical	0.6	0	0.6
Team lead	8a	1.4	0	1.4
Totals		**20.46**	**7.6**	**12.82**

ND Service A&C

Post	Band	Establishment	Vacancy/Mat Leave	Available
Admin & Clerical	3	2.26	1.6	0.66
Admin & Clerical	4	1	0	1
Admin & Clerical	5	1	0.2	0.8
NHSP	4	1	0	1
NHSP	3	2	0	2
Totals		**7.26**	**1.8**	**5.46**

Key
A&C
Assessing clincicians
Assists assessments, triage
reviews only (no assessments)
Care of People Waiting

Commentary

Total vacancy/mat leave across the service is 15.6 wte (27%). This includes vacancy and maternity leave but does *not* include sick leave in the month. Not included are staff currently working their notice, although their capacity for new assessments reduces then stops during this period.

This equates to a reduction of
20% ADHD
37% AAT
25% A&C

The service is currently utilising skill mix i.e. recruiting additional Assistant Psychologists to further support assessments.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13 December 2022
Title	**Executive Report**
	Item for Noting
Purpose	This Executive Report updates the Board of Directors on significant events since it last met.
Business Area	Corporate
Author	Chief Executive
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	None
Equality and Diversity Implications	N/A
SUMMARY	This Executive Report updates the Board of Directors on significant events since it last met.
ACTION REQUIRED	To note the report and seek any clarification.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Meeting 13 December 2022

EXECUTIVE REPORT

1. Never Events

Directors are advised that no 'never events' have occurred since the last meeting of the Trust Board.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

2. Staff Flu and COVID Booster Vaccination Campaign

December 2022 - Uptake of Flu vaccine as of 1st December.

Uptake of the flu vaccine by staff remains lower this year, but this remains in line with the national picture. Communications with staff continue and a Survey Monkey has been cascaded to understand further why staff have not taken up the flu vaccine this year, with the intention of adapting the programme further if required before the end of the month. Current efforts to increase uptake are focused on our wards and services who care for our highest risk patients.

Approximately 400 staff have been vaccinated elsewhere and 114 vouchers given out, these are included in the numbers below.

Flu vaccine uptake **45.27%**

Flu vaccine uptake breakdown by Division:

Directorate	Staff Due	Vaccinated	Not Vaccinated	% Uptake
371 Children, Young People, Families & Learning Disabilities Services	888	483	405	**54.39%**
371 Other Health Services Service	183	90	93	**49.18%**
371 Mental Health West Services	842	340	502	**40.38%**
371 Community Health East	637	266	371	**41.76%**

Directorate	Staff Due	Vaccinated	Not Vaccinated	% Uptake
371 Community Health West Services	1043	477	566	**45.73%**
371 Head of Inpatient (MH) Services	309	109	200	**35.28%**
371 Mental Health East Services	367	110	257	**29.97%**
371 Corporate Services	615	336	279	**54.63%**
TOTAL	**4884**	**2211**	**2673**	**45.27%**

Uptake of Covid Vaccine as of 1st December **41.58%**

All staff who have been vaccinated elsewhere are also included in the numbers below.

Covid vaccine uptake breakdown by Division:

Directorate	Staff Due	Vaccinated	Not Vaccinated	% Uptake
371 Children, Young People, Families & Learning Disabilities Services	888	450	438	**50.68%**
371 Other Health Services Service	183	88	95	**48.09%**
371 Mental Health West Services	842	322	520	**38.24%**
371 Community Health East	637	436	201	**68.45%**
371 Community Health West Services	1043	73	970	**7.00%**
371 Head of Inpatient (MH) Services	309	110	199	**35.60%**
371 Mental Health East Services	367	313	54	**85.29%**
371 Corporate Services	615	239	376	**38.86%**
TOTAL	**4884**	**2031**	**2853**	**41.58%**

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

3. Update from the Care Quality Commission (CQC) on Changing their Operational Teams/Structures

Changing our operational teams

Our strategy (accessed via the CQC's website at: https://www.cqc.org.uk/sites/default/files/Our_strategy_from_2021.pdf) sets out an ambition to regulate in a smarter way, adapting and responding to risk, uncertainty and demand. To deliver this, we need to change how we work.

At the heart of this change will be a new regulatory approach (accessed via the CQC's website at: https://www.cqc.org.uk/about-us/how-we-will-regulate) built around a single assessment framework. To deliver this approach we will make changes to our teams, introducing a new structure and roles. We will let you know when these changes will affect you. It's important that we make these changes to enable us to:

- look at the quality of health and care services across a local area
- give a more up-to-date view of quality
- be more efficient, consistent and effective
- provide more tailored support to health and care providers.

How we're changing

We're bringing together our specialist sector teams (adult social care, hospitals, primary medical services) into one Operations group. This will break down barriers that previously separated the different sectors. These teams will work across four geographic areas or 'networks'. They will be responsible for carrying out our assessments of quality. The four networks are:

- London and East of England
- Midlands
- North
- South

Our new senior leadership team leads our Operations group. This team comprises director roles that replace previous deputy chief inspector roles. As part of this wider Operations group, we are also establishing a National Operations directorate. This will include registration and national operations teams, for example oral health and children's services.

We're splitting the roles and responsibilities involved in carrying out assessments.

Within the networks, we'll divide ourselves into local teams. These teams will include colleagues with a mix of expertise and experience of different types of health and social care services. This will make sure we can share specialist skills and knowledge about all sectors. Bringing together people with different perspectives will give us the best view of services across a local area.

Our new teams will be made up of assessors, inspectors, regulatory co-ordinators and regulatory officers. An operations manager will lead each team. Depending on the services in a particular area, teams will contain a mix of these roles:

- **Assessors:** ensure we have an ongoing view of quality, safety and risk for services in their area. Supported by the inspector and regulatory co-ordinator,

they will make judgements about the quality of care. To do this they will consider evidence collected from all sources – both on and off site.

- **Inspectors:** lead our enforcement activity. While assessors will collect evidence off-site, inspectors will gather evidence on site visits. We call these site visits inspections.

- **Regulatory co-ordinators:** help carry out engagement with providers and local groups of people. They will support us with triaging information and collecting evidence.

- **Regulatory officers:** support administrative duties. For example, inspection planning and gathering the experiences of people using services.

We're enabling more tailored support

Inspectors and assessors will still use their expertise and experience in their specific type of service or sector. But senior specialists with expertise in each sector will be available to support them. We will also continue to use our specialist advisors. Combining expertise and our new regulatory coordinator role, means we can give more tailored and efficient support to providers and other stakeholders. All these colleagues will be supported by a central hub. This will monitor performance of our teams, share best practice and standards, and ensure consistency.

For providers, this means:

- You'll still be assessed by CQC colleagues who are experts in your service type. But our teams can have better conversations with you about how things are working between your service and the other services you interact with in the local area.

- We'll provide more tailored and efficient support in our relationship with your service. You can speak with members of our local teams for different types of advice and rely less on one person to provide support.

- We'll have an up-to-date view of quality and better understanding of what is driving poor or outstanding care. This means we can support improvement specifically where it's needed and promote good care.

These changes will also bring benefits for the public:

- People will have a better understanding of what the quality of care is like in the services where they live. We'll be able to look at all types of care across an area, in a way that's much more in line with how people access care.

- People will be able to make more informed decisions about their care because we'll provide a more up-to-date view of quality.

- People will be more involved because of better quality and more consistent engagement. This includes with local Healthwatch and other local advocacy and community groups that represent the public. These groups include or act for people most at risk of having a poorer experience of care and those who face inequalities.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

4. Overseas Nurses

New figures show that almost as many overseas nurses are coming to work in the UK compared with the number trained here. The Nursing and Midwifery Council (NMC) said that an influx of workers from India, the Philippines and Nigeria mean that the number registering from overseas has quadrupled in the last four years. The data show in total, 11,496 nurses, midwives and nursing associates who were trained abroad joined the NMC in the six months to September 2022.

Executive Lead: Julian Emms, Chief Executive

5. Hewitt Review

As part of the focus on the NHS in the recent autumn statement, it was announced that the government had asked Patricia Hewitt to conduct a review of both the autonomy and accountability of the recently launched integrated care systems (ICSs).

To date, the review has a vaguely defined purpose to “explore how to empower local leaders to focus on improving outcomes for their populations” — the exact terms of reference are, however, expected imminently.

In short however, the review is expected look to identify the most efficient and effective ways of harnessing the true potential of the ICS – whether that be making local leaders more accountable for things like performance and expenditure via a devolution of power across the board or simply reducing the number of national targets to allow local leaders the bandwidth to make the right choices for their areas.

This will not be straightforward – NHS England is not the only player on the pitch. ICS and providers are also regulated by the CQC and many other bodies have a legitimate interest in understanding what is going on within organisations and systems, including local authority overview and scrutiny committees, professional regulators, deaneries, the Health and Safety Executive and more. The complexity is a fact of life, but it makes it all the more important that central bodies understand the totality of the reporting burden placed on local organisations, and the part they can play in ensuring the burden is proportionate to the accountabilities placed on local leaders.

This is by no means the first time that the relationship between national organisations and local NHS trusts and commissioners have been reviewed. Given the current context, the risk may be that while reducing the weight of external oversight and empowering ICSs to focus on their local communities feels more important than ever, the state of the NHS performance across the country makes it harder than ever for politicians at the centre to loosen their grip.

Executive Lead: Julian Emms, Chief Executive

Presented by Julian Emms
Chief Executive
13 December 2022

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Meeting Date	13 December 2022
Title	**October 2022 Finance Report**
	ITEM FOR NOTING
Purpose	To provide an update to the Board on the Trust's Financial Performance to 31 October 2022.
Business Area	Finance
Author	Rebecca Clegg, Director of Finance
Relevant Strategic Objectives	Strategic Objective 2: Work with partners to deliver integrated and sustainable services to improve health outcomes for our populations. True North Goal 4: Money Matters – to deliver services that are efficient and financially sustainable.
CQC Registration/Patient Care Impacts	Achievement of CQC Well Led standard.
Resource Impacts	n/a
Legal Implications	Compliance with statutory Financial Duties.
Equality and Diversity Implications	n/a
SUMMARY	The Trust is continuing to report better than planned financial performance with a £0.1m surplus against a YTD deficit plan of £0.7m. This includes the impact of the 22/23 pay award in respect of back-payment and associated funding as agreed with ICSs. The Trust has completed a mid-year forecast and is holding to a forecast YE deficit of £0.9m in line with plan. The Trust's cash position remains strong with a closing balance at 31 October 2022 of £63.2m. The Trust has spent £0.1m of capital against a YTD plan of £4.1m. We fully expect to recover this slippage in year and expect to spend to plan by year end.
ACTION	The Board is asked to note the Trust's financial performance.

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year 2022/23

October 2022

Purpose

To provide the Board and Executive with a summary of the Trust's financial performance for the period ending 31 October 2022.

Document Control

Version	*Date*	*Author*	*Comments*
1.0	10/11/22	Rebecca Clegg	Draft
2.0	10/11/22	Paul Gray	Final

Distribution

All Directors.

All staff as appropriate.

Contents

Dashboard & Summary Narrative

Target		Year to Date			Forecast Outturn		
		Actual	Plan		Forecast	Plan	
		£m	£m	Achieved	£m	£m	Achieved
1a	Income and Expenditure Plan	0.1	-0.7	Yes	-0.9	-0.9	Yes
2a	CIP - Identification of Schemes	7.5	10.1	No	7.5	10.1	No
2b	CIP - Delivery of Identified Schemes	2.9	4.7	No	n/a	10.1	n/a
3a	Cash Balance	63.2	50.5	Yes	46.7	46.7	Yes
3c	Aged Receivables > 90 days	0.1	n/a	n/a	n/a	n/a	n/a
3d	Aged Payables > 90 days	0.2	n/a	n/a	n/a	n/a	n/a
3e	Better Payment Practice Code Value NHS	63%	95%	No	95%	95%	Yes
3f	Better Payment Practice Code Volume NHS	88%	95%	No	95%	95%	Yes
3g	Better Payment Practice Code Value non-NHS	92%	95%	No	95%	95%	Yes
3h	Better Payment Practice Code Volume non-NHS	93%	95%	No	95%	95%	Yes
4a	Capital Expenditure not exceeding CDEL	1.0	4.1	Yes	8.7	8.7	Yes

Key Messages

The table above provides a high level summary of the Trust's performance against key financial duties and other financial indicators. The key points to note are:

- We are performing better than planned on Income and Expenditure. At month 6, we took a mid year forecast and our assessment is for a forecast range of between a £1.5m deficit and a £2m surplus, with OAPs and workforce recruitment being the key variables. As a result we are continuing to forecast that we will be on plan for a £0.9m deficit at the end of the year. Our review at month 7 indicates that no change is required to our forecast view at this stage.

- The national pay award has been now been paid for the most staff groups and funded with an uplift from NHS commissioners.

- The Trust planned to deliver £10.1m of cost improvements in order to achieve the planned deficit. Our CIP delivery is £1.8m less than planned and there remains £2.5m of unidentified schemes, plus some identified schemes at risk and which will not deliver as planned, furthering the requirement for new initiatives.

- The underperformance on Better Payment Practice code non-NHS invoices by value relates to a single invoice from the PFI provider received in advance and which was settled in early August. The underperformance on NHS invoices relates to NHSPS invoices which have required additional validation.

System View

The contract hosted by Frimley ICB for services across Frimley and BOB IBCs is now signed. Discussions are well underway regarding the use of slippage on SDF.

Although both ICSs are behind plan YTD, both were continuing to forecast breakeven as at month 6, which is the latest month for which data is available.

2.0 Income & Expenditure

Oct-22	In Month Act £'m	In Month Plan £'m	In Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	22/23 Plan £'m
Operating Income	27.3	27.0	0.3	186.3	185.2	1.2	318.8
Elective Recovery Fund	0.2	0.2	(0.0)	0.9	0.9	(0.0)	2.0
Donated Income	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	0.0
Total Income	**27.5**	**27.2**	**0.3**	**187.2**	**186.1**	**1.2**	**320.8**
Staff In Post	18.1	18.8	(0.7)	122.3	127.3	(4.9)	221.2
Bank Spend	1.9	1.4	0.6	13.2	9.4	3.8	16.2
Agency Spend	0.6	0.4	0.2	4.2	2.8	1.4	4.5
Total Pay	**20.6**	**20.5**	**0.1**	**139.8**	**139.5**	**0.3**	**241.9**
Purchase of Healthcare	1.8	1.4	0.4	12.1	11.0	1.1	16.7
Drugs	0.5	0.5	0.0	3.2	3.1	0.1	5.3
Premises	1.2	1.2	0.0	8.4	8.5	(0.1)	14.7
Other Non Pay	1.2	1.7	(0.5)	9.9	11.0	(1.1)	20.1
PFI Lease	0.7	0.6	0.1	4.3	4.1	0.2	7.0
Total Non Pay	**5.4**	**5.4**	**0.0**	**37.9**	**37.7**	**0.2**	**63.7**
Total Operating Costs	**25.9**	**25.9**	**0.1**	**177.7**	**177.2**	**0.5**	**305.6**
EBITDA	**1.5**	**1.3**	**0.2**	**9.5**	**8.9**	**0.7**	**15.1**
Interest (Net)	0.2	0.3	(0.1)	1.9	2.3	(0.5)	4.0
Depreciation	1.1	0.9	0.2	6.4	6.5	(0.0)	10.8
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Disposals	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PDC	0.2	0.1	0.1	1.2	0.8	0.4	1.3
Total Financing	**1.5**	**1.4**	**0.2**	**9.5**	**9.6**	**(0.1)**	**16.2**
Reported Surplus/ (Deficit)	**0.0**	**(0.0)**	**0.1**	**0.1**	**(0.7)**	**0.8**	**(1.0)**
Adjusted Surplus/ (Deficit)	**0.0**	**(0.1)**	**0.1**	**0.1**	**(0.7)**	**0.8**	**(0.9)**

Key Messages

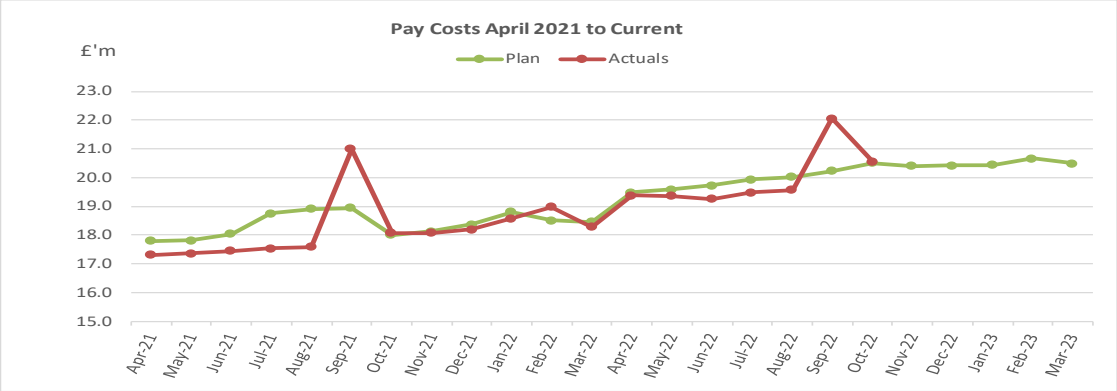
The table above gives the financial performance against the Trust's income and expenditure plan as at 31 October 2022.

In October the Trust is reporting breakeven in month and has a small surplus YTD against a £0.7m deficit plan.

Pay costs reflect the full impact of the pay award and back pay for all but a very few staff. Funding from BOB ICB took account of the issues created by the tariff inflator for Mental Health and Community Trusts. We continue to have an issue for other NHS commissioners.

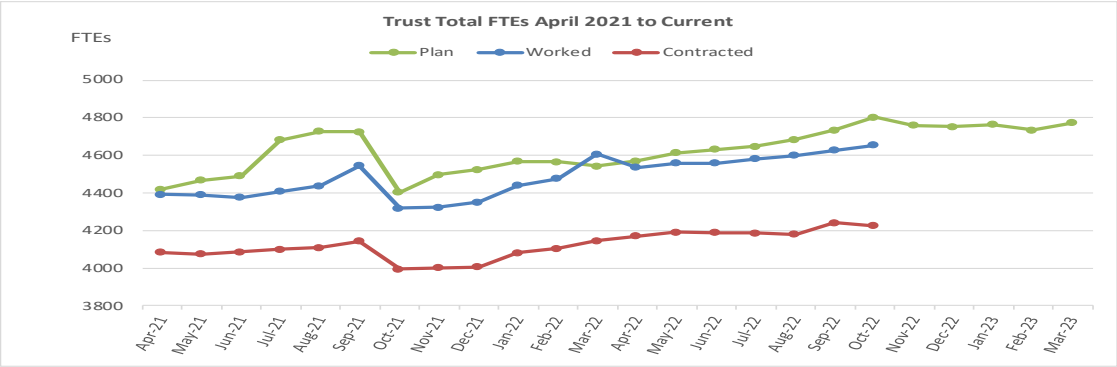
The recently announced changes to the Employer NIC rates to be effective from 1 November 2022 will result in a 0.5% reduction in the tariff inflation and this will be applied to our funding in November and will be offset by a corresponding reduction in costs.

Workforce



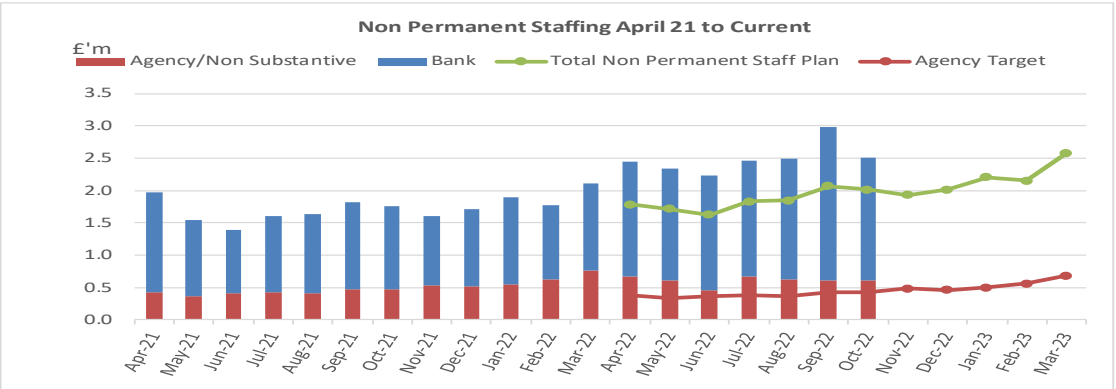
Staff Costs

YTD	£'m
2022/23	139.7
2021/22	126.3
▲	11%
Prior Yr	**£'m**
Oct-22	20.6
Oct-21	18.1
▲	14%



FTEs

Prior Mth	CFTE	WFTE
Oct-22	4,226	4,655
Sep-22	4,242	4,627
	0% ▼	1% ▲
Prior Yr	**CFTE**	**WFTE**
Oct-22	4,226	4,655
Oct-21	3,996	4,319
	2% ▲	3% ▲



Staff Costs

YTD	Bank £'m	Agency £'m
2022/23	13.2	4.2
2021/22	8.7	3.0
	51% ▲	41% ▲
Prior Yr	**£'m**	**£'m**
Oct-22	1.9	0.6
Oct-21	1.8	0.5
	8% ▲	26% ▲

Key Messages

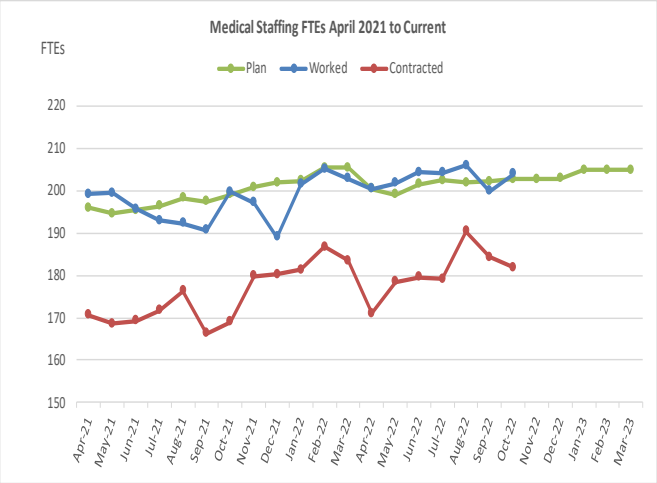
Pay costs in month were £20.6m, reducing from the previous month when the back dated pay award was made for most staff groups. In month, we have seen a decrease in contracted WTEs (16) and an increase in worked WTEs (28) as expected for October.

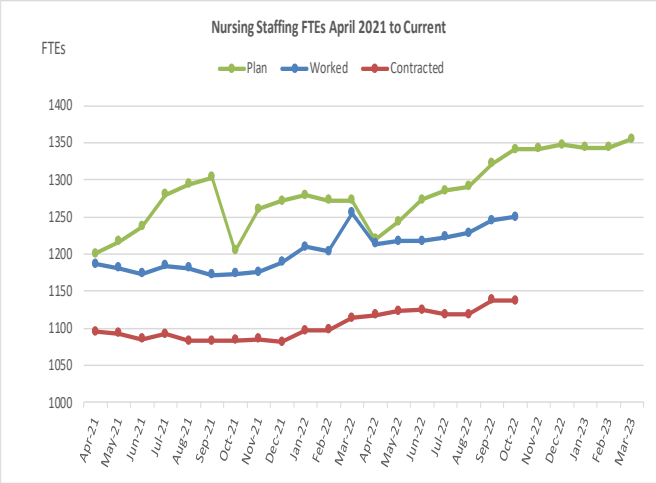
We are continuing to offset in part, substantive vacancies with higher levels of temporary staffing (£5.2m higher than plan year to date). Bank and agency usage was similar to the previous month, with the decrease in bank costs related to the back dated pay award (£0.5m) which was accounted for in the previous month.

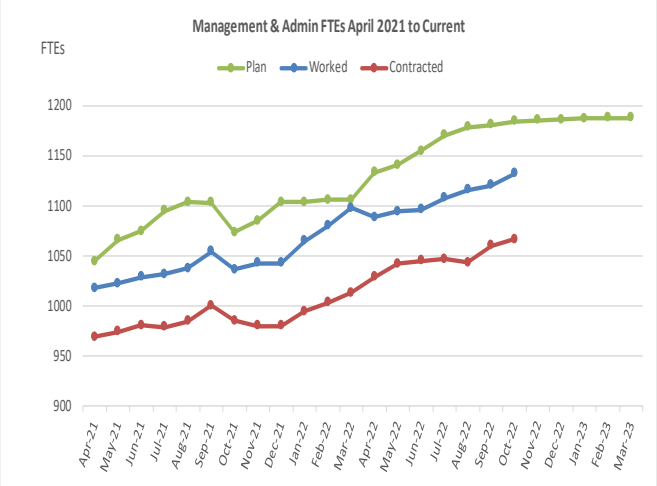
The clinical excellence awards which are usually paid in February each year were paid in October with a total of £350k against a plan of £300k.

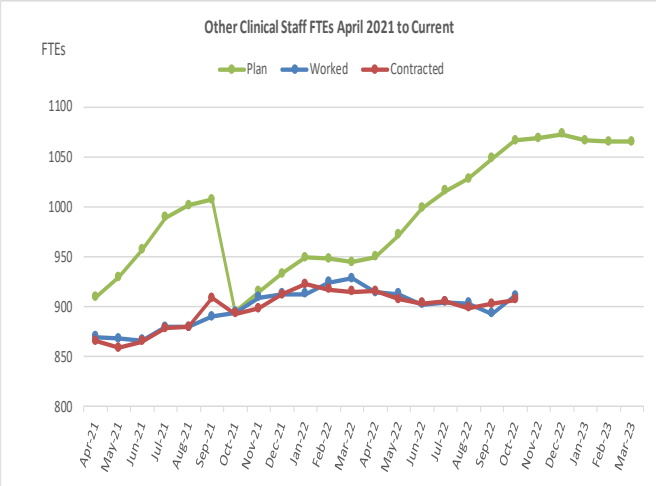
NHSE/I has reintroduced an agency ceiling, which applies at a system level. There is an expectation that costs will be a minimum of 10% lower than in 21/22. Our agency costs grew gradually during 21/22 due in part to the need to cover medical staffing vacancies and continued pressures filling rotas in West Call. This run rate has continued into the current year and unchanged will result in costs c20% higher than last year despite a plan to reduce agency usage significantly. A representation of a 10% reduction in spend (compared with 2021/22) has been added to the chart.

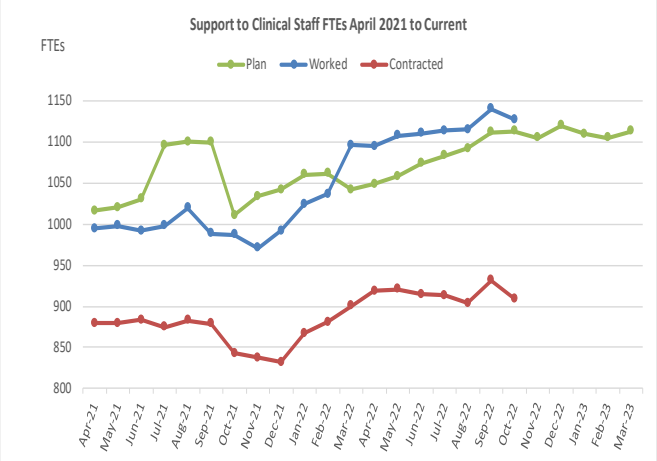
Staffing Detail

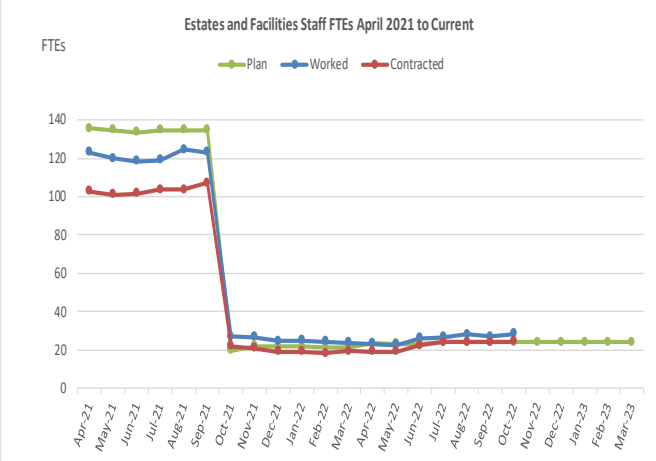












Key Messages

The tables above provides current staffing numbers broken down into core staffing groups.

In month, we have seen a decrease in contracted WTEs (16) and an increase in worked WTEs (28).

The decreases in contracted WTEs was seen mainly in the Mental Health West division (-5 CRHTT, -9 IAPT –4 LD) and in Corporate (-6) offset in part by increases in CAMHS and Community Services.

Income & Non Pay

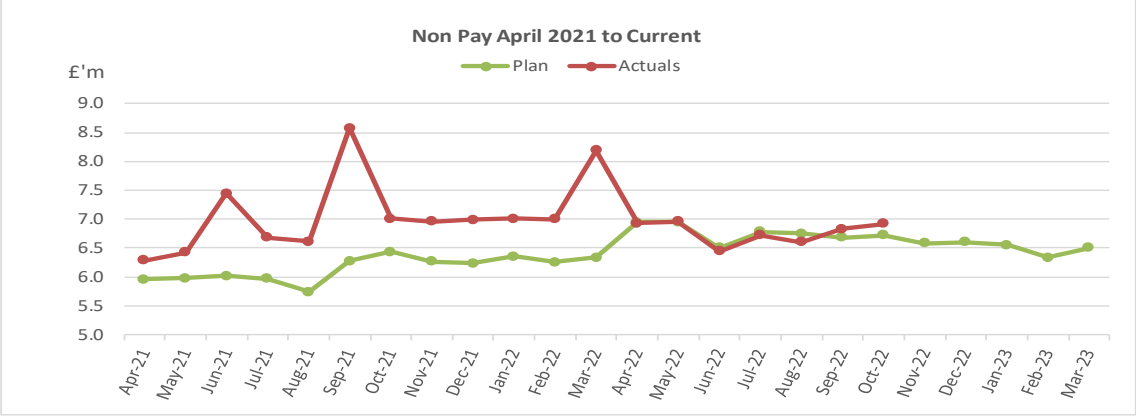
Income

YTD	£'m
2022/23	187.2
2021/22	168.9
▲	11%
Prior Yr	**£'m**
Oct-22	27.5
Oct-21	23.6
▲	17%

Key Messages

The graph above reflects the Trust's planned and actual income. Income has reduced from the previous month where we funded the back dated pay award. The income in month for the pay award which was higher than the planned 2%, is offset by deferred income/slippage on investments linked to lower than expected recruitment. Slippage is being monitored closely by both ICBs. Our proposals for how slippage is used have been presented to Frimley ICBs and will be presented to BOB ICB commissioners in mid November.

The YTD position includes ERF income in line with plan. ICBs are being advised to assumed that there is no clawback of ERF income in the second half of the year.



Non Pay

YTD	£'m
2022/23	47.4
2021/22	49.0
▼	-3%
Prior Yr	**£'m**
Oct-22	6.9
Oct-21	7.0
▼	-1%

Key Messages

Non Pay spend was £6.9m in month, which was slightly above plan linked to higher than planned expenditure on Out of Area Placements.

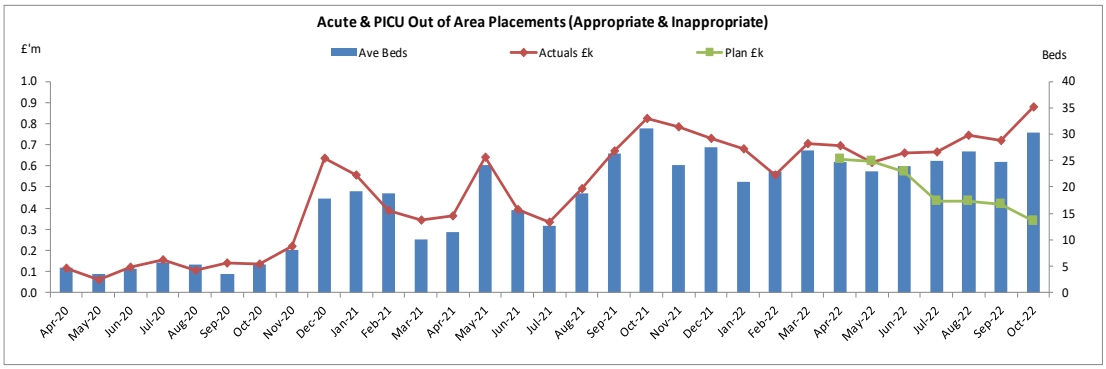
The average number of placements has increased from 25 in September to 30 in October, with the monthly costs increasing from £0.72m to £0.88m. We are continuing to see suppliers push for significant price increases given the current rates of inflation and supply chain issues.

The contractual arrangement with NHSPS mitigates our risk on utility price increases for NHSPS properties, with costs passed through to ICBs under the historical arrangement. We are expecting to see an increase in gas and electric costs of £653k compared with the previous year, most of which will be in the second half of the year.

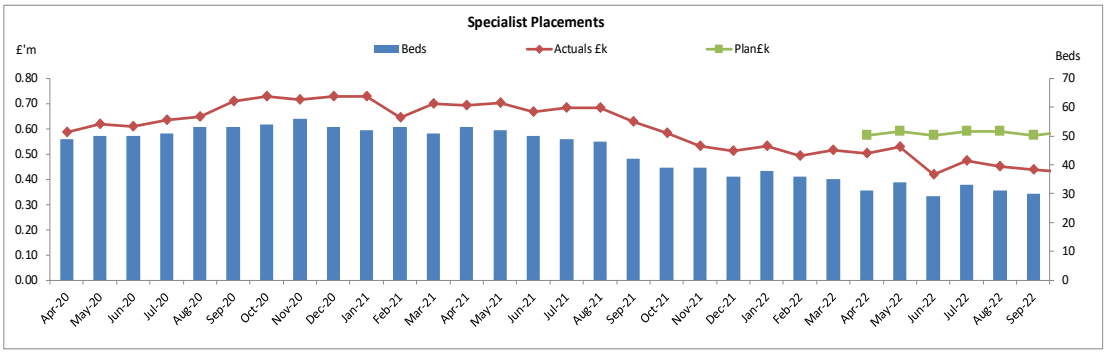
The Trust is benefiting from an increase in bank interest rates and has generated around £0.5m YTD in interest.

Depreciation has been lower than planned due to slippage on the capital programme but is offset in month by adjustments made in relation to the revaluation of our PFI assets.

Placement Costs



OAPs	
YTD	£'m
2022/23	5.0
2021/22	2.9
▲	*72%*
Prior Yr	£'m
Oct-22	0.9
Oct-21	0.8
▲	*6%*



Specialist Placements	
YTD	£'m
2022/23	3.2
2021/22	4.1
▼	*-20%*
Prior Yr	£'m
Oct-22	0.4
Oct-21	0.6
▼	*-26%*

Key Messages

Specialist Placements. The number of placements has decreased from 30 in September to 25 in October with costs decreasing from £0.44m in September to £0.43m in October. The average price has increased in year as we have unoccupied beds for one of block contracts as part of the process of withdrawing from 31 October 2022.

Out of Area Placements. The average number of placements has increased from 25 in September to 30 in October, with the monthly cost increasing from £0.72m to £0.88m.

The Bed Optimisation Programme has now been reset and the project group meets monthly with a status exchange every month, this therefore equates to a fortnightly discussion on the prevailing issues. Each of the workstreams has project support and clinical leadership and a QI approach is being applied to the work. The number of extra-contractual beds has been amended based on what has worked over the prior 6 months. We now contract for 11 Acute beds only and had a plan to taper the usage of these as the financial year progresses, to effectively achieve the zero OAPs trajectory. However, this is now under review given the level of activity we are seeing. Dr Sodhi is leading a review of all patients with a psychotic illness who have a LOS of 65+ days.

The Community Enhance Rehabilitation Service business case has now been approved and this will support the work on the psychosis pathway, providing an alternative to bed based provision and both a step up/step down offer.

PICU work is concentrating on flow through the service to ensure that we can effectively step people down in a more timely manner. Since May 2022 we have discharge 13 patients from Sorrell ward, however due to the continued high levels of demand and acuity we have not been able to return patients of OAP PICU beds. We have ceased the purchase of ECA PICU beds because they were not a cost effective use of resource as they could not always be accessed when required. We will continue to spot purchase PICU beds where they are clinically required. We continue to have significant demand for PICU beds including prison transfers, which whilst do not count as an inappropriate out of area bed against the OAPs trajectory we are seeing the financial impact.

The bed flow fortnight did not achieve the level of reduced occupancy as anticipated which was due to the level of demand coming in during that period. We have maintained daily bed flow meetings between PHH, CRHTT and the locality teams which is helping with whole system overview of the pressures and has enable clearer plans for patients who have long LOS.

From the 13th November we are planning to reduce our OAP acute overspill beds to 11 and will have an escalation to Director on Call if there is a request to admit to an additional bed. Over the next 7 days we are working across teams to facilitate discharges and step downs/recalls to PPH.

