Council of Governors General Meeting (held in public)

10 September 2019, 14:00 to 16:00
Conference Rooms, Walkergate Park, Benfield Road, Newcastle, NE6 4QD

Agenda

1. Welcome and Introductions

Welcome to the Council of Governors meeting held in public.

Verbal

Ken Jarrold, Chair

The big issues considered within this agenda are:
* Service User and Carer Involvement Strategy

2. Apologies for absence

Verbal

Ken Jarrold, Chair

3. Minutes for approval

Verbal

Ken Jarrold, Chair

03 Governors meeting 14 May 2019 FINAL minutes approved by KJ.pdf (7 pages)

4. Matters arising not included on the agenda

Verbal

Ken Jarrold, Chair

5. Declarations of Interest

Verbal

Ken Jarrold, Chair

Business Items

6. Chair's Report

Verbal

Ken Jarrold, Chair

7. Chief Executive's Report

Enclosure

John Lawlor, Chief Executive

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07.a CEO Report Aug 4th Sept.pdf (3 pages)

07.b. Appendix 1. Building healthier communities.pdf (74 pages)

07.c. Appendix 2. A Manifesto for new PM.pdf (16 pages)

8. Governors' Questions

Note: Questions relating to the agenda and papers may be asked at the meeting. For issues not covered by this meeting, questions must be submitted at least 3 working days in advance by emailing corporateaffairs@ntw.nhs.uk

Verbal

Ken Jarrold, Chair

9. Non-Executive Director Appointment Approval

Enclosure

Ken Jarrold, Chair

09. Final - proposed report to CoG NED Appointment.pdf (3 pages)

10. Consitution

Decision

Debbie Henderson, Deputy Director of Communications and Corporate

10.a CNTW Constitution Exec Summary Sept 19.pdf (10 pages)

10.b CNTW Constitution Sept 19 Final.pdf (69 pages)

10.c . CNTW Constitution Sept 19 - Annex 9.pdf (54 pages)

Governor Feedback, including:

11. Feedback from Governor Representatives on Board Committees

11.1. Feedback from Resource and Business Assurance Committee

Verbal

Victoria Bullerwell & Bob Waddell, Governor Representatives

11.2. Feedback from Audit Committee

Verbal

Victoria Bullerwell, Governor Representative

11.3. Feedback from Quality and Performance Committee

Verbal

Margaret Adams & Anne Carlile,

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Governor Representatives

11.4. Feedback from Mental Health Legislation Committee

Verbal

Fiona Grant & Denise Porter
Governor Representatives

12. Feedback from Governors Working Groups and Committees

Verbal

Committee Representatives/
Working Group Chairs

12.1. Update from the Nominations Committee

Verbal

Ken Jarrold/ Margaret Adams,

12.2. Update from the Governors Steering Group

Verbal

Ken Jarrold

12.3. Update from the Governors Quality Group

Verbal

Margaret Adams, Chair

13. Feedback from External Events and Meetings

13.1. Feedback from the Governor Advisory Committee

Verbal

Anne Carlile

Items for information (discussion by exception only)

14. Board of Directors Minutes:

Enclosure

Ken Jarrold, Chair

14.1. 24 April 2019

14.1 Board of Directors Minutes 24 April 2019.pdf (7 pages)

14.2. 22 May 2019

14.2 Board of Directors Minutes 22 May 2019.pdf (7 pages)

14.3. 3 July 2019

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14.3 Board of Directors Minutes 3 July 2019.pdf (8 pages)

15. Any other business

Verbal

Ken Jarrold, Chair

Break

Big Issue Items

16. Service User and Carer Involvement Strategy

16a. Service User-Carer Involvement Strategy final.pdf (8 pages)

16b. Service User-Carer Involvement Strategy Appendix.pdf (4 pages)

17. Date, time and venue of next meeting:

The next Council of Governors meeting held in public Thursday, 7 November 2019, 2 pm to 4 pm. Walkergate Park, Benfield Road, Newcastle, NE6 4QD.

Ken Jarrold, Chair

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Northumberland, Tyne and Wear NHS Foundation Trust

Council of Governors Meeting (held in public)
Tuesday, 14 May 2019, 2.00 – 4.00 pm
Conference Rooms, Walkergate Park, Newcastle

Draft Minutes

Present:

Ken Jarrold	Chair
Margaret Adams	Public Governor, South Tyneside
Stephen Blair	Public Governor, Newcastle, Rest of England/Wales
Russell Bowman	Service User Governors, Neuro Disability Services
Anne Carlile	Carer Governor, Adult Services
Kevin Chapman	Staff Governor, Clinical
Andrew Davidson	Service User Governor, Learning Disability Services
Andrew Fothergill	Service User Governor, Adult Services
Prof Kim Holt	Appointed Governor, Northumbria University
Annie Murphy	Community & Voluntary Services Governor
Fiona Regan	Carer Governor, Learning Disability Services
Dr Uma Ruppa Geethanath	Staff Governor, Medical
Janice Santos	Carer Governor, Children & Young People's Services
Bob Waddell	Staff Governor, Non Clinical
Cheryl Wright	Public Governor, Gateshead

In Attendance:

David Arthur	Non-Executive Director
Dr Les Boobis	Non-Executive Director
Alexis Cleveland	Non-Executive Director and Deputy Chair
Chris Cressey	Associate Director of Finance and Business Development
Jennifer Cribbes	Corporate Affairs Manager
James Duncan	Deputy Chief Executive/Executive Director of Finance
Anna Foster	Deputy Director, Commissioning and Quality Assurance
Debbie Henderson	Deputy Director, Communications and Corporate Affairs
John Lawlor	Chief Executive
Paul McCabe	Director of Estates and Facilities, NTW Solutions
Wendy Pinkney	Corporate Affairs Officer (notes)
Michael Robinson	Non-Executive Director
Chris Rowlands	Equality and Diversity Lead
Lynne Shaw	Acting Executive Director of Workforce and Organisational Development
Peter Studd	Non- Executive Director

Public/Governor Support: Support Worker to Andrew Davidson

Apologies:

Colin Browne	Carer Governor, Older People's Services
Victoria Bullerwell	Staff Governor, Non-Clinical
Fiona Grant	Service User Governor, Adult Services (Lead Governor)
Cath Hepburn	Public Governor, North Tyneside
Claire Keys	Staff Governor, Clinical
Dr Rajesh Nadkarni	Medical Director
Prof Daniel Nettle	Newcastle University Governor
Gary O'Hare	Executive Director of Nursing and Operations

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Denise Porter	Appointed Governor, Rethink Mental Illness
Lisa Quinn	Executive Director of Commissioning and Quality Assurance
Jack Wilson	Service User Governor, Children and Young People's Services

Item	Discussion
1/19	**Welcome and Introductions** Ken Jarrold, Chair, welcomed everyone to the meeting and a round of introductions followed.
2/19	**Apologies for absence** Apologies for absence were received as recorded above.
3/19	**Council of Governors - Minutes for approval** The minutes of the meeting of 5 March were approved as an accurate and true record, with no amendments required.
4/19	**Matters arising not included on the agenda** **Item 11** – Annual Plan and Finance Update James Duncan advised that there had been no return queries received regarding the Trust's Annual Plan and Operational Plan. He added that the national review of capital spend was a big issue and he would keep governors updated on progress. Although the end of year finance of a £4.6 million surplus is a large amount, if delivered, increased funding would be received. Ken Jarrold commented that the financial year end is in a very stable position and expressed his gratitude to everyone involved in delivering such a good result.
5/19	**Declarations of interest** – None received.
	Business Items
6/19	**Chair's Report** Ken Jarrold spoke of the following: • **Visit to Cumbria on 4 July** Ken Jarrold informed the meeting that Fiona Grant, Lead Governor, Margaret Adams, Co-chair of the Nominations Committee/Chair of Quality Sub Group, Debbie Henderson and himself would be attending the North Cumbria Council of Governors meeting on 4 July and would update governors on outcome. Ken added that changes to the Trust's constitution would be necessary to accommodate two new governors. • **Nominations Committee** Ken advised that there would be a meeting today to look at NED recruitment and commented on the need to consider diversity, particularly gender, on the Board. He also advised that applications would be welcomed from an individual with a strong link to the Cumbria area, in light of the forthcoming service transfer. • **Thinking about Service Users/Carers** Ken spoke of the work that governors Margaret Adams and Anne Carlile were involved in with Vida Morris on the new Service User/Carer Strategy.

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	• **NHS Providers Governors Conference, London – 9 May** Ken stated that governors Denise Porter, Margaret Adams and Bob Waddell had attended the event with Debbie Henderson to present their showcase of good practice. A lot of positive comments were received from people visiting their display. Denise found the trip to be very positive and engaging. Bob felt it was recognised that NTW did a lot in comparison to other Trusts in terms of governor and member engagement. Margaret referred to comments made from other Trusts in recognition of the support provided to them by NTW.by NTW. Ken felt it was important to showcase good practice in the role of the governors and to ensure the fundamental principle of accountability is not lost in the future, given the changing landscape of the NHS. Ken thanked Jennifer Cribbes for organising the trip and the group involved in the showcase for their attendance. • Ken informed the meeting of John Lawlor's pending visit to Buckingham Palace to receive an OBE. Congratulations were expressed.
7/19	**Chief Executive's report** **Trust Updates:** **1. North Cumbria Mental Health and Learning Disability Services** John Lawlor commented that the workforce and building transfer is still ongoing, with a four stage HR process involving TUPE, TUPE light, remaining staff and any vacancies for external advert. It was expected that most posts would be filled by the end of July. Lynne Shaw stated the process was presently moving into stage 4, wider recruitment for vacant posts working towards a 1 October deadline. John referred to the commencement of an engagement plan in North Cumbria involving engagement with staff and key stakeholders, including Integrated Care Communities, (GPs), Local Authorities, third sector organisations and Healthwatch organisations. Staff roadshows are planned to take place over the coming months. Feedback received so far is that leadership development workshops have been valuable and the staff are passionate about driving forward improvements and working together. **2. Mental Health Services in Bengaluru** John confirmed that the consultancy work will be paid for and reinvested into our services. The development of public funded mental health services to the poorest 40% in India is proposed. This will be mainly through electronic working and John also noted that the Trust could gain significant learning, as feedback has shown that they have some innovative ways in terms of the support provided to younger people in India. Anne Carlile felt this would be a good opportunity to develop the Trust's digital services and john added that Elections in India are all run electronically, involving over 800m people.

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	Uma Ruppa Geethanath suggested that a group of volunteers may be available and this could enhance recruitment of medical staff. **<u>Action</u>:** To discuss with Dr Rajesh Nadkarni **Regional Updates:** 3. **Integrated Care Systems** John gave an update on the ongoing work, including discussions around more system working rather than a focus on individual organisations. Agreement on how organisations will work in the system across the North-East and North Cumbria, will be coming to Board for ratification in due course. Margaret Adams asked if there was progress around governance and it was confirmed that it was being looked into how lay members, NEDs and Chairs fit into the structure. John emphasised the need for appropriate governance to be acknowledged. **National Updates:** 4. **Clinically Led Review of Access Standards** John referred to his report. 5. **Financial Framework for Integrated Care Systems** John referred to his report. 6. **King's Fund Report Outcomes for Mental Health** John referred to the King's Fund report with reference to mental health, for consideration across the Trust as an outcome based approach is developed.
8/19	**Review of Terms of Reference for Council of Governors meetings held in public** Debbie Henderson presented the Council of Governors Terms of Reference for approval. No comments received. **<u>Approved</u>:** • The Council of Governors approved the Terms of Reference for the Council of Governors meetings.
9/19	**Provider License Self Certification 9FT4(8))** Debbie Henderson spoke to her paper, explaining that the report reflects the level of activities from the Council of Governors. She added that although NTW was ahead of a lot of Trusts, there was still lots of work to be done in terms of opportunities for engagement between the Council of Governors and members.
10/19	**Governors' Questions** • Kevin Chapman requested clarification around the proposed congestion and toll charges in the local area, stating that there would be a significant impact On Trust and staff, for example, it was understood this would incur a charge for travel to St Nicholas Hospital. James Duncan advised that the charge would only apply to old cars, although the toll charge would be for the bridges. James acknowledged that it is an issue but added that it is a national requirement and the Trust is working

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	through some of the detail and will report back on progress to a future meeting. Les Boobis commented that it was a low emission zone; the charge was only for central Newcastle and the toll was for three of the bridges equating to £1.70 per journey per car. • Stephen Blair mentioned the 111 number for patient use as an issue and John Lawlor advised there is already a link between 111 and our services in Sunderland and South Tyneside. It was noted that there is a charge for 101 but not for 999 or 111. **Action:** • A further update on the potential impact of the Clean Air Strategy proposals on the Trust.
Governor Feedback, including:	
11/19	11.0 **Feedback from Governor Representative on Board Committees:** 11.1 **Resource and Business Assurance Committee -** Bob Waddell said as a regular attender he could provide assurance that the committee is operating efficiently within their terms of reference. 11.2 **Audit Committee** – in the absence of Victoria Bullerwell, David Arthur advised that there were no significant issues to report. 11.3 **Quality and Performance Committee -** Margaret Adams commented there were a lot of documents due to the time of year and workforce focussed. Anne Carlile added that the group was always well supported by governors, who are always welcome and there had been more requests from staff members to observe. 11.4 **Mental Health Legislation Committee -** Good feedback received.
12/19	12.0 **Committee and Working Groups Update, Working Group Chairs:** 12.1 **Nominations Committee –** Meeting to be held today. 12.2 **Steering Group –** Ken Jarrold advised regarding agenda setting for 2019 and upcoming AMM on 18 July, to include speakers Lionel Joyce and Jack Wilson plus the 'Hope' video. 12.3 **Quality Sub Group** – Margaret Adams reported on three presentations in March: Always events, ICS and 5Ps. The next meeting is scheduled for 23 May at 9.30 am and will include a presentation on Autism Spectrum Disorder.
13/19	13.0 **Feedback from Events/Meetings:** 13.1 **Feedback from Events:** Nothing to report. 13.2 **Feedback from Governor Advisory Committee:** Anne Carlile reported that she had attended a meeting on 9 April which included lots of information. The next meeting is in July. Anne added that all governors should receive the GAC newsletter.
14/19	**Board of Directors Meeting Minutes** The Council of Governors noted the Board minutes of: 23 January 2019 27 February 2019 27 March 2019

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15/19	**Any other business** a) Debbie Henderson advised that only nine responses had been received in response to the Governors Review of Effectiveness survey and it was essential that more be completed to enable any issues to be acted on. Ken Jarrold emphasised that responses from governors regularly attending meetings were most important. b) Cheryl Wright provided examples of the Top Tips postcards and requested governors to submit any tips via the Corporate Affairs office, as these were proving to be very helpful to service users.
	B R E A K
	Big Issue Items
16/19	**Quality Account update** Anna Foster circulated copies of the Quality Account. Discussion ensued around the impact of policies, waiting times and research opportunities, increased demand for referrals, monitoring methods, schools involvement and the need for more collaborative working. James Duncan confirmed that these conversations are taking place within the Trust but there are no simple answers. Anna mentioned responses to the Friends and Family test for staff has increased from 81% to 88%, as well as being 75% for service users and 25% of carers. Ken Jarrold stated that more information is required regarding why referrals have increased and the reasons behind admissions, which is quite complex. It was suggested that national research can be identified and reported back on.
17/19	**Staff Survey Results** Chris Rowlands presented the results of the Autumn 2018 Staff Survey. Discussion ensued around the difficulties encountered by staff to complete the survey, those on long term sickness, proof of anonymity and standard of questions. Chris advised that there was a new Appraisal policy to be launched and a review of the sickness absence policy, as well as health and wellbeing initiatives being explored. Lynne Shaw confirmed that all localities/CBUs have no individual results identified and are therefore anonymous. Although completion of the survey is optional, staff should be allocated time to complete.
18/19	**NTW Solutions update** Paul McCabe and Chris Cressey presented a summary of NTW Solutions' performance in 2018/19 and a brief "forward look" for 2019/20. Discussion ensued around the Cedar programme and a potential conflict of interest regarding the Lease Car Scheme and restrictions on driving as well as the ethics of the Trust making money out of the scheme. James Duncan advised that the Trust looked at the best possible outcome in terms of money balance and consideration was also given as a whole by the Trust, on whether to bring the Lease Car Scheme in-house or continue externally. The focus being on developing a commercial focus and generating income for the Trust.

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	David Arthur stated that the Audit Committee in the next couple of years, intended to examine if the process is offering assurance of receiving value for money. Peter Studd as Chair of NTW Solutions, stated that compared with a big range of private sector organisations and charging etc., we are well within the market. Two years on from the launch, it is running smoothly and hitting performance targets, although very early days. However, the relationship between the Trust and NTW Solutions has remained strong.
	Close There being no further business to discuss, the Chair declared the meeting closed.
19/19	**Dates, times and venues of next meetings:** Council of Governors Engagement Session – **Tuesday, 4 June 2019** (2.00 – 4.00 pm) Conference Rooms, Walkergate Park Annual Members' Meeting - **Thursday, 18 July 2019** (3.00 – 4.30 pm) Jubilee Theatre, St Nicholas Hospital Council of Governors Quality Sub-Group – **Thursday, 25 July 2019** (9.30 am – 12.00 pm) Conference Room 1, Walkergate Park Council of Governors Meeting (held in Public) - **Tuesday, 10 September 2019** (2.00 – 4.00 pm) Conference Rooms, Walkergate Park Council of Governors Engagement Session – **Thursday, 10 October 2019** (2.00 – 4.00 pm) Conference Rooms, Walkergate Park

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Northumberland, Tyne and Wear NHS Foundation Trust

Council of Governors Meeting

Meeting Date:	4 September 2019

Title and Author of Paper:	Chief Executive's Report John Lawlor, Chief Executive

Paper for Debate, Decision or Information: Information

Key Points to Note:

Trust updates

1. Trust Name
2. NHS Staff Survey
3. Climate Change

Regional updates

4. NE & N. Cumbria Integrated Care System (ICS) Memorandum of Understanding

National updates

5. Building healthier communities: the role of the NHS as an anchor institution
6. A Manifesto for the new Prime Minister

Outcome required: For information

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Chief Executive's Report

4 September 2019

Trust updates

1. **Trust Name**
   As we will soon be providing services to the population of Cumbria, as well Northumberland, Tyne and Wear we have decided to change our name to reflect the geographical area to which we provide services.

   To give parity and equity to all areas we serve, and in line with NHS identity guidelines, our name will be alphabetical, therefore the decision which has been made is that on 1 October we will become Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust.

   We are currently undertaking a process of engagement with staff, stakeholders and the public in North Cumbria and I am sure the Board will join us in welcoming our new colleagues on the 1st October.

2. **NHS Staff Survey**
   The survey will launch in mid-September and we will continue to encourage staff to take part and to give as much feedback as possible.

   Last year's response was 66.5%, with 39 questions seeing an improvement in scores, 21 a deterioration and 21 remaining the same. Based on these outcomes a Trust wise action plan had been developed to focus on violence and aggression, bullying and harassment, improving satisfaction with the quality of care that staff are able to deliver, quality of appraisals, health and wellbeing and addressing ethnicity and disability issues. In addition, each locality and department has looked at the specific issues raised and have developed local actions.

3. **Climate Change**
   The organisation has recently been having conversations and presentations about the health impacts of climate change to ensure that we and our partners are doing all that we can to raise awareness of sustainability and to prevent future harm by limiting our environmental impact.

   A new Corporate Decisions Team sub group, chaired by James Duncan, has recently been convened to consider these important issues and to develop an involvement & engagement strategy as we know that our staff, service users and carers have lots of ideas about sustainable practices. A fuller update will be reported to the Trust Board later this year.

Regional updates

4. **NE & N. Cumbria Integrated Care System (ICS) Memorandum of Understanding**
   A Memorandum of Understanding has been developed through consultation with the organisations involved, to create a framework in which all the NHS organisations across the region will work together. This will include CCGs, NHS Foundation Trusts and national regulators, most particularly NHSI/NHSE, HEE and PHE. This will be considered at the Board meeting to seek agreement to the MoU being adopted across the ICS.

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National updates

5. **Building healthier communities: the role of the NHS as an anchor institution**
   Attached as ***Appendix 1*** *or click* ***here*** to access the report which was recently published by The Health Foundation, an independent charity committed to bringing about better health and care for people in UK. The report outlines the opportunities for the NHS to maximise its contribution to the health and wellbeing of local populations. This includes widening access to quality work, purchasing and partnering locally and social benefit, and reducing its environmental impact.

   The report argues that more can be done to support and challenge the NHS to embrace its role as an anchor institution and in doing so, advance the welfare of local people.

6. **A Manifesto for the New Prime Minister**
   The NHS Confederation and its networks have jointly compiled this briefing for the new Prime Minister, the Rt Hon. Boris Johnson MP. This briefing sets out seven key challenges for the NHS in 2019 and beyond including, funding, social care and the NHS in a post-Brexit world. I have attached as ***Appendix 2*** or click **here** to access the report.

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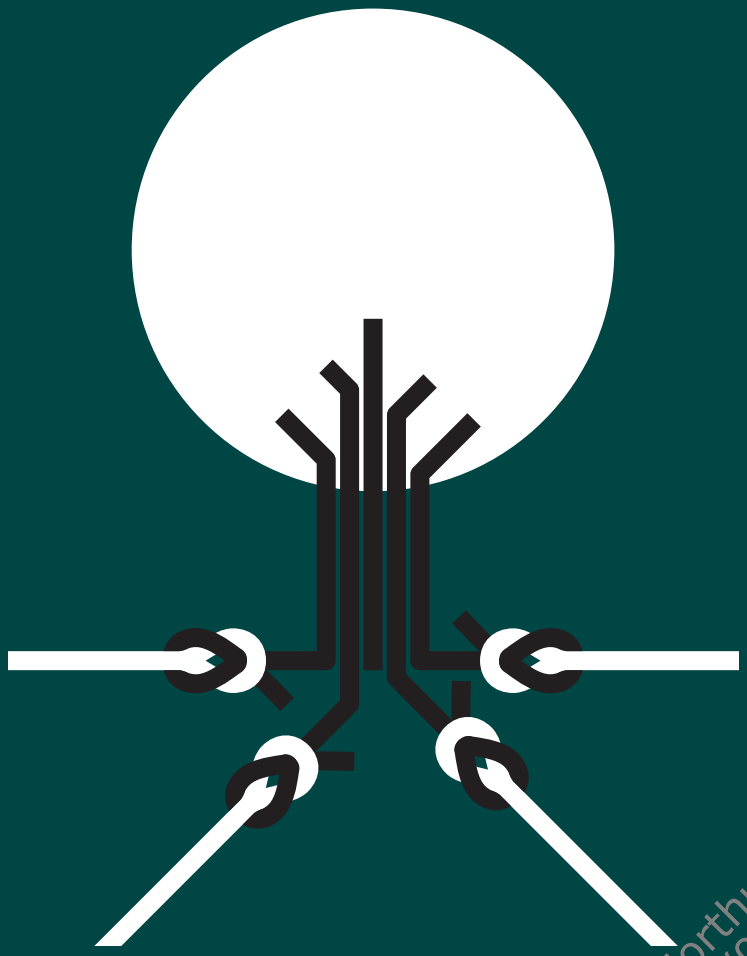
Research

August 2019

Building healthier communities: the role of the NHS as an anchor institution

Sarah Reed, Anya Göpfert, Suzanne Wood, Dominique Allwood and Will Warburton



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The Health Foundation

Acknowledgements

The authors would like to express their gratitude to those who gave up their time to support this work. This paper would not have been possible without Jo Bibby, who conceived the original idea for this work and provided invaluable thought leadership throughout.

Thanks also to our advisory group, those who peer reviewed this work and colleagues at NHS England and NHS Improvement for providing thoughtful comments on early drafts of this report. We would also like to thank colleagues at the Health Foundation for their support and guidance during the research and production of this report, including Ruth Thorlby, Ben Gershlick, Laura Wallace, Josh Kraindler, Yannish Naik and Tim Horton. Errors and omissions remain the responsibility of the authors alone.

This work draws on research by CLES and The Democracy Collaborative, funded by the Health Foundation, and we would like to thank Neil McInroy, Frances Jones, Tom Lloyd Goodwin, Ted Howard and Katie Parker for their collaboration throughout.

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Building healthier communities: the role of the NHS as an anchor institution
is published by the Health Foundation,
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Contents

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Executive summary

What this report is about and why it matters

Widening health inequalities and growing pressures on health care services have prompted a fundamental conversation about the role of the NHS in prevention and its broader influence in local communities. The British economy is one where wages and living standards are stagnating and 22% of the population live in poverty.[1] People from the most socially deprived areas of England die nearly a decade earlier and spend 18 fewer years in good health than people born in the least deprived areas.[2] And while health care services on their own are insufficient to overcome these inequalities, the NHS could make a far greater contribution to this goal: it is the largest employer in the country, spends billions on goods and services each year and controls significant land and physical assets – all of which make it a powerful 'anchor institution'.

Anchor institutions are large, public sector organisations that are called such because they are unlikely to relocate and have a significant stake in a geographical area – they are effectively 'anchored' in their surrounding community. They have sizeable assets that can be used to support local community wealth building and development, through procurement and spending power, workforce and training, and buildings and land.

Anchors have a mission to advance the welfare of the populations they serve. They tend to receive (or are significant stewards of) public resources, and often have a responsibility to meet certain standards on impact or value. These characteristics mean that the NHS, like other anchors, is well placed to have a powerful voice in where and how resources are spent locally. The NHS can also lead by example, and help spread and champion the principle of anchor institutions in local economies.

The idea of anchor institutions is not new. In the UK, however, other public sectors (such as local government and universities) have arguably been more conscious of their role as anchors.[3,4] There are signs that this is changing; there is growing enthusiasm across the NHS for how health care organisations make up a key part of the social and economic fabric of communities, and can do more to channel their strategic influence to improve population health.

This report explores how NHS organisations act as anchor institutions. It gives examples of what anchor practices look like in a health care context, and how anchor institutions can maximise their influence on the wider determinants of health, as follows.

- Chapters 1 and 2 introduce the **concept of anchor institutions** and set out the case for change.
- Chapter 3 discusses **employment**, and how the NHS can widen access to quality work for communities furthest from the labour market, and be a better employer and place to build a career for more local residents.

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- Chapter 4 looks at how **procurement and commissioning** can derive greater social value by shifting more NHS spend locally and towards organisations that provide greater community benefit.
- Chapter 5 considers how the NHS can make better use of its **capital and estate** by supporting the development of community assets like affordable housing and creating community spaces for local groups and businesses.
- Chapter 6 looks at how the NHS can promote **environmental sustainability** in its own operations and in the broader community.
- Chapter 7 discusses how the NHS can accelerate progress and impact at scale by working more effectively as a **partner across a place**, both within its own structures and with other anchor institutions in the local economy.

The central argument of this report

The size, scale and reach of the NHS means that it has a significant influence on the health and wellbeing of local populations. But how it chooses to function and leverage its resources will determine the extent of that impact. More can be done to support and challenge the NHS to embrace its role as an anchor institution and maximise the social and economic value it brings to local communities.

There are a range of promising anchor activities taking place across the NHS that provide an important foundation from which to advance progress. Though NHS organisations are all in very different stages of their role as anchors, where anchor practices are happening, they tend to be discrete, narrow in scope and not intentionally applied or integrated into central and local systems or organisational strategies. Nor are anchor approaches being evaluated in any systematic way to know where to prioritise efforts and what actions are likely to have the greatest impact on population outcomes.

There are opportunities at each level of the system to help the NHS more consciously adopt an anchor mission and to understand the impact of different approaches so that they become a central part of how NHS organisations function.

Considerations for practice and policy and taking it forward

Supporting NHS organisations to embrace their anchor mission is key to harnessing the NHS's powerful influence on community health and wellbeing. While NHS organisations face many immediate pressures that can make it difficult to adopt anchor strategies, the examples in this report show how parts of the NHS are taking a pragmatic approach and aligning anchor practices with other strategic objectives. While most change will be delivered at the organisational level, there is a key role for local system, regional and national leaders to help scale approaches, cultivate an anchor mission and support an environment where these practices become an embedded part of how the NHS operates.

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This report draws on examples of promising practice and identifies key opportunities to help NHS organisations meet their potential as anchor institutions, regardless of the area of anchor activity being pursued (summarised in Table 1 below). We also surface some of the key tensions that may have to be worked through to balance priorities and direct efforts along an anchor mission, and present some examples of where practices have overcome them. These are summarised in Table 3 and discussed in more detail throughout the report. The report proposes key actions for national and regional policymakers, local system leaders, and NHS providers and networks to help the NHS advance its role as an anchor institution.

Table 1: Steps towards realising the NHS's potential as an anchor institution

1.	Build a baseline understanding of current practice to know where to prioritise action and establish informed goals.
2.	Develop metrics and evaluate the impact of interventions.
3.	Establish clear and visible leadership to embed anchor practices within organisational and system strategies.
4.	Enable staff to act on a collective vision for enhancing community health and wellbeing.
5.	Support the sharing and spread of ideas through networks.
6.	Engage proactively with communities to ensure that anchor strategies meet the needs of local people and to maximise impact on narrowing inequalities.

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Figure 1: What makes the NHS an anchor institution?

NHS organisations are rooted in their communities. Through its size and scale, the NHS can positively contribute to local areas in many ways beyond providing health care. The NHS can make a difference to local people by:

Purchasing more locally and for social benefit
In England alone, the NHS spends £27bn every year on goods and services.

Using buildings and spaces to support communities
The NHS occupies 8,253 sites across England on 6,500 hectares of land.

Working more closely with local partners
The NHS can learn from others, spread good ideas and model civic responsibility.

Widening access to quality work
The NHS is the UK's biggest employer, with 1.6 million staff.

Reducing its environmental impact
The NHS is responsible for 40% of the public sector's carbon footprint.

As an anchor institution, the NHS influences the health and wellbeing of communities simply by being there. But by choosing to invest in and work with others locally and responsibly, the NHS can have an even greater impact on the wider factors that make us healthy.

References available at www.health.org.uk/anchor-institutions

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Chapter 1: Introduction

It is increasingly accepted that good health is shaped by the conditions in which people live, learn, work and age, with access to clinical care playing an important but more minor role.[5,6,7,8,9,10,11,12] In addition to its core purpose of delivering health care services, the NHS has the potential to influence these conditions: it is the largest employer in the UK, spends billions on goods and services each year and controls significant land and physical assets – all of which give it enormous economic clout in local communities. Through its scale, size and relationship with local populations, the NHS represents a powerful 'anchor institution' that can positively influence the social, economic and environmental factors that help create good health in the first place.

The idea of anchor institutions is not new. Until now, though, it has mainly been local government and universities that have more consciously recognised their role as anchors.[3,4] There are signs that this is changing. The *NHS Long Term Plan* promised to explore the potential of the NHS as an anchor institution and identify examples of NHS initiatives that have benefited their surrounding communities.[13] But how the health service chooses to operate and leverage its resources will determine the extent of that impact. Questions remain as to how the NHS can best be supported and challenged to think differently about the social and economic value it brings to local populations.

This report explores how NHS organisations act as anchor institutions in five areas:

- employment
- procurement and commissioning for social value
- use of capital and estates
- environmental sustainability
- as a partner across a place.

It showcases where NHS organisations are already implementing anchor practices, and discusses opportunities for how practice and policy can evolve to maximise the NHS's contribution to local communities.

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What are anchor institutions?

The term anchor institution gets used in different ways, but for the purposes of this report we are referring to large, public sector organisations that are unlikely to relocate and have a significant stake in a geographical area. Anchors have sizeable assets that can be used to support local community wealth building and development, through procurement and spending power, workforce and training, and assets such as buildings and land. Anchors have a mission to advance the welfare of the populations they serve. They tend to receive (or are significant stewards of) public resources, and often have a responsibility to meet certain standards on impact or value. These characteristics mean that the NHS, like other anchors, is well placed to have a powerful voice in where and how resources are spent. The NHS can also lead by example and help spread and champion the principles of anchor institutions in local economies.

Our approach

This report draws on a number of workstreams, including the following.

1. Research commissioned by the Health Foundation and produced by the Centre for Local Economic Strategies (CLES) and The Democracy Collaborative (TDC), which included a review of evidence on the role and impact of anchor institutions, as well as three case studies: University Hospitals Birmingham NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust and East Lancashire Hospitals NHS Trust.
2. Interviews about existing practice from a range of perspectives, including the acute sector, community and mental health trusts, primary care, clinical commissioning groups (CCGs), research, policy and local government. Interviewees included leads for transformation, sustainability, purchasing, public health, partnerships, estates and workforce.
3. Workshops with an expert advisory group to identify the greatest opportunities for progress. Participants included representatives from acute trusts, local government, national bodies, academia, primary care, commissioners and the voluntary sector.

For each of the five areas (employment, procurement, capital and estates, environmental sustainability and partnerships), we explain why it matters, provide examples of what anchor practices look like in the NHS and briefly explore the policy context. We conclude with a summary of implications for practice and policy moving forward.

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Chapter 2: Setting out the case for change – the role of the NHS in a local place

There is increasing concern about inequalities in different parts of the UK where the conditions for living life in good health are poor and deteriorating. Across England, wages, living standards and productivity are stagnating and more than one in five people (22%) now live in poverty.[1] Poverty represents a profound economic and social loss to the UK: the British economy spends an estimated £78bn pounds dealing with the effects of poverty.[14] People living in poverty are more likely to have poor health, and this is reflected in persistent inequalities in health outcomes.[15]

People born in the most deprived 10% of local areas in England are expected to die nearly a decade earlier and have 18 fewer years in good health.[16] While these inequalities are primarily driven by broader factors that sit outside the health system, there are several reasons why the NHS should and can play a stronger role in supporting their reduction.

The protection of health care spending relative to other parts of the public sector since 2011 creates a moral case for maximising the value and reach of NHS funding to improve population health and wellbeing. Health care accounted for 30% of public service spending in 2016/17 compared to 26% in 2009/10 and 23% in 1999/2000,[17] and budget reductions to local government have put both public health and social care services under severe pressure.

There is also an instrumental argument: even if the root causes of poor health and health inequalities are primarily driven by factors outside the control of the health sector, it is the NHS that deals with many of the consequences. It faces increased demand from preventable behavioural and socioeconomic causes,[18] and it is therefore logical to extract the most value from the NHS in its wider role within local communities.

Thinking of the NHS in this wider role goes with the grain of policy both in England and across the UK. The 2014 *NHS Five Year Forward View* demanded a 'radical upgrade in prevention',[19] with the 2019 *NHS Long Term Plan* expanding on this to set out a strategy to strengthen the NHS's contribution to tackling health inequalities and improving population health.[20] The government's Green Paper on prevention set out proposals to make progress on their ambition to extend healthy life expectancy in the UK by five years by 2035[21,22] (though the proposals have been criticised for not going far enough to narrow the inequalities between the richest and poorest needed to achieve this aim).[23] Wales and Scotland have already adopted cross-government approaches to improving health and wellbeing, placing duties on public bodies to take action to tackle the socioeconomic conditions that widen inequalities.[24,25]

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Since 2016, health policy in England has also encouraged the NHS to plan and deliver services in collaboration with other bodies locally. Sustainability and transformation partnerships (STPs) and the emerging integrated care systems (ICSs) bring the NHS and local government together to design and deliver services to meet local population needs from a common pool of resources.[26] Though still very much under development, the promise of these partnerships is that the NHS may have more scope to establish and work towards common goals with sectors like housing, education and employment. In Scotland and Wales, health and social care are further integrated and NHS bodies have greater flexibility to work together to develop new approaches to improve population health.

Supporting inclusive economies

There is a growing synergy between the place-based lens of the NHS and broader policy that emphasises localism in shaping the socioeconomic environments in which we live.

The idea of inclusive economies – enabling all communities to benefit and contribute to economic success – has garnered significant attention nationally and internationally over the past decade. This is partly due to a recognition that economic growth has often failed to 'trickle down' and alleviate poverty or increase living standards across all communities as expected.[27] In England, growth has been concentrated in London and the South, with other parts of the country falling significantly behind.[28]

Inequalities and deprivation threaten long-term economic stability as many people become trapped in low-productivity work or are excluded from the benefits of growth altogether.[29,30] Local leaders have therefore increasingly turned to anchor institutions to create the conditions needed to support a healthy population, and help tackle inequalities while boosting economic growth.[31] Devolution and the subsequent creation of local enterprise partnerships* (LEPs) and local industrial strategies have been promoted as ways of giving more power to local communities. Though an emergent area of policy, these agendas are seen as an opportunity to bring economic players together across a place to drive productivity and distribute growth more fairly across the country – although whether these policies will lead to a narrowing of inequalities remains to be seen.[32,33] There is an inherent risk that increased localism could even widen socioeconomic divides if already advantaged places are better positioned to leverage local resources and capacities for the benefit of residents.[30] This makes it ever more important to consider the distinct role that health sector organisations play as anchors in local communities, given that the NHS exists everywhere and carries with it significant assets that can be channelled for public good.

The NHS is a key part of the social and economic fabric in all communities, and as an anchor is well placed to work with other sectors to support place-based approaches that promote prosperity and create the foundation for healthy communities. There is growing recognition that health systems have an important and positive impact on economies, and can improve health and wellbeing (directly and indirectly) through the size and nature

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* Announced in 2010, LEPs are private-sector-led partnerships between local businesses and local public sector bodies. Their aim is to help set local economic priorities and undertake activities to drive local economic development and job creation. LEP boards are led by a chairperson from local businesses, with board members drawn from local industry, educational institutions and the public sector.

of their role.[34,35] However, the complexities of the NHS have often meant that health care organisations have acted as institutional siloes, often looking upwards to regulatory bodies more than outwards to their community for direction and to drive change. But given the economic challenges the UK is facing and the recent focus on localism, there is now a key opportunity for the NHS to work with other local leaders to develop a common agenda and support economic strategies that improve the socioeconomic conditions of local communities. This goal is important not only for building more inclusive economies, but for the NHS itself; by more consciously leveraging its resources and actions, the health sector can have even greater strategic influence across a place and be part of broader conversations that improve the context in which it works.

Learning from anchor practices

In the chapters that follow, we set out examples of anchor practices in a health care context to show how the NHS can leverage its assets to maximise its influence. These examples come from the grey literature and interviews, highlighting existing anchor practices in the NHS and what it might take to broaden their impact.

There are many ways of considering how the NHS functions as an anchor institution. We restrict our focus to examples related to five key areas: employment, procurement and commissioning, capital and estates, environmental sustainability and working in partnership across a place. Many of the examples involve provider trusts, because of their relatively large size. This should not be taken to imply that other parts of the NHS cannot function as anchor institutions, or have less scope or responsibility to intervene in the social determinants of health. Indeed, the formulation of primary care networks (PCNs) in England may create new opportunities to work at scale and implement anchor strategies in primary care. While most actions will take place at the level of the organisation, the report discusses how local system and regional/national NHS leaders can help create an environment in which NHS organisations more fully embrace their anchor mission and maximise their contribution to local economies. We focus primarily on England, given its different context and recent opportunities, and given that the other countries of the UK are making more progress in some areas.

