Excellence as our standard

NHS
North Tees and Hartlepool
NHS Foundation Trust

Board of Directors Meeting

Thursday 4 April 2023

at 9:00am

Boardroom

University Hospital of Hartlepool

North Tees and Hartlepool
NHS Foundation Trust

University Hospital of North Tees
Hardwick
Stockton on Tees
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28 March 2024

Dear Colleague

A meeting of the **Board of Directors** will be held in public, on **Thursday, 4 April 2024 at 9.00am** in the **Boardroom, University Hospital of Hartlepool.**

Yours sincerely

Professor Derek Bell, OBE
Joint Chair

Agenda

			Led by
1.	(9.00am)	Apologies for Absence	Chair
2.	(9.00am)	Declaration of Interest	Chair
3.	(9.00am)	Learning from Lived Experience	L Robertson
4.	(9.30am)	Minutes of the meeting held on, 1 February 2024 **(enclosed)**	Chair
5.	(9.45am)	Matters Arising and Action Log **(enclosed)**	Chair
Items for Information			
6.	(9.55am)	Report of the Group Chair **(enclosed)**	Chair
7.	(10.05am)	Report of the Group Chief Executive **(enclosed)**	S Hunter
8.	(10.15am)	Retrospective approval of documents executed under seal **(enclosed)**	N Atkinson
Governance			
9.	(10.20am)	Constitution Approval **(enclosed)**	S Irvine
10.	(10.30am)	Group Board Delegation **(enclosed)**	S Irvine
Items to Receive			
11.	(10.45pm)	Pathology Managed Service Contract **(enclosed)**	N Atkinson

12.	Assurance Report of Risk Management Group **(enclosed)**	N Atkinson

13. (10.55am) Any Other Business

Date of next meeting
(**To be confirmed**)

Glossary of Terms

Strategic Aims and Objectives

Putting Our Population First

- Create a culture of collaboration and engagement to enable all healthcare professionals to add value to the healthcare experience
- Achieve high standards of patient safety and ensure quality of service
- Promote and demonstrate effective collaboration and engagement
- Develop new approaches that support recovery and wellbeing
- Focus on research to improve services

Valuing Our People

- Promote and 'live' the NHS values within a healthy organisational culture
- Ensure our staff, patients and their families, feel valued when either working in our hospitals, or experiencing our services within a community setting
- Attract, Develop, and Retain our staff
- Ensure a healthy work environment
- Listen to the 'experts'
- Encourage the future leaders

Transforming Our Services

- Continually review, improve and grow our services whilst maintaining performance and compliance with required standards
- Deliver cost effective and efficient services, maintaining financial stability
- Make better use of information systems and technology
- Provide services that are fit for purpose and delivered from cost effective buildings
- Ensure future clinical sustainability of services

Health and Wellbeing

- Promote and improve the health of the population
- Promote health services through full range of clinical activity
- Increase health life expectancy in collaboration with partners
- Focus on health inequalities of key groups in society
- Promote self-care

North Tees and Hartlepool NHS Foundation Trust

Minutes of a meeting of the Board of Directors held in Public on Thursday, 1 February 2024 at 9.00am at the University Hospital of North Tees / Via Video Link

Present:

Professor Derek Bell, Group Chair*	DB
Stacey Hunter, Group Chief Executive* (Items 1 to 16 only)	SH
Ann Baxter, Vice Chair/Non-Executive Director*	AB
Chris Macklin, Non-Executive Director*	CM
Fay Scullion, Non-Executive Director*	FS
Alison Fellows, Non-Executive Director* via video link	AF
Professor Liz Barnes, Non-Executive Director*	LB
Neil Atkinson, Managing Director*	MD
Dr Elaine Gouk, Interim Chief Medical Officer*	ICMO
Kate Hudson-Halliday, Acting Director of Finance*	ADoF
Lindsey Robertson, Chief Nurse/Director of Patient Safety and Quality*	CN/DoPS&Q
Rowena Dean, Acting Chief Operating Officer	ACOO
Gary Wright, Deputy Chief People Officer*	DCPO
Stuart Irvine, Director of Strategy, Assurance & Compliance/Company Secretary	DoSA&C/CS

In Attendance:

Mel Cambage, Associate Director of Nursing Experience and Improvement (Item 3 only)
Lynne Calder, Senior Clinical Matron (Item 3 only)
Stephanie Worn, Associate Director of Midwifery (Item 16 only)
Jules Huggan, Freedom to Speak Up Guardian (Item 19 only)
Ruth Dalton, Deputy Director of Communications, Engagement & Marketing (Items 1 to 16 only)
Angela Warnes, Lead Governor via video link
Mike Scanlon, Elected Governor for Hartlepool
Alan Smith, Elected Governor for Hartlepool via video link
Paul Garvin, Elected Governor for Stockton
Rachel Farmer, Member of the Public
Heidi Holliday, Secretary to the Trust Board [note taker]

BoD/5201 Apologies for Absence / Welcome

The Joint Chair welcomed everyone to the meeting and introduced Stacey Hunter the newly appointed Group Chief Executive.

Apologies for absence were reported from Susy Cook, Chief People Officer/Director of Corporate Affairs.

BoD/5202 Declaration of Interests

The Chair of the meeting referred to the Trust's declaration of interest register and asked attendees if any new declarations needed to be noted. The Chair noted there were no perceived conflicts of interest from the agreed agenda. Should a conflict arise during the course of the meeting, affected individuals should raise the conflict and a decision would be made to ensure appropriate action was taken.

BoD/5203 Learning from Lived Experience

The CN/DoPS&Q welcomed Lynne Calder, Senior Clinical Matron and Mel Cambage, Associate Director of Nursing Experience and Improvement to the meeting regarding the Virtual Frailty Ward (VFW) explaining she had had the opportunity to recently use the service from a personal perspective and observed the patient centred, safe care being provided.

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* voting member

An overview of the Hospital at Home Frailty Team, also known as the Virtual Frailty Ward (VFW) was provided. The team provided an early supportive discharge/admission avoidance service to enable frail patients to be supported to recover within their own home, including nurse led care provision, one to one support overnight, daily MDT and digital monitoring linked to triage and pharmacy assessments. The service also received direct GP referrals and accessed the North East Ambulance Service (NEAS) dispatch stack for suitable patients.

Patient studies were being shared with GPs and Consultants to raise their understanding of the service and feedback from GPs to date had been positive. A discussion ensued with a number of queries regarding the service.

It was agreed data regarding the number of avoided admissions would be shared at a future meeting as there was ongoing work including, dashboards and episodes of care which were being discussed at the Quality Committee and a future celebration of the service was being planned.

In respect of the volume of beds being saved in the hospital and patients being supported in the community, it was reported there had been 24 beds saved the previous week and expansion of the pathways into other areas linked to day case, surgery and elective care was being considered. A meeting was scheduled for Monday, 5 March 2024 to discuss this further and engagement to date had been positive.

The Board of Directors agreed to be advocates of the service and would raise awareness of the service and in particular, the Step Down service.

Regarding the ambulance dispatch stack, it was explained that there was no category limit regarding eligible patients with category 2, 3 and 4 patients being taken during winter. However, it was noted that it was harder to take patients when there was less service pressure. It was reported that work was ongoing with South Tees Hospitals NHS Foundation Trust (STHFT) to agree a rota across the region.

The Group Chief Executive requested an opportunity to shadow the team at a later date.

The Board of Directors thanked Lynne Calder and Mel Cambage for the presentation and thanked the Team for their work.

Resolved: (i) that, the story be noted; and
(ii) that, further information regarding data of the number of admissions avoided be shared at a future meeting; and
(iii) that, the Group Chief Executive be invited to shadow the team at a later date.

BoD/5204 Minutes of the meeting held on, Thursday, 9 November 2023

Resolved: that, the minutes of the meeting held on, Thursday, 9 November 2023 be confirmed as an accurate record.

BoD/5205 Matters Arising and Action Log

There were no matters arising from the minutes of the previous meeting and an update was provided against the action log.

Resolved: that, the update be noted.

BoD/5206 Report of the Joint Chair

A summary of the Joint Chair's report was provided with key points highlighted.

- An important event due to take place in February was the signing of the Group Partnership Agreement, which would be attended by Sir Liam Donaldson, Chair, North East and North Cumbria Integrated Care Board (NENC ICB).

- An Education, Training & Workforce Event was scheduled to take place on Wednesday, 21 February 2024 with Universities and STHFT to discuss future collaborative working.
- Following guidance issued by NHS England regarding the new Fit and Proper Person Test (FPPT) Framework, it was reported that the updated FPPT had been undertaken for all Board and Director level staff at the Trust and the Joint Chair had authorised the required submission to NHS England confirming there were no issues to report.
- Joint Board and Governor Walkabouts continued with another successful walkabout taking place on Thursday, 18 January 2024. Positive feedback included great culture and energy and commitment from staff.
- On Wednesday, 5 June 2024 the Trust would be holding its next Volunteer Service Thank You Event, which would be taking place during Volunteer Week and invitations were to be extended to colleagues at STHFT.

Resolved: that, the content of the report be noted.

BoD/5207 Joint Partnership Board Update

The Vice Chair presented the Joint Partnership Board (JPB) Update Report and highlighted the key issues.

- Four key papers were discussed including an update from the Company Secretaries relating to the Governance workstream and the planning of robust governance arrangements, a presentation on the consultation process to form a joint Executive Team for the Group, an update from the Clinical Strategy Event held on 24 January 2024 and an engagement plan and finance update.
- Work continued with the Communications Team regarding the name of the Group. The survey closed the previous day and an update on that was to be provided at the next meeting.
- The Joint Chair was working with the Non-Executive Directors to identify ways to support the team going through the process.

The Group Chief Executive thanked the Executive Directors and colleagues going through the consultation process for their positive engagement. Whilst it was an uncertain and challenging time, the hope was to retain as much talent in both trusts as possible and to transition in a safe and proactive way.

Resolved: (i) that, the content of the report be noted; and
(ii) that, an update from the Group name survey be provided at the next meeting.

BoD/5208 Report of the Managing Director

The MD presented the Report of the Managing Director and highlighted key points.

- Operational pressures were being seen across the Trust with bed occupancy increased to approximately 97%, all resilience beds opened and an increase in the number of super stranded patients. The Trust was however, continuing to deliver above the national standard of 70% for the Urgent 2 Hour Community response
- Following a procurement exercise undertaken by the NENC ICB for an integrated Urgent and Emergency service across Teesside, the Trust and its partners (STHFT, North East Ambulance Service (NEAS) and Hartlepool and Stockton Health (HaSH)) had been awarded the contract, which would commence on 1 April 2024. The Trust was the lead organisation from a contracting perspective.
- The Trust continued to exceed the overall four-hour national standard, achieving 82.99% in December despite a significant increase in urgent and emergency attendances compared to the previous month. Despite the increase of ambulance arrivals to the Emergency Department, the handover completion rate was reported at 97.35%, with the Trust continuing to be one of the best performing organisations.

- Following the Getting It Right First Time (GIRFT) visit, held on Wednesday, 20 December 2023, to the elective hub at the University Hospital of Hartlepool, the Trust had successfully achieved accreditation, which was positive.
- The Referral to Treatment (RTT) incomplete pathway continued to be a challenge and in December the Trust reported 71.70% against a standard of 92.00%, with 157 patients waiting over 78 weeks by the end of March 2024. Action plans were in place to ensure patients waiting were seen as soon as possible.
- The Trust continued to plan and respond to Industrial Action challenges, ensuring patients remained safe. The MD thanked and acknowledged the support of staff and teams during those times.
- The Master Collaboration Agreement and lease agreement between Research and Development (R&D) and Future Meds had been signed and the official launch took place on Tuesday, 30 January 2024.
- The Month 9 NENC financial YTD position was reporting at £33.7m deficit, compared to a deficit YTD plan of £51.0m, which indicated that the ICS was ahead of plan by £17.3m. The Trust continued to provide support and was expected to exceed the financial plan and post a surplus.
- All Trusts with a Neonatal Unit designation were asked to assist with the Thirlwall Inquiry to understand how babies in hospital were kept safe. The Chief Medical Officer and Non-Executive Director completed the submission on behalf of the Trust. An update was to be provided as and when necessary.
- Final NHS Planning Guidance for 2024/25 was due to be published by the end of December 2023 however, was still awaited. The Trust continued to plan based upon the draft guidance.
- Remedial works following the identification of Reinforced Autoclaved Aerated Concrete (RAAC) were due to be completed in March 2024, with a regular annual plan going forward. The cost for the replacement of the RAAC roofs was circa £4.9m and discussions were taking place with NHS England regarding external funding.
- The Staff Survey closed late November 2023, with a response rate of approximately 50%. High level results were now available however, were embargoed until early March 2024.
- As part of the Hartlepool Town Deal initiative, the Trust had successfully received capital funding of £1.25m to develop a regional Health and Social Care Academy, at the University Hospital of Hartlepool on Ward 10, which the MD and Group Chair had recently visited. In addition to the capital funding, a successful bid for £200k funding had been made to the Local Skills Improvement Fund (LSIF) to support costs associated with additional equipment.
- Current uptake for Covid vaccinations reported at 23% and Influenza vaccinations reported at 49%. An action plan had been developed with a focus on areas of low uptake and providing vaccines in wards/departments as well as the dedicated vaccination hub.
- Work had begun to apply an uplift to approximately 500 eligible Clinical Support Worker staff backdated to July 2021, when new Agenda for Change profiles were published. The uplift would be implemented in a phased manner due to the complexities associated with calculating payment for each of the affected members.

Following a query, it was confirmed that an update on the New Hospital Outline Business Case (OBC) would be provided at a future meeting. The first draft was expected to be ready by March/April 2024 and discussions were taking place at Executive Team meetings.

Resolved:
(i) that, the content of the report be noted; and
(ii) that, an update on the Thirwall questionnaire was to be provided at a future meeting; and
(iii) that, a further update on the Staff Survey results be provided at a future meeting; and
(iv) that, an update on the New Hospital Outline Business Case be provided at a future meeting.

BoD/5209 Board of Directors Annual Declaration of Interests Register

The DoSA&C/CS presented the Board of Directors Annual Declaration of Interest Register report and highlighted the key issues. In accordance with Annex 7 of the Trust's Constitution, the Board of

Directors of NHS Foundation Trusts were required to declare interests that may conflict with their position as a Director or Non-Executive Director of the Trust.

The Trust completed an exercise to update the declarations of interest of all Board members and the register was updated, which was attached to the report. The register was to be referred to in the Trust's Annual Report and was available for inspection by the public on the Trust's website.

Internal audit recently undertook a review of the process followed, which was positive. It was recommended that minutes of meetings were strengthened regarding declared conflicts of interest and new narrative was being incorporated along with including copies of registers to meeting papers.

The Joint Chair reported on a further declaration that was to be added to the register.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the declaration of interest be updated to include the Joint Chairs further declaration.

BoD/5210 Board Assurance Framework Quarter 3: 2023/24

The DoSA&C/CS presented the Board Assurance Framework (BAF) Quarter 3: 2023/24 report and highlighted the key issues.

Following a detailed review of the BAF and external benchmarking information, the Trust undertook a transitional and controlled process to move from 12 original BAF domains to seven. The reported position to 31 December 2023, included the revised seven BAF domains, with a separate domain in draft format (Trust Estate), to enable greater focus on the multi-faceted nature of the strategic red risk. All domains were reviewed by the responsible authors and directors. All new proposed risks were reviewed by the weekly Trust's Operational Delivery Group prior to approval.

There were 35 strategic risks reported, with two risks current risk rating outside of the approved risk appetite of the Resources Committee. An update was provided on the two red risks which related to the delivery of savings and the ageing estate. The risks were planned to be reassessed when planning for 2024/25. The Trust was liaising with the ICB regarding the BAF to ensure that the wider system risks were on the radar of the ICB.

In response to a number of queries, the DoS,A&C/CS explained that the high rated risk around delivery of savings, was due to the recurrent delivery of the Cost Improvement Plan (CIP), as not all savings were being delivered on a recurrent basis posing a risk in future years. The CITO confirmed that the current rating for the digital risk was correct and would continue to be reviewed on a monthly basis.

Resolved: that, the content of the report be noted.

BoD/5211 Integrated Performance Report

The CN/DoPS&Q, DCPO, ADoF and the ACOO presented the Integrated Performance Report (IPR) for December 2023 and highlighted the key points.

Safe:

- The Trust reported no serious incidents during December and had not reported any Never Events since April 2023.
- A validation exercise was being undertaken on the Trust's new patient safety reporting platform Inphase, to ensure that the right information was being captured. Incidents were now called events.
- Slight increase in infection rates had been reported in month, most noticeably Clostridium Difficile (C diff), with cases reported in December exceeding the internal annual threshold.
- No falls resulting in significant harm and two falls reported with moderate harm, which were subject to review through the Trust's Safety Response process.
- A decrease in Category 3 pressure ulcers was reported in November 2023, in both community

and hospital settings, and an increase in reports of Category 2 damage however, this was in line with a higher number of overall reporting.

Effective:

- The latest SHMI value was 94.52 (August 2022 to July 2023), which was an increase from the previous rebased value of 94.45 (July 2022 to June 2023).
- The Trust was on track to achieve a 15% reduction in outpatient reviews.
- There had been 70 reportable cancellations in December 2023, with the main reason being clinical prioritisation for both urgent and cancer patients. Industrial action and staff sickness across theatres, surgery and anaesthetics were also contributory factors.

Caring:

- The Trust received 1,612 Friends and Family Test (FFT) returns, which was a decrease from the previous month. The Very Good or Good responses returned for December was 90.69%.
- The Volunteer Service continued to be used to encourage uptake, particularly in the inpatient and A&E areas.

Responsive:

- The Referral to Treatment incomplete pathway standard continued to be a challenge nationally.
- The reduction in the number of patients waiting for diagnostic tests had reduced slightly from the end of November 2023, due to the impact of capacity and loss of the mobile MRI scanner. This was reinstated in early January and an improved position was noted.
- The Cancer 28-day faster diagnosis and Cancer 31-days had both met the standard however, the 62-day standard continued to be a challenge. There had been an improvement in performance compared to the previous month although, remained below the 85% standard. Work was ongoing to proactively contact individuals to discuss options.

Well Led (People & Finance):

- The Trust's absence rate as at the end of November 2023 was reported at 5.69%, which was a decrease on the previous month's rate of 5.72% and exceeded the Trust's absence threshold of 4%. Supporting details were explained.
- The Trust had a tolerance of 95% compliance for staff annual appraisals and the position for December 2023 stood at 87.44%, which was a slight increase of 0.23% from the previous month. The Organisational Development (OD) team were working on a project to streamline the appraisal process and to align the documentation to STHFT documentation.
- Mandatory training compliance for December 2023 was 89.92%, which represented an increase from the previous month of 0.32%. Following a comprehensive review, agreement had been reached to move to a 'core' and 'non-core' mandatory training approach with a single report system via ESR. The Education Team and Business Intelligence (BI) Team were co-producing a dashboard with Yellowfin, which would allow oversight.
- Staff turnover for December 2023 was 8.43%, which was comparable to the previous reporting period and within the Trust's tolerance threshold of 10%.
- At month 9, the Trust was reporting an in-month surplus of £0.296m, which was 0.601m ahead of plan.
- The Trust's cash position was £61.5m, against a plan of £64.8m, which was £3.3m behind plan.

It was reported that the Audit Committee had reviewed the BAF and IPR as part of the overall system, and were assured that both documents were now very robust.

In respect of the impact of Bank Holidays and staff capacity on theatre cancellations it was proposed that this should not be included as planning as it was part of routine planning. CM reported on the internal audit report and the number of actions regarding theatre utilisation confirming that a number of actions had already been completed and the remaining actions had completion dates agreed.

It was noted that staff turnover and vacancies were monitored in the People Committee and significant improvement had been made in respect of vacancies following positive work around culture.

Discussions had taken place at the Quality Committee regarding sickness absence and in particular why stress related absence had increased however, referrals to in-house psychology had reduced. It was agreed to discuss further at the next Quality Committee the importance of having clear pathways to Occupational Health and Alliance, with only complex cases being referred to Psychology. Mental Health was a national issue and there was a 10% increase in prevalence above the sector average. Assurance was provided that this was a focus for the Trust and work was ongoing to explore working collaboratively with STHFT.

A query was raised regarding mandatory training and Medics and if there were any inherent risks. It was confirmed that this was an area of focus and that revalidation processes were followed as well as medical annual clinical excellence processes as a level of compliance. There was a newly established medical workforce team to address these areas.

Resolved: that, the content of the report be noted.

BoD/5212 Fit and Proper Person Test Framework Compliance

The DoSA&C/CS presented the Fit and Proper Person Test (FPPT) Framework Compliance report and highlighted the key issues.

Following publication of revised FPPT requirements for board members, the Trust took the decision to extend the process to both new and existing board members, non-voting directors and deputy directors strengthening governance, with the process being undertaken in two phases. A portfolio of evidence was required to be collected and retained for each Board member to be assessed against the requirements and recorded centrally on ESR. On completion and validation of testing for each board member, the Chair would submit an overview of the findings to NHS England as part of a required submission. In addition, as the Trust was operating under Group arrangements with STHFT and was the host organisation for the Group Chair and Group Chief Executive, a letter of confirmation would be issued to STHFT confirming each individual was a fit and proper person. The outcome of the FPPT would also be reported at the next Council of Governors meeting.

The Board of Directors accepted the recommendations within the report and acknowledged the significant amount of work undertaken to be ahead of the requirements, which was commended.

Resolved:
(i) that, the content of the report be noted; and
(ii) that, a letter of confirmation be sent to STHFT confirming the Group Chair and Group Chief Executive were fit and proper persons; and
(iii) That, the outcome of the Fit and Proper Person Test assessment for board members be reported at the next Council of Governors meeting.

BoD/5213 Learning from Deaths Report

The ICMO presented the Learning from Deaths Report and highlighted the key issues.

The Trusts Medical Examiner (ME) Service continued to scrutinise 100% of inpatient deaths, and had extended the service into the community, ahead of the statutory requirement to be established by April 2024. A standard reporting template had been agreed with the Lead Coroner Officer, to facilitate reporting for closed inquests and guide the Coroner in their decisions.

The Trust currently had around 20 trained reviewers to undertake Structured Judgement Reviews (SJR). The reviewers were multidisciplinary and represented medical, nursing and allied healthcare professionals. The team had completed 12 SJRs between April and September 2023 and all were considered to be expected deaths with no evidence of preventability. One case was initially thought to show ‘slight evidence of preventability’ but following a second review it was classed as “not preventable”.

The Board of Directors supported the current business case to facilitate the robust Learning from Deaths process including the timely SJRs, structured and systematic sharing of finding and linking to quality improvement.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the Board of Directors supported the current business case to facilitate the robust Learning from Deaths process including the timely SJRs, structured and systematic sharing of finding and linking to quality improvement.

BoD/5214 Guardian of Safe Working Hours Quarterly Report

The ICMO presented the Guardian of Safe Working Hours Quarterly Report and highlighted the key issues.

The report provided data and identified trends captured through the exception reporting system and from the Junior Doctor Forum. A total of 88 exception reports were submitted between 1 August and 31 October 2023. The majority of reports submitted were from Foundation Year One Doctors (66%) and Foundation Year Two Doctors (24%). Medicine specialties continued to receive the most exceptions (61%) however, Medicine also had the higher proportion of trainees in comparison to other specialties.

An ongoing issue was in respect of the provision of out-of-hours catering facilities for staff working in the evening. It was highlighted that arrangements had been put in place including investment for equipment in order to provide food out of hours. However, following a couple of months this was withdrawn due to lack of demand. It was agreed that the MD would discuss this issue with NTH Solutions LLP again and an update would be taken to a future Group Board meeting. The ACPO advised that installation of hot food vending machines would be in place by the end of the financial year.

The term for the Guardian was usually a minimum of three years and it was recommended that, when a term was due to come to an end, the Trust appoint a successor with at least a six month crossover period to ensure robust transition.

It was noted that the Learning from Deaths reports were discussed in detail at the People Committee on a quarterly basis.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the MD discuss out of hours catering facilities again with NTH Solutions LLP and an update be taken to a future Group Board meeting.

BoD/5215 Professional Workforce Bi-Annual Report

The CN/DoN&PS presented the Professional Workforce Bi-Annual Report and highlighted the key issues and progress in respect of previously identified actions.

Professional workforce review panels had been held across November and December 2023, where data, professional judgement and patient outcomes were reviewed to fully triangulate information and agree recommended changes to current workforce roles and establishments. Patient acuity and dependency levels were identified using the Safer Nursing Care Tool (SNCT), which was the only nationally approved, evidence-based tool to support safe staffing within in-patient areas.

The monitoring of safe staffing within maternity was via the Birthrate+ acuity app and a review undertaken every three years with the last review taking place in 2023. Following a review of workforce metric data from June 2023 to November 2023, it was noted from a Trust wide perspective, that safe staffing had been maintained throughout the period.

The Trust continued to focus on improving the vacancy position and turnover across the Nursing and Midwifery roles and forecasting to the end of January 2024 reported the Registered Nurse (RN) vacancy position reduced to 21.06wte (1.43%) and the Health Care Support Workers vacancy position expected to reduce to 4.22wte (0.65%). The Registered Maternity vacancy position was forecasting an over recruited position of +2wte by the end of March 2024.

Patient Safety meetings took place across the Trust on a weekly basis where all potential and actual harms were discussed from the previous week. The review of patient acuity and dependency had helped to address whether harm had occurred because of reduced nurse staffing.

In line with national guidance, a 21 day SNCT data collection had been taken across all adult and Paediatric wards in October 2023. It was suggested that the Critical Care Unit had a slight over establishment, which was reflective of the requirement for the unit to be staffed to 100% occupancy as per the Guidelines for the Provision of Intensive Care (GPIC) standards.

Resolved: (i) that, the significant assurance provided with the exception of the highlighted services be noted; and
(ii) that, the staffing establishment in place remained fit for purpose and there were no risks to highlight.

BoD/5216 Perinatal Quality Surveillance Model Reports

Stephanie Worn, Associate Director of Midwifery presented the Perinatal Quality Surveillance Model Reports and highlighted the key issues.

There were a number of key performance metrics being monitored and targeted workstreams ongoing including post-partum haemorrhage, which had led to a reduction. Work continued to maintain this position and a deep dive into January's figures was being undertaken. Improvements were being seen in reducing smoking in pregnancy and the Trust was reporting below the NENC average.

Nationally there were challenges to ensure optimal patient experience and elective capacity for inductions of labour (IOL) and the service was exploring a collaborative with STHFT in a joint IOL Quality Improvement Project. Safety Culture, Operational risk, Reliability/burnout and Engagement (SCORE) staff survey results were expected in February 2024. The perinatal quadrumvirate had oversight of the survey and would be carrying out a thematic review of the results. Safe staffing continued to be monitored via the Birthrate+ acuity app red flag system.

The in-month position for the 10 safety actions (SA) reported that the Trust was on track for compliance for nine out of the 10 SAs.

A detailed overview of the focused work that had taken place within Maternity in preparation for a further visit by the Care Quality Commission (CQC) was provided. One aspect of the work had been maternity triage as a priority service for development. The Trust had accepted support from an external provider who had developed a maternity triage system and a number of workshops were to be held.