Cost Improvement Programme

Cost Improvement (Cash releasing) Scheme	In Month Act £'k	In Month Plan £'k	In Month Var £'k	YTD Act £'k	YTD Plan £'k	YTD Var £'k	Plan £'k
Trust Wide Schemes							
Out of Area Placements - Volume	0.0	221.6	(221.6)	0.0	489.7	(489.7)	1,821.4
Out of Area Placements - Price	0.0	40.9	(40.9)	0.0	115.8	(115.8)	354.0
Opt to Tax (Historic)	125.0	125.0	0.0	875.0	875.0	0.0	1,500.0
Opt to Tax (Recurrent)	37.0	37.0	0.0	259.0	259.0	0.0	444.0
Contribution from New Investments	12.0	8.0	4.0	50.1	56.0	(5.9)	96.0
EFM Recharge to NHSPS	0.0	281.0	(281.0)	0.0	527.0	(527.0)	732.0
Procurement / ICS Procurement	1.0	26.0	(25.0)	3.2	170.0	(166.8)	300.0
Medicines Optimisation	0.0	4.0	(4.0)	0.0	28.0	(28.0)	50.0
Interest Receivable	130.0	0.0	130.0	511.5	0.0	511.5	0.0
Long Term Placements	83.0	0.0	83.0	543.0	0.0	543.0	0.0
Recruitment Slippage	0.0	0.0	0.0	400.0	400.0	0.0	400.0
Division/Corp Schemes Local Delivery							
Total smaller value schemes	21.0	85.5	(64.5)	226.0	383.5	(157.5)	845.0
Corporate Schemes Trust Decision							
Corporate Schemes - FWH Vacating Early	0.0	0.0	0.0	0.0	0.0	0.0	105.0
Review of Management Structures	0.0	50.0	(50.0)	0.0	50.0	(50.0)	550.0
System Supported Schemes							
Agency - Price Cap Compliance (ICS Temporary Staffing Project)	0.0	25.0	(25.0)	0.0	25.0	(25.0)	150.0
Agency - Improved Procurement (ICS Temporary Staffing Project)	0.0	25.0	(25.0)	0.0	25.0	(25.0)	150.0
Unidentified	**0.0**	**142.6**	(142.6)	**0.0**	**1,267.1**	(1,267.1)	**2,597**
Total Cost Improvement	**409.0**	**1,071.6**	**(662.6)**	**2,867.7**	**4,671.0**	**(1,803.3)**	**10,094.0**

Key Messages

The Trust's initial financial plan for 22/23 included a requirement to deliver £9.7m of cost improvements in order to achieve the deficit plan that has been submitted. The requirement was increased by £0.4m in June when the Trust agreed to take a share of the BOB system deficit to bring the overall system plan back to breakeven.

There remains a £2.6m unallocated target which reflects the gap between our plan submission and the identified savings schemes. We continue to work to identify schemes in excess of this value to take account of slippage and to contribute to recurrent financial sustainability.

The EFM "recharge" to NHSPS saving remains at risk, in part due to the construct of the agreement with NHSPS governing the transfer of services under the original business transfer agreement. The Trust is engaged in Exec level conversations with NHSPS over this in respect of retained costs from the transfer of services in October 21 and is also engaged with ICBs regarding changes to the annual charging schedules for the properties concerned.

The additional £0.4m CIP required for BOB ICS has been delivered through recruitment slippage from Q1. Discussions are ongoing about any further allocation of the system gap to providers by BOB ICB.

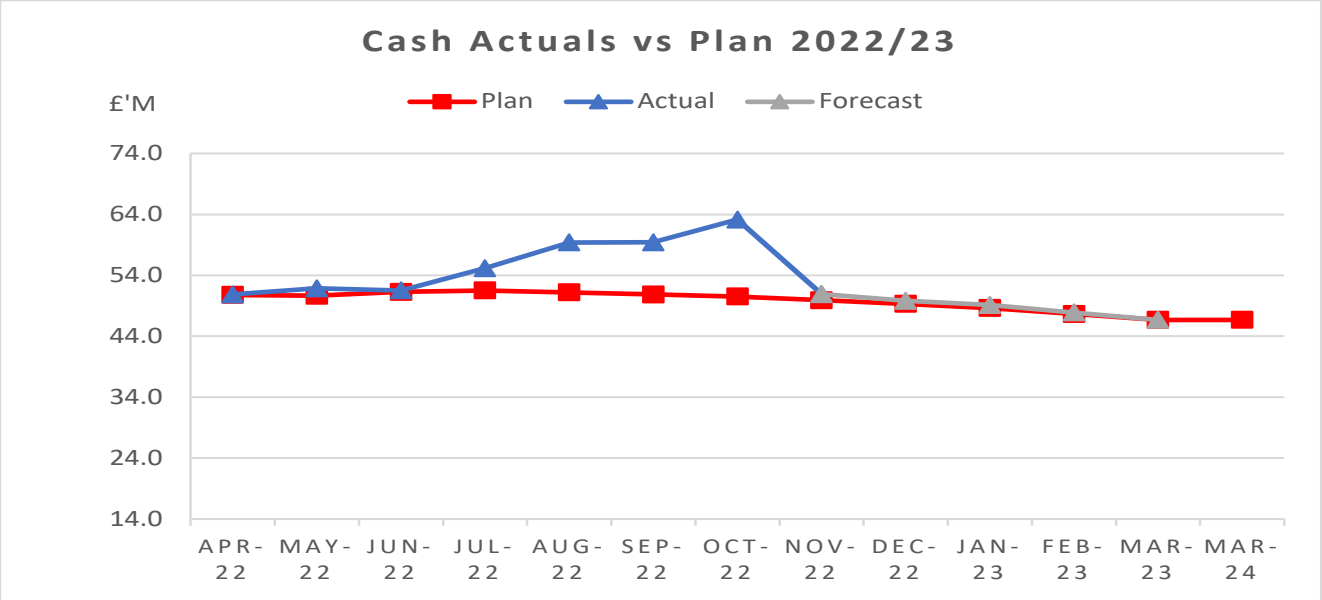
The number of long term placement placements continues at a lower than planned level offsetting the underperformance on the OAPs CIP. This is in part due to the withdrawal from the contracted beds at Rosebank, which completed on 31/10/22 with further savings expected as a result.

The review of management structures is underway, although given its complexities, the majority of savings are likely to impact later in the year and into the following year.

Given the historically low levels of usage and rates paid, there has been little identified through the ICS Temporary Staffing Programme in respect of in year benefit. However NHSE/I's recently issued system agency ceiling will require us to look again at agency costs with a view to reducing costs in year.

3.0 Cash

Cashflow	21/22 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m
Reported Surplus / (Deficit)	1.7	0.1	0.0	0.1	0.1	(0.7)	0.8
Remove Finance Charges through SoCI	4.0	0.2	0.3	(0.1)	1.9	2.3	(0.4)
Remove PDC Dividend accrual through SoCI	0.9	0.2	0.1	0.1	1.2	0.8	0.4
Remove Profit on Disposal of Assets	(1.4)	0.2	0.1	0.1	1.2	0.8	0.4
Operating Surplus/(Deficit)	**5.2**	**0.4**	**0.4**	**0.0**	**3.1**	**2.4**	**0.7**
Depreciation and Impairments	9.4	1.1	0.9	0.2	6.4	6.5	(0.1)
Operating Cashflow	***14.6***	***1.5***	***1.3***	***0.2***	***9.5***	***8.9***	***0.6***
Net Working Capital Movements	***11.6***	***3.1***	***(0.1)***	***3.2***	***6.3***	***(4.4)***	***10.7***
Proceeds from Disposals	2.2	0.0	0.0	0.0	0.0	0.0	0.0
Donations to fund Capital Assets	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Donated Capital Assets	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital Expenditure (Net of Accruals)	(8.1)	(0.2)	(0.9)	0.7	(1.9)	(4.6)	2.7
Investments	***(5.8)***	***(0.2)***	***(0.9)***	***0.7***	***(1.9)***	***(4.6)***	***2.7***
PFI Finance Lease Repayment	(1.6)	(0.2)	(0.1)	(0.1)	(1.0)	(1.0)	0.0
RoU Asset Finance Lease Repayment	0.0	(0.2)	(0.2)	0.0	(1.4)	(1.5)	0.1
Net Interest	(3.9)	(0.2)	(0.3)	0.1	(1.9)	(2.3)	0.4
PDC Received	0.7	0.0	0.0	0.0	0.0	0.0	0.0
PDC Dividends Paid	(0.8)	0.0	0.0	0.0	(0.3)	0.0	(0.3)
Financing Costs	***(5.5)***	***(0.6)***	***(0.7)***	***0.1***	***(4.6)***	***(4.8)***	***0.2***
Other Movements	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Cash In/(Out)Flow	***14.8***	***3.8***	***(0.3)***	***4.1***	***9.3***	***(4.9)***	***14.2***
Opening Cash	39.1	59.4	50.9	8.5	53.9	55.4	(1.5)
Closing Cash	***53.9***	***63.2***	***50.5***	***12.7***	***63.2***	***50.5***	***12.7***



Key Messages

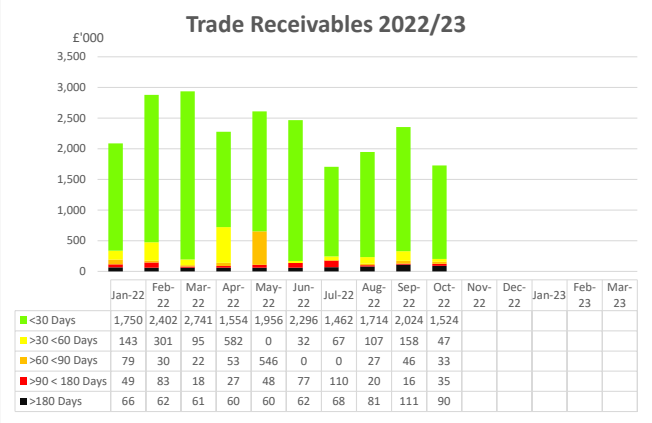
The closing cash balance for September was £63.2m, which is £12.7m above the revised plan . The year to date operating surplus is £0.8m above plan contributing to increase in cash. The Trust continues to carry deferred income balances linked to SDF which has not been spent in line with the plan. It is also linked to the timing of payment runs which have been realigned to facilitate working day one reporting. This means that payment runs in the final week of the month are paid in the next financial reporting period resulting in a gain in cash over the period. Average daily cash balances have increased by £1.1m as a result, which will reduce PDC Dividend risk. The variance to plan is also the result of capital slippage on the capital programme (£3.4m). The Trust is benefiting from increase in bank interest rates and has generated around £0.5m YTD in interest since April 2022.

3.0 Balance Sheet

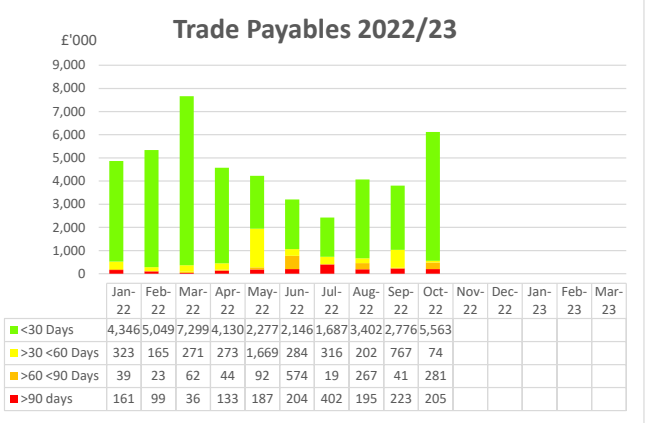
Balance Sheet	21/22 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m
Intangibles	4.2	3.2	3.2	(0.1)	3.2	3.2	(0.1)
Property, Plant & Equipment (non PFI)	42.6	40.7	36.2	4.5	40.7	36.2	4.5
Property, Plant & Equipment (PFI)	70.2	69.1	57.5	11.5	69.1	57.5	11.5
Property, Plant & Equipment (RoU Asset)	0.0	15.0	12.6	2.5	15.0	12.6	2.5
Receivables	0.2	0.2	0.2	0.0	0.2	0.2	0.0
Total Non Current Assets	**117.2**	**128.2**	**109.8**	**18.5**	**128.2**	**109.8**	**18.5**
Trade Receivables & Accruals	8.9	12.3	8.8	3.5	12.3	8.8	3.5
Other Receivables	0.2	0.2	0.2	0.0	0.2	0.2	0.0
Cash	53.9	63.2	50.5	12.7	63.2	50.5	12.7
Trade Payables & Accruals	(35.4)	(38.0)	(32.7)	(5.3)	(38.0)	(32.7)	(5.3)
Current PFI Finance Lease	(1.7)	(1.7)	(1.7)	0.0	(1.7)	(1.7)	0.0
Current RoU Asset Finance Lease	0.0	(2.5)	(2.3)	(0.2)	(2.5)	(2.3)	(0.2)
Other Current Payables	(12.5)	(19.0)	(12.8)	(6.2)	(19.0)	(12.8)	(6.2)
Total Net Current Assets / (Liabilities)	**13.3**	**14.5**	**10.0**	**4.4**	**14.5**	**10.0**	**4.4**
Non Current PFI Finance Lease	(23.8)	(22.8)	(22.8)	0.0	(22.8)	(22.8)	0.0
Non Current RoU Finance Lease	0.0	(13.1)	(10.7)	(2.3)	(13.1)	(10.7)	(2.3)
Other Non Current Payables	(1.8)	(1.8)	(1.6)	(0.2)	(1.8)	(1.6)	(0.2)
Total Net Assets	***104.9***	***105.0***	***84.7***	***20.3***	***105.0***	***84.7***	***20.3***
Income & Expenditure Reserve	32.2	32.3	31.8	0.5	32.3	31.8	0.5
Public Dividend Capital Reserve	20.7	20.7	20.7	0.0	20.7	20.7	0.0
Revaluation Reserve	52.0	52.0	32.2	19.8	52.0	32.2	19.8
Total Taxpayers Equity	***104.9***	***105.0***	***84.7***	***20.3***	***105.0***	***84.7***	***20.3***

Key Messages

Following completion of year end audit for 2021/22 in October, the prior year fixed asset and revaluation reserve closing balances and subsequently in year balances have been updated to reflect the increase in Depreciated Replacement Cost valuations for the two PFIs and Greenham Trust Wing that has seen an increase in of around £20m.



	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
<30 Days	1,750	2,402	2,741	1,554	1,956	2,296	1,462	1,714	2,024	1,524					
>30 <60 Days	143	301	95	582	0	32	67	107	158	47					
>60 <90 Days	79	30	22	53	546	0	0	27	46	33					
>90 < 180 Days	49	83	18	27	48	77	110	20	16	35					
>180 Days	66	62	61	60	60	62	68	81	111	90					



	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
<30 Days	4,346	5,049	7,299	4,130	2,277	2,146	1,687	3,402	2,776	5,563					
>30 <60 Days	323	165	271	273	1,669	284	316	202	767	74					
>60 <90 Days	39	23	62	44	92	574	19	267	41	281					
>90 days	161	99	36	133	187	204	402	195	223	205					

Key Messages

Overall receivables balances decreased by £0.6m due primarily to a decrease in current aged debt (<30 days). All aged debt over 30 days decreased by £0.1m. Overall payables increased by £2.3m, mainly due to an increase in current balances (£2.8m). This relates primarily to the Q3 invoices for rent and service charges for NHSPS properties and the PPH Unitary Payment for Month 7. All these invoices were paid on the 1st of November. All aged payables over 30 days decreased by £0.7m. There are a small number of high value invoices for placements that are not paid as we are awaiting credit notes.

4.0 Capital Expenditure

Schemes	Current Month			Year to Date			FY	FY
	Actual £'000	Plan £'000	Variance £'000	Actual £'000	Plan £'000	Variance £'000	Plan £'000	Forecast Outturn £'000
Estates Maintenance & Replacement Expenditure								
Erleigh road Change of Service - Phase 2	0	33	(33)	80	33	47	150	80
Extension for Clinical Space - CHH	0	3	(3)	0	8	(8)	450	0
Other Trust Owned Properties	0	17	(17)	0	17	(17)	70	0
Leased Non Commercial (NHSPS)	17	50	(33)	17	180	(163)	240	124
Head Office Relocation	2	217	(214)	42	867	(824)	1,300	1,566
MSK Relocation	7	45	(38)	7	245	(238)	335	686
Leased Commercial Other	0	30	(30)	(0)	80	(80)	140	0
Leased Non Commercial (NHSPS)	0	13	(13)	7	13	(7)	20	7
Environment & Sustainability	1	6	(5)	11	22	(11)	50	24
Windsor Consolidation (Dedworth)	103	33	70	111	433	(322)	500	1,256
Various All Sites	0	83	(83)	0	204	(204)	616	163
Statutory Compliance	0	22	(22)	4	58	(54)	150	115
Subtotal Estates Maintenance & Replacement	**131**	**552**	**(421)**	**280**	**2,161**	**(1,880)**	**4,021**	**4,021**
IM&T Expenditure								
IM&T Business Intelligence and Reporting	0	0	0	0	0	0	120	120
IM&T Refresh & Replacement	33	347	(314)	58	859	(801)	2,782	2,782
IM&T System & Network Developments	62	19	43	475	131	344	260	475
IM&T GDE & Community Projects	(1)	18	(18)	105	177	(72)	242	242
IM&T Digitial Strategy	56	106	(51)	118	744	(625)	1,275	1,060
Subtotal IM&T Expenditure	**149**	**489**	**(340)**	**756**	**1,910**	**(1,155)**	**4,679**	**4,679**
Subtotal CapEx Within Control Total	**280**	**1,041**	**(761)**	**1,036**	**4,071**	**(3,035)**	**8,700**	**8,700**
CapEx Expenditure Outside of Control Total								
PPH 'Place of Safety	0	33	(33)	1	33	(32)	1,600	150
PPH Zonal Heating Controls	0	42	(42)	0	167	(167)	250	0
Statuory Compliance	0	15	(15)	0	40	(40)	100	126
Environment & Sustainability / Zero Carbon	0	0	0	0	0	0	200	0
Other PFI projects	0	45	(45)	31	179	(147)	185	155
Health Bus (Donated)	0	0	0	0	0	0	0	34
Subtotal Capex Outside of Control Totals	**0**	**135**	**(135)**	**33**	**419**	**(387)**	**2,335**	**465**
Central Funding								
EOI Funding - CYPF Reading (25 Erleigh Road)	0	0	0	0	0	0	0	299
Sub Total Central Funding Outside of Control Totals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**299**
Total Capital Expenditure	**280**	**1,176**	**(896)**	**1,069**	**4,490**	**(3,422)**	**11,035**	**9,464**

Key Messages

Schemes within Control total at month seven are underspent by £3m due in part to delays in Estates projects (Head Office Relocation, Dedworth/Fairacres and MSK Adam Villas - £1.4m). The Head Office Relocation & Dedworth projects have started with contractors on site. The Adlam Villas project is due to start now the lease has been signed. The forecast outturn on these projects is £1.3m higher than planned and is funded by rephasing and prioritising the existing Estates capital schemes with some planned slippage into 2023/24.

IM&T Digital Strategy (£0.6m) and IM&T Refresh & Replacement (£0.8m) are underspend offset by an overspend on Ad-hoc Locality. We are currently reviewing the forecast outturn and have opportunities to bring forward Estates projects should there be slippage on IM&T schemes.

The Trust was successful in bidding for UEC capital £0.3m and the project is in pre-planning stage. The project will develop space at 25 Erleigh Road for the diversion of young people in crisis from the ED in Reading.

The Trust also has five new leases starting in this financial year with Right of use Asset valued at £3m as per IFRS16 and we are waiting guidance from NHS England regarding additional CRL cover for these new in year leases.

The Trust has submitted a bid against the Public Sector Decarbonisation Scheme (Salix).

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper - Public

Board Meeting Date	13th December 2022
Title	**True North Performance Scorecard** **Month 7 (October 2022) 2022/23**
	Item for Noting
Purpose	To provide the Board with the True North Performance Scorecard, aligning divisional driver metric focus to corporate level (Executive and Board) improvement accountability against our True North ambitions, and Quality Improvement (QI) break through objectives for 2022/23.
Business Area	Trust-wide Performance
Author	Chief Financial Officer
Relevant Strategic Objectives	2 - To provide safe, clinically effective services that meet the assessed needs of patients, improve their experience and outcome of care, and consistently meet or exceed the standards of Care Quality Commission (CQC) and other stakeholders.
CQC Registration/Patient Care Impacts	All relevant essential standards of care.
Resource Impacts	None.
Legal Implications	None.
Equality and Diversity Implications	None.
Summary	The True North Performance Scorecard for Month 7 2022/23 (October 2022) is included. Individual metric review is subject to a set of clearly defined “business rules” covering how metrics should be considered dependent on their classification for driver

	improvement focus, and how performance will therefore be managed. The business rules apply to three categories of metric: • **Driver metric**: the few key improvement drivers with target performance and will be the focus of meeting attention. • **Tracker Level 1 metric**: no attention required if within set threshold for the period. Threshold performance usually defined by regulator / external body and relates to "must do" national standards or areas of focus. Update required if threshold performance is missed in one month. • **Tracker metric**: no attention required unless performance is deteriorating from threshold for a defined period (over four months). Threshold set internally, where sustained underperformance will trigger a review of threshold level or need to switch to a driver metric dependent on capacity. **Month 7** **Performance business rule exceptions, red rated with the True North domain in brackets:** **Breakthrough and Driver Metrics** Context and update to driver performance to be provided in discussion of counter measure action and development: • Physical Health Checks – 7 Parameters for People with Severe Mental Illness (SMI) **(Harm Free Care) -** at 79% against a revised stretch target of 95%. The Slough team are the top contributor, which masks good performance in teams such as Bracknell (100%) and the West at (94%). • I Want Great Care Positive Score **(Patient Experience)** - at 93.3% against a 95% target. It is taking time to see improvements due to new system and processes. • I Want Great Care Compliance Rate **(Patient Experience)** - at 3.6% against a 10% target. An improvement this month but is taking time to see improvements due to new system and processes. • Physical Assaults on Staff **(Supporting Our Staff)** – 57 against a target of 44. Campion unit was the top contributor with 13 incidents, with Daisy and Orchid next with 9 incidents each, then Rose and Rowan ward with 8 each. • Staff turnover (including fixed-term posts) **(Supporting Our Staff)** – 16.5% against a 16% target. A challenging area which remains a focus for the organisation.

	• Variance from year-to-date NHSE Efficiency Plan **(Money Matters)** – At -1803 against a target of 0. **Tracker 1 Metrics (where red for 1 month or more)** • Meticillin-resistant Staphylococcus Aureus (MSSA) Bacteraemias (Cumulative year to date) **(Regulatory Compliance)** – No incidents in month. There was 1 incident in September making the year to date total 2. • People with Common Mental Health Conditions Referred to IAPT Completing a Course of Treatment Moving to Recovery - **(Regulatory Compliance)** – at 47%, below the 50% target, with three months red. • Proportion of Patients Referred for Diagnostic Tests who have been Waiting for Less than 6 weeks (DM01 – Audiology) **(Regulatory Compliance)** – reduced further to 35% against a target of 95%. Significant staffing issues are contributing to this breach position. Processes reviewed and recovery underway. An audit is scheduled to support a recovery position. • Sickness rate **(Regulatory Compliance)** – red at 4.56% for September against a target of 3.5%. This is not a "hard" compliance focus with NHSI but is tracked. Twelve months red. • Children and Young People (CYP) referred for an assessment or treatment of an Eating Disorder (ED) will access NICE treatment <1 week (Urgent) **(Regulatory Compliance)** – red at 66.7% against a 95% target. This is a newly introduced national target that is challenging to achieve for trusts as evidenced by regional and national benchmarking. **Tracker Metrics (where red for 4 months or more)** • Health Visiting: New Birth Visits within 14 days **(Patient Experience)** – at 69.8% against a 90% target. Root cause analysis is staff capacity in the Reading team which is impacting the figures. • Mental Health Delayed Transfers of Care **(Money Matters)** - at 9.64% against a target of 7.5%. A positive reporting shift is placing a focus on mental health delays in the systems. • Increase in Elective Care Activity from 2019/20 baseline (physical health only) – first appointment **(Money Matters)** - at -0.2% against a target of 4%. A challenging recovery target, with limited-service inclusion for the Trust. • Increase in Elective Care Activity from 2019/20 baseline (physical health only) – follow up appointment **(Money Matters)** - at -13% against a

	target of 4%. A challenging recovery target, with limited-service inclusion for the Trust. • Mental Health Non-Acute Occupancy rate **(Money Matters)** - at 87.4% against an 85% target. • Mental Health Acute Occupancy rate (excluding home leave) **(Money Matters)** - at 97.2% against an 85% target. Red for 12 months. • Mental Health: Acute Average Length of Stay (bed days) **(Money Matters)** – reduced to 35 days against a target of 30 days. Pressures continue, and length of stay remains a focus for teams. An improvement project is underway.
Action	The Board is asked to note the True North Scorecard.

True North Performance Scorecard – Business Rules & Definitions

The following metrics are defined as and associated business rules applied to the True North Performance Scorecard:

Driver - True North / break through objective that has been prioritised by the organisation as its area of focus	**Tracker Level 1-** metrics that have an impact due to regulatory compliance	**Tracker -** important metrics that require oversight but not focus at this stage in our performance methodology

Rule #	Metric	Business Rule	Meeting Action
1	**Driver** is **Green** in current reporting period	Share success and move on	**No action** required
2	**Driver** is **Red** in current reporting period	Share top **contributing reason**, the amount this contributor impacts the metric, and **summary of initial action(s)** being taken	Standard structured **verbal** update
3	**Driver** is **Red** for **2+** reporting periods	Produce full structured **countermeasure summary**	Present full written **countermeasure analysis and summary**
4	**Driver** is **Green** for **6** reporting periods	Retire to **Tracker** level status	Standard structured **verbal** update and retire to **Tracker**
5	**Tracker 1 (or Tracker)** is **Green** in current reporting period	**No action** required	**No action** required
6	**Tracker** is **Red** in current reporting period	Note metric performance and move on unless they are a **Tracker Level 1**	If **Tracker Level 1,** then structured **verbal** update
7	**Tracker** is **Red** for **4** reporting periods	Switch to **Driver** metric	Switch and replace to **Driver** metric (decide on how to make capacity i.e. which **Driver** can be a **Tracker**)

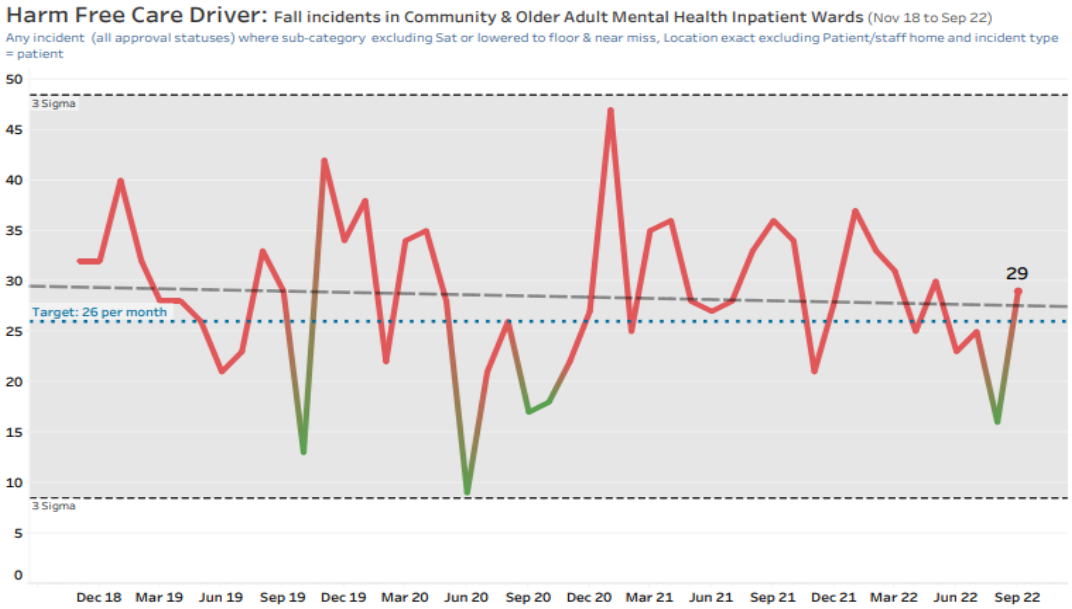
Business Rules for Statistical Process Control (SPC) Charts

Why Use SPC Charts

We intend to use SPC charts to gain a better understanding about what our data is telling us. We can use this understanding to support making improvements. It will ensure we don't overreact to normal variation within a system.

Components of an SPC Chart

The charts have the following components with an example below:



- A target line (the blue dotted line)
- A longer series of data points
- Upper Control Limit (UCL) to 3 Sigma
- Lower Control Limit (LCL) to 3 Sigma
    - These process limits (UCL & LCL) are defined by our data and calculated automatically. If nothing changes with the process, we can expect 99% of data points to be within these limits. They tell us what our system is capable of delivering. Our data will vary around these process limits. It provides a context for targeting improvement.

Variation

There are 2 types of variation:

1. Common cause variation, which is 'normal' variation (within the UCL & LCL)
2. Special cause variation (or unusual variation) which is something outside of the normal variation and outside of the process control limits (UCL & LCL)

Rules

- A series of 6 or more data points above or below the target is statistically relevant. It indicates that something in process has changed.
- A trend: either rising or falling of more than 6 data points – we should investigate what has happened.
    - We should reset baseline following a run of 6 data points (either up or down).
- Follow the True North Performance business rules for other metric actions.

Harm Free Care

Metric	Target	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
Falls incidents in Community & Older Adult Mental Health Inpatient Wards	26 per month increased from 20 in Feb 22	21	28	37	33	31	25	30	23	25	16	28	15
Self-Harm Incidents on Mental Health Inpatient Wards (excluding LD)	67 per month	141	86	170	88	112	92	96	101	89	89	72	57
Number of suicides (per month)	SI =<3	4	1	1	2	2	1	3	2	3	3	0	2
Physical Health Checks 7 Parameters for people with severe mental illness (SMI)	90% until Sept 22, then 95%	71%	74%	78%	81%	80%	78%	78%	79%	80%	79%	80%	79%

Patient Experience

IWGC Positive Score %	95% compliance from April 22	90%	92%	92%	79%	93.2%	94%	92.7%	95.2%	95.2%	94.1%	95.5%	93.3%
IWGC Compliance %	10% compliance	7.0%	1.7%	0.3%	0.4%	0.8%	0.6%	1.0%	1.3%	2.3%	2.2%	3.4%	3.6%

Performance Scorecard - True North Drivers (October 2022)

Supporting our Staff

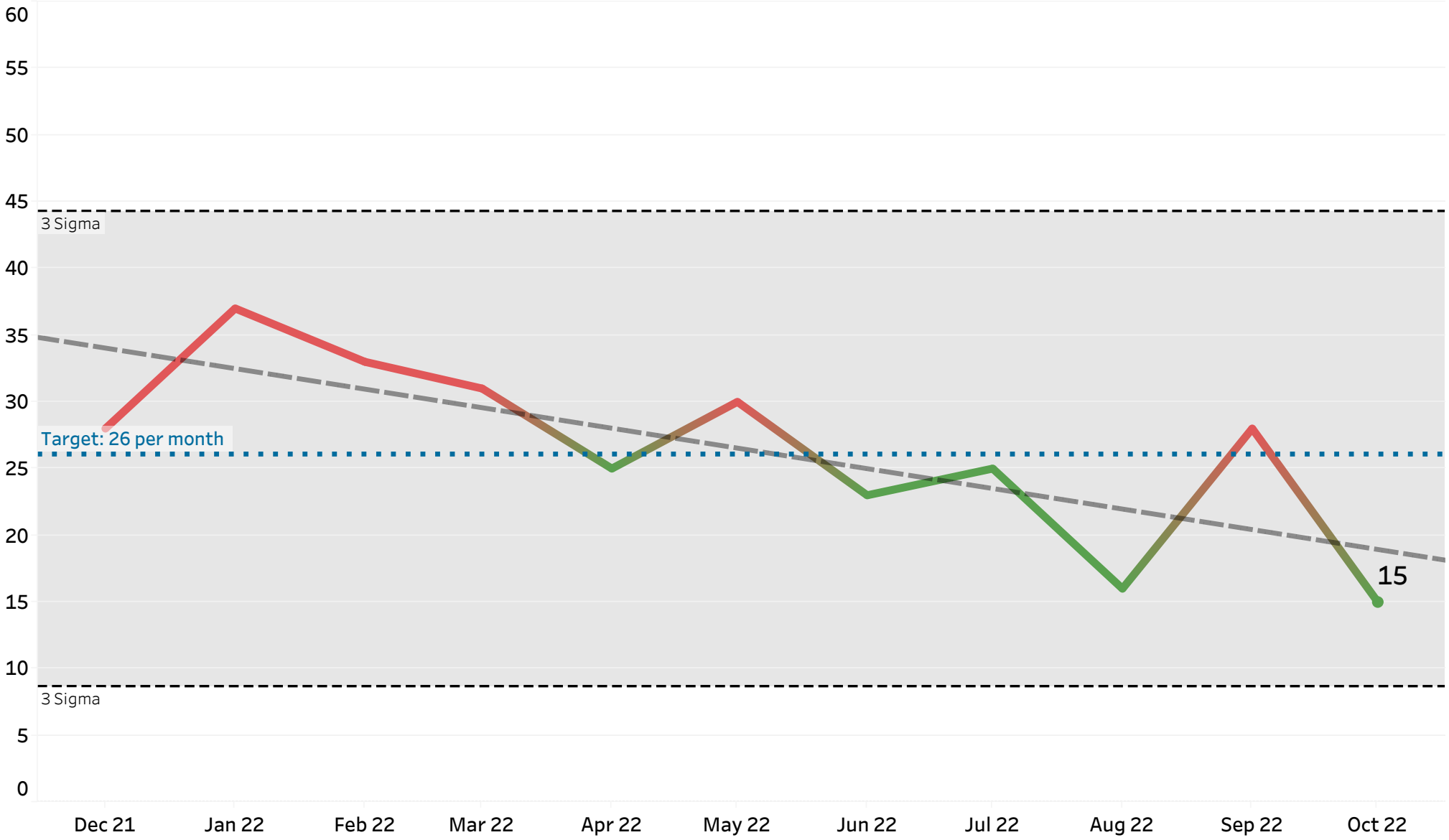
Metric	Target	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
Physical Assaults on Staff	44 per month	65	55	57	115	92	117	69	62	50	53	53	57
Staff turnover (excluding fixed term posts)	<=16% per month	15.44%	15.31%	15.32%	15.37%	15.93%	16.19%	16.71%	16.76%	16.89%	17.02%	16.98%	16.5%

Money Matters

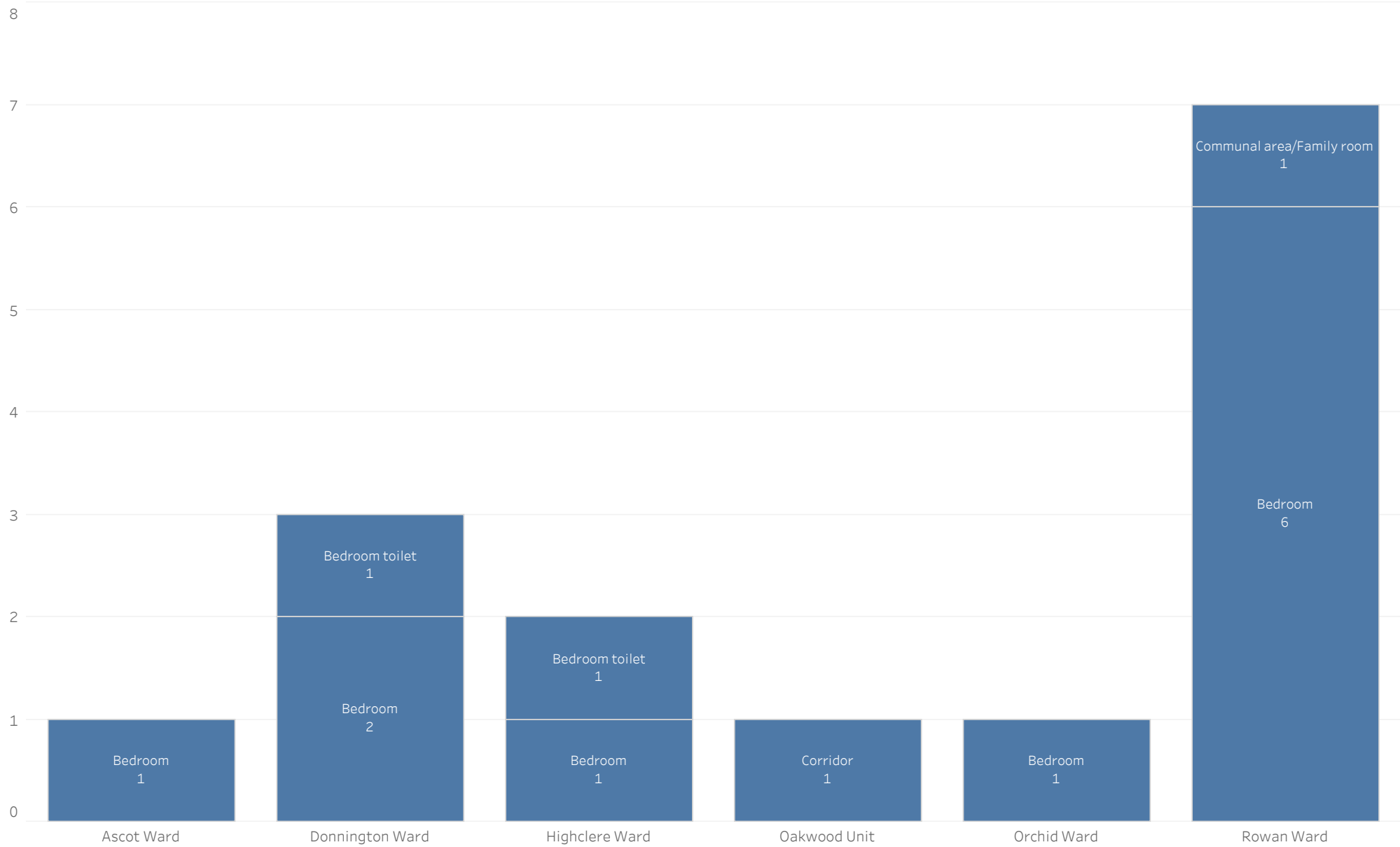
Variance from YTD NHSE financial control total (£'k)	<£0k							-3	32	-149	-400	-506	-714	-774
Variance from YTD NHSE efficiency plan (£'k)	>£0k							112	134	490	183	-571	-1141	-1803
Inappropriate Out of Area Placements	276 Cumulative Total Q3 2022/23	195	266	405	92	191	363	69	114	226	144	329	524	266

