Council of Governors

3 November 2022 | 10.00am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	10.00am	Verbal	Noting	P O'Neill
2.	Apologies for absence	10.01am	Verbal	Noting	P O'Neill
3.	Declaration of interests	10.02am	Verbal	Noting	P O'Neill
4.	Minutes of the previous meeting held on 28 July 2022	10.03am	✓	Approval	P O'Neill
5.	Matters arising and action log update	10.04am	✓	Noting	P O'Neill
6.	Chairman and Chief Executive's opening remarks	10.05am	Verbal	Noting	P O'Neill/ G Doherty
7.	Update from Subgroup Chairs	10.20am	Verbal	Noting	J Miller/ P Spadlo
8.	SAFETY AND QUALITY				
8.1	Ockenden update	10.30am	✓	Noting	S Cullen
8.2	Infection prevention and control annual report 2021/22	10.40am	✓	Noting	S Cullen
8.3	Winter planning update	10.50am	Verbal	Noting	F Button
9.	STRATEGY AND PERFORMANCE				
9.1	Patient Experience Strategy 2022-25	11.00am	✓	Noting	S Cullen
9.2	New Hospitals Programme update	11.15am	✓	Discussion	J Hawker
10.	GOVERNANCE AND COMPLIANCE				
10.1	Trust Constitution	11.25am	✓	Approval	J Foote
10.2	Feedback on Chair's and Non-Executive Directors' 2021/22 appraisals	11.35am	Verbal	Noting	P O'Neill
10.3	Re-appointment of Non-Executive Director	11.45am	✓	Approval	J Foote

№	Item	Time	Encl.	Purpose	Presenter
10.4	Register of interests	11.55am	✓	Approval	J Foote
10.5	Non-Executive Director update – Finance and Performance Committee Chair	12.00pm	Pres	Noting	T Whiteside
10.6	Non-Executive Director update – Audit Committee Chair	12.10pm	Pres	Noting	T Watkinson
10.7	Update on hybrid virtual meetings for Council Workshops and Development Sessions	12.20pm	Verbal	Noting	J Foote
10.8	Council Development Plan 2021/22 update	12.25pm	✓	Noting	J Foote
11.	ITEMS FOR INFORMATION (taken as read)				
11.1	Clinical Services Strategy		✓		
11.2	Corporate and Governor Calendar 2023-24		✓		
11.3	Governor opportunities and activities summary		✓		
11.4	Governor issues report		✓		
11.5	**Minutes of Governor Subgroups**: (a) Care and Safety Subgroup – 14 July 2022 (b) Membership Subgroup – 6 June and 8 August 2022 (c) Chairs, Deputy Chairs and Lead Governor – 4 July 2022		✓		
11.6	Date, time and venue of next meeting: *26 January 2023, 1.00pm, Microsoft Teams*	12.30pm	Verbal	Noting	P O'Neill
12.	REVIEW OF MEETING PERFORMANCE				
12.1	Discussion on how the meeting in public has been conducted	12.31pm	Verbal	Discussion	All
13.	RESOLUTION TO REMOVE PRESS AND PUBLIC				
13.1	Resolution to exclude members of the press and public	12.35am	Verbal	Approval	P O'Neill

Council of Governors Public Meeting

28 July 2022 | 1.00pm | Microsoft Teams

PRESENT	DESIGNATION	26/4/22	28/7/22	3/11/22	26/1/23
CHAIRMAN AND GOVERNORS					
Professor E Adia (Chair)	Chairman	P	P		
Dr Keith Ackers	Public Governor	P	P		
Will Adams	Appointed Governor (Local Authority)	A	P		
Pav Akhtar	Public Governor	P	P		
Takhsin Akhtar	Public Governor	P	P		
Rebecca Allcock	Staff Governor	P	A		
Peter Askew	Public Governor	P	A		
Sean Barnes	Public Governor	P	P		
Alistair Bradley	Appointed Governor (Local Authority)	P	P		
Sheila Brennan	Public Governor	P	P		
Paul Brooks	Public Governor	P	P		
Anneen Carlisle	Staff Governor	P	A		
David Cook	Public Governor	P	A		
Kristinna Counsell	Public Governor	P	A		
Dr Margaret France	Public Governor	P	P		
Steve Heywood	Public Governor	P	P		
Waqas Khan	Staff Governor	A	A		
Lynne Lynch	Public Governor	P	P		
Janet Miller	Public Governor	P	P		
Jacinta Nwachukwu	Appointed Governor (Universities)	A	A		
Eddie Pope	Appointed Governor (Local Authority)	A	A		
Frank Robinson	Public Governor	P	P		
Suleman Sarwar	Appointed Governor (Local Authority)	P	A		
Anne Simpson	Public Governor	A	P		
Mike Simpson	Public Governor	P	P		
Piotr Spadlo	Staff Governor	P	P		
David Watson	Public Governor	P	P		
Paul Wharton-Hardman	Public Governor	P	P		
IN ATTENDANCE					
Karen Brewin *(minutes)*	Associate Company Secretary	P	P		
Ailsa Brotherton	Director of Continuous Improvement	-	-		
Faith Button	Chief Operating Officer	-	-		
Victoria Crorken	Non-Executive Director	P	P		
Sarah Cullen	Director of Nursing, Midwifery & AHPs	-	P		
Stephen Dobson	Chief Information Officer	-	-		
Gary Doherty	Director of Strategy and Planning	-	P		
Naomi Duggan	Director of Communications	P	P		
Jennifer Foote	Company Secretary		P		
Kevin McGee	Chief Executive	P	P		
Professor P O'Neill	Non-Executive Director	-	P		
Ann Pennell	Non-Executive Director	P	P		
Dr Gerry Skailes	Medical Director	-	-		
Kate Smyth	Non-Executive Director	P	P		
Karen Swindley	Workforce and Education Director	P	P		

Tim Watkinson	Non-Executive Director	P	-		
Jim Whitaker	Non-Executive Director	P	P		
Tricia Whiteside	Non-Executive Director	P	P		
Peter Wilson	Associate Non-Executive Director		P		
Jonathan Wood	Deputy Chief Executive/Finance Director	-	-		

P – present | **A** – apologies | **D** – Deputy
***Quorum**: 9 members must be present of which at least 1 must be a Public Governor; 1 must be a Staff Governor; and 1 must be an Appointed Governor*

Observer: Mr S McGuirk

PRESENTERS IN ATTANDANCE	
Minute 64/22	Kerry Hemsworth, Deputy Director of Education
Minute 64/22	Nichola Verstraelen, Research Nurse – Team Leader
Minute 65/22	Jerry Hawker, Senior Responsible Officer – New Hospitals Programme
Minute 71/22	Christopher Paisley, Senior Manager, KPMG

55/22 Chair and quorum

Professor E Adia noted that due notice of the meeting had been given to each member and that a quorum was present. Accordingly, the Chair declared the meeting duly convened and constituted.

56/22 Apologies for absence

Apologies for absence were received and recorded in the attendance matrix.

57/22 Declaration of interests

There were no conflicts of interest declared by the Governors in respect of the business to be transacted during the meeting.

58/22 Minutes of the previous meeting

The minutes of the meeting held on 28 April 2022 were approved as a true and accurate record.

59/22 Matters arising and action log

A copy of the action log had been circulated with the agenda including updates on the outstanding actions.

60/22 Chair's and Chief Executive's opening remarks

This was the last meeting of the Chair before he stood down on 31 August 2022. The Chair delivered a personal message to Council members thanking them for their exceptional support during his three-year tenure and provided reflections on his time as Trust Chair. The message also included thoughts moving forward and his continued involvement through his appointment to the Integrated Care Board (ICB).

The Chief Executive provided an update on system working and the continued operational pressures being experienced, including the position within the emergency department, flow, elective recovery, staffing levels and financial challenges.

Patients waiting 104-weeks had practically been eradicated with only a small number of clinically specialist patients remaining to be treated. Focus would now be directed to eradicating the number of patients waiting 78-weeks which needed to be cleared by the end of March 2023 and a system process had been established across Lancashire and South Cumbria organisations to combine the waiting list to equalise the workload. It was recognised that autumn and winter would be difficult operationally for the NHS with the forecast of a flu outbreak in the autumn followed by winter which would affect flow into hospitals. Capacity and demand plans were currently being produced to support predictions including additional beds and what could be introduced in the community to assist with flow. It was emphasised that the role of the ICS would be vital in respect of sustainable long-term plans for health and care systems.

61/22 Patient Experience Annual Report 2021/22

A report had been circulated with the agenda providing an overview of the outcomes associated with the Patient Experience and Involvement Strategy 2018-21 and highlights from the report were provided for information. It was noted a refreshed strategy was being co-designed with stakeholders which would be published in due course.

In response to a question regarding provision of information leaflets to patients on discharge, it was confirmed that providing written information to patients had been negatively impacted by the pandemic. Arrangements were in place to include appropriate questions in the STAR accreditation framework regarding communication with patients which would assist with testing the position moving forward. Reference was also made to the lack of space on wards for patients to socialise while in hospital, for example day rooms, and a query was raised regarding why the new Cuerden ward had not included a day room. Finally, reference was made to an issue raised by the CQC regarding patient information written on bed boards which it was understood should not be recorded. In relation to social spaces for patients, it was noted space was challenging and as system capacity was addressed and internal beds closed it may be possible to consider how space was utilised. Specifically, for the Cuerden ward, funding was provided for capacity and demand to increase the bed base therefore it was not possible to introduce a day room as there was a need to maximise the number of available beds. In respect of bed boards, it was confirmed that if patients consented to information appearing on the board then the CQC had indicated they would be comfortable with that approach.

- **The Council**
  - **Received the report and noted the contents.**
  - **Noted the closure of the 2018-21 Patient Experience and Involvement Strategy and the plan to approve the new strategy at the Safety and Quality Committee meeting in September 2022.**

62/22 Update from Chair of each Subgroup

The Chairs of the respective Membership and Care and Safety Subgroups provided an overview of the topics discussed at recent meetings and the following points were noted:

(a) *Care and Safety Subgroup (CaSS)*

In addition to the standing patient experience and estates updates, the Subgroup reviewed the terms of reference; received updates on outpatient letters and the safety surveillance system; received an overview of the STAR framework; an overview of the short-term informatics strategy; and an update on the smoking cessation service (TACT). It was noted that arrangements were also being progressed to re-open the PALS office at Chorley and South Ribble Hospital.

(b) *Membership Subgroup*

The Subgroup membership had been updated and continued to be well supported by the communications team and the Head of Widening Participation and Appenticeships who now attended the meeting. A review was undertaken of the objectives in the Membership Strategy action plan and a number of Governors had attended an external event to promote Trust membership and engage with the local community regarding their views on Trust services. The next meeting would be held in August and a further meeting had been arranged late September to discuss promoting the membership with BAME and young people.

63/22 **Non-Executive Director update: Education, Training and Research Committee Chair**

The update included a presentation on the role and responsibilities of the Chair of the Education, Training and Research Committee, including the subgroups reporting to the Committee; membership of the Committee; items discussed; strategic ambitions for education and research; and opportunities within the New Hospitals Programme (NHP). A copy of the slide presentation would be circulated to Governors following the meeting.

64/22 **Education and Research Strategy update**

The Deputy Director of Education and Research Nurse joined the meeting and delivered presentations on the respective education and research strategies. Copies of the slide presentations would be circulated to Governors following the meeting.

Discussion was held regarding how Governors could assist with delivery of the strategies. It was noted that Governor support for the strategies would be important particularly in terms of progress with the NHP. Support was already provided in terms of promoting the strategies, being advocates for the Trust and involvement in ongoing initiatives, such as research groups, patients as educators and widening participation referred to earlier in the Membership Subgroup update. Research and development would also be important in attracting and retaining staff therefore Governors' participation in cementing the Trust's reputation would be key. Discussion was also held regarding reducing health inequalities and it was noted one of the Trust's research nurses had been seconded to a national NHS equality and diversity role. There were also staff in the Trust looking at the Equality, Diversity and Inclusion Strategy to recruit staff and patients from all ethnicities. Plans were also being developed to look at some collaborative work with the University of Central Lancashire on their ARC programme looking at health inequalities, so there was focus on the health inequalities research agenda.

65/22 New Hospitals Programme update

The New Hospitals Programme Senior Responsible Office joined the meeting to provide an update on the NHP and the Council was reminded of the two shortlisted options for the Trust (partial rebuild on the existing Preston site, or a new hospital build).

During the last three months the NHP team had worked closely with the Trust's senior leaders and staff to develop the options in terms of what it would mean for patients, staff and the facilities; how services would be provided including interdependent services; potential site options; and economic benefits in relation to both options. A meeting had been held with the Trust Board on 21 July 2022 to outline the findings and it was expected further information on the options would be published over the coming months. The Council was reminded the NHP was a national programme which continued to progress and develop. A large part of the programme was Hospital 1:0 which related to a new generation hospital and the NHP team was working closely with the national NHP team on what a new hospital would look like. Reference was made to education, training and research and the NHP team was considering how this would look within the programme and a lead role was being taken on demand and management in this area from 2030 through to 2040. Progress with the NHP would be dependent on final agreement of capital funding and the national NHP team was working with the government and HM Treasury to bring forward funding plans later in the year.

In response to a question regarding whether there was any further information on site options, the Senior Responsible Officer confirmed that land agents had undertaken site searches and worked closely with Lancashire County Council and district councils and four potential sites had been identified which were being taken through technical assessment for suitability. It was noted the choice of a potential site was a combination of technical suitability (right size and topography) and alignment with ambitions to address inequalities; good access; and appropriateness of working with partners. It was emphasised that other sites may come forward in the future and the robust technical assessment process would be undertaken on any and all potential site options.

66/22 Operational (Annual) Plan 2022/23

The Director of Strategy and Planning delivered a presentation on the 2022/23 operational plan including progress with delivery against the 10 national requirements. A copy of the slide presentation would be circulated to Governors following the meeting.

Discussion was held regarding how the Trust compared across the country in terms of waiting times and whether work had been undertaken to benchmark against the best performing organisations. It was noted Lancashire and South Cumbria had the longest waiting times regionally although that was not an unusual pattern as tertiary providers appeared to have longer wait times. Working as a system meant it was possible to offer patient choice for treatment and the number on the waiting list was reducing. In respect of benchmarking, Lancashire and South Cumbria was in a better position than Manchester and about the same as Mersey and Cheshire and nationally there were some areas in the Southwest where there were longer wait times. It was confirmed that anonymised benchmarking data was received showing how the system was operating in relation to other organisations and clinical networks. Professor T Briggs, leader of the Getting It Right First Time (GIRFT) programme, had also visited theatres on the Chorley site and met clinical teams, therefore, a good system was in place to spread best practice.

67/22 Non-Executive Director update: Charitable Funds Committee Chair

A presentation was delivered on the role and responsibilities of the Chair of the Charitable Funds Committee, including background information on the structure and how the Committee functioned; an overview of expenditure and the approval process for funding requests; and the investment strategy. A copy of the slide presentation would be circulated to Governors following the meeting.

In response to a question on how Governors could attend Committee meetings, the Chair advised that it was not appropriate for Governors to attend meetings of Committees of the Board as that would be outside the Governor remit.

68/22 Re-appointment of Non-Executive Director

A report had been circulated with the agenda providing information for the Council to consider re-appointment of T Whiteside for a second term of office and an overview of the contents was provided.

- **RESOLVED THAT the Council re-appoint T Whiteside for a second term of office from 9 September 2022 up to and including 8 September 2025.**

69/22 Governor 360-degree feedback

The Council was reminded of the invitation this year to complete 360-degree feedback to support the Non-Executive Directors' annual appraisal process and training had been offered to Governors at the end of May 2022. However, it was understood the Council had agreed some time ago that 360-degree feedback training was mandatory for Governors and only those Governors trained could completed the 360-degree feedback, however all Governors had been invited to participate in the survey this year irrespective of training status. This had raised questions about the appropriateness of whether the training should be mandated and the role of the Governor. It was noted that as part of the new national framework for Non-Executive Director appraisals, the Workforce and Education Director and Company Secretary would revisit the overall appraisal process for Non-Executive Directors, supported by Governor engagement, and a proposal would be brought to the Council of Governors for consideration and approval.

- **RESOLVED THAT the Council support the proposal to review the appraisal process for Non-Executive Directors including 360-degree feedback from Governors.**

Action:

- **The overall process for Non-Executive Directors' appraisals to be revisited, supported by Governor engagement, and a proposal brough to the Council for consideration and approval.**

70/22 Annual Report and Accounts 2021/22 (laid before Parliament)

A copy of the Annual Report and Financial Accounts for 2021/22, which had been laid before Parliament on 6 July 2022, had been circulated with the agenda for information. It was noted the report would be published on the Trust's website following the Board of Directors' meeting on 4 August 2022.

- **The Council received the 2021/22 Annual Report and Accounts and noted the contents.**

71/22 Presentation from External Auditor – ISA 260 report and Annual Audit Report

Copies of the ISA 260 and Annual Audit reports had been circulated with the agenda and the Senior Manager from KPMG (the Trust's external auditors) joined the meeting and delivered a presentation, outlining KPMG's responsibilities and highlights from the work undertaken by the team in relation to the 2021/22 annual reporting process. It was pleasing to note the Trust had received an unqualified opinion on the Trust's financial statements and a positive outcome in relation to value for money. A copy of the slide presentation would be circulated to Governors following the meeting.

- **The Council received the reports and noted the contents including the unqualified opinion on the Trust's financial statements and positive outcome on value for money.**

72/22 Annual Members Meeting report

A report had been circulated with the agenda outlining the mandated content of the 2022 annual members' meeting (AMM) scheduled for 12 October 2022, other stipulations that had been considered and the draft programme for the meeting. It was proposed that a virtual AMM be held, and the Council was asked whether there were any further suggestions regarding the presentation to be delivered at the AMM in addition to the proposed presentation contained in the schedule.

It was noted that in previous years Governors had been consulted regarding the proposed presentation therefore it was agreed that if Governors had any suggestions for a second presentation, they should email the Company Secretary inbox by mid-August and the team would attempt to accommodate an additional presentation.

- **RESOLVED THAT the Council endorse the programme for the AMM as presented, subject to consideration by Governors on a second presentation.**

Action:

- **Governors to consider and propose additional topics for a second presentation at the AMM and email suggestions to the Company Secretary inbox by mid-August 2022.**

73/22 Hybrid virtual meetings for Council Workshops and Development Sessions

Discussion was held regarding the potential to hold hybrid virtual meetings and the experiences, both positive and negative, of those who had been involved in such meetings in the past. Where hybrid meetings had worked well there had been significant investment in IT resources and, conversely, worked less well where limited software platforms were in place and technology in the room did not support easy involvement from participants. There was a preference for reverting to face-to-face meetings although there was a need for caution moving into autumn and winter due to the forecast flu outbreak and potential spikes in Covid-19 infection therefore account would need to be taken of infection prevention and control guidance.

The Company Secretary confirmed that over the next few months work would be undertaken to understand when hybrid meetings would be a realistic option, any resources or investment required, or any other potential options to achieve the same or better outcome. There would also be a need to consider the views of the new Chair and comments received from Governors would form part of those discussions.

- **The Company Secretary would further explore the potential for a workable solution for hybrid meetings taking into account comments received from Governors and the view of the new Chair of the Trust.**

74/22 Council Development Plan update

A report had been circulated with the agenda providing a further update on the status of the Council Development Plan since last reported to the Council at the April meeting. It was noted that the new Chair of the Trust would also have a view on how to develop the Council in the future.

In response to a question regarding the status of erecting Governor photo boards across the Trust, it was noted that the communications team was looking at digital boards. It was also noted that some Governors had not yet arranged for their official photograph to be taken and once all official photographs were available, they would be uploaded to the digital boards which would be available in key strategic locations across the Trust.

- **The Council received and noted the status of the Council Development Plan.**

75/22 Items for information

The following reports were circulated with the agenda and the contents noted for information:

(i) Quality Account 2021/22
(ii) Governor opportunities and activities summary
(iii) Governor issues report
(iv) Minutes of Governor Subgroups:
  - Care and Safety Subgroup – 24 March and 16 May 2022
  - Membership Subgroup – 4 April 2022
  - Chairs, Deputy Chairs and Lead Governor – 4 April 2022

76/22 Date, time and venue of next meeting

The next meeting of the Council of Governors will be held on Thursday, 3 November 2022 at 10.00am using MS Teams.

77/22 Reflections on how the meeting had been conducted

Some Governors commented on the high-quality reports and good presentations delivered during the meeting.

78/22 Resolution to exclude press and public

RESOLVED THAT press and public be excluded from the meeting.

Action log: Council of Governors (part I) – 28 July 2022

There are no outstanding actions from previous Council meetings.

COMPLETED ACTIONS ***(for information)***

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	37/21	29 Apr 2021	*Nursing, Midwifery, AHPs and Care Givers' Strategy* – a further update to be provided in six months.	S Cullen	To be confirmed	**Completed** **Update for 26 October 2021** – reporting on the strategy stood down due to the pandemic. **Update for 3 November 2022** – the strategy has been incorporated into a Trust Clinical Services Strategy which is included on the agenda.
2.	39/22	26 Apr 2022	*Update on Council and Subgroup virtual meetings* – explore the possibility of a hybrid model for Council Workshops and Development Sessions with feedback provided at the next Council meeting.	J Foote	3 Nov 2022	**Completed** **Update for 28 July 2022** – a hybrid model is under consideration. However, due to a resurgence in Covid-19 current arrangements remain in place. The Company Secretary to further investigate the options and provide an update at the November meeting. **Update for 3 November 2022** – update included on the agenda.
3.	40/22	26 Apr 2022	*Council Development Plan update* – liaise with the Communications team and check progress with erecting Governor photo boards on both hospital sites.	K Swindley	28 Jul 2022	**Completed** **Update for 28 July 2022** – this action is included as part of the communication plan. The type of boards is currently being revisited to ensure ease of updating Governor photos. **Update for 3 November 2022** – Governor photos displayed on digital screens across the Trust as well as paper versions within the notice boards on various corridors on both hospital sites.

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
4.	69/22	28 Jul 2022	*Governor 360-degree feedback: Non-Executive Director appraisals* – the overall appraisal process for Non-Executive Directors to be revisited, supported by Governor engagement, and a proposal brought to the Council for consideration and approval.	P O'Neill/ J Foote	Apr 2023	**Completed** **Update for 3 November 2022** – the issues have been picked up as part of the wider review of the appraisal process, to be completed and in place for adoption for the 2022/23 appraisal round.
5.	72/22	28 Jul 2022	*Annual Members' Meeting* – Governors to consider and propose additional topics for a second presentation at the AMM and email suggestions to the Company Secretary inbox by mid-August 2022.	Governors	15 Aug 2022	**Completed** **Update for 3 November 2022** – suggestions received and 'Set for Surgery' to be included as the second presentation at the AMM on 12 October 2022. Arrangements are being made with the Surgery Division.
6.	Several	28 Jul 2022	*Slide presentations* – the six slide presentations shared during the meeting to be circulated to Governors.	K Brewin	3 Nov 2022	**Completed** **Update for 3 November 2021** – presentations circulated by email on 29 July 2022.

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Ockenden – The Final Report
March 2022

Excellent care with compassion

@LancsHospitals

Lancashire Teaching Hospitals
NHS Foundation Trust

Key Findings

- External investigation commissioned into care provided to families at Shrewsbury and Telford Trust during period 2000 - 2019 following concerns raised by two families as they ‘just needed answers’
- Review led by Donna Ockenden
- 1486 cases included in review
- Initial findings published in December 2020 with 41 recommendations for practice identified
- Final report published in March 2022
- Next high profile maternity report East Kent due in October 2022
- Following this, Nottingham maternity services next year

Lancashire Teaching Hospitals
NHS Foundation Trust

"Trust had failed to investigate, learn and improve and thus had failed to safeguard families within their care"

Lancashire Teaching Hospitals
NHS Foundation Trust

Key pillars of focus

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families
5. Low caesarean section rate

Lancashire Teaching Hospitals
NHS Foundation Trust

Validated compliance with 7 initial IEAS as per Trust Board on 9 February 2022

Immediate and Essential Actions	Total	Full compliance	Partial compliance	Non compliance
IEA1 Enhanced safety	7	7		
IEA2 Listening to women	5	3	2	
IEA3 Staff working and training together	6	3	3	
IEA4 Managing complex pregnancy	6	1	4	1
IEA5 Risk assessment at each contact	3	1	2	
IEA6 Monitoring of fetal wellbeing	4	1	3	
IEA7 Informed consent	5	5		
Workforce planning	5	4	1	
Total	41	25	15	1

Lancashire Teaching Hospitals
NHS Foundation Trust

Additional 15 IEAS (unvalidated) Gap Analysis – October 2022

Immediate and Essential Actions	Total	Full compliance	Partial compliance	Non compliance	Regional Requirement
Workforce planning and sustainability	11		4	4	3
Safe staffing	10		6	4	
Escalation and accountability	5	1	2	2	
Clinical governance - leadership	7		3	4	
Clinical governance - incident investigation	7	1	6		
Learning from maternal deaths	3		1	1	1
Multidisciplinary training	7	3	3	1	
Complex antenatal care	5		2	3	
Preterm birth	4	1	3		
Labour and birth	6	1	2	3	
Obstetric anaesthesia	8			8	
Postnatal care	4		1	3	
Bereavement care	4		2	2	
Neonatal care	8			8	
Supporting families	3		3		
Total	92	7	38	43	4

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Conclusion

- CNST 10 key safety actions
- Safe staffing
- Commissioned service – Maternal Medicine
- Senior Midwifery Advocate
- Combined maternity neonatal improvement plan

Lancashire Teaching Hospitals
NHS Foundation Trust

Ockenden 15 IEA
Detailed actions

15 Immediate and Essential Actions

Lancashire Teaching Hospitals
NHS Foundation Trust

1. Workforce planning and sustainability	**Essential action:** The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.
	Essential action: The Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.
2. Safe Staffing	**Essential action:** All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.
3. Escalation and Accountability	**Essential action:** Staff must be able to escalate concerns if necessary. There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times.

4. Clinical Governance-Leadership	**Essential action:** Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems
5. Clinical Governance – Incident Investigation and Complaints	**Essential action:** Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.
6: Learning From Maternal Deaths	**Essential action:** Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.
7: Multidisciplinary Training	**Essential action:** Staff who work together must train together. Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend.Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training.

8: Complex Antenatal Care	**Essential action:** Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care. Trusts must provide services for women with multiple pregnancy in line with national guidance Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy.
9: Preterm Birth	**Essential action:** The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019).
10: Labour and Birth	**Essential action:** Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units.
11: Obstetric Anaesthesia	Essential action: Essential action: In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm. Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events. Staffing shortages in obstetric anaesthesia must be highlighted

12: Postnatal Care	**Essential action:** Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times.
13. Bereavement Care	**Essential action:** Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.
14: Neonatal Care	**Essential action:** There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.
15. Supporting Families	**Essential action:** Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision. Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care.

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors

Infection Prevention and Control Annual Report 2021/2022

Report to:	Council of Governors	**Date:**	3rd November 2022
Report of:	Nursing, Midwifery and AHP Director	**Prepared by:**	Dr D Orr Dr M Pasztor Matron S Marsh

Purpose of Report

For approval	☐	**For noting**	☒	**For discussion**	☐	**For information**	☐

Executive Summary:

The purpose of this paper is to provide an overview of the progress made against the annual Infection Prevention and Control Plan for 2021/2022 and update the Council of Governors on the Trust's performance against key areas of Infection Prevention and Control.

During the period 2021/2022 the COVID-19 pandemic has continued with the National Health Service (NHS) operating under significant pressure at a national Level 4 incident level.

In 2021/22 the summary points of the IPC specialty include;

- Three waves (increase incidences) of COVID-19 in the hospital leading to 355 COVID-19 positive patients in the Trust
- 1 hospital acquired MRSA
- The Clostridium *difficile* trajectory was exceeded by 14 cases and has led to the introduction of faecal testing expected to more accurately identify the source of infection, identify and isolate C.*difficile* earlier in the patients journey.
- Assurance received in relation to water safety compliance
- Achieved the target reduction in total antimicrobial consumption and consumption of watch/reserve antibiotics
- Decontamination - SGS Recertification Audit took place 11/2021 on Standard ISO 13485: 2016 certificate valid from December 2021 to December 2024.
- Assurance received regarding endoscopy testing with a plan to upgrade the decontamination facilities in 2022 to move to compliance with Joint Accreditation Group (JAG).
- Additional actions taken to manage the risk of the age of estate in relation to ventilation.
- The COVID-19 operational risk continues to be escalated to the Board of Directors at a score of 20, with several reviews of the IPC Board Assurance Framework received by the Board of Directors. It is anticipated the COVID-19 risk score will reduce at the next review due to the end of the fifth wave of the pandemic.

The report contains an update on the actions delivered in the 2020/21 IPC plan, 36/46 actions have been completed in year, some delayed due to COVID-19, where a delay has occurred the reason for this is given alongside the plan for how this is being addressed and carried forward. This closes the IPC plan for 2021/22 and presents the 2022/2023 IPC plan for approval.

It is recommended the:

I. The Council of Governors note the contents of the Annual report and acknowledge the scrutiny afforded to the detail at Safety and Quality Committee and confirm that it is assured of progress against the 2021/22 Annual Plan.
II. Note the IPC Annual Plan 2022/2023.

Appendix one – IPC Annual Plan 21-22
Appendix two – IPC Annual Plan 22-23

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Infection Prevention and Control Committee, 18/05/2022
Safety and Quality Committee (27 May 2022)

1. Background

The purpose of this paper is to provide an overview of the progress made against the Infection Prevention and Control Annual Plan for 2021/2022 and update the Council of Governors on the Trust's performance against the annual objectives for methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infection and *Clostridioides difficile* infection (C. difficile).

Infection Prevention and Control (IPC) remains a key priority for Lancashire Teaching Hospitals (LTHTR). The IPC team continues to work closely with other providers across the health economy. Dr David Orr, a Consultant Microbiologist, currently holds the Director of Infection Prevention and Control (DIPC) role and the Nursing, Midwifery and AHP Director maintains the Executive responsibility for IPC with the Deputy Nursing, Midwifery and AHP Director, Catherine Silcock leading the operational delivery of the agenda. Dr Orr is also supported by Dr Monika Pasztor who is Associate Director of Infection Prevention Control (ADIPC) and the Matron for IPC, Sarah Marsh.

Hospitals across the UK were challenged in 2021/22 by the COVID-19 pandemic; however, LTHTR was particularly challenged due to the high community prevalence and its poor estate, evidenced by the Trusts participation in the New Hospitals programme. This results in proportionally lower levels of side-rooms that do not meet the demands of the patient population who require them, poor ventilation in a large number of clinical areas and lack of space for separation between bed spaces. As identified in the report the infection control team responded to a rise in nosocomial cases in a proactive way to implement measures to reduce hospital-acquired infection. The data supplied from Information Technology and Business Intelligence colleagues was invaluable to identify problem areas and assess the response to Infection control initiatives.

Multidisciplinary Post Infection Reviews (PIRs) continue to be a key strategy for learning and improvement. The PIR process promotes a culture of learning and openness rather than blame.

This report presents the details of IPC performance of Lancashire Teaching Hospitals Trust (LTHTR) in 2021/2022 with the focus on key IPC issues and includes the 2021/2022 programme which details the completion of improvement actions in line with the ten domains of the Hygiene Code which accompanies the Health and Social Care Act.

The Infection Prevention and Control Annual Plan 2021/2022 is attached for information and closure. 36/46 actions have been completed in year, some delayed due to COVID-19 carried forward to 2022/23 Annual Plan. The 2022/2023 Annual Plan is also attached for approval. This will expand and build on improvements made in 2021/2022.

2. Discussion

TRUST PERFORMANCE RELATED TO ORGANISMS OF CONCERN

2.1 MRSA Bacteraemia

Staphylococcus aureus is a bacterium that commonly colonises human skin and mucosa. Most strains of *S. aureus* are sensitive to the more commonly used antibiotics, and infections can be effectively treated. However, some *S. aureus* bacteria are more resistant. Those resistant to the antibiotic methicillin are termed methicillin-resistant *S. aureus* (MRSA). Bacteraemia occurs when bacteria gets into the bloodstream.

Infection Prevention and Control continues to be a key priority for us and the incidence of MRSA is outlined below:

- In 2018-19 there were zero incidents of hospital onset MRSA bacteraemia & 2 cases of community onset MRSA.

- In 2019-20 there was 1 incident of hospital onset MRSA bacteraemia and 2 cases of community onset MRSA.
- In 2020-21 there have been 0 incidents of hospital onset MRSA bacteraemia and 0 cases of community onset MRSA.
- In 2021-22 there have been 1 incident of hospital onset MRSA bacteraemia and 2 cases of community onset MRSA.

Cases are investigated by a multi-disciplinary team using the national Post Infection Review Tool and discussed with the Director of Infection Prevention & Control to identify causes and actions for future prevention. The hospital associated case identified in August 2021 was reviewed and the key contributing factor was a delay in decolonisation.

2.2 **Clostridioides *difficile* Infection**

Clostridioides difficile (C. difficile) is an anaerobic bacterium that is present in the gut. It can be found in healthy people, where it causes no symptoms (up to 3% of adults and 66% of infants). In some instances strains of *C. difficile* can grow to unusually high levels and attack the intestines, causing mild to severe diarrhoea. Patients who are commonly affected are elderly and/or immunocompromised; exposed to antibiotics and *C. difficile* from spores from the environment.

The prevention of C. difficile infection remains a key priority for our organisation. Reviewing the history there is evidence of increasing prevalence. During 2017-18 there were 60 cases and during 2018-19 there were 51 cases. This was an improving picture in relation to the overall objective of not exceeding 65 cases a year for the organisation during that reporting period. There was then an increase in 2019-20, due to a change in definitions of community vs hospital cases, with 130 cases against an objective of 84 cases.

Due to the COVID-19 pandemic there was no national objective set by NHSI/E for 2020-21, hence the previous year's target continued set at a local objective of 84. In 2020-21 there was an improvement in the number of healthcare associated *C. difficile* cases as compared with 2019-20, although it remained higher than the objective being 100 cases.

The national objective set by NHSI/E for the year 2021-22 was 118. There was an increase in hospital acquired cases during 2021-22 in comparison to previous years with a total of 132 cases against an objective of 118.

- Hospital Onset Healthcare Associated = 114
- Community Onset Healthcare Associated = 18

From the 114 Hospital onset cases, 102 have already been reviewed to date and there were lapses in care identified for 78 cases: no lapses in care identified in 24 cases and 12 cases are still under review at the time of writing.

It is acknowledged that the Trust has exceeded the yearly objective of 118 cases for this reporting period. All hospital cases are reviewed by an expert group including the Director of Infection Prevention and Control or Deputy Director of Infection Prevention and Control, Infection Prevention and Control Matron, Infection Prevention and Control Nurse, Antimicrobial Pharmacist or Specialist Antimicrobial Technician, Governance representative, Ward Manager, Ward Matron and Consultant in charge of the patients care.

The review process facilitates a greater understanding of the individual cause of the C. difficile cases to determine whether or not there were any lapses in the quality of care provided. This is so an appropriate plan of action to address any problems identified and to promote learning. A lapse in care is based on the checklist detailed in the national guidance and includes omissions which would not have contributed to the

development of *C. difficile* infection however may more globally contribute to the prevention of spread in other patients. Common themes in terms of lapses in care included:

- A lack of documentation of risk assessment around diarrhoea and need for isolation
- A lack of documentation of escalation of isolation requirements to site/bed management
- Sampling delays
- IPC audits (environment and IPC practice) not reaching required standard
- Less than optimum bay decontamination after *C. difficile* cases and carriage due to bed-pressures/constraints caused by the COVID-19 pandemic (inability to fog areas on occasion)
- Continued use of Laxatives after *C. difficile* diagnosis
- Isolation delays due to limited isolation facilities

During the COVID-19 pandemic, isolation of patients with diarrhoea was more challenging due to reduced availability of side rooms associated with the isolation of COVID-19 patients. There was also a significant increase in broad-spectrum antimicrobial consumption which mirrored the pandemic waves. Antimicrobials are a major risk factor for *C. difficile*.

For the coming year, as the COVID-19 pandemic reduces in intensity, there will be a renewed focus on *C. difficile* and the known actions to reduce incidence. In 2021/22 a *C. difficile* action plan was developed and while there was some success in completing the actions identified, the following interventions are being realised in 2022/23;

- Implementation of the Rapid Intestinal Infection PCR test
- Roll out of whiteboards on wards for view of patients with diarrhoea
- Standardisation of nursing documentation on QuadraMed which includes diarrhoea risk assessments
- Review the fogging and cleaning systems in place in regard to the National Cleaning Standards
- Establish processes to allow proactive fogging across the organisation
- Further refine the BI app displaying all patients with diarrhoea across the Trust to identify patients who require risk assessments for testing and isolation

Focus on learning from lapses in care are triangulated in the Antimicrobial Management Group and Divisional Infection Prevention and Control meetings and we have focused on antimicrobial stewardship, hand hygiene, environmental hygiene and timely isolation of patients with symptoms of diarrhoea. Hospital onset *C. difficile* review is undertaken during the monthly CDI Panel meeting with the Clinical Commissioning Group (CCG) leading to a Health economy wide approach to learning and reduction.

2.3 SARS coronavirus-2 (SARS-CoV-2) - COVID-19

On 31 December 2019, World Health Organisation (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan, Hubei Province, China. A novel coronavirus SARS coronavirus-2 (SARS-CoV-2) was subsequently identified and symptoms were Flu-like initially and also included a loss or change in the normal sense of taste or smell.

The virus is mainly transmitted by respiratory droplets and aerosols, and by direct or indirect contact with infected secretions. Infection control, which, in large part, relies on segregation of infected from non-infected individuals, is incredibly difficult as one third of infected individuals have no symptoms but are still able to transmit the infection to others. We suffered from key disadvantages as compared to other similar trusts when it comes to preventing nosocomial COVID-19, mainly relating to its estate:

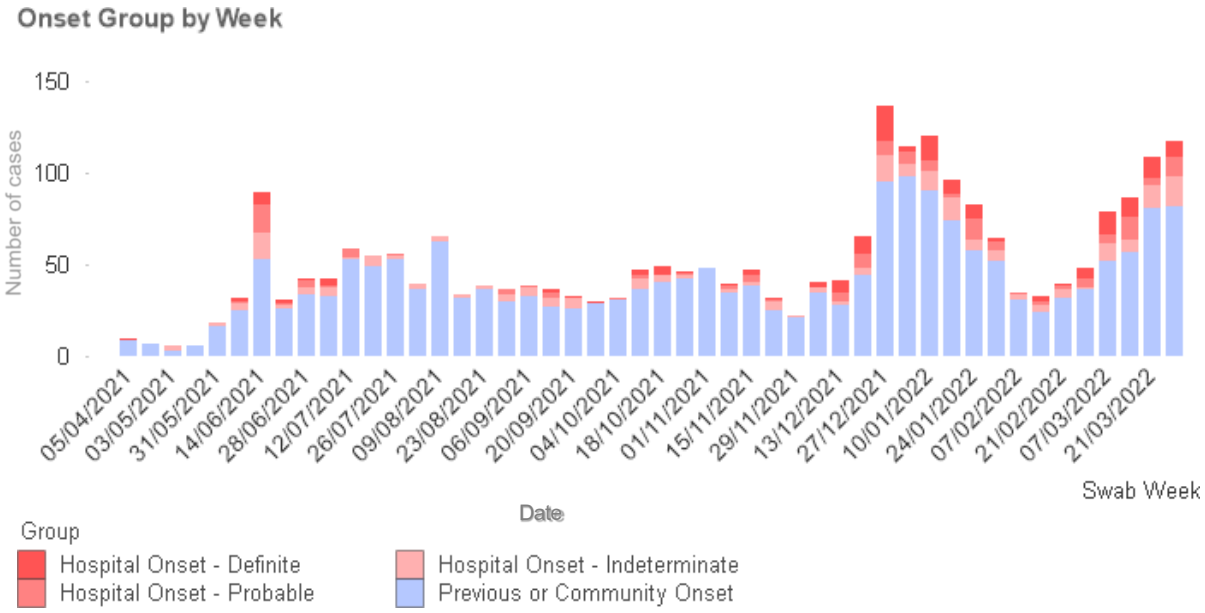
2.3.1 Only 20% of the beds at LTHTR are in side rooms making it difficult to segregate patients

2.3.2 A large number of hospital bays have virtually no ventilation and COVID-19 spreads more readily in poorly ventilated areas

2.3.3 A 2-metre separation between bed spaces was not possible in most areas

During the 5 waves of the pandemic LTHTR, like all Trusts in the NHS, unfortunately had significant numbers of Hospital acquired or Nosocomial COVID-19 infections. Presented in Figure 25, there is a breakdown of the number of hospital onset versus community onset cases by week.

Graph 1- Hospital Onset versus Community Onset COVID-19 infections



Source: LTHTR data

From April 2021 – March 2022 the Trust continued with the measures introduced in the previous year to reduce Nosocomial cases. The key measures are;

- Point of care testing in admission areas, resulting in better streaming of infected versus non-infected patients at the point of entry to the organisation.
- Continued use of Rapid confirmatory COVID-19 tests.
- Information Technology (IT) driven contact tracing system to identify bay contacts of infected patients in the 48 hours before a positive result.
- Bed re-organisation with the designation of COVID-19 wards.
- A program of regular testing of all inpatients increasing to 3 times per week.
- Asymptomatic staff testing by lateral flow tests.
- A communication strategy to improve awareness and compliance with infection control procedures.
- Transparent screens/curtains between patient spaces.
- Use of 'Redi-rooms' to isolate patients where side-rooms not available.
- The use of High Efficiency Particulate Absorbing (HEPA) air-purifiers to inadequately ventilated areas with high risk of transmission

For the year April 2021 – March 2022 the Nosocomial rate stood at 13% which was significantly less than the previous year when the Nosocomial rate was 29%. This reduction occurred despite higher community prevalence and transmissibility, associated with newer variants in 2021/22.

Table 1 Cases of COVID-19 by Month and Designation April 20 – March 21

Date	HODHA	HOPHA	HOIHA	CO	**Total**
Apr-20	34	37	47	271	0
May-20	20	40	19	88	167
Jun-20	10	16	13	32	71
Jul-20	1	1	3	6	11

Aug-20	1	1	3	6	11
Sep-20	3	1	7	54	65
Oct-20	36	46	44	208	334
Nov-20	77	71	54	215	417
Dec-20	72	97	71	196	436
Jan-21	20	49	34	376	479
Feb-21	10	13	7	166	196
Mar-21	4	3	3	80	90

Key: **HODHA** = Hospital onset definite healthcare associated
HOPHA – Hospital onset probable healthcare associated
HOIHA - Hospital onset indeterminate healthcare associated
CO - Community onset

Table 2 Cases of COVID-19 by Month and Designation April 21 – March 22

	HODHA	HOPHA	HOIHA	CO	**Total**
Apr-21	0	0	0	27	27
May-21	0	0	3	15	18
Jun-21	12	24	19	97	152
Jul-21	6	6	11	173	196
Aug-21	1	2	9	152	164
Sep-21	2	4	14	122	142
Oct-21	7	4	14	129	154
Nov-21	4	7	8	120	139
Dec-21	35	21	22	173	251
Jan-22	32	25	33	291	381
Feb-22	6	7	21	111	145
Mar-22	49	29	38	239	355

Source: LTHTR data

3.0 OTHER OUTBREAK INVESTIGATIONS IN 2021/22

3.1 Norovirus Outbreak – Hazelwood

In March 2022, the Trust had the first Norovirus outbreak for more than 2 years. The outbreak lasted 2 weeks and, although the morbidity impact on individual patients was low, it resulted in the loss of 47 patient bed-days, as is typical for Norovirus outbreaks in hospital. It is expected that Norovirus outbreaks will be more common as we exit the COVID-19 pandemic, due to loss of immunity in the general population. As with other seasonal viruses, Norovirus incidence was very low in the pandemic and immunity, due to prior exposure, is short-lived.

A summary meeting was held at the end of the Norovirus outbreak to discuss lessons learnt. Elements of positive feedback included:

- The key role of rapid testing to identify the outbreak and track infection throughout the ward
- Daily outbreak meetings, which included domestics – coordination between bed emptying and deep cleaning/fogging
- Appropriate designation of staff for infected vs non-infected areas
- Domestic services support for cleaning

- Appropriate use of contingency plans, to open bays, in a planned way, if severe bed-pressures arose

Since this outbreak, rapid testing has now been implemented in the Emergency Department (ED) to screen all patients presenting with Diarrhoea and or Vomiting, where gastroenteritis is being considered as a differential diagnosis. In one month, the new test identified 4 patients presenting to ED with Norovirus who, left undetected, may have caused further outbreaks.

3.2 MRSA colonisation – the neonatal unit (NNU)

Four cases of MRSA were identified between 10/02/22 and 04/04/22 among babies in NNU. There was an additional presumptive MRSA case, but the organism was later identified as methicillin sensitive staphylococcus (MSSA) in national reference laboratory.

Multi-locus sequence typing (MLST) typing revealed two parallel transmission events of MRSA: One epidemiological link was between a mother and her newborn. A post-partum wound swab grew MRSA in the mother in the community, however, this was not communicated to the neonatal unit.

One of the actions was for the IPC team, on receipt of a positive MRSA result, to check the status of all postpartum mothers' babies and advise on decolonisation. The family of the baby was offered decolonisation in this incident.

The other epidemiological link was identified between two babies in the neonatal unit, learning from this case identified the importance of decontaminating breast pumps between use. The investigation identified areas to improve in hand hygiene compliance, clutter due to restricted storage capacity and damaged estate. Remedial work for damaged estate was recommended and implemented. IPC audits were increased, and staff reminded of their responsibility to implement IPC measures including hand-hygiene. Storage units were procured to tackle clutter on the unit. No MRSA positive staff were identified on screening. The outbreak investigation was closed on 11/05/22 and no further linked cases were identified.

4.0 KEY INTERVENTIONS TO PREVENT NOSOCOMIAL INFECTION

4.1 Antimicrobial Stewardship

The Trust Antimicrobial Management Group (AMG) meets every two months to review antimicrobial stewardship and includes representation from microbiology, pharmacy in both LTHTR and the Community and the IPCT.

In 2021/2022 the antimicrobial stewardship (AMS) team have continued to expand antimicrobial stewardship activities, including reintroduction of microbiology ward rounds.

