Western Sussex Hospitals
NHS Foundation Trust

Meeting of the Board of Directors

09:30 to 12:45 on Thursday 28 November 2019

Bateman Room, Chichester Medical Education Centre, St Richard's Hospital, Spitalfield Lane, Chichester, PO19 6SE

AGENDA – MEETING IN PUBLIC

No.	Time	Item	Format	Lead
1.	09.30	**Welcome and Apologies for Absence** To note	Verbal	Chair
2.	09.30	**Declarations of Interests** To note	Verbal	All
3.	09.30	**Minutes of Board Meeting held on 26 September 2019** To approve	Enclosure	Chair
4.	09.30	**Matters Arising from the Minutes** To note progress and agree any further actions	Enclosure	Chair
5.	09.35	**Report from Chief Executive** To receive and note overview of the Trust's activities	Presentation	Marianne Griffiths
		INTEGRATED PERFORMANCE REPORT		
6.	10.05	**Introduction from Chief Executive** To receive and note overview of the Trust's activities	Enclosure	Marianne Griffiths
7.	10.15	**Quality Improvement** To receive and agree any necessary actions	Enclosure	George Findlay Maggie Davies
8.	10.25	**Systems and Partnerships** To receive and agree any necessary actions	Enclosure	Pete Landstrom
9.	10.35	**Sustainability** To receive and agree any necessary actions *After these two sections the Chair of Finance and Performance Committee will be invited to provide their report included at item 11* To receive assurance from Committee and recommendations from the Committee	Enclosure	Karen Geoghegan
10.	10.45	**Our People** To receive and agree any necessary actions *At this point the Chairs of the Committees will be invited to provide any additional assurance from the work of their committees.*	Enclosure	Denise Farmer
		ASSURANCE REPORTS FROM COMMITTEES		
11.	-	**Report from Finance and Performance Chair**		

		- **from the meeting on the 28 October** To receive assurance from Committee and recommendations from the Committee	Enclosure	Lizzie Peers
		- **from the meeting on the 25 November**	Verbal	Lizzie Peers
12.	10.55	**Report from Charitable Funds Chair**		
		- **from the meeting on the 03 October** To receive assurance from Committee and recommendations from the Committee	Enclosure	Joanna Crane
13.	11.05	**Report from Audit Chair**		
		- **from the meeting on the 03 October** To receive assurance from Committee and recommendations from the Committee	Enclosure	Lizzie Peers
14.	11.15	**Board Assurance Framework** To approve for publication on the web site	Enclosure	Glen Palethorpe
		SERVICE PRESENTATION		
15.	11.25	**Estates and Facilities Presentation** To receive assurance over application of patient first processes	Presentation	Estates Division
		OUR PEOPLE		
16.	11.40	**National approach to Flu Vaccinations** To receive and agree any necessary actions	Enclosure	Maggie Davies
		QUALITY		
17.	11.50	**Seven Day Services Board Assurance Framework** To receive and agree any necessary actions	Enclosure	George Findlay
18.	12.00	**Dementia Strategy** To approve	Enclosure	Maggie Davies
		WELL LED & COMPLIANCE		
19.	12.15	**Company Secretary Report** To note	Enclosure	Glen Palethorpe
		OTHER		
20.	12.25	**Any Other Business** To receive and action	Verbal	Chair
21.	12.30	**Questions from the public** To receive and respond to questions submitted by the public	Verbal	Chair
22.	12.45	**Date and time of next meeting:** The next meeting in public of the Board of Directors is scheduled to take place at **10:30** on **30 January 2020** in the John Bull Conference Room, WHEC, Worthing Hospital.	Verbal	Chair

To resolve to move to into private session

The Board now needs to move to a private session due to the confidential nature of the business to be transacted

Trust Board of Directors Quoracy
A meeting of the Board shall be quorate and shall not commence until it is quorate.
Quoracy is defined as meaning that at least half of the Board must be present, including one Non-executive Director and one Executive Director. This means that at least 6 voting members must be present. A Director shall be deemed as present if he joins the meeting by telephone or other means, provided that he can hear and be heard by all other Directors present at the meeting

Minutes of the Board of Directors meeting held in Public at 09.30am on Thursday 26 September 2019, John Bull Conference Room, Worthing Health Education Centre, Worthing Hospital, Lyndhurst Road, Worthing.

Present:	Alan McCarthy	Chairman
	Patrick Boyle	Non-Executive Director
	Mike Rymer	Non-Executive Director
	Joanna Crane	Non-Executive Director
	Lizzie Peers	Non-Executive Director
	Jon Furmston	Non-Executive Director Adviser
	Dame Marianne Griffiths	Chief Executive
	George Findlay	Chief Medical Officer & Deputy Chief Executive
	Denise Farmer	Chief Workforce and OD Officer
	Pete Landstrom	Chief Strategy and Delivery Officer
	Karen Geoghegan	Chief Financial Officer
	Maggie Davies	Chief Nurse
	Amanda Fadero	Managing Director
In Attendance:	Colin Spring	Chief of Service – Surgery (For Item 15)
	Kim Cheetham	Head of Nursing – Surgery (For Item 15)
	Sharon Reed	Lead Infection Prevention and Control Nurse (For Item 16)
	Dr Susie Jerwood	Consultant Microbiologist (For Item 16)
	Glen Palethorpe	Group Company Secretary
	Tanya Humphrys	Board Administrator

TB/09/19/01 Welcome and Apologies

1.1 The Chair welcomed all those present to the meeting.

1.2 Apologies were received from Kirstin Baker.

TB/09/19/02 Declarations of Interests

2.1 There were no declarations of interest.

TB/09/19/03 Minutes of Board Meeting held on 25 July 2019

3.1 The Board received the minutes of the meeting held on 25 July 2019.

3.2 **The Board resolved that the minutes of the Board meeting held on 25 July 2019, would be approved as a correct record of the meeting and signed by the Chairman.**

TB/09/19/04 Matters arising from Minutes

4.1 The Matters Arising from previous meetings were received.

4.2 All Matters Arising related to items on the agenda or were on a forward agenda plan and the Board agreed to close all items.

TB/09/19/05 Chief Executive's Report

5.1 Dame Marianne Griffiths introducted the Chief Executives report and highlighted the following key areas.

5.2 **Support for Mental Health Patients** – Marianne advised the Board that

there was good news for mental health patients in the Western Sussex area with investment and improvements being jointly implemented by the Trust and Sussex Partnership NHS Foundation Trust, including the expansion of the Community Crisis team to 24/7 and confirmation that the mental health liaison teams in both A&E departments will also be expanded.

5.3 **Refer a Friend** – the Board was advised that the Trust had launched a scheme as part of the wider recuritment campaign, that would also provide an incentive to staff.

5.4 **IM&T Investment** – Marianne explained to the Board that the Trust had invested almost £5m in new IT innovations and improvements for both staff and patients. Marianne added that she would like to invite the IM&T department to do a service presentation for the Board.
ACTION: IM&T to attend a future Board to give a service presentation. **GF**

5.5 **AGM** – Marianne highlighted that the Trust had held its Annual General Meeting in July which had been well attended and had showcased the Trust's Discharge Project to discharge patients before midday to improve flow. A significant improvement in the pilot wards where this has been implemented was praised.

5.6 Marianne went on to highlight to the Board the regulatory meetings that had been attended over the previous two months, noting that it had been a very busy couple of months for the work with the STP in relation to the convertingof the NHS 10 year plan into STP workstreams.

5.7 Finally Marianne explained that the Trust had now completed all three components of the CQC inspection and explained that at present the timescales expected were that the draft report is expected at the beginning of October with the final report due to be released around the 20 October. Marianne commented that she could not be more proud of the staff and thanked all those that had been involved.

5.8 The Board **NOTED** the Chief Executive's Report.

TB/09/19/06 Integrated Performance Report

6.1 Dame Marianne Griffiths introduced the Integrated Performance Report explaining that Patient First is the Trust's methodology encapsulating the Trust's vison, values and goals and how it aligns its processes and governance, highlighting that there are three key streams of work that feed into the Trust's Patient First True North; Breakthrough Objectives, Corporate Projects and Strategic Initiatives.

6.2 **Quality**
George Findlay updated the Board on the key messages from the Quality section of the report noting that the Trusts' focus had been on being in the top 20% in the Country for HSMR which had been achieved until very recently when there has been a deterioration bring the Trust down to the 48th percentile.

6.3 George explained that changes in Sepsis coding, particularly at St Richard's had impacted this, but there remains a reduction in actual deaths. However the coded expected decrease in deaths is higher due to increases in coding for UTIs with a less expected mortality outcome and a decrease in the coding of Sepsis as the primary diagnosis where an

expected death is higher. It was noted that there was a monthly sepsis group that is chaired by the Medical Director and is looking closely at the accuracy of coding. George noted that Crude Mortality was decreasing and drew the Board's attention to the graph at slide 6 of the presentation.

6.4 Maggie Davies advised the Board that there had been a reduction in patients suffering pressure damage for the second consecutive month, it was noted that where there has been a reduction in damage to patients and that the newly purchased electric beds have helped with this.

6.5 The Board was updated in relation to the Patient Safety Thermometer indicator outcome, that the actual number of patients who suffered no new harm during their inpatient stay was 98.9% against the Trust target of 99%. Maggie explained that this triangulated well with mortality.

6.6 In relation to Patient Experience it was noted that the Trust had received 41 complaints during August, in Month 5 66% of complaints collectively were closed within 25 working days, delivering the Trust improvement goal. Maggie explained that this was largely down to early engagement with families.

6.7 The Trust continues to receive very good 'recommend rates' through the national Family and Friends Test, Maggie did note that the Trust still needs to improve its inpatient response rate.

6.8 The Chairman invited the Chair of the Quality Assurance Committee, Mike Rymer, to update the Board on their recent meeting and the assurances received in relation to Quality.

6.9 Mike explained that the Quality Assurance Committee had received a Deep Dive into Mental Health which the Committee had found very helpful and assuring that steps were being taken to provide support for those patient affected most, in particular the system wide approach.

6.10 It was noted that the Committee had received the Quarterly Divisional Clinical Governance Review report where the Committee noted the concerns in Radiology with their increased vacancies, but were assured that the measures in place to recruit substantively to those posts, Mike commented that the Committee has been advised that this was a national issue.

6.11 The Committee received the Quality Strategy for 2019-2021 which it had recommended for Board approval and was to be received by the Board later on the agenda.

6.12 Lizzie Peers asked what the governance process was in relation to the oversight of the Mortality coding issue. George explained that the Trust conducts regular coding audits which look at quality and application of process, but added that the coders are only able to code what is written so there is a lot of education with junior doctors and coders will often sit in the department and code in real time.

6.13 **Systems & Partnerships**

Amanda Fadero drew out the following key points in respect of the Trust's operational performance in August 2019:

- The Trust saw continued significant increases in numbers of emergency patients attending both A&Es, with an increase of 9.2% in August 2019 compared to August 2018, with 15.2% increase in over 85s attending.

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- A&E 4hr performance for August 2019 was 86.3%, compared to 86.28% national performance.
- RTT compliance in June 2019 was 82.0% with no patients waiting over 52 weeks. Lower activity impacted, alongside higher demand than planned. The Trust is refocussing efforts to increase activity with support from alternative providers, increased productivity and additional internal WLIs and locum support.
- Cancer performance for August 2019 is compliant against 6 of 8 cancer targets with provisional 78.1% for patients treated within 62 days. National average performance was 77.6%.
- Diagnostic performance was marginally non-compliant at 1.5%. This was mainly due to continued capacity pressure for endoscopic modalities. Additional locum support has been secured in September and Trust is projecting recovery September.

6.14 The Chairman invited the Chair of the Finance and Performance Committee, Lizzie Peers, to update the Board on their recent meeting and the assurances received in relation to Systems & Partnerships.

6.15 Lizzie advised the Board that the Finance and Performance Committee had spent a long time scrutinising Trust performance for August and discussed at length the improvement and action plans recognising that a number of plans are in train. It was noted that the Committee will continue to scrutinise to ensure that good quality care is being maintained, in addition it was noted that the Committee would be receiving a Deep Dive into RTT performance in October.

6.16 Dame Marianne Griffiths commented that as a Trust we are used to achieving A&E, Cancer and Diagnostic targets and acknowledged that there have been demand issues with an unprecedented demand for the Trust's services and recognised the challenge this placed on Trust staff; however the expectation is that the Trust will return to compliance.

6.17 **Sustainability**

Karen Geoghegan advised the Board that at the end of August the Trust reported a deficit of £0.53m. This brings the cumulative position, excluding PSF and MRET, to £1.56m which is in line with the planned position. It was noted that at the Trust needed to deliver its control total at the end of Quarter 2 and was forecasting delivery of the year-end control total.

6.18 Karen explained that the Medical staff expenditure was an area of increased focus to ensure that spend is kept down but there is a notable increase in elective activity. Karen drew the Board's attention to the Finance dashboard, noting that the Trust is retaining a financial risk rating of 1, the best rating possible.

6.19 The Trust continues to perform in line with the Efficiency Programme but this needs to be closely monitored to ensure that for the year this remains on track. Capital expenditure is above plan but Karen noted that it was planned to bring expenditure forward this year and that the Capital Investment Group would continue to review the forecast to ensure that expenditure on the full year programme is not exceeded.

6.20 The Chairman invited the Chair of the Finance and Performance Committee, Lizzie Peers, to update the Board on their recent meeting and the assurances received in relation to Sustainability.

6.21 Lizzie advised the Board that the Committee did discuss the risks to both the Trust's Efficiency and Finance targets despite the fact that they are

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currently on track. Divisional performance and delivery of their targets to date will be incorporated into the October reports in addition to a paper on year end delivery plans.

6.22 **Our People**
Denise Farmer noted the key areas from the staff engagement section of the report and drew the Board's attention to the following highlights in particular that next week [w/c 30 September 2019] would see the launch of the NHS annual staff survey process. Denise explained that the Trust tracks certain questions from the survey through the year and when using the current internal results the Trust would achieve the breakthrough target for staff engagement.

6.23 It was noted that the Trust had been very engaged with staff in relation to patient first, the imminent annual STAR awards and the thank you cups, this level of engagement is what is thought to have helped the Trust achieve its highest engagement score to date.

6.24 Denise advised the Board that the Trust had just launched the 'Best Place to Work' platform which was allowing staff to have their say, Denise explained that there were a number of new things that had come out of the discussions such as referring to staff by their band rather than job role. The Board was advised that all of the information collected will feed into the ongoing staff engagement work at the Trust.

6.25 The Board **NOTED** the Integrated Performance Report.

TB/09/19/07 Report from the Finance and Performance Committee Chair

7.1 The Board **NOTED** the Report from the Finance and Performance Committee Chair, highlights of which had been received as part of the Integrated Performance Report.

TB/09/19/08 Report from the Quality Assurance Committee Chair & Quality Strategy for 2019 – 2021.

8.1 George Findlay introduced the Quality Strategy for 2019-2021 and explained that this was a refresh of the previous strategy and continued to frame the Trust's four key objectives which are very closely linked to Patient First. It was noted that the strategy had been developed in consultation with stakeholders.

8.2 The Board **NOTED** the Report from the Quality Assurance Committee Chair, highlights of which had been received as part of the Integrated Performance Report and **APPROVED** the Quality Strategy for 2019-2021.

TB/09/19/09 Board Assurance Framework

9.1 Glen Palethorpe drew the Board's attention to the summary of the key strategic risks within the Board Assurance Framework (BAF) and noted that the information received through the integrated performance report and assurance reports from Committee Chair's link to the details in the BAF. Glen commented that there had been no changes in the risk scores from Quarter 1 to Quarter 2, but that it was likely there would be a change from Quarter 2 to Quarter 3. The Board agreed that no changes were required to the scores.

9.2 The Board **NOTED** the Board Assurance Framework.

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TB/09/19/10 Critical Care Service presentation

10.1 Colin Spring and Kim Cheetham introduced the Critical Care presentation and drew the Board's attention to the following key areas.

10.2 Colin explained to the Board that the presentation that was being shared was given to the CQC during the recent inspection to provide them with a service overview. It was noted that the division comprises of 5 care groups and has two clinical leads, one per site.

10.3 Colin drew the Board's attention to slide 7, which provided a Divisional overview of activity over the previous year of 2018/19. It was noted that critical care now experienced pressure and demand issues all year round which very much mirrors what is happening in the rest of the hospital.

10.4 Colin highlighted the Critical Care Service overview, which drew attention to the following points:

- Critical Care Units are in place at both St Richards and Worthing Hospitals:
- There are 22 Flexible Level 3 and Level 2 Beds across both sites
- There are 5 Enhanced Surgical Care Unit (ESCU) Beds at Worthing Hospital
- There is 24/7 dedicated Intensivist Consultant Cover (one on each site)
- There were some 1,275 Critical Care Unit admissions in 2018/19
- Critical Care Outreach for 7 days is provided at both St Richards and Worthing Hospitals
- The Trust in response to deteriorating patient use hospital wide e-Observations and is complaint with the National Early Warning Score
- There are routine follows up on all ICU discharges to wards to minimise re-admission
- The Trust holds monthly Out Patient Follow Up clinics for all patients in ICU to support then post discharge

10.5 The Board's attention was drawn to slides 10 – 11 which detailed the areas of improvement implemented by the service following the previous CQC inspection in 2016.

10.6 Kim explained to the Board the areas that the service was particularly proud of and that the primary one being patient care and that the teams have a strong ethos of compassionate care. Kim went on to explain that the teams put together a diary for those patients that stay longer than 72 hours to allow them to regain the time they have lost.

10.7 Kim drew the Board's attention to slide 16 which detailed patient feedback that the service had received and highlighted how proud the service was of the staff and that in 2018 they had been nominated for a STAR award for achieving their CQUIN target making WSHT the only Trust in the Country to have achieved this target.

10.8 Patrick Boyle commended Colin and Kim on their presentation and all that had been achieved by the service and in particular the patient feedback which the teams should be really proud of.

10.9

The Board **NOTED** the Critical Care Service Presentation.

TB/09/19/11 Annual Infection Control Report 2018/19

11.1 Dr Susie Jerwood and Sharon Reed introduced the Annual Infection Control Report and highlighted the following key points.

11.2 Susie explained to the Board that the Infection Prevention & Control (IPC) team was a fairly new and small team, covering a considerable amount of work across the Trust. In the last year one of the highlights was that in 2018/19 there had been no cases of MRSA compared to 3 the previous year.

11.3 The Board was advised that there was still an issue with high rates of contaminated blood cultures especially from emergency areas. The IPC team has been feeding back rates to the teams directly and it is hoped that the introduction and trial of blood culture packs will support this improvement.

11.4 Sharon Reed advised the Board that the Trust had 32 cases of post-72 hour C-Diff infection against a national target of 38 which was a fantastic achievement. It was noted that 15 of them were due to lapses in care all of which went through a root-cause analysis that was led by an Executive and all of which provided good learning opportunities that will be shared.

11.5 The Board was taken through other key areas of the presentation:

- The Trust is now mandated to collate numbers of *E. coli, Klebsiella spp.* and *Pseudomonas aeruginosa* bacteraemias.
- An Initiative was launched in April 2017 to reduce Gram-negative infections by 50% by 2021.
- Anaylsis has identified that most of the *E. coli* bacteraemias are within patients from the community
- There has been a drop in *E. coli* bacteraemias from 418 in 2016/17 to 343 in 2018/19 representing a drop of 17.9%

11.6 It was noted that between April and June 2018 there was a Community outbreak of measles, which resulted in the Trust sending out 97 warn and inform letters, to advise patients that they may have come into contact with someone infected with measles.

11.7 Audits & Observations:

- In total 126 main infection prevention audits were performed across all 3 sites during 2018/19.
- Each audit takes a minimum of 2 hours.
- Main Audit trends include;
  - Laundry room floors.
  - Contaminated bladed fans.
  - Incorrect waste segregation.
  - Cluttered bays/bedsides.
  - Condition of floors (bays/corridors).

11.8 Mike Rymer commented in relation to the lapses of care, there was no mention of issues concerning the use of antibiotics. Susie commented that there are fewer problems and figures for inappropriate antibiotic use are down in comparison to those previously.

11.9 The Board discussed different ways to increase the uptake of a free flu jab for staff across the Trust; Susie added that the Trust would be also providing more patients with a flu jab this year.

11.10 The Board **NOTED** the Infection Prevention and Control Annual Report 2018/19.

TB/09/19/12 Nurse Staffing Capacity Report

12.1 Maggie Davies presented the Nurse Staffing Capacity Report and highlighted the following key points.

12.2 The Board was advised that the report incorporates key national, regional and local staffing indicators providing assurance for the Board and highlighting issues of concern.

12.3 It was noted that there are vacancies within the Trust but alongside that WSHT has the best bank workforce in the area, the Trust also has a very successful overseas recruitment campaign within the Trust coupled with an ambitious social media campaign locally with the view to engaging with potential new employees.

12.4 A review of all adult ward nurse staffing templates led by the Chief nurse and senior nurses in January 2019 was able to identify that there were a number of wards that required additional night support, Maggie drew the Board's attention to Table 1 which provided the staffing rations on adult wards within the Trust

12.5 Maggie took the Board through other key areas of the report, highlighting that the Trust now has a dedicated midwifery manager on call 24/7 and that there would be a review of paediatric nursing.

12.6 The Board **NOTED** the Nurse Staffing Capacity Report.

TB/09/19/13 Winter Plan

13.1 Amanda Fadero presented the Winter Plan and drew out the following key points.

13.2 The Board was advised that the Trust had a dedicated Resilience Director that had been working on ensuring that that the Winter Plan incorporated all the key areas of learning from last year. Amanda explained that this was a process that the Trust goes through annually and that it is a system wide responsibility to ensure that our hospitals, primary care and community services are resilient. The Winter Plan is tested, assured and signed off by all organisations and the system as part of the process.

13.3 Amanda explained that the primary objective of all planning was that patients have access to timely care and although emergency flows increase, elective demand is also significant over Winter. It was noted that the Trust was building on last year's plan and part of the plan is to also ensure that our workforce is cared for and the Trust has the right workforce in the right place.

13.4 The Board's attention was drawn to the Operational Capacity Slide of the presentation which detailed the plans for both Worthing and St Richard's. It was noted that the Trust would be promoting the use of ambulatory care and all elective surgical care will continue with a focus on day case activity.

13.5 Amanda highlighted to the Board the system risks within the plan and that the Trust was planning for an additional 3.2% growth on top of the current increase in growth within the system. Pete Landstrom commented that the management of surges is the key but acknowledged it varies greatly week on week.

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13.6 The Board **NOTED** the Winter Plan.

TB/09/19/14 Company Secretary Report

14.1 Glen Palethorpe presented the Company Secretary Report and explained that the report provided the Board with an update on matters for which the Trust has complied with NHSi or other regularly requirements.

14.2 **2018/19 Health and Safety Annual report**
The Trust produces an Annual report on the Trust's compliance with its Health and Safety requirements. The detailed oversight of this work is delivered via the Health and Safety Committee.

14.3 The overall conclusion for 2018/19 as supported by the Health and Safety Committee is:
The Trust has been compliant with its H&S requirements, there were no HSE reactive or planned inspections and the Trust has had no HSE performance actions taken against it.

14.4 The Board **NOTED** the Annual Health and Safety Report 2018/19.

TB/09/19/15 Other Business

15.1 Dame Marianne Griffiths and the Chairman took the opportunity to thank both Amanda Fadero, who was stepping as interim Managing Director and Jon Furmston, who was retiring as a Non-Executive Director for their hard work, dedication and support and wished them both good luck for the future.

TB/07/19/16 The Chair formally closed the meeting

TB/07/19/17 Questions from Members of the Public

17.1 Governor Alan Wilcox took the opportunity to commend the Board on the changes made to the Board papers over the last year making them more manageable and accessible.

17.2 Alan went on to thank the Trust following recently becoming a service user and commended the staff that he had encountered, commenting that he had received amazing service from a brilliant hospital.

17.3 Claudia Fisher asked the Board what its response was to the impending change in climate and what plans the Trust had in place to reduce its impact on climate change. In response Dame Marianne Griffiths explained that WSHT had a robust sustainability plan and it is the intention of the Trust to set up a Sustainability Group that would be chaired by the CEO to progress further actions.

TB/07/19/18 Resolution into Board Committee

18.1 The Board resolved to meet in private due to the confidential nature of the business to be transacted.

TB/07/19/19 Date of Next Meeting

19.1 It was noted that the next Board Meeting would take place on **Thursday 28 November 2019** in the **Bateman Room, CMEC, St Richard's Hospital, Chichester.**

Tanya Humphrys
Board Administrator
September 2019

Signed as a correct record of the meeting

Chair…………………………………………………..

Date…………………………………………………..

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MATTERS ARISING
Trust Board

Agenda Item: 4

Meeting	Minute Ref	Action	Responsible Person	Deadline	Status
26 September 2019	**TB/09/19/5.4**	**CEO Report** – IM&T to attend a future Board to give a service presentation.	Ian Arbuthnot	**January 2020**	On the forward agenda plan for January Board.

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	5	Meeting:	Trust Board	Meeting Date:	28 Nov 19
Report Title:	Chief Executive Report				
Sponsoring Executive Director:			Dame Marianne Griffiths, Chief Executive		
Author(s):			Jonathan Keeble, Director of Communications & Engagement		
Report previously considered by and date:			N/A		

Purpose of the report:			
Information	✓	Assurance	☐
Review and Discussion	☐	Approval / Agreement	☐
Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	☐	Staff confidentiality	☐
Patient confidentiality	☐	Other exceptional circumstances	☐
Link to Trust Strategic Themes:			
Patient Care	✓	Sustainability	✓
Our People	✓	Quality	✓
Systems and Partnerships	☐		

Any implications for:	
Quality	
Financial	
Workforce	

Link to CQC Domains:			
Safe	☐	Effective	☐
Caring	✓	Responsive	☐
Well-led	✓	Use of Resources	☐

Communication and Consultation:

Executive Summary:

This report provides an overview for the Trust's activities for the months of October and November.

Key Recommendation(s):

The Board is asked to **NOTE** this report.

Chief Executive's Report

November 2019

Western Sussex Hospitals
NHS Foundation Trust

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Headlines: Care Quality Commission

First acute trust to receive *Outstanding* in all key CQC inspection areas

Western Sussex Hospitals is the first non-specialist acute trust in the country to be rated 'Outstanding' in all the key inspection areas assessed by the Care Quality Commission (CQC), improving upon the trust's first 'Outstanding' rating from four years ago. The government's health watchdog awarded the highest possible rating for services at Worthing, St Richard's and Southlands hospitals, following a rigorous inspection process which took place from June to August this year. CQC inspectors determined services are safe, effective, caring, responsive, well-led and resourced properly – with each category receiving an 'Outstanding' rating. And the new CQC report also confirms Western Sussex Hospitals as the first-ever acute trust to be rated 'Outstanding' for the safety of its services.

The CQC inspectors commended the "exceptional compassion" of staff, a "genuinely open culture", and "an environment in which excellence in clinical care flourished". The report states: "Staff felt engaged and proud to work for the trust. Results of a pulse survey in June showed that 93% of staff recommended the trust as a place to work and 97% as a place to be treated."

Are services safe?	Outstanding ☆
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆
Are resources used productively?	Outstanding ☆

Western Sussex Hospitals
NHS Foundation Trust

They said it…

They said it…Caring

“Staff cared for patients with exceptional compassion. Feedback and our observations confirmed that staff treated them well and with kindness.

There was a strongly upheld view from all medical and nursing staff that the patients’ wishes were respected and that their needs came first in all decisions.”

They said it…Culture

“Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff were committed to upholding the primacy of the patients.”

They said it…Leadership

“There was an inclusive, effective and compassionate leadership structure. Leaders were competent and had high levels of experience, and continually demonstrated the capability and capacity to provide excellent and sustainable care.”

They said it…Patient First

“There was exceedingly high ‘buy in’ from staff across the trust to the Patient First strategy and methodology. Staff felt engaged and proud to work for the trust. Staff spoke about and framed all organisational performance and development around the Patient First strategy.

The trust provided system wide leadership and was driving system wide improvements through expansion of their Patient First approach.”

Overall Trust Rating 2019

	Safe	Effective	Caring	Responsive	Well-led	Overall
St Richard's Hospital	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
Worthing Hospital	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
Southlands Hospital	Good	Good	Good	Good	Good	Good
Overall Trust	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding

Service ratings 2016

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent & Emergency Care	Good	Good	Outstanding	Outstanding	Outstanding	Outstanding
Medical & Older People	Good	Good	Outstanding	Outstanding	Outstanding	Outstanding
Surgery	Good	Good	Outstanding	Requires Improvement	Good	Good
Critical Care	Requires Improvement	Good	Outstanding	Requires Improvement	Good	Requires Improvement
Maternity	Outstanding	Outstanding	Outstanding	Good	Outstanding	Outstanding
Paediatrics	Outstanding	Good	Outstanding	Outstanding	Outstanding	Outstanding
End of Life Care	Good	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
Outpatients & Diagnostics	Good	Not rated	Good	Requires Improvement	Good	Good
Overall	Good	Outstanding	Outstanding	Requires Improvement	Outstanding	Outstanding

Service ratings 2019

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent & Emergency Care	Good	Good	Outstanding	Outstanding	Outstanding	Outstanding
Medical & Older People	Good	Good	Outstanding	Outstanding	Outstanding	Outstanding
Surgery	Good	Good	Outstanding	Requires Improvement	Good	Good
Critical Care	Good	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
Maternity	Outstanding	Outstanding	Outstanding	Good	Outstanding	Outstanding
Paediatrics	Outstanding	Good	Outstanding	Outstanding	Outstanding	Outstanding
End of Life Care	Good	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
Outpatients & Diagnostics	Good	Not rated	Good	Good	Good	Good
Overall	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding

Southlands Hospital 2016

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients & Diagnostics	Good	Not rated	Good	Requires Improvement	Good	Good
Overall	Good	Good	Good	Requires Improvement	Good	Good

Southlands Hospital 2019

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients & Diagnostics	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Wonderful reaction (video)

Headlines

10th annual Patient First STAR Awards best yet

Smiles, surprise and pride flowed freely at the trust's staff recognition awards on Thursday 26 October. Every year it just keeps getting better. The love and care we have for our colleagues, patients and hospitals was plain for all to see and celebrate. This is why this event is one of the best highlights of my year and our tenth annual awards in the Worthing Assembly Hall were the best yet.

More people attended than ever before and we even had four *Pets As Therapy* dogs scamper up onto the stage, along with their owners, to collect the Volunteer of Year prize.

The biggest applause on the night though went to our Domestics (cleaning teams), who were our extremely worthy winners of the *Team of the Year* award. This was the most competitive category with 174 nominations! Colleagues from Southlands, Worthing and St Richard's, represented their teams on the night and were absolutely over the moon to win.

Headlines

Teams unite for World Patient Safety Day

Staff celebrated the first ever *World Patient Safety Day* on Tuesday 17 September, to champion a simple message: "Speak up for patient safety." The patient safety team toured the hospitals with colleagues, delivering slices of cake and discussing patient safety with staff and patients. In the evening, Worthing Hospital joined landmarks across the world floodlit in orange to mark the WHO's new World Patient Safety Day.

Mabuhay! Welcome to new Filipino nurses

More than 30 new nurses have joined the trust from the Philippines in the past couple of months. Since we relaunched our overseas recruitment campaign three years ago we are delighted to have welcomed more than 150 new qualified nurses. We recently gave job offers to a further 60 from the Philippines too. Meanwhile, we continue to do all we can to attract the best nurses in the UK to come and work at Western Sussex.

Proud to be a research active trust

Congratulations to colleagues in gastroenterology and associated research team as the trust once again has been commended for its research activities. For two years running they have come top in patient recruitment to multicentre research studies in gastrointestinal disease throughout Kent, Surrey and Sussex. Meanwhile, the trust also was the eighth best recruiter into national mouth cancer research which its hoped will save 21,000 lives a year.

Headlines

Long service awards

We were delighted to honour 44 members of staff for their long NHS service at two special gatherings recently.
This year we introduced our new style long service afternoon tea events which took place at the Harbour Hotel in Chichester and The Palm Court Pavilion in Worthing. I believe this adds a special and appropriate sense of occasion to this celebratory event and honours the commitment shown by the staff who have achieved 40 or more years NHS service.

Getting greener

Reducing energy consumption and waste is high on everyone's agenda and following on from the launch of our Green travel Plan last year we have now started a new Green Matters Steering group which I chair to ensure our trust reduces its environmental footprint. Recently the Estates and Facilities team held a drop-in session and their staff who provided more than 100 green improvement ideas.

New Gynaecology Ambulatory Unit

A collaborative team effort between our Women & Children Division and Capital Planning is helping to transform the way we provide care for women. The new GAU in Worthing provides a modern, safe and comfortable environment for women requiring outpatient treatment, appointments for hysteroscopy, colposcopy, fast track/two-week rule, emergency and early pregnancy clinics. It is designed to enable the teams to carry out more than one clinic at a time and it meets all the quality standards for the cervical screening facilities.

Headlines

Patient First Open Day

Last week we welcomed more than 50 executive and senior management team members from across Europe and the UK to a Patient First open day hosted at Worthing Hospital. Our visitors gained an exclusive insight into the journey of both Western Sussex Hospitals and Brighton and Sussex University Hospitals. They learned how staff across the organisation have taken up the Patient First approach, striving to continuously make things better, safer and more efficient for our patients.

Welcome to new lead governor

I am delighted to welcome Lyn Camps as our new lead governor. Our Council of Governors acts a link between the trust's members and our Trust Board and our governors are valued volunteers who represent the views of local people and act as critical friends. Lyn will be ably supported by John Thompson as deputy lead governor. I wish to thank John for his stalwart support and commitment to the trust, our staff and patients over the past few years as lead governor. Thank you.

Inter-professional student conference

Our Practice Development team hosted their fourth annual inter-professional national conference last week, welcoming 120 student physios, OTs, radiotherapists, operating department practitioners, paramedics, midwives, nurses, dietitians and trainee nurse associates from across the country to St Richard's Hospital. Such events are excellent recruitment opportunities and really help to put our trust on the map and cementing our reputation for excellence among the staff of tomorrow.

Diary highlights

- CQC staff briefings – St Richard's, Worthing, Southlands
- Sussex Workforce Race Equality Conference
- Meetings with partner organisations
- Lean Transformation Summit
- Acute Network
- NHS Providers Annual Conference
- University of Chichester Graduation
- Consultant engagement briefings
- Women's Leaders Network Annual Conference

Looking ahead

Safe and timely care over winter

The winter months are extremely challenging for our staff as demand for services increases year on year. We plan in partnership with the wider health and care system to ensure we continue to deliver safe and timely care to all our patients, both those in need of emergency and planned care. We are expanding our earlier discharges improvement work and reducing length of stay for patients through new ways of working and more ambulatory pathways. This year we also introduced new Frailty Intervention Teams to provide a specialist geriatric support service for frail patients attending A&E. We will also have additional primary care support in our hospitals over winter.

Planning for the future

After nearly three years of supporting Brighton & Sussex University Hospitals through a joint-management contract we have decided to further develop the relationship between BSUH and Western Sussex Hospitals under the leadership of a single board and executive team. This new group structure is a strategic alliance which will ensure we do what is best for our patients and best enable ourselves to deliver the ambitions of the NHS Long Term Plan. The trusts and their assets will remain separate, operating as equal partners and the benefits of our current relationship will be maintained and extended. Work to determine the best group structure is ongoing and further details will be provided in due course as decisions are made.

Agenda Item:	6-10	Meeting:	Trust Board	Meeting Date:	28 Nov 2019
Report Title:	Integrated Performance Report				
Sponsoring Executive Director:			Marianne Griffiths, George Findlay, Maggie Davies, Pete Landstrom, Karen Geoghegan and Denise Farmer		
Author(s):			Marianne Griffiths, George Findlay, Maggie Davies, Pete Landstrom, Karen Geoghegan and Denise Farmer		
Report previously considered by and date:			Individual elements considered by relevant Board Committee		

Purpose of the report:			
Information	☐	Assurance	✓
Review and Discussion	✓	Approval / Agreement	☐
Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	☐	Staff confidentiality	☐
Patient confidentiality	☐	Other exceptional circumstances	☐
Link to Trust Strategic Themes:			
Patient Care	✓	Sustainability	✓
Our People	✓	Quality	✓
Systems and Partnerships	✓		
Any implications for:			
Quality			
Financial			
Workforce			
Link to CQC Domains:			
Safe	✓	Effective	✓
Caring	✓	Responsive	✓
Well-led	✓	Use of Resources	✓
Communication and Consultation:			

Executive Summary:

Attached is the Trust's integrated performance report.

Key Recommendation(s):

To note the content and following receipt of the Committee assurance reports, consider if there are areas for referral back to the Committees where enhanced assurance is required.

Integrated Performance Report

November 2019

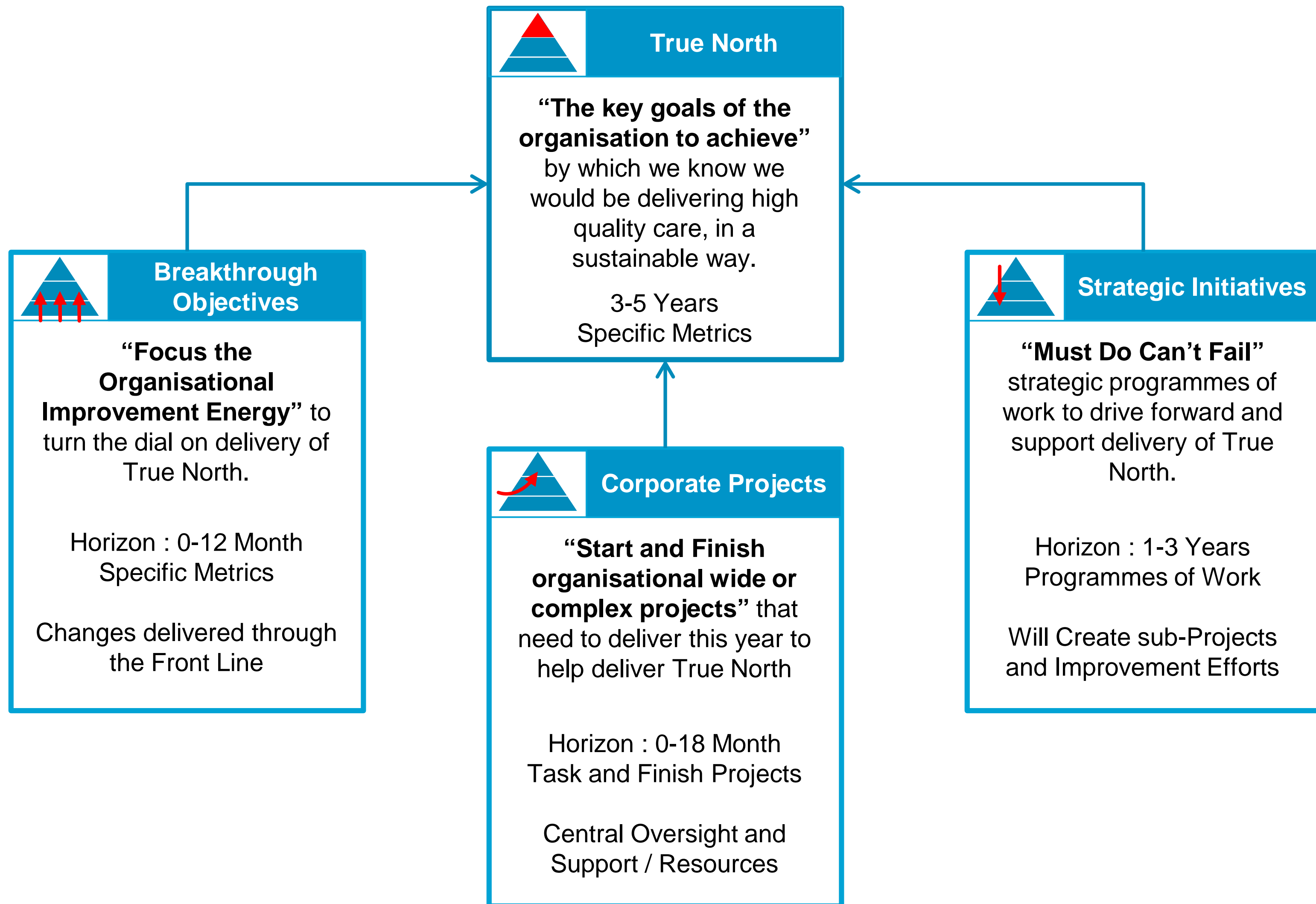
Western Sussex Hospitals
NHS Foundation Trust

Contents

Structure of the report

Introduction - Patient First
Quality Improvement
Systems and Partnership
Sustainability
People

Patient First Strategy Deployment Framework



Patient First True North

Key Goals for the Organisation to achieve sustainably

Patient

Patient Satisfaction

Target: Family & Friends Recommend Rate >96%

Sustainability

Financial Management

Target: Break Even

People

Staff Engagement

Target: Engagement Score Top in the Country

Quality

Preventable Mortality

Target: HSMR Top 20% in the Country

Avoidable Harm

Target: Patient Safety Thermometer 99% Harm Free Care

Systems & Partnerships

Non Elective Care

Target: A&E 95% <4hrs

Elective Care

Target: RTT 92% <18wks

Quality Performance - Effectiveness

Quality

Preventable Mortality

Target: HSMR Top 20% in the Country

Avoidable Harm

Target: Patient Safety Thermometer 99% Harm Free Care

Key messages for Board

Effectiveness:.

