Public Board of Directors

Wed 24 April 2024, 15:45 - 17:30

Guy's and St Thomas' NHS Foundation Trust

Agenda

15:45 - 15:48
3 min

1. Welcome and apologies

Charles Alexander (Verbal)

15:48 - 15:50
2 min

2. Declarations of interest

15:50 - 15:55
5 min

3. Minutes of the previous meeting held on 31st January 2024

3. 20240131 Public BoD Meeting Minutes vFinal.pdf (4 pages)

15:55 - 16:05
10 min

4. Chairman's report

Charles Alexander (Verbal)

16:05 - 16:45
40 min

5. Chief Executive's report

Ian Abbs

5. 20240424 CEO Report_public BoD vFinal.pdf (11 pages)

16:45 - 17:05
20 min

6. Apollo Programme Update

Jon Findlay

6. Apollo - BoD Apollo and Mychart update 24th April FINAL.pdf (8 pages)

17:05 - 17:15
10 min

7. Trust Constitution update

Edward Bradshaw

7. Trust Constitution update.pdf (4 pages)
7.1 Appendix 1 - GSTT Constitution v3 draft_tracked.pdf (90 pages)

17:15 - 17:30
15 min

8. Updates from chairs of Board committees

Board Committee Chairs (Verbal)

17:30 - 17:30
0 min

9. Reports from Board committees:

9.1. Audit and Risk Committee

a. Minutes 28 February 2024

9.1 20240228 Audit Risk Commttee minutes vFinal.pdf (5 pages)

9.2. Finance, Commercial and Investment Committee

a. Minutes 24 January 2024
b. Financial Report at Month 11

9.2 20240124 Finance Commercial Investment Board Committee Minutes v.Final.pdf (5 pages)
9.2[b} Finance report M11 Final - V2.pdf (17 pages)

9.3. People, Culture and Education Committee

a. Minutes 6 March 2024

9.3 20240306 People Culture and Education Board Committee - Minutes_final draft v1.0.pdf (5 pages)

9.4. Quality and Performance Committee

a. Minutes 17th January 2024
b. Integrated Performance Report for March 2024

9.4 20240117 Quality and Performance Board Committee Minutes - DRAFT v1.2.pdf (5 pages)
9.4 [c] GSTT IPR Public Board March 2024 Final.pdf (18 pages)

9.5. Transformation and Major Programmes Committee

a. Minutes 7 February 2024

9.5 20240207 Transformation Major Programmes Board Committee Minutes v0.5wip.pdf (5 pages)

17:30 - 17:30
0 min

10. Register of documents signed under seal

Ian Abbs

10. Documents Signed under Trust Seal, 18 January 2024 to 17 April 2024.pdf (3 pages)

17:30 - 17:30
0 min

11. Any other business

(Verbal)

Guy's and St Thomas' NHS Foundation Trust

BOARD OF DIRECTORS

Wednesday 31 January 2024, 3:45pm – 5.30pm
Robens Suite, Guy's Hospital and MS Teams

Members Present:	Charles Alexander (Chair)	Sally Morgan
	Miranda Brawn	Ian Playford
	Gemma Craig (for Avey Bhatia)	Pauline Philip
	Steven Davies	Reza Razavi
	Jon Findlay	Julie Screaton
	Simon Friend	Simon Steddon
	Felicity Harvey	Lawrence Tallon
	Deirdre Kelly	
In attendance:	Sarah Austin	Richard Grocott-Mason
	Gubby Ayida	Anita Knowles
	Edward Bradshaw (minutes)	Denis Lafitte
	Stephanie Calvert	Phil Mitchell
	Sarah Clarke	Tendai Wileman
	Jay Dungeni	
	Members of the Council of Governors, members of the public and members of staff.	

1. Welcome and apologies

1.1. The Chair welcomed the Board of Directors and all staff, governors and members of the public in the room and online.

1.2. Apologies had been received from Ian Abbs, Avey Bhatia, Nilkunj Dodhia, and Javed Khan.

2. Declarations of interests

2.1. There were no declarations of interest.

3. Minutes of the meeting held on 18 October 2023

3.1. The minutes of the previous meeting were agreed as an accurate record.

4. Chair's Update

4.1. The Chair had accepted the resignation of Dr Javed Khan as non-executive director of the Trust with effect from 1 April 2024. On behalf of the Board, the Chair thanked Dr Khan for his service to the Trust, including the time he spent as non-executive director of Royal Brompton and Harefield NHS Foundation Trust prior to the merger with Guy's and St Thomas'.

4.2. The Chair informed the Board that, following discussions with NHS England and the South East London Integrated Care Board (ICB), he had resigned from his position as Chair of King's College Hospital NHS Foundation Trust and would continue as Chair of Guy's and St. Thomas' NHS Foundation Trust (the Trust). All parties had agreed that both King's College Hospital and the Trust currently needed their own chair to ensure there was dedicated leadership and sufficient capacity to focus on addressing the significant challenges both trusts were facing.

5. Chief Executive's Update

5.1. The Deputy Chief Executive presented the Board with a comprehensive overview of the Trust's latest quality, safety, access and financial performance, and how the Trust was working to maintain operational performance and deliver a balanced financial position whilst addressing the increasing demand for many of its services, including diagnostic, cancer and urgent and emergency care. Board members accepted the urgency of the actions that were required to strengthen the Trust's overall performance for the benefit of its patients.

5.2. Following the implementation of Epic, the new electronic patient record system, in October 2023, operational focus had now shifted to stabilising the use of the new system and achieving pre-Epic activity levels across the Trust. The Trust remained committed to delivering its 2023/24 operational plan, including its objective to significantly reduce the number of patients waiting longest for treatment. The Board noted that ongoing industrial action was presenting challenges for the Trust in realising its plan, with significant disruption to planned activity levels during each period of such action. Board members acknowledged the resilience of staff in dealing with the challenges that recurrent industrial action had caused, and formally recorded their thanks and appreciation for staff efforts in this regard.

5.3. The Board welcomed news that staff and patient response to the implementation of Epic remained overwhelmingly positive. A fuller update on Epic, including the patient experience of MyChart, would be brought back to the next meeting.

ACTION: JF

5.4. The Trust's cancer services had recently been allocated into tier one of the national tiering process led by NHS England. This would provide additional support to enable the Trust to work with partners to sustainably deliver improved waiting time performance across all cancer services. The Trust was also being supported by the South East London Cancer Alliance to help analyse key bottlenecks in the cancer pathways. The Board noted that focus for the next three months would be on the achievement of the faster diagnosis standard, and a reduction in the number of patients waiting over 62 days for treatment. This led to discussion about the key actions being taken to achieve these priorities and meet the targets agreed with NHS England for end of March 2024.

5.5. Board members were pleased to note that the new Patient Safety Incident Response Framework (PSIRF) had been launched in December 2023, accompanied by a new incident reporting system, RADAR. There was discussion about the status of implementation and the benefits the new framework would bring. An update was provided regarding the staff 'flu and COVID-19 vaccination programme, and the Board noted that recent outbreaks of *Staphylococcus aureus* ('MRSA') and *Candida auris* had been well-managed through a range of interventions. The Board noted that a benchmarking exercise with Shelford hospitals had showed the Trust had the lowest rate of healthcare-associated *C. difficile* infection, and commended those involved with the development of a new rapid blood test that could diagnose and monitor patients at risk of sepsis, which was being trialled for the first time in the UK at the Trust.

5.6. The Trust's financial position to the end of December 2023 was a deficit of £15.5m. Although this was a £4.1m improvement from the previous month, the overall underlying position had not materially changed as the majority of these improvements were non-recurrent. The position also remained behind the year-to-date plan due to additional costs from inflation and shortfalls against efficiency targets. Board members sought assurance about how the Trust was delivering its efficiency programme and how it was continuing to identify schemes to meet the overall target for the year. There was discussion about the projected full-year outturn

against the Trust's plan, and recognition that the 2024/25 financial year was likely to be even more challenging. The Trust's cash balance was being carefully managed, and the Committee noted an analysis of the main drivers of the cash reduction from the previous month. Capital expenditure to date was slightly higher than the phased plan and there was discussion about how the Trust would ensure full-year capital spend remained within its Capital Departmental Expenditure Limit (CDEL) allocation. The Board reaffirmed its commitment to prioritising the capital expenditure allocation for maintenance and refurbishment of estates, digital infrastructure and medical equipment.

5.7. There had been two IT outages in recent weeks. The first, in December 2023, affected the Guy's, St Thomas' and community sites and was caused by the expiry of security certificates. The second, in January 2024, had resulted from a failure of switches within the Atos data centre which had led to two hours of downtime for approximately 20% of Epic users across all sites, and had also affected King's College Hospital. The Board sought assurance that business continuity arrangements had been invoked as necessary and that actions were being taken to ensure such outages could not reoccur.

5.8. The Board noted further updates including:

- The Trust's first anti-racism statement had been published earlier that month which set out the organisation's commitment to actively tackling racism in all its forms, acknowledge and challenge personal biases, and adapt ways of working to actively promote inclusivity and diversity;
- The Trust had been chosen by the Department of Health and Social Care (DHSC) to host a new Regional Research Delivery Network (RRDN) for south London, as part of a national network that would enable research activity to follow patient and service user need, ensuring research was conducted in communities living with the greatest disease burden, in collaboration with patients, carers and the public;
- The state-of-the-art Children's Day Surgery Unit at Evelina London Children's Hospital had been officially opened by Her Royal Highness, The Princess of Wales in December 2023. The new space-themed facility has two operating theatres and would help Evelina London to treat an additional 2,300 children per year; and
- In the *Newsweek* best hospital analysis 2024, St Thomas' Hospital was ranked first and Guy's Hospital ranked fourth out of all UK hospitals, with Royal Brompton Hospital ranked ninth globally for cardiology services.

6. Freedom To Speak Up bi-annual report

6.1. The Chief People Officer provided an overview of the Freedom To Speak Up service in the 12 months to September 2023. The service had recently been restructured following additional investment, with two Deputy Freedom To Speak Up Guardians now in post. The number of Speaking Up Champions, previously known as 'advocates', had remained stable at around 300 staff volunteers and continued to closely reflect the diversity demographics of the organisation.

6.2. The Board reviewed a range of data which showed the breakdown of the 262 cases that had been dealt with during this period was marginally higher than the preceding 12-month period, and remained significantly more than many of the Trust's peers. The Board welcomed this as evidence that staff had good awareness of the service, though noting that the NHS staff survey 2022 showed that staff both nationally and at the Trust felt less safe to speak up, and were less confident that their concerns would be acted upon than in previous years. There was some discussion about the possible reasons for this, and Board members noted that the case

data could be split into categories such as ethnicity, banding and staff group in order to help target communications.

6.3. The newly-formed People, Culture and Education Committee, established in September 2023, was closely monitoring the actions being taken to promote a culture of openness across the Trust, ensure the service was visible, and encourage staff to speak up when necessary.

6.4. There were queries about whether staff fully understood when the speak up service should be used, and how the service dovetailed with other management processes to ensure staff concerns could be resolved. An overview was provided about how learnings from the cases recorded by the service were shared in the Trust to help prevent re-occurrence of similar situations. Board members agreed this remained a critical service and reaffirmed their commitment to its purpose, value and objectives.

7. Updates from Board Committee Chairs

7.1. The non-executive chairs of the committees of the Trust Board summarised the key areas of discussion, the key risks noted and the key decisions made in the committee meetings held since the last public Board meeting on 18 October 2023. These updates supported the minutes of the meetings, which were included in the Board paper pack.

8. Reports from Board committees for noting

8.1. The Board noted the minutes from the committee meetings held since the last public Board meeting.

8.2. One amendment was requested to the minutes in the pack relating to the meeting of the Transformation and Major Programmes Board Committee on 22 November 2023, in which it had been stated that the Trust had found reinforced autoclaved aerated concrete (RAAC) in the boiler house at Guy's Hospital. Subsequent testing had confirmed that this was not, in fact, RAAC.

9. Register of documents signed under seal

9.1. The Board noted the record of documents signed under the Trust Seal.

10. Any other business

10.1. The Deputy Chief Executive recorded his thanks to Sarah Austin, the Chief Executive of the Integrated and Specialist Medicine Clinical Group, who was attending her last public Board meeting before she retired from the NHS after 46 years' service.

The next public meeting of the Board of Directors would be held on 24 April 2024

Guy's and St Thomas' NHS Foundation Trust

GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
BOARD OF DIRECTORS
WEDNESDAY 24 APRIL 2024

Title:	**Chief Executive's Report to the Board of Directors**
Responsible executive:	**Professor Ian Abbs, Chief Executive Officer**
Paper author:	**Edward Bradshaw, Director of Corporate Governance and Trust Secretary**
Purpose of paper:	Chief Executive's Board of Directors Report
Main strategic priority:	All Trust Strategic Priorities
Relevant BAF risk:	• All BAF risks
Key issues summary:	• This report sets out the key developments since the last public Board meeting on 31 January 2024 that the Chief Executive wishes to bring to the attention of the Board of Directors. • The report also summarises the latest quality, safety, access and financial performance of Guy's and St Thomas' NHS Foundation Trust and how the Trust is working hard to maintain operational performance and deliver a strong financial position, whilst addressing increasing demand for many of our services. • The report includes updates on major and strategic programmes of work, where significant achievements have been made since the January 2024 public Board meeting.
Paper previously presented at:	• The content of this report has largely been discussed in other forums, including Board committees, but has been amalgamated for the first time in this report.
Recommendation(s):	The BOARD is asked to: 1. **Note** the report.

Guy's and St Thomas' NHS Foundation Trust

GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
BOARD OF DIRECTORS
WEDNESDAY 24 APRIL 2024

1. Children's cancer services

1.1. I am pleased to inform the Board that, in a meeting held in public on 14 March 2024, NHS England selected Evelina London Children's Hospital by to be the future Principal Treatment Centre for very specialist cancer treatment services for children living in south London and much of south east England. This means that, in future, these crucial services will be located in a dedicated children's hospital with the vast majority of paediatric services under one roof, which will also bring our region into line with children's cancer care delivery in the rest of England. Bringing together staff from the current Principal Treatment Centre, including the world-renowned team from The Royal Marsden NHS Foundation Trust, with the many specialist teams at Evelina London who already care for children with complex medical conditions, will provide joined-up care for children with cancer, in family-friendly facilities. I would like to pay tribute to the hard work and commitment of colleagues who have worked on these plans, and to everyone who took part in the public consultation at the end of last year.

1.2. We will now begin a significant programme of work to prepare our clinical and capital plans to deliver the future vision that patients, families and staff deserve. In this, we remain fully committed to working with patients, their families, staff from the current service, and other partners to design the new service with children, young people and staff at its heart, to ensure continuity of care during the transition period and to agree a plan for the transfer of the service.

2. Senior appointments

2.1. Since the last public Board meeting the Trust has made two new senior appointments. Louise Dark, currently the Managing Director of King George's Hospital, part of Barking, Havering and Redbridge University Hospitals NHS Trust, will join us in June as the new Chief Executive of the Integrated and Specialist Medicine Clinical Group. Louise will replace Sarah Austin, who left us last month, and I would like to thank Sarah for her contribution to the Trust over the past four years, and to her 46 years of NHS service. Sarah leaves with our very best wishes and has played a huge part in establishing the Clinical Group and helping lead us through the COVID-19 pandemic.

2.2. Crystal Akass, currently Chief People Officer at the Royal Free London NHS Foundation Trust, has been appointed to replace our Chief People Officer Julie Screaton, who leaves us in August 2024. Julie joined the Trust in 2017 and I am particularly grateful to Julie for her work in supporting the integration of the workforce between Guy's and St Thomas' and Royal Brompton and Harefield following the merger in February 2021. We look forward to welcoming Crystal, whose skills and experience, both in the NHS and wider public services, will be vital as we continue to develop and support our diverse and talented staff.

2.3. Finally, whilst not a direct Trust appointment, the Board should note that Laurie Lee has been formally appointed as the substantive Chief Executive of the Guy's and St Thomas' Foundation. Laurie has held the position on an interim basis since April 2023, and I look forward to continuing to work with Laurie and further developing the relationship between the Trust and the Foundation.

3. Delivering healthcare across the Trust: activity, performance and quality

3.1. Activity levels and operational performance: A key objective for the Trust is to continue to recover core service activity and improve access to our services for patients, whilst maintaining and improving the world-class quality of care we provide. A comprehensive activity and performance overview report is included in the Board's paper pack for this meeting which sets out how we are performing against the plans we have agreed with NHS England and against national standards more broadly.

3.2. The Trust is continuing to experience significant disruption to planned activity levels continuing during each period of industrial action, and the implementation of Epic in October 2023 necessitating a planned reduction in activity to enable the system to be launched safely. However, I am pleased to report that we have now returned to pre-Epic elective activity levels, which was a major goal for us to achieve by the end of 2023/24.

3.3. As indicated in the activity and performance report, the Trust met the majority of its 2023/24 operational plans which had been agreed with NHS England at the start of the year. In particular, the Board should note the good progress that has been made with cancer performance, though with further work still to do. Routinely meeting national standards for cancer treatment is one of the Trust's key operational priority areas and further detail about this is set out in the clinical groups' update section later on in this report. However, the Trust is not complacent and recognises there is significantly more work to do, particularly in areas such as remaining long waiting elective patient cohorts. In addition, the Trust recognises that it needs to improve its diagnostics performance, and this will be a key focus over the coming months.

3.4. Industrial Action: Both clinical and non-clinical staff across the Trust have continued to work hard to maintain the safety of our patients during the periods of industrial action, maintaining access to urgent and emergency services and prioritising the treatment of patients with the most acute health needs. To enable this, I regret that the Trust has again had to cancel a significant number of inpatient and outpatient appointments.

We fully recognise colleagues' right to take part in these strikes; equally we understand the frustration and distress this causes for our patients and their families, as well as the increased risk of harm. The Trust will continue to press for an urgent resolution to the issue.

3.5. Quality and safety: Key quality and safety metrics and clinical outcomes data continue to show that the Trust provides very high-quality patient care across its services. Data from February 2024 shows that the Trust has retained one of the lowest mortality rates in the country. Our Care Hours Per Patient Day (CHPPD) performance, which measures safe staffing rates in nursing and midwifery, remains positive compared to trusts both nationally and in the Shelford Group. Whilst good progress is being made to ensure Structured Judgement Reviews (SJRs) are consistently completed in a timely manner across all clinical groups, there remains more work to ensure the Trust responds to complainants within the timescale outlined in Trust policy. The new Local Risk Management System - Radar - which replaced Datix as the organisation's Local Risk Management System in March 2024 will enable improved reporting on trends and themes arising from complaints. Since the Trust's internal ward accreditation programme recommenced, we celebrated the first 'gold' accreditation result on Princess Alexandra Ward at the Royal Brompton Hospital; my congratulations go to the team on their achievement, which is an improvement on their initial 'bronze' rating last year.

3.6. Patient Experience: Patient communication, including appointment letters, contacting the Trust by telephone and appointments being rescheduled or delayed, are the main issues that patients raise with our patient advice and liaison service (PALS). We are looking at ways to improve in all these areas. The results of the 2023 National Maternity Survey, published in February 2024, continue to show improvement. All clinical groups have now established patient experience and engagement groups to improve patient experience.

3.7. Risk and incident management: In December 2023 the Trust transitioned to the new national Patient Safety Incident Response Framework (PSIRF). The implementation of PSIRF was one of the Trust's key quality priorities for the financial year and an essential source of assurance on patient safety and quality of care across the organisation. A key enabler to embedding PSIRF is the rollout of Radar, as referenced earlier in this report. This included a new incident reporting form to comply with NHS England's regulatory requirements as part of the National 'Learning from Patient Safety Events system' and this is now in place across all sites and services. Following a successful go-live, and the new system will help the Trust to maintain and improve its positive incident reporting culture.

3.8. Assisted Conception Unit (ACU) and Human Fertilisation and Embryology Authority (HFEA): In February I briefed the Board about a complex incident within the ACU at Guy's Hospital. This is under active investigation and management, and we are working in close cooperation with the Human Fertilisation and Embryology Authority and the CQC. Further actions taken building on those implemented immediately after the incident will be reported to the Board in due course.

3.9. Infection Prevention and Control: We continue to experience an ongoing outbreak of *Candida auris* at St Thomas' Hospital. A total of 59 patients have been affected. 57 of these patients were detected following screening and colonised only. Two patients had *Candida auris*

identified in a clinical specimen, but this did not adversely affect their ongoing treatment. There is no reported harm and no delays to patients' treatment or care. A range of measures are in place to manage this incident. An outbreak of *Carbapenemase Producing Enterobacteriaceae* continues at Harefield Hospital; a range of measures are in place to manage this. We have also experienced outbreaks of norovirus at the Evelina Children's Hospital. Only three COVID-19 outbreaks have been identified this calendar year, a substantial reduction compared with previous years.

3.10. Martha's Rule: Following the sad death of Martha Mills from sepsis in hospital in 2021, NHS England has committed to implement 'Martha's Rule' to ensure the vitally-important concerns of the patient and those who know the patient best are listened to and acted upon. The first phase of Martha's Rule will commence in 2024/25 with the recruitment of pilot sites to test and lead on the implementation. Guy's and St Thomas' has expressed interest to become one of these and will apply in due course.

4. Sustaining and improving the Trust's financial performance

4.1. The Trust reported a deficit of £16.7m at the end of February 2024 versus its planned deficit of £0.7m. The main drivers of this variance were the under-delivery of the Trust's financial efficiency programme, the impact of industrial action resulting in increased expenditure and a reduction in expected private patient income. More detail is set out in the month 11 finance report that is included in the Board meeting papers. The Trust's cash position at the end of February was £104.9m. The main drivers of the cash position are set out in the finance report. Capital expenditure to date of £100.5m has been recorded against the Trust's capital departmental expenditure limit (CDEL) funded schemes; whilst this is in excess of the annual CDEL plan, the Trust expects to finish the year within its total CDEL limit.

4.2. The Trust's full-year outturn forecast was a surplus of £28.5m, although recent developments regarding receipt of income linked to industrial action and the lower elective recovery fund income means that the Trust will likely finish with an outturn surplus nearer £10m.

5. Planning for 2024/25

5.1. The Board has set the Trust's objectives for 2024/25 and these are shown in Appendix 1. Meanwhile, following receipt of national planning guidance, the Trust is continuing to refine its business plan for 2024/25. We anticipate that the challenging conditions experienced in 2023/24 will continue and even intensify in some areas. We anticipate continued growth in demand for services across almost all patient pathways including elective, non-elective and diagnostic care; this will reinforce the need for effective working with partner organisations to manage demand, reduce waiting times and continue to drive greater equality of access to healthcare services across South East London.

5.2. Key areas of focus for the Trust during the coming year will be the identification and delivery of a significant financial efficiency programme, through both cost controls and opportunities to transform the way we work, as well as work to improve operational productivity. The Trust's

draft financial and operational plans contain a significant level of risk, which reflects the challenging environment across the sector. The Trust has submitted a breakeven financial plan at draft submission stage. A recent session of the Trust's Council of Governors produced a number of helpful contributions to the business planning process and will help to ensure the Trust's plans continue to meet the needs of its staff, patients, the wider public and its partner organisations.

5.3. Simultaneously, work is continuing to develop the Trust's new five-year organisational strategy which will replace *Together we care 2018 – 2023*. It is anticipated that the new strategy will be published in the coming months.

6. Epic electronic health record system

6.1. Since the go-live of Epic, our new electronic patient record system, in October 2023, our focus has shifted from implementation to stabilising use of the new system. This includes resolving workflow issues and supporting staff as they become more familiar with using the system. In doing this, the Trust is continuing to work collaboratively with its partners King's College Hospital NHS Foundation Trust and our shared pathology provider Synnovis. Work is also being undertaken to prepare for the optimisation phase, so that the transformational benefits of Epic can be realised. The Trust continues to see impressive progress in the number of downloads of the MyChart app, and the use of the MyChart patient helpdesk is also increasing month-by-month.

6.2. However, since the launch of Epic there has been some impact on the Trust's ability to submit all the external data and reports in line with statutory and regulatory requirements, including hospital episode statistics (HES) and mortality monitoring and outcomes. A number of underlying causes have been identified; the risk has been escalated to the corporate risk register and is being actively mitigated.

7. Supporting our workforce

7.1. NHS 2023 staff survey: More than 8,900 colleagues (38% of our workforce) completed the NHS staff survey in autumn 2023 and the Trust again scored above the national average in a number of areas: the percentage of staff who said the care of patients/service users is our top priority (82%, versus the national average of 75%), the percentage of staff who said they would be happy to recommend the Trust as a place to receive care/treatment (81% versus 63%) and the percentage of staff who would be happy to recommend the Trust as a place to work (70% versus 61%). However, we are not complacent and also recognise that we need to do more to improve in some areas, including equality, diversity, and inclusion; bullying and harassment; career progression; and staff health and wellbeing. We remain committed to prioritising these areas in our action plan for the coming year. We recognise that these are long-standing issues, and although some interventions are showing a positive impact, we need to do more to ensure tangible improvements for all of our staff.

7.2. Pay gap reports: Recently-published data shows that our gender pay gap in 2023 is continuing to reduce year-on-year, as assessed by both the mean and median calculations, and that, in 2023, we reported the lowest gender pay gap since we first started to report in 2017. We recognise that the gap continues to be driven by the lower proportion of women represented in senior management roles and in senior medical and dental roles. The pay gaps between white colleagues and those of other ethnic backgrounds are more pronounced, particularly for Black staff who are over-represented in junior staffing positions and under-represented in senior positions. The gap is smaller when the pay of disabled staff is compared to able-bodied staff, although it should be noted that the number of staff disclosing their disability status is very low and not currently a true representation of the Trust demographic. The overarching Trust Equality Diversity and Inclusion (EDI) improvement plan aligns with NHS England's EDI improvement plan and six High Impact Actions.

7.3. Celebrating equality, diversity and inclusion and our commitments to being an anti-racism organisation: There have been many occasions since the last public Board meeting where Trust staff have had opportunity to celebrate the diversity of our workforce. This includes LGBT+ history month (February), Women's history month (March) and Neurodiversity celebration week (commencing 18 March). Earlier this year we published our first-ever anti-racism statement in recognition of our responsibility to address the things that perpetuate racism. On 21 March we marked International Day for the Elimination of Racial Discrimination by taking the opportunity to reaffirm our commitment to anti-racism and tackling discrimination in all its forms.

7.4. Freedom to Speak Up: The Trust continues to maintain a positive and transparent reporting culture. The 2023 NHS staff survey results showed the Trust scored above the national average in the percentage of staff who feel that they have 'a voice that counts'. The Trust also recently completed a 'reflection and planning tool' issued by NHS England and the National Freedom to Speak Up Guardian's Office which provided assurance about the strength of its speaking-up arrangements, whilst also identifying important areas for improvement in 2024/25.

8. Our infrastructure

8.1. Patient-Led Assessments of the Care Environment (PLACE): The Trust has recently achieved ratings at, or above, the national average across all categories in the latest PLACE assessments. The findings, released by NHS England in February, underscore our dedication to delivering exceptional healthcare services. Of particular note were our scores for the crucial areas of hospital cleanliness, food, environment, privacy and dignity. We are aware that there are areas for continued improvement and we are developing plans to address these in response to patient feedback so we can maintain and improve the high standards we aim for across the Trust.

8.2. Capital developments: Our capital expenditure plan for 2024/25 is reflective of the Board's commitment to invest in its digital and estates infrastructure, and key medical equipment, to ensure they support the delivery of high-quality care. I am pleased to inform the Board that, after considerable delay, the new Nuffield theatres are due to open in June. Planning work is also continuing at pace to support future developments in Evelina London Children's Hospital, and to increase operating theatre capacity.

9. Key updates from our clinical groups

Cancer and Surgery

9.1. In January 2024 the Trust was placed into regulatory 'tiering' by NHS England for its cancer performance. Significant progress has been made in addressing the backlog of patients waiting for cancer treatment, which has reduced from a high of 457 patients in January 2024 to 239 patients at 31 March; this is ahead of the target trajectory of 255. Performance against the faster diagnosis standard remains on track to recover to over 70% by the end of March, although validation of the data is still ongoing. Work is also underway to agree recovery actions internally and across shared treatment pathways within south east London, to improve 62-day performance in 2024/25.

9.2. Significant progress has been made on reducing the number of patients waiting over 78 weeks for treatment. We were ahead of our trajectory at the end of the 2023/24 financial year, and now focused on reducing this number to zero. We are also working hard to ensure we have no patients waiting over 65 weeks from September 2024. The Trust's programme to improve theatre productivity has been reviewed and refreshed following the launch of Epic last year. The core workstreams are focused on supporting the continued recovery of elective activity and include improved timetabling, central pre-operative assessment, in-theatre flow and High Intensity Theatre lists.

Evelina London Women's and Children's

9.3. On 2 April, Evelina London Children's Hospital, working in partnership with Great Ormond Street Hospital and South London and Maudsley NHS foundation trusts, launched a new specialist service for children and young people who need gender-related care and support. The service is one of two regional centres, with the other based in north west England that will support these patients with their mental and physical health, including emotional, psychological and social aspects. A multidisciplinary team of health professionals includes specialist children's doctors, mental health clinicians and youth and support workers. The service has been designed through national professional and public consultation, and feedback to deliver improved care. Support and will adapt over time to follow best practice and the latest evidence and learning from children and young people.

9.4. In March, inspiring 9-year-old Tony Hudgell, one of our long-term patients who has raised an incredible £1.8 million for Evelina London Children's Charity, visited our new space-themed children's day surgery unit where he was presented with a ceiling tile immortalising him in the hospital that saved his life. The ceiling tile shows him as an astronaut - with his crutches, prosthetic legs, and a name badge. The new unit provides everything needed for day surgery in one family friendly space and its development was generously supported by Tony's incredible fundraising.

Integrated and Specialist Medicine

9.5. The Clinical Group continues to focus on the challenges of providing appropriate and timely care for patients in mental health crisis care needing urgent and emergency support. A great deal of work is continuing to deliver much-needed gains in capacity, care, flow and community development.

9.6. Over the past year our community services have delivered a 65% increase in virtual ward capacity, enabling more patients to be cared for outside hospital, in a familiar environment such as their home. These gains have meant the Trust met its NHS England virtual ward target, built stronger partnerships across organisational boundaries and progressed pilots in remote monitoring technology. This, coupled with expansions to Neighbourhood Nursing teams, has improved links to primary care and helped us to better balance service provision across South East London.

Heart, Lung and Critical Care

9.7. As part of our commitment to clinical research the Clinical Group was delighted to be awarded a grant of £2.9m by the National Institute for Health and Care Research (NIHR) for the development of a Cardiorespiratory Healthtech Research Centre; this will help to build on research strengths at St Thomas' hospital and across the organisation.

9.8. In March 2024 the Clinical Group celebrated its partnership with the National Heart and Lung Institute and Siemens, whose state-of-the-art 'CIMA.x' MRI scanner has just been installed in the Squire Centre at the Royal Brompton Hospital. This means the Trust now has the largest heart MRI scanning service for NHS patients in the country, and one of the largest in the world. The new scanner will benefit patient care and research and was generously supported by the Royal Brompton & Harefield Hospitals Charity.

9.9. Over the past year, the transplant team at Harefield Hospital delivered the highest number of heart transplants in the country (44), with all patients surviving. This is also the Hospital's highest number of heart transplants in 10 years. The Hospital is also thought to have delivered the second largest number of lung transplants in the country (29). We are incredibly proud of the transplant service and the work it does as part of a thriving advanced heart failure programme. Harefield Hospital also celebrated having the longest-surviving heart transplant patient in the world, Bert Janssen, who received his heart transplant aged 17 in 1984. Bert has been recognised by the Guinness World Records and his story was covered by international, national and local media.

10. South East London provider collaboration

10.1. The Trust continues to work with King's College Hospital NHS Foundation Trust and Lewisham and Greenwich NHS Trust as part of the South East London Acute Provider Collaborative (APC) to support and accelerate the delivery of high-quality and efficient services for the local population and address the key challenges currently faced by the system. A joint piece of work to further develop the APC model to ensure

we are working effectively as place-based partners and making the most of the opportunities offered by working together for the communities we collectively serve is currently underway. The Board will be apprised of the outcome of this work in due course.

11. Trust awards

11.1. On Friday 1 March we were able, for the first time since the pandemic, to celebrate our Trust Awards finalists and announce our winners as part of a grand ceremony at the Park Plaza Westminster Bridge hotel, close to St Thomas' Hospital. With more than 950 nominations received this year, it is clear how much pride and appreciation we have for our colleagues. We had a diverse range of award presenters who revealed our well-deserved award winners, with our executive directors joined by other colleagues who play key roles across the Trust, including network leads, speak up champions, reverse mentors, housekeepers and nursing associates. Huge congratulations to all those who were shortlisted and a big thank you to Guy's & St Thomas' Charity and Royal Brompton & Harefield Hospitals Charity for supporting the event.

12. Board committee meetings and supporting information

12.1. The following meetings have taken place since the last public Board meeting in January 2024. Unless indicated, minutes for these meetings are included in the Board paper pack, together with minutes that were finalised too late for inclusion in the paper pack from the previous Board meeting.

- Transformation & Major Programmes Board Committee: 7 February 2024
- Audit & Risk Committee: 28 February 2024
- People, Culture & Education Committee: 6 March 2024
- Quality and Performance Board Committee: 3 April 2024 – *minutes not included in Board paper pack as they are not yet complete*

13. Consultant Appointments from 1 January 2024 – 31 March 2024

13.1. The Board is invited to note the following consultant appointments made since the last report:

Name of post	Appointee	Post Type	Start date
Consultant in Anaesthesia and Critical Care	Jason Van Schoor	Newly-created post	01/02/2024
Consultant in Dermatology (Lympoma and Melanoma)	Bjorn Rhys Thomas	Newly-created post	26/02/2024
Consultant in General Paediatrics	Kate Louise Dharmarajah	Newly-created post	04/03/2024
Consultant in Infectious Diseases and General Medicine	Alex Paddy Salam	Newly-created post	01/04/2024
Consultant in Paediatric Radiology	Harsimran Laidlow-Singh	Vacant post	01/04/2024

Name of post	Appointee	Post Type	Start date
Consultant in Hand Surgery	George Richard Francis Murphy	Vacant post	22/04/2024
Consultant in Oncology and Gynaecology	Priyanka Hiteshkumar Patel	Vacant post	15/05/2024
Consultant in Heart & Lung Transplantation, MCS & Acquired Cardiac Surgery	Anton Sabashnikov	Vacant post	20/05/2024
Consultant in Palliative Medicine	Heena Khiroya	Newly-created post	22/05/2024
Consultant in Breast Surgery	Karina Louise Cox	Newly-created post	01/06/2024

Appendix 1: Trust objectives 2024/25

Our Trust objectives for 2024/25

1	**Ensure all patients receive timely, high quality care**, with a particular focus on treating more patients who need planned care, and on diagnosing and treating cancer
2	**Deliver our financial plan, focusing on reducing our costs and increasing productivity**, so that we can deliver excellent care today and in the future
3	**Deliver the benefits of Epic**, including the MyChart patient portal, to improve safety, patient experience and efficiency
4	**Support, develop and empower our staff**, building an inclusive culture with a specific focus on anti-racism

To achieve our objectives we will **work with our partners** where this supports the delivery of common goals, and we will continue to **drive innovation**

Guy's and St Thomas' NHS Foundation Trust

GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
BOARD OF DIRECTORS
WEDNESDAY 24 APRIL 2024

Title:	**Apollo Programme Update**
Responsible executive:	**Jon Findlay, SRO Apollo Programme / Chief Operating Officer**
Paper author:	**Joanna Turville, Associate Director for the Apollo Programme**
Purpose of paper:	Provide an update on the Apollo Programme's progress
Main strategic priority:	Safely implement EPIC the Electronic Health Record
Key issues summary:	• Apollo has moved from 'implementation' to 'stabilisation' and, as before, this phase continues to be run jointly with King's College Hospital and Synnovis. • Alongside the joint stabilisation governance arrangements, the Trust has established its own 'Epic Stabilisation Group' to provide time to consider stabilisation in an internal Trust setting. • The programme and organisation have developed a set of programme stabilisation objectives to work through alongside individual Clinical Group priorities
Paper Previously presented at:	• A more detailed report has been presented at the Joint Stabilisation Board (JSB) on the 13th March 2024
Recommendation(s):	The BOARD is asked to: 1. Note the update

Guy's and St Thomas' NHS Foundation Trust

GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
BOARD OF DIRECTORS
WEDNESDAY 24 APRIL 2024

1. Introduction

1.1. The Board is receiving an update on the progress of the Apollo Programme noting that a more detailed review was taken through the Apollo Joint Stabilisation Board (JSB) on the 13th March 2024.

1.2. The Apollo programme, now 6 months post go live, continues to work through the stabilisation phase to address the key challenges still facing both GSTT and King's College Hospital (KCH) in effectively embedding the new system before work starts to deliver optimal use of the investment. Stabilisation continues to be largely being run as a joint exercise between GSTT, KCH and Synnovis.

1.3. The fundamental pieces of the joint stabilisation governance, which are agreed between the three organisations, are:

- **Joint Stabilisation Board (JSB)**: an executive-level body with members from all three organisations. It meets monthly and is responsible for realising the Apollo benefits and approving cross-organisational approaches and strategies for Apollo-wide changes and priorities.
- **Workflow Oversight Committee (WOC)**: meets weekly (currently) and is responsible for the review and oversight of WOT progress, decisions, escalations, and capacity, as well as discussing and making decisions on cross-cutting changes. Reports progress and escalations to JSB, and is held to account by the JSB.
- **Workflow Optimisation Teams (WOTs)**: 21 clinically-led teams responsible for the prioritisation and resolution of issues, as well as the efficient action of change within the services they encompass.

1.4. GSTT has a separate, individual 'Epic Stabilisation Group' which provides time for the Trust to:

- take its own view of stabilisation activities being undertaken at the WOT and WOC levels; and
- (as a result) establish a Trust 'viewpoint' to take into JSB meetings to inform discussion and decision-making.

1.5. The programme continues to make good progress across a stabilisation workplan, including a set of key programme objectives covering key elements of technical, operational, reporting and finance and benefits realisation targets. In addition, key priorities for each Clinical Group are being worked through in collaboration with the programme team and delivery teams in each Clinical Group.

2. Stabilisation Objectives – Key Highlights

2.1. The high level descriptor of the 12 stabilisation objectives and the status of delivery are shown here with further detail on those rated as red following on below:

	Objective	Owner (Title)	Operational Stabilisation Status					
			w/b 4th Mar	w/b 11th Mar	w/b 18th Mar	w/b 25th Mar	w/b 1st Apr	w/b 8th Apr
1	Diagnostics activity returned to pre-go-live	Director of Performance and Information & Deputy Director of Operations – Apollo	Red	Red	Red	Red	Red	Red
2	Outpatient activity returned to pre-go-live	Director of Performance and Information & Deputy Director of Operations – Apollo	Amber	Amber	Amber	Amber	Amber	Amber
3	Inpatient activity returned to pre-go-live	Deputy Director of Operations – Apollo	Red	Amber	Amber	Amber	Red	Red
4	Patient flow stabilised	Chief Clinical Information Officers	Amber	Amber	Amber	Green	Green	Green
5	Pharmacy meds workflow compliance, stock & financial reconciliation stabilised	Chief Nursing Information Officers	Red	Amber	Amber	Amber	Amber	Amber
6	Information & Reporting	Director of Performance and Information	Red	Red	Red	Red	Red	Red
7	Clinical Safety Metrics within accepted parameter	Chief Clinical Information Officers	Amber	Amber	Amber	Amber	Amber	Amber
8	Technology and infrastructure stabilised	GSTT Chief Information Officer & Director of Clinical Systems	Red	Amber	Amber	Amber	Amber	Amber
9	Data migration including decommissioning plans complete	Apollo Technology Director & Chief Clinical Information Officers	Amber	Amber	Amber	Green	Green	Green
10	Training & Personalisation	Chief Clinical Information Officers	Amber	Amber	Amber	Green	Green	Green
11	Stabilisation benefits identified & enabled	GSTT Benefits Lead	Amber	Amber	Amber	Green	Green	Green
12	Governance (approach to current and post-stabilisation agreed)	GSTT Benefits Lead	Amber	Complete	Complete	Complete	Complete	Complete

Figure 2: Summary of stabilisation objectives and delivery status – note this is at aggregated programme level across GSTT and KCH

2.2. Diagnostics activity returned to pre-go live levels

2.2.1. There have been some significant technical challenges with the diagnostic applications as well as counting and processing of diagnostic orders in EPIC, which has contributed to the inability to return to pre go live levels and significant performance challenges in DM01. The technology fixes to address these issues have now been largely implemented.

2.2.2. Alongside the technology challenges, there have also been issues with the workflow and individual user difficulties. A robust project management approach has been taken to address this and progress is now being made in moving the activity levels back towards pre go-live levels. This does however, continue to take significant clinical and programme resource.

2.3. Inpatient activity returned to pre go-live levels

2.3.1. Inpatient activity is above pre-live levels in aggregate. However, daycase activity remains a concern in certain areas. Work is on-going to establish the comparator in EPIC for these pathways.

2.3.2. A key remaining focus is on the day case build in children's pathways and on "day case errors" which need to be resolved to capture all activity accurately.

2.4. Information and reporting

2.4.1. The Trust continue to submit required external returns as they have done so since go live and are now submitting 19 out of 40 'priority 1' external returns

2.4.2. Critical focus is on preparation for, and submission of, activity datasets in May 23 to enable commissioning datasets and billing.

2.4.3. There has been good progress on key priority internal dashboards such as live ED, theatres, beds, referrals, un-outcomed and PTLs

3. MyChart – our new patient portal

3.1. MyChart is our new patient portal, as part of the Epic system. Patients now have wide-ranging access to their healthcare information via the app, as well as tools to engage with our services outside appointments. MyChart is a cornerstone of our ambitions to transform ambulatory care, and can also help to free up phone lines for patients who would prefer not to use the app.

3.2. Patients can view their appointment information, letters and medical information in the app, as well as test results which are released as clinically appropriate. Questionnaires and messages from clinical teams can also be seen and responded to by patients in MyChart, enabling communication between, or in place of, follow up appointments. Patients are able to cancel appointments (with some exceptions, such as chemotherapy) and, in some services, to select times for future appointments.

3.3. Across Guy's and St Thomas' and King's College Hospitals, over 275,000 patients registered for MyChart in the first five months since launch – over 1 registration per second. This is the fastest growing, and already one of the largest, versions of the app in the NHS. Unvalidated data indicates that over 30,000 patients over the age of 70 have registered for the app.

3.4. Benefits are already being delivered by this new portal. Over 200,000 test results have been released to patients via the app, and over 300,000 pre-appointment questionnaires have been completed – helping to reduce administrative time in outpatient appointments. The rate of missed appointments for patients with MyChart is 5%, which is substantially lower than the average rate for the trust.

3.5. The success of the launch so far was helped by the close involvement of patients and staff in the design and development of the Mychart app, customising its wording and layout to be as accessible and easy to use as possible. A wide-ranging communication and promotional campaign across the trust's sites, and online, has helped to raise awareness of this new service for patients.

3.6. There is recognition that in the wider programme of work additional patient participation that would be beneficial. We are working on re-establishing patient participation as we progress out of the stabilisation phase.

3.7. Patients are supported to use MyChart by a dedicated patient helpdesk, which has received over 7,000 enquiries to date. The trust's website also contains guidance, FAQs and an animated video to provide information on the most common queries. Importantly, MyChart remains an optional way of accessing information, and patients do not need to register, and can opt out of receiving information about the app if they wish.

3.8. In addition, a volunteer co-ordinator has been in place since November 2023, and volunteers have since helped nearly 800 patients to understand the service or register for an account.

3.9. Patients have fed back that they like being able to see appointments and add them to their phone calendars; they have found the app easy to use and informative; and they found the use of the app an efficient way to access the information they needed. Others have been concerned at receiving too many prompts; have wanted to use larger font sizes in the app; or have reported issues receiving verification codes to register.

3.10. Community outreach workshops are being arranged for March/April, to help generate further insight on patient and community views on the app, and highlight areas for further improvement to reduce the risk of digital exclusion.

3.11. Maximising the benefits of MyChart is included in the trust's corporate priorities for 2024/25, and plans are being developed to provide enhanced support to patients to maximise uptake, respond to feedback, and reduce digital exclusive, as well as to help services use these new tools to transform care, and to continue to innovate and add functionality to the portal over time.

4.0 Primary Care Update

4.1 General Practice colleagues expressed initial concerns regarding the lack of engagement at go-live and their preparedness prior to the go-live. Numerous challenges did emerge during the go live phase, the majority of which related to pathology ordering and results, and the TQuest system used for this, but with other issues relating to referrals, radiology ordering and results and letters.

4.2 We have worked collaboratively throughout this period to prioritise issues and through joint resolution we have addressed the high priority issues that were causing system-wide issues for GPs and work continues to address the smaller issues or those affecting individual GPs or individual practices. We are now leveraging the GP collaboration forum to identify opportunities for improvement and developing small cross-organisational groups to tackle specific topics.

5.0 Benefits Update

5.1 Benefits delivery is now largely taking place in the Clinical Groups as part of the ongoing efficiency of delivering the services. Oversight for collating impact and identifying new benefits continues to be undertaken by the Apollo programme team.

5.2 Good progress has been made on the decommissioning of legacy systems and the reduction of transcription costs. Savings of over

£2.8m have been identified and committed for the decommissioning of legacy systems.

5.3 In addition to those benefits identified in the Full Business Case the team are working closely with Epic to ensure they identify and monitor further benefits through the implementation of the integrated EHR.

6.0 Conclusion

6.1 We are now 6 months post go live and the programme continues to recognise the strong collaboration between the programme team and organisations resources, working through a stabilisation plan systematically, prioritising as required and taking on any urgent emergent issues as they arise.

6.2 Momentum must continue to ensure all workflows are optimised and users are able to function as efficiently as possible using the new system.