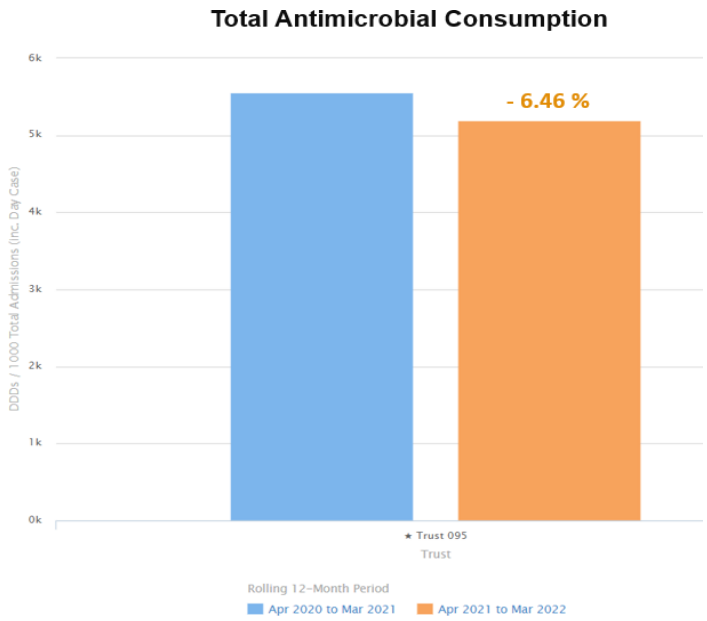
The AMS team undertakes quarterly antibiotic prescription point prevalence audits, and the Trust has remained >90% compliant with documented indication on the drug chart and antimicrobial choice compliant with guidelines or recommended by microbiology.

There are a range of metrics used to demonstrate good antimicrobial stewardship to promote safety in the management of antibiotics which include: Documented indication on the Prescription; Compliance with Guidelines; Compliance with guidelines or recommended by Microbiology; Compliance with stop/review date on the prescription; compliance with a review documented within 72hrs on the prescription chart. There has been lack of compliance with review documented within 72hrs on the prescription chart due to the accessibility of Electronic Prescribing and Medicines Administration (EPMA) work queue and the volume of information that sits within the work queue. The AMS team have worked with IT and introduced a new format for antimicrobial reviews which has been embedded within a new ward round proforma. Preliminary results indicate this has significantly increased compliance.

Efforts made for World Antimicrobial Awareness Week (WAAW) 2021 were recognised for positive escalation. Activities included an AMS awareness video which was also used external to the trust, an EPMA order-set race which helped raise the profile of this functionality and daily twitter updates.

Total antimicrobial consumption (i.e., the number of antimicrobials used measured against the number of admissions) was 6.46 % lower in in 2021-22 compared to 2020-21 and is shown in the graph 1 below. The NHS standard contract for 2022-23 requires a 4% reduction in use of antimicrobials which fall into 'Watch' and 'Reserve' categories (as defined by the World Health Organisation) from 2018 baseline. So far, the Trust has seen a 4.48% reduction for these categories in 2021-22 compared to 2017-18 which shows the trajectory is on target. The AMG will continue to monitor metrics.

Graph 2 Total Antimicrobial consumption



4.2 Water Safety

The Trust Water Safety Group (WSG) has continued to meet virtually during the COVID-19 pandemic with official reporting to the Trust Health and Safety Governance Committee and information provided to the Infection Prevention and Control Committee in relation to any potential waterborne infection risks.

The Trust Water Safety Plan remains in place and capital developments are managed in line with this. Hydrop who provide the Authorising Engineer for Water have updated the Trust Water Safety Plan in line with new/revised guidance however this remains in draft format awaiting a review by all stakeholders. During 2022/23 there is a planned external audit to be performed by the Authorising Engineer to assess compliance and identify any gaps.

Water testing for Pseudomonas aeruginosa (P. aeruginosa) continues in Augmented Care Areas in line with Health technical memoranda (HTM) 04-01 with samples collected every 6 months. If out of range results occur, then these are dealt with in line with the Water Safety Plan and HTM guidance. An investigation took place due to a neonate developing sepsis with P. aeruginosa in November 2021. Additional water samples were taken in response to this and P. aeruginosa was detected in the outlet from the room in which the baby was nursed. Remedial work was carried out by Estates in line with HTM 04-01 and resolved the contamination. However, typing showed that the water and clinical isolates were distinct, therefore there was no link between the water supply and the baby's illness. However, this incident did highlight the importance of adhering to best practice for hand wash basin use in Augmented Care Areas and led to a review of practices in this unit.

This investigation highlighted the importance of a fast and responsive laboratory testing service for water samples. Currently samples are processed off site and a proposal has been written to bring this on site to the clinical diagnostic laboratory.

Legionella sampling regimes have been recently revised to strengthen compliance with the HTM and advice received from the Authorising Engineer to ensure both local and systemic contamination may be detected in high-risk areas. The new contract for this increased testing is now in place to ensure monthly sampling starts to take place in augmented care areas on a rotational basis and other areas (sentinel outlets) on a quarterly basis.

The Hydrotherapy Pool has operated at reduced capacity due to social distancing guidelines. Pool Water Treatment Advisory Group (PWTAG) Technical Notes on management of pools during COVID-19 were adopted, but the focus has now moved to following local IPC guidance with sessional cleaning and social distancing. The Hydrotherapy Policy was fully reviewed and updated in 2021. Weekly microbiological testing continues in line with this and there have been no significant abnormalities with these results. The Hydrotherapy Review Group continues to meet on a quarterly (minimum) basis and reports to Water Safety Group.

4.3 Ventilation

The Department of Health gave comprehensive guidelines and advice on engineering technology in health care premises via Health Technical Memorandums. HSE (Health and Safety Executive) have also issued guidance on how to keep indoor premises safe during COVID-19 pandemic with regards to ventilation.

All workplaces need an adequate supply of fresh air. That can be provided either by natural ventilation from doors and windows, or by mechanical ventilation. The recommendations and the health care standards have changed over the time. Therefore, there is a high variety of standards in use across LTHTR.

Adequate ventilation reduces the viral load of the air and reduces the risk of aerosol transmission of viruses. This guidance should be used in conjunction with other infection control measures to prevent transmission such as making sure heath care workers are not infectious, the number of the people in an area is controlled and limited, using appropriate Personal Protective Equipment (PPE), disinfecting surfaces, reducing the time spent in closed areas and controlling aerosol generation procedures.

The hospital premises of the Trust are in general ageing. The inpatient areas in Royal Preston Hospital are poorly ventilated in general.

To mitigate the risk of spreading the infection and providing fresh air a trial was undertaken on 4 sample bays on 2 wards whereby the air quality was monitored 24/7. The wards in question were Wards 20 and 24 and where selected as a comparison between wards that had been upgraded to meet a compliant HTM03 specification (E.g., Ward 20) and a significant proportion of the wards which do not meet the HTM03 ventilation guidance (E.g. ward 24). Results from the trial have demonstrated that the risks of airborne transmission are significantly reduced when HTM compliant ventilation is installed.

As the costs and access to retrospectively upgrade ward ventilation is constrained there was a need to mitigate the risk of the poor ventilation related to the potential spread of COVID-19 infection. To do this the Trust has procured over 100 mobile air purifier machines. These units are capable removing bacteria and viruses from closed areas. Their capacities are limited and cannot be used everywhere, and it should be noted that they re-circulate air inside as opposed to replacing with fresh air. These air purifiers have been deployed in the most at risk inpatients areas including the non-compliant ward bays and COVID Majors unit in the Emergency Department.

The air purifiers are also used for temporary deployment after cardiac arrests. Poorly ventilated outpatient clinics undertaking high risk procedures have also been supplied with air purifiers in order to reduce the fallow times in between the patients for aerosol generating procedures. Additional Air purifying systems have been resourced for offices and staff rest rooms to prevent in house spread of COVID- 19 infection among staff.

It is recommended that all new buildings and departmental refurbishment in future should meet the full HTM03 ventilation recommendations to better control the associated risks of airborne transmission of infection.

4.4 Decontamination

In September 2021 SGS External Auditors carried out an audit regarding the transition from 93/42/EEC to UK MDR2002 Regulation 14, the certificate is valid from December 2021 to December 2026.

SGS Recertification Audit took place November/December 2021 on Standard ISO 13485: 2016 certificate valid from December 2021 to December 2024.

Transition of instrumentation for the New Day case Theatres at Chorley District Hospitals (CDH), Ophthalmology Theatres & Clinics from Royal Preston Hospitals (RPH) to CDH, all instrument trays had to be re-barcoded for the track & traceability of instrumentation.

The updated guidance in January 2020 on 'Reducing the risk of transmission of Creutzfeldt-Jakob Disease (CJD) from surgical instruments used for interventional procedures on high-risk tissues. The updated guidance requires instruments being kept moist in theatres for 2 hours prior to reprocessing. The sterile services procedures were updated in line with the agreed process with theatres & staff training implemented in 2021.

4.5 Endoscopy

The Operational Engineer confirms that weekly, quarterly and annual testing of endoscopy washer/disinfector machines are up to date. The results can be viewed on the same spreadsheet as the Hospital Sterilisation and Decontamination Unit (HSDU) results (decontamination test schedule 2021). There is an upgrade in the facilities due to start at RPH to comply with the Joint Advisory Group (JAG) audit.

4.6 Environmental Cleaning /Disinfection and Waste Management

Environmental cleaning/disinfection processes that were put in place in response to the COVID-19 pandemic remain. The COVID-19 outbreak has also put extra pressure on waste management in the Trust. Using more PPEs and vaccines and segregating the clinical waste according to new regulations have been challenging. New Waste Management Standard Operating Procedure was published by NHS England in September 2020 and has been updated twice since. To comply with these new rules and regulations around the COVID-19 pandemic a gap analysis has been completed, and new local Standard Operating Procedures (SOPs) have been created for all health care areas.

The Trust continues to work towards sustainable waste management and implementation of the Trust's Green Plan. LTHTR does not landfill any non-clinical waste streams, which are either recycled or recovered.

A number of waste streams are separately segregated for recycling including; cardboard, plastic bottles, confidential waste paper (following shredding), waste electrical and electronic equipment, wood, mattresses, batteries, fluorescent tubes, cooking and engine oils, IT consumables and scrap metal.

Garden waste at RPH is composted and food waste from our food outlets is sent for recovery via anaerobic digestion. Where feasible furniture and equipment is reused via the on-line Warp-it system, although a cyber-attack has limited the use of this system over the last year. The system should be up and running again soon but thanks to the Portering Teams a large amount of equipment has been reused manually with their help.

Although Covid is still having an impact on clinical waste production, it is anticipated that this will start to level off in the next few months. However, this may be replaced by increased wastes produced from additional post Covid activity. The clinical waste contract has been extended for a further year although this has incurred additional costs due to national Covid pressures, and recent driver and fuel shortages.

The new colour coding system implementation for clinical waste will be restarting this year, with the aim of further improving segregation and efficiencies.

The Strategic and Operational Waste Groups continue to provide an excellent forum for waste issues, discussions and projects. This has been further strengthened by the introduction of the Trust's Social Value Group who also meets regularly. Working alongside the Communications Team and Blended Learning Teams, engagement with all staff will be taking place to increase waste awareness, education and training over the next year.

It is more important now than ever, that all staff, wards, departments and contractors play their role in ensuring and promoting sustainable waste management. This includes following policies and procedures for the segregation and storage of waste, along with reviewing procurement of products and services that could adversely affect the waste we produce. It is essential that the organisation focuses on the waste hierarchy of reduction, reuse, recycling and recovery, rather than disposal, with waste reduction being the ultimate aim.

5.0 Financial implications

None.

6.0 Legal implications

Non-compliance presents a risk to regulation breaches that would impact on the registration of the organisation.

7. Risk profile

ID	Title	Description	Current score
693	Covid 19	There is a risk that the organisation's operational capability (clinical and non-clinical) will be significantly affected as a result of the Omicron variant and increased infection transmissibility of the COVID 19 Pandemic in the UK. The key risks identified relate to: include 1. Workforce - Having sufficient workforce who are suitably trained to deliver services and participate in the restoration plan. There is the potential for sickness to increase to 25-30% based on early findings in the South. 2. Safety and Quality - Having sufficient planned and unplanned care provision of suitable beds and equipment to deliver safe and effective experiences of care. 3. Operational - Having sufficient estate to continue to dual run emergency facilities on two sites whilst commencing restoration. 4. Financial - The ability to deliver financial efficiency plans whilst responding to increase in demand and restoration. 5. Reputational - Demonstrating sufficient responsiveness in the organisations recovery and restoration following the pandemic. This could result in an inability to deliver services that consistently deliver excellent care.	20
1157	Increased C.*difficile* Infection	There is a risk that we will breach our national objective for C.*difficile* for 2022/23 and that patients will contract C.*difficile* whilst an inpatient in the Trust. In 2020 this risk was significantly increased due to the impact on ward environment, patient numbers and care delivery capabilities during the Covid 19 pandemic. If there is an increased rate of C.*difficile* infection there is an increased impact to patient safety and patient experience, along with potential reputational damage to the Trust regarding Infection Prevention and Control practices.	16
1302	Insufficient side rooms to meet Infection prevention & control requirements & demand	We have proportionately less side rooms at LTHTR than in other comparable hospitals. We have only 20 % side room as a total of our bed capacity as compared to 30 % for ELTH. This increases the risk of Healthcare associated infections and outbreaks and potential death to patients from infections acquired in hospital and Risks to reputational loss. There are not enough side rooms across the Trust for the demand this results in bed blocking in E.D and causes delays for patients already bays awaiting a side room due to Infection. This poses a risk of spreading infections and potential outbreaks of multiple infections such as C.*difficile* and Norovirus. This could also put the Trust at risk of breaching the annual objective due to spread of infection and increase in C.difficile and other infection rates.	16

8. Impact on stakeholders

None noted.

9. Recommendations

It is recommended that:

I. The Council of Governors note the contents of the Annual report and acknowledge the scrutiny afforded to the detail at Safety and Quality Committee and confirm that it is assured of progress against the 2021/22 Annual Plan.
II. Note the IPC Annual Plan 2022/2023.

APPENDIX 1

Infection Prevention and Control (IPC) Annual Programme 2021/2022

The annual programme for 2021/2022 will continue to have a strong focus on effective communication, education and learning to provide clean, safe care. It will strengthen and embed actions implemented in 2018/2019. In order to improve patient safety and reduce healthcare associated infections, infection prevention and control must continue to have a high profile as an evidence-based specialty and patient safety issue within the organisation.

Communication of lessons learned, especially following post infection reviews (PIR), is a key strategy to support the Annual Programme. The PIR process introduced in 2017/2018 continues to be strengthened. This PIR process comprises a multidisciplinary team meeting including clinical teams, support services and governance and has been applied to a range of infection prevention and control incidents.

The annual programme is based upon SMART principles and has 9 sections, all of which have the relevant Health & Social Care Act Hygiene Code criteria assigned. The 9 sections are as follows: 1) Staffing 2) Education & Development 3) Information sharing and communication 4) Audit & Surveillance 5) Post infection review 6) Environment 7) Antimicrobials 8) Winter preparedness 9) policies and procedures

This annual programme details developments and changes to the IPC service, which will be introduced to improve patient safety, reduce healthcare associated infections and strengthen learning and communication.

The Divisions and IPC team will be responsible for delivery of this programme and progress will be monitored monthly at the Trust Infection Prevention and Control Committee (IPCC) meetings

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

				Ongoing Task	Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	1.1.0									
IPCT		Develop closer working of the IPC Team with the operational site management team to support operational bed management and patient safety	1	Deputy Nursing, Midwifery & AHP Director	Restructure the membership of the IPCC and include Trust operational management in the membership	Deputy Nursing, Midwifery & AHP Director	Q1	Y		
	1.2.0									
IPCT		Review when 7 day working is required and what is possible		Matron IPC / Deputy Director of Nursing	Wrtie a paper to provide 7/7 working	Matron IPC	Q1	Ongoing		SM has completed the financial costings surrounding 7/7 working with finance. CS is working on a proposal to be presented at Board. The IPC Team are currently providing a restricted service on weekends. Carried over to next years plan

Ongoing Task Milestone

Domain	Reference	Aim	Relevant Hygeine Code Criterion	Lead	Actions	Action By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	2.1.0									
Education Programme	2.1.1	Ensure that there is a comprehensive education programme that meets the needs of Trust staff	4, 6, 10	Matron IPC	To review and update the mandatory infection prevention and control education delivered to clinical and non-clinical staff	IPC Team / Lead nurse / Blended Learning team	Q3	Y		The IPC Team are liaising with Blended Learning in terms of reviewing both learning packages and updating the E-learning
	2.1.2	Expand IPC education to the bed management team to support operational management in the Trust	4, 6, 10	Matron IPC	To develop bespoke learning for the bed management team based on best practice guidelines and real life clinical cases	IPC Team	Q1,2,3,4	Y		1:1 training has been completed with each of the bed management team as well as IPC training sessions with site management.The IPC Team support the bed management team daily via telephone, MS Teams and by completing isolation audits
	2.2.0									
Mandatory Training	2.2.1	To reduce vascular device associated bloodstream infections	4,6	Divisions	To include the numbers and review outcome and learning of Vascular device infection in the Divisional reports for presentation at IPCC	Divisions with support of CVAD team	Q 1,2,3,4	Y		Included in each Division's monthly IPC report
	2.3.0									
		Expand the infection prevention and control link worker programme throughout the Trust to strengthen IPC communication and cascade IPC training for frontline staff	1	Matron IPC	Increase the number of education sessions for IPC link workers and continue to provide a quarterly report on progress of the link worker programme at IPCC	IPC Team	Q1,2,3,4	Ongoing		The IPC Link Nurse Day scheduled for 28/10 was stood down due to capacity in the IPC team. The next day has not yet been arranged. Continued to next years plan
	2.4.0									
		Improve knowledge surrounding sampling on admission areas		Lead IPC Nurse	Provide bespoke training for admission areas, particularly focusing on management of diarrhoea including ED	IPC Team	Q2	Y		At CDI PIRs, the management of patients with diarrhoea is discussed and actions are created for learning. The Continuous Improvement Team are doing a specific focus on CDI which will include training. Rapid testing is now in place and whiteboards are being introduced in the Trust.
	2.5.0									
		Develop a new process for Post Infection Reviews		Deputy Nursing, Midwifery & AHP Director	Write a paper describing the process for PIRs with governance leads taking responsibility for the PIR	Deputy Nursing, Midwifery & AHP Director	Q1	Y		Governance leads are now planning and scheduling PIR meetings to ensure the meetings are quorate. The actions from the PIRs are being uploaded to Datix to record progress and completion.
	2.6.0									
		Identify and report IPC audit gaps in standards through divisional IPCC.		Matron IPC / Data Admin IPC	Feedback through divisional committees and feedback to IPCC.	Matron IPC / Data Admin IPC	Q1, Q2, Q3, Q4	Y		Included in monthly IPC Teams report

				Ongoing Task	Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	3.1.0									
Electronic Communications		Enhance communication, education and awareness of IPC issues in the Trust via social media	4,6	Matron IPC	Use IPCT twitter account to communicate to Trust and local community and health economy including other local acute Trusts about activities and themed events	IPC Team	Q 1,2,3,4	Y		The IPC twitter page is being updated regularly
	3.2.0									
Reducing healthcare associated infection		Sharing learning and examples of good practice around IPC within the Trust.	1, 4, 6	Divisional Leads	Divisional leads to provide evidence of cross divisional working with audits and reviews detailed in the divisional IPCC reported	Divisional Leads	Q2	Y		Each division to share
	3.3.0									
		Develop strategy to include positive feedback in communications		Deputy Nursing, Midwifery & AHP Director /IPC Nurses	Develop a strategy document for celebrating good practice and success	Deputy Nursing, Midwifery & AHP Director /IPC team	Q1	Y		Letters have been drafted and issued celebrating good practice on behalf of the IPCC
	3.4.0									
		Change communications from 'this is what has to happen' to what can be celebrated and has been achieved		Deputy Nursing, Midwifery & AHP Director /IPC Nurses	Implement strategy	Deputy Nursing, Midwifery & AHP Director /IPC team	Q4	Y		As part of CDI PIR's good practice is always celebrated and actioned to share with areas as well as being fed to IPCC. Positive escalation is discussed at each IPCC.
	3.5.0									
	3.5.1	Develop a closer relationship with IT		DIPC / Chief Information Officer	Obtain IT support to support IPC dashboards	DIPC / Chief Information Officer	Q1	Y		Dashboards for CDI and RSV are now Live
	3.5.2	Develop a closer relation with the Lab		DIPC	Set up quarterly meetings	DIPC	Q1	Y		Quarterly meetings have been arranged between the IPC team and the Lab. The next meeting is scheduled for 06/01/2022

Domain	Reference	Aim	Relevant Hygiene Code Criterion	Lead	Actions	Action By	Completion Due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	4.1.0									
Infection Prevention and Control Reports		To communicate the LTHTR performance against mandatory infection objectives in the IPC Team report and Board papers for 2020/2021	1,4	DIPC	Revise IPC Team report to reflect changes in mandatory reporting and the objectives for 2020/2021(confirmation of objectives awaited at time of writing)	DIPC	Q1	Y		
	4.2.0									
Surgical Site Infection		Ensure that LTHTR is compliant with reporting on mandatory surgical site infection surveillance in orthopaedics and completes actions for continuous improvement	1,4	Orthopaedic Directorate	To report collated quarterly data and ongoing actions for improvement to IPCC	Divisional Nursing Director/ Mandatory SSI lead	Q 2,4	Y		
	4.3.0									
Gram negative bloodstream infection		Improve intelligence about contributory factors for Gram negative bacteraemia in LTHTR as part of the Central Lancashire Health Economy reduction plan for 2020/2021	1,4	DIPC	To report progress biannually to IPCC	DIPC	Q 2,4	Y		
	4.4.0									
Surveillance	4.4.1	To strengthen surveillance of multidrug resistant bacteria in the Trust	1,4,8	Matron IPC	To implement contract tracing function in the Quadramed	Matron / IPC Team	Q3	Ongoing		Focused on CDI and RSV initially. Carried over to next years plan
	4.4.2	Develop IT software to expand monitoring of multidrug resistant organisms and HCAI's	8	DIPC / Information specialist / Chief Information Officer	To implement IT software including IPC actions taken to provide assurance	DIPC / Information specialist / Chief Information Officer	Q1	Ongoing		Focusing first on C.difficile and RSV. Dashboards for CDI and RSV are now Live. Carried over to next years plan
	4.4.3	Review what we are auditing and the audit process and ensure cycle complete		DIPC / Matron IPC	Meet to review	DIPC / Matron IPC	Q3	Ongoing		STAR, National Cleaning Standards and IPC to amalgamate audits. Carried over to next years plan
	4.4.4	Introduce at least fortnightly senior infection prevention walkabouts		DIPC / Deputy Director of Nursing / IPC Team	Review estate and identify any environmental issues	DIPC / Deputy Director of Nursing / IPC Team	Q1, 2,3,4	Y		Fortnightly IPC walkabouts have been completed and are continually scheduled with the DIPC, Deputy Director of Nursing and a member of the IPC Team
	4.5.0									
Sepsis management improvement		To improve sepsis management in LTHTR	4,6	Matron IPC / IPC Team	To present a report on progress around improving the management of sepsis	Sepsis Lead	Q 1, 2,3,4	Y		Awaiting Q3 report
	4.6.0									

Carbapenemase producing Enterobacterales		Review the National guidance for CPE testing and implementation		Lead Biomedical Scientist for Microbiology	Write a business case to make CPE testing compliant with national guidance	Associate DIPC	Q2	Y		The business case of the CPE screening is in progress. The draft policy is under review

				Ongoing Task	Milestone					
Domain	Reference	Aim	Relevant Hygeine Code Criterion	Lead	Actions	Action By	Completion Due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	5.1.0									
Post Infection reviews	5.1.1	To share and embed the learning from Post Infection Reviews (PIRs)	1,4,6	DIPC	Completion of the Action plan from PIRs to be detailed in Divisional IPCC reports and presented at Trust IPCC	IPC Team	Q 2,4	Y		Divisional IPC Chair's reports have been updated to include C.difficile cases, outcomes and completed actions
	5.1.2	Ensure the Governance leads attend and lead the PIR process by arranging meetings, including stakeholders		Deputy Nursing, Midwifery & AHP Director	Agree approach to coordination of PIR and ensure this links to divisional governance arrangements.	Governance leads		Y		Divisional Governance teams now co-ordinate PIRs and monitor and report actions to Datix.
	5.1.3	Create C.difficile specific Datix dataset which includes 'lapses of care' and actions which can then be easily collated by divisions.		DIPC / Deputy Divisional Nursing Director / Governance and Risk Manager	Agree at MDT collaborative what is required and commission work to create the data set.	DIPC / Deputy Divisional Nursing Director / Governance and Risk Manager	Q1	Y		PIR outcomes are now added to datix by Governance teams as well as actions
	5.2.0									
		Ensure IPC incidents, complaints and risk register are visible in IPCC		Deputy Nursing, Midwifery & AHP Director	Ensure IPC incidents, complaints and risk register are included in the IPCC Agenda	IPC Data Admin	Q1,2,3,4	Y		IPC incidents, complaints and risk register are included in the IPCC Agenda monthly
	5.3.0									
		Ensure lessons are learnt in terms of mortality relating to COVID-19		DIPC	Provide a report on the outcome of structured judgement reviews for COVID-19 to IPCC	DIPC	Q3	Y		

Ongoing Task | Milestone

Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	6.1.0									
Water safety		Provide assurance to IPCC in regards to water safety management	2	Assistant Director of Estates	Provide quarterly reports to IPCC on water safety management including abnormal results and remedial actions	Water Safety Group	Q1, Q2,Q3,Q4	Y		
	6.2.0									
Environmental and Equipment Cleaning and Decontamination	6.2.1	To improve the cleanliness of the environment	2	Matron IPC	Review and define the Trust cleaning standards in compliance with National Cleaning standards for 2021/2022	Associate Director of Facilities	Q2,Q4	Y		
	6.2.2	To improve the cleanliness of environment	2	Associate Director of Facilities	Chair report Estates and Facilities partnership board	Hotel Services Manager	Q1, Q2, Q3, Q4	Y		
	6.2.3	Provide assurance of the of the Trust's environmental cleanliness and report the findings to Divisions on a monthly basis.	2	Associate Director of Facilities	Monitor progress and compliance and report monthly to IPCC. IPC Team to support and provide guidance on products.	Hotel Services Manager/IPC Team	Q1, Q2, Q3, Q4	Y		
	6.2.4	To provide assurance of compliance with Trust environmental cleaning and decontamination procedures	2	Associate Director of Facilities	Collate and include data on audits of joint monitoring in Divisional IPCC agenda, Divisional Nursing reports, Harm free Care.	DNDs / Hotel Services Manager	Q1,2,3,4,	Y		
	6.2.5	To provide assurance of compliance with Trust environmental cleaning and decontamination procedures from a Nursing perspective	2	Matron IPC Team	Implementation of a discharge cleaning checklist and include data on audits in Divisional IPCC agenda	DNDs / IPC Team	Q1,2,3,4,	Y		Has been to design authority. Large piece of work as it is an organisational change. Will be approached from an admission perspective rather than discharged.
	6.2.6	To ensure all cleaning information is up to date		Matron IPC / Associate DIPC	Review and monitor all literature and available information is kept up to date	Domestic Management / IPC Leads. Associate DIPC	Q3	Ongoing		Continued to next years plan
	6.3.0									
Decontamination		To provide assurance to the IPCC in regard to Decontamination management	2	Decontamination Lead	Provide monthly reports to IPCC on Decontamination management including track and trace and remedial actions from findings	Decontamination Manager	Q1,Q2,Q3,Q4	Ongoing		Continued to next years plan
	6.4.0									
		Review and implement a strategy on air purification and ventilation		Estates	Provide a bi-annual report and create a ventilation policy	Associate DIPC / Assistant Director of Estates	Q2, 4	Ongoing		Continued to next years plan
	6.5.0									
		Reduce the number of incidents of dirty equipment going back to medical services.		DNDs	Develop a Trust-wide process	DNDs	Q1	Y		
	6.6.0									
		IPCT to strengthen environmental audit to highlight the estate failure that effect infection control and escalate		Matron IPC	Feedback at divisional IPC and IPCC	IPC Team	Q1,Q2,Q3,Q4	Y		
	6.7.0									

		Review isolation facilities and utilisation in emergency department		DIPC	Present a report on the isolation facilities and develop an audit process	DIPC	Q3	Ongoing		Verbal report - unable to fit Redi-rooms in ED due to size. Working with IT to work into app surrounding a live isolation room audit. Carried over to next years plan

Ongoing Task Milestone

Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	7.1.0									
Antimicrobial stewardship	7.1.1	Provide assurance to IPCC that objectives are being met in relations to CQUIN for sepsis and AMR	3	AMR Lead	Quarterly report on point prevalence audits	AMR lead	Q1, Q2,Q3,Q4	Y		Awaiting Quarter 3 report
Antimicrobial stewardship	7.1.2	Strengthen knowledge and skills of IPC nursing team around antimicrobial stewardship	3	Deputy Nursing, Midwifery & AHP Director	IPC nursing team member to complete non-medical prescribing course.	Matron IPC & Lead Nurse	Q4	Y		Helen Leach is in the process of completing the application for this year's intake. Sonya Magrath completed the non-medical prescribing course in 2020-21

8.0 Winter Preparedness & Resilliance

				Ongoing Task	Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	8.1.0									
Norovirus		IPC preparation for Norovirus season is in place by end of October 2021	5, 6	Deputy Nursing, Midwifery & AHP Director	To present a winter preparedness paper to IPCC to include outbreak management	DIPC/Matron IPC	Q2	Y		Completed, Policy will be re-issued to staff when new rapid testing is implemented and available to site managers. Duplicate action for next years plan
	8.2.0									
Influenza		IPC preparation including POCT for seasonal influenza in place by end of October 2021	5, 6	Deputy Nursing, Midwifery & AHP Director	To present a winter preparedness paper following a multidisciplinary meeting led by Operations/Emergency preparedness team to IPCC to reinforce management and risk assessment of all patients with suspected influenza	DIPC/Matron IPC	Q2	Y		Quick reference guides have been sent to Bed Management and Point of Care testing has been implemented.
	8.3.0									
COVID 19		IPC preparation for the impact of further waves of COVID 19 and future pandemics	5, 6	Deputy Nursing, Midwifery & AHP Director	To present to IPCC a multidisciplinary position paper to focus on identifying challenges around the physical environment, actions required to address them to develop future resilience for infection incidents	Deputy Nursing, Midwifery & AHP Director	Q2	Y		
	8.4.0									
Emergency Preparedness		Review the emergency preparedness plan		Head of EPRR and Patient Flow	Review and update the emergency preparedness plan collaboratively	DIPC / Head of EPRR and Patient Flow / IPC Team	Q4	Ongoing		Meeting to be arranged with DIPC / Head of EPRR and Patient Flow / IPC Team. Carried over to next years plan

			Ongoing Task		Milestone					
Domain	**Reference**	**Aim**	**Hygiene Code Criterion**	**Lead**	**Actions**	**Actioned By**	**Completion due**	**Complete Y/N**	**RAG**	**Embedded Evidence Y/N N/A**
	9.1.0									
Policy and procedure		Provide assurance policies and procedural documents are in date and complete to enable the prevention of infections.	9	IPC Matron / DIPC	Provide assurance through the monthly IPC report of the status of policies owned by IPC and that they are in date and reviewed within the required time	IPC Matron / DIPC / IPC Team	Q1, 2, 3, 4	Y		

Appendix 2

Infection Prevention and Control (IPC) Annual Programme 2022/2023

The annual programme for 2022/2023 will continue to have a strong focus on effective communication, education and learning to provide clean, safe care. It will strengthen and embed actions implemented in 2021/2022. In order to improve patient safety and reduce healthcare associated infections, infection prevention and control must continue to have a high profile as an evidence-based specialty and patient safety issue within the organisation.

Communication of lessons learned, especially following post infection reviews (PIR), is a key strategy to support the Annual Programme. The PIR process introduced in 2017/2018 continues to be strengthened. This PIR process comprises a multidisciplinary team meeting including clinical teams, support services and governance and has been applied to a range of infection prevention and control incidents.

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This annual programme details developments and changes to the IPC service, which will be introduced to improve patient safety, reduce healthcare associated infections and strengthen learning and communication.

The Divisions and IPC team will be responsible for delivery of this programme and progress will be monitored monthly at the Trust Infection Prevention and Control Committee (IPCC) meetings

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3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Ongoing Task Milestone

Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	1.1.0									
IPC Team	1.1.1	Develop closer working of the IPC Team with the operational site management team to support operational bed management and patient safety	1,2	Deputy Nursing, Midwifery & AHP Director	Restructure the membership of the IPCC and include Trust operational management in the membership	Deputy Nursing, Midwifery & AHP Director	Q1	On Track		Bed Management have been invited to IPCC
	1.2.0									
IPC Team	**1.2.0**	Restructure of the IPC Team	4,5,6	Matron IPC / Deputy Nursing, Midwifery & AHP Director	Investigate financial funding for the expansion of the IPC Team	Deputy Nursing, Midwifery & AHP Director	Q2	On Track		Awaiting Finance information for Band 6 and 7's
	1.3.0									
Inter-relations / Wider Community / Strategic working	1.3.1	Standardise working across the ICS	1,2,3,4,5,6,7,8,9	Matron IPC / DIPC	Work collaboratively with the ICS providing IPC strategic working, expertise and driving future changes	Matron IPC / DIPC	Q4	On Track		Work is being completed and an end of year report will be brought to IPCC.
	1.3.2	Provide consultancy for external charities to support in IPC practice	1,2,3,4,5,6,7,9	Matron IPC	Liaise with Derian House to provide IPC advise, auditing and education	Matron IPC / IPC Team	Q2	On Track		Work is being completed and an end of year report will be brought to IPCC.

Ongoing Task Milestone

Domain	Reference	Aim	Relevant Hygeine Code Criterion	Lead	Actions	Action By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	2.1.0									
Education Programme	2.1.1	Ensure that there is a comprehensive education programme that meets the needs of Trust staff	4, 6, 10	Matron IPC	To review and update, if necessary, the mandatory infection prevention and control education delivered to clinical and non-clinical staff	IPC Team / Lead nurse / Blended Learning team	Q4			
	2.1.2	Expand IPC education to the bed management team to support operational management in the Trust	4, 6, 10	Matron IPC	To develop bespoke learning for the bed management team based on best practice guidelines and real-life clinical cases	IPC Team	Q1,2,3,4	On Track		QuadraMed side room audit, invite to Link nurse sessions, complete bespoke training sessions
	2.1.3	Continue the Infection Prevention and Control link worker programme throughout the Trust to strengthen IPC communication and cascade IPC training for frontline staff	1,2	Lead IPC Nurse	Increase the number of education sessions for IPC link workers and continue to provide a quarterly report on progress of the link worker programme at IPCC	IPC Team	Q1,2,3,4	On Track		Agendas, sign in sheets, presentations
	2.1.4	Improve knowledge surrounding sampling and isolation for patients with diarrhoea in the Trust	1,2,3,4,5,6,7	Matron IPC	Provide bespoke training focusing on the management of diarrhoea	Lead IPC Nurses / IPC Team	Q2	On Track		
	2.1.5	Manage isolation rooms accordingly	1,2,6,7,9	Matron IPC	Implement a live system on QuadraMed to identify infectious patients in side rooms to produce reports to support Bed Management in the de-isolation of patients to ensure isolation rooms are utilised effectively.	Bed Management / IPC Team	Q2	On Track		
	2.1.6	Improve compliance with mandatory IPC / ANTT training with Foundation (Junior) Doctors	1,4,6	Educational Supervisor Lead	Create a mandatory IPC / ANTT training plan for Foundation (Junior) Doctors	Educational Supervisor Lead	Q3			IPCC Education programme (compliance improvement)

Ongoing Task Milestone

Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	3.1.0									
Electronic Communications		Enhance communication, education, and awareness of IPC issues in the Trust via social media	4,6	Matron IPC	Use the IPC Team Twitter account to communicate to Trust and local community and Health economy including other local acute Trusts about activities and themed events	IPC Team	Q 1,2,3,4	On Track		The IPC twitter page is being updated regularly
	3.2.0									
Patient Lived Experience	3.2.1	Sharing learning and examples of good practice around IPC within the Trust.	1, 4, 6	Divisional Leads	Divisional leads to provide quarterly patient lived experience / story to share learning and good practice or lessons learnt	Divisional Leads	Q 1,2,3,4	Ongoing		Discussed at IPCC and agreed that W&C will provide the patient lived experience / story for Quarter 1, Surgery for Quarter 2, DCS for Quarter 3 and Medicine for Q4. W&C to present in September IPCC

					Ongoing Task	Milestone				
Domain	**Reference**	**Aim**	**Relevant Hygiene Code Criterion**	**Lead**	**Actions**	**Action By**	**Completion Due**	**Complete Y/N**	**RAG**	**Embedded Evidence Y/N N/A**
	4.1.0									
Infection Prevention and Control Reports	4.1.1	To communicate the LTHTR performance against mandatory infection objectives in the IPC Team report and Board papers for 2022/2023	1,4	DIPC	Review IPC Team report to reflect changes in mandatory reporting and the objectives for 2022/23	DIPC	Q1	Y		
	4.2.0									
Surgical Site Infection	4.2.1	Ensure that LTHTR is compliant with reporting on mandatory surgical site infection surveillance in orthopaedics and completes actions for continuous improvement	1,4	Orthopaedic Directorate	To report collated quarterly data and ongoing actions for improvement to IPCC	Divisional Nursing Director/ Mandatory SSI lead	Q 2,4	Ongoing		Awaiting report as evidence - is in progress
	4.2.2	To improve the auditing process for the surveillance of Surgical Site Infections	1,5,8	Orthopaedic Directorate	BI to standardise IT applications to improve the auditing process	Orthopaedic Directorate / Bi-portal	Q3	Ongoing		From an improvement perspective, the detail and assurance for the report needs strengthening and there has been a small working group meeting fortnightly for improvements. Currently work is being completed with the IT team to look at developments in QuadraMed to improve the auditing process.
	4.2.3	To reduce vascular device associated bloodstream infections	4,6	Divisions	To report progress biannually to IPCC and quarterly to Divisions	Divisions with support of CVAD team	Q 2,4	Ongoing		Awaiting report as evidence - is in progress
	4.3.0									
Gram negative bloodstream infection	4.3.1	To reduce Gram-negative bacteraemia cases	1,5,6,8	DIPC / CCG Quality & Performance Specialist / Always Safety-First Leads	Task and Finish Group including the CCG as part of the Always Safety-First Improvement process to promote education and standardisation of documentation to allow consistent auditing	DIPC / CCG Quality & Performance Specialist / Always Safety First Leads	Q3			Catheter audits have been completed and improvements have been made to documentation and will go live at the end of September - QuadraMed analysts focusing on diarrhoea first.
	4.3.2	Improve intelligence about contributory factors for Gram negative bacteraemia in LTHTR as part of the Central Lancashire Health Economy reduction plan for 2022/23	1,5,6,8	DIPC / CCG Quality & Performance Specialist	Work with the CCG on producing High Impact Interventions for the reduction of Gram negative bacteraemia	DIPC / CCG Quality & Performance Specialist	Q 2,4	On Track		
	4.4.0									
Surveillance	4.4.1	Monitor and review Line infections in NICU to improve line management and reduce infection	1,5,6,8	Bi portal / NICU Consultant	BI-portal team to review and put a system in place to provide line surveillance for NICU patients	Bi portal / NICU Consultant	Q3	Ongoing		Update from Dr Sandeep Dharmaraj in September IPCC
	4.4.2	Review what we are auditing and the audit process and ensure cycle complete	1,2	DIPC / Matron IPC	IPC Matron and Quality Matron to review and update audits to improve the IPC section of the STAR audit	DIPC / Matron IPC	Q2	Ongoing		The STAR monthly and visit templates have been reviewed by IPC Matron and STAR Matron. The updates will be presented at the Matrons monthly meeting for approval and input. A task and finish group is being started regarding mattress cleaning and audits.
	4.4.3	Continue with senior Infection Prevention and Control Environmental checks	1,2	DIPC / Deputy Director of Nursing / IPC Team	Review estate and identify any environmental issues	DIPC / Deputy Director of Nursing / IPC Team	Q1,2,3,4	On Track		
	4.5.0									
Sepsis management improvement	4.5.1	To improve sepsis management iin LTHTR	4,6	Divisional Nursing Directors / Matron IPC	To present a report on progress around improving the management of sepsis and monitor the actions set in IPCC	Sepsis Lead	Q1,2,3,4	On Track		

Ongoing Task Milestone

Domain	Reference	Aim	Relevant Hygeine Code Criterion	Lead	Actions	Action By	Completion Due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	5.1.0									
Post Infection reviews	5.1.1	To share and embed the learning from Post Infection Reviews (PIRs)	1,4,6	DIPC	Completion of the Action plan from PIRs to be detailed in Divisional IPC reports and presented at Trust IPCC	IPC Team	Q1,2,3,4	On Track		Discuss standardisation of Divisional Chair's reports
	5.1.2	Ensure IPC incidents, complaints, patient feedback and IPC risk register are visible in IPCC	1,4,6	Deputy Nursing, Midwifery & AHP Director	Demonstrate an improvement in the frequency of IPC incidents and complaints	IPC Data Admin	Q1,2,3,4	On Track		Included in each IPCC Agenda
	5.1.3	Share learning from Outbreak management to highlight good practice and areas for learning and improvement	1,4,6	Matron IPC	Include any outbreaks and periods of increased incidents within the IPC Team report	IPC Team	Q1,2,3,4	Y		Included in each IPC Teams report

Ongoing Task Milestone

Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	6.1.0									
Water safety		Provide assurance to IPCC regarding water safety management	2	Assistant Director of Estates	Provide quarterly reports to IPCC and the Trust Health and Safety Governance Group on water safety management including abnormal results and remedial actions	Water Safety Group	Q1,2,3,4	On Track		
	6.2.0									
Environmental and Equipment Cleaning and Decontamination	6.2.1	To improve the cleanliness of the environment	2	Matron IPC	Review and define the Trust cleaning standards in compliance with National Cleaning standards for 2022/2023	Associate Director of Facilities	Q2, Q4	Ongoing		The monitoring standards have been completed. The enhanced measures implemented throughout the pandemic have remained with chlorine and enhanced cleaning.
	6.2.2	To improve the cleanliness of environment	2	Associate Director of Facilities	Chairs report Estates and Facilities partnership board	Hotel Services Manager	Q1,2,3,4	On Track		
	6.2.3	Provide assurance of the Trust's environmental cleanliness and report the findings to Divisions on a monthly basis.	2	Associate Director of Facilities	Monitor progress and compliance and report monthly to IPCC. IPC Team to support and provide guidance on products.	Hotel Services Manager/IPC Team	Q1,2,3,4	On Track		
	6.2.4	To ensure all cleaning information is up to date	2	Matron IPC / Associate DIPC	Review and monitor all literature and available information is kept up to date. Review new fogging and decontamination systems to ensure that areas are decontaminated appropriately and efficiently.	Domestic Management / IPC Leads. Associate DIPC	Q3	On Track		Trials of the new fogging system have commenced.
	6.2.5	Ensure Mattresses are fit for purpose and replenished as required	1,2	Associate Director of Facilities	Complete Annual Mattress audit to discard of any Mattresses that do not meet the Trust's standards	Associate Director of Facilities	Q3			
	6.3.0									
Decontamination	6.3.1	To provide assurance to the IPCC regarding Decontamination management	2	Decontamination Lead	Provide quarterly reports to IPCC on Decontamination management including track and trace and remedial actions from findings	Decontamination Lead	Q1,2,3,4	On Track		
	6.3.2	Identify and report Decontamination audit gaps in standards through divisional IPC.	2	Decontamination Lead	Provide monthly reports to divisional IPC meetings to strengthen the current audit and for feedback and improvement for assurance of current gaps in audits	Decontamination Lead	Q1,2,3,4	On Track		
	6.4.0									
Ventilation	6.4.1	Review and implement a strategy on air purification and ventilation	1,2	Estates	Provide a bi-annual report and create a ventilation policy	Associate DIPC / Assistant Director of Estates	Q2, 4	Ongoing		
	6.5.0									
Medical Devices	6.5.1	Reduce the number of incidents of dirty equipment going back to medical services.	1,2	Divisional Nursing Directors	Task and Finish group meeting to be held to review a Trust-wide process	Divisional Nursing Directors	Q1	Ongoing		Task and finish group meeting has been arranged for September

Ongoing Task Milestone

Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	7.1.0									
Antimicrobial stewardship	7.1.1	Provide assurance of Trust performance against Start Smart and Focus antimicrobial stewardship standards'	3	AMR Lead	Quarterly report on point prevalence audits	AMR lead	Q1, Q2, Q3, Q4	On Track		
	7.1.2	Strengthen knowledge and skills of IPC nursing team around antimicrobial stewardship	3	Deputy Nursing, Midwifery & AHP Director	IPC nursing team member to complete non-medical prescribing course.	Matron IPC & Lead Nurse	Q4	On Track		Both Lead IPC Nurses are completing the Mary Seacole Leadership course this Autumn. The prescribing course will be looked at in the next financial year.