- The Learning from Deaths briefing for Q2 is reported to the Board in a separate paper but has not identified any new emerging themes salient to the changes in Trust HSMR.

Quality Performance - Mortality

Crude Mortality Rates

The number of non-elective patients (crude mortality rate) who died in October was 175 (2.71%) from 6457 discharges compared with 2.7% in September and in line with October 2018 (2.64%).

Worthing and Southlands Hospitals reported 94 deaths of 3407 discharges (2.76%) and St Richards Hospital reported 81 deaths of 3050 discharges (2.66%).

The year to date mortality rate is 2.78% and the rolling 12 month mortality rate is 2.71% both metrics remain positively below the target.

Quality Performance - Mortality

HSMR

As at July 2019 the Trust **HSMR** was 102.0

- Worthing: 99.6
- St Richards: 104.2

  - The Trust level HSMR continues to increase (60th percentile nationally) with St Richards increasing at a faster rate to the point where from April 2019 St Richards HSMR has a higher point value than Worthing (Slide 7).
  - Observed mortality is this financial year now on an upward trajectory, however the current position for both sites remains below the 24 month average (Slide 8)
  - There are 5 significant diagnosis groups at Trust level with Skin & Subcutaneous Tissue Infections continuing to alert within both the Dr Foster HSMR model and the SHMI (May 19)

Quality Performance - Mortality

HSMR - Key factors

Key contributing factors leading to the current increasing HSMR at St Richards are:

- A low and decreasing comorbidity rate at St Richards
- A reducing palliative care crude & observed rate
- A changing coded case-mix at St Richards following the implementation of the Septicemia coding changes appear to have resulted in a deteriorating SMR position. This is due to a greater change within the denominator than has been seen nationally. This adversely effects the HSMR. This change has also impacted on a further range of diagnoses at St Richards and to date Pneumonia and UTIs have been identified as having materially changed in terms of coded activity and observed mortality.

Quality Performance - Mortality

Coding

The Worthing site appears to have implemented the national coding changes in 2017 & 2018, however the impact is not as great as this site has seen a fall in activity more in line with the national change during 2018 relating to Septicemia

Sepsis coding St.Richard's has emerged as a significant contributor to the Trust's rising HSMR and a monthly sepsis coding reconciliation meeting chaired by the medical director has been implemented to verify coding practice. This is being expanded to include the other areas of variation identified by Dr Foster e.g. palliative care and comorbidity coding. A desktop review with Dr Foster will be incorporated into this program of work.

Quality Performance - Mortality

SHMI

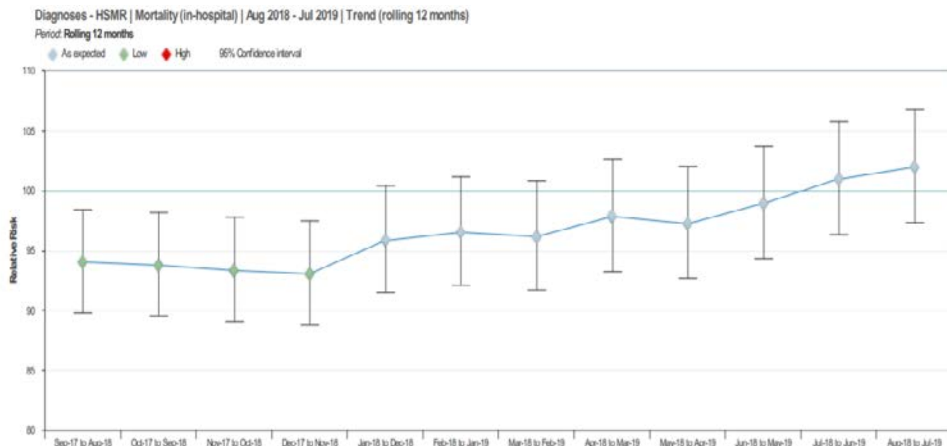
As at May 2019 the Trust **SHMI** was 97.86 (as expected)

- Worthing: 97.81
- St Richards: 97.83

  - There is an emerging trend with St Richards SHMI point value starting to rise – April & May which mirrors the trends within the HSMR

HSMR – 24 Month Trend

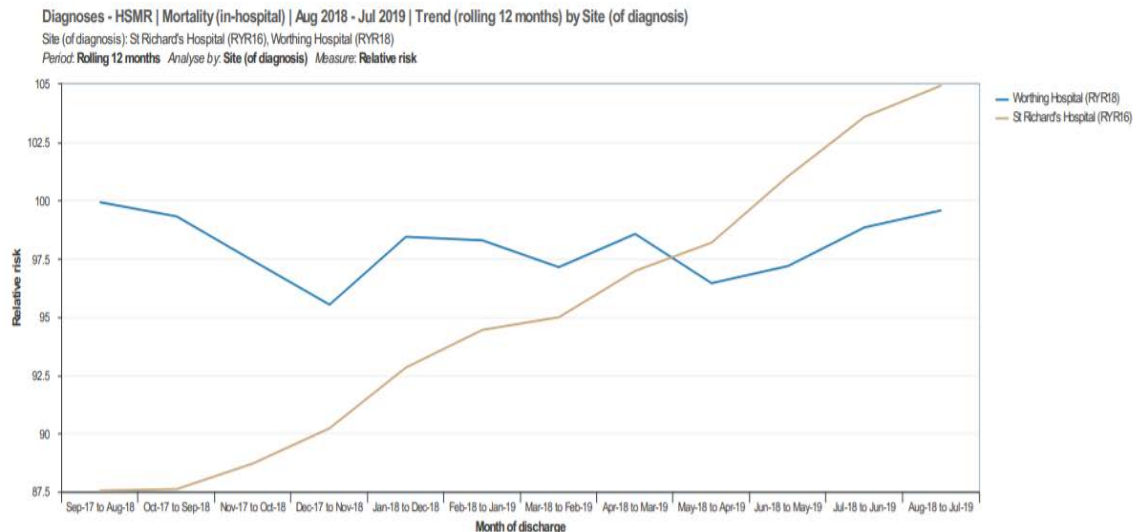
Rolling 12 month trend @ Trust level



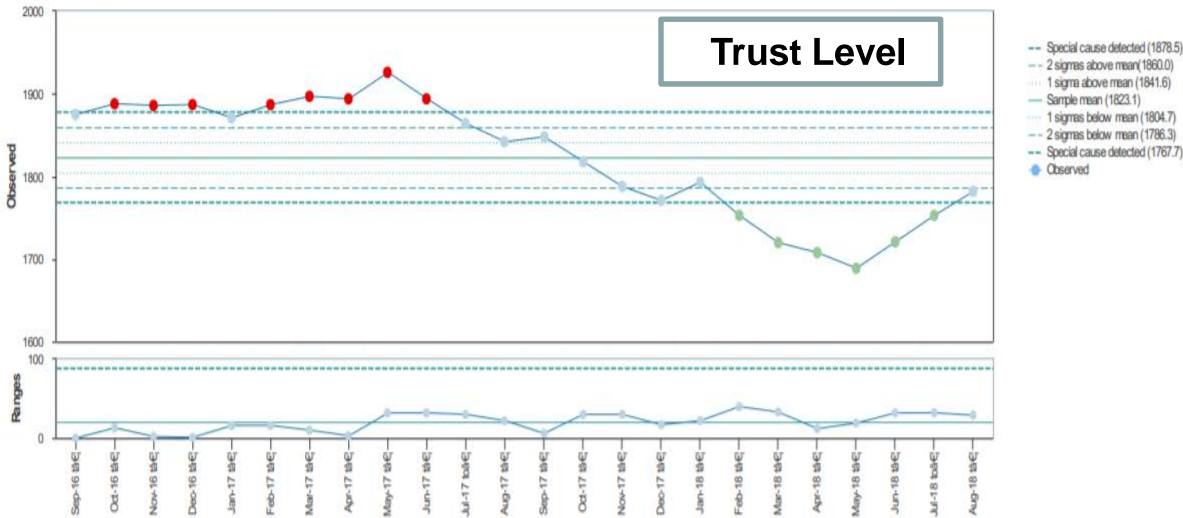
The Trust has seen an "as expected" HSMR for a number of months, however, the point value from June 2019 is
for the first time over 100

Rolling 12 month trend @ Site level (No CI)

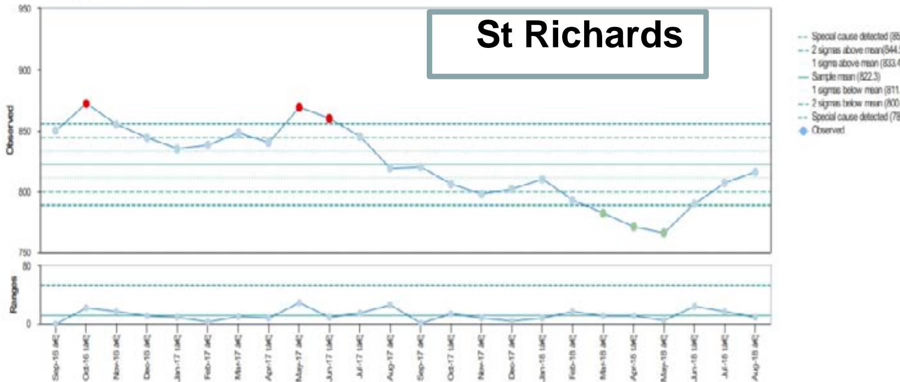
At Site level there is a marked increase in the HSMR at St Richards over the past 12 months with the last four months having a higher HSMR than Worthing.

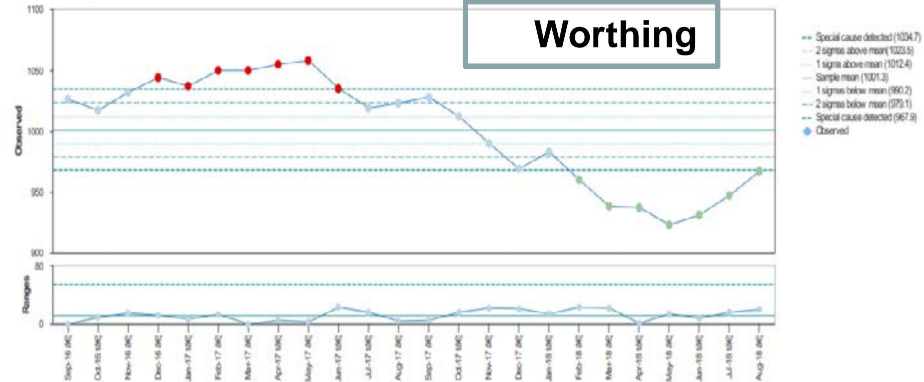


HSMR Observed Mortality - 24m Trend



Using a 12 month rolling figure as a basis both sites are seeing an increase in observed mortality within the last 3 data points, however, both remain below the 24 month average with Worthing remaining significantly low.





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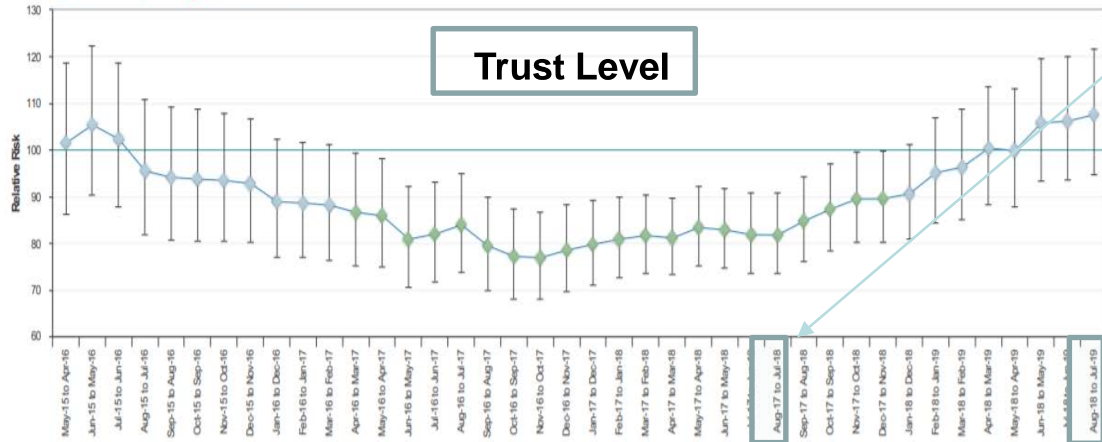
Septicemia Site Level Trends

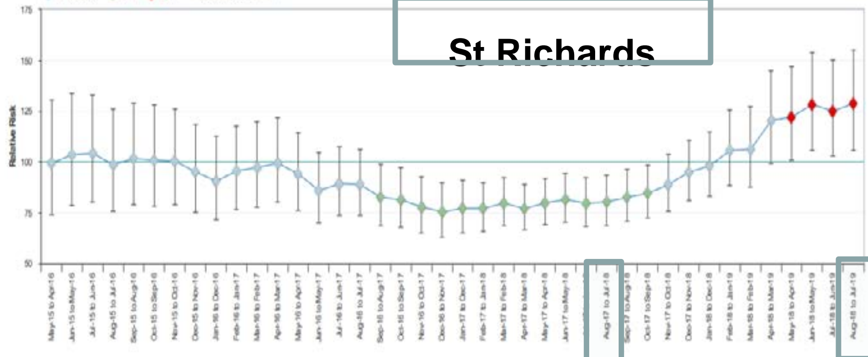


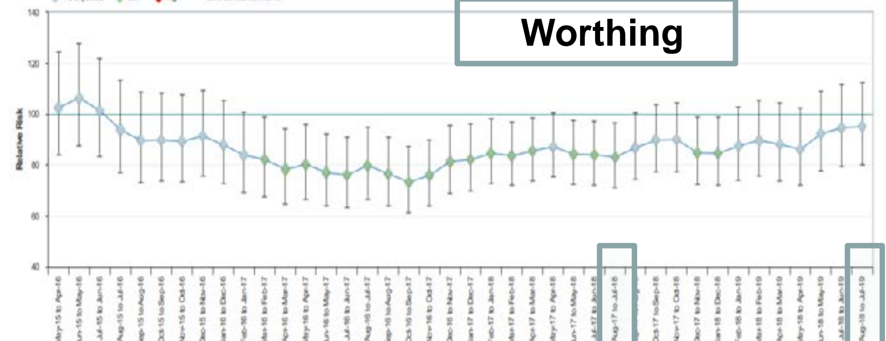
Percentage of Non-Elective HSMR

July 2018
Worthing 8.0%
St Richards 8.7%
Trust 8.3%
National 6.2%

July 2019
Worthing 5.6%
St Richards 3.9%
Trust 4.8%
National 4.7%

Coding changes





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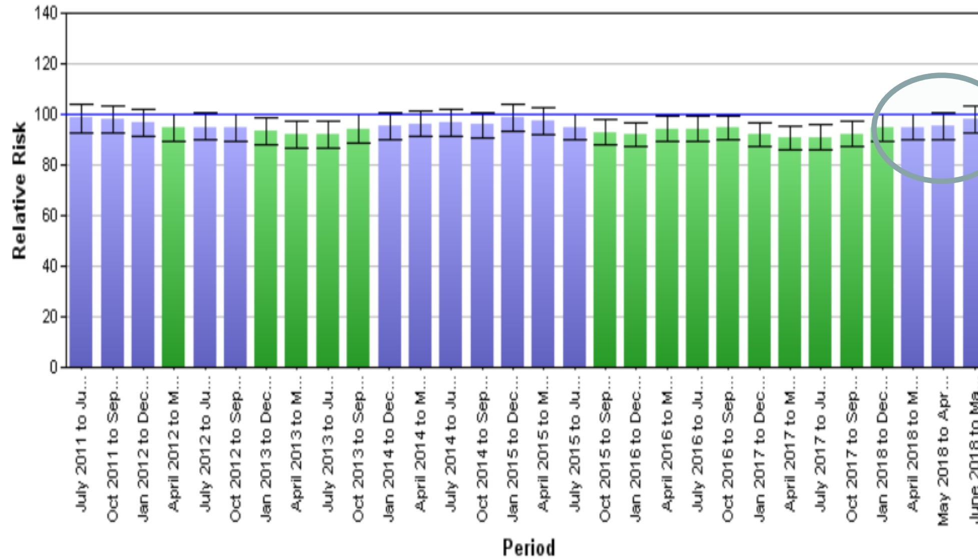
SHMI Site Level Trends

St Richards

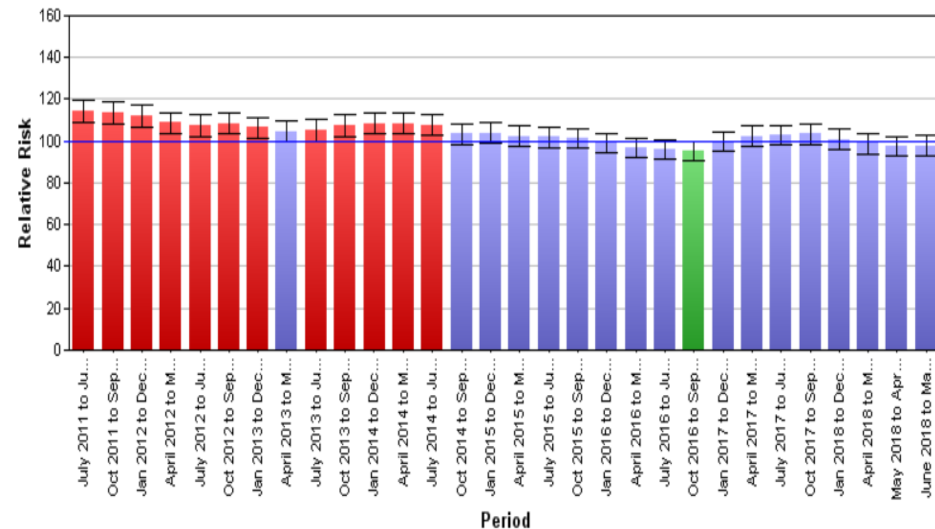
SHMI by data period



There appears to be an upward trend in the point value of the St Richards SHMI mirroring the increasing HSMR

Worthing

SHMI by data period



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Quality Performance - Effectiveness

- The Learning from Deaths briefing is reported to the Board in a separate paper but has not identified any new emerging themes salient to the changes in Trust HSMR.
- Stroke Sentinel National Audit Program – the most recent performance is SSNAP rating B for both the Chichester and Worthing sites. The ratings are reported quarterly in arrears.
- Dementia care – night moves for patients with dementia were within target but have increased since September rising from 9 to 20. This is attributed to a rise in the activity and acuity of patient care.

Quality Performance - Safety

INCIDENT REPORTING

- Previously the Trust has been identified as a negative outlier with the National Learning and Reporting System (NRLS) as being a low reporter of incidents. In October 2019 the Trust reported 962 patient safety incidents. The increase in incident reporting should therefore be viewed as a positive step to demonstrate staff openness and willingness to both report and action incidents in relation to patient safety.

- Medication incidents. October's reported data has seen a slight decrease in reporting to 69. As the Trust encourages a culture of transparency and incident reporting, the pharmacy team continues to link with the Trust analyst team to review the current scorecard targets and improvement trajectory.

- Any incidents that are reported as causing significant harm (moderate, severe or resulting in the death of a patient) are notified immediately to the senior team in the Trust including the chief nurse and the chief medical officer with at least weekly updates on progress.

- In October 13 significant harm incidents were reported, against a yearly target of 153 (YTD actual 89), remaining within the Trust target.

Quality Performance - Avoidable Harm

Quality

Preventable Mortality

Target: HSMR Top 20% in the Country

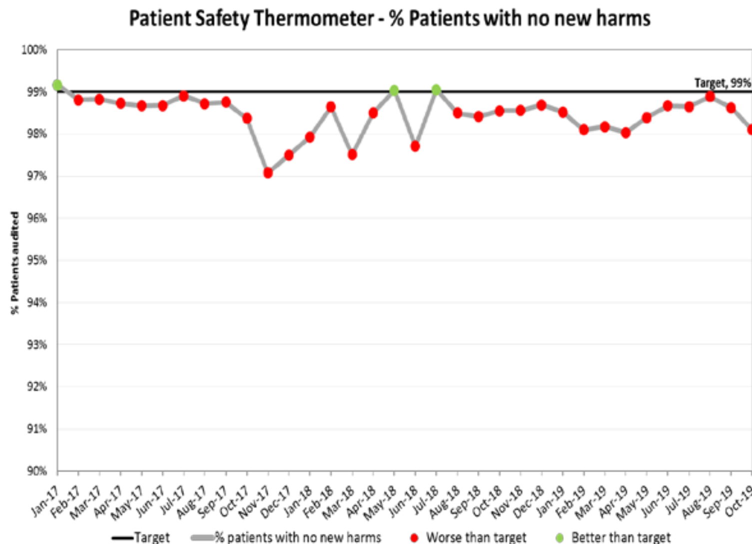
Avoidable Harm

Target: Patient Safety Thermometer 99% Harm Free Care

Key messages for Board

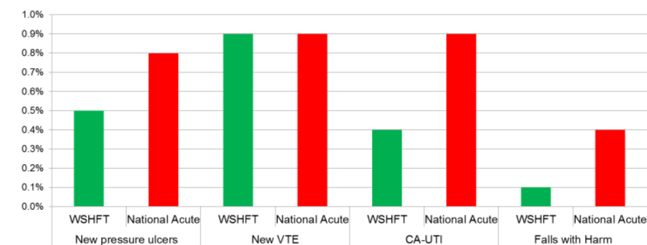
True North Metrics: Patient Safety Thermometer:

The patient safety thermometer data is gathered on one day each month. This tool looks at point prevalence of four key harms: Falls, Pressure Ulcers, Urinary Tract infections and VTE (venous thromboembolism). In October, data was collected for 943 patients. The proportion of patients who suffered no new harm during their inpatient stay at WSHFT was 98.1% against the Trust target of 99%. This compares to national performance of 97.7%



NHS Safety Thermometer
Breakdown of Harms

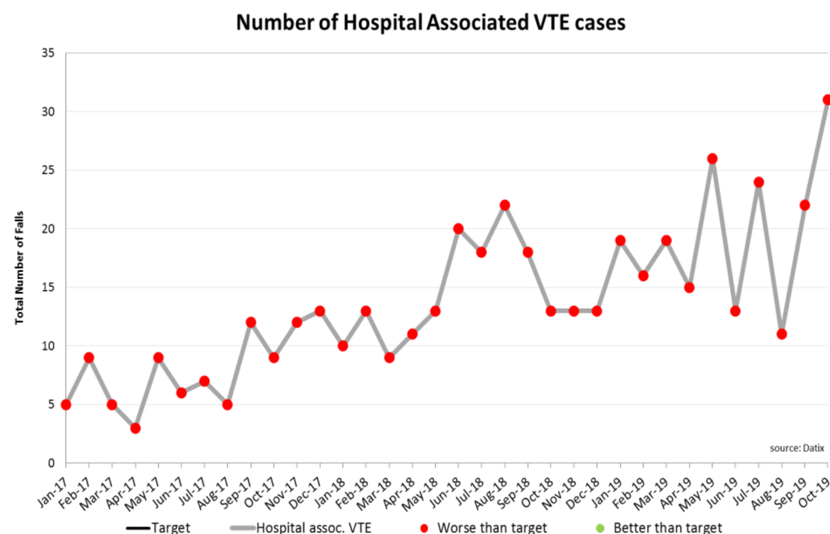
October 2019
WSHFT: 98.1% Harm Free Care (New)
National Acute Trusts: 97.7% Harm Free Care (New)

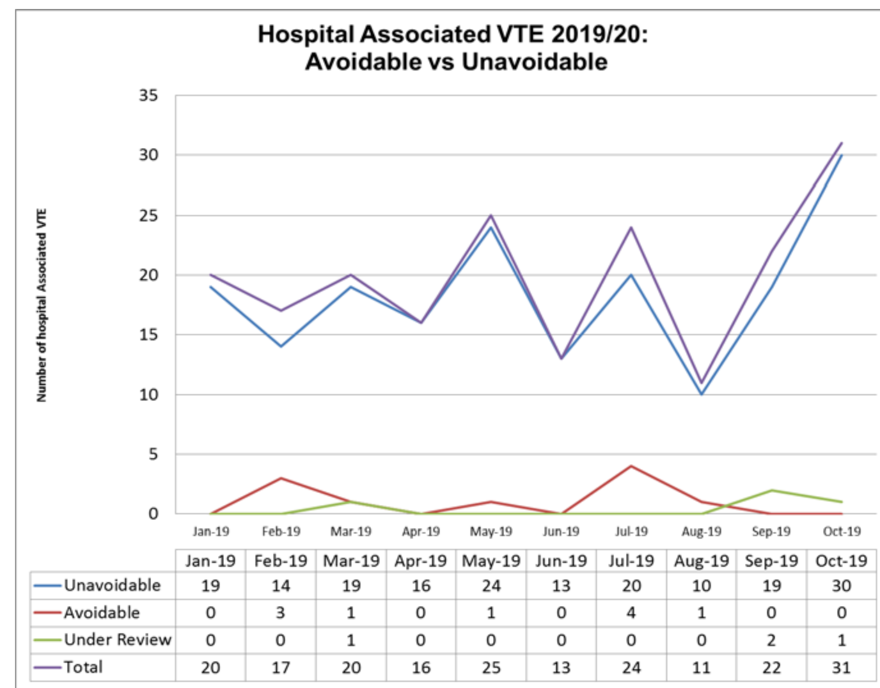


Category 2 pressure ulcers and VTE are the top contributors and have key improvement programmes underway aiming to deliver reduction. Aside from VTE the Trust performance is consistently above the national picture for acute trusts.

Avoidable Harm– Breakthrough Objective

Reducing Hospital Associated VTE: goal to reduce avoidable VTE by 50% by end March 2020





	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Unavoidable	19	14	19	16	24	13	20	10	19	30
Avoidable	0	3	1	0	1	0	4	1	0	0
Under Review	0	0	1	0	0	0	0	0	2	1
Total	20	17	20	16	25	13	24	11	22	31

Current Performance

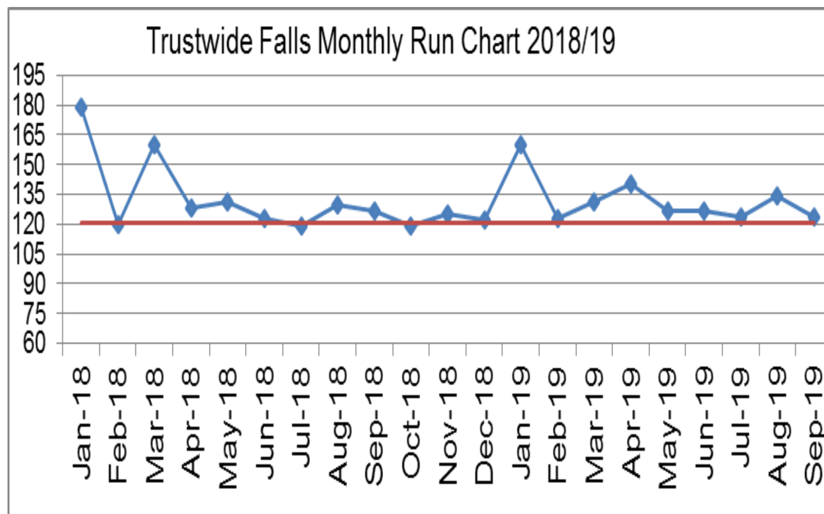
- Overall cases of Hospital Associated VTE continue to rise with 31 cases in October
- Three cases remain under review.
- The increase in overall numbers may reflect improved case finding as the number of avoidable cases year to date = 6, representing a reduction of 50% compared to same period last year.

Actions Underway:

- Orthopaedic governance session to review recent avoidable cases.
- Commenced value stream mapping of fracture clinic pathway for patients with lower limb immobilisation
- Participating in VTE GIRFT programme
- Driver wards focus on flagging patients where anticoagulation is paused and use of flowtrons in stroke patients

Avoidable Harm– Key Metrics

Falls

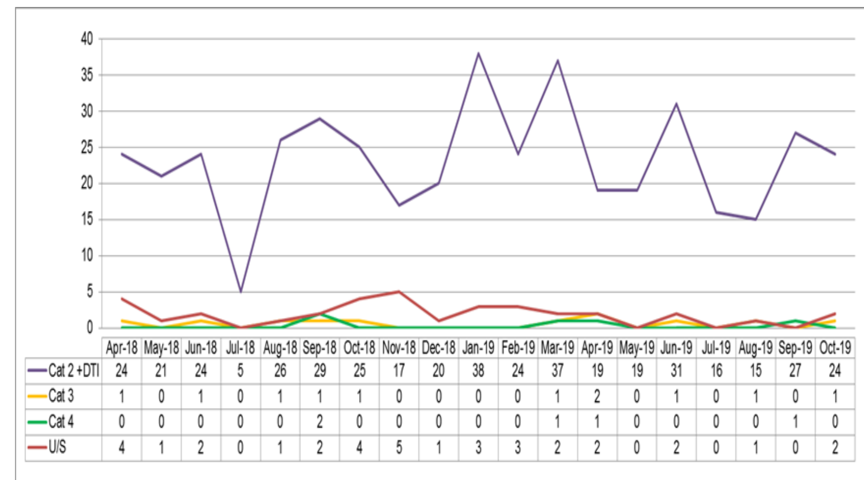


Trust Goal: no more than 120 falls each month

Current Performance and Actions

- 126 falls in month, maintaining performance narrowly above monthly goal(120 falls)
- Work continues for the national falls CQUIN which focusses on compliance with recording of lying and standing blood pressure, provision of mobility aids and avoidance of psychotropic medication.
- PFIS methodology being adopted in favour or retrospective case note review
- Continence improvement work continues as falls related to continence remains a key theme.

Pressure Ulcers



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Cat 2 +DTI	24	21	24	5	26	29	25	17	20	38	24	37	19	19	31	16	15	27	24
Cat 3	1	0	1	0	1	1	1	0	0	0	0	1	2	0	1	0	1	0	1
Cat 4	0	0	0	0	0	2	0	0	0	0	0	1	1	0	0	0	0	1	0
U/S	4	1	2	0	1	2	4	5	1	3	3	2	2	0	2	0	1	0	2

Trust goal: 10 reduction i.e. no more than 2 patients develop category 3 and above ulcer in hospital

Current Performance and Actions:

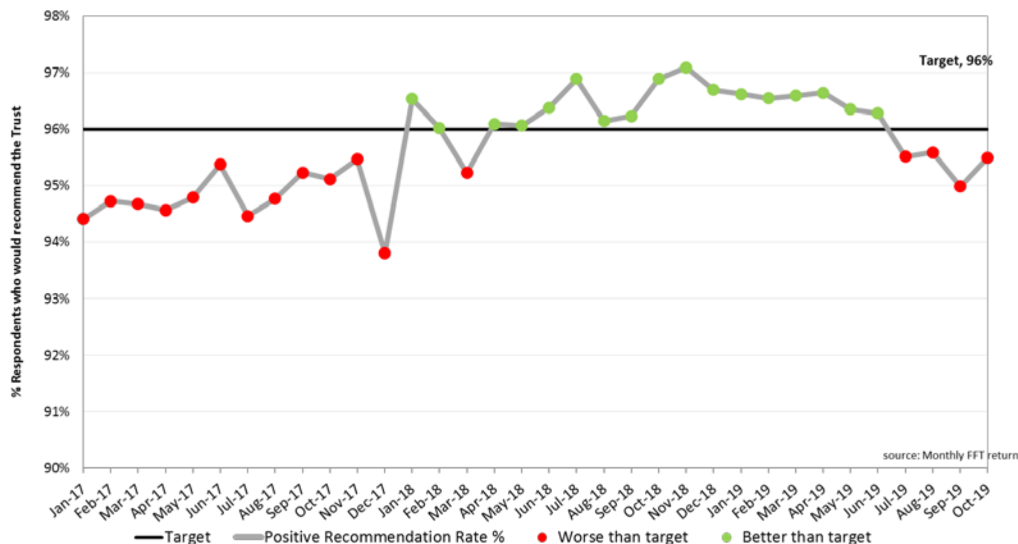
- 2 patients(3 ulcers) developed a cat 3 or above ulcer , meeting the monthly goal
- Year to date this represents a 30% reduction
- The overall number of less serious(cat 2) ulcers remains higher than desired.
- Focus on device related ulcers which remain a key theme – orthopaedic red tape project full roll out
- TED stocking ward based education and process observation planned for November .
- Trust wide static mattress and seat cushion completed in month.

Quality Performance – Experience

Key Messages for the Board

True North Metric: to be a top 20% of NHS Trusts in the country for recommendation by patients responding to the Friends and Family Test.
Family & Friends Recommend Rate >96%

- Improved performance in month compared to September
- Inpatients and Outpatients have met the recommendation goals(inpatient response rate below target)
- Maternity only narrowly missed their 97% recommendation goal
- A/E: key themes of waiting times, communication and addressing pain are key themes of current improvement work



Current Performance:

Inpatients: 97% recommendation (goal = 97%)
Response rate: 35.1% (goal = 40%)

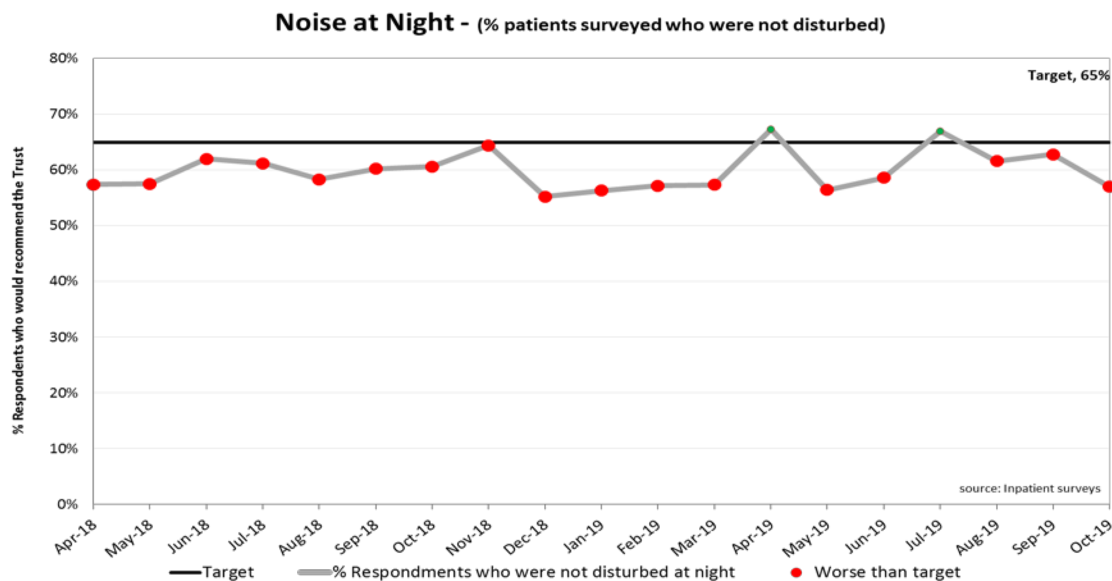
A/E : 92% recommendation (goal = 93%)
Response rate: 28.5% (goal = 20%)

Outpatients: 97% recommendation(goal = 97%)
Response Rate: N/A

Maternity: 96.6% recommendation(goal = 97%)
Response rate: 43.8% (goal = 40%)

Quality Performance – Experience – Breakthrough Objective

Improving Satisfaction With Noise at Night: Goal = 65% satisfaction by end March 2020



Current Performance and Actions:

- 57% satisfaction in October representing a reduction compared to previous 3 months.
- Detailed surveys of staff and patients have been completed in September across adult wards; analysis of results will support divisional improvement work. Paediatrics are also planning survey work to engage with families.
- Driver wards have been confirmed
- Facilities and estates working with 5 wards to test out improvement ideas
- Disturbance due to night time transfers, patients with confusion and being woken for medication or observations are key themes
- Communication campaign to be planned to support awareness work with teams

Systems & Partnerships – Summary

Systems & Partnerships

Non Elective Care

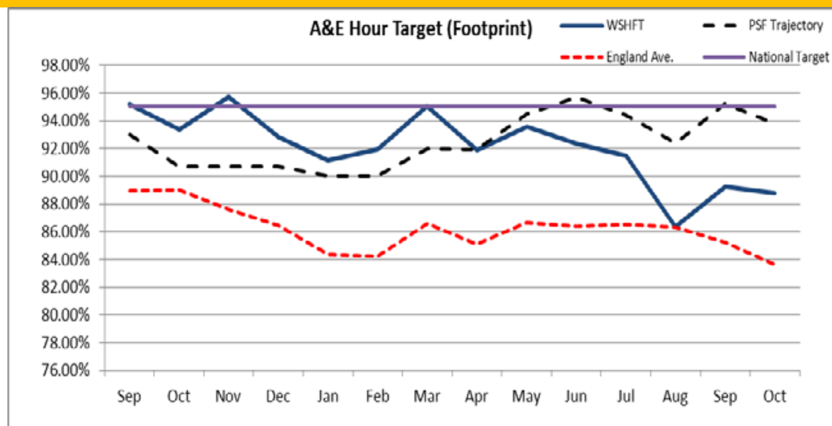
Target: A&E 95% <4hrs

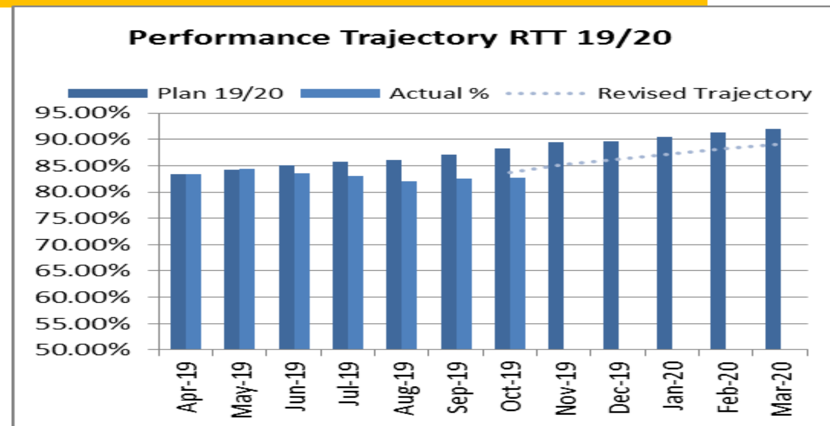
Elective Care

Target: RTT 92% <18wks

- The Trust saw continued significant increases in numbers of emergency patients attending both A&Es, with +16.7% October-19 compared to October-18. with a 13.9% increase in patients aged over 85 years. The YTD activity is +8.5% compared to the same period in 18/19, with +15.2% increase in over 85s.
- Overall bed occupancy at the Trust has increased to 94.6% in October-19 which is 1.7% higher than the prior month. Trust had 19 more 7 day LOS patients in hospital on average each day in October-19 compared with the prior month. This is 16 more than October-18.
- A&E 4hr performance for October-19 was 88.8%, compared to the national performance of 83.6%. There have been zero 12 hr breaches.
- RTT compliance in October-19 was 82.7%. One patient waited longer than 52 weeks for treatment in October-19. The Trust is refocussing efforts to increase activity with support from alternative providers, increased productivity and additional internal WLIs and locum support. The overall waiting list size reduced by 338 compared to the prior month.
- Cancer performance for October-19 is compliant against 5 of 7 reportable cancer targets with provisional 62 day performance or 84.5%. National average performance was 76.9% (September-19).
- Diagnostic performance was marginally non-compliant at 1.4%. The waiting list increased by 608 in October-19 compared to the prior month with the biggest increase being in non-obstetric ultrasound. National performance (September-19) was 3.8%.

Systems & Partnerships – True North Metrics





- Oct-19 A&E performance was 88.8%
- Oct-19 saw a 5.6% increase in ambulance conveyances, a 16.7% increase in A&E attendances and a 4.1% increase in subsequent emergency admissions compared to Oct-18
- Over 85 admissions up 5.6% compared to Oct-18
- There has been a 37.5% increase in the time in the dept for Mental Health patients as a proportion of all patient time in the department Oct-19 compared to Oct-18

- Oct-19 RTT performance was 82.7% for all specialties
- One patient waited longer than 52 weeks for treatment.
- The overall size of the waiting list reduced by 338 waiters from September to October.
- Key areas of pressure remain Orthopaedics, Ophthalmology, OMFS services and Gastroenterology – plans in place for all specialties

Actions Underway:

- Kaizen led early morning discharge programme.
- Super Stranded improvement programme (LHE wide)
- Additional medical staff deployed within A&E
- Additional bed capacity opened at SRH
- Partnership programme of care for Mental Health with successful commissioning of CORE24 Mental Health services agreed
- GP Extended Hubs commencing 1st August
- New Medical staffing model commences 1st August

Actions Underway:

- Continued improvement theatre and outpatient efficiency programmes
- Additional capacity both internally and from external partners to mitigate loss of activity through WLI and pension concerns
- Substantive recruitment plans to fill vacancies in context of national shortages in some areas
- Enhanced weekly speciality PTL reviews in place and daily task and finish group ophthalmology.