Harm Free Care Driver: Fall incidents in Community & Older Adult Mental Health Inpatient Wards (Dec 21 to Oct 22)

Any incident (all approval statuses) where sub-category excluding Sat or lowered to floor & near miss, Location exact excluding Patient/staff home and incident type = patient

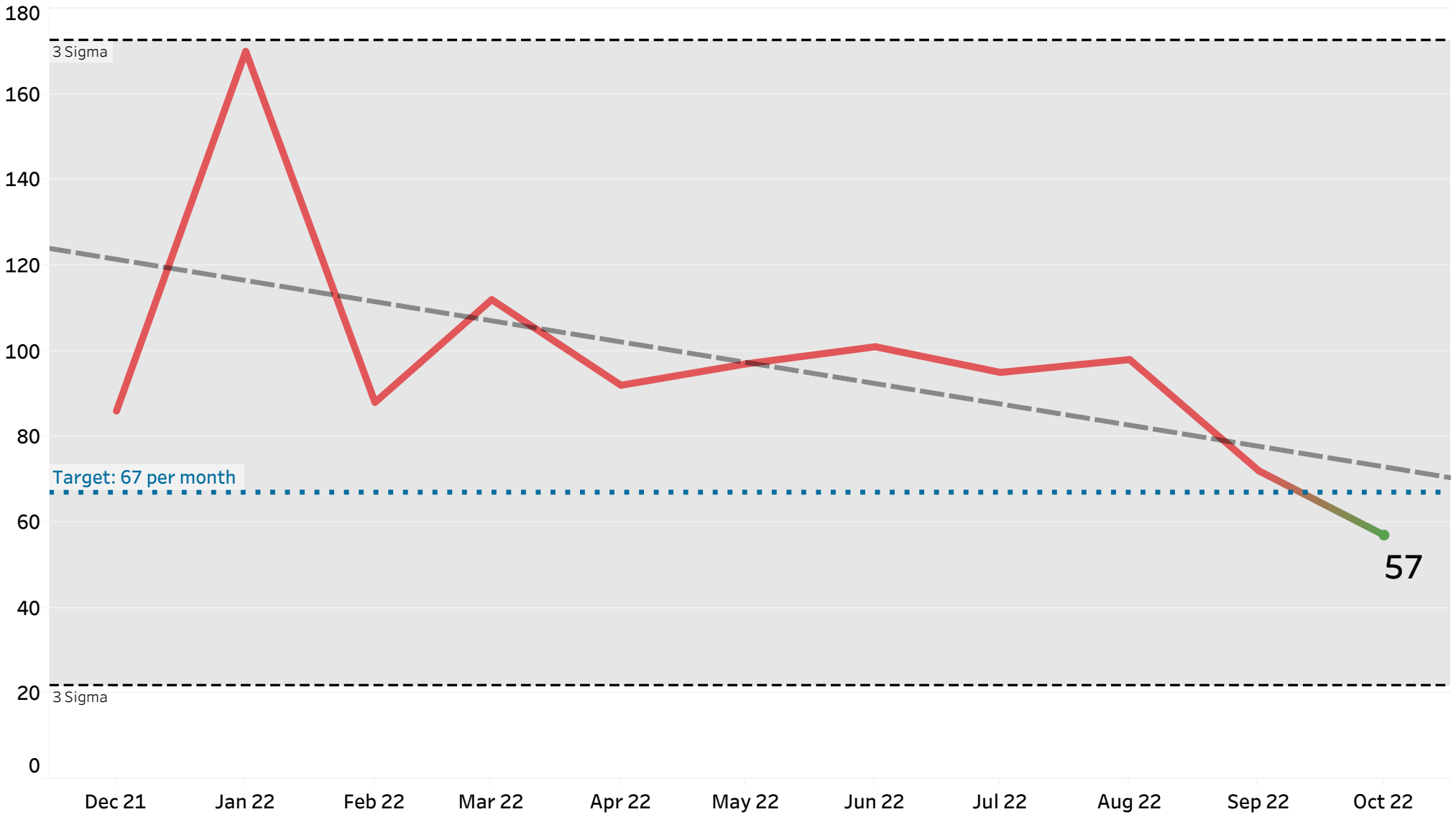


Harm Free Care Driver: Fall incidents in Community and Older Adult Mental Health Inpatient Wards (Oct 2022)

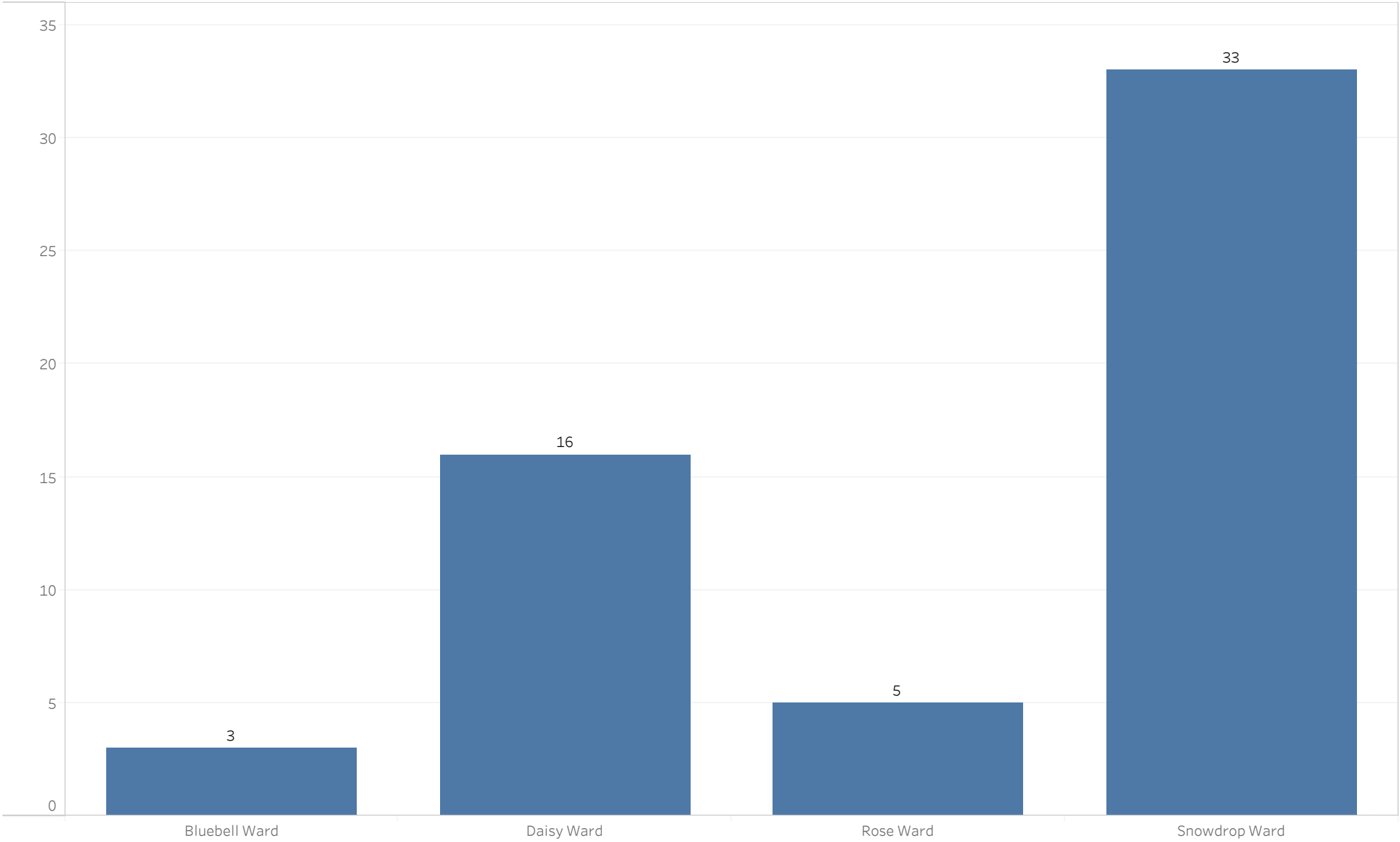


Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) (Dec 21 to Oct 22)

Any incident (all approval statuses) where category = self harm

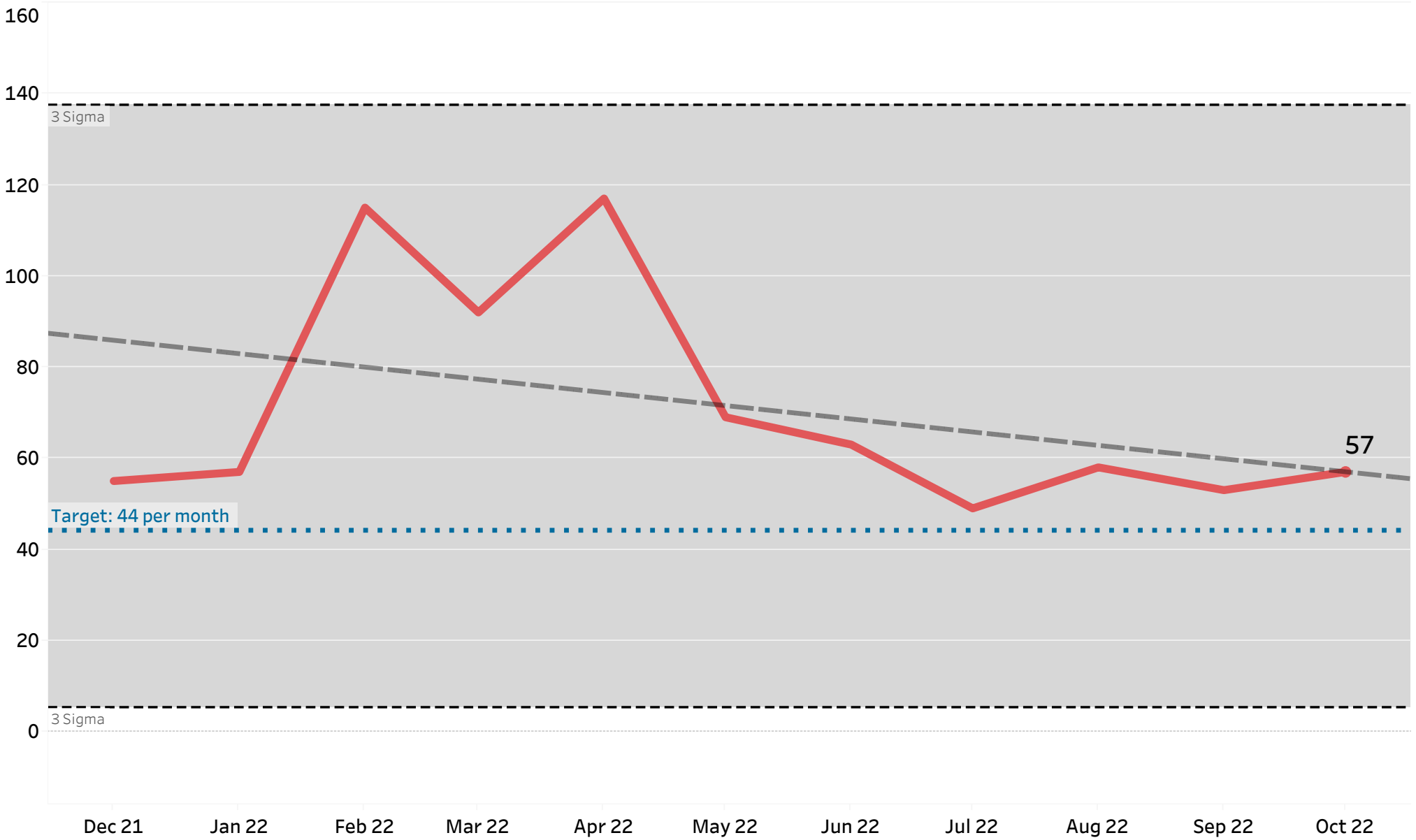


Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) by location (Oct 2022)

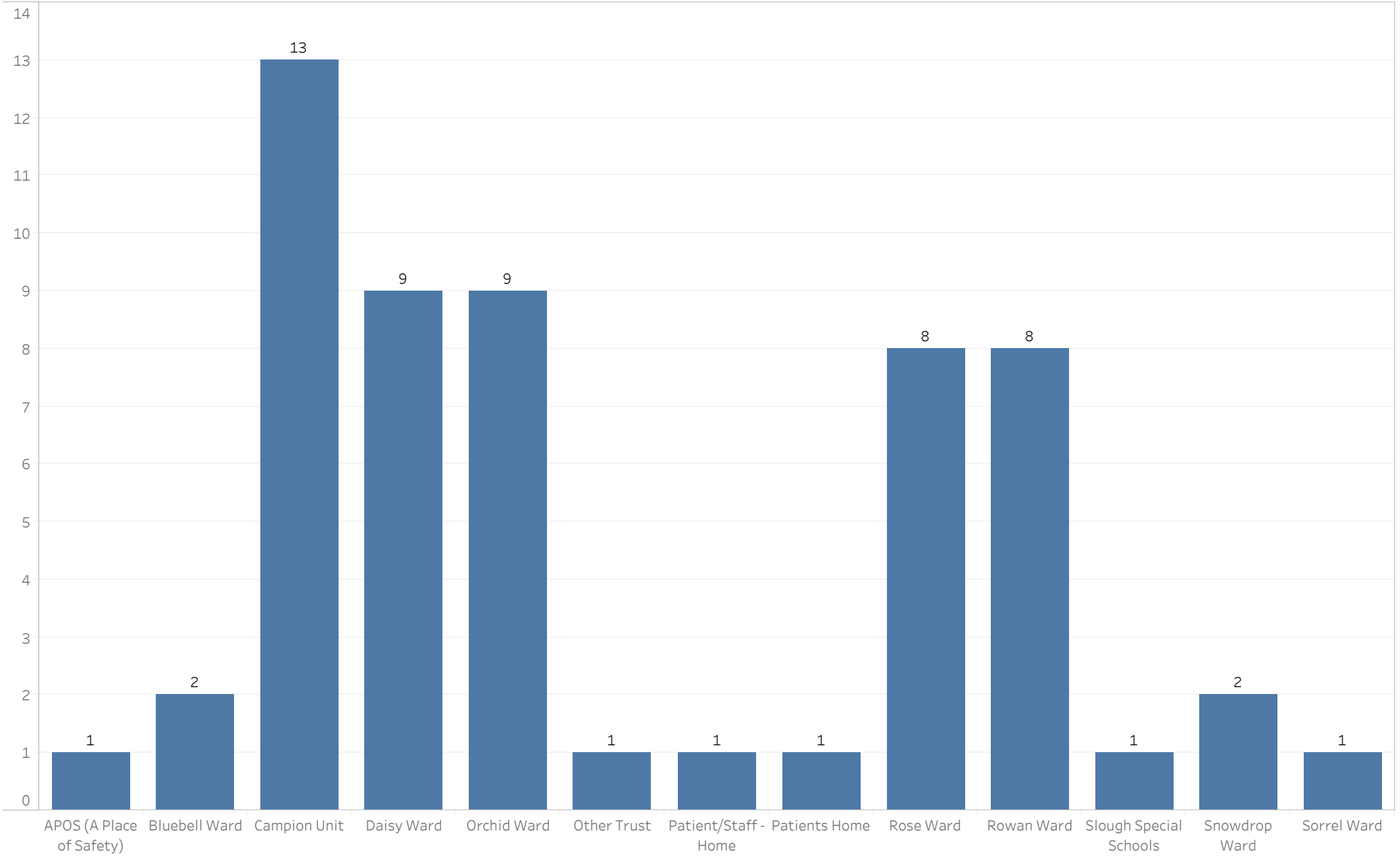


Supporting Our Staff Driver: Physical Assaults on Staff (Dec 21 to Oct 22)

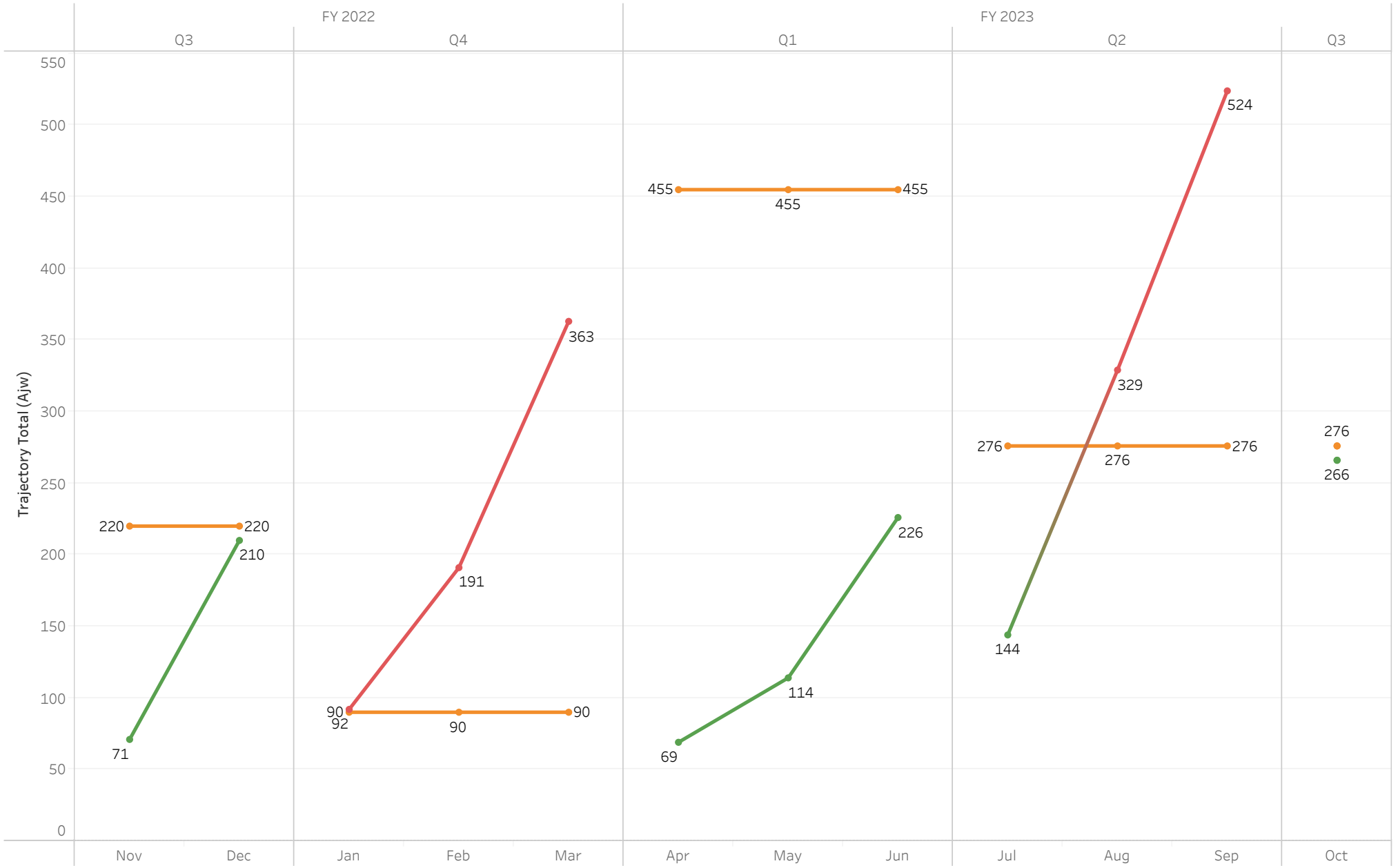
Any incident where sub-category = assault by patient and incident type = staff



Supporting Our Staff Driver: Physical Assaults on Staff by Location (Oct 2022)



Money Matters Driver: Inappropriate Out of Area Placements



True North Supporting Our Staff Summary

Tracker Metrics

		Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
Statutory Training: Fire: %	90% compliance	91.8%	92.3%	91.2%	92.5%	92.3%	92.0%	91.7%	91.8%	91.8%	91.1%	90.7%	89.6%
Statutory Training: Health & Safety: %	90% compliance	95.8%	95.6%	92.6%	95.3%	95.4%	95.5%	95.3%	95.5%	95.9%	95.9%	96.0%	96.1%
Statutory Training: Manual Handling: %	90% compliance	91.3%	91.4%	95.5%	91.0%	89.0%	88.9%	88.3%	90.2%	89.2%	90.8%	90.0%	91.4%
Mandatory Training: Information Governance: %	95% compliance from April 22	95.2%	94.8%	96.4%	95.0%	96.1%	95.9%	96.2%	95.8%	96.0%	95.9%	96.9%	96.5%
PDP (% of staff compliant) Appraisal: %	95% compliance by 31 May 2022	91.4%	91.4%	87.5%	86.1%	79.2%	12.7%	86.2%	98.2%	92.3%	91.4%	89.9%	88.1%

True North Patient Experience Summary

Tracker Metrics

		Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
Mental Health: Prone (Face Down) Restraint	4 per month	3	2	3	2	0	7	4	2	0	1	3	1
Patient on Patient Assaults (MH)	25 per month	17	14	10	25	7	15	20	12	17	14	21	21
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	96.7%	89.1%	77.4%	87.4%	93.0%	95.0%	100%	85.1%	86.5%	87.2%	82.5%	69.8%
Mental Health: Uses of Seclusion	13 in month	2	0	19	10	11	6	6	5	9	6	7	6

		Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
Mental Health Clustering within target: %	80% compliance	79.5%	78.7%	77.2%	77%	78%	79%	80%	81%	79.0%	77.2%	80.4%	79.8%

True North Harm Free Care Summary

Tracker Metrics

Metric	Threshold / Target	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
Pressure ulcers acquired due to lapse in (Inpatient Wards)	<10 incidents	0	0	0	0	0	0	0	0	0	0	0	0
Pressure ulcers acquired due to lapse in (Community East)	< 6 incidents	0	0	0	0	0	0	0	0	0	0	0	0
Pressure ulcers acquired due to lapse in (Community West)	< 6 incidents	0	0	0	0	1	0	0	0	0	0	0	0
Mental Health: AWOLs on MHA Section	10 per month from April 2022	8	2	4	3	12	13	13	11	15	8	7	10
Mental Health: Absconsions on MHA section (Excl: Failure to return)	8 per month	3	5	7	1	7	14	7	3	1	8	0	1
Mental Health: Readmission Rate within 28 days: %	<8% per month	5.20	5.5	5.55	4.90	6.32	9.83	4	5.79	7.92	2.85	5.87	6.45
Patient on Patient Assaults (LD)	4 per month	1	2	1	18	1	9	1	1	0	2	2	2
Uptake of at least one patient outcome measure (ReQoL) in adult Mental Health for new referrals from April 2019	20% from June 2021	14.0%	13.5%	14.0%	14.3%	15.1%	14.6%	15%	14.6%	14.1%	13%	13.5%	13.3%
Suicides per 10,000 population in Mental Health Care (annual)	7.4 per 10,000	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7
Self-Harm Incidents within the Community	31 per month	0	0	15	19	3	2	12	25	32	36	8	21
Gram Negative Bacteraemia	1 per ward per year	0	0	0	0	0	0	0	0	0	0	0	0

True North Money Matters Summary

Tracker Metrics

		Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
Mental Health: Delayed Transfers of Care (NHSI target) Monthly and Quarterly)	7.50%	2.60%	1.60%	3.40%	4.01%	8.95%	10.8%	10.2%	9.49%	8.73%	10.1%	8.78%	9.64%
Increase in Elective Care Activity from 19/20 Baseline (Physical Health only) - First Appointment	4.00%						1.26%	5.75%	0.27%	-4.2%	-6.8%	-6.3%	-0.2%
Increase in Elective Care Activity from 19/20 Baseline (Physical Health only) - Follow Up Appointment	4.00%						-6.9%	-4.9%	-4.0%	-7.5%	-15.%	-13.%	-13.%
Community Inpatient Occupancy	80-85% Occupancy	85.5%	81.5%	83.5%	83.4%	74.7%	85%	86.5%	86.0%	82.5%	80.7%	83.6%	87.4%
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): %	80% Occupancy	92.09%	86.72%	73.56%	80.90%	73.04%	81.02%	73.04%	88%	90.51%	80.82%	87.72%	87.90%
DNA Rate: %	5% DNAs	4.59%	2.90%	4.79%	4.73%	4.56%	4.71%	4.90%	5%	4.92%	1.02%	5.19%	5.24%
Community: Delayed transfers of care Monthly and Quarterly: %	7.5% Delays	5%	4.39%	6.20%	8.64%	11.7%	18.4%	12.6%	11.3%	2.91%	11.9%	10.3%	18.5%
Mental Health: Acute Occupancy rate (excluding Home Leave):%	85% Occupancy	93.1%	91.2%	92.2%	87.2%	91.1%	86%	93.3%	86%	94.4%	95.9%	94.2%	97.2%
Mental Health: Acute Average Length of Stay (bed days)	30 days	52	53	58	58	37	45	49	50	38	47	43	35

Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
C.Diff due to lapse in care (Cumulative YTD)	6	2	2	3	3	3	0	0	2	2	2	2	2
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) infection rate	tbc	1	0	0	0	0	0	0	0	0	0	0	0
Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate per 100,000 bed days	0	0	0	0	0	0	0	0	0	0	0	0	0
Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias (YTD)	0	1	1	1	1	1	0	1	1	1	1	2	2
Count of Never Events in rolling six- month period (Safe Domain)	0	0	0	0	0	0	0	0	0	0	0	0	0
EIP: People experiencing a first episode of psychosis treated with a NICE approved package of care within 2 weeks of referral: %	60% treated	100	71.3	85.7	66.7	100	100	80	100	86	100	100	83.3
A&E: maximum wait of four hours from arrival to admission/transfer /discharge: %	95% seen	99.5	99.1	99.5	98.8	99.1	98	98.9	99.0			99.5	99.2
People with common mental health conditions referred to IAPT will be treated within 18 weeks from referral: %	95% treated	100	100	100	100	100	100	100	100	100	100	100	100
People with common mental health conditions referred to IAPT will be treated within 6 weeks from referral: %	75% treated	97	97	97	98	97	97	96	96	95	96	94	95
People with common mental health conditions referred to IAPT completing a course of treatment moving to recovery: %	50% treated	54	53	52	52	52.5	52	52	56.0	51.8	49	49	47
Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 - Audiology): %	95% to March 2025	99.7	99.7	99.7	100	98.8	99.2	98.2	71.7	47.1	55.6	40.9	35
Diabetes - RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	100	100	100	100	100	100	100	100	100	100	100	100
CPP- RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	98	100	100	98.3	98	99.5	99.5	100	100	99.2	97.8	98.7
Sickness Rate: %	<3.5%	4.92	5.46	5.33	4.59	4.30	4.53	3.95	4.41	5.29	4.37	4.56	
CYP referred for an assessment or treatment of an ED will access NICE treatment <1 week (Urgents): %	95%	46.4%	75%	50%	50%	75%	83.3%	78%	50%	85.7%	50%	66.7%	66.7%
CYP referred for an assessment or treatment of an ED will access NICE treatment <4 weeks (Routines): %	95%	68%	87.5%	46%	50%	87.5%	80%	100%	100%	87.5%	100%	100%	100%
Patient Safety Alerts not completed by deadline	0	0	0	0	0	0	0	0	0	0	0	0	0

Regulatory Compliance - System Oversight Framework

SYSOF

Metric	Threshold / T..	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
Community Health Services: 2 Hour Urgent Community Response %.	80%	88.5%	84%	80.4%	83.2%	81.3%	88.4%	88.2%	89.2%	90.2%	90.4%	88.2%	92.2%
E-Coli Number of Cases identified	Tbc	1	1	1	1	0	0	0	1	0	1	0	1
Mental Health 72 Hour Follow Up	80%	90.5%	92%	90.1%	87.5%	86.4%	96.4%	95.5%	98.4%	94.7%	98.5%	98.5%	96.5%

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13th December 2022
Title	**People and Equality, Diversity and Inclusion Strategy Update**
Item for Noting	
Purpose	**To update the board on our progress and next steps on delivery of each workstream in the People and Equality, Diversity and Inclusion Strategy**
Business Area	**People Directorate**
Author	**Jane Nicholson, Director of People**
Relevant Strategic Objectives	True North Goal 2: Supporting our staff. However, the People Strategy supports all of our goals. The Equality, Diversity and Inclusion Strategy supports both our patients and our people.
CQC Registration/Patient Care Impacts	Deliver safe, compassionate, high-quality care and a good patient experience through a skilled and engaged workforce. The CQC measures our progress against Equality, Diversity and Inclusion objectives both for population health inequalities and also our workforce.
Resource Impacts	The paper will update the board on our Workforce Challenges and provide an update on our Equality, Diversity and Inclusion work which has a dedicated team to support this work.
Legal Implications	N/A
Equality and Diversity Implications	Updates on Equality, Diversity and Inclusion work included in this paper.

SUMMARY	The purpose of this paper is to give the Board oversight of the current People and Equality, Diversity and Inclusion Strategy workstreams led by the People Directorate in support of our workforce challenges.
ACTION REQUIRED	To note the report and seek any clarification.

NHS
Berkshire Healthcare
NHS Foundation Trust

Key Workforce Challenges

September 2022

Jane Nicholson

Key Workforce Challenges

NHS
Berkshire Healthcare
NHS Foundation Trust

Challenge	Action
Supply of Clinical Staff	- Workforce Planning Linked to Business Planning - Increasing apprenticeships - International nurses - Improving recruitment and onboarding processes - Focusing recruitment effort on hard to fill roles
Turnover approaching 17%	Rapid Improvement Event to address issues and agree countermeasures
Staff Progression Disparity	- Talent management roll out to wider organisation - Sponsorship Programme for under-represented groups - Apprenticeships and career pathways
Staff Experience	- Violence Reduction Strategy and action plan - Refresh of leadership offer including Allyship and Cultural Intelligence

Context: Vacancy Rates

NHS
Berkshire Healthcare
NHS Foundation Trust

Trust Name	Sector	HCSW vac rate M02	HCSW vac WTE M02	HCSW rank	RN vac rate M02	RN vac WTE M02	RN rank
University Hospital Southampton NHS Foundation Trust	Acute	25.6%	391.1	1	9.0%	366	20
Maidstone and Tunbridge Wells NHS Trust	Acute	20.5%	151.5	2	18.0%	379	5
Medway NHS Foundation Trust	Acute	19.5%	113.3	3	15.5%	227	9
Portsmouth Hospitals University NHS Trust	Acute	16.8%	189.4	4	12.2%	331	12
Surrey and Borders Partnership NHS Foundation Trust	Mental Health	16.2%	93.8	5	30.5%	281	1
Sussex Community NHS Foundation Trust	Community	15.9%	105.1	6	10.1%	152	18
Royal Surrey NHS Foundation Trust	Acute	13.8%	90.5	7	7.4%	113	24
East Sussex Healthcare NHS Trust	Acute	13.5%	183.7	8	12.0%	282	14
Queen Victoria Hospital NHS Foundation Trust	Specialist	12.5%	13.7	9	15.1%	35	10
Royal Berkshire NHS Foundation Trust	Acute	11.2%	81.3	10	16.3%	343	8
Solent NHS Trust	Community	10.9%	59.9	11	11.9%	118	15
East Kent Hospitals University NHS Foundation Trust	Acute	10.6%	159.3	12	17.1%	539	7
Southern Health NHS Foundation Trust	Mental Health	9.8%	108.5	13	17.8%	361	6
Buckinghamshire Healthcare NHS Trust	Acute	9.7%	73.6	14	10.2%	206	17
Oxford University Hospitals NHS Foundation Trust	Acute	9.1%	137.2	15	7.4%	317	23
Kent and Medway NHS and Social Care Partnership Trust	Mental Health	8.2%	60.5	16	25.4%	299	4
Oxford Health NHS Foundation Trust	Mental Health	8.1%	55.6	17	29.5%	553	3
Berkshire Healthcare NHS Foundation Trust	Mental Health	7.9%	48.0	18	12.5%	156	11
Sussex Partnership NHS Foundation Trust	Mental Health	6.1%	51.5	19	30.1%	519	2
Ashford and St Peter's Hospitals NHS Foundation Trust	Acute	4.5%	24.9	20	12.2%	148	13
University Hospitals Sussex NHS Foundation Trust	Acute	3.9%	67.7	21	1.0%	45	26
Kent Community Health NHS Foundation Trust	Community	3.2%	12.4	22	11.1%	145	16
Dartford and Gravesham NHS Trust	Acute	0.9%	5.1	23	7.9%	110	22
Frimley Health NHS Foundation Trust	Acute	0.9%	10.1	24	10.1%	298	19
Hampshire Hospitals NHS Foundation Trust	Acute	0.0%	0.0	25	2.2%	47	25
Surrey and Sussex Healthcare NHS Trust	Acute	0.0%	0.0	27	8.5%	126	21
Isle of Wight NHS Trust	Acute	0.0%	0.0	26	0.2%	2	27

Source:
SE Quality Report
August 2022

Context: AHP Vacancy Rates

NHS
Berkshire Healthcare
NHS Foundation Trust

AHP Vacancy % Rates and Vacant WTE by System - as at May 2021				
Vacancy Type	Buckinghamshire, Oxfordshire And Berkshire West		South East - Total	
	Rate %	WTE	Rate %	WTE
Registered Paramedics	9.4%	122.6	19.5%	545.6
Registered Radiography (Therapeutic)	38.1%	69.3	18.5%	104.5
Registered Nurses (Working in Theatres - B5+)	12.9%	53.4	12.2%	229.67
Registered Chiropody/Podiatry	23.8%	27.2	11.7%	44.5
Registered Occupational Therapist	6.9%	38.1	7.1%	172.1
Registered Radiography (Diagnostic)	3.4%	15.6	6.3%	147.4
Registered Orthoptics/Optics	7.8%	4.2	6.0%	10.3
Registered Dietetics	5.2%	6.9	5.5%	34.3
Registered Operational Department Practitioners	4.1%	7.9	5.2%	62.3
Registered Speech & Language Therapy	5.4%	13.4	4.9%	46.2
Registered Art / Music/ Drama Therapy	0.0%	0.0	4.3%	2.3
Registered Physiotherapist	3.8%	27.4	3.8%	124.7
Registered Prosthetics and Orthotics	0.0%	0.0	0.0%	0.0

The data shown was created by HEE as at March 2021. Vacancy calculation is an imperfect process, and the data should be treated as indicative not absolute.