Based on our findings, we conclude by suggesting actions at each level of the health and care system, including by national and regional policymakers, by local system leaders (that is, STPs and ICSs) and by local NHS providers or networks.

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Chapter 3: The NHS as an employer

Why this matters

The NHS employs more than 1.6 million people in the UK[36] and, with more than 350 career options, is a critical source of economic opportunity for local people. Figure 2 shows the percentage of jobs the health sector contributes locally by level of STP. The figure demonstrates how the NHS, which accounts for most of these jobs, is a major driver of employment in each regional economy, though some areas (the North and parts of London) are more reliant on the NHS for employment relative to other sectors.

There is a strong link between work and health; for work to have a positive impact on health, it must be 'good work' – providing stable employment, paying a living wage, and offering fair working conditions, work-life balance and career progression.[37] By helping more residents – particularly those furthest from the labour market – into quality work, the health system can improve the welfare of its local communities and begin to narrow inequalities. Building a workforce that is more representative of the local area can also better respond to patients' needs. Furthermore, employing local people can contribute to reducing the carbon impact of the health sector by reducing the number of staff reliant on transportation to get to work.

Anchor workforce strategies involve thinking not only about how the NHS can grow local workforce supply and widen access to employment for local communities, but also how it can be a better employer and place to build a career for more people. It acts as an anchor not only in the number of jobs it creates, but in how it can support the health and wellbeing of its staff through good employment conditions and the working environment – a timely undertaking, given the enormous workforce pressures confronting the NHS.

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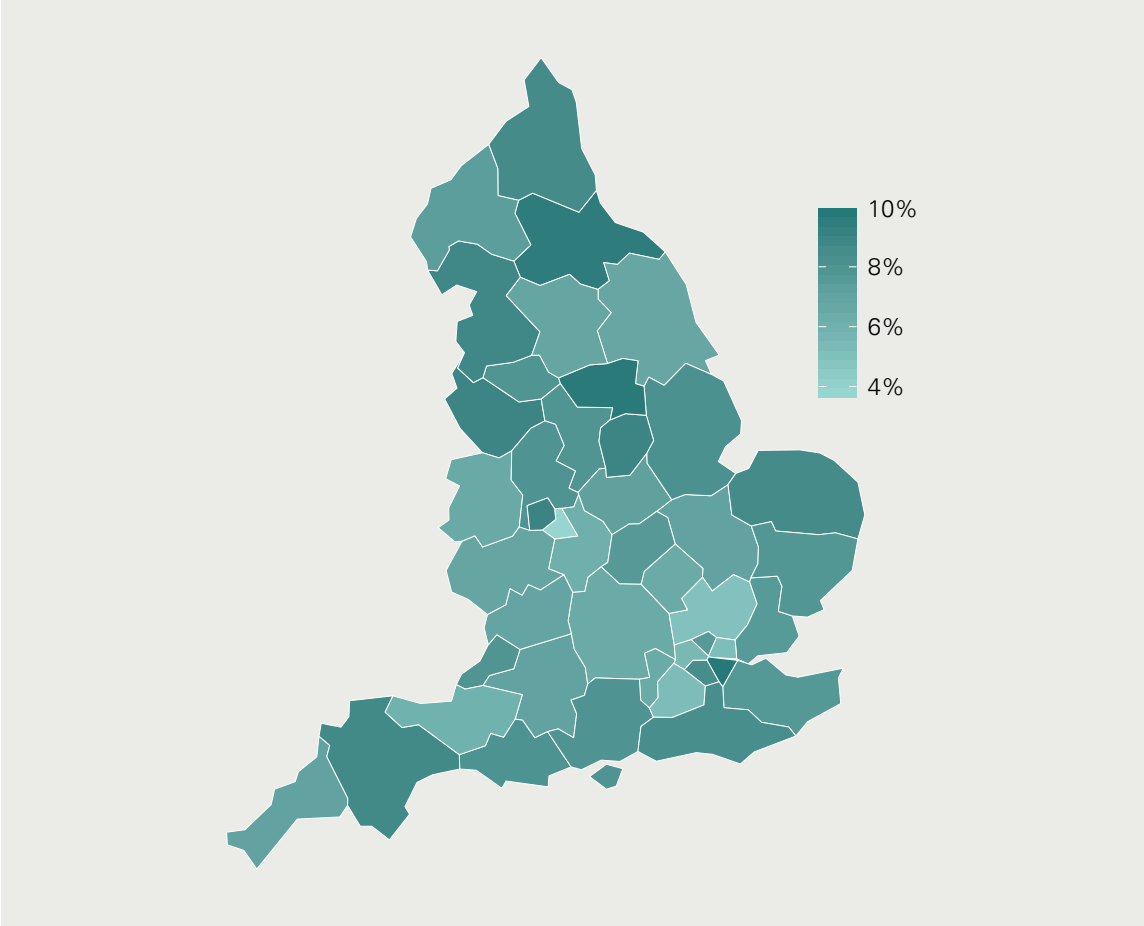
Figure 2: Health employment as a percentage of total employment by STP level



Office for National Statistics, Business Register and Employment Survey (2017)

Notes: data are for all people employed in hospital activities, medical and dental practice activities and other human health activities (eg, medical nursing homes, rehabilitation centres, psychiatric hospitals, etc.). Data will include people working in the private sector as well as part-time.

What do anchor workforce strategies look like in practice?

Widening workforce participation

1. Targeting positions for local people
2. Understanding local demographics and opportunities
3. Creating pre-employment programmes, work placements and volunteer work experience

Building the future workforce

1. Engaging young people and supporting career development
2. Increasing the number and types of apprenticeships

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Being a good employer

1. Supporting health and wellbeing of staff
2. Supporting fair pay and conditions of employment
3. Supporting professional development and career progression

Policy context

Workforce shortages are the biggest threat facing the health and care system, with significant implications for the quality of care. Hospitals and mental health and community providers in England alone are reporting vacancies of more than 100,000 full-time equivalent (FTE) staff.[58] Based on current trends, the NHS will continue to fall substantially short of the workforce it needs unless there are significant actions to increase staff supply.[38]

There are multiple strategies that the NHS, as an anchor institution, can adopt to address workforce shortages, including better attention to career progression and training for NHS employees, with numerous efforts targeting support roles, including health care assistants. This includes the Health Education England *Talent for Care Strategic Framework*,[39] which aims to create more opportunities for people to start and build a career in the NHS. Alongside this, the *Widening Workforce Participation Strategy*[40] established a programme to expand access to education, employment and development opportunities for under represented communities. The *Interim NHS People Plan* also explicitly recognises the NHS's responsibility, as an anchor, to support employment opportunities for local communities by creating new job pathways and making the NHS a more inclusive work environment and better employer for more people.[41] The government's *Industrial Strategy* also creates further scope for the NHS to work with local partners to improve local skills development.

Apprenticeships are another mechanism for widening access to employment. A new apprenticeship levy came into effect in 2017, and as the largest employer in the UK, the NHS has led the public sector in its use. In health and social care, around 420,000 people have started apprenticeships since 2011.[42] The levy covers the costs of training, but not the apprentices' wages. Smaller employers, like GP practices, can also access the levy to pay 90% of their apprenticeship training costs. There are plans to create 100,000 more apprenticeships in England by 2020, including nursing and health care assistants, and in IT, estates and facilities, domestic and housekeeping services, and business administration.[42,43]

Workforce shortages are compounded by poor experiences for some groups of staff. The 2018 *NHS Workforce Race Equality Standard* survey found that 15% of black and minority ethnic (BME) staff reported experiencing discrimination in the past 12 months, and that 28% did not believe that their organisation provided equal opportunities for career progression (this compares to 7% and 13% of white staff, respectively).[44] These inequalities need urgent attention. The *Interim NHS People Plan* promises to deliver a more compassionate and inclusive culture that promotes equality of opportunity for all staff.[41]

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Learning from practice

Widening workforce participation

1. Targeting positions for local people

NHS organisations have worked with community partners to target certain positions for local residents, who might otherwise face barriers to work. Partners include local councils and other community organisations that often have deeper reach and insight into local populations, which helps identify potential candidates and promote work opportunities.

For example, Barts Health NHS Trust has a proportion of roles available to locally unemployed applicants. In the same way that some roles are ring-fenced for internal hires, the trust prioritises local hires for a certain number of entry-level positions and works with local authorities to identify and match potential candidates (see case study on page 19).

To monitor progress, some organisations are using targets to increase the percentage of local hires – a practice adopted by some hospitals in the United States. In 2015, Johns Hopkins Health System and Johns Hopkins University launched HopkinsLocal, which stipulated that 40% of new hires for entry-level positions should come from Baltimore neighbourhoods with high poverty and unemployment. Hopkins met this target within the first year and by 2018, 47% of targeted positions (381 new hires) were filled by residents from these areas.[45] The hospital worked with local organisations to identify unemployed and underemployed individuals for specific jobs, and provided tailored training, skills development and assistance with the application process. Residents who apply through the programme are guaranteed a first look by recruiting managers.

These recruitment methods need to reach as wide a pool of applicants as possible. This means writing job descriptions accessibly, advertising NHS roles in a broad range of outlets and using selection techniques that support inclusivity and diversity. NHS Employers and Health Education England (HEE) have created a range of tools, resources and guidance to support NHS organisations to engage local communities throughout the recruitment process, offering a helpful starting point when developing or expanding anchor strategies.[46]

2. Understanding local demographics and opportunities

Where possible, NHS organisations should aim to employ a staff mix that is drawn from, and broadly representative of, the local population it serves. This requires baseline data to know where employees come from to ensure that areas with the highest levels of deprivation are represented in the workforce, and that people from these areas have equal opportunity to advance their careers.

The Leeds Teaching Hospitals NHS Trust has been thinking critically about how to build career opportunities for local people from deprived or excluded communities, and is working with Leeds City Council through a new programme called Priority Neighbourhoods. This initiative uses local data to develop 'neighbourhood profiles' to help target local investments and create more opportunities in areas that fall within the 1% of the most deprived areas nationally.

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‘Some little things have been easy to do. For example, some of the most disadvantaged neighbourhoods in Leeds are on our doorstep, like Lincoln Green, which has a high percentage of people who’ve recently emigrated to the UK. Feedback from those working in the priority neighbourhood highlighted that many people felt helpless as to how to get on a career pathway. In-work poverty was and is a key challenge. Working with the council we have run a series of recruitment events locally to promote routes into careers, alongside an employability programme and language courses. This has seen us make around 30 hires from within the neighbourhood and surrounding area. We’re currently planning our next cohort.’

Director of Policy and Partnerships
Leeds Teaching Hospitals NHS Trust

3. Creating pre-employment programmes, work placements and volunteer work experience

A growing number of NHS organisations (supported by strategies such as *Widening Participation* and *Talent for Care*) are developing employability programmes that provide training and support to help local people acquire the skills needed to work in health and care, often linked to direct work experience, training or volunteer roles.[*,47]

One example is the University Hospitals Birmingham NHS Foundation Trust, which has worked with local partners like The Prince’s Trust to establish a Learning Hub (set up in 2008). This is a purpose-built centre fully staffed to offer pre-employment advice, training, guidance and direct links to jobs in the NHS to unemployed local people and those furthest from the labour market. In a 12-week programme, participants complete 3-week volunteer work placements in roles across the NHS and receive mentoring from trust employees.[48] To ensure that the recruitment opportunities are widely accessible, the organisation has agreed to accept references from social workers instead of traditional employment references, for refugee populations. The Learning Hub has so far supported nearly 2,500 local people into employment within the trust and partner organisations since it opened.[49]

East Lancashire Hospitals NHS Trust has launched a programme that offers more residents a chance to gain a qualification and volunteer work experience within the trust. Partnering with the Department for Work and Pensions and Blackburn College, the trust provides pre-employment training for the long-term unemployed, homeless people, people with learning disabilities and people struggling with drugs and alcohol.[50] Participants complete a 3-week course at Blackburn College on employability skills in adult and child care, then

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* Volunteering takes many forms and can give a range of benefits to the recipient, the organisation and the individual who is giving time. For the purposes of this report, we focus specifically on the benefits of volunteer opportunities in terms of providing work experience opportunities and supporting skills development and routes into employment for different populations.

do a 2-week volunteer work placement within the trust in roles including catering, laundry services or business administration. Twenty-five people completed the training as part of the first cohort in 2018, four of whom have secured permanent employment within the trust.

Survey data from HEE show that in 2015/16, there were nearly 800 employability programmes of this nature across the NHS, with 1,219 participants, many of which targeted local people or underrepresented populations.[47] The roles targeted have tended to be lower-banded operational and administrative roles that are critical to the running of the NHS. However, there may be further scope to expand opportunities and connect more local people to clinical roles in nursing and allied health professions that have clear progression routes and where more staff are needed.

It will be important to evaluate these programmes robustly. At the sites where we conducted interviews, there has been limited attention to measuring effectiveness of pre-employment support and other efforts to widen workforce participation. Indeed, a HEE survey found that fewer than half (48%) of NHS organisations with an employability programme had evaluated it.[43] Yet the limited evidence available suggests these programmes can work: an evaluation commissioned by HEE of programmes offered in three trusts (Manchester University NHS Foundation Trust, South Tees Hospitals NHS Foundation Trust and North Bristol NHS Trust) found that of 732 people participating in a programme at one of the sites, 52% went on to work at the trust as an apprentice or in a permanent job.[43,51]

So far, pre-employment programmes have been created in large hospital trusts with limited offers in general practice or commissioning.[47] This suggests that more support is needed to encourage other NHS organisations to follow suit. This could be an important part of STP/ICS planning – to develop a wider health employment programme that links local people to opportunities across the sector. The introduction of PCNs may also create more scope to pool resources and develop pre-employment programmes or work placements for general practice across a locality.

There are examples of health and care organisations working together to develop opportunities across a local system. As part of the North West London Health and Care Partnership, the NHS is working with local councils and unions to develop a formal skills partnership to help more local people from disadvantaged backgrounds access good-quality work. Since forming the partnership, the NHS in west and north west London has become the largest provider of supported employment opportunities for young people with special education and development needs. By working more closely with the council, NHS organisations have made new relationships with other large employers locally (such as Heathrow Airport) and are developing further joint programmes to benefit local people.[52] The *Interim NHS People Plan* promises a shift to devolving more responsibility to STPs/ICSs for workforce planning,[41] creating further opportunities to develop collaborative approaches for improving the economic prospects of more people.

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Building the future workforce

1. Engaging young people and supporting career development

Helping young people to gain the skills and qualifications they need to pursue careers of their choice is key to supporting a healthy transition into adulthood.[53] In the UK, over 10% of young people aged 16–24 are not in education, employment or training (NEET),[54] which can have serious long-term effects on their economic prospects and employability. As an anchor in local communities, the NHS can work with local partners to help break down barriers to future employment for young people.

A growing number of NHS organisations are collaborating with local schools and community organisations to expose more young people to careers in the NHS, raise the profile of different types of NHS jobs and help support skills development locally. This has also been a part of HEE's *Widening Participation* strategy, which has introduced a framework to support the NHS to partner with schools to create new training opportunities and mentoring for students.[40]

Through our research, we have identified several examples of trusts implementing initiatives to support young people to understand potential NHS career options and to gain the experience and skills needed to work within the sector and broader local economy. Many of these examples focus on young people from disadvantaged communities.

For example, Birmingham has one of the highest rates of youth unemployment in the country, and the local trust has developed programmes that target young people at risk of homelessness and unemployment. In addition to its programmes with The Prince's Trust through its Learning Hub (see page 15),[55] the University Hospitals Birmingham NHS Foundation Trust is also working with Birmingham City Council to deliver Youth Promise Plus – a city-wide initiative providing training, support and work opportunities to at least 16,000 young people (aged 15–29) classed as NEET. Together with Birmingham and Solihull NHS trusts, the local hospitals have committed to supporting 850 participants through this programme.[49]

The Leeds Teaching Hospitals NHS Trust is also promoting careers to young people in the local area. It has appointed a cohort of staff to act as health career ambassadors to promote NHS opportunities in local schools. It has also established a work experience programme that enables young people to directly observe the trust's work in both clinical and non-clinical areas. After finding that the initial uptake of work experience placements came from younger people in more affluent areas, the trust has started to target schools in more deprived postcodes to redress the balance.

2. Increasing the number and types of apprenticeships

NHS apprenticeships can offer paid employment, protected learning time and clear career progression from support worker through to a degree or postgraduate-level qualification.[56] They can be used to support new trainees as well as internal staff looking to advance in their careers.

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Some NHS organisations have used the funds they contribute to the apprenticeship levy to scale their approach. The Leeds Teaching Hospitals NHS Trust is one of a few organisations piloting a nurse apprenticeship programme, to give more people from different backgrounds an opportunity to access NHS careers. The pathway involves a 6-week traineeship with a guaranteed interview on completion for a Level 1 apprentice clinical support role. Building on the initial success, the trust has expanded the programme to include roles in administration, facilities, medical engineering and other clinical support areas. In 2018, apprentices accounted for 3% of the trust's workforce; since 2015, it has increased its apprenticeships by 51% each year.[57]

Stakeholders we interviewed welcomed the concept of a compulsory employer funded and led training programme like the apprenticeship levy, but felt that some changes are needed for it to provide greater local benefit. For example, it would be better in some cases if unused funds could be retained within the sector or within localities, rather than redistributed elsewhere. There is also a lack of data on where people move on to after completing their apprenticeship, which hampers understanding of how the programme supports career prospects, and for whom.

Some felt that the levy should have explicit aims to boost social mobility, so that the funds could support economic prospects for people from disadvantaged backgrounds or who have not benefited from apprenticeships so far. This could mean prioritising a certain number of placements for local people living in more deprived areas and who are underrepresented in the NHS clinical workforce. The *Interim NHS People Plan* committed to explore how the apprenticeship levy could evolve to support more inclusive pathways into NHS careers,[41] which may provide an impetus to implement some of these changes. In either case, given the challenges NHS organisations already face in using the levy,[58] any changes must be balanced and not overly burdensome to administer.

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Case study 1: Barts Health NHS Trust

Based in east London, Barts Health NHS Trust is the largest NHS trust in England, with an annual total workforce spend of £869m and around 16,500 staff. It has high vacancy and staff turnover rates, exceeding 10% and 13% respectively. The trust's response to this provides a good example of how an NHS organisation can combine a range of programmes and initiatives in one of the key anchor areas to focus on improving local health, wellbeing and social mobility, while also addressing workforce pressures.

Targeting positions to help local unemployed people

To employ more local people, particularly from disadvantaged backgrounds, the trust ring-fences a proportion of entry-level roles for local applicants. These vacancies are shared with local authorities who help identify and match potential candidates based on their skills, interests and other requirements. The most common positions targeted are clinical and corporate roles that do not require advanced degrees, ensuring that they are accessible to residents who may not have high educational attainment.

The public health team advocating for this change needed buy-in from recruitment managers, who worried that prioritising local applicants would limit choice of candidates. The team argued that even if fewer applicants were shortlisted for each role, this process was more efficient as candidates were pre-screened and pre-matched by the local authority according to their skills and interests.

Supporting career opportunities for younger people in the area

The trust has also been working with schools and community partners on programmes designed to generate qualified and prepared local applicants from socially disadvantaged communities.

Project Search East London, run in partnership with local schools and employment services, aims to increase career opportunities within the trust for young people with learning difficulties and/or disabilities. Adapted from an initiative at Cincinnati Children's Hospital in the United States, it provides employability skills training and job placements for young people at Barts. In the five years since it launched, 54% of participants (46 interns) have moved into paid employment in roles including ward clerk and ward host, and in catering and portering.[59] The project has a designated job coach who works with managers to provide inductions, define work placement duties and support interns with any specific learning or workplace issues.[59] Project Search is also being adapted by some other NHS organisations across the UK.

Barts Health NHS Trust has also recently launched a Health Horizons programme, a multi-pronged strategy to help more young people locally build their careers in the NHS. Run by the trust in partnership with Barts Charity and supported by the JP Morgan Chase Foundation, the programme works with schools across local boroughs to increase awareness of NHS careers and promote the NHS as a local employer. The trust has appointed sector career champions and mentors working with secondary schools and local councils to offer career advice, run career awareness events and recruit for volunteer work experience placements.

For students aged 16–18, the programme works with Jobcentre Plus and local authorities to identify career opportunities in target boroughs and deliver coaching and interview training. The programme is building local supply in roles where recruitment has been especially challenging, including allied health professions, nursing and nursing associates, health care assistants and health care navigators. As of summer 2019, it is yet to be fully implemented, but aims to recruit 400 students to work experience placements or apprenticeships and support 100 participants through pre-recruitment programmes (with a target of 50% ultimately going on to employment in health or social care).

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Being a good employer

1. Supporting health and wellbeing of staff

The NHS has an opportunity to improve the health and wellbeing of local people in the way it treats and supports its own large body of staff. Supporting a happy and healthy NHS workforce can also have a knock-on impact on the health and wellbeing of the wider community, given the number of connections NHS staff have through their families and social networks.[60] The latest NHS staff survey results reveal that the NHS could do much more to promote a healthier working environment. While there have been improvements in some areas, less than a third of staff reported that their trust takes positive action on health and wellbeing.[61]

Many NHS employers have prioritised improving staff health and wellbeing, offering workplace wellness schemes to reduce stress and promote healthy lifestyles. Though important, these strategies need to be carefully designed to be accessible to all and to not inadvertently widen inequalities within the workforce. Studies have shown that employees who participate in workplace wellness programmes often have higher incomes and are in better health than those who do not.[62]

This was a case in point at the Royal Free London NHS Foundation Trust, where an internal review of its workplace programmes revealed that, of the 1,700 participants, only 10% were from bands 1 and 2 – despite these staff having some of the highest rates of referrals to occupational health and missing the most work days due to musculoskeletal issues. These staff also reported feeling extremely stressed at work and often ignored or unvalued. The trust therefore co-designed a workplace wellness programme with staff in the facilities team (including porters, domestic and security staff), which led to a range of activities including cooking classes, family and social events, a financial advice workshop and group walks. An independent (unpublished) evaluation indicates that the programme brought benefits, including more staff reporting that they felt valued, physically active and less stressed at work. The evaluation also suggests a reduction in sickness absences of 1.6 days for porters and domestic care staff compared to a control arm of other band 2 staff during the 12 months of the project. The trust now needs to find a way to sustain the programme beyond its initial national grant funding.

2. Supporting fair pay and conditions of employment

An important determinant of staff wellbeing is the terms and conditions of their employment, including receiving a fair wage and having a good work–life balance. Low pay can lead to financial hardship, trapping people in in-work poverty,* with important implications for health and wellbeing. Being an anchor means ensuring that the NHS provides secure employment and fair compensation so that all its staff can live with financial security, not least because in some areas the NHS is the largest employer.

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* 'In-work poverty' refers to individuals living in households where income is below the poverty threshold despite one member of the household working either full-time or part-time. The poverty threshold is defined as under 60% of the average household income (before housing costs).

The Health Foundation's *Closing the Gap* report with The King's Fund and Nuffield Trust shed light on the current challenges in staff pay and how they impact on different employee groups.[58] The 2018 pay deal marked an important change in how NHS staff are paid, lifting the 1% cap and resulting in almost all staff receiving real-term pay increases. Staff in lower bands received the biggest increases, and from 2019/20, every worker employed directly through the NHS is now paid at least the real living wage.[63]

Lifting the pay cap is a crucial step for many NHS staff experiencing hardship. For example, the Royal College of Nursing (RCN) reported that the number of nurses and health care assistants receiving a grant from the RCN Foundation to alleviate severe financial hardship had doubled between 2010 and 2016.[64] And a Unison survey of 12,000 NHS employees in lower-paid roles showed that 21% had to take on another paid job to make ends meet.[65] As the *Closing the Gap* report makes clear, it is critical that pay for NHS staff keeps up with the cost of living beyond 2021/22 (when the pay deal expires) if the NHS is to support the financial security of all who work for it.

The NHS also needs to remunerate staff fairly, addressing the persistent ethnic and gender pay gaps, if NHS organisations are going to maximise their potential as anchor institutions and provide a model for other employers.[58] The NHS also has an opportunity to go further and influence the wellbeing of many more workers by extending living wage and fair working condition standards to all its contracted employees.

3. Supporting professional development and career progression

Supporting staff to meet their full potential and advance in their roles is a key feature of any good human resources (HR) policy, but is particularly important for anchor institutions. Given the size, scale and varied nature of its workforce, the NHS has a key opportunity to ensure that no one gets trapped at the low end of the labour market. It can do much to help staff progress into higher-wage positions – for example, by mapping out clear potential career pathways for all roles and offering continuing professional development and training for staff at all levels, not just those in the highest-paid bands.

While the NHS has focused at both the national and local level to improve staff development, there is significant scope to ensure that these opportunities are accessed equally across staff groups. For example, people from BME backgrounds are underrepresented in leadership positions, with the 2018 *NHS Workforce Race Equality Standard* report revealing that over half of trusts (52%) have no BME representation in the 'very senior manager' pay band.[66] The percentage of chairs and non-executives of NHS trusts from a BME background has nearly halved, from a peak of 15% in 2010 to 8% today.[67] As with pay, it is important that the NHS seeks to understand what is driving inequality and develop strategies to redress this.

Equality of opportunity is also important in the context of broader technological advances that will change the nature of health care work. The *Topol Review* noted that clinical staff will need new training and development to acquire the skills that digital transformation requires.[68] These changes offer an opportunity to improve the quality and efficiency of health care, but the workforce implications must be closely considered. For example, where new technology brings automation of care or tasks, the risks to lower-banded support roles

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(an important entry point to NHS careers for many people) should be monitored. As an anchor institution supporting inclusive employment, the NHS must use technology to upskill and advance all roles, not just those in the highest-paid positions. The Care City case study below provides an example of an inclusive professional development strategy that has used digital enhancement to improve the career prospects for more junior members of staff.

Case study 2: Care City

First established by North East London Foundation Trust and the London Borough of Barking and Dagenham, Care City is a centre for healthy ageing and social regeneration that works across northeast London. The area has 10% unemployment and the lowest life expectancy in London. Care City brings investment and opportunity to help regenerate the boroughs. One way it does this is by testing new ways of using digital technology to improve the skills of people working in support roles, such as health care assistants. Funded through the Test Beds programme run by NHS England and the Office for Life Sciences,[69] the programme involves three components:

- Building the skills and confidence of domiciliary carers to use new technology that helps spot deterioration among patients with long-term conditions early, and supports better medication management.
- Training health care assistants working in primary care to support patients who have been prescribed a digital application by a GP to make use of the technology and help prevent deterioration of long-term conditions.
- Teaching skills to administrators in acute care to provide support for people with heart failure and administer digital programmes that support education and exercise between appointments.

Care City leadership saw an opportunity with this programme to develop people in support roles – who often have the least access to technology – to improve the way they deliver care.[70] An evaluation is underway; the team hopes that the digital training will not only improve care delivery and the patient experience but also support future career prospects and professional advancement for more junior members of the health and social care workforce.

Summary and implications for practice and policy

Growing a local workforce and making the NHS a better place to build a career are areas where the NHS has the largest scope to maximise its role as an anchor. These goals also align with the policies and programmes the NHS is pursuing to address recruitment and retention challenges.

At the national level, delivering the *NHS Interim People Plan* can support NHS organisations to widen workforce participation and create more diverse and accessible pathways into NHS careers. This includes ensuring adequate funding and resources for training and development so that all staff can progress in their roles, and that opportunities are inclusive and help break down the barriers to advancement that exist for many staff groups. Where policy levers (such as the apprenticeship levy) already exist, they should be reviewed and, if necessary, reformed to ensure that they create opportunities for communities who could benefit the most.

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At the local system level, STPs and ICSs should enable NHS organisations to advance anchor strategies as part of local workforce plans, and develop joint approaches with local partners that improve employment prospects for local people. The NHS's regional teams can also help share learning and evidence between systems.

There is also scope for individual organisations to do more to widen participation, increase the numbers of local people they employ and ensure good work for current and prospective employees. NHS providers could make inclusion, diversity and local hiring explicit organisational goals, and work with partners to deliver more volunteering, work experience, apprenticeships, skills training and coaching to build a pipeline of future employees and prepare more people for work in the NHS. This requires both local demographic data and baseline data about existing staff to identify the greatest areas of need and to target interventions. Once staff are in post, every opportunity should be taken to support staff health and wellbeing and create equal opportunities for career development and progression.

If approached correctly, anchor strategies can respond to workforce pressures at the same time as improving health and addressing inequalities within local communities. These strategies need to be accompanied by clear targets and metrics to help assess progress and the wider impact of these strategies over time.

Practical resources to support implementation

Economic and Social Impacts and Benefits of Health Systems (World Health Organization Regional Office for Europe)

NHS Workforce Health and Wellbeing Framework (NHS Employers)

Recruiting from your community (NHS Employers)

The Talent for Care. A National Strategic Framework to Develop the Healthcare Support Workforce (Health Education England)

Think Future – tools, resources and learning (NHS Employers)

What Comes Next? National Strategic Framework for Engagement with Schools and Communities to Build a Diverse Healthcare Workforce (Health Education England)

Widening Participation. It Matters! Our Strategy and Initial Action Plan (Health Education England)

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Chapter 4: The NHS as a purchaser and commissioner for social value

Why this matters

The NHS has significant purchasing power, spending £27bn each year on goods and services in England alone.[71] Decisions about what the NHS decides to buy, and how, have ramifications on local population health and wellbeing. Procuring and commissioning* more goods and services from local small and medium-sized enterprises (SMEs) and voluntary and community sector organisations can have an important economic impact, as resources spent locally have a multiplier effect and are reinvested in the local community at a faster rate than resources spent with national corporations.[72,73] There is limited conclusive evidence on the size of local multipliers and the extent to which local procurement stimulates local economic growth.† This will depend in large part on the nature of local economies, but some studies have shown an effect ranging between 1.7 and 2.1 (for example, investing £1 in a local economy generates between £1.70 and £2.10 worth of growth).[74,75,76,77]

An analysis of procurement data of 10 anchor organisations in Leeds (four local authorities, two colleges, a university, a hospital, a CCG and a housing association) found that they collectively spend £1.4bn a year on goods and services, nearly half of which (£665m) left the local economy.[78] The analysis concluded that by shifting 5%–10% of their spend locally, these anchors could generate between £168m and £196m a year of additional economic activity in the local economy when multipliers are factored in.[74] By spending more resources within the community, anchor organisations may help local businesses to grow, employ more people and pay higher wages, thereby stimulating local economic development.

* Procurement and commissioning are both used in reference to social value and mean slightly different things. In this paper, we use the following definitions:

- **Commissioning** is the process that public sector organisations go through to assess and determine what services are needed for a local area and choose what and how to allocate resources to provide services that meet those needs. Commissioning is a cyclical process involving many steps to meet strategic objectives, including identifying need, scoping the market for potential providers, drawing in expertise, establishing service specifications, deciding how to resource the service, selecting a suitable supplier, and evaluating and monitoring performance against service specifications. Commissioned services can be funded in many ways, including providing the service in-house, grant funding or procurement from external providers.
- **Procurement** refers to the method of purchasing goods and services by public sector organisations from other external or third-party organisations, resulting in a contract.

Source: www.gmcvo.org.uk/system/files/issues%2019.pdf

† Local multipliers are used to estimate the knock-on effects (for example, new employment opportunities or increased incomes locally) of stimulus spending on local economic growth. A multiplier greater than 1 corresponds to a positive growth stimulus (returning more than £1 for each pound invested locally), whereas a multiplier less than 1 indicates a net loss from spending.

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The NHS could also derive greater social benefit from the money it spends by introducing principles of social value into its contracts and procurement processes. There is no standard definition of 'social value', but it broadly refers to the wider societal benefits that can be gained from purchasing decisions (over and above those to the contracting organisation) – for example, by specifying that jobs are created locally with living wages and fair working conditions. By choosing to work with suppliers that advance social, environmental and economic outcomes in their local populations, the NHS can secure even greater value from its investments and support broader community health and wellbeing. By changing its procurement and commissioning processes, the NHS can also lead by example and influence other organisations in its supply chain, thereby having a wider community impact.

What do anchor procurement strategies look like in practice?

Shifting more spend locally

1. Building local capacity and supporting local supply chains

Embedding social value into purchasing decisions

1. Prioritising and monitoring social value
2. Building organisational capability and capacity for social value

Policy context

Applying anchor strategies to NHS procurement is not without challenge, as this is an area where NHS organisations have less local flexibility, particularly in England. This is especially true following the introduction of the Future Operating Model (FOM), which aims to improve efficiency and effectiveness of NHS purchasing by introducing greater standardisation and price transparency.

It is expected that once the FOM is fully implemented, 80% of the NHS's spend in England on everyday hospital goods, consumables and capital equipment will be purchased through centralised procedures.[79] The FOM was developed in response to recommendations in Lord Carter's review into operational productivity in English hospitals, which determined that the NHS could do more to leverage its collective buying power to reduce unwarranted variation in prices and procurement approaches and help release savings.[80] The FOM covers 11 'category towers' or areas of spend, including medical consumables, capital equipment and common goods, but there are still areas where the NHS has more flexibility to procure locally, including catering and hotel services.

Even with these changes, procurement and commissioning can still be used to improve health outcomes for local communities. In England and Wales, the 2012 Social Value Act requires public sector commissioners to consider how the services they buy support wider

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social, environmental and economic wellbeing when they procure services above OJEU (Official Journal of the European Union) thresholds.[81,82] Scotland has a similar policy, where the government requires contracting authorities to consider how procurement can help reduce inequalities and shift more spend towards SMEs in contracts of £4m or above.[83] In Wales, the government also requires public sector organisations to apply a community benefits policy to all procurement, regardless of the value of the contract (though outcomes need only be reported on contracts worth over £2m).[84] The UK government also committed to spending £1 in every £3 with SMEs by 2020,[85] and there are separate requirements in England that food and catering services procured by central government or the NHS must meet specified social and environmental aims.[86]

The legislation should, in theory, promote anchor practices, but there are significant differences in how NHS organisations have applied its principles.[87] In England, a 2017 analysis of CCG Freedom of Information Act requests revealed that only 13% of clinical commissioners actively considered social value as part of decision making, and 43% had no policy in place.[88]

Although this variation suggests room for improvement, some NHS organisations are already using social value and purchasing decisions to benefit the local community.

Learning from practice

Shifting more spend locally

1. Building local capacity and supporting local supply chains

An important first step in shifting more spend locally is to understand current purchasing practices. NHS organisations can conduct internal audits of procurement spend to identify the percentage of purchasing that stays within the local region, and then work out how to reallocate more of the purchasing budget towards local organisations. The Centre for Local Economic Strategies (CLES) benchmarked spend at two NHS provider trusts by examining procurement data on goods and services from their top 300 suppliers for 2017/18 (see Table 2).

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Table 2: Procurement spend of East Lancashire Hospitals NHS Trust and Leeds Teaching Hospitals NHS Trust, 2017/18

	Procurement spend	Percentage spend in local authority	Percentage spend in wider region	Percentage 'leakage' outside wider region*
Leeds Teaching Hospitals NHS Trust	£482m	28% (Leeds City)	31% (West Yorkshire including Leeds)	69%
East Lancashire Hospitals NHS Trust	£117m	19% (Burnley and Blackburn-with-Darwin)	23% (Lancashire)	77%

This shows that significant spend at each trust is 'leaking' out of the local economy, and there is potential to work with local suppliers and get more value from procurement. How local economic boundaries are defined will vary by area, but benchmark analysis can help organisations set reasonable targets for retaining more spend within communities.

Once an organisation understands its purchasing practices, it needs to find ways to prioritise local suppliers. Stakeholders reported pushback from staff who fear that requiring suppliers to be local is anti-competitive and violates existing regulations. While regulatory frameworks do prevent NHS organisations from requiring suppliers to be only local or use only local labour, procurement experts we spoke to said that it can be specified that potential suppliers must help advance local community development. More can be done to provide training and clarity to purchasing teams on what is legally possible and how to enforce social value.

Some efforts by anchors to procure more goods and services locally have been criticised as protectionist or inefficient.[89,90] It is important to fully evaluate and understand the impact of these strategies; anchor strategies should aim to boost the competitiveness of local suppliers, not shield them from competition. Any effort to shift more spend locally must be in line with existing regulations that require services to be competitively procured. Audit functions can be bolstered to help ensure these potential risks are mitigated and that local suppliers compete credibly on costs and quality.

Shifting more spend locally will also depend on the capacity and capability of the local supplier market, and may not be possible in all areas of spend. Anchor organisations have a role in supporting local supply chains and ensuring that local businesses, social enterprises and SMEs can compete for and secure NHS contracts. Existing tools and guidance make clear that building local capacity starts in the pre-procurement phase, identifying which resources and services can be secured by organisations working in and with people from

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* To provide context to these figures, CLES has created an average of the spend of the 26 analyses it has carried out covering procurement in a range of anchor organisations (including local authorities and higher education institutions). It finds that on average, anchors spent 36% of total spend inside the local authority boundary and 63% within a wider regional area.

the community.[91,92] This may involve conducting audits and outreach with the local economy to identify opportunities and build new relationships, particularly with SMEs and voluntary sector organisations. Local NHS charities are often well placed to know voluntary sector organisations or SMEs in the area with whom to engage.

Interviewees noted how this engagement can help build awareness and encourage smaller organisations to bid for and win contracts. Engagement also helped contracting organisations understand the barriers that local organisations face in working with the NHS. Experts we spoke to thought that STP and ICS leadership could be helpful in coordinating this engagement across a larger area, but that individual organisations still need to conduct their own engagement and outreach, particularly in the lead-up to large projects and contracts being advertised. Procurement leads described how it can be difficult to reach smaller organisations that may not always have the capacity or staff to engage in outreach. This is why NHS organisations should also consider taking other measures alongside engagement, like ensuring prompt payment terms or unbundling contracts into smaller parts so that SMEs are more able to compete, and are not required to deliver all aspects of a service to be successful. Interviewees warned, however, that enacting these strategies can be administratively time-consuming, and not all NHS teams have capacity and expertise to do this.

Some anchor organisations have also developed toolkits and guidance for suppliers to help organisations understand the required criteria and improve the quality of applications. For example, the Greater Manchester Combined Authority developed a toolkit for suppliers that lists clear examples of what provider organisations can offer as part of their bids against core social value criteria, alongside a list of resources to help organisations implement these practices.[93] And in Wales, the Co-operative Centre (a community development agency that supports social enterprises and co-operatives) has developed modules and guidance for suppliers demonstrating ways they can contribute to broader social value, as well as tools and techniques for reporting against criteria.[94]

More can be done at the national and regional level to help NHS organisations spend more locally. For example, in England, stakeholders noted how the FOM towers (see page 25) could incorporate at least one regional provider (where possible) in categories to give NHS organisations an opportunity to retain resources within the health economy where appropriate.

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Case study 3: North Bristol local food procurement

North Bristol NHS Trust changed its approach to procurement of catering services to purchase more food locally. In 2018, 54% of its food spend went towards local produce. It has been awarded Food for Life certification by the Soil Association, recognising excellence in catering that provides environmentally sustainable and ethical food.