Systems & Partnerships – Key Metrics

Cancer Metrics

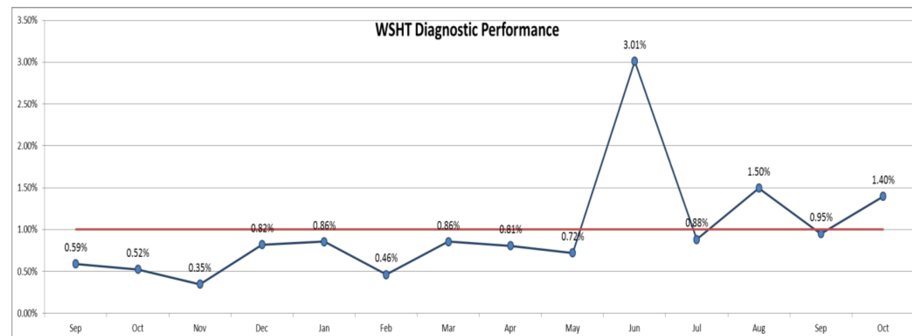
Cancer Performance			Amber
	Target	2019/20 YTD	Oct-19
Monthly and YTD			
2wk GP to 1st OP	93.0%	90.3%	79.4%
2wk GP to 1st OP (Breast)	93.0%	95.8%	95.7%
31day subsequent treatment (surgery)	94.0%	97.5%	100.0%
31day subsequent treatment (drug)	98.0%	98.7%	100.0%
31day subsequent treatment (all)	96.0%	97.5%	98.0%
62day referral to treatment (screening)	90.0%	92.3%	97.2%
62day referral to treatment (upgrade)	85.0%	80.5%	76.4%
62day referral to treatment (all Cancers)	85.0%	81.9%	84.5%

- The Trust was compliant against 5 of 7 reportable cancer metrics in Oct-19.
- 84.5% of patients were treated within the 62 day target in Oct-19 provisionally.
- Significant continued growth in cancer referrals - up a further 7.2% in 19/20, above the increased 18.2% in 18/19

Actions Underway:

- Implementation of Optimal Pathway project (for colorectal patients) plus equivalent streamlined processes for prostate cancers
- Additional specialist nursing for prostate cancers
- Additional diagnostic capacity (imaging and histopathology).
- Enhanced daily tracking for over 62 day waiters with clear escalation rules , to expedite next steps for each patient.
- Review of MDT processes to ensure timely decision making.
- Focus on reduction to 7 day for first outpatient appointment.

Diagnostic 6 Weeks



- Diagnostic performance was non-compliant with the national target in Oct-19 at 1.4% (compared to National of 3.8%)
- The overall diagnostic waiting list increased by 608 compared to Oct-19
- NOUS has seen the biggest increase in waiting list size overall

Actions Underway:

- Additional locums have been engaged in September to clear the backlog
- Trust Nurse Endoscopists have backfilled additional sessions in July to clear the backlog
- Washers at SRH are back in service Mid-September
- Medium term innovations in pathways adopting FIT testing proposed to support increases in recurrent capacity

Sustainability - Summary

Sustainability

Financial Management

Target: Break Even

- At the end of Q2, the Trust reported a surplus of £2.3m which was in line with the plan for the same period. Delivery of the quarterly control total means that the Trust has now earned £2.9m of PSF income.
- The underlying financial position remains challenging and in M7 the Trust is reporting a deficit of £0.5m which has reduced the year to date position to a surplus of £1.8m (excluding PSF and MRET).
- This is the first time this year that the Trust has reported a position that is not in line with the financial plan.
- The Trust is forecasting delivery of the year-end control total of £2.5m and the actions required to achieve the control total have been discussed at Trust Executive Committee and at Finance and Performance Committee.
- The actions required are challenging, will need whole Trust ownership and will require close monitoring. There is limited head-room both in the Trust and within the local health economy to manage financial risks during the remainder of year. Emerging risks will need to be closely managed and fully mitigated.

Sustainability - Key Metrics

SOF Finance Rating — G

	Plan	Actual/ Forecast
Year to Date	1	1
Year End Forecast	1	1

At the end of October the aggregate finance rating is a '1'.

Control Total (exc PSF) Surplus £k — A

	Plan	Actual/ Forecast
Year to Date (exc PSF*) £k	2,260	1,822
Year End Forecast (exc PSF) £k	2,459	2,459
Year to Date (inc PSF) £k	7,917	8,249
Year End Forecast (inc PSF) £k	14,062	14,832

The Trust is reporting a surplus of £1.82m excluding PSF and MRET funding, which is £0.44m behind the year to date plan. The operating cost base remains above plan due to bed capacity utilised above planned levels and increased usage of temporary medical workforce.

Efficiency & Transformation Programme £k — A

	Plan	Actual/ Forecast
Year to Date £k	7,363	7,069
Year End Forecast £k	11,728	11,728

In October the Trust has delivered £0.7m efficiency savings against a plan of £1m, reporting a £0.3m slippage. Back Office efficiencies have partially mitigated ongoing slippage with Medicine Division schemes.

Capital £k — A

	Plan	Actual/ Forecast
Year to Date £k	6,166	6,767
Year End Forecast £k	20,304	20,304

Capital expenditure remains above plan due to earlier purchase of replacement medical equipment and the completion of schemes deferred from the previous year.

*PSF includes two funding streams - provider sustainability funds and MRET funding.

Sustainability - Key Metrics

Income £k — G

	Plan	Actual/ Forecast
Year to Date £k	269,069	275,093
Year End Forecast	464,566	463,015

Income is £6m above plan at the end of October. Income from patient care activities is above plan as Accident and Emergency attendances and emergency admissions continue to be high. Private patient income and income from the injury cost recovery scheme continue to be below planned levels so far this year.

Operating Costs £k — R

	Plan	Actual/ Forecast
Year to Date £k	(252,798)	(259,561)
Year End Forecast £k	(437,899)	(436,452)

Operating costs are £6.76m adverse to plan at the end of October. The key contributor to the £3.3m adverse pay position remains Medical expenditure. Clinical supplies within Surgery and Pathology continue to remain the key drivers to the adverse non pay position.

Agency Ceiling £k — G

	Plan	Actual/ Forecast
Year to Date £k	8,278	7,181
Year End Forecast £k	14,969	7,181

Agency spend remained at a similar level to the previous month. There has been a sustained increased in agency expenditure since July although expenditure is favourable against the YTD agency ceiling by £1.1m.

Cash £k — G

	Plan	Actual/ Forecast
Year to Date £k	32,568	22,630
Year End Forecast £k	28,620	28,620

At the end of October cash is behind plan by £10m as cash reserves have been utilised to maintain our Creditor Days position and pay for earlier than planned capital expenditure (replacement medical equipment).

Sustainability - Action & Recommendations

There are no actions required of the Board.

The Board is asked to note the following:

- The actions required to deliver the year-end position have been reviewed at Finance and Performance Committee.
- Expenditure ceilings have been communicated to operational divisions and review meetings with each division have taken place with the Chief Financial Officer or Finance Director.
- There will be further checkpoint meetings with each Division during November to monitor progress and ensure that the necessary support is in place.
- Returning bed capacity to the planned levels through reducing the number of patients with a long length of stay is a key action in delivering performance improvement. An Executive led programme focusing on long length of stay patients has been implemented.
- The Trust is continuing to forecast delivery of the year-end control total. This will be challenging and will require close management. Finance and Performance Committee will provide oversight of the delivery plan on behalf of the Board.

Workforce Performance – Summary

People

Staff Engagement

Target: Engagement Score Top in the Country

1.0 INTRODUCTION

- Engagement score – at 8.0 and therefore above target of 7.6
- Breakthrough objective – 71.88% staff able to make improvements happen in their area of work against a target of 63%
- Pay – overall £527k adverse position , medical pay £626k adverse. YTD £3.24m adverse
- Overall performance in relation to Workforce management is favourable with the exception of appraisal and statutory and mandatory training

Operational Performance – Capacity and Capability

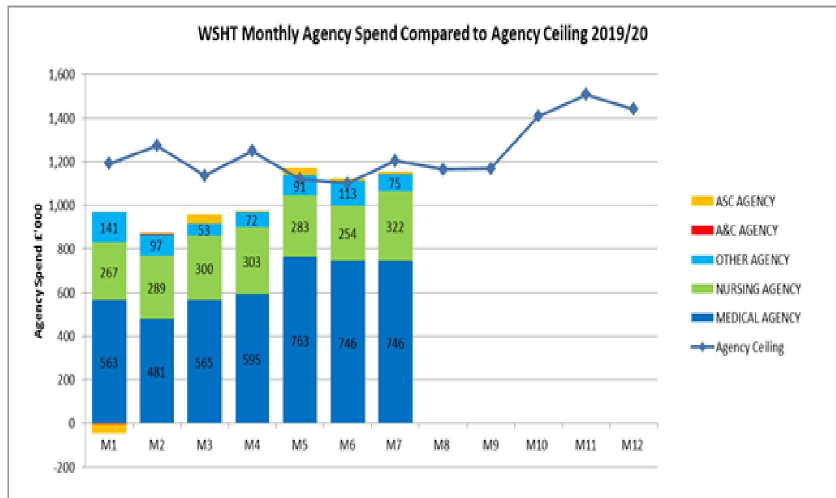
In October 2019 the budgeted establishment requirement increased by +40WTE, and the volume of contracted staff increased by +66WTE, driven partly by higher numbers of nursing workforce. This has reduced the Trust's vacancy gap to under 10%. Temporary workforce volume has remained relatively static.

		Last Month M6	This Month M7	Variance
Budgeted Establishment	wte	6841.1	6881.6	↑
Worked to Budget (wte)	%	98.1%	98.0%	↓
Temporary Workforce (wte)	%	10.7%	10.8%	↑
Agency	%	1.7%	1.8%	↑
Bank	%	8.5%	8.5%	→

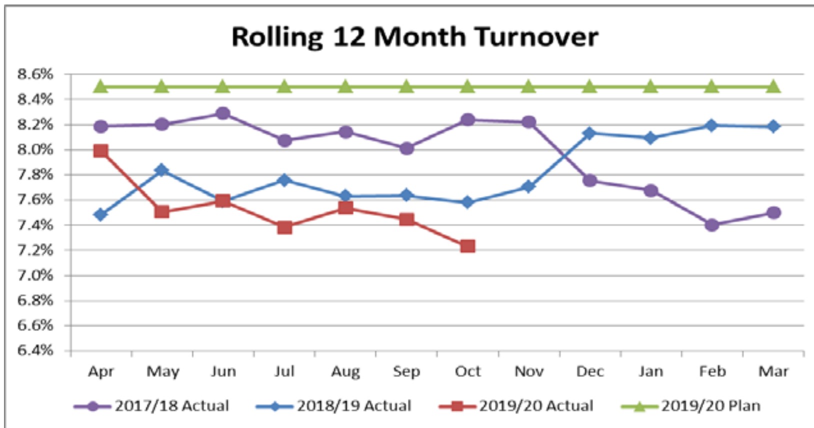
	Annual	In Month			Year to Date		
	Budget £000s	Budget £000s	Actual £000s	Variance £000s	Budget £000s	Actual £000s	Variance £000s
PAY							
Medical Staff	(86,653)	(7,255)	(7,880)	(626)	(51,087)	(54,819)	(3,732)
Nursing Staff	(116,446)	(9,602)	(9,811)	(208)	(67,582)	(68,510)	(928)
Professional Staff	(42,279)	(3,568)	(3,429)	138	(24,668)	(24,005)	663
Admin & Management Staff	(44,942)	(3,777)	(3,618)	160	(26,313)	(25,479)	834
Estates Staff	(16,740)	(1,386)	(1,377)	9	(9,769)	(9,851)	(82)
Total	(307,060)	(25,589)	(26,115)	(527)	(179,420)	(182,664)	(3,244)

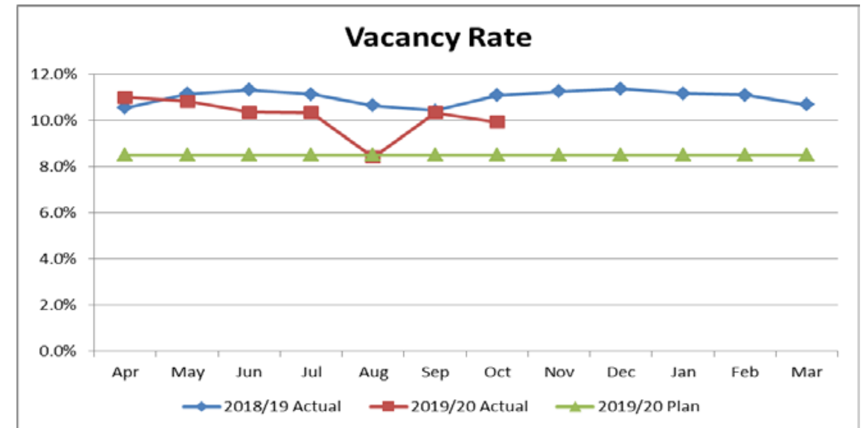
This month the Trust spent £26.1m on workforce, £527k above budget. The majority of overspend continues to be in medical staffing, where £626k of spend above budget has resulted in a YTD spend variance of +£3.7m. There was a reduction in medical budget and spend from M6 due to backdated pay award last month. Total workforce spend is YTD £3.2m above budget. The majority of the overspend remains within the Medicine division, who are progressing recovery actions to reduce workforce spend.

Whilst October's agency spend is higher than September, it is below the set ceiling for the first time in three months. Nursing agency increased in month to the highest value this year in response to operational pressures . A review of the nursing workforce trajectory for the next 3-5 years is taking place to understand future pressures and recommended counter-actions around recruitment and retention. Actions to reduce medical workforce spend are primarily required within the Medicine division, where reductions in length of stay are being encouraged to improve patient experience and improve efficiency.



Operational Performance – Key Metrics





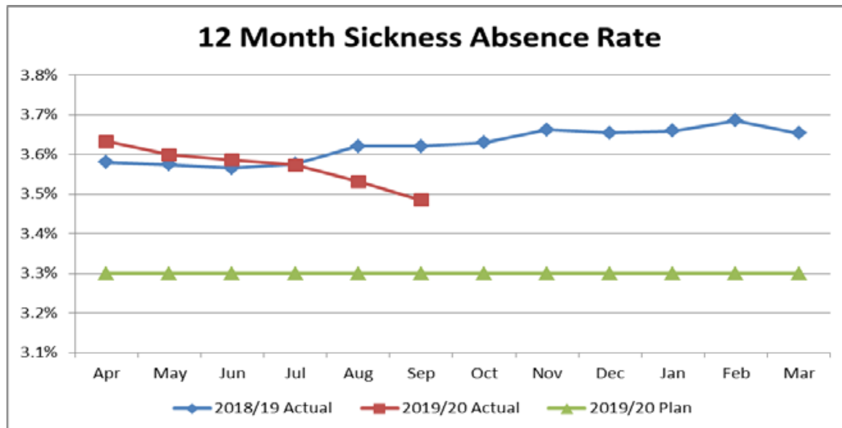
- Staff turnover has continued to decline in October and is now 7.2%, significantly below plan
- All Divisions other than Core have turnover lower than plan
- Core Division have seen an increase in retention rates for Allied Health Professionals and Professional, Scientific and Therapeutic staff

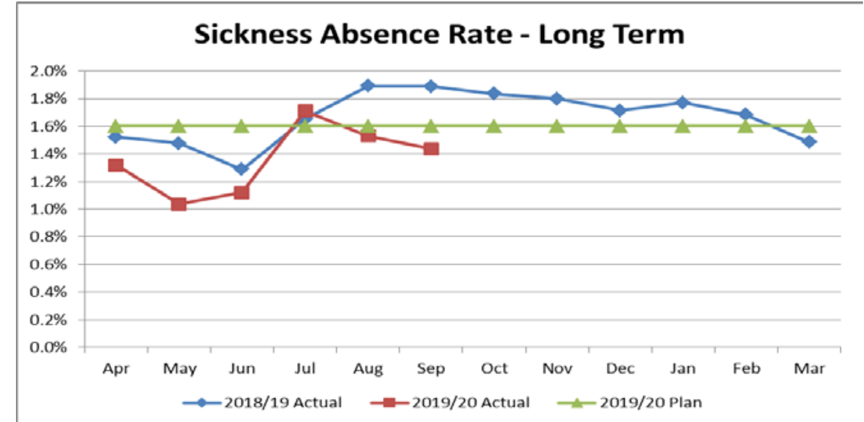
- Vacancy rate increased in September but then decreased in October
- Vacancy rate is above plan but lower than the same time last year

Improvement Focus:
- Core Division continuing to progress their work on retention
- Work to introduce on line exit interviews is ongoing with sample Divisional reports due by end November

Improvement Focus:
- 5 year workforce plans for nursing being developed to include refreshed strategies for domestic and international recruitment, retention, apprentices and new roles.

Operational Performance – Key Metrics





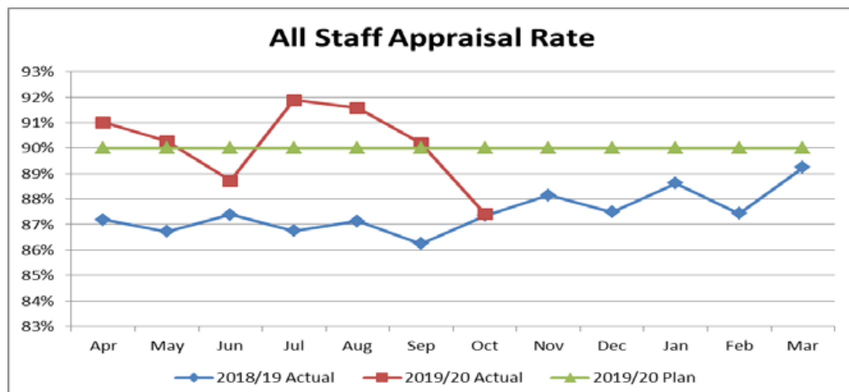
- Rolling sickness absence rate has improved during August and September and is now at it's lowest level since February 2018
- Decrease in 12 month sickness absence has been seen across all Divisions, other than Core
- Long term absence has decreased in last 2 months and is now below plan

- Mental health related absence continues to be higher than musculoskeletal absence
- Initial feedback from mental health champion training has been positive. Pilot programme to be extended with additional courses being offered in January
- Other activities being taken forward to improve staff mental health include the development of our Time2Change pledge and the review of debriefing support for staff following a challenging incident or

Improvement Focus:

- To continue Divisionally led projects to improve sickness absence rates

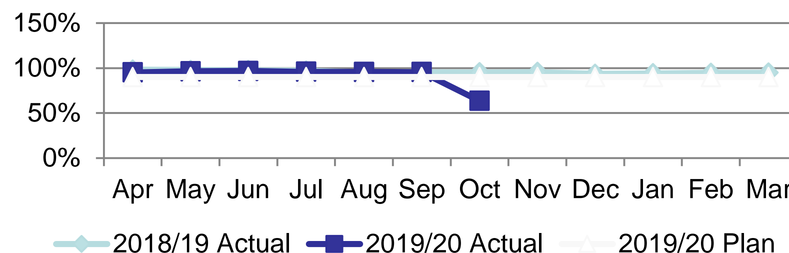
Operational Performance – Key Metrics



- Appraisal rates have dropped significantly in Oct and are now below the planned level of 90%
- Decreases have been seen in medical and non medical appraisal rates and across all clinical Divisions

Improvement Focus:
- Recovery plans to be monitored through SDR

Child Protection Training Rate



- 7 out of 9 STAM modules remain above the Trust target of 90%
- Attendance rates for Safeguarding Children has fallen from 63.4% this month. Impacted by change to Level 2 Safeguarding Children from 3 yearly to annually resulting in reduced compliance
- Resus training is slightly below the Trust target at 88% but is continuing to improve
- Whilst the overall rate for Safeguarding Adults is 92.5%, the attendance rates for L2 (clinical staff) is currently at 75.46% (an increase of 1.2% since last month.) The Safeguarding Adults team is working hard to deliver more face to face training and promote e-learning

Improvement Focus:
- Continue to work with the Medical Director and divisions to improve the attendance rates for Medical staff.
- Improve attendance of clinical staff Levels 2 and 3 Safeguarding Children and Safeguarding Adults training by 31 March 2020.

Improving Staff Engagement

Staff Engagement Score (Pulse Survey)

- Score of 8.0 with 213 participants compared to 7.65 in October 2018. This is against a target of 7.6.
- October was another very active engagement month celebrating the Trust's CQC's Outstanding ratings
- Celebrated 40 years' NHS service with 44 staff at afternoon tea events in Chichester and Worthing
- Staff advocacy is a key component of the engagement score and in month 90% of staff recommended the organisation as place to work. 95.5% of staff recommended the trust as place to be treated
- Unfortunately between June and September a clerical transposition error occurred due to a change in data extract format from third party data provider. This has been rectified and the information standard operating process has been enhanced to mitigate risk of this happening in the future. There is no correlation between this indicator's process and any other board based indicator in terms of further data quality risk

Breakthrough Objective (Pulse Survey)

- 71.88% of staff were able to make improvements happen in their area of work
- Compares to 65.84% in October 2018
- Reflects roll out of PFIS refresh and change of content and emphasis on Western Sussex Way module delivered on Health and Safety days

Best Place to Work

- An online platform to engage staff on ideas for the Best Place to Work ran from 10 September and closed 25 September
- 6,500 staff were invited by email to participate in a conversation about what is important to them and what it would take to be the best place to work invited
- Of those participating about 70% (1,173) actively engaged with over 483 ideas, 1,780 comments and 16,876 votes on those ideas and comments
- A detailed analysis of the top ideas will be presented early December to the Trust Executive Team which will inform our improvement plan

Staff Survey

- 2019 Staff Survey has been open since 3 October and closes on 29 November
- A mixture of electronic and paper questionnaires have been sent with completion widely promoted
- As at 15 November WSHT have a response rate of 46% compared to 53% in 2018. A communications drive continues throughout November

Improving Staff Engagement

Health and Wellbeing

- The work to improve staff mental health is noted under Operational Performance - Long term absence narrative above
- Flu Campaign underway. Uptake level at end of week 6 is 46.7% of all staff and 48.5% of frontline staff

Equalities and Inclusion

- WRES conference held 14 November for NHS organisations across Sussex with involvement from WSHFT stakeholders
- The Trust is working with the national WRES Implementation team to agree and finalise the detail of aspirational goals and action plans by 2028 as part of the national WRES leadership strategy
- Final 3 year WDES action plans are scheduled for QRC on 5 December

Recruitment and Retention

- Fiona Ashworth, Chief Operating Officer has been appointed and commences 2 January 2020

Workforce Systems

- Programme of work to improve compliance and embed functionality of Safecare commenced. Compliance dropped slightly to 80.8%
- Benefits of roll-out of e-rostering for junior doctors in general medicine continue to be realised. This includes reduction in additional unfunded duties, reductions in EWTD and Junior Doctor contract breaches and reduction in locum bank and agency use
- A ‘Go live’ is anticipated in Dept. of Medicine for the Elderly at Worthing on 4 December

Reducing Abusive Behaviours

- Above and Below the Line behaviour standards agreed.
- Structured programme of planned activities to launch and embed are in place including staff training
- Patient facing activities will take place in the new year, giving us the opportunity to focus on the internal launch ahead of Christmas

Improving Staff Engagement and Communications

Patient First STAR Awards

- 350 members of staff and guests attended this year's Patient First STAR Awards on 26 September at Worthing Assembly Hall
- The annual staff recognition awards are organised by the communications teams and supported by *Love Your Hospital* charity
- In total, more than 40 staff and volunteer nominees and teams received prizes on the night
- A video of the 10th annual awards on the Trust's YouTube channel has received more than 1,000 views
- The awards were shared with a large external audience via social media on the night:
    - Facebook - reach 56,000
    - Twitter - 32,600 impressions
    - Instagram - 856 likes
- The event featured in local newspapers following a trust news release praising staff achievement
- A record 806 nominees are receiving personalised certificates of congratulations and celebratory 2019 awards lanyards

First acute trust to receive Outstanding rating in all key CQC inspection areas

- The communications team ensured staff and volunteers were the first to learn about the trust's new Outstanding CQC report
- 500 staff attended briefing sessions on 21 October (day before publication), with hundreds also watching a live video link across the trust
- Hundreds of staff also attended all-staff photocalls at the hospital main entrances, with local newspapers and media recording events
- On 22 October, the CQC published the report and the trust's news release was featured by local television, radio and newspapers
- The communications team shared the news directly too through social media and video clips
- The first Facebook post alone reached more than 82,250 people, with 15,755 engagements and nearly 700 shares
- A video of the day on the trust's YouTube channel has received nearly 1,500 views to date

Staff briefing / Q&A sessions with executive team

The communications team organises staff briefings and Q&A sessions with the executive team in each of the trust's hospitals.

- Since 25 March, approximately 1,500 members of staff have attended more than 23 meetings
- Further meetings are arranged each month for Autumn / Winter

NHS
Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	11	Meeting:	Trust Board	Meeting Date:	28 Nov 19
Report Title:	Finance and Performance Committee Report to Board				
Sponsoring Executive Director:			Lizzie Peers, Non-Executive Director		
Author(s):			Lizzie Peers, Non-Executive Director		
Report previously considered by and date:			N/A direct report to Board		

Purpose of the report:			
Information	✓	Assurance	✓
Review and Discussion	✓	Approval / Agreement	☐
Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	☐	Staff confidentiality	☐
Patient confidentiality	☐	Other exceptional circumstances	☐
Link to Trust Strategic Themes:			
Patient Care	✓	Sustainability	✓
Our People	✓	Quality	✓
Systems and Partnerships	✓		
Any implications for:			
Quality			
Financial			
Workforce			
Link to CQC Domains:			
Safe	☐	Effective	☐
Caring	☐	Responsive	☐
Well-led	☐	Use of Resources	☐

Communication and Consultation:

Executive Summary:

The Finance and Performance Committee met on 28 October 2019 and was quorate as it was attended by four Non-Executive Directors and the Chief Finance Officer, Chief Workforce and Organisational Development Officer, Chief Medical Officer and Chief Nurse. The Director of Human Resources was also in attendance.

The Committee received its planned items and debated these reports in accordance with its cycle of business.

Key Recommendation(s):

The Board is asked to **NOTE** the assurances received at the meeting and that based on these the Committee did not refer any matter to any other Committee. The Committee referred Systems and Partnerships Risk 5.1, back to the Executives for review.

NHS
Western Sussex Hospitals
NHS Foundation Trust

To: Trust Board Date: 28 November 2019

From: Finance and Performance Committee Agenda Item: 11

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Finance & Performance Committee	**28 October 2019**	**Lizzie Peers**	✓	☐

Declarations of Interest Made

There were no declarations of interest

Assurance received at the Committee meeting

- The Committee **RECEIVED** the financial performance reports for Month 6. The Committee was **ASSURED** in respect of the Trust's performance against the plan for Month 6 with the Trust recording a £0.73m surplus excluding PSF and MRET which is in line with the Trust's approved plan. However the Committee noted that a number of non-recurrent adjustments had been brought forward to support delivery to date. As such significant improvements in divisional run rates are required to achieve the year end control total with medical pay overspend continuing to be a significant pressure. The Committee agreed to continue to closely monitor the work being delivered to mitigate the increase in activity levels and manage expenditure. The Committee was **ASSURED** over the plans supporting the delivery of the control total but noted the level of risk to delivery and the significant challenge this presented.

- The Committee **RECEIVED** the Efficiency Programme update, noting that in Month 6 the programme was on track to meet with year to date delivery of £4.3m against a plan of £4.3m with forecast outturn for full delivery of the plan although it was noted that the current level of achievement was supported by the application of various one off items and some schemes over performance with other schemes needing to step up performance to ensure delivery of the year end value. The highest risks remained with the high value, complex, transformational schemes which were not all delivering their planned values due to increased demand pressure. The Committee noted the increased risk in the plan but was **ASSURED** by the mitigations in place and that the BAF correctly records the current level of risk.

- The Committee **RECEIVED** the Workforce Performance report and were ASSURED over the delivery of the workface related KPIs.

- The suite of operational performance reports was **RECEIVED** by the Committee, which noted the Trust's position against constitutional standards and discussed the trajectories in place to improve the Trust's performance. Whilst demand is a key pressure on the Trust's ability to deliver its set performance targets it was recognised that there are also some good opportunities to improve internal productivity to assist in mitigating some of this increased demand pressure. The Committee noted that the Trust was behind its planned trajectories for A&E, two of the Cancer Metrics and RTT but had returned to in month compliance for diagnostics. The Committee recognised the demand and activity delivery risks and was **ASSURED** that the BAF correctly records this level of risk excluding Risk 5.1 which the Committee **AGREED** would need to be referred to the Executive for review with a suggested change in score from 9 to 12 for quarter 3. This request was made due to the scale of system challenges and the impact these have on the patient flow, length of stay, Trust performance, costs and staffing.

- The Committee **RECEIVED** a Deep Dive in Referral to Treatment Time (RTT) and was **ASSURED** by the mitigations and recovery actions detailed within the report to support the Trust returning to a compliant position.

- The Committee **RECEIVED** a quarterly update on the Trust's Capital Plan 2019/20 and was **ASSURED** that the plan was on track to meet the year-end forecast.

Actions taken by the Committee within its Terms of Reference

The Committee referred Systems and Partnerships Risk 5.1, back to the Executives for review.

Items to come back to Committee / Group (Items Committee / Group keeping an eye on)

- The Committee requested a deep dive in respect of the Trust's A&E performance plans at its next meeting.

Items referred to the Board or another Committee for decision or action

Item	Referred to
▪ The Committee referred no matters to other Board Committees and referred no matter to the Public Board.	

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	12	Meeting:	Trust Board	Meeting Date:	28 Nov 19
Report Title:	Charitable Funds Committee Highlights Report to Board				
Sponsoring Executive Director:	Joanna Crane, Non-Executive Director				
Author(s):	Joanna Crane, Non-Executive Director				
Report previously considered by and date:	Not applicable as direct report				

Purpose of the report:			
Information	✓	Assurance	✓
Review and Discussion	✓	Approval / Agreement	☐
Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	☐	Staff confidentiality	☐
Patient confidentiality	☐	Other exceptional circumstances	☐
Link to Trust Strategic Themes:			
Patient Care	✓	Sustainability	☐
Our People	✓	Quality	☐
Systems and Partnerships	✓		
Any implications for:			
Quality			
Financial			
Workforce			
Link to CQC Domains:			
Safe	☐	Effective	✓
Caring	☐	Responsive	☐
Well-led	✓	Use of Resources	☐
Communication and Consultation:			

Executive Summary:

The Charitable Funds Committee met on the 03 October 2019 and was quorate as it was attended by three Non-Executive Directors, the Chief Workforce and OD Officer and the Trust Finance Director. In attendance was the Group Company Secretary along with the Head of Charitable Operations.

The Committee received its planned items and debated these reports in accordance with its cycle of business.

Key Recommendation(s):

The Board is asked to **NOTE:**

That the Committee received the Love your Hospital Annual Report and Annual Accounts for 2018/19 and is recommending them to the Board of Trustees for approval.

Western Sussex Hospitals NHS Foundation Trust

To: Trust Board Date: 28 November 2019

From: Charitable Funds Committee Agenda Item: 12

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Charitable Funds Committee	**03 October 2019**	**Joanna Crane**	✓	☐

Declarations of Interest Made

None

Assurance received at the Committee meeting

- The Committee **RECEIVED** the Investment Report for the period up to the 31 August 2019 noting the value of the LYH investment portfolio and was **ASSURED** that the return made by the investment manager was in line with benchmarks.
- The Committee **RECEIVED** the Strategic and Operational Report for June to August 2019. A slight drop in income was noted, although the Committee was **ASSURED** by the measures in place to recover the position with a number of future events planned it was agreed to highlight this to the Board.

Actions taken by the Committee within its Terms of Reference

- The Committee **RECEIVED** the Love Your Hospital Annual Report and Accounts and acknowledged the positive comments from Kreston Reeves, particularly in relation to the smooth process for 2018/19. The Committee **RECOMMENDED** the Annual Report and Accounts to the Board of Corporate Trustees for approval.
- The Committee **APPROVED** three Charitable Funds bid requested and **RECOMMENDED** a fourth to the Board of Trustees for approval.

Items to come back to Committee (Items the Committee is keeping an eye on)

- The Committee requested that a summary of options was brought back to the Committee in relation to a Legacy Pipeline in January 2020.
- Information in relation to historic funds with no movement would be reported at the next meeting.
- The Chair and the Head of Charitable Operations would refresh the risk register prior to the Committee's next meeting in January.

Items referred to the Board or another Committee for decision or action

Item	Referred to
The Committee wished to highlight to the Board the reduction in Charity income over the last Quarter.	**Board – For information only**
The Committee recommended the Breast Ultrasound to the Board of Trustees for Approval.	**Board of Trustees – For approval**
The Committee recommended the Charity Accounts and Annual Report to the Board of Trustees for Approval	**Board of Trustees – For approval**

Western Sussex Hospitals
NHS Foundation Trust

Date: 28 November 2019

Agenda Item:	13	Meeting:	Trust Board	Meeting Date:	28 Nov 19
Report Title:	Audit Committee Report to Board				
Sponsoring Executive Director:			Jon Furmston, Non-Executive Director		
Author(s):			Jon Furmston, Non-Executive Director		
Report previously considered by and date:			N/A direct report to Board		

Purpose of the report:			
Information	☐	Assurance	✓
Review and Discussion	☐	Approval / Agreement	☐
Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	☐	Staff confidentiality	☐
Patient confidentiality	☐	Other exceptional circumstances	☐
Link to Trust Strategic Themes:			
Patient Care	✓	Sustainability	✓
Our People	✓	Quality	✓
Systems and Partnerships	✓		
Any implications for:			
Quality			
Financial			
Workforce			
Link to CQC Domains:			
Safe	☐	Effective	☐
Caring	☐	Responsive	☐
Well-led	✓	Use of Resources	☐

Communication and Consultation:

Executive Summary:

The Audit Committee met on the 03 October 2019 and was quorate as it was attended by four Non-Executive Directors. Attending the meeting were also the Trust's External and Internal Auditors, the Trust's Local Counter Fraud Specialist, the Chief Financial Officer, Director of Finance and the Group Company Secretary. The Chief Workforce and Organisational Development Officer was also in attendance for the BAF deep dive into the "People Risks".

The Committee received its planned items and debated these reports in accordance with its cycle of business.

Key Recommendation(s):

The Board is asked to **NOTE:**

The assurances secured through the reports reviewed and that the Committee did not refer any matters to the executive for review following its review of the BAF.

Western Sussex Hospitals NHS Foundation Trust

To: Trust Board

From: Audit Committee

Agenda Item: 13

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Audit Committee	**03 October 2019**	**Jon Furmston**	✓	☐

Declarations of Interest Made

No interests were declared.

Assurance received at the Committee meeting

- The Committee **RECEIVED** the BAF and information on the supporting high scoring risks and agreed that the BAF encapsulated the key strategic risks, that the assigned oversight committees for each risk were appropriate and that the expected assurances were reasonable.
- The Committee **RECEIVED** final reports from the Internal Auditors in relation to four recently completed audits; Expected Date of Discharge, Bed Management, Sickness Management and Patient Experience. It received positive **ASSURANCE** in relation to these reports and the progress made against recommendations from both these and previous audits.
- The Committee **RECEIVED** an update from the External Auditors and were **ASSURED** that reflections and learning from 2018/19 would be incorporated into the 2019/20 Year-End plan.
- The Committee received **ASSURANCE** from the Local Counter Fraud Specialist update, in particular that RSM had assisted the Trust in submitting the Counter Fraud Authority procurement thematic assessment.
- The Committee **RECEIVED** a detailed overview of the "people risks" and the assurances that support their current risk scores. The Committee was **ASSURED** and confirmed that the current risk scores were appropriate. The Committee had a useful discussion on the effectiveness of the BAF as a tool for managing and capturing current people risks.
- The Committee **RECEIVED** a Post Project Evaluation on the Relocation of Colposcopy Services. The Committee was **ASSURED** by the Benefits Realisation and that the Trust was now meeting all the quality assurance standards as a result of the relocation.

Actions taken by the Committee within its Terms of Reference

- The Committee received and recommended the Annual Review and Report to the Council of Governors on the External Auditors to the Council of Governors for **APPROVAL**.

Items to come back to Committee (Items Committee keeping an eye on)

- Progress against the actions and recommendations from the Internal Audits following further updates to the Quality Assurance Committee.

Items referred to the Board or another Committee for decision or action	
Item	**Referred to**
▪ Quality Assurance Committee to receive updates in relation to actions and recommendations from the following Audits at their next meeting: o Bed Management o Patient Experience o Sickness Management	**Quality Assurance Committee**

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	14	Meeting:	Board	Meeting Date:	28 Nov 2019
Report Title:	Q3 Board Assurance Framework – 2019/20				
Sponsoring Executive Director:	Glen Palethorpe, Group Company Secretary				
Author(s):	Glen Palethorpe, Group Company Secretary				
Report previously considered by and date:	TEC – has seen Q2 with Q3 scheduled to be presented on the 12 December 2019 QAC – has seen Q2 with Q3 scheduled to be presented on the 5 December 2019 F&P – 25 November 2019				

Purpose of the report:			
Information	☐	Assurance	✓
Review and Discussion	☐	Approval / Agreement	✓
Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	☐	Staff confidentiality	☐
Patient confidentiality	☐	Other exceptional circumstances	☐
Link to Trust Strategic Themes:			
Patient Care	✓	Sustainability	✓
Our People	✓	Quality	✓
Systems and Partnerships	✓		

Any implications for:	
Quality	Quality related strategic risks
Financial	Finance related strategic risks
Workforce	Workforce related strategic risks

Link to CQC Domains:			
Safe	✓	Effective	✓
Caring	✓	Responsive	✓
Well-led	✓	Use of Resources	✓

Communication and Consultation:

The Board Assurance Framework has been prepared in conjunction with each of the five Chief Officers, focussing on respective strategic objectives and determining their associated strategic risks.

Executive Summary:

Introduction

The Trust has identified 11 strategic risks to the delivery of its objectives. The oversight of the management of these strategic risks is documented within the Board Assurance Framework. Each risk has an assigned oversight committee who review the detail of the listed assurances and their impact on the current score along with the delivery of the actions to reduce to or maintain the risk at its target score.

For quarter 3 at 17th November there have been TWO changes from the Q2 assessed risk scores. These changes are in relation to sustainability risks 2.1 and 2.2 which have increased.

BAF Summary

The table overleaf shows by risk, their current score and their target risk score. Noting that for one risk (3.2) this continues to be scored at its target score and thus the BAF process for this risk is

about securing assurance that this acceptable (target) level of risk is maintained.

The table also shows pictorially the movement in risk between the current score for Q3 and that recorded for Q1. (⟷ No change, ↑ an increase in risk and ↓ a decrease in risk)

BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	**Risk Scores**											
	Opening risk			**Q2**			**Q3**			**Target**		
	I	**L**	**T**	**I**	**L**	**T**	**I**	**L**	**T**	**I**	**L**	**T**
1. Patient ***Quality Assurance Committee***												
1.1 we are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in adverse reputational impact and loss of market share	2	3	**6**	2	3	**6** ⟷	2	3	**6** ⟷	2	2	**4**
2. Sustainability ***Finance and Performance Committee***												
2.1 We are unable to align or invest in our workforce, finance, estate and IM&T infrastructure effectively to support operational resilience, deliver our strategic and operational plans and improve care for patients	3	4	**12**	3	4	**12** ⟷	4	4	16 ↑	3	3	**9**
2.2 We cannot continue to deliver ongoing efficiencies and flex our resources in an agile way resulting in the Trust not being able to live within its resources given the rising demands on our services	3	4	**12**	3	4	**12** ⟷	4	4	16 ↑	3	3	**9**
2.3 We are unable to meet high standards of financial stewardship meaning we cannot sustain compliance with our statutory financial duties	3	3	**9**	3	3	**9** ⟷	3	3	9 ⟷	3	3	**9**
3. People ***Quality Assurance Committee***												
3.1 We are unable to appropriately develop cultural change and involve and engage staff in a way that leads to continuous improvements in patient experience, patient outcomes, and staff morale and wellbeing	3	3	**9**	3	3	**9** ⟷	3	3	**9** ⟷	3	2	**6**
3,2 We are unable to meet our workforce requirements through the effective recruitment, development, training and retention of staff adversely impacting on patient experience and the safety, quality and sustainability of our services	3	3	**9**	3	3	**9** ⟷	3	3	9 ⟷	3	3	**9**
4. Quality Improvement ***Quality Assurance Committee***												
4.1 We are unable to deliver and demonstrate compliance with regulatory requirements or clinical standards adversely impacting on patient safety and our registration and accreditation by regulatory and supervisory bodies	2	3	**6**	2	3	**6** ⟷	2	3	**6** ⟷	2	2	**4**
4.2 We are unable to deliver service improvements and improve safety, care quality and outcomes for our patients or demonstrate that our services are	2	3	**6**	2	3	**6** ⟷	2	3	**6** ⟷	2	2	**4**

clinically effective												
5. Systems and Partnerships ***Finance and Performance Committee***												
5.1 We are unable to develop and maintain collaborative relationships with partner organisations based on shared aims, objectives, and timescales leading to an adverse impact on our ability to operate efficiently and effectively within our health economy in line with the NHS Long Term Plan	3	3	**9**	3	3	**9** ↔	3	3	**9** ↔	3	2	**6**
5.2 We are unable to define and deliver the strategic intentions, plans and optimal configuration that will enable our services to be sustainable, leading to an adverse impact on their future viability.	4	3	**12**	4	3	**12** ↔	4	3	**12** ↔	4	2	**8**
5.3 We are unable to deliver and demonstrate consistent compliance with operational and NHS constitutional standards resulting in an adverse impact on patient care and the reputation of the Trust	4	3	**12**	4	3	**12** ↔	4	3	**12** ↔	4	2	**8**

Committee Review

Each BAF risk has an allocated lead oversight Committee, however, it is recognised that for some risks other Committees will also receive assurance against elements of control with respect to that risk.