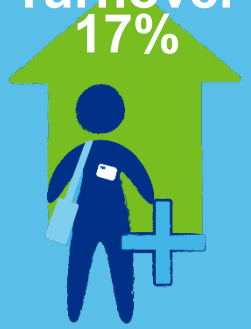
- Paramedic data shown is for SCAS only within BOB.
- The data shows significant vacancy rates for key professions in both the South East and in BOB
- For many professions the vacancy rate in BOB is similar to or worse than the South East average. This means that competition for these professions is fierce both regionally and locally.
- Podiatry vacancy rates are particularly high in BOB and Frimley, and not an issue in the rest of SE. The cause of this problem is being explored in a focused piece of work across BOB and Frimley and will feed into a regional summit late in 2021

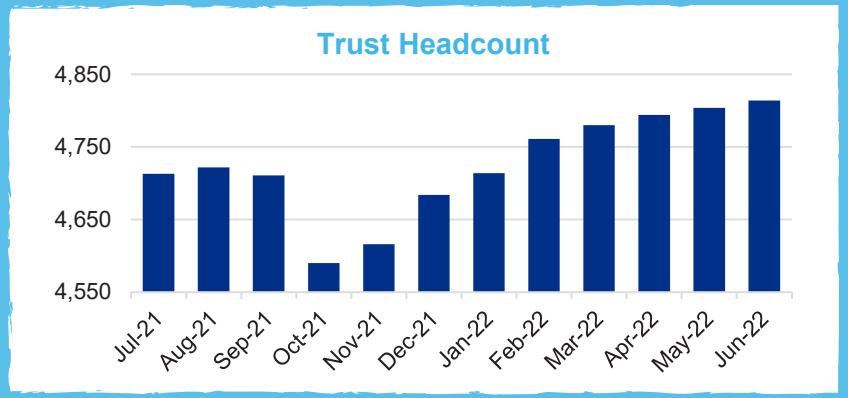
Source BOB AHP Report October 2021

Context: BHFT Workforce Data

Berkshire Healthcare NHS Foundation Trust

Turnover 17%

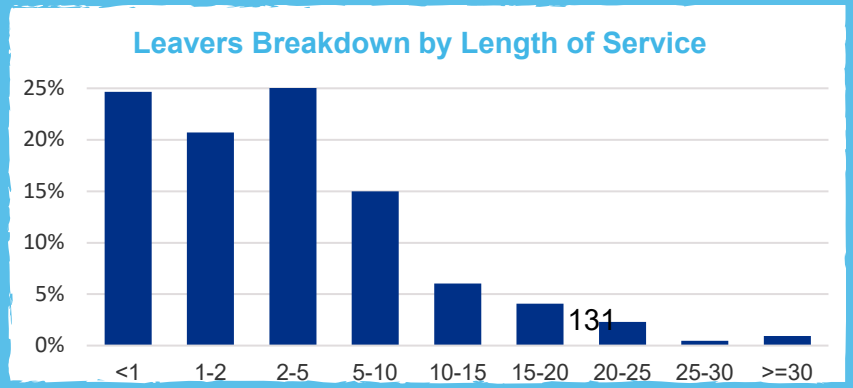




Current Vacancy Rates

Nursing	161
AHP	88
All vacancies	548

Leavers up 31%



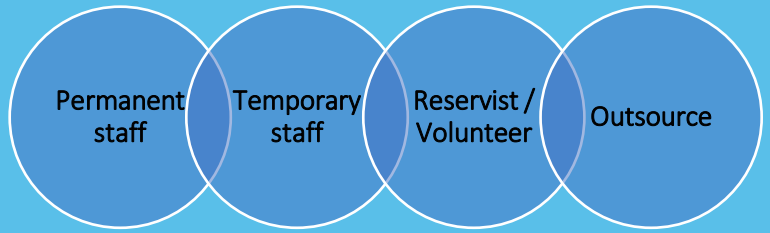
Current Adverts

Nursing	56
AHP	18

Plans to address Workforce Supply

Berkshire Healthcare NHS Foundation Trust

- Effective workforce planning ensures appropriate levels of staff are available to deliver safe, high quality care to patients and service users
- It needs preparing at every level from individual service to system-wide
- And requires an evidence-base integrating workforce availability, finance and activity
- It must be realistic!
- Our workforce and what demand they could meet should be viewed holistically, and considering our 4 main groups



Workforce Model

Ad hoc Recruitment	Student Recruitment	International Recruitment	Growing our Own

- Delivery may need creative thinking due to current/anticipated shortage of skills, or changes in financial envelope or activity
- The design may need to shift so that our workforce availability and options meet our activity and finance by considering
  - Skill mix
  - Digital
  - Other transformation

Our Plans to Address Supply

Berkshire Healthcare NHS Foundation Trust

Short term plan

1. Improved workforce planning and investment in workforce to fill our gaps eg apprenticeships
2. More focus on candidate attraction with creation of dedicated Candidate Attraction team and Recruitment Partners to support services with hard to fill recruitment or big recruitment campaigns

Long term plan

1. Business Process Improvement (BPI) to make our recruitment processes simpler and more efficient
2. Take away interviewing where not needed e.g. temp to perm trial or automatic B5-6 competency progression

Progress to date

Berkshire Healthcare NHS Foundation Trust

We have achieved...

- International Nurses Recruitment Programme started in May 2021 with a pilot with Oxford Health
- In 2021, 4 nurses were recruited to the trust – 3 passed OSCE
- In 2022, we moved to a cohort model and signed up with a new agency:
  - 7 adult nurses arrived in June – all passed OSCE
  - 9 adult nurses arrived in Sept/Oct
  - 5 mental health nurses under offer

Progress to date - Apprenticeship data

Berkshire Healthcare NHS Foundation Trust

We have achieved...

Clinical Apprenticeship planned finishing dates (combined into 6 monthly cohorts)

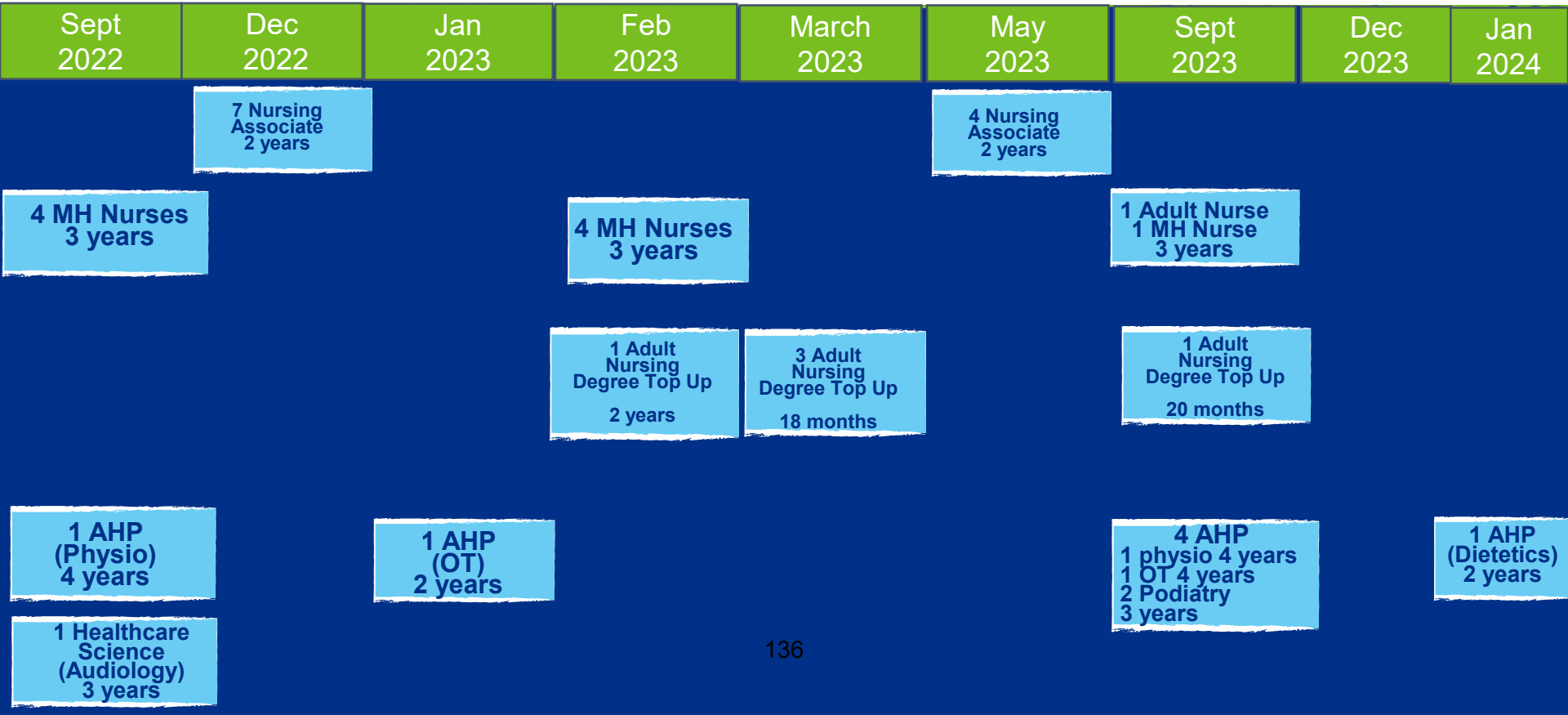
Finishing Date	NAA	RNDA	OT	Physio	Psychological Well being Practitioner	Advanced CLinical Practitioner
Oct 22 - March 23	6	8			8	10
April 23 - Sept 23	2	4	2	3		
Oct 23 - March 24	3	6				
April 24 - Sept 24	1		1	1		
Oct 24 - March 25	8					
April 25 - Sept 25		5	3			
Oct25 - March 26		5				

Workforce funding planned spending data

FY	22/23	23/24	24/25	25/26	26/27	27/28	28/29
Remaining	£311,356	£238,245	£708,460	£1,154,294	£1,371,265	£1,394,539	£1,400,000
Spent	£200,643.92	£784,754.79	£691,540	£245,706.31	£28,735.23	£5,460.65	£0.00
	13 NDA 8 NAA 1 Physio 1 OT 1 Audiology	3 NDA 3 NAA 2 Podiatry 1 OT 1 Physio 1 Dietetics					

2022/23 Apprenticeship Plan

Berkshire Healthcare NHS Foundation Trust



2022/23 IR Plan

Berkshire Healthcare NHS Foundation Trust

Dec 2022	Jan 2023	Mar 2023	May 2023	July 2023	Sept 2023	Nov 2023	Dec 2023

- 5 MH Nurses
- 9 AHP
- 5 adult/MH nurses – cohort 3
- 7 adult nurses – cohort 4
- 8 adult nurses – cohort 5
- 5 MH Nurses

Retention rapid improvement event

Berkshire Healthcare NHS Foundation Trust

Two day QI event held

8-9 Sept 2022

40 attendees from across the trust

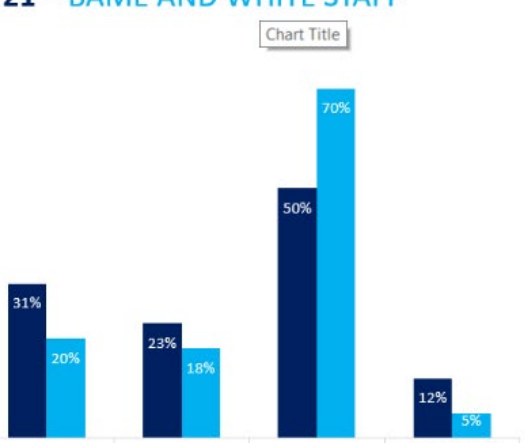
A number of key themes identified and plans being drawn up to address

Outputs will be shared in due course

Staff Disparities – Progression and Experience

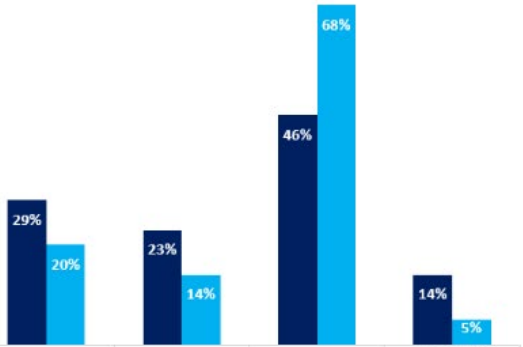
The experience of our staff, particularly our BAME and Disabled colleagues is not always positive, and this is not acceptable.

2020/21 – BAME AND WHITE STAFF



	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	Percentage believing that the trust provides equal opportunities for career progression or promotion	In the last 12 months have you personally experienced discrimination at work from any of the following Manager, team leader or other colleagues
2020/21 BAME Staff	31%	23%	50%	12%
2020/21 White Staff	20%	18%	70%	5%

2021/22 – BAME AND WHITE STAFF



	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	Percentage believing that the trust provides equal opportunities for career progression or promotion	In the last 12 months have you personally experienced discrimination at work from any of the following Manager, team leader or other colleagues
2021/22 BAME Staff	29%	23%	46%	14%
2021/22 White Staff	20%	14%	68%	5%

Staff Progression Disparity: Action Plan

There is a disparity between the progression of our BAME and Disabled Staff and our White and Non-Disabled Staff

Action:

- Talent management roll out to wider organisation
- Sponsorship programme for under-represented groups
- Inclusive leadership competency framework training
- Apprenticeships and career pathways

Staff Experience

Berkshire Healthcare NHS Foundation Trust

941 physical assaults on staff
1020 verbal assaults

95 staff were victims of 700 incidents!

Those 95 staff took 1,268 sick days

Average 5 sick days after an assault

308 assaults on Community Staff

693 assaults on PPH staff

Cost of assaults is £1.3m

Staff Experience Actions

NHS
Berkshire Healthcare
NHS Foundation Trust

New Nexus Page
https://nexus.berkshirehealthcare.nhs.uk/no-excuse-for-abuse

New Conflict Management Approach

Anti-Racism and anti-discrimination approach

Violence Prevention and Reduction Strategy and Policy

Civility and Respect Training

Next steps

Berkshire Healthcare
NHS Foundation Trust

Apprenticeships

Candidate Attraction

Retention

Employer of choice

Recruitment marketing and social media strategy

Recruitment automation

International AHP and nursing

Competency based progression

People Strategy Summary Report - November 2022

NHS
Berkshire Healthcare
NHS Foundation Trust

People Strategy Key Priorities	Work Strand	Plan on a Page	Progress Measure	Status	Key Risks	Mitigations	Next Steps	RAG Rating
Growing & Retaining our People	Retaining Staff	We will achieve high levels of engagement across all of our services and increase the numbers of staff who feel they have an influence on how we work and make decisions. We will improve recruitment, retention and satisfaction of our staff.	To keep our voluntary staff turnover to less than 16% throughout 2022/2023.	There was an upward trend in voluntary staff turnover during 2021/22, and the very ambitious target set in March 2021 fo the end of 2021/22 was not achieved. Whilst the Trust turnover remains high, (and higher than some ICS partners), and the current figure is above 16% at 17%.	The number of leavers remains high and of concern, partly as high turnover continues to increase the pressure on existing staff.	Pipeline strategies are developing and in addition to the introduction of new fixed term Recruitment Partners in each of the Divisions to support fast track recruitment and hard to fill posts, there is much focus on international recruits (nursing and a small pilot for AHPs) and apprenticeships and early careers innovation.	0	
			RIE Retention	With the support of the QI team, a rapid inprovement event has been held in 8th and 9th September 2022 with stakeholders from HR and services attending.	Waiting for outcome of steering group	Following the RIE in September, we have an action plan consisting of 5 workstreams that address the main areas to reduce our turnover. A talent attraction and retention steering group has been established and ToR are currently being drawn up for each of the five workstreams.		

Work Strand	Plan on a Page	Progress Measure	Status	Key Risks	Mitigations	Next Steps	RAG Rating
Attracting & Onboarding Staff	Attracting a skilled and engaged workforce who will deliver safe, compassionate, high quality care and a good patient experience	Deliver international recruitment programme for 2022 - 14 international nurses and 3 OTs and 1 podiatrist	2022 adult nurse target exceeded - 17 nurses have joined this year. 7 have passed OSCE, with another 8 currently going through training. MH nurse recruitment remains challenging. Following successful HEE bid for AHPs, recruitment campaign underway for 3 OTs and 1 podiatrist. We have engaged with NHSP to recruit a further AHP's.	The recruitment of international nurses is very labour intensive, and there is much learning from experience underway for both the recruitment work and the clinical education team. We have had feedback regarding the disparity of financial support between international candidates and those who join through out programme.	Plans being put in place to ensure that the workload of managing international nurses recruitment, onboarding, pastoral support, OSCE preparation and exam is evenly distributed throughout the year, rather than spikes in workload. We are putting together a business case to address this disparity.	International Recruitment - develop plans for 2023 cohorts and ensure procurement tender process followed to appoint new agency. Following a recruitment QI workshop held this month looking at the end-to-end processes we have developed an action plan to address and we are also working closely with Trac to understand how to utilise the recruitment system better and more efficently for both candidates and managers	
		Create and deliver a successful candidate attraction strategy by reducing time to hire and giving candidates a better experience	Candidate attraction approach created. Now that we have a dedicated early careers manager on board we have planned and delivered 12 school/university events to date, an example is a virtual community nursing event where we recruited two candidates and another 7 for NHSP working collaboratively with services and recruitment partners. We are also working with AHP professional leads, services and Mar Comms to ensure visibility of our BHFT events engagement plan.	To deliver our candidate attraction marketing strategy, admin support is required due to volume of work.	Recruitment underway for a temporary part-time administrator to support creation of our careers hub.		
		Introduce initiatives to ensure BHFT is an inclusive employer, accessible to all	A number of projects are underway, including sharing questions interview pilot, we are now looking to explore this as a research project with a local university. BOB inclusive recruitment project for HCSW. We are drawing plans to attend a wide variety of events to ensure we attract a diverse workforce for example we are attending an Over 50s job centre event this month. We have created a recruitment marketing toolkit to ensure we are exploring new channels to promote our roles like lgbtjobs.co.uk.	0	0		

Work Strand	Plan on a Page	Progress Measure	Status	Key Risks	Mitigations	Next Steps	RAG Rating
Training & Clinical Education		To review our clinical skills progamme and to provide inclusive, accessible and high quality training programmes to our clinical workforce as appropriate for the professional role, development needs and level of practice and a system to monitor essential skills training compliance .	Phase 1 is completed. All clinical skills training programmes reviewed and revalidated and transfered from SLATE to Nexus learning platform. Phase two: Essential training matrix and a new tab to monitor compliance are under development. Training matrix will be ready by 31 DEc 2022 and the software development is due to complete by March 2023 CE administrators have completed Totara user training to support guest account creation	A small number of services are still working on the essential skills data.	Team are supporting services to complete the data collection tool Ongoing conversations with Estates and Clinical trainer group to oput contingency plans in place. Exploring options to offer training on the ward.		
		Develop and execute a strategy to strengthen relevant training pathways and academic partnerships to support widening participation and workforce development from entry level to advanced level of practice so that we have a minimum of 60 extra clinical candidates per year available for recruitment into various workforce vacancies	T -level programme - Progressing as expected. Reservist programme has been commenced International nurse programme - First cohort is compleetd and 100% pass. Second cohort starting in October. Mental Health CBT platform is being developed by the national team. We aim to develop in-house MH OSCE training in 2023. Bridging programme in place . Progressing as expected. RTP/PIN/Student recruitment: Programmes are in place; recruitment strategy under development. Discussion at November SPG 2022 Apprenticeship - Talent attraction and retention steering group is established and actions agreed. Implementation of the apprenticeship audit recommendations is in progress. WP/apprenticeship team vacancies are filled. Apprenticeship principles document is under dvelopment. Paper being presented to December SPG.	No processes for the recruitment and retention of the learners being training through these pathways (T-level, PIN programme, RTP, Pre-reg)	Processes under development		

		Our ambition is to ensure clinical education within Berkshire Healthcare is outstanding and equitable for all relevant workforce groups. We will achieve this by planning and delivering high quality, accessible training that is relevant to professional roles and aligned to Trust priorities to support professional developmenta and to maintain safe levels of clinical skills mix within patient facing teams.	Complete a review of our statutory and mandatory training programme, and make sure there is sufficient training to meet the needs of our workforce now and in the future and to make sure these programmes are equally and easily accessible to all staff.	Training venue - Erlegh House/St Marks/Upton: Storage areas for RESUS & Manual handling have been built in Erlegh & St Marks. Upton (Sanctuary Rm) buidling has been signed off and will be completed by end of Nov. Training Schedule: Venues have been secured for Manual handling (MH), RESUS and clinical education courses from Jan-Jun23. MH dates have been published from Jan - Mar23. RESUS dates to be published by end of Nov once agreement made on launch date of new RESUS training titles. This should be confirmed on Friday 25th Nov at RESUS council meeting.	MH training has a significant in-balance of renewal dates across 2023. (25% Jan-Jun, 75% Jul-Dec). This needs to be addressed. Finalisation of all Induction venues for Jan-Jun23.	Manual handling dates for Jan-Mar23 have been published for EH & Upton courses. 6 dates for WBCH will be publish by 02/12/22.	New training space workshop resources agreed, so project can formally commence. Phase 2 of our project is a review of stat man training. The first step is to understand the variety and amount of training that professional groups are required to do and to link this into calculations of safe staffing The Training and Clinical Education teams will be working with the Education Advisory Group to ensure that there is clear governance for any changes to training or training processes. The expand and convert programmes to increase clinical candidates by 50 have all started and are progressing to plan. We also continue to work on the improvement of training processes through our Business Process Improvement work.	
				Provision of RESUS training to workforce: Current compliance across the four RESUS titles - 78.2% (743 non compliant staff).	Focus on BLS/ILS & Ward combined Skills training needs during Nov-Dec22 has created a significant back-log of DPABLS & PABLS training requirements. Consideration needs to be given to the changes to the RESUS course offering that will be introduced in the first half of 2023. There are also some significant peaks in training demand across the year that require balancing out.	January and February 2023 RESUS courses will be published on Monday 5th December. These will have focus on addressing the back-log of DP-ABLS & P-ABLS training requirements. Investigating into external venue options and equipment transprtation + associated costs (Bracknell OLC & Maestro's).		
				Appraisal Platform - Review of first draft platform held on Nov .9th with Think-Learn. Planned testing as active users to take place from W/C 21st Nov and review group meeting in W/C 12th Dec to submit feedback.	Appraisal: Current ESR hierarchy may allow administrators with super-user access sight of the wider teams appraisal content. This was discussed at the appraisal 1st feedback session 28/11/22.	Solutions to this position are being explored and will be reviewed at the next feedback session.		
				ESR/LMS interface project - ESR data file has been uploaded to Think-Learn. Meeting scheduled for 30/11/22 to go through file testing process.	None currently	Meeting with Think-Learn 30/11/22.		
				DNA & Late cancellation data - Pearly Thomas will be using this as her Yellow Belt project. The Training & Compliance team will assist with data requests to support this activity.	The situation that we are experiencing with our RESUS training provision is a direct outcome from the level of DNA's that have been experienced over the past 12mnths. We need to address this problem urgently.	The QMIS approach to provide some actions that will address the on-going challenges of DNA's. The provision of training at localities through moving out of FWH.		
				Development of Nexus system - Updates on the following areas: - Reporting access for line managers. This is now live but has not been launched to Trust. Team will be creating support materials in Oct prior to launch. Meeting with Think-Learn to release wider acces to data to specific roles (HRBP's, Business managers...etc). Creation of 'Essential training' area for clinical education titles. See PT for update. Defining areas of responsibility for Nexus course ownership for CE & Compliance teams. Meeting held on 12th Sept. Actions from meeting to be completed and further collaboration between S&M and CE teams.	ESR hierarchy project will remove admin access to training report data for teams. Defined areas of course ownership need to be established between CE & Compliance teams to ensure consistency & collaborative working.	Meeting dates set for CE & Compliance team to discuss who will support what course content within Nexus. Supporting tools currently being devised to support launch of reporting access.		

				Kindness Programme - Launched on 4th Nov. As of 21/11/22 - 70 delegates have registered for sessions A & B. 33 have attended A & 13 have attended B.	Need to relaunch programme through L&D news. Will be promoted every-other week. Some session dates will be cancelled in Dec due to low number. A Kind Life are contacting delegates directly and informing them of available dates.	List of those that have registered and attended is being shared weekly with the HRBP's to review who has completed the training.		

People Strategy Key Priorities	Work Strand	Plan on a Page	Progress Measure	Status	Key Risks	Mitigations	Next Steps	RAG Rating
Looking After Our People	**Wellbeing & Rewards**	Continuing to support the health and wellbeing of our staff, particularly focusing on reducing sickness absence related to stress and MSK by developing our psychological and physical support offer	To achieve the top score for the percentage of people reporting that the organisation takes positive action on health and wellbeing within our peer group in the Staff Survey.	The Trust Wellbeing Plan launched with the People Strategy has been fully delivered and now needs updating. This will incorporate key wellbeing deliverables as outlined below. Wellbeing Matters continues to grow across the ICS audience. Funding has been delivered for 22/23 - ongoing funding for next year is uncertain.	People have dealt with many challenges during Covid and the pandemic and are now having to deal with the cost of living crisis We risk staff becoming unwell both mentally and physically and potentially burning out with higher levels of stress and anxiety.	Wellbeing Plan will be designed to support our people as much as possible in these situations. It will draw on best practice, specialised support and embedding this at a local level	- Refresh Wellbeing Plan, seeking to address the current needs of our people and includes and expands upon a number of the initiatives currently in progress as part of the people Plan. the Plan will be realigned with the Every Action Counts guidance received by Trusts and monitored through the Safety Culture Group. - Continue to work actively with system partners and seek to expand collaboration through the ICS using system funding.	

People Strategy Key Priorities	Work Strand	Plan on a Page	Progress Measure	Status	Key Risks	Mitigations	Next Steps	RAG Rating
Belonging to the Trust	Talent & Leadership	We are focused on our leaders and managers to ensure that they are equipped to support their teams with inclusive behaviours and that they take the necessary action to create an organisational culture that supports inclusion and belonging for all. We know that our disabled, LGBTQ+ and BAME staff all have worse employment experiences compared to other staff so we need to understand the reasons why and tackle inequalities and differentials in experience. Through this we will - improve the recruitment, retention and satisfaction of our staff.	To ensure that Berkshire Healthcare is a great place to work for everyone, we aim to increase our position in the NHS Staff Survey to best in class within the 'immediate manager theme'. We will focus on improving the leadership behaviours in those areas of our trust with lower leadership scores.	Our corporate work continues to plan. In addition, targeted work has commenced with those areas with lower scores. However, we need the commitment of local teams to tackling these issues for this work to be successful. The People Strategy, EDI strategy and Staff Survey results have been presented and discussed with the BAME, Pride and Purple networks. Meetings have taken place with CYPF, Estates and Facilities, People & HR, Mental Health West, Pharmacy, CHS East with meetings booked for MH East Division and CHS West. The results have been shared with the HRBP to pass onto the PPH SLT outcome of PPH visit. RIE Retention has taken place	Local engagement around the leadership theme continues however we are mindful of current pressures on services due to conflicting priorities and a risk of overburdening tired and busy managers and teams. Services are reporting they do not have time to do some of the activities we know lead to better engagement due to work pressures.	The People and EDI Strategies are now mission critical and this may bring more focus to this work as local QI priorities in services. We continue to work with teams on a case by case basis and support as necessary.	This work forms part of the Trust EDI Strategy and is also part of our EDI strategic priorities. As such this programme reports via the Diversity Steering Group. Detailed updates on these strands of work can be found in the EDI Strategy Update. Our Leadership work progresses well with an interim Excellent Managers Programme that includes content to support delegates with increasing their EDI skills.	
		0						
	Work Strand	Plan on a Page	Progress Measure	Status	Key Risks	Mitigations	Next Steps	RAG Rating
	BAME Transformation Programme - Addressing Disparities of Experience - bullying, harassment and microaggressions	We know that our disabled, LGBTQ+ and B.A.M.E. staff all have worse experiences and fewer opportunities for career progression compared to other staff so we need to understand the reasons why and tackle inequalities and differentials in experience. We will have zero tolerance to bullying and harassment. We will reduce violence and aggression towards staff. Our recruitment and retention processes and opportunities for career progression will be fair and equitable for all staff to attract and retain a diverse workforce	That no one in our trust experiences bullying or harassment and our first step towards achieving this is that by 2023 we have eliminated the differential in experience between staff with identified inequalities in comparison to the rest of our people.	This is a long-term priority. Work continues to progress well. However early indications on our gender pay gap report suggests that our position is worsening and we will provide a full update on this will be going to the Board. The agenda is progressing well and we will be able to share more information in due course. There has been actions identified in WRES & WDES improvement plan appendices to detail initatives to address the differential in experience. These include the development of violence reduction strategy and the dispute resolution framework and REN sponsorship programme. The trust is in the process of developing an anti-racist programme supported by an emerging anti-racism task force for which ToR have been drafted.	There are local strands of work in some services to address violence, bullying and harassment. There is a risk that we don't co-ordinate this activity resulting in duplication and a fragmentation of approach.	The Safety Culture Group will now take oversight and coordination of the violence reduction work.	Gold Egele has engaged with other members of staff who have previously worked on the three worksteams detailed in the key deliverables below to ascertain at what stage they are at and receive any updates. Options being considered - create a job matching process for candidates who wish to be considered for the alternative same band roles so that they can be matched with vacancies in other teams/services. Create a job matching process for the band 5-6 nursing candidates who meet pre-defined competances and behaviours, this will be rolled out to AHP roles at a later date. Both will be a pre-cursor to the development of an external/internal talent pool process. Secondment policy review and internal staff policy, guaranteed interviews for internal staff.	
	Inclusive Patient Experience	•Having a clear approach to capturing ED&I patient data across protected groups remains a priority and forms part of ongoing commitment to aligning with changing trends and legal frameworks. •Embed the Accessible Information Standard for disabled patients across all services and all protected groups. •Harassment, bullying or abuse from patients, relatives or the public in last 12 months against BAME staff – which we have addressed above •Embed reasons for and recording of patient demographics to improve health outcomes. •Identify actions and resources needed to identify health inequalities through community engagement There is a reducing health inequalities sub group focusing on differentials in experience •Continue to promote LGBT+ engagement and support through Stonewall and Reading Pride. •Co-produce actions and resources needed for Trans patient's pathways	That we have a clear approach to capturing ED&I patient data across all protected groupss and forms part of ongoing commitment to aligning with changing trends and legal framework and our first step towards achieving this is that by 2023 we have eliminated the differential in experience between patients with identified inequalities in comparison to the rest of our people.	This is a long term priority. Work continues to progress well. GE has initiated a co-production on Accessible Information Standards with the staff networks and wider staff groups. Digital transformation has approved a request for changes on Rio completed by GE and next steps is a f2f to be facilitated by Digital transformation to sccope what the AIS will look like. This piece encompasses and impacts almost all the current patient objectives. This co-production is also aligned with the reducing health inequalities subgroup workstrand. Reducing Health Inequalities working group is meeting on 30th November 2022 to identify what work is needed for the accessible information standard and other engagement piece which they have been tasked by the RHI steering group.	There are local strands of work in some services to address health inequalities. There is a risk that we don't co-ordinate this activity resulting in duplication and a fragmentation of approach.	The Reducing Health Inequalities Working Group will now take oversight and coordination of the reducing health inequalities work and report to the Oversight Group.	•Focused on reducing bullying and harassment from patients with capacity towards BAME staff and focused on our inpatient mental health unit, PPH where most incidents occur. •Clearly communicating our expectations of behaviours to patients and carers and have a policy to escalate any issues including sanctions against patients with capacity who behave inappropriately towards staff •Embed the Accessible Information Standard for disabled patients across all services and all protected groups.	

People Strategy Key Priorities	Work Strand	Plan on a Page	Progress Measure	Status	Key Risks	Mitigations	Next Steps	RAG Rating
New ways of working	Digital Transformation	We will make all of our services more efficient and reduce waste We will work with services to plan the workforce required as they redesign and integrate services to improve patient experience and outcomes	Reduction of our workforce gaps	A number of services are experiencing impactful workforce and skills gaps, combined with high demand/waiting lists and expansion plans. This is resulting in rising demand for immediate workforce support from a depleted market, and in some cases, little capacity/resourcing to look further ahead until this is addressed. Continuing to work with services and finance to understand workforce demands including commissioning changes e.g. CAMHS, West Mental Health Transformation and Ageing Well. During the operational planning round for 2022/23 and beyond, increased focus will be applied to identifying affordable target establishments – some vacancies will need to be removed for the services without investment and significant transformation required to deliver within our available resource. This may require us to deliver some of our services differently.	For some of the ambitious workforce growth plans that are supported by funding flows, the current state of readily available workforce for both substantive and temporary staffing does not align. Demand for support from the People Directorate is high but we have limited resources to support this work. The workforce supply issues are also driving up agency charge rates with high competition to secure limited staff, in addition to significantly increasing the overall demand for temporary staff.	A restructure in the HR Team creating HR BP posts will enable a higher level of focus for these activities. We are looking at ways to expand their ability/capacity and give them further tools to be able to support the services through sharing of internal knowledge and looking at other learning options available within the system. The ICS-wide temporary staffing programme of work to develop shared and agile workforce, and deliver an improved grip and control over agency usage/compliance/enhancements has commenced. Identifying our true vacancy gap (for services without investment) and our affordable establishment remains a priority and the HR Team will form part of the Operational Planning rounds led by Finance and the services.	The Trust faces significant workforce challenges as we try to adapt and sustain services post-Covid. We have a People Recovery Plan which links into many of the strands of work in the People and EDI strategies. The plan focuses on supporting staff wellbeing, sustainable service recovery underpinned by workforce planning and supporting our people and our teams to work in new ways. Frimley currently has the highest vacancy rate in the SE and BOB is not far behind.	
			Agree and deliver a plan to streamline those people processes that involve the most waste, duplication of effort or potential for error, releasing the administrative burden on our people and allowing more time to care for our patients.	This is a collaborative project with colleagues in IMT. We are now in the user testing phase of stage six which is automation of the A form, seperately following the recruitment workshop this month we have identified a number of quick wins which we are in discussion with IT to implement.	Finances and resources may constrain the ambition of this project.	The business case for our work needs to be self-sustaining returning value equal or greater to the investment.		
	Post COVID 19 Workforce Planning	Developing our four pillars of workforce growth to attract new and existing talent to reduce workforce gaps and deliver our services, providing the bext possible patient care	Month on month increase in total substantive workforce to meet operational plan (and supporting initiatives such as temp > perm) to c4600 FTE by March 2023 (to be adjusted at later date due to the need to align with operational planning/financial reset for 23/24*), utilising bank/necessary agency where appropriate to support safe services and mitigate the gaps	Substantive staffing increased to 4106fte (worked) in November. Bank/agency currently mitigating gaps due to vacancy, sickness and increased workload supporting an additional 550fte (bank increased to 471fte, and agency dropped to 79fte).	0	0	Evaluation of HCA Development Trial at PPH as part of the temp to perm initiative	

Trust Board Paper

Meeting Date	13th December 2022
Paper Title	**Quarterly Status Report on Key Trust Initiatives**
	Item for Noting
Purpose	This document updates Board members on the current status of the Trust's key programmes and projects
Business Area	Corporate
Author	Director of Projects
Presented by	Alex Gild
Relevant Strategic Objectives	The portfolio of initiatives addresses all the Trust's True North goals
CQC Registration/Patient Care Impacts	The portfolio of programmes and projects includes activities to maintain our CQC registration and improve standards of patient care, outcomes and experience.
Budget/Resource Impacts	As per individual projects
Equality, Diversity and Inclusion Implications	As per individual projects
Brief Executive Summary	Paper to provide assurance and oversight of the Trusts Strategic initiatives and the projects that will deliver True North and strategic priorities. The report provides a status update on the Trust's combined programme, projects, and strategy implementation.
Recommendation/ Action Required	The Board is asked to note the status of the Trust's key initiatives.

Berkshire Healthcare NHS Foundation Trust

Quarterly Status Report on Key Trust Initiatives

Author: Karen Watkins & Neil Murton, Director of Projects

Director: Alex Gild, Deputy Chief Executive

Date: 30th November 2022

Purpose

This document has been prepared to update the Trust Board at its December 2022 meeting regarding the status of the organisation's portfolio of key programmes and projects prioritised as Mission Critical and Important, together with other priorities and initiatives to deliver the Trust's vision and Trust North Goals.

Members of the Trust Board are asked to review and note the report.

Document Control

Version	Date	Author	Comments
1	30.11.2022	Karen Watkins & Neil Murton	The document reflects the highlights of the Combined Projects/SIP Report submitted to the Business & Finance Executive on 28th November 2022

Distribution:

All Trust Board Members

Document References

Document Title	Date	Published By
Quarterly Status Report on Key Trust Initiatives	August 2022	Karen Watkins & Neil Murton Director of Projects
Quarterly Status Report on Key Trust Initiatives	April 2022	Karen Watkins & Neil Murton Director of Projects
Quarterly Status Report on Key Trust Initiatives	Jan 2022	Karen Watkins Director of Projects
Status Report on Trust Strategic Initiatives	Sept 2021	Karen Watkins Director of Projects
Status Report of Trust Strategic Initiatives as impact by the COVID-19 Pandemic	May 2021	Karen Watkins, Director of Projects
Status Report of Trust Strategic Initiatives as impact by the COVID-19 Pandemic	Feb 2021	Neil Murton Director of Projects

CONTENTS

Purpose of Paper

To provide an update, assurance and oversight of the Trust's Strategic initiatives and the projects that will deliver True North and strategic priorities.

Introduction

The Trust identifies its significant strategic projects and programmes through a strategic prioritisation process which references a Strategic Filter. This process was established as part of the Trust's Quality Improvement (QI) Programme and provides the Trust with control over its programme and project portfolio, including assurance that it is focusing on the right priorities ("True North") and that there is best use of resource in the organisation.

Prioritised projects are included on the Trust's Strategic Prioritisation Board and progress of those projects is monitored at Executive level through a monthly Report to the Executive Business & Finance Group.

That report was provided to Board Members in May, September, and December 2021 to provide an update on the Trust's key schemes. It was then requested that an overview be provided for members, rather than the full report and the first of these was provided for the February 2022 Trust Board and most recently to the September 2022 meeting.

An overview is provided here of the projects and programmes on the Strategic Prioritisation Board, including the highlighting of newly established initiatives; those moving to business as usual; those recently closed, together with any initiatives currently reporting an Amber or Red RAG status along with associated implications and risks.

