Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS

14 March 2024

The Boardroom, West Park Hospital, Edward Pease Way, Darlington, DL2 2TS and via MS Teams at 1.30 p.m.

AGENDA

NOTE: there will be a confidential session at 1.00pm for the Board of Directors to receive a patient story.

Standard Items (1.30 pm – 1.45 pm)

1	Chair's welcome and introduction	Chair	Verbal
2	Apologies for absence	Chair	Verbal
3	Declarations of interest	All	Verbal
4	Minutes of the last ordinary meeting held on 8 February 2024	Chair	Draft Minutes
5	Board Action Log	Chair	Report
6	Chair's report	Chair	Report
7	Questions raised by Governors in relation to matters on the agenda *(to be received by 1pm on Tuesday 12 March 2024)*	Board	Verbal

Strategic Items (1.45 pm – 3.00 pm)

8	Board Assurance Framework Summary Report	Co Sec	Report
9	Chief Executive's Report	CEO	Report
10	Integrated Performance Report	Asst CEO	Report

BREAK

Goal 1: To co-create a great experience for our patients, carers and families (3.10 pm – 3.25 pm)

11	Feedback from Leadership Walkabouts	EDoCA&I	Report
12	Report of the Chair of the Quality Assurance Committee	Committee Chair (BR)	Report
13	Report of the Chair of Mental Health Legislation Committee	EMD	*Item deferred*

Goal 2: To co-create a great experience for our colleagues (3.25 pm – 4.15 pm)

14	Report of the Chair of People, Culture & Diversity Committee	Committee Chair (JM)	Report
15	Establishment Review Report	CN	Report
16	Leadership Academy	EDfP&C	Report
17	Pay Gaps (Gender and Ethnicity)	EDfP&C	Report

Governance (4.15 pm - 4.20 pm)

18	Constitutional Change	Co Sec	Report

Matters for information

19	Use of the Trust's seal	Co Sec	Report

Exclusion of the Public:

20	**Exclusion of the public:** The Chair to move: *"That representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:* *Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office-holder or applicant to become an office-holder under, the Trust.* *Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Trust.*	Chair	Verbal

	Information which, if published would, or be likely to, inhibit – *(a) the free and frank provision of advice, or* *(b) the free and frank exchange of views for the purposes of deliberation, or* *(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.*		

David Jennings
Chair
8 March 2024

Contact: Karen Christon, Deputy Company Secretary
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Tees, Esk and Wear Valleys NHS Foundation Trust

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 8 FEBRUARY 2024 VIA MS TEAMS

Present:
D Jennings, Chair
B Kilmurray, Chief Executive
R Barker, Non-Executive Director
Z Campbell, Executive Managing Director, North Yorkshire, York & Selby Care Group
C Carpenter, Non-Executive Director.
P Hungin, Non-Executive Director
K Kale, Executive Medical Director
J Maddison, Non-Executive Director
B Murphy, Executive Chief Nurse
J Murray, Non-Executive Director
J Preston, Non-Executive Director and Senior Independent Director
B Reilly, Non-Executive Director and Deputy Chair
L Romaniak, Executive Director of Finance, Information and Estates
P Scott, Executive Managing Director, Durham, Tees Valley and Forensics Care Group and Deputy Chief Executive
A Bridges, Executive Director of Corporate Affairs and Involvement (non-voting)
M Brierley, Assistant Chief Executive (non-voting)
H Crawford, Executive Director of Therapies (non-voting)
S Dexter-Smith, Executive Director for People and Culture (non-voting)

In attendance:
P Bellas, Company Secretary
K Christon, Deputy Company Secretary (minutes)
C Lanigan, Associate Director of Strategic Planning and Programmes
S Theobald, Associate Director of Performance

Observers:
S Double, Alder
K North, Deputy Director for People and Culture

23-24/145 CHAIR'S WELCOME AND INTRODUCTION

The Chair welcomed everyone to the meeting and commented on the valuable staff story provided prior to the board meeting.

23-24/146 APOLOGIES FOR ABSENCE

Apologies were noted from M Brierley, who was not able to attend the full meeting.

23-24/147 DECLARATIONS OF INTEREST

None.

23-24/148 MINUTES OF THE LAST MEETING HELD ON 11 JANUARY 2024

Agreed: *The minutes be accepted as an accurate record of the meeting, for signature by the chair.*

23-24/149 BOARD ACTION LOG

In discussion the following points were noted:

1. P Bellas advised that topics had been sought for the board seminars for 2024/25 and the draft programme would be shared with the Chair and Chief Executive in February. The board would also be consulted on the board and committee timetable for 2024/25. [Action 22/144 refers]

2. B Kilmurray noted that an update on the provider collaborative would be provided at the meeting and as and when work progressed. [Action 23-24/135 refers]

3. B Kilmurray advised that industrial action had not impacted on waiting lists due to the way in which the trust operated. Clinicians and consultants had been redeployed to ensure cover in urgent and inpatient services and where appointments had been cancelled, they had been rearranged as soon as possible.

   Commenting further, Z Campbell confirmed that steps had been taken to ensure that where appointments had been cancelled, they did not impact on the same individuals. K Kale also noted that all emergency procedures had remained in place throughout the period of strike action.

   B Kilmurray noted that the BMA had balloted on a further period of strike action and confirmed that the trust had a positive working relationship with the local negotiating committee to support the planning and management of strike action.

4. It was agreed that a timescale would be included in respect of the completion of work to improve the reporting of patient outcomes [Action 23-24/236 refers].

Action: K Kale

23-24/150 CHAIR'S REPORT

Noted.

23-24/151 QUESTIONS FROM GOVERNORS

A Bridges noted a request from a governor to explain acronyms and this was supported in the interests of public transparency.

23-24/152 BOARD ASSURANCE FRAMEWORK

The Chair welcomed the work undertaken to develop strategic reports for the board - the Board Assurance Framework (BAF), the Integrated Performance Report (IPR) and the Our Journey to Change Delivery Plan - and noted his intention to review the BAF on conclusion

of the discussion for those items to understand if any changes were required to the strategic risks.

P Bellas presented the report, which provided information on strategic risks within the BAF to support the board's discussions at the meeting. He commented on the review of the BAF, which would be considered in full in the private session, and additional information incorporated into the report on timescales and triggers that would change and reduce risk scores to target.

In discussion the following points were raised:

1. P Bellas commented on reasons for the delay to information on digital and cyber strategic risks and the first line of defence, which would be provided in the next iteration of the report and noted his preference to present the report at the meeting, rather than delay the new report to March, and this was supported.

   The Chair acknowledged the priority given to Cito implementation by the executive lead on digital and cyber risks and proposed that the executive team provide support to ensure the BAF was completed.

2. S Dexter-Smith confirmed that the trust understood safe staffing requirements and undertook to update the report to reflect the development of comprehensive workforce plans.

3. The Chair suggested that the board would consider how the BAF could be used to drive its conversations and he welcomed the clarity it provided on strategic risks, the gap between actual and target risk scores and how that gap would be closed. He suggested the trust tolerated a degree of risk that was higher than desired. However, this was in line with other NHS organisations.

4. The Chair noted that BAF risk 3, co-creation, had the widest gap between actual and target risk scores and welcomed the opportunity for board oversight of that risk.

5. The Chair welcomed the positive and negative assurances outlined for BAF risk 4 and proposed that this approach be applied consistently across the report.

6. It was acknowledged that narrative on the control ratings for BAF risk 11, Roseberry Park, were subject to legal privilege and not included in the public report.

7. The Chair queried the positive and negative assurances provided in respect of BAF risk 12, financial sustainability, and how they related to the overall BAF risk score. In response L Romaniak referenced information provided in the board papers on financial challenges related to the use of agency staff and premia rates for medical locums impacting on value for money, achievement of recurrent cash releasing efficiency savings (CRES) which impacted the underlying position, risks to delivery of the capital rectification programme within the national context of a constrained NHS capital departmental expenditure limit (CDEL), all of which supported the current level of risk and challenges from a sustainability perspective.

8. P Bellas advised that risk scores had not been included in the summary report in response to previous concerns that they may be misinterpreted. In respect of the information provided, he noted that scores referred to as -C or -L related to ratings out of 5 for consequence and likelihood and suggested that the re-inclusion of the risk score would help to provide context for those scores.

   The Chair proposed a discussion with the Chair of Audit and Risk Committee on the most appropriate approach to information provided in the report. **Action: P Bellas**

23-24/153 CHIEF EXECUTIVE'S REPORT

B Kilmurray presented the report, which provided a briefing on important topical issues that were of concern to the Chief Executive. In discussion the following points were raised:

1. P Hungin expressed concern about challenges related to implementation of the Senior Intervenor action plan and assessment of the trust against a new benchmark. In response B Kilmurray noted the commitment from ADAS to work with the system on development of a housing strategy, and the need for engagement with the housing sector to unlock investment and sites for development. He acknowledged concerns about staffing instability and reflected that continuity of care and development of a therapeutic relationship was critical, and that two identified lead professionals would provide additional resilience.

   B Reilly suggested that the report highlighted known concerns and noted the reliance of the trust on system partners to support timely discharge.

   Commenting further, J Preston welcomed the opportunity for an approach that would hold individual organisations to account. He proposed that whilst this work was important the trust would not be distracted from the care provided to what was a significant cohort of patients.

   P Scott commented on progress made over the preceding 18 months to consider how partners would work together to respond to the needs of patients and he suggested the report was helpful in that it had captured known issues and would build momentum for change, supported by an accountability framework.

   B Kilmurray concurred with the points raised and he and the Chair welcomed the opportunity to consider a different approach and relationship with partners in order to resolve current issues. The Chair reflected that whilst the report focused on process, leadership and collective responsibility would be important to move forward. He also noted that where the trust was not listed as the lead, it would still have an important role to play.

2. The Chair welcomed the seriousness to which the trust had taken the independent review of Greater Manchester NHSFT and noted that QAC would provide an update in due course.

3. B Kilmurray noted the CQC prosecution would commence on 26 February 2024 and the trust was mindful of the impact on service users, families and staff, and support would be provided.

23-24/154 INTEGRATED PERFORMANCE REPORT (IPR)

The board received the report, which provided oversight of the quality of services and assurance on actions taken to improve performance in required areas, and which proposed there was reasonable assurance on the oversight of the quality of services delivered.

In presentation, S Theobald drew attention to: areas with limited performance assurance and negative controls assurance, where performance improvement plans (PIPs) had been developed; the recommendation to QAC to establish a new measure on the number of restrictive interventions used; trust wide and care group headlines and the intention to report key actions from PIPs in the IPR; and adult mental health/mental health services for older people (AMH/MHSOP) where the clinician reported outcome measure would not change but the patient reported outcome measure would report against goal based outcomes identified through DIALOG.

P Scott reported from Durham, Tees Valley and Forensics Care Group and welcomed the opportunity to provide meaningful data against goal based outcomes. He noted there was a number of measures outlined in the headline report that related to inpatient services and outlined support through the Getting It Right First Time (GIRFT) Programme to carry out an in-depth review of community and inpatient services to improve the pathway, which would lead to an improvement in performance measures and reduce out of area placements. He also noted a positive reduction in staff leavers and sickness absence.

Z Campbell reported from North Yorkshire, York and Selby Care Group and noted improvements in relation to clinician reported outcomes in AMH and children and young people services (CYP), and use of learning from that to support improvement in other areas. She went on to note: a reduction in instances of moderate and severe harm; an increase in reported serious incidents in Ripon, which had been due to a backlog and staff vacancies, and the team had been placed in business continuity; challenges related to timely access to Talking Therapies and between first and second treatment targets, which reflected staffing challenges and for which a PIP had been developed; and demand for memory assessment services, where a project had been established with partners to review provision and innovative approaches for overall wellbeing.

In discussion the following points were raised:

1. C Carpenter welcomed the progress made on development of the IPR, which demonstrated the trust understood its performance. She noted the board was not sighted in the current report on PIPs and therefore had less clarity on actions and when those would improve performance, and the impact they would have on the Corporate Risk Register (CRR) and BAF.

   The Chair concurred that triangulation between the IPR, BAF and CRR would be important, and risks would not be reduced where actions had no impact.

S Theobald acknowledged the absence of PIP information in the report and advised that this was a priority. Preparatory work had been undertaken to ensure PIPs outlined SMART objectives and when change was expected, and information would be included in a future iteration of the IPR.

2. B Reilly expressed concern about performance against inpatients feeling safe, where issues were multifactorial, and she advised that QAC would remain sighted on this measure.

3. K Kale noted that a PIP would assist to increase clinician reported outcome measures and was not expected to improve patient reported outcome measures. The Chair acknowledged the point raised and noted the board had agreed to hold a seminar on outcome measures, recognising that the organisation would wish to understand the difference that services had made to patients.

4. L Romaniak noted the challenge reflected in the IPR in respect of increased unique caseloads and referenced new information shared with Executive Directors which demonstrated that around one third of overall caseloads related to neurodevelopmental cases, including in CYP services and AMH services. This was the single biggest strategic – as opposed to operational performance – challenge from a caseload perspective. Commenting further, P Scott proposed that the GiRFT programme would provide support to understand the underlying issues to the increase in caseloads and pathways that would support timely patient discharge.

5. In respect of the national indicator that 85% of patients receive a follow up 72 hours after discharge, B Murphy provided assurance that the measure was overseen by Executive Review of Quality Group and the trust continued to achieve beyond the minimum requirement. There had been one instance where this had not been possible as the individual had travelled overseas.

6. B Murphy recognised the quality and financial risks related to use of out of area placements and reflected that where ward occupancy was at 100%, there would also be an impact on staff time to reflect and work with patients.

   The Chair concurred there were a number of underlying challenges flagged by the measure and proposed that the trust be clear on plans and timescales to mitigate that.

7. S Theobald noted work undertaken to develop committee dashboards, the first of which would be launched at People, Culture and Diversity Committee and then rolled out to the other committees.

The Chair brought the discussion to a close and thanked S Theobald and her team for work they had undertaken on development of the IPR, to provide assurance to the board that there was clarity on areas of concern, actions in place, timescales and progress made.

23-24/155 OUR JOURNEY TO CHANGE DELIVERY PLAN, PROGRESS REPORT

C Lanigan presented the report, which provided assurance on projects and workstreams pertaining to the current Our Journey to Change (OJTC) 2023/24 Delivery Plan.

In discussion the following points were noted:

1. L Romaniak highlighted progress made on the appointment of the Energy and Waste Officer and sustainability lead, and funding secured for LED light fittings and installation, to support energy efficiency. She noted there were further opportunities for energy efficiency that had been highlighted through the recent Estates Return Information Collection (ERIC) benchmarking for 2022/23. This intelligence would be used to inform the development of related action plans with discussion at the imminent Strategy and Resources Committee.

2. C Carpenter queried the prioritisation of delivery within the plan and proposed that whilst all priorities were important, those linked to quality and safety were more pressing, and she would, for example, support a delay to the green plan if that was necessary to ensure progress was made on those priorities.

   C Lanigan confirmed that the Project Management Office had focused on delivery of quality and safety related priorities.

   B Kilmurray noted that development of the 2024/25 Delivery Plan would include prioritisation of proposals in the context of limited resources. He went on to advise that where the report highlighted delays, they had been risk assessed and agreed by Management Group.

3. J Preston queried the extension granted to the Autism Adult Neurodevelopmental Service priority in DTVF and given the public interest in this service, it was agreed that an update on delivery would be provided at the next meeting. **Action: P Scott**

23-24/152 BOARD ASSURANCE FRAMEWORK (continued)

Following discussion on the IPR and OJTC, the Chair returned to the BAF and invited Executive Director risk leads to comment on the assurance they had, that key controls outlined in the BAF, would respond to the risk described.

1. In respect of BAF risk 1, safe staffing, S Dexter-Smith advised that she was comfortable with the trajectory of progress and commented on: international nurse recruitment that would take place during 2024/25; the soft launch of the Academy in April 2024; work undertaken by the staff Health and Wellbeing Council; and the focus on staff development, now that the restructure had been embedded.

   The Chair proposed that the BAF provide a sense of the progress described.
   Action: S Dexter-Smith

2. In respect of BAF risk 2, demand, P Scott advised that he was hopeful that work undertaken to understand pressure points and provide assurance on safety and patient experience, would lead to an improvement. He proposed there was good

operational oversight and referenced the support that would be provided through the GiRFT programme.

Commenting further, Z Campbell noted work undertaken with system partners to review pathways and suggested that there had started to be a shift in demand as a result.

B Kilmurray welcomed the opportunity to work with partners in a transformational way to consider wider health and equalities work and optimise patient flow that would support the trust to meet demand within existing capacity.

3. In respect of BAF risk 3, co-creation, A Bridges expressed confidence that action undertaken would provide a building block on which co-creation aspirations would be delivered. She noted the inclusion of patient experience and commented on the positive progress made to develop and implement a new complaints process, which had been reported to QAC, and the use of patient experience data to help inform co-creation activity.

   B Reilly, Chair of QAC, noted that committee had received positive assurance on development of the complaints procedure and welcomed the passion that A Bridges had brought to co-creation. She queried if the reported risk score for co-creation was too high, and the Chair proposed that this be reviewed by the executive team.

   Action: A Bridges

4. In respect of BAF risk 4, quality of care, B Murphy proposed that there was good assurance that the trust understood the risk to quality and improvements had been noted. She commented on: learning from patient safety events and implementation of the Patient Safety Incident Response Framework (PSIRF); progress made to reduce restrictive practice; the impact of demand on experience; clarity sought by the board on outcomes; and development of the IPR for use across the organisation and potential to integrate performance and quality reporting.

5. In respect of BAF Risk 5, regulatory compliance, B Kilmurray drew attention to discussion on regulatory compliance throughout the board's agenda and discussion at QAC on matters related to quality of care.

23-24/156 REPORT OF THE CHAIR OF QUALITY ASSURANCE COMMITTEE

B Reilly, Chair of QAC, presented the report and advised that committee had not proposed any change to BAF risks, as a result of the discussion at the meeting. She provided an overview of matters raised in the report, which included: risks related to implementation of InPhase; limited assurance on compliance with life support training; concern about involvement payments, which did not meet national guidance; consideration of proposals to deliver improved physical health care; and the trust's response to recommendations arising from the review into failings at The Edenfield Centre in Manchester. She also noted a concern expressed about staffing based in prisons and potential for a board seminar on the development of prison services.

She welcomed the quality of reports provided to committee to support its discussions and suggested she was more assured on the quality of services, then she had been previously. She placed on record her thanks to all those involved in the committee, including the Executive Chief Nurse, Executive Medical Director and care group managing directors.

In discussion the following points were raised:

1. P Hungin, Chair of Mental Health Legislation Committee (MHLC), noted that MHLC would receive a report on the extent of use of restrictive practice and B Murphy confirmed that QAC received a report that focused on progress made to reduce its use.

2. P Hungin welcomed the opportunity for committee to understand proposals around prison staffing, for assurance. **Action: P Scott**

3. B Reilly confirmed that committee was content that alerts raised with the board had moved with sufficient speed and there was clarity on mitigation in place.

   Commenting further, B Murphy advised that she was confident on the direction of travel for InPhase. She proposed that prison staffing concerns were unique, and challenges had been recognised and responded to with some success. In respect of use of restraint, she noted that a deep dive had been commissioned and expressed confidence that work would be undertaken to respond to areas of concern, and progress would be reported to QAC.

   The Chair welcomed the honest update provided and recognised the need to help and support colleagues on wards to reduce incidents of restrictive practice and noted that QAC would keep the board informed of progress.

4. J Maddison, Chair of ARC, confirmed that committee had received a report on risks related to implementation of InPhase and had taken assurance on work that would be undertaken in response and would monitor progress alongside QAC.

   Responding to a query from the Chair, B Murphy confirmed she was assured on arrangements in place to mitigate potential risks. She suggested that implementation of the system alongside PSIRF and Cito may have contributed to the challenges seen and expressed caution that there would be an impact on staff experience, albeit that was manageable.

23-24/157 EQUALITY DELIVERY (EDS) SYSTEM 2022 (FOR INFORMATION)

The board received the report, which proposed there was good assurance that the trust had followed a robust process to complete EDS 2022 and meet its obligations under the NHS contract.

S Dexter-Smith presented the report and provided an update in relation to the reasonable adjustments team, where Executive Workforce Resources Group had agreed to extend the pilot by a year, to allow the team longer to demonstrate it had become cost neutral. She noted the positive impact on staff experience and the opportunity to consider reasonable adjustments before staff were in post. She also referenced development of the Domestic

Violence, Sexual Abuse and Sexual Violence Charter and the positive impact this would have on staff experience.

In discussion the following points were raised:

1. J Maddison welcomed the development of the charter and noted the large number of staff that had attended a recent staff session on sexual safety.

2. J Maddison queried how wheelchair adaptations discussed at the Long Term Health Conditions Network would be taken forward and S Dexter-Smith confirmed that requirements would be considered through the Estates Masterplan and staff training had been moved to accessible venues.

   L Romaniak advised that the trust had agreed to undertake the first phase of access audits at four large inpatient sites, where there was the highest footfall, and subject to market testing, consideration would be given to a wider audit programme to inform necessary changes. Commenting further, she also noted her awareness of the significant benefits of the work of the Reasonable Adjustments Team through her engagement as executive lead for the Neuro Diverse Staff Network.

3. J Murray commented on the value of training to ensure staff awareness and support to ensure staff had confidence in identifying any concerns. She also noted receipt of a related positive staff story at People, Culture and Diversity Committee.

4. S Dexter-Smith noted the trust's intention to move to in person welcome events for new staff and the Chair proposed that they be used to highlight expected behaviours.

The Chair brought the public session to a close and placed on record his thanks to P Hungin, at his last meeting, for the expertise and challenge he had brought to board discussions, and the kindness and support he had offered to other board members.

In response, P Hungin commented on the positive progress the trust had made and the quality of leadership provided by the executive team and Non-Executive Directors, and he thanked board colleagues for support and friendship they had shown him.

23-24/158 EXCLUSION OF THE PUBLIC

Agreed *that representatives of the press and other members of the public be excluded from the remainder of the meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution.*

On conclusion of the confidential session, the meeting ended at 5.50pm.

Board of Directors
Public Action Log

RAG Ratings:

	Action on track
Completed	Action completed
	Action due/Matter due for consideration at the meeting.
	Action outstanding but no timescale set by the Board.
	Action outstanding and the timescale set by the Board having passed.
	Action superseded
	Date for completion of action not yet reached

Updates since the last board meeting are provided in bold

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
29/09/2022 22/10/2022 27/04/2023 09/11/2023	22/144 22/174 23-24/06 23-24/111 23-24/117 23-24/119	Topics for board seminars	a) Mental Capacity Act b) Reported outcomes following treatment c) what transformation may mean for future services d) Baroness Hollins' report on those with a learning disability and/or autistic people e) strategic discussion on the trust's financial position f) impact of peer support workers	MD CEO Co Sec	Jun-23		Apr-23: proposed board & committee dates circulated w/c 24 April for consultation May-23: the seminar programme will be developed to take account of topics identified by the board during the year. Oct-23: BoD invited to submit proposals for Board Seminars. It is expected that the programme will also include topics that arise during preparation of the delivery plan Jan-24: Board invited to propose topics Feb-24: Draft programme to be shared with Chair/CEO in Feb
26/01/2023	23/215 23-24/5	BAF	Format to be reviewed to consider potential for a table detailing the target level of risk, actual risk and gap	Co Sec	Sep-23	**Completed**	Apr-23: timescale changed to August 2023 to align with the outcome of the full review of the BAF due commence in May-23 Sept-23: BAF Review to conclude in Oct-23 Nov-23: BAF review to be completed in January. Risk descriptions due to be considered by the board in November - see private agenda item 7 **Mar24: revised format provided to the board**
26/01/2023	23/215		Risk tolerance - Executive Directors and committees to scrutinise the position to understand how long high risks had remained at their current level and what related action was proposed.	Exec Directors, Committee Chairs	Jun-23	**action superseded**	Mar-23: Discussed by QuAC in March-23 Next cycle of committee meetings will be May 2023 Sept-23: BAF Review to conclude in Oct-23 Nov-23: BAF review due to conclude in Jan-24 **Feb24: BAF review concluded. Changes to risks means that the action is now superseded. Committee have been asked to review trajectories as part of the moderation of the refreshed BAF.**
27/04/2023	23-24/11		BAF report to reflect the impact of the financial position on delivery of priorities for 2023/24	Co Sec EDoFI&E	Sep-23		May23: Linked to full review of the BAF due to commence in May-23 Sept-23: BAF Review to conclude in Oct-23 Oct-23: EDG BAF workshop on 4-Oct-23 agreed next steps for Executive review Nov-23: BAF review due to conclude in Jan-24 **Mar24: redrafts considered at SRC.**
25/05/2023			Board discussion to be held on areas of the BAF where the IPR had reported there is limited performance assurance and negative controls assurance, and where the target date has passed.	Co Sec	Sep-23	**Completed**	Linked to the review of the BAF Sept-23: BAF Review to conclude in Oct-23 Nov-23: BAF review due to conclude in Jan-24 **Feb-24: BAF review concluded - revised BAF agreed Feb-24**
08/02/2024	**23-24/152**		**Co Sec to discuss with Chair of ARC most appropriate approach to clarify use of -C and -L in the public report.**	**Co Sec**			
08/02/2024	**23-24/152**		**BAF risk 1, Safe Staffing - narrative to be updated to reflect progress described at the meeting (feb24)**	**EDfPC&D**	**Mar-24**	**Completed**	

Board of Directors
Public Action Log

RAG Ratings:

	Action on track
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	Action outstanding but no timescale set by the Board.
	Action outstanding and the timescale set by the Board having passed.
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Updates since the last board meeting are provided in bold

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
08/02/2024	**23-24/152**		**BAF risk 3, Co-creation - BAF risk score to be reviewed.**	**EDfCA&I**	**Mar-24**	**Completed**	
27/04/2023	23-24/17	Establishment Review	Format of the report to be revised, to include summarised actions proposed to mitigate risks highlighted and to outline the level of assurance provided to the board.	CN	Mar-24	**See agenda item 15**	Next report to the board due March 2024 Sept23: noted that a verbal update had been provided on the significant work underway to assure on safer staffing, to meet external reporting requirements and to progress steps to meet the deadline of March 2024 Jan24: data collection is complete, there are some issues with validity, currently been analysed. CN will discuss next steps with CEO and Chair in relation to data validity
27/06/2023	23-24/47	Annual Report and Accounts	Chair to raise with COG T&F group, governor attendance at Audit & Risk Committee when committee consider the annual report and accounts and draft annual Quality Account Report	Chair	May-24		**Information circulated to Governors 01/03/24 to register their interest, prior to the next Council of Governors meeting on 19 March 2024.**
13/07/23	23-24/62	National Investigation into MH inpatient care settings	CEO to provide further information once ToR are available	CEO	Autum 23	**Completed**	Sept-23: the HSIB website reports that the investigation will be launched in Autumn 2023. Oct-23: HSIB overview circulated to the board of Directors by email **Mar24: information circulated to board 08/03/24**
13/07/23	23-24/66	Section 17 leave	Board to receive feedback from the Urgent Care Programme Board in relation to variance in how the act is used.	MD DTVF MD NYYS	Nov-23	**Completed**	Sept-23: First meeting of the UCPB to be held in October - P Scott to progress the action with K Kale in the interim Jan-24: Report provided to EDG to provide assurance on implementation of the policy and many management action required - agreed that a report would be provided to QAC or MHLC on implementation Feb24: the group nurse/medical directors will bring an update to MHLC in February 2024. Mar24: discussed at MHLC (see report)
12/10/23	23-24/100	Responding to issues raised by freedom to speak up arrangements	Trust to consider greater use of analytical data, alongside existing tools, to ensure all issues that arose through freedom to speak up arrangements had been captured and considered.	EDfP&C	Mar-24	**Completed**	Deferred to March 2024 - to follow discussion with FTSU Guardian and at Quality Board. **Update – FTSU and wider data shared at Quality Board in February and well received. No further concerns noted.** **Employee relations report presented to both committee and EDG in Feb. Propose to close action and integrate as standard into appendix for FSTU report, thereby enabling independence of FTSU report alongside wider data for board consideration**
09/11/23	23-24/120	Use of restraint	Progress report to Council of Governors on action taken to reduce the use of restraint	CN	Mar-24		Next CoG meeting 19 March 2024
11/01/24	23-24/131	Lived Experience	Lived Experience Directors be invited to attend the board in March 2024. Executive Directors to consider how the board could take advantage of lived experience input at all board meetings.	CEO	Apr-24	**Completed**	Lived Experience Directors invited to attend the Board in April 2024 (Note: LE Directors report into Care Group MD's)

Board of Directors
Public Action Log

RAG Ratings:

	Action on track
Completed	Action completed
	Action due/Matter due for consideration at the meeting.
	Action outstanding but no timescale set by the Board.
	Action outstanding and the timescale set by the Board having passed.
	Action superseded
	Date for completion of action not yet reached

Updates since the last board meeting are provided in bold

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
11/01/24	23-24/135	ToR - Commissioning Committee	Executive Directors to consider most appropriate arrangements for responsibilities previously held by Commissioning Committee	CEO	Mar-24		**The responsibilities previously held by Commissioning Committee have been mapped to QAC and S&RC, for their discussion and agreement. QAC has considered these and revised its ToR for approval by the board. S&RC has deferred this to their next meeting in May 2024.** **All committees have reviewed their ToR during 2023/24 and a report outlining all proposed changes will brought to the board, as soon as S&RC have the opportunity to discuss and finalise any changes. Board can be assured that all responsibilities devolved by the board are captured appropriately across the committees terms of**
11/01/24	23-24/135	Provider Collaboratives	CEO to provide a briefing to the board on the background and direction of travel of provider collaborative arrangements.	CEO	Ongoing	**See confidential agenda item 4**	Feb24: update provided in CEO report and will continue as/when required **Mar24: see confidential CEO Report**
11/01/24	23-24/136	Patient outcomes	Timescales to be provided for completion of current work to improve the reporting of patient outcomes.	EMD			Linked to board seminar session
11/01/24	23-24/137	Corporate Risk Register	Report to provide an 'at a glance' summary of risk movement across the year.	CN	Q2 2024/25		
11/01/24	23-24/137	Corporate Risk Register	Report to include timescales to indicate when a target rating would be achieved.	CN	Apr-24		Next report due April 2024
11/01/24	23-24/138	Charitable Funds	LR to consider how governance arrangements could reflect independent assurance provided by Non-Executive Directors	EDoFI&E	Apr-24		Discussing establishment of a new Charitables Committee formed from ARC NED membership supplemented by other colleagues, e.g. potentially staff wellbeing council / Lived Experience with SRC and ARC chair / Trust secretariat. Propose might meet 6-monthly (for example for 30 minutes following ARC). Trust secretary considering alongside scheduling of 2024/25 Board and Committee Meetings
11/01/24	23-24/144	Staff Survey	Report to be provided on the results of the Staff Survey	EDfP&C	Apr-24		Results shared at PCDC time out and people journey delivery plan reviewed and agreed in light of the results. Implications to be reported to the board in March/April 2024 **Mar24: see CEO report**
08/02/24	**23-24/151**	**Our Journey to Change**	**Update on delivery of the Autism Adult Neurodevelopmental Service in DTVF to be provided at the next meeting**	**P Scott**	**Mar-24**		**Proposed for discussion in April 2024 - in order that the care group can provide a more meaningful report (delay in IIC waiters report due to migration to Cito)**

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Chair's Report: 8th February – 13th March 2024.

Headlines:

External:

- Weekly Mental Health Chairs' Network : Rainbow Mind, Learning Disabilities & Autism, Out of Area Placements
- Meeting Yorkshire and Humberside Foundation Trust Chairs: issues of common interest & also H&NY Provider Chairs meeting reflections on recent H&NY event.
- Humber & North Yorkshire ICS Chairs & Non-Executive Directors event, including 'Sensing the Signals'
- Board of Directors February 2024.
- National meeting of NHSE Board and all ICS and Trust Chairs: national policy picture, likely planning 2024/5 guidance, quality systems
- Meeting Durham Care Partnership : the role of the Voluntary & Community Sector.
- Meeting of York Community Mental Health Transformation Leadership Group
- Meeting with South & North Tees Trusts, and the four North East medical schools / Universities.
- Meeting Dr Lade Smith, President Royal College of Psychiatrists, with colleagues.
- NHS Providers session : Mental Health – policy framework, Labour Party review.

Council of Governors (CoG)

- CoG Task & Finish Group: role of Governor, and role of Non-Executive Directors, and role of Council of Governors, as distinct from Trust Board. Bringing to a conclusion this work, and likely reporting themes to Council of Governors & Board.
- Locality meeting with North Yorkshire, York & Selby Governors
- Meeting with Governors : revisions to the Constitution learning from events of 2023.

Internal

- Monthly Chair and Non-Executive Meeting
- Various Living The Values Awards (Lanchester Road Hospital).
- Monthly catch-up with Director of Finance & Estates : 2024/5 likely NHS financial plan, and TEWV 2023/4 likely outturn
- Meeting Deloitte's : well-led review and Governance work.
- Meeting with lawyers : Roseberry Park Hospital PFI
- Meeting on Comms Strategy.
- Quality Assurance Committee.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**14 March 2024**
Title:	**Board Assurance Framework – Summary Report**
Executive Sponsor(s):	**Brent Kilmurray, Chief Executive**
Report Author:	**Phil Bellas, Company Secretary**

Report for:	***Assurance***		***Decision***	
	Consultation		***Information***	✓

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	✓
2: To co-create a great experience for our colleagues	✓
3: To be a great partner	✓

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
10	Regulatory Compliance	Under its Provider Licence, the Trust must take all reasonable precautions against the risk of failure to comply with: a. The Conditions of the Licence, b. Any requirements imposed on it under the NHS Acts, and c. The requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

Executive Summary:

Purpose: The purpose of this report is to support discussions at the meeting by providing information on the risks included in the Board Assurance Framework (BAF).

Proposal: Board Members are asked to take the strategic risks, included in the BAF, into account during discussions at the meeting.

Overview: The BAF brings together all relevant information about risks to the delivery of the Trust's strategic goals.

A summary of the BAF is attached which is based on the strategic risks as agreed by the Board under minute 23-24/C/73 (9/11/23). It seeks to provide information on related key controls and positive and negative assurances relating to them, which have been identified since the last board meeting.

The board will recognise that it receives a number of reports to each meeting that are pertinent to the BAF risks, including:

- Integrated Performance Report
- Chief Executive's Report
- Board Committee Reports
- Monthly Finance Report (confidential)
- Reportable Issues Log (confidential)

Prior Consideration and Feedback	None relating to this report.
Implications:	None relating to this report.
Recommendations:	The Board is asked to take the strategic risks into account during its discussions at the meeting.

BAF Summary

Ref	Strategic Goals 1	2	3	Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
1	✓	✓		**Safe Staffing** **There is a risk** that some teams are unable to safely and consistently staff their services **caused by** factors affecting both number and skill profile of the team. **This could result** in an unacceptable variance in the quality of the care we provide, a negative impact on the wellbeing and morale of staff, and potential regulatory action and a lack of confidence in the standard of care.	DoP&C	PCDC	**High 20** (C5 xL4)	**Moderate 10** (C5 x L2) **Q3, 25/26**	**Q1, 25/25** Workforce plans in place for all services (-1L)	**Good** ↑	Knowing which staff we need and where↑	▪ Daily operational processes in care groups ▪ Monthly e-roster reviews re fill rates etc ▪ Safe staffing reports re shifts over 13 hours, missing RN, missed breaks	**Positive:** **PCDC (20/2/24) -** ▪ Good assurance in relation to the People Journey ▪ Good assurance that a robust process has been undertaken in running networks for staff from protected groups, listening to them and taking action to address their concerns ▪ Good assurance and that the right actions are being taken to maintain the Trust's Apprenticeship workforce **IPR -** ▪ Metric 21: Staff in post with a current appraisal (increased controls assurance) **Negative:**	**Public Agenda Item 15** – Establishment Review Report **Public Agenda Item 16** – Leadership Academy **Public Agenda Item 17** – Pay Gaps **Confidential Agenda Item 8** – Trust Delivery Plan 2024/25 - working draft **Confidential Agenda Item 9** – Freedom to Speak Up Model
											Ensuring that staff are recruited to and safely deployed to the right places	▪ Rosters for inpatient services ▪ Daily management huddles/ staffing calls ▪ Daily safety huddles on wards		
											Staff are appropriately trained to support people using our services	▪ Daily safety huddles on wards ▪ Increasing number of development JDs in place to ensure people are safely developed into more senior roles ▪ Individual and manager compliance reports available weekly		
											Staff are supported to maintain their wellbeing, feel they belong and choose to stay and work here.	▪ Quarterly reviews and annual appraisals support staff ▪ Supervision – managerial and clinical ▪ OH provision ▪ Multiple H&W interventions including comprehensive support and psychological services – all with outcome measures		
											Ensuring that local leaders and managers are equipped to lead and maintain safe staffing	▪ Recruitment processes inc LE panel members ▪ 3 year leadership programme and quarterly leadership events for service management level and above		
											Early understanding of when things go wrong	▪ Operational escalation processes ▪ Links from services to ePCD increasingly strengthening ▪ Thinking about leaving interviews ▪ 'Working in TEWV' monthly online meetings		
2	✓			**Demand** **There is a risk** that people will experience unacceptable waits to access services in the community and for an inpatient bed **caused by** increasing demand for services, commissioning issues and a lack of flow through services **resulting in** a poor experience and potential avoidable harm.	Mng Dir	QuAC	**High 16** (C4 xL4)	**Moderate 12** (C4 xL3) **31/3/24**	**31/3/24** (-1L)	**Good**	Partnership Arrangements	▪ Weekly operational interface meetings with Local Authority partners to support flow within inpatient services	**Positive:** **Negative:**	**Public Agenda Item 15** – Establishment Review Report **Confidential Agenda Item 8** – Trust Delivery Plan 2024/25 - working draft
											Demand Modelling	▪ Associate Director of Strategic Planning and Programmes – Lead for demand modelling in the Trust		
											Operational Escalation Arrangements	▪ Inpatient wards – Management of admissions through PIPA process and the operational daily escalation calls ▪ Bed Management Team – Responsible for the oversight and management of the use of beds ▪ On-call arrangements – Agreement of actions in response escalation ▪ Freedom to Speak Up Guardian – Point of contact for staff with concerns about quality e.g. the impact of demand ▪ Daily Lean Management Processes – to understand and escalate risks associated with operational delivery are in place across inpatient and community services		
											Integrated Performance Reporting	▪ Operational delivery of performance standards by wards and teams		

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3									▪ Performance Department – Management of the IPR including validation of data, oversight of data quality and reporting to the various tiers of the governance structure		
											Establishment Reviews	▪ Safe Nursing Workforce Staffing Standards Team – Responsible for managing and delivering the establishment review process. This is based on: ▪ Acuity dependency assessments for each ward using the MHOST tool and professional judgements ▪ General Management reviews, including discussions with Matrons, on the ward assessments ▪ Assessments of a range of data including benchmarking, patient outcomes, staffing information e.g. use of temp staff and overtime ▪ Care Group Boards – Review the outcomes of the establishment reviews and development of proposals (included in the Establishment Review reports to the BoD) ▪ Finance Department – Reviews of affordability of the outcome of establishment reviews *(Reports to the FSB/EDG)*		
											Strengthen voice of Lived Experience	▪ Role of peer workers. ▪ Expanding opportunities of lived experience roles, including lived experience facilitators and senior lived experience roles/peers ▪ Service level service user and carer user groups ▪ Triangle of care ▪ Patient Experience reporting ▪ Understanding our complaints themes and impact on services ▪ Patient Safety Partners - PSIRF ▪ Partnership with clinicals networks – cocreation of clinical care initiatives and models ▪ Commissioning VCS lived in core services to meet identified needs		
3	✓			**Co-creation** **There is a risk** that if we do not fully embed co-creation **caused by** issues related to structure, time, approaches to co-creation and power **resulting in** fragmented approaches to involvement and a missed opportunity to fully achieve OJTC	DoCAI	QuAC	**High 15** (C5xEsL3)	**Low 5** (C5 x L1) **Q2/Q3 2024/25**	**Q2/Q3 2024/25** ▪ Co-creation Framework: final chapters to completed and rolled out trust-wide (-1L) ▪ Review to provide assurance on patient experience data (-1L)	**Good**	Further develop the co-creation infrastructure	▪ Director of Corporate Affairs and Involvement – Responsible for the delivery of the Cocreation priorities set out in Our Journey to Change (OTJC), and associated Delivery Plan ▪ Head of Co-creation ▪ Lived Experience Directors ▪ Involvement & Engagement (I&E) team ▪ Patient Experience team ▪ Peer Support team ▪ Clinical Leaders ▪ Service Managers	**Positive:** **QuAC (7/3/24) -** ▪ Good assurance related to complaints **Negative:**	**Confidential Agenda Item 8** – Trust Delivery Plan 2024/25 - working draft
											Friends and Family / Patient Experience Survey	▪ Director of Corporate Affairs and Involvement – Overall accountability for ensuring that the patient experience data and reporting of such, meets the statutory requirements ▪ Head of Patient Experience ▪ Patient and Carer Experience Team – Responsible for the organisation of patient experience activities including the Patient Experience Survey ▪ Performance Team – Responsible for the delivery of the Integrated		

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3									Performance Approach including the patient experience metric (based on FFT data)		
											Complaints Policy	▪ Chief Executive – Overall accountability for ensuring that the Complaints Policy meets the statutory requirements ▪ Director of Corporate Affairs and Involvement – Responsible for the development, implementation and monitoring of the complaints policy ▪ Head of Patient Experience - Responsible for facilitating the effective reporting, investigation, and communication of all complaint activity ▪ Complaints Team Manager – Responsible for managing the complaints' function including the central database for complaints and producing statistical data ▪ Trust Organisational Learning Group – triangulation between all sources of intelligence to identify and act on service improvements. ▪ General Managers/Service Managers ▪ Ward/Team Managers/Modern Matrons ▪ Complaints Team		
4	✓	✓	✓	**Quality of Care** **There is a risk** that we will be unable to embed improvements in the quality of care consistently and at the pace required across all services to comply with the fundamental standards of care; **caused** by short staffing, the unrelenting demands on clinical teams and the lead in time for significant estates actions **resulting** in a variance in experience and a risk of harm to people in our care and a breach in the Health and Social Care Act.	CN	QuAC	**High 16** (C4 x L4)	**Moderate 9** (C3 x L3) **1/4/25**	A number of actions will cumulatively achieve target score: ▪ Achieve safer staffing across all services – to within tolerable levels (1/4/25) ▪ Reduce occupancy on inpatient wards to 85% (TBC) ▪ Complete inpatient safety estates works (1/4/25) ▪ Transform community services and reduce waits for services (TBC) ▪ Achieve a minimum of 85% compliance across all services with mandatory training, supervision and appraisal (TBC) ▪ Demonstrate robust floor to board quality governance (1/9/25)	**Good**	Friends and Family/Patient Experience Survey	▪ Head of Patient Experience ▪ Patient Experience Team – Responsible for the organisation of patient experience activities including the Patient Experience Survey ▪ Performance Team – Responsible for the delivery of the Integrated Performance Approach including the patient experience metric (based on FFT data)	**Positive:** **QuAC (7/3/24) -** ▪ Good assurance that risks to quality are identified, understood, reported and have mitigations in place ▪ Good assurance on the implementation of PSIRF **Negative:** **IPR -** ▪ Metric 5: Adults and Older Persons showing measurable improvement following treatment - patient reported (reduced performance assurance)	**Confidential Agenda Item 8** – Trust Delivery Plan 2024/25 - working draft
											Patient and carer engagement and involvement structures and processes	▪ Involvement and Engagement Team – Delivery of I&E activities in conjunction with services ▪ Peer Support Workers		
											Our Quality and Safety Strategic Journey	▪ Chief Nurse – Responsible for the development of Our Quality and Safety Journey ▪ Workstreams and key performance indicators have been developed for each of the Journey's four priorities ▪ The professional structure with the care groups have day to day oversight of the quality and safety of care ▪ Integrated Performance Dashboard is utilised to identify variance in care delivery ▪ Learning from serious incidents and near misses		
											Incident management policies and procedures	▪ Chief Nurse ▪ Responsible for ensuring the systems for incident reporting, identification of patient safety issues and reporting appropriate incidents through correct procedures is in place ▪ Clinical and operational Managers medical Staff, modern matrons responsible for the operational implementation of the policy and associated guidelines. ▪ MDT in teams ensure effective after action reviews.		

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3								Governance arrangements at corporate, directorate and specialty levels	▪ Individual Executive Directors – Responsible for the implementation and delivery of governance arrangements relating to their portfolios including: ▪ ERQ (CN) – Responsibilities include oversight of Serious Untoward Incident/Never Event management processes and receive lessons learnt for sharing across the Trust as appropriate ▪ CGBs (Mgt Dirs) – Responsibilities include Oversight of the day to day management of an effective system of integrated governance, risk management and internal control across the whole Care Group's activities		
											Performance Management of Serious Incident Review	▪ Patient Safety Team - ▪ Responsible for ensuring all reportable serious incidents are reviewed within the agreed timescales following an internal governance process ▪ Daily patient safety huddles to review incidents of moderate harm and above to identify areas of immediate action and learning and support timely dissemination of information to mitigate risks ▪ Implementation of PSIRF Jan 24		
5	✓	✓	✓	**Digital** **There is a risk that** failure to implement appropriate, cost effective and innovative approaches to digital infrastructure, **caused by** lack of resources, infrastructure challenges and digital expertise **resulting in** limited delivery of OJTC goals today and for the future.	**ACE**	**SRC**	**-**	**-**	**-**	**-**	Initial EPR Rollout and stabilisation Phase Governance		**Positive:** **Negative:**	**Confidential Agenda Item 8** – Trust Delivery Plan 2024/25 - working draft
											Robust Clinical Change Control			
											Digital Strategy linked to Our Journey to Change			
											New Control - Replacement strategy for IT infrastructure and devices			
											New Control - Incident response, back-up and recovery, business continuity and disaster recovery plans are in place and periodically exercised.			
6	✓	✓	✓	**Estate / Physical Infrastructure** **There is a risk** of delayed or reduced essential investment **caused by** constrained capital resources **resulting in** an inability to adequately maintain, enhance or transform our inpatient and community estate, adversely impacting patient and colleague outcomes/experience.	**DoFE**	**SRC**	**Medium 12** (C4 x L3)	**Low 6** (C3 x L2) **2028/29**	**2028/29** Estates Master Plan delivery achieves proposed rationalisation of estate to reduce call for capital and revenue funding on non-core assets (-1C & -1L) *(Note: Two other*	**Good**	NENC Infrastructure board	▪ Executive Director of Finance and Estates/Facilities and Director of Estates, Facilities & Capital (or their deputies) represent the Trust at NENC meetings	**Positive:** **Negative:**	**Confidential Agenda Item 8** – Trust Delivery Plan 2024/25 - working draft
											Estates Master Plan	▪ EFM Directorate – Responsible for the preparation / delivery of the EMP in conjunction with the Care Groups based on an established prioritisation framework ▪ Finance Department – Responsible for the preparation of the annual capital and revenue		

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3											
									actions have been identified which may reduce or increase likelihood score but this will not be clear until the outcomes are known: ▪ *NENC ICB CDEL funding methodology – March 2025* ▪ *Confirmation of national capital allocations - 2025/26 to 2027/28)*			financial plans for Board approval		
											CIG & CPSG	▪ Estates, Facilities, Capital and Finance teams work closely to ensure engagement across the Trust to collate capital investment priorities, risk / impact assess these and support agreement of final annual capital plan and medium term capital requirements		
											Estates, Facilities & Capital Directorate Management Team Meeting	▪ All of the directorate's functions provide monthly assurance reports to this meeting which is chaired by the Director of Estates, Facilities and Capital		
											ERIC, PLACE and PAM national annual reporting / benchmarks submission and monitoring	▪ EFM Directorate responsible for: ▪ **PLACE** ▪ Organising (with CA&I) the PLACE assessment visits ▪ Compiling the information ▪ Submission of the information to NHSE ▪ Preparation of the Action Plan ▪ **ERIC** Compiling and submitting ERIC submission to NHSE ▪ **PAM** Self-assessment against the questions included in the PAM and on the delivery of resultant action plans, processes in train to ensure timely submission		
											ERIC Green Plan submission and monitoring	▪ EFM Directorate responsible for compiling and submitting Green Plan submission to NHSE / ensuring progress to deliver milestones		
											Environmental Risk Group	▪ Director of Estates, Facilities and Capital ensures aligned CPSG and ERG agendas, including close collaboration with Chief Nurse / MD DTVF joint chairs ▪ Directors of Operations / Operational teams support identification of environmental issues ▪ Service desk tracks levels of maintenance issues		
7	✓	✓	✓	**Cyber Security** **There is a risk** of a successful cyber-attack or breach, **caused by** global threats, digital and data security and literacy, **resulting in** compromised patient safety, business continuity, systems and information integrity and loss of confidence in the organisation.	**ACE**	**SRC**	**High**	**High (March 2024) (-1L to achieve)**	**March 2024** Approval of new investment (-1L)	-	Controls information not provided due to security concerns		**Positive:** **Negative:**	

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3											
8	✓	✓	✓	**Quality Governance** **There is a risk** that our floor to Board quality governance does not provide thorough insights into quality risks **caused by** the need to further develop and embed our governance and reporting including triangulating a range of quality and performance information **resulting in** inconsistent understanding of key risks and mitigating actions, leading to variance in standards.	**CN**	**QuAC**	**Moderate 12** (C4 x L3)	**Moderate 9** (C3 x L3) **01/01/25**	A number of actions will cumulatively achieve target score: ▪ Implement the Quality Dashboard ▪ Embed the Executive Review of Quality and supporting forums as an enabler to identifying and managing risks to quality of care ▪ Develop the role of the Associate Director of Nursing and Quality to increase curiosity into the Fundamental Standards of Care ▪ Review and relaunch the Quality and Safety priorities within Our Journey to Change ▪ TEWV Leadership Academy will help all leaders enact their role to safeguard and improve quality	**Good**	Open and transparent culture working to organisational values steered by Our Journey to Change	▪ Cohesive Board ▪ Engaged and visible Executive ▪ High Quality Care Group Directors ▪ Substantive recruitment of service leadership and clinical teams	**Positive:** **ARC (6/2/24) -** ▪ Internal Audit reviews provided substantial assurance for the NICHE complaints action plan, and good assurance on embedding NICHE action plans **QuAC (7/3/24) -** ▪ Substantial assurance evidenced for delivery and monitoring of clinical audit and effectiveness ▪ Good assurance from the progress report from Drug & Therapeutics ▪ Good assurance that there is a clear understanding of the progress made against each NICHE recommendation. **Negative:** **QuAC (7/3/24) -** ▪ Reasonable assurance on the delivery of progress with compliance to the application of the Duty of Candour requirement ▪ Reasonable assurance that sexual safety monitoring is taking place with mitigations in place for mixed sex accommodation	
											Executive and Operational Organisational Leadership and Governance Structure	▪ Chief Executive – Responsible for the Operational Leadership and Governance Structure ▪ Executive Directors – Responsible for the delivery of key elements of the Leadership and Governance Structure within their portfolios ▪ Co Sec – Responsible for the provision of secretariat services within the governance structure ▪ Care group clinical leaders responsible for the oversight of care delivery		
											Quality Improvement Approach and Team	▪ The QI team is well established and embedded into services		
											Oversight / Insight / Foresight	▪ Performance team are responsible for measuring and reporting performance ▪ Chief Nurse leads the nursing and quality directorate who have responsibility to measure and report out on - patient safety - quality governance -audit - infection, prevention and control - safeguarding - risk -Use of Force ▪ Chief Nurse lead the executive review of quality reporting to QuAC ▪ Medical Director leads on a number of patient safety priorities including Mortality review and Sexual Safety ▪ Care groups have dedicated clinical leaders at director delivery levels with a role to assess delivery of care standards		
9			✓	**Partnerships and System Working** **There is a risk that** failure to take a proactive role and engage effectively with partners **caused by** capacity challenges including spanning 2 ICSs and multiple local authorities **limits** our ability to influence service transformation and improve the health of the communities we serve.	**ACE**	**SRC**							**Positive:** **Negative:**	
10			✓	**Regulatory compliance** **There is a risk** that failure to comply with our regulatory duties and obligations, at all times, could **result** in enforcement action and financial	**CEO**	**Board**	**Moderate 10** (C5 x L2)	**Moderate 8** (C4 x L2) **31/03/25**	**31/3/25** Delivery of CQC Improvement Plan (-1C)	-	Statutory Reporting	▪ Reporting requirements and timetables developed by the Company Secretary ▪ Information provided by designated leads ▪ Annual Accounts (and related submissions) undertaken by the	**Positive:** **ARC (6/2/24) -** ▪ Good assurance with Counter Fraud	**Public Agenda Item 17** – Pay Gaps (Gender and Ethnicity)

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3											
				penalties and damage our reputation								▪ Finance Staff ▪ Reports produced by Corporate Affairs and Communications based on submissions received	Progress, with no overdue actions ▪ Good assurance from the Internal Audit review of the use of the mental health act ▪ Good assurance from the Internal Audit review of the development and embeddedness of the risk management framework, recognising that InPhase continues to present some challenges as it embeds. ▪ Good assurance evidenced from the refreshed BAF that the strategic risks are being managed effectively and being maintained appropriately ▪ Good assurance on the process that was taken to co-produce the CQC Improvement Plan and actions are being delivered to timescales **MHLC (27/2/24) -** ▪ Good assurance regarding the oversight of inspection activity and completion of actions from CQC MHA Inspections ▪ Substantial assurance that the number of times detained patients are discharged by the tribunal or hospital mangers is within a normal range ▪ Good assurance that the legislative requirements for patients held in the trust on a s136, are being met in all areas ▪ Substantial assurance that patients are given their rights when first detained and a robust escalation process is in place	**Public Agenda Item 18** – Constitutional Change
											Provider Licence	▪ Board certification processes undertaken by the Company Secretary ▪ Delivery of related by policies by operational and corporate departments ▪ Commissioning of external governance reviews, preparation of evidence for and support by the ACE and Co Sec ▪ Delivery of improvement plans by designated leads		
											Environmental Sustainability	▪ The Estates, Facilities and Capital Team are maintaining day to day BAU		
											Compliance with the CQCs Fundamental Standards of Quality and Safety	▪ Day to day delivery of the fundamental standards by ward and team staff ▪ Responsibility for delivery of each element of the CQC Action Plan designated to lead Directors ▪ Chief Nurse is the lead Executive for relationship management with the CQC		
											Compliance with Mental Health Legislation (MHL)	▪ Delivery of the requirements of MHL by ward and team staff		
											NHSE Financial Controls	▪ Annual budget prepared by DoFE ▪ Monthly finance returns prepared and submitted to NHSE by the Finance Department ▪ Budget holder management of individual budgets		
											Financial Regulations (e.g. HMRC requirements)	▪ Correct VAT coding of invoices on Cardea by those placing an order ▪ Timely and accurate entry / submission of staff information into HealthRoster, MSS or by mail to the payroll department ▪ For capital schemes / complex services VAT Liaison are contacted to advise on VAT treatment		
											Equality, Diversity, Inclusion and Human Rights	▪ The Director of People and Culture has operational responsibility for Equality, Diversity, Inclusion and Human Rights throughout the Trust in both Employment and Service Delivery ▪ EDIHR Lead and officers: ▪ Provision of support for inclusion networks ▪ Compilation of Equality Act 2010 data ▪ Compilation of evidence and consultation on the EDS ▪ Support for the development of the Trust's equality objectives ▪ Designated managers/leads: ▪ Completion of equality analyses ▪ Delivery of actions under the EDS ▪ All staff are responsible for co-operating with measures introduced by management to ensure equality of opportunity and non-discriminatory practices, including making sure that people have equality of access to service provision		