Quality Assurance Committee

The Committee's review of the risks to which they have allocated oversight and their receipt of assurance at their meetings across Quarter 1, Quarter 2 and the start of Quarter 3 did not identify any negative assurance that required any risk to be referred back to the Executive for review for being under stated.

Finance and Performance Committee

The Committee's review of the risks to which they have allocated oversight and their receipt of assurance at their meetings across Quarter 1 and the start of Quarter 2 did not identify any negative assurance that required any risk to be referred back to the Executive for review for being under stated. However at the end of Quarter 2 the Committee recognised the reports from the Executive showed increased risk in relation to the financial position of the Trust and the increase in demand as a pressure on risk 5.3 in relation to the delivery of the Trust's operational targets.

The Committee agreed that the receipt of their expected reports and assurance would enable them to recognise or endorse if a change in the current score is needed over the next few months if the service demands continue to exceed the Trust and wider health economy assumptions.

The Committee at its meeting in August also asked for the BAF to reflect the General Ledger update planned for 2019/20 within risk 2.3, recognising this did not alter the current risk score.

The Committee at its meeting in October did recognise the pressure within the wider system which could increase the risk in relation to strategic risk 5.1.

The BAF reflects an increase in the current risk score for both risk 2.1 and 2.2 moving these to a current score of 16 for each risk. Countermeasure reports in the form of the Trust's road map to

deliver the Trust's control total have been presented to Finance and Performance Committee for October and November and include information on planned mitigations and the delivery of which will be tracked within the routine reports to Finance and Performance Committee.

Audit Committee

The Audit Committee considered the BAF along with the key highly scoring risks that underpin the BAF and felt there was no need to refer any risk to the Executive for review for being under stated.

The Committee did undertake a more detailed review at its October Committee meeting of risks 3.1 and 3.2 to complement the reviews undertaken by the Quality Assurance and Finance and Performance Committees and confirmed that the reported assurance did support the stated current risk scores.

Trust Executive Committee

The Trust Executive Committee considers the BAF alongside the highly scored divisional / corporate risks. The Committee has not identified any increasing divisional risks that have required a reassessment of the scored strategic risks.

Key Recommendation(s):

The Board is recommended to consider the level of current risk recorded within the BAF against reported assurances via the various Committees and assurances provided direct to the Board over the period covered by this report and agree that the BAF represents a balanced view of assurance and its impact on the key risks to the achievement of the Trust's stated objectives.

Appendix A

Risk Appetite Statement

The Boards of NHS Trusts are accountable for ensuring the quality, safety and sustainability of the services they provide to patients. Western Sussex Hospitals NHS Foundation Trust sets clear expectations for the Trust through strategic objectives.

The Trust operates in a high risk environment and the day to day management of risk is an expected and integral part of the business of any healthcare provider. Overall, the Board has a **moderate** appetite for risk in relation to the achievement of its objectives and takes active and ongoing actions as part of our daily operational management and strategic planning to reinforce our risk controls in order to minimise risk to a tolerable level.

Our Board Assurance Framework and risk registers will continue to reflect material risks that may prevent the Trust from fulfilling its role in delivering clinical services which meet regulatory and NHS Constitutional standards and the expectations of our stakeholders and patients. We have defined our appetite for risk in relation to our strategic objectives as follows:

Patient Care: We make delivering an excellent care experience for our patients our highest priority. However, we will accept **moderate** risks to patient experience if this is required to achieve patient safety and quality improvements.

We have a **low** risk appetite for actions and decisions that, whilst taken in the interests of ensuring quality, safety and sustainability, may affect the reputation of the Trust or of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Board.

Safety: We will deliver safe, high quality clinical services and demonstrate they achieve optimal clinical outcomes and deliver best practice for our patients whilst ensuring we meet regulatory standards. Overall, our risk appetite for safety is **low**. Specifically:

We have a **low** appetite for risks that could result in poor quality care or unacceptable clinical risk, non-compliance with standards or poor clinical or professional practice.

We have a **low** appetite for risks that may jeopardise patient safety.

We recognise that it can be in the best interests of patients to have a **moderate** appetite for some individual patient care and treatment risks in order to achieve the best outcomes. Therefore we support our staff to work in collaboration with the people who use our services to develop appropriate and safe care and treatment plans based on assessment of need and clinical risk.

We will apply strict safety protocols for all of clinical and non-clinical activity, when and wherever possible. We will report, record and investigate our incidents and ensure that we continue to learn lessons to improve the safety and quality of our services.

Sustainability: We strive to use our resources efficiently and effectively for the benefit of our patients and their care and ensure our services are clinically, operationally, and financially sustainable. We will always aim to achieve this objective; however, overall we have a **moderate** appetite for risk in this area. Specifically:

We have a **moderate** appetite for some financial risks where this is required to mitigate risks to patient safety or quality of care. We will ensure that all such financial responses deliver optimal value for money.

We are committed to providing patient care in a therapeutic environment and providing staff with an environment and supporting infrastructure in which to perform their duties. However, we have a **moderate** appetite for some risks related to our infrastructure and estate except where these adversely impact on patient safety, care quality and regulatory compliance

We will increase our appetite for financial risk to **significant** in some instances and consider all potential delivery options to ensure the delivery of our objectives. Our appetite for risk in this area recognises the financial environment in which NHS trusts are operating, and the requirement to maintain regulatory and constitutional standards. A decision to take this level of risk would be based on a rigorous risk assessment and a review of the robustness of the controls and would require sign off by the Board.

We are prepared to support investments for return and minimise the possibility of financial loss by managing associated risks to a tolerable level. Value and benefits will be considered and resources allocated in order to capitalise on opportunities.

People: We value and respect all our staff equitably, involve them in decisions about the services they provide and offer the training and development they need to fulfil their roles. We will rarely accept risks that would limit our ability to achieve this objective and the Trust's overall risk appetite for workforce related risks is **low**. Specifically:

We have a **low** appetite for risks related to the recruitment, retention and training of staff to deliver safe, high quality services and good patient experience.

We have **no** appetite for risks associated with unprofessional conduct, bullying, or an individual's competence to perform roles or tasks safely nor any incidents or circumstances which may compromise the safety of any staff members and patients or contradict our values.

We have a **moderate** appetite for risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing, and staff development models where these enhance or improve patient safety, care quality, service delivery or financial sustainability.

We have **no** appetite for any risk that could result in staff being non-compliant with legislation, or any frameworks provided by professional bodies.

We have **no** appetite for any risk that could result in us being in breach of our contractual or statutory responsibilities in relation to our staff or in a breach of our staff's employment rights.

Systems and Partnerships: We will collaborate with commissioners, local authorities, our other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards. Overall we have a **moderate** appetite for risks to the achievement of this objective. Specifically:

We have a **moderate** appetite for risk where this results in improvements in the design or delivery of healthcare services for our patients or the population we serve. Our appetite for risk in this area recognises that the Trust operates in a complex environment and is subject to very challenging economic conditions and changing demographics with intense scrutiny. We consider the risks associated with innovation, creativity and clinical research to be an essential part of the Trust's risk profile. We increase our appetite for risk in this area to **significant** in order to maximise the opportunities to improve patient outcomes and the Trust's sustainability. . A decision to take this level of risk would be based on a rigorous risk assessment and a review of the robustness of the controls and would require support of the Board.

We will collaborate with commissioners, local authorities, our other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards.

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Agenda Item:	15	**Meeting:**	Trust Board	**Meeting Date:**	28 Nov 19
Report Title:	Estates and Facilities Update				
Sponsoring Executive Director:			Karen Geoghegan, Chief Financial Officer		
Author(s):			David McLaughlin, Interim Director of Estates and Facilities		
Report previously considered by and date:			N/A		

Purpose of the report:			
Information	✓	Assurance	✓
Review and Discussion	☐	Approval / Agreement	☐
Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	☐	Staff confidentiality	☐
Patient confidentiality	☐	Other exceptional circumstances	☐
Link to Trust Strategic Themes:			
Patient Care	✓	Sustainability	✓
Our People	✓	Quality	✓
Systems and Partnerships	✓		

Any implications for:	
Quality	
Financial	
Workforce	

Link to CQC Domains:			
Safe	✓	Effective	✓
Caring	☐	Responsive	✓
Well-led	✓	Use of Resources	✓

Communication and Consultation:

Executive Summary:

Estates and Facilities have really focused on improvements and adding value to the Trust in the previous quarters, we have also been developing our people with a strong emphasis on team engagement. This presentation and handbook provide insight in to the work that's been delivered and being carried out with a high numbers of areas to celebrate including:

1. CQC Preparations
2. Reducing corridor clutter
3. Reducing backlog maintenance
4. Fire Safety
5. Waste processes
6. Staff engagement
7. Patient first improvement projects
8. Cleaning standards
9. Energy usage reduction
10. E&F Training Academy

Key Recommendation(s):

The Board is asked to **NOTE** this presentation.

Estates and Facilities

November 2019

David McLaughlin
Director of Estates and Facilities

Western Sussex Hospitals
NHS Foundation Trust

Contents

- Estates and Facilities
- Soft Services
- Efficiency
- Hard
- Engagement
- Compliance
- Sustainability
- Fire
- Awards

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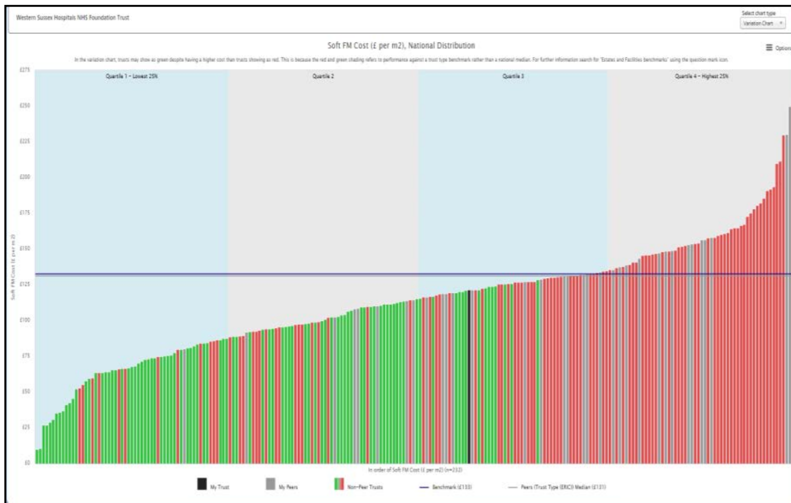
Estates and Facilities: Soft FM



- Cleaning costs marginally above benchmark of £43/m^2 . Decision not to reduce cleaning input to maintain high standards of cleanliness and low infection control rates
  - Hospital onset C Diff was 10.3 cases/100k bed days (national average 13.7)
  - National Standards of Cleanliness 97% (benchmark 90%)
  - PLACE score 99.7% (best quartile 99.4)
- Rapid turnaround in ward areas to support patient flow and reduce the need for escalation capacity

Western Sussex Hospitals
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Estates and Facilities: Efficiency

2018/19: Delivered efficiency savings of £1.2m (4.3% of cost base)

Cleaning:

- Service review has delivered cost saving whilst maintaining cleaning input hours
- Realigned working patterns, moving from night to days
- Reduced number of managers and increased supervisors to increase productivity
- Full year effect saving of £300k per annum.
- Forecast to maintain cost/m^2 at 2017/18 levels despite increased activity levels and AfC pay award.

Portering:

- Standardisation project
- Aligning working practices and terms and conditions between sites
- Delivery of quality improvements
- Efficiency increases aid patient flow
- Winners of Chairman's Award in Patient First STAR awards 2018

Laundry:

- Full review of laundry service to make recommendations for service improvements

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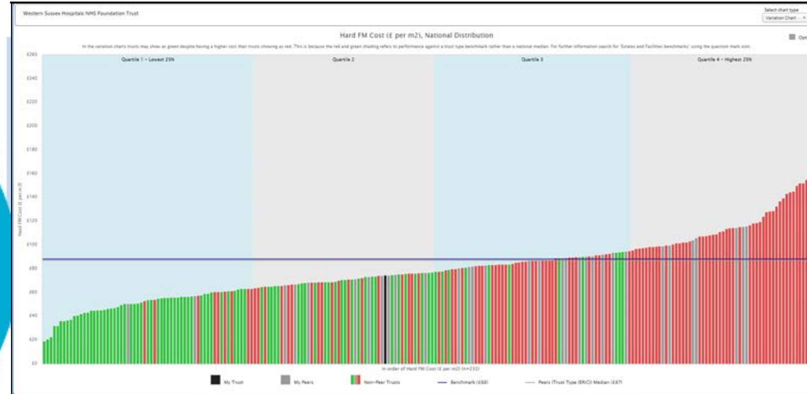
Estates and Facilities: Hard FM



- Hard FM costs below benchmark (£75/m² vs £88/m²)
- Maintenance performance consistently above KPI targets & SCART Compliance - 90%
- Energy: above benchmark addressed through review of contracts and engagement in STP Combined Heat and Power procurement, 5% reduction in utility usage achieved for 2019 / 2020 CIP
- Water: On site laundry service, implementing solution to allow laundry to be supplied from on-site well
- Waste: focus on staff training on waste streams. Cost reduced to £254/tonne in 2018/19

Estates and Facilities: Staffing

Staff Engagement:

- Introduction of improvement boards using Patient First methodology
- 25 staff trained as facilitators by Kaizen team
- 132 changes implemented in Yr1 including:
    - Introduction of knee pads (reducing MSK injuries)
    - Changes to patient meal service on delivery suite (reducing food waste)
    - Changes to patient transfer arrangements between Breast Clinic (improving patient experience)

Estates and Facilities Academy:

- Introduced "Academy" for supervisors to up-skill staff and give them the support and knowledge to do their jobs well
- 36 graduates in Yr1
- 5% increase in appraisal completion to 91%
- 12% increase in staff feeling supported in development
- 14% increase in staff feeling valued

Western Sussex Hospitals
NHS Foundation Trust

Hard FM Services Compliance Dashboard

Microsoft Excel - 2019 2020 COMPLIANCE MASTER DASHBOARD

COMPLIANCE DASHBOARD

Nov-19

Policies · Risk · Lost Time Inj. · Complaint Days · SCART · Tech Complianc · PPM · Reactive · Fac. Compliance · Technical Cleaning · Waste to Landfill · PLACE · P&L · Capital · CIP · Appraisals · Mand. Training

SCART Compliance	Technical Compliance	P&L YTD	Facilities Compliance	Technical Cleaning Scores
94.29%	94%	Income, Pay, Non Pay, EBITDA	95.76%	V.High 98% 98.0%; High 95% 96.5%; Sig. 85% 91.5%; Low 75% 86.0%

% Planned Maintenance	% Reactive Maintenance	CIP YTD	Lost Time Injuries	Waste Management
UNDER CONSTRUCTION	UNDER CONSTRUCTION	DELIVERED; RISK LEVEL	437 Days Since Last Injury; Cost of LTI YTD £-; Hours Lost YTD 0	Incineration, Landfill, Recycle; 0%; 100%

Policies	Risk Register	Capital	PLACE Audit	Complaints
94%	100.0%	#DIV/0!	Cleaning, Condition, P&D, Food, TOTAL	2.8

NOTES

Appraisals %	Mandatory Training %
86.60%	91.1%

MASTER SHEET · Summary · SCART · Technical · Planned · Reactive · Lost Time Inj · Risk Reg · Finance · CIP · Capital · Fac Compliance · Cleaning · PLACE · WASTE · Policies

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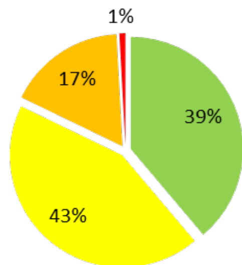
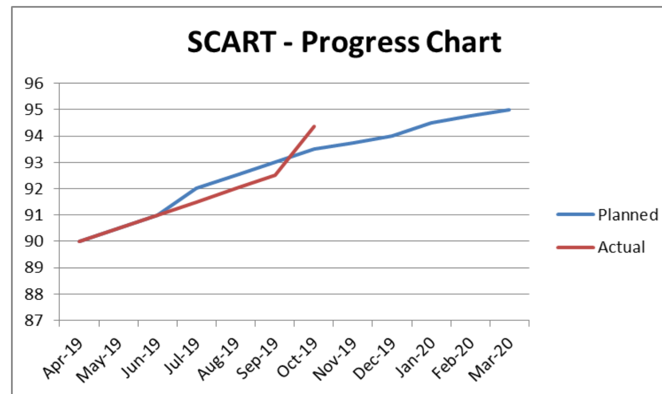
Hard FM Services Compliance

- SCART now being utilised to measure technical procedural compliance, E&F targeting a compliance level of 95% in year 2019 / 2020





Sustainability

Green Travel Plan:

- Introduction of new cycling storage with increased security
- Modernised and improved changing facilities for staff
- Introduction of Easit scheme helping deliver concessions to staff using public transport
- Cross site minibus / park and ride

- Taken 2,000 car journeys off the roads which is the equivalent to 60 tons of CO_2 saved every year.
- Commended at the Health Business Awards 2018

Western Sussex Hospitals
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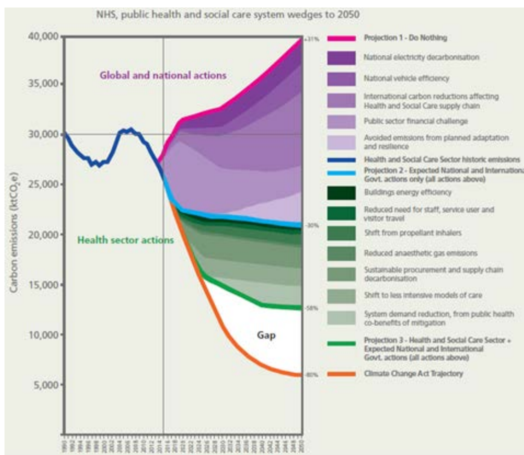
Sustainability

New Green Steering Group

1. Waste
2. Energy and utilities
3. Green Travel
4. Sustainable Development management Plan - 2025

Sustainable Development Management Plan

Western Sussex Hospitals NHS Foundation Trust



- Dame Marianne Chair
- Trust Champions
- Trust Wide Membership

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Fire Safety

CQC

- Fire Risk Assessment reviews (FRA) 100% complete all areas.
- 100% fire equipment and statutory compliance audit
- Fire information packs available at nurse stations for ward staff.
- Signage reviewed for all areas.
- A new clutter management process established with robust controls, this process is now being sustained as part of BAU.
- Additional training provided for all Sisters & Ward Managers on review and understanding of the FRA.

EQUIPMENT CERTIFICATE
PLEASE SECURE TO EQUIPMENT
HELP DESK NUMBER 83999
WARD
DATE
EQUIPMENT CLEANED
PORTERS INFORMED VIA HELP DESK
FOR DISPOSAL
BED FOR STORAGE
FOR REPAIR
ESTATES REQUISITION NUMBER
PRINT NAME

Western Sussex Hospitals
NHS Foundation Trust

Fire Safety

1. Fire Stopping priority 1 complete West Block SRH, fire stopping contract awarded for the remaining P1 and a large portion of the P2 works across all three sites.
2. Fire Door survey complete Southlands and Worthing, SRH is underway now, remedial actions from the surveys are being captured for delivery by priority this year.
3. Fire damper survey, service and remedial works project is underway with all trust areas expected to be visited this year, the highest priority repairs will also be delivered in year.
4. Prioritisation and progress shared with the West Sussex Fire Safety Team during our enforcement visit.

Yes

Tel: 0330 222 3333
Email: BusinessFireSafety@westsussex.gov.uk

Our Ref: H4000

West Sussex Fire and Rescue Service
Business Fire Safety
Horsham Fire Station
Hurst Road
Horsham
West Sussex
RH12 2DN

David McLaughlin
Director Estates and Facilities
West Sussex Hospitals NHS Foundation Trust

David.Mclaughlin@wsht.nhs.uk

Date: Tuesday, 18 June 2019
Please ask for: Ian Stocks

Dear Mr McLaughlin,
The Regulatory Reform (Fire Safety) Order 2005:

Premises: St Richards Hospital, Spitalfield Lane, Chichester, West Sussex, PO19 4SE

I am pleased to advise you that a reasonable standard of fire safety was evident in the areas that I saw when I visited your premises on Tuesday, 04 June 2019.

You should note that my visit was enough for me to decide that the premises are not a high risk. You have an on-going duty periodically to review your fire risk assessment and fire safety measures to avoid high risks.

You can find further advice and guidance on our website:
https://www.westsussex.gov.uk/fire-emergencies-and-crime/west-sussex-fire-rescue-service/business-fire-safety/

Further Recommendations

It would be a wise investment of your time to consider how a fire may affect your business continuity and plans for growth. There is a wealth of useful information and advice available free of charge from https://www.westsussex.gov.uk/business-and-consumers/ and
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/137994/Business_Continuity_Managment_Toolkit.pdf

Please see and complete the checklist here to help you assess how your business is prepared for an emergency

We value your feedback, to help us improve our service we request your comments here

Western Sussex Hospitals
NHS Foundation Trust

5% Reduction in energy usage

- Special “Energy Saving” events run at Worthing & St Richard’s
- Current Trust energy consumption data displayed and efficiency tips and tools from utility companies shared with staff
- All staff invited to contribute energy-saving suggestions
- Over 100 ideas submitted during the two half-day drop-in events
- 5 “winning ideas” selected and prizes awarded to staff
- Winning ideas now being researched and implemented

NHS
Western Sussex Hospitals
NHS Foundation Trust

1. Introduction of new waste disposal model utilising the latest compaction machinery
2. Programme of updating waste holds across all three sites
3. 80% of domestic waste is recycled at a Materials Recycling Facility
4. Proactive working approach with the Health and Safety Executive to ensure compliancy
5. Increase in WTE`s to ensure waste is collected in a timely manner with additional waste generated

Western Sussex Hospitals
NHS Foundation Trust

Team of the Year

Domestics
Patient First STAR
Awards 2019

NHS
Western Sussex Hospitals
NHS Foundation Trust

Chairman's Award

Patient First STAR Awards 2018

NHS
Western Sussex Hospitals
NHS Foundation Trust

Thank you

Western Sussex Hospitals
NHS Foundation Trust

Estates & Facilities

always going above & beyond

Western Sussex Hospitals
NHS Foundation Trust

2009 - 2019

Always improving

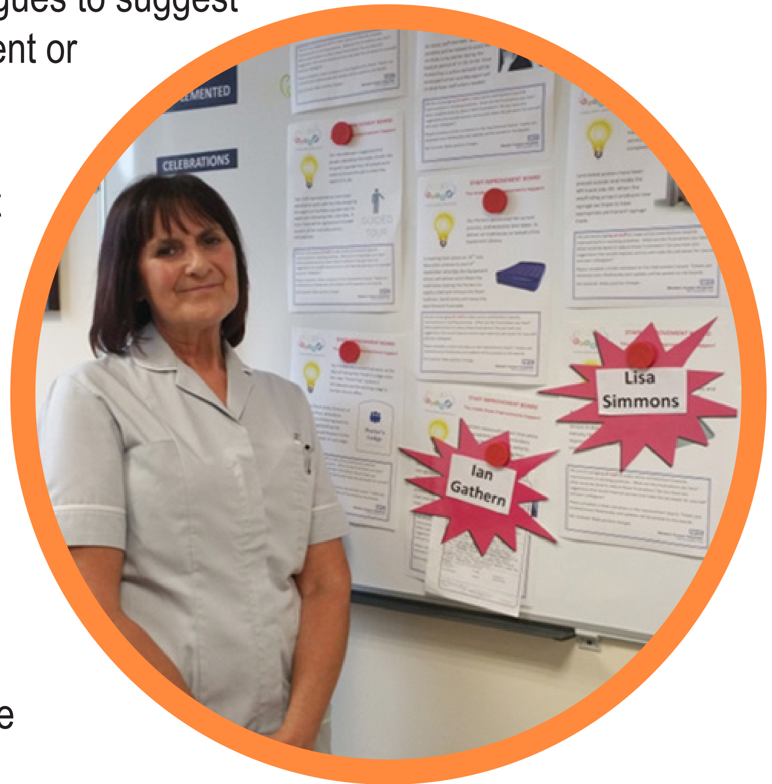
Staff improvement boards encourage colleagues to suggest improvements to service, hospital environment or sustainability.

More than 120 patient-focused improvement tickets have been posted by frontline staff and acted upon.

Staff are asked what fdrustrations they face and what could be done to ease them?

What ideas do they have to imrpove service for patients and to help colleagues at work?

Divisional "Change champions", like Lisa, are identified and awarded with prizes.



Think green!

More than 100 energy-saving ideas were received from frontline staff following two recent ideas events.

Suggestions are now being feeded into a Green Steering Group organised by Estates & Facilities.

Energy Saving Events

Over 100 energy-saving ideas submitted by front-
E&F staff who attende
two events

A tall story!

A cuddly toy giraffe was reunited with its owner thanks to a trust Facebook appeal and trust security guard Stev White 'sticking his neck out'!

During his inpatient stay, Mr Giraffe was pictured having a flu jab and visiting a number of different areas to look for his owner.

The social media appeal reached more than 62,000 people before it was 'spotted' by a very happy Kerys and her family.

This is far from the first time Steve has helped lookafter lost cuddly toys and gone to great lengths to reunite them with their lovced ones.

Building heroes

Estates & Facilities supports the Building for Heroes Charity, providing on the job training for former armed forces personnel.

There are currently more than 120,000 unemployed veterans of working age in Britain today, as well as a 230,000 person skills shortage within the construction industry.

Building heroes is a West Sussex based charity that provides military veterans with the skills to transition into a new career in construction.

The charity recently visited the accommodation block at St Richard's to complete some on the job training.

Some fantastic work was completed in two houses and a block of flats.

Doubling engagement

The division devised a special Supervisor Academy to boost staff engagement and improve strategic delivery.

The 14 training sessions developed in conjunction with supervisors include expert tuition and aseries of relevant workshops.

In the years since the Academy's introduction, staff engagement doubled from 3.68 to 7.78.

The division is now developing a manager Academy which will launch later this year.

Candidates said…

Academy content was relevant and useful

Managers said…

I would recommend the Supevisors Academy to other managers

Staff engagement score before the Academy launched (Jan '18) was 3.68. This increased to 7.78 after all 4 cohorts of the Supervisor's Academy had graduated

Staff survey reported 12% improvement in identifying training needs and 9% increase in managers supporting staff with training & development needs.

For charity mate

The Estates & Facilities teams support chosen charities with extra activities, such as fun runs, fire walking, Christmas jumpers,c ycling and marathons.

Eastes colleague Lee took part in a cycling event to raise money to develop a private space for bereaved parents on the delivery ward.

Alex from Portering and Dale from Car Parking (pictured below with Lee) are keen charity supporters.

Caring for each other

The Estates & Facilities staff care and engagement group was launched in 2018 to allow staff to discuss issues and suggestions in a new forum.

Key acheivements include “This is who we are boards” which introduce teams and their service to patients, visitors and staff as well as computer access points for non-office based staff.

The group also prompted the launch of a divisional newsletter, regular staff Q&A sessions and a popular staff discount booklet.

Newsletter

Western Su

r Estates & Facilities Staff

Directors Message

Colleagues I just want to say a big thank you for the amazing
day working in Facilities and Estates, I have been thanked by
the recent weeks for the extra mile you have all gone in prepa
CQC visits.

I have been thinking about what we have achieved together s
months and thought it would be good to remind us all what a

- High cleaning standards leading to low infection rates when compared to the national median
- Lower than the national average hard services costs but still delivering KPI'S and a safe comp Compliance to statute)
- Significant improvements to waste processes and associated costs
- Clean clutter free corridors
- Achieved 5 stars with Environmental Health Organisation for our catering facilities in Worth
- Implemented a new cross site and park & ride mini bus scheme
- Installation of an interim kitchen for patient catering in SRH
- Porters continue to receive positive feedback weekly for their contribution to our patients
- New COSHH processes and locking arrangements in all clinical areas
- A very strong pass in a recent Fire Safety inspection of SRH by the local Fire Brigade
- Successfully transferred housekeepers in to our catering department as new food service assis
- E&F is an integral part of the trust and key to a successful CQC inspection.
- Constantly deliver cost improvements

I am extremely proud to be a part of this team, please continue with the same momentum and I kno
th the outstanding service you all deliver for our patients at Western every day.

David Jones Farewell Message

years and 2 months it is time for me to bid you farewell, as I move to become Director of Fa
However, before I go I would like to thank you all for your hard work and support. The
going from strength to strength. We have reviewed most of the services, improved co
the Trust but most importantly we have been instrumental in improving the experie

cellence in service across the board and it has been a pleasure to be your di
e stewardship of David McLaughlin the division will continue to go from

Estates & Facilities

Divisional Leadership

Interim Director of Estates and Facilities
David McLaughlin

Interim Deputy Director of Estates and Facilities
Suzanne Fisher

What the division is proud of:

The Estates and Facilities Division provides quality support services to the Trust, supporting clinical needs and enhancing patient experience. Departments within the Division include Domestics, Portering, Patient Catering, Security, Waste, Accommodation, Telecoms, Laundry, Estates and Transport.

- Domestics – 90% in Patient-Led Assessments of the Care Environment (PLACE) and 95% Technical Audit Scores (both above the NHS Guidelines)
- Domestics – Working closely with clinical teams in the reduction of infection rates i.e. C.Diff/MRSA
- Domestics - Recruited in to all substantive positions and using no agency
- Catering – 5 Star Environmental Health Officer (EHO) rating
- Catering – Providing 346,000 quality inpatient meals per year
- Portering – Winner of Chairman's Award at the Patient First Star Awards 2018
- Green Travel – Reducing carbon emissions by nearly 60 tonnes per year
- Waste - More than 80% of Trust waste is recycled
- Laundry – 4 million items of linen laundered per annum
- Car Parking - Provided for more than 600,000 vehicles per year
- Telecoms - Ensuring 21,000 calls per month are connected
- Reception - Providing a friendly welcome to all Trust visitors at Main Receptions
- Supervisor Academy has helped more than 40 staff
- Security - Crime reduction campaigns and raised awareness
- Estates - continued improvements to the water infrastructure delivering sustained improvements
- Estates - 33,709 breakdown tasks completed 2018-2019
- Estates - Property Appraisal Six Facet Survey comprising Physical Condition, Functional
- Suitability, Space Utilisation, Quality of the Internal Environment, Statutory Requirements and asset register have been completed for all three sites
- Estates - Heating boilers have been upgraded at St Richard's to improve our business continuity and carbon reductions

Addressing our challenges:

- Staff engagement with our improvement huddles
- Improving accommodation facilities
- Improving the Trust's energy usage
- Promoting waste amnesties across the Trust
- Service reviews including Laundry services, Transport, Switchboard and Patient Catering
- Improving the Estates Reactive and Preventative Maintenance CAFM System
- Manager Academy – Helping to support staff and managers
- Reducing abusive behaviour
- Increased recycling targets to achieve zero to landfill by 2020

Agenda Item:	16.	Meeting:	Trust Board	Meeting Date:	November 2019
Report Title:	Flu Vaccination Campaign Update				
Sponsoring Executive Director:		Maggie Davies, Chief Nurse			
Author(s):		Jo Fanning, Assistant Director HR			
Report previously considered by and date:					

Purpose of the report:			
Information	☐	Assurance	✓
Review and Discussion	☐	Approval / Agreement	☐
Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	☐	Staff confidentiality	☐
Patient confidentiality	☐	Other exceptional circumstances	☐
Link to Trust Strategic Themes:			
Patient Care	✓	Sustainability	☐
Our People	✓	Quality	✓
Systems and Partnerships	☐		

Any implications for:	
Quality	Nothing to note
Financial	Nothing to note
Workforce	Nothing to note

Link to CQC Domains:			
Safe	✓	Effective	☐
Caring	✓	Responsive	☐
Well-led	✓	Use of Resources	☐

Communication and Consultation:

Communication Team actively involved in the flu Vaccination Campaign

Executive Summary:

The report provides the Trust Board with an update of the current Flu Vaccination campaign for 19/20 and an evaluation of the Flu Vaccination campaign for 18/19.

Key Recommendation(s):

The Committee is asked to note

To: Trust Board | Date: November 2019

From: Flu Steering Group | Agenda Item: 16

FOR INFORMATION

Seasonal Flu Vaccination Campaign 2019/20

1.0 Introduction

1.1 The Trust undertakes an annual staff flu vaccination programme and over the last 3 years this has been set against a national CQUIN target. The 2019 flu vaccination programme launched on 3rd October 2019 and will run until 28th February.

1.2 The Trust vaccinated 65.8% of frontline staff by the end of the vaccination campaign in February 2019. This was a 0.9% reduction on the final position for 2017/18 and was below the nationally mandated CQUIN vaccination target of 75%. The Trust vaccinated 63.7% of all staff, which was also a reduction of 0.9% on the previous year.

1.3 The target for 2019/20 has increased to 80% of frontline staff.

2.0 Reflections of Flu vaccination campaign 2018/19

2.1 A review of the 2018/19 campaign was undertaken and a paper presented to Quality Board identifying the learning and actions to be taken. The review included hosting a joint event with local NHS Trusts to share learning and best practice. The key points identified were:

1. Importance of workplace vaccinators, linking with identified areas
2. Need to improve the timing of training and provision of information to workplace vaccinators to ensure they were able to vaccinate as soon as the vaccine became available
3. Focus efforts on the first 8 weeks of the campaign to ensure as many staff as possible could be vaccinated early to ensure greatest benefit from vaccination but also to avoid campaign weariness
4. Ensure effective education as to the importance of receiving vaccine; recognising feedback that there are some cultural differences in approach to vaccination
5. Need to replicate model of dedicated workplace vaccinator for Facilities and Estates, including information sessions and support to communicate effectively to a range of nationalities
6. Medical staff uptake was identified as an area for improvement
7. Data quality was a significant challenge within 2018/19. No other Trusts had identified a suitable electronic solution that reduced the need for paper but one Trust felt that a strong link with the issuing of vaccines through Pharmacy had led to more accurate data

3.0 Flu Vaccination campaign 2019/20

3.1 The 2019/20 programme launched on the 3 October 2019 and took into consideration the learning from 2018/19. The good practice highlighted above from last year has been incorporated into the plan including:

1. Maintaining the high number of workplace vaccinators linked to dedicated cost centres
2. Replicating the effective dedicated input to Facilities and Estates
3. Clear communication strategy focusing on the importance of receiving the vaccine

3.2 The improvements for this year include:

1. A more robust training programme for workplace vaccinators with information packs provided at the point of training
2. Flu campaign focused for 10 weeks October to December 2019, with an 8 week incentive scheme offering a thank you of £25 voucher through a weekly prize draw
3. Chiefs of Service and Clinical Directors identifying appropriate meetings and events where vaccination can be offered to medical staff
4. Communications focused at medical staff e.g. Curious Clinician talk
5. Improvements to data capture process, with all forms collated through Pharmacy and timely input within the Trust

3.3 The Flu Vaccination campaign 2019/20 has been overseen by the Flu Group membership of which includes Chief Nurse, Divisional Flu leads, Pharmacy, Infection Control, Occupational Health, HR, Staffside Chair and CQUIN lead. The group meet weekly to review plans and escalate concerns. Weekly reports are provided on uptake levels so focused attention can be given on areas where uptake is low.

3.4 As part of the flu campaign planning the flu group undertook a self assessment against the NHS England NHS Improvement Healthcare worker flu vaccination best practice management checklist. The self assessment is included in Appendix 1.

4. Current Position

As of the 18 November the uptake levels by staff group are:

WSHFT Flu Vaccination Campaign (as at 18 November 2019)		
Staff type	**Vaccinated (No of staff)**	**Vaccinated (%)**
Doctors	356	42%
NHS infrastructure support	477	37%
Other qualified ST&T	153	64%
Qualified nursing, midwifery & health visiting staff (Qualified nurses)	1021	50%
Qualified ST&T/Qualified AHPs	279	48%
Support to doctors and nursing staff	822	48%
Support to STT staff	278	49%
Grand Total:	**3384**	**47%**

5.0 Monitoring and Reporting

5.1 The Flu Group will continue to provide regular reports on uptake both within the Trust and to Department of Health. A final report at the end of the campaign will be provided to Trust Board.

6.0 Recommendation

The Board is asked to:

a) **Note** this paper

Appendix 1 – Self – assessment

A	Committed Leadership	Compliance	Comments
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.		Full communication campaign sharing Trust commitment to offering the flu vaccine to all staff. Process in place for collection of 'declines' data
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers.		Stocks of quadrivalent (including egg free vaccine) ordered and arrived.
A3	Board receive an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt.		Board Paper to be presented November 2019.
A4	Agree on a board champion for flu campaign.		Chief Nurse
A5	All board members receive flu vaccination and publicise this		Completed and publicised in social media during launch.
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives.		Flu team formed with Divisional flu leads, HR, OH, CQUIN lead, Pharmacy, Infection Control, Communications and Staffside representative
A7	Flu team to meet regularly from August 2019		Flu Group Whatsapp set up and Flu Group meet weekly.
B	**Communications Plan**	**Compliance**	**Comments**
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions		Mythbusting used in all communications including social media, intranet and posters.
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper		Drop in clinics are electronically published and on posters. Details of workplace vaccinators also available electronically and on posters.
B3	Board and senior managers having their vaccinations to be publicised		Completed and publicised in social media, including photos
B4	Flu vaccination programme and access to vaccination on induction programmes		Flu vaccination programme promoted at induction
B5	Programme to be publicised on screensavers, posters and social media		Communication campaign includes posters and social media and front page of intranet
B6	Weekly feedback on % uptake for directorates, teams and professional groups		Weekly feedback provided on % uptake by Division, staff group and cost centre
C	**Flexible accessibility**	**Compliance**	**Notes**
C1	Peer Vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered.		168 workplace vaccinators in place, covering all clinical areas.
C2	Schedule for easy access drop in clinics agreed		Drop in clinics are electronically published and on posters. Details of workplace vaccinators also available electronically and on posters.
C3	Schedule for 24 hour mobile vaccinators to be agreed		Workplace vaccinators available across different shift patterns, late night and weekend clinics and walkabouts offered
D	**Incentives**	**Compliance**	**Notes**
D1	Board to agree on incentives and how to publicise		8 x £25 Amazon vouchers as a thank you for early uptake.
D2	Success to be celebrated weekly		Regular updates in Headlines and on social media.

Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	17	Meeting:	Trust Board	Meeting Date:	28 Nov 19
Report Title:	7 Day Services – Board Assurance Framework				
Sponsoring Executive Director:	George Findlay, Chief Medical Officer				
Author(s):	Tim Taylor, Medical Director				
Report previously considered by and date:					

Purpose of the report:			
Information	☐	Assurance	✓
Review and Discussion	☐	Approval / Agreement	✓
Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	☐	Staff confidentiality	☐
Patient confidentiality	☐	Other exceptional circumstances	☐
Link to Trust Strategic Themes:			
Patient Care	✓	Sustainability	☐
Our People	☐	Quality	✓
Systems and Partnerships	✓		

Any implications for:	
Quality	Implementation of the 4 priority 7 Day Services standards ensures consistent consultant assessment within 14 hours of admission, robust processes for daily or twice daily consultant reviews and ready access to diagnostics and interventions.
Financial	Strengthening consultant weekend cover for the Emergency Floor at Chichester to support the delivery of S2 and S8 will require additional resource.
Workforce	Future consultant job planning needs to support the delivery of S2 and S8

Link to CQC Domains:			
Safe	✓	Effective	✓
Caring	✓	Responsive	☐
Well-led	✓	Use of Resources	☐

Communication and Consultation:

The report is to be shared with NHSI&E before the 29th November 2019 once approved by the Trust Board

Executive Summary:

The Board Assurance Framework for 7 Day Services is an NHSI&E requirement and appraises progress against the 10 7DS standards with a focus on the priority standards 2,5,6&8. The Trust does not meet standard 2 (consultant review within 14h of admission) and standard 8 (once and twice daily consultant review) but does meet the 2 other priority standards. There has been deterioration in S8 that was met when assessed earlier this year. The BAF provides the outcomes for the validation of the use of the eWhiteboard as a valid measure for S2, a gap analysis and mitigation. Implementation of the 4 priority 7 Day standards is a corporate project.