7.0 Recommendation

7.1 The board is asked to note progress.

Guy's and St Thomas' NHS Foundation Trust

GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
BOARD OF DIRECTORS
WEDNESDAY 24 APRIL 2024

Title:	**Trust Constitution update**
Responsible executive:	**Tendai Wileman, Chief of Staff and Director of Organisational Change**
Paper author:	**Edward Bradshaw, Director of Corporate Governance and Trust Secretary**
Purpose of paper:	To seek Board approval for a number of changes to the Trust Constitution
Main strategic priority:	All Trust Strategic Priorities
Relevant BAF risk(s):	• N/a
Key issues summary:	• The Trust Constitution sets out the fundamental principles for how the Trust is governed, with a primary focus on the role and composition of the Board of Directors and Council of Governors. The latest version of the Constitution is dated February 2022. • The updates that are being proposed have been collated by the Trust's lawyers, DAC Beachcroft, the Trust Secretary and a working group of governors. The changes are primarily to ensure the Constitution is consistent with legislation (Health and Care Act 2022) and new regulatory guidance issued by NHS England, and will also tighten up language and process.
Paper previously presented at:	• N/a
Recommendation(s):	The BOARD is asked to: 1. **Approve** the updates to the Trust Constitution (Appendix 1); 2. **Note** that the changes also require approval from the Council of Governors at its meeting on 24 April.

Guy's and St Thomas' NHS Foundation Trust

GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
BOARD OF DIRECTORS
WEDNESDAY 24 APRIL 2024

1. Introduction

1.1. The Trust Constitution sets out the fundamental principles for how the Trust is governed, with a primary focus on the role and composition of the Board of Directors and Council of Governors. The latest version of the Constitution is dated February 2022.

1.2. At their public meetings on 24 April both the Trust's Board and Council of Governors will be asked to approve an updated Trust Constitution. The updates that are being proposed have been collated by the Trust's lawyers, DAC Beachcroft, the Trust Secretary and a working group of governors. They will help to ensure the Constitution is consistent with legislation (Health and Care Act 2022) and new regulatory guidance issued by NHS England, and will also tighten up language and process.

2. Main proposed updates

	Ref	Proposed change	Rationale
1	7.4.4 & 7.4.6	The eligibility of patient carer governors to remain governors until the end of their current terms is clarified and aligned with that of patient governors.	To enable the Trust to retain governors until the end of their current terms and also to ensure consistency between sub-categories of the patient constituency.
2	8.8.1	Removal of appointed governor from London Borough of Hillingdon	Hillingdon Council voted against nominating a governor to the GSTT CoG.
3	8.8.2	Amendment of number of governors from the South East London ICB (formerly CCG) from two to one.	To take into account that members of the ICB, including KCH, SLaM and both local councils in SEL are already represented on the Council of Governors.
4	8.9.1.4	Removal of appointed governor from "an academic organisation chosen by the Board of Directors"	Provision appears never to have been used. Trust already has governors from KCL, LSBU, Imperial College.
5	8.12	Governors will be entitled to serve three terms of three years (currently two terms).	Reflects time taken to understand size and complexity of the Trust, and aligns with NED terms.
6	8.13.3	A threshold of 75% of governors is required to remove a governor from the CoG.	Specific threshold currently missing; 75% is in line with NHSE guidance.
7	8.14.1.6	Addition of a condition that a person may not become or continue as a	To bring constitution fully in line with the NHS provider

	Ref	Proposed change	Rationale
		governor if they are subject to a moratorium period under a debt relief order (under Part 7A of the Insolvency Act 1986).	licence requirements for governors to be fit and proper persons.
8	8.18.1 to 8.18.10 (inclusive)	Remove and replace with the following: "The Council of Governors shall elect one of the elected Governors as the Lead Governor in accordance with the terms of appointment set out in the Lead Governor role description approved by the Council of Governors."	Lead Governor appointment process considered to be unnecessarily complex. Proposed approach mirrors that of a number of other trusts.
9	9.2.2.3	To increase the number of voting executive directors: • from between five and eight • to between five and eleven	To provide the facility to consider future changes to the number of voting executive directors, as agreed by RemCom in February 2024.
10	9.8.2	Chair's term to be revised from 4+4+4 years to 4+4+2 years.	Consistency with other NEDs. As with other NEDs, retains condition that final term would be in exceptional circumstances only.
11	9.9	Addition of a reference to the Senior Independent Director of the Board of Directors.	Position required by the NHS Code of Governance, hence being formalised.
12	9.10.1.5	More explicit reference to Directors needing to be 'fit and proper' persons.	Reflects NHS England's updated FPP framework published in late 2023.
13	9.10.1.6	NEDs are unable to take on senior/leadership roles in the ICB in the same area(s) in which the Trust operates.	Mechanism to avoid conflicts of interests.
14	11	Addition of conditions to enable the Trust (if needed) to exercise some of its statutory functions via delegation or via joint working arrangements under the Health and Care Act 2022.	Reflects provisions of the 2022 Health and Care Act
15	Annex 2	Update standing orders to reflect modern ways of working (eg removing of 'paper ballots' and introduction of attendance by electronic means).	Aligns constitution with current ways of working.
16	Annex 2 – SO 4	Addition of a means for governors to make resolutions in correspondence.	Aligns constitution with current ways of working.
17	Throughout	Remove references to CCGs and Monitor and update to ICBs and NHS England.	These are no longer statutory bodies.

3. Recommendations

3.1. The Board is asked to:

- **Approve** the updates to the Trust Constitution (Appendix 1);
- **Note** that the changes also require approval from the Council of Governors at its meeting on 24 April.

GUY'S & ST THOMAS' NHS FOUNDATION TRUST

(A PUBLIC BENEFIT CORPORATION)

CONSTITUTION

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1. DEFINITIONS AND INTERPRETATION

1.1 In this constitution:

"Accounting Officer"	means that person who from time to time discharges the functions of Accounting Officer of the Trust for the purposes of Government accounting.
"Area of the Trust"	means the area specified as the area of the Public Constituency in Annex 1.
"Board of Directors"	means the board of directors of the Trust as constituted pursuant to this Constitution and the 2006 Act.
"British Islands"	has the same meaning as it has when used in the 2006 Act, currently "the United Kingdom, the Channel Islands and the Isle of Man".
"Chair"	means the Chair of the Trust.
"Chief Executive"	means the chief executive of the Trust.
"Class"	means the division of a Membership Constituency by reference to the description of individuals eligible to be Members of it.
"Code of Conduct for Governors"	means the code of conduct for Governors as set out in Annex 5~~Annex 5~~~~Annex 5~~.
"Combined Authority"	means a combined authority established under section 103 of the Local Democracy, Economic Development and Construction Act 2009.
"Council of Governors"	means the Council of Governors as constituted pursuant to this Constitution.
"Director"	means a director on the Board of Directors.
"Dispute Resolution Procedure"	means the dispute resolution procedure set out at Annex 6~~Annex 6~~~~Annex 6~~.
"Elected Governor"	means a Public Governor, Staff Governor or Patient Governor.
"Election Scheme"	means the electoral system specified at Annex 3 or as otherwise may be specified in regulations made by the Secretary of State.
"Financial Year"	means any period of twelve months beginning on 1st April.
"Governor"	means a person who is a member of the Council of Governors.
"GST Clinicalians~~ians~~ Staff Class"	means the Staff Class defined in paragraph 7.3.7.
"GST CSD Staff Class"	means the Staff Class defined in paragraph 7.3.6.
"GST Other Staff Class"	means the Staff Class defined in paragraph 7.3.8.

"Health Service Body"	shall have the same meaning as in Section 9(4) of the 2006 Act.
"ICB"	means an Integrated Care Board established under Chapter A3, Part 2 of the NHS Act 2006.
"Local Authority"	means: (a) a county council in England; (b) a district council in England, other than a council for a district in a county for which there is a county council; (c) a London borough council; (d) the Council of the Isles of Scilly; (e) the Common Council of the City of London.
"Local Authority Governor"	means a Governor appointed in accordance with paragraph 8.98.98.8.
"System Governor"	means a Governor appointed in accordance with paragraph 8.88.88.7.
"Material Transaction"	is defined in paragraph 19.419.417.4.
"Member"	means a member of the Trust.
"Membership Constituency"	means any of (1) the Patients' Constituency; (2) the Public Constituency; or (3) the Staff Constituency.
~~**"Monitor"**~~	~~means the body corporate referred to in section 61 of the 2012 Act. Since April 2016, Monitor is part of NHS Improvement.~~
"Nominations Committee"	means a committee of the Council of Governors established in accordance with paragraph 8.208.208.19.
"Non Principal Purpose Activities	means activities other than the provision of goods and services for the purposes of the National Health Service in England.
"Partner Hospital Governor"	means a Governor appointed in accordance with paragraph 8.118.118.10
"Partner Hospitals"	mean any organisation specified in paragraph 8.11.18.11.18.10.1.
"Partnership Governor"	means a System Governor, a Local Authority Governor, a University Governor or a Partner Hospital Governor.
"Patient"	means a person within the definition at paragraph 7.4.2.
"Patient Carer"	means a person within the definition at paragraph 7.4.4.
"Patients' Constituency"	means a constituency of the Trust constituted in accordance with paragraph 7.4.

"Patient Governor"	means a Governor elected by the Members of the Patients' Constituency in accordance with paragraph 8.6~~8.6~~8.5~~5~~.
"Pooled fund"	means a fund: (a) which is made up of payments received in accordance with the arrangements from Relevant Bodies that are party to the arrangements, and (b) out of which payments may be made in accordance with the arrangements towards expenditure incurred in the exercise of functions in relation to which the arrangements are made.
"Principal Purpose"	is defined in paragraph 3.1.
"Public Constituency"	means the constituency of the Trust constituted in accordance with paragraph 7.2.
"Public Constituency Area"	means any of the Public Constituency areas specified in Column 2 of the Table set out in Annex 1.
"Public Governor"	means a Governor elected by the Members of the Public Constituency in accordance with paragraph 8.5~~8.5~~8.4~~4~~.
"RBH Clinicalians Staff Class"	means the Staff Class defined in paragraph 7.3.9.
"RBH Other Staff Class"	means the Staff Class defined in paragraph 7.3.10.
"RBHFT"	means the Royal Brompton and Harefield NHS Foundation Trust (prior to its dissolution).
"RBHFT Constitution"	means the Constitution of RBHFT immediately prior to its dissolution.
"Register of Members"	means the register of members which the Trust is required to have and maintain under Paragraph 20 of Schedule 7 to the 2006 Act.
"Relevant Body"	has the meaning given by section 65Z5(2) of the NHS Act 2006. It includes NHS England, an ICB, an NHS Trust, and NHS Foundation Trust or such other body as may be prescribed.
"Secretary"	means the Trust Secretary or any other person appointed by the Trust to perform the duties of the Trust Secretary including a joint, assistant or deputy Secretary or such other person as may be appointed by the Trust to perform the functions of the Secretary under this Constitution.
"Significant Transaction"	is defined in paragraph 19.2~~19.2~~17.2~~2~~.
"Staff Class"	means any of the GST CSD Staff Class, the GST Clinicalians Staff Class, the GST Other Staff Class, the RBH Clinicalians Staff Class or the RBH Other Staff Class.

"Staff Constituency"	means the constituency of the Trust constituted in accordance with paragraph 7.3.
"Staff Governor"	means a Governor elected by the Members of the Staff Constituency in accordance with paragraph 8.78.78.6.
"the 2006 Act"	means the National Health Service Act 2006, as amended from time to time.
"the 2012 Act"	means the Health and Social Care Act 2012, as amended from time to time.
"the Trust"	means the Guy's & St Thomas' NHS Foundation Trust.
"Trust Hospital"	means all or any hospital or other patient care facilities administered by the Trust from time to time and designated by the Trust as falling within this definition.
"University Governor"	means a Governor appointed in accordance with paragraph 8.108.108.9.

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

1.3 Unless the contrary intention appears or the context otherwise requires:

1.3.1 words or expressions contained in this Constitution bear the same meaning as in the 2006 Act.

1.3.2 references in this Constitution to legislation include all amendments, replacements, or re-enactments made to that legislation;

1.3.3 references to legislation include all regulations, statutory guidance or directions made in respect of that legislation;

1.3.4 references to paragraphs are to paragraphs in this Constitution;

1.3.5 all annexes referred to in this Constitution form part of it; and

1.3.6 words importing the singular shall include the plural and vice versa.

2. NAME

2.1 The name of the Foundation Trust is Guy's & St Thomas' NHS Foundation Trust.

3. PRINCIPAL PURPOSE

3.1 The Trust's principal purpose is the provision of goods and services for the purposes of the National Health Service in England ("the Principal Purpose").

3.2 The Trust's total income in each Financial Year from the Principal Purpose must be greater than its total income from Non Principal Purpose Activities.

4. OTHER PURPOSES

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

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

4.1.2 the promotion and protection of public health.

4.2 Subject to the requirements set out in paragraph 1818~~16~~, the Trust may also carry on other activities for the purpose of making additional income available in order better to carry on the Principal Purpose.

5. POWERS

5.1 The Trust shall have all the powers of an NHS Foundation Trust as set out in the 2006 Act.

6. FRAMEWORK

6.1 The Trust shall have three Membership Constituencies, a Council of Governors and a Board of Directors. The Board of Directors will exercise the powers of the Trust. The Membership Constituencies will elect certain of their Members to the Council of Governors in accordance with this Constitution and other Governors will be appointed by various bodies which are also set out in this Constitution. The Council of Governors will fulfil those functions imposed on it by the 2006 Act and by this Constitution.

7. MEMBERS

7.1 The Membership Constituencies

7.1.1 The Trust shall have three Membership Constituencies, namely:

7.1.1.1 the Public Constituency constituted in accordance with paragraph 7.2;

7.1.1.2 the Staff Constituency constituted in accordance with paragraph 7.3; and

7.1.1.3 the Patients' Constituency constituted in accordance with paragraph 7.4.

7.1.2 An individual may become a Member by application to the Trust in accordance with this Constitution or, where so provided for in this Constitution, by being invited by the Trust to become a Member of a Staff Class of the Staff Constituency in accordance with paragraph 7.3.

7.1.3 Where an individual applies to become a Member of the Trust, the Trust shall consider their application for membership as soon as reasonably practicable following its receipt and in any event no later than 28 days from the date upon which the application is received and unless that individual is ineligible for membership or is disqualified from membership the Secretary shall cause their name to be entered forthwith on the Trust's Register of Members and that individual shall thereupon become a Member.

7.1.4 Where an individual is invited by the Trust to become a Member in accordance with paragraph 7.3.2 that individual shall automatically become a Member and shall have their name entered on the Trust's Register of Members following the expiration of 14 days after the giving of that invitation unless within that period the individual has informed the Trust that they do not wish to become a Member.

7.1.5 An individual shall become a Member on the date upon which their name is entered on the Trust's Register of Members and that individual shall cease to be a Member upon the date upon which their name is removed from the Register of Members as provided for in this Constitution.

7.1.6 The Trust shall take reasonable steps to secure that taken as a whole the actual Membership of the Public Constituency and the Patients' Constituency is representative of those eligible for such Membership.

7.1.7 In deciding which areas are to comprise the Area of the Trust, or in deciding whether there shall continue to be a Patients' Constituency, the Trust shall have regard to the need for those eligible for such membership to be representative of those to whom the Trust provides services.

7.2 Public Constituency

7.2.1 Members of the Public Constituency shall be individuals who:

7.2.1.1 live in one of the Public Constituency Areas specified in column 2 of the Table set out in Annex 1;

7.2.1.2 are not eligible to become a Member of the Staff Constituency and are not Members of any other Membership Constituency;

7.2.1.3 are not disqualified from membership under paragraph 7.5;

7.2.1.4 are at least 18 years of age at the time of their application to become a Member; and

7.2.1.5 have applied to the Trust to become a Member and that application has been accepted by the Trust in accordance with paragraph 7.1.3.

7.2.2 The Public Constituency is to be divided into the following three Public Constituency Areas as follows:

7.2.2.1 Public Constituency Area 1 (see Annex 1, Row 3, Column 2);

7.2.2.2 Public Constituency Area 2 (see Annex 1, Row 4, Column 2);

7.2.2.3 Public Constituency Area 3 (see Annex 1, Row 5, Column 2).

7.2.3 The minimum number of Members required for each Public Constituency Area shall be the number given in the corresponding entry in column 3 of the Table set out at Annex 1.

7.2.4 An individual shall be deemed to live in one of the areas referred to at paragraph 7.2.2 and/or paragraph 7.2.3 above if this is evidenced by their name appearing on the then current Electoral Roll at an address within the Area of the Trust or the Trust acting by the Secretary is otherwise satisfied that the individual lives within the Area of the Trust.

7.3 Staff Constituency

7.3.1 Members of the Staff Constituency shall be individuals:

7.3.1.1 who:

(a) are employed under a contract of employment with the Trust which has no fixed term or is for a fixed term of at least 12 months; or

(b) have been continuously employed under a contract of employment with the Trust for at least 12 months; or

(c) exercise functions for the purposes of the Trust other than under a contract of employment with the Trust, have continuously exercised such functions for the Trust for at least 12 months, whose place of work is at the Trust and who are acknowledged in writing by the Trust as falling

within the parameters of this paragraph 7.3.1.1(c). For the avoidance of doubt, individuals who exercise functions for the purposes of the Trust include a person who is:

i Employed by a university, any other NHS Trust or a voluntary organisation within the meaning of the 2006 Act and who holds an honorary contract with the Trust; or

ii A registered volunteer at the Trust.

7.3.1.2 who have not been disqualified from membership under paragraph 7.5; and

7.3.1.3 who are at least 18 years of age at the date of their application under paragraph 7.1.2 or invitation to become a Member (as the case may be) under paragraph 7.3.2.

7.3.2 Subject to paragraph 7.1.4, an individual who is:

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

7.3.2.2 invited by the Trust to become a member of the appropriate Staff Class within the Staff Constituency as defined in paragraph 7.3.5,

shall become a member of the Trust as a member of the appropriate Staff Class within the Staff Constituency.

7.3.3 Chapter 1 of Part XIV of the Employment Rights Act 1996 applies for the purpose of determining whether an individual has been continuously employed by the Trust for the purposes of paragraph 7.3.1.1(b) or has continuously exercised functions for the Trust for the purposes of paragraph 7.3.1.1(c).

7.3.4 Notwithstanding the effect of paragraph 7.3.3 above, employment of individuals by RBHFT immediately prior to its dissolution shall count as part of their continuous employment with the Trust for the purpose of paragraph 7.3.1.1(b) and/or the continuous exercise of functions for the Trust for the purposes of paragraph 7.3.1.1(c).

7.3.5 The Staff Constituency is to be divided into five Staff Classes as follows:

7.3.5.1 the GST CSD Staff Class;

7.3.5.2 the GST Clinicalians Staff Class;

7.3.5.3 the GST Other Staff Class;

7.3.5.4 the RBH Clinicalians Staff Class;

7.3.5.5 the RBH Other Staff Class.

7.3.6 The Members of the GST CSD Staff Class are Members of the Staff Constituency who are employed under a contract of employment with the Trust in the Trust's Community Services Directorate.

7.3.7 The Members of the GST Clinicalians Staff Class are Members of the Staff Constituency who are not Members of any other staff class, are not eligible to be Members of any other staff class and are regulated by a regulator overseen by the Professional Standards Authority for Health and Social Care, or are otherwise designated by the Trust from time to time as eligible to be members of this Staff Class.

7.3.8 The Members of the GST Other Staff Class are Members of the Staff Constituency who are not Members of any other Staff Class, are not eligible to be Members of any other Staff Class and who are designated by the Trust from time to time as eligible to be Members of the GST Other Staff Class.

7.3.9 The Members of the RBH Clinicalians Staff Class are individuals who are Members of the Staff Constituency who:

7.3.9.1 are not Members of any other Staff Class;

7.3.9.2 are employed under a contract of employment with the Trust and primarily work at the Royal Brompton Hospital and/or the Harefield Hospital or any other place that was part of RBHFT;

7.3.9.3 are not eligible to be Members of the GST CSD Staff Class, GST Other Staff Class or RBH Other Staff Class; and

7.3.9.4 are regulated by a regulator overseen by the Professional Standards Authority for Health and Social Care, or are otherwise designated by the Trust from time to time as eligible to be members of this Staff Class.

7.3.10 The Members of the RBH Other Staff Class are individuals who are Members of the Staff Constituency who:

7.3.10.1 are not Members of any other Staff Class;

7.3.10.2 are not eligible to be Members of the GST CSD Staff Class, GST Clinicalians Staff Class or RBH Clinicalians Staff Class;

7.3.10.3 are designated by the Trust from time to time as eligible to be Members of the RBH Other Staff Class

7.3.10.4 are employed under a contract of employment with the Trust and primarily work at the Royal Brompton Hospital and/or the Harefield Hospital.

7.3.11 For the purposes of paragraphs 7.3.7 and 7.3.9 above, regulators overseen by the Professional Standards Authority for Health and Social Care include:

7.3.11.1 The General Dental Council;

7.3.11.2 The General Medical Council;

7.3.11.3 The General Optical Council;

7.3.11.4 The General Osteopathic Council;

7.3.11.5 The General Pharmaceutical Council;

7.3.11.6 The Health & Care Professions Council;

7.3.11.7 The Nursing & Midwifery Council;

7.3.11.8 The Pharmaceutical Society of Northern Ireland;

7.3.11.9 The General Chiropractic Council;

7.3.11.10 Social Work England.

7.3.12 The minimum number of Members required for each Staff Class shall be the number given in the corresponding entry in column 3 of the Table set out at Annex 1.

7.3.13 A person who is eligible to be a Member of the Staff Constituency may not become or continue as a Member of any other Membership Constituency.

7.3.14 Members of the GST Clinicalians Staff Class and the RBH Clinicalians Staff Class shall be considered to remain employed in the relevant capacity if they shall have been appointed to a position within the management structure of the Trust.

7.4 Patients' Constituency

7.4.1 Members of the Patients' Constituency shall be individuals who:

7.4.1.1 are Patients or Patient Carers;

7.4.1.2 are not eligible to become a Member of the Staff Constituency and are not Members of any other Membership Constituency and are not otherwise disqualified for membership;

7.4.1.3 have made an application to the Trust to become a Member and whose name has been entered on the Register of Members in accordance with paragraph 7.1.3; and are not less than 18 years of age at the time of their application to become a Member.

7.4.2 A Patient is an individual whose name is recorded as a patient on the Trust's patient administration system or other record maintained by the Trust for the purpose of identifying patients of the Trust and:

7.4.2.1 who has attended the Trust as a patient within the period of five years immediately prior to that person applying to become a Member; or

7.4.2.2 who has required regular or intermittent access to the Trust's services over the course of a serial or long-term condition.

7.4.3 Subject to paragraph 7.4.4, ~~F~~for the purposes of paragraph 7.4.2.1 above, a person ceases to be a Patient when: five years have elapsed since their last attendance at the Trust as a patient.

7.4.4 Where a person has been elected as a Patient Governor, a person ceases to be a Patient only where:

7.4.4.1 Five years have elapsed since their last attendance at the Trust as a patient; and

(a) Their three-year term of office has come to an end, or

(b) They have resigned from that office.

~~7.4.4~~7.4.5 A Patient Carer is an individual who:

~~7.4.4.1~~7.4.5.1 is not less than 18 years of age at the date of applying to become a Member; and

~~7.4.4.2~~7.4.5.2 provides care on a regular basis for a Patient who has not attained the age of 18 years or who is by reason of physical or mental incapacity unable to discharge the functions of a Member; and

~~7.4.4.3~~7.4.5.3 does not (as set out in Paragraph 3(6) of Schedule 7 to the 2006 Act) provide that care:

(a) by virtue of a contract of employment or other contract with any person; or

(b) as a volunteer for a voluntary organisation; and

~~7.4.4.4~~7.4.5.4 has either been:

(a) nominated by that Patient as their Patient Carer for the time being for the purposes of this paragraph and has been accepted by the Trust as that Patient's Patient Carer for that purpose; or

(b) has been accepted by the Trust as a Patient Carer for the purposes of this paragraph where the Patient is under 18 years of age or lacks the legal or mental capacity to nominate that individual as their Patient Carer and the Trust has to the extent that it is reasonably practicable to do so consulted with that Patient as to their wishes and has then agreed to treat that individual as the Patient Carer for the purposes of this paragraph provided the individual has agreed in writing to act in that capacity and are otherwise qualified in accordance with this paragraph 7.4.4.

~~7.4.4.5~~7.4.5.5 An individual shall not be eligible to apply to become a Member of the Patient Carer Class or to continue as a Member of the Patient Carer Class if:

(a) the Patient is a Member; or

(b) the Patient has withdrawn their nomination of that individual under paragraph 7.4.5.4~~7.4.5.4~~7.4.4.4~~4~~(a) as their Patient Carer; or

(c) the Patient Carer is or becomes a Member of some other Membership Constituency or Class of Membership Constituency under this Constitution; or

(d) the Patient on whose behalf they are a Patient Carer is ~~ineligible or~~ disqualified from membership under paragraph ~~7.5~~ 7.5.1.2 or 7.5.1.3.~~; or~~

~~(d)~~(e) where paragraph 7.4.5.4~~7.4.5.4~~7.4.4.4~~4~~(b) applies the Patient becomes capable of discharging the functions of a Member and attains the age of 18 years of age.

7.4.6 Where a person has been elected as a Patient Governor from the Patient Carer Class and the patient on whose behalf they are a Patient Carer ceases to be a patient under paragraph 7.4.3, that person only ceases to be a Patient Carer where:

7.4.6.1 Their three-year term of office has come to an end, or

7.4.6.2 They have resigned from that office.

~~7.4.5~~7.4.7 References in paragraphs 7.4.2 to 7.4.4 to the "Trust" include references to RBHFT (before its dissolution).

~~7.4.6~~7.4.8 The Patients' Constituency is to be divided into three classes as follows:

~~7.4.6.1~~7.4.8.1 the GST Patient Class;

~~7.4.6.2~~7.4.8.2 the RBH Patient Class; and

~~7.4.6.3~~7.4.8.3 the Patient Carer Class.

~~7.4.7~~7.4.9 The Members of the GST Patient Class are Members of the Patients' Constituency who are not members of the RBH Patient Class or the Patient Carer Class.

~~7.4.8~~7.4.10 The Members of the RBH Patient Class are members of the Patients' Constituency who are not members of the GST Patient Carer Class and:

~~7.4.8.1~~7.4.10.1 Immediately prior to its dissolution, were members of any of the patient constituency classes (other than the carers' class) of RBHFT (as more particularly set out at Annex 3 to the RBHFT Constitution);

~~7.4.8.2~~7.4.10.2 Who have attended the Royal Brompton Hospital or the Harefield Hospital as patients within the period of five years immediately prior to applying to the Trust to become a Member of the RBH Patient Class; or

~~7.4.8.3~~7.4.10.3 Who have required regular or intermittent access to the services of the Royal Brompton Hospital or the Harefield Hospital over the course of a serial or long-term condition.

~~7.4.9~~7.4.11 The Members of the Patient Carer Class are members of the Patients' Constituency who;

~~7.4.9.1~~7.4.11.1 Immediately prior to its dissolution, were members of the carers' class of RBHFT; or

~~7.4.9.2~~7.4.11.2 Qualify as a Patient Carer under paragraph 7.4.4.

7.5 Disqualification from Membership

7.5.1 An individual shall not become or continue as a Member if:

7.5.1.1 they are or become ineligible under paragraphs 7.2, 7.3 or 7.4 to be a Member; or

7.5.1.2 the Council of Governors resolves for reasonable cause that their so doing would or would be likely to:

(a) prejudice the ability of the Trust to fulfil its principal purpose or other of its purposes under this Constitution or otherwise to discharge its duties and functions; or

(b) harm the Trust's work with other persons or bodies with whom it is engaged or may be engaged in the provision of goods and services; or

(c) adversely affect public confidence in the goods or services provided by the Trust; or

(d) otherwise bring the Trust into disrepute; or

7.5.1.3 the Council of Governors resolves or ever has resolved in accordance with paragraph 8.13.3~~8.13.3~~8.12.3 that their tenure as a Governor be terminated.

7.5.2 It is the responsibility of each Member to ensure their eligibility at all times and not the responsibility of the Trust to do so on their behalf. A Member who becomes aware of their ineligibility shall inform the Trust as soon as practicable and that person shall thereupon be removed forthwith from the Register of Members and shall cease to be a Member.

7.5.3 Where the Trust has reason to believe that a Member is ineligible for Membership under paragraphs 7.2, 7.3 or 7.4 or may be disqualified from Membership under this paragraph 7.5, the Secretary shall carry out reasonable enquiries to establish if this is the case.

7.5.4 Where the Secretary considers that there may be reasons for concluding that a Member or an applicant for membership may be ineligible or be disqualified from Membership they shall advise that individual of those reasons in summary form and invite representations from the Member or applicant for membership within 28 days or such other reasonable period as the Secretary may in their absolute discretion determine. ~~—~~Any representations received shall be considered by the Secretary and they shall make a decision on the Member's or applicant's eligibility or disqualification as soon as reasonably practicable and shall give notice in writing of that decision to the Member or applicant within 14 days of the decision being made.

7.5.5 If no representations are received within the said period of 28 days or such longer period (if any) permitted under the preceding paragraph, the Secretary shall be entitled nonetheless to proceed and make a decision on the Member's or applicant's eligibility or disqualification notwithstanding the absence of any such representations from them.

7.5.6 Any decision made under this paragraph 7.5 to disqualify a Member or an applicant for membership may be referred by the Member or applicant concerned to the Dispute Resolution Procedure under paragraph 222~~220~~.

7.6 Termination of Membership

7.6.1 A person's Membership shall be terminated if they:

7.6.1.1 resign by giving notice in writing to the Secretary;

7.6.1.2 are disqualified under paragraph 7.5; or

7.6.1.3 die.

7.6.2 When any of the circumstances set out in paragraph 7.6.1 arise the Secretary shall cause that person's name to be removed from the Register of Members forthwith and they shall thereupon cease to be a Member.

7.7 Voting at Council of Governors Elections

7.7.1 A Member may not vote at an election for a Public Governor or Patient Governor (as the case may be) unless within the specified period they have made a declaration in the specified form that they are a Member of the Public Constituency or Patients' Constituency (as the case may be) and stating the particulars of their qualification to vote as a Member of that Membership Constituency for which an election is being held. It is an offence knowingly or recklessly to make such a declaration which is false in a material particular.

7.7.2 The form and content of the declaration and the period for making such a declaration for the purposes of paragraph 7.7.1 shall be specified and published by the Trust from time to time and shall be so published not less than 28 days prior to an election.

8. COUNCIL OF GOVERNORS

8.1 The Trust shall have a Council of Governors which shall consist of forty ~~one~~three Governors as set out in paragraph 8.2. The aggregate number of Governors who are Public Governors or Patient Governors shall be more than half the total number of Governors.

8.2 The Council of Governors shall consist of:-

8.2.1 ten Public Governors elected in accordance with paragraph 8.5~~8.5~~8.4~~.~~.

8.2.2 twelve Patient Governors elected in accordance with paragraph 8.6~~8.6~~8.5~~.~~.

8.2.3 eight Staff Governors elected in accordance with paragraph 8.7~~8.7~~8.6~~.~~.

8.2.4 ~~thirteen~~ ten Partnership Governors comprising:

8.2.4.1 ~~three~~ two System Governors appointed in accordance with paragraph 8.8~~8.8~~8.7~~.~~.

8.2.4.2 three ~~four~~ Local Authority Governors appointed in accordance with paragraph 8.9~~8.9~~8.8~~.~~.

8.2.4.3 three~~four~~ University Governors appointed in accordance with paragraph 8.10~~8.10~~8.9~~.~~.

8.2.4.4 two Partner Hospital Governors appointed in accordance with paragraph 8.11~~8.11~~8.10~~.~~.

8.3 At all times more than half the Governors will be elected by members of the Public Constituency or the Patients' Constituency and the composition of the Council of Governors will satisfy the provisions of paragraph 9 of Schedule 7 to the Act.

~~8.3~~8.4 No person shall be eligible to be elected or appointed (as the case may be) a Governor in accordance with the terms of this Constitution unless at the date of their nomination for election or upon the date of their appointment they have attained the age of 18 years.

~~8.4~~8.5 Public Governors

~~8.4.1~~8.5.1 There shall be ten Public Governors elected from the Public Constituency. The number of Governors to be elected from each Public Constituency Area shall be as set out in Annex 1.

~~8.4.2 For the purposes of Annex 1, from the day of adoption of this revised constitution, any Public Governor previously elected from the Public Constituency shall be deemed as having been elected from Public Constituency Area 1.~~

~~8.4.3~~8.5.2 Members of the Public Constituency may elect any of their number to be a Public Governor, subject to paragraphs 8.4~~8.3~~ and 8.5.4~~8.5.4~~8.4.5~~.~~.

~~8.4.4~~8.5.3 If contested, the election shall be by secret ballot in accordance with the Election Scheme, using the first past the post method of voting.

~~8.4.5~~8.5.4 A person shall not stand for election to the Council of Governors as a Public Governor unless within the previous six months they have made a declaration in the form specified in Annex 4~~Annex 4~~Annex 4~~Annex 4~~:

~~8.4.5.1~~8.5.4.1 of the particulars of their qualification to vote as a Member of the Public Constituency

~~8.4.5.2~~8.5.4.2 that they are not prevented from being a Governor by Paragraph 8 of Schedule 7 to the 2006 Act; and

~~8.4.5.3~~8.5.4.3 that they are not otherwise disqualified under paragraph 8.14~~8.14~~8.13.

~~8.4.6~~8.5.5 A Public Governor shall not vote at a meeting of the Council of Governors unless within the period since their election they have made a declaration in the form specified in Annex 4~~Annex 4~~Annex 4.

~~8.4.7~~8.5.6 The declaration required under paragraphs 8.5.4.1~~8.5.4.1~~8.4.5.1 and 8.5.4.2~~8.5.4.2~~8.4.5.2 and the equivalent provisions of the declaration required under paragraph 8.5.5~~8.5.5~~8.4.6 are required by Section 60 of the 2006 Act. It is a criminal offence knowingly or recklessly to make a declaration under Section 60 of the 2006 Act which is false in a material particular.

~~8.5~~8.6 Patient Governors

~~8.5.1~~8.6.1 There shall be twelve Patient Governors elected from the Patients' Constituency. The number of Governors to be elected from each Patient Class shall be as set out in Annex 1.

~~8.5.2 For the purposes of Annex 1, from the day of adoption of this revised constitution, any Patient Governor previously elected from the Patients' Constituency who qualifies as a Patient Carer under paragraph 7.4.37.4.4 shall be deemed as having been elected from the Patient Carer Class.~~

~~8.5.3~~8.6.2 Members of the Patients' Constituency may elect any of their number to be a Patient Governor, subject to paragraph 8.4~~8.3~~ and paragraph 8.6.4~~8.6.4~~8.5.5.

~~8.5.4~~8.6.3 If contested, the election shall be by secret ballot in accordance with the Election Scheme, using the first past the post method of voting.

~~8.5.5~~8.6.4 A person shall not stand for election to the Council of Governors as a Patient Governor unless within the previous six months they have made a declaration in the form specified in Annex 4~~Annex 4~~Annex 4:

~~8.5.5.1~~8.6.4.1 of the particulars of their qualification to vote as a Member of the Patients' Constituency;

~~8.5.5.2~~8.6.4.2 that they are not prevented from being a Governor by Paragraph 8 of Schedule 7 to the 2006 Act; and

~~8.5.5.3~~8.6.4.3 that they are not otherwise disqualified under paragraph 8.14~~8.14~~8.13.

~~8.5.6~~8.6.5 A Patient Governor shall not vote at a meeting of the Council of Governors unless within the period since their election they have made a declaration in the form specified in Annex 4~~Annex 4~~Annex 4.

~~8.5.7~~8.6.6 The declaration required under paragraphs 8.6.4.1~~8.6.4.1~~8.5.5.1 and 8.6.4.2~~8.6.4.2~~8.5.5.2 and the equivalent provisions of the declaration required under paragraph 8.6.5~~8.6.5~~8.5.6 are required by Section 60 of the 2006 Act. It is a criminal offence knowingly or recklessly to make a declaration under Section 60 of the 2006 Act which is false in a material particular.

~~8.6~~8.7 Staff Governors

~~8.6.1~~8.7.1 There shall be eight Staff Governors elected from the Staff Constituency. The number of Governors to be elected from each Staff Class shall be as set out in Annex 1.

~~8.6.2 For the purposes of Annex 1, from the day of adoption of this revised constitution any Staff Governor previously elected from the CSD Staff Class, the Clinicalians Staff Class or Other Staff Class shall be deemed as having been elected from the GST CSD Staff Class, GST Clinicalians Staff Class or GST Other Staff Class respectively.~~

~~8.6.3~~8.7.2 Members of a Staff Class within the Staff Constituency may elect any of their number to be a Staff Governor for that Staff Class subject to paragraph 8.4 ~~8.3~~.

~~8.6.4~~8.7.3 If contested, the election will be by secret ballot in accordance with the Election Scheme, using the first past the post method of voting.

~~8.6.5~~8.7.4 A Staff Governor shall not vote at a meeting of the Council of Governors unless within the period since their election they have made a declaration in the form specified in Annex 4.

~~8.7~~8.8 System Governors

~~8.7.1~~8.8.1 Each of:

~~8.7.1.1~~8.8.1.1 the South East London ~~CCG~~ICB; and

~~8.7.1.2~~8.8.1.2 the North West London ~~Health and Care Partnership~~ICB,

are specified organisations for the purposes of paragraph 9(7) of Schedule 7 to the 2006 Act.

~~8.7.2~~8.8.2 The South East London ~~CCG~~ ICB shall be entitled to appoint ~~two~~ one System Governor~~s~~ and the North West London ~~Health and Care Partnership~~ICB shall be entitled to appoint one System Governor, in accordance with a process of appointment agreed with the Secretary. The absence of any such agreed process shall not preclude either organisations from appointing its System Governors.

~~8.7.3~~8.8.3 Notwithstanding the foregoing provisions of this paragraph the Trust shall in its absolute discretion be entitled:

~~8.7.3.1~~8.8.3.1 to give not less than six months' notice to any of the organisations referred to in paragraphs 8.8.1~~8.8.1~~~~8.7.1~~ and 8.8.2~~8.8.2~~~~8.7.2~~ terminating their right to appoint a System Governor and upon the expiration of that notice period or such other date as the Trust and the relevant organisation may agree that their right to appoint a System Governor shall be terminated and the period of office of the Governor appointed by that organisation shall also come to an end on that date; and

~~8.7.3.2~~8.8.3.2 to appoint another organisation for which the Trust provides goods and services to replace that organisation to which notice has been given under paragraph 8.8.3.1~~8.8.3.1~~~~8.7.3.1~~,

save that these provisions shall at all times be operated so as to ensure that the number of organisations entitled to appoint a System Governor under paragraph 8.8.1~~8.8.1~~~~8.7.1~~ remains lower or equal to the number of System Governors specified in paragraph 8.2.4.1.

~~8.8~~8.9 Local Authority Governors

~~8.8.1~~8.9.1 Each of the following local authorities :

~~8.8.1.1 London Borough of Hillingdon;~~

~~8.8.1.2~~8.9.1.1 London Borough of Lambeth;

~~8.8.1.3~~8.9.1.2 London Borough of Southwark; and

~~8.8.1.4~~8.9.1.3 Royal Borough of Kensington and Chelsea,

shall be entitled to appoint a member or officer of the local authority as a Local Authority Governor in accordance with a process of appointment agreed by it with the Secretary.

~~8.8.2~~8.9.2 The absence of any such agreed process of appointment shall not preclude either of the local authorities named in paragraph 8.9.1~~8.9.1~~8.8.1 from appointing its Local Authority Governor.

~~8.8.3~~8.9.3 If a local authority named in paragraph 8.9.1~~8.9.1~~8.8.1 declines or fails to appoint a Local Authority Governor within three months of being requested to do so by the Trust, the Secretary shall consult each local authority whose area includes the whole or part of the Area of the Trust and the Trust in its absolute discretion shall extend an invitation to any of those local authorities to appoint a Local Authority Governor in substitution for the local authority which has failed or declined to do so.

~~8.8.4~~8.9.4 A Local Authority Governor appointed under paragraph 8.9.3~~8.9.3~~8.8.3 shall then serve on the Council of Governors for the period stipulated in paragraph 8.12.4~~8.12.4~~8.11.4. At the end of that period the Trust shall in its absolute discretion decide whether for the purposes of paragraph 8.9.1~~8.9.1~~8.8.1 to permit that local authority which had failed or declined to appoint a Local Authority Governor to appoint a Local Authority Governor for the next period (provided it remains eligible to do so) or to invite the local authority which had appointed a Local Authority Governor in substitution to do so.

~~8.9~~8.10 University Governors

~~8.9.1~~8.10.1 The following organisations shall be entitled to appoint one University Governor in accordance with a process of appointment agreed by it with the Secretary:

~~8.9.1.1~~8.10.1.1 King's College London

~~8.9.1.2~~8.10.1.2 Imperial College London

~~8.9.1.3~~8.10.1.3 London Southbank University

~~8.9.1.4 An academic organisation chosen by the Board of Directors.~~

~~8.9.2~~8.10.2 The absence of any such agreed process shall not preclude any of the above from appointing its University Governor.

~~8.10~~8.11 Partner Hospital Governors

~~8.10.1~~8.11.1 The following organisations shall be entitled to appoint one Partner Hospital Governor in accordance with a process of appointment agreed by it with the Secretary:

~~8.10.1.1~~8.11.1.1 King's College Hospital NHS Foundation Trust; and

~~8.10.1.2~~8.11.1.2 South London and Maudsley NHS Foundation Trust.

~~8.10.2~~8.11.2 The absence of any such agreed process of appointment shall not preclude any Partner Hospital from appointing its Governor.

~~8.11~~8.12 Terms of Office

~~8.11.1~~8.12.1 A Public Governor:

~~8.11.1.1~~8.12.1.1 shall hold office for a period of three years;

~~8.11.1.2~~8.12.1.2 is eligible for re-election at the end of that period for two further terms of three years ~~for one further and final three year term~~; and

~~8.11.1.3~~8.12.1.3 shall cease to hold office if they cease to be a Member of the Public Constituency.

~~8.11.2~~8.12.2 A Patient Governor:

~~8.11.2.1~~8.12.2.1 shall hold office for a period of three years;

~~8.11.2.2~~8.12.2.2 is eligible for re-election at the end of that period for two further terms of three years ~~for one further and final three year term~~; and

~~8.11.2.3~~8.12.2.3 shall cease to hold office if they cease to be a Member of the Patients' Constituency.

~~8.11.3~~8.12.3 A Staff Governor:

~~8.11.3.1~~8.12.3.1 shall hold office for a period of three years;

~~8.11.3.2~~8.12.3.2 is eligible for re-election at the end of that period for two further terms of three years ~~for one further and final three year term~~; and

~~8.11.3.3~~8.12.3.3 shall cease to hold office if they cease to be a Member of the Staff Constituency.

~~8.11.4~~8.12.4 Subject to paragraph 8.12.5~~8.12.5~~~~8.11.5~~, a Partnership Governor:

~~8.11.4.1~~8.12.4.1 shall hold office for a period of three years;

~~8.11.4.2~~8.12.4.2 is eligible for reappointment at the end of that period for two further terms of three years ~~for one further and final three year term~~; and

~~8.11.4.3~~8.12.4.3 shall cease to hold office if the organisation which appointed them withdraws its appointment of them.

8.12.5 No Governor shall hold office for more than nine years in total. ~~of nine years in total on the Council~~.

~~8.11.5~~8.12.6 For the purposes of paragraph 8.12.4~~8.12.4~~~~8.11.4~~ above, Partnership Governors appointed before ~~the adoption of this revised constitution~~1 February 2021 shall be deemed as having been appointed for the first time on that~~e~~ day ~~of adoption of this revised constitution~~.

~~8.11.6~~8.12.7 Governors shall cease to be Governors forthwith if their tenure is terminated under paragraph 8.13~~8.13~~~~8.12~~ or they are disqualified from being a Governor under paragraph 8.14~~8.14~~~~8.13~~.

~~8.12~~8.13 Governor Termination of Tenure

~~8.12.1~~8.13.1 A Governor may resign from that office at any time during the term of that office by giving notice in writing to the Secretary.

~~8.12.2~~8.13.2 If a Governor fails to attend any meeting of the Council of Governors for a consecutive period of twelve months or alternatively for three successive meetings of the Council of Governors, their tenure of office shall be terminated immediately by the Secretary unless, on application by that Governor to the Council of Governors, the Council of Governors resolves that:

~~8.12.2.1~~8.13.2.1 the absence was due to reasonable cause; and

~~8.12.2.2~~8.13.2.2 the Governor will be able to start attending meetings of the Council of Governors within such a specified period as the Council of Governors considers reasonable.

~~8.12.3~~8.13.3 The Council of Governors may, by a resolution requiring a majority of not less than 75% of ~~the Council of Governors~~those present and entitled to vote at a properly constituted meeting of the Council of Governors, terminate a Governor's tenure of office if for reasonable cause it considers that:

~~8.12.3.1 they are disqualified from becoming or continuing as a Member under this Constitution; or~~

~~8.12.3.2~~8.13.3.1 they have knowingly or recklessly made a false declaration for any purpose provided for under this Constitution or in the 2006 Act; or

~~8.12.3.3~~8.13.3.2 their continuing as a Governor would or would be likely to:

(a) contravene the Code of Conduct for Governors as set out at Annex 5~~Annex 5~~~~Annex 5~~ or as may be otherwise adopted by the Trust from time to time; or

(b) prejudice the ability of the Trust to fulfil its principal purpose or other of its purposes under this Constitution or otherwise to discharge its duties and functions; or

(c) harm the Trust's work with other persons or bodies with whom it is engaged or may be engaged in the provisions of goods and services; or

(d) adversely affect public confidence in the goods or services provided by the Trust; or

(e) otherwise bring the Trust into disrepute.