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3									▪ Public Health Consultant engaged to develop the Trust's approach to tackling health inequalities	for any patients who have not had their rights withing three days of detention ▪ Good assurance that the administrative and medical scrutiny processes for MHA documentation takes place ▪ Substantial assurance that the CQC have been notified of every instance of absence without leave ▪ Good assurance that the Trust has followed a robust process in analysing detentions under the Mental Health Act by gender and ethnicity and comparing these to national figures to understand differences between the numbers of anticipated and actual detentions **PCDC (20/2/24) -** ▪ Good assurance that a robust process had been undertaken when completing the Pay Gap reports **QuAC (7/3/24) -** ▪ Good assurance that the Trust has met the regulatory requirements relating to safer staffing **Negative:** **MHLC (27/2/24) -** ▪ Reasonable assurance on the progress of implementation of the positive and safe plan ▪ Reasonable assurance that the Trust is meeting its requirements under the MCA ▪ Reasonable level of assurance that the use and reporting of DoLS is being carried out as required	
											Information Governance	▪ Day to day compliance with the requirements of the Information Governance Policy by all staff. ▪ Training on information governance mandatory for all staff ▪ Relevant staff administration of DPA and FoIA requests ▪ Information Governance Team – co-ordination and oversight of DPA requests ▪ Communications Team – co-ordination and oversight of FOIA requests ▪ Estates Team – co-ordination and oversight of EIR requests ▪ Designated Information Assets Owners, supported by Information Asset Assistants – management of information risk and maintenance of information asset registers ▪ SIRO and Caldicot Guardian – Responsible for championing IG across the Trust		
											Risk Management Arrangements	▪ Care Group Managing Directors, General Management Tier and Service Management Tier – ▪ Consider capture and maintain risks raised by staff in local risk registers ▪ Develop and implement action plans to ensure risks identified are appropriately treated ▪ Ensure that appropriate and effective risk management processes are in place and that all staff are made aware of the risks within their work environment ▪ Other Executive Directors - Responsible for ensuring effective systems for risk management, are in place within their directorate ▪ Head of Risk Management – Day to day management of the Trust Risk Register		
											Health Safety and Security (HSS)	▪ The Trust has a Health, Safety and Security Team who manage the day-to-day Health and Safety requirements in line with all relevant parliamentary acts ▪ Reporting system is in place for the reporting of incidents which fall under the requirements of Reporting of Incidents of Disease and Dangerous Occurrences regulation (RIDDOR) ▪ Provision of HSS information for new employees at Trust induction. ▪ HSS awareness training forming part of all staff mandatory package. ▪ HSS online tool kit available for all services, wards and departments across the trust. ▪ Regular workplace audits undertaken by the HSS team. ▪ Incidents recorded on 'InPhase' are shared with relevant service leads, including HSS. This enables investigation of incidents to identify trends and flag any remedial actions		
											Executive and Care Group Leadership, management and	▪ Individual Executive Directors – Responsible for the implementation and delivery of		

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3								governance arrangements	governance arrangements relating to their portfolio ▪ Individual staff compliance with the range of policies relating to regulatory compliance e.g. health and safety	**PCDC (20/2/24) -** ▪ Limited assurance in respect of the three aligned risks due to the lack of clarity in the report as to what was 'moving the dial' in relation to the movement of risk between quarters from the information provided **QuAC (7/3/24) -** ▪ Reasonable assurance regarding progress with the CQC Improvement Plan	
											Inquests and Coroners	▪ Inquest Team - Management of the Inquest process from a Trust perspective including: ▪ Arranging and compiling witness statements and submission to Coroner ▪ Instruction of Solicitors ▪ Co-ordination and compilation of information ▪ Provision of support for staff ▪ Preparation of responses to Regulation 28 Reports by staff nominated by the CEO		
11	✓	✓	✓	**Roseberry Park** **There is a risk that** the necessary Programme of rectification works at Roseberry Park, limited access to capital funding, and associated PFI termination legal case **could adversely affect** our service quality, safety, financial, and regulatory standing.	**DoFE**	**Board**	**High**	**Moderate (TBC) (-1C & -1L)**	TBC	**Good**	Controls ratings subject to legal privilege		**Positive:** **Negative:**	
12	✓	✓	✓	**Financial Sustainability** **There is a risk that** constraints in real terms funding growth **caused by** government budget constraints and underlying financial pressures **could adversely impact** on the sustainability of our services and/or our service quality/safety and financial, and regulatory standing	**DoFE**	**SRC**	**High 20** (C5 x L4)	**Moderate 12** (C4 x L3) **2028/29**	TBC	**Good**	ICB Financial Governance including Mental Health LDA Sub Committee and CEO and DoF financial planning groups and sub groups	▪ DoFE member of ICS DoF/CFO group ▪ DoFE member of ICS Resource Allocation Steering Group ▪ CEO member of NENC CEO provider collaborative group ▪ CEO leading HNY provider collaborative work for MHLDA ▪ COOs leading Provider collaborative work to assess implications for beds / pathways and clinical models	**Positive:** **IPR** ▪ Metric 24: Financial Plan: SOCI - Final Accounts - Surplus/Deficit *(increased performance assurance)* ▪ Metric 25a: Financial Plan: Agency expenditure compared to agency target *(increased performance assurance)* **Negative:** **IPR** ▪ Metric 26: Use of Resources Rating - overall score *(reduced controls assurance)* ▪ Metric 30: Cash balances (actual compared to plan) *(reduced controls*	**Confidential Agenda Item 7** – Finance Update (Month 10 Finance Report and Financial Plan)
											Financial Sustainability Board	▪ Financial reporting using intelligence from Care Groups, Directorates and costing transformation programme to inform management of underlying financial position		
											Business Planning and Budget Setting Framework and in Year Financial Forecasting & Recovery Arrangements	▪ ACE -Responsible for the delivery of the Business Planning Framework ▪ DoFE and ESRG – Responsible for arrangements to develop the Financial Plan including tracking the recurrent and non-recurrent implications and underlying financial position and cost drivers ▪ Managing Directors (for Care Groups) and other Execs (for their Directorates) responsible for management of costs with budgets and/or agreed forecasts and informing assumptions to underpin financial planning using business planning processes. *(Reporting into FSB and ESRG*		

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3											
												into EDG with assurances into S&RC and Board)	*assurance)*	
13	✓	✓	✓	**Public confidence** **There is a risk that** ongoing external scrutiny and adverse publicity **could lead to** low public and stakeholder perception and confidence in the services we provide	**DoCAI**	**Board**	**High 20** (C5 x L4)	**Moderate 10** (C5 x L2) **April 24**	**31/3/24** Refreshed trust-wide communications strategy (-1L)	Reasonable	Communications Strategy	▪ Director of Corporate Affairs and Involvement ▪ Head of Communications ▪ Communications team	**Positive:** **Negative:**	
											Stakeholder Communications and Engagement Strategy	▪ Trust Board ▪ Director of Corporate Affairs and Involvement ▪ Care Group Board Directors ▪ Head of communications ▪ Corporate Affairs and Stakeholder Engagement Lead ▪ Communications team		
											Social Media Policy	▪ Director of Corporate Affairs and Involvement – responsible for the development, implementation and monitoring of the social media policy ▪ Head of communications ▪ Comms team – responsible for ongoing monitoring of social media ▪ General Managers/Service Managers – ▪ Ward/Team Managers/Modern Matrons – as above ▪ Complaints team ▪ Patient experience team ▪ Clinical leaders ▪ Service managers ▪ People and Culture		

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**14 March 2024**
Title:	**Chief Executive's Public Report**
Executive Sponsor(s):	**Brent Kilmurray, Chief Executive**
Author(s):	**Brent Kilmurray**

Report for:				
	Assurance		***Decision***	
	Consultation		***Information***	✓

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	✓
2: To co-create a great experience for our colleagues	✓
3: To be a great partner	✓

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
10	**Regulatory Compliance**	There is a risk that failure to comply with our regulatory duties and obligations, at all times, could result in enforcement action and financial penalties and damage our reputation
12	**Financial Sustainability**	There is a risk that constraints in real terms funding growth caused by government budget constraints and underlying financial pressures could adversely impact on the sustainability of our services and/or our service quality/safety and financial, and regulatory standing

Executive Summary:

Purpose:	A briefing to the Board of important topical issues that are of concern to the Chief Executive.
Proposal:	To receive and note the contents of this report.
Overview:	Update on the CQC Prosecution, 2024 Budget and planning, and Leadership Competency Framework, and the Staff Survey
Prior Consideration and Feedback	n/a
Implications:	No additional implications.
Recommendations:	The Board is invited to receive and note the contents of this report.

CQC Prosecution

Members of the Board will be well aware that the CQC prosecution went to trial on the week of the 26th February. All evidence and closing statements were presented and concluded on the week, however due to some aspects of the proceedings taking longer than planned and the lack of availability of court time the verdict has been held over until Monday 11th March. Clearly, we will have had the verdict by the time of our meeting, therefore we will be able to reflect more then on the outcome.

2024 Budget and NHS Planning

Following this week's Budget we expect to receive planning guidance any time now. NHSE has signalled that the main priorities are likely to remain very similar with a clear focus on elective waiting lists, urgent and emergency care, cancer, primary care access and mental health.

As outlined in the budget, there will be an overall revenue increase of £2.5bn for the NHS, protecting funding levels in real terms and assisting with targeted investments in reducing waiting times and other performance improvements.

It is likely to be made clear that the Mental Health Investment Standard will be held, with additional funding identified to support the expansion of Talking Therapies and Individual Placement Support – in line with the Chancellor's commitments to improve the employment prospects of being with mental health issues. The other area likely to see targeted investment is children's services.

Other positive news is the identification of £3.4bn of capital over 3 years to support new technology and digital investments. This is linked to the agreement that the investments being made are contingent on an agreement to boost productivity across the NHS. The NHS has committed to deliver a 1.9% average productivity growth between 2025/26 and 2029/30. This links to the NHS Long Term Workforce plan commitments and will represent £35bn of cumulative savings by 2029/30.

NHS England will start reporting against new productivity metrics regularly from the second half of 2024/25 at a national, integrated care board and trust level. New incentives will be introduced to reward providers that deliver productivity improvement at a local level. Further detail will be set out in the summer.

The Director of Finance and Estates will provide further, updated information on the planning process at the meeting.

Leadership Competency Framework

The NHS leadership competency framework (LCF) for board members was launched on 28th February 2024 and follows multiple reports specifically referencing leadership and management in the NHS: Francis (2013), Kirkup (2018), Kark (2019), and Messenger (2022). Kark's review of the fit and proper person test (FPPT), specifically included a recommendation for 'the design of a set of specific core elements of competence, which all directors should be able to meet and against which they can be assessed'. It will be reviewed as part of the planned review of the FPPT framework in 2025. NHS England » NHS leadership competency framework for board members

The LCF was published alongside a **revised chair appraisal framework,** incorporating the new competencies, and is part of NHSE's planned suite of management and leadership development frameworks, tools and resources. NHS England » Framework for conducting annual appraisals of NHS chairs (CAF)
It applies to all board members of NHS provider organisations, integrated care boards (ICBs) and NHSE's board, equally to non-executive directors (NEDs) and executive directors and sets out aspirational competencies, recognising that not all leaders will meet all competencies at all times. It is designed to reflect NHS values and aligns with its 'leadership way' and 'people promise' publications, and the seven principles of public life (Nolan principles). National leadership programmes and support for board directors and aspiring directors will have the competencies built into them.
The framework is built on six domains with a description of what good looks like for each:

1. Driving high quality and sustainable outcomes
2. Setting strategy and delivering long-term transformation
3. Promoting equality and inclusion, and reducing health and workforce inequalities
4. Providing robust governance and assurance
5. Creating a compassionate, just and positive culture
6. Building a trusted relationship with partners and communities

It is important to note that Foundation Trusts (FT) have legal autonomy over NED (including chair) recruitment and appointments, and many FTs have developed their own approaches to this and appraisals, working with their councils of governors. The LCF does not reference the role of councils.

Next steps - national
A new board member appraisal framework is due this autumn. This will also provide guidance on how to assess performance against the six domains and will be differentiated according to whether board members have been in post less than 12 months, or are more experienced.
A three year 'roadmap' setting out details of wider work supporting managers and leaders in the NHS is promised 'shortly'.
This will include a management and leadership framework for the workforce as a whole, to include standards and competencies that will be aligned to defined levels of management.

Next steps – TEWV
1. Recruitment: The competency domains should be incorporated into all board member job descriptions and recruitment processes by 1 April 2024, to help evaluate applications and design assessment processes. We will apply this to all new board roles from April 2024 onwards. We will also review the LCF for the elements that are relevant to corporate deputy and care group board roles although this will take a longer period of time.

2. Appraisal: The competency domains should be used in board member appraisals and to support the development of individuals and the whole board. The Director for People and Culture and Company Secretary will work with the CEO and Chair ahead of the next round of board appraisals.
Specific responsibilities - There are specific responsibilities for different board members in relation to appraisals:
Chairs

- Assure themselves that individual board members can demonstrate broad competence across the domains
- Assure themselves there is 'strong, in-depth evidence of achievement against the competency domains collectively across the board' and ensure appropriate development if not

- Include relevant information in board member references

All board members

- Self-assess against the six competency domains as preparation for annual appraisal, incorporating development activity.
- Chief executives and senior independent directors - carry out appraisals for executives and chairs respectively, based on the framework and other objectives, and ensure findings feed into personal development plans. The Chair appraisal framework now incorporates the six domains and their underlying competencies: this is optional for organisations to use but chairs should be assessed against the 'broad principles' of the LCF through multi-source assessment.

3. Council of Governors

We need to ensure that the council of governors is sighted on the both the competencies and revised chair appraisal framework.

2023 Staff Survey

The staff survey results were published on 7th March. 48% of colleagues responded to the survey, an increase of 4% on last year (3,782 participants). In overall summary, we have continued to improve in across the majority of the areas and we 10th in the overall positive score change rankings within our group of 23 organisations.

In the important areas of colleagues being happy for family to be cared for here and would recommend us as a place to work we have improved have improved by 3.7% and 2.76% respectively. Importantly, we have seen improvements in areas relating to harassment and bullying, being treated fairly in errors and incidents, reduction in working additional unpaid hours and belief we have enough staff to do the job effectively.

There are some important areas for us to consider how to improve relating to feeling a personal attachment to teams, improvements in reasonable adjustments for disabilities, increasing confidence in addressing safety concerns linked to clinical practice.

Appendix - The six leadership competency domains of the LCF

1 Driving high-quality and sustainable outcomes

The skills, knowledge and behaviours needed to deliver and bring about high quality and safe care and lasting change and improvement – from ensuring all staff are trained and well led, to fostering improvement and innovation which leads to better health and care outcomes.

2 Setting strategy and delivering long-term transformation

The skills that need to be employed in strategy development and planning, and ensuring a system wide view, along with using intelligence from quality, performance, finance and workforce measures to feed into strategy development.

3 Promoting equality and inclusion, and reducing health and workforce inequalities

The importance of continually reviewing plans and strategies to ensure their delivery leads to improved services and outcomes for all communities, narrows health and workforce inequalities, and promotes inclusion.

4 Providing robust governance and assurance

The system of leadership accountability and the behaviours, values and standards that underpin our work as leaders. This domain also covers the principles of evaluation, the significance of evidence and assurance in decision making and ensuring patient safety, and the vital importance of collaboration on the board to drive delivery and improvement.

5 Creating a compassionate, just and positive culture

The skills and behaviours needed to develop great team and organisation cultures. This includes ensuring all staff and service users are listened to and heard, being respectful and challenging inappropriate behaviours.

6 Building a trusted relationship with partners and communities

The need to collaborate, consult and co-produce with colleagues in neighbouring teams, providers and systems, people using services, our communities, and our workforce. Strengthening relationships and developing collaborative behaviours are key to the integrated care environment.

For information:

NHS values

- Working together for patients
- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Everyone counts

Seven principles of public life

- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honesty
- Leadership

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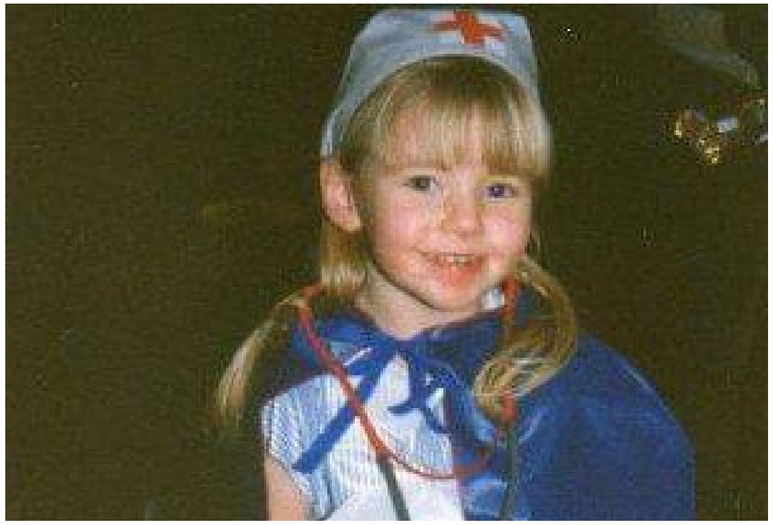
Communications Dashboard
February 2024

Tees, Esk and Wear Valleys
NHS Foundation Trust

This month we...

- Celebrated Mental Health Nurses Day
- Continued our Wellbeing Winter Campaign
- Launched CITO on 5 February
- Celebrated Children's Mental Health week
- Celebrated the year of the dragon according to the Chinese zodiac
- Celebrated LGBT+ month



We celebrated Mental Health Nurses Day

Visited CAMHS in Redcar to celebrate Children's Mental Health Week.

We celebrated National Apprenticeship Week

Continued our winter wellbeing campaign with stories from people in our care

Media and Online

Tees, Esk and Wear Valleys
NHS Foundation Trust

In the media

11

Media enquiries handled by the team

5

Media releases issued

17

Total pieces of coverage across online news, TV and radio

News Stories

- **Phone support can ‘reduce loneliness and depression’ in older people -** *Northern Echo online*
- **TEWV NHS boss admits more improvements needed - but praises change -** *Northern Echo online*
- **Mental Health Nurse Sam calls on others to consider career in profession -** *Hambleton Today*
- **Trial looming for TEWV Mental Health Trust accused of 18 year old who lost her life -** *Teesside Live*
- **Mental Health Trust failings contributed to man’s suicide, coroner finds -** *ITV online*

Media and Online

Tees, Esk and Wear Valleys
NHS Foundation Trust

Our website

90,101

+113.5% YOY

Page views

Staff intranet

1,154,284

Page views

Top 3 visited pages

1. Job vacancies
- 33,143 views
2. Services
- 2,542 views
3. What to do in a mental health crisis
- 2,196 views

Top staff intranet news stories

1. Mental health nurse inspired to help others - 859 views
2. Cito Live - 791 views
3. Mental Health Nurses Day - 720 views
4. Emma Thompson celebration of life - 582 views
5. Trust team marks milestone first year of helping to keep families together - 491 views
6. Paris read-only use start menu or link - 393 views

Social Media - our audience

Tees, Esk and Wear Valleys
NHS Foundation Trust

26,514

Total followers

670

New followers

105,822

People who saw our content (impressions)

2,608

Engagements

Top posts

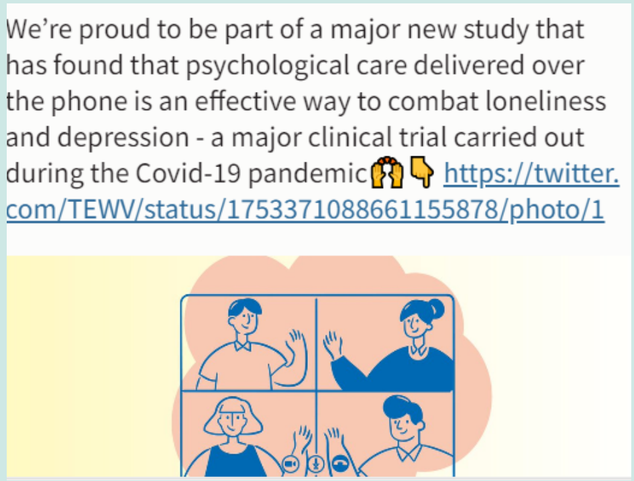
Tees, Esk and Wear Valleys
NHS Foundation Trust

Facebook

Impressions - 6128

Engagement - 589

Twitter



Impressions - 2116

Engagement - 270

Linkedin

Impressions - 934

Engagement - 154

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**14th March 2024**
Title:	**Board Integrated Performance Report as 31st January 2024**
Executive Sponsor(s):	**Mike Brierley, Assistant Chief Executive**
Author(s):	**Sarah Theobald, Associate Director of Performance**

Report for:				
	Assurance	✓	***Decision***	
	Consultation		***Information***	

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	✓
2: To co-create a great experience for our colleagues	✓
3: To be a great partner	✓

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
1. 2. 3. 4. 5. 6. 9. 11. 15.	Recruitment & Retention Demand Involvement and Engagement Experience Staff Retention Safety Regulatory Action Governance & Assurance Financial Sustainability	The Integrated Performance Report is part of the assurance mechanism that provides assurance on a range of controls that relate to our strategic risks.

Executive Summary:

Purpose: The Board Integrated Performance Report (IPR) aims to provide oversight of the quality of services being delivered and to provide assurance to the Board of Directors on the actions being taken to improve performance in the required areas.

Proposal: It is proposed that the Board of Directors receives this report with **reasonable** assurance regarding the oversight of the quality of services being delivered. There are four areas within the Integrated Performance Dashboard (IPD) with **limited performance assurance** and **negative controls assurance;** in addition, there are **several areas of concern** within the National Quality Standards/Mental Health Priorities and the NHS Oversight Framework. There are mitigations within each of the Headlines which summarise the improvement actions and the impact expected.

Overview: There are several updates to this month's IPR which are as follows:

- The inclusion of the new *Restrictive Intervention* measure
- The updated *Inpatients reporting they feel safe* measure
- The exclusion of the *Staff Leaver Rate* measure – see individual page for further detail
- The inclusion of the NHS Oversight Framework (as at Quarter 3 23/24)

The overall **reasonable** level of assurance has been determined based on the Performance & Controls Assurance Framework for the Board Integrated Performance Dashboard (IPD) and progress against the National Quality Standards/Mental Health Priorities/NHS System

Oversight Framework.

There are "Headlines" for each of the sections: the Integrated Performance Dashboard (page 5); the National Quality Standards/Mental Health Priorities (page 46), and the NHS Oversight Framework (page 49). These headlines include mitigations which describe how we intend to improve performance, the impact of the actions and when we expected to see the impact. We are continuing to use the Performance Improvement Plans (PIPs) as a tool to support improvement; however, the improvement actions are now within the IPR (where completed). The key changes for the IPD are shown in italics on page 9 within the Performance & Controls Assurance Overview.

The People Culture & Diversity Committee are recommending the following standards for the people measures in the IPD:

- Staff Leaver Rate – 11%*
- Sickness Absence Rate – 5.5%
- Percentage of staff recommending the trust as a place to work – 60%
- Percentage of staff feeling they are able to make improvements happen in their area of work – 65%

**Please note that this recommendation was based on the historic information previously included in the IPD which has been removed from the report. Whist we still feel this recommendation is valid, we will revisit this once we have the refreshed data to ensure it remains appropriate.*

The Integrated Performance Report (IPR) is part of the assurance mechanism that provides assurance on a range of controls that relate to our strategic risks (see page 44 alignment of measures to the Board Assurance Framework). The two key risks currently are:

- **(BAF Risk 15) Financial Sustainability & (CRR risk 1260)** There is a risk that if we do not optimise and make effective use of our annual financial resources this may result in regulatory interventions and/or adversely impact quality.
- **(BAF Risks 1 and 5) Recruitment and Staff Retention** There is a risk that our inability to recruit and retain sufficient qualified and skilled staff (a common risk shared by all providers) might jeopardise our ability to provide high quality/safe services. In addition, there are multiple factors that could contribute to staff not choosing to stay with the Trust once we have recruited them. This will undermine the provision of safe and sustainable services as well as putting individual staff and patients at risk of harm.

Prior Consideration and Feedback

The Integrated Performance Report was discussed by Executive Directors Group and the Care Group individual IPRs by the Care Group Boards in February 2024.

Implications:

There are no identified implications in relation to receipt of this report to the Board of Directors.

Recommendations:

The Board of Directors is asked to:

1. Note the information contained within the report.
2. Note the actions in place to manage any areas where performance is not where we would want it to be.
3. Confirm it is assured on the actions being taken to improve performance in the required areas.
4. Approve the proposed standards recommended by the People Culture & Diversity Committee

Tees, Esk and Wear Valleys
NHS Foundation Trust

Board Integrated Performance Report

As at 31st January 2023

Report produced by: Amy Walford, Performance Lead (Corporate) and Sarah Theobald, Associate Director of Performance
Date the report was produced: 28th February 2024

For any queries on the content of this report please contact: Sarah Theobald, Associate Director of Performance
Contact Details:: sarah.theobald@nhs.net

journey to change

CONTENTS

Our Guide To Our Statistical Process Control Charts

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Within our Board Integrated Performance Dashboard we use Statistical Process Control Charts to determine whether we have any underlying causes for concern. SPC is an analytical tool that plots data over time; it helps understand variation in data and in doing so guides when and where it is appropriate to take action.

Variation: natural (common cause) or real change (special cause)?

Special Cause Improvement Low is good	We're aiming to have low performance and we're moving in the right direction.
Special Cause Improvement High is good	We're aiming to have high performance and we're moving in the right direction.
Common Cause – no significant change	No significant change in the data during the reporting period shown
Special Cause Concern Low is good	We're aiming to have low performance and we're moving in the wrong direction.
Special Cause Concern High is good	We're aiming to have high performance and we're moving in the wrong direction.
Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	We're currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.
Special cause variation of a decreasing nature where DOWN is not necessarily improving nor concerning.	We're currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.

Assurance: is the standard achievable?

Target Pass	We will consistently achieve the target/standard
Target Pass / Fail	Our performance is not consistent and we regularly achieve or miss the target/standard
Target Fail	We will consistently fail the target/standard

Please note assurance on whether the standard/plan is achievable is now included for a number of measures. Standards for the remaining ones will be progressed, where required.

Our Approach to Data Quality and Action

Tees, Esk and Wear Valleys NHS Foundation Trust

Data Quality
On a bi-annual basis we undertake a data quality assessment on our Board measures as part of our assurance to the Board. Our data quality assessment focuses on 4 key elements: robustness of the measure, data source, data reliability and audit. The latest assessment on all measures has been completed during September 2023 and the results incorporated within this report.

Note: The development of the local audit/assurance framework to support the assessment will be completed in quarter 4 2023/24, with a view to undertaking the first assessments in quarter 1 2024/25. This element has, therefore, been omitted from the latest assessment.

Action Status
Our action status is informed by a combination of current performance, performance over time (including trends) and general intelligence.

When we interpret a Statistical Process Control chart we look at the current variation depicted within the chart, how our performance is compared to what we are trying to achieve, whether we have assurance that we will achieve the standard (if applicable) and whether our performance over time is improving.

Data Quality Assessment status

DQ ★	Data Quality Assessment Score over 90%	No actions required
DQ ✓✓	Data Quality Assessment Score 70% to 89%	No actions required; but a small number of improvements identified
DQ ✓	Data Quality Assessment Score 50% to 69%	Some actions required
DQ ✗	Data Quality Assessment Score less than 50%	Significant work is required

Action status

Positive Assurance
We are doing well in this area and no action is required at this time

No Concerns
We are performing consistently in this area and no action is required at this time

Continuous Improvement
Whilst the SPC/data indicates there are no specific concerns at present, we want to continuously improve in this area

An Area of Concern
We are concerned with our performance in this area and action is required to improve

Board Integrated Performance Dashboard Headlines

Headlines

- **Patient and Carer Experience** no significant change however, both measures achieving standard in January and the number of responses to each measure is showing special cause improvement (an increase).
- **Inpatients Feeling Safe** special cause concern and please note this is the revised measure which now includes the option “quite a lot”. There is no significant change to the number of responses for this measure.
- **CYP Outcomes** no significant change in Patient reported Outcome Measure (PROM) and below standard however, special cause improvement for Clinician Reported Outcome Measure (CROM) although also below standard.
- **AMH / MHSOP Outcomes** special cause concern and below standard for Patient Reported Outcome Measure and Clinician Reported Outcome Measure .
- **Bed Pressures** no significant change in bed occupancy or inappropriate out of area bed days; however further increase in the latter.
- **Patient Safety / Incidents** no significant change across all measures however, an increase is visible for the number of Restrictive Interventions Used. There was 1 unexpected Inpatient unnatural death reported on the Strategic Executive Information System (STEIS) during January.
- **Uses of Mental Health Act** no significant change.
- **Staff** Whilst there is no significant change for sickness an increasing trend is visible. There is also no significant change for mandatory training or appraisal; however, we are achieving standard in January for mandatory training.
- **Demand** no significant change in referrals however, special cause concern continues for caseload.
- **Finance** significant recurrent underlying pressures but improved performance relative to in-year control totals and increasing confidence of ability to deliver 2023/24 break even plan.

Risks / Issues*

Of most concern:
- Adults and Older Persons Patient reported Outcome Measure
- Caseload
- Financial Plan: Agency expenditure
- Agency price cap compliance
- CRES Performance – Recurrent

Of concern:
- Inpatients feeling safe
- Adults and Older Persons Clinician Reported Outcome Measure

Positive Assurance

Significant improvement seen in:
- Children and Young Persons Clinician Reported Outcome Measure

Positive assurance for:
- CRES Performance – Non-Recurrent

Mitigations

Inpatients feeling safe
Durham Tees Valley & Forensic Care Group (DTVFCG) have revised their Performance Improvement Plan (PIP) and the new actions are for Peer Workers and Patients to create their own Leaflets outlining, what would they want other patients to know when they arrive, what would help them feel safe; suggestion boxes on wards to support people to raise questions or concerns in an anonymous/less intrusive way and a monthly checklist to explore how many patients attended various sessions so activities can be tailored to suit the cohort of patients. It is anticipated that the impact of these improvement actions should be seen by May 2024 with a 5% increase in inpatients reporting they feel safe.

AMH/MHSOP Patient reported Outcome Measure and Clinician Reported Outcome Measure
DTVFCG have developed a PIP and the actions are for Adult services (specifically EIP and Treatment and intervention teams) to focus greater discussion and challenge utilising the team and service level dashboards; for Older Persons services to add this measure to the team and service level governance dashboards and for both Adult and Older Persons services clinical supervision and caseload management agendas/processes to be updated to include support and discussion around completion of outcomes and reviews of patients not making an improvement. It is anticipated that the impact of these improvement actions should be seen in May 2024 with a 5% increase in Adults and Older Persons showing measurable improvement. North Yorkshire, York & Selby Care Group are continuing to work on their PIP to ensure it includes SMART actions that support improvement.

Caseload
DTVFCG have revised their PIP and have identified several actions to address the back log of waiters within CYPS neurodevelopmental teams which includes implementing a revised neuro assessment protocol and a refresh of the Patient Tracker meetings. It is anticipated these actions will eliminate over 3 year waits by the end of Q1. AMH services will pilot work within Sedgefield teams to implement a revised assessment process for ADHD and ASD pathways working with Primary Care colleagues. It is anticipated this action will increase assessment and reduce 80% of referrals coming into intervention teams by June 2024. North Yorkshire, York & Selby Care Group are continuing to work on their PIP to ensure it includes SMART actions that support improvement; however following completion of demand and capacity work in MHSOP services for memory patients, the Integrated Care Board have agreed to undertake a project focusing on a stepped model across the wider system.

Finance
We have provided assurance to the ICB and NHSE that we project delivery of our 2023/24 breakeven plan, based on a mid-case scenario. Performance is being tracked against monthly 'control totals', including assessing worst and best case assumptions and with improved performance at Month 10.

NOTE: See individual pages for full details of the improvement actions and expected impact/timescales

Integrated Performance Dashboard Headlines - Durham Tees Valley & Forensic Care Group

Headlines

- **Patient and Carer Experience** no significant change with patient and carer experience
- **Inpatients Feeling Safe** special cause concern
- **CYP Outcomes** special cause concern in PROM, however, special cause improvement for CROM, but both remain below standard
- **AMH / MHSOP Outcomes** special cause concern and below the standard for PROM and CROM
- **Bed Pressures** no significant change in bed occupancy and below the mean, however, special cause concern in OAPs.
- **Patient Safety / Incidents / Mental Health Act** no significant change across all measures.
- **Staff** no significant change in sickness, mandatory training and appraisal. However, upward trend noted in sickness.
- **Demand** no significant change in referrals; however special cause concern in caseload driven by AMH and CYPS.
- **Finance** significant challenges in relation to financial recovery to achieve breakeven by the end of the year.

Risks / Issues*

Of most concern:

- AMH/MHSOP PROMS and CROMs
- Unique Caseload
- Financial Plan: Surplus/Deficit

Of concern:

- Inpatients feeling safe
- CYP PROM
- OAPs
- Agency price cap compliance
- Agency Spend

Positive Assurance

Significant improvement seen in:

- CYP CROM

Mitigations

We have Performance Improvement Plans (PIP) in the following areas which include SMART actions that support improvement:

- Inpatients Feeling Safe
- CYP PROM
- New AMH/MHSOP PROM and CROM
- Bed Pressures
- Caseload
- Safer Staffing (Financial Plan) Trustwide
- Agency Reduction (Financial Plan) Trustwide

The improvement actions are detailed within the individual slides for each measure except for the two relating to Financial Plan. These will be included in next month's report.

Finance – we have provided assurance to the ICB that the financial plan will be delivered (breakeven) with control totals now set. The Trust will monitor adherence to control totals to manage risk and provide mitigations.

Integrated Performance Dashboard Headlines – North Yorkshire, York and Selby

Headlines

- **Patient and Carer Experience** no significant change, with patient and carer experience above standard
- **Inpatients Feeling Safe** no significant change.
- **CYP Outcomes** no significant change in PROM and below standard; special cause improvement for CROM and below standard
- **AMH / MHSOP Outcomes** special cause concern and below standard for PROM and special cause improvement for CROM and below standard
- **Bed Pressures** no significant change in bed occupancy and below the mean; OAPs special cause improvement
  Patient Safety / Incidents no significant change across all measures
- **Staff** Sickness and Appraisals no significant change however decreasing trend. Mandatory Training no significant change with an increasing trend.
- **Demand** no significant change in referrals and caseload
- **Finance** significant challenges in relation to financial recovery to achieve breakeven by the end of the year.

Risks / Issues*

Of most concern:
- AMH/MHSOP PROM

Of concern:
- Appraisals
- Financial Plan: Surplus/Deficit
- Financial Plan: Agency expenditure
- Agency price cap compliance

Positive Assurance

Improvement seen in:
- CYP PROM & CROM
- AMH/MHSOP CROM
- Inappropriate OAP
- Incidents of moderate or severe harm

Mitigations

We are continuing to work on the Performance Improvement Plans (PIP) in the following areas to ensure they include SMART actions that support improvement:

- AMH/MHSOP PROMS
- Appraisals

Finance – we have provided assurance to the ICB that the financial plan will be delivered (breakeven) with control totals now set. The Trust will monitor adherence to control totals to manage risk and provide mitigations.

Performance & Controls Assurance Overview

Tees, Esk and Wear Valleys NHS Foundation Trust

Controls Assurance Rating	Performance Assurance Rating: Substantial	Good	Reasonable	Limited
Positive		• CYP showing measurable improvement following treatment - clinician reported • CRES Performance – Non-Recurrent		
Neutral		• Patients surveyed reporting their recent experience as very good or good • Carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for • Serious Incidents reported on STEIS • Incidents of moderate or severe harm • Medication Errors with a severity of moderate harm and above • Unexpected Inpatient unnatural deaths reported on STEIS • Uses of the Mental Health Act • New unique patients referred	• CYP showing measurable improvement following treatment - patient reported • Bed Occupancy (AMH & MHSOP A & T Wards) • Inappropriate OAP bed days for adults that are 'external' to the sending provider • Restrictive Intervention Incidents Used • Staff recommending the Trust as a place to work • Staff feeling they are able to make improvements happen in their area of work • Percentage Sickness Absence Rate • Compliance with ALL mandatory and statutory training • Staff in post with a current appraisal **increased controls assurance*	
Negative		• Financial Plan: SOCI - Final Accounts - Surplus/Deficit **increased performance assurance* • Financial Plan: Agency expenditure compared to agency target **increased performance assurance* • Use of Resources Rating - overall score **reduced controls assurance*	• Inpatients reporting that they feel safe whilst in our care • Adults and Older Persons showing measurable improvement following treatment - clinician reported • Capital Expenditure (Capital Allocation) • Cash balances (actual compared to plan) **reduced controls assurance*	• Adults and Older Persons showing measurable improvement following treatment - patient reported **reduced performance assurance* • Unique Caseload • Agency price cap compliance • CRES Performance - Recurrent

NOTE Measure 18 Staff Leaver Rate not included in the above overview – see individual page for further details

Board Integrated Performance Dashboard

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
1)	Percentage of patients surveyed reporting their recent experience as very good or good	QAC		?	92.00%	92.20%	92.00%
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for	QAC		?	75.00%	75.69%	75.00%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC	L	?	75.00%	78.13%	75.00%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC		F	35.00%	24.09%	35.00%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC	L	F	55.00%	44.86%	55.00%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	H	F	50.00%	46.46%	50.00%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC	L	F	30.00%	19.67%	30.00%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC				98.69%	
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC				705	
10)	The number of Serious Incidents reported on STEIS	QAC				124	
11)	The number of Incidents of moderate or severe harm	QAC				593	
12)	The number of Restrictive Interventions Used	QAC				8,637	
13)	The number of Medication Errors with a severity of moderate harm and above	QAC				13	
14)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				4	
15)	The number of uses of the Mental Health Act	MHLC				3,380	

Rep Ref	Our People measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
16)	Percentage of staff recommending the Trust as a place to work	PC&D				54.12% (Jul - 2023)	
17)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D				61.95% (Jul - 2023)	
19)	Percentage Sickness Absence Rate (month behind)	PC&D				5.91%	
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D		?	85.00%	86.65%	85.00%
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D		?	85.00%	77.93%	85.00%

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
22)	Number of new unique patients referred	S&RC				84,947	
23)	Unique Caseload (snapshot)	S&RC	H			65,270	

Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	S&RC	5,370,377	3,374,625
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	16,681,000	14,958,671
25b)	Agency price cap compliance	S&RC	100.00%	62.18%
26)	Use of Resources Rating - overall score	S&RC	3	3
27)	CRES Performance - Recurrent	S&RC	12,200,000	7,051,000
28)	CRES Performance - Non-Recurrent	S&RC	2,498,000	7,643,151
29)	Capital Expenditure (CDEL)	S&RC	12,689,000	9,084,538
30)	Cash against plan	S&RC	61,453,000	60,134,902

NOTE Measure 18 Staff Leaver Rate not included in the above dashboard – see individual page for further details

01) Percentage of Patients surveyed reporting their recent experience as very good or good

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Background / Standard description:
We are aiming for 92% of patients surveyed, reporting their recent experience as very good or good

What does the chart show/context:
During January **1037** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **93.73% (972)** scored "very good" or "good".

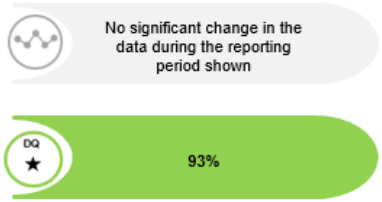
There is no significant change at Trust/Care Group level in the reporting period; however, we are showing special case improvement (an increase) in the number of patients who have responded to this question.

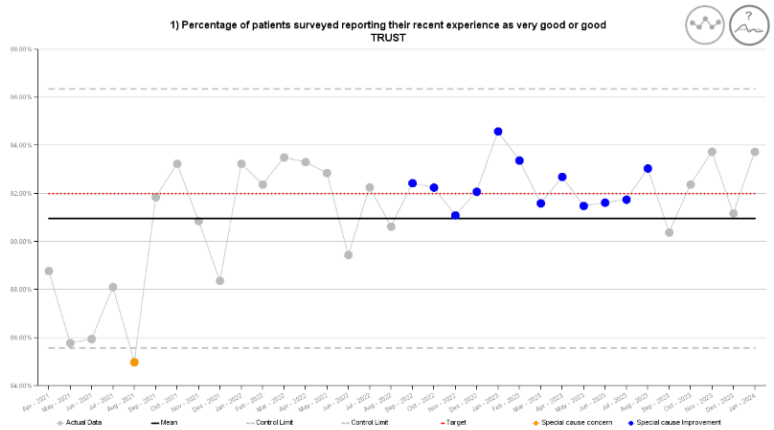
Health & Justice and Secure Inpatient Services within Durham, Tees Valley & Forensic Care Group are both showing special cause improvement (high) for patients reporting their recent experience as very good or good.

The latest National Benchmarking data (November 2023) shows the England average (including Independent Sector Providers) was 88% and we were ranked **15** in the list of providers. We were also ranked highest for the total number of responses received.

Underlying issues:
There are no underlying issues to report.

Actions:
- The Patient & Carer Experience Group are going to consider how a patient or carer could understand the performance of each individual team and what key 5 things they might look for (by end of April 2024)





02) Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 75% of carers reporting, they feel they are actively involved in decisions about the care and treatment of the person they care for

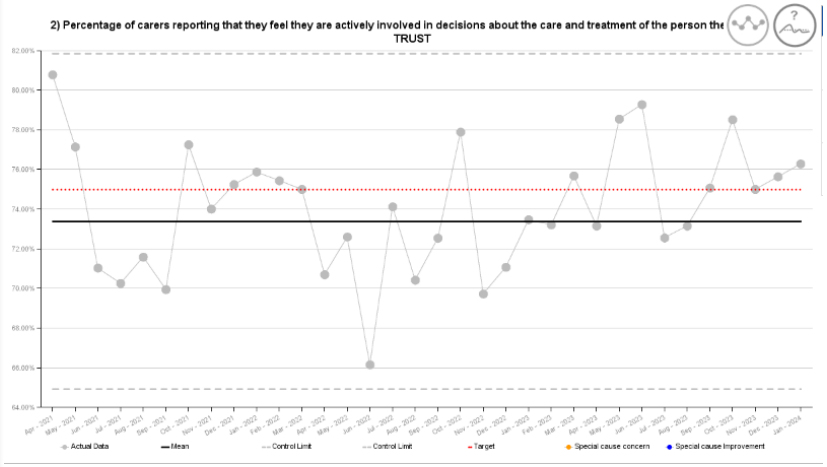
What does the chart show/context:
During January, **388** carers responded to the question in the carer survey: Question: "Do you feel that you are actively involved in decisions about the care and treatment of the person you care for?". Of those, **296 (76.29%)** scored "yes, always".

There is no significant change at Trust/Care Group level in the reporting period; however, we are showing special cause improvement (an increase) in the number of carers who have responded to the question.

Secure Inpatient Services within Durham, Tees Valley & Forensic Care Group are showing special cause improvement (high) for patients surveyed, reporting their recent experience as very good or good.

Underlying issues:
- Engagement with various patient groups
- Barriers to collecting feedback include:
    - Access to and up to date surveys through the various mechanisms
    - Up to date carer and team information
    - Lack of feedback including display of feedback

Actions:
- The barriers to collecting feedback were followed up by the Service Improvement Delivery Group (SIDG) and several actions are now being implemented via the Service Improvement Plans, with further ideas/suggestions being explored as part of the ongoing quality visits **Completed**
- The Patient & Carer Experience Team are working with the Recovery College to develop an e-learning package to deliver the Carer Awareness training and are continuing to deliver face to face training with an increased number of sessions.



03) Percentage of inpatients reporting that they feel safe whilst in our care

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 75% of inpatients reporting, they feel safe whilst in our care

What does the chart show/context:
During January, **172** patients responded to the overall experience question in the patient survey: Question: "During your stay, did you feel safe?". Of those, 142 **(82.56%)** scored "yes, always" and "quite a lot".

There is special cause concern (low performance) at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period. There is also no significant change in the number of inpatient who have responded to the question.

Update: The feeling safe measure has been in place for several years and has only included the response 'yes always' to the question Did you feel safe? Patients in our care will encounter a range of emotions and feelings whilst with us therefore they are not always going to feel safe, and this may be for several genuine reasons e.g., their own illness, other patients etc. therefore we have expanded the answer option to include 'yes always' and 'quite a lot' giving the two answer configuration in line with the other measures within the IPD. All the data has been refreshed in this report in line with this change. We will revisit the "standard" we are aiming for in early 2024/25.

Underlying issues:
- There are several factors that can influence whether a patient feels safe, e.g. staffing levels, other patients, environment.
- Self Harm in inpatient settings can cause other patients to feel unsafe

Actions:
- Durham Tees Valley & Forensic Care Group have revised their Performance Improvement Plan (PIP) and the new actions are for Peer Workers and Patients to create their own Leaflets outlining, what would they want other patients to know when they arrive, what would help them feel safe; Suggestion boxes on wards to support people to raise questions or concerns about feeling safe in an anonymous/less intrusive way and a monthly checklist to explore how many patients attended the Mutual Help, Activities, and psycho-social sessions etc so activities can be tailored to suit the cohort of patients. It is anticipated that the impact of these improvement actions should be seen by May 2024 with a 5% increase in inpatients reporting they feel safe.

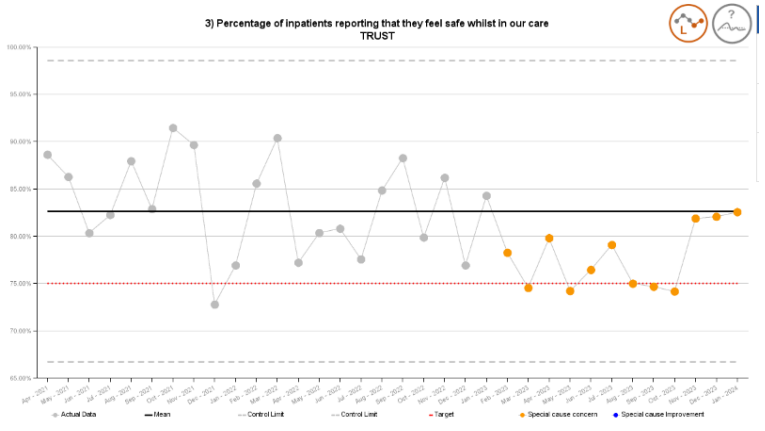
We're aiming to have high performance and we're moving in the wrong direction.

Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

DQ

87%

An Area of Concern
We are concerned with our performance in this area and action is required to improve



Actions continued:
- The Consultant Clinical Psychologist for AMH services in Durham and Tees Valley is undertaking a self harm review/pilot work across all Trust Adult Mental Health wards including PICUs. This will now be completed by the end of February 2024.
- The Patient & Carer Experience Team have revisited the benchmarking work previously undertaken to understand how we compare to other organisations and are now looking to identify any key learning that can be taken forward within the Trust (by the end of March 2024).

04) Percentage of CYP showing measurable improvement following treatment - patient reported

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 35% of CYP showing measurable improvement following treatment - patient reported

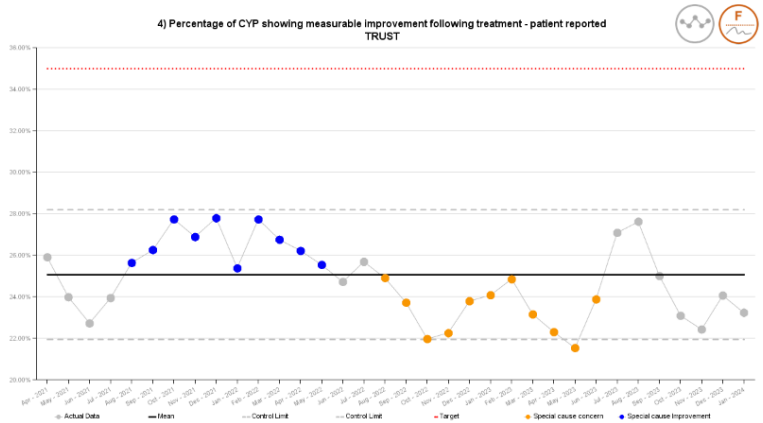
What does the chart show/context:
For the 3-month rolling period ending January **680** patients were discharged from our CYP service with a patient rated paired outcome score. Of those**, 158 (23.24%)** made a measurable improvement.

The accepted Patient Rated Outcome Measures are CORS / ORS / GBO (goal-based outcomes) / RCADS / SDQ / SCORE-15 / PHQ-9 / GAD-7 / CORE-10.

There is no significant change at Trust level in the reporting period; however, there is special cause concern (low performance) within Durham Tees Valley and Forensic Care Group and special cause improvement (high performance) in North Yorkshire, York & Selby Care Group.

Underlying issues:
- This measure currently doesn't include Parent Rated outcomes (which is valid) or some of the newer assessment tools

Actions:
- Durham Tees Valley & Forensic Care Group have revised their Performance Improvement Plan (PIP) and the new actions are to add this measure to the team and service level governance dashboards and begin reporting against this and for clinical supervision and caseload management agendas/processes to be updated to include support and discussion around completion of outcomes and reviews of patients not making an improvement. It is anticipated that the impact of these improvement actions should be seen in April 2024 with a 5% increase in CYP showing measurable improvement.
- Management Group have now approved the updates to the measure to include Parent Rated outcomes and the new assessment tools. This will be actioned by the Business Intelligence Team post CITO.



05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 55% of Adults and Older Persons showing measurable improvement following treatment - patient reported

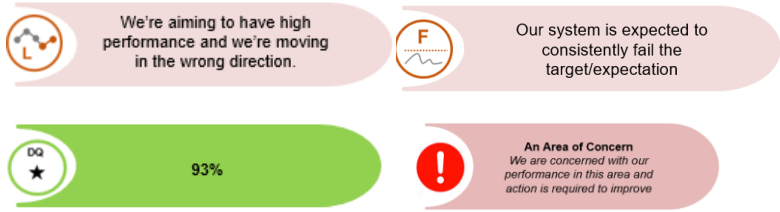
What does the chart show/context:
For the 3-month rolling period ending January **1927** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 815 (42.29%)** made a measurable improvement.

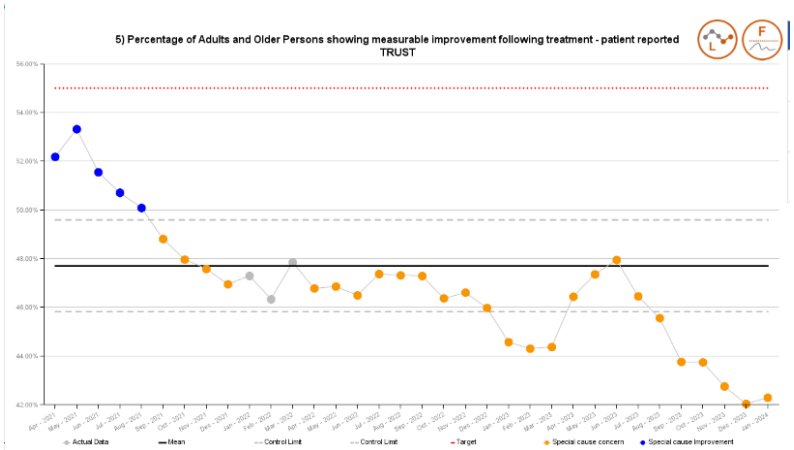
The accepted Patient Rated Outcome Measure is Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS).

There is special cause concern (low performance) at Trust level and for both Care Groups in the reporting period. Special cause concern is in relation to AMH services in both Care Groups. Whilst there is no significant change in MHSOP services, performance is consistently low and is therefore a concern.

Underlying issues:
- Timeliness and frequency of completing outcomes is impacting

Actions:
- General Managers for Durham and Tees Valley Adults and Older Persons services to undertake a deep dive into the data by the 31st January 2024 to identify specific areas of concern and required improvement. **Completed**
- Durham Tees Valley & Forensic Care Group have developed a Performance Improvement Plan (PIP) and the actions are for Adult services (specifically EIP and Treatment and intervention teams) to focus greater discussion and challenge by utilising the team and service level dashboards including details of discharges and paired numbers; and for clinical supervision and caseload management agendas/processes to be updated to include support and discussion around completion of outcomes and reviews of patients not making an improvement. For Older Persons services actions are to add this measure to the team and service level governance dashboards and begin reporting against this measure; and for clinical supervision and caseload management agendas/processes to be updated to include support and discussion around completion of outcomes and reviews of patients not making an improvement. It is anticipated that the impact of these improvement actions should be seen in May 2024 with a 5% increase in Adults and Older Persons showing measurable improvement.





Actions continued:
- North Yorkshire, York & Selby Care Group are continuing to work on their Performance Improvement Plan (PIP) to ensure it includes SMART actions that support improvement.

06) Percentage of CYP showing measurable improvement following treatment - clinician reported

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 50% of CYP showing measurable improvement following treatment - clinician reported

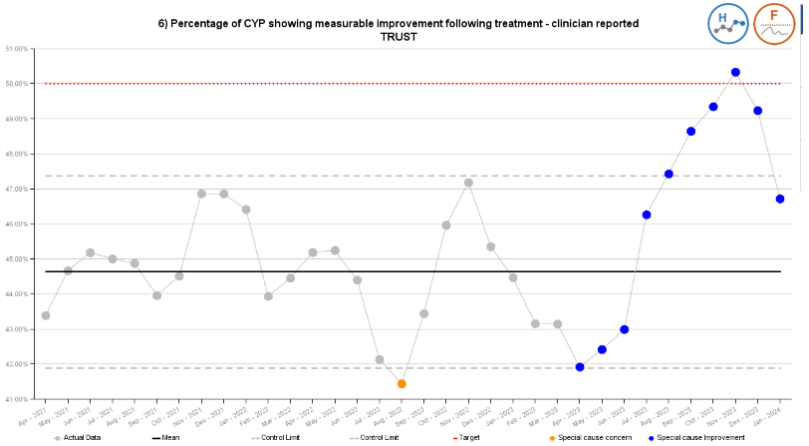
What does the chart show/context:
For the 3-month rolling period ending January 762 patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 356 (46.27%)** made a measurable improvement.

The accepted Clinician Rated Outcome Measures are Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and Children's Global Assessment Scale (CGAS)

There is special cause improvement (high performance) at Trust level and for both Care Groups.

Underlying issues:
There are no underlying issues to report

Actions:
A decline in performance is evident and a deep dive will be undertaken within both Care Groups during February to identify the cause.



07) Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 30% of Adults and Older Persons showing measurable improvement following treatment - clinician reported

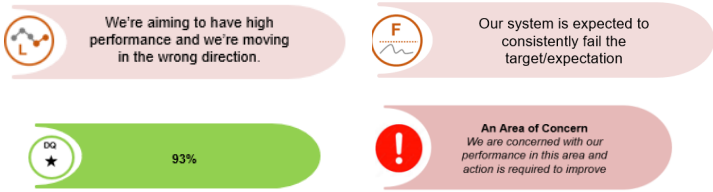
What does the chart show/context:
For the 3-month rolling period ending January **3281** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 636 (19.38%)** made a measurable improvement.

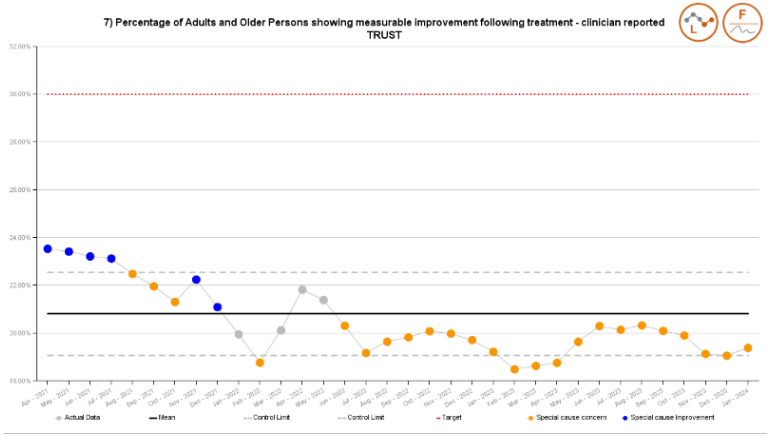
The accepted Patient Rated Outcome Measure is Health of the Nation Outcome Scales (HoNOS).

There is special cause concern (low performance) at Trust level and for Durham, Tees Valley & Forensic Care Group (AMH and MHSOP services) in the reporting period. However, it should be noted that that there is special cause improvement (high performance) for North Yorkshire, York & Selby Care Group.

Underlying issues:
Please see issues against measure 5) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported

Actions:
Please see actions against measure 5) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported





08) Bed Occupancy (AMH & MHSOP A & T Wards)

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
During January, **10,850** daily beds were available for patients; of those, **10,452 (96.33%)** were occupied. Overall occupancy including independent sector beds was **98.01%**

There is no significant change at Trust level or for both Care Groups in the reporting period; however, there is special cause concern (poor performance) in AMH services within Durham, Tees Valley & Forensic Care Group. Special cause improvement (good performance) is noted in MHSOP within Durham, Tees Valley & Forensic Care Group

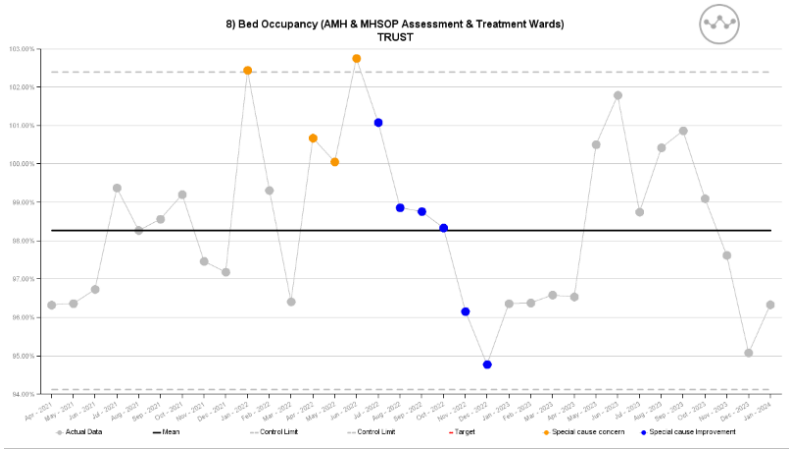
Underlying issues:
- Clinically Ready for Discharge – specifically around accommodation
- Patient flow and adherence to PIPA process
- Length of stay (linked to above issues)
- Greenlight admissions
- Ministry of Justice (MoJ) patients

Actions:
- Durham Tees Valley & Forensic Care Group have revised their Performance Improvement Plan (PIP) and the new actions are:
  - To review the 30, 60, 90 day report out agendas to ensure they are more action focused; for Care Group Board members and Urgent Care supercell members to attend ward 'Report out' meeting across AMH services and provide feedback and leadership support to ensure standards are met and to develop a standard process for monitoring of patients clinically ready for discharge across urgent care wards. It is anticipated that the impact of these improvement actions should be seen in April 2024 with a 50% reduction of patients with a length of stay over 60 days.
  - To identify best practice across other NHS trusts to support the review of our discharge policy. Policy expected to be implemented by end of April 2024. It is anticipated that the impact of this action should be a reduction in length of stay to an average of 30 days.
  - To identify patients that are clinically ready for discharge where there are delays and offer support to clinical teams to address the barriers; to ensure standard approach is taken across Local Authority Meetings to address these delays; to identify patients they require additional support from senior leadership team and arrange stop the line meeting; and to review/update Stop

No significant change in the data during the reporting period shown

DQ 87%

An Area of Concern
We are concerned with our performance in this area and action is required to improve



Actions continued:
the line processes and share with clinical teams. It is anticipated that theimpact of these actions should be seen in April 2024, with a 50% reduction in the number of patients clinically ready for discharge.
- North Yorkshire, York & Selby Care Group are continuing to work on their Performance Improvement Plan (PIP) to ensure it includes SMART actions that support improvement.

09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Background / standard description:
We are aiming to have no more than 60 out of area bed days by 31st March 2024. This is also the Mental Health Priority monitored at Trust level.

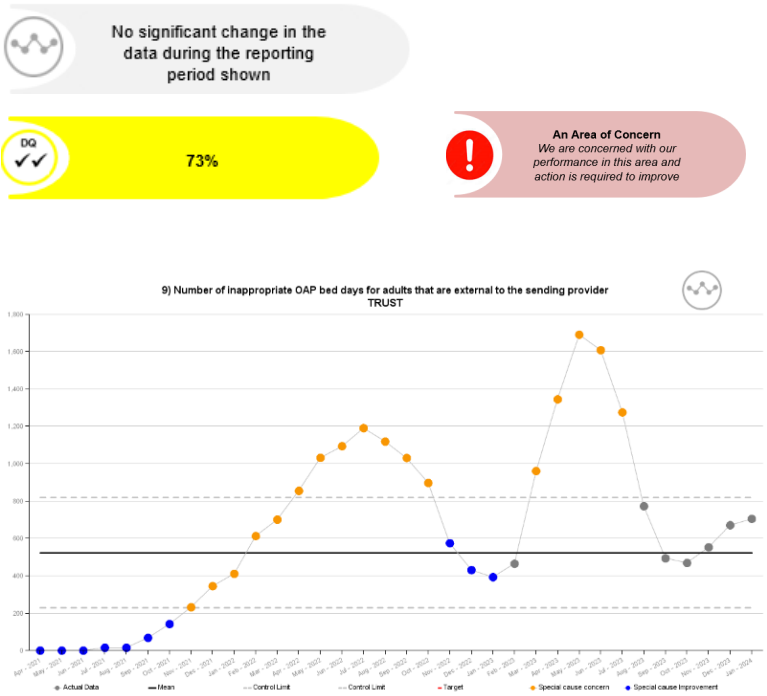
What does the chart show/context:
For the 3-month rolling period ending January **705 days** were spent by patients in beds away from their closest hospital.

There is no significant change at Trust level in the reporting period; however, there is special cause concern (poor performance) for Durham, Tees Valley & Forensic Care Group (AMH services). This correlates with bed occupancy in AMH services for this Care Group. It should be noted, however that there is special cause improvement (good performance) in the North Yorkshire, York & Selby Care Group.

Performance against the trajectories agreed with the ICBs is shown in the **additional table below**. We are significantly exceeding the agreed number of OAP bed days.

Underlying issues:
Bed Occupancy is impacting on our ability to admit patients to our beds

Actions:
See measure 8) Bed Occupancy



ICB Trajectories versus actual performance

Number of inappropriate OAP bed days for adults that are either 'internal' or 'external' to the sending provider	Quarter 1 23/24		Quarter 2 23/24		Quarter 3 23/24		Quarter 4 23/24 (January)	
	Ambition	Actual	Ambition	Actual	Ambition	Actual	Ambition	Actual
Trust	334	1608	246	494	153	671	60	705
North East & North Cumbria ICB	334	1445	246	436	153	608	60	577
Humber & North Yorkshire ICB	0	163	0	58	0	63	0	128

10) The number of Serious Incidents reported on STEIS

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
14 serious incidents were reported on the Strategic Executive Information System (STEIS) during January.

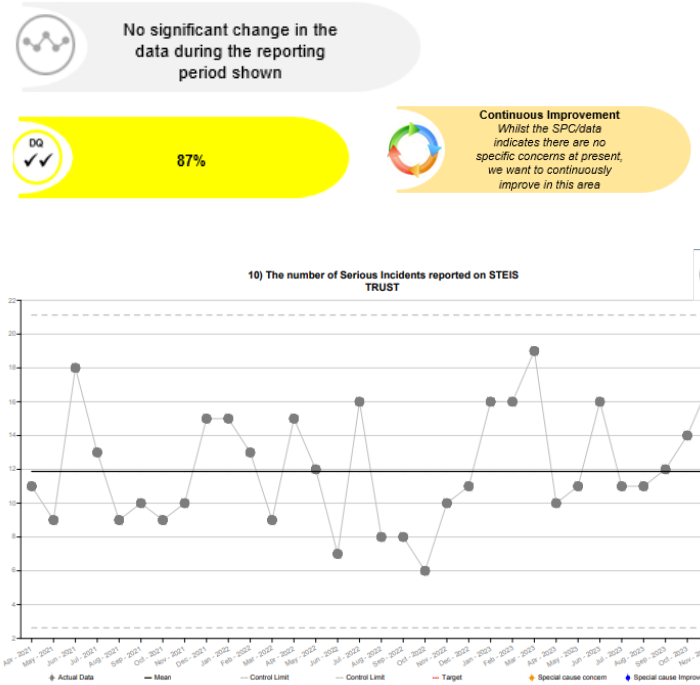
There is no significant change at Trust/Care Group in the reporting period.

Each incident has been subject to an after-action review/early learning by services and then reviewed within the Patient Safety huddle.

Update:
As of 29th January 2024, the Trust transitioned to the National Patient Safety Incident Framework (PSIRF). This new framework advocates a more proportionate approach to investigations. The full investigations (closest equivalent to current measure) will be referred to as Patient Safety Incident Investigations (PSII).

Underlying issues:
There are no underlying issues to report

Actions:
- The Data Quality Assessment will be reviewed by the Business Intelligence and Performance Teams working with the Process Owner in Q4 23/24.



To note:
Whilst we know the incident data recorded in InPhase is accurately reported through IIC, there are areas where data quality can be improved, which is to be expected following a transfer to a new recording system. With InPhase the visibility of some of the areas of poor quality in incident records has become more visible, therefore we have agreed several actions to support improvement in the quality of the incident data recorded:
- Additional communications have been sent via the weekly briefing and included in a weekly InPhase Weekly Newsletter circulated to key staff groups.
- We have set up a weekly group with key corporate stakeholders, who will identify through their reporting processes, any key areas of concerns and actions needed to improve the quality of data.
- The full roll-out of local incident review is now in place; however, as this process is new to some areas, additional support is being provided and we expect the quality of data to improve as the new processes are fully embedded. In addition, as part of the ongoing review of incidents, the relevant specialists and Central Team will continue to pick up areas of poor-quality reporting, and these will be addressed on an ongoing basis.

11) The number of Incidents of moderate or severe harm

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the chart show/context:
66 incidents of moderate or severe harm were reported during January.

There is no significant change at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period. It should be noted that there is special cause improvement (low) for the North Yorkshire, York & Selby Care Group.

Each incident has been subject to an after-action review/early learning by services. These reviews are then considered in the Patient Safety huddle to determine if any further investigation is required.

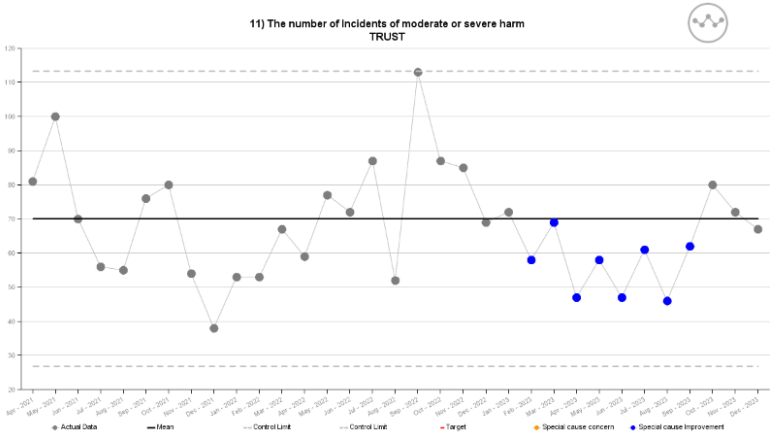
Underlying issues:
- As incidents are reviewed, the severity could be reduced or increased (early indications are that severity is usually reduced).

Actions:
- In line with Patient Safety Incident Response Framework (launch 29th January 2024) the Care Groups' process for completing after-action review/early learning reviews will be through a Multi-Disciplinary Team (MDT) approach. The learning from all incidents will be pulled together and themed by the Patient Safety Team and shared monthly with the Organisational learning Group
- The Data Quality Assessment will be reviewed by the Business Intelligence and Performance Teams working with the Process Owner in Q4 23/24.

No significant change in the data during the reporting period shown

DQ 80%

Continuous Improvement
Whilst the SPC/data indicates there are no specific concerns at present, we want to continuously improve in this area



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- The full roll-out of local incident review is now in place; however, as this process is new to some areas, additional support is being provided and we expect the quality of data to improve as the new processes are fully embedded. In addition, as part of the ongoing review of incidents, the relevant specialists and Central Team will continue to pick up areas of poor-quality reporting, and these will be addressed on an ongoing basis.

12) The number of Restrictive Intervention Used

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
967 types of Restrictive Interventions were used during January.

There is no significant change at Trust level in the reporting period. Durham Tees Valley & Forensic Care Group are showing special cause improvement (low); however North Yorkshire, York & Selby Care Group are showing special cause concern (high) for MHSOP services. It should be noted that AMH services within Durham Tees Valley & Forensic Care Group are also showing special cause concern (high).

Update:
This is a new measure specifically for this report and replaces the number of Restrictive Intervention Incidents previously included.

Underlying issues:
As this is a new measure for this report, work is being undertaken to understand any underlying issues. This will be updated next month.

Actions
See underlying issues.

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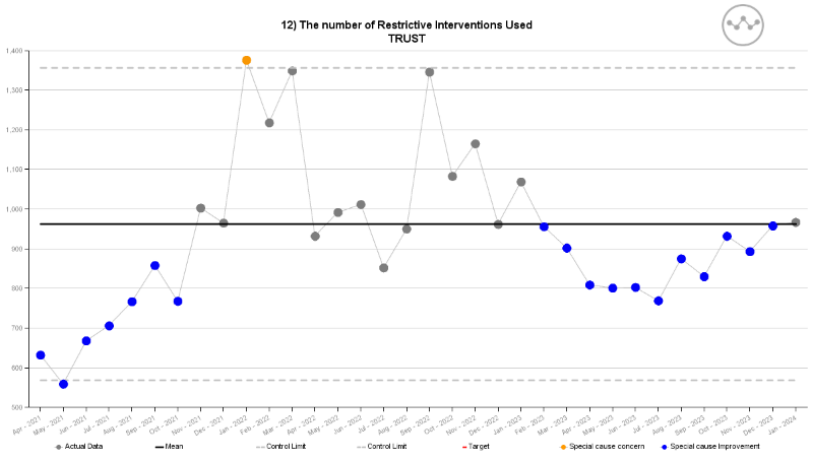
No significant change in the data during the reporting period shown

Data Quality: is pending assessment
Action status: is pending review by the care groups and process owner



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The full roll-out of local incident review is now in place; however, as this process is new to some areas, additional support is being provided and we expect the quality of data to improve as the new processes are fully embedded. In addition, as part of the ongoing review of incidents, the relevant specialists and Central Team will continue to pick up areas of poor-quality reporting, and these will be addressed on an ongoing basis.

13) The number of Medication Errors with a severity of moderate harm and above

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
0 medication errors were recorded with a severity of moderate harm, severe or death during January.

There is no significant change at Trust/Care Group in the reporting period.

Underlying issues:
- EPMA (electronic prescribing & medicines administration) will enable more timely prescribing and administration of medication to patients and will reduce the risk of errors once embedded.
- As incidents are reviewed, the severity could be reduced or increased (early indications are that severity is usually reduced).

Actions:
- During Q4 23/24 we will complete the Project Initiation Document for the community roll out which will begin early 24/25.
- The Chief Pharmacist is undertaking a review of the incidents reported for this measure to ensure they are an accurate representation. This will be completed by the end of February 2024.

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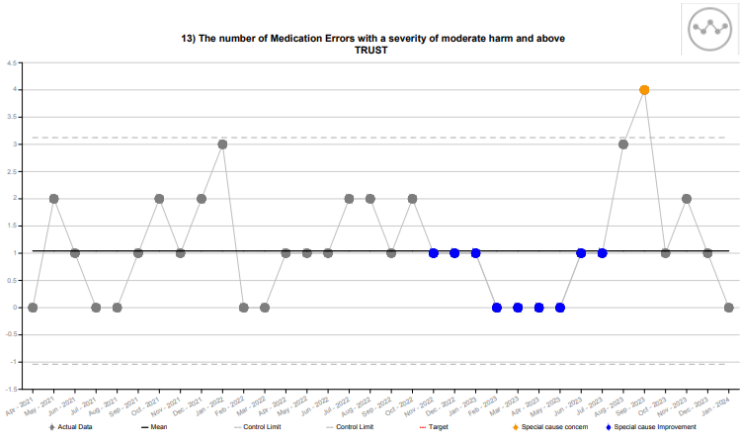
No significant change in the data during the reporting period shown

DQ

80%

Continuous Improvement
Whilst the SPC/data indicates there are no specific concerns at present, we want to continuously improve in this area



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- The full roll-out of local incident review is now in place; however, as this process is new to some areas, additional support is being provided and we expect the quality of data to improve as the new processes are fully embedded. In addition, as part of the ongoing review of incidents, the relevant specialists and Central Team will continue to pick up areas of poor-quality reporting, and these will be addressed on an ongoing basis.

14) The number of unexpected Inpatient unnatural deaths reported on STEIS

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
1 unexpected Inpatient unnatural deaths were reported on the Strategic Executive Information System (STEIS) during January*. **This has been confirmed by the Patient Safety Team based on a manual check.*

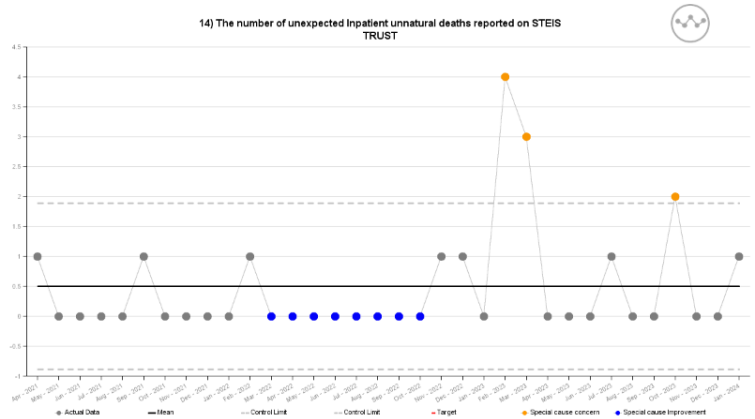
Update:
The unexpected Inpatient unnatural death reported in July has now been confirmed as a natural death.

Underlying issues:
There are no underlying issues to report

Actions:
There are no specific improvement actions appropriate incident review will follow.

No significant change in the data during the reporting period shown

DQ 87%



15) The number of uses of the Mental Health Act

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
There were **331** uses of the Mental Health Act during January.

There is no significant change at Trust/Care Group in the reporting period. However, it should be noted that special cause improvement (low) is showing for Secure Inpatient Services within Durham Tees Valley and Forensic Care Group and for Adult Learning Disability Services within North Yorkshire, York & Selby Care Group.

Underlying issues:
There are no underlying issues to report

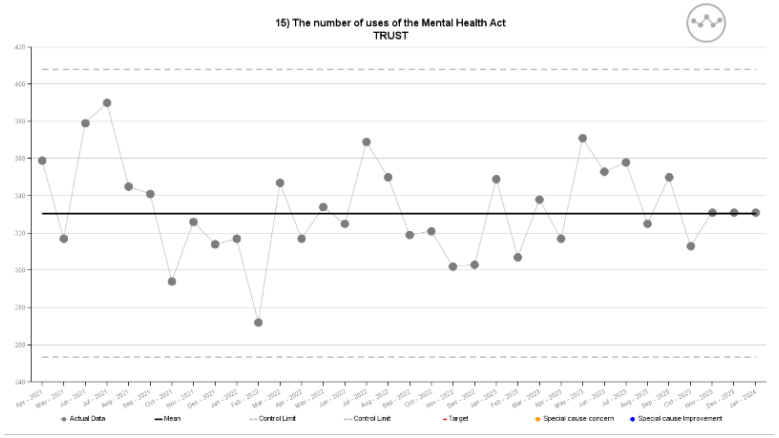
Actions:
There are no specific improvement actions required

No significant change in the data during the reporting period shown

DQ

73%

No Concerns
We are performing consistently in this area and no action is required at this time



16) Percentage of staff recommending the Trust as a place to work

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
1276 staff responded to the July 2023 Pulse Survey question "I would recommend my organisation as a place to work" Of those, **702 (55.02%)** responded either "Strongly Agree" or "Agree".

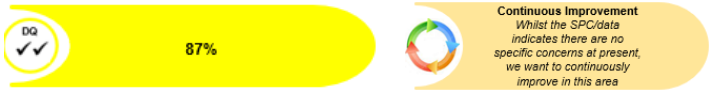
Whilst we have limited data in this area, the line chart demonstrates there is no significant change in the reporting period.

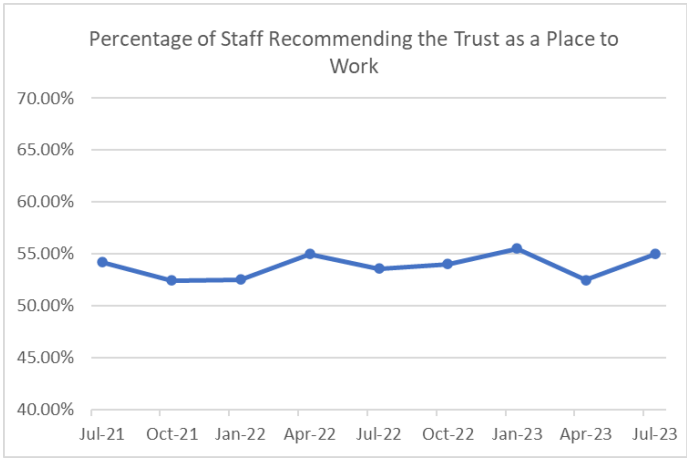
The latest survey (October 2023) was the annual National Staff Survey undertaken by Picker. Picker will provide us with our data in January 2023; however, these results will be under embargoed until March 2024.

**Please note the survey is only undertaken once a quarter*

Underlying issues:
We currently have limited data on the percentage of staff recommending the Trust as a place to work.

Actions:
Whilst we don't have a specific improvement action; we do have a programme of work within the Safer Staffing Group which is focusing on retention. This includes flexible working opportunities; an extensive health and wellbeing offer covering Employee Support Services, Employee Psychological services, financial resilience, Intention to leave interviews/focus groups and a wide range of career development opportunities.





17) Percentage of staff feeling they are able to make improvements happen in their area of work

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
1276 staff responded to the July 2023 Pulse Survey question "I am able to make improvements happen in my area of work" Of those, **791 (61.99%)** responded either "Strongly Agree" or "Agree".

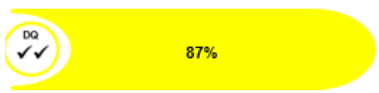
Whilst we have limited data in this area, the line chart demonstrates a slight improvement in the reporting period.

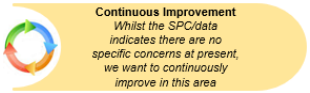
The latest survey (October 2023) was the annual National Staff Survey undertaken by Picker. Picker will provide us with our data in January 2023; however, these results will be under embargoed until March 2024.

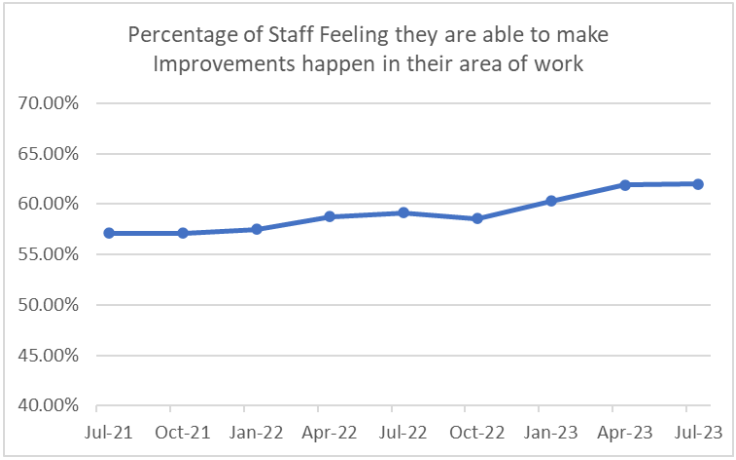
**Please note the survey is only undertaken once a quarter*

Underlying issues:
We currently have limited data on the percentage of staff feeling they are able to make improvements happen in their area of work.

Actions:
- The Trust has embarked on a 5-year (November 2027) stepped approach to Quality Improvement (QI) Training support staff to identify where improvements can be made and to feel empowered to suggest and develop those improvements.
- Our Journey To Change focuses on our cultural development through a wide range of engagement, communication and learning opportunities to enable and empower our staff to make changes in their area of work.







18) Staff Leaver Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

Update:
We have temporarily removed the data and chart for staff leaver rate as we have some concerns that the data may not be an accurate representation which was identified during routine analysis. Work is being undertaken to understand the issue(s) and rectify this, where needed, as soon as possible. It is anticipated the data and chart will be re-introduced in next month's report with a level of assurance as to the data accuracy.

The latest (October 2023) National Benchmarking for NHS Staff Leaver Rate published on NHS England NHS Oversight Framework Dashboard shows we were ranked 10 (previously ranked 8 this financial year) of 71 Trusts Mental Health & Learning Disability Trusts (1 being the best with the lowest leaver rate) and are placed in the highest performing quartile range.

Underlying issues (*for those who do leave and tell us why):
- Staff wanting a new challenge
- Role not being as expected
- Work-life balance

Actions:
- The Associate Director of Operational Delivery & Resourcing will facilitate the launch of the next Internal Transfer scheme by the end of January 2024, with a view to supporting internal transfers and reducing challenges in staff retention. **Completed**
- We have a programme of work within the Safer Staffing Group which is focusing on retention. This includes flexible working opportunities; an extensive health and wellbeing offer covering Employee Support Services, Employee Psychological services, financial resilience, Intention to leave interviews and a wide range of career development opportunities. A report on the reasons people stay will be provided to Executive People Culture Diversity Group in March.
- We have developed a Performance Improvement Plan focusing on E Roster effectiveness which includes actions on publishing rotas in a timely manner and improving level loading of annual leave in line with Trust guidance both of which support staff wellbeing and should have a positive impact.

19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
There were **229,961.31** working days available for all staff during December (reported month behind); of those, 15,737.03 **(6.84%)** days were lost due to sickness.

Whilst there is no significant change at Trust level and for most areas in the reporting period there is a visible increase in sickness absence as shown in the SPC chart displayed. The areas showing special cause concern (high) are Company Secretary, Children and Young Peoples Services and Management within Durham, Tees Valley & Forensic Care Group and Adult Mental Health Services within North Yorkshire, York & Selby Care Group.

There are several areas however, showing special cause improvement (low) which are Corporate Affairs and Involvement, Estates and Facilities Management, Adult Learning Disabilities and Secure Inpatient Services within Durham, Tees Valley & Forensic Care Group and Management within North Yorkshire, York & Selby Care Group.

National Benchmarking for NHS Sickness Absence Rates published 25th January 2024 (data ending September 2023) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is **5.48%** compared to the Trust mean of **5.89%.**

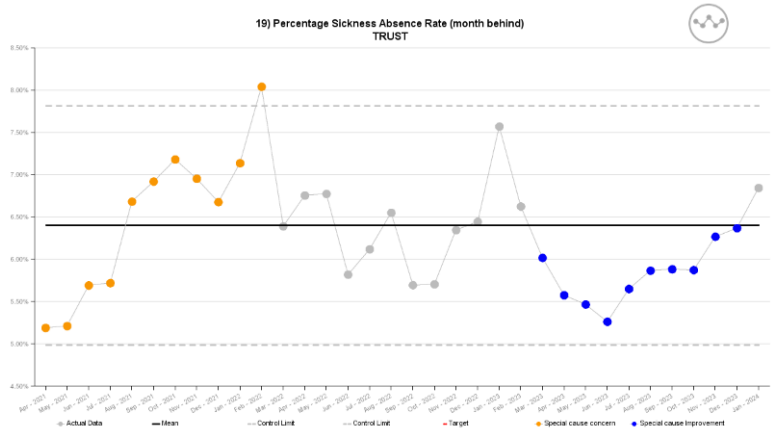
Underlying issues:
- Anxiety/stress is the main reason of sickness absence

Actions:
- People & Culture are focusing on the health, wellbeing and resilience of our staff. This includes flexible working opportunities, Employee Support Services, Employee Psychological services and Health & Wellbeing Champions. There is also an engagement programme including monthly health and wellbeing meetings, guest speakers and newsletters for staff.
- Sickness audits are now being undertaken by People & Culture colleagues to understand whether sickness absence is being managed in line with procedures. Early indications show there is limited assurance.

No significant change in the data during the reporting period shown

DQ 87%

An Area of Concern
We are concerned with our performance in this area and action is required to improve



20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 85% compliance with mandatory and statutory training

What does the chart show/context:
178,826 training courses were due to be completed for all staff in post by the end of January. Of those, **154,957** (**86.65%**) were completed.

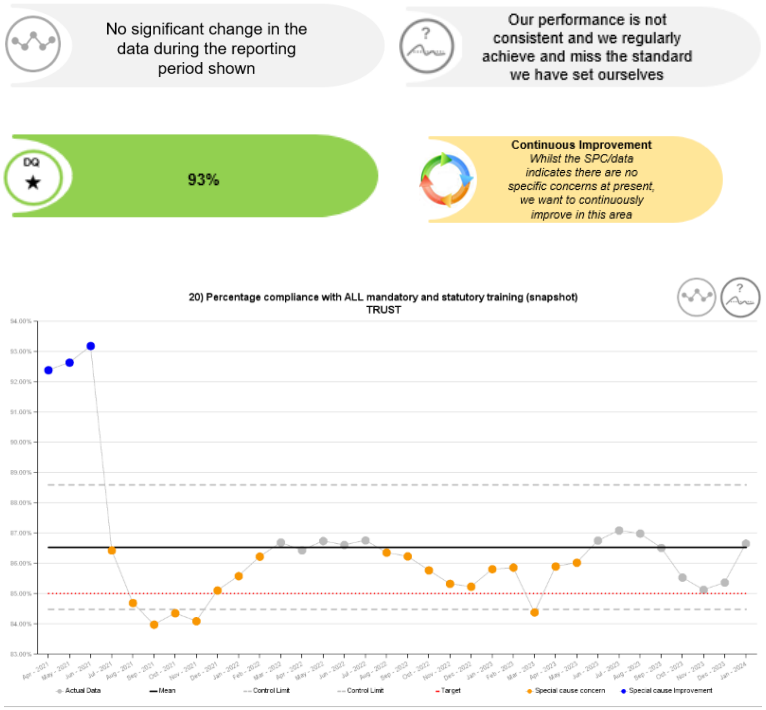
There is no significant change at Trust level and for most areas in the reporting period. However, there are several areas showing special cause concern (low performance) which are Digital and Data, Estates and Facilities Management, Medical, Adult Mental Health and Management within Durham Tees Valley & Forensic Care Group and Adult Mental Health Services within North Yorkshire, York & Selby Care Group. To note there are several areas showing special cause improvement (high) which are Adult Learning Disabilities, Mental Health Services for Older People and Secure Inpatient Services within Durham, Tees Valley & Forensic Care Group and Children and Young People's Services and Mental Health Services for Older People within North Yorkshire, York & Selby Care Group.

As at the 6th February 2024 , by exception compliance levels below 85% are as follows:

	Number Compliant	Total Number	% Compliant
1) Trust Board	79	125	63.20%
2) Nursing and Governance	1568	1933	81.12%

Underlying issues:
- Staff unable to be released to attend training (high DNA rate)
- Staff double booking courses which reduces availability
- Lack of capacity for Positive & Safe training courses
- Lack of suitable training rooms
- Misalignment of competencies and staff on ESR

Actions:
- Training Department are actively following up all staff who DNA and identifying and rectifying where staff double book on courses to increase availability
- Positive & Safe training Level 1 will change from 1st February 2024 with the requirement to be every 2 years
- The training portfolio for Positive & Safe is being reviewed currently with a potential implementation date of April 2024.



Actions continued:

- We are constantly reviewing the availability of training rooms across trust premises.
- A Quality Improvement Event is planned for March 2024 to review mandatory training requirements for all staff including how/where this is delivered.
- We have developed a new Performance Improvement Plan which consolidates actions across all the areas of concern. The actions include ensuring alignment of staff competencies correctly on ESR and following up all staffing information not correctly recorded on ESR. It is anticipated that the impact of these actions should be the achievement of 85% by the end of March 2024 and thereafter.

20) Percentage compliance with ALL mandatory and statutory training – Supporting Information

Tees, Esk and Wear Valleys NHS Foundation Trust

Information Governance & Data Security Training

Background / standard description:
We were aiming for 95% compliance for Information Governance & Data Security Training (as required by the Data Security and Protection Tool Kit) by the end of March 2024; however, NHS England have now allowed some flexibility with the required standard.

What does the data show/context:
7796 were due to be completed by the end of January. Of those, **6932 (88.92%)** were completed.

As at the 6th February 2024 , by exception compliance levels below 95% are as follows:

	Number Compliant	Total Number	% Compliant
1) Corporate Affairs and Involvement	28	35	80.00%
2) Trust Board	10	12	83.33%
3) North Yorkshire, York and Selby	1608	1851	86.87%
4) Durham, Tees Valley and Forensic	4031	4550	88.59%
5) Digital and Data Services	154	172	89.53%
6) Therapies	129	143	90.21%
7) Company Secretary	11	12	91.67%
8) Medical	203	221	91.86%
9) Estates and Facilities Management	415	441	94.10%
10) People and Culture	138	146	94.52%
11) Nursing and Governance	105	111	94.59%
12) Assistant Chief Exec	36	38	94.74%

Underlying issues:
- NHSE have now allowed some flexibility with the required standard which we will need to review.
- Staff Sickness
- Staff capacity
- Misalignment of staff on ESR

Actions:
- All new starters are being contacted to ensure training is completed as part of the Trust Welcome/Induction
- The Business Intelligence Team will revise an existing measure to align it to NHS England's criteria by end of January 2024 **Completed**

All other mandatory and statutory training

As at the 6th February 2024 , by exception compliance levels below 85% are as follows for the following courses sorted by lowest performance:

	Number Compliant	Total Number	% Compliant
1) Follow Up	11	18	61.11%
2) Positive and Safe Care Level 2 Update*	1078	1647	65.45%
3) Rapid Tranquilisation 1	184	277	66.43%
4) Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year*	197	293	67.24%
5) Face to Face Medication Assessment	1519	2203	68.95%
6) Moving and Handling - Level 2 - 2 Years*	645	934	69.06%
7) Resuscitation - Level 1 - 1 Year	1751	2508	69.82%
8) Fire Safety - 2 Years**	5862	7846	74.71%
9) Medicines Management Annual Module	442	587	75.30%
10) Positive and Safe Care Level 1*	3093	4064	76.11%
11) Resuscitation - Level 2 - Adult Basic Life Support - 1 Year*	2001	2623	76.29%
12) Patient Safety Level 2	3983	5188	76.77%
13) Annual Medicines Optimisation Module	1741	2182	79.79%
14) MCA - MCA and Young People Aged 16/17	689	862	79.93%
15) Infection Prevention and Control - Level 2 - 1 Year	4885	6088	80.24%
16) Safe Prescribing	209	260	80.38%
17) Observation & Engagement	1374	1695	81.06%
18) Safeguarding Level 3**	3137	3856	81.35%
19) Controlled Drugs - Inpatient	406	493	82.35%
20) Rapid Tranquilisation 2	435	528	82.39%
21) Essentials for Patient Safety for Board L1	15	18	83.33%
22) Fire Safety - 1 Year	6604	7841	84.22%
23) LD & Autism Tier 1 E-Learning	6509	7725	84.26%
24) Mental Health Act Level 2	3188	3783	84.27%
25) Information Governance and Data Security - 1 Year	6932	7796	88.92%

*Indicates face to face learning ** face or face via MST

Actions continued for Information Governance & Data Security Training**:**
- We have developed a new Performance Improvement Plan which consolidates actions across all the areas of concern. The actions include validating outstanding staff lists and following up with individuals; monitoring compliance in weekly huddles and ensuring they are booked in diaries in advance; following up all information not correctly recorded on ESR. It is anticipated that the impact of these actions should be the achievement of 95% by the end of March 2024 and thereafter.

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 85% of staff in post with a current appraisal

What does the chart show/context:
Of the **6757** eligible staff in post at the end of January; **5266** (**77.93%)** had an up-to-date appraisal.

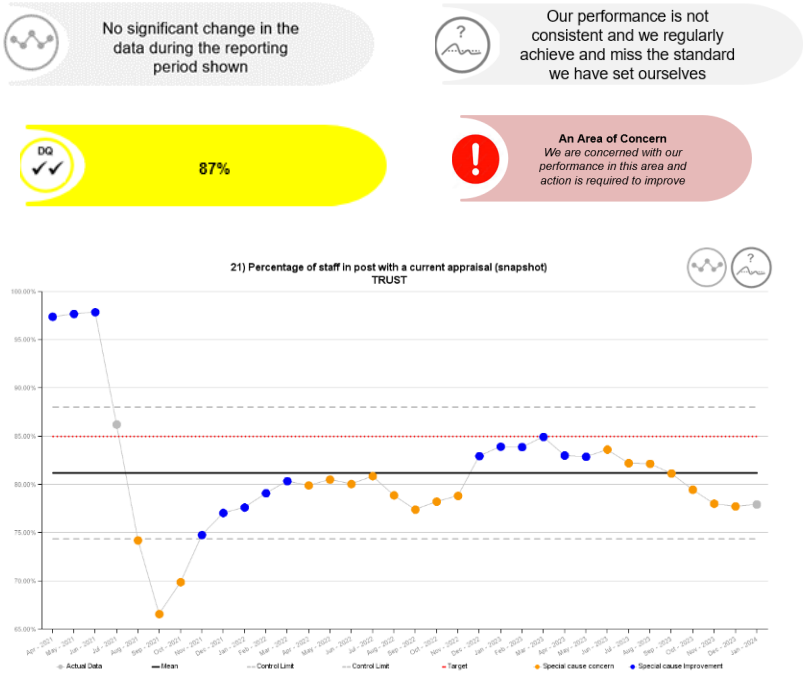
There is no significant change at Trust level and for several areas in the reporting period. However, there are several areas showing special cause concern (low performance) which are Corporate Affairs and Involvement, Estates and Facilities Management, Children and young Peoples Services within Durham, Tees Valley & Forensic Care Group and North Yorkshire, York & Selby Care Group/Adult Mental Health Services. To note the are a small number of areas showing special cause improvement (high) which are Finance, Nursing & Governance and People & Culture and Adult Learning Disabilities within Durham, Tees Valley & Forensic Care Group.

As at the 6th February 2024, by exception compliance levels below 85% are as follows:

	Number Compliant	Total Number	% Compliant
1) Company Secretary	5	10	50.00%
2) Therapies	24	42	57.14%
3) Medical	136	197	69.04%
4) Digital and Data Services	123	162	75.93%
5) Nursing and Governance	75	97	77.32%
6) Durham, Tees Valley and Forensic	3144	4042	77.78%
7) North Yorkshire, York and Selby	1218	1562	77.98%
8) Assistant Chief Exec	27	34	79.41%
9) Corporate Affairs and Involvement	26	32	81.25%

Update:
We have decided to stop using WorkPal from 13th March 2024 and other options are being explored.

Underlying issues:
- Our structured approach to high quality appraisal conversations through WorkPal has impacted
- Some completed appraisals from WorkPal have not transferred onto ESR and some supervisors are not correctly recording appraisals on ESR
- Staff Sickness of both staff and managers
- Staff not being aligned correctly on ESR
- Lack of monitoring process by services



Actions:
- We have developed a new Performance Improvement Plan which consolidates actions across all the areas of concern. The actions include booking all outstanding appraisals; validating outstanding staff lists; monitoring compliance in weekly huddles and ensuring they are booked in diaries in advance; following up all information not correctly recorded on ESR and training for supervisors. It is anticipated that the impact of these actions should be the achievement of 85% by the end of March 2024 and thereafter.
- A plan on a page for completing appraisals is being developed (January 2024) **Completed**
- Appraisal training is planned from March 2024 (post CITO) for both managers and staff (appraiser and appraisee)

22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
8,628patients referred in January that are not currently open to an existing Trust service.

There is no significant change at Trust/Care Group in the reporting period; however, we are showing an unexpected level of variation – a continued shift of low referrals for AMH services within North Yorkshire, York & Selby Care Group.

Underlying issues:
There are no underlying issues to report

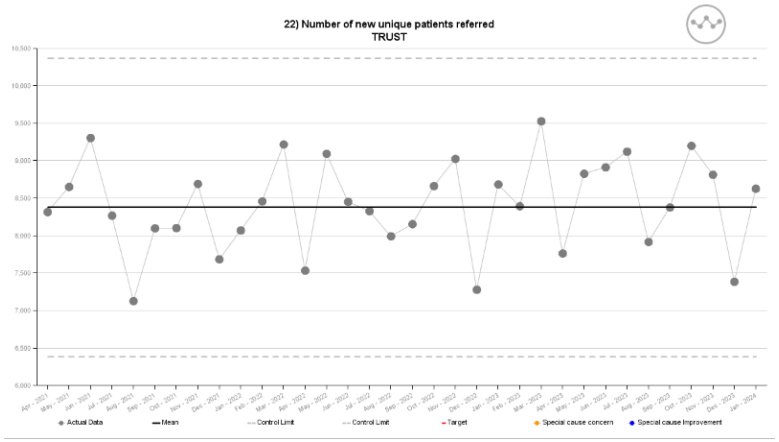
Actions:
There are no specific improvement actions required

No significant change in the data during the reporting period shown

DQ

93%

Continuous Improvement
Whilst the SPC indicates there are no specific concerns at present, we want to continuously improve in this area



23) Unique Caseload (snapshot)

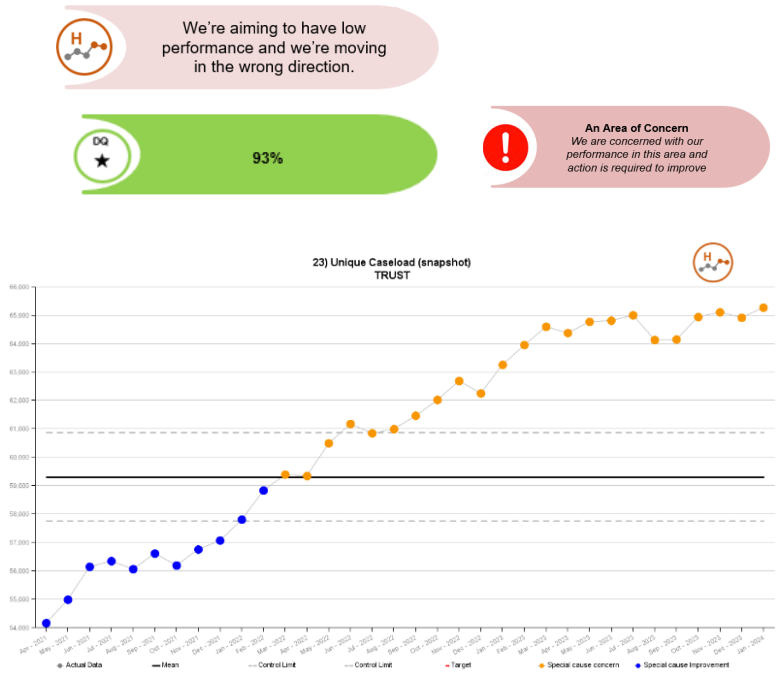
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the chart show/context:
65,270 cases were open, including those waiting to be seen, as at the end of January 2023.

There is special cause concern (high) at Trust and for Durham Tees Valley and Forensic Care Group (CYP and AMH services) in the reporting period. There is also special cause concern in CYP and MHSOP services within North Yorkshire, York & Selby Care Group.

Underlying issues:
- An increase in referrals in CYP services for neuro diverse patients across both Care Groups
- An increase in referrals in AMH services within Durham Tees Valley Forensic Care Group for neuro diverse patients
- An increase in referrals in MHSOP services for memory patients in North Yorkshire, York & Selby Care Group
- Increase in referrals has led to a backlog of waiters, whilst referrals have levelled, they are higher than they used to be

Actions:
- Durham Tees Valley & Forensic Care Group have revised their Performance Improvement Plan (PIP) and have identified several actions to address the back log of waiters within CYPS neurodevelopmental teams which includes implementing a revised neuro assessment protocol and a refresh of the Patient Tracker meetings. It is anticipated these actions will eliminate over 3 year waits by the end of Q1. AMH services will pilot work within Sedgefield teams to implement a revised assessment process for ADHD and ASD pathways working with Primary Care colleagues. It is anticipated this action will increase assessment and reduce 80% of referrals coming into intervention teams by June 2024.
- North Yorkshire, York & Selby Care Group are continuing to work on their Performance Improvement Plan (PIP) to ensure it includes SMART actions that support improvement.
- Following completion of demand and capacity work in MHSOP services for memory patients in North Yorkshire, York & Selby Care Group, the Integrated Care Board have agreed to undertake a project focusing on a stepped model across the wider system.



Actions continued:
- The Task & Finish Group within Corporate Services met late January 2024, to triangulate key measures/data that relate to caseload so we can better understand the issues and how we support improvement. A further meeting has been arranged in February to commence this work.

24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the data show/context:
The financial position to 31st January 2024 is an operational deficit of **£3.37m** against a planned year to date deficit of **£5.37m**, or a **(£2.0m)** favourable plan variance. This includes the benefit from a £2.3m allocation of national 2023/24 pressures funding reported in Month 8 and provided to support delivery of key operational priorities in the remaining months. The Trust reforecast the position at Month 7, using this as the basis to establish 'control totals' for Care Groups and Directorates for each month to year end. The control total for M10 was an in-month deficit of £0.27m compared to an actual surplus of (£1.25m), or a (£1.52m) favourable variance to control total in month. The cumulative variance to control total at Month 10 is (£1.20m) favourable largely owing to receipt of unplanned Health Education England funding.

- **Agency expenditure** in January 2024 was £1.15m, or £0.36m below plan in month, and £14.96m YTD, or £1.58m below plan to date, showing an improved favourable variance trend. This includes impacts from actions to exit non-clinical agency assignments and reducing costs relating to complex care packages. Ongoing usage includes material costs linked to inpatient occupancy and rosters, medical cover and costs within Health and Justice. The trust had **no off-framework agency assignments** in month.
- **Independent sector beds** - the Trust used 355 non-Trust bed days in month (225 in December, or a 130 bed day increase) at a cost of £0.25m (including estimates for unvalidated periods of occupancy and average observation levels pending billing). Year to date costs were £2.70m (£2.45m prior month) and **£1.59m more than the £1.11m year to date plan**. This remains a key area of clinical and management focus including through the new Urgent Care Programme Board (chaired by the Managing Director for DTVF).
- **Taxis and Secure Patient Transport** cost £2.23m to January, or **£0.88m more than plan**. A quality improvement event identified grip and control recommendations as well as alternative options. The results, and need for additional Care Group action, are being closely monitored, but demonstrate a 50% reduction in taxi utilisation compared to quarter 1. The Chief Nurse is overseeing actions to ensure robust governance around Secure Transport and a recently approved procurement will reduce unit costs going forward, the benefit of this is being assessed.
- **Planned CRES** are **£6.36m behind plan** to date. Key adverse variances relate to independent sector bed pressures for Adult Mental Health, level loading of Inpatient roster to reduce agency costs, review of surge posts and actions to reduce taxi/transport costs. Delivery of **unplanned CRES of £6.36m** to date (including interest receivable, with an interest rate at 5.2% for the past two months) is fully mitigating adverse performance against planned schemes**. Composite CRES achievement** is therefore **in line with plan** to the end of January but with a recurrent underlying risk to delivery.

The Trust provided assurance to the ICB and NHSE that we project delivery of our 2023/24 breakeven plan, based on a mid-case scenario. Performance is being tracked against monthly 'control totals', including assessing worst and best case assumptions and with improved performance at Month 10.

Our system is hitting the target/expectation

93%

An Area of Concern
We are concerned with our performance in this area and action is required to improve

24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit

Tees, Esk and Wear Valleys NHS Foundation Trust

Underlying issues:

- We need to reduce bed occupancy including through reduced lengths of stay to reduce reliance on independent sector beds.
- We recognise that agency expenditure and safe staffing levels are significantly impacting our financial plan including due to agency premia rates above price cap.
- We need to deliver CRES schemes to achieve our financial plan and deliver recurrent programmes to address our underlying financial pressures.
- We need to continue to track delivery of our 2023/24 breakeven financial plan, including compared to the reforecast and control totals agreed in late November 2023.

Actions:

- Please see actions within measures 08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider.
- Leads have revised their Performance Improvement Plans (PIP) for E Roster Effectiveness and Agency Reduction and the new actions are shown below with additional scrutiny at the new joint bi-monthly Executive Workforce and Resources Group:

E Roster Effectiveness

To publish rotas in a timely manner to ensure effective planning with the expected outcome that 50% of rotas published in line with Trust target of 42 days prior to the commencement of the roster period by April 2024.

To improve level loading of annual leave in line with Trust guidelines (11% to 17%) of contracted staff per week with the expected outcome that 50% of teams achieving target for annual leave level loading, by Grade Type (Registered Nurse / Unregistered Nurses) and to consistently achieve this target by April 2024.

Agency Reduction

- To re-negotiate rates of pay with framework agencies for RN's and all new RN's onboarded will be within cap rates with the expected outcome to be zero by beginning of March 2024.
- To continue recruitment in areas with high demand with a Trust wide RN vacancy rolling advert and a HCA advert targeting specific area with the expected outcome of increasing bank fill rates to 60%, reduction in agency fill rates to 18% and increasing the number of bank workers by 5%. It is expected the impact of these actions will be seen by the end of March 2024.
- Increase in engagement with agency workers in hard to fill areas to encourage moving from agency to bank with the expected outcome of transitioning 15% of agency workers to bank workers. It is expected the impact of these actions will be seen by the beginning of April 2024.
- Review the current timeframes for when shifts are outsourced to agencies and reduce these where possible (specific to NYYS as DTVF completed). Expected impact increase in bank fill rate and reduction in agency use as per above.

- The efficiency hub will be co-ordinated by a Programme Manager with recruitment completing. Terms of reference for the team / group are being established.
- The efficiency hub will provide support to enable focus on key strategic financial recovery actions including to manage and reduce over-establishments (including relating to Surge posts), ensure the efficiency rostering of inpatient staffing, and linked to inpatient occupancy, flow and Out of Area Placements moving ahead to 2024/25.
- Variances to monthly control totals are monitored with a re-assessment made of the continued deliverability of our breakeven plan, including with reference to worst and best case, as well as the mid case scenario assumed.

25a) Financial Plan: Agency expenditure compared to agency target

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:
Agency expenditure for January 2024 was £1.15m, or £0.36m below plan, and £14.96m YTD, or £1.58m below plan to date. This represents an improved favourable variance in month, including from actions to exit non-clinical agency and off-framework assignments.

NHS planning guidance introduced system agency cost caps of 3.70% of pay bill. As at Month 10 Trust agency expenditure represented 4.65% of pay bill (around 6% 2022/23). Planned agency costs for 2023/24 were relatively in line with 2022/23 outturn. Reducing agency volume and premia is a key focus, including from actions to exit non-clinical assignments with a significant reduction observed from October onwards. The trust has reported a WTE reduction in agency of 102 from April 2023 to January 2024, and the annualised premia has reduced from £4.6m in March 2023 to £3.7m in January 2024 (£0.9m reduction), demonstrating a positive influence of actions taken to date.

The Trust's ability to reduce temporary (including agency) staffing reliance will in part link to sickness absence, but equally to net new recruitment (including to medical, qualified nursing, inpatient, and health and justice hot spots) and securing alternative whole system models of care for specialist adult learning disability packages of care and high-cost medical assignments.

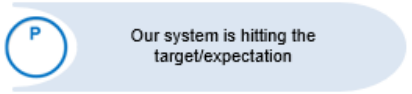
We recognise that volume pressures and rate premia associated with agency expenditure are significantly impacting our financial plan. To address this, we have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance.

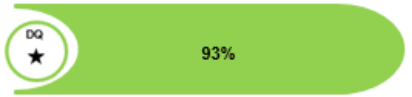
**Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.*

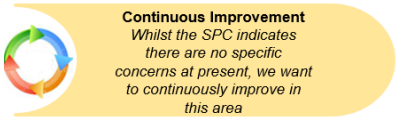
Underlying issues:
We need to continue to ensure a sustainable permanent workforce, including in key shortage professions e.g. medical and nursing, and to use temporary staffing more optimally including through improved rostering and regularly reviewing our safer staffing levels relative to clinical need.

Actions:
The Executive Workforce and Resources Group are overseeing the following actions to improve rostering:

- Outline clear governance flow in Care Groups related to how rosters are overseen, including specific information on roles and responsibilities **Completed**
- Look at central analysis of roster data to identify useful questions indicated by the data, with a view to providing areas of focus for discussion during live training **Completed**
- Re-visit roster rules to ensure optimal rosters and equity for colleagues (December 2023) *Update expected at next meeting early February 2024*
- Develop roster training programme (running 3 x weekly Jan-March 2024)







25b) Agency price cap compliance

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:
2,779 agency shifts were worked in January 2024, with **1,728** shifts compliant **(62%)** and 1,051 non-compliant (38%).

This is 63 more overall shifts than December and is equivalent to approximately 90 shifts per day (88 per day in December).