To make this change, the catering team conducted a large audit to identify what produce was available locally and the financial implications of switching suppliers. They removed certain menu options (lamb) that could not be sourced within a 50-mile radius. This increased costs slightly: for example, beef cost 1p more per meal when sourcing from a local and organic provider. The director of facilities, who was supportive of the change from the start, looked for savings from elsewhere to offset the increase. Existing regulations helped gain senior backing for the approach, as trusts are already required by the Department of Health and Social Care to have a food and drink strategy that supports procuring more food from local, sustainable sources.[95 96]

Embedding social value into purchasing decisions

1. Prioritising and monitoring social value

There are promising examples of NHS organisations that have embedded social value into procurement processes, either by introducing explicit weightings or designing core contract specifications so that suppliers must meet specific conditions – for example, creating local jobs and training opportunities, paying a living wage and adopting environmentally sustainable practices.

To aid this process, some NHS organisations have established frameworks and action plans with specified outcomes and definitions for social value to assess bids and help measure performance against social objectives. Doing so often requires sophisticated cross-department working to write contract specifications and agree common aims and procedures. Stakeholders we interviewed noted that senior leaders play an important role in developing a clear vision and strategy for social value to underpin these efforts and ensure they are consistently applied.

STPs/ICSs also have an important role in strengthening the application of social value across a health economy. At present, very few STP plans (13%) refer explicitly to social value,[88] though some do include related objectives around narrowing inequalities, improving access to housing and reducing poverty. STP and ICS leads could work with partners across a place to agree shared objectives and define common metrics for social value, which in turn could help reduce local variation in how the concept of social value is adopted in a local health economy and could help mainstream it in practice.

Even where frameworks exist, the NHS could take a broader approach to have an even greater impact on community health and wellbeing. For example, when NHS organisations consider social value it tends to be primarily as part of competitive tender processes, which are limited to large contracts. Applying these principles more systematically across areas where the NHS has greater flexibility (such as hotel and catering services), even though they may be of lower value, can help maximise spend for community benefit. Stakeholders noted that the overall weighting NHS organisations give to social value when scoring

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contracts tends to be low (between 5% and 10%), with most value placed on cost and quality. This is lower than local government, where social value weightings can be as high as 30%.

Applying more weighting to social value increases the likelihood of selecting suppliers who provide greater community benefit, but even so, there are trade-offs. For example, requiring that all suppliers pay their staff a living wage can make a service more expensive to deliver:

> 'Often we have no flexibility to increase the cost of running a service, so requiring suppliers to pay a living wage means we can't deliver the whole service to the same level. This is made harder by the fact that we face pressure to achieve cost savings on contracts year on year… This is why we've started with a weighting of 10%, with the goal of increasing it slowly over time. This felt more manageable to our purchasing team.'

Head of partnership
Clinical commissioning group

There are still limited accountability mechanisms for enforcing the use of social value, which interviewees believed may contribute to inconsistencies in how it is applied. To be compliant with the Social Value Act, public sector commissioners are only required 'to consider' social value in purchasing decisions, yet they are rarely scrutinised to show what 'consideration' means. Even with the incorporation of social value into the NHS Standard Contract in England,[97] CCGs and trusts reported not being required to provide evidence for how they meet the requirements.

Strengthening the legislation so that public bodies are required to formally incorporate social value into purchasing decisions could help mainstream it in practice. In 2018, the government announced plans to do just that – making social value an explicit requirement of central government contracts.[98] Legislative proposals intended to ease the implementation of the *NHS Long Term Plan* also aim to introduce a 'best value test'. Although more detail is needed on how the test will operate, this has the potential to support system leaders to incorporate wider considerations of public and social value when commissioning services.[99] But legislative changes notwithstanding, there is more that can be done to build greater accountability for social value across the sector. Interviewees said that NHS England and NHS Improvement could help introduce stronger incentives for social value, either by encouraging use of weightings or helping to define minimum key performance indicators (KPIs) through existing levers, including CCG assurance frameworks and STP/ICS guidance. They could also set minimum social value standards for the NHS nationally, establish common metrics and showcase promising practices that can be adapted locally. The Scottish government, for instance, has issued guidance

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for contracting authorities on how to define community benefit requirements as part of procurement, with suggestions for how public sector organisations can develop metrics to monitor performance against national and local outcomes.[100]

However, even where national standards and resources exist to support more progressive procurement, they have not always become embedded in practice. For example, the Government Buying Standards for Food and Catering Services (GBSF) requires all central government departments and the NHS in England to meet basic minimum standards for sustainability and socioeconomic value, and to use a balanced score-card when evaluating bids to ensure that more complex criteria, like how companies source from SMEs, are factored into procurement. A 2017 government review found that while significant progress had been made to adopt GBSF standards, almost half of NHS trusts were not fully compliant.[101] According to stakeholders we interviewed, the scorecard has been difficult to mandate centrally, given that these services are procured so differently across organisations and often involve sub-contractors that can be harder to monitor.

Many NHS organisations also lack the means to ensure that their suppliers follow through on social value commitments. Establishing monitoring frameworks so that NHS organisations can systematically collect evidence and track progress against social value indicators could help build accountability and increase the benefit of anchor procurement strategies.[102] However, stakeholders noted that contract management can be time-consuming, and should be proportionate to the size of the contract to avoid being overly burdensome.

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Case study 4: Wales community benefits measurement tool

Wales provides an example of how to monitor and build accountability for social value at national and local levels. The government requires public sector organisations to report on the broader community benefit of contracts over £1m (though organisations are encouraged to consider social value as part of all procurement decisions, irrespective of value).

To aid this, the Welsh government has established a community benefits measurement tool to help organisations capture the full range of outcomes, including worksheets and guidance for purchasing managers to report on a number of defined measures. These include whether procurement budgets have: supported businesses based in Wales and SMEs; helped local unemployed people to find work; diverted waste from landfills; and created new apprenticeships and training opportunities. Organisations report to the government, which can then track the broader social value and multiplier effect of public spend.[103]

While designed primarily as a reporting tool, this resource has also provided a consistent way for organisations to measure outcomes. It is used locally by organisations as part of their ongoing contract management process to ensure that suppliers meet agreed standards for social value.

Case study 5: Social value in Salford

Salford provides one of the more advanced examples of what a collective approach to social value and progressive procurement can look like. In 2016, organisations across the public, private, voluntary and community sectors formed the Salford Social Value Alliance, which supports all partner organisations to deliver services and contracts with social value in mind. In 2017, it launched a campaign to make a 10% improvement across 11 social and environmental outcomes by 2021. This included increasing the number of residents from vulnerable groups accessing jobs and training; supporting more people to cycle when commuting; and directing more spend towards local organisations.

The alliance includes local NHS organisations, which took part in early engagement activities to help establish shared principles for how to embed social value priorities in health and care commissioning and procurement. Salford CCG has since developed an action plan for social value,[104] which acknowledges its role as an anchor and builds on the metrics set in the 10% campaign. It is also expected that this strategy will help underpin developments through the ICS and joint working with the local council as part of integrated commissioning arrangements.[104]

The alliance has also created toolkits and resources to help partner organisations embed community benefit into commissioning and procurement decisions, and to measure impact.[105] The city council has taken the lead in producing annual reports on social impact. In 2018, 59% of local government's direct procurement spend was with Salford-based suppliers, nearly half of their wage bill goes towards residents and 18 council suppliers are accredited Living Wage Foundation employers (up threefold on the previous year).[106]

2. Building organisational capability and capacity for social value

It is essential that any effort by system leaders to embed social value comes with capability building for those in charge of procurement. Interviews revealed how purchasing managers – even those who understand the importance and concept of social value – often have limited capacity and capability to incorporate principles in their daily work:

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‘The expertise of our patient meals contract manager, for example, is to make sure that our patients are satisfied with the quality of their meal, and that they get what they need to support their recovery. It’s not usually in their skill set to write contracts to drive social value and provide evidence for how they are increasing local employment and reducing gender pay gaps across employees… Even when they understand why the principles of social value are a priority, it is not something they have been trained to do.’

Sustainability lead
Acute trust

Purchasing teams must also be given the time and space to build skills and knowledge on social value and explicit permission to integrate these outcomes into contracting decisions. System and organisational leaders can help signal more clearly that social value is a priority, and take steps to ensure that local teams see it as part of their role.[107] They also have a role in facilitating sharing of learning evidence and good practice. Numerous tools and resources exist to help support staff training on social value and progressive purchasing practices. For example, the NHS Sustainable Development Unit (SDU) has developed a range of resources, including a learning module, case studies and social value calculator, to help NHS organisations apply the Social Value Act.[108] Social Enterprise UK has developed a *Social Value Guide* to help procurement managers and commissioners apply social value in practice.[109] Some of our interviewees from CCGs also mentioned developing training packages on social value for use by procurement teams across their health economy. (Further resources to support staff capability and knowledge on social value are available in the box on page 35.)

The experience of NHS trusts also shows the value of having a designated sustainability or social value lead who can oversee local purchasing initiatives and link up efforts across departments. Interviewees said that the person in this role can also train purchasing managers across the organisation and ensure that strategies are applied systematically (also freeing up capacity among purchasing managers, who are often pressured to meet other efficiency targets).

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‘It can be helpful to have someone who sees supporting social value across the organisation as their primary role and has the knowledge to think of the same problem through different lenses. Workforce teams don’t always work with procurement teams, or with estates – it can be really helpful to have someone who can link efforts and help bring these functions together as part of one strategy.’

Sustainability lead
Acute trust

Stakeholders also emphasised the value of designating a board member to lead on social value and sustainability to help join up efforts as part of a more centralised organisational approach.

Summary and implications for practice and policy

Directing more of the NHS’s spend towards community benefit is not without challenge, given that many purchasing decisions are made centrally. However, there are still areas of procurement (particularly within services) where purchasing can be a lever to stimulate local economic development and support broader socioeconomic aims. There is legislation in each country of the UK to support this, but more must be done nationally to help clarify definitions, metrics and opportunities to fully embed social value principles. This means defining minimum standards nationally and putting in place accountability for delivering social value across the system.

While implementation will look different based on local and organisational contexts, there are opportunities nationally to develop templates, standard contract language and measurement tools that can be adapted by local systems to avoid unnecessary duplication of efforts.

Underlying all these efforts will be a need to build greater organisational capability. For NHS organisations, this means giving purchasing managers the time, training and resources they need to develop new expertise and progressive procurement approaches. Local system and organisational leaders should signal promoting social value as a priority and ensure that teams are given the permission to adopt new approaches. NHS organisations should also be encouraged to learn from other local partners (such as councils) with experience in implementing progressive procurement policies. Driving change will require baseline data on current practices so that each organisation can set informed and realistic targets for directing more spend towards community benefit. It also requires organisations to understand their local markets and address barriers that local suppliers face when trying to work with the NHS. And, as with all anchor practices, progressive procurement approaches will have greater impact if included as an explicit organisational aim, with someone leading on coordination and monitoring across the organisation.

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Practical resources to support implementation

Creating Social Value – module (Sustainable Development Unit)

Economic and Social Impacts and Benefits of Health Systems (World Health Organization Regional Office for Europe)

Social Value Calculator (Sustainable Development Unit)

Social Value Toolkit. Guidance for Suppliers (Greater Manchester Combined Authority)

Social Values Forums Toolkit (Wales Co-operative Centre)

The Public Services (Social Value) Act 2012. An Introductory Guide for Commissioners and Policy Makers (Department for Digital Culture, Media and Sport)

The Social Value Guide. Implementing the Social Services (Public Value) Act (Social Enterprise UK)

Using the Social Value Act to Reduce Health Inequalities in England Through Action on the Social Determinants of Health (Public Health England and UCL Institute of Health Equity)

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Chapter 5: The NHS as a land and capital asset holder

Why this matters

NHS organisations often have significant physical assets that can be leveraged for community benefit. Though data are limited on the exact size of the NHS's entire estate portfolio, it includes 8,253 trust and primary care sites across 6,500 hectares of land in England alone.[110]

Anchor strategies involve thinking about how the NHS can manage and develop its land and estates to support broader social, economic and environmental aims – for example, by working with partners to support more high-quality, affordable housing and widening access to community spaces. This is especially important for lower-income groups, which tend to have poorer-quality housing and less access to green and community spaces.[111]

Housing is an important driver of health; physical and mental health is affected by quality of housing, where it is located and how connected it is with the wider community.[112] Estimates from 2011 suggest that poor quality housing costs the NHS around £2.5bn per year.[113] Affordable housing close to workplaces can benefit staff, while helping to improve retention and offering environmental benefits.

Communities are also more resilient when people are connected through social networks,[114] and opening NHS buildings and land for community use or supporting the development of green spaces can provide vital opportunities for social interaction.[115] The NHS also influences the local economy through who it lets operate and conduct business in its facilities (such as stores and food outlets). By providing more opportunities for SMEs and working with organisations that promote social good, the NHS can further support community wealth development.

What do anchor capital strategies look like in practice?

Expanding community access to NHS property

1. Enabling local groups and businesses to use NHS estates

Converting and selling estate for community benefit

1. Supporting access to affordable housing or housing for key workers using NHS estate
2. Working in partnership across a place to maximise the wider value of NHS estates
3. Developing accessible community green spaces

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Policy context

In many parts of the country, NHS estates are in poor condition, lacking sufficient buildings and infrastructure to meet clinical demands.[117] The capital budget for investments in buildings and maintenance has declined in real terms between 2010/11 and 2017/18, leading to chronic maintenance backlogs and many NHS sites needing significant upgrades.[117] The government did recently announce a £1.8bn short-term capital funding increase for the NHS in England, but this level of investment falls well short of what is required to bring NHS infrastructure to modern standards.[113,116] These immediate pressures can make it difficult for the NHS to consider the wider value of its estate for local communities.

This context has put pressure on the NHS to raise capital through sales of land and assets, which have more than doubled since 2010/11.[117] In 2017 the government published the Naylor Review to help develop a new strategy for NHS estates, which reinforced the need for the NHS to dispose of surplus land to free up more funding for capital.[118] Financial pressures have meant that NHS organisations are sometimes incentivised to sell land and assets to the highest bidder as an opportunity to plug funding gaps.[119]

At the same time, there is now greater emphasis on how unused or surplus NHS land can be used to widen access to affordable housing. The Naylor Review recommended that any NHS land that is sold should be developed into housing for NHS staff as a priority, and that 30,000 homes could be built on land belonging to acute estates.[118] This would support broader government aims to accelerate the development of new housing across the UK and help achieve the Department of Health and Social Care's aims of releasing NHS land to build 26,000 more homes by 2020.[120] According to 2019 figures, NHS trusts have nearly 890 hectares of surplus land that could be sold or converted.[121] Lack of affordable housing has compounded the recruitment and retention challenges currently facing the NHS,[122] providing further impetus to use surplus estate to develop housing for staff, particularly clinicians.

However, ownership and control of NHS estates is complex, with important implications for how property can be sold and repurposed for community benefit. NHS trusts own most of the land they occupy, though this is not the case with general practices, which typically lease land from NHS Property Services (which owns and manages over 10% of all NHS estate), community health partnerships or owners outside of the NHS.[118] This means that the opportunities to implement anchor strategies will look different across the sector, as accountability sits with different NHS organisations.

Moreover, since the 1990s, NHS organisations have used private finance initiatives (PFIs) to fund building development.[123] PFIs allow the NHS to use private finance to fund capital projects, and usually mean that NHS organisations only obtain full ownership of the asset once payments have been completed (typically 30 years). This places further constraints on the ability of some NHS organisations to use their estate for broader community benefit.

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Given the context, it is not surprising that we see fewer examples of NHS organisations adopting anchor practices on the use of land and estates compared with areas like employment. However, there are opportunities to think differently about how the NHS leverages its assets for social benefit.

Learning from practice

Expanding community access to NHS property

1. Enabling local groups and businesses to use NHS estates

The NHS often has facilities that are not used at certain times (such as weekends), which means it can offer the space to community groups at little or no cost. This could make a big difference to small local charities and organisations that otherwise would have no access to space, and help enhance social networks locally.

For example, University Hospitals Birmingham NHS Foundation Trust regularly gives community groups free use of its buildings and facilities, allowing charities to host their annual conferences there. It is also looking into hosting free film screenings for the community in unused lecture theatres. Some trusts are also allowing local schools to use their space in the evenings and at weekends for arts programming.

Another way the NHS can support staff and the wider community is by offering childcare facilities on site, increasing the provision of childcare available in the local community. Sussex Community NHS Foundation Trust, for example, offers nursery places on three sites for NHS and emergency services staff, also reserving some places for local families.

As an anchor, the NHS can also support community development by leasing its retail space to local community businesses, thereby encouraging patients, staff and visitors to spend local. Some hospitals host farmers' markets on trust estates that are open to the broader community. Cambridgeshire Community Services NHS Trust, after consulting with the community advisory group, is opting to work with a locally owned cafe rather than a large national chain while rebuilding a community hospital.

Some NHS organisations have reported that PFI contracts can restrict their ability to allow local businesses to sell on-site due to exclusivity clauses (although some NHS organisations have been able to negotiate access for local businesses on PFI-owned sites). For example, Southmead Hospital in North Bristol worked with PFI contractors to negotiate a weekly local farmers' market on-site for patients and visitors using locally sourced produce. The trust had to demonstrate how the farmers' market would not be in direct competition to existing shops within the hospital. To help make the produce more affordable for residents, the farmers' market agreed to reduce profit margins to help expand access to healthy food within the trust and community. In exchange, the trust provides volunteers to help run the stall.

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Converting and selling estate for community benefit

1. Supporting access to affordable housing or housing for key workers using NHS estate

Given the links between housing and health, there is a case for NHS organisations to ensure that their decisions around land use support the needs of their staff, the local community and, over time, contribute to reducing health problems from poor housing. Our interviews with stakeholders revealed that where such efforts are taking place, they are often motivated by more immediate issues of improving recruitment and retention, rather than part of an anchor mission to tackle inequalities:

> 'We are absolutely struggling to recruit nurses because no nurses can afford to live and work in some areas, so it is in our interest to somehow build affordable housing, so you can subsidise nursing staff to live in the community, which means they're not going to be struggling to recruit those staff.'
>
> **Deputy director of strategy**
> NHS England

There are opportunities to align the NHS's strategic priorities around workforce with broader social objectives, and some NHS organisations are explicitly prioritising social value as part of decisions to sell land. For example, when NHS Property Services sold the former St George's hospital site in Hornchurch for £40m (the largest reinvestment in the NHS through sale of surplus land), 15% was allocated for social housing and 1.6 hectares of land retained to host a new community health centre.[124]

When selling surplus land, or redeveloping its own land, the NHS could more actively consider social value and the impact on the wider community – though doing so is not always straightforward. Stakeholders we interviewed expressed concern that most NHS land sold by trusts does not include affordable housing provision. A New Economics Foundation analysis of NHS surplus land sales in 2017/18 found that of the sites with planned homes, two-thirds will be unaffordable for nurses on an average salary.[125] Even when there are provisions for affordable housing embedded in the sale agreement, it is not always achieved. For example, in West Yorkshire, a large housing developer committed at the point of sale to building 30% affordable housing on the site of Pontefract General Infirmary – a figure later reduced to 6% after declaring 'financial unviability'.[126] Strong accountability mechanisms are necessary to ensure that the full social value of NHS estates can be realised after sales are completed. NHS organisations will not always have full control over decisions on the use of their surplus estate for affordable housing, as local authorities often have the primary role. This makes developing partnerships ever more important in delivering these aims.

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Converting NHS land and facilities for community use can also require significant upfront investment that many NHS organisations cannot afford in the current financial climate. Stakeholders emphasised the overriding pressures in the NHS from system leaders and trust boards to sell any surplus land on the open market to the highest bidder, even if gains are short-term:

> 'We've engaged with housing associations, we've engaged with primary care associations, all are very keen for us to promote and take forward plans to develop affordable housing. We find ourselves slightly thwarted by the centre… They are completely focused on today's agenda as opposed to a more broad, long-term view.'
>
> **Deputy director of planning**
> Acute trust

Housing associations, local councils and other community organisations often miss out on development opportunities as they have fewer resources than private developers to make competitive bids. However, interviewees said there is scope for the NHS to pursue alternatives to open market sale and enter into joint ventures with housing associations or councils, who may be able to help attract upfront investment for the development of housing and community spaces. This could help ensure that more of the NHS's land benefits the community; for example, the NHS could sell land to or enter a leasing arrangement with housing associations, who then develop the land themselves and give the NHS a share of the rental income.[127] However, the need to offset current deficits may severely limit these options. Interviews and learning from the grey literature suggest that, where this is possible, partnerships tend to be more successful if the housing association and the NHS have long-standing relationships and the housing association can make a clear financial case which directly benefits the individual NHS provider.[128]

2. Working in partnership across a place to maximise the wider value of NHS estates

Beyond the sale of surplus assets, NHS organisations in some areas are working proactively with other anchors to help improve the local built environment to support community health and wellbeing.

At the national level, NHS England's Healthy New Towns programme is bringing together NHS providers, commissioners, local government and other partners to test how new housing developments can advance population health through 10 demonstrator sites.[129] The *NHS Long Term Plan* committed to publishing guidance based on learning from the programme to help other local areas work together to develop healthier built environments. There will also be a new quality standard to incentivise future developments that support prevention.[20]

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Cambridgeshire Community Services NHS Trust is negotiating with the Ministry of Defence and the local council, which own adjacent land, to manage the whole site as one plot on which to rebuild a smaller hospital and develop affordable housing. While the circumstances in Cambridgeshire are specific, with strong historical relationships, they highlight the potential for the NHS to partner across a place and to think differently around land use when opportunities arise. STPs and ICSs may provide further scope for the NHS to build these relationships and work more collaboratively to improve local planning and the built environment for health.

If NHS organisations are to make the most of opportunities to use their estate for public good, then meaningful public engagement during the planning process is essential. This has been an important lesson from Healthy New Towns, which highlighted the importance of developing a shared vision with local people on how space can be used, and actively involving communities and residents in decision making on new developments.[130] Partnerships and local stewardship can unlock this, particularly with marginalised and underrepresented communities, as local councils and housing authorities may have different relationships with the community and can be instrumental in forging new links.

3. Developing accessible community green space

Given the positive associations between quality green space and health and wellbeing outcomes, some NHS organisations are exploring how they can create more accessible community parks. These green spaces provide a habitat for wildlife and space for physical activity, and contribute to improved health and wellbeing, particularly for people who otherwise would not have access.

Some NHS sites have existing green space that they have opened to the local community, and others are working to develop green space on unused land. For example, Bromley-by-Bow Centre – a GP practice and community charity based in a socially deprived area in east London – owns 3 acres of land that it has converted into green space, with a children's play area, an allotment and garden. And at a primary care centre near Sunderland, staff worked with NHS Property Services and a local charity, Groundwork, to convert derelict space into a community garden and allotment. The space is now used to run a gardening course as part of a community mental health recovery programme.

Summary and implications for practice and policy

Taking a broader view of the socioeconomic value of NHS capital and estate can be difficult. The demands placed on NHS capital and lack of capital funding puts pressure on the system to immediately dispose of surplus land, typically to the highest bidder. While these pressures will continue, there are examples of good anchor practices where NHS organisations are supporting the development of affordable housing and other community assets and doing more to open their doors to community organisations. However, there is more that can be done.

Nationally, NHS policymakers can support local action by providing clear guidance and clarity to NHS organisations on how to embed provisions for social value into sales and monitor their implementation, and signal this as a priority.

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At the local system level, NHS organisations can work with other public sector partners to develop joint strategies that optimise the use of public estate for broader social objectives, such as affordable housing and green spaces. This can also help with immediate organisational pressures around staff recruitment or retention.

For individual organisations, knowing how best to leverage land and estates for social value starts with a detailed understanding of existing estate portfolios to see what can be opened for community use or converted from surplus land. NHS organisations should build relationships with housing associations and local councils to pursue alternatives to open market sale. They should also engage in discussions with local residents to explore community needs for space, and how NHS land and estates can be used to meet those needs.

Practical resources to support implementation

Housing Associations and the NHS: New Thinking, New Partnerships (The Smith Institute)

Putting Health into Place. Introducing NHS England's Healthy New Towns programme (TCPA, The King's Fund, The Young Foundation, Public Health England, NHS England)

Supporting the Healthy New Towns programme (The King's Fund)

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Chapter 6: The NHS as a leader for environmental sustainability

Why this matters

NHS organisations have a significant impact on the environment and are some of the largest contributors to climate change and air pollution. The NHS alone is responsible for 40% of public sector emissions in England.[131]

Delivering high-quality health and care places numerous demands on natural resources and the environment, such as:

- use of energy, water and consumables, including plastics
- waste production and waste management
- travel, which requires fossil fuels and contributes to air pollution.

In 2017, the health and social care system used 27.1 million tonnes of CO_2e and 2.23 billion m^3 of water. This includes 589,000 tonnes of waste and 9.5 billion travel miles generated by NHS providers.[132] Indeed, health and care-related travel constitutes around 5% of all road travel in England.[132] Given its large carbon footprint, any action the NHS takes to support responsible consumption and reduce waste can have a significant impact on the environment. This is important not only to reduce the carbon impact, but to support more sustainable utilisation of finite resources overall.

The climate crisis has serious direct and indirect consequences for health.[133] Toxic air pollution is associated with acute and chronic health conditions that cost health and social care £157m in 2017.[134] Exposure to air pollution is estimated to cause the equivalent of 40,000 premature deaths in the UK each year, and more than 2,000 GP practices and 200 hospitals are in areas affected by toxic air.[135,136] Climate change and air pollution also disproportionately affect disadvantaged and vulnerable populations.[137,138] These communities are more exposed to climate hazards, more vulnerable to the harms they cause and have relatively fewer resources to cope or recover from their effects, thereby further entrenching inequalities.[139,140,141] And while improving environmental sustainability will have benefits beyond local populations, it is one of the main ways the NHS has influence as an anchor institution, and can improve the wider determinants of health and support community development. It has the power and responsibility to influence action on a broader scale to reduce its contribution to climate change and protect resources for the health of future generations.

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What do anchor environmental sustainability strategies look like in practice?

Adopting sustainable practices within the NHS

1. Developing leadership and staff buy-in for environmental sustainability

Influencing sustainable practices in the community

1. Helping shape community environments and behaviours and influencing local suppliers

Policy context

Public sector organisations are legally required to deliver environmental sustainability as outlined in the Climate Change Act 2008, which commits the UK to reducing its carbon emissions by 80% by 2050.[142] The legislation has since been amended to introduce a target to bring all greenhouse gas emissions to net zero by 2050.[143] NHS leaders have enacted several changes to help deliver on these aims. NHS England and Public Health England jointly fund the SDU, which helps NHS organisations with expert advice and guidance on how to support environmental and social sustainability. NHS organisations in England are also required by the NHS Standard Contract to produce an annual Sustainable Development Management Plan that sets out how they will reduce carbon emissions.[144] And as previously discussed, Wales, Scotland and England each have legislation in place to promote the social value of public purchasing, including considerations for broader environmental sustainability.

The *NHS Long Term Plan* re-emphasised the importance of reducing greenhouse gas emissions and air pollution associated with delivering health care, and acknowledged the need for collective action from all NHS organisations to reach these targets.[20] The NHS has made progress over the past decade by reducing its carbon output by 18.5%,[132] though as one of the world's biggest organisations with one of the largest carbon footprints in the UK public sector, these improvements could go much further if the NHS embraced and developed its role as an anchor institution.

Learning from practice

Adopting sustainable practices within the NHS

1. Developing leadership and staff buy-in for environmental sustainability

Reducing the health and care system's carbon footprint involves taking action in several areas, including improving energy efficiency, supporting more sustainable travel for patients and staff, and reducing waste and water consumption.

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As with all complex improvements, changing organisational behaviour to support environmental sustainability needs leadership and commitment from senior leaders.[102,145] Interviewees told us that responsibility for implementation has often been left to sustainability officers without more senior or board-level support. This has often meant that interventions lack coordination and visibility, and could have a greater impact if they were part of an organisation-wide strategy.

Stakeholders who have managed to get senior leaders on board emphasised the importance of creating a vision that appeals to corporate strategic aims. Clearly linking environmental sustainability to goals around improving health has been helpful for some:

> ‘I just kept banging my drum (about) the whole 40,000 excess deaths a year in the UK due to air quality. So, that stat always hits home.’
>
> **Sustainability lead**
> Acute trust

There is also a lack of accountability on sustainable development within the system. Despite a strong legal context for action, there are no sanctions or incentives beyond national targets for action on sustainable development, which are insufficient on their own to motivate and drive change. One promising development is that the SDU is developing a dashboard to help organisations understand their baseline, assess their readiness and set individual targets in line with their own goals. This data will amalgamate to STP and ICS level to support greater system accountability and regional planning.[146]

Adopting more sustainable operational practices also relies on staff engagement at all levels, requiring a shift in culture, attitudes and knowledge.[147] Research suggests that staff resistance often comes from feelings of having insufficient knowledge or skills to implement change and not knowing the impact of interventions.[147,107] Giving teams the tools and resources they need to feel empowered to implement solutions and measure impact is key to supporting the NHS to support environmental sustainability for local communities.

During interviews, senior leaders commented that NHS organisations have often been able to make the greatest progress on reducing local air pollution, partly because this is an area with clearly defined metrics that can more easily demonstrate impact.

There are numerous tools and resources to support teams to reduce pollution. These include the Clean Air Hospital Framework, which offers best practice and guidance on how hospitals can improve outdoor and indoor air quality in key areas like procurement, travel, construction and energy generation.[148] The SDU’s Health Outcomes of Travel Tool supports NHS organisations in measuring the impact of travel and transport, helping to quantify the impact of pollution from different sources and how to reduce them.[149] The SDU is also developing frameworks to support progress in other areas where the NHS can have an impact, including recycling schemes, biodiversity, responsible chemical disposal, responsible construction and conservation.[146]

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A number of interviewees felt that action on sustainability has become easier as more staff are aware of the climate crisis and its impact. Organisational champions and communication campaigns have helped build a sense of shared motivation, responsibility and ownership over solutions. The NHS has an important role to play in educating staff about what they can do, both at work and outside of work.

'When I started here, it was just me and nobody really taking sustainability on… Slowly, got more people on board … After a couple of minutes, you can tell them what it's about and a lot of people, the light bulb just clicks that it's just good business; like being efficient and using all your resources whether it be staff, the patients we're dealing with or the environmental impacts of your actions … The tide turned quite a few years ago.'

Sustainability lead
Acute trust

Examples of action by NHS organisations include promoting use of public transport or walking and cycling to work, monitoring waste generation and recycling rates, and installing more energy efficient heat and power sources. But NHS organisations and local systems could do more to coordinate their efforts. There is also an opportunity for regional and national policymakers and the SDU to share good practice and innovations – something NHS England and NHS Improvement have committed to as part of the *NHS Long Term Plan*.

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Case study 6: University Hospitals of North Midlands NHS Trust and Beat the Cold

University Hospitals of North Midlands NHS Trust has launched an initiative to establish more sustainable and affordable energy sources and reinvest savings in the community.[150] Recognising the links between hospital readmissions during winter and poor heating and living conditions, it worked with residents and the local council to crowdfund for 1,100 solar panels, installed on NHS hospital buildings. By switching to renewable energy, the trust saved nearly £300,000 that was invested into a local charity, Beat the Cold, which tackles cold-related sickness and fuel poverty.[150] This initiative has helped strengthen relationships between the trust and residents. Early evaluation suggests the project has helped achieve savings by reducing the rate of readmissions, particularly among elderly people and other vulnerable groups. Having the support of the chair of the board was essential:

'It was so important that we had the support of the hospital chairman. On the day we were putting the solar panels up a member of the board tried to stop us… The hospital chairman had to overrule him.'

Business development manager
Beat the Cold

Influencing sustainable practices in the community

1. Helping shape community environments and behaviours and influencing local suppliers

As an anchor, the NHS can use its voice to push for broader developments that support the environmental health of local communities. For example, some NHS organisations have advocated for more public transport routes and cycling lanes to NHS hospitals, which benefits individuals' health as well as the environment. This has knock-on benefits for local public transportation, which research has shown can help improve social inclusion and stimulate economic regeneration in deprived areas.[151]

For example, Epsom and St Helier University Hospitals NHS Trust has been working with local councils to improve public transport links to the hospital for staff and the local community. After receiving repeated complaints about the difficulty of getting to the hospital via public transport, the sustainability officer at the trust negotiated with local councils to pilot a new 'on-demand' bus service for residents in Surrey, with a designated bus stop on the hospital site. The staff shuttle bus has become a public bus service, and the trust has negotiated with Transport for London to further extend bus services to the hospital.

Purchasing and commissioning can also be harnessed to influence sustainability practices in the community. The supply chain is one of the biggest components of the health and social care system's carbon footprint, accounting for 57% of its carbon emissions in

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2017,* with the largest hotspots being medical instruments and equipment, followed by pharmaceuticals.[128,152] As discussed in the procurement section, the NHS can reduce some of this by working with local suppliers to reduce its carbon output.

For example, as part of its Care without Carbon strategy, Sussex Community NHS Foundation Trust is working with suppliers to reduce carbon emissions, which make up 60%–70% of the trust's overall carbon footprint. The sustainability team has embedded sustainability criteria and metrics into the tendering process by setting targets for suppliers to reduce their vehicle emissions over the lifetime of the contract.

Improving environmental sustainability in the wider community requires strong partnership working, and much can be achieved by anchors working together – something we explore in the next chapter.

Summary and implications for practice and policy

As one of the largest public sector resource users and polluters, the NHS must take action to reduce its environmental impact. Beyond changing its own organisational practices, the NHS can drive progress within local communities by using its influence at all levels of the system to advocate for broader changes that promote sustainability and improve the wellbeing of communities, particularly for disadvantaged populations who face the highest levels of environmental risk.

For national bodies, this means moving beyond simply setting national targets on narrowly defined areas such as air pollution to supporting the development of metrics, tools and resources across all domains of environmental sustainability and supporting capability at the front line.

At the local system level, organisations can work together to develop shared goals and strategies to improve environmental sustainability and track their impact. The NHS is also well placed to work with other anchors to influence supplier behaviour and make local transport or infrastructure more environmentally sustainable.

NHS organisations need strong leadership to give visibility to strategies, align efforts with other organisational priorities and maximise the influence of the NHS on environmental sustainability within their local area. Understanding which of their practices and activities have an adverse environmental impact is an important first step; securing engagement and buy-in from staff is also essential to finding solutions. Organisations should educate their staff and offer skills, resources and tools so they can take action.

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* This includes carbon emissions associated with the extraction, processing, assembly, packaging, transport, storage and handling of products and materials that are directly and indirectly consumed by service providers.

Practical resources to support implementation

Care Without Carbon – our strategy (Sussex Community NHS Foundation Trust)

Clean Air Hospital Framework (Global Action Plan)

Health Outcomes of Travel Tool (Sustainable Development Unit)

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Chapter 7: The NHS as a partner across a place

Why this matters

Across each dimension of anchor activity, the NHS can accelerate progress by working with others across a place – both within the NHS and with anchors from other sectors – to scale impact and develop shared approaches. The combined assets of anchor institutions (in terms of local jobs, spending and land) can be significant; working collaboratively can give anchors more reach into the community than they would have individually, and allows sharing of best practice. And by working together locally, anchors can use their collective influence to encourage other organisations in their local economies to adopt similar practices.

Establishing anchor partnerships and collaboratives can be key to developing greater intentionality and shared purpose around an anchor mission. There are, however, some contextual and wider issues around place-based anchor collaboration that must be carefully considered.

What do anchor partnerships look like in practice?

Partnering with other anchor institutions across a place

1. Developing anchor collaboratives and networks to support shared approaches locally

Partnering with other NHS anchors

1. Developing networks to support shared learning and spread good practice

Policy context

The growing focus on place-based approaches to improve health and economic outcomes, both within and across local areas, has changed the dynamics of how anchor institutions may function and work together across a place.

In some areas, devolution has brought sectors together to think collectively about how to channel assets to improve the wellbeing of local populations. For example, the Greater Manchester devolution deal, which gave the combined authority control over £6bn spend on health and social care in the 10 boroughs, has supported anchors to develop a joint strategy for improving population health and economic prosperity across the city region.[153] But even when health and social care have been incorporated into plans, the NHS has not always actively contributed to broader economic strategy development and discussions.[154]

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Likewise, the delivery of the government's *Industrial Strategy* relies on place-based approaches and calls on combined authorities and LEPs to come together to develop ways to spur growth across local communities.[155] The extent to which NHS organisations have engaged with LEPs has been mostly limited: very few LEPs have NHS representation on their boards, though there are some exceptions – like in Dorset, where the chief system integration officer for the local CCG is a member.[156,157] Stakeholders have noted that there is an opportunity for the NHS to take a more active role in supporting the delivery of these place-based strategies, given the significant economic assets they bring, and their powers to improve skills development, innovation, employment and infrastructure to support productivity.* Moreover, working in partnership on these strategies can open up opportunities to access new funding streams.

'We are very much trying to take an approach looking at how the local NHS organisations begin to play their part in shifting conversation. I don't think what we've ever done particularly well in the NHS is to say, "What is the role of our organisation in contributing to the economic success of that area?" I don't think we've made that connection powerfully enough, yet.'

Strategy lead
Combined authority

Within health and care, we have identified a number of opportunities for STPs and ICSs to develop anchor approaches around common aims. These are relatively new forums for partnership working and it is too early to tell whether they will realise their promise of supporting more collaboration around prevention. None of the 2016 STP plans referred explicitly to an anchor mission, and few described initiatives to work on anchor-like strategies to intervene in the wider determinants of health. However, as ICSs are a key part of the delivery mechanism for the *NHS Long Term Plan*, they may create the incentive for NHS organisations to develop their anchor role and collaborate with local partners for the benefit of local communities.

The emphasis on place, both within the NHS and in broader government policy, creates fertile ground for NHS organisations to think differently about their role in a place. If harnessed effectively, it could provide the conditions needed to support greater collaboration to develop communities and take collective action to tackle inequalities and improve the socioeconomic environments needed for good health.

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* The NHS Confederation's *Health in all local industrial strategies?* briefing offers examples of how health intersects with local industrial strategies and ways the NHS can engage with LEPs to shape their development around mutual aims. Source: www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/Health-in-all-local-industrial-strategies.pdf

Learning from practice

Partnering with other anchor institutions across a place

1. Developing anchor collaboratives and networks to support shared approaches locally

Anchor institutions in several UK cities have started to work more closely to combine their influence and scale impact in local communities. This has often taken a range of forms including collaboratives, networks and economic coalitions, with shared objectives around a common anchor mission.

For example, in Sheffield the NHS has joined with local universities, housing associations, colleges, the city council, chamber of commerce and voluntary sector organisations to drive a collective commitment to building a more inclusive local economy. Led by the city council, the Sheffield City Partnership has developed a framework with a vision, commitments and shared objectives for implementing a city-wide approach to: education, skills and work; environmental sustainability and inequality; procurement; and homelessness and violent crime.[158] The framework provides focus for working together around an anchor mission. It is also being underpinned by extensive engagement with local people to help identify what an inclusive economy would mean for them, and help define common standards and indicators to help track progress and ensure that resources are invested in the areas that could bring the greatest community benefit.