~~8.12.4~~8.13.4 Upon a Governor resigning under paragraph 8.13.1~~8.13.1~~~~8.12.1~~, or upon the Council of Governors resolving to terminate a Governor's tenure of office under paragraphs 8.13.2~~8.13.2~~~~8.12.2~~ or 8.13.3~~8.13.3~~~~8.12.3~~ that Governor shall cease to be a Governor and their name shall be forthwith removed from the Register of Governors notwithstanding any reference to the Dispute Resolution Procedure.

~~8.12.5~~8.13.5 Any decision of the Council of Governors to terminate a Governor's tenure of office may be referred by that Governor to the Dispute Resolution Procedure within 28 days of the date upon which notice in writing of the Council of Governors' decision is given to the Governor.

~~8.12.6~~8.13.6 A Governor who resigns under paragraph 8.13.1~~8.13.1~~~~8.12.1~~ or whose tenure of office is terminated under paragraph 8.13.2~~8.13.2~~~~8.12.2~~ shall not be

eligible to stand for re-election for a period of three years from the date of their resignation or removal from office or the date upon which any appeal against their removal from office is disposed of, whichever is the later.

8.12.78.13.7 A Governor whose tenure of office is terminated under paragraph 8.13.38.13.38.12.3 shall not be eligible to stand for re-election.

8.138.14 Disqualification

8.13.18.14.1 A person may not become or continue as a Governor if:

8.13.1.18.14.1.1 they are a Director or Secretary of the Trust, or a governor, director or secretary of another Health Service Body, unless they are appointed as a Partnership Governor by an organisation which is a Health Service Body;

8.13.1.28.14.1.2 they are an occupant of the same household as, and/or they are an immediate family member of, a Governor or a Director or Secretary of the Trust;

8.13.1.38.14.1.3 in the case of a Staff Governor, Public Governor or Patient Governor they cease to be a Member of the Membership Constituency or the Class of a Membership Constituency by which they were elected;

8.13.1.48.14.1.4 in the case of any other Governor the appointing organisation withdraws its appointment of them;

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

8.14.1.6 they are subject to a moratorium period under a debt relief order (under Part 7A of the Insolvency Act 1986);

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

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

8.13.1.88.14.1.9 they are the subject of a Sex Offenders Order and/or their name in included in the Sex Offenders Register;

8.13.1.98.14.1.10 they have failed or refused to undergo Disclosure and Barring Service checks in accordance with the Trust's DBS Policy;

8.13.1.108.14.1.11 by reference to information revealed by a Disclosure and Barring Service check, they are considered by the Trust to be inappropriate on the grounds that their appointment may adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;

8.13.1.118.14.1.12 ~~Monitor~~ NHS England has exercised its powers to remove that person as a Governor or has suspended them from office or has disqualified them from holding office as a Governor for a specified period or ~~Monitor~~ NHS England has exercised any of those powers in relation to the person concerned at any time

whether in relation to the Trust or some other NHS Foundation Trust;

~~8.13.1.12~~8.14.1.13 they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a Health Service Body;

~~8.13.1.13~~8.14.1.14 they are a person whose tenure of office as chair or as a governor, member or director of a Health Service Body has been terminated on the grounds that their appointment was not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

~~8.13.1.14~~8.14.1.15 they have had their name removed, from a relevant list of medical practitioners pursuant to Paragraph 10 of the National Health Service (Performers Lists) (England) Regulations 2013 or Section 151 of the 2006 Act (or similar provision elsewhere), and have not subsequently had their name included in such a list;

~~8.13.1.15~~8.14.1.16 they are incapable by reason of mental disorder, illness or injury of managing and administering their property and affairs;

~~8.13.1.16~~8.14.1.17 they have failed or refused to make any declaration required by paragraph 8.5~~8.5~~8.4 or 8.6~~8.6~~8.5; or

~~8.13.1.17~~8.14.1.18 they refuse~~s~~ to confirm that they will abide by the Code of Conduct for Governors as set out at Annex 5~~Annex 5~~Annex 5 or as may be otherwise adopted by the Trust from time to time.

~~8.13.2~~8.14.2 The provisions of paragraph 8.14.1~~8.14.1~~8.13.1 apply to elected and appointed Governors and to those seeking election or appointment.

~~8.13.3~~8.14.3 Where an individual has been elected or appointed to be a Governor and they become disqualified for appointment they shall notify the Secretary in writing of such disqualification as soon as practicable and in any event within 14 days of first becoming aware of those matters which render them disqualified.

~~8.13.4~~8.14.4 If it comes to the notice of the Secretary that the Governor is disqualified, whether at the time of the Governor's appointment or later, the Secretary shall immediately declare that the individual in question is disqualified and give notice to them in writing to that effect as soon as practicable and in any event within 14 days of the date of the said declaration.

~~8.13.5~~8.14.5 Upon the giving of notice under paragraph 8.14.3~~8.14.3~~8.13.3 or paragraph 8.14.4~~8.14.4~~8.13.4 that individual's tenure of office, if any, shall be terminated forthwith and they shall cease to be a Governor and their name shall be removed from the Register of Governors. Any Governor may refer any dispute they may have with regard to that decision to the Dispute Resolution Procedure at paragraph 22~~22~~20.

~~8.14~~8.15 Vacancies

~~8.14.1~~8.15.1 Where a Governor's membership of the Council of Governors ceases for one of the reasons set out in paragraph 8.13~~8.13~~8.12 or paragraph 8.14~~8.14~~8.13, Public Governors, Staff Governors and Patient Governors shall be replaced in accordance with paragraphs 8.15.2~~8.15.2~~8.14.2 to 8.15.5~~8.15.5~~8.14.5 and other Governors shall be replaced in accordance with

the processes for appointment agreed with the relevant appointing body pursuant to paragraphs 8.8~~8.8~~.8~~7~~ to 8.11~~8.11~~8.~~10~~.

8.14.2~~8~~.15.2 For the purposes of paragraphs 8.15.3~~8.15.3~~8.14.3 to 8.15.5~~8.15.5~~8.14.5 the following definitions apply:

8.14.2.1~~8~~.15.2.1 A "**cohort**" consists of those Governors in the same Membership Constituency (or Class of a Membership Constituency, as the case may be) whose current term of office commenced on the same date.

8.14.2.2~~8~~.15.2.2 A "**first vacancy**" is where an ~~elected~~ Elected Governor ceases to hold office during their term of office and they are the first Governor from their cohort to do so.

8.14.2.3~~8~~.15.2.3 A "**second vacancy**" is where an ~~elected~~ Elected Governor ceases to hold office during their term of office and they are not the first Governor from their cohort to do so.

8.14.3~~8~~.15.3 Subject to paragraph 8.15.4~~8.15.4~~8.14.4:

8.14.3.1~~8~~.15.3.1 on the occurrence of a first vacancy the Trust shall offer the candidate who secured the next highest number of votes in the last election for the Membership Constituency (or Class of a Membership Constituency, as the case may be) in which the vacancy has arisen the opportunity to assume the vacant office (the "**Reserve Governor**").

8.14.3.2~~8~~.15.3.2 If the Reserve Governor assumes the vacant office, they shall hold office for a period of three years. They will be eligible for re-election at the end of that period for one further and final three year term, except where they have previously held office as a Governor in that Membership Constituency.

8.14.3.3~~8~~.15.3.3 If the Reserve Governor is unwilling to fill the vacancy, an election will be held in accordance with the Election Scheme as soon as reasonably practicable.

8.14.4~~8~~.15.4 Where an election is due to be called within six months of a first vacancy having arisen, the office will stand vacant until such election, unless this causes the aggregate number of Governors who are Public Governors and Patient Governors to be less than half the total membership of the Council of Governors. In that event the vacancy shall be filled in accordance with paragraph 8.15.3~~8.15.3~~8.14.3.

8.14.5~~8~~.15.5 On the occurrence of a second vacancy an election will be held in accordance with the Election Scheme, save that if an election is due to be called within six months of the vacancy having arisen the office will stand vacant until such election, unless this causes the aggregate number of Governors who are Public Governors and Patient Governors to be less than half the total membership of the Council of Governors. In that event an election will be held in accordance with the Election Scheme as soon as reasonably practicable.

8.14.6~~8~~.15.6 The Returning Officer under the Election Scheme shall maintain a record of votes cast at each election under the Election Scheme for the above purposes and the Returning Officer shall conduct or shall oversee the conducting of the process set out in paragraphs 8.15.3~~8.15.3~~8.14.3 and 8.15.5~~8.15.5~~8.14.5.

~~8.15~~8.16 Roles and Responsibilities of the Council of Governors

~~8.15.1~~8.16.1 The general responsibilities of the Council of Governors are to:

~~8.15.1.1~~8.16.1.1 hold the non-executive Directors individually and collectively to account for the performance of the Board of Directors; and

~~8.15.1.2~~8.16.1.2 represent the interests of the Members of the Trust as a whole and the interests of the public.

~~8.15.2~~8.16.2 The specific rights and duties of the Council of Governors are:

~~8.15.2.1~~8.16.2.1 in a ~~General Meeting~~general meeting of the Council of Governors to:

(a) appoint or remove the Chair and the other non-~~-~~executive Directors of the Trust. The removal of any non-executive Director shall require the approval of three-quarters of the total number of Governors;

(b) approve the appointment of the Chief Executive of the Trust by the non-executive Directors;

(c) decide the remuneration and expenses and the other terms and conditions of office of the non-executive Directors;

(d) appoint or remove the Trust's auditor; and

(e) receive and consider the Trust's annual accounts, any auditor's reports on those annual accounts and the annual report from the Board of Directors;

~~8.15.2.2~~8.16.2.2 to be consulted by the Board of Directors regarding the Board of Directors' preparation of the forward planning information for each Financial Year;

~~8.15.2.3~~8.16.2.3 to determine whether it is satisfied that the carrying on of any proposed Non Principal Purpose Activity will not to any significant extent interfere with the fulfilment by the Trust of the Principal Purpose or the performance of its other functions;

~~8.15.2.4~~8.16.2.4 to approve any proposal to increase by 5% or more the proportion of the Trust's total income in any Financial Year attributable to Non Principal Purpose Activities;

~~8.15.2.5~~8.16.2.5 to approve any Significant Transaction, and to be consulted before the Trust enters into any Material Transaction;

~~8.15.2.6~~8.16.2.6 to respond as appropriate when consulted by the Board of Directors;

~~8.15.2.7~~8.16.2.7 to require one or more Directors to attend a meeting of the Council of Governors for the purpose of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or Directors' performance);

~~8.15.2.8~~8.16.2.8 to approve any merger, acquisition, separation or dissolution~~-~~ application in respect of the Trust before the application is made to NHS England; and

~~application in respect of the Trust before the application is made to Monitor; and~~

~~8.15.2.9~~8.16.2.9 to exercise such other powers and to discharge such other duties as may be conferred on the Council of Governors under this Constitution.

~~8.15.3~~8.16.3 If ~~Monitor~~NHS England has appointed a panel for advising governors, a Governor may refer a question to that panel as to whether the Trust has failed or is failing to act in accordance with this Constitution or Chapter 5 of the 2006 Act. A Governor may only refer a question under this paragraph if more than half of the members of the Council of Governors voting approve the referral.

~~8.15.4~~8.16.4 All Governors shall comply with the Code of Conduct for Governors set out in Annex 5~~Annex 5~~~~Annex 5~~.

~~8.16~~8.17 Expenses

~~8.16.1~~8.17.1 Governors shall not receive remuneration for acting as Governors but may receive expenses as provided for in this paragraph.

~~8.16.2~~8.17.2 The Trust may pay travelling and other expenses to Governors at the rates set out in the Trust's policy on Business Travel and Subsistence.

~~8.17~~8.18 Meetings

~~8.17.1~~8.18.1 The Council of Governors shall comply with the Standing Orders for its practice and procedure set out in Annex 2.

~~8.17.2~~8.18.2 The Council of Governors shall meet not less than three times in each Financial Year.

8.18.3 The Trust shall publicise and hold a general meeting of the Council of Governors to take place each calendar year ~~in September July of each year.~~ at which the Council of Governors shall receive from the Board of Directors in accordance with paragraph 9.11.11~~9.11.11~~9.10.11 and shall then consider:

(a) the Trust's annual accounts;

(b) any report of the auditor on them; and

~~(a)~~(c) the Trust's annual report~~.~~

~~8.17.3~~8.18.4 No proceedings of the Council of Governors shall be invalidated by any vacancy in its membership or any defect in the appointment or election of any Governor.

~~8.18~~8.19 Lead Governor

8.19.1 The Council of Governors shall appoint one of its Elected Governors as Lead Governor in accordance with the terms of appointment set out in the Lead Governor Role Description approved by the Council of Governors.

~~8.18.1 In this paragraph 8.18 only:~~

~~8.18.1.1 "**Appointment Meeting**" means:~~

- ~~if there is an Election in a calendar year, the first meeting of the Council of Governors to take place after the Election; or~~

- if there is no Election scheduled in a calendar year, the first meeting of the Council of Governors to take place after the anniversary of the last Election, and

8.18.1.2 "**Election**" means an election to fill a vacancy on the Council of Governors other than an election under paragraph 8.14.3.3 or 8.14.5.

8.18.2 Any Governor who, immediately after the Appointment Meeting, will have at least one year of their term remaining, may nominate themselves for the office of Lead Governor by giving notice to the Chair at least ten clear days before the Appointment Meeting.

8.18.3 As long as at least one nomination has been received in accordance with paragraph 8.18.2, the Council of Governors shall appoint the Lead Governor at the Appointment Meeting.

8.18.4 If:

8.18.4.1 one nomination has been received, the nominated Governor shall be appointed Lead Governor at the Appointment Meeting;

8.18.4.2 more than one nomination has been received, the Council of Governors shall choose the Lead Governor by paper ballot at the Appointment Meeting, and if there is an equality of votes, the tied nominees shall draw lots to decide which of them shall be chosen;

no nomination has been received, the office shall lie vacant until the next Appointment Meeting.

8.18.58.19.2 The Secretary shall ensure that MonitorNHS England is provided with details of the serving Lead Governor.

8.18.6 Subject to paragraph 8.18.7, the Lead Governor shall hold office until the results are announced of the next Election after their appointment.

8.18.7 If no Election is held within one calendar year of the incumbent Lead Governor's appointment, the Lead Governor shall hold office for one year.

8.18.8 The serving Lead Governor may nominate themselves for re-appointment as long as they will have at least one year of their term as a Governor remaining after the next Appointment Meeting.

8.18.9 The Lead Governor may resign from the office at any time by giving written notice to the Chair, and shall cease to hold the office immediately if they cease to be a Governor or if they become leader of any working group of the Council of Governors.

If a Lead Governor ceases to hold office during their term, the second- placed nominee in the last ballot for the office shall be offered the opportunity to assume the vacant office for the unexpired balance of the retiring Lead Governor's term. If that candidate does not agree to fill the vacancy it will then be offered to the third-placed nominee and so on until the vacancy is filled. If no candidate is available or willing to fill the vacancy, the office shall remain vacant until the next Appointment Meeting.

8.18.108.19.3 The Lead Governor's duties shall be as follows:

8.18.10.18.19.3.1 facilitating communication between Governors and members of the Board of Directors;

~~8.18.10.2~~8.19.3.2 assisting the Chair in setting the agenda for meetings of the Council of Governors and other meetings involving Governors;

~~8.18.10.3~~8.19.3.3 chairing the Council of Governors when required to do so by the Standing Orders attached at Annex 2;

~~8.18.10.4~~8.19.3.4 contributing to the appraisal of the Chair in such manner and to such extent as the person conducting the appraisal may see fit;

~~8.18.10.5~~8.19.3.5 initiating proceedings to remove a Governor where circumstances set out in this Constitution for removal have arisen (without prejudice to the right of any other Governor to initiate such proceedings);

~~8.18.10.6~~8.19.3.6 liaising, as appropriate, with councils of governors for other NHS Foundation Trusts, and

~~8.18.10.7~~8.19.3.7 such other duties, consistent with the 2006 Act and this Constitution, as may be approved by the Governors.

~~8.19~~8.20 Nominations Committee

~~8.19.1~~8.20.1 The Council of Governors may appoint a Nominations Committee consisting of all or some Governors to assist it in carrying out the functions set out in paragraph 9.6 but not otherwise.

~~8.20~~8.21 Conflict of Interest of Governors

~~8.20.1~~8.21.1 If a Governor has a pecuniary interest, whether direct or indirect, in any contract, proposed contract or other matter which is under consideration by the Council of Governors or has any other conflict of interest they shall disclose that to the rest of the Council of Governors as soon as they are aware of it.

~~8.20.2~~8.21.2 The Council of Governors shall abide by the Standing Orders attached at Annex 2 specifying the arrangements for excluding Governors from discussion or consideration of the contract or other matter as appropriate where the Governor has a pecuniary interest or any other conflict of interest in relation to it.

~~8.21 Transitional provisions~~

~~8.21.1 Notwithstanding anything to the contrary in this Constitution:~~

~~8.21.1.1 From the date of adoption of this revised Constitution all Governors shall be appointed or elected (as the case may be) in accordance with its provisions.~~

~~8.21.1.2 Each Governor serving at the date of adoption of this revised Constitution shall serve under the arrangements existing at the time of their election or appointment (as the case may be).~~

~~8.21.1.3 For the avoidance of doubt, at all times more than half the Governors will be elected by members of the Public Constituency or the Patients' Constituency and the composition of the Council of Governors will satisfy the provisions of paragraph 9 of Schedule 7 to the Act.~~

9. BOARD OF DIRECTORS

9.1 The Trust shall have a Board of Directors which shall consist of executive and non-executive Directors.

9.2 The Board of Directors shall comprise:

9.2.1 the following non-executive Directors:

9.2.1.1 a Chair; and

9.2.1.2 no fewer than five nor more than eleven other non-executive Directors one of whom shall be appointed having been nominated by King's College London; and

9.2.2 the following executive Directors:

9.2.2.1 a Chief Executive (who shall also at all times be the Accounting Officer);

9.2.2.2 a Finance Director; and

9.2.2.3 not less than three nor more than nine~~six~~ other executive Directors.

9.3 The executive Directors shall include one person who is a registered medical practitioner or registered dentist (within the meaning of the Dentists Act 1984) and one other who is to be a registered nurse or registered midwife.

9.4 The power to appoint non-executive Directors and executive Directors shall at all times be exercised so as to ensure that the aggregate voting rights vested in the Chair and non-executive Directors exceed the aggregate of those votes vested in the executive Directors. The Directors shall at all times have one vote each save that the Chair shall be entitled to exercise a second or casting vote where the number of votes for and against a motion is equal.

9.5 Only a Member of the Public Constituency or the Patients Constituency or an individual exercising functions for King's College London may be appointed as a non-executive Director.

9.6 Non-executive Directors are to be appointed as follows:

9.6.1 The Council of Governors shall create a duly authorised Nominations Committee consisting of some or all Governors in accordance with paragraph 8.20~~8.18~~;

9.6.2 The Nominations Committee shall seek the views of the Board of Directors as to their recommended criteria and process for the selection of candidates and, having regard to those views, shall then seek, shortlist and interview such candidates as the Nominations Committee considers appropriate and shall make recommendations to the Council of Governors as to potential appointments as non-executive Directors and shall advise the Board of Directors of those recommendations;

9.6.3 The Nominations Committee shall be at liberty to request the attendance of and seek advice and assistance from persons other than members of the Nominations Committee or other Governors in arriving at its said recommendations; and

9.6.4 The Nominations Committee shall provide advice to the Council of Governors on the levels of remuneration for the Chair and non-executive Directors.

9.6.5 The Nominations Committee shall receive reports on behalf of the Council of Governors on the process and outcome of appraisal for the Chair and non-executive Directors.

9.6.6 The Council of Governors shall resolve in general meeting to appoint such candidate or candidates as they consider appropriate and shall have regard to the recommendation of the Nominations Committee and views of the Chief Executive and the Board of Directors in reaching that decision. The Secretary will convey the decision of the Council of Governors to the successful candidate.

9.7 The validity of any act of the Trust shall not be affected by any vacancy among the Directors or by any defect in the appointment of any Director.

9.8 Terms of Office

9.8.1 The non-executive Directors ~~(excluding the Chair)~~(including the Chair) shall be eligible for appointment for two four-year terms of office, and in exceptional circumstances a further term of two years. No non-executive Director ~~(excluding the Chair)~~ shall be appointed to that office for a total period which exceeds ten years in aggregate.

~~9.8.2 The Chair shall be eligible for appointment for two four year terms of office, and in exceptional circumstances a further term of four two years. The Chair shall not be appointed to that office for a total period which exceeds twelve years in aggregate.~~

~~9.8.3~~9.8.2 The executive Directors including the Chief Executive (and Accounting Officer) and the Finance Director shall hold office for a period in accordance with the terms and conditions of office decided by the relevant committee of non-executive Directors.

~~9.8.4~~9.8.3 Where a non-executive Director, other than a non-executive Director appointed having been nominated by King's College London, ceases to be a Member they shall cease to be eligible to be a non-executive Director and shall resign as such or if they fail or decline to do so they shall be removed from office in accordance with the terms of this Constitution.

9.9 The Senior Independent Director

9.9.1 In consultation with the Council of Governors, the Board of Directors may appoint one of the independent non-executive Directors as the Senior Independent Director, for such term (not exceeding the remainder of their term as non-executive director) as defined in their terms of appointment.

9.9.2 The Senior Independent Director shall perform the role set out in the NHS Foundation Trust Code of Governance, and any such other functions as defined in their terms of appointment (in consultation with the Council of Governors).

~~9.9~~9.10 Disqualification

~~9.9.1~~9.10.1 A person may not become or continue as a Director if:

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

9.10.1.2 they are subject to a moratorium period under a debt relief order (under Part 7A of the Insolvency Act 1986);

~~9.9.1.1~~9.10.1.3 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;

~~9.9.1.2~~9.10.1.4 they have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them;

9.10.1.5 they do not to satisfy all the fit and proper person requirements referred to in Regulations 5(3) and 5(4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014;

9.10.1.6 in the case of a non-executive Director,

(a) they no longer satisfy paragraph 9.5; or

~~(a)~~(b) they are the Chair, the Chief Executive or an ordinary member of South East London ICB or North West London ICB.

~~9.9.1.3~~9.10.1.7 they are otherwise disqualified at law from acting as a director of an NHS Foundation Trust;

~~9.9.1.4~~9.10.1.8 ~~Monitor~~NHS England has exercised its powers under the 2006 Act to remove that person as a Director of the Trust or any other Foundation Trust within their jurisdiction or has suspended them from office or has disqualified them from holding office as a Director of the Trust or of any other Foundation Trust for a specified period;

~~9.9.1.5~~9.10.1.9 they are a person whose tenure of office as 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 public service, for non-attendance at meetings or for non-disclosure of a pecuniary interest;

~~9.9.1.6~~9.10.1.10 they have had their name removed, from a relevant list of medical practitioners pursuant to Paragraph 14 of the National Health Service (Performers Lists) (England) Regulations 2013 or Section 151 of the 2006 Act (or similar provision elsewhere), and has not subsequently had their name included in such a list; ~~or~~

~~9.9.1.7~~9.10.1.11 they have within the preceding two years been dismissed otherwise than by reason of redundancy from any paid employment with a Health Service Body.~~.~~

~~9.9.2~~9.10.2 Any person who is disqualified from becoming or continuing as a Director on any of the grounds set out in paragraph 9.10.1~~9.10.1~~9.9.1 shall forthwith resign as a Director of the Trust or if they decline or fail to do so shall be removed forthwith by the Board of Directors and a new Director appointed in their place in accordance with the provisions of this Constitution.

~~9.10~~9.11 Roles and Responsibilities

~~9.10.1~~9.11.1 The powers of the Trust shall be exercisable by the Board of Directors on its behalf.

~~9.10.2~~9.11.2 Any of those powers may be delegated to a committee of Directors or to an executive Director in accordance with a Scheme of Delegation approved by the Board of Directors.

9.10.39.11.3 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.

9.10.49.11.4 Subject to paragraph 9.11.39.11.39.10.3, a committee established pursuant to paragraph 9.11.29.11.29.10.2 above may meet in common with a committee of Directors of another NHS Foundation Trust.

9.10.59.11.5 A committee of non-executive Directors established as an audit committee shall monitor, review and carry out such functions in relation to the auditor outlined in paragraph 161614 as are appropriate.

9.10.69.11.6 The non-executive Directors shall appoint or remove the Chief Executive (and Accounting Officer). The appointment of a Chief Executive (but not their removal) shall require the approval of the Council of Governors.

9.10.79.11.7 A committee consisting of the Chair, the Chief Executive (and Accounting Officer) and the other non-executive Directors shall appoint the executive Directors.

9.10.89.11.8 The Trust shall establish a committee of non-executive Directors to decide the remuneration and allowances and the other terms and conditions of office of the executive Directors.

9.10.99.11.9 The Trust may establish advisory committees whose membership may include Governors, executive and non-executive Directors of the Trust, external advisors and other persons as the Trust may think fit.

9.10.109.11.10 The Board of Directors shall provide forward planning information in respect of each Financial Year to MonitorNHS England. The Board of Directors shall have regard to the views of the Council of Governors when preparing the forward planning information.

9.10.119.11.11 The Board of Directors shall present to the Council of Governors in a general meeting the Trust's annual accounts, any report of the auditor on them, and the Trust's annual report.

9.10.129.11.12 All the functions of the Trust under paragraphs 17.417.415.4, 17.517.515.5 and 17.717.715.7 are delegated by this Constitution to the Chief Executive as Accounting Officer.

10. ANNUAL PUBLIC MEETING OF THE MEMBERS

10.1.1 The Trust shall hold a public meeting of its Members in September each year. This meeting may be combined with the meeting of the Council of Governors referred to in paragraph 8.18.38.18.38.17.3.

10.1.2 At least one Director shall attend the meeting and present the following documents to the Members at the meeting:

10.1.2.1 the annual accounts

10.1.2.2 any report of the auditor on them; and

10.1.2.3 the annual report.

10.1.3 Where an amendment has been made to this Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust), at least one Governor shall attend the next annual public meeting to be held, at which the

Governor shall present the amendment and the Members shall be entitled to vote on whether they approve the amendment.

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

11. JOINT WORKING AND DELEGATION ARRANGEMENTS

11.1 The Trust may make arrangements for the joint exercise of any of its functions jointly with any other person.

11.2 For the purposes of exercising of its functions jointly with any other or more of the following bodies:

11.2.1 a Relevant Body;

11.2.2 a Local Authority;

11.2.3 a Combined Authority,

the Trust may:

11.2.4 establish a joint committee with the relevant body or bodies and arrange for the relevant functions to be exercised by that joint committee;

11.2.5 arrange for one or more of the bodies, or a joint committee of the bodies, to establish and maintain a Pooled Fund.

11.3 The Trust must have regard to any guidance published by NHS England under section 65Z7 of the NHS Act 2006.

~~11.~~12. MEETINGS OF DIRECTORS

~~11.1~~12.1 The Board of Directors shall adopt Standing Orders covering the proceedings and business of its meetings. These shall include setting a quorum for meetings, both of executive and non-executive Directors. The proceedings shall not however be invalidated by any vacancy of its membership or defect in a Director's appointment.

~~11.2~~12.2 Before holding a meeting, the Board of Directors shall send a copy of the agenda to the Council of Governors.

~~11.3~~12.3 As soon as practicable after holding a meeting, the Board of Directors shall send a copy of the minutes of the meeting to the Council of Governors.

~~11.4~~12.4 Meetings of the Board of Directors shall be open to members of the public, unless and to the extent that the Board of Directors has resolved that members of the public should be excluded from a meeting for such special reasons as the Board of Directors considers appropriate.

~~12.~~13. CONFLICTS OF INTEREST OF DIRECTORS

~~12.1~~13.1 Each Director has a duty to avoid a situation in which the Director has or can have a direct or indirect interest that conflicts or possibly may conflict with the interests of the Trust. This duty is not infringed if the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or if the matter has been authorised in accordance with this Constitution.

~~12.2~~13.2 Each Director has a duty not to accept a benefit from a third party by reason of being a director or doing or not doing anything in that capacity. This duty is not

infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

~~12.3~~13.3 If a Director is aware that they have in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, they shall disclose the nature and extent of that interest to the other Directors as soon as they are aware of it and in all cases, before the Trust enters into the transaction or arrangement. If any declaration proves to be or becomes inaccurate or incomplete, the Director shall make a further declaration.

~~12.4~~13.4 A Director need not declare an interest:

~~12.4.1~~13.4.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

~~12.4.2~~13.4.2 if, or to the extent that, the directors are already aware of it;

~~12.4.3~~13.4.3 if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered:

~~12.4.3.1~~13.4.3.1 by a meeting of the Board of Directors; or

~~12.4.3.2~~13.4.3.2 by a committee of the Directors appointed for that purpose under this Constitution.

~~12.5~~13.5 The Board of Directors shall adopt Standing Orders making further provision about Directors' interests and specifying the arrangements for excluding Directors from discussion or consideration of a contract or other matter as appropriate.

~~13.~~14. REGISTERS

~~13.1~~14.1 The Trust shall have and maintain:

~~13.1.1~~14.1.1 a Register of Members showing, in respect of each Member, the Membership Constituency (and Class within a Membership Constituency, where appropriate) to which they belong;

~~13.1.2~~14.1.2 a register of Governors;

~~13.1.3~~14.1.3 a register of interests of Governors;

~~13.1.4~~14.1.4 a register of Directors; and

~~13.1.5~~14.1.5 a register of interests of Directors.

~~13.2~~14.2 The information to be included in the above registers shall be such as will comply with the requirements of the 2006 Act, any subordinate legislation made under it and the provisions of this Constitution.

~~13.3~~14.3 Members will be removed from the Register of Members if:

~~13.3.1~~14.3.1 the Member is no longer eligible or is disqualified; or

~~13.3.2~~14.3.2 the Member dies.

~~14.~~15. PUBLIC DOCUMENTS

~~14.1~~15.1 The following documents of the Trust shall be available for inspection by members of the public free of charge at all reasonable times:

~~14.1.1~~15.1.1 a copy of the current Constitution;

~~14.1.2~~15.1.2 a copy of the latest annual accounts and of any report of the auditor on them; and

~~14.1.3~~15.1.3 a copy of the latest annual report.

~~14.2~~15.2 All documents required by Paragraphs 22(1)(g) to 22(1)(p) inclusive of Schedule 7 to the 2006 Act (relating to special administration) shall be available for inspection by members of the public free of charge at all reasonable times.

~~14.3~~15.3 Any person who requests it shall be provided with a copy or extract from any of the above documents.

~~14.4~~15.4 If the person requesting a copy or extract under this paragraph is not a Member of the Trust, the Trust may impose a reasonable charge for providing the copy or extract.

~~14.5~~15.5 The registers mentioned in paragraph 14~~14~~12 shall all be made available for inspection by members of the public except in circumstances prescribed by regulations made under the 2006 Act. The Trust shall not make any part of its Register of Members available for inspection by members of the public that shows details of:

~~14.5.1~~15.5.1 any Member who belongs to the Patients' Constituency where that Member has not consented to their details being made so available; or

~~14.5.2~~15.5.2 any other Member if they so request.

~~15.~~16. AUDITOR

~~15.1~~16.1 The Trust shall have an auditor and shall provide the auditor with every facility and all information which they may reasonably require for the purposes of their functions under Chapter 5 of Part 2 of the 2006 Act.

~~15.2~~16.2 A person may only be appointed auditor if they (or in the case of a firm each of its members) are eligible for appointment as a statutory auditor or local auditor within the meaning of Paragraphs 23(4)(a) or (aa) 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.

~~15.3~~16.3 The appointment of the auditor by the Council of Governors is covered in paragraph 8.16.2.1~~8.16.2.1~~8.15.2.1(d), and the monitoring of the auditor's functions by a committee of non-executive Directors is covered in paragraph 9.11.5~~9.10.3~~.

~~15.4~~16.4 The auditor shall carry out their duties in accordance with Schedule 10 to the 2006 Act and in accordance with any directions given by ~~Monitor~~NHS England on standards, procedures and techniques to be adopted.

~~16.~~17. ACCOUNTS

~~16.1~~17.1 The Trust shall keep proper accounts and proper records in relation to the accounts, which shall comply with any directions made by ~~Monitor~~NHS England with the approval of the Secretary of State, as to the content and form of the Trust's accounts.

~~16.2~~17.2 The accounts shall be audited by the Trust's auditor.

~~16.3~~17.3 The following documents shall be made available to the Comptroller and Auditor General for examination at their request:

~~16.3.1~~17.3.1 the accounts;

~~16.3.2~~17.3.2 the records relating to them; and

~~16.3.3~~17.3.3 any report of the auditor on them.

~~16.4~~17.4 The Trust (through its Chief Executive and Accounting Officer) shall prepare in respect of each Financial Year annual accounts in such form as ~~Monitor~~NHS England may with the approval of the Secretary of State direct.

~~16.5~~17.5 The Trust shall comply with any directions given by ~~Monitor~~NHS England with the approval of the Secretary of State as to:

~~16.5.1~~17.5.1 the period or periods in respect of which the Trust should prepare accounts; and

~~16.5.2~~17.5.2 the audit requirements of any such accounts.

~~16.6~~17.6 In preparing accounts the Trust shall comply with any directions given by NHS England ~~Monitor~~ with the approval of the Secretary of State as to:

~~16.6.1~~17.6.1 the methods and principles according to which the accounts are to be prepared; and

~~16.6.2~~17.6.2 the content and form of the accounts.

~~16.7~~17.7 The Trust shall:

~~16.7.1~~17.7.1 lay a copy of the annual accounts, and any report of the auditor on them, before Parliament;

~~16.7.2~~17.7.2 send copies of those documents to ~~Monitor~~NHS England within such period as ~~Monitor~~NHS England may direct; and

~~16.7.3~~17.7.3 send copies of any accounts prepared pursuant to paragraph 15.5, and any report of an auditor on them to ~~Monitor~~ NHS England within such period as ~~Monitor~~ NHS England may direct.

~~17.~~18. ANNUAL REPORTS AND FORWARD PLANS

~~17.1~~18.1 The Trust shall prepare annual reports and send them to ~~Monitor~~NHS England.

18.2 The reports shall, in particular, review the extent to which the Trust has exercised its functions:

18.2.1 in accordance with the plans published under section 14Z52 (joint forward plans for integrated care board and its partners) and section 14Z56 (joint capital resource plan for integrated care board and its partners) of the 2006 Act;

18.2.2 consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised) of the 2006 Act.

~~give information on:~~

~~17.2~~18.3 The reports shall also give information on:

~~17.2.1~~18.3.1 the impact that income received by the Trust from Non Principal Purpose Activities has had on the Principal Purpose.

~~17.2.2~~18.3.2 any steps taken by the Trust to secure that (taken as a whole) the actual Membership of its Public Constituency and the Patients' Constituency is representative of those eligible for such Membership;

~~17.2.3~~18.3.3 any exercise by the Council of Governors of its power to require a Director to attend a meeting for the specific reasons set out in paragraph 8.16.2.7~~8.16.2.7~~~~8.15.2.7~~;

~~17.2.4~~18.3.4 the Trust's policy on pay, on the work of the committee of non-executive Directors established to decide the remuneration and allowances and the other terms and conditions of office of the executive Directors, and on such other procedures as the Trust has on pay;

~~17.2.5~~18.3.5 the remuneration of the Directors and on the expenses of the Governors and the Directors; and

~~17.2.6~~18.3.6 any other information ~~Monitor~~NHS England requires.

~~17.3~~18.4 The Trust shall comply with any decision ~~Monitor~~NHS England makes as to:

~~17.3.1~~18.4.1 the form of the reports;

~~17.3.2~~18.4.2 when the reports are to be sent to it; and

~~17.3.3~~18.4.3 the periods to which the reports are to relate.

~~17.4~~18.5 The Trust shall give information to ~~Monitor~~NHS England as to its forward planning in respect of each Financial Year. The forward planning information shall be prepared by the Board of Directors who in doing so shall have regard to the views of the Council of Governors (which in turn may be informed by a group of Governors).

~~17.5~~18.6 The forward planning information shall include information on:

~~17.5.1~~18.6.1 the Non Principal Purpose Activities that the Trust proposes to carry on; and

~~17.5.2~~18.6.2 the income that the Trust expects to receive from doing so.

~~17.6~~18.7 Where the forward planning information contains a proposal that the Trust carry out Non Principal Purpose Activities, the Council of Governors shall:

~~17.6.1~~18.7.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of the Principal Purpose or the performance of its other functions; and

~~17.6.2~~18.7.2 notify the Board of Directors of its determination.

~~17.7~~18.8 The Trust may only implement any proposal to increase by 5% or more the proportion of its total income in any Financial Year attributable to Non Principal Purpose Activities if more than half of the members of the Council of Governors voting approve the proposal's implementation.

~~18.~~19. SIGNIFICANT TRANSACTIONS

~~18.1~~19.1 The Trust may enter into a Significant Transaction only if more than half of the members of the Council of Governors voting approve entering into the transaction.

~~18.2~~19.2 "**Significant Transaction**" means:

~~18.2.1~~19.2.1 the acquisition of, or an agreement to acquire, whether contingent or not, assets the value of which is more than 25% of the value of the Trust's gross assets before the acquisition; or

~~18.2.2~~19.2.2 the disposition of, or an agreement to dispose of, whether contingent or not, assets of the Trust the value of which is more than 25% of the value of the Trust's gross assets before the disposition; or

~~18.2.3~~19.2.3 a transaction that has or is likely to have the effect of the Trust acquiring rights or interests or incurring obligations or liabilities, including contingent

liabilities, the value of which is more than 25% of the value of the Trust's gross assets before the transaction.

~~18.3~~19.3 For the purpose of this paragraph 19~~19~~17~~17~~:

~~18.3.1~~19.3.1 "gross assets" means the total of fixed assets and current assets;

~~18.3.2~~19.3.2 in assessing the value of any contingent liability for the purposes of sub-paragraph 19.2.3~~19.2.3~~17.2.3~~17.2.3~~, the Directors:

~~18.3.2.1~~19.3.2.1 must have regard to all circumstances that the Directors know, or ought to know, affect, or may affect, the value of the contingent liability; and

~~18.3.2.2~~19.3.2.2 may rely on estimates of the contingent liability that are reasonable in the circumstances; and

~~18.3.2.3~~19.3.2.3 may take account of the likelihood of the contingency occurring.

~~18.4~~19.4 The views of the Council of Governors will be taken into account before the Trust enters into any proposed transaction which would exceed a threshold of 10% for any of the criteria set out in paragraph 19.2~~19.2~~17.2~~17.2~~ (a "Material Transaction").

~~19.~~20. INDEMNITY

~~19.1~~20.1 Governors and Directors who act honestly and in good faith and not recklessly will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Council of Governors or Board of Directors functions. Any such liabilities will be liabilities of the Trust.

~~19.2~~20.2 The Trust may make such arrangements as it considers appropriate for the provision of indemnity insurance or similar arrangement for the benefit of the Trust to meet all or any liabilities which are properly the liabilities of the Trust under paragraph 20.1~~20.1~~18.1~~18.1~~.

~~20.~~21. INSTRUMENTS ETC

~~20.1~~21.1 The Trust is to have a seal which shall not be affixed except under the authority of the Board of Directors.

~~20.2~~21.2 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.

~~21.~~22. DISPUTE RESOLUTION PROCEDURE

~~21.1~~22.1 The Trust shall apply the Dispute Resolution Procedure set out at Annex 6~~Annex 6~~Annex 6~~Annex 6~~ to this Constitution in regard to disputes:

~~21.1.1~~22.1.1 with Members and potential Members in relation to matters of eligibility and disqualification; and

~~21.1.2~~22.1.2 with Governors in relation to matters of eligibility, disqualification and termination of tenure; and

~~21.1.3~~22.1.3 between the Council of Governors and the Board of Directors in relation to the interpretation and application of their respective powers and obligations under this Constitution.

~~22.~~23. AMENDMENT OF THE CONSTITUTION

~~22.1~~23.1 The Trust may make amendments to this Constitution only if:

~~22.1.1~~23.1.1 more than half of the members of the Board of Directors voting; and

~~22.1.2~~23.1.2 more than half of the members of the Council of Governors voting, approve the amendments.

~~22.2~~23.2 An amendment shall have no effect in so far as the Constitution would, as a result of the amendment, not accord with Schedule 7 of the 2006 Act.

~~22.3~~23.3 The Trust shall inform ~~Monitor~~NHS England of amendments to the Constitution.

~~22.4~~23.4 If an amendment relates to the powers or duties of the Council of Governors, paragraphs 10.1.3~~10.1.39.11.3~~ and 10.1.4~~10.1.49.11.4~~ shall apply.

~~23.~~24. MERGERS, ACQUISITIONS, SEPARATIONS AND DISSOLUTION

~~23.1~~24.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

ANNEX 1:

CONSTITUENCIES OF THE TRUST

1.	2.	3.	4.
Name of Membership Constituency	Area/Qualification	Minimum number of Members	Number of Governors
Public Constituency Area 1 – around Guy's and St. Thomas' Hospitals	The London Borough of Lambeth, The London Borough of Southwark, The London Borough of Lewisham, The London Borough of Wandsworth, The City of Westminster.	250	8
Public Constituency Area 2 – around Royal Brompton and Harefield Hospitals	1. North London Comprising the following electoral areas: Harrow; Hillingdon; Brent; Ealing; Hounslow; Kensington & Chelsea and Hammersmith & Fulham; Barnet; Enfield; Haringey; Camden; Islington; City; Tower Hamlets; Hackney; Waltham Forest; Newham; Barking & Dagenham; Redbridge; Havering. and 2. Bedfordshire, Hertfordshire & Essex Comprising the following electoral areas: Bedford; Central Bedfordshire; Luton; Broxbourne; Dacorum; East Herts; Hertsmere; North Herts; St Albans; Stevenage; Three Rivers; Watford; Welwyn; Hatfield; Harlow; Epping Forest; Brentwood; Basildon; Castle Point; Rochford; Maldon; City of Chelmsford; Uttlesford; Braintree; Colchester; Tendring; Thurrock; Southend.	150	1
Public Constituency Area 3 – the rest of England and Wales	All other electoral wards and boroughs in England and Wales not included above	50	1

GST Patient Class	Patients as defined in paragraph 7.4.97.4.97.4.7 of this Constitution	250	7
RBH Patient Class	Patients as defined in paragraph 7.4.107.4.107.4.8 of this Constitution	250	3
Patient Carer Class	Patient Carers as defined in paragraph 7.4.117.4.117.4.9 of this Constitution	100	2
GST CSD Staff Class	As defined in paragraph 7.3.6 of this Constitution	100	1
GST Clinicalians Staff Class	As defined in paragraph 7.3.7 of this Constitution	100	3
GST Other Staff Class	As defined in paragraph 7.3.8 of this Constitution	100	2
RBH Clinicians Clinical Staff Class	As defined in paragraph 7.3.9 of this Constitution	100	1
RBH Other Staff Class	As defined in paragraph 7.3.10 of this Constitution	100	1

ANNEX 2:

STANDING ORDERS FOR THE REGULATION OF PROCEEDINGS AND BUSINESS OF THE COUNCIL OF GOVERNORS

These Standing Orders form part of the Constitution of the Guy's & St. Thomas' Hospital NHS Foundation Trust.

1. INTERPRETATION

1.1 The Chair shall be the final authority on the interpretation of Standing Orders.

2. THE TRUST

2.1 All business shall be conducted in the name of the Trust.

3. MEETINGS OF THE COUNCIL OF GOVERNORS

3.1 **Admission of the Public and the Press** - The public and representatives of the press shall be afforded facilities to attend all meetings of the Council of Governors but shall be required to withdraw upon the Council of Governors resolving as follows:

> "*That representatives of the Press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted publicity on which would be prejudicial to the public interest*".

3.2 The right of attendance referred to above carries no right to ask questions or otherwise participate in the meeting.

3.3 The Chair (or other person presiding under the provisions of Standing Order 3.14) shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press to ensure that the business of the meeting shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Council of Governors resolving as follows:

> "*That in the interests of public order the meeting adjourn for (the period to be specified) to enable the completion of business without the presence of the public*".

Nothing in these Standing Orders shall require the Council of Governors to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Council of Governors.

3.4 **Calling Meetings** - Ordinary meetings of the Council of Governors shall be held at such times and places as it may determine.

3.5 Meetings of the Council of Governors may only be called in accordance with this paragraph. The Chair may call a meeting of the Council of Governors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Governors, has been presented to them, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to them, at the Trust's headquarters, such one third or more Members may forthwith call a meeting.

3.6 **Notice of Meetings** - Before each meeting of the Council of Governors a notice of the meeting, specifying the business proposed to be transacted at it and indicating that it

has been approved by the Chair or by an officer of the Trust authorised by the Chair, ~~and signed by the Chair or by an officer of the Trust authorised by the Chair to sign on their behalf~~ shall be delivered to every Governor by electronic means or, where expressly requested by a Governor, by post to their usual place of residence, ~~or sent by post to the usual place of residence of such Governor~~ so as to be available to them at least ~~seven~~ five clear days before the meeting.

3.7 Subject to Standing Order 3.9, lack of service of the notice on any Governor shall not affect the validity of a meeting.

3.8 In the case of a meeting called by Governors in default of the Chair, the notice shall be signed by those Governors and no business shall be transacted at the meeting other than that specified in the notice.

3.9 The notice referred to in Standing Order 3.8 shall be delivered to each Governor by electronic means, or, where expressly requested by a Governor, by post to their usual place of residence. Failure to serve such a notice on more than three Governors will invalidate the meeting. ~~A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.~~

3.10 Before each meeting of the Council of Governors a public notice of the time and place of the meeting, and the public part of the agenda, shall be ~~displayed~~ published ~~at~~ on the Trust's ~~office~~ website at least three clear days before the meeting.

3.11 **Setting the Agenda** - The Council of Governors may determine that certain matters shall appear on every agenda for a meeting of the Council of Governors and shall be addressed prior to any other business being conducted. (Such matters may be identified within these Standing Orders or following subsequent resolution shall be listed in an Appendix to the Standing Orders.)