- Regional reporting of sickness levels suggested peer mental health providers have experienced similar challenges. The Trust's ability to reduce temporary (including agency) staffing reliance will in part link to sickness absence but equally to net new recruitment (including to medical, qualified nursing, inpatient health and justice hot spots) and securing alternative whole system models of care for specialist adult learning disability packages of care and high-cost medical assignments. Other key areas of focus include actions to ensure optimal roster efficiency.
- Further refinement of shift data relating to the above takes place up to the NHSE Temporary Staffing submission mid-month which may result in minor differences between reported data.
- We recognise that volume pressures and rate premia associated with agency expenditure are significantly impacting our financial plan. To address this, we have developed a **Performance Improvement Plan** that outlines the actions that are being taken to support improvement and increased assurance.

**Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.*

Underlying issues:
Particular persistent challenges relate to levels of medical staffing vacancies requiring cover from premia rate locum assignments

Actions:
In addition to actions from 25a) supporting improved compliance, the Trust is also progressing a second phase of International Recruitment to aim to recruit a more sustainable medical and nursing workforce and reduce reliance on agency costs. Medical assignments attract the highest value and percentage premia rates.

F — Our system is not hitting the target/expectation

DQ — 80%

An Area of Concern
We are concerned with our performance in this area and action is required to improve

26) Use of Resources Rating - overall score

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:
The overall rating for the trust is a **3** for the period ending 31st January against a planned rating of **3**.

The **Use of Resources Rating** (UoRR) was impacted by Covid-19 with national monitoring suspended. The Trust has continued to assess the UoRR based on plan submissions compared to actual performance.

- The **capital service capacity metric** assesses the level of operating surplus generated, to ensure Trusts can cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 1.02x, which is 0.33x better than plan and is **rated as a 4** (0.13x better than plan in December).
- The **liquidity metric** assesses the number of days' operating expenditure held in working capital (current assets less current liabilities). The Trust's liquidity metric is 16.0 days; this is behind plan by 2.6 days but is **rated as a 1** (3.8 days behind plan in December).
- The Income and Expenditure **(I&E) margin metric** assesses the level of surplus or deficit against turnover. The Trust has an I&E margin of -0.88%, this is better than plan by 0.55% and is **rated as 3** (0.28% better than plan in December).
- **The agency expenditure metric** assesses agency expenditure against planned costs for the Trust. Costs of £14.96m are £1.58m (9.55%) less than plan and would be **rated as a 1.** (The agency metric assesses performance against plan). NHS planning guidance suggested that providers' (and aggregate system level) agency expenditure should not exceed 3.7% of pay bill. As at Month 10 agency expenditure was 4.7% of pay.

Specifically for agency please refer to **25a) Financial Plan: Agency expenditure compared to agency target & 25b) Agency price cap compliance.**

The Trust's financial performance results in an **overall UORR** of **3** for the period ending 31st January and **is in line with plan.**

**Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.*

Underlying issues:
There are no underlying issues to report. As recovery actions to support delivery of the Trust's planned breakeven position are achieved, confidence levels relating to achievement of the planned 2023/24 UORR have increased as compared to the mid-year financial risk assessment.

Actions:
There are no specific improvement actions required.

27) CRES Performance - Recurrent

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:
We planned to deliver **£12.20m** recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£7.05m recurrent CRES**. This is **£5.15m adverse variance** against planned recurrent schemes.

Following the submission of our financial plan, which includes £15.5m recurrent CRES, key areas of focus are:

- Individual scheme baseline assessment by Care Group, including actions to support delivery.
- Quality impact assessments (QIA) to be completed for all schemes and signed off locally by relevant clinical and management leads, with final approval of schemes by Medical Director, Director of Nursing and Management Directors and Executive Director Group oversight.

Recurrent CRES delivery for the year is behind plan at Month 10 with specific performance noted as:
- £1.30m under-delivery of CRES for OAPs Reduction in AMH (Performance Improvement Plan in place)
- £1.63m under-delivery of CRES for Surge post review (Pay)
- £0.45m CRES for Agency (Inpatient level loading of rosters – actions in train via sub group of safer staffing group)
- £0.26m CRES for Taxi spend reduction (Improvement Event and associated actions being progressed, but with notably reduced taxi run rates)
- £1.51m CRES for other schemes
- Recurrent CRES unachieved £5.15m to date

***Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.*

Underlying issues:
We need to deliver CRES schemes to achieve our financial plan.

Actions:
Please see measure - 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit.

F — Our system is not hitting the target/expectation

DQ — 80%

An Area of Concern
We are concerned with our performance in this area and action is required to improve

28) CRES Performance – Non-Recurrent

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the data show/context:
We planned to deliver **£2.50m** of non-recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£7.64m, a (£5.15m) favourable variance** against planned non-recurrent schemes.

The Trust planned to deliver full year non-recurrent Cash-Releasing Efficiency Savings (CRES) of **£5.38m** for 2023/24 with key areas of focus including interest receivable and operational grip and control measures to be identified in-year.

Non-Recurrent CRES delivery for the year is ahead of plan at Month 10 relating to:

Planned Schemes:

- £1.14m Unachieved CRES Non Recurrent Grip & Control (Non Pay)
- (£0.37m) Non Recurrent Grip & Control Trust wide Recovery Actions / budget rebasing (Non Pay)

Unplanned Schemes:

- (£1.24m) Interest Receivable (interest rate has been 5.2% for the last two months)
- (£0.01m) Income Contribution
- (£4.67m) Largely relating to Learning Disability and Medical run rate reductions

Composite year to date non-recurrent CRES **over delivery** of **(£5.15m).**

NOTE *Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.*

Underlying issues:
There are no underlying issues to report

Actions:
Financial Planning activities will confirm the extent to which the same actions can be delivered recurrently (or non-recurrently) and any other scope to deliver new non-recurrent CRES in 2024/25 to mitigate underlying financial pressures.

P — Our system is hitting the target/expectation

DQ — 80%

Continuous Improvement
Whilst the SPC indicates there are no specific concerns at present, we want to continuously improve in this area

29) Capital Expenditure (Capital Allocation)

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:
Capital expenditure was **£9.08m** at the end of January against a year to date budget of **£12.69m** resulting in a **£3.60m** underspend.

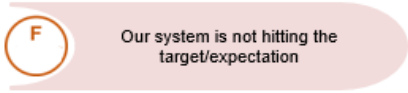
- Whilst several favourable and adverse variances contribute to the current position key areas include previously anticipated costs of 2023/24 schemes which completed in the 2022/23 financial year, slippage against start dates for lifecycle schemes and a change to plan for medical education centre development at Lanchester Road.

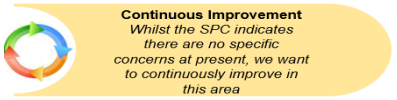
- The Trust is forecasting to outturn in line with planned performance on aggregate but notes an unplanned upside in relation to actual costs for phase 1 patient safety works Tees. Must do actions for 2024/25 financial year have been brought forward to aim to ensure outturn spend in line with capital allocation. Material lifecycle schemes with a delayed start are now supported by purchase orders.

- Any delays to planned inpatient environment schemes are communicated to the Environmental Risk Group to manage any associated risks. There is a delay in the start to Phase 3 sensor door works due to inability to secure escorts for contractors.

Underlying issues:
There are no underlying issues to report.

Actions:
Work is continuing to review progress against milestone plans for lifecycle works and to progress schemes that are being brought forward to utilise under spending, including from Phase 1 Teesside works.





30) Cash balances (actual compared to plan)

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:
We have an actual cash balance of **£60.14m** against a planned year to date cash balance of **£61.45m** which is **(£1.31m) adverse variance** to plan.

- This is mainly due to movements on working balances, as the Trust has increased the speed of supplier payments and a delay in the receipt of £1.7m national Public Dividend Capital support for the Frontline Digitisation capital scheme – this has been confirmed and is expected in February 2024.
- The Trust has narrowly failed to achieved the 95.0% Better Payment Practice Code (BPPC) target compliance for the prompt payment suppliers, achieving a combined year to date BPPC of 94.7%. We continue to support the use of Cardea to make processes as efficient as possible, and ensure suppliers are paid promptly.
- The value of debt outstanding at 31st January 2024 was £2.59m, with debts exceeding 90 days amounting to £0.51m (excluding amounts being paid via instalments and PIPS loan repayments). £0.13m has since been credited and re-raised at the customers request.
- Three whole government accounting organisations account for 73% of total debts greater than 90 days old (£0.28m), progress continues to be made to receive payment for older debts. No outstanding debts have been formally challenged

Underlying issues:
In additional to information at measure 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit, the Trust needs to expend significantly more via its annual capital programme budget than is generated internally from depreciation, meaning the Trust's annual cash reserves are gradually reducing.

Actions:
In addition to actions at measure 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit, the Trust has recently secured national capital funding for Frontline Digitisation (£1.7m) and LED lighting (£0.8m). These schemes would otherwise have further depleted Trust cash balances.

F — Our system is not hitting the target/expectation

DQ ★ — 93%

No Concerns
We are performing consistently in this area and no action is required at this time

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Which strategic goal(s) within Our Journey to Change does this measure support?

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

	Measure	Goal 1 - To Co-Create a great experience for our patients, carers and families	Goal 2 - To Co-Create a great Experience for our Colleagues	Goal 3 - To be a great partner
BIPD_01	Percentage of Patients surveyed reporting their recent experience as very good or good	√	√	
BIPD_02	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for	√	√	
BIPD_03	Percentage of inpatients reporting that they feel safe whilst in our care	√	√	
BIPD_04	Percentage of CYP showing measurable improvement following treatment - patient reported	√		
BIPD_05	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	√		
BIPD_06	Percentage of CYP showing measurable improvement following treatment - clinician reported	√	√	
BIPD_07	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	√	√	
BIPD_08	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	√	√	√
BIPD_09	Number of inappropriate OAP bed days for adults that are 'external' to the sending provider	√		
BIPD_10	The number of Serious Incidents reported on STEIS	√	√	
BIPD_11	The number of Incidents of moderate or severe harm	√		
BIPD_12	The number of Restrictive Intervention Incidents	√	√	
BIPD_13	The number of Medication Errors with a severity of moderate harm and above	√		
BIPD_14	The number of unexpected Inpatient unnatural deaths reported on STEIS	√		√
BIPD_15	The number of uses of the Mental Health Act	√		
BIPD_16	Percentage of staff recommending the Trust as a place to work	√	√	√
BIPD_17	Percentage of staff feeling they are able to make improvements happen in their area of work	√	√	√
BIPD_18	Staff Leaver Rate	√	√	√
BIPD_19	Percentage Sickness Absence Rate	√	√	√
BIPD_20	Percentage compliance with ALL mandatory and statutory training	√	√	√
BIPD_21	Percentage of staff in post with a current appraisal	√	√	√
BIPD_22	Number of new unique patients referred	√	√	√
BIPD_23	Unique Caseload (snapshot)	√	√	
BIPD_24	Financial Plan: SOCI - Final Accounts - Surplus/Deficit			
BIPD_25b	Financial Plan: Agency expenditure compared to agency target			
BIPD_25a	Agency price cap compliance			
BIPD_26	Use of Resources Rating - overall score			
BIPD_27	CRES Performance - Recurrent			
BIPD_28	CRES Performance - Non-Recurrent			
BIPD_29	Capital Expenditure (CDEL)			
BIPD_30	Cash balances (actual compared to plan)			

Which risk(s) within our Board Assurance Framework does this measure support/provide assurance towards?

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

	Measure	1. Recruitment and Retention	2. Demand	3. Involvement and Engagement	4. Experience	5. Staff Retention	6. Safety	7. Infrastructure	8. Cyber Security	9. Regulatory Action	10. Influence	11. Governance and Assurance	12. Roseberry Park	13. West Lane	14. CITO	15. Financial Sustainability
BIPD_01	Percentage of Patients surveyed reporting their recent experience as very good or good			√	√	√	√			√						
BIPD_02	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for			√	√	√	√									
BIPD_03	Percentage of inpatients reporting that they feel safe whilst in our care			√	√	√	√			√						
BIPD_04	Percentage of CYP showing measurable improvement following treatment - patient reported			√	√		√					√				
BIPD_05	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported			√	√		√					√				
BIPD_06	Percentage of CYP showing measurable improvement following treatment - clinician reported			√	√		√					√				
BIPD_07	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported				√		√					√				
BIPD_08	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	√	√		√	√	√					√				√
BIPD_09	Number of inappropriate OAP bed days for adults that are 'external' to the sending provider		√		√							√				√
BIPD_10	The number of Serious Incidents reported on STEIS			√	√		√			√						
BIPD_11	The number of Incidents of moderate or severe harm			√	√		√			√		√				
BIPD_12	The number of Restrictive Intervention Incidents			√	√	√	√			√						
BIPD_13	The number of Medication Errors with a severity of moderate harm and above				√		√			√						
BIPD_14	The number of unexpected Inpatient unnatural deaths reported on STEIS			√	√	√	√									
BIPD_15	The number of uses of the Mental Health Act		√	√	√	√	√			√		√				
BIPD_16	Percentage of staff recommending the Trust as a place to work	√		√	√	√	√			√	√	√				
BIPD_17	Percentage of staff feeling they are able to make improvements happen in their area of work	√	√	√	√	√	√			√	√	√				
BIPD_18	Staff Leaver Rate	√				√	√					√				√
BIPD_19	Percentage Sickness Absence Rate	√	√			√	√			√						√
BIPD_20	Percentage compliance with ALL mandatory and statutory training	√		√	√	√	√		√	√		√				√
BIPD_21	Percentage of staff in post with a current appraisal	√			√	√	√			√		√				
BIPD_22	Number of new unique patients referred		√				√					√				√
BIPD_23	Unique Caseload (snapshot)		√			√	√					√				√
BIPD_24	Financial Plan: SOCI - Final Accounts - Surplus/Deficit									√		√				√
BIPD_25b	Financial Plan: Agency expenditure compared to agency target									√		√				√
BIPD_25a	Agency price cap compliance									√		√				√
BIPD_26	Use of Resources Rating - overall score									√		√				√
BIPD_27	CRES Performance - Recurrent									√		√				√
BIPD_28	CRES Performance - Non-Recurrent									√		√				√
BIPD_29	Capital Expenditure (CDEL)									√		√	√			√
BIPD_30	Cash balances (actual compared to plan)									√		√	√			√

National Quality Standards and Mental Health Priorities Headlines

Headlines

- **72 hour follow up** achieving target
- **EIP waiting times** achieving target in all areas except Vale of York
- **Talking Therapies waiting times (6 and 18 weeks)** consistently achieving target
- **Child Eating Disorders waiting times** failing target in all areas for routine cases except for Tees Valley; and consistently failing target in all areas for urgent cases except North Yorkshire
- **Talking Therapies: Access –** failing target in all areas except for Tees Valley, however, please note achievement in County Durham for the month of January; **Recovery -** achieving target; **1st to 2nd treatment waits** - failing target in all areas however, target achieved in North Yorkshire in Q3 and January.
- **Children: 1 contact** consistently achieving target however, **Paired Outcomes** consistently failing target
- **AMH/MHSOP 2 contacts** achieving target in all areas except Vale of York
- **OAP bed days (inappropriate)** consistently failing target **This is also the MH Priority monitored at Trust level – see IPD measure 9 for further details*
- **Specialist Community Perinatal Mental Health (PMH) services** failing target in all areas except Tees Valley

Risks / Issues

Of most concern:

- Child Eating Disorders Waiting Times (except Tees Valley routine cases and North Yorkshire urgent cases)
- Talking Therapies Access (except Tees Valley)
- Talking Therapies 1st to 2nd treatment (except North Yorkshire)
- Childrens Paired Outcomes
- OAP bed days (inappropriate)
- Specialist Community PMH services (except Tees Valley)

Of concern:

- EIP Waiting Times Vale of York only
- Adults/Older Persons 2 contacts Vale of York only

Positive Assurance

- 72 hour follow up
- Talking Therapies waiting times (6 and 18 weeks)
- Talking Therapies Recovery
- CYP 1 contact

Note *Talking Therapies previously known as IAPT*

Mitigations

Child Eating Disorders waiting times
Durham Tees Valley & Forensic Care Group (DTVFCG) have revised their Performance Improvement Plan (PIP) and the new actions are to consider appropriate use of therapy codes for young people presenting with ARFID; exploring dietetic consultation to the treatment team and to ensure assessing practitioner is treatment lead. It is anticipated these actions should eliminate any further breaches. North Yorkshire, York & Selby Care Group are continuing to work on their PIP to ensure it includes SMART actions that support improvement.

Talking Therapies Access
DTVFCG have revised their PIP and the new actions are to promote suitability criteria/referral routes; Therapy Support Workers contacting patients prior to their assessment; formulation of SPA dashboard to track capacity and demand to maximise capacity. It is anticipated these actions will improve the number of referrals and reduce DNAs from 20% to 12% by the end of May 2024. North Yorkshire, York & Selby Care Group are continuing to work on their PIP to ensure it includes SMART actions that support improvement.

Talking Therapies 1st to 2nd treatment waits
DTVFCG have revised their PIP and the new actions are to implement a gatekeeping process for low intensity step ups; review demand and align capacity to ensure availability of slots; develop a standardised VCB for the Leadership Teams so resources and demand can be aligned; amend the report out process and attendance to include monitoring the outcome of assessments and use of CCBT importance and workshops will be prioritised. It is anticipated these actions will improve waiting times by 5-10% by May 2024.

Childrens Paired Outcomes
A business case was developed for a dedicated outcomes team however, a more comprehensive options appraisals, risk and quality impact assessment is required prior this going to Care Group Boards in April.

OAP bed days (inappropriate)
DTVFCG have revised their PIP and the new actions are focused on reducing length of stay and those clinically ready for discharge that are delayed. (See measure 8 Bed Occupancy within IPD for full details). North Yorkshire, York & Selby Care Group are continuing to work on their PIP to ensure it includes SMART actions that support improvement.

Specialist Perinatal Mental Health
North Yorkshire, York & Selby Care Group are continuing to work on their PIP to ensure it includes SMART actions that support improvement.

EIP waiting times
North Yorkshire, York & Selby Care Group are recruiting to 4 posts for the York and Selby EIP team and are recruiting temporary staff in the interim.

Adult/Older Persons 2 contacts
North Yorkshire, York & Selby Care Group have completed the deep dive work and have identified that one of the main underlying issues in the reduction of contacts is the York and Selby EIP team. As outlined above in respect of waiting times, recruitment is under way to improve staff capacity.

National Quality Standards and Mental Health Priorities Dashboard

Tees, Esk and Wear Valleys NHS Foundation Trust

National Quality Requirements

Measure	Agreed S-ICBL Ambition	County Durham					Tees Valley					North Yorkshire					Vale of York				
		Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD
Percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care	80%	88.99%	93.19%	89.50%	86.75%	90.17%	86.40%	90.65%	85.37%	81.40%	87.01%	87.30%	93.16%	85.32%	86.96%	88.44%	79.38%	93.14%	89.02%	81.82%	86.62%
Percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care	60%	63.64%	63.77%	63.77%	63.64%	63.72%	73.68%	69.05%	82.50%	65.38%	74.06%	85.71%	88.24%	83.33%	100.00%	88.52%	73.33%	50.00%	28.57%	50.00%	51.16%
Percentage of Service Users referred to an NHS Talking Therapies programme who wait six weeks or less from referral to entering a course of NHS Talking Therapies treatment	75%	99.47%	99.86%	99.57%	99.11%	99.57%	99.46%	100.00%	99.65%	99.63%	99.70%	99.54%	99.70%	99.52%	100.00%	99.63%	99.20%	99.81%	99.62%	100.00%	99.60%
Percentage of Service Users referred to an NHS Talking Therapies programme who wait 18 weeks or less from referral to entering a course of NHS Talking Therapies treatment	95%	100.00%	99.97%	99.96%	100.00%	99.98%	100.00%	100.00%	99.83%	100.00%	99.95%	99.94%	99.94%	99.95%	100.00%	99.95%	99.93%	100.00%	99.95%	100.00%	99.96%
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks (rolling 12 months)	95%	83.82%	84.13%	82.19%	83.95%	83.95%	91.01%	95.12%	96.34%	96.25%	96.25%	80.00%	78.05%	83.33%	92.50%	92.50%	78.33%	83.05%	81.82%	81.25%	81.25%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week (rolling 12 months)	95%	76.67%	67.74%	64.86%	71.05%	71.05%	50.00%	50.00%	62.50%	55.56%	55.56%	87.50%	87.50%	83.33%	100.00%	100.00%	71.43%	71.43%	80.00%	66.67%	66.67%

Local Quality Requirements

Measure	Agreed S-ICBL Ambition	County Durham					Tees Valley					North Yorkshire					Vale of York				
		Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	*	2662	2899	2780	1342	9683	557	603	575	272	2007	1723	1672	1879	690	5964	1495	1607	1838	600	5540
IAPT: The proportion of people who are moving to recovery	50.00%	51.69%	51.01%	48.57%	51.84%	50.52%	54.39%	56.75%	48.42%	50.00%	52.87%	51.55%	53.67%	53.76%	50.59%	52.76%	54.26%	58.34%	56.95%	57.70%	56.70%
IAPT:Percentage of people who have waited more than 90 days between first and second appointments	<10%	13.92%	12.91%	13.05%	16.80%	13.69%	19.76%	18.56%	23.47%	22.67%	20.91%	17.57%	12.63%	6.13%	4.09%	11.08%	31.15%	26.61%	25.43%	29.12%	27.83%
Number of CYP aged 0-17 supported through NHS funded mental health with at least one contact (rolling 12 months)	*	9978	10236	10454	10407	10407	11653	11598	11500	11452	11452	4319	4098	4062	4005	4005	4544	4528	4505	4496	4496
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	40.00%	22.46%	25.75%	21.99%	18.60%	22.86%	28.53%	27.12%	26.76%	21.95%	26.66%	38.24%	37.80%	33.17%	34.85%	36.00%	30.38%	25.53%	27.35%	21.77%	26.69%
Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services for adults and older adults with severe mental illnesses (rolling 12 months)	*	8193	8151	8240	8374	8374	6825	7122	7535	7662	7662	4162	4144	4105	4067	4067	3341	3183	3075	3062	3062
Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider (rolling 3 months)	*	1445	436	608	577	577	1445	436	608	577	577	163	58	63	128	128	163	58	63	128	128
Number of women accessing specialist community PMH services in the reporting period (cumulative)	*	207	278	340	368	368	233	310	392	419	419	77	95	124	138	138	37	67	92	92	92

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NOTES ** Denotes individual plans agreed by area; Q4 is January (part)*

NHS Oversight Framework Headlines (as at Quarter 3 23/24)

Headlines

- We are currently placed within **Segment 3** which is "*Bespoke mandated support"*
- **OAP (inappropriate)** consistently failing target, but in the interquartile range nationally **This is also monitored at Trust level – see IPD measure 9 for further details.*
- **Access:** consistently failing target for **Talking Therapies** however achieving for **CYP 1 contact**. Failing the Q3 **AMH/MHSOP 2 contacts** target in Humber & North Yorkshire Integrated Care Board (HNY ICB), and consistently failing **Specialist Community Perinatal Mental Health services** within the same area. **These measures are Mental Health Priorities – see relevant section of this report for further details*
- **Patient Safety Alerts,** consistently achieving target
- **Overall CQC Rating** remains 'Requires Improvement' but in the interquartile range nationally
- **Adult & Older Adult Length of Stay** consistently failing target; however, **Adult** is in the highest performing quartile nationally and **Older Adult** is in the interquartile range.
- **The likelihood of BME or disabled applicants being appointed from shortlisting** consistently failing target
- **Senior Leaders who are women** and/or **disabled** consistently achieve target; however, those from a **BME background** consistently fail target and are in the lowest performing quartile nationally.
- **Staff Leaver Rate** remains in the highest performing quartile nationally
- **Sickness Absence** consistently increasing and in the lowest performing quartile nationally
- **CQC well-led rating** remains 'Requires Improvement' and in the lowest performing quartile nationally
- **Agency Price Cap** consistently failing target however, **Agency Spend** consistently achieving. **This and the other financial measures are monitored at Trust level – see IPD measures 24, 25, 27 & 28 for further details*

Risks / Issues

Of most concern:

- OAP bed days (inappropriate)
- Talking Therapies Access
- Senior Leaders from a BME Background
- CQC well-led rating
- Sickness absence rate
- Agency Price Cap

Of concern:

- Specialist Community Perinatal Mental Health services **(**HNY ICB)
- Adult & Older Adult Length of Stay
- The likelihood of BME or disabled applicants being appointed from shortlisting.

Positive Assurance

- CYP 1 contact
- AMH/MHSOP 2 contacts (North East & North Cumbria Integrated Care Board – NENC ICB)
- Perinatal Access (NENC ICB)
- Patient Safety Alerts
- Senior Leaders who are Women and / or disabled.
- Staff Leaver Rate

NHS Oversight Framework Headlines (as at Quarter 3 23/24)

Mitigations

OAP bed days (inappropriate) *also in IPD and Mental Health Priorities Headlines*
Durham Tees Valley & Forensic Care Group (DTVFCG) have revised their Performance Improvement Plan (PIP) and the new actions are focused on reducing length of stay and those clinically ready for discharge that are delayed. (See measure 8 Bed Occupancy within IPD for full details). North Yorkshire, York & Selby Care Group are continuing to work on their PIP to ensure it includes SMART actions that support improvement.

Talking Therapies Access *also in Mental Health Priorities Headlines*
DTVFCG have revised their PIP and the new actions are to promote suitability criteria/referral routes; Therapy Support Workers contacting patients prior to their assessment; formulation of SPA dashboard to track capacity and demand to maximise capacity. It is anticipated these actions will improve the number of referrals and reduce DNAs from 20% to 12% by the end of May 2024. North Yorkshire, York & Selby Care Group are continuing to work on their PIP to ensure it includes SMART actions that support improvement.

Senior Leaders from a BME Background
Talent board & Leadership academy will be set up in Q1 24/25, with particular focus on career development for those in underrepresented groups.

CQC well-led rating
We have co-created an Improvement plan with Care Groups and Specialty leads in response to the Must and Should Do recommendations within the October Inspection Report; taking into account work already completed, actions being addressed by established workstreams and ongoing improvement plans.

Sickness absence rate
Targeted work continues including, the re-introduction of sickness audits and continued focus on high levels of absence and top 5 teams.

Agency Price Cap
Planned costs for 2023/24 were relatively in line with 2022/23 outturn representing a reduction in cost owing to the favourable plan variance year to date. However, the trust price cap compliance is 62%, which is behind the planned 100% compliance. Volume pressures and rate premia associated with agency expenditure are significantly impacting our financial plan. To address this, we have developed a PIP to support improvement.

Specialist Community Perinatal Mental Health services *also in Mental Health Priorities Headlines*
North Yorkshire, York & Selby Care Group are continuing to work on their PIP to ensure it includes SMART actions that support improvement.

Adult & Older Adult Length of Stay
For DTVFCG please see mitigations for OAP bed days (above) which are applicable to this measure also. A review of those North Yorkshire and York patients exceeding 60- and 90- day stays, has confirmed all were due to complex needs and were therefore appropriate.

Appointment of BME or disabled applicants
We have a robust Workforce Race Equality Standard (WRES) action plan, which includes piloting the virtual interview platform (Scalable Automated Multiple Mini Interviews (SAMMI)) to reduce bias in the recruitment process, and the development of an action plan to increase the diversity of staff and hyperlocal recruitment.

NHS Oversight Framework Dashboard (as at Quarter 3 23/24)

Tees, Esk and Wear Valleys NHS Foundation Trust

Quality, Access & Outcomes: Mental Health						
Measure	Oversight Standard	Tees, Esk & Wear Valleys NHS Trust				
		Q1	Q2	Q3	Latest National Position	
Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider	0	1608	494	671	Interquartile range as at September 2023 (480) 26 out of 56 Trusts	

Measure	Oversight Standard	North East & North Cumbria ICB				Humber & North Yorkshire ICB			
		Q1	Q2	Q3	Latest National Position	Q1	Q2	Q3	Latest National Position
IAPT access (total numbers accessing services)	100.00%	87.54%	95.24%	91.24%	Lowest performing quartile (a position of concern) as at October 2023 (62%) 32 out of 42 ICBs	87.30%	83.67%	91.57%	Interquartile range as at October 2023 (70%) 23 out of 42 ICBs
Children and young people (ages 0-17) mental health services access (number with 1+ contact)	100.00%	113.64%	114.70%	115.33%	Interquartile range as at October 2023 (94%) 15 out of 42 ICBs	122.25%	118.98%	118.17%	Interquartile range as at October 2023 (85%) 23 out of 42 ICBs
Overall Access to Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	100.00%	114.12%	116.06%	119.87%	Interquartile range as at October 2023 (95%) 19 out of 42 ICBs	103.75%	101.31%	99.28%	Interquartile range as at October 2023 (97%) 17 out of 42 ICBs
Women accessing specialist community perinatal mental health services	100.00%	194.69%	130.09%	108.12%	Interquartile range as at October 2023 (85.3%) 31 out of 42 ICBs	87.02%	61.83%	54.96%	Lowest performing quartile (a position of concern) as at October 2023 (35.4%) 40 out of 42 ICBs

Quality of Care, access & outcomes: Safe, high-quality care		Q1	Q2	Q3	Latest National Position
National Patient Safety Alerts not completed by deadline	0	0	0	0	
Consistency of reporting patient safety incidents	100%	100.00%	* National reporting paused pending the introduction of the new Learn from Patient Safety Events (LFPSE) service		
Overall CQC rating	N/A	Requires Improvement			Interquartile range as at November 2023. 51 out of 69 Trusts
NHS Staff Survey compassionate culture people promise element sub-score	As per staff survey benchmarking group results	6.9			Lowest performing quartile (a position of concern) as at **2022 survey** (6.85) 65 out of 71 Trusts
NHS Staff Survey raising concerns people promise element sub-score	As per staff survey benchmarking group results	6.7			Interquartile range as at **2022 survey** (6.71) 43 out of 71 Trusts
Adult Acute Length of Stay Over 60 Days	0%	13.78%	13.30%	14.26%	Highest performing quartile (a positive position) as at October 2023 (13%) 6 out of 52 Trusts
Older Adult Acute Length of Stay Over 60 Days	0%	25.81%	33.58%	42.74%	Interquartile Range as at October 2023 (29%) 16 out of 52 Trusts
Quality of care, access and outcomes; Compassionate and inclusive culture		**Q1**	**Q2**	**Q3**	**Latest National Position**
Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants	1.00	1.70	1.70	*data now only provided on a 6 month basis	Interquartile range as at 2023 (1.8) 48 out of 69 Trusts
Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants	1.00	0.99	0.99		Interquartile range as at 2023 (1.1) 50 out of 69 Trusts

Notes:

- *Within the Framework Trusts are ranked nationally and placed into one of three ranges: the lowest performing quartile, an interquartile range and the highest performing quartile, the highest quartile being the best.*
- *Talking Therapies previously known as IAPT*

NHS Oversight Framework Dashboard (as at Quarter 3 23/24)

Tees, Esk and Wear Valleys NHS Foundation Trust

People; Belonging in the NHS - Proportion of staff in senior leadership roles who a) are from a BME background b) are women c) disabled staff		Q1	Q2	Q3	Latest National Position
BME background	12%	1.37%	1.72%	5.88%	Lowest performing quartile (a position of concern) as at 2022 calendar year (1.28%) 67 out of 69 Trusts
Women	62%	65.75%	64.22%	63.73%	Interquartile range as at October 2023 (64.2%) 29 out of 45 Trusts
Disabled staff	3.20%	10.96%	11.64%	8.33%	Interquartile range as at 2023 (6.02%) 19 out of 69 Trusts
People; Looking after our people		**Q1**	**Q2**	**Q3**	**Latest National Position**
Staff survey engagement theme score	As per staff survey benchmarking group results	6.80			Lowest performing quartile (a position of concern) as at **2022 survey** (6.85) 65 out of 71 Trusts
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	As per staff survey benchmarking group results	7.00%			Interquartile range as at **2022 survey** (7.32%) 24 out of 71 Trusts
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	As per staff survey benchmarking group results	14.00%			Interquartile range as at **2022 survey** (13.7%) 34 out of 71 Trusts
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	As per staff survey benchmarking group results	23.00%			Highest performing quartile (a positive position) as at **2022 survey** (22.7%) 17 out of 71 Trusts
Staff Survey - We Are Compassionate and Inclusive People Promise element score	As per staff survey benchmarking group results	7.40			Interquartile range as at **2022 survey** (7.44) 53 out of 71 Trusts
NHS Staff Leaver rate	None	11.66%	11.56%	11.49%	Highest performing quartile (a positive position) as at September 2023 (6.59%) 10 out of 71 Trusts
Sickness absence rate (working days lost to sickness)	None	5.44%	5.80%	6.21%	Lowest performing quartile (a position of concern) as at July 2023 (5.89%) 60 out of 71 Trusts
Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	As per staff survey benchmarking group results	63.00%			Interquartile range as at 2022 calendar year (62.4%) 20 out of 71 Trusts
Leadership and Capability; Leadership		**Q1**	**Q2**	**Q3**	**Latest National Position**
CQC well-led rating	N/A	Requires Improvement			Lowest performing quartile (a position of concern) as at November 2023 53 out of 69 Trusts
Finance and use of resources		**Q1**	**Q2**	**Q3**	**Latest National Position**
Financial efficiency - variance from efficiency plan - Recurrent	N/A	£1,178,000	£3,858,000	£6,269,000	Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.
Financial efficiency - variance from efficiency plan - Non-Recurrent	N/A	£363,000	£2,645,000	£5,349,151	
Financial stability - variance from break-even	N/A	£3,881,456	£4,424,811	£4,700,532	
Agency spending: Agency spend compared to the agency ceiling	100%	86.26%	99.96%	91.08%	
Agency spending: Price cap compliance	100%	67%	63%	61.61%	

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of: Board of Directors
Date: 14 March 2024
Title: Feedback from Leadership Walkabouts
Executive Sponsor(s): A Bridges, Director of Corporate Affairs & Involvement
Author(s): A Bridges

Report for:				
	Assurance	✓	***Decision***	
	Consultation		***Information***	✓

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	✓
2: To co-create a great experience for our colleagues	✓
3: To be a great partner	✓

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
All		The report highlights summarised feedback from leadership walkabouts in February 2024, which can contribute to the Board's understanding of strategic risks, quality of services and the operation of key controls.

Executive Summary:

Purpose: The purpose of this report is to provide the Board with high-level feedback from leadership walkabouts that took place on 26 February 2024.

Overview:

1 **Background**

1.1 The Trust undertakes a monthly programme of regular leadership walkabouts to services. These visits are not inspections but enable teams to hold conversations directly with Board Members and Governors to raise any matters of importance. Visits were stood down in January 2024 due to the roll-out of CITO.

1.2 Walkabouts provide an opportunity for Board to meet with teams to really understand the strengths of the service and consider the more challenging areas, and how we can work together to resolve these and co-create any potential solutions. Actions are also captured and monitored via Management Group.

2 **Speciality areas visited**

2.1 Leadership walkabouts took place on 26 February 2026 across MHSOP and CAMHS community services:

- Whitby Mental Health Service for Older People (MHSOP) Community Mental Health Team (CMHT)
- Stockton Mental Health Service for Older People (MHSOP) Community

Mental Health Team (CMHT)
- Malton Mental Health Service for Older People (MHSOP), Springwood Unit
- Forensic CAMHS, Middlesbrough

3 **Key issues**

- Strengths:
  - Putting patients first: several examples of putting patients at the heart of what their service offers, with positive feedback received via Friends and Family Test (FFT). Great examples of innovative models of care eg positive behaviour support where the team approached all patients thinking about least restrictive practice, with good de-escalation and distraction skills.
  - Compassionate and caring staff: strong, resilient and adaptable teams who supported each other, and went the extra mile was common theme across those visited, all very proud and passionate about what they do.
  - Multi-disciplinary teams (MDT): multi-disciplinary structure really helpful, with right skills mix led to good problem solving approach supporting patients in their journey, including into different pathways, and/or linking in with other services. Relationships with GPs and voluntary and community sector for example were well developed.
- Challenges:
  - Improved staffing: number of posts being readvertised several times and remain unfilled, which meant that getting, retaining and training people with the right skill mix was an area of concern to meet Trust safe staffing targets and increased demand. Trac and timeliness of the recruitment process still remained an issue across teams visited.
  - Geography / rurality / location: all teams reported some kind of issues with the facility they were based in, either not being fit for purpose for patients, accessibility issues, sharing with other services, or their physical location eg meant that patients / families had to travel long distances, and indeed led to staffing issues given travel required, including out of hours support. This also led to many teams feeling quite ‘detached’ from the Trust itself, which led to view of being undervalued.
  - Demand v’s investment: growing population and areas of high deprivation (health inequalities) having huge impact on services ability to provide appropriate services within existing capacity (teams aren’t being invested in to match demand). In some services, funding was woefully lacking and needed ‘whole system’ approach.

3.2 For assurance, lead Directors have reviewed feedback received and agreed actions with teams visited, which will be monitored.

Recommendations: The Board is asked to:
- Receive and note the summary of feedback as outlined.
- Consider any key issues, risks or matters of concern arising from the visits held in February 2024.

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Committee Key Issues Report		
Report Date to Board of Directors – 14 March 2024		
Date of last meeting: 7 March 2024		**Report of: The Quality Assurance Committee**
		Quoracy was achieved.
1	**Agenda**	The Committee considered the following matters: • Summary of Executive Review of Quality Group • Integrated Performance Dashboard (IPD) • Briefing Report for Birch Ward, West Park Hospital • Trust Quality and Learning Report • Quality Priorities Quarter 3 2023/24 Progress • Quality Assurance and Improvement Programme 2024/25 for approval • CQC Improvement Plan • Progress with PSIRF • Sexual Safety Annual Statement of Compliance • Positive and Safe • Drug and Therapeutics • Complaints • Crisis Line Performance from the Care Groups • Feeling Safe Reports from the Care Groups • Impact of Short Staffing • Safe Staffing • NICHE Recommendations • Duty of Candour Performance • CQUIN • BAF • Corporate Risk Register The Committee held a confidential meeting on 7 March 2024 to: • Approve the minutes of the confidential meeting held on 1 February 2024 • Consider an SBARD report related to Birch Ward.
2a	**Alert**	The Committee alerts the Board on the following matters: **From the NYYS and DTVF Care Groups:** • Quality issues were considered related to Birch Ward. Immediate actions taken to ensure safety and additional senior leadership support provided. • Occupancy levels in AMH and PICU remain a concern, which is a potential impact on reaching quality standards and on staffing morale. • Five wards below 50% compliant for quality review audits in DTVF. • Three uses of the use of tear proof clothing, one in Bedale and two in SIS. • Three incidents of mechanical restraint (soft cuffs) in SIS. • In NYY one episode of seclusion on Ebor ward. • Deep dive commissioned by the Chief Nurse into range of restrictive practices including transferring people for the use of seclusion facilities. This will be reported in April/May 2024. • Some HMP teams continue to experience recruitment challenges with improvements expected by Quarter 2. • InPhase continues to cause short term reporting issues. Additional resources agreed at EDG to support the care groups will take at least three months to recruit to. Assurance evidenced that reporting incidents is continuing. • Crisis line call answering performance remains a concern in NYY. DTVF has introduced a 111(2) screening role which has led to some improvement.

		Other business matters: • Work underway to examine those patients who are in long term seclusion for full floor to board understanding. One gentleman is in our care who has not had access to outside space for an unacceptable period. Plans are being expedited to improve this situation. An improved experience for this gentleman and safety for both the patient and staff will be the priority. • Limited assurance linked to progress with three CQUIN measures, which remain fairly static.
2b	**Assurance**	The Committee wishes to draw the following assurances to the attention of the Board: **From the Care Groups:** The Executive Review of Quality group was able to give good assurance that risks to quality are identified, understood, reported and have mitigations in place. • No use of prone restraint in NYY. • Positive progress continues with completing the review of the historical backlog of incidents. • PSIRF is resulting in evidence of immediate actions being taken in relation to MDT after action reviews following incidents. **Other business matters:** • Reasonable assurance on the performance and controls assurance framework. Performance Improvement Plans now included in the Integrated Performance Report. Areas remain static with the area of most concern linked to the adult outcome measures. Board seminar planned in May 2024 to understand this further. • Sustained improvement in record keeping for physical health from inpatient quality reviews. • Significant progress made on delivery of the quality priorities 2023/24 for Quarter 3. All actions completed for this year. Lived Experience Directors, service users and carers to support development of next year's priorities taking a coproduction approach to ensure the Quality Priorities are relevant to the people we serve. • Substantial assurance evidenced for delivery and monitoring of clinical audit and effectiveness. • Approval given for the proposed draft Quality Assurance & Improvement Programme for 2024/25. • Reasonable assurance regarding progress with the CQC Improvement Plan. Approval given to extend three individual actions on their timescales for delivery. One of these relates to the reducing restrictive practice plan to ensure there is sufficient time for this to be co-produced and not a top-down approach. • Good assurance on the implementation of PSIRF, with a reduction in reporting of PSIIs in line with early implementers and good assurance that after action reviews are leading to early learning. The system change has landed positively with the services who are taking ownership and responsibility for their own incidents and learning. • Good assurance related to complaints with compliance for responding to complaints rising to 63%. • Good assurance from the progress report from Drug & Therapeutics including the roll out of electronic prescribing and medicines optimisation (EPMA). • Good assurance that there is a clear understanding of the progress made against each NICHE recommendation. Reasonable assurance on progress with the recommendations except for one relating to autism assessments for looked after children which is a multi-agency action for which TEWV does not lead. However, the

		Committee was made aware of communication on formal feedback from NICHE being tardy. • The annual Safer Staffing paper was discussed in detail, good assurance was taken that we have met our regulatory requirements. The recommendations were accepted in full. There was good assurance that a monthly oversight group will pay close attention to Safe Staffing in inpatient services. • Reasonable assurance on the delivery of progress with compliance to the application of the Duty of Candour requirement.
2c	**Advise**	The Committee wishes to advise on the following matters to the attention of the Board: **From the Care Groups:** • Continued focus will be given to reducing restrictive practice and specifically the use of prone restraint. A meaningful piece of work will be done with service users and staff to take this forward, with the aim of setting some timescales for eliminating prone restraint to bring TEWV in line with the progress made by others to improve safety and quality of care. • Work to be done to interrogate short term sickness and granting special leave to ensure that we are using resources effectively. • Care groups will routinely report on mixed sex accommodation breaches going forward. • Decision taken to move away from zonal care model in MHSOP Westerdale South where the same model will be used as the rest of DTVF organic wards. Decision supported by Executive Clinical Leaders. • There were 119 wards/teams who did not complete the friends and family survey. Easier and more impactful ways of capturing this important data is being considered through a QI event. **Other business matters:** • Reasonable assurance is provided from the Integrated Performance Report against a range of performance indicators. • Shifts worked over 13 hours to be explored in hot spot areas such as Overdale Ward. • An audit to consider physical health care following rapid tranquilisation will be discussed at ward report out for physical health monitoring to improve how we demonstrate our attention on patient safety. • Letters sent to Coroners with the aim of improved engagement with the offer to meet. • Organisational learning group working on triangulating the information from complaints and the SI process with the involvement of families. • Reasonable assurance that sexual safety monitoring is taking place with mitigations in place for mixed sex accommodation. No breaches with mixed sex accommodation in the previous year. Ambition to move away from mixed sex accommodation in PICU and AMH wards was noted. • The Committee were content with the risk scores and trajectories set out in the refreshed Board Assurance Framework (BAF). Some attention might be given to the trajectory for co-creation with the ambition to move from high to low. The BAF should be reviewed further to ensure that it contains up to date information only.
2d	**Review of Risks**	From the reports presented and the matters of business discussed, the Committee considered that risks are being managed effectively with more visibility of triangulating current and emerging risks linked to delivery of the quality and safety strategy. Risk about staffing levels in crisis services to be properly articulated in the BAF.

3		**Actions to be considered by the Board**	The Board is asked to note the report.
4		**Report compiled by**	Bev Reilly, Chair of the QAC, Deputy Chair of Trust/Non-Executive Director, Beverley Murphy, Chief Nurse and Donna Keeping, Corporate Governance Manager

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People, Culture and Diversity Committee: Key Issues Report		
Report Date: 14 March 2024	**Report of: People, Culture and Diversity Committee**	
Date of last meeting:20 February 2024	The meeting was quorate.	
1	**Agenda: The following agenda items were considered during the meeting:** • Colleague Story/Experience • Delivering the People Journey • Staff Networks • Pay Gaps (Gender and Ethnicity) • Health and Well-being Update • Committee Action Log - PCDC/23/40.1 (closed 22/73.4) • Corporate Risk Register • Board Assurance Framework • Integrated Performance report • Quarterly Apprenticeship Update • Freedom to Speak Up Guardian Report	
2a	**Alert** **The Corporate Risk Register** The Committee confirms limited assurance in respect of the three aligned risks due to the lack of clarity in the report as to what was 'moving the dial' in relation to the movement of risk between quarters from the information provided. Patrick Scott and Sarah Dexter-Smith to raise the issue with Beverley Murphy and relevant Executives. Whilst verbal assurance was provided at the meeting, a 'deep dive' into the 3 risks is to be provided for the next meeting. Jill Murray to write to the Chair of Audit and Risk Committee, the Chief Executive and the Chair of the Trust due to the longevity of the issue regarding the report structure not facilitating the monitoring of the movement of risks between quarters - originally escalated in February 2023. The Committee continues to highlight the need for the report to include an 'at a glance' 'RAG' rating and a clear audit trail being provided to record the risk mitigation (progress, stagnation or regress) and the reason for the changes to the risk score.	
2b	**Assurance** **The Committee can confirm assurance on the following matters:** **Integrated Performance Report** The Committee notes that: • There is an overall reasonable level of assurance based on the Performance and Controls Assurance Framework for the Board Integrated Performance Dashboard (IPD), with no major areas of concern; • The sickness rate is at 5.89%, not too dissimilar to the national mean at 5.46%. PIPs were to be produced for this at Care Group level as a Trust-wide PIP was regarded as too generic; and • PIPs were being finalised for Mandatory and Statutory training and Appraisal to be submitted to Executive Directors' Group the following week. In future they would be incorporated within the Integrated Performance Report. **Delivering the People Journey** The Committee notes that the Delivery Plan is now halfway through. To support the ongoing tracking of impact, metrics from the People Journey had been reviewed by executive People, Culture and Diversity Group for the leaver and sickness absence rates, alongside Staff Survey targets for 'recommending the Trust as a place to work' and 'feeling able to make improvements in their area of work'. The Committee notes that additional training places have been created for Positive and Safe Level 2 training and the DNA rate for Face-to-Face training has reduced from 45% to typically below 20% across courses because of rostering, preparation and protecting time for people to attend training. In addition, progress is being made on the strategic work regarding employing and hosting 16-18 year-olds on work experience in order to attract young people to the Trust.	

Positive links made on the most recent trip to Kerala resulted in 20 medical staff being appointed to the medical workforce, although it will take some time for them join and commence in substantive posts.

The Committee notes that a new system will replace Work-pal which will end on 13 March 2024 and the data will be input into ESR in the interim. Assurance is given that the new system will satisfy the requirements of the CQC and other contract requirements.

The Committee confirms good assurance in relation to the People Journey and agrees the People Standards as follows:

- target leavers' rate of 11%;
- sickness rate of 5.5%;
- 60% for recommending the Trust as a place to work; and
- 65% for feeling able to make improvements in their area of work.

Staff Networks

The Committee confirms it has good assurance that a robust process has been undertaken in running networks for staff from protected groups, listening to them and taking action to address their concerns. It notes that the networks continue to meet monthly to support 'Our Journey to Change' and the Public Sector Equality Duty, examples of their work include:

- The BAME Network has a number of International Nurses attending;
- The Armed Forces Network are planning an event at the Last Post, veterans bar and museum;
- Posturite are to commence an Access Audit at Roseberry Park Hospital;
- Most of the Networks have representatives who have volunteered to participate in videos for Health and Well-being week;
- The Menopause Café has a range of guest speakers and other sessions planned;
- Neuro-diversity Celebration Week to take place in the middle of March;
- A successful 'lunch and learn' has taken place on the topic of 'Working Carers', along with a series of roadshows, stall at the AGM and the Working Carers Network is considering applying for a 'Carers' Confident' Bronze Level Award.

Pay Gaps (Gender and Ethnicity)

The Committee notes that the Trust has been obliged to report on gender pay gaps on an annual basis since 2018, to comply with the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017. From 2024, the Trust is also expected to report on ethnicity pay gaps. There are 6 measures which the Trust is required to report on:

- Mean gender/ethnicity pay gap;
- Median gender/ethnicity pay gap;
- Mean bonus gender/ethnicity pay gap;
- Median bonus gender/ethnicity pay gap;
- The proportion of males and females or white and BAME staff receiving a bonus payment;
- The proportion of males and females or white and BAME staff in each quartile pay band; and
- Gross Pay.

The data is from a snapshot of those on full pay working on 31 March 2023 (including Bank staff).

The Committee notes that the gender profile of staff remained largely unchanged from 2017 (at 77% female and 23% male) and that the Consultant workforce was split evenly Male: Female. The overall median gender pay gap had decreased since last year from 7.56% to 5.26%. A key difference between 2023 and 2022, were changes within Band 9 and Executive roles. In 2022, females accounted for 69% of this group whereas in 2023, they accounted for 52%. Males in this banding had increased from 31% in 2022 to 48% in 2023. The Committee notes this is a smaller staff group and acknowledges that this is not reflective of the Trust population as a whole and will be monitored.

Whilst the data indicated equal numbers of males and females received Clinical Excellence Awards (CEA), overall, there were more males receiving larger monetary amounts which was evident by the mean bonus gender gap percentage. However, both the mean and median amounts of bonus pay had reduced compared with the previous year, meaning the gap was reducing. The Committee notes that

the Clinical Excellence Awards scheme is under review at a national level. Historically, once people had been given awards, they continued for the duration of an individual's career, although more recent awards had to be re-earned. In recent years, due to Covid, all eligible people had received them, although in the future they would have to apply. Accordingly, People and Culture will work with Medical Development to offer support to part time staff with their applications as part-time female employees or those with long-term health conditions applied rarely for CEA prior to Covid. Generally, pay in relation to CEA was comparable between White and BAME consultants. The impact of the review of the scheme will be monitored, and the information brought to a future meeting.

Another factor influencing pay gaps is bonus pay. A proportionate number of females and males received long service awards this year compared to the Trust demographics. This was comparable with the previous year's findings. Overall, there are relatively few staff in receipt of long service awards (118 were white and 3 were from BAME backgrounds).

An increasing number of staff are benefitting from salary sacrifice schemes, with some staff (predominantly female) having several salary sacrifices, although the number of deductions varied considerably between schemes (with leased cars having the highest level of deduction). The Committee notes that a very low percentage of the BAME workforce are accessing salary sacrifice schemes.

The number of BAME staff within the organisation is low and a high percentage of the BAME workforce in the Trust are medical. Therefore, when calculating average pay for BAME staff, data could be skewed by smaller numbers of higher paid staff. The Committee notes that there are very low levels of BAME staff within higher bands (excluding medical grades), and a need to explore the barriers (if any) to progression.

The Committee notes that the Trust restructure does not appear to have had an impact on pay gaps. Disability will be considered for the first time next year in pay gap reports. The Committee also notes that various actions are being undertaken to impact on pay gaps, including:

- Piloting the virtual interview platform (SAMMI), which aims to reduce the bias in the recruitment process;
- Sharing recruitment data with Care Group Boards;
- Creating a dedicated workforce planning role;
- Leadership development programmes are in place, with unconscious bias being included within Managers bitesize sessions;
- Inclusive recruitment, including a review of job descriptions and identifying gender bias in language used, particularly in more senior roles;
- Working differently, hybrid working and encouraging flexible working options in more roles. Trial of 9-day fortnight in one Care Group;
- Plan to deliver a second mid-career programme, for staff from protected characteristics with stretch, shadowing, and developmental opportunities;
- Undertaking further analysis of data to understand career progression in roles (lower to middle levels). This includes understanding the current roles of these staff and the areas that they work. Work with the BAME staff network to understand if there are barriers for progression in these areas; and
- Promoting the Steps Towards Employment Programme (STEP) within the local BAME communities.

The Committee confirms that it has good assurance that a robust process had been undertaken when completing the Pay Gap reports, including the proposed actions which demonstrate the Trust's commitment to equality. In addition, it agrees to the publication of Gender Pay Gap data on the Trust and government website by 30 March 2024.