On Tuesday, 19 December 2023 the Trust activated the Maternity Escalation Policy to ensure safety of maternity services for a period of 5 hours due to substantial operational pressure. A review of the activation was underway to identify any additional learning. The Vice Chair had visited the service the day after the activation of the Escalation Policy and provided an overview of feedback from staff, which had been positive. The Vice Chair assured the Board the service was well monitored and regulated and that leadership and culture within the service was of high importance.

Following a query regarding the implementation of Badgernet, it was confirmed that there had been no concerns raised and that staff welcomed the system.

Stephanie Worn left the meeting.

Resolved: that, the content of the report be noted.

BoD/5217 Responsible Officer's Medical Appraisal and Revalidation Report

The ICMO presented the Responsible Officer's Medical Appraisal and Revalidation Report and highlighted the key issues. The report provided a summary of Medical Appraisal and Revalidation activity within the Trust for the period 1 April 2022 to 31 March 2023. The delay in the presentation of the report was noted.

Appraisal compliance for 2022/23 was 99.03%. All outstanding appraisals had been progressed with two doctors having had their appraisals extended until the end of August 2023 due to returning from illness and one doctor had been escalated to the Deputy Responsible Officer for non-compliance of the appraisal. A number of improvements to the appraisal process had been identified and were being implemented.

During the period of 1 April 2022 to 31 March 2023 there were 39 revalidation recommendations and nine deferrals made to the GMC by the Trust. It was noted that the Trust had a much lower deferral rate than the average for England however, it was committed to reducing the deferral rate further.

Resolved: that, the content of the report be noted.

BoD/5218 Sexual Safety Charter

The DCPO presented the Sexual Safety Charter and highlighted the key issues.

In September 2023, NHS England launched the Sexual Safety in Healthcare organisational charter, which sought to change the culture around sexual safety within the healthcare system in collaboration with key system partners. The Trust had committed to a zero-tolerance approach to unwanted, inappropriate and harmful sexual behaviours within the workplace.

The Charter was made up of ten commitments, which aimed to support organisations in strengthening their approach, and it was anticipated that signatories of the charter would work to implement all ten commitments by July 2024. A project group had been developed with key individuals from across the Trust, whose areas of responsibility were directly linked to the remit of the charter. This would be monitored via the People Group and People Committee.

Cultural work was being undertaken to reassure staff that the service was confidential and to encourage the use of safe spaces to share individual experiences and learning, acknowledging this may be difficult due to the sensitivity of experiences relating to sexual assault and/or harassment. It was important to ensure that there was a standalone awareness campaign on sexual safety in its own right, which would need specific communication and marketing across the Trust. A Sexual Safety Policy was being developed in collaboration with STHFT, which would be a useful tool to give staff confidence that the Trust would take allegations of sexual assault and/or harassment seriously, ensure timely responses to concerns and that individuals reporting incidents would be treated with dignity and respect.

A progress report was to be taken to the People Committee in six months' time.

Resolved: that, the content of the report be noted.

BoD/5219 Freedom to Speak Up Update and Reflection and Planning Tool

Jules Huggan, the Freedom to Speak Up Guardian (FTSUG) attended the meeting and presented the Freedom to Speak Up Update, Reflection and Planning Tool Report.

In 2022, NHS England and the National Guardian's Office published new and updated Freedom to Speak Up guidance and a Freedom to Speak Up reflection and planning tool, designed to help deliver the NHS People Promise for workers, to ensure they had a voice and to develop a speaking up culture. Details of how the tool would be implemented was provided and it was noted that the Trust intended to review the tool every two years, although this was not mandatory.

Whilst the tool had been completed for the Trust, it was acknowledged that there was ongoing work within the Group and key relationships were already in place with the FTSUG at STHFT. Opportunities to provide support across sites, share best practice and significant progress made to date had been agreed. Following a query regarding opportunities for wider collaboration across networks, it was noted that FTSUGs attended quarterly network meetings to share best practice and a FTSU Conference was scheduled to take place on Thursday, 14 March 2024.

A concern had been raised regarding training, which the DCPO was looking into. It was also noted that the Non-Executive Directors were due to attend a Freedom to Speak Up: E-Learning Follow Up Workshop on Thursday, 8 February 2024.

The Group Chief Executive confirmed that at the last NENC Chief Executive's meeting, it was agreed that a session would be held to share learning and to ensure that this was taken forward across the system. It was agreed that a session should also be held with Governors. The Board thanked Jules Huggan for the presentation and her hard work done to date.

Jules Huggan left the meeting.

Resolved: (i) that, the content of the report be noted; and
(ii) that, a session on FTSU be scheduled with the Governors.

BoD/5220 Assurance Report of Audit Committee

AF presented the Assurance Report of the Audit Committee for October and highlighted the key issues.

Work was ongoing around timely reporting and the cycle of business. Action points from the Committee would also be included in the cycle of business.

Resolved: that, the content of the report be noted.

BoD/5221 Assurance Report of Quality Committee

FS presented the Assurance Report of the Quality Committee and highlighted the key issues.

Infection rates remained within the agreed threshold however, were increasing, which was being monitored. Departments had been tasked to review outstanding clinical audits and were asked to provide an action plan at the next meeting.

Significant pressures with regards to Mental Health provision were being seen on Wards and in Accident & Emergency, which was being monitored.

Resolved: that, the content of the report be noted.

BoD/5222 Assurance Report of People Committee

AB presented the Assurance Report of the People Committee and highlighted the key issues.

Staff Networks were being developed and linked to the culture of Freedom to Speak Up and sexual safety. A number of significant improvements had taken place in recent months regarding the development of the Health and Social Care Academy and an update report would be brought to a future meeting as it developed. An EDI Network had been held the previous week and all staff networks had the opportunity to present an update on work streams, which had been very positive.

It was highlighted that the report was more detailed than other Assurance Reports and it was agreed that this be reviewed to ensure consistency.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the Assurance Reports be reviewed to ensure consistency going

forward.

BoD/5223 Assurance Report of Resources Committee

CM presented the Assurance Report of the Resources Committee and highlighted the key issues.

It was reported that there were concerns initially with regards to the breadth of the Committees agenda however, this was now resolved with each of the required items being given the appropriate time. As the Trust moved into the new financial year, key areas of focus for the Committee were improving timelines, the utilisation of funds and overseeing investments.

It was noted there was a typing error on the report covering the meeting held on 5 January 2024, which would be rectified.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the typing error on the report covering the meeting held on 5 January 2024, be rectified.

BoD/5224 Assurance Report of Risk Management Group

The MD presented the Assurance Report of the Risk Management Group and highlighted the key issues.

The meeting focused on the risk register, strategic and emerging risks and how they linked to the BAF. A report on open and overdue internal audit recommendations had been reviewed and work was planned to ensure that staff had a good understanding of risk management.

Resolved: that, the content of the report be noted.

BoD/5225 Assurance Report of Charitable Funds Committee

CM presented the Assurance Report of the Charitable Funds Committee and highlighted the key issues.

Resolved: that, the content of the report be noted.

BoD/5226 Assurance Report of Investment Committee

CM presented the Assurance Report of the Investment Committee and highlighted the key issues.

Resolved: that, the content of the report be noted.

BoD/5227 Any Other Business

There was no other business to discuss.

BoD/5228 Date and Time of Next Meeting

Resolved: that, the next meeting be held on, Thursday, 4 April 2024 in the Boardroom at the University Hospital of Hartlepool.

The meeting closed at 12.00noon.

Signed:  Date: 4 April 2024

BoD Public

Date	Ref.	Item Description	Owner	Deadline	Completed	Notes
27 April 2023	BoD/5047	***Report of the Managing Director*** Board Development Session to be held at a later date regarding the Health and Care Academy and the wider picture.	SC/SI	31 March 2024	Ongoing	A review of board meetings, development sessions and board seminars has been undertaken and five sessions were agreed to be delivered by Aqua. Two sessions have been delivered and an evaluation meeting was held with Aqua in January 2024 to agree areas of coverage and this needs to be finalised. Two further Board seminars were held on PSIRF on 29 November and new CQC Single Assessment Framework on 7 December 2023. A future session in the Health & Care Academy will be planned. A development session regarding the Health & Social Care Academy will be confirmed. Going forward this will be included in the Group Development Plan.
09 November 2023	BoD/5188	***Integrated Performance Report*** High level overview report to be brought to a future Board meeting regarding work around theatre utilisation.	RD	05 June 2024	Ongoing	A combined update on the Hub at the University Hospital of Hartlepool and theatre utilisation was scheduled to be taken to the Group Board scheduled for 5 June 2024.
09 November 2023	BoD/5192	***Winter Resilience Plan*** A further update be brought to a future meeting on developments of the delivery plan.	RD	15 May 2024		An update report was scheduled to be brought to the May Board meeting.
09 November 2023	BoD/5193	***NHS Core Standards for EPRR*** A further report be brought to the next meeting detailing the Trust's final level of compliance, a summary of work completed, a forward EPRR work programme for the upcoming year and an update on the full cycle of business, including major incident planning.	RD	01 February 2024	Completed	This item was covered within the MD Report on 1 February 2024.
09 November 2023	BoD/5195	***Report of Resources Committee*** All Board members to ensure they are up to date and compliant with cyber security mandatory training as soon as possible.	ALL	01 February 2024	Completed	All members confirmed they were up to date with mandatory training.
09 November 2023	BoD/5197	***Data Protection SIRO Report - DSPT Year End 2022/23*** Trend analysis information to be included in future reports going forward. A Board Development Session be confirmed to focus on Cyber as soon as possible.	KA SI/SH		Completed.	The Cyber Development Session has been confirmed for 15 Fberuary 2024.

Board of Directors

Title of report:	Group Chair's Report										
Date:	4 April 2024										
Prepared by:	Sarah Hutt, Assistant Company Secretary										
Sponsor:	Professor Derek Bell, Group Chair										
Purpose of the report	The purpose of the report is to update the Board of Directors on key local, regional and national issues.										
Action required:	Approve		Assurance		Discuss		Information	x			
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing People	x	Transforming our Services	x	Health and Wellbeing	x			
Which CQC Standards apply to this report	Safe	x	Caring	x	Effective	x	Responsive	x	Well Led	x	

Executive Summary and the key issues for consideration/ decision:

The report provides an overview from the Group Chair and provides important information from health and wider contextual related news and issues that feature at a national, regional and local level. Key areas covered in this report include;

- Group and Joint Working
- Group Non-Executive Director roles
- NHSE ICB and Chairs Event
- NENC ICS and ICB Chairs Meeting
- Education, Training and Workforce event
- Cyber Security

Board Assurance Framework/Corporate Risk Register risks this paper relates to:

This paper relates to all strategic objectives and Board Assurance Framework (BAF) domains.

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*

Equality, diversity and or inclusion	x	Reputational	x
Workforce	x	Environmental	
Financial/value for money	x	Estates and Facilities	
Commercial		Compliance/Regulatory	x
Quality, safety, experience and effectiveness	x	Service user, care and stakeholder involvement	x
Board Subcommittee meetings where this item has been considered (specify date)		Management Group meetings where this item has been considered (specify date)	

N/A	N/A
Recommendation	The Board of Directors are asked to note the content of this report.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

4 April 2024

Report of the Group Chair

1. Introduction

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

2. Key Issues and Planned Actions

2.1 Group and Joint Working

The Joint Partnership Board met on 21 February 2024 and 20 March 2024. Work is progressing regarding governance arrangements for the Group, and it was agreed to recommend to the statutory Boards delegation of those joint functions which were permissible. As part of the establishment of the six Clinical Boards, recruitment to the triumvirate positions had commenced with a positive response. Shortlisting has been completed and interviews will take place in early April.

The Digital work stream is continuing with further engagement sessions taking place during March, which will help to identify immediate priorities and to shape the Group Digital Strategy. An action plan is being developed to support this work.

Engagement and regular communications regarding the Group continue to develop and a dedicated weekly update for staff from the Group Chief Executive has been introduced.

2.2 Group Non-Executive Director roles

A number of discussions have been held with all our Non-Executive and Associate Non-Executive Directors regarding the future 'group' Non-Executive roles. A proposal setting out the process for appointment and details of the appointments to these 'group' roles has been considered and agreed at a meeting in Common of both Nomination Committees. A recommendation for the appointments will be presented for approval at an extra ordinary meeting in common of both Council of Governors on 28 March 2024.

2.3 NHSE ICB and Chairs Event

I attended an NHSE ICB and Chairs event in London on 28 February 2024, where the key discussion points included productivity, key priorities and data. It is expected that the main challenge will be to look at productivity in the broadest sense. For most trusts there is a productivity gap with less than 10% of trusts able to demonstrate increased productivity, most show a decline in productivity even corrected for demand, case mix and sickness absence. Agency costs are showing some improvement however, bank and temporary staff costs are increasing. For 2024/25 funding is less in real terms, however funding for mental health services will be protected.

There will be a continued focus on the priority areas of 4 hour performance, ambulance handover delays, elective waiting times, 62 day cancer standard and 28 day faster diagnosis. It was noted that overall performance against the 62 day cancer standard and 28 day faster diagnosis has seen an improvement.

The intelligent use of data was emphasised to improve quality of care, flow and performance and to inform necessary action and improvement, including better evidence of the use of data required at Board level. It is important to understand the variation in outcomes locally, regionally and nationally.

Other items included noting that Professor Tim Kendall, National Clinical Director for Mental Health was awarded a CBE in the 2024 New Year's Honours List for his services to mental health in England.

As part of the National Stroke Service Model and the Integrated Stroke Delivery Networks, the national team will be undertaking a programme of visits to all Thrombectomy service providers. There is a renewed focus on the reduction of healthcare associated infections (HCAI), with an increase regionally and nationally being reported, particularly in respect of Clostridium Difficile (C diff), cases.

The national direction of travel is to join Maternity and Neonatal services, known as Perinatal services going forward. This is part of a three year delivery plan to make maternity and neonatal care safer, more personalised and more equitable for women, babies and families.

Martha's Rule will be implemented across the NHS from April 2024 in a phased approach. It requires all staff, patients, families and carers in NHS trusts to have 24/7 access to a rapid review from a critical care outreach team who they can contact should they have concerns about a patient. Martha's Rule was developed following the sad case of Martha Mills who died in 2021 after developing sepsis in hospital and concerns regarding her deterioration were not listened to. The Coroner ruled that Martha probably would have survived had she been moved to intensive care earlier.

An initiative to support continuous improvement across the NHS at every level is being launched. NHS Impact (Improving Patient Care Together) is a single improvement approach across five components to support organisations to delivery continuous improvement.

2.4 NENC ICS and ICB Chairs Meeting

I attended the NENC ICS and ICB Chairs meeting on 20 February 2024 where the focus was around maintaining and progressing fair shares principles across the region recognising the significant financial challenges being faced. There was also a requirement to recognise the risks around the digital agenda and the need to improve data sharing. An ICB estates strategy was expected to be published at the end of March.

2.5 Education, Training and Workforce Event

I was pleased to be able to host an event on 21 February 2024 with a number of Universities present who provide education and training to medical, nursing, allied health professions, science and technology and admin and management colleagues. The event was the first of many to start to look at the types of workforce we will need for the future and what training will be required.

2.6 Cyber Security

The Board received Cyber Security Awareness training as part of a Board Seminar on 15 February 2024. The externally facilitated session was approved by the National Cyber Security Centre and provided vital information regarding external threats nationally and globally, major risks, preventions and deterrents ensuring board members were aware of their individual and organisational responsibilities.

3. Recommendation

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

Professor Derek Bell
Group Chair

Excellence as our standard

North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Group Chief Executive's Report										
Date:	4 April 2024										
Prepared by:	Sarah Hutt, Assistant Company Secretary										
Executive sponsor:	Stacey Hunter, Group Chief Executive										
Purpose of the report	The purpose of the report is to provide an update to the Board of Directors on key local, regional and national issues.										
Action required:	Approve		Assurance		Discuss		Information	x			
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing People	x	Transforming our Services	x	Health and Wellbeing	x			
Which CQC Standards apply to this report	Safe	x	Caring	x	Effective	x	Responsive	x	Well Led	x	

Executive Summary and the key issues for consideration/ decision:

The report provides an overview of the health and wider related news as well as issues that feature at a local, regional and national level.

Key areas in this report include:

- The NHS Leadership Competency Framework for board members
- Spring Budget Statement
- Independent Inquiry into the issues raised by the David Fuller case
- Tees Valley Group
- Group Executive Appointments
- Clinical Services Strategy
- Clinical Support Worker (Band 2 / Band 3)
- Community Diagnostic Centre
- Health and Social Care Academy
- Visits

Board Assurance Framework/Corporate Risk Register risks this paper relates to:

This paper relates to all strategic objectives and Board Assurance Framework (BAF) domains.

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*

Equality, diversity, inclusion	x	Reputational	x
Workforce	x	Environmental	x
Financial/value for money	x	Estates and Facilities	x
Commercial	x	Compliance/Regulatory	x
Quality, safety, experience and effectiveness	x	Service user, care and stakeholder involvement	x

Board Subcommittee meetings where this item has been considered (specify date)	Management Group meetings where this item has been considered (specify date)
N/A	N/A
Recommendation	The Board of Directors are asked to note the content of the report.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

4 April 2024

Report of the Group Chief Executive

1. Introduction

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

2. Key issues

2.1 NHS Leadership Competency Framework

NHS England have published a new leadership competency framework (LCF) for board members of provider organisations, integrated care boards (ICBs) and NHS England. The framework has been developed following engagement with various stakeholders and incorporating best practice from other industries in response to a recommendation from the 2019 Tom Kark KC review of the Fit and Proper Persons Test (FPPT). It will be applicable for board member recruitment, appraisals and will inform future board leadership and management training.

The LCF provides a consistent competency and skills framework for board members comprising six domains to self-assess against as part of the annual FPPT 'fitness' attestation. The six competency domains will form the basis of board member appraisals and be incorporated into role descriptions and recruitment processes from 1 April 2024.

A new Chair Appraisal Framework has also been published incorporating the LCF competencies to be used for the 2023/24 appraisal process. A new appraisal framework is also being developed for board members and is expected to be published in the Autumn. The Trust and South Tees Hospitals NHS Foundation Trust (South Tees) are looking to be early adopters of the framework.

The three new frameworks form part of a wider programme of management and leadership development to implement recommendations from the Messenger Review (Health and social care review: leadership for a collaborative future).

2.2 Spring Budget Statement

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

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

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

2.3 Independent Inquiry into the issues raised by the David Fuller case

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

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

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

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

2.4 Tees Valley Group Model

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

2.5 Group Executive Appointments

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

Following on from confirmation of the group appointments, Lindsey Robertson, Chief Nurse/Director of Patient Safety & Quality announced her intention to leave her role with the organisation. I would like to thank Lindsey on behalf of the Board for her commitment and valued contribution to the Trust, and wish her well for the future.

As part of the second part of group appointments, I can confirm that Ruth Dalton has been appointed as Group Communications Director and Dr Deepak Dwarakanath has been appointed as the Site Medical Director as part of the site leadership team.

2.6 Clinical Services Strategy

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

leadership for each of the six Clinical Boards is currently underway and interviews are planned for April 2024.

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

2.7 Clinical Support Worker (Band 2 Band 3)

The release of updated Agenda for Change national profiles for clinical support workers (in the combined nursing job family), resulted from concerns that the duties and tasks in some clinical support worker (CSW) and maternity support worker (MSW) roles had changed significantly over time and job descriptions may not have been reviewed regularly and updated. As a consequence some banding outcomes may have become out of date and inconsistent when viewed against other NHS jobs. Work was undertaken in collaboration with care groups and staff side colleagues to review and update as necessary all clinical support worker job descriptions.

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

2.8 Community Diagnostic Centre

Progress of the new build Community Diagnostic Centre (CDC) on the Riverside at Stockton is on track with the foundations, structural steel work and sub-flooring now complete. The CDC is part of the strategic plan for the health system in the Tees Valley to develop diagnostic capacity, focusing on early diagnosis and treatment with improved outcomes. This is a collaborative project with South Tees and local authority partners.

Workforce plans to support the CDC have been agreed and will shortly progress to advert. The CDC is expected to open this Summer.

2.9 Health and Social Care Academy

As part of the Hartlepool Towns Deal initiative, the Trust has been successful in attracting capital funding of £1.25m to develop a Health and Social Care Academy. Working with key stakeholders including Hartlepool College of Further Education, the Academy will be located at the University Hospital of Hartlepool. Construction commenced at the start of the year and is anticipated to be complete in late Spring.

In addition to the capital funding, the Trust successfully bid for c. £200k funding from the Local Skills Improvement Fund (LSIF) to support the purchase of technology equipment for the Academy.

2.10 Visits

We were pleased to welcome Emily Lawson, Chief Operating Officer for NHS England to the Trust recently and as part of the visit were able to showcase our virtual ward model, discharge pathway and the urgent and emergency care departments.

Earlier this month, Matt Vickers, MP for Stockton South visited to tour the new robotic and emergency maternity theatre space at the University Hospital of North Tees, which is currently under construction.

I am pleased to report that Sarah-Jane Marsh, the National Director of Urgent and Emergency Care and Deputy Chief Operating Officer for NHS England will be visiting the Trust in early April. We are planning to share the work colleagues are delivering across the Urgent and Emergency Care pathways including the excellent community offer to our communities.

3. Recommendation

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

Stacey Hunter
Group Chief Executive

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NHS North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of report:	Retrospective Approval of Documents Executed Under Seal										
Date:	4 April 2024										
Prepared by:	Sarah Hutt, Assistant Company Secretary										
Executive sponsor:	Neil Atkinson, Managing Director										
Purpose of the report	The purpose of the report is to obtain retrospective approval from the Board for a number of documents executed under seal.										
Action required:	Approve	x	Assurance		Discuss		Information				
Strategic Objectives supported by this paper:	Putting our Population First	x	Valuing People	x	Transforming our Services	x	Health and Wellbeing	x			
Which CQC Standards apply to this report	Safe		Caring		Effective	x	Responsive		Well Led		

Executive Summary and the key issues for consideration/ decision:

The NHS Act 2006, paragraph 29(1), Schedule 7 set out the requirement for foundation trust constitutions to make provision for the authentication of the fixing of the company's seal to execute documents as required.

A number of transactions were carried out that required documents to be executed under seal. These are detailed below:

1. A 125 year lease between Stockton Borough Council (Landlord) and North Tees & Hartlepool NHS Foundation Trust (Tenant) relating to the Tees Valley Community Diagnostic Centre, Waterfront, Stockton.

Document	Date Sealed	Signed By
A lease between: Tees Valley Community Diagnostic Centre, Waterfront, Stockton. Between: 1. Stockton Borough Council and 2. North Tees and Hartlepool NHS Foundation Trust	16 February 2024	Neil Atkinson Managing Director Witnessed by: Elaine Gouk, Interim Chief Medical Officer

2. A 60 year underlease between North Tees and Hartlepool NHS Foundation Trust and Northern Power Grid (North East) PLC relating to the Tees Valley Community Diagnostic Centre, Waterfront, Stockton and part of the substation to grant access to Northern Power Grid.

Document	Date Sealed	Signed By
Deed of Surrender relating to: Tees Valley Community Diagnostic Centre, Waterfront, Stockton. Between: 1. North Tees and Hartlepool NHS Foundation Trust and 2. Northern Power Grid (North East) PLC	16 February 2024	Neil Atkinson, Managing Director Witnessed by: Elaine Gouk Interim Chief Medical Officer

There are no risk implications associated with this report.			
Equality, diversity and or inclusion		Reputational	
Workforce		Environmental	
Financial/value for money		Estates and Facilities	
Commercial		Compliance/Regulatory	x
Quality, safety, experience and effectiveness		Service user, care and stakeholder involvement	
N/A		N/A	
	The Board of Directors is requested to grant retrospective approval for the signing of this document.		

North Tees and Hartlepool NHS Foundation Trust

Excellence as our standard

Board of Directors

Title of report:	Review of the Trust's Constitution										
Date:	4 April 2024										
Prepared by:	Sarah Hutt, Assistant Company Secretary										
Executive sponsor:	Stuart Irvine, Director of Strategy, Assurance and Compliance/Company Secretary										
Purpose of the report	The purpose of the report is to highlight the key changes made to the Trust's Constitution to reflect updated guidance and group working with South Tees Hospitals NHS Foundation Trust and to seek final approval from the Board of Directors.										
Action required:	Approve	X	Assurance		Discuss	x	Information	x			
Strategic Objectives supported by this paper:	Putting our Population First		Valuing People	x	Transforming our Services		Health and Wellbeing				
Which CQC Standards apply to this report	Safe		Caring		Effective		Responsive		Well Led	x	

Executive Summary and the key issues for consideration/ decision:

In line with good governance practice, the Trust's Constitution should be reviewed every 3 years to ensure it remains up to date and reflects current practice, unless there is a significant change prompting earlier review. Following progress with the group model with South Tees Hospitals NHS Foundation Trust (South Tees), it was agreed to review both Constitutions with a view of alignment where possible and to ensure that both documents incorporated any changes to legislation and guidance, including a focus on system working.

Both Constitutions have now been reviewed and are predominantly aligned, with key changes summarised below, with full details provided in the attached report;

- Inclusion of additional purpose of the Trust and duties for the Board of Directors and Council of Governors to reflect health system requirements.
- The tenure for Governors and Non-Executive Directors has been updated to state a maximum term of 9 years.
- Update to the detail of the Board of Directors – Composition, removing a redundant sentence, linked to the historic Executive Team structure.
- The addition of the statutory appointment of the Company Secretary.
- Proposed replacement of CCG appointed governors with 1 x ICB governor and 1 x voluntary organisation governor (to be agreed).
- Amendment to state that in the event the Trust has governor vacancies, following an election process, a further election will take place. This replaces the process to have temporary arrangements.
- Addition of a more detailed dispute resolution process in Annex 6 for Governors.
- Reference to the Health and Care Act 2022.

The proposed changes were presented and agreed at the Trust's Directors Team on 30 January 2024 and approved by the Council of Governors meeting on 15 February 2024. Attached as **Appendix A** is the updated Constitution, which reflects the above changes.			
Board Assurance Framework/Corporate Risk Register risks this paper relates to:			
This paper relates to all aspects of the Board Assurance Framework.			
Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity, inclusion		Reputational	x
Workforce	x	Environmental	
Financial/value for money		Estates and Facilities	
Commercial		Compliance/Regulatory	x
Quality, safety, experience and effectiveness	x	Service user, care and stakeholder involvement	x
Board Subcommittee meetings where this item has been considered (specify date)		Management Group meetings where this item has been considered (specify date)	
Council of Governors – 15 February 2024		Trust Directors Team – 30 January 2024	
Recommendation	The Board of Directors is requested to; - Note that the updated Constitution was approved by the Council of Governors on 15 February 2024; and - Consider and approve the updated Constitution.		