While the potential benefits of greater collaboration between anchors are clear, a range of structural and contextual factors conspire to make partnering around an anchor mission difficult. For one, each anchor has different accountability and governance mechanisms that affect their ability to develop and implement anchor strategies. Across each category of anchor activity, organisations will be accountable to different stakeholders, require different administrative processes and have different financial constraints, affecting their ability to work together across a place.[159]

Having a clearly defined geographical area can help focus efforts,[160] but the geographical footprint and population that each anchor works to, even when in the same locality, can vary.

> ‘We are all trying to get the best spend of our local pound, really, but there are challenges with that. We have different footprints – at the trust we are part of the ICS footprint, which is a different footprint from the city region. So, we have this constant footprint debate, which plays out when you’re trying to articulate the governance framework, the accountability, the permissions, and who has the authority to make decisions.’
>
> **Deputy chief executive**
> Acute provider trust

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This is why stakeholders have emphasised that when developing collaborative approaches, it can be helpful to be flexible, by establishing common objectives and minimum standards for advancing anchor goals but allowing each organisation to determine the most appropriate path to implementation.

Without pre-existing relationships, collaboration at any level is even harder,[161] and so a first step for anchor institutions is to find the time and space to foster working relationships. The exact method will vary, but it is often less about setting up new forums or mechanisms for collaboration and more about identifying those places where different anchor institutions already come together and using those as building blocks to build alignment around an anchor mission. In the current context, this may include health and wellbeing boards, local partnership boards, LEPs, or STP and ICS boards. Regardless of the forum, stakeholders emphasised the need to have the space and time to co-develop a shared vision to drive successful collaboration.

> 'There are a lot of potential benefits to STPs and ICSs for developing anchor partnerships and approaches, but I don't think we've realised them yet… But we probably just haven't had enough space and time to think all that through well.'
>
> **Non-executive director**
> Acute trust

Building these relationships undoubtedly takes significant time, and it can be difficult to establish trust, respect and mutual understanding in the short term. Evaluations of the Greater Manchester devolution deal found that Manchester's strong sense of place and 30-year history of partners working together was pivotal to delivering the plan and linking up policies to improve population health and wellbeing.[162]

Given the different structures and focus of anchor organisations, it can also be difficult to know the best level at which to engage within each organisation around place-based strategies. Interviewees from outside the NHS said it is not immediately clear who holds responsibility or the most relevant expertise. Having a designated anchor or sustainability lead within NHS organisations can help, as it makes it obvious who to start conversations with, in cases where the NHS has not always taken part (for example, as part of LEPs).

Relationships have also been helped by working with third-party organisations who can act as a convener and facilitator and provide much-needed additional capacity to support partnership working. For example, the Joseph Rowntree Foundation has worked with Leeds[163] (see case study 7) and CLES with places like Birmingham and Preston to bring different anchors together to provide forums for discussion and develop a common approach.[164]

Local government has also frequently been an important driver of cross-sector collaboration, as in Sheffield, where councils have linked anchor partnerships to broader strategies around supporting more inclusive community development. NHS stakeholders

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we interviewed noted that when working in partnership, it is essential to recognise the value and expertise that other sectors bring, and be willing to work as equal partners alongside other sectors:

> 'You know, (NHS organisations) should be partners, and we are partners with our local community. We shouldn't be putting ourselves up on a pedestal, and then there's a risk of that sometimes … we have a lot to contribute to the local growth agenda and the sustainability agenda, but we should do that in partnership.'
>
> **Deputy chief executive**
> Acute trust

Collaborative anchor approaches have been developed in procurement, where NHS organisations are working with other anchors to maximise the social value of public spend. Adopting joint progressive procurement strategies can help retain more money locally while also sending a collective market signal that social objectives are a priority, which can influence supplier behaviour.[78] For example, in Birmingham, partners across the STP have agreed to apply a 10% social value weighting in their contracts and use procurement to meet shared social aims, including increasing the number of apprenticeships, recruiting more people from vulnerable populations and lowering carbon emissions.[165]

By working collaboratively, anchor organisations can help build a common language for social value and reduce variation in how the concept is understood and applied in practice across a health economy. Interviews with stakeholders revealed that commissioners and providers often use a mix of approaches that contribute to a lack of clarity in how to interpret social value while also unnecessarily duplicating efforts. For instance, in one local area, a trust had to respond to two local authorities with different requirements for social value to deliver the same sexual health service:

> 'The service specification looked exactly the same, but we had to report different types of evidence to show how we would meet standards for social value. This required a degree of expertise in how to respond to contracts, that thankfully we had, but not all providers do. It also created inefficiencies without changing anything fundamental about our approach to social value or increasing the community benefit we would bring in the way we delivered the service.'
>
> **Head of sustainability**
> Acute trust

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STP and ICS leadership can help establish common standards while reducing duplication by coming up with contracting templates that can be adapted by anchors across the partnership.

Case study 7: Leeds City Region anchor framework

In Leeds, anchor organisations from across the city have formed an anchors collaborative and agreed common goals for supporting inclusive development. Working with the Joseph Rowntree Foundation, the collaborative developed a tool for partners to self-assess how they perform on five anchor dimensions (employment, procurement, capital, service delivery and corporate responsibility), visualise where they want to be and identify what actions they can take to get there. The framework has also helped anchors establish common goals and have a broader impact by sending a powerful collective signal to the local economy that narrowing inequalities and supporting inclusive economic development are priorities. To support this effort, Leeds City Council has also created a data dashboard so that areas with the greatest needs and inequalities can be targeted.[166]

Though the framework establishes clear goals and specific actions for all partners, flexibility in how the tool is adapted and applied within each organisation is key.

Case study 8: Birmingham anchor network

A new network has formed in Birmingham to explore how six anchors can work together, including Queen Elizabeth Hospital, Birmingham City Council, the police, University of Birmingham, local colleges and the local housing association.[167] This network builds on work these organisations have done with the Centre for Local Economic Strategies (CLES) funded by the Barrow Cadbury Trust to map their collective assets and understand their baseline contribution to the Birmingham and West Midlands economy.[167] With combined annual budgets of £6bn and more than 50,000 employees, the network will support anchors to develop individual strategies and advocate for an anchor approach on workforce, procurement and management of land and assets.[168] One collective priority is around construction, as a significant proportion of money leaks from the local economy from new building projects, and the upcoming Commonwealth 2022 games in Birmingham present an opportunity to shift practice. The network is also developing ways to measure the impact of different approaches to better understand how anchor practices can benefit communities.

Partnering with other NHS anchors

1. Developing networks to support shared learning and spread good practice

In addition to coming together across a place, there is an opportunity for NHS organisations to work together to develop their collective identity as anchor institutions to tackle common issues. Peer networks can be a powerful tool in generating knowledge and supporting a culture of learning.[169] However, there is currently no formal network of health care anchors in the UK. The NHS Confederation and the SDU have been convening NHS organisations to facilitate shared learning, provide expertise and develop skills

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around local economic development and environmental and social sustainability,[170] but our interviewees felt there could be more collaborative networks and communities of practice to help make an anchor mission an institutional priority across the NHS.

In the United States, The Democracy Collaborative (TDC, which supports a network of more than 40 health care systems) could serve as a model for the NHS. These health systems together employ 1.5 million people and purchase over $50bn worth of goods and services annually. The network allows health care organisations to share knowledge, work through common challenges, identify areas for joint working and co-develop tools that can be adapted by each organisation to accelerate progress.[171] A key aim is to help members drive culture change within their respective organisations and adopt more intentional and conscious anchor strategies within their health system's overarching strategy. Since its inception, members have implemented changes in their local areas, including investing in affordable housing, committing to living wages for all staff and creating new career pathways for non-clinical entry-level roles.

In the UK, there are also examples of anchor collaboration within other sectors. For instance, 37 vice-chancellors recently signed a Civic Universities Statement Agreement pledging to prioritise the social, economic, environmental and cultural life of their local communities. This includes specific commitments to collaborate with each other and other anchor institutions to support their aims.[172] There are also dedicated programmes and networks in local government,[3] housing,[173] and the arts and culture sectors.[174]

Summary and implications for practice and policy

NHS organisations can work with each other, and with other anchor organisations across a place, to share learning and establish common goals so that the anchor mission more directly informs how the NHS functions within a place. As many of the examples have demonstrated, where individual institutions have come together to collaborate on a shared vision and work together to hold each other to account, the benefits can be significant.

There is a real opportunity to capitalise on STPs and ICSs to help the NHS forge new partnerships across a place and develop shared approaches and anchor strategies as part of broader system plans. Anchor strategies may also provide a gateway for the NHS to take part in other place-based strategic discussions, including with LEP, to help align approaches with broader economic proposals that improve the health and wellbeing of communities. National leaders should work with partners to create space for NHS organisations to come together to share and spread ideas through action learning and to work through challenges unique to the NHS context.

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Practical resources to support implementation

A Partnership Framework for an Inclusive and Sustainable Economy (Sheffield City Partnership)

Anchor Collaboratives: Building Bridges with Place-Based Partnerships and Anchor Institutions (The Democracy Collaborative)

Community Wealth Building Through Anchor Institutions (Centre for Local Economic Strategies)

Health In All Local Industrial Strategies? (NHS Confederation)

Healthcare Anchor Network (The Democracy Collaborative)

Leeds City Region Anchor Institution Progression Framework (Leeds City Council)

Local Growth Academy (NHS Confederation)

Learning from other sectors

Civic University Agreements – List of Signatories (Civic University Commission)

Great Places Commission Interim Report (National Housing Federation)

Inquiry into the Civic Role of Arts Organisations. Phase 2. What Happens Next? (Calouste Gulbenkian Foundation)

Leading Places programme (Local Government Association)

Local Access (Big Society Capital and Access)

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Conclusion: actions and opportunities for change

Consciously adopting an anchor mission

In this report we have explored a range of opportunities for the NHS to harness its considerable influence to have an even greater impact on the health and wellbeing of communities. There are many anchor activities already taking place across the sector that provide an important foundation on which the NHS can build. NHS organisations are all at different stages in embracing their role as anchors, but where strategies are being adopted, they tend to be discrete and narrow in scope, rather than joined up and embedded as part of central, local system or organisational strategies. Anchor approaches are often being applied in one area only (for example, workforce). While NHS organisations will have to start somewhere, the greatest impact will come from pursuing changes in each domain of anchor influence and with other anchors and partners across a place. It is also the case that anchor practices are not yet being evaluated systematically to understand what actions have the strongest impact on population outcomes. More needs to be done to help NHS organisations cultivate an anchor mission and know where to prioritise efforts, both within their organisations and in their local communities.

This report has also identified cross-cutting opportunities – regardless of the area of anchor activity being pursued – to make anchor practices more embedded in the NHS, and these are summarised below. While most actions will be delivered at the level of NHS organisations and networks, national, regional and local system leaders have a strong role in signalling the anchor mission as a priority and supporting an environment where these changes can happen. These opportunities are set out in Table 4.

Adopting new ways of working for an anchor mission requires time, resources and upfront investment that can be hard for NHS organisations to come by. The report has highlighted tensions the NHS may have to work through to balance priorities and direct its anchor efforts (described in Table 3). These tensions play out at different levels of the system and are not always inevitable, but when they do arise can often be mitigated or managed with careful implementation and planning. For instance, the NHS can boost international recruitment to address shortages in certain jobs and geographies while also taking steps to increase local workforce supply over the long term. The examples given throughout the report show how the NHS can shift practice by taking a pragmatic approach and aligning anchor practices with other system goals.

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Table 3: Potential tensions between anchor practices and the current policy/ practice context

Anchor practices	Tensions to balance
A desire to develop the local labour market and create pipelines into NHS jobs and careers.	The need to fill vacancies quickly to address severe workforce shortages requires a focus on external labour sources, including international recruitment.
An aspiration to increase social value by taking a wider range of factors into account when making decisions on purchasing and procurement.	A push to reduce costs and increase efficiency, given the wider economic climate and financial pressures on the health service.
A desire to increase capability in the local supply chain, leading to more local purchasing and procurement.	A need to avoid potentially anti-competitive behaviour.
A focus on developing strong and resilient local places in specific geographical areas.	The risk of widening inequalities (as those places with the largest or best-resourced anchors will benefit most and may draw resources away from neighbouring areas).
A desire to allow flexibility for NHS anchors to adapt activity to meet local context and local needs.	A national drive for greater standardisation of activities to reduce variation.

What can the NHS do now to develop its role as an anchor?

1. Build a baseline understanding of current practice to know where to prioritise action and establish informed goals.

Data are key to helping organisations understand their baseline levels of activity and assess their readiness to change. Baseline audits can generate information on purchasing behaviour, use of estates, employment practices and environmental impact. This can then inform goal-setting and targets for shifting behaviours based on current levels of practice.

Baseline data can also help signal where there may be more immediate opportunities and where change will have to happen over the longer term. NHS organisations may find it easier to start in domains such as employment, where there is clear data on vacancies and local unemployment to show where to target efforts, and where anchor actions align with broader organisational strategies. Within procurement, NHS organisations can use data to establish achievable targets of how much spend can be shifted locally, identifying which contracts are up for renewal that may lend themselves to working with local suppliers. People with improvement skills are well placed to support the development of aims and measures to inform goals, and the ability to facilitate change.

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2. Develop metrics and evaluate the impact of interventions

Data are also vital for measuring the impact of interventions and building the business case for future investment. National leaders can help establish metrics in each area of anchor activity for local NHS organisations and STP/ICS leads to use to assess progress, and fund evaluations of the wider impact and return on investment. This could build on existing work such as the framework developed in Leeds (see page 55) that defines metrics across different anchor dimensions to help organisations measure progress around shared goals. Within procurement, some local system leaders have already defined metrics to help guide purchasing decisions and build an understanding of the broader social impact of public spend (see Chapter 4). STPs and ICSs can help track progress across a place by creating dashboards that pool data from partner organisations and help guide future strategy. Evaluation requires significant resources and time, so it is important that teams are funded and supported with the skills and capacity necessary to use data effectively to inform decision making.

3. Establish clear and visible leadership to embed anchor practices within organisational and system strategies

Leadership is needed at each level of the system to make anchor practices visible and an integrated part of organisational and system strategies. Unless leaders see an anchor mission as a core part of the NHS's role and responsibility to local communities, little will be achieved. At the organisational level, gaining board support will be an essential early step to ensure that efforts are adequately resourced and prioritised over the long term. Nominating a board-level lead for anchor strategy can help cement that support, while raising the profile of anchor practices across the organisation and connecting them up. Beyond board support, having a designated manager – for example, an anchor or sustainability lead – to oversee and coordinate anchor practices across an organisation can be a key driver in getting efforts off the ground and integrating anchor strategies into operating models.

Linking anchor practices to existing organisational priorities and goals can be useful in gaining senior buy-in. For example, showcasing how anchor practices that build local workforce supply or provide more affordable housing for staff can address staff recruitment and retention challenges at the same time as helping to reduce inequalities, can gain traction for these ideas. And when there are tensions between short-term performance pressures and longer-term improvements to population health, having board-level support can give staff the permission and air-cover needed to prioritise practices in support of an anchor mission.

At the local system level, STP and ICS leads have an opportunity to work with system partners to create a shared view around an anchor mission and embed strategies as part of delivery plans. This requires building consensus around common aims and identifying which anchor strategies are best done in partnership to achieve more ambitious and long-term goals. Local system leaders have a role in articulating a clear vision for inclusive development while permitting flexibility for organisations, to account for different contexts.

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While most anchor practices will be delivered at the organisational and local system levels, national leaders can be instrumental in helping to shape the collective vision of how the NHS acts as an anchor and setting expectations about its broader role in the local community. The explicit references to anchor institutions in the *NHS Long Term Plan* and *Interim NHS People Plan* are positive developments that help signal the anchor mission as a priority. There may be more opportunities to incorporate an anchor approach into other national frameworks and guidance – for example, through the CCG improvement and assessment framework, or STP/ICS guidance. These frameworks should be backed by proactive support to ensure that teams have the resources and capability needed to support effective implementation. There is also a role for national leaders to help clarify definitions and provide guidance and templates to ensure consistency in anchor practices and how they can be integrated into NHS practice.

4. Enable staff to act on a collective vision for enhancing community health and wellbeing

Change will not happen unless staff are engaged in the anchor mission and have the time, skills and capability needed to embed anchor practices within daily roles. The anchor mission may offer an opportunity to tap into employees' intrinsic motivation, by connecting operational functions like HR, procurement and facilities management to the aims for front-line delivery – that is, improving the health and wellbeing of local communities. One way to do this is to co-produce and design potential solutions directly with staff so that they feel ownership over the challenges and feel part of the collective vision for supporting wider community health and wellbeing.

It is also the case that anchor practices may be new territory for staff, who may need support to incorporate considerations for population health and social value effectively into their daily roles. We have cited numerous resources and tools throughout this report to help staff put these ideas into practice. NHS organisations should use these tools as a starting point, and national and system leaders should ensure that local teams have the skills and capabilities needed to carry out these practice changes and develop methods that support a consistent approach.

Where there are gaps in skills and expertise, working in partnership can also help the NHS build greater capacity. Working with partners can bring different perspectives and skills from outside health care that are invaluable and give NHS organisations greater reach into local communities. Many of the examples of anchor activity we have highlighted involve NHS organisations collaborating with local community, public sector or commercial partners on a specific initiative. Whether this is working with housing associations to ensure that NHS land is developed for affordable housing, or engaging local government around improving public transport for staff and patients, effective partnerships often a core component of success.

5. Support the sharing and spread of ideas through networks

Sharing knowledge and ideas can help the NHS more intentionally adopt and apply anchor strategies in practice. Networks could add value and support the NHS to maximise its anchor role at different levels: locally, by convening anchors across a place to support

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community cohesion, align practices around a shared vision and maximise combined impact; and nationally, to facilitate peer learning and help health care organisations carry out anchor activities more effectively and efficiently.

STPs/ICSs can play a key role in convening and establishing these relationships across anchors in a locality. The introduction of PCNs may also create an opportunity to align operational practices and strategy in general practice around an anchor mission, and feed into broader goals of improving population health at the STP/ICS level. Regional and national leaders are well situated to encourage and support NHS organisations from different localities to convene and share learning and expertise across NHS peers. Whether national or local, networks may benefit from working with an independent third-party facilitator to build consensus and sustain engagement over the long term.

6. Engage proactively with communities to ensure that anchor strategies meet the needs of local people and to maximise impact on narrowing inequalities

Maximising the NHS's contribution to community health and wellbeing requires a deep understanding of local priorities and needs. This means engaging with residents in new ways to explore their needs and developing a shared vision and strategy for how the NHS can be a better partner for and leader in change. For example, being a better and more inclusive employer requires an understanding of the needs of residents who face the greatest barriers to employment. It means getting residents' views on how NHS estate and land can add most value, and creating access to community spaces for those who need them most. This type of engagement requires connecting with people who are seldom heard and poorly served – something that many NHS organisations may not currently be equipped to do, which makes partnership working and local collaboration essential. Local organisations should prioritise this engagement as part of the design and delivery of different interventions, and local system leaders may also be well placed to coordinate engagement strategies across a place.

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Table 4: Opportunities for action by different stakeholders

Opportunity	Action	For action by
Build a baseline understanding of current practice to know where to prioritise action and establish informed goals	Conduct internal audits to set targets and goals for shifting practice.	NHS provider organisations and networks*
Develop metrics and evaluate practices to understand the impact of different interventions	Continuously monitor and collect data to track impact of anchor strategies, ensuring teams have the resources and capacity needed to make effective use of data and make evaluation a priority.	NHS provider organisations and networks
	Establish dashboards that pool data and track progress across a place.	Local system leaders†
	Help define metrics for tracking and measuring impact at the local system and organisational levels.	National/regional policy makers‡
Establish clear and visible leadership to embed anchor practices within organisational and system strategies	Designate a board-level lead for anchor strategy and operational lead to help coordinate and align efforts across an organisation.	NHS provider organisations and networks
	Embed anchor strategies as part of local system plans to help deliver broader aims on population health and prevention.	Local system leaders
	Establish clarity around common definitions to build system understanding of what anchor practices look like, and how they support broader social value and community benefit.	National policy makers
	Send clear signals through national policy, guidance and frameworks that the anchor mission is a priority for the NHS.	National policy makers

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* Trusts, GP practices, PCNs, etc.

† STP/ICS leads, CCGs, etc.

‡ NHS England and NHS Improvement, for example.

Enable staff to act on a collective vision for enhancing community health and wellbeing	Co-design solutions directly with teams, appealing to intrinsic motivation among staff.	NHS provider organisations and networks
	Use existing tools, resources and guidance to build capability, awareness and knowledge around anchor practices.	NHS provider organisations and networks
	Work in partnership with other organisations that may have greater community reach or skills and expertise to support implementation of anchor practices.	NHS provider organisations and networks Local system leaders
	Deliver support programmes that equip teams with the resources, skills and expertise needed to operationalise anchor practices and strategies.	National policy makers Local system leaders
Support the sharing and spread of ideas through networks	Establish place-based networks that convene anchors across a locality to develop a shared vision and objectives for improving community health and wellbeing.	Local system leaders
	Encourage and support NHS organisations to convene through networks to learn and share practice for applying anchor strategies in the NHS context.	National policy makers
Engage proactively with communities to ensure that anchor strategies meet local needs and to maximise impact on narrowing inequalities	Work in partnership to engage with communities, particularly seldom heard groups, to ensure that all residents have a voice in shaping anchor approaches and strategies.	Local NHS providers and networks Local system leaders

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The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

We make links between the knowledge we gain from working with those delivering health and health care and our research and analysis. Our aspiration is to create a virtuous circle, using what we know works on the ground to inform effective policymaking and vice versa.

We believe good health and health care are key to a flourishing society. Through sharing what we learn, collaborating with others and building people's skills and knowledge, we aim to make a difference and contribute to a healthier population.

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NHS CONFEDERATION

A MANIFESTO FOR THE NEW PRIME MINISTER

A view of the NHS in 2019 and a prescription of priorities for health and social care

Northumberland, Tyne and Wear
09/02/2019 09:06:55

JULY 2019

The NHS Confederation

The NHS Confederation is the membership body that brings together and speaks on behalf of all organisations that plan, commission and provide NHS services in England, Wales and Northern Ireland. We support our members by:

- being an influential system leader
- representing them with politicians, national bodies, the unions and in Europe
- providing a strong national voice on their behalf
- supporting them to continually improve care for patients and the public.

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About this briefing

The NHS Confederation and its networks have jointly compiled this briefing for the new Prime Minister, the Rt Hon. Boris Johnson MP.

This briefing sets out seven key challenges for the NHS in 2019 and beyond including, funding, social care and the NHS in a post-Brexit world.

The NHS Confederation looks forward to working with the Prime Minister and Secretary of State for Health and Social Care to overcome the challenges and deliver better outcomes for patients in the months and years ahead, as set out in this prescription of priorities for health and social care.

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Key points

Realising the aims of the NHS Long Term Plan

- The UK Government must ensure that sufficient funds are available to pay for aspects of the health and care service not covered by last year's £20.5 billion boost in NHS England funding in order to achieve the goals of the NHS Long Term Plan. These include capital spending, training and education budgets, public health and social care.
- Supporting the evolutionary approach to reform set out in the plan will help develop the necessary local relationships between the NHS, local government and voluntary and private sector providers.
- Prioritising legislative reforms that will improve mergers and acquisitions policy, simplify commissioning requirements (including procurement), and facilitate joint working will be welcome.

Harnessing the benefits of local leadership

- There is an opportunity for the new Prime Minister to act as a champion for local health and care systems, which promise to ensure health and care services are better rooted in communities and more tailored to the needs of local populations.
- Senior politicians can show leadership by supporting local health and care leaders to make meaningful decisions about how services should be organised, within the parameters of an effective regulatory framework.
- The government should avoid making any changes that will have the effect of further centralising decision making with the arm's length bodies, given the emphasis on local leadership in the Long Term Plan.

Supporting the NHS workforce

- Given the potential impact of the pension annual allowance taper on the availability of senior clinical staff, the government should either reform aspects of the tax system or the NHS pension scheme to rectify this problem.
- The 2019 spending review must set a realistic budget for Health Education England to restore investment in training clinicians, facilitate recruitment and retention programmes and mitigate the effects of the loss of the nursing bursary.
- Better value could be achieved by using some of the apprenticeship levy funding to support a wider range of training activities to help deliver successful apprenticeships.
- Integrated care systems should be further empowered to better influence their local labour market, with devolved powers over strategy and planning, supply and retention and deployment.

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Achieving financial sustainability

- The UK Government should invest in NHS education, training and staff development beyond 2020/21 to help the NHS attract and retain new staff.
- The government should commit to greater capital investment to arrest the decline in NHS estates and facilities, and to enable NHS leaders to modernise services.
- Without improved public health funding, the progress of the prevention agenda within the Long Term Plan will be undermined, leading to more serious and costly health need in future.

Maintaining progress on mental health

- Previous pledges to increase mental health funding should be acted on, with funding reaching the front line.
- Leaders should capitalise on young people's interest in mental health by opening more avenues into mental health roles and expanding the number of mental health places available at medical and nursing schools.
- The new Prime Minister should support the publication of the forthcoming white paper in response to the independent review of the Mental Health Act and commit to bringing forth a new mental health bill.

Creating a sustainable social care system

- Eligibility for social care services should be widened and based on need instead of means to pay.
- Any new settlement should provide secure, long-term funding at a level that enables the social care system to operate effectively and deliver the outcomes that people want and need.
- There needs to be both short term funding increases to cover immediate gaps in provision and a long term financial settlement.

Mitigating the risks of Brexit

- Medical supply chains should be protected to ensure that the import and export of medications between the UK and the EU can continue after Brexit. At present, this represents 45 million 'patient packs' (items of medication) leaving the UK and 37 million entering the UK each month.
- Reciprocal healthcare should be honoured so that 190,000 UK pensioners living in the EU continue to receive healthcare in the member state in which they reside.
- Without workforce agreements in place, the NHS could be short of 51,000 nurses by the end of the Brexit transition period. And in social care (which has become increasingly reliant on EEA nationals), the sector will struggle even more.

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Introduction

It is a time of unprecedented challenge and opportunity for health and care services. During a prolonged period of constrained funding and against a backdrop of escalating demand for services, the NHS has taken significant steps to improve its efficiency. Social care has faced even greater funding pressures, resulting in a reduction in the availability of care services across England and Wales.

Recognising that this was not a sustainable position from which to approach the next decade, NHS England in January published a new ten-year strategy for the NHS, the NHS Long Term Plan. This strategy builds on previous policy goals around boosting community provision, expanding ambulatory care and making services more joined up to improve the experience of patients in order to reduce reliance on hospital-based services. The plan includes a welcome focus on some clinical priorities where there is the potential to improve outcomes. These include mental health, children's health, cancer, cardiovascular disease, maternity and neonatal health, stroke, diabetes and respiratory care.

The mechanism for driving improvement set out in the Long Term Plan is to empower local systems encompassing health and care providers and commissioners to take the lead in developing solutions tailor made for the populations they serve. This emphasis on local leadership has been warmly received within the NHS, on the basis that only by genuinely empowering leaders to use their local knowledge will we be able to drive further significant improvements and efficiencies in the way we organise and provide services.

The Long Term Plan has been well received within the NHS, but there are some enduring challenges. Funding for social care, public health, workforce, training and capital remains unresolved, and will need to be addressed in a government spending review. NHS England has identified some legislative reforms which may be useful to accelerate delivering the Long Term Plan, but these will need to be adopted sensitively. Unless serious and systemic problems relating to social care provision, workforce and NHS capital spending are addressed, any have the potential to derail the Long Term Plan's success. Brexit is another issue of high significance to the NHS in terms of its potential impact on staffing, access to medicines and clinical trial availability.

Provided these challenges are addressed, there is an opportunity for the new Prime Minister to champion the work underway under the Long Term Plan, while leading a radical reshaping of the nature of social care provision in England.

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Realising the aims of the NHS Long Term Plan

The NHS remains an iconic and highly valued element of the UK's public service offer. However, our population is ageing and more people are living for longer, often with multiple long-term conditions.

Over the last five years, the health service has performed well, maintaining services and delivering significant improvements in care in spite of huge increases in demand and little extra funding. The NHS has been treating more patients within most of the constitutional standard areas, but for many years it has been unable to meet key waiting time targets. The Powis Review, which published an interim report in March, is in the process of reviewing clinical standards to ensure they are appropriate for current clinical practice, but it's important that any future changes to NHS waiting times targets do not dilute patient access to care. Many NHS organisations throughout England have also been unable to balance their books.

An ultimate objective of the Long Term Plan is to enable NHS organisations to get back on track financially and to return to previous high levels of performance against clinical standards. That said, the plan is not solely about responding to challenges. It puts in place the foundation to adopt new technologies and to improve quality and safety for patients, for instance through adopting new models of provision such as primary care networks and same day emergency care.

The NHS Long Term Plan therefore arrives at a critical point for the NHS. The plan's more ambitious elements raise the prospect of a health service which embraces the digital era and radically changes the way care is provided. Many of the plan's recommendations involve ramping up progress in areas such as care coordination and increasing provision in the community in order to reduce reliance on services provided in hospitals. These changes are widely recognised as being important for effective, modern healthcare that can respond to rising demand over the next decade as well as improving public health and tackling health inequalities.

Following publication of the Long Term Plan, NHS England and NHS Improvement (the two national arm's length bodies with responsibility for how health and care services are delivered) announced a series of proposed legislative changes designed to remove some existing and perceived barriers to collaboration. The main purpose of these was to remedy aspects of the 2012 Health and Social Care Act that were introduced when the realities on the ground facing health and care services were very different.

The main vehicle to achieve this is local health systems, known as integrated care systems (ICSs), which will see local leaders driving forward service improvements and population health outcomes, based on an assessment of what is needed in their areas. Championing these measures offers an opportunity to lead a reform programme that capitalises on local health and care leaders' expertise in serving their populations.

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As health and care leaders work to implement the Long Term Plan's goals, we recommend the following steps for a new government:

1. Ensure the NHS has the necessary resources to deliver the plan

The £20.5 billion funding boost for the NHS announced by former prime minister Theresa May represented a welcome and necessary injection of cash into a stretched system. But funding arrangements for several critical areas of health service spending remain unresolved, as they fall under the remit of the comprehensive spending review. The UK Government should ensure that the necessary resource is provided in the spending review to ensure sustainable approaches to social care, public health, workforce, training and capital spending. The significance of this extra funding is addressed in more detail in sections 4 and 6 of this document. There is a real risk that if the spending review does not address the challenges in these areas, the plan itself could fail.

2. Support the health and care system to transform while ensuring sustainability of provision

One of the most successful elements of the Long Term Plan is that it takes an evolutionary, rather than a revolutionary, approach to reforming the health service. The NHS has undergone radical reform over the last decade. Our members have told us there is no appetite for a top-down reorganisation of the NHS.

The continuity underpinning many of the commitments in the plan, along with adequate funding, will be important factors in the ability of health and care leaders to stabilise the system and ensure its sustainability. Health and care leaders have identified the importance of giving new systems space and time so that strong and effective partnerships between the NHS, local government, third sector and private providers of health and social care services described in the plan can reach fruition. Supportive encouragement of the development of this, rather than further reform, will be important to ensure that the NHS has the best chance of achieving stability.

3. Facilitate greater local collaboration

The proposed legislative reforms facilitate greater local collaboration. Our members support removing merger and acquisition oversight of trusts by the Competition and Markets Authority (CMA), but also believe that changing procurement duties to remove section 75 requirements and introducing a 'best value test', will make a positive contribution to achieving more joined up local systems.

Commissioners and providers have said that making procurement less burdensome will be welcome, but it is important that commissioners retain the ability to secure the best possible services for patients, whether from an NHS, independent, voluntary sector or social enterprise in order to deliver value for money from the new funding.

We support in principle introducing integrated trusts in England, allowing the creation of joint committees, and simplifying commissioning arrangements including to allow joint commissioning for some functions. However, for each of these changes, we need to proceed at an appropriate pace and to be clear that the replacement approach would not introduce other difficulties. For example – when creating joint committees between commissioners and providers, it's important the unique role of clinical commissioners is not undermined.

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Harnessing the benefits of local leadership

Achieving the changes set out in the Long Term Plan for the NHS in England requires a shift in emphasis from the historic 'top down' model of NHS management to an approach which is more locally led. NHS England and NHS Improvement are spearheading this transition.

The main vehicle in the Long Term Plan for achieving locally-led change is the integrated care system (ICS). This is a local partnership, encompassing NHS provider and commissioner organisations, local authorities and others, which takes collective responsibility for managing resources, delivering NHS standards and improving the health of local people through prevention and public health measures. The ICS approach is relatively new – at present, more than a third of England's population is covered by an ICS, but it is intended that there will be full coverage by 2021.

Steps that ICSs can take to address the fundamental challenges facing the NHS include making more services available closer to people's homes, making sure patients with multiple conditions experience more 'joined-up' care, and focusing effort on preventing people from getting ill in the first place, where possible. ICSs are significant because they provide a forum for joint strategic decision making that has not previously been available at a local level, and also because they emphasise the clinical voice in these strategic decisions.

The NHS Confederation supports the approach set out in the Long Term Plan for the NHS in England. There are three ways in which we would urge a new government to help drive forward this agenda:

1. Advocate for approaches that empower local leaders to make decisions about what is needed in the health systems they run

There is an opportunity for the new Prime Minister to act as a champion for these emerging systems, which promise to ensure health and care services are better rooted in communities and more tailored to the needs of local populations. Doing so would help to raise the profile of this work and to increase the momentum behind the changes.

2. Champion local leaders as they put in place the machinery to effect change

Perhaps the most well-received element of the Long Term Plan is its emphasis on allowing the knowledge and expertise that exists within health and care systems to service improvement through meaningful local partnership.

There is sometimes an understandable desire in Whitehall to see greater standardisation across the service, as well as a strong push from the Treasury to see measurable results from the additional investment. But this can be at the expense of solutions that are genuinely responsive to local circumstances. Senior politicians can help local leaders by supporting them to make meaningful decisions about how services should be organised, within the parameters of an effective regulatory framework.

3. Politicians can empower local health leaders

The UK Government should avoid making any changes that will have the effect of further centralising decision making with the arm's length bodies, given the emphasis on local leadership in the Long Term Plan.

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Supporting the NHS workforce

With a significant shortage of more than 100,000 staff, including 40,000 nurse vacancies, the case for greater investment in education and training for both existing staff and new entrants is compelling. A recent survey of our members in England emphasised the magnitude of concern NHS leaders have that they will be able to meet increased demand for staff with 65 per cent saying they were not confident that they would be able to achieve this. In addition, recent decisions around pension reform led to senior clinical staff reducing their availability in order to avoid large tax penalties on pensions, compounding staffing issues.

We urge the UK Government to prioritise the following issues:

1. Pension reform

The annual allowance, which limits the amount of tax relief on pension saving, has been a growing problem for members of the NHS Pension Scheme in England and Northern Ireland. The annual allowance has reduced substantially over time; tapering of the standard annual allowance was introduced and employees are exhausting their carry-forward of unused annual allowance from prior years. This has resulted in some members of the scheme receiving large and unexpected tax bills. There are two potential solutions: reforming the tax system or reforming the NHS Pension Scheme. We would welcome urgent engagement on this issue with the Treasury.

2. Policy which supports recruitment to social care and health

There are widespread concerns about the ability of the NHS to plug the workforce gap. In line with the commitments given in NHS England's Interim People Plan, it is of vital importance that the 2019 Spending Review sets a realistic budget for Health Education England to restore investment for continuing professional development and consider other potential financial incentives to attract people into training following the end of the nursing bursary. Moreover, there must be a long term migration policy which enables recruitment of vital social care and health staff.

3. Apprenticeship Levy

Better value could be gained from this levy if employers in the NHS were able to use some of the levy funding to support a wider range of training activities to help deliver successful apprenticeships. We also recommend allowing the use of the levy to support backfill for apprenticeships that require significant supernumerary time as part of their training.

4. Locally- led workforce strategy

A one-size-fits-all approach to developing our workforce is no longer the best way for the NHS and social care. In line with other areas of responsibility, there needs to be greater influence and accountability for workforce at local level. This is central to the broader Integrated Care System agenda.

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Achieving financial sustainability

For some time, the NHS provider sector has been operating with a deficit. In 2018, the NHS Confederation commissioned the report *Securing the future* to model the funding needs of the country's health and care system over the next 15 years. Subsequently, the government dedicated an extra £20.5 billion to the NHS in England by 2023, representing a 3.4 per cent real-terms increase in annual funding for NHS England and an annual increase of 3.9 per cent for social care.

We welcome this additional funding, but we fear it will not be enough to drive the improvements and innovation in health services that the public rightly expects. For health services to be truly improved, The Health Foundation and the Institute for Fiscal Studies calculated a 4 per cent real-terms increase in public spending on both the NHS and on the health sector at large would be required. The £20.5 billion does not address areas of need such as capital investment, public health, social care, workforce, education and training, which fall under the remit of the comprehensive spending review.

The Long Term Plan seeks to remedy this financial challenge in part through service level change, but the scale of the task is significant, and steps will need to be taken separately in order to improve the financial stability of the service. In particular, we support plans to move beyond the current control total approach to a system which takes better account of the realities facing different NHS organisations.

Our recommendations for the financial challenge:

1. Invest in education, training and staff development

With the NHS suffering from a shortage of more than 100,000 vacancies and with Health Education England having seen its budget cut by 24 per cent since 2013/14, the case for greater investment in education and training could not be more compelling.

2. Fund capital investment to modernise services and improve efficiency

Capital investment in buildings, equipment and IT has been cut in recent years due to rising pressures on daily running costs within the NHS. Capital per worker in trusts reduced by 17 per cent between 2010/11 and 2017/2018. In a recent survey of NHS Confederation members in England, 85 per cent said that a lack of NHS capital investment has inhibited the ability of local systems to deliver the goals of the NHS Long Term Plan. Unless the UK Government commits soon to greater capital investment, the health service's current maintenance backlog of more than £6 billion will grow and local NHS leaders will remain unable to modernise services and facilities.

3. Deliver resources for public health to realise the vision of prevention

The public health grant has been reduced in real terms by £850 million since 2014/15. This is equivalent to a reduction in the grant of 23 per cent in real spending per person over the past five years. In our recent survey of NHS Confederation members, 80 per cent stated that reductions in public health spending have restricted the ability of their local system to deliver NHS services either "somewhat" or "to a great extent". Without improved public health funding, the prevention agenda of the NHS Long Term Plan will be greatly undermined, leading to an accumulation of health problems which could be prevented now and will instead have to be addressed in the future at greater expense.

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Maintaining progress in mental health

We welcome the increased policy focus on mental health services since 2010. This includes the introduction of the first ever national waiting times standards in mental health and legislating for parity of esteem. However, a large care deficit still exists, with fewer than four in ten people who need support accessing it.[1] We are also detaining more and more people every year under the outdated Mental Health Act and the racial disparities in detention rates are unacceptable.

The commitments in the Long Term Plan to increase the spend on mental health as a proportion of the entire NHS budget, and to increase the proportion of the mental health budget that is spent on children and young people is a step towards true parity. There exists an exciting opportunity to build on the many positive advancements in mental health awareness and provision in recent years. In order to achieve this, we propose that you consider three key areas of importance.