3.12 A Governor desiring a matter to be included on an agenda shall make their request in writing to the Chair at least 10 clear days before the meeting, subject to Standing Order 3.6. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chair.

3.13 **Chair of Meeting** – The Chair shall preside at meetings of the Council of Governors and shall be entitled to exercise a casting vote where the number of votes for and against a motion is equal.

3.14 If the Chair is absent from a meeting of the Council of Governors, the ~~Governors~~ Chair shall appoint another non-executive Director to preside over that meeting and they shall exercise all the rights and obligations of the Chair including the right to exercise a second or casting vote where the number of votes for and against a motion is equal.

3.15 If any matter for consideration at a meeting of the Council of Governors relates to the conduct or interests of the Chair or of the non-executive Directors as a class, neither the Chair nor any of the non-executive Directors shall preside over the period of the meeting during which the matter is under discussion. In these circumstances the period of the meeting shall be chaired by the Lead Governor, or in their absence, by another Governor chosen by the Governors. This person shall exercise all the rights and obligations of the Chair including the right to exercise a second or casting vote where the number of votes for and against a motion is equal.

3.16 **Notices of Motion** – A Governor desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This Standing Order shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to Standing Order 3.8.

3.17 **Withdrawal of Motion or Amendments** - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.18 **Motion to Rescind a Resolution** - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Governor(s) who gives it and also the signature of four other Governors. When any such motion has been disposed of by the Council of Governors, it shall not be competent for any Governor to propose a motion to the same effect within six months; however the Chair may do so if they consider it appropriate.

3.19 **Motions** - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

3.20 When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:

3.20.1 An amendment to the motion.

3.20.2 The adjournment of the discussion or the meeting.

3.20.3 That the meeting proceed to the next business.

3.20.4 The appointment of an ad hoc committee to deal with a specific item of business.

3.20.5 That the motion be now put.

3.21 No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

3.22 **Chairman's Ruling** - Statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevance, regularity and any other matters shall be observed at the meeting.

3.23 **Voting** – If, in the opinion of the Chair, a vote should be required on a question at a meeting, the result shall be determined by a majority of the votes of the Governors present and voting on the question. A Governor who attends the meeting by electronic means allowing simultaneous communication with all other persons attending the meeting (whether in person or by electronic means) shall be deemed to be present.

3.24 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot, or an equivalent electronic voting method, may also be used if a majority of the Governors present so request.

3.25 If a Governor so requests, their vote (other than by paper ballot or equivalent electronic voting method) shall be recorded by name upon any vote. ~~(other than by paper ballot).~~

3.26 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

3.27 **Minutes** - The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting ~~where they will be signed by the person presiding at it.~~

3.28 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.29 Minutes shall be circulated with the notice of the next meeting or otherwise in accordance with Governors' wishes. Where providing a record of a public meeting, the minutes shall be made available to the public.

3.30 **Suspension of Standing Orders** - Except where this would contravene any provision of the constitution or any statutory provision or any direction made by ~~Monitor~~NHS England, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Governors are present, including one ~~elected~~ Elected Governor and one nominated Governor and that a majority of those present vote in favour of suspension.

3.31 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

3.32 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Governors.

3.33 No formal business may be transacted while Standing Orders are suspended. Formal business shall include the proposal of motions and the determination of questions and resolutions, by voting or otherwise.

3.34 The Audit Committee of the Board of Directors shall review every decision of the Council of Governors to suspend Standing Orders.

3.35 **Record of Attendance** - The names of the Governors present at the meeting shall be recorded in the minutes.

3.36 **Quorum** - No business shall be transacted at a meeting of the Council of Governors unless at least one-third of the whole number of Governors are present including at least one elected Member from the Public Constituency, one elected member from the Patients' Constituency, one elected Member from the Staff Constituency and one nominated Governor. A Governor who attends the meeting by electronic means allowing simultaneous communication with all other persons attending the meeting (whether in person or by electronic means) shall be deemed to be present.

3.37 If a Governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Order 7~~7~~6 or 8~~8~~7) they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.38 Any resolution for the removal of a non-executive Director shall require the approval of three-quarters of the total number of Governors.

4. WRITTEN RESOLUTIONS

4.1 At the discretion of the Chair, or upon a requisition signed by at least one-third of the whole number of Governors, a matter which may be decided by the Council of Governors in a meeting other than a general meeting of the Council of Governors may be determined by way of a written resolution signified by the Governors who would have been entitled to vote upon it had it been proposed at a meeting of the Council of Governors.

4.2 A written resolution shall include the following:

4.2.1 A description of the matter to be decided and any accompanying documents;

4.2.2 A conflicts of interest declaration;

4.2.3 Guidance notes informing Governors how to signify their agreement to the resolution and the date by which it must be passed if it is not to lapse.

4.3 A copy of the written resolution shall be circulated by the Secretary to all Governors by electronic means (or, where expressly requested by a Governor, by post to their usual place of residence) either by way of identical documents sent to all Governors, or by way of a single document to be signified by all Governors.

24.2 A written resolution may comprise several copies to which one or more Governors have signified their agreement.

4.4 A written resolution is passed when:

4.4.1 For decisions requiring a simple majority, a majority of the Members of the Council of Governors signify their agreement to the resolution; or

4.4.2 For decisions requiring a 75% majority, at least 75% of the Members of the Council of Governors signify their agreement to the resolution.

4.5 A written resolution will lapse if the requisite majority of Members of the Council of Governors fail to signify their agreement to the written resolution within 28 days beginning with the circulation date.

4.6 The Secretary shall keep a record of all written resolutions passed.

~~4.~~5. NOMINATIONS COMMITTEE

~~4.1~~5.1 The Council of Governors shall create a duly authorised Nominations Committee consisting of some or all of its Members in accordance with paragraph 8.20~~8.20~~8.19 of the Constitution.

~~4.2~~5.2 The Nominations Committee shall seek the views of the Board of Directors as to their recommended criteria and process for the selection of candidates and, having regard to those views, shall then seek, shortlist and interview such candidates as the Nominations Committee considers appropriate and shall make recommendations to the Council of Governors as to potential appointments as non-executive Directors and shall advise the Board of Directors of those recommendations.

~~4.3~~5.3 Subject to any provisions to the contrary in this Standing Order 4, the provisions of Standing Order 3, as far as they are applicable, shall apply with appropriate alteration to meetings of the Nominations Committee.

~~4.4~~5.4 The Secretary shall attend the Nominations Committee and take minutes of any proceedings.

~~4.5~~5.5 The Nominations Committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Council of Governors), as the Council of Governors, shall decide subject to the provisions of the Constitution. Such terms of reference shall have effect as if incorporated into the Standing Orders.

~~4.6~~5.6 The Council of Governors shall approve the appointments to the Nominations Committee. The chair of the Nominations Committee shall be the Chair.

~~4.7~~5.7 **Confidentiality** - A member of the Nominations Committee shall not disclose a matter dealt with by, or brought before, the Nominations Committee without its permission until the Nominations Committee shall have reported to the Council of Governors or shall otherwise have concluded on that matter.

~~4.8~~5.8 A member of the Nominations Committee shall not disclose any matter reported to or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or the committee shall resolve that it is confidential.

~~5.~~6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

5.16.1 Interests which should be regarded as "relevant and material" and which, for the avoidance of doubt, should be included in the register, are:

(a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).

(b) Ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

(c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.

(d) A position of authority in a charity or voluntary organisation in the field of health and social care.

(e) Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services.

(f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks.

(g) Membership of clubs, societies or organisations whose purpose may include furthering the business or personal interests of their members by undeclared or informal means. Such organisations include Masonic lodges and religious societies whose membership consists of professional and business people.

If Governors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair.

5.26.2 At the time the interests are declared, they should be recorded in the Council of Governors minutes as appropriate. Any changes in interests should be officially declared at the next Council meeting following the change occurring. It is the obligation of the Governor to inform the Secretary of the Trust in writing within 7 days of becoming aware of the existence of a relevant or material interest. The Secretary will amend the Register upon receipt within 3 working days.

5.36.3 Governors' directorships of companies (Standing Order 6.16.15.1(a)), or in companies likely or possibly seeking to do business with the NHS (Standing Order 6.16.15.1(b)), should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

5.46.4 During the course of a Council meeting, if a conflict of interest is established, the Governor(s) concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established (including by way of written resolution). If there is a dispute as to whether a conflict of interest does exist, a majority will resolve the issue with the Chair having the casting vote.

5.56.5 There is no requirement for the interests of Governors' spouses or partners to be declared. Note however that Standing Order 887 requires that the interest of Governors' spouses, if living together, in contracts should be declared.

5.66.6 **Register of Interests** - The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Member Governors. In particular the Register will include details of all directorships and other relevant and material interests which have been declared, as defined in Standing Order 6.26.25.2.

5.76.7 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

5.86.8 The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

6.7. DISABILITY OF CHAIR OR GOVERNOR IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

6.17.1 Subject to the following provisions of this Standing Order, if a Governor or the Chair has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Council of Governors at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

6.27.2 The Trust may require the Chair or a Governor to withdraw from a meeting of the Council of Governors while any contract, proposed contract or other matter in which they have a pecuniary interest, is under consideration.

6.37.3 For the purpose of this Standing Order the Chair or Governor shall be treated, subject to Standing Order 8.28.27.2 and Standing Order 8.68.67.6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

(a) they, or a nominee of their, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

(b) they are a partner of, or are in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

(c) and in the case of family or close personal relationships the interest of one party shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

6.47.4 The Chair or Governor shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only of their membership of a company or other body, they no beneficial interest in any securities of that company or other body of an interest in any company, body or person with which they are connected as mentioned in Standing Order 7.37.36.3 which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a member or director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

6.57.5 Where the Chair or a Governor:

(a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

(b) the total nominal value of those securities does not exceed one-hundredth of the total nominal value of the issued share capital of the company or body, and

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which they have a beneficial interest does not exceed one-hundredth of the total issued share capital of that class; and

this Standing Order shall not prohibit them from taking part in the consideration or discussion of a contract or other matter or from voting on any question with respect to it without prejudice however to their duty to disclose their interest.

6.67.6 Standing Order 887 applies to the committee of the Council of Governors as it applies to the Council of Governors and applies to any member of the committee as it applies to a Governor.

7.8. STANDARDS OF BUSINESS CONDUCT

7.18.1 **Interest of Governors in Contracts** - If it comes to the knowledge of a Governor, that a contract in which they have any pecuniary interest not being a contract to which they are a party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive of the fact that they are interested therein. In the case of married persons, or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

7.28.2 A Governor must also declare to the Chief Executive any other employment or business or other relationship of theirs, or of a member of their family or of someone with whom they have a close personal relationship, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

7.38.3 **Canvassing of, and Recommendations by, Governors in Relation to Appointments** - Canvassing of Governors directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

7.48.4 A Governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this Standing Order shall not preclude a Governor from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.58.5 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

7.68.6 **Relatives of Governor** - Candidates for any staff appointment shall when making application disclose in writing whether they are related to any Governor. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render the, liable to instant dismissal.

7.78.7 The Governors shall disclose to the Chief Executive any relationship with a candidate of whose candidature that Governor is aware. It shall be the duty of the Chief Executive to report to the Council of Governors and Board of Directors any such disclosure made.

7.88.8 On election or appointment, Governors should disclose to the Trust whether they are related to any other Governor or holder of any office under the Trust.

7.98.9 Where the relationship of a Governor is disclosed, the Standing Order headed 'Disability of Chair or Governor in proceedings on account of pecuniary interest' (Standing Order 6) shall apply.

8.9. MISCELLANEOUS

8.19.1 **Standing Orders to be given to Governors** - It is the duty of the Chief Executive to ensure that existing Governors and all new Governors are notified of and understand their responsibilities within Standing Orders.

8.29.2 **Review of Standing Orders** – These Standing Orders shall be reviewed every two yearsannually by the Council of Governors. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

8.39.3 Variation and Amendment of Standing Orders - These Standing Orders shall be amended only if:

(a) a notice of motion under Standing Order 3.16 has been given; and no fewer than two thirds of the total of the Governors vote in;

(b) favour of amendment; and

(c) the variation proposed does not contravene a statutory provision or direction made by ~~Monitor~~NHS England.

ANNEX 3

ELECTION SCHEME

MODEL ELECTION RULES 2014

PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

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

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

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

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

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

"*e-voting*" means voting using either the internet, telephone or text message; "*e-voting information*" has the meaning set out in rule 24.2;

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

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

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

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

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

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

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

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

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

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

"*telephone voting facility*" has the meaning set out in rule 26.2; "*telephone voting record*" has the meaning set out in rule 26.5 (d);

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

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

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

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

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

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

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

PART 2: TIMETABLE FOR ELECTIONS

2. Timetable

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

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

3. Computation of time

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

a Saturday or Sunday;

Christmas day, Good Friday, or a bank holiday, or

a day appointed for public thanksgiving or mourning,

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

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

PART 3: RETURNING OFFICER

4. Returning Officer

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

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

5. Staff

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

6. Expenditure

6.1 The corporation is to pay the returning officer:

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

such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

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

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

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

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

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

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

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

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,

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

the contact details of the returning officer

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:

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

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:

full name,

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

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

11. Declaration of interests

11.1 The nomination form must state:

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

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

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

12. Declaration of eligibility

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

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

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

13. Signature of candidate

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

(a) they wish to stand as a candidate,

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

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

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

14. Decisions as to the validity of nomination

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

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

(b) decides that the nomination form is invalid,

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

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

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

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

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

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

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

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

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

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

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

15. Publication of statement of candidates

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

15.2 The statement must show:

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

(b) the declared interests of each candidate standing, as given in their nomination form.

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

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

16. Inspection of statement of nominated candidates and nomination forms

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

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

17. Withdrawal of candidates

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

18. Method of election

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

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

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

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

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

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot

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

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

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

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

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

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

(i) configured in accordance with these rules; and

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

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

(iii) configured in accordance with these rules; and

(iv) 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:

(v) configured in accordance with these rules; and

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

20. The ballot paper

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

20.2 Every ballot paper must specify:

(a) the name of the corporation,

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

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

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

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

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

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

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

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

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

(a) that the voter is the person:

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

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

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

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

("declaration of identity")

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

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

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

Action to be taken before the poll

22. List of eligible voters

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

22.2 The list is to include, for each member:

(a) a postal address; and,

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

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

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

23. Notice of poll

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

(a) the name of the corporation,

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

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

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

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

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

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

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

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

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

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

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

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

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

(a) a ballot paper and ballot paper envelope,

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

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

(d) a covering envelope; ("postal voting information").

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

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

(b) the voter's voter ID number,

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

("e-voting information").

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

(a) only be sent postal voting information; or

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

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

for the purposes of the poll.

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

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

25. Ballot paper envelope and covering envelope

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

25.2 The covering envelope is to have:

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

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

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

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

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

26. E-voting systems

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

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

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").

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

(a) require a voter to:

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

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

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

(b) specify:

(i) the name of the corporation,

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

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

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

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

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

(vii) the contact details of the returning officer;

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

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

(i) the voter's voter ID number;

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

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

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

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

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

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

(a) require a voter to

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

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

(b) specify:

(i) the name of the corporation,

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

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

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

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

(vi) the contact details of the returning officer;

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

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

(i) the voter's voter ID number;

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

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

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

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

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

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

(a) require a voter to:

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

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

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

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

(c) 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

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

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

The poll

27. Eligibility to vote

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

28. Voting by persons who require assistance

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

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

29. Spoilt ballot papers and spoilt text message votes

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

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

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

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

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

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

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

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

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

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

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

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

(a) the name of the voter, and

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

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

30. Lost voting information

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

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

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

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

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

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

(a) the name of the voter

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

(c) the voter ID number of the voter.

31. Issue of replacement voting information

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

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

(a) the name of the voter,

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

(c) the voter ID number of the voter.

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

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

Polling by internet, telephone or text

33. Procedure for remote voting by internet

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

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

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

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

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

34. Voting procedure for remote voting by telephone

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

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

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

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

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

35. Voting procedure for remote voting by text message

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

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

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

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

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

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

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

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

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

(b) the unique identifier on a ballot paper.

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

37. Validity of votes

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

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

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

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

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

(a) mark the ballot paper "disqualified",

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

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

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

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

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

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

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

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

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

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

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

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

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

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

39. De-duplication of votes

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

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

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

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

(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.

PART 6: COUNTING THE VOTES

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:

(i) ballot papers that have been returned; and

(ii) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word “rejected” on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub- paragraphs (a) to (c) of rule STV44.3.

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 next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing 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 is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub- parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(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.

STV53. Declaration of result for uncontested elections

STV53.1 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.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with "rejected in part",

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

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

54.2 The returning officer must not open the sealed packets of:

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

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

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

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

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll,

or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

The returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the 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 –

(b) any rejected ballot papers, including ballot papers rejected in part,

(i) any rejected text voting records, including text voting records rejected in part,

(ii) any disqualified documents, or the list of disqualified documents,

(iii) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(iv) the list of eligible voters, or

(v) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established–

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

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

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(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).

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift,

donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 4:

DECLARATION OF ELIGIBILITY TO STAND FOR ELECTION TO THE COUNCIL OF GOVERNORS AND TO VOTE AT A MEETING OF THE COUNCIL OF GOVERNORS

GUY'S & ST THOMAS' NHS FOUNDATION TRUST

1. A person shall not stand for election to the Council of Governors as a Public Governor or as a Patient Governor unless within the previous six months they have made a declaration in the form specified in this Annex 4:

   1.1 of the particulars of their qualification to vote as a Member of the Public Constituency;

   1.2 that they are not prevented from being a Governor by Paragraph 8 of Schedule 7 to the 2006 Act; and

   1.3 that they are not otherwise disqualified under paragraph 8.148.148.13.

2. An ~~elected~~ Elected Governor shall not vote at a meeting of the Council of Governors unless within the period since their election they have made a declaration in the form specified in this Annex 4.

3. Paragraph 8 of Schedule 7 to the 2006 Act provides that you may not become or continue as a Governor of the Trust if you have been:

   3.1 adjudged bankrupt or your estate has been sequestrated and, in either case you have not been discharged;

   3.2 you have made a composition or arrangement with, or entered into a Trust Deed for your creditors and you have not been discharged in respect of it; or

   3.3 you are a person who has in the preceding five years has been convicted in the British Islands of any offence for which a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on you;

4. There are other circumstances in which you may not become or continue as a Member of the Trust or a Governor. Before voting at a Council of Governor's meeting you should satisfy yourself as to your eligibility and that you are not disqualified. A copy of the Constitution can be obtained from the Trust Secretary.

5. If you are in any doubt as to your eligibility please contact the Trust Secretary.

6. Would you therefore please complete the information below and return it to the Trust in accordance with the instructions given in the final paragraph.

7. This document constitutes your formal declaration for the purposes of Section 60(3) of the 2006 Act.

8. **IT IS A CRIMINAL OFFENCE** if you make a declaration which you know to be false in some material respect or if you make such a declaration recklessly which is false in some material respect.

9. ***If you wish to vote at a meeting of the Council of Governors this form must be returned to the Trust Secretary after your election and before the vote in question.***

1. My Name	
2. My Address	
3. My Trust Membership Number	
4. The Membership Constituency of which I am a Member is as appears opposite (*insert full name of Membership Constituency of which you are a Member*)	
5. The details of why I am entitled to be a Member of that Class are as appears opposite (*insert details*)	
6. I declare (a). that the above statements are correct to the best of my knowledge and belief and (b). I remain eligible to be a Member of the above Membership Constituency and am not otherwise disqualified from membership of the Trust (c). I am not prevented from being a Governor by Paragraph 8 of Schedule 7 to the National Health Service Act 2006	
Signature	Date

ANNEX 5:

CODE OF CONDUCT FOR GOVERNORS

As a member of the Guy's and St Thomas' NHS Foundation Trust Council of Governors I will:

- Do right to all manner of people without fear or favour, affection or ill-will;
- Treat other Governors, Directors and Trust staff with respect and fairness at all times
- Uphold the Nolan principles of public life
- Act at all times in the best interests of the Trust and refrain from acting in a manner that could reasonably be regarded as bringing my office or the Trust into disrepute
- Actively support the values of the Trust in developing as a successful Foundation Trust; so as to maximise the benefits for the members and the public
- Act to support the directors with a view to promoting success of the Trust at all times
- Contribute to the work of the Council of Governors in order for it to fulfil its role and functions as defined in the Trust's constitution
- Recognise that the role of the Council of Governors is as part of the governance of the Trust and so the governors have no managerial role
- Respect the confidentiality of information received as a governor
- Adhere to the Trust's rules and policies, including the constitution, standing orders and standing financial instructions
- Regularly attend meetings of the Council of Governors, members' meetings and training events
- Conduct myself in a manner that reflects positively on the Foundation Trust, acting as an ambassador for the Trust

The Seven Principles of Public Life (Nolan)

Selflessness

Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

Integrity

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness

Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership

Holders of public office should promote and support these principles by leadership and example.

These principles apply to all aspects of public life. The Nolan Committee has set them out here for the benefit of all who serve the public in any way.

ANNEX 6:

DISPUTE RESOLUTION PROCEDURE

1. In the event of a dispute with:

   (a) a Member or prospective Member in relation to matters of eligibility or disqualification; or

   (b) a Governor or prospective Governor in relation to matters of eligibility, disqualification or termination of tenure,

   the individual concerned shall be invited to an informal meeting with the Secretary or with one or more Directors to discuss the matters in dispute, any Director(s) to be determined by mutual agreement of the Secretary and the individual concerned. If not resolved, the dispute shall be referred to a panel consisting of the Chair, at least one ~~elected~~ Elected Governor and either the Secretary or at least one Director. The decision of that panel shall be final.

2. A dispute arising between the Council of Governors and the Board of Directors shall be referred to the joint consideration of a panel consisting of the Chair, the Chief Executive and two Governors nominated by the Council of Governors. The Chair shall not participate in the nomination of Governors to this panel. The panel shall use all reasonable endeavours to facilitate the resolution of the dispute.

3. In the event that a resolution is not reached under paragraph 2 of this Dispute Resolution Procedure the panel constituted pursuant to that paragraph shall consult the Council of Governors and Board of Directors to determine whether the matter should be referred to mediation, in which case, an external mediator shall be appointed by the Centre for Dispute Resolution or such other organisation as the panel shall agree.

4. Nothing in this Dispute Resolution Procedure shall preclude any party from referring any dispute to a court of competent jurisdiction in England and Wales, or a Governor from exercising their right under paragraph 8.16.3~~8.16.3~~8.15.3 of the Constitution.

Guy's and St Thomas' NHS Foundation Trust

BOARD OF DIRECTORS
AUDIT AND RISK COMMITTEE

Wednesday 28th February 2024, 1.15pm – 4.15pm
Robens Suite, Guy's Hospital

Members present:	Nilkunj Dodhia (Chair)	Simon Friend
	Miranda Brawn	Deidre Kelly
In attendance:	Kate Blake (item 7)	Ruth Liley
	Edward Bradshaw	Charles Martin
	Beverley Bryant (from 1.30pm)	Hari Mollett (item 5)
	Shamima Chowdhury (item 7)	Satwinder Nandrha
	Shaun Cochrane (item 7)	Damien O'Brien
	Paul Dossett (until 3.30pm)	Adeola Ogunlaja (minutes)
	Catherine Eyre	Lawrence Tallon
	Jon Findlay (item 5)	Chloe Wild (item 7)
	Claire Harrison (item 7)	Tendai Wileman
	Simon Lane	Andrea Williams-McKenzie (item 7)
	Pia Larsen	

1. Welcome and apologies

1.1. The Chair welcomed colleagues to the meeting of the Audit and Risk Committee (the Committee). There were no apologies from Committee members, although Ian Abbs and Steven Davies who attended regularly sent apologies.

2. Declarations of interest

2.1. There were no declarations of interest.

3. Minutes of previous meeting held on 20 December 2023

3.1. The minutes of the previous Committee meeting held on 20 December 2023 were approved as an accurate record, subject to a change to paragraph 6.3 to reflect that the findings from the internal audit of consultant job planning and payments on ESR were not presented at the previous meeting, but would be presented at this meeting.

3.2. The Committee received an update about the work being done to progress the actions and recommendations of the internal audit of space usage, in order to maximise usage of the clinical and non-clinical space available across the Trust's estate.

4. Review of action log

4.1. The Committee reviewed the action log, noting that most open actions would be addressed at this meeting.

5. Annual emergency preparedness resilience and response (EPRR) report

5.1. The Committee received an annual report on the Trust's emergency preparedness to meet the NHS England emergency preparedness resilience and response (EPRR) core standards. The Trust had a set of plans to respond to and manage major incidents and business continuity issues, and had provided substantial assurance to NHS England during the assurance review of 26 September 2023. Plans were also in place for the five areas that required full assurance.

5.2. The Committee discussed areas of most concern, noting in particular business continuity in the event of site-wide IT incidents. The two recent IT outages in December 2023 and January 2024, were being reviewed to ensure continuous improvement of business continuity arrangements. Whilst the business continuity plan to revert to paper-based systems had worked successfully, there were risks associated with this and further work to do on educating staff on appropriate use of paper forms. The Committee noted that there were relevant training and exercises in place for EPRR, with further online training being developed for easier access.

RESOLVED

5.3. The Committee agreed the assurance outcome of the Trust's emergency preparedness.

6. External audit update

Audit progress report and sector update

6.1. The Committee received an update from its external auditor, Grant Thornton, on the progress made in delivering its external auditor responsibilities, and a sector update highlighting relevant national issues and developments, including common themes emerging from audits of NHS organisations.

6.2. The account indicative audit plan had been presented to the Committee in December 2023, with the final audit plan to be presented at the Committee's next meeting in May 2024. The audit findings would be reported to the Committee meeting on 19 June, after which the final audited accounts would be signed by the Trust. The external auditors were in regular discussion with the Trust's finance team to address emerging issues, and good progress was being made.

Management responses to planning inquiries

6.3. The Trust's responses to the 'general enquiries of management' made by the auditors were presented, with Committee members noting that there were no significant differences to responses of previous years. The audit approach for going concerns was discussed and agreed.

7. Internal audit update

Progress report

7.1. The Committee noted that a new set of standards were being issued for public sector internal audits, coming to effect in January 2025, and the Committee would be advised of the implications once the standards had been updated. Discussion followed on the internal audit reports completed since the previous meeting of the Committee.

7.2. The findings from the audit on consultant job planning and payments were noted, including the inconsistencies found between payments made to consultants on the electronic staff records (ESR) payroll system to data on the consultant job planning system (SARD). Explanations were provided for these inconsistencies, and the Committee noted the work being done to develop a more robust and effective consultant job planning process going forward. This included the development of and training on processes and procedures for central oversight and consistency across the organisation.

7.3. The Committee noted the findings of the report, and required an action plan to address the issues, to be monitored primarily by the People, Culture and Education Board Committee, with any operational impact reported to the Quality and Performance Board Committee, and progress updates brought to the Committee as appropriate.

ACTION: MB, TW

7.4. The Committee received an overview of the steps being taken to address the findings of the audit of payroll costs discussed at the Committee meeting on 17 May 2023. The Trust intended to continue with recruitment and retention premiums, to be used where there were difficulties recruiting appropriate staff due to market pressures. A new policy had been approved to ensure an equitable and consistent approach across the organisation. The findings of the internal audit report would be presented to the People, Culture and Education Board Committee for oversight, and to monitor progress against the recommended actions.

ACTION: AW-M

7.5. The Committee discussed the findings of the audit of water safety with a particular focus on legionella controls within Borough Wing at Guy's Hospital. The audit found that the primary control for reducing the risk of legionella growth was maintaining temperature standards, which was not always possible. The Essentia team was taking necessary action, although significant changes to the Trust's infrastructure were needed to ensure compliance with national standards. The Trust's water safety risk would be appropriately recorded on the corporate risk register, and an update on implementation of the recommendations of the audit report would be brought to the Committee in six months' time.

ACTION: RL, CM

7.6. An audit had been undertaken of research and development (R&D) income and expenditure, which found that the processes for managing R&D income were complex, with a number of departments involved in the flow of information to achieve correct invoicing. This included the involvement of the King's Health Partners clinical trials office, employed by King's College London (KCL). Analysis of R&D income had also proved difficult due to the methods used for account coding.

7.7. The finance team would review current arrangements with KCL to ensure all R&D income due to the Trust was received and properly accounted for, VAT issues appropriately managed, account codes understood and policies and standing instructions complied with.

7.8. A progress update would be brought to the Committee in six months' time.

ACTION: DO'B, KB

Draft outline annual plan

7.9. The Committee received a draft outline of the internal audit plan for the next financial year, including a review against the strategic three-year plan. Cyber security remained a high risk, and the Trust had not met the standards for the NHS data security protection toolkit self-assessment in recent years. The Committee proposed that audit work was carried out to identify where improvements could be made and greater assurance provided.

7.10. A more detailed plan on cyber security would be brought to a future meeting of the Committee.

ACTION: BB

8. Counter fraud update

8.1. The Committee received a report on counter fraud activity for the period 1 December 2023 to 31 January 2024. This included a summary of the cases where fraud or irregularity had been identified.

8.2. A key theme identified was staff members working whilst off sick from their substantive posts, despite the Trust raising awareness that this was not permitted. It was noted that there had been an increase in dual employment since increased home working during and post the Covid-19 pandemic, which highlighted the need for more robust line management.

9. IT incident update

9.1. An update was provided on the IT incident which occurred on 19 December 2023, causing significant disruption to the Trust's data network and affecting services across Guy's, St Thomas' and community sites. The cause of the incident was noted, along with its impact and the actions and next steps being taken as a result. This included the commissioning of an external review of the Trust's IT infrastructure services to provide greater assurance around the Trust's IT resilience, and clarity around the split of responsibilities between the Trust and its suppliers.

9.2. The Committee recognised that IT outages were inevitable and that they should be managed in an effective and robust manner to minimise impact and increase workforce confidence in the Trust's IT infrastructure and response to incidents. Consideration should also be given to third party risks to the Trust's infrastructure, and management of these risks.

10. Risk management update

Trust risk appetite statement

10.1. The Committee received an update on the work being done to develop the Trust's risk appetite statement, which reflected the amount and type of risk that the organisation was willing to tolerate in pursuit of its objectives. A proposed risk appetite statement and tolerance levels were presented to the Committee, reflecting changes made to terminology and proposed tolerance levels following consideration by the Board at its away day in December 2023. There was debate about the extent to which the draft tolerance levels reflected how the Trust operated in practice, and the need to converge the two. It was agreed that further Board discussion was needed to finalise the appropriate risk tolerance levels.

ACTION: CM

Board assurance framework update

10.2. Further to the changes to the Board Assurance Framework (BAF) document and process requested at the Board away day on 1 December 2023, as s summarised in a paper to the Committee on 20 December 2023, the Committee noted the updates. The BAF was linked more closely to risk appetite and tolerance levels, enabling the Board to assess whether action was needed to control the risk and reduce its impact and/or likelihood to acceptable levels.

RESOLVED

10.3. Committee members supported the changes made to the BAF document and process.

11. Finance updates

Financial operations update

11.1. The Committee received a paper which outlined the key accounting estimates and judgements that formed material numbers in the accounts, and their proposed approach. The Committee was also asked to consider the approach for building top-up cyber insurance in the next financial year. Following discussion, it was agreed that further information was needed about insurance coverage and protection before a decision could be taken.

ACTION: DO'B, CE

Procurement review and update to Standing Financial Instructions

11.2. Updates had been made to the Trust's standing financial instructions (SFIs) regarding the procurement and management of contracts, to reflect the recent changes to the public procurement regulations and the new public procurement spend thresholds, and to support the Chief Procurement Officer to improve current practices across the Trust.

RESOLVED

11.3. The Committee approved the proposed updates to the Trust's SFIs.

Stock expiry, influenza vaccine

11.4. The Committee received an update on the expiration of influenza vaccines, noting the reasons for the procurement of surplus vaccines for the South East London (SEL) population. Payments had been received from SEL integrated care board and the vaccination manufacturers towards covering a portion of the financial loss, and the Committee was asked to approve funding of the remaining cost of £270k.

RESOLVED

11.5. There Committee approved the stock write-off of £270k.

12. Any other business

12.1. There was no other business.

The next meeting will be held on Wednesday 8th May 2024

BOARD OF DIRECTORS
FINANCE, COMMERCIAL AND INVESTMENT COMMITTEE

Wednesday 24th January 2024, 1:30pm – 3:45pm
Robens Suite, Guy's Hospital

Members present:	Simon Friend (Chair)	Nilkunj Dodhia
	Ian Abbs	Pauline Philip
	Charles Alexander	Ian Playford
	Steven Davies	Lawrence Tallon
In attendance:	Edward Bradshaw	Alison Mould
	Tom Davies (items 8 – 10)	Damien O'Brien
	Tara Knight (Minutes)	Peter Parr
	Anita Knowles (from item 9)	Peter Thompson
	Simon Mendy	Simon Wombwell

1. Welcome and apologies

1.1. The Chair welcomed colleagues to the meeting of the Finance, Commercial and Investment Board Committee (the Committee). Apologies had been received from Avey Bhatia and Jon Findlay.

2. Declarations of interest

2.1. There were no declarations of interest.

3. Minutes of the previous meeting

3.1. The minutes of the meeting held on 1st November 2023 were approved as an accurate record.

4. Review of action log

4.1. The Committee noted the open actions and the work that was taking place to address these. All proposals to close actions were accepted except for action 38, regarding private patient income, which would be reviewed again at the next meeting.

5. Board Assurance Framework risks

5.1. The Committee was reminded about the two strategic risks on the Board Assurance Framework that it owned; these related to the Trust's financial sustainability and the impact of restrictions on capital expenditure. These would be kept in mind during discussions and the risks would be reviewed later in the meeting.

6. 2023/24 Month 9 Finance Report

6.1. The Chair preceded the substantive agenda items with an acknowledgement of the acute financial challenges that were being experienced across the NHS. In light of these, there was a clear need for the Committee to provide robust oversight and scrutiny of the in-year financial position versus plan, the steps being taken to reduce the Trust's underlying deficit ahead of what was expected to be an even more difficult year in 2024/25, and how the Trust and its partners were working to address the South East London system deficit. It was acknowledged that the scale of the challenges, particularly at the system level, were unlikely to be resolvable without regional or national intervention.

6.2. The Committee was informed that the Trust's year-to-date financial performance for the nine months to 31st December 2023 was a deficit of £15.5m versus the planned breakeven position. Although there had been an in-month improvement of £4.1m, the underlying position had not materially changed as the majority of these improvements were non-recurrent.

6.3 The Committee was reminded that, following discussions with NHS England and the South East London Integrated Care Board in December 2023, the Trust had agreed a revised full-year financial plan for 2023/24 that moved from a breakeven position to a surplus of £28.5m. The main reasons for this change were the receipt of additional funding related to industrial action, and further funding from system and NHS England (NHSE) budgets. The key assumptions supporting the revised financial plan were set out, including the assumption that industrial action would fully cease at the end of November 2023.

6.4 In light of the planned reduction in activity to accommodate the implementation of the Trust's new electronic health record system (Epic), the Trust was in negotiations with NHS England for income protection in relation to Elective Recovery Funding (ERF) adjustments. Activity levels following Epic go-live had been lower than expected and, whilst there had been no changes to the annual leave policy, messages about staff using their annual leave entitlement had been reinforced locally. Committee members sought reassurance that this would not be at the detriment of delivering activity levels to which the Trust had committed. In light of January's industrial action and impact of Epic on the ERF there was heightened risk of not achieving the revised full year plan for 2023/24, though this would be subject to ongoing attention and scrutiny by the Committee.

6.5. The Trust's cash balance was being carefully managed, and the Committee noted an analysis of the main drivers of the cash reduction. The Trust's public divided capital (PDC) application for cash support was received in October 2023 and had been included within the reported position. Capital expenditure to date was noted as being slightly higher than the phased plan at month 9 and there was discussion about how the Trust would ensure full-year capital spend remained inside the Trust's Capital Departmental Expenditure Limit (CDEL) allocation.

6.6. It was agreed that a small group of non-executive directors and executives would meet between Committee meetings to scrutinise and review aspects of both operational and financial performance. A meeting would be scheduled to make the arrangements for this.

ACTION: EB

6.7. The Committee noted the ICS Financial Plan for 2023/24 and an update on the Trust's performance against the Better Payment Practice Code.

7. Annual Planning Update (Capital and Revenue)

7.1. Although NHS England was yet to publish its priorities and business planning guidance for 2024/25, it had advised ICBs and trusts to start planning for next year and had reiterated that system planning would need to achieve and prioritise financial balance. The financial allocations for 2024/25 had been published and NHS England had advised that the overall financial framework would remain consistent. Systems had also been advised to work on the basis that initial planning returns would be expected by the end of February 2024. The Committee was informed that, on this basis, the Trust had assumed that it was unlikely that its initial overall numbers would change materially once the guidance was released.

7.2. The Committee noted the latest financial projection for 2024/25 and the key assumptions underpinning this. The projection was currently based on delivery of an estimated £93.8m efficiency target, and work was in train to develop options of how this would be distributed to operational budgets. Committee members acknowledged the significant financial pressure the Trust was facing, but agreed it was important to ensure that the financial plan was realistic and achievable. It was considered unlikely that the Trust would be able to go further to help balance the system position.

7.3. The predominantly non-recurrent nature of the current year improvements would mean the opening 2024/25 position would be a significant underlying deficit. Part of the reason for this was that some parts of the Trust's workforce had grown disproportionately compared to level of activity and productivity since the start of the COVID-19 pandemic. Though this was a common issue throughout the health sector, plans would be finalised by the end of the financial year to undertake a targeted reduction in posts where staffing levels had grown significantly. This would supplement the corporate recruitment freeze that had been implemented in recent months. Committee members sought clarity on how this would be done, noting the nature of the communications that would be needed, and emphasised the importance of engaging clinical group chief executives and trade unions throughout. It would also be vital that this did not impair the activity levels, that had been agreed with NHS England, or the ongoing optimisation of the Epic system. It was also recognised that headcount reduction alone would not be enough to address the deficit and other areas of focus would also be needed as part of the 2024/25 efficiency programme.

7.4. There was discussion about the possible need for central revenue cash support, including how common such a request was amongst trusts regionally and nationally, and the potential regulatory implications of this.

7.5. The initial capital expenditure allocations for 2024/25 reflected the Board's commitment to focus on maintaining and improving internal infrastructure. Although there was high demand from clinical groups for further capital, current commitments and the need to increase the spending on infrastructure replacement and maintenance would mean that there was only a moderate amount available for new schemes next year.

7.6. It would be important to remain pragmatic about the system deficit going into 2024/25. It was agreed that whilst the three members of the SEL Acute Provider Collaborative (APC) needed to work at pace to identify financial opportunities, they could not, by themselves, close the system financial gap given its scale. Expectations on this would need to be managed with regional and national partners. Regular updates on the system-wide approach would come back to the Committee as a standing item.

ACTION: SD

8. IFRS 16 CDEL Update

8.1. The Committee received an update on the Trust's implementation of International Financial Reporting Standard (IFRS) 16, following guidance issued from NHS England in December 2023 regarding the impact of IFRS16 on trusts' CDEL allocations. The 2023/24 plan had been developed in the absence, but in expectation of the Trust's IFRS CDEL allocation, which was yet to be confirmed. Subsequently, the Department of Health and Social Care (DHSC) had announced a national uplift of the CDEL allocation, which would be apportioned at a system level to SEL Integrated Care Board (ICB).

8.2. The number of leases signed in year was below plan and there may be an underspend against the CDEL uplift. The finance team would work with Essentia to identify any property leases planned for 2024/25 that could be brought forward to minimise any underspend. Further planning guidance from NHS England for 2024/25 was yet to be published therefore the current guidance would be used to anticipate how leases would be managed in next year's capital plan. An upper limit on the value of leases was anticipated in the coming months.

8.3. The CDEL uplift would not be ringfenced, which might have suggested that overspend in capital could be traded with an underspend on the IFRS16 uplift. However, IFRS16 expenditure against the CDEL uplift was now mandated as part of the national reporting arrangements. If circumstances arose where uplift was used to support overspends on capital rather than covering incremental impact of IFRS16, it was anticipated that a specific explanation and rationale would be sought by the DHSC.

8.4. The Committee noted the risks presented by the guidance, particularly for the children's hospital programme, and how it could influence short-term versus long-term planning. The Trust was undertaking a review of all of its managed services agreements to identify which would meet the IFRS16 criteria and need to be accounted for under the CDEL allocation.

9. Financial Improvement Programme update

9.1. The Committee received an update on the progress against the financial improvement plan, including progress against the financial savings target. More work was needed to reach the target that would enable the Trust to achieve its financial plan, although the Committee noted the delivery challenges the Trust had faced, particularly industrial action and the implementation of Epic.

9.2. In 2024/25, it was unlikely that there would be the same level of non-recurrent support available as in this financial year; the core savings target was expected to stand. Next year the approach would be to focus on cross-cutting themes, working with all clinical groups in a consistent way, supporting them with central resource whilst ensuring they were also held accountable. An update would be brought to the next Committee meeting.

ACTION: SW

10. Apollo Financial Update

10.1. Three months post go-live, the Trust was in the process of reconciling the cost position with colleagues at King's College Hospital (KCH), as this was a shared programme with contracts across both organisations. The Committee noted a number of cost pressures that had arisen whilst the reconciliation was being finalised, the largest of which was in relation to the increasing number of users of the Epic system. Licences were payable based on the number of concurrent users, and, since go-live, there had been an increase in the number of licenses which came with additional costs. The Trust's Data, Technology and Information (DT&I) team would actively monitor and manage usage to mitigate the cost pressures going forward. Roughly 200 additional staff had been recruited to implement Epic, and a DT&I consultation was underway to reduce the headcount and thus the pay cost.

10.2. The Committee noted ongoing work to review the headcount across DT&I to ensure that th team was able to manage the stabilisation and optimisation of the Epic system and the Trust's IT infrastructure more broadly. The Inter-Trust Collaboration Agreement with King's College Hospital was currently being updated to ensure effective recharge mechanisms were in place, which would be particularly important for the management of cashflow. A paper on benefits delivery would be considered by the Transformation and Major Programmes Board Committee in February. There was good governance around the decommissioning of legacy systems and realisation of costs savings, as well as sign off on access to patient data, ensuring it would be correctly stored and accessible by clinicians when needed.

11. Changes to Regulatory Requirements Governing Public Procurement

11.1. The Committee noted an update on the key regulatory changes for the procurement of healthcare services, goods and non-healthcare related services that would come into force in various phases during 2024.

12. Children and Young People's Gender Service

12.1. The Committee noted an update on the financial status of the Children and Young People's Gender Service, including the latest indicative costs of providing the service. Direct costs incurred in 2023/24 have been agreed for reimbursement, and a revenue funding envelope for 2024/25 had also been agreed. The Trust is leading on the estates workstream, and capital costs would be confirmed once an estates solution was secured. Following funding approval by NHS England, the Trust would be in a position to sign a contract with an estates provider. An annual standard NHS England contract

would be used to help moderate expenditure, although the Committee noted there was some financial risk attached to this. There remained a number of issues to be resolved ahead of planned go-live of the services on 1 April 2024.

13. Board Assurance Framework

13.1. The Board Assurance Framework risks owned by the Committee were reviewed and the updates made to the controls and assurances were noted. In light of discussions throughout the meeting, the language around the BAF risks would be strengthened to reflect the financial sustainability issue.

ACTION: SD

14. Any other business

14.1. The tender for the Outpatient Pharmacy contract had now been finalised. The contract had been through the standstill period and had been awarded to Boots.

14.2. Peter Parr, Head of Financial management, would be retiring from the Trust at the end of March. Peter was thanked for his role in leading the Trust's financial management services for many years.