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

4 April 2024

Review of the Trust's Constitution

Report of the Director of Strategy, Assurance & Compliance/ Company Secretary

1. Introduction/Background

1.1 North Tees & Hartlepool NHS FT were authorised as a foundation trust (FT) in December 2007. All NHS FTs (in accordance with the NHS Act 2006) are required to have a constitution that is primarily based upon a national model core constitution, with some elements that can be tailored to meet the requirements of individual organisations.

1.2 This is one of the most important corporate documents in any FT as it contains detailed information about how that foundation trust will operate. Any amendments to the constitution require the approval of both the board of directors and the council of governors.

1.3 The content of an FT's constitution is legally mandated and is also influenced by the code of governance for NHS provider trusts (the code), published by the regulator, which contains guidance on how the FT should operate.

1.4 The key components/content of the constitution are;

- Membership arrangements e.g. categories of membership (such as public, staff etc.) and geographical boundaries for each constituency.
- The composition, election, tenure, disqualification and removal for the Council of Governors (including model rules).
- The composition, appointment, disqualification, removal and voting arrangements for the Board of Directors – includes the requirement to comply with F&PPT guidance.
- The Standing Orders (the form and function of the Board of Directors and Council of Governor meetings).
- Maintenance of registers such as members, governors and declarations of interest.
- The requirement to have internal and external auditors (Council of Governor responsibility to appoint and remove external auditors).
- Requirements for the annual report and accounts.
- The process to follow for significant transactions (linked to income, assets and capital).
- The requirement for Council of Governors to approve an application for acquisition, merger, separation or dissolution.
- Reference to the 2022 Health and Care Act.

1.5 When reviewing the proposed updates to the constitution, the following points need to be considered;

- The Health & Care Act 2022 and revised Provider Licence provided a clear mandate to remove legal barriers to facilitate collaboration between organisations and the provision of integrated care in the health and care system.
- The purpose is to improve the care, health and wellbeing of the population.
- Key requirements include;

- To comply with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.
- Engaging consistently in shared planning and decision making with partners in system and place based partnerships and provider collaborative.
- The collective responsibility with partners for delivery of high quality and sustainable services across system (Integrated Care System) and place footprints.
- Take responsibility for delivery of agreed system improvements and decisions.

2. Main content of report

2.1 The Group is making significant progress to work in collaboration and support the delivery of objectives set out in the Partnership Agreement. The Board of Directors of North Tees & Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust approved the Partnership Agreement on 29 November 2023. As a result of the recent review of the constitutions of both trusts, they are now aligned and will continue to be monitored. The Model Rules contained in the constitution are unchanged.

2.2 Attached as **Appendix A** is the updated Trust constitution and the key changes to the constitution are set out below and are consistent with the content that was presented to the Council of Governors meeting on 15 February 2024;

Council of Governors – Tenure (Section 11 – page 9)

This means that elected Governors and appointed Governors can serve a maximum term of 9 years. This term is consistent with the maximum term of a Non-Executive Director. This ensures that the maximum time served ensures independence and objectivity.

Board of Directors – Composition (Section 20 – page 13)

Proposal to remove 20.9 – a fifth voting executive director shall be a designate from the remaining executive director cohort. This is a redundant sentence and links to the historic Executive Team structure.

Board of Directors – Appointment and Removal of the Company Secretary (Section 26 – page 14)

This has been added to the constitution as the Company Secretary is a statutory appointment (as per the Code of Governance for NHS Provider Trusts 2022 – section 2.15). This strengthens the role of the Company Secretary.

Annex 3 – Composition of Council of Governors (Page 28)

Amendment to reflect the formation of the integrated care system and replace x2 clinical commissioning group governors with;

- One NENC ICB representative; and
- One ‘system health or care organisation’ representative.

This aligns with the requirement to establish relationships and representation with the wider system and population. It also provides flexibility for the Trust to appoint a representative from the wider health and care system.

Annex 5 – Additional Provisions – Council of Governors (Section 5 – Page 80)

Amendment to state that in the event the Trust has governor vacancies, following an election process, a further election will take place. This replaces the process to have temporary arrangements.

Annex 6 – Standing Orders for the Practice and Procedure of the Council of Governors (Page 82)

A new set of detailed paragraphs have been included to provide clarity in the event of a dispute (Section 5 – Dispute Resolution). Provides an informal and formal approach to resolving a dispute and provides the Council of Governors with an option to inform the Independent Regulator of NHS Foundation Trusts if the Trust has not responded constructively to concerns raised. Annex 8 – Further Provisions (Section 4.2 – page 102) provides details of an existing dispute resolution process. It is proposed that the new process in Section 5 is adopted as this is a more detailed process and is also consistent with the existing process in the South Tees FT constitution.

3. Key issues, significant risks and mitigations

3.1 The risk relating to the constitution is that the content is not consistent with legal or regulatory requirements of the Trust. In order to mitigate this risk, confirmation has been received from the Trust's legal advisors that the proposed amendments are legal and consistent with guidance.

4. Conclusion/Summary/Next steps

4.1 The updated Trust constitution has been updated to reflect current legal and regulatory requirements and was updated alongside the review of the Constitution of South Tees Hospitals NHS Foundation Trust, resulting in alignment. Subject to approval from the updated Constitution by the Board of Directors, this will be published on the Trust's website.

5. Recommendation

5.1 The Board of Directors is asked to;

- Note that the updated Constitution was approved by the Council of Governors on 15 February 2024; and
- Consider and approve the updated Constitution.

Stuart Irvine

Director of Strategy, Assurance & Compliance/Company Secretary

North Tees and Hartlepool
NHS Foundation Trust

North Tees and Hartlepool NHS Foundation Trust

Constitution

[updated: February 2024 in conjunction with South Tees Hospitals NHS FT]

Introduction

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

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

North Tees and Hartlepool NHS Foundation Trust Constitution
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1. Name

The name of the foundation trust is North Tees and Hartlepool NHS Foundation Trust (the "trust").

2. Principal purpose

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

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

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

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

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

2.2.3 the promotion and protection of public health; and

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

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

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

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

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

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

3. Powers

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

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

3.3 The powers of the Board of Directors, which may be delegated to a committee of directors or to an executive director, are detailed in the 2006 Act and in the trust's reservation of powers to the board and delegations of powers.

4. Membership and constituencies

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

4.1.1 a public constituency; and
4.1.2 a staff constituency

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

5. Application for membership

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

6. Public constituency

6.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the trust.

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

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

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

7. Staff constituency

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

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

or

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

7.2 Individuals, who exercise functions for the purposes of the trust (which for the avoidance of doubt shall not include non-executive directors), otherwise than under a contract of employment with the trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

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

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

7.5 Automatic membership by default – staff

An individual who is:

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

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

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

8. Restriction on membership

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

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

8.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the trust are set out in Annex 8 – Further Provisions.

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

9. Council of Governors – composition

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

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

9.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 1 and Annex 3.

10. Council of Governors – election of governors

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

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

10.3 For the avoidance of doubt, any such amendments made to the model rules for elections from time to time do not require consultation and/or approval in

accordance with paragraph 37 of this constitution. For the avoidance of doubt, the trust cannot amend the model rules for elections.

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

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

10.6 Election of lead governor

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

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

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

10.6.4 This appointment shall be made from the public governors.

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

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

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

11. Council of Governors – tenure

Subject to the provisions of paragraph 12:

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

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

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

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

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

12. Council of Governors – disqualification and removal

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

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

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

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

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

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

12.1.6 a person who has been convicted of any offence of violence against or dishonesty in relation to a member of the trust's staff or the trust itself.

12.1.7 a member of staff who is under investigation for gross misconduct, subject to disciplinary action or has been suspended in the course of their duties until the matter is spent.

12.2 In addition to those criteria listed above, further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 5.

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

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

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

13. Council of Governors – Duties of Governors

13.1 The general duties of the Council of Governors are:

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

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

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

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

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

14. Council of Governors – meetings of governors

14.1 The chair of the trust (that is, the chair of the Board of Directors, appointed in accordance with the provisions of paragraph 23) or, in their absence the vice chair (appointed in accordance with the provisions of paragraph 24 below), shall preside at meetings of the Council of Governors. The Council of Governors should meet at least 4 times per year.

14.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons including:

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

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

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

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

15. Council of Governors – standing orders

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

16. Council of Governors – Referral to the Panel

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

16.1.1 to act in accordance with its constitution, or
16.1.2 to act in accordance with provisions made by or under Chapter 5 of the 2006 Act.

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

17. Council of Governors - conflicts of interest of governors

17.1 If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the

Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The standing orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

18. Council of Governors – travel expenses

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

19. Council of Governors – further provisions

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

20. Board of Directors – composition

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

20.2 The Board of Directors is to comprise:

20.2.1 a non-executive chair

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

20.2.3 a minimum of 5 executive directors.

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

20.4 The chief executive shall be the Accounting Officer.

20.5 Where more than one individual is appointed jointly to a post of director, those individuals shall count for the purposes of this paragraph as one person.

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

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

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

21. Board of Directors – General Duty

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

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

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

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

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

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

22.3 They are not disqualified by virtue of paragraph 23 below.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26.1 The whole Board shall appoint or remove the Company Secretary.

27. Board of Directors – disqualification

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

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

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

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

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

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

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

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

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

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

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

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

27.1.11 A person who is unable or unwilling to sign an annual declaration that they continue to meet the Care Quality Commission's Fit and Proper Persons regulations.

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

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

28. Board of Directors – Meetings

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

29. Board of Directors – standing orders

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

30. Board of Directors - conflicts of interest of directors

30.1 Each director has a duty to avoid a situation in which the director has or can have a direct or indirect interest that conflicts or possibly may conflict with the interests of the trust. This duty is not infringed if the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or if the matter has been authorised in accordance with this constitution.

30.2 Each director has a duty not to accept a benefit from a third party by reason of being a director or doing or not doing anything in that capacity. This duty is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

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

30.4 A director need not declare an interest:

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

30.4.2 if, or to the extent that, all the directors are already aware of it;

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

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

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

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

31. Board of Directors – remuneration and terms of office

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

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

32. Registers

The trust shall have:

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

32.2 a register of members of the Council of Governors;

32.3 a register of interests of governors;

32.4 a register of directors; and

32.5 a register of interests of the directors.

33. Admission to and removal from the Registers

33.1 The Trust's company secretary will be responsible for the maintenance of, admission to and removal from the registers under the provisions of this constitution.

33.2 Each director and governor shall advise the company secretary as soon as practicable of anything which comes to his/her attention or which he/she is aware of which might affect the accuracy of the matters recorded in any of the registers

referred to in paragraph 34.

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

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

33.3.2 the member dies.

34. Registers – inspection and copies

34.1 The trust shall make the registers specified in paragraph 27 available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

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

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

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

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

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

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

35. Documents available for public inspection

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

35.1.1 a copy of the current constitution;

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

35.1.3 a copy of the latest annual report; and

35.2 The trust shall also make the following documents relating to a special administration of the trust available for inspection by members of the public free of charge at all reasonable times:

35.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act;

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

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

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

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

35.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (Regulator's decision), 65KB (Secretary of State's response to Regulator's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act;

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

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

35.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act; and

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

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

35.4 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.

36. Auditor

36.1 The trust shall have an auditor.

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

37. Audit committee

37.1 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.

38. Accounts

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

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

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

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

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

38.6 The trust shall:

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

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

38.6.3 send copies of any accounts prepared pursuant to paragraph 33.2, and any report of an auditor on them to the Regulator within such period as the Regulator may direct.

39. <u>Annual report, forward plans and non NHS work</u>

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

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

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

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

39.5 The forward planning information must include information about –

39.5.1 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

39.5.2 the income it expects to receive from doing so.

39.6 Where the forward planning information contains a proposal that the trust carry on an activity of a kind mentioned in sub-paragraph 39.5.1 the Council of Governors must –

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

39.6.2 notify the directors of the trust of its determination.

39.7 Where the trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purpose of the health service in England may implement

the proposal only if more than half of the members of the Council of Governors of the trust voting approve its implementation.

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

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

40.1.1 the annual accounts;

40.1.2 any report of the auditor on them;

40.1.3 the annual report.

40.2 The documents shall also be presented to the members of the trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance. The trust may combine a meeting of the Council of Governors convened for the purposes of paragraph 40.1 with the Annual Members' Meeting.40.3 Where an amendment has been made to this constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the trust), at least one governor shall attend the next Annual Members' Meeting to be held, at which the governor shall present the amendment and the members shall be entitled to vote on whether they approve the amendment.

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

41. Significant Transactions

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

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

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

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

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

42. Acquisition, Merger, Separation and Dissolution

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

43. Instruments

43.1 The trust shall have a seal.

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

43.3 The seal shall be kept by the company secretary.

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

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

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

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

44. Interpretation and definitions

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

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

the 2006 Act is the National Health Service Act 2006.

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

The 2022 Act is the Health and Care Act 2022.

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

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

constitution means this constitution and all annexes to it.

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

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

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

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

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

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

The Regulator is the body corporate known as NHS England, as provided by section 61 of the 2012 Act or its successor.

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

45. Amendment to constitution

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

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

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

45.2 Amendments take effect as soon as the conditions in paragraph 38.1 are satisfied, but an amendment shall have no effect in so far as the constitution would, as a result of the amendment, not accord with Schedule 7 of the 2006 Act.

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

45.4 If an amendment relates to the powers or duties of the Council of Governors (or is otherwise with respect to the role that the Council of Governors has as part of the trust), paragraphs 34.4 and 34.5 of the constitution shall apply.

46. Law and guidance

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

47. Indemnity

47.1 Governors and directors who act honestly and in good faith and not recklessly will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Council of Governors or Board of Directors functions. Any such liabilities will be liabilities of the trust.

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

ANNEX 1

THE PUBLIC CONSTITUENCY

Name of Constituency	Area	Minimum Number of Members	Number of Governors
Stockton	Stockton	52	11
Hartlepool	Hartlepool	28	6
Easington	Easington	10	2
Sedgefield	Sedgefield*	10	2
Rest of England	Any area of England other than Stockton, Hartlepool, Easington or Sedgefield	1	1

Each of these areas comprises local authority wards and parliamentary constituencies for the purpose of local government elections in England.(*Sedgefield comprises those local authority electoral wards and parliamentary constituencies which are geographically aligned to the trust's catchment area).

The trust will ensure that (taken as a whole) the actual membership of its public constituency is representative of those eligible for such membership.


Stanley
Chester-le-Street
Houghton-le-Spring
Kimblesworth
Hetton
Pittington
Durham
Easington
Croxdale
Spennym
Sedgefield
Hartlepool
Coundon Grat
Newton Aycliffe
Redcar
Stockton
Darlington
Nunthorpe
Guisborough

ANNEX 2

THE STAFF CONSTITUENCY

The minimum number of members required for the staff constituency is to be 50.

ANNEX 3

COMPOSITION OF COUNCIL OF GOVERNORS

1. Council of Governors structure

1.1 The Council of Governors of the trust shall include:

1.1.1 21 public governors selected by the public constituency;

1.1.2 1 rest of england public governor elected by the public constituency;

1.1.3 6 staff governors elected by the staff constituency;

1.1.4 11 partnership Governors appointed by stakeholders comprising;

1.1.4.1 3 representatives from regional universities;
1.1.4.2 1 NENC ICB representative;
1.1.4.3 1 system health or care organisation representative
1.1.4.4 3 local authority representatives;
1.1.4.5 3 Healthwatch representatives.

1.2 It would be the trust's responsibility to write to each of the above to invite representation on the trust's Council of Governors.

1.3 The public governors must total more than half of the total membership of the Council of Governors.

1.4 The chair of the Trust shall chair the Council of Governors.

2. Public governors

2.1 Members of the public constituency may elect any of their number to be a public governor.

2.2 If contested, the election must be by secret ballot.

2.3 The model rules for elections, including:

2.3.1. the specified forms of, and period for, declarations to be made by candidates standing for office and members as a condition of voting; and

2.3.2 the process if the election is uncontested.

are set out in Annex 4.

2.4 A person may not stand for election to the Council of Governors as a public governor unless they have made a declaration in the form specified in and within the time period stated in Annex 4. The particulars of their qualification to vote as a member of the public constituency for which the election is being held and the fact that they are not prevented from being a member of the Council of Governors by paragraph 8 to Schedule 7 of the 2006 Act or by paragraph 1 of Annex 8 below

(disqualification) need to be stated. It is an offence to knowingly or recklessly make a declaration under section 60 of the 2006 Act which is false in a material particular.

3. Staff governors

3.1 Members of the staff constituency may elect any of their number to be a staff governor.

3.2 If contested, the election must be by secret ballot.

3.3 The model rules for elections, including:

3.3.1 the specified forms of, and periods for, declaration to be made by candidates standing for office and members as a condition of voting; and

3.3.2 the process if the election is uncontested

are set out in Annex 4.

3.4 A person may not stand for election to the Council of Governors as a staff governor unless they have made a declaration, in the form specified in and within the time stated in Annex 4, that they are not prevented from being a member of the Council of Governors by paragraph 8 to Schedule 7 of the 2006 Act or by paragraph 1 of Annex 8 below (disqualification).

4 **Appointed Governors**

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

5 **Partnership organisations**

5.1 The organisations which are partnership organisations are the;

5.1.1 University of Newcastle upon Tyne;
5.1.2 University of Sunderland; and
5.1.3 University of Teesside.

5.2 Partnership governors will be appointed by the partnership organisations in accordance with the process agreed with the company secretary.

6. ICB Representative

6.1 The following ICB may appoint one representative:

6.1.1 NENC ICB

6.2 These governors will be appointed in accordance with a process to be agreed between the trust and the ICB.

7. System health or care organisation representative

7.1 These governors will be appointed in accordance with a process to be agreed between the trust and the chosen organisation.

8. Local authority governors

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

8.1.1 Hartlepool Borough Council;

8.1.2 Stockton on Tees Borough Council; and

8.1.3 Durham County Council.

8.2 These governors will be appointed in accordance with a process to be agreed between the local authority and the trust.

9 Healthwatch governors

9.1 The following healthwatch organisations may each appoint one Healthwatch governor:

9.1.1 Healthwatch Stockton on Tees

9.1.2 Healthwatch Hartlepool

9.1.3 Healthwatch County Durham

9.2 These governors will be appointed in accordance with a process to be agreed between the Healthwatch organisation and the trust.

ANNEX 4

THE MODEL RULES FOR ELECTIONS

North Tees and Hartlepool NHS Foundation Trust (Council of Governors)

Rules for the Conduct of Elections for Public and Staff Governors

PART 1: INTERPRETATION

1. Interpretation

PART 2: TIMETABLE FOR ELECTION

2. Timetable
3. Computation of time

PART 3: RETURNING OFFICER

4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election
9. Nomination of candidates
10. Candidate's particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination forms
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination forms
17. Withdrawal of candidates
18. Method of election

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity (public and patient constituencies)

Action to be taken before the poll

22. List of eligible voters
23. Notice of poll
24. Issue of voting information by returning officer

25. Ballot paper envelope and covering envelope
26. E-voting systems

The poll

27. Eligibility to vote
28. Voting by persons who require assistance
29. Spoilt ballot papers and spoilt text message votes
30. Lost voting information
31. Issue of replacement voting information
32. ID declaration form for replacement ballot papers (public and patient constituencies)
33 Procedure for remote voting by internet
34. Procedure for remote voting by telephone
35. Procedure for remote voting by text message

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

36. Receipt of voting documents
37. Validity of votes
38. Declaration of identity but no ballot (public and patient constituency)
39. De-duplication of votes
40. Sealing of packets

PART 6: COUNTING THE VOTES

41. Interpretation of Part 6
42. Arrangements for counting of the votes
43. The count
44. Rejected ballot papers and rejected text voting records
45. First stage
46. The quota
47 Transfer of votes
48. Supplementary provisions on transfer
49. Exclusion of candidates
50. Filling of last vacancies
51. Order of election of candidates

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

52. Declaration of result for contested elections
53. Declaration of result for uncontested elections

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll
55. Delivery of documents
56. Forwarding of documents received after close of the poll

57. Retention and public inspection of documents
58. Application for inspection of certain documents relating to election

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

59. Countermand or abandonment of poll on death of candidate

PART 10: ELECTION EXPENSES AND PUBLICITY

Expenses

60. Election expenses
61. Expenses and payments by candidates
62. Expenses incurred by other persons

Publicity

63. Publicity about election by the corporation
64. Information about candidates for inclusion with voting information
65. Meaning of “for the purposes of an election”

PART 11: QUESTIONING ELECTIONS AND IRREGULARITIES

66. Application to question an election

PART 12: MISCELLANEOUS

67. Secrecy
68. Prohibition of disclosure of vote
69. Disqualification
70. Delay in postal service through industrial action or unforeseen event

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Timetable

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

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

3. Computation of time

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

(a) a Saturday or Sunday;

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

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

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

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

4. Returning Officer

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

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

5. Staff

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

6. Expenditure

6.1 The corporation is to pay the returning officer:

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

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

7. Duty of co-operation

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

8. Notice of election

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

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

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

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

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

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

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

(g) the contact details of the returning officer

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

9. Nomination of candidates

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

9.2 The returning officer:

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

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

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

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication),

and

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

11. Declaration of interests

11.1 The nomination form must state:

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

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

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

12. Declaration of eligibility

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

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

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

13. Signature of candidate

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

(a) they wish to stand as a candidate,

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

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

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

14. Decisions as to the validity of nomination

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

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

(b) decides that the nomination form is invalid,

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

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

candidacy.

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

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

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

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

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

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

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

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

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

15. Publication of statement of candidates

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

15.2 The statement must show:

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

(b) the declared interests of each candidate standing,

as given in their nomination form.

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

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

the statement.

16. Inspection of statement of nominated candidates and nomination forms

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

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

17. Withdrawal of candidates

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

18. Method of election

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

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

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

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

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

19. Poll to be taken by ballot

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

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

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

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

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

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

(i) configured in accordance with these rules; and

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

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

(i) configured in accordance with these rules; and

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

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

(i) configured in accordance with these rules; and

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

20. The ballot paper

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

20.2 Every ballot paper must specify:

(a) the name of the corporation,

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

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

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

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

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

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

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

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

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

(a) that the voter is the person:

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

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

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

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

("declaration of identity")

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

electronic method.

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

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

Action to be taken before the poll

22. List of eligible voters

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

22.2 The list is to include, for each member:

(a) a postal address; and,

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

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

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

23. Notice of poll

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

(a) the name of the corporation,

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

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

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

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

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

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

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

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

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

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

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

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

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

(a) a ballot paper and ballot paper envelope,

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

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

(d) a covering envelope;

("postal voting information").

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

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

(b) the voter's voter ID number,

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

(d) contact details of the returning officer,

("e-voting information").

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

(a) only be sent postal voting information; or

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

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

for the purposes of the poll.

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

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

25. Ballot paper envelope and covering envelope

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

25.2 The covering envelope is to have:

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

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

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

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

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

26. E-voting systems

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

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

26.3 If text message voting is a method of polling for the relevant election then the

returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

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

(a) require a voter to:

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

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

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

(b) specify:

(i) the name of the corporation,

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

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

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

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

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

(vii) the contact details of the returning officer;

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

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

(i) the voter’s voter ID number;

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

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

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

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

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

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

(a) require a voter to

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

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

(b) specify:

(i) the name of the corporation,

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

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

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

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

(vi) the contact details of the returning officer;

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

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

(i) the voter's voter ID number;

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

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

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

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

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

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

(a) require a voter to:

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

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

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

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

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

(i) the voter's voter ID number;

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

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

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

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

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

The poll

27. Eligibility to vote

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

28. Voting by persons who require assistance

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

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

29. Spoilt ballot papers and spoilt text message votes

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

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

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

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

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

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning

officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

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

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

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

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

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

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

(a) the name of the voter, and

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

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

30. Lost voting information

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

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

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

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

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

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

(a) the name of the voter

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

applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

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

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

(a) the name of the voter,

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

(c) the voter ID number of the voter.

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

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

Polling by internet, telephone or text

33. Procedure for remote voting by internet

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

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

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

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

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

34. Voting procedure for remote voting by telephone

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

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

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

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

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

35. Voting procedure for remote voting by text message

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

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

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

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

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

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

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

36.2 The returning officer may open any covering envelope or any ballot paper envelope

for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

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

(b) the unique identifier on a ballot paper.

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

37. Validity of votes

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

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

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

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

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

(a) mark the ballot paper "disqualified",

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

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

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

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

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

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

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

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

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

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

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

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

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

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

39. De-duplication of votes

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

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

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

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

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

(a) mark the ballot paper "disqualified",

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

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

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

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

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

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

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

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

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

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

40. Sealing of packets

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

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

(b) the ID declaration forms, if required,

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

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

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

41. Interpretation of Part 6

41.1 In Part 6 of these rules:

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

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

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

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

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

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

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

or

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

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

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

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

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

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

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

of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,
"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules 47.4 or 47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:
  (i) the use of such software for the purpose of counting votes in the relevant election, and
  (ii) a policy governing the use of such software, and
(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:
  (iii) ballot papers that have been returned; and
  (iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and
(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote

counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

44. Rejected ballot papers and rejected text voting records

44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule 44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule 44.3.

45. First stage

45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

46. The quota

46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

46.2 The result, increased by one, of the division under rule 46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules 47.1 to 47.3 has been complied with.

47. Transfer of votes

47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule 47.1.

47.3 The returning officer is, in accordance with this rule and rule 48, to transfer each sub-parcel of ballot documents referred to in rule 47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

47.4 The vote on each ballot document transferred under rule 47.3 shall be at a value

("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

47.6 The returning officer is, in accordance with this rule and rule 48, to transfer each sub-parcel of ballot documents referred to in rule 47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

47.7 The vote on each ballot document transferred under rule 47.6 shall be at:

(a) a transfer value calculated as set out in rule 47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

47.8 Each transfer of a surplus constitutes a stage in the count.

47.9 Subject to rule 47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total

numbers of votes and the candidate next above such candidates.

47.11 This rule does not apply at an election where there is only one vacancy.

48. Supplementary provisions on transfer

48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

48.2 The returning officer shall, on each transfer of transferable ballot documents under rule 47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

48.3 All ballot documents transferred under rule 47 or 49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule 47 or 49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

49. Exclusion of candidates

49.1 If:

(a) all transferable ballot documents which under the provisions of rule 47 (including that rule as applied by rule 49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule 50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule 49.12 applies, the candidates with the then lowest votes).

49.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule 49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

49.3 The returning officer shall, in accordance with this rule and rule 48, transfer each sub-parcel of ballot documents referred to in rule 49.2 to the candidate for whom the next available preference is given on those ballot documents.

49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

49.5 If, subject to rule 50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule 49.1 into sub- parcels according to their transfer value.

49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

49.7 The vote on each transferable ballot document transferred under rule 49.6 shall be at the value at which that vote was received by the candidate excluded under rule 49.1.

49.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall

proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule 49.1.

49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules 47.5 to 47.10 and rule 48.

49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

50. Filling of last vacancies

50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing

candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

51. Order of election of candidates

51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule 47.10.

51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

52. Declaration of result for contested elections

52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the North Tees and Hartlepool 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 who he or she has declared elected.