Trust prioritised projects

The current portfolio of prioritised programmes and projects included on the Strategic Prioritisation Board is listed below, against the True North goals they primarily support. Strategic initiatives (shown in coloured font) also now feature on the board. Larger scale projects will inevitably support more than one True North Goal and therefore the groupings below reflect the main True North goal the project supports.

Supporting True North Goal 1 – Harm Free Care (Providing safe services) • Community Hospitals ePMA (electronic prescribing and medicines administration) • Safety Strategy • CYPF Referral Management System	**Supporting True North Goal 3 – Good Patient Experience (improving outcomes)** • East Children's Therapies (currently paused) • Community Mental Health Transformation Programme (incorporating Frimley and BOB CMH transformation) • BHFT One Team (CMHT transformation and Alternative to CPA) • Neurodiversity Strategy • Virtual Wards (Berkshire West Hospital at Home) • Community Rehabilitation Enhanced Support Team (CREST) • Op Courage • Digital Strategy • Access & Flow
Supporting True North Goal 2 – Supporting Our People (A great place to work) • Workforce (Our People Strategy) • EDI Strategy	**Supporting True North Goal 4 – Money matters (A financially sustainable organisation)** • PPH Bed Optimisation • Green Plan • Redevelopment of East Community Hospitals (Frimley Integrated Care Hub Programme) * • Reading Estates Review Part 2* • Replacement of Fitzwilliam House*

* These initiatives do not feature on the Prioritisation Board but are included with reports to the Business & Strategy Executive Group.

Summary of Project progress end of November 2022

The status of the Trust's key Programmes and Projects is summarised below:

Project	RAG Status	Comment (see report section below for further detail)
Children's Therapies East	Paused	Paused due to lack of progress and dependency on other organisations. Project due to be reactivated in January 2023.
People Strategy		Overall, Amber, but the Attraction & Retention workstream continues to report RED. Retention RIE to update on counter measures, note turnover reduced to <17% in October 2022.
EDI Strategy		Organisation Anti-Racism commitment / impact being scoped alongside targeted community service action, building on success at Prospect Park Hospital in actively tackling discrimination against staff.
Community Mental Health Transformation Programme		This programme now incorporates the Frimley and BOB CMH transformations.
Berkshire Healthcare One Team		The scope of this initiative includes core CMHT provision and Alternative to CPA.
Prospect Park Bed Optimisation		Significant work being undertaken, but currently behind schedule re. achieving its bed usage and reduction in acute/PICU out of area placements.
Community Rehabilitation Enhanced Support Team (CREST)		Due to recruitment challenges, CREST is now planned to commence in January 23.
ePMA (electronic prescribing)		Now working to a later timescale with implementation plan on track to deliver community ward system.
Safety Strategy		
Green Plan		Progress impacted by challenges in recruiting Sustainability Manager (interim now appointed).
Neurodiversity Strategy Implementation		Strategy complete and implementation prioritised in November as Important.
CYPF Referral Management System		Resourcing issues – Red until resolved
Virtual Wards (Berkshire West Hospital at Home)		NHSE/I initiative to improve capacity and flow.
Redevelopment of East Community Hospitals		Red due to significant concerns about affordability and achievability.
Fitzwilliam House replacement		Now rated Green due to certainty around the future premises and associated timescales. Staff currently being consulted.

Reading Estates Review Part 2		Strategic Outline Case approved. Outline Business Case development will commence when resources allow.
Southeast Op Courage veterans' MH/wellbeing services collaborative		The award of this contract with the Trust as lead provider has recently been confirmed. The mobilisation project to establish the new service arrangements is underway.

Two projects are rated Red:

Redevelopment of the East Berkshire Community Hospitals – This is a Frimley system initiative to establish Integrated Care Hubs across the ICS and include new build and refurbishments of NHS community estate. The Trust has been supporting the project team (particularly regarding financials) and outline business cases have been developed. However, there are significant concerns about affordability and achievability, particularly considering reduced access to central capital. Consideration of alternative schemes/approaches is likely to be required.

CYPF Referral Management System - This project is to improve the effectiveness and efficiency of the referral process for all CYPF services, initially prioritising CAMHS and CYPIT. There has been a significant increase in demand since the current arrangements were established in 2017 and these are no longer fit for purpose. The initiative was previously reporting Amber due to uncertainty around resourcing, but is now reporting Red. Further analysis of current problems has yielded a preferred solution which represents a major change in scope and would require significant support from corporate services (yet not confirmed), together with a revised timeline.

Six projects are rated Amber:

People Strategy - This includes several workstreams. A key determinant of the overall status of Amber relates to the work on attracting & retaining staff, which is reporting as Red. The turnover rate for October 2022 has reduced just below 17%, still reflecting continued pressures in the employment market and the number of leavers remaining high.

EDI Strategy - actions are continuing to progress in accordance with plans, yet these have not yielded the desired impact and the initiative is consequently reporting as Amber. Developing an Anti-Racism focus, commitment and intent in the organisation may help to break-through on WRES indicators in actively addressing staff experience of discrimination, based on positive action and impact noted by staff and patients at Prospect Park Hospital.

Prospect Park Bed Optimisation project – This initiative (comprising a number of work streams) is reporting as Amber as it is currently behind schedule regarding achieving its associated targets. A considerable amount of work is being undertaken to bring this under control, but the number of acute overspill placements remains high. There is a bed flow issue for Slough and a high average length of stay for patients from Wokingham.

The national target date for the eradication of inappropriate out of area placements (OAPs) is March 2024, but the Trust's target to achieve this is being retained as March 2023. This will be reviewed in the New Year.

Community Rehabilitation Enhanced Support Team (CREST) - Progress on the establishment of the team has been impacted by the absence of the Service Manager and due to the initial advertising of the key role of Team Leader failing to attract any applicants. Alternative arrangements are being progressed and it is still planned for an initial service offering to commence in January 2023. The initial focus of the team will be to bring people in specialist mental health placements back into Berkshire and support them in a community setting. The OAPs Team have identified patients who may be supported in this way and their care arrangements are currently being reviewed.

Green Plan – This initiative previously reported as Amber due to the key post of Sustainability Manager remaining vacant and proving challenging to fill (with consequent impact on progress). An interim manager was recruited in October, with the implementation plan and associated required resources needing to be reviewed and prioritised.

Reading Estates Review (Part 2) – A Strategic Outline Case has been developed and approved. The next steps involve development work to compile an Outline Business Case. A review and extension of the timeline for this initiative is likely, in view of the Trust's capital funding position.

Note that the Community Hospital ePMA (electronic prescribing system) was previously reporting as Amber due to resourcing issues, but at the November Business & Finance meeting was judged to be Green considering confirmed revised plans. The first ward is due to "Go Live" in February, with all being completed by June 2023.

One project is Paused

Children's Therapies East – This initiative (previously Red) was paused due to associated risks, lack of progress and the dependency on other organisations. Following indication of support from the local authorities, the project is due to be reactivated in January 2023. Investment is to be sought from the ICB to make funding recurrent. Given the general NHS funding situation, the scope of this initiative may require review, including discussions with commissioners to confirm priorities.

Recent changes to the portfolio of Programmes and Projects

Detailed below, are programmes and projects that have recently been established and added to our Strategic Prioritisation Board; established schemes now moving to business usual, together with initiatives that have recently closed.

New Key Initiatives

The following initiatives have been presented and prioritised by the Trust

Berkshire Healthcare One Team – The objective of this initiative is the development of a Berkshire wide specialist community mental health offer that provides specialist, step-up interventions, processes to enable step up/step down and easy in/easy out approach to care alongside the ICS Community Mental Health Transformation programmes.

Its aims include reducing unwarranted variation across the Trust's six Community Mental Health Teams and Older People Mental Health Teams; improving access and flow between community mental health services; reduce boundaries and barriers between primary/secondary care/Voluntary Sector, as well as those between existing secondary care services. The scope of the initiative also includes supporting delivery of the alternative to Care Programme Approach (CPA) project

The One Team project was considered in September and prioritised as **Mission Critical**.

Op Courage – Berkshire Healthcare submitted a bid for this service to veterans, in partnership with Sussex Partnership and Walking with the Wounded. It would establish the Trust as a lead provider for the South-East Region. In anticipation of a successful award of this contract, the mobilisation project to establish the new service arrangements was considered in October and prioritised as **Mission Critical**. In November, the award of the contract to the Trust and its partners was announced. The new service arrangements will commence from April 2023.

Neurodiversity Strategy Implementation – Following the successful production of the Neurodiversity Strategy in May 2022, plans have been developed for its implementation. The strategy itself has been well-received and feedback indicates that staff support this as a priority. The implementation project was considered against the Strategic Filter in November and has been prioritised as **Important**.

Initiatives moving to business as usual:

There are no prioritised schemes currently moving to business as usual.

The programme for Berkshire East Ageing Well is due to continue until March 2023. As this project is being managed with no external or corporate resource required, it has been agreed that it can be completed as a "local" project and no longer features on the Prioritisation Board.

The following initiatives have been recently closed:

Quality Improvement Programme – Transition to a business partnership model was delayed due to senior staffing changes. The Closure Report was finally presented in October.

Conclusion

Overall, the Trust has continued to achieve satisfactory progress in pursuit of its True North Goals. However, following the conclusion of several key initiatives earlier in the year, a number of schemes are encountering challenges, as detailed above. In the case of the EDI strategy and Prospect Park Optimisation, the significant activity devoted to priority areas has yet to yield the required improvements. For other schemes here is a clear theme of resource issues impacting on progress – e.g., the later timescale for ePMA and the Green Plan. Resource availability will

influence the next steps for the CYPF Referral Management System and availability of capital funding will determine what is possible for the Reading Estates Review and the redevelopment of the East Berkshire Community Hospitals. In addition, the on-going efforts needed to address the continuing high rate of staff turnover indicate that this remains a major focus for the organisation.

Action

The Board is asked to note the progress of the strategic projects and initiatives.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13 December 2022
Title	**Use of Trust Seal**
	ITEM FOR NOTING
Purpose	This paper notifies the Board of use of the Trust Seal
Business Area	Corporate
Author	Company Secretary
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Compliance with Standing Orders
Equalities and Diversity Implications	N/A
SUMMARY	The Trust's Seal was affixed to: • A 10 year lease at 3 Adlam Villas, 40 Greenham Road, Newbury with a tenant break options at the 5th and 7th years) for healthcare use. The landlord obtained planning permission for a change of use from offices to healthcare and these will be occupied by our expanding MSK Physio team
ACTION	To note the update.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13 December 2022
Title	**Code of Governance for NHS Provider Trusts Compliance Report**
	ITEM FOR NOTING
Purpose	The purpose of the report is to inform the Trust Board about the governance requirements as set out in NHS England's Code of Governance for NHS Provider Trusts published on 27 October 2022 and to provide an assessment of the Trust's compliance with the new Code.
Business Area	Corporate
Author	Company Secretary
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	NHS Provider Trusts are required to comply with the Code of Governance and to explain any areas of non-compliance in their Annual Reports.
Equalities and Diversity Implications	N/A
SUMMARY	
ACTION	The Trust Board is requested to: a) Note the requirements as set out in NHS England's Code of Governance for NHS Provider Trusts b) and to note the Trust's compliance with the Code.

NHS England's Code of Governance for NHS Provider Trusts

1.0 Introduction

1.1 The new Code of Governance for NHS Provider Trust's was published on 27 October 2022. The new code replaces the NHS Foundation Trust Code of Governance, which was last updated in 2014. For the first time, the code will apply to all trusts. The Code can be accessed via the link below: https://www.england.nhs.uk/wp-content/uploads/2022/10/B2076-code-of-governance-for-nhs-provider-trusts-october-22-1.pdf

1.2 The new Code applies from April 2023.The Code sets out a common overarching framework for the corporate governance of trusts, reflecting developments in UK corporate governance and the development of integrated care systems.

Key points:

- Corporate governance is the means by which boards lead and direct their organisations so that decision-making is effective, risk is managed and the right outcomes are delivered.
- In the NHS this means delivering high quality services in a caring and compassionate environment while collaborating through system and place-based partnerships and provider collaboratives to integrate care.
- The Code reflects best practice relating to board leadership and purpose, division of responsibilities, composition, succession and evaluation, audit, risk, internal control and remuneration.
- Trusts must comply with each of the provisions of the code or, where appropriate, explain in each case why the trust has departed from the code.

1.3 The code is structured in five main sections containing the principles and provisions:

- A - Board leadership and purpose
- B - Division of responsibilities
- C - Composition, succession and evaluation [of the board]
- D - Audit, risk and internal control and
- E – Remuneration

1.4 The provisions are drawn together in a "disclosures" section: a checklist against which compliance can be self-assessed and which must be reported against in trusts' annual reports. The Trust's current compliance with the new Code of Governance is set out at appendix 1 of the report.

2.0 Recommendations

The Trust Board is requested to:

a) Note the requirements as set out in NHS England's Code of Governance for NHS Provider Trusts

b) Note the Trust's compliance with the Code of Governance

Code of Governance for NHS Provider Trusts – Trust Compliance

Comply or Explain Requirements

Section	Requirement	Comments	Compliant
A, 2.2	The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place- based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners, and other decisions.	The Trust is currently reviewing its Mission, Vision and Values as part of the Strategy Refresh	Yes
A, 2.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five- year joint plan for health services and annual capital plan agreed by the ICB and its partners, and to ensure that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.	The Trust Board receives a monthly True North Performance Scorecard Report.	Yes
A, 2.5	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, e.g. from the internal audit function, to provide an adequate and reliable level of assurance.	The Trust Board receives a monthly True North Performance Scorecard Report.	Yes
A, 2.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.	The Trust Board and/or the Quality Assurance Committee receive assurance reports relating to clinical governance – this includes compliance reports in relation to	Yes

Section	Requirement	Comments	Compliant
		recommendations from external inquiries etc.	
A, 2.7	The chair should regularly engage with stakeholders including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of the stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.	The Chair regularly visits service and meets both patients and staff. The Chair also meets with system chairs. The Trust holds an annual members meeting in September.	Yes
A, 2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.	The Trust has a Freedom to Speak Up Guardian who presents a six monthly report to the Trust Board.	Yes
A, 2.10	The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement.	The Trust Board's Annual Fit and Proper Persons Test Compliance Report provides an opportunity to review Board member's interests. The Board's register of interests are also published on the Trust's website.	Yes
A, 2.11	Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a Non-Executive Director has any such concerns, they should provide a written statement to the chair, for circulation to the board.	To be acted upon if and when required.	Yes
B, 2.1	The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring	There is a meeting review section after every Board meeting where the	Yes

Section	Requirement	Comments	Compliant
	that adequate time is available for discussion of all agenda items, in particular strategic issues.	Chair invites members of the Board to reflect on the meeting	
B, 2.2	The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.	The Chair holds monthly virtual informal “coffee morning” chats with governors – this provides an opportunity for governors to identify any areas of training and/or information the governors require	Yes
B, 2.3	The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of Non-Executive Directors in particular and ensuring a constructive relationship between executive and Non-Executive Directors.	The Trust Board undertakes an annual review of effectiveness which includes a question around Board culture.	Yes
B, 2.4	A foundation trust chair is responsible for ensuring that the board and council work together effectively.	The Board and Council work effectively together	Yes
B, 2.5	The chair should be independent on appointment when assessed against the criteria set out in Section B, provision 2.6. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.	The Chair was independent on appointment. The Trust has a vice chair and a senior independent director. The Audit Committee Chair does not hold any other role in the Trust.	Yes
B, 2.7	At least half the board of directors, excluding the chair, should be Non-Executive Directors whom the board considers to be independent.	There are 6 Non-Executive Directors and 5 Executive Directors (excluding the Chair and Chief Executive on the Board).	Yes
B, 2.8	No individual should hold the positions of director and governor of any NHS foundation trust at the same time.	No individual is both a director and a governor of an NHS foundation trust.	Yes
B, 2.9	The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For	The Council of Governors’ Appointments and Remuneration Committee reviews the Trust	Yes

Section	Requirement	Comments	Compliant
	foundation trusts, the council of governors should take into account the value of appointing a Non-Executive Director with a clinical background to the board of directors, as well as the importance of appointing diverse Non-Executive Directors with a range of skill sets, backgrounds and lived experience.	Board's skills mix and diversity and ensure that the Trust's Recruitment Consultants focus their recruitment efforts on producing long/short lists of candidates that meet those requirements.	
B, 2.10	Only the committee chair and members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.	The Company Secretary attends all Board Sub-Committees to advice on process and to take the minutes of the proceedings. Other non-members of the Committees attend by invitation.	Yes
B, 2.11	In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent Non-Executive Directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust Non-Executive Directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the chair appraisal framework.	The Senior Independent Director undertakes the Chair's annual appraisal. The Council of Governors' Appointments and Remuneration Committee oversees Chair's appraisal process. The Senior Independent Director seeks feedback from a range of stakeholders, including governors, system partners, Chief Executive, Non-Executive Directors, Chairs of the Staff Networks etc.	Yes
B, 2.12	Non-Executive Directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the Non-Executive Directors without the executive directors present.	The Chief Executive is responsible for managing appointing, removing and managing the performance of executive directors. The Chair receives copies of each executive directors' completed appraisals and has an opportunity to give his comments. The Chief Executive presents an overview of each	Yes

Section	Requirement	Comments	Compliant
		executive director's performance at the Appointments and Remuneration Committee set up to review executive/VSM remuneration. The Chair or another Non-Executive Director is part of the interview panel for a new executive director. The Chair has fortnightly meetings with the Non-Executive Directors. The Company Secretary is in attendance at these meetings.	
B, 2.14	When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one Non-Executive Directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.	The Trust's current executive directors are not Non-Executive Directors/chairs of other organisations.	Yes
B, 2.15	All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.	The Company Secretary supports both the Board and the Council of Governors. The requirement for the Board to appoint and remove the Company Secretary is set out in the Trust's Constitution.	Yes
B, 2.16	The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.	The Trust Board fulfils responsibilities in relation to clinical governance.	Yes

Section	Requirement	Comments	Compliant
B, 2.17	All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer.	The Board operates as a unitary board.	Yes
B, 2.18	All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, Non-Executive Directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.	The Board has established sub committees to review quality, audit and financial and performance etc matters in more detail.	Yes
B, 2.19	The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions.	The Trust Board's Annual Review of Effectiveness includes a question around the frequency of meetings.	Yes
C, 2.1	The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and Non-Executive Directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from the ICB, and the foundation trust should engage with NHS England to agree the approach.	Both Appointments and Remuneration Committees consider succession planning and the skills mix of the Board as part of the appointments and selection process of executive and Non-Executive Directors. The composition of interview panels will be considered on a case by case basis.	Yes
C, 2.2	There may be one or two nominations committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for Non-Executive Directors (including the	The Council of Governors' Appointments and Remuneration Committee reviews the Board's size and skills mix prior to starting the	Yes

Section	Requirement	Comments	Compliant
	chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non- executive directors, including the chair.	recruitment process for a new Non-Executive Director/Chair	
C, 2.3	The chair or an independent Non-Executive Director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of Non-Executive Directors or the chair.	A Non-Executive Director chairs the Trust Board's Appointments and Remuneration Committee. The Chair of the Council of Governors' Appointments and Remuneration Committee is the Trust Chair. The Lead Governor or the Senior Independent Director chairs the meeting in the absence of the Trust Chair or when the Trust Chair is conflicted.	Yes
C, 2.4	The governors should agree with the nominations committee a clear process for the nomination of a new chair and Non-Executive Directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.	The Council of Governors' Appointments and Remuneration Committee is responsible for overseeing the recruitment process for Non-Executive Directors and for nominating candidates for appointment. The Council of Governors is responsible for approving those appointments.	Yes
C, 2.5	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team should generally be used for the appointment of the chair and Non-Executive Directors.	The Trust appoints an external Recruitment Agency to source suitably qualified Non-Executive Directors	Partial
C, 2.6	Where an NHS foundation trust has two nominations committees, the	The Council of Governors' Appointments and Remuneration	Yes

Section	Requirement	Comments	Compliant
	nominations committee responsible for the appointment of non- executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.	Committee consists of four governors and the Trust Chair.	
C, 2.7	When considering the appointment of Non-Executive Directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.	The Council of Governors' Appointment and Remuneration Committee review the skill mix and Board diversity prior to the recruitment of Non-Executive Directors.	Yes
C, 3.1	NHS England is responsible for appointing chairs and other non- executive directors of NHS trusts. A committee consisting of the chair and Non-Executive Directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, non- executive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.	For NHS Trusts only	
C, 4.1	Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	The Trust has a Fit and Proper Persons Test Policy for Board and staff on VSM contracts. The Trust ensures that on appointment, governors meet the Provider Licence requirements in relation to the Fit and Proper Persons Test.	Yes

Section	Requirement	Comments	Compliant
C, 4.3	The chair should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment the chair was an existing Non-Executive Director. The need for extension should be clearly explained and should have been agreed with NHS England.	The Council of Governors have approved the Chair's appointment until 30 November 2025 (he will have served nine years).	Yes
C, 4.4	Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re- election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.	The Trust ensures that no governor serves more than three consecutive terms of three years. The Trust's Governor elections are conducted by CIVICA. The Trust will ensure that CIVICA are aware of the requirement around prior performance information etc.	Partial
C, 4.5	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and Non-Executive Directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and Non-Executive Directors of NHS trusts. NHS foundation trusts and NHS trusts should make use of NHS Leadership Competency Framework for board level leaders.	The Senior Independent Director is responsible for conducting the Chair's appraisal. The Council of Governors' Appointments and Remuneration Committee overseas the Chair's appraisal process. The Chair presents the outcome of his appraisals of each of the Non-Executive Directors to the Council of Governors' Appointments and Remuneration Committee.	Yes
C, 4.6	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.	The Chair is responsible for conducting the Non-Executive Directors' and Chief Executive's annual appraisals. The Chair is also	Yes

Section	Requirement	Comments	Compliant
		a signatory to the Executive Directors' appraisals.	
C, 4.8	Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on: • holding the Non-Executive Directors individually and collectively to account for the performance of the board of directors • communicating with their member constituencies and the public and transmitting their views to the board of directors • contributing to the development of the foundation trust's forward plans. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors.	The Council of Governors' last review of effectiveness was conducted in 2019. A review of effectiveness is planned for early 2022.	Yes
C, 4.10	In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited circumstances: where they have imposed an additional condition relating to governance in the trust's licence	The Trust's Constitution sets out the process for removing a governor.	Yes

Section	Requirement	Comments	Compliant
	because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.		
C,4.11	The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.	The Council of Governors' Appointments and Remuneration Committee reviews the skills mix of the Board and considers succession planning in relation to the Non-Executive Directors.	Yes
C,4.12	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.	The Appointments and Remuneration Committee will undertake a risk assessment if and when an Executive Director leaves the Trust's employment outside the terms of their contract.	Yes
C, 5.1	All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.	All new Board members undertake a comprehensive induction. New governors meet with the Chair and Company Secretary and are invited to attend NHS Providers' Governor Induction programme.	Yes
C, 5.2	The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training including on equality diversity and inclusion, including unconscious bias.	The Chair ensures that the Trust Board and the Council of Governors are provided with opportunities for learning and development. The membership of the Council of Governors' Appointments and Remuneration Committee includes	Yes

Section	Requirement	Comments	Compliant
		two new governors newly appointed to the Committee. Prior to the next recruitment round, the Committee will receive EDI and unconscious bias training.	
C, 5.3	To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.	The Board and Council are briefed about the Trust's policies and procedures.	Yes
C, 5.4	The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.	New Board members receive a comprehensive induction and are invited to attend the relevant NHS Providers' Induction programme. Both Executive and Non-Executive Directors undertake service visits and meet staff and patients. Executive Directors can access both internal and external training programmes at the Trust's expense.	Yes
C, 5.5	The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	The Chair discusses training and development needs as part of his annual appraisal with Non-Executive Directors. New Executive Directors meet with the Chair to discuss their Board role as part of their induction process.	Yes
C, 5.6	A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	All newly appointed/elected governors receive a Governor Handbook containing information about the Trust and the role of the Governor. New governors also	Yes

Section	Requirement	Comments	Compliant
		receive an induction from the Chair and Company Secretary and are invited to attend NHS Providers' Core Skills course for governors. Governors receive regular briefings about the work of the Trust and about the wider system context.	
C, 5.8	The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.	Both the Trust Board and the Council of Governors receive high quality information and there are opportunities both during and outside of meetings for individuals to raise any questions and/or to seek any clarifications.	Yes
C, 5.9	The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and Non-Executive Directors; as well as facilitating appropriate induction and assisting with professional development as required.	The Council of Governors has four informal joint meetings a year – two of which are held jointly with the full Trust Board and two which are held jointly with the Non-Executive Directors.	Yes
C, 5.10	The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.	The Council of Governors receives a quarterly performance report – the contents of which have been agreed with the governors. All Board reports include a cover sheet which draws attention to any key points etc.	Yes
C, 5.11	The board of directors and in particular Non-Executive Directors may reasonably wish to challenge assurances received from the executive	The Board can call upon both internal and if appropriate, external	Yes

Section	Requirement	Comments	Compliant
	management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.	experts to advice/brief them on any key issues.	
C, 5.12	The board should ensure that directors, especially Non-Executive Directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non- executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.	This will be acted up on if and when required.	Yes
C, 5.13	Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.	Board and Council Committees re supported by appropriate staff.	Yes
C, 5.14	Non-Executive Directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a Non-Executive Director of a trust as they would in other similar roles.	The Chair holds monthly meetings with the Non-Executive Chairs with the Company Secretary in attendance. This provides an opportunity for individual Non-Executive Directors to raise any issues of concern and/or to be kept up to date with any developments across the Trust.	Yes
C,5.16	Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan, and then inform the council of governors which of their views have been incorporated in the NHS foundation trust's plans and explain the reasons for any not being included.	The Trust invites the governors to input into the Trust's strategy at the joint Trust Board/Council of Governors meetings and at bespoke meetings (a strategy session was	Yes

Section	Requirement	Comments	Compliant
		recently held with the governors to seek their views as part of the Strategy Refresh process.	
C,5.17	The trust should arrange appropriate insurance to cover the risk of legal action against its directors. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. Governors may have the benefit of an indemnity and/or insurance from the trust. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.	The Trust's third part public liability insurance provided via NHS Resolution covers governors	Yes
C, 2.1	The board of directors should establish an audit committee of independent Non-Executive Directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.	The Audit Committee comprises three Non-Executive Directors. The Trust Chair is not a member of the Audit Committee. Two members of the Audit Committee (including the Audit Committee Chair) have recent and relevant financial experience.	Yes
C, 2.2	The main roles and responsibilities of the audit committee should include: • monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them • providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy	The Audit Committee fulfils the functions as set out in C,2.2. The Audit Committee produces an annual report to the Council of Governors setting out how it has fulfilled its role over the last 12 month period.	Yes

Section	Requirement	Comments	Compliant
	• reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent Non-Executive Directors or by the board itself • monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors • reviewing and monitoring the external auditor's independence and objectivity • reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements reporting to the board of directors on how it has discharged its responsibilities.		
D, 2.3	A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re- tender its external audit at least every 10 years and in most cases more frequently than this.	The Council of Governors has recently appointed new External Auditors for the Trust.	Yes
D, 2.5	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services.	The Trust does not purchase non-audit services from its external auditors	Yes
E, 2.1	Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions.	The Trust Board's Appointments and Remuneration Committee is responsible for setting the remuneration of the Chief Executive, Executive Directors and staff on Very Senior Manager contracts. This includes determining whether annual	Yes

Section	Requirement	Comments	Compliant
	• Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long- term interests of the public and patients. • Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria which reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate. • Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed and must be limited to the lower of £17,500 or 10% of basic salary. The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.	pay awards are consolidated or non-consolidated in accordance with the Committee's Remuneration Policy.	
E, 2.2	Levels of remuneration for the chair and other Non-Executive Directors should reflect the Chair and Non-Executive Director remuneration structure.	The Council of Governors' Appointments and Remuneration Committee is responsible for setting the Chair and Non-Executive Directors' remuneration. All Non-Executive Directors receive the same remuneration (£15,000 per annum) – this is slightly above NHS England's recommended remuneration. However, the Trust does not provide any additional responsibility allowances.	Partial
E, 2.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their	The Terms of Reference of the Trust Board's Appointments and	Yes

Section	Requirement	Comments	Compliant
	directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.	Remuneration include approval of the arrangements for the termination of employment of the Chief Executive, Executive Directors and Very Senior Managers and other contractual terms, having regard to any national guidance. The Committee also approves contractual payments over £100,000 to all staff. Contractual payments between £50,000-£99,000 are approved by an Executive Committee and reported to the Committee for information.	
E, 2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity.	The Trust will consult with the NHS England regional director on any future director level severance payment	Yes
E, 2.7	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.	The Trust is compliant with this requirement and defines "senior management" as staff on VSM contracts.	Yes

The provisions listed below require information to be made **available to governors,**

even in the case that the trust is compliant with the provision.

Section	Requirement	Comments	Compliant
C, 4.9	The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest which prevents the proper exercise of their duties. This should be shared with governors.	The Trust's Constitution sets out the Governor removal process.	Yes
C, 5.7	The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors.	Both the Trust Board and the Council of Governors receive information to enable them to discharge their respective duties. The Chief Executive and Deputy Chief Executive keep members of the Trust Board and the Council of Governors updated on the work of the Trust's two Integrated Care Boards.	Yes

The provisions listed below require supporting information to be made **available to members**, even in the case that the trust is compliant with the provision.

Section	Requirement	Comments	Compliant
C, 2.9	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.	The Trust's Governor elections are conducted via CIVICA. The Trust will ensure CIVICA are aware of this requirement.	Partial

The provisions listed below require information to be made **publicly available,** even in the case that the trust is compliant with the provision. This requirement can be met by making supporting information available on request

Section	Requirement	Comments	Compliant
B, 2.13	The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available.	This information is available to the public upon request.	Yes
C, 4.2	Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.	This information is included in the Trust's Annual Report which is published on the website.	Yes
E, 2.6	The board of directors should establish a remuneration committee of independent Non-Executive Directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.	The terms of reference of the Trust Board's Appointments and Remuneration Committee are available upon request. The Director of People attends the Trust Board's Appointments and Remuneration Committee meeting (accept when the Committee is considering her remuneration etc).	Yes

Section	The following requirements are to be included in the Trust's Annual Report 2022-23
A, 2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.

Section	The following requirements are to be included in the Trust's Annual Report 2022-23
A, 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.
A, 2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision- making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.
B, 2.6	The board of directors should identify in the annual report each non- executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a Non-Executive Director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance- related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the Non-Executive Director is independent, it needs to be clearly explained why.
B, 2.13	**The annual report should give the number of times the board and its committees met, and individual director attendance.**

Section	The following requirements are to be included in the Trust's Annual Report 2022-23
B,2.19	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.
C, 2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.
C, 2.8	The annual report should describe the process followed by the council of governors to appoint the chair and Non-Executive Directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.
C, 4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.
C, 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.
C, 4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served the gender balance of senior management and their direct reports.

Section	The following requirements are to be included in the Trust's Annual Report 2022-23
C,5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.
D,2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.
D,2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.
D,2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.
D,2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.
D,2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the *DHSC group accounting manual* and *NHS foundation trust annual reporting manual* which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.
E,2.3	Where a trust releases an executive director, e.g. to serve as a non- executive director elsewhere, the remuneration disclosures in

Section	The following requirements are to be included in the Trust's Annual Report 2022-23
	the annual report should include a statement as to whether or not the director will retain such earnings.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13 December 2022
Title	**Review and Revision of the Trust's Constitution**
	ITEM FOR APPROVAL
Purpose	This paper seeks the Council's approval of a revision of the Trust's constitution following a thorough review undertaken by the Trust's Solicitors
Business Area	Corporate
Author	Company Secretary
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Compliance with Standing Orders and relevant statutory and regulatory requirements
Equalities and Diversity Implications	N/A
SUMMARY	The Trust's constitution sets out the framework for governance of the organisation in conjunction with relevant statutory and regulatory requirements. The constitution largely follows the original 'model' constitution adopted by most NHS Foundation Trusts. The constitution was last reviewed in 2018. The Trust's legal advisers, DAC Beachcroft, were instructed to undertake a complete review of the constitution and to propose changes to bring it in line with best practice and new legislation. A summary of the changes is set out in the attached proposed appendix. The main changes being proposed are a new review process for excluded member(s) and making it more explicit that meetings of the Council of Governors and Trust Board can include in person, using

	electronic communication or hybrid meetings. An updated Trust Constitution with the key changes highlighted in red has been circulated separately. The proposed changes to the Constitution will also be presented to the Council of Governors meeting on 7 December for approval. Once approved the changes will be presented to the Annual Members Meeting in September 2023 for ratification.
ACTION	The Trust Board is invited to approve the proposed changes to the Trust's Constitution.

Revision of Trust Constitution

Introduction

- The Constitution of the Trust is a key document which frames much of the governance of the organisation, e.g. the standing orders that govern Board and Council meetings. It is a statutory requirement that changes have to be approved by both the Board and Council of Governors.

- The Trust's legal advisers were requested to undertake a thorough review of the Trust's Constitution and to propose changes that:

    - Ensured full statutory and regulatory compliance;
    - Reflected improvements that had developed since the introduction of the Foundation Trust model
    - Addressed the Trust's own actual experience of operating with the current constitution
    - Provided clarity in any areas of potential confusion or uncertainty.
    - Included a new review process for excluded members in line with the Trust's process for reviewing vexatious complainants

- The Trust is not permitted to change the Model Rules for Governor Elections. The governor election rules are set nationally.

- Changes to the constitution require approval of both the Trust Board and Council of Governors. The changes also need to be ratified at the next Annual General Meeting.

- The Company Secretary invited interested governors to a meeting held on 26 October 2022 to review the proposed changes to the Constitution and to make suggestions for any additional changes. The Company Secretary would like to put on record her thanks to the governors below who attended the meeting for their help and support.

    - Brian Wilson, Lead Governor
    - Graham Bridgman
    - Steven Gillingwater
    - June Carmichael
    - Madeline Diver
    - Julie Hill, Company Secretary.

- For ease of identification of key changes, the following Appendix provides a summary of the main elements of the revision.

Trust's Constitutional Review 2022

The proposed changes are highlighted in red type

Page No	Proposed Changes	Comments
	References to "Monitor" have been deleted and replaced with "NHS England"	
	References to "Deputy Chair" to be replaced with "Vice Chair"	
	References to "NED(s)" have been replaced with "Non-Executive Director(s)	
	References to "Director of Finance" to be replaced with "Chief Financial Officer"	
	References to "Primary Care Trusts" have been deleted	
	References to "his or her" and "he or she" have been replaced with "their" and "they"	
	List of Contents – hyperlinks have been added for ease of reference when accessing the electronic version of the document	
	Change of order It is proposed to put the Variation Schedule at the back. It is proposed to put the Interpretation and Definitions section at the front of the document.	
Page 1	**Interpretation and definitions** Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this Constitution shall bear the same meaning as in the 2006 Act. References in this Constitution to legislation include all amendments, replacements or re-enactments made. References to legislation include all regulations, orders, statutory guidance or directives Where this Constitution refers to publication of a document by:- • NHS England, this includes reference to its predecessor bodies including Monitor, the NHS Trust Development Authority and the NHS Commissioning Board Authority; • the Department of Health and Social Care, this includes reference to the Department of Health. • 2022 Act means the Health and Care Act 2022;	Updated following changes to NHS England
Page 2	• Hospital means: Prospect Park Hospital, Wokingham Hospital, Wexham Park Hospital, West Berkshire Community Hospital, St Mark's Hospital, King Edward VII Hospital, Heatherwood Hospital, Royal Berkshire Hospital and any associated hospitals, establishments or facilities;	
Page 3	• Trust Headquarters means the [to be amended with the address of the new HQ];	
Page 4	The Trust: 1. aims to provide the best possible patient care, based on	

Page No	Proposed Changes	Comments
	evidence and in a culture that encourages continuous improvement; 2. will listen to patients, families and carers (as appropriate) and understand what they have to say and encourage their involvement in decisions about their care; 3. aims to provide a clean, healthy and welcoming hospital environment for patients, visitors and staff; 4. aims to improve the patient's experience of care provided at its Hospitals and by its services respecting their privacy and preserving their dignity; 5. will have open and honest communications between staff and patients, families and carers (as appropriate); 6. will recognise the contribution of staff by developing and supporting them to do their jobs better, and involving them in decision making; 7. aims to provide high quality services through working in partnership; 8. shall exercise its functions effectively, efficiently and economically; 9. shall respect the rights of the members of the community it serves, its employees and people dealing with the Trust as set out in the Human Rights Act 1998.	
	Foundation Trust Governance Structure~~The Foundation Trust governance model is described in greater detail in the Foundation Trust Code of Governance (published by Monitor, the regulator), in respect of which the Trust must either comply or explain (in its annual report each year) its reasons for not doing so. As the model envisages, it is essential for the success of the Trust that the Board and the Council work effectively together. The basis for this relationship is set out in the Constitution and is detailed in the Policy on Board of Directors/Council of Governors Engagement.~~ ~~The Foundation Trust governance model is described in greater detail in the Foundation Trust Code of Governance (published by Monitor, the regulator), in respect of which the Trust must either comply or explain (in its annual report each year) its reasons for not doing so. As the model envisages, it is essential for the success of the Trust that the Board and the Council work effectively together. The basis for this relationship is set out in the Constitution and is detailed in the Policy on Board of Directors/Council of Governors Engagement.~~	The Trust is required to comply with NHS England's Code of Governance for NHS Provider Trusts or to explain in its Annual Report the reason(s) for non-compliance. It is proposed to delete this section because it is not required.
Page 6	3.4 Where the Trust is exercising the functions of the managers referred to in s.23 of the Mental Health Act 1983 (as amended), those functions may be exercised by any three or	New section added

Page No	Proposed Changes	Comments
	more persons authorised by the Board of Directors, each of whom must be neither an Executive Director of the Board of Directors nor an employee of the Trust. 3.5 In exercising its powers, the Trust will have regard to: 3.5.1 s.63A of the 2006 Act (duty to have regard to wider effect of decisions), also referred to as the "Triple Aim". 3.5.2 s.63B of the 2006 Act (duties in relation to climate change). 3.6 The Trust may arrange for any functions exercisable by it to be exercised by or jointly with any one or more of the bodies set out in section s.65Z5(1) of the 2006 Act. Where such a function is exercisable jointly the bodies may arrange for the function to be exercised by joint committee as set out in ss.65Z6 of the 2006 Act.	
Page 8	8.6 The Trust shall give any member at least 14 days' written notice of a proposal to remove them from membership under paragraphs 8.5.3 and: 8.6.1 the notice shall state the date by which the member must respond by if they wish to make any representations; 8.6.2 the Trust shall consider any representations made by the member during that notice period, and the Secretary shall decide whether to remove the member; 8.6.3 within 14 days after receiving notice of the Secretary's decision, a person wishing to dispute the decision may require the Secretary to refer the matter to the Council of Governors to determine whether the decision was fair and reasonable taking all relevant matters in to account; 8.6.4 where a member does not ask the Secretary to refer their proposed removal to the Council of Governors, they shall cease to be a member 14 days after receiving notice of the Secretary's decision; 8.6.5 where a member does ask the Secretary to refer their proposed removal to the Council of Governors, they shall continue to be a member until the Council of Governors has reached a decision on their membership and provided them with notice; 8.6.6 the decision of the Council of Governors shall be final. 8.7 An individual member removed under paragraph 8.6 may make a request to the Secretary that their membership removal be reviewed by the panel of the Council of Governors, chaired by a Non-Executive Director and their eligibility to be a member will be considered at the following points: 8.7.1 No earlier than 12 months from the date of the first review for removal ("the first review").	A new review process for excluded member(s) to bring this in line with the Trust's process for reviewing vexatious complainants.