Ongoing Task Milestone

Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	8.1.0									
Norovirus	8.1.1	Improve Norovirus management and knowledge across the organisation	5, 6	Deputy Nursing, Midwifery & AHP Director	Ensure the Norovirus policy is shared within the Divisions and educated to Link Nurses and implemented in outbreak management	DIPC/Matron IPC	Q1	On Track		Link Nurse sessions, outbreak meetings, shared learning
	8.2.0									
Influenza	8.2.1	IPC preparation including POCT for seasonal influenza in place	5, 6	Deputy Nursing, Midwifery & AHP Director	Hold a multidisciplinary meeting led by Operations/Emergency preparedness team and report to IPCC to reinforce management and risk assessment of all patients with suspected influenza	DIPC/Matron IPC	Q2	Ongoing		Meeting is scheduled for September
	8.3.0									
Emergency Preparedness	8.3.1	Review the emergency preparedness plan		Head of EPRR and Patient Flow	Review and update the emergency preparedness plan collaboratively	DIPC / Head of EPRR and Patient Flow / IPC Team	Q1	Ongoing		Meeting is scheduled for September

				Ongoing Task	Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	9.1.0									
Policy and procedure	9.1.1	Provide assurance policies and procedural documents are in date and complete to enable the prevention of infections and education of staff	1,4,9	IPC Matron / DIPC	Provide assurance through the monthly IPC report of the status of policies owned by IPC and that they are in date and reviewed within the required time	IPC Matron / DIPC / IPC Team	Q1, 2, 3, 4	Y		

			Ongoing Task	Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	10.1.0									
CDI Reduction Plan	10.1.1	Improve Nursing documentation surrounding diarrhoea	1,4,6	Chief Nursing Information Officer	Include a question around diarrhoea in standardised nursing documentation	DNDs Delegates DIPC IPC Matron	Q1	Y		Nursing Kardex has been updated regarding diarrhoea, SBAR and fluid balance however further work is in progress to strengthen.
	10.1.2	Timely management of treatment and isolation of patients	1,2,7	DIPC / IPC Team	Explore Risk assessing all Type 5,6,7 stools as per the Department of Health Guidelines	DIPC / IPC Team	Q1	Y		
	10.1.3	Improve estates issues in areas with high C. difficile infection rates	1,2,7	Assistant Director of Estates	Develop an action plan to correct estates issues prioritising areas with high C. difficile infection	Matron IPC	Q3	On Track		IPC environmental checks have been completed highlighting areas of concern and areas that require improvement. IPC Matron has raised this at the Estates and Facilities partnership board and the Capital team. There is a priority list awaiting funding.
	10.1.4	Have a collective Trust-wide approach on diarrhoea and isolation compliance	1,2,4,5,7	DIPC / IPC Team	Education on use of whiteboards to review patients with diarrhoea and isolation compliance	DIPC / IPC Team	Q1	Y		Is discussed and demonstrated at CDI PIR meetings, ward rounds and Link Nurse days. Wards are now utilising the dashboard and reviewing patients daily.
	10.1.5	Identify CDI rapidly to aid in the appropriate isolation and management of patients	1,2,4,5,6,7	DIPC / IPC Team	Encourage use of Rapid Intestinal Testing to identify patients with CDI and other infections to utilise isolation facilities and improve patient safety	DIPC / IPC Team	Q1	Y		Is discussed and demonstrated at CDI PIR meetings, ward rounds and Link Nurse days
	10.1.6	Ensure the case for Rapid Intestinal testing is established		DIPC / IPC Team	Perform an evaluation on the efficacy of the Rapid Intestinal Testing	DIPC / IPC Team	Q1	Y		
	10.1.7	Timely management of treatment and isolation of patients		IPC Team	Ensure diarrhoea dashboard is reviewed daily and shared with Clinical Leader / Nurse co-ordinator	IPC Team	Q1	Y		IPC Team report
	10.1.7	Gain assurance on the completion of fogging following cases of C. difficile	1,2	Director of Facilities	Highlight the hotspot areas of C. difficile in the Trust and develop an action plan regarding fogging and the implementation of planned fogging	Matron IPC	Q2	Ongoing		The hotpsot areas have been identified and Divisional Nursing Directors are reviewing plans to decant over weekends.

			Ongoing Task	Milestone						
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	11.1.0									
Living with COVID 19		Introduce living with COVID-19 Guidance	1, 2, 5, 6	Deputy Nursing, Midwifery & AHP Director	Provide education and updates on recent changes in National Guidance. Update Trust policy in accordance with changes	Deputy Nursing, Midwifery & AHP Director	Q1	Y		

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors Report

Patient Experience and Involvement Strategy			
Report to:	Council of Governors	**Date:**	3rd November 2022
Report of:	Nursing, Midwifery and AHP Director	**Prepared by:**	A Brotherton, S Cullen, C Silcock
Part I	✓	**Part II**	

Purpose of Report							
For approval	☐	**For noting**	☒	**For discussion**	☐	**For information**	☐

Executive Summary:

The purpose of this paper is to present the new 2022 – 2025 Patient Experience and Involvement Strategy. The strategy has been co-designed with patients, colleagues and partners utilising NHS Improvements' Patient Experience Framework 2021, publications from the Health Foundation and the Kings Fund.

The strategy is framed upon the consistent principles adopted within the Always Safety First Strategy.

i. Insight,
ii. Involvement
iii. Improvement

The strategy sets out the approach to improving patient experience in Lancashire Teaching Hospitals after considerable consultation and triangulation of qualitative and quantitative data from the entire suite of data on patient experience available. The strategy will be overseen by the Patient Experience and Involvement Group who provides a chairs report to the Safety and Quality committee and progress will be presented annually to the Safety and Quality committee.

It is recommended that the Council of Governors:

1) Note the strategy and agree to receive an annual update report on progress.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To offer excellent health care and treatment to our local communities	☒	Consistently Deliver Excellent Care	☒
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive innovation through world-class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration
Safety & Quality Committee September 2022

Together

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust







Patient Experience and Involvement Strategy
2022–2025

Excellent care with compassion

Always Safety First

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Contents

Patient Experience is everybody's business

Foreword

"Patients and their carers are our best witnesses of healthcare. Being centre of the healthcare process, unlike most staff, they observe almost the whole process of care, meaning that they can provide invaluable insights into the quality and delivery of care provision. An evidence-based approach to patient experience can help improve services for both patients, and those delivering services" (Health Foundation 2013).

At Lancashire Teaching Hospitals NHS Foundation Trust, we understand that improving the experience for patients and their carers, our staff and our partners is fundamental to everything that we do. As we launch our second Patient Experience and Involvement strategy, we have reviewed the evidence base for improving patient experience and engaged with our patients, families, carers, colleagues, and governors as our strongest partners to co-produce our vision, strategy and implementation plan to continually improve our patients experience.

In developing this strategy our teams have reviewed the Patient Experience Improvement Framework (NHS England, 2018), an evidence-based organisational development tool that gives Trusts a framework to assess their current approaches to experience of care. This framework uses the areas of leadership, culture, collecting data, triangulating data, learning for improvement and reporting to inform the development of Patient Experience strategies and delivery plans to cover all aspects of experience of care from patients, families and carers as well as staff.

We understand that during the Covid-19 pandemic improving patient experience was difficult for healthcare organisations, especially during times when visitors were not permitted. As we launch this strategy, we commit to maximising improvements in patient experience. By working together, we can build on our compassionate culture, recognising the connectivity between staff and patient experience and nurture the conditions required for continuous improvement in patient experience to flourish.

People's lived experience is a powerful tool to improve existing services and identify new and better ways to meet their needs (King's Fund, 2022). We will listen and learn from the local communities that we serve in a variety of different ways moving forward. Through this strategy we commit to using the insights and intelligence from our extensive sources of data from local Healthwatch teams to large scale national patient surveys, citizen assemblies and service user stories to co-produce our improvements.

We also commit to learning from the best as we further involve our patients and local communities. Co-production is a meeting of minds coming together to find shared solutions. From the launch of this strategy, we will involve people who use our services not only in consultations but through working together from the start to the end of any project that affects them, we will co-produce better solutions and services together. "When co-production works best, people who use services and their carers are valued by organisations as equal partners, can share power and have influence over decisions made" (King's Fund 2022) and this is our commitment to the communities we serve.

Through this strategy and implementation plan we will also embed patient experience into our improvement programmes at every level and will co-produce and deliver an ambitious patient experience improvement programme, aiming to learn from global leaders in this field.

We thank our patients, local communities, staff, partners and governors who have been involved in the development of this strategy and look forward to working with you as equal partners to deliver this strategy.

Sarah Cullen
Nursing, Midwifery & AHP Director

Kevin McGee
Chief Executive

Prof. Paul O'Neill
Acting Chairman

Dr. Gerry Skailes
Medical Director

Strategy overview

Our three year strategy (2022-2025) is designed around our Trust ambition to Consistently Deliver Excellent Care for our patients and describes the Lancashire Teaching Hospitals ambition to deliver a positive patient experience delivered in partnership, whilst improving outcomes and reducing harm, getting it right first time and ensuring a safe, caring environment.

Developing the strategy

Our previous Patient Experience and Involvement Strategy ended in March 2022. Continuing the work, we have focused on listening and learning, whilst setting a vision for our new Patient Experience and Involvement Strategy 2022-2025. We asked patients, relatives, carers, colleagues, governors, and partner organisations to contribute to setting the actions in the strategy. We have actively sought the views from patient groups who represent those with protected characteristics and recognise the importance of intersectionality when considering this feedback. We have also used intelligence and insight from patient feedback, national patient surveys, friends and family tests, complaints, concerns and compliments and Care Quality Commission (CQC) reports to inform our actions. We will continue to work in partnership with these forums to review progress and constantly look for ways to improve and involve patients in any changes we make to our services.

We understand that patient experience has been impacted upon by the COVID-19 pandemic and this has potentially changed what good patient experience feels and looks like whilst also changing some of the processes and ways of working in clinical environments. Whilst challenging, this brings an opportunity to reshape what good looks like in the 'living with Covid-19' world.

We have learned from our feedback that whilst we often get things right for our patients, further improvements are required to ensure consistency across pathways of care and coordinated compassionate care in all of our services.

The Patient Experience and Involvement Strategy is closely linked to a number of our Trust strategies including our Equality, Diversity and Inclusion strategy, our Workforce Strategy, our Mental Health and Dementia Strategy and also our Safety Strategy, Always Safety First. We know that patients and families often identify risks and if listened to, this provides an opportunity to avoid harm in healthcare settings. This is an important part of our strategy and aligns closely to the Always Safety First Strategy.

We also know the environment where care is provided has a significant impact on experience. Lancashire Teaching Hospitals is part of the New Hospitals Programme nationally. This recognises the age of the estate and the limitations this presents in upgrading estate work. However, our patients tell us that cleanliness is one of the most important features and we will strive, particularly where the estate remains challenging to ensure cleanliness is prioritised.

It is important to us that our staff feel proud of the care they deliver and would recommend the organisation as a place to work and a place to receive care. These principles should be seen as golden threads throughout the strategy.

Defining our approach to patient experience

NHS Improvement published a patient experience improvement framework in June 2018 which identified the following consistent themes which have been incorporated into the framework to support self-assessment at an organisational level. The self-assessment will be undertaken in partnership with our patients to provide a baseline measure.

Theme	Key elements that impact on patient experience
Leadership	• Where all the workforce and stakeholders were aware of and worked with an organisation strategy with an explicit patient safety focus, this reflected services that were well designed to meet the needs of patients. • Where staff were proud of the organisation and engagement in quality improvement and the strategy were strong, this was reflected in excellent interactions between staff and patients and between staff themselves. • Visible and accessible leadership sets the tone for the staff. • Where the board heard a patient story at every meeting the executive and non-executive directors appeared to have an understanding of patients' experiences.
Organisational Culture	• An open and transparent organisational culture has a positive impact on staff and patients. • Where there were highly encouraged and evident innovation and quality improvement programmes, there was also a notable improvement in the patient experience. • Where there is a culture of all staff groups showing pride in their work and in being part of the organisation, this seemed to lead to a real commitment to learn from mistakes. • Where staff were proud of their organisation as a place to work and spoke highly of the culture coupled with consistently high levels of constructive engagement, staff at all levels were keen to contribute to service improvement which led to a positive patient experience. • Patients also have a positive experience where there is a culture of safety across an organisation that puts the patient first and gives patient experience the highest priority with the implementation of real-time patient feedback.
Compassionate Care	• Patient experience is positive when staff give care that is compassionate, involves patients in decision-making and provides them with good emotional support. • Patient experience was enhanced when staff ensured there was time for patients to ask questions, when people using the services were treated as individuals and their specific emotional needs considered, including their cultural, emotional and social needs. • Patients and public voice should be heard through a number of sources including the council of governors feeding information into the trust, with clear processes for feedback. • Where staff created a strong, visible, person-centred culture, they were highly motivated and inspired to offer the best possible care to patients. • The appointment of a head of patient experience indicated organisational commitment to this aspect of quality. • Patient experience was positive when patients and their families felt involved and understood what to expect in relation to their care. Patient experience was improved where staff treated patients with dignity and respect at all times.

Safe Staffing Levels	• Nurse staffing levels appear to be a decisive factor in good patient experience. • When escalation processes were well defined and embedded throughout the organisation to ensure safe staffing this appeared to link to a positive patient experience. Staff did not appear to feel the burden of nurse vacancies when staffing levels and skill mix were planned, implemented and reviewed to keep patients safe at all times. • A strong culture of shared ownership for patients, along with effective multidisciplinary working, had a direct impact on patient and staff experience. • Effective multidisciplinary working secured good outcomes and seamless care. Where a multidisciplinary approach was actively encouraged there were examples of co-ordinated care having a positive impact on patient experience. When staff in all disciplines worked well together for the benefit of patients, patient experience was positive, and this correlated with Friends and Family Test and the staff survey
Consistent Incident Reporting and learning lessons	• Where there was a strong 'just'* culture staff felt empowered to report incidents and recognised the importance of reporting them to ensure patient safety. • Patients had a positive experience even when complaining as long as complaints were responded to in a timely and appropriate manner. This usually resulted from in a conversation with the patient and being open about the incident. In these cases the Duty of Candour was followed and trust processes were open and transparent for patients, families and carers. • Where there was a wide range of data to monitor and measure clinical outcome this was related to a positive patient experience, assurance provided at board level and an Outstanding-rated organisation. • Where there was effective governance and assurance the board had clear oversight of the risks affecting the quality, experience, and safety of care for patients.

Source: Adapted from the NHS Improvement Patient Experience Framework
*This has been updated from the self assessment of the framework to reflect the latest work on just culture.

Coproduction - a new way of working (King's Fund 2022)

Coproduction outlines a different way of working in which the relationship between patients and local communities who use our services changes from basic engagement or consultation to a more meaningful form of involvement with a more equitable level of power between partners. Within this strategy we make a commitment to work in partnership with our patients, their carers, staff, governors and wider partners to coproduce the service improvements that will deliver improvements in patient experience on an equal footing. Working together we will design and deliver a comprehensive patient experience programme.

Our patients' experience is also a key component of quality improvement, where patient feedback can identify areas that need improving and how they could be improved. There is a strong link between people having positive experiences of care and other aspects of quality, including clinical effectiveness and patient safety *(Doyle et al 2013)*.

Measuring Impact

The Health Foundation have undertaken an evidence scan focused on measuring patient experience which included a review of 328 empirical studies.

Strategies for measuring patient experience can be viewed along a continuum, from those that collect detailed descriptive feedback to those that collate numerical data. The measurement plan for this strategy will include both quantitative and qualitative data.

The Strategy

The strategy has been divided into three sections:

(i) **Insight**: Improve our understanding of patient experience and involvement by listening and drawing insight from multiple sources of information.

(ii) **Involvement**: Equip patients, colleagues and partners with the skills and opportunities to improve patient experience throughout the whole system.

(iii) **Improvement**: Design and support improvement programmes that deliver effective and sustainable change.

Through this strategy we recognise the opportunity to shape a culture that is more sensitive to listening and acting on feedback that is consciously inclusive, individualised and sensitive to the needs of the patient and family. By doing this we aim to change the way services are delivered to design out the health inequalities in our systems and processes.

Our ambition is to better and consciously meet the needs of people, who due to protected characteristics are more likely to incur negative experiences.

Key enablers and stakeholders are identified within the strategy, specifically creating the infrastructure for improving patient experience. The successful delivery of this strategy is underpinned by culture, leadership, engagement and education programmes of work. These programmes of work will be supported by robust data analysis at patient group level to ensure we are able to listen and act more effectively.

Measurement Strategy

We will have a suite of outcome measures that will enable us to measure success and these are aligned to Our Big Plan. The improvement measures are identified within the insight section of the strategy and include:

- Reduction in complaints
- Improved recommendations via Friends and Family test
- Increased responses to Friends and Family test
- Increased compliments
- Improved outcomes in National patient surveys
- Improved response times to concerns and complaints
- Reduced number of 2nd complaints
- Increased evidence of patient co-production
- Improved training metrics in communication, customer care and early resolution

Our Big Plan strategy

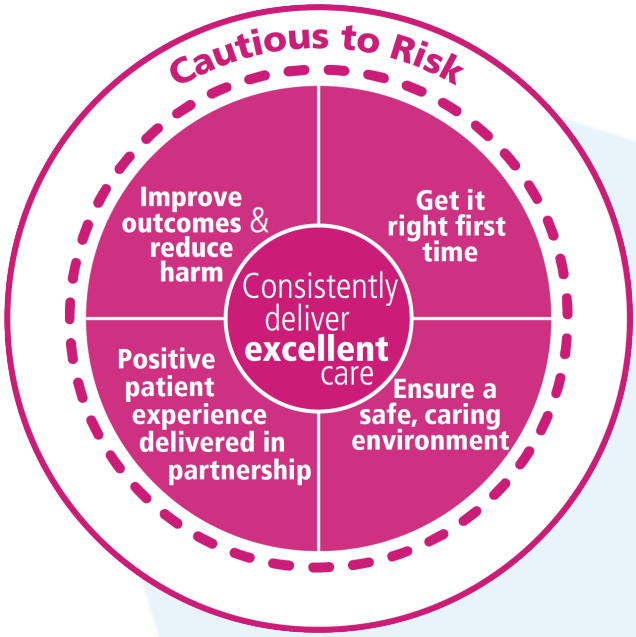
Alignment to Trust objectives

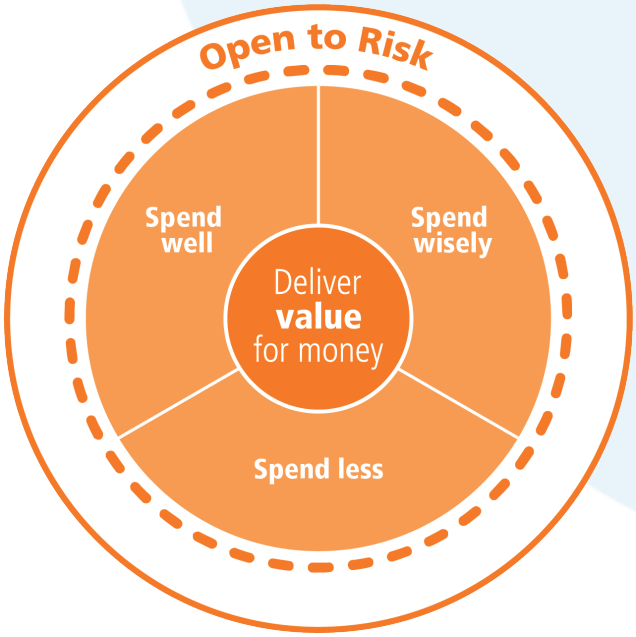
The objectives defined in this plan are framed on the Trust's core objectives which are:

- To provide sustainable and outstanding healthcare to our local communities
- To offer a range of high quality services to patients in Lancashire and South Cumbria
- To drive health innovation through world class education, training and research

These objectives are translated into key deliverables founded on four ambitions:

Our three year strategy (2022-2025) is designed around our Trust ambition to Consistently Deliver Excellent Care for our patients and describes the Lancashire Teaching Hospitals ambition to deliver a positive patient experience delivered in partnership, whilst improving outcomes and reducing harm, getting it right first time and ensuring a safe, caring environment. However, patient experience is reliant on each of the ambitions within our big plan and as such the strategy should be read alongside Our Big plan and supporting strategies.





How our patients will see and feel our values in action

At Lancashire Teaching Hospitals our values set out the behaviours we expect our staff to show to one another when caring for you as one of our patients. Our values are at the very centre of what we all do and define who we are both as individuals and as an organisation.

Our values are more than just words, they are the bedrock of our organisation and should remain constant in every situation. We seek to live by our values so we can create a positive, trusting, supportive atmosphere enabling us to always deliver an exceptional quality of care. We have high standards for our staff, we believe that we should always act with professionalism, integrity, compassion, empathy, understanding, showing dignity and respect to staff, patients and families from all groups or backgrounds.

We hope as a patient or relative you will be able to see us live the values in how we communicate, behave, work and care, we would want them to be apparent in every interaction we have with you.

The five core values we live by are;

Being Caring and Compassionate

To demonstrate we are working in line with this value we will:

- Use every opportunity to show care and compassion
- Have 'I'm here to help' frame of mind
- Try to understand what it is like to be in your shoes
- Be honest
- Give you the time and opportunity to express how you feel
- Take action to help make things better
- Provide you with information as a way of reducing the fear of the unknown
- Provide feedback to explain what has happened if things go wrong
- Be welcoming and friendly at all times

Recognising Individuality

To demonstrate we are working in line with this value we will:

- Listen to you in order to understand your views
- Ask you how you feel about your treatment
- Seek to understand your needs so we can provide you with the most appropriate care or service
- Check that you understand what we have said and provide you with a more simple explanation if need be
- Be self aware, understanding the impact our behaviour has on you and your relatives
- Try to understand your feelings and identify what we can do to assist you
- Give feedback in a sensitive yet constructive manner
- Be respectful of all

Seeking to Involve

To demonstrate we are working in line with this value we will:

- Ask you for your opinion, making you feel equal in any conversation
- Address you and not talk in front of you as though you are not there
- Use a communication style that emphasises listening over lecturing
- Seek to involve other colleagues, in order to provide you with the right level of expertise and determine what approach would be the best for you
- Give thanks and value all contributions regardless of who makes it
- Offer to get involved rather than waiting to be asked
- Explain why, so you can understand the reasons for the decision and what it means for you
- Offer guidance when complex choices have to be made

Building Team Spirit

To demonstrate we are working in line with this value we will:

- Work as one joined up team towards a common goal – providing you with high quality care
- Do what it takes to provide a high quality service by stepping outside of our 'normal' job roles if necessary to smooth out problem areas
- Take a shared approach to your care by effectively communicating across the team, ensuring colleagues have the information they need to understand your situation and to prevent you from having to repeat information
- Make use of each others' strengths, using colleagues' skills and knowledge to provide the best possible service
- All work to the same standards providing a seamless service regardless of the situation, time of day and who is involved
- Be courteous and polite
- Challenge colleagues in an appropriate manner if standards are not being met or values are not being 'lived'
- Use tact and tolerance when dealing with others

Taking Personal Responsibility

To demonstrate we are working in line with this value we will:

- Welcome constructive feedback then take steps to make changes in line with the feedback received
- Reflect on our own behaviour/performance identifying what could be improved
- Take a problem solving approach to challenges, issues or difficulties
- Propose solutions to resolve problems or processes that are not working
- Take issues on as they arise, rather than pretending we haven't noticed them in the hope someone else will sort it out
- Recognise that each of us is responsible for our own deeds, actions and language used
- Apologise for mistakes made and seek to put things right
- Be concerned when things are 'not right'

Delivering the Plan

The Patient Experience and Involvement Group, a sub-committee of the Safety and Quality Committee will oversee the implementation of this strategy, the committee will focus on the three major areas of work: insights, involvement and improvement.

This committee is made up of patients, carers, patient and carer groups, governors and staff colleagues and has a flattened hierarchy of team members to optimise our data and experience driven intelligence to identify the improvement priorities ('insights'),further improving the involvement of our patients, staff and stakeholders in designing the improvements required ('involvement') and overseeing the design, testing, implementation and monitoring of our improvement programmes ('improvement').

The deliverables outlined in this strategy will be delivered through the Patient Experience and Involvement sub-committee and monitored by the Trust Safety and Quality Committee, the committee will use the intelligence created through the subcommittee to inform future priorities of 'Our Big Plan'.

Progress will be monitored through a Patient experience dashboard, which will be developed. Progress will be reported via an annual report to the Safety and Quality Committee.

The Safety Triangulation Accreditation (STAR) Programme will be a key vehicle to test the deliverables of the strategy in action from ward to board and reported to Safety and Quality Committee and Board.

The strategy is applicable to all areas of the organisation including inpatient, outpatient, community and satellite services, adult,children and young people, maternity, intensive care and rehabilitation services.

The action plan will be reviewed quarterly to ensure delivery continues to remain on track and to ensure it continues to fully align with the Trust's Big Plan

The strategy will be considered as a fundamental strategy of the organisation and will evolve each year, considering broader learning elicited through other strategies across the organisation.

Our clinical and corporate teams will work together to implement this strategy. Each team will have a clearly defined role in supporting improvements in patient experience.

The 3 Year Patient Experience and Involvement implementation Plan

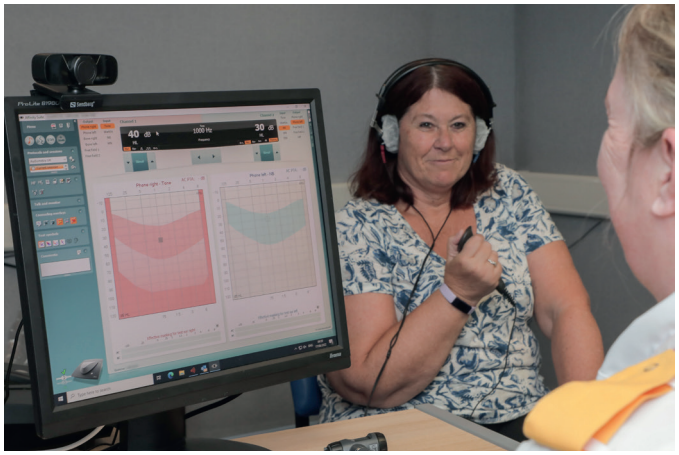
1. INSIGHT	**AIM:** *Improve our understanding of patient experience and involvement by listening and drawing insight from multiple sources of information.*

We will adopt and promote key patient experience measurement principles and use culture metrics to better understand how good patient experience is by:.

- Having an emphasis on continual feedback from patients, families and carers and measurement for improvement.
- Listening to patients
- Identify opportunities for improvement based on real feedback and act on these responsively

Year 1	Year 2	Year 3
Driving improvement We will create a dashboard of patient experience and involvement measures. Initiate key programmes of work and define reporting and monitoring arrangements for programmes of work. The dashboard will triangulate feedback sources e.g., themes from complaints, Friends and Family test, patient surveys to keep focus on our key areas of improvement.	**Driving improvement** We will use intelligence from the patient experience and involvement committee to inform improvement priorities for MCA.	**Driving improvement** We will review and refine the approach. We will deliver the improvement programme identified at the end of year 2.
Defining key programmes of work We will define key improvement (top 5 programmes of work) and initiate Plan-Do-Study-Act (PDSA) cycles on leading patient experience programmes of work.	**Defining key programmes of work** We will evaluate outcome of the PDSA methodology, refine and apply to next set of key programmes of work. We will establish a way to capture live feedback that enables services to be more responsive.	**Defining key programmes of work** We will design an improvement programme focused on leveling up the clinical areas to the level of the best.
Patient experience equality, diversity and inclusion We will mandate collection of each protected characteristic to enable the analysis of inequalities and patient experience processes, functions and outcomes. We will organise reports within the organisation to enable teams to review data through the eyes of people with protected characteristics developing a road map for year 2.	**Patient experience equality, diversity and inclusion** Based on a year 1 of analysis, we will identify key priorities within each area based on protected characteristic data. We will expand the definition of protected characteristics to include Indices of multiple deprivation analysis.	**Patient experience equality, diversity and inclusion** We will demonstrate improvements in identified areas of inequalities based on year 1 and 2 analysis and programmes of work.
Thematic analysis We will carry out a thematic analysis of patient complaints and concerns to be undertaken in each division, using the outcomes to inform areas of focus to improve patient experience. We will use this to understand gap where there may be an under-representation of feedback, and consider opportunities for feedback in the patient's journey (for example mental health).	**Thematic analysis** We will repeat thematic analysis to identify new themes to address, building the findings into the work programme.	**Thematic analysis** We will repeat thematic analysis to identify new themes to address, building the findings into the work programme.

Year 1	Year 2	Year 3
Friends and family feedback We will ensure all departments are actively participating in friends and family. We will increase the number of ways that patient can provide feedback including paper and other languages and acting upon the responses.	**Friends and family feedback** We will increase by 10% the volume of feedback from Friends and family looking at maximising ways to do this and acting upon the responses.	**Friends and family feedback** We will maintain the increase in friends and family feedback acting upon responses.
Patient experience culture We will establish baseline measurement of patient experience culture triangulating information from surveys, and patient feedback (including information communicated through patient forums).	**Patient experience culture** We will agree how to measure culture in relation to patient experience.	**Patient experience culture** We will repeat and embed learning from the feedback.
Research We will participate in The Health Foundation 'Scale, Spread and Embed' research project coordinated by Imperial College Healthcare NHS Foundation Trust. As a Phase 1 site, we will collaborate and test the use of natural language processing of free text specifically on patient experience feedback.	**Research** We will continue to participate in The Health Foundation 'Scale, Spread and Embed' research project coordinated by Imperial College Healthcare NHS Foundation Trust. In collaboration with the Phase 1 and 2 sites, refine and innovate to develop intelligence and insights provided by the digital advances testing the approach through continuous improvement methodology. We will proactively seek to be involved in research relating to patient experience.	**Research** We will internally develop advances made within the research period to refine and embed the digital advances to support Trust improvement initiatives specifically relating to patient feedback.



Year 1	Year 2	Year 3
National patient experience surveys We will ensure that results of each of the national surveys learning to be presented to Patient Experience and Involvement sub-committee and Safety and Learning Group to broaden opportunity to learn and develop action plans in response.	**National patient experience surveys** We will ensure delivery of the actions agreed in response to the National patient experience surveys.	**National patient experience surveys** We will evaluate the success to date and plan and deliver the work programme for year 3.
We will benchmark national survey and Benchmarking Standard responses to peer organisations to learn from what is working well elsewhere and strive to improve the national ranking position.	We will incorporate learning from peer organisations into Trust action plans and aim to improve the national ranking position.	We will evaluate actions to date and aim to improve the national ranking position to the next best quartile.
Improving patient experience communications We will link with the communications team to ensure that key lessons learned from thematic analysis of patient feedback is cascaded across the organisation and externally.	**Improving patient experience communications** We will develop sources of communication to ensure that learning is far reaching and evaluate the approach.	**Improving patient experience communications** We will re-evaluate lessons learned and modes of communication to continue to reiterate key messages.
We will link with the Always Safety First Committee to ensure that key patient experience themes related to safety are incorporated into the Always Safety First Bulletin and be physically displayed throughout key public areas of the organisation demonstrating a transparent approach to learning from safety within the organisation.	We will ensure that learning from Always Safety First will be evident throughout the organisation, with case studies and teams celebrating the successes of the programmes.	Teams will be supported to gain national recognition for their achievements.
We will ensure that colleague and patient experience feedback is displayed in all areas.	We will evaluate the display of patient experience feedback and improve if and where necessary.	We will continually improve the way that patient feedback is displayed and increase learning from other organisations and external partners.
STAR accreditation We will review the patient experience metrics embedded within the STAR process. We will reintroduce Governors to be involved in the STAR accreditation visits to enable real time patient feedback. We will collate themes and trends from patient experience measures to inform opportunities for improvement. Plans will be monitored.	**STAR accreditation** We will evaluate actions and improvements in response to STAR accreditation visits,. re-evaluate questions and actions agreed.	**STAR accreditation** We will continually learn from thematic analysis from STAR accreditation process to inform actions and learning.
Seldom Heard groups We will define those at highest risk and agree the approach to collecting feedback on what matters to the people in these groups. We will seek new ways to collect insights from groups that are less heard.	**Seldom Heard groups** A programme of improvement work will be created for these groups to spread learning across the organisation.	**Seldom Heard groups** We will build on the new insights and agree year 3 actions with the evolving sources of feedback.
Equality Quality Impact Assessment We will review the policy to ensure EQIA are undertaken in partnership with patients and the results are meaningful and apply to all change projects.	**Equality Quality Impact Assessment** We will develop a mechanism for sharing the outputs of EQIA processes to broaden insight in all divisions on patients views and feelings on change proposals.	**Equality Quality Impact Assessment** We will routinely access patient views and have mechanisms in place in all divisions to do so in an inclusive way.

2. INVOLVEMENT	**AIM:** *Equip patients, colleagues and partners with the skills and opportunities to improve patient experience throughout the whole system.*

We will commit to nurture a culture in our organisation where all teams are focused on creating a positive experience for each other and our patients:

- Plan and deliver people's care and treatment with them, including what is important and matters to them.
- Work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services.
- Treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.
- Listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress.

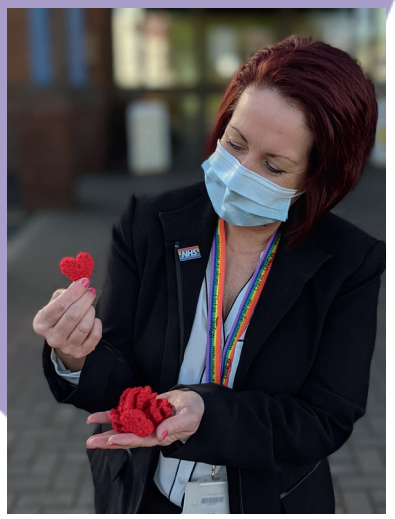
Year 1	Year 2	Year 3
Patients, carers, families and lay people as partners in safety We will align with the Always Safety First strategy and recruit to the role of Patient Safety Partners (PSP) representative of the community we serve. We will ensure that the PSP will reflect the diversity of the community we serve.	**Patients, carers, families and lay people as partners in safety** We will take feedback from the PSP to review the Always Strategy First year 1 and ensure year 2 reflects the areas that are important to them.	**Patients, carers, families and lay people as partners in safety** We will evaluate the PSP role and identify priorities for delivery in year 3.
The PSP will join the Always Safety First subcommittee and participate in the evaluation of evidence and design of solutions focusing on what matters to patients. We will recruit a senior midwifery advocate.	We will create a network of advocates and Patient safety Partners across the organisation to share experiences across specialities.	We will take the learning from year 1 and 2 and agree year 3 with the Patient safety Partners and senior Midwifery advocate.
Leadership We will define the role of leaders within the organisation in relation to patient experience and involvement and working with patients as partners.	**Leadership** We will ensure that Leaders at every level of the organisation will have an objective linked to improving patient experience as part of their annual appraisal.	**Leadership** We will evaluate effectiveness of interventions and activity in year 2 and use to inform year 3 priorities.
We will commit that all clinical areas will identify patient experience and involvement champions. The champions will continue to work with existing mental health , safeguarding and learning disability champions.	Representatives from the champions will be present to share their views at the patient experience and involvement group.	Patient champions will ensure that patient forums are established in their specialties.
We will increase ward leadership in wards greater than 28 beds in recognition of the challenges of managing large clinical areas.	We will commit to evaluating the impact on patient experience and involvement that having 2 leaders on large wards has made.	We will embed the learning from the evaluation once we understand the impact made on experience and involvement having 2 leaders has made.
Patient experience and involvement training We will agree a training programme and hierarchy of training needs.	**Patient experience and involvement training** We will train all clinical and non-clinical department managers as per training requirements.	**Patient experience and involvement training** We will monitor the training plan at departmental level.
We will develop leaders aligned with our Organisational Development programme so that living the values is directly linked to patient experience front and centre in all that we do.	We will showcase leaders who are creating cultures focused on patient experience.	We will continue to showcase leaders who are creating cultures focused on patient experience.

Year 1	Year 2	Year 3
We will develop a training module for leaders to understand the principles of local resolution, concern and complaints and how to respond.	We will achieve training for leaders by 50%. We will ensure this training is implemented and evaluated for effectiveness.	We will further increase training for leaders by 50%. We will continue to embed training and evaluate contribution to improving patient experience during annual appraisal.
Training in co-design will be identified, this will be delivered through FCA and MCA programmes.	All clinical departments will participate in improvement via FCA and MCA and embrace the patient co-design work.	Evaluate the impact of MCA and FCA participation on patient experience.
We will support all staff and students with a booklet about our Involvement services for patients, carers and our community.	We will increase access to this information ensuring colleagues can access the involvement booklet via clinical practitioners, induction, QR codes and our staff intranet.	We will maintain and update the Involvement booklet via our Patient Experience and Involvement team.
We will develop training sessions that have experts by experience co-delivering the training, to ensure learning from the patient, family or carer.	We will continue to develop the training to enhance the skills of our staff to support patients in enhanced levels of care and the use of activity or helpful strategies.	We will provide training in intersectional approach understanding that no one has just one identity and making sure that one identity e.g. a physical disability is not seen as a stand alone issue.
Volunteer involvement We will create a template and single point of contact for volunteers to give feedback on areas that can improve patient experience and involvement.	**Volunteer involvement** We will ensure that this feedback is acted upon and monitored for improvement.	**Volunteer involvement** We will develop the volunteer service via feedback and learning to continue to improve.
We will recruit a core group of volunteers to work with the patient experience team to enhance involvement and promote improvements. We will ensure full representation of the local diverse community to share their views on services and what matters most to them through the Patient Experience Involvement Group and other annual events, such as PRIDE, Windrush etc.	We will enhance volunteer training to enable them to support patient experience projects. We will use the feedback from each event to make a commitment to improve an area based on the feedback received.	We will continue to use feedback from patients/carers to explore and develop projects such as 'Navigation guides' using the volunteer service.
Working in partnership We will refresh the organisations approach to. "Hello my name is". We will ensure that all staff names are visible to patients.	**Working in partnership** We will ensure that "hello my name is" becomes embedded and is assessed via the STAR process.	**Working in partnership** We will continue to promote "Hello my name is". We will continue to assess via STAR process.
We will ask all inpatients what matters to them, and bed boards will be completed holistically and specifically based on the patient's preferences.	We will ensure that this process is embedded using direct feedback and the STAR process.	We will evaluate the use of bedboards.
We will engage with external partners and charities e.g. Galloways, Healthwatch, NCompass and our local Partnership Boards, amongst others via the patient experience and involvement group to be fully inclusive and ensure views and experiences are heard.	We will review membership and continue to check we are fully inclusive and learning.	We will continue to review membership of the involvement group and continue to check we are fully inclusive and learning from lived experiences.

Year 1	Year 2	Year 3
We will agree an approach that engages patients in new developments from their inception. We will continue to promote access to healthcare by events such as 'Our Health Day' for people with a learning disability and / or autism.	We will ensure that patients views are paramount and heard in all change and new developments using a checklist approach.	We will ensure that no new projects can be agreed unless it is evident that patient's views have been sought as part of the scoping work.
We will ensure that holistic assessment of patient's requirements are made and any reasonable adjustment plans are in place where needed.	We will ensure all staff are trained in Reasonable adjustments on internal systems.	We will ensure use of data from reasonable adjustments for clarity on our communities' diverse needs.
We will work in partnership to promote shared decision making between disabled people and health services, utilising the Kings fund publication Partnering for inclusion. https://www.kingsfund.org.uk/sites/default/files/2022-07/Partnering_for_inclusion_easy_read.pdf.	We will ensure all chairs of Trust patient forums report and feed into the Patient Experience and Involvement Group.	We will use new approaches developed through partnering for inclusion to hear more from those less well heard and design improvements fro specific groups.
We will build on current internal patient forums and connect with external partners to make system changes that affect a large number of people most likely to experience inequalities.	We will agree priorities as a system and work with partners across central Lancashire to improve experiences f those most likely to suffer health inequalities.	We will encourage collaboration and promotion of projects beneficial to patients and our communities.
Sharing lived experiences We will use narrative, data and lived experience to frame issues and engage towards a shared purpose with staff, patients and carers to improve learning and effect change in team meetings.	**Sharing lived experiences** We will have evidence examples of learning from sharing lived experiences and provide examples of positive patient experience change as a result.	**Sharing lived experiences** We will share examples of lived experiences as part of learning bulletins and partnership with patients to improve services.
Engaging with faith leaders We will ensure that we listen to what our patients tell us they need in relation to their faith.	**Engaging with faith leaders** We will continue to ensure representation of all faiths and cultures.	**Engaging with faith leaders** We will continue to provide information and education support for all staff in the production of guidebooks around culture and faiths.
We will continue to improve on recognising the needs from patients in all ethnic and religious groups.	We will use STAR to test the availability of faith resources as agreed in our faith forums.	We will continue to research and provide staff with support around any additional religious needs that may be required.
We will ensure that the bereavement boxes are present on every ward and this is tested as part of STAR. We will acknowledge religious events and ensure that these are treated with respect.	We will continue to provide and update the Trust Equality Diversity and Inclusion calendar to share relevant religious dates.	We will enhance our participation in religious events which will be inclusive of more services such as catering and communications.
We will provide the appropriate faith leader (if requested) to work collectively to deliver end-of-life care.	When requested cultures and faiths are respectfully recognised and represented during the patient journey.	Chaplaincy will ensure multi-faith representation is available.

Year 1	Year 2	Year 3
Patient Contribution to Case Notes (PCCN), Forget Me Not, Patient passports We will develop and implement a plan to ensure wards and departments are effectively using tools to enhance patient experience whilst in hospital. We will monitor progress via STAR. We will embed these tools in the role of the clinical area patient experience champions.	**Patient Contribution to Case Notes (PCCN), Forget Me Not, Patient passports** We will evidence increased utilisation of the tools, gathering feedback around their effectiveness.	**Patient Contribution to Case Notes (PCCN), Forget Me Not, Patient passports** We will share examples of the contribution these tools have made to improving patient experience and continue to embed.
Interpreter services We will assess the interpreter services provision for the current service needs to ensure current technology, advice and guidance for staff to access on behalf of patients and their carers.	**Interpreter services** We will evaluate interpreter service provision to ensure it maintains fit for purpose.	**Interpreter services** We will continue to evaluate interpreter service provision. Interpreter services to be commissioned jointly with patients and carers.
We will increase recruitment of volunteers who can use sign language.	We will create a data base for volunteers who can use sign language.	We will continue to recruit volunteers who use British sign language to welcome patients before contracted interpreters are sourced.
We will measure feedback and satisfaction with users of interpreting services.	We will act upon feedback from users of interpreting services.	We will continue to evaluate and act upon feedback as part of quality assurance meetings with providers.
We will carry out thematic review of any incidents/complaints in relation to interpreter services.	We will ensure an action plan is in place to respond to learning from incidents/ complaints regarding interpreter services.	We will ensure actions are embedded in practice and continue to evaluate.
Bedside handovers We will engage with patients to review our process for bedside handovers, updating policy and maintaining confidentiality. We will consider areas that can be used for confidentiality when discussing sensitive matters or when external assessment is being completed (for example mental health).	**Bedside handovers** We will audit the process via STAR.	**Bedside handovers** We will review and re-audit the process.
Transformation programmes We will ensure that patients are involved in co-production of transformation projects ensuring that value-added components of the programmes is intrinsically linked to patients value added.	**Transformation programmes** We will ensure that all transformation programmes have evidence of patient involvement.	**Transformation programmes** We will ensure that all transformation programmes have evidence of patient involvement and co-production.
Making every contact count We will ensure that we take every opportunity to promote healthy lifestyles engaging in opportunities to offer advice and guidance around smoking cessation, reducing alcohol intake and promoting healthy lifestyles.	**Making every contact count** We will capture health promotion information and discussions on Quadramed.	**Making every contact count** We will capture health promotion information and discussions on Quadramed.

Year 1	Year 2	Year 3
Accessible Information Standard We will obtain a baseline of current standards that are met and mitigate any gaps creating an action plan towards making health care information accessible to identify, record, flag, share and meet information and communication support needs of patients, service users, carers and patients with a disability, impairment or sensory loss. https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/	**Accessible Information Standard** We will review annually in order to benchmark current position ensuring actions are being progressed and audit under the responsive Key Line of Enquiry to confirm k compliance with the standard.	**Accessible Information Standard** We will review annually to benchmark current position ensuring actions are being progressed and audit under the responsive Key Line of Enquiry to confirm compliance with the standard.
Patients Key Contacts We will respond to the feedback from patients with chronic or long term conditions who tell us that they value the role of a key worker as a point of contact to help navigate and support decision making. We will review what is working well and set this as our standard and benchmark where there are gaps in this provision.	**Patients Key Contacts** We will ensure that patients who do not have a key worker are informed of who they should contact and work towards improving this provision.	**Patients Key Contacts** We will ensure that patients who do not have a key worker are informed of who they should contact and work towards improving this provision.
Research We will continue to raise the profile of involving patients in research by promoting research studies and explaining why involvement in research is important for overall patient experience.	**Research** We will increase the number of patients involved in research and share stories of what this has meant to them and how this has affected their experience.	**Research** We will promote patient experience at research topics for internal degree and masters research topics and share the outcomes.



3. IMPROVEMENT	**AIM:** *Design and support improvement programmes that deliver effective and sustainable change.*

We will commit to continuously improve the experiences of patients and families in our organisation. We will seek to improve:

- the patient journey from admission, treatment and discharge
- the successful handover of accurate information to reduce duplication and increase confidence in the care patients and families receive.
- waiting and confidential areas for patients and families
- the therapeutic interventions for people in hospital beds

Year 1	Year 2	Year 3
Nutrition and hydration and assistance with meals We will provide food which is inclusive, tailored to patient's needs at the right time, right place and right patient.	**Nutrition and hydration and assistance with meals** We will measure the quality and provision of catering as a thematic review to establish whether actions taken have led to improvements.	**Nutrition and hydration and assistance with meals** We will gather feedback and continue to evaluate the effectiveness of actions taken to improve, identifying and responding to new intelligence.
We will celebrate with inclusive food faith events ensuring this is time sensitive when necessary.	We will improve the rating of food in the national surveys. We will improve the PLACE rating.	We will improve the rating of food in the national surveys. We will improve the PLACE rating.
We will ask you what you want to order and provide you with information so that you can make the right choice for yourself. We will ensure that patients with special requirements have their needs met e.g. such as patients who have Parkinson's and need to eat with medication. This will be tested through STAR. We will ensure all that require support at meal times, receive this and this is tested through STAR.	We will increase the availability of reasonable adjustments to support nutrition and hydration.	We will test the effectiveness of this using experts by experience.
Quality assurance We will agree a process to quality assure the responses to complaints and concerns and implement this process.	**Quality assurance** We will agree a process to quality assure the responses to complaints and concerns and implement this process.	**Quality assurance** We will agree a process to quality assure the responses to complaints and concerns and implement this process.
Maternity & Neonatal Transformation We will ensure that women will not feel alone and will treat them with kindness and respect. This will be measured through the national maternity survey.	**Maternity & Neonatal Transformation** We will utilise national initiatives such as the "15 steps" approach and "Whose Shoes?" to review and improve the care provided and environment it is provided in.	**Maternity & Neonatal Transformation** We will continue to gather feedback and evaluate the effectiveness of actions taken to improve the maternity service.
We will make sure that women have the contact details of their midwife. We will ensure that women are able to make a personalised care and support plan during their pregnancy, for labour and birth and following the birth of their baby.	We will continue to implement new national directives as they emerge and ensure action plans are shared with the Maternity Voices Partnership.	We will continue to implement new national directives as they emerge and ensure action plans are shared with the Maternity Voices Partnership.
We will ensure women can access help and advice and advice about feeding their babies during their care journey.	We will ensure breastfeeding areas will be improved across the organisation and in line with the baby friendly initiative.	We will increase the number of breastfeeding areas will increase. We will increase compliance with baby friendly Initiative (BFI) accreditation.