Quarterly Apprenticeship Update

The Committee confirms good assurance and that the right actions are being taken to maintain the Trust's Apprenticeship workforce. Work is being undertaken to review where Apprenticeships are being offered and how the Trust can best make the maximum difference to health inequalities overall, areas of multiple deprivation and where it was hardest to recruit to specific professions. The Committee notes

	that a total of 24 Providers are involved in Apprenticeships, more than previously, covering the whole of the Trust footprint. The Committee notes the following risks and mitigations: • The Trust being unable to take on Under-18s. However, this is being addressed through strategic work regarding 16-18 year-olds, including attracting individuals to the Trust and linking with T-levels; and • HCAs being expected to complete all elements of the HCA framework within a 2-year period. However, it is taking existing learners longer than expected to complete the diploma which is causing a 'bottleneck'. This in turn is impacting on the ability of the Trust to enroll new learners. Further work is taking place with Managers and Associate Directors of Nursing to address this.
2c	**Advise** **The Committee would like to advise the Board on the following matters:** **Colleague Story** The Committee notes the excellent work of the Voluntary Services Team which supports 150-200 volunteers and services including therapy dogs, driving, delivering Covid items, and even providing a music session at Scarborough. A Volunteer attended, informing of the following: • Her experience as a volunteer for the Trust with an Adult Male Acute Ward and the Check and Chat service, following her own recovery; • That training involved completing the 60-hour training and achieving the Volunteer Passport; • How patients saw her 'Volunteer' badge and trusted her, seeing her as a 'useful light at the end of the tunnel'; • How she was led by the patients in terms of what was discussed, for example, their hobbies or what they were struggling with and how she felt that she 'bridged the gap' between patients, their family, and the medical/healthcare professionals; and • The training, protocol and contact with Karen Sidgwick, Voluntary Services Team Co-ordinator were all very supportive. The Committee notes that when MHSOP patients are well enough for discharge from the service, they can maintain contact with their 'Check and Chat' volunteer as they are both able to transfer to 'Silver Talk' with Age UK to continue regular calls, which provides reassurance. **Board Assurance Framework** The Committee identifies that the new BAF risk: *'There is a risk that some teams are unable to safely and consistently staff their services caused by factors affecting both number and skill profile of the team. This could result in an unacceptable variance in the quality of the care we provide, a negative impact on the wellbeing and morale of staff, and potential regulatory action and a lack of confidence in the standard of care'* provides more clarity, which will in turn give greater assurance. In addition, it highlights the importance of the BAF being supported by a high-quality Corporate Risk Register. The Committee comments that the work on the format of the new BAF is of excellent quality. **Committee Action Log – PCDC/23/40.1 (closed risk 22/73.4)** The Committee notes that an update on the timescales for the further work in relation to the pay and conditions of the Duty Nurse Co-ordinator role would be provided for a future meeting, as the work had been delayed due to the implementation of the Cito programme. Noted that the Trust posts are at a lower band than other Trusts, however, the role may be different and clarification is being sought. The Committee confirms that Staff-side will be involved with the work which will be taken to JCC. **Health and Well-being Update** The Committee notes the following: • The staff-led Health and Wellbeing Council is well established, looking at charitable funding streams and working in partnership to generate ideas – 45 bids were brought forward and 18 had been approved; • The work on the Better Health at Work Awards is progressing, aiming towards Gold Accreditation in October 2024. There are five campaigns as part of this:

		○ Domestic Abuse and Sexual Violence initiatives, including signing up to the Sexual Safety Charter and Action Plan. In support of this, events were taking place in Durham in late February with the Clive Ruggles Trust; ○ Alcohol and substance misuse, advise, guidance and support; ○ Advice on the Menopause; ○ Wellbeing for harder to reach staff groups such as those who were shift workers or who worked for Estates and Facilities Management; ○ Work on well-being environments across all sites to ensure people felt like they belonged; • Advice, guidance and support is being provided on Financial Resilience to staff via various routes, such as the coffee break sessions which had been well attended. Information was provided about two credit unions. In addition, Counter Fraud gave a presentation and advice to staff; • Procurement of the Occupational Health Service is progressing – this is being considered across both ICS as a scaled-up project over a 2-year period; • Greater functional alignment of the Equality, Diversity and Inclusion Team and the non-clinical elements of the Health and Well-being Team is being progressed, with a new model for health and well-being to be in place from 1 March 2024 to offer seamless support to staff. The Committee agreed that the position on vaping would be discussed with Nursing and Governance and an update be provided for a future meeting. **Freedom to Speak Up Guardian Report (FTSU)** The Committee notes that the message about the service appears to be more widely communicated as: • Case numbers are increasing; • The service has been able to obtain Independent Reviewers more easily in recent times; and • A total of 16 Ambassadors have been recruited, following 2 training events. In addition, the Committee notes the support of Senior Leaders who have been resolving issues escalated with the service, sometimes within the same day. Regular meetings with Care Group leads to capture 'lessons learnt' from such cases are to be scheduled. The Committee notes that developments in FTSU services were discussed at a recent Quality Board with no concerns raised.
2d	**Risks**	No new risks identified.
Recommendation: The Board is asked to note the contents of this report.		
3	**Any Items to be escalated to another Board Sub-Committee/Board of Directors**	Jill Murray to write to the Chair of Audit and Risk Committee, the Chief Executive and the Chair of the Trust due to the longevity of the issue regarding the Corporate Risk Register report structure not facilitating the monitoring of the movement of risks between quarters - originally escalated in February 2023.
4	**Report compiled by:** Deborah Miller, ***Corporate Governance Manager*** Jillian Murray, ***Non-Executive Director (Committee Chair)*** Sarah Dexter-Smith, ***Executive Director of People and Culture*** Minutes are available from: Deborah Miller	

DM/04/03/24

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Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**14th March 2024**
Title:	**Annual Staffing Establishment Review 2023-24**
Executive Sponsor(s):	**Beverley Murphy, Chief Nurse**
Author(s):	**Joe Bergin, Nurse Consultant Safer Staffing**

Report for:				
	Assurance	✓	***Decision***	
	Consultation		***Information***	✓

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers, and families	✓
2: To co-create a great experience for our colleagues	✓
3: To be a great partner	✓

Contribution to the delivery of the Strategic Goal(s):

In order to consistently deliver high quality safe care, we need to have establishments that meet patient need and as a Board we need to understand any risk to delivery. The annual review ensures that we understand the dependency needs of people in our care and that we understand the risks to meeting those needs. This clearly links to all strategic goals.

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
1	**Recruitment**	Inability to recruit sufficient qualified and skilled staff might jeopardise our ability to provide high quality/safe services
4	**Quality of care**	Risk to embedding improvements in the quality of care consistently and at the pace required across all services.
5	**Staff retention**	Multiple factors could contribute to staff not choosing to stay with the Trust. This will undermine the provision of safe and sustainable services as well as putting individual staff and patients at risk of harm.
8	**Quality governance**	Risk that floor to Board quality governance does not provide thorough insights into quality risks.

Executive Summary:	
Purpose:	The purpose of this report is to: i) provide assurance that an annual establishment review has been conducted in line with national regulatory requirements. ii) sight the Board on the risks to quality and recommendations being taken forward to address the risks.

Proposal:	Report to be presented to the Board of Directors for assurance and for the Board to take good assurance that we have met the national regulatory requirements. Board to note the potential impact to quality within Adult Mental Health wards and PICU presented by the reported lack in skill mix and over occupancy. Board to note the summary of issues and the recommendations made to address them.
Overview:	Daily focus by clinical and operational leaders ensures that we use all available resources to keep wards safe. In line with National Quality Board requirements, we conduct a review at least annually to assess our ability to deploy staff to provide safe and high-quality care. The outcome of the review is reported through our governance to the Board of Directors, this review is referred to as the Safer Staffing report. This 2024 report details the Trust approach to the mandated systematic review of staffing resources to ensure safe staffing levels are met according to national workforce guidelines and standards as described in the NHS Improvement 'Developing Workforce Safeguards' (NHSE/I, 2018) and the National Quality Board (NQB) guidelines (NHS, 2018). The report delivers against expectation 1 and 2 of the NQB requirements and discusses expectation 3. Engagement with clinical and operational services sought professional judgement reports from the teams regarding their staffing establishments. Professional judgement was further supported by an evidence base following the same approach determined from a QI event in 2019 which is recommended to be reviewed in 2024. **Key areas of focus include:** • **Fill rates (actual staff on duty)** - indicate a stubborn issue within adult mental health admission wards and PICUs in consistently achieving the planned number of Registered Nurses (RN) on duty. • **RN to HCA skill mix** - most inpatient services do not consistently achieve the budgeted skill mix. • **RN vacancies** - remain high in some services. • **Risk compared to previous year** - the professional Judgement RAG 2023/24 rating show 21 teams in the Red or Red Amber position, an improvement on the 33 in 2022/23. However, 9 teams remain in Red and Red/Amber across both 2022/23 and 2023/24. One ward is in the 9 teams in the red rated zone.

	• **High level of acuity/ nursing dependency** - MHOST data demonstrates high dependency specifically on acute and PICU wards. • **Trend of decreasing supportive engagement** – when considered over three years however it has been static over the past 12 months at circa 36 patients per day requiring enhanced observations. • **Care Hours Per Patient Day (CHPPD)** - when measured against peer trusts from the latest available Model Hospital inpatient data our reported CHPPD is lower than peers however, we do not include the MDT in the calculations where other Trust do. • **Bed occupancy** - is set at 85% for the threshold in national staffing establishment setting, in TEWV most adult admission wards and PICUs consistently exceed this occupancy significantly. MHSOP also exceed this threshold for several wards. • **Headroom** - a significant number of teams struggle to effectively work within their headroom requirements, the headroom at TEWV is generous. • **Temporary staffing** - a significant number of wards are exceeding the Trust thresholds for the percentage of temporary monthly staffing usage (25% for bank and 4% for agency). • **SIS, LD and Autism bed modelling** - is taking place in 2024 and may impact the establishments. • **E roster management** - is not currently efficient across all wards.
Prior Consideration and Feedback:	The review has been conducted in the clinical teams and shared with key directors. The paper was presented at the Quality Assurance Committee March 2024, was noted at the executive people and culture group and will be presented to People and Culture Committee.
Implications:	The Board Assurance Framework recognises that 'Inability to recruit and retain sufficient qualified and skilled staff might jeopardise our ability to provide high quality/safe services'. The following clinical risks are associated with inadequate nursing and care staffing capacity and capability: • Inadequate staffing numbers and skill mix may compromise effective, safe and compassionate care. • Poor monitoring of staffing capacity and capability can lead to unacceptable patterns of inadequate staffing. • If unsafe staffing levels go undetected or become accepted practice risks may not be effectively mitigated. Failure to provide required staffing could present a breach in our ability to meet the requirements of the Health and Social Care Act.

Recommendations:	Report to be presented to the Board of Directors for assurance and for the Board to take good assurance that we have met the national regulatory requirements. Board to note the potential impact to quality within Adult Mental Health wards and PICU presented by the reported lack in skill mix and over occupancy. Board to note the summary of issues and the recommendations made to address them.

1. PURPOSE:

The purpose of this report is to provide information and assurance of the clinical staffing establishments reviewed over the period September 2023 – January 2024 in line with the NQB requirements. It outlines the current Trust approach to the required systematic review of staffing resources to ensure safe staffing levels are met according to national workforce guidelines and standards as described in the NHS Improvement 'Developing Workforce Safeguards' (NHSE/I, 2018) and the National Quality Board (NQB) guidelines (NHS, 2018). This report delivers against expectation 1 and 2 of the NQB requirements and discusses expectation 3.

The aims of the annual evidence-based staffing establishment review process are to:

- Strengthen assurance and accountability for safe, sustainable, and productive staffing.
- Promote a consistent, systematic, and proactive approach to staffing decisions which supports delivery of CQC fundamental standards.
- Improve governance processes from ward to Board regarding workforce and the risks to achieving required staffing and skill mix.
- Increase staff awareness, engagement, and participation in workforce solutions.
- Support Board engagement with workforce challenges and issues.
- Ensure compliance with NHSE/I requirements.
- Improve staff welfare, morale and wellbeing.
- Support a reduction in temporary staffing usage, particularly agency staff.

The review utilises the following approaches in its methodology:

- Professional Judgement.
- The Mental Health Optimal Staffing Tool (MHOST) for Acuity/Dependency.
- Care Hours Per Patient Day (CHPPD).
- Peer group validation.
- Benchmarking and review of national guidance including Model Hospital data.
- Review of e-Rostering data.
- Review of ward-based metrics.
- Review of patient experience data.

The data set that was used to support the process is not detailed in this report, it can be provided if required. The data set includes:

- NHS Guidance and Recommendations
- Actions from March 2023 Staffing Establishment Review
- Professional Judgement Responses
- General Manager / SIDG and Care Group Reports
    - RAG Ratings for Red and Red/Amber Teams
    - Themes
    - Summary of Actions & Board Requests
- Mental Health Optimal Staffing Tool (MHOST)
    - MHOST Reliability and Validity
    - MHOST and LDOST Acuity Profiles
    - MHOST WTE Results
- Formal Observations and Engagements
- SafeCare Red Flags
- Fill Rates

- Care Hours Per Patient Day (CHPPD)
- Model Hospital Benchmarks
- Bed Occupancy
- Admissions and Discharges
- Shifts Greater Than 13 Hours
- Missed Breaks
- Headroom Requirements
- Vacancies and Recruitment and Retention Update
- Budgeted Pay vs Actual Pay Expenditure
- Flexible Staffing Expenditure
    - Agency Expenditure
- Temporary Staffing Requests, Fulfilment and Update
- Patient Experience.

The number of metrics considered and the various methodologies and ways of considering staffing data that is applied is thorough. An analysis of the outcome data was provided by the Nurse Consultant in Safer Staffing following which a summary of issues and recommendations supported by the Chief Nurse is provided.

2. KEY FINDINGS:

Service's Professional Judgement Reports. 207 clinical teams were identified for inclusion in the establishment review process which comprised of 122 community teams (62%), 27 specialist service teams (14%) and 48 inpatient teams (24%). 10 teams did not provide a final rating (DTVF – 4xAMH admission wards and 3xAMH CMHT; 1xMHSOP CMHT, 1xSIS ward; NYYS 1x AMH CMHT). Team managers completed a professional judgement report and correlated this with team specific workforce and patient related data and provided RAG rating of their team based upon the criteria shown in Table 1.

RED	RED / AMBER	AMBER	AMBER / GREEN	GREEN
Not Safe	**Partially Safe**	**Safe**	**Safe**	**Safe**
Major adjustment required	Significant adjustment required	Although moderate adjustments required	Although minor adjustments required	No changes required
Not Safe and poor quality	Partially Safe and concerns about quality	Safe and Satisfactory quality	Safe and good quality	Safe and High quality

Table 1: Professional Judgement RAG rating criteria

Following review of individual team reports General Managers compiled a service summary report and RAG rating then discussed this further within Service and Care Group governance frameworks. The summary of the final team RAG ratings from the establishment reviews are shown in Table 2.

Nov-23	RAG Rating					Grand Total
Service Setting	Red	Red Amber	Amber	Amber Green	Green	
Inpatient	0	6	27	13	2	48
Community	5	9	31	54	23	122
Urgent Care	0	1	12	5	9	27
Grand Total	**5**	**16**	**70**	**72**	**34**	**197**

Table 2: RAG ratings for Clinical Teams from General Managers / SIDG

Table 3 highlights the improved picture based upon the RAG ratings of comparing 2022 and 2023, despite some services remaining in BCP and experiencing ongoing staffing pressures. Based upon service feedback. In comparison to 2022:

- There is a shift from red and red/amber ratings for inpatient teams, going from a combined total of 33 teams in 2022 to 21 teams in this 2023 review.
- Of the teams completing the survey, **zero** inpatient teams report as Red and 6 as Red-Amber.
- Urgent care, specialist teams and community teams report a similar position with decrease in teams within the red and red/amber end of the spectrum.

RAG Rating - Comaprison 2023 and 2022										
Service Setting	Red		Red Amber		Amber		Amber Green		Green	
Year	2023	2022	2023	2022	2023	2022	2023	2022	2023	2022
Inpatient	0	3	6	2	27	41	13	7	2	2
Community	5	4	9	16	31	30	54	59	23	12
Urgent Care	0	3	1	5	12	16	5	13	9	1
Grand Total	**5**	**10**	**16**	**23**	**70**	**87**	**72**	**79**	**34**	**15**

Table 3: RAG ratings comparison for Clinical Teams - November 2023 vs November 2022

Table 4 shows that 9 teams of the 33 teams reporting Red and Red/Amber categories for 2022 remain in this category in 2023, most notably AMH Ripon CMHT remaining at Red.

CG	Spec	Setting	Team Name	2022 RAG	2023 RAG
NYYS	AMH	CMHT	AMH RIPON COMMUNITY	Red	Red
DTVF	CAMHS	CMHT	CAMHS D AND D NORTH DURHAM	Red / Amber	Red Amber
DTVF	CAMHS	CMHT	CAMHS D AND D SOUTH DURHAM	Red / Amber	Red Amber
DTVF	CAMHS	UC	CAMHS NORTH TEES NEURO ASSESSMENT	Red / Amber	Red Amber
NYYS	AMH	CMHT	AMH NYY PERINATAL	Red	Red Amber
NYYS	AMH	CMHT	AMH YORK AND SELBY MENTAL WELLBEING ACCESS TEAM	Red Amber	Red Amber
NYYS	AMH	CMHT	AMH YORK OUTREACH RECOVERY TEAM	Red Amber	Red Amber
NYYS	CAMHS	CMHT	CHILD AND YP NY AND Y CRISIS TEAM	Red	Red Amber
NYYS	MHSOP	IP	MHSOP IP MALTON SPRINGWOOD	Red Amber	Red Amber

Table 4: Red & Red/Amber teams in 2022 remaining in this category for 2023.

Board approved investments 2022 - 23

The Q2 22/23 establishment setting review presented to the Trust Board September 2022 resulted in the approval of the permitted expenditure of staffing establishments for LD and MHSOP services. The original models have been revised to further support the reduction of agency spend and meet the evolving needs of the services. MHSOP NYY&S have had final approval from the Director of Finance and Chief Nurse to proceed with the revised model.

DTV&F MHSOP are also recruiting to a revised model within the agreed expenditure, this has required some changes to the approach of zonal observations. DTV&F LD have not enacted the investment as the care and delivery model for the future are under review, the service is in a different position from the point at which the investment was agreed.

Assessment using the MHOST and LDOST

MHOST assessments are from inpatient wards during November 2023 excluded day units, wards undergoing closure, respite units, and single patient wards. 19 of the 47 considered wards were excluded from the final dataset of results; 7 wards recording less than 8 patients

during the census period, and 12 wards did not complete the required minimum 21 days of assessment.

This assessment concluded that TEWV wards are functioning at a high level of acuity and nursing dependency, this could be linked to the use of additional staffing beyond the funded establishments. The consistent over 100% occupancy rates on some wards, mostly AMH wards, will be impacting this finding. However, the data also showed that over a three-year period the use of Supportive Observations Enhanced has reduced although the data also shows that in 2023 the reduction has plateaued.

Care Hours Per Patient Day (CHPPD) and Skill Mix

CHPPD is based upon actual hours worked and is benchmarked against peer trusts within the online NHS Model Hospital. At a Trust level our skill mix shows a slightly adverse position against our regional peers. The latest available online service level data is from June 2023 which shows clearly that AMH services (which includes adult admission wards, adult rehab wards, and eating disorders) are significantly lower than other peer providers, as are Secure inpatient services but to a lesser degree than AMH. Other services are shown to sit above the peer provider median benchmark value. Model Hospital data shows a combined average for LSU and MSU. More work is needed to understand if the investment in senior nursing roles has been taken into account and also the exclusion of the wider MDT which other peer Trusts include in this calculation.

Fill Rates

The available data clearly shows that the increased fill rate of HCAs across the shift patterns are compensating for the reduced availability of RNs in some areas alongside increased acuity. This presents a risk to quality of care and clinical leadership and oversight on the ward. There is also a financial risk with the use of large numbers of health care support.

It is of interest that the HCAs may be overrepresented in formal workforce processes, and it will be important to consider if wards that do not have a good level of RN to HCA skill mix show an increased likelihood of conduct or competency issues in HCAs – this is currently unknown.

Missed breaks and extended shifts times

This metric is a useful proxy in understanding acuity. Against an approximate average of 19800 shifts each month an average 2.6% report missed breaks and 0.4% report shifts > 13 hours.

Four of the West Park wards [Maple (30), Cedar (22), Elm (19), and Willow (14)] are on average over the 5 months reviewed record the highest for the number of shifts > 13 hours. The highest number of missed breaks [Kestrel Kite (254), Overdale (198), Clover/Ivy (186), Northdale (131), and Mallard (121)] show that 13 of the top 15 are wards at Roseberry Park, and 10 of these are SIS wards.

Headroom requirements and roster performance

For the rostered wards reviewed it is clearly indicated that teams struggle to effectively meet their headroom requirements, that indicated that the operational management of how staff are deployed needs to improve. Annual leave is not being level loaded across 12 months of the year with clear indication that peak holiday times see absence beyond what is manageable. The number of staff on a working day and not being included in the number of people on shift

is beyond agreed levels which includes protected time, audit time, compassionate leave, parenting leave and so on.

Remarkably 67% of teams face difficulties in achieving headroom requirements of 27.7% for RNs, and this figure is even higher for HCAs. The monthly Safer Staffing group is considering this as a key metric and supporting operational leaders to better understand how our staffing resources are being used.

Sickness levels for clinical services (is above the Trust headroom target of 4.2% and so continues to challenge workload and availability of skilled staff. The percentage of inpatient teams each week experiencing levels of sickness absence above this threshold is currently significant and requires operational attention.

Inefficient and ineffective rostering, such as poor management of unavailability's and deployment of staff, will have a negative impact upon the ability to correctly staff the team according to patient needs and lead to a dependency on the use of flexible staffing options such as bank, agency, and overtime. Additionally, to achieve safety ward leaders, matrons and the MDT are often required to be part of the staffing numbers, which in turn can lead to a reduction in activities such as appraisals, training, and supervision.

Vacancies

The vacancy position (source finance data for December 2023) of budgeted WTEs to contracted WTEs for the clinical teams remains a clear priority. The number of RN vacancies (all service areas) has reduced 404.01 in Feb 2023 to 347.36 Dec 2023 showing a reduction across the 10-month period. This does not take into account the registered nurse Jan 2024 new starters cohort. This is most significant registered nurse vacancies are in community and AMH / PICU services.

Bed Occupancy

An average bed occupancy of 85% is the threshold used in staffing establishment setting. Beyond this point is where safety and efficiency are at risk (BMA 2022). There is an increased bed occupancy that consistently exceeds this 85% threshold for AMH most specifically the admission and PICU wards where values more than 100% are frequently seen. This will impact quality of care. Of the 59 wards the overall average bed occupancy for Jan 2023 to Dec 2023 shows as 82%, 34 (58%) wards had an average bed occupancy greater than 85%, with 28 of those 34 wards having an average occupancy of greater than 95%. The pressures show to be most significant within AMH services.

Ward Admission Rates

The number of inpatient admissions, and therefore discharges, on AMH admission wards are significantly higher than on other ward specialities. Foss Park AMH wards see an average of 24 admissions each per month with other admissions wards averaging between 12 and 18 admissions per month. The number of admissions and discharges and the increased bed occupancy and reported high dependency is a significant factor in the increased staffing demand on AMH admission wards.

Flexible/Temporary staffing expenditure

Comparing December 23 to February 2023 use of temporary staffing shows a 2.3% reduction in agency and a corresponding 1.2% increase in bank expenditure (including medical staff).

The flexible staffing costs across Jan 22 to Dec 23 totals £38M, with agency staffing costs contributing £18.2M of this total. There has been a general downward trend across nursing agency use across all inpatient services, however more notably within AMH. Extensive work by the temporary staffing team to maintain agency cost within cap and eliminating off framework agency has contributed to the reduction nursing agency expenditure as well as a reduction in vacancies.

Nursing Temporary Staffing Shift Requests

Temporary staffing (nurse bank and agency) requests saw a peak of more than 11,000 requests in July 2022 and has seen a steady reduction since then to circa 8,000 in Dec/Jan 2023/24. However, there remains a high number of individual wards exceeding the planned thresholds for the percentage of temporary staffing usage. Both care groups use more than 50% temporary HCAs on nights over the last 6 months and there is a high proportion of agency staff used for both RNs and HCAs on night shifts which is more apparent on the weekends. These figures are higher for NYY&S services.

We induct and support all temporary staffing to mitigate the risks of dependency on temporary staffing however we do need to stay focused to further reduce the reliance and the reported pattern of temporary staffing use.

SafeCare, Red Flags and Datix Reporting

Safe Care can highlight staffing and dependency issues on a shift by means of a Red Flag the use of red flags support the matron and/or duty nurse coordinator with dynamic local actions to mitigate the issue(s) are currently showing a split of 88% staff-related and 12% patient-related. Distribution of red flags shows a peak incidence of Monday (17%) and Friday (16%). There has been in reduction in the number of Datix reports and InPhase reports - it is to be noted that the change in systems may have a potential impact on this reporting.

We do need to improve how we consider Red Flags for staffing against incident data, the monthly Safer Staffing group are sighted on this priority.

Observation Levels

An average 36 (6%) patients per day require support with increased levels of observation and engagement from an average daily patient population of 648. Although there has been a reduction in the number of 1:1 observation over a three-year period, in the last 12 months the level of additional observations has remained with the range of 17 to 36 patients per day, with peaks in this type of observation noted in April and November. The use of 2:1 or 3:1 or greater has remained at static level across the past 12 months, with an additional staffing requirement to support these levels of observation ranging from 7 to 21 per day.

Patient Experience

Feeling safe is one of the Trusts key strategic priorities, this is currently monitored Trustwide by looking at the number of patients that respond "Yes, always", to the question, "during your stay on the ward, did you feel safe?". Analysis of this metric indicates that the Trust continues to fall below the required target. To better understand why patients' report that they do not always feel safe, "Feeling Safe" focus groups were established in each Care Group, identifying learning which includes, but is not limited to "staffing", "violence and aggression on the ward" and "environment". Following the completion of each focus group, learning was shared with service leads and individual Care Groups.

Further follow up visits were undertaken with improvements noted in SIS and Learning Disability services. In DTV&F a performance improvement notice was given to the Care Group and a piece of work was undertaken to identify individual actions to improve compliance, this piece of work is led by the Director of Lived Experience for the Care Group.

Recruitment and Retention
The vacancy rate and retention rate has improved across the year and 32 international nurses have passed their OSCEs and have or are moving into registered nurse posts. We will continue with the existing approach as we are seeing an improving trend.

3. SUMMARY OF ISSUES AND RECOMMENDATIONS:

a. Review inpatient staffing establishments – we have recognised that in some services improving the vacancy factor is a stubborn issue. The Chief Nurse with the Executive Director of Therapies is leading a piece of work to support our teams to consider alternative staffing models which utilise a wider mix of professionals on inpatient wards. We should take the opportunity to be innovative and look to move beyond traditional ways of considering staffing establishments and encourage thinking differently about meeting people's needs and having a stimulated workforce with a good career pathway.

b. Adult Mental Health – adult admissions and PICUs have high acuity, high levels of bank and agency usage, and extremely high staffing fill rates, high bed occupancy, high levels of admission rates, and low CHPPD values when compared to peer Trusts (via model hospital). E roster data also suggests that rota management is not efficient.

   The Urgent Care Board is bringing increasing focus to bed utilisation.

   The monthly safer staffing group will pay particular attention to the rota management of adult admission and PICU wards by supporting operational leaders to recognise risks and hot spots and to look for evidence of improvement. The aim should be to level load leave, to improve the timeliness of rotas being published and ensure that substantive registered nurses are level loaded across the working week and across 24/7. The group will report to the Executive Review of Quality and the impact of the focus can be reported to the Quality Assurance Committee as required.

   The use of enhanced observations requires additional focus.

c. Health care support workers filling registered nurse duties - The use of health care support workers to fulfil registered nurse duties is likely to have an impact on quality of care and staff experience and needs to be addressed.

   Griffiths et al (2019), whilst acknowledging the importance role health care assistants (support workers) play in maintaining safety of hospital wards, states emphatically that they cannot act as substitutes for registered staff, highlighting the potential consequences and negative impacts on patient safety. He further concludes that "the adverse consequences of RN shortages are unlikely to be remedied by increasing the numbers of lesser trained nursing staff in the workforce".

   This pattern will be a KPI considered in the monthly Safer Staffing group.

d. SIS – A 'Must Do' action from a CQC inspection in July 2023 identified that sufficient staff must be provided to enable the provision of consistent care to patients. Bed modelling work following the provider collaborative review will continue, this work should be supported via the Safe Staffing Group and will be reported through to the Quality Assurance Committee via the Executive Review of Quality as required.

e. Health Roster and Safecare – it is essential that the Safer Staffing Group engage Service Managers and General Managers to support:
   i) Embedding of SafeCare across all inpatient areas regarding compliance
   ii) Increased focus upon e-roster KPI's and efficient rostering
   iii) Continued roll out of community e-rostering.
   iv) Increased focus on data quality within the e-rostering software.

   We should also consider how we capture in health roster the use of staff not currently captured on the roster to achieve safe staffing for example the ward manager or matron working in the staffing number.

f. Unavailability of staff - this metric in each team needs urgent operational focus to ensure that we are using the available staffing resource to support high quality care and that we are being financially prudent. If we establish that our systems and processes are leading to a significant number of RNs not being available to being on duty we will need to consider what needs to change.

g. Therapies – we need to consider more closely how these staff groups are captured within CHPPPD to ensure we are comparing our performance more consistently with peer trusts.

h. Community and Urgent Care teams – consider the potential to progress the use of acuity, dependency, and complexity models for the settings to further support staffing establishments alongside other related demand and capacity modelling.

i. Teams remaining in Red / Red Amber from 2022 – further review to be completed by the end of Q1 2024 – 25 to support these teams to reduce staffing and care delivery pressures.

j. Future workforce planning - will need to give close consideration towards how best to approach the use of new and novel nursing roles. We have invested in a range of new roles such as Nursing Associates, Advanced Clinical Practitioners, Practice Development Practitioners to name a few, we need to better understand how we can best utilise this potential to support meeting patient needs and requirements.

4. RECOMMENDATIONS:

Report to be presented to the Board of Directors for assurance and for the Board to take good assurance that we have met the national regulatory requirements.

Board to note the potential impact to quality within Adult Mental Health wards and PICU presented by the reported lack in skill mix and over occupancy.

Board to note the summary of issues and the recommendations made to address them.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**14th March 2024**
Title:	**TEWV Leadership Academy**
Executive Sponsor(s):	**Brent Kilmurray**
Author(s):	**Sarah Dexter-Smith and Angela Wright**

Report for:				
	Assurance		***Decision***	
	Consultation	x	***Information***	x

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	**X**
2: To co-create a great experience for our colleagues	**X**
3: To be a great partner	**X**

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
1, 3, 4, 8	**Safe Staffing, Co-creation, Quality of Care, Quality Governance**	We are building a community with a purpose, able to deliver high quality care now and in the future. Fundamental to this is an effective and sustainable senior workforce able to lead change and innovation, nurture colleagues' development and wellbeing, and ultimately ensure the safety and quality of the care we provide, whilst attending to public resource and our impact on the inequalities in our local communities.

Executive Summary:

Purpose: The paper outlines the development of the TEWV Leadership academy, its purpose and the timelines for development and launch.

Proposal: Delivering Our Journey to Change and navigating the challenging agenda we face as a Trust is going to require us all to be able to fulfil our roles to the best of our ability, individually and collectively, including with partners and our communities. Our managers and leaders need to be in a position to create the conditions to deliver OJTC and to maximise opportunities for people in our communities with mental health, learning disabilities and autism needs. We have begun a comprehensive leadership and management programme for all colleagues in formal roles within our governance structure. The Leadership Academy (name to be confirmed) is intended to raise our offer and support to a more ambitious and transparent model, incorporating more demanding and rewarding opportunities with partners across our systems.

Overview: **Context**

Being a leader or manager in the NHS is a choice that we make and a privilege to undertake. It means that we are implicitly, if not explicitly, agreeing to deliver our strategy, live our values and do our best for our patients, families, communities and colleagues. In order to do that we need to attain a consistency of approach and understanding, so that the way we lead and manage enables colleagues to deliver the best care to

our communities and ensure our colleagues' experience of working in the Trust is a positive and fulfilling one.

The Trust also has a need to make sure that we have the skills, mindsets and attitudes in place to deliver on our agenda not just now but in the future – delivery of the kind of care that we provide is an infinite endeavour and needs a sustainable long sighted approach to its leadership and management.

Ongoing personal development is essential for managers and leaders as much as it is for clinicians and as a Trust, we have an obligation to enable and support this. We therefore need to nurture talent and develop people at all stages of their careers to ensure we can keep moving forward and have a healthy pipeline of people properly prepared and willing to pick up the most challenging roles.

The Leadership Academy

The Leadership Academy will be led through the People and Culture directorate, sponsored by the CEO, and delivered by a broad faculty each with their own specialist skills aligned to specific modules.

The Academy will be a virtual and physical place of learning. It is important that the details of the approach and content is co-created with our leadership community. As such it will link closely to the professional reference groups who, between them, cover all staff in the trust, ensuring that needs of each professional group are met and that interdisciplinary learning is effective.

Some programmes will require participants to undertake a stretch assignment, covering "wicked problems" or areas of development such as, for example only: Achieving Net Zero; Poverty Proofing our services; Developing AI in clinical services; bridging the social care provider gap; improving the physical health of our communities. Participants will work in teams and have a full 12 months to develop their plans, implement their plan and evaluate the impact.

Objectives

- To ensure that every leadership and management position is filled with a competent and confident colleague.
- To ensure that every leadership vacancy has a strong short list when advertised.
- To improve core leadership capabilities of our senior and emerging colleagues, ensuring they are able to perform their duties and lead their teams to the highest level.
- To increase all kinds of diversity in leadership positions at every levels.
- To ensure that leaders are confident in living and embedding our values and creating a positive, progressive and learning culture.
- To ensure that our leadership community can lead and engage the outside world in a positive and constructive way.

Deliverables

- A core programme of development, attended by all leaders and

managers in TEWV (foundation level)
- An advanced programme to 12-20 leaders/ managers per year, in conjunction with system partners
- A mid career programme to support those exploring options for the second part of their careers
- A transparent and accessible talent development programme ensuring flexible succession planning with clarity on expectations for each role and guidance in place for best practice in recruitment processes to senior roles
- Oversight of access to national and regional programmes where there are limited spaces or high cost (financial or time) implications
- Oversight of project and dissertation content for funded courses such as MA/MSc to ensure that time invested in leadership and management programmes supports OJTC
- 95% of participants will complete the courses and have an ongoing personal career development plan.
- 75% of participants will have successfully passed a “shortlist readiness panel” enabling them to progress to shortlist in a suitable promotion opportunity within the subsequent two years.
- Explore the option of a shadow board providing spaces for both aspirant executive and non-executive roles in conjunction with partners, ensuring the whole system benefits from the time afforded to colleagues taking part.

Prior Consideration and Feedback

The content of this paper was initially shared and then developed through the quarterly leadership and management events. It has been supported by the Value Circle and had input from Maxine Power who has developed a Leadership Academy in the NW of England. Members of the professional reference groups have been involved in designing early content and learning from our existing leadership and management development offers has contributed to the development so far. The work has already commenced in terms of delivery of year one of the core leadership and management programme to al colleagues from service management level and above in clinical, operational and corporate roles.

Implications:

There are financial implications if the Academy is to be delivered in entirety – this will be considered through the imminent business planning cycle.

If the Academy is not implemented, a core development offer will continue to be made through the Organisational Development Team. However, we will have lost a significant amount of momentum in the organisation and the opportunity to deliver a step change in transparency of opportunity and engagement of colleagues at all levels and more effective cross system development for current and future senior colleagues.

Recommendations:

The Board is recommended to approve the continued development of the Leadership Academy and to provide comment on the strategic direction and purpose as appropriate.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Trust Board**
Date:	**14 March 2024**
Title:	**Pay Gaps (Gender and Ethnicity)**
Executive Sponsor(s):	**Sarah Dexter-Smith, Director of People and Culture**
Author(s):	**Helen Cooke, EDHR Officer** **Sarah Dallal Equality, Diversity, Inclusion and Human Rights & Voluntary Services Lead.**

Report for:				
	Assurance	**x**	***Decision***	
	Consultation		***Information***	

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	**X**
2: To co-create a great experience for our colleagues	**X**
3: To be a great partner	**X**

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
1	**Safe staffing**	The following report includes both the statutory requirements of the gender pay gap reporting and pay gap reporting relating to race which is a new requirement for 2024. Pay gaps can negatively affect the retention of the NHS workforce. They can make it harder to recruit and can have a detrimental impact on staff experience when in post. The Trust is committed to understanding any pay differentials and taking appropriate action.

Executive Summary:

Purpose:

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 introduced a statutory requirement to produce information outlining details of any gender pay differences that exist within an organisation. As from April 2018 public, private and voluntary sector organisations with 250 or more employees were required to report on their gender pay gaps using six different measures.

The purpose of the report is to demonstrate adherence to the statutory requirements of the gender pay gap reporting legislation along with further context to explain any gender pay differences with a view to demonstrate our commitment to equality.

In June 2023 the Equality, Diversity and Inclusion Plan set out six targeted actions to address direct and indirect prejudice and discrimination. One of these related to pay gaps and the requirement to analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. Gender and ethnicity pay gap reporting should be in place by 2024.

Attached to this report are detailed gender and ethnicity pay gap reports. These reports include the required reporting fields, associated context and proposed actions.

Proposal:

To request confirmation that the Board has good assurance that the Trust is meeting its statutory requirements by producing data in relation to pay differences that exist within the organisation.

To recommend to the Board that they agree to the actions identified within both reports and to the publication of the gender pay information on the Trust and government website as is required.

Overview:

Reporting on gender pay differences is a statutory requirement of the Equality Act 2010. This must be completed annually, reporting on the specific measures. The proposal for good assurance that we understand and are acting on our data is based on the information in the appendices which demonstrates that that the following has been reported upon in line with national guidance:

- The mean gender pay gap
- The median gender pay gap
- The mean bonus gender pay gap
- The median bonus gender gap
- The proportion of males and females receiving a bonus payment
- The proportions of male and female in each quartile of pay

The same metrics have been produced for the Trust's first Ethnicity Pay Gap report.

Summary of key findings

Gender Pay Gap Report:

1) The median gender pay gap has decreased compared to last year
2) There is a reduction from last year in the number of females in the Band 9/Very Senior Manager Pay grades from 69% - 52%. It should be noted this is a small group of staff.
3) However, comparing data from 2017 with 2023 shows that the proportion of females in bands 8d, 9 & VSM pay and in consultant posts have had the largest increases.
4) Whilst there were equal numbers of males and females receiving Clinical Excellence Awards (CEA) overall, there were more males receiving larger monetary amounts which is evident by the mean bonus gender gap percentage. However, both the mean and median amounts of bonus pay have reduced compared with last year. It is important to note that compared to the Trust gender split, within the consultant staff group there is a more even split of male and females.
5) A proportionate number of females and males received long service awards this year compared to the Trust demographics. This is comparable with last year's findings.

Ethnicity Pay Gap Report

6) The number of BAME staff within the organisation is low (circa 8%) and a high percentage of the BAME workforce in the Trust are medical. Therefore, when calculating average pay for BAME staff, data could be skewed by smaller numbers of higher paid staff.
7) When separating non-medical & VSM pay and medical pay grades the data shows that there is a pay gap evident in both groups.
8) A very low percentage of the BAME workforce are accessing salary sacrifice schemes.
9) Generally, pay in relation to CEA is comparable between white and BAME consultants
10) Proportionally, fewer BAME staff were eligible for long service awards.
11) There are very low levels of BAME staff within higher bands, (excluding medical grades).

Prior Consideration and Feedback

This report was considered by the People, Culture and Diversity Committee on 20 February 2024. The Committee were in agreement with the proposed recommendations.

However it has been agreed that future reports will be more brief and more visual in presentation to ensure that they are more accessible to colleagues and the public.

Implications:

Failure to complete and publish the Pay Gap reports in accordance with the requirements of the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 may have regulatory consequences

Recommendations:

The purpose of the report is to demonstrate adherence to the statutory requirements of the gender pay gap reporting legislation and ethnicity pay gap reporting along with further context to demonstrate our commitment to equality.

The Board is asked to confirm that it has good assurance that a robust process has been undertaken when completing the Pay Gap reports, including the proposed actions and comment accordingly.

The Board is asked to agree to the publication of Gender Pay Gap data on the Trust and government website by 30 March 2024.

Further information

Tees, Esk and Wear Valleys NHS Foundation Trust Gender Pay Gap Report – 2023

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 introduced a statutory requirement to produce information outlining details of any gender pay differences that exist within an organisation. As from April 2018 public, private and voluntary sector organisations with 250 or more employees were required to report on their gender pay gaps using six different measures.

This is the seventh report and is based upon a snapshot date of **31st March 2023.** We are required to publish data on the Government Equalities Office website and on the Trust website by 30th March 2024 and annually going forward.

The gender pay gap shows the difference between the average (mean or median) earnings of men and women. This is expressed as percentage of men's earnings e.g., women earn 15% less than men). The gender pay gap differs from equal pay in the following way. Equal pay deals with the pay differences between men and women who carry out **the same jobs, similar jobs or work of equal value**. It is unlawful to pay people unequally because they are a man or a woman. The gender pay gap shows the differences in the average pay between men and women.

The following report includes the statutory requirements of the gender pay gap reporting legislation along with further context to demonstrate our commitment to equality. Pay gaps can negatively affect the retention of the NHS workforce. They can make it harder to recruit and can have a detrimental impact on staff experience when in post. The Trust is committed to understanding any differences identified in the gender pay report and will undertake further analysis to gain a better understanding as to the reason for the differences and to take action where appropriate.

Finally, it is important to note that analysis of pay gaps are multi-dimensional and complex. Undertaking pay gap reports helps us to identify where pay differences exist and identify actions to understand those disparities better. Reporting annually is an important step to allow us to see how our pay disparities are changing.

The gender profile of the Trust

78.0% **22.0%**

The gender profile split in the Trust has changed by 1% in the past year and since reporting commenced in 2017 it has changed minimally from 77% female and 23% male.

Please note these figures exclude bank workers. The remainder of the report includes data pertaining to substantive staff plus any bank workers who worked on 31 March 2023. This is in accordance with the Gender Pay Gap reporting requirements.

In line with gender pay gap reporting we are required to report annually on the following:

- Mean gender pay gap
- Median gender pay gap
- Mean bonus gender gap *
- Median bonus gender gap *
- The proportion of males receiving a bonus payment *
- The proportion of females receiving a bonus payment *
- Proportions of males and females in each quartile of pay band

*Under the regulation payments that would fall under the remit of bonus would include Clinical Excellence Awards for consultants and Long Service Awards.

Mean and Median Gender Pay Gap

The mean gender pay gap and median gender pay gap for **all employees** is detailed below. Gross pay calculations are used for these purposes.

In line with guidance, only staff on full pay are included in the calculations therefore staff on reduced pay for sickness, maternity or other reasons are excluded. Overtime payments are also excluded from these calculations.

Mean Gender Pay Gap

11.91% less than males - equating to £2.38 per hour less

Median Gender Pay Gap

5.26% less than males - equating to £0.91 per hour less

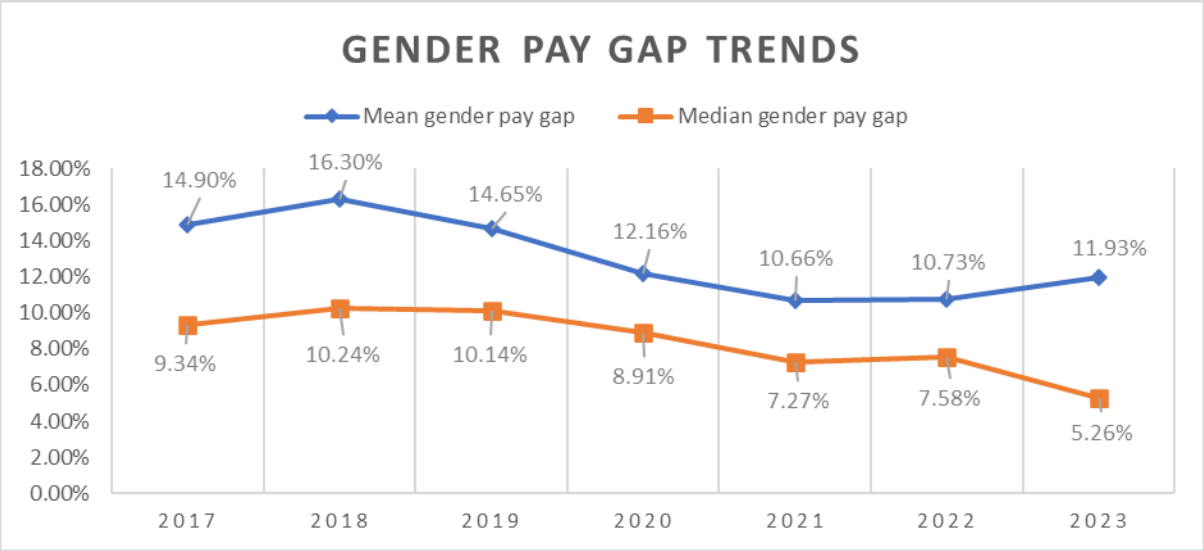
Mean	Gender	Mean Hourly Pay	Difference	Gap
Overall	Male	£20.00	£2.38	11.91%
	Female	£17.62		
Median	**Gender**	**Median Hourly Pay**	**Difference**	**Gap**
Overall	Male	£17.21	£0.91	5.26%
	Female	£16.31		

The mean gender pay gap linked to the amount a female is paid has increased in the past year from 10.73% to 11.91%. From an hourly rate perspective this equates to a mean

gender pay gap increase in the past year from £2.02 per hour to £2.38 per hour less than males.

The median gender pay gap has reduced from 7.58% to 5.26% which from an hourly rate perspective equates to a median gender pay gap change in the past year from £1.22 per hour to £0.91 per hour less than males.

The graph below highlights the mean and median gender pay gap reported figures between March 2017 and March 2023 for comparison purposes.



From a statistical point of view, the median is considered to be a more accurate measure as it is not skewed by very low or very high hourly pay. However, it can more likely that very highly paid people tend to be men and the very low paid people tend to be women. The mean provides an important picture of the pay gap as it reflects this issue. Therefore, it is good practice to use both mean and median when reporting on pay gaps.

There are number of possible contributory factors which can influence the gender pay gap differences. The Trust operates a number of **salary sacrifice schemes** which affords staff the opportunity to purchase vouchers towards childcare costs, purchase a cycle, electrical goods or a lease car.

The costs associated with salary sacrifice schemes are deducted prior to calculating gross pay. This will have an impact on the gross pay calculations undertaken to determine the mean and median gender pay gap and will be one of a number of contributory factors which may be causing the differences being reported.

The tables below summarise the number of salary sacrifice arrangements in place and costs per month. It is important to note that some staff have more than one salary sacrifice in place (some have up to 5) and that amounts of deductions can vary considerably. Each individual salary sacrifice arrangement is counted as there is a deduction against each which results in a reduction in gross salary.

Gender	Female
Row Labels	**Count of Employee Number**
Bike	72
Car Scheme	581
Childcare	80
Electronics	639
Gym	9
Travel & Leisure	8
Grand Total	**1389**

Gender	Male
Row Labels	**Count of Employee Number**
Bike	27
Car Scheme	211
Childcare	19
Electronics	151
Gym	6
Travel & Leisure	2
Grand Total	**416**

As you would expect, in line with the gender split within the organisation, the majority of staff opting to participate in one or more salary sacrifice schemes are female (accounting for 77% of the salary sacrifices). The schemes which are most popular are electronics and lease cars, the latter of which has the largest cost associated. Both of these categories have seen an increase in uptake in the past year, particularly females, with more than 100 additional deductions taking place for both of those schemes.

Agenda for Change and Executive Pay

When medical staff are removed from the calculations, the gender pay gap decreases which is common amongst NHS Trusts. The mean and median gender pay gaps for those staff employed on Agenda for Change terms and conditions and Executive Pay is detailed below.

Mean Gender Pay Gap (AfC & Executive Pay)

3.61% less than males - equating to £0.64 per hour less

Median Gender Pay Gap (AfC & Executive Pay)

4.42% less than males – equating to £0.73 per hour less.

Comparing this 2023 data with the previous year shows the mean gender pay for staff on AFC & Executive pay has increased from the previous year of 3.52% to 3.61%. The median gender pay gap has decreased from 4.56% to 4.42%.

Mean	Gender	Mean Hourly Pay	Difference	Gap
	Male	£17.62	£0.64	3.61%
	Female	£16.98		
Median	**Gender**	**Median Hourly Pay**	**Difference**	**Gap**
	Male	£16.52	£0.73	4.42%
	Female	£15.79		

Medical and Dental

The information below highlights the mean gender pay gap and median gender pay gap for those staff employed on **Medical and Dental terms and conditions**. The figures include the Clinical Excellence Awards payments that are paid to eligible medical staff. The medical workforce is a section of the workforce with a higher proportion of males.

Mean Gender Pay Gap (M&D)

7.92% less than males -
equating to £3.65 per hour less

Median Gender Pay Gap (M&D)

3.19% less than males –
equating to £1.56 per hour less

Mean	Gender	Mean Hourly Pay	Difference	Gap
Medical only	Male	£46.06	£3.65	7.92%
	Female	£42.41		
Median	**Gender**	**Median Hourly Pay**	**Difference**	**Gap**
Medical only	Male	£49.10	£1.56	3.19%
	Female	£47.54		

Compared with last year there has been a reduction in the gender pay gap within the medical workforce from both a mean and median calculation. The mean gender pay gap within the medical workforce has decreased from 10.7% in 2022 to 7.92% in 2023. The median gender pay gap has also decreased between male and females in the past year from 3.31% to 3.19%.

Bonus Payments

Under the national Medical & Dental terms and conditions Consultants are eligible to apply for Clinical Excellence Awards (CEA). These awards recognise individuals who demonstrate achievements in developing and delivering high quality patient care over and above the standard expected of their role and are part of a commitment to the continuous improvement of the NHS. The table below highlights the mean and median bonus pay linked to clinical excellence awards.

Gender	Mean Bonus Pay	Median Bonus Pay
Male	£7,463	£2,416
Female	£4.065	£2,416
Difference	£3,397	£0
Pay Gap %	45.5%	0.00%

At the time of reporting the Trust was operating a local clinical excellence award scheme based on the national terms and conditions. For the 2023 award year it was agreed locally following guidance that the same process would be followed as that which took place in 2022. This meant that the Trust could again stand down the usual formal process of application and review for CEA's. Instead, the money could be divided equally between all eligible individuals, and they received a non-consolidated and non-pensionable payment for the year. Therefore, everyone received the same amount of award for 2023.

There are also however several individuals receiving historic awards from 2017 which are recurrently paid each year. Once an award had been made the Consultant continues to receive that level of award going forward. A further submission may be made the following year and as a consequence progression through the varying payment levels occurred.

All of the Trust eligible 136 Consultants received a Clinical Excellence Award in the reporting year. Whilst there was a generally equal split of males and females receiving Clinical Excellence Awards, overall, there were more males receiving larger monetary amounts due to the national awards which is evident by the mean bonus gender gap percentage. It is important to note that compared to the Trust gender split, within this staff group there is more even split of male and females.

Comparing this year's data with 2022, both the mean and median bonus payments amounts are lower which indicates that there are less staff with very high levels of CEA awards. This is particularly demonstrated by the median results.

Long Service Awards

The Trust operates a locally agreed long service award scheme to recognise the service of staff who have 25 years NHS service. The award is a £100 gift voucher. In the reporting period a total of 122 staff received an award. **99 females (81%) and 23 males (19%)** received an award.

Under the Regulation we are required to include payments which relate to profit sharing, productivity, performance, incentive or commission should be included in the bonus calculations. It could be argued long service awards do not provide the incentive usually associated with the criteria outlined above. Guidance from ACAS states that such payments with a monetary value should be included in the bonus calculations.

Total Bonus Payments

The table below provides **combined details of the clinical excellence awards and long service awards**. These figures are very similar to last years.

Gender	Mean Bonus Pay	Median Bonus Pay
Male	£5,602	£2,416
Female	£1,715	£100
Difference	£3,887	£2,316
Pay Gap %	69.4%	95.7%

It is important to recognise when combining the bonus awards in this way the data is skewed as long service awards are predominantly paid to women, with a higher proportion of males receiving clinical excellence award payments. These payments are also not prorated.

Overall percentage of males and females receiving bonus payments

2.4 %

4.9%

The guidance requires us to calculate the percentage of males and females who have received a bonus as a percentage of all employed males and females (not just those on full pay which other aspects of the gender reporting require us to do).

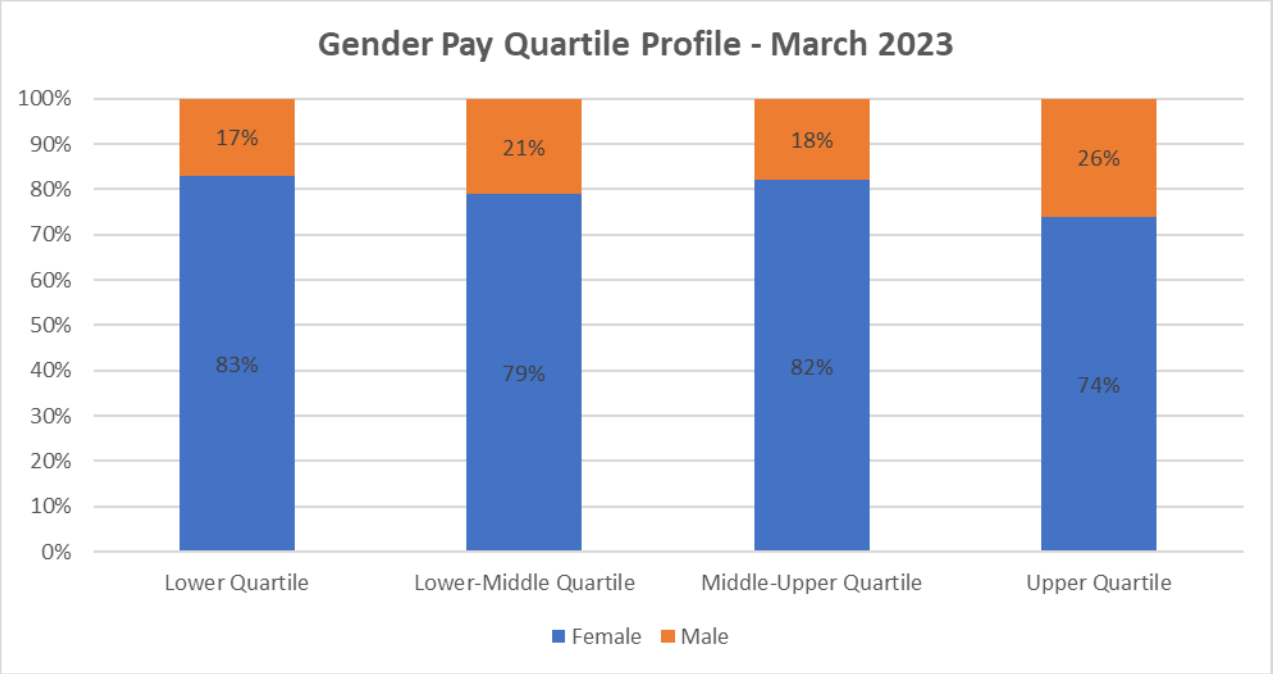
In total 167 females received a CEA and or long service award and 91 males received a CEA and / or Long Service award. The key difference in percentage is linked with more males receiving CEA.

Gender Pay Quartile Profile

The following graph shows the proportion of males and females in each pay quartile. The lower quartile represents the lowest salaries in the Trust and the upper quartile represents the highest salaries. The Trust employs more women than men in every quartile.

The middle-upper quartile in 2023 has shown an increase in the proportion of females within that quartile from 79% to 82%.

The remaining quartiles have remained broadly the same.



Gender Breakdown by Pay Band

The three graphs below provide a comparison of the Trusts gender profile breakdown by pay band as at March 2023, 2022, and March 2017 when reporting commenced.

The key change between 2023 and 2022 are changes within Band 9 and Executive roles. In 2022, females accounted for 69% of this group whereas in 2023 they account for 52%. Males in this banding have increased from 31% in 2022 to 48% in 2023.

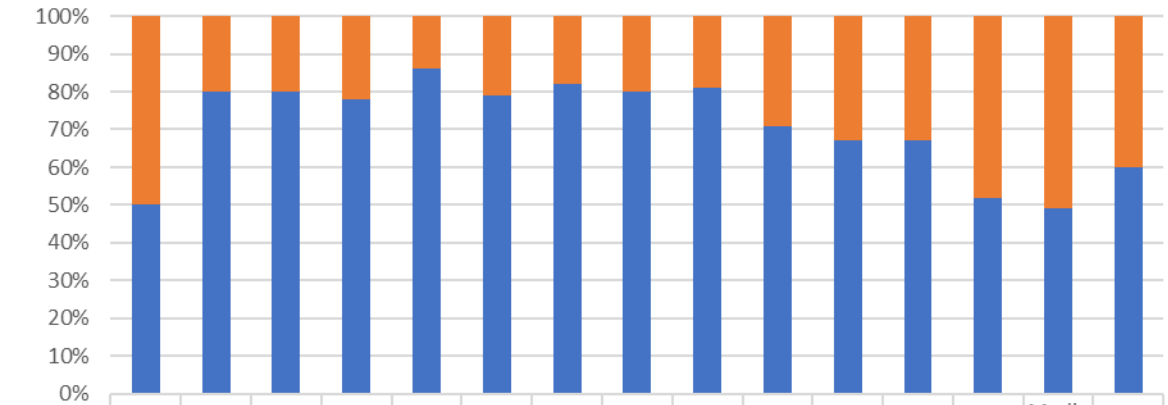
Comparing data from 2017 with 2023 shows that the proportion of females in bands 8d, 9 & Executive pay and in consultant posts have had the largest increases. Females in 8d posts have increased from 57% to 67% between 2017 – 2023. Band 9 and executive pay grades have seen an increase in females from 43% to 69% in 2022, this has then reduced in 2023 to 52%.