Date of next meeting – Wednesday 1st May 2024

NHS
Guy's and St Thomas'
NHS Foundation Trust

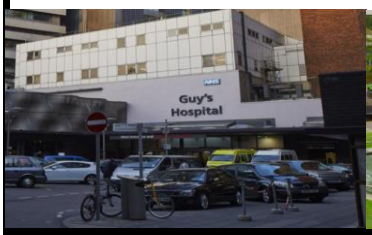
Trust Executive Committee

26th March 2024

Finance Report - 23/24
Month 11

Guy's and St Thomas' NHS Foundation Trust

Guy's and St Thomas'
NHS Foundation Trust

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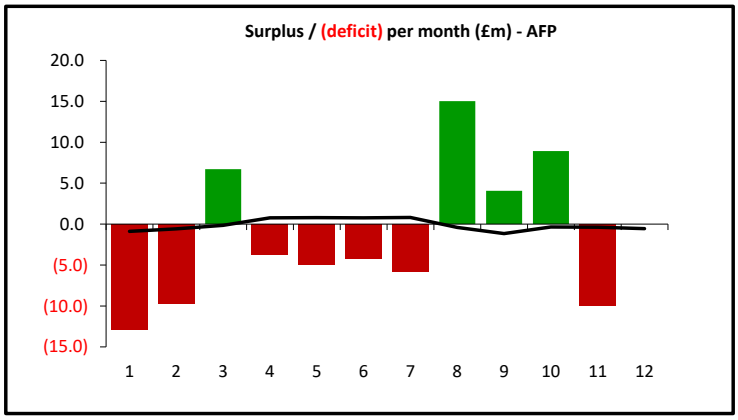
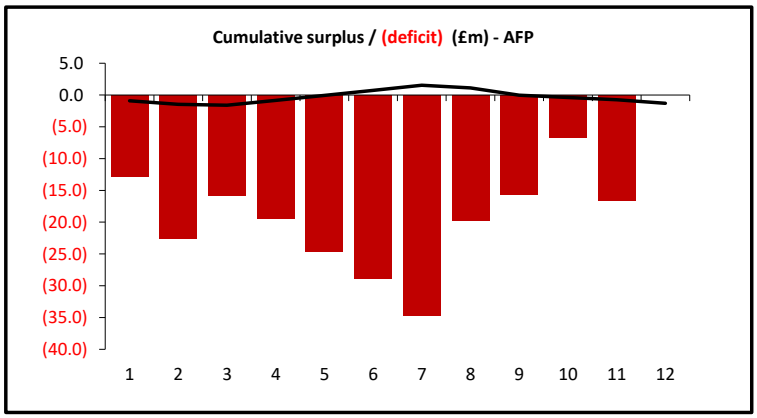
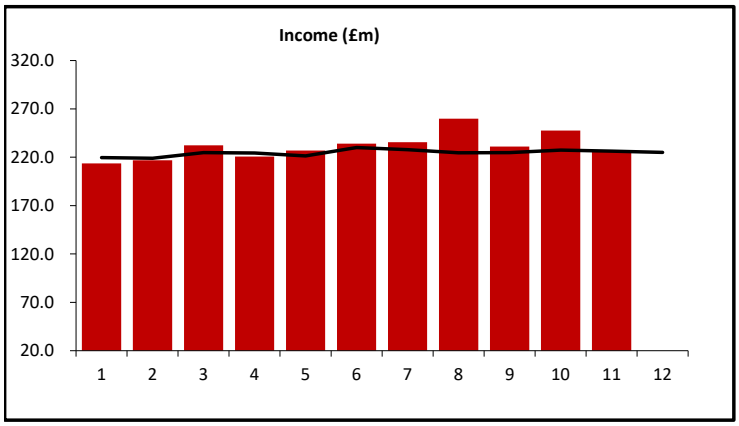
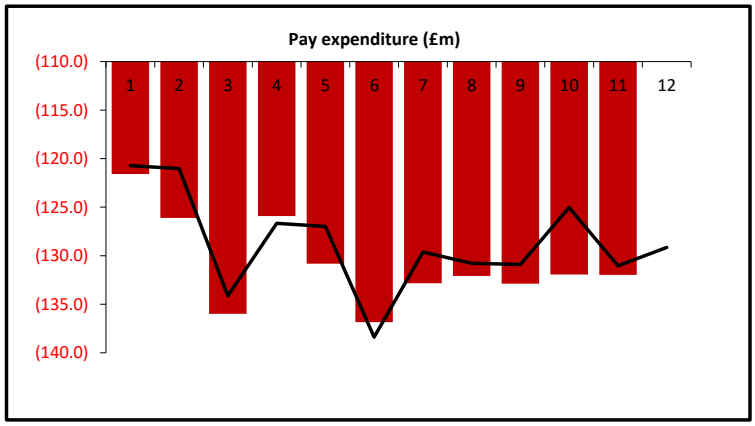
Summary Financial Performance - Trust

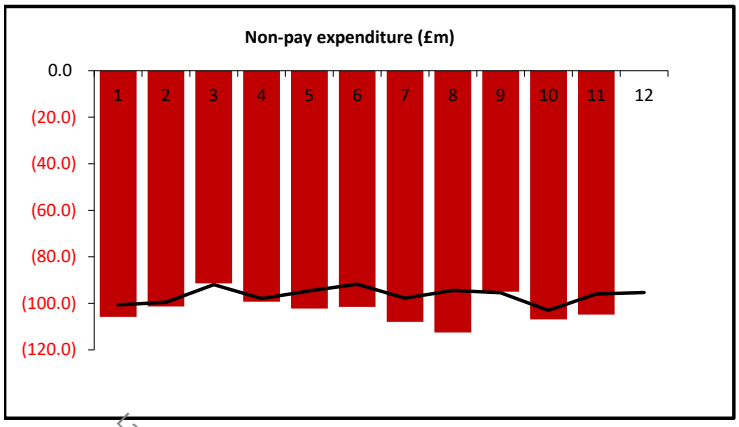
Income and Expenditure	Budget Mth £m	Actual Mth £m	Variance Mth £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
Income	225.6	226.9	**1.3**	2,465.6	2,546.3	**80.7**
Pay	(131.0)	(132.0)	**(0.9)**	(1,415.2)	(1,439.0)	**(23.7)**
Non Pay	(94.9)	(104.9)	**(10.0)**	(1,051.1)	(1,124.0)	**(72.9)**
Surplus / (Deficit) - Adjusted Financial Position (AFP)	**(0.4)**	**(10.0)**	**(9.6)**	**(0.7)**	**(16.7)**	**(15.9)**
DODA	(1.1)	(0.9)	**0.2**	(12.0)	(10.6)	**1.4**
Capital Donations	0.8	1.1	**0.3**	5.0	5.2	**0.3**
Technical Adjustments	0.0	0.0	**0.0**	0.0	0.1	**0.1**
Surplus / (Deficit) - Excl Fin Adj's	**(0.6)**	**(9.8)**	**(9.1)**	**(7.8)**	**(21.9)**	**(14.1)**

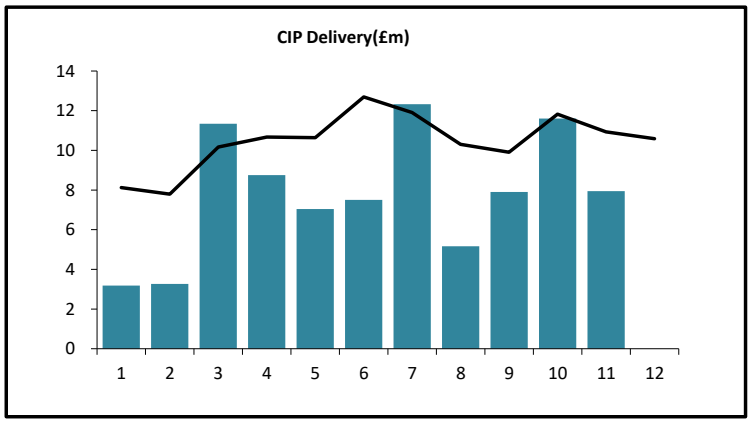












Finance Report Commentary

Executive Summary

Summary: YTD performance the Trust is reporting a deficit of £16.7m in terms of the adjusted financial performance measurement, which is £15.9m worse than plan:

- **Elective Recovery Fund Performance:** in respect of EPIC implentation the Trust has provisionally agreed ERF clawback with NHSE of £16.4m for 2023/24 (which is based on our best estimate of actual activity delivered since go-live), of which £15.1m is reflected in the Month 11 Position.
- **Additional Funding Allocations:** in respect of industrial action, the release of ICB reserves and the release of NHSE prescribed budgets have allowed the Trust to account for £34.4m of additional income to date. In addition Genomics income is £7.7m above plan.
- **CIP delivery:** YTD £86.0m of CIPs achieved resulting in a total under delivery against the Trusts CIP programme of £28.9m driven both by unidentified and unachieved CIPs. The under-delivery is included within both pay and non pay budgets.
- **Balance Sheet Flexibility:** to date £17.7m of non-recurrent benefits have been realised which is £0.5m less than plan. These are included in the CIP delivery position noted above.
- **Prior Year accruals:** a review of prior year expenditure accruals within operational budgets has resulted in previously anticipated expenditure reducing by £3.2m. This has been partially offset in month by prior year rates charges of £1.4m.
- **Industrial Action:** an assessment of the impact of industrial action since April is £10.9m. The main drivers of which are increased pay expenditure to cover colleagues less salary deductions made and reductions in private patient activity.
- **Independent Sector:** expenditure incurred in respect of independent sector usage is £10.4m more than budgeted.
- **EPIC implementation and Support:** revenue costs above that initially planned in relation to the EPIC implementation of £16.9m are included in the reported position.
- **Contract Growth funding:** shortfalls in payments by Commissioners have been provided for in the reported position with an assessed YTD impact of £12.0m which is £9.3m more than plan.

Income: YTD performance £80.7m better than plan, the main drivers of which are:

- **Additional Funding allocations** of £19.7m as noted above
- **Elective Recovery Fund Performance** reduction of £15.1m as noted above
- **Genomics** income from Specialist Commissioning is £20.4m above plan.
- **SEL ICB:** £8.6m above plan where additional income has been received in respect of IFRS16 funding, revenue consequences of capital schemes and mental health beds usage.
- **Income in relation to the** Vaccination Programme of £5.6m has been included in the reported position which is off-set by additional pay and non pay costs.
- **Non patient care income** £19.5m of Apollo expenditure incurred on behalf of KCH is to be recharged
- Where Commissioners are paying less than the nationally mandated contract calculations the underpayments are currently being accrued pending resolution of the disputes. A provision for risk of non-payment has been made within non-pay.

Pay budgets: YTD expenditure of £1,439m is £23.7m worse than plan; February pay costs of £132.0m, while consistent with the prior month, represents an increase of £1.3m when compared to the average of the prior periods.

- Among the main drivers of the overspend are the impact of the recent industrial action which has been assessed as £9.3m, costs incurred in relation to the vaccination programme of £4.9m which are off-set by additional income and Apollo implementation £3.5m.
- There remains a significant overspend against pay budgets within the ISM CG of £8.9m, an improvement of £1.1m from last month. £2.5m is attributed to the impact of the industrial action and £1.1m as identified Apollo implementation costs there remain concerns over planned CIP delivery.

Non Pay budgets (including Reserves and Unidentified CIPs): YTD performance £72.9m worse than plan, the main drivers of which are:

- Unidentified CIP targets of £17.2m across operational budgets with a YTD impact of £15.7m
- On-going use of the Independent sector has resulted in expenditure above plan of £10.4m.
- Drugs and clinical supplies budgets are £22.2m overspent.
- Premises and Other operating expenses are £25.5m overspent, due to £30.8m of Apollo costs of which £19.5m is to be invoiced to KCH.
- To support the current position and to mitigate expenditure in the current run rate reserves of £10.5m have been released.

Balance Sheet: The Trust closed month eleven with a cash balance of £104.9m; this is a decrease of £26.4m from the opening balance on 1st April 2023.

- The application for cash support was approved and the cash of £57.5m received in October. Of the additional funding of £34.4m, £28.3m has been received as cash.

Drivers of YTD Group Variances £000

Variance Type	Cancer & Surgery	Evelina London	HLCC	ISM	Essentia	Corporate	Other	Trust Total
Pay	(7,149.0)	6,140.1	(2,051.5)	(8,921.3)	(1,749.2)	4,766.4	(14,765.0)	**(23,729.7)**
Further Improvement Target	(2,604.0)	(1,324.6)	(391.6)	(157.2)	(2,198.8)	(8,700.7)	(321.1)	**(15,698.1)**
Internal Recharges	583.7	(47.2)	(248.4)	(883.9)	346.4	(1,082.8)	326.9	**(1,005.3)**
Non Pay	(12,249.2)	5,978.1	2,026.0	(19,658.0)	1,073.4	(32,544.2)	(848.1)	**(56,221.9)**
Income (Excl Clin Income Adj)	(7,491.4)	2,747.3	(1,982.0)	(4,368.9)	4,957.4	14,408.8	72,452.2	**80,723.5**
Total (Excl Clin Income Adjs)	**(28,909.8)**	**13,493.7**	**(2,647.5)**	**(33,989.3)**	**2,429.2**	**(23,152.6)**	**56,845.0**	**(15,931.5)**
Clinical Income Adjustment (excl pass through D&D)	3,831.4	845.8	3,007.4	2,134.5	(0.0)	11,754.6	(21,573.7)	**0.0**
Pass Through Drugs & Devices Clinical Income	0.0	(8,077.5)	0.0	0.0	0.0	0.0	8,077.5	**0.0**
Total (Incl Clin Income Adjs)	(25,078.5)	6,262.0	359.9	(31,854.8)	2,429.2	(11,398.0)	43,348.7	(15,931.5)

SNAPSHOT VARIANCE DRIVERS - £000's

	Cancer & Surgery	Evelina London	HLCC	ISM	Essentia	Corporate	Other	Trust Total
Staffing								
Medical Staff	(5,799.0)	(2,155.7)	(34.9)	(5,910.2)	(2.2)	(3,955.5)	(3,195.4)	**(21,052.8)**
Nursing Staff	43.5	5,170.5	(5,252.5)	(1,518.1)	(191.4)	990.8	(1,170.6)	**(1,927.8)**
PAMs	(249.6)	317.3	1,364.3	690.9	(1.9)	(735.1)	(654.0)	**731.8**
Professional & Technical (PTB)	445.8	184.3	2,564.1	710.3	(5.6)	(964.0)	707.0	**3,641.8**
Admin & Clerical	2,607.6	1,611.1	(3,677.8)	(2,441.5)	1,965.6	9,240.7	(8,332.2)	**973.5**
Estate and Facilities Staff	1.7	72.5	45.6	(67.1)	(2,971.6)	(239.9)	(152.2)	**(3,311.1)**
All Other Staff	(4,199.0)	940.1	2,939.6	(385.7)	(542.1)	429.4	(1,967.6)	**(2,785.2)**
Total Pay	**(7,149.0)**	**6,140.1**	**(2,051.5)**	**(8,921.3)**	**(1,749.2)**	**4,766.4**	**(14,765.0)**	**(23,729.7)**
Non-Pay								
Drug Costs	(13,853.7)	6,930.1	305.4	(12,354.8)	(10.8)	1,865.1	2,960.7	**(14,157.9)**
Clinical Supplies	122.2	(1,577.1)	(1,815.4)	(1,179.1)	(612.7)	(1,036.0)	(1,918.3)	**(8,016.2)**
Premises Costs	140.6	193.0	(2,474.3)	(1,765.7)	5,068.1	(23,134.8)	1,976.2	**(19,997.0)**
Purchase of Healthcare from non-NH	661.3	(430.7)	(1,703.6)	(3,695.1)	0.0	(3,796.0)	399.4	**(8,564.8)**
Establishment Costs	(76.9)	24.6	824.1	(1,152.4)	(479.4)	665.8	(3,469.7)	**(3,664.0)**
Other Non-Pay Costs	757.4	838.2	6,889.8	489.1	(2,891.7)	(7,108.4)	(796.4)	**(1,822.0)**
Total Non-Pay	**(12,249.2)**	**5,978.1**	**2,026.0**	**(19,658.0)**	**1,073.4**	**(32,544.2)**	**(848.1)**	**(56,221.9)**

Summary: YTD the Trust is reporting an adverse variance to plan of £16.7m measured on an adjusted financial performance basis.

The key drivers of the adverse position are CIP delivery which to date has under-performed by £25.9m across both unidentified and unachieved CIPs, the impact of industrial action of £10.9m, use of the independent sector where costs are £10.4m in excess of budget, additional EPIC implementation costs of £16.9m. Partly off-setting these are the additional funding received of £19.7m, Genomics income of £7.7m and PY accruals and rebates within operational budgets of £24.7m.
Following the implementation of EPIC, clinical income within Clinical Groups is now reported on a block contract basis with some adjustments in respect of pass through drugs and devices income. This is likely to continue for the remainder of the financial year until recording and reporting issues are resolved.

At a clinical group level, only Evelina London is ahead of plan once the clinical income adjustment on a block contract basis and pass through drugs and devices are taken into account.

Underlying Performance £000

Variance Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Trust Total
												0.0	0.0
Current Month Adjusted Financial Performance (AFP)	**(12,898.6)**	**(9,625.5)**	**6,709.4**	**(3,841.8)**	**(5,031.5)**	**(4,113.7)**	**(5,813.4)**	**15,024.9**	**3,962.1**	**8,937.1**	**(9,980.0)**		**(16,671.0)**
Industrial Action	(1,475.8)	(1,780.9)	(798.7)	(960.5)	(1,067.5)	(1,604.6)	(566.0)	224.2	(788.3)	(1,460.1)	(591.8)		**(10,869.8)**
Current Year Independent Sector Usage	(1,223.0)	(1,192.5)	(1,199.0)	(1,519.1)	(1,257.7)	(1,213.3)	(801.4)	(1,326.4)	(837.6)	(8.1)	480.4		**(10,097.7)**
Balance Sheet Flexibility	0.0	0.0	4,975.0	4,552.2	(18.4)	0.0	4,444.7	28.8	3,700.0	0.0			**17,682.3**
Prior Year (Costs) \ Benefits	(526.0)	686.4	1,215.9	243.3	697.2	1,248.4	2,380.2	(388.7)	4,586.0	13,414.5	1,122.5		**24,679.7**
Non-Recurrent \ One-Off Items	(627.6)	(371.0)	(180.8)	(1,029.0)	(1,385.9)	(866.5)	(1,294.0)	(1,770.0)	(3,094.9)	(7,218.9)	(2,790.3)		**(20,628.9)**
Accruals Released	47.7	152.0	11.4	540.9	0.0	115.0	30.3	22.0	2,022.1	445.8	1,514.4		**4,901.6**
Current Month Errors \ Omissions	(1,049.3)	(65.8)	293.0	(231.0)	173.5	125.0	(551.9)	(758.5)	(962.0)	(696.9)	(223.1)		**(3,947.0)**
Prior Period Corrections	0.0	1,105.6	93.8	(364.0)	285.0	167.5	(430.0)	662.0	758.5	147.3	1,068.4		**3,494.1**
Capital \ Revenue Transfers	(76.0)	(390.0)	466.0	(130.2)	130.2	(579.9)	(76.0)	(76.0)	0.0	(76.5)	(123.6)		**(932.0)**
Movements in Bad Debt Provisions	(1,233.7)	(234.3)	(2,630.4)	599.2	(95.9)	0.0	(5,673.0)	(701.7)	3,277.8	(150.3)	(2,877.4)		**(9,719.9)**
Reserve Accruals \ Released	0.0	0.0	11,799.2	623.2	1,087.5	135.0	58.6	22.0	378.2	445.8	2,328.4		**16,878.0**
Additional Funding \ Clawback \ Elective Recovery Funding (ERF) \ Genomics					564.0	(564.0)	0.0	23,816.2	2,608.6	6,304.6	(13,074.4)		**19,655.1**
Underlying Recurrent AFP position	**(6,734.9)**	**(7,534.9)**	**(7,335.9)**	**(6,166.9)**	**(4,143.4)**	**(1,076.2)**	**(3,334.9)**	**(4,729.2)**	**(7,686.3)**	**(2,210.2)**	**3,186.5**	**0.0**	**(47,766.4)**

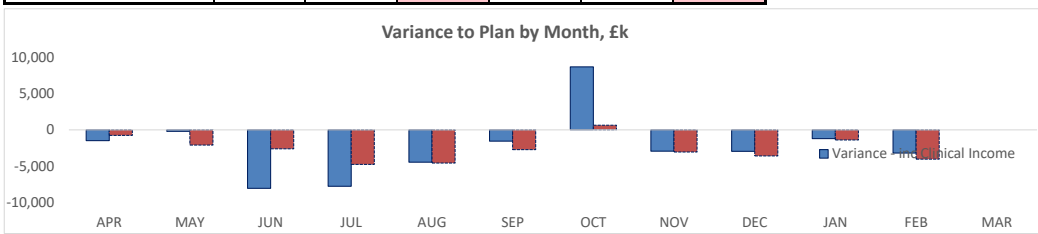
Summary: the reported position for February is a deficit of £10.0m; within this position there are potential net non-recurrent \ retrospective impacts which total £13.2m (favourable) giving an Underlying AFP position of a £3.2m surplus.

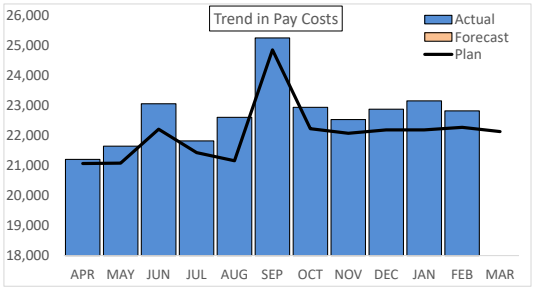
- The agreement of prior year income billing and a review of Clinical Group and Directorate accruals for both the current and previous year, in addition to recovery of rebates, has resulted in a net benefit of £3.3m. These are shown across Prior Year Benefits and Accruals Released in the above table. This was offset by additional costs relating to prior year rates charges of £1.4m
- Additional non-recurrent funding from Commissioners totalled £2.0m in February, however this was offset by the Elective Recovery Fund reduction of £15.1m of funding reflected in February.
- Other significant in month impacts on the reported position include the financial impact of industrial action of £0.9m. The latter may be understated due to a catch up of potential costs following the recent resumption.

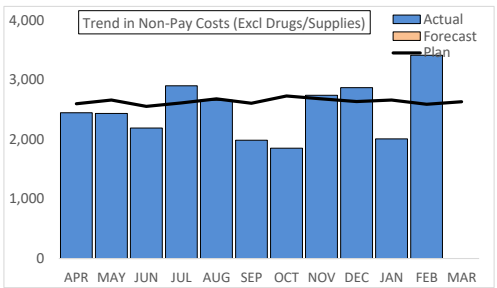
Cancer & Surgery Clinical Group - Financial Performance

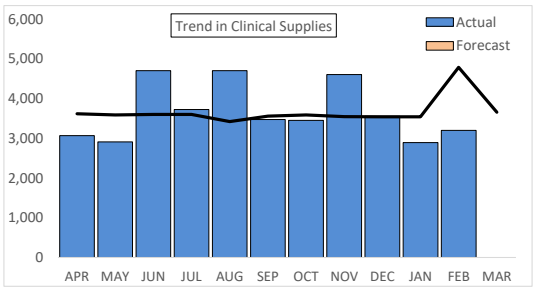
1. Summary Financial Performance

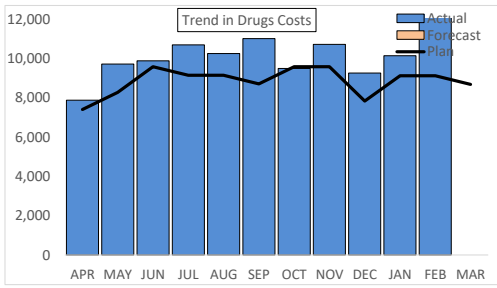
Type	This Month			Year to Date		
	Budget (£k)	Actual (£k)	Variance (£k)	Budget (£k)	Actual (£k)	Variance (£k)
Pay	(22,275)	(22,822)	(547)	(242,779)	(249,928)	(7,149)
Further Improvement Target	214	0	(214)	2,604	0	(2,604)
Internal Recharges inc Overheads	(9,316)	(9,187)	129	(115,640)	(115,056)	584
Non Pay	(16,481)	(18,936)	(2,455)	(166,759)	(179,008)	(12,249)
Income (Excl Clin Income Adj)	3,622	2,692	(930)	40,187	32,695	(7,491)
Total (Excluding Income Adjustment)	**(44,236)**	**(48,253)**	**(4,017)**	**(482,387)**	**(511,296)**	**(28,910)**
Clinical Income Adjustment (excl pass through D&D)	35,430	36,259	829	381,815	385,646	3,831
P/T Drugs & Devices Clinical Income	8,390	8,390	0	89,721	89,721	0
Total	**(416)**	**(3,604)**	**(3,188)**	**(10,851)**	**(35,929)**	**(25,078)**











Clinical Activity Volumes

Type	This Month			Year to Date			Vs 2019-20	
	Budget (#)	Actual (#)	Variance (#)	Budget (#)	Actual (#)	Variance (#)	2019-20 YTD	% of 2019-20
Elective								
Daycase								
Non-elective								
Outpatient New								
Outpatient F/up								
Dialysis								
Chemo Delivery								
Radiotherapy								

To Follow

Summary

YTD Position

The Clinical Group has reported a year to date position of £25.1m behind plan to M11.

The main drivers of the position YTD are:

Clinical Income £3.8m ahead of plan.
Hosted Services £3.6m ahead of plan, offset in Income.

Further Improvement Target £2.6m behind plan
This is a pro-rata of the £2.8m remaining target. As background, the Group had £13.9m to identify as part of 23-24 business planning.

Pay £7.1m overspent
Themes to note :
Medical pay £4.8m, drivers include costs of additional clinics, high rate of bank shifts paid at RTT rates, unclaimed pay awards.
Unmet Headcount reduction target £2.6m [total £5m]
Industrial Action and EPIC associated pay cost £1.2m, offset by
A&C, Nursing, Scientific & Professional and Professional & Technical vacancies £0.3m
R&D £0.6m underspent, offset within Income.

Non Pay & Internal Recharges £11.7m overspent
High cost drugs & devices c.£13.9m overspent. The expectation is that this would be broadly offset by clinical income.
Bad debt £1.2m, driven by LGT sub-contract for QMS theatres.
Clinical Supplies £1.2m overspent. See actions.
R&D £3.3m underspent, offset within Income.

Income (Excl Clin Income Adj) £7.5m behind plan
Driven by Hosted Services £3.9m behind plan, offset in Clinical Income. R&D £4.0m behind plan, offset within Non Pay and Pay

Key Issues

1. CIPs
- Delivery of agreed CIPs - including headcount challenge of c.£5m
- Identification of further CIPs to address the remaining target c.£2.8m

2. Activity Recovery
Recovery will be two fold :
- Capture and coding - particularly around resolving the issues around outpatient activity capture and understanding the drivers of the pass-through position
- Operational recovery, appreciating IA will impact on this aspiration.

3. Reducing HCA
This will support the centrally reported CIP. Currently delayed as awaiting the opening of refurbished Nuffield Theatres.

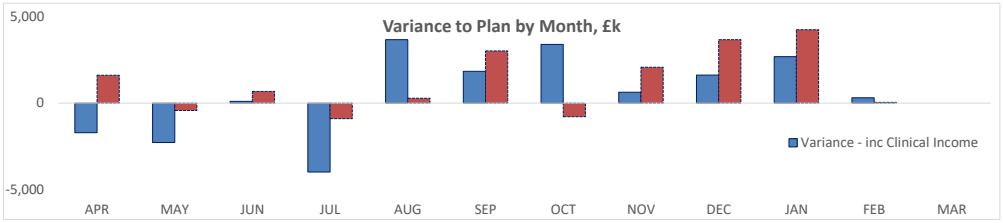
4. Procurement Support
In understanding the drivers of the high clinical supply spend. Including price and volume changes.

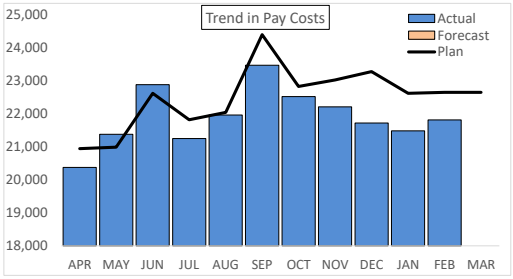
5. Medical Pay
Reducing reliance on premium bank rates (RTT) to provide cover.

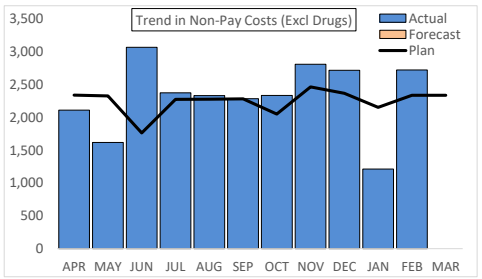
Evelina London Clinical Group - Financial Performance

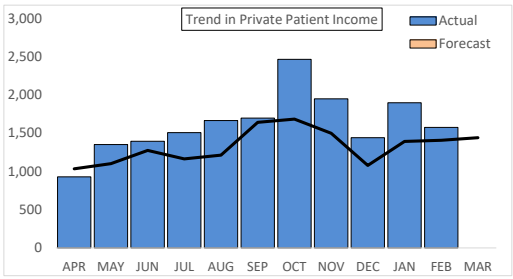
1. Summary Financial Performance

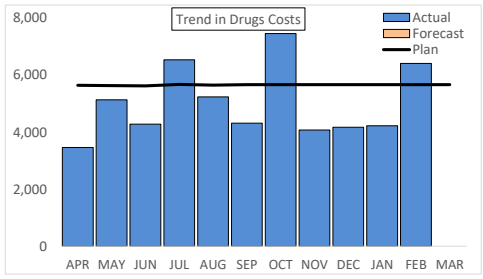
Type	This Month			Year to Date		
	Budget (£k)	Actual (£k)	Variance (£k)	Budget (£k)	Actual (£k)	Variance (£k)
Pay	(22,648)	(21,809)	838	(247,172)	(241,032)	6,140
Further Improvement Target	(871)	0	871	1,325	0	(1,325)
Internal Recharges inc Overheads	(8,133)	(8,141)	(8)	(103,773)	(103,821)	(47)
Non Pay	(8,002)	(9,128)	(1,126)	(86,825)	(80,846)	5,978
Income (Excl Clin Income Adj)	4,404	3,871	(533)	37,417	40,164	2,747
Total (Excluding Income Adjustment)	**(35,249)**	**(35,208)**	**42**	**(399,029)**	**(385,535)**	**13,494**
Clinical Income Adjustment (excl pass through D&D)	30,607	30,870	263	335,770	336,616	846
P/T Drugs & Devices Clinical Income	5,065	5,065	0	55,710	47,632	(8,078)
Total	**423**	**727**	**304**	**(7,549)**	**(1,287)**	**6,262**











Clinical Activity Volumes

Type	This Month			Year to Date			Vs 2019-20	
	Budget (#)	Actual (#)	Variance (#)	Budget (#)	Actual (#)	Variance (#)	2019-20 YTD	% of 2019-20
Elective								
Daycase								
Non-elective								
Outpatient New								
Outpatient F/up								
Paediatric Critical Care								
Antenatal pathways								
Deliveries								
A&E attendances								

To Follow

Summary

Evelina reported a M11 performance £304k ahead of plan taking the YTD position to £6.26m ahead of plan.

The in month position materially reflects the £1.0m release of prior year accruals in addition to ongoing private patient income overperformance £169k.

This is partly offset by high drug expenditure (£741k adv) primarilty Haematology drugs within Medicine.

YTD Position

The key drivers of the M11 YTD positions are:

- **Further Improvement Target (£1.3m).**
- **NHS Income (£7.2m)** behind plan. Within this, (£8.1m) relates to Zolgensma pass through income, where six infusions have been given against a plan of eleven YTD. Offsetting this, hosted ODN income is above planned levels following additional allocations earlier in the year. It is likely that some of this additional income will need to be deferred at year end where recruitment timelines do not allow for workplans to be fully delivered in year.
- **Pay is £6.1m underspent.** Within this there is £(2.4m) attributable to IA & carenotes reconciliation costs giving an underlying pay position of £8.5m underspent. Nursing remains underspent reaching £5.17m YTD excluding IA, notably reflecting continued high vacancy levels in PICU (£1.1m fav) and Universal Community Services (£1.0m fav), along with childrens wards (£1.4m fav). Medical is (£0.8m) overspent after identified IA costs, affecting 4/5 clinical directorates but most notably in Medicine & Women's. High sickness & maternity leave, and additional sessions to recover work cancelled due to IA (notably in maternity) are key drivers.
- **Non pay is £6.0m underspent**, of which £6.9m relates to drugs. There have been six Zolgensma infusions to date at a cost of £8.1m, against a plan of eleven. Clinical supplies are £(1.6m) overspent, with Women's and Medicine seeing the majority of overspends (£1.0m) & (£0.5m) adv respectively.
- **Other income is £2.8m ahead of plan**, within which private patient income is £3.4m ahead primarily driven by Gastro, Cardiac and Respiratory work. This is offset by salary recharge income not yet billed for in R&D £(1.3m) adv.

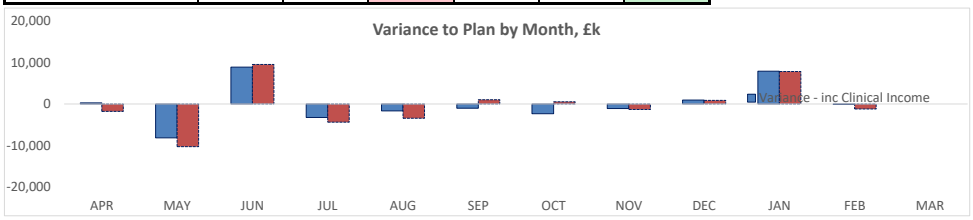
Key Issues

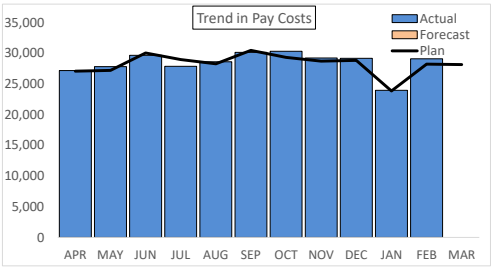
- The scale of savings still to find are material (£0.5m; 0.2% direct expenditure excluding pass through costs) and delivering savings to the full extent of the target without compromising activity delivery or safety will be challenging, especially given continued IA and management focus on Apollo. This gap predominantly sits in Medicine & CSTA, as Community, CRIC & Women's have closed their gaps for the year.
- While excellent progress on CIP identification has been made to date (99% at CG level), 32% of identified CIPS are NR and will need to be found again next year. As stands, the financial challenge for 2024-25 is in the order of £10.4m, a decrease from 2023-24.
- High clinical supplies spend to date requires further investigation to confirm extent to which this should be and is offset in income, and degree of recurrence in levels of spend. ACU is a key focus area where costs are running materially higher than prior years month on month - procurement support has been requested to understand key drivers and explore options to reduce spend.
- The cessation of reporting NHS Income variably in group positions has materially improved Evelina's reported performance, however income impacts remain real for the organisation. Limitations in data availability, and capacity in central teams to support investigations given Epic demands, will impact the group's ability to make improvements in this space.
- The Central Contracts and Income Team have confirmed that the Neuro drug, Risdiplam, is being billed as C&V, but has not been reported accurately internally to date. The pressure is a full year impact c£1.7m if not resolved. but within the reported group position this is mitigated via income now being broken-even.

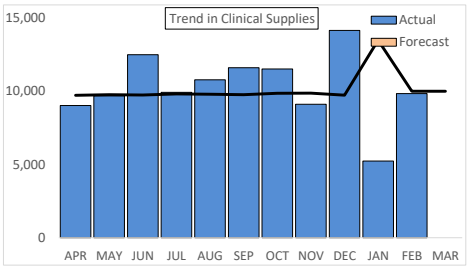
Heart, Lung and Critical Care Clinical Group - Financial Performance

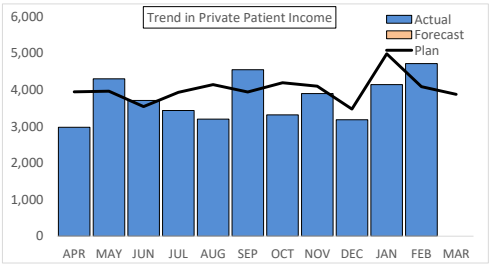
1. Summary Financial Performance

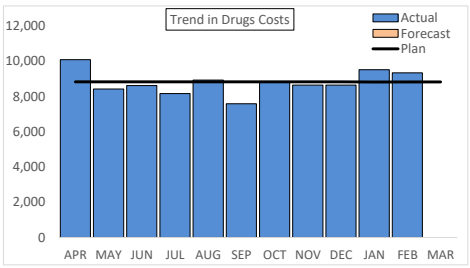
Type	This Month			Year to Date		
	Budget (£k)	Actual (£k)	Variance (£k)	Budget (£k)	Actual (£k)	Variance (£k)
Pay	(28,199)	(29,058)	(859)	(310,595)	(312,647)	(2,052)
Further Improvement Target	76	0	(76)	392	0	(392)
Internal Recharges	(9,192)	(9,229)	(37)	(106,370)	(106,619)	(248)
Non Pay	(21,168)	(23,697)	(2,529)	(234,638)	(232,612)	2,026
Income (Excl Clin Income Adj)	6,501	8,787	2,286	71,074	69,092	(1,982)
Total (Excluding Income Adjustment)	**(51,983)**	**(53,198)**	**(1,215)**	**(580,137)**	**(582,785)**	**(2,648)**
Clinical Income Adjustment (excl pass through D&D)	34,990	36,087	1,097	399,283	402,291	3,007
P/T Drugs & Devices Clinical Income	12,845	12,845	0	141,291	141,291	0
Total	**(4,148)**	**(4,267)**	**(119)**	**(39,563)**	**(39,203)**	**360**











Clinical Activity Volumes

Type	This Month			Year to Date			Vs 2019-20	
	Budget (#)	Actual (#)	Variance (#)	Budget (#)	Actual (#)	Variance (#)	2019-20 YTD	% of 2019-20
Elective								
Daycase								
Non-elective								
Outpatient New								
Outpatient F/up								
Critical Care Days								

To Follow

Summary

The Clinical Group is reporting an adverse variance to plan in month of (£0.1m), and a favourable position YTD of £0.4m.

In month, Private Patient Income is £0.6m favourable to plan, representing a significant improvement compared to previous months which have been behind plan. This improvement is across Harefield, Brompton Heart and Brompton Lung directorates.

Net (£0.9m) of prior year costs have been incurred in month, including a (£1.3m) backdated charge for increased rates at Wimpole Street, which is being disputed, and (£0.4m) costs relating to historic balances following the migration onto the new Finance system. These costs are offset by the release of a number of prior year provisions, including £0.5m for nursing agency charges in Brompton Heart.

In month, deferred income for Cardiovascular Networks was released and the corresponding expenditure accrued, to ensure the correct accounting treatment for this activity. This correction is driving a favourable position under Other Operating Income of £0.6m, which is offset in full within their Pay and Non Pay spend.

The underlying Pay position, excluding prior year gain, industrial action and the above correction to Cardiovascular Networks, is (£1.0m) overspent. This continues the increase seen last month compared to previous months' trend and is most significant within the Harefield, Brompton Heart and Cardiovascular directorates. PACCS has also seen an increase though is still favourable to plan on Pay, both in month and YTD.

The underlying Non Pay position is adverse to plan in month by (£0.9m), an increase compared to trend due to ageing NHS and non NHS debts resulting in a (£0.8m) bad debt charge in month. Clinical Supplies are favourable to plan £0.4m but this includes a £1.4m credit transferred from the balance sheet relating to Goods Received Not Invoiced (GRNI) on the RBH sites, following the change in process on the new Finance system. Excluding this, Clinical Supplies are overspent (£1.0m) due to an increase in the Harefield directorate.

NHS clinical income targets for commissioning contracts are again broken-even in month. £0.7m additional income for the Genomics lab was recognised in month following confirmation of increased funding Trust-wide for 23/24.

YTD Position

Within the YTD position, Pay budgets are overspent by (£4.4m) excluding prior year provisions released. Within this position, the adverse impact of Industrial Action on Pay is estimated to be (£2.7m). The underlying YTD Pay position is therefore adverse to plan by (£1.7m) YTD.

Private Patient Income is behind plan YTD by (£2.9m), of which (£2.1m) is estimated to be the impact of Industrial Action. The remaining adverse variance is predominantly at Harefield, where a £1m stretch target is not being achieved in full, principally because of limited access for private practice to surgical capacity during recent infection outbreaks earlier in the year. On a recurrent basis this target is viewed as credible and we have seen improvement in M11 as noted above.

In total, the estimated YTD financial impact of Industrial Action is (£4.8m) across the Clinical Group; (£2.1m) PP income, and (£2.7m) pay expenditure.

CIP delivery is behind plan by (£0.3m); an improvement following the M11 recovery in Private Patient activity and means the clinical group is delivering 97% of target YTD .

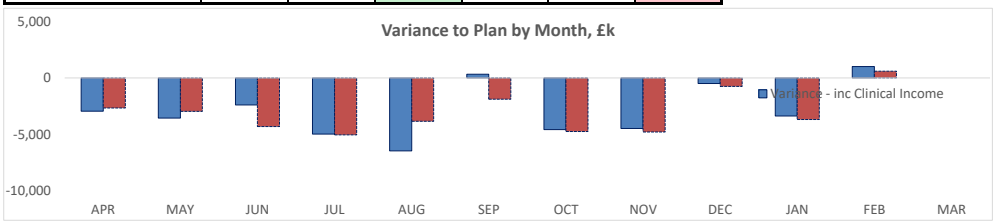
Key Issues

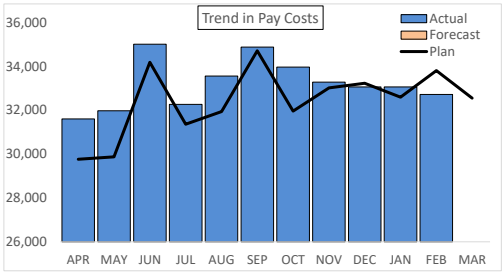
- Adverse impact on capacity and resilience of delays in capital scheme in Nuffield House @ Guy's, compromising sleep service activity.
- Candida auris: reduced L1 bed base at STH during the closure of Sarah Swift ward in Q3, and further outbreak in L3/L2 capacity in East Wing in Q4.
- Ongoing challenges to patient step-down from L3/L2 beds into L1 wards at STH. Patient Flow Improvement programme mobilising.

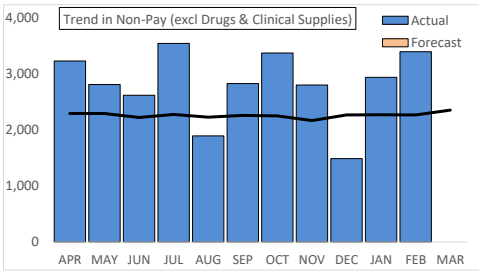
Integrated and Specialist Medicine Clinical Group - Financial Performance

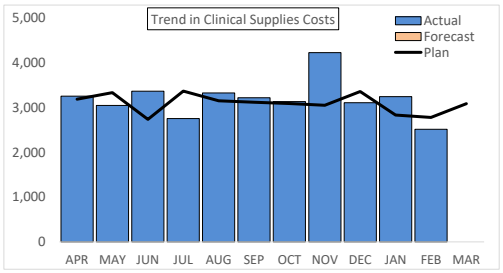
1. Summary Financial Performance

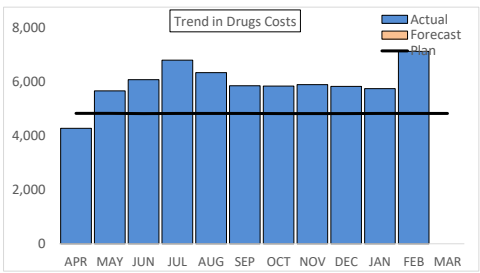
	This Month			Year to Date		
	Budget (£k)	Actual (£k)	Variance (£k)	Budget (£k)	Actual (£k)	Variance (£k)
Pay	(33,804)	(32,717)	1,087	(356,422)	(365,343)	(8,921)
Further Improvement Target	14	0	(14)	157	0	(157)
Internal Recharges inc Overheads	(10,197)	(7,506)	2,691	(95,595)	(96,479)	(884)
Non Pay	(9,859)	(13,017)	(3,158)	(111,727)	(131,385)	(19,658)
Income (Excl Clin Income Adj)	5,685	5,682	(3)	58,610	54,242	(4,369)
Total (Excluding Income Adjustment)	**(48,160)**	**(47,558)**	**602**	**(504,976)**	**(538,966)**	**(33,989)**
Clinical Income Adjustment (excl pass through D&D)	37,353	37,753	400	402,496	404,631	2,134
P/T Drugs & Devices Clinical Income	4,912	4,912	0	54,021	54,021	0
Total	**(5,895)**	**(4,893)**	**1,002**	**(48,459)**	**(80,314)**	**(31,855)**











Clinical Activity Volumes

Type	This Month			Year to Date			Vs 2019-20	
	Budget (#)	Actual (#)	Variance (#)	Budget (#)	Actual (#)	Variance (#)	2019-20 YTD	% of 2019-20
Elective								
Daycase								
Non-elective								
Outpatient New								
Outpatient F/up								
Imaging								
A&E attendances								

To Follow

Summary

YTD Position

at M11 is £1m favourable, in month, but an adverse position of (£31.9m) cumulatively, for the Clinical Group

FIT

• £157k Adv - unidentified target in Pharmacy due to RBH / GSTT merge – reconciliation of CIPs between ISM and HLCC - to be addressed in BP and Bud 24/25

CLINICAL INCOME - excl adj

• **£(4.1m) adv** includes the anticipated run-rate variance to income target in Pharmacy Tech Svcs: £(1.5m) adv, as well as CLIMP Nuclear Medicine paused capacity of £(1.9m); both driven by Pharmacy Regulator compliance requirements.

CLINICAL INCOME - adj

• **£1.9m fav** income reported as block contract from M07.
• Private/Overseas Pts has marginally increased to (£0.23m) behind plan in aggregate with Med Specs continuing to over-perform.

P/T DRUGS & DEVICES

• income reported as block contract from M07 and therefore not aligning with the cost base

PAY

• £(8.9m) adv YTD; £1.1m fav variance in month, showing a lower spend than recent months.
• AGM, CLIMP, & Mgt, continue to be adverse in month against budget, with all other directorates showing favouravle positions in the month. The position included £182k Non rec benefits in the month;
• £(4.1m) yet to be identified CIP included in pay budget
• Apollo resource in the CG: £(1.1m) YTD

NON-PAY

• £(19.7m) adv in non-pay, £(3.2m) in month
• £(9.9m) is pass-thru cost effects for drugs, devices (no performance offset in income as set to plan from Mth7)
• £(2.0m) is non pass-thru drugs split across AGM (ED and Gen Med) as well as CLIMP (NucMed) and Med Specs (Diabetes) - activity with some phasing effects but subject to directorate and pharmacist review to pinpoint drives.
• £(1.2m) adv YTD in net clinical supplies across ILS, Dental, CLIMP and Pharmacy includes impacts of Pharmacy Regulator compliance pause & remediation.
• £(2.77m) is MH-driven external bed capacity in Purch of Healthcare
• £(1.5m) is additional activity initiatives in Imaging
• £0.18m bad debt with an adverse movement in the month of (£0.7m);
• £(1.76m) across Premises, notably AGM, CLIMP R&D & Pharmacy, where key driver is remediation costs but includes other repairs - STTH Aseptic facility
• £(1.2m) across Establishment with overspends in Dictation Svcs, Travel and Other.