52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule 44.1,

(f) the number of rejected text voting records under each of the headings in rule 44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with "rejected in part",

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

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

54.2 The returning officer must not open the sealed packets of:

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

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

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

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

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed

pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in

accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that the Regulator has declared that the vote was invalid.

59. Countermand or abandonment of poll on death of candidate

59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to the Regulator under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to the Regulator for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to the Regulator by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. The Regulator will refer the application to the independent election arbitration panel appointed by The Regulator.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 The Regulator shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

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67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 5

ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

1 A person may not vote at an election for a public governor unless within the specified period they have made a declaration in the specified form stating the particulars of their qualification to vote as a member of the constituency for which an election is being held. It is an offence to knowingly or recklessly to make such a declaration which is false in a material particular.

2. Partnership governors (including all organisations in the wider health and care system), as the case may be, shall cease to hold office where the relevant appointing organisation notifies the company secretary of the withdrawal of their appointment of them.

3. Subject to paragraph 3A below and in addition to those criteria listed in paragraph 12.1 of the constitution a person may not become or continue as a governor of the trust if:

3.1 They have within the preceding 2 years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body.

3.2 They are a person whose tenure of office as the chair or as a member or director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest.

3.3 They are an executive or non-executive director of the trust, or a non-executive director, chair or chief executive or executive director of another NHS organisation.

3.4 They have been removed from membership of a professional body or from a list of registered medical, dental, nursing or other health care practitioners as a result of disciplinary action or any conclusion that the continued inclusion of that person's name on any such list or membership of any such professional body would be prejudicial to the efficiency of the services to which the professional body or list relates and has not subsequently been re-instated to membership or such a list.

3.5 They are incapable by reason of mental disorder, illness or injury of managing and administering their property and affairs.

3.6 The Council of Governors reasonably considers that they are unfit to discharge the functions of a governor.

3.7 They have been disqualified from membership of their profession by the professional or regulatory body.

3.8 They bring the trust into disrepute or their actions are detrimental to the interests of the trust.

3.9 They have had their name placed on the registers of Schedule 1 offenders pursuant to the Sex Offenders Act 1977 and/or the Children's and Young Person's Act 1993.

3.10 They fail to confirm acceptance of the Council of Governors code of conduct, and/or a breach of the code of conduct.

3.11 They are a member of parliament.

3A. Further to paragraph 3, a person may not become or continue as a public governor if they are a governor in another NHS organisation.

3B. Where a person has been elected or appointed to be a governor and they become disqualified for appointment under paragraph 12.1 of the constitution and/or paragraph 3 or 3A above they shall notify the company secretary in writing of such disqualification.

3C. If it comes to the notice of the trust at the time of their appointment or later that the governor is so disqualified, the trust shall immediately declare that the person in question is disqualified and notify them in writing to that effect.

3D. Upon receipt of any such notification, that person's tenure of office, if any, shall be terminated and they shall cease to act as a governor.

3E. The nominations committee on behalf of the Council of Governors will decide whether a governors position should be terminated in the event of any of the above actions occurring or a breach of the Council of Governors code of conduct has occurred. The sub-committee shall subsequently call a general meeting of the Council of Governors to approve their decision for the removal of a governor.

3F A staff governor who is suspended from staff duties for any reason will also be suspended from their role as a governor for the duration of their suspension. Whilst a staff governor is under investigation, they cannot attend meetings of the Council of Governors in any capacity, but missing any meetings of the Council of Governors will not count as failure to attend for the purpose of 4.2 below.

4. **Termination of Tenure**

4.1 A governor may resign from office at any time during the term of that office by giving notice in writing to the company secretary.

4.2 If a governor fails to attend for 3 consecutive meetings of the Council of the Governors their tenure of office is to be immediately terminated unless the other governors are satisfied that:

4.2.1 the absence was due to a reasonable cause; and

4.2.2 they will be able to start attending meetings of the Council of Governors again within such a period as they consider reasonable.

4.3 In the event that the governor failed to attend further meetings they may be terminated after consideration by the nominations committee.

5. **Managing Vacancies**

5.1 The validity of any act of the trust is not affected by any vacancy among the governors or by any defect in the appointment of any governor.

5.2 In the event that the trust has Governor vacancies remaining following an election process, a further election will take place.

6. Roles and responsibilities of Council of Governors at a general meeting

6.1 In addition to those powers contained elsewhere in this constitution the roles and responsibilities of the governors at a general meeting are:

6.2 To approve the remuneration and allowances, and the other terms and conditions of office, of the non-executive directors.

6.3 To appoint or remove the trust's auditor.

6.4 To both consider and be presented with the annual accounts, any report of the auditor on them, and the annual report at the annual general meeting of the trust.

6.5 To give the views of the Council of Governors to the directors for the purposes of the preparation (by the directors) of the document containing information as to the trust's forward planning in respect of each financial year to be given to the Regulator.

6.6 To respond as appropriate when consulted by the directors in accordance with this constitution.

6.7 Such other duties as may be agreed with the directors from time to time.

6.8 A governor elected to the Council of Governors by the public constituency or the staff constituency may not vote at a meeting of the Council of Governors unless, within one month of election or by the date of the next Council of Governors Meeting after their election (whichever is the sooner) they have made a declaration in the form found at Annex 4 that they are a member of the public constituency, or the staff constituency and are not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 to the 2006 Act or is otherwise prevented under this constitution

6.9 Committees and Sub-Committees

6.9.1 the Council of Governors may appoint committees consisting of its members to assist it in carrying out its functions. A committee appointed under this paragraph may appoint a sub-committee;

6.9.2 these committees or sub-committees may, where appropriate and reasonable, call upon outside advisers to help them in their tasks.

6.10 Code of conduct

The Council of Governors shall at all times comply with the provisions of the trust's Council of Governors code of conduct as varied by the Board of Directors from time to time.

ANNEX 6

STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

1. Meetings of the Council of Governors

1.1 Admission of the public and the press - The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Council of Governors but shall be required to withdraw upon the Council of Governors resolving as follows:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting because the confidential nature of the business to be transacted is such that publicity would be prejudicial to the public interest".

1.2 The chair (or vice chair) shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Council of Governors' business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Council of Governors resolving as follows.

"That in the interests of public order the public withdraw from the meeting for (the period to be specified) to enable the Council of Governors to complete business without the presence of the public".

1.3 Nothing in these standing orders shall require the Council of Governors to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Council of Governors.

1.4 Calling meetings - ordinary meetings of the Council of Governors shall be held at such times and places as determined by the trust. Meetings may be held virtually by means of digital technology.

1.5 The chair may call a meeting of the Council of Governors at any time. If the chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of governors, has been presented to them, or if, without so refusing, the chair does not call a meeting within 7 days after such requisition has been presented to them, at the trust's headquarters, such one third or more governors may forthwith call a meeting.

1.6 Notice of meetings - Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the chair or by an officer of the trust authorised by the chair to sign on their behalf shall be delivered to every governor, or sent by post to the usual place of residence of such governor, so as to be available to them at least 6 days before the meeting.

1.7 Lack of service of the notice on any governor shall not affect the validity of a meeting.

1.8 In the case of a meeting called by governors in default of the chair, the notice shall be signed by those governors and no business shall be transacted at the meeting other than that specified in the notice.

1.9 Failure to serve such a notice on more than 3 governors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post, and by electronic means.

1.10 Setting the agenda - The Council of Governors may determine that certain matters shall appear on every agenda for a meeting of the Council of Governors and shall be addressed prior to any other business being conducted. Such matters may be identified within these standing orders or following subsequent resolution shall be listed in an appendix to the standing orders.

1.11 A governor desiring a matter to be included on an agenda shall make their request in writing to the chair at least 14 days before the meeting, subject to standing order 1.8. Requests made less than 8 days before a meeting may be included on the agenda at the discretion of the chair, and if agreed would be taken under any other business.

1.12 Chair of meeting - At any meeting of the trust, the chair, if present, shall preside. If the chair is absent from the meeting the vice chair, if there is one and they are present, shall preside. If the chair and vice chair are absent, the senior independent director or the lead governor shall preside.

1.13 If the chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the vice chair, if present, shall preside. If the chair and vice chair are absent, or are disqualified from participating, the senior independent director or the lead governor shall preside.

1.14 Annual general meeting - The trust will publicise and hold an annual general meeting in public.

1.15 Notices of motion - A governor of the trust desiring to move or amend a motion shall send a written notice there of at least 10 days before the meeting to the chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being in compliance with these standing orders. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to standing order 1.8.

1.16 Withdrawal of motion or amendments - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the chair.

1.17 Motion to rescind a resolution - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the governors who gives it and also the signature of 3 other governors. When any such motion has been disposed of by the trust, it shall not be competent for any governor other than the chair to propose a motion to the same effect within 3 months; however the chair may do so if he considers it appropriate.

1.18 Motions - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment there to.

1.19 When a motion is under discussion or immediately prior to discussion it shall be open to a governor to move:

- an amendment to the motion;
- the adjournment of the discussion or the meeting;
- that the meeting proceed to the next business;
- the appointment of an ad hoc committee to deal with a specific item of business;
- that the motion be now put.

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

1.20 Chair's ruling - Statements of governors made at meetings of the trust shall be relevant to the matter under discussion at the material time and the decision of the chair of the meeting on questions of order, relevance, regularity and any other matters shall be observed at the meeting.

1.21 Voting - Save where all public governors present are unanimous in opposing a motion, every question at a meeting shall be determined by a majority of the votes of the governors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote. In the event that a motion is opposed by all public governors present, that motion shall not be passed.

1.22 All questions put to the vote shall, at the discretion of the chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the governors present so request, and the chair agrees such a request.

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

1.24 If a governor so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

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

1.26 Minutes - The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where, if approved at the meeting, they will be signed by the person presiding at it.

1.27 No discussion shall take place upon the minutes except upon their accuracy or where the chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the meeting subsequent to the meeting to which the minutes relate.

1.28 Where providing a record of a public meeting the minutes shall be made available to the public (required by the code of practice on openness in the NHS).

1.29 Suspension of standing orders - Except where this would contravene any statutory provision any one or more of the standing orders may be suspended at any meeting, provided that at least two-thirds of the Council of Governors are present, including one staff governor and one public governor, and that a majority of those present vote in favour of suspension.

1.30 A decision to suspend standing orders shall be recorded in the minutes of the meeting.

1.31 A separate record of matters discussed during the suspension of standing orders shall be made and shall be available to the governors.

1.32 No formal business may be transacted while standing orders are suspended.

1.33 The audit committee shall review every decision to suspend standing orders.

1.34 Variation and amendment of standing orders - These standing orders shall be amended only if:

- a notice of motion under standing order 1.15 has been given;
- no fewer than half the total of the trust's public governors vote in favour of amendment;
- at least two-thirds of the governors are present; and
- the variation proposed does not contravene a statutory provision.

1.35 Record of attendance - The names of the governors present at the meeting shall be recorded in the minutes.

1.36 Quorum - No business shall be transacted at a meeting of the Council of Governors unless at least one-third of the whole number of the governors are present, including at least 4 public governors.

1.37 If a governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see standing order 4.5) they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

1.38 The Council of Governors will receive, discuss and approve any proposed amendments to the constitution presented to them at a general meeting of the Council of Governors.

2. Committees

2.1 Appointment of committees - The Council of Governors may appoint committees of the Council of Governors, consisting wholly or partly of governors.

2.2 A committee appointed under standing order 2.1 may appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include governors).

2.3 These standing orders, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committees established by the Council of Governors.

2.4 Each such committee or sub-committee shall have such terms of reference and powers in relation to the business of the Council of Governors, and be subject to such conditions (as to reporting back to the Council of Governors), as the Council of Governors shall decide. Such terms of reference shall have effect as if incorporated into the standing orders.

2.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Council of Governors.

2.6 Confidentiality - A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Council of Governors or shall otherwise have concluded on that matter.

2.7 A governor or a member of a committee shall not disclose any matter reported to the Council of Governors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or committee shall resolve that it is confidential.

3. Declarations of interests and register of interests

3.1 Declaration of interests - The trust's constitution requires governors to declare interests which are relevant and material to the Council of Governors of which they are a member. All governors should declare such interests, and are required to review these each year.

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

3.2.1 directorships, including non-executive directorships held in public or private limited companies (with the exception of those of dormant companies);

3.2.2 ownership or part-ownership of public or private limited companies, businesses, majority or controlling share holdings in organisations or consultancies likely or possibly seeking to do business with the NHS;

3.2.3 a position of authority in a charity or voluntary organisation in the field of health and social care;

3.2.4 any connection with a voluntary or other organisation contracting for NHS services.

3.2.5 any family connections with any of the above or any other NHS, voluntary, public or private body which provides services to the trust.

3.4 If governors have any doubt about the relevance of an interest, this should be discussed with the chair.

3.5 At the time governors' interests are declared, they should be recorded in the Council of Governors minutes of the relevant meeting. Any changes in interests should be declared at the next Council of Governors' meeting following the change occurring.

3.6 Governors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Council of Governors' annual report. The information should be kept up to date for inclusion in succeeding annual reports.

3.7 During the course of a Council of Governors' meeting, if a conflict of interest is established, the governor concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

3.8 For the purposes of this standing order 3 there is no requirement for the interests of governors' spouses or partners to be declared. Note that standing order 4 which is based on the Health Authorities (Membership and Procedure) Regulations 1996 requires that the interest of governors' spouses, if living together, in contracts should be declared.

3.9 Register of interests - The chief executive will ensure that a register of interests is established to record formally declarations of interests of governors. In particular the register will include details of all directorships and other relevant and material interests which have been declared by governors, as defined in standing order 3.2.

3.10 These details will be kept up to date by means of an annual review of the register in which any changes to interests declared during the preceding 12 months will be incorporated.

3.11 The register will be available to the public and the chief executive will take reasonable steps to bring the existence of the register to the attention of the local population and to publicise arrangements for viewing it. To view the register, contact should be made to the company secretary.

4 Role and Responsibilities of the Council of Governors

4.1 The Council of Governors shall:

4.1.1 hold the non-executive directors individually and collectively to account for the performance of the Board of Directors; and

4.1.2 represent the interests of the members of the trust as a whole and the interests of the public.

4.2 The roles and responsibilities of the governors are at a general meeting or otherwise to:

4.2.1 give the views of the Council of Governors to the directors for the purposes of the preparation (by the directors) of the document containing information as to the trust's forward planning in respect of each financial year to be given to the Regulator;

4.2.2 require one or more directors to attend a meeting of the Council of Governors for the purpose of obtaining information about the trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the trust's or directors' performance); and/or

4.2.3 respond as appropriate when consulted by the directors.

4.3 The governors also have the specific role and function of:

4.3.1 providing views to the Board of Directors on the strategic direction of the trust;

4.3.2 developing membership; and

4.3.3 representing the interests of the members.

4.4 If the Regulator has appointed a panel for advising governors, a governor may refer a question to that panel as to whether the trust has failed or is failing to act in accordance with this constitution or Chapter 5 of the 2006 Act. A governor may only refer a question under this paragraph if more than half of the members of the Council of Governors voting approve the referral.

4.5 The trust will take steps to ensure that governors are equipped with the skills and knowledge they require in their capacity as governors of this trust.

5. Dispute Resolution

5.1 The chair, or vice chair (if the dispute involves the chair) of the Board and the Council of Governors, shall first endeavour through discussion with members of the Council of Governors and directors or, to achieve the earliest possible conclusion, appropriate representatives of them to resolve the matter to the reasonable satisfaction of both parties.

5.2 Failing resolution under 5.1 above then the Board and the Council of Governors, shall, at its next formal meeting, approve the precise wording of a Disputes Statement setting out clearly and concisely the issue or issues giving rise to the dispute.

5.3 The chair, or vice chair (if the dispute involves the chair) of the Board and the Council of Governors, shall ensure that the Disputes Statement, without amendment or abbreviation in any way, shall be an Agenda Item and Agenda Paper at the next formal meeting of the Board or Council of Governors as appropriate. That meeting shall agree the precise wording of a Response to Disputes Statement.

5.4 The chair, or vice chair (if the dispute involves the chair) of the Board and the Council of Governors, shall immediately or as soon as is practicable, communicate the outcome to the other party and deliver the Response to Disputes Statement. If the matter remains unresolved or only partially resolved then the procedure outlined above shall be repeated.

5.5 If, in the opinion of the chair, or vice chair (if the dispute involves the chair) and the Board or the Council of Governors, and following the further discussion prescribed in 5.4, there is no further prospect of a full resolution or, if at any stage in the whole process, in the opinion of the joint chair or vice chair, as the case may be, there is no prospect of a resolution (partial or otherwise) then they shall advise the Council of Governors and the Board accordingly.

5.6 On the satisfactory completion of this disputes process the Board shall implement agreed changes.

5.7 On the unsatisfactory completion of this disputes process the view of the Board shall prevail.

5.8 Nothing in this procedure shall prevent the Council of Governors, if it so desires, from informing the Independent Regulator of NHS Foundation Trusts that, in the Council of Governors' opinion, the Board has not responded constructively to concerns of the Council of Governors that the Trust is not meeting the Terms of its Authorisation.

ANNEX 7

STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

1. **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.

2. **Meetings of the Board of Directors**

2.1 Admission of the public and the press – Meetings of the Board of Directors shall be open to the public and press, but members of the public and press shall be required to withdraw upon the Board of Directors resolving as follows:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting because the confidential nature of the business to be transacted is such that publicity would be prejudicial to the public interest".

2.2 The chair (or vice chair) shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board of Directors' business shall be conducted without inappropriate interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board of Directors resolving as follows:

"That in the interests of public order the public withdraw from the meeting for (the period to be specified) to enable the Board of Directors to complete business without the presence of the public".

2.3 Nothing in these standing orders shall require the Board of Directors to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board of Directors.

2.4 Calling meetings - Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine. Meetings may be held virtually by means of digital technology.

2.5 The chair may call a meeting of the Board of Directors at any time. If the chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of the Board of Directors, has been presented to them, or if, without so refusing, the chair does not call a meeting within 7 days after such requisition has been presented to them, at the trust's headquarters, such one third or more directors may forthwith call a meeting.

2.6 Notice of meetings - Before each meeting of the Board of Directors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the

chair or by an officer of the trust authorised by the chair to sign on their behalf shall be delivered to every director, or sent by post to the usual place of residence of such director, so as to be available to them at least 5 clear days before the meeting.

2.7 Subject to standing order 2.9, lack of service of the notice on any director shall not affect the validity of a meeting.

2.8 In the case of a meeting called by directors in default of the chair, the notice shall be signed by those directors and no business shall be transacted at the meeting other than that specified in the notice.

2.9 Failure to serve such a notice on more than three directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

2.10 Setting the agenda - The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Board of Directors and shall be addressed prior to any other business being conducted. Such matters may be identified within these standing orders or following subsequent resolution shall be listed in an appendix to the standing orders.

2.11 Before holding a meeting, the Board of Directors will send a copy of the agenda (but not supporting papers) to the Council of Governors.

2.12 A director desiring a matter to be included on an agenda shall make their request in writing to the chair at least 5 clear days before the meeting, subject to standing order 1.8. Requests made less than 5 days before a meeting may be included on the agenda at the discretion of the chair.

2.13 Chair of meeting - At any meeting of the trust, the chair, if present, shall preside. If the chair is absent from the meeting the vice chair, if there is one and they are present, shall preside. If the chair and vice chair are absent the directors present shall choose a non-executive director from among them to preside.

2.14 If the chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the vice chair, if present, shall preside. If the chair and vice chair are absent, or are disqualified from participating, the directors present shall choose a non-executive director from among them to preside.

2.15 Notices of motion - A director of the trust desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the meeting to the chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion or amendment being moved during the meeting, without notice on any business mentioned on the agenda subject to standing order 2.9.

2.16 Withdrawal of motion or amendments - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the chair.

2.17 Motion to rescind a resolution - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the directors who gives it and also the signature of three other directors. When any such motion has been disposed of by the trust, it shall not be competent for any director other than the

chair, or such other director as the chair may at their discretion agree, to propose a motion to the same effect within 3 months; however the chair may do so if they consider it appropriate.

2.18 Motions - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment there to.

2.19 When a motion is under discussion or immediately prior to discussion it shall be open to a director to move:

- an amendment to the motion;
- the adjournment of the discussion or the meeting;
- that the meeting proceed to the next business;
- the appointment of an ad hoc committee to deal with a specific item of business;
- that the motion be now put.

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

2.20 Chair's ruling - Statements of directors made at meetings of the trust shall be relevant to the matter under discussion at the material time and the decision of the chair of the meeting on questions of order, relevance, regularity and any other matters shall be observed at the meeting.

2.21 Voting - Save where all voting directors present are unanimous in opposing a motion, every question at a meeting shall be determined by a majority of the votes of the directors present and voting on the question.

2.22 All questions put to the vote shall, at the discretion of the chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

2.23 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.

2.24 If a director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

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

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

2.27 No discussion shall take place upon the minutes except upon their accuracy or where the chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

2.28 Minutes of all public meetings shall be made available to the public (required by the code of practice on openness in the NHS) on the trust's website.

2.29 The agendas and minutes of the public board meetings shall be sent to all members of the Council of Governors.

2.30 Suspension of standing orders - Except where this would contravene any statutory provision any one or more of the standing orders may be suspended at any meeting, provided that at least two-thirds of the Board of Directors are present and that a majority of those present vote in favour of suspension.

2.31 A decision to suspend standing orders shall be recorded in the minutes of the meeting.

2.32 A separate record of matters discussed during the suspension of standing orders shall be made and shall be available to the directors.

2.33 No formal business may be transacted while standing orders are suspended.

2.34 The audit committee shall review every decision to suspend standing orders.

2.35 Variation and amendment of Standing Orders - These standing orders shall be amended only if:

- a notice of motion under standing order 1.14 has been given;
- no fewer than half the total of the trust's directors vote in favour of amendment;
- at least two-thirds of the directors are present;
- the variation proposed does not contravene a statutory provision.

2.36 Record of attendance - The names of the directors present at the meeting shall be recorded in the minutes.

2.37 Quorum - No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of the voting directors are present including at least one executive director and one non-executive director. Where appropriate a director may join the meeting by video conference or telephone.

2.38 If a director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see standing order 4.5) they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

2.39 Where a directors post is shared jointly by more than one individual:

2.39.1 any or all of those persons may attend or take part in meetings of the Board of Directors;

2.39.2 if several of those individuals are present at a meeting they may cast 1 vote between them on any matter being considered if they agree;

2.39.3 if several of those individuals are present at a meeting no vote shall be cast on any matter being considered if they disagree; and

2.39.4 the presence of any number of those individuals is to count as the presence of one director for the purposes of determining whether the required quorum is present at a meeting of the Board of Directors.

2.40 The Board of Directors will ensure the constitution is kept up to date and will, where necessary update the constitution and bring proposals to the Council of Governors for approval.

3. Committees

3.1 Appointment of committees - The Board of Directors may establish committees of the Board of Directors, consisting wholly or partly of directors.

3.2 A committee appointed understanding order 2.1 may establish sub-committees consisting wholly or partly of members of the committee (whether or not they include directors).

3.3 These standing orders, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Board of Directors.

3.4 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide. Such terms of reference shall have effect as if incorporated into the standing orders.

3.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board of Directors.

3.6 Confidentiality - A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter in accordance with the terms of reference of that committee.

3.7 A director or a member of a committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

4. Declarations of interests and register of interests

4.1 Declaration of interests - The trust's constitution requires directors to declare interests which are relevant and material to the Board of Directors and any committee or sub-committee of which they are a member. All existing directors should declare such interests. Any directors appointed subsequently should do so on appointment.

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

4.2.1 directorships, including non-executive directorships held in public or private limited companies (with the exception of those of dormant companies);

4.2.2 ownership or part-ownership (which shall be deemed to include majority or controlling shareholdings) of public or private limited companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

4.2.3 a position of authority in a charity or voluntary organisation in the field of health and social care;

4.2.4 any connection with a voluntary or other organisation contracting for NHS services.

4.3 If directors have any doubt about the relevance of an interest, this should be discussed with the chair.

4.4 At the time directors' interests are declared, they should be recorded in the Board of Directors minutes of the relevant meeting. Any changes in interests should be declared at the next Board of Directors' meeting following the change occurring.

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

4.6 During the course of a Board of Directors' meeting, if a conflict of interest is established, the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

4.7 There is no requirement for the interests of directors' spouses or partners to be declared. Note however that standing order 3 which is based on the Health Authorities (Membership and Procedure) Regulations 1996 requires that the interest of directors' spouses, if living together, in contracts should be declared.

4.8 Register of interests - The chief executive will ensure that a register of interests is established to record formally declarations of interests of directors. In particular the register will include details of all directorships and other relevant and material interests which have been declared by directors, as defined in standing order 3.2.

4.9 These details will be kept up to date by means of an annual review of the register in which any changes to interests declared during the preceding 12 months will be incorporated.

4.10 The register will be available to the public and the chief executive will take reasonable steps to bring the existence of the register to the attention of the local population and to publicise arrangements for viewing it.

4.11 Where a director has a direct or indirect interest in a proposed transaction or arrangement with the trust, they should declare the nature and extent of the interest to the other directors.

If the declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

Such declaration must be made before the Foundation trust enters into the transaction or arrangements.

Exceptions to the need to make a declaration apply where:

- the director is not aware of the interest or of the transaction or arrangement;
- the interest cannot reasonably be regarded as likely to give rise to a conflict of interest;
- the directors are already aware of the interest;
- the interest concerns terms of the director's appointment that have been or are to be considered by a meeting of the Board of Directors or by a committee of the directors appointed for the purpose under the constitution.

5. **Disability of directors in proceedings on account of pecuniary interest**

5.1 Subject to the following provisions of this standing order, if a director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board of Directors at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

5.2 The secretary of state and/or the Regulator may, subject to such conditions as they may think fit to impose, remove any disability imposed by this standing order in any case in which it appears to each of them in the interests of the NHS that the disability shall be removed.

5.3 The Board of Directors shall exclude a director from a meeting of the trust while any contract, proposed contract or other matter in which they have a pecuniary interest, is under consideration.

5.4 Any expenses payable to a director in accordance with this constitution shall not be treated as a pecuniary interest for the purpose of this standing order.

5.5 For the purpose of this standing order the chair or a director shall be treated, subject to standing order 5.2 and standing order 5.6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

5.5.1 they, or a nominee of theirs, 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

5.5.2 they are a partner of, or are in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

and in the case of married persons, civil partners and or people living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this standing order to be also an interest of the other.

5.6 A director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

5.6.1 of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;

5.6.2 of an interest in any company, body or person with which they are connected as mentioned in standing order 5.5 above 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.

5.7 Where a director:

5.7.1 has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

5.7.2 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

5.7.3 if the share capital is of more than one class, the total nominal value of shares of any 1 class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class;

this standing order shall not prohibit them 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 their duty to disclose their interest.

5.8 Appointment to corporate or unincorporated associations

5.8.1 any director of the trust shall take directorships or other roles in corporate or unincorporated associations when nominated to do so by the Board of Directors;

5.8.2 unless otherwise determined by the Board of Directors, and subject to any statutory provisions to the contrary, all delegated powers and limits detailed in these standing orders and any other standing orders of the trust applying to individual directors shall also apply when they are acting in the capacity of a director, partner or leader in corporate or unincorporated associations approved by the Board of Directors.