Priorities for mental health:

1. Workforce

Mental health sees some of the highest vacancies in the NHS, especially in mental health and learning disability nursing. We should capitalise on young people's interest in mental health by opening additional avenues into the sector, expanding the number of places in medical and nursing schools, reviewing the impact of tuition fees on mental health nursing and work through all levels of education to promote mental health careers. We also need to better support the mental health and wellbeing of the entire workforce and take action to encourage more staff to stay working in the health and care system.

2. Funding

Previous pledges made on mental health investment need to be followed through and the additional funding must reach the frontline. Capital funding, vital for implementing the Long Term Plan and the recommendations of the Independent Review of the Mental Health Act must be provided as part of the forthcoming Spending Review, and increased investment is needed in mental health research to identify the most effective interventions.

3. Mental Health Act reform

The new Prime Minister should support the publication of the forthcoming white paper in response to the Independent Review of the Mental Health Act and commit to bringing forth a new Mental Health Bill during this parliament.

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1. The Mental Health Policy Group (2019), *Towards mental health equality: A manifesto for the next Prime Minister*

Creating a sustainable social care system

We warmly welcome the commitment made during the new Prime Minister's leadership campaign to solving the social care crisis via a cross-party approach. With 1.4 million older people unable to access the support they need, 58 per cent of people over 60 living with at least one long-term condition and an ageing population, the challenges facing social care are significant and will require strong and bold leadership.

Health and social care must be viewed as a singular, integrated system that has at its heart the wellbeing of the entire UK population. The NHS Confederation is leading a coalition of 15 health organisations calling for reform to secure the future of the social care sector. Without reform and investment in social care, we risk putting the ambitions of the NHS Long Term Plan at risk.

Our recommendations for social care are:

1. Widen eligibility

Eligibility should be based on need and must be widened to make sure that those with unmet or under-met need have access to appropriate care and support. Around 2.1 million people in the UK were estimated to have received some level of informal care in 2014, but the number of family and friends providing unpaid care in England increased from 4.9 million in 2001 to 5.4 million in 2011. Moreover, Age UK have identified that at least 1.4million people have unmet or under met need.

2. Secure a long-term settlement

Any new settlement should provide secure, long-term, funding at a level to enable the social care system to operate effectively and deliver the outcomes that people want and need. The settlement needs to address immediate needs from April 2020, as well as putting the social care sector on to a sustainable path for the longer term. That will require the right funding, workforce and a diverse and stable market of providers. This will need to be supported by good quality, trusted information and advice to help people navigate the care system effectively. The Spending Review presents an essential opportunity to invest in social care at the same scale as the gGovernment is now investing in the NHS.

3. Reform and integrate services

A recent report commissioned by the NHS Confederation, and undertaken by the Institute for Fiscal Studies and the Health Foundation, calculated that social care is facing high growth in demand pressures, which are projected to rise by around £18 billion by 2033–34. That means social care funding would need to increase by 3.9 per cent a year to meet the needs of an ageing population and an increasing number of younger adults living with disabilities. We recognise that any significant additional funds must be accompanied by reform and improved service delivery. Social care services and the NHS are working together to transform and integrate local care services, but they can only go so far when services are being placed under so much strain.

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Mitigating the risks of Brexit

Patients must not suffer because of the Brexit process. We recognise the enormous effort that has gone into making these plans as robust as possible. But the truth is that much of this is outside of the control of the NHS and our members; that is why we continue to advocate a negotiated deal which will provide maximum protection for patients.

Around three quarters of our medicines and over half our clinical consumables come from, or via, the European Union and so it is vital that the supply chain continues to work.

We have worked closely with the Department of Health and Social Care, to make sure that we are in the strongest possible position once the UK leaves the EU. Under the Brexit Health Alliance, we have been working with industry to make recommendations to government on Brexit. And as part of the Cavendish Coalition, we have been addressing the implications of Brexit for the health and care workforce. While we will continue to work with the Department of Health and Social Care and others to prepare the sector for all scenarios, there should be no illusions about the severe implications of no deal for the NHS.

Brexit also has unique challenges for the NHS Confederation's members in Northern Ireland, including concerns around the land border with the Republic of Ireland. Specifically, measures will need to be put in place to minimise the impact of Brexit on staff who live in the Republic of Ireland and work in Northern Ireland, as well as supporting the continuation of cross border services that are already in place. The lack of devolution and the current incapacity to make political decisions remains of significant concern in Northern Ireland at such a complex time of change.

The key risks of no-deal Brexit:

Medical supply chains

45 million patient packs go to the EU from the UK every month, and 37 million patient packs go to the EU from the UK. In the short term, there could be delays in importing medicines due to new border arrangements, requiring stockpiling and good supply chain management to ensure there will be no shortages. The creation of a medicines authorisation regime separate from the rest of the EU could lead to further delays. The UK could be excluded from the European Rare Diseases Network. This raises particular concerns regarding orphan medicines (treatments that aren't commercially viable for the UK market alone) as to whether such medicines will even reach the UK market, which will have implications for the treatment of rare diseases.

Reciprocal healthcare and public health

190,000 UK pensioners living in the EU currently have the right to receive healthcare in the member state in which they reside. The ending of reciprocal healthcare agreements could disrupt patient care, effectively leaving UK nationals in the rest of the EU currently in receipt of medical cover through the S1 scheme without health care. The arrangements in place for the European Health Insurance Card could also come to an end. On public health there could therefore be an impact on NHS services if some people decided to return to the UK for treatment. If the UK no longer had a relationship with the European Centre for Disease Prevention and Control, both UK and European health protection will be weakened due to a reduction in information exchange.

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Workforce

The Cavendish Coalition commissioned the National Institute of Economic and Social Research last year to undertake a major study of workforce implications through Brexit. The report found that the NHS could be short of 51,000 nurses, enough to staff 45 hospitals, by the end of the Brexit transition period. And in social care (which has become increasingly reliant on EEA nationals with a 68 per cent increase between 2011 to 2016), the sector is under considerable strain with a vacancy rate of 12.3 per cent and will have to navigate a transition period in which a critical portion of its workforce considers its future. In the event of no deal, new immigration rules could affect the ability of the NHS to recruit doctors and other medical staff from the rest of the EU, and there may be changes to current rules around the mutual recognition of medical qualifications.

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For more information or to discuss any of these points, please contact Victoria Fowler, Public Affairs Manager: victoria.fowler@nhsconfed.org

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Northumberland, Tyne and Wear NHS Foundation Trust

Council of Governors Meeting

Meeting Date: 10 September 2019

Title and Author of Paper:

Nominations Committee report on the appointment of two Non-Executive Directors

Debbie Henderson, Deputy Director of Communications and Corporate Affairs on behalf of Ken Jarrold and Margaret Adams, Co-Chairs of the Nominations Committee.

Paper for Debate, Decision or Information: Decision

Key Points to Note:

The Nominations Committee has led a process on behalf of the Council of Governors for the appointment of the two Non-Executive Directors.

The process and outcome is described in the attached paper.

Outcome required:

The Nominations Committee recommends that the Council of Governors approves the recommendation to appoint Darren Best and Paula Breen as Non-Executive Directors

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Northumberland, Tyne and Wear NHS Foundation Trust

Council of Governors meeting 10th September 2019
Report of the Governors' Nomination Committee

Recommendation to appoint Non-Executive Directors

1. Purpose

The purpose of this paper is to present the Council of Governors with the recommendation from the Governors' Nomination Committee in relation to the appointment of two Non-Executive Directors.

2. Summary

At its meeting on 14th May 2019, the Nomination Committee discussed in detail the recruitment process for the appointment of a Non-Executive Director, following the decision of Miriam Harte to stand down as of 31st March 2019.

The Nomination Committee reviewed and agreed the job description, person specification and method of recruitment at its meeting. As part of this review, the Committee recognised the lack of gender balance within the Non-Executive Director cohort and made specific reference to the need for gender equality and diversity within the advert. Also, given the Trusts plans to take on North Cumbria mental health and learning disabilities services from Cumbria Partnership NHS Foundation Trust in 2019, the advert was clear that the Trust would welcome applications from candidates with a strong connection to the Cumbria area.

The advert was issued on Tuesday 21st May with a closing date on 7th June. 38 applications were received. On Thursday 13th June, the Panel shortlisted seven candidates for interview.

3. Interview process

The following members of the Nomination Committee undertook the role of the Appointment Interview Panel:

- Ken Jarrold, Chairman of the Council of Governors/Co-Chair of the Nomination Committee
- Fiona Grant, Lead Governor/Service User Governor for Adult Services
- Margaret Adams, Co-Chair of the Nomination Committee/Public Governor for South Tyneside
- Denise Porter, Appointed Governor for the Community and Voluntary Sector
- Bob Waddell, Non-Clinical Staff Governor

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The Panel was also supported by: John Lawlor, Chief Executive and Debbie Henderson, Deputy Director of Communications and Corporate Affairs.

Interviews took place on Friday 28th June and Thursday 11th July and included a formal interview and focus group comprised of Governors, Executive Directors and Non-Executive Directors.

It was noted that the calibre of the candidates was particularly high and that the Trust's Constitution provided for two Non-Executive Directors to be appointed should the Committee feel the Board would benefit from the additional skills, expertise and diversity this may bring. The Panel arrived at a consensus to recommend the appointment of Darren Best and Paula Breen as Non-Executive Directors of the Trust.

Darren has had an extensive career as a public servant, serving as a police officer for 30 years, undertaking senior policing roles for over a decade and executive roles locally, regionally and nationally. Darren has recently retired as Deputy Chief Constable for Northumbria Police.

Paula has operated in senior executive and non-executive roles in business leadership including education, for many years. Paula is the Practice Manager for the Temple Sowerby Medical Practice in Penrith and is involved in setting up the Eden Primary Care Network. Paula lives near Penrith and has been a Councillor and Cabinet member for Eden District Council.

4. Recommendation

The Council of Governors are asked to approve the recommendation to appoint Darren Best and Paula Breen as Non-Executive Directors of Northumberland, Tyne and Wear NHS Foundation Trust for a period of three years as of 1st October 2019 (subject to all appropriate recruitment checks, including Fit and Proper Persons).

Ken Jarrold
Co-Chair of the Governors' Nomination Committee and Chairman of the Council of Governors

Margaret Adams
Co-Chair of the Governors' Nomination Committee

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Northumberland, Tyne and Wear NHS Foundation Trust

Council of Governors

Meeting Date: 10 September 2019
Title and Author of Paper: Trust Constitution – Debbie Henderson, Deputy Director of Communications and Corporate Affairs
Executive Lead: John Lawlor, Chief Executive
Paper for Debate, Decision or Information: Decision and approval
Key Points to Note: Following the decision to transfer North Cumbria Mental Health and Learning Disabilities services from Cumbria Partnerships NHS Foundation Trust, the Trust's Constitution has been reviewed to accommodate the new Cumbria footprint. The review of the Constitution was undertaken with the support of a Constitution Review Group comprised of Governors and led by Debbie Henderson and Fiona Grant, Lead Governor. The main changes to the Constitution are in relation to the composition of the Council of Governors and membership constituencies as follows: - Inclusion of one additional position for a Cumbria Public Governor - Increase of one additional position for a Clinical Staff Governor - Increase of one additional position for a Non-Clinical Staff Governor - Inclusion of one additional position for an Appointed Governor to represent Cumbria County Council (a statutory requirement) The Constitution also confirms the Trust's new name of Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust and if approved, will come into effect on 1st October 2019. Given the last review of the Constitution was undertaken in 2015, an opportunity was taken to bring the Constitution in line with the requirements of NHSI's Model Constitution and any relevant regulation and guidance since that date. A summary document is also attached which outlines changes, other than those which mirror the Model Constitution or regulation, in further detail.
Risks Highlighted: None
Does this affect any Board Assurance Framework/Corporate Risks: No
Equal Opportunities, Legal and Other Implications: Yes – reflects the Trust's new footprint as of 1st October 2019 and ensures representation from all geographical areas covered by the Trust.
Outcome Required / Recommendations: The Council of Governors is asked to approve the revised Constitution.
Link to Policies and Strategies: Trust's Provider Licence Requirements, and NHS Improvement – Model Constitution

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Northumberland, Tyne and Wear NHS Foundation Trust – Constitution Review September 2019

Section/ Paragraph	Revision	Rationale
Service user and carer constituency	Addition *(in italics)* The Service User and Carer Constituency shall be divided into *two class descriptions* of individuals who are eligible for membership of the Service User and Carer Constituency	Factual accuracy (was *five descriptions)*
Council of Governors – tenure	Addition An elected Governor may not hold office for longer than a continuous period of nine consecutive years, and may not stand for another constituency, different to their current constituency, if they have served for nine consecutive years on the Council of Governors.	Clarity of wording and requirements – revised from 8 to 9 years in line with current guidance and election planning.
Council of Governor – disqualification and removal	Addition - A person who is included in any barred list established under the Safeguarding Vulnerable Persons Act 2006 or any equivalent list; - A person who is a spouse, partner, parent or child of a member of the Council of Governors or Board of Directors. - They are a member of the Local Authority's Health Overview and Scrutiny Committee or Health and Wellbeing Board.	To reflect best practice and current guidance since 2015
Board of Directors – appointment of Vice-Chair	Addition *(in italics)* The Council of Governors at a general meeting of the Council of Governors shall appoint one of the non-executive directors as a vice chair, *having taken the advice of the Chairman.*	To reflect support for the Council of Governors
Board of Directors – disqualification	Addition - A person who is included in any barred list established under the Safeguarding Vulnerable Adults Act 2006 or any equivalent list. - In the case of a Non-Executive Director, a person who is no longer a member of a Public or Service User and Carer Constituency. - They are the subject of a disqualification order made under the Company Directors Disqualifications Act 1986 - They are the spouse, partner, parent or child of a member of the Board of Directors or Council of Governors. - They are a person whose tenure of office as a Chairman or as a member or Director of a health service body has been terminated on the grounds that their appointment	To reflect best practice and current guidance since 2015

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Section/ Paragraph	Revision	Rationale
	is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest. - They have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a public body. - They are a member of the Local Authority's Health Overview and Scrutiny Committee or Health and Wellbeing Board. - They are a person who is a medical practitioner and who has been removed from the register of medical practitioners held by the General Medical Council, in accordance with the Medical Act, or has been suspended from that register, and not subsequently had their name returned to the register. - A person who is a Director, Governor or Governing Body member or equivalent of another NHS body *except with the approval of the Board of Directors for Executive Directors and Council of Governors for Non-Executive Directors.*	To reflect common practice and system-wide working within ICS/ICPs
Indemnity	Members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out their personal resources any personal civil liability which in incurred in the execution or purported execution of their Board functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust.	Now included in many Constitutions – common query for Governors
Amendment to the Constitution	Addition *(in italics)* More than half of the members of the Council of Governors of the trust *present and voting* approve the amendments, and more than half of the members of the Board of Directors of the trust *present and voting* approve the amendments	For clarity in decision making
Mergers and significant transactions	Addition *(in italics)* 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 *in post at the time of voting.* The trust may enter into a significant transaction only if more than half of the members of the Council of Governors *present and voting* approve entering into the transaction	For clarity and decision making
Mergers and significant transactions	Revision Significant transaction defined as 25% of: the value of the trust's annual turnover before the acquisition, disposition or transaction (previously 10%).	In line with other Trust definitions – deemed as common approach across the sector

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Section/ Paragraph	Revision	Rationale
	Addition The views of the Council of Governors will be taken into account before the Trust enters into any proposed transaction which would exceed the threshold of 10% for any of the criteria specified.	To enable Governors views and opinions to be heard before entering into a transaction at this level
Annex 1 – Public Constituency	Addition Inclusion of Cumbria Public Constituency (minimum number of 100 members)	To reflect the new locality of North Cumbria (minimum of 100 members to enable early elections to be held)
Annex 2 – Staff Constituency	Addition *(in italics)* Staff who exercise functions for the purposes of the trust, otherwise than under a contract of employment with the trust may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months. *This includes any members of staff employed by any subsidiary company of the Trust*	To ensure staff members in NTW Solutions remain members of the Staff Constituency / members of the Council of Governors
Annex 3 – Service User and Carer Constituency	Revision Amended from people who have used the services from 4 years to 6 years	Factual accuracy – to reflect the main body of the constitution
Annex 4 – Composition of the Council of Governors	Revision Public Constituency now includes 1 post for Cumbria Public Governor Appointed Constituency now includes 1 post for Cumbria County Council Two posts for University representatives, not specified, to be appointed on a rotational basis at the discretion of the Chair/Company Secretary. Removed Transitional Arrangements section removed completely.	To reflect the new locality of North Cumbria Given the large geographical area covered by the Trust, a rotational approach would not have an adverse impact on the size Council of Governors and maintain effectiveness. No longer applicable
Annex 5 – Further provisions for	Revised	Amended from '3 consecutive meetings' – too restrictive

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Section/ Paragraph	Revision	Rationale
Governor (Termination of Tenure)	A Governor's term of office shall be terminated if the Governor fails to attend three general meetings of the Council of Governors in a 12 month period. Revised *(in italics)* …… otherwise bring the trust *or the Council of Governors* into disrepute or be detrimental to the interests of the trust	Inclusion of Council of Governors as a collective body
Annex 5 – Further provisions for Governor (Termination of Tenure)	Removed A Governor who resigns or whose tenure of office is terminated under the above provisions shall not be eligible to stand for re-election for a period of 2 years from the date of his/her resignation or removal from office or the date upon which any appeal against removal from office is disposed of whichever is the later.	Undermines the decision of the Council of Governors. A decision to remove a Governor under the process outlined in the Constitution should be held in perpetuity.
Annex 5 – Further provisions for Governor (Disqualification)	Addition - A person may not become or continue as a Governor if they are the spouse, partner, parent or child of another member of the Council of Governors or Board of Directors. - A person may not become or continue as a Governor if they are a Director of the Trust, or a Governor or Director of another NHS Trust or NHS Foundation Trust.	To avoid actual conflicts of interest and potential imbalance on the Council of Governors/Board of Directors
Annex 5 – Further provisions for Governor (Disqualification)	Addition A person may not become or continue as a Governor if: - They are a person who is subject to an order under the Sexual Offences Act 2003; - They are a person who is included in any barred list established under the Safeguarding Vulnerable Groups Act 2006 or any equivalent list; - They are a person where disclosures revealed by a Disclosure and Barring Services check against them are such that it would be inappropriate for them to continue as a Governor as it would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute; - They have within the preceding two years been dismissed, otherwise than by reason of resignation or redundancy, from any paid employment within a public body; - They have previously been removed as a Director or Governor of the Trust, or been removed as a Director or Governor of another NHS Foundation Trust.	To reflect best practice and guidance since 2015.

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Section/ Paragraph	Revision	Rationale
Annex 5 – Further provisions for Governor (Vacancies)	Addition *(in italics)* Elected Governors shall be replaced by inviting the person who was placed second in the previous election to fill the vacancy for the remaining period of the former Governor's term of office, provided *the person placed second is not disqualified from becoming a Governor by virtue of paragraph above*	To reflect potential change of eligibility during the time between standing for elections and stepping in
Annex 5 – Further provisions for Governor (Vacancies)	Removed Where 4.1 cannot apply, elected Governors shall be replaced in by-elections in accordance with the Electoral Rules.	To reduce costs of election for minimum number of posts
Annex 5 – Further provisions for Governor (Appointment of Lead Governor)	Addition The Council of Governors shall appoint one of the Governors to be Lead Governor of the Council of Governors via a process agreed with the Council of Governors, Chairman and Company Secretary.	New section
Annex 5 – Further provisions for Governor (Disclosure of interests)	Addition If a Governor has a pecuniary interest (financial), personal or family interest, whether that interest is actual or potential, 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 they become aware of it. Any Governor who has a material interest in a matter defined below shall declare such an interest to the Council of Governors and: - Shall withdraw from the meeting and play no part in the relevant discussion or decision; and - Shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counter). - Any Governor who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a decision of the remaining Governors in accordance with 2.1.3 of this Annex. Subject to the exceptions detailed in 6.5 below, a material interest is:	New section to reflect current guidance on standards of business conduct since 2015

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Section/ Paragraph	Revision	Rationale
	- Any Directorship of a company, including Non-Executive Directorships held in limited companies (with the exception of dormant companies); - Any interest held by a Governor in any company or business, which in connection with the matter, is trading with the Trust, or is reasonably likely to be considered as a potential trading partner with the Trust; - Any interest in a voluntary or other organisation providing health and social care services to the NHS; - A position of authority in a charity or voluntary organisation in the field of health and social care; and - Any personal, or familial connection with any organisation, entity, company or business, considering entering into or having entered into a financial arrangement with the Trust including, but not limited to, tenders, contracts or banks. The exception which shall not be treated as material interests are as follows: - Shares not exceeding 2% of the total shares in issue in any company whose shares are listed on any public exchange; - An employment contact held by staff governors; - An Appointed Governor's employment contracts with their appointing organisation.	
Annex 6 – Further provisions in relation to the Trust's membership	<u>Revised</u> Amended eligibility to 'termination of membership' to accurately reflect the content <u>Addition</u> A member may be expelled by a resolution approved by not less than two-thirds of the Council of Governors attending and voting at a general meeting (unless they are a Governor, then paragraph XX of Annex XX should be applied). The following procedure for considering removal of a members should be adopted: - Any member may complain to the Company Secretary that another member has acted in a way detrimental to the Trust; - If a complaint is made, the Council of Governors may itself consider the complaint having taken such steps as it considers appropriate to ensure that each member's point of view is heard and may either;	Eligibility already covered in main body of Constitution No current provision outlining a process for removal of a member.

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Section/ Paragraph	Revision	Rationale
	a) Dismiss the complaint and take no further action; b) For a period not exceeding 12 months, suspend the rights of the member complained of to attend Members meetings and vote under this Constitution; c) Arrange for a resolution to expel the member complained of to be considered at the next General Meeting of the Council of Governors. If a resolution to expel a member is to be considered at a General Meeting of the Council of Governors, details of the complaint must be sent to the Member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting. At the meeting, the Council of Governors will consider the evidence in support of the complaint and such evidence as the Member complained of may wish to place before them. If the Member complained of fails to attend the meeting without due cause as determined by the Chairman of the Council of Governors, the meeting may proceed in their absence. A person expelled from membership will cease to be a member upon the declaration by the Chairman of the meeting that the resolution to expel them is carried. No person who has been expelled from membership is to be re-admitted except by resolution carried by the votes of two-thirds of the Council of Governors who are present at a General Meeting.	
Annex 7 – Standing Orders for the practice and procedure of the Council of Governors (Quorum)	<u>Addition</u> 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, that person shall no longer count towards the quorum. If a quorum is then not available for discussion and/or 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.	Clarity around conduct and expectations of meetings. Given the wider geography covered by the Trust, participation by telephone and video-link can be advantageous (i.e., inclement weather

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Section/ Paragraph	Revision	Rationale
	Members of the Council of Governors can participate in meetings or committee meetings by telephone or video link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting. Should any member of the Council of Governors participate in meetings by telephone or video link for a specific item on the agenda, they must participate at the commencement of the agenda item, and remain present until the Chairman has deemed the item closed.	conditions and personal safety; accessibility for some governors; when key decisions may be required i.e., mergers and acquisitions.
Annex 7 – Standing Orders for the practice and procedure of the Council of Governors (Voting)	Revision *(in italics)* If at least *one-third of the Governors* present so request, the voting on any question may be recorded so as to show how each Governor present and voting gave his vote.	Amended from 'three' governors previously – an error
Annex 7 – Standing Orders for the practice and procedure of the Council of Governors (Voting)	Addition No resolution of the Council of Governors shall be passed if it is opposed by all of the Public and Service User and Carer Governors present. All decisions taken in good faith at a meeting of the Council of Governors or any committee of the Council of Governors shall be valid, even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of any of the Governors present at the meeting.	Reflects the statutory requirement that more than 50% of Governors should be from the Public and Service User, Carer Constituencies Safeguards decision making
Annex 7 – Standing Orders for the practice and procedure of the Council of Governors	Addition The Council of Governors may form advisory sub-committees under a written Terms of Reference, which must be approved by the Council of Governors. Advisory meetings may include members of the Board and other Trust representatives, or service users. The Council of Governors may appoint the membership of sub-committees	Currently no provision for the appointment of sub-committees of the Council of Governors

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Section/ Paragraph	Revision	Rationale
(Appointment of Sub-Committee)	of the Council of Governors and all acts of proceedings of advisory committees shall be reported to the Council of Governors. These Standing Orders in their entirety, as far as they are applicable, shall apply also, with the appropriate alternation, to meetings of the sub-committees of the Council of Governors. The Council of Governors may not delegate any of its statutory powers to any of its sub-committees. The sub-committees to be established by the Council of Governors are: the Nomination Committee, the Terms of Reference of which shall be made available on the Trust's website. In addition, the Council of Governors may establish other sub-committee and groups as it deems necessary to assist it in exercising its functions.	
Annex 8 – Standing Orders for the practice and procedure of the Board of Directors (appointment of committees)	Addition *(in italics)* Every *statutory* committee shall have a *Non-Executive Director* Chair, appointed by the Trust Chair	Clarity that all statutory sub-committees of the Board should be chaired by a Non-Executive Director

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CUMBRIA, NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST

CONSTITUTION

SEPTEMBER 2019

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Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

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1. Interpretation and definitions

Unless otherwise stated, words or expressions contained in this Constitution shall bear the same meaning as in The National Health Service Act 2006 as amended by The Health and Social Care Act 2012.

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

The 2006 Act is The National Health Service Act 2006

The 2012 Act is The Health and Social Care Act 2012

Annual Members' Meeting is defined in paragraph 11 of the constitution

Constitution means this constitution and all annexes to it

Council of Governors - Means The Council of Governors of the trust as constituted in accordance with the constitution and which has the same meaning as the "Board of Governors" in The 2006 Act

Monitor - Is the body corporate known as "monitor", as provided by section 61 of The 2012 Act

The Accounting Officer - Is the person who from time to time discharges the functions specified in paragraph 25(5) of schedule 7 to 2006 Act

2. Name

The name of the foundation trust is Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (The Trust)

3. Principe purpose

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

3.1 The trust does not fulfil its principle 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.

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

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

3.2.2 The promotion and protection of public health

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

4. Powers

4.1 The powers of the trust are set out in the 2006 Act, subject to any restrictions in the Trust's Provider License

4.2 All the powers of the trust shall be exercised by The Board of Directors on behalf of the trust

4.3 Subject to the provisions of The Mental Health Act 2007 any of these powers may be delegated to a committee of directors or to an executive director

5. Membership and constituencies

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

5.1 A Public Constituency

5.2 A Staff Constituency

5.3 A service User and Carer Constituency

6. Application for membership

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

7. Public Constituency

7.1 An individual who lives in an area specified in Annex 1 as an area for a Public Constituency may become or continue as a member of the trust aligned to the electoral area in which they live.

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7.2 Those individuals who live in an area specified for a Public Constituency are referred to collectively as a Public Constituency

7.3 The minimum number of members in each Public Constituency is specified as Annex 1.

7.4 In addition an individual who lives outside the electoral wards within the Trusts boundaries but within England and Wales may become a public member of the Newcastle and the rest of England and Wales Public Constituency.

8. Staff Constituency

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

8.2 He/she is employed by the trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months

> **8.2.1** He/she has been continuously employed by the trust under a contract of employment for at least 12 months

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

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

8.4 The Staff Constituency shall be divided into three descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2

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Automatic membership by default- staff

8.6 An individual who is:

8.6.1 Eligible to become a member of the Staff Constituency

8.6.2 Invited by the trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency shall become a member of the trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless he/she informs the trust that he/she does not wish to do so

9. Service User and Carer Constituency

9.1 An individual who has within the period specified below attended any of the trusts premises as a service user or as the carer of a service user may become a member of the trust

9.2 The period referred to above shall be the period of six years immediately preceding the date of an application by the service user or carer of a service user to become a member of the trust

9.3 Those individuals who are eligible for membership of the trust by reason of the previous provisions are referred to collectively as the Service User and Carer Constituency

9.4 The Service User and Carer Constituency shall be divided into two classes descriptions of individuals who are eligible for membership of the Service User and Carer Constituency, a description of individuals being specified within Annex 3 and being referred to as a class within the Service User and Carer Constituency

9.5 Anyone providing care under or by virtue of a contract or as voluntary work, does not come within the category of those who qualify for membership of the Service User and Carer Constituency unless that person has been recognised by the relevant local authority as being a carer under section 10 (10) of the Care Act 2014

9.6 the minimum number of members in each class of the Service User and Carer Constituency is specified In Annex 3

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10. Restriction on membership

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

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

10.3 An individual must be at least 14 years old to become a member of the trust

10.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the trust are set out in Annex 6 - Further Provisions

11. Annual Members' Meeting

11.1 The Trust shall hold an annual meeting of its members (Annual Members' Meeting) The Annual Members' Meeting shall be open to members of the public.

12. Council of Governors - composition

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

12.2 The composition of the Council of Governors is specified in Annex 4

12.3 The members of the Council of Governors , other than the appointed members, shall be chosen by election by their constituency or where there are classes within a constituency, by their class within that constituency the number of governors to be elected by each constituency, or where appropriate by each class of each constituency is specified in Annex 4

13. Council of Governors- election of governors

13.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules on the basis of first past the post (FPP) polling and the Model Election Rules current at the time of publication of this constitution are attached as Annex 10

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13.2 The Model Election Rules as published from time to time form part of this constitution. The Model Election Rules current at the time of publication of this constitution as attached as Annex 9

13.3 a subsequent variation of the Model Election Rules shall not constitute a variation of the terms of this constitution for the purposes of paragraph 44 of the constitution (amendments of the constitution)

13.2 an election, if contested, shall be by secret ballot.

14. Council of Governors- tenure

14.1 an elected governor may hold office for a period of up to 3 years

14.2 an elected governor is eligible for re-election at the end of their term of office

14.3 an elected governor shall cease to hold office if he/she ceases to be a member of the constituency or class by which he/she was elected. An appointed governor may hold office for an initial period of up to 3 years;

14.4 an appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him/her. Further provisions relating to a governors tenure of office are set out in Annex 6.

14.5 an appointed governor shall be eligible for re-appointment at the end of his/her term

14.6 an elected governor may not hold office for longer than a continuous period of nine consecutive years and may not stand for another constituency. Different to their current constituency, if they have served for nine consecutive years on the Council of Governors.

15. Council of Governors- disqualification and removal

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

15.1.1 A person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged

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15.1.2 A person who has made a composition or arrangement with or granted a deed for his/her creditors and has not been discharged in respect of it

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

15.1.4 A person who within the preceding five years has been convicted in the British Islands of any offence if he/she was detained under a court order made pursuant to the Mental Health Act 1983 for a period of not less than three months

15.1.5 A person who within the preceding five years has been subject to an Anti-Social Behaviour order made under the Crime and Disorder Act 1998 as amended

15.1.6 A person who is included in any barred list established under Safeguarding Vulnerable Adults Act 2006 or any equivalent list. A person who has at any time been subject to the notification requirements under part 2 of the Sexual Offences Act 2003 or a Sex Offenders Order made under the Crime and Disorder Act 1998 as amended

15.1.7 An 'unfit person' as defined in the trust's provider license (as may be amended from time to time.

15.1.8 A person who is a spouse, partner, parent or child of a member of the Council of Governors or Board of Directors.

16. Council of Governors- duties of governors

16.1 The general duties of the Council of Governors

16.1.1 To hold the non-executive directors individually and collectively to account for the performance of the Board of Directors

16.1.2 To represent the interests of the members of the trust as a whole and the interests of the public

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

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17. Council of Governors- meetings of governors

17.1 The chair of the trust (i.e. The Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 25 below) or, in his/her absence, The Vice Chair (appointed in accordance with the provisions of paragraph 28 below) shall preside at meetings of The Council of Governors.

17.2 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

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

18. Council of Governors- standing orders

The standing orders for the practice and procedure of The Council of Governors are attached at Annex 7.

19. Council of Governors- referral to the panel

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

19.1.1 To act in accordance with its constitution

19.1.2 To act in accordance with provision made by or under chapter 5 of the 2006 Act

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

20. Council of Governors- conflicts of interest of governors

If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by The Council of Governors. The governor shall disclose that interest to the members of The Council of Governors as soon as he/she becomes aware of it. The Standing Orders for the

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Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

21. Council of Governors- travel expenses

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

22. Council of Governors- further provisions

Further provisions with respect to The Council of Governors are set out in Annex 5

23. Board of Directors- composition

23.1 The trust is to have a Board of Directors, which shall comprise both executive and non-executive directors'

23.2 The Board of Directors is to comprise:

23.2.1 A non-executive Chair

23.2.2 A minimum of 7 other non-executive directors

23.2.3 7 executive directors

23.3 One of the executive directors shall be The Chief Executive

23.4 The Chief Executive shall be The Accounting Officer

23.5 One of the executive directors shall be The Finance Director

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

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

23.8 The Board of Directors shall at all times be constituted so that at least half of the board excluding the chair, shall be independent non-executive directors

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24. Board of Directors- General duty

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

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

25.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the chair of the trust and the other non-executive directors.

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

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

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

26.1 He/she is a member of a Public Constituency

26.2 He/she is a member of The Service User and Carer Constituency

26.3 Where any of the trusts' hospitals includes a medical or dental school provided by a university, he/she exercises functions for the purposes of that university

26.4 He/she is not disqualified by virtue of paragraph 29 below

27. Board of Directors- appointment and removal of The Chief Executive and other executive directors

27.1 The non-executive directors shall appoint or remove The Chief Executive

27.2 The appointment of The Chief Executive shall require the approval of The Council of Governors

27.3 A committee consisting of The Chair, The Chief Executive and the other non-executive directors shall appoint or remove the other executive directors

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28. Board of Directors- appointment of vice chair

The Council of Governors at a general meeting of The Council of Governors shall appoint one of the non-executive directors as a vice chair, having taken the advice of The Chairman

29. Board of Directors – disqualification

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

29.1 A person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged

29.2 A person who has made a composition or arrangement with or granted a trust deed for. His/her creditors and has not been discharged in respect of it

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

29.4 A person who is the subject of an order under The Sexual Offences Act 2003

29.5 A person who is included in any barred list established under The Safeguarding Vulnerable Adults Act 2006 or any equivalent list

29.6 A person who within the preceding five years has been convicted in The British Islands of any offence if he/ she was detained under a court order made pursuant to The Mental Health Act 1983 for a period of not less than three months

29.7 A person who within the preceding five years has been subject to an Anti-Social Behaviour Order made under The Crime and Disorder Act 1998 as amended

29.8 A person who has at any time been subject to the notification requirements of The Sexual Offences Act 2003 or a Sex Offenders Order made under The Crime and Disorder Act 1998 as amended

29.9 An 'unfit person' as defined in the trust's provider license (as may be amended from time to time)

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29.10 In the case of a Non-Executive Director, a person who is no longer a member of The Public Constituency

29.11 A person who is a Director, Governor or Governing Body member or equivalent of another NHS body except with the approval of The Board of Directors for Executive Directors and Council of Governors for Non-Executive Directors

29.12 A person who does not comply with the CQC guidance regarding appointments to senior positions in organisations subject to CQC regulations i.e. The CQC's Fit and Proper Person Test.

29.13 They are the subject of a disqualification order made under The Company Directors Disqualifications Act 1986

29.14 They are the spouse, partner, parent or child of a member of The Board of Directors or The Council of Governors

29.15 They are a person whose tenure of office as a Chairman or as a member of Director of 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 non-disclosure of a pecuniary interest

29.16 They have within the preceding two years been dismissed, otherwise than by reason of redundancy from any paid employment with a public body

29.17 They are a member of The Local Authority's Health Overview and Scrutiny Committee or Health and Wellbeing Board

29.18 They are a person who is a medical practitioner and who has been removed from the register of medical practitioners held by The General Medical Council, in accordance with The Medical Act or has been suspended from that register and not subsequently had their name returned to the register

30. Board of Directors – meetings

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

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

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31. Board of Directors – standing orders

The standing orders for the practice and procedure of the Board of Directors are attached at Annex 8.

32. Board of Directors - conflicts of interest of directors

32.1 The duties that a director of the trust has by virtue of being a director include in particular

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

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

32.2 The duty referred to in sub-paragraph 32.1.1 is not infringed if

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

32.2.2 The matter has been authorized in accordance with the constitution.

32.3 The duty referred to in sub-paragraph 32.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

32.4 In sub-paragraph 32.1.2, “third party” means a person other than

32.4.1 The trust

32.4.2 A person acting on its behalf.

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

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

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

32.8 This paragraph does not require a declaration of an interest of

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which the director is not aware or where the director is not aware of the transaction or arrangement in question.

32.9 A director need not declare an interest

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

32.9.2 If or to the extent that, the directors are already aware of it;

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

32.9.3.1 By a meeting of the Board of Directors, or

32.9.3.2 By a committee of the directors appointed for the purpose under the constitution.

33. Board of Directors – remuneration and terms of office

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

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

34. Registers

The trust shall have:

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

34.2 A register of members of the Council of Governors;

34.3 A register of interests of governors;

34.4 A register of directors

34.5 A register of interests of the directors.

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35. Registers – inspection and copies

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

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

35.2.1 Any member of the Service User and Carer Constituency;

35.2.2 Any other member of the trust, if he/she so requests.

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

35.3.1 They are to be available for inspection free of charge at all reasonable times; and

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

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. Documents available for public inspection

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

36.1.1 A copy of the current constitution;

36.1.2 A copy of the latest annual accounts and of any report of the auditor on them;

36.1.3 A copy of the latest annual report;

36.2 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 a:

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36.2.1 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.

36.2.2 Copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

36.2.3 Copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

36.2.4 Copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

36.2.5 Copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act.

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

36.2.7 Copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;

36.2.8 Copy of any final report published under section 65I (administrator's final report).

36.2.9 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.

36.2.10 Copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

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

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

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37. Auditor

37.1 The trust shall have an auditor.

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

38. Audit committee

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

39. Accounts

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

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

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

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

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

40. Annual report and forward plans and non NHS work

40.1 The trust shall prepare an Annual Report and send it to Monitor.

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

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

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

40.5 Each forward plan must include information about –

40.5.1 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

40.5.2 The income it expects to receive from doing so.

40.6 Where a forward plan contains a proposal that the trust carry on an activity of a kind mentioned in sub-paragraph 42.5.1 the Council of Governors must

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

40.6.2 Notify the directors of the trust of its determination.

40.7 A trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the Council of Governors voting approve its implementation.

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

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

41.1.1 The annual accounts

41.1.2 Any report of the auditor on them

41.1.3 The annual report.

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41.2 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.

41.3 The trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 43.1 with the Annual Members' Meeting.

42. Indemnity

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

43. Instruments

43.1 The trust shall have a seal.

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

44. Amendment of the constitution

44.1 The trust may make amendments of its constitution only if

44.1.1 More than half of the members of the Council of Governors of the trust present and voting approve the amendments, and

44.1.2 More than half of the members of the Board of Directors of the trust present and voting approve the amendments.

44.2 Amendments made under paragraph 44.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

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

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

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amendment.

44.3.2 The trust must give the members an opportunity to vote on whether they approve the amendment.

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

44.5 Amendments by the trust of its constitution are to be notified to Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

45. Mergers etc. and significant transactions

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

45.2 The trust may enter into a significant transaction only if more than half of the members of the Council of Governors present and voting approve entering into the transaction.