Year 1	Year 2	Year 3
We will seek to receive feedback in addition to Friends and Family and complaints to understand ways in which our services can improve experience for parents.	We will continue to co-design service improvements. We will upgrade the provision of birthing pools to ensure water births are accessible for all who choose this as a birthing option.	We will continue to co-design service improvements.
We will involve parents in the co-production of neonatal services utilising the "neomates" group to facilitate this.	We will become a neonatal network accredited Family Integrated Care Unit (FiCare).	We will respond to family feedback and focus on improvement in response to their experience
We will ensure partners can stay and support women during antenatal periods on the ward.	We will provide an outdoor space for women in labour that is conducive to the birth process.	We will identify the next area to improve with our Maternity Voices Partnership.
We will improve the facilities and experience for women who experience miscarriage. We will participate and achieve accreditation in standards set to support women who have had a miscarriage.	We will provide an improved baby memorial area. We will provide 7-day bereavement support services.	We will improve the facilities further for women who experience miscarriage.
Children and Young People We will ensure that children and young people have therapeutic activities which are fully implemented in clinical areas.	**Children and Young People** We will ensure that children and young people have therapeutic activities which are fully implemented in clinical areas and monitor.	**Children and Young People** We will ensure that children and young people have therapeutic activities which are fully implemented in clinical areas and monitor.
We will improve overnight facilities to optimise young people and children's outcomes.	We will improve review feedback on overnight facilities to optimise young people and children's outcomes.	We will review feedback on overnight facilities to optimise young people and children's outcomes.
We will ensure that age-appropriate activities are provided for 16 and 17 year olds being cared for on adult wards.	We will ensure that age-appropriate activities are provided for 16 and 17 year olds being cared for on adult wards.	We will ensure that age-appropriate activities are provided for 16 and 17 year olds being cared for on adult wards.
We will introduce a parent group to gain feedback and promote co-production in service change.	We will agree parent priorities to improve and co design these.	We will continue to work in partnership exploring the needs of looked after children using social care advocates
We will provide a multi-sensory space for children with disabilities at the Broadoaks site.	We will explore the provision of outdoor play for children on each of our sites.	We will implement increases in outdoor play provision.
We will introduce the role of patient experience lead for children to provide additional support across all areas.	We will learn from this and adopt the learning to clinical areas where children are seen in across the organisation.	We will continue to share the learning from the patient experience lead.
We will ensure that children and young people have an appropriate process to raise concerns or make a complaint and we will ensure feedback from the Emotional Health Family and Friends Test is collated and reviewed for learning. We will identify a training plan in relation to play for children's ward and ED.	We will enact the plan and train 50% of the staff in formal play training. We will roll out the process for children to raise a concern to all clinical areas they are seen in the organisation.	We will monitor the impact of the improvements through the national patient and parent surveys.

Year 1	Year 2	Year 3
Estate In recognition of the impact that our estate makes on patient experience we commit to a refurbishment plan for three clinical areas each year. Year 1 . • Gordon Hesling Building entrance – introduction of volunteer support space • Mental health facilities in ED for Children and adults • Create an alternative to hospitals for patients who do not meet the criteria to reside.	**Estate** We will commit to a refurbishment plan for three further clinical areas each year.	**Estate** We will commit to a refurbishment plan for three further clinical areas each year.
Pain management We will focus on improving pain management and test the effectiveness of this through STAR.	**Pain management** We will share learning from areas that manage pain more effectively.	**Pain management** We will see improvements in national audits relating to pain management.
End of life care We will continue to use the end of life Big Room to deliver integrated, collaborative palliative and end of life care and improve patient and carer experience and service outcomes based on principles of respect, dignity and compassion.	**End of life care** We will explore areas to be used for end of life quiet rooms for families.	**End of life care** Provide quiet areas for families of patients at end of life and for bereaved families.
We will define an increased target audience for advanced communication skills training.	We will achieve the target set once the audience is reviewed.	We will extend the number of people training in advanced communication skills.
We will embed the CARING model as our pledge to patients in last days of life and their loved ones.	We will monitor and evaluate CARING through the STAR audit.	We will continue to evaluate the impact of the CARING approach.
We will recruit families who have had experiences of bereavement to work in partnership to improve services.	We will use the national NACEL audit to drive the areas we focus on improving.	We will review and set an improvement goal for each of these in year 3.
We will deliver in partnership a Hospice at Home service to increase the number of patients who are able to die in their preferred place of care.	We will create the case to formally commission hospice at home pending outcome measures supporting hypothesised benefits.	We will deliver in partnership a hospice at home service that meets the need of the local population.
We will ensure bereavement services are available to all who experience loss 7 days per week.	We will ensure bereavement services are available to all who experience loss 7 days per week.	We will ensure bereavement services are available to all who experience loss 7 days per week.
Lost property We will ensure our processes around patient valuables is robust using patient experiences to build on the procedures we have in place.	**Lost property** We will ensure our process is established within all areas and test this using STAR. We will investigate when items are lost and share lessons learned to reduce the occurrence of this.	**Lost property** We will monitor this service regularly and listen to feedback in order to instil confidence from our patients and visitors to the Trust.

Year 1	Year 2	Year 3
Improve facilities for people while they wait We will ensure patients know timescales of any delays in clinical areas.	**Improve facilities for people while they wait** We will ensure details are provided of expected wait times and regularly update this information.	**Improve facilities for people while they wait** We will monitor wait times in clinical areas and adapt time slots if data shows continual trends of long waits.
We will provide comfortable and appropriate seating, that meets the needs of those using it in line with reasonable adjustments. This will be tested through STAR.	We will ensure that areas that experience long waits such as ED will have access to comfortable environments.	We will continue to listen to feedback from our patients and develop services.
Improving patient flow We will engage in improvement programmes via the Urgent and Emergency care transformation board to improve our patient flow throughout the hospital. This will reduce time patients spend in the emergency department and assessment units and ensure that patients time in hospital is value added and reduce waiting for services that will progress the pathway of care. We will ensure that discharge is well coordinated and occurs early in the day.	**Improving patient flow** We will continue to monitor our performance and seek out opportunities to continually improve patient flow, asking patients what matters to them.	**Improving patient flow** We will monitor our outcome measures and seek new ways to maintain progress.
Improve patient experience for those living with dementia We will promote understanding of our dementia community.	**Improve patient experience for those living with dementia** We will ensure all staff complete Dementia training.	**Improve patient experience for those living with dementia** We will continue to educate staff through e-learning packages.
We will ensure purple activity boxes are available to all patients and tested through STAR.	We will ensure purple activity boxes are available to all patients and updated following patient feedback over the year.	We will introduce innovative approaches to managing the experience of patients with dementia.
We will ensure promotion of Dementia champions in all clinical areas. We will ensure this Patient Experience Strategy is in line with the Dementia Strategy and progress monitored in relation to pathways, the Dementia Experience and Empowerment project (DEEP) and co-production with patients living with a dementia and their families and carers.	We will continue to promote the use of Forget Me Not passports. We will report progress on the Mental health and dementia strategy to the safeguarding Board and patient experience group.	We will report progress on the Mental health and dementia strategy to the safeguarding Board and patient experience group.

Year 1	Year 2	Year 3
Improve facilities for patients with a physical disability, autism, learning disability, mental health condition We will continue to promote the use of the Hospital Passport.	**Improve facilities for patients with a physical disability, learning disability, mental health condition** We will ensure a copy of the passport is taken so we can provide specific individualised care.	**Improve facilities for patients with a physical disability, learning disability, mental health condition** We will provide staff with information and updates on sources available through our Patient experience and Involvement team.
We will ensure all reasonable adjustments are recorded on our systems and test the use of this through STAR.	We will collate data so future appointments can be adapted to the requirements of the patient.	We will evidence increased use of reasonable adjustment tab on Quadramed.
We will ensure staff liaise with the Learning Disabilities team for specialist advise.	We will review progress with our partners to agree the next set of actions for blind, visually impaired	We will evidence an increased number of MDT care planning forums take place leading to improved person centred care.
We will continue to provide ward activity boxes for partially sighted or blind communities and test this through STAR.	We will review progress with our partners to agree the next set of actions for blind, visually impaired.	We will review progress with our partners to agree the next set of actions for blind, visually impaired.
We will continue to upgrade estate with hearing adjuncts in line with best practice and ensure we work with local groups to test the impact of our focus on hard of hearing and deaf communities.	We will review progress with our partners to agree the next set of actions for deaf and hard of hearing	We will review progress with our partners to agree the next set of actions for deaf and hard of hearing.
We will engage in the Learning Disability partnership Board and Autism Partnership Board working alongside experts by experience and our multi-agency partners to re-establish a Health sub group.	We will implement the national learning disability and autism strategy.	We will implement the national learning disability and autism strategy.
We will ensure promotion of the Learning Disability Champions and Mental health Champions. We will ensure this Patient Experience Strategy is in line with the Mental Health Strategy, the Learning Disability Plan and Autism Strategy.	We will monitor this through the safeguarding and patient experience and improvement group.	We will monitor this through the safeguarding and patient experience and improvement group.
Cancer care We will introduce a patient experience lead in Radiotherapy with a focus on improving the experience for patients attending for radiotherapy and establish a service user group.	**Cancer care** We will evaluate the impact that the patient experience lead in Radiotherapy with a focus on improving the experience for patients attending for radiotherapy and establish a service user group.	**Cancer care** We will ensure the patient experience lead is embedded in practice.
We will establish a cancer patient listening service to gain live feedback from cancer patients and address issues at the time if possible.	We will explore involvement in addressing the needs and support of service users receiving services from different clinical teams e.g. Buddying in different services and co-facilitating training with Macmillan Engagement Facilitator to build confidence, skills and knowledge.	We will involve patients and volunteers to work alongside the Macmillan assistant manager to work with patients in the community and provide care closer to home.
We will develop a cancer and end of life service user recruitment strategy.	We will continue Service users to be involved with the MPACE project and close working with key Macmillan figures.	We will explore a partnership approach with the third sector to share volunteer opportunities and collaborative working.
We will provide the Hope course using service users to facilitate the course in partnership with third sector partners..	We will continue to implement Service user involvement in all cancer interviews. We will continue to deliver and promote the HOPE courses for patients with cancer.	We will ensure Cancer patient and carers forum increases in membership.

Year 1	Year 2	Year 3
We will develop a work programme for the promotion of service user opportunities.	We will increase the diversity of patients and partners.	We will develop a process for patients as partners to present to the Board of Directors the progress made in this area.
We will develop a virtual forum for patients and carers to link in when they want and to choose which opportunities, they wish to be involved in.	We will continue to recruit service users for the forum and widen recruitment to the forum for diverse range of services users and carers to include BME, LGBTQ, over 75s, working age, disabilities, from all economic backgrounds etc.	We will deliver on the areas determined as priority areas for each protected characteristic group.
We will develop an standard operating procedure. to involve service users in all interviews for cancer staff. We will develop a training package guide for service users to assist in opportunities they can be involved in.	We will evaluate the effectiveness of this approach in partnership with patients.	We will focus on specialities that evaluate less effectively in the national cancer survey.
We will continue Service user involvement with the MPACE project and close working with key Macmillan figures.	We will test the cancer website against the exemplar and agree the next year improvements.	We will celebrate achievements and share the positive areas of practice.
We will continue to work with patients in develop the cancer website.	We will focus on specialities that evaluate less effectively in the national cancer survey	We will continue to focus on specialities that evaluate less effectively in the national cancer survey.
Patient involvement in safe discharge We will commence discharge planning from the time patients are admitted to the hospital	**Patient involvement in safe discharge** We will use discharge improvement work to ensure discharge occurs earlier in the day for patients and families.	**Patient involvement in safe discharge** We will continue to evidence improvement in this area.
We will ensure that discharge needs are clearly documented and shared with partner organisations where consent is given, this will reduce the need for patients and carers to repeat needs and wishes to achieve safe discharge.	We will commit that learning from discharge incidents will be shared and actions agreed.	We will learn from discharge incidents wand this will be shared and actions agreed.
We will review our patient information leaflet and relaunch this so it is shared with all patients to ensure a safe discharge.	We will ensure that the use of the patient information leaflet is tested through STAR.	We will ensure that use of the patient information leaflet will continue to be monitored.
We will introduce live feedback on the discharge process, this will be used to drive improvement in this area. Wards will be tested on this through STAR.	We will use feedback to change process or information shared.	We will build a reporting dashboard that tracks and time stamps discharge process.
We will continue to plan ahead for discharges and ensure where possible discharge letter and take-home medication is on the ward with the patient the day before their planned discharge.	We will work closely with carers service to better identify informal carers when planning patient discharges and offer onward referral for carers support and assessment. We will fully embed the "nothing said about me without me" principle for all discharge planning discussions.	We will evaluate the effectiveness of these interventions through the national patient survey.
We will implement post discharge follow up calls to a minimum of 50 patients per week (within 48hrs of discharge) who have has an inpatient stay, this will support ensuring they are safe, identify if any unmet needs were missed prior to discharge and ensure signposted or referred for relevant support. We will also gather feedback around their discharge and what could be improved.	We will include patient representatives on future improvement workstreams internally and across partner organisation improvement work. We will implement using patient feedback, changes and improvements to the process, this will be tested through the national patient survey.	We will implement using patient feedback, changes and improvements to the process, this will be tested through the national patient survey.

Year 1	Year 2	Year 3
We will have consistent representation at the care home collaborative to understand discharge impact on care and nursing homes with the aim to improve relationships and trust between organisations building further on the trusted assessor model.	We will demonstrate a year on year increase in the number of trusted assessments between the regulated care sector. We will evaluate progress on improving discharges with regulated care settings and agree priorities.	We will evaluate progress on improving discharges with regulated care settings and agree priorities.
Essential carer role We will introduce the essential carer role into a small number of adult inpatient test sites and evaluate the effectiveness using Plan, Do, Study, Act (PDSA) cycles.	**Essential carer role** Following evaluation of the test sites we will role this out to all wards in order to meet patient's needs.	**Essential carer role** We will embed the principles of the essential carer role as standard practice.
We will develop an Essential carer role standard operating procedure and an information leaflet to support implementation.	Based on the feedback and learning we will adapt the essential carer role so we achieve the best patient and essential carer experience.	We will embed changes using feedback to promote better Carer experience.
We will continue to support our Carers via our Carers Forum.	We will share learning from carers forums and use to influence improvement.	We will set year 3 priorities based on listening to carers.
We will consistently ensure we use Carers Lanyard.	We will use Carers stories and experiences to develop and improve services.	We will monitor and record Carer feedback, involvement and inclusion in all areas of patient care.
We will promote services available to Carers such as Z beds. We will continue to promote our Carers Charter and test this in practice using STAR.	We will use our Involvement services to educate staff around services available for our Carers.	We will improve facilities for carers to take a break form caring when in the organisation.
We will ensure Carers involvement in all clinical assessments and test this through STAR. We will incorporate Johns Campaign into our way of doing things.	We will ensure all clinical services recognise carer involvement.	We will include carer involvement in the newly designed electronic patient record and test this through STAR.
Promote get up get dressed keep moving We will encourage patients to get up, get dressed and keep moving wherever possible to prevent deconditioning and maximise rehabilitation and experience. We will embed this in practice in 3 wards across the organisation.	**Promote get up get dressed keep moving** We will share the learning from the pilot sites to role out across all inpatient wards.	**Promote get up get dressed keep moving** We will embed these principles as our standard.
Promote occupational and purposeful activities for our inpatients We will encourage our inpatients to engage in occupational and purposeful activities and when indicated provide suitable resources. e.g. activity packs with items such as colouring, paint sets, knitting, cross stitch, cross words, puzzles, poetry, creative writing etc. We will ensure the Intranet has accessible resources for staff to download for our patients. We will roll out the newly developed Reminiscence Boxes for use with our patients living with dementia.	**Promote occupational and purposeful activities for our inpatients** We will review resources and gather feedback from patients and staff.	**Promote occupational and purposeful activities for our inpatients** We will review resources and gather feedback from patients and staff.

Reference List

Doyle, Lennox & Ball (2013) A systematic review of evidence on the links between patient experience and clinical safety and effectiveness accessed at https://bmjopen.bmj.com/content/3/1/e001570

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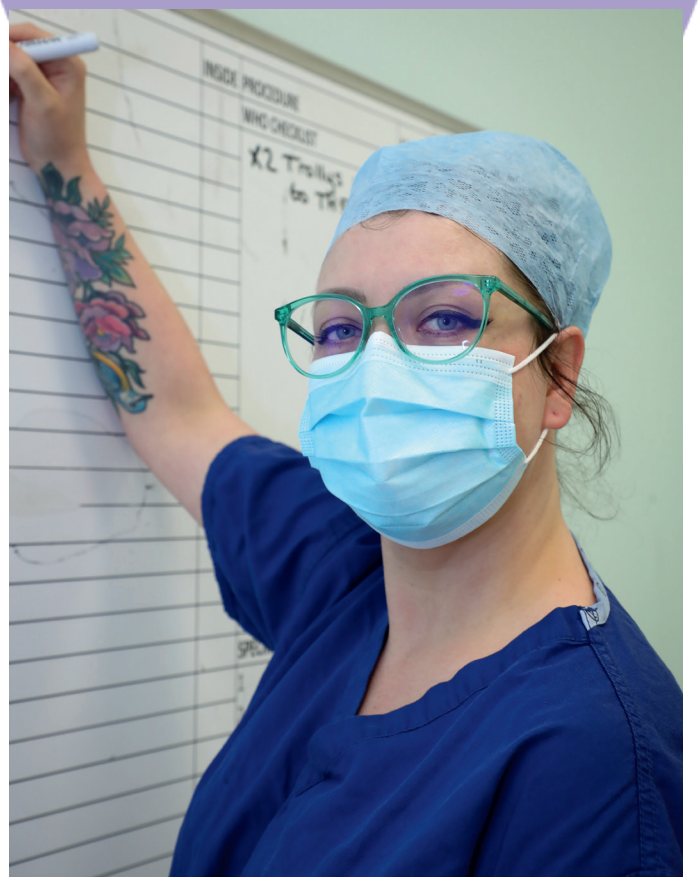
The Heath Foundation (2013)Measuring patient experience https://bit.ly/3SmPuBV

The Kings Fund (2022) How does the health and care system hear from people and communities? accessed at https://www.kingsfund.org.uk/publications/health-care-system-people-and-communities

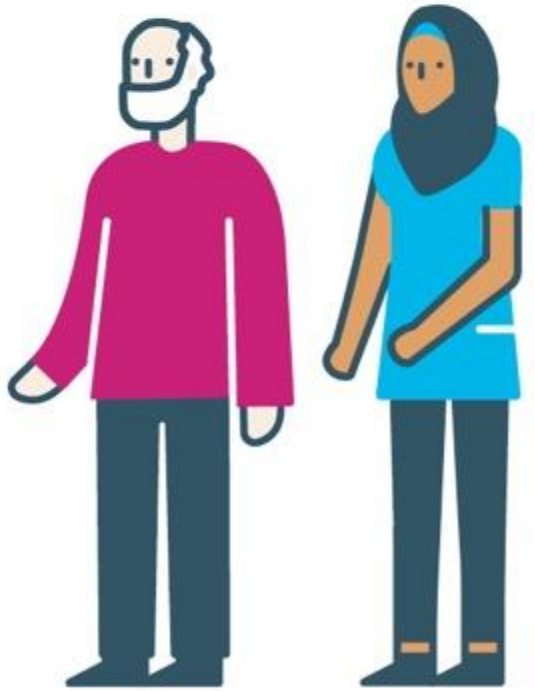


Lancashire & South Cumbria
New Hospitals
Programme

New Hospitals Programme

Update to LTHTr Council of Governors

3 November 2022



New Hospitals Programme: background

Lancashire & South Cumbria New Hospitals Programme

- Some ageing buildings beyond repair
- A once-in-a-generation opportunity
- Working in partnership with all NHS organisations and wider partners, including local authorities, district councils and universities
- On track to start building 2025 and to complete on site by 2030
- Part of national New Hospital Programme.

Ambitions

Lancashire & South Cumbria New Hospitals Programme

The New Hospitals Programme (NHP) offers a once-in-a-generation opportunity to transform our hospitals and the services we provide for local people by 2030

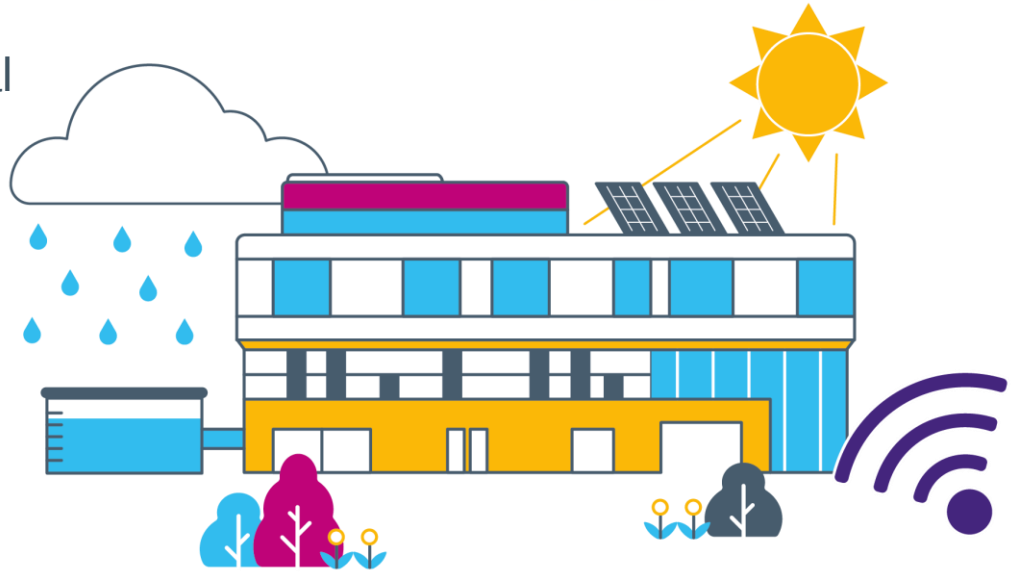
We aim to:

- Build world-leading, purpose-built hospital facilities
- Make Lancashire and South Cumbria a centre of excellence for hospital care
- Enable new technologies and therapies
- Bring more jobs and opportunities
- Provide better hospital access and experience for patients.

Objectives

Lancashire & South Cumbria New Hospitals Programme

1. Provide patients with high-quality, next generation acute hospital facilities that will improve health outcomes across our population.
2. Design new hospital buildings and facilities that can meet demand and are flexible and sustainable.
3. Reduce health inequalities and be ready to meet the health needs of the people of Lancashire and South Cumbria – both now and in the future.
4. Improve service delivery and provide access to cutting edge hospital technologies and deliver the best possible quality of care.
5. Increase resource capacity and effectiveness, working collaboratively to increase integration in service delivery.
6. To have a positive impact on our local area, bringing jobs, skills and contracts to Lancashire and South Cumbria's businesses and residents.



Timeline

Lancashire & South Cumbria New Hospitals Programme

March 2021
NHP launch

May 2021
NHP website and social media channels launched

July 2021
Case for Change published

* Public consultation

Submit Strategic Outline Case (SOC)

Submit Full Business Case (FBC)
Feb 2025

April / May 2021
Online workshops participation campaign launch

Options development (longlist to shortlist)

Submit Outline Business Case (OBC)
Jan 2024

Start onsite
2025

NHS England and NHS Improvement Assurance – stage 1 strategic sense check - COMPLETE

* if required / dependent on options, Pre-Consultation Business Case developed prior to this.

Complete onsite by September 2030

Shortlist of proposals

Lancashire & South Cumbria New Hospitals Programme

Royal Preston Hospital
partial rebuild / refurbishment

Or

Royal Preston Hospital
new site

Royal Lancaster Infirmary
partial rebuild / refurbishment

Or

Royal Lancaster Infirmary
new site

All the above options include investment in Furness General Hospital

All the above options will be benchmarked against a business as usual and do minimum option

Progress update

Lancashire & South Cumbria New Hospitals Programme

Significant progress against work programme, including:

- ✓ Detailed analysis of shortlisted options – ongoing
- ✓ Completion of a formal land search through appointed agents
- ✓ Equality, health inequality impact and risk assessment, and travel analysis underway
- ✓ Launch of Your Hospitals, Your Say – public facing report detailing the output of engagement to date
- ✓ Alignment with the Lancashire and South Cumbria Integrated Care Board strategies, emerging Provider Collaborative Board clinical vision and Trust clinical strategies.

Current stage: development of recommendations

Lancashire & South Cumbria New Hospitals Programme

- Each shortlisted proposal has been comprehensively assessed for deliverability, affordability, value for money, and viability, considering feedback from patients, local people and staff.
- Key elements have been considered, including service configuration; what would be required in terms of rooms, beds and other provisions to be able to meet the operational, space and location requirements; and site location options.
- This work has resulted in recommendations for preferred options of new hospitals on new sites and alternative options of rebuild on the existing sites for both Royal Preston Hospital and Royal Lancaster Infirmary.
- These will need to be considered in the context of capital affordability and benefits including addressing inequalities, clinical outcomes, productivity and wider socio-economic benefits.
- They will also be considered alongside “business as usual” and “do minimum” options, both standard options required in all business cases.

Overview: What could this mean for Royal Preston Hospital?

Lancashire & South Cumbria New Hospitals Programme

Preferred option

Our preferred option for Royal Preston Hospital is a **new state-of-the-art hospital on a new site** within around a 10-mile radius of the current RPH site, with an improved and enhanced urgent and emergency service, increased capacity for specialised services and the opportunity to maximise significant quality and productivity gains.

Alternative option

The Programme's alternative option for RPH is an improved Royal Preston Hospital on the current site to include a new urgent and emergency care village, together with replacement of some inpatient facilities for non-elective medical and surgical patients, and the replacement of nine theatres and diagnostic facilities.

Overview: What could this mean for Royal Lancaster Infirmary?

Lancashire & South Cumbria New Hospitals Programme

Preferred option

Our preferred option for Royal Lancaster Infirmary is a **new state-of-the-art hospital on a new site**, within around a 10-mile radius of the current RLI site, providing an opportunity to significantly improve patient experience, the quality of services provided, and improve the environment for patients, visitors and staff.

Alternative option

The Programme's alternative option for RLI is an improved Royal Lancaster Infirmary in the current location to include a new urgent and emergency care village, together with reprovision of critical care, maternity and neonatal, and some inpatient accommodation and diagnostics.

Potential new site options

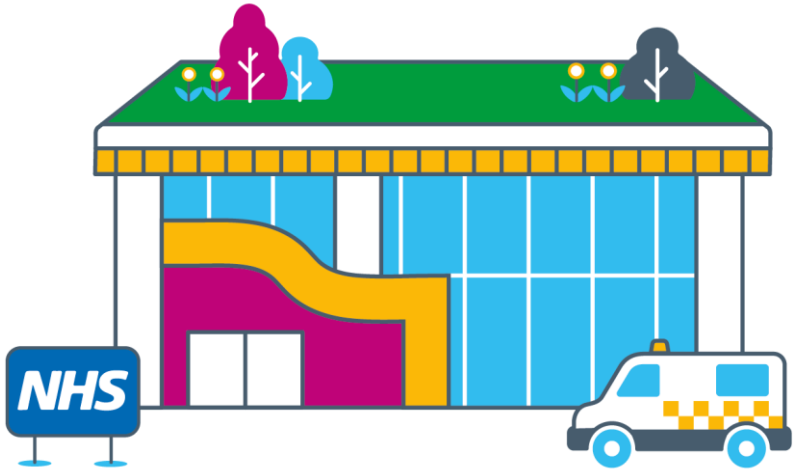
Lancashire & South Cumbria New Hospitals Programme

- Technical appraisal completed (subject experts) – provides go / no go criteria.
- Additional assessments ongoing, including equality, health inequality impact and risk assessment, and travel and transport analysis.
- Additional sites may come forward and will be subject to the same appraisal process.
- Any indication of technically preferred sites at this stage are helpful, but too early to be formalised and will be subject to potential consultation.

New build for Royal Preston Hospital

Lancashire & South Cumbria New Hospitals Programme

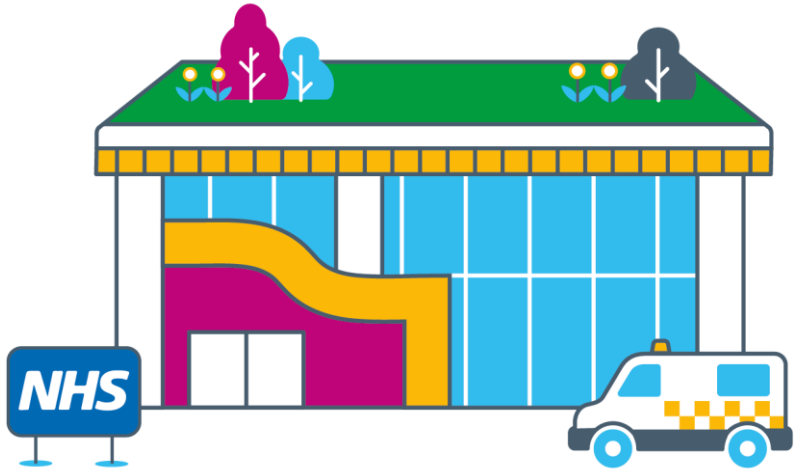
- State-of-the-art new build on a new site, providing major trauma and specialist services to the population of Lancashire and South Cumbria and acute hospital services to Central Lancashire
- Increased capacity for specialist services (providing greater patient choice)
- Fully addresses the Case for Change, improves care for patients and the work environment for staff
- Designed and built to the national Hospital 1.0 (centralised design and standardised approach, configurable to site and hospital needs)
- 70% single en-suite rooms, Net Zero Carbon, digitally enabled
- Significant system wide benefits
- Maximises the wider socio-economic potential
- Clinical, operational and cost efficiency benefits
- Education, training, and research will be embedded as part of a networked Lancashire and South Cumbria model, maximising the campus style approach.



New build for Royal Lancaster Infirmary

Lancashire & South Cumbria New Hospitals Programme

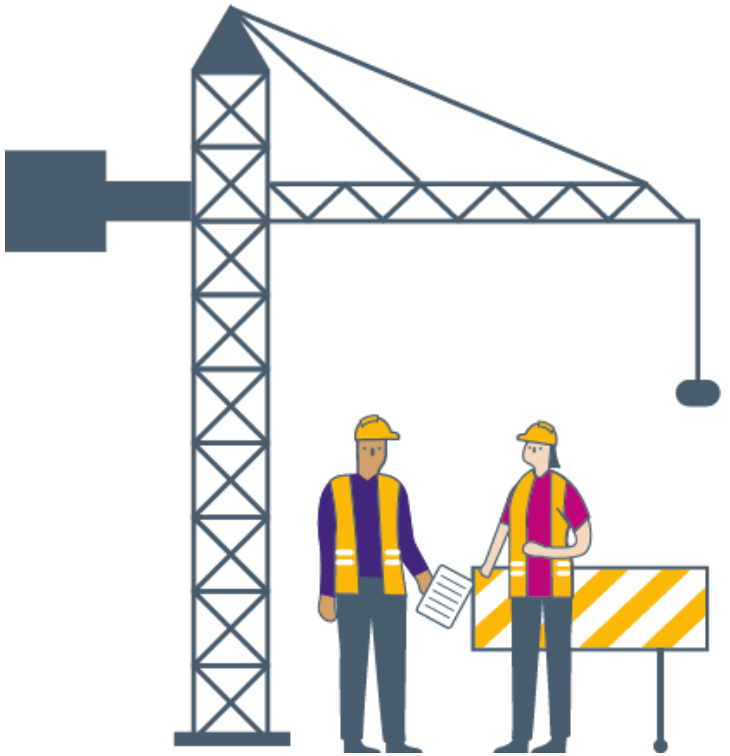
- A world class hospital facility delivering better care in a better environment for patients and staff
- Fully addresses the Case for Change, improves care for patients and the work environment for staff
- 70% single rooms
- Fully meets Net Zero Carbon
- Digitally enabled
- Designed and built to national Hospital 1.0, using modern methods of construction
- Education, training and research embedded as part of a Lancashire and South Cumbria networked model
- Opportunity to maximise partnerships
- Delivery of significant efficiency and productivity gains.



Alternative options: partial rebuild - context

Lancashire & South Cumbria New Hospitals Programme

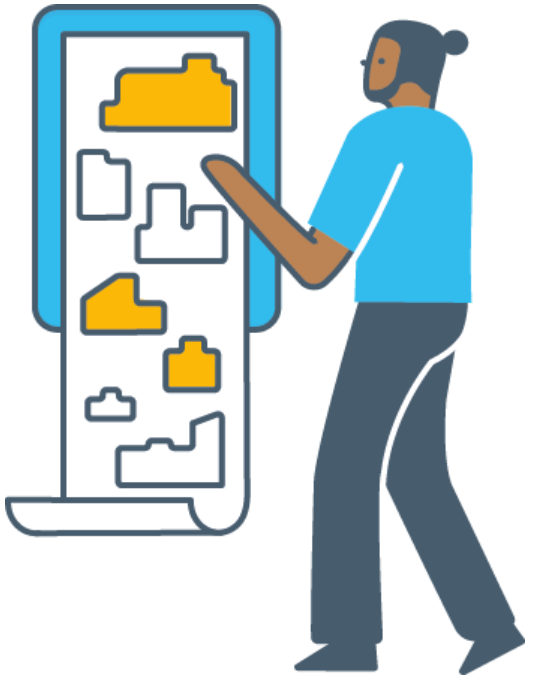
- Developed through a series of workshops with input from clinical, operational, estates and finance leads along with the New Hospitals Programme team.
- Based on previous work, the partial rebuild options prioritise buildings with the greatest need for investment.
- Provides the opportunity for significant transformation, improved patient experience, performance and efficiency, particularly in Urgent and Emergency Care.
- Partial rebuild would include new urgent and emergency care villages and some supporting areas.
- Needs to be clinically viable, with maximum contribution to addressing backlog maintenance.



Partial rebuild: Royal Preston Hospital

Lancashire & South Cumbria New Hospitals Programme

The Programme's alternative option for RPH is an improved Royal Preston Hospital on the current site to include a new urgent and emergency care village, together with replacement of some inpatient facilities for non-elective medical and surgical patients, and the replacement of nine theatres and diagnostic facilities.

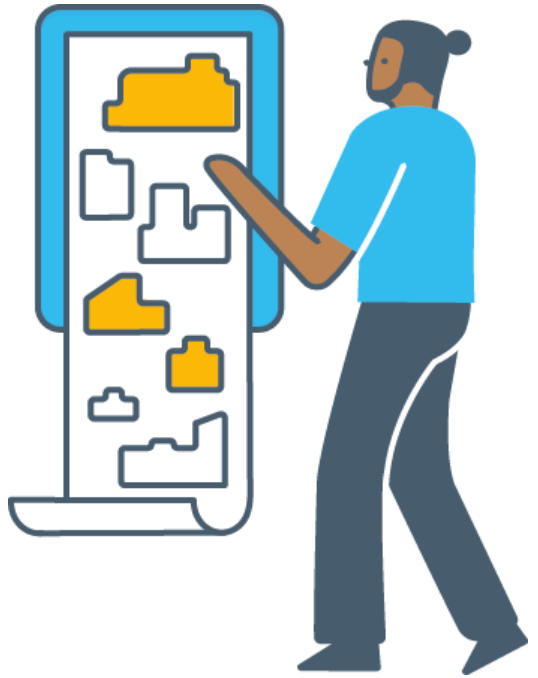


- Would bring a range of improvements, particularly for patients needing urgent and emergency care and would improve clinical adjacencies.
- Only partially addresses the Case for Change and the ambitions of the national New Hospital Programme, e.g., it would only partially deliver on environmental and sustainability targets because some of the old buildings and existing gas boilers would remain.
- As much of the new facilities would provide single en-suite rooms for patients as possible, but not at the scale achievable within a new build.
- Does not address all the required backlog maintenance or tackle issues with the long-term viability of current facilities, such as the much-needed replacement of the ageing ward block, which would still need to be addressed longer term.
- It also limits opportunities to make service and quality improvements in the future.

Partial rebuild: Royal Lancaster Infirmary

Lancashire & South Cumbria New Hospitals Programme

The Programme's alternative option for RLI is an improved Royal Lancaster Infirmary in the current location to include a new urgent and emergency care village, together with reprovision of critical care, maternity and neonatal, and some inpatient accommodation and diagnostics.



- Would bring a range of improvements, particularly for patients needing urgent and emergency care and people accessing maternity services, along with improving clinical adjacencies.
- Only partially addresses the Case for Change.
- Does not address all the required backlog maintenance or the ambitions of the national New Hospital Programme, e.g., would only partially deliver on environmental and sustainability targets because some of the old buildings and existing gas boilers would remain.
- As much of the new facilities would provide single en-suite rooms for patients as possible, but not be at the scale achievable within a new build.
- It also limits opportunities to make service and quality improvements in the future.

How we have been involving and engaging local people and staff

Lancashire & South Cumbria New Hospitals Programme

We want to make sure local people and colleagues

- Are aware and informed about proposals
- Know how they can get involved
- Understand why decisions are made
- Feel enthusiastic about what is possible
- Have trust in the process.

Our engagement has covered six areas

Lancashire & South Cumbria New Hospitals Programme

1. Benchmarking public perceptions of hospitals in Lancashire and South Cumbria

2. Hopes, fears, and desires for new hospital facilities in Lancashire and South Cumbria

3. Identifying possible solutions to the Case for Change

4. Developing Critical Success Factors for evaluating proposals

5. Responses to a longlist of viable solutions

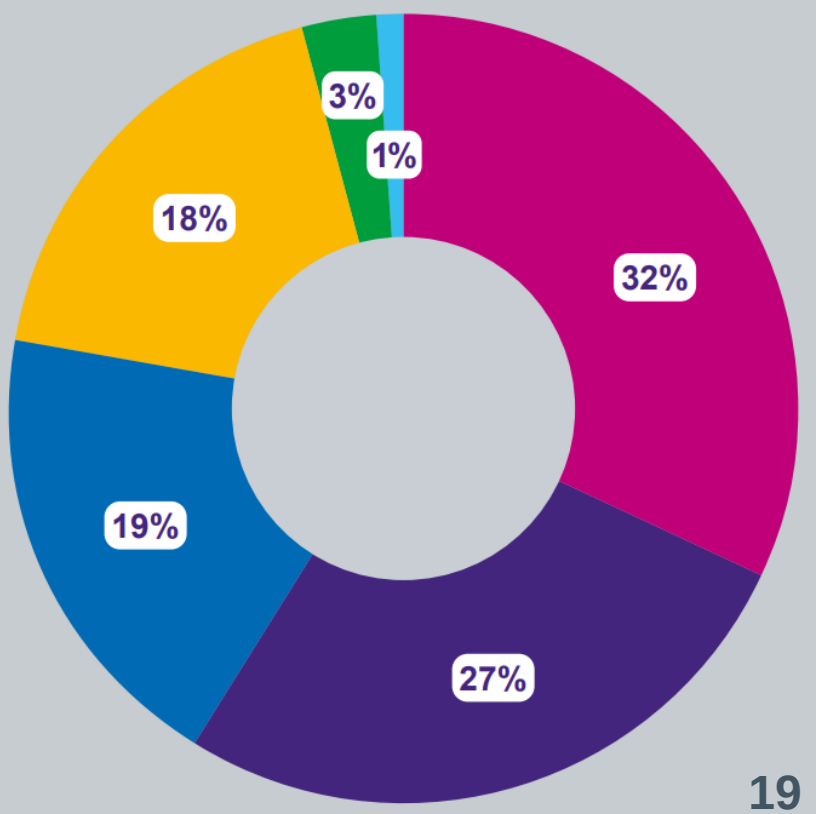
6. Responses to a shortlist of viable solutions.

Who have we heard from?

Lancashire & South Cumbria New Hospitals Programme

- As of **31 August 2022**, over a 20-month period, **15,579** different individuals have been involved in one or more New Hospitals Programme engagement activities, interacting with us 30,802 times:

Engagement statistics	Volume	Proportion
Members of the public	9,716	32%
Expert patient groups	968	3%
Patients and service users	5,423	18%
Under-represented communities and health inclusion groups	8,370	27%
NHS staff	5,938	19%
Political e.g., MPs, local authorities	297	1%
Other / Not classified (anonymity protected)	90	>1%
Total (includes cross over between groups)	30,802	100%
Unique individuals engaged	**15,579**	



Facts and figures

Lancashire & South Cumbria New Hospitals Programme

- **5,837** people completed website surveys.
- **2,999** people joined The Big Chat online discussion across three different conversations.
- **1,075** staff attended four New Hospitals Programme Colleague Summits.
- **4,018** people took part in in-depth interviews (over the phone, in-person and online) across three waves of market research.
- Social media content reached **1.42 million** people, across Facebook and Twitter.
- **20,279** people visited the Lancashire and South Cumbria New Hospitals Programme website, **1,837** people have subscribed to the New Hospitals Programme email newsletter.
- **235** people from 30 different inclusion groups in under-represented communities participated in workshops held by Healthwatch Together. **6,041,344** opportunities to see or hear were generated through local advertising.
- **25** local MPs and **20** local authorities have been kept up to date on the latest developments and proposals.
- **796** local people had face-to-face conversations through Healthwatch roadshow events.**16** locations across Barrow-in-Furness, Chorley, Kendal, Lancaster, Leyland, Preston and Ulverston were visited. [Statistics as of 31 August 2022]

What have we heard?

Lancashire & South Cumbria New Hospitals Programme

Key themes of feedback include:

- Widespread support in favour of funding for new hospital facilities
- Travel and accessibility considerations are the biggest NHP talking point
- Hospital sites must be ‘future-proofed’ to meet the region’s long-term needs
- People are open to the use of digital tools to enable care closer to home
- New hospital facilities should be designed with sustainability in mind
- A single hospital on a new central site is not acceptable to key audiences.

Your Hospitals, Your Say

Find out more in the Your Hospitals, Your Say report:

www.newhospitals.info/YourHospitalsYourSay

Next steps

Lancashire & South Cumbria New Hospitals Programme

1. Complete the detailed feasibility analysis of each shortlisted option, including site footprint, land availability, planning considerations and financial affordability
2. Development of a Pre-Consultation Business Case (PCBC) to outline recommended option(s) - subject to confirmation on the requirement to consult
3. Scrutiny and approvals from decision makers within the NHS, the Government and local authorities
4. Agreement of preferred option
5. Building of new hospital facilities completed by 2030

Engagement with patients, public, staff and wider stakeholders to continue throughout

Lancashire & South Cumbria New Hospitals Programme

How you can get involved

- Encourage your colleagues, networks and groups, family and friends to get involved
- Help spread the word about events and activities – and ways to have your say
- Share your feedback at different stages of the process

To find out more, visit www.newhospitals.info

@NewHospitalsLSC
#NewHospitalsProgramme

/NewHospitalsLSC

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors Report

Review of Constitution			
Report to:	Council of Governors	**Date:**	3 November 2022
Report of:	Company Secretary	**Prepared by:**	J Foote
Part I	✓	**Part II**	

Purpose of Report							
For approval	☒	**For noting**	☐	**For discussion**	☐	**For information**	☐

Executive Summary:

The current version of the constitution has been in place since 2018. A review of the document was commissioned by the Trust in 2022 by Hempsons Solicitors with the dual aim of ensuring the revised constitution would be agile and fit for purpose for new ways for working under an Integrated Care System and was compliant with the requirements of the Health & Care Act 2022.

The revision received input, scrutiny and oversight from a working group of governors established for that purpose.

The Constitution, as set out in full as an appendix to the report requires both the approval of the Council of Governors and the agreement of the Board of Directors to take effect.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To offer excellent health care and treatment to our local communities	☒	Consistently Deliver Excellent Care	☒
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive innovation through world-class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Constitution Review Working Group

1. **The constitution**

The constitution is the primary framework document for the governance of the Trust. It sets out, at a high level, the rules and requirements to ensure smooth and effective governance. It is supported in turn by a raft of ancillary governance documents, including Standing Orders, Terms of Reference, Codes and Strategies. These documents set out the processes and procedures for good governance in more detail.

2. **Areas of Revision and Working Group Rationale**

Amendment	**Rationale**
Updated names, terminology and references throughout to comply with Health & Care Act 2022 and other legislation.	Required for the document to be compliant with statute
Neatening of references and narrative to avoid duplication and allow for clarity of guidance	Version 10 of the Constitution contained a number of areas of duplication and clauses which benefitted from more succinct drafting, but which did not alter the intent.
Staff constituency – addition of a constituency for unregistered healthcare and support workers separate to nurses and midwives	Allows for a clearer and fairer staff representation
Removal of volunteers as a separate constituency	Compliant with statute (with the assurance that volunteers are able to stand as public governors)
Reduction of partnership organisations to an appointed governor from a partner University	Maintains links with higher education and recognises the Trust‘s focus on education. The working group agreed that using various partner organisations to ‘tick boxes’ for membership did not necessarily lead to effective engagement or diversity and this could be pursued through the public governor constituency.
Removal of the prohibition on appointment as a director if also a director of another Trust or NHS body.	Recognition that this narrowed the choice of the Trust when searching for future directors and that collaborative working might need the Trust to have flexibility on this point. The working group agreed that, as any appointment decision rested on the recommendation of the Nominations Committee and the approval of the Council of Governors, sufficient control was retained.
Reference the position of Associate Non-Executive Director	Allows for clarity for this new role.
Annex 3 – Investigation procedure for governors	Redrafted to comply with HR best practice. The working group required explicit articulation of the need to set a timescale for investigations, after which time non-engagement itself could be a potential reason for removal. This was agreed as a necessary requirement to close a gap in the current process.

3. **Financial implications**

Legal costs for advice and drafting by Hempsons.