5.9 Standing order 5 applies to a committee or sub-committee of the Board of Directors as it applies to the Board of Directors and applies to any member of any such committee or sub-committee (whether or not they are also a director) as it applies to a director.

6. Delegation of powers

6.1 Subject to Standing Order 5.2, the non-executive directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the trust. The non-executive directors may exercise collective authority when acting as members of or when chairing a committee or sub-committee of the trust which has delegated powers.

6.2 Subject to any directions as may be given by the Regulator, the Board of Directors may make arrangements for the exercise, on behalf of the Board of Directors, of any of its functions by a committee or sub-committee appointed in accordance with standing order 2, or by a committee of directors or an executive director as delegated by the Board of Directors of the trust, in each case subject to such restrictions and conditions as the Board of Directors deems appropriate.

6.3 The chair has certain delegated executive powers and must comply with the terms of their appointment and these standing orders in respect of exercising such delegated executive powers.

6.4 Subject to standing order 5.7, certain powers and decisions may only be exercised by the Board of Directors in formal session. Such powers and decisions are set out in the trust's "schedule of matters reserved to the board" document.

6.5 Further provisions relating to the delegation of the Board of Directors' powers are set out in the trust's "reservation of powers to the board and delegation of powers" document.

6.6 Directors shall exercise their authority in accordance with the terms of the constitution and the following documents:

6.6.1 Standing financial instructions;

6.6.2 Reservation of powers to the board and delegation of powers;

6.6.3 Schedule of matters reserved to the board;

6.6.4 Scheme of delegation.

All of which are to have effect as if incorporated into these standing orders.

6.7 The powers which the Board of Directors has reserved to itself may in an emergency or for an urgent decision be exercised by the chief executive and the chair after having consulted at least two non-executive directors. The exercise of such powers by the chief executive and chair shall be reported to the next meeting of the Board of Directors for formal ratification.

6.8 Those functions of the trust which have not been reserved to the Board of Directors or expressly delegated shall be exercised on behalf of the Board of Directors by the chief executive. The chief executive shall determine which function they will perform personally and shall nominate officers of the trust to exercise the remaining functions for which the chief executive will retain accountability to the trust.

6.9 The chief executive shall prepare the scheme of delegation which shall be subject to the approval of the Board of Directors. The chief executive may periodically

propose amendments to the scheme of delegation which shall be subject to the approval of the Board of Directors.

6.10 The powers of the trust established under statute shall be exercised by the Board of Directors meeting in public, except as otherwise provided for in the constitution.

7. Finance director

7.1 The trust's finance director shall be responsible for the provision of the financial advice to the trust and to its directors and for the supervision of financial control and accounting systems.

8. Chair

8.1 The chair shall be responsible for the leadership of the Board of Directors and the Council of Governors.

8.2 The chair shall take responsibility either directly or indirectly for and oversee the induction of the non-executive directors, their portfolios of interests and assignments and their performance.

8.3 The chair shall work closely with the chief executive and shall ensure that key and appropriate issues are discussed by the Board of Directors and/or the Council of Governors (as appropriate) in a timely manner, with all the necessary information and advice being made available to the Board of Directors and/or the Council of Governors (as appropriate) to inform debate and subsequent resolutions.

9. Policy statements and procedures

9.1 The Board of Directors and/or duly appointed committees/sub-committees will from time to time agree and approve policy statements and/or procedures which will apply to activities undertaken by the trust and to all or specific groups of staff employed, and subcontractors, agents, suppliers and consultants engaged by or exercising functions on behalf of, the trust. The decisions to approve such policy statements and procedures shall be recorded in an appropriate minute of the relevant meeting of the Board of Directors, committee or sub-committee and will be deemed, where appropriate, to be an integral part of the constitution.

9.2 The following policy statement and procedures of the trust:

9.2.1 the standards of business conduct for trust staff policy; and

9.2.2 the disciplinary policy and procedure

shall have an effect as if incorporated into these standing orders.

ANNEX 8

FURTHER PROVISIONS

1. **Disqualification for membership**

1.1 A person may not be a member of the trust if they:

1.1.1 are under the age of 16 years;

1.1.2 have been convicted of any offence of violence against or dishonesty in relation to a member of the trust's staff or the trust itself or;

1.1.3 if the Council of Governors reasonably considers that they:

1.1.3.1 are unable or unfit to discharge the functions of a member;

1.1.3.2 may bring the trust into disrepute; and

1.1.3.3 has habitually and persistently and without reasonable grounds instituted complaints against the trust.

and the Council of Governors so resolves at a general meeting. No person who has been prevented or expelled from membership under this paragraph 1.1.3 shall be readmitted except by a resolution carried by the votes of two-thirds of the Council of Governors present and voting at a general meeting.

1.1.4 It is the responsibility of the members to ensure their eligibility and not the trust, but if the trust is on notice that a member may be disqualified from membership, they shall carry out all reasonable enquiries to establish if this is the case. Members must be proactive and notify the trust immediately upon becoming aware of any issues concerning their or any member's eligibility.

2. **Termination of membership**

2.1 A member shall cease to be a member if they:

2.1.1 resign by notice to the trust's membership office;

2.1.2 fulfil any of the criteria set out at 1.1 above.

3. **Board of Directors' termination of tenure and disqualification**

3.1 A non-executive director may resign from that office at any time during their term of office by giving notice to the company secretary.

3.2 A director shall cease to be a director if:

3.2.1 in the case of a non-executive director, they are no longer a member of the public constituency;

3.2.2 they are a person whose tenure of office as a chair or as a member of or director of a health service body has been terminated on the grounds that

their appointment is not in the interests of public service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

3.2.3 they have been removed from membership of a professional body or from a list of registered medical, dental, nursing or other health care practitioners as a result of disciplinary action or any conclusion that the continued inclusion of that person's name on any such list or membership of any such professional body would be prejudicial to the efficiency of the services to which the professional body or list relates and has not subsequently been re-instated to membership or such a list;

3.2.4 they have within the preceding 2 years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

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

3.2.6 they become a member of the Council of Governors.

4. **Other**

4.1 Indemnity

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

5. Compliance – Other Matters

5.1 Members of the Council of Governors must behave in accordance with the seven Nolan principles of behaviour in Public Life, and both the Trust's and Council of Governors Code of Conduct as amended from time to time:

- **Selflessness**

Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends

- **Integrity**

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties

- **Objectivity**

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit

- **Accountability**

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office

- **Openness**

Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands

- **Honesty**

Holders of public office have a duty to declare any private interest relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest

- **Leadership**

Holders of public office should promote and support these principles by leadership and example

Board of Directors

Title of report:	Group Board Delegation Proposal										
Date:	4 April 2024										
Prepared by:	Stuart Irvine, Director of Strategy, Assurance & Compliance/Company Secretary										
Executive sponsor:	Stacey Hunter, Group Chief Executive										
Purpose of the report	To request the unitary Board of Directors of North Tees & Hartlepool NHS Foundation Trust, to delegate authority to the Group Board for jointly exercised functions, in accordance with the Health & Care Act 2022 and NHS England guidance.										
Action required:	Approve		Assurance		Discuss	x	Information	x			
Strategic Objectives supported by this paper:	Putting our Population First		Valuing People	x	Transforming our Services		Health and Wellbeing				
Which CQC Standards apply to this report	Safe		Caring		Effective		Responsive		Well Led	x	

Executive Summary and the key issues for consideration/ decision:

Background

North Tees & Hartlepool NHS Foundation Trust (NTHFT) and South Tees Hospitals NHS Foundation Trust (STHFT) established and agreed a Memorandum of Understanding in May 2021, in support of working collaboratively. This resulted in the formation of a Joint Strategic Board (JSB), with no delegated functions as committees in common. This was renamed to Joint Partnership Board (JPB) in October 2021, with membership extended on 15 June 2022 and Terms of Reference were updated in July 2022.

The JPB was established under the new Health & Social Care Act ('the Act') in 2022 as a Single Joint Committee (enabling it to make legally binding decisions) supported by the Integrated Care Board on 19 October 2022. Updated TOR and Schedule 1 (detailing the delegated matters from each unitary Board) were agreed. The Partnership Agreement between NTHFT and STHFT, NHS England (NHSE) NHS North East and North Cumbria Integrated Care Board (ICB) was agreed in November 2023 and officially signed February 2024.

Proposals

Attached at **Appendix A** to this report is the signed Partnership Agreement and attached as **Appendix B** are the Terms of Reference of the Group Board, which includes Schedule 1.

The governance arrangements of the Group Board are set out in detail in the attached report and cover the following key areas;

- Corporate Documents (Constitution, Standing Financial Instructions, Scheme of Delegation etc.

- Conflicts of Interest
- Assurances
- Unitary Board Strategic Objectives
- Group Formation
- Risk and next steps

Conclusion

Due to differences in meetings dates, a proposal to seek delegated authority from STHFT Board of Directors will be sought on 2 April 2024 and a verbal update will be provided by the Company Secretary at the meeting on 4 April 2024, regarding the decision.

The Group Board has now been formed and allows the unitary Board of Directors of North Tees & Hartlepool NHS Foundation Trust to delegate authority to the Group Board, ahead of the first planned meeting on 17 April 2024.

Board Assurance Framework/Corporate Risk Register risks this paper relates to:
This report links to all domains in the Board Assurance Framework.

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity, inclusion		Reputational	x
Workforce	x	Environmental	
Financial/value for money		Estates and Facilities	
Commercial		Compliance/Regulatory	x
Quality, safety, experience and effectiveness	x	Service user, care and stakeholder involvement	x

Board Subcommittee meetings where this item has been considered (specify date)	Management Group meetings where this item has been considered (specify date)
Joint Partnership Board – 20 March 2024	N/A

Recommendation	The Board of Directors is asked to; • Consider and approve to delegate authority to the Group Board for jointly exercised functions, in accordance with the Health & Care Act 2022 and NHS England guidance. • Approve the carry forward of the strategic objectives of the Trust for 2024/25 and the supporting Board Assurance Frameworks; and • Note that the first meeting of the Group Board will be 17 April 2024.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Board of Directors

4 April 2024

Group Board Delegation Proposal

Report of the Director of Strategy, Assurance & Compliance/ Company Secretary

1. Introduction/Background

1.1 North Tees & Hartlepool NHS Foundation Trust (NTHFT) and South Tees Hospitals NHS Foundation Trust (STHFT) established and agreed a Memorandum of Understanding in May 2021, in support of working collaboratively. This resulted in the formation of a Joint Strategic Board (JSB), with no delegated functions as committees in common. This was renamed to Joint Partnership Board (JPB) in October 2021, with membership extended on 15 June 2022 and Terms of Reference were updated in July 2022.

1.2 The JPB was established under the new Health & Social Care Act ('the Act') in 2022 as a Single Joint Committee (enabling it to make legally binding decisions) supported by the Integrated Care Board on 19 October 2022. Updated TOR and Schedule 1 (detailing the delegated matters from each unitary Board) were agreed. The Partnership Agreement between NTHFT and STHFT, NHS England (NHSE) NHS North East and North Cumbria Integrated Care Board (ICB) was agreed in November 2023 and officially signed February 2024.

2. Main content of report

2.1 Attached at **Appendix A** to this report is the signed Partnership Agreement. It was recognised that the Partnership Agreement would be an evolving document and the attached version contains a slight amendment, based on legal advice which will reflect the required content of the Partnership Agreement, subject to approval. Proposed amendments are shows with tracked changes in the document.

2.2 This provides the basis of the signed and formal agreement of both Trusts to work in group arrangements. The document will be continue to be subject to change and should the need arise for further amendments, they would need to be formally agreed and approved.

2.3 Attached as **Appendix B** are the Terms of Reference of the Group Board, which includes Schedule 1. This states that all functions that can be jointly exercised by the Group Board will be delegated and the items that cannot be delegated to the Group Board and must remain at unitary Board level, is explicitly stated. This is in accordance with NHSE Guidance Arrangements for Delegation and Joint Exercise of Statutory Functions – Schedule F.

2.4 Items that cannot be delegated, will be presented to meetings of the unitary Board of Directors meetings of each Trust and this will be included in the annual cycle of business and annual schedule of meetings.

2.5 To provide clarity to the Group Board and unitary Board of Directors meetings, a new cover sheet template will confirm delegated authority.

Corporate Documents

2.6 The Constitutions of each Trust have recently been aligned as much as possible, with the exception of necessary differences e.g. constituency details etc. and were approved by the respective Council of Governors in February 2024. The Constitution is a separate agenda item for Board approval.

2.7 The extant Scheme of Delegation and Standing Financial Instructions of each Trust will be adopted by the Group Board and requests seeking future approval from the Group Board will need to be compliant with both versions. Over the next 12 months, an exercise will be undertaken to align these documents.

Conflict of Interest

2.8 As part of Group arrangements, careful consideration has been given to the risk that directors may have conflicts of interest by reason of being jointly appointed directors of both Trusts. Under Group arrangements and by delegating jointly exercised functions, there are a number of reference points permitting this to occur;

- Overall NHS legal and policy framework for collaboration
- Specific statutory provisions for managing conflicts
- NHS best practice
- Authorisation of joint director roles

2.9 The focus of attention will not be whether there is a conflict of interest, instead the focus will be on ensuring robust processes are in place to provide all relevant information to support informed and robust decision making in the best interest of patients and the population the Group serves.

Assurance

2.10 The Trusts made the decision from the outset to ensure there was sufficient, knowledgeable and experienced governance resource in place to support the journey to Group arrangements, including the temporary retention of the respective Company Secretaries of each Trust.

2.11 Board Assurance Frameworks and risk management processes will remain in place for each Trust, with a view to ensuring standardisation and consistency in a controlled and managed approach. Governance arrangements below committee level will remain in place to ensure assurance and escalation processes continue to operate effectively.

2.12 Further underpinning this process has been the provision of legal advice from the outset and throughout the process, as and when required, which has been acknowledged by the auditors of both Trusts.

2.13 A Group Risk Management Workshop was held with relevant stakeholders in March 2024 and this included the Audit Committee chairs of each Trust, internal audit and external audit representation and the legal advisor. During the meeting, it was acknowledged that the Group and each Trust would be reliant upon the independent assurance provided by respective internal and external auditors and feedback would continue to be sought. It was agreed that an audit would be included in the annual internal audit plan for each Trust in 2024/25 to obtain independent assurance on governance arrangements.

2.14 At the last meeting of the JPB on 20 March 2024, it was agreed to support the decision to proceed to seek approval from the unitary Board of Director meetings on 2nd April 2024 (South Tees Hospitals NHS Foundation Trust) and 4th April 2024 (North Tees & Hartlepool NHS

Foundation Trust) to delegate authority to the Group Board, note that the first meeting of the Group Board will be 17 April 2024.

Unitary Board Strategic Objectives

2.15 The strategic objectives of North Tees & Hartlepool NHS Foundation Trust are proposed to be carried forward into 2024/25 and will be considered in light of the strategic objectives of South Tees Hospitals NHS Foundation Trust and the development of a vision, mission statement and strategic objectives of the Group in early 2024/25. The strategic objectives of both Trusts are set out below;

North Tees & Hartlepool NHS Foundation Trust	South Tees Hospitals NHS Foundation Trust
• Putting Patients First • Valuing Our People • Transforming Our Services • Health & Wellbeing	• Best for safe, clinically effective care and experience. • A great place to work. • A centre of excellence, for core and specialist services, research, digitally supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond. • Deliver care without boundaries in collaboration with our health and social care partners. • Make best use of our resources.

2.16 A draft timescale of October 2024 has been set for a review of strategic objectives of each Trust, to allow embedding of group arrangements, completion of group development sessions and to compare them to draft strategic objectives of the Group.

Group Board Formation

2.17 Following a recent exercise to appoint to jointly appoint into Group Executive Director roles and jointly appoint Non-Executive Directors, the Group Board has now been formed and was approved by the Remuneration Committee, Nominations Committee and Council of Governors respectively during March 2024.

3. Key issues, significant risks and mitigations

3.1 The risks in relation to the formation of the Group Board related to delays in forming the Group Board and potential regulatory or legal action, linked to group proposals. This has been mitigated throughout the process by ensuring appropriate resource has been in place to support the associated work, sourcing legal advice from the outset and effective engagement with the auditors of both Trusts. There has also been extensive stakeholder engagement (internal and external) throughout the process.

4. Conclusion/Summary/Next steps

4.1 Due to timing issues of writing this paper and to ensure consistency across each Trust, a proposal to seek delegated authority from STHFT Board of Directors will be sought on 2 April 2024 and a verbal update will be provided by the Company Secretary at the meeting on 4 April 2024, regarding the decision.

4.2 The Group Board has now been formed and allows the unitary Board of Directors of North Tees & Hartlepool NHS Foundation Trust to delegate authority to the Group Board, ahead of the first planned meeting on 17 April 2024.

5. Recommendation

5.1 The Board of Directors is asked to;

- Consider and approve to delegate authority to the Group Board for jointly exercised functions, in accordance with the Health & Care Act 2022 and NHS England guidance.
- Approve the carry forward of the strategic objectives of the Trust for 2024/25 and the supporting Board Assurance Frameworks; and
- Note that the first meeting of the Group Board will be 17 April 2024.

Stuart Irvine

Director of Strategy, Assurance & Compliance/Company Secretary

Partnership Agreement

1. Overview and Introduction

1.1 This partnership agreement is a formal statement of commitment on behalf of three parties: North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust; and NHS North East and North Cumbria Integrated Care Board (ICB). It builds on considerable work over a number of years to strengthen collaboration between the Trusts on a range of activities with the aim of improving care and outcomes for patients and the wider communities which the Trusts serve. The Trusts have now agreed to adopt a group model working within the wider health system of the Integrated Care System for North East and North Cumbria and this Agreement is key to defining the implementation of that model. The Agreement's purpose is:

1. To set out the design of the operating model for the Group and a plan for the governance and resourcing arrangements which will enable its success;
2. To agree the priorities to be progressed during the coming months and a roadmap for the implementation and launch of the group model;
3. To signal a willingness to continue to strengthen the collaboration through further collaborative working, recognising that the development and implementation of the group model will need to be an iterative process.

1.2. All parties agree that there are major benefits from the effective implementation of greater collaboration to help to address deep-rooted health issues in the population served by the Trusts. The Tees Valley has a higher than average prevalence of chronic disease and the high demand for services to tackle these issues is likely to be exacerbated by a demographic shift over the period to 2040, through which the over 65 population of the Tees Valley increases while the under 65 population decreases in absolute terms[1].

1.3 High levels of deprivation and major social and economic variations including a scarcity of quality employment for some in the area drive health inequalities and demand for services in the Tees Valley and parts of County Durham and North Yorkshire. All Tees Valley local authorities are more deprived than the national average and there are stark differences across the Tees Valley and within individual boroughs. Given that there is a clear link between higher levels of deprivation and higher levels of poor health and preventable mortality, these overall levels of deprivation and the variation across the Tees Valley and beyond create a complex pattern of demand for hospital and community services.

1.4 By working collaboratively the parties will be better able to address these high and varied levels of demand and the Trusts' ability to meet the needs of the shared population will improve. The principle of the Trusts working together is already well established over a number of years and across many specialties.

1.5 The group model will enable the parties to develop the capability and capacity to deliver a significant strategic transformation and realise the benefits of collaboration. The benefits of deepening collaboration include, but are not limited to:

- Better tackling endemic health issues by collaborating on solutions;

[1] ONS quoted in the Tees Valley Economic Assessment 2022

- An unwavering focus on quality (by which we mean patient safety, clinical effectiveness and patient experience) supported by joining up our practices and systems;
- Delivering high quality and sustainable services, improving through learning and increasing resilience;
- Creating a stronger single and coherent voice for communities which is more influential regionally and nationally;
- Maintaining and enhancing local access to key services by making the most of the whole estate and greater integration with partners;
- Maximising the collective power of the existing and future workforce and providing enhanced career possibilities for our staff;
- Growing and developing our own health care workforce (doctors, nurses, AHPs, managers etc.) by close working with local secondary and tertiary education providers, and strengthening our research capacity;
- Addressing disparities in care by adopting joint models to ensure better outcomes; and
- More efficient and resilient corporate services.

1.6. In determining the best structure to enable enhanced collaboration, a range of potential models were considered and the Trusts agreed to adopt a group model, in which each organisation retains its statutory accountabilities, but there is a shared leadership structure, with shared clinical services, culture and practices. This reflects a new stage of maturity in the collaboration between the parties as it has evolved and the critical factor in the decision has been to adopt the structure which can best benefit patient care and the wider population. The Trusts also recognise their key role as leaders across the health care system within the Integrated Care System and believe this too can best be delivered through the adoption of a group model. The group operating model is described in more detail in 2.1 below.

1.7 This Partnership Agreement builds on several years of progressively greater collaboration between the parties which has been reflected in governance changes. A Memorandum of Understanding setting up a Joint Strategy Board, later renamed the Joint Partnership Board (JPB) was signed in May 2021; and a Joint Chair was appointed across the two Trusts. In October 2022 the JPB was established as a Single Joint Committee able to make legally binding decisions; and a revised Terms of Reference was agreed, delegating specific matters from the Trust Boards. In late 2022 the North East and North Cumbria ICB commissioned an external independent strategic review to take stock of progress on collaboration and this review made recommendations on how to deepen the collaboration. In 2023 the JPB agreed to adopt a group model and to push forward with a programme of work to deliver that model. The JPB has been renamed the Group Board and any references in this Partnership Agreement to the JPB or Joint Partnership Board now mean the Group Board..

1.8 Since the agreement to move forward with a group model, work has been underway to design the specific form of that model for the Trusts. During this phase there has been engagement with clinical leaders and external partners, recognising that a joint clinical strategy lies at the heart of the success of the group model and that effective outcomes often rely on joint working with external partners. That level of engagement will intensify throughout the programme through:

- Multi-channel communications with our staff to seek input;
- Ongoing discussions with partners in other NHS Trusts, in particular County Durham and Darlington NHS Foundation Trust and Tees, Esk and Wear Valleys

NHS Foundation Trust; primary care; local authorities; and the voluntary sector; and

- Regular two-way feedback with patients and the wider population, including via the Councils of Governors.

1.9 With the approval of this Agreement the priorities for action within the next phase of the Group's development will be initiated. Subject to progress with these key priorities in the coming months, these will enable the Group to be established during quarter 1 2024/25. It is proposed that the JPB regularly reviews progress in the delivery of the priorities during the mobilisation phase to determine the specific timeline for launch of the group model. We recognise that the programme of work will be an iterative process and we will continue to look for more opportunities to strengthen and deepen our collaboration.

1.10 The parties have agreed a set of principles which define the work of the Group:

- The very best care for everyone
- Equity of access for services[2]
- Respect, compassion and dignity in everything we do
- Learning from all, everyone counts
- Improving lives by working together across Tees Valley and parts of North Yorkshire and areas of County Durham – Peterlee, Easington and Sedgefield
- Using all possible resources effectively and efficiently

These principles both describe the shared values which we expect all staff to demonstrate and also the objectives we hold in delivering the programme.

2. Group Operating Model

2.1 The Trusts shall implement their group operating model by exercising their powers under sections 65Z5 and 65Z6 of the National Health Service Act 2006 to extend the functions that are exercisable jointly with each other and to authorise their Joint Partnership Board (being a joint committee) to exercise such functions in accordance with updated terms of reference that they shall each approve. The group operating model will provide the organisational structures and governance necessary for the Group to operate efficiently and effectively and deliver the Group's strategic ambitions for patients and the wider population. It will also ensure that we maintain proper accountability for our performance and finances, both at a Group level, and where it remains necessary, at a Trust level.

2.2 The Trusts shall report and be accountable operationally and financially as follows:

- The Trusts shall continue to report and be accountable operationally and financially as separate corporate bodies
- Additionally the Trusts will commence reporting in shadow form on a Group basis
- Subsequently, subject to the agreement of the ICB and NHS England, the Trusts will move to a position where they report on a Group basis and are accountable operationally and financially at a Group level rather than as individual Trusts.

2.3 The Trusts have agreed the following key components of the group operating model:

[2] Including compliance with the Equalities Act 2010 and associated legal framework

- Group leadership: board arrangements and executive capacity/capability;
- Clinical teams to develop clinical strategy and transformation;
- Site leadership teams responsible for operational delivery; and
- Corporate services supporting the Group, site and clinical leadership.

2.4 In the process of developing the group operating model a range of design principles have been applied:

- A clinically-driven "Patient First" ethos whereby patients are at the heart of what we do;
- Strategic decision-making which reflects the overall benefit of the Group rather than its component parts;
- A capable distributed leadership model to enable clinical transformation;
- A need to ensure statutory and regulatory requirements continue to be met;
- Form follows function in the design of structures;
- We should start from existing organisational structures in order to retain stability and talent within the Trust structure;
- We avoid duplication and ensure efficiency through clarity of roles;
- We provide enough capacity at Group level to drive strategy;
- A matrix structure in which all senior roles have responsibility and accountability for Group strategy and performance;
- We retain a place-based focus into the communities we serve; and
- Cost effectiveness and potential for efficiencies.

Board Arrangements

2.5 The aim of the group leadership structure will be to provide effective strategic leadership, accountability and oversight of the group model. It will be headed by the Joint Chair, a role which has been in place since 2021. The Trusts have recruited a Joint Group Chief Executive to lead the executive team.

2.6 The Trusts are standardising their committee structures and as part of the move to a group model have agreed to adopt a Group Board structure with all decisions and accountability that can be delegated flowing through the Group Board and its joint committees. The Trusts intend to review and revise their constitutions as necessary to allow these changes during the mobilisation phase, subject to the approval of the Councils of Governors.

2.7 Where joint committees are not currently permitted by legislation and a separate committee is required for each Foundation Trust (for Audit, Remuneration and Charitable Funds) these committees will meet as Committees in Common.

2.8 The composition of the Group Board will ensure that it meets all statutory requirements and the principles of good governance while being as efficient as possible.

2.9 The intention wherever possible will be for Non-Executive roles to be held jointly with both organisations making simultaneous appointments. Non-Executive roles will hold responsibility for engagement with specific place-based communities.

2.10 There will be a transition plan in place to move to a revised Group Board structure during the mobilisation phase and ahead of the formal launch of the Group, subject to the agreement of NHS England and the ICB.

2.11 With their agreement the intention is that the Councils of Governors for each Trust will normally meet as Committees in Common, with separate meetings by exception, and the nominations committees will also do so. The Councils of Governors has a key role in many of the proposed changes, for example in having approved the appointment of the Group CEO and in appointing and continuing to hold Non-Executive directors to account.

Clinical Leadership

2.12 Clinical leadership will play a key role in the emerging Group – both to drive clinical strategy and ensure delivery of high quality clinical services. Clinical leadership will be provided by a series of clinical boards which will be responsible for leading transformational change in a range of agreed specialities. The proposed clinical boards and a Clinical Strategy Council will sit centrally in the group operating model, with the Clinical Strategy Council reporting directly to the Group Executive and clear delegated accountabilities. It is vital that there is a strong connection between senior clinicians leading clinical transformation, the Group Executive and the Group Board.