Key Recommendation(s):

For noting and approval then sharing with NHSI&E

7 Day Hospital Services Self-Assessment

Organisation	**Western Sussex Hospitals NHS Foundation Trust**
Year	**2018/19**
Period	**Autumn/Winter**

NHS

Western Sussex Hospitals NHS Foundation Trust: 7 Day Hospital Services Self-Assessment Spring/Summer 2018/19

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	The 4 core 7DS standards now form a Trust Corporate Project with PMO support and monthly updates at the Trust Executuve Committee meetings. Realtime performance information is available using the whiteboard and is shared regularly with the clinical leaders in a 7DS dashboard. A comparative audit has been undertaken to verify the accuracy of the whiteboard as a data source for S2 compared with information collected directly from the clinical record. The records for 290 patients admitted as an emergency between April and September 2019 were reviewed and compared with the information from the whiteboard. The findings indicated that although there was a slight variation in the time to consultant review depending on which data source was used that this was not statistically significant. Overall performance for October as recorded on eWhiteboard and based on data from 2,562 emergency admissions is 63% for WSHT. Performance is stronger at Worthing (66.%) compared to Chichester (60%). Overall weekday performance is 65.6% and is stronger on the Worthing site (67%) compared to Chichester (63.5%). Overall weekend performance is 54.2% with significantly stronger performance at Worthing (61.5%) compared to Chichester (46.2%) The eWhiteboard data shows a modest improvement since the April audit showing a rise in overall performance in S2 from 60% to 63%. The improvement is attibutable to weekday performance. Weekend performance is static. Analysis of whiteboard data for the three months from August until the end of October shows that performance at Worthing shows little variation across the days of the week although is strongest on Mondays. At Chichester there is greater variation meeting S2 and the best performance is achieved on Tuesdays with the poorest performance at weekends. The corporate project is now well established with monthly steering group meetings. Developments include	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
		Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes mix of on site and off site by formal arrangement	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available on site	No the intervention is only available on or off site via informal arrangement	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	The Trust is working to formalise the agreements that are currently in place with BSUH for interventional radiology. The WSHT service has been under pressure due to consultant vacancies and recruitment is ongoing.	Emergency Renal Replacement Therapy	Yes available on site	Yes available on site	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes available on site	Yes available off site via formal arrangement	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	The September retrospective audit for S8 audited 459 patients over 7 Days including a weekend. Performance was compliant for weekdays with once daily (98%) and twice daily reviews (100%) across sites and for the individual sites. However neither site achieved the standard for once daily review at weekends. Worthing achieved 99% once daily reviews for weekdays dropping to 45% at weekends. Chichester achieved 97% for weekdays dropping to 50% at Weekends . S8 was fully achieved in the April audit which was undertaken as a live exercise and may have captured additional information. However it was very resource intensive and relied on a significantly smaller sample sizer. Identification of the patients acuity and the need for review is undertaken at handover and prior to ward rounds using the hospital whiteboard and e-handover tools and the Trust policy delineating the process for the level of review required is under development. Escalation of the deteriorating patient is achieved through PatientTrack and NEWS2 was implemented in mid 2018 and supported by a protocol. With regard to the resources available to deliver this standard, consultant job planning is described under S2 but in addition reviews for admitted patients outside the EF are undertaken on consultant's job planned post take ward rounds. At Worthing the DOME consultants are now job planned to provide additional predictible on-call at weekends to strengthen S2 & 8.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Standard 1 - Patient Experience: Patient Experience is seen as a strong Trust Priority and analysis shows no variation in Family and Friends feedback between weekdays and weekends. Work on consent processes in ongoing with action plans in place following a BDO and internal audit to ensure consistency and that patients with impaired capacity are managed appropriately. Standard 3 - MDT Review: Improving the proportion of discharges before mid day is a key part of the Systems and Partnerships workstream of patient first. This includes establishing a discharge date early in the admission, prompt MDT review incorporated into the once and twice daily Board Rounds (up to 3 times on the EF) on each ward. The Multi-Professional team meet to talk through each patients management plan and review the EDD. In addition there is full MDT meeting for more in depth reviews held once or twice a week. Standard 4 - Shift Handover - the allocate e-patient tool is used for regular handovers and a handover policy is in development. Standard 7 - Mental Health - this is an area of targetted work with increased presentations of MH patients to the ED's and significant delays for patients awaiting MH beds. A workshop was held with Sussex Partnership Trust and the commissioners in May 19 and an action plan agreed. A 5 bedded Cinical Assessment Unit opens in June 19 in Hove for MH patients in crisis with a maximum stay of <24h. The vacant joint liaison psychiatry & community post at Chichester will be appointed in July 19. Existing resourses consist of the site based teams available on each site 8-10 each day and cover from local Mental Health Hospital overnight. Plans to implement the Core 24/7 plan for liaison services are under discussion. Standard 9 - Transfer to community, primary and social care. The Trust has a improvement programme to support discharge and transfers with partners. We have escalation process that include daily discussions and in depth reviews of all MFFD and super stranded patients three times a week. There is a by weekly senior review of Top 20 Super Stranded patients across the Trust. Standard 10 - Quality Improvement: Patient First Improvement Programme has been rolled out across WSHFT with a focus on continuous improvement throughout the organisation. review of clinical outcomes is a core part of the clinical governance program and doctor's appriasal.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	No, the standard is not met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 8	No, the standard is not met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Thrombolysis is provided on both sites and services are currently rated as SSNAP B. However Worthing performance dipped from SSNAP A due to maintainence work on the CT scanner. An Action Plan is in place following GIRFT visit in Autumn 2018. A service development is also under consideration jointly with Coastal West Sussex CCG and other interested organisations. With regard to S 2&8. Agreement has been reached to strengthen consultant weekend staffing for stroke with sessions job planned for both sites at weekends commencing in June 19.

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

Agenda Item:	18	Meeting:	Trust Board	Meeting Date:	28th November 2019
Report Title:	Draft Trust Dementia Strategy 2019 - 2020				
Sponsoring Executive Director:			Maggie Davies – Chief Nurse		
Author(s):			Frances Usher-Smith, Dementia Matron		
Report previously considered by and date:			PEEG – 30th September 2019 Dementia Strategy Group – 17th October 2019 Quality Board – 21st October 2019 Trust Executive Committee – 24th October 2019 Nursing, Midwifery and Allied Health Professionals Board – 30th October 2019		

Purpose of the report:			
Information	✓	Assurance	☐
Review and Discussion	☐	Approval / Agreement	✓
Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	☐	Staff confidentiality	☐
Patient confidentiality	☐	Other exceptional circumstances	☐
Link to Trust Strategic Themes:			
Patient Care	✓	Sustainability	✓
Our People	✓	Quality	✓
Systems and Partnerships	✓		

Any implications for:	
Quality	Describes Dementia Strategy for the next 3 years
Financial	
Workforce	

Link to CQC Domains:			
Safe	✓	Effective	☐
Caring	✓	Responsive	☐
Well-led	✓	Use of Resources	☐

Communication and Consultation:

Executive Summary:

As an acute care provider, Western Sussex Hospitals NHS Foundation Trust (WSHFT) is committed to ensuring that our services are able to respond to the needs of our population and work collaboratively with our partners within the local health economy.

Please see attached Dementia Strategy 2019-2022 for approval.

Key Recommendation(s):

The Board is asked to **APPROVE** the 2019-2022 Dementia Strategy

Western Sussex Hospitals NHS
NHS Foundation Trust

WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST

DEMENTIA STRATEGY

2019 - 2022

The Environment

Objective	Measurement	Evidence of Achievement	Year of Achievement
To continue to work collaboratively with Estates and Facilities to follow the dementia friendly approach for any environmental changes and ensure continued compliance.	Continued support from Estates at Strategic Meetings and advice given regarding compliance factors to meet Estates standards whilst promoting a dementia friendly environment.	All new initiatives, refurbishments or replacement equipment is in line with the Trust Dementia Environmental Guidance.	2019 - 2020
To promote and continue to introduce new therapeutic activities for inpatients.	Introduction of new initiatives within the inpatient areas	Purchasing of equipment and documented records of inpatients undertaking therapeutic activities.	2019 - 2020
To promote and encourage the introduction of the new finger food menus across the hospitals.	Monitor for first 6 months after introduction to ascertain baseline level and then re - evaluate after a year.	Catering records of finger food usage across sites.	2019 - 2020
To have a completed Sensory Garden at both St Richards and Worthing Hospitals.	Monitor progress against Garden Working Group Action Plans.	Completed gardens on both sites.	2020 - 2021
To promote and encourage the use of communal dining tables.	Increase of 10% of patients eating at a table and availability of tables on wards.	Observation on wards at patients lunchtimes.	2021 - 2022
To improve the signage and way finding within the hospitals.	Implementation plan through the Trust Wayfinding Group.	Presence of new signage throughout both sites.	2021 - 2022

Dementia Friendly Hospital

Objective	Measurement	Evidence of Achievement	Year of Achievement
To continue with our pledge to the John's Campaign, Dementia Action Alliance Friendly Hospitals.	Use of Carers passports and promoting a dementia friendly environment, reflective within the carers survey.	Numbers of Carers passports used and all new initiatives, refurbishments or replacement equipment is in line with the Trust Dementia Environmental Guidance. Carers Survey results.	2019 - 2022
To promote and encourage the use of the Carers passports in line with the Carers policy reinforcing the benefits.	Use of Carers passports and Carers surveys.	Number of Carers passports used and feedback from Carers Survey in addition to Carers Support West Sussex,	2019 - 2020
To support the Trust deconditioning project by encouraging patients with a dementia to be dressed in their own clothes.	An increase in the number of patients dressed in their own clothes.	Observation on wards during rounds and peer reviews.	2019 - 2020
Encourage use of the activity boxes, digital reminiscence systems and any new meaningful activities.	Requests from wards for advice on activities and number of patients partaking in activity with volunteers and staff.	Observation on wards during rounds and peer reviews. Carers survey feedback. Volunteer feedback.	2020 - 2021
To promote the spiritual and social aspects of hospital life utilising volunteers and the chaplaincy teams.	Increase of numbers patients receiving visits by chaplaincy team.	Feedback from Lead Chaplain	2020 - 2021
Develop admission packs for patients with a dementia in all inpatient areas.	Monitor progress in the conception of this initiative.	Presence of admission packs available on wards.	2021 - 2022

Workforce And Education

Objective	Measurement	Evidence of Achievement	Year of Achievement
To develop the Trust Intranet site for Dementia.	Progress on the development of the site.	A Trust intranet site for Dementia that is fit for purpose.	2019 - 2020
Standardisation of the contents and delivery of the Tier 2 training on both sites.	Review of the Tier 2 training programme.	Programme for Tier 2 training identical across sites.	2019 - 2020
Development of further role specific and bespoke training.	An increase in the number of staff trained in dementia relative to their field.	Training records from L and D unit.	2019 - 2022
To further explore with the L and D team staff training regarding safety and de - escalation.	In collaboration with progress against the reducing abusive behaviours education workstream.	Availability of training and training records from L and D unit	2020 - 2021
Increase the number of Dementia Champions across the Trust and provide a more structured approach to the meetings.	Monitor attendance and numbers at the Dementia champions meetings.	Attendance records from meetings.	2020 - 2021
To work with the MCA and LD Leads to improve training for medical staff in the fields of MCA, Capacity and Consent.	An increase in the number of medical staff trained in this and capacity assessments present in notes.	Training attendance records and improved compliance with the documentation of capacity assessments in notes.	2021 - 2022
To explore the possible provision of Tier 3 training opportunities.	Monitor progress of possible options that could be considered.	Options appraisal produced for Tier 3 training.	2021 - 2022

Dementia Care Pathway

Objective	Measurement	Evidence of Achievement	Year of Achievement
To maintain strong collaboration with SPFT, OPMH, BSUH and SCT.	Continued close working relationships and joint working reflective at strategic meetings.	Meeting attendance records and minutes demonstrating sharing of best practice.	2019 - 2022
Continuation of strong links with Community Matrons for admission avoidance.	Monitoring of care home admissions and regular meetings with matrons.	Records of care home admissions and meetings with matrons.	2019 - 2022
Continue to monitor and further decrease the number of night moves by 25%.	Monthly monitoring and validation of night moves.	Monthly report of figures to the Trust Quality Report	2019 - 2022
To escalate early detection of concerns and support with appropriate placement of patients.	Attendance to family meetings and best interest meetings as required.	Documentation within patients notes.	2019 - 2022
Review the Trust Dementia nursing care plan.	Progress of development of a revised care plan.	Revised care plan ratified and in place across the Trust.	2020 - 2021
Review the Trust Delirium Protocol and explore role opportunities related to this.	Meeting progress with Clinical Lead for Delirium and progress of possible options that could be considered.	Reviewed protocol and options appraisal for new roles.	2020 - 2021
Promote the concept and educate staff, patients and carers in advanced care planning.	An increase in the awareness and knowledge of staff within the field of advanced care planning.	Documentation within patients notes.	2021 - 2022
Explore the feasibility of optical and hearing specialists to visit the wards.	Monitor progress of options that could be considered.	Options appraisal produced for these services.	2021 – 2022

Communication and Collaborative Working

Objective	Measurement	Evidence of Achievement	Year of Achievement
Revisit the content and relaunch a revised Carers Survey.	Progress against the development of a new survey.	Launch of new Carers Survey	2019 - 2020
Promote and reinvigorate the Knowing Me document.	An increase in the completion and meaningful use of the Knowing Me document.	Weekly audits of the presence and completion of the Knowing Me documents.	2019 - 2020
Promote and encourage the use of the Knowing Me magnets within the wards.	An increase in the use of the Knowing Me magnets.	Presence of magnets on patient information boards on the wards.	2019 - 2020
To involve patients, family and carers in supportive discharge planning.	Attendance to family meetings and best interest meetings as required.	Documentation in notes and reduction in failed discharge rates.	2020 - 2021
To further develop links and opportunities for shared learning with Learning Disabilities and Safeguarding teams.	Attendance at strategy meetings and progress against LD and Safeguarding strategies in alignment with Dementia.	Minutes of strategic meetings and progress against action logs.	2020 - 2021
Develop a pre – operative dementia document and pre – emptive post – operative delirium plan.	Progress against the development of the documents.	Production of the plans available	2021 - 2022
To maintain strong collaboration with SPFT, OPMH, BSUH and SCT.	Continued close working relationships and joint working reflective at strategic meetings.	Meeting attendance records and minutes demonstrating sharing of best practice.	2019 - 2022

Dementia Performance

Objective	**Measurement**	**Evidence of Achievement**	**Year of Achievement**
To introduce CQUIN assessment training onto the junior doctors induction programme.	Allocation of a session on the induction programme.	Training attendance records from CMEC and WHEC.	2019 - 2020
Maintenance of above 90% screening rates for all inpatients aged 75 and over.	Weekly monitoring of levels using systems information services.	Monthly report of figures to the Trust Quality Report.	2019 - 2022
Continue to monitor and further decrease the number of night moves by 25%.	Monthly monitoring and validation of night moves.	Monthly report of figures to the Trust Quality Report	2019 - 2022
Continue to reduce the length of stay particularly those longer than 21 days.	Monitoring of inpatient length of stay using systems information services.	Monthly length of stay figures reported to Trust Executive Committee.	2020 - 2021
To explore the need for a Delirium CNS role or alternative options and if required aim to introduce in 2020.	Monitor progress of options that could be considered.	Options appraisal produced for possible requirements.	2020 - 2021
To continue to monitor and reduce both complaints and clinical incidents involving patients with a dementia.	Monthly monitoring of levels by Complaints and Patient safety teams.	Complaints and Clinical Incident reports to Triangulation Committee.	2019 - 2022

SUMMARY OF PRIORITIES

- Improved patient and carers experience of care – Dementia Friendly Hospital
- Improved environment for inpatients - Environment
- Reduction in formal and informal complaints – Dementia Friendly Hospital / Workforce and Education
- Earlier involvement with family in discharge planning – Communication and Collaborative Working
- Reduction of 25% in night ward moves for patients with a dementia – Dementia care pathway / Dementia Friendly Hospital
- Increased dementia training figures by 10% each year for WSHFT staff – Workforce and Education / Performance
- Increased conflict resolution and de - escalation training figures by 10% each year and awareness - Workforce and Education / Dementia Friendly Hospital

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DEMENTIA STRATEGY 2019 - 2022

Frances Usher-Smith July 2019

Version 3 November 2019 FUS

Western Sussex Hospitals NHS
NHS Foundation Trust

CONTENTS

1. Introduction
2. The Environment
3. Dementia Friendly Hospital
4. Workforce and Education
5. Dementia Care Pathway
6. Communication and Collaborative Working
7. Dementia Performance
8. Summary of Priorities
9. Appendices of the 6 Workstream 3 year Priority Plans

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INTRODUCTION

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Dementia is a global phenomenon and is recognised as one of the most important health and social care challenges of our generation.

The demographics of our local population consist of a high number of elderly frail people, many of whom have a diagnosis of dementia. Figures from the Alzheimer's Society 2019, estimate that in West Sussex there are between 15 – 17, 000 people with a dementia diagnosis and 5,000 more without a diagnosis. With current growth, this figure is set to increase by 26% in 2021. Over the past 3 years we have seen a significant increase in those people being admitted to our acute hospitals. Between April 2018 and March 2019 we cared for 3956 people with a dementia in our 2 acute inpatient hospitals. This was an increase of over 1,000 inpatients in comparison to the previous year. Worthing is recorded as the town having the second highest population of elderly frail people in England.

As an acute care provider, Western Sussex Hospitals NHS Foundation Trust (WSHFT) is committed to ensuring that our services are able to respond to the needs of our population and work collaboratively with our partners within the local health economy.

We recognise the need for a comprehensive WSHFT Dementia Strategy that is reflective of those needs and incorporates our organisational values of Patient First.

Within this we support the ethos and principles of person centred care reflective of the John's Campaign and Dementia Action Alliances intentions.

The previous WSHFT Dementia Strategy was introduced in 2014 over a 5 year period and provided a structure to improving patient care for those people with a dementia and their carers. This new strategy will span a 3 year period of 2019 – 2022 and continue to provide a framework for improvements in care monitored by the Trust Dementia Strategy Group and reporting to the Trust Quality Board.

Following a series of focus groups, user involvement, together with over 100 patients, carers and staff feedback from the 2018 National Dementia Audit; the 2019 Strategy will consist of work streams to further enhance the patient experience that persons with a dementia will have whilst in our care. In addition to the information obtained through the National Dementia Audit 2018, the Strategy will also be reflective of the most recent National Institute of Clinical Excellance (NICE) Guidance 2018. The Dementia Strategy will support the WSHT Quality Strategy 2019 – 2021 which was informed by widespread public engagement via a set of webpages and survey monkey. It will also closely relate to all aspects of the Patient Experience Strategy. The Strategy will continue to include close collaborative working across all Divisions in the Trust and also strengthen our working with our external partnership organisations.

In February 2015 The Department of Health (DoH) published the Prime Minister's Challenge on Dementia 2020, which sets out what the government wants to see in place by 2020 in order for England to be;

- The best country in the world for dementia care and support and for people with dementia their carers and families to live.
- The best place in the world to undertake research into dementia and other neurodegenerative disease.

The Well Pathway for Dementia is a transformational framework developed by NHS England and referenced in the Prime Minister's Challenge on Dementia 2020: Implementation Plan (2016).

The Well Pathway identifies five key stages of care through which service development should focus

- Preventing well
- Diagnosing well
- Supporting well
- Living well
- Dying well

Our vision is that patients within our Trust will receive first class care within the field of dementia supporting these five key stages of care. The first three stages we will support in collaboration with our Primary Care partner organisation. The last two stages will be undertaken by us with close liaison with our Palliative Care specialist services.

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The work streams identified within the 2019 – 2022 WSHFT Dementia Strategy focus on the following:

- The Environment
- Dementia Friendly Hospital
- Workforce and Education
- Dementia Care Pathway
- Communication and Collaborative Working
- Performance

THE ENVIRONMENT

Through the last Strategic plan, the Environmental Guidance was written and approved for a standardised dementia friendly approach for any future refurbishments based upon the Kings Fund recommendations. Across the Trust 4 wards have now been refurbished. The Estates and Facilities Division work collaboratively with the Dementia Team in ensuring that full compliance in all environmental changes are adhered to. There has been the installation of 4 rest stops with images on each inpatient site supporting the dementia friendly hospitals charter and making for a more pleasant environment. There has also been the implementation of the Garden Working groups to commence the sensory garden project for each inpatient site.

The areas identified for the 2019 - 2022 Strategic plan are:

- To continue to work collaboratively with Estates, Facilities and Capital to follow the dementia friendly approach for any environmental changes and ensure continued compliance.
- To have a completed sensory garden at both St. Richards and Worthing Hospitals.
- To improve the signage and way finding within the hospitals.

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- To promote and encourage the introduction of the new finger food menus across the hospitals.
- To promote and encourage the use of communal dining tables.
- To promote and continue to introduce new therapeutic activities for inpatients.

DEMENTIA FRIENDLY HOSPITAL

Achievements have been made since 2014 with our hospitals becoming Dementia Friendly Hospitals. We have signed up to the Dementia Friendly Hospitals Charter as part of the Dementia Action Alliance, have made a pledge to support the John's Campaign and now have a WSHFT Carer's Policy embedded in practice. There are replenished activity boxes on all wards and Digital Reminiscence Systems available on both sites for interactive engagement with patients. The Trust internet information for people with a dementia and their carers has also been updated.

The areas identified for the 2019 – 2022 Strategic Plan are:

- To continue with our pledge to the Dementia Action Alliance and John's Campaign.
- To promote and encourage the use of the Carers Passport reinforcing the benefits.
- To develop admission packs for patients with a dementia in all inpatient areas.
- To support the Trust deconditioning project by encouraging patients with a dementia to be dressed in their own clothes.
- To promote the social and spiritual aspects of hospital life utilising volunteers and the chaplaincy teams.
- Encourage use of the activity boxes, Digital Reminiscence Systems and any new meaningful activities.

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WORKFORCE AND EDUCATION

Training and Education was a strong part of the previous Strategy with many new initiatives introduced as a consequence of that. The Tier 1 training on both sites is now delivered to all staff on and updated an annual basis. The Tier 2 training is delivered as a 2 day course on both sites 4 times a year. Role specific training to porters, security, housekeepers and estates staff has commenced. There are now Dementia Champions across the Trust and Knowing Me volunteers trained to specifically volunteer with patients with a dementia.

The areas identified for the 2019 - 2022 Strategic plan are:

- To standardise the contents and delivery of the Tier 2 training on both sites.
- To develop further role specific and bespoke training
- To increase the number of Dementia Champions and provide a more structured approach to the meetings.
- To work with the Mental Capacity Act (MCA) and Learning Disability (LD) Leads to improve training for medical staff in the fields of MCA, Capacity and Consent
- To further explore with the Learning and Develoment team staff training regarding safety and de-escalation.
- To explore the possible provision for tier 3 training.
- To develop the intranet for staff education.

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DEMENTIA CARE PATHWAY

Progress against the Dementia Care Pathway has been demonstrated over the past 5 years with new initiatives introduced during this timeframe. The incidence of patients with a dementia being moved at night has decreased; falls and pressure injury rates have reduced; delirium protocols have been introduced; multi - disciplinary and best interest meetings are embedded in practice and carers have

open visiting rights as in the Trust Carers Policy. The dementia team also introduced a project to work collaboratively with the Community Matrons in monitoring admissions from care home to identify trends and learning needs.

The areas identified for the 2019 -2022 Strategic plan are:

- To maintain strong collaboration with Sussex Partnership Foundation Trust (SPFT), Older Persons Mental Health Liaison Teams (OPMH) and Sussex Community Trust (SCT).
- To continue the strong links with community Matrons liaising with the admission avoidance team.
- Continue to monitor and further decrease the amount of night moves.
- Review the Trust Dementia nursing care plan.
- Promote the concept and educate staff, patients and carers in advanced care planning.
- To escalate early detection of concerns and support with appropriate placement of patients.
- Explore feasibility of optical and hearing specialists to visit the wards.
- Revisit the Trust Delirium Protocol and explore role opportunities related to this.

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COMMUNICATION AND COLLABORATIVE WORKING

Effective communication to enable the delivery of person centred care to our patients has been a vital part of the Strategy and will continue to be so. Since 2014, the Trust has introduced the Knowing Me document and undertaken weekly audits of compliance in the use of this. Knowing Me magnets are used on the wards and both the Sema system and Patient Trac have a dementia flag for easy identification of patients. The written information for patients, carers and staff has been reviewed and updated regularly. The Dementia team have worked closely with SPFT, SCT and Brighton and Sussex University Hospitals Trust (BSUH), to enable the sharing of best practice ideas and ways of working.

The areas identified for the 2019 - 2022 Strategic plan are:

- To revisit the content and relaunch the carers' questionnaire.
- To promote and reinvigorate the Knowing Me document.
- To promote and encourage the use of the Knowing Me magnets.
- To involve patients and family in discharge planning, supporting carers in doing so.
- To further develop links and opportunities for shared learning with Learning Disabilities and Safeguarding teams.
- To develop a pre-operative dementia document and pre-emptive post - operative delirium plan.
- To maintain collaborative working with neighbouring Trusts.

DEMENTIA PERFORMANCE

The Dementia Strategic Plan for performance was originally based upon the national CQUIN scheme requirements with targets set for the Trust. These included: screening 90% of emergency admissions aged 75 and over for signs of a dementia and communicating this with GP's; reducing the number of ward and night moves and reducing the length of stay. The CQUIN incentives were discontinued in 2016 however, the Trust has continued to report on these key performance indicators to maintain standards. We have also fully participated in the 2016 and 2018 National Audit of Dementia and undertaken a gap analysis against the 2016 and 2018 NICE Guidance reflecting a 96% compliance level.

The areas identified for the 2019 - 2022 Strategic plan are:

- To introduce CQUIN assessment training onto the junior doctors induction.
- To maintain above 90% screening for all inpatients aged 75 and over.
- To continue to monitor and reduce the number of ward and night moves.
- To continue to reduce length of stay particularly those longer than 21 days
- To explore the need for a Delirium Clinical Nurse Specialist role and if required aim to introduce in 2020.

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- To continue to monitor and reduce both complaints and clinical incidents involving patients with a dementia.

SUMMARY OF PRIORITIES

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The indicators of success will be identified through a combination of both quantative and qualitative methodology. They will all relate to the Prime Minister's Challenge, John's Campaign and Patient First together with supporting both the Trust Patient Experience Strategy and Quality Strategy. The sources of these will be via the WSHFT Quality Dashboard, Learning and Development Records, National Audits and Patient, Carer and Staff feedback. Linked to the work streams these will include:

- Improved patient and carers experience of care – Dementia Friendly Hospital
- Improved environment for inpatients - Environment
- Reduction in formal and informal complaints – Dementia Friendly Hospital / Workforce and Education
- Earlier involvement with family in discharge planning – Communication and Collaborative Working
- Reduction of 25% in night ward moves for patients with a dementia – Dementia care pathway / Dementia Friendly Hospital
- Increased dementia training figures by 10% each year for WSHFT staff – Workforce and Education / Performance
- Increased conflict resolution and de - escalation training figures by 10% each year and awareness - Workforce and Education / Dementia Friendly Hospital

Western Sussex Hospitals NHS
NHS Foundation Trust

APPENDIX 1

The Environment

Objective	Measurement	Evidence of Achievement	Year of Achievement
To continue to work collaboratively with Estates and Facilities to follow the dementia friendly approach for any environmental changes and ensure continued compliance.	Continued support from Estates at Strategic Meetings and advice given regarding compliance factors to meet Estates standards whilst promoting a dementia friendly environment.	All new initiatives, refurbishments or replacement equipment is in line with the Trust Dementia Environmental Guidance.	2019 - 2020
To promote and continue to introduce new therapeutic activities for inpatients.	Introduction of new initiatives within the inpatient areas	Purchasing of equipment and documented records of inpatients undertaking therapeutic activities.	2019 - 2020
To promote and encourage the introduction of the new finger food menus across the hospitals.	Monitor for first 6 months after introduction to ascertain baseline level and then re - evaluate after a year.	Catering records of finger food usage across sites.	2019 - 2020
To have a completed Sensory Garden at both St Richards and Worthing Hospitals.	Monitor progress against Garden Working Group Action Plans.	Completed gardens on both sites.	2020 - 2021
To promote and encourage the use of communal dining tables.	Increase of 10% of patients eating at a table and availability of tables on wards.	Observation on wards at patients lunchtimes.	2021 - 2022
To improve the signage and way finding within the hospitals.	Implementation plan through the Trust Wayfinding Group.	Presence of new signage throughout both sites.	2021 - 2022

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Western Sussex Hospitals NHS
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APPENDIX 2

Dementia Friendly Hospital

Objective	Measurement	Evidence of Achievement	Year of Achievement
To continue with our pledge to the John's Campaign, Dementia Action Alliance Friendly Hospitals.	Use of Carers passports and promoting a dementia friendly environment, reflective within the carers survey.	Numbers of Carers passports used and all new initiatives, refurbishments or replacement equipment is in line with the Trust Dementia Environmental Guidance. Carers Survey results.	2019 - 2022
To promote and encourage the use of the Carers passports in line with the Carers policy reinforcing the benefits.	Use of Carers passports and Carers surveys.	Number of Carers passports used and feedback from Carers Survey in addition to Carers Support West Sussex,	2019 - 2020
To support the Trust deconditioning project by encouraging patients with a dementia to be dressed in their own clothes.	An increase in the number of patients dressed in their own clothes.	Observation on wards during rounds and peer reviews.	2019 - 2020
Encourage use of the activity boxes, digital reminiscence systems and any new meaningful activities.	Requests from wards for advice on activities and number of patients partaking in activity with volunteers and staff.	Observation on wards during rounds and peer reviews. Carers survey feedback. Volunteer feedback.	2020 - 2021
To promote the spiritual and social aspects of hospital life utilising volunteers and the chaplaincy teams.	Increase of numbers patients receiving visits by chaplaincy team.	Feedback from Lead Chaplain	2020 - 2021
Develop admission packs for patients with a dementia in all inpatient areas.	Monitor progress in the conception of this initiative.	Presence of admission packs available on wards.	2021 - 2022

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APPENDIX 3

Workforce And Education

Objective	Measurement	Evidence of Achievement	Year of Achievement
To develop the Trust Intranet site for Dementia.	Progress on the development of the site.	A Trust intranet site for Dementia that is fit for purpose.	2019 - 2020
Standardisation of the contents and delivery of the Tier 2 training on both sites.	Review of the Tier 2 training programme.	Programme for Tier 2 training identical across sites.	2019 - 2020
Development of further role specific and bespoke training.	An increase in the number of staff trained in dementia relative to their field.	Training records from L and D unit.	2019 - 2022
To further explore with the L and D team staff training regarding safety and de - escalation.	In collaboration with progress against the reducing abusive behaviours education workstream.	Availability of training and training records from L and D unit	2020 - 2021
Increase the number of Dementia Champions across the Trust and provide a more structured approach to the meetings.	Monitor attendance and numbers at the Dementia champions meetings.	Attendance records from meetings.	2020 - 2021
To work with the MCA and LD Leads to improve training for medical staff in the fields of MCA, Capacity and Consent.	An increase in the number of medical staff trained in this and capacity assessments present in notes.	Training attendance records and improved compliance with the documentation of capacity assessments in notes.	2021 - 2022
To explore the possible provision of Tier 3 training opportunities.	Monitor progress of possible options that could be considered.	Options appraisal produced for Tier 3 training.	2021 - 2022

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APPENDIX 4

Dementia Care Pathway

Objective	Measurement	Evidence of Achievement	Year of Achievement
To maintain strong collaboration with SPFT, OPMH, BSUH and SCT.	Continued close working relationships and joint working reflective at strategic meetings.	Meeting attendance records and minutes demonstrating sharing of best practice.	2019 - 2022
Continuation of strong links with Community Matrons for admission avoidance.	Monitoring of care home admissions and regular meetings with matrons.	Records of care home admissions and meetings with matrons.	2019 - 2022
Continue to monitor and further decrease the number of night moves by 25%.	Monthly monitoring and validation of night moves.	Monthly report of figures to the Trust Quality Report	2019 - 2022
To escalate early detection of concerns and support with appropriate placement of patients.	Attendance to family meetings and best interest meetings as required.	Documentation within patients notes.	2019 - 2022
Review the Trust Dementia nursing care plan.	Progress of development of a revised care plan.	Revised care plan ratified and in place across the Trust.	2020 - 2021
Review the Trust Delirium Protocol and explore role opportunities related to this.	Meeting progress with Clinical Lead for Delirium and progress of possible options that could be considered.	Reviewed protocol and options appraisal for new roles.	2020 - 2021
Promote the concept and educate staff, patients and carers in advanced care planning.	An increase in the awareness and knowledge of staff within the field of advanced care planning.	Documentation within patients notes.	2021 - 2022
Explore the feasibility of optical and hearing specialists to visit the wards.	Monitor progress of options that could be considered.	Options appraisal produced for these services.	2021 – 2022

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APPENDIX 5

Communication and Collaborative Working

Objective	Measurement	Evidence of Achievement	Year of Achievement
Revisit the content and relaunch a revised Carers Survey.	Progress against the development of a new survey.	Launch of new Carers Survey	2019 - 2020
Promote and reinvigorate the Knowing Me document.	An increase in the completion and meaningful use of the Knowing Me document.	Weekly audits of the presence and completion of the Knowing Me documents.	2019 - 2020
Promote and encourage the use of the Knowing Me magnets within the wards.	An increase in the use of the Knowing Me magnets.	Presence of magnets on patient information boards on the wards.	2019 - 2020
To involve patients, family and carers in supportive discharge planning.	Attendance to family meetings and best interest meetings as required.	Documentation in notes and reduction in failed discharge rates.	2020 - 2021
To further develop links and opportunities for shared learning with Learning Disabilities and Safeguarding teams.	Attendance at strategy meetings and progress against LD and Safeguarding strategies in alignment with Dementia.	Minutes of strategic meetings and progress against action logs.	2020 - 2021
Develop a pre – operative dementia document and pre – emptive post – operative delirium plan.	Progress against the development of the documents.	Production of the plans available	2021 - 2022
To maintain strong collaboration with SPFT, OPMH, BSUH and SCT.	Continued close working relationships and joint working reflective at strategic meetings.	Meeting attendance records and minutes demonstrating sharing of best practice.	2019 - 2022

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APPENDIX 6

Dementia Performance

Objective	Measurement	Evidence of Achievement	Year of Achievement
To introduce CQUIN assessment training onto the junior doctors induction programme.	Allocation of a session on the induction programme.	Training attendance records from CMEC and WHEC.	2019 - 2020
Maintenance of above 90% screening rates for all inpatients aged 75 and over.	Weekly monitoring of levels using systems information services.	Monthly report of figures to the Trust Quality Report.	2019 - 2022
Continue to monitor and further decrease the number of night moves by 25%.	Monthly monitoring and validation of night moves.	Monthly report of figures to the Trust Quality Report	2019 - 2022
Continue to reduce the length of stay particularly those longer than 21 days.	Monitoring of inpatient length of stay using systems information services.	Monthly length of stay figures reported to Trust Executive Committee.	2020 - 2021
To explore the need for a Delirium CNS role or alternative options and if required aim to introduce in 2020.	Monitor progress of options that could be considered.	Options appraisal produced for possible requirements.	2020 - 2021
To continue to monitor and reduce both complaints and clinical incidents involving patients with a dementia.	Monthly monitoring of levels by Complaints and Patient safety teams.	Complaints and Clinical Incident reports to Triangulation Committee.	2019 - 2022

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Agenda Item:	19	Meeting:	Board	Meeting Date:	28 Nov 2019
Report Title:	**Company Secretary Report**				
Sponsoring Executive Director:			Glen Palethorpe, Group Company Secretary		
Author(s):			Glen Palethorpe, Group Company Secretary		
Report previously considered by and date:			Health and Safety Committee regarding the Health and Safety Annual report		

Purpose of the report:			
Information	☐	Assurance	✓
Review and Discussion	✓	Approval / Agreement	✓
Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	☐	Staff confidentiality	☐
Patient confidentiality	☐	Other exceptional circumstances	☐
Link to Trust Strategic Themes:			
Patient Care	✓	Sustainability	✓
Our People	✓	Quality	✓
Systems and Partnerships	✓		
Any implications for:			
Quality			
Financial			
Workforce			
Link to CQC Domains:			
Safe	✓	Effective	✓
Caring	✓	Responsive	✓
Well-led	✓	Use of Resources	✓
Communication and Consultation:			

Executive Summary:

This report provides the Board with a update on matters for which the Trust has complied with a NHS I or other regularly requirements. This report does not seek to duplicate matters that are subject to separate agenda items at today's board meeting.

Learning from Deaths report Q2 – Appendix 1

The Trust is required to receive reports on learning from deaths. The Board is reminded that the detail of this report is scrutinised by the Quality Assurance Committee especially in respect of the Trust's processes for learning from the review of deaths. The focus for learning is to improve the Trust's processes. The outcome of this learning manifests itself in the Trust's mortality indices; these are tracked within the routine report to the Board as part of the Integrated Performance Report.

Constitution review – Appendix 2

It is good practice to review the Trust's constitution periodically the last review was in August 2018.

Principle Changes

- The alignment of approval levels for significant matters within the Constitution;
- Allowing governors to serve for 3 terms of 3 years which would match the length of office NEDs can hold;
- Clarifying within the constitution what does happen in that each Board member must meet the

requirements of the CQC fit and proper persons requirement, whilst many of these requirements were listed this addition allows for when the CQC make any changes the achievement of these requirements becomes an automatic qualifying requirement for continuation on the Board
- Codifying within the constitution the use of co-opted governors where it has not been possible to fill the position by election

There were also a small number of typographical and presentational changes, including the opportunity to consolidate various supporting documents that have been generated including the Governor Role Description, Lead Governor Role Description and the Code of Conduct into this one document. The supporting documents have not been subject to review for a few years and by consolidating these into the constitution they will be both subject to regular review to maintain their alignment with the main constitution and also be more accessible to new governors.

Key Recommendation(s):

The Board is recommended to

NOTE the Trust's learning from deaths report and note the learning identified from the structured judgement review process.

To **APPROVE** the changes to the Constitution and recommend this to the Council of Governors for their approval

Western Sussex Hospitals NHS Foundation Trust

Agenda Item:	19	Meeting:	Trust Board	Meeting Date:	28/11/2019
Report Title:	Learning from Deaths				
Sponsoring Executive Director:			George Finlay Chief Medical Officer		
Author(s):			Tim Taylor Medical Director, Simon Higgs Clinical Effectiveness		
Report previously considered by and date:					

Purpose of the report:			
Information	☐	Assurance	✓
Review and Discussion	✓	Approval / Agreement	☐
Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	☐	Staff confidentiality	☐
Patient confidentiality	☐	Other exceptional circumstances	☐
Link to Trust Strategic Themes:			
Patient Care	✓	Sustainability	☐
Our People	☐	Quality	✓
Systems and Partnerships	☐		

Any implications for:	
Quality	Learning and quality improvement from the review of deaths
Financial	Nil
Workforce	Training requirements and time for individuals to undertake and respond to learning

Link to CQC Domains:			
Safe	✓	Effective	✓
Caring	✓	Responsive	✓
Well-led	✓	Use of Resources	☐

Communication and Consultation:

A plan for communication is being developed

Executive Summary:

The purpose of the briefing is to update the Board of progress in the implementation of the structured approach for reviewing the deaths of patients to provide assurance on care and identify areas where it could have been improved

Key Recommendation(s):

The Board is asked to: Receive and **NOTE** the implementation of the 'Learning from Deaths' policy and the learning identified from structured mortality reviews.

1. Screening of Deaths

1.1 The Trust currently screens deaths at consultant level using a set of prompts designed to cover areas where problems in care may occur and this is a route for referral for in depth Structured Judgement Review.

1.2 In Quarter 1 72 % of deaths were screened through this process at the time of this report.

1.3 In addition deaths occurring in categories as defined in the ‘Learning from Deaths Policy’ are automatically identified for SJR

1.4 It is recognised that the current process for screening has limitations and can lead to delays in identifying cases for full review. The Trust aspires to move toward a daily review process. A pilot of a new Daily Mortality Review Panel process was held at the end of Q2 (WASH) and beginning Q3 (SRH) which was very successful. See Appendix 1

2. Outcomes from Structured Judgement Reviews (LD refers to patients with learning difficulties)

Table 1 – Q4 Updated: At the time of the Q4 report a number of cases were still undergoing investigation. Table 1 provides an update which includes the outcome of these cases*.

	Total Deaths (not LD)	Total Deaths Reviewed (not LD)	Avoidable Deaths (not LD)	LD Deaths	LD Deaths Reviewed internally	LD Deaths Completed Reviews by LeDeR process	Avoidable LD Deaths*	Total % of deaths reviewed
Jan 2019	210	14	0	2	2	0	0	6.6%
Feb 19	161	28	2*	0	0	0	0	17.4%
March 19	191	20	1	2	2	0	0	10.5%
Total (Q4 18/19)	562	64	3	4	4	0	0	9.7%

Table 2

	Total Deaths (not LD)	Total Deaths Reviewed (not LD)	Avoidable Deaths* (not LD)	LD Deaths	LD Deaths Reviewed internally	LD Deaths Completed Reviews by LeDeR process	Avoidable LD Deaths*	Total % of deaths reviewed
April 19	167	33	2*	2	2	2	0	20.9%
May 19	186	26	1	0	0	0	0	13.9%
June 19	167	24	0	0	0	0	0	14.4%
Total (Q1 19/20)	520	83	3	2	2	2	0	16.3%

*Death more likely than not due to problems in the care of the patients

At the time of writing this report, there has been one death identified in the SJR process in Q1 that were considered more likely than not due to problems in the care of the patient. *It should be noted that four cases continue to be under investigation by the Division. It should also be noted that at the time of publication of this report there are 3 cases from Q1 that have had 2 reviews, which are awaiting mortality panel. Q1 will therefore be updated in the Q2 report 2019-20

2.1 The Department of Health provides a dashboard for Trusts to use to publish data on the number of deaths that have been reviewed in their organisations. See Table 1. All deaths, bar 1, occurring in Quarter 1 referred for SJR have been reviewed.