4. **Legal implications**

Amendments to the Constitution require the approval of both the Council and Board:

22. AMENDMENT OF THE CONSTITUTION

22.1 No amendment shall be made to this Constitution unless:

22.1.1 more than half of the governors of the Trust voting approve the amendments, and:

22.1.2 more than half of the members of the Board of Directors of the Trust voting approve the amendments.

22.2 Amendments made under paragraph 22.1 take effect as soon as the conditions in that paragraph are satisfied.

5. **Risks**

The Constitution is the primary governance framework for the Trust. As such it needs to be compliant with statute and agile enough to respond to the governance requirements of the Board and Council of Governors. A regular review of the constitution allows for sufficient scrutiny and testing to ensure it remains fit for purpose.

6. **Impact on stakeholders**

The revision makes some improvements to the staff constituencies.

7. **Recommendations**

The Council of Governors is recommended to approve the revised constitution.

Lancashire Teaching Hospitals NHS Foundation Trust

Constitution of Lancashire Teaching Hospitals NHS Foundation Trust

Version 11:

[ ] 2022

Excellent care with compassion

CONTENTS

1. DEFINITIONS

1.1 Unless the contrary intention appears or the context otherwise requires, words or expressions contained in this Constitution bear the same meaning as in the National Health Service Act 2006,as amended.

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

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

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

1.5 In this Constitution:

"the 2006 Act"	means the National Health Service Act 2006
"the 2012 Act"	means the Health and Social Care Act 2012
"accounting officer"	means the person who, from time to time, discharges the functions specified in paragraph 25(5) of schedule 7 to the 2006 Act
"annual members' meeting"	is defined at paragraph 10 of this Constitution
"appointed governors"	means those members of the Council of Governors appointed by a local authority or a partnership organisation
"area of the Trust"	means the area specified in Annex 1
"Board of Directors"	means the board of directors of the Trust
"Chair"	means the Chair of the Trust
"Chief Executive"	means the Chief Executive of the Trust
"code of conduct"	means the code of conduct for members of the Council of Governors adopted by the Council of Governors from time to time
"Company Secretary"	means the secretary of the Trust or any other person appointed to perform the duties of the secretary, including a joint, assistant or deputy secretary
"Constitution"	means this Constitution and all annexes to it
"Council of Governors" or "Council"	means the Council of Governors of the Trust
"director"	means a member of the Board of Directors
"elected governors"	means those members of the Council of Governors elected by the public constituency and the staff constituency
"executive director"	means an executive director of the Trust
"financial auditor"	means the person appointed to audit the accounts of the Trust by the Council of Governors, in accordance with the 2006 Act

“financial year”	means any period of twelve months beginning with 1 April
“governor”	means a member of the Council of Governors
“local authority governor”	means a member of the Council of Governors appointed in accordance with paragraph 11.6.3
“member”	means a member of the Trust
“NHS England”	means the body corporate established pursuant to Section 1H(1) of the 2006 Act
“Nominations Committee”	means the nominations committee constituted in accordance with paragraph 12.5.3
“non-executive director”	means a non-executive director of the Trust
“partner”	means, in relation to another person, a member of the same household living together as a family unit
“partnership governor”	means a member of the Council of Governors appointed by the partnership organisation
“partnership organisation”	means the organisation named in this Constitution that is entitled to appoint a partnership governor;
“public constituency”	means the constituency of the Trust constituted in accordance with paragraphs 7.2 and 7.3
“public governor”	means a member of the Council of Governors elected by the members of the public constituency
“registered dentist”	means a registered dentist within the meaning of the Dentists Act 1984
“registered medical practitioner”	means a fully registered person within the meaning of the Medicines Act 1983 who holds a licence to practise under that Act
“Regulated Activities Regulations”	means the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
“senior staff”	means the executive directors, the Company Secretary and other senior staff designated by the Appointments, Remuneration and Terms of Employment Committee or any successor body as such
“staff constituency”	means the constituency of the Trust that is constituted in accordance with paragraphs 7.5 to 7.10
“staff governor”	means a member of the Council of Governors elected by the members of one of the classes of the staff constituency
“the Trust”	means Lancashire Teaching Hospitals NHS Foundation Trust; and

2. NAME AND STATUS

The name of the Trust is Lancashire Teaching Hospitals NHS Foundation Trust and its legal status is a public benefit corporation.

3. PRINCIPAL PURPOSE

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

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

3.3 The Trust may provide goods and services for any purposes related to:

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

3.3.2 the promotion and protection of public health.

3.4 The Trust may also carry on activities other than those mentioned in paragraph 3.3 for the purpose of making additional income available in order to better carry on its principal purpose.

4. POWERS

4.1. The Trust shall have all the powers of a Foundation Trust as set out in the 2006 Act, in particular it may:

4.1.1. exercise functions jointly with other bodies or persons;
4.1.2. arrange for functions exercisable by it to be exercised by other bodies; and
4.1.3. exercise functions on behalf of other bodies.

4.2. The Trust may do anything which appears to it to be necessary or expedient for the purpose of or in connection with its functions. In particular it may:

4.2.1. acquire and dispose of property,

4.2.2. enter into contracts,

4.2.3. accept gifts of property (including property to be held on trust for the purposes of the Trust or for any purposes relating to the health service), and

4.2.4. employ staff.

4.3. Any power of the Trust to pay remuneration and allowances to any person includes the power to make arrangements for providing, or securing the provision of, pensions or gratuities (including those payable by way of compensation for loss of employment or loss or reduction of pay).

4.4. The Trust may borrow money for the purposes of or in connection with its functions, subject to any statutory or regulatory limits that may be imposed from time to time.

4.5. Subject to any restrictions imposed by NHS England and taking into account any guidance issued by NHS England, the Trust may invest money (other than money held by it as trustee) for the purposes of or in connection with its functions. The investment may include investment by:

4.5.1. forming, or participating in forming, bodies corporate; and

4.5.2. otherwise acquiring membership of bodies corporate.

4.6. The Trust may give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its functions.

5. COMMITMENTS

5.1 The Trust shall exercise its functions effectively, efficiently and economically.

Representative membership

5.2 The Trust shall at all times strive to ensure that (taken as a whole) its actual membership is representative of those eligible for such membership. To this end the Trust shall at all times have in place and pursue a membership strategy whichshall be approved by the Council of Governors. The membership strategy shall be reviewed by the Council of Governors from time to time.

Co-operation with health bodies

5.3 In exercising its functions, the Trust shall co-operate with special health authorities, Integrated Care Boards, NHS trusts and NHS foundation trusts and with NHS England and the Care Quality Commission in the exercise of their statutory functions.

Respect for rights of people

5.4 In conducting its affairs, the Trust shall respect the rights of members of the community it serves, its employees and people dealing with the Trust as set out in the Human Rights Act 1998.

Openness

5.5 In conducting its affairs, the Trust shall have regard to the need to provide information to members and conduct its affairs in an open and accessible way.

Prohibiting distribution

5.6 The profits or surpluses of the Trust are not to be distributed either directly or indirectly in any way at all among members of the Trust.

6. FRAMEWORK

6.1 The Trust shall have a Board of Directors, a Council of Governors and two membership constituencies as set out in this Constitution.

Members

6.2 Members may attend and participate in the annual members' meeting, vote in elections to, and stand for election for, the Council of Governors, and take such other part in the affairs of the Trust as is provided for in this Constitution.

Council of Governors

6.3 The general duties of the Council of Governors, which are to be carried out in accordance with this Constitution, are set out in paragraph 11.2. The specific roles and responsibilities of the Council of Governors, which are to be carried out in accordance with this Constitution, are set out below:

6.3.1 at a Council of Governors meeting

6.3.1.1 to appoint or remove the Chair and the other non-executive directors;

6.3.1.2 to approve the appointment (by the non-executive directors) of the Chief Executive;

6.3.1.3 to decide the remuneration and allowances, and the other terms and conditions of office, of the non-executive directors;

6.3.1.4 to appoint or remove the Trust's financial auditor;

6.3.1.5 to appoint or remove any other external auditor appointed to review and publish a report on any other aspect of the Trust's affairs;

6.3.1.6 to receive and consider the annual accounts, any report of the financial auditor on them and the annual report.

6.3.2 to provide their views to the Board of Directors when the Board of Directors is preparing the document containing information about the Trust's forward planning;

6.3.3 to respond as appropriate when consulted by the Board of Directors in accordance with this Constitution;

6.3.4 to undertake such responsibilities as the Board of Directors shall from time to time request;

6.3.5 to prepare and from time to time to review the Trust's membership strategy, and its policy for the composition of the Council of Governors;

6.3.6 where appropriate to act collectively and through individual governors to communicate with members of the Trust about developments in the Trust and the work of the Council of Governors.

Board of Directors

6.4 The business of the Trust is to be managed by the Board of Directors, who shall exercise all the powers of the Trust, subject to any contrary provisions of the Act as given effect by this Constitution.

7. MEMBERS

7.1 The members of the Trust are those individuals whose names are entered in the register of members. Every member of the Trust is either a member of the public constituency or a member of one of the classes of the staff constituency.

7.2 Subject to this Constitution, membership is open to any individual who:

7.2.1 is 16 years of age or over;

7.2.2 is entitled under this Constitution to be a member of the public constituency or one of the classes of the staff constituency; and

7.2.3 completes a membership application form in whatever form the Company Secretary specifies, unless paragraph 7.9 applies.

Public constituency

7.3 Membership of the public constituency is open to individuals:

7.3.1 who live in the area of the Trust (as specified in Annex 1); and

7.3.2 who are not eligible to be members of any of the classes of the staff constituency.

The members of the public constituency are collectively referred to in this Constitution as the'public constituency'.

7.4 The minimum number of members of the public constituency is to be four (4).

Staff constituency

7.5 The staff constituency is divided into five classes as follows:

7.5.1 doctors and dentists who are registered to practise;
7.5.2 nurses and midwives who are registered to practise;
7.5.3 other healthcare professionals and healthcare scientists, registered or unregistered, employed in a clinical capacity including (without limitation) all allied health professionals, scientists and psychologists;
7.5.4 unregistered healthcare support workers;
7.5.5 non-clinical staff, including (without limitation) all staff employed in management, administrative, clerical, facilities and estates, and ancillary staff who are not involved in delivering direct patient care.

7.6 Membership of one of the classes of the staff constituency is open to individuals who are employed by the Trust under a contract of employment and who either:

7.6.1 are employed by the Trust under a contract of employment which has no fixed term or a fixed term of at least twelve (12) months; or

7.6.2 have been continuously employed by the Trust under a contract of employment for at least twelve (12) months.

7.7 Individuals who exercise functions for the purposes of the Trust otherwise than under a contract of employment with the Trust, and who have exercised such functions continuously for a period of at least twelve (12) months, may become or continue as members of the staff constituency. For the avoidance of doubt, this doesnot include those who assist or provide services to the Trust on a voluntary basis.

The members of the classes of the staff constituency are collectively referred to in this Constitution as the staff constituency.

7.8 The Company Secretary shall make a final decision about the class of the staff constituency of which an individual is eligible to become or continue as a member.

7.9 All individuals who are entitled under this Constitution to become members of one of the classes of the staff constituency, and who

7.9.1 have been invited by the Trust to become a member of the appropriate class; and

7.9.2 have not informed the Trust within a period of twenty-eight days from the invitation being sent that they do not wish to do so;

shall become members of the appropriate class without an application being made.

7.10 A person who is eligible to become a member of one of the classes of the staff constituency may not become or continue as a member of the public constituency and may not become or continue as a member of more than one class of the staff constituency.

7.11 The minimum number of members of each class of the staff constituency is to be four (4).

8. DISQUALIFICATION FROM MEMBERSHIP

8.1 A person may not become, or continue as, a member of the Trust if within the five (5) years prior to the date of their application for membership of the Trust, or at any time whilst they are a member of the Trust, they were, or are, involved as a perpetrator in an incident or incidents of serious abuse or violence at any of the Trust's hospitals or facilities or against any of the Trust's employees or other

persons who exercise functions for the purposes of the Trust, or against any volunteers at the Trust.

9. TERMINATION OF MEMBERSHIP

9.1 An individual shall cease to be a member of the Trust if:

9.1.1 they resign by notice to the Company Secretary;

9.1.2 they die;

9.1.3 the Company Secretary prepares a report for the Council of Governors recommending that their membership is terminated and the Council of Governors decides, following consideration of the report, to terminate their membership;

9.1.4 they cease to be entitled under this Constitution to be a member;

9.1.5 correspondence sent by the Trust to the member is returned to the Trust as undelivered (whether electronically or by post) and the Trust is unable to contact the member by other means.

9.2 Any person may complain to the Company Secretary that a member has acted in a manner that is detrimental to the interests of the Trust.

9.3 Where:

9.3.1 the Trust has reason to believe that an individual is ineligible for membership of the Trust or (if they are already a member) that their membership of the Trust should be terminated by virtue of paragraph 8.1 above; or

9.3.2 the Trust receives a complaint from any person about a member acting in a manner that is detrimental to the interests of the Trust,

the Company Secretary shall carry out any necessary investigation and shall prepare a report for the Council of Governors which shall:

9.3.3 where paragraph 9.3.1 applies, make a recommendation to the Council of Governors about whether the individual is eligible to become or continue as a member; and

9.3.4 where paragraph 9.3.2 applies, make a recommendation to the Council of Governors about any action that should be taken in respect of that member, which may include expelling the individual from membership of the Trust.

9.4 The Council of Governors shall consider any report prepared by the Company Secretary pursuant to paragraph 9.3 above at a meeting of the Council of Governors held in private. The Council of Governors shall resolve (by a majority vote) what action should be taken, which may include expelling the individual from membership of the Trust or, in the case of a prospective member of the Trust, determining that they are not eligible to become a member.

9.5 No person who has been expelled from membership of the Trust is to be re-admitted except by a resolution approved by at least two-thirds of the members of the Council of Governors who are present at the relevant Council of Governors' meeting. A person who has been expelled from membership of the Trust can only apply for re-admittance as a member after a period of at least twelve (12) months has passed since their expulsion.

10. ANNUAL MEMBERS' MEETING

10.1 The Trust is to hold a members' meeting called the annual members' meeting within nine months of the end of each financial year.

10.2 The annual members' meeting shall be open to all members of the Trust, governors, directors, representatives of the Trust's financial auditor and to members of the public. The Council of

Governors may invite representatives of the media, and any experts or advisors whose attendance they consider to be in the best interests of the Trust to attend an annual members' meeting.

10.3 The annual members' meeting shall be convened by the Company Secretary.

10.4 The Council of Governors may decide where the annual members' meeting is to be held and may also, for the benefit of members, arrange for the annual members' meeting to be held in different venues from year to year.

10.5 At the annual members' meeting the Board of Directors shall present to the members:

10.5.1 the annual accounts;
10.5.2 any report of the financial auditor on them;
10.5.3 any report of any other external auditor of the Trust's affairs;
10.5.4 the annual report; and
10.5.5 forward planning information for the next financial year.

10.6 Notice of the annual members' meeting is to be given:

10.6.1 by notice to members in appropriate local media and the members' newsletter;

10.6.2 by notices in the main premises of the Trust;

10.6.3 by notice on the Trust's website; and

10.6.4 by notice in writing to the Council of Governors and the Board of Directors, and to the financial auditor;

at least fourteen (14) clear days before the date of the meeting. The notice must:

10.6.5 state that the meeting is the annual members' meeting;

10.6.6 give the time, date and place of the meeting; and

10.6.7 indicate the business to be dealt with at the meeting.

10.7 Before the annual members' meeting can do business there must be a quorum present. Except where this Constitution says otherwise, a quorum is six (6) members.

10.8 It is the responsibility of the Council of Governors, the chair of the meeting and the Company Secretary to ensure that at any annual members' meeting sufficient information is provided to members to enable discussion to take place.

10.9 The Chair of the Trust shall act as the chair at the annual members' meeting. The Chair may nominate a director of the Trust to chair an annual members' meeting in their absence. If neither the Chair nor any director nominated to act as chair is present, the governors present shall elect one of the public governors present to be chair. If there is only one governor present and willing to act, they shall be chair.

10.10 If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to such time and place as the Council of Governors may determine. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of members present during the meeting is to be a quorum.

11. COUNCIL OF GOVERNORS

11.1 The Trust is to have a Council of Governors. It is to consist of public governors, staff governors, local authority governors and partnership governors.

11.2 The general duties of the Council of Governors, which are to be carried out in accordance with this Constitution, are:

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

11.2.2 to represent the interests of the members of the Trust as a whole and the interests of the public.

The general duties of the Council of Governors set out in this paragraph 11.2 are in addition to the specificroles and responsibilities of the Council of Governors set out in paragraph 6.3.

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

11.4 The number of public governors is to be more than half of the total number of governors on the Council of Governors.

11.5 The composition of the Council of Governors, subject to the 2006 Act, shall seek to ensure that

11.5.1 the interests of the community served by the Trust are appropriately represented; and

11.5.2 the level of representation of the public constituency, the classes of the staff constituency and the appointing organisations strikes an appropriate balance having regard to their legitimate interest in the Trust's affairs

and, to this end, the Council of Governors, when appropriate, shall propose amendments to this Constitution.

11.6 The Council of Governors of the Trust is to comprise:

11.6.1 eighteen (18) public governors elected from the public constituency;

11.6.2 five (5) staff governors from the classes of the staff constituency as defined in paragraph 7.5, as follows:

11.6.2.1 doctors and dentists who are registered to practise – one (1) staff governor;

11.6.2.2 nurses and midwives who are registered to practise – one (1) staff governor

11.6.2.3 other healthcare professionals and healthcare scientists, registered and unregistered, employed in a clinical capacity – one (1) staff governor;

11.6.2.4 unregistered healthcare support workers – one (1) staff governor;

11.6.2.5 non-clinical staff including (without limitation) all staff employed in management, administrative, clerical, facilities and estates, and ancillary staff who are not involved in delivering direct patient care – one (1) staff governor;

11.6.3 four (4) local authority governors, one of whom may be appointed by each of Lancashire County Council, Chorley Borough Council, South Ribble Borough Council and Preston City Council; and

11.6.4 one (1) partnership governor appointed by the partnership organisation as set out in paragraph 11.7.

11.7 The Company Secretary shall invite one of the University of Manchester or University of Central Lancashire or Lancaster University to be a partnership organisation specified for the purposes of paragraph 9(7) of Schedule 7 to the 2006 Act. The appointment as partnership organisation shall be for a term expiring at the end of the term of office of the governor appointed by that partnership organisation unless it is agreed by the Company Secretary and partnership organisation to extend the term or to re-appoint that organisation and for either a reappointment of the partnership governor under paragraph 11.15.3 or the appointment of a new partnership governor by that organisation.

Elected governors

11.8 Public governors are to be elected by members of the public constituency and staff governors are to be elected by members of their class of the staff constituency. Each class/constituency may elect any of their number to be a governor in accordance with the provisions of this Constitution.

11.9 If contested, the elections must be by secret ballot.

11.10 Elections shall be carried out in accordance with the Model Election Rules as published from time to time by NHS Providers, with any minor amendments that the Trust considers appropriate from time to time. The Model Election Rules current at the date of this Constitution being approved are set out in Annex 2 incorporating minor Trust amendments. A subsequent variation of the Model Election Rules in Annex 2 to implement changes to the model published by NHS Providers shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 21 of the Constitution.

11.11 Elections shall be carried out using the single transferable vote system.

11.12 A member of the public constituency may not vote at an election for a public governor unless within twenty-one (21) days before they vote they have made a declaration in the form specified by the Company Secretary that they are qualified to vote as a member of the public constituency. It is an offence to knowingly or recklessly make such a declaration which is false in a material particular.

Local Authority governors

11.13 The Company Secretary, having consulted each local authority, is to adopt a process for agreeing the appointment of the local authority governor with that local authority.

Partnership governor

11.14 The partnership governor is to be appointed by the partnership organisation in accordance with a process agreed with the Company Secretary.

Terms of office for governors

11.15 Governors:

11.15.1 who are elected shall hold office for a period of up to three (3) years;

11.15.2 who are appointed (as a partnership governor or as a local authority governor) shall hold office for a period of up to three (3) years (as shall be determined by the relevant partnership organisation or local authority);

11.15.3 are eligible for re-election or re-appointment (as applicable) at the end of that period;

11.15.4 may not hold office for longer than a maximum of nine years in aggregate in the capacity of either an elected or appointed governor of the Trust.

For the purposes of these provisions concerning terms of office for governors, 'year' means a period of twelve (12) consecutive calendar months commencing upon the date of first appointment as a governor as confirmed in writing by the Company Secretary.

The maximum of nine (9) years in aggregate means that on expiry of any such period in office,an individual's appointment as a governor shall cease and that individual shall not be eligible to be elected or appointed to serve a further term of office on the Council of Governors.

Eligibility to be a governor

11.16 A person is not eligible to become a governor and, if already holding such office, will immediately cease to be eligible if:

11.16.1 they are under sixteen (16) years of age;

11.16.2 they are a director of the Trust, or a governor or director of an NHS body or of another NHS foundation trust;

11.16.3 they are the spouse, partner, parent or child of a member of the Board of Directors of the Trust;

11.16.4 being a member of the public constituency, they refuse to sign a declaration in the form specified by the Company Secretary of particulars of their qualification to vote as a memberof the Trust, and that they are not prevented from being a member of the Council of Governors;

11.16.5 they are subject to an order under the Sexual Offences Act 2003 and/ or their name is included in the Sex Offenders Register;

11.16.6 they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

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

11.16.8 they have within the preceding five (5) years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three (3) months or more (without the option of a fine) was imposed;

11.16.9 they have within the preceding two (2) years been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a health service body;

11.16.10 they are a person whose tenure of office as the chair or as a member or director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service for reasons including non-attendance at meetings, or for non- disclosure of a pecuniary interest;

11.16.11 they have had their name removed, other than by reason of resignation, from any list prepared under sections 91, 106, 123 and 147A (when or if brought into force) of the 2006 Act and have not subsequently had their name included on such a list;

11.16.12 they have within the preceding five (5) years been involved as a perpetrator in an incident or incidents of serious abuse or violence at any of the Trust's hospitals or facilities or against any of the Trust's employees or other persons who exercise functions for the purposes of the Trust, or against registered volunteers;

11.16.13 they are an unfit person within the meaning of the Trust's provider licence, save where NHS England has provided its approval in writing to them becoming or continuingas a governor;

11.16.14 they fail to provide the required confirmation of their fitness to continue as a governor to the Company Secretary, in the form prescribed by the Trust, within fourteen (14) days of such confirmation being demanded without reasonable cause;

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

11.16.16 they are included in any barred list established under the Safeguarding Vulnerable Adults Act 2006 or any equivalent list;

11.16.17 they fail to submit to a check through the Disclosure and Barring Service when requested by the Trust;

11.16.18 with reference to information disclosed as a result of a check through the Disclosure and Barring Service, they are considered by the Trust to be ineligible to become or continue as a governor of the Trust on the grounds that their appointment as a governor may affect public confidence in the Trust or bring the Trust into disrepute; or

11.16.19 the Council of Governors has ever resolved in accordance with paragraph 11.18.8 that his or her tenure as a governor be terminated.

Termination of office and removal of members of the Council of Governors

11.17 A person holding office as a governor shall immediately cease to do so if:

11.17.1 they cease to be eligible to be a governor pursuant to paragraph 11.17;

11.17.2 they resign by notice in writing to the Company Secretary;

11.17.3 they fail to attend three (3) consecutive Council meetings, unless they provide:

11.18.2.1 clear reasons to the Company Secretary for their absence and their absence was due to reasonable cause; and

11.18.2.2 assurance that they will be able to start attending meetings of the Trust again within such a period as the Company Secretary considers reasonable;

11.17.4 in the case of an elected governor, they cease to be a member of the constituency or class of the constituency by which they were elected;

11.17.5 in the case of an appointed governor, the appointing organisation terminates the appointment;

11.17.6 they have refused to undertake training which the Chair deems necessary for the relevant governor to undertake for the proper discharge of his or her duties as a governor;

11.17.7 they have failed to sign and deliver to the Company Secretary a statement in the form required by the Company Secretary confirming acceptance of the Trust's code of conduct within 14 days of such confirmation being demanded without reasonable cause; or

11.17.8 the Council of Governors resolves in accordance with Annex 3 that his or her tenure as a governor be terminated.

11.18 A staff governor who is suspended from their role as an employee shall be suspended from their role as a governor for the period of the suspension.

11.19 It is the responsibility of each governor to ensure they are eligible to hold office as a governor at all times and not the responsibility of the Trust to do so on their behalf. A governor who becomes aware of their ineligibility shall inform the Trust as soon as practicable.

11.20 Where the Trust has received a formal complaint in relation to a governor, or there is reason to believe there are groundsfor a governor's removal, then the procedure set out in Annex 3 must be followed.

Vacancies amongst governors

11.21 Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply.

11.22 Where the vacancy arises amongst the appointed governors, the Company Secretary shall request that the appointing organisation appoints a replacement to hold office for a term of up to three (3) years.

11.23 Where the vacancy arises amongst the elected governors, subject to paragraph 11.24 the seat shall remain vacant until the next scheduled annual election, at which point the relevant seat will be filled for a new term of up to three (3) years.

11.24 In circumstances where the number of public governors is equal to or less than half the total number of governors on the Council of Governors due to in-year vacancies, the Council will be required to call an extraordinary election in order to fill all of the vacant elected governor seats (so as to ensure the number of public governors in post is always more than half of the total number of governors on the Council of Governors, as required by paragraph 11.4).

Expenses and remuneration of governors

11.25 The Trust may reimburse governors for travelling and other costs and expenses at such rates as the Board of Directors decides. These are to be disclosed in the annual report.

11.26 Governors are not to receive remuneration.

Meetings of the Council of Governors

11.27 The Council of Governors is to meet at least four (4) times in each financial year. Save in the caseof emergencies or the need to conduct urgent business, the Company Secretary shall give at least fourteen (14) days' written notice of the date and place of every meeting of the Council of Governors to all governors. Notice will also be published in appropriate local media, the members' newsletter and on the Trust's website.

11.28 Meetings of the Council of Governors may be called by the Company Secretary, or by the Chair. Eight (8) members of the Council of Governors (including at least two (2) elected governors and one (1) appointed governor) may request the Company Secretary to call a meeting of the Council of Governors by giving written notice to the Company Secretary requesting that a meeting is called and specifying the business to be carried out. The Company Secretary shall send a written notice to all governors as soon as possible after receipt of such a request. The Company Secretary shall call a meeting on at least fourteen (14) but not more than twenty-eight (28) days' notice to discuss the specified business. If the Company Secretary fails to call such a meeting then the Chair or four (or more) governors shall call a meeting.

11.29 All meetings of the Council of Governors are to be held in public unless the Council of Governors decides otherwise in relation to all or part of a meeting for special reasons, such as for reasons of commercial confidentiality. The Chair may exclude any member of the public, or the public generally, from a meeting of the Council of Governors if the attendance of the public generally, or specific individuals, is interfering with or preventing the proper conduct of the meeting.

11.30 A quorum of the Council of Governors shall be formed upon the attendance of at least nine (9) governors, including:

11.30.1 at least one (1) public governor; and

11.30.2 at least one (1) staff governor or at least one (1) appointed governor.

11.31 The Chair of the Trust or, in their absence, the Vice Chair of the Board of Directors, or in their absence one of the non-executive directors, is to preside at meetings of the Council of Governors.Where the Chair, Vice-Chair and other Non-Executive D irectors are all absent, an appropriate representative will be appointed from amongst the governors present at the meeting to preside at the meeting and have a casting vote. This will normally be the Lead Governor where he or she is present at the meeting. If the person presiding at any meeting of the Council of Governors is disqualified from participating in the meeting on the grounds of a declared conflict of interest, the meeting will be chaired in accordance with the Council of Governors' Standing Orders.

11.32 The Council of Governors may invite the Chief Executive or any other member or members of the Board of Directors, or a representative of the Trust's auditor or other advisors to attend and speak at a meeting of the Council of Governors.

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

11.34 The Council of Governors may meet in person, virtually or in a hybrid of virtual and in person attendance. The Council of Governors may resolve that the attendance of governors at particular meetings must be by a specified method of attendance. Unless otherwise resolved by the Council

of Governors, it shall be for the Company Secretary to determine the most appropriate form of attendance at the meetings convened from time to time. The members of the Council of Governors who participate in meetings of the Council of Governors by telephone,video or computer link where permitted shall be deemed to be present in person at the meeting.

11.35 If a question is put to the vote at a meeting of the Council of Governors, it shall be determined in accordance the Council of Governor Standing Orders

11.36 The Council of Governors may not delegate any of its powers to a sub-group, but it may appoint sub-groups consisting of governors, directors, and/ or other persons to assist the Council of Governors in carrying out its functions. The Council of Governors may, through the Company Secretary, request that advisors assist the Council of Governors or any sub-group it appoints in carrying out its duties.

11.37 All decisions taken in good faith at a meeting of the Council of Governors or of any sub-group shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of governors attending the meeting. Any vacancy in the membership of the Council of Governors shall not invalidate the proceedings at any meeting of the Council of Governors or of any sub-group.

Disclosure of interests

11.38 A governor shall declare any pecuniary or other interests in accordance with the requirements set out in the Council of Governors' standing orders.

11.39 The Council of Governors has adopted its own standing orders for its practice and procedure, in particular for its procedure at meetings.

Declaration

11.40 A public governor may not vote at a meeting of the Council of Governors, following their election or re-election, unless, before attending the meeting, they have made a declaration in the form specified by the Company Secretary of the particulars of their qualification to vote as a member of the Trust and that they are not prevented from being a governor.

11.41 A public governor shall be deemed to have confirmed the declaration upon attending each subsequent meeting of the Council of Governors.

12. BOARD OF DIRECTORS

12.1 The Trust is to have a Board of Directors. It is to consist of executive and non-executive directors. The number of non-executive directors must be more than half of the total number of directors on the Board of Directors. 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.

12.2 The board shall comprise:

12.2.1 the following non-executive directors:

12.2.1.1 a Chair;

12.2.1.2 up to seven (7) other non-executive directors;

12.2.2 the following executive directors:

12.2.2.1 the Chief Executive (who is the accounting officer),;

12.2.2.2 a Finance Director,

12.2.2.3 a Medical Director who is to be a registeredmedical practitioner or a registered dentist (within the meaning of the Dentists Act 1984),

12.2.2.4 a Nursing Director who is to be a registered nurse or registered midwife; and

12.2.2.5 up to two other executive Directors.

12.3 The Board of Directors may appoint one (1) of the non-executive directors to be Vice Chair of the Board in accordance with the Standing Orders for the Board of Directors. If the Chair is unable to discharge their office as Chair of the Trust or if the Chair ceases to hold office for any reason, the Vice Chair of the Board of Directors shall be acting Chair of the Trust.

12.4 Only a member of the public constituency is eligible for appointment as a non-executive director.

12.5 Non-executive directors are to be appointed by the Council of Governors using the following procedure:

12.5.1 The Board of Directors will determine the skills and experience required for non-executive directors taking external advice, where appropriate.

12.5.2 Appropriate candidates (normally not more than five (5) for each vacancy) will be identified by the Nominations Committee through a process of open competition, which takes account the skills and experience required;

12.5.3 The Nominations Committee will:

12.5.3.1 be chaired by the Chair of the Trust or the Vice Chair or, in their absence another non-executive director; and

12.5.3.2 be constituted in accordance with its terms of reference, as amended from time to time.

The Chair of another trust or another appropriate person may be invited to act as an independent assessor to the Nominations Committee.

12.5.4 Once suitable candidates have been identified, the Nominations Committee shall make recommendations to the Council of Governors.

12.5.5 The Council of Governors, at a general meeting, shall appoint the Chair and the other non-executive directors. The Council of Governors shall have regard to the recommendations of the Nominations Committee in making its decision.

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

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

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

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

12.10 The Chief Executive may invite one or more employees to attend meetings of the Board of Directors. Any such attendance at meetings will be on a non-voting basis.

12.11 The Board of Directors may appoint or remove individuals as non-voting associate non-executive directors to assist the Board of Directors. Non-voting associate non-executive directors may be excluded from meetings of the Board of Directors by the Board of Directors. The appointment or removal of non-voting associate non-executive directors does not require the approval of the Council of Governors.

12.12 Where a new Chief Executive is being appointed, the views of the incumbent or former Chief Executive may be sought but they shall have no other right to be involved in the appointments process.

12.13 Where a new Chair is being appointed, the views of the incumbent or former Chair may be sought but they shall have no other right to be involved in the appointments process.

Terms of Office

12.14 The Chair and the non-executive directors are to be appointed for a period of office in accordance with the terms and conditions of office decided by the Council of Governors at a Council meeting. A non-executive director may be re-appointed without a competitive process. Any re-appointment of a non-executive director by the Council of Governors shall be subject to a satisfactory appraisal carried out in accordance with procedures which the Board of Directors have approved.

12.15 A non-executive director (including the Chair) may serve on the Board of Directors for longer than six (6) consecutive years, subject to annual reappointment. A non-executive director ofthe Trust (including the Chair) may not hold office for longer than nine (9) years in aggregate in the capacity of either the Chair or a non-executive director of the Trust.

12.16 The Board shall appoint a committee of non-executive directors (which shall be known as the Appointments, Remuneration and Terms of Employment Committee of non-executive directors) to decide the terms and conditions of office, including the remuneration and allowances, of senior staff.

Disqualification

12.17 A person may not become or continue as a director of the Trust if:

12.17.1 they are a member of the Council of Governors;

12.17.2 they are the spouse, partner, parent or child of a member of the Board of Directors of the Trust;

12.17.3 they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

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

12.17.5 they have within the preceding five (5) years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three (3) months or more (without the option of a fine) was imposed;

12.17.6 they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

12.17.7 they are a person whose tenure of office as a Chair or as a member or director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for reasons including non-attendance at meetings, or for non- disclosure of a pecuniary interest;

12.17.8 they have had their name removed, other than by reason of resignation, from any list prepared under sections 91, 106, 123 and 147A (when or if brought into force) of the 2006 Act and have not subsequently had their name included on such a list;

12.17.9 they have within the preceding two (2) years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

12.17.10 they have refused to sign and deliver to the Company Secretary a statement in the form requiredby the Board of Directors confirming acceptance of the code of conduct for directors;

12.17.11 they are an unfit person within the meaning of the Trust's provider licence, save where

NHS England has provided its approval in writing to them becoming or continuing as a director;

12.17.12 they fail to satisfy the requirements of Regulation 5(3) of the Regulated Activities Regulations;

12.17.13 they fail to provide the required confirmation of their fitness to continue in post to the Company Secretary, in the form prescribed by the Trust, within 14 days of such confirmation being demanded, without reasonable cause;

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

12.17.15 they are the subject of an order under the Sexual Offences Act 2003 and/ or their name is included in the Sex Offenders Register;

12.17.16 they are included in any barred list established under the Safeguarding Vulnerable Adults Act 2006 or any equivalent list;

12.17.17 they fail to submit to a check through the Disclosure and Barring Service when requested by the Trust; or

12.17.18 with reference to information disclosed as a result of a check through the Disclosure and Barring Service, they are considered by the Trust to be ineligible to become or continue as a director of the Trust on the grounds that their appointment as a director may adversely affect public confidence in the Trust or bring the Trust into disrepute.

12.18 Where the Trust has received a formal complaint, or there is reason to believe there are grounds for removal, in relation to a director then:

12.18.1 if the individual concerned is an executive director, the Trust's disciplinary procedure shall be applied; and

12.18.2 if the individual concerned is a non-executive director, the procedure set out in Annex 4 shall be followed.

12.19 Any person who is disqualified from becoming or continuing as a director of the Trust on any of the grounds set out in paragraph 12.17 shall, if holding office as a director, resign as a director of the Trust or, if they decline or fail to do so, they shall be removed from office in accordance with the provisions of this Constitution.

Committees and delegation

12.20 The Board of Directors may delegate any of its powers to a committee of directors or to an executive director.

12.21 The Board of Directors shall appoint an Audit Committee of at least three non-executive directors to perform such monitoring, reviewing and other functions as are appropriate, including tomonitor the exercise of the financial auditor's functions.

Meetings of the Board of Directors

12.22 Save in the case of emergencies or the need to conduct urgent business, the Company Secretary shall giveat least fourteen (14) days' written notice of the date and place of every meeting of the Board of Directors to all directors.

12.23 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.

12.24 Meetings of the Board of Directors are called by the Company Secretary, or by the Chair. Four (4) directors may request the Company Secretary to call a meeting of the Board of Directions by giving written notice to the Company Secretary requesting that a meeting is called and specifying the

business to be carried out. The Company Secretary shall send a written notice to all directors as soon as possible after receipt of such a request. The Company Secretary shall call a meeting on at least fourteen (14) but not more than twenty-eight (28) days' notice to discuss the specified business. If the Company Secretary fails to call such a meeting then the Chair or four (4) directors shall call such a meeting.

12.25 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.

12.26 Four (4) directors, including not less than two (2) executive directors (one (1) of whom must be the Chief Executive or their nominee) and not less than two (2) non-executive directors (one (1) of whom must be the Chair or the Vice Chair of the Board) shall form a quorum.

12.27 The members of the Board of Directors may participate in meetings of the Board of Directors by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

12.28 The Chair, or in their absence the Vice Chair of the Board of Directors, is to chair meetings of the Board of Directors. If the Chair and Vice Chair are absent, such Non-Executive Director as the Directors present shall choose shall preside.

12.29 Subject to the following provisions of this paragraph, questions arising at a meeting of the Board of Directors shall be decided by a majority of votes.

12.29.1 In case of an equality of votes the Chair shall have a second and casting vote unless they are prevented from voting by paragraph 12.39.

12.29.2 No resolution of the Board of Directors shall be passed if it is opposed by all of the non-executive directors present or by all of the executive directors present.

12.30 The Board of Directors has adopted standing orders covering the proceedings and business of its meetings. Subject to any contrary provision of the Standing Orders – Board of Directors, all decisions taken in good faith at any meeting of the Board of Directors or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or in the appointment of directors attending the meeting. Any vacancy in the membership of the Board of Directors shall not invalidate the proceedings at any meeting of the Board of Directors or of any committee.

Conflicts of interest of directors

12.31 The duties that a director of the Trust has, by virtue of being a director, include in particular:

12.31.1 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;

12.31.2 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

12.32 The duty referred to in sub-paragraph 12.31.1 is not infringed if:

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

12.32.2 the matter has been authorised in accordance with the Constitution. For a matter to be authorised it must:

12.32.2.1 have been approved in advance by the Board of Directors and the minute book shall be conclusive evidence of such approval; or

12.32.2.2 be linked with a course of action previously approved by the Board of

Directors, such that a reasonable person would expect the director to find themselves in such a situation or to accept such a benefit as a result.

12.33 The duty referred to in sub-paragraph 12.31.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

12.34 In sub-paragraph12.31.2, “third party” means a person other than:

12.34.1 the Trust; or

12.34.2 a person acting on its behalf

12.35 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.

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

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

12.38 A director need not declare an interest:

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

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

12.38.3 if, or to the extent that, it concerns terms of the director’s appointment that have been or are to be considered:

12.38.3.1 by a meeting of the Board of Directors; or

12.38.3.2 by a committee of the directors appointed for the purpose under the Constitution

12.39 Any director who has an interest in a matter that is required to be declared in accordance with paragraphs 12.35 to 12.38 above shall declare such interest in writing to the Company Secretary within seven (7) days of the interest arising and to the Board of Directors at the next meeting and:

12.39.1 shall withdraw from the meeting and play no part in the relevant discussion ordecision; and

12.39.2 shall not vote on any issue arising out of or connected with the matter (and if by inadvertence they do remain and vote, their vote shall not be counted).

12.40 Details of any such interest shall be recorded in the register of the interests of directors.

12.41 Any director who fails to disclose any interest required to be disclosed under the preceding paragraphs must permanently vacate their office if required to do so:

12.41.1 in the case of an executive director, by a decision taken in accordance with paragraph 12.6 or paragraph 12.8, as applicable, above; and

12.41.2 in the case of a non-executive director, by a decision taken in accordance with paragraph 12.9 above.

12.42 If a director is in doubt as to whether an interest should be disclosed they should discuss this with the Chair.

Expenses

12.43 The Trust may reimburse senior staff's travelling and other costs and expenses at such rates as the Appointment, Remuneration and Terms of Employment Committee of non-executive directors decides. These are to be disclosed in the annual report.

12.44 The remuneration and allowances for directors are to be disclosed in bands in the annual report.

13. COMPANY SECRETARY

13.1 The Trust shall have a Company Secretary, who may be an employee. The Company Secretary may not be a governor, nor the Chief Executive or the Finance Director. The Company Secretary's functions shall include:

13.1.1 acting as Company Secretary to the Council of Governors and the Board of Directors, and anycommittees;

13.1.2 summoning and attending all members' meetings, meetings of the Council of Governors and the Board of Directors, and keeping the minutes of those meetings;

13.1.3 keeping the register of members and other registers and books required by this Constitution to be kept;

13.1.4 having charge of the Trust's seal;

13.1.5 acting as returning officer in any elections;

13.1.6 publishing to members in an appropriate form information which they should have about the Trust's affairs;

13.1.7 preparing and sending to NHS England and any other statutory body all returns which are required to be made.

13.2 Minutes of every annual members' meeting, of every meeting of the Council of Governors and of every meeting of the Board of Directors are to be kept. Minutes of meetings will be received at the next meeting for agreement. Any amendment to the minutes shall be agreed and recorded at the meeting. The agreed minutes will be conclusive evidence of the events of the meeting.

13.3 The Company Secretary is to be appointed and removed by the Board of Directors.

14. REGISTERS

14.1 The Trust is to have:

14.1.1 a register of members showing, in respect of each member, the constituency and (where relevant) the class of the constituency to which they belong;

14.1.2 a register of members of the Council of Governors;

14.1.3 a register of directors;

14.1.4 a register of interests of the members of the Council of Governors;

14.1.5 a register of interests of the directors.

14.2 The Company Secretary shall remove from the register of members the name of any member who ceases to be entitled to be a member under the provisions of this Constitution.

14.3 The Company Secretary is to provide NHS England with up to date information on elected and appointed members of the Council of Governors and directors.

14.4 The registers referenced in paragraph 14.1 shall be made available for inspection by members of the public, except in circumstances prescribed by regulations and in particular where any member requests that their details are not available for inspection pursuant to the Public Benefit Corporation (Register of Members) Regulations 2004.

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

14.5.1 the registers are to be available for inspection free of charge at all reasonable times; and

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

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

15. PUBLIC DOCUMENTS

15.1 The following documents of the Trust are to be available for inspection by members of the public free of charge at all reasonable times, and shall be available on the Trust's website:

15.1.1 a copy of the current Constitution;

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

15.1.3 a copy of the report of any other external auditor of the Trust's affairs appointed by the Council or members of the Council of Governors;

15.1.4 a copy of the latest annual report;

15.1.5 a copy of the latest information as to its forward planning;

15.1.6 a copy of the Trust's membership development strategy;

15.1.7 a copy of the Trust's policy for the composition of the Council of Governors

15.2 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:

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

15.2.2 a copy of any report laid under s.65D (appointment of trust special administrator) of the 2006 Act

15.2.3 a copy of any information published under s.65D (appointment of trust special administrator) of the 2006 Act

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

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

15.2.6 a copy of any notice published under s.65F (administrator's draft report), s.65G (consultation plan), s.65H (consultation requirements), s.65J (power to extend time), s.65KA (NHS England's decision), s.65KB (Secretary of State's response to NHS England's decision), s.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

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

15.2.8 a copy of any final report published under s.65L (administrator's final report) of the 2006 Act

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

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

15.3 Any person who requests it is to be provided with a copy or extract from any of the above documents. The Trust may impose a reasonable charge for providing the copy or extract, but a member is entitled to a copy or extract free of charge.

16. FINANCIAL AUDITOR AND OTHER EXTERNAL AUDITORS

16.1 The Trust is to have a financial auditor and is to provide the financial auditor with every facility and all information which he may reasonably require for the purposes of his functions under Chapter 5 of Part 2 of the 2006 Act.

16.2 A person may only be appointed as the financial auditor if they (or in the case of a firm, each ofits members) are eligible for appointment as a statutory auditor or a local auditor within the meaning of paragraphs 23(4)(a) or 23(4)(aa) of Schedule 7 to the 2006 Act or are a member of one or more of the bodies referred to in paragraph 23(4)(c) of Schedule 7 to the 2006 Act.

16.3 The Council of Governors at a Council meeting shall appoint or remove the Trust's financial auditor.

16.4 The financial auditor is to carry out their duties in accordance with Schedule 10 to the 2006 Act and in accordance with any directions given by NHS England on standards, procedures and techniques to be adopted.

16.5 The Board of Directors may resolve that external auditors be appointed to review and publish a report on any other aspect of the Trust's performance. Any such auditors are to be appointed bythe Council of Governors.

17. ACCOUNTS

17.1 The Trust shall keep proper accounts and proper records in relationto the accounts.

17.2 NHS England may, with the approval of the Secretary of State, give directions to the Trust as to the content and form of its accounts.

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

17.4 The following documents will be made available to the Comptroller and Auditor General for examination at his request:

17.4.1 the accounts;

17.4.2 any records relating to them; and

17.4.3 any report of the financial auditor on them.

17.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the accounting officer.

17.6 The annual accounts, any report of the financial auditor on them, and the annual report are to be presented to the Council of Governors at a Council meeting. The Trust may combine a meeting of the Council convened for the purposes of presenting these documents to the Council with the annual members' meeting.

17.7 The Trust shall lay a copy of the annual accounts, and any report of the financial auditor on them, before Parliament and send copies of those documents to NHS England within such period as NHS England may direct.

18. ANNUAL REPORTS, FORWARD PLANS AND NON-NHS WORK

18.1 The Trust shall prepare an annual report and send it to NHS England.

18.2 The Trust is to give information as to its forward planning in respect of each financial year to NHS England.

18.3 If the Trust proposes to increase by five per cent (5%) or more the proportion of its total income in any financial year that is attributable to activities other than the provision of goods and services for the purposes of the health service in England, the Trust may only implement the proposal if more than half of the members of the Council of Governors voting approve the proposal's implementation. For example, the Council of Governors will be required to vote where the Trust proposes to increase its non-NHS income from 2% to 7% or more of the Trust's total income.