2.13 Clinical boards will be led by triumvirates (Medical, Nursing or Allied Healthcare Professional, and General/Operational Manager) and chaired by a clinician; all drawn from the two Trusts. Clinical boards may also include external clinical expertise for example drawn from primary care. Clinical boards will have dedicated support from corporate services including HR and business intelligence which is aligned across the Group to support effective decision-making and operation.

2.14 The Clinical Strategy Council (chaired by the Chief Medical Officer) will oversee and drive the development of the overarching clinical strategy and ensure coherence across clinical boards as well as wide engagement with clinical leaders. This is critical to ensure that the strategy can then be translated into local operational implementation. This Council will draw its membership from clinical leaders across both organisations, the Group Executive and site leadership teams and be accountable to the Group Executive.

2.15 To realise the benefits of working as a Group, we need to ensure a safe transition. We are therefore, initially at least, keeping the current Care Group structure at North Tees and the Collaboratives structure at South Tees.

2.16 The clinical strategy is described in more detail at 3.1.

Group and Site Leadership Teams

2.17 Group and Site Leadership teams, each with clearly defined responsibilities, will together provide the strategic, oversight and operational capabilities to drive improvement. The Group director team (led by the Group CEO) will develop a range of enabling strategies (including quality, people, estates, digital, finance and communications) to support delivery of the clinical strategy. It will hold executive accountability for the Group on behalf of both Trusts and will be responsible for driving performance across the Group. The Group director team will also be the 'guiding mind' to ensure that effective executive governance arrangements are in place and working well.

2.18 It is proposed that in place of executive director posts for each Trust the following executive posts will be at Group level and sit as members of the Board:

- Group CEO

- Chief Medical Officer
- Chief Nursing Officer
- Chief Finance Officer
- Managing Director North Tees and Hartlepool
- Managing Director South Tees
- Chief People Officer
- Chief Strategy Officer

2.19 The following roles will also sit at group level but will not be members of the Board:

- Director of Estates
- Chief Information and Technology Officer
- Director of Communications
- Board Secretary

There may be further roles designated as Group roles in due course.

2.20 Site leadership teams will be responsible for delivery (quality, performance, operations and finance). Site leadership teams will need to work effectively within agreed group governance arrangements and will contribute significantly to strategic development and delivery. These teams will initially reflect existing Trust arrangements in order to maintain stability, but the roles will both be responsible for their own areas and expected to make a wider contribution to the Group. Each site team will be led by a Managing Director, who will be a voting member on the Group Board and will also be personally accountable for a Group-wide strategic activity or function.

2.21 There will be site director roles reporting to the site Managing Director. These will consist of medical, nursing, allied health and operations leadership roles. Proposals for specific site director roles will be developed and will reflect the operational requirements of each site. Site leadership teams will also play a key role in working with local system partners in local place-based partnerships and in our communities.

2.22 Clinicians will be involved in due course to assess the feasibility of alignment of collaborative/ clinical directorate structures and leadership arrangements in each site. This will evolve over time to determine how best to connect Group and site clinical leadership arrangements in an effective matrix structure.

2.23 In the next phase of detailed design of the executive governance structures, roles and responsibilities, it will be critical to articulate the respective functions of the Group and site arrangements. There will need to be clarity about the value of the Group Executive structure, that there is no duplication in roles and that the aggregate value of the matrix (Group and site) is capable of addressing the significant strategic agenda ahead as well as ensuring effective operational delivery.

Corporate Services

2.24 Effective corporate services are needed to support the Group to achieve its goals, with each service being designed to provide capable leadership operating at scale and working effectively within Group and site structures.

2.25 All corporate services will move towards joint service provision with a single strategy and single responsible director. Each Group director will be responsible for the developing plans for the transformation of corporate services and we will instigate an overarching programme for the work to be taken forward.

2.26 The delivery model will vary between these enabling services, with a combination of centralised Group functions designed to benefit from economies of scale; business partnering from embedded teams using an agreed framework; and functions devolved to a trust level but with professional oversight at a group level.

2.27 The delivery strategies setting out initial plans for the transformation of each corporate service are described in more detail in 4.1.

Further development

2.28 These outline proposals for the group operating model will inform the development of the detailed governance arrangements and operating structures during the mobilisation phase. We envisage that these detailed proposals will be developed by January 2024 subject to the feasibility of the Group CEO engaging in this prior to starting in role. Their input will be crucial in finalising these proposals. This will then be followed by a formal consultation period and agreement to a firm implementation plan and timescales.

Exercise of joint functions

2.29 Subject to Clause 2.32 from a date to be agreed by both Trusts' Boards:

- The Trusts shall jointly exercise their joint functions as set out in Schedule 1
- The Group Board shall exercise for the Trusts all their joint functions in accordance with Group Board Terms of Reference that both Trusts' Boards have approved
- The Group Board may appoint one or more sub-committees of it
- The Group Board may authorise one of the Trusts to contract with a third party on behalf of itself alone or both Trusts jointly and/or severally subject to compliance with the Trusts' standing orders and standing financial instructions.

2.30 If the Group Board appoints a sub-committee, then

- The Group Board may authorise the sub-committee to exercise joint functions that the Group Board subdelegates to the sub-committee in its ToR
- The members of a sub-committee of the Group Board may comprise or include individuals who are or are not members of the Group Board

2.31 Both Trusts agree that in the exercise of their joint working arrangements, members of either Trust's or both Trusts' workforce may be line managed by duly authorised officers of either Trust or both Trusts.

2.32 Subject to Clause 2.33, the Trusts agree that they, the Group Board and its sub-committees, and directors and officers must always comply with this Agreement and with each of the Trust's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation when they are exercising joint functions.

2.33 The proceedings of the Group Board shall not be invalidated by any vacancy in its membership or by any defect in the appointment of a member of the Group Board.

Exercise of reserved functions

2.34 Both Trusts shall continue to exercise separately their reserved functions as set out in Schedule 2.

2.35 The Trusts agree that the Group Board shall not at any time exercise their reserved functions.

3. Clinical Strategy

3.1 The joint clinical strategy is at the heart of this Partnership Agreement. Its clear aim is to improve patient care and the health outcomes for the wider population through the transformation of clinical practice by both Trusts working together in a single integrated model. It will be developed by our experienced clinical teams of doctors, nurses, Allied Health Professionals and scientists in conjunction with our patients and colleagues in primary care, local authorities and the voluntary sector.

3.2 Key transformation priorities will be to ensure we deliver high quality and accessible services; to reduce unwarranted variation in outcomes; to make our Group a great place to work and address workforce challenges; and to achieve financial efficiency.

3.3 In delivering this transformation we will adhere to the following principles:

- The primacy of quality in all we do;
- Care will be provided as close to home as possible, whilst ensuring it is clinically effective and appropriate to local population needs;
- Prevention and early intervention must be supported across health and social care;
- We will support partners to ensure every child has the best possible start in life;
- The maintenance of strong community services focussed on prevention, admission avoidance and early discharge; and the specific needs of frail elderly;
- Mental health and well-being must be considered equal to physical health needs;
- There should be strong collaboration across health and social care, including sharing information;
- Evidence-based and best practice healthcare provision, avoiding unnecessary duplication, to promote a consistent standard of access across the Tees Valley;
- Single, unified referral, treatment and discharge planning;
- Equity of access and outcomes across the Tees Valley; and
- Provision of high quality specialist and tertiary services for the local and regional population which we serve.

3.4 Our joint clinical strategy will be strongly aligned to the ICB clinical strategy as it is developed and we will play a full role in helping to develop the strategy for the wider system. The clinical strategy sees the system as whole and looks widely across the Tees Valley and beyond and to partners as well as the Trusts. There are three key supply-side drivers:

- The need to establish clinical sustainability, given the increased demand and increased complexity;
- Improving recruitment, retention and career routes for our staff, and tackling shortage areas, by making our Group an employer of choice; and
- Ensuring long-term financial sustainability by making our Group's practices efficient while demonstrating the impact we can have with a fair share of funding allocation.

3.5 The strategy will be a live document which will evolve and develop over time so that more specialties are brought within a truly collaborative model.

3.6 While the ultimate aim of the clinical strategy is that it will cover all specialties, our initial proposal is that we will focus on the following strategic priority areas where we can drive rapid service transformation:

- Medicine – with a focus on optimising operation pathways and Urgent and Emergency Care flow;
- Urgent and Emergency Care – given the key drivers of the national focus on the new 4 hour target and ambulance handover delays, and the local development of a revised UTC model in our Group;
- Community Services and virtual ward – as a key plank of our winter plan and support for acute hospital decompression as well as an enabler of further acute service design;
- Surgery and elective recovery – as a key national target with a major clinical need along with the potential financial benefits of bringing work back from the independent sector;
- Women and children's services – with the major national focus on maternity services and the clinical benefits of paediatric service redesign; and
- Diagnostics, including the development of the joint Community Diagnostic Centres.

3.7 For each of these strategic priorities (and in due course extending to all clinical areas), a clinical board will be formed and appointments made via an open and transparent process to the triumvirate leadership roles (Medical, Nursing or Allied Healthcare Professional, and General/Operational Manager) with a chair appointed from among that triumvirate. The clinical board will have responsibility for developing strategy in each clinical area and identifying the clinical pathways for initial review, with subsequent proposals for service transformation. Where appropriate boards will involve external partners (e.g. the Community Services board could include representatives from primary care, social care and the voluntary sector). The intention is for the six priority clinical boards to be operational by Q4 2023/24.

3.8 The Clinical Strategy Council will be responsible for the development of the clinical strategy and will oversee the work of the clinical boards. It will also ensure that there is a strong connection between senior clinicians leading clinical transformation, the Group executive and the Group Board. This distributed leadership model will ensure that the clinical transformation is successful.

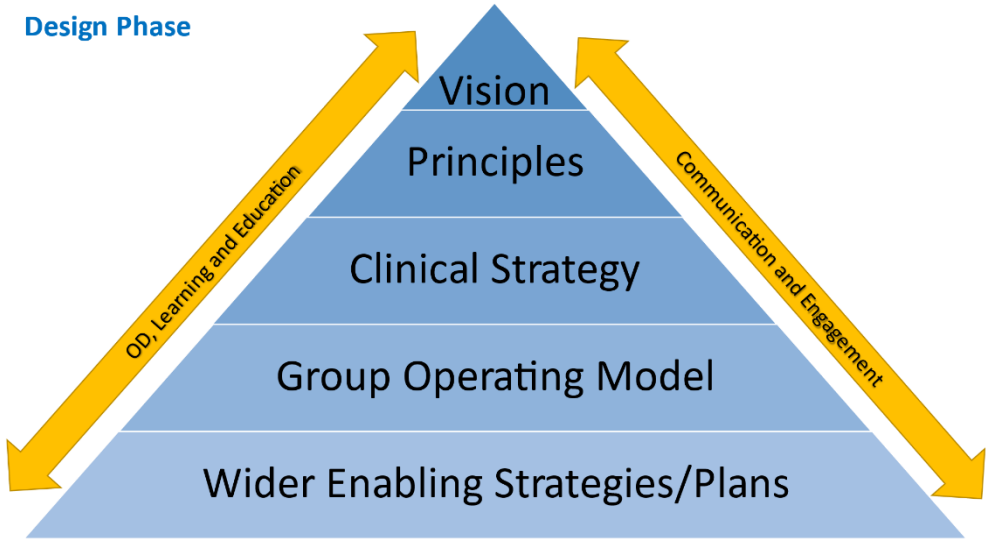
3.9 The clinical boards will delegate operational responsibility for subsequent delivery of any agreed pathway changes to relevant clinical teams (Collaborative Boards and Care Groups) and site teams, but have a continued oversight and assurance role for programme.

3.10 There is a high level of interdependence between the clinical strategy and corporate services which will support clinical transformation. In principle the requirements of the clinical strategy drive the transformation of corporate services, although a review of corporate services may create additional opportunities which had not been envisaged. For example, the availability of spare clinical estate may mean that the transformation of certain clinical services are prioritised. We will continue to map and work through these interdependencies throughout the delivery of the programme.

4. Delivery Strategies

4.1 The Group will need to develop a suite of strategies to enable delivery of the clinical strategy, to secure greater coherence for the Group and to maximise the use of all available resources so that they drive efficient and effective services. These strategies will include quality, people, estates, digital, finance and communications.

A visual representation of this approach is set out below.



4.2 These enabling strategies will set out the ambition to be delivered in the coming 3-5 year period and will identify priority programmes of work required to progress the strategic goals. They will be informed by the emerging priorities of the clinical strategy and by an appraisal of strategic challenges and opportunities facing the Group.

4.3 Group directors (when appointed) will be responsible for the development of these strategies.

4.4 As they take forward these strategic priorities, Group directors will also lead the work to develop plans for the integration of corporate services across the Group and will ensure that these arrangements provide the capacity and capability required to develop and deliver these enabling strategies in the future.

4.5 Set out below is an initial description of the purpose of the specific delivery strategies. These strategic goals will continue to iterate in the coming months, together with greater clarity on priority programmes of work that will be needed and also opportunities for more immediate 'just do it' actions to be agreed.

Quality Strategy
To ensure that our patients, across the Tees Valley and beyond, receive the same standard of high quality and safe care, no matter which care setting they attend. We will achieve this through the development of a collective quality strategy, delivered through joint governance arrangements. The emphasis will be on ensuring that the care and treatment we provide is founded on best practice and evidence with a focus on excellence in patient safety and experience, leading to optimal outcomes for our patients.

People Strategy
To develop the future workforce necessary to deliver the clinical strategy and enable the Group to be an employer of choice (through innovative and inclusive HR practice). It will focus on substantive recruitment (reducing reliance on temporary staffing and addressing key shortfalls); developing the Group training and education 'offer' and creating the conditions for an inclusive culture to thrive through a unified approach to organisational and leadership development. Policies will be aligned and will reflect best practice.

Estates Strategy
To develop ambitious plans for improving the condition and utilisation of the estate; specifically developing plans for the North Tees hospital site (in view of the existing infrastructure challenges). It will initially review utilisation of the estates and develop future plans, aligned to the priorities of the clinical strategy.

Digital Strategy
To unify the digital infrastructure across the Group to enable the delivery of high quality patient care across all clinical services. Plans will be developed to secure interoperability across existing EPRs in the short term pending delivery of the long term single digital solution.

Finance Strategy
To create financial sustainability for the Group. There will be close alignment with the clinical strategy and the enabling strategies to assess the opportunities for best use of financial resources, reduce duplication and secure inward investment (e.g. capital resources and resources linked to structural debt).

Communications & Engagement
To ensure that an intensive and ongoing communications and engagement approach is in place with the local population, patients, staff and stakeholders that demonstrates an open and inclusive culture and places value on partnerships.

4.6 In the engagement sessions we have held with clinicians and wider staff groups two priority areas were clear. First, making progress on a Group digital strategy so that barriers to working across sites and sharing necessary clinical data were reduced; and second the importance of considering workforce issues. As a result of this feedback, these strategies will be accelerated.

5. Roadmap to the launch of the group model

5.1 The outputs of the initial design phase of the group model have been incorporated into this partnership agreement. Progress has been made in developing the outline group operating model, plans for clinical leadership arrangements to lead the clinical strategy and transformation and proposals for the further development of key enabling strategies. This has been achieved by the Joint Partnership Board, clinical leaders and the ICB working together to shape the future of the group model and agree early priorities.

5.2 This section of the partnership agreement describes how further progress will be made during this next 'mobilisation' phase. Subject to progress in the coming months, it will be feasible for the group to be launched in the early part of 2024/25. A small core team is in place to direct the development programme, led by the Associate Director

of Group Development. Joint resources are already committed to the programme and should specific priorities require further resourcing, proposals will be brought to the JPB for approval. Executive directors and their teams are also working together increasingly on agreed joint priorities.

5.3 The Group development team brings executive directors and ICB representation together to provide executive leadership and is co-chaired by the Managing Directors. The JPB provides board direction and oversight and also includes ICB representation. These arrangements will continue through the mobilisation phase and will in due course be superseded by the new group governance model.

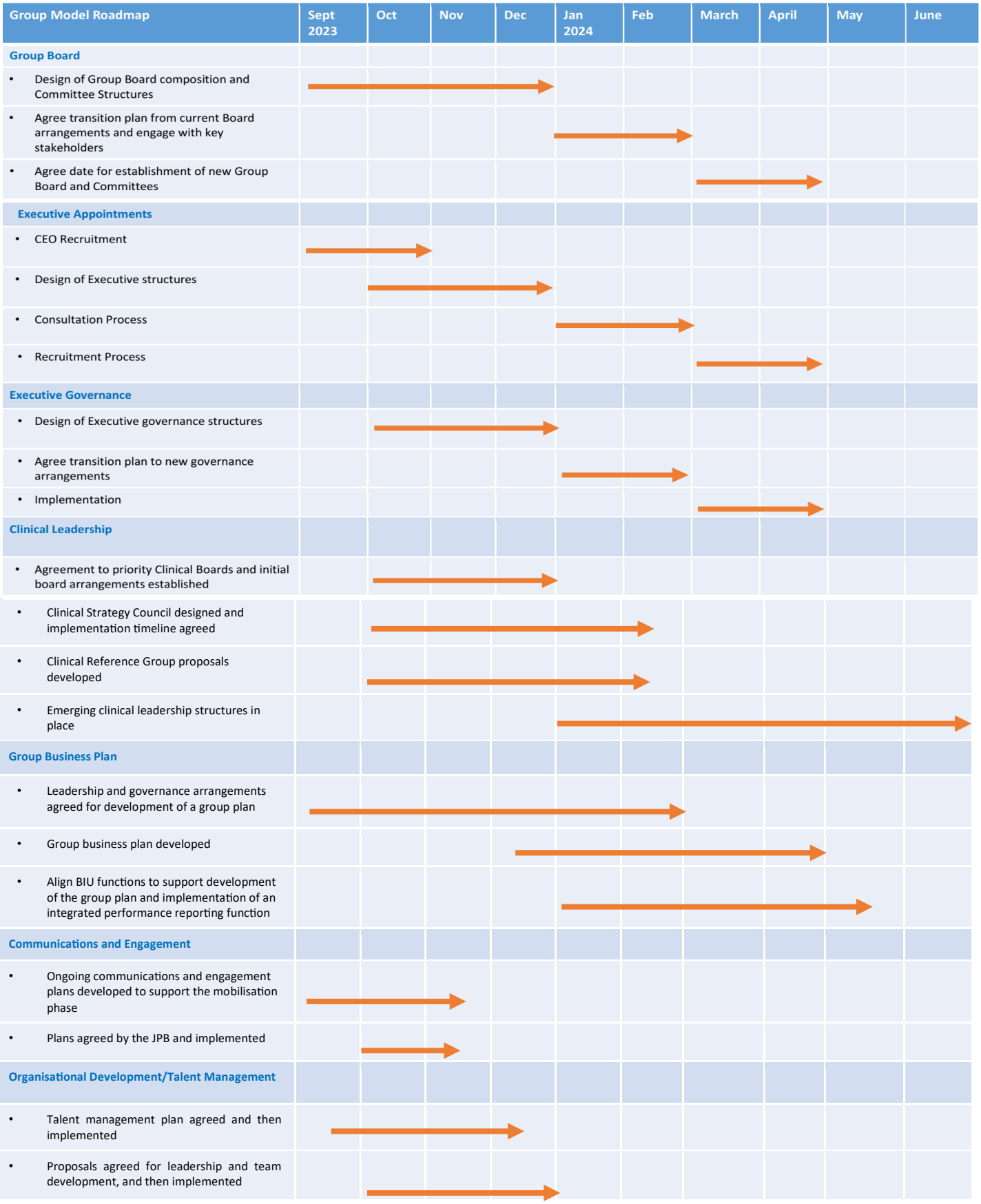
5.4 It is proposed that the following components of the operating model should, as a minimum, be in place ahead of the launch of the Group. These combine to provide a coherence to the Group and ensure that the necessary leadership and governance arrangements are established to lead strategic transformation and ensure robust operational delivery.

- New Group board and committee arrangements in place
- Key Group and site directors appointed following recruitment of Group CEO
- Executive governance arrangements in place
- Priority clinical boards and clinical strategy council established
- A Group business plan for 2024/25 in place

5.5 These key priorities inform the Group development programme in its mobilisation phase. This is set out in the roadmap below, which outlines the forward plans over the coming months and will be reviewed regularly by the JPB. A communications and engagement plan will be developed to ensure that the development programme progresses in an inclusive and transparent way, involving all key stakeholders. An effective organisational development plan will also be needed, focused on ongoing leadership and team development and talent management i.e. coaching support for staff impacted by these organisational changes.

5.6 Roadmap

Fig 1: Roadmap to the launch of the Group Model



6. Conclusion

6.1 This Partnership Agreement sets out a formal commitment by all parties to work towards the launch of a group operating model in Q1 24/25 to deliver the many benefits for our patients, staff and the wider population the Trusts serve. It has been developed through the dedication of staff, who have often been doing this work alongside other priorities; the boldness shown by the Boards of both Trusts in driving towards a new future; and the engagement of all our partners who are critical to the success of the transformation envisaged. The Trusts are grateful to the ICB for their support and direction throughout.

6.2 All parties recognise that circumstances are very likely to mean changes to the specifics of the Agreement but this does not dilute the clarity of vision and determination to deliver the benefits of the collaborative approach. Following the approval of the Agreement we will move to initiate the changes, and accelerate those changes already underway. Alongside that we will intensify our efforts to listen to our staff, patients and external partners to ensure that the clinical transformation the heart of this Agreement is successful.

6.3 As well as the initiation of change, the mobilisation phase will also include full programme planning with an increased level of detail and documentation. The Joint Partnership Board will continue to review progress on the implementation of the Agreement on a monthly basis and hold action owners to account to ensure that the programme is delivered.

6.4 While it is clear that there is much to do, we believe firmly that the future health of the people of Tees Valley and beyond will be transformed by the path this Partnership Agreement sets out.

This Agreement is signed on behalf of the three parties:

Professor Derek Bell OBE
Joint Chair
South Tees Hospitals NHS Foundation Trust
North Tees and Hartlepool NHS Foundation Trust

Professor Sir Liam Donaldson
NHS North East and North Cumbria ICB[3]

[3] As host ICB for North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust

North Tees and Hartlepool NHS Foundation Trust

South Tees Hospitals NHS Foundation Trust

Group Board of Directors
Terms of Reference

1. Purpose

The following Parties have entered a Partnership Agreement for provider collaboration and agreed to establish a Joint Committee which will be known as the Group Board. The Parties are:

North Tees and Hartlepool NHS Foundation Trust (NTHT); and
South Tees Hospitals NHS Foundation Trust (STHT).

The purpose of the Group Board will be to provide the formal, strategic leadership of the partnership arrangements between the two Parties. It will be responsible for overseeing, coordinating and ensuring delivery of the strategic intent of the partnership to secure the future of high quality, safe and sustainable healthcare across the Tees Valley and North Yorkshire.

It will provide a forum for both Parties:

- To build agreement across the Parties to drive action around a shared vision and strategic intent

- To exercise their joint functions (including delegated decision-making) in accordance with the Partnership Agreement.

2. Scope

The Parties will work collectively and collaboratively as a Group Board to develop solutions that support the future delivery of safe and sustainable health and care services across the population of the Tees Valley and North Yorkshire.

The shared objectives and priorities are identified in the Partnership Agreement.

3. Appointment of the Group Board as a Joint Committee

The Parties have agreed in their Partnership Agreement to appoint the Group Board as a joint committee in accordance with these terms of reference.

4. Group Board Membership

The voting members of the Group Board comprise the Group Chairman and the voting Board of Director members of NTH and STH Trust Statutory Boards.

The Company Secretaries from both Trusts will be in attendance.

Co-opted non-voting members will join the Group Board according to subject matter expertise as required by the nature of business on each agenda.

5. Quorum

The Group Board will be quorate when at least one-third of the whole number of the Directors appointed by each Trust, (including at least one non- executive director and one executive director from each of the Trust Statutory Boards) are present.

6. Delegated authority

The Parties have delegated authority for the exercise of joint functions (including relevant decision-making) to the Group Board in the terms set out in Schedule 1 scheme of delegation.

7. Decision making

The Group Board will generally operate on the basis of forming a consensus on all issues considered, taking account of the views expressed by all members. It will look to make decisions on a 'best for the Tees Valley and North Yorkshire' basis. The Group Chair will seek to ensure that any lack of consensus is resolved amongst members.

If the Group Board is unable to reach a consensus on an issue, the Group Chair may put the issue to a vote. The vote will be carried if:

- A majority of voting members present and voting are in favour (and in the event of a tied vote the Group Chair shall have a casting vote), and

- The voting members in favour include not less than half the NTHT voting directors present and not less than half the STHT voting directors present.

8. Accountability and reporting

The Parties agree that members of the Group Board will use all reasonable endeavours to translate its recommendations and decisions into actions through their respective Boards.

The Group Board has a key role within the wider governance and accountability arrangements of individual organisations. The minutes, and a summary of key messages will be submitted to all Parties after each meeting.

9. Conduct and Operation

The Group Board will meet on a frequency agreed to carry out its business but this will be no less than bi monthly. Members should be in attendance for at least 75% of meetings over any 12 month period.

Extraordinary meetings may be called for a specific purpose at the discretion of the Group Chair. Where possible, a minimum of seven working days' notice will be given when calling any extraordinary meeting.

The agenda and supporting papers will be sent to members and attendees no less

than five working days before any meeting. The Chair will give notice in the agenda whether the meeting will be in public or private. Urgent papers will be permitted in exceptional circumstances at the discretion of the Group Chair.

Both the NTH and STH Board of Directors' Standing Orders will apply to the conduct and operation of the Group Board insofar as these terms of reference do not provide otherwise.

10. Managing Conflicts of Interest

Each member must abide by all policies of the organisation it represents in relation to conflicts of interest.

Where any Group Board member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Group Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member may participate in meetings (or parts of meetings) in which the relevant matter is discussed.

Where the Group Chair decides to exclude a member, the relevant organisation represented by that member may send a deputy to take the place of the conflicted member in relation to that matter,

11. Secretariat

The secretariat function for the Group Board will be provided by the Corporate Office. The Company Secretaries will be responsible for arranging meetings, recording notes and actions from each meeting, preparing agendas, and agreeing these with the Group Chair.

12. Review

These terms of reference will be reviewed at least annually by the Statutory Boards of each Trust. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the partnership.

Schedule 1 – Delegated Authority

See attached.

South Tees Hospitals NHS Foundation Trust

North East and North Cumbria

North Tees and Hartlepool NHS Foundation Trust

Partnership Agreement Schedules

Schedule 1 – Joint Functions

Schedule 2 – Reserved Functions

Schedule 1 Joint functions

1. Joint functions of the Trusts are any functions of the Trusts which are not reserved functions as set out in Schedule 2.

2. Joint functions include but are not limited to:

   2.1. Each of the Trust's functions to provide goods and services, namely hospital accommodation and services and community health services, for the purposes of the health service

   2.2. All the Trusts' functions that NHS England has categorised as 'Open to Joint Exercise of Functions' in *Arrangements for delegation and joint exercise of statutory functions* as reproduced in the table set out in Paragraph 3 below (excluding references to legislation that is applicable to or in force in Wales only).