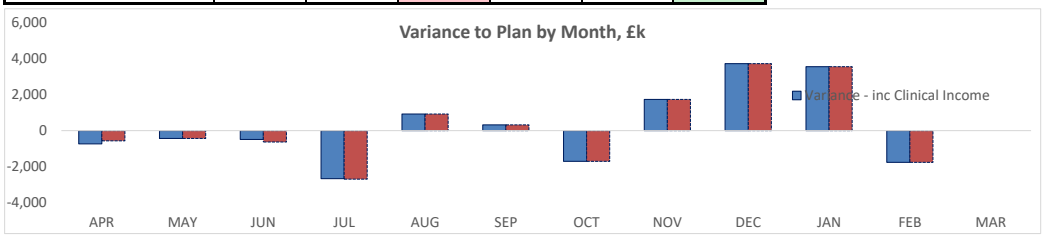
Key Issues

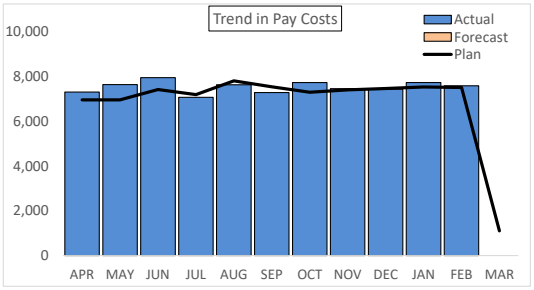
•ISM: a number of the above and below matters are included in the CG financial improvement plan as workstreams to improve
•ISM: commissioned activity income actuals behind plan at M06 in certain specialties
•ISM: Pathology YTD recharges were corrected in M11, with £2.8m crediting the SAS budget. There may be a further adjustment in M12, again the the SAS budget. ISM now report a (£1m) adv variance against budget for Internal Recharges. Dental and AGM - preliminary work has been undertaken to categorise coding issues, although the level of queries are notably lower than those within SAS Pathology;
•ISM: Drugs - M10 included the 1st cut of pharmacy data from Epic Willow drugs module, catching up on the M07-09 actuals. A central accrual has been made based on run rate, and this continues to be reviewed vs historical trend. In month Drugs charges increased by £1.3m, notably within SAS, relating an allocation of price increase charges;
•ISM: Vacancy, bank and agency - key focus driven by CEO with overall plan to turn around and recover back to budget; Nursing & AHP agency and bank remain material spends, although offset by vacancies in some directorates.
•ISM: Drugs (non-pass-thru) - AGM continuing at adverse trend, (£1.2m) adv YTD;
•ISM: Clinical supplies - M11 spend levels lower than YTD run rate with a favourable varaince against in month budget. However, we continue to show an adverse position against budget. we have shared an analysis of clinical supplies with Procurement team for support to identify charges
•ISM: Pharmacy Regulator compliance & remediation pause impacts - impact on year-to-go although Tech Svcs has recently increased its order book and contracts value
•BP: run-rate and funding matters - included in recurrent outturn and business planning work
• AGM: MH - Cygnet contract purchase of healthcare capacity - unfunded in FY23/24, part of MH business case
• ISM: ongoing Industrial Action impacts & Apollo costs
• ISM: methodology to resolve medical staffing cost pressure (jnr

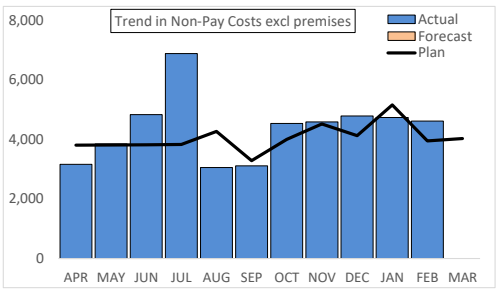
Essentia - Financial Performance

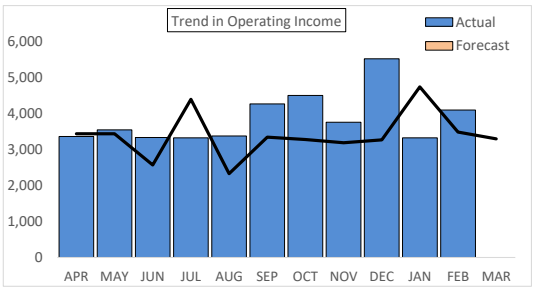
1. Summary Financial Performance

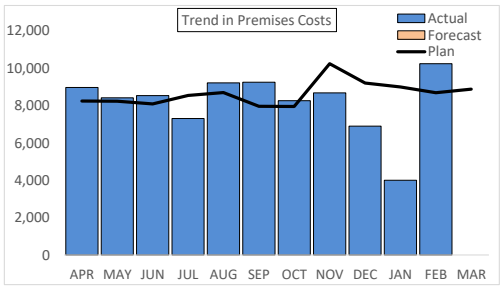
Type	This Month			Year to Date		
	Budget (£k)	Actual (£k)	Variance (£k)	Budget (£k)	Actual (£k)	Variance (£k)
Pay	(7,503)	(7,581)	(79)	(80,988)	(82,737)	(1,749)
Further Improvement Target	4	0	(4)	2,199	0	(2,199)
Internal Recharges inc Overheads	10,139	10,174	34	123,635	123,982	346
Non Pay	(12,694)	(15,022)	(2,328)	(140,029)	(138,955)	1,073
Income (Excl Clin Income Adj)	3,488	4,101	613	37,496	42,454	4,957
Total (Excluding Income Adjustment)	**(6,565)**	**(8,329)**	**(1,764)**	**(57,686)**	**(55,257)**	**2,429**
Clinical Income Adjustment (excl pass through D&D)	2,217	2,217	(0)	23,651	23,651	(0)
P/T Drugs & Devices Clinical Income	0	0	0	0	0	0
Total	**(4,348)**	**(6,111)**	**(1,764)**	**(34,035)**	**(31,606)**	**2,429**











Summary

YTD Position

The Group reported an underspend of £2.4m to the end of February.

- **Income £5.0m over achieved**

Of the £5.0m over recovery, £2.3m relates to one off CIPs and £0.9m relates to prior year benefits. In month 9 a new rental agreement for an existing tenant was agreed which has improved the position by £1.3m YTD.
Other benefits include the utility charges for tenants which were reviewed and updated (£0.7m YTD) there are also additional pass through income for Environmental waste offset by additional costs (£0.8m.).

- **Pay £1.7m over plan**

Of the £1.7m overspend ,£2.1m relates to services that were included in the internal recharges. This is mainly related to St Thomas' site services.
£0.9m relates to an unachieved vacancy factor. Of the original target 1/3 has been achieved.
In month the Overall bank costs was stable , of bank usage YTD. 24% relates to additional requests and 9.1% of costs is covering sickness.
There are underspends in RBH, Q&I and transport. There is also a £0.5m underspend in Guys engineering which is offset by use of contractors.

- **Non-Pay £1.1m under plan**.

YTD there has been a release of £5.8m of prior year accruals taking this into account the Group's non pay performance is £4.7m over budget. The main headlines are:
£1.7m is the impact of in year business cases, and £0.2m as the impact of industrial action.
A net £1.0m relates to services that were included in the internal recharges.
To date bad debts provisions are £0.5m adverse.
Utilities costs are £0.4m below target and this includes £0.5m of pass through costs. In month this has worsened by £0.6m at RBH due to problems with the gas meter readings.
Transport costs are £1.7m overspent YTD due to double running earlier in the year of which COVID costs are £0.1m to date.
Additional costs of £0.8m have been incurred for the hire of equipment and urgent maintenance work and cost of Legionella is £0.6m to date. The impact of new properties is £0.6m YTD and £0.1m of costs were incurred against the fire strategy business case.
To date there have been non recurring benefits of £4.4m on rates rebates and reductions of £0.4m on service charges on properties. These benefits are included in the Groups CIPs achieved.

- **Internal recharges £0.3m over achieved**

As part of the Trusts suspension of reporting of internal recharges, the £1.5m favourable variance shown to M6 was reversed to show a small favourable variance relating to hosted services and private patients.

- **CIPs £2.2m below recurrent plan.**

The FIT target on the ledger has yet to be updated for the additional income noted above. This leaves the Group £0.4m below its recurrent target. Non recurring benefits of £13.6m have been achieved leaving a net £13.2m over achievement.
The Group has identified £21.9m of CIP opportunities, of which £6.6m are recurrent.

Key Issues

The Group is forecasting a year end position of £5m below plan due to the non recurring benefits. For 24/25 the initial Group forecast is £14.6m over plan offset by £6.8m of CIP opportunities that are being developed. The fortnightly Directorate call continue to review the position for 24/25.

The Groups executive and Directors continue to be involved in ensuring the workforce understand the financial challenge. The Finance team continue to improve the understanding of financial data across all budget holders.

Drivers of YTD Group Variances - Corporate and Other £000

Variance Type	Pay	Further Improvement Target	Internal Recharges	Non Pay	Income (Excl Clin Income Adj)	Total (Excl Clin Income Adjs)	Internal Income Adjustment (Offsets with Trust Income)	Total (Incl Clin Income Adjs)
Chief Operating Officer	550.4	(725.5)	0.0	(3,297.0)	180.5	(3,291.5)	21.7	(3,269.8)
Director of Finance	1,839.2	(1,847.7)	(9.7)	3,101.8	(19.6)	3,063.9	0.0	3,063.9
DT&I	(645.1)	(9.5)	(0.0)	(30,643.6)	19,469.2	(11,829.2)	0.0	(11,829.2)
Workforce	1,225.0	(1,754.1)	56.3	(1,173.6)	(2,037.2)	(3,683.6)	2,570.9	(1,112.7)
Chief Executive	1,522.4	(228.4)	(1,705.4)	(517.1)	(528.0)	(1,456.5)	2,776.9	1,320.4
Medical Director	368.3	(4,216.4)	0.0	(1,500.0)	333.7	(5,014.5)	5,872.5	858.1
Chief Nurse	(911.9)	(41.5)	(157.1)	(1,484.6)	2,045.7	(549.4)	339.1	(210.4)
GSTT R&D NIHR	499.6	0.0	733.1	2,462.3	(4,541.3)	(846.2)	356.9	(489.3)
Commercial	318.4	122.4	0.0	508.3	(494.0)	455.2	(183.3)	271.8
GSTS Pathology Payroll	0.0	0.0	(0.0)	(0.4)	0.0	(0.4)	0.0	(0.4)
Total Corporate	**4,766.4**	**(8,700.7)**	**(1,082.8)**	**(32,544.2)**	**14,408.8**	**(23,152.6)**	**11,754.6**	**(11,397.6)**
Trust Income	0.0	0.0	0.0	(1,502.5)	67,414.8	65,912.3	(28,634.1)	37,278.2
Reserves	(2,876.9)	0.0	1,222.2	1,346.5	510.6	202.5	0.0	202.5
Pathology	81.0	(321.1)	(895.3)	(5,697.6)	1,348.4	(5,484.7)	70.0	(5,414.7)
Interest Receivable	0.0	0.0	0.0	5,549.9	0.0	5,549.9	0.0	5,549.9
Vaccination Programme	(4,884.5)	0.0	(0.0)	(1,277.4)	5,113.8	(1,048.1)	512.5	(535.6)
Coronavirus [HCOVID]	0.0	0.0	0.0	(104.1)	0.0	(104.1)	0.0	(104.1)
GSTT Enterprises Ltd	(112.2)	0.0	0.0	689.2	0.0	576.9	0.0	576.9
Pathology Services Ltd	0.0	0.0	0.0	(461.8)	0.0	(461.8)	0.0	(461.8)
Essentia Trading Ltd P/L	(6,972.3)	0.0	0.0	(5,197.7)	12,613.7	443.7	0.0	443.7
Capital Depreciation	0.0	0.0	(0.0)	6,836.2	0.0	6,836.2	0.0	6,836.2
Other	0.0	0.0	0.0	(1,028.8)	6.2	(1,022.6)	0.0	(1,022.6)
Total Other	**(14,765.0)**	**(321.1)**	**326.9**	**(848.1)**	**87,007.6**	**71,400.4**	**(28,051.6)**	**43,348.7**
Total Corporate and Other	**(9,998.7)**	**(9,021.8)**	**(755.9)**	**(33,392.3)**	**101,416.4**	**48,247.7**	**(16,297.0)**	**31,951.1**

Summary - YTD Position

COO:
Directorate is reporting an adverse position of £3.3m , with significant portion (£4.3m) linked to unfunded Independent Sector expenditure. This is an improvement of £764k compared to last month, primarily due to revision of HCA expenditure. Notably, invoices received up to Jan-24 were significantly lower than our previous estimate. The remainder of the variance is due to unmet CIP target in Inpatient Services and unfunded Site Nurse Practioners.

Director of Finance:
Finance Director's YTD position is £2.9m ahead of plan, primarily due to £1.9m overachievement of VAT benefit from Lloyds Pharmacy and YTD underspends of £316k in pay from vacant positions. Additionally, there were PY accruals of £300k released last month.
Procurement is also reporting a favourable YTD variance of £150k this month, due to number of in month movements; **(a)** Retention of 22/23 LPP SEL Member Benefit Payment (£196k), **(b)** Correction to Linen and Laundry stock valuation amounting to £205k, **(c)** Higher invoiced value in SLAM SLA compared to estimate **(d)** Retention of Dartford Stock Warehouse YTD 4% handling fee (c£600k), which will subsequently cease in 24/25

DT&I:
DT&I is reporting a YTD overspend of £11.8m in M11 primarily driven by unfunded Apollo costs of £14.6m (net of income from KCH). This is being partially offset by underspends of £2.8m in BAU budgets.

Workforce:
Directorate is reporting an adverse YTD position of c£1.1m. This is mainly driven by suspension of Internal recharges earlier in the year, resulting in directorate to absorb signific ant VISA costs (£1.5m) associated with international recruitment which is partially offset by the release of prior year accruals of £662k this month. These costs were traditionally recharged to respective clinical groups.

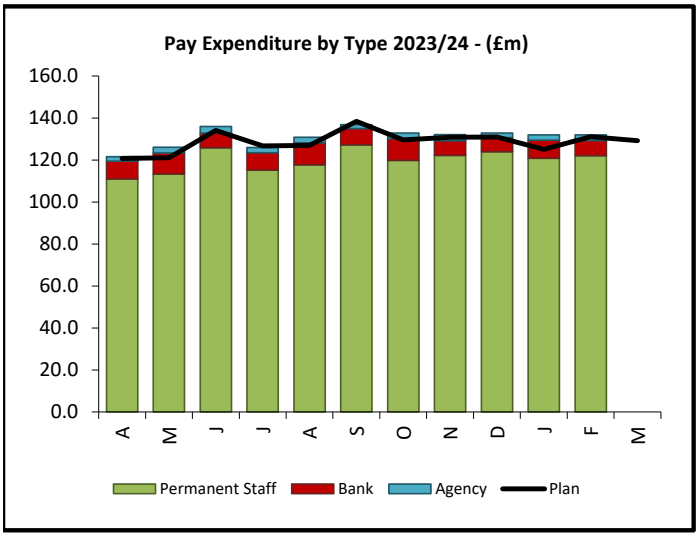
Chief Executive:
Directorate's favourable YTD position of £1.3m is mainly attributable to Deputy Chief Exec budgets. Both Pay and Non-Pay budgets are ahead of plan driven mainly by the underspend in RBH & GSTT integration budgets.

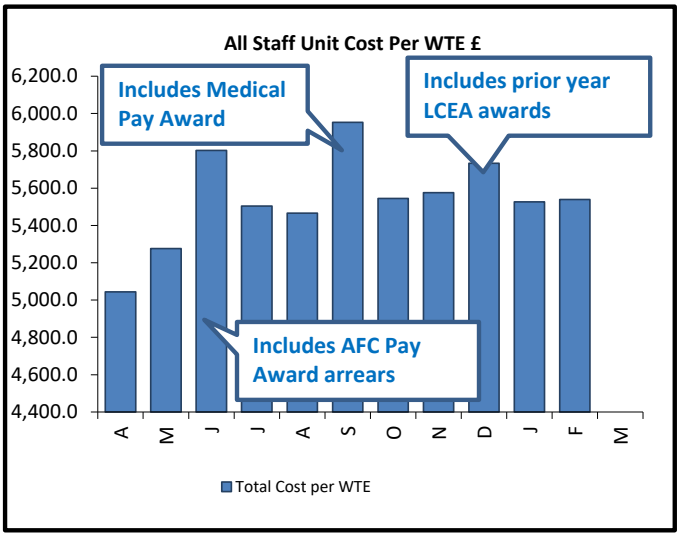
Medical Director:
Directorate is reporting a favourable position of £858k in M11, representing a notable improvement of £1.9m compared to previous month. The main driver behind this improvement is the receipt and recording of Genomics growth funding fom NHSE amounting to YTD c£4.1m.
However, the YTD variance for Medical Directorate remains adverse at £934k. This is primarily due to overspends in both Pay and Non-pay, stemming from a historical deficit in funding. These deficits have been identified and quantified, mainly affecting Medical Education, and Medical Director.

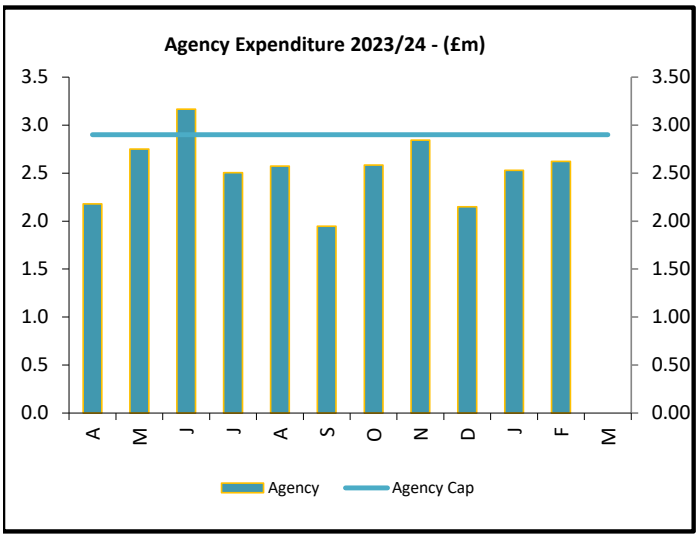
Chief Nurse:
Directorate is reporting an improved YTD adverse position of £210k in M11. Pay and unmet CIP target in Infection control are the main drivers of the adverse position.
The overspend in Pay is attributed to historical insufficient funding for Consultants and SPRs within Infection Control contr ibuting to the overall adverse position.

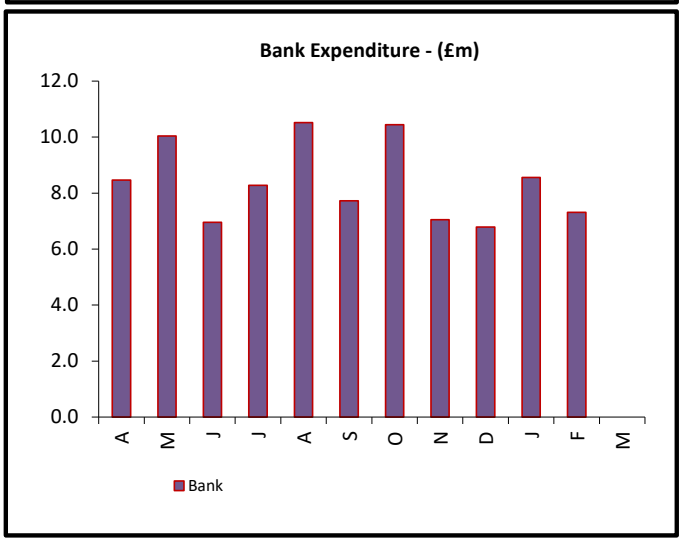
Commercial:

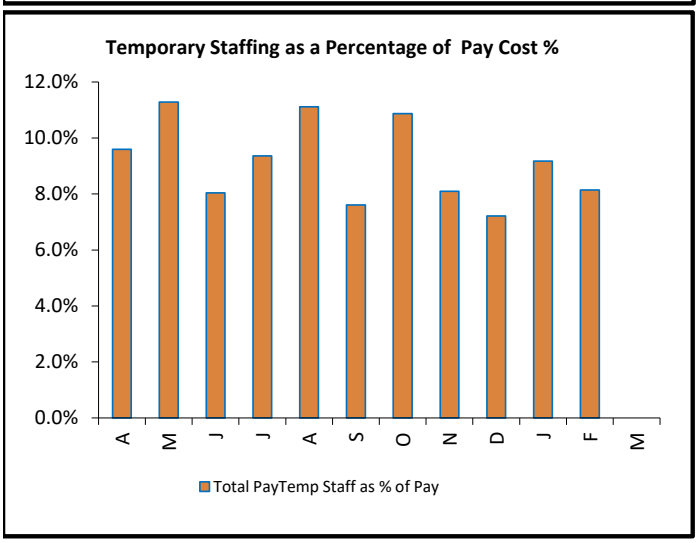
Key Payroll Metrics - Trust

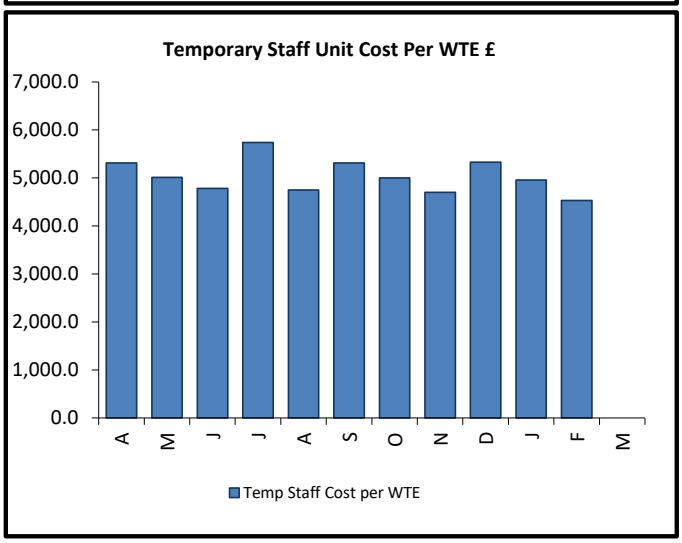








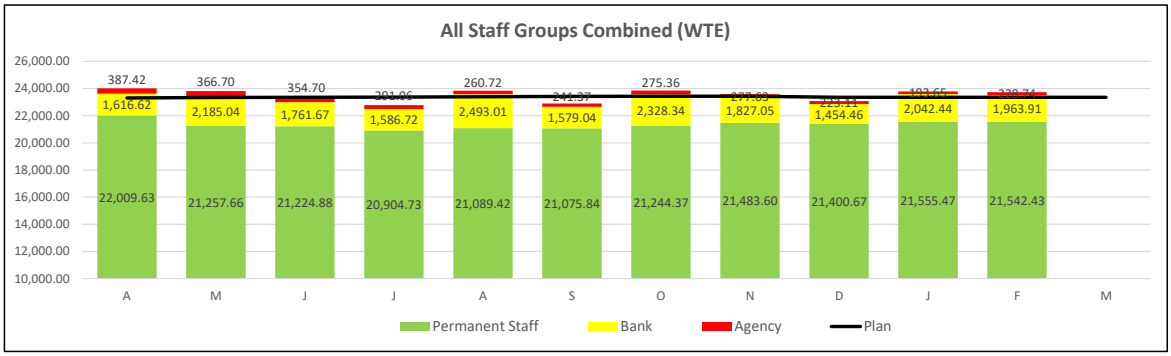


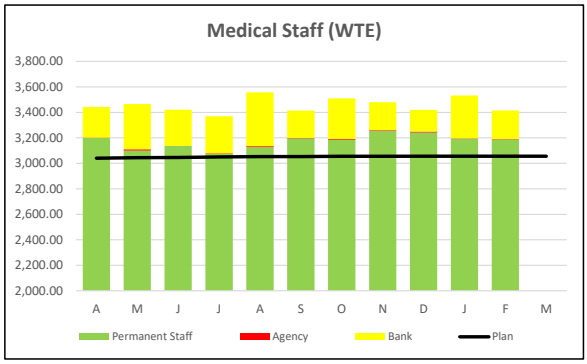


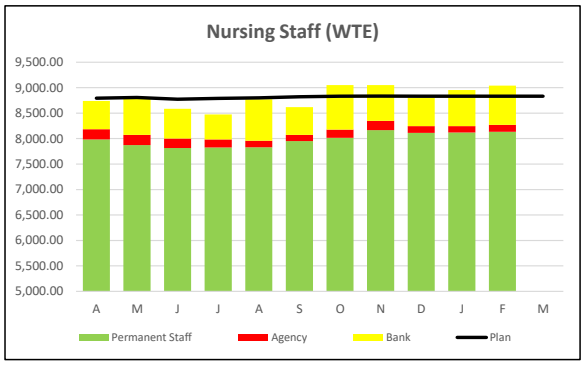
The NHSE agency cap for the Trust for 23/24 is £2.90M per month (based on 100% of 23/24 spend). YTD the Trust has been averaging agency spend of £2.53M per month; £0.37M below the 23/24 cap, for the month of Feb the Trust was below the agency cap by £0.28M. From 2023/24 performance against the agency cap will once again become a key performance metric.

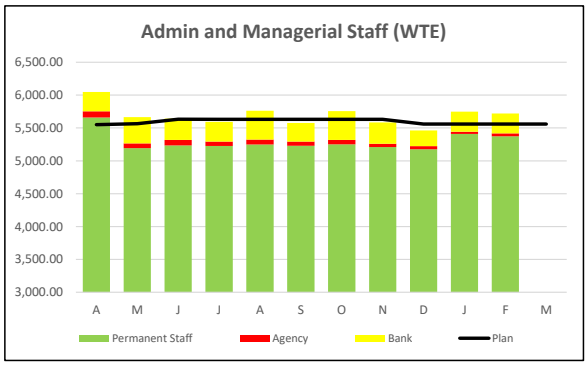
Bank expenditure, when flattened to take account of 4 or 5 week months is c.£8.4M per month, this is slightly below the trend noted in 2022/23 of £8.5M, driven by the impact of the industrial action. The Trust is in the process of reviewing its temporary staffing controls.

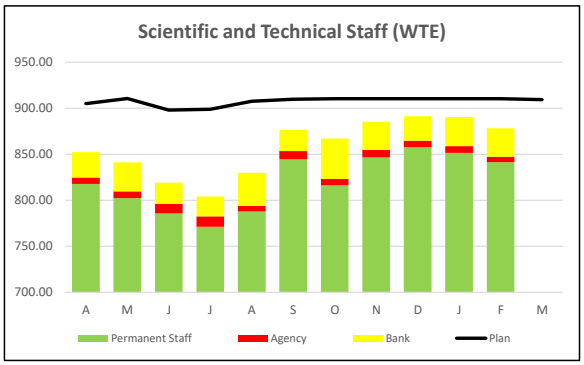
Staffing Utilisation (WTE's) - Trust

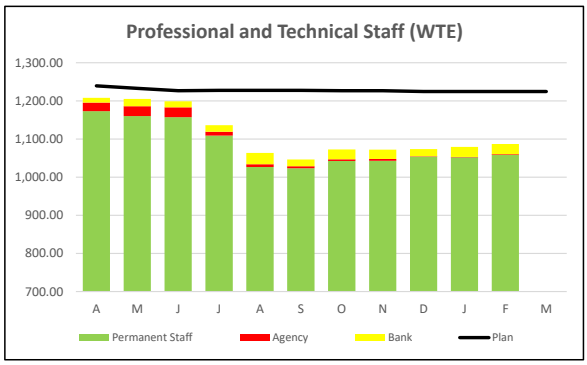


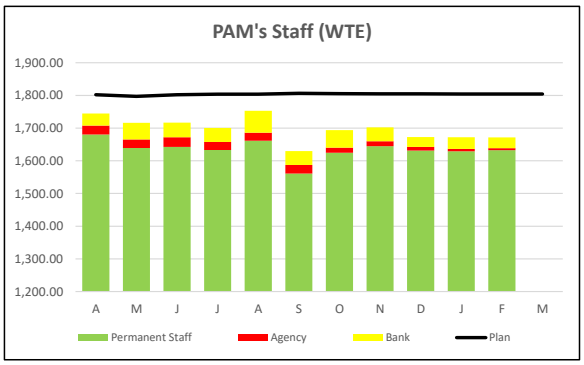


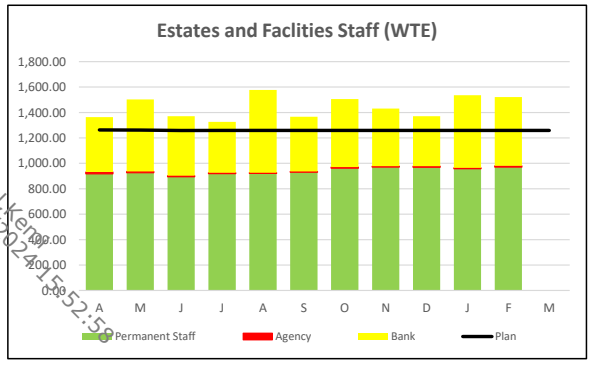


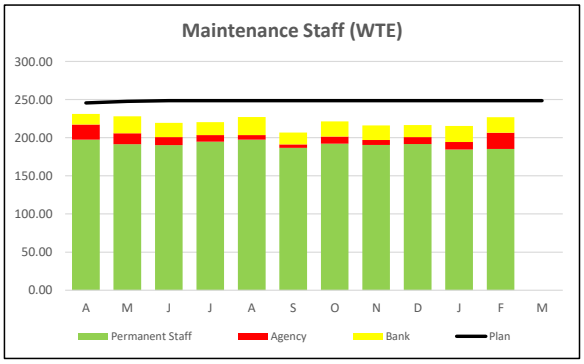












Trust Balance Sheet - £000

	Opening Balance @ 01/04/23 £000	Closing Balance @ 29/02/2024 £000	Movement £000
Fixed Assets			
Property, Plant Equipment	1,849,003	1,837,096	(11,907)
Intangible Assets	157,171	196,600	39,429
Investment property	75,134	75,135	-
Trade & Other Receivables Non-Current	7,911	8,113	202
Other Financial Assets	2,196	2,349	153
Total Fixed Assets	**2,091,415**	**2,119,293**	**27,878**
Current Assets			
Inventories	48,015	61,316	13,301
Cash & Cash Equivalents	130,760	104,927	(25,833)
Trade & Other Receivables - Current	262,298	266,498	4,200
Total Current Assets	**441,073**	**432,741**	**(8,332)**
Creditors: Amounts Falling Due Within One Year	(499,350)	(507,150)	(7,800)
Borrowings: Amount Falling Due within One Year	(51,622)	(23,666)	27,956
Provisions For Liabilities & Charges	(1,755)	(782)	973
Net Current Assets / (Liabilities)	**(111,654)**	**(98,857)**	**12,797**
Fixed & Net Current Assets / (Liabilities)	**1,979,761**	**2,020,436**	**40,675**
Creditors: Amounts Falling Due More Than 1 Yr	-	-	-
Borrowings: Amount Falling Due More Than 1 Yr	(301,674)	(297,413)	4,261
Provisions For Liabilities & Charges	(13,925)	(13,849)	76
NET ASSETS	**1,664,162**	**1,709,174**	**45,012**
Financed by:			
Taxpayers Equity			
Public Dividend Capital	593,146	660,057	66,911
Revaluation Reserve	564,338	564,338	0
Other reserves	743	743	-
Retained Earnings	505,935	484,036	(21,899)
Total Taxpayers Equity	**1,664,162**	**1,709,174**	**45,012**

The Trust closed the month with a cash balance of £104.9M, a reduction of £25.8M from the opening balance on 1st April 2023.

An analysis of the reduction in cash is contained on P15.

Trust Capital Programme

Source	Current Mth Plan	Current Mth Spend	Current Mth Variance	YTD Capital Plan	YTD Spend	YTD Variance	Capital Plan
	£000	£000	£000	£000	£000	£000	£000
In-Flight Programmes							
TYA Cancer Ward relocation	0	219	(219)	7,900	4,400	3,500	6,300
East Wing Critical Care Unit	0	(52)	52	4,000	3,982	18	5,700
Nuffield Theatres	0	(114)	114	2,000	4,904	(2,904)	3,100
Oral Medicine Expansion	0	1	(1)	100	(175)	275	100
Assisted Conception Unit storage	0	(38)	38	1,000	1,172	(172)	1,000
RBH Chillers	0	0	0	1,000	550	450	1,000
DTI Strategic Network	500	214	286	7,400	4,416	2,984	11,000
Telephony refresh	167	7	160	1,833	1,685	148	2,000
Investment in MedTech company	0	0	0	900	0	900	900
Cancer Centre Re-cladding	0	81	(81)	0	4,692	(4,692)	0
Patient Centric Supply Chain	0	92	(92)	0	178	(178)	0
Oracle Cloud	0	0	0	0	200	(200)	0
Windows 10	0	(60)	60	0	1,220	(1,220)	0
Slippage on Inflight							(4,100)
Block Allocations							
Estates Maintenance Backlog	1,083	829	254	11,917	5,261	6,656	13,000
Medical Equipment (exl. Cath Labs)	750	1,482	(732)	8,250	5,251	2,999	9,000
DT&I (inc. Data Centre and NHS Mail)	742	199	542	8,158	1,931	6,227	8,900
Infrastrucutre and Resilience							
Theatres	250	255	(5)	2,750	763	1,987	3,000
Cath Labs	100	1	99	1,100	4	1,096	2,300
Trust Major Programmes							
Orthopaedics Centre of Excellence	167	30	137	1,833	470	1,363	2,000
Paediatric Oncology	0	0	0	0	0	0	0
Clinical Group Risk and Priority Schemes							
Maternity Assessment Unit	0	0	0	200	0	200	200
Third Obstretric Treatment Room	0	19	(19)	1,000	197	803	1,000
Linac at Guys	330	23	307	3,670	475	3,195	4,000
Central Assumptions							
Slippage	(833)	0	(833)	(9,167)	0	(9,167)	(10,000)
Contingency	100	0	100	1,100	0	1,100	5,600
Others							
Asset Management	0	384	(384)	0	2,288	(2,288)	0
DT&i	0	359	(359)	0	2,802	(2,802)	0
Others	0	(358)	358	0	1,628	(1,628)	0
TOTAL INTERNALLY FUNDED	4,755	9,096	(4,341)	89,538	100,454	(10,916)	100,000
CHARITY FUNDED							
AI Centre OLS Programme (Innovate UK)	67	22	44	733	504	230	800
Others - Notional	643	1,149	(506)	4,357	440	3,917	5,000
TOTAL CHARITY FUNDED SCHEMES	710	1,171	(462)	5,090	944	4,147	5,800
PDC FUNDED							
Image Sharing	0	0	0	600	0	600	600
iRefer	0	0	0	975	0	975	975
Lims and Interoperability	100	0	100	0	0	0	840
Digital Pathology	0	0	0	0	0	0	450
TLHC	0	0	0	0	0	0	439
Automated Red Blood Cell Exchange	0	0	0	0	0	0	60
Cyber Improvement Programme (CIP) PDC	0	0	0	0	0	0	137
Electronic Patient Record (EPR) Digitisation	0	0	0	0	0	0	3,656
Strategic Transformation of Aseptic Services	0	0	0	0	0	0	600
1 CT scanner	0	0	0	0	0	0	1,404
Connecting Care Records Funding	0	0	0	0	0	0	250
Novaseq X	0	0	0	0	0	0	1,116
Equipment including Fridges, Freezers.	0	0	0	0	0	0	90
TOTAL PDC FUNDED SCHEMES	100	0	100	1,575	0	1,575	10,617
						0	
TOTAL CAPITAL	5,565	10,267	(4,703)	96,203	101,398	(5,194)	116,417

Trust Cashflow

	Apr-23 £m Actual	May-23 £m Actual	Jun-23 £m Actual	Jul-23 £m Actual	Aug-23 £m Actual	Sep-23 £m Actual	Oct-23 £m Actual	Nov-23 £m Actual	Dec-23 £m Actual	Jan-24 £m Actual	Feb-24 £m Actual	Mar-24 £m Forecast
Opening Balance	**131**	**134**	**122**	**106**	**88**	**90**	**40**	**121**	**118**	**88**	**79**	**105**
RECEIPTS												
NHS Acute Activity Income	180	189	235	191	199	197	204	188	192	223	204	216
Education/Merit awards/R&D	20	1	0	17	0	0	23	2	0	0	0	0
Other income	72	68	28	28	51	35	35	30	27	30	40	41
Loan / PDC received	0	0	0	0	0	0	58	0	0	3	9	0
Sub-total Receipts	**271**	**258**	**263**	**236**	**250**	**232**	**320**	**221**	**219**	**256**	**253**	**257**
PAYMENTS												
Salaries & Wages	66	68	96	69	72	74	71	72	74	72	72	72
PAYE / Superannuation/ NI	55	56	51	96	57	56	63	58	58	62	58	58
Creditors	146	144	128	89	121	131	107	96	118	133	97	130
Dividend Paid / Loan repayment	1	1	3	0	3	26	1	1	3	0	3	23
Sub-total Payments	**268**	**269**	**278**	**254**	**253**	**286**	**242**	**227**	**254**	**268**	**231**	**283**
Net in Month Cash Movement	**3**	**-11**	**-15**	**-19**	**-3**	**-55**	**77**	**-6**	**-35**	**-12**	**23**	**-25**
Subsidiaries Bank Bal.	**5**	**4**	**5**	**4**	**4**	**4**	**4**	**4**	**4**	**3**	**3**	**4**
Closing Balance	**134**	**122**	**106**	**88**	**90**	**40**	**121**	**118**	**88**	**79**	**105**	**84**

Debtors	> 90 Days £m's
NHS debtors	11.7
Contract ICB debtors	8.4
Non-NHS debtors	48.9
Total	**69.0**

Creditors	> 90 Days £m's
NHS creditors	10.6
Non-NHS creditors	19.2
Total	**29.8**

Cashflow Movement to Current Balance	£m's
Opening balance 1st April 2023	**130.8**
I&E YTD Deficit	-21.9
Bal' Sheet Flexibility - Non Cash	-29.9
Depreciation - Non Cash	90.1
Contract payment shortfalls	-13.4
PDC (from Oct' 23)	17.0
VAT Rebate	9.1
Capital Payments	-85.9
Loan Repayments	-16.3
Cash Support	57.5
Movement in Working Capital	-32.1
Closing balance 29th February 2024	**104.9**

The Trust ended M11 with a cash balance of £104.9m (partly boosted by the weekly creditor run falling one-day later), and is now forecasting this to reduce to £84m by the end of the year.

The current cash balance of £104.9m is a reduction of £25.9m from the £130.8m 23/24 opening balance. The main drivers of which are shown in the table "Cashflow Movement to Current Balance". These include our YTD deficit of £21.9m (increased from £12.2m at M10), contract payment shortfalls of £13.4m, capital payments of £85.9m, a VAT rebate of £9.1m, loan repayments of £16.3m (principal) and the cash support of £57.5m. Also included are non-cash adjustments with regard to balance sheet flexibility, depreciation and PDC which form part of the YTD deficit of £21.9m.

The capital payments of £85.9m includes £14.9m that relate to last year and were accrued. This, along with the cash balance movement, is one of the main causes of the movement in working capital. The forecast cash balance of £84m is largely due to the dividend payment in March.

There remains significant pressure on Creditor payments, which the forecast seeks to recognise, however our NHS debtors compare favourably, proportionately, to most other NHS organisations.
A significant element of our non-NHS debtor position is driven by Private Patient debt, for the most part successfully collected, albeit some elements (Embassies), taking a prolonged period of time to collect. Overseas visitor debts can also be problematic to collect.

BPPC YTD performance 2023/24	Volume %	Value %
NHS Invoices	72%	80%
Non NHS Invoices	91%	85%
Total	**90%**	**84%**

Guy's and St Thomas' NHS Foundation Trust

BOARD OF DIRECTORS
PEOPLE, CULTURE AND EDUCATION COMMITTEE

Wednesday 6 March 2024, 1pm – 4pm
Grand Committee Room, St Thomas' Hospital

Members Present:	Miranda Brawn (Chair)	Daghni Rajasingam
	Charles Alexander	Reza Razavi
	Avey Bhatia – until 3.45pm	Julie Screaton
	Felicity Harvey	Lawrence Tallon
In attendance:	Ria Burnett (minutes)	Sandra Noonan
	Jay Dungeni	Pav Ponnoosami
	Rob Godfrey	Neil Rees – item 9
	Helen Kay – item 9	Tendai Wileman
	Anita Knowles – from 1.40pm	Andrea WilliamsMckenzie
	Claire Mallinson	Claire Wills
	Paul Mouzouros	Lucy Yasin

1. Welcome and Apologies

1.1. The Chair welcomed colleagues to the meeting of the People, Culture and Education Committee (the Committee). Apologies had been received from Ian Abbs, Gubby Ayida, Deirdre Kelly and Simon Steddon.

2. Declarations of Interest

2.1. There were no declarations of interest.

3. Minutes of the previous meeting held on 6 December 2023

3.1. The minutes of the previous meeting of the Committee on 6 December 2023 were agreed as an accurate record, with the removal of a typographical error in section six.

4. Review of action log

4.1. The Committee reviewed the action log. It was agreed that the three actions recommended for closure, action 3 on data on ethnicity and banding, 4 on reflections from the Board Away Day and 6 on cultural and relational impacts of ongoing strike action could be closed.

5. Board Assurance Framework risks

5.1. The Committee owned two strategic risks on the Board Assurance Framework (BAF) regarding the recruitment and retention of sufficient numbers of staff to deliver high-quality services, and the health and wellbeing of these staff. These risks would be kept in mind during discussions.

6. Operational People Metrics - Focus on PDR

6.1. The Committee received an overview of the current workforce metrics to support visibility of current and future workforce challenges. The latest data included a focus on performance development review (PDR) compliance, as completion was at 70.54% compared with the Trust's target of 95%. The Committee noted concerns about accuracy of this data, that relevant data cleansing and work to improve compliance in any event were in progress. The live Heart Lung and Critical Care Clinical Group 'book the date' campaign was an example of a measure which had improved compliance. The Committee recognised the significance of achieving compliance, particularly as this was important for staff development and an important area of focus for CQC inspectors and formed part of the well led domain.

6.2. The Committee noted that levels of long-term sickness were higher than short term sickness. The ledger cleanse process was focused on vacancy levels, and it was expected that levels would reduce significantly once that process was complete. Service automation, for example, in overpayments, would increase efficiencies. Updating of the Trac recruitment system would help drive up recruitment. The Committee agreed that there should be increased focus on automation and use of artificial intelligence to assist the delivery of swift and necessary changes for the benefit of staff and patients, and that the CITI team would present proposals at a future meeting.

6.3. The highest number of discrimination claims received by the Trust related to disability. Work within the workforce relations team was focused on learning from experience to ensure sufficient work place adjustments were made and sickness absence was managed more effectively in the early stages.

7. National Staff Survey Results

7.1. The Committee received a high-level summary of findings shared under national embargo until 7 March 2024. Key issues included both negative and positive data. As the launch of the national survey had coincided with the Trust's launch of Epic, internal publication and circulation of the survey had been delayed. This may have contributed to engagement levels which were 9% lower than 2023, and 7% below the national average.

7.2. The Trust Executive would examine the results in detail and agree necessary improvement actions, including enhanced engagement between senior executives/managers with staff, the appropriate capture of this, and increasing the survey response rate.

8. Gender, ethnicity and disability pay gap

8.1. Alongside required publication of the gender pay gap report, the Trust would voluntarily publish data on the disability and ethnicity pay gaps with the aim of improving staff and patient experience. It was noted that a centralised approach to reasonable adjustments where required would better support line managers. Further, the Communications team

would remind staff about the availability of sunflower lanyards for staff with invisible disabilities.

ACTION: AK

8.2. The synergies between the national staff survey results of the previous two years were highlighted. Overall, although some improvements had been identified in the latest results, these were not substantial and accordingly further improvements were required.

8.3. There was discussion about the local and national clinical excellence awards, the potential for these to contribute to the gender pay gap and corresponding need for the Trust to encourage and support its relevant female workforce to apply for them.

8.4. Noting that data had to be reported in a prescribed format, the Committee requested additional narrative and explanation of the survey results to help drive improvements, including more detailed analysis of salary differences within bands. The Chief People Officer would approve the revised format of this information,

ACTION: JD

9. Health and Wellbeing Options

9.1. The Committee received a summary of the benefits of the health and wellbeing offerings of the Trust, and specifically the 'Showing we care about you programme' (SWCAY). It was agreed that the Programme was extremely valuable to staff and to the Trust's reputation. The Committee noted that funding from Guy's and St. Thomas' Foundation was set to reduce from Spring 2024, and the various impacts of this which would require full consideration and management in order to maintain the benefits of SWCAY. In the near term, continued financial support from the Foundation was essential.

10. Trust values and behaviours

10.1. The Committee received an update on the progress made on the Trust's values and behaviours, which were an important part of a well led organisation, and that they would form a component part of the Trust's revised strategy.

10.2. The Committee noted that key themes arising from staff engagement on corporate values and behaviours were emerging, and discussed ways of enhancing this engagement as an important step in the integration agenda. The Committee requested increased engagement work with staff of the Heart Lung and Critical Care Clinical Group, consultants and staff in the community.

ACTION: TW

10.3. It was suggested that the next Committee meeting should be held at the Royal Brompton Hospital and this would be explored by the corporate affairs team.

ACTION: RB

11. Anti-racism statement - update following launch

11.1. The Committee received an update on the anti-racism engagement activities that had taken place following the launch of the anti-racism statement, including the establishment of an anti-racism advisory group and Trust-wide engagement activities further to anti-racism in action. The Organisational Development team was scoping of a leadership development programme. Whilst much further progress was needed, including in relation to appropriate terminology, the initial work was encouraging.

11.2. The Committee discussed the current ways in which racism could be reported at the Trust, including via Freedom to Speak Up (FTSU), and that the new Radar system did not include a specific category for such reporting; this would be reviewed,

ACTION: JD

11.3. The Committee was pleased to note the Shadow Board which was being implemented within the Heart Lung and Critical Care (HLCC) Clinical Group as an additional layer of scrutiny and how this could be duplicated across the Trust. It was noted the weblink for this went to the HLCC intranet and should be amended to include the GTi site as well. The Communication team would look at this to ensure a consistent approach.