19. INDEMNITY

19.1 Members of the Council of Governors and the Board of Directors (together with any non-voting associate non-executive directors and/or any employee who is invited to attend meetings of the Board of Directors) and the Company Secretary who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, or participation in meetings of the Board of Directors where relevant, save where theyhave acted recklessly. Any costs arising in this way will be met by the Trust. The Trust may purchase and maintain insurance against this liability for its own benefit and for the benefit of members of the Council of Governors and the Board of Directors and the Company Secretary.

20. EXECUTION OF DOCUMENTS

20.1 A document purporting to be duly executed under the Trust's seal or to be signed on its behalf is to be received in evidence and, unless the contrary is proved, taken to be so executed or signed.

20.2 The Trust is to have a seal, but this is not to be affixed except under the authority of the Board of Directors.

21. AMENDMENT OF THE CONSTITUTION

21.1 No amendment shall be made to this Constitution unless:

21.1.1 more than half of the governors voting approve the amendments, and:

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

21.2 Amendments made under paragraph 21.1 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.

21.3 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):

21.3.1 at least one (1) governor must attend the next annual members' meeting and present the amendment, and

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

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

21.5 Amendments by the Trust of its Constitution are to be notified to NHS England. For the avoidance of doubt, NHS England'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.

22. MERGERS ETC. AND SIGNIFICANT TRANSACTIONS

22.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the governors.

22.2 The Trust may enter into a significant transaction only if more than half of the governors present and voting approve entering into the transaction.

22.3 "Significant transaction" means any transaction determined by NHS England to be significant in accordance with the *Transactions guidance – for trusts undertaking transactions, including mergers and acquisitions*, (November 2017), as may be updated from time to time, excluding any transaction covered by the *Addendum to the transactions guidance – for trusts forming or changing a subsidiary* (November 2018), as may be updated from time to time.

23. DISSOLUTION OF THE FOUNDATION TRUST

23.1 The Trust may not be dissolved except by order of the Secretary of State for Health and Social Care, in accordance with the 2006 Act.

24. HEAD OFFICE

24.1 The Trust's Head Office is at Royal Preston Hospital, Sharoe Green Lane, Fulwood, Preston, PR2 9HT.

ANNEX 1: AREA OF THE TRUST

The area of the Trust shall comprise all of the component electoral wards in the following Local Authority areas:

- Blackburn with Darwen
- Blackpool
- Bolton
- Bury
- Cheshire East
- Cheshire West
- Cumbria
- Halton
- Knowsley
- Liverpool
- Lancashire
- Manchester
- Oldham
- Rochdale
- Salford
- Sefton
- St. Helens
- Stockport
- Tameside
- Trafford
- Warrington
- Wigan
- Wirral

MODEL ELECTION RULES 2014
(WITH MINOR TRUST AMENDMENTS)

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 (published by 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;

"NHS England" means the corporate body established pursuant to Section 1H(1) of the 2006 Act;

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Timetable

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

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

3. Computation of time

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

(a) a Saturday or Sunday;

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

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

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

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

4. Returning Officer

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

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

5. Staff

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

6. Expenditure

6.1 The corporation is to pay the returning officer:

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

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

7. Duty of co-operation

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

8. Notice of election

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

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

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

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

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

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

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

(g) the contact details of the returning officer

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

9. Nomination of candidates

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

9.2 The returning officer:

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

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

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

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

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

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

11. Declaration of interests

11.1 The nomination form must state:

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

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

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

12. Declaration of eligibility

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

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

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

13. Signature of candidate

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

(a) they wish to stand as a candidate,

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

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

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

14. Decisions as to the validity of nomination

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

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

(b) decides that the nomination form is invalid,

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

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

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

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

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

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

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

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

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

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

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

15. Publication of statement of candidates

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

15.2 The statement must show:

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

(b) the declared interests of each candidate standing,

as given in their nomination form.

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

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

16. Inspection of statement of nominated candidates and nomination forms

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

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

17. Withdrawal of candidates

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

18. Method of election

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

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the Council of Governors, those candidates are to be declared elected in accordance with Part7 of these rules.

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

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

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

19. Poll to be taken by ballot

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

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

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

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

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

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

(i) configured in accordance with these rules; and

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

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

(i) configured in accordance with these rules; and

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

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

(i) configured in accordance with these rules; and

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

20. The ballot paper

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

(a) that the voter is the person:
(i) to whom the ballot paper was addressed, and/or

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

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

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

("declaration of identity")

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

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

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

Action to be taken before the poll

22. List of eligible voters

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

23. Notice of poll

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

(a) the name of the corporation,

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

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

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

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

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

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

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

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

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

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

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

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

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

(a) a ballot paper and ballot paper envelope,

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

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information

by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

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

(b) the voter's voter ID number,

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

("e-voting information").

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

(a) only be sent postal voting information; or

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

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

for the purposes of the poll.

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

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

25. Ballot paper envelope and covering envelope

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

25.2 The covering envelope is to have:

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

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

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

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

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

26. E-voting systems

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

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

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

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

(a) require a voter to:

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

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

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

(b) specify:

(i) the name of the corporation,

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

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

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

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

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

(vii) the contact details of the returning officer;

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

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

(i) the voter’s voter ID number;

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

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

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

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

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

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

(a) require a voter to

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

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

identity;

(b) specify:

(i) the name of the corporation,

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

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

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

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

(vi) the contact details of the returning officer;

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

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

(i) the voter's voter ID number;

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

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

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

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

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

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

(a) require a voter to:

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

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

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

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

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

(i) the voter's voter ID number;

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

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

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

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

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

The poll

27. Eligibility to vote

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

28. Voting by persons who require assistance

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

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

29. Spoilt ballot papers and spoilt text message votes

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

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

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

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

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

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

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

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

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

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

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

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

(a) the name of the voter, and

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

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

30. Lost voting information

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

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

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

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

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

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

(a) the name of the voter

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

(c) the voter ID number of the voter.

31. Issue of replacement voting information

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

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

(a) the name of the voter,

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

(c) the voter ID number of the voter.

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

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

Polling by internet, telephone or text

33. Procedure for remote voting by internet

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

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

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

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

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

34. Voting procedure for remote voting by telephone

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

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

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

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

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

35. Voting procedure for remote voting by text message

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

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

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

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

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

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

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

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

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

(b) the unique identifier on a ballot paper.

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

37. Validity of votes

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

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

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

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

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

(a) mark the ballot paper "disqualified",

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

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

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

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

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

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

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

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

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

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

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

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

(b) record the name of the voter in the list of disqualified documents, indicating that a

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

declaration of identity was received from the voter without a ballot paper, and

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

39. De-duplication of votes

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

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

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

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

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

(a) mark the ballot paper “disqualified”,

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

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

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

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

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

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

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

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

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

40. Sealing of packets

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

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

(b) the ID declaration forms, if required,

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

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

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

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

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

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

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

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

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

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,
"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing

candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the Council of Governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or theprovisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference

for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word “rejected” on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number oftext voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall

be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub- parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the nextavailable 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 nextavailable preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot

documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference isrecorded, 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 markedthat, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub- parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub- parcel of ballot documents with the highest transfer value he or she shall proceed to transferin 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

(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 candidateare 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.

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 ofGovernors 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

(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.

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with “rejected in part”,

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

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

54.2 The returning officer must not open the sealed packets of:

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

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

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

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

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new

voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of

directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that NHS England has declared that the vote was invalid.

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 orclass.

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 votingrecords and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the 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).

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 NHS England under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words, and

(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")

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 ofa 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.

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 NHS England for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to NHS England by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. NHS England will refer the application to the independent election arbitration panel appointed by NHS England.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 NHS England shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 3: INVESTIGATION PROCEDURE - GOVERNORS

1. Where the Company Secretary considers that serious or substantial concerns have been raised about a governor, the Company Secretary shall convene a panel comprising a minimum of three (3) individuals (who, for the avoidance of doubt, do not have to be governors) to consider those concerns and to decide on the appropriate course of action (the "Panel").

2. The Chair shall usually determine the membership of the Panel. The Panel will usually comprise the Chair, the Lead Governor and the chair of a sub-group of the Council of Governors. If the matter concerns the Lead Governor, then an alternative individual shall be appointed to the Panel. The Chair may, where appropriate, delegate to another individual responsibility for selecting the membership of the Panel.

3. If the Panel determines that an investigation is required, the Panel, with support from the Company Secretary (or alternative appropriate individual(s) if considered appropriate), shall decide who shall carry out the investigation and shall determine the terms of reference for the investigation. The Panel may be joined by advisors (including legal advisors) for any part of any proceedings before them, but all decisions of the Panel will be the Panel's alone.

4. The Panel shall determine whether any restrictions should be imposed on the governor's activities and, if so, for what period of time pending the resolution of the concerns. The restrictions may include:

   (i) requiring the governor not to access the Trust's sites for the purposes of his/ her governor role; and

   (ii) requiring the governor not to attend meetings of the Council of Governors or of any sub-group of which the governor is a member.

5. If the Panel determines that an investigation is warranted and the governor fails to comply with the investigative process, the Panel may recommend to the Council of Governors that the governor is removed from office.

6. If the Panel determines that an investigation is not warranted, the Panel shall make a recommendation to the Council of Governors about how to proceed.

7. The Panel shall be responsible for determining the timeline for each stage of the process conducted in accordance with this Annex 3. If the governor fails to engage with any stage of the process within the timeline stipulated by the Panel, the Panel may recommend to the Council of Governors that the governor is removed from office.

Investigation

8. Where an investigation is to be carried out, the investigator shall comply with the terms of reference for the investigation, which shall include preparing a report for the Panel.

9. On receiving the investigator's report, the Panel shall invite the governor concerned to make written and/or oral representations to the Panel. The governor may be accompanied by a representative at his/her own cost.

10. Having considered the investigator's report and the representations of the governor concerned, the Panel shall make a recommendation to the Council of Governors as to a proposed course of conduct, which may include removing the governor from office.

Decision of the Council of Governors

11. The Company Secretary shall convene a meeting of the Council of Governors, which shall be held in private session, to consider the Panel's recommendation. The Council of Governors may request a member of the Panel to attend the meeting to present the Panel's recommendation and, where an investigation has been carried out, the findings of the investigation.

12. The Council of Governors shall decide whether to accept the Panel's recommendation or whether another course of action is appropriate. The Council of Governors may only consider a proposal to remove the governor from office if this has been recommended by the Panel.

13. Any decision of the Council of Governors to remove the governor from office shall require the approval of three-quarters of the members of the Council of Governors present and voting. Any such decision shall only take effect in accordance with paragraph 15 below.

14. The Company Secretary shall give notice in writing to the governor concerned of the Council of Governor's decision within seven (7) days of the date of the meeting at which the decision was taken.

15. If the Council of Governors resolves to remove the governor from office, that resolution shall only take effect:

    (i) on the expiry of seven (7) days, if the governor does not dispute the decision; or

    (ii) where an independent assessor is appointed and confirms in writing that, in his or her view, the decision of the Council of Governors to remove the governor from office was reasonable.

Independent Assessor

16. If the Council of Governors resolves to remove the governor from office and the governor concerned disputes this decision, he or she may request that the matter is referred to an independent assessor, who shall determine whether the proposed removal of the governor from office is reasonable. Any such request must be made in writing to the Company Secretary within seven (7) days of receipt by the governor of the notice of the Council of Governors' decision.

17. In the event that the governor requests that the matter is referred to an independent assessor, the Trust and the governor concerned shall try to agree on the identity of the independent assessor, who may be, for example, the Senior Independent Director or the Chief Executive of another Trust. Where the Trust and the governor are unable to reach agreement, the Trust acting reasonably shall appoint the assessor.

18. If the governor requests that the matter is referred to an independent assessor pursuant to paragraph 16, the governor shall remain subject to any restrictions imposed by the Panel on his or her activities pursuant to paragraph 4 above until such time as the independent assessor confirms his decision. The Panel shall consider whether such restrictions remain appropriate and may make any variations that it considers fit.

19. Once the independent assessor has notified the parties in writing of his or her decision, the parties shall take such steps (if any) as are required to give effect to that decision.

ANNEX 4: INVESTIGATION PROCEDURE – NON-EXECUTIVE DIRECTORS

Where the Trust has received a formal complaint in relation to the Chair or any other non-executive director, or where there is reason to believe there are grounds for removal of the Chair or any other non-executive director, the procedure outlined in this Annex 4 shall apply. For the purpose of this Annex 4, the term '*Chair of the Nominations Committee*' shall mean the Chair, save in circumstances where the Chair is under investigation, in which case the reference to the Chair of the Nominations Committee shall be interpreted as a reference to the Vice Chair.

Investigation

1. The Chair of the Nominations Committee shall commission an investigation and appoint a suitably experienced investigating officer (who may be external to the Trust) to investigate the facts and establish whether there is a case to answer and to prepare a report for the Nominations Committee.

2. The investigating officer shall not be responsible for recommending to the Council of Governors an appropriate course of action, as this is the responsibility of the Nominations Committee.

3. Investigation and fact finding should be undertaken in a timely way and where possible should take no longer than six weeks.

4. The non-executive director concerned shall be invited to make written and/or oral representations to the investigating officer in respect of the matter, and such representations must be provided within a period of twenty-eight (28) days from the date of the invitation. Any representations received shall be considered by the investigating officer and contained within their written report. The non-executive director concerned may be accompanied at his or her own cost.

5. The Nominations Committee may at any time determine that it is in the best interests of the Trust for the non-executive director concerned to be suspended from the Board of Directors pending the outcome of the investigation. A suspension risk assessment will be completed in conjunction with the Chief People Officer. Suspension shall not be applied automatically and will be considered on a case-by-case basis. The suspension of a non-executive director shall be reviewed by the Chair of the Nominations Committeeafter a period of twenty-eight (28) calendar days, and every fourteen (14) calendar days thereafter until such time as the matter has been determined.

Recommendation by the Nominations Committee

6. The Nominations Committee shall receive the report of the investigating officer and shall make a recommendation to the Council of Governors as to a proposed course of action (which may include no action to be taken) as soon as reasonably practicable and shall give notice in writing of that recommendation to the person concerned within seven (7) days of the recommendation being made.

7. The recommendation shall be based on a majority vote of the Nominations Committee and, for the avoidance of doubt, it is not the Nominations Committee's responsibility to reach a decision itself, as this is the responsibility of the Council of Governors.

Decision of the Council of Governors

8. The Company Secretary shall convene on behalf of the Nominations Committee an extraordinary meeting of the Council of Governors, which shall be held in private session, on no less than fourteen (14) calendar days' notice given to both the Council of Governors and the non-executive director concerned. A representative of the Nominations Committee should present the findings of the investigation and make the appropriate recommendation to the Council of Governors.

9. The Council of Governors will consider the Nominations Committee's recommendation but is at liberty to reject the Nominations Committee's recommendation in reaching its decision.

10. The Council of Governors will receive representations from both the Nominations Committee and from the non-executive director concerned. If the non-executive director concerned fails to attend the Council meeting without due cause, the Council meeting may proceed in his or her absence.

11. The Council of Governors should only exercise its power to remove the Chair or another non- executive director as a last resort. Reasons for removal will depend on the particular circumstances and may include, but are not limited to:
    (i) material breach of the Trust's code of conduct;
    (ii) the non-executive director concerned having acted in a manner detrimental to the interests of the Trust;
    (iii) the Council of Governors consider that it is not in the best interests of the Trust for the non-executive director concerned to continue on the Board;
    (iv) the non-executive director concerned losing the confidence of the Council of Governors and/or the Board of Directors; and/or
    (v) there are grounds for disqualification under paragraph 12.17 of the Constitution.

12. A decision of the Council of Governors to:
    (i) remove a non-executive director (including the Trust Chair) requires the approval of three-quarters of the total number of governors (not just those governors present and voting at the extraordinary meeting of the Council of Governors); or
    (ii) take no action or implement any other 'non-removal' sanction requires the approval of more than half of those governors present and voting at the relevant extraordinary meeting of the Council of Governors.

13. In making its decision, the Council of Governors shall adhere to the following:
    (i) any proposal for removal must have been recommended by the Nominations Committee (in accordance with paragraphs 6 and 7 above);
    (ii) reasons for the proposal must be provided to the non-executive director concerned who shall be given the opportunity to respond to such reasons;
    (iii) in making a decision on any proposal, the Councilof Governors shall take into account the annual appraisal of the relevant non-executive director; and
    (iv) if any proposal to remove a non-executive director is not approved at the relevant extraordinary meeting of the Council of Governors,no further proposal can be put forward to remove such non-executive director based upon the same reasons within twelve (12) months of the meeting.

14. The decision of the Council of Governors will be confirmed in writing (including the reasons for the decision) to the person concerned by the Company Secretary within seven (7) days of the date of the extraordinary meeting of the Council of Governors.

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors Report

Re-appointment of Non-Executive Director

Report to:	Council of Governors	**Date:**	3 November 2022
Report of:	Company Secretary	**Prepared by:**	K Brewin

Purpose of Report

For approval	☒	**For noting**	☐	**For discussion**	☐	**For information**	☐

Executive Summary:

Under Schedule 7, paragraph 17(1) of the National Health Service Act 2006, it is for the Council of Governors at a general meeting to appoint, re-appoint or remove the Non-Executive Directors. The purpose of this report is to provide information for the Council to consider re-appointment of Mr T Watkinson whose term of office is due to expire on 31 March 2023.

In line with the Trust's Constitution (paragraph 12.6), any re-appointment of a Non-Executive Director by the Council of Governors shall be subject to a satisfactory appraisal carried out in accordance with procedures which the Board of Directors have approved. All Non-Executive Directors have successfully completed their 2021/22 annual appraisals which this year were supported by 360-degree feedback from Board colleagues and Governors were also invited to contribute to a 360-degree survey. Discussions have been held with Mr T Watkinson who has confirmed his intention to serve for a further term, as determined by the Trust Constitution and subject to approval by the Council of Governors. Further supporting information is provided in the main body of the report.

It is recommended that the Council approve the Nominations Committee recommendation to re-appoint Mr T Watkinson for the period 1 April 2023 up to and including 31 March 2024 (year two annual re-appointment).

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To offer excellent health care and treatment to our local communities	☒	Consistently Deliver Excellent Care	☒
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive innovation through world-class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Nominations Committee (16 September 2022)

1. Role and responsibilities of the Non-Executive Director

A Non-Executive Director works alongside other Non-Executive and Executive Directors as equal members of the Board of Directors. They share responsibility with the other Directors for the decisions made by the Board and for the success of the organisation in leading the local improvement of healthcare services.

Non-Executive Directors use their individual skills alongside their personal experience as a member of the community to:

- provide independent judgement and advice on issues of strategy, vision, performance, resources and standards of conduct and to constructively challenge, influence and help the Executive Team develop proposals on such strategies to enable the organisation to fulfil its leadership responsibilities for healthcare of the local community;
- ensure that the Board sets challenging objectives for improving its performance across the range of its functions;
- monitor, in accordance with agreed Board procedures, the performance and conduct of management in meeting agreed goals and objectives and statutory responsibilities, including the preparation of annual reports and annual accounts and other statutory duties;
- contribute to the determination of appropriate levels of remuneration for identified senior staff;
- take an active part in Committees established by the Board of Directors to exercise delegated responsibility;
- as a member of Committees of the Board, appoint, remove, support, encourage and where appropriate 'mentor' senior Executives;
- bring independent judgement and experience from outside the Trust and apply this to the benefit of the Trust, its stakeholders and its wider community;
- assist fellow Directors in providing entrepreneurial leadership to the Trust within a framework of prudent and effective controls, which enable risk to be assessed and managed;
- assist fellow Directors in setting the Trust's values and standards and ensure that its obligations to its stakeholders and the wider community are understood and fairly balanced at all times;
- ensure that the organisation values diversity in its workforce and demonstrates equality of opportunity in its treatment of staff and patients and in all aspects of its business; and
- engage positively and collaboratively in Board discussion of agenda items and act as an ambassador for the Trust in engagement with stakeholders including the local community.

2. Background

The following provides an overview of previous experience, key skills, knowledge and experience and the roles undertaken by Mr T Watkinson that provide assurance to the Board.

2.1 Overview of previous experience, skills and knowledge

A qualified accountant with over 25 years' experience in senior audit positions in the public sector. He was previously the Group Chief Internal Auditor for the Ministry of Justice and prior to that was a District Auditor with the Audit Commission, including terms of office in Lancashire County Council, Preston City Council and Chorley Borough Council. He has led national teams and taken a lead role for the Audit Commission in the development of methodology for improving the performance of local authorities.

He has experience of working in major accountancy firms providing audit and consultancy services to the public sector including the NHS. He has also been employed as an accountant and a Chief Internal Auditor within the NHS. Outside of the Trust, he is an independent member of the UK Statistics Authority's Audit and Risk Assurance Committee.

In August 2022, he stepped down from the role of Vice Chair having expertly occupied that position for much of his term of office as a Non-Executive Director.

2.2 **Roles undertaken within the Trust**

He undertakes a number of different roles that provide assurances to the Board including:

- Chair of the Audit Committee
- Member of the Finance and Performance Committee
- Member of the Appointments, Remuneration and Terms of Employment Committee
- Member of the Rosemere Management Committee
- Non-Executive Director Lead for Freedom to Speak Up and Raising Concerns Group
- Non-Executive Director Lead for Internal Audit
- Non-Executive Director Lead for External Audit
- Non-Executive Director Lead for Patient Flow

2.3 **Senior Independent Director**

Following interviews with Non-Executive Director candidates on 16 September 2022 for the vacant Senior Independent Director role, the Board (in consultation with the Nominations Committee) endorsed the appointment of Mr T Watkinson as Senior Independent Director with effect from 20 September 2022.

2.4 **Additional duties**

In addition to the portfolios described, the Non-Executive Directors undertake a range of additional duties, such as Board workshops and development sessions and attend virtual events such as Fab Feedback Friday and STAR accreditation awards. They also attend ad hoc Committee meetings where they are not a member to ensure they are sighted on issues and assurance across all Non-Executive Directors' portfolios.

During the unique challenges faced over the past couple of years, particularly in respect of the Covid-19 pandemic, it has been necessary to hold a number of extraordinary part II Board meetings and the Non-Executive Directors demonstrated a flexible and agile approach to accommodate the arrangements usually at short notice.

2.5 **Annual appraisal**

He has been appraised by the Chair of the Trust in each of his years of appointment and has consistently met the objectives agreed. His most recent appraisal was held in August 2022 and involved 360-degree feedback from Board colleagues and this year Governors were invited to also contribute to the 360-degree survey. He again had a successful appraisal and met all the objectives for 2021/22.

3. Financial implications

There are no financial implications arising from this report.

4. Legal implications

The relevant section within the Trust's constitution regarding reappointments (para. 12.6) states that:

"The Chair and the Non-Executive Directors are to be appointed for a period of office in accordance with the terms and conditions of office decided by the Council of Governors at a general meeting. Any re-appointment of a Non-Executive Director by the Council of Governors shall be subject to a satisfactory appraisal carried out in accordance with procedures which the Board of Directors has approved.

A Non-executive Director (including the Chair) may serve on the Board of Directors for longer than six (6) consecutive years, subject to annual reappointment. A Non-Executive Director of the Trust (including the Chair) may not hold office for longer than a maximum of nine (9) years in aggregate in the capacity of either the Chair or a Non-Executive Director of the Trust."

The relevant sections of the NHS Foundation Trust Code of Governance relating to re-appointments are as follows:

"The Board of Directors and the Council of Governors should also satisfy themselves that plans are in place for orderly succession for appointments to the Board, so as to maintain an appropriate balance of skills and experience within the NHS Foundation Trust and on the Board." (Supporting principle B.2.c)

"The Governors should agree with the Nominations Committee a clear process for the nomination of a new Chairperson and Non-Executive Directors. Once suitable candidates have been identified the Nominations Committee should make recommendations to the Council of Governors." (Provision B.2.5)

"All Non-Executive Directors and Elected Governors should be submitted for re- appointment or re-election at regular intervals…The Council of Governors should ensure planned and progressive refreshing of the Non-Executive Directors." (Supporting principle B.7.a)

"In the case of re-appointment of Non-Executive Directors, the Chairperson should confirm to the Governors that following formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and to demonstrate commitment to the role. Any term beyond six years (e.g. two three-year terms) for a Non-Executive Director should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the Board. Non-Executive Directors may, in exceptional circumstances, serve longer than six years (e.g. two three-year terms following authorisation of the NHS Foundation Trust) but this should be subject to annual re-appointment. Serving more than six years could be relevant to the determination of a Non-Executive's independence." (Provision B.7.1)."

5. Risks

Should the Council of Governors not approve re-appointment of the Non-Executive Director then there is a risk to the composition of the Board of Directors and the ability for the business of the Trust to be delivered in line with the Trust's Constitution and its Provider Licence.

6. Impact on stakeholders

There is no impact on stakeholders arising from this report.

7. Recommendations

It is recommended that the Council approve the Nominations Committee recommendation to re-appoint Mr T Watkinson for the period 1 April 2023 up to and including 31 March 2024 (year two annual re-appointment).

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Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors Report

Register of Interests			
Report to:	Council of Governors	**Date:**	3 November 2022
Report of:	Company Secretary	**Prepared by:**	K Brewin
Part I	✓	**Part II**	

Purpose of Report							
For approval	☒	**For noting**	☐	**For discussion**	☐	**For information**	☐

Executive Summary:

In line with the Trust's Constitution (section 11, sub-sections 11.39 to 11.44) there is a requirement for Governors to declare any material interests that would impact on their role as a Governor or member of the Council of Governors. The purpose of this report is to present information to the Council on the declared interests of each Governor as at 31 October 2022. The register of interests is included as appendix 1.

It is the responsibility of every Governor to ensure any changes to their interests are notified to the Office of the Company Secretary at the time of the change to their interests so the central register can be updated

It is recommended that the Council:

I. Receive the report and approve the declared interests detailed in appendix 1.
II. Note the requirement to ensure any changes are notified to the Office of the Company Secretary at the time of the change.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

None

1. **Context**

In line with the Trust's Constitution (section 11, sub-sections 11.39 to 11.44) there is a requirement for Governors to declare any material interests that would impact on their role as a Governor or member of the Council of Governors.

It is the responsibility of every Governor to ensure any changes to their interests are notified to the Office of the Company Secretary at the time of the change to their interests so the central register can be updated.

Appendix 1 includes declared interests of each Governor as at 31 October 2022.

2. **Financial implications**

There are no financial implications associated with the recommendations in the report.

3. **Legal implications**

Section 11 (sub-sections 11.39 to 11.44) of the Trust's Constitution have been reproduced below:

Disclosure of interests

11.39 Any governor who has a material interest in a matter as defined below shall declare such interest on their behalf or on behalf of their partner/close family members to the Council of Governors, and:

11.39.1 shall withdraw from the meeting and play no part in the relevant discussion or decision

11.39.2 shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

11.40 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 majority of the remaining governors.

11.41 Subject to the exceptions below, a material interest is:

11.41.1 any directorship of a company;

11.41.2 any interest held by a governor in any firm or company or business which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust;

11.41.3 any interest in a voluntary or other organisation providing health and social care services to the National Health Service;

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

11.41.5 any connection with any organisation, entity or company considering entering into or having entered into a financial arrangements with the Trust including but not limited to lenders or banks.

11.42 The exceptions which shall not be treated as material interests are as follows:

11.42.1 shares not exceeding two per cent (2%) of the total shares in issue held in any company whose shares are listed on any public exchange;

11.42.2 an employment contract held by a staff governor;

11.42.3 an employment contract with a local authority held by a local authority governor;

11.42.4 an employment contract with a partnership organisation held by a partnership governor.

11.43 The Council of Governors is to adopt its own standing orders for its practice and procedure, in particular for its procedure at meetings.

Declaration

11.44 An elected governor may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the form specified by the Secretary of the particulars of their qualification to vote as a member of the Trust and that they are not prevented from being a governor. An elected governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors, and every agenda for the meetings of the Council of Governors will draw this to the attention of elected governors.

4. Risks

There are no risks associated with the recommendations in the report.

5. Impact on stakeholders

There are no stakeholder impacts associated with the recommendations in the report.

6. Recommendations

It is recommended that the Council:

I. Receive the report and approve the declared interests detailed in appendix 1.
II. Note the requirement to ensure any changes are notified to the Office of the Company Secretary at the time of the change.

Council of Governors

Register of Interests as at 31 October 2022

Lancashire Teaching Hospitals
NHS Foundation Trust

Name	Position	Declared Interest
Keith Ackers	Public Governor	• No interests declared
Will Adams	Appointed Governor (representing South Ribble Borough Council)	• Councillor at South Ribble Borough Council • Member of Penwortham Town Council • Member of the Labour Party • Employee of Southport and Ormskirk NHS Trust
Pav Akhtar	Public Governor	• Outpatient at Lancashire Teaching Hospitals NHS FT • Carer of an outpatient at Lancashire Teaching Hospitals NHS FT • Member of Lancashire Teaching Hospitals NHS FT • Related to T Akhtar (public governor) at Lancashire Teaching Hospitals NHS FT • Chair of Organ Donation Committee at Lancashire Teaching Hospitals NHS FT • Chief Diversity and Inclusion Officer, NHS Blood and Transplant • Non-Executive Director of Healthwatch England • Member of Unite the Union • Member of the Labour Party • Councillor at Preston City Council
Takhsin Akhtar	Public Governor	• Carer of outpatient at Royal Preston Hospital • Member of Lancashire Teaching Hospitals NHS FT • Related to P Akhtar (public governor) at Lancashire Teaching Hospitals NHS FT • Registered Nurse, East Lancashire NHS Trust • Member of Royal College of Nursing • Member of Labour Party
Rebecca Allcock	Staff Governor (representing Allied Health Professionals and Healthcare Scientists)	• No interests declared
Peter Askew	Public Governor	• Commercial relationship with Pervasent (software supplier)
Sean Barnes	Public Governor	• No interests declared
Alistair Bradley	Appointed Governor (representing Chorley Borough Council)	• Councillor at Chorley Borough Council • Executive Leader and Leader of the Labour Group • Executive Member (Economic Development and Public Sector Reform) • Director of Growth Lancashire Ltd Company • Member of Central Lancashire Strategic Planning Joint AdvisoryCommittee • Member of District Councils Network • Member of Lancashire Police and Crime Panel • Member of Local Government Association – General Assembly and Associated Groups
Sheila Brennan	Public Governor	• No interests declared

Anneen Carlisle	Staff Governor (representing Nurses, Midwives and Health Care Assistants)	• No interests declared
David Cook	Public Governor	• No interests declared
Kristinna Counsell	Public Governor	• *No declarations received*
Margaret France	Public Governor	• Councillor at Chorley Borough Council • Lead Member for Shared Services, Joint Working and Community Well-being • Member of Labour Party • Member of Unite the Union
Steve Heywood	Public Governor	• No interests declared
Lynne Lynch	Public Governor	• No interests declared
Janet Miller	Public Governor	• New Hospitals Programme – NHP Ambassador • Patient representative on the Lancashire and South Cumbria Integrated Care Board Urgent Care Programme for Central Lancashire
Eddie Pope	Appointed Governor (representing Lancashire County Council)	• Councillor at Lancashire County Council • Councillor at West Lancashire Borough Council
Frank Robinson	Public Governor	• No interests declared
Suleman Sarwar	Appointed Governor (representing Preston City Council)	• Councillor at Preston City Council (St Matthew's Ward) • Member of Labour Party • Member Champion for Mental Health and Suicide Prevention for Preston City Council
Anne Simpson	Public Governor	• No interests declared
Mike Simpson	Public Governor	• No interests declared
Piotr Spadlo	Staff Governor (representing non-clinical staff)	• No interests declared
David Watson	Public Governor	• No interests declared
Paul Wharton-Hardman	Public Governor	• Member of the Labour Party • Councillor for South Ribble Borough Council • Justice of the Peace (Magistrate) – Lancashire Bench • Student nurse with placements at Lancashire Teaching Hospitals NHS Foundation Trust • Councillor at Farrington Parish Council • Member of the Royal College of Nursing

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Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors Report

Council Development Plan update							
Report to:	Council of Governors			**Date:**	3 November 2022		
Report of:	Company Secretary			**Prepared by:**	K Brewin		
Part I	✓			**Part II**			
Purpose of Report							
For approval	☐	**For noting**	☒	**For discussion**	☐	**For information**	☐

Executive Summary:

The purpose of this report is to provide the Council of Governors with an update on the Council Development Plan approved at the Council meeting on 26 October 2021.

The Council has received an update at each meeting since the plan was approved and appendix 1 provides a further update in the RAG-rated column on the status of some of the outstanding actions.

It is recommended that the Council of Governors receive the report and note the contents for information.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☐	Consistently Deliver Excellent Care	☐
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☐	Great Place To Work	☐
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☐
		Fit For The Future	☐

Previous consideration

Not applicable

1. **Financial implications**

   There are no financial implications associated with the recommendations in this report.

2. **Legal implications**

   There are no legal implications associated with the recommendations in this report.

3. **Risks**

   There are no risk implications associated with the recommendations in this report.

4. **Impact on stakeholders**

   The effective operation of the Council of Governors is a significant component of the Trust's assurance arrangements and the development plan will further enhance working relationships between Governors.

5. **Recommendations**

   It is recommended that the Council of Governors receive the report and note the contents for information.

Appendix 1: Council Development Plan

COUNCIL OF GOVERNORS DEVELOPMENT PLAN **Appendix 1**

THEME	ISSUES	ACTIONS	RESPONSIBLE/LEAD	STATUS
MEMBERSHIP	Lack of diversity amongst membership with some groups under-represented	Review and update of membership strategy. Workshop planned 13th October 2021 to develop strategy.	Karen Swindley	
		Ideas to be written into refreshed strategy	Karen Swindley	
		Strategy to be signed off by Council of Governors	Pav Akhtar	
	Engaging with members has been difficult during covid and acknowledgement that engagement methods may need to change.	Engagement approach to be considered as part of the review of the membership strategy	Karen Swindley	
		Governor engagement plan developed to be approved by Council of Governors	Karen Swindley	
	Recognise that to attract diversity amongst governors, level of commitment and ability to attend events must be balanced and facilitated	Explore use of hybrid meetings in the future	Company Secretary	Work being undertaken to explore hybrid meetings
	Longstanding issues of governor vacancies for some constituencies	Review of Constitution	Hempsons	Review of the Constitution completed, and Working Group meeting held with Governors
		Approval of revised constitution by council of governors	Karen Swindley	Revised Constitution included on the November Council agenda for approval
ORGANISATION	Difficulty in accessing core information, eg, constitution	Information Management system to be sourced and implemented	Stephen Dobson/Karen Brewin	Meeting tool under consideration
	Need to improve the level of administrative support available to governor groups	Review of Corporate Affairs Office to build in appropriate levels of support for governor groups	Karen Swindley	
		Recruitment to new roles	Karen Brewin	

		Allocation of responsibilities	Karen Brewin	
	Lack of workshops over the last 18 months	Workshops dates to be agreed and incorporated into corporate calendar for 2022	Karen Brewin	
		Governors to agree workshop content to allow for appropriate facilitators to be identified and secured to avoid cancellation of events	Governors	
	Response to governor queries	Revisit governor process map	Karen Swindley	
		Agree process map	Governors	
		Re-issue process map	Karen Swindley	
GOVERNOR CONTRIBUTION	Differing views of the role and expectations of the governors	Debate and agree minimum contribution to ensure appropriate – COG workshop	Karen Swindley	
		Ensure commitment is clearly laid out to governor candidates	Company secretary	
		Ensure commitment is clear in induction	Company secretary	
		Undertake annual assessment of whether governors are meeting minimum requirements for annual report to council of governors	Company secretary	
		Governor workshop on contributing with confidence	Karen Swindley	
		Implement the governor engagement plan	Karen Brewin	Limitations due to increase in Covid
		360-degree training for governors to contribute to NED appraisals in Q1 2022/23	Karen Swindley	
	Governors would like to get to know one another better and develop relationships	Council workshop focused on relationship building	Karen Swindley	
		Recovery roadmap for return to face-to-face meetings	Karen Swindley	Council/Subgroup meetings held virtually. Workshops/Development Sessions held in person

		Include pen portraits of governors on the new internet site	Naomi Duggan	
		Ensure governor photo boards are maintained up to date	Governor volunteers	Governor photos updated and published on Trust screens
COUNCIL MEETINGS	Insufficient engagement in council meetings and too much focus on information giving	Review process for getting items on the agenda to ensure governors have greater influence on the items discussed	Company Secretary	Agendas items discussed and agreed at Chairs, Deputy Chairs and Lead Governor meetings with the Chair and Chief Executive
		Revisit format of the COG meeting to time agendas to allow for debate	Company Secretary	All agendas are timed for Council and Subgroup meetings
		Use COG to garner views on forward looking issues	Company Secretary	
		Include governor queries report on the COG agenda	Company Secretary	
		Standing item on COG agenda for key issues and priorities for the next quarter	Company Secretary	
		Develop a separate corporate calendar for governor events	Company Secretary	Events calendar produced, requires input from governors as discussed at the Membership Subgroup

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NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Council of Governors

Clinical Services Strategy

Report to:	Council of Governors	**Date:**	3rd November 2022
Report of:	Medical Director	**Prepared by:**	G Skailes, S Canty and K Howarth

Purpose of Report

For approval	☐	**For noting**	☐	**For discussion**	☐	**For information**	☒

Executive Summary:

The purpose of this report is to provide an update on the revised summary Clinical Services Strategy, outlining our clinical priorities as an organisation and how these align with the developing priorities of Place, the Provider Collaborative Board (PCB) and the wider Integrated Care System (ICS) Clinical Strategies and priorities as well as the work on the New Hospitals Programme (NHP). Board members are asked to note that further work is underway at an ICS, PCB and Place level to finalise the clinical strategies and priorities for the wider system. It is anticipated that further work will be required to update and refine our Clinical Services Strategy as further work is undertaken on the NHP and at Place, PCB and ICS level.

This Clinical Services Strategy has been co-produced by colleagues across the Trust and reviewed a number of times by Board members before being finalised. It describes how services will be transformed in a way that will fully align with the New Hospitals Programme Framework Model of Care and will focus on whole population health and reduce health inequalities, with patients as partners in the management of their health. It outlines the key drivers for change at a local level and also acknowledges the on-going changes in the NHS system architecture and the need to align with and shape the emerging system Clinical Strategy, as well as aligning with the Trust's Big Plan, the Strategic Planning framework and other key corporate strategies. The strategy outlines the ways that this will be achieved, measured and evaluated and monitored via the Trust's governance processes.

The Divisions have developed Divisional and Specialty level clinical strategies to take the overall strategy forward. These have been discussed with the Executive team and reviewed to establish what senior support is needed to progress these.
These Divisional Strategies will be reviewed on a 6 monthly basis as part of our Divisional Improvement Forums to ensure progress is being made and to help form the basis for the overall Trust Strategy to be reviewed and refreshed.

On approval of this Clinical Services Strategy an engaging narrative will be developed for staff, patients and our local population.

It is recommended that:

I. The Council of Governors receive the updated strategy and notes the summary Clinical Services Strategy.

II.	The Council of Governors note the need for this strategy to be refined in line with the further work planned at an ICS, PCB and Place level as these clinical strategies and priorities are further developed, to ensure continued alignment across the system.

Trust Strategic Aims and Ambitions supported by this Paper:			
Aims		**Ambitions**	
To provide outstanding and sustainable healthcare to our local communities	☐	Consistently Deliver Excellent Care	☐
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☐	Great Place To Work	☐
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☐
		Fit For The Future	☐

1. Introduction

Significant work has been undertaken to develop the Trust Clinical Services Strategy (2022-2025). This has been co-designed with our clinical leaders, frontline staff and operational leaders. There is a lot to deliver, with some large-scale transformation for a number of clinical services in preparation for our new hospital, as we design and implement new models of care which are fit for the future.

In developing this strategy, full consideration has been given to the significant challenges experienced in our system that relate to our clinical models of care and pathway redesign and the significant drivers for change are outlined.

2. Discussion

The summary Clinical Services Strategy covers all services (acute and community) and specialist services provided by LTH. The strategy outlines the following priorities:

- ***Our Trust Strategic Objectives and Our Big Plan:*** Delivery of the Trust's Clinical Strategy will be supported by a range of our other strategies including our Workforce and Organisational Development Strategy, Information Technology Strategy, Continuous Improvement Strategy, Financial Strategy and Communication Strategy and is fully aligned to the priorities outlined in the Big Plan.
- ***Our Strategic Clinical Priorities*** to provide outstanding and sustainable healthcare to our local communities. This includes reduction of waiting lists following the Covid-19 pandemic; transforming Urgent and Emergency Care and protecting Elective services
- ***Delivery of our specialised services to patients in Lancashire and South Cumbria:*** the strategy outlines the Trust's priorities for the improved provision of high quality tertiary services over the course of the clinical services strategy. This includes continuing to provide our existing tertiary services, creation of new collaborations and networked services across our ICS.
- ***Driving health innovation through world class education, teaching and research:*** the strategy outlines how our Education and Research Strategies will support the delivery of the Clinical Strategy.
- ***System working in the new NHS landscape,*** implementing national and regional schemes and transformation programmes currently taking place at three levels across our system; ICS level, Place

and organisational level. The strategy outlines our plans to make a leading contribution to these priorities as the major specialist centre for Lancashire and South Cumbria

- **Clinical networks:** the strategy outlines our intention to support and develop existing clinical networks across the ICS and consider new areas of collaboration.
- **Fragile clinical services:** responding to COVID-19 highlighted that we have some fragile clinical services linked to the current available skilled workforce to sustain services. We will work with partners to support and consolidate these services across our wider system.
- **Reducing Health Inequalities:** our commitment to reducing health inequalities is outlined in this Clinical Services Strategy including working closely with the Central Lancashire Determinants of Health System Delivery Board and our Data Science Group to understand key areas of focus and enable agreed metrics to be monitored.
- **New Hospital Programme:** we have a once-in-a-generation opportunity to transform our region's hospitals by 2030. By creating a network of brand new and refurbished facilities, we will help local people live longer, healthier lives. By doing this, we will also make Lancashire and South Cumbria a world-leading centre of excellence for hospital care.

Implementing our Clinical Services Strategy

The strategy summary outlines at a high level how the strategy will be delivered through robust implementation plans at divisional and clinical specialty level through:

- **Planning:** benchmarking and learning from best practice, engagement on our proposed service changes, business case development and delivery plan development.
- **Communications and engagement:** development of an engaging narrative for our organisation and communication and engagement with external stakeholders
- **Measuring Success:** In the three year lifespan of this strategy our ambition is to move our CQC rating to good and to support the organisation and the ICS to move from SOF 3 to SOF 2. In the development of implementation plans, each clinical speciality/division will set the measures of success and in the longer term the successful delivery of our strategy will be measured against six key outcomes outlined in the strategy.

3. Financial implications

The delivery of the clinical strategy has a number of financial implications for the Trust including capital investment, especially for the larger schemes such as the Emergency Village to ensure our estate is fit for purpose for the future of Urgent and Emergency Care. There are also financial implications of the implementation of new clinical models, integrated pathways of care and new workforce models. These will need to be fully developed and costed as the detail work is undertaken.

4. Legal implications

None identified.

5. Risks

The most significant risks to the delivery of the Clinical Services Strategy are:

- ***Finance and investment*** – sufficient capital and revenue will be required to redesign our services as outlined in the strategy.
- ***Workforce*** – recruitment and retention challenges and the development and expansion of new clinical and support roles.

- ***Alignment of the clinical strategies*** that are in development at ICS, PCB and Place levels and alignment with other provider organisations.

Further work is now required at divisional and clinical specialty level to identify and mitigate the risks.

6. Impact on stakeholders

The proposals outlined in the summary Clinical Services Strategy have implications for our stakeholders, especially in relation to the integration of community services and the development of new clinical models of care. Further work will be required with our stakeholders to plan the delivery of the strategy and the co-design of services.

7. Recommendations

It is recommended that:

I. The Council of Governors receive the updated strategy and notes the summary Clinical Services Strategy.
II. The Council of Governors note the need for this strategy to be refined in line with the further work planned at an ICS, PCB and Place level as these clinical strategies and priorities are further developed, to ensure continued alignment across the system.

Together

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Summary of
Clinical Services Strategy 2021–2024

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Contents

Foreword

We are delighted to launch the Trust's Clinical Services Strategy 2022-2025 which has been co-designed with our clinical leaders, frontline staff and operational leaders. This strategy has been developed to be fully aligned with the system level New Hospitals Programme Framework Model of Care and outlines the roadmap for our clinical services development and redesign for the next three years.

There is a lot to deliver, with some large-scale transformation for a number of clinical services in preparation for our new hospital, as we design and implement new models of care which are fit for the future. In designing our new models of care, we will focus on targeted population health management and reducing inequalities, co-designing clinical models and services with our patients as partners, to improve their health and life expectancy. We will continue to work collaboratively with local partners to drive improvements and provide integrated care to meet the needs of our communities. Our commitment to delivering this strategy and measuring its success is fundamental to the delivery of high-quality clinical services.

In developing this strategy, full consideration has been given to the significant challenges experienced in our system that relate to our clinical models of care and pathway redesign.

The significant drivers for change include: COVID recovery, the need for an emergency village on the RPH site with sufficient assessment capacity and the need to maintain acute services on two sites, community integration (to address the lack of integrated pathways and the need to work flexibly), workforce challenges, health inequalities and financial recovery. Addressing these challenges will improve both patient and staff experience.

This clinical strategy covers all services (acute and community) and specialist services provided by Lancashire Teaching Hospitals (LTH).

Our thanks to all of our clinicians and operational leaders who have led the work to develop our system level framework model of care. This has provided the framework to guide our work over the next three years. This clinical strategy will be supported by a measurement strategy to track our improvements and achievements. This strategy will be fully aligned to our annual 'Big Plan' and the implementation of the strategy will be through the divisional teams and overseen by the Safety and Quality Committee and the Trust Board.

Dr Gerry Skailes

Medical Director

Sarah Cullen

Nursing, Midwifery & AHP Director

Faith Button

Chief Operating Officer

Our Trust Strategic Objectives and Our Big Plan

To provide outstanding and sustainable healthcare to our local communities

To offer a range of high quality specialist services to patients in Lancashire and South Cumbria

To drive health innovation through world class education, training and research

Delivery of the Trust's Clinical Strategy will be supported by a range of other detailed plans such as our Workforce and Organisational Development Strategy, Information Technology Strategy, Continuous Improvement Strategy, Financial Strategy and Communication Strategy.