"Significant transaction" means:

45.2.1 The acquisition of, or an agreement to acquire, whether contingent or not, assets the value of which is more than 25% of the value of the trust's annual turnover before the acquisition; or

45.2.2 The disposition of, or an agreement to dispose of, whether contingent or not, assets of the trust the value of which is more than 25% of the trust's annual turnover before the disposition; or

45.2.3 transaction that has or is likely to have the effect of the trust acquiring right or interests or incurring obligations or liabilities, including contingent liabilities, the value of which

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is more than 25% of the value of the trust's annual turnover before the transaction.

45.3 For the purpose of this paragraph, in assessing the value of any contingent liability for the purposes of paragraph 45.2 the directors:

45.3.2 Must have regard to all circumstances that the directors know, or ought to know, affect, or may affect, the value of the contingent liability; and

45.3.3 May rely on estimates of the contingent liability that are reasonable in the circumstances: and

45.3.4 May take account of the likelihood of the contingency occurring.

45.4 The views of the Council of Governors will be taken into account before the Trust enters into any proposed transaction which would exceed the threshold of 10% for any of the criteria set out in paragraph 45 above.

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ANNEX 1 – THE PUBLIC CONSTITUENCY

1.1 Individuals who live in one of the electoral wards, i.e. in one of the Trust's Local Authority boundaries, may become a member of the public constituency aligned to the electoral area in which they live:

Name of the Public Constituency	Area of the Public Constituency by Electoral ward / Council areas	Minimum number of members
Northumberland	Northumberland County Council	250
Newcastle upon Tyne (and the rest of England and Wales)	Newcastle upon Tyne City Council	250
Gateshead	Gateshead Metropolitan Borough Council	250
North Tyneside	North Tyneside Metropolitan Borough Council	250
South Tyneside	South Tyneside Metropolitan Borough Council	250
Sunderland	Sunderland City Council	250
Cumbria	Cumbria County Council	250
Total		**1750**

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1.2 In addition an individual who lives outside the boundaries defined in 1.1. But within England and Wales may become a public member of the Newcastle upon Tyne and rest of England and Wales public constituency.

1.3 The Membership Development Strategy details differential future targets for membership based on percentage population in each public constituency.

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ANNEX 2 – THE STAFF CONSTITUENCY

1.1 The staff constituency is divided into 3 classes of individuals as follows:

Staff Constituency	Individuals eligible for Membership of that class	Minimum number of Members
Medical Staff Class	Those individuals defined in paragraph 1.2 below	20
Other Clinical Staff Class	Those individuals defined in paragraph 1.3 below	200
Other Non-Clinical Staff Class	Those individuals defined in paragraph 1.4 below	200
Total		**420**

1.2 The members of the medical class are individuals who are members of the staff constituency who are fully registered persons within the meaning of the consolidated Medical Act 1983 as amended (and in the case of medical practitioners, who hold a licence and are fully authorised to practice).

1.3 The members of the other clinical class are individuals who are members of the staff constituency whose regulatory body falls within the remit of the Professional Standards Authority for Health and Social Care established under section 25 of the NHS Reform and Health Care Professions Act 2002 as amended, but are not fully registered persons within the meaning of the consolidated Medical Act 1983 as amended. Examples include Nurses, Occupational Therapists, Psychologists, Pharmacists, and Social Workers etc. (and where appropriate have live registration to practice).

1.4 The members of the other non-clinical staff are individuals who are members of the staff constituency who do not come within paragraphs 1.2 or 1.3 above. Examples include Healthcare Assistants, Administrative, Estates and Support staff etc.

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1.5 Members of the staff constituency are to be individuals;

a) Who are employed by the trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months, or who has been continuously employed by the trust under a contract of employment for at least 12 months

b) Who exercise functions for the purposes of the trust, otherwise than under a contract of employment with the trust may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months. This includes any members of staff employed by any subsidiary company of the Trust

c) Who are not disqualified from membership under Annex 6 of this Constitution

d) Who have been invited by the trust to become a member of the Staff Constituency (as a member of the appropriate class) and have not informed the trust that they do not wish to do so.

1.6 A person who is eligible to be a member of the staff constituency, may not become or continue as a member of any other constituency and may not become or continue as a member of more than one staff class.

1.7 Where a member is eligible for more than one staff class or if any confusion exists as to the most appropriate staff class, the trust's decision will be final. The decision will be delegated to the Company Secretary.

1.8 For the purposes of paragraph 8 of the Constitution, Chapter 1 of Part 14 of the Employment Rights Act 1996 shall apply for the purposes of determining whether an individual has been continuously employed by the trust or has continuously exercised functions for the purposes of the trust.

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ANNEX 3 – THE SERVICE USER AND CARER CONSTITUENCY

1. The Service User and Carer Constituency

1.1 The Service User and Carer constituency is divided into classes of individuals as follows:

Service User Class	Minimum number of Service User Members
Service Users who within the preceding 6 years have used the trust's adult services, including substance misuse, forensic and specialist services (eating disorders, affective disorders, mother and baby, gender dysphoria, specialist psychological therapy and mental health services for the deaf	100
Service Users who within the preceding 6 years have used the trust's children and young people's services	50
Service Users who within the preceding 6 years have used the trust's older people's services	50
Service Users who within the preceding 6 years have used the trust's learning disability services	50
Service Users who within the preceding 6 years have used the trust's neuro-disability services	50
Total	**300**
Carer Class	**Minimum number of Carer Members**
Carers who within the preceding 6 years have cared for an individual who has used the trust's adult services, including substance misuse, forensic and specialist services (eating disorders, affective disorders, mother and baby, gender dysphoria, specialist psychological therapy and mental health services for the deaf	50

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Carers who within the preceding 6 years have cared for an individual who has used the trust's children and young people's services	25
Carers who within the preceding 6 years have cared for an individual who has used the trust's older people's services	25
Carers who within the preceding 6 years have cared for an individual who has used the trust's learning disability services	25
Carers who within the preceding 6 years have cared for an individual who has used the trust's neuro-disability services	25
Total	**150**

1.2 In accordance with the Membership Development Strategy, differential membership targets will be set for each class over time.

1.3 Where a member may be eligible for more than one Service User and Carer class, that member may choose the class they wish to be in. A person who is eligible for more than one class, but does not express a preference will be allocated to an appropriate class by the trust. The decision will be delegated to the Company Secretary.

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ANNEX 4 – COMPOSITION OF COUNCIL OF GOVERNORS

1.1 The composition of the Council of Governors is as follows:

Constituency – Public (elected)	Number of Governors	Total
Class: Northumberland	1	
Class: North Tyneside	1	
Class: South Tyneside	1	
Class: Gateshead	1	
Class: Sunderland	1	
Class: Cumbria	1	
Class: Newcastle upon Tyne, rest of England and Wales	1	
Public total		**7**
Constituency – Service User and Carer (elected)	Number of Governors	Total
Class: Service User (elected)		
Adult Services	2	
Children and Young People's Services	1	
Learning Disability and Autism Services	1	
Neuro-disability Services	1	
Older People's Services	1	
Service User total		**6**
Class: Carer (elected)		

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Adult Services	2	
Children and Young People's Services	1	
Learning Disability and Autism Services	1	
Neuro-disability Services	1	
Older People's Services	1	
Carer total		**6**
Constituency – Staff (elected)	Number of Governors	Total
Medical	1	
Clinical	3	
Non-Clinical	3	
Staff total		**7**
Constituency – Appointed	Number of Governors	Total
Northumberland County Council	1	
North Tyneside Metropolitan Borough Council	1	
Newcastle upon Tyne City Council	1	
South Tyneside Metropolitan Borough Council	1	
Gateshead Metropolitan Borough Council	1	
Sunderland City Council	1	
Cumbria County Council	1	
Total Local Authority Appointed		**7**
Newcastle University	1	
Northumberland University	1	
Total University Appointed		**2**

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Community and Voluntary Sector	2	
Total CVS Appointed		**2**
TOTAL COMPOSITION		**37**

1.2 When future vacancies for an appointed Governor arise, the trust may in its absolute discretion decide whether to permit that Local Authority, University or Community Voluntary (Third) Sector partner which had first failed or declined to appoint a governor to do so for the next period of office.

1.3 Where vacancies exist in the publicly elected constituencies, University and Community Voluntary (Third) Sector Partner Governors may be temporarily stood down to ensure the Council of Governors is balanced in favour of publicly elected Governors, pending the outcome of an election or by-election.

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ANNEX 5 – FURTHER PROVISIONS IN RELATION TO THE COUNCIL OF GOVERNORS

FURTHER PROVISIONS

1 COUNCIL OF GOVERNORS – TERMS OF OFFICE

Public Governors; Service User and Carer Governors and Staff Governors can hold office for a period of up to three years and will be eligible for election following that period subject to a maximum term of nine years; or

(a) Until he/she ceases to be a member of the constituency he represents if sooner;

1.2 Local Authority Governors can hold office for an initial period of up to three years and will be eligible for reappointment at the end of that term, up to a maximum of nine years; or

(a) until the individual vacates the post if sooner;

(b) Until the Local Authority withdraws its sponsorship of the individual (by notice to the Board Secretary to that effect) if sooner.

1.3 University Partner Governors:

(a) Appointments to these posts will be nominated by: the University of Newcastle, the University of Northumbria at Newcastle, the University of Sunderland and the University of Cumbria, on a rotational basis at the discretion of the Chairman

(b) University Partner Governors can hold office for an initial period of up to three years and will be eligible for reappointment at the end of that term, up to a maximum of nine years; or

(c) until the University agrees with the Trust that another individual will take up the post if sooner; or

(d) Until the University withdraws its sponsorship of that individual (by notice to the Board Secretary to that effect) if sooner.

1.4 Community Voluntary Sector Partner Governors

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(e) Community Voluntary Sector Partner Governors can hold office for an initial period of up to three years and will be eligible for reappointment at the end of that term, up to a maximum of nine years; or

(f) Until the individual's organisation withdraws its sponsorship of that individual (by notice to the Board Secretary to that effect) if sooner.

2 Termination of Tenure

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

2.1.1 by the Governor giving notice in writing to the trust of his resignation from office at any time during that term of office;

2.1.2 Immediately, if the Governor fails to attend three consecutive Council of Governors meetings, unless the Chair is satisfied that:

(a) the absence was due to a reasonable cause; and

(b) He/she will be able to start attending meetings of the Council of Governors again within such a period as they consider reasonable.

2.1.3 If the Council of Governors resolves to terminate his/her term of office on the grounds that in the reasonable opinion of three quarters of the Governors present and voting at a meeting of the Council of Governors convened for that purpose; his/her continuing as a Governor would or would be likely to:-

(c) prejudice the ability of the trust to fulfil its principal purpose or purposes under this constitution or otherwise discharge its duties and functions; or

(d) prejudice the trust's work with any other person or organisation with whom it is engaged or may be engaged in the provision of goods and services; or

(e) adversely affect public confidence in the goods and services provided by the trust; or

(f) otherwise bring the trust or the Council of Governors into disrepute or be detrimental to the interests of the trust; or

(g) not be in the best interests of the trust; or

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2.1.4 He/she has failed or refused to undertake and/or satisfactorily complete any training which the Council of Governors has required him/her to undertake in his capacity as a Governor; or

2.1.5 he/she has in his conduct as a Governor failed to comply in a material way with the values and principles of the NHS or the trust; or

2.1.6 He/she has committed a material breach of any code of conduct applicable to the Governors of the trust.

2.1.7 He/she is a vexatious or persistent litigant or complainant with regard to the trust's affairs and his continuance in office would not be in the best interests of the trust.

2.1.8 He/she is elected to a political post, e.g. Member of Parliament. Any Governor putting himself forward as a candidate for such a post should "stand down" as a Governor pending the outcome. Missing meetings pending the outcome of any such election shall not count as failure to attend for the purpose of paragraph 2.1.2 above.

2.1.9 Upon a Governor resigning or upon the Council of Governors resolving to terminate a Governor's tenure of office in accordance with the above provisions that Governor shall cease to be a Governor and his/her name shall be removed forthwith from the Register of Governors.

2.2 Any decision of the Council of Governors to terminate a Governor's tenure of office may be referred by the Governor to the disputes resolution process referred to in Paragraph 8, Annex 5 within 14 days of the date upon which notice in writing of the Council of Governors decision is given to the Governor.

2.3 Where a Governor is declared ineligible or disqualified from office or his term of office as a Governor has been terminated (otherwise than as a consequence of his own resignation) and that person disputes the decision, he shall as soon as reasonably practicable be entitled to attend a meeting with the Chair and Chief Executive of the trust, who shall use reasonable endeavours to facilitate such a meeting, to discuss the decision with a view to resolving any dispute which may have arisen but the Chair and Chief Executive shall not be entitled to rescind or vary the decision which has already been made.

2.4 In support of the Council of Governors proactively managing the arrangements specified in 2.1.2 above, the Council of Governors may grant a governor a "leave of absence" from their duties as a Governor. This facilitates the Council of Governors considering a Governor's circumstances in advance of the Governor failing to attend three consecutive meetings, enables cover arrangements for the Governor to

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be put in place at the earliest opportunity and may benefit the Governors concerned, e.g. if suffering from ill health.

3 Disqualification

3.1 A person may not become or continue as a Governor of the Trust if:

(a) He/she is less than the minimum age of 16 years;

(b) In the case of a Public Governor or Service User and Carer Governor or a staff Governor, he/she ceases to be a member of the constituency he/she represents;

(c) he/she is the spouse, partner, parent or child of another member of the Council of Governors or Board of Directors;

(d) They are a Director of the Trust, or a Governor or Director of another NHS Trust or NHS Foundation Trust;

(e) In the case of a Local Authority, Community Voluntary (Third) Sector or University Partner Governors, the appointing organisation withdraws their sponsorship of him/her;

(f) He/she is a member of the Local Authority Health Overview and Scrutiny Committee or the Health and Wellbeing Board;

(g) He/she has been dismissed, otherwise than by reason of redundancy, from any paid employment with a public service body, including for the avoidance of doubt the Trust;

(h) He/she is a person whose tenure of office as the chair or as a member or Director of a public service body has been terminated on the grounds that his/her appointment is not in the interests of that public service, for nonattendance at meetings, or for non-disclosure of a pecuniary interest;

(i) He/she is an Executive or Non-Executive Director of the Trust, or a Governor, Non-Executive Director, Chair, Chief Executive or Executive Director of another NHS foundation trust, except in the case of a Local Authority Governor, who may become a Governor at another NHS foundation trust;

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(j) He/she has 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;

(k) He/she is incapable by reason of continuing mental incapacity, illness or injury of managing and administering his/her own affairs or property;

(l) They are a person who is subject to an order under the Sexual Offences Act 2003;

(m) They are a person who is included in any barred list established under the Safeguarding Vulnerable Groups Act 2006 or any equivalent list

(n) They are a person where disclosures revealed by a Disclosure and Barring Services check against them are such that it would be inappropriate for them to become r continue as a Governor to would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;

(o) They have within the preceding two years been dismissed, otherwise than by reason of resignation or redundancy, from any paid employment within a public body;

(p) They have previously been removed as a Director or Governor of the Trust, or been removed as a Director or Governor of another NHS Foundation Trust;

(q) He/she brings the Council of Governors or any of its member organisations into disrepute;

(r) He/she fails to abide by the constitution as set out in this document; or

(s) He/she has failed to make, or has falsely made, any declaration required to be made under section 60 of the 2006 Act.

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3.2 If a Staff Governor is suspended/excluded from duties for any reason, he/she will also be suspended from his/her role as a Governor for the duration of that suspension/exclusion. Whilst he/she is suspended, he/she may not attend meetings of the Council of Governors in any capacity, but missing meetings of the Council of Governors by virtue of suspension/exclusion will not count as failure to attend for the purposes of paragraph 2.1.2

3.3 Subject to paragraph 3.1, if a Governor is under investigation for a criminal offence, excluding minor traffic offences, he/she will be suspended from his/her role as a Governor for the duration of that investigation. Whilst a Governor is suspended, that Governor may not attend meetings of the Council of Governors in any capacity, but missing meetings of the Council of Governors by virtue of suspension will not count as failure to attend for the purposes of paragraph 2.1.2

3.4 Where a person has been elected or appointed as a Governor and he/she becomes disqualified under paragraph 3.1, he/she shall notify the Company Secretary in writing of such disqualification.

If it comes to the notice of the Company Secretary at the time of his/her appointment or later that the Governor is so disqualified, the Chairman shall immediately convene a meeting of the Council of Governors membership panel comprising the Chairman of the Trust (and Council of Governors), an Appointed Governor, two Public Governors and a Staff Governor. The final decision on disqualification from eligibility to become, or remain a Governor will rest with this membership panel. The Chair will have a casting vote but no vote otherwise. The decision of the panel on whether to disqualify the person in question will be notified to him in writing by the Company Secretary.

Upon receipt of any such notification, that person's term of office, shall be terminated and he/she shall cease to act as a Governor.

4 Vacancies

4.1 Where membership of the Council of Governors ceases for one of the reasons set out in paragraph 2 of Annex 5 or terminates for whatever reason, elected Governors shall be replaced by inviting the person who was placed second in the previous election to fill the vacancy for the remaining period of the former Governor's term of office, provided:

(a) the period to when the seat is up for election is greater than 3 months

(b) The election was held in the last three years

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(c) The person placed second in that election received at least 20% of the votes cast in the election.

(d) The person placed second in that election is still a member of the relevant constituency.

(e) The person placed second is not disqualified from becoming a Governor by virtue of paragraph 3 above.

4.2 The time a person appointed under 4.1 serves as a Governor shall count towards the maximum period of office in paragraph 14.1.

4.4 Where an appointed Governor post falls vacant, the appointing organisation will appoint another Governor within 3 months of the Company Secretary receiving notification from the appointing organisation of the vacancy.

4.5 No defect in the election or appointment of a Governor nor any deficiency in the composition of the Council of Governors shall affect the validity or any act or decision of the Council of Governors made prior to the deficiency being known.

5. Appointment, remuneration and allowances of the Chair and Non-Executive Directors

5.1 The remuneration and allowances for the Chairman and Non-Executive Directors of the Trust are to be set by the Council of Governors (the Company Secretary taking independent advice on behalf of the Council of Governors where required) and are to be published in the Trust's annual report.

5.2 The Council of Governors shall resolve in a general meeting to appoint such candidate or candidates to the positions of Chair and non-executive director as it considers appropriate and in reaching its decision shall have regard to the views of the Board of Directors and of the Governors' Nominations Committee as to the suitability of the available candidates.

5.3 The Council of Governors shall appoint a Vice-Chair in accordance with paragraph 28 of the constitution.

5.4 Governors are not to receive remuneration.

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6. Meetings

6.1 The Council of Governors will meet no less than 4 times per year.

6.2 At a general meeting no later than 30 September in each year, the Council of Governors are to receive and consider the annual accounts, any report of the auditor on them, and the annual report. The general meeting may be combined with the Annual Members' Meeting, the provisions for which are set out in paragraph 11.

6.3 The Council of Governors' Standing Orders as set out in Annex 7 of the constitution provides for further details of the practice and procedure at Council of Governors' meetings.

7. Committees and Sub-Committees

7.1 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.

7.2 These committees or sub-committees may call upon outside advisers for assistance.

7.3 Such committees or sub-committees may make recommendations to the Council of Governors but final decision making powers rest with the full Council of Governors.

7.4 A member of a committee shall not disclose to any third party a matter dealt with by or brought before the committee, without that committee's permission until that committee has reported to the Council of Governors or has otherwise concluded action on that matter.

7.5 A member of a committee shall not disclose any matter to any third party if the Council of Governors or committee resolves that **it is confidential.**

7.6 The Council of Governors shall establish a committee of its members to be called the Nominations Committee to discharge those functions in relation to the appointment and removal of the Chair and Non-Executive Directors and their remuneration and allowances and other terms and conditions.

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8. Disputes Resolution – Governors and Directors

8.1 The Council of Governors and Board of Directors must be committed to developing and maintaining a constructive and positive relationship. The aim at all times is to resolve any potential or actual differences of opinion quickly, through discussion and negotiation.

8.2 If the Chair cannot achieve resolution of a disagreement through informal efforts, the Chair will follow the dispute resolution procedure outlined below. The aim is to resolve the matter at the first available opportunity and only to follow this procedure if initial action fails to achieve a resolution:

(a) The Chair will call a joint meeting (Resolution Meeting) of the members of the Council of Governors and Board of Directors, to take place as soon as possible, but no later than 20 clear working days following the date of the request. The meeting must comprise at least two thirds of the membership of the Council of Governors and at least two thirds of the membership of the Board of Directors. The meeting will be held in private. The aim of the meeting is to resolve the conflict. The Chair will have the right to appoint an independent facilitator to assist the process. Every reasonable effort must be made to reach agreement.

(b) If a Resolution Meeting of the members of the Council of Governors and Board of Directors fails to resolve a conflict, the Board of Directors will decide the disputed matter.

(c) If following the Resolution Meeting, and any decision of the Board of Directors, the Council of Governors considers that implementation of the decision will result in the trust failing to comply with the constitution, its Provider Licence or to act in accordance with provision made by or under Chapter 5 of the 2006 Act, a governor may refer the issue in accordance with paragraph 19 of the constitution.

8.3 The right to call a Resolution Meeting rest with the following, in the sequence of escalation shown:

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(a) The Chair

(b) The Chief Executive

(c) Two thirds or more of the Council of Governors

(d) Two thirds or more of the Board of Directors

9. Appointment of Lead Governor

9.1 The Council of Governors shall appoint one of the Governors to be Lead Governor of the Council of Governors via a process agreed with the Council of Governors, Chairman and Company Secretary.

10. Disclosure of Interests

10.1 If a Governor has a pecuniary interest (financial), personal or family interest, whether that interest is actual or potential, 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 they become aware of it.6.2 Any Governor who has a material interest in a matter defined below shall declare such an interest to the Council of Governors and:

10.1.1 Shall withdraw from the meeting and play no part in the relevant discussion or decision; and

10.1.2 Shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counter).

10.2 Any Governor who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a decision of the remaining Governors in accordance with 2.1.3 of this Annex.

10.3 Subject to the exceptions detailed in 6.5 below, a material interest is:

10.3.1 Any Directorship of a company, including Non-Executive Directorships held in limited companies (with the exception of dormant companies);

10.3.2 Any interest held by a Governor in any company or business, which in connection with the matter, is trading with the Trust, or is reasonably likely to be considered as a potential trading partner with the Trust;

10.3.3 Any interest in a voluntary or other organisation providing health and social care services to the NHS;

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10.3.4 A position of authority in a charity or voluntary organisation in the field of health and social care; and

10.3.5 Any personal, or familial connection with any organisation, entity, company or business, considering entering into or having entered into a financial arrangement with the Trust including, but not limited to, tenders, contracts or banks.

10.4 The exception which shall not be treated as material interests are as follows:

10.4.1 Shares not exceeding 2% of the total shares in issue in any company whose shares are listed on any public exchange;

10.4.2 An employment contact held by staff governors;

10.4.3 An Appointed Governor's employment contracts with their appointing organisation.

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ANNEX 6 – FURTHER PROVISIONS IN RELATION TO THE TRUST'S MEMBERSHIP

FURTHER PROVISIONS

1. Termination of Membership

1.1 A person may not be a member of the Trust if:

1.1.1 They resign by notice to the Company Secretary's Office;

1.1.2 They are deceased;

1.1.3 They have been dismissed from membership under the provisions of this constitution

1.1.4 They cease to be entitled under this Constitution to be a member of their allocated constituency

1.2 It is the responsibility of 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.

1.3 Membership of the Public and Service User and Carer Constituencies is deemed to have commenced upon the receipt of a completed membership application form by the Trust's Membership Office.

1.4 Membership of the Staff Constituency is automatic for qualifying staff, but staff may opt out by notifying the Company Secretary's Office..

1.5 A member may be expelled by a resolution approved by not less than two-thirds of the Council of Governors attending and voting at a general meeting (unless they are a Governor, then paragraph XX of Annex XX should be applied). The following procedure for considering removal of a members should be adopted:

1.5.1 Any member may complain to the Company Secretary that another member has acted in a way detrimental to the Trust;

1.5.2 If a complaint is made, the Council of Governors may itself consider the complaint having taken such steps as it

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considers appropriate to ensure that each member's point of view is heard and may either;

a) Dismiss the complaint and take no further action

b) For a period not exceeding 12 months, suspend the rights of the member complained of to attend Members meetings and vote under this Constitution

c) Arrange for a resolution to expel the member complained of to be considered at the next General Meeting of the Council of Governors.

1.6 If a resolution to expel a member is to be considered at a General Meeting of the Council of Governors, details of the complaint must be sent to the Member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

1.7 At the meeting, the Council of Governors will consider the evidence in support of the complaint and such evidence as the Member complained of may wish to place before them.

1.8 If the Member complained of fails to attend the meeting without due cause as determined by the Chairman of the Council of Governors, the meeting may proceed in their absence.

1.9 A person expelled from membership will cease to be a member upon the declaration by the Chairman of the meeting that the resolution to expel them is carried.

1.10 No person who has been expelled from membership is to be re-admitted except by resolution carried by the votes of two-thirds of the Council of Governors who are present at a General Meeting.

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ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

1. Meetings

1.1 The Chair may call a meeting of the Council of Governors at any time. If the Chair is requested and refuses or fails to call a meeting, on receipt of a written request, within seven days of such refusal or failure, signed by at least one third of the whole number of Governors, one third or more of the Governors may call a meeting.

1.2 Ordinary meetings (General Meetings) of the Council of Governors, whether public or private shall be held at regular intervals at such times and places as the Council of Governors may determine.

1.3 Where meetings are held in public, the public and representatives of the press shall be afforded facilities to attend all General 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 having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest"

1.4 The Chair (or Vice Chair) shall give such directions as he/she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption 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 meeting adjourn for (the period to be specified) to enable the Council of Governors to complete business without the presence of the public."

1.5 Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust.

1.6 The trust will make such provisions as may be necessary to enable Governors with special requirements to participate in meetings e.g. by providing advocates, signers for the deaf.

1.7 The trust shall decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to

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attend and address any of the Council of Governors meetings and may change, alter or vary these terms and conditions as it deems fit.

1.8 At a general meeting held by 30 September in each year, the Trust's Directors shall present the Trust's audited accounts and annual report and any report on the accounts to the Council of Governors. This meeting can be combined with the Annual Members' Meeting.

1 Chair and Vice Chair

1.1 The Chair of the Trust Board of Directors will act as Chair of the Council of Governors and in his absence the Vice Chair of the Board of Directors will act as Chair of the Council of Governors.

1.2 In the absence of both the Chair and Vice Chair of the Board of Directors, the Senior Independent Director will act as Chair of the Council of Governors.

2 Chair of Meetings

2.1 At any meeting of the Council of Governors the Trust Chair, if present, shall preside. The Chair shall have a casting vote but no vote otherwise.

2.2 If the Chair is absent from the meeting, the Trust Vice Chair, shall preside. In the absence of both the Chair and Vice Chair of the Board of Directors, the Senior Independent Director shall preside. In the absence of the Chair, Vice Chair and Senior Independent Director another Non-Executive Director shall preside.

2.3 Should there be a vote on any matter relating to the Chair directly, (which for the avoidance of doubt would not include an issue affecting other members of the Board of Directors), the casting vote would be exercised by the Vice Chair of the Board of Directors. Should there be a vote on any matter relating to the Non-Executive Directors directly, neither the Chair nor the Vice Chair should preside. In such circumstances, the Lead Governor shall preside over and to have the casting vote on such matters.

3 Notice of Meetings

3.1 Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted thereat, and signed by the Chair or by an officer authorised by the Chair to sign on his behalf, shall be delivered to every Governor, at their usual place of residence, so as to be available to such Governor at least seven days before the meeting:

3.2 For public meetings of the Council of Governors a notice of the meeting shall be placed on the trust's website;

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3.3 Want of service of such notice on any Governor shall not affect the validity of a meeting or any decision thereat;

3.4 In the case of a meeting called by Governors in default of the Chair or in his/her absence the Vice Chair, the notice shall be signed by those Governors who called the meeting, being no less than one third of the whole Governors and no business shall be transacted at the meeting other than that specified in the notice.

3.5 Executive and non-executive directors shall be invited to attend all meetings of the Council of Governors to provide such information as may be necessary for the successful functioning of the Council of Governors e.g. finance, performance, medical, nursing reports.

4 Record of Attendance

4.1 The names of Governors present at the meeting shall be recorded in the minutes of the meeting.

5 Quorum

5.1 No business shall be transacted at a Council of Governors meeting unless at least one-third of the whole number of Governors are present, i.e.one third of the whole number of Governors in post at the time of the decision, including at least 50% from the Public and Service Users' and Carers' constituencies and one Governor from the Staff Constituency.

5.2 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, that person shall no longer count towards the quorum. If a quorum is then not available for discussion and/or passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

5.3 Members of the Council of Governors can participate in meetings or committee meetings by telephone or video link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

5.4 Should any member of the Council of Governors participate in meetings by telephone or video link for a specific item on the agenda, they must participate at the commencement of the agenda item, and remain present until the Chairman has deemed the item closed.

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6 Minutes

6.1 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 thereat.

6.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

6.3 Minutes of the meetings held in public will be available on the trust's website.

7 Notice of Motion

7.1 Subject to the provisions of Section 9 below, a Governor desiring to move a motion shall send a notice thereof at least ten clear days before the meeting to the Board Secretary, who shall insert in the agenda for the meeting all notices so received that are permissible under the appropriate order. This paragraph shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

8 Motions

8.1 All motions and amendments to resolutions must have a proposer and seconder otherwise they shall not be discussed or put to a meeting.

8.2 The mover of a motion shall have a right of reply at the close of any discussion on a motion or any amendment thereto.

8.3 Motions which may be moved during Debate. When a motion is under debate or immediately prior to discussion no other motions shall be moved except the following:-

8.3.1 Amendments to the motion;

8.3.2 The adjournment of the discussion or the meeting;

8.3.3 That the meeting proceed to the next business;

8.3.4 The appointment of an ad hoc committee to deal with a specific item of business;

8.3.5 That the question be now put to a motion to exclude the public (including the press);

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9 Motion to Rescind a Motion

Notice of motion to rescind any resolution, (or the general substance of any resolution), which has been passed within the preceding six calendar months, shall bear the signature of the Governor who gives it and also the signature of two other Governors. When any such motion has been disposed of by the Council of Governors, it shall not be permitted for any Governor other than the Chair to propose a motion to the same effect within six months.

10 Chair's Ruling

10.1 The decision of the Chair on questions of order, relevancy and regularity (including procedure on handling motions) and his interpretation of the Standing Orders shall be final. In this interpretation he shall be advised by the Chief Executive and/or the Board Secretary.

11 Voting

11.1 Subject to the provisions of the Constitution, every question at a meeting, which the Council of Governors agrees should be put to the vote, shall be determined by a majority of the votes of the Governors present. In the case of an equality of votes, the Chair shall have a casting vote.

11.2 All questions put to the vote shall, at the discretion of the Chair, be determined by oral expression or by show of hands provided that, upon any question the Chair may direct, or it may be proposed, seconded and carried that a vote be taken by paper ballot.

11.3 If at least one-third of the Governors present so request, the voting on any question may be recorded so as to show how each Governor present and voting gave his vote.

11.4 If a Governor so requests, his/her vote shall be recorded by name.

11.5 In no circumstances may an absent Governor vote by proxy.

11.6 No resolution of the Council of Governors shall be passed if it is opposed by all of the Public and Service User and Carer Governors present.

11.7 All decisions taken in good faith at a meeting of the Council of Governors or any committee of the Council of Governors shall be valid, even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of any of the Governors present at the meeting.

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12 Conflict of Interest

12.1 The Constitution requires Governors to declare all interests which they, or their spouse or partner, have which would be considered as relevant and material to the Council of Governors. Interests should be declared on election or appointment, or as soon as possible after a change has occurred.

12.2 At the time Governors interests are declared, they should be recorded in the minutes of the Council of Governors. Any changes in interests should be declared at the next Council of Governors meeting after the change has occurred.

12.3 If during the course of a meeting of the Council of Governors a conflict of interest is established, the Governor concerned shall withdraw from the meeting and play no further part in the relevant discussion or decision. For the avoidance of doubt this includes voting on an issue where a conflict is established. If there is a dispute as to whether a conflict exists, the majority will resolve the issue in consultation with the Board Secretary, with the Chair having the casting vote.

12.4 Interests which should be regarded as relevant or material are:

a) Directorships, including non-executive directorships held in private companies or plcs;

b) Ownership, part-ownership or directorships of private companies, businesses or consultancies possibly seeking to do business with the Trust;

c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the Trust;

d) A position of authority in a charity or voluntary organisation in the field of health or social care;

e) Any connection with a voluntary or other organisation contracting for Trust services to the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks.

12.5 If Governors have any doubt about the relevance of an interest, this should be discussed with the Board Secretary.

12.6 Declarations of interest will be a standing agenda item at the beginning of every meeting.

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13. Register of Interests

A register of Governors' interests will be held by the Trust and will be made available for inspection on request.

14. Confidentiality

14.1 Matters to be dealt with by the Council of Governors following the exclusion of members of the public and representatives of the press shall be confidential to the Council of Governors.

14.2 Governors, Directors Officers or any employee or any other representative in attendance at a Council of Governors meeting, or any of its committees, in private shall not reveal or disclose the contents of papers, discussions or minutes of the items taken in private, outside of the meeting, without the express permission of the Chairman and any such occurrence will be treated as a breach of the relevant Governor/Director/Officer Code of Conduct.

15. Appointment of committees and sub-committees

15.1 The Council of Governors may form advisory sub-committees under a written Terms of Reference, which must be approved by the Council of Governors. Advisory meetings may include members of the Board and other Trust representatives, or service users. The Council of Governors may appoint the membership of sub-committees of the Council of Governors and all acts of proceedings of advisory committees shall be reported to the Council of Governors.

15.2 These Standing Orders in their entirety, as far as they are applicable, shall apply also, with the appropriate alternation, to meetings of the sub-committees of the Council of Governors.

15.3 The Council of Governors may not delegate any of its statutory powers to any of its sub-committees.

15.4 The sub-committees to be established by the Council of Governors are: the Nomination Committee, the Terms of Reference of which shall be made available on the Trust's website. In addition, the Council of Governors may establish other sub-committee and groups as it deems necessary to assist it in exercising its functions.

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ANNEX 8 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

TRUST BOARD OF DIRECTORS

Note: This Annex has been prepared to be used as a standalone document in addition to being part of the Constitution.

1. INTRODUCTION

1.1 Statutory Framework

a) The trust is a Public Benefit Corporation established by the granting of Authorisation by Monitor.

b) The statutory functions conferred on the trust are set out in the NHS Act 2006 and in the trust's Provider Licence. All business shall be conducted in the name of the trust.

c) All the powers of the trust shall be exercised by the Board of Directors on its behalf, but any of those powers may be delegated to a committee of directors or to an executive director. The Board of Directors is required to adopt a schedule of matters reserved for decision by the Board of Directors, Board committees' terms of reference and a document outlining details of delegation to individuals (i.e. the Decision Making Framework). These documents shall outline such restrictions and conditions the trust thinks fit and shall have effect as if incorporated into the Standing Orders.

2. Appointment of the Chair and Non-Executive Directors

The Chair and Non-Executive Directors shall be appointed by the Council of Governors in accordance with paragraphs 25 of the Constitution.

3. Terms of Office of the Chair and Non-Executive Directors

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

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4. Appointment of Vice Chair

4.1 Any Non-Executive Director appointed as Vice Chair, may at any time resign from the office of Vice Chair by giving notice in writing to the Chair.

4.2 The vice Chair may preside at meetings of the Board of Directors in the following circumstances:

- When there is need for someone to have the authority to chair any meeting of the Board of Directors when the Chair is not present; or

- On occasions when the Chair declares a pecuniary interest or other interest in accordance with paragraph 32 of the Constitution that prevents him from taking part in the consideration or discussion of the matter before the Board of Directors.

5. Independent Directors

At least half of the Board of Directors, excluding the Chair, shall comprise non-executive directors determined by the Board of Directors to be independent. The Board of Directors shall appoint one of the independent non-executive directors to be the senior independent director. The senior independent director shall be available to members and Governors if they have concerns which contact through normal channels of the Chair, Chief Executive or Finance Director has failed to resolve or for which such contact is inappropriate. The Vice Chair may be appointed as the Senior Independent Director but this is not mandatory. The Council of Governors is responsible for appointing the Vice-Chair following the advice and guidance of the Chairman.

6. Calling Meetings

6.1 The Chair may call a meeting of the Board of Directors at any time. If the Chair is requested and refuses or fails to call a meeting, on receipt of a written request, within seven days signed by one third of the whole number of Directors, one third or more of the Directors may call a meeting.

6.2 Ordinary meetings of the Board of Directors whether public or private shall be held at regular intervals at such times and places as the Board may determine.

6.3 Where meetings are held in public, the public and representatives of the press shall be afforded facilities to attend all formal meetings of the Board of Directors, but shall be required to withdraw upon the Board resolving as follows: “That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to

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the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest"

6.4 The Chair (or Vice Chair) shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption 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 resolving as follows: "That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public"

6.5 Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust.

6.6 Matters to be dealt with by the Board of Directors following the exclusion of representatives of the press, and other members of the public, as provided above, shall be confidential to the Board.

6.7 Directors and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked "In Confidence" or minutes headed "Items Taken in Private" outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

7. Observers at such meetings

The Trust shall decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

8. Chair of Meetings

8.1 At any meeting of the Board of Directors the Chair, if present, shall preside.

8.2 If the Chair is absent from the meeting, the Vice Chair, if present, shall preside.

8.3 If the Chair and Vice Chair are absent, such Non-Executive Director as the members present shall choose, shall preside.

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8.4 If the Chair is absent temporarily on the grounds of a declared conflict of interest, the Vice Chair, if present, shall preside. If the Chair and Vice Chair are absent, or are disqualified from participating, such Non-Executive Director as the Directors present shall choose shall preside.

9. Notice of Meetings

9.1 Before each meeting of the Board of Directors a notice of the meeting, specifying the business proposed to be transacted thereat, and signed by the Chair or by an officer authorised by the Chair to sign on his behalf, shall be delivered to every Director, at their usual place of residence, so as to be available to such Director at least seven days before the meeting.

9.2 For public meetings of the Board of Directors a notice of the meeting shall be placed on the trust's website;

9.3 Want of service of such notice on any Director shall not affect the validity of a meeting or any decision made thereat;

9.4 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors calling the meeting and no business shall be transacted at the meeting other than that specified in the notice.

9.5 Agendas and available supporting papers will be circulated to Directors five days before the meeting but will certainly be despatched no later than three working days before the meeting, save in an emergency. Failure to serve such a notice on more than three Directors will invalidate the meeting. A notice shall be presumed to have been served one working day after posting.

9.6 Before each public meeting of the Board of Directors, a public notice of the time and place of every meeting, and the public part of the agenda, shall be displayed at the Trust's offices and website, at least three working days before the meeting.