2.2 The table above shows the Q1 19/20 data for WSHFT. LD refers to deaths in patients with learning disabilities. Note that 'LD deaths reviewed' refers to the external LeDeR process. All LD deaths have been reviewed both internally and by LeDeR.

2.3 The SJRs review 6 discreet areas of care. Table 2 shows the level of care that the patients have been recorded as receiving across the reviews of deaths in Quarter 1.

2.4 The SJRs also categorises problems into broad themes where issues identified. Table 3 shows these for deaths in Quarter 1, from first reviews.

Table 3: Data labels show the number of responses for the criteria

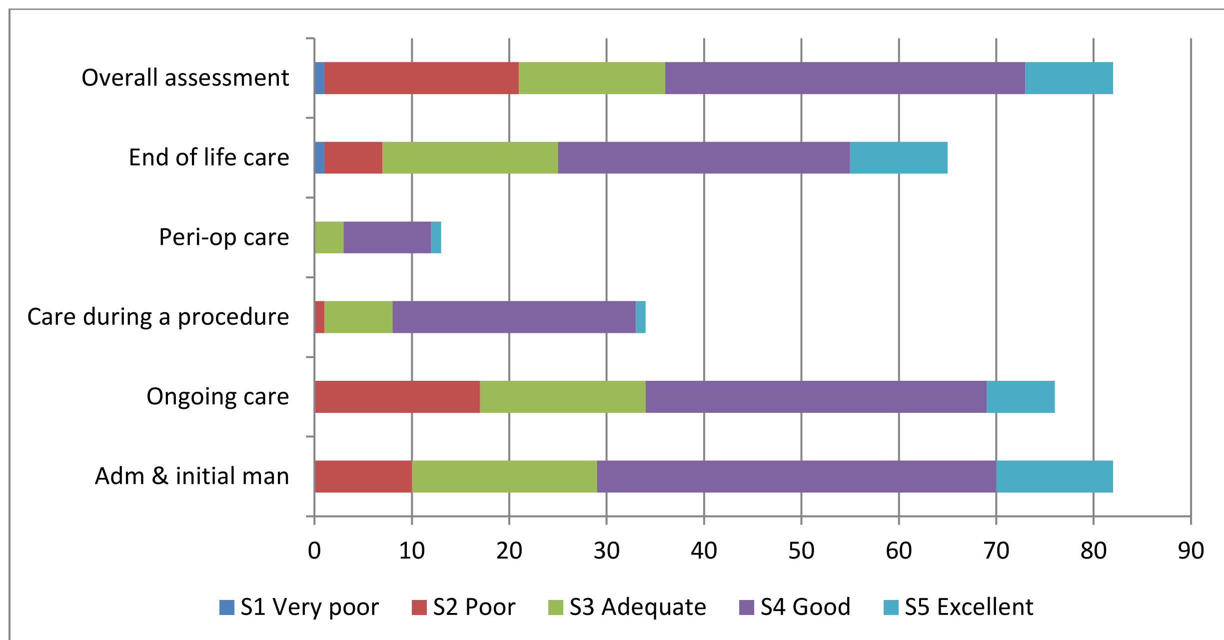
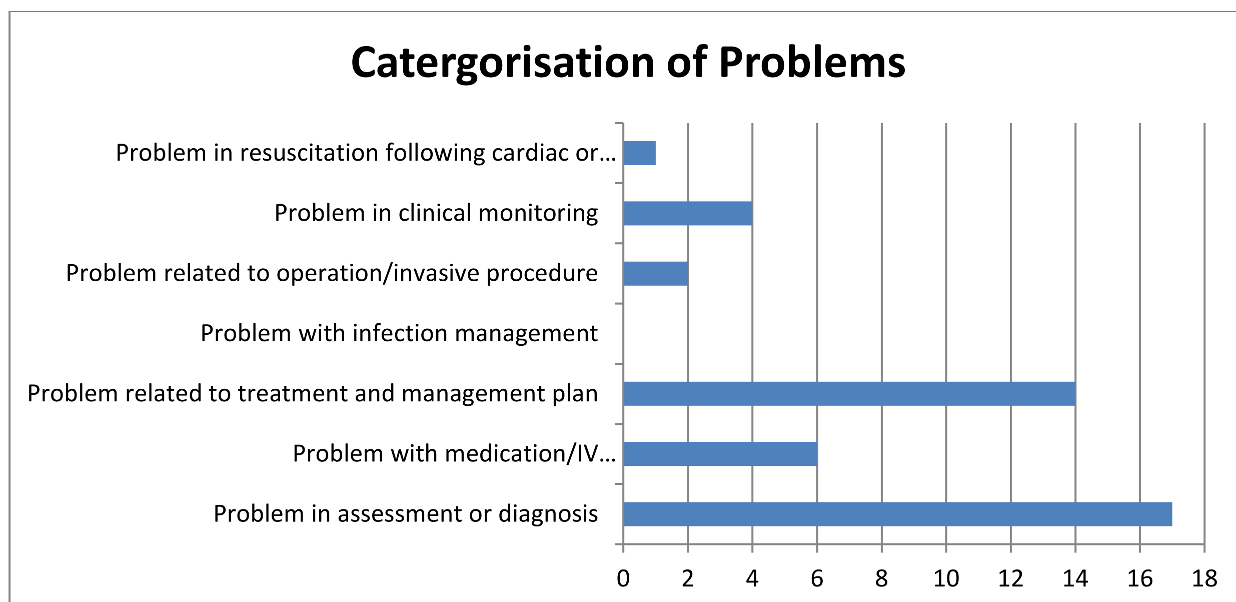


Table 4: Data labels show the number of responses for the criteria from all first reviews



Structured Judgement Reviews Q1 - Learning

Overall Care Score	Learning Themes	Actions
Excellent Care	Several examples of very well documented decision making and support given to patient and family by medical and palliative care team when patient on EOLC.	Feedback to relevant clinical teams. Use as examples in training and to triangulation committee
Good Care	Examples of very good multidisciplinary working and communication regards end of life discussion with patient and family. Good examples of multi-agency working around meeting the needs of patients with learning disabilities at the end of life. Examples of prompt assessment and escalation in acutely ill patients.	Feedback to relevant clinical teams
Adequate Care	Examples of late recognition of end of life with unclear ceilings of treatment.(E.g multiple MET calls for patients on EOLC pathway). Examples of DNACPR information not being readily available.	Use to inform work programme of the deteriorating patient group and EOLC board.
Poor Care	Examples of late recognition and escalation in the deteriorating patient with vulnerability of staffing at the weekend being a factor Inadequate management of fluid balance. Lack of senior input/clear treatment plan. Unclear communications surrounding ceilings of treatment	Use to inform work programme of the deteriorating patient group Feedback to clinical teams. Raise issue through triangulation/ learning forums Feed back to individual clinicians Use to inform work programme of the deteriorating patient group and EOLC board, with particular reference to the implementation of the RESPECT tool.
Very Poor Care	Inadequate initial assessment and clerking, in two cases. Lack of recognition and escalation	Feedback to individual clinicians

	of deterioration.	Use to inform work programme of the deteriorating patient group and EOLC board.

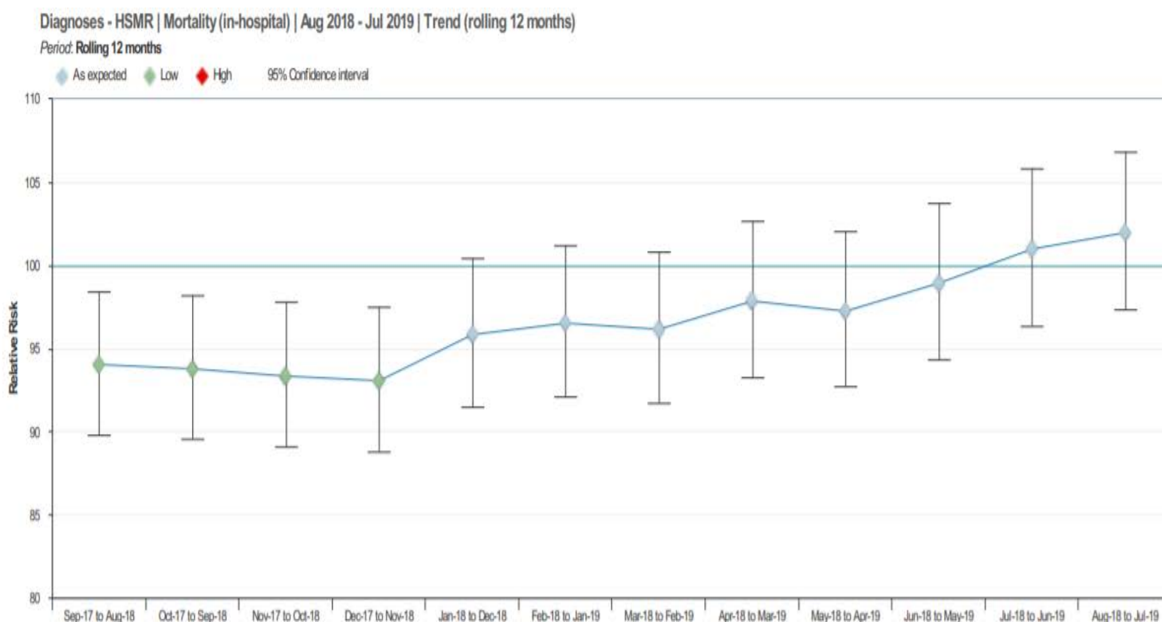
3. Capacity and Risk

3.1 For reviews of deaths occurring in Q1 capacity has remained an issue as a slightly revised way of working is established and new reviewers gain experience.

3.2 Missing/partially scanned and chronologically misfiled patient records on Evolve have become more frequent and affect the ability to undertake reviews. This is being escalated on a case by case basis.

4. Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR)

4.1 For the 12 months to July 2019 performance using HSMR is 102 (with 100 being the expected). There have been no mortality outliers reported for WSHFT from the CQC or the Dr Foster Unit at Imperial College. Work understanding and responding to the recent rise in HSMR has been taking place as part of the Trust reducing preventable mortality True North objective.



5. Progress and Next Steps

5.1 A change in the current screening process to a 'daily' review process has been successfully piloted on both sites, end of Quarter 2, beginning of Quarter 3 2019 with view to rolling out across the organisation. The evaluation of this will be considered by QAC in its next meeting.

5.2 Despite a rising HSMR the review process has not raised any additional associated concerns and the number of reviews identifying poor or very poor care remains low.

5.3 A business case has been submitted to establish the medical examiner and medical examiner officer role by the end of March 2020. The aim will be to integrate these roles into the daily review process.

5.4 A detailed project plan covering the implementation of daily review, implementation of the medical examiner and medical examiner officer roles, reducing the SJR backlog and strengthening the learning and feedback process will be agreed at the Trust Quality Board and included in the Q2 report.

5.5 Learning from review activity continues to be presented in a number of internal and external forums, with a health economy wide event organised by WSHFT planned for December 2019

5.6 Improvements in the LeDeR process should be noted. All deaths of patients with learning difficulties in Q1 were reviewed both by the Trust and through the independent LeDeR reviews

6. Recommendation

6.1 The Board is asked to receive and note this report and the learning identified from the structured judgement review process.

Simon Higgs – Head of Clinical Effectiveness

Mary Evans – Learning from Deaths Manager

Agenda Item:	19	Meeting:	Board	Meeting Date:	28 Nov 19
	APPENDIX 2 Constitution Review				
Sponsoring Director:			Glen Palethorpe, Group Company Secretary		
Author(s):			Glen Palethorpe, Group Company Secretary		
Report previously considered by and date:					
Purpose of the report:					
Information			☐	Assurance	☐
Review and Discussion			✓	Approval / Agreement	✓
Report:					

Background

It is good practice to review the Trust's constitution periodically the last review was in August 2018.

Annual review

This review has taken the opportunity to consolidate various supporting documents that have been generated including the Governor Role Description, Lead Governor Role Description and the Code of Conduct into this one document. The supporting documents have not been subject to review for a few years and by consolidating these into the constitution they will be both subject to regular review to maintain their alignment with the main constitution and also be more accessible to new governors.

Principle Changes

Within the Constitution the approval levels required for significant matters have been aligned to be consistent throughout. This has been set at two thirds of all Governors for such matters as; significant transactions, the removal of the Chair, NEDs or a Governor and changes to the Constitution itself. Other matters it is clear these will be by simple majority of those present, subject to the Council meeting its stated quoracy requirements.

Para 14.1 ad 14.3 to allow governors to serve for 3 terms of 3 years which would match the length of office NEDs can hold.

Para 23, wording has been added to clarify that the composition of the Board to be complaint with it being a non executive led board will have with the chair more voting non executives and voting executives.

Para 25 has been adjusted to be clear that you can not be a disqualified and be a NED regardless of your being a Trust member.

Para 31 wording has been added that the Board member must meet the requirements of the CQC fit and proper persons requirement, many of these requirements are then listed but this addition allows for when the CQC make any changes the achievement of these requirements becomes an automatic qualifying requirement for continuation on the Board

Annex 1 – 3 have been placed into one annex, this consolidates the separate constituency details into one page

Annex 6 (now annex 4) – 2.4 aligned the time to flag potential discrepancies to 7 days in line with the code of conduct requirements

Annex 6 (now annex 4) – 3.11 to remove the waiting period for re-standing as a governor for those retiring as there may be personal reasons a governor needs to stand down that may then change and the person would wish to stand again but would be ineligible for three years to do so within the current constitution. The gap remains in place for those whose office is terminated by the Council, to prevent them from re-standing in the election their removal creates.

Annex 6 (now annex 4) – 4.14.3 the removal of the automatic termination of a governor for failing to attend two successive council meetings without reasonable known cause. Failure to fulfil the role of Governor is dealt with under the code of conduct.

Annex 6 (now annex 4) – 3.20 the addition of wording allowing the co-opting of non voting members to fill vacancies following an unsuccessful appoint through an election. Also the wording has been removed to truncate the period of office of those appointed mid term as the Council would seek to not have all governors up for election at the same time.

Annex 7 (now annex 5) 1.17 and 1.18 removed the requirement to use the postal service but instead seeking to have as the default process the use of electronic means and makes it clear the distribution of papers is days rather than working days as the Trust seeks to provide the latest available information which may be more recent than 5 working days before any meeting. Also added that the CoG agenda is subject to agreement by lead governor (this is practically delivered through the pre-cog meetings)

Annex 8 (now annex 6) 3.16 and 3.17 removed the requirement to use the postal service but instead seeking to have as the default process the use of electronic means and makes it clear the distribution of papers is days rather than working days as the Trust seeks to provide the latest available information which may be more recent than 5 working days before any meeting.

Annex 8 (now annex 6) 3.18 the quoracy for Board has been adjusted to require at least 2 NEDs and 2 Execs to be part of the 6 members required to be quorate. This provides for a stronger balance to be maintained for each meeting.

Annex 9 (now annex 7) part C is not required as it duplicates matters within the main constitution

The addition of the Governor and Lead Governor Role Descriptions and Code of Conduct as appendices to the main constitution (annex 8 and 9).

Code of Conduct has been tidied up to be consistent with other changes to the constitution.

Recommendation

To **APPROVE** the changes to the Constitution and recommend this to the Council of Governors for their approval

NHS Foundation Trust

Western Sussex Hospitals NHS Foundation Trust

NHS Foundation Trust

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Annex 3 – The Model Election Rules

Annex 4 – Additional Provisions – Board of Governors

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Annex 8 – Role Descriptions for Governor and Lead Governor

Annex 9 – Governor Code of Conduct

1. Interpretation and definitions

Unless otherwise stated, 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 & Social Care Act 2012.

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

The 2006 Act is the National Health Service Act 2006.

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

Annual Members Meeting is defined in paragraph 13 of the constitution

Constitution means this constitution and all annexes to it.

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

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.

2. Name

The name of the Foundation Trust is Western Sussex Hospitals NHS Foundation Trust (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 fulfill 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 better to carry on its principal purpose.

4. Powers

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

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

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

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 and

5.3 a patients' 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 individuals who live in an area specified as an area for any public constituency are referred to collectively as the Public Constituency.

7.3 The minimum number of members in each area for the 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 12 months; or

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

8.2 Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

8.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.4 The Staff Constituency shall be divided into six descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 1 and being referred to as a class within the Staff Constituency.

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 1.

Automatic membership by default – staff

8.6 An individual who is:

8.6.1 eligible to become a member of the Staff Constituency, and

8.6.2 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. Patients' Constituency

9.1 An individual who has, within the period specified below, attended any of the Trust's hospitals as either a patient or as the carer of a patient may become a member of the Trust.

9.2 The period referred to above shall be the period from 1 January 2008.

9.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Patients' Constituency.

9.4 An individual providing care in pursuance of a contract (including a contract of employment) with a voluntary organisation, or as a volunteer for a voluntary organisation, does not come within the category of those who qualify for membership of the Patient Constituency.

9.5 The minimum number of members in the Patients' Constituency is specified in Annex 1.

10. Restriction on membership

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

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

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

10.4 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 7 – Further Provisions.

11. Annual Members' Meeting

11.1 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.

12. Council of Governors – composition

12.1 The Trust is to have a Council of Governors, which shall comprise both elected and appointed governors.

12.2 The composition of the Council of Governors is specified in Annex 2.

12.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are areas or classes within a constituency, by their area or class within that constituency. The number of governors to be elected by each constituency, or, where appropriate, by each area or class of each constituency, is specified in Annex 2.

13. Council of Governors – election of governors

13.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules.

13.2 The Model Election Rules as published from time to time by the Department of Health form part of this constitution. The Model Election Rules current at the date of the Trust's Authorisation are attached at Annex 3.

13.3 A subsequent variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of this constitution for the purposes of paragraph 41 of the constitution (amendment of the constitution).

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

14. Council of Governors - tenure

14.1 Subject to the provisions of Annex 4, an elected governor may hold office for a period of up to 3 years and at the end of his term he shall be eligible for re-election for two further terms of up to 3 years.

14.2 An elected governor shall cease to hold office if he ceases to be a member of the constituency, area or class by which he was elected.

14.3 An appointed governor may hold office for a period of up to 3 years and at the end of his term he shall be eligible for re-appointment for two further terms of up to 3 years.

14.4 An appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him.

15. Council of Governors – disqualification and removal

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

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

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

15.2.2 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;

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

15.3 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 4.

15.4 Provisions as to the removal of Governors are set out Annex 4 and Annex 8 in respect of the Code of Conduct of Governors.

16. Council of Governors – duties of governors

16.1 The general duties of the Council of Governors are –

16.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors; and
16.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public.

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

See also Annex 9 for role descriptions

17. Council of Governors – meetings of governors

17.1 The Chairman of the Trust (i.e. the Chairman of the Board of Directors, appointed in accordance with the provisions of paragraph 26.1 or paragraph 27.1 below) or, in his absence, the Deputy Chairman (appointed in accordance with the provisions of paragraph 24 below), shall preside at meetings of the Board of Governors.

17.2 Meetings of the Council of Governors shall be open to members of the public unless the Council of Governors decides otherwise in relation to all or part of any particular meeting. Members of the public shall be excluded from meetings of the Council of Governors only where the business under discussion is commercially sensitive or is otherwise considered to be confidential.

17.3 For the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

18. Council of Governors – standing orders

The standing orders for the practice and procedure of the Council of Governors are attached at Annex 5.

19. Council of Governors – referral to the Panel

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

19.1.1 to act in accordance with its constitution; or
19.1.2 to act in accordance with provisions made by or under Chapter 5 of the 2006 Act

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

20. Council of Governors - conflicts of interest of governors

If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

21. Council of Governors – travel expenses

The Trust may pay travelling and other expenses to members of the Council of Governors at rates, and in accordance with a policy, determined by the Trust.

22. Council of Governors – further provisions

Further provisions with respect to the Council of Governors are set out in Annex 4.

23. Board of Directors – composition

23.1 The Trust is to have a Board of Directors, which shall comprise both executive and non-executive directors. The composition will be that there will always be with the Chair more Voting Non Executives than Voting Executives.

23.2 The Board of Directors is to comprise:

23.2.1 a non-executive Chairman

23.2.2 upto 6 other non-executive directors; and

23.2.3 upto 6 executive directors.

23.3 One of the executive directors shall be the Chief Executive.

23.4 The Chief Executive shall be the Accounting Officer.

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

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

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

24. Board of Directors – general duty

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

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

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

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

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

26.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the chairman of the Trust and the other non-executive directors.

26.2 Removal of the chairman or another non-executive director shall require the approval of two thirds of the voting membership of the Council of Governors.

26.3 The initial chairman and the initial non-executive directors are to be appointed in accordance with paragraph 27 below.

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

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

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

27.3 The criteria for qualification for appointment as a non-executive director set out in paragraph 25 above (other than disqualification by virtue of paragraph 31 below) do not apply to the appointment of the initial chairman and the initial other non-executive directors in accordance with the procedures set out in this paragraph.

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

28. Board of Directors – appointment of deputy chairman and senior independent director

28.1 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the non-executive directors as a deputy chairman.

28.2 The Board shall, following consultation with the Council of Governors, appoint one of the independent non-executive directors as a Senior Independent Director to act in accordance with Monitor's Code of Governance and the Board's Standing Orders.

28.3 The offices of Deputy Chairman and Senior Independent Director may be held by the same Non-executive Director.

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

29.1 The non-executive directors shall appoint or remove the Chief Executive.

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

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

29.4 A committee consisting of the Chairman, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors.

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

30.1 The non-executive directors shall appoint the chief officer of the applicant NHS Trust as the initial Chief Executive of the Trust, if he wishes to be appointed.

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

31. Board of Directors – disqualification

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

31.1 A person who fails to meet the requirements of the CQC fit and proper person regulations

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

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

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

32. Board of Directors – meetings

32.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

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

33. Board of Directors – standing orders

33.1 The standing orders for the practice and procedure of the Board of Directors are attached at Annex 6

33.2 The Board of Directors may adopt such procedures and protocols as it shall deem to be appropriate for the good governance of the Trust from time to time.

34. Board of Directors - conflicts of interest of directors

34.1 The duties that a director of the Trust has by virtue of being a director include in particular –

34.1.1 A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

34.1.2 A duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

34.2 The duty referred to in sub-paragraph 34.1.1 is not infringed if –

34.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

34.2.2 The matter has been authorised in accordance with the constitution.

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

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

34.4.1 The Trust, or

34.4.2 A person acting on its behalf

34.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors

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

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

34.8 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

34.9 A director need not declare an interest –

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

34.9.2 If, or to the extent that, the directors are already aware of it:

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

34.9.3.1 by a meeting of the Board of Directors, or

34.9.3.2 by a committee of the directors appointed for the purpose under the constitution.

34.10 A matter shall be authorised for the purposes of paragraph 34.2.2:

34.10.1 the Board of Directors by majority disapplies the provision of the constitution which would otherwise prevent a director from being counted as participating in the decision-making process;

34.10.2 the director's interest cannot reasonably be regarded as likely to give rise to a conflict of interest; or

34.10.3 the director's conflict of interest arises from a permitted cause (as determined by the Board of Directors from time to time).

35. Board of Directors – remuneration and terms of office

35.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other non-executive directors.

35.2 The Trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

36. Registers

The Trust shall have:

36.1 a register of members showing, in respect of each member, the constituency to which he belongs and, where there are areas or classes within it, the area or class to which he belongs;

36.2 a register of members of the Council of Governors;

36.3 a register of interests of governors;

36.4 a register of directors; and

36.5 a register of interests of the directors.

37. Admission to and removal from the registers

37.1 Further provisions as to the registers are set out within Annex 7.

38. Registers – inspection and copies

38.1 The Trust shall make the registers specified in paragraph 36 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

38.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of –

38.2.1 any member of the Patients' Constituency; or

38.2.2 any other member of the Trust, if he so requests

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

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

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

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

39. Documents available for public inspection

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

39.1.1 a copy of the current constitution;

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

39.1.3 a copy of the latest annual report.

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

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

39.4 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:

39.4.1 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.

39.4.2 a copy of any report laid under section 65D (appointment of Trust special administrator) of the 2006 Act.

39.4.3 a copy of any information published under section 65D (appointment of Trust special administrator) of the 2006 Act.

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

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

39.4.6 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.

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

39.4.8 a copy of any final report published under section 65I (administrator's final report).

39.4.9 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.

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

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

39.6 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.

40. Auditor

40.1 The Trust shall have an auditor.

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

41. Audit committee

41.1 The Trust shall establish a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate. The membership and terms of reference of the Audit Committee shall be subject to approval by the Board of Directors.

42. Accounts

42.1 The Trust must keep proper accounts and proper records in relation to the accounts.

42.2 Monitor may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

42.3 The accounts are to be audited by the Trust's auditor.

42.4 The Trust shall prepare in respect of each financial year annual accounts in such form as Monitor may with the approval of the of the Secretary of State direct.

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

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

43.1 The Trust shall prepare an Annual Report and send it to Monitor.

43.2 The Trust shall give information as to its forward planning in respect of each financial year to Monitor.

43.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

43.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

43.5 Each forward plan must include information about –

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

43.5.2 the income it expects to receive from doing so.

43.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 43.5.1 the Council of Governors must –

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

43.6.2 notify the directors of the Trust of its determination.

43.7 A Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of 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.

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

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

44.1 the annual accounts

44.2 any report of the auditor on them

44.3 the annual report.

44.2 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.

44.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 44.1 with the Annual Members' Meeting.

45. Instruments

45.1 The Trust shall have a seal.

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

46. Amendment of the constitution

46.1 The Trust may make amendments of its constitution only if –

46.1.1 Two thirds of the voting membership of the Council of Governors approve the amendments, and

46.1.2 Two thirds of the voting membership of the Board of Directors approve the amendments.

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

46.3 Where an amendment is made to the constitution in relation to the powers and duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust) –

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

46.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

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

47. Mergers etc. and significant transactions

47.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of two thirds of the voting membership of the Council of Governors.

47.2 The Trust may enter into a significant transaction only if Two thirds of the voting membership of the Council of Governors approve entering into the transaction.

47.3 In this paragraph, the following words have the following meanings:

47.3.1 "Significant transaction" means a transaction which meets any one of the tests below:

the fixed asset test; or

the turnover test;

47.4 The turnover test is met if, following the completion of the relevant transaction, the gross income of the Trust will increase or decrease by more than 25%.

47.5 The fixed asset is met if the assets which are the subject of the transaction exceeds 25% of the fixed assets of the Trust.

47.6 A transaction:

47.6.1 includes all agreements (including amendments to agreements) entered into by the Trust

47.6.2 excludes a transaction in the ordinary course of business including the renewal, extension or entering into an agreement in respect of healthcare services carried out by the Trust;

47.6.3 excludes any agreement or changes to healthcare services carried out by the Trust following a reconfiguration of

services led by the commissioners of such services;

47.6.4 excludes any grant of public dividend capital or the entering into of a working capital facility or other loan, which does not involve the acquisition or disposal of any fixed asset of the Trust.

48. Indemnity

48.1 Members of the Board of Directors and Council of Governors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust.

48.2 The Trust may purchase and maintain for members of the Board of Directors and Council of Governors insurance in respect of directors' and officers' liability, including, without limitation, liability arising by reason of the Trust acting as a corporate Trustee of an NHS charity.

ANNEX 1 – CONSTITUENCY DETAILS

THE PUBLIC CONSTITUENCY

(Paragraphs 7.1 and 7.3)

The areas specified for public constituency are the five local authority areas described in the table below, which also sets out the minimum numbers required in each area.

Area	Minimum Number of Members per Area
Adur	90
Arun	220
Chichester	160
Horsham	65
Worthing	150

THE STAFF CONSTITUENCY

(Paragraphs 8.4 and 8.5)

Class	Minimum Number of Members per Class
Medical and Dental (registered practitioners)	100
Nursing & Midwifery	100
Additional Clinical Services	100
Scientific, Technical and Professional (including Allied Health Professionals)	100
Estates and Ancillary	100
Administrative and Clerical	100

THE PATIENTS' CONSTITUENCY

(Paragraphs 8.4 and 8.6)

The minimum number of members in the patients' constituency is 75.

ANNEX 2 – COMPOSITION OF COUNCIL OF GOVERNORS

Elected Governors

Constituency	Area/Class	Number
Public	Adur	2
Public	Arun	5
Public	Chichester	3
Public	Horsham	1
Public	Worthing	3
Patients	None	1
Staff	Medical and Dental (registered practitioners)	1
Staff	Nursing & Midwifery	1
Staff	Scientific, Technical and Professional (including Allied Health Professionals)	1
Staff	Additional Clinical Services	1
Staff	Estates and Ancillary	1
Staff	Administrative and Clerical	1
Total Number of Elected Governors		**21**

Appointed Governors

Type	Governor Appointed By:	Number
Local Authority	Arun District Council Chichester District Council Worthing Borough Council West Sussex County Council	1 1 1 1
Partnership*	Brighton & Sussex Medical School	1
Partnership*	University of Brighton	1
Partnership*	Partnership* A governor shall be appointed, by agreement amongst all the following organisations, from time to time for a 3-year appointment (Subject to Section 13.3 and 13.4 of the constitution). In the absence of agreement amongst the organisations, the appointment shall be by rotation in the order listed below. A governor appointed by these organisations may hold office for a period of up to 3 years and at the end of his/her term s/he shall be eligible for re-appointment for one further term of up to 3 years only – maximum of 6 years The Friends of Chichester Hospitals The Friends of Worthing Hospitals The League of Friends of Southlands Hospital	1
Total Number of Appointed Governors		**7**
Total Number of Governors		**28**

**Note:* *For the purposes of the Trust Constitution a Partnership organisation is a body as detailed in Schedule 7 of the National Health Service Act 2006 (as amended from time to time).*

Annex 3 - Model Election Rules
Western Sussex Hospitals NHS Foundation Trust

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1. Interpretation

Part 2 – Timetable for election

2. Timetable
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4. Returning officer
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10. Candidate's particulars
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45. Sealing up of documents relating to the poll
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50. Countermand or abandonment of poll on death of candidate

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Expenses

51. Election expenses
52. Expenses and payments by candidates
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54. Publicity about election by the corporation
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Part 11 – Questioning elections and irregularities

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Part 12 – Miscellaneous

58. Secrecy
59. Prohibition of disclosure of vote
60. Disqualification
61. Delay in postal service through industrial action or unforeseen event

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Part 1 - Interpretation

1. Interpretation

(1) In these rules, unless the context otherwise requires -

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

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

"the regulator" means the Independent Regulator for NHS foundation Trusts; and

"the 2006 Act" means the NHS Act 2006

(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 election

2. Timetable

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

Proceeding	**Time**
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination papers to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than 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

(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.

(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

(1) Subject to rule 64, the returning officer for an election is to be appointed by the corporation.

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

5. Staff

Subject to rule 64, 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

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

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

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

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

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

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

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

(e) the address for return of nomination papers and the date and time by which they must be received by the returning officer,

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

(g) the contact details of the returning officer, and

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

9. Nomination of candidates

(1) Each candidate must nominate themselves on a single nomination paper.

(2) The returning officer-

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

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

but it is not necessary for a nomination to be on a form supplied by the returning officer.

10. Candidate's particulars

(1) The nomination paper must state the candidate's -

(a) full name,

(b) contact address in full, and

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

(d) a statement in support of the application upto 250 words

11. Declaration of interests

The nomination paper must state –

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

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

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

12. Declaration of eligibility

The nomination paper must include a declaration made by the candidate–

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

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

13. Signature of candidate

The nomination paper must be signed and dated by the candidate, indicating that –

(a) they wish to stand as a candidate,

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

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

14. Decisions as to the validity of nomination

(1) Where a nomination paper is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer-

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

(b) decides that the nomination paper is invalid,

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

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

(2) The returning officer is entitled to decide that a nomination paper is invalid only on one of the following grounds -

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

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

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

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

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

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

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

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

15. Publication of statement of nominated candidates

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

(2) The statement must show –

(a) the name, contact address, and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing, as given in their nomination paper.

(3) The statement must list the candidates standing for election in alphabetical order by surname.

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

16. Inspection of statement of nominated candidates and nomination papers

(1) The corporation is to make the statements of the candidates and the nomination papers supplied by the returning officer under rule 15(4) available for inspection by members of the public free of charge at all reasonable times.

(2) If a person requests a copy or extract of the statements of candidates or their nomination papers, the corporation is to provide that person with the copy or extract free of charge.

17. Withdrawal of candidates

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

(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.

(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.

(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

(1) The votes at the poll must be given by secret ballot.

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

(3) The corporation may decide that voters within a constituency or class with 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.

(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.

(5) Before the corporation decides, in accordance with rule 19.3 that an e-voting method 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;

20. The ballot paper

(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.

(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 vote 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.

(3) Each ballot paper must have a unique identifier.

(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)

(1) In respect of an election for a public or patient constituency a declaration of identity must be issued with each ballot paper.

(2) The declaration of identity is to include a declaration –

(a) that the voter is the person to whom the ballot paper was addressed,
(b) that the voter has not marked or returned any other voting paper in the election, and
(c) for a member of the public or patient constituency, of the particulars of that member's qualification to vote as a member of the constituency or class within a constituency for which the election is being held.

(3) The declaration of identity is to include space for –

(a) the name of the voter,

(b) the address of the voter,

(c) the voter's signature, and

(d) the date that the declaration was made by the voter.

(4) The voter must be required to return the declaration of identity together with the ballot paper.

(5) The declaration of identity must caution the voter that, if it is not returned with the ballot paper, or if it is returned without being correctly completed, the voter's ballot paper may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

(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.

(2) The list is to include, for each member:

(a) a mailing 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

(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

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

(g) the address for return of the ballot papers, and the date and time of the close of the poll,

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

(i) the address and final dates for applications for replacement ballot papers, and

(j) the address for return of the ballot papers, and the date and time of the close of the poll, and

(k) the contact details of the returning officer.

24. Issue of voting documents by returning officer

(1) As soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following documents to each member of the corporation named in the list of eligible voters–

(a) ballot paper and ballot paper envelope,

(b) declaration of identity (if required),

(c) information about each candidate standing for election, pursuant to rule 59 of these rules, and

(d) a covering envelope.

(“postal voting information”)

(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)

(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.

(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.

(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

(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.

(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.

(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 declaration of identity if required, and

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

26. E-voting systems

(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").

(2) 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

The poll

27. Eligibility to vote

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

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

(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

(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 a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

(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.

(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 declaration of identity, if required, has not been returned.

(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.

30. Lost ballot information

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

(2) The returning officer may not issue a replacement ballot paper for 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 , and

(c) has ensured that the declaration of identity if required has not been returned.

(3) After issuing a 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, and

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

(c) the voter ID number of the voter.

31. Issue of replacement voting information

(1) If a person applies for a 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 a replacement voting information unless, in addition to the requirements imposed 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.

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

(a) the name of the voter, and

(b) the details of the unique identifier of the replacement ballot paper issued under this rule.

(c) the voter ID number of the voter

32. Declaration of identity for replacement ballot papers (public and patient constituencies)

(1) In respect of an election for a public or patient constituency a declaration of identity must be issued with each replacement ballot paper.

(2) The declaration of identity is to include a declaration –

(a) that the voter has not voted in the election with any ballot paper other than the ballot paper being returned with the declaration, and

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

(3) The declaration of identity is to include space for –

(a) the name of the voter,

(b) the address of the voter,

(c) the voter's signature, and

(d) the date that the declaration was made by the voter.

(4) The voter must be required to return the declaration of identity together with the ballot paper.

(5) The declaration of identity must caution the voter that if it is not returned with the ballot paper, or if it is returned without being correctly completed, the replacement ballot paper may be declared invalid.

Polling by internet

33. Procedure for remote voting by internet

(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.

(2) When prompted to do so, the voter will need to enter his or her voter ID number,

(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.

(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,

(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.

Procedure for receipt of envelopes

34. Receipt of voting documents

(1) Where the returning officer receives a

(a) covering envelope, or
(b) any other envelope containing a declaration of identity 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 35 and 36 are to apply.

(2) The returning officer may open any ballot paper envelope for the purposes of rules 35 and 36, but must make arrangements to ensure that no person obtains or communicates information as to –

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

(b) the unique identifier on a ballot paper.

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

35. Validity of ballot paper

(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 a declaration of identity if required that has been correctly completed, signed, and dated.

(2) Where the returning officer is satisfied that paragraph (1) has been fulfilled, he or she is to –

(a) put the declaration of identity if required in a separate packet, and

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

(3) Where the returning officer is not satisfied that paragraph (1) has been fulfilled, he or she is to –

(a) mark the ballot paper "disqualified",

(b) if there is a declaration of identity accompanying the ballot paper, mark it as "disqualified" and attach it the ballot paper,

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

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

(4) An internet vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record 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.

(5) Where the returning officer is satisfied that rule xxx has been fulfilled, he or she is to:

(a) mark the internet voting record "disqualified".
(b) record the voter ID number on the internet voting record, in the list of disqualified documents; and

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

36. Declaration of identity but no ballot paper (public and patient constituency)

Where the returning officer receives a declaration of identity if required but no ballot paper, the returning officer is to –

(a) mark the declaration of identity "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 declaration of identity in a separate packet.

37. De-duplication of votes

(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.

(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

(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.

(4) Where an internet voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record "disqualified",

(b) record the voter ID number on the internet voting record in the list of disqualified documents;

(c) place the internet voting record in a separate packet, and

(d) disregard the internet voting record when counting the votes in accordance with these rules.

38. Sealing of packets

As soon as is possible after the close of the poll and after the completion of the procedure under rules 35 and 36, the returning officer is to seal the packets containing–

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

(b) the declarations of identity if required,

(c) the list of spoilt ballot papers,

(d) the list of lost ballot papers,

(e) the list of eligible voters, and

(f) the list of tendered ballot papers.

Part 6 - Counting the votes

39. Arrangements for counting of the votes

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

40. The count

(1) The returning officer is to –

(a) count and record the number of ballot papers that have been returned,

(b) the number of internet voting records that have been created and

(c) count the votes according to the provisions in this Part of the rules

(2) The returning officer, while counting and recording the number of ballot papers and internet votes and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper.

(3) The returning officer is to proceed continuously with counting the votes as far as is practicable.

41. Rejected ballot papers

(1) Any ballot paper –

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to paragraphs (2) and (3) below, be rejected and not counted.

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

(3) A ballot paper on which a vote is marked –

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

(4) The returning officer is to –

(a) endorse the word "rejected" on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under paragraph (2) or (3) above, endorse the words "rejected in part" on the ballot paper and indicate which vote or votes have been counted.

(5) The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings –

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

42. Equality of votes

Where, after the counting of votes is completed, an equality of votes is found

to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

Part 7 – Final proceedings in contested and uncontested elections

43. Declaration of result for contested elections

(1) In a contested election, when the result of the poll has been ascertained, the returning officer is to –

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected–

(i) where the election is held under a proposed constitution pursuant to powers conferred on the Western Sussex Hospitals NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

(2) The returning officer is to make –

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule 39(5),

available on request.

44. Declaration of result for uncontested elections

In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election –

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

Part 8 – Disposal of documents

45. Sealing up of documents relating to the poll

(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,

(b) the ballot papers endorsed with "rejected in part",

(c) the rejected ballot papers, and

(d) the statement of rejected ballot papers.

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

(2) The returning officer must not open the sealed packets of –

(d) the disqualified documents, with the list of disqualified documents inside it,

(e) the declarations of identity,

(f) the list of spoilt ballot papers,

(g) the list of lost ballot papers,

(h) the list of eligible voters, and

(i) the list of tendered ballot papers.

or access the complete electronic copies of the internet voting records created in accordance with rule 26 and held in a device suitable for the purpose of suitable for the purpose of storage.

(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.

46. Delivery of documents

Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 45 the returning officer is to forward them to the chair of the corporation.

47. Forwarding of documents received after close of the poll

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 ballot papers are made too late to enable new ballot papers to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

48. Retention and public inspection of documents

(1) The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the regulator, cause them to be destroyed.

(2) With the exception of the documents listed in rule 53(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.

(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.

49. Application for inspection of certain documents relating to an election

(1) The corporation may not allow the inspection of, or the opening of any sealed packet containing –

(a) any rejected ballot papers, including ballot papers rejected in part,

(b) any disqualified documents, or the list of disqualified documents,

(c) any counted ballot papers,

(d) any declarations of identity, or

(e) the list of eligible voters,

by any person without the consent of the Regulator.

(2) A person may apply to the Regulator to inspect any of the documents listed in (1), and the Regulator may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

(3) The Regulator's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

(4) On an application to inspect any of the documents listed in paragraph (1), –

(a) in giving its consent, the regulator, and

(b) and making the documents available for inspection, the corporation,

must ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that the regulator has declared that the vote was invalid.

Part 9 – Death of a candidate during a contested election

50. Countermand or abandonment of poll on death of candidate

(1) If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to

(a) countermand notice of the poll, or, if ballot papers have been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

(2) Where a new election is ordered under paragraph (1), no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

(3) Where a poll is abandoned under paragraph (1)(a), paragraphs (4) to (7) are to apply.

(4) The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 33 and 34, and is to make up separate sealed packets in accordance with rule 35.

(5) The returning officer is to –

(a) count and record the number of ballot papers that have been received, and

(b) seal up the ballot papers into packets, along with the records of the number of ballot papers.