The female consultant workforce has increased from 42% in 2017, to 47% to then 49% in 2023.

Females in other medical grades have seen a fluctuation, starting at 62% of the other medical grades in 2017, females made up 65% in 2022 and this has reduced to 60% in 2023.

Band 1 was closed to new entrants from 1 December 2018, therefore the number of overall staff in this banding will continue to reduce.

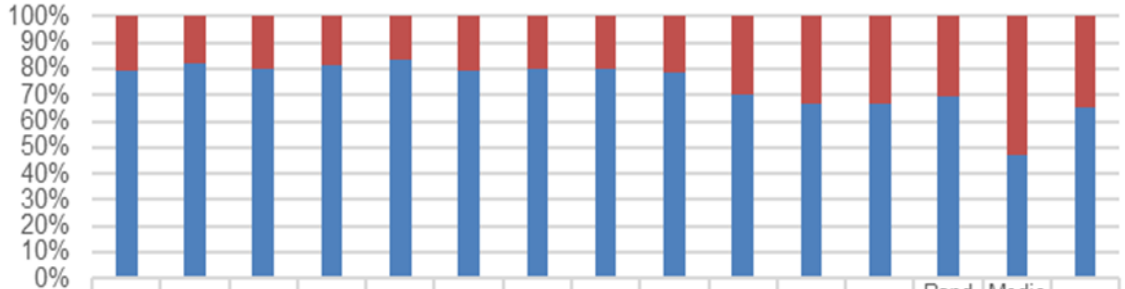
Gender Breakdown by Pay band - March 2023



	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9 & Execs	Medical Consultant	Other Medical
Male	50%	20%	20%	22%	14%	21%	18%	20%	19%	29%	33%	33%	48%	51%	40%
Female	50%	80%	80%	78%	86%	79%	82%	80%	81%	71%	67%	67%	52%	49%	60%

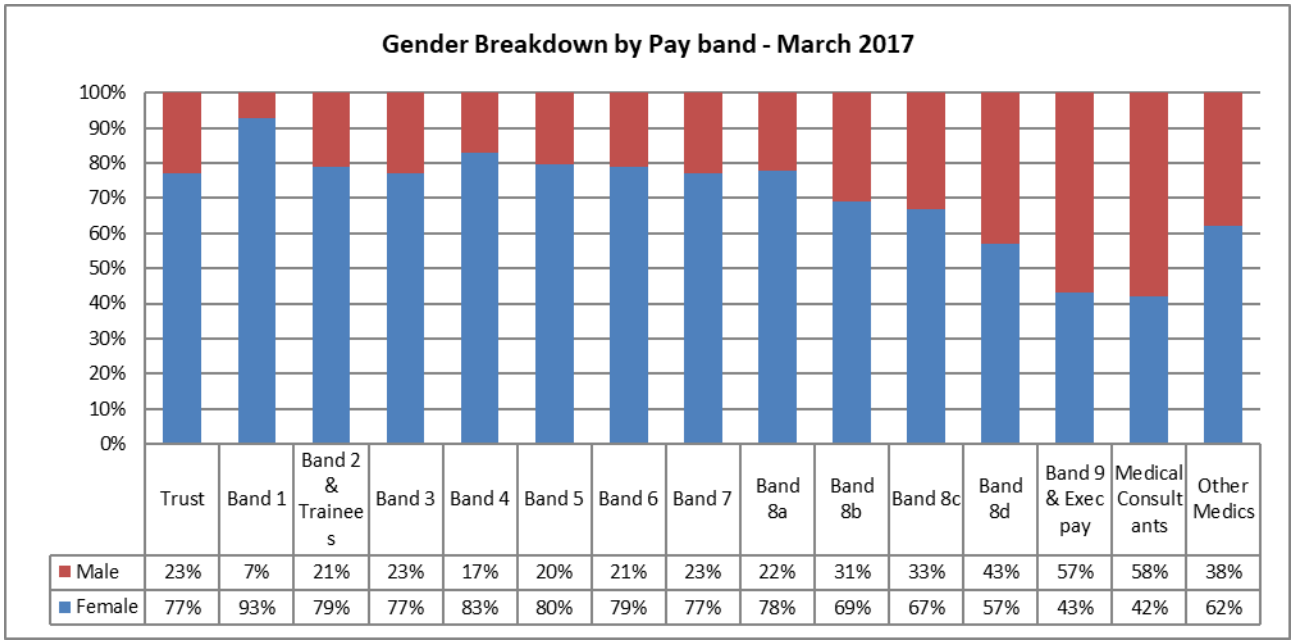
Female Male

Gender Breakdown by Pay band - March 2022



	Total	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9 & Exec pay	Medical Consultant	Other medics
Male	21%	18%	20%	19%	16%	21%	20%	20%	21%	30%	33%	33%	31%	53%	35%
Female	79%	82%	80%	81%	84%	79%	80%	80%	79%	70%	67%	67%	69%	47%	65%

Female Male



	Trust	Band 1	Band 2 & Trainees	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9 & Exec pay	Medical Consultants	Other Medics
Male	23%	7%	21%	23%	17%	20%	21%	23%	22%	31%	33%	43%	57%	58%	38%
Female	77%	93%	79%	77%	83%	80%	79%	77%	78%	69%	67%	57%	43%	42%	62%

Key Findings:

- The overall median gender pay gap has decreased since last year from 7.56% to 5.26%
- There has been a decrease in the median gender pay gap for both staff in AFC and Executive pay grades and in the median pay gap within the medical workforce when analysed separately.
- There is an increasing number of staff benefitting from salary sacrifice schemes, some staff have numerous salary sacrifices and the amount of deductions can vary considerably between schemes i.e. lease car will have the highest level of deduction.
- Comparing gender of staff by pay band, the key change between 2023 and 2022 are changes within Band 9 and Executive roles. In 2022, females accounted for 69% of this group whereas in 2023 they account for 52%. Males in this banding have increased from 31% in 2022 to 48% in 2023. It should be noted this is smaller staff group but notable that this is not reflective of the Trust population and therefore propose that the Trust will continue to review how this changes in future years.
- Comparing data from 2017 with 2023 shows that the proportion of females in bands 8d, 9 & Executive pay and in consultant posts have had the largest increases. Again, these are smaller groups of staff but the Trust will continue to monitor this.
- Whilst there were equal numbers of males and females receiving clinical excellence awards, overall, there were more males receiving larger monetary amounts which is evident by the mean bonus gender gap percentage. However, both the mean and median amounts of bonus pay have reduced compared with last year, meaning the gap is reducing. It is important to note that compared to the Trust gender split, within this staff group there is more even split of male and females compared to previous years which means that equal amounts of females and males can be considered for clinical excellence awards.
- A proportionate amount of females and males received long service awards this year compared to the Trust demographics. This is comparable with last years findings.

Update on Progress from Gender Pay Report 2022

Last year it was proposed that further work was undertaken to understand the Trusts data relating to its pay gaps in more detail. This included carrying out a pay gap analysis by ethnicity which has been undertaken and a separate report produced.

A comparison of gender by grade has been undertaken to understand if the management restructure which took place in 2022 has had a significant impact on the gender split. Based on the graphs immediately above there are no significant changes apparent however there is an increased percentage of females in Band 8d, 9 and Executive pay bands.

A more detailed review of the Clinical Excellence Awards showed that whilst there is an even gender split between our eligible consultants in receipt of CEA, it is apparent that more male consultants have higher levels of awards than females. It also appears that there is a reduction in the number of consultants with national awards which is likely to linked to staff retiring which has impacted on the median percentage relating to CEA. During the pandemic, a temporary arrangement was agreed whereby all eligible consultants received a CEA without having to go through an application process. The awards were therefore spread across the consultant workforce. This year consultants will revert back to applying for awards so this may have an impact to consider in next year's report. In addition, the CEA scheme is due for a review nationally therefore how CEA are processed and impact on the pay gap in future may change.

Reviewing the salary sacrifice data in more detail has shown that there is a high number of staff accessing salary sacrifice schemes (1443), with 77% being attributed to females and the amounts deducted impacting on gross salaries. A number of staff have more than one salary sacrifice deduction (some up to 5) all of which impact on gross salary calculations. The number of staff accessing salary sacrifices has increased compared with last year.

Current Trust actions that impact on Pay Gaps:

- Piloting the virtual interview platform (SAMMI), which aims to reduce the bias in the recruitment process.
- Continue to produce and share information with Care Boards regarding recruitment statistics.
- Dedicated workforce planning role
- Leadership development programmes in place, unconscious bias is included within Managers bitesize sessions.
- Inclusive recruitment, including a review of job descriptions and identifying gender bias in language used, particularly in more senior roles.
- Working differently, hybrid working and encouraging flexible working options in more roles. Trialling 9-day fortnight in one of the Care Groups.
- Shared parental leave.

Proposed Areas for Further Action:

1) To review the findings from the Ethnicity pay gap analysis and potentially explore other protected characteristics in future.

2) Dependent on the future of the Clinical Excellence Awards scheme, link with the Trusts Medical Development team to ensure females and staff working parttime are supported to apply for CEA.

3) Consider undertaking an analysis of leavers by gender and their respective point on the scale comparing this with new starters by gender and their point on scale by key job roles. This may provide more understanding around the percentage of female leavers and joiners and their average hourly rates

Tees, Esk and Wear Valleys NHS Foundation Trust Ethnicity Pay Gap Report – 2023

In June 2023 the Equality, Diversity and Inclusion Plan set out six targeted actions to address direct and indirect prejudice and discrimination, that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce. High Impact action 3 requires us to develop and implement an improvement plan to eliminate pay gaps.

We are required to analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards. Plans should be in place for sex and race by 2024, disability by 2025 and other protected characteristics by 2026. The Trust already report on gender pay gaps.

A pay gap is the difference between the average hourly pay of employees in one group in comparison to another group. For example, women in comparison to men or LGBTQ+ in comparison to heterosexual.

This is different to equal pay. Equal pay is a person being paid the same for the same role and it is unlawful to pay someone differently for doing the same job based on a protected characteristic.

The Trust is committed to understanding any differences identified in the ethnicity pay report and will undertake further analysis to gain a better understanding as to the reason for the differences and to take action where appropriate. Pay gaps can negatively affect the retention of the NHS workforce. They can make it harder to recruit and can have a detrimental impact on staff experience when in post.

This is our first ethnicity pay gap report. We have analysed information using the categories: White, Not Stated (which includes not known) and BAME. BAME is all other ethnic minority groups combined. At this stage we have not broken down BAME any further due to the small numbers in each category and recommendations are that there should be at least 50 staff in each group to ensure statistical robustness.

Guidance on ethnicity pay gaps has been produced in May 2023 with recommendations as to what metrics organisations can consider using to measure their ethnicity pay gap. We have applied the calculations and analysis methods used in Gender Pay Gap reporting.

It is recommended that we review the mean and median ethnicity pay gaps, mean and median bonus gaps and proportions of ethnicities in each quartile of pay bands.

Under the regulations, payments that would fall under the remit of a bonus includes Clinical Excellence Awards for consultants and Long Service Awards.

Finally, it is important to note that analysis of pay gaps are multi-dimensional and complex. Undertaking pay gap reports helps us to identify where pay differences exist and identify actions to understand those disparities better. Reporting annually is an important step to allow us to see how our pay disparities are changing.

The ethnicity profile of the Trust

Ethnicity	Percentage
BAME	8.3%
Not Stated	2%
White	89.7%

Please note these figures exclude bank workers. The remainder of the report includes data pertaining to substantive staff plus any bank workers who worked on 31 March 2023.

Mean and Median Ethnicity Pay Gap

The mean ethnicity pay gap and median ethnicity pay gap for **all employees** is detailed below. Gross pay calculations are used for these purposes. This includes enhancements, clinical excellence awards and long service awards. Overtime payments are excluded from these calculations.

In line with guidance, only staff on full pay are included in the calculations therefore staff on reduced pay for sickness, maternity or other reasons are excluded. Staff who did not state their ethnicity or are classified as unknown are not included within these figures.

Mean	Ethnicity	Mean Hourly Pay	Difference	Gap
Overall	White	£17.82	-£4.27	-23.97%
	BAME	£22.09		
Non-medical & exec	White	£17.17	£1.08	6.27%
	BAME	£16.09		
Medical only	White	£46.95	£4.65	9.91%
	BAME	£42.30		

The overall figure suggests that there is not an ethnicity pay gap between white and BAME staff overall and that BAME staff are paid higher than white staff.

However, by breaking down the pay gap to non-medical and executive pay and medical separately it can be seen that there is an ethnicity pay gap evident. The reason for this difference is that overall, we have a low number of BAME staff employed compared to white staff. This impacts on the average hourly pay of that group of staff compared with the average hourly rates of the much larger white workforce in each grade. For example, in Band 2, there are 14 BAME staff and 450 white staff.

Also, our BAME workforce has a significantly higher proportion of medics within it which results in a higher average hourly rate. 16.5% of the BAME workforce are medics compared with 1.6% of the white workforce.

The overall median ethnicity pay gap table below also appears to demonstrate that there is not an ethnicity pay gap between white and BAME staff for the same reasons. Therefore, it is helpful to view a breakdown by non-medical and executive pay and medical which identifies that a pay gap exists.

Median	Ethnicity	Median Hourly Pay	Difference	Gap
Overall	White	£16.58	-£0.66	-3.99%
	BAME	£17.24		
Non-medical & exec	White	£16.12	£1.64	10.18%
	BAME	£14.48		
Medical only	White	£49.10	£3.43	6.99%
	BAME	£45.67		

In addition to the proportion of BAME staff employed by the Trust, there are other possible contributory factors which can influence the pay gap differences. The Trust operates a number of **salary sacrifice schemes** which affords staff the opportunity to purchase vouchers towards childcare costs, purchase a cycle, electrical goods or a lease car.

The costs associated with salary sacrifice schemes are deducted prior to calculating gross pay. This will have an impact on the gross pay calculations undertaken to determine the mean and median gender pay gap and will be one of a number of contributory factors which may be causing the differences being reported.

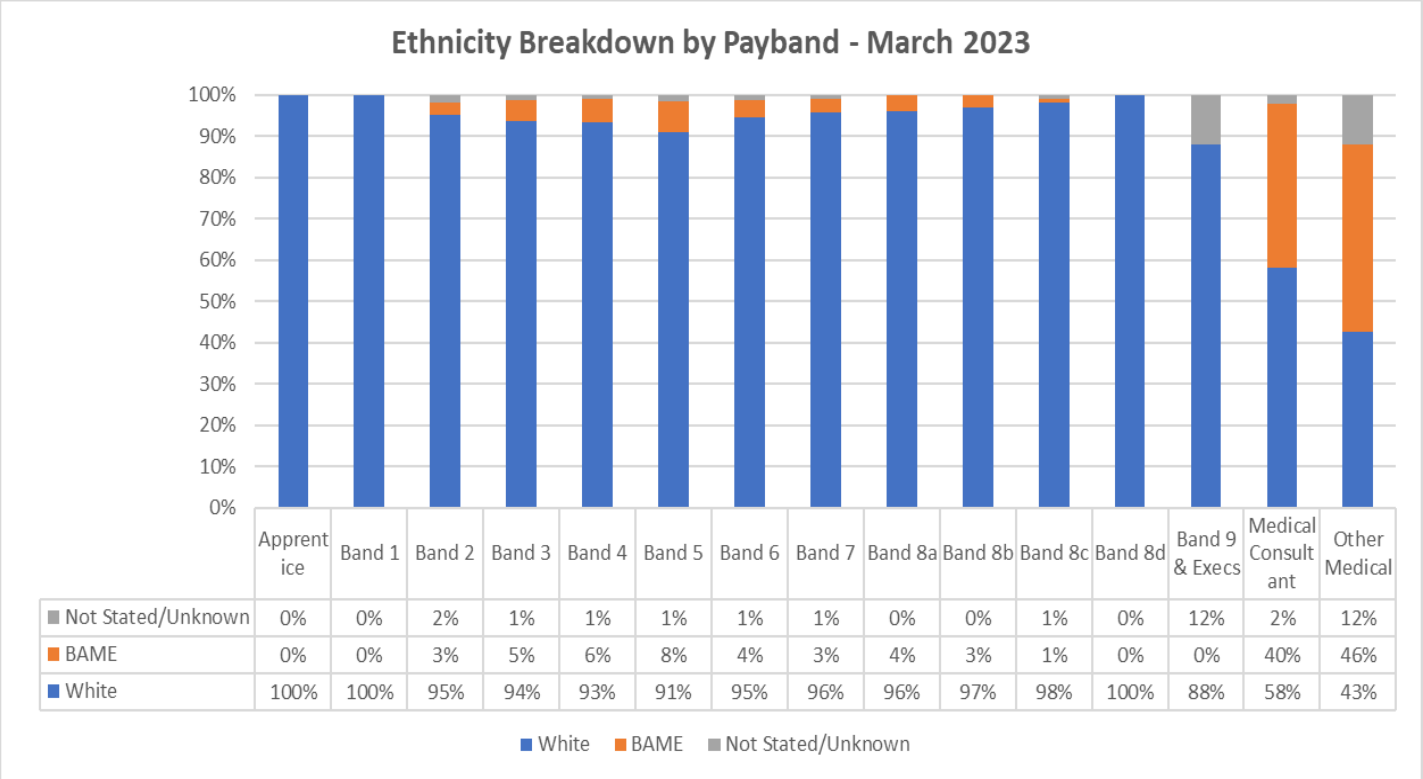
The numbers of BAME staff who have salary sacrifice deductions is low, with 77 staff accessing this benefit compared with 1714 white staff. BAME staff accessing the scheme equates to 4.3% of all salary sacrifices within the Trust and 11.6 % of the BAME workforce. 21% of the white workforce are accessing salary sacrifices. Therefore, lower numbers of BAME staff are experiencing a reduction in their gross salary compared with white staff.

A breakdown by type of salary sacrifice for BAME staff has not been provided due to staff being potentially identifiable due to the low numbers involved.

Ethnicity Breakdown by Pay Band

The following graph provides a breakdown of ethnicity by pay band. It is clear that largest numbers of our BAME workforce are within the medical workforce.

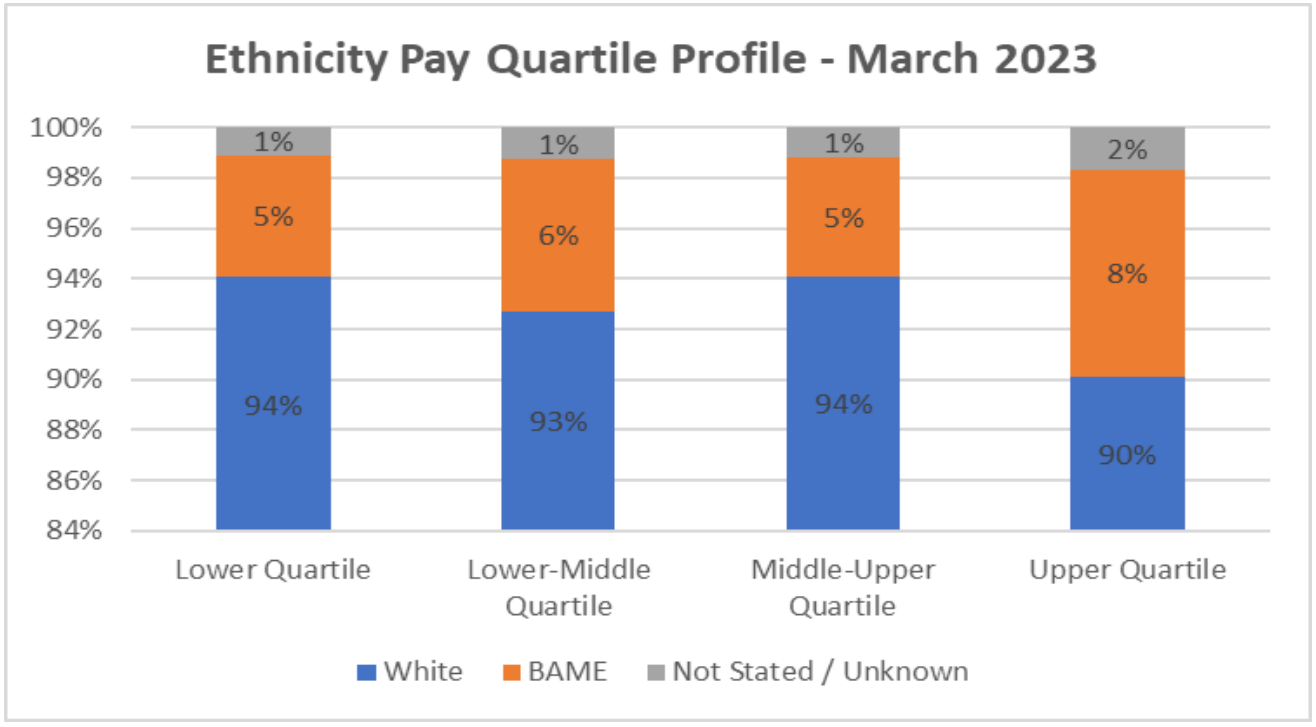
Band 1 was closed to new entrants from 1 December 2018, therefore the number of overall staff in this banding will continue to reduce**.**



	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9 & Execs	Medical Consultant	Other Medical
Not Stated/Unknown	0%	0%	2%	1%	1%	1%	1%	1%	0%	0%	1%	0%	12%	2%	12%
BAME	0%	0%	3%	5%	6%	8%	4%	3%	4%	3%	1%	0%	0%	40%	46%
White	100%	100%	95%	94%	93%	91%	95%	96%	96%	97%	98%	100%	88%	58%	43%

Ethnicity Pay Quartile Profile

The following graph shows the proportion of staff by ethnicity in each pay quartile. The lower quartile represents the lowest salaries in the Trust and the upper quartile represents the highest salaries. The Trust employs more white staff than BAME staff in every quartile. Reflecting that a large proportion of our BAME workforce are medics, the highest percentage of BAME staff are within the upper quartile.



Bonus Payments

Under the national Medical & Dental terms and conditions Consultants are eligible to apply for Clinical Excellence Awards (CEA). These awards recognise individuals who demonstrate achievements in developing and delivering high quality patient care over and above the standard expected of their role and are part of a commitment to the continuous improvement of the NHS. The table below highlights the mean and median bonus pay linked to clinical excellence awards.

Ethnicity	Mean Bonus Pay	Median Bonus Pay
White	£5,752	£2,416
BAME	£6,035	£2,416
Difference	-£283	£0
Pay Gap %	-4.92%	0.00%

At the time of reporting the Trust was operating a local clinical excellence award scheme based on the national terms and conditions. For the 2023 award year it was agreed locally following guidance that the same process would be followed as that which took place in 2022. This meant that the Trust could again stand down the usual formal process of application and review for CEA's. Instead, the money could be divided equally between all eligible individuals, and they received a non-consolidated and non-pensionable payment for the year. Therefore, everyone received the same amount of award for 2023.

There are also however several individuals receiving historic awards from 2017 which are recurrently paid each year. Once an award had been made the Consultant continues to receive that level of award going forward. A further submission may be made the following year and as a consequence progression through the varying payment levels can occur.

All the Trust eligible 136 Consultants received a Clinical Excellence Award in the reporting year. 79 were white (58%), 52 were from BAME backgrounds (38%) and 4 had not stated / unknown ethnic origins (4%).

The data suggests that white consultants are paid marginally less CEA amounts compared with BAME consultants. However, due to the small number of staff receiving these payments, one or 2 staff with high or low CEA levels can have a significant impact on the overall averages, as the median bonus pay for BAME and white consultants is the same.

Long Service Awards

The Trust operates a locally agreed long service award scheme to recognise the service of staff who have 25 years NHS service. The award is a £100 gift voucher. In the reporting period a total of 122 staff received an award. Of which 118 were White (96.7%), 3 were from a BAME background (2.5%) and 1 had not stated their ethnicity (0.8%). The the number of BAME staff receiving a long service award is disproportionately low compared with the 8% of the Trust workforce that the BAME workforce make up.

Under the Regulation we are required to include payments which relate to profit sharing, productivity, performance, incentive, or commission should be included in the bonus calculations. It could be argued long service awards do not provide the incentive usually associated with the criteria outlined above. Guidance from ACAS states that such payments with a monetary value should be included in the bonus calculations.

Total Bonus Payments

The table below provides **combined details of the clinical excellence awards and long service awards**. It should be noted that the numbers of BAME staff involved in these calculations is very low and overall, as a proportion of the workforce, the numbers of staff receiving bonus's as per these guidelines is very small. These payments are also not prorated.

When combining CEA and long service awards, this data suggests that BAME staff receive higher pay than white staff in relation to bonus.

Ethnicity	Mean Bonus Pay	Median Bonus Pay
White	£2,367	£100
BAME	£5,777	£2,416
Difference	£3,411	£2,316
Pay Gap %	-144%	-2316%

Overall percentage of receiving bonus payments

The guidance requires us to calculate the percentage of white and BAME staff who have received a bonus as a percentage of all employed white and BAME staff (not just those on full pay which other aspects of the reporting require us to do).

8.3% of BAME staff received a bonus in 2023.
2.4% of white staff received a bonus in 2023.

The difference in percentages will be linked to the proportion of the BAME workforce which are medical and are therefore eligible for clinical excellence awards.

Key Findings:

1) The number of BAME staff within the organisation is low and a high percentage of the BAME workforce in the Trust are medical. Therefore, when calculating average pay for BAME staff, data could be skewed by smaller numbers of higher paid staff.
2) When separating non-medical & executive pay and medical pay grades the data shows that there is a pay gap evident in both groups.
3) A very low percentage of the BAME workforce are accessing salary sacrifice schemes.
4) Generally, pay in relation to CEA is comparable between white and BAME consultants.
5) Proportionally, fewer BAME staff were eligible for long service awards.
6) Very low levels of BAME staff within higher bands, (excluding medical grades).

The Model Employer trajectories set aspirational goals for each organisation to increase BAME representation at leadership levels, currently the Trust has lower levels of BAME representation at bands 8c, 8d and 9.

WRES data for 2023 showed that white staff are more 1.83 times likely to be appointed than BAME staff, this is worse position that reported in previous year. Staff survey findings show that BAME staff are more likely to believe the trust provides equal opportunities for career progression or promotion.

Specific actions in place to improve this and impact on the pay gap include:

- Deliver a second mid-career programme, for staff from protected characteristics which will include stretch/shadowing/developmental opportunities.
- Undertake further analysis of data to understand the data on career progression in roles (lower to middle levels). This includes understanding the current roles of these staff and the areas that they work. Work with the BAME staff network to understand if there are barriers for progression in these areas.
- Piloting the virtual interview platform (SAMMI), which aims to reduce the bias in the recruitment process.
- Promote the Steps Towards Employment Programme (STEP) within the local BAME communities.

Proposed Areas for Further Action:

4) To scope out the feasibility in future of breaking BAME categories down even further to understand any pay gaps between ethnicities. This may not be possible due to the very low number of staff in each category.

5) To explore the reasons for low numbers of BAME staff being eligible for long service awards and if this is linked with retention of our BAME workforce in the NHS and associated reasons.

6) Explore if any reasons for the lower numbers of BAME staff in certain pay grades within the Trust. Potentially exploring the progression from lower bands to middle bands and identifying any themes / barriers.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of: **Board of Directors**

Date: **14 March 2024**

Title: **Constitutional Change**

Executive Sponsor(s): **-**

Report Author: **Phil Bellas, Company Secretary**

Report for:	***Assurance***		***Decision***	✓
	Consultation		***Information***	

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	✓
2: To co-create a great experience for our colleagues	✓
3: To be a great partner	✓

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
10	Regulatory Compliance	The Trust must have a legally binding Constitution in accordance with para. 1 (1) of the NHS Act 2006 (as amended).

Executive Summary:

Purpose: The purpose of this report is to seek the approval of proposed amendments to the Trust's Constitution

Proposal: The Board is asked:

(1) To approve the changes to the Constitution highlighted in Annex 1 to this report.

(2) Recommend the approval of the changes to the Council of Governors.

Overview: The Trust must have a legally binding Constitution in accordance with para. 1 (1) of the NHS Act 2006 (as amended).

A review of the Constitution has been undertaken, the aims of which have been:

1. To reflect the changes introduced by the Health and Social Care Act 2022 particularly those relating to integration, the triple aim and the structural changes to the NHS.
2. To respond to changes in the external environment e.g. the local government reorganisation in North Yorkshire.
3. To learn from experience.
4. To future proof the Constitution.
5. To generally update the Constitution following changes within the Trust over the last few years.

A copy of the Constitution, with the proposed changes highlighted, is attached as Annex 1 to this report.

Board Members will note the proposal to remove the schedule of reservation of powers and scheme of delegation from the Constitution. It is intended that these provisions should be included in a separate document (as a means of future proofing the Constitution) which will be presented to the Board for approval in due course.

Any changes to the Constitution must be approved by both the Board and the Council of Governors. If the Board is content with the proposed changes it is asked to recommend the amendments to the Council for approval at its meeting to be held on 19th March 2024.

Prior Consideration and Feedback

Informal discussions were held with the Chair, the Senior Independent Director, the Lead Governor and Mr Emerson and Mr Combs, Public Governors, to gain feedback on initial thinking and options, particularly in regard to the public constituencies, the composition of the Council and learning from over the last two years.

A Governor Development Event was held on 15th February 2024 to discuss the proposed changes to the Constitution. The issues raised at the meeting and subsequently, together with responses, are provided in Annex 2 to this report.

Implications:

None relating to this report.

Recommendations:

The Board is asked to:

(1) Approve the amendments set out in Annex1 to this report.

(2) Recommend the amendments to the Council of Governors for approval.

Annex 1

Tees Esk and Wear Valleys NHS Foundation Trust Constitution

May 2022

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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1 Interpretation and definitions

1.1 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this Constitution shall bear the same meaning as in the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and the Health and Social Care Act 2022..

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

1.3 The 2006 Act is the National Health Service Act 2006 (as amended).

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

1.5 The 2022 Act is the Health and Social Care Act 2022.

1.65 The Annual Members' Meeting is defined in paragraph 10 of the Constitution.

1.76 Constitution means this Constitution and all annexes to it.

~~1.7 **Monitor** is the corporate body known as Monitor, as provided by Section 61 of the 2012 Act.~~

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

1.9 In this Constitution:

"Board of Directors" means the Board of Directors of Tees, Esk and Wear Valleys NHS Foundation Trust established in accordance with paragraph 15 of schedule 7 of the 2006 Act.

"Director" means a person whose name is included in the register of directors of Tees, Esk and Wear Valleys NHS Foundation Trust.

"Governor" means a person whose name is included in the register of governors of Tees, Esk and Wear Valleys NHS Foundation Trust.

"Chair" means one of the non-executive Directors appointed by the Council of Governors as the "Chairman" of Tees, Esk and Wear Valleys NHS Foundation Trust as required by paragraph 16(1)(b) of schedule 7 of the 2006 Act.

"Company Secretary" means an officer appointed by the Board of Directors as the principal advisor to the Board of Directors and Council of Governors on compliance with the law, regulation and constitutional matters.

"Deputy Chair" means one of the non-executive Directors appointed by the Council of Governors to discharge the duties of the Chair on occasions when the Chair is absent or incapacitated.

"Finance Director" means a Director who is a CCAB-qualified accountant and whose appointment is required under paragraph 16(1)(a) of schedule 7 of the 2006 Act.

~~"Trust Company Secretary" means an officer appointed by the Board of Directors as the principal advisor to the Board of Directors and Council of Governors on compliance with law, regulation and standing orders.~~

Integrated Care Board means a body established by NHS England under section 19 of the 2022 Act.

"Member" means a person whose name is included in the register of members of Tees, Esk and Wear Valleys NHS Foundation Trust.

"NHS England" means an executive non-departmental public body of the Department of Health and Social Care, formerly known as the NHS Commissioning Board, established under the 2012 2012.

"Secretary of State" means the Secretary of State for Health and Social Care~~.~~

"Annual Report" means a document prepared in accordance with paragraph 26 of schedule 7 of the 2006 Act.

"Forward Plan" means a document prepared in accordance with paragraph 27 of schedule 7 of the 2006 Act.

"Annual Accounts" means the financial accounts prepared accordance with paragraph 25 of schedule 7 of the 2006 Act.

"Subsidiary" ~~has the same meaning as in s.1159 of the Companies Act 2006 and not being a Trust Trading Vehicle.~~ means a separate, distinct legal entity for the purposes of taxation, regulation and liability owned or partly owned by the Trust. 'Subsidiary' includes companies limited by shares or companies limited by guarantee, limited liability partnerships and community interest companies. Joint ventures also fall within the definition.

~~"Trust Trading Vehicle" means a body, not being a company limited by shares or guarantee, established to carry on a trading initiative on behalf of the Trust including but not limited to:~~
~~- limited liability partnership;~~
~~- joint venture; or~~

~~- collaboration~~
~~but excluding a Subsidiary.~~

2 Name

The name of the Foundation Trust is Tees, Esk and Wear Valleys NHS Foundation Trust (hereinafter known as the Trust).

3 Principal purpose

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

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

3.3 The Trust may provide goods and services for any purposes related to:

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

3.3.2 the promotion and protection of public health.

3.4 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 to better carry on its principal purpose.

4 Powers

4.1 The powers of the Trust are set out in the 2006 Act (as amended~~) by the 2012 Act)~~.

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

4.3 Subject to paragraph 4.4 below, any of these powers may be delegated to a committee of Directors or an executive Director.

4.4 Where the Trust is exercising functions of the managers referred to in section 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, none of whom must be an executive Director of the Trust or an employee of the Trust.

4.5 The Trust may arrange for any of the functions exercisable by the Trust to be exercised by or jointly with any one or more of the following:
4.5.1 a relevant body;
4.5.2 a local authority within the meaning of section 2B of the 2006 Act;
4.5.3 a combined authority.

4.6 The Trust may also enter into arrangements to carry out the functions of another relevant body, whether jointly or otherwise.

4.7 Where a function is exercisable by the Trust jointly with one or more of the other organisations mentioned at paragraph 4.6, those organisations and the Trust may:
4.7.1 arrange for the function to be exercised by a joint committee of theirs;
4.7.2 arrange for the Trust, one or more of those other organisations, or a joint committee of them, to establish and maintain a pooled fund

4.8 The Trust must exercise its functions effectively, efficiency and economically.

4.9 In making a decision about the exercise of its functions, the Trust must have regard to all likely effects of the decision in relation to:
4.9.1 the health and well-being of (including inequalities between) the people of England;
4.9.2 the quality of services provided to (including inequalities between benefits obtained by) individuals by or in pursuance of arrangements made by relevant bodies for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England;
4.9.3 efficiency and sustainability in relation to the use of resources by relevant bodies for the purposes of the health service in England.

4.10 In the exercise of its functions, the Trust must have regard to its duties under section 63B of the 2006 Act (complying with targets under section 1 of the Climate Change Act 2008 and section 5 of the Environment Act 2021, and to adapt any current or predicted impacts of climate change in the most recent report under section 56 of the Climate Change Act 2008).

4.11 For the purposes of this section, “relevant body” means NHS England, an integrated care board, an NHS trust, an NHS foundation trust (including the Trust) or such other body as may be prescribed under section 65Z5(2). “Relevant bodies” means two or more of these organisations as the context requires.

4.12 The arrangements under this paragraph 4 shall be in accordance with:

4.12.1 any applicable requirements imposed by the 2006 Act or regulations made under that Act;

4.12.2 any applicable statutory guidance that has been issued and

4.12.3 otherwise on such terms as the Trust sees fit.

5 Membership and constituencies

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

5.1 a public constituency

5.2 a staff constituency.

6 Application for membership

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

7 Public constituency

7.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Trust.

7.2 Those members who live in an area specified as a public constituency are referred to collectively as a Public Constituency.

7.3 The minimum number of members in each Public Constituency is specified in Annex 1.

8 Staff Constituency

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

8.1.1 he is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least twelve (12) months; or

8.1.2 he has been continuously employed by the Trust under a contract of employment for at least twelve (12) months.

8.2 Those individuals who are eligible for membership of the Trust by reason of the previous provisions in paragraph 8.1 are referred to collectively as the Staff Constituency.

8.3 The Staff Constituency shall be divided into ~~five~~ three descriptions of individuals who are eligible for membership of the Staff Constituency, with each description of individuals being specified within Annex 2 and referred to as a class within the Staff Constituency.

8.4 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

Automatic membership by default – staff

8.5 An individual who is:

8.5.1 eligible to become a member of the Staff Constituency; and

8.5.2 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 he informs the Trust that he does not wish to do so.

9 Restriction on membership

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

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

9.3 An individual must be at least fourteen (14) years old to become a member of the Trust.

9.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 9.

10 Annual Members' Meeting

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

10.2 Further provisions about the Annual Members' Meeting are set out in Annex 10.

11 Council of Governors – composition

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

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

11.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 4.

12 Council of Governors – election of Governors

12.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules.

12.2 The Model Election Rules, as published by ~~the~~ NHS Providers~~Foundation Trust Network in August 2014~~ are attached as Annex 5.

12.3 A subsequent variation of the Model Election Rules shall not constitute a variation of the terms of this constitution for the purposes of paragraph 44 of the Constitution.

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

12.5 The Constitution makes further provisions on holding of elections. These are set out in Annex 6.

13 Council of Governors - tenure

13.1 An elected Governor may hold office for a period of up to three (3) years.

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

13.3 An elected Governor shall be eligible for re-election at the end of his term, for up to two (2) further periods of up to three (3) years, making a maximum total continuous period in office of nine (9) years. For the avoidance of doubt where a break in tenure occurs, either during or following the end of a term of office, the nine (9) year limit will recommence.

13.4 An appointed Governor may hold office for such ~~a~~ period ~~of up to three (3) years~~ as agreed with the appointing organisation.

13.5 An appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him.

13.6 An appointed Governor shall be eligible for re-appointment at the end of his term.

14 Council of Governors – disqualification and removal

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

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

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

14.1.3 a person who within the preceding five (5) years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three (3) months (without the option of a fine) was imposed on him.

14.2 Governors must be at least sixteen (16) years of age at the date they are nominated for election or appointment.

14.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 6.

14.4 The Constitution makes provisions for the termination of office and removal of members of the Council of Governors. These are set out in Annex 6.

15 Council of Governors- duties of Governors

15.1 The general duties of the Council of Governors are -

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

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

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

16 Council of Governors – meetings of Governors

16.1 The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 25.1 or paragraph 26.1 below) or, in his absence, the Deputy Chair (appointed in accordance with the provisions of paragraph 27 below), shall preside at meetings of the Council of Governors. If both the Chair and Deputy Chair are absent or incapacitated for any reason, a Governor or a non-executive Director shall be elected to preside from amongst those present.

16.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from all or part of any meeting for special reasons, following appropriate resolution by the Council of Governors made in accordance with its Standing Orders.

16.3 For the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

16.4 Further provisions with respect to the requirement for Directors to attend meetings of the Council of Governors are set out in Annex 7.

17 Council of Governors – Standing Orders

The Standing Orders for the practice and procedure of the Council of Governors are attached at Annex 7.

18 Council of Governors – referral to the Panel

18.1 In this paragraph, the Panel means a panel of persons appointed by NHS England ~~Monitor~~ to which a Governor of an NHS foundation trust may refer a question as to whether the trust has failed or is failing -

18.1.1 to act in accordance with its constitution; or

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

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

19 Council of Governors - conflicts of interest

If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

20 Council of Governors – travel expenses

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

21 Council of Governors – further provisions

Further provisions with respect to the Council of Governors are set out in Annex 6.

22 Board of Directors – composition

22.1 The Trust is to have a Board of Directors, which shall comprise both executive and non-executive Directors.

22.2 The Board of Directors is to comprise:

22.2.1 a non-executive Chair;

22.2.2 a non-executive Deputy Chair;

22.2.3 5-9 other non-executive Directors; and

22.2.4 5-9 executive Directors.

22.3 One of the executive Directors shall be the Chief Executive.

22.4 The Chief Executive shall be the Accounting Officer.

22.5 One of the executive Directors shall be the Finance Director.

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

22.7 One of the executive Directors is to be a registered nurse or a registered midwife.

22.8 The number of non-executive Directors shall always exceed the number of executive Directors.

23 Board of Directors – general duty

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

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

24.1 A person may be appointed as a non-executive Director only if:

24.1.1 he is a member of a Public Constituency; and

24.1.2 he is not disqualified by virtue of paragraph 29 below.

25 Board of Directors – appointment and removal of Chair and other non-executive Directors

25.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the Trust and the other non-executive Directors.

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

25.3 The initial Chair and the initial non-executive Directors are to be appointed in accordance with paragraph 26 below.

26 Board of Directors – appointment of initial Chair and initial other non-executive Directors

26.1 The Chair of the Trust shall be appointed as the initial Chair of the trust if he wishes to be appointed.

26.2 The power of the Council of Governors to appoint the other non-executive Directors of the Trust is to be exercised, so far as possible, by appointing as the initial non-executive Directors of the Trust any of the non-executive Directors of the Trust (other than the Chair) who wish to be appointed.

26.3 The criteria for qualification for appointment as a non-executive Director set out in paragraph 24 above (other than disqualification by virtue of paragraph 29 below) do not apply to the appointment of the initial Chair and the initial other non-executive Directors in accordance with the procedures set out in this paragraph.

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

27 Board of Directors – appointment of deputy Chair and senior independent director

27.1 The Council of Governors at a general meeting of the Council of Governors may in its absolute discretion appoint one of the non-executive Directors as a deputy Chair.

27.2 The Board of Directors at a general meeting of the Board of Directors shall in its absolute discretion appoint one of the non-executive directors as the Senior Independent Director.

28 Board of Directors - appointment and removal of the Chief Executive and other executive Directors

28.1 The non-executive Directors shall appoint or remove the Chief Executive.

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

28.3 A committee consisting of the Chair, the Chief Executive and the other non-executive Directors shall appoint or remove the other executive Directors and the Company Secretary.

29 Board of Directors – disqualification

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

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

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

29.1.3 a person who within the preceding five (5) years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three (3) months (without the option of a fine) was imposed on him.

29.1.4 a person who fails to meet the requirements of regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

29.2 This Constitution makes further provisions for the termination of office and disqualification of Directors in Annex 9.

30 Board of Directors – meetings

30.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

30.2 Before holding a meeting, the Board of Directors must send a copy of the agenda for the meeting (but not the reports relating thereto) to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must make available a copy of the minutes of the meeting to the Council of Governors.

31 Board of Directors – Standing Orders

The standing orders for the practice and procedure of the Board of Directors, are attached at Annex 8

32 Board of Directors - conflicts of interest of Directors

32.1 The duties that a Director of the Trust has by virtue of being a Director include in particular -

32.1.1 a duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust; and

32.1.2 a duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

32.2 The duty referred to sub-paragraph 32.1.1 is not infringed if –

32.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or

32.2.2 the matter has been authorized in accordance with the Constitution.

32.3 The duty referred to in sub-paragraph [32.1.2] is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

32.4 In sub-paragraph 32.1.2, "third party" means a person other than –

32.4.1 the Trust ; or

32.4.2 a person acting on its behalf.

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

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

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

32.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

32.9 A Director need not declare an interest -

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

32.9.2 if, or to the extent that, the Directors are already aware of it; or

32.9.3 if, or to the extent that, it concerns the terms of the Director's appointment that have been or are to be considered –

32.9.3.1 by a meeting of the Board of Directors; or

32.9.3.2 by a committee of Directors appointed for the purpose under the Constitution.

32.10 Further provisions on the declaration of interests by Directors are set out in Annex 8.

33 Board of Directors – remuneration and terms of office

33.1 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.

33.2 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~~ the other executive Directors and the Company Secretary.

34 Registers

34.1 The Trust shall have:

34.1.1 a register of members showing, in respect of each member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;

34.1.2 a register of members of the Council of Governors;

34.1.3 a register of interests of Governors;

34.1.4 a register of Directors; and

34.1.5 a register of interests of the Directors.

34.2. The ~~Trust~~ Company Secretary shall be responsible for keeping the registers up to date from information received by him, and the registers may be kept in either paper or electronic form.

35 Admission to and removal from the register of Members

35.1 Subject to paragraph 8.5 above, Members must complete an application in the form prescribed by the ~~Trust~~ Company Secretary.

35.2 The Trust Secretary shall maintain the register in two parts:

35.2.1 Part one, will be the register referred to in the 2006 Act, which 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 36 below.

35.2.2 Part two will contain all the information from the application form and shall not be made available to the public unless required as a matter of law.

35.3 For the avoidance of doubt the Trust may 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.

35.4 Removal of members from the Members Register shall be in accordance with paragraph 9.4 of this Constitution.

36 Registers – inspection and copies

36.1 The Trust shall make the registers specified in paragraph 34.1 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

36.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows personal details of any member of the Trust, if the member so requests subject always to any legal requirements to do so.

36.3 Subject to 36.4 below and so far as the registers are required to be made available:

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

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

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

37 Documents available for public inspection

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

37.1.1 a copy of the current Constitution;

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

37.1.3 a copy of the latest annual report.

37.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

37.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts

coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act;

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

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

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

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

37.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act;

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

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

37.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act; and

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

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

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

38 Auditor

38.1 The Trust shall have an auditor.

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

39 Audit Committee

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

40 Accounts

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

40.2 ~~Monitor~~ NHS England may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

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

40.4 The Trust shall prepare in respect of each financial year annual accounts in such form as ~~Monitor~~ NHS England may with the approval of the Secretary of State direct.

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

41 Annual report, forward plans and non-NHS work

41.1 The Trust shall prepare an Annual Report and send it to ~~Monitor~~ NHS England.

41.2 In accordance with the 2006 Act the Annual Report must in particular review:

41.2.1 the extent to which the Trust has exercised its functions in accordance with the plans published under—

(a) section 14Z52 (joint forward plans for integrated care board and its partners), and

(b) section 14Z56 (joint capital resource use plan for integrated care board and its partners).

41.2.2 the extent to which the Trust has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised).

41.~~3~~2 In accordance with the 2006 Act ~~T~~the Annual Report must include -

~~41.2.1 information on any steps taken by the foundation trust to secure that (taken as a whole) the actual membership of any public constituency and (if there is one) of a patients' constituency is representative of those eligible for such membership;~~

~~41.2.2 information on any occasions in the period to which the report relates on which the Council of Governors exercised its power to require a Director to attend a meeting of the Council of Governors;~~

~~41.2.3 information on the foundation trust's policy on pay and on the work of the remuneration committee and such other procedures as the foundation trust has on pay;~~

~~41.2.4 information on the remuneration of the Directors and on the expenses of Governors and Directors; and~~

~~41.2.5 any other information required by Monitor.~~

41.3.1 information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of any public constituency and (if there is one) of the patients' constituency is representative of those eligible for such membership;

41.3.2 information on any occasions in the period to which the report relates on which the Council of Governors exercised its power under paragraph 10C (Power to require a Director to attend a meeting of the Council);

41.3.3 information on the Trust's policy on pay and on the work of the committee established under paragraph 18(2) and such other procedures as the corporation has on pay;

41.3.4 information on the remuneration of the directors and on the expenses of the governors and the directors,

41.3.5 any other information required by NHS England.

41.~~3~~4 The Trust shall give information as to its forward planning in respect of each financial year to NHS England ~~Monitor~~.

~~41.4 The document containing the information with respect to forward planning (referred to above) shall be prepared by the Directors.~~

~~41.5 In preparing the document, the Directors shall have regard to the views of the Council of Governors.~~

~~41.6 Each forward plan must include information about –~~

~~41.6.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on; and~~

~~41.6.2 the income it expects to receive from doing so.~~

~~41.7 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 41.6.1 the Council of Governors must –~~

~~41.7.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfillment by the Trust of its principal purpose or the performance of its other functions; and~~

~~41.7.2 notify the Directors of the Trust of its determination.~~

41.~~8~~5 A Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

42 Presentation of the annual accounts and reports to the Governors and members

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

42.1.1 the annual accounts; ~~and~~

42.1.2 any report of the auditor on them; and

42.1.3 the annual report.

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

42.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 42.1 with the Annual Members' Meeting.

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 Amendment of the Constitution

44.1 The Trust may make amendments to the Constitution only if –

44.1.1 more than half of the members of the Council of Governors of the Trust voting approve the amendments; and

44.1.2 more than half of the members of the Board of Directors of the Trust voting approve the amendments.

44.2 Amendments made under paragraph 44.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act

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

44.3.1 at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment; and

44.3.2 the Trust must give the members an opportunity to vote on whether they approve the amendment.

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

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

45 Statutory and ~~Mergers etc.~~ and significant transactions

45.1 The Trust may only apply for a statutory transaction (a merger, acquisition, separation, ~~or~~ dissolution or transfer scheme) with the approval of more than half of the members of the Council of Governors.

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

45.3 "Significant transaction" means:

45.3.1 a significant service contract ~~or other agreement~~ which exceeds the reporting threshold set by NHS England~~which will lead to an increase by 5% or more in the proportion of the Trust's total income in any financial year attributable to activities other than the provision of goods and services for the purposes of health service in England and which is not included in the latest approved version of the Forward Plan~~; or

45.3.2 a commercial transfer which exceeds the reporting thresholds set by NHS England; or

45.3.3 financing arrangements that are considered to be novel, contentious or repercussive (regardless of value); or

45.3.~~42~~ t~~T~~he establishment of or a material change to a Subsidiary~~; or~~

~~45.3.3 A transaction which meets any one of the following criteria:~~
~~the gross assets which are subject to the transaction are greater than 10% of the gross assets of the Trust; or~~
~~the earnings before interest, taxes, depreciation, and amortization ("EBITDA") attributable to the assets which are subject to the transaction are greater than 25% of the EBITDA of the Trust; or~~
~~the income attributable to the assets which are subject to the transaction is greater than 15% of the total income of the Trust.~~

~~45.4 For the purposes of 45.3.2 above "subsidiary" means a corporate body in which the Trust:~~

~~45.4.1 holds a majority of the voting rights; or~~

~~45.4.2 is a member and has the right to appoint or remove a majority of its board of directors; or~~

~~45.4.3 is a member and controls alone, pursuant to an agreement with others, a majority of its voting rights.~~

ANNEX 1 – THE PUBLIC CONSTITUENCIES
(Paragraph 7)

1 **The Public Constituencies**

There shall be twelve (12) Public Constituencies which are coterminous with the local authority election boundaries. The number of Governor places available for election within each Public Constituency (except for the Rest of England Public Constituency) is based on 1 Governor for every 60,000 people residing in that locality. The Public Constituencies are:

Public Constituency	Electoral area of:	Minimum number of members	Number of Elected Governors from ~~1st~~ 30th June 2024~~October 2015~~
Stockton-on-Tees	Stockton on Tees Borough Council	100	3
Hartlepool	Hartlepool Borough Council	100	2
Darlington	Darlington Borough Council	100	2
Durham	Durham County Council	100	~~9~~8
Middlesbrough	Middlesbrough Borough Council	100	2
Redcar and Cleveland	Redcar and Cleveland Borough Council	100	2
North Yorkshire~~Scarborough and Ryedale~~	North Yorkshire Council~~Scarborough Borough Council and Ryedale District Council~~	100	~~6~~3
~~Hambleton and Richmondshire~~	~~Hambleton District Council and Richmondshire District Council~~	~~100~~	~~2~~
~~Harrogate and Wetherby~~	~~Harrogate Borough Council and the Wetherby Ward of Leeds City Council~~	~~100~~	~~3~~
City of York and Rest of England	City of York Council and all electoral areas in England which are not included in another Public Constituency	100	3
~~Selby~~	~~Selby District Council and the Wolds Weighton and Pocklington Provincial Wards of the East Riding of Yorkshire Council.~~	~~100~~	~~2~~
~~Rest of England~~	~~All electoral areas in England which are not~~	~~100~~	~~1~~

	~~included in another Public Constituency~~		

2. Should a Public Constituency fail to achieve the above minimum numbers, no election shall take place, until such time as the minimum number is reached. An election within that area will then take place within a time period determined by the Chair.

ANNEX 2 – THE STAFF CONSTITUENCY

(Paragraphs 8.3 and 8.4)

1. **The Staff Constituency**

The Staff Constituency is divided into 3 (three) classes. These are:

Class	Minimum number of members	Number of Elected Governors
Corporate Directorates	150	1
Durham, Tees Valley and Forensics Care Group	400	3
North Yorkshire York and Selby Care Group	200	1

2. Should an individual class within the Staff Constituency fail to achieve the above minimum numbers, no election shall take place in that class, until such time as the minimum number is reached. An election within that class will then take place within a time period determined by the Chair of the Trust.

3. Staff will only be able to become a member and vote in one class within the Staff Constituency.

ANNEX 3 – THE PATIENTS' CONSTITUENCY

NOT APPLICABLE

ANNEX 4 – COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraphs 11.2 and 11.3)

COMPOSITION OF THE COUNCIL OF GOVERNORS		
Constituency		**Number of Governors from 30/6/2024 ~~1/4/20~~**
Public	Stockton-on-Tees	3
	Hartlepool	2
	Darlington	2
	Durham	~~9~~8
	Middlesbrough	2
	Redcar & Cleveland	2
	~~Scarborough and Ryedale~~North Yorkshire	~~3~~6
	~~Hambleton and Richmondshire~~	~~2~~
	~~Harrogate and Wetherby~~	~~3~~
	City of York and Rest of England	3
	~~Selby~~	~~2~~
	~~Rest of England~~	~~1~~
Staff	Corporate Directorates	1
	Durham, Tees Valley and Forensics Care Group	3
	North Yorkshire, York and Selby Care Group	1
Appointed Governors	Durham County Council	1
	Darlington Borough Council	1
	Hartlepool Borough Council	1
	Stockton-on-Tees Borough Council	1
	Middlesbrough Borough Council	1
	Redcar & Cleveland Borough Council	1
	North Yorkshire ~~County~~ Council	1
	City of York Council	1
	University of Teesside	1*
	University of Sunderland	1*
	University of York	1*
	University of Newcastle	1*
	~~NHS County Durham CCG~~ Voluntary Organisations Network North East*	1*
	~~NHS Tees Valley CCG~~ Vol Org NYY to be specified*	1*
	~~NHS North Yorkshire CCG~~	~~1*~~
	~~NHS Vale of York CCG~~	~~1*~~
TOTAL		**48~~54~~**

Notes:

1 The terms of Governors holding office on ~~1st April~~ 30th June 202~~4~~4 are unaffected by the amendments to the Constitution which come into force on that day.

2 The appointing organisations marked (*) in the above schedule are specified for the purposes of sub-paragraph 9(7) of Schedule 7 for the 2006 Act (as amended).