3. The table referred to in paragraph 2.2 is as follows:

Section 43 NHS Act 2006	(2) An NHS foundation trust may provide goods and services for any purposes related to— (a) the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and (b) the promotion and protection of public health. (2A) An NHS foundation trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes. (3) [An] NHS foundation trust may also carry on activities other than those mentioned in [subsection (2)][...] for the purpose of making additional income available in order better to carry on its principal purpose.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 44 NHS Act 2006	(6) According to the nature of its functions, an NHS foundation trust may, in the case of patients being provided with goods and services for the purposes of the health service, make accommodation or further services available for patients who give undertakings (or for whom undertakings are given) to pay any charges imposed by the NHS foundation trust in respect of the accommodation or services. (7) An NHS foundation trust may exercise the power conferred by subsection (6) only to the extent that its exercise does not to any significant extent interfere with the performance by the NHS foundation trust of its functions.	COMMISSIONING	Yes
Section 47 NHS Act 2006	(1) An NHS foundation trust may do anything which appears to it to be necessary or expedient for the purpose of or in connection with its functions. (2) In particular it may– (a) acquire and dispose of property, (b) enter into contracts, (c) accept gifts of property (including property to be held on trust for the purposes of the NHS foundation trust or for any purposes relating to the health service), (d) employ staff. (3) Any power of the NHS foundation trust to pay remuneration and allowances to any person includes power to make arrangements for providing, or securing the provision of, pensions or gratuities (including those payable by way of compensation for loss of employment or loss or reduction of pay). (4) “The purposes of the NHS foundation trust” means the general or any specific purposes of the trust (including the purposes of any specific hospital at or from which services are provided by the trust).	ANCILLARY FUNCTION	Yes
Section 47A NHS Act 2006 as inserted by section 64 of the Health and Care Act 2022	Joint exercise of functions An NHS foundation trust may enter into arrangements for the carrying out, on such terms as the NHS foundation trust considers appropriate, of any of its functions jointly with any other person.	CORPORATE	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 56 NHS Act 2006	(1) An application may be made jointly by– (a) an NHS foundation trust, and (b) another NHS foundation trust or an NHS trust [established under section 25], to the regulator for [the dissolution of the trusts and the establishment of a new NHS foundation trust.] (1A) An application under this section may be made only with the approval of more than half of the members of the council of governors of each applicant (that is an NHS foundation trust). (2) The application must– (a) be supported by the Secretary of State if one of the parties to it is an NHS trust, (b) specify the property and liabilities proposed to be transferred to the new NHS foundation trust,[and][...] (d) be accompanied by a copy of the proposed constitution of the new trust [.][...] (4) The regulator must grant the application if it is satisfied that such steps as are necessary to prepare for the dissolution of the trusts and the establishment of the proposed new trust have been taken.[...] (11) [On the grant of the application], the proposed constitution of the NHS foundation trust has effect, but the directors of the applicants may exercise the functions of the trust on its behalf until a board of directors is appointed in accordance with the constitution.	CORPORATE	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 56A NHS Act 2006	56A Acquisitions (1) An application may be made jointly by— (a) an NHS foundation trust (A), and (b) another NHS foundation trust or an NHS trust established under section 25 (B), to the regulator for the acquisition by A of B. (2) An application under this section may be made only with the approval of more than half of the members of the council of governors of each applicant (that is an NHS foundation trust). (3) The application must— (a) be supported by the Secretary of State if B is an NHS trust, and (b) be accompanied by a copy of the proposed constitution of A, amended on the assumption that A acquires B. (4) The regulator must grant the application if it is satisfied that such steps as are necessary to prepare for the acquisition have been taken. (4A) Where the regulator proposes to grant the application, it may by order make provision for the transfer of employees of B to A on the grant of the application. (5) On the grant of the application, the proposed constitution has effect, but where a person who is specified as a director of A in the constitution has yet to be appointed as such, the directors of A may exercise that person's functions under the constitution.	CORPORATE	Yes
Section 63 NHS Act 2006	An NHS foundation trust must exercise its functions effectively, efficiently and economically.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 63A NHS Act 2006	(1) In making a decision about the exercise of its functions, an NHS foundation trust must have regard to all likely effects of the decision in relation to— (a) the health and well-being of the people of England; (b) the quality of services provided to individuals— (i) by relevant bodies, or (ii) in pursuance of arrangements made by relevant bodies, for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England; (c) efficiency and sustainability in relation to the use of resources by relevant bodies for the purposes of the health service in England.	ANCILLARY FUNCTION	Yes
Section 65Z5 NHS Act 2006 as inserted by Section 71 of the Health and Care Act 2022	Joint working and delegation arrangements (1) A relevant body may arrange for any functions exercisable by it to be exercised by or jointly with any one or more of the following— (a) a relevant body (b) a local authority (within the meaning of section 2B); (c) a combined authority. (2) In this section "relevant body" means— (a) NHS England, (b) an integrated care board, (c) an NHS trust established under section 25, (d) an NHS foundation trust, or (e) such other body as may be prescribed.	CORPORATE	Yes
Section 65Z6 NHS Act 2006 as inserted by Section 71 of the Health and Care Act 2022	Joint committees and pooled funds (1) This section applies where a function is exercisable jointly (by virtue of section 65Z5 or otherwise) by a relevant body and any one or more of the following— (a) a relevant body; (b) a local authority (within the meaning of section 2B); (c) a combined authority. (2) The bodies by whom the function is exercisable jointly may— (a) arrange for the function to be exercised by a joint committee of theirs; (b) arrange for one or more of the bodies, or a joint committee of the bodies, to establish and maintain a pooled fund.	CORPORATE	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 72 NHS Act 2006	(1) It is the duty of NHS bodies to co-operate with each other in exercising their functions.	ANCILLARY FUNCTION	Yes
Section 82 NHS Act 2006	In exercising their respective functions NHS bodies (on the one hand) and local authorities (on the other) must co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.	ANCILLARY FUNCTION	Yes
Section 223L NHS Act 2006	(1) NHS England may set joint financial objectives for integrated care boards and their partner NHS trusts and NHS foundation trusts. (2) An integrated care board and its partner NHS trusts and NHS foundation trusts must seek to achieve any financial objectives set under this section.	CORPORATE	Yes
Section 223LA NHS Act 2006	(1) An integrated care board and its partner NHS trusts and NHS foundation trusts must exercise their functions with a view to ensuring that their expenditure in a financial year (taken together) does not exceed the aggregate of any sums received by them in the year.	CORPORATE/ ANCILLARY	Yes
Section 223M NHS Act 2006	(1) Each integrated care board and its partner NHS trusts and NHS foundation trusts must exercise their functions with a view to ensuring that, in respect of each financial year— (a) local capital resource use does not exceed the limit specified in a direction by NHS England; (b) local revenue resource use does not exceed the limit specified in a direction by NHS England.	CORPORATE/ ANCILLARY	Yes
Section 242 NHS Act 2006	(1B) Each relevant English body must make arrangements, as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved (whether by being consulted or provided with information, or in other ways) in– (a) the planning of the provision of those services, (b) the development and consideration of proposals for changes in the way those services are provided, and (c) decisions to be made by that body affecting the operation of those services.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 249 NHS Act 2006	(1) In exercising their respective functions, NHS bodies (on the one hand) and the prison service (on the other) must co-operate with one another with a view to improving the way in which those functions are exercised in relation to securing and maintaining the health of prisoners.	ANCILLARY FUNCTION	Yes
Criminal Justice Act 2003, Section 325(3)	In establishing those arrangements [for the purpose of assessing and managing risks posed by relevant sexual and violent offenders &c], the responsible authority [i.e. the chief officer of police, the local probation board for that area [or (if there is no local probation board for that area) a relevant provider of probation services] and the Minister of the Crown exercising functions in relation to prisons, acting jointly] must act in co-operation with the persons specified in subsection (6); and it is the duty of those persons to co-operate in the establishment by the responsible authority of those arrangements, to the extent that such co-operation is compatible with the exercise by those persons of their [relevant functions]. [NHS trusts are included among persons in sub-s (6)(h).]	ANCILLARY FUNCTION	Yes
Mental Health (Care and Treatment) (Scotland) Act 2003, Section 31	(1) Where it appears to a local authority that the assistance of a Health Board, a Special Health Board or a National Health Service trust– (a) is necessary to enable the authority to perform any of their duties under section 25 or 26 of this Act [i.e. relating to provision of care and support services and services designed to promote well-being and independence]; or (b) would help the authority to perform any of those duties, the authority may request the Health Board, Special Health Board or National Health Service trust to co-operate by providing the assistance specified in the request. (2) A Health Board, a Special Health Board or a National Health Service trust receiving a request under subsection (1) above shall, if complying with the request– (a) would be compatible with the discharge of its own functions (whether under any enactment or otherwise); and (b) would not prejudice unduly the discharge by it of any of those functions, comply with the request.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
National Health Service Trust (Scrutiny of Deaths) (England) Order 2021, article 3	(1) An NHS trust in England may scrutinise the death of any person who has died in England where— (a) a senior coroner is not under a duty to investigate the death under section 1 of the Coroners and Justice Act 2009, or (b) it is unclear whether the death is one which a registered medical practitioner would be required to notify to the relevant senior coroner under the Notification of Deaths Regulations 2019.	ANCILLARY FUNCTION	Yes
Social Workers Regulations 2018, reg 7	(1) The persons specified for the purposes of section 53(1)(d) of the Act [i.e the Children and Social Work Act 2017, which requires Social Work England ("the regulator") to cooperate with, among others, any person specified in regulations made by the Secretary of State] are—[...] (d) any NHS trust established under section 25 of the National Health Service Act 2006,	ANCILLARY FUNCTION	Yes
Children Act 2014, s11(2); (4)	(2) Each person and body to whom this section applies [which includes NHS Trusts by ss(1)] must make arrangements for ensuring that– (a) their functions are discharged having regard to the need to safeguard and promote the welfare of children; and (b) any services provided by another person pursuant to arrangements made by the person or body in the discharge of their functions are provided having regard to that need. (4) Each person and body to whom this section applies must in discharging their duty under this section have regard to any guidance given to them for the purpose by the Secretary of State.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Children Act 2014, Section 25(5) [Applicable in Wales only]	(1) Each local authority in Wales must make arrangements to promote co-operation between– (a) the authority; (b) each of the authority's relevant partners [which includes NHS Trusts by ss(4)(e)]; and (c) such other persons or bodies as the authority consider appropriate, being persons or bodies of any nature who exercise functions or are engaged in activities in relation to children in the authority's area. (2) The arrangements under subsections (1) and (1A) [not reproduced here] are to be made with a view to— (a) improving the well-being of children within the authority's area, in particular those with needs for care and support; (b) improving the quality of care and support for children provided in the authority's area (including the outcomes that are achieved from such provision); (c) protecting children who are experiencing, or are at risk of, abuse, neglect or other kinds of harm (within the meaning of the Children Act 1989). (5) The relevant partners of a local authority in Wales must co-operate with the authority in the making of arrangements under this section.	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 25(6) [Applicable in Wales only]	(6) A local authority in Wales and any of their relevant partners may for the purposes of arrangements under this section– (a) provide staff, goods, services, accommodation or other resources; (b) establish and maintain a pooled fund [as defined by ss(7)].	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 25(8) [Applicable in Wales only]	(8) A local authority in Wales and each of their relevant partners must in exercising their functions under this section have regard to any guidance given to them for the purpose by the Welsh Ministers.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Children Act 2014, Section 27(3) [Applicable in Wales only]	(3) An NHS trust to which section 25 [see lines above] applies must– (a) appoint an executive director, to be known as the trust's "lead executive director for children and young people's services", for the purposes of the trust's functions under that section; and (b) designate one of the trust's non-executive directors as its "lead non-executive director for children and young people's services" to have the discharge of those functions as his special care.	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 28(2) [Applicable in Wales only]	(2) Each person and body to whom this section applies [including an NHS trust all or most of whose hospitals, establishments and facilities are situated in Wales, by ss(1)(c)] must make arrangements for ensuring that– (a) their functions are discharged having regard to the need to safeguard and promote the welfare of children; and (b) any services provided by another person pursuant to arrangements made by the person or body in the discharge of their functions are provided having regard to that need.	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 28(4) [Applicable in Wales only]	(4) The persons and bodies referred to in subsection (1)(a) to (c) and (i) must in discharging their duty under this section have regard to any guidance given to them for the purpose by the Assembly.	ANCILLARY FUNCTION	Yes
Domestic Violence, Crime and Victims Act 2004, Section 9(2), (3)	(3) It is the duty of any person or body within subsection (4) establishing or participating in a domestic homicide review (whether or not held pursuant to a direction under subsection (2)) to have regard to any guidance issued by the Secretary of State as to the establishment and conduct of such reviews.	ANCILLARY FUNCTION	Yes
Mental Health Units (Use of Force) Act 2018, s2(1) [Not in force]	(1) A relevant health organisation [which includes NHS trusts by s13] that operates a mental health unit must appoint a responsible person for that unit for the purposes of this Act.	ANCILLARY FUNCTION	Yes
Mental Health Units (Use of Force) Act 2018, s3(1) [Not in force]	(1) The responsible person for each mental health unit must publish a policy regarding the use of force by staff who work in that unit.	ANCILLARY FUNCTION	Yes
Mental Health Units (Use of Force) Act 2018, s11(2) [Not in force]	(2) In exercising functions under this Act, responsible persons and relevant health organisations [which includes NHS Trusts by s13] must have regard to guidance published [by the SoS by ss(1)] under this section.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s4(3) [In force in Wales only]	(3) The following persons must, when exercising functions under this Part, have regard to any relevant guidance contained in the code [on additional learning needs issued by the Welsh Ministers by ss(1)]— […] (h) an NHS trust;	ANCILLARY FUNCTION	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s20 [In force in Wales only]	(4) If a matter is referred to an NHS body [which includes an NHS Trust by s99(1)] under this section, the NHS body must consider whether there is a relevant treatment or service [as defined by ss(6)] that is likely to be of benefit in addressing the child's or young person's additional learning needs. (5) If the NHS body identifies such a treatment or service, it must— (a) secure the treatment or service for the child or young person, (b) decide whether the treatment or service should be provided to the child or young person in Welsh, and (c) if it decides that the treatment or service should be provided to the child or young person in Welsh, take all reasonable steps to secure that the treatment or service is provided in Welsh.	COMMISSIONING	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s21 [In force in Wales only]	Various duties (not set out in full here) consequent on the NHS body identifying (or not identifying) a relevant treatment or service per s20	COMMISSIONING	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s64 [In force in Wales only]	(1) This section applies where a health body mentioned in subsection (2) [which includes an NHS Trust], in the course of exercising its functions in relation to a child who is under compulsory school age and for whom a local authority is responsible, forms the opinion that the child has, or probably has, additional learning needs. (3) The health body must inform the child's parent of its opinion and of its duty in subsection (4). (4) After giving the parent an opportunity to discuss the health body's opinion with an officer of the body, the health body must bring it to the attention of the local authority that is responsible for the child or, if the child is looked after, to the attention of the local authority that looks after the child, if the health body is satisfied that doing so would be in the best interests of the child. (5) If the health body is of the opinion that a particular voluntary organisation is likely to be able to give the parent advice or other assistance in connection with any additional learning needs that the child may have, it must inform the parent accordingly.	REGULATORY	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s65 [In force in Wales only]	(1) Subsection (2) applies if a local authority requests a person mentioned in subsection (4) [which includes NHS Trusts] to exercise the person's functions to provide the authority with information or other help, which it requires for the purpose of exercising its functions under this Part. (2) The person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person that decides not to comply with a request under subsection (1) must give the local authority that made the request written reasons for the decision.	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s76 [In force in Wales only]	(1) The Education Tribunal for Wales may, in relation to an appeal under this Part,— (a) exercise its functions to require an NHS body to give evidence about the exercise of the body's functions; (b) make recommendations to an NHS body about the exercise of the body's functions. (3) An NHS body to whom a recommendation has been made by the Tribunal must make a report to the Tribunal before the end of any prescribed period beginning with the date on which the recommendation is made. [ss(4) specifies the contents of the report.]	REGULATORY	Yes
Regulation and Inspection of Social Care (Wales) Act 2016, s178 [in force in Wales only]	(2) A regulatory body [i.e. the Welsh Ministers and SCW, by s176(1)] must, in the exercise of its relevant functions, seek to co-operate with a relevant authority [which includes, by s177(1)(e) an NHS Trust] if the regulatory body thinks such co-operation— (a) will have a positive effect on the manner in which the body exercises its functions, or (b) will assist the body in achieving its general objectives.	REGULATORY	Yes
Regulation and Inspection of Social Care (Wales) Act 2016, s178 [in force in Wales only]	(3) Where a regulatory body requests the co-operation of a relevant authority under subsection (2) the authority must comply with the request unless the authority— (a) is prevented from co-operating in the manner requested by any enactment or other rule of law, (b) thinks that such co-operation would otherwise be incompatible with its own functions, or (c) thinks that such co-operation would have an adverse effect on its functions.	REGULATORY	Yes
Regulation and Inspection of Social Care (Wales) Act 2016, s178 [in force in Wales only]	(4) If a relevant authority requests the co-operation of a regulatory body, the body must comply with that request unless the body— (a) is prevented from co-operating in the manner requested by any enactment (including this Act) or other rule of law, (b) thinks that such co-operation would otherwise be incompatible with the regulatory body's own functions, or (c) thinks that such co-operation would have an adverse effect— (i) on the body's functions, or (ii) on achieving the body's general objectives.	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Well-being of Future Generations (Wales) Act 2015, Parts 2 and 3	Not reproduced in full here, the Act confers various duties on public bodies to do things in pursuit of the economic, social, environmental and cultural well-being of Wales in a way that accords with the sustainable development principle and to require public bodies to report on such action. "Public bodies", by section 6, includes NHS Trusts.	REGULATORY	Yes
Counter-terrorism and Security Act 2016, s26	(1) A specified authority [which includes, by Schedule 6, and NHS Trust] must, in the exercise of its functions, have due regard to the need to prevent people from being drawn into terrorism.	ANCILLARY FUNCTION	Yes
Counter-terrorism and Security Act 2016, s38	(1) The partners [which include NHS Trusts by Schedule 7] of a panel [i.e. a panel established by a LA by s36] must, so far as appropriate and reasonably practicable, act in co-operation with— (a) the panel in the carrying out of its functions; (b) the police [and local authorities] in the carrying out of their functions in connection with section 36.	CORPORATE	Yes
Counter-terrorism and Security Act 2016, s38	[By ss(3) the duty of a partner of a panel to act in co-operation with the panel includes the giving of information (subject to ss(4)) and extends only so far as the co-operation is compatible with the exercise of the partner's functions under any other enactment or rule of law.]	CORPORATE	Yes
Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, reg 4(1)	(1) Each public authority listed in Schedule 2 [which includes NHS Trusts] to these Regulations must publish information to demonstrate its compliance with the duty imposed by section 149(1) of the Act [i.e. the public sector equality duty of the Equality Act 2010]. [See further regs 4(2) onwards and reg 6 for requirements as to publication and exemption for authorities with fewer than 150 employees]	REGULATORY	Yes
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 6(1)	(1) Where an NHS trust or an NHS foundation trust supplies a drug or appliance to a patient for the purpose of treatment, the NHS trust or the NHS foundation trust (as the case may be) must, subject to paragraphs (3) to (6), make and recover from the patient for the supply of [continues as to charges to be made in respect of particular items] [See further reg 6 for exemptions]	COMMISSIONING	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 7(1)	(1) Where drugs or appliances are supplied to a patient, including during the out of hours period, for the purpose of treating that patient, by a prescriber at a walk-in centre, the NHS trust, NHS foundation trust or other person responsible for the management of the centre, must, subject to paragraphs (3) to (5), make and recover from that patient for the supply of [continues as to charges to be made in respect of particular items] [See further reg 7 for exemptions]	COMMISSIONING	Yes
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 10(1)	(9) Where a claim to an exemption has been made but is not substantiated, and in consequence of the claim a charge has not been recovered, if—[…] (b) the drugs or appliances were supplied by an NHS trust or an NHS foundation trust as mentioned in regulation 6, then that NHS trust or NHS foundation trust must recover that charge from the person concerned […]	COMMISSIONING	Yes
National Health Service (Charges to Overseas Visitors) Regulations 2015	The Regulations place various duties (not set out in full here) on "relevant bodies" (which includes NHS Trusts, by reg 2) to make and recover charges for the provision of relevant services to overseas visitors. Further, NHS Trusts, in meeting their obligations to make and recover charges from overseas visitors, must (by reg 3A) enter certain specified information against record against the overseas visitor's consistent identifier.	COMMISSIONING	Yes
National Health Service (Optical Charges and Payments) Regulations 2013, reg 2(2)	(2) Where a charge is payable by virtue of paragraph (1) [a charge for such amount for glasses and contact lenses as determined by the SoS], the NHS trust or NHS foundation trust, or other person on its behalf, that supplies or is to supply the glasses or contact lenses must– (a) on arranging to supply the glasses or contact lenses, make the charge, and (b) on supplying the glasses or contact lenses or having them available for supply, recover the charge from the person supplied or to be supplied (if the charge has not previously been paid).	COMMISSIONING	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
National Health Service (Optical Charges and Payments) Regulations 2013, reg 10(1)	(1) An NHS trust or NHS foundation trust which, following a sight test, issues a prescription for an optical appliance to a person who— (a) has indicated that they are an eligible person; or (b) is an eligible person by virtue of regulation 8(5), must issue to that person a voucher relating to the optical appliance prescribed. [See further reg 10(2) for requirements on issuing a voucher]	COMMISSIONING	Yes
Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013/218, reg 23	This provision imposes consultation duties (not set out in full here) on a "responsible person" ("R") (which may be a "service provider", a definition which by reg 23(14) includes an NHS Trust) where R has under consideration any proposal for a substantial development of the health service. This is subject to reg 23(12) which sets out the circumstances in which the functions in reg 23 are to be carried out by a responsible commissioner in the place of a service provider.	ANCILLARY FUNCTIONS	Yes
NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012, reg 4	(1) This regulation applies where a clinical commissioning group, NHS trust or NHS foundation trust and a local authority propose to designate a body as a Care Trust under section 77(1) of the 2006 Act, or propose to revoke such designation. (2) Where this regulation applies, the body and the local authority must, before designating or revoking the designation, as the case may be, consult jointly such persons as appear to them to be affected by the proposed designation or revocation.	REGULATORY	Yes
Care Act 2014, s6	(1) A local authority must co-operate with each of its relevant partners [which, by ss(7) includes each NHS body in the authority's area, defined in turn by ss(8) as NHS trust or NHS foundation trust which provides services in the authority's area], and each relevant partner must co-operate with the authority, in the exercise of— (a) their respective functions relating to adults with needs for care and support, (b) their respective functions relating to carers, and (c) functions of theirs the exercise of which is relevant to functions referred to in paragraph (a) or (b).	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Social Services and Well-being (Wales) Act 2014, s17	(5) A Local Health Board or an NHS Trust providing services in the area of a local authority must, for the purposes of this section [which imposes a duty on Welsh LAs to secure the provision of information, advice and assistance], provide that local authority with information about the care and support it provides in the local authority's area.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s118	(2) Where a child who is accommodated in Wales—[…] (g) in any accommodation provided by or on behalf of an NHS Trust or by or on behalf of an NHS Foundation Trust, ceases to be so accommodated after reaching the age of 16, the person by whom or on whose behalf the child was accommodated or who carries on or manages the home or hospital (as the case may be) must inform the local authority or local authority in England within whose area the child proposes to live. [subject to ss(3) which provides that the duty if the accommodation has been provided for a consecutive period of at least three months.]	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s120	(1) Subsection (2) applies where a child is provided with accommodation in Wales by a Local Health Board, an NHS Trust or a local authority in the exercise of education functions ("the accommodating authority")— (a) for a consecutive period of at least 3 months, or (b) with the intention, on the part of that authority, of accommodating the child for such a period. (2) The accommodating authority must notify the appropriate officer [as defined by ss(4)] of the responsible authority [as defined by ss(3)]— (a) that it is accommodating the child, and (b) when it ceases to accommodate the child.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s134	Not reproduced in full here, this section makes provision for "Safeguarding Boards" and regulations governing them. By ss(2)(d) an NHS Trust is designated as a partner of a Safeguarding Board.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Social Services and Well-being (Wales) Act 2014, s161B	(1) The Welsh Ministers may require a person falling within subsection (2) [which includes an NHS Trust] to provide them with— (a) any documents, records (including medical or other personal records) or other information— (i) which relate to the exercise of a social services function of a local authority, and (ii) which the Welsh Ministers consider it necessary or expedient to have for the purposes of a review under section 149A or 149B; (b) an explanation of the content of— (i) any documents, records or other information provided under paragraph (a), or (ii) any documents or records provided to an inspector conducting an inspection of premises under section 161 in connection with a review under section 149B. [Subject to ss(3) which provides that a person is not required to provide documents, records or other information under subsection (1) if the person is prohibited from providing them by any enactment or other rule of law.]	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Social Services and Well-being (Wales) Act 2014, s162(6)	(1) A local authority must make arrangements [with a view to promoting the matters specified in ss(3)] to promote co-operation between— (a) the local authority, (b) each of the authority's relevant partners [including, by ss(4)(f) an NHS Trust providing services in the area of the authority] in the exercise of— (i) their functions relating to adults (ii) their other functions the exercise of which is relevant to the functions referred to in sub-paragraph (i), and (c) such other persons or bodies as the authority considers appropriate, being persons or bodies of any nature who or which exercise functions or are engaged in activities in relation to— (i) adults within the authority's area with needs for care and support, or (ii) adults within the authority's area who are carers. (6) The relevant partners of a local authority must co-operate with the authority in the making of arrangements under this section.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s162(7); (9)	(7) A local authority and any of its relevant partners may for the purposes of arrangements under this section— (a) provide staff, goods, services, accommodation or other resources; (b) establish and maintain a pooled fund [defined at ss(7)]; (c) share information with each other.	COMMISSIONING	Yes
Social Services and Well-being (Wales) Act 2014, s162(7); (9)	(9) A local authority and each of its relevant partners [including, by ss(4)(f) an NHS Trust providing services in the area of the authority] must, in exercising their functions under this section, have regard to any guidance given to them for the purpose by the Welsh Ministers.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Social Services and Well-being (Wales) Act 2014, s164(1), (3)	(1) If a local authority requests the co-operation of a person mentioned in subsection (4) [includes an NHS Trust] in the exercise of any of its social services functions, the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.	REGULATORY	Yes
Social Services and Well-being (Wales) Act 2014, s164(2); (3)	(2) If a local authority requests that a person mentioned in subsection (4) [includes an NHS Trust] provides it with information it requires for the purpose of the exercise of any of its social services functions, the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.	REGULATORY	Yes
Social Services and Well-being (Wales) Act 2014, s164(5)	(5) A local authority and each of those persons mentioned in subsection (4) [includes an NHS Trust] must in exercising their functions under this section have regard to any guidance given to them for the purpose by the Welsh Ministers.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Social Services and Well-being (Wales) Act 2014, s164A(1), (3)	(1) If a local authority requests the co-operation of a person mentioned in subsection (4) [includes NHS Trusts] in the exercise of its functions mentioned in subsection (5) [relating to functions under Children Act 1989 &c], the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.	REGULATORY	Yes
Social Services and Well-being (Wales) Act 2014, s164A(2), (3)	(2) If a local authority requests that a person mentioned in subsection (4) [includes NHS Trusts] provides it with information it requires for the purpose of the exercise of any of its functions mentioned in subsection (5) [relating to functions under Children Act 1989 &c], the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.	REGULATORY	Yes
Children and Families Act 2014, s28	(1) A local authority in England must co-operate with each of its local partners [which includes, by ss(2)(m), an NHS Trust or NHS Foundation Trust which provides services in the authority's area, or which exercises functions in relation to children or young people for whom the authority is responsible], and each local partner must co-operate with the authority, in the exercise of the authority's functions under this Part.	ANCILLARY FUNCTIONS	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Children and Families Act 2014, s31	(1) This section applies where a local authority in England requests the cooperation of any of the following persons and bodies in the exercise of a function under this Part—[…] (g) an NHS trust or NHS foundation trust. (2) The person or body must comply with the request, unless the person or body considers that doing so would— (a) be incompatible with the duties of the person or body, or (b) otherwise have an adverse effect on the exercise of the functions of the person or body. (3) A person or body that decides not to comply with a request under subsection (1) must give the authority that made the request written reasons for the decision.	ANCILLARY FUNCTIONS	Yes
Children and Families Act 2014, s77	(4) The persons listed in subsection (1) [including at ss(1)(l) NHS Trusts] must have regard to the [Code of Practice issued by the SoS pursuant to ss(1)] in exercising their functions under this Part.	ANCILLARY FUNCTIONS	Yes
Equality Act 2010 c. 15	Refers to all functions under this Act	CORPORATE	Yes
Health Act 2009 c. 21	Refers to entire Act.	REGULATORY	Yes
Health and Social Care Act 2008 c. 14	All duties of an NHS Trust under this Act	REGULATORY	Yes
Local Government and Public Involvement in Health Act 2007 c. 28	All duties of an NHS Trust under this Act	REGULATORY	Yes
Health Act 2006 c. 28	Refers to entire Act.	REGULATORY	Yes
Health and Social Care (Community Health and Standards) Act 2003 c. 43	Refers to entire Act.	REGULATORY	Yes
Mental Capacity Act 2005 c. 9	Refers to entire Act.	REGULATORY	Yes
Health and Social Care Act 2008 c. 14	All functions of a Trust under this Act.	REGULATORY	Yes
Local Audit and Accountability Act 2014 c. 2	Refers to entire Act.	REGULATORY	Yes

Schedule 2 Reserved functions

1. Reserved functions are any functions of the Trusts that they cannot lawfully delegate or jointly exercise or otherwise are functions that NHS England has categorised as not 'Open to Joint Exercise of Functions' in *Arrangements for delegation and joint exercise of statutory functions* as reproduced in the table set out in under paragraph 2 below.