Page No	Proposed Changes	Comments
	8.7.2 No earlier than 36 months after the date of the outcome of the first review ("the second review"); and 8.7.3 No earlier than sixty month intervals after the date of the outcome of the second review. 8.8 When making a request under paragraph 8.7 the individual must make such a request in writing to the Secretary and outline whether they wish to be considered as eligible to be a member and the reasons for the requested review. The Trust shall endeavour to issue a decision in writing within 28 days of receipt of the request.	
Page 12	14. Council of Governors – general duties 14.1 The general duties of the Council of Governors are to: 14.1.1 hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors 14.1.2 represent the interests of the members of the Trust, the public and staff as a whole 14.1.3 feedback information about the Trust, its vision and its performance to members, the public and stakeholder organisations.	Updated to make it more explicit that governors represent the interests of the public and staff as well as members of the Trust.
Page 12	15.3 Meetings of the Council of Governors shall take place as regularly as necessary to discharge its duties and at least four times per calendar year.	
Page 14	22. Board of Directors – appointment and removal of Chair and other Non-Executive Directors 22.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair and the other Non-Executive Directors. In doing so, the Council of Governors shall take into account the applicable Code of Governance.	
Standing Orders of the CoGs Page 71	2.2 Calling Meetings 2.2.1 Meetings of the Council of Governors shall be held at such times and places and of such format including in person, by using electronic communication or hybrid, as the Council of Governors may determine and there shall be at least four meetings in any year including:…..	Various sections of the Constitution updated to take account holding virtual meetings
Standing Orders of the CoGs Page 72	2.3.2 Before each meeting of the Council of Governors a public notice of the time and place, and if appropriate remote access/electronic communications arrangements, of the meeting, and if possible the public part of the agenda, shall be advertised on the Trust's website at least seven days before the meeting, save in the case of emergencies.	
Standing Orders of	2.10.3 All questions put to the vote shall, at the discretion of the Chair	

Page No	Proposed Changes	Comments
the CoGs Page 74	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. In the event of a meeting held using electronic communication, an electronic voting facility will be made available, including when appropriate, the facility for holding a secret ballot.	
Standing Orders of the CoGs Page 74	2.10.7 A Governor may only vote if present (either in person or by electronic communication) at the time of the vote on which the question is to be decided; no Governor may vote by proxy.	
Standing Orders of the CoGs Page 76	4.3 The Council of Governors shall approve the members of the Council of Governors' Appointments and Remuneration Committee.	
Standing Orders of the Board of Directors P84	3.2.1 Ordinary meetings of the Board of Directors shall be held at such times and places and in such format as the Board of Directors may determine.	
Standing Orders of the Board of Directors P85	3.4.1 Agendas and supporting papers will be sent to members of the Board of Directors at least three Clear Days before the meeting, save in emergency. Failure to serve such a notice on more than three members of the Board of Directors will invalidate the meeting. A notice shall be presumed to have been served one day after posting and in the case of by electronic communication on the day it is sent.	
Standing Orders of the Board of Directors P87	3.13.3 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 or by appropriate electronic means. A paper ballot may also be used if a majority of the Directors present so request.	
Standing Orders of the Board of Directors P89	3.18.3 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO7) he or she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least 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 considers the recommendations of the Appointments and Remuneration Committee	
Standing Orders of the Board of Directors	9.2 ~~EU Directive Governing~~ Public Procurement 9.2.1 ~~European Union Directive on~~ The Public Procurement Regulations ~~implementing them in UK law~~ shall take precedence over	Updated to delete references to EU Procurement Law

Page No	Proposed Changes	Comments
P94	these SOs with regard to procedures for awarding all forms of contracts and shall have effect as if incorporated in these SOs. 9.2.2 The Trust shall comply as far as is practicable with the requirements of the Department of Health and Social Care "Capital Investment Manual" and “Estatecode” and associated relevant guidance issued by NHSE in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health and Social Care guidance "The Procurement and Management of Consultants within the NHS". The Trust will also comply with the Guidance from NHSE entitled "Best Practice in Making Investments" and the Regulatory Framework.	Updated to include “Social Care”
Standing Orders of the Board of Directors P97	9.6 Contracts (including lease contracts) 9.6.1 The Trust may only enter into contracts within its statutory powers and shall comply with: 9.6.1.1 these SOs. 9.6.1.2 the Trust's SFIs. 9.6.1.3 ~~EU Directives and other~~ all applicable statutory provisions; and 9.6.1.4 any relevant directions including the Capital Investment Manual and guidance on the Procurement and Management of Consultants. 9.6.1.5 Where required by the Public Procurement Regulations contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited. 9.6.2 Contracts shall include lease and hire purchase agreements. 9.6.3 In all contracts made by the Trust, the Board shall endeavour to obtain value for money. The Chief Executive shall nominate an Officer who shall oversee and manage each contract on behalf of the Trust.	
Standing Orders of the Board of Directors P102	13. Signature of Documents 13.1 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. 13.2 The Chief Executive or Nominated Officers shall be authorised, by resolution of the Board of Directors, 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 of Directors or committee or sub-committee to which the Board of Directors has delegated appropriate authority. 13.3 Where authority to sign documents is granted under the Constitution, signatures may be electronic, provided that, where	

Page No	Proposed Changes	Comments
	required by law or a regulatory body wet ink signatures shall be used. For the avoidance of doubt, unless and until the Trust is able to electronically seal documents, documents signed under seal will continue to be signed by way of wet ink.	

Berkshire Healthcare
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust

The Constitution (and Annexures)

Approved by the Council of Governors and Board of Directors

December 2022

Contents page

Berkshire Healthcare NHS Foundation Trust

(A Public Benefit Corporation)

Constitution

Interpretation and definitions

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this Constitution shall bear the same meaning as in the 2006 Act.

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

References to legislation include all regulations, orders, statutory guidance or directives

Where this Constitution refers to publication of a document by:-

- NHS England, this includes reference to its predecessor bodies including Monitor, the NHS Trust Development Authority and the NHS Commissioning Board Authority;
- the Department of Health and Social Care, this includes reference to the Department of Health.

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

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

In this Constitution:-

- **2006 Act** means the National Health Service Act 2006;
- **2012 Act** means the Health and Social Care Act 2012;
- **2022 Act** means the Health and Care Act 2022;
- **Accounting Officer** means the person who from time to time discharges the functions specified in paragraph 25 of Schedule 7 to the 2006 Act and in the Accounting Officer Memorandum published by NHSE;
- **Appointment Committee** means a committee appointed by the Council of Governors pursuant to paragraphs 1.2.5 and 1.2.6 of Appendix 3 of Annex 9;
- **Appointed Governor** means a Local Authority Governor, or an Other Partnership Governor;
- **Area of the Trust** means the area, consisting of all the areas, specified in Annex 1, as an area for a public constituency;
- **Audit Committee** means a committee of the Board of Directors as established pursuant to paragraph 37;
- **Auditor** means the Auditor of the Trust appointed by the Council of Governors pursuant to paragraph 36;
- **Board of Directors** means the Board of Directors as constituted in accordance with this Constitution;
- **Budget** means a resource, expressed in financial terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions on the Trust
- **Chair** means the Chair of the Trust;
- **Chief Executive** means the Chief Executive of the Trust;
- **Clear Day** means a day of the week not including Saturday, Sunday or a public holiday
- **Complaints Handling Policy** means the Trust's complaints handling policy, as adopted by the Applicant NHS Trust and as amended from time to time by the Board of Directors;

- **Constitution** means this Constitution together with the Annexes and Appendices attached hereto;
- **Council of Governors** means the Council of Governors as constituted in accordance with this Constitution;
- **Deputy Chair** means one of the NEDs appointed by the Council of Governors, either generally or for a specific meeting, to preside at a meeting of the Council of Governors in the absence of the Chair
- **Director** means a member of the Board of Directors, and includes both Executive and Non-Executives;
- **Director's Code of Conduct** means the code of conduct for Directors of the Trust, as adopted by the Applicant NHS Trust and as amended from time to time by the Board of Directors, which all Directors must subscribe to;
- **Elected Governor** means a Staff Governor or a Public Governor;
- **Election Scheme** means the election rules set out at Annex 5 of the Constitution;
- **Finance Director** means the Chief Financial Officer of the Trust;
- **Financial year** means each successive period of twelve months beginning with 1st April;
- **Funds held on trust** means those funds which the Trust holds at the date of its incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under the 2006 Act. Such funds may or may not be charitable;
- **Governor** means a member of the Council of Governors;
- **Governor's Code of Conduct** means the code of conduct for Governors of the Trust, as adopted by the Applicant NHS Trust and as amended from time to time by the Board of Directors, which all Governors must subscribe to;
- **Health Service Body** shall have the meaning ascribed to it in section 9(4) of the 2006 Act;
- **Hospital** means: Prospect Park Hospital, Wokingham Hospital, Wexham Park Hospital, West Berkshire Community Hospital, St Mark's Hospital, King Edward VII Hospital, Heatherwood Hospital, Royal Berkshire Hospital and any associated hospitals, establishments or facilities;
- **Local Authority Governor** means a member of the Council of Governors appointed by one or more local authorities whose area includes the whole or part of the Area of the Trust;
- **Local Authority Partnership Agreement** means an agreement between the Trust and a local authority under s.75 of the 2006 Act;
- **Local Healthwatch** means an organisation as defined in s.222 of the Local Government and Public Involvement in Health Act 2007.
- **Member** means a member of the Trust;
- **Model Election Rules** means the model election rules for use in elections of foundation trust councils of governors as published by the NHS Providers (formerly the Foundation Trust Network);
- **NHS England**, a body corporate established under Section 1H of the 2006 Act;
- **Nominated Officer** means an Officer charged with responsibility for discharging specific tasks within the SOs and SFIs
- **Non-Executive Director** means a Non-Executive Director member of the Board of Directors who does not hold an executive office of the Trust
- **Officer** means an employee or other person holding paid appointment or office with the Trust;

- **Other Partnership Governor** means a member of the Council of Governors appointed by a partnership organisation other than a local authority;
- **Public Governor** means a member of the Council of Governors elected by the members of a public constituency;
- **Public Procurement Regulations** means The Public Contracts Regulations 2015 SI 2015/102 as amended from time to time and The Concession Contracts Regulations SI 2016/273 as amended from time to time;
- **Regulatory Framework** means the 2006 Act, the 2012 Act, the 2022 Act and the Trust's provider licence.
- **Scheme of Delegation** means the Reservation of Powers to the Board of Directors and Delegation of Powers;
- **Secretary** means the Secretary of the Trust or any other person or body corporate appointed to perform the duties of the Secretary of the Trust, including a joint, assistant or deputy secretary;
- **SFIs** means Standing Financial Instructions
- **SOs** means Standing Orders;
- **Staff** Governor means a member of the Council of Governors elected by the members of the staff constituency;
- **Trust** means the Berkshire Healthcare NHS Foundation Trust;
- **Trust Headquarters** means [to be amended with new HQ];
- **Trust Subcontractor** means a contractor to the Trust whose employees exercise functions on behalf of the Trust and which is listed in the register Maintained by the Secretary pursuant to paragraph 33.7.1;
- **Volunteer** means an individual who carries out functions on behalf of the Trust on a voluntary basis under a scheme designated by the Secretary pursuant to paragraph 33.8.1; and
- **Voluntary Organisation** means a body other than a public or local authority, the activities of which are not carried on for profit.

Introduction

This document is the Constitution of Berkshire Healthcare NHS Foundation Trust (the Trust). The Constitution sets out the corporate governance arrangements for the Trust. Much of it is in a form specified by law.

As context for those detailed governance arrangements this foreword sets out the Trust's purpose, mission, values and strategy. The following section summarises the Trust's governance arrangements, focusing in particular on the relationship between the Board of Directors and the Council of Governors.

The Trust: overview and purpose

The Trust provides specialist mental health and community health services to a population of around 900,000 within Berkshire. The Trust operates from more than 100 sites across the county, including its community hospitals, Prospect Park Hospital, clinics and WestCall Out of Hours Service. The Trust also provides health care and therapy to people in their own homes.

The Trust's values

The Trust operates within the seven core principles of the NHS, set out in the NHS Constitution:

1. The NHS provides a comprehensive service, available to all.
2. Access to NHS services is based on clinical need, not an individual's ability to pay.
3. The NHS aspires to the highest standards of excellence and professionalism.
4. The NHS aspires to put patients at the heart of everything it does.
5. The NHS works across organisations boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.
6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
7. The NHS is accountable to the public, communities and patients that it serves.

The Trust also has its own core principles:

The Trust:

1. aims to provide the best possible patient care, based on evidence and in a culture that encourages continuous improvement;
2. will listen to patients, families and carers (as appropriate) and understand what they have to say and encourage their involvement in decisions about their care;
3. aims to provide a clean, healthy and welcoming hospital environment for patients, visitors and staff;
4. aims to improve the patient's experience of care provided at its Hospitals and by its services respecting their privacy and preserving their dignity;
5. will have open and honest communications between staff and patients, families and carers (as appropriate);
6. will recognise the contribution of staff by developing and supporting them to do their jobs better, and involving them in decision making;
7. aims to provide high quality services through working in partnership;
8. shall exercise its functions effectively, efficiently and economically;
9. shall respect the rights of the members of the community it serves, its employees and people dealing with the Trust as set out in the Human Rights Act 1998.

Foundation Trust Governance Structure

The Trust is required by law to establish a governance structure which comprises a Board of Directors, a Council of Governors, and members. The Trust has two membership constituencies – public members, and staff members. The majority of the Trust's Governors are elected by the Trust's public members.

The Trust's Directors have a general statutory duty to act with a view to promoting the success of the organisation so as to maximise the benefits for the members of the Trust as a whole and for the public. The Board is responsible for all aspects of the Trust's performance and for its objectives, priorities and strategy, the Board must, however, have regard to the Council's view on the Trust's strategy and plans. The Board comprises a (non-executive) Chair and Non-Executives, who are appointed and may be removed by the Council, and executive directors.

The Council comprises Governors who are elected by the Trust's members and other Governors who are appointed by local partner organisations. The Governors have two general statutory duties: (1) to hold the NEDs individually and collectively to account for the performance of the Board, and (2) to represent the interests of the members of the Trust as a whole and of the public. The Governors also have a number of specific statutory duties. In addition to representing the interests of the members and the public, the Governors are required to feed back to them on the performance of the Trust.

The Constitution sets out the Trust's membership constituencies and refers to the policy which defines the processes by which individuals may become members.

1. Name

1.1 The name of the foundation trust is Berkshire Healthcare NHS Foundation Trust (the Trust).

2. Principal purpose

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

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

2.3 The Trust may provide goods and services for any purposes related to the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.

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.

3. Powers

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

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

3.3 Subject to paragraph 3.4 below, any of these powers may be delegated to a committee of directors or to an executive director.

3.4 Where the Trust is exercising the functions of the managers referred to in s.23 of the Mental Health Act 1983 (as amended), those functions may be exercised by any three or more persons authorised by the Board of Directors, each of whom must be neither an Executive Director of the Board of

Directors nor an employee of the Trust.

3.5 In exercising its powers, the Trust will have regard to:

3.5.1 s.63A of the 2006 Act (duty to have regard to wider effect of decisions), also referred to as the "Triple Aim".

3.5.2 s.63B of the 2006 Act (duties in relation to climate change).

3.6 The Trust may arrange for any functions exercisable by it to be exercised by or jointly with any one or more of the bodies set out in section s.65Z5(1) of the 2006 Act. Where such a function is exercisable jointly the bodies may arrange for the function to be exercised by joint committee as set out in ss.65Z6 of the 2006 Act.

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; or

4.1.2 the staff constituency.

4.2 In deciding which areas are to comprise the Area of the Trust, or in deciding whether there should be a patients' constituency, the Trust shall have regard to the need for those eligible for such membership to be representative of those to whom the Trust provides services.

4.3 The Trust shall at all times take steps to secure that taken as a whole the actual membership of the Public Constituency is representative of those eligible for such membership. To this end:

4.3.1 the Trust shall at all times have in place and pursue a membership strategy which shall be approved by the Council of Governors, and shall be reviewed by them from time to time, and at least every three years; and

4.3.2 the Council of Governors shall present to each annual members meeting:

4.3.2.1 a report on the steps taken to secure that taken as a whole the actual membership of its public constituencies and of the classes of the staff constituency is representative of those eligible for such membership.

4.3.2.2 the progress of the membership strategy; and

4.3.2.3 any changes to the membership strategy.

5. Application for membership

5.1 An individual who is eligible to become a member may do so on application to the Trust, or by being invited by the Trust to become a member of the staff constituency in accordance with paragraph 7.

5.2 An individual shall become a member on the date their name is added to the Trust's register of members and shall cease to be a member on the date their name is removed from the register of members.

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.

6.2 Those members who live in an area specified for a public constituency are referred to collectively as a "public constituency".

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

6.4 An individual who ceases to live in any area specified in Annex 1 shall cease to be a member of any public constituency. A member who moves from one area to another shall become a member of the public constituency for that new area. Members should notify the Trust of any change of address.

6.5 In the case of any doubt the Trust's decision as to whether or not an individual lives in an area shall be final.

7. Staff Constituency

7.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member provided:

7.1.1 he or she is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

7.1.2 he or she has been continuously employed by the Trust under a contract of employment for at least 12 months.

7.2 Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as members of the staff constituency if they have exercised these functions continuously for a period of at least 12 months. For the avoidance of doubt, the definition of individuals who exercise functions for the purposes of the Trust includes individuals who are Volunteers.

7.3 Chapter 1 of Part XIV of the Employment Rights Act 1996 applies in determining whether an individual has been continuously employed by the Trust for the purposes of paragraph 7.1.2 above or has continuously exercised functions for the purposes of the Trust for the purpose of paragraph 7.2 above.

7.4 Those individuals who are eligible for membership by reason of this paragraph 7 are referred to collectively as the “staff constituency”.

7.5 The staff constituency shall be divided into two descriptions of individuals who are eligible for membership of the staff constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the staff constituency.

7.6 The minimum number of members in each class of the staff constituency is specified in Annex 2.

7.7 An individual who is:

7.7.1 eligible to become a member of the staff constituency; and

7.7.2 invited by the Trust to become a member of the staff constituency and a member of the appropriate class within the staff constituency, shall become a member of the Trust as a member of the staff constituency and appropriate class within the staff constituency without an application being made unless they inform the Trust that they does not wish to do so.

8. Restriction on membership

8.1 A member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

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

8.3 An individual shall not be eligible for membership if he or she:

8.3.1 is under 12 years of age.

8.3.2 fails or ceases to fulfil the criteria for membership of any of the constituencies.

8.3.3 has demonstrated aggressive or violent behaviour at any Hospital or other trust premises or during

any other interaction with Trust staff or Sub-contractors or Volunteers and following such behaviour he or she has been asked to leave or has been removed or excluded from any Hospital or other Trust premises or programmes of home or community visits, under the Trust's policy for withholding treatment from violent/aggressive patients: zero tolerance.

8.3.4 has been confirmed by the Trust to be a 'vexatious complainant' as defined in the Trust's policy on handling of complaints.

8.3.5 has been removed from being a member of another NHS Foundation Trust.

8.3.6 has been deemed by the Trust to have acted in a manner contrary to the interests of the Trust; or

8.3.7 has previously been removed from being a member of the Trust under paragraph 8.5.3.

8.4 Members should ensure their own eligibility for membership and inform the Trust if they cease to be eligible.

8.5 A member shall cease to be a member if—

8.5.1 they resign by notice in writing to the Trust,

8.5.2 they die, or

8.5.3 they cease to be eligible for membership under paragraph 8.3 and they are removed from membership following the process set out in 8.6 below.

8.6 The Trust shall give any member at least 14 days' written notice of a proposal to remove them from membership under paragraphs 8.5.3 and:

8.6.1 the notice shall state the date by which the member must respond by if they wish to make any representations;

8.6.2 the Trust shall consider any representations made by the member during that notice period, and the Secretary shall decide whether to remove the member;

8.6.3 within 14 days after receiving notice of the Secretary's decision, a person wishing to dispute the decision may require the Secretary to refer the matter to the Council of Governors to determine whether the decision was fair and reasonable taking all relevant matters in to account;

8.6.4 where a member does not ask the Secretary to refer their proposed removal to the Council of Governors, they shall cease to be a member 14 days after receiving notice of the Secretary's decision;

8.6.5 where a member does ask the Secretary to refer their proposed removal to the Council of Governors, they shall continue to be a member until the Council of Governors has reached a decision on their membership and provided them with notice;

8.6.6 the decision of the Council of Governors shall be final.

8.7 An individual member removed under paragraph 8.6 may make a request to the Secretary that their membership removal be reviewed by the panel of the Council of Governors, chaired by a Non-Executive Director and their eligibility to be a member will be considered at the following points:

8.7.1 No earlier than 12 months from the date of the first review for removal ("the first review").

8.7.2 No earlier than 36 months after the date of the outcome of the first review ("the second review"); and

8.7.3 No earlier than sixty month intervals after the date of the outcome of the second review.

8.8 When making a request under paragraph 8.7 the individual must make such a request in writing to the Secretary and outline whether they wish to be considered as eligible to be a member and the reasons for the requested review. The Trust shall endeavour to issue a decision in writing within 28 days of receipt of the request.

9. Council of Governors – composition

9.1 The Trust is to have a Council of Governors, which shall comprise both Elected Governors and Appointed Governors.

9.2 The composition of the Council of Governors is specified in Annex 4.

9.3 The members of the Council of Governors, other than the Appointed Governors, 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 4.

9.4 At all times more than half of the Governors shall be Elected Governors who are elected by the members of the public constituency.

10. Council of Governors – election of Governors

10.1 Elections for Elected Governors shall be conducted in accordance with the Model Election Rules, as may be varied from time to time, which are attached at Annex 5.

10.2 A variation of the Model Election Rules shall not constitute a variation of the terms of this Constitution.

10.3 An election, if contested, shall be by secret ballot, using the first-past-the-post system.

10.4 A person may not vote at an election for or stand for election as an Elected Governor unless within the specified period stated in the Model Election Rules he or she has made a declaration in the specified form setting out the particulars of his qualification to vote or stand as a member of the constituency for which the election is being held. It is an offence (other than in relation to the Staff Constituency) to knowingly or recklessly make such a declaration which is false in a material particular.

11. Council of Governors – tenure

11.1 Governors may hold office for a period of up to three years.

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

11.3 An Appointed Governor shall cease to hold office if the sponsoring organisation withdraws its sponsorship of them by notice in writing to the Trust.

11.4 Subject to paragraph 11.6 below, an Elected Governor shall be eligible for re-election at the end of their term.

11.5 Subject to paragraph 11.6 below, an Appointed Governor shall be eligible for reappointment at the end of their term.

11.6 Elected Governors and Appointed Governors may hold office for a maximum of nine consecutive years.

12. Council of Governors – disqualification and removal

12.1 A person may not become or continue as a member of the Council of Governors if they:

12.1.1 have been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

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

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

12.1.4 have within the preceding five years been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a Health Service Body;

12.1.5 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;

12.1.6 are a Director of the Trust, or a director, chair, or chief executive officer of another NHS Foundation Trust;

12.1.7 are a Governor of another NHS Foundation Trust which is considered by the Secretary, at their absolute discretion, to be in competition with the Trust;

12.1.8 have had their name removed from a list maintained under regulations pursuant to sections 91, 106 or 123 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and he or she has not subsequently had their name included in such a list; or

12.1.9 they lack capacity within the meaning of the Mental Capacity Act 2005 to carry out all the duties and responsibilities of a governor.

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

12.3 A Governor who becomes disqualified must notify the Secretary as soon as practicable and in any event within 14 days of first becoming aware that he or she is disqualified. Upon receipt of such notice the Secretary shall confirm receipt and shall remove the Governor's name from the Register of Governors such that the Governor ceases to act as a Governor.

12.4 If the Trust becomes aware that a Governor is disqualified, the Secretary shall give them notice that he or she is disqualified as soon as practicable. Upon despatch of any such notification, that person's tenure of office, if any, shall be terminated and he or she shall cease to act as a Governor.

12.5 A Governor's term of office shall be terminated:

12.5.1 by the Governor giving the Secretary notice in writing of their resignation from office at any time during the term of that office.

12.5.2 by the giving of a notice under paragraph 12.3 or 12.4;

12.5.3 by the Council of Governors if a Governor fails to attend two consecutive meetings of the Council of Governors, unless the Council of Governors is satisfied that:

12.5.3.1 the absence was due to a reasonable cause; and

12.5.3.2 the Governor will resume attendance at meetings of the Council of Governors again within such a period as it considers reasonable.

12.5.4 if the Council of Governors resolves that:

12.5.4.1 an individual continuing as a Governor would or would be likely to prejudice the ability of the Trust to fulfil its principal purpose or of its purposes under this constitution or otherwise to discharge its duties and functions,

12.5.4.2 an individual continuing as a Governor would or would be likely to prejudice the Trust's work with other persons or body with whom it is engaged or may be engaged in the provision of goods and services,

12.5.4.3 an individual continuing as a Governor would or would be likely to adversely affect public

confidence in the goods and services provided by the Trust,

12.5.4.4 an individual continuing as a Governor would or would be likely to otherwise bring the Trust into disrepute or be detrimental to the interest of the Trust,

12.5.4.5 an individual continuing as a Governor would or would be likely to prejudice the ability of the Council of Governors to discharge its duties and responsibilities efficiently and effectively,

12.5.4.6 it would not be in the best interests of the Trust for them to continue in office as a Governor,

12.5.4.7 an individual is a vexatious or persistent litigant or complainant with regard to the Trust's affairs and their continuance in office would not be in the best interests of the Trust,

12.5.4.8 an individual has failed or refused to undertake and/or satisfactorily complete any training which the Council of Governors has required them to undertake in their capacity as a Governor,

12.5.4.9 an individual has in his conduct as a Governor failed to comply in a material way with the values and principles of the National Health Service or the Trust, and/or this constitution, or

12.5.5 an individual has committed a material breach of this Constitution and/or any code of conduct applicable to Governors and/or the Standing Orders for Governors.

12.6 Where there are concerns about a Governor's conduct (including but not limited to where any of the circumstances in 12.5.4 above apply) the Chair or, if the Chair has a conflict of interest, the Vice Chair, shall be authorised to take such action as may be immediately required, including but not limited to:

12.6.1 suspension of the Governor concerned so that the matter can be investigated. Any suspension of a Governor shall be confirmed to them in writing in such form as the Chair may decide in the circumstances.

12.6.2 commissioning a fair and independent investigation into the matter, to be conducted by one or more individuals with relevant experience, either from within or outside of the Trust.

12.7 Where an investigation identifies that a Governor has failed to comply with this Constitution, and/or any code of conduct applying to Governors, and/or the Standing Orders

12.7.1 the Governor concerned shall be notified in writing of the non-compliance and he or she shall be invited to respond within a defined appropriate and reasonable timescale. The Governor shall be invited to address the Council of Governors in person if the matter cannot be resolved satisfactorily through correspondence; and

12.7.2 the Governors shall consider the findings of the investigation and the response of the Governor whose conduct is being investigated. The Governors may decide whether to approve a statement setting out the investigated Governor's non-compliance, provided this is approved by two-thirds of the Governors present and voting and by a simple majority of the Public Governors present and voting.

12.8 Where the Council of Governors decides to approve a statement of non-compliance it may impose such sanctions as shall be deemed appropriate. Such sanctions may include the issuing of a written warning as to the Governor's future conduct and consequences of further non-compliance, suspension from office for a period to be determined by the Council of Governors, non-payment of expenses and removal of the Governor from office.

12.9 Where a resolution to remove a Governor from office under paragraph 12.5.4 is proposed and the Governor concerned disagrees with the proposal, the Chair shall offer the Governor in question the opportunity to have the evidence reviewed by an independent assessor. The Chair and the Governor concerned shall seek to agree on a mutually acceptable independent assessor. If no agreement can be reached within 14 days of an individual being proposed, the Chair shall decide. The independent assessor shall be provided with terms of reference for the review, to be approved by the Chair, requiring the review principally to determine whether or not the proposal is reasonable. Following the outcome of any review, the proposer of the resolution to remove the Governor from office should consider whether or not to withdraw their proposal.

12.10 A proposal to remove a Governor from office (including following any review by an independent assessor) under paragraph 12.5.4, shall be considered in a meeting of the Council of Governors. A majority of 75% of the Governors present and voting at that meeting shall be required to pass such a resolution.

12.11 The Standing Orders for Governors may provide further for the process to be adopted in cases relating to the termination of a Governor's tenure.

12.12 A Governor whose term of office is terminated before it expires shall not be eligible to be a Governor for five years from the date of termination, except by resolution carried by a majority of the Council of Governors voting.

13. Council of Governors – vacancies

13.1 If an Elected Governor's seat falls vacant for any reason before the end of the term of office it shall be filled by the second place candidate in the last held election for that seat, provided that the second place candidate achieved at least five percent of the vote in that election. If that individual declines it shall be filled by the third place candidate provided that the third place candidate achieved at least five percent of the vote in the last held election for that seat (the "Reserve Governor"). If the vacancy is filled in this way the Reserve Governor shall be eligible to serve two full three year terms (subject to re-election) in addition to the partial term served.

13.2 If a Reserve Governor is not available a by-election shall be held unless an election is due within nine months in which case the seat shall stand vacant until the following scheduled election. With regards to tenure, paragraphs 11.1, 11.2, 11.4 and 11.6 of this constitution shall apply to any Governor elected following a by-election.

13.3 If an Appointed Governor's term of office is terminated before it expires, the Trust will invite the relevant appointing body to appoint a new Governor to hold office for the remainder of the term of office.

13.4 The validity of any act of the Council of Governors is not affected by any vacancy among the Governors or by any defect in the appointment of any Governor.

14. Council of Governors – general duties

14.1 The general duties of the Council of Governors are to:

14.1.1 hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors

14.1.2 represent the interests of the members of the Trust, the public and staff as a whole

14.1.3 feedback information about the Trust, its vision and its performance to members, the public and stakeholder organisations.

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

15. Council of Governors – meetings of Governors

15.1 The Chair or, in their absence the Vice Chair, shall preside at meetings of the Council of Governors, and the person chairing the meeting shall have a casting vote.

15.2 Meetings of the Council of Governors shall be open to members of the public unless the Council of Governors has resolved to exclude members of the public for special reasons.

15.3 Meetings of the Council of Governors shall take place as regularly as necessary to discharge its duties and at least four times per calendar year.

15.4 For the purposes of obtaining information about the Trust's performance of its functions or the

Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting of the Council of Governors.

16. Council of Governors – Standing Orders

16.1 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.

17. Council of Governors - conflicts of interest of Governors

17.1 If a Governor has a financial, non-financial professional or non-financial personal 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 or she becomes aware of it.

17.2 The Standing Orders for Governors shall make provision for the disclosure of interests and arrangements following any such disclosure, including, where appropriate, the exclusion of a Governor declaring an interest from the discussion or consideration of the matter in respect of which an interest has been disclosed.

18. Council of Governors – remuneration and travel expenses

18.1 Governors are not to receive remuneration from the Trust, provided that this shall not prevent the remuneration of Governors by their employer.

18.2 The Trust may pay travelling and other expenses to members of the Council of Governors at such rates as the Trust decides from time to time.

19. Board of Directors – composition

19.1 The Trust has a Board of Directors, which comprises both Executive and Non-Executives.

19.2 The Board of Directors comprises:

19.2.1 a Non-Executive Chair

19.2.2 a maximum of eight other Non-Executive Directors (one of whom may be nominated to be the Senior Independent Director); and

19.2.3 a maximum of seven Executive Directors.

19.3 One of the Executive Directors is the Chief Executive.

19.4 The Chief Executive is the Accounting Officer.

19.5 One of the Executive Directors is the Chief Financial Officer.

19.6 One of the Executive Directors is a registered medical practitioner or a registered dentist.

19.7 One of the Executive Directors is a registered nurse or a registered midwife.

19.8 The Board of Directors shall at all times be constituted so that the number of Non-Executive Directors (including the Chair) is equal to or exceeds the number of Executive Directors.

19.9 The validity of any act of the Board of Directors is not affected by any vacancy among the directors or by any defect in the appointment of any Director.

20. Board of Directors – general duty

20.1 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.

21. Board of Directors – qualification for appointment as a Non-Executive Director

21.1 A person may be appointed as a Non-Executive Directors only if:

21.1.1 He or she is a member of a Public Constituency or where any of the Trust's hospitals includes a medical or dental school provided by a university, he or she exercises functions for the purposes of that university; and

21.1.2 He or she is not disqualified by virtue of paragraph 26 below.

22. Board of Directors – appointment and removal of Chair and other Non-Executive Directors

22.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair and the other Non-Executive Directors. In doing so, the Council of Governors shall take into account the applicable Code of Governance.

22.2 At the General Meeting referred to at paragraph 22.1 the Council of Governors shall decide the:

22.2.1 period of office

22.2.2 remuneration and allowances; and

22.2.3 the otherr terms and conditions of office of the Chair and other Non-Executive Directors.

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

23. Board of Directors – appointment of Vice Chair

23.1 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Non-Executive Directors to be the Vice Chair.

24. Board of Directors – appointment of Senior Independent Director

24.1 The Board (in consultation with the Council of Governors) may appoint any independent Non-Executive Director as the Senior Independent Director, for such period not exceeding the remainder of their term as a Non-Executive Director as they may specify on appointing them.

24.2 Any Non-Executive Director so appointed may at any time resign from the office of Senior Independent Director by giving notice in writing to the Chair. The Board (in consultation with the Council of Governors) may thereupon appoint another independent Non-Executive Director as Senior Independent Director.

24.3 The Senior Independent Director shall perform the role set out in “The NHS Foundation Trust Code of Governance” issued by NHSE.