ANNEX 5 –THE MODEL RULES FOR ELECTIONS

(Paragraph 12.2)

PART 1: INTERPRETATION

1. Interpretation

PART 2: TIMETABLE FOR ELECTION

2. Timetable
3. Computation of time

PART 3: RETURNING OFFICER

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

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election
9. Nomination of candidates
10. Candidate's particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination forms
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination forms
17. Withdrawal of candidates
18. Method of election

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity (public and patient constituencies)

Action to be taken before the poll

22. List of eligible voters
23. Notice of poll
24. Issue of voting information by returning officer

PART 8: DISPOSAL OF DOCUMENTS

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

PART 10: ELECTION EXPENSES AND PUBLICITY

Expenses

Publicity

PART 11: QUESTIONING ELECTIONS AND IRREGULARITIES

PART 12: MISCELLANEOUS

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 (Monitor, 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 his or her functions under these rules,

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

7. Duty of co-operation

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

PART 4: STAGES 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 his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

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

(a) they wish to stand as a candidate,

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

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

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

14. Decisions as to the validity of nomination

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

election unless and until the returning officer:

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

(b) decides that the nomination form is invalid,

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

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

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

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

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

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

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

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

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

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

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

15. Publication of statement of candidates

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

15.2 The statement must show:

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

(b) the declared interests of each candidate standing,

as given in their nomination form.

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

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

16. Inspection of statement of nominated candidates and nomination forms

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

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

17. Withdrawal of candidates

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

18. Method of election

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

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

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

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

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

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot

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

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

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

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

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

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

(i) configured in accordance with these rules; and

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

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

(i) configured in accordance with these rules; and

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

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

(i) configured in accordance with these rules; and

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

20. The ballot paper

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

20.2 Every ballot paper must specify:

(a) the name of the corporation,

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

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

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

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

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

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

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

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

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

(a) that the voter is the person:

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

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

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

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

("declaration of identity")

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

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

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

Action to be taken before the poll

22. List of eligible voters

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

22.2 The list is to include, for each member:

(a) a postal address; and,

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

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

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

23. Notice of poll

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

(a) the name of the corporation,

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

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

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

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

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

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

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

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

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

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

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

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

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

(a) a ballot paper and ballot paper envelope,

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

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

(d) a covering envelope;

("postal voting information").

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

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

(b) the voter's voter ID number,

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

("e-voting information").

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

(a) only be sent postal voting information; or

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

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

for the purposes of the poll.

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

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

25. Ballot paper envelope and covering envelope

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

25.2 The covering envelope is to have:

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

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

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

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

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

26. E-voting systems

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

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

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

26.4 The returning officer shall ensure that the polling website and internet

voting system provided will:

(a) require a voter to:

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

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

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

(b) specify:

(i) the name of the corporation,

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

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

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

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

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

(vii) the contact details of the returning officer;

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

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

(i) the voter's voter ID number;

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

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

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

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

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

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

(a) require a voter to

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

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

(b) specify:

(i) the name of the corporation,

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

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

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

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

(vi) the contact details of the returning officer;

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

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

(i) the voter's voter ID number;

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

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

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

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

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

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

(a) require a voter to:

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

(ii) where the election is for a public or patient constituency,

make a declaration of identity;

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

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

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

(i) the voter's voter ID number;

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

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

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

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

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

The poll

27. Eligibility to vote

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

28. Voting by persons who require assistance

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

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

29. Spoilt ballot papers and spoilt text message votes

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

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

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

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

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

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

(a) the name of the voter, and

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

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

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

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

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

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

(a) the name of the voter, and

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

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

30. Lost voting information

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

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

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

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

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

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

(a) the name of the voter

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

(c) the voter ID number of the voter.

31. Issue of replacement voting information

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

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

(a) the name of the voter,

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

(c) the voter ID number of the voter.

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

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

Polling by internet, telephone or text

33. Procedure for remote voting by internet

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

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

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

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

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

34. Voting procedure for remote voting by telephone

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

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

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

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

whom he or she wishes to vote.

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

35. Voting procedure for remote voting by text message

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

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

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

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

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

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

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

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

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

(b) the unique identifier on a ballot paper.

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

37. Validity of votes

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

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

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

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

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

(a) mark the ballot paper "disqualified",

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

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

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

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

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

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

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

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

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

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

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

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

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

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

39. De-duplication of votes

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

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

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

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

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

(a) mark the ballot paper "disqualified",

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

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

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

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

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

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

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

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

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

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

40. Sealing of packets

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

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

(b) the ID declaration forms, if required,

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

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

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

PART 6: COUNTING THE VOTES

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41. Interpretation of Part 6

41.1 In Part 6 of these rules:

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

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

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

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

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

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

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

or

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

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

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

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

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

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

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules 47.4 or 47.7.

42. Arrangements for counting of the votes

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

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:
  (i) the use of such software for the purpose of counting votes in the relevant election, and
  (ii) a policy governing the use of such software, and
(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:
  (iii) ballot papers that have been returned; and
  (iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

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

44. Rejected ballot papers and rejected text voting records

44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

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

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

44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be

rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

44.4 The returning officer is to endorse the word “rejected” on any text voting record which under this rule is not to be counted.

44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule 44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule 44.3.

45. First stage

45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

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

45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

46. The quota

46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

46.2 The result, increased by one, of the division under rule 46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules 47.1 to 47.3 has been complied with.

47. Transfer of votes

47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on

which first preference votes are given for that candidate into sub-parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule 47.1.

47.3 The returning officer is, in accordance with this rule and rule 48, to transfer each sub-parcel of ballot documents referred to in rule 47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

47.4 The vote on each ballot document transferred under rule 47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

47.6 The returning officer is, in accordance with this rule and rule 48, to transfer each sub-parcel of ballot documents referred to in rule 47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

47.7 The vote on each ballot document transferred under rule 47.6 shall be at:

(a) a transfer value calculated as set out in rule 47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

47.8 Each transfer of a surplus constitutes a stage in the count.

47.9 Subject to rule 47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

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

48. Supplementary provisions on transfer

48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

48.2 The returning officer shall, on each transfer of transferable ballot documents under rule 47:

(a) record the total value of the votes transferred to each candidate,

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

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

48.3 All ballot documents transferred under rule 47 or 49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule 47 or 49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

49. Exclusion of candidates

49.1 If:

(a) all transferable ballot documents which under the provisions of rule 47 (including that rule as applied by rule 49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule 50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule 49.12 applies, the candidates with the then lowest votes).

49.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule 49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

49.3 The returning officer shall, in accordance with this rule and rule 48, transfer each sub-parcel of ballot documents referred to in rule 49.2 to the candidate for whom the next available preference is given on those ballot documents.

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

49.5 If, subject to rule 50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule 49.1 into sub- parcels according to their transfer value.

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

49.7 The vote on each transferable ballot document transferred under rule 49.6 shall be at the value at which that vote was received by the candidate excluded under rule 49.1.

49.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule 49.1.

49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each

candidate,

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

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

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules 47.5 to 47.10 and rule 48.

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

49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

50. Filling of last vacancies

50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

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

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

51. Order of election of candidates

51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule 47.10.

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

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

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

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

52. Declaration of result for contested elections

52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [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.

52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule 44.1,

(f) the number of rejected text voting records under each of the headings in rule 44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the 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 his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

59. Countermand or abandonment of poll on death of candidate

59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the

returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

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 his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a

meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

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 6 - ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

ELIGIBILITY TO BE A MEMBER OF THE COUNCIL OF GOVERNORS

A person may not be a candidate in an election to the Council of Governors or become a member of the Council of Governors, and if already holding such office will immediately cease to do so, if:

1. They are a Director of the Trust; a Director of a Subsidiary~~; or hold a similar position of authority within any Trust Trading Vehicle~~; ~~or a governor~~ or a director of another NHS Foundation Trust or any other NHS body or a body providing health or social care (as defined in section 9 of Health and Social Care Act 2008)~~–~~ unless they are an appointed member of the Council of Governors.

2. They are the spouse, partner, parent or child of any person described in paragraph (1) above.

3. They are under the age of 16.

4. They are a member of a Local Authority's Scrutiny Committee covering health matters.

5. They are a director of, or hold an equivalent position of leadership or authority in, a Local Healthwatch.

6. Being a member of one of the Public Constituencies they refuse or fail to sign a declaration, in the form specified by the Council of Governors, giving particulars of their qualification to vote as a member of the Trust, and that they are not prevented from being a member of the Council of Governors.

7. They are a vexatious complainant of the Trust.~~, as defined by Trust policy~~

8. They have been involved within the last ten (10) years as a perpetrator in a serious incident of assault or violence, or in one or more incidents of harassment, against any of the Trust's employees or other persons who exercise functions for the purposes of the Trust, or against registered volunteers.

9. They have been excluded from any of the Trust premises within the last ten (10) years.

10. Their name is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act

2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.

11. On the basis of disclosures obtained through an application to the Disclosure and Barring Service they have not been considered suitable in accordance with the Trust's Disclosure and Barring Service (DBS) Policy.

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

13. They are a person whose tenure of office as the Chair or as a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest~~.~~

14 They have been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals and have not been subsequently reinstated to such a register.

15 They are a person who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986.

16 They are not a fit and proper person to be a Governor of a Foundation Trust in accordance with the Licence.

17 They have, within the preceding 5 (five) years, had their membership of the Council of Governors terminated and have been removed from office as a Governor of the Trust by reason of:
(a) their failure to attend meetings; or
(b) their failure to undertake training; or
(c) them having committed a serious breach of the Trust's and/or Council of Governors' Code of Conduct; or acted in a manner detrimental to the interests of the Trust; or having failed to discharge their responsibilities as a member of the Council of Governors.

TERMINATION OF OFFICE AND REMOVAL OF MEMBERS OF THE COUNCIL OF GOVERNORS (also see paragraph 14.4 of the Constitution)

A person holding office as a member of the Council of Governors shall immediately cease to do so if:

1. They resign by notice in writing to the Company ~~Trust~~ Secretary;

2. It otherwise comes to the notice of the ~~Trust~~ Company Secretary at the time the member of the Council of Governors takes office or later that the

member of the Council of Governors is disqualified in accordance with paragraph 14 of the Constitution;

3. They fail to attend two meetings of the Council of Governors in any financial year, unless the Chair is satisfied that:

   a. The absences were due to reasonable causes; and

   b. They will be able to start attending meetings of the Trust again within such a period as the Chair considers reasonable.

4. In the case of an elected member of the Council of Governors, they cease to be a member of the Trust or a member of the Public Constituency or Staff Class for which they were elected~~.~~

5. In the case of an appointed member of the Council of Governors, the appointing organisation terminates the appointment;

6. They have failed to undertake any training which the Council of Governors require all members of the Council of Governors to undertake, unless the ~~members of the Council of Governors are~~ Chair is ~~satisfied that:~~

   a. The failure to undertake training was due to reasonable cause; and

   b. They will be able to undertake the required training within such a period as they consider reasonable.

7. They have failed to sign and deliver to the ~~Trust~~ Company Secretary within one month of their election or appointment a statement in the form required by the Council of Governors confirming acceptance of the Trust's and/or the Council of Governors' Code of Conduct.

8. They are removed from the Council of Governors by a resolution approved by a majority of the remaining members of the Council of Governors present and voting at a General Meeting on the grounds that:

   a. They have committed a serious breach of the Trust's and/or Council of Governors' Code of Conduct, or

   b. They have acted in a manner detrimental to the interests of the Trust, or

   c. They have failed to discharge their responsibilities as a member of the Council of Governors.

FURTHER PROVISIONS RELATING TO THE TERMINATION OF OFFICE AND REMOVAL OF MEMBERS OF THE COUNCIL OF GOVERNORS

These provisions apply where the Chair and Lead Governor have reasonable cause to believe that a Governor might have committed a serious breach of the Trust's and/or Council of Governors' Code of Conduct, or have acted in a manner detrimental to the interests of the Trust, or have failed to discharge their responsibilities as a member of the Council of Governors.

In those circumstances:

1 The Chair and Lead Governor shall jointly report to the Council of Governors on the alleged behaviour of the Governor.

2 If the Council of Governors considers the Governor's alleged behaviour might be sufficiently serious as to potentially warrant the termination of their office and removal from the Council of Governors it shall:
- (a) commission the Lead Governor to undertake an investigation to establish the facts of the alleged behaviour; and
- (b) decide whether the Governor should be suspended from office pending the outcome of the investigation.

3 The Company Secretary shall arrange for independent resources to be provided to Lead Governor to support the conduct of the investigation.

4 In conducting the investigation, the Lead Governor shall take advice to ensure that reasonable adjustments are made to enable the Governor to be able to participate in the investigation.

5 Failure by the Governor to participate in the investigation shall not prevent the investigation being concluded.

6 The Lead Governor shall report to the Council of Governors should there be delays, due to any cause, in the progress of the investigation.

7 A report on the outcome of the Investigation shall be provided by the Lead Governor to the Chair.

8 Where the Chair is assured that the investigation has been undertaken appropriately and the Governor has a case to answer, they and the Lead Governor shall submit a motion to the Council of Governors which will:
- (a) seek ratification of the investigation's conclusions (on the basis of the balance of probabilities); and
- (b) recommend an appropriate sanction to be applied to the Governor, taking into account the impact of the Governor's behaviour, including, if appropriate, termination of their office and removal from the Council of Governors

9 The Council of Governors shall determine the motion is accordance with Standing Orders.

Provisions relating to the Referral of Potential Breaches of Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to the Senior Independent Director

Any alleged breaches of Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by the Chair or a Non-Executive Director, raised by a Governor, shall only be referred to the Senior independent Director for investigation if more than half of the members of the Council of Governors voting approve the referral.

The disclosure of any allegations of a breach of Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 or matters which could be considered a breach of the Regulation by a Governor prior to them being considered by the Council of Governors or during any investigation conducted by the Senior Independent Director shall be regarded as a serious breach of the Trust's or Council of Governors' Code of Conduct.

REQUIREMENT OF MEMBER OF THE COUNCIL OF GOVERNORS TO NOTIFY TRUST

Where a person has been elected or appointed to be a member of the Council of Governors and they become disqualified from office under paragraph 14 of this constitution, they shall notify the Company~~Trust~~ Secretary in writing of such disqualifications.

FURTHER PROVISIONS RELATING TO ELECTIONS

(1) In any year when a Governor is due to retire the ordinary day of election ("the Annual Election") to fill the vacancy shall be a day in June agreed by the Chair.

(2) A Governor elected at an Annual Election shall take up office on 1st July of that year.

RETIREMENT OF GOVERNORS

(1) Those Governors representing the Public or Staff Constituencies, who are due to retire in any given year, shall retire on 30th June of that year.

FILLING OF CASUAL VACANCIES

(1) Subject to the provisions of this section, if there is a casual vacancy for a Governor for any of the public constituencies or the staff classes an election in accordance with the Model Election Rules to fill the vacancy shall be held unless:

(a) an elected Governor's seat falls vacant for any reason within six months of their election to office, in which case the Company ~~Trust~~ Secretary shall invite the next highest polling candidate for the public constituency or staff class at the most recent election, who is willing to take office, to fill the seat (the "Reserve Governor"); or

(b) An elected Governor's seat falls vacant for any reason within six months of their ordinary day of retirement, subject to paragraph 3 below, the seat shall stand vacant until the next annual election.

(c) An annual election is due to be held within a period of six months of the casual vacancy arising.

(2) The day of election to fill a casual vacancy in any office mentioned in (1) above shall be fixed by the Chair, in consultation with the Company ~~Trust~~ Secretary.

(3) Paragraphs (1) (b) and 1 (c) above shall not apply and an election shall be held to fill the vacancy if the Chair considers that there is a reasonable possibility that during the six month period the total number of unfilled vacancies of public Governors would mean that the public Governors are not in the majority on the Council of Governors.

(4) A person elected under paragraph (1) or (3) or a "Reserve Governor" invited under paragraph (1)(a) shall hold office to fill the casual vacancy until the date upon which the person whose seat he is elected/invited to fill would have regularly retired.

(5) Where a vacancy arises amongst the appointed members of the Council of Governors, the Company ~~Trust~~ Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office.

(6) Subject to the provisions of the Standing Orders for the Practice and Procedure of the Council of Governors set out at Annex 7, the validity of any act of the Council of Governors shall not be affected by any vacancy among the Governors or by any defect in the election or appointment of any Governor.

ROLES AND RESPONSIBILITIES

In undertaking its duties as set out under paragraph 15 of the Constitution, the general roles and responsibilities of the Council of Governors shall be:

Advisory – To communicate to the Board of Directors the wishes of members and the wider community.

Guardianship – To ensure that the Trust operates in accordance with its Licence. In this regard it acts as a Trustee for the welfare of the organisation.

Strategic – To advise on the longer term direction to help the Board effectively determine its policies.

In particular the Council of Governors is to:

1. Develop the membership of the Trust and represent the interests of the members in accordance with its Membership Strategy.

2. ~~Present its views to the Board of Directors for the purposes of the preparation (by the Directors) of the document containing information on the Trust's forward Plan in respect of each financial year to be given to Monitor. In particular the Council of Governors shall notify the Board of Directors of its determination as to whether it is satisfied that any proposed activities, other than those for the provision of goods and services for the purposes of the health service in England, will not, to any significant extent, interfere with the fulfilment of the Trust's principal purpose under paragraph 3.1 of this Constitution or the performance of its other functions.~~

23. Determine any proposals by the Board of Directors to increase by 5% or more the proportion of the Trust's total income, in any financial year, attributable to activities other than for the provision of goods and services for the purposes of the health service in England.

3. Respond to any matter as appropriate when consulted by the Board of Directors.

4. Appoint or remove the Chair and the other non-executive Directors in accordance with paragraph 25 of this Constitution.

5. Decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and other non-executive Directors in accordance with paragraph 33 of this Constitution.

6. Approve the appointment of the Chief Executive in accordance with paragraph 28 of this Constitution.

7. Consider the Annual Accounts, any reports of the auditor on them, and the Annual Report.

8. Appoint or remove the Trust's external auditor.

9. Determine (in conjunction with the Board of Directors) any questions on ~~mergers, acquisitions or separation of the Trust~~ statutory transactions.

10. Determine (in conjunction with the Board of Directors) whether the Trust should be dissolved.

11. Determine any significant transactions proposed by the Board of Directors.

12. Consider any matters raised by NHS England~~Monitor~~, an integrated care board or the Care Quality Commission which could have or lead to a substantial change to the Trust's financial well being, healthcare delivery performance, or reputation and standing or which might otherwise affect the Trust's compliance with the terms of its Licence or its registration of services.

13. Determine (in conjunction with the Board of Directors) any proposed changes to the Trust's Constitution.

1~~5~~4. Decide whether to refer a matter to ~~Monitor~~ NHS England's Panel in accordance with paragraph 18 of the Constitution.

APPOINTMENT OF NON-EXECUTIVE DIRECTORS (including Chair and Deputy Chair)

1. The Council of Governors shall establish a Committee of the Council of Governors and the Board of Directors ("the Nomination and Remuneration Committee") to assist in the process of appointment of non-executive Directors (including Chair and Deputy Chair). The Committee shall comprise up to four suitably qualified members of the Council of Governors and two Directors (at least one of whom will be the Chair of the Trust or the Senior Independent Director). The Committee may have an independent advisor in attendance if appropriate.

2. The process to be followed in the appointment of the Chair and non-executive Directors shall be agreed by the Council of Governors based on the Code of Governance for NHS Foundation Trusts, the Licence, guidance published by the Care Quality Commission and advice received from the Nomination and Remuneration Committee.

REMUNERATION OF THE CHAIR AND OTHER NON-EXECUTIVE DIRECTORS

In order to determine the proper level of remuneration and allowances that should be paid to the Chair and other non-executive Directors the Council of Governors may, from time to time, and at least every three years, consult, at the Trust's expense, with external professional advisers.

PROVISION OF TRAINING AND DEVELOPMENT FOR GOVERNORS

The Trust shall make available any reasonable resources required by the Council of Governors to ensure Governors are equipped with the skills and knowledge they require in their capacity as such.

STAFF CONSTITUENCY - TIME TAKEN OUT OF NORMAL WORKING HOURS TO PERFORM COUNCIL OF GOVERNORS DUTIES

Leave from Trust duties to carry out Council of Governors duties will be dealt with In accordance with the Trust's Special Leave Policy. Special leave to undertake obligations for the Council of Governors will be considered alongside any other special leave previously or subsequently granted to staff.

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

(Paragraph 17)

FOREWORD

The Tees, Esk & Wear Valleys NHS Foundation Trust (the "Trust") is a public benefit corporation that was established in accordance with the provisions of National Health Service Act 2006 (as amended).

The principal places of business are across County Durham, Darlington, The Tees Valley, Scarborough, Whitby, Ryedale, Hambleton and Richmondshire and Harrogate and the Vale of York and the head office is located at Trust Headquarters, Flatts Lane Centre, Flatts Lane, Normanby, Middlesbrough, TS6 0SZ.

These Standing Orders (SOs) are for the regulation of the Trust's Council of Governors proceedings and business.

The Council of Governors will conduct its business in as open a way as possible and shall:

1. Observe the Nolan principles of Public Life of selflessness, integrity, objectivity, accountability, openness, honesty and leadership;

2. At all times seek to comply with the NHS Foundation Trust Code of Governance;

Everything done by the Council of Governors should be able to stand the test of scrutiny, public judgment on propriety, and professional codes of conduct.

The Council of Governors will in its business be as transparent as it can be about its activities to promote confidence between the Council of Governors, the membership, the Board of Directors, staff, services users and the public.

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8. Declaration of Interests and Register of Interests

Declaration of Interest
Register of Interests

9. Training and Development

10. Performance Evaluation

11. Compliance – Other Matters

12. Resolution of Disputes with Board of Directors

13. Changes to Standing Orders

1. INTERPRETATION

1.1 Any expression to which a meaning is given in the National Health Service Act 2006 (as amended) has the same meaning in this interpretation and in addition:

"ATTEND" or **"ATTENDANCE"** means being present either in person or remotely.

"BOARD" means the Board of Directors, formally constituted in accordance with this Constitution and consisting of a Chair and non-executive Directors, appointed by the Council of Governors and the executive Directors, appointed by the non-executive Directors and (except for his own appointment) by the Chief Executive.

"CHAIR" is the non-executive Director appointed by the Council of Governors with the responsibility for the leadership of the Council of Governors and for presiding at its meetings. The Chair shall be deemed to include the non-executive Director appointed by the Council of Governors to take on the Chair's duties if the Chair is absent from the meeting or is otherwise unavailable, known as the Deputy Chair. The term Chair shall also, for the purposes of these standing orders refer to the person appointed by the Council of Governors to preside in exceptional circumstances should either the Chair or Deputy Chair be temporarily unavailable.

"CLEAR DAY" - means a day of the week excluding the day the document becomes available, the day the meeting is held/notice submitted, Saturdays, Sundays and public holidays.

"COMMITTEE" means a committee formed by the Council of Governors with specific Terms of Reference and membership approved by the Council.

"COUNCIL" means the Council of Governors, formally constituted in accordance with this Constitution meeting in public and presided over by a Chair.

"GOVERNOR" means a person elected or appointed to the Council of Governors.

"IN PERSON" means the physical presence of an individual.

"LEAD GOVERNOR" means a Governor, appointed by the Council of Governors, to act as a point of contact for the Council of Governors with

Monitor (in cases where it is considered inappropriate for communication to be undertaken through the Chair or Trust Secretary) and the Care Quality Commission.

"MEETING" means a meeting of the Council of Governors, which may be in person and/or remotely, for which notice has been given in accordance with these Standing Orders.

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

"OFFICER" means an employee of the Trust

"PLACE" in relation to a meeting, any reference to a "place" means the place where a meeting is held, or to be held, which may be:

- a specified location; or
- a virtual, digital or electronic platform/location including but not limited to platforms/locations accessed remotely via "Apps", internet locations, web addresses or conference call telephone numbers; or
- both.

"PRESENT" means attendance at a meeting either in person or remotely in accordance with the terms of these Standing Orders.

"REMOTE" or **"REMOTELY"** means attendance via electronic, digital or other virtual means including, but not limited to, telephone conference, video conference, live webcasts, and live interactive streaming provided such electronic means satisfies the requirements set out at S.O. 4.17.1b of this Annex 7.

"**SENIOR INDEPENDENT DIRECTOR"** means one of the non-executive Directors appointed by the Board of Directors to whom Governors may raise concerns about the performance of the Chair or the Trust if they consider it is inappropriate or impractical to express these concerns to the Chair or officers of the Trust. The Senior Independent Director also leads the Board on matters pertaining to the appointment and appraisal of the Chair and provides advice to the Chair under the disputes resolution procedure.

"SO" means standing order

1.2 Save as permitted by law, the Chair shall be the final authority on the interpretation of Standing Orders (on which he shall be advised by the Company~~Trust~~ Secretary, Chief Executive and Director of Finance).

2. GENERAL INFORMATION

2.1 The purpose of these Standing Orders is to ensure that the highest standards of Corporate Governance and conduct are applied to all Council meetings and associated deliberations. The Council shall at all times seek to comply with the NHS Foundation Trust Code of Governance published by NHS England~~Monitor.~~

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

2.3 A Governor who has acted honestly and in good faith will not have to meet out of his or her own personal resources any personal or civil liability which is incurred in the execution or purported execution of his or her function as a Governor save where the Governor has acted recklessly. On behalf of the Council, and as part of the Trust's overall insurance arrangements, the Board shall put in place appropriate insurance provision to cover such indemnity.

3. COMPOSITION OF THE COUNCIL OF GOVERNORS

3.1 The composition of the Council shall be in accordance with the Trust's Constitution and shall include the Chair.

3.2 **Duties of the Deputy Chair –** Where the Chair has died or has otherwise ceased to hold office or where he has been unable to perform his duties as a Chair owing to illness, absence from England and Wales or any other cause, references to the Chair shall, so long as there is no Chair able to perform their duties, be taken to include references to the Deputy Chair.

~~3.3 **Lead Governor –** The Lead Governor shall be appointed by the Council. It shall be for the Council to determine the period of office of the Lead Governor, normally a period of up to three (3) years after which the Council shall review the appointment. Should there be a requirement to remove the Lead Governor this shall be carried out in accordance with SO 4.8.1.~~

3.3 **Lead Governor**

3.3.1 The Lead Governor shall be appointed by the Council.

3.3.2 It shall be for the Council to determine the period of office of the Lead Governor, normally a period of up to three (3) years after which the Council shall review the appointment.

3.3.3 No Governor should be appointed as the Lead Governor for more than two consecutive periods except in accordance with SO 3.3.5.

3.3.4 A nominated Governor shall require more than half of the members of the Council of Governors present voting in favour of their appointment as the Lead Governor.

3.3.5 Where a Governor would be ineligible for appointment under SO 3.3.3 above, they may be nominated and be appointed as the Lead Governor for a further period where no other Governor is willing to be nominated or where the position remains vacant following a vote under SO 3.3.4.

3.4 The Lead Governor shall produce a written report to the Council of Governors on his activities when the appointment to the role is due for review.

4. MEETINGS OF THE COUNCIL OF GOVERNORS

4.1 General

4.1.1 General meetings of the Council inclusive of an Annual General Meeting shall be held at times and places as the Council may determine.

4.1.~~1a~~2 The Council of Governors shall review, annually, the arrangements for conducting its meetings.

4.1.~~2~~3 The Council will publicise and hold an Annual General Meeting to receive the annual report and annual accounts within a reasonable period after the end of each financial year, but not before the annual report and accounts have been laid before Parliament.

4.1.~~3~~4 The Annual General Meeting shall be combined with an Annual Members' Meeting in accordance with paragraph 10 of this Constitution. Further provisions about Annual Members' Meetings are set out in Annex 10 of this Constitution.

4.2 Admission of the Public

4.2.1 A meeting of the Council shall be open to the public except to the extent that they are excluded by resolution under SO 4.2.~~2~~5 below.

4.2.~~1~~2.~~a~~ Where a meeting is accessible to the public through remote means it is open to the public whether or not members of the public are able to attend in person.

4.2.~~1~~.3~~a~~ The Chair may determine that attendance by members of the public shall be in person, by remote means or both.

4.2.~~1~~.4~~b~~ Where remote access to a meeting is provided the Chair must be satisfied that the arrangements will enable members of the public in attendance to be able to hear, and where practicable see, the business transacted at the meeting.

4.2.5 The Council may by resolution exclude the public from a meeting during consideration of an item of business whenever it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that there would be disclosure to them of confidential information as defined in SO 4.2.~~3~~6 below.

4.2.6 The descriptions of information which are, for the purposes of this Standing Order, to be treated as confidential information are those for the time being specified in Annex 9 to this Constitution.

4.2.7 The reasons for the exclusion of the public from a meeting shall be included in the agenda for the meeting and recorded in the minutes.

4.3 **Attendance at meetings by Directors**

4.3.1 Directors may attend meetings of the Council (both public and confidential sessions) by standing invitation.

4.3.2 Directors may address meetings of the Council at the discretion of the Chair.

4.3.3 Directors may be excluded from the consideration of confidential business by resolution of the Council or by ruling of the Chair.

4.3.4 The Council may require a Director to attend a meeting of the Council to obtain information about the Trust's performance of its functions or the Director's performance of his duties in accordance with Paragraph 10C of Schedule 7 of the National Health Service Act 2006 by either:

4.3.4.1 resolution of the Council; or

4.3.4.2 notice in writing being given to the Chair by ten (10) Governors.

4.3.5 The resolution or notice under SO 4.3.4 shall identify the Director whose attendance is required at a meeting of the Council; the date and time of the meeting of the Council which the Director is required to attend; and include particulars of the information which the Council wishes to obtain from the Director.

4.3.6 The Chair shall notify the Director of the requirement to attend a meeting of the Council. The notice shall include the matters specified in SO 4.3.5.

4.3.7 If, upon being given notice under SO 4.3.6, a Director refuses to attend or fails to attend the meeting of the Council the matter shall be referred to the Chair. If the Chair is unable to resolve the non attendance he shall:

4.3.7.1 in the case of a non-executive Director, refer the matter to the Council of Governors' Nomination and Remuneration Committee for investigation and report, including recommendations, to the Council of Governors; or

4.3.7.2 in the case of an executive Director, refer the matter to the Nomination and Remuneration Committee of the Board of Directors for investigation and report, including recommendations, to the Board of Directors.

4.3.8 The Chair shall report to the next general meeting of the Council on action taken in accordance with SO 4.3.7.2. If the Council is dissatisfied with the outcome of any action taken it may invoke the disputes resolution procedure set out in Annex 9 to the Constitution.

4.4 **Calling Meetings**

Notwithstanding, SO 4.1.1 above, the Chair may, in exceptional circumstances, call a meeting of the Council at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Governors, or if without so refusing the Chair does not call a meeting within fourteen days after a requisition to do so, then the Governors may forthwith call a meeting provided they have been requisitioned to do so by more than one-third of the Governors.

4.5 **Notice of Meetings**

4.5.1~~a~~ A notice specifying the date, time and place of a meeting of the Council of Governors and signed by the Chair, or by an officer authorised by the Chair to sign on his/her behalf, shall be sent to each Governor at least five (5) clear days before each meeting of the Council. Where the meeting is to be held or be accessible remotely, such notice shall also include details of how to access the meeting or, if this is not known at the time the notice is issued, details shall be circulated or otherwise made available as soon as practicable. Lack of service of the notice on any Governor shall not affect the validity of a meeting subject to SO 4.5.~~3~~5.

4.5.~~1b~~2 The notice of the meeting shall also specify the business proposed to be transacted at the meeting (the agenda).

4.5.~~1c~~3 The notice of the meeting provided to each Governor shall be:

(i) delivered by hand; or

(ii) sent by post to their usual place of residence; or
(iii) sent via electronic means.

4.5.~~2~~4 Notwithstanding the above requirement for notice, the Chair may waive notice on written receipt of the agreement of at least 50% of Governors in office~~.~~

4.5.~~5~~3 In the case of a meeting called by Governors in default of the Chair, the notice shall be signed by those Governors calling the meeting and no business shall be transacted at the meeting other than that specified in the notice. Failure to serve such a notice on more than three quarters of all Governors will invalidate the meeting. A notice will be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

4.6 Setting the Agenda

4.6.1 The Chair is responsible for leading on setting the agenda for meetings of the Council of Governors, and ensuring that adequate time is available for discussion of all agenda items.

4.6.2 The agenda for each general meeting of the Council shall include items to enable Governors:

4.6.~~2~~1.1 to ask questions on any matters contained in the confirmed minutes of any meeting of the Board of Directors held since the last meeting of the Council.

4.6.~~2~~1.2 to review any reports received from the Care Quality Commission about the Trust's compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009 and to consider making comments or observations on the matters included in those reports.

4.6.~~3~~2 The Council may also determine that certain matters shall appear on every agenda for a meeting of the Council and shall be addressed prior to any other business being conducted.

4.6.~~4~~3 A Governor desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least ten (10) clear working days before the meeting. Requests made less than ten (10) clear days before a meeting may be included on the agenda at the discretion of the Chair. The matter shall be included in the agenda for the next general meeting of the Council unless otherwise stated in the request.

4.7 **Chair of the Meeting**

At any meeting of the Council, the Chair, if present, shall preside. If the Chair is absent from the meeting the Deputy Chair shall preside. Otherwise, such Governor or non-executive Director, as the Governors present shall choose, shall preside.

4.8 **Notices of Motion**

4.8.1 A Governor desiring to move or amend a motion shall send a written notice thereof at least the (10) clear days before the meeting to the Chair, who, unless in his opinion he considers it to be out of order, illegal, impermissible or improper, shall insert it in the agenda for the meeting. ~~All notices so received are subject to the notice given being permissible under the appropriate regulations~~. This paragraph shall not prevent any motion being moved during the meeting, without notice, on any business mentioned on the agenda subject to SO 4.5.

4.8.2 A motion or amendment, once moved and seconded, may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

4.8.3 Notice of motion to amend or rescind any resolution (or general substance of any resolution), which has been passed within the preceding six (6) calendar months, shall bear the signature of the Governor who gives it and also the signature of four other Governors. When any such motion has been disposed of by the Council it shall not be competent for any Governor to propose a motion to the same effect within six (6) months; however the Chair may do so if he considers it appropriate.

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

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

a) An amendment to the motion.
b) The adjournment of the discussion or the meeting.
c) The appointment of an ad hoc committee to deal with a specific item of business.
d) That the meeting proceed to the next business.
e) That the motion shall be now put.

Such a motion, if seconded, shall be disposed of before the motion which was originally under discussion or about to be discussed. No amendment to

the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion. In the case of motions under d) and e), to ensure objectivity motions may only be put by a Governor who has not previously taken part in the debate.

4.8.6 A motion to remove the Chair or a non-executive Director must be in writing and be signed by at least ten (10) Governors and set out the reasons why the removal of the Chair or non-executive Director is proposed.

4.9 Reference of a matter to ~~Monitor~~NHS England's Panel

4.9.1 A Governor wishing to refer a matter to NHS England's~~Monitor's~~ Panel may only do so on the passing of a resolution by the Council following notice under SO 4.8.1.

4.9.2 The notice of motion to refer a matter to ~~Monitor's~~NHS England's Panel shall identify the provisions of this Constitution or the provisions made by or under Chapter 5 of the National Health Service Act 2006 with which the Governor considers the Trust has failed or is failing to act.

4.10 **Chair's Ruling**

Statements of Governors made at the meetings of the Council shall be relevant to the matter under discussion at the material time and the ruling of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

4.11 **Preservation of Order**

The Chair, acting reasonably, may exclude any Governor, Director, observer or member of public from the meeting if they are acting contrary to these Standing Orders, disregarding the rulings of the Chair under SO 4.10 above or if they are interfering with or preventing the reasonable conduct of the meeting.

4.12 **Adjournment**

4.12.1 Any meeting may be adjourned by the Chair (whether or not it has commenced) to such time and place as the Chair shall state, where acting reasonably it appears to the Chair that:

4.12.1.1 Governors wishing to attend the meeting cannot be properly or conveniently accommodated in or access the place appointed for the meeting;

4.12.1.2 the conduct of the persons present prevents, or is likely to prevent, the orderly continuation of the business of the meeting; or

4.12.1.3 an adjournment is otherwise necessary so that the business of the meeting may be properly conducted;

and any business remaining on the agenda shall stand adjourned until that adjourned meeting.

4.12.2 In addition the Chair may at any time adjourn the meeting where a quorum is present to another place and time with the consent of the meeting and shall be obliged to do so if directed by a majority of those present at the meeting.

4.12.3 Notice of the adjourned meeting shall be dispatched to all Governors not present at the meeting as soon as possible, but in any event no later than 2 (two) days prior to the date of the adjourned meeting (if possible).

4.13 Voting

4.13.1 Decisions at meetings shall be determined by a majority of the votes of the Governors present and voting. In the case of any equality in votes, the Chair shall have a second or casting vote.

4.13.2 All decisions 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 or electronic ballot may also be used if a majority of the Governors present so request. A vote cast by paper or electronic means shall be counted only if it is delivered to the ~~Trust~~Company Secretary within a reasonable period as determined and notified to Governors by the Chair.

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

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

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

4.14 **Suspension of Standing Orders (SOs)**

4.14.1 Except where this would contravene any statutory provision, any one or more of these Standing Orders may be suspended at any meeting, provided

that at least two-thirds of Governors are present and that the majority of those present vote in favour of the suspension.

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

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

4.14.4 No formal business may be transacted while SOs are suspended.

4.15 **Record of Attendance**

The names of the Governors present at the meeting shall be recorded in the minutes.

4.16 **Minutes**

4.16.1 The minutes of the proceedings of the meeting shall be drawn up and maintained as a public record. They will be submitted for agreement at the next general meeting where they will be signed by the person chairing it.

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

4.16.3 Minutes shall be circulated in accordance with Governors' wishes. The minutes of the meeting shall be made available to the public except for minutes relating to business conducted when members of the public are excluded from a meeting under SO 4.2.

4.17 Quorum

4.17.1 No business shall be transacted at a meeting of the Council of Governors unless at least one –third of Governors, in office ~~post~~, are present.

4.17.~~1a~~2 A Governor shall be classed as being present at a meeting if:
- ~~-~~(a) They are present in person at the location (if any) specified in the notice in which the meeting is being held; or
- ~~-~~(b) They are in "remote attendance" at the meeting.

4.17.~~1b~~3 A Governor shall satisfy the following conditions to be counted as being in "remote attendance" at a meeting:
- ~~-~~(a) They have verbally confirmed or otherwise indicated their presence to the Chair;

-(b) They are able to hear, and where practicable see, and be so heard and, where practicable, be seen by the other Governors in attendance; and

-(c) They are able to be heard and, where practicable, be seen by members of the public attending the meeting.

4.17.~~1c~~4 Any question as to whether a Governor satisfies the conditions for "remote attendance" in S.O. 4.17.~~1b~~3, at any or a particular time, shall be determined by the Chair.

4.17.~~2~~5 If a Governor has been disqualified from participating in the discussion of any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

5. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

5.1 **Emergency Powers –** The powers which the Council has retained to itself within these Standing Orders may in an emergency be exercised by the Chair after having consulted at least five (5) elected Governors. The exercise of such powers by the Chair shall be reported to the next formal meeting of the Council.

5.2 **Delegation to Committees –** The Council may agree from time to time to the delegation of its duties to committees or sub-committees, which it has formally constituted. To ensure clarity of purpose the Constitution and Terms of Reference of these committees, or sub-committees, and their specific powers shall be laid out in accordance with Trust policy and approved by the Council.

5.3 **Delegation to a Member of the Council of Governors –** The Council may delegate duties to an individual Governor but only under a clear remit approved by the Council.

6. Committees – Further Provisions

6.1 Save as stipulated in this Constitution the Council may appoint other committees of the Council consisting wholly of Governors. Non-members of the Council may attend such committees if appropriate under the committee's terms of reference but they shall have no vote.

6.2 A committee so appointed may appoint sub-committees consisting wholly of Governors. Non-members of the Council may attend such sub-committees if appropriate under the sub-committee's terms of reference but they shall have no vote.

6.3 With the exception of SO 4.2 (Admission of the public) these Standing Orders, as far as they are applicable, shall apply also, with the appropriate alteration, to meetings of any committees or sub-committees established by the Council.

6.4 Meetings of committees and sub-committees of the Council shall be held in private unless otherwise agreed by the committee or sub-committee.

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

6.6 Committees may not delegate their powers to a sub-committee unless expressly authorised by the Council.

6.7 Governors to serve on the Nomination and Remuneration Committee must be appointed by the Council.

6.8 The Council shall determine the process for the appointment of Governors to any of its other committees.

6.9 The membership of sub-committees shall be determined by the relevant committee.

6.10 With the exception of the Nomination and Remuneration Committee, it shall be for each individual committee to appoint its Chair and vice-Chair and the chairmen of its sub-committees.

6.11 The Chair of the Nomination and Remuneration Committee shall be the Chair of the Trust. The Senior Independent Director shall be the Chair of the Committee if the Chair of the Trust is absent or for matters pertaining to the appointment, appraisal and remuneration of the Chair of the Trust.

7. CONFIDENTIALITY

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

7.2 A Governor or a non-member of the Council of Governors in attendance at a committee shall not disclose any matter dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or committee resolves that it is confidential.

8. DECLARATION OF INTERESTS AND REGISTER OF INTERESTS

8.1 Declaration of Interests

Governors are required to comply with the Trust's policy on Conflicts of Interest ~~standards of business conduct and to declare interests that are relevant and material to the Council.~~ All Governors should declare ~~such~~ their interests on appointment and on any subsequent occasion when a conflict arises.

~~8.1.1 Interests regarded as "relevant and material" are:~~

~~a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).~~
~~b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.~~
~~c) Employment with any private company, business or consultancy.~~
~~d) Significant share holdings (more than 5%) in organisations likely or possibly seeking to business with the NHS.~~
~~e) A position of authority in a statutory, charitable or voluntary organisation in the field of health and social care.~~
~~f) Any connection with a voluntary or other organisation contracting for NHS Services.~~

8.1.1~~2~~ If a Governor has any doubt about the relevance of an interest, they should discuss it with the Chair who shall advise them whether or not to disclose the interest.

8.1.~~3~~2 At the time Governors' interests are declared, they should be recorded in the Council's minutes and (if appropriate) entered in a Register of Interests of Governors to be maintained by the Company ~~Trust~~ Secretary. Any changes in interests should be declared at the next Council meeting following the change occurring.

~~8.1.4 Governors' directorships of companies likely or possibly seeking to do business with the NHS shall be published in the Trust's Annual Report.~~

8.1.3 Information on the interests of Governors shall be disclosed in the Annual Report in accordance with guidance published by NHS England.

8.1.45 During the course of a Council meeting, if a conflict of interest is established, the Governor concerned shall withdraw from the meeting and play no part in the relevant discussion or decision unless two-thirds of those Governors present agree otherwise.

8.1.56 In the case of persons co-habiting the interest of one partner or spouse shall, if known to the other, be deemed for the purposes of the Constitution and these Standing Orders to be also an interest of the other, and a Governor shall be required to register and declare such interests.

8.2 Register of Interests

8.2.1 The Company ~~Trust~~ Secretary will ensure that a Register of Interests is established to record formally declarations of interests of Governors.

8.2.2 Details of the Register will be kept up to date and reviewed annually.

8.2.3 The Register will be available to the public.

9 TRAINING AND DEVELOPMENT

9.1 ~~Each year~~ Tthe Council shall agree a scheme of training and development to be undertaken by Governors to ensure that they are equipped with the skills and knowledge required to undertake their role and duties.

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10. PERFORMANCE EVALUATION

10.1 The Chair, with the assistance of the ~~Trust~~ Company Secretary, shall lead, at least annually, an assessment of the collective performance of the Council. This process will act as the basis for determining the scheme of training and development under SO 9.1.

11. COMPLIANCE – OTHER MATTERS

11.1 Governors shall comply with Standing Financial Instructions prepared by the Director of Finance and approved by the Board of Directors for the guidance of all staff employed by the Trust.

11.2 Members of the Council of Governors must behave in accordance with Code of Conduct for Governors of the Trust.

12. RESOLUTION OF DISPUTES WITH BOARD OF DIRECTORS

12.1 The process for resolving disputes between the Council and Board of Directors is set out in Annex 9 to the Constitution.

13. CHANGES TO STANDING ORDERS

13.1 These Standing Orders shall be amended only if:

13.1.1 A notice of motion under Standing Order 4.8 has been given; and

13.1.2 More than half of the members of the Council of Governors present vote in favour of amendment; and

13.1.3 The amendment proposed does not contravene a statutory provision; and

13.1.4 The amendment is agreed by Board of Directors.

13.2 Any change to these standing orders under SO 13.1 which amend the powers and duties of the Council shall cease to have effect, if members do not approve the amendment upon a vote being taken at an Annual Members' Meeting in accordance with paragraph 44 of this Constitution.

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

(Paragraph 31)

CONTENTS

~~Procurement of Agency Staff~~
~~Healthcare Services Contracts~~
~~Cancellation of Contracts~~
~~Determination of Contracts for Failure to Deliver Goods or Material~~
~~Contracts Involving Funds Held on Trust~~

~~13. DISPOSALS~~

~~14. IN-HOUSE SERVICES~~

13. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

Custody of Seal
Sealing of Documents
Register of Sealing

16. SIGNATURE OF DOCUMENTS

15 DISSEMINATION OF STANDING ORDERS

~~**Attached 1– SCHEME OF DECISIONS RESERVED TO THE BOARD AND SCHEDULE OF DECISIONS/DUTIES DELEGATED BY THE BOARD**~~

~~Role of the Chief Executive~~
~~Caution over use of delegated powers~~
~~Directors' ability to delegate their own delegated powers~~
~~Absence of Directors or officers to whom powers have been delegated~~
~~Matters reserved for the Board of Directors~~
~~Delegation of powers~~

1. INTRODUCTION

The principal place of business of the Trust is Flatts Lane Centre, Flatts Lane Normanby, Middlesbrough, Cleveland, TS6 0SZ.

NHS Foundation Trusts are governed by a Regulatory Framework that confers the functions of the Trust and comprises: Acts of Parliament and in particular the National Health Service Act 2006 ('the 2006 Act') as amended by the Health and Social Care Act 2012; the Health and Social Care Act 2022; their constitutions; and the terms of their Licence granted by Monitor.

The Regulatory Framework requires the Board of Directors to adopt Standing Orders for the practice and procedure of the Board of Directors.

The Board of Directors will conduct its business in as open a way as possible and will:

1. Observe the Nolan principles of Public Life of selflessness, integrity, objectivity, accountability, openness, honesty and leadership;

2. At all times seek to comply with the NHS Foundation Trust Code of Governance;

Everything done by the Trust should be able to stand the test of scrutiny, public judgment on propriety, and professional codes of conduct.

These Standing Orders (SOs) are for the regulation of the Board of Directors' proceedings and business.

2. INTERPRETATION

Save as permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders on which he should be advised by the ~~Trust~~ Company Secretary, Chief Executive and Director of Finance.

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

"ATTEND" or **"ATTENDANCE"** means in person or remotely.

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

"ASSOCIATE NON-EXECUTIVE DIRECTOR" is a person appointed by, and accountable to, the Board of Directors to provide additional advice or expertise to the Board. Associate Non-Executive Directors are not Directors of the Trust for the purposes of the 2006 Act and thus are non- voting appointees without executive or delegated executive functions or any powers to bind the Trust.

"BOARD" means the Board of Directors, formally constituted in accordance with this Constitution and consisting of a Chair, and non-executive Directors, appointed by the Council of Governors and executive Directors, appointed by the non-executive Directors and (except for his own appointment) by the Chief Executive.

"BUDGET" shall mean a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

"CHAIR" is the person appointed by the Council of Governors to lead the Board to ensure it successfully discharges its overall responsibility for the Trust as a whole. The Chair shall be deemed to include the non-executive Director appointed by the Council of Governors to take on the Chair's duties if the Chair is absent from the meeting or is otherwise unavailable, known as the Deputy Chair. The term Chair shall also, for the purposes of SOs refer to the person appointed by the Board to preside in exceptional circumstances when both the Chair and Deputy Chair are temporarily unavailable.

"CHIEF EXECUTIVE" shall mean the chief officer of the Trust.

"CLEAR DAY" - means a day of the week excluding the day the document becomes available, the day the meeting is held/notice submitted, Saturdays, Sundays and public holidays.

"COMMITTEE" shall mean a committee formed by the Board of Directors.

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

"EXECUTIVE DIRECTOR" is a person appointed through the Nomination and Remuneration Committee of the Board of Directors to be a member of the Board of Directors.

"FUNDS HELD ON TRUST" shall mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Sch 3 and 4 para 14.1c National Health Service Act 2006. Such funds may or may not be charitable.

"IN PERSON" means the physical presence of an individual.

"LICENCE" means the licence granted by Monitor under Chapter 3 of the Health and Social Care Act 2012.

"MEETING" means a meeting of the Board of Directors for which notice has been given in accordance with these Standing Orders and which may take place in person and/or remotely.

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

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

"NON-EXECUTIVE DIRECTOR" is a person appointed through the Nomination and Remuneration Committee of the Council of Governors to be a member of the Board of Directors. Initially non-executive Directors of the applicant NHS Trust will automatically become non-executive Directors of the Foundation Trust. This includes the Chair of the Trust.

"OFFICER" means an employee of the Trust.

"PLACE" in relation to a meeting, any reference to a "place" means the place where a meeting is held, or to be held, which may be:

- a specified location; or
- a virtual, digital or electronic platform/location including but not limited to platforms/locations accessed remotely via "Apps", internet locations, web addresses or conference call telephone numbers; or
- both.

"PRESENT" means attendance at a meeting either in person or remotely in accordance with the terms of these Standing Orders.

"REMOTE" or **"REMOTELY"** means attendance via electronic, digital or other virtual means including, but not limited to, telephone conference, video conference, live webcasts, and live interactive streaming provided such electronic means satisfies the requirements set out at S.O. 4.42.1b of this Annex 8.

"**SENIOR INDEPENDENT DIRECTOR"** means one of the non-executive Directors appointed by the Board of Directors to whom Governors may raise concerns about the performance of the Chair or the Trust if they consider it is inappropriate or impractical to express these concerns to the Chair or officers of the Trust. The Senior Independent Director also leads the Board on

matters pertaining to the appointment and appraisal of the Chair and provides advice to the Chair under the disputes resolution procedure.

"SFIs" means Standing Financial Instructions.

"SOs" means Standing Orders.

"TRUST" means the Tees Esk and Wear Valleys NHS Foundation Trust.

3. THE BOARD OF DIRECTORS – ITS COMPOSITION, APPOINTMENTS AND INDEMNITY ARRANGEMENTS

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

3.2 All funds received in trust shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

3.3 The powers of the Trust established under statute shall be exercised by the Board meeting except as stated in SO 5.

3.4 The Board of Directors has resolved that certain powers and decisions may only be exercised or made by the Board. These powers and decisions are set out in "Reservation of Powers to the Board" and have effect as if incorporated into the Standing Orders. The Board of Directors must adopt Standing Financial Instructions (SFIs) as an integral part of these Standing Orders setting out the responsibilities of individuals.

3.5 **Composition of the Board of Directors**

The composition of the Board of Directors shall be in accordance with paragraph 22 of the Constitution.

3.6 **Terms of Office of the Chair and Members of the Board**

The period of tenure of office of the Chair and each non-executive Director and the terms and conditions of service of the Chair and non-executive Directors shall be determined by the Council of Governors based on the provisions of the Constitution and guidance contained in the NHS Foundation Trust Code of Governance published by NHS England ~~Monitor~~.

3.7 **Appointment of the Chair and non-executive Directors** – the Chair and non-executive Directors are appointed/removed by the Council of Governors.

3.8 **Appointment of Deputy Chair** – The Council of Governors at a general meeting of the Council of Governors may appoint one of the non-executive Directors as the Deputy Chair.

3.9 Any non-executive Director so elected may at any time resign from the office of Deputy Chair by giving notice in writing to the Chair. The Council of Governors may thereupon appoint another non-executive Director as Deputy Chair in accordance with SO 3.8.

3.10 **Powers of Deputy Chair** – Where the Chair of the Trust has died or has otherwise ceased to hold office or where he has been unable to perform his/her duties as Chair owing to illness, absence or any other cause, references to the Chair in the Standing Orders shall, so long as there is no Chair able to perform his/her duties, be taken to include references to the Deputy Chair.

3.11 **Senior Independent Director** – The Board shall appoint one of the non-executive Directors as a "Senior Independent Director" in consultation with the Council of Governors.

3.12 In accordance with paragraph 28 of this Constitution the non-executive Directors shall appoint the Chief Executive (which appointment shall be approved by the Council of Governors) and a committee consisting of the Chair, Chief Executive and the non-executive Directors shall appoint or remove the other executive Directors.

3.13 The Board shall appoint a ~~Trust~~ Company Secretary, who, under the direction of the Chair, shall ensure information flows within the Board and Council of Governors and their Committees, between Directors and members of the Council of Governors, and between senior management and the Board. The ~~Trust~~ Company Secretary shall also advise the Board and Council of Governors on all governance matters and shall facilitate induction and professional development as required.

3.14 A Director and the ~~Trust~~ Company Secretary, who has acted honestly and in good faith will not have to meet out of his own personal resources any personal civil liability which is incurred in the execution or purported execution of his or her function as a Director/ Company~~Trust~~ Secretary save where the Director/~~Trust~~ Company Secretary has acted recklessly. On behalf of the Directors/ Company ~~Trust~~ Secretary and as part of the Trust's overall insurance arrangements the Board shall put in place appropriate insurance provision to cover such indemnity.

3.15 Non-executive Directors may, at the Trust's expenses, seek external advice or appoint an external adviser on any material matter of concern provided

the decision to do so is a collective one by the majority of non-executive Directors.

3.16 **Associate Non-Executive Directors** – The Board may appoint Associate Non-Executive Directors on terms and conditions and to undertake such duties as specified by the Board.

4. MEETINGS OF THE BOARD OF DIRECTORS

4.1 Admission of the Public

4.1.1 All meetings of the Board shall be open to the public except to the extent that they are excluded by resolution under SO 4.1.~~2~~3 below.

4.1.~~1a~~2 Where a meeting is accessible to the public through remote means it is open to the public whether or not members of the public are able to attend in person.

4.1.~~2~~3 The Board may by resolution exclude the public from a meeting during consideration of an item of business whenever it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the public were present during consideration of that item of business there would be disclosure to them of confidential information as defined in SO 4.1.~~3~~4 below

4.1.~~3~~4 The descriptions of information which are, for the purposes of this Standing Order, confidential information are those for the time being specified in Annex 9 to the Constitution.

4.1.~~4~~5 The reasons for the exclusion of the public from a meeting shall be included in the agenda for the meeting and recorded in the minutes.

4.1.~~5~~6 The Chair shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of or access by the public.

4.1.~~5a~~7 The Chair may determine that attendance by members of the public shall be restricted to access either in person or by remote means only.

4.1.~~5b~~8 Where remote access is provided the Chair must be satisfied that the arrangements will enable the public to be able to hear, and where practicable see, the business transacted at the meeting.

4.1.~~6~~9 Nothing in these Standing Orders shall require the Board to allow members of the public 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 Chair.

4.2 **Confidentiality** - Directors and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers or minutes marked 'Confidential" outside of the Board of Directors meeting, without the express permission of the ~~Board~~ Chief Executive. This prohibition shall apply equally to the content of any discussion during the Board of Directors' meeting which may take place on such reports or papers.

4.3 **Calling Meetings** - Ordinary meetings of the Board of Directors shall be held at such times and places as the Board may determine.

4.4 The Chair may call a meeting of the Board 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 Directors, has been presented to him/her, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to him/her at the Trust's Headquarters, such one third or more Directors may forthwith call a meeting.