ACTION: AK

11.4. It was agreed that the learning from the anti-racism programme should be shared across the Trust for the benefit of all colleagues with protected characteristics.

12. Freedom to Speak Up Policy - A reflection and planning tool

12.1. The Committee was advised that NHS England's (NHSE) and the National Guardian's Office (NGO) updated national FTSU policy for the NHS focused on the importance of inclusive and consistent speaking up arrangements and driving learning through listening.

12.2. NHSE and the NGO had published a reflection and planning tool, to help the NHS deliver the People Promise for workers, by ensuring they had a voice that counts and by developing a speaking up culture. The self-assessment improvement tool had been designed to help organisations and their leadership teams identify their strengths and gaps within their FTSU services.

12.3. The Trust had completed its self-assessment and this had been approved by the non-executives, and FTSU Guardian. Development areas to address in the next six months to a year were set out and noted by the Committee. Non-executive representation at the Committee was discussed and would be reviewed by Corporate Affairs.

ACTION: LY

13. People, Culture & Education Board Assurance Framework

13.1. The Committee reviewed the proposed updates to the two workforce-related risks on the BAF. No changes had been made to the controls or level of assurance since the last

meeting. There was a discussion about the PDR tools used, including development and talent management tools used for bands eight and nine.

14. Any other business

14.1. It was raised that a staff story was previously discussed and could be useful at each meeting and the Staff Governor agreed to progress this.

ACTION: CW

14.2. There was a discussion about job planning which arose as an action following the recent Audit and Risk Committee. A plan would be implemented to take this forward.

ACTION: MB, JS

Guy's and St Thomas' NHS Foundation Trust

BOARD OF DIRECTORS
QUALITY AND PERFORMANCE COMMITTEE

Wednesday 17th January 2023, 1:15am – 4:30pm
Robens Suite, Guy's Hospital

Members present:	Pauline Philip (Chair)	Jon Findlay
	Ian Abbs	Felicity Harvey
	Charles Alexander	Deirdre Kelly
	Avey Bhatia	Reza Razavi
	Beverley Bryant (from item 7)	Simon Steddon
In attendance:	Sarah Austin	Mark Mason
	Gubby Ayida	Marianna Masters
	Gina Brockwell (from item 12)	Phil Mitchell
	Sarah Clarke	Damien O'Brien
	Marcia de Costa (from item 5)	Harry Richardson (minutes)
	Róisín Fitzsimons (to item 7)	Jacqueline Sinclair
	Richard Grocott-Mason	Tendai Wileman
	Anita Knowles	Lucy Yasin
	Ruth Liley	

1. Welcome and apologies

1.1. The Chair welcomed colleagues to the meeting of the Quality and Performance Committee (the Committee). No apologies had been received.

2. Declarations of interest

2.1. There were no declarations of interest.

3. Minutes of the previous meeting(s)

3.1. The minutes of the previous meeting held on 8th November 2023 were approved as an accurate record.

4. Review of the action log

4.1. An update was received on the outstanding actions from previous meetings. It was agreed that actions 48 (activity projections), 53 (APC activity), 56 (lone-worker audit), 60 (overdue complaints), and 61 (mental health capacity) would be closed because updates for each were included within the papers. Actions 59 (PSIRF briefing) and 62 (paediatric spinal summit) would be addressed shortly. An update on action 63 (Epic user devices) would follow subsequently.

5. Board Assurance Framework

5.1. The Committee noted the Board Assurance Framework ('BAF') Strategic Risks for which it was responsible, namely Operational Performance and Quality of Care.

6. Staff Story

6.1. The Committee heard about the experience of a visually impaired staff member in the period following the Epic go-live. The transition had proved challenging as Epic had limited accessibility

functionality for those with visual impairments and also for those with neurodivergent conditions. The Trust had raised this with Epic and created a working group to address the issues, and had contacted other Trusts who had implemented Epic to learn from their experience and best practice.

7. Feedback from visits

The Committee recognised a number of visits had taken place over the Festive period and thanked staff for their efforts in working over the Christmas and New Year period and in supporting critical services during the recent industrial action.

8. Quality and safety update

8.1. The Committee received the standing report on quality and safety and noted the limited assurance assessment that remained for the Quality of Care BAF risk. It was confirmed that the Patient Safety Incident Response Framework had launched successfully on 4th December 2023 following a successful conference on Education for Patient Safety and that the planned implementation of the Radar software would be undertaken in phases until the end of March 2024, at which point Radar would replace the existing Datix system. The phased approach was in recognition of competing pressures for staff.

8.2. The Learning for Improvement Group was highlighted as an effective and transparent means by which to review serious incidents and to discuss the steps that could be taken to reduce the risk of reoccurrence. Trust Executive and Non-Executive Directors were encouraged to observe these meetings where possible. This group replaces the Serious Incident Assurance Panel and reflects the new framework approach.

8.3. It was noted that Administration Safety remained the highest clinical risk for the Trust. Following the Epic implementation and move to stabilisation, the Senior Responsible Officer role would transfer from the Chief Nurse to the Chief Operating Officer in the week commencing 22nd January 2024. The Chief Nurse was thanked for her leadership in ensuring a successful go-live for Epic on 5th October 2023.

8.4. Following the agreed delegation of standard complaint responses to the Clinical Group Chief Executives from February 2024, it was noted that the Trust Chief Executive would consider and sign all complex responses.

8.5. A target had been established for zero overdue complaints by the end of April 2024.

8.6. *Candida auris* was noted as having been detected in East Wing at St Thomas'. There had been no instances of patient harm recorded as a result.

8.7. The Committee noted a visit by the Human Fertilisation and Embryology Authority, and that further details would be provided at the next meeting.

9. Operational performance and activity

9.1. The Committee received an update on the Trust's operational performance and activity, and noted the decision by NHS England to place the Trust into 'Tier 1' for cancer performance. The 62-day and Faster Diagnosis Standard ('FDS') pathways were highlighted as challenged.

9.2 The Trust met NHS England on 16th January 2024, and performance reporting arrangements for the remainder of Q4 2023/24 were agreed. NHS England confirmed that, to return to 'Tier 2',

the Trust would need to reduce its 62-day cancer backlog to 255, and improve FDS performance to reach 75% by the end of March 2024.

9.3 As the next Quality and Performance Board Committee meeting was on 3rd April 2024, Committee members would be kept separately informed of progress made during the period to March 2024.

ACTION: TW

9.4 The Trust had committed to reducing the number of patients waiting more than 78 weeks to 65 by the end of March 2024. Capacity issues within paediatric spinal services across London had contributed to the number of 78-week waits, and a mutual aid process had been agreed across multiple providers within the region.

9.5 The Committee noted that the Emergency Department's performance against the 4-hour target had improved to 70.9% at the end of December 2023, driven largely by a reduced demand profile relative to the attendances experienced during the same period in previous years. It was highlighted that, while some 12-hour waits occur, these were almost exclusively for mental health patients for whom bed capacity remained an issue. Conversations were ongoing at system level, including directly with the South London and Maudsley NHS Foundation Trust, on this issue. However, assurance could not be provided that additional beds would be used to mitigate emergency attendances and waits. In addition, workforce issues remained in hiring suitably skilled staff, and the challenges were expected to remain for the Emergency Department for the foreseeable future.

10. Infrastructure

10.1 IT incident

10.1.1 The Committee received an update on the IT incident on 19th December 2023, and confirmation was provided that the cause was the expiry of security certificates.

10.1.2 The incident affected the Guy's, St Thomas' and community sites but did not impact either the Royal Brompton or Harefield sites.

10.1.3 A contractual review of the service provided by external partners had been commissioned. The security certificates had been renewed and all other security certificates reviewed to provide assurance, alongside other mitigations, that this type of incident would not reoccur.

10.1.4 An update on a second smaller scale IT incident on 12th January 2024 resulting from a failure within the Atos data centre was provided. A formal investigation had commenced and a rapid assessment was also underway to determine why the relevant failsafe was not activated.

10.1.5 A broader review of the Trust's Data, Technology and Information service would be commissioned to obtain a better understanding of the organisation's risk and resilience profile. Staff would be provided with an update about the issues which had arisen and caused disruption.

10.2 Estates update

10.2.1 The Committee received an update on the works undertaken across the Trust's estate. Confirmation was provided that there was no Reinforced Aerated Autoclaved Concrete at the Guy's boiler house or anywhere else on the Trust's estate.

10.2.2 The deterioration in the performance of the Trust's patient transport service in the second half of 2023 was noted. Given the attendant risks, the Trust Executive Committee would consider

the matter further and ensure suitable continuity arrangements were in place as may be required.

10.2.3 Ongoing ventilation issues in the Nuffield theatres were noted, together with a likely timescale of May 2024 for them to return to use.

10.2.4 The mobile CT scanner had been delivered and was due to be become operational by the end of January 2024. In addition, the remedial works to Mark, Edward, and Sarah Swift Wards had been completed on time and to plan.

10.2.5 Work continued to remove the 'Point of Use' water filters to address the recommendations detailed at the previous meeting.

11. Cancer and Surgery Update

11.1. The Committee noted the Clinical Group's assurance scorecard and received an update on the internal work undertaken to meet the planned trajectory for cancer performance.

11.2. The theatre refurbishment programme continued, and the importance of ensuring that this did not adversely impact on surgical capacity was noted.

11.3. As at 5th January 2024, there were 48 overdue complaints, of which 10 were categorised as complex and 38 as standard.

12. Evelina London – Women's and Children's Update

12.1. The Committee noted the Clinical Group's assurance scorecard and received an update on the work undertaken to ensure compliance with the NHS Resolution, Clinical Negligence Scheme for Trusts, and Maternity Incentive Scheme standards.

12.2. The Clinical Group was thanked for its work to complete the safety actions associated with this, and in submitting its responses to the Thirlwall Inquiry.

12.3. There were 24 overdue complaints.

13. Heart, Lung and Critical Care Update

13.1. The Committee noted the Clinical Group's assurance scorecard and noted the efforts that had been undertaken to mitigate the closure of Sarah Swift Ward and sustain sufficient vascular beds by utilising day-case beds in the cardiovascular service.

13.2. Overdue complaints had reduced to 10 since the Group's most recent Performance Review Meeting.

14. Integrated and Specialist Medicine Update

14.1. The Committee noted the Clinical Group's assurance scorecard and the ongoing actions to address the external review of the aseptic pharmacy conducted by Specialist Pharmacy Services in November 2023.

14.2. It was noted that the Clinical Group retained a 'nil' assurance rating for Use of Resources due to a significant adverse variance against its financial plan. It was clarified that this rating did not reflect the Trust's confidence that the necessary steps were being taken to correct the position.

14.3. As at 22nd December 2023, there were 23 overdue complaints, and progress was being made to reach zero by the end of March 2024.

15. Board Assurance Framework

15.1. The Committee approved the Strategic Risks 1 (Operational Performance) and 2 (Quality of Care) in the Trust's BAF.

16. Statutory and Regulatory Reports

16.1. The Committee noted the contents of the statutory and regulatory reports. It was requested that the level of detail contained in the reports be reviewed to ensure that the most effective assurance was being provided to the Committee.

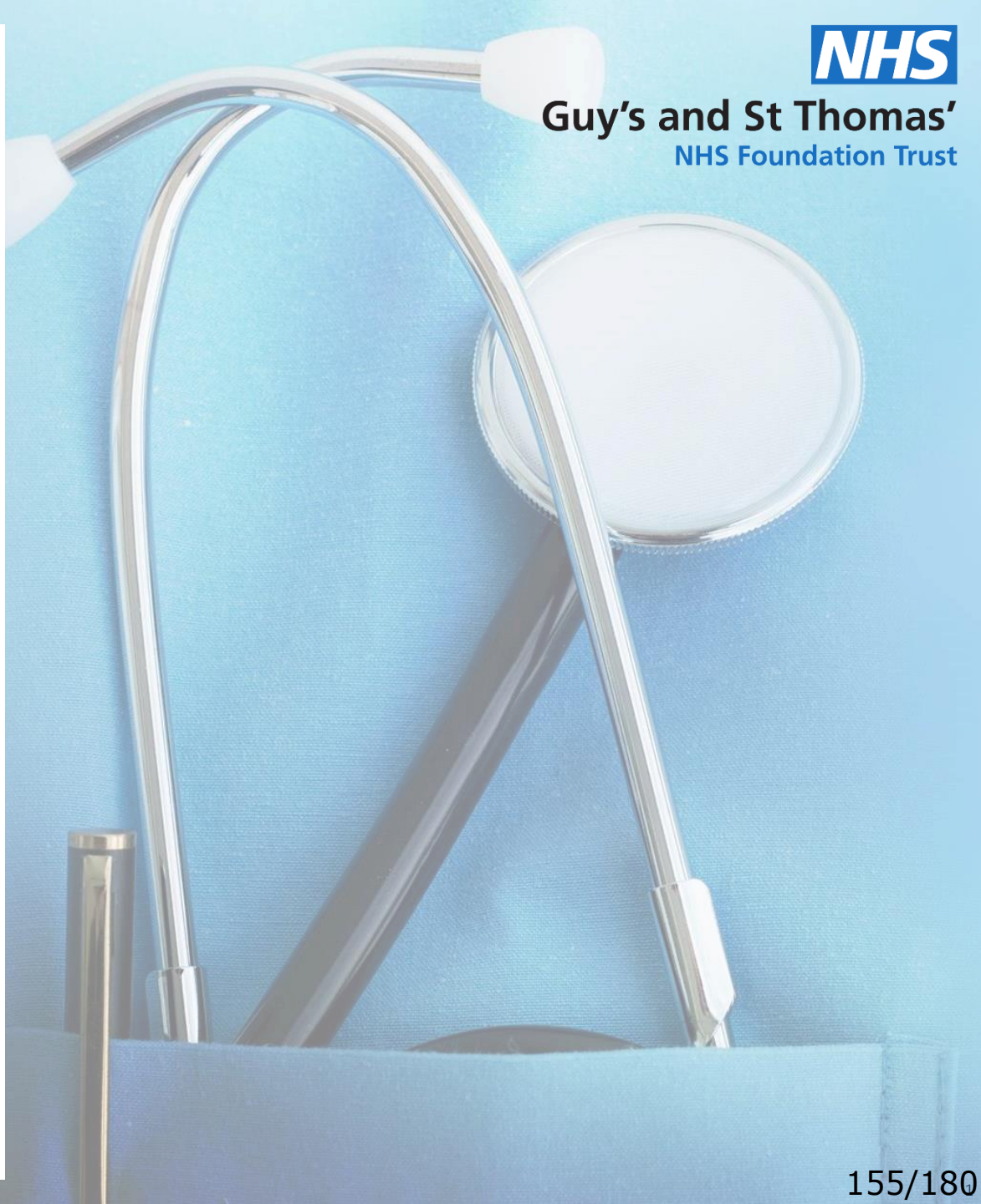
ACTION: TW / RL

16.2. It was confirmed that, for future meetings, the statutory and regulatory reports would be separately indexed in the Trust's Board software.

17. Any Other Business

17.1. There was no further business.

The next meeting of the Committee would be held on Wednesday 3rd April 2024.



Guy's and St Thomas'
NHS Foundation Trust

Integrated Performance Report

March 2024

Introduction

Guy's and St Thomas'
NHS Foundation Trust

About this pack

The Trust produces this Integrated Performance Report (IPR) to provide our Board, Executive team, Clinical Groups and other stakeholders the performance position across our core domains[1] of Safe, Effective, Caring, Responsive, People and Enablers/Use of Resources.

The IPR includes:

- Highlight Reports – a selection of indicators highlighted for Board discussion on the basis of Statistical Process Control (SPC) variation and those indicators that are most significant for national reporting.
- Supporting Information – this section provides information on reporting content and logic.

**Where Royal Brompton and Harefield (RBH) data is not included for an indicator, this will be stated. Work is ongoing to include RBH Clinical Group data for all metrics within this report.*

[1]The source of our core domains:
- Safe, Effective, Caring and Responsive - CQC
- People - NHS People Plan
- Enablers/Use of Resources - NHS E/I

Highlight Report Contents

March 2024

Guy's and St Thomas' NHS Foundation Trust

The indicators below have been determined by the domain leads as highlights for this month's report.

Domain	Indicator	Actual	Target	Page
Responsive	Percentage of A&E patients that waited less than 4 hours to be seen (type 1, 2 and 3)	75.5%	76.0%	4
Responsive	Number of patients spending >12 hours in A&E from decision to admit (DTA)	32	0	5
Responsive	Percentage of patients waiting over 6 weeks for a diagnostic test	46.48%	1.0%	6
Responsive	Percentage of cancer referrals seen within 2 weeks(Feb 24)	89.8%	93.0%	7
Responsive	Percentage of cancer referrals meeting the faster diagnosis standard of outcome of suspected cancer within 28 days of referral(Feb 24)	72.8%	75.0%	8
Responsive	Percentage of cancer patients starting their subsequent treatment within 31 days of treatment plan agreement (surgical)(Feb 24)	85.6%	96.0%	9
Responsive	Percentage of cancer patients starting their first treatment within 62 days of all urgent GP referrals(Feb 24)	31.0%	85.0%	10
Responsive	62Day Cancer Backlog	239	255	11
Responsive	Outpatients New – Percentage of 19/20 Activity	99.1%	-	12
Responsive	Outpatients Follow Up – Percentage of 19/20 Activity	93.1%	-	13
Responsive	Elective Daycase - Percentage of 19/20 Activity	89.1%	-	14
Responsive	Elective Overnight - Percentage of 19/20 Activity	88.1%	-	15
Responsive	Number of pathways on the waiting list currently waiting more than 65 weeks to start treatment	953	-	16
Responsive	Number of pathways on the waiting list currently waiting more than 78 weeks to start treatment	66	-	17

SPC and level definitions

Definitions for SPC flags and level thresholds for each indicator can be found within the support information in the appendix

Responsive

Percentage of A&E patients that waited less than 4 hours to be seen (type 1, 2 and 3)

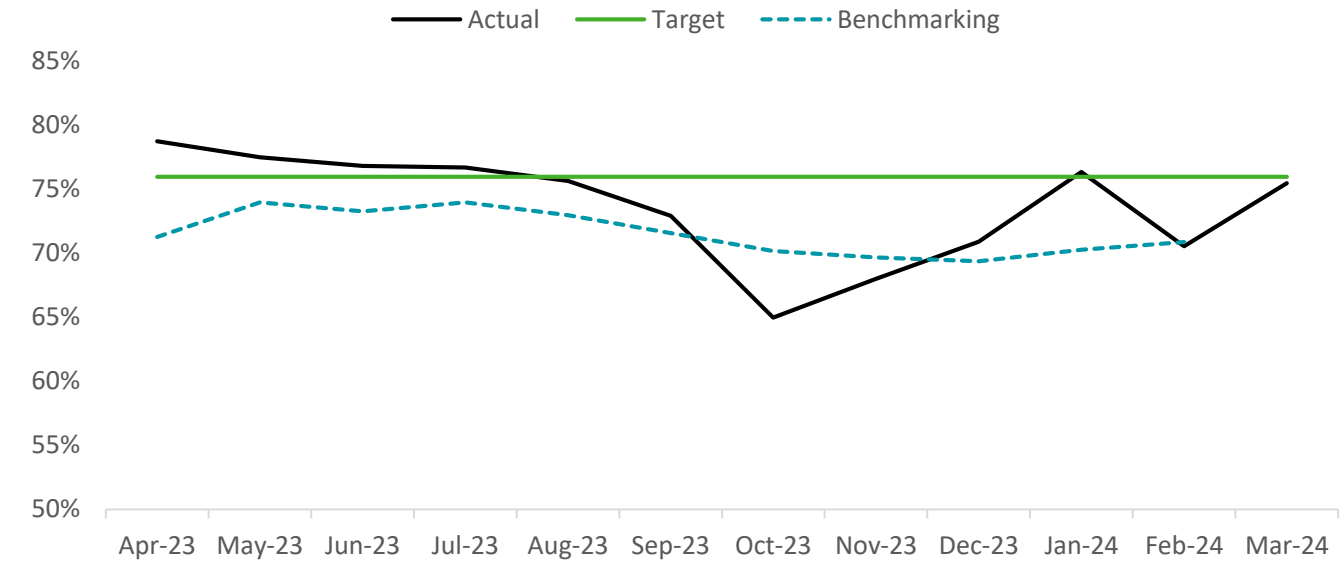
Guy's and St Thomas' NHS Foundation Trust

Mar-24	Target
75.5%	76.0%

NHS England Benchmarking (average performance across general hospitals)

Dec-23	Jan-24	Feb-24
69.4%	70.3%	70.9%

A&E stays less than 4 hours (type 1 2 3)



Clinical Group Overview

Data is unavailable at clinical group level

Updates since previous month

- In March the Trust improved from February's 4-Hour performance position of 70.6% by 4.9 percentage points to 75.5%, narrowly missing the national target of 76%.
- The Trust is committed to improving this position further and meeting the 2024/25 target of 78% by March 2025.

Current issues

- A continued high volume of mental health patients impacting on length of stay.
- Optimising EPIC.
- Tackling challenges to patient flow, from improved portering to discharge and transport.

Key dependencies

- High volume of psychiatric patients, with longer lengths of stay.
- Diagnostics capacity.
- Optimising EPIC to improve functionality – portering, bed management, discharge.

Future actions

- To implement the identified actions from the patient flow workstream which includes the acute medicines flow and home for lunch initiatives.
- To implement the findings from the successful and fruitful Multi Agency Discharge Event in March 2024.

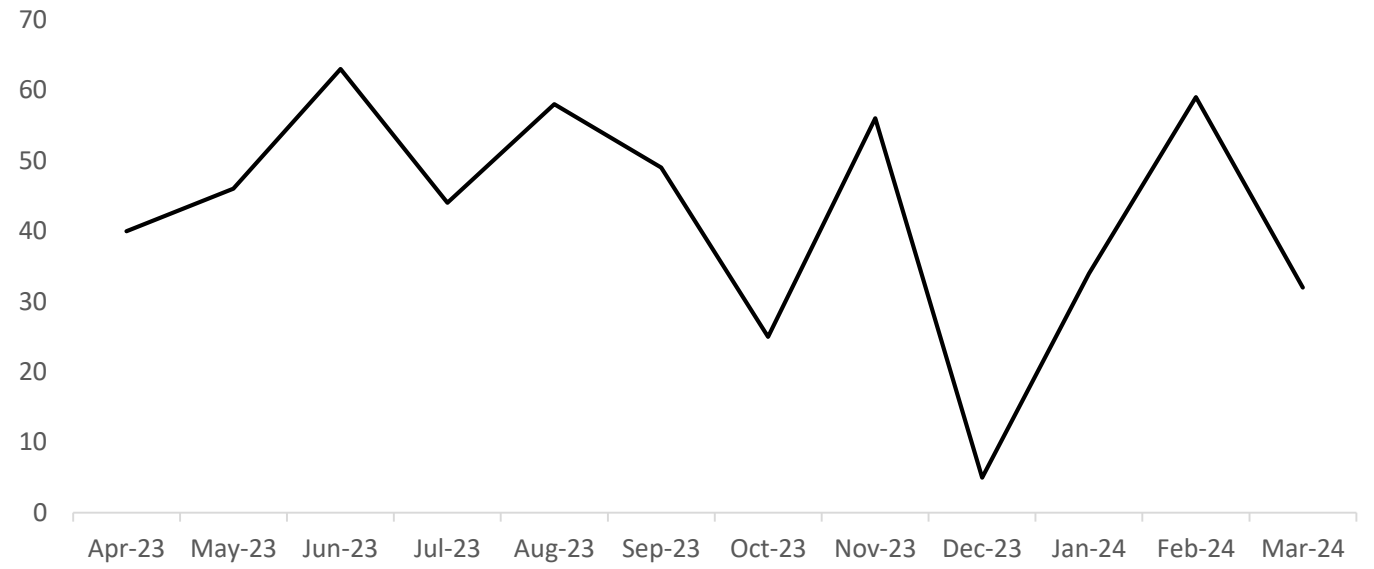
Responsive

Number of patients spending >12 hours in A&E from decision to admit (DTA)

Guy's and St Thomas' NHS Foundation Trust

Mar-24	Target
32	0

Number of patients spending >12 hours in A&E from decision to admit (DTA)



Clinical Group Overview

Data is unavailable at clinical group level

Updates since previous month

- The number of 12-Hour Decision to Admit breaches which took place in March is 32, this is a reduction of 27 on February's submitted position. The Trust continues to work with system partners to improve pathways for these vulnerable patients.

Current issues

- Developing staff capabilities and service resilience to better manage psychiatric patients.
- The level of need and complexity for psychiatric patients often involves a longer length of stay which is not beneficial to the patient.

Key dependencies

- Capacity within A&E due to longer lengths of stay, and impact on patient flow.
- Work with system partners to continually review and improve pathways and capacity across the ICS to better serve this patient cohort.

Future actions

- Implement a Mental Health Strategy which includes, staff training.
- Work with system partners to ensure pathways and capacity flex to meet the need of this patient cohort.

Responsive

Percentage of patients waiting over 6 weeks for a diagnostic test

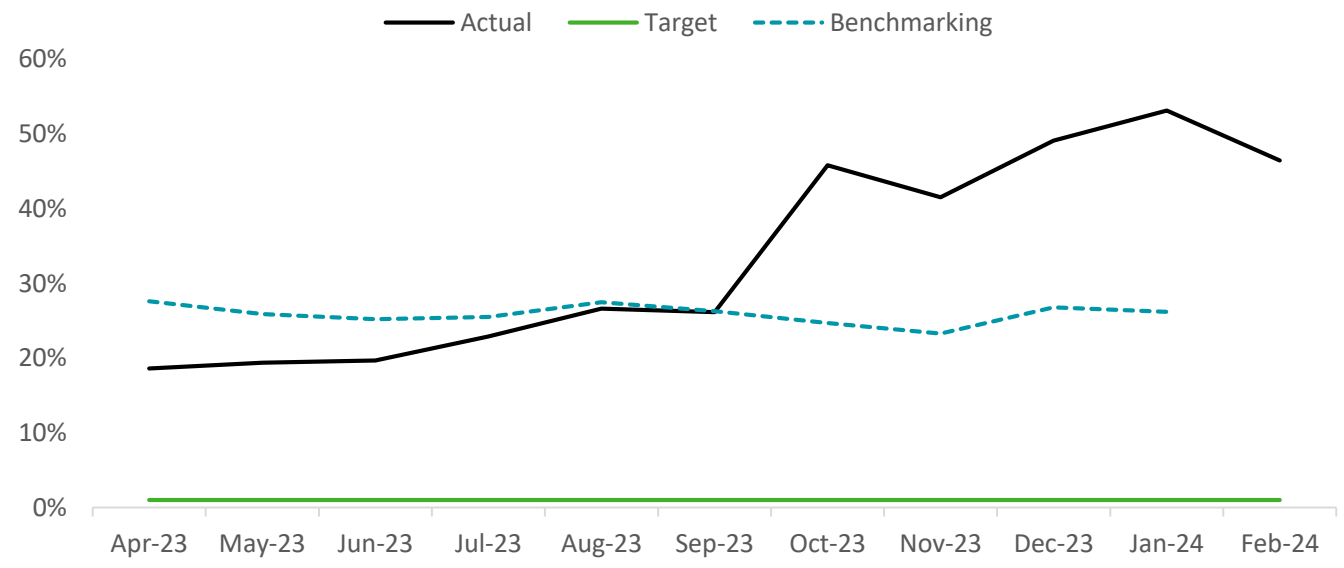
Guy's and St Thomas' NHS Foundation Trust

Feb-24	Target
46.48%	1.0%

NHS England Benchmarking (average performance across hospitals)

Nov-23	Dec-23	Jan-24
23.3%	26.8%	26.2%

Diagnostic waits - % over 6 weeks



Clinical Group Overview

Data is unavailable at clinical group level.

Updates since previous month

- The Trust's submitted DM01 position for March is 46.48%, this is an improvement of 6.66 percentage points on February's position of 53.14%.
- Additional resources are being deployed to drive sustainable improvements in diagnostic performance with a focus on improving performance in 2024/25.

Current issues

- Stabilise migrated diagnostic data within EPIC.
- Increasing staff capabilities and confidence across the Trust in using EPIC for diagnostics.
- Increase capacity to meet demand across the sector.
- Eliminate long waits for diagnostic tests.
- The Trust is currently a benchmarking outlier.

Key dependencies

- Stabilising diagnostic data within EPIC in order to then optimise the available functionality.
- Work with system partners to balance demand with capacity, acknowledging demand is forecast to increase national and locally.

Future actions

- Optimise EPIC functionality to improve the management of diagnostic patient waiting lists.
- Develop system strategies with partner Trusts to eliminate long waits and improve equity of access.
- Work with Primary Care to improve referral pathways.

Responsive

Percentage of cancer referrals seen within 2 weeks

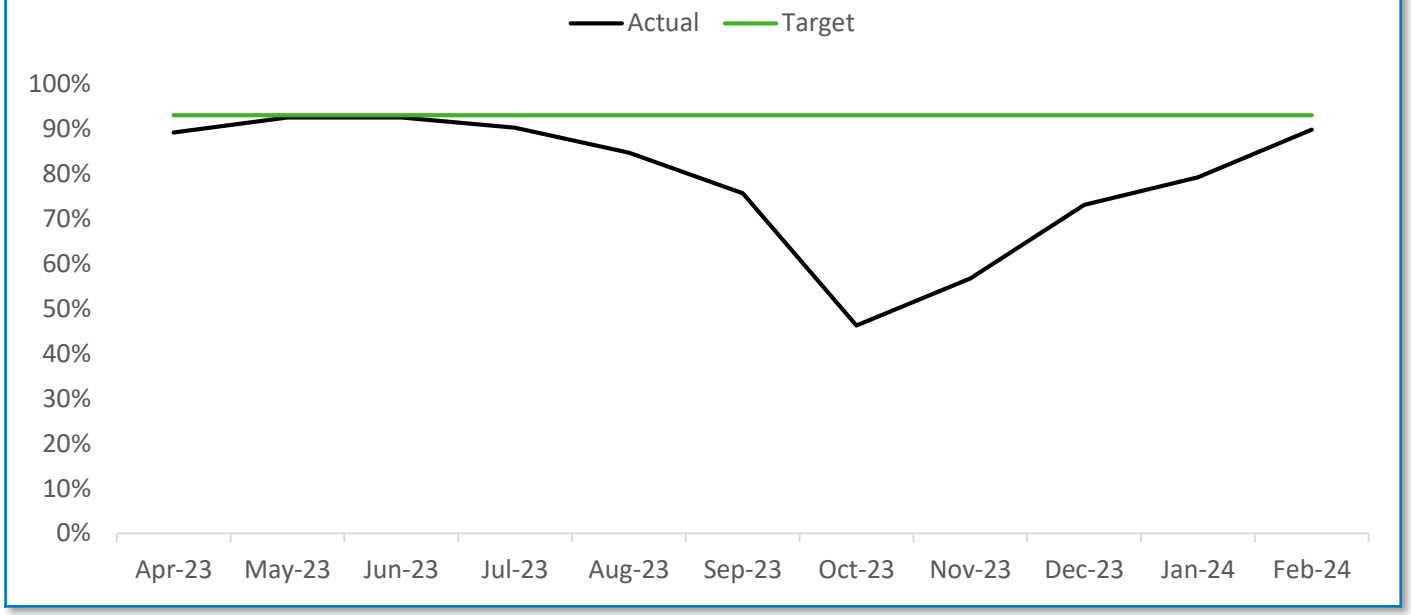
Guy's and St Thomas' NHS Foundation Trust

Feb-24	Target
89.8%	93.0%

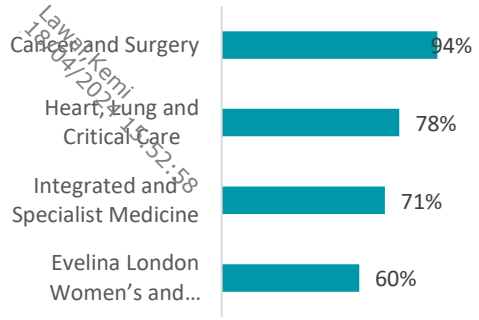
NHS England Benchmarking (average performance across hospitals)

Jul-23	Aug-23	Sep-23
77.5%	74.8%	74.0%

Cancer - 2 week wait



Clinical Group Overview



Updates since previous month

- Following the transition to Epic, the Trust has successfully stabilised cancer data with all PTLs being reconciled. The Trust's submitted position for February is 89.6%, this being a 10.4 percentage point improvement on January's submitted position of 79.2%.

Current issues

- Managing demand fluctuations and the impact of Industrial Action and Bank Holidays on capacity.
- Oral Surgery capacity and increased demand.

Key dependencies

- Diagnostic capacity for direct to test patients.
- Demand fluctuations and service level polling ranges on e-RS.
- Outpatient space.
- Industrial Action.

Future actions

- Continue to focus on delivering the required front end capacity to sustain a compliant 14 day position and 7 day where possible in order to support a sustained Faster Diagnosis Standard in line with the agreed 24/25 plan.

Responsive

Percentage of cancer referrals meeting the faster diagnosis standard of outcome of suspected cancer within 28 days of referral

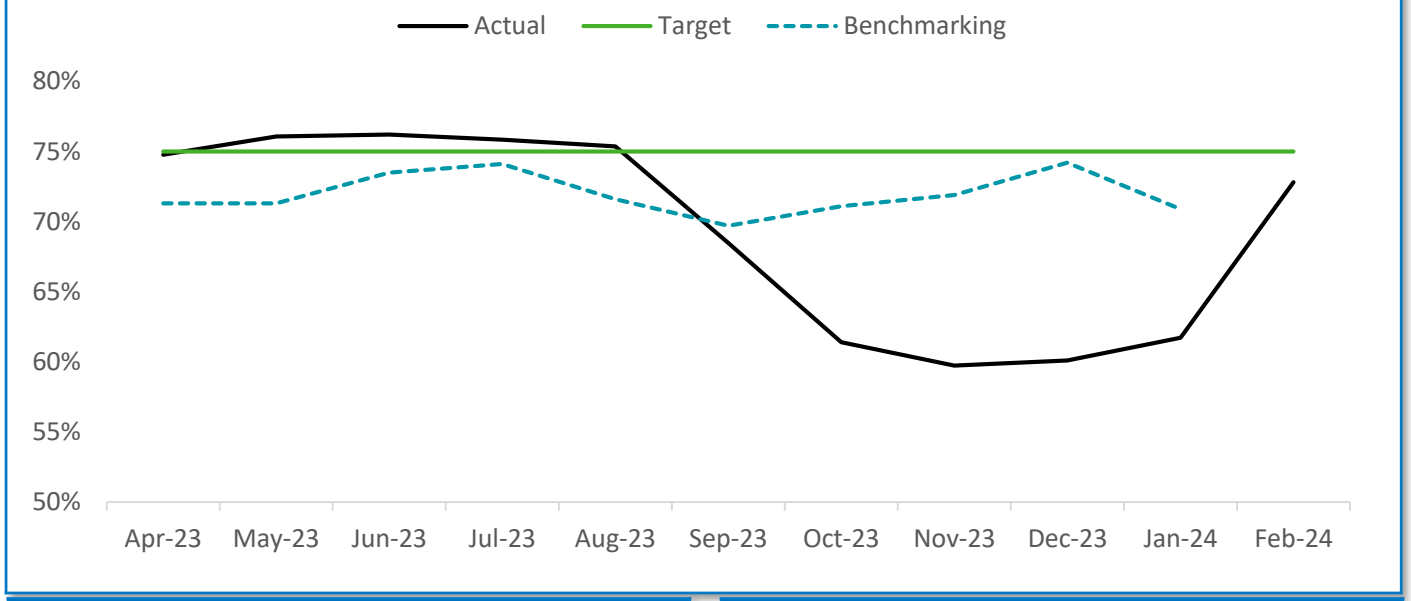
Guy's and St Thomas' NHS Foundation Trust

Feb-24	Target
72.8%	75.0%

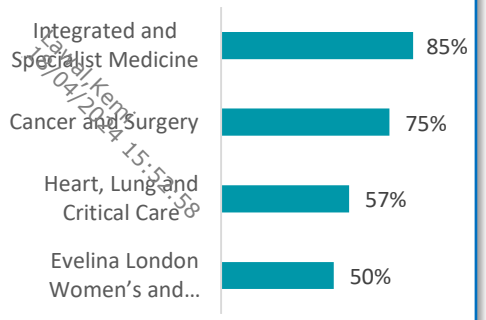
NHS England Benchmarking (average performance across hospitals)

Nov-23	Dec-23	Jan-24
71.9%	74.2%	70.9%

Cancer - FDS



Clinical Group Overview



Updates since previous month

- The Trust's submitted position for February is 72.8%, this is 11.1 percentage points up on January's submitted position of 61.7%.
- February's performance brings the Trust back in line with benchmarking averages, and sets the Trust on a trajectory to reach 75.0% in March 24.

Current issues

- Sustainably delivering the required capacity for outpatients and diagnostics.
- Reaching and sustaining greater than 90% performance in high through-put services.
- Managing demand fluctuations and the impact of Industrial Action on capacity.

Key dependencies

- Imaging, Pathology and Surgical Capacity
- Front end outpatient and diagnostic capacity.
- Demand fluctuations.
- Industrial Action.

Future actions

- Focus on meeting the 24/25 ambition of reaching 77% by March 25 whilst aiming to ensure that diagnosed and undiagnosed cancers average wait to diagnosis are equal.
- Focus for March improvement Gynae, GI and Urology

Responsive

Percentage of cancer patients starting their subsequent treatment within 31 days of treatment plan agreement (surgical)

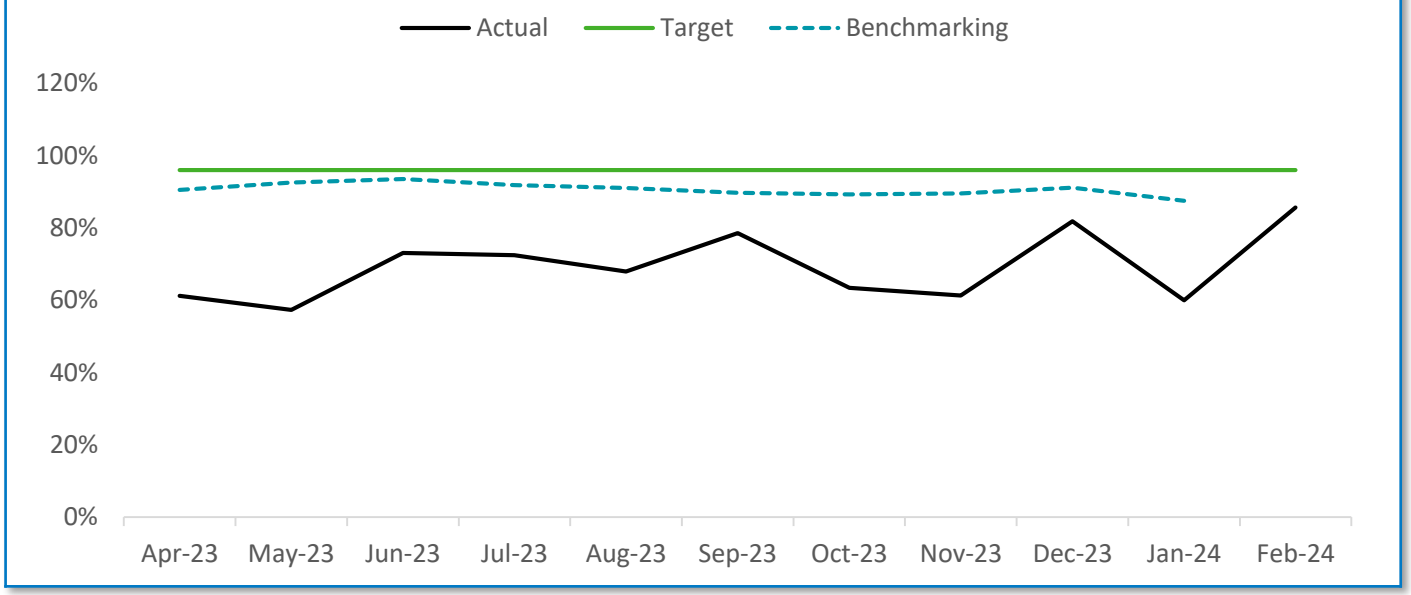
Guy's and St Thomas' NHS Foundation Trust

Feb-24	Target
85.6%	96.0%

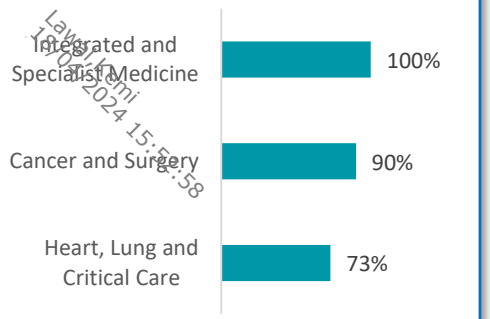
NHS England Benchmarking (average performance across hospitals)

Nov-23	Dec-23	Jan-24
89.5%	91.1%	87.5%

Cancer - 31 day subs treatments - surgical



Clinical Group Overview



Updates since previous month

- In February the Trust's submitted position for the 31-Day Cancer standard is 85.6%, this is an improvement of 25.6 percentage points on January's submitted position of 60.0%.
- February's performance aligns the Trust with benchmarking performance averages.

Current issues

- Late referrals from other providers in South East London and the South East of England.
- Delivering sustainable treatment levels to deal with demand taking into account compromised surgical capacity due to Industrial Action and Bank Holidays.

Key dependencies

- Inter Provider Referrals.
- Treatment capacity (surgical).
- Industrial Action.

Future actions

- Continue the work with system partners to implement the Trust's Cancer Recovery Plan with a focus on inter Trust referrals requiring timely surgical treatment.
- Continue the excellent work across services and tumour groups to mitigate risks to service delivery and productivity.

Responsive

Percentage of cancer patients starting their first treatment within 62 days of all urgent GP referrals

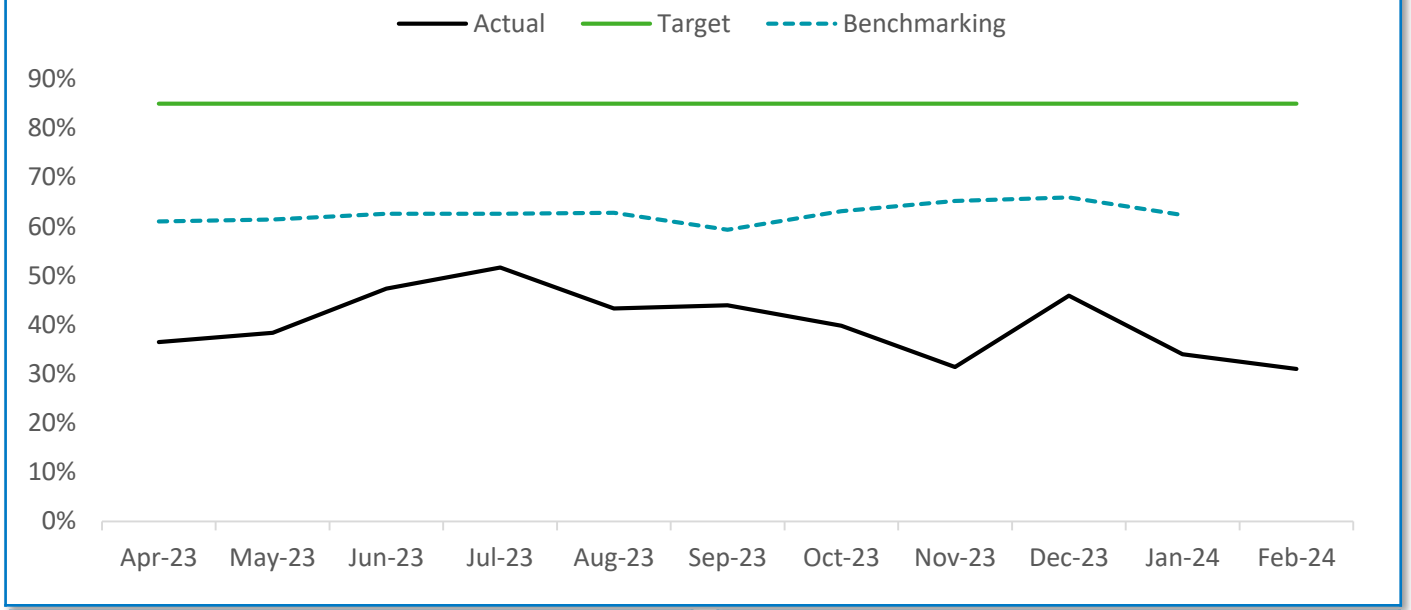
Guy's and St Thomas' NHS Foundation Trust

Feb-24	Target
31.0%	85.0%

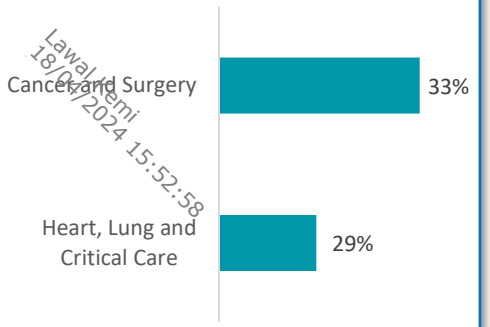
NHS England Benchmarking (average performance across hospitals)

Nov-23	Dec-23	Jan-24
65.2%	65.9%	62.3%

Cancer - 62 day urgent GP referrals



Clinical Group Overview



Updates since previous month

- The Trust's 62 day performance remains an outlier, with the Trust's position in February being 31.0%, this being a deterioration of 3 percentage points on January's submitted position of 34.0%.
- This is reflective of the Trusts focus on clearing the 62 day backlog which has dramatically reduced in recent months.

Current issues

- Late referrals from other providers in South East London and the South East of England and treating patients within 24 days.
- Trust focus on backlog clearance adversely impacting 62 day performance.
- Reducing average FDS waits for cancer diagnosis.
- Industrial Action and Bank Holidays impacting on activity.