10. Setting the Agenda

10.1 The Board may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

10.2 A Director desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least ten working days before the meeting. The request should state whether the item of business is propose to be transacted in the presence of the public and should include appropriate supporting information.

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Requests made less than ten working days before a meeting may be included on the agenda at the discretion of the Chair.

11. Petitions

Where a petition has been received by the Trust the Chair shall include the petition as an item for the agenda of the next Board meeting.

12. Record of Attendance

The names of the Chair and Directors present at the meeting shall be recorded in the minutes.

13. Quorum

No business shall be transacted at a Board of Directors meeting unless at least one-third of the whole number of Directors are present, including at least one Executive and one Non-Executive Director.

14. Minutes

14.1 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.

14.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

14.3 Minutes shall be circulated in accordance with Directors' wishes. Where providing a record of a public meeting, the minutes shall be made available to the public.

15. Notice of Motion

Subject to the provisions of section 16 below, a Director desiring to move a motion shall send a notice thereof at least ten days before the meeting to the Board Secretary, who shall insert in the agenda for the meeting all notices so received that are in order. This paragraph shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

16. Motions

16.1 All motions and amendments to resolutions must have a proposer and seconder otherwise they shall not be discussed or put to a meeting.

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16.2 The mover of a motion shall have a right of reply at the close of any discussion on a motion or any amendment thereto.

16.3 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

16.3.1 An amendment to the motion;

16.3.2 The adjournment of the discussion or the meeting;

16.3.3 That the meeting proceed to the next business (*);

16.3.4 The appointment of an ad hoc committee to deal with a specific item of business;

16.3.5 That the motion now be put (*);

16.3.6 That a Director be not further heard; or

16.3.7 A motion to exclude the public (including the press)

16.3.8 (*) In the case of sub-sections denoted by (*) above, to ensure objectivity, motions may only be put by a Director who has not previously taken part in the debate and who is eligible to vote.

16.4 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.

17. Motion to Rescind a Resolution

Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months, shall bear the signature of the Director who gives it and also the signature of two other Directors. When any such motion has been disposed of by the Board of Directors, it shall not be permitted for any Director other than the Chair to propose a motion to the same effect within six months.

18. Emergency Motions

Subject to the agreement of the Chair, a Director may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of the urgency. If in order, it shall be declared to the Board at the commencement of the business of the meeting as an additional item in the agenda. The Chair's decision to include or exclude the item shall be final.

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19. Content of Motions

19.1 The Chair may exclude from the debate at his discretion any such motion of which notice was not given on the notice of convening the meeting other than a motion relating to:

19.1.1 The reception of a report;

19.1.2 Consideration of any item of business before the Board;

19.1.3 The accuracy of the minutes;

19.1.4 That the Board proceed to the next business;

19.1.5 That the Board adjourn;

19.1.6 That the question now be put.

20. 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.

21. Chair's Ruling

Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and other means shall be final.

22. Voting

22.1 Every question at a meeting shall be determined by a majority of the votes of the Directors present and voting on the question and, in the case of the number of votes for and against a motion be equal, the Chair of the meeting shall have a second and casting vote.

22.2 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by show of hands. A paper ballot may also be used if a majority of Directors present so request.

22.3 If at least one third of the Directors present and the Chair so request, the voting (other than by ballot paper) on any question may be recorded so as to show how each Director present and voted or abstained.

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22.4 If a Director so requests, his vote shall be recorded by name upon any vote (other than by paper ballot).

22.5 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

22.6 An officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity, or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director.

22.7 An officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status, may not exercise the voting rights of the Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

23. Interest of Directors in Contracts and Other Matters

23.1 A register of Directors' interests will be held by the Trust and will be made available for inspection on request.

23.2 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, he/she shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

23.3 The Trust may exclude a Director from a meeting of the Board of Directors while any contract, proposed contract or other matter in which he/she has a pecuniary interest, direct or indirect, is under consideration.

23.4 The Trust may, subject to any terms set by Monitor, terminate the appointment of any Non-Executive Director who fails, as required, to declare a pecuniary interest, and in the case of an Executive Director who fails to declare an interest or is found to have used the position or knowledge for private advantage, may take disciplinary action leading to his/her dismissal.

23.5 Any remuneration, compensation or allowances payable to a Chair or other Non-Executive Director in accordance with the remuneration and allowances and other terms and conditions of office decided by the

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Council of Governors, shall not be treated as pecuniary interest for the purpose of this regulation.

23.6 Interests which should be regarded as relevant or material are:

Directorships, including non-executive directorships held in private companies or plcs

I Ownership, part-ownership or directorships of private companies, businesses or consultancies possibly seeking to do business with the Trust;

II Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the Trust

III A position of authority in a charity or voluntary organisation in the field of health or social care;

IV Any connection with a voluntary or other organisation contracting for Trust services to the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks.

A Director shall be treated, subject to the next following paragraphs, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if

23.6.1 He/she or a nominee is a member 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

23.6.2 He/she is a partner, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration and in the case of married persons living together the interest of one spouse shall, if known to the other, be deemed to be also the interest of the other.

23.7 The Chair or a Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:-

23.7.1 Of his/her membership of a company or other body if he/she has no beneficial interest in any securities of that company or other body;

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23.7.2 Of an interest of his/her or of any company, body or person with which he/she is connected as mentioned 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.

23.8 Where the Chair or a Director 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 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 if the share capital is of more than one class in which he/she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class, this shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to his/her duty to disclose his interest.

24. Register of Interests

24.1 The Company Secretary will ensure that a Register of Interests is established to formally record 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 both Executive and Non- Executive Directors, as previously defined. The Register will be held by the Board Secretary.

24.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared in the preceding 12 months will be incorporated, while recognising that interests should be declared as soon as possible.

24.3 Declarations of interest will be a standing agenda item at the beginning of every Board of Directors meeting.

24.4 The Register shall be made available for inspection by members of the public, except if otherwise prescribed by regulations. So far as the registers are required to be made available, they are to be available for inspection free of charge at all reasonable times and a person who requests a copy of or extract from the register is to be provided with a copy or extract. 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.

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25. Appointment of Committees and Sub-committees

25.1 Subject to any directions by Monitor, the Board of Directors may, and if directed as aforesaid shall, appoint committees of the Board of Directors, or together with one or more NHS Foundation Trusts, NHS Trusts, commissioners or other statutory partner organisations, appoint joint committees, consisting wholly or partly of the Chair and Directors of the Trust or other health service bodies or wholly of persons who are not Directors or other health service bodies in question.

25.2 A committee or joint committee appointed under this regulation may, subject to such directions as may be given by Monitor or the appointing Board of Directors, appoint sub-committees consisting wholly or partly of Directors of the committee or joint committee (whether or not they are Directors of the Trust); or wholly of persons who are not Directors of the committee of the Trust.

25.3 The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Trust. In which case the term 'Chair' is to be read as a reference to the Chair of the committee as the context permits, and the term 'Member' is to be read as a reference to a Member of the committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public).

25.4 Each committee shall have such terms of reference and powers, and be subject to such conditions (as to reporting to the Board of Directors), as the Trust shall decide and shall be in accordance with any relevant legislation and regulation as may be applicable. Such terms of reference and powers shall have effect as if incorporated into Standing Orders.

25.5 Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board of Directors. This is subject to that all powers of the trust shall be exercised by the Board of Directors on its behalf, but any of those powers may be delegated to a committee of directors or to an executive director.

25.6 The Board of Directors shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines that persons who are neither Directors nor officers shall be appointed to a committee, the terms of such appointment shall be within the powers of the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings and/or expenses in accordance, where appropriate, with national guidance.

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25.7 Where the Board is required to appoint persons to a committee and/or to undertake statutory functions, and where such appointments are to operate independently of the Board, such appointments shall be made in accordance with applicable statute and regulations, and with any guidance issued by Monitor.

25.8 The committees established by the Board shall include:

-The Audit Committee

-The Remuneration Committee

-The Mental Health Legislation Committee

25.9 Proceedings in Committee to be Confidential.

25.9.1 A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded action on that matter.

25.9.2 A Director or a member of a committee shall not disclose any matter reported to the Board of Directors or committee, if the Board of Directors or committee shall resolve that it is confidential.

25.10 Every committee shall have a Non-Executive Director Chair, appointed by the Trust Chair.

25.11 Except where approved by the Board of Directors, business shall not be transacted at any meeting of any committee of the Trust unless at least one third of the whole number of the committee is present provided that in no case shall the quorum of the committee be less than two members.

26. Conflict of Interests

During the course of a meeting of the Board of Directors if a conflict of interest is established, the Director concerned shall withdraw from the meeting and play no further part in the relevant discussion or decision. For the avoidance of doubt this includes voting on an issue where a conflict is established. If there is a dispute as to whether a conflict exists, the majority will resolve the issue with the Chair having the casting vote.

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27 CQC's Fit and Proper Person Test for Directors (Regulated Activities Regulations)

27.1. Regulation 5 of the Regulated Activities Regulations states that the Trust must not appoint or have in place an individual as a director, or performing the functions of or equivalent or similar to the functions of, such a director, if they do not satisfy all the requirements set out in paragraph 3 of that Regulation.

27.2. The requirements of paragraph 3 of Regulation 5 of the Regulated Activities Regulations are that:

(a) The individual is of good character

(b) The individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed

(c) The individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed

(d) The individual has not 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

(e) None of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

27.3. The grounds of unfitness specified in Part 1 of Schedule 4 to the Regulated Activities Regulations are:

(a) The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged

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(b) 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

(c) The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986

(d) The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it

(e) 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

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

27.4. Part 2 of Schedule 4 to the Regulated Activities Regulations expands on good character as follows:

(g) Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence

(h) Whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

28. Suspension of Standing Orders

28.1 Except where this would contravene any statutory provision or any guidance issued by Monitor, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two thirds of the Board are present, including one Executive and one Non-Executive Director and that the majority of those present vote in favour of suspension.

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28.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

28.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and other Directors.

28.4 No formal business may be transacted while Standing Orders are suspended.

29. Variation and Amendment of Standing Orders

These Standing Orders shall be amended only if:

(a) A notice of motion under Standing Order has been given

(b) Approved by the Board of Directors

(c) The variation proposed does not contravene a statutory provision made by the Secretary of State or any term of the Trust's Provider Licence

(d) The amendment is made in accordance with the terms of the Trust's Constitution paragraph 45

30. Review of Standing Orders

These Standing Orders shall be reviewed annually by the Board of Directors. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

31. Notice

Any written notice required by these Standing Orders shall be deemed to have been given on the day the notice was sent to the recipient.

32. Disputes Resolution

32.1 The Council of Governors and Board of Directors must be committed to developing and maintaining a constructive and positive relationship. The aim at all times is to resolve any potential or actual differences of opinion quickly, through discussion and negotiation.

32.2 If the Chair cannot achieve resolution of a disagreement through informal efforts, the Chair will follow the dispute resolution procedure outlined below. The aim is to resolve the matter at the first available opportunity and only to follow this procedure if initial action fails to achieve a resolution:

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(a) The Chair will call a joint meeting (Resolution Meeting) of the members of the Council of Governors and Board of Directors, to take place as soon as possible, but no later than 20 working days following the date of the request. The meeting must comprise at least two thirds of the membership of the Council of Governors and at least two thirds of the membership of the Board of Directors. The meeting will be held in private. The aim of the meeting is to resolve the conflict. The Chair will have the right to appoint an independent facilitator to assist the process. Every reasonable effort must be made to reach agreement.

(b) If a Resolution Meeting of the members of the Council of Governors and Board of Directors fails to resolve a conflict, the Board of Directors will decide the disputed matter.

(c) If following the Resolution Meeting and any decision of The Board of Directors or The Council of Governors considers implementation of the decision will result in the trust failing to comply with the constitution or to act in accordance with provision made by or under Chapter 5 of the 2006 Act. A governor may refer the issue in accordance with paragraph 19 of the constitution

32.3 The right to call a Resolution Meeting rest with the following, in the Sequence of escalation shown:

(a) The Chair

(b) The Chief Executive

(c) Two thirds or more of The Council of Governors

(d) Two thirds or more of The Board of Directors

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Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Foundation Trust Network

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Model Election Rules 2014

For use in elections to FT councils of governors

Model Election Rules 2014

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PART 1 INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

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

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

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

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

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

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

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

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

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

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

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

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

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

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

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

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

"*telephone short code"* means a short telephone number used for the purposes of

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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.

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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.

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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.

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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:

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(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.

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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.

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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.

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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.

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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,

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("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,

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(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:

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(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

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(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;

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(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

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(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

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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

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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.

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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.

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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:

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(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.

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

39. De-duplication of votes

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

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

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

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

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

(a) mark the ballot paper "disqualified",

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

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

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

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

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

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

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

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

(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:

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(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.

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STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

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

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

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

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

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

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

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

or

(b) which is excluded by the returning officer under rule STV49,

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

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

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

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

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"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:
  (i) the use of such software for the purpose of counting votes in the relevant election, and
  (ii) a policy governing the use of such software, and
(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

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(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

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(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

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FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word "rejected" on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words "rejected in part" on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

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(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word "rejected" on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words "rejected in part" on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

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and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the

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next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing

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candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any

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stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are

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excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

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(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

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PART 7 FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

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(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.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

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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

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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

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(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

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PART 9 DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

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

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

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(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

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Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

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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.

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PART 11 QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor.

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as Monitor may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election.

66.6 If Monitor requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the person or panel of persons nominated in accordance with rule 66.7 shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 Monitor may prescribe rules of procedure for the determination of an application including costs.

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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

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(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.

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The Foundation Trust Network (FTN) is the membership organisation for NHS acute hospitals and community, mental health and ambulance services.

The FTN acts as the public voice for those NHS trusts, helping to deliver high quality care and shaping the system in which they operate.

The FTN has over 227 members – more than 92% of all NHS foundation trusts and aspirant trusts.

For further information contact John Coutts, Governance Advisor
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The Foundation Trust Network
Registered in England No 07525114
Registered Office
One Birdcage Walk, London SW1H 9JJ

Foundation Trust Network

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Board of Directors Meeting (PUBLIC)

24 April 2019, 13:30 to 15:30
Conference Room 1 & 2, Ferndene, Prudhoe, NE42 5PB

Attendees

Ken Jarrold (Chair), John Lawlor (Chief Executive), David Arthur (Non-Executive Director), Les Boobis (Non-Executive Director), Alexis Cleveland (Non-Executive Director), James Duncan (Executive Director of Finance and Deputy Chief Executive), Rajesh Nadkarni (Executive Medical Director), Gary O'Hare (Executive Director of Nursing and Chief Operating Officer), Lisa Quinn (Executive Director of Commissioning and Quality Assurance), Michael Robinson (Non-Executive Director), Lynne Shaw (Acting Executive Director of Workforce and Organisational Development), Peter Studd (Non-Executive Director)

In attendance

Debbie Henderson (Deputy Director Communications and Corporate Affairs), Jennifer Cribbes (Corporate Affairs Manager)

Meeting minutes

1. Service User/Carer Experience

Presentation

Ken Jarrold opened the meeting and welcomed those in attendance.

A special welcome was extended to Russell Bowman, Trust Governor for Neuro-Disability Services who was in attendance to share his personal experience as a Service User.

The Board thanked Russell for attending and sharing his powerful and insightful story.

2. Apologies

Verbal/Information
Chair

3. Declarations of Interest

Verbal/Information
Chair

4. Minutes of the previous meeting: Wednesday 27 March 2019

Decision
Chair

The Board agreed that the minutes of the 27 March 2019 were a true and accurate record of the meeting.

4. BoD meeting in public April minutes.pdf

5. Action list and matters arising not included on the agenda

Discussion
Chair

Action 26.09.18 (5) Crisis Team phone lines
Gary O'Hare provided an update in relation to the position will the Crisis Team phone lines. It was explained that work would be completed alongside NTW Innovations to ensure that the Trust obtains an improved telephone system which will now enable tracking and reporting of abandoned calls. It was agreed that the action would be deferred until July to allow the work to be completed.

Action 26.01.19 (14) Visit feedback themes report
Gary O'Hare advised that Anthony Deery had developed a new report which had been included at item 15 of this agenda.

5. BoD Meeting held in public Action List.pdf

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6. Chair's Remarks

Verbal/Information
Chair

Ken Jarrold provided a verbal update and referred to the recent Council of Governors meeting which hosted a visit from East London NHS Foundation Trust. Ken thanked Governors Margaret Adams and Anne Carlile who visited East London NHS Foundation Trust and developed a relationship with their Corporate Governance and People Participation Team. Ken explained that it was a very special meeting and made reference to the East London People Participation Team in which he commended them on their work. Ken explained that we could take learning from the East London Team to develop and improve NTW.

Ken advised that he had visited the Kinnersley inpatient rehabilitation service based at St Georges Park and was very impressed at the services it provides. Ken recommended that Non-Executive Directors visit the service in the near future.

The Board received and noted the Chair's Remarks.

7. Chief Executive's Report

Information
Chief Executive

John Lawlor spoke to the enclosed Chief Executive's report to provide the Board with Trust, Regional and National updates. John provided further details in relation to the transfer of North Cumbria Mental Health and Learning Disability Services to NTW, ongoing work to support the development of Mental Health services in Bengaluru, the Integrated Care System which included the position in relation to Provider Sustainability Funding.

The Board received and noted the contents of the Chief Executive's report.

7. CE Report April 2019 DRAFT.pdf

Quality, Clinical and Patient Issues

8. NTW Zero Suicide Plan

Discussion
Dr Uri Torres Consultant Psychiatrist

Dr. Uri Torres spoke to the enclosed report and presentation to update the Board in relation to the Trust's Zero Suicide plan. Detail was provided in relation to the National Suicide Prevention Strategy workplan, the Regional picture, the NCISH 10 Steps to Safer Services and NCISH Toolkit, Expected outcomes from our Zero Suicide Plan, Innovations, Risks, System Challenges and Evaluation of effectiveness.

Gary O'Hare thanked Dr Torres for her presentation and questioned if the Trust had links to the relevant Local Authorities. It was explained that NTW had developed some good relationship based on the expertise that we can offer.

Discussion took place in relation to the variances between Middlesborough and South Tyneside.

Damian Robinson explained that the Trust had been developing relationships and working well with Public Health. Damian referred to a recent meeting with Local Authorities that was hosted by NTW.

The Board received and noted the NTW Zero Suicide Plan.

8. NTW Zero Suicide Plan.pdf
8.1 NTW Zero Suicide Plan for Inpatient Services (002).pdf
8.2 TRUST BOARD PRESENTATION ZERO SUICIDE PLAN.pdf

9. Service User and Carer experience (Quarter 4)

Discussion
Executive Director Of Commissioning And Quality Assurance

Lisa Quinn spoke to the enclosed report to update the Board on the service user and carer experience feedback received for quarter 4. Lisa explained that there had been a slight decline in the quarter. However, there had been an improving trend month on month.

Discussion took place regarding the variation of results between localities. Gary O'Hare advised that he would raise the variation at the Business Delivery Group meeting.

The Board received and noted the Service User and Carer Experience report for quarter 4.

9. BoD Service User and Carer Experience Report Q4 201819.pdf

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10. Guardian of safe working hours

Decision
Executive Medical Director

Rajesh Nadkarni spoke to the enclosed report to update the Board on safe working hours of Junior Doctors, January to March 2019. Further detail was provided in relation to the junior doctor contracts, exception reports received for the period and agency locum bookings.

Rajesh highlighted that the Trust now has an additional 22 trainees employed directly by NTW who are working as Trust Grade Doctors and Teaching Fellows.

Rajesh advised that the Trust was working on a bid to obtain funds that had been allocated by Matt Hancock, Secretary of State as part of the BMA Fatigue and Facilities charter.

In response to a question raised by Ken Jarrold in relation the Emergency Rotas having been implemented on one occasion during the period in comparison to it being implemented 23 times during the last period, Rajesh explained it was a result of the 22 trainees directly employed by NTW as they have provided cover.

10.1. Guardian of Safe Working HoursTrust Board Q 1 Report April 2019.pdf
10.2 Q1 Jan to Mar 19 Final Report.pdf

11. Board Assurance Framework and Corporate Risk Register (Quarter 4)

Decision
Executive Director Of Commissioning And Quality Assurance

Lisa Quinn spoke to the Board Assurance Framework and Corporate Risk register and referred to the April Board Development meeting where changes had been proposed. Lisa explained the changes which included a risk being de-escalated from the Board Assurance Framework to Executive Level, changes to the risk description for the Board Assurance Framework risk and changes to the risk appetite statements.

Lisa explained that the changes had been reviewed at the Board sub-committees.

The Board received and approved the changes to the Board Assurance Framework and Corporate Risk Register.

11. Board BAF CRR Annual Review - Progress Report April 19 - amended following CDTR.pdf

12. Commissioning and Quality Assurance Report (Month 12)

Decision
Executive Director Of Commissioning And Quality Assurance

Lisa Quinn spoke to the Commissioning and Quality Assurance report to update the Board in relation to the Trust's position against the Single Oversight Framework (SOF).

Lisa highlighted that the number of adults waiting more than 18 weeks to access non-specialised services had increased in month 12 from 49 to 57. However, there had been a decrease in those waiting over 18 weeks for access to children's community services.

James Duncan spoke to the finance section of the report and confirmed that the Trust has a year to date surplus which is ahead of plan. James further explained that since the report was written, the Trust had received an additional £1.7m incentive funding.

John Lawlor highlighted the Trust's staff sickness position and noted that there had been a 0.5% reduction in sickness absence.

In response to a question raised by Les Boobis, Lisa explained that the consolidated end of year information is included in the Trust's Quality Account.

The Board recieved and noted the Commissioning and Quality Assurance Report for month 12.

12. BoD Monthly Commissioning Quality Assurance Report - Month 12.pdf

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13. Safer Care Report (Quarter 4)

Discussion
Executive Director Of Nursing/ Chief Operating Officer

Damian Robinson spoke to the enclosed report to update the Board on safety related activity for the period January to March 2019.

Damian referred to the report that showed a slight increase in the overall number of incidents reported in the quarter in comparison to the previous quarter. It was explained that all incidents were low-level concerns.

Damian explained that there had been a reduction in the number of complaints received during the year in comparison to 2017-18. However, a thematic review conducted showed an increase in the number of complaints received in relation to staff communication. It was explained that the results of the thematic review had been shared with the business units to support improvement.

In response to a question raised by Alexis Cleveland, Damian explained how complaints are categorised.

Les Boobis referred to the increase in employer liability claims and questioned if they had been occurring in a specific area in the Trust. Lynne Shaw clarified that they had not occurred in a specific area.

Discussion took place relating to the TalkFirst initiative, its importance, and impact.

The Board received and noted the contents of the Safer Care Report for Quarter 4.

13. Q4 Safer Care Report (including Learning From Deaths) - Final.pdf

14. Analysis of Natural and Unnatural deaths

Discussion
Executive Director Of Nursing/ Chief Operating Officer

Damian Robinson spoke to the enclosed report to update the Board in relation to the analysis conducted on Natural and Unnatural deaths. Damian explained that the analysis had been conducted on deaths recorded in the NTW SafeGuard system for the eight financial years 2010/11 to 2017/18.

It was explained that the suicide rate was slightly below the median value across England. However, there had been an increase in relation to deaths within addiction services.

In response to a question raised by Peter Studd, Damian explained that the decrease in inpatient deaths could be a consequence of the removal of ligature points.

Les Boobis questioned the number of deaths pending conclusion. Damian explained that the Trust is awaiting the coroner's decision.

James Duncan referred to the reduction of deaths occurring within three months of discharge from hospital and noted the improvement that the Trust was now achieving a follow up with those discharged within 3-4 days.

The Board recived and noted the Analysis of Natural and Unnatural deaths report.

14.1 Analysis of natural and unnatural deaths 2010-11 to 2017-18 (Front Sheet....pdf
14.2 Analysis of natural and unnatural deaths 2010-11 to 2017-18 (Board paper....pdf

15. Visit Feedback Themes (Quarter 4)

Discussion
Executive Director Of Nursing/ Chief Operating Officer

Gary O'Hare presented the report to update the Board on visits that had been undertaken by senior leaders during the last quarter and the issues raised.

Gary referred to the new format and structure of the report which is now presented by themes.

The Board noted that the report had improved.

The Board received and noted the Vist Feedback Themes report for the Quarter 4 period.

15. Visit Update - Q4.pdf

Workforce

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16. Staff Friends and Family Report (Quarter 4)

Discussion
Acting Executive Director Of Workforce And Organisational Development

Lynne Shaw spoke to the enclosed report to update the Board on the quarter 4 results of the Staff Friends and Family Survey. Lynne explained that there had been a slight decrease in responses during the quarter. However, there had been no change in the number of positive responses received for both questions. The key themes were explained to relate to staffing levels and waiting times.

Alexis Cleveland commented that it was reassuring that the identified themes were the issues that the Sub Committees of the Board concentrate on improving.

The Board received and noted the Staff Friends and Family Report for quarter 4.

16. Staff Friends and Family Test Qtr4 (2018-19) V1.1 2019.pdf

Strategy and Partnerships

17. CEDAR Project

Decision
James Duncan, Deputy Chief Executive/ Executive Director Of Finance

17.1. - Updated Strategic Outline Case

James Duncan spoke to the updated CEDAR Strategic Outline Case and reminded the Board that the Strategic Outline Case had been approved at the October Board meeting and submitted to NHSI at the end of November.

It was explained that the Trust had been requested to update the Strategic Outline Case to include further information and clarify the proposal.

Peter Studd referred to page 40 of the report that shows the Non-Executive Director as the Senior Responsible Officer. Peter raised the need for this to be amended as the Executive Director is the Senior Responsible Officer. James explained that this was an error and agreed to amend the report.

Subject to the change agreed, the Board recieved and approved the updated CEDAR Strategic Outline Case.

17.1.1 CEDAR SOC Cover Sheet.pdf
17.1.2 CEDAR SOC (NTW) (180419) (TB).pdf

17.2. - Approval of Interim Funding

James Duncan spoke to the enclosed CEDAR approval of interim funding report that set out the expenditure needed to complete the business cases and the enabling works at Northgate Hospital.

James provided detail in relation to the associated risks and explained that the CEDAR Board would be meeting the next day to consider the report.

Ken Jarrold commended the scheme stating its importance in terms of service provision.

The Board approved the request for interim funding as set out within the report. It was agreed that the Board would be consulted should the CEDAR Board suggest any amendments at their meeting.

17.2.1 CEDAR board paper.pdf
17.2.2 Cashflow Summary SRM-NTW 11-4-19 rev A.pdf

18. Integrated Care System Update

Verbal/Information
Chief Executive

John Lawlor provided a verbal update on the Integrated Care System plans applicable to NTW. John explained that the focus had moved towards Integrated Care Partnerships (ICP) in which NTW was a member of two (North and Central). It was explained that James Duncan is the NTW Executive working with the North ICP and Lisa Quinn is the NTW Executive working with the Central ICP.

The Board received and noted the Integrated Care System update.

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Regulatory

19. Quarterly Report to NHS I & submissions

Discussion
Executive Director Of Commisssioning And Quality Assurance

Lisa Quinn referred to the enclosed report to highlight to the Board the information submitted to external regulators for the quarter 4 period.

In response to a question raised by Alexis Cleveland and Les Boobis in relation to Capital Service Capacity, James Duncan explained that the debt in relation to the Ferndene site would be paid off in the next year which will improve the position.

The Board received and noted the Trust's quarter 3 position.

19. BoD Quarterly Report on NHS Improvement (Single Oversight Framework) Q4 2018-19.pdf

20. CQC Must Do Action Plans

Discussion
Executive Director Of Commisssioning And Quality Assurance

Lisa Quinn spoke to the enclosed reports up update the Board on the CQC Must Do Action Plan Quarter 4 position. Lisa explained that a number of actions had been completed since the last inspection which had been progressing well. It was explained that Clinical Audits would be conducted to understand the impact of the improvements made.

In response to a question raised by Alexis Cleveland, Lisa explained that the CQC would inspect those areas again as part of their regular inspection cycle.

The Board recieved and noted the CQC Must Do Action Plans update for the Quarter 4 period.

21. Contract update

Verbal/Information
Executive Director Of Commisssioning And Quality Assurance

Lisa Quinn provided a verbal update on the progress of the Contract update. Lisa confirmed that the documentation would be presented to the Board meeting in May.

The Board recieved and noted the Contract update.

Minutes/Papers for Information

22. Committee updates

Verbal/Information
Non-Executive Directors

Alexis Cleveland, Chair of the Quality and Performance Committee explained that there had been a lot of requests from staff to attend the Committee as an observer.

Ken Jarrold supported staff attending the Committee for their development and to gain an understanding of Governance.

Discussion took place relating to developing a waiting list or using Skype facilities.

There was nothing significant to note from other Committee meetings.

The Board received and noted the update from Committees.

23. Council of Governors' Issues

Verbal/Information
Chair

Ken Jarrold referred to the recent Governors meeting which hosted a visit from East London Foundation Trust. Ken invited Governors to comment on the meeting. Bob Waddell, Staff Governor, commented that it had been a very good meeting and that we could take learning from the East London Team to develop and improve NTW.

Ken Jarrold thanked the Governors present for attending the Board meeting.

24. Any other Business

Chair

There was no further business to note for this meeting.

25. Questions from the Public

Discussion
Chair

There were no questions from members of the public in attendance at this meeting.

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Date, time and place of next meeting:

26. Wednesday, 22 May 2019, 1:30 pm to 3:30 pm, St Nicholas Hospital, Jubilee Road, Gosforth.

Information
Chair

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Board of Directors Meeting (PUBLIC)

22 May 2019, 13:30 to 15:30
Board Room, St Nicholas Hospital, Gosforth, NE3 3XT

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

Attendees

Board members

Ken Jarrold (Chair), John Lawlor (Chief Executive), David Arthur (Non-Executive Director), Les Boobis (Non-Executive Director), Alexis Cleveland (Non-Executive Director), James Duncan (Executive Director of Finance and Deputy Chief Executive), Rajesh Nadkarni (Executive Medical Director), Gary O'Hare (Executive Director of Nursing and Chief Operating Officer), Lisa Quinn (Executive Director of Commissioning and Quality Assurance), Lynne Shaw (Acting Executive Director of Workforce and Organisational Development)

Apologies

Michael Robinson (Non-Executive Director), Peter Studd (Non-Executive Director)

In attendance

Jennifer Cribbes (Corporate Affairs Manager), Anna Foster (Deputy Director of Commissioning and Quality Assurance), Tony Gray (Head of Safety and Security), Debbie Henderson (Deputy Director Communications and Corporate Affairs), Damian Robinson (Group Medical Director, Safer Care)

Members of the Public

Bob Waddell (Staff Governor), Margaret Adams (Public Governor), Fiona Regan (Carer Governor), Mr Saint (Member of the Public)

Meeting minutes

1. Service User/Carer Experience

Information

Adam Watson delivered a verbal presentation to share his story and journey of recovery.

The Board thanked Adam for his very honest and open account of his experience and discussion took place in relation to the value of engaging with individuals with lived experience.

John Lawlor invited Adam to connect with the Trust to explore ways of helping to improve our services further.

The Board further thanked Adam and praised him for all his hard work.

2. Apologies

Information
Chair

Ken Jarrold opened the meeting and welcomed attendees.

Apologies were received from:
Peter Studd, Non-Executive Director.
Michael Robinson, Non-Executive Director.

3. Declarations of Interest

Information
Chair

There were no new conflicts of interest declared.

4. Minutes of the previous meeting: Wednesday 24 April 2019

Decision
Chair

The minutes of the meeting held on 24 April 2019 were agreed as a true and accurate record.

4. BOD Draft minutes 24 April 2019.pdf

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5. Action list and matters arising not included on the agenda

Discussion
Chair

Action List
There were no actions to review at this meeting.

Matters arising
There were no matters arising.

5. BoD Meeting held in public Action List.pdf

6. Chair's Remarks

Information
Chair

Ken Jarrold provided a verbal update and made the Board aware that the Trust is reviewing the way it engages with service users and carers. Ken stated the importance of engagement with service users and carers and explained the new approach that is being shaped with the support of Vida Morris.

The Board recieved and noted the Chair's remarks.

7. Chief Executive's Report

Information
Chief Executive

John Lawlor spoke to the enclosed Chief Executive's report to update the Board on key areas.

Detail was provided in relation to the transfer of service from North Cumbria, Contract update, Investors in People, ICS Mental Health Workstream Regional Workshop, Panorama programme on Whorton Hall Hospital, Newcastle Health and Care - System Leadership Development Programme, Capital Funding for 2019/20, Launch of Productivity Metrics for Mental Health Community Services, Primary Care Networks and the NHS Providers Briefing on the future of NHS Boards in respect of partnership arrangements.

Discussion took place relating to the re-accreditation of Investors In People (IIP) and the significant debate and consideration made to renew accreditation due to the associated costs. Alexis Cleveland confirmed that she was happy that the Trust had decided to renew the accreditation

Lynne Shaw explained the process and timescales and advised that the IIP assessors may request to meet with Board members.

The Board received and noted the Chief Executive's report.

7.1 CE Report May 2019 DRAFT.pdf
7.2 CE Report - Appendix 1.pdf
7.3 CE Report - Appendix 2.pdf

Quality, Clinical and Patient Issues

8. State of the North East 2018: Public Mental Health and Wellbeing

Group Medical Director, Safer Care

Damian Robinson spoke to the enclosed report to update the Board on the key areas in the recent publication of Public Health England “State of the North East 2018: Public Mental Health and Wellbeing” published in February 2019.

Further information was provided in relation to the big issues. Discussion took place relating to the issue of deprivation and Children's mental health.

A significant discussion took place relating to the correlation in respect of self-harm being a potential predictor of suicide. This was also discussed in relation to the Trust's Zero Suicide plan.

Rajesh Nadkarni observed that work can be conducted with Primary Care Networks to develop a regional approach.

Ken welcomed the report and raised the importance of working with Service Users and Carers. Damian was asked to keep the Board sighted on developments.

Ken Jarrold raised the concept of social wealth and explained strengths in the area which included good health services, high levels of social inclusion and green areas.

The Board recieved and noted the State of the North East 2018: Public Mental Health and Wellbeing report.

8.1 State of the North East 2018 - summary for Board May 2019 - cover sheet.....pdf
8.2 State of the North East 2018 - summary for Board May 2019.pdf

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9. Commissioning and Quality Assurance Report (Month 1)

Discussion
Executive Director Of Commissioning And Quality Assurance

Lisa Quinn spoke to the enclosed Integrated Commissioning and Quality Assurance Report for April 2019 (month 1) to update the Board on issues arising in the month and progress against quality standards.

It was explained that the Trust's position in month 1 was similar to the previous position at month 12. It was also explained that the Trust is performing well at an organisational level and that CCG and NHS England contracts had been signed.

Lisa brought the Board's attention to key challenges which included CPA metrics, access to services and clinical training targets.

James spoke to the finance section of the report and explained that the Trust's financial position at month 1 was broadly on track with the plan.

The Board received and noted the Commissioning and Quality Assurance Report (Month 1).

9. BoD Monthly Commissioning Quality Assurance Report - Month 1.pdf

10. Committees Terms of Reference

Decision
Executive Director Of Commissioning And Quality Assurance

Lisa Quinn spoke to the enclosed Committees' Terms of Reference report and explained that the Terms of Reference for Board meetings, Sub-Committees and Assurance meetings are reviewed on an annual basis. Lisa advised that all of the Terms of Reference had been reviewed by the relevant meetings prior to its inclusion in the report.

Lisa requested that the Terms of Reference for the Charitable Funds and Corporate Decisions Team be deferred to the October Board meeting to allow amendments to be made. The Board approved this request.

Alexis Cleveland requested an amendment to the Quality and Performance Committee Terms of Reference, to change the Non-Executive members from 2 to 3.

It was agreed that the amendment would be made and that Debbie Henderson would issue the approved Terms of Reference to the relevant individuals.

The Board recieved and approved the Terms of Reference.

10. Board Sub Committee ToR Annual Review 2019.pdf

11. Safer Staffing Levels (Quarter 4)

Discussion
Executive Director Of Nursing And Chief Operating Officer

Gary O'Hare spoke to the enclosed safer staffing report which included exception data and analysis of all ward staffing against safer staffing levels for Quarter 4.

Gary brought the Board's attention to the section of the report that highlighted wards that were outside of the agreed staffing levels during the quarter and the explanation for this within the narrative.

It was noted that there had been a reduction in Nursing Bank and Agency Usage.

Alexis Cleveland commented that the inclusion of narrative had improved the report and requested that future reports include any areas of concern.

The Board recieved and noted the Safer Staffing Levels report for the quarter 4 period.

11. Safer Staffing Levels Quarter 4 Report May 2019.pdf

Workforce

12. Workforce Directorate Quarterly update

Discussion
Acting Executive Director Of Workforce And Organisational Development

Lynne Shaw spoke to the enclosed quarterly Workforce report to update the Board on the key work and developments across the Trust.

Further information was provided in relation to the BAME recruitment event, work ongoing to support Reservists and Veterans and the new pay progression system for staff on agenda for change terms and conditions.

Lynne further made the Board aware that the Trust had been shortlisted for a Nursing Times Workforce Award for Pioneering oversees nurse recruitment in a mental health and disability NHS Trust.

The Board recieved and noted the Workforce Directorate Quarterly update.

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12. Quarterly Workforce Report - May 2019.pdf

13. Freedom to Speak Up (6mth update)

Discussion
Acting Executive Director Of Workforce And Organisational Development

Lynne Shaw spoke to the enclosed Whistleblowing/Concerns Raised report to update the Board on issues raised and logged by the workforce team between October 2018 and March 2019.

It was explained that 7 cases had been reported and categorised as raising a concern. However, there had been a further 12 cases that had been raised directly with the Freedom to Speak Up Guardian during the same period. Lynne explained that there had been an emerging theme in the concerns raised which related to staff attitudes.

Lynne advised that the Freedom to Speak Up Guardian had increased his days from 1 day to 2 days and that 16 more champions had been trained.

In response to a question raised by Margaret Adams, Lynne explained that Neil Cockling is well recognised and that there were a number of posters throughout the Trust with Neil's photo and contact details. It was explained that a further campaign was required to make staff aware of the Freedom to Speak Up Champions.

John Lawlor further shared that he receives a number of e-mails from staff raising their concerns which may indicate that staff feel comfortable to raise concerns with senior staff in NTW.

In response to a concern raised by Les Boobis, Gary O'Hare explained that there are two Freedom to Speak up Guardians in Cumbria.

Lynne further explained that staff are encouraged to raise issues at a local level and therefore there are likely to be a lot more raised than those centrally logged that are just dealt with by local managers.

Ken Jarrold referred to the emerging theme of staff attitudes and suggested that a focus group is held to explore this further alongside the recent staff survey feedback.

13. Board report Whistleblowing and Raising Concerns Update - Nov18 - March.pdf

Regulatory

14. Annual Security Management Report

Discussion
Executive Director Of Nursing And Chief Operating Officer

Tony Gray spoke to the annual Security Management Report to update the Board on the security arrangements currently in place within the Trust. Tony explained that it was the 11th annual Security Management Report and that there is no legal requirement for the report to be produced.

Further information was provided in relation to the Lone Working System and Body Camera pilot.