(6) The returning officer is to endorse on each packet a description of –

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

(7) Once the documents relating to the poll have been sealed up and endorsed pursuant to paragraphs (4) to (6), the returning officer is to deliver them to the chairman of the corporation, and rules 52 and 53 are to apply.

Part 10 – Election expenses and publicity

Election expenses

51. Election expenses

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 to the regulator under Part 11 of these rules.

52. Expenses and payments by candidates

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.

53. Election expenses incurred by other persons

(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.

(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 58 and 59.

Publicity

54. Publicity about election by the corporation

(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.

(2) Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 59, 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.

(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.

55. Information about candidates for inclusion with voting documents

(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.

(2) The information must consist of –

(a) a statement submitted by the candidate of no more than 250 words, and

(b) a photograph of the candidate.

56. Meaning of "for the purposes of an election"

(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.

(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

57. Application to question an election

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

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

(3) An application may only be made to the Regulator by -

  (a) a person who voted at the election or who claimed to have had the right to vote, or

  (b) a candidate, or a person claiming to have had a right to be elected at the election.

(4) The application must –

  (a) describe the alleged breach of the rules or electoral irregularity, and

  (b) be in such a form as the Regulator may require.

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

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

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

  (b) The determination by the person or persons nominated in accordance with Rule 61(7) shall be binding on and shall be given effect by the corporation, the applicant and the members

of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

(c) The Regulator may prescribe rules of procedure for the determination of an application including costs.

Part 12 – Miscellaneous

58. Secrecy

(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 a ballot paper or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the candidate(s) for whom any member has voted.

(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.

(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.

59. Prohibition of disclosure of vote

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.

60. Disqualification

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.

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

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 and declarations of identity,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll, with the agreement of the Regulator.

ANNEX 4 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

1. INTERPRETATION

1.1 In these Provisions, the clauses relating to Interpretation in the Constitution shall apply and the words and expressions defined in the Constitution shall have the same meaning.

2. APPLICATION OF THESE PROVISIONS

2.1 These Provisions apply to all meetings of the Council of Governors ("the Council") and all other relevant activities of the Governors. All Governors, Non-executive Directors and staff are required to abide by these Provisions, which also apply to any persons attending meetings of the Council.

2.2 Except where required by law or the constitution, at any meeting of the Council the Chairman (or in his absence, the person deputising for him) shall be the final authority on the interpretation of these Provisions (on which he should be advised by the Chief Executive and the Secretary).

2.3 Whilst the Secretary shall be responsible for ensuring that relevant staff are made aware of these Provisions, staff members are expected to familiarise themselves with the Provisions.

2.4 In the event of any actual or suspected non-compliance with these Provisions, the Governor or member of staff identifying such shall report it to the Secretary within 7 calendar days of the actual or suspected non-compliance being identified. The Secretary shall be responsible for taking action in respect of the report, which shall, where non-compliance is identified, include a report to the next scheduled meeting of the Council. Such a report shall be recorded in the minutes of the Council meeting and, subject to the Chairman's decision, shall be reported to the Board of Directors ("the Board").

3. APPOINTMENT AND REMOVAL OF GOVERNORS

Election and Appointment to Office

3.1 Governors shall be elected or appointed by the means and on terms of office as prescribed by this constitution.

3.2 As more fully detailed in clauses 3.3-3.10 below, the first election to the Council shall, in order that future elections shall occur on a phased basis, be conducted in such a way as to result in the initial terms of office for Governors set out below:

Constituency	Class	3-year terms	2-year terms	Total
Public	Adur	1	1	2
Public	Arun	2	2	4
Public	Chichester	2	1	3
Public	Horsham	1	0	1
Public	Worthing	2	1	3

Patients	None	2	1	3
Staff	Medical and Dental	1	0	1
Staff	Nursing & Midwifery	0	1	1
Staff	Additional Clinical Services	1	0	1
Staff	Scientific, Technical, Professional	0	1	1
Staff	Estates & Anciliary	1	0	1
Staff	Administrative and Clerical	0	1	1
	Totals	12	10	22

3.3 In relation to the first election to the Council, for the Adur class of the public constituency, the candidate with the highest number of votes shall hold office for a period of three years, except as otherwise provided by this Constitution, before the next election in relation to his office takes place. The candidate with the second highest number of votes shall hold office for a period of two years, except as otherwise provided by this Constitution, before the next election in relation to his office takes place.

3.4 In relation to the first election to the Council, for the Arun class of the public constituency, the two candidates with the first and second highest number of votes shall each hold office for a period of three years, except as otherwise provided by this Constitution, before the next election in relation to their respective offices takes place. The candidates with the third and fourth highest number of votes shall each hold office for a period of two years, except as otherwise provided by this Constitution, before the next election in relation to their respective offices takes place.

3.5 In relation to the first election to the Council, for the Chichester and Worthing classes in the public constituency, the two candidates with the first and second highest number of votes shall each hold office for a period of three years, except as otherwise provided by this Constitution, before the next election in relation to their respective offices takes place. The candidate with the third highest number of votes shall hold office for a period of two years, except as otherwise provided for by this Constitution, before the next election in relation to his office takes place.

3.6 In relation to the first election to the Council, for the Horsham class in the public constituency, the candidate with the highest number of votes shall hold office for a period of three years before the next election in relation to his office takes place.

3.7 In relation to the first election to the Council, for the patients constituency, the two candidates with the first and second highest number of votes shall each hold office for a period of three years, except as otherwise provided by this Constitution, before the next election in relation to their respective offices takes place. The candidate with the third highest number of votes shall hold office for a period of two years before the next election in relation to his office takes place.

3.8 In relation to the first election to the Council, for the Medical & Dental, Additional Clinical Services and Estates & Ancillary classes in the staff constituency, the candidate with the highest number of votes shall hold office for a period of three years before the next election in relation to his office takes place. For the Nursing & Midwifery, Scientific, Technical and Professional and Administrative & Clerical classes in the staff constituency, the candidate with the highest number of votes shall hold office for a period of two years before the next election in relation to his office takes place.

3.9 In all cases described within clauses 3.3 to 3.7 above, in relation to the first election to the Council, in the case of an uncontested election terms of office shall be decided by drawing lots, which will take place at a meeting of the Council of Governors.

3.10 With the exception of the initial terms of office, in relation to the first election to the Council set out above, Governors will be elected for three-year terms.

3.11 A Governor shall be eligible for re-election or re-appointment at the end of his first term, for one further term. A Governor may not serve as a Governor for more than three consecutive terms (resulting in a maximum of none years) without a break. A Governor whose tenure of office is terminated shall not be eligible for re-appointment or to stand for re-election for a period of three years from the date of removal from office or the date upon which any appeal against his removal from office is disposed of whichever is the later except by resolution carried by a two thirds of the voting members of the Council

3.12 A Governor shall, within 21 days of election or appointment, sign and deliver to the Secretary a declaration in the form prescribed at Appendix A. No Governor shall be entitled to vote or count in the quorum at a meeting of the Council of Governors until his declaration has been received by the Secretary. Such a declaration shall be valid for the Governor's term of office.

Removal or Resignation from Office

3.13 A person shall not be eligible to become or continue in office as a Governor if:

3.13.1 any of the grounds contained in paragraph 14 of the Constitution apply to him;

3.13.2 in the case of an Elected Governor, he ceases to be eligible to be a member of the Trust or constituency. For the avoidance of doubt and in accordance with Constitution clause 13.2, a Public Governor who ceases to be eligible to be a member of that Public Constituency by virtue of moving to another area, shall cease to hold office. Subject to clause 3.11 of these Provisions and the Constitutional provisions in respect of eligibility for holding office as a Governor, a person ceasing to hold office by the means described in this clause shall be eligible to stand for election in the area to which he has moved.

3.13.3 he is a member of a Staff Class and any professional registration relevant to his eligibility to be a member of that Staff Class has been suspended for a continuous period of more than six months;

3.13.4 in the case of an Appointed Governor, the appointing organisation withdraws its appointment of him or the organisation ceases to exist;

3.13.5 he has within the preceding two years been lawfully dismissed otherwise than by reason of redundancy from any paid employment with a health service body;

3.13.6 he is a person whose term of office as the chair or as a member or director of a health service body has been terminated on the grounds that his continuance in office is no longer in the best interests of the health service, for non-attendance at meetings or for non-disclosure of a pecuniary interest;

3.13.7 he has had his name removed by a direction under Section 154 of the 2006 Act from any list prepared under Part 4 of that Act and has not subsequently had his name included in such a list;

3.13.8 he has failed to make, or has falsely made, any declaration as required to be made under Section 60 of the 2006 Act or has spoken or voted in a meeting on a matter in which they have direct or indirect pecuniary or non-pecuniary interest and he is judged to have acted so by a majority of not less than three quarters of the Council.

3.13.9 Monitor has exercised its powers to remove him as a Governor of the Trust or has suspended him from office or has disqualified him from holding office as a Governor of the Trust for a specified period or Monitor has exercised any of those powers in relation to him on any other occasion whether in relation to the Trust or some other NHS Foundation Trust;

3.13.10 he has received a written warning from the Trust for verbal and/or physical abuse towards any person;

3.13.11 he does not agree to (or, having agreed, fails to) abide by the values as published by the Trust;

3.13.12 he has been placed on the registers of Schedule 1 Offenders pursuant to the Sexual Offences Act 2003 (as amended) and/or the Children and Young Person's Act 1933 to 1969 (as amended) and his conviction is not spent under the Rehabilitation of Offenders Act 1974;

3.13.13 he is incapable by reason of mental disorder, illness or injury in managing and administering his property and/or affairs;

3.13.14 he is a member of the UK Parliament;

3.13.15 he is a Director of the Trust or a Governor of another NHS Foundation Trust;

3.13.16 he is a member of a relevant local authority Overview and Scrutiny Committee; or

3.13.17 he is not 16 years of age, or older, at the closing date for nominations for election or appointment.

3.13.18 his term of office is terminated pursuant to paragraph 3.14 below;

Termination of Office

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

3.14.1 by the Governor giving notice in writing to the Secretary of his resignation from office at any time during that term of office;

3.14.2 by a majority of the Governors present and voting at a meeting of the Council if any grounds exist under paragraph 3.13 above

3.14.3 if the Council resolves to terminate his term of office on the grounds that in the reasonable opinion of two thirds of the voting membership of the Council of Governors at a meeting of the Council convened for that purpose that his continuing as a Governor would or would be likely to:

(a) prejudice the ability of the Trust to fulfill its principal purpose or of its purposes under this Constitution or otherwise to discharge its duties and functions; or

(b) prejudice the Trust's work with other persons or body with whom it is engaged or may be engaged in the provision of goods and services; or

(c) adversely affect public confidence in the goods and services provided by the Trust; or

(d) otherwise bring the Trust into disrepute or be detrimental to the interests of the Trust.

3.14.4 If two thirds of the voting membership of the Council of Governors and voting at a meeting of the Council resolve that:

(a) it would not be in the best interests of the Trust for that person to continue in office as a Governor; or

(b) the Governor is a vexatious or persistent litigant or complainant with regard to the Trust's affairs and his continuance in office would not be in the best interests of the Trust; or

(c) the Governor has failed to or refused to undertake and/or satisfactorily complete any training which the Council has required him to undertake in his capacity as a Governor by a date six months from the date of his election or appointment; or

(d) he has in his conduct as a Governor failed to comply in a material way with the values and principles of the National Health Service or the Trust, the Constitution, and/or the Terms of Authorisation; or

(e) he has committed a material breach of any Role Description or Code of Conduct applicable to Governors of the Trust and/or these Provisions.

3.15 Where a person has been elected or appointed to be a Governor and he becomes disqualified from that appointment he shall notify the Secretary in writing of such disqualification as soon as practicable and in any event within 14 calendar days of first becoming aware of those matters which rendered him disqualified, and the Secretary shall report the matter to the Council and the Board.

3.16 Upon a Governor resigning or ceasing to be eligible to continue in office that person shall cease to be a Governor and his name shall be removed from the Register of Governors.

Vacancies

3.17 Where a Governor resigns or his office is terminated, elected Governors shall be replaced in accordance with paragraphs 3.19 and 3.20 below and, in the case of Appointed Governors, the Trust shall within 30 days of the vacancy having arisen invite the appointing body to appoint a new Governor to hold office for the remainder of the term of office.

3.18 Where a Governor is declared ineligible or disqualified from office or his term of office as a Governor has been terminated (otherwise than as a consequence of his own resignation) and that person disputes the decision, he shall as reasonably practicable be entitled to attend a meeting with the Chairman and Chief Executive of the Trust, who shall use their reasonable endeavours to facilitate such a meeting, to discuss the decision with a view to resolving any dispute which may have arisen but the Chairman and Chief Executive shall not be entitled to rescind or vary the decision which has already been taken.

3.19 Where an Elected Governor ceases to hold office during the first six months of his term of office, the Trust shall offer the unsuccessful candidate who secured the highest number of votes in the last election for the area or class in which the vacancy has arisen, the opportunity to assume the vacant office for the unexpired balance of the retiring Governor's term of office. If that candidate is unwilling, or unable, to fill the vacancy it will then be offered to that unsuccessful candidate who secured the next highest number of votes.

3.20 If there is no reserve candidate, or the reserve candidate is unable or unwilling to fill the vacancy, the Council may seek to co-opt a non-voting associate governor from that constituency or agree to allow that office will stand vacant until the next scheduled election unless by so doing this causes the aggregate number of Governors who are Public or Patient Governors to be less than half the total membership of the Council. In that event an election will be held in accordance with the Election Scheme as soon as reasonably practicable.

3.21 No defect in the election or appointment of a Governor or any deficiency in the composition of the Council shall affect the validity of any act or decision of the Council.

4. DECLARATIONS AND REGISTER OF GOVERNORS' INTERESTS

4.1 In accordance with the Constitution, Governors are required to declare on election or appointment and in the manner prescribed below any direct or indirect pecuniary interest and any other interest which is relevant and material to the business of the Trust. The responsibility for declaring an interest is solely that of the Governor concerned.

4.2 Such a declaration shall be made by completing and signing a form, as prescribed by the Secretary from time to time setting out any interests required to be declared in accordance with the Constitution or these Provisions and delivering it to the Secretary within 28 days of a Governor's election or appointment or otherwise within seven days of becoming aware of the existence of a relevant or material interest. The Secretary shall amend the Register of Interests upon receipt of notification within one month.

4.3 If a Governor is present at a meeting of the Council of Governors and has an interest of any sort in any matter which is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter and, if he has declared a pecuniary interest, he shall not take part in the consideration or discussion of the matter.

4.4 The term "relevant and material interests" may include (but may not be limited to) the following:

4.4.1 directorships, including non-executive directorships held in private or public limited companies (with the exception of those of dormant companies);

4.4.2 ownership or part-ownership or directorships of companies or other types of organisation which are likely to or are seeking to do business with the NHS;

4.4.3 a position of authority in a charity or voluntary organisation operating in the field of health and social care, including any which are contracting for or are commissioning NHS services;

4.4.4 any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks;

4.4.5 research funding/grants that may be received by an individual or their department;

4.5 Any traveling or other expenses or allowances payable to a Governor in accordance with this Constitution shall not be treated as a pecuniary interest.

4.6 Subject to any other provision of this Constitution, a Governor shall be treated as having an indirect pecuniary interest in a contract, proposed contract or other matter, if:

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

4.6.2 he is a partner, associate or employee of any person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the same.

4.7 A Governor shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

4.7.1 of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body;

4.7.2 of an interest in any company, body, or person with which he is connected, which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

4.8 In the case of persons living together the interest of one partner or spouse shall, if known to the other, be deemed for the purposes of these Provisions to be also an interest of the other.

4.9 If a Governor has any doubt about the relevance of an interest, he must take advice from the Secretary.

5. STANDARDS OF CONDUCT

5.1 Governors shall comply with the terms of the Role Description for Governors which shall be approved by the Council and the Board, and which the Secretary shall issue to Governors upon election or appointment to the Council. The Governors shall also comply with any codes of conduct or other standards referenced in the Role Description.

5.2 In the event that there are concerns about a Governor's performance or conduct, the Chairman, with the support of the Lead Governor and Secretary where necessary, will address these directly with the Governor concerned. Where necessary, the Chairman will make recommendations to the Council, including in respect of any proposal that the Council should remove the Governor from office in which case the Provisions of section 3 of these Provisions shall apply.

5.3 For further information see Annex 9.

6. REMUNERATION AND BUSINESS EXPENSES

6.1 Governors shall not receive remuneration.

6.2 The Trust is permitted to reimburse traveling expenses to Governors for attendance at meetings of the Council, or for any other business authorised by the Chairman as being reasonably within the role and duties of a Governor, at a rate and in accordance with a policy to be determined by the Board of Directors.

6.3 Expenses will be reimbursed by the Secretary on receipt of a completed and signed expenses form provided by the Secretary.

6.4 A summary of expenses paid to Governors will be published in the Annual Report.

7. COMPOSITION AND ROLE OF COUNCIL OF GOVERNORS

7.1 The composition of the Council shall be as set out in Annex 2 of the Constitution.

7.2 Subject to the 2006 Act (as amended and/or replaced from time to time), the role of the Council is defined in its Terms of Reference which shall be approved by the Council and the Board.

7.3 Subject to the 2006 Act (as amended and/or replaced from time to time), the role of the Chairman shall be as defined in a Role Description which shall be approved by the Council and the Board.

7.4 The role of the Deputy Chairman shall be as defined in a Role Description which shall be approved by the Council and the Board.

7.5 The role of the Lead Governor and Deputy Lead Governor shall be as defined in a Role Description which shall be approved by the Council and the Board, this is contained within Annex 8.

8. COMMITTEES OF THE COUNCIL

8.1 Subject to the constitution, the Terms of Authorisation and such binding guidance as may be given by Monitor, the Council may and, if so required by Monitor, shall appoint committees of the Council consisting wholly or partly of members of the Trust (whether or not they include Governors) or wholly of persons who are not members of the Trust (whether or not they include Governors). The Council shall not delegate any of its powers to a committee but committees may act in an advisory capacity to assist the Council in carrying out its functions.

8.2 These Provisions of the Council shall apply with appropriate alteration to any committees established by the Council.

8.3 Each such committee or sub-committee shall have such terms of reference. Such terms of reference and the membership of committees or sub-committees shall be subject to approval by the Council.

8.4 The Council shall approve the appointment of the Chair and members for each of the committees which it has formally constituted. Where the Council

determines that persons who are neither Governors nor staff shall be appointed to a committee, the terms of such appointment shall be determined by the Council. The Council may request that external advisers assist them or any committee they appoint in carrying out its duties.

8.5 Elected and Appointed governors may form a sub-committee – the Pre-Council of Governors Committee – to prepare for forthcoming Council meetings.

9. SUSPENSION, AMENDMENT AND REVIEW OF THESE PROVISIONS

Suspension

9.1 These Provisions shall not be suspended except:

9.1.1 where urgent action is required and the Chairman considers it to be in the interests of the Trust to waive one or more of the Provisions, he may do so subject to such action being reported to the next meeting of the Council

9.1.2 at a meeting of the Council, at least half of the total number of Governors are present, such number to include not less than one third of the Public Governors, not less than one third of the Staff Governors and not less than one third of the Appointed Governors

9.2 Any decision to waive Provisions shall be recorded in the minutes of the next meeting of the Council and shall be reported to the Audit Committee.

Amendment and Review

9.3 These Provisions shall be reviewed one year after approval by the Council and then at least every three years thereafter.

9.4 These Provisions shall be amended only if:

9.4.1 the variation proposed does not contravene a statutory provision, the Terms of Authorisation or the Constitution; and

9.4.3 at least three quarters of the Governors present and voting at a meeting of the Council, including one Staff Governor, one Public Governor and one Appointed Governor are in favour of amendment.

9.4.4 The proposed amendment(s) has/have been discussed the Board.

9.5 All amendments to these Provisions shall be subject to approval through any process prescribed by Monitor.

APPENDIX A

DECLARATION BY GOVERNOR

WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST
(the "Trust")

I, ... (insert full name)

of
....
....
....(insert address)

Hereby declare that I am entitled to:-

(a) be elected to the Council of Governors as a Governor elected by one of the public constituencies/ the staff constituencies* because I am a member of one of the public constituencies/ /staff constituencies *; or

(b) be appointed to the Council of Governors as a governor because I have been appointed by a nominating organisation

and that I am not prevented from being a member of the Council of Governors of the Trust by paragraph 8 of Schedule 7 of the National Health Service Act 2006 or under the Constitution of the Trust and that I am entitled to vote at meetings of the Council of Governors as a governor pursuant to such appointment or election.

Signed ....

Print
Name……………………………...

Date of Declaration ....

ANNEX 5 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

1. MEETINGS OF THE COUNCIL OF GOVERNORS

Frequency of Meetings

1.1 The Council of Governors ("the Council") shall decide the frequency of and calendar for its meetings, subject to the Council holding a minimum of four general meetings per year. The Secretary shall ensure that within the meeting cycle of the Council, general meetings are called at appropriate times to consider matters as required by the 2006 Act and the Constitution.

1.2 Notwithstanding clause 1.1 above, the Chairman may at any time call a meeting of the Council. If the Chairman refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Governors including at least two elected and two appointed Governors, has been presented to him/her, or if, without so refusing, the Chairman does not call a meeting within 7 days after such requisition has been presented to him/her, at the Trust's Headquarters, such one third or more Governors may forthwith call a meeting of the Council.

Admission of the Public

1.3 By effect of these Standing Orders only, the public shall be invited to attend all meetings of the Council unless the Council decides otherwise in relation to all or part of any particular meeting. The public shall be excluded from meetings of the Council only where the business under discussion is commercially sensitive or is otherwise considered to be confidential.

1.4 The Chairman may exclude any member of the public from a meeting of the Council if the person is interfering with or preventing the proper conduct of the Council's business. The Chairman's decision in this respect shall be final.

1.5 The Chairman shall decide the arrangements through which any questions from members of the public will be asked and answered.

Admission of Directors

1.6 Subject to Provisions in relation to interests, any Director or their nominated representatives shall have the right to attend meetings of the Council and, subject to the decision of the Chairman, to speak to any item under consideration.

Chairman for Meetings of the Council

1.7 Subject to clause 1.9 below, the Chairman of the Trust, or in his absence, the Deputy Chairman shall preside at meetings of the Council. Neither the Chairman nor any person deputising for him shall be a member of the Council and he shall not have a vote on matters considered by the Council.

1.8 The Deputy Chairman may preside at meetings of the Council in the following circumstances:

1.8.1 when there is a need for someone to have the authority to chair any meeting of the Council when the Chair is not present

1.8.2 when the remuneration, allowance and other terms and conditions of the Chair are being considered.

1.8.3 when the appointment of the Chair is being considered, should the current Chair be a candidate for re-appointment.

1.8.4 on occasions when the Chair declares a pecuniary interest that prevents him from taking part in the consideration or discussion of a matter before the Council.

1.9 If it would not be appropriate for the Chairman or the Deputy Chairman to preside, one of the other Non Executive Directors shall preside. If in exceptional circumstances it would not be appropriate for any Non Executive Director to preside, the Council shall appoint one of its members to preside at that meeting. This shall normally be the Lead Governor.

1.10 Statements made by Governors at meetings of the Council shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final and shall be observed at the meeting.

Notice, Agenda and Papers for Meetings

Notice of Meeting

1.11 Before each meeting of the Council, a notice of the meeting signed by the Chairman or by an officer of the Trust authorised by the Chairman to sign on his/her behalf shall be delivered to every member of the Council, or sent by post to the usual place of residence of such Governor, no less than five clear working days in advance of the meeting. Clear days shall not include the date on which the notice is sent or the day of the meeting.

1.12 Except in the case of emergencies or in case of a need to conduct urgent business, the Secretary shall give to all Governors at least 10 clear days written notice of the date and place of every meeting of the Council. Written notice shall be deemed to include communication by email. The notice shall be published on the Trust's website and otherwise made available to members of the public as considered appropriate by the Trust.

1.13 In the case of a meeting called by the Governors in default of the Chairman, the notice shall be signed by those respective Governors and no business shall be transacted at the meeting other than that specified in the notice. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of post or otherwise on the day following electronic or facsimile transmission. Lack of service of the notice on any Governors shall not affect the validity of a meeting.

Agenda and Notification of Business

1.14 At the direction of the Council, the Secretary shall draw up and maintain an agenda plan for the Council's meetings in each calendar year. The agenda plan shall take account of the work-plan for the Council, which it will agree with the Board of Directors ("the Board"). The agenda plan shall be approved by the Council at least once in each calendar year.

1.15 The Council may 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.

1.16 A Governor desiring a matter to be included on an agenda shall specify the question or issue to be included by request in writing to the Chairman or the Secretary at least three clear business days before Notice of the meeting is given. Requests made less than three days before the Notice is given may be included on the agenda at the discretion of the Chairman.

1.17 Before each meeting of the Council, an agenda setting out the business of the meeting, approved by the Chairman or by an officer of the Trust authorised by the Chairman on his/her behalf agreed by the Lead or Deputy Lead Governor, shall be posted on line or delivered electronically to the membership of the Council of Governors, specifying the business proposed to be transacted at it at least five clear days before the meeting. The agenda shall include any items of business identified in the approved agenda plan, any items which the Council has directed to appear on any or all of the agenda for its meetings and any specific items or motions requested by one or more Governors and approved by the Chairman. The agenda shall be published on the Trust's website prior to the meeting and otherwise made available to members of the public as considered appropriate by the Trust.

Papers for Meetings

1.18 The Secretary shall be responsible for compiling and distributing to Governors (and, where their attendance is permitted, members of the public) papers for meetings of the Council. Papers shall be issued at least five clear days prior to each meeting of the Council. Papers will only be tabled at the Council's meetings in exceptional circumstances and then only with the prior approval of the Chairman.

Quorum for Meetings

1.19 A meeting of the Council shall be quorate and shall not commence until it is quorate. Quoracy is defined as meaning that the following requirements are all satisfied:

1.19.1 there shall be present at the meeting at least one third of all Governors
1.19.2 of those present, at least 51% shall be Elected Governors
1.19.3 of whom at least two shall be Elected Public Governors

A Governor shall be deemed as present if he joins the meeting by telephone or other means, provided that he can hear and be heard by all other Governors present at the meeting.

If the meeting is not quorate within 15 minutes after the due starting time, it shall be reconvened at time to be agreed by the Chairman.

1.20 If a Governor has declared a direct pecuniary interest in any matter, the Governor must leave the meeting room, and will not count towards the quorum of the meeting, during the consideration, discussion and voting on the matter. If a quorum is then not available for the discussion and/or the passing or a resolution on any matter, that matter may not be discussed further or voted upon at that meeting.

1.21 Where a Governor:

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

1.21.2 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

1.21.3 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;

1.21.4 the Governor shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to his duty disclose his interest.

1.22. A Governor who has declared a non-pecuniary interest in any matter may participate in the discussion and consideration of the matter but may not vote in respect of it: in these circumstances the Governor will count towards the quorum of the meeting.

1.23 The minutes shall record any declarations of interests on the part of Governors and any action taken in respect of them.

Conduct of Business

1.24 Save as otherwise provided in the Constitution and/or the 2006 Act, if the Chair so determines or if a Governor requests, a question at a meeting shall be determined by a majority of the votes of the Governors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a casting vote.

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

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

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

1.28 In no circumstances may an absent Governor vote by proxy.

Minutes of Meetings

1.29 The minutes of the meeting, which shall include the names of the Governors present, shall be drawn up and submitted for the Council's approval at its next meeting. Subject to the Chairman's approval, the minutes may be circulated in draft form to Governors prior to the Council's next meeting and made available to the public (including through the Trust's website).

1.30 No discussion shall take place upon the draft minutes except upon their accuracy or where the Chair considers discussion appropriate (for example, on matters arising). Any amendment to the draft minutes of the previous meeting shall be recorded in the minutes of the present meeting. Once draft minutes have been approved (including with regard to any amendments made), they shall be deemed ratified and signed by the person who presided at the meeting at which their accuracy was discussed.

Written Resolutions

1.31 Where the Council so decides in respect of any matter or, where it is necessary, at the discretion of the Chairman, the Council may take decisions by means of a written resolution.

1.32 A resolution in writing sent to all Governors and signed by at least 75% of them shall be as valid and effective as if it had been passed at a meeting of the Council duly convened and held. Such a resolution may consist of several documents in the same form, each signed by one or more of the Governor.

2. SUSPENSION, AMENDMENT AND REVIEW OF THESE STANDING ORDERS

Suspension

2.1 These Standing Orders shall not be suspended except:

- 2.1.1 where urgent action is required and the Chairman considers it to be in the interests of the Trust to waive one or more of the Standing Orders, he may do so subject to such action being reported to the next meeting of the Council
- 2.1.2 at a meeting of the Council, at least half of the total number of Governors are present, such number to include not less than one third of the Public Governors, not less than one third of the Staff Governors and not less than one third of the Appointed Governors

2.2 Any decision to waive Standing Orders shall be recorded in the minutes of the next meeting of the Council and shall be reported to the Audit Committee.

Amendment and Review

2.3 These Standing Orders shall be reviewed one year after approval by the Council and then at least annually thereafter.

2.4 These Standing Orders shall be amended only if:

- 2.4.1 the variation proposed does not contravene a statutory provision, the Terms of Authorisation or the Constitution; and
- 2.4.3 at least three quarters of the Governors present and voting at a meeting of the Council, including one Staff Governor, one Public Governor and one Appointed Governor are in favour of amendment.
- 2.4.4 The proposed amendment(s) has/have been discussed the Board.

2.5 All amendments to these Standing Orders shall be subject to approval through any process prescribed by Monitor.

ANNEX 6 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

1. INTERPRETATION

1.1 In these Standing Orders, the provisions relating to Interpretation in the Constitution shall apply and the words and expressions defined in the Constitution shall have the same meaning.

2. APPLICATION OF STANDING ORDERS

2.1 These Standing Orders apply to all meetings of the Board of Directors ("the Board") and all other relevant activities of the Directors. All Directors and staff are required to abide by these Standing Orders, which also apply to any persons attending meetings of the Board.

2.2 Except where required by law or the constitution, at any meeting of the Board the Chairman (or in his absence, the person deputising for him) shall be the final authority on the interpretation of these Standing Orders (on which he should be advised by the Chief Executive and the Secretary).

2.3 Whilst the Secretary shall be responsible for ensuring that relevant staff are made aware of these Standing Orders, staff members are expected to familiarise themselves with the provisions.

2.4 In the event of any actual or suspected non-compliance with these Standing Orders, the person identifying such shall report it to the Secretary within 14 calendar days of the actual or suspected non-compliance being identified. The Secretary shall be responsible for taking action in respect of the report, which shall, where non-compliance is identified, include a report to the next scheduled meeting of the Board. Such a report shall be recorded in the minutes of the Board meeting.

3. MEETINGS OF THE BOARD OF DIRECTORS

Frequency of Meetings

3.1 The Board shall decide the frequency of and calendar for its meetings, subject to the Board holding not less than four per year. The Secretary shall ensure that within the meeting cycle of the Board, meetings are called at appropriate times to consider matters as required by the 2006 Act and the Constitution.

3.2 Notwithstanding clause 3.1 above, the Chairman may at any time call a meeting of the Board. If the Chairman refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Directors, has been presented to him, or if, without so refusing, the Chairman does not call a meeting within 7 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 of the Board.

Admission of the Public and Observers

3.3 By effect of these Standing Orders only, the public shall be invited to attend all meetings of the Board unless the Board decides otherwise in relation to all or part of any particular meeting. The Board may also invite observers to attend its meetings.

3.4 The public shall be excluded from meetings of the Board only where the business under discussion is commercially sensitive or is otherwise considered to be confidential. The Chairman may exclude any member of the public from a meeting of the Board if the person is interfering with or preventing the proper conduct of the Board's business. The Chairman's decision in this respect shall be final.

3.5 The Chairman shall decide the arrangements through which any questions from members of the public will be asked and answered.

Chairman for Meetings of the Board

3.6 The Chairman of the Trust, or in his absence, the Deputy Chairman shall preside at meetings of the Board.

3.7 The Deputy Chairman may preside at meetings of the Board in the following circumstances:

3.7.1 when there is a need for someone to have the authority to chair any meeting of the Board when the Chair is not present

3.7.2 on occasions when the Chair declares a pecuniary interest that prevents him from taking part in the consideration or discussion of a matter before the Board.

3.8 If it would not be appropriate for the Chairman or the Deputy Chairman to preside, one of the other Non Executive Directors shall preside.

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

Notice, Agenda and Papers for Meetings

Notice of Meeting

3.10 Before each meeting of the Board, a notice of the meeting signed by the Chairman or by an officer of the Trust authorised by the Chairman to sign on his behalf shall be delivered to every member of the Board, or sent by post to the usual place of residence of such Director, no less than five clear working days before the meeting. Clear days shall not include the date on which the notice is sent or the day of the meeting.

3.11 Except in the case of emergencies or in case of a need to conduct urgent business, the Secretary shall give to all Directors at least 10 clear working days written notice of the date and place of every meeting of the Board.

Written notice shall be deemed to include communication by email. Notice will also be published on the Trust's website.

3.12 In the case of a meeting called by the Directors in default of the Chairman, the notice shall be signed by those respective Directors and no business shall be transacted at the meeting other than that specified in the notice A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of post or otherwise on the day following electronic or facsimile transmission. Lack of service of the notice on any Directors shall not affect the validity of a meeting.

Agenda and Notification of Business

3.13 At the direction of the Board, the Secretary shall draw up and maintain a plan for the agenda of the Board's meetings in each calendar year. The agenda plan shall take account of the work-plan for the Board, which it will agree with the Council. The agenda plan shall be approved by the Board at least once in each calendar year.

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

3.15 A Director desiring a matter to be included on an agenda shall specify the question or issue to be included by request in writing to the Chairman or the Secretary at least three clear business days before Notice of the meeting is given. Requests made less than three days before the Notice is given may be included on the agenda at the discretion of the Chairman.

3.16 Before each meeting of the Board, an agenda setting out the business of the meeting, approved by the Chairman or by an officer of the Trust authorised by the Chairman on his behalf shall be delivered electronically to every member of the Board, specifying the business proposed to be transacted at it at least five clear days before the meeting. The agenda shall include any items of business identified in the approved agenda plan, any items which the Board has directed to appear on any or all of the agenda for its meetings and any specific items or motions requested by one or more Directors and approved by the Chairman. The agenda shall be published on the Trust's website prior to the meeting and otherwise made available to members of the public as considered appropriate by the Trust.

Papers for Meetings

3.17 The Secretary shall be responsible for compiling and distributing to Directors (and, where their attendance is permitted, members of the public) papers for meetings of the Board. Papers shall be issued at least five clear days prior to each meeting of the Board. Papers will only be tabled at the Board's meetings in exceptional circumstances and then only with the prior approval of the Chairman.

Quorum for Meetings

3.18 A meeting of the Board shall be quorate and shall not commence until it is quorate. Quoracy is defined as meaning that at least half of the Board must be present, including two Non-executive Directors and two Executive Directors. A Director shall be deemed as present if he joins the meeting by telephone or other means, provided that he can hear and be heard by all other Directors present at the meeting.

3.19 If the meeting is not quorate within 15 minutes after the due starting time, it shall be reconvened at time to be agreed by the Chairman.

3.20 If a Director has declared a direct pecuniary interest in any matter, the Director must leave the meeting room, and will not count towards the quorum of the meeting, during the consideration, discussion and voting on the matter. If a quorum is then not available for the discussion and/or the passing or a resolution on any matter, that matter may not be discussed further or voted upon at that meeting.

3.21 Where a Director:

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

3.21.2 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

3.21.3 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;

3.21.4 the Director shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to his duty disclose his interest.

3.22 A Director who has declared a non-pecuniary interest in any matter may participate in the discussion and consideration of the matter but may not vote in respect of it: in these circumstances the Director will count towards the quorum of the meeting.

3.23 The minutes shall record any declarations of interests on the part of Directors and any action taken in respect of them.

3.24 An Officer who has been appointed to act 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, and shall therefore count towards the quorum. An Officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence in the absence of a formal acting arrangement shall not exercise the voting rights of the Executive Director or count towards the quorum. The

minutes shall record the status of Officers attending to represent Executive Directors.

Conduct of Business

3.25 Save as otherwise provided in the Constitution and/or the 2006 Act, if the Chair so determines or if a Director requests, a question at a meeting shall be determined by a majority of the votes of the Director present and voting on the question and, in the case of any equality of votes, the person presiding shall have a casting vote.

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

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

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

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

Minutes of Meetings

3.30 The minutes of the meeting, which shall include the names of the Director s present, shall be drawn up and submitted for the Board's approval at its next meeting. Subject to the Chairman's approval, the minutes may be circulated in draft form to Directors prior to the Board's next meeting and made available to the public (including through the Trust's website)..

3.31 No discussion shall take place upon the draft minutes except upon their accuracy or where the Chair considers discussion appropriate (for example, on matters arising). Any amendment to the draft minutes of the previous meeting shall be recorded in the minutes of the present meeting. Once draft minutes have been approved (including with regard to any amendments made), they shall be deemed ratified and signed by the person who presided at the meeting at which their accuracy was discussed.

Written Resolutions

3.32 Where the Board so decides in respect of any matter or, where it is necessary, at the discretion of the Chairman, the Board may take decisions by means of a written resolution.

3.33 A resolution in writing sent to all Directors and signed by at least 75% of them shall be as valid and effective as if it had been passed at a meeting of the Board duly convened and held. Such a resolution may consist of several documents in the same form, each signed by one or more of the Directors.

4. SUSPENSION, AMENDMENT AND REVIEW OF THESE STANDING ORDERS

Suspension

4.1 These Standing Orders shall not be suspended except:

4.1.1 where urgent action is required and the Chairman considers it to be in the interests of the Trust to waive one or more of the Standing Orders, he may do so subject to such action being reported to the next meeting of the Board

4.1.2 at a meeting of the Board, at least half of the total number of Directors are present, such number to include on Non-executive Director

4.2 Any decision to waive Standing Orders shall be recorded in the minutes of the next meeting of the Board and shall be reported to the Audit Committee.

Amendment and Review

4.3 These Standing Orders shall be reviewed one year after approval by the Board and then at least annually thereafter.

4.4 These Standing Orders shall be amended only if:

4.4.1 the variation proposed does not contravene a statutory provision, the Terms of Authorisation or the Constitution; and

4.4.3 at least three quarters of the Board present and voting at a meeting of the Board are in favour of amendment.

4.4.4 The proposed amendment(s) has/have been discussed the Council.

4.5 All amendments to these Standing Orders shall be subject to approval through any process prescribed by Monitor.

ANNEX 6 – FURTHER PROVISIONS

1. INTERPRETATION

1.1 In these Provisions, the clauses relating to Interpretation in the Constitution shall apply and the words and expressions defined in the Constitution shall have the same meaning.

PART A – PROVISIONS RELATING TO THE BOARD OF DIRECTORS

2. APPLICATION OF PROVISIONS

2.1 These Provisions apply to all meetings of the Board of Directors ("the Board") and all other relevant activities of the Directors. All Directors and staff are required to abide by these Provisions, which also apply to any persons attending meetings of the Board.

2.2 Except where required by law or the constitution, at any meeting of the Board the Chairman (or in his absence, the person deputising for him) shall be the final authority on the interpretation of these Provisions (on which he should be advised by the Chief Executive and the Secretary).

2.3 Whilst the Secretary shall be responsible for ensuring that relevant staff are made aware of these Provisions, staff members are expected to familiarise themselves with the provisions.

2.4 In the event of any actual or suspected non-compliance with these Provisions, the person identifying such shall report it to the Secretary within 14 calendar days of the actual or suspected non-compliance being identified. The Secretary shall be responsible for taking action in respect of the report, which shall, where non-compliance is identified, include a report to the next scheduled meeting of the Board. Such a report shall be recorded in the minutes of the Board meeting.

3. APPOINTMENT AND REMOVAL OF DIRECTORS

The provisions of this Section 3 shall be subject always to the first paragraphs numbered 21 to 31 (inclusive) in this Constitution.

Chairman and Non-executive Directors

3.1 The Council of Governors ("the Council") shall in General Meeting appoint and, where necessary, remove (with the approval of three-quarters of the Council) the Chairman and Non-executive Directors.

Chief Executive

3.2 There shall be a Nominations & Remuneration Committee of the Board which shall be responsible for appointing the Chief Executive. When the Committee is considering the appointment of the Chief Executive, it shall comprise of the Chairman and as many of the Non-executive Directors as the Board decides. The Committee shall make a recommendation to the Chairman and the other Non-executive Directors, and their decision shall be subject to approval by the Council.

Executive Directors

3.3 The Board shall establish a Committee to appoint the Executive Directors. The Committee shall comprise of the Chairman, the Non-executive Directors and the Chief Executive. The Committee's decision shall be final.

Terms of Office and Process

3.4 There shall be written policies and processes, approved by the Board, to set out the process by which the Chairman, Non-executive Directors, Chief Executive and Executive Directors shall be appointed, and through which their terms and conditions of appointed shall be decided. In the case of the Chairman, Non-executive Directors and the Chief Executive, these policies and processes shall be subject to the approval of the Council.

3.5 Save for the initial Chairman and initial Non-executive Directors who shall be appointed for a term in accordance with Clause 23.4 of the Constitution, the Chairman and the Non-executive Directors shall be appointed for a term of three years. Subject to other relevant provisions in the Constitution, Non-executive Directors shall be subject to re-appointment thereafter at intervals of no more than 3 years. Non-executive Directors may serve for a term beyond 6 years subject to annual re-appointment. No Non-executive Director shall serve for a term of more than nine years in aggregate.