Key dependencies

- Inter Provider Referrals.
- Backlog clearance.
- Imaging, Pathology and Surgical Capacity
- Demand fluctuations.
- Industrial Action.

Future actions

- Focus on working with system partners to sustainably deliver the 24/25 ambition of reaching 65% overall performance for the Trust (70% internal).
- Focus on 'treat 24' initiative and reducing variation on shared diagnostic pathways through joint working in SEL.
- Focus on the Trusts cancer recovery plan.

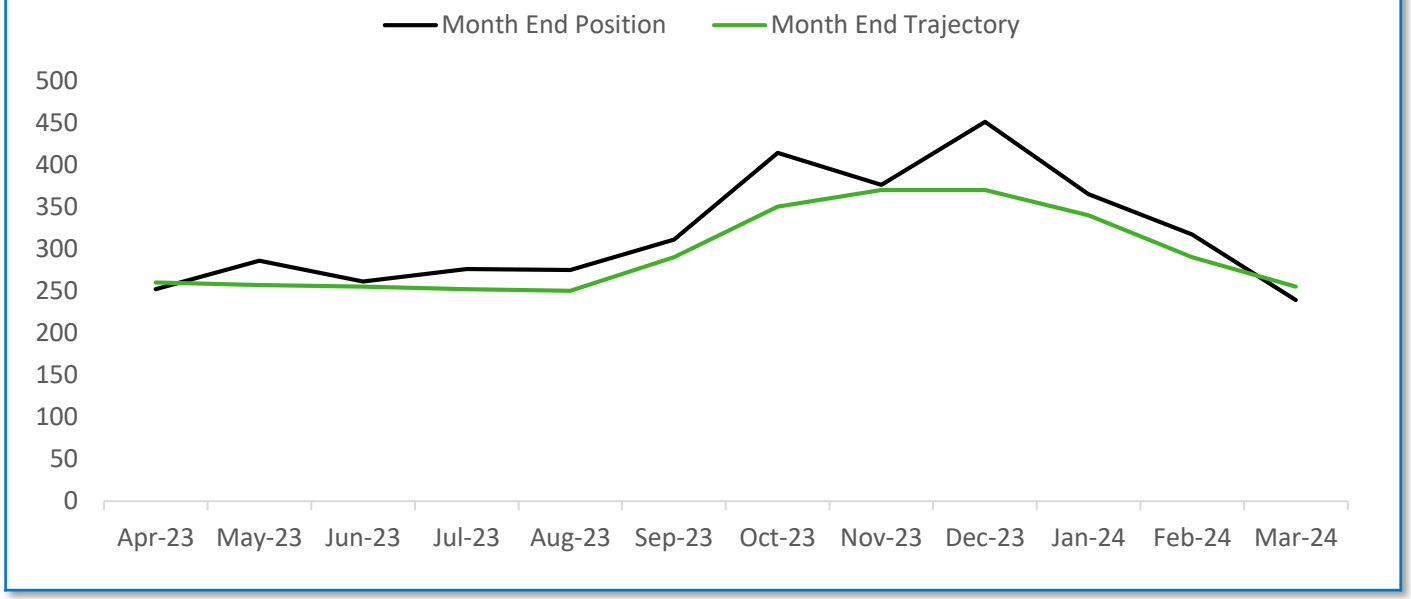
Responsive

62Day Cancer Backlog

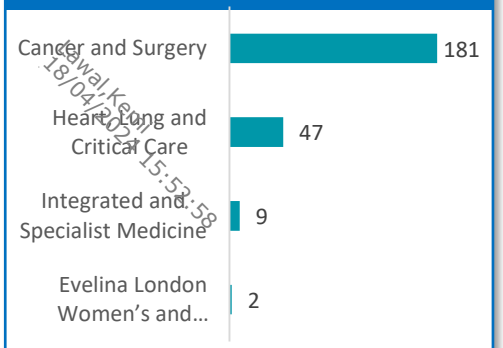
Guy's and St Thomas'
NHS Foundation Trust

Mar-24	Trajectory
239	255

Cancer – 62 Day backlog



Clinical Group Overview



Updates since previous month

- The cancer backlog has reduced by 25% (78) since February.
- There has been an overall reduction of 47% (212) since the peak of 451 patients in December with reductions seen across all tumour groups and large decreases seen in Breast, Gynae, H&N Lung and Urology.

Current issues

- Late referrals from other providers in South East London and the South East of England.
- Matching capacity and demand for treatment and diagnostics.
- Managing demand fluctuations and the impact of Industrial Action on capacity.

Key dependencies

- Surgical and Diagnostic capacity.
- Front end capacity to see and diagnose patients in a timely manner.
- Demand fluctuations.
- Inter Provider Referrals.
- Industrial Action.

Future actions

- Continue to build on great progress and further refine recovery plans to deliver a sustainable backlog position and to focus on reaching the 62 day performance ambition of 70% (internal) for the Trust in 2024/25.
- To work with system partners on improving performance for patients on a shared pathway.

Responsive

Outpatients New – Percentage of 19/20 Activity

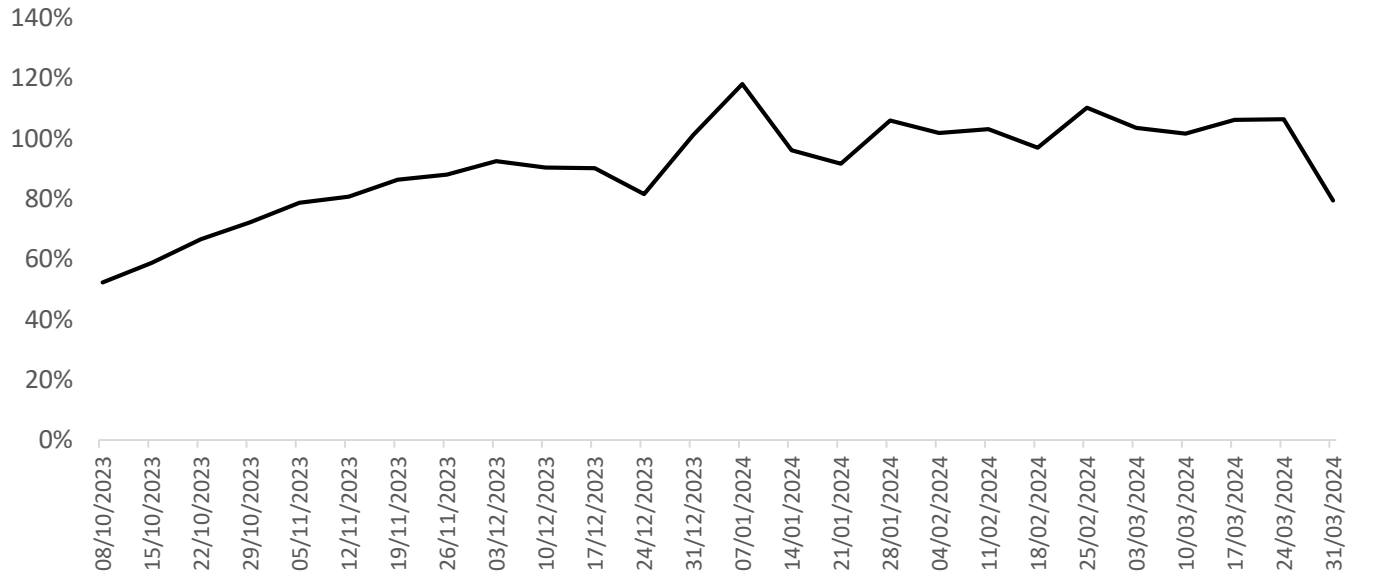
Guy's and St Thomas' NHS Foundation Trust

Week Ending 31st March 4 week avg	Target
99.1%	-

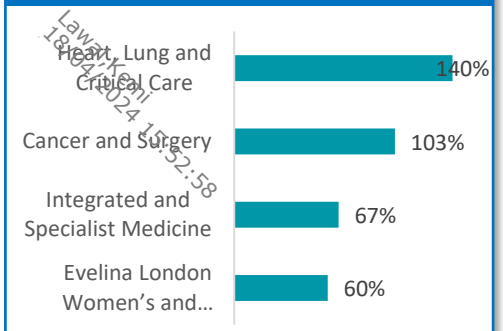
Activity recovery in September to November was impacted by planned reductions as part of the implementation of Epic.

1920 4 week average includes bank holiday in the numerator and not the denominator

Outpatient New – Percentage of 19/20 activity



Clinical Group Overview



Updates since previous month

- Recovering New Outpatient activity to pre-pandemic levels remains a priority for the Trust and in March the Trust recorded New Outpatient activity to be 98.3%.

Current issues

- Developing staff capabilities across the Trust in using EPIC
- Optimise Epic functionality
- Deliver pre-pandemic levels of activity to support the elimination of long waits.
- Improve productivity.

Key dependencies

- Stabilising activity data within Epic.
- Drive Outpatient transformation by delivering more New appointments across the system in comparison to follow ups.
- Optimising EPIC functionality across Clinical Groups.
- Industrial Action.

Future actions

- Provide ongoing support to stabilise and optimise data within Epic.
- Continue to review service recovery plans.
- To focus on delivery of the required 24/25 activity levels as outlined in the Trusts operational plan.

Responsive

Outpatients Follow Up – Percentage of 19/20 Activity

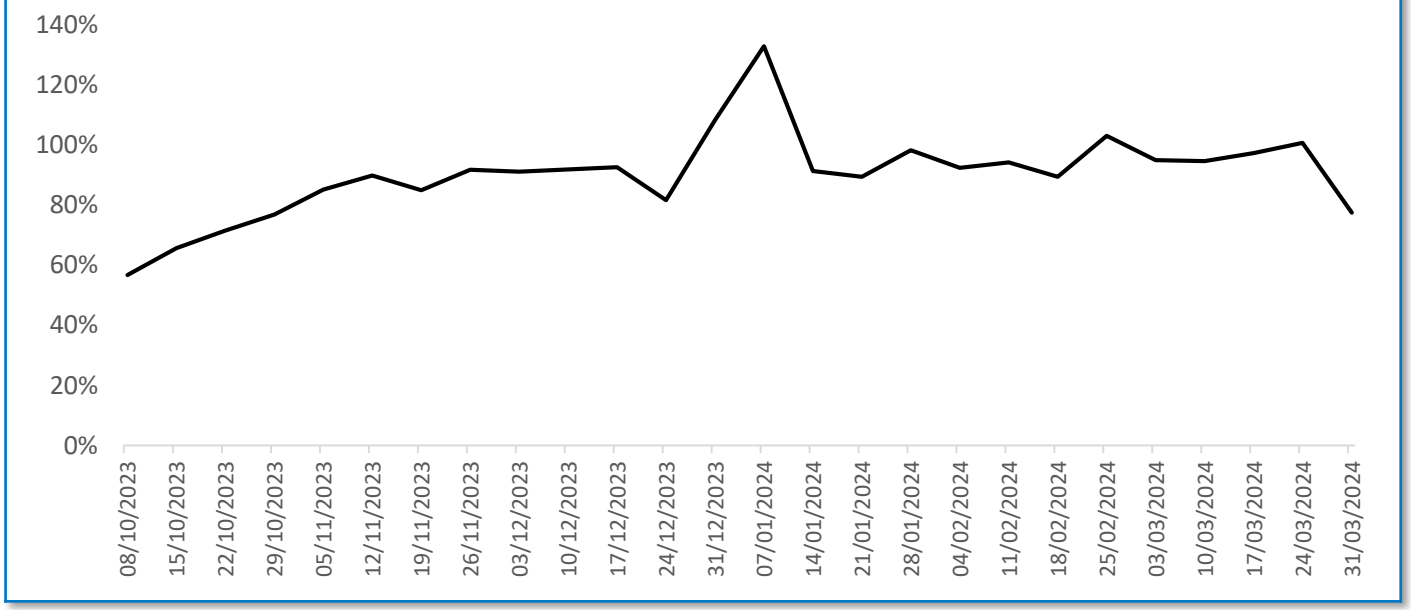
Guy's and St Thomas' NHS Foundation Trust

Week Ending 31st March 4 week avg	Target
93.1%	-

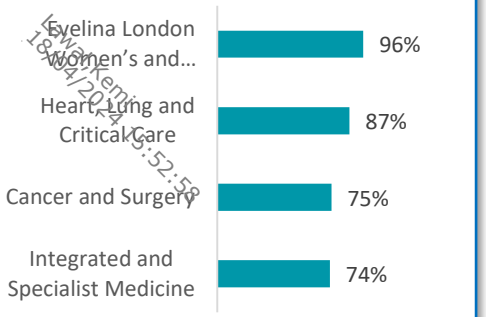
Activity recovery in September to November was impacted by planned reductions as part of the implementation of Epic.

1920 4 week average includes bank holiday in the numerator and not the denominator

Outpatient Follow Up – Percentage of 19/20 activity



Clinical Group Overview



Updates since previous month

- In March the Trust's 4 week average for Outpatient Follow Up activity is 92.4% against 19/20 activity levels.
- The Trust is committed to ensuring more patients receive timely outpatient care and treatment supporting a reduced number of long waiting patients in the Trust.

Current issues

- Developing staff capabilities across the Trust in using EPIC
- Optimise Epic functionality
- Eliminate long waits.
- Improve productivity

Key dependencies

- Stabilising activity data within Epic.
- Driving Outpatient transformation and supporting more patients to transfer to Patient Initiated Follow Up pathways and remote monitoring where clinical risk allows.
- Optimising EPIC functionality across Clinical Groups.

Future actions

- Continue to review service recovery plans
- Provide ongoing support to stabilise and optimise data within Epic.
- Work with system partners to ensure demand is balanced with system capacity to improve patient experience and treatment outcomes

Responsive

Elective Daycase - Percentage of 19/20 Activity

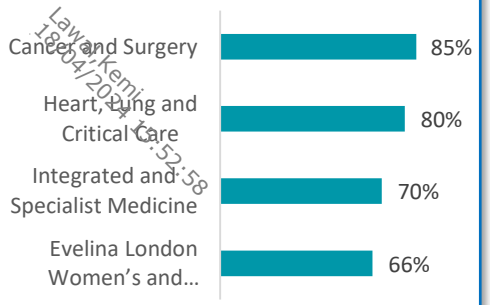
Guy's and St Thomas' NHS Foundation Trust

Week Ending 31st March 4 week avg	Target
89.1%	-

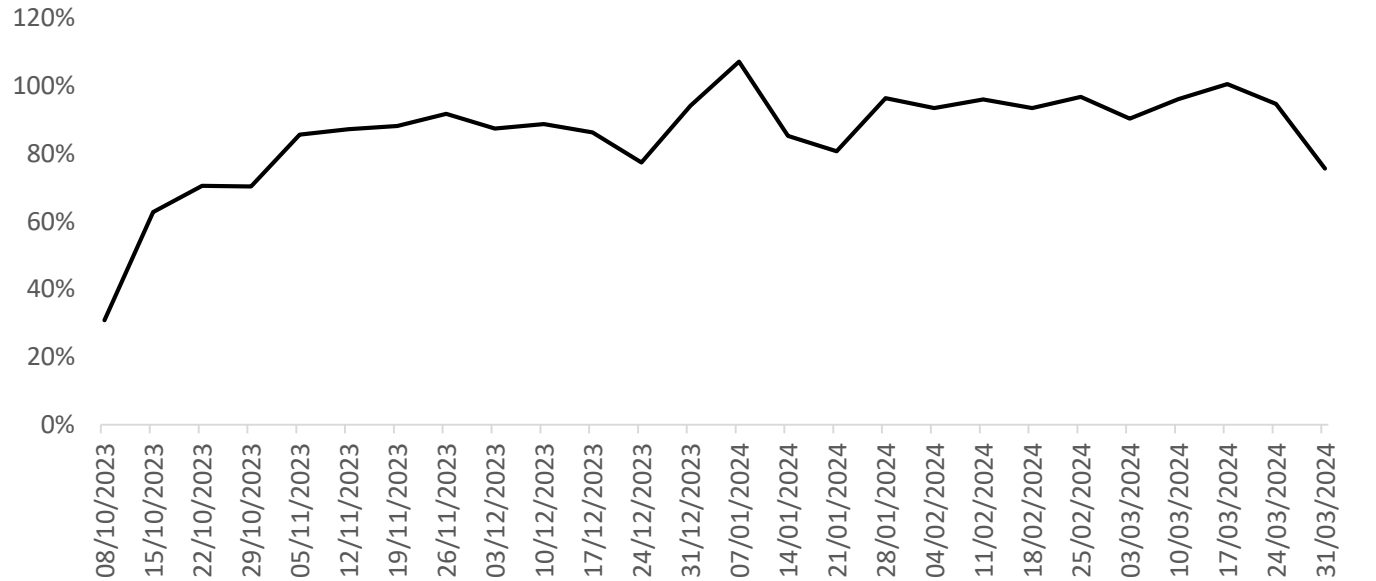
Activity recovery in September to November was impacted by planned reductions as part of the implementation of Epic.

1920 4 week average includes bank holiday in the numerator and not the denominator

Clinical Group Overview



Elective Daycase- Percentage of 19/20 activity



Updates since previous month

- The Trust's 4 week average for Day Case activity levels in March is 91.6% against the 19/20 baseline.
- Recovering to pre-pandemic Day Case activity levels remains a primary focus of the Trust.

Current issues

- Developing staff capabilities across the Trust in using EPIC
- Optimise Epic functionality
- Eliminate long waits.
- Improve productivity.

Key dependencies

- Increasing and protecting diagnostic and surgical capacity.
- Stabilise and optimise Epic data.
- Work with system partners to balance demand and capacity across the ICS through new community based initiatives.
- Industrial Action.
- Surgical capacity and theatre productivity.

Future actions

- Continue to implement GIRFT recommendations across specialities to improve Day Case productivity.
- Continue to review service recovery plans
- Provide ongoing support to stabilise and optimise data within Epic.
- Optimise surgical capacity in the Trust and externally where possible.

Responsive

Elective Overnight - Percentage of 19/20 Activity

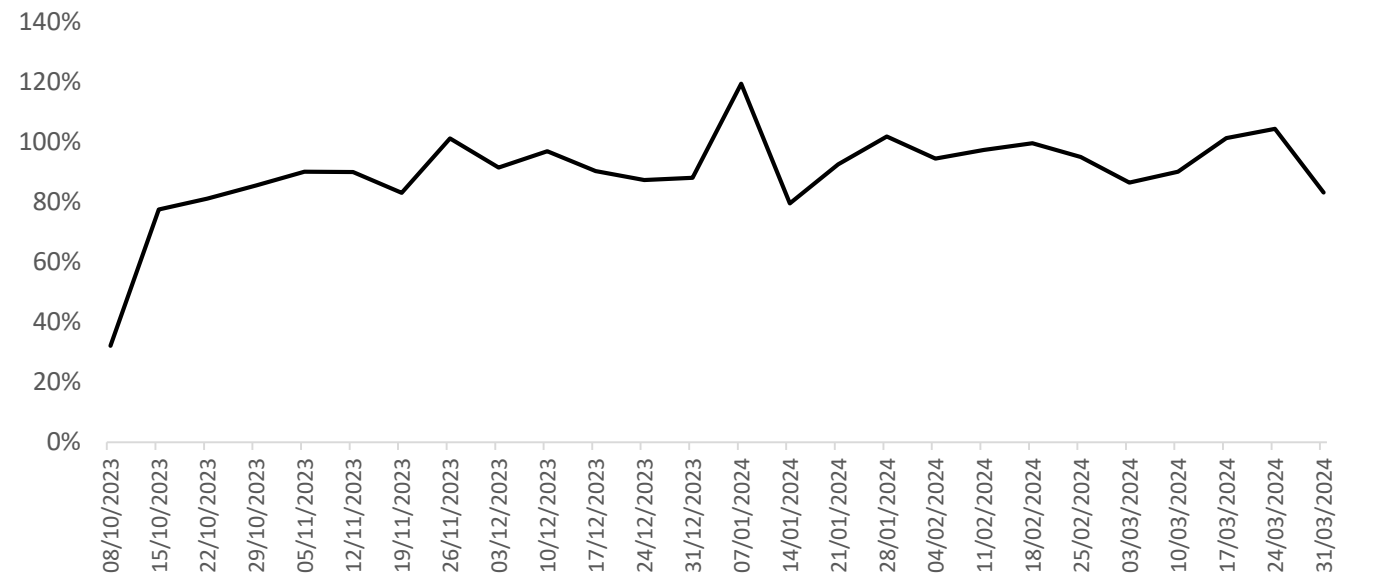
Guy's and St Thomas' NHS Foundation Trust

Week Ending 31st March 4 week avg	Target
88.1%	-

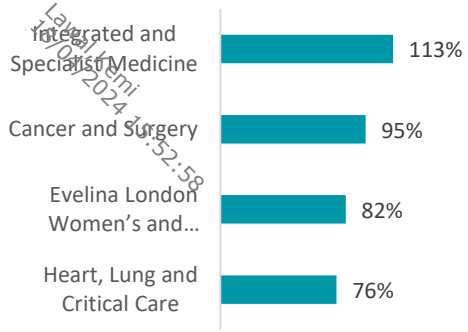
Activity recovery in September to November was impacted by planned reductions as part of the implementation of Epic.

1920 4 week average includes bank holiday in the numerator and not the denominator

Elective Overnight - Percentage of 19/20 activity



Clinical Group Overview



Updates since previous month

- The Trust's 4 week average for Elective Overnight activity levels in March is 94.4% against the 19/20 baseline.

Current issues

- Developing staff capabilities across the Trust in using EPIC
- Optimise Epic functionality.
- Eliminate long waits.
- Improve productivity.
- Improve patient flow.

Key dependencies

- Increasing and protecting diagnostic and surgical capacity.
- Stabilise and optimise Epic data.
- Implement initiatives identified through the Patient Flow workstreams and the Multi Agency Discharge Event in March 2024.

Future actions

- Continue to implement initiatives to improve patient flow.
- Implement recommendations from GIRFT to improve productivity.
- Continue to review service recovery plans
- Provide ongoing support to stabilise and optimise data within Epic.

Responsive

Number of pathways on the waiting list currently waiting more than 65 weeks to start treatment

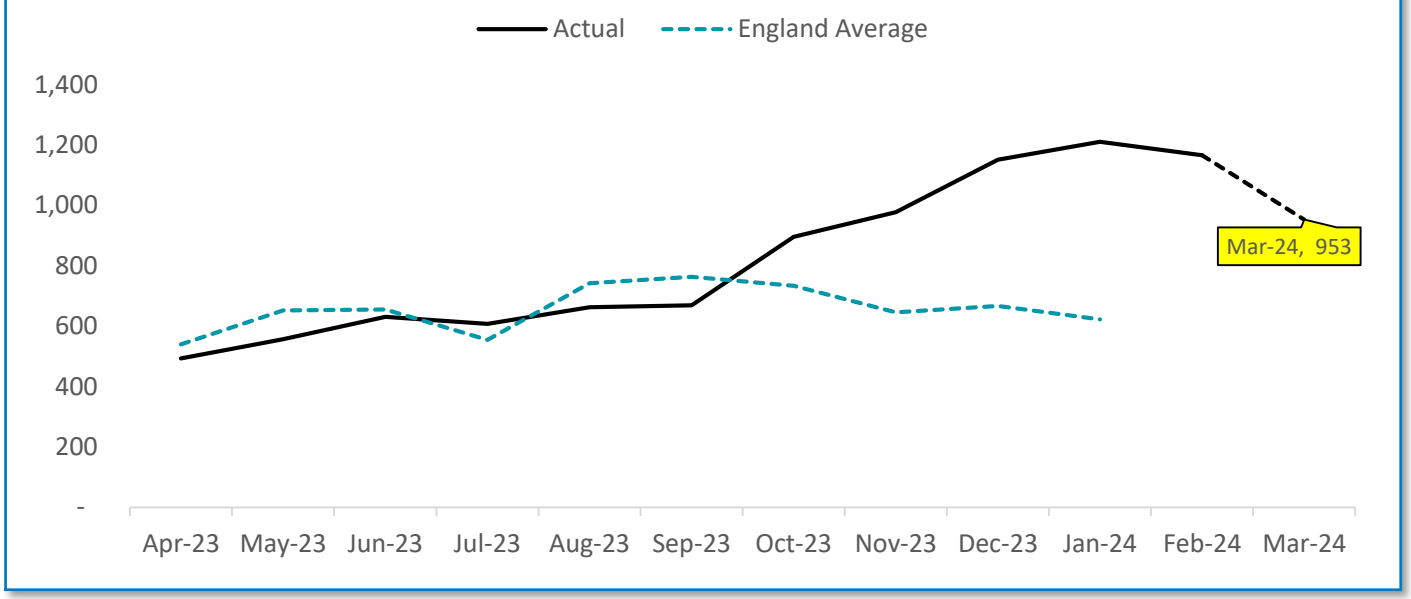
Guy's and St Thomas' NHS Foundation Trust

Feb-24	Target
1,166	-

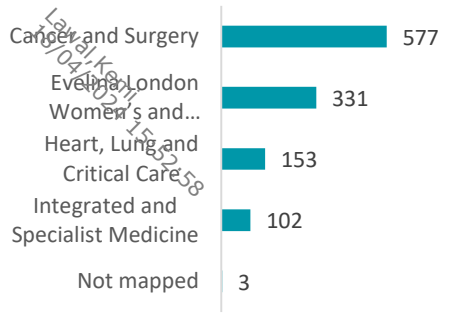
NHS England Benchmarking

Nov-23	Dec-23	Jan-24
645	667	622

RTT - Incomplete pathways over 65weeks



Clinical Group Overview



Updates since previous month

- In February the Trust's submitted position for the number of incomplete pathways over 65 weeks is 1,166.
- This is a reduction of 44 on January's figure and this, alongside the latest weekly submitted position of 953 for March, captures the hard work completed by services in striving to eliminate all 78 week waits by the end of the year alongside work completed in stabilising data within Epic.

Current issues

- Developing staff capabilities across the Trust in using Epic and in turn to fully optimise Epic functionality.
- Activity recovery and productivity.
- Prioritisation alongside cancer and urgent and emergency care.

Key dependencies

- Stabilising Referral-To-Treatment data within Epic.
- Recovering services to pre-pandemic levels of activity.
- Continue to work with system partners on mitigating against areas where demand and/or complexity/acuity is a challenge through mutual aid and any other supporting initiatives
- Limited national capacity for some specialities (Paed Spinal).

Future actions

- Continue to refine service recovery plans to eliminate the number of patients waiting longer than 65 weeks in line with 2024/25 operational planning guidance.
- Ongoing support to stabilise and optimise data within Epic.
- Implement recommendations from GIRFT to improve productivity.

Responsive

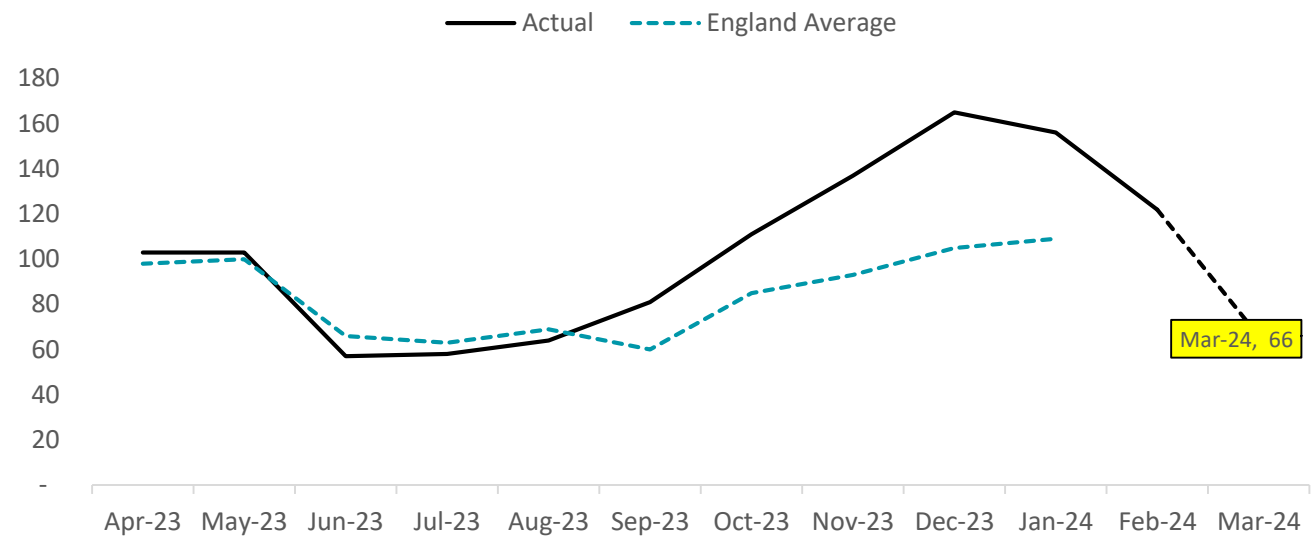
Number of pathways on the waiting list currently waiting more than 78 weeks to start treatment

Guy's and St Thomas' NHS Foundation Trust

Feb-24	Target
122	-

Out of 66 78 week waiters in March 24, 63 are internal patients, 3 are mutual aid patients

RTT - Incomplete pathways over 78weeks



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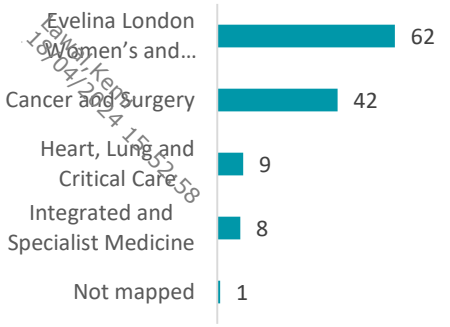

Updates since previous month

- In February the Trust's submitted position for the number of incomplete pathways of over 78 weeks is 122.
- This is a reduction of 34 on January's figure and this, alongside the latest weekly submitted position of 66 for March, captures the hard work completed by services in striving to eliminate all 78 week waits by the end of the year alongside work completed in stabilising data within Epic.

Current issues

- Developing staff capabilities across the Trust in using Epic and in turn to fully optimise Epic functionality.
- Activity recovery and productivity.
- Prioritisation alongside cancer and urgent and emergency care.

Key dependencies

- Stabilising Referral-To-Treatment data within Epic.
- Recovering services to pre-pandemic levels of activity.
- Continue to work with system partners on mitigating against areas where demand and/or complexity/acuity is a challenge through mutual aid and any other supporting initiatives
- Limited national capacity for some specialities (Paed Spinal).

Future actions

- Continue to refine service recovery plans to eliminate the number of patients waiting longer than 65 weeks in line with 2024/25 operational planning guidance.
- Ongoing support to stabilise and optimise data within Epic.
- Implement recommendations from GIRFT to improve productivity.

Supporting Information

SPC definitions

Guy's and St Thomas' NHS Foundation Trust

Statistical Process Control (SPC) charts allow you to identified statistically significant changes in data. The SPC confidence (or process) limits represent the expected range for data points if variation is within the expected limits. A number of rules have been applied in line with the NHSE SPC approach to identify when indicators are showing special variation. Each rule is calculated using the latest month values.

Common cause variation

Indicator has not triggered any SPC rules for current month

Special cause variation – single point

A single point outside the SPC confidence limits (mean +/- 3 sigma)

Special cause variation – trend/shift

A run of 7 points above or below the mean (a shift), or a run of 7 points consecutively ascending/descending (a trend)

Special cause variation – moving range

There is a large change in the moving range (greater than 3.27 & average moving range)

Special cause variation – 2 of 3

2 out of 3 points are within 1 sigma of the upper or lower confidence limit

BOARD OF DIRECTORS
TRANSFORMATION AND MAJOR PROGRAMMES COMMITTEE

Wednesday 07 February 2024, 1pm – 4pm
Robens Suite, Guy's Hospital

Members Present:	Ian Playford – Chair	Simon Friend
	Ian Abbs	Felicity Harvey
	Charles Alexander	Reza Razavi
	Steven Davies	Lawrence Tallon

In attendance:	Gubby Ayida	Sarah Henderson (item 12)
	Simon Bampfylde	Anita Knowles
	Robert Barr (items 10-12)	Leah Mansfield
	Victoria Borwick	Simon Mendy
	Beverley Bryant (items 1-6)	Phil Mitchell
	Ronny Cheung (item 8)	James O'Brien (item 12)
	Sarah Clarke (items 11-16)	Simon Steddon
	Jon Findlay	Tendai Wileman
	Richard Grocott-Mason	Lucy Yasin (minutes)
	Laura Gudefin (item 8)	

1. Welcome and Apologies

1.1. The Chair welcomed colleagues to the Transformation and Major Programmes Board Committee (the Committee). Apologies had been received from Avey Bhatia.

2. Declarations of Interest

2.1. There were no declarations of interest.

3. Minutes of the Previous Meeting (22nd November 2023

3.1. The minutes of the previous meeting of the Committee, held on 22 November 2023, were agreed as an accurate record subject to two amendments to paragraph 13.1. The first amendment was that it was only the possibility that Reinforced Autoclaved Aerated Concrete (RAAC) had been identified at Guy's Boiler House, and it had since been confirmed that there was no RAAC present. The second amendment was to clarify that only accessible aluminium composite panels had been removed from the Cancer Centre. The small number that were categorised as inaccessible remained in place and advice was being sought on whether removal or treatment was required.

4. Matters Arising and review of Action Log

4.1. The action log was reviewed and the following points noted:

- 4.1.1. Action 34 (terms of reference amendments) was closed as the amendments had been made.
- 4.1.2. Actions 35 and 36 (Apollo stabilisation and benefits) were closed as these were on the agenda at item six and regular reports on stabilisation, optimisation and benefits realisation would continue to come to the Committee.
- 4.1.3. Action 39 (Children's hospital programme) was closed as this was agenda item 12.
- 4.1.4. Action 41 (Children's Day Treatment Centre lessons learned) was closed as this was agenda item 12.
- 4.1.5. Action 42 (Key worker accommodation) was closed as an update was provided in the quarterly estates report at agenda item 14.
- 4.1.6. Action 43 (Integrated Trust Operating Model Programme) was closed as this was agenda item seven.

4.2. It was agreed in discussion that the most effective use of Committee time would be aided by increased clarity on the programmes within the Committee's scope, clarity as to original and any replacement benefit realisation areas, with updates on activity and clear ownership and responsibility. Further a review of the quality and coherence of the papers would help this. A degree of standardisation and increased focus on tangible aspects would help both on papers and benefit tracking to ensure there is no cross over on programmes, cost improvement programmes and broader efficiency activity.

5. Board Assurance Framework Risks

5.1. The Committee was reminded of the strategic risks assigned to it on the Board Assurance Framework.

6. Apollo Programme: Stabilisation and benefits realisation

Stabilisation

6.1. The stabilisation work focused on ensuring the underpinning technical and operational outputs delivered fundamental business processes that were effective and efficient to enable benefits realisation. The work was proving more challenging than had been anticipated, with a number of complex and difficult issues to be resolved. It was, therefore, expected that stabilisation work would continue throughout the calendar year. A paper setting out a clear plan for the stabilisation phase, including resourcing requirements and a timetable with clear prioritisation and accountability of the issues to be resolved, was due to be submitted to the Trust Executive Committee the following week.

6.2. Optimisation work would continue in tandem as different parts of the organisation were at different stages.

6.3. The Committee would receive a full report on stabilisation and optimisation for assurance purposes ahead of the next Committee meeting.

ACTION JF

Benefits

6.4. A review of the benefits detailed in the business case for the Apollo Programme was underway as there had been considerable change in the operating environment since approval of the business case. Delivery dates for benefits had also been impacted by the delay to the go live date. As such, a revised benefits baseline, with revised dates, clear categories and accountability was under development.

6.5. The Committee acknowledged that the revised baseline was required given the passage of time and the stabilisation challenges, as these had impacted when and where efficiencies could be made, but noted the quantum of benefits to be delivered over the life of the programme as included in the business case remained.

6.6. The revised baseline would be presented to the Committee at its next meeting.

ACTION JF

6.7. The Committee noted the report.

7. Integration and Trust Operating Model

7.1. The paper provided a review of what had been delivered since the merger with Royal Brompton Hospital and Harefield Hospital in February 2021, and what remained outstanding. Programmes of work had to be aligned with objectives and be part of a clear prioritised plan to deliver all of the remaining requirements. Further, the review recommended that full integration should be an executive objective for 2024/25 to ensure continued focus.

7.2. The Committee requested further clarity on the integration programme and that there was clear accountability at executive level for delivering the tangible outcomes and to what remaining benefit.

ACTION TW

RESOLVED

7.3. The Committee noted progress to date and agreed the recommendation to include integration as an executive objective for 2024/25.

7.4. The Committee noted the intention to stand down the Integrated Trust Operating Model Programme Board and reconstitute it as a Trust Integration Board.

7.5. The Committee endorsed the set of priorities proposed, noting that the clinical academic integration for the cardiovascular speciality was fundamental and a clear strategy to deliver this at pace was required.

8. Transforming ambulatory care – MyChart

8.1. Over 251,000 patients from the Trust and King's College Hospital NHS Foundation Trust had registered on MyChart since its launch as part of the Epic electronic health record system in October 2023. This provided significant opportunity to drive transformation of care and improve patient experience. The Trust was committed to delivering this transformation and there was strong support from the Committee, which was keen for the Trust to push for further progress..

8.2. The Committee noted the report and looked forward to a further discussion, including cost, implementation and how the MyChart portal formed part of the Trust's wider programmes landscape at a future meeting.

ACTION AB

9. Quality management and improvement strategy

9.1. The quality management and improvement content proposed for the Trust's 2030 Strategy was presented. This had been developed on the basis of academic evidence, and provided a single definition of quality across the Trust alongside an organisation-wide quality management system as the systematic way of measuring, planning and implementing quality and quality improvement.

9.2. A detailed overview of the revised approach received strong support from the Committee, which emphasised that careful planning of both communication and implementation would be key to its success. There was discussion about how this approach would inform the way in which the Trusts deals with partnerships.

RESOLVED

9.3. The Committee reviewed and approved the structure of the quality management system as outlined in the paper, and the plans for its development and implementation.

9.4. The Committee supported the inclusion of the revised quality management and improvement approach in the GSTT 2030 strategy which encapsulated the Trust's commitment to continuous improvement.

9.5. The Committee supported the mobilisation of a programme to develop and implement the quality management system, led by the Trust's Centre for Innovation, Transformation and Improvement and Quality and Assurance Directorate, as a continuation of the work already underway, and would review the position, cost and resourcing of this in the wider programmatic review at the next meeting.

10. Capital financing strategy

10.1. The Chief Financial Officer provided an update on the capital financing strategy for the Trust's major capital programmes, and noted that discussions were ongoing with Guy's and St Thomas' Foundation on how the Foundation and Trust could work together to deliver an element of the larger strategic programmes.

11. Capital operating model update

11.1. The Trust's capital portfolio was undergoing a period of significant change due to the difficult capital landscape and delivery challenges of the Trust's capital projects. A review of the capital operating model had been completed and a number of improvement actions identified. There was a strong appetite for change, which needed to be holistic and systemic.

11.2. The next stage was to develop a final and costed structure for the capital portfolio. A strategic discussion on risk appetite to ensure alignment of need and impact, and improvement of the efficiency and effectiveness of the Trust's approach to contracting were necessary.

11.3. The report was noted.

12. Children's hospital programme

Children's hospital programme update (item's 12.1 and 12.4)

12.1. The Committee was asked to approve the recommendation that the strategic outline case for the Children's Hospital Programme be split into two outline business cases (OBCs).

12.2. The first OBC would cover the work required to accommodate paediatric cancer in the event NHS England commissioned these services from Evelina London Children's Hospital. A decision was expected in March 2024.

12.3. The second OBC would be formed of two-parts focused on delivering capacity to meet future demand in the medium-long term, and the longer-term plan for the colocation of children's cardiac, respiratory and intensive care with Evelina London Children's Hospital. A separate workstream was focused on the shorter-term colocation options for children's cardiac, respiratory and intensive care that required minimal capital investment.

12.4. The plans took account of the lessons learned from the Children's Day Treatment Centre and the capital operating model work.

RESOLVED

12.5. The Committee approved the proposed way forward for the Children's Hospital Programme as outlined in the paper.

12.6. The Committee approved the financial envelope for the Children's Hospital Programme, noting the proposed financial management and assurance mechanisms including key decision gateways.

12.7. The Committee noted the risks in respect of potential delays to key decisions.

Children's Day Treatment Centre (CDTC): Lessons learned and benefits realisation (items 12.3 and 12.4)

12.8. There was strong link between the lessons learned from the CDTC and the capital operating model paper at item 11, as the CDTC had formed part of the review. Assurance was provided that the lessons learned had been captured and were being implemented in the approach to the Children's Hospital Programme.

12.9. The benefits for the CDTC were broadly on track and were being monitored through the Children's Hospital Programme and the Evelina executive, as well as by the Committee.

13. Theatres programme update

13.1. The operating theatre productivity programme, which had been paused during Epic implementation, had been relaunched and opportunities to increase productivity to manage delays in cancer treatment were being sought. The Nuffield theatres were progressing and a decant plan was in place.

13.2. The work on a contingency plan to the Guy's Surgical Hub OBC had also been paused owing to the prioritisation of cancer waiting times management, and subject to confirming the impact on bed demand in the potential contingency locations, but was now being progressed.

13.3. It was noted that the Chief Executive of the Cancer and Surgery Clinical Group would be taking over the leadership of the theatres group of the Acute Provider Collaborative (APC) and would progress the APC work focused on operating theatre productivity across the system. Whilst this would not solve fundamental capacity issues, it could be helpful in the near term.

13.4. Work to progress the preferred option of the Guy's Surgical Hub OBC continued. The OBC submission to NHS England was being prepared, and work to secure sector support necessary for the submission, continued.

13.5. The Trust's theatres programme, which included the operating theatre maintenance programme as well as the Guy's Surgical Hub OBC and contingency planning work, currently had no dedicated project management resource. The Committee was clear that operating theatre capacity was a critical aspect of the Trust's ability to deliver and sought assurance that the resource issue was being addressed ahead of the meeting. It was recommended that a regular report on operating theatre productivity by service across the Trust was shared with the Committee to fully manage this and support its role in making the case for investment.

ACTION JF

RESOLVED

13.6. The Committee noted the progress to date, and the progress towards securing sector support. It was requested that a further update be provided at the next meeting to include detail on resourcing of the programme.

ACTION SC

14. Estates quarterly update

14.1. The Committee noted the report and progress on the estates development strategy.

15. TMP Board Assurance Framework

15.1. The Committee agreed that the Apollo 'go live' risk had materialised into an issue that was being tracked through the stabilisation board.

15.2. The other risks were noted.

16. Any other business

16.1. There was no other business.

Guy's and St Thomas' NHS Foundation Trust

GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
BOARD OF DIRECTORS
WEDNESDAY 24 APRIL 2024

Title:	**Documents Signed under Trust Seal, 18 January 2024 to 17 April 2024**
Responsible executive:	**Ian Abbs, Chief Executive**
Paper author:	**Joshua Roles, Senior Business Manager**
Purpose of paper:	For Information
Main strategic priority:	Work with partners where this supports the delivery of common goals
Relevant BAF risk(s):	• N/A
Key issues summary:	• In line with the Trust's Standing Financial Instructions, the Chairman, Charles Alexander and Professor Ian Abbs, Chief Executive are required to sign contract documents on behalf of the Trust, under the Foundation Trust's Seal.
Paper previously presented at:	• N/A
Recommendation(s):	The BOARD is asked to: 1. Note the record of documents signed under Trust Seal.

Guy's and St Thomas' NHS Foundation Trust

GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
BOARD OF DIRECTORS
WEDNESDAY 24 APRIL 2024

1. Introduction

In line with the Trust's Standing Financial Instructions, Professor Ian Abbs, Chief Executive and Charles Alexander, Chairman signed document numbers 1058 to 1064 under the Foundation Trust's Seal during 18 January 2024 to 17 April 2024.

2. Recommendation

The Board is asked to note the record of documents signed under Trust seal.

Number	Description	Date
1058	Dead of Easement relating to electricity cables at Minnie Kidd House, 51a Hazelbourne Road, London (SW12 9NU)	19/02/2024
1059	Lease between GSTT (as landlord) and Select Service Partner UK Limited (as tenant) relating to Premises serving refreshments at Third Floor Evelina Children's Hospital AND Lease between GSTT (as landlord) and Select Service Partner UK Limited (as tenant) relating to Premises serving refreshments at the ground floor entrance of Guy's Hospital.	19/02/2024
1060	Deed of surrender of Part Ground Floor, Block 8, St Thomas' Hospital between (1) South London and Maudsley NHS Foundation Trust and (2) Guy's and St Thomas' Foundation Trust. SLaM had occupied this space for over 10 years to run a fracture clinic.	01/03/2024
1061	Lease between (1) South London and Maudsley NHS Foundation Trust and (2) Guy's and St Thomas' Foundation Trust for the part of First Floor Gassiot House, St Thomas' Hospital in order to create a new fracture clinic space.	01/03/2024

1062	Deed of variation of the Neighbourly Deed dated 16th April 2019 in relation to Chelsea Farmer's Market and 2 Dovehouse Street to relax certain mutual covenants and to discharge the crane oversail licence burdeing the Chelsea Farmer's Market site; and Deed of Covenant - where a lessee of 2 Dovehouse Street is released from its existing deed of covenant and enters into a replacement deed of covenant to comply with the terms of the Neighbourly Deed (as varied).	01/03/2024
1063	NEC4 Engineering and Construction contract between (1) Guy's and St Thomas' Foundation Trust and (2) Marcon Construction Ltd for construction works and design responsibility for the Radiotherapy LINAC replacement project located in the Borough Wing Basement at Guy's Hospital.	01/03/2024
1064	Deed of variation to 79 Wimpole Street, as changes to the lease will allow the landlord to undertake the enabling works required for the new CT scanner.	28/03/2024