25. Board of Directors – appointment and removal of the Chief Executive and other Executive Directors

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

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

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

26. Board of Directors – disqualification

26.1 A person may not become or continue as a member of the Board of Directors if they:

26.1.1 have been adjudged bankrupt or whose estate has been sequestrated and (in either case) they have not been discharged

26.1.2 have made a composition or arrangement with, or granted a trust deed for their creditors and have not been discharged in respect of it; or

26.1.3 have within the preceding five years been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them or

26.1.4 have had their tenure of office as a chair or as a member or director of a Health Service Body 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;

26.1.5 have had their name removed from a list maintained under regulations pursuant to sections 91, 106, or 123 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and they have not subsequently had their name included on such a list;

26.1.6 have within the preceding two years been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a Health Service Body;

26.1.7 are an executive or Non-Executive Director or a Governor of another NHS Foundation Trust, or a Governor, Executive Director, Non-Executive Director, Chair, or Chief Executive of another Health Service Body, unless they are or will become a Non-Executive Director of the Trust and the Chair considers that their position at another NHS Foundation Trust or Health Service Body does not give rise to a conflict of interest;

26.1.8 in the case of a Non-Executive Director, no longer satisfies the criteria for appointment;

26.1.9 in the case of an Executive Director, no longer employed by the Trust

26.1.10 is a member of a Local Healthwatch;

26.1.11 is a member of a local authority's overview and scrutiny committee for health matters;

26.1.12 is the subject of a disqualification order made under the Company Directors' Disqualifications Act 1986;

26.1.13 is a partner or spouse of an existing Director;

26.1.14 is an 'unfit person' as defined in the Trust's provider licence (as may be amended from time to time), or

26.1.15 does not meet any other statutory requirement for being a director of an NHS foundation trust.

27. Board of Directors – meetings

27.1 Meetings of the Board of Directors shall be open to the public, unless the Board of Directors has resolved that members of the public should be excluded for special reasons.

27.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors

must send a copy of the minutes of the meeting to the Council of Governors.

28. Board of Directors – Standing Orders

28.1 The Standing Orders for the Practice and Procedure of the Board of Directors (the "Standing Orders for Directors"), as may be varied from time to time, are attached at Annex 7.

29. Board of Directors – conflicts of interest of Directors

29.1 The duties that a Director has by virtue of being a Director include in particular—

29.1.1 a duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust; and

29.1.2 a duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

29.2 The duty referred to in sub-paragraph 29.1.1 is not infringed if—

29.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

29.2.2 the matter has been authorised in accordance with the constitution.

29.3 The duty referred to in sub-paragraph 29.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

29.4 In sub-paragraph 29.1.2, "third party" means a person other than—

29.4.1 the Trust, or

29.4.2 a person acting on its behalf.

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

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

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

29.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

29.9 A Director need not declare an interest—

29.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest,

29.9.2 if, or to the extent that, the Directors are already aware of it, or

29.9.3 if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered—

29.9.3.1 by a meeting of the Board of Directors, or

29.9.3.2 by a committee of the Directors appointed for the purpose under the constitution.

29.10 The Standing Orders of the Board of Directors shall include provisions about the disclosure of interests and arrangements for a Director with an interest to withdraw from a meeting in relation to the matter in respect of which he or she has declared an interest.

30. Board of Directors – remuneration and terms of office

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

30.2 The Trust shall establish a committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors.

31. Registers

31.1 The Trust shall have:

31.1.1 a register of members showing, in respect of each member, the constituency to which he or she belongs and, where there are classes within it, the class to which he or she belongs

31.1.2 a register of members of the Council of Governors

31.1.3 a register of interests of Governors

31.1.4 a register of Directors; and

31.1.5 a register of interests of the Directors.

31.2 The Secretary shall be responsible for compiling and maintaining the registers, and the registers may be kept in either paper or electronic form. Removal from any register shall be in accordance with the provisions of this Constitution. The Secretary shall update the registers with new or amended information as soon as is practical and in any event within 14 days of receipt.

32. Admission to and removal from the registers

32.1 Register of members

32.1.1 Subject to paragraph 7.7 above, members must complete and sign an application in the form prescribed by the Secretary.

32.1.2 The Secretary shall maintain the register in two parts. Part one, which shall be the register referred to in the 2006 Act, shall include the name of each member and the constituency or class to which they belong, and shall be open to inspection by the public in accordance with paragraph 33 below. Part two shall contain all the information from the application form and shall not be open to inspection by the public nor may copies or extracts from it be made available to any third party. Notwithstanding this provision the Trust shall extract such information as it needs in aggregate to satisfy itself that the actual membership of the Trust is representative of those eligible for membership and for the administration of the provisions of this Constitution.

32.2 Register of Governors

32.2.1 The register shall list the names of Governors, their category of membership of the Council of Governors (public, staff, local authority, or other partnership organisation) and an address through which they may be contacted which may be the Secretary.

32.3 Register of Interests of the Governors

32.3.1 The register shall contain the names of each Governor, whether he or she has declared any interests and, if so, the interests declared in accordance with this Constitution or the Standing Orders for Governors.

32.4 Register of Directors

32.4.1 The register shall list the names of Directors, their capacity on the Board of Directors and an address through which they may be contacted which may be the Secretary.

32.5 Register of interests of Directors

32.5.1 The register shall contain the names of each Director, whether he or she has declared any interests and, if so, the interests declared in accordance with this Constitution or the Standing Orders for Directors.

32.6 Register of Designated Trust Subcontractors

32.6.1 The register shall contain the names of each Trust Subcontractor which is designated by the Trust for the purposes of membership of the Trust.

32.7 Register of Designated Volunteer Schemes

32.7.1 The register shall contain the names of each volunteer scheme which is designated by the Trust for the purposes of membership of the Trust.

33. Registers – inspection and copies

33.1 The Trust shall make the registers specified in paragraph 32 above available for inspection by members of the public, except in the circumstances set out in paragraphs 33.2 to 33.4 below or as otherwise prescribed by regulations.

33.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member if the member so requests.

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

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

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

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

34. Documents available for public inspection

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

34.1.1 a copy of the current Constitution

34.1.2 a copy of the latest annual accounts and of any report of the Auditor on them; and

34.1.3 a copy of the latest annual report.

34.2 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:

34.2.1 a copy of any order made under s.65D (appointment of trust special administrator), s.65J (power to extend time), s.65KC (action following Secretary of State's rejection of final report), s.65L (trusts coming out of administration) or s.65LA (trusts to be dissolved) of the 2006 Act

34.2.2 a copy of any report laid under s.65D (appointment of trust special administrator) of the 2006 Act

34.2.3 a copy of any information published under s.65D (appointment of trust special administrator) of the 2006 Act

34.2.4 a copy of any draft report published under s.65F (administrator's draft report) of the 2006 Act

34.2.5 a copy of any statement provided under s.65F (administrator's draft report) of the 2006 Act

34.2.6 a copy of any notice published under s.65F (administrator's draft report), s.65G (consultation plan), s.65H (consultation requirements), s.65J (power to extend time), s.65KA (NHSE's decision), s.65KB

(Secretary of State's response to NHSE's decision), s.65KC (action following Secretary of State's rejection of final report) or s.65KD (Secretary of State's response to re-submitted final report) of the 2006 Act

34.2.7 a copy of any statement published or provided under s.65G (consultation plan) of the 2006 Act

34.2.8 a copy of any final report published under s.65I (administrator's final report) of the 2006 Act

34.2.9 a copy of any statement published under s.65J (power to extend time) or s.65KC (action following Secretary of State's rejection of final report) of the 2006 Act and

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

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

34.4 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.

35. Auditor

35.1 The Trust shall have an Auditor.

35.2 The Council of Governors shall appoint or remove the Auditor at a general meeting of the Council of Governors.

36. Audit Committee

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

37. Accounts

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

37.2 NHSE may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

37.3 The accounts are to be audited by the Auditor.

37.4 The Trust shall prepare in respect of each Financial Year annual accounts in such form as NHSE may with the approval of the Secretary of State direct.

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

37.6 The Trust shall:

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

37.6.2 send copies of those documents to NHSE within such period as NHSE may direct; and

37.6.3 send copies of any accounts prepared pursuant to paragraph 37.2, and any report of an auditor on them to NHSE within such period as NHSE may direct.

38. Annual report and forward plans and non-NHS work

38.1 The Trust shall prepare annual reports and send them to NHSE.

38.2 The reports shall give information on:

38.2.1 the impact that income received by the Trust otherwise than from the provision of goods and services for the purposes of the health service in England has had on the provision by the Trust of goods and services for those purposes.

38.2.2 any steps taken by the Trust to secure that (taken as a whole) the actual membership of its Public Constituency is representative of those eligible for such membership;

38.2.3 any exercise by the Council of Governors of its power to require a Director to attend a meeting;

38.2.4 the Trust's policy on pay, on the work of the committee of Non-Executive Directors established to decide the remuneration and allowances and the other terms and conditions of office of the executive Directors, and on such other procedures as the Trust has on pay;

38.2.5 the remuneration of the Directors and on the expenses of the Governors and the Directors; and

38.2.6 any other information NHSE requires.

38.3 The Trust shall comply with any decision NHSE makes as to:

38.3.1 the form of the reports

38.3.2 when the reports are to be sent to it; and

38.3.3 the periods to which the reports are to relate.

38.4 The Trust shall give information to NHSE as to its forward planning in respect of each Financial Year. The document containing the information with respect to forward planning shall be prepared by the Board of Directors who in doing so shall have regard to the views of the Council of Governors.

38.5 The forward planning information shall include information about

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

38.5.2 the income it expects to receive from doing so.

38.6 Where the forward planning information contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 38.5.1 the Council of Governors must:

38.6.1 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

38.6.2 notify the Board of Directors of its determination.

38.7 The Trust may not implement a proposal for carrying on activities of a kind mentioned in sub-paragraph 38.5.1if the Council of Governors has:

38.7.1 determined that it is not 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

38.7.2 has notified the Board of Directors of that determination.

38.8 If 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, the Trust may implement the proposal only if more than half of the members of the Council of Governors voting approve its implementation.

39. Mergers etc., and Significant Transactions

39.1 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.

39.2 The Trust may enter into a Significant Transaction only if more than half of the members of the Council of Governors voting approve entering into the transaction.

39.3 "Significant Transaction" means:

39.3.1 the acquisition of, or an agreement to acquire, whether contingent or not, assets the value of which is more than 25% of the value of the Trust's gross assets before the acquisition; or

39.3.2 the disposition of, or an agreement to dispose of, whether contingent or not, assets of the Trust the value of which is more than 25% of the value of the Trust's gross assets before the disposition; or

39.3.3 a transaction that has or is likely to have the effect of the Trust acquiring rights or interests or incurring obligations or liabilities, including contingent liabilities, the value of which is more than 25% of the value of the Trust's gross assets before the transaction.

39.4 For the purpose of this paragraph 39:

39.4.1 "gross assets" means the total of fixed assets and current assets

39.4.2 in assessing the value of any contingent liability for the purposes of sub-paragraph 39.3.3, the Directors:

39.4.3 must have regard to all circumstances that the Directors know, or ought to know, affect, or may affect, the value of the contingent liability; and

39.4.4 may rely on estimates of the contingent liability that are reasonable in the circumstances; and

39.4.5 may take account of the likelihood of the contingency occurring.

40. Meetings of Council of Governors to consider annual accounts and reports

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

40.1.1 the annual accounts

40.1.2 any report of the Auditor on them; and

40.1.3 the annual report.

41. Annual Members' Meeting

41.1 The Trust shall hold an annual meeting for its members and members of the public each year. This meeting may be combined with the general meeting of the Council of Governors referred to in paragraph 40.

41.2 At least one Director shall attend the meeting and present the following documents to the members at the meeting:

41.2.1 the annual accounts

41.2.2 any report of the auditor on them; and

41.2.3 the annual report.

42. Amendment of the Constitution

42.1 The Trust may make amendments to this Constitution only if:

42.1.1 more than half of the members of the Council of Governors voting approve the amendments; and

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

42.2 Amendments take effect as soon as the conditions in paragraph 42.1 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.

42.3 The Trust shall inform NHSE of amendments to the Constitution.

42.4 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 public 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.

42.5 If more than half the members voting 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. Instruments

43.1 The Trust shall have a seal.

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

44. Indemnity

44.1 Members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their board functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust.

44.2 The Trust may take out insurance either through the NHS Litigation Authority or otherwise in respect of Directors' and officers' liability, including liability arising by reason of the Trust acting as a corporate trustee of an NHS charity.

45. Dispute Resolution

45.1 In the event of any dispute between the Council of Governors and the Board of Directors:

45.1.1 in the first instance the Chair on the advice of the Secretary, and such other advice as the Chair may see fit to obtain, shall seek to resolve the dispute

45.1.2 if the Chair is unable to resolve the dispute he or she shall appoint a special committee comprising equal numbers of Directors and Governors to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute; and

45.1.3 if the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Chair may refer the dispute back to the Board of Directors who shall make the final decision.

ANNEX 1

The Public Constituency

(Paragraph 6)

PUBLIC CONSTITUENCIES OF THE TRUST

NAME OF CONSTITUENCY	AREA	MINIMUM NUMBER OF MEMBERS	NUMBER OF GOVERNORS
Wokingham	All electoral wards within Wokingham District Council area	220	3
Bracknell	All electoral wards within Bracknell Forest Borough Council area	220	3
Slough	All electoral wards within Slough Borough Council area	220	3
Reading	All electoral wards within Reading Borough Council area	220	3
West Berkshire	All electoral wards within West Berkshire Council area	220	3
Windsor & Maidenhead	All electoral wards within Windsor & Maidenhead Royal Borough Council area	220	3
Rest of England	**England other than the six areas noted above**	50	1
	Minimum Membership	**1,370**	
	Public Governors		**19**

ANNEX 2

The Staff Constituency

(Paragraph 7)

1. Staff Constituency: Classes

1.1 There shall be two classes of staff members as follows:

1.1.1 Staff members who are employed by the Trust as: Nurses; Nursing Assistants; Doctors (including those with provisional registration); Pharmacists; Psychologists; Psychotherapists; Occupational Therapists; Speech Therapists; and other Allied Health Professionals, will be Assigned to the "Clinical Staff Class";

1.1.2 Finance, Human Resources, Information Technology, Facilities and Estates and Administration & Clerical staff who are employed by the Trust will be Assigned to the "Non Clinical Staff Class"; and

1.2 Trust Subcontractors and Volunteers will be Assigned to the "Non Clinical Staff Class".

1.3 The minimum number of members required for each staff class shall be:

1.3.1 Clinical Staff Class – 500

1.3.2 Non Clinical Staff Class – 500

1.4 Individuals who are eligible to be a member of the Staff Constituency may not become or continue as a member of more than one staff class, and individuals who are eligible to join more than one staff class shall be allocated to the staff class for which they are primarily employed.

ANNEX 3

Composition of Council of Governors

(Paragraph 9)

1. Composition

1.1 The Council of Governors shall comprise:

1.1.1 19 Public Governors;

1.1.2 4 Staff Governors comprised of the following:

1.1.2.1 2 being elected by the "Clinical Staff Class "

1.1.2.2 2 being elected by the "Non Clinical Staff Class"

1.1.3 6 Local Authority Governors; and

1.1.4 3 Other Partnership Governors.

1.2 The number of Public Governors is to be more than half of the total membership of the Council of Governors.

1.3 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:

1.3.1 The University of Reading, of Whiteknights, PO Box 217, Reading, Berkshire, RG6 6AH, a university currently incorporated by Royal Charter granted on 1 February 1926 (the "University of Reading");

1.3.2 The Alzheimer's Society, a registered charity and company limited by guarantee who is registered on the Central Register of Charities under registration number 296645 and who is incorporated in England under Company Number 02115499 and whose registered address is Gordon House, 10 Greencoat Place, London SW1P 1PH (the "Society"); and

1.3.3 British Red Cross Society (Thames Valley), a registered charity with number 220949 of John Nike House, 90 Eastern Avenue, Reading RG1 5SF ("British Red Cross").

2. Appointed Governors

2.1 Local Authority Governors

2.1.1 Bracknell Forest Borough Council, Windsor & Maidenhead Royal Borough Council, Slough Borough Council, Reading Borough Council, Wokingham District Council, and West Berkshire Council their successor organisations may each appoint one Local Authority Governor by notice in writing Signed by the leader of the relevant Council or a member of the relevant Council executive, and delivered to the Secretary.

2.2 Other Partnership Governors

2.2.1 The University of Reading may appoint one Other Partnership Governor by notice in writing signed by the Vice Chancellor or a Pro Vice Chancellor of the University of Reading and delivered to the Secretary;

2.2.2 British Red Cross may appoint one Other Partnership Governor by notice in writing Signed by the Chief Executive of British Red Cross and delivered to the Secretary; and

2.2.3 The Society may appoint one Other Partnership Governor by notice in writing signed by the Chief Executive of the Society and delivered to the Secretary.

ANNEX 4

The Model Election Rules

(Paragraph 10)

MODEL ELECTION RULES 2014

PART 1: INTERPRETATION

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 (December 2013) or any later version of such code.

"*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;

"*Monitor*" means the corporate body known as Monitor 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.

PART 2: TIMETABLE FOR ELECTIONS

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.

PART 3: RETURNING OFFICER

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 their 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 their functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

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 their 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 them 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 their 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 their 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 their vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts their 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 their 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 their declaration of identity with their 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 their 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 their 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 their 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 their 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 their voter ID number in order to be able to cast their 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 their 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 their 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 their ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

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 their 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 their voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

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 their 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 their 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 their 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 their vote.

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

34. Voting procedure for remote voting by telephone

34.1 To cast their 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 their 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 their 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 their vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast their 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 their 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.

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

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

(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.

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6

STV41.1 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 STV49,

"*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 STV46,

"*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 STV47.4 or STV47.7.

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.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 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.

STV44.2 The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.

STV44.3 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.

STV44.4 The returning officer is to endorse the word “rejected” on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by them under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by them under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 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.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 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.

STV46.2 The result, increased by one, of the division under rule STV46.1 (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”).

STV46.3 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 STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 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.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 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).

STV47.5 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.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(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.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, 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.

STV47.10 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.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 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.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(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.

STV48.3 All ballot documents transferred under rule STV47 or STV49 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.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 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.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, 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 STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 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).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, 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 STV49.1 into sub- parcels according to their transfer value.

STV49.6 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).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 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 or she has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 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.

STV49.11 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 STV47.5 to STV47.10 and rule STV48.

STV49.12 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.

STV49.13 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.

STV50. Filling of last vacancies

STV50.1 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.

STV50.2 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.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 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 STV47.10.

STV51.2 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 or she obtained the quota.

STV51.3 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.

STV51.4 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.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chair of the NHS Trust, or

(ii) in any other case, to the chair of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 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 [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chair of the NHS Trust, or

(ii) in any other case, to the chair of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 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 STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

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 chair of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

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 chair 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 their vote was given, and

(ii) that Monitor has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by them in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39 and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and 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.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chair of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 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.

STV59.2 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).

PART 10: ELECTION EXPENSES AND PUBLICITY

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 Monitor 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 their 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 their own services voluntarily, on their own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

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 Monitor 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 Monitor 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. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

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 Monitor 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.

PART 12: MISCELLANEOUS

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

Standing Orders for the Practice and Procedure of the Council of Governors

(Paragraph 16)

1. Interpretation and Definitions

1.1 Save as otherwise permitted by law, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he or she should be advised by the Chief Executive and Secretary).

1.2 Terms used in these Standing Orders have the meaning given to them in the Constitution.

1.3 Words importing the masculine gender include the feminine gender and vice versa.

2. Meetings of the Council of Governors

2.1 Admission of the Public, Press and Observers

2.1.1 The public and representatives of the Press shall be afforded reasonable facilities to attend all meetings of the Council of Governors except where it resolves that members of the public and representatives of the Press be excluded from all or part of a meeting on the grounds that:

2.1.1.1 any publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or

2.1.1.2 for other reasons stated in the resolution and arising from the nature of the business or the proceedings that the Council of Governors believe are special reasons for excluding the public from the meeting in accordance with the Constitution.

2.1.1.3 Nothing in these Standing Orders shall require the Council of Governors to allow members of the public and 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.

2.1.1.4 In the event that the public and press are admitted to all or part of a meeting, the Chair (or other person presiding) shall give such directions as he or she thinks fit in regard to the arrangements for meetings and accommodation of the public and press so as to ensure that the Council's business shall be conducted without interruption and disruption. The public and the press shall be required to withdraw upon the Council resolving "that in the interests of public order the meeting adjourn for (period to be specified) to enable the Council to complete its business without the presence of the public".

2.1.1.5 The Trust may make such arrangements from time to time as it sees fit with regards to extending of invitations to observers to attend and address the Council.

2.2 Calling Meetings

2.2.1 Meetings of the Council of Governors shall be held at such times and places and of such format including in person, by using electronic communication or hybrid, as the Council of Governors may determine and there shall be at least four meetings in any year including:

2.2.1.1 an annual meeting no later than the 30 September in each year apart from the first year, when the Council of Governors are to receive and consider the annual accounts, any report by the Auditor and the annual report; and

2.2.1.2 any other meetings required of the Governors in order to fulfil their functions in accordance with the Constitution.

2.2.2 The Secretary may call a meeting of the Council of Governors at any time. If the Secretary refuses to call a meeting after a requisition for that purpose, signed by at least one third of the whole number of the Governors and specifying the business to be transacted at the meeting, has been presented to them, or if, without so refusing, the Secretary does not call a meeting within 5 Clear Days after such requisition has been presented to them at the Trust's Headquarters, such one third or more of the Governors may forthwith call a meeting for the purpose of conducting that business.

2.3 Notice of Meetings

2.3.1 Before each meeting of the Council of Governors, a notice of the meeting specifying the general nature of the business proposed to be transacted at it and signed by the Chair or by an officer authorised by the Chair to sign on their behalf, shall be sent via email to the usual email address, or sent by post to the usual place of residence, of every Governor, so as to be available to them at least 10 Clear Days before the meeting save in the case of emergencies.

2.3.2 Before each meeting of the Council of Governors a public notice of the time and place, and if appropriate remote access/electronic communications arrangements, of the meeting, and if possible the public part of the agenda, shall be advertised on the Trust's website at least seven days before the meeting, save in the case of emergencies.

2.3.3 Want of service of the notice on any one Governor shall not affect the validity of a meeting but failure to serve such a notice on more than three Governors will invalidate the meeting. A notice (including a notice sent by email) shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of posting.

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

2.3.5 Agendas will be sent to Governors before the meeting and supporting papers, whenever possible, shall accompany the Agenda, but will certainly be despatched no later than three Clear Days before the meeting, save in the case of emergencies.

2.4 Annual Meeting

2.4.1 The Council of Governors shall hold an annual meeting of the Council of Governors in every calendar year so that there are no more than fifteen calendar months between one meeting and the next and shall present to that meeting:

2.4.1.1 A report on the proceedings of its meetings held since the last annual meeting.

2.4.1.2 A report on the progress since the last annual meeting in developing the membership strategy including the steps taken to ensure that the actual membership is fully representative of the persons who are eligible to be members under the Constitution.

2.4.1.3 A report on any change to the composition or membership of the Council of Governors which has taken place since the last annual meeting; and

2.4.1.4 A report containing such comments as it wishes to make regarding the performance of the Trust and the accounts of the Trust for the preceding financial year and the future service development plans of the Trust.

2.5 Setting the Agenda

2.5.1 The Council of Governors may determine that certain matters shall appear on every Agenda for a meeting and shall be addressed prior to any other business being conducted.

2.5.2 A member of the Council of Governors desiring a matter to be included on an Agenda, including a formal proposition for discussion and voting on at a meeting, shall make their request in writing to the Chair at least 10 Clear Days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. The Chair shall include on the Agenda any matter contained in a request

received at least 10 Clear Days before the meeting. Requests made less than 10 Clear Days before a meeting may be included on the Agenda at the discretion of the Chair.

2.6 Petitions

2.6.1 Where a petition has been received by the Trust, the Chair shall include the petition as an item for the Agenda of the next Council of Governors meeting.

2.7 Chair of Meeting

2.7.1 At any Council of Governors meeting, the Chair if present, shall preside.

2.7.2 If the Chair is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest the Deputy Chair shall preside.

2.7.3 If the Vice Chair is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest, another Non-Executive Director as shall be appointed by the Council of Governors shall preside.

2.7.4 If all the Non-Executive Directors are absent or are incapable of taking part on the grounds of a conflict of interest, a Governor shall be appointed by the Council of Governors to preside.

2.8 Agenda Proposals

2.8.1 Where a Governor has requested inclusion of a matter on the Agenda in accordance with Standing Order 2.5.2 above as a matter to be formally proposed for discussion and voting on at the meeting, the provisions of this Standing Order 2.8 shall apply in respect of the proposition:

2.8.2 The mover of the proposition shall have a right of reply at the close of any discussion on the proposition or any amendment thereto.

2.8.3 When a proposition is under discussion or immediately prior to discussion it shall be open to a Governor to move:

2.8.3.1 an amendment to the proposition.

2.8.3.2 the adjournment of the discussion or the meeting.

2.8.3.3 that the meeting proceed to the next business.

2.8.3.4 the appointment of an ad hoc committee to deal with a specific item of business.

2.8.3.5 that the motion be now put.

2.8.3.6 that the public be excluded from the meeting in relation to the discussion concerning the proposition under Standing Order 4.1.1.

2.8.4 In the case of sub-paragraphs 2.8.3.3 and 2.8.3.5.5 above, to ensure objectivity these matters may only be put by a Governor who has not previously taken part in the debate and who is eligible to vote.

2.8.5 No amendment to the proposition shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the proposition.

2.8.6 Subject to paragraph 2.9.1, the mover of a proposition shall have a maximum of five minutes to move and three minutes to reply. Once a proposition has been moved, no other Governor shall speak more than once or for more than three minutes.

2.9 Chair's Ruling

2.9.1 Statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

2.10 Voting

2.10.1 A Governor may not vote at a meeting of the Council of Governors unless he or she has made a declaration in the form specified within Schedule A of these Standing Orders, that he or she is a member of the constituency which elected them and is not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 to the 2006 Act or under the Constitution. Such declaration must be dated at least 7 Clear Days prior to the commencement of the meeting.

2.10.2 Except as stated otherwise in the constitution or these Standing Orders, every question at a meeting shall be determined by a majority of the votes of the Governors present and voting on the question.

2.10.3 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. In the event of a meeting held using electronic communication, an electronic voting facility will be made available, including when appropriate, the facility for holding a secret ballot.

2.10.4 Whoever is Chair of the meeting of the Council of Governors shall in the case of an equality of votes on any question or proposal have a casting vote.

2.10.5 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.

2.10.6 If a Governor so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

2.10.7 A Governor may only vote if present (either in person or by electronic communication) at the time of the vote on which the question is to be decided; no Governor may vote by proxy.

2.10.8 Any matter which could be decided by the Council of Governors in a meeting may be determined by written resolution. A written resolution shall, with any accompanying papers which are relevant, describe the matter to be decided and provide for Governors to sign the resolution to confirm their agreement. A written resolution may comprise identical documents sent to all Governors, each to be signed by a Governor, or one document to be signed by all Governors. A written resolution shall be passed only when at least a majority of the Governors, including a majority of Governors who are members of the public constituency of the Trust, approve the resolution in writing within the timescale imposed in such a notice. The Secretary shall keep records of all written resolutions.

2.11 Minutes

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

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

2.12 Suspension of Standing Orders

2.12.1 Except where this would contravene any provision of the Regulatory Framework, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Governors are present, there is a majority of Governors who are members of the public constituency of the Trust, and that a majority of those present vote in favour of suspension.

2.12.2 A decision to suspend the Standing Orders shall be recorded in the minutes of the meeting.

2.12.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and Governors.

2.12.4 No formal business may be transacted while Standing Orders are suspended.

2.13 Variation and Amendment of Standing Orders

2.13.1 These Standing Orders shall be amended only if:

2.13.1.1 a notice of proposal under Standing Order 4.5.2 has been given; and

2.13.1.2 at least half the total number of Governors vote in favour of amendment; and

2.13.1.3 the variation proposed does not contravene a provision of the Regulatory Framework.

2.14 Record of Attendance

2.14.1 The names of the Chair and Governors present at the meeting shall be recorded in the minutes.

2.15 Quorum

2.15.1 No business shall be transacted at a meeting unless at least one third of all the Governors are present, including at least one third of the Public Governors.

2.15.2 If at any meeting there is no quorum present within 30 minutes of the time fixed for the start of the meeting, the meeting shall stand adjourned for at least five Clear Days and upon reconvening, those present shall constitute a quorum.

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

2.16 Meetings: Electronic Communication

2.16.1 In this Standing Order "communication" and "electronic communication" shall have the meanings set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof.

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

2.16.3 A meeting at which one or more of the Governors attends by way of electronic communication is deemed to be held at such a place as the Governors shall at the said meeting resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the Governors attending the meeting are physically present, or in default of such a majority, the place at which the Chair of the meeting is physically present.

2.16.4 Meetings held in accordance with this Standing Order are subject to requirements in respect of quorum. For such a meeting to be valid, a quorum MUST be present and maintained throughout the meeting.

2.16.5 The Minutes of a meeting held in this way MUST state that it was held by electronic communication and that the Governors were all able to hear each other and were present throughout the meeting.

3. Lead Governor and Deputy Lead Governor

3.1 The Governors shall appoint a Lead Governor and a Deputy Lead Governor at the first meeting of the Council of Governors and at each annual meeting of the Council of Governors thereafter.

3.2 Without prejudice to the right of any Governor to communicate directly with NHSE, the Lead Governor will be the point of contact between NHSE and the Council of Governors.

3.3 Without prejudice to the rights of any Governor to communicate directly with the Chair, the Lead Governor shall be responsible for receiving from Governors and communicating to the Chair any

comments, observations and concerns expressed to them by Governors (other than at meetings of the Council of Governors) regarding the performance of the Trust or any other serious or material matter relating to the Trust or its business

3.4 The Deputy Lead Governor shall be responsible for supporting the Lead Governor in their role and for performing the responsibilities of the Lead Governor whenever he or she is known to be unavailable.

3.5 Each Governor shall communicate any comment, observation or concern which he or she may have to the Lead Governor in the first instance and only to the Deputy Lead Governor if the Lead Governor is known to be unavailable.

3.6 The Lead Governor and Deputy Lead Governor shall be elected by, and from amongst, the Governors who have been elected as Governors from the public constituency of members.

3.7 The Lead Governor and the Deputy Lead Governor so appointed shall hold office until the next annual meeting of the Council of Governors but shall be eligible for re-appointment at that time.

3.8 Nominations forms for appointment as Lead Governor and Deputy Lead Governor shall be sent out not less than 15 Clear Days prior to the annual meeting of the Council of Governors. Each nomination shall be made in writing by the Governor seeking appointment and must be returned to the principal place of business of the Trust addressed to the Secretary to arrive not less than three Clear Days before the meeting.

3.9 There shall be separate forms of nomination for appointment to the position of Lead Governor and the position of Deputy Lead Governor and eligible Governors may be nominated for both positions.

3.10 In the event of there being two or more nominations for either appointment a secret ballot shall be held of all the Governors present at the meeting with each Governor present having one vote for each contested appointment.

3.11 The meeting shall adjourn while the ballot is taken and the Governor whose nomination receives the largest number of votes for each position shall be appointed.

3.12 In the event of an equality of votes the Chair of the meeting shall have a casting vote.

3.13 If a Governor shall receive the largest number of votes for appointment as both Lead Governor and Deputy Lead Governor that Governor shall be appointed as Lead Governor and the Governor who received the second largest number of votes for the position of Deputy Lead Governor shall be appointed as Deputy Lead Governor

3.14 The result of the ballot shall be announced at the meeting.

4. Committees

4.1 The Council of Governors may appoint committees of the Council of Governors to assist it in the proper performance of its functions under the Regulatory Framework, consisting wholly or partly of the Chair and Governors. The Council of Governors may appoint to such committees, persons who are neither Governors, nor Directors or Officers of the Trust.

4.2 Each such committee shall have such terms of reference and powers and be subject to such conditions as the Council of Governors shall decide and shall be in accordance with the Regulatory Framework and any guidance issued by NHSE, but the Council of Governors shall not delegate to any committee any of the powers or responsibilities which are to be exercised by the Council of Governors at a formal meeting. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.3 The Council of Governors shall approve the members of the Council of Governors' Appointments and Remuneration Committee.

4.4 A committee appointed under Standing Order 4 may, subject to approval given by the Council of Governors, appoint sub-committees consisting wholly or partly of members of the committee. Where committees are authorised to establish sub-committees, they may not delegate their powers to the sub-committee unless expressly authorised by the Council of Governors.

4.5 These Standing Orders, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council of Governors (and to sub-committees established with the approval of the Council of Governors) with the terms "Chair" to be read as a reference to the Chair of the committee, and the term "Governor" to be read as a reference to a member of the committee as the context permits.

4.6 Any Committee or Sub-Committee established under this Standing Order 4 may call upon outside advisers to assist them with their tasks, subject to the advance agreement of the Board of Directors. Any conflict arising between the Council of Governors and the Board of Directors under this paragraph shall be determined in accordance with the Dispute Resolution Procedure as set out at Paragraph 45 of the Constitution.

4.7 Where the Council of Governors is required to appoint persons to a committee to undertake statutory functions, and where such appointments are to operate independently of the Council of Governors, such appointments shall be made in accordance with applicable statute and regulations and with guidance issued by NHSE.

4.8 Where the Council of Governors determines that persons who are neither Governors, nor Directors or Officers of the Trust, shall be appointed to a committee, the terms of such appointment shall be determined by the Council of Governors subject to the payment of travelling expenses and other allowances being in accordance with such sum as may be determined by the Board of Directors.

4.9 If the Board of Directors agrees, the Council of Governors may appoint Governors to serve on joint committees with the Board of Directors or committees of the Board of Directors. Where Governors are appointed to committees of the Board of Directors they shall have observer status only.

5. Declarations of Interests and Register of Interests

5.1 Declaration of Interests

5.1.1 The Regulatory Framework requires each Governor to declare to the Secretary:

5.1.1.1 any actual or potential, direct or indirect, financial interest which is material to any discussion or decision they are involved or likely to be involved in making as described in Standing Orders 5.2.2, 5.2.3 and 5.2.6; and

5.1.1.2 any actual or potential, direct or indirect, non-financial professional interest, which is material to any discussion or decision they are involved or likely to be involved in making, as described in Standing Orders 5.2.4 and 5.2.6; and

5.1.1.3 any actual or potential, direct or indirect, non-financial personal interest, which is material to any discussion or decision they are involved or likely to be involved in making, as described in Standing Order 5.2.5 and 5.2.6.

5.1.2 Such a declaration shall be made either at the time of the Governor's election or appointment or as soon thereafter as the interest arises, but within five Clear Days of becoming aware of the existence of that interest, and in a form prescribed by the secretary which shall be included as Schedule B.

5.1.3 In addition, if a Governor is present at a meeting of the Council of Governors and has an interest of any sort in any matter which is the subject of consideration, he or she shall at the meeting and as soon as practicable after its commencement disclose the fact and the Chair shall then decide what action to take. This may include excluding the Governor from discussions on the matter and/or prohibiting the Governor from voting on any question with respect to the matter. Subject to Standing Order 5.2.3, if a Governor has declared a financial interest (as described in Standing Order 5.2.2) he or she shall not take part in the consideration or discussion of the matter.

5.1.4 Any interest declared at a meeting of the Council of Governors and subsequent action taken should be recorded in the minutes of the Council of Governor's meeting at which the interest was declared. Any changes in interests should be officially declared at the next relevant meeting following the change occurring.

5.1.5 This Standing Order 7 applies to any committee, sub-committee or joint committee of the Council of

Governors and applies to any member of any such committee, sub-committee, or joint committee (whether or not he or she is also a Governor).

5.1.6 Governors' interests will be disclosed in the Trust's Annual Report, at least to comply with the Financial Reporting Manual as published by NHSE but the Annual Report may also refer to the published declaration of interests of Governors.

5.2 Nature of Interests

5.2.1 Interests which should be regarded as "material" are ones which a reasonable person would take into account when making a decision regarding the use of taxpayers' money because the interest has relevance to that decision. Material interests are to be interpreted in accordance with guidance issued by NHSE.

5.2.2 A financial interest is where a Governor may receive direct financial benefits (by either making a gain or avoiding a loss) from the consequences of a decision of the Council of Governors. This could include:

5.2.2.1 directorships, including Non-Executive Directorships held in another organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding; or

5.2.2.2 employment in an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding; or

5.2.2.3 a shareholding, partnerships, ownership or part ownership of an organisation which is doing or is likely to do business with an organisation in receipt of NHS funding.

5.2.3 A Governor shall not be treated as having a financial interest in a matter by reason only:

5.2.3.1 of shares or securities held in collective investment or pensions funds or units of authorised unit trusts; or

5.2.3.2 of an interest in any company, body or person with which he or she is connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Governor in the consideration or discussion of or in voting on, any question with respect to that matter; or

5.2.3.3 of any travelling or other expenses or allowances payable to a Governor in accordance with the Constitution.

5.2.4 A non-financial professional interest is where a Governor may obtain a non-financial professional benefit from the consequence of a decision that the Council of Governors makes, such as increasing their professional reputation or status or promoting their professional career. This could include situations where a Governor is:

5.2.4.1 an advocate for a particular group of patients; or

5.2.4.2 a clinician with a special interest; or

5.2.4.3 an active member of a particular specialist body; or

5.2.4.4 an advisor for the Care Quality Commission or National Institute of Health and Care Excellence.

5.2.5 A non-financial personal interest is where a Governor may benefit personally from a decision that the Council of Governors makes in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include where the Governor is:

5.2.5.1 a member of a voluntary sector board or has a position of authority within a voluntary sector organisation with an interest in health and/or social care; or

5.2.5.2 a member of a lobbying or pressure group with an interest in health and/or social care.