Our Strategic Clinical Priorities

1) To provide outstanding and sustainable healthcare to our local communities

Reduction of waiting lists following COVID-19

The COVID-19 pandemic that commenced in March 2020 has fundamentally changed the landscape for the NHS and impacted on all clinical services across the organisation. The growth of our waiting lists following COVID-19 has been significant, and treating the increased number of patients will be a key priority for all specialties. Through this strategy period we will reduce our waiting list for outpatients, diagnostics and procedures, with the aim to be compliant with the NHS constitution. We will need to consider all options to increase clinical activity, with extended working and collaborating with the independent sector.

The system working with Integrated Care System (ICS) partners, implementing national and regional schemes throughout this period has enabled a number of transformational pieces of work to progress. Transformation programmes are currently taking place at three levels across our system;

- **ICS level**
- **Place level**
- **Organisational level**

The details of priorities at an ICS level are detailed in the ICS clinical strategy and are being reviewed as part of the developing Provider Collaborative Board (PCB) clinical strategy.

The details of the priorities for the Trust to deliver each year are detailed in Our Big Plan and the planning framework.

Capital developments have supported the replacement of RPH day case theatres into facilities at Chorley and South Ribble Hospital (CDH), alongside a Surgical Enhanced Care Unit (SECU), improvements in recovery areas in endoscopy, expansion of the emergency department at Royal Preston Hospital (RPH) and refurbishment of high dependency paediatric facilities. Enhancements were made to the existing critical care build to provide further compliance to infection control guidance.

Transforming Urgent and Emergency Care

There is an urgent need to improve the physical environment of the RPH Emergency Department and provide appropriately sized assessment facilities adjacent to the ED. We are writing a case for capital funding to enable this work to commence as rapidly as possible which on completion will improve the flow of emergency patients, reduce the number of patients requiring admission to hospital and reducing the length of stay of those who are admitted.

As part of the New Hospitals Programme we will review the current provision of emergency and acute medical services as well as critical care services on both of our hospital sites to produce recommendations for the future configuration of our services which are likely to need to be put to public consultation.

The ambition to separate elective and non-elective services across the organisation continues in this strategy and a key focus for clinical services is implementing and consolidating this across our organisation. This will reduce patient cancellations due to a lack of an available bed, and will protect infection prevention control pathways.

The non-elective services have a number of areas of focus within this strategy. Initial steps to re-open the CDH emergency department have been taken, and the strategic intention is to move from a 12 hour to a 24 hour emergency department, when it is possible to safely staff the emergency department. A review of the overarching strategy for the Chorley site and the non-elective pathways is also underway.

In line with the NHS long term plan the Same Day Emergency Care (SDEC) pathways will be expanded in adults and children's services, and diversion of patients into the most appropriate pathway via 111 assessment schemes will be enhanced and implemented through the existing Urgent and Emergency care platforms. This will result in more patients being cared for without the need for a hospital admission.

The strategic ambition is that to respond to increasing demand by allowing further admission avoidance, workforce models will be developed to provide robust seven day services for all non-elective specialities (for both adult and children's services) to include SDEC pathways, hot clinics and virtual wards. The acute hospitals services where appropriate will be integrated with and supported by community health and care services.

The capacity of the emergency department has been increased through COVID-19. This strategy recognises the pathway transformation opportunities that could be gained with co-locating acute services with modern emergency village facilities and is the next phase to this work. This would bring the medical and surgical assessment units with the correct capacity to be co-located with the emergency department. This will improve senior decision making and closer collaboration between acute specialties, and improve earlier discharge by ensuring early and regular senior clinical review. Inpatient admission when required will be to the correct specialty ward.

Protecting Elective Services

The national direction to separate services was further reinforced in the green elective site requirements through COVID-19 and allows us to further focus on the utilisation of the CDH site as an elective hub. The strategy for the organisation is to further increase the volume and number of elective services at CDH and appropriate support services that are required alongside this. Neurosurgery, Plastic Surgery, and potentially Gynaecology will develop their elective service by using the CDH elective site.

The strategic direction for routine day case children's surgery will be to also utilise the CDH elective hub, enabling protected and efficient pathways for the majority of children's surgery, with the smaller number of more complex surgery or children with more complex needs receiving surgery on the RPH site.

Ophthalmology services are implementing long term transformation plans with a purpose built facility at CDH that enables high volume quality pathways fit for the future. The next step is to further work across the system and integration with community pathways to ensure only those patients that would benefit from hospital care have to travel to hospital.

Services will work collaboratively with partners across the ICS and the Lancashire and South Cumbria Cancer Alliance to improve and sustain cancer performance, to implement national optimal pathways, to develop Community Diagnostic Centres (CDCs), promote early diagnosis and equitable access. The commencement of the CDC at The Preston Healthport providing CT, MRI and obstetric ultrasound scans is a welcome first step for our local population. There is a plan to increase this community provision to include cardiorespiratory and endoscopy examinations over the next 2 years.

A key element of the transformation of elective care relates to outpatients, and the alternatives to traditional outpatient (OP) appointments. These will be described in further detail within each specialty's clinical strategy and implementation plan but will focus on a number of areas;

- Enhanced advice and guidance to reduce OP referrals
- Creation of more one stop appointments including diagnostics pre-appointment
- Increasing the virtual offer
- Patient initiated follow up allowing patients with stable conditions to avoid regular hospital follow up but to be able to access their specialist team should the need arise
- Focus on understanding and reducing 'did not attend' (DNA) or 'was not brought' (DNA in children)

The telemedicine suite has opened on site at RPH and allows teams to work in a purpose built environment when completing virtual clinics, freeing up clinical facilities.

2) To offer a range of high quality specialised services to patients in Lancashire and South Cumbria

The Trust will continue to focus on ensuring the improved provision of high quality tertiary services over the course of the clinical services strategy. This includes continuing to provide our existing tertiary services, creation of new collaborations and networked services across our ICS. The PCB clinical strategy aims to describe these in greater detail.

We will continue to provide the following tertiary services;

- Radiotherapy and Specialist Cancer Surgery
- Major Trauma
- Neurosciences
- Plastics & Burns
- Renal
- Specialist Mobility and Rehabilitation Centre
- Vascular
- Neonatal Intensive Care

Plans for a clearly identified and integrated Neurosciences Centre for Lancashire and South Cumbria (similar to those already established in Manchester and Liverpool) will be progressed to help improve recruitment, service co-ordination and the profile of the Neuroscience specialties.

Significant improvements to Renal Medicine service provision are being implemented by locating provision in areas away from the LTHTR "hub" to support community provision and improved patient accessibility.

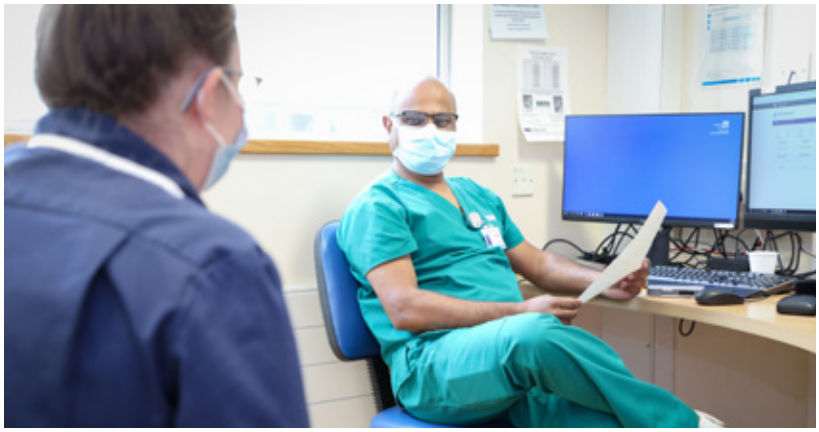
Plastic surgery capacity will be increased, and the breadth of treatments reviewed to enable equitable access for patients in the ICS.

The Specialist Mobility And Rehabilitation Centre (SMRC) will continue to support national rehabilitation priorities and the military veterans programme. The robotic programme has been sustained, and the specialties will continue to ensure that there is equitable access to these procedures by ensuring the national direction for increased robotic surgery is available locally.

In line with the ICS Clinical Strategy and the Provider Collaborative priorities, LTH is well positioned as the major specialist centre for Lancashire and South Cumbria to make a leading contribution to these priorities.

We plan to develop:

- a comprehensive stroke centre within the Trust, following designation by the ICS, alongside a related development to expand of our mechanical thrombectomy service
- the L&SC regional Pathology collaboration is continuing to develop its clinical model and mobilisation of procurement. With the anticipated approval of the full business case construction of the state of the art regional hub will commence in early 2023
- a L&SC Specialist Vascular Surgery Unit to provide a networked service across the region
- [a] L&SC Head and Neck cancer surgery and oral maxillofacial surgery (OMFS) networked service across the region
- Radiotherapy operational delivery networks (ODNs) will be established by 2022 – we are working in collaboration with the Christie and Clatterbridge Cancer centers to achieve national recommendations as part of the North West Radiotherapy ODN
- the five year road map for aligning Urology Cancer Services will be reviewed to explore and identify any developments to take forward with system partners including consideration of a single specialist surgical centre for complex urology cancers
- in maternity, the creation of a maternal medicine centre for L&SC at RPH and the development of the NW maternal medicine network will be progressed
- provision of further tertiary paediatric services for children and young people in L&SC to allow access to services more locally (e.g. Children's rheumatology, Children's pain services) will be explored and advanced in conjunction with the well-established tertiary children's services in Manchester and Liverpool.



3) To drive health innovation through world class education, teaching and research

The Education and Research Strategies support the delivery of the Clinical Strategy by ensuring we provide high quality education for our students and staff and we provide a wide range of accessible research and innovation projects. There is robust evidence that leading healthcare organisations that maximise recruitment of patients to clinical trials and other research studies deliver higher quality care.

Education

The primary objectives of our education strategy are:

- to deliver and support education and training for our current and future workforce at Lancashire Teaching Hospitals NHS Foundation Trust
- to extend our education and training offer to healthcare staff locally, regionally, nationally and internationally

The model focuses on the three key components to successful careers:

- Getting in – creating and inspiring opportunities and access to careers
- Getting on – developing staff skills and competencies through excellent education and training
- Going further – offering career-enhancing education opportunities that enable career progression

Research

Our vision is to be the highest recruiting and most innovative, patient and staff-focussed Research & Innovation (R&I) collaborative in Lancashire and South Cumbria. Our research strategy has the following strategic aims which support the delivery of our Clinical Strategy:

- To continue building the capability and capacity within the Trust to lead and deliver high quality research and innovation and offer our patients greater access, an enhanced experience and better care through access to research, clinical trials and experimental medicine.
- Forge better links to our local/partner Higher Educational Institutions (HEIs) and significantly increase clinical academic appointments at all levels in the Trust.
- Academic partnerships in women's health and child health will be developed, joint clinical/research roles created and research/research education supported to enhance services and support service development opportunities.
- To increase the presence and profile of R&I in the Trust and in doing so the opportunities for staff, patients and the public to engage with the research agenda and provide a route for them to direct and influence Trust research and innovation priorities.
- Significantly enhance research quality and infrastructure and develop a full operational governance framework for R&I that feed into the Workforce and Education Directorate (WED) and trust level governance, effectively and appropriately.
- Develop a commercial and innovation strategy for R&I that feed into the Trust's plans for commercialisation, and WED's plans to develop an Innovation Hub for Education, Training and Research.
- Complement and service the Trust's plans for Improvement, both continuous (CI) and Service (SI).

4) System working in a new NHS landscape

Local Services: Integration, Place Based Care

Building on our existing successful integration programme in frailty and the emerging integration programme for respiratory services we will work with our partners to ensure that our local services and systems are fully integrated to provide joined up, seamless care with improved local access. For some of these priorities, the work will be delivered through the new System Level Model for Improvement.

Priorities for future programmes include (further details can be found in the Big Plan):

- Therapies
- Psychology
- Cardiac services
- Diabetes
- Autistic spectrum disorder and the Special Educational Needs and Disability (SEND) agenda
- Acute and Community Children's services review

Clinical networks

Our strategy is to support and develop existing clinical networks across the ICS and consider new areas of collaboration. Clinical networks have been developed in L&SC for Ophthalmology, Urology, ENT, MSK, Gynaecology, General Surgery, Oral and Maxillofacial Surgery (OMFS) and Anaesthetics/Perioperative pathways. These groups have representation from all system partners involved in the relevant clinical pathways to drive best practice and shared learning, utilising GIRFT, model hospital data. These groups also facilitate development of consistent clinical pathways, removing unwarranted variation and consider the opportunities to provide mutual aid where required. These networks are in addition to the existing Operational Delivery Networks in a number of areas that have been established for some time together with the long standing cancer clinical reference groups for all cancer specialities supported by the Cancer Alliance.

Fragile clinical services

Responding to COVID-19 highlighted that we have some fragile clinical services linked to the current available skilled workforce to sustain services. The system working, particularly through clinical networks, has enabled some early work to take place to provide mutual aid and consider working more closely together as networked services to provide more resilience. Our strategic aim would be that we will recognise which of our clinical services are fragile, through specialty level clinical strategies, and we will work to support and consolidate the service rather than divesting.

Reducing Health Inequalities

Our commitment to reducing health inequalities is outlined in this Clinical Services Strategy and our Always Safety First (ASF) Strategy, building on the foundations of our patient safety culture and systems, with a focus on recognising our role to identify and take steps to reduce health inequalities.

We will work closely with the Central Lancashire Determinants of Health System Delivery Board and our Data Science Group to understand key areas of focus and enable agreed metrics to be monitored. We have committed to engaging with patients as partners, staff and other stakeholder groups setting specific actions for our teams, local stakeholders and individual clinicians to address inequalities in patient safety.

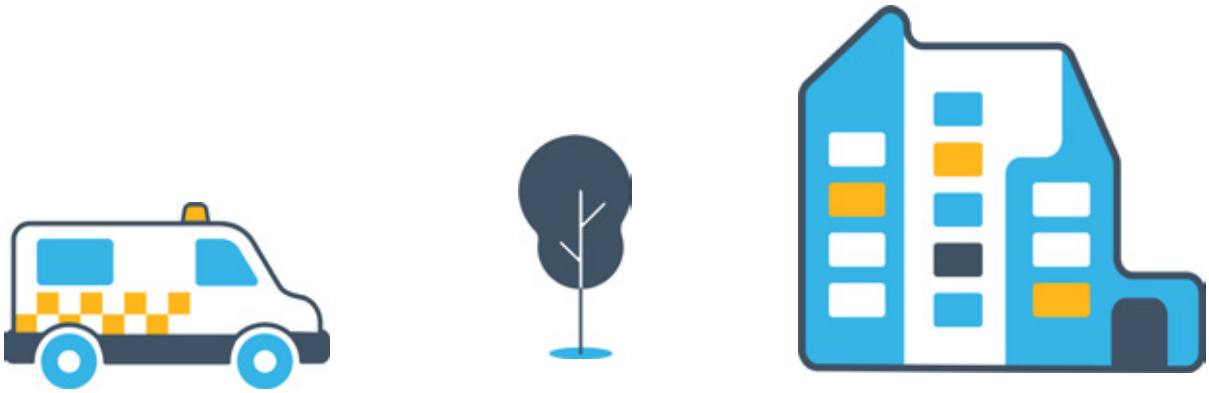
As described in our patient engagement and involvement strategy, patients, visitors and partners will be central to identifying the improvements required to ensure health inequalities are thoroughly considered and addressed as part of this work and patients feel they receive individualised care in our services.

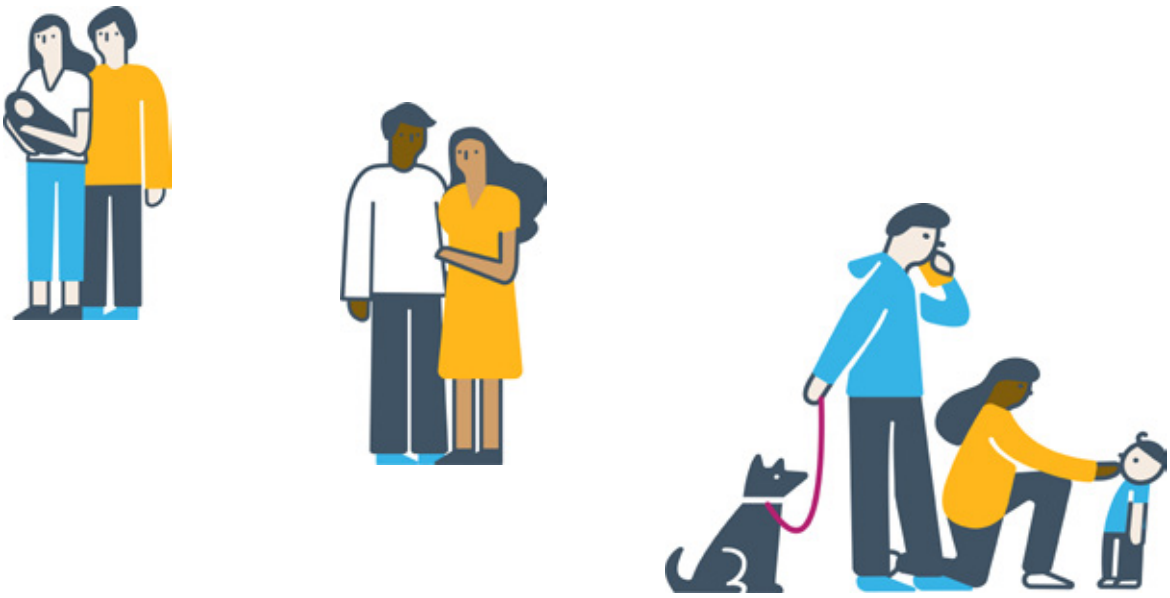
New Hospital Programme

We have a once-in-a-generation opportunity to transform our region's hospitals by 2030. By creating a network of brand new and refurbished facilities, we'll help local people live longer, healthier lives. By doing this, we'll also make Lancashire and South Cumbria a world-leading centre of excellence for hospital care.

The New Hospitals Programme is currently in development, creating the case for change and developing the Framework Model of Care. Our clinical strategy has taken account of the work underway to design the Framework Model of Care and is fully aligned. The clinical models of care will be incorporated into the delivery plans for this strategy where appropriate. This strategy outlines the work now required within Lancashire Teaching Hospitals NHS Foundation Trust to redesign our clinical services to deliver improvements for our local population and to be ready to transition to our new hospital.

Lancashire & South Cumbria
New Hospitals
Programme





Implementing our Clinical Services Strategy

We will now develop a robust implementation plan for the delivery of our strategy.

Planning

- **Benchmarking and learning from best practice**: The use of getting it right first time (GIRFT) visits and recommendations will inform the strategy and vision in many of the specialty strategies. Systematic analysis of the model hospital opportunities will allow further benchmarking and provide services with examples of organisations that are excelling in their delivery of highly efficient and good quality clinical care. Our strategy is to improve any services identified as outliers to the median and to ensure all services move towards best practice.
- **Engagement on our proposed service changes**: The speciality level clinical strategies contain various service changes that are at a formative stage. These will require further development involving our patients, staff and wider stakeholders to co-design future services.
- **Business case development**: A number of the proposals outlined in our Clinical Service Strategies will require a robust business case before proceeding to implementation and therefore in the event that the priorities cannot be funded, delivery will remain a risk.
- **Delivery plan development**: The Trust Planning Framework and the Clinical Service Strategies outline the key actions and timelines required to deliver this strategy. Detailed specialty level strategies and delivery plans will now be developed, which are aligned to and will inform the annual planning process.

Communications and engagement

- **Development of an engaging narrative for our organisation**: On approval of this Clinical Services Strategy an engaging narrative will be developed for staff, patients and our local population. This will be an integral part of our Communication Strategy.
- **Communicate and engage with external stakeholders**: Delivering this Clinical Services Strategy will require us to work closely with local partners.

Divisional Clinical Strategies

- **Development of Divisional Clinical Strategies**: Using this document as a foundation to build on our Divisions have developed Divisional and Specialty level Clinical Strategies to take forward our overall strategy and reflect service specific factors/circumstances. The Executive team have met with each Divisional team to review and discuss their strategies, ensuring congruence with the overall Trust Clinical Strategy and identifying key areas where senior support will be required to move forward. These Divisional Strategies will be reviewed on a 6 monthly basis as part of our Divisional Improvement Forums to ensure progress is being made and to help form the basis for the overall Trust Strategy to be reviewed and refreshed.

Measuring Success

In the three year lifespan of this strategy our ambition is to move our Care Quality Commission (CQC) rating to good and to support the organisation and the ICS to move from SOF 3 to SOF 2.

In the development of implementation plans, each clinical speciality/division will set the measures of success.

Successful delivery of our strategy, its successors and the system clinical strategies in the long-term will be measured against six key outcomes:

1. **Improved health and wellbeing of our local population**: measured by health outcomes such as life expectancy, mortality and morbidity and health inequalities between regions
2. **Reduction in Health Inequalities**
3. **Improved outcomes for our patients**: measured by clinical outcomes, safety and patient experience
4. **Improved patient experience**: measured by patient satisfaction and patient reported outcomes
5. **A great place to work**: measured by staff and trainee satisfaction, and our ability to recruit and retain our talented workforce
6. **A financially sustainable system**: measured by efficiency and productivity and the sustainability of Lancashire Teaching Hospitals NHS Foundation Trust and our partners in Central Lancashire and the ICS.

Please do not print!

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Corporate and Governors' Calendar 2023-24

This calendar contains the dates of all meetings for the following:

BOARD OF DIRECTORS AND COMMITTEES OF THE BOARD:

- Appointments, Remuneration and Terms of Employment (ARTE) Committee
- Audit Committee
- Board Development Sessions
- Board of Directors
- Board Workshops
- Charitable Funds Committee
- Education, Training and Research Committee
- Finance and Performance Committee
- Non-Executive Directors' meetings
- Safety and Quality Committee
- Workforce Committee

COUNCIL OF GOVERNORS, SUBGROUPS, AND MISCELLANEOUS MEETINGS:

- Care and Safety Subgroup
- Chairs, Deputy Chairs and Lead Governor
- Council Development Sessions
- Council of Governors
- Council Workshops
- Membership Subgroup
- Nominations Committee
- Joint Board and Council Development Sessions
- Annual Members' Meeting
- Lancashire Hospitals Services Board

If you have any queries, please contact Corporate Affairs by email:
company.secretary@lthtr.nhs.uk

Excellent care with compassion

2023-24 Overview *(The venues in the Calendar will be kept under constant review and a revised version published on the Trust's website on a regular basis)*

APRIL 2023		
03	10.00am – 12.00pm	Chairs, Deputy Chairs and Lead Governor
03	2.00pm – 4.00pm	Membership Subgroup
04	1.00pm – 3.30pm	Board Development Session
06	1.00pm – 6.00pm	Board of Directors
11	1.00pm – 3.00pm	Education, Training and Research Committee
20	10.30am – 1.00pm	Audit Committee
20	6.00pm – 8.00pm	Joint Board and Council Development Session
25	2.00pm – 5.00pm	Finance and Performance Committee
27	1.00pm – 4.00pm	Council of Governors
28	12.30pm – 3.00pm	Safety and Quality Committee

MAY 2023		
02	1.00pm – 3.30pm	Board Workshop
04	10.00am – 1.00pm	Council Workshop
09	1.00pm – 3.00pm	Workforce Committee
15	10.00am – 12.30pm	Care and Safety Subgroup
23	2.00pm – 5.00pm	Finance and Performance Committee
26	12.30pm – 3.00pm	Safety and Quality Committee

JUNE 2023		
01	1.00pm – 6.00pm	Board of Directors
05	2.00pm – 4.00pm	Membership Subgroup
06	1.00pm – 3.30pm	Board Development Session
08	10.30am – 12.00pm	Appointments, Remuneration and Terms of Employment (ARTE) Committee
13	1.00pm – 3.00pm	Education, Training and Research Committee
15	10.30am – 1.00pm	Audit Committee
16	1.00pm – 2.00pm	Lancashire Hospitals Services (LHS) Board
20	1.00pm – 2.30pm	Charitable Funds Committee
22	10.00am – 1.00pm	Council Development Session
27	2.00pm – 5.00pm	Finance and Performance Committee
30	12.30pm – 3.00pm	Safety and Quality Committee

JULY 2023		
03	10.00am – 12.00pm	Chairs, Deputy Chairs and Lead Governor
04	1.00pm – 3.30pm	Board Workshop
06	1.00pm – 3.30pm	Care and Safety Subgroup
11	1.00pm – 3.00pm	Workforce Committee
25	10.00am – 1.00pm	Council of Governors
25	2.00pm – 5.00pm	Finance and Performance Committee
27	11.00am – 12.30pm	Nominations Committee
28	12.30pm – 3.00pm	Safety and Quality Committee

AUGUST 2023		
01	1.00pm – 3.30pm	Board Development Session
03	1.00pm – 6.00pm	Board of Directors
07	2.00pm – 4.00pm	Membership Subgroup
08	1.00pm – 3.00pm	Education, Training and Research Committee
11	1.00pm – 4.00pm	Council Workshop
22	2.00pm – 5.00pm	Finance and Performance Committee
25	12.30pm – 3.00pm	Safety and Quality Committee

SEPTEMBER 2023		
05	1.00pm – 3.30pm	Board Workshop
08	1.00pm – 4.00pm	Council Development Session
12	1.00pm – 3.00pm	Workforce Committee
15	1.00pm – 2.00pm	Lancashire Hospitals Services (LHS) Board
18	10.00am – 12.30pm	Care and Safety Subgroup
19	1.00pm – 2.30pm	Charitable Funds Committee
21	10.30am – 1.00pm	Audit Committee
21	2.00pm – 3.30pm	Appointments, Remuneration and Terms of Employment (ARTE) Committee
26	2.00pm – 5.00pm	Finance and Performance Committee
27	6.00pm – 8.00pm	Annual Members' Meeting
29	12.30pm – 3.00pm	Safety and Quality Committee

OCTOBER 2023		
03	1.00pm – 3.30pm	Board Development Session
05	1.00pm – 6.00pm	Board of Directors
09	10.00am – 12.00pm	Chairs, Deputy Chairs and Lead Governor
09	2.00pm – 4.00pm	Membership Subgroup
10	1.00pm – 3.00pm	Education, Training and Research Committee
17	6.00pm – 8.00pm	Joint Board and Council Development Session
24	2.00pm – 5.00pm	Finance and Performance Committee
27	12.30pm – 3.00pm	Safety and Quality Committee

NOVEMBER 2023		
02	1.00pm – 4.00pm	Council of Governors
07	1.00pm – 3.30pm	Board Workshop
09	6.00pm – 8.00pm	Council Workshop
14	1.00pm – 3.00pm	Workforce Committee
16	1.00pm – 3.30pm	Care and Safety Subgroup
24	12.30pm – 3.00pm	Safety and Quality Committee
28	2.00pm – 5.00pm	Finance and Performance Committee

DECEMBER 2023		
04	2.00pm – 4.00pm	Membership Subgroup
05	1.00pm – 3.30pm	Board Development Session
07	1.00pm – 6.00pm	Board of Directors
12	1.00pm – 3.00pm	Education, Training and Research Committee
14	6.00pm – 8.00pm	Council Development Session
15	1.00pm – 2.00pm	Lancashire Hospitals Services (LHS) Board
18	10.00am – 12.00pm	Chairs, Deputy Chairs and Lead Governor
19	10.30am – 12.00pm	Charitable Funds Committee
19	2.00pm – 5.00pm	Finance and Performance Committee

JANUARY 2024		
05	12.30pm – 3.00pm	Safety and Quality Committee
09	1.00pm – 3.00pm	Workforce Committee
15	10.00am – 12.30pm	Care and Safety Subgroup
16	1.00pm – 3.30pm	Board Workshop
18	10.30am – 1.00pm	Audit Committee
23	10.00am – 1.00pm	Council of Governors
23	2.00pm – 5.00pm	Finance and Performance Committee
26	12.30pm – 3.00pm	Safety and Quality Committee

FEBRUARY 2024		
01	1.00pm – 6.00pm	Board of Directors
05	2.00pm – 4.00pm	Membership Subgroup
06	1.00pm – 3.30pm	Board Development Session
13	1.00pm – 3.00pm	Education, Training and Research Committee
15	10.00am – 1.00pm	Council Workshop
23	12.30pm – 3.00pm	Safety and Quality Committee
27	2.00pm – 5.00pm	Finance and Performance Committee

MARCH 2024		
05	1.00pm – 3.30pm	Board Workshop
07	1.00pm – 3.30pm	Care and Safety Subgroup
12	1.00pm – 3.00pm	Workforce Committee
15	10.00am – 11.00am	Lancashire Hospitals Services (LHS) Board
15	1.00pm – 4.00pm	Council Development Session
19	1.00pm – 2.30pm	Charitable Funds Committee
21	10.30am – 12.00pm	Appointments, Remuneration and Terms of Employment (ARTE) Committee
26	2.00pm – 5.00pm	Finance and Performance Committee
29	12.30pm – 3.00pm	Safety and Quality Committee

Appointments, Remuneration and Terms of Employment (ARTE) Committee

Date	Time	Venue	Final date for receipt of reports:
08/06/2023	10.30am – 12.00pm	Virtually using Microsoft Teams	01/06/2023
21/09/2023	2.00pm – 3.30pm	Virtually using Microsoft Teams	14/09/2023
21/03/2024	10.30am – 12.00pm	Virtually using Microsoft Teams	14/03/2024

Members	In attendance
Chairman Non-Executive Directors	Chief Executive Officer Chief People Officer Company Secretary Associate Company Secretary (minutes)

Audit Committee

Date	Time	Venue	Final date for receipt of reports:
20/04/2023	10.30am – 1.00pm	Virtually using Microsoft Teams	13/04/2023
** 15/06/2023	10.30am – 1.00pm	Virtually using Microsoft Teams	08/06/2023
21/09/2023	10.30am – 1.00pm	Virtually using Microsoft Teams	14/09/2023
18/01/2024	10.30am – 1.00pm	Virtually using Microsoft Teams	11/01/2024

** *To approve the Annual Report and Accounts*

Members	In attendance
Four Non-Executive Directors: - Tim Watkinson (Chair) - Ann Pennell - Jim Whitaker - Tricia Whiteside	Chief Executive Officer (as required) Chief Finance Officer/Deputy Chief Executive Officer Deputy Director of Finance Chief Nursing, Midwifery and AHP Officer Assistant Director of Financial Services Internal and External Audit representatives Associate Director of Risk and Assurance Company Secretary Corporate Affairs Officer (minutes)

Board Development Sessions

Date	Time	Venue	Final date for receipt of reports:
04/04/2023	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	28/03/2023
06/06/2023	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	30/05/2032
01/08/2023	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	25/07/2023
03/10/2023	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	26/09/2023
05/12/2023	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	28/11/2023
06/02/2024	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	30/01/2024

Members	In attendance
Chairman Non-Executive Directors Chief Officers	Director of Strategy and Planning Director of Continuous Improvement Director of Communications and Engagement Chief Information Officer Deputy Director of Workforce and Organisational Development and/or External Facilitator Company Secretary Corporate Affairs Officer (notes and actions)

Board of Directors

Date	Time	Venue	Final date for receipt of reports:
06/04/2023	1.00pm – 6.00pm	Virtually using Microsoft Teams	30/03/2023
01/06/2023	1.00pm – 6.00pm	Virtually using Microsoft Teams	25/05/2023
03/08/2023	1.00pm – 6.00pm	Virtually using Microsoft Teams	28/07/2023
05/10/2023	1.00pm – 6.00pm	Virtually using Microsoft Teams	27/09/2023
07/12/2023	1.00pm – 6.00pm	Virtually using Microsoft Teams	30/11/2023
01/02/2024	1.00pm – 6.00pm	Virtually using Microsoft Teams	25/01/2024

Members	In attendance
Chairman Non-Executive Directors Chief Officers	Director of Strategy and Planning Director of Continuous Improvement Director of Communications and Engagement Chief Information Officer Company Secretary Associate Company Secretary (minutes)

Board Workshop

Date	Time	Venue	Final date for receipt of reports:
02/05/2023	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	25/04/2023
04/07/2023	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	27/06/2023
05/09/2023	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	29/08/2023
07/11/2023	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	31/10/2023
16/01/2024	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	09/01/2024
05/03/2024	1.00pm – 3.30pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	27/02/2024

Members	In attendance
Chairman Non-Executive Directors Chief Officers	Director of Strategy and Planning Director of Continuous Improvement Chief Information Officer Director of Communications and Engagement Company Secretary Corporate Affairs Officer (notes and actions)

Charitable Funds Committee

Date	Time	Venue	Final date for receipt of reports:
20/06/2023	1.00pm – 2.30pm	Virtually using Microsoft Teams	13/06/2023
19/09/2023	1.00pm – 2.30pm	Virtually using Microsoft Teams	12/09/2023
19/12/2023	10.30am – 12.00pm	Virtually using Microsoft Teams	12/12/2023
19/03/2024	1.00pm – 2.30pm	Virtually using Microsoft Teams	12/03/2024

Members	In attendance
Three Non-Executive Directors: - Kate Smyth (Chair) - Victoria Crorken - Tricia Whiteside Chief Finance Officer/Deputy Chief Executive Officer Chief Nursing, Midwifery and AHP Officer Head of Rosemere Head of Fundraising and Charity Governance	Assistant Finance Director Company Secretary Corporate Affairs Officer (minutes)

Education, Training and Research Committee

Date	Time	Venue	Final date for receipt of reports:
11/04/2023	1.00pm – 3.00pm	Virtually using Microsoft Teams	04/04/2023
13/06/2023	1.00pm – 3.00pm	Virtually using Microsoft Teams	06/06/2023
08/08/2023	1.00pm – 3.00pm	Virtually using Microsoft Teams	01/08/2023
10/10/2023	1.00pm – 3.00pm	Virtually using Microsoft Teams	03/10/2023
12/12/2023	1.00pm – 3.00pm	Virtually using Microsoft Teams	05/12/2023
13/02/2024	1.00pm – 3.00pm	Virtually using Microsoft Teams	06/02/2024

Members	In attendance
Three Non-Executive Directors: - Professor Paul O'Neill (Chair) - Victoria Crorken - Kate Smyth Chief Nursing, Midwifery and AHP Officer Chief People Officer Director of Continuous Improvement Director of Research *(or in his absence the Head of Research and Innovation)* Director of Undergraduate Medical Education Director of Postgraduate Medical Education	Deputy Medical Director for Professional Standards Deputy Director of Education Head of Research and Innovation Head of Training and Compliance Director of Communications and Engagement Company Secretary Corporate Affairs Officer (minutes)

Finance and Performance Committee

Date	Time	Venue	Final date for receipt of reports:
25/04/2023	2.00pm – 5.00pm	Virtually using Microsoft Teams	18/04/2023
23/05/2023	2.00pm – 5.00pm	Virtually using Microsoft Teams	16/05/2023
27/06/2023	2.00pm – 5.00pm	Virtually using Microsoft Teams	20/06/2023
25/07/2023	2.00pm – 5.00pm	Virtually using Microsoft Teams	18/07/2023
22/08/2023	2.00pm – 5.00pm	Virtually using Microsoft Teams	15/08/2023
26/09/2023	2.00pm – 5.00pm	Virtually using Microsoft Teams	19/09/2023
24/10/2023	2.00pm – 5.00pm	Virtually using Microsoft Teams	17/10/2023
28/11/2023	2.00pm – 5.00pm	Virtually using Microsoft Teams	21/11/2023
19/12/2023	2.00pm – 5.00pm	Virtually using Microsoft Teams	12/12/2023
23/01/2024	2.00pm – 5.00pm	Virtually using Microsoft Teams	16/01/2024
27/02/2024	2.00pm – 5.00pm	Virtually using Microsoft Teams	20/02/2024
26/03/2024	2.00pm – 5.00pm	Virtually using Microsoft Teams	19/03/2024

Members		In attendance
Three Non-Executive Directors: - Tricia Whiteside (Chair) - Tim Watkinson - Jim Whitaker Chief Operating Officer	Chief Finance Officer/Deputy Chief Executive Officer Chief People Officer Chief Medical Officer or Chief Nursing, Midwifery and AHP Officer *(50:50 shared attendance)*	Operational Finance Director Deputy Finance Director Director of Strategy and Planning Chief Information Officer Head of Planning Company Secretary Corporate Affairs Officer (minutes)

Non-Executive Directors' meetings

Date	Time	Venue

The Non-Executive Directors are scheduled to meet informally on a monthly basis and will review the frequency as required.

Members	In attendance
Chairman Non-Executive Directors	Chief Executive Officer or Chief Finance Officer/Deputy Chief Executive Officer Company Secretary

Safety and Quality Committee

Date	Time	Venue	Final date for receipt of reports:
28/04/2023	12.30pm – 3.00pm	Virtually using Microsoft Teams	21/04/2023
26/05/2023	12.30pm – 3.00pm	Virtually using Microsoft Teams	19/05/2023
30/06/2023	12.30pm – 3.00pm	Virtually using Microsoft Teams	23/06/2023
28/07/2023	12.30pm – 3.00pm	Virtually using Microsoft Teams	21/07/2023
25/08/2023	12.30pm – 3.00pm	Virtually using Microsoft Teams	18/08/2023
29/09/2023	12.30pm – 3.00pm	Virtually using Microsoft Teams	22/09/2023
27/10/2023	12.30pm – 3.00pm	Virtually using Microsoft Teams	20/10/2023
24/11/2023	12.30pm – 3.00pm	Virtually using Microsoft Teams	17/11/2023
05/01/2024	12.30pm – 3.00pm	Virtually using Microsoft Teams	29/12/2023
26/01/2024	12.30pm – 3.00pm	Virtually using Microsoft Teams	19/01/2024
23/02/2024	12.30pm – 3.00pm	Virtually using Microsoft Teams	16/02/2024
29/03/2024	12.30pm – 3.00pm	Virtually using Microsoft Teams	22/03/2024

Members		In attendance
Three Non-Executive Directors: - Ann Pennell (Chair) - Professor Paul O'Neill - Kate Smyth	Chief Operating Officer Chief Medical Officer Chief Nursing, Midwifery and AHP Officer Director of Continuous Improvement	Director of Strategy and Planning Operational Finance Director Associate Director of Safety and Learning Associate Director of Risk and Assurance Deputy Director of Nursing, Midwifery and AHPs Company Secretary Corporate Affairs Officer (minutes)

Workforce Committee

Date	Time	Venue	Final date for receipt of reports:
09/05/2023	1.00pm – 3.00pm	Virtually using Microsoft Teams	02/05/2023
11/07/2023	1.00pm – 3.00pm	Virtually using Microsoft Teams	04/07/2023
12/09/2023	1.00pm – 3.00pm	Virtually using Microsoft Teams	05/09/2023
14/11/2023	1.00pm – 3.00pm	Virtually using Microsoft Teams	07/11/2023
09/01/2024	1.00pm – 3.00pm	Virtually using Microsoft Teams	02/01/2024
12/03/2024	1.00pm – 3.00pm	Virtually using Microsoft Teams	05/03/2024

Members	In attendance
Three Non-Executive Directors: - Jim Whitaker (Chair) - Victoria Crorken - Kate Smyth Chief Nursing, Midwifery and AHP Officer Chief Operating Officer Chief People Officer Director of Continuous Improvement	Operational Finance Director Deputy Medical Director for Professional Standards Deputy Director of Workforce and Organisational Development Associate Director of Workforce (Business Partnering and Advice) Associate Director of Workforce (Resourcing and Transformation) Company Secretary Corporate Affairs Officer (minutes)

Care and Safety Subgroup

Date	Time	Venue	Final date for receipt of reports:
15/05/2023	10:00am - 12:30pm	Virtually using Microsoft Teams	08/05/2023
06/07/2023	1:00pm - 3:30pm	Virtually using Microsoft Teams	30/06/2023
18/09/2023	10:00am - 12:30pm	Virtually using Microsoft Teams	11/09/2023
16/11/2023	1:00pm - 3:30pm	Virtually using Microsoft Teams	09/11/2023
15/01/2024	10.00am - 12.30pm	Virtually using Microsoft Teams	08/01/2024
07/03/2024	1.00pm - 3:30pm	Virtually using Microsoft Teams	29/02/2024

Members	In attendance
Governors	Non-Executive Director (Kate Smyth) Divisional Director of Facilities and Services Associate Director of Patient Quality, Experience and Engagement Patient Experience Lead Company Secretary Corporate Affairs Officer (minutes)

Chairs, Deputy Chairs and Lead Governor

Date	Time	Venue	Final date for receipt of reports:
03/04/2023	10.00am - 12.00pm	Virtually using Microsoft Teams	27/03/2023
03/07/2023	10.00am - 12.00pm	Virtually using Microsoft Teams	26/06/2023
09/10/2023	10.00am - 12.00pm	Virtually using Microsoft Teams	02/10/2023
18/12/2023	10.00am - 12.00pm	Virtually using Microsoft Teams	11/12/2023

Members	In attendance
Chairs and Deputy Chairs of Council Subgroups (or nominee) Lead Governor Chairman Chief Executive Officer	Company Secretary Corporate Affairs Officer (minutes)

Council Development Sessions

Date	Time	Venue	Final date for receipt of reports:
22/06/2023	10.00am-1.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	15/06/2023
08/09/2023	1:00pm-4:00pm	Seminar Room A1, Education Centre 3, Chorley & South Ribble Hospital	01/09/2023
14/12/2023	6:00pm-8:00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	07/12/2023
15/03/2024	1:00pm-4:00pm	Seminar Room A1, Education Centre 3, Chorley & South Ribble Hospital	08/03/2024

Members	In attendance
Chairman Governors	Executive Directors – *to be confirmed* Company Secretary Corporate Affairs Officer (notes and actions)

Council of Governors

Date	Time	Venue	Final date for receipt of reports:
27/04/2023	1.00pm – 4.00pm	Virtually using Microsoft Teams	20/04/2023
25/07/2023	10.00am – 1.00pm	Virtually using Microsoft Teams	18/07/2023
02/11/2023	1.00pm – 4.00pm	Virtually using Microsoft Teams	26/10/2023
23/01/2024	10.00am – 1.00pm	Virtually using Microsoft Teams	16/01/2024

Members	In attendance
Chairman Governors	Chief Executive Officer Non-Executive Directors *(on rotational basis)* Chief Officers *(on rotational basis)* Company Secretary Associate Company Secretary (minutes)

Council Workshops

Date	Time	Venue	Final date for receipt of reports:
04/05/2023	10.00am-1.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	27/04/2023
11/08/2023	1:00pm-4:00pm	Seminar Room A1, Education Centre 3, Chorley & South Ribble Hospital	04/08/2023
09/11/2023	6:00pm-8:00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	02/11/2023
15/02/2024	10.00am-1.00pm	Seminar Room A1, Education Centre 3, Chorley & South Ribble Hospital	08/02/2024

Members	In attendance
Chairman Governors	Chief Executive Officer Company Secretary Corporate Affairs Officer (notes and minutes)

Membership Subgroup

Date	Time	Venue	Final date for receipt of reports:
03/04/2023	2.00pm - 4.00pm	Virtually using Microsoft Teams	27/03/2023
05/06/2023	2.00pm - 4.00pm	Virtually using Microsoft Teams	29/05/2023
07/08/2023	2.00pm - 4.00pm	Virtually using Microsoft Teams	31/07/2023
09/10/2023	2.00pm - 4.00pm	Virtually using Microsoft Teams	02/10/2023
04/12/2023	2.00pm - 4.00pm	Virtually using Microsoft Teams	27/11/2023
05/02/2024	2.00pm – 4.00pm	Virtually using Microsoft Teams	30/01/2024

Members	In attendance
Governors	Non-Executive Director (Tricia Whiteside) Widening Partnership Manager Company Secretary Corporate Affairs Officer (minutes)

Nominations Committee

Date	Time	Venue	Final date for receipt of reports:
27/07/2023	11.00am – 12.30pm	Virtually using Microsoft Teams	20/07/2023

Members	In attendance
Chairman One Staff Governor *(or their nominee)* Two Public Governors *(or their nominee)* One Appointed Governor *(or their nominee)*	Chief Executive Officer Chief People Officer Company Secretary Corporate Affairs Officer (minutes)

Joint Board and Council Development Session

Date	Time	Venue	Final date for receipt of reports:
20/04/2023	6.00pm – 8.00pm	Lecture Hall, Education Centre 3, Chorley & South Ribble Hospital	13/04/2023
17/10/2023	6.00pm – 8.00pm	Lecture Room 1, Education Centre 1, Royal Preston Hospital	10/10/2023

Members	In attendance
Chairman Non-Executive Directors Chief Officers Director of Strategy and Planning Director of Continuous Improvement Chief Information Officer Director of Communications and Engagement Governors	Company Secretary Corporate Affairs Officer (notes and actions)

Annual Members' Meeting

Date	Time	Venue
27/09/2023	6.00pm – 8.00pm	Virtually using Microsoft Teams Live

Members	In attendance
Chairman Non-Executive Directors Chief Officers Director of Strategy and Planning Director of Continuous Improvement Chief Information Officer Director of Communications and Engagement *All other staff welcome to attend*	Communications Team Company Secretary Associate Company Secretary Corporate Affairs Officers

Lancashire Hospitals Services Board

Date	Time	Venue	Final date for receipt of reports:
16/06/2023	1.00pm - 2.00pm	Virtually using Microsoft Teams	09/06/2023
15/09/2023	1.00pm - 2.00pm	Virtually using Microsoft Teams	08/09/2023
15/12/2023	1.00pm - 2.00pm	Virtually using Microsoft Teams	08/12/2023
15/03/2024	10.00am - 11.00am	Virtually using Microsoft Teams	08/03/2024

Members	In attendance
Two Trust Non-Executive Directors: - Victoria Crorken - Jim Whitaker Trust Deputy Chief Executive Officer/Chief Finance Officer Trust Deputy Director of Workforce and OD Managing Director – LHS (Pharmacy) Limited	Operational Finance Director Trust's Assistant Finance Director Company Secretary Corporate Affairs Officer (minutes)

Corporate and governors' calendar 2023-24 – version 5 – October 2022

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Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors Report

Governor Opportunities and Activities – August - October 2022

Report to:	Council of Governors	**Date:**	3 November 2022
Report of:	Governors	**Prepared by:**	J Leeming
Part I	✓	**Part II**	

For approval	☐	**For noting**	☐	**For discussion**	☐	**For information**	☒

Executive Summary:

The purpose of this report is to update the Council of Governors on the opportunities, events and activities Governors have been involved in during August to October 2022.