4.5 **Notice of Meetings** –

4.5.1~~a~~ A notice specifying the date, time and place of a meeting of the Board of Directors and signed by the Chair, or by an officer authorised by the Chair to sign on his/her behalf, shall be sent to each Director at least three (3) clear days before each meeting of the Board. Where the meeting is to be held or be accessible remotely, such notice shall also include details of how to access the meeting or, if this is not known at the time the notice is issued, details shall be circulated or otherwise made available as soon as practicable.

4.5.~~1b~~2 The notice of the meeting shall also specify the business proposed to be transacted at the meeting (the agenda).

4.5.~~3~~2 The notice of the meeting provided to each Director shall be:
(i) delivered by hand; or
(ii) sent by post to their usual place of residence; or
(iii) sent by electronic means.

4.~~4~~6 Prior to each meeting a copy of the notice under SO 4.5.1~~a~~ shall be made available to each Governor.

4.~~7~~5 Want of service of the notice on any Director or failure to make available a copy of the notice to any Governor shall not affect the validity of a meeting subject to S.O. 4.~~8~~6.

4.~~8~~6 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 or emergency motions allowed

under these Standing Orders. Failure to serve such a notice on more than three (3) Directors will invalidate the meeting. A notice sent by post shall be presumed to have been served one day after posting.

4.~~7~~9 Before each public meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be published on the Trust's website together with electronic or other access details where applicable.

4.~~10~~8 **Setting the Agenda** - The Board may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

4.~~9~~11 A Director desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least ten (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. Requests made less than ten 10 days before a meeting may be included on the agenda at the discretion of the Chair.

4.~~10~~12 **Petitions** - Where a petition has been received by the Trust the Chair of the Board shall include the petition as an item for the agenda of the next Board meeting subject to the powers granted to the Chair by these Standing Orders to regulate arrangements for Board meetings.

4.1~~3~~1 **Chair of Meeting** - At any meeting of the Board, the Chair, if present, shall preside. If the Chair is absent from the meeting the Deputy Chair, if there is one and he is present, shall preside. If the Chair and Deputy Chair are absent such Director (who is not also an officer of the Trust) as the Directors present shall choose shall preside.

4.1~~4~~2 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Deputy Chair, if present, shall preside. If the Chair and Deputy Chair are absent, or are disqualified from participating, such non-executive Director as the Directors present shall choose shall preside. If any matter for consideration at a meeting of the Board of Directors relates to the interests of the Chair or to the interests of the non-executive Directors as a class, neither the Chair nor any of the non-executive Directors shall preside over the period of the meeting during which the matter is under discussion. The Directors (excluding the Chair or the non-executive Directors) shall elect one of their number to preside during that period and that person shall exercise all the rights and obligations of the Chair including the right to exercise a second or casting vote where the number of votes for and against a motion is equal.

4.13 **Decision Making -** When making decisions in the exercise of its functions which relate to the provision of health care for the purposes of the NHS, the Board shall comply with its duty relating to the triple aim, including any guidance published thereon by NHS England, of achieving:

4.13.1. better health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing)
4.13.2 better quality of health care services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services)
4.13.3. more sustainable and efficient use of resources by NHS bodies,

4.145 **Notices of Motion** - A Director desiring to move or amend a motion shall send a written notice thereof at least ten (10) clear days before the meeting to the Chair, unless in his/her opinion he/she considers it to be out of order, illegal, impermissible or improper, shall insert it in the agenda for the meeting. . ~~who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations.~~ This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda, subject to SO 4.~~19~~18.

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

4.167 **Motion to Rescind a Resolution** - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six (6) calendar months shall bear the signature of the Director who gives it and also the signature of four (4) other Directors. When any such motion has been disposed of by the Board, it shall not be competent for any Director other than the Chair to propose a motion to the same effect within six (6) months; however the Chair may do so if he considers it appropriate.

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

4.1819 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

- An amendment to the motion.
- The adjournment of the discussion or the meeting.
- That the meeting proceed to the next business. (*)
- The appointment of an ad hoc committee to deal with a specific item of business.

- That the motion be now put. (*)
- A motion resolving to exclude the public (including the press).

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

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

4.1920 **Chair's Ruling** - Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the ruling of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final. In this interpretation he shall be advised by the ~~Trust~~ Company Secretary on standing orders and the case of Standing Financial instructions by the Director of Finance.

4.201 **Preservation of Order** - The Chair, acting reasonably, may exclude any Director, or observer or member of the public from the meeting if they are acting contrary to these Standing Orders, disregarding the rulings of the Chair under paragraph 4.2019 above or if they are interfering with or preventing the reasonable conduct of the meeting.

~~4.22 (Deleted)~~

4.231 **Voting** - Every question put to a vote at a meeting shall be determined by a majority of the votes of the Directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote.

4.224 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 ballot, taken by paper or electronic means, may also be used if a majority of the Directors present so request. A vote cast by paper or electronic means shall be counted only if it is delivered to the ~~Trust~~ Company Secretary within a reasonable period as determined and notified to the Directors by the Chair.

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

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

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

4.2~~6~~8 An officer who has been appointed formally by the Board to act up for an executive Director during a period of incapacity or temporarily to fill an executive Director vacancy, shall be entitled to exercise the voting rights of the executive Director. An officer attending a meeting of the Board 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.

4.2~~7~~9 **Minutes** - The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ordinary meeting where they will be signed by the person presiding at it.

4.2830 No discussion shall take place upon the minutes except upon their accuracy ~~or where the~~ Chair ~~considers discussion appropriate~~. Any amendment to the minutes due to inaccuracy only shall be agreed and recorded at the next meeting.

4.2931 **Provision of minutes of meetings of the Board to the Council of Governors**

4.3~~0~~2 Copies of the confirmed minutes relating to any part of a meeting held in public shall be published on the Trust's website and Governors shall be notified accordingly.

4.3~~3~~1 Copies of the confirmed minutes for any part of a meeting from which the public were excluded under SO 4.1.2 shall be made available for inspection by Governors at least one hour before the next general meeting of the Council of Governors.

4.3~~2~~4 **Joint Directors** - Where the office of a Director is shared jointly by more than one person:

(a) either or both or any of those persons may attend or take part in meetings of the Board of Directors:
(b) if both/any are present at a meeting they should cast one vote if they agree:
(c) in the case of disagreements no vote should be cast;
(d) the presence of either/any or both/any of those persons should count as the presence of one person for the purposes of SO 4.4~~2~~0 (Quorum).

4.3~~3~~5 **Suspension of Standing Orders** - Except where this would contravene any provision of the Constitution or any direction made by ~~Monitor~~ NHS England, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Directors are present, including one

executive Director and one non-executive Director, and that a majority of those present vote in favour of suspension.

4.346 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

4.357 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Directors.

4.368 No formal business may be transacted while Standing Orders are suspended.

4.379 The Audit and Risk Committee shall review every decision to suspend Standing Orders.

4.3840 **Variation and Amendment of Standing Orders** - These Standing Orders shall be amended only if:

- a notice of motion under SO 4.154 has been given; and
- more than half of the Directors present vote in favour of amendment; and
- the variation proposed does not contravene a statutory provision and
- the amendment is agreed by the Council of Governors

4.3941 **Record of Attendance** - The names of the Directors present at the meeting shall be recorded in the minutes.

4.402 **Quorum** - No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of the Directors appointed, (including at least one non-executive Director and one executive Director) are present.

4.42a1 A Director shall be classed as being present at a meeting if:

(a) They are present in person at the location (if any) specified in the notice in which the meeting is being held; or

(b) They are in "remote attendance" at the meeting.

4.42b A Director shall satisfy the following conditions to be counted as being in "remote attendance" at a meeting:

(a) They have verbally confirmed or otherwise indicated their presence to the Chair.

(b) They are able to hear, and where practicable see, and be so heard and, where practicable, be seen by the other Directors in attendance; and

(c) They are able to be heard and, where practicable, be seen by members of the public attending the meeting.

4.42c3 Any question as to whether a Director satisfies the conditions for "remote attendance" in S.O. 4.42b, at any or a particular time, shall be determined by the Chair.

4.443 An officer in attendance for an executive Director but without formal acting up status may not count towards the quorum.

4.454 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one executive Director to form part of the quorum shall not apply where the executive Directors are excluded from a meeting (for example when the Board of Directors considers the recommendations of the Nomination and Remuneration ~~and Terms of Service~~ Committee). The above requirement for at least one non-executive Director to form part of the quorum shall not apply where all the non-executive Directors are excluded from a meeting.

4.465 **Adjournment of Meetings -** The Board of Directors may, by resolution, adjourn any meeting to some other specified date, place and time and such adjourned meeting shall be deemed a continuation of the original meeting. No business shall be transacted at any adjourned meeting which was not included in the agenda of the meeting of which it is an adjournment.

4.45.a7 Any meeting may be adjourned by the Chair (whether or not it has commenced) to such time and place as the Chair shall state, where acting reasonably it appears to the Chair that:

4.475.a.1 Directors wishing to attend the meeting cannot be properly or conveniently accommodated in or access the place appointed for the meeting;

4.475.a.2 the conduct of the persons present prevents, or is likely to prevent, the orderly continuation of the business of the meeting; or

4.475.a.3 an adjournment is otherwise necessary so that the business of the meeting may be properly conducted;

and any business remaining on the agenda shall stand adjourned until that adjourned meeting.

4.486 When any meeting is adjourned to another day, other than the following day, notice of the adjourned meeting shall be sent to each Director specifying the business to be transacted.

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

5. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

5.1 The Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 6.1 or 6.2 below or by a Director of the Trust in each case subject to such restrictions and conditions as the Board thinks fit.

5.2 **Emergency Powers** – The powers which the Board has retained to itself within these Standing Orders~~–~~ may in emergency be exercised jointly by the Chief Executive and the Chair after having consulted at least two other 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.

5.3 **Delegation to Committees** – The Board shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, 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.

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

5.5 The Chief Executive shall prepare a Scheme of Decisions Reserved to the Board and Schedule of Decision/Duties Delegated by the Board, identifying their proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board as indicated above.

5.6 Nothing in the Schedule of Decision/Duties Delegated by the Board shall impair the discharge of the direct accountability to the Board of the Director of Finance, other Director or the ~~Trust~~ Company Secretary to provide information and advise the Board in accordance with any statutory requirements.

5.7 The arrangements made by the Board as set out in the Scheme of Decisions Reserved to the Board and Schedule of Decision/Duties Delegated by the Board shall have effect as if incorporated in these Standing Orders.

5.8 If for any reason these Standing Orders are not complied with, full details of the non compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the Board and officers have a duty to disclose any non compliance with these Standing Orders to the Chief Executive or ~~Trust~~ Company Secretary as soon as possible.

6. COMMITTEES

6.1 **Formation of Committees** – The Board may form committees of the Trust, consisting wholly or partly of members of the Board of Directors or wholly of persons who are not members of the Board of Directors.

6.2 A committee so formed under SO 6.1 may form sub-committees consisting wholly or partly of members of the committee (whether or not they include Directors) or wholly of persons who are not members of the Trust committee (whether or not they include Directors).

6.3 The Standing Orders of the Trust, as far as they are applicable and with the exception of SO 4.1 (Admission of the public) shall apply with appropriate alteration to meetings of any committees or sub-committee formed by the Board or a committee respectively.

6.4 All meetings of committees and sub-committees established by the Board shall be held in private unless agreed by the committee or sub-committee.

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

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

6.7 The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines that persons, who are neither non-executive Directors nor Directors, shall be appointed to a committee, the terms of such appointment shall be defined by the Board. Those appointed would be entitled to the payment of travelling and other allowances.

6.8 Where the Trust is required to appoint persons to a committee and/or to undertake statutory functions and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with the regulations and directions laid down by the Board of Directors.

6.9 The Board may appoint sub-committees of the Board. Attendance at these Boards will be determined in the committees' terms of reference.

6.10 The following committees shall be established and maintained by the Board:

- Audit and Risk Committee
- Nomination and Remuneration Committee
- Mental Health Legislation Committee
- Quality Assurance Committee

Other committees and sub-committees of the Board may be formed from time to time.

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

7. CONFLICTS OF INTEREST

7.1 **Duties of Directors** – It it the duty of each Director to comply with the Trust's Policy on Conflicts of Interestsn accordance with paragraph 32 of the Constitution and the Trust's standards of business conduct. A a Director must:

7.1.1 Avoid any situation in which they have (or may have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

7.1.2 Not accept a benefit from a third party that conflicts (or possibly may conflict) with the interests of the Trust.

7.1.3 Declare any interests (either direct or indirect) they may have, including the nature and extent of any interest, in:

(a) any proposed transaction or arrangements with the Trust; or

(b) any other relevant or material matter relating to the Board of which they are a member.

7.1.4 Register any interests, in the register kept under paragraph 35.1.5 of the Constitution, including any all former employment/roles in the two years prior to taking up an appointment with the Trust, where there is or may be perceived to be a conflict of interest

7.2 A Director must seek advice from the Chair or the Company ~~Trust~~ Secretary if they have any doubt about the relevancy of a potential or actual interest.

7.3 **Relevant and Material Interests**

7.3.1 Interests which should be regarded as "relevant or material" under SO 7.1.3 (b) are:

(a) directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);

(b) ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

(c) majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;

(d) a position of trust in a charity or voluntary organisation in the field of health and social care;

(e) any connection with a voluntary or other organisation contracting for NHS services; and

(f) any other commercial interest in the decision the committee or Board meeting may be considering.

7.4 **Declarations of Interests**

7.4.1 A Director shall declare any interests under SO 7.1.3:

(a) on appointment;

(b) if relating to an interest under SO 7.1.3(a), before the Trust enters into the proposed transaction or arrangement;

(c) at any meeting at which the proposed transaction, arrangement or relevant and material matter is being considered either at the start of the meeting or as soon as they become aware of it; and

(d) if appropriate in the register kept in accordance with paragraph 35.1.5 of the Constitution.

7.4.2 A further declaration of interest must be made if the original declaration of interest under SO 7.4.1 proves to be, or becomes, inaccurate or incomplete.

~~7.5 Interests of Spouses or Cohabiting Partners~~

~~7.5.1 The interests of a Director's spouse or cohabiting partner shall, for the purposes of SO 7.1.3 be treated as if they are the interests of the Director themselves.~~

7.56 Disability of Directors in proceedings on account of interests

7.654.1 If a Director is present at a meeting at which a matter in which they have an interest is being considered they shall, unless the interest in the subject of a dispensation under SO 7.87:

7.56.1.1 Declare the interest in accordance with SO7.4.1(c).

7.56.1.2 For a ~~direct pecuniary~~ financial interest, withdraw from the meeting room whilst the matter is being considered.

7.65.1.3 For a~~n~~ indirect financial ~~pecuniary~~ interest arising from their being a Director of a Subsidiary ~~or holding an equivalent position of authority in a Trust Trading Vehicle~~, participate in the consideration or discussion but not vote on any matters concerning the Subsidiary ~~or Trust Trading Vehicle~~.

7.65.1.4 For all other indirect ~~pecuniary~~ interests of a financial nature, take no part in the consideration of or discussion on the matter, without the Chair's agreement, or vote on any question with respect to it except in circumstances set out in SO 7.87.7.53.

7.56.1.5 For all other interests participate in the consideration or discussion on the matter or vote on any question in respect of it as they consider appropriate.

7.56.2 The Board of Directors may exclude the Chair or a Director from a meeting of the Board by resolution if they have reasonable cause to believe that he has a direct pecuniary interest in any matter under consideration.

7.67 Record of Declarations of Interests

7.67.1 The interests of a Director shall be recorded in:

(a) the minutes of the meeting at which the interest was declared in accordance with SO 7.4.1 (c); and
(b) In the register of interests in accordance with SO 7.4.1 (d).

7.~~7~~8 Interpretation, Savings and Dispensations

7.~~7~~8.1 The duty of a Director under SO 7.1.1 is not infringed if

(a) the situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or
(b) the matter has been authorised in accordance with the Constitution.

7.~~7~~8.2 The duty of a Director under SO 7.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

7.~~8~~7.3 In SO 7.1.2 "third party" means a person other than:
(a) the Trust; or
(b) a person acting on its behalf.

7.~~7~~8.4 A Director shall not be regarded as having an interest if they are not aware of it or of the transaction or arrangement in question.

7.~~8~~7.5 A Director need not declare an interest in a matter:
7.~~8~~7.5.1 if it cannot reasonably be regarded as likely to give rise to an interest;
7.~~7~~8.5.2 if, or to the extent that, the Directors are already aware of it. (A Director may only rely on this provision if the interest has been declared previously at a meeting of the Board or it is recorded in the Register of Interests); or
7.~~7~~8.5.3 if, or to the extent that, it concerns the terms of the Director's appointment that have been or are to be considered -
(a) By a meeting of the Board of Directors; or
(b) By a committee of the Directors appointed for the purpose under the Constitution

7.~~7~~8.6 Any remuneration, compensation or allowances payable to a Director by virtue of paragraph 11 of Schedules 3 and 4 to the National Health Service Act 2006 shall not be treated as a ~~pecuniary~~ financial interest for the purpose of this Standing Order.

7.~~7~~8.7 For the purposes of SO 7.~~6~~5:

7.~~7~~8.7.1 The Chair or Director shall be treated, as having an indirect ~~pecuniary~~ interest of a financial nature in a contract, proposed contract or other matter, if:

(a) he, or a nominee of him, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a ~~direct pecuniary~~ financial interest in the other matters under consideration; or

(b) he is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a financial ~~direct pecuniary~~ interest in the other matter under consideration.

7.~~7~~8.7.2 The Chair or Director shall not be treated as having a financial ~~pecuniary~~ interest (either direct or indirect) in any contract, proposed contract or other matter by reason only because:

(a) of their membership of a company or other body, if he has no beneficial interest in any securities of that company or other body;

(b) of an interest in any company, body or person with which he is connected as mentioned in SO 7.3.1 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a member in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.~~7~~8.7.3 Where the Chair or a Director:

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

(b) the total nominal value of those securities does not exceed one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one hundredth of the total issued share capital of that class,

this Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

7.~~8~~9 **Application to meetings of Committees and Sub-Committees**

7.~~8~~9.1 Standing Order 7.~~8~~7 applies to a committee or sub-committee of the Board as it applies to the Board and applies to any member of any such committee or sub-committee (whether or not they are also a Director) as it applies to a Director.

8. STANDARDS OF BUSINESS CONDUCT

8.1 **Policy** - Staff must comply with all ~~the~~ Trust~~'s detailed Standards of Business Conduct~~ polices relating to standards of conduct~~and Capability policy documents~~ including the Conflicts of Interest Policy~~.~~

8.2 **Interests of Officers in Contracts** – If it comes to the knowledge of a Director of the Trust that a contract is which he has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Chief Executive of the fact that he is interested therein.

8.3 An officer must also declare to the Chief Executive any other employment or business or other relationship of him/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. The Trust requires interests, employment or relationships so declared by staff to be entered in a register of interests of staff.

8.4 **Canvassing of, and recommendations by, Members in relation to Appointments** –

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

8.5 A Director shall not solicit for any person any appointment by the Board of Directors or recommend any person for such appointment, but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Board, if required

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

8.7 **Relatives of Members of the Board of Directors** – Candidates for any staff appointment shall when making application disclose in writing whether they are related to any member of the Board or the holder of any office within the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

8.8 The Chair, and every Director of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature the Chair, or Director is aware. It shall be the duty of the Chief Executive or nominated Director to report to the Board any such disclosure made.

8.9 Prior to or on acceptance of an appointment, the Chair and Directors must disclose to the Board whether they are related to any other member or holder of any office under the Trust.

8.10 Where the relationship of a Director or another member of the Board or another member of the Trust is disclosed, SO 7.~~6~~5 shall apply.

9. RESOLUTION OF DISPUTES WITH THE COUNCIL OF GOVERNORS

9.1 The procedure for the resolution of disputes between the Board and the Council of Governors is set out in Annex 9 to the Constitution.

10. NOTIFICATION TO ~~MONITOR~~ NHS ENGLAND AND THE COUNCIL OF GOVERNORS

10.1 The Board shall notify ~~Monitor~~ NHS England and the Council of Governors of any major changes in the circumstances of the Trust which have made or could lead to a substantial change to its financial well being, healthcare delivery performance, or reputation and standing or which might otherwise affect the Trust's compliance with the terms of its Licence.

10.2 The requirement for the Board to notify the Council of Governors under SO 10.1 above includes, but is not limited to, the provision of the following information:

10.2.1 notification of concerns by the Care Quality Commission and any compliance actions or enforcement notices related thereto;

10.2.2 the expiry; loss, cancellation, withdrawal or other termination without renewal; suspension; or any modification of terms of its registration with the Care Quality Commission;

10.2.3 a statement setting out any material changes to services that ~~those services~~ the Trust is required to provide as Commissioner Requested Services ~~and notification of any changes thereto~~;

10.2.4 any application made ~~notice provided~~ to ~~Monitor~~ NHS England in relation to the disposal or relinquishment of control over any relevant asset as defined within the Licence;

10.2.5 any notice received from NHS England~~Monitor~~ that it has concerns about the ability of the Trust to continue as a going concern;

10.2.6 A notice received from NHS England about the Trust's ability to continue to provide commissioner requested services or NHS commissioned services due to quality stress

~~10.2.6 a copy of any certificate provided to Monitor as to the availability of required resources;~~ or

10.2.7 any notification provided to NHS England ~~Monitor~~ when the Directors are aware of any circumstance that causes them to no longer have expectation that the Trust will have reasonable resources available to it.

11. BOARD PERFORMANCE

11.1 The Chair, with the assistance of the ~~Trust~~ Company Secretary, shall lead, at least annually, a performance assessment process for the Board. This process should act as the basis for determining individual and collective professional development programmes for Directors.

12. TENDERING AND CONTRACT PROCEDURE

12.1 **Duty to comply with Standing Orders and Standing Financial Instructions** – The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders (except where Suspension of SOs is applied) and the Standing Financial Instructions.

~~12.2 **Formal Competitive Tendering** – 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 for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.~~

~~12.3 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 (c) to (f) below) where:~~

~~(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the threshold set by the Board on the advice of the Director of Finance; or~~

(b) the timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for waiving tender procedures; or

(c) specialist expertise is required and there is clear and convincing evidence readily at hand that it is available from only one source; or

(d) the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different parties for the new task would be inappropriate; or

(e) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; or

(f) where provided for in the Capital Investment Manual. The limited application of the single tender rules should not be used to avoid competition or for administrative convenience or to avoid further work to a party originally appointed through a competitive procedure.

(g) Where it is decided that competitive tendering is not applicable and should be waived by virtue of (b) to (e) above the fact of the waiver, and the reasons should be documented and reported by the Chief Executive to the Board in a formal meeting.

12.4 Except where SO 12.3, or a requirement under SO 12.2, applies, the Board shall ensure that invitations to tender are sent to a sufficient number of firms/individual 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.

12.5 The Board shall ensure that normally the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists. Where in the opinion of the Director of Finance it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive for approval.

12.6 Tendering procedures are set out in the Standing Financial Instructions.

12.7 **Competitive Quotations** – are required where formal tendering procedures are waived under SO 12.3 (a) or (b) and where the intended expenditure or income exceeds, or is reasonably expected to exceed the threshold set by the Board on the advice of the Director of Finance.

12.8 Where quotations are required under SO 12.8 they should be obtained from at least three firms/individuals on the approved list based on specifications or terms of reference prepared by, or on behalf of, the Board.

12.9 Quotations should be in writing unless the Chief Executive or their 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.

12.10 All quotations should be treated as confidential and should be retained for inspection.

12.11 The Chief Executive or their nominated officer should evaluate the quotations and select the one which gives the best 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.

12.12 Non-competitive quotations in writing may be obtained for the following purposes:

(a) the supply of goods/services of a special character for which it is not, in the opinion of the Chief Executive or their nominated officer, possible or desirable to obtain competitive quotations; or

(b) the goods/services are required urgently. Failure to place the work properly is not a justification for waiving tender procedures.

12.13 **Where tendering or competitive quotation is not required** – The Trust shall use the agreed management procurement process for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented. Procurement shall normally be through the procurement process unless agreed by the Chief Executive or a nominated officer.

12.14 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 may also determine from time to time that in-house services should be market tested by competitive tendering.

12.15 **Private Finance** – When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector;

(b) Where the sum exceeds delegated limits (at the time of writing £8m except for property leases where the other level is £4m.

(c) 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.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

12.16 **Contracts** – The Trust may only enter into contracts within its statutory powers and shall comply with:

(a) Standing Orders;
(b) The SFIs;
(c) EU Directives and other statutory provisions;

12.17 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

12.18 **Procurement of Agency Staff** – The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment regarding staff, agency staff or temporary staff service contracts.

12.19 **Healthcare Services Contracts** – shall be drawn up in accordance with Department of Health model contracts.

12.20 The Chief Executive shall nominate officers with power to negotiate for the provision of healthcare services with purchasers of healthcare.

12.21 **Cancellation of Contracts** – Except where specific provision is made in model forms of Contracts or standard Schedules of Conditions approved for use within the National Health Service and in accordance with Standing Orders 12.2 and 12.3, 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 the contractor shall have offered, or given or agreed to give, any person any gift (exceeding £10) 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 of any other contract with the Trust; or
- 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
- if in relation to any contract with the Trust the contractor or any person employed by them or acting on their behalf shall have committed any offence under the Prevention of Corruption Acts 1889 and 1916 and other appropriate legislation.

12.22 **Determination of Contracts for Failure to Deliver Goods or Material** – 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 cancel 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 cancelled the goods or material remaining to be delivered. The clause 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.

12.23 **Contractors 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 Act.

13 DISPOSALS

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) 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 their nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items with an estimated sale value of less than £10,000 (this figure to be reviewed annually);

(d) items arising from works of construction, demolition or site clearance which should be dealt with in accordance with the relevant contract;

(e) land or buildings whether or not classed as a "relevant asset" under the Trust's Licence.

~~14. IN-HOUSE SERVICES~~

~~14.1 In all cases where the Trust determines that in-house services should be subject to competitive tendering the following groups shall be set up:~~

~~(a) Specification group, comprising the Chief Executive or nominated officer(s) and specialists(s);~~

~~(b) In-house tender group, comprising representatives of the in-house team, a nominee of the Chief Executive and technical support; and~~

~~(c) Evaluation group, comprising normally a specialist officer, a supplies officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £250,000, a nominated Non-Executive Director should be a member of the evaluation team.~~

~~14.2 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.~~

~~14.3 The evaluation group shall make recommendations to the Board.~~

~~14.4 The Chief Executive shall nominate an officer to oversee and manage the contract.~~

1~~5~~3. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

1~~5~~3.1 **Custody of Seal** – The Common Seal of the Trust shall be kept by the Chief Executive or nominated person in a secure place.

1~~5~~3.2 **Sealing of documents-** 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 by an officer to whom the Board of Directors has delegated its powers.

1~~5~~3.3 Where it is necessary that a document shall be sealed the seal shall be affixed in the presence of two Directors or a Director and the ~~Trust~~ Company Secretary and shall be attested by them. The Directors approving and attesting the document shall not be from the originating department.

1~~5~~3.4 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an Officer nominated by him/her).

153.5 The form of the attestation of documents shall be "The Common Seal of the Tees Esk and Wear Valleys NHS Foundation Trust was hereto affixed in the presence of ……".

153.6 **Register of Sealing** – An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and attested the seal. A report of all sealing shall be made to the next Board of Directors meeting. (The report shall contain details of the seal number, the description of the document and date of sealing).

164. SIGNATURE OF DOCUMENTS

164.1 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.

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

~~17~~ 15. DISSEMINATION OF STANDING ORDERS

The Chief Executive is responsible for ensuring all existing Directors and officers, and all new appointees are notified of, an understand their responsibility within the Standing Orders.

Attached 1

~~Scheme of Decisions Reserved to the Board and Schedule of Decision/Duties Delegated by the Board~~

~~1. Introduction~~

~~Standing Order 5.5 of the Board of Directors provides that the Chief Executive shall prepare a Scheme of Decisions Reserved to the Board and Schedule of Decision/Duties Delegated by the Board, identifying his/her proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion.~~

~~The purpose of this document is to provide details of those powers which are reserved to the Board, while at the same time detailing those delegated to the appropriate level. However, the Board remains accountable for all of its functions, even those delegated to the~~ Chair~~, individual Directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.~~

~~1.1 Role of the Chief Executive~~

~~All powers of the Trust which have not been retained as reserved by the Board or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions he shall perform personally and which functions have been delegated to other Directors and officers.~~

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

~~1.2 Caution over the Use of Delegated Powers~~

~~Powers are delegated to Directors and officers on the understanding that they would not exercise delegated powers in any matters which in their judgment was likely to be a cause for public concern.~~

~~1.3 Directors' Ability to Delegate their own Delegated Powers~~

~~The Scheme of Delegation shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the Trust's Budgetary Control Framework and other established procedures within the Trust.~~

~~**1.4 Absence of Directors or Officer to Whom Powers have been Delegated**~~

~~In the absence of a Director or officer to whom powers have been delegated those powers shall be exercised by that Director or officer's superior unless alternative arrangements have been approved by the Board. It may be fitting for the~~ Chair ~~to take advice from the designated Deputy Chief Executive (where such a designation exists) or the most appropriate Director, depending on the particular issue.~~

~~**2. Matters Reserved to the Board**~~

~~**2.1** It is for the Board to determine those matters on which decision are reserved unto itself. These reserved matters are set out in paragraphs 2.2 to 2.10 below:~~

~~**2.2 General Enabling Provision**~~

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

~~**2.3 Internal Control**~~

~~2.3.1 Approval of, suspension, variation or amendments of Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business.~~

~~2.3.2 Ratification or otherwise, of instances of failure to comply with Standing Orders brought to the Chief Executives' or Trust Secretary's attention.~~

~~2.3.3 Approval of a scheme of delegation of powers from the Board to officers.~~

~~2.3.4 To require and receive the declaration of officers' and Board members' interests, which may conflict, with those of the Trust and determining the extent to which that Director or officer may remain involved with the matter under consideration.~~

~~2.3.5 Requiring and receiving the declaration of interests from officers, which may conflict, with those of the Trust.~~

~~2.3.6 Discipline Directors and senior employees who are in breach of statutory requirements or Standing orders.~~

2.3.7 Approval of the disciplinary procedure and personal responsibility framework for officers of the Trust.

2.3.8 Approval of arrangements for dealing with complaints.

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

2.3.10 Establishment of terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board.

2.3.11 To receive reports from committees including those which the Trust is required by regulation to establish and to take appropriate action thereon.

2.3.12 To confirm the recommendations of the Trust's committees where the committees do not have executive powers.

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

2.3.14 Approval of arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.

2.4 Appointments

2.4.1 The setting up and dismissal of committees.

2.4.2 The appointment and approval of the terms and conditions of service including the responsibilities of Associate Non-Executive Directors.

2.4.3 The appointment of the Senior Independent Director taking into account the views of the Council of Governors.

2.4.4 The appointment of members of any committee of the Board of Directors.

2.4.5 The appointment, appraisal, discipline and dismissal of the Trust Secretary.

2.4.6 The nomination of persons to be directors or senior officers of a Subsidiary or to hold a similar position of authority in a Trust Trading Vehicle.

2.4.7 The appointment of a person or persons to act on the Trust's behalf in relation to its shareholding in any Subsidiary including representing the Trust at meetings of the Subsidiary and executing any notices received from the Subsidiary.

2.5 Policy Determination

2.5.1 The approval and monitoring of the Trust's policies and procedures for the management of risk.

2.5.2 The approval of Trust policies in relation to investments.

2.6 Strategy and Business Plans and Budgets

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

2.6.2 The approval of the Trust's Forward Plan subject to:

- Consultation with the Council of Governors.
- The approval of the Council of Governors if, in any year, it is proposed to increase by more than 5% the proportion of its total income attributable to non-NHS services.

2.6.3 Overall approval of programmes of investment to guide the letting of contracts for the supply of clinical services.

2.6.5 Approval of individual proposals for making write-offs and special payments above the limits of delegation (£50,000) previously delegated to the Chief Executive and Director of Finance by the Board.

2.6.6 Approval of arrangements for consultation on service reconfiguration proposals in excess of £500,000 per annum or of a novel or contentious nature.

2.6.7 The approval of any merger, acquisition, separation, dissolution or significant transaction (as defined in paragraph 45 of the Constitution) in conjunction with the Council of Governors.

2.7 Direct Operational Decisions

2.7.1 Acquisition, disposal (including relinquishing control) or change of use of land and/or buildings in excess of £500,000 or (subject to the consent of Monitor) where the said land and/or building is a "relevant asset" as detailed in the Trust's Licence.

2.7.2 The introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant where:

- it is of a novel or contentious nature, or if it has a gross annual income or expenditure (that is before any set off) in excess of £500,000 or 20% of budget; or
- it is a Commissioner Requested Service as defined in the Trust's Licence.

2.7.3 Approval of individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £500,000 over a 3 year period or the period of the contract if longer.

2.7.4 Approval of individual compensation payments over £25,000.

2.7.5 Agreement to policy on litigation against or on behalf of the Trust.

2.8 Financial and Performance Reporting Arrangements

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

2.8.2 Approval of the opening or closing of any bank or investment account, excluding individual patient accounts.

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

2.8.4 Consideration and approval of the Trust's Annual Report including the Annual Accounts and Quality Account/Report.

2.8.5 Receipt and approval of the Annual Report for funds held on trust.

~~**2.9 Regulatory Matters**~~

~~2.9.1 The approval of any certificates, notices or other information required to be provided to Monitor under the conditions of the Licence.~~

~~**2.10 Audit Arrangements**~~

~~2.10.1 To approve audit arrangements (including arrangements for the separate audit of funds held in trust) and to receive reports of the Audit Committee meetings and take appropriate action.~~

~~2.10.2 The receipt of the annual audit letter received from the external auditor (or other document prepared by the external auditors in lieu of an annual audit letter) and agreement of action on the recommendation where appropriate of the Audit Committee.~~

3. Delegation of Powers

3.1 Delegation to Committees

The Board may determine that certain of its powers shall be exercised by Standing Committees. The composition and terms of reference of such committees shall be that determined by the Board from time to time taking into account where necessary the requirements of Monitor and/or the Charity Commissioners (including the need to appoint an Audit Committee and a Remuneration Committee). The Board shall determine the reporting requirements in respect of these committees. In accordance with SO 5.3 committees may not delegate executive powers to sub-committees unless expressly authorised by the Board.

Scheme of delegation Implied by Standing Orders for Board of Directors

SO REF: DELEGATED DECISIONS AND DUTIES

4.1.5a CHAIR

Give directions on arrangements for meetings including accommodation of the public.

4.1.5a CHAIR

Determine that attendance by members of the public shall be restricted to access in person, by remote means or both.

4.1.5b CHAIR

To be satisfied that arrangements for remote access to meetings will enable the public to be able hear, and where practicable see, the business transacted at the meeting.

4.1.6 CHAIR

Determine whether or not proceedings at Board meetings can be recorded or oral reports can be made of those proceedings as they take place.

4.4 CHAIR

Call meetings.

4.4.2 CHAIR

Determine any question as to whether, at any particular time, a Director satisfied the conditions for remote attendance at a meeting.

4.5 CHAIR OR NOMINATED OFFICER

Sign notices of Board meetings.

4.9 TRUST SECRETARY

Give public notice of Board meetings.

4.12 CHAIR

Arrange consideration of petitions by the Board.

4.13 CHAIR

Chair all Board meetings and associated responsibilities.

4.20 CHAIR

Give final ruling in questions of order, relevancy and regularity of meetings.

4.21 CHAIR

Exclude any Director, observer or member of the public from a meeting if they are acting contrary to Standing Orders, disregarding the rulings of the Chair or interfering with or preventing the reasonable conduct of the meeting.

4.23 CHAIR

Have a second or casting vote.

4.39 AUDIT COMMITTEE

Review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board).

4.45a CHAIR

Adjourn meetings in the interests of attendance and access; orderly conduct; or for the proper conduce of business.

5.2 CHAIR & CHIEF EXECUTIVE

Exercise the powers which the Board has retained to itself within Standing Orders in an emergency after having consulted at least two non-executive Directors.

5.5 CHIEF EXECUTIVE

Prepare a Scheme of Decisions Reserved to the Board and Decisions/Duties Delegated by the Board for approval by the Board

8.8 CHIEF EXECUTIVE

Receive and report to the Board on disclosures made by the Chair or Directors on relationship between themselves and a candidate of whose candidature they are aware. .

11 CHAIR

Lead the annual performance assessment of the Board.

(Note: The Senior Independent Director leads the annual performance assessment of the Chair)

12.3 CHIEF EXECUTIVE

Delegate authority to waive tendering procedures to named officers.

12.3 NAMED OFFICERS

Waive tendering procedures without reference to Chief Executive in the circumstances listed in 12.1 (a) and (b).

12.3(a) DIRECTOR OF FINANCE

Advise the Board on thresholds above which formal tenders must be obtained in line with procurement systems (electronic or written)

12.3 CHIEF EXECUTIVE

Waive tendering procedures relating to SO 12.3 (c) to (f).

12.3 CHIEF EXECUTIVE

~~Document the reasons why, and report tenders waived by virtue of SO12.3(b) to (e), to the Board in a formal meeting.~~

~~12.5 CHIEF EXECUTIVE:~~

~~Decide on use of a firm not on the approved suppliers list on the advice of the Director of Finance.~~

~~12.7 DIRECTOR OF FINANCE~~

~~Advise the Board on threshold above which Competitive Quotations must be obtained in line with procurement systems (electronic or written)~~

~~12.9 CHIEF EXECUTIVE OR NOMINATED OFFICER:~~

~~Determine that a quotation need not be in writing if this would be impracticable.~~

~~12.11 CHIEF EXECUTIVE OR NOMINATED OFFICERS~~

~~Evaluate quotations and select the one which gives best value.~~

~~12.14 CHIEF EXECUTIVE~~

~~Demonstrate there is best value for money for all services provided under contract or in-house.~~

~~12.15 CHIEF EXECUTIVE~~

~~Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector.~~

~~12.17 CHIEF EXECUTIVE~~

~~Nominate an officer to oversee and manage each contract on behalf of the Trust.~~

~~12.18 CHIEF EXECUTIVE~~

~~Nominate officers to enter into contracts of employment, regarding staff, agency staff or consultancy service contracts.~~

~~12.20 CHIEF EXECUTIVE~~

~~Nominate officers with power to negotiate for the provision of healthcare services with purchasers of healthcare.~~

~~13(a) CHIEF EXECUTIVE OR NOMINATED OFFICER~~

~~Determine any items to be sold by sale or negotiation.~~

~~13.4 CHIEF EXECUTIVE~~

~~Nominate an officer to oversee and manage a contract (for in-house services) on behalf of the Trust.~~

~~15.1 CHIEF EXECUTIVE Keep the seal in safe place and maintain a register of sealing.~~

~~15.3 DIRECTORS AND TRUST SECRETARY~~

~~Approve and sign all building, engineering, property or capital documents. (Any two as delegated by the Board)~~

~~16.2 CHIEF EXECUTIVE~~

~~Approve and sign all documents which will be necessary in legal proceedings.~~

~~16.2 CHIEF EXECUTIVE (OR OFFICERS NOMINATED BY THE BOARD)~~

~~Sign, on behalf of the Trust, any agreement or document not requested to be executed as a deed.~~

~~17 CHIEF EXECUTIVE~~

~~Ensure that existing Directors and employees, and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions.~~

ANNEX 9 - Further Provisions

1 Disqualification from Membership

A person may not become a member if:

1. Within the last 10 years they have been involved in a serious incident of violence at any of the Trust's hospitals, facilities or sites or against any of the Trust's employees, or registered volunteers.

2. They are under 14 years of age.

3. They have acted in a way, which is detrimental to the Trust.

A person may not become or remain a member of the Public Constituency if they are eligible to become a member of the Staff Constituency.

A person may not be a member of more than one constituency.

Where the Trust is on notice that a member may be disqualified from membership, or may no longer be eligible to be a member it shall give the member 14 days written notice for them to show cause why their name should not be removed from the register of members. On receipt of any such information supplied by a member, the ~~Trust~~ Company Secretary may, if he considers it appropriate, remove the member from the Register of Members. In the event of any dispute the Company ~~Trust~~ Secretary shall refer the matter to the Council of Governors. All Members of the Trust shall be under a duty to notify the Company ~~Trust~~ Secretary of any change in their particulars, which may affect their entitlement as a member.

2 Termination of Membership

A member shall cease to be a member if:

1. They resign on notice to the Company ~~Trust~~ Secretary;

2. They cease to be entitled under this Constitution to be a member of any of the constituencies;

3. They are expelled under this Constitution;

4. If it appears to the Company ~~Trust~~ Secretary that they no longer wish to be a member and after enquiries made in accordance with a process approved by the Council of Governors, they fail to confirm that they wish to continue to be a member of the Trust.

3 Expulsion

A member may be expelled by a resolution of the Council of Governors. The following procedure is to be adopted:

1. Any member may complain to the Company ~~Trust~~ Secretary that another member has acted in a way detrimental to the interests of the Trust.

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

   a. Dismiss the complaint and take no further action; or

   b. Arrange for a resolution to expel a member to be considered at the next meeting of the Council of Governors.

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

4. At the meeting the Council of Governors will consider oral and written evidence produced in support of the complaint and any oral and written evidence submitted for or on behalf of the member about whom complaint has been made.

5. If the member complained of fails to attend the meeting without due cause the meeting may proceed in their absence. A person expelled from membership will cease to be a member upon the declaration by the Chair of the meeting that the resolution to expel them is carried. No person who has been expelled from membership is to be re-admitted except by a resolution carried by the votes of two-thirds of the members of the Council of Governors present and voting at a meeting of the Council of Governors.

4 Board of Directors Termination of Tenure and Disqualification

i. A non-executive Director may resign from that office at any time during his term of office by giving notice to the Company ~~Trust~~ Secretary

ii. In the case of a non-executive Director, he is no longer a member of the public constituency.

iii. He becomes a member of the Council of Governors

iv. He ceases to be a fit and proper person to be a Director of a Foundation Trust in accordance with the requirements set out in the Licence and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

v. He is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986.

He is otherwise disqualified at law from holding the office of non-executive Director of an NHS Foundation Trust

5 Classes of information to be treated as confidential

The classes of information to be treated as confidential for the purposes of Standing Order 4.2.~~3~~6 of the Council of Governors and Standing Order 4.1.~~4~~3. of the Board of Directors shall be as follows:

1. Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office-holder or applicant to become an office-holder under, the Trust.

2. Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Trust.

3. Information relating to any particular applicant for, or recipient or former recipient of, any financial assistance provided by the Trust.

4. Information relating to the financial or business affairs of any particular person (other than the Trust).

5. The amount of any expenditure proposed to be incurred by the Trust under any particular contract for the acquisition of property or the supply of goods or services.

6. Any terms proposed or to be proposed by or to the Trust in the course of negotiations for a contract for the acquisition or disposal of property or the supply of goods or services.

7. The identity of the Trust (as well as of any other person, by virtue of paragraph 4 above) as the person offering any particular tender for a contract for the supply of goods or services.

8. Any documents relating to the Trust's forward plans prepared in accordance with paragraph 27 of schedule 7 of the National Health Service Act 2006.

9. Information which, if published would, or be likely to, inhibit -
   (a) the free and frank provision of advice, or

(b) the free and frank exchange of views for the purposes of deliberation, or

(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.

10. Information relating to any consultations or negotiations, or contemplated consultations or negotiations, in connection with any labour relations matter arising between the Trust and employees of, or office-holders under, the Trust.

11. Any advice received or information obtained from legal or financial advisers appointed by the Trust or action to be taken in connection with that advice or information.

12. Any action taken or to be taken in connection with the prevention, investigation or prosecution of crime.

13. Information:
(a) prohibited from disclosure by or under any enactment, or
(b) which if disclosed by the Trust would be incompatible with any EU obligation or would constitute or be punishable as a contempt of court.

14. Information which is held by the Trust with a view to its publication, by the Trust or any other person, at some future date (whether determined or not), and it is considered reasonable, in all the circumstances, to withhold the information from disclosure until that date.

6. RESOLUTION OF DISPUTES BETWEEN THE BOARD OF DIRECTORS AND THE COUNCIL OF GOVERNORS

Should a dispute arise between the Board of Directors and Council of Governors -

1. The Chair or Deputy Chair (if the dispute involves the Chair) of the Trust, as appropriate, shall first endeavour through discussion with the Council of Governors and Board of Directors (or, to achieve the earliest possible conclusion, appropriate representatives of them) to resolve the matter to the reasonable satisfaction of both parties.

2. Failing resolution under (1) above then the Board or the Council of Governors, as appropriate, shall, at its next formal meeting, approve the precise wording of a Disputes Statement setting out clearly and concisely the issue or issues giving rise to the dispute.

3. The Chair or Deputy Chair (if the dispute involves the Chair) shall ensure that the Disputes Statement, without amendment or abbreviation in any way, shall be an Agenda Item and Agenda Paper at the next formal meeting of the

Board or Council of Governors as appropriate. That meeting shall agree the precise wording of a Response to Disputes Statement.

4 The Chair, or Deputy Chair (if the dispute involves the Chair), as appropriate, shall immediately or as soon as is practicable, communicate the outcome to the other party and deliver the Response to Disputes Statement. If the matter remains unresolved or only partially resolved then the procedure outlined in (3) above shall be repeated.

5. If, in the opinion of the Chair, or Deputy Chair (if the dispute involves the Chair), as appropriate, and following the further discussion prescribed in (4), there is no further prospect of a full resolution or, if at any stage in the whole process, in the opinion of the Chair or Deputy Chair, as the case may be, there is no prospect of a resolution (partial or otherwise) then they shall advise the Council of Governors and the Board accordingly.

6. At each stage in the process, and in particular prior to determining whether there is no prospect of resolution, the Chair, or Deputy Chair (if the dispute involves the Chair) shall consult with the Senior Independent Director.

7. On the satisfactory completion of this disputes process the Board shall implement any agreed changes.

8. On the unsatisfactory completion of this disputes process the view of the Board shall prevail unless the matter falls within the statutory powers of the Council of Governors.

9. Nothing in this procedure shall prevent the Council of Governors, if it considers it appropriate following advice from the Senior Independent Director, Lead Governor and the Company ~~Trust~~ Secretary from:
   a. informing ~~Monitor~~ NHS England that it believes the Board has not responded constructively to concerns about the Trust's compliance with its Licence.
   b. Referring a matter to NHS England's ~~Monitor's~~ Panel in accordance with paragraph 18 of the Constitution.
   c. Making a direct referral to the Care Quality Commission if it considers the issue giving rise to the dispute will lead to the Trust failing to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

ANNEX 10 – ANNUAL MEMBERS' MEETING

1. General

1.1 A meeting of the Members of the Foundation Trust ("The Annual Members' Meeting) shall be held annually in accordance with paragraph 10 of the Constitution.

2. Interpretation

2.1 All words and expressions shall have the same meaning as those provided in the Standing Orders of the Council of Governors (Annex 7 to the Constitution).

3. Combination of the Annual Members' Meeting and the Annual General Meeting of the Council of Governors.

3.1 Unless otherwise agreed by the Chair of the Trust, the Annual Members' Meeting will be combined with the Annual General Meeting of the Council of Governors.

4. Calling the Annual Members' Meeting

4.1 The date and time of the Annual Members' Meeting shall be agreed by the Chair of the Trust in consultation with the Council of Governors.

4.2 The place for the meeting shall be fixed by the Chair of the Trust.

5. Notice of the Annual Members' Meeting

5.1 Notice of an Annual Members Meeting must be given:

5.1.1 to all Members (who are included in the register kept under paragraph 34.1.1 of the Constitution on the date the notice is given);

5.1.2 to all Governors;

5.1.3 in a paid-for newspaper circulating in the Trust's area; and

5.1.4 on the Trust's website

at least 14 clear days before the date of the meeting.

5.2 The notice shall give the time, date and place of the meeting and indicate the business proposed to be transacted at it. Where a meeting is to be held

remotely, either in whole or in part, this shall be stated in the notice together with details of how to access the meeting.

5.3 A copy of the notice must also be sent to all Directors and to the External Auditor (unless they are notified of the meeting in accordance with paragraph 4.1.1 above).

5.4 Want of service of the notice on any Member of the Trust shall not affect the validity of a meeting.

6. Business to be transacted at the Annual Members' Meeting

6.1 The following business must be transacted at the Annual Members' Meeting:

6.1.1 the presentation of the Annual Accounts;

6.1.2 the presentation of any report prepared by the External Auditors on the Annual Accounts;

6.1.3 the presentation of the Annual Report; and

6.1.4 the consideration of any motions to ratify any amendment to the Constitution which has been agreed since the last Annual Members' meeting in relation to the powers and duties of the Council of Governors.

6.2 A motion under paragraph 6.1.4 above, in relation to each specific amendment to the Constitution, shall be set out in the notice for the meeting and moved by the Chair of the meeting.

6.3 No other business shall be transacted at an Annual Members' Meeting.

7. Chair of the Annual Members' Meeting

7.1 The Chair of the Trust, if present, shall preside.

7.2 If the Chair is absent, the Deputy Chair of the Trust, shall preside.

7.3 If both the Chair and Deputy Chair are absent, a Governor or non-executive Director, chosen by the Governors of the Trust, shall preside.

7.4 The ruling of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

8. Preservation of Order

8.1 The Chair acting reasonably, may exclude any Member, Governor, Director, officer of the Trust or member of the public from the meeting if they are interfering with or preventing the reasonable conduct of the meeting.

9. **Presentation of the Annual Accounts and Annual Report**

9.1 The Annual Accounts and Annual Report shall be presented by the Chief Executive (or by a Director appointed by him).

10. Quorum

10.1 No business shall be transacted at an Annual Members' Meeting unless there are at least fifty (50) Members present.

10.2 A Member shall be classed as being present at a meeting if:
(a) They are present in person at the location (if any) specified in the notice in which the meeting is being held; or
(b) They are in "remote attendance" at the meeting.

10.3 A Member shall satisfy the following conditions to be counted as being in "remote attendance" at a meeting:
(a) They have verbally confirmed or otherwise indicated their presence to the Chair.
(b) They are able to hear, and where practicable see, and be so heard and, where practicable, be seen by the other Members in attendance.

10.3 Any question as to whether a Member satisfies the conditions for "remote attendance" in para. 10.3, at any or a particular time, shall be determined by the Chair.

11. Voting

11.1 The method of voting on any motion under paragraph 6.1.4 shall be determined by the Chair.

12. **Minutes**

12.1 The minutes of the Annual Members' Meeting shall be approved at the next ordinary meeting of the Council of Governors.

13. Adjournment

13.1 An Annual Members' Meeting may be adjourned by the Chair (whether or not it has commenced) to such time and place as the Chair shall state, where acting reasonably it appears to the Chair that:

(a) Members wishing to attend the meeting cannot be properly or conveniently accommodated in or access the place appointed for the meeting;

(b) the conduct of the persons present prevents, or is likely to prevent, the orderly continuation of the business of the meeting; or

(c) an adjournment is otherwise necessary so that the business of the meeting may be properly conducted;

and any business remaining on the agenda shall stand adjourned until that adjourned meeting.

Annex 2

Issues raised in connection with Proposed Changes to the Constitution

	Issue	Response
1	Should provisions be included in the Constitution in relation to the Council of Governors engaging with the ICBs and holding them to account.	It is not considered appropriate to include provisions relating to this issue in the Constitution as there is no statutory or regulatory framework requiring the ICBs to engage with the Council or accede to a request to attend a meeting. However, there is nothing to prevent the Council, by resolution, from inviting representatives of the ICBs to attend meetings of the Council to provide briefings or to discuss matters of common interest.
2	Transitional arrangements for the appointment of the next Lead Governor as Ann McCoy's term of office is due to be completed on 31 March 2024.	A suggestion that Cllr McCoy's term of office should be extended to the end of June 2024, to enable the proposed amendments to the Constitution to be determined, was supported by Governors attending the Governor Development Event. A report to formalise this position is due to be considered by the Council at its meeting to be held on 19th March 2024.
4	Whether the request from the Council for Board Members to register interests, relating to all former employment/roles held by them in the two years prior to taking up an appointment with TEWV, where there is or may be perceived to be a conflict of interest, has been reflected in the revised Constitution.	This matter has been included in the revised Standing Orders of the Board of Directors.
5	How should the issue of partner organisations appointing Governors with little or too specific an interest is one area of mental health be addressed.	It is for each partner organisation to determine who it should appoint as its representative on the Council unless the nominee is barred from being a Governor (see Annex 6 to the Constitution). However, the Trust is able to provide information on its services and the role of the Council of Governors to support the organisation's appointments process.
6	How long a period is required before a Governor, who has completed their maximum term, can become a Governor again.	No specific time period is set. There would only need to be a break in membership of the Council. It is likely the minimum break would be 12 months given the electoral cycle.

7	Would a conflict of interest arise if an partner organisation received funding from the Trust.	It is likely that any conflict of interest would be able to be managed.
8	In regard to the proposed changes to the North Yorkshire Public Constituency, how would Governors understand the area if they are all from the same place.	There are risks that all the Governors could come from one part of the Constituency; however, this is considered to be unlikely given the experience in County Durham. Under the NHS Act 2006 the boundaries of the Public Constituencies must be based on those of local authorities and, since the reorganisation of local government in the County and the abolition of the District Councils, change is required.
9	Why are Governors excluded from the confidential sessions of meetings of the Board of Directors.	Both the Board and the Council need the ability to hold meetings in private respecting their individual roles. The outcome of Board discussions on material issues are likely to be reported to the Council of Governors.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of: **Board of Directors**

Date: **14 March 2024**

Title: **Register of Sealing**

Executive Sponsor(s): **Brent Kilmurray, Chief Executive**

Report Author: **Phil Bellas, Company Secretary**

Report for:	***Assurance***		***Decision***	
	Consultation		***Information***	✓

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	✓
2: To co-create a great experience for our colleagues	✓
3: To be a great partner	✓

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
10	Regulatory Compliance	Under its Provider Licence, the Trust must take all reasonable precautions against the risk of failure to comply with: a. The Conditions of the Licence, b. Any requirements imposed on it under the NHS Acts, and c. The requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

Executive Summary:

Purpose: To advise the Board of the use of the Trust's seal in accordance with Standing Order 15.2.

Proposal: The Board is asked to receive and note this report.

Overview: The Trust's seal has been used as follows:

Ref	**Document**	**Sealing Officers**
427	Settlement and release agreement relating to Roseberry Park Hospital	Patrick Scott, Managing Director DTVF Phil Bellas, Company Secretary
428	Parent company guarantee relating to Roseberry Park	Patrick Scott, Managing Director DTVF Phil Bellas, Company Secretary

429	Renewal lease relating to rooms at the Pioneering Care Centre, Newton Aycliffe	Patrick Scott, Managing Director DTVF Phil Bellas, Company Secretary
430	TP1 form relating to garden land at Lanchester Road Hospital	Ann Bridges, Director of Corporate Affairs and Involvement Phil Bellas, Company Secretary
431	TP1 form relating to garden land at Lanchester Road Hospital	Ann Bridges, Director of Corporate Affairs and Involvement Phil Bellas, Company Secretary

Prior Consideration and Feedback None relating to this report.

Implications: None relating to this report.

Recommendations: The Board is asked to note this report.