5.2.6 A Governor will be treated as having an indirect financial interest, non-financial professional interest or non-financial personal interest where he or she has a close association with another individual

who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision in which the Governor is involved in making. This includes material interests of:

5.2.6.1 close family members and relatives, including a spouse, partner, parent, child or sibling.

5.2.6.2 close friends and associates; and

5.2.6.3 business partners.

5.2.7 If Governors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair. 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.

5.3 Register of Governors

5.3.1 The Register of Governors shall list the names of Governors, their category of membership of the Council of Governors, the dates defining their terms of office, and an address through which they may be contacted which may be the Secretary.

5.4 Register of Governors' Interests

5.4.1 The Secretary shall keep a Register of Interests of Governors which shall contain the names of each Governor, whether he or she has declared any interest, and if so, the interest declared.

6. Standards of Business Conduct

6.1 Members of the Council of Governors shall comply with the Trust's Code of Conduct and any guidance issued by NHSE.

7. Appointments and Recommendations

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

7.2 Informal discussions outside the Appointment Committee or Nominations Committee, whether solicited or unsolicited, should be declared to the panel or committee.

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

7.4 The Chair and every Governor shall disclose to the Chief Executive or their delegated officer any relationship between themselves and a candidate of whose candidature that Governor or Officer is aware. It shall be the duty of the Chief Executive or his delegated officer to report to the Council of Governors any such disclosure made.

7.5 On appointment, members of the Council of Governors should disclose to the Council of Governors whether they are related to any other member of the Council of Governors or holder of any office in the Trust.

7.6 Where the relationship to a member of the Council of Governors of the Trust is disclosed, Standing Order 5 shall apply.

8. Miscellaneous

8.1 The Secretary shall provide a copy of these Standing Orders to each Governor and endeavour to

ensure that each Governor understands their responsibilities within these Standing Orders.

8.2 These Standing Orders including all documents having effect as if incorporated in them shall be reviewed no less frequently than every two years and any resulting changes approved by the Board of Directors and the Council of Governors.

8.3 If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Council of Governors for action or ratification. All Governors have a duty to disclose any non-compliance with these Standing Orders to the Chair as soon as possible.

SCHEDULE A

Declaration to the Secretary of Berkshire Healthcare NHS Foundation Trust

A person may not stand for election to the Council of Governors as a public governor unless he or she has made a declaration in the form specified below of their qualification to vote as a member of the public constituency and is not prevented from being a member of the Council of Governors by paragraph 12 (disqualification and removal).

THE DECLARATION

I hereby declare that I am entitled to stand for election to the Council of Governors as a governor elected by the public constituency because I am a member of the public constituency and I am not prevented from being a member of the Council of Governors of the Trust by paragraph 8 of Schedule 7 to the National Health Service Act 2006, which states;

A person may not become or continue as a member of the Council of Governors if he or she:

- has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
- has made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it;
- has within the preceding five years been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.
- has within the preceding five years been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a Health Service Body;
- he or she is 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;
- he or she is a Director of the Trust, or a director, chair, or chief executive officer of another NHS Foundation Trust;
- he or she is a Governor of another NHS Foundation Trust which is considered by the Secretary, at their absolute discretion, to be in competition with the Trust;
- he or she has had their name removed from a list maintained under regulations pursuant to sections 91, 106, or 123 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and he or she has not subsequently had their name included in such a list; or
- he or she lacks capacity within the meaning of the Mental Capacity Act 2005 to carry out all the duties and responsibilities of a governor.

I further hereby declare that I am entitled to stand for election to the Council of Governors as a governor elected by the public constituency under the Constitution of the Trust.

Signed……Name……

Dated …….

SCHEDULE B

Prescribed Form of Declaration of Interests

Declaration to the Secretary of Berkshire Healthcare NHS Trust Foundation Trust

I hereby declare that I am at the date of this declaration a member of the [Public/Staff] constituency, and I am not prevented from being a member of the Council of Governors by reason of any provision of the Constitution.

I declare that I have read and fully understood the Standing Orders for Governors.

I fully understand the requirements to declare interests as outlined within the Standing Orders for Governors.

(Please delete either one or two below)

1 I confirm that I have no current interest to declare

2 I have the following interests to declare.

I agree to abide by the conditions outlined in the Standing Orders for Governors and to maintain updated information within the register of Governors interests as defined within the Standing Orders for Governors

Name …… Date……

Signature……..

ANNEX 6

Standing Orders for the Practice and Procedure of the Board of Directors

(Paragraph 28)

1. Interpretation and Definitions

1.1 Save as otherwise permitted by law, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he or she should be advised by the Chief Executive and Secretary).

1.2 Terms used in these Standing Orders have the meaning given to them in the Constitution.

1.3 Words importing the masculine gender include the feminine gender and vice versa.

2. The Trust Board

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

2.2 All funds received in trust shall be in the name of the Trust as corporate trustee.

2.3 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.

2.4 The Trust has the functions conferred on it by the Regulatory Framework. Accountability for charitable Funds held on trust is to be made to the Charity Commission. Accountability for non-charitable Funds held on trust is only to NHSE

2.5 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board of Directors in formal session. These powers and decisions are set out in the Scheme of Delegation and have effect as if incorporated into the SOs.

2.6 Removal of the Chair and other Non-Executive Directors

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

2.7 Appointment and Powers of Deputy-Chair

2.7.1 For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chair, the Council of Governors may appoint a Non-Executive Director to be Vice-Chair for such period, not exceeding the remainder of his term as Non-Executive Director of the Trust, as the Council of Governors may specify on appointing them.

2.7.2 Any Non-Executive Director so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Council of Governors. The Council of Governors may thereupon appoint another Non-Executive Director as Vice Chair in accordance with the provisions of SO 2.12.3.

2.7.3 Where the Chair of the Trust has died or has ceased to hold office, or where he or she has been unable to perform their duties as Chair owing to illness, conflict of interest or any other cause, the Deputy-Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these SOs shall, so long as there is no Chair able to perform their duties, be taken to include references to the Deputy - Chair. Where both the Chair and Vice Chair are unable to perform their duties owing to illness, conflict of interest or any other cause, another Non-Executive Director as may be appointed by the Council of Governors shall

act as Chair.

3. Meetings of the Trust

3.1 Admission of the Public and the Press

3.1.1 Meetings of the Board of Directors shall be open to the public, unless and to the extent that the Board of Directors has resolved that members of the public should be excluded from a meeting on the grounds that

3.1.1.1 any publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or

3.1.1.2 for other reasons stated in the resolution and arising from the nature of the business or the proceedings that the Board of Directors considers are special reasons for excluding the public from the meeting in accordance with the Constitution.

3.1.2 The public and representatives of the press shall be afforded reasonable facilities to attend all public events or meetings of the Board of Directors, including the Annual General Meeting.

3.1.3 The Chair shall give such directions as he or she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board of Directors 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.

3.1.4 Nothing in these SOs shall require the Board of Directors to allow members of the public or representative 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 Board of Directors.

3.2 Calling Meetings

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

3.2.2 The Chair may call a meeting of the Board of Directors 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 members of the Board of the Directors, and this 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 members of the Board of Directors may forthwith call a meeting.

3.3 Notice of Meetings

3.3.1 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 Chair, or by an Officer of the Trust authorised by the Chair to sign on his behalf, shall be delivered to every Director, or sent by post to the usual place of residence of every Director, so as to be available to them at least three Clear Days before the meeting.

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

3.3.3 Want of service of the notice on any one member of the Board of Directors shall not affect the validity of a meeting.

3.3.4 In the event of an emergency giving rise to the need for an immediate meeting, SOs 3.3.1 to 3.3.4 shall not prevent the calling of such a meeting without the requisite three Clear Days' notice provided that every effort is made to make personal contact with every Director who is not absent from the United Kingdom and the Agenda for the meeting is restricted to matters arising in that emergency.

3.4 Agendas

3.4.1 Agendas and supporting papers will be sent to members of the Board of Directors at least three Clear Days before the meeting, save in emergency. Failure to serve such a notice on more than three members of the Board of Directors will invalidate the meeting. A notice shall be presumed to have been served one day after posting and in the case of by electronic communication on the day it is sent.

3.4.2 Before each public meeting of the Board of Directors a public notice of the time and place of the meeting, and the public part of the Agenda, shall be displayed at the Trust's Headquarters and on the Trust's website at least three Clear Days before the meeting.

3.4.3 Before holding a meeting, the Board of Directors will send a copy of the agenda (but not supporting papers) to the Council of Governors. The agenda sent to the Governors will include the business to be transacted in any private meeting of the Board of Directors.

3.5 Setting the Agenda

3.5.1 The Board of Directors may determine that certain matters shall appear on every Agenda for a meeting of the Trust and shall be addressed prior to any other business being conducted. (Such matters may be identified within these SOs).

3.5.2 A Director desiring a matter to be included on an Agenda shall make his request in writing to the Chair at least 14 Clear Days before the meeting, subject to SO3.3. The Chair shall include on the Agenda any matter contained in a request received at least 14 Clear Days before the meeting. Requests made less than 14 Clear Days before a meeting may be included on the Agenda at the discretion of the Chair. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information.

3.6 Petitions

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

3.7 Chair of Meeting

3.7.1 At any meeting of the Board of Directors, the Chair if present, shall preside. If the Chair is absent from the meeting the Vice Chair, if there is one and he or she is present, shall preside. If the Chair and Vice Chair are absent such Non-Executive Director (who is not also an Officer of the Trust) as the Directors present shall choose shall preside.

3.7.2 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Vice Chair, if present, shall preside. If the Chair and Vice Chair are absent, or are disqualified from participating, such Non-Executive Director (who is not also an Officer of the Trust) as the Directors present shall choose shall preside.

3.8 Chair's Ruling

3.8.1 Statements of Directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

3.9 Notices of Motion

3.9.1 Subject to the provisions of SO 3.11 'Motions: Procedure at and during a meeting' and SO 3.12 'Motion to Rescind a Resolution', a member of the Board wishing to move or amend a motion shall send a written notice to the Chair.

3.9.2 The notice shall be delivered at least 14 Clear Days before the meeting. The Chair shall include in the agenda for the meeting all notices so received that are in order and permissible under these Standing Orders and the appropriate Regulations. Subject to SO 3.3.3, this Standing Order shall not prevent any motion being moved without notice on any business mentioned on the agenda for the

meeting.

3.10 Emergency Motions

3.10.1 Subject to the agreement of the Chair, and subject also to the provision of SO 3.11 'Motions: Procedure at and during a meeting', a Director of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

3.11 Motions: Procedure at and during a meeting

3.11.1 Who may propose

3.11.1.1 A motion may be proposed by the Chair of the meeting or any Director of the Board present. It must also be seconded by another Director of the Board.

3.11.2 Contents of motions

3.11.2.1 The Chair may exclude from the debate at his discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

3.11.2.1.1 the reception of a report;

3.11.2.1.2 consideration of any item of business before the Board;

3.11.2.1.3 the accuracy of minutes;

3.11.2.1.4 that the Board proceed to next business;

3.11.2.1.5 that the Board adjourn;

3.11.2.1.6 that the question be now put.

3.11.3 Amendments to motions

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

3.11.3.2 Amendments to motions shall be moved relevant to the motion and shall not have the effect of negating the motion before the Board.

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

3.11.4 Rights of reply to motions

3.11.4.1 Amendments

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

3.11.4.2 Substantive/original motion

3.11.4.2.1 The member of the Board who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.11.5 Withdrawing a motion

3.11.5.1 A motion, or an amendment to a motion, once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.11.6 Motions once under debate

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

3.11.6.1.1 an amendment to the motion;

3.11.6.1.2 the adjournment of the discussion, or the meeting;

3.11.6.1.3 that the meeting proceed to the next business;

3.11.6.1.4 that the question should be now put;

3.11.6.1.5 the appointment of an 'ad hoc' committee to deal with a specific item of business;

3.11.6.1.6 that a member be not further heard.

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

3.11.6.3 If a motion to proceed to the next business or that the question be now put, is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote. Subject to paragraph 3.8, the mover of a motion shall have a maximum of five minutes to move and five minutes to reply. Once a motion has been moved, no Director shall speak more than once or for more than five minutes.

3.12 Motion to Rescind a Resolution

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

3.12.2 When any such motion has been dealt with by the Board of Directors, it shall not be competent for any Director other than the Chair to propose a motion to the same effect within six months; however the Chair may do so if he or she considers it appropriate. This Standing Order 3.12.2 shall not apply to motions moved in pursuance of a report or recommendations of a committee or the Chief Executive.

3.13 Voting

3.13.1 Except as stated otherwise in the constitution or these Standing Orders, every question 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 Chair of the meeting shall have a second or casting vote.

3.13.2 If the number of Non-Executive Directors (including the Chair) in a meeting of the Board of Directors is equal to the number of executive Directors, the Chair (and in his absence, the Deputy Chair), shall have a casting vote at meetings of the Board of Directors in accordance with these Standing Orders.

3.13.3 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 or by appropriate electronic means. A paper ballot may also be used if a majority of the Directors present so request.

3.13.4 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.

3.13.5 If a Director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

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

3.13.7 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 the minutes.

3.14 Minutes

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

3.14.2 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. Minutes shall be retained in the Chief Executive's office

3.14.3 Board 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.

3.14.4 As soon as practicable after holding a meeting, the Board of Directors shall send a copy of the minutes of the meeting to the Council of Governors.

3.15 Suspension of Standing Orders

3.15.1 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.

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

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

3.15.4 No formal business may be transacted while SOs are suspended.

3.15.5 The Audit Committee shall review every decision to suspend SOs.

3.16 Variation and Amendment of Standing Orders

3.16.1 These Standing Orders shall be amended only if:

3.16.1.1 relevant notice of a meeting has been served in accordance with SO3.3.

3.16.1.2 a notice of motion under SO 3.9 has been given.

3.16.1.3 a majority of Non-Executive Director vote in favour of amendment.

3.16.1.4 at least two-thirds of the Directors are present; and

3.16.1.5 the variation proposed does not contravene the Regulatory Framework, or any other statutory provisions.

3.17 Record of Attendance

3.17.1 The names of the Directors present at the meeting shall be recorded in the minutes.

3.18 Quorum

3.18.1 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 are present including at least one Executive Director and one Non-Executive Director and the Chair.

3.18.2 An Officer in attendance for an Executive Director but without formal acting up status may not count

towards the quorum.

3.18.3 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO7) he or she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least 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 considers the recommendations of the Appointments and Remuneration Committee

3.19 Meetings: Electronic Communication

3.19.1 In this Standing Order "communication" and "electronic communication" shall have the meanings set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof.

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

3.19.3 A meeting at which one or more of the Directors attends by way of electronic communication is deemed to be held at such a place as the Directors shall at the said meeting resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the Directors attending the meeting are physically present, or in default of such a majority, the place at which the Chair of the meeting is physically present.

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

4. Arrangements for the Exercise of Functions by Delegation

4.1 Subject to SO2.6 and such guidance as may be given by Monitor, the Board of Directors may make arrangements for the exercise of any of its functions by a committee or sub-committee appointed by virtue of SO 5.1 below or by a Director or an Officer of the Trust in each case subject to such restrictions and conditions as the Board of Directors considers appropriate. Delegated Powers are defined in a separate document (the Scheme of Delegation). That document has effect as if incorporated into these Standing Orders.

4.2 Emergency Powers

4.2.1 The powers which the Board of Directors has retained to itself within these SOs may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

4.3 Delegation to committees

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

4.4 Delegation to Officers

4.4.1 Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to a committee or subcommittee or joint committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions he or she will perform personally and shall nominate Officers to undertake the remaining functions for which he or she will still retain accountability to the Board of Directors.

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

4.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Finance Director or other Executive Director to provide information and advise the Board in accordance with any statutory requirements. Outside these statutory requirements the Finance Director shall be accountable to the Chief Executive for operational matters.

4.4.4 The arrangements made by the Board of Directors as set out in the Scheme of Delegation shall have effect as if incorporated in these SOs.

4.5 Duty to Report Non-Compliance with Standing Orders

4.5.1 If for any reason these SOs 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 of Directors for action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these SOs to the Secretary as soon as possible.

5. Committees

5.1 Appointment of Committees

5.1.1 Subject to SO2.6 the Board of Directors may appoint committees of the Trust consisting wholly of Directors.

5.1.2 A committee appointed under SO5.1.1 may, subject to such guidance as may be given by the Board of Directors or other health service bodies in question, appoint sub-committees consisting wholly of Directors.

5.1.3 The SOs of the Board of Directors, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Board of Directors, in which case the term “Chair” is to be read as a reference to the Chair of the committee as the context permits, and the term “member" is to be read as a reference to a member of the committee also as the context permits. (There is no requirement to hold meetings of committees, established by the Trust in public.)

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

5.1.5 Where committees are authorised to establish sub-committees, they may not delegate Executive powers to the sub-committee unless expressly authorised by the Board of Directors.

5.1.6 The Board of Directors shall approve the appointments to each of the committees, which it has formally constituted. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.1.7 The Board may also operate as a committee in accordance with SO 4.3.2. Any decisions taken by the Board in Committee (i.e., Seminar meeting of the Board) must be brought to the next meeting of the Board.

5.2 Confidentiality

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

5.2.2 A Director or a member of a committee shall not disclose any matter reported to the Board of

Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

6. Interface between the Board of Directors and the Council of Governors

6.1 The Board of Directors will cooperate with the Council of Governors as far as possible in order to comply with the Regulatory Framework in all respects and in particular in relation to the following matters which are set out specifically within the Constitution.

6.2 The Directors, having regard to the views of the Council of Governors, are to prepare the information as to the Trust's forward planning in respect of each financial year to be given to NHSE.

6.3 The Directors are to present to the Council of Governors at a general meeting the annual accounts, any report of the Auditor on them, and the annual report.

6.4 The annual reports shall give information on:

6.4.1 the impact that income received by the Trust otherwise than from the provision of goods and services for the purposes of the health service in England has had on the principal purpose.

6.4.2 any steps taken by the Trust to secure that (taken as a whole) the actual membership of its Public Constituency is representative of those eligible for such membership; and

6.4.3 any exercise by the Council of Governors of its power to require a Director to attend a meeting.

6.4.4 the Trust's policy on pay, on the work of the committee of Non-Executive established to decide the remuneration and allowances and the other terms and conditions of office of the executive Directors, and on such other procedures as the Trust has on pay.

6.4.5 the remuneration of the Directors and on the expenses of the Governors and the Directors; and

6.4.6 any other information NHSE requires.

6.5 The Trust shall comply with any decision NHSE makes as to:

6.5.1 the form of the reports.

6.5.2 when the reports are to be sent to it; and

6.5.3 the periods to which the reports are to relate.

6.6 In order to comply with the Regulatory Framework in all respects and in particular in relation to the matters which are set out above, the Council of Governors may request that a matter which relates to paragraphs 39 and/or 40 of the Constitution is included on the Agenda for a meeting of the Board of Directors.

6.7 If the Council of Governors so desires such a matter as described within SO 6.5 to be included on an Agenda item, they shall make their request in writing to the Chair at least 14 Clear Days before the meeting of the Board of Directors, subject to SO 3.3. The Chair shall decide whether the matter is appropriate to be included on the Agenda. Requests made less than 14 Clear Days before a meeting may be included on the Agenda at the discretion of the Chair.

7. Declarations of Interests and Register of Interests

7.1 The Regulatory Framework requires members of the Board of Directors to declare to the Secretary:

7.1.1 any actual or potential, direct or indirect, financial interest which is material to any discussion or decision they are involved or likely to be involved in making as described in Standing Orders 7.7.2 and 7.7.7; and

7.1.2 any actual or potential, direct or indirect, non-financial professional interest which is material to any discussion or decision they are involved or likely to be involved in making, as described in Standing Orders 7.7.4 and 7.7.7; and

7.1.3 any actual or potential, direct or indirect, non-financial personal interest, which is material to any discussion or decision they are involved or likely to be involved in making, as described in Standing Order 7.7.5 and 7.7.7.

7.2 All existing members of the Board of Directors should declare such interests as soon as the Director in question becomes aware of it. Any members of the Board of Directors appointed subsequently should do so on appointment.

7.3 Such a declaration shall be made by completing and signing a form, as prescribed by the Secretary from time to time, setting out any interests required to be declared outside a meeting in accordance with the Constitution or the SOs and delivering it to the Secretary on appointment or as soon thereafter as the interest arises, but within 7 Clear Days of becoming aware of the existence of a material interest.

7.4 In addition, if a Director is present at a meeting of the Board of Directors and has an interest of any sort in any matter which is the subject of consideration, he or she shall at the meeting and as soon as practicable after its commencement disclose the fact and the Chair shall then decide what action to take. This may include excluding the Director from discussions on the matter and/or prohibiting the Director from voting on any question with respect to the matter. Subject to Standing Orders 7.7.3 and 7.7.4, if a Director has declared a financial interest (as described in Standing Order 7.7.2) he or she shall not take part in the consideration or discussion of the matter.

7.5 Any interest declared at a meeting of the Board of Directors and any subsequent action taken, should be recorded in the minutes of the Board of Director's meeting at which the interest was declared. Any changes in interests should be officially declared at the next relevant meeting following the change occurring.

7.6 Directors' interests will be disclosed in the Trust's Annual Report, at least to comply with the Financial Reporting Manual as published by NHSE, but the Annual Report may also refer to the published declaration of interests of Directors.

7.7 Nature of Interests

7.7.1 Interests which should be regarded as "material" are ones which a reasonable person would take into account when making a decision regarding the use of taxpayers' money because the interest has relevance to that decision. Material interests are to be interpreted in accordance with guidance issued by NHSE.

7.7.2 A financial interest is where a Direct may receive direct financial benefits (by either making a gain or avoiding a loss) from the consequences of a decision of the Trust. This could include:

7.7.2.1 directorships, including Non-Executive Directorships held in another organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding; or

7.7.2.2 employment in an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding; or

7.7.2.3 a shareholding, partnerships, ownership or part ownership of an organisation which is doing or is likely to do business with an organisation in receipt of NHS funding.

7.7.3 A Director shall not be treated as having a financial interest in any matter by reason only:

7.7.3.1 of shares or securities held in collective investment or pensions funds or units of authorised unit trusts; or

7.7.3.2 of an interest in any company, body or person with which he or she is connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that matter.

7.7.4 Any remuneration, compensation or allowances payable to a Director by virtue of paragraph 18 of Schedule 7 of the 2006 Act shall not be treated as a financial interest for the purpose of this SO.

7.7.5 A non-financial professional interest is where a Director may obtain a non-financial professional benefit from the consequence of a decision that the Trust makes, such as increasing their professional reputation or status or promoting their professional career. This could include situations where a Director is:

7.7.5.1 an advocate for a particular group of patients; or

7.7.5.2 a clinician with a special interest; or

7.7.5.3 an active member of a particular specialist body; or

7.7.5.4 an advisor for the Care Quality Commission or National Institute of Health and Care Excellence.

7.7.6 A non-financial personal interest is where a Director may benefit personally form a decision that the Trust makes in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include where the Director is:

7.7.6.1 a member of a voluntary sector board or has a position of authority within a voluntary sector organisation with an interest in health and/or social care; or

7.7.6.2 a member of a lobbying or pressure group with an interest in health and/or social care.

7.8 A Director will be treated as having an indirect financial interest, non-financial professional interest or non-financial personal interest where he or she has a close association with another individual who has a financial interest, a non-financial professional interest, or a non-financial personal interest who would stand to benefit from a decision of the Trust. This includes material interests of:

7.8.1 close family members and relatives, including a spouse, partner, parent, child or sibling.

7.8.2 close friends and associates; and

7.8.3 business partners.

7.9 If Directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chief Executive. 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.

7.10 SO, 7 applies to any committee, sub-committee of the Board of Directors and applies to any member of any such committee or sub-committee (whether or not he or she is also a Director).

7.11 Register of Interests

7.11.1 The Register of Interests shall contain the names of each Director, whether he or she has declared any interests and, if so, the interests declared in accordance with the Constitution or these SOs.

7.11.2 The Secretary must amend the appropriate Register of Interests within 3 Clear Days of receipt of a declaration of a material interest made under SO 7.3.

7.11.3 The Register of Interests will be available to the public and the Chair will take reasonable steps to bring the existence of the Register of Interests to the attention of the local population and to publicise arrangements for viewing it. Copies or extracts of the Register of Interests must be provided to members of the Trust free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the Register of Interests.

7.11.4 In establishing, maintaining, updating and publicising the Register of Interests, the Trust shall comply with all guidance issued from time to time by NHSE. The details of Directors' interests recorded in the Register of Interests will be kept up to date by means of a regular review as necessary of the Register of Interests by the Chief Executive or Secretary during which any changes of interests

recently declared will be incorporated.

8. Standards of Business Conduct

8.1 Policy

8.1.1 Directors and Officers should comply with the NHS Foundation Trust Code of Governance 2006, the Trust Code of Conduct and Department of Health and Social Care Guidance contained in HSG 1993/5 “Standards of Business Conduct for NHS Staff” and the "Code of Conduct for NHS Managers 2002 ". This section of SOs should be read in conjunction with these documents.

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

8.2.1 Canvassing of Directors or members if any committee of the Board of Directors directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of these SOs shall be included in application forms or otherwise brought to the attention of candidates.

8.2.2 A Director of the Board of Directors shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this SO shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust in relation to any appointment.

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

8.3 Relatives of Directors or Officers

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

8.3.2 The Directors and every member and Officer of the Trust shall disclose to the Chief Executive any relationship between themselves and a candidate of whose candidature that member or Officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

8.3.3 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board whether they are related to any other member of the Board of Directors or holder of any office in the Trust.

8.3.4 Where the relationship to an Officer or another Director to a Director of the Trust is disclosed, SO 7 shall apply.

8.4 External Consultants

8.4.1 SO8 will apply equally to all external consultants or other agents acting on behalf of the Trust. The Trust's Scheme of Delegation should be adhered to at all times.

9. Tendering and Contract Procedure

9.1 Duty to comply with Standing Orders

9.1.1 The procedure for making all contracts by or on behalf of the Trust shall comply with these SOs (except where SO 3.15 is applied).

9.2 Public Procurement

9.2.1 The Public Procurement Regulations shall take precedence over these SOs with regard to procedures for awarding all forms of contracts and shall have effect as if incorporated in these SOs.

9.2.2 The Trust shall comply as far as is practicable with the requirements of the Department of Health and Social Care "Capital Investment Manual" and “Estatecode” and associated relevant guidance issued

by NHSE in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health and Social Care guidance "The Procurement and Management of Consultants within the NHS". The Trust will also comply with the Guidance from NHSE entitled "Best Practice in Making Investments" and the Regulatory Framework.

9.2.3 The Tendering and Contract Procedure is governed by 3 ranges of expenditure (refer to the Scheme of Delegation):

9.2.3.1 Formal Competitive Tendering details are contained in SO9.3.

9.2.3.2 Competitive Quotations details are contained in SO9.4.1-9.4.; and

9.2.3.3 Expenditure where Tendering or Competitive Quotations are not required (details are contained in SO10).

9.3 Formal Competitive Tendering

9.3.1 The Trust shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DoH); for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

9.3.2 Formal tendering procedures may be waived by Officers to whom powers have been delegated by the Chief Executive without reference to the Chief Executive (except in (9.3.2.5) to (9.3.2.8) below) where:

9.3.2.1 the estimated expenditure does not, or is not reasonably expected to, exceed £25,000 (this figure to be reviewed annually); or

9.3.2.2 the estimated expenditure is expected to exceed £25,000 (this figure to be reviewed annually) but does not, or is not reasonably expected to exceed the applicable threshold for the purchase under the Public Procurement Regulations; or

9.3.2.3 by virtue of Part 1 of the Public Contracts Regulations 2015 or Part 2, Chapter 2 of the Concessions Contracts Regulations, the contract does not require a tendering process; or

9.3.2.4 the supply is proposed under special arrangements negotiated by the DoH in which event the said special arrangements must be complied with.

9.3.2.5 the timescale genuinely precludes competitive tendering (and this complies with any applicable Public Procurement Regulations). Failure to plan the work properly is not a justification for single tender; or

9.3.2.6 after considering the specification, specialist expertise is required and is available from only one source (and this complies with any applicable Public Procurement Regulations); or

9.3.2.7 the task is essential to complete the project, AND arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate (and this complies with any applicable Public Procurement Regulations); or

9.3.2.8 there is a clear benefit to be gained from maintaining continuity with an earlier project (and this complies with any applicable Public Procurement Regulations). However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; or

9.3.2.9 where provided for in the Capital Investment Manual.

9.3.3 The limited application of the single tender rules should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

9.3.4 Where it is decided that competitive tendering is not applicable and should be waived by virtue of 9.3.2.5to 9.3.2.8 above the fact of the waiver and the reasons should be documented and reported by the Chief Executive to the Board of Directors in a formal meeting and the provisions of the applicable Public Procurement Regulations complied with.

9.3.5 Except where SO 9.3, or a requirement under SO 9.2, applies, the Board of Directors shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

9.3.6 The Board of Directors shall ensure that normally the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists [see Appendix of the Standing Financial Instructions]. Where in the opinion of the Finance Director it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive.

9.3.7 The Tendering Procedure is set out in Appendix 1 to the Standing Financial Instructions.

9.3.8 The Board of Directors shall review the Tendering Procedure not less than every two years.

9.4 Quotations

9.4.1 Quotations are required where formal tendering procedures are waived under SO9.3.2.1 or SO9.3.2.2 and where the intended expenditure or income exceeds or is reasonably expected to exceed the limits defined in the Scheme of Delegation.

9.4.2 Where quotations are required under SO 9.3 they should be obtained from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Board of Directors.

9.4.3 Quotations should be in writing unless the Chief Executive or his Nominated Officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotation should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

9.4.4 All quotations must be treated as confidential and should be Retained for inspection.

9.4.5 The Chief Executive or his Nominated Officer should evaluate the quotations and select the one which gives value for money. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record and approved by the Chief Executive and the Director of Finance.

9.4.6 Non-competitive quotations in writing may be obtained for the following purposes:

9.4.6.1 the supply of goods/services of a special character for which it is not, in the opinion of the Chief Executive or his Nominated Officer, possible or desirable to obtain competitive quotations.

9.4.6.2 the goods/services are required urgently. The approval of the Director of Resources or his Nominated Officer will be required for this course of action.

9.4.7 Where tenders or quotations are not required, because expenditure is below the limits set in the Scheme of Delegation, the Trust shall procure goods and services in accordance with procurement procedures approved by the Board of Directors.

9.4.8 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. The Board of Directors may also determine from time to time that in house services should be market tested by competitive tendering (SO11).

9.5 Private Finance

9.5.1 When the Board of Directors proposes, or is required, to use finance provided by the private sector the following should apply:

9.5.1.1 The Chief Executive and Finance Director shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

9.5.1.2 The proposal must be specifically agreed by the Board of Directors in the light of such professional advice as should reasonably be sought in particular with regard to vires.

9.5.1.3 The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

9.6 Contracts (including lease contracts)

9.6.1 The Trust may only enter into contracts within its statutory powers and shall comply with:

9.6.1.1 these SOs.

9.6.1.2 the Trust's SFIs.

9.6.1.3 all applicable statutory provisions; and

9.6.1.4 any relevant directions including the Capital Investment Manual and guidance on the Procurement and Management of Consultants.

9.6.1.5 Where required by the Public Procurement Regulations contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

9.6.2 Contracts shall include lease and hire purchase agreements.

9.6.3 In all contracts made by the Trust, the Board shall endeavour to obtain value for money. The Chief Executive shall nominate an Officer who shall oversee and manage each contract on behalf of the Trust.

9.7 Personnel and Agency or Temporary Staff Contracts

9.7.1 The Chief Executive shall nominate Officers with delegated authority to enter into contracts for the employment of other Officers, to authorise regarding of staff, and enter into contracts for the employment of agency staff or temporary staff service contracts.

9.8 Healthcare Services Agreements

9.8.1 Healthcare Services contracts made between two NHS organisations for the supply of healthcare services, will be legally binding contracts based on the models issued by NHSE.

9.8.2 The Chief Executive shall nominate Officers with power to negotiate for the provision of healthcare services with purchasers of healthcare.

9.9 Cancellation of Contracts

9.9.1 Except where specific provision is made in model forms of contracts or standard schedules of conditions approved for use within the NHS, there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if:

9.9.1.1 the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust; or

9.9.1.2 for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the Trust, or if the like acts shall have been done by any person employed by them or acting on his behalf (whether with or without the knowledge of the contractor); or

9.9.1.3 if in relation to any contract with the Trust the contractor or any person employed by them or acting on his behalf shall have committed any offence under the Prevention of Corruption Acts 1989 and

1916, the Bribery Act 2010, and other appropriate legislation.

9.9.2 Where a contract is subject to the Public Procurement Regulations in full, that contract shall also include the termination clauses required by the applicable Regulation.

9.10 Determination of Contracts for Failure to Deliver Goods or Material

9.10.1 There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good (a) such default, or (b) in the event of the contract being wholly determined the goods or materials remaining to be delivered.

9.10.2 The clause referred to at 9.10.1 shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

9.11 Contracts Involving Funds held on Trust

9.11.1 Contracts involving Funds held on Trust shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Acts.

10. Disposals

10.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

10.1.1 any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his Nominated Officer.

10.1.2 obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust.

10.1.3 items to be disposed of with an estimated sale value of less than £1,000, this figure to be reviewed annually.

10.1.4 items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract.

10.1.5 land or buildings concerning which DoH guidance has been issued but subject to compliance with such guidance; or

10.1.6 any matter which NHSE has issued alternate specific guidance in relation to.

11. In-House Services

11.1 In all cases where the Trust determines that in-house services should be subject to competitive tendering the following groups shall be set up:

11.1.1 Specification group, comprising the Chief Executive or Nominated Officer(s) and specialist(s).

11.1.2 In-house tender group, comprising representatives of the in-house team, a nominee of the Chief Executive and technical support.

11.1.3 Evaluation group, comprising normally a specialist Officer, a supplies Officer and a Finance Director representative. For services having a likely annual expenditure exceeding £500,000, a non-Officer member should be a member of the evaluation team.

11.2 All groups should work independently of each other but individual Officers may be a member of more than one group. No member of the in-house tender group may, however, participate in the evaluation of tenders.

11.3 The evaluation group shall make recommendations to the Board of Directors.

11.4 The Chief Executive shall nominate an Officer to oversee and manage the contract.

12. Custody of Seal and Sealing of Documents

12.1 Custody of Seal

12.1.1 The Common Seal of the Trust shall be kept by the Chief Executive or Nominated Officer in a secure place.

12.2 Sealing of Documents

12.2.1 The Common Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board of Directors or of a committee, thereof or where the Board of Directors has delegated its powers.

12.2.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Finance Director (or an Officer nominated by them) and authorised and countersigned by the Chief Executive (or an Officer nominated by them who shall not be within the originating Directorate).

12.3 Register of Sealing

12.3.1 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Board of Directors at least quarterly.

13. Signature of Documents

13.1 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.

13.2 The Chief Executive or Nominated Officers shall be authorised, by resolution of the Board of Directors, 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 of Directors or committee or sub-committee to which the Board of Directors has delegated appropriate authority.

13.3 Where authority to sign documents is granted under the Constitution, signatures may be electronic, provided that, where required by law or a regulatory body wet ink signatures shall be used. For the avoidance of doubt, unless and until the Trust is able to electronically seal documents, documents signed under seal will continue to be signed by way of wet ink.

14. Miscellaneous

14.1 Standing Orders to be given to members and officers

14.1.1 It is the duty of the Chief Executive to ensure that existing Directors and Officers and all new appointees are notified of and understand their responsibilities within Standing Orders and SFIs. Updated copies shall be issued to staff designated by the Chief Executive. New designated Officers shall be informed in writing and shall receive copies where appropriate of SOs.

14.2 Documents having the standing of Standing Orders

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

14.3 Review of Standing Orders

14.3.1 Standing Orders shall be reviewed annually by the Trust. The requirement for review extends to all documents having the effect as if incorporated in SOs.

14.4 **Corporate Documents** – Specific to the setting up of the Trust shall be held in a secure place by the Chief Executive.

15. Variation Schedule

Subject	Approved by Monitor	Ref:
Reduction in quoracy at Governor meetings	10 Feb 2009	Paul Streat
Removal of Patient/Carer Membership Constituency	21 January 2010	Lizzie Alabaster
Revision reflecting TCS transaction – April 2011	May 2011	Paul Streat
Revision reflecting change of partnership organisation – removal of Stroke Association and inclusion of The Ark Trust	October 2011	Paul Streat
Revision to reflect October 2012 changes arising from Health & Social Care Act 2012	November 2012	Hitesh Patel

Subject	Approved by Directors	Approved by Governors
Revision to reflect April 2013 changes arising from Health & Social Care Act 2012 (May 2013)	14 May 2013	16 May 2013
Revision reflecting change of partnership organisations – removal of the Ark Trust and Berkshire Association of Clubs for Young People and inclusion of AgeUK Berkshire and University of West London	10 September 2013	19 September 2013
Revisions following general review and to incorporate specific requested amendments	14 April 2015	20 May 2015
Revisions to ensure on going compliance	10 July 2018	20 June 2018
Revisions to ensure on going compliance and an excluded member review process		