The Governor role is to represent the interests of Foundation Trust members, the public and organisations Appointed Governors represent. The events and engagement opportunities that Governors have been involved in are recorded in the report and attached as appendix 1.

It should also be noted that several of our Governors also undertake voluntary roles across both our hospital sites.

It is recommended that the Council of Governors receive the report and note the contents for information.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To offer excellent health care and treatment to our local communities	☒	Consistently Deliver Excellent Care	☒
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive innovation through world-class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

None

1. Background

Governors have an important part to play by listening to the views of the Trust's members, the public and other stakeholders, and representing their interests in the Trust. This means, for example, gathering information about people's experiences to help inform the way the Trust designs, reviews or improves services effectively. Governors also have a role in communicating information from the Trust to members and to the public, such as information about the Trust's plans and performance. Successful engagement calls for an ongoing working relationship between a Foundation Trust and its members and the public, with patients and service users at the heart of this. Governors are supported in their work by other groups of people at the Trust including Executive and Non-Executive Directors and the Corporate Affairs Office.

2. Financial implications

There are no financial implications associated with the recommendations in this report.

3. Legal implications

There are no legal implications associated with the recommendations in this report.

4. Risks

There are no risk implications associated with the recommendations in this report.

5. Impact on stakeholders

Positive engagement with membership is a critical role for the Governors.

6. Recommendations

It is recommended that the Council of Governors receive the report and note the contents for information.

There are a number of regular activities which Governors could be involved in including:

Fabulous Feedback Friday
Held monthly and virtually throughout the Covid-19 pandemic, teams provide an overview of their service at the Trust. Governors are provided with the opportunity to explore, receive insights and have a deeper understanding of the service being presented. The events have a broad reach and include invitations to Governors, Board Members, and a range of senior leaders throughout the Trust.

STAR celebration events
Held three times per year and virtually throughout the Covid-19 pandemic, teams present the peer support activity in which they have been involved as part of the STAR accreditation framework as well as celebrating achievements.

PLACE (Patient Led Assessment of the Care Environment)
The national programme usually takes place annually at each of our hospital sites (Chorley and South Ribble and Royal Preston Hospital). It is an opportunity for Governors to engage with patients and training is provided by the Trust. The programme is being reviewed nationally and further information on the changes is awaited.

Strategic Operating Group (SOG) Debrief
Every Friday between 10am and 12noon a Strategic Operations Group meeting is held during which leaders from across the Trust review existing pressures and make important decisions about our hospitals' current and future operational challenges. Governors along with staff can attend the debrief every Friday afternoon between 2pm and 2.15pm.

The list below does not include Governors' scheduled meetings and workshops.
All activities were held using virtual platforms unless indicated otherwise.

EVENT: excluding scheduled meetings and workshops	**DATE: August – October 2022**
Staff Ambassador Inclusion Forum	2 August 2022
Patient Experience Involvement Group	17 August 2022
NHP Trust Engagement	18 August 2022
Patient Issues Car Parking Group	18 August 2022
Patient Experience Improvement Group	23 August 2022
Carers Forum	24 August 2022
Preparation for Preston Pride	25 August 2022
Car Parking Group Monthly Meeting	25 August 2022
Dementia Strategy Meeting	5 September 2022
Patient Letters Working Group	5 September 2022

Fab Friday Feedback (Portering Service)	9 September 2022
Patient Experience Involvement Group	14 September 2022
Preston Pride Final Preparations	21 September 2022
Preston Pride	24 September 2022
Membership Task and Finish Group re recruitment of members from groups who are not well represented in the membership	26 September 2022
Patient Experience Improvement group	27 September 2022
Staff Ambassador Inclusion Forum	28 September 2022
Dementia Strategy	3 October 2022
Governors Virtual Coffee Catch Up	7 October 2022
Dementia Champions meeting at RPH	12 October 2022
Annual Members Meeting	12 October 2022
Fab Friday Feedback	14 October 2022
GOLD STAR Event	17 October 2022
Membership Task and Finish Group re recruitment of members from groups who are not well represented in the membership	18 October 2022
Dementia Champions meeting at CDH	19 October 2022
Patient Experience Involvement Group	19 October 2022
Patient Issues Car Parking Group	20 October 2022
Patient Experience Improvement Group	25 October 2022
Carers Forum	26 October 2022
Car Parking Group Monthly Meeting	27 October 2022

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Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors Report

Governor Issues Report							
Report to:	Council of Governors			**Date:**	3 November 2022		
Report of:	Company Secretary			**Prepared by:**	N Gauld		
Part I	✓			**Part II**			
Purpose of Report							
For approval	☐	**For noting**	☐	**For discussion**	☐	**For information**	☒

Executive Summary:

The purpose of this report is to provide visibility of the issues and concerns raised by Governors for information.

The agreed process for Governors to raise issues and concerns is through the Senior Executive Assistant (Natalie.gauld@lthtr.nhs.uk). These are then passed to the appropriate manager for investigation and response. A response is then provided to the Governor who raised the issue.

The attached report contains a summary of the issues raised since the last report to the Council and covers the period between August 2022 to date along with details of the responses provided.

It is recommended that the Council receives the report and notes the contents for information.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Not applicable

1. **Introduction**

The purpose of this report is to provide visibility of the issues and concerns raised by Governors for information.

The agreed process for Governors to raise issues and concerns is through the Senior Executive Assistant (Natalie.gauld@lthtr.nhs.uk). These are then passed to the appropriate manager for investigation and response. A response is then provided to the Governor who raised the issue.

The report contains a summary of the issues raised since the last report to the Council and covers the period between August 2022 to date along with details of the responses provided.

2. **Activity report**

During the reporting period, six concerns/issues were raised through the governor process map.

All concerns/issues have been closed within timescales for response, with the exception of the final issue listed below. The issue has recently been raised and a response will be provided in due course.

A summary of the issues raised is provided below:

- 1 concern was raised regarding inclusion of Morecambe Bay within the Lancashire and South Cumbria Procurement Cluster. The Chief Finance Officer confirmed that Morecambe Bay and Lancashire and South Cumbria NHS Foundation Trusts chose to maintain the status quo with the departments. This information was shared, and the concern closed.
- 1 concern was raised directly with Governors regarding assurance that the Trust is meeting all safety standards. A Non-Executive Director confirmed that concerns have already been raised and assurance provided.
- 1 concern was raised regarding the CEO Communication Briefs not being received by Governors. The missing bulletins were forwarded, and IT contacted to ensure the distribution list is up to date.
- 1 concern was raised regarding the fire alarm at Chorley and South Ribble Hospital and confusion regarding the text on the fire panel which is out of date. The Director for Estates and Facilities has contacted the Fire Safety Manager to ensure the text is updated to reflect the change of purpose for buildings at Chorley such as removal of the maternity block.
- 1 concern was raised regarding the fire alarm at Broadoaks Child Development Centre which was causing upset to local residents due to sounding for a considerable length of time on a Sunday morning. It was also raised that Ward 17 are having issues regarding the patient call system and an update on when the work would be completed was queried. The Director for Estates and Facilities confirmed Ward 17 was scheduled to have work commence on the call system in September 2022. No update was provided regarding Broadoaks, although no further complaints have been received from residents.
- 1 concern was raised on 22 October regarding ambulances waiting at A&E. The Chief Operating Officer has been contacted for a response and this is currently awaited.

3. **Financial implications**

There are no financial implications associated with this report.

4. **Legal implications**

There are no legal implications associated with this report.

5. **Risks**

There are no risks associated with this report.

6. **Impact on stakeholders**

There is no impact on stakeholders associated with this report.

7. **Recommendation**

It is recommended that the Council receives the report and notes the contents of this report for information.

Care and Safety Subgroup

14 July 2022 | 1.00pm | Microsoft Teams

PRESENT	DESIGNATION	16/05	14/07	19/09	24/11	16/01	23/03
Janet Miller	Public Governor *(Chair)*	P	P				
Paul Wharton-Hardman	Public Governor *(Deputy Chair)*		P				
Keith Ackers	Public Governor	P	P				
Rebecca Allcock	Staff Governor	P	P				
Peter Askew	Public Governor	P					
Paul Brooks	Public Governor	P	P				
David Cook	Public Governor	A	P				
Kristinna Counsell	Public Governor	P	P				
Margaret France	Public Governor	P	P				
Steve Heywood	Public Governor	A	P				
Lynne Lynch	Public Governor	P	P				
Frank Robinson	Public Governor	P	P				
Ann Simpson	Public Governor	A	P				
Mike Simpson	Public Governor		A				
Piotr Spadlo	Staff Governor	P	P				
David Watson	Public Governor	P	A				
IN ATTENDANCE							
Alison Cookson	Patient Experience and Involvement	P	P				
David Hounslea	Director of Facilities and Services	P	A				
Christmas Musonza	Associate Director of Patient Quality, Experience and Engagement	A	A				
Kate Smyth	Non-Executive Director	P	P				
Joanne Wiseman	Corporate Affairs Officer (minutes)	P	P				

P – present | **A** – apologies
***Quorum**: 50% of the Subgroup's total membership at the time of the meeting*

Presenters: **Karen Hatch**, Clinical Business Manager – *(item 6)*
Ailsa Brotherton, Director of Continuous Improvement and **Kurt Bramfitt,** Senior Associate Director of Continuous Improvement - *(item 7)*
Kathryn Dickinson, Quality Assurance Matron - (*item 8)*
Janet Young, Deputy Chief Information Officer - *(item 14)*
Gemma Wright, Service Improvement Facilitator *(item 15)*

1. **Chair and quorum**

J Miller noted that due notice of the meeting had been given to each member and that a quorum was present. Accordingly, the Chair declared the meeting duly convened and constituted.

2. **Apologies for absence**

Apologies for absence were received and recorded in the attendance matrix at the front of the minutes.

3. **Declarations of interest**

There were no declarations made by Subgroup members in respect of the business to be transacted during the meeting.

4. **Minutes of the previous meeting**

The minutes of the previous meeting held on 16 May 2022 were approved as an accurate record.

5. **Matters arising and action log**

A copy of the action log had been circulated with the agenda and it was noted the majority of actions had been completed to time with the exception of action below:

Action 1: K Smyth will provide further updates around the PPCV group as she receives them.
Action 2: No update provided from R O'Brien however K Swindley had informed P Spadlo that the water dispenser requirement had been added to the list being managed by R O'Brien.

The Chair highlighted to the subgroup that at a recent workshop Governors were reminded to use the Process Map in order to raise issues.

6. **Patient Letters Update**

K Hatch informed the subgroup that A Lewthwaite has a meeting with the Continuous Improvement team tomorrow (15th July) regarding the letters and will take feedback to the letters working group. The Chair asked if the terms of reference for the working group have been formulated and circulated and K Hatch informed that she is not aware of them being completed as of yet.

K Ackers advised that he has been asked to read digital letters for some patients and they are difficult, especially for vulnerable people who cannot use a mobile phone to access the letter. K Hatch explained that the Trust issues thousands of letters each week and the feedback regarding digital letters is extremely positive and informed that a postal letter is issued if the digital letter is not opened after 24 hours of the link being received. K Hatch explained the process of registering a mobile number with the Trust and that allows patients to view their digital letter. During the last 5 years the Trust has made huge progress in improving this process. The Trust receives less than 1% of complaints regarding communications issued from the Trust. K Hatch asked for this to be recognised and celebrate that the Trust receives positive feedback regarding the letters and text reminders. The patient can access the digital portal and reschedule an appointment and this is a positive responsive approach. Like other Trusts, appointments are sometimes cancelled especially whilst the long waiting patients are being cleared and additional clinics are being held. Any changes to appointments are communicated verbally rather than issuing numerous letters. There are volunteers and Outpatients reception staff who help patients to find the right department. K Hatch asked if there are any particular cases where the letter is of a poor quality or contains incorrect details, to provide this evidence so this can be investigated and corrected. There are around 70% of Trust letters that go from the digitalised system however there are still some specialist teams that type their own but should still be following the same principles of the format.

F Robinson added that some patients produce the reminder letter without the full information so this is not to be confused with the first letter with the full information. K Hatch informed that clinics are moved on a daily basis and the Estates teams are good at

sign posting throughout the hospital to capture these daily changes. K Counsell advised that when receiving a text for a child appointment, the text states 'your child' but not their name and this can be confusing. K Hatch advised that names can be added manually when setting up the patient letter and to get in touch to do this.

Action:

- **K Ackers to email copies of digital letters without full information to K Hatch.**

7. **Safety Surveillance System**

A Brotherton thanked those for all of their assistance with the design of the safety surveillance system. K Bramfitt shared a presentation regarding implementation and sustainability of the Always Safety First Strategy which was then shared on email with the subgroup members. P Wharton-Hardman advised that the initiative will really benefit and improve the outcomes for patients and advised that risk assessments are done in a variety of ways, some being paper based and others input on QuadraMed and asked if there is a plan for this to be standardised across the Trust. K Bramfitt advised that this is an ongoing transition that is being reviewed.

K Ackers asked if a risk assessment had been undertaken for hospital acquired Covid cases. A Brotherton informed that S Cullen and C Silcock have reported numerous papers at the Safety and Quality Committee reviewing the Covid risk and at the beginning of the pandemic this identified requirements which were then implemented, one being the plastic barriers between bed spaces and improving ventilation. A Brotherton is unaware of any new action plans from risk assessments for Covid but will review outside the meeting and advise as an action.

S Heywood asked if the implemented improvements for pressure ulcers and falls are measured. K Bramfitt informed that they saw some fantastic results from the improvements working collaboratively and using the continuous improvement methodology. There have been learnings to understand the ability of the reliability of interventions being carried out. The Safety Surveillance System provides assurance and also allows wards to see their performance. With a reduction in pressures that the Trust has been experiencing, there is a hope to re-energise and launch the platform. A Brotherton added that as seen with the VTE assessments being implemented in QuadraMed and being prominent for every patient, this led to sustained improvements. Another undertaking is the work around the CQC feedback for rapid cycle improvement like the oxygen prescribing and the approach to improve the process electronically and flag when things are not happening which provides real time data. By combining the data information and the intelligence from the Safety Surveillance System this will lead to a sustained improvement.

The Chair asked what type of bedside equipment will be used to collate the bedside data. K Bramfitt informed that they are currently testing innovative digitalisation and explained the technology behind the Near Frequency Communication, similar to using the pad that a person taps using a payment card. A tag can be fitted to each bed and when a mobile or iPad is tapped this opens a secure survey which can be designed to an individual's care requirements. A Brotherton advised that Governors will also be invited to attend the STAR assurance visits once the current Covid pressures reduce so they will have the opportunity to see the work in progress.

Action:

- **A Brotherton to update the group of any new action plans from risk assessments for Covid.**

8. **STAR Update**

Matron K Dickinson introduced herself and informed that the Governor involvement in the STAR Assurance visit is very much appreciated and STAR has continued to develop during the five years since its introduction. K Dickinson explained the process of the STAR inspections and the importance of having 'fresh eyes' to review an area. The last two years have been very difficult during the Covid 19 restrictions so the introductory training sessions in place on the 18 and 22 July will continue however the physical visits will be postponed until the current wave of infections reduces. The visits are unannounced and on occasion, the visits are changed due to staffing issues but the team will always endeavour to inform anyone who is scheduled to attend a visit. K Dickinson reiterated the need to have complete confidentially with regards to the visit location so that no department has knowledge of the pre-planned audit.

P Wharton-Hardman asked if the STAR audits are only conducted in the daytime. K Dickinson advised that they are currently Monday to Friday during key hours however, on occasion they return to one of the 120 area's later in the day but the main part of the visit is between 10am to 2pm. Night time and weekend visits have been discussed as the next stage of the STAR Assurance development.

P Spadlo asked how often an area is visited. K Dickinson explained that if an area is red rated they will be re-visited every two months, amber rated area is every three months and the green rated area for silver and gold STAR are re-visited every six months. Visits were suspended for some of the Covid peak times, so the team is currently behind schedule. Inpatient wards facing more challenges and red rated areas are prioritised. The team has recently recruited and have two new facilitators joining in August and the Lead will also return to work, so they should be able to cover two areas per day. The Governor contribution to support the visits is valued by the Trust.

9. **Patient Experience Strategy 2022 Update**

C Musonza sent apologies therefore no report was provided and the subgroup will be updated at the next meeting.

10. **Estates and Facilities Update**

The report had been circulated with the agenda and the Chair informed that D Hounslea had sent apologies.

11. **Patient Experience and Involvement Update**

The report was circulated on the agenda provided by A Cookson who gave a brief overview of the content of the paper.

K Ackers asked if patients receive a discharge leaflet when they are admitted. A Cookson informed that she is not aware of one being given on admission however some wards and

Outpatients provide a leaflet following a procedure. The Trust website also contains some discharge information for some departments. A Cookson confirmed that the Trust still predicts discharge dates, to assist with bed management and availability.

P Spadlo asked who co-ordinates the day at the Preston PRIDE and A Cookson confirmed that this will be the ambassadors for the LGBTQ forum and she is currently leading on this. The Chair informed that the Governors always have a Membership presence at Preston Pride.

12. **Funding from Governors Charity Update**

The charitable funding application and criteria provided by J Miller was circulated on the agenda and all Care and Safety Subgroup members were asked to read the application prior to the meeting, to allow a vote during the meeting. P Wharton-Hardman declared a conflict of interest as he is a student nurse and refrained from contributing to the discussion.

R Allcock advised that she did not believe the application met the criteria as this is not for patients and this was echoed by the majority. M France added that it is very difficult to retain staff so with that in mind any benefits for students and retaining loyal staff contributes towards patient care. M France added that if it contributes towards staff feeling valued and she supported the application to which K Counsell agreed. The majority of the subgroup confirmed they did not support the application and the Chair informed that she would advise the applicant of other sources of funding.

Action:

- **The Chair will send a rejection a letter to the applicant**

13. **Non-Executive Director update**

K Smyth informed that she would provide a report to share with the subgroup.

14. **IM&T: Digital Strategy Update**

J Young informed that the digital strategy presentation is around 30 slides however there is a shorter presentation that was circulated to the subgroup. J Young shared the presentation to provide an overview of the strategy. J Young also informed the subgroup of the HIMS levels that demonstrate the maturity of digitalisation and advised that the Trust was a level 5 aiming to become a level 6 and in 2019 the criteria changed for the health informatics security. The new criteria led to other organisations and peers becoming a level 3 or 4, under the 5 and the Trust was asked to re-visit this with the HIMS lead. The Trust has recently been assessed and is at a level 5 and 76% towards achieving level 6.

S Heywood asked how funding is managed across the ICS and how the Trust is managing the increased risk for a single point of failure across the ICS. J Young advised that capital funding is no longer available and now sourced from digital bids. J Wood the Finance Director chairs the Capital Forum and this is where capital bids requests are submitted. The EPR across the whole of the ICS will have one database that each of the sites will have access to, which will ensure if one organisation's system shuts down, the remaining organisations will not be affected.

F Robinson had observed that the accuracy depends on the inputting of correct information and asked if there is any way to validate the accuracy. J Young informed that as the Trust moves closer to having real time data and automated information, the better the validation options will be. From an EPMA position, the move away from handwritten prescriptions there is an algorithm in the background that prompts a check for incorrect information. Therefore, if a medicine reacts with another medicine the system will alert this to the prescriber.

P Spadlo asked how clinical information is shared between various hospitals. J Young informed that this is encrypted information sent via SharePoint which will run more seamlessly using Office 365. Patient information is also collated in LPRES and GP's are now also updating with the patient information.

15. **Smoking cessation service TACT (formerly CURE) Update**

G Wright shared the presentation that was circulated with the agenda and provided the subgroup with an overview.

P Wharton-Hardman advised that a disclaimer is still being used on some wards and advised that he has witnessed staff taking patients to the front of the hospital to smoke and asked if something could be added to education to stop this practice. G Wright informed that the Education team are currently reviewing this especially for new starters but this will also be addressed with the wards. However, it is predicted that it will take around 6 months to embed the smoke free message within the Trust as there is treatment available and pushing patients to the main entrance to smoke is not acceptable.

The Chair observed that the videos and information leaflets appear to focus mainly on smoking with only a small focus around vaping. This is especially prominent as vaping within the 11–15-year-old age group has now doubled and young people do leave the wards to vape. G Wright informed that NHSE and the Department of Health are currently in a transition phase therefore the Trust is waiting for the national guidance around vaping to be able to update the smoke free policy. P Spadlo advised that he has seen many smokers stood outside of the Rosemere Centre and asked if anything more could be done to prevent this. G Wright informed that Sharoe Green entrance and the main entrance are also areas that have been identified. There is work ongoing with the Education team as this will also apply to staff and visitors, not only patients. The Chair advised that when patients and visitors are challenged for smoking outside entrances, they often inform that they are not smoking in the hospital as they consider outside being permitted. The signage needs to be clearer so that a 'no smoking in this hospital' cannot be misinterpreted. G Wright advised that feedback from staff is that they are concerned of any backlash when challenging anyone for smoking in the grounds. Different phrases have been added to the guidance and the TACT team have spoken to Quit Squad and Psychologists within the Trust for the best way to approach people without creating any aggravation.

16. **Reflections on the meeting**

There were no reflections.

17. **Request for future meeting topics**

No requests suggested this month however there are still items to cover that were suggested in the May meeting.

18. **Any other business.**

The Chair advised that she had a message from S Iaconianni to inform that the PALS office at Chorley Hospital has been vacated by the surgical team and it will be converted back to a PALS office once it has been refurbished.

D Hounslea has advised that the patient call system on ward 18 is being updated and ward 17 will be next.

19. **Date, time and venue of next meeting**

The next meeting of the Care and Safety Subgroup will be held on 19 September 2022 at 10.00am using Microsoft Teams.

Membership Subgroup

6 June 2022 | 2.00pm | Microsoft Teams

PRESENT	DESIGNATION	04/04	06/06	08/08	10/10	05/12
Piotr Spadlo	Staff Governor *(Chair)*	P	P			
Mike Simpson	Public Governor *(Deputy Chair)*	P				
Keith Ackers	Public Governor					
Rebecca Allcock	Staff Governor	P	A			
Sean Barnes	Public Governor	A				
Margaret France	Public Governor	P	P			
Hazel Hammond	Public Governor	P				
Steve Heywood	Public Governor	P	P			
Trudi Kay	Public Governor	P				
Lynne Lynch	Public Governor	A	P			
Janet Miller	Public Governor	P	P			
Frank Robinson	Public Governor	P	P			
David Watson	Public Governor	P	A			
Sheila Brennan	Public Governor		P			
IN ATTENDANCE						
Naomi Duggan	Director of Communications and Engagement	A	A			
Adam Sharples	Marketing Manager	P	P			
Karen Swindley	Strategy, Workforce and Education Director	A	P			
Tricia Whiteside	Non-Executive Director	P	P			
Jackie Higham	Head of Widening Participation & Apprenticeships		P			

P – present | **A** – apologies
***Quorum**: 50% of the Subgroup's total membership at the time of the meeting*

1. **Chair and quorum**

The Chair noted that due notice of the meeting had been given to each member but as attendance was below 50% of the membership of the group, the meeting was not quorate. The Chair welcomed new members, Jackie Higham, Head of Widening Participation & Apprenticeships and Sheila Brennan, Public Governor.

2. Apologies for absence

Apologies for absence were received and recorded in the attendance matrix at the front of the minutes.

3. Declarations of interest

There were no declarations made by Subgroup members in respect of the business to be transacted during the meeting.

4. Minutes of the previous meeting held on 4 April 2022.

J Miller noted that the date of the next meeting was incorrect, and this should be amended.

5. Matters arising and action log

The action log was updated.

6. Review of Terms of Reference

The Chair went through each point of the Terms of Reference asking for any comments, which were reflected in the document.

2.2 iv – K Swindley clarified the Corporate Affairs Team looks after the membership database, which allows communication to be sent out to members. J Miller queried that before there used to be a named contact, but K Swindley noted it is just the Corporate Affairs Team but agreed we can check telephone contact numbers for membership purposes.

K Swindley queried the 50% attendance rate for quoracy and whether we should review membership on this basis. S Heywood suggested making the quorum a third of the group. T Whiteside agreed and stated that we need to re-establish membership to gauge quoracy. J Miller noted for CASS they have 15 members but need to chase up colleagues who don't attend on 3 consecutive occasions.

Resolution:

- **The Chair will email out asking for who wants to continue as a member.**

7. Promoting the membership of the Trust

J Higham shared a presentation, which gave an overview of what was discussed at the coffee morning meeting from the Widening Participation tutors who are trying to engage younger people in Trust membership. The team engages with the community through programmes and activities to promote careers at our hospitals, which is a great way of promoting membership of the Trust. They offer work familiarisation, work experience, pre-employment programme and much more. Non-clinical placements start this month and clinical placements resume in September. Over the last 12 months, we have 12 for PWAP, 3 Kickstart candidates, 21 college ward supports, changing chapters is starting at the end of this month. T-levels will also be starting in September.

Over the next 12 months they have several exciting projects planned including the new Changing Chapters programme, reintroducing a hybrid model for work experience, working with the Careers & Engagement Team to develop the new NHS Career platform and bring in college membership ambassadors with exclusive benefits for registering peers to Trust membership. In addition to all of this they will also be releasing videos to promote membership across social media platforms such as TikTok and Snapchat ensuring they do not breach any licensing issues and.

K Swindley stated we need to ensure we maximise the opportunities particularly around young people and with BAME groups and questioned whether we can have a unique membership offer for young people if it would attract them. A Sharples noted it is great maximising our own platforms and channels, but we need to look at what can we do with the wider community, such as a link with PNE and so on.

8. Membership Strategy action plan

The Chair went through each of the actions to ensure clarity and ownership. With regards to the action around promoting the role of the Governors, K Swindley suggested filming 24 hours in the life of a Governor as publicity material. A Sharples suggested the formation of a small group to identify local youth, faith and sports clubs with which Governors would want to develop links to improve membership uptake.

It was agreed that the promotional material needs to be reviewed. J Miller suggested having an allocated iPad to sign people up to be members when attending events.

There was discussion around ensuring there is a focus on the health service discount for members. T Whiteside stated that we need to be able to use external social media platforms to branch out to people outside of the Trust.

Resolution:

- **The Chair to approach the local council Governors for suggestions of groups to engage with to encourage membership from young people and BAME groups.**
- **J Miller to enquire about the possibility of 2 additional iPads being provided for Governors to be used at events to register new members.**

9. Reflections of the meeting

Not discussed.

10. Requests for future meeting topics

No suggestions.

11. Any other business

S Heywood noted that it has been suggested previously to include membership promotional material with appointment letters, which K Swindley confirmed this is done in most departments.

The Chair raised the question of linking information about how to become a member to our Friends and Family test and there was discussion around including a separate leaflet about membership. K Swindley stated this is not the right vehicle for this and is unsure of the benefits of doing this. A Sharples agreed and the administration around this is quite cumbersome.

J Miller asked if someone could do a stock check with what promotional material we have with regards to membership.

The Chair reminded all of the next date of the Governor coffee catchup on 4 July at 2pm via MS Teams, which has been shared on social media and the hospital TV screens.

Resolution:

- **The Chair to discuss Explore the possibility of linking information about how to become a member to our Friends and Family test with Stephanie Iaconanni and will report back at the next meeting.**

- **A small group of Governors to be agreed by the Chair to review existing stock and requirements.**

12. Date, time and venue of next meeting

The next meeting of the Membership Subgroup will be held on 8 August 2022, 2pm via MS Teams.

Membership Subgroup

8 August 2022 | 2.00pm | Microsoft Teams

PRESENT	DESIGNATION	04/04	06/06	08/08	10/10	05/12
Piotr Spadlo	Staff Governor *(Chair)*	P	P	P		
Mike Simpson	Public Governor *(Deputy Chair)*	P	A	P		
Keith Ackers	Public Governor			P		
Rebecca Allcock	Staff Governor	P	A			
Sean Barnes	Public Governor	A	A	A		
Sheila Brennan	Public Governor		P	P		
David Cook	Public Governor	A	A	P		
Margaret France	Public Governor	P	P	A		
Steve Heywood	Public Governor	P	P	P		
Lynne Lynch	Public Governor	A	P			
Janet Miller	Public Governor	P	P	P		
Frank Robinson	Public Governor	P	P	P		
IN ATTENDANCE						
Naomi Duggan	Director of Communications and Engagement	A	A			
Adam Sharples	Marketing Manager	P	P	P		
Karen Swindley	Strategy, Workforce and Education Director	A	P			
Tricia Whiteside	Non-Executive Director	P	P	A		
Jackie Higham	Head of Widening Participation & Apprenticeships		P	P		
Jennifer Foote	Company Secretary			P		
Joanne Leeming	Corporate Affairs Officer *(minutes)*	P	P	A		
Joanne Wiseman	Corporate Affairs Officer *(minutes)*			P		

P – present | **A** – apologies
***Quorum**: 50% of the Subgroup's total membership at the time of the meeting*

Observer: Alison Cookson, Patient Experience and Involvement Lead

1. **Chair and quorum**

The Chair noted that due notice of the meeting had been given to each member and a quorum was present.

2. **Apologies for absence**

Apologies for absence were received and recorded in the attendance matrix at the front of the minutes.

3. **Declarations of interest**

There were no declarations made by Subgroup members in respect of the business to be transacted during the meeting.

4. **Minutes of the previous meeting held on 6 June 2022**

The minutes of the meeting held on 6 June 2022 were agreed as a correct record subject to the following amendments:

- Remove previous members from the attendance matrix and list the Head of Widening Participation and Apprenticeships as in attendance.
- Include an action on page 3 regarding exploring the possibility of two additional iPads being provided for Governors to be used at events to register new members.

Reference was made to how the resolution and actions had been recorded and the correct terminology would be discussed with the Corporate Affairs Team. Members were also reminded that should the Subgroup not be quorate then decisions could not be taken at meetings.

Actions:

- **Minutes to be amended as identified.**
- **Action to be included on page 3 regarding exploring provision of additional iPads for use at events to register new members.**

5. **Matters arising and action log**

The outstanding actions were reviewed, and the action log would be updated following the meeting.

Discussion was held regarding how young members could be engaged. It was suggested including a dedicated page in the next edition of the Trust Matters magazine containing information that would appeal to younger members of the community. Colleges would also be starting their academic year in September and the College of Students could assist with engaging younger people.

Reference was made to an upcoming meeting a Governor would be attending with the Chairman of Chorley Football Club and it was suggested this could be a route to promote the membership. The Chair confirmed this would be discussed this with the Governor outside the meeting. A request was made that the Communications Team be fully sighted on any promotional communications in which Governors would be involved.

Action:

- **S Brennan and P Spadlo to discuss the option of engaging with the Chairman of Chorley Football Club to discuss engagement with young people.**

6. **Review of Terms of Reference**

It was agreed to postpone any changes to the Terms of Reference until the review of the Constitution had been completed. An annual review of the Terms of Reference would align for both the Care and Safety Subgroup and the Membership Subgroup.

7. **Membership Strategy Action Plan**

A detailed review was undertaken of the Membership Strategy action plan including whether deadlines could be applied to each action. The action plan would be updated following the meeting.

During discussion it was noted that delivery of some of the actions would be dependent on funding and a meeting would be held with the finance department to understand the budget allocation including any funding to support membership activities.

8. **Reflections of the meeting**

There were no reflections put forward by Subgroup members.

9. **Requests for future meeting topics**

There were no suggestions for future meeting topics.

10. **Date, time, and venue of next meeting**

The next meeting of the Membership Subgroup will be held on 10 October 2022, 2pm via MS Teams.

Chairs, Deputy Chairs and Lead Governor with the Chairman and Chief Executive

4 July 2022 | 10.00am | Microsoft Teams

PRESENT	DESIGNATION	04/04/22	04/07/22	03/10/22	09/01/23
Professor E Adia (Chair)	Chairman	P	A		
Kevin McGee	Chief Executive	P	A		
Steve Heywood	Lead Governor	A			
Janet Miller	Lead Governor	P	P		
Mike Simpson	Deputy Chair, Membership Subgroup	P	P		
Piotr Spadlo	Chair of Membership Subgroup	P	P		
Paul Wharton-Hardman	Deputy Chair, Care and Safety Subgroup	P	P		
IN ATTENDANCE					
Jennifer Foote	Company Secretary		P		
Karen Swindley	Strategy, Workforce and Education Director	A	P		
Tim Watkinson	Vice Chairman		C		
Jonathan Wood	Deputy Chief Executive		P		
Jo Wiseman *(minutes)*	Corporate Affairs Officer	P	P		
P – present | **A** – apologies | **C** - Chair					

1. Apologies for absence

Apologies for absence were received and recorded in the attendance matrix at the front of the minutes.

2. Minutes of the previous meeting

The minutes of the meeting held on 4 April 2022 were agreed as a true and accurate record.

3. Matters arising and action log

The action log had been circulated with the agenda and the following comments were noted on specific actions:

Action 1. *Lead Governor update* – J Wood advised that further information will be covered in his briefing but changes are implemented at times when necessary changes are enforced due to waves of Covid and the action is completed.

Action 2. *Any other urgent business* – J Wood advised that in clinical areas with vulnerable patients masks are worn and this is now being relaxed in other areas, however some staff are still choosing to wear them. K Swindley advised that regional infection control teams are currently discussing the option to mandate mask wearing again in light of the Covid infection rate increase. Managers of areas reinforce mask wearing rules for staff and no audits are undertaken.

Action 3. *Any other urgent business* – J Wood is waiting for an update from the Head of Facilities who is currently on sick leave. Action remains open.

Action 4. *Any other urgent business* – K Swindley informed that the car parking charges were discussed at the working group and there will be no reduction in car park charges for home working staff, however official part-time staff will have reductions relating to their hours.

The completed action regarding the accuracy of candidate information recorded for nominations that J Miller had highlighted, was discussed and it was noted that non-qualified individuals were recruited to administer Covid vaccinations following some training. K Swindley advised that it would not always be possible to check if someone had volunteered outside of the Trust. K Swindley confirmed that the code of conduct and constitution references that candidates must not provide false information.

The action log would be updated and, where appropriate, actions marked completed and removed from the active action log.

4. Chairman and Chief Executive update on key issues

T Watkinson advised that he has informed E Adia that he intends to stand down as Vice Chairman however he will continue in his role as Non-Executive Director. T Watkinson confirmed the E Adia finishes as Chairman at the end August 2022 and T Watkinson will remain as Vice Chair until a new Vice-Chair is appointed. The Constitution states that the Vice Chair acts up as Chairman until the post is recruited.

J Wood updated with the following information:

- The Covid infection rate is increasing with the two new Omicron variants and this is impacting admissions. These variants appear to be less severe but still having severe consequences for some patient groups. The current levels are being closely monitored as hospital pressures rise. Staff will still isolate if they catch Covid and this adds to the pressures. The Nightingale Unit was decommissioned at the end of last week and will be removed from Royal Preston over the next few weeks. It is hoped that the new Cuerden ward at Chorley Hospital will be open next week. Work is ongoing with the Trust partners for alternative care facilities outside of hospital.
- From the 1 July 2022 the Integrated Care Board is now a live organisation following the disbandment of the CCG. The Integrated Care Board is focusing on five key platforms of change for this current year and the first is regarding the urgent care and flow within our communities. The Urgent Care Optimisation is chaired by K McGee and they will have focus on alternative care outside of hospital, with the creation of virtual wards and care across the community. Restoration is another area of focus on waiting lists and progress is ongoing however this can be impacted due to staff sickness rates. Corporate Services for the 5 NHS Trusts are under consideration as there are some duplications. The clinical pathways and clinical networks are being reviewed to also avoid the duplication and waste that sit within the services. The Integrated Care Board will also focus on the collaboration at scale which looks at opportunities for packages of care typically outside of the public supply. The senior leadership of the Integrated Care Board is almost fully recruited and the next levels of management will follow.
- The Provider Collaborative Board briefing took place last week and over 600 people joined the on line update from senior stakeholders. Discussions took place around

working together collaboratively in the future and the importance of these changes to become more successful and improve services.

5. Draft Council of Governors agendas (part I and part II) – 28 July 2022

The draft Council of Governors agenda's for part I and part II had been circulated with the agenda. K Swindley explained all the agenda items and all agreed subject to the change below:

K Swindley advised that the November Council of Governors meeting will have fewer statutory items and it was agreed that the 28 July 2022 extensive agenda, would be revised to defer the Non-Executive Director update from the Safety and Quality Committee to the next Council of Governors meeting.

T Watkinson is on annual leave therefore unable to attend the Council of Governors meeting and informed that the accounts had been presented and approved by the Audit Committee.

K Swindley confirmed that the Non-Executive Director 360 appraisals will not be completed by the end of July and will go to part II Council of Governors in November.

Action:

- **K Brewin to defer the Non-Executive Director update from the Safety and Quality Committee to the next Council of Governors meeting on 03 November 2022.**

6. Subgroups and Lead Governor updates

(a) ***Care and Safety Subgroup*** *(Janet Miller)*

Janet Miller advised since the last meeting on 04 April 2022, there has been one Care and Safety Subgroup meetings held on the 16 May 2022.

- Faith Button presented information regarding the waiting lists and the targets in place to be achieved by June 2022.
- David Hounslea updated the subgroup on the progress of the modular build going to be known as Cuerden Ward, car parking and the new wheelchairs on order.
- Steph Iaconianni Head of PALS attended to provide the subgroup with an overview of trends and themes of complaints and concerns that the Trust receive.
- Alison Cookson provided the subgroup with an update on the Patient Experience Involvement Group regarding the deaf awareness and carers forum and the communication challenges faced between staff and patients who have learning disabilities, visually impaired or blind and patients who are deaf. Ideally Alison would like the training to be included in mandatory training which is not possible so has created a helpful guide in the form of a booklet. The Patient Experience updated strategy is not yet complete and J Miller is disappointed as the last one expired in 2021.
- The first national healthcare estates and facilities day was held on the 15 June 2022 and J Miller had invited colleagues to participate.
- Rachel O'Brien attended and provided the subgroup with an update on the refurbishments being undertaken within the Trust. It was noted that there are a lack of

water dispensers in the MRI and X-Ray departments and the out of hours lack of facilities in the Rosemere area.

- J Miller requested the Governor involvement in STAR Assurance visits recommence and Matron Kathryn Dickinson is providing training on 18 and 22 July 2022.
- J Miller and F Robinson are now representing patients at the newly formed car parking group and it has come to light that student nurses pay for parking yet volunteers park for free.
- The working group who are reviewing the standard of hospital letters appear to be making slow progress. It was agreed to meet monthly however the second meeting has not been held yet.
- The Terms of Reference were reviewed and agreed and Non-Executive Director involvement has been reduced from two to one, being Kate Smyth.
- J Miller was re-elected as Chair of the subgroup and Paul Wharton-Hardman is now the Deputy Chair.

M Simpson suggested that issues highlighted in the subgroups could be taken forward to the Council of Governor meeting. K Swindley advised that this meeting could hopefully resolve issues before they go to the Council of Governor meeting so the report would then be able to provide assurance that the issue has been resolved. The last two years have been challenging and there have been delays to items like updating the Patient Experience Strategy due to operational pressures. C Silcock is attending the next Council of Governor meeting on 28 July 2022 to present the updated strategy. The car parking issues raised by J Miller are also being reviewed by the car parking group. STAR Assurance audits are also back on the agenda however this may change depending on the Infection Control and Prevention guidance. The pace in which the patient letter working group is progressing is of a concern and will be included in the escalation from the Care and Safety Subgroup report. K Swindley agreed to discuss the level of progress for the standard of letters with F Button and S Cullen. J Miller added that the communications issues also includes the text messages that are circulated to patients. J Miller informed that the lack of water dispensers also need to be escalated and K Swindley requested that P Spadlo send over the details and she will check that the areas are on the list that R O'Brien holds.

(b) ***Membership Subgroup*** *(Piotr Spadlo)*

P Spadlo informed that the last Membership Subgroup meeting was held on the 6 June 2022 and provided an overview of the issues discussed, with highlights including:

- P Spadlo commenced as Chair of the Membership subgroup following P Akhtar stepping down from the role. M Simpson is supporting as Vice Chair.
- P Spadlo is reviewing the best options for promoting the membership subgroup and invited Jackie Higham who is Head of Widening Participation and Apprenticeships to join. The Widening Participation team are helping to create media promotions and hospital screens.
- The delivery of the membership strategy was discussed and covered the objectives and action plan. The subgroup reviewed the terms of reference and the possibility of linking with the test for the Friends and Family.
- A small group was formed to review the promotion of the subgroup in the wider community with a view to increasing the membership for the younger members and the BAME community.

- On 15 June, P Spadlo, J Miller, M Simpson and P Wharton-Hardman had the opportunity to promote the New Hospital Programme and the Membership at the recruitment roadshow.
- The coffee catch up meetings are proceeding with one being held later today and the next Membership Subgroup is on 8 August 2022.

J Miller asked if there has been any updates regarding the Governor noticeboards that were discussed at the last Membership subgroup meeting and P Spadlo informed that he is still awaiting the information. P Spadlo advised that he is also waiting to hear back from the Communications team regarding adding information to the membership section on the website. K Swindley advised that the Communications team have been short staffed but will ask Naomi if she can progress the request submitted by P Spadlo.

Action:

- **P Spadlo to email K Swindley with the departments without water dispensers so she can request they are added to the list held by R O'Brien.**
- **K Swindley to discuss the level of progress for the standard of letters with F Button and S Cullen.**
- **K Swindley to ask N Duggan if she can progress the request submitted by P Spadlo, to add information to the membership section of the website.**

(c) ***Lead Governor update*** *(Janet Miller)*

J Miller informed that the NHS Providers National Governor Focus Conference is being held on line over the next three days. J Miller attended the Provider Collaboration Board briefing on the 29 June 2022 which was well attended but it was disappointing that questions were unanswered due to time constraints however it was agreed that the questions would be collated and answers circulated. J Miller and P Wharton-Hardman attend the Leyland Festival on 2 June 2022 to promote the New Hospitals Programme and recruit new members. J Miller noted that it appears odd that the Trust no longer supports apprenticeship schemes for plumbers or electricians following the attendance at the recruitment roadshow.

T Watkinson thanked J Miller and P Spadlo for their updates and advised that the Non-Executive Directors and members who are not able to attend their meetings would appreciate these updates and it was agreed that a Chair's report could be provided from both the Membership Subgroup and Care and Safety Subgroup.

Action:

- **J Foote to arrange for the Corporate Affairs Officers to implement a Chairs Report for both the Membership Subgroup and Care and Safety Subgroup.**

7. Any other urgent business

(a) Mental Health Patients in ED at RPH

J Miller advised that she recently spent time with the Security Team and attended an incident to locate a missing patient with a history of mental health. Staff appear to spend a lot of time caring for mental health patients and the CCG had previously commissioned a mental health service for the Richmond Fellowship based in Preston

and have a drop in centre called the Haven. J Miller thought that the Trust would utilise this service and also discovered that the bungalow opposite Royal Preston has been purchased by Lancashire County Council for the purpose of looking after young mental health patients. J Miller witnessed a young patient who had fled from the bungalow and the Trust's security team were called to assist as the patient was on a busy main road. J Miller notes that there is a lack of working together across the services as the security team were not aware of the services provided in the bungalow but Lancashire County Council.

J Wood advised that the incidents of mental health are increasing in the community and mental health organisations are being allocated additional resource to manage this. These issues span across various agencies which unfortunately are not fully working together yet. In the absence of the CCG, further discussions between the agencies will be required, to communicate and work together more effectively. J Wood is aware of the improvements at Lancashire Care Foundation Trust who are investing more in the urgent care interventions for mental health episodes. J Wood thanked J Miller from bringing this to the meeting as this type of case study can be used as part of the discussions at place-based meetings. J Wood will write to Jane Mellor to ask about the Haven facility and if this is still operational, how the referral pathway can be improved. T Watkinson added that these incidents help to check if the correct protocols are in place and if staff in the security team and the Emergency Department know who to contact. K Swindley added that the Trust is reliant on the management teams to manage the operational protocols.

Action:

- **J Wood to write to Jane Mellor to ask about the Haven facility which is part of the Richmond Fellowship and if this is still operational and if so how the referral pathway can be improved.**
- **J Wood to establish who is taking responsibility for the mental health patients within the place-based partnership.**

(b) GoTo Doc

J Miller informed that some of the volunteers have been spoken to in a harsh manner by members of the GoToDoc team when there have been a lack of wheelchairs at Chorley Hospital. A patient also informed J Miller that they had been spoken to in a rude manner by a member of the GoToDoc. K Swindley advised that these issues need to be reported at the time so that they can be addressed. The volunteers can report this through the Volunteer Manager or directly through GoToDoc and everyone has the right to raise any concerns.

(c) 360-Degree Training

J Miller informed that in 2018 under the previous Company Secretary no longer in post, it was identified that the 360 degree feedback did not work as well as it should have and it was agreed that all Governors should have training prior to the elections so that established and trained Governors only would participate. Governors were offered training which was held earlier this year but not all Governors attended but all Governors were invited to participate in the 360 degree feedback process. K Swindley was not aware of this being a formal agreement by the Council of Governors and is not sure why this would have been agreed as Governors have a duty to hold Non-Executives to account and therefore everyone has a right to comment on performance. The timing of obtaining the 360 degree feedback is before the Non-Executive Director

appraisals. She did not consider it was appropriate to make the 360 degree feedback training mandatory as it is not complicated to complete and training would not stop individuals making inappropriate comments. She cited the example where patients are asked to provide feedback on Doctors via this route without training. A guide or an eLearning module to support the Governor understanding to provide 360 degree feedback is most likely to be the way forward. It was agreed that the Council of Governors will need to review and approve the 360 degree feedback process again at the next meeting 28 July 2022. J Foote informed that she has experience of 360 degree appraisals for both an internal and external set of appraisals and agreed to review the process during the next 12 months and will seek council approval for this on 28 July 2022.

Action:

- **J Foote agreed to review the 360 degree feedback process from Governors during the next 12 months.**
- **K Brewin to include the 360 Appraisal Process for approval on the Council of Governor Agenda for 28 July 2022.**

8. Date, time and venue of next meeting

The next meeting will be held on Monday, 3 October 2022 at 10.00am using Microsoft Teams.