2. The table referred to in paragraph 1 is as follows:

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 27A NHS Act 2006	(1) A public benefit corporation must hold an annual meeting of its members. (2) The meeting must be open to members of the public. (3) At least one member of the board of directors of the corporation must attend the meeting and present the following documents to the members at the meeting— (a) the annual accounts, (b) any report of the auditor on them, (c) the annual report. (4) Where an amendment is made to the constitution in relation to the powers or duties of the council of governors of a public benefit corporation (or otherwise with respect to the role that the council has as part of the corporation)— (a) at least one member of the council of governors must attend the next meeting to be held under this paragraph and present the amendment, and (b) the corporation must give the members an opportunity to vote on whether they approve the amendment. (5) If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the corporation must take such steps as are necessary as a result.	CORPORATE	**No**
Section 37 NHS Act 2006	(1) An NHS foundation trust may make amendments of its constitution only if— (a) more than half of the members of the council of governors of the trust voting approve the amendments, and (b) more than half of the members of the board of directors of the trust voting approve the amendments.	CORPORATE	**No**
Section 42B (6) NHS Act 2006 as inserted by section 62 of the Health and Care Act 2022	Limits on capital expenditure (6) A trust that is the subject of an order under this section must not exceed the capital expenditure limit imposed by the order during the financial year to which it relates.	CORPORATE / REGULATORY	**No**
Section 43 NHS Act 2006	(1) The principal purpose of an NHS foundation trust is the provision of goods and services for the purposes of the health service in England.	CORPORATE	**No**
Section 43 NHS Act 2006	(3D) An NHS foundation trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the council of governors of the trust voting approve its implementation.	CORPORATE	**No**

Section 46 NHS Act 2006	(1) An NHS foundation trust may borrow money for the purposes of or in connection with its functions. [...] (4) An NHS foundation trust may invest money (other than money held by it as trustee) for the purposes of or in connection with its functions. (5) The investment may include investment by– (a) forming, or participating in forming, bodies corporate, (b) otherwise acquiring membership of bodies corporate. (6) An NHS foundation trust may give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its functions.	CORPORATE / ANCILLARY	**No**
Section 50 NHS Act 2006	An NHS foundation trust must pay to the regulator such fee as the regulator may determine in respect of its exercise of functions under— (a) section 39; (b) section 39A.	REGULATORY	**No**
Section 51A NHS Act 2006	(1) An NHS foundation trust may enter into a significant transaction only if more than half of the members of the council of governors of the trust voting approve entering into the transaction. (2) “Significant transaction” means a transaction or arrangement of such description as may be specified in the trust's constitution. (3) If an NHS foundation trust does not wish to specify any descriptions of transaction or arrangement for the purposes of subsection (2), the constitution of the trust must specify that it contains no such descriptions.	CORPORATE	**No**
Section 56B NHS Act 2006	(1) An application may be made to the regulator by an NHS foundation trust for the dissolution of the trust and the establishment of two or more new NHS foundation trusts. (2) An application under this section may be made only with the approval of more than half of the members of the council of governors of the applicant. (3) The application must, by reference to each of the proposed new trusts— (a) specify the property and liabilities proposed to be transferred to it; (b) be accompanied by a copy of its proposed constitution. (4) The regulator must grant the application if it is satisfied that such steps as are necessary to prepare for the dissolution of the trust and the establishment of each of the proposed new trusts have been taken. (5) On the grant of the application, the proposed constitution of each of the new trusts has effect but, in the case of each of the new trusts, the proposed directors may exercise the functions of the trust on its behalf until a board of directors is appointed in accordance with the constitution.	CORPORATE	**No**

Section 57A NHS Act 2006	57A Dissolution (1) An application may be made by an NHS foundation trust to the regulator for dissolution. (2) An application under this section may be made only with the approval of more than half of the members of the council of governors of the applicant.	CORPORATE	**No**
Section 61 NHS Act 2006	(1) An NHS foundation trust must take steps to secure that (taken as a whole) the actual membership of any public constituency and (if there is one) of the patients' constituency is representative of those eligible for such membership.	CORPORATE	**No**
Chapter 5A NHS Act 2006	Trusts Special Administration.	REGULATORY	**No**
Domestic Violence, Crime and Victims Act 2004, Section 9(2), (3)	(2) The Secretary of State may in a particular case direct a specified person or body within subsection (4) [including NHS trusts established under section 25 of the National Health Service Act 2006 or section 18 of the National Health Service (Wales) Act 2006 by ss(4)(a)] to establish, or to participate in, a domestic homicide review [as defined by ss(1)].	ANCILLARY FUNCTION	**No**
Charities Act 2011, ss149; 152	Various provisions as to the audit/examination of the accounts of an "English NHS charity" (which would include a charitable trust, the trustees of which are an NHS Trust), including requirements as to the auditor/independent examiner and the giving of guidance by the Charities Commission	REGULATORY	**No**
Policing and Crime Act 2017, s1	(1) A collaboration agreement [as defined by ss(3)] may be made by— (a) one or more persons within a paragraph of subsection (2), and (b) one or more persons within another paragraph of that subsection. (2) Those persons are— (a) an ambulance trust in England, (b) a fire and rescue body in England, and (c) a police body in England. [See further sections 3 and 4 regarding collaboration agreements]	CORPORATE	**No**
Investigatory Powers Act 2016, Part 3	Not reproduced in full here, this part of the Act contains provision for applications by "relevant public authorities" to the Investigatory Powers Commissioner for authorisations to obtain communications, and the granting of authorisations by a designated officer in a relevant public authority in specific circumstances. "Relevant public authority" includes (by Schedule 4) ambulance trusts.	REGULATORY	**No**
Immigration Act 1999, s20A	Not reproduced in full here, this provision confers a duty on NHS Trusts to supply a "nationality document" at the direction of the SoS, if the SoS has reasonable grounds for believing is lawfully in the possession of an NHS Trust.	REGULATORY	**No**

Network and Information Systems Regulations 2018	Not reproduced in full here, the regulations make provision for the identification of "operators of essential services" (OES) (where they provide an essential service as specified in Schedule 2 of the regs and where they (a) rely on network and information systems; and (b) satisfy a threshold requirement described for that kind of essential service. NHS Trusts are specified in Schedule 2. An OES is subject to duties relating to notification of their status to a designated competent authority and take appropriate and proportionate technical and organisational measures to manage risks posed to the security of the network and information systems on which their essential service relies.	CORPORATE	**No**
Housing Act 1996, s213B	NHS Trusts are included among the public authorities specified by Homelessness (Review Procedure etc) Regulations 2018 (see reg 10 and Schedule) for the purposes of this provision: (1) This section applies if a specified public authority considers that a person in England in relation to whom the authority exercises functions is or may be homeless or threatened with homelessness. (2) The specified public authority must ask the person to agree to the authority notifying a local housing authority in England of— (a) the opinion mentioned in subsection (1), and (b) how the person may be contacted by the local housing authority. (3) If the person— (a) agrees to the specified public authority making the notification, and (b) identifies a local housing authority in England to which the person would like the notification to be made, the specified public authority must notify that local housing authority of the matters mentioned in subsection (2)(a) and (b).	REGULATORY	**No**
Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, reg 5(1)	(1) Each public authority listed in Schedule 2 [which includes NHS Trusts] to these Regulations must prepare and publish one or more objectives it thinks it should achieve to do any of the things mentioned in paragraphs (a) to (c) of section 149(1) of the Act. [See further regs 5(2) onwards and reg 6 for requirements as to publication.]	CORPORATE	**No**
Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, Schedule 1(2)	Not reproduced in full here, a relevant public authority is subject to a duty to publish annual information relating to gender pay gap information relating to employees.	CORPORATE	**No**
Controlled Drugs (Supervision of Management and Use) Regulations 2013	The Regulations place various duties (not set out in full here) on "designated bodies" (which includes NHS Trusts, by reg 7) in relation to the supervision, management and use of controlled drugs	REGULATORY	**No**

Children and Families Act 2014, s23	(1) This section applies where, in the course of exercising functions in relation to a child who is under compulsory school age, a clinical commissioning group, NHS trust or NHS foundation trust form the opinion that the child has (or probably has) special educational needs or a disability. (2) The group or trust must— (a) inform the child's parent of their opinion and of their duty under subsection (3), and (b) give the child's parent an opportunity to discuss their opinion with an officer of the group or trust. (3) The group or trust must then bring their opinion to the attention of the appropriate local authority in England. (4) If the group or trust think a particular voluntary organisation is likely to be able to give the parent advice or assistance in connection with any special educational needs or disability the child may have, they must inform the parent of that.	ANCILLARY FUNCTIONS	**No**
Mental Health Act 1983	Refers to entire Act.	REGULATORY	**No**
Mental Capacity Act 2005	Refers to entire Act.	REGULATORY	**No**
Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008/1858	Refers to entire Regulations.	REGULATORY	**No**
Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008/1184	Refers to entire Regulations.	REGULATORY	**No**

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NHS North Tees and Hartlepool NHS Foundation Trust

Board of Directors

Title of Report	Joint procurement of Blood Sciences equipment and reagents via Managed Service Contract										
Date:	4 April 2024										
Prepared by:	Karl Hubbard, Pathology Director										
Executive sponsor:	Neil Atkinson, Managing Director										
Purpose of the report	This paper provides the details of the service being procured, why the contract is required, the process followed, and the expected benefits achieved by entering into the new contract. It also provides assurance relating to the accounting of the capital requirements and the understanding of any national approvals process.										
Action required:	Approve	X	Assurance		Discuss		Information				
Strategic Objectives supported by this paper:	Putting our Population First	X	Valuing People	X	Transforming our Services	X	Health and Wellbeing	X			
Which CQC Standards apply to this report	Safe	X	Caring	X	Effective	X	Responsive	X	Well Led	X	

Executive Summary and the key issues for consideration/ decision:

Key Details

This new pathology managed service contract has been procured through a collaborative procurement process which included NTH, CDDFT and STH and as such has provided, not only cash releasing, recurrent savings but will provide a route to developing technologies within Pathology testing for the term of the contract.

The Board provided virtual approval on 6 March 2024 for the managed service contract for the provision of pathology services to North and South Tees NHS FT for the next 10 years. This was facilitated via a fully compliant procurement exercise. This replacement contract releases recurrent, annual savings of £2,368,418 across the two Trusts. This was signed before the deadline of 12th of March 2024. Full details are provided in the attached paper.

Board Subcommittee meetings where this item has been considered (specify date)	Management Group meetings where this item has been considered (specify date)
N/A	N/A

Does the report impact on any of the following areas:

Equality, diversity and or disability		Reputational	
Workforce		Environmental	
Financial/value for money	X	Estates and Facilities	

Commercial		Compliance/Regulatory	
Quality, safety, experience and effectiveness	X	Service user, care and stakeholder involvement	X
	The Board of Directors is asked to; - Note the previously approved decision of the Board of Directors in respect of the Managed Service contract.		

North Tees and Hartlepool NHS Foundation Trust

South Tees Hospitals NHS Foundation Trust

Joint procurement of Blood Sciences equipment and reagents via Managed Service Contract

Executive Summary

1.0 Introduction

Pathology is a clinical support service providing diagnostic, monitoring, and treatment services across a range of specialities. Haematology, biochemistry, immunology, coagulation, and blood transfusion together make up blood sciences.

The equipment and reagents to provide these services are complex and expensive and historically is procured via a managed service with both primary and third-party suppliers for a prolonged duration of circa 10 years plus.

To ensure the increasing demands on laboratory healthcare can be met, access to modern, efficient, automated, and integrated systems that can handle accelerated and increasingly complex workflows are required and therefore consideration has been given to replacing outdated and unsupported equipment at the end of its contractual life.

In 2020 in support of the regional and national ambitions of interoperable pathology services for strategic purposes, and as set out in the agreed joint business case between North and South Tees to develop the Tees Valley Pathology Service (TVP), it was agreed that CDDFT, North Tees and Hartlepool NHS Trust and South Tees Hospitals, would collaborate on a joint procurement project. At this point, each of the Trusts existing managed service contracts had reached or were about to reach the end of its natural life and was therefore, it was recognised that the joint approach to replace existing equipment across the range of blood science specialities would provide a robust business continuity strategy in the south of the region.

The three Trusts agreed to jointly fund a Tower 8 procurement company, Akeso, to support development of the service specification and run the tender, given the scale of the project, the staff resource required and other competing priorities (continued development of the Tees Valley Pathology Service (TVP) and the PATH5 regional LIMS project) and the potential risk of market challenge.

A tender document was presented to market during spring / summer 2022, based on extensive collaborative discussion between the Trusts on a specification for blood sciences, with an agreed two-phased approach – cellular sciences will follow later by

mini-competition by the successful overall managed service contract provider. Two companies submitted bids for the contract, Siemens, and Beckman Coulter.

A detailed scoring and moderation process took place, to ensure all parties had a consistent and agreed outcome: an agreed preferred bidder acceptable to both CDDFT and TVP. The procurement exercise identified the preferred bidder as Siemens Healthineers with the outcome confirmed in January 2023. From this point, a robust implementation plan has been considered and developed with contract schedules, risks and governance strenuously reviewed by all parties including finance and procurement teams. The intention was to create separate contracts for the three organisations based on workload, however, as the development of the TVP service has continued to progress a decision to procure one single contract for both North Tess & Hartlepool and South Tees Hospitals was taken by the Tees Valley pathology Executive Group.

2.0 Proposal

Both North Tees and Hartlepool and South Tees Hospitals have had laboratory managed service contracts in place since 2008 and 2010 respectively, and while some equipment has been replaced much has now passed its expected lifespan. The Beckman managed service contract (North Tees & Hartlepool) has reached the end of its life, despite being extended for a period of 2 years with the Siemens contract (South Tees) expiring this year 2024. Had the Trusts not entered a collaborative model each organisation would have needed to renew contracts independently one another.

The cost of the single TVP contract has been calculated according to the combined workload of both organisations, taking into consideration the creation of a hub and essential services lab approach that the TVP operating model has developed.

The equipment (analyser type) and reagents are procured based on total number of requests received and samples processed as a result. There has been a steady increase year on year in both organisations as more complex patient pathways and overall demand dictates.

3.0 Benefits

There are significant benefits associated with taking a collective approach:

- New equipment will ensure patient test results are provided in a timely manner, not delayed by unplanned equipment downtime caused by aging end of life equipment;

- New tests can be brought into services to provide a wider range of diagnostic repertoire that will enhance patient care, supporting future developments / opportunities to grow the business;

- Reference ranges will be standardised providing consistency for all service users across the Tees Valley and acknowledging that patients do transfer from one site to another during their treatment pathway;

- Repatriation of outsourced tests to support improved turnaround time, to enable clinical teams to provide improved service to patients without waiting for referred test results to be available. This will also reduce the costs associated with outsourcing;

- Detailed performance reports on test status are described in the contract schedules, with the ability to create high quality management reports on performance, inventory, and quality control all of which will support improvement and maintenance of quality standards as performance will be more easily and accurately reviewed;

- Continue to benefit from VAT reclamation;

- Economies of scale from shared procurement;

- Ensures as much equipment is in contract as possible, reducing need for capital replacements during the lifetime of the contract.

- Detailed quarterly review of financial performance to ensure annual financial forecasts of expected spend can be made, and;

- Ability to support specialist workload (e.g. immunology) at one site within the three Trust group at more efficient costs to all.

Contract extensions with Beckman are in place until December 2024 and Siemens until December 2025.

4.0 Contract Value

The proposed managed service contract value is estimated below and demonstrates a potential £2.4m saving across the Group.

North Tees					
Beckman Coulter	**2022**	**2023**	**2024**	**New Contract Year One**	
Biochemistry	£1,414,284	£1,540,468	£1,859,057	825,927	
Haematology	£343,727	£340,595	£369,808	124,511	
Annual Total	**£1,760,033**	**£1,883,086**	**£2,228,865**	**£750,439**	

South Tees					
Siemens	**2022**	**2023**	**2024**	**New Contract Year One**	
Biochemistry	£1,309,409	£1,411,530	£1,722,736	1,344,204	
Immunology	£768,462	£864,185	£1,103,804	861,268	
Haematology	£834,052	£829,548	£876,301	683,753	
Viral Serology	£289,361	£298,953	£347,601	271,223	
Annual Total	**£3,201,284**	**£3,404,216**	**£4,050,442**	**£3,160,450**	

	New Contract Year One	**Saving**
Total	**£3,910,889**	**2,368,418**

The savings on a Trust basis are:

- North Tees & Hartlepool FT (based on 34% of activity) = £789,473
- South Tees Hospitals (based on 66% of activity) = £1,578,945

5.0 Group Capital Position

The capital requirement for North Tees and South Tees over the 10-year period amounts to £8,823,785. Of which, £4,045,788 relates to equipment including IT hardware, with the remainder relating to capital maintenance over the life of the estimated contract.

Each Trust is required to treat the equipment within their respective capital programme.

South Tees Impact

South Tees has an allocation of £2.8 million set aside within its 2024/25 CDEL allocation to cover its element of the investment.

North Tees Impact

North Tees & Hartlepool has an allocation of £0.975 million set aside in its 2024/2025 CDEL allocation to cover its element of the investment.

This CDEL requirement is partially offset by the historic Beckman managed service contract (circa £400k) every two years (current contract length). This was currently built into financial years 2023/24 and 2025/26. The contract with Beckman only included a small proportion of equipment, with the majority of the contract relating to support charges and managed services fees.

6.0 Implementation of the proposed Managed Service Contract

With regards to implementation dates for the managed service contract, they are estimated as follows:

1. Friarage Hospital Laboratory - will begin works on 20th March 2024 with the first stage complete by 12th June 2024 to allow site preparation to accommodate GP workloads and support other parts of implementation plans.

2. North Tees Hospital Laboratory - works will begin 20th March 2024 and first stage to be complete by 15th October 2024 to allow movement of work areas to support estates reconfiguration and equipment moves that will facilitate the management of the Beckman contract by December 2024 (contract end date).

3. James Cook Hospital Laboratory – works will commence by 12th June 2024 once FHN can temporarily take GP workloads. Work will continue through various stages up to July 2025.

7.0 Risks

The key risks which will potentially negatively impact on the continued development of the TVP service and wider joint procurement with CDDFT, relates to timescales.

The current Akeso framework expires on the **12th March 2024**. Failure to sign the contract with Siemens prior to this deadline will result in all three Trusts having to start

again with a full tender process which this current process has demonstrated is a lengthy and protracted process.

At present, the South Tees Board are expected to approve the managed service contract on 5th March 2023 and subsequently, the North Tees & Hartlepool Board on 6th March 2023 (virtually).

CDDFT have already approved their element of the managed service contract on 28th February 2023.

8.0 NHSE Approval

As part of the approval process, NHS England guidance, specifically the "*Capital investment and property business case approval guidance for NHS trusts and foundation Trusts*" has been considered.

This guidance clarifies the requirements regarding the approval process and delegated limits for Trusts in distress. The current limit is £25 million. This is the whole life capital cost over the term of the arrangement including running costs such as maintenance. In the case of schemes requiring investment over £25 million the approval process would require submission to NHS England and DHSC Joint Investment Sub-Committee (JISC).

As outlined above, the whole life capital element of this Contract amounts to £8.8 million which would not require external approval.

9.0 Summary

CDDFT, North Tees and South Tees are the three Trusts in the North 1 network who all had an urgent requirement to replace equipment and so agreed to collaborate on a procurement exercise, to maintain the mandate of network collaboration.

The objective was to gain value for money through efficiency of scale, and collaboration of testing where appropriate, while enabling the Trusts to procure new equipment that will see services maintained and able to cope with increases to workload, test new developments and any changes to the needs of our population for the next decade and more.

10.0 Next Steps

The next steps are as follows:

- To seek approval and the delegated authority for the signing of the managed service contract by the three Trusts;
- Sign the new contract(s) before 12th March 2024;
- Agree final implementation plans with Siemens, and;
- Commence product installation.

11.0 Recommendations

The Group Executive Director Team / Board of Directors are asked to:

- Support and approve the managed service contract;
- Acknowledge and approve the delegated authority required by both North Tees & Hartlepool NHS Foundation Trust and South Tess Hospitals NHS Foundation Trust to support contract signature prior to 12 March 2024.
- Acknowledge the progress to date of the development of the TVP service, and collaboration with CDDFT to reach the final stage of the procurement process which complements both the local network procurement and improvement strategies.

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North Tees and Hartlepool NHS Foundation Trust

Report to the Board of Directors

Title of report	Assurance Report of the Risk Management Group										
Date	4 April 2024										
Prepared by	Stuart Irvine, Director of Strategy, Assurance & Compliance/Company Secretary										
Executive sponsor	Neil Atkinson, Managing Director										
Purpose of the report	To provide assurance to the Board of Directors regarding the operational oversight and management of risk and assurance and that strategic risks are being managed and mitigated to support the delivery of strategic objectives.										
Action required	For Decision		For Assurance	X	For Information	X					
Strategic Objectives supported by this report	Putting our Population First		Valuing People		Transforming our Services	X	Health and Wellbeing				
CQC Domain(s) supported by this report	Safe		Caring		Effective	X	Responsive	X	Well Led	X	

Executive Summary and the key issues for consideration/ decision:

In October 2023, the Executive Risk Management Group (RMG) was introduced by the Managing Director to replace the Executive Risk Meeting. The RMG agenda brings together key functions that support the effective oversight of risk management processes to support the delivery of the Trust's objectives, by identifying risks and their effective management and mitigation. The RMG has an established forward plan that identifies key assurance information for discussion and action, supporting the ongoing process of risk maturity within the Trust.

The Risk Management Group met on 26th January 2024, 7th March 2024 and 28th March 2024. A summary of the key areas discussed are listed below;

- Monthly risk register report identifying compliance with policy, comparisons from the previous month's activity and highlights high risks within the Trust.
- Monthly Report from the Operational Delivery Group on the emergent risks that have been reviewed from the previous month's activity.
- Education progress to increase the ongoing awareness of risk management processes.
- Monthly Director Report (detailing AuditOne progress of delivering the internal audit plan for 2023/24).
- A report on internal audit recommendations (open and overdue).

Key points to note from the meetings are;

- The Trust's use of benchmarking regionally and nationally to inform risk management processes.
- The establishment of a Board Assurance Framework domain for the Trust's Estate, which evidences the actions the Trust takes to mitigate associated risks. This is formally reported to the Resources Committee on a monthly basis.
- The development of strategic risks onto a single plan on a page, illustrating approved risk appetites and rating of strategic risks in summary format. This will be shared via Managers Briefings on a monthly basis.

- The roll out of HFMA Governance and Risk modules to increase awareness and a plan to roll out the modules within the Trust.
- The development of bite-size Risk Management training videos that will be made available to all Trust staff via the intranet.
- A reduction in the number of overdue internal audit recommendations from 48 in December 2023 to 29 in March 2024 and no high graded recommendations overdue.

All Executive Directors provide a summary of the emergent risks and issues that have been identified within the committees, supporting the identification and oversight risks that cut across Executive portfolios.

The RMG supports the delivery of the Trust's strategic objectives of the organisation, providing oversight and scrutiny on the process and the emergent risks that may prevent delivery.

Items For Escalation

There are no matters to escalate to the Board of Directors, but to note there are four strategic risks that are outside of approved risk appetite, which were reported to Resources Committee on 26th March 2024.

Strategic Risk linked to the Board Assurance Framework this report relates to:
This report relates to all domains of the Board Assurance Framework.

Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and inclusivity	X	Reputational	X
Workforce	X	Environmental	X
Financial/value for money	X	Estates and Facilities	X
Commercial	X	Compliance/Regulatory	X
Quality, safety, experience and effectiveness	X	Service user, care and stakeholder involvement	X

Board Subcommittee meetings where this item has been considered (specify date)	Management Group meetings where this item has been considered (specify date)
N/A	Risk Management Group; - 26th January 2024 - 7th March 2024 - 28th March 2024

Recommendation	The Board of Directors is asked to note the work of the Risk Management Group the assurance provided relating to the oversight and scrutiny of the risk management process and emergent risks.