Tony explained that the Board would receive a live demo of the Lone Working system at the July Board Development Meeting.

Ken Jarrold asked when the Trust would receive the evaluation from the body camera pilot. Tony explained that the pilot would be taking place over the next 3 months and it would be likely that the evaluation would be received in 6 months. Gary O'Hare explained that body camera technology has real potential in terms of safety for staff and service users. Gary further advised that the Board could receive the evaluation in a report or at a Board Development Meeting.

Alexis Cleveland thanked Tony for his work.

John Lawlor asked if there was an agreed methodology for obtaining feedback from service users. Tony explained that there was an agreed approach and confirmed that Paul Sams, Peer Support Worker was leading on the piece of work to obtain service user feedback.

In response to a question raised by James Duncan, Tony explained that the way drug-related incidents had been reported changed during the reporting period. Therefore, the increase could be a result of the new reporting system as well as an increase in incidents.

14. Security Management Annual Report - Board of Directors v2 Final-22 May 2....pdf

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15. Board Self Certification to NHS Improvement (Condition FT4(8))

Decision
Executive Director Of Commisssioning And Quality Assurance

Lisa Quinn spoke to the enclosed Board Self-Certification to NHS Improvement report and explained that NHS Foundation Trusts are required by NHS Improvement to self-certify the declaration by 30 June 2019 to maintain their Provider Licence.

Lisa referred to the evidence provided within the report that demonstrates the Trust's compliance.

The Board was asked to confirm compliance in relation to Condition FT4(8) of the Provider Licence which confirms that the Trust has complied with required governance standards and objectives.

The Board approved that the Trust is compliant with Provider Licence Condition FT4(8).

15.1 BoD - FT4 - Corporate Governance Statement - Self Declaration.pdf
15.2 FT4 Self cert for signing.pdf

16. Provider Licence Self-Certification Annual Board Statement - Training of Governors

Decision
Deputy Director Communications And Corporate Affairs

Debbie Henderson spoke to the enclosed Board Self-Certification to NHS Improvement report in relation to Governor training. She explained that NHS Foundation Trusts are required by NHS Improvement to annually self-certify the declarations to maintain their Provider Licence. Debbie referred to the evidence provided which demonstrates the Trust's compliance and explained that NTW Governors are very active which was also recognised at the recent NHS Providers Governors showcase event.

Debbie advised that the Council of Governors, at their meeting on the 17 May 2018 confirmed that they are happy to recommend to the Board of Director's completion of the Board Statement, confirming that the Trust has provided the necessary training to its Governors during 2018/19.

The Board approved the Trust's compliance with Governors' Training.

16. Provider License Self-Cerr CoG training 2018-19.pdf

17. Board Self-Certifications G6(8) CoS7(3)

Decision
Executive Director Of Commisssioning And Quality Assurance

Lisa Quinn spoke to the enclosed Board Self-Certification to NHS Improvement report and explained that NHS Foundation Trusts are required by NHS Improvement to self-certify the declarations by 31 May 2019 to maintain their Provider Licence.

Lisa referred to the evidence provided within the report that demonstrates the Trust's compliance.

The Board was asked to confirm compliance in relation to Condition G6(3) of the Provider Licence which confirms that the Trust complies with the NHS Act 2009, Health Service Act 2012 and has regard to the NHS Constitution.

The Board was further asked to confirm compliance with Condition CoS7(3) that the Trust has the required resources available to provide services if providing commissioner requested services.

The Board approved that the Trust is compliant with Provider Licence Condition G6(3) and CoS7(3).

17.1 BoD - G6 and CoS7 - Compliance with Licence Declaration - May 2019 v2.pdf
17.2 G6 Self Cert for signing.pdf

18. Contract update

Discussion
Executive Director Of Commisssioning And Quality Assurance

Lisa Quinn spoke to the enclosed report to provide the Board with an update on 2019-20 contract negotiations. Lisa confirmed that NTW had agreed and signed all local CCG and NHSE contracts.

In response to a question raised by Alexis Cleveland, Lisa explained that the guidance relating to the Mental Health Investment Standard is now more specific.

The Board recieved and noted the Contract update.

18. Contracts Update 2019-20.pdf

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19. Quality Account Approval

Decision
Deputy Director Of Commissioing And Quality Assurance

Anna Foster spoke to the enclosed Quality Account Report and explained the extensive engagement process undertaken to support its development. Anna further explained that the draft Quality Account had been reviewed at a number of the Trust's sub-committees and Council of Governors meetings.

Anna explained that Trust auditors issued the Audit Committee with a draft assurance report in respect of the Quality Account and explained that the 2019-20 Quality Priorities had been approved by the Board in March 2019. The Board was asked to approve the Quality Report and the Statement of Directors' Responsibilities contained within the Quality Report.

Lisa Quinn thanked Anna, the team and Council of Governors who contributed to the development of the report.

Ken Jarrold, James Duncan, and Margaret Adams further commended the report.

Rajesh Nadkarni explained that he was pleased to see the inclusion of the Junior Doctors' Guardian within the report.

Alexis Cleveland requested an amendment to state 'one of 4' on page 3.

Ken Jarrold thanked Anna for her hard work developing the report.

The Board approved the Quality Account including the Statement of Directors' Responsibilities contained within the Quality Account Report.

19.1 BoD - quality acount 18-19 - Final version for Board May 2019.pdf
19.2 Draft Quality Account v2.2 Board version.pdf

Minutes/Papers for Information

20. Committee updates

Information
Non-Executive Directors

There was nothing to update from Committees.

21. Council of Governors' Issues

Information
Chair

Ken Jarrold commenced by referring to the work in relation to NTW's new approach towards engaging with Service User and Carers and advised that Governors would be closely linked with the process.

Ken made reference to the Council of Governors meeting on the 14 May and shared that he had been disappointed as a result of the acoustics in the room, room layout and the number of items on the agenda. Ken explained that work was ongoing to look at improving the meetings.

Ken informed the Board that Margaret Adams, Fiona Grant, Debbie Henderson and himself would be attending the Cumbria Partnership Council of Governors' General Meeting held in public on the 4 July 2019.

Margaret Adams updated the Board in relation to the recent NHS Providers Governors Showcase. It was explained to have been a very successful event with over 200 Governor delegates in attendance. Margaret described the amount of interest that the NTW stand had, particularly in relation to the membership phone cards, top tips and how we engage young members. It was further stated that other Trust's had thanked NTW for supporting them with their improvement journeys. They had also stated their appreciation to James Duncan.

Debbie Henderson informed the Board that work was commencing to update the Trust's constitution and Governors' constitution Group would be meeting regularly to complete the work.

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22. Questions from the Public

Discussion
Chair

There were no questions from the public.

23. Any other Business

Chair

Ken Jarrold extended a further thank you to Adam Watson for attending and sharing his story with the Board.

Date, time and place of next meeting:

24. Wednesday, 3 July 2019, 1:30 pm to 3:30 pm, Kiff Kaff, St Georges Park, Morpeth, Northumberland, NE61 2NU.

Information
Chair

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Draft Minutes

Board of Directors' meeting held in public		
Wednesday, 3 July 2019	**1.30pm – 3.30pm**	Kiff Kaff, St. George's Park Morpeth Northumberland NE61 2NU

Present:

Ken Jarrold	Chair
David Arthur	Non-Executive Director
Dr Leslie Boobis	Non-Executive Director
Michael Robinson	Non-Executive Director
Peter Studd	Non-Executive Director
John Lawlor	Chief Executive
James Duncan	Deputy Chief Executive / Executive Director of Finance
Gary O'Hare	Executive Director of Nursing and Chief Operating Officer
Lisa Quinn	Executive Director of Commissioning and Quality Assurance
Lynne Shaw	Acting Executive Director of Workforce and Organisational Development

In attendance:

Margaret Adams	Public Governor
Gail Bayes	Deputy Director NTW Academy
Jennifer Cribbes	Corporate Affairs Manager
Cllr Maria Hall	Appointed Local Authority Governor
Debbie Henderson	Deputy Director of Communications and Corporate Affairs

Apologies:

Alexis Cleveland	Non-Executive Director
Rajesh Nadkarni	Executive Medical Director

Agenda Item		Action
1	**Service User/Carer Experience** Michelle Smitheram, Ward Manager, Kinnersley Ward, St. George's Park delivered a presentation to update the Board on the recently established St George's Park Rehabilitation Carer Group. In response to a question raised by John Lawlor relating to lessons learned from the implementation of the group, Michelle explained that a lot of work had been undertaken to ensure that the carers group was well advertised. This included contacting carers by post and telephone to explain that the group is focused on supporting carers and that the meetings are informal.	

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	Gary O'Hare enquired if there had been any carers who had continued to attend after the person they care for had been discharged from inpatient care. Michelle confirmed that that there was a carer who had continued to attend. Michelle explained that any carer can attend for as long as they would like to; irrespective of whether the person they care for is within inpatient care or being cared for in the community. James Duncan asked if they had been trying to engage with those hard to reach. Michelle explained that the team is continuing to mention the group to those hard to reach. It was further explained that the named nurses were providing carers with the details to the group during the weekly telephone call they make. Margaret Adams congratulated Michelle on the work completed and suggested that Michelle link in with the Carer, Service User and Involvement Team. Ken Jarrold thanked Michelle on behalf of the Board and praised the work that had been completed to support carers. Ken particularly highlighted that he was pleased with the inclusion of all carers.	
2	**Welcome and apologies** Ken Jarrold opened the meeting and welcomed attendees. Apologies were received from: Alexis Cleveland, Non-Executive Director. Rajesh Nadkarni, Executive Medical Director.	
3	**Declarations of interest** There were no new conflicts of interest declared.	
4	**Minutes of the previous meeting: Wednesday 22 May 2019** The minutes of the meeting held on 22 May 2019 were agreed as a true and accurate record.	
5	**Action list and matters arising not included on the agenda** **<u>Action List</u>** **Action 26.09.19(5) Crisis Team phone lines** Gary O'Hare commenced by reminding the Board of the position in relation to the Crisis Team phone lines. Gary explained improvements that had been made which included the removal of the answer phone and introduction of reporting systems to monitor calls. **<u>Matters arising</u>** There were no matters arising.	
6	**Chair's Remarks** Ken Jarrold provided a verbal update and made the Board aware of a number of national developments that had occurred since the last	

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	Board meeting. These included the publication of the NHS Long Term Plan Implementation Framework, NHS Interim people plan and the Labour Party's pledge to introduce a Future Generations Wellbeing Act. Ken stated that he was very encouraged by the recognition of workforce issues and the future direction of the NHS. **The Board received and noted the Chair's remarks.**	
7	**Chief Executive's Report** John Lawlor spoke to the enclosed Chief Executive's report to provide the Board with Trust, Regional and National updates. John provided further details in relation to the transfer of North Cumbria Mental Health and Learning Disability Services to NTW, current position in relation to Learning Disabilities services, the Trust's Pedometer challenge and the ICS status awarded for the North East and North Cumbria. James Duncan spoke to the CEDAR update section of the report and confirmed that the strategic outline case had been approved. John Lawlor provided further detail in relation to the North Regional Talent Board, NHS Pensions and related issues, MIND Analysis of NHS Mental Health Spending and Designing Integrated Care Systems in England. Ken Jarrold commented that he was pleased to see the focus on talent management and also on social prescribers. **The Board received and noted the Chief Executive's report.**	
Quality, Clinical and Patient Issues:		
8	**Service User and Carer Strategy** Ken Jarrold introduced Margaret Adams, Governor and thanked her for the detailed presentation delivered to the Board within the Development Meeting held earlier that day. Margaret Adams introduced the Service User and Carer Strategy and requested the Board's approval to enable the strategy to be adopted by the Trust. The Board thanked everyone who had been involved in the development of the strategy. Ken commended the strategy and explained that the Trust takes service user and carer experience very seriously. **The Board approved the Service User and Carer Experience strategy.**	

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9	**Commissioning and Quality Assurance Report (Month 2)** Lisa Quinn spoke to the enclosed Integrated Commissioning and Quality Assurance Report for May 2019 (month 2) to update the Board on issues arising in the month and progress against quality standards. Lisa commenced by highlighting that the Trust had received one Mental Health Act reviewer visit report since the last meeting. Lisa referred to the outstanding action relating to access to outside space and explained that building work had been recently approved which will allow access to outside space where not available. The position in relation to the number of people waiting more than 18 weeks to access services was explained to have reduced in both non-specialised adult services and children's community services in Newcastle/Gateshead. Lisa advised that the provisional sickness figure for April 2019 is 5.0% which is in line with the Trust's target. Lisa highlighted that there had been an increase in out of areas placements during the month which had subsequently increased the pressure on inpatients services. David Arthur highlighted an error in the sickness figures where 10 May 2018 should be 10 May 2019. James Duncan spoke to the finance section of the report and explained that the finance position at month 2 was slightly ahead of plan. James highlighted the small deficit and explained that it had been a result of the one-off payment that had been provided to agenda for change staff who are at the top of their scale. James further explained that the Trust had overspent on bank and agency staff during the month and an update will be provided at the end of the quarter. Peter Studd commented on the improvement in relation to staff sickness figures. A discussion followed relating to the Trust's target of 5% and if the target should be reviewed. **The Board received and noted the Commissioning and Quality Assurance Report (Month 2).**	
Strategy and Partnership:		
10	**Risk Management Strategy** Lisa Quinn spoke to the enclosed report to update the Board on the Trust's progress in relation to the Risk Management ambitions outlined in the strategy. It was explained that the progress provided had been completed on the current NTW footprint. However, from 1st October 2019, Cumbria will also be included within the review. **The Board received and noted the Risk Management Strategy update.**	

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Workforce		
11	**An NHS Workforce for the Future - Our Interim People Plan** Lynne Shaw spoke to the enclosed report to update the Board on the recently published document 'An NHS Workforce for the Future - Our Interim People Plan'. Lynne provided further detail on the structure of the plan, key themes, workforce shortages and creation of new 'skill mix' roles to support the emerging models of care. Lynne referred to the section of the report that provided detail on related work currently being undertaken within NTW. Les Boobis referred to the current concerns associated with the NHS Pension scheme and commented on the conflict it has with the purpose of the Interim People Plan. John Lawlor explained that there were a number of discussions taking place with respect to the NHS final Pension Scheme and the associated tax implications. Ken Jarrold commended the Interim People Plan and focus it has on the NHS workforce. Peter Studd referred to the section of the report on retention and recruitment and stated that he was pleased with the increase in exit survey response rates. Lynne explained that the Board would be provided with further information at a future Board meeting. **The Board received and noted the update on the published 'An NHS Workforce for the Future - Our Interim People Plan' document.**	
12	**NTW Academy – Board Update** Gail Bayes spoke to the enclosed report to update on the progress made by NTW Academy. Gail explained that the Academy had increased the use of technology and detail was provided in relation to the benefits this had brought to the Trust. These included saving a significant number of clinicians' hours as a result of developing online training as opposed to using a traditional face to face approach where clinicians would spend time traveling to a venue. A further update was provided on the launch of the degree level nursing apprenticeships which was explained to have been very successful with good feedback having been received. Gail explained that going forward, there will be two nursing apprenticeship programmes per year and that Cumbria will be included in the next cohort. Gary O'Hare explained that Sunderland University would remain to be the University provider for the next cohort as Cumbria University is not yet in a position to support the programme. Peter Studd commended the work undertaken by the Academy and questioned if the Academy would be subject to OFSTED inspections. Gary	

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	O'Hare explained that the universities were the provider and that they would be subject to the OFSTED reviews. Peter further questioned the completion and retention rates for those on NTW Academy apprenticeships and asked if the Academy would be in the position to provide the Board with a report that contains recruitment and retention data. Gail explained that all individuals on the apprenticeship schemes were also employees of NTW and a pledge has been developed to encourage retention. It was confirmed that no apprentices had withdrawn from the programme to date. Gary O'Hare explained further benefits which included the ability to recruit and develop staff with values that are aligned to the Trust. James Duncan praised the work completed by the Academy and commented that although the development of the nursing apprenticeship was a risk due to being a new approach, the scheme is already demonstrating its worth and potential. Gail further explained that the Academy had received a number of requests to develop courses including a request from AHP colleagues to develop an AHP pathway. It was explained that the Academy is working in line with the Workforce Plan. Ken Jarrold praised the work conducted and highlighted the benefits of the apprenticeships which allow individuals to develop and become qualified whilst working and earning a wage. This was also said to be a benefit to NTW and subsequently our Service Users and Carers as we develop a strong workforce with good experience. **The Board received and noted the NTW Academy update.**	
13	**NTW Academy – Opportunities for the Development of Managers and Leaders** Gail Bayes spoke to the enclosed report to update the Board on NTW Academy development opportunities for Managers and Leaders. Gail provided background information on the development that has been provided by the Trust and explained that two risks had been identified. It was explained that the risks relate to people progressing into band 7 and associate director roles. Gail provided information on the development of the Trust's talent management approach to career progression and explained the proposal to run two development programmes one for band 5/6 level staff (to develop into Band 7 roles) and another for band 7/8a level staff (to develop into associate director roles). Gail further explained that each participant would be provided with a mentor who they will be able to shadow to gain practical experience. Finally, Gail provided information on a potential third option where prospective managers could undertake practical learning without pursuing an academic qualification. It was explained that this might also provide opportunities to those with academic qualifications who lack experience or confidence to pursue a more senior role.	

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	John Lawlor commented that he felt it was important to include the third option. Lisa Quinn further supported the third option as it provided opportunities for clinical and non-clinical staff. Lynne Shaw commented that she was very supportive of the whole approach which aligns to changes with regional and national talent management approaches. Gary O'Hare explained that the Academy will provide each individual with a quality assured mentor who will support and shape their development. Peter Studd referred to the national graduate management scheme and asked if NTW would still be supporting the scheme. Discussion took place relating to the advantages and disadvantages of the national scheme. Gail highlighted that the Academy was developing bespoke training for our staff and provided the example that participants who already have a degree would be provided with the opportunity to complete a masters course. In response to a question raised by Les Boobis, Gail explained that backfill would not be provided to cover whilst individuals are completing Academy studies as there is a percentage of time built into each department that allows for staff development. Discussion took place in relation to the benefits of those being out on academic studies as it can provide the individual next in line the opportunity to act up and gain experience in a more senior role. Ken Jarrold commented that he would like the Trust to remain involved with the national graduate scheme. Ken further explained the importance of developing our people which will, in turn, have a positive impact on staff morale, sickness and the quality of care provided. Ken stated that people development was a passion of his and that he would be happy to help and support the work of the Academy. **The Board received and noted the NTW Academy – Opportunities for the Development of Managers and Leaders update.**	
Minutes/Papers for Information		
14	**Committee updates** There was nothing to update from Committees.	
15	**Council of Governors' Issues** Ken Jarrold commenced by providing an update on the work of the Governors' Nominations Committee. Ken explained that the Committee members had been conducting a significant piece of work to recruit to the vacant Non-Executive Director position. Ken thanked everyone involved for their hard work. Ken further advised that he would be attending the Cumbria Partnership Trust Council of Governors meeting the following day alongside Debbie	

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	Henderson, Deputy Director of Communications and Corporate Affairs, Fiona Grant, NTW Lead Governor and Margaret Adams, NTW Deputy Lead Governor. **The Board received and noted the Council of Governors' Issues.**	
16	**Any Other Business** There was no other business to discuss.	
17	**Questions from the public** Anne Clarke, member of the public in attendance, commended the work of NTW Academy and enquired if online training could be developed for carers. Gail Bayes explained that the Academy had received a number of requests for training and organised to speak to Anne to explore this further.	
18	**Date, time and place of next meeting** Wednesday, 7 August 2019, 1:30 pm to 3:30 pm, Training Room 4, Hopewood Park, Waterworks Road, Ryhope, Sunderland, SR2 0NB.	

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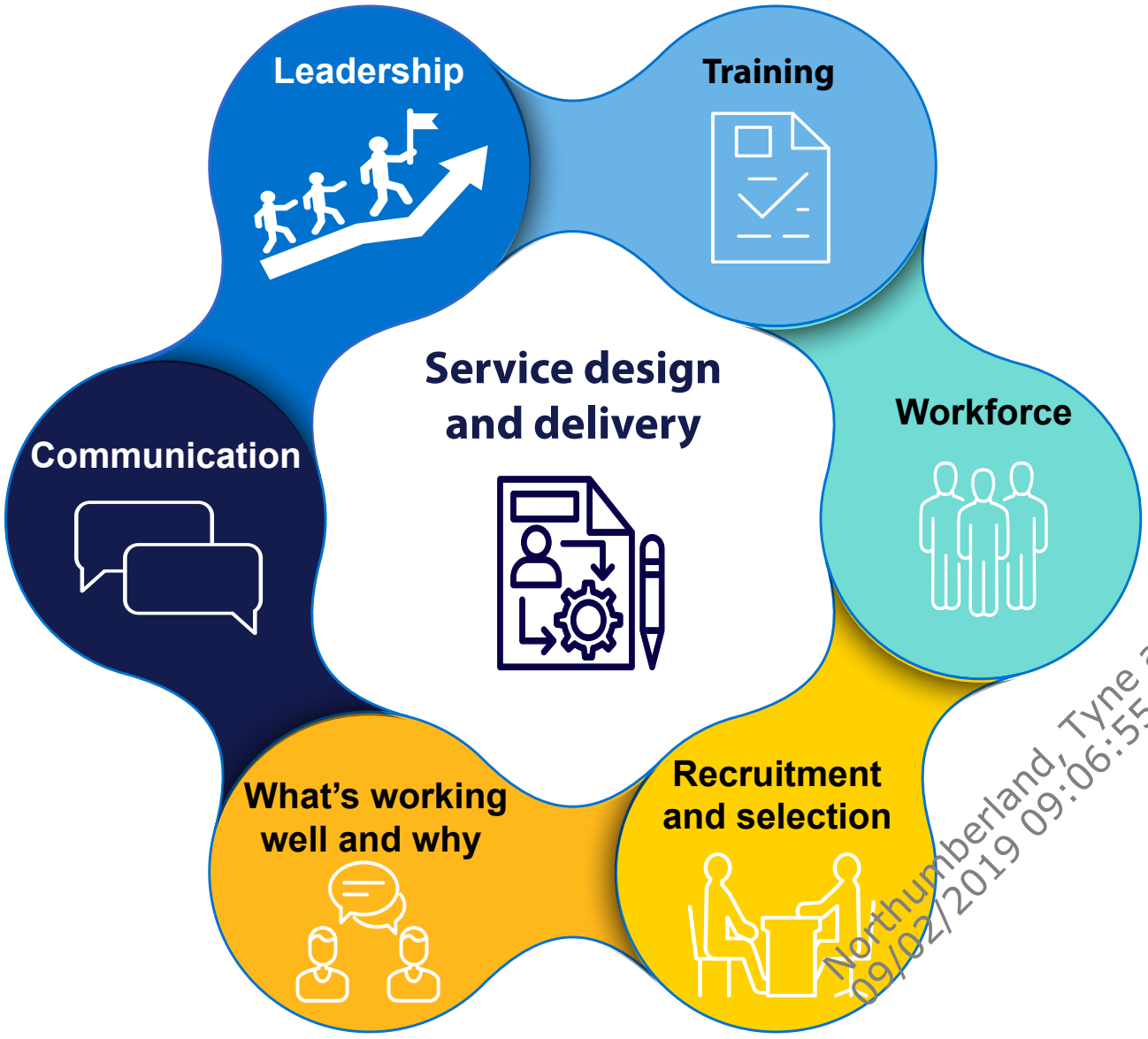
Together:

Service user and carer involvement strategy



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Background

This strategy builds upon the previous Service User and Carer Involvement Strategy (2016).

The involvement and engagement of service users carers and staff has been implicit throughout the development of this strategy. This has been achieved through joint workshops, discussion groups and development sessions. Across all of the engagement events conversations have been encouraged amongst people in attendance to consider and respond to the following key questions:

- What does ideal involvement look like?
- What has worked well/not worked so well in the past?
- How do we get to where we want to be?

Appendix one provides the detail behind the strategy development.

Context

The NHS five year forward view says that we need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services. The latest report from NHS England states 'Making progress on our priorities and addressing the challenges the NHS faces over the next two years cannot be done without genuine involvement of patients and communities.'

Traditional approaches to the way we deliver care arguably emphasises the expertise of health and care workers. It is important to acknowledge that there are two sets of experts: experts who have professional training and acquired experience, who make the best use of research and theories and experts who have personal lived experience of distress (or of caring for a loved one) and recovery, discovery and resilience.

It is important that we recognise expertise by lived experience on equal terms as professional expertise. This suggests a different kind of relationship between health professionals and service users.

It's about involvement:

- Ensuring that service users and carers are at the heart of everything we do
- Sharing knowledge and expertise
- Working with service users and carers as equal partners

NHS England defines service user and carer involvement as:

- "The process by which people who are using or have used a service become involved in the planning, development and delivery of that service."

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Our definition of involvement:

When we asked people 'what is involvement?' they said:

- Wherever possible service users and carers collaboratively work **together** with staff in the design, delivery and development of services **(Service design and delivery, workforce)**

- Service users, carers and staff work **together** to make sure that the Trust is able to deliver and develop services that are safe, effective, caring, responsive and well-led (**What's working well and why?)**

- It's about dialogue: being listened to, feeling valued, sharing our views, coming to a mutual understanding, making decisions **together** and working **together** to implement solutions and developments **(Communication)**

- Service users, carers and staff work **together** to make sure that the people we employ share our values and have the skills that are required of them to do what is needed and to develop our work **(Recruitment and selection and training)**

- Service users, carers and staff are **together**, recognised as leaders and given equal opportunity to develop their leadership capabilities **(Leadership)**

When we asked people to identify the signs that involvement is working, they said:

"It's about a change in culture: We need to see and feel that things are different. This should be demonstrated through the words and actions of everyone."

Involvement is about making sure that we

- Devolve power, choice and control to people using services, their carers, communities and to frontline clinical staff. It's about us all working together
- Regard the people who use and deliver our services as an asset, as contributors, as a resource
- Encourage service users, carers and frontline clinical staff to take more responsibility and to share the responsibility for the way we deliver care and manage our services together
- Do all that we can encourage active participation in all that we do

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Involvement is not about

- Asking for service users and carers opinions on ideas, plans, or proposals developed by health and care staff
- Offering choice between options developed by health and care staff
- Asking service users and carers 'what do you want?' with the expectation that health and care staff will be expected to deliver this and then defending your inability to deliver by saying, 'yes, but…'
- Inviting 'one or two' service users or carers onto committees or interview panels
- Defining this group of people only by their status as 'consumers' of services and not by the attributes they may have

Why is this strategy of relevance, now?

The Trusts strategy, **Caring, Discovering, Growing: Together** highlights both the challenges and opportunities that we need to address over the next five years. This means everyone working differently and 'smarter'. It means altering or completely reshaping services giving people better quality and experience for less money. It means reinvesting any money saved in more and better services and so extending access to care. Only by getting everyone involved and working together, will a network of services be provided which can meet the changing needs of people in the 21st century within the limits of the budgets available. Our Trust is committed, as part of this strategy to work with service users and carers in partnership, to provide excellent care, supporting people on their personal journey to wellbeing.

"Service users and carers should be at the heart of everything we do and getting this right is the single most important thing we can do to achieve our strategic ambitions."

NTW Five Year Strategy, 2017

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Together, service user and carer involvement strategy - strategy on a page

Our seven strategic ambitions:

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Embedding the strategy: Making it feel real

Strategies feel real when they become embedded into the way we work; when people start to take practical actions.

1. The first step is to talk to others about the strategy, to have conversations together. Not everyone will agree with the content and some may perceive the ambitions as a threat to the way they work.

2. The second step is for each and every one of us to think about what each of the ambitions means and to reflect on what we might need to do in order to achieve our ambitions. Change happens because we want it to.

3. The third step is for groups of service users, carers and staff to talk about the strategy together. To agree on and to develop joint actions. To work together.

4. The fourth step is for the organisation, as a whole, to think about what it might need to do differently, in order to support the embedding of the strategy. Staff should not do this in isolation however, all staff (including corporate and business teams) need to think about how they involve service users and carers, as equal partners, in this work. Working together.

Along the way we need to bring people with us, we need to embrace and support each other and recognise that change means different things to different people. This strategy will challenge the beliefs of some people. We cannot legislate for its implementation. Change will happen because the time is right and because people want to change.

How will we know we have made a difference?

We have identified a series of strategic ambitions that identifies way forward, and have emphasised the importance of everyone making sure that the doing of it, is part of their business. So far we have heard about many practical suggestions from those of you who have attended some of the engagement events that might help us to embed the strategy; to make it real. We don't want to be prescriptive about this though. We want you to drive these changes. We will do what we can to support you and our Council of Governors and Board of Directors will ensure that we are able to deliver on it.

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Glossary of terms used:

Co-production - Co-production is where service users, carers and staff share power to plan and deliver services together, recognising that both partners have a vital contribution to make. Co-production acknowledges that service users and carers are experts in their own circumstances and capable of making decisions, while professionals must move from being fixers to facilitators. Co-production requires a relocation of power towards service users and carers. Where activities are co-produced, both services and communities become far more effective agents of change.

Engagement - Engagement is about understanding and involving the different groups interested or impacted by the work you do, and building relationships with them. The purpose can be to develop a long-term conversation and dialogue, or to reach a specific goal through collaboration. But good engagement isn't a tick-box exercise – it needs to employ different routes and techniques to reach groups and make sure they are involved. Engagement is about listening, hearing and attending to needs and by doing so we value, care for and respect others.

Equal partners - Ensures that the people who use our services, our staff, partner agencies and the wider public are fully engaged and involved in all aspects of the planning, shaping and delivery of our services; and that individuals are fully involved in their own care and support. Equal partners covers many levels of involvement and inclusion, each implying a different level of relationship between service providers, patients/service users, carers and citizens.

Inclusion - Inclusion is 'the state of being included.' It is used by rights activists to promote the idea that all people should be freely and openly accommodated without restrictions or limitations of any kind. It is described by some as the practice of ensuring that people feel they belong, are engaged, and connected. It is a universal human right whose aim is to embrace all people, irrespective of race, gender, disability or other attribute which can be perceived as different.

Involvement - Service user involvement is the active participation of a person with lived experience of distress in shaping their personal health plan, based on their knowledge of what works best for them. As the wider benefits of inclusion have become apparent and recognised, it has also come to mean the active inclusion of the perspectives of service users collectively in the design, commissioning, delivery and evaluation of services, as well as in policy development locally and nationally. This has been the accepted definition for many years, though progress towards achieving genuine service user involvement across the health sector has been gradual.

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Membership is completely free and as a member you can:

- Give your views on the Trust's plans and any issues that interest you
- Vote in the governor elections or stand as a governor yourself
- Receive regular information about the Trust

If you you would like to know more about the Service user and carer involvement strategy please contact the: Patient and Carer Engagement Team: 01670 501 816

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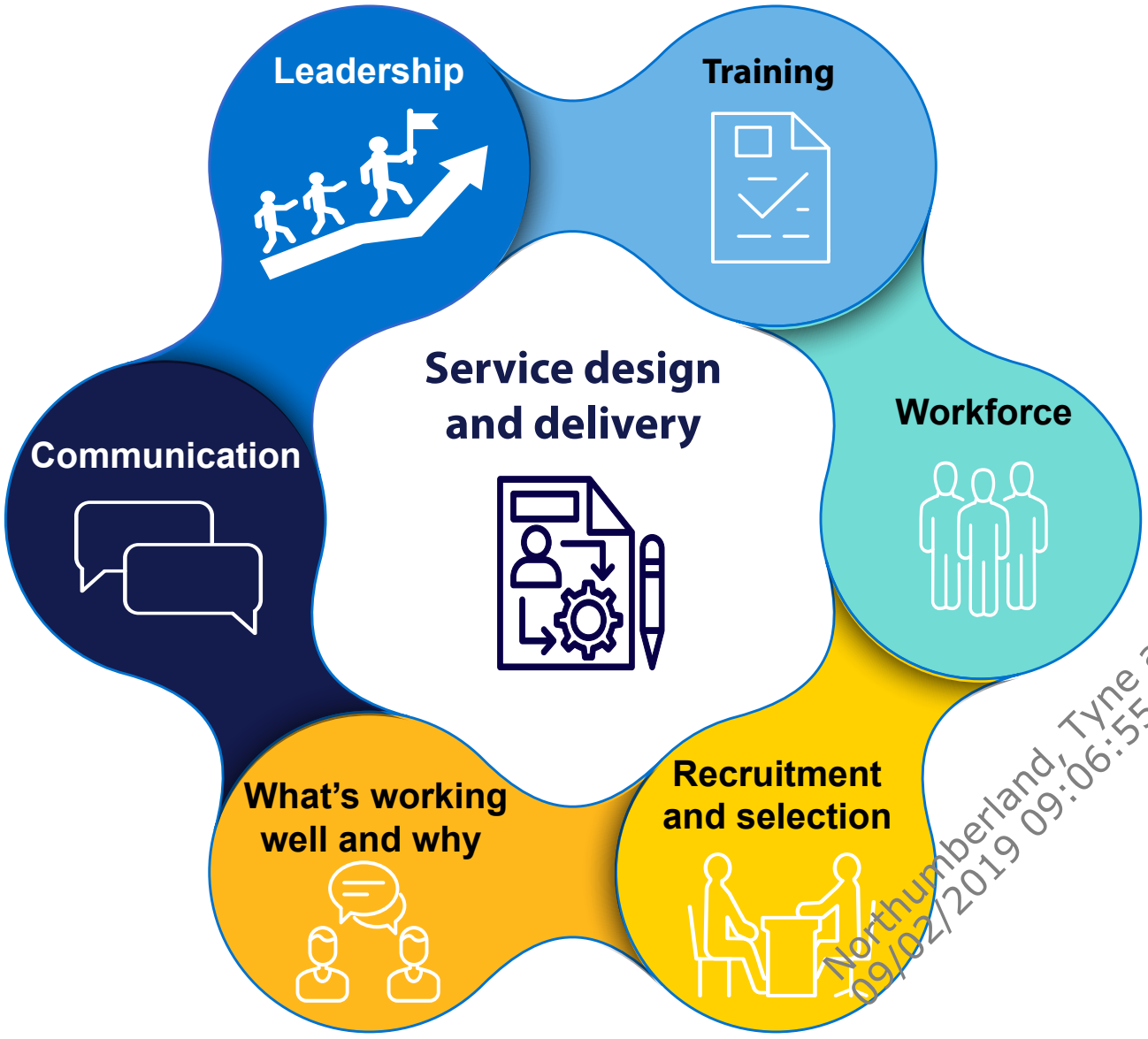
Developing the service user and carer involvement strategy

Appendix 1



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These are peoples comments on developing the strategy. When we asked people to identify how we might achieve each of the strategic ambitions, this is what they said:

Service design and delivery – this is what we heard:

What does ideal involvement look like?

- Service users and carers are involved, as equal partners, in the design, delivery and evaluation of the way that care is provided

What has/has not worked in the past?

- Has: Some good examples of work e.g. recovery colleges
- Hasn't: This is not locally consistent

How do we get to where we want to be?

- Harness and learn from examples of good practice and build on it
- Grass roots involvement of service users and carers in all aspects of the way that care is shaped and delivered
- This ambition needs to be owned by everybody; built into the personal objectives of staff and teams, and we need to give serious consideration as to how we can nurture and support service users and carers to feel like they can make a difference and learn from their experiences, good and not so good

Training – this is what we have heard:

What does ideal involvement look like?

- Service users and carers are involved in the design and delivery of training and development initiatives

What has/has not worked in the past?

- Has: Examples of successful initiatives involving service users and carers leading on or co-producing training
- Has: Recovery college volunteers
- Has: Service user deliver insight/awareness into the pathway for individuals, tell the story, make it real at the Carer Champion Forum
- Hasn't: Some examples of good work but this is not consistent; not enough opportunities

How do we get to where we want to be?

- Go back to the beginning, grass roots, get the basics right
- Involvement needs to be at the heart of training and development initiatives

Communications – this is what we have heard:

What does ideal involvement look like?

- Service users and carers help shape the way that we communicate – helping to develop effective, accessible, targeted, meaningful and jargon free methods of communication

What has/has not worked in the past?

- Has: Service user involvement in the 'Write To Me' pilot to reduce the jargon and the ensuring that letters are sent to them first and copied to the GP
- Hasn't: Some good examples of work but this is not consistent
- Hasn't: Communication is often jargon laden and 'hit and miss,' it is not always easy to speak to the right person at the right time

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How do we get to where we want to be?

- Harness and learn from what is good and build on it
- Involvement in the design and delivery of the Trust's communications strategies, communication tools and initatives

What works well and why - this is what we have heard:

What does ideal involvement look like?

- Service users and carers are involved, as equal partners, in all aspects of the assurance process - to ensure that our services are safe, effective, caring, responsive to people's needs and well led
- Examples of monitoring and evaluation initiatives could include meaningful involvement with Points of You questionnaire and the Care Quality Commission (CQC) inspection process

What has/has not worked in the past?

- Has: Service user identified for each ward area to assist in collecting feedback
- Hasn't: From the engagement work completed to date, few examples have been given. Question was asked; has service user and carer monitoring become a thing of the past? Clarity over what the word 'assurance' means was requested

How do we get to where we want to be?

- Grass roots involvement of service users and carers in all aspects of the assurance, monitoring and evaluation process; what's working well and why?

Recruitment and selection - this is what we have heard:

What does ideal involvement look like?

- Service users and carers involved in all aspects of the recruitment and selection process – designing jobs and job adverts, and developing interview questions, being on panels, being informed of outcomes

What has/has not worked in the past?

- Has: Some involvement in designing questions and on panels
- Hasn't: This is not consistent

How do we get to where we want to be?

- Involvement should not be an afterthought
- Develop a bank of people who want to and can be involved

Workforce - this is what we have heard:

What does ideal involvement look like?

- Service users, carers and staff have lived experience, and are valued for their unique insights and acquired expertise
- Service users and carers are employed on the basis of the contribution that they can make

What has/has not worked in the past?

- Has: Employment of peer support workers
- Has: Time to Change campaign
- Has: Volunteers participating in recovery colleges

How do we get to where we want to be?

- Review/revise recruitment and selection processes
- Grass roots involvement of service users and carers in workforce planning, policies and procedures

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Leadership - this is what we have heard:

What does ideal involvement look like?

- Leadership development has a key role to play in improving our ability to deliver great care. Service users and carers have unique insights and acquired expertise and need to be embraced, as equals, as leaders
- Leadership development initiatives should be open to and directed at enhancing the capabilities and maximising the contribution of service users and carers

What has/has not worked in the past?

- Has: Successful programmes developed and provided for over 140 people in past five years
- Has: We have a dedicated resource and a committed number of people who want to make this work
- Has: We have more initiatives planned and have network of service users, carers and staff working on this, supported by key organisational leaders
- Has: The Trust is leading the way regionally and asking the local leadership academy to support the development of leadership initiatives for service users and carers
- Hasn't: Joint programmes comprising service users, cares and staff have not always worked well

How do we get to where we want to be?

- Continue to co-produce leadership development initiatives open to service users and carers
- Ensure service users and carers are afforded the same opportunities as staff, and that this is backed up at a regional and national level

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