Appointments – Other Matters

3.6 No defect in the election or appointment of a Director nor any deficiency in the composition of the Board shall affect the validity of any act or decision of the Board.

3.7 The Trust may confer on a person the title "Director" as an indication of his seniority and/or the corporate nature of his responsibilities within the Trust but such a person shall not be an Executive Director of the Trust for the purposes of the 2006 Act unless he is a member of the Board of Directors as defined by the Constitution and, therefore, subject to clause 3.24 of Annex 6, he will have no right to vote at meetings of the Board.

Removal or Resignation from Office

3.8 A person shall not be eligible to become or continue in office as a Director if:

3.8.1 in respect of a Non-executive Director, he does not meet the criteria for eligibility in paragraph 21 of the Constitution;

3.8.2 in respect of any Director, any of the grounds contained in paragraph 27 apply to him;

3.8.3 he has within the preceding two years been lawfully dismissed otherwise than by reason of redundancy from any paid employment with a health service body;

3.8.4 he has had his name removed by a direction under Section 154 of the 2006 Act from any list prepared under Part 4 of that Act and has not subsequently had his name included in such a list;

3.8.5 Monitor has exercised its powers to remove him as a Director of the Trust or has suspended him from office or has disqualified him from holding office as a Director of the Trust for a specified period or Monitor has exercised any of those powers in relation to him on any other occasion whether in relation to the Trust or some other NHS Foundation Trust;

3.8.6 he has been placed on the registers of Schedule 1 Offenders pursuant to the Sexual Offences Act 2003 (as amended) and/or the Children and Young Person's Act 1933 to 1969 (as amended) and his conviction is not spent under the Rehabilitation of Offenders Act 1974;

3.8.7 he is incapable by reason of mental disorder, illness or injury in managing and administering his property and/or affairs;

3.8.8 he is a Governor of the Trust or a Director of another NHS Foundation Trust;

Termination of Tenure

3.9 A Director's term of office shall be terminated:

3.9.1 if he is a Non-executive Director and he gives notice in writing to the Secretary of his resignation from office at any time during that term of office;

3.9.2 if he is an Executive Director and he gives notice in writing to the Chief Executive of his resignation from office at any time;

3.10 Where a person has been appointed to the Board and he becomes disqualified from that appointment he shall notify the Secretary in writing of such disqualification as soon as practicable and in any event within 14 calendar days of first becoming aware of those matters which rendered him disqualified.

3.11 A Director whose tenure of office is terminated shall not be eligible for re-appointment for a period of three years from the date of his resignation or removal from office or the date upon which any appeal against his removal from office is disposed of whichever is the later except by resolution carried by a majority of the Board present and voting at a meeting.

3.12 Upon a Director resigning or ceasing to be eligible to continue in office that person shall cease to be a Director and his name shall be removed from the Register of Directors.

Vacancies

3.13 Where a Director resigns or his office is terminated, the vacancy shall be filled through the processes agreed as set out in clause 3.4 above.

4. DECLARATIONS AND REGISTER OF DIRECTORS' INTERESTS

4.1 In accordance with the Constitution, Directors are required to declare on appointment and in the manner prescribed below any direct or indirect pecuniary interest and any other interest which is relevant and material to the business of the Trust.

4.2 Such a declaration shall be made by completing and signing a form, as prescribed by the Secretary from time to time setting out any interests required to be declared in accordance with the Constitution or these Provisions and delivering it to the Secretary within 28 days of a Director's appointment or otherwise within seven days of becoming aware of the existence of a relevant or material interest. The Secretary shall amend the Register of Interests upon receipt of notification within one month.

4.3 If a Director is present at a meeting of the Board and has an interest of any sort in any matter which is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter and, if he has declared a pecuniary interest, he shall not take part in the consideration or discussion of the matter.

4.4 The term "relevant and material interests" may include (but may not be limited to) the following:

4.4.1 directorships, including non-executive directorships held in private or public limited companies (with the exception of those of dormant companies);

4.4.2 ownership or part-ownership or directorships of companies or other types of organisation which are likely to or are seeking to do business with the NHS;

4.4.3 a position of authority in a charity or voluntary organisation operating in the field of health and social care, including any which are contracting for or are commissioning NHS services;

4.4.4 any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks;

4.4.5 research funding/grants that may be received by an individual or their department;

4.5 Any traveling or other expenses or allowances payable to a Director in accordance with this Constitution shall not be treated as a pecuniary interest.

4.6 Subject to any other provision of this Constitution, a Director shall be treated as having an indirect pecuniary interest in a contract, proposed contract or other matter, if:

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

4.6.2 he is a partner, associate or employee of any person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the same.

4.7 A Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

4.7.1 of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body;

4.7.2 of an interest in any company, body, or person with which he is connected, which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

4.8 In the case of persons living together the interest of one partner or spouse shall, if known to the other, be deemed for the purposes of these Provisions to be also an interest of the other.

4.9 If a Governor has any doubt about the relevance of an interest, he must take advice from the Secretary.

5. STANDARDS OF CONDUCT

5.1 Subject to the 2006 Act (as amended and/or replaced from time to time), Directors shall comply with the terms of relevant Role Descriptions which shall be approved by the Board and, as set out in these Provisions, the Council, and which the Secretary shall issue to Directors upon appointment to the Board. The Directors shall comply with any codes of conduct or other standards referenced in Role Descriptions.

5.2 In the event that there are concerns about a Non-executive Director's performance or conduct, the Chairman, with the support of the Secretary where necessary, will address these directly with the Non-executive Director concerned. Where necessary, the Chairman will make recommendations to the Board, including in respect of any proposal that the Board should remove the Non-executive Director from office in which case the provisions of section 3 of these Provisions shall apply.

5.3 In the event that there are concerns about an Executive Director's performance or conduct, the Chief Executive, with the support of the Secretary and others where necessary, will address these directly with the Executive Director concerned. Where necessary, the Chief Executive will make recommendations and/or reports to the Board, including in respect of any proposal that the Board should remove the Executive Director from office in which case the provisions of section 3 of these Provisions shall apply.

6. REMUNERATION AND BUSINESS EXPENSES

6.1 The Trust is permitted to reimburse traveling expenses to Non-executive Directors for attendance at meetings of the Board, or for any other business authorised by the Chairman as being reasonably within the role and duties of a Non-executive Director, at a rate to be determined by the Council of Governors. The Chief Executive shall be responsible for authorising expenses incurred by Executive Directors, to be paid at a rate to be determined by the Chairman and Non-executive Directors.

6.2 A summary of expenses paid to Directors will be published in the Annual Report.

7. COMPOSITION AND ROLE OF BOARD OF DIRECTORS

7.1 All of the Board's business shall be conducted in the name of the Trust.

7.2 Subject to the 2006 Act (as amended and/or replaced from time to time), the role of the Board is defined in its Terms of Reference which shall be approved by the Board of Governors and the Board of Directors.

7.3 Subject to the 2006 Act (as amended and/or replaced from time to time), the composition of the Board shall be as set out in the Constitution.

7.4 Subject to the 2006 Act (as amended and/or replaced from time to time), the role of the Chairman and the role of Non-executive Director shall be as defined in Role Descriptions which shall be approved by the Council and the Board.

7.5 The Council shall appoint one of the Non-executive Directors to be Deputy Chairman. The role of the Deputy Chairman shall be as defined in a Role Description which shall be approved by the Council and the Board.

7.6 The Board shall appoint one of the Non-executive Directors to be the Senior Independent Director ("SID"). The role of Senior Independent Director shall be as defined in the Role Description which shall be approved by the Board.

8. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

8.1 Subject to the Constitution, Terms of Authorisation or any relevant statutory provision, the Board may make arrangements for the delegation, on behalf of the Board, of any of its powers to a committee of directors or to an executive director.

8.2 The Board shall delegate responsibility and authority on any terms which it considers to be appropriate, such terms to be defined in written terms of reference approved by the Board.

8.3 The Board's arrangements for the exercise of functions through delegation shall be set out within a Scheme of Delegation to be approved by the Board. This shall include delegation to Committees and to Officers, and shall specify those matters which are reserved to the Board to decide.

9. COMMITTEES OF THE BOARD

9.1 Subject to the 2006 Act (as amended and/or replaced from time to time), the Board shall establish an Audit Committee and a Nominations & Remuneration Committee, whose role, responsibilities and authority shall be defined in terms of reference to be approved by the Board in accordance with the first

paragraphs numbered 31 and 37 in this Constitution. The Board shall appoint the Chairmen and the Members of the Committees.

9.2 Subject to the constitution, the Terms of Authorisation and such binding guidance as may be given by Monitor, the Board may and, if so required by Monitor, shall appoint other committees of the Board consisting wholly or partly of Directors or wholly of persons who are not Directors. The Board shall not delegate any of its powers to such committees but committees may act in an advisory capacity to assist the Board in carrying out its functions.

9.3 These Provisions of the Board shall as far as they are applicable apply with appropriate alteration to any committees established by the Board.

10. PROFESSIONAL ADVICE

10.1 The Board shall have direct access to any independent advice which it considers necessary for the proper discharge of its functions, such advice normally being obtained by the Secretary. Such advice shall be commissioned through terms of reference to be agreed by the Board and may be presented in written form and/or by advisors attending meetings of the Board. The Trust shall meet the cost of any such advice commissioned by the Board. The Board shall establish a policy to set out the circumstances in which and the arrangements through which advice shall be taken and reported to the Board.

11. DIRECTORS AND GOVERNORS: WORKING ARRANGEMENTS

Engagement, Collaboration and Consultation

11.1 The Board and the Council shall agree work-plans for their meetings and activities, which shall be complementary and integrated. The work-plans shall identify the matters on which and, where possible, the timetable over which the Board and the Council shall consult each other about the business which they deal with. The work-plans shall take account of the Trust's strategy and business plans.

11.2 As a minimum, the Board shall consult the Council on the following matters:

11.2.1 proposals for the Trust's strategy and its annual Business Plan;

11.2.2 proposals for significant service developments;

11.2.3 the Trust's operational performance and delivery against plans generally;

11.2.4 service reviews and evaluations in respect of the Trust's services; and

11.2.5 development of the Trust's membership and plans for engagement with patients and the public generally.

11.3 The Board shall present to the Council the Trust's Annual Accounts, Annual Report and Auditors Report in accordance with the terms of this Constitution and of the 2006 Act.

11.4 The Board and the Council shall hold at least one joint meeting per year.

11.5 Directors and Governors may agree to attend each other's' meetings through a schedule to be agreed by the Board and the Council.

Informal Communication

11.6 The Chairman shall use his reasonable endeavours to promote communication between the Board and the Council, including through:

11.6.1 participation of the Board in the induction, orientation and training of Governors;

11.6.2 development of special interest relationships between Non-Executive Directors and Governors;

11.6.3 discussions between Governors and the Chairman and/or the Chief Executive and/or Directors through the office of the Chief Executive or his nominated officer;

11.6.4 involvement in membership recruitment and briefings at events organised by the Trust.

Formal Communication

11.7 Where it is otherwise necessary, such as where it is prescribed by the Constitution, Provisions, Terms of Authorisation or elsewhere, the Board and the Council shall communicate formally by the means set out below:

11.7.1 the Council may and, where required, shall at any time ask for matters to be referred to the Board. Any such referrals shall be made through the Chairman who shall arrange for the matter to be added to the agenda for the next scheduled meeting of the Board;

11.7.2 in the absence of the Council agreeing to refer a matter to the Board, any Governor may through the Chairman refer a matter to the Board of Directors but if the Chair declines to refer any such issue the said Governor may refer it provided that two thirds of the Governors present approve his request to do so. The Chairman shall then refer the matter to the Board and provide the response to the Council;

12. RESOLUTION OF DISPUTES

12.1 In the event of dispute between the Council and the Board then the dispute resolution procedure set out below shall be followed in order to resolve the matters concerned. The Council and the Board shall at all times recognise their roles and responsibilities as defined in the Constitution, Provisions, Terms of Reference and any other documents approved.

12.2 The Chairman or, in the event that the dispute is about the conduct or performance of the Chairman, the Senior Independent Director, shall endeavour through discussion with Governors and Directors or, if it is

considered to be more expedient, appointed representatives of them, to resolve the matter to the reasonable satisfaction of both parties.

12.3 In the event that it is not possible to resolve the dispute through the process described in 12.2 above, the Chairman or, in the event that the dispute is about the conduct or performance of the Chairman, the Senior Independent Director, shall appoint a special committee comprising equal numbers of Directors and Governors to consider the circumstances and to clearly and concisely produce a recommendation statement to the Council and to the Board with a view to resolving the dispute (the "Recommendation Statement").

12.4 The Chairman or, in the event that the dispute is about the conduct or performance of the Chairman, the Senior Independent Director, shall ensure that the Recommendation Statement, without amendment or abbreviation in any way, shall be considered at the next scheduled meeting of both the Council and the Board. Where it is considered necessary or expedient to convene a meeting of the Council or of the Board earlier than is otherwise scheduled then the Chairman shall do so and in this event the relevant provisions of Provisions shall apply.

12.5 If in the opinion of the Chair or, in the event that the dispute is about the conduct or performance of the Chairman, the Senior Independent Director, and following the further discussions prescribed in 12.4 there is no further prospect of a full resolution or, if at any stage in the process, in the opinion of the Chair or the Senior Independent Director (as the case may be) there is no prospect of a resolution (partial or otherwise) then he shall advise the Council and the Board accordingly. In the event that the dispute cannot be resolved, the decisions of the Board shall prevail. In the event that the dispute is resolved to the satisfaction of the Council and the Board the Board shall implement the decisions taken.

12.6 Nothing in this procedure shall prevent the Council, through the Lead Governor, from informing Monitor that in the Council's reasonable opinion its concerns are such that if they remain unresolved the Trust will be at risk of breaching the terms of its Authorisation.

PART B – MEMBERSHIP OF THE TRUST

13. ELIGIBILITY FOR MEMBERSHIP

General

13.1 An individual shall not be eligible for membership of the Trust if he:

13.1.1 fails or ceases to fulfill the criteria for membership of any of the constituencies;

13.1.2 was formerly employed by the Trust or the Applicant NHS Trust and in the preceding two years was lawfully dismissed other than by reason of redundancy;

13.1.3 has been involved as a perpetrator in a serious incident of violence or abuse in the last five years at any of the Trust's hospitals or against any of the Trust's Governors, Directors, staff members or patients;

13.1.4 has been placed on the registers of Schedule 1 Offenders pursuant to the Sexual Offences Act 2003 (as amended) and/or the Children & Young Person's Acts 1933 to 1969 (as amended) and his or her conviction is not spent under the Rehabilitation of Offenders Act 1974;

13.1.5 does not agree to abide by the Trust values as published by the Trust;

13.1.6 has been identified as a vexatious complainant or has been excluded from treatment at any of the Trust's hospitals due to unacceptable behaviour;

13.1.7 is deemed, in the reasonable opinion of the Trust, to have acted in a manner contrary to the interests of the Trust; or

13.1.8 is under the age of sixteen years.

13.2 It is the responsibility of members to ensure that they are eligible for membership but if the Trust is on notice that a member may be disqualified from membership, the Trust shall carry out all reasonable enquiries to establish whether or not this is the case.

13.3 Where an individual is held by the Trust to be ineligible and/or disqualified from membership of the Trust and disputes the Trust's decision in this respect, the matter shall be referred to the Secretary (or such other officer of the Trust as the Chief Executive may nominate) as soon as reasonably practicable thereafter.

13.4 The Secretary (or his nominated representative) shall:

(a) review the decision having regard to any representations made by the individual concerned and such other material, if any, as the Secretary considers appropriate;

(b) either confirm the decision or make some other decision as appropriate based on the evidence which he has considered; and

(c) communicate his decision and the reasons for it in writing to the individual concerned as soon as reasonably practicable.

13.5 If the member is aggrieved of the decision of the Secretary he may appeal in writing to the Council Governors ("the Council") within 14 days of the Secretary's decision. The Council shall consider the matter at its next meeting and its decision shall be final

Public Membership

13.6 For the purposes of determining whether an individual lives in a public constituency, an individual shall be deemed to do so if;

13.6.1 his name appears on the electoral roll at an address within the said area and the Trust has no reasonable cause to conclude that the individual is not living at that address; or

13.6.2 he Trust is otherwise satisfied that the individual lives within the said area.

Patient Membership

13.7 An individual shall be deemed to be eligible for membership of the patient constituency if:

13.7.1 his name appears on the Trust's systems as having been a patient in the period since 1 January 2008; or

13.7.2 he has been recorded by the Trust as having in the period since 1 January 2008 attended any of the Trust's hospitals as the carer of a patient; or

13.7.3 he can otherwise provide evidence of his having been a patient at any of the Trust's hospitals, or a carer of a patient, within the period since 1 January 2008. and in the reasonable opinion of the Trust the evidence is conclusive; and

13.7.4 he does not live within any of the areas defined as public constituencies.

Staff Membership

13.8 An individual shall be deemed to be eligible for membership of the staff constituency if he meets the eligibility criteria set out in the Constitution.

13.9 The members of the Medical and Dental Practitioners' staff class are individuals who are members of the staff constituency who are fully registered with their appropriate professional body, and, in the case of medical practitioners, who hold a licence to practice. For the avoidance of doubt the medical and dental practitioners' staff class shall also include junior doctors who are not yet fully registered with their appropriate professional body.

13.10 The members of the Nursing and Midwifery staff class are individuals who are members of the staff constituency and whose regulatory body, the Nursing and Midwifery Council, falls within the remit of the Council for the Regulation of Health Care Professions established by section 25 of the NHS Reform and Health Care Professionals Act 2002

14. APPLICATION FOR MEMBERSHIP

14.1 Where a person wishes to apply to become a member of the Trust, the following procedure shall apply

14.1.1 the Trust shall upon request supply him with a form of application for membership in a form determined by the Trust;

14.1.2 upon receipt of the said form of application duly completed and signed by the applicant (or in the Trust's discretion signed on behalf of the applicant) the Trust shall as soon as is reasonably practicable and in any event within 28 working days of receipt of the duly completed form consider the same;

14.1.3 unless the applicant is ineligible for membership or is disqualified from membership, the Trust shall cause his name to be entered on the Trust's Register of Members and shall give notice in writing to the applicant of that fact;

14.1.4 upon the applicant's name being entered on the Trust's Register of Members he shall become a member;

14.1.5 the information to be included in the Trust's Register of Members shall include the following details relating to that member:

(a) his/her full name and title;

(b) his/her date of birth;

(c) his/her full postal address;

(d) his/her home telephone number (if any);

(e) his/her email address (if any);

(f) the constituency and, where relevant, the area or class of which he/she is a member;

(g) the date upon which he/she became a member;

(h) his/her gender and ethnicity, and

14.2 For the avoidance of doubt and subject to the restrictions on making available register at paragraph 34.2 of the Constitution, where a member of the public makes a request to inspect the Register of Members, pursuant to paragraph 34 of the Constitution (Registers – inspection of copies), the Trust shall disclose only those parts of the Register that detail the members' names, constituency, and, where relevant, their area or class within that constituency in accordance with paragraph 20 and paragraph 22(3) of Schedule 7 of the 2006 Act.

15. REGISTER OF MEMBERS

15.1 For the avoidance of doubt, an individual shall become a member on the date upon which his/her name is entered on the Trust's Register of Members and shall cease to be a member upon the date on which his/her name is removed from the Register of Members as provided for in this Constitution.

15.2 The Register of Members and all other Registers shall be maintained in accordance with this Constitution or in accordance with the 2006 Act. The Registers shall be reviewed and updated regularly and, in the case of the Register of Members, within 14 days of receipt of any new or amended information about members.

15.3 Where in the reasonable opinion of the Trust a member is no longer eligible or is disqualified from Membership of the Trust it shall be entitled to remove the name of that individual from the Register of Members and that individual shall thereupon cease to be a Member provided always that this power shall not be exercised until the Trust has given not less than fourteen days written notice to the member addressed to him at the address given in the Register of Members of its intention to remove him from the Register and that member has not within that period notified the Trust of his wish to continue as member and provided proof satisfactorily to the Trust of his continued eligibility.

16. TERMINATION OF MEMBERSHIP

16.1 A person shall cease to be a member if:

1.16.1 he resigns by notice in writing to the Trust;

1.16.2 he ceases to be entitled under this Constitution to be a member of any area within the Public Constituency or of any of the classes of the Staff Constituency or the areas of the Patient Constituency;

1.16.3 he is expelled from membership in accordance with the provisions of this Constitution;

1.16.4 he dies.

16.2 An individual who is a member of the Public Constituency shall cease to be eligible to continue as a member if he ceases to live in the area of the Public Constituency of which he is a member save as provided elsewhere in these rules. In the event that a member moves to another Public Constituency area and requests to be a member in that area, if the Trust is satisfied that the individual concerned lives in such other area, that individual shall thereafter be treated as a member of that other area within the Public Constituency.

16.3 Where an individual is a member by virtue of their eligibility to be a member of a Staff Class and they cease to be eligible for membership of that Staff Class but are eligible for membership of some other Staff Class, then the Trust may give notice to that member of its intention to transfer him to that other Staff Class on the expiration of a period of time or upon a date specified in the said notice and shall after the expiration of that notice or date amend the Register of Members accordingly.

PART C – OTHER PROVISIONS

17. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

17.1 The Common Seal of the Trust shall be kept by the Chief Executive or designated officer in a secure place.

17.2 The seal of the Trust shall not be affixed to any documents unless the sealing has been authorised by a resolution of the Board, a committee, or, where the Board so decides, one or more Officers. The seal shall only be affixed in the presence of two Directors.

17.3 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose and shall be signed by those who attested the seal. A report of all sealings shall be made to the Board at least quarterly. (The report shall contain details of the seal number, a description of the document and the date of sealing).

18. SIGNATURE OF DOCUMENTS

18.1 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.

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

19. SECRETARY

19.1 The Trust shall have a Secretary, who may be an employee. The Secretary shall not be a Governor, or the Chief Executive or the Finance Director.

19.2 The Secretary shall be appointed and, where necessary, removed only by the Chairman and Chief Executive acting jointly, who shall report their actions to the Board and the Council.

19.3 The Secretary's functions shall be set out within a Job Description which shall be approved by the Chairman and the Chief Executive.

20.0 INDEMNITY FOR GOVERNORS, DIRECTORS AND THE SECRETARY

20.1 Members of the Council and the Board and the Secretary, who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their duties, save where they have acted recklessly. Any costs arising in this way will be met by the Trust and the Trust shall have the power to purchase suitable insurance or make appropriate arrangements with the National Health Service Litigation Special Health Authority to cover such costs.

ANNEX 8

Role Description for Trust Governor

Job Title: Trust Governor, Western Sussex Hospitals Foundation Trust

Accountable to: Chairman and Council of Governors

Job Summary: Governors are elected by members or appointed by partner organisations to be members of the Council of Governors. The Council has certain statutory responsibilities; contributes to the development of the Trust's strategies; holds the Non-Executive Directors to account for the performance of the Trust and represent the views of members, partner organisations and the public, and provide feedback to them on the Trust's plans and performance.

Statutory Responsibilities

- Appoint and, if appropriate, remove the Chair
- Appoint and, if appropriate, remove the other Non-Executive Directors
- Decide the remuneration and allowances and other terms and conditions of office of the Chair and other Non-Executive Directors
- Approve (or not) the appointment of a new Chief Executive
- Approve and, if appropriate, remove the Trusts auditor
- Receive the Trusts Annual Accounts and Annual report at a general meeting of the Council of Governors
- Hold the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors
- Represent the interests of the members of the Trust
- Approve Significant Transactions as defined by NHS Improvement guidance
- Approve an application by the Trust to enter into a merger or acquisition
- Decide whether the Trust's non-NHS work would significantly interfere with its principal purpose; and
- Approve amendments to the Trust's Constitution

Duties and Responsibilities

The Trust's elected and appointed Governors are expected to:

1. Engage actively with members (or, for appointed Governors, the management of the appointing organisation) to understand and to represent to the Board the views of the members/appointing organisation;

2. Through engagement, feedback to members/appointing organisations the Trust's progress against plans and priorities, its operational performance and its proposals for strategic direction in the future;

3. For elected Governors, take a leading and active role in engaging with members in their constituencies, particularly when the Board consults the Council on matters such as plans, priorities and service reviews;

4. Support events such as stakeholder and medicine for all meetings and engage with members and the public;

5. Attend events to recruit new members of the Trust;

6. Contribute actively and constructively to the activities of the Council (as defined in

the Terms of Reference), particularly in respect of its statutory and regulatory duties and powers, including by preparing for and attending meetings of the Council and any Committees or working groups it establishes;

7. Acknowledge the role of the Board in setting strategy and directing the work of the Trust, with Governors having the opportunity to comment upon draft strategies;

8. Develop and act to maintain a constructive and positive working relationship with the Board, particularly in respect of joint meetings, consultation on the Board's plans and strategies and when the Council is exercising its formal powers in relation to the Board;

9. Actively participate in the work of any panel; group or working party that you join;

10. Act at all times in the best interests of the Trust and maintain the highest standards of integrity, confidentiality and probity, including by declaring any relevant interests in accordance with the requirements of the FT Constitution and any policies which the Trust establishes;

11. Adhere to the Trust's values and comply with the FT Constitution, Standing Orders, Code of Conduct and all other relevant requirements;

12. Wherever possible, participate in reasonable and necessary training and development activity (individually and/or collectively) as agreed with particular Governors and with the Council;

13. Wherever possible, respond positively to any other requests for contributions or engagement which the Board might reasonably make in relation to the role of Governors.

Attributes, Skills and Experience

The Trust recognises the importance of establishing an effective Council of Governors who have the skills and experience necessary to make a significant contribution to the future of the organisation, including holding the Board to account.

Therefore, the Trust expects that, with support and training where necessary, Governors will be able to:

- make an active and constructive contribution at meetings of the Council, focusing on the issues under consideration and not representing single-issue groups or otherwise acting outside the best interests of the Trust;

- develop and maintain a constructive working relationship with the Chairman, other Governors, the Board and staff;

- engage in an active, constructive and professional manner with members and other stakeholders in the community;

- understand, interpret and comment upon performance and other information presented by the Board;

- demonstrate a commitment to the Trust, its patients and the role of the Council in ensuring continuous improvement and development of the organisation.

Commitment
The minimum statutory requirement is that Governors attend the Council of Governors meetings each year. However, to make a full and constructive contribution Governors are expected to attend as a minimum:

- the Council of Governors meetings
- Pre-Council of Governors meetings Non-Executive Director/Governor Meetings
- Joint Board and Governor Workshops
- The Trust Annual General Meeting .

Governors will benefit from attending Chair/CEO Briefings; Governor Information Seminars and any training events provided by the Trust.

The Governor role can be enriched by taking opportunities to meet with patients and by being a member of either the Membership and Engagement Committee or the Patient Engagement and Experience Committee.

From time to time Governors are invited to join working parties, advisory groups, etc. A Governor choosing to do so, is expected to play a full and active role and report to Council as appropriate.

Governors must be willing to travel to any of the hospitals in the Trust as required.

It is anticipated that Governors should be able to devote 20 – 40 hours a month on Trust Governor Business, including time reading papers, responding to emails and preparing for meetings

New Governors will be “buddied” by more experienced Governors and likewise will be expected to buddy new Governors in their turn. Governors will also have the opportunity to work with Ambassador Members to recruit new Members of the Trust and support Membership event.

Eligibility for Election/Appointment
The FT Constitution and Provider License set out the criteria for eligibility for election or appointment to the Council, together with the terms of office. The constitution is compliant with and drawn from relevant legislation and NHS Improvement’s regulatory requirements.
In summary you must be a member of the Trust and be a fit and proper person. Governors can only serve a maximum of two consecutive terms of three years within the same constituency.

ANNEX 8

Lead & Deputy Lead Governor

Role Description

Accountability:

The Lead and Deputy Lead Governors are accountable to the Council of Governors collectively as a serving Member of the Council.

The Role:

- To be an external point of contact for NHS Improvement (formerly Monitor) where it may be considered inappropriate for the Chairman or his nominated deputy, or for the Company Secretary to deal with a particular matter.

- To facilitate communications and a good working relationship between the Governors and the Executive Board and Trust Board including acting as the principle independent channel for communications between the Governors and Executive Board and Trust Board through the Chairman, Chief Executive, Company Secretary or Senior Independent Director.

- To consult routinely with the Governors, Chair and Company Secretariat regarding the planning and preparation of the Council of Governors agenda.

- To be a member of the Nominations and Remuneration Committee.

- To contribute to the appraisal of the Chairman by the Senior Independent Director, supported by the Company Secretary, in accordance with the process determined by the Council of Governors including the collation of input from other Governors and the Nominations and Remuneration Committee on the performance of the Chairman.

- Contribute to the determination of the appraisal process of the Non-executive Directors to be undertaken by the Chairman and supported by the Nominations and Remuneration Committee.

- To recommend to the Council of Governors on behalf of the Nominations and Remuneration Committee any appointments/reappointments of Chair; Non-executive Directors and/or the Chief Executive.

- To take an active role in the activities of the Council of Governors and to meet with the Chairman and Company Secretariat on a regular basis to discuss relevant issues.

- Support the Chairman and Company Secretary in any action to remove a Governor due to unconstitutional behaviour in accordance with the Code of Conduct.

- To be involved in the induction process for any newly appointed Public Governor.

- The Lead Governor may call upon the support of the other Governors, the Chairman, the Company Secretary and the Senior Independent Director to carry out their role effectively to the benefit of the Council of Governors.

- In liaison with the Chairman and Company Secretary, support the development of the skills and strengths of the Council of Governors and raise public awareness of all Governors.

- To chair meetings of Council of Governors where the Trust Chair, Vice-Chair or other Non-Executive Director cannot chair the meeting due to a conflict of interest.

- Where approved by the Council and/or the Chairman speak for and represent the Council at the AGM and on other occasions

- Other duties as requested by the Council of Governors or the Chairman.

- Chair the Pre-Council of Governors meeting and any informal meetings.

The Person:

To fulfil this role effectively, the Lead Governor will need to:

- Be a publically elected Governor

- Have the confidence of Governor colleagues and members of the Executive Board and Trust Board

- Be able to forge constructive working relationships with colleagues

- Understand NHSI's role, the available guidance and the basis upon which NHSI may take regulatory action

- Be committed to the success of the Foundation Trust and understand the Trust's Constitution

- Have the ability to influence and negotiate

- Be able to present a well-reasoned, unbiased argument

- Demonstrate ability to maintain confidentiality of information.

The Appointment:

The tenure is one financial year with the option for re-election annually in accordance with due process, for up to the full tenure period of the elected Governor's 'appointment'.

In accordance with a process agreed by the Council of Governors, the Company Secretariat will administer an annual nomination and election/re-election procedure that will require: -

- Submission of an expression of interest (for re-election and for new election candidates)

- Submission of a statement for support of no more than 250 words supporting candidature (only for NEW nominations and/or contested elections);

- Election by 'show of hands' or by secret ballot as determined by the relevant Council meeting.

Additional:
The Lead Governor will work closely with and be supported and deputised for by a Deputy Lead Governor whose appointment will follow the same procedure above. It is anticipated, where terms of office accord, that the Deputy Lead Governor will put themselves forward for Lead Governor position when that position becomes vacant, remaining subject to the appointment process above.

NHS
Western Sussex Hospitals
NHS Foundation Trust

Code of Conduct for Governors

1.00 INTRODUCTION

1.01 The Council of Governors (the Council) in support of the individual governors has established a Code of Conduct for Governors which codifies the expectations of its individual Governors and the process which will be followed should there be a need to consider if a Governor has deviated from this Code.

2.00 FRAMEWORK FOR COUNCIL OF GOVERNORS

2.01 The Foundation Trust operates within a legal, regulatory and governance framework established by the NHS Act 2006, the Health &Social Care Act 2012, Monitor's Code of Governance and Compliance Framework (and other regulatory requirements) and the Trust's Constitution. The Constitution defines the membership of the Council and defines the arrangements for appointing (and where necessary, removing) Governors.

2.02 This regulatory and governance framework is supplemented by the Code of Conduct for Governors and the Role Description for Governors, both of which reflect the statutory responsibilities for the Council. It should be noted that nothing within this Code of Conduct shall take precedence over or in any way amend the Constitution or any regulatory requirements.

3.00 ROLE OF THE COUNCIL OF GOVERNORS

3.01 The role of the Council is defined in law and in Monitor's regulatory and governance framework, including the Constitution. Although the role is not repeated here it is important as context for this Code of Conduct to recognise that it is essential for the good governance of the Foundation Trust for the Council and the Board of Directors (the Board) to engage actively and constructively. Such an approach will ensure that the Council is able to contribute to the development of the organisation's strategy and plans, approve transactions where appropriate, hold the Non-executive Directors to account (for the performance of the Board), and represent to the Board the views of members and the public. This approach will also ensure that the Board takes into account the views of the Council – for example, in relation to the Trust's strategy - and that it seeks the Council's timely approval for transactions and other proposals as defined in the Constitution.

4.00 BOARD OF DIRECTORS/COUNCIL OF GOVERNORS ENGAGEMENT

4.01 The Terms of Reference for the Board and for the Council (and relevant Role Descriptions) state that the Board and Council will engage actively and constructively, recognising the Board's responsibility for determining the Trust's strategy and for directing and controlling the organisation. The Terms of Reference and the Constitution commit to a jointly-agreed work-plan to set out for each financial year the way in which the Board and the Council will work together. This will ensure that the Board and the Council consider business in a co-ordinated way, ensuring that the Council has the opportunity to comment on or approve (as appropriate by reference to the Constitution) proposals at the correct time.

4.02 This Code of Conduct commits the Council as a whole and Governors

individually to engaging proactively and constructively with the Board, acting through the Chairman, Senior Independent Director and any Lead Governor where appropriate according to their roles. The Council will work with the Board for the best interests of the Trust as a whole, taking into account all relevant advice and information presented to or requested by the Council. The Council will not unduly delay responses to proposals from the Board, acting proactively to agree with the Board the information which the Council will need in order properly to consider proposals.

5.00 CONDUCT OF GOVERNORS

5.01 This section of the Code sets out the conduct which all Governors agree to abide by. These commitments are in addition to compliance with Monitor's requirements, the Code of Governance, the Constitution, Terms of Reference for the Council and Role Description for Governors.

Personal Conduct

5.02 Governors agree that they will:

a) act in the best interests of patients and the Trust as a whole in the delivery of services within relevant financial and operational parameters;

b) be honest and act with integrity and probity at all times;

c) respect and treat with dignity and fairness, the public; patients; relatives; carers; NHS staff and partners in other agencies;

d) not seek to profit from their position as a Governor or in any way use their position to gain advantage for any person;

e) respect and value their fellow Governors as colleagues;

f) ensure that no person is discriminated against on grounds of religion or belief; ethnic origin; gender; marital status; age; disability; sexual orientation or socio-economic status;

g) show their commitment to team working by working constructively with their fellow Governors and the Board as well as with their colleagues in the NHS and the wider community;

h) accept responsibility for their actions and generally take seriously the responsibilities which are commensurate with the decision-making rights assigned to the Council through the legal and regulatory framework;

i) seek to ensure that the best interests of the public; patients; carers and staff are upheld in decision making and that those decisions are not influenced by gifts or inducements or any interests outside the Trust;

j) not make, permit or knowingly allow to be made any untrue, misleading or misrepresentative statement either relating to their own role or to the functions or business of the Trust;

k) at all times, uphold the values and core principles of the NHS and the Trust as set out in its Constitution;

l) conduct themselves in a manner which reflects positively on the Trust and not in any manner which could be regarded as bringing it into

disrepute, whether they are on Trust property or fulfilling their public function in the wider community;

m) seek to ensure that the membership of the constituency from which they are elected is both properly informed and represented, or if they are appointed, then the body from which they are appointed is both properly informed and represented;

n) at all times, uphold the seven principles of public life as set out by the Committee on Standards in Public Life (also known as the Nolan Committee and the Wicks Committee) as below:

Selflessness: Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves; their family or friends or other interested parties.

Integrity: Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity: In carrying out public business, including making public appointments; awarding contracts or recommending individuals for awards or benefits, holders of public office should make choices on merit.

Accountability: Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness: Holders of public office should be as open as possible about all the decision and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty: Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership: Holders of public office shall promote and support these principles by leadership and example.

o) seek advice from the Chairman or the Company Secretary on matters relating the Constitution, governance requirements or conduct, and have regard to the advice given to them.

Confidentiality

5.03 Governors will respect the confidentiality of the information to which they are made privy to as a result of their membership of the Council, except where information is made available in the public domain.

5.04 Governors will understand, endorse and promote the Trust's Information Governance and Security Policy in every aspect of their work.

5.05 Governors will make no public statements on behalf of the Trust or communicate in any way with the media without the prior consent of the Chairman or a designated officer from the Trust's Communications department.

Declaration of Interests

5.06 It is essential for good corporate governance and to maintain public confidence in the Trust that all decision making is robust and transparent. To support this, the Constitution and the Trust's Policy on Declaration of Interests set out requirements for Governors to declare relevant interests (as defined in the Constitution). Governors have a statutory responsibility to avoid interests which may conflict with the interests of the Trust.

5.07 Governors will declare interests on request from the Secretary or, as required by the Constitution, whenever they become aware of a potential conflict of interest in respect of a matter being considered by the Council. Governors should seek advice from the Secretary or the Chairman where they are unsure as to whether an interest needs to be declared. Declared interests will be included in a Register of Interests, which will be published.

6.00 PARTICIPATION IN MEETINGS AND IN TRAINING AND DEVELOPMENT

6.01 The Council is required by the Constitution to hold meetings as required each year. The schedule for these meetings and for other activities will be proposed by the Secretary and is subject to approval by the Council. Governors will attend meetings of the Council, and of any committees or working groups to which they are appointed, or they will give apologies for absence where they are not able to attend. 6.02 The Trust has a statutory duty to support the Council to discharge its responsibilities, including through training and development for Governors. A programme of development and information seminars will be developed each year and it is expected that Governors will participate in such activities.

7.00 UPHOLDING THIS CODE OF CONDUCT

7.01 The Constitution provides that where there are concerns as to the conduct or performance of a Governor these are to be addressed in the first instance by the Chairman, with support from the Secretary, to include training and development where is considered relevant and necessary. Where such concerns exist the Chairman will write to the Governor concerned to set out the concerns and the action agreed to rectify or otherwise address them.

7.02 The Constitution provides for the circumstances in which a Governor can be removed from office, including where any Governor fails to comply with this Code of Conduct. It is for the Chairman to propose removal from office if this is necessary after all other course of action, including training and development where relevant, have been exhausted. As required by the Constitution, it is for the Council to determine (in accordance with rules set out in the Constitution) whether any Governor should be removed from office following a proposal from the Chairman.

Process for investigating potential non-compliance with this Code

7.03 The process outlined below is to provide a framework for reviewing any alleged Non-Compliance together with key principles to be followed. It should be noted that this process applies to all Governors irrespective of category (Public, Patient, Staff or Appointed).

7.04 Should a member of the Trust or a member of the Council of Governors be made aware that the behavior of a Governor is such that there may be a breach of the Code of Conduct they should inform the Chair or the Company Secretary as soon as possible. Upon receipt of such a notification the Chair will determine within 7 working days whether there is a prima facie case to address.

7.05 If the Chair in consultation with the Lead Governor (expect if the referral is about the Lead Governor and in this case this would be in consultation with the Deputy Lead Governor) believes there is a case the Governor concerned will be notified

and an initial investigation will be undertaken by a Governors Compliance Committee which will be convened for the purpose of investigating the complaint. The Governors Compliance Committee will consist of the Chair, 1 Staff Governor, I Public/Patient Governor and 1 Appointed Governor (a total of 3 Governors). The Governors' Compliance Committee will not include any person who has already been involved in the complaint process.

7.06 An initial investigation will be conducted this will be undertaken by the Company Secretary or an appropriate member of their team. The Initial investigation will seek to gather appropriate statements from the 'complainant' and/or witnesses. This should normally be completed within 15 working days.

7.07 Once information has been gathered the Governor concerned will be invited to meet with the Governors Compliance Committee to respond to the issues. For personal support, on a non-professional basis, the governor may choose at all times to be accompanied. The Committee should meet within 10 working days of the completion of the investigation.

7.08 The purpose of Governors Compliance Committee meeting will be to establish whether there is sufficient information upon which a complaint could be upheld. At the conclusion of the meeting the Committee will decide if the matter should be referred to the Council and the Committee will make a recommendation to the Council in respect of the Governor. The recommendation to the Council of Governors will include the sanctions they deem appropriate. Such sanctions may range from the issuing of a written warning as to the Governor's future conduct and consequences, a requirement to undertake training, the suspension and/or removal of the Governor from office.

7.09 Following the Governors Compliance Committee meeting the Governor under investigation will be formally written to within 5 working days setting out the recommendation prior to presentation to the Council.

7.10 The Council will in considering the most serious of sanctions (suspension / removal) require the stated level of support from the Governors (2/3rds of ALL governors). For all other sanctions the normal simple majority of those in attendance will be required.

7.11 The Monitor Code of Governance, P34 para B.6.6 will apply. " Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be requested to consider the evidence and determine whether the proposed removal is reasonable or otherwise."

7.12 All statements and reports to the Governors Compliance Committee and the Council will be held by the Company